

Beyond Abuja: A Primer on Approaches for Timely and Targeted Health Budget Advocacy

Building on the
Tanzanian Experience

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Introduction

Global targets for financial resources for health are well established (see Figure 1). A number of global initiatives stipulate the minimum amount of domestic financial resources governments *should* allocate to health. In either relative or absolute terms, these targets advocate for: sustained increases in public spending for health, increased efforts to garner greater resources for constrained health systems, increased country ownership of health responses, improved health outcomes, and a move toward universal health coverage.

Why financial targets have been ineffective

Despite these targets being well understood and well publicized, few low- and middle-income countries currently meet them, suggesting their limited impact as advocacy tools for domestic public spending on health. For example, most African countries have committed—through the 2001 Abuja Declaration—to spend at least 15 percent of the government’s total budget on health. Of the five countries that achieved the 15 percent target in 2002, none were able to maintain that level of domestic health spending, and between 2002 and 2014, the share of government spending allocated to health decreased in about half of African countries. Only four countries—Ethiopia, the Gambia, Malawi, and Swaziland—were above the Abuja target in 2014 (World Bank, 2016).

Figure 1. International Health Spending Targets

Public spending on health should equal



Sources: OAU, 2001; Savedoff, 2003; Stenberg et al., 2017

Why countries struggle to meet financial targets

There are many reasons countries struggle to meet financial targets. The targets do not reflect a country’s population characteristics, disease burden, health infrastructure, use of services, or costs of service delivery; nor do they convey the potential health and development outcomes associated with increased public spending on health. In short, current financial targets suffer from a lack of contextualization and illustration of impact. As a result, the targets do not appear to resonate strongly with key stakeholders when developing and executing countries’ budgets.

All governments face resource constraints and all sectors must compete for these limited resources.

Current financial targets suffer from a lack of contextualization and illustration of impact. The health sector needs to frame its advocacy for increased public spending on health in terms that are more outcome-oriented, evidence-based, contextualized, and compelling to budgetary decision-makers, particularly in ministries of finance.

There is clear evidence that universal health coverage performance improves as countries increase public spending on health (Jowett et al., 2016). As such, the health sector needs to frame its advocacy for increased public spending on health in terms that are more outcome-oriented, evidence-based, contextualized, and compelling to budgetary decision-makers, particularly in ministries of finance. This requires understanding the underlying political landscape and tailoring approaches to the priorities and political and economic realities in a given country.

Latest targets are more contextualized, but may still have limited value for domestic advocacy

The World Health Organization (WHO) released new financial targets for health spending in July 2017, estimating that low-income countries need to spend \$112 per capita annually (Stenberg et al., 2017), as opposed to the \$86 per capita previously calculated by Chatham House in 2014 (McIntyre and Meheus, 2014). This estimate was calculated from WHO's modeling of the resources required to achieve Sustainable Development Goal (SDG) 3—Healthy Lives and Wellbeing. The analysis took into account country income level and type (e.g., conflict-affected low-income countries were separated from other low-income countries), and resulted in a range of estimates, cautioning against adopting a single target. Compared to previous resource

needs estimates, the analysis increased the number and type of countries included, broadened the scope of costing, and was based on the more ambitious health system goals set out in SDG 3.

The new targets, however, are likely to suffer from similar issues afflicting previous targets. Indeed, WHO advises that cost estimates should not be interpreted as universal spending targets applicable to every country and that spending a certain amount would not necessarily result in a specific outcome. Nevertheless, these lofty targets will undoubtedly be oft-quoted on the international stage. For example, based on the 2017 analysis, WHO advocates that spending an additional \$58 per person on health annually would avert 97 million deaths globally between now and 2030 (WHO, 2017b). As such, like previous targets, the current WHO estimates will likely suffer from a lack of contextualization and practicality, limiting their value for domestic budget advocacy, which ultimately requires a more tailored approach.

The Tanzanian Experience: A Collaboration in Budget Advocacy

The Health Policy Plus (HP+) project, funded by the U.S. Agency for International Development and the U.S. President's Emergency Plan for AIDS Relief, supports domestic budget advocacy for health in Tanzania, working with advocates to frame health spending in more compelling ways. Advocates there have struggled to effectively articulate the health sector's demand for public funding. For the past 10 years, Tanzania's budget allocation to health has averaged around 10.8 percent of total government spending, and since 2011, around 1.8 percent of gross domestic product (GDP) (inclusive of on-budget support to the health basket fund from donors) (Lee et al., 2016).¹ During the fiscal year (FY) 2016/17 budgeting process,

¹ On-budget support refers to donor funding given directly to the recipient country government to be managed and spent through national mechanisms. The health basket fund in Tanzania is a funding mechanism that pools resources from several donors for health. These resources are not earmarked, providing some flexibility in their use. In other countries, this is commonly referred to as a sector-wide approach for health.

advocates called on the Tanzanian Ministry of Finance and Parliament to allocate additional funds to the Ministry of Health, Community Development, Gender, Elderly and Children's (MOHCDGEC) development budget in order to pay down the government's increasing debt to the Medical Supply Division and to increase funding for supply chain management for drugs (HP+, 2016a). Along with this ask, there was broader advocacy by the MOHCDGEC and development partners for the government to at least maintain, and preferably increase, the percentage of total government spending allocated to health (HP+, 2016b).

Results to date

The outcome of this advocacy work was mixed. The FY 2016/17 development budget did include a new allocation of TZ 251.5 billion—largely for the Medical Supply Division and supply chain costs—and in nominal terms, the overall health budget increased. However, the recurrent budget decreased and partially offset the increased allocation to the development budget. Critically, the health budget actually fell as a proportion of total government spending (Lee et al., 2016). This shows a lack of results for the broader advocacy agenda led by the MOHCDGEC and its development partners and may be reflective of some decision-makers viewing health as a relatively lower priority compared to other sectors.

Ongoing challenge

The Tanzanian health sector is persistently underfunded. With current budget allocations, the MOHCDGEC faces significant resource gaps to finance the *Health Sector Strategic Plan, July 2015–2020* (Lee et al., 2016). These gaps will hinder progress toward universal health coverage and reduce the MOHCDGEC's ability to meet the goals outlined in the plan, including improving the quality of primary healthcare; ensuring adequate human resources and supplies in all facilities; and reaching the entire population with key interventions, such as basic and emergency obstetric care (MOHSW, 2015).

The Need for a New Approach

Given the mixed results of the budget advocacy process in Tanzania for FY 2016/17, major changes to the health budget will be unlikely without strong, innovative approaches to budget advocacy. This reality has spurred wider discussion on the need for other frameworks that would better link budget advocacy to the broader development context and health outcomes. The most useful frameworks would formalize advocacy around the budget process, yielding more consistent, positive results for the health sector. With this in mind, HP+ has outlined four potential approaches for budget advocacy that can be used in sequence or in combination across audiences (see Figure 2).

Figure 2: Summary of Budget Advocacy Approaches

Strategic Approaches

Approach 1: Leverage Impending Change in National Income Status

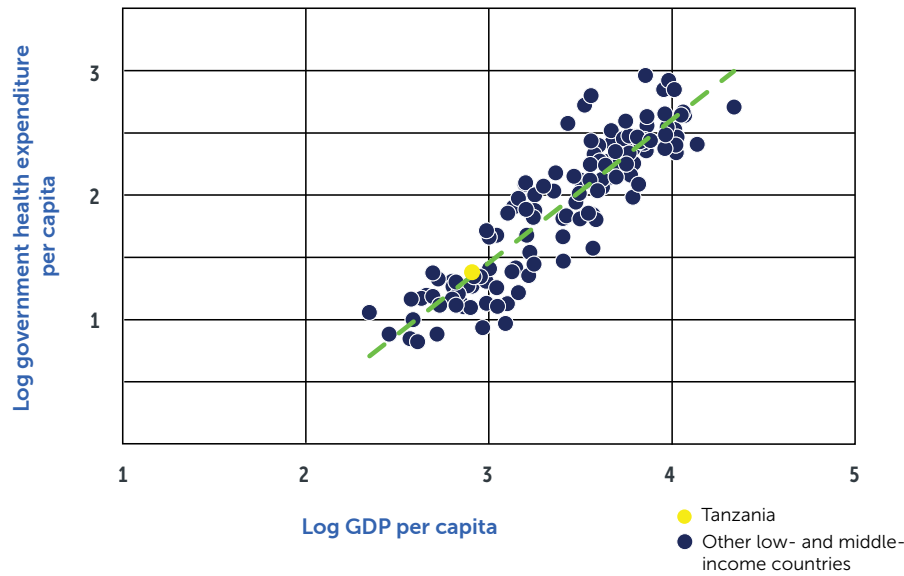
Approach 2: Emphasize National Commitments to Global Targets for Health

Approach 3: Promote Health as an Investment

Process-oriented Approach

Approach 4: Seize Opportunities from Program-based Budgeting

Figure 3: Correlation between GDP and Government Health Expenditure per Capita among Low- and Middle-Income Countries, 2014



Source: WHO, 2017a; World Bank, 2017a

The Underlying Principles of Four New Budget Advocacy Approaches

The approaches outlined in Figure 2 target middle-income countries and countries on the cusp of reaching middle-income status.² Figure 3 displays the strong correlation between increases in GDP per capita and government health expenditure per capita. It does not, however, illustrate a process that will happen regardless of advocacy, nor a relationship that necessarily suggests sufficient funding for health. For increased GDP to translate to greater resources for government spending, governments must effectively assess and collect taxes. In this context, greater tax effort (a measure of how well a country is doing in terms of tax collection, relative to what could be reasonably expected given its economic potential) is critical to ensure that economic gains generate more public resources, which can increase fiscal space for health. However, the empirical evidence suggests that increased tax revenue in isolation does not automatically translate into increased health spending—it requires deliberate action

(Soe-Lin et al., 2015). Further, while health spending may increase in nominal terms (as it has in Tanzania), it may not increase as a proportion of total government spending without intentional, consistent, and effective budget advocacy. Therefore, the goal of HP+'s advocacy approaches is to secure proportionately larger allocations to the health sector in middle-income countries, beyond the expected nominal increases as tax bases grow. The first three approaches focus on informing the underlying argument for increased public spending on health. The final, fourth approach, which makes use of program-based budgeting reforms, is more process-oriented and, in conjunction with the other approaches, builds a more compelling case to allocate additional resources to health.

The three Ts

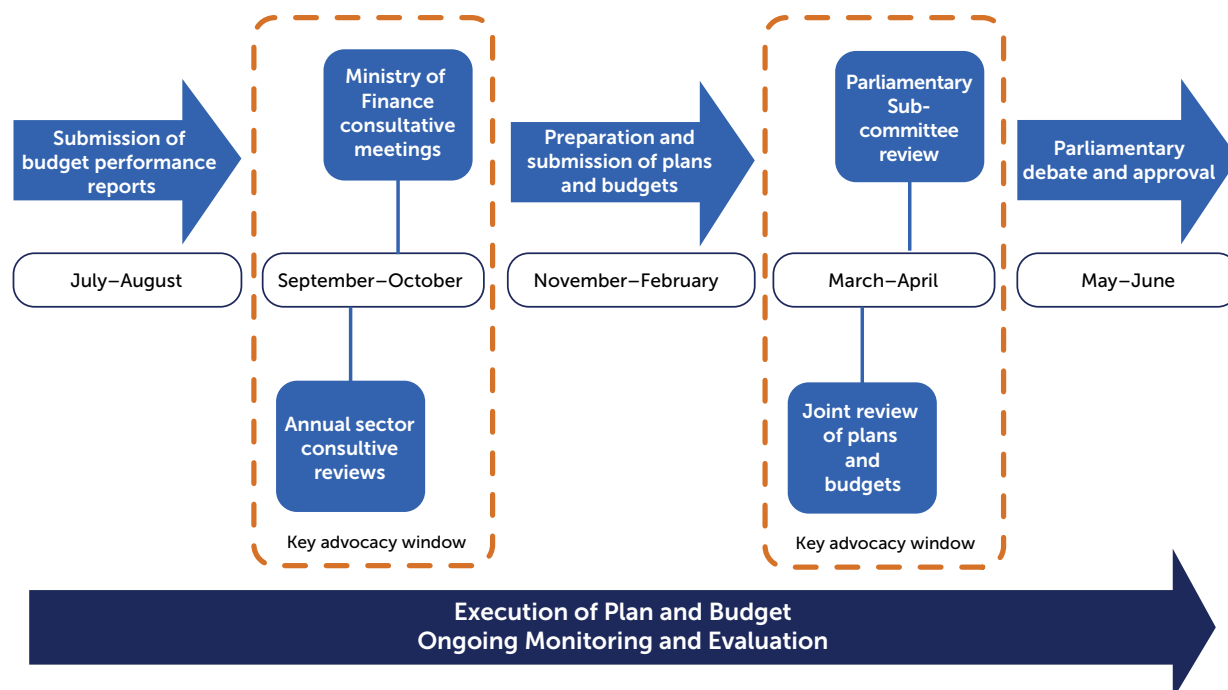
The four approaches are underpinned by three common advocacy principles: *timing*, *targeting*, and *telling*.

TIMING

Timing of budget advocacy is critical to maximize effectiveness regardless of the

² The World Bank defines lower-middle income as countries with gross national income per capita greater than US\$1,025 (World Bank, 2017b).

Figure 4: Tanzania’s Annual Budgetary Process Highlighting Key Windows for Advocacy



underlying argument. In Tanzania, HP+ assisted the MOHCDGEC and development partners to document the annual budgetary process and reveal key advocacy windows (see Figure 4). These time intervals drive the advocacy agenda to ensure messages are delivered when decision-makers are most receptive. Approaches that are more process-driven and analytical may require longer preparation time and more capacity development for advocates. Others may only require the targeted presentation of existing facts to key high-level decision-makers to be effective.

TARGETING

Effective advocacy must also *target* the right audience, whether Ministry of Finance personnel, key “influencers” such as executive office staff, or civil society leaders. In many sub-Saharan African countries, parliamentarians, especially those on key committees, can be a powerful voice for social sector priorities. Each target has unique priorities, political-economic pressure points, and appetites for quantitative or analytical arguments.

Effective budget advocacy will use the appropriate mix of the approaches discussed depending on the intended target.

TELLING

Advocates also need to *tell* a single, compelling story—a unified narrative around the desired change and why it is important for the country, its development agenda, and its citizens. Newly middle-income countries facing declining external support, for example, may see popular sentiment around self-reliance and sustainable development that they can weave throughout advocacy approaches. The approaches discussed here should complement budget advocacy; each may be more or less useful with a specific audience. However, they should all aim to convey a common story around the need for greater public spending on health.

Budget advocacy for public spending in health is only going to become more important as external funds continue to decline and domestic resources become more significant.

APPROACH 1 SUMMARY

Leverage Impending Change in National Income Status

A country's change in income status creates opportunities to promote greater increases in government spending. Budget advocates can use a country's anticipated transition to middle income status to encourage greater domestic allocations to health beyond nominal increases due to increasing GDP.

- Prescriptive policies: Development partner policies mandate increased government funding as part of their co-financing and transition policies for middle-income countries.
- Changing expectations:
 - Citizens' demands for greater self-reliance can encourage governments to increase funding for health beyond donors' requirements.
 - Healthcare demand increases with income levels and governments will need to meet that demand.
 - Civil society often plays a critical role in supporting the health system and governments will need to be able to maintain funding to them as donors phase out.

These approaches are premised on an assumption that the health sector is efficient, making rational allocations, and using available resources to maximize health outcomes for each dollar spent. The approaches also assume that the public sector has sufficient management and system capacity to absorb additional funding for the health sector. We do not underestimate the need for more allocative and technical efficiency and management capacity. However, those efforts are beyond the scope of this brief, which focuses on how the public health sector can make a more compelling case to increase the amount of domestic resources at its disposal.

Approach 1: Leverage Impending Change in National Income Status

As developing countries like Tanzania transition to lower middle-income status, nominal increases in domestic public health spending are likely as GDP grows. A country's change in income status, however, creates two other opportunities to promote even greater increases in government spending on health. The first is prescriptive, directed by international donors through co-financing requirements and transition policies. The second is more citizen-driven and aspirational, based on changing expectations and demands from citizens as a country starts to get richer.

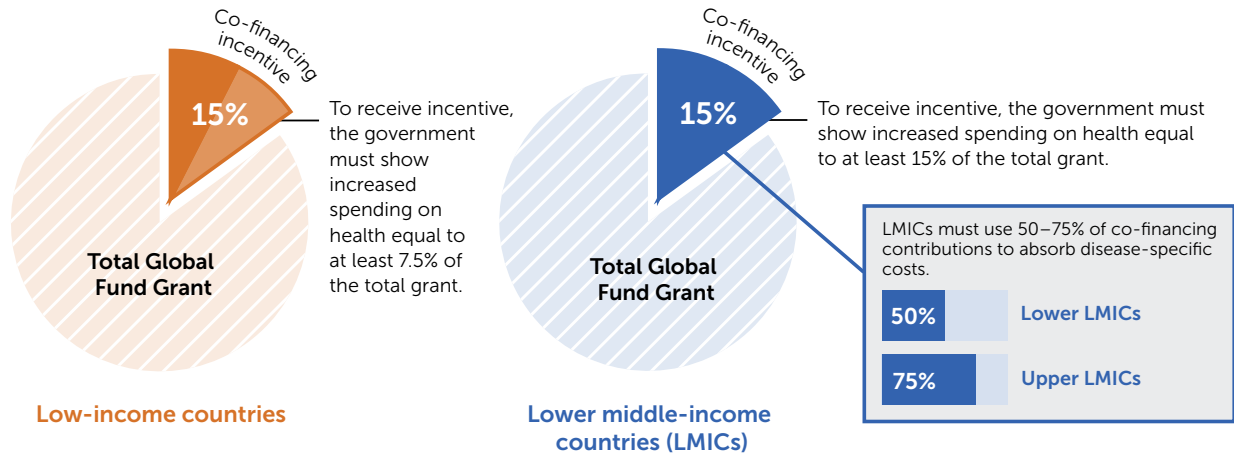
Build on development partner policies

Development partners, like the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) and Gavi, have increasing co-financing requirements as countries' income levels rise. These are explicit, mandatory requirements for future funding allocations. These requirements can have advocacy value as a basis for exhorting greater budgets from ministries of finance, both specifically for the vertical programs the co-financing requirement targets and for health in general.

As signatories to funding agreements, aid-recipient governments are required to increase public funding for health to continue receiving donor funds. The Global Fund's recently updated sustainability, transition, and co-financing policy, for example, includes "co-financing requirements aimed at incentivizing greater domestic resources for health." First, to access allocations, all countries must demonstrate that government spending on health will increase over the implementation period. This is measured as the percentage of total government budget allocated to the health sector each year. Second, at least 15 percent of a country's allocation is held as a co-financing incentive. Depending on income level, countries have progressive requirements to access this portion of the grant. Low-income countries must show increased government spending equal to at least half of this incentive (i.e., 7.5 percent of the entire grant). Middle-income countries have to show increased domestic

Figure 5: Global Fund Co-financing Requirements*

- 1. Government spending on health must increase over the implementation period.
- 2. Governments must increasingly absorb disease-specific program costs.



* Example is based on a 15% co-financing incentive.

commitments at least equal to the entire incentive (15 percent or greater).

The Global Fund policy is also increasingly prescriptive on how countries must spend these commitments, with the intent of encouraging country ownership of disease programs. Low-income countries have no restrictions and can direct increased funding to disease programs or to more general health system spending. Once a country crosses the middle-income threshold however, it must use between 50 and 75 percent of its co-financing requirements to absorb disease specific costs (increasing with income level) (see Figure 5).

This policy is new and being applied for the first time to the Global Fund’s 2017–2019 funding cycle. The effects of these policies remain to be seen, but their impact on health sector spending can be shaped by budget advocates. As such, these new requirements present a critical opportunity for budget advocacy. There is now explicit language requiring increased domestic investments in health, coupled with financial incentives. The requirements for spending on disease-specific programs in middle-income countries increase the likelihood that these domestic requirements will actually represent additional funding for the health system, as it would be

challenging to pull funds from things such as general health spending on human resources, drugs and supplies, and facilities to fund disease-specific programs.

Donors like the Global Fund and Gavi are aligning their sustainability and co-financing policies around the shared objective of increasing domestic resources for health, in particular domestic resources to fund the disease areas they were supporting (Gavi, 2016; Global Fund, 2017). Advocates have a role to play in ensuring the policies are implemented. Advocates must work to understand what the requirements are and exactly what they mean for government spending commitments, so that governments and donors alike can be held accountable. Advocates also have a role as independent observers of the process, to make sure governments adhere to the letter and spirit of the donor co-financing policies and ensure the sustainability of disease responses so that high coverage of services continues even in the absence of external support.

Such concrete requirements from the Global Fund and Gavi have higher likelihood of success in promoting greater government spending as they operate on medium-term timelines and ideally apply a highly

consultative process between donors and aid recipient governments. Further, these requirements are explicitly linked to economic progress in terms of gross national income (GNI) per capita, portraying funding needs in terms that resonate with ministries of finance and other government decision-makers. This relevance to financial decision makers may be augmented by the fact that co-financing policies, like the Global Fund's, make incentive funds contingent on recipient country health spending.

Advocates on their part can use these donor policies, especially during this first funding cycle under the new Global Fund policy, to encourage greater domestic health spending. However, it is important to note that in the long run, this approach may not necessarily increase total funding for the health sector as increased domestic spending for key, donor-funded programs—like HIV or malaria—will at least be partially offset by the decline and eventual cessation of external resources for these health areas.

Recognize potential broader effect

Advocates can leverage these externally-influenced changes for broader effects. Implementing co-financing requirements can give governments experience in funding new areas of commodity procurement or creating social contracting mechanisms to fund services provided by non-governmental organizations (Global Fund, 2017). They can also build confidence in the government's ability to own, fund, and improve key health services. This should be a key focus of advocacy, targeted to Ministry of Health leaders and potentially those within the Ministry of Finance. Highlighting increased co-financing requirements as concomitant with middle-income status, advocates should call for increased government ownership of the health system and improvements in public financial management capacity.

Countries with externally-dependent health sectors that haven't yet reached middle-income status can examine scenarios of how and when

the country's status may change. In response, advocates can develop phased advocacy plans that mirror government strategies to achieve policy, budgetary, and operational targets.

In both current and future middle-income countries, advocates and their advocacy targets should consider domestic financing mechanisms, including innovative or blended financing options, to develop longer-term strategies to increase sustainable domestic health financing. Under this approach, budget advocates can frame government budgetary actions within a story of transition with consistent, multi-year advocacy.

Harness population expectations

Perceptions of rising per capita and aggregate national income are associated with changing expectations around access to, and quality of, public healthcare (Gottret and Schieber, 2006; Jakovljevic and Getzen, 2016). Another common theme, seen in East Africa, is that as countries get richer, they face “so called diseases of affluence,” like hypertension, cardiovascular disease, diabetes, and co-morbidities of obesity (IOM, 2014, p. 24). This epidemiological change that accompanies rising incomes creates a dual burden of disease—infectious diseases and malnutrition are still prevalent, but non-communicable diseases start to rise due to lifestyle changes (IOM, 2014). As a result, there may be citizen expectations that the government will need to invest in the health sector, particularly in preventive and promotive health, to curb harmful trends and meet demand for appropriate health services (Savedoff, 2012).

As countries become wealthier, citizens and civil society may also have growing expectations that governments will fund a greater proportion of the health system with local resources, commensurate with increased local ownership and autonomy. Advocates may be able to use the expectation of greater self-reliance to encourage decision-makers to increase domestic resources for externally-funded programs in advance of mandated increases in funding requirements.

For example, Gavi notes that both Rwanda and Sierra Leone have contributed more than is required under their stipulated co-financing requirements and are thus progressing more rapidly toward country ownership of their immunization programs (Gavi, 2017). Advocates can harness these changing expectations and the positive effects of increased country ownership to target key thought leaders, influencers, and senior government figures to push for greater allocations to health, potentially increasing total resources available rather than just offsetting declining external funding.

Approach 2: Emphasize National Commitments to Global Targets for Health

Harness normative power of global commitments

As often reported in the media, most developing countries have committed to meeting global health outcomes or health sector targets. These public commitments offer a distinct opportunity for budget advocates; one that is often not fully leveraged. Governments endorse these goals on the global stage, but may not follow-through nationally.

However, development commitments like the past Millennium Development Goals and current SDGs have significant normative power if properly applied within a local narrative and targeted to the right audiences. Raising these commitments in the context of a unified story for increased domestic spending can be useful in holding governments accountable to committing the necessary funds to achieve the targets. International development targets may be a more effective tool than domestic targets in holding governments accountable. Domestic targets are set, implemented, and monitored by ministries of health, while with international targets there is greater scrutiny and visibility on government's progress toward meeting them and hence greater reputational risk for failing to do so. However, using international commitments to hold government accountable for mobilizing resources for health can be challenging if stakeholders and decision-makers in-country do not fully accept the proposed targets; a possibility if the targets are considered externally imposed.

Distinguish from financial targets

International financial targets, like the Abuja Declaration, that were also publicly signed and promoted, should prompt government action on the basis that they carry the same reputational risk. However, they may differ from more recent development commitments in that financial targets appear more arbitrary and are not easy to relate to current priorities or outcomes. International health and development targets expressed in tangible outcomes

APPROACH 2 SUMMARY

Emphasize National Commitments to Global Targets for Health

Global targets for health are highly publicized and have normative power and reputational risk associated with not meeting them.

- Represents a means to hold governments accountable to committing the resources necessary to reach agreed upon targets
- Prioritizes the most relevant health outcomes for achieving universal health coverage
- Requires identifying and monitoring intermediate outcomes
- Promotes multi-year targeted advocacy toward established targets

can connect better with advocates and their target audiences. For example, mortality rate reductions resonate with health advocates, but also government decision-makers, and perhaps more importantly, the population at large. Such global targets for health are more likely to resonate with a broader range of domestic decision-makers and stakeholders than traditional Abuja-style financial targets.

Operationalize international commitments into domestic budgets

A challenge for advocates is how to translate international commitments into an operational budgetary ask for an increased annual allocation for health. Achieving a target may require the government to prioritize the health interventions or system strengthening actions that have been proven to be most cost-effective. The ability to act on these prioritized issues can be framed within the capacity and purview of the government in an aspirational middle-income country focused on self-sufficiency. Advocates should work to ensure that basic budget-line items are maintained so that the money allocated for prioritized interventions—needed to reach these targets—represents new resources for the health sector.

Timing and targeting of advocacy efforts around this approach require advocates to link budgetary process with those public sector activities that affect intermediate outcomes, which contribute toward longer-term health targets.

Set intermediary outcomes toward tangible progress

The SDGs, for example, include a target maternal mortality rate of 70 deaths per 100,000 births. Advocating for increased investment to prevent maternal mortality, however, can seem daunting for decision-makers and intangible on an annual basis (in line with budgetary cycles). Instead, increased investment in interventions known to improve maternal health, such as increasing the number of pregnant women who attend at least four antenatal care visits and have deliveries assisted by a skilled birth

attendant, may be easier to communicate in terms of budgetary needs (such as for human resource requirements, training, equipment and supplies, and improved infrastructure). These intermediate interventions and actions may more clearly demonstrate progress, though ministries of health will need mechanisms to collect substantial amounts of data to track annual progress and spending impact. This approach allows for tangible progress to be measured against well-established development targets and promotes accountability. With long-term targets, such as the health-related SDGs, it allows for consistent, multi-year advocacy.

Approach 3: Promote Health as an Investment

Identify returns on investment in health

Advocates need to tell overarching, broad narratives around the need for increased spending on health. There is strong evidence that health is a sound investment for government resources and this narrative ties in with both changes in income status and international agreements. Improvements in population health provide social and economic returns several fold the initial investment (Jamison et al., 2013). Ministries of health and other advocates can build the case for increased public funding for health based on the benefits from a healthier population, which benefit other sectors as well. Of particular significance to governments and ministries of finance, improved population health increases GDP. From 1970–2000, reductions in mortality accounted for 11 percent of GDP growth in low- and middle-income countries (Jamison et al., 2013). Healthy adults are more productive workers and healthy children stay in school longer, develop and perform better, and ultimately earn more. Figure 6 illustrates some of the pathways through which health contributes to GDP growth.

This empirical base can be used to develop strong health investment cases—supported

by success stories from other countries—and a growing body of evidence on the economic returns from investing in health (Jamison et al., 2013; Stenberg et al., 2014). Budget advocates can tailor these cases to the local context and illustrate how increased public spending on health will achieve these potential returns.

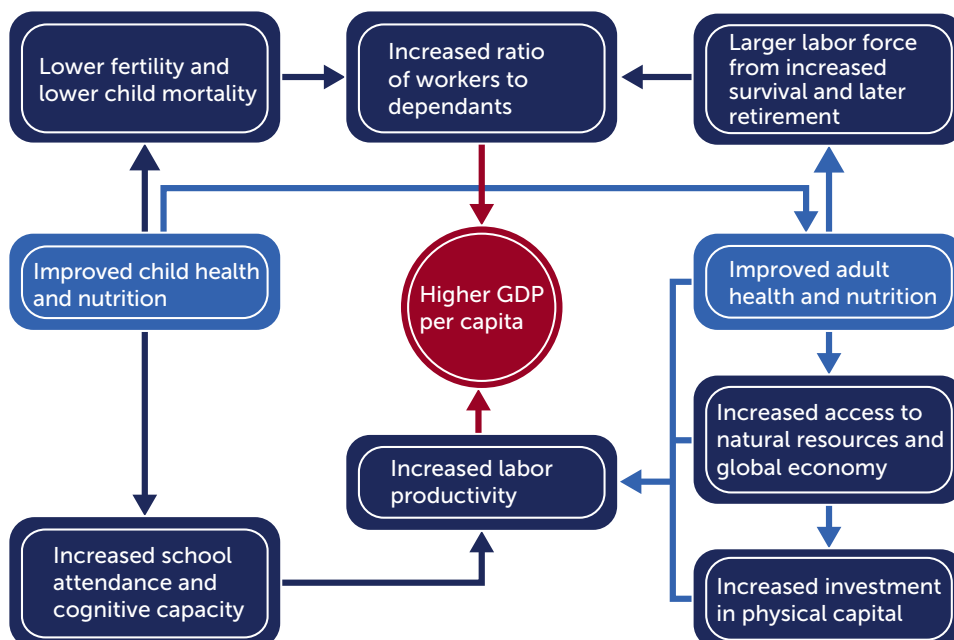
This approach reframes government spending on health, including on public health worker wages and benefits, as an investment rather than as a cost. It directly links health to broader development outcomes and articulates health funding in terms that resonate with financial decision-makers—economic growth and returns on investment. An important nuance is that the economic payoff from investing in health is mostly realized in the long term (particularly for preventive and promotive health, child health, and public health efforts) though some are quite immediate (e.g., a reduction in sick days increases labor productivity). The challenge facing budget advocates is to accurately quantify these short- and longer-term benefits to support a cogent argument of increased budget asks.

Compare returns across sectors

As a first step, budget advocates could focus on the benefits of investments in health resulting from a healthier population. In time, and as the availability and quality of evidence and sophistication of analysis increase, advocates can highlight the benefits of investments in health, relative to investments in other sectors.

This approach frames health spending in a way that makes it comparable with spending for other social sectors, like education,

Figure 6: Links between Health and per Capita GDP



Recreated from: Jamison et al., 2013

APPROACH 3 SUMMARY

Promote Health as an Investment

Beyond the social benefits of improved health and reduced mortality, health spending creates economic returns. This reframes health as an investment that benefits the economy and other sectors in terms that resonate with ministries of finance. Budget advocates should quantify the benefits of increased health spending on:

- Increased workforce participation
- Improved worker productivity
- Lowered dependency ratios (healthy people live longer, retire later, and have fewer children)
- Enhanced child health, growth, and nutrition
- Improved educational attainment
- Increased savings and investment

as directly related to future employment and earnings. It could also be extended to the non-social sectors by demonstrating how, for example, health spending may be comparable to investing in long-term, large-scale infrastructure, as both support economic development and future growth in GDP. This could be particularly effective for targeting ministries of finance as they decide on annual budget allocations and to inform their prioritization of health within a limited resource envelope.

Approach 4: Seize Opportunities from Program-based Budgeting

Traditional line-item government budget structures pose significant challenges to better budget advocacy. They resist linkages to outcomes as well as to overall narratives of national improvement or tracking progress toward international goals. Program-based budgeting frames the entire budget process in terms of specific activities that lead toward desired outcomes and creates new opportunities for advocates to make their case. This more process-oriented approach is intended to be used in conjunction with the other three, which provide the underlying advocacy arguments.

Over 80 percent of African countries are introducing, or are committed to introducing, some form of program-based budgeting, though progress is incremental (see Figure 7) (Worthington and Lienert, 2013). Program-based budgeting is a government-wide reform that reframes the budgeting process from being line item and input based (salaries, equipment, etc.) to a process driven by strategic priorities, planned interventions, and desired results for the budget period. These priorities, interventions, and results are often born out of health sector strategic plans.

Demonstrate value for money

Program-based budgeting can improve budget advocacy efforts by providing succinct and prioritized asks accompanied by granular

planning and costing data. It demonstrates what the Ministry of Finance is receiving for its investment in each program area, rather than quantifying inputs based on use without linking them to objectives or intended outcomes.

Program-based budgeting requires ministries of health to choose targets, identify and cost the activities and inputs necessary to reach them, and then request funding accordingly by each program area. Such a system makes it considerably easier for health advocates—within ministries of health or outside—to better articulate requests to decision-makers. This approach can allow ministries of health to demonstrate they have the planning, budgeting, monitoring, and reporting capacity necessary to effectively use increased allocations. In this way, program-based budgeting is far more compelling to ministries of finance than line-item budgets.

Prepare for the long haul of reform

Implementing a program-based budgeting system may require significant effort and investment by a ministry of health. The ministry may need to build a system with the necessary data collection, costing, monitoring, and reporting capacity. Demonstrating results with such data is critical for securing the same or increased level of allocation in the following years. Program-based budgeting reforms, therefore, require a favorable service delivery, monitoring, regulatory, and political environment and are an ineffective reform to implement in isolation.

Implementing reforms for program-based budgeting will likely take several years and advocates must be prepared for this. All the benefits of program-based budgeting may not be immediately apparent. Mauritius, considered a program-based budgeting success story in Africa, is lauded for rapid implementation of the reform. However, it still spent nine years from pilot to implementation (2003 to 2011). While budget formulation processes usually improve markedly from the outset of implementation, budget execution

Figure 7: Status of Implementation of Program-based Budgeting (PBB) Reforms as of 2012



Recreated from: Worthington and Lienert, 2013

and accountability for annual performance often take several budget cycles to improve. Budget advocates have a critical role to play at every step of the budgetary process to promote consistent, positive feedback to key decision-makers in ministries of finance (see Figure 8).

Before You Begin: Conduct a Stakeholder Analysis

The three strategic approaches, combined with the fourth process-oriented program-based budgeting approach, are intended to give budget advocates a range of options from which to customize a long-term budget advocacy agenda. The agenda should take into account a country's context and be rooted in the three Ts framework:

- Time advocacy opportunities
- Target advocacy to the audience
- Tell a consistent and compelling narrative

With this in mind, a useful exercise to help facilitate budget advocacy planning is for budget advocates—from development

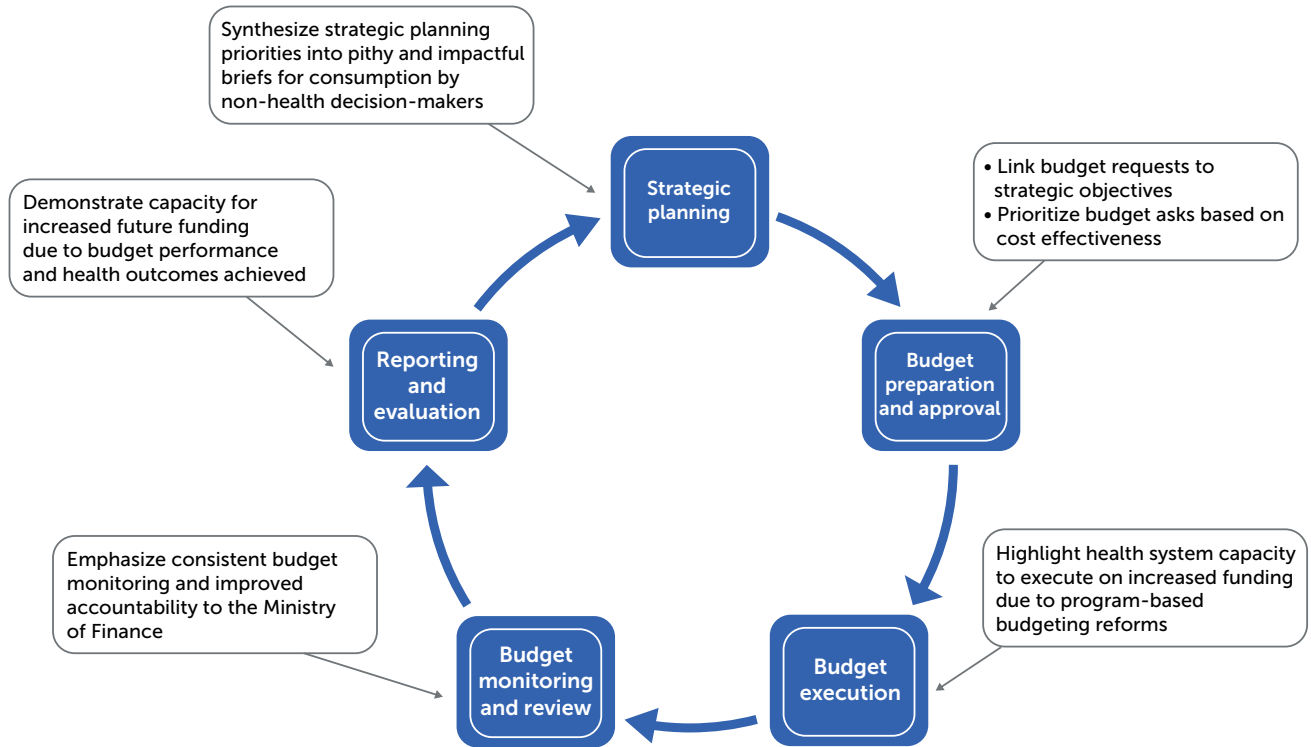
APPROACH 4 SUMMARY

Seize Opportunities for Program-based Budgeting

Program-based budgeting is driven by a focus on funding activities that lead to desired health outcomes. It enables ministries of health to improve their capacity to plan, budget, execute, monitor, and report accordingly—and manage more funds.

- Uses granular planning and costing data to support advocacy efforts
- Links funding provided for each health program to objectives and outcomes
- Budget advocates play a critical role at every step of the process

Figure 8: Role of Advocates throughout the Program-Based Budgeting Cycle



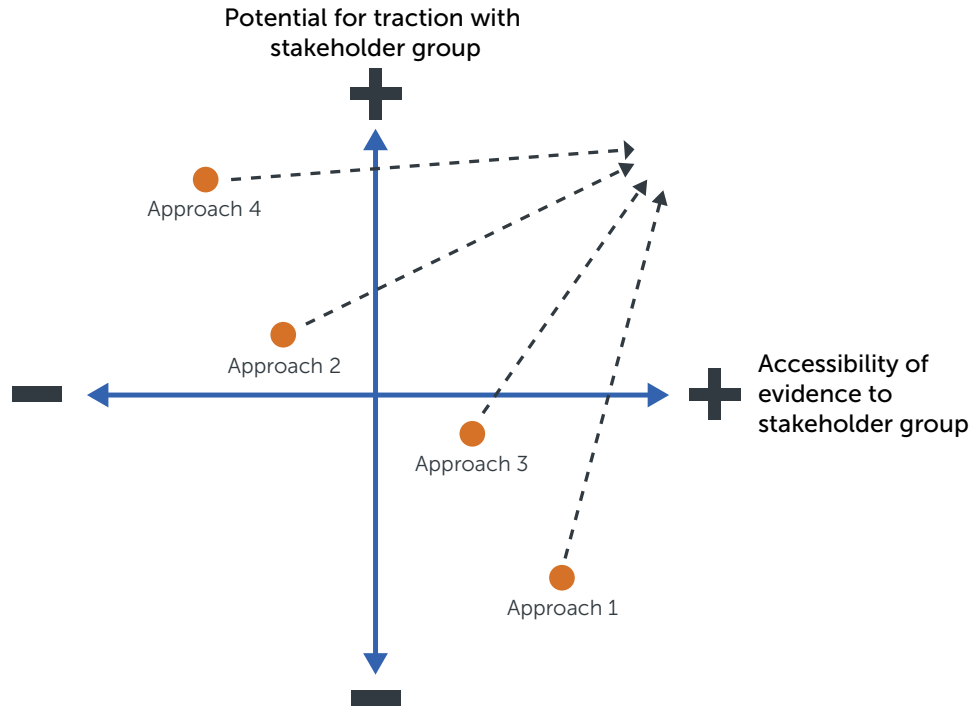
partners, civil society, and the health sector—to conduct stakeholder analyses. For each target stakeholder group, advocates should evaluate each of the four approaches based on: 1) accessibility of the evidence, and 2) potential relevance for the advocacy target. The value of each approach will vary by audience and advocates should think of each of criteria along a spectrum. Figure 9 offers an illustrative example of how such as stakeholder analysis might be conducted.

Each of the four approaches requires evidence of varying degrees of complexity. The rationale and potential effectiveness of each approach needs to be carefully considered in light of the intended advocacy target. For example, to advocate for health as an investment (Approach 3) will require an intensive effort to obtain and analyze data relevant to the local context. The data will also need to be distilled in a way that will resonate with different stakeholder groups. Program-based budgeting (Approach 4), on the other hand, may turn out to be a more effective starting point for budget

advocacy with certain stakeholder groups because the stakeholders are familiar with the evidence base and receptive to the approach.

Similarly, it is important to consider the potential for traction with each stakeholder group. Traction will depend on the stakeholder group's political priorities, sector experience, and other internal and external influences. After conducting a stakeholder analysis, advocates should start with the approaches that are in the top-right quadrant—those that have higher traction and are viewed by stakeholders as having more accessible evidence to back them. At the same time, advocates should begin a parallel process to try to move those approaches that have lower traction and that stakeholders view as less accessible to a more acceptable place. As evidence for those lower ranked approaches becomes more accessible and stakeholders' appetite for the approaches grows, advocates can consider adding them to their long-term advocacy strategy.

Figure 9: Illustrative Stakeholder Analysis for Budget Advocacy*



* Actual plotting of approaches depends on the context and would be different for each stakeholder considered.

Conclusion

We are entering an era of structural reform in health financing in many low- and middle-income countries. Countries and development partners are exploring new health financing reforms including rolling out social or national health insurance schemes and performance-based financing mechanisms. However, government health budgets will continue to play a dominant role in funding national health systems. Budget advocacy for public spending in health is only going to become more important as external funds continue to decline and domestic resources become more substantial. Our hope is that the approaches described here, strategically timed and targeted to key stakeholders, provide a useful conceptualization for budget advocates to make a compelling case for increasing public spending on health in an evolving health financing landscape.

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