Center for Global Development

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From Overall Fiscal Space to Budgetary Space for Health: Connecting Public Financial Management to Resource Mobilization in the Era of COVID-19

Hélène Barroy and Sanjeev Gupta

Abstract

This paper advances the concept of budgetary space for health, which explores resources available for health that are generated through higher public expenditure, better budget allocations, and through improved public financial management (PFM). The budget decomposition approach presented in the paper provides insight into the extent to which each factor drives expansion in budgetary space for health. The approach is applied to 133 low- and middle-income countries (LMICs) between 2000–2017 and finds that around 70% of budgetary space for health is driven by changes in overall public expenditure, while about 30% is directly attributable to the share of the budget allocated to health. Further, PFM improvements can maximize or even enlarge budgetary space for health. A key implication of the analysis is that health policymakers should systematically link PFM reforms to budgetary space for health by supporting comprehensive country assessments and by enhancing the effectiveness of budget dialogue between finance and health authorities.

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Key policy messages

1. Ministries of finance play an important role in creating budgetary space for health— fiscal decisions made by finance ministries drive 70% of funding.

2. Health ministries play an equally important role—effective engagement in the budgeting process can provide up to 30% of budgetary space for health, on average.

3. Health policymakers should expand revenue discussions to include public financial management (PFM), paying special attention to the importance of strengthening budget allocation and execution to expand budgetary space for health.

4. Strengthening PFM is arguably one of the most effective approaches to maximize existing budgetary space for health; the approach is especially critical given the revenue constraints expected in the COVID-19 era.

5. Four key PFM-related interventions have been shown to enhance budgetary space for health: (i) reducing unnecessary spending by exploring flexible budget structures (ii) influencing budget allocation decisions through a results-based approach to budget negotiation; (iii) reducing unused revenues by working towards full budget execution; and (iv) shaping future allocations through good budget performance.

I. Introduction

The United Nations Millennium Declaration and its Millennium Development Goals (MDGs) galvanized efforts by world leaders to meet the needs of those most in need. In the years immediately after the goals were adopted, there was global interest in financing accelerated progress towards the MDGs. During this time, the idea of creating space for priority public spending within a country's fiscal landscape attracted widespread attention. In a paper published in 2005, economist Peter Heller, who worked at the International Monetary Fund, defined fiscal space as "the availability of budgetary room that allows a government to provide resources for a desired purpose without any prejudice to the sustainability of a government's financial position" [1].

A year later, Heller explored the concept of fiscal space specifically for the health sector. In a seminal paper published in *Health, Policy and Planning*, he identified five opportunities to expand fiscal space for health: (i) raising revenue; (ii) reprioritizing expenditure; (iii) borrowing; (iv) using seigniorage[1]; and (v) mobilizing external grants [2]. In 2010, this concept was further refined by the World Bank, which identified five pillars for fiscal space for health expansion in low- and middle-income countries (LMICs): (i) economic growth; (ii) budget prioritization; (iii) earmarking of certain revenues; (iv) improved efficiency of spending in health; and (v) external resources [3].

When comparing Heller's framework to the five World Bank pillars, key differences arise. First, the World Bank framework focuses on economic growth as a macrofiscal driver for a health budget, while Heller's approach targets revenues. Second, the World Bank framework includes earmarked funds, such as social health insurance contributions or public health taxes, while excluding seigniorage as a possible revenue source. Third, the two approaches have a different understanding of budget reprioritization. In Heller's approach, budget reprioritization is intrinsically linked to improved efficiency of spending—where funds are re-prioritized across sectors and policy areas when same outputs can be obtained with fewer resources. By contrast, budget reprioritization in Tandon and Cashin's framework implies increasing the share of the budget allocated to health, irrespective of other considerations. Despite these differences between the two approaches, the overall framing of the concept is broadly similar, and hereinafter we refer to both Heller and Tandon and Cashin's approaches as the "initial framework", in line with the common usage in the empirical literature.

The development of the initial framework marked a significant conceptual advancement in health financing, by situating health reforms within a broader macrofiscal context. This helped to deepen the understanding of macrofiscal realities within the health community. Empirical studies in about 40 countries since the development of the framework have shown that the macrofiscal performance of an economy is often an important consideration behind rising budget allocations for health. There is further evidence to suggest that increasing the share of budget dedicated to health has the potential to significantly expand health sector

[1] Seigniorage is the difference between the face value of money and the cost to produce it and may be counted as revenue for a government when the money it creates is worth more than it costs to produce.

resources and that earmarked revenues provide relatively fewer resources overall for the health sector [4, 5]. While studies have identified measures to improve efficiency in health spending, such as reducing ghost workers, negotiating drug prices, and refining provider payment mechanisms, there is limited evidence on whether the resulting cost-savings are redeployed within health sector budgets and they actually translate into more resources for health.[2]

These same studies have also exposed important gaps in understanding. There has been significant variation in how the concept of "fiscal space for health" was interpreted and assessed in the empirical work. From a methodological perspective, the absence of commonly agreed metrics to estimate "fiscal space for health" resulted in variations and inconsistencies in the analytical approaches used [4, 6]. It also led to the use of subjective assessments in many cases, with limited consideration of political economy and a lack of alignment with current budgeting processes. These factors likely have an impact on the level of influence that assessments have on a country's budgetary decisions. An additional point to note is that there has been a proliferation of global or country studies looking at fiscal space from a specific health angle, whether this be for disease-based purposes such as a fiscal space analysis for HIV/AIDS or malaria programmes [7, 8], or for certain inputs, such as human resources for health, or sub-groups in health (e.g. children) [9]. This has led to segmentation of the thinking around fiscal space in the sector, fragmented discourses between finance and health officials, as well as a disproportionate focus on additional resources with little consideration on how better use of existing budget allocations can generate space for health budgets.

Fifteen years after Heller first introduced the concept, there is a growing consensus in the health financing community around the need for a more harmonized and consistent approach to "fiscal space for health" [10]. This is in large part due to major changes in the macrofiscal and health financing landscapes over the past fifteen years. The adoption of the 2030 Development Agenda and its Sustainable Development Goals (SDGs) in 2015 put an increased focus on domestic public resources [11] and how countries could meet the financing requirements for UHC [12–14]. This spurred interest in more systematic ways to align domestic budgets with financing requirements [15], through both revenue generation and public financial management (PFM) [16–18]. Increasingly, "fiscal space for health" is not viewed as solely a question of finding additional revenues. Space for health sector's budget is also seen as potentially deriving from improved financial management policies in the health sector.

In addition, with a massive impact on the macrofiscal landscape [19], the COVID-19 crisis has reinforced the need for health authorities to have a more informed and effective engagement in budgeting processes to secure adequate funding for both COVID-19 purposes and other essential health services [20]. In a context of overall revenue contraction,

[2] The efficiency frontier studies show that the scope for enhancing efficiency of public spending on health is immense not only in developing countries but also in advanced economies [24–27]. The difficulty in translating these inefficiencies into additional resources is a reflection of political and institutional constraints facing the health sector.

more allocations from domestic resources will do little if PFM systems do not enable funds to be allocated to priorities and are fully executed by health service providers [21].

With the advent of the COVID-19 crisis, this paper introduces a new notion of budgetary space for health, that is yet another step forward in the thinking that originated with Heller and Tandon and Cashin's initial framework. Building on the updated definition of overall fiscal space that the IMF recently put forward [22, 23], this paper offers a new perspective that systematically connects revenue and expenditure policies to budgetary space for health expansion. The paper also includes a quantitative assessment approach that can be used to identify the effect that various revenue and expenditure factors may have on improved budgetary space for health. The paper further offers a deep dive into the relationship between PFM and budgetary space for health and identifies ways in which PFM improvements can enhance budgetary space for health. We close by highlighting the implications of this work for future country assessment and budget dialogue between the Ministry of finance and health.

II. Connecting overall fiscal space and budgetary space for health in a budgetary framework

The following section introduces the notion of budgetary space for health, describes its key components, and shows how each component fits into the budget process.

Defining budgetary space for health

Budgetary space for health can be defined as potential resources to be budgeted and used for health, through the PFM system. Within this definition, budgetary space for health depends on three main components: (i) the overall expenditure envelope; (ii) budget allocation decisions; and (iii) rules and practices for budget use, or PFM.

The concept of budgetary space for health broadens Heller's original definition of fiscal space for health to include both revenue and expenditure, thus including the impact that PFM systems have on resources available within a sector. The definition is the natural outcome of our growing understanding that resources available in the health sector depend not only on the level of funding (i.e. revenues) but also on how funds are allocated, formulated within health budgets, and managed through the PFM system. The added PFM component is particularly relevant in light of a growing evidence that shows how PFM weaknesses can alter the availability of resources within the health sector [28, 29]. Historical budget under-execution in health is estimated to limit budgetary space by 20–40% in sub-Saharan African countries [28].

The proposed shift in terminology from "fiscal space for health" to budgetary space for health builds on the need to reflect both sides of the coin. The budget available for the health sector stems from the overall fiscal space derived on the basis of economy's macrofiscal considerations—on which health authorities have a limited control, as well as from budgetary decisions—concerning both allocation for health and its utilization—for which health authorities have a significant role.[3] The term "fiscal space for health" is therefore misleading especially in policy dialogue.

[3] Budgetary space for health is itself endogenous to the way public resources are raised for the health sector. Where payroll or social contributions constitute a major share of revenue sources, the analysis of budgetary space for health becomes complex as revenues are dependent on the evolution of the formal-informal composition of the labor force. While this may be an important consideration for advanced economies with well-established social contribution-based systems, in most LMICs payroll taxes usually constitute a relatively small share of health budget, and therefore budgetary space for health remains largely dependent on discretionary allocations from national budget. In any case, the issues pertaining to PFM practices and policies remain valid in executing health budgets even in countries wholly dependent on payroll tax contributions.

Components of budgetary space for health

Figure 1 unpacks the three components of budgetary space for health, and also shows how each component interrelates with the others and fits into the budget process.

Component 1
Annual public expenditure envelope

The first component that determines budgetary space for health is the annual public expenditure envelope (Figure 1; Component 1) which, in turn, is determined by the overall fiscal space (Figure 1; grey arrow). Overall fiscal space is, in its own turn, determined by various macrofiscal factors. The IMF recently updated its list of interconnected factors that influence overall fiscal space to include economic growth, revenue, fiscal policies, debt, the size of contingent liabilities, access to capital financing, deficit rules and monetary policies (Box 1) [22, 23]. The positioning of public expenditure as a primary driver of budgetary space for health is a noticeable shift that separates the budgetary space for health approach from the initial framework, in which economic growth played a direct role.[4]4 In our approach, economic growth is included as part of the drivers of the overall fiscal space in line with the updated IMF approach.

Because overall fiscal space is dynamic, there can also be a reverse effect in which overall fiscal space is influenced by public expenditure policies (Figure 1; green arrow). For example, an extension in a health benefit package could improve fiscal space through growth effects.

Component 2
Share of the public expenditure envelope dedicated to health

The second component that determines budgetary space for health is the share of the public expenditure envelope that is allocated to the health sector (Figure 1; Component 2). The size of this share depends upon budget allocation decisions by the legislature and competitive budget negotiations between the finance ministry and sector ministries. While the share of the budget allocated to health may largely be a political decision and the result of unbalanced powers, it may also depend on whether the budget proposal is well-developed, including its formulation, costing and linkages to a results framework, all of which pertain to the quality of PFM processes and the effectiveness of health sector's engagement in budget planning.

Component 3
Effective and flexible public expenditure management

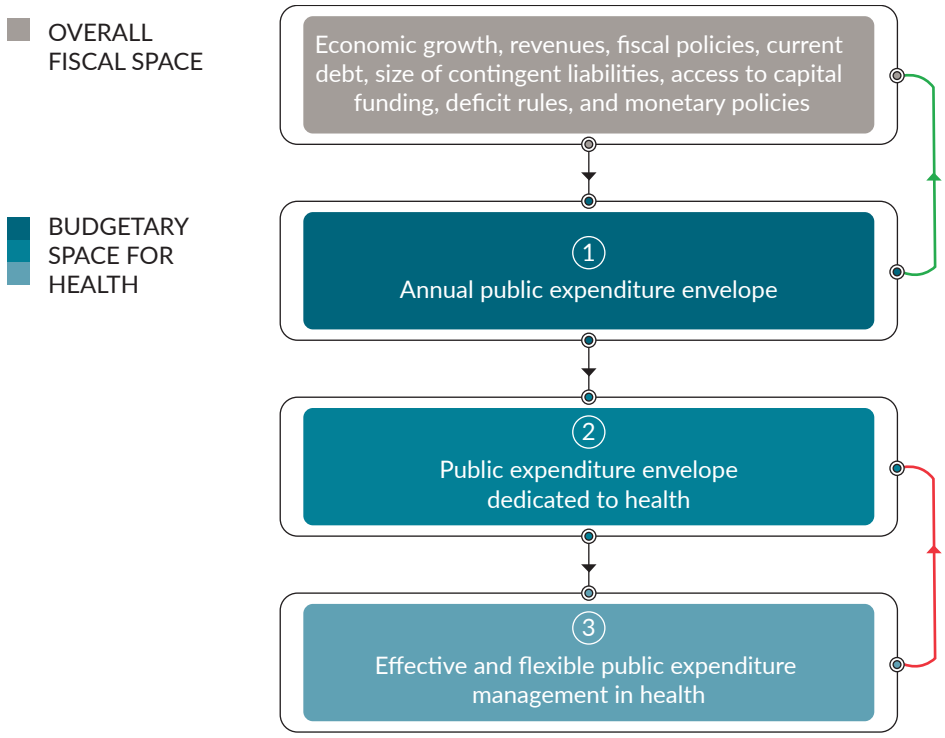
Once the share of the budget allocated to the health sector is defined, a key factor in determining budgetary space for health is the effectiveness and flexibility of the public expenditure management system (Figure 1; Component 3). This is, essentially, where PFM and the rules and practices of budget use come into play, including how budgeted funds are allocated to priorities and implemented through the health system. If funds are poorly allocated and used ineffectively by health service providers, this may reduce the existing

[4] In Tandon and Cashin, fiscal space for health is a function of GDP per capita, government expenditure as a share of GDP and the budget's health share [3].

budgetary space for the sector. The inclusion of this third component in the budgetary space for health approach is critical to ensuring a comprehensive understanding of budgetary space that accurately reflects the realities of the public finance processes in place. Given the importance of this particular component, we have included a separate section in this paper to discuss it in greater detail (see Section IV).

One additional element of the approach to note is the red arrow in Figure 1 that leads from Step 3 back to Step 2. This arrow represents the influence that PFM may have on future budget allocations for health. If the sector is able to execute its budget fully and/or demonstrates an effective and efficient use of allocated resources, it may be able to successfully campaign for a higher sector allocation in the future.

Figure 1. Consolidating overall fiscal space and budgetary space for health in a budgetary framework



Box 1. New IMF definition of overall fiscal space and a new assessment approach

In May 2018, the IMF adopted a uniform definition of fiscal space in an effort to improve the consistency of assessments across countries. The IMF defined fiscal space as "the room for undertaking discretionary fiscal policy relative to existing plans without endangering market access and debt sustainability". While the new definition retains a strong focus on debt sustainability, which is particularly important within a context of rising debt [30], it adds market access as a key determinant of overall fiscal space. This addition reflects the growing importance of market funding for public expenditure, including in LMICs. The new definition also encompasses more criteria for both revenue and the expenditure, thereby reflecting more accurately the complex interconnections between macroeconomic conditions, fiscal policies and capital market access in driving fiscal space [31]. The framework is designed to provide policymakers with more information on the availability of fiscal space over a period of 3 to 4 years.

The new approach includes more than 50 indicators and is laid out as a four-step process (see Annex 1):

Step 1. Identify a baseline scenario looking at macroeconomic conditions, fiscal revenues, existing policies, and the level of contingent liabilities.

Step 2. Conduct an analysis of fiscal space prospects, including plausible stress tests analyzing the fiscal impact of extreme events, such as a large fall in economic output because of a pandemic.

Step 3. Assess the effects of possible expansionary fiscal policies, such as large increases in priority spending, on future fiscal space and the economy.

Step 4. Propose a bottom-line desk assessment and recommendation based on a scaled score, from no space to substantial space.

The new approach acknowledges the dynamic reality of fiscal space, taking into account the economic environment, the impact of current fiscal policies on growth and debt sustainability, and the level of existing contingent liabilities (e.g. pensions, insurance funds) on the projected availability of fiscal space. Contingent liabilities were not captured in the initial framework so the IMF's move to include them in their new approach is an important step forward. The updated approach is also tailored to income groups (e.g. low-income countries [LICs], advanced countries) and to the structure of the economy (e.g. whether it is dependent on natural resources or not) [32]. It takes into consideration the macroeconomic uncertainty in LICs that can arise from macroeconomic volatility, fiscal risks, a reliance on natural resources, or fluctuating commodity prices.

(continued)

Box 1. Continued

The new IMF approach was first used in 2017 –2018 in the Article IV consultations of 34 advanced and emerging economies, including three in Africa (i.e. Angola, Nigeria and South Africa) [23]. It was used again in 2019–2020 to assess another 31 countries. The first round of assessments showed that there was at least some fiscal space in most countries—reflecting "low financing needs, extended debt maturities, a greater share of local currency borrowing, and favourable interest rate-growth differentials"—and that advanced economies generally had more space than emerging markets. Fiscal space was limited in countries where risks to financing were prohibitive or critically based on sovereign spreads (e.g. Argentina, Egypt, Nigeria) or the debt profile (e.g. Brazil, Pakistan). Where risks to financing as well as debt were low or, at most, moderately high (e.g. Indonesia, Morocco, Philippines, Thailand), there was some space. Where there was the feasibility of expansionary fiscal policies and low risks to financing (e.g. Kazakhstan), there was substantial space.

III. Driving budgetary space for health: breaking down the role of each component

The following section translates the concept of budgetary space for health into practice. It introduces a quantitative budget decomposition approach that provides insight into the extent to which each component of budgetary space for health drives expansion.

A simple approach to understanding the drivers of budgetary space for health

Each of the three components of budgetary space for health described earlier—the overall expenditure envelope, budget allocation decisions, and PFM—drives expansion to a different extent. Well-informed policy actions require an in-depth understanding of which factors are most effective at expanding budgetary space. Building on the budgetary space for health approach described in Section I, we developed a simple analytical model that can help shape that understanding. Box 2 describes this model in detail and shows how it can be used to identify changes in a country's overall public expenditure as well as in the share of budget allocated to health to determine budgetary space for health. The impact that PFM systems may have on budgetary space for health is not accounted for here, as it requires a qualitative approach which is described in more detail in Section IV.

Findings from a budget decomposition analysis of 133 LMICs

The budget decomposition approach described in Box 2 was applied to LMICs to identify the role public expenditure and budget allocation played in shaping budgetary space for health between 2000–2017. The analysis found, perhaps unsurprisingly, that the overall level of public expenditure is the main driver of expanded budgetary space for health. About 70% of budgetary space for health is generated by a change in the overall level of public expenditure. About 30% is attributable to a change in the share of the budget allocated to health.[5] Consistent patterns emerge when analysed by country income and WHO region, where the impact of the average change in share of budget allocated to health on the expansion of budgetary space for health ranges from 38% in LICs, to 29% in lower-middle-income countries and 31% in upper-middle-income countries (Table 1, Figure 2).

The findings from the analysis of 133 LMICs also reveal large variations across countries in terms of how significantly the change in budget share affected budgetary space for health

[5] Similar conclusions were obtained in another recent analysis conducted by the World Bank. While the included variables differed from this study, Tandon et al [33] found that in LMICs changes in economic growth and public expenditure estimated as a share of GDP contributed to a cumulative 83% of the change in public spending on health between 2000–2015, while the share of budget dedicated to health contributed to 17% (calculations by the authors).

expansion. In 20[6] of the 133 LMICs, the change in the share of budget allocated to health contributed to more than half of the expansion in budgetary space for health on average over the period. However, for the majority of countries, this percentage was below 30%—the sample average (Figure 3). In the LICs sample, increases in budget share generated a per capita expansion of budgetary space for health generally below US$10 annually (Figure 4).

Box 2. Budget decomposition approach

In the budget decomposition approach, a change in budgetary space for health is the function of a change in the share of the budget dedicated to health and a change in overall public expenditure. Budgetary space for health is estimated as per capita public expenditure on health from domestic sources [34],[a] while the share of the budget dedicated to health is equal to the health share of public expenditure from domestic sources [34] and the overall public expenditure corresponds to per capita public expenditure [35], excluding debt service [35]. Overall public expenditure is further divided into three factors: government revenues (estimated as per capita government revenues excluding grants) [35], net borrowing (estimated by per capita net borrowing) [35], and other sources of financing (resulting from the difference between per capita overall public expenditure and the other variables).

The calculations consist of three main steps:

Step 1—Growth rates. Log growth rates of per capita public expenditure on health (P), public expenditure's health share (H) and overall public expenditure (E) were calculated through the difference between two years (t and t-1) throughout the period, and then averaged for each country for 2000–2017. Standard growth rates for government revenue (R), net borrowing (B) and other sources of financing (O) were estimated for each country and each year, and then averaged for 2000–2017.

Step 2—Contributions to budgetary space for health. The average contributions of (H) and (E) to (P) for 2000–2017 was estimated through the quotient of the average log growth rate of (H) and (E) to the one of (P) per country.[b] The average contribution of (R), (B) and (O) to (P) consisted of first estimating their average contribution to (E), and then by multiplying its average contribution to (E) by the average contribution of (E) to (P) for 2000–2017.

Step 3— Estimations by income level and WHO region. For each variable, the contribution was first estimated by country and then averaged by income group and WHO region for 2000–2017.

a. Converted into international dollars using purchasing power parity (PPP) exchange rates.

b. When the log growth rate is negative, then its absolute value is used to calculate the contribution to budgetary space for health.

[6] The 20 countries are: Angola, Burundi, Central African Republic, Chad, Comoros, Gabon, Guinea Bissau, Haiti, Iraq, Lebanon, Madagascar, Malaysia, Maldives, Mauritania, Micronesia, Nigeria, Timor Leste, Tuvalu, Venezuela, and Yemen.

Table 1. Summary of findings: drivers of budgetary space for health by income level and WHO region (2000–2017)

	Average 2000–2017			Logarithmic growth rate (%)			Contribution of budgetary space for health components (%)				
Subsamples	$\bar{P}$	$\bar{H}$ (%)	$\bar{E}$	$\hat{P}_t$	$\hat{H}_t$	$\hat{E}_t$	$\hat{H}_t/\hat{P}_t$	$\hat{E}_t/\hat{P}_t$	$(\hat{E}_t.\check{K}_i)/\hat{P}_t$	$(\hat{E}_t.\check{B}_i)/\hat{P}_t$	$(\hat{E}_t.\check{O}_i)/\hat{P}_t$
LMICs	200.98	8.50	2,170.08	5.40	0.19	5.21	32.22	67.78	27.26	21.60	18.75
Low-income	20.85	6.42	353.15	4.28	−1.06	5.34	38.34	61.66	20.45	21.56	19.34
Lower-middle income	99.56	7.59	1,299.68	5.98	0.46	5.53	29.74	70.26	27.41	21.44	21.70
Upper-middle income	380.45	10.36	3,858.56	5.56	0.67	4.87	30.84	69.16	31.05	21.76	15.90
Eastern Mediterranean Region	198.75	7.64	2,522.17	4.19	0.30	3.86	38.91	61.09	20.53	21.92	17.86
European Region	324.13	9.35	3,310.97	8.26	0.83	7.43	19.99	80.01	40.01	18.78	21.18
African Region	81.80	6.98	1,139.40	4.68	−0.03	4.72	38.92	61.08	20.84	23.47	16.77
South-East Asia Region	137.58	6.71	1,551.83	8.55	2.22	6.33	28.58	71.42	29.19	20.43	21.81
Region of the Americas	320.67	11.51	2,802.51	4.59	0.40	4.19	26.42	73.58	33.52	25.21	15.47
Western Pacific Region	238.14	8.92	2,699.60	4.54	−1.25	5.79	32.90	67.10	26.66	15.74	24.20

Figure 2. Drivers of budgetary space for health by income group, 2000–2017 average share (%)

This figure shows the relative contribution of budget share for health (gray) and of overall public expenditure (blue) to the change in budgetary space for health in 133 LMICs between 2000–2017 in percentage terms. The contribution of overall public expenditure is further broken down into three driving factors: government revenues, net borrowing and other financing sources.

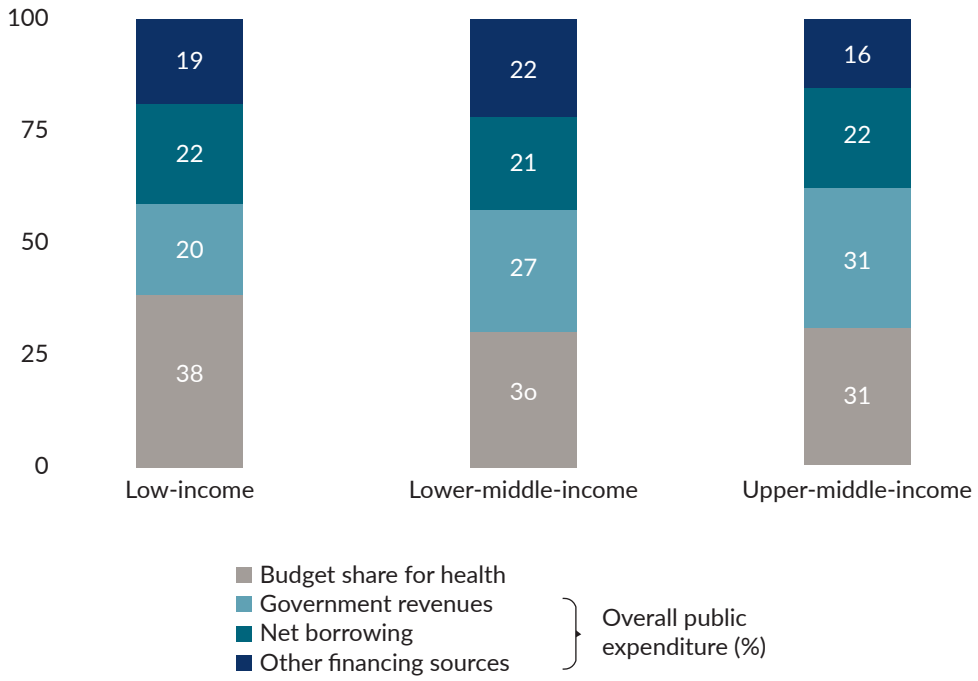
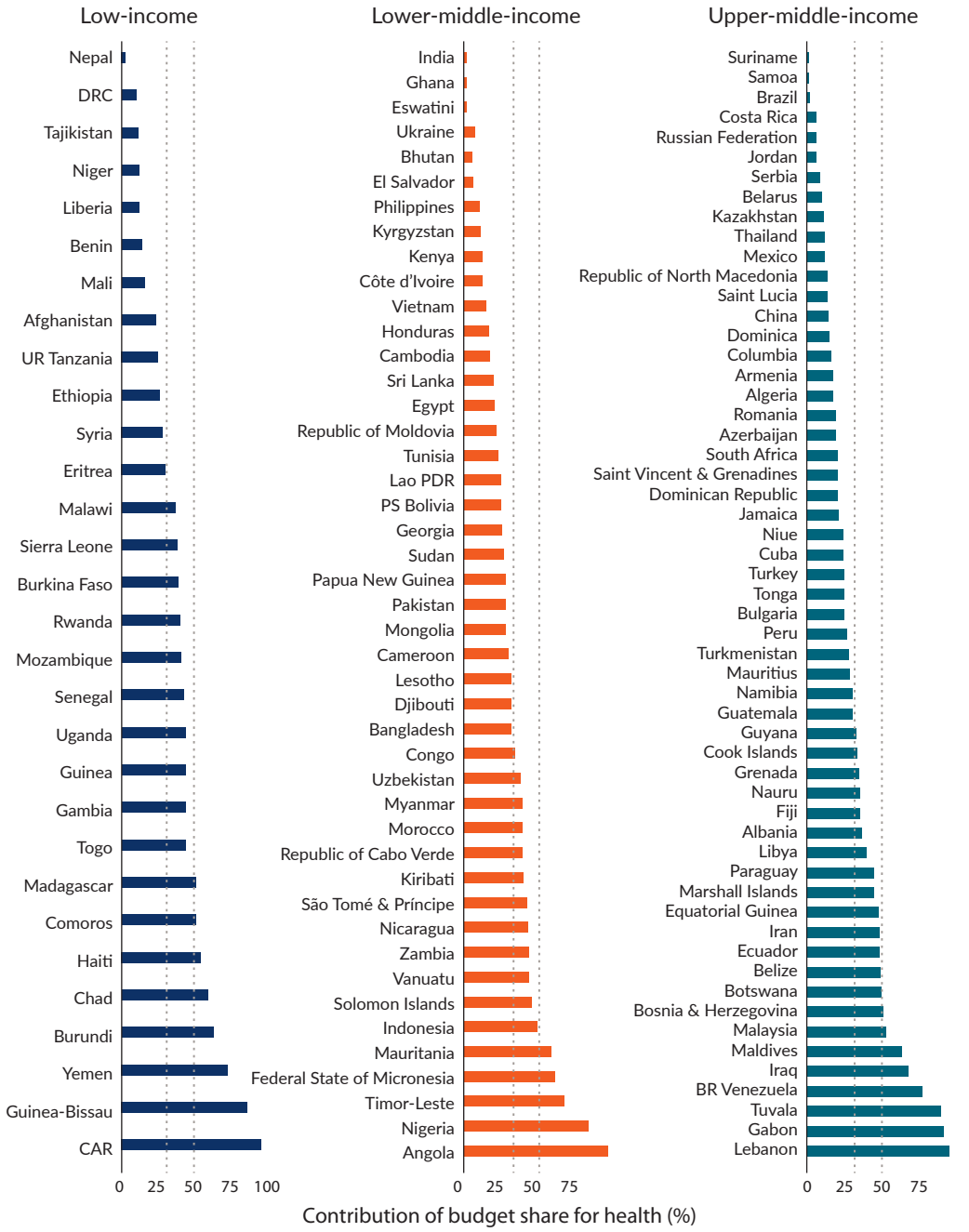


Figure 3. Average contribution of change in budget share for health to budgetary space for health by country, 2000– 2017 (%)

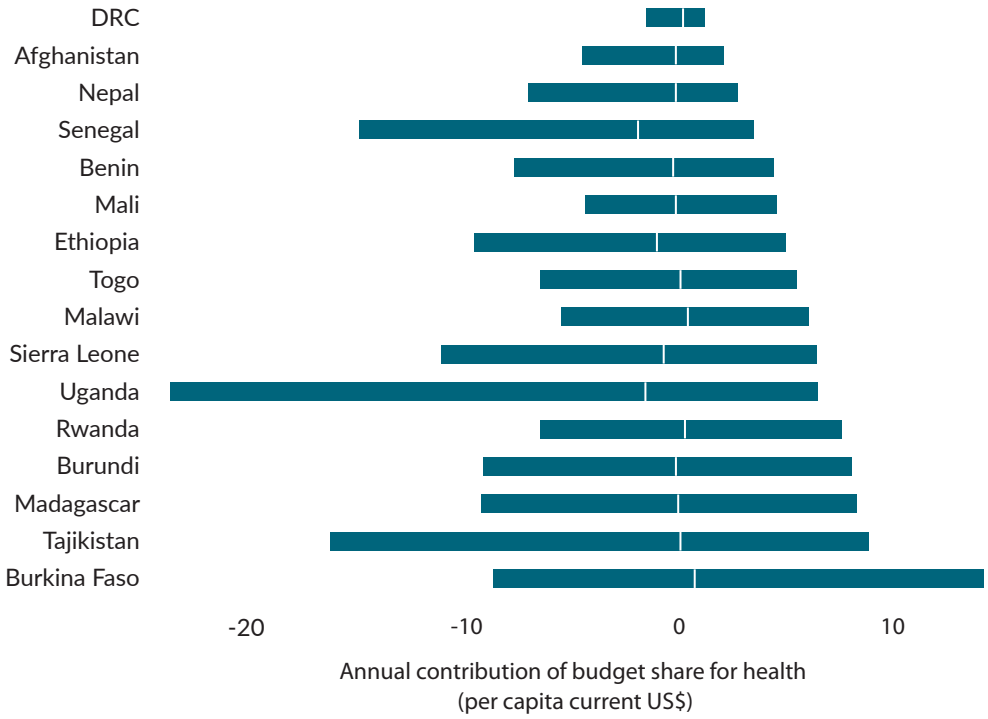
This figure shows the average contribution of budget share for health to the change in budgetary space for health in 133 LMICs between 2000–2017 in percentage. The indicative dotted lines mark 30% (sample average) and 50% of contribution.



DRC=Democratic Republic of Congo, UR Tanzania=United Republic of Tanzania, CAR=Central African Republic, Lao PDR=Lao People's Republic, PS Bolivia=Plurinational State of Bolivia, BR Venezuala=Bolivarian Republic of Venezuela.

Figure 4. Annual contribution of the change in budget share for health to budgetary space for health by country, per capita (current US$)

This figure shows the minimum (left hand), maximum (right hand) and mean (white line) of the annual contribution of the change in budget share for health to budgetary space for health, in per capita terms (current US$) for the sample of low-income countries.



DRC=Democratic Republic of Congo.

IV. Incorporating a public financial management dimension to budgetary space for health

The following section explores the third component of budgetary space for health: the rules and practice of budget use, or PFM. The section offers suggestions for PFM improvements at each stage of the budget cycle that have potential for expanding budgetary space for health.

Overall links between PFM and budgetary space

In the past, issues related to PFM were often overlooked in discussions around the availability of resources. This is due in part to the historical approach to fiscal space and PFM, in which both concepts were treated as separate disciplines with separate communities of experts exploring ideas separately [22, 36, 37]. In the past, those focused on fiscal space directed their attention primarily on the importance of additional revenues, whereas public finance experts focused more on expenditure policies a nd reforms. Despite the previous reluctance to view fiscal space and PFM under one umbrella, there are evident linkages between the two concepts. Poor PFM is a constraint for fiscal discipline[7] and also a barrier to realizing the full potential of budgetary space in practice.

There is now a growing body of evidence that shows the impact PFM processes have on public spending in general and, more specifically, in the health sector [17, 21, 28, 38, 40, 41]. The most often cited example is the late, incomplete, and misaligned budget releases that significantly limit the actual budget envelope available for the sector in many LMICs [28]. Conversely, PFM rules that are effective (e.g. releasing funds in a predictable and timely manner) and flexible (e.g. allowing funds to be reallocated across budget lines) are likely to increase the possibility of maximizing existing budgetary space for health.

Though there is an increasing amount of evidence around the importance of PFM for public spending on health, there is a limited body of knowledge on how better public expenditure management can potentially enhance the amount of funding available for the sector.

PFM improvements to enhance budgetary space for health

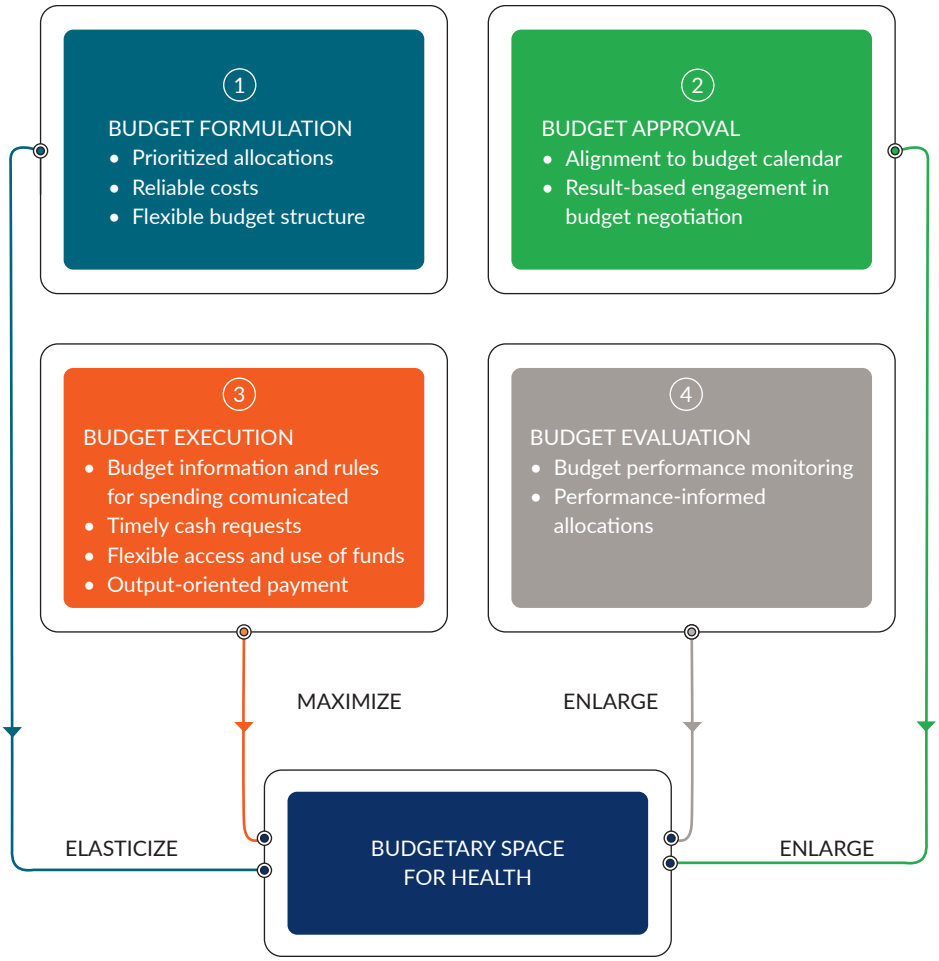
At each stage of the budget cycle (budget formulation, budget negotiation and approval, budget execution, and budget monitoring and evaluation), there are potential ways in which PFM improvements can enhance budgetary space for health (Figure 5):

[7] As has been demonstrated through Public Expenditure and Financial Accountability (PEFA) assessments and other similar evaluations [39], lack of budget credibility often leads to unpredictable and misaligned spending that, in turn, can lead to issues around financial sustainability and debt.

1. Budget formulation

During Stage 1 of the budget cycle, budget formulation, PFM improvements can free up more resources and make budgetary space for health more flexible or elastic. The rigid budget structures and appropriation mechanisms of line-item allocations often limit reallocations and can hinder the optimal mix of inputs by health service providers [40, 41]. This situation, which is common among LMICs, often leads to unnecessary spending on specific inputs towards the end of the fiscal year—even though there may no longer be a need to spend the full amount under a specific line item, purchases may still be made solely for budget compliance reasons. This is an unnecessary consumption of budgetary space for health. Improving how budgets are structured can reduce unnecessary expenditures, realign expenditures with priorities and enhance budgetary space for health by making it more elastic. Using more flexible approaches to formulate health budgets, such as programme- or output-oriented approaches [17, 40], is likely to enhance space for priority health spending.

Figure 5. PFM and budgetary space for health throughout the budget cycle: a policy road map



2. Budget negotiation and approval

PFM interventions during Stage 2 of the budget cycle, the budget negotiation and approval stage, can help enlarge the level of future budgetary space for health. A passive approach to this critical stage of the budget cycle may result in limiting budget allocations for the sector. A more proactive and results-based approach to budget negotiations and approvals is likely to have a direct impact on the level of budget share allocated to health. While politics and power matters,[8] a budget's share for health will be determined by the technical preparation done in advance of budget negotiations, the robustness of the results framework, and a budget's alignment with the overall budgetary process and calendar [28, 43]. When done effectively, this health sector's engagement during the budget negotiation and approval stage can expand budgetary space for health.

3. Budget execution

The execution of health expenditure materializes budgetary space for health. PFM improvements during budget execution, Stage 3 of the budget cycle shown in Figure 5, can *maximize* existing budgetary space for health. For example, strengthening budget execution practices to ensure the predictable and timely release of funds can reduce the level of unused revenues, helping to ensure the full use of existing budgetary space by health service providers. There is empirical evidence in several LMICs to support this idea, showing that improved budget execution can have a sizable impact on maximizing budgetary space for health.[9] Notwithstanding decreases in revenue mobilization that may impact the level of available resources across sectors, there are several policy actions that pertain to both finance and health that can help improve budget execution upstream (e.g. quality of revenue forecasts, multi-year plans, costs estimates, budget formulation) and downstream (e.g. cash plans, procurement management, control system) in the health sector [28].[10] When implemented effectively, these interventions can reduce the gap between the adopted or theoretical budgetary space for health and actual budgetary space for health.

[8] Budget negotiations are strongly influenced by the balance of power among various ministers, and especially between the Ministry of Finance and the Ministry of Health. It is more difficult for an institutionally weak Ministry of Health to gain support for its budget proposals, even when they are well documented and based on strong analysis [42].

[9] For instance, in sub-Saharan African countries it was estimated that, on average, eliminating bottle-necks for the use of mobilized revenues for health would have increased health ministry budgets by about 15% between 2008 and 2016. In extreme cases, it could be as high as 40% of unused revenues [28, 44].

[10] For example, on the finance side, policy should focus on actions such as enhancing quality of revenue forecasts or improving the timeliness of budget releases. On the health side, policy actions should focus on items such as strengthening the quality of budget plans and the timeliness of cash requests, as well as reducing fragmentation in funding streams. Often in health, policy actions for better execution are also linked to providing more flexibility in fund management at the facility level [45].

4. Budget monitoring and evaluation

Effective budget monitoring and evaluation can help *enlarge* budgetary space for health when it is used to inform future budget allocations. The use of budget performance information to secure higher allocations has been proven to work successfully in several contexts. High-income countries with a long experience of using "spending reviews" have demonstrated that it can focus governments to improve expenditure prioritisation and to find budgetary space for new spending priorities [46]. More broadly, improving the quality and consistency of financial data would create a better foundation upon which to build stronger arguments for an increase in budget allocations [47]. Also, effective internal and external auditing can provide useful guidance for improving PFM and spending efficiency.

V. Budgetary space for health in practice: implications for research and policy

The following section briefly describes some of the research and policy implications associated with budgetary space for health, including how and when to conduct an analysis of budgetary space and how the concept can be used to shape a more effective budgetary dialogue between the finance and health sectors.

Research implications

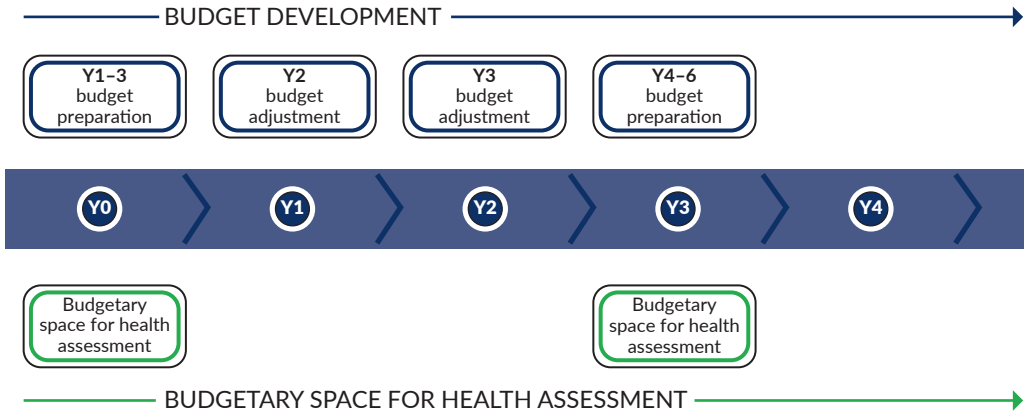
Country assessments of budgetary space for health must be comprehensive and include PFM-related issues.[11] An assessment that focuses solely on the revenue side of the equation will not provide a comprehensive picture of the existing or potential budgetary space for health. Incorporating public expenditure management into the approach will provide a broader understanding of the budgetary space available for health and of realistic ways to expand it. A comprehensive approach should also include a step back into the history of the country itself—including historical contributions to the drivers of budgetary space—in a systematic and consolidated manner. The budget decomposition approach described earlier is one possible way to assess historical contributions of drivers to budgetary space for health that can help develop a robust country-focused evidence base for the future decisions. See Box 3 for more specific guidance on how to ensure a comprehensive approach to each component.

In addition to being comprehensive, the assessment must also be aligned with the budgeting process. In order for assessments to lead to meaningful policy development, the process by which the study is conducted is as important as the scope of the assessment itself. Country assessments of budgetary space for health should be synchronized with budgeting processes and timelines. If the process is not a routine practice within the budgetary process, a careful sequencing as shown in Figure 6 and as defined below will be helpful to link analysis with the multi-year budget calendar. With multi-year budget plans, finance authorities determine sector ceilings based on revenue forecasts, typically over a three-year period. During the budget development phase (Year 0), sector engagement in the budget dialogue is critical. This is the right time to conduct a budgetary space for health assessment with a view to influencing the three-year allocation plan. Since budget ceilings are updated every year, health sector engagement is also critical each year at the beginning of the annual budget calendar, before the ceilings are determined, in order to influence any adjustment to annual

[11] A country assessment of budgetary space for health is not a prerequisite for policy development or the development of multiyear budget plans, but it can be a useful approach to enhance both endeavours. While a multi-year budget plan would ideally provide sufficient information to ensure a predictable level of resources available for the sector, in practice this is not always the case. An assessment of budgetary space for health at the start of the budget cycle can help influence budget allocation decisions, both in terms of the size of the allocation for the sector and the possible use and distribution of resources within the sector's budget envelope.

envelopes for the sector.[12] At the end of the three-year cycle (Year 3), the Ministry of Health (MoH) should update the budgetary space for health assessment to support the development of the next budget cycle (Year 4–Year 6) (Figure 6).

Figure 6. Connecting budgetary space for health to a multi-year budgeting calendar



Box 3. A comprehensive approach to budgetary space for health assessment

1. Overall public expenditure

Health stakeholders are discouraged from assessing the complex interactions between multiple macrofiscal factors. Instead, existing assessments of overall fiscal space by the finance sector should be used to inform government-wide capacity to increase overall public expenditure over the medium term. In the absence of such assessments, scenarios can be developed using country multi-year expenditure frameworks (e.g. Medium-Term Expenditure Framework [MTEF]) that generally provide revenue and expenditure forecasts. In some countries, expenditure frameworks that are developed specifically for the health sector can also serve to capture projected public spending on health more precisely, if revenue and expenditure data are sufficiently reliable.

(continued)

[12] Another helpful budget tool is the budget circular that is, in most countries, transmitted to all ministries at the beginning of the budget cycle. The circular typically includes basis of fiscal policies in the budget proposals, and if creating budgetary space for health is a priority, the circular can set objectives and provide guidance to position ministries' proposals.

Box 3. Continued

2. Budget allocation
A mixed study method that combines a budget decomposition approach with a qualitative feasibility assessment is essential. The analysis should look at the historical dynamics of budget prioritization which are specific to each country context. A budget decomposition analysis, such as the one developed in this paper, can be used to understand the historical trajectory of budgetary space for health and the relative contribution of the change in budget share in a given context. To provide meaningful scenarios for future levels of budget share for health, this quantitative approach should be paired with a qualitative assessment. The latter would take into consideration societal, legal, and political economic considerations that may have implications for potential increases. Societal implications may include the social climate or redistribution priorities; legal implications may include legal provisions on specific budget allocation decisions; and political considerations may include the political climate and appetite for more health spending. Determining the share of budget allocated to health based on global or regional targets is discouraged, as predefined targets are less sensitive to country specific dynamics.

3. Public expenditure management or PFM
There are three aspects to consider under this component. First, studies should identify key weaknesses primarily in budget formulation and execution that hinder the effective programming and use of budgeted resources in the health sector. As a second step, key corrective actions need to be identified to help eliminate or reduce these barriers, thereby enhancing budgetary space for health.[a] Third, it is important to provide with complementary information on the potential gains that could be generated through targeted PFM improvements. For example, quantifying the degree to which budgetary space would be enhanced if budget execution was improved.

a. The following guidance can be used to identify key PFM bottlenecks in health, as well possible policy responses, throughout the budget cycle [17, 48–50].

Policy implications

There are also a number of important policy implications that can be drawn from the work around budgetary space for health.

First, PFM must be systematically included in budgetary space for health discussions. This is important in the context of COVID-19 as countries seek to increase health sector allocations to fight the pandemic. Unless improvements in PFM systems and practices are obtained, health spending increases may not come to fruition. The budgetary space for health approach can be used as a prompt for policymakers to develop a more comprehensive understanding of the current and potential budgetary space, which includes both revenue and expenditure. This work can facilitate a more comprehensive approach to budgetary dialogues in health by bringing PFM to the forefront of discussions and connecting it to

budgetary space. Health policymakers are encouraged to move beyond revenue-focused discussions and expand them to include PFM, with special attention paid to the ways in which strengthening PFM processes can expand budgetary space for health. This work outlines some of the concrete inputs for the implementation of PFM-related interventions that can enhance budgetary space for health, including: (i) exploring flexible budget structures to free-up unnecessary spending; (ii) using a results-based approach in budget negotiation to influence budget allocation decisions; (iii) working towards full budget execution to reduce unused revenues; (iv) using budget performance to shape future allocations, possibly enlarging them.

Second, a budgetary space for health strategy must be grounded in country-specific evidence, instead of relying on global or regional budget targets. For many years, increases in the share of budget allocated to health have been at the forefront of strategies to expand budget budgetary space for the sector developed by key stakeholders in health, including development partners. The adoption of the Abuja Declaration [51] helped forge the opinion that increasing the share of budget allocated to health to 15% in African countries' budgets would be an effective way to expand resources for the sector. However, as this paper demonstrates, increases in the level of budget share generate relatively limited per capita expansion of budgetary space for health in LMICs, because of what is commonly understood as the denominator effect, as well as limitations in budget advocacy strategies. While increasing the share of health in budgets continues to be important for the political visibility of the health sector in the budget process, especially for low-prioritisation countries, the work presented in this paper should encourage health policymakers to look beyond budget share alone. Increases in budget share will not lead to significant change for health spending. It is time to develop strategies for budgetary space for health with finance authorities that are based on a comprehensive understanding of historical country dynamics and bottlenecks.

It is time to draw up a "new national pact" between finance and health authorities in order to guarantee sufficient, flexible and accountable budgetary space for services linked to COVID-19 and other essential health needs.

Concluding remarks

The introduction of the fiscal space framework in the early 2000s has led to important contributions. Over the past 15 years, the framework has helped health authorities to deepen understanding of macrofiscal realities and situate health reforms within a broader context. Today, with the current focus on domestic public resources, it is time to provide additional support for countries to help them align their budgets with the financing requirements for UHC and fighting COVID-19. The notion of budgetary space for health introduced in this paper is an attempt to meet these goals, helping to link resources available for health to the realities of public finance today.

Budgetary space for health helps countries understand both the revenue and expenditure side of health resources and provides a practical approach that gives health and finance authorities the ability to understand how their actions impact available budgetary space. By expanding the focus beyond revenue to include budget allocation decisions and the rules and practice of budget use, health authorities are given the opportunity to engage in a more comprehensive and balanced budgetary dialogue with finance authorities.

Looking forward to the next 10 years, we encourage countries to reconsider their assessment approaches in the context of multi-year budget plans and revisit their overall approaches to expanding budgetary space for health. Strategies that are developed to enhance budgetary space for health should reflect the particular challenges and opportunities of each country and be guided by past and present country dynamics. It is likely that a closer examination of PFM policies will be the most effective way forward to enhance budgetary space for health in most LMICs. With strong country leadership and supportive global development partners, it may prove to become one of the most realistic path forward to supporting UHC and the COVID-19 suite.

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Annex 1. IMF list of key steps and indicators to assess the overall fiscal space

Initial state

Macroeconomic conditions

- Gross public debt
- Gross financing needs (GFN) Output gap
- Fiscal multipliers estimated range (revenue and expenditure)
- Is monetary policy appropriate? Member of a currency union?

Expenditure balance considerations

- Current account balance
- Net international investment position Estimated current account gap
- EBA exchange rate overvaluation

Resource dependency

- Non-renewable commodity exports Variation of commodity prices
- Net national savings
- Non-resource revenue as a share of total government revenues
- Ratio of proven reserves of natural resources to current extraction

Contingent liability risks

- Banking sector NPL ratio
- Fiscal costs for past financial sector rescue Assets of domestic financial sector
- Cost of past natural disasters damage
- Non-financial sector corporate debt
- Size of outstanding PPP's projects
- Stock-flow-adjustment

Fiscal space under the baseline and stress tests

Is financing available?

- Have sovereign bond spreads breached bookmarks? Last 12 months? Last 5 years?
- Do debt profile indicators breach benchmarks?
- Public financial assets

State of debt burden indicators

- Does debt level breach the benchmark during projection period?
- Probability of breaching the benchmark at end of projection period
- Do GFN breach the benchmark during projection period?
- Does debt trajectory at least stabilize in the last 2 years?
- Contingent liability stress test

Source: [23]

Fiscal space under expansionary fiscal scenario

Macro impacts

- End of projection year
- Change in potential GDP relative to baseline at the end of the projection period
- Change in nominal GDP relative to baseline at the end of the projection period

Debt burden indicators

- Does debt level breach the benchmark during the projection period?
- Does debt level breach the benchmark at the end of the projection period?
- Does GFN breach the benchmark during projection period?
- Does debt trajectory at least stabilize in last 2 years?

Desk bottom-line

- Desk rating (with fiscal rules)
- Desk rating (without fiscal rules