

HEALTH FINANCING CASE STUDY No 12
BUDGETING IN HEALTH

BUDGET STRUCTURE REFORMS AND TRANSITION TO PROGRAMME BUDGETING IN HEALTH: LESSONS FROM ARMENIA

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EXECUTIVE SUMMARY

Armenia has been implementing budget reforms since late 1990s, and emerging evidence indicates that the country has made visible progress in shifting to programme-based budgeting in health. As a result of introducing programme budgeting, by 2018, 43 activities managed by the Ministry of Health have been consolidated into eight programmes with a view to have a stronger alignment with health sector policy priorities. Budget allocations to the Basic Benefit Package of health services can be identified in the current budget structure. This is an important step in ensuring that the Government meets its commitment to the population and ensures financing of basic health services to its citizens.

As a result of these reforms, the National Assembly can now scrutinize budgets more effectively in terms of assessing the extent to which proposed budgets are consistent with public policy objectives. Also, with programme budgeting, indicators reflecting quantity, quality and timeliness of services have been developed and are actively used by the Ministry of Health, independent experts and the National Assembly to track performance of and budget allocations to specific priority services.

At the same time, the effect of this reform has been limited because of unclear links between policy priorities as expressed in existing strategic documents and budgetary programmes, weaknesses associated with performance measurement framework, continued appropriation at detailed activity level, and weak role of programme managers. The Government is making efforts to strengthen performance measurement framework. Specifically, programme indicators have been introduced in the draft 2019 budget law. This is an important step because until recent changes the programme budgets in Armenia contained a large number of activity indicators but no programme indicators. However, there are remaining concerns regarding their quality.

Appropriations at detailed activity level do not correspond to programme logic, and continue to limit flexibility in management of resources and pose an excessive burden to line ministries, including health. Thus, service providers must submit their requests for changes in budget allocations between activities to the State Health Agency under the Ministry of Health, which then has to consolidate these requests and submit these for further approval to the Ministry of Finance and then to the Government. While some argue that this is a necessary measure to avoid inappropriate use of resources, this is not in line with good practices in programme budgeting.

Also, there is a need to ensure a more systematic approach to linking sector strategies to MTEF and to the annual programme-based budget. Links among the State Targeted Health Programmes, various other national health programmes (for example, Health Promotion Strategic Programme), MTEF and annual budget programmes are not clear. It is advisable to re-examine the current structure of the various programmes to ensure they have common goals, reflecting health sector policy priorities. The current programme classification can be improved to achieve better alignment with health sector strategies and policy priorities.

MOH should clarify and strengthen the role of programme managers. Although there is no need to strictly align the organizational structure of MOH with the programme structure, it is extremely important to specify parties – programme managers – responsible for implementation of each programme and empower them.

Programme statements (“programme passports”) are a key element in developing programmes and they should be developed regularly and for all programmes. Developing or revising these in health in Armenia may provide a good opportunity to also review programme content and performance indicators.

Health development partners are well placed to support the Ministry of Health in addressing several of these remaining challenges.

1. INTRODUCTION

Armenia has been implementing budget reforms since late 1990s, and emerging evidence indicates that the country has made visible progress in shifting to programme-based budgeting in health. It presents a particularly interesting case in designing budget programmes, given its experience of consolidating initially small and fragmented activities into larger and more comprehensive programmes, providing opportunities for improved transparency of the budget and better alignment of programmes with policy priorities. This step is also in line with good practices in programme budgeting.

Armenia has an interesting and perhaps unique experience when it comes to the process of transition to programme-based budgeting. Unlike Kyrgyzstan or most other LMICs, Armenia did not go from input-based line item budgeting to programme-budgeting. Instead, at least in health, it is going from a very detailed activity-based budgeting to programme-budgeting. However, it is a long road. While it is expected that full programme budgeting will be introduced in 2019, it seems that the budget will still be appropriated at the activity level, at least for the first year.

Therefore, the full effect of this transition on the health sector, particularly in the area of strategic purchasing, will not be seen immediately. While providers in Armenia do not experience strict input controls as they do in a number of other LMICs [1], they are constrained by the way many of the activities are formulated in the health budget and the fact that appropriations are done at activity

level. This puts providers in a situation where if they have a higher demand for laboratory diagnostic services as compared to emergency medical care services, they cannot shift resources across these activities without approval of the MOH, which then consolidates such requests and seeks the endorsement from the MOF.

In total seven state entities receive funding under the health division of functional classification (4 ministries and 3 agencies which are either directly under the Government or under one of the ministries). The current report focuses on the budget managed by the Ministry of Health, which is 98 percent of total health budget (division 7).

This study is part of a broader WHO programme of work on budgeting for health, which includes identifying good country practices and lessons on designing and implementing budgetary programmes in the health sector. The main goals are: (i) to provide an in-depth assessment of the current health budget structure, including the treatment of immunization in budget, (ii) analyze the effectiveness of the transition towards programme-budgeting and its implications for the health sector, and (iii) to provide recommendations for adjustments in budget structures in health.

The study is based on a document review, followed by key informant interviews, conducted between February and April 2018. The initial results were shared with the Ministry of Health authorities in June 2018 and a formal dissemination workshop held in

November 2018. The report is based on the data collected between January - June 2018, and therefore does not reflect the most recent changes introduced in the draft 2019 budget law currently submitted to the National Assembly. The draft 2019 budget law contains changes in some programme names and codes as well as their content. There are also programme-level indicators of performance, which were absent in the 2018 budget. However, following the consultations with the Ministry of Health, it was determined that key findings and recommendations made in the original report were still highly relevant.

Armenia has made significant progress in implementing budget structure reforms. At the same time, it still faces challenges in defining programmes, in managing expenditures by programme, and in monitoring programme performance. It is hoped that this work will enable Armenia to take advantage of the experience in other countries in order to deepen its current reforms, while at the same time demonstrating its achievements in this area.

2. CONTEXT OF THE TRANSITION TO PROGRAMME BUDGETING IN HEALTH

Starting with late 1990s Armenia has undertaken major reforms in health care system, including a publicly funded and nominally universal Basic Benefits Package (BBP), strengthening of primary health care (PHC) services with accompanying reduction in hospital capacity, output-based provider payment methods, and civil service reforms [2-4]. As part of these reforms, operation and ownership of health care providers was devolved to regional and local governments. While the Ministry of Health remained responsible for tertiary-level institutions, most hospitals and polyclinics became the responsibility of governments at the regional level. They were given responsibility for managing their financial resources, setting prices for services not included in the state-funded health care package, deciding on staffing mix and setting terms and conditions of service [2]. They were also permitted, within the limits of tax legislation, to retain any profits generated and invest surplus income as they saw fit. Health care providers were subsequently transformed into closed joint-stock companies (CJSC). CJSCs were allowed to enter into contracts and generate revenue from commercial activities.

During the same time, output-based provider payment methods were introduced and have been evolving since. Currently, PHC providers receive capitated rates adjusted by age based on the number of patients enrolled. The rates are adjusted according to available budget. Hospital and specialist outpatient services receive global budgets based on an agreed

number of hospital cases. Global budgets are defined by the available budget and over-execution of contracts is not accepted [3]. The staff of the hospitals and polyclinics are not considered to be civil servants and salaries are part of the capitation and case-based payments. Providers received funding by activity line with budgets for each activity specified in their contracts. Thus, ex ante budgetary controls were by activity and not by inputs

The most important step in the reform of the healthcare system was the adoption of the **Law on Medical Care and Services (LMCS)** in 1996 by the National Assembly. Based on LMCS:

- The government creates and implements state targeted health programmes (STHP) in order to fulfill its constitutional obligations on health protection;
- Citizens have the right to choose a health care provider;
- Financing sources of medical care and service are: state budget, insurance contributions, out-of-pocket payments, other sources.

State targeted health programmes (STHPs) form the annual plan of strategic programmes prepared by the Ministry of Health and approved by the Government. They outline the main priorities and objectives, as well as specific measures or activities. However, they do not present measurable outcomes. There are five targeted programmes:

- Primary health care,
- Medical assistance and services for socially vulnerable populations and special groups,
- Medical assistance to socially significant and special diseases,
- Maternal and child health services, and
- Sanitary-epidemiological services (see Annex 1 for details).

As it is explained in detail further, STHPs played an important, although not always clear, role in the way budget groupings have evolved over the years in Armenia.

Budgeting reforms in Armenia were initiated in the context of major fiscal adjustment following a simultaneous decline in both real output (by more than 50 percent) and in the relative size of the Government (total expenditures declined from 35 percent to about 25 percent of GDP). This resulted in a sharp decline of the real level of public expenditures by about 3 times between early 1990 and the mid-1990s [5]. The first stage of the reforms was marked by creation of the Budget System Legislation: **Law on Budget System** (approved in 24.06.1997, GL-137), **Treasury Law** (approved in 27.07.2001, GL-211) and **Procurement Law** (approved in 16.12.2016, GL-21), revising budget classification, introducing the Central Treasury with amalgamation of government accounts into the Single Treasury Account, and building the necessary information technology system. **The Law on Budget System (LBS)**, adopted in 1997, provides formal regulations and the methodological framework concerning budget preparation, execution and reporting.

One of the key public financial management reforms steps was the introduction of a **Medium-term expenditure framework**

(MTEF) as a mandatory component of the annual budget process through the amendment to the **Law on Budget System** in 2003. This step established a basis for linking long-term strategic plans with budget process. According to the World Bank [6], in Armenia, as a result of the MTEF implementation, broad budgetary allocations are increasingly aligned to expressed policy priorities. The budget process is divided into two stages: i) preparation of the MTEF, containing the macro-fiscal framework, aggregate resource envelope and key fiscal policy priorities and ii) the detailed budget preparation process. MTEF is therefore a foundation of the annual budget law.

MTEF in Armenia consists of a top-down approach to determine the resource envelope that serves as a constraint for bottom-up cost estimates of activities, which at times are also referred to as financed programmes. MOF consolidates the two parts, prepares proposals related to expenditure ceilings for all sectors and presents it to the Government. The Government discusses the MOF proposal and approves the MTEF.

According to MTEF 2017 – 2019, there are following nine priority areas in health:

- i. Supply of fully or partially subsidized medicines for priority population groups and conditions
- ii. Regulation and supervision of pharmaceutical activities
- iii. Development of primary health care and selection by population of doctors in charge for provision of primary health care
- iv. Emergency medical services
- v. Development and implementation of service packages for priority population groups at hospital level

- vi. Ensuring access to specialized hospital services for socially vulnerable and other priority population groups
- vii. Prevention of infectious diseases and ensuring capacity to control their spread and transmission
- viii. Prevention of infectious diseases through immunization services
- ix. Maternal and child health care and improvement of reproductive health

MTEF priority areas in health are based on State Targeted Health Programmes and their activities, although they do not necessarily always correspond. MOH Policy Departments are responsible for identifying these priorities, based on the STHP and other strategic health documents. They have remained stable over the past five years, although activities or policy measures will change from year to year. Expenditures in MTEF are presented using functional classification, and not by these nine priority areas.

The MTEF document provides a good overview of Government priorities, but it lacks measurable indicators and operational strategies to achieve these objectives. It includes information about ongoing activities that are being implemented within the framework of existing policy (baseline budget) and new initiatives. The three-year

rolling framework sets a binding ceiling for the first year and indicative out-year ceilings. All spending agencies and categories of spending are covered.

During 2010-2017 the GoA has provided a more conservative projection of its expenditures when developing MTEF: health budget in out-years of MTEFs is either reduced or stays at the same level. For example, looking at the 2013–2015 MTEF, the 2013 budget is slightly above the 2014 budget and is almost the same as the 2015 projected budget. In 2018-2020 MTEF the government is planning to reduce health financing to 1.2 percent of GDP in 2019 (AMD 75.9 billion compared to AMD 78.4 billion in 2018) and 1.06 percent in 2020 (AMD 73.6 billion).

When compared to the actual health expenditures (2011 – 2016) or approved annual budget for health (2017 – 2018), starting with 2015 the annual budget tends to be slightly higher compared to expenditure ceiling defined by MTEF (e.g., MTEF 2016-2018 envisaged AMD 82.5 billion for 2016 the actual budget was AMD 88.6 billion). In general, the annual health sector budget and MTEF in Armenia appear to be aligned with increase in budget credibility and predictability as evidenced by the high PEFA score for budget credibility [4, 7].

3. OVERVIEW OF THE CURRENT BUDGETING PROCESS AND CLASSIFICATION SYSTEM

According to the LBS, the budget period goes from 1 January to 31 December. Usually the budget preparation for the next year starts more than one year in advance when the Prime Minister issues the related decree. The Treasury is responsible for budget execution. All payments are processed through the Treasury electronic payment system.

The GoA presents to the National Assembly information about budget execution within 40 days after the end of each quarter and publishes that information within 45 days after the end of the quarter. The GoA presents the annual budget execution report to the National Assembly by May 1 of the next year.

The consolidated budget is comprised of the state budget and municipal budgets. Central and municipal budgets use the same classifications approved by the MOF. The Budget is presented and approved according to the classification structure and coding¹ recorded in the LBS and in subsequent regulations by MOF. There are five classifications used in presenting the budget in the current system: (1) Functional, (2) Administrative, (3) Economic, (4) Regional, and (5) Programme (see Box 1). The functional, economic, and

administrative classifications currently in use are in accordance with GFS 2001 [8] and were approved by the MOF (Order #5 from 9 January 2007). Programme classification is part of the draft 2019 Annual Budget Law. Prior to this, it was an Annex to the Budget Message but not part of annual budget laws.

Figure 1 presents the page of the 2018 budget appropriations of hospital services (03) of the health division (07) of the functional classification of the state budget. As it demonstrates, the annual budget is approved at a very detailed level of the functional classification (level 4), which is also referred to as funded programme, creating some confusion as described in Box 1 above. Unlike in other countries of similar income in the region or outside of it, given that under the economic classification the health expenditures are largely appropriated through one line-item, it is this detailed functional classification which poses constraints on the financial managerial autonomy of providers.

Unlike in many other LMICs of the region [1, 9], there are no strict input-based line-item budgeting in health in Armenia. While economic and administrative classifications are officially used for the general public budget, most appropriations to the health sector are under two lines of economic classification: “goods and services” and “capital expenditures”. Goods and services cover all the costs of service providers (including salaries of doctors, nurses, the supporting and administrative staff of service

1 Until 2008, these were based on the classification in the IMF's Manual of Government Financial Statistics (GFS86). Government Finance Statistics Manual 2001 (GFSM 2001) classification was fully adopted by 2010. See International Monetary Fund (2009). Republic of Armenia: Report on the Observance of Standards and Codes— Data Module, Response by the Authorities, and Detailed Assessment Using the Data Quality Assessment Framework (DQAF) Washington, DC.

providers, their utility, transportation and other costs) and are not reflected in the state budget in detail. Thus, there is no separate line item for salaries. Service providers spend the allocations they have received from the budget as acquisition of “goods and services” according to the budgets approved by their own boards. Only the central apparatus of the MOH and some projects funded by the Global

Fund are presented with detailed breakdown of economic classification, that is include information about salaries and premiums, detailed appropriations for electricity, communication, insurance, office supply, transport, renovation of facilities, acquisition of new assets, etc.

Box 1: Definition and use of the term “programme”

The term programme is used and understood differently by line ministries, including health, and the Ministry of Finance. Also, the use of this term is not consistent across different strategic and budget related documents. According to the Law on Budgetary System, a “programme” is a group of policy actions (or measures) targeting the achievement of specific outcomes. However, MOH, similar to other line ministries, uses the term “programme” more broadly: for example, it has a number of programmes targeting certain diseases, such as National TB Programme or National Programme for the Prevention of STIs (see **Table 1 in Annex 2**). This is observed in other countries as well, and not specific to Armenia.

Further confusion arises with the usage of the term due to the way functional classification was applied in Armenia. Although the Law on Budgetary System provides a clear definition of what constitutes a budgetary programme, the fourth level of functional classification in Armenia is referred to as “programmes”. In 2007, when Armenia adopted GFS 2001, the functional classification was approved at three levels: divisions, groups and classes, following COFOG [8]. The annual budget, however, also presents a fourth level of the functional classification, which are essentially activities, but are referred to as programmes. For example, the title of the column of the annex of the budget that presents the budget in functional classification is formulated in the following way: **“Titles of divisions, groups and classes of functional classification, funded programmes and responsible bodies.”**

Thus, each medical service in this annex is referred to as “programme”. This use of the term programme to refer to the lowest level of functional classification over the past ten years leads to the fact that even those working on programme budgeting implementation need to constantly clarify (a) whether they are referring to programmes as in a group of activities or interventions intended to contribute to a common set of outcomes, specific objectives and outputs, or (b) whether they are referring to programmes as in the lowest level of functional classification, which are often activities, although they vary in their level of aggregation.

In this report, the term programme or budgetary programme will be used primarily as it is used in programme budgeting literature. When describing the 4th level of functional classification, the terms such as “activities”, “policy measures” or “funded programmes” will be used.

Figure 1: Appropriations to health in the state budget of Armenia for 2018, according to the functional classification of budget expenditures

Division N	Group N	Class N	Titles of divisions, groups and classes of functional classification, funded programmes and responsible bodies	(thousand AMD)
			HEALTH, including	84 074 202.6
7	3		Inpatient services, including	40 192 829.3
7	3	2	Specialized inpatient services, including	6 175 985.4
			Medical care services for TB	1 321 162.7
			<i>Ministry of Health</i>	1 321 162.7
			Medical care services for intestinal and other infection diseases	1 219 950.8
			<i>Ministry of Health</i>	1 219 950.8
			Medical care services for mental and narcological patients	2 515 293.1
			<i>Ministry of Health</i>	2 515 293.1
			Medical care services for oncological and hematological diseases	1 117 578.8
			<i>Ministry of Health</i>	1 117 578.8
			Medical assistance to trafficking victims	2 000.0
			<i>Ministry of Health</i>	2 000.0
7	3	3	Maternal and child medical services, including	14 740 196.3
			Obstetric medical care services	6 253 798.6
			<i>Ministry of Health</i>	6 253 798.6
			Medical care services for gynecological diseases	366 976.7
			<i>Ministry of Health</i>	366 976.7
			Medical care services for children	8 119 421.0
			<i>Ministry of Health</i>	8 119 421.0
7	4		Public healthcare services, including	3 997 338.1
7	4	1	Public healthcare services, including	3 997 338.1
			Population's sanitary and epidemiological safety and public health services	1 873 580.7
			<i>Ministry of Health</i>	1 873 580.7
			National immunoprophylaxis programme	1 825 286.2
			<i>Ministry of Health</i>	1 825 286.2
			Blood collection services	252 951.0
			<i>Ministry of health</i>	252 951.0
			Hygiene and anti-epidemic expert examination service	45 520.2
			<i>Ministry of Health</i>	45 520.2

Source: Annual budget law 2018, attachment N 1, Table 1. Available at http://www.minfin.am/website/images/website/byuje%20ev%20krknaki%20harkum/byuje_uxerdz/Orenqi%20havelvacner.rar

Figure 2 presents the page of the 2018 budget with appropriations for services under classification 07-03-02 (specialized medical services) by economic classification. As described above, activities are referred to as programmes or funded programmes under the existing functional classification, but under programme classification these are below the programme level.

The Armenian budget is about 4000 pages long and presents information in outmost detail. For example, one can find information about appropriations in every division of functional classification by group, class,

service, ministry or agency, and the line of economic classification. They are presented in various annexes to the law. The different budget classifications in the annexes of the budget law (administrative, economic, functional, and programme) all have the same legal status and all need to be approved by the National Assembly. Similar to Moldova [10], this also leads to some confusion about the meaning and content of “line item”, which is a cross-section of these different classifications. The budget execution report complies exactly with the format approved by the National Assembly.

Figure 2: Appropriations to health in the state budget of Armenia for 2018, according to the economic classification of budget expenditures

Budget line	Total sum of class	Funded programmes			
	(thousand AMD)	Medical care services for TB		Medical care services for intestinal and other infection diseases	
		Sum by programme	Including by agents	Sum by programme	Including by agents
			RA Ministry of Health		RA Ministry of Health
	1	2	3	4	5
TOTAL EXPENDITURES	6 175 985.4	1 321 162.7	1 321 162.7	1 219 950.8	1 219 950.8
included					
CURRENT EXPENDITURES	6 175 985.4	1 321 162.7	1 321 162.7	1 219 950.8	1 219 950.8
included					
ACQUISITION OF GOODS AND SERVICES	6 175 985.4	1 321 162.7	1 321 162.7	1 219 950.8	1 219 950.8
included					
OTHER SERVICES ACQUISITION BY CONTRACTS	6 175 985.4	1 321 162.7	1 321 162.7	1 219 950.8	1 219 950.8
included					
- Other services of general character	6 175 985.4	1 321 162.7	1 321 162.7	1 219 950.8	1 219 950.8

Source: Annual budget law 2018, attachment N 1, Table 07-03-02. Available at http://www.minfin.am/website/images/website/byuje%20ev%20krknaki%20harkum/byuje_uxerdz/Orenqi%20havelvacner.rar

Note: In this presentation, financed programmes refer to policy measures or activities of the programme classification. See Box 1 for details.

4. PROCESS OF THE REFORM IMPLEMENTATION

The Government of Armenia decided to take a step-by-step approach (Figure 3). As stated by one of the senior staff members of the Ministry of Finance:

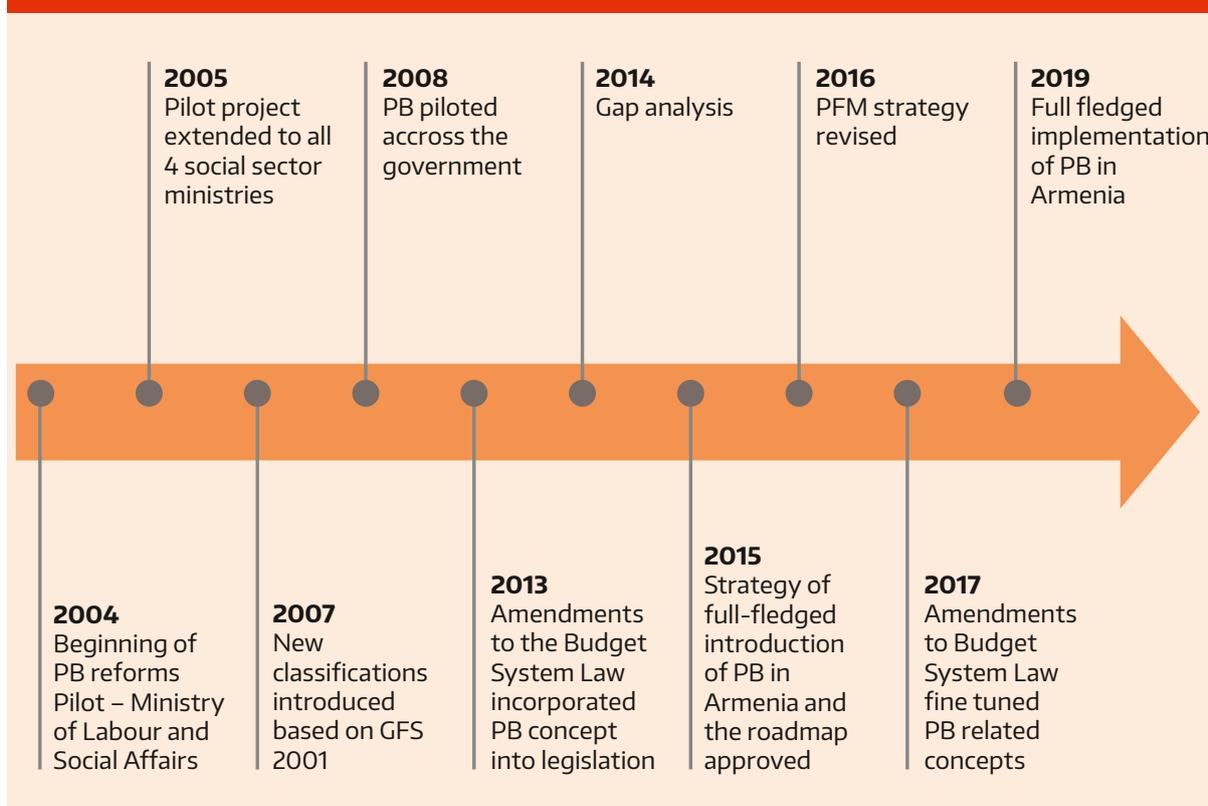
In Armenia, we like to take a cautious approach and think through the steps before taking any action. We do not think that an overnight approach works for us because there are also risks associated with moving too fast from input-based line-item budgeting to programmes. And of course, it takes time to educate people so they accept this new approach.

Similar opinion was voiced by development partners as well as experts.

Programme budgeting reforms followed MTEF implementation in 2004 with a goal of achieving better results in producing public goods and delivering public services. Programme budgeting reforms were a logical part of the fiscal reforms launched in late 1990s.

According to the key informant interviews, the primary objective of programme budgeting

Figure 3: Timeline of implementation of programme budgeting in Armenia



Source: Compiled by authors.

Note: PB denotes programme budgeting.

was improved expenditure prioritization in the context of highly constrained fiscal capacity. Getting better value for money was the key motivation behind the programme budgeting reforms.

In the initial stage, between 2004 and 2008, methodological guidelines for the introduction of programme budgeting were developed, approved and piloted in social sector ministries, including MOH. During these years, programme-based budgets were not part of the official budget documents. Non-financial quantitative indicators for policy measures (activities) were not systematically presented and many programmes did not have them.

In 2010, based on results of the PEFA 2008, the Government of Armenia developed the “Public Financial Management Strategy” and its Implementation Plan for the period 2010-2015 where programme budgeting was outlined as one of the key reform steps [11]. The full-fledged transition to PBB was postponed as it was determined that certain gaps in legal basis, auditing functions, alignment of the chart of accounts, financial management information system, and capacity of the staff in line ministries needed to be addressed before such transition.

On April 30, 2013, the country took a major step in PBB implementation when the National Assembly passed a set of amendments to the Law of the RA “On Budgetary System of the Republic of Armenia”, making programme budgeting mandatory. Previously, programme budgeting was not perceived as a core principle of public financial management of the country, depended on individuals driving the process, and was not legally binding. With these amendments, it became required to present an annual budget using programme

classification and to report non-financial budget performance data.

The reforms were driven by the Ministry of Finance and supported by the external partners, including EU, UK DFID, GIZ, USAID and the World Bank, as part of their support for the overall PFM system reforms. UK DFID and GIZ have provided particularly focused support to programme budgeting.

Based on our discussions with key informants, it appears that the National Assembly has played a key role in later stages of the reform when perhaps the initial enthusiasm from the Government has started waning as it can happen with a long reform process. As the legislators became aware of the potential of the programme budgeting they also became its strong supporters, if not champions. By closely working with the legislators and continued investment in building their capacity GIZ in particular created internal demand for performance information linked to budgets and by extension PBB reforms.

The State Health Agency under the MOH was also actively involved in early years of transition to programme budgeting, including the development of programme descriptions or statements (referred to as passports in Armenia and described in detail in the next section), although the overall process of defining programmes was led by the MOF and its experts.

Development partners and UN technical agencies who traditionally support the health sector, including WHO, were not involved in these reforms although this is starting to change. In 2018, UNICEF conducted a review of budgetary programmes from a perspective of maternal and child health

5. STRUCTURE AND CONTENT OF BUDGETARY PROGRAMMES

The programme structure in Armenia is still evolving and there are still issues on how well the current programme structure in health reflects policy priorities and contribute to better prioritization and transparency. Programme structure in Armenia has two levels: programmes and activities (or policy measures). There are eight programmes under the overall responsibility of the Ministry of Health (Table 1). The programme titles and their overall number have been stable since the early 2005 when programme budgeting was piloted in health, but the type and number of activities under each of them has changed significantly over the years.

The largest programmes (Outpatient services, Hospital services, and Public health services) seem to correspond to groups in functional classification [8]. There is a separate programme for support or general services, as it is generally recommended [12].

State targeted health programmes (see **Section II**) and budgetary programmes for health are closely linked due to the way programmes were identified and defined in Armenia. When the STHP were developed, they included actions or activities which were then grouped together based on their overall objectives to form sub-groups as per the functional classification of expenditures

according to GFS 1986.² Therefore, when the programme-based budgeting began as a pilot, MOH used STHP activities and the way they were grouped already under the existing functional classification of expenditures to form these programmes. Also, as one of the interviewees who has been engaged in the budget reforms from the very beginning noted, an important consideration for the way programmes were defined in these early years in Armenia was the need to assign expenditures by programme without going through complicated bottom-up costing and cost allocation processes – the logic in line with recommendations by Robinson [12]. Thus, STHP underpin both programme and functional classification in Armenia.

However, there is no one to one correspondence between the STHP and budgetary programmes. On the one hand, state targeted health programme on Primary health care corresponds closely to the budgetary programme on Outpatient services (See Annex Table 2). On the other hand, state targeted health programme on Maternal and child health is divided into several activities

2 According to GFS 1986, Health was in Group 5 with the following sub-groups: 5.1 Hospital affairs and services, 5.2 Clinics, and medical, dental, and paramedical practitioners, 5.3 Public health affairs and services, 5.4 Medicaments, prostheses, medical equipment and appliances, or other prescribed health related products, 5.5 Applied research and experimental development related to the health and medical delivery system, 5.6 Health affairs and services not elsewhere classified. See International Monetary Fund (1986). *A Manual on Government Finance Statistics (GFSM 1986)*. Washington, DC, International Monetary Fund.

Table 1: Programmes managed by the Ministry of Health, 2018

Code	Title	Objective as stated in the budgetary document
1001	Policy development, programme coordination and monitoring	Support the achievement of goals envisaged by programmes that are under supervision of the Ministry of Health
1003	Public health	Stop and reverse the spread of diseases, protect donor blood
1099	Outpatient services	Protect and improve the health of the population, improve early detection and prevention of diseases, gradually reduce hospitalization
1150	Hospital Services	Reduce illnesses and mortality
1110	Alternative work services	Assuring participation in defense of Armenia envisaged by the Constitution
1142	Medical assistance and specific professional services	Protect and improve health of the population, break and reverse diseases, increase quality of and access to medical services
1053	Modernization of health system and improvement of efficiency	Improve quality and access to medical assistance and services
1081	Library services	Improve education and awareness of the population, supporting educational goals of strategic programmes, development of scientific, technical and cultural potential of Armenia

Source: The attachment at the Government message for the Law on the State Budget 2018, Republic of Armenia

across two programmes: Outpatient and Hospital services. Also, state targeted health programme on Medical assistance and services for socially vulnerable populations and special groups is reflected only as an activity under the programme of Outpatient medical services.

The number and nature of activities varies widely among the programmes. For example, in the 2018 budget, under the Outpatient services programme, there are 11 activities, ranging from Ambulatory-polyclinic³ services (which received more than 70 percent of the programme budget) to dental services for children (which received 0.2 percent of the programme budget). Activities under the programme Modernization of health system and improvement of efficiency are essentially externally funded projects grouped together,

3 A polyclinic is a clinic that provides both general and specialist examinations and treatments to outpatients.

regardless of their objectives. Also, most of the capital expenditures sit under this programme as they are funded through external assistance. Thus, this programme contains anything from acquisition of medical equipment for the National TB center to transfers to support for consultation and research by AIDS centers. Medical assistance and specific professional services is another programme where there is no obvious common product line. It contains activities such as forensic and genetic services, supply of pharmaceuticals to patients included in special groups, access to modern contraceptives and services related to coordination of activities related to TB.

The programme-based budget document contains a very brief one sentence description of the programme, its expected output, followed by a list of activities (see Figure 4). No further details are provided.

While the strategy for the introduction of

programme budgeting in Armenia [13] envisions creation of uniform programme descriptions or programme statements (referred to as “programme passports”), as of today, this has not been done on a systematic basis as acknowledged during key informant interviews as well as in the 2016 revised strategy for PFM system reform [14]. As envisioned in the strategy [13], these “programme passports” should be developed for each budgetary programme and describe the goal of the programme, its legal basis,

beneficiaries, policy measures and activities, outcome and output indicators. Descriptions must also include problem tree diagnosis, demonstrating the value of the programme and its chosen activities. In health, only three programmes seem to have developed these passports. Thus, five remaining programmes need to still do so. Also, even those three, which have been developed, are likely to be out-of-date now: the “passport” for Outpatient services was developed in 2014 and has not been updated since then.

Figure 4: Programme classification of the health budget

Programme	Activity	Programme/Policy measure (activity)	(thousand AMD)
1150		Programmes	
		Inpatient medical services	40 176 947.3
		<i>Programme descriptions</i>	
		Hospital treatment of socially important diseases, hospital treatment of people entitled to medical and diagnostic services and diagnostic expertise	
		<i>Description of final outcome</i>	
		Reduction of illnesses and mortality	
		Policy measure: services	
	ԱԾ01	Medical services to socially vulnerable and people included in special groups	9 506 387.6
		<i>Description of service provided</i>	
		Medical services to socially vulnerable and people included in special groups – according to the list approved by the Government of Armenia Decree	
		The name of organization to providing services	
		Medical organizations (hospitals)	
	ԱԾ05	Medical services related to tuberculosis	1 321 162.7
		<i>Description of service provided</i>	
		Medical services related to tuberculosis – according to the list approved by the Ministry of Health	
		<i>The name of organization to providing services</i>	
		Medical organizations (hospitals, medical centers and other types of inpatient medical services provider)	

Source: Government Annual Budget Message, attachment N 14. Available at http://www.minfin.am/website/images/website/byuje%20ev%20krknaki%20harkum/byuje_uxerdz/Bacatragri%20havelvacner.rar

6. PERFORMANCE MEASUREMENT FRAMEWORK AND INDICATORS

Performance measures at programme level have only been introduced in 2019 draft budget law. While this is a welcome step in strengthening performance measurement framework, the quality of the indicators is still inadequate.

Moreover, it appears that line ministries, including health, will have to continue reporting on a large number of activity level indicators to the Ministry of Finance on a quarterly basis and to the National Assembly on annual basis.

According to a recent study [11], there were about 2400 qualitative and quantitative indicators across all the sectors reported to the Assembly. In 2018, MOH managed eight programmes with 43 activities measured by 139 indicators, or on average 3.2 indicators per activity. It is reasonable and in line with general recommendations to have on average three indicators per activity [12]. However, it is unnecessarily burdensome and is not conducive to higher transparency and accountability if one has to review on average 17 indicators to understand performance of one programme.

Moreover, there are no outcome indicators, i.e. indicators to which several health programmes contribute and which reflect the overall health system goals in Armenia.

Data on performance indicators are collected on a monthly basis through several types of reports. For most of them, MOH uses the automated systems. Comprehensive health information system has been in place in Armenia since 1999, and it has been updated in 2017. Medical organizations submit monthly electronic reports to MOH which contain information about quantities and amounts of monthly works done in different groups, classes and services of functional classification. Following electronic reports are provided:

- Performance within the framework of hospital, dental and primary healthcare services,
- Aggregate report on the sex and age composition of registered population.

MOH analyses the reports and inputs the financial indicators into the Treasury electronic system. The Financial Department

Table 2: Health budget programmes and non-financial indicators

	2008	2012	2016	2017	2018
Programmes	8	8	8	8	8
Activities	62	66	73	74	43
Indicators: Quantitative/Qualitative	138/18	175/15	136/32	140/32	121/18

of the State Health Agency under MOH monitors the financial performance of “policy measures” (or activities) funded and services provided. In case of deviations the financial department requests the monitoring and control department to review the report of a particular programme or service. As noted above, the MOH is required to report on performance measures on a quarterly basis to the MOF and on an annual basis to the National Assembly. In cases, where there is a deviation from the indicator target of more than 5 percent explanatory note must be provided by the MOH to MOF, which then consolidates all such notes from line ministries and agencies and submits them to the Assembly.

Reporting of indicators at activity level with a requirement to provide explanation for even small deviations from targets may result in perverse incentives. Existing indicators often

focus on target number of people receiving certain types of services. As expected, there is a difference between planned and actual. However, for a number of indicators actual number equals exactly the target. For example, according to 2016 budget execution report, the planned number of people below 18 years of age to receive medical services by general therapists and family doctors was 617 600. The reported actual number was exactly same as the planned figure. Another example is the number of patients receiving free medicines. The planned and actual number of people matches exactly (155 000 people). This suggests that the system is not working from a management perspective. It is highly unlikely that these actual numbers would be met exactly. It is unclear to what extent the incentive to avoid explanations impacts the accuracy of these reported figures. Performance information, however, does not directly impact budget allocation decisions.

7. ORGANIZATIONAL STRUCTURE AND ROLE OF PROGRAMME MANAGERS

MoH has three policy departments, a public health division and ten supporting units. The three policy departments are:

- Department of policy of medical assistance containing Division of policy of outpatient medical services and Division of policy of inpatient medical services
- Department of maternal and child health services containing Division for maternal and reproductive health services and Division for child health services
- Department of pharmaceutical policy and medical technologies containing Division on pharmaceutical policy and Division for medical technologies and coordination of international assistance.

Four agencies report to MoH, including:

- Licensing agency
- State Health Agency
- Health Inspection Agency
- Health Project Implementation Unit (in charge for implementation of externally funded projects).

There are no specific departments or divisions responsible for specific budgetary programmes, except the Financial-Economic Division. This has negative consequences

on how well programmes are linked with policy priorities, their contents and quality of performance information. The policy departments are responsible for development of state policy in respective areas (concept papers, strategies, norms and technical specifications for services, etc.).

According to the Strategy for the introduction of programme budgeting in Armenia [13] and confirmed during interviews for this study, policy departments responsible for State Targeted Health Programmes or National Health Programmes are not involved in formulating, managing, and reporting budgetary programmes. Based on the team's discussions, there appears to be a general perception that the budget is the responsibility of Financial-Economic and Accounting Divisions of the MoH, with no clear accountability lines for the policy departments.

While there is no official mapping of departments and divisions to programmes, it appears that for most programmes there are potentially corresponding units within MOH (**Table 3**), which should enable the Ministry to identify appropriate programme managers as it is a generally recommended practice [15].

Table 3: Mapping of budgetary programmes to organizational structure of the MOH

Programme	Department/ Division
Policy development, programme coordination and monitoring	This is a programme for support services. Human resource management department, Legal department, Financial-economic department, Public relations division etc would typically belong here.
Public health	- Public health division
Outpatient services	- Department of policy of medical assistance / Division of policy of outpatient medical services - Department of maternal and child health services
Hospital Services	- Department of policy of medical assistance / Division of policy of inpatient medical services - Department of maternal and child health services
Alternative work services	- Human resource management department
Medical assistance and specific professional services	- Department of pharmaceutical policy and medical technologies
Modernization of health system and improvement of efficiency	- Financial-economic department - Health Project Implementation Unit
Library services	- This programme could be put as an activity under the first programme on Policy development, programme coordination and monitoring, which would then include all the support functions.

8. SPECIAL FOCUS: IMMUNIZATION SERVICES

Until 2006, immunization services (costs related to cold chain and service delivery) were under the Maintenance of hygienic and anti-epidemic service. Procurement of vaccines was funded through external assistance and not reflected in the main budget.

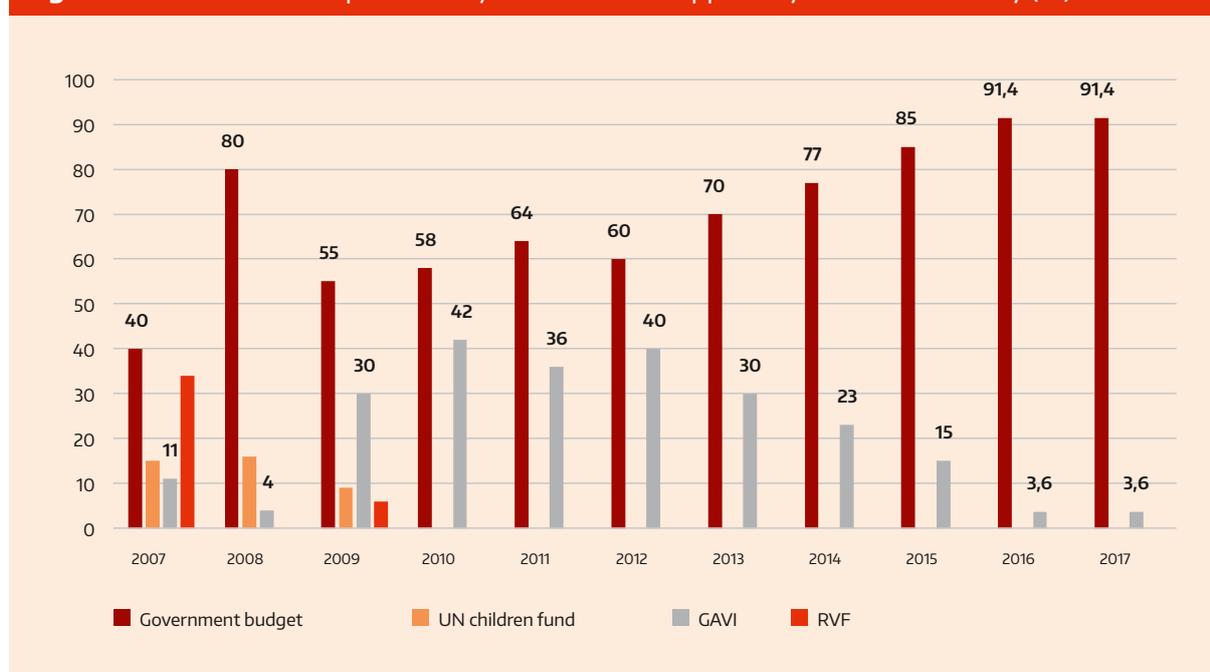
Since 2007, immunization services became re lected in the budget as a separate activity – The National Immunization Programme – within the Public Health Programme. Vaccine procurement, cold chain maintenance, outreach activities were then included in the main budget under one programme and activity line (the National Immunization Programme). However, certain costs related

to logistic services of the vaccine procurement and delivery such as transportation are relected under a separate activity Population Sanitary-Epidemiological Safety and Public Health Services.

Starting from 2016, quantitative indicators have increased from 1 to 7 because what used to be one indicator on the number of vaccinated persons was divided into seven by type of vaccine, for example, number of children vaccinated against TB, number of newborns vaccinated against hepatitis B etc.

Four coverage indicators (for example, BCG coverage, DTP3 coverage) were reflected

Figure 5: Share of vaccine procured by the state and supplied by donor community (%)



Source: MTEF 2018-2020, <http://www.minfin.am/website/images/website/mijnajamket/Havelvacner.rar>

in the Population Sanitary-Epidemiological Safety and Public Health Services activity until 2016. Starting with 2017, these indicators sit with the National Immunization Programme activity, which appears to be more logical.

Based on these performance indicators, the immunization services are performing well in Armenia. The coverage continues to stay above 90 percent of the target population for all the vaccines included in the National Immunization Programme.

Donor community supplied vaccines since independence of Armenia in line with the National Immunization Calendar. The role of external support started to gradually decline after 2005 as the state began allocating funding for procurement of vaccines.

The GOA increased allocations for the National Immunization Programme from AMD 160 million in 2007 to AMD 1890.4 million in 2017 (11.8 times). However, in 2018, there seems to be a small decrease in the budget for immunization programme (Figure 6). Budget execution appears to be stable over the past ten years, although there is a large over-execution in 2014 and under-execution in 2016.

Given the need to control new diseases and taking into account the effectiveness of vaccination in preventing mortality, in 2017-2018 the Government with support of GAVI introduced the HPV vaccine. GAVI will support with AMD 88.4 million in 2017 and AMD 80.3 million in 2018. From 2019 onwards MOH will use state budget funds to acquire the vaccine.

Figure 6: Budget allocation and execution for the national immunization programme



Overall, the current budget classification where National Immunization Programme (NIP) is a separate activity appears to provide good visibility to it and protection.

It is easily located and tracked within the health budget. Currently, NIP is tracked through a set of seven indicators, all of which are subject to scrutiny by the National Assembly. Tracking performance at an activity level and the requirement for the ministries, including

the MOH, to submit this information to the National Assembly on annual basis provides further accountability mechanism. With full programme budgeting implementation, where appropriations and performance monitoring are done at programme level, it is important for the Public Health Programme to include key immunization coverage indicators, ensuring that accountability for timely vaccination of children is not lost.

9. INITIAL EFFECTS OF THE REFORM PROCESS

National Assembly members can now scrutinize budgets more effectively in terms of assessing the extent to which proposed budgets are consistent with public policy objectives. As a result of introducing programme budgeting, by 2016, 860 activities were grouped into 153 programmes in programme classification [14]. In health, this means consolidation of 43 activities found in 2018 budget into 8 programmes. It is expected that once programme budgeting is fully functioning with performance measures developed and the budget appropriated at programme level, the state budget in Armenia will become significantly less fragmented, more transparent and more understandable to the legislature as well as to the public. According to PEFA 2014, the effect of these reforms is already visible [4]. According to it, the overall quality of legislative scrutiny of the annual budget laws has increased through the formal presentation to the National Assembly of the budget in the programme budgeting format along with the line item format. At the same time, the effect of this reform is limited because of lack of strong performance measures at programme level and the continued appropriations at activity level.

As a result of programme budgeting, indicators reflecting quantity, quality and timeliness of services have been developed and are actively used by the Ministry of Health, independent experts and the National Assembly to track performance of and budget allocations to particular priority services. For example, one can identify in the state budget allocations to medical services

related to TB at outpatient level or to the National Immunization Programme. These can be then mapped to performance measures (number of vaccines procured, number of patients who received treatment, number of children vaccinated etc). While large volume of information can be daunting or confusing, Armenia is certainly several steps ahead of other low- and middle-income countries with line-item input-based budgeting and without any performance measures linked to and presented together with financial data as part of the annual budget. According to the Deputy Minister of Health, the Ministry carefully reviews activity indicators when reviewing activities on the annual basis and formulating next year's budget request.

Programme budgeting structure allows tracking of the resources for the Basic Benefit Package (BBP), although it requires mapping activities across various programmes. A key step in health system reforms in Armenia was the introduction of the BBP, and ensuring consistent and adequate funding for it must be a key priority for the Government. The programme classification allows one to monitor how well the Government meets this commitment. Although BBP is not a separate programme and one needs to go through several programmes to select services included in the package, the fact that it is possible to use publicly available budget documents to trace budget allocations for BBP forms a strong basis for improving Government accountability and ensuring financing of basic health services to all the Armenian citizens.

Allocation by programme is shown in Figure 7 and reflects the growing emphasis on strengthening primary care services. Inpatient and outpatient medical services are the two major programmes implemented by MoH, receiving respectively 31-36 percent and 42-49 percent of total funding. While the share of inpatient services programme has been decreasing since 2012, the share of outpatient services programme has been on the rise. Public health programme receives 5-6 percent of MoH budget and has been stable over the past decade. The alternative labor services and library services programmes receive less than 0.5 percent of the MOH budget and both are comprised of one activity (policy measure). The strategic goals of these two programmes are not quite clear and it seems that they should not form separate programmes.

Since 2007 the execution of health budget has been generally strong, as it is also reflected in the execution rate of the three main health programmes (Figure 8). Overall for health, the actual financing deviated substantially from the originally approved budget in 2009 (17.7 percent) and 2013 (11.6 percent). The largest contraction occurred in 2009 when Armenia’s economy experienced significant economic decline. In most other years, actual health budget expenditures fluctuated from originally approved budget very little. The extent to which programme budgeting contributed to strong execution rates is unclear since appropriations and controls remained at detailed activity level with insufficient autonomy afforded to line ministries and the actual spending units.

Figure 7: Allocation by programme (approved budget)

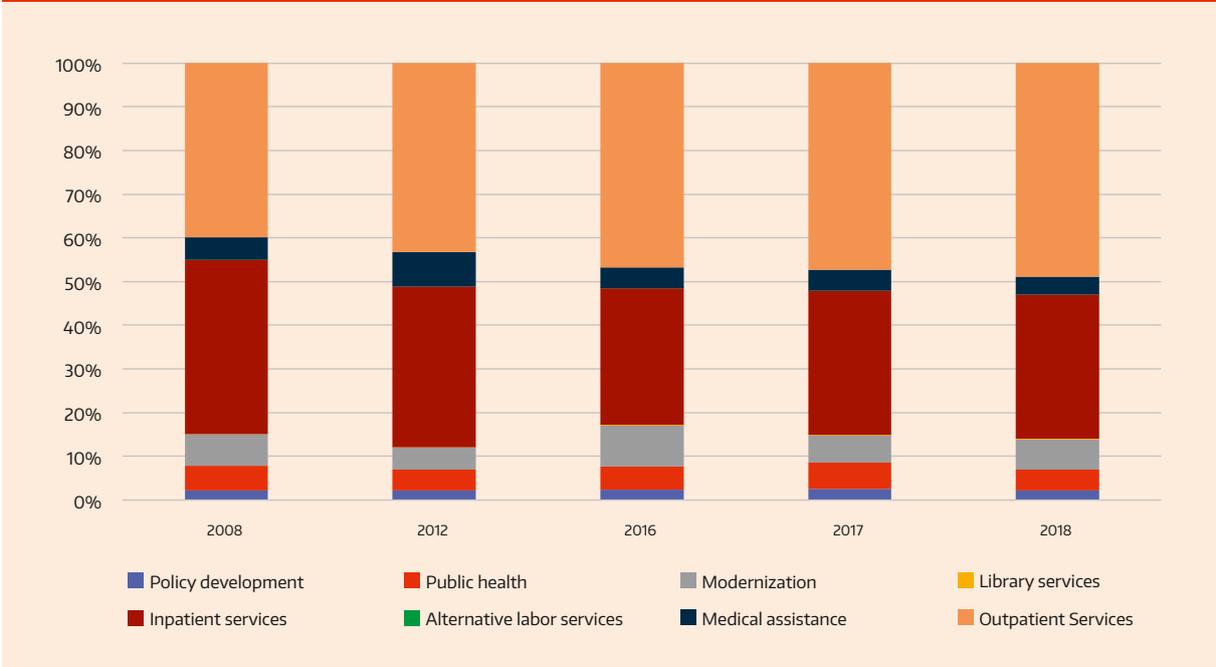
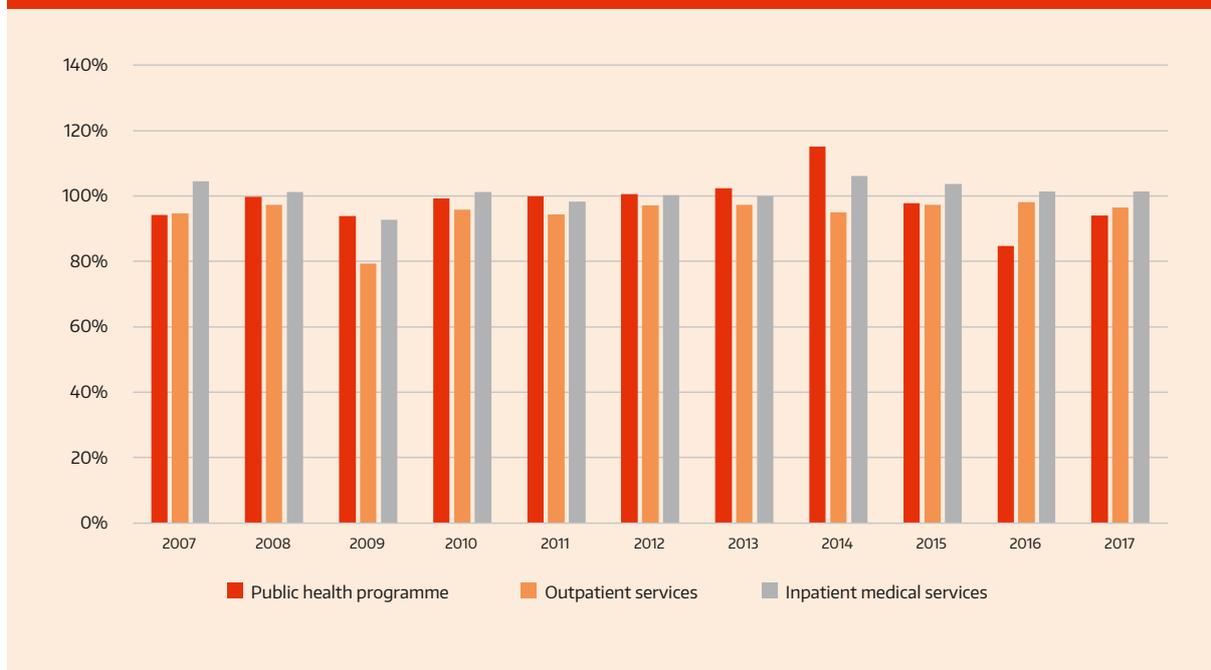


Figure 8: Budget execution of public health, outpatient and inpatient medical services programmes, 2007-2017 (%)



Source: Annual budget execution reports for 2007-2017. http://www.minfin.am/hy/page/petakan_byujei_hashvetvutyun/

10. POLICY RECOMMENDATIONS TO IMPROVE PROGRAMME BUDGETING IN HEALTH

- 1. There is a need to ensure a more systematic approach to linking sector strategies to MTEF and to the annual programme-based budget.** Links among the State Targeted Health Programmes, various national health programmes (for example, Health Promotion Strategic Programme), MTEF and budgetary programmes are not clear. As shown in Figure 9, it is proposed to consolidate the major documents of the sector – STHP, individual national and state programmes and others – into one document articulating MoH strategy. Based on this, MTEF priorities and budgetary programmes in health should be revised. Development partners active in health could support the MOH in this effort.
- 2. It is advisable to re-examine the current structure of the programmes to ensure they have common goals, reflecting health sector policy priorities.** As it is described above, the current programme classification can be improved to achieve better alignment with health sector strategies and policy priorities. Specifically, programme on Library services should be grouped together either with other support functions or with other similar activities on education, research and information, which can then form a separate programme. An activity on Supply of pharmaceuticals to patients of inpatient and outpatient facilities and people included in special groups contains 76 percent of the funding under the programme on Medical assistance and specific professional services. Otherwise, this programme seems to have a variety of activities where a common product line is difficult to identify. This should be done as a joint exercise led by the MOH and with strong participation from MOF and support from development partners active in health. While some of the programme content has changed in 2019 draft budget, there are still issues with the way programmes are defined and the activities they contain, which at time appear to have been put there without a clear logical basis.
- 3. Programme budgeting usually also involves legal appropriation of funds in the budget on a programme basis.** While transition to programme budgeting involves certain risks and cannot be taken overnight without having in place basic PFM characteristics in place, for health to take the full advantage of the programme budgeting there is a need to move away from activity-based appropriations and requirement for the MOH to report on 100+ activity indicators to the MOF and the NA. Both appropriations and performance monitoring should be done at programme level.
- 4. Performance measures need to be revised to reflect more accurately the programme objectives.** This would improve quality of the programme-based budget, allow civil society and legislators to understand and track performance of various programmes and would shift the

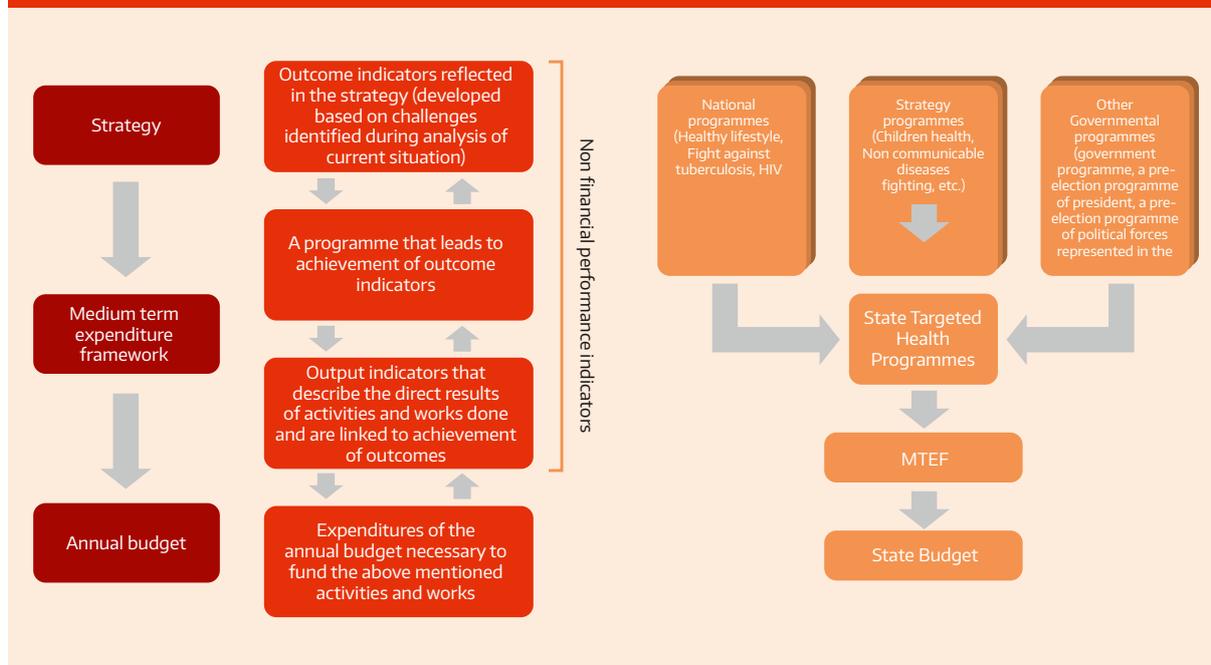
focus from activities to results. Moreover, a strong logical framework that leads from intermediate to final output and outcomes requires some synthesizing of activity level information at programme level, which is missing when there are no good programme indicators. At the same time, there will still be a need to have indicators on activities and inputs. However, these should be used within the MoH by programme managers for management purposes only, not reported to the NA.

- 5. MOH should clarify and strengthen the role of programme managers.** Although there is no need to strictly align the organizational structure of MoH with the programme structure, it is extremely important to specify parties

– programme managers – responsible for implementation of each programme. Programme managers must be responsible for successful implementation of programmes and closely involved in their development and monitoring.

- 6. Programme statements (“programme passports”) are a key element in developing programmes and they should be developed regularly and for all programmes.** Developing or revising these in health in Armenia may provide a good opportunity to also review programme content and performance indicators. Health development partners, such as WHO, are well placed to support the Ministry of Health in the development of these important budget documents.

Figure 9: The Armenian framework linking strategies with the budget



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ANNEXES

ANNEX 1. STATE HEALTH TARGETED PROGRAMMES FOR 2018

Approved by the GOA Protocol Decree No41 from 28 September, 2017

Primary health care

- Assure continuity of development of PHC sector based on the fact that it is the most efficient way of developing and reforming the health system and also targeting provision of accessible, socially fair and equitable medical services to population of Armenia.

Medical assistance and services for socially vulnerable populations and special groups

- Provision of necessary hospital and professional medical services to population from socially vulnerable and special groups. The list of socially vulnerable and special groups of population is approved by the GOA Decree N°318-N from 4 March, 2004

Medical assistance to socially sensitive and special diseases

- Early discovery of socially sensitive and special diseases, medical assistance to ill people and continuous control, promotion of healthy lifestyle and knowledge about hygiene.

Maternal and child health services

- Assuring accessibility and the necessary volume of medical assistance to children, implementation of precautionary measures to reduce child mortality and cases of illness.

Sanitary-epidemiological services

- implementation of hygiene and anti-epidemic control measures nationwide;
- organizing hygiene and anti-epidemic measures for the purpose of preventing infectious diseases and intoxication;
- organizing socio-hygienic surveys of the impact of environmental factors on public health;
- Conducting organizational-methodological regulation of efforts to ensure the hygiene and anti-epidemic safety of population;
- creating an adequate system of hygiene and anti-epidemic norms and rules;
- increasing the level of the population's knowledge on hygiene and medicine

ANNEX 2. THE LIST OF NATIONAL PROGRAMMES AND STRATEGIES

	Title	Legal basis
1	National Programme of Fight against Tuberculosis	GoA Decree N°1680-N from 4 December, 2003
2	Prevention, early disclosure and treatment of more common non-infectious diseases	MOH Order N°18-N from 24 September, 2008
3	Fight against AIDS/HIV in 2017-2021	GoA Protocol Decree N°25 from 15 June, 2017
4	Fight against three diseases with the highest mortality: (1) blood circulation system, (2) cancer; and (3) diabetes.	GoA Protocol Decree N°11 from 24 March, 2011
5	National Programme Immunization 2016-2020	GoA Protocol Decree N°10 from 17 March, 2016
6	“Child and adolsenet health improvement” National strategy	GoA Protocol Decree N°34 from 2 Sept, 2016
7	Reproductive health strategy	GoA Protocol Decree N°24 from 23 June, 2016
8	Programme against transmitters of infectious diseases in Armenia	GoA Protocol Decree N°22 from 29 May, 2014
9	National Programme for the Prevention of STIs	MoH order N3130-A from 27 Dec, 2014
10	Target programme for Viral Hepatitis Control and Prevention	MoH order N3131-A from 27 Dec, 2014
11	Programme of the provisions of the Convention on Biological Weapons in the Republic of Armenia	GoA Protocol Decree N°7 from 16 Feb, 2017
12	The programme on the implementation of the National Action Plan for the Armenia on behalf of UN Security Council Resolution 1540	GoA Protocol Decree N°95-A from 5 Feb, 2015
13	Health Promotion Strategic Programme	GoA Protocol Decree N°50 from 27 Nov, 2014
14	Traumatism Prevention Strategy	GoA Protocol Decree N°2 from 22 Jan, 2015
15	Antimicrobial drug resistance control and prevention strategy	GoA Protocol Decree N°32 from 8 Jul, 2015

ANNEX 3. STATE TARGETED HEALTH PROGRAMME – PRIMARY HEALTH CARE

Programme Title	Programme Goal	Programme Activities	Programme Actions	Actions to be financed
Primary health care of population	In 2018, the continuity of the development of primary health care based on the fact that it is the most effective way of health promotion and reform, as well as the provision of access to medical care, social justice and equity for the population	<ol style="list-style-type: none"> 1) Prevention and treatment of diseases of special social significance in specialized outpatient / polyclinical health institutions, i.e., oncology, anti-tuberculosis, psycho-neurology, narcology, endocrinology, derma-venereal centers, clinics, dispensary departments of health units 2) Early detection of non-communicable diseases, primary and secondary prevention, treatment and rehabilitation 3) Continuous improvement in medical care by developing interconnection between primary and specialized healthcare levels 	<ol style="list-style-type: none"> 1) Implementing measures for ensuring protection of public health, disease prevention, diagnosis, treatment and ongoing surveillance of patients, and, as necessary, organizing hospitalization of those in need for hospital treatment by the therapist, pediatrician, family doctor for the entire population without restriction on visits, 2) Organization of healthy lifestyle awareness raising measures for the entire population by the therapist, pediatrician, family doctor 3) Ensuring the first emergency care of patients in all outpatient/polyclinical institutions, irrespective of the form of their ownership, for the entire population 4) Ensuring specialized consultancy to the entire population by specialty doctors of outpatient/ polyclinic institutions through oncology, psychiatry/narcology, derma-venereal, anti-tuberculosis, infectious disease units, without restrictions on visits 5) Ensuring the conduct of special and hard-to-access diagnostic tests in specialized medical institutions for patients receiving treatment in outpatient-polyclinic, based on valid medical instructions 6) Organization of provision of outpatient / polyclinic health care to population by all specialty practitioners, without restrictions on visits and laboratory-instrumental diagnostic tests 7) Organization of provision of dental health care to socially vulnerable groups of population and children under 8 8) Investigation of persons involved in risk group for early detection and prevention of tuberculosis, diabetes, cardiovascular disease, periodic disease, HIV 9) Provision of pre-medical care and services to the population through paramedical-obstetrical stations in rural areas 10) Ensuring obstetrical-gynecological care of pregnant women and patients with gynecological diseases 11) Continuous management of non-communicable diseases for prevention of secondary complications 12) Rehabilitation treatment for some of the most common diseases for secondary prevention (tuberculosis, cardiovascular, gastrointestinal and nervous system diseases) 13) Ensuring provision of medications to population free of charge or under privileged conditions through therapists, pediatricians, family doctors, 13) improving the quality of medical care in primary health care, developing clinical guidelines for the treatment of some diseases and applying them in performance based financing system 	<p>Ambulator-polyclinic medical services</p> <p>Specialized outpatient care</p> <p>Sports medicine and anti-doping control services</p> <p>Services for conducting hemodialysis HIV/AIDS prevention and medical care services</p> <p>Dental care services</p> <p>Emergency medical care services</p>



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