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Defining and Managing Budget Programs in the Health Sector: The Brazilian Experience

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Case Study

CONTENTS

This case study was commissioned as part of the 2018 IBP-World Health Organization's joint paper on program budgeting in the health sector, **Program Budget Structure in the Health Sector: A Review of Program-Based Budgeting Practices in Low- and Middle-Income Countries**. *Each case focuses on how a given country introduced and modified their approach to program budgeting over time, and the implications for the budget program structure under the respective ministries of health. While all case studies report on countries with budget programs, each country has followed a different approach (using different terms) to orienting their budget toward performance, of which their program budget and program structure is only one element. The cases, as well as the synthesis paper and related materials, are available here: https://www.internationalbudget.org/analysis-insights/program-budgets.*

INTRODUCTION

With a population of more than 200 million and the eighth largest economy in the world, Brazil is a regional and global emerging power to be reckoned with. In terms of per capita income and human development, Brazil ranks only 79th and 80th respectively, highlighting the challenges that the country still faces when it comes to poverty, inequality and social development. According to World Bank data, Brazil spent 8.9 percent of GDP on health in 2015, up from 8.4 in 2000. This is well above the regional average (7.4 percent) but well below the average for OECD countries (12.5 percent). In terms of health indicators, Brazil does reasonably well in comparison to both regional and global standards, with life expectancy at 75 years and a maternal mortality ratio of 44 per 100,000 live births. However, the country is characterized by strong inequality and regional disparities. Its federal system means that most basic and intermediate services are provided by municipal and state level governments, making the delivery of health services complex and of variable quality.

This short case study looks at how the Brazilian government has approached program budgeting in the health sector, and assesses the way in which it has linked health spending with key policy objectives for the health sector. After a brief historical overview of the development of program budgeting in Brazil, we take a closer look at how budget programs are designed and managed in the health sector, highlight a series of key challenges that the government faces, and conclude with some summary considerations.

A BRIEF HISTORY OF PROGRAM BUDGETING IN BRAZIL

The roots of program budgeting in Brazil date back to the 1930s-40s, when the government made some attempts to relate public spending with the implementation of a series of activities linked to the achievement of specific objectives – calling them "services" rather than "programs". It was only in the 1960s, however, that program budgeting was introduced in a more systematic manner. Law No. 4320 of 1964, which provides the legal basis for much of public financial management to this day, introduced programs as the instruments to link capital spending

to targets that describe the realization of public works or service delivery. Further regulation of the matter came in 1967 with Decree No. 200, which ushered in the use of multi-year sectoral and regional programs as planning instruments, along with an annual "program budget" (*orçamento-programa*) which would detail the annual implementation of those multi-year programs. The parameters of the new Constitution of 1988 continued in this direction without bringing any big changes. It defines the key planning and budgeting instruments as: (a) the Pluriannual Plan (*Plano plurianual*, or PPA), which is formulated over the first year of a presidential mandate and covers a period of 4 years; (b) the Law of Budgetary Guidelines (*Lei de Diretrizes Orçamentárias*, or LDO) to be passed every year to define the key parameters and policy directives that will orient budget formulation; and (c) the annual Budget Law (*Lei Orçamentária Anual*, or LOA). The PPA is meant to define objectives and targets for national, regional and sectoral government plans and programs, while LDOs and LOAs are supposed to translate these into yearly priorities and activities.

The use of the "program" terminology throughout these early decades, however, although clearly intended to link government policy objectives with the key activities meant to achieve them, was not based on a full-fledged results-oriented approach aimed at promoting more effectiveness in public spending. Rather, it was seen as an additional classification system that allowed for building bridges between plans and budgets, rather than a way to more directly ensure that objectives were met.

In preparation for the PPA 2000-2003, efforts in the late 1990s focused on developing a more comprehensive and strategic approach to using budget programs to improve government performance and linking spending with results. Decree No. 2829 of 1998 states that all government actions for the delivery of goods or services directly aimed at addressing society's demands should be structured in programs oriented towards the achievement of the strategic objectives defined for the duration of the PPA. It calls for each program to include, among other things, the definition of an objective, the designation of an organization responsible, and the complement of deadlines, indicators and targets. And, it further indicates that a results-oriented management system should be introduced, through the appointment of program managers within the organizations responsible for each program, the development of an information system to support results-oriented management, and the realization of annual evaluations to verify results achieved, limit waste and inform resource allocation in future years.

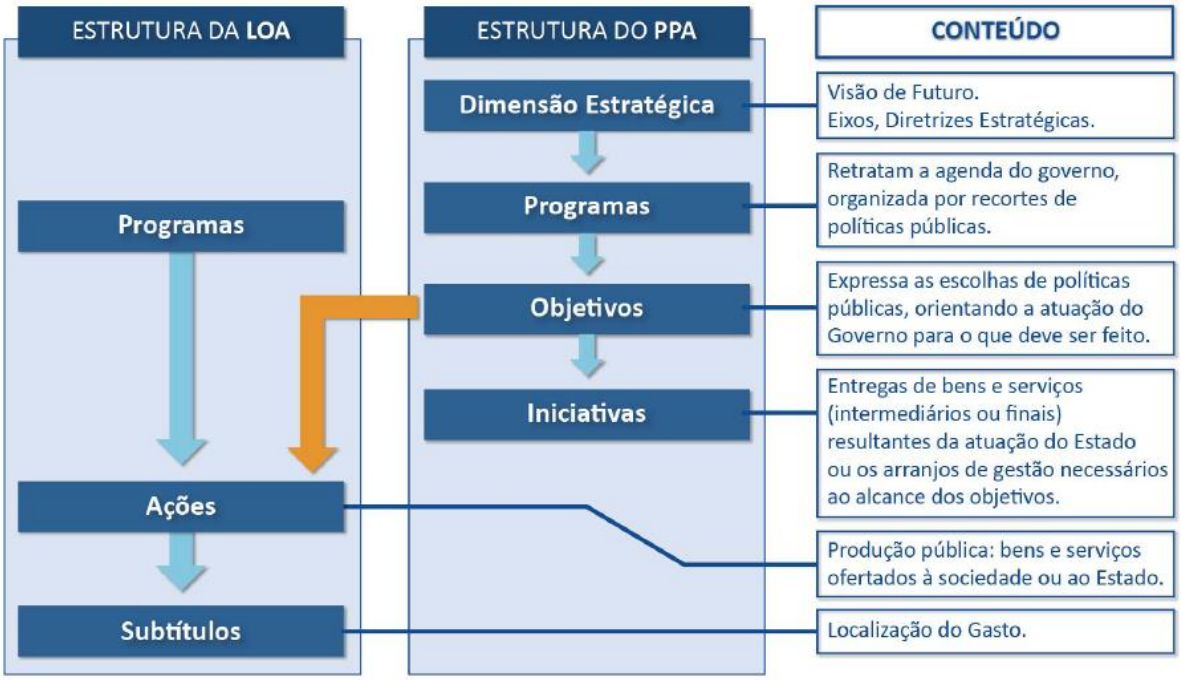
Over the decade that followed, and until the formulation of the PPA 2012-2015, these were the principles and practices that supported the development of program budgeting throughout the Brazilian government. Programs would be defined at the beginning of each four-year cycle during the formulation of the PPA, and these programs would then be reflected in annual budgets, alongside their budget allocation. Programs were structured around a "problem" that government action was meant to address, and organized as a set of activities to be financed in order to solve that problem. A set of tools and methods were developed to assist ministries in the formulation of program-based budgets, and of defining activities within each program.

Coming up to the formulation of the PPA 2012-2015, and following heated debate within the planning ministry, the government decided that a change was needed. The idea of programs as building blocks of a results-oriented management approach "aimed at achieving strategic objectives" – as the PPA 2008-2011 Law still indicated – was substituted by an approach in which programs were defined as "expressing and orienting government action" (PPA 2012-2015 Law), and were rather aimed at explaining the government's agenda to the public, with no immediate link to results. Underscoring this was a shift from management to communication, and from a more technical approach to a more political one. This was probably due to a number of factors, including a realization that using programs as "management units" was very difficult and had not delivered as expected, and that some of the easy gains made during the boom decade were going to give way to more difficult times. Some interviewees also spoke about the influence of individual planning directors and their personal views on what system should be adopted.

Following this shift, the number of programs was drastically reduced, and many of the key ministries were left with a small number of very broad programs, which were mostly meant to summarize in a very broad sense what the government's vision was for a specific sector rather than to detail how resources were going to be spent in support of specific objectives and targets. This has resulted in the need for all of the technical details – including budgetary allocations – to be detailed at lower levels. More specifically, each program is broken down into a series of "objectives" that the government intends to pursue, and into "budgetary actions" (*Ações Orçamentárias*) that in many cases can be considered as sub-programs. While some of these budgetary actions consist of small-scale activities and projects, others – like primary healthcare and pharmaceuticals – had previously been designated as separate programs in the earlier approach, given their large size and complexity.

Figure 1 below, taken from the latest Technical Manual (*Manual Técnico do Orçamento*, or MTO 2018) produced by the federal budget office in the Ministry of Planning, Development and Management, summarizes and explains the relationship between the PPA and the LOA under the current approach. At the beginning of each PPA cycle, the planning ministry defines the programs that outline the government's agenda for each area of public policy. There are two main types of programs: (a) "thematic programs" which focus on delivering goods and services to society; and (b) "management, maintenance and services programs" which cover support services of different kinds. For each program, a set of objectives are defined, which in turn are broken down into more specific initiatives. Annual budgets, in turn, use the same program structure as the PPA, and breakdown each program into budgetary actions for which detailed budget information is provided, including responsible agency, source of funding, type of spending, etc. In principle, the key link between annual budgets and the PPA is that – as a ministry official put it – groups of actions contribute to a specific objective. In fact, Volume II of the LOA groups actions by objective, providing at least some detail of how yearly spending is supposed to contribute to broad policy priorities in each sector.

FIGURE 1: INTEGRATION BETWEEN BUDGETARY ACTIONS AND THE PPA



Source: MTO 2018, page 37.

In order to better understand how the system works – or is meant to work – and the challenges that it faces, we now turn to the specific case of the health sector.

PROGRAM BUDGETING IN HEALTH: WHAT DOES IT LOOK LIKE?

This section reviews how budget programs in the health sector are structured across the PPA and LOA, how they have evolved since 2000, and what they look like in the latest LOA (2018).

Over the period from 2000 to 2012, PPAs and LOAs included approximately 40 programs for the health sector, about two thirds of which fell under the main responsibility of the Ministry of Health. Among these, the largest ones were consistently those for hospital care (*Atenção Hospitalar e Ambulatorial*), primary healthcare (*Atenção Básica*), pharmaceuticals, preventable diseases/ immunizations, sexually transmitted diseases and professional training for health workers. Many of these programs, however, were subject to changes from year to year, rendering the tracking of program spending over time quite difficult. For example, health surveillance for different types of diseases was aggregated for no obvious reason or explanation, and program names were quite often changed, without any clear indication of associated changes in their content and coverage. In addition, two

separate programs always existed for the payment of salaries of active employees, and of pensions to retired employees, taking up around 20 percent of total budgeted expenditure.

From 2012 onwards, as mentioned above, the shift towards a smaller number of more aggregated programs began to be implemented, and most of the key programs in health were brought under a unique thematic program – "program 2015". Referred to as "Improvement of the Universal Health System" (*Aperfeiçoamento do Sistema Único de Saúde*) in the PPA 2012-2015, after the introduction of the latest PPA in 2016 this program's name was officially changed to "Strengthening of the Universal Health System" (*Fortalecimento do Sistema Único de Saúde*).

The PPA 2016-2019 devotes 14 pages to program 2015, identifying more than 30 indicators that should be monitored to assess its performance, and then setting out a very large number of targets and initiatives grouped under 12 objectives, which range from a very encompassing "*Expand and qualify access to health services, in a timely manner, with an emphasis on humanization, equity and meeting health needs, improving policies for basic and specialized outpatient and hospital care*" (objective 0713) to a much more specific "*Strengthen social control mechanisms and channels of interaction with health users, guaranteeing transparency and citizen participation*" (objective 0724). Many of the objectives are linked to what previously were separate programs – e.g. professional training, health surveillance, access to pharmaceuticals, etc. In the PPA, however, only an indicative overall budget figure for each program is provided, rather than a more specific allocation to more specific objectives or initiatives. For program 2015, R$ 102.5 billion is allocated for the first year of the PPA (2016), while an indicative total allocation of R$ 348.6 billion is included for the remaining three years (2017-2019).

Details for the annual health budget are provided in Volume IV of the LOA. The LOA 2018 allocates an overall budget of R$ 130.8 billion to the Ministry of Health, of which R$ 106.1 billion (81 percent) is allocated to program 2015, and R$ 22.1 billion (17 percent) to the two programs covering salaries (2115) and pensions (0089). The remaining amounts are for smaller components of programs mostly managed by other ministries, such as basic sanitation, food security and promoting the health of indigenous people, or for so-called "Special Operations" (*Operações Especiais*) programs, including contributions to international organizations, and contingency reserves.

The total budget for the Ministry is managed through six budgetary units, which include two foundations, two agencies, a hospital and the National Health Fund (*Fundo Nacional da Saúde*), which manages 93 percent of total budget resources. Each of these units manages a certain number of budgetary actions. The Oswaldo Cruz Foundation (*Fiocruz*) – with a total budget of R$ 2.6 billion – focuses mostly on health research, while the National Health Foundation (*Fundação Nacional da Saúde*) is responsible for managing actions for the basic sanitation program that falls under the Ministry of Health's responsibility, with a budget of R$ 3.6 billion. The National Agency for Health Surveillance and for Supplementary Health are responsible for a couple of budgetary actions each, and have budgets of R$ 0.9 billion and R$ 0.4 billion respectively.

The National Health Fund is responsible for managing the bulk of budgetary actions – which number about one thousand in total – though most of them consist of transfers to states and municipalities for funding health services of their competence. That means, for example, that there is a very large number of budgetary actions that correspond to transfers to individual municipalities for funding service delivery and maintenance of primary healthcare, and similar transfers to states for secondary and tertiary care. Many of the larger budgetary actions include funding for both central and decentralized activities for work areas like immunizations, professional training and pharmaceuticals that in earlier budgets figured as separate programs. For each budgetary action an output indicator is included, usually of a very general kind and of difficult interpretation. For example, budgetary action 20YD on professional training ("*Educação e Formação em Saúde*") designates a total number of beneficiaries as its output indicator, with no specifics on whether this corresponds to the number of staff trained nor to the kinds of training the budget is supposed to fund. Other actions are related to process indicators, including all of those that are transfers to lower levels of government.

TABLE 1. EXAMPLE OF HOW HEALTH TRAINING IS ADDRESSED IN VARIOUS DOCUMENTS (EXTRACT)

PPA 2016-2019	**LOA 2018 – Volume II**	**LOA 2018 – Volume IV**
Program 2015: Strengthening of the SUS	Program 2015: Strengthening of the SUS	Program 2015: Strengthening of the SUS
Objective 0721: Promote training and permanent education, etc.	Objective 0721: Promote training and permanent education, etc.	
Target 029N – Achieve 38,500 scholarships for residency programs Target 04HF – Qualify 380,000 health professionals		
Initiative 05TO – Broaden access to permanent education for health professionals Initiative 05UH – Strengthen communities of practice and collaborative networks […]		
	Budgetary Action 20YD – Education and training in health	Budgetary Action 20YD – Education and training in health No. of beneficiaries: 6,440 (Fundação Oswaldo Cruz) No. of beneficiaries: 58,910 (Fundo Nacional de Saúde)

In Volume II of the LOA a correspondence is drawn between individual budgetary actions and objectives drawn from the PPA. So, for example, the professional training budgetary action is pretty much the only one that contributes to the related PPA objective. In principle, that would suggest that it should be easier to link the budgetary allocation and its related output targets in the LOA to the targets and initiatives that are listed under this objective in the PPA. However, as can be seen in Table 1 above, targets and initiatives in the PPA are of a very varied nature, and are not easily linked with the targets identified for the relevant budgetary action in the LOA. It could well be that the more than 60,000 beneficiaries of training indicated in the LOA are part of the 380,000 for the PPA as a whole, but there are no details about how that is supposed to happen, or about how other targets are to be met.

Other, broader PPA objectives include a much larger number of budgetary actions. The previously mentioned objective on access to healthcare, for example, includes 27 actions with a total budget equivalent to more than half of the total health budget. The link to the targets and initiatives identified in the PPA, however, is often not very clear. Some of the budgetary actions – especially those related to specific infrastructure projects like the construction of a hospital – can easily be identified in both documents. In many other cases, though, it is much less obvious exactly how individual budgetary actions, or groups of them, are supposed to contribute to PPA targets and initiatives.

PROGRAM BUDGETING IN HEALTH: HOW IT WORKS AND KEY CHALLENGES

This section discusses some important aspects of the definition and management of budget programs in the health sector and is primarily aimed at contributing important elements for cross-country comparisons.

The concept of "program" is often used in loose terms by government, which can complicate both transparency and accountability. Programs, as identified in the PPA, are meant to shape budget allocations and government intervention across sectors. But the health ministry often uses the term "program" to describe interventions and communicate with the public in ways that can create some confusion. On the ministry's homepage there is a link to a section of the website called "actions and programs", which one would expect to have direct linkages to items in the PPA and LOA using the same terminology. Yet, many of the initiatives described on that page do not appear at all in budget documents, leaving people wondering how the government intends to implement them. For example, the Family Health Strategy (*Estratégia Saúde da Família*) appears as a program on the ministry's website, but no similarly named program appears in budget documents, despite appearing as one of the targets in the PPA.

The overall responsibility for designing the broad structure of budget programs belongs to the planning ministry, which reviews and updates it every four years, as part of the process for formulating the PPA. While, of course,

some consultations with sector ministries occur, the key decisions are made by the planning ministry. The decision to shift towards a more aggregated program structure, for example, was an initiative of the planning ministry during the formulation of the PPA 2012-2015. The idea was presented to sector ministries for discussion, and was accepted by most of them, including the health ministry, without major pushbacks. This is also because it is the sector ministries that ultimately decide how many and which budgetary actions to include in their budget proposal, in consultation with the federal budget office (*Secretaria Federal de Orçamento*, or SOF). And it is against budgetary actions – or sub-programs – that ministries really plan their interventions and activities, and that resources are appropriated in the LOA.

Detailed budget planning happens below the level of budgetary actions and related resource allocations, using so-called budgetary plans (*Planos Orçamentários*, or POs). These are not included in the budget proposal, but are available on the planning ministry's website through a portal called *Painel do Orçamento*, where detailed data can be pulled up from the government IFMIS using different fields. Again, using professional training in health as an example, the action includes six POs, including support for health-related technical schools and training centers, for continuing education in health and for development of university degrees in strategic areas for the health system as a whole. These POs, however, do not include specific indicators or targets.

The health ministry felt that being responsible for an individual thematic program, no matter how large or complex, would provide them with additional flexibility in managing available resources. Given that programs are defined in the PPA law, and can only be changed through a legislative process, transforming major programs into large budgetary actions within a unique program would make shifting resources between various areas under the ministry's responsibility easier. Such an increase in flexibility, however, was questioned by a budget specialist in Congress, who said that the law determines fairly strict procedures for shifting funds around budgetary actions as well. A section of the LOA (Art. 4) details limitations to such shifts and requires the process to be vetted and approved by the planning ministry. It is only at the level of POs that each ministry has direct responsibility and flexibility to adjust allocations.

Over the years, a decision was taken to create separate programs for salaries and other staff costs, rather than to attribute staff costs to specific programs or actions. In the years between 2000 and 2012, when programs were intended as tools for promoting results-oriented management, some effort was put into a more comprehensive costing of activities, including staff costs, but due to the complexities involved, this was never fully realized. Also, a choice was made to limit the focus of budgetary actions on specific diseases, in order to be better able to respond flexibly to emergencies such as epidemics. For example, while in 2000 specific budget programs existed for fighting malaria, dengue fever and tuberculosis, in the LOA 2018 this is no longer the case, with budgetary actions more generally tackling infectious diseases of different kinds.

The relationship between the structure of programs and budgetary actions and the administrative structure of the health ministry is complicated by the use of the National Health Fund as the main channel for managing funds in the health sector. As already indicated, foundations and agencies under the health ministry are allocated budgetary resources for specific activities, but the bulk of the budget is channeled through the Fund, with no specific indication of which Department (or *Secretaria*) is responsible for its management and implementation. As already indicated, many such allocations are transfers to states and municipalities, but quite a few large ones are registered as national-level actions, and therefore managed by the federal ministry. Looking at the ministry's structure, it is not difficult to figure out who should be responsible for which budgetary actions. For example, the Department for Pharmaceutical Assistance and Strategic Inputs is clearly the part of the Ministry of Health's structure responsible for most actions related to ensuring adequate access to medicines. However, no information to explain this is available in the budget documents.

As already indicated, the output or process indicators included in the budget proposal for each budgetary action bear little relation to the objectives and targets defined for programs as a whole in the PPA. This is partly due to the fact that while objectives and targets are defined in the PPA every four years, indicators for budgetary actions are defined through the annual budget process. Planning and budgeting are often treated as separate functions with limited integration. In the LOA, the process or output indicators identified for individual budgetary actions are not easily linked with the targets identified for objectives in the PPA, which in turn are not always clearly related to the long list of impact indicators that are meant to monitor performance at the program level.

In terms of reporting, getting a full picture of what happened during budget execution for specific budgetary actions in the health sector is a complex task. There are three kinds of reports and sources of information that can be used to track spending, outputs and results. The first one is the Annual Management Report (*Relatório Annual de Gestão*, or RAG) published by the health ministry. This provides aggregate spending information which is not broken down by budgetary action, only by broader categories and sub-functions. It also reports on actual progress toward targets under each objective drawn from the PPA and the National Health Plan (*Plano Nacional de Saúde*, or PNS), and indicates which budgetary actions contributed to that target, but again without detailing how much was spent for each, and on what. The second source is the Annual Evaluation Report (*Relatório Anual de Avaliação*) on the PPA, published yearly by the planning ministry. This report includes performance information on targets under each objective, with an indication of necessary remedial actions, in its Annex 2, and financial information on budget execution by budgetary action in its Annex 4, but without making any links between the two. Finally, detailed management reports (*Relatórios de Gestão*) are submitted by individual departments within the health ministry to the supreme audit institution (*Tribunal de Contas da União*, or TCU). These last ones are very detailed reports for specific areas of responsibility within the ministry and include information for each budgetary action, covering both financial and non-financial information on the indicators associated with each action as well as a short explanatory narrative. While the full combination of these reports allows a fairly detailed picture of the

implementation of budgetary actions, the multiplicity and fragmentation of reporting renders such an exercise very difficult and time-consuming.

Reporting and accountability is further complicated by the decentralized nature of health service delivery. Around two thirds of the financial resources in the health ministry's budget consist of transfers to states and municipalities to fund the delivery of health services under their responsibility. Most of these transfers are termed "Fund-to-Fund", as they are channeled from the National Health Fund to similar funds which exist in each state and municipality. While the LOA details the specific budgetary actions that the funds are meant to be spent on, the actual financial transfers happen in two overall blocks, one for recurrent and one for investment spending. This recently introduced reform – previously transfers were structured according to seven different areas of intervention – was meant to provide local governments with more flexibility in budget execution, and to help avoid the building up of unspent funds. By further delinking the approved budget from execution modalities, many are worried that it will weaken accountability for budget execution and make it much more difficult for central agencies to have a clear idea of how funds are actually being spent, without recourse to detailed audits.

Actual oversight and accountability provided by Congress is very limited. According to a number of people interviewed, despite the wealth and detail of information that is published by government and provided to Congress, parliamentarians have shown very limited interest in holding the executive accountable for program execution and for performance against objectives and targets identified in the PPAs and LOAs. Their interest in annual budgets and their execution is usually limited to specific investments which benefit their electoral base, and sometimes are linked to controversial "individual parliamentary amendments" (*Emendas Parlamentares Individuais*) that they can include in the approved budget and which the executive is obligated to execute up to a certain amount, or to items which get wide coverage in the media and on which therefore they feel pressured by public opinion. Recent examples include special committees that were created to accompany the Zika virus outbreak in 2016, and the military intervention to boost safety in Rio de Janeiro in 2018.

CONCLUSIONS

This short paper has brought together evidence from documents, reports and interviews with key informants on program budgeting in the Brazilian health sector.

Brazil has a very long history of using program budgeting to organize public spending and link it with public policy objectives. Approaches to the use of program budgets have shifted and morphed numerous times over the years, but have been more or less consistent over the past two decades, when the purpose and use of different planning and budgeting instruments was better structured and firmed up. Over this time, however, the actual shape and content of budget programs in the health sector have seen a number of important changes, leading to the current

structure of a single, comprehensive program for the sector as a whole, broken down into a very large number of budgetary actions, some of which are very broad and worth many billion Reais, while others entail just a few million and have a specific and narrow focus.

The architecture for linking public spending with a specific set of activities aimed at achieving policy objectives and of indicators for monitoring progress is quite complex, and involves a multiplicity of planning and budgeting instruments, and reporting arrangements. The system is characterized by high levels of transparency, in the sense that a large amount of information is made publicly available. That information importantly includes manuals and guidelines, making it possible, in principle, to figure out how public funds are being spent and with what results. Unfortunately, due to the large number of often disconnected systems and reports, accessing and understanding the available information is quite difficult. And using it for accountability purposes is even more complicated, due to the decentralized nature of health service delivery and to weak parliamentary oversight. As a consequence, the potential of Brazil's program budgeting systems and practices to improve health service delivery remains mostly untapped, and budget and performance information is rarely effectively utilized to inform and improve government decision-making and action.

ANNEX 1. INTERVIEWS

1. **Jorge Luiz Rocha Reghini Ramos**, Adjunct Under Secretary for Planning and Budget, Ministry of Health
2. **Fabiola Sulpino Vieira**, Specialist in Public Policy and Government Management, Institute for Applied Economic Research (Ipea)
3. **Aritan Borges Avila Maia**, Budget Consultant, Federal Senate
4. **Carlos Ocké-Reis**, Researcher, Institute for Applied Economic Research (Ipea), and President, Brazilian Association of Health Economics (ABrES)
5. **Euler Albergaria de Melo**, General Coordinator, Federal Budget Office, Ministry of Planning, Development and Management
6. **Luiz Fernando Arantes Paulo** and **Ricardo Dislich**, Secretariat for Planning and Economic Issues, Ministry of Planning, Development and Management

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