This report synthesizes qualitative and quantitative information required for the review of public financial management (PFM) in the health sector in the WHO South-East Asia Region. It unpacks PFM issues in health to describe common challenges and bottlenecks, reviews knowledge gaps, and illustrates good reform practices among Member States. The report highlights opportunities for improvement and contributes towards building the momentum on aligning health financing and PFM systems in the Region.

This report will be useful for government officials in their decision-making on health policy and planning, as well as in monitoring and evaluation processes. Development partners and technical agencies can benefit through the identification of potentially strategic areas to support countries. Those in civil society and the nongovernmental sector can use this report to bolster their advocacy efforts. Researchers can delve deeper into the report to analyse country-specific challenges and reform options, as well as to assess how these reforms sustain health financing for universal health coverage.
Leveraging public financial management for universal health coverage in the WHO South-East Asia Region

A Regional Synthesis Report
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### Acronyms and abbreviations

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<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>APA</td>
<td>Annual Performance Agreement</td>
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<tr>
<td>ASEAN</td>
<td>Association of Southeast Asian Nations</td>
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<tr>
<td>BPJS</td>
<td>Badan Penyelenggara Jaminan Sosial Kesehatan</td>
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<tr>
<td>CiGAS</td>
<td>Computerized Integrated Government Accounts System</td>
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<td>e-PEMS</td>
<td>electronic Public Expenditure Management System</td>
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<td>e-MENSCR</td>
<td>electronic Monitoring and Evaluation System of National Strategy and Country Reform</td>
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<td>FMIS</td>
<td>financial management information system</td>
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<td>FTE</td>
<td>fiscal transparency evaluation</td>
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<td>GDP</td>
<td>gross domestic product</td>
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<td>GFMIS</td>
<td>Government Financial Management Information System</td>
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<td>GIFMIS</td>
<td>Government Integrated Financial Management Information System</td>
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<tr>
<td>IBP</td>
<td>International Budget Partnership</td>
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<tr>
<td>ICT</td>
<td>information and communications technology</td>
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<td>IEC</td>
<td>information, education and communication</td>
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<td>INTOSAI</td>
<td>International Association of Supreme Audit Institutions</td>
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<td>IPSAS</td>
<td>International Public Sector Accounting Standards</td>
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<td>ITMIS</td>
<td>Integrated Treasury Management Information System</td>
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<td>MoHFW</td>
<td>Ministry of Health and Family Welfare</td>
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<td>MoPH</td>
<td>Ministry of Public Health</td>
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<tr>
<td>MTBF</td>
<td>medium-term budgetary framework</td>
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<tr>
<td>MTEF</td>
<td>medium-term expenditure framework</td>
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<td>MTFF</td>
<td>medium-term fiscal framework</td>
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<td>MTPF</td>
<td>medium-term performance framework</td>
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<td>PAEC</td>
<td>Public Sector Audit Evaluation Committee</td>
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<td>PEFA</td>
<td>public expenditure and financial accountability Reviews</td>
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<td>PFM</td>
<td>public financial management</td>
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<td>PM-JAY</td>
<td>Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana</td>
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<tr>
<td>SAC</td>
<td>State Audit Committee</td>
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<td>SAI</td>
<td>supreme audit institution</td>
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<td>SAO</td>
<td>State Audit Office</td>
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<td>SDGs</td>
<td>Sustainable Development Goals</td>
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<td>SuTRA</td>
<td>Subnational Treasury Regulatory Application (Nepal)</td>
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<td>UCS</td>
<td>Universal Coverage Scheme</td>
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<td>UHC</td>
<td>universal health coverage</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Robust public financial management (PFM) systems play a crucial role in achieving universal health coverage (UHC). When combined with adequate and sustainable domestic public funds, robust PFM systems help facilitate health financing reforms, and enable the allocation, use and accounting of public funds in a transparent and accountable manner. The effective integration of PFM and health financing systems can yield significant synergistic benefits, ensuring a sustainable and predictable flow of resources, aligning priorities with available funds and promoting strategic purchasing.

In the recovery from the COVID-19 crisis, countries of the WHO South-East Asia Region have a unique opportunity to strengthen and align PFM and health financing systems, which together we must grasp. This will enhance the efficiency, transparency and accountability of public funds allocated to health services, while the overall quality of PFM systems – and their alignment with health financing architecture – will help build resilient health financing systems.

To achieve these outcomes, this report addresses critical knowledge gaps, highlights evidence on PFM issues in the health sector, identifies common challenges and bottlenecks, and outlines several successful reform practices among countries of the Region. It notes a series of key challenges encountered in budget formulation, budget execution, and budget monitoring and accountability, and outlines ways to improve priority setting and resource estimation. The report also underscores several key lessons learned from the COVID-19 pandemic, such as the need for flexibility and efficiency in the allocation and management of health sector resources, both during an emergency response and in the recovery phase.

To expedite progress towards UHC, the report offers five broad recommendations, which emphasize the need for renewed understanding, commitment and sustained joint engagement to strengthen the interface between PFM systems and health financing. The recommendations also call for enhanced and continued policy dialogue between health and finance authorities during budget formulation, budget execution and accountability phases, and the incorporation of lessons learnt from the COVID-19 response into PFM reforms.

I urge all stakeholders involved in health financing reforms and public financial management to appropriately utilize this report, as together we continue our journey towards more resilient, better aligned PFM and health financing systems to achieve UHC, and a healthier, more equitable Region for all.

Dr Poonam Khetrapal Singh
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World Health Organization
South-East Asia
Acknowledgements

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We take this opportunity to express our appreciation for the robust and continuous support provided by our government counterparts in the ministries of health and ministries of finance of Member States of the South-East Asia Region.

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Executive summary

PFM for progress towards UHC

A robust public financial management (PFM) system is a necessary enabling condition for health financing reforms towards universal health coverage (UHC). PFM indicates the rules that govern the allocation, use and accounting of public funds. There are significant opportunities for a PFM system and a health financing system to complement each other. A strong PFM system allows for a sustainable and predictable flow of public funds, concurrently matches resources to priorities, ensures prompt availability of funds to service delivery units, allows for reasonable flexibilities in the use of funds, and promotes transparency and accountability. Such a system supports and reinforces health financing functions of raising revenue, pooling risk and strategic purchasing.

The WHO South-East Asia Region is gradually recovering from the economic and public health shocks of the acute phase of the COVID-19 pandemic. There is a synergistic opportunity for the PFM system and the broader health financing system to reinforce and complement each other to achieve more effective and efficient use, transparency and accountability of public funds for health in the Region. The prospects of a resilient health financing system and “building back better” will hinge on the quality of PFM systems and their interface with the health financing architecture in all countries of the Region.

Health financing and PFM transitions in the South-East Asia Region

Countries of the Region are at different levels of PFM maturity and reform trajectory. Common challenges persist across all phases of the PFM cycle, particularly in maintaining credible and comprehensive budgets, improving budget execution, and enhancing budget accountability in general and more specifically in the health sector.

This report aims to address some of these key knowledge gaps and to contribute to building the momentum on alignment of health financing and PFM systems for all countries in the Region. It attempts to unpack the evidence surrounding PFM issues in the health sector, to identify common challenges and bottlenecks, and to illustrate good reform practices among countries of the Region.

Challenges in budget formulation

Throughout the Region, there are gaps in priority setting, resource estimation and forecasting, and there remains a general weakness in the ability to match the needs with available resources.

Budget structures and classification systems are largely in transition to result-oriented approaches in informing resource allocation and management decisions. This involves transitioning from over-reliance on incremental and line-item budgeting towards the use of programme classifications in budgets. While medium-term expenditure frameworks (MTEFs) are formally integrated with the budget process in most Member countries, they have often been of limited value in formulating credible annual budgets and forward estimates for outyears are unreliable.
Budget discussions, engagement and negotiations are often neglected areas in the health policy-making circles. The engagement of health and central finance authorities (Ministry of Finance or national treasury) in countries of the Region is variable and there does not seem to exist a structured and standard mechanism for taking decisions on budget allocations, with political influences also at play. The limited awareness and engagement of health officials on PFM is compounded by gaps in budget negotiation skills and poor implementation of budgeting rules and processes in the health sector.

**Challenges in budget execution**

Several countries of the Region lie below the global averages in public sector budget execution, a widely pervasive weaknesses across most countries, that could limit their ability to progress towards UHC.

The foremost challenge leading to poor health budget execution emerges from unrealistic budgets. The health sector in many countries continues to face common challenges in the form of a high degree of centralization at the Ministry of Finance, multiple levels of ex-ante administrative controls, rigidity in budget lines and inflexibilities in fast-tracking expenditure or moving funds. Further, while most countries have some form of devolved governance structures in the health sector, this is not matched by the assignment of expenditure responsibilities and financial management skills and capacities at the local level. In addition, the opportunities for health facilities to gain greater autonomy and financial flexibilities have not been optimally harnessed in the Region.

**Challenges in budget monitoring and accountability**

A well-designed financial management and reporting system is closely associated with the quality, accountability and equity objectives of health financing for UHC. The Region is characterized by poor overall fiscal transparency. The Open Budget Survey, 2021 revealed that out of eight countries of the Region, which provided the expert-ranked scores for 2021, only three countries scored above the global average of overall budget transparency. There is a continuing need to make government financial information on the health sector easily accessible and appealing to potential users and stakeholders, harnessing the use of digital technologies and the internet.

Several countries have invested significant resources over the past 25 years in strengthening and automating their public financial management information systems (FMIS). This has led to improvements in budget structures, and the monitoring and accountability of health spending. For example, there has been gradual progress in integrating donor financing into the national PFM systems reducing parallel reporting systems in countries with a substantial donor presence. However, countries continue to face challenges in terms of the timeliness and accuracy of the information reported, and inflexibilities of central reporting systems. External audit focuses largely on compliance and financial audit and has not yet been extended to assess the value for money achieved from the health sector’s spending programmes.

**Learning from COVID-19**

The COVID-19 pandemic has imposed tremendous fiscal pressure on governments across the Region, uncovering several PFM vulnerabilities that need to be addressed not just for response to the immediate crisis but for a sustained recovery and health financing resilience. Flexibility and efficiency in the allocation and management of health sector resources are critical for an effective emergency
response. During an emergency, recalibrating and adjusting PFM systems can ensure that funds are quickly allocated and made available for spending at the service delivery units. Maintaining some of these mechanisms throughout the recovery phase can help create a more resilient and agile health financing framework and support countries’ progress towards UHC.

**Recommendations for the health sector in the Region**

The report offers the following five broad recommendations on strengthening PFM systems in the Region that would help accelerate progress towards UHC:

- A renewed understanding, commitment and sustained joint engagement is necessary to strengthen the interface between PFM systems and health financing.
- Budget formulation is a powerful entry point for dialogue between health and finance authorities to enhance strategic outlook, flexibility and accountability in use of public finance for health.
- Mechanisms for budget execution and accountability need to be unpacked at a more granular level to identify remedial actions for health, finance and local government authorities.
- Lessons learnt from the COVID-19 pandemic response offer new knowledge and experience to build more resilient PFM system in health.
- Development partners and technical agencies have an important catalytic role to accelerate the implementation of PFM reforms in health.
Introduction

Centrality of public funds for progress towards UHC

Universal health coverage (UHC), generally understood as a situation where everyone, irrespective of their ability-to-pay, receives the health services they need – which are of reasonable quality and without having to undergo financial hardship – has assumed centre-stage of health policy reforms around the world. Countries of the WHO South-East Asia Region have reaffirmed their commitments through a Regional Strategy for UHC adopted in September 2012 (1).

Despite global and regional commitments, the current macro-fiscal situation in several countries, particularly accentuated by the COVID-19 pandemic, could possibly hinder progress towards UHC. A majority of developing countries risk failure to achieve their targets for UHC and Sustainable Development Goals (SDGs) unless urgent steps are taken to strengthen health financing performance anchored on resilience and sustainability (2). Domestic public funds are increasingly recognized as an essential component of a high-performing, sustainable and equitable health financing system that can drive progress towards UHC (2–6). Within its macroeconomic and fiscal context, a country’s public health financing system must be able to generate sufficient and sustainable resources to support achievement of its goals and objectives. As a country increases its investments in the health sector, its reliance on out-of-pocket payments (known for inefficiency, regressivity and impoverishment impacts) and external resources (characteristically uncertain and volatile) declines contributing to better management and control, resilience and sustainability of its health finances.

Beyond fiscal space

The Region is gradually recovering from the economic and public health shocks of the acute phase of the COVID-19 pandemic. The impact of the pandemic is likely to be deep and long-lasting. Projected declines in government revenues as a share of gross domestic product (GDP) across Asia and the Pacific are expected to be larger in magnitude relative to the average declines projected globally (7). Considering the persistence of COVID-19 and as countries gradually move towards the post-pandemic years, prospects for government revenue and growth continue to remain uncertain and raise worrying concerns on its impact on the health budget.

Staying on course for UHC in such challenging macro-fiscal environments would require identifying rapid solutions to both spending more and spending better. Resources for UHC are not just about finding additional revenues, but more importantly, about improving financial management policies and applying fit-for-purpose tools to enable enhanced budgetary space and effective prioritization in the health sector. Public financial management (PFM) has been recognized as an important driver to maximize budgetary space for health (8–10). Additional budgetary room can be created by improving spending priorities, generating efficiency gains and enhancing accountability for results in the health sector through a more robust and efficient PFM system. For a PFM system to

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1 The Member States of the WHO South-East Asia Region are: Bangladesh, Bhutan, Democratic People’s Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and Timor-Leste.
perform well, it should be transparent, efficient and, in general, facilitate the smooth operation of the health system by ensuring that resources get to the right places in a timely, accountable fashion².

**Building resilience in health financing**

The COVID-19 pandemic exposed several vulnerabilities in the health financing systems across countries of the Region. Among the important highlights of the pandemic response were the need for sustained, predictable and flexible funds, timely availability of these funds at the frontlines and the efficiency and agility of PFM systems. The prospects of a resilient health financing system and “building back better” will depend on governments’ ability to mobilize and use public funds effectively, especially during emergencies, raising important questions about the quality of PFM systems in the respective countries. Country experiences gained during the pandemic response provide unique opportunities to examine their respective PFM systems in the health sector and empower them to take concrete actions to accelerate and scale up PFM reforms for a more resilient health financing system.

**PFM and health financing interface**

PFM is a system through which governments manage public resources (both revenue and expenditure) and the immediate-, medium- and long-term impact of such resources on the economy and society (11). It is typically concerned with the laws, organizations, systems and procedures available to governments to mobilize and use public resources effectively, efficiently and transparently.

A health financing system encompasses the policies, institutions and arrangements that govern the mobilization and use of resources in the health system and is typically understood by the functions of raising revenue, pooling risk, strategic purchasing, stewardship, and benefit design and rationing. A robust health financing system geared towards UHC is typically defined though three main attributes: sufficient financing, equitable and efficient use of resources, and accountability (12).

![Fig. 1. Health financing and PFM interface](image)

**Source:** Aligning public financial management and health financing. WHO, OECD and R4D; 2017

² Chapter 6 in Health system performance assessment: a framework for policy analysis / Irene Papanicolas, Dheepa Rajan, Marina Karanikolos, Agnes Soucat, Josep Figueras, editors (Health Policy Series, No. 57)
There exist significant opportunities for the PFM and health financing systems to reinforce each other to achieve more effective and efficient use, transparency and accountability of public funds for health, as illustrated by the interlinkages in their respective attributes (Fig. 1). A robust PFM system is a necessary enabling condition for health financing reforms towards achieving UHC, including in contexts predominated by health insurance funds (13). A PFM system that allows for a sustainable and predictable flow of public funds, matches resources to priorities, ensures prompt availability of funds to service delivery units, allows for reasonable flexibilities in the use of funds and promotes transparency and accountability is critical for health financing reforms towards UHC (5,12).

Health financing and PFM transitions in the South-East Asia Region

The WHO South-East Asia Region has witnessed significant gains in population health over the past decade (1). Progress towards UHC is demonstrated by the positive trend in UHC indicators between 2010 and 2021 in all countries of the Region (Fig. 2). While a wide mix of health financing arrangements characterize countries of the Region (Fig. 3), the general challenge on health financing for UHC has been the continuing low overall investments in health. Current health spending as a percentage of GDP has remained the lowest among all WHO regions over the past two decades barely having increased to 4.5% of GDP in 2018 (14). With out-of-pocket health spending predominant in five countries (Fig. 3) – public financing for health in the Region is generally low. The health sector expenditures comprised less than 10% of total government expenditure in most countries, and less than 5% in four countries of the Region (14).

**Fig. 2. Progress in UHC between 2010 and 2021**

The health financing ecosystem of the Region offers significant opportunities for strengthening PFM systems as a means of increasing both the volume and efficiency of public financing for health. There has been scarce documentation of PFM experiences in the health sector in countries of the Region. A review of public expenditure and financial accountability (PEFA) assessments of countries of the Region yields mixed results. On average, countries showed strength in policy-based fiscal strategy and budgeting as well as in the framework of accounting, recording, and reporting. External scrutiny and audit remain the weakest area, in general, followed by predictability and control in budget execution. As has been the context in several low- and middle-income countries, the capacities of health ministries are limited to the exercise of basic accounting and financial control functions, while finance ministries are largely in control of budget execution and internal control mechanisms (10). There continue to be unique challenges to specific countries, depending on the maturity of the respective PFM systems. In general, the widely accepted principle of “getting the basics right” applies,


Fig. 3. Sources of health financing, 2020

Source: Initiated by multiple international development partners, PEFA has become the acknowledged standard for assessing public financial management performance. It identifies 94 characteristics (dimensions) across 31 key components of PFM (indicators) in seven broad areas of activity (pillars). For more information: https://www.pefa.org/.

3
i.e., credible, and comprehensive budgets, improved budget execution, timely and comprehensive
reporting, along with drawing opportunities from what the health sector can effectively manage/
contribute to the overall PFM ecosystem, to contribute to the broader health financing objectives.

About this report

Notwithstanding the growing momentum on the significance of PFM in health financing for UHC,
there is paucity of literature and stock taking on lessons learnt and experiences gained in the
Region. There is a need to better understand the nuances of the PFM system in the health sector,
the implications of general PFM reforms to the sector and the achievements and progresses made
by countries of the Region. There exist significant opportunities for health financing practitioners to
engage in understanding and harnessing the value of PFM for health financing reforms in individual
countries and collectively in the Region for stock-taking and planning for priority actions and strategies.

This report aims to address some of these gaps and contribute to building the momentum
on alignment of health financing and PFM systems for countries of the Region. It attempts to
unpack and synthesize the evidence surrounding PFM issues in the health sector, identify common
challenges and bottlenecks and illustrate good practices among countries of the Region, as a step
towards understanding the ecosystem of PFM in health. The focus is on drawing common challenges
and shared lessons, and not on comparative assessment among countries. Drawing lessons from
experiences of PFM reform of individual countries and identifying opportunities for improvements,
the report aims to present practical approaches for policy decisions and interventions on advocacy
and implementation of PFM-related health financing reforms. It further draws on emerging global
evidence and guidance to suggest best practices and actions for countries of the Region to better
support PFM-related health financing reforms towards UHC.

The analyses were based on a mixed evidence synthesis approach. Primarily, structured
questionnaires were administered, and key informants’ interviews were conducted in five countries
of the Region (Bhutan, Maldives, Nepal, Sri Lanka, and Thailand), based on their expressed interest in
country diagnostics, uncovering several in-depth PFM issues in the health sector. The report benefited
from a questionnaire used to inform health financing system during COVID-19 in the Member States,
including Bangladesh, India, Indonesia, and Myanmar, supported by health systems staff at the WHO
Country Offices. A desk review of the published and grey literature was carried out to collate regional
level as well as country-specific experiences and challenges for countries of the Region. Subject experts
of the Region were consulted for clarifications and additional information, whenever necessary. The
report also builds upon the ongoing work of WHO through bottleneck assessments and policy dialogue
with countries of the Region. Finally, comparable datasets were constructed using databases from
PEFA and the International Budget Partnership (IBP).

The structure of the report is inspired by the framework of alignment of PFM and health financing
using the budget cycle approach (budget formulation, budget execution and budget monitoring)
(12). Chapters 2, 3 and 4 discuss existing arrangements, key challenges and lessons learnt in the
health sector with regards to budget formulation, budget execution and budget monitoring in the
Region. Chapter 5 reflects on the lessons learnt during COVID-19. Finally, chapter 6 presents the
overall conclusions and proposes key recommendations for the health sector in the Region.
Budget formulation

Health budgets are defining instruments of a government’s health policy. Budgets reflect the priorities of the government’s policy and help ensure fiscal discipline while improving transparency and accountability in the use of resources (11). An efficient and effective budget potentially allows for more efficient allocation and use of public resources, reduces fragmentation and promotes accountability.

The implications of health budget formulation on health financing objectives for UHC, while critical, are not adequately appreciated by health and central finance authorities. First, the quality of the budget formulation process determines the level, allocation and adequacy of public funding for health based on justification of investments, negotiations and power influences. Second, it connects to the efficiency objectives of health financing, which is increasingly gaining prominence in countries’ progress towards UHC. How a budget is formulated and allocated, including to subnational and local levels, has a direct impact on how well and how efficiently funds can and will be used and to further the goal of strategic purchasing (15, 16). Third, it supports equity objectives. A fair and equitable distribution of resources across populations and/or geographical areas is directly linked to health sector outputs (17). Health budget formulation impacts all three attributes of health financing system: raising revenue, pooling and purchasing (Fig. 1).

Budget formulation, as the first and defining step of the PFM cycle, sets the scope of the entire budget process. The process for developing budgets and setting spending priorities will determine whether policy priorities are matched and reflected in final resource allocations. A well formulated and articulated health budget would contribute to better alignment of budgets with health priorities, lead to enhanced accountability and transparency in the use of resources and may somewhat contribute to flexibility of managing health finance (11).

Strategic outlook, priority setting and costing

The process of sound budget formulation anchors on strategic goals and health investment/financing decisions. A budget that translates the health sector vision and goals into costed, actionable and justified interventions forms the basis of a realistic and credible health budget. A credible process of budget formulation responds to at least three questions: (i) what are the country’s health priorities?; (ii) how much will these priorities cost in the medium and short runs?; (iii) what trade-offs must be made in allocating available funds to current needs?

Countries of the Region have made significant progress towards UHC with respect to both conceptual thinking as well as implementation, with improving equity in health as the prime focus of their national health sector strategic plans (1). In addition, inspired through the public sector performance management reforms generally, some countries have made major inroads into result-orientation of their plans and strategies, including linking them with budgetary resources (see Box 1 for selected examples).

Notwithstanding the strong policy and foundations of strategic planning process, there continue to be gaps in priority setting, resource estimation and forecasting, and the general inability to match the needs with available resources. As has been observed (15), lack of explicit priority-setting mechanisms and inappropriate costing approaches fuelled by poor information systems contribute
Leveraging public financial management for universal health coverage in the WHO South-East Asia Region

Box 1. Annual Performance Agreements in Bangladesh and Bhutan

Bangladesh

The Government of Bangladesh has implemented Annual Performance Agreements (APAs) to strengthen performance management in public sector organizations. APAs (performance contracts in the form of a Memorandum of Understanding) are signed annually between the Cabinet Division and all other ministries/divisions. The APAs provide summary of the most important results that a ministry/division expects to achieve during the financial year. It contains the agreed objectives, performance indicators and targets to measure progress. The main purpose of introducing APAs was to move organizational focus from process-orientation to result-orientation and establish an objective and fair basis to evaluate performance of each ministry/division.

Bhutan

As an initiative to link national five-year plan goals, annual sector objectives, resources and individual work plans of public officials, Bhutan has adopted a system of APAs. APAs are signed agreements between the budgetary bodies and the Office of the Prime Minister, which negotiates and establishes organizational direction and performance targets. Instituted in 2014–2015 fiscal year and gradually strengthened over the years, significant progress has been made in linking the planning framework with the budgetary resources. Currently, annual budgets are prepared and budget negotiations are based on the APAs and their agreed performance targets. Budgetary agencies are required to first finalize their APAs and prepare their budget proposal aligned with the APAs.

Sources and further information:

to disconnects between health budget allocations and needs in countries. Within the framework of top-down policy and bottom-up planning approach (central finance authorities set and promulgate normative budgeting guidelines, rules and ceilings while line ministries and other budgetary agencies provide their expenditure bids), the health sector continues to struggle with developing realistic and costed operational plans that are aligned with long-term strategic goals and the macro-fiscal realities of their countries. Fragmentation in budget development and oversight continue to hamper strategic approach, efficiency and coherence in some countries. For example, in Bangladesh, there are two separate budgets in the health sector: non-development budget (mostly recurrent) and development budget (mostly capital development activities), under separate budget preparation, management and reporting structures. While the non-development budget is prepared by the financial management wing of the Ministry of Health and Family Welfare (MoHFW) and approved by the Ministry of Finance, the development budget is prepared by the planning wing of the MoHFW and approved by the Planning Commission through the Annual Development Programme (ADP) (18). This approach of dual-budgeting could potentially result in coordination issues, efficiency losses and mismatch in recurrent cost implications of capital expenditure. Amidst the differences in approaches and administrative processes in budget development among countries of the Region, there is a need to improve the need estimation and costing of annual health sector budget particularly in view of the projected public resources envelopes, considering overall fiscal guidance and potential trade-offs.
Budget structure and classification

The way budgets are structured and classified have an important bearing on the rest of the budget cycle (execution, monitoring, reporting). Classifying budgetary transactions in some form (economic, functional, administrative and other characteristics) is necessary for policy formulation and analysis, to ensure compliance and for day-to-day administration of the budget (11). Specifically, the way budgets are classified (which determines the manner in which budgetary transactions would subsequently take place) would impact the implementation of the budgeted activities leading to implications on the overall performance and progress status.

Fig. 4 presents the PEFA scores assigned to countries of the Region for the strength of their budget classification and consistency with international standards. Three of the nine countries are below the global averages, which could lead to weaknesses in tracking transactions and hamper allocation of resources to strategic priorities, service delivery and accountability.

Fig. 4. PEFA scores for budget classification

![PEFA scores graph]

Traditional line-item budgets focus on providing considerable details about what amount the government spends on inputs. However, there are concerns on inefficiencies it can potentially create such as rigidities, inflexibilities and increasing bureaucratic red tape. These attributes make it difficult for health budget managers to adjust to changing needs and circumstances.

The way budgets are formulated, presented and executed impacts the manner in which health-care providers are paid and, therefore, determines the ability of a purchaser to move from passive to more strategic purchasing. For example, where budgets are presented as detailed inputs (salary, furnishing, travel) or administrative units (department A, hospital Y, facility Z), it is difficult to understand the linkage between the spending and policy or programmatic priorities. Appropriations based on detailed economic and administrative classifications are problematic in the health sector and could severely limit strategic purchasing (19). Considering the inflexibilities in paying providers in input-based line-items budgets, it becomes impractical to provide incentives to service providers or apply any meaningful strategic purchasing approaches. Strengthening provider payment methods and contracting based on health outputs and results are better supported by programme budgeting.
Programme-based classification offers an important opportunity to further the goal of strategic purchasing, while at the same time improving alignment of budget with policy priorities and supporting accountability for sector performance (16). A programme budget structure can help align budgetary allocations with health policy goals, by connecting inputs used and activities performed to outputs and results, through adequate monitoring and reporting on performance metrics. Additionally, it can provide a normative framework for policy development and accountability to facilitate implementation of strategic purchasing (16,19,20).

Budget structures and classification systems in the Region are largely in transition, mostly as part of general public sector reforms, evolving from input-based methods to more result-oriented approaches in informing resource allocation and management decisions. This implies transitioning from the incremental and line-item budgeting towards programme classification of budget. At the moment, legal or administrative mandates require the presentation of budget documents using a mix of economic, functional, programme and other classifications, which are very diverse and evolving, for countries of the Region. Although historical incremental budgeting (year-on-year) with inflation-linked increases remains the common practice in countries of the Region, most countries have introduced reforms towards output- or programme-based classification of budget (Fig. 5). However, even as countries plan and formulate health budgets by programmes, they continue to execute and report following administrative lines or inputs. The continuing weaknesses in the conceptual framework and guidelines on programme budgeting by the Ministry of Finance along with the weak health sector capacities in several countries of the Region continue to hamper the progress on implementing programme budgeting in health. Besides the availability of quality and reliable budget execution data, there is also an objective challenge in finding alignment between the output-orientation of the annual budget and the longer-term outcome-orientation of the indicators in the national strategies. A health budget should aspire to align as closely as possible with the national strategy, the organizational goals and key results and performance indicators.

Fig. 5. Mapping of phases of programme-based budgeting reforms

Phase 1: Pilot
- Maldives
- Myanmar
- Nepal
- Sri Lanka

Phase 2: Enactment
- Bangladesh
- Bhutan
- India
- Timor-Leste

Phase 3: Full implementation
- Indonesia
- Thailand

Source: Dale E et al., 2022 (19)

Note: As an update, Bangladesh, Bhutan, India and Timor-Leste are reflected under phase 2 considering the existing legal requirements to present budgets by programmes in these countries.

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The term "programme" is used to denote several nomenclatures used with similar meaning such as programme, outcome or result. A programme is a set of activities that meets the same set of specific policy objectives (for example maternal health, vaccination and control of noncommunicable diseases).
The wide variety of approaches in classifying budget may potentially result in misalignment and reduce flexibility in budget formulation and allocation of resources for the health sector. Capital budgets, usually for development-related expenditure, are typically classified, executed and monitored separately. Usually for smaller countries (such as Maldives, Bhutan and Timor-Leste), on the justification of economies of scale, budgets for drugs and medical consumables are centrally programmed and executed. For example, Maldives has adopted the concept of “open budget” for drugs and consumables, whereby this budget line is treated as an open budget item and expenditures on this item are not made according to fixed budget allocations.

Furthermore, external resources and development assistance continue to be an important source of health finance for several countries of the Region. While the value of this financing source is huge, if not integrated into the overall national planning and budgeting system, it poses a risk of fragmenting the financing pool, creating multiple resource allocation and management processes, increasing administrative burden and limiting the scope of resource monitoring and accountability.

Box 2. Programme-based budgeting in the health sector in Indonesia

Performance-based budgeting (including programme-based budgeting) was formally introduced in 2004 in Indonesia. This transition, primarily driven to improve accountability of the budget and the budgeting process, had the following objectives:

- to improve the categorization of government transactions;
- to provide an objective and proportional description of government activities;
- to maintain consistency with public sector accountability standards; and
- to simplify the presentation and increase the statistical credibility of government finance.

Consequently, budget documents are presented in a way that allows budget lines to be traced according to both functional and programme classification. The detailed information in the budget documents informs about the organizational unit, function of the organization, programmes, activities, types of spending, budget categories, and sources of finance. In the budget implementation document, for example, spending is classified by organization, function, and type of expenditure. There is also information on indicators, allowing the Ministry of Health and oversight institutions to measure the performance of the ministry and its institutions.

The Ministry of Health in 2016 had implemented nine programmes by eight working units (six directorates, an inspectorate, and a general secretariat) within the ministry. These nine programmes were administration (consisting of management and technical task implementation support programme and increasing supervision and accountability of the staff programme); diseases (Disease Prevention and Control Programme); interventions that address nutrition and health condition improvement (Public Health Development Programme); health-care service delivery programmes (Health Service Development Programme, Pharmacy and Medical Devices Programme); health research (Health Research and Development Programme); and a transfer programme (National Health Insurance Support Programme).

Source: Nurman A, Inisiatif P. Program budgeting in the health sector in Indonesia. International Budget Partnership; 2018
https://www.internationalbudget.org/publications/program-budgeting-health-sector-indonesia/
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For countries, which continue to have significant development assistance in health, there has been gradual progress over time in integrating donor financing into the national PFM systems, particularly for general budgetary support by external partners and donors. Several countries have made it a requirement to include financial provision for all externally funded projects in the annual budget estimates. However, there continue to exist several (vertical) donor project financing mechanisms necessitating their own system of programming and financial management, fragmenting the process and pool of health finance.

Moving away from annual to multi-year

As the PFM system evolved globally, the case for setting budgetary plans within some kind of medium-term framework has been widely accepted (11). An annual timeframe is inadequate to accommodate health programmes that typically have costs and benefits extending several years. A medium-term framework enables a financing assurance needed for a more strategic and policy-oriented spending priorities. It facilitates more realistic planning and resource prioritization. For example, since the medium-term expenditure framework (MTEF) became an integral part of the budget management process in Nepal, the deviation between budgeted and actual expenditures has fallen sharply and the share of public spending targeting the poor has risen (21). Globally, MTEFs have a significant positive effect on share and volatility of health expenditure, and the effect gets stronger with the move from medium-term fiscal to budgetary to performance frameworks (MTFF to MTBF to MTPF) (21). This, however, entails that countries effectively use their medium-term frameworks to inform health budget preparation to reap their benefits.

The MTEF, typically a three-year rolling framework covering the next annual budget and two additional years, provides a strategic orientation in budgeting and could help strengthen strategic planning and resource allocation. The medium-term macro-fiscal framework has been developed and implemented in most countries. Nepal, Indonesia, Myanmar and Thailand have the MTEF as part of their budget strategy and formulation process but with varying degrees of comprehensiveness. Additionally, other countries of the Region have some form of multi-year approach to budgeting.

Box 3. Outcome budgeting in India

Over the past few years, India has undergone a remarkable transition in government performance management systems through an articulation of annual output–outcome monitoring framework – a tool for enabling greater accountability and transparency in public expenditure as well as for maximizing value for money.

Since 2017–2018, budget documents reflect not just the financial outlays of schemes and projects of the ministries, but also the expected outputs and outcomes presented together in the form of an “Outcome Budget”. Outcome budgeting is a process that aligns resources with results. The financial outlays, outputs and outcomes are presented together to the Parliament in measurable terms, bringing in greater accountability for the agencies involved in the execution of government schemes and projects.

This includes Bangladesh and Bhutan with a MTBF and Maldives with some form of MTFF), also with varying degrees of comprehensiveness but all premised to strengthen policy or results-based budgeting. Fig. 6 presents the PEFA scores assigned to countries of the Region for the quality and comprehensiveness of their medium-term budgeting process.

**Fig. 6. PEFA scores for medium-term/multi-year perspective in budgeting**

While MTEFs are formally integrated with the budget process in most countries, MTEFs employed by countries of the Region have often been of limited value to predict annual sectoral budgets and forward estimates do not effectively inform the budgetary ceilings for outyears. In practical terms, the annual budget may be poorly informed by the MTEF because the budget timetable is too tight or rushed, budgeting continues to remain incremental in nature, coverage is limited and often excludes donor-financed projects, and expenditure ceilings are frequently ignored. Weak and inadequate translation of strategic plans for the health sector into MTEF and poor linkages between fiscal envelope and organizational goals are other areas of concern, rendering several MTEFs as merely symbolic in the Region.

**Budget discussion and negotiation**

Budget discussions, engagement and negotiations are often neglected areas in health policy circles. Resource allocation decisions for health are influenced by power relations, informal behaviours, information gaps, failure to follow rules and calendars and influence by other actors outside of the health sector (22). It is, therefore, critical that the health sector engages proactively and comprehensively in the budget process. In most countries of the Region, the engagement of health and central finance authorities are variable and there does not seem to exist an explicit, structured and standard mechanism on allocation decisions, with large informality and political influences at play. Such a scenario could potentially lead to allocation decisions based on the short-term and popular
priorities, negotiation prowess and political clout. There are identifiable gaps between the high level of prioritization of health by the governments in countries of the Region and the ability of the health sector to mobilize resources to meet the level of these commitments. These gaps signal limited awareness and engagement of health officials on PFM generally and reveal limitations in planning and budgeting processes in the health sector; weak coordination among the planners and finance managers within the health sector; and weak investment proposals, low level of negotiation skills and poor implementation of budgeting rules and processes in the health sector. Considering that the health sector is competing for a limited fiscal space among many other high priority spending areas, this calls for a more proactive and strategic approach to budget discussions and negotiations.

**Box 4. Phased modernization of PFM in Myanmar**

The 2018 Public Financial Management Reform Programme Strategy of Myanmar foresees a modernization of the PFM legal and regulatory framework, systems and practices to support Myanmar’s socioeconomic development objectives and public service delivery. The government has taken a phased approach to modernize the PFM architecture in view of the nature, scope and implications of such reforms.

The first phase is geared towards establishing the legal and regulatory foundations, primary systems for fiduciary management and to enhance the capacity of officials. The second phase of the PFM reform strategy is aimed at further strengthening the legal and regulatory framework and information systems in line with international standards and good practices. This phase allows for increased focus on macro-fiscal stability and creation of additional fiscal space to support Myanmar’s socioeconomic development. The third phase of the PFM reform strategy is aimed at consolidation of all PFM reform activities with a focus on enhancing efficiency and quality of public spending. This phase allows for greater focus on public investment management, public procurement reform and PFM in key public services such as health and education.

Sources:
Budget execution, the next essential stage of the PFM cycle, is concerned with the various processes of implementing the budget; from formal appropriations to undertaking and processing of transactions through commitments, verifications, issue of payment orders and the payment itself, along with the budget execution controls designed to ensure compliance (11). To put it simply, this stage is where public funds are actually spent to implement activities.

The budget execution process is that stage during which purchasing of health services actually takes place and provider payment mechanisms are operationalized. It is important to unpack the different arrangements of health financing prevalent among countries, as they bear important implications on how public funds are executed or used to purchase health services. Suboptimal execution of the allocated budget represents a missed opportunity for progress towards UHC and undermines the health sector’s ability to deliver services (23). Fig. 7 provides guidance to visualize the linkages between different health financing arrangements and budget execution processes.

![Fig. 7. Health financing and budget execution](image)

<table>
<thead>
<tr>
<th>Health financing arrangements</th>
<th>Main execution rules and processes</th>
</tr>
</thead>
<tbody>
<tr>
<td>No provider/purchaser split</td>
<td>Regular PFM rules for transfers to various budget holders/units, and potentially to facilities</td>
</tr>
<tr>
<td>Fiscal decentralization</td>
<td>Intergovernmental transfers, from central to subnational levels</td>
</tr>
<tr>
<td>Separate purchasing agency (split)</td>
<td>Transfers to purchaser(s)</td>
</tr>
<tr>
<td>Health services provision by non-governmental organizations (NGOs)</td>
<td>Procurement and contract management of NGOs</td>
</tr>
</tbody>
</table>

Source: Piatti-Funfkirchen M et al., 2021 (23)

Countries of the Region host a multitude of health financing arrangements that govern the flow of funds in the health sector. In several countries, governments directly execute the budget and provide health services. There are countries with separate purchasing agencies or feature nongovernmental organizations (NGOs) to deliver health services where the scope of PFM protocols is variable. Several countries of the Region have devolved fiscal responsibilities to subnational governments. Even within individual countries, a combination of these arrangements predominantly exists. Fig. 8 presents a stylized flow of funds broadly generalizable for the Region and demonstrates the centrality of public funds in the health system. Once the funds are approved, they are disbursed to ministries of health through a government dedicated bank. At the state/region/provincial level, appropriations could be either directly deposited by ministries of finance/treasury to lower-tier health units or health facilities or public funds could be transferred to the state/region budget departments before being distributed in phases to the spending units through the government dedicated bank. Any bottleneck at any of the junctions will have a spill-over effect on each of the downstream activities, and ultimately, on the delivery of services.
A key issue enveloping these arrangements for flow of funds is the tension between probity and performance, or in other words, securing an appropriate balance between control and flexibility. PFM rules are often intended to limit discretion of public officials to prevent wasteful and even corrupt spending. This often results in poor quality decisions on spending. While controls are essential to ensure compliance and prevent mismanagement of resources, a very rigid structure in the classification and movement of funds can be detrimental to efficient management and delivery of health services.

In the sections below, we discuss in detail the issues related to budget execution in health. It is important to distinguish between the budget execution rate, which refers to the proportion of the budget used, and the budget execution process, which refers to the rules and processes that govern how a budget is implemented (23). Budget execution rates are proxies of the quality of the budget execution process.

Budget execution rates

Budget execution rates are an indication of the credibility of the budget. Consistently high variations (over- or under-execution) reflect on issues related to limitations in planning, cost estimation and quality of budget formulation as well as the challenges in budget execution.

In most countries of the Region, the PEFA scores for overall government aggregate expenditure out-turn⁶ compared to the original budget were between 2 and 3, the moderate range of scores. Benchmarking the global average score of 2.7 (24), four of the nine countries of the Region fell below

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⁶ This indicator measures the extent to which aggregate budget expenditure out-turn reflects the amount originally approved in the government budget. Significant deviations from the original, approved budget undermines fiscal discipline and the ability of governments to control the total budget and, subsequently, to manage risk.
the average while three countries were just about the average (Fig. 9). In addition, evidence across lower- and middle-income countries indicates that health budget is systematically implemented at a lower rate than the general government budget, or other comparable sectors such as education (23). The overall situation indicates widely pervasive weaknesses in budget execution across most countries, which could potentially be limiting their ability to deliver health services and their progress towards UHC.

Fig. 9. PEFA scores for aggregate expenditure out-turn

Disaggregated assessment of budget execution reveals that execution rates differ by the nature or type of expenses. Budget execution rates in health are systematically higher for recurrent expenditures than they are for capital expenditures. This conforms to the generally observed trend in lower- and middle-income countries where budget execution rates in health are systematically higher for wages and salaries than they are for goods and services or capital expenditures (22,23).

This situation is representatively demonstrated by the trends in budget execution rates in Sri Lanka and Timor-Leste (Fig. 10). These differences in execution rates between recurrent and capital expenditure – given the sensitivities around procurement, the rigidity of rules and the amount of red tape normally associated with purchasing and the additional dimension of logistic and supply chain challenges – usually disrupt the health sector development plans and capital projects with late or missed deliveries. Capital budgets are characterized by uncertainty due to potential changes in priorities, costs and other longer-term factors. Expenditure on capital projects and purchases appears lagging behind recurrent expenditure by an average of 26% over the 5-year period in Sri Lanka and by 34% in Timor-Leste, though the pandemic-related disruption in 2020 played a major role in the case of Timor-Leste.
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**Fig. 10. Health budget execution rates in Sri Lanka and Timor-Leste**

<table>
<thead>
<tr>
<th>Year</th>
<th>Recurrent</th>
<th>Capital</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>73%</td>
<td>92%</td>
</tr>
<tr>
<td>2016</td>
<td>40%</td>
<td>81%</td>
</tr>
<tr>
<td>2017</td>
<td>60%</td>
<td>89%</td>
</tr>
<tr>
<td>2018</td>
<td>70%</td>
<td>78%</td>
</tr>
<tr>
<td>2019</td>
<td>66%</td>
<td>94%</td>
</tr>
<tr>
<td>2020</td>
<td>99%</td>
<td>81%</td>
</tr>
</tbody>
</table>

**Fig. 11. Budget execution and UHC goals**

<table>
<thead>
<tr>
<th>UHC goals</th>
<th>How budget execution issues affect the UHC goal</th>
</tr>
</thead>
</table>
| Efficiency | The availability of promised funds is essential for efficiency in use.  
Delaying the release of funds can impede service delivery and other activities.  
Cuts in the operational budget can lead to an imbalance of inputs.  
Arrears lead to price increases.  
Rigidity in spending rules can undermine efficiency in spending.  
Fragmentation in budget execution protocols across financing sources creates inefficiencies. |
| Equity     | Poor budget execution can undermine an equitable budget.  
Health service providers may resort to user fees to compensate for public budget shortfalls. |
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<table>
<thead>
<tr>
<th>UHC goals</th>
<th>How budget execution issues affect the UHC goal</th>
</tr>
</thead>
</table>
| Quality   | Budgets that are insufficiently funded can compromise service quality.  
           | Slow and irregular cash releases can compromise service quality   
           | Rigidities in protocols for spending also create service quality issues. |
| Accountability | Spending beyond appropriations or the authorized budget creates an accountability problem.  
                   | Poor financial information systems can undermine accountability.  
                   | While financial accountability is critical, cumbersome budget execution requirements can place an unnecessary burden on medical staff. |

Source: Piatti-Funfkirchen M et al., 2021 (23)

Furthermore, budget execution processes determine possibilities of strategic purchasing and output-oriented provider payment approaches. For example, the institution of results-linked block grants for recurrent expenditures in all budgetary bodies, targeted reforms of integrated financial management information systems (FMIS) and budget monitoring tools able to link expenditures to performance-based budgets help move purchasing from a passive and historically driven mode to a more strategic and goal-driven approach.

The latest PEFA reports reveal the overall picture for predictability and control in budget execution – which is a reasonable proxy of budget execution process and comprises several measures of accounting, predictability, procurement and expenditure – as variable across the Region with four of the nine countries of the Region below the average global scores for 2022 (Fig. 12). Key issues and common challenges are examined below:

**Fig. 12. PEFA scores for predictability and control in budget execution**

<table>
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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Myanmar</td>
<td>1.5</td>
<td>1.0</td>
<td>1.5</td>
<td>2.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>India</td>
<td>1.0</td>
<td>1.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Nepal</td>
<td>1.5</td>
<td>1.0</td>
<td>1.5</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
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<tr>
<td>Thailand</td>
<td>2.5</td>
<td>2.0</td>
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<td></td>
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<tr>
<td>Global average</td>
<td>1.75</td>
<td>1.5</td>
<td>1.75</td>
<td>1.75</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Bangladesh</td>
<td>2.5</td>
<td>2.0</td>
<td>2.5</td>
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<td></td>
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<tr>
<td>Timor-Leste</td>
<td>2.0</td>
<td>1.5</td>
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<td></td>
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<td></td>
<td></td>
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<tr>
<td>Maldives</td>
<td>2.5</td>
<td>2.0</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bhutan</td>
<td>2.5</td>
<td>2.0</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Indonesia</td>
<td>2.5</td>
<td>2.0</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Global average</td>
<td>2.0</td>
<td>1.5</td>
<td>2.0</td>
<td>1.5</td>
<td></td>
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<td></td>
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</tbody>
</table>

**Poorly formulated and unrealistic budgets**

The foremost challenge for a poor execution process emerges from unrealistic budgets. While there have been improvements in budget formulation approaches in several countries of the Region through gradual introduction of performance-orientation and multi-year outlook to budgeting and other measures, much of these reforms continue to be presentational and without direct linkages
to how the flow of funds are accounted for. This severely constrains a country’s capacity, efficiency and equity in spending the health budget, along with the credibility and ability of the health sector to secure additional resources. Accountability is key for achieving credibility through results. Ministries of health that continue to present unrealistic budgets in the face of poor execution rates will not be deemed credible and will risk being overlooked in terms of competitive negotiations, even when they might have compelling arguments. There continues to be a challenge of developing a realistic and credible budget that could convince the finance authorities and decision-makers in most countries of the Region. Costed investment proposals – considering the overall fiscal situation – and direct linkage of budgeted amounts with activities, projects, programmes and outcomes are necessary for credible budget proposals.

Efficiency in fund releases

In terms of efficiency of the flow of funds, availability of budgeted funds and prompt/timely release of these funds have implication on the ability of managers to implement their plans and ultimately on service delivery (23). Health sectors in the Region reported myriad ways in which delays in release of funds/expenditure hamper implementation and absorption capacity (see Fig. 13 for selected examples). Common challenges observed in the Region include a high degree of centralization of budget management at the level of the Ministry of Finance, rigidity in budget lines, inflexibilities in fast-tracking or moving funds and multiple levels of ex-ante administrative controls.

![Fig. 13. Selected responses from country experts on bottlenecks in release of funds](image)

<table>
<thead>
<tr>
<th>Country</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nepal</td>
<td>&quot;However, sometimes it happens that the spending units cannot complete the documents to be submitted. In that case, delay in payment occurs. Similarly, delay in payment also generally occurs at the end of the fiscal year due to the large demand at a time.&quot;</td>
</tr>
<tr>
<td>Thailand</td>
<td>&quot;Yes, in every part of the process at every level. This is due the process itself being designed to have a lot of steps in order to maintain transparency, have check and balances. There are a lot of documents that need to be prepared in the right ways, resulting in ‘jams’ in any type of procurement and payment/expenditure release.&quot;</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>&quot;At both the line ministry and provincial level, generally, there are no or minimum delays in release of cash for recurrent expenditure. However, there are often long delays in expenditure releases for capital items often leading to underutilization of the capital allocations. Delays occur both at the provincial chief secretary level and at the treasury level.&quot;</td>
</tr>
</tbody>
</table>

Capacity constraints in decentralized settings

An important issue in budget execution, particularly in decentralized fiscal settings, relates to the capacity of health managers in financial management and reporting. While most countries have some form of devolved governance structures in the health sector, this is not matched by assignment of expenditure responsibilities and financial management capacities at the local level. For example, while the legal structure for decentralization exists and has been well documented in Timor-Leste, the lack of clarity over delegated competencies from the central to the municipal level and associated funding has led to slow progress in implementation (25). Policies and methods to translate responsibilities into expenditure package and financial management structures should be developed along with sufficient capacity-building for local health managers.
Real-time tracking of budgets and expenditure

Another common challenge for countries of the Region is the availability of prompt (and preferably real-time) information on budget and expenditure for health managers and programme implementers. This lack of real-time budget-monitoring system at the implementation level is compared to “driving blindfolded” and, thereby, limiting the judicious use of available resource to optimize health gains. There is often late implementation and last hour rush, which leads to crowding of the activities in the final quarter of the fiscal year and consequent lack of time to accomplish all activities that had been planned.

Transfer of funds to health facilities

Health facilities and their managers need reasonable certainty on availability of funds and a certain level of flexibility in allocating resources to achieve planned outputs and results. While evidence is scarce, the existing PFM architecture in countries of the Region poses significant limitations in allowing such autonomy and financing flexibilities to health facilities.

There are compelling arguments for greater control and flexibility over budgets at the health facility level (26). While there are promising benefits that budget flexibilities offer in responding to changing local needs and preferences, there is a need to weigh in the skills and capacities of the finance or health officials to manage such flexibilities and the potential risks of fraud and corruption. One particularly promising initiative that is gaining interest of health financing and PFM practitioners globally is the “direct facility financing” approach. Direct facility financing means funds inclusive of government general revenue are transferred directly to the facility’s bank account. This financing relies on the three principles of (i) facility autonomy; (ii) output-based provider payment; and (iii) sound financial management and accountability (27).

Box 5. PFM system for local governments in Nepal

The Government of Nepal launched the Subnational Treasury Regulatory Application (SuTRA), an online financial management system for local governments. SuTRA aims to ensure transparency, accountability, efficiency and effectiveness in financial management at the local level. Since its development in 2017 and official adoption in 2019, all 753 local governments had used SuTRA for at least a few core functions among its modules on budgeting, accounting and financial reporting.

SuTRA has continued to evolve over the years depending on the needs and requirements of both local and federal governments. Presently, there are 13 modules and five submodules. This gradual approach to expansion of SuTRA was intended for simplicity in use, allowing time for learning while doing and focusing on priority PFM functions. In 2021, SuTRA will account for a total of NPR 262.75 billion (US$ 2.23 billion) in fiscal transfers to the 753 local governments, in addition to managing local revenue.

SuTRA illustrates a strong example of digital solutions for PFM in decentralized contexts, and demonstrate (i) the value in balancing simplicity in use of PFM functions; (ii) adaptation and learning by doing; and (iii) the important role of government in leading and driving such solutions.

Adapted from:
Quality, comprehensiveness and transparency of financial information are essential ingredients of an effective budget process, accountability, fiscal sustainability and good governance. Financial information reporting aligned with and supported by performance information enables justification of the resources spent as well as informs future planning for health. This facilitates clear understanding of how public funds for health have been utilized and how they contribute to the overall goals and objectives of the health sector.

A well-designed and effectively operationalized financial management and reporting system is, thus, closely related to the efficiency, quality, accountability and equity objectives of health financing for UHC. First, it helps ensure that health resources are channelled to priority populations, interventions and services. Second, it enables making payments to providers based on service outputs and performance. Finally, the government is made accountable for the appropriate and intended use of public funds.

**Fiscal transparency**

Transparency is at the heart of budget monitoring and accountability. The idea of fiscal transparency embraces the timely and systematic disclosure of all policies and transactions related to the revenues, spending and borrowing, together with the assets and liabilities of government entities, whether at the central, regional or local level, and also government-owned entities, including public enterprises. Fiscal transparency mandates that information on public revenue and expenditure should be made accessible and intelligible to the people.

The overall fiscal transparency status in countries of the Region reflects significant opportunities on how budget monitoring and transparency could possibly be improved. The Open Budget Survey, 2021 reveals that out of eight countries of the Region, which provided the expert-ranked scores for 2021, just three have surpassed the global average of government-wide budget transparency.

**Box 6. Fiscal transparency evaluation in Maldives**

Maldives is among the pioneering countries of the Region to have undertaken a fiscal transparency evaluation (FTE) in collaboration with the International Monetary Fund as part of ongoing efforts to enhance fiscal transparency and strengthen the PFM system. The exercise evaluates the country’s fiscal reporting, forecasting, budgeting, risk analysis and management practices.

As per the report, Maldives has made considerable progress in improving fiscal transparency in recent years with performance in fiscal forecasting and budgeting is stronger relative to other areas. The country also documents strengths in legislative control over public spending, legal framework for budgeting, budget unity and timely publications of budget related information. Fiscal risk analysis and management is identified as a prominent challenge amidst the country’s reliance on tourism revenue, among others.

The full report with recommendations is available at: https://www.imf.org/-/media/Files/Publications/CR/2021/English/1MDVEA2021001.ashx
scores (Fig. 14). In Thailand (among the better performers), significant commitment exists for providing good quality, timely and comprehensive information on government policies in the fiscal area, budgets and fiscal out-turns, through a number of publications, budget documents and websites (29). Indonesia started publishing a Citizen Budget from 2012 and open-data portal to publish all budget documents in a machine-readable format (data-apbn.kemenkeu.go.id) (30). Timor-Leste uses the Budget Transparency Portal that hosts information on budget structure and execution, in addition to budget law, manuals and other key public financial information (budgettransparency.gov.tl). Globally, public engagement in the budget process is the weakest link in accountability systems (28). While the Open Budget Survey scores are generalized public sector scores, they hold particular significance for the health sector where transparency, client consultations and accountability are important enablers of progress towards UHC.

![Budget transparency scores (Open Budget Survey, 2021)](image)

### Source: Open Budget Survey, 2021 (28)

There is a continuing need to make government financial information easily accessible and appealing to potential readers in most countries of the Region. Country experiences reveal that use of digital technologies and internet offer huge opportunities to improve access to government financial information, move beyond fixed or static information to customizable information, creatively structure and present financial information in an appealing manner to keep the public informed and engaged about the financial affairs of the government.

### Government financial management system, standards and policies

A sound accounting and financial management system is the foundation of a government’s capacity to allocate and use resources efficiently and effectively (11). They play important roles in measuring and documenting the financial consequences of budgetary transactions as well as providing information to the stakeholders on government’s performance.

There have been important developments in the Region with several countries having invested significant resources over the past 25 years in strengthening and automating public FMIS. These remarkable developments in treasury computerisation and integration with the banks have allowed for real-time information on availability and utilization of public funds, minimizing float or idle funds and the need for borrowing unless truly warranted. Several of these PFM reform components have
translated into strengthening of health budget structures, monitoring and accountability. For example, there has been gradual progress in integrating donor financing into the national PFM systems reducing parallel reporting systems in countries with substantial donor presence. Similarly, the scope and coverage of FMIS has been extended to the level of health facilities in several countries. However, having a robust FMIS is a necessary but not sufficient condition for a good financial management system. The tool needs to be supported by policies, standards, accountability and culture of sound financial management practices. Countries continue to face challenges in terms of timeliness and accuracy of the information reported, inflexibilities of the central reporting system and the weak link in performance-orientation during financial reporting and accountability. Further, a majority of countries continue to use cash as the basis of accounting, thus limiting the benefit from a more comprehensive view of expenditure in the health sector.

The government financial information system continues to evolve and mature in several countries of the Region:

- In Thailand, the Government Financial Management Information System (GFMIS) comprehensively records budget allocations, expenditures, commitments made and available cash against which additional expenditures can be incurred.
- In Sri Lanka, the implementation of the Integrated Treasury Management Information System (ITMIS) brings public finance management online, while also incorporating commitment accounting, contract management and asset management (31). The Computerized Integrated Government Accounts System (CIGAS) was introduced to streamline expenditure reporting both at the line ministry level and provincial level.

Box 7. Budget transparency portal in Timor-Leste

To enhance citizen participation and engagement in the budget process and execution, Timor-Leste has established the Budget Transparency Portal. The portal hosts information on budget information and execution, in addition to budget law, manuals and other key public financial information.

The Ministry of Finance updates budget information on the portal once the proposed budget is submitted to the national Parliament. Budget information includes Budget Book 1–6 comprising budget overview, annual plans, special fund, infrastructure fund, municipalities, RAEOA-ZEESM (Special Administrative Region Authority of Oé-Cusse Ambeno), budget details, and Development Partners Budget. The calendar for budget preparation is also uploaded. This is to facilitate access to the public, civil society organizations and other stakeholders to access, analyse and participate in the plenary sessions. Through the portal, Timor-Leste aims to promote a culture of transparency, reduce risk of corruption, further its democratic principles and give citizen greater control over state affairs.

The portal covers details and updates on the government financial information and performance: approved budget amount (Budget); what has been paid (Actuals); amounts reserved in the budget but without a contract yet (Commitment), and amounts reserved in the budget with a contract (Obligation). Customized reports can be prepared by the users in PDF, Word, Excel, XML and HTML formats.

The portal is accessible at: http://budgettransparency.gov.tl
In India, information on resources transferred and received by health-care service delivery units under various centrally sponsored/funded schemes (e.g., national health mission) are available centrally and reflected in the consolidated financial reports prepared by the state level agency quarterly. The system also enables making available data from lowest level/final beneficiary.

In Bhutan, all donor funds, irrespective of the source of funding are routed through the government budgetary mechanism, where all information on expenditures is also reported in fiscal reports through the electronic Public Expenditure Management System (e-PEMS).

Nepal relies on its Computerized Government Accounting System (CGAS) for government-wide reporting.

Maldives plans to roll out a financial accounting system (SAP), including at the regional level, to reduce issues related to inefficient bookkeeping and petty cash system.

The planned computerization as part of phase III (2023–2025) of the PFM System Reformation Strategy, 2013–2025 in Myanmar has been envisaged to provide a sophisticated information technology-based budget and expenditure management system (32).

Quality and timeliness of annual financial statements is one of the key indicators to gauze the strength of government FMIS. Fig. 15 presents the PEFA scores for completeness, timeliness and consistency of annual financial reports for the countries against the global average for 2022, and demonstrates that, besides a few, a majority of countries have a similar status on the quality and timeliness of their annual financial statements.

![Fig. 15. PEFA scores on quality of annual financial reports](chart)

Notwithstanding the development of new and better government financial information systems, there are continuing challenges in budget monitoring for the health sector. Countries of the Region continue to report several issues related to inflexibilities and rigidities of the FMIS to the needs of the health sector, which leads to delays in movement of funds within and among programmes. Added to this are the weak internal systems to monitor spending within the ministries of health. These issues, besides adversely impacting the agility of health finance, limit access to information required for budget monitoring by frontline managers. The central reporting system, with its own structures and reporting formats, contributes to difficulties and delays in consolidating budget and expenditure
reports for the health sector. Often, there are inadequacies in the central reporting system compared to the information and monitoring needs of the health sector, which limits crucial information to health planners and policy-makers. In addition, several parallel systems exist. For example, summarizing reports from different hospitals/institutions and the health sector in the provinces still needs to be done manually in Sri Lanka. In some countries with significant donor presence such as Nepal and Timor-Leste, multiple reporting to development partners continues to exist. In Thailand, health agencies lament the inefficiency of having to report twice into separate databases: one for the Budget Bureau’s e-budgeting system and one for the Office of the National Economic and Social Development Council’s Electronic Monitoring and Evaluation System of National Strategy and Country Reform (eMENSCR). There are opportunities to reduce inefficiencies and administrative burden through integration, either by unifying the systems or adopting appropriate interfaces to link these different systems.

Accrual accounting can strengthen the mechanisms for accountability in the government through better transparency, fiscal credibility, achieving value for money and promoting financially sustainable decision-making (33). The majority of countries of the Region are still using the cash basis of accounting though several are in the process of adopting the changes in accounting standards, either through adoption of updated cash basis International Public Sector Accounting Standards (IPSAS) or accrual basis IPSAS (Fig. 16). While this involves a wider public finance reform, the health sector could benefit from a more comprehensive view of its investment and expenditure through the adoption of the new accounting standards.

<table>
<thead>
<tr>
<th>Countries</th>
<th>2020 Financial reporting basis</th>
<th>2025 Financial reporting basis (forecast)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>Cash</td>
<td>Partial accrual</td>
</tr>
<tr>
<td>Bhutan</td>
<td>Cash</td>
<td>Cash</td>
</tr>
<tr>
<td>DPR Korea</td>
<td>No data yet</td>
<td>No data yet</td>
</tr>
<tr>
<td>India</td>
<td>Cash</td>
<td>Cash</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Accrual</td>
<td>Accrual</td>
</tr>
<tr>
<td>Maldives</td>
<td>Cash</td>
<td>Accrual</td>
</tr>
<tr>
<td>Myanmar</td>
<td>No data yet</td>
<td>No data yet</td>
</tr>
<tr>
<td>Nepal</td>
<td>Cash</td>
<td>Cash</td>
</tr>
<tr>
<td>Sri Lanka</td>
<td>Partial accrual</td>
<td>Partial accrual</td>
</tr>
<tr>
<td>Thailand</td>
<td>Partial accrual</td>
<td>Partial accrual</td>
</tr>
<tr>
<td>Timor-Leste</td>
<td>Partial accrual</td>
<td>Partial accrual</td>
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</tbody>
</table>


In most countries of the Region, there remains an extremely weak link in performance-orientation during financial reporting and accountability. While result-orientation in planning has made some progress with assignment of performance indicators, the use of such indicators in assessing the effectiveness and efficiency of financial expenditure is extremely weak. Monitoring and accountability frameworks in most countries of the Region are largely characterized by fragmented
sector performance and financial performance information, usually produced in disregard of each other. While this represents a major transformation in budgetary outlook, considering that even countries with much matured programme-based budgeting continue to face issues particularly with regard to the use of performance information in the budget process [34], the health sector could take incremental steps to bridge the gap between programmatic information and financial information to enable more robust monitoring and accountability in the sector.

Poor capacity in budgeting and financial management among health managers, both among managers in the finance departments of ministries of health as well as health and finance managers at subnational levels and in health facilities, continue to plague several countries of the Region. The shortage of health personnel in the peripheral administrative centres, typically prevalent in the Region, adds pressure to the limited staff at health centres (usually comprising health professionals such as doctors and nurses) to undertake extra administrative functions.

**External audit and scrutiny**

The process of external audit, largely considered the custodian of public interest, is a critical public policy instrument of accountability facilitating prevention and reporting of any miscues of public funds by the government.

Several types of audits are being practised in the Region depending on what is being analysed and reported on: compliance audit (compliance with laws and regulations); financial audit (fair presentation of financial results and position); and performance audit (value for money). While countries employ their own mechanism of external audits and scrutiny, traditionally, the focus is largely on compliance and financial audits. Health ministries are often confronted with observations mostly focused on the justifications for expenditures rather than justifications for value for money or outcomes resulting from the resources being utilized. While compliance and fair presentation of financial statements are absolutely essential, health-care service delivery results must also be evaluated against performance benchmarks or desired output targets, agreed upon during budget formulation. The goal of accountability is to ensure that financial reports are accurate and compliant with regulations. The goal, however, is best achieved when expenditures are correctly mapped to programmes and key results, thereby providing value-for-money arguments with attention to allocative efficiency (doing the right things) and technical efficiency (doing things right).

While 10 of the 11 countries of the South-East Asia Region have supreme audit institutions that are full members of the International Association of Supreme Audit Institutions (INTOSAI), none of the supreme audit institutions (SAI) in South Asia has the degree of independence prescribed by the INTOSAI (SAIs are not independent from the government they audit in respect of personnel policies and funding arrangements and that the legislation supporting the independence are dated [35] or there exists variable progress on audit quality among the ASEAN (Association of Southeast Asian Nations) region with some countries clearly ahead of others [36].

The audit reports are valuable resources in terms of compliance and financial control. However, there are challenges in making the optimum use of these reports owing to delays in release of these reports and inadequate follow-up. Fig. 17 presents the PEFA score on external audit, which assesses whether public finances are independently reviewed and there is external follow-up on the implementation of recommendations for improvement, benchmarked against the global average score for 2022. Four of the nine countries are below the global averages and represent very weak performance.
Box 7. Multi-level audits in Thailand

Generally, three levels of auditing take place:

1. **Internal clearance process within the Ministry of Public Health (transactional level):** Transactions undergo an internal clearance process within the different divisions, departments, and subunits of the ministry as they request for disbursement/withdrawal of funds from the treasury. All transactions must meet the intended purposes of withdrawal as dictated by the responsibilities and authority of operation of the divisions and departments.

2. **Internal audit within the Ministry of Public Health (holistic level):** It is performed by an internal inspection/audit office that does annual auditing and inspections for ministry’s departments and agencies. Guidelines and policies for the internal auditing process are established by the Public Sector Audit Evaluation Committee (PAEC) consisting of government officials such as permanent secretaries, overlooking all public sector auditing.

3. **External audit:** External audit of the expenditures of the Ministry of Public Health is done by the State Audit Office (SAO) of the Kingdom of Thailand, which has been given jurisdiction by the Constitution of the Kingdom of Thailand. The SAO reports directly to the Prime Minister. The SAO is an independent organization under the supervision of the State Audit Committee (SAC), headed by the Auditor General, responsible for auditing all government budgetary agencies.

More information on the SAO is available at: https://www.audit.go.th/en/mandate
Overview

The COVID-19 pandemic, besides its severe health and socioeconomic impacts, imposed tremendous fiscal pressure on governments across the Region. These fiscal strains uncovered several vulnerabilities, including those in the PFM architecture, which need to be addressed not just for response to immediate crisis but for sustained and long-term recovery (37).

The significant pressures on PFM were not unique to the Region. Globally, key PFM challenges emerged from (i) the need for additional financial resources; (ii) ensuring timely availability of funds to service delivery units; (iii) sound and transparent recording and reporting of resources deployed; and (iv) ensuring business continuity (38). Across countries of the Region, the pandemic tested and unearthed strengths and deficiencies of PFM systems, reinforced their importance, inspired several updates and innovations and presented significant opportunities for governments to strengthen their respective PFM ecosystems.

Fig. 18. COVID-19 and PFM adjustments in the South-East Asia Region

<table>
<thead>
<tr>
<th>PFM component</th>
<th>Examples of PFM changes and innovation in the South-East Asia Region</th>
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</thead>
<tbody>
<tr>
<td>Budget formulation and raising revenue</td>
<td>Supplementary budget</td>
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<tr>
<td></td>
<td>Grants, loans and extrabudgetary funds</td>
</tr>
<tr>
<td></td>
<td>Mechanisms of laws and governance to allow decisions on special powers for resource allocation</td>
</tr>
<tr>
<td></td>
<td>Donations (monetary or material), voluntary contributions from the private sector, communities and individuals</td>
</tr>
<tr>
<td>Budget execution</td>
<td>Budgetary reallocation/reprogramming</td>
</tr>
<tr>
<td></td>
<td>Use of virements</td>
</tr>
<tr>
<td></td>
<td>Special procurement rules and procedures that fast-tracked expenditure management</td>
</tr>
<tr>
<td></td>
<td>A national committee to oversee partnerships between the government and private facilities (Maldives)</td>
</tr>
<tr>
<td></td>
<td>Relaxation of budget transfer restrictions within states, authorized ministries to allocate budget savings to COVID-19-related expenditure (India)</td>
</tr>
<tr>
<td></td>
<td>Contracting out to the private sector</td>
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<tr>
<td></td>
<td>Use of revenue from health facilities (Thailand)</td>
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</tbody>
</table>
### Examples of PFM changes and innovation in the South-East Asia Region

<table>
<thead>
<tr>
<th>PFM component</th>
<th>Examples of PFM changes and innovation in the South-East Asia Region</th>
</tr>
</thead>
</table>
| Budget monitoring | - New budget heads/programming codes for COVID-19  
- Customized dashboard for COVID-19 resource mapping (Myanmar)  
- New national integrated patient database to support surveillance and billings, lab results and reimbursement of lab and treatment fees (Thailand)  
- Use of GFMIS for disbursement of non-budgetary resource to frontlines (Bhutan) |

### Budget formulation and raising revenue

There were substantive shifts in government investments and prioritization of health budget in response to the COVID-19 pandemic. Countries of the Region mobilized and allocated significant public funds, comprising budgetary resources, private contributions and external support, to address resource needs for COVID-19 response. In addition, most countries sought loans from lending institutions to expand their available budgetary space. Some country examples are:

1. The response involved the creation of extrabudgetary funds drawing from public, private and external funds (Sri Lanka and Nepal).
2. In Bhutan, additional funding has been provided by the National Resilience Fund established to meet social and economic welfare measures in the country, besides the COVID-19 Response Fund, through voluntary contributions from the citizens and organizations.
3. In Myanmar, the government established the COVID-19 Vaccination Fund to procure vaccines by providing seed funding, while calling for donation from people and organizations.
4. In Timor-Leste, an extraordinary transfer was made from the Petroleum Fund (a national wealth fund used for emergency purposes) to the state budget to finance COVID-19 health services.
5. Public and health insurance funds (the Universal Coverage Scheme (UCS) in Thailand and Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (PM-JAY) in India were mobilized to address the massive financial resources required to address the COVID-19 response. For example, there have been multiple Decrees and Cabinet resolutions approving the central budget and loan use to cope with the pandemic in Thailand (39) followed by additional top-up, amounting to over US$ 200 million, in the regular budget for each of the three public health insurance schemes in the first half of fiscal year 2021 for COVID-19 screening and vaccination services (40).
6. In Indonesia, a national emergency stimulus package to address the COVID-19 outbreak was established as part of the Badan Penyelenggara Jaminan Sosial Kesehatan (BPJS Kesehatan).
Besides significantly increasing the government budgetary allocations to the health sector in several countries of the Region (14), available public funds were diverted towards response efforts through reprogramming and virements. The prompt access to savings and de-prioritized activities of other budgetary bodies (line ministries and agencies) enabled the health sector to play a quick and agile role in response efforts.

**Budget execution and provider payments**

Several countries of the Region amended the PFM systems to ensure that budget resources were promptly disbursed to the frontlines and subnational levels and subjected to enhanced flexibility in allocation and spending authorization. Mechanisms for laws and governance were established to allow special powers for decisions on resource allocation in most countries. In India, restrictions on budget transfer within states were relaxed and ministries were authorized to allocate budget savings to COVID-19-related expenditure. Health facilities in Thailand could retain their revenue for general use, including COVID-19-related expenditure. Special procurement rules and procedures were adopted that fast-tracked expenditure management in several countries of the Region.

The private sector was an important player in the national response to COVID-19 particularly in countries where the private sector accounts for a large proportion of health-care delivery such as Indonesia, and some Indian states (14). The Thai government reimbursed, through central budget and loans, services purchased from qualified private providers using the same rate, terms and conditions as applied for public facilities (40). In some instances, COVID-19-related services were purchased from the private sector in countries where the private sector is less prominent. In Maldives, a national-level committee was established to oversee partnerships between the government and private facilities in response efforts.

**Budget monitoring**

In response to the pandemic, new budget heads or programming codes were created for COVID-19-related expenditures in most countries of the Region. This enabled better tracking and accountability for the resources allocated, while improving forward estimates and planning in subsequent years. The pandemic facilitated rapid innovations in FMIS in several countries such as a customized dashboard for COVID-19 resource mapping in Myanmar or the use of e-PEMS for disbursement of non-budgetary cash grants in Bhutan.

**Summary**

The PFM system plays a critical role during emergencies as demonstrated by COVID-19 pandemic responses of different countries. Amidst the challenging macro-fiscal environments, it is not just the volume of resources available, but the efficiency in allocation and management of these resources that matters. How public budgets are allocated and managed were as important as the overall funding dedicated to the COVID-19 pandemic response (41). How quickly funds were mobilized and allocated and how flexibly and promptly were the frontlines able to access and spend these funds largely determined the effectiveness of the pandemic response.

For countries where private providers account for a large share of health services provision – such as Bangladesh, India and Indonesia where private provision accounts for 60–80% of outpatient visits and 40–60% of inpatient cases (42) – recalibrated engagement with the private sector becomes an
important policy avenue. Governments may evaluate their responses during the COVID-19 pandemic and incorporate lessons learnt in strategic purchasing and contracting with private providers to strengthen the public–private framework for a more robust and resilient health financing system for UHC (43).

The pandemic stimulated useful adjustments and innovations in resource mobilization, intersectoral collaboration in financing, private sector contracting, fast-tracking spending, simplifying procurement processes and adoption of digital technologies. Similarly, there were practices such as relaxation of internal control processes, expedited procurement or creation of extrabudgetary funds, which need to be reassessed going forward. Some of these spending modalities may not be affordable, may create fiscal risks and could undermine fiscal sustainability (10). Maintaining and improving upon some of the useful adjustments and innovations can help create a more resilient health financing framework to support countries’ progress towards UHC. While it is not immediately clear which of these adjustments and innovations will possibly be retained by countries of the Region, there are several lessons: first and foremost, strengthening the PFM fundamentals of planning, budgeting, reporting and internal controls is critical. Second, a flexible budget structure, which relies on programme envelopes rather than detailed line items, responds better to the health sector, including needs of emergency preparedness. Finally, the PFM system may be proactively redesigned to accommodate better and more strategic purchasing from private providers to strengthen the public–private framework in health services delivery.
The way forward

Call for action

PFM is critical for health financing resilience and progress towards UHC. Moving forward, the recognition that the PFM system is a critical element of a country’s health financing framework should generate renewed interest and commitment among health planners, researchers and policy-makers.

Reforms and adjustments in PFM must lead to a more responsive and resilient health system and service delivery model through a suitable balance between compliance, control, flexibility and accountability of public finance. A collaborative role and joint engagement of the Ministry of Finance and Ministry of Health, in particular, are critical in improving allocative and technical efficiency of public funding to increase budgetary space for UHC. These efforts should also consider, in a consolidated manner, engagement of health sector entities at the subnational level, to ensure that decentralization of health budgeting and spending functions contribute to gains in efficiency and better service delivery outcomes.

A country’s health system needs to drive the process. Health sector engagement in PFM is presented as the PFM in health flywheel (Fig. 19), a generic framework to guide health sector officials and stakeholders. Health sector officials need to be continuously abreast and proactive about the PFM reforms and their interfaces with health financing policies and objectives. The flywheel effect occurs when small wins accumulate over time, creating momentum that keeps the progress moving.
Recommendations

We outline key conclusions and policy recommendations to strengthen PFM response and alignment with health financing objectives, for countries of the South-East Asia Region, to accelerate progress towards UHC.

1. **A renewed understanding, commitment and sustained joint engagement is necessary to strengthen the interface between PFM systems and health financing**

   With growing appreciation about the interconnectedness of PFM issues with health financing and service delivery, PFM is assuming centre-stage of health financing reforms towards UHC. While PFM is a whole-of-government process typically under the stewardship of ministries of finance, the health sector has a significant role to play in ensuring that the PFM architecture and reforms are in synchronization with the goals and objectives of the national health sector. Ministries of finance would be concerned about the overall fiscal scenario, standardization and cross-sectoral challenges; the role of advocating for and promoting health sector-specific issues, therefore, lies squarely with the ministries of health. While most PFM reforms are beneficial to the health sector, there are some specific challenges in the health sector that must feature in reform discussions: flexibilities in financial management, fiscal decentralization, financial autonomy and accountability of health facilities. Health sector’s active participation in the PFM reform process and continuous dialogue between health and central finance authorities is, therefore, critical. Such collaborative platforms could also address other fiscal policies of mutual interest such as health taxes on alcohol, tobacco, sugar-sweetened beverages and other products harmful for health.

2. **Budget formulation is a powerful entry point for dialogue between health and finance authorities to enhance strategic outlook, flexibility and accountability in use of public finance for health**

   The way budgets are formulated, structured and presented illustrates the pathway through which resources are linked to expected outputs and it reflects the continuum of planning, budgeting and monitoring processes. It bears huge influence on actual budget implementation and the subsequent accountability for results. The budget formulation process is, therefore, the most promising PFM mechanisms to align public resources with priorities of the health sector and support progress towards UHC. Three measures are suggested: (i) better programming, forecasting and costing of priorities of the health sector; (ii) multi-year perspective in budgeting for enhanced predictability and sustainability of resources; (iii) moving from input-based budgeting to health budgets that are formulated and executed on the basis of goal-oriented programmes to build stronger linkages between budget allocations and sector priorities as well as support strategic purchasing goals. These measures are interrelated and tend to reinforce each other, strengthening the overall budget formulation process.
3. **Mechanisms for budget execution and accountability need to be unpacked at a more granular level to identify remedial actions for health, finance and local government authorities**

Suboptimal execution of allocated budget represents a missed opportunity for progress towards UHC. Tackling budget execution issues in health, besides addressing inefficiencies and accountability in service delivery, contributes to negotiation capacity in resource allocation decisions and enhances budgetary space for health. Any adjustment to the budget execution process must aim towards ensuring timely, sustained and efficient flow of funds to the service providers/frontlines along with accountability. The report outlines three action points: (i) conduct context-specific granular assessment to better understand the root causes of health budget under spending; (ii) invest in an information and communications technology (ICT) system to make health data interoperable with the PFM system, integrate and automate linkages with the banks and facilitate real-time budget monitoring and reporting especially at the subnational and health facilities level; and (iii) enhance financial management knowledge and skills among health sector managers; in the finance departments of ministries of health as well as health and finance managers at subnational levels and in health facilities. Considering the need for an optimum balance between financial flexibility and control, reforms need to adopt an incremental and phased approach.

4. **Lessons learnt from the COVID-19 pandemic response offer new knowledge and experience to build more resilient PFM system in health**

Experiences from the COVID-19 pandemic offer an opportunity to re-evaluate PFM challenges in the health sector and provide policy solutions to health and PFM authorities. The crisis demonstrated that PFM arrangements and capacity significantly influence the overall effectiveness of the health response. Countries adopted several modalities for emergency spending and measures for flexibility as well as modifications and innovations in their PFM and service delivery systems. As countries continue the process of “building back better”, careful and context-specific assessment and adjustment of these emergency regulations, the PFM architecture and service delivery systems is opportune. Sustaining and further strengthening some of the appropriate PFM adjustments and innovations can help create a more resilient health financing environment for UHC.

5. **Development partners and technical agencies have an important catalytic role to accelerate the implementation of PFM reforms in health**

While PFM adjustments and reforms are typically the decisions of governments, development partners can play an important role, particularly where their presence is significant, by avoiding parallel mechanisms for funding and reporting. Useful approaches to better use country systems and support accountability include: facilitate integration of existing mechanisms for financial reporting (e.g. for specific diseases); support consolidation of information for financial and non-financial performance of the health sector; help simplifying and making the PFM system more user-friendly for the health sector; support redefining roles, responsibilities and capacities of subnational entities in financial management; and contribute to enhancing incentives for financial monitoring and accountability at levels of the health system. International financial institutions, technical partners and researchers need to come together to support governments in analytical work and assessments, strengthening institutional and governance mechanisms, knowledge-sharing and capacity-building to strengthen the PFM system in the health sector.
References


43. Tsilaajav T, Mathauer I, Oliveira Cruz V. Purchasing health services to respond to COVID-19 – how to involve and contract private sector providers in the Southeast Asia Region? Social health protection network (P4H); 2020 (https://p4h.world/fr/node/9320, accessed 24 February 2023).
Annex 1. PEFA scores (2016 framework)
Annex 2. PEFA scores (2011 framework)
This report synthesizes qualitative and quantitative information required for the review of public financial management (PFM) in the health sector in the WHO South-East Asia Region. It unpacks PFM issues in health to describe common challenges and bottlenecks, reviews knowledge gaps, and illustrates good reform practices among Member States. The report highlights opportunities for improvement and contributes towards building the momentum on aligning health financing and PFM systems in the Region.

This report will be useful for government officials in their decision-making on health policy and planning, as well as in monitoring and evaluation processes. Development partners and technical agencies can benefit through the identification of potentially strategic areas to support countries. Those in civil society and the nongovernmental sector can use this report to bolster their advocacy efforts. Researchers can delve deeper into the report to analyse country-specific challenges and reform options, as well as to assess how these reforms sustain health financing for universal health coverage.