BUDGET EXECUTION IN HEALTH: FROM BOTTLENECKS TO SOLUTIONS

DRC
Ethiopia
Lao PDR
Pakistan
Solomon Islands

CASE STUDY SERIES

WORLD BANK GROUP

PREFACE

Health budget allocation and execution are critical to ensuring that health systems function effectively, equitably, and sustainably. The importance of budget execution in health extends far beyond mere fund disbursement; it is central to the health systems' ability to deliver essential services, improve health outputs, and advance toward universal health coverage (UHC).

The report "Budget Execution in Health: From Bottlenecks to Solutions" identifies common pitfalls and opportunities for reform through synthesizing findings from case studies across the world. This special issue of country case studies[1] is a companion to the synthesis report and delves deeper into concrete examples of the principles, practices, and challenges associated with budget execution in the health sector. Country-specific examples offer valuable insights and lessons for both practitioners and scholars, highlighting the complexities and nuances of budget execution in diverse health contexts. The series is intended as a resource for policymakers, health managers, financial officers, and stakeholders involved in health budget planning, implementation, and oversight.

Accountability is at the core of budget execution. Health systems are accountable not only to the governments and institutions that fund them but, more importantly, to the populations they serve. Effective budget execution ensures that allocated resources are spent in a timely way and as intended, that expenditures are monitored and adjusted in real time to meet emerging needs, and that the impact of spending is evaluated to inform future planning. This requires robust financial management systems, transparent processes, and the capacity to respond to unforeseen challenges—whether these arise from economic fluctuations, political changes, and/or public health emergencies.

The importance of aligning budget execution with broader health policy goals is one of the key themes explored in this special series. Health budgets should be viewed as an integral component of national health strategies. The ability to execute budgets effectively is often contingent upon clear and explicit links between financial planning and health priorities. For example, the success of initiatives aimed at strengthening primary health care, combating infectious diseases, or improving maternal and child health depends on the timely and efficient allocation and use of resources. Therefore, budget execution should be strategically aligned with these priorities, ensuring that funds are channeled to where they are most needed and can have the greatest impact.

1 These case studies—in Democratic Republic of Congo, Ethiopia, Lao People's Democratic Republic, Pakistan, and Solomon Islands—have been developed from unpublished reports that include extensive analysis. If you are interested in any of these more detailed country-specific materials, please contact Alix Beith at abeith@worldbank.org.

Another critical aspect discussed in this series is the role of governance and institutional capacity as they relate to budget execution. Effective budget execution requires strong institutions that can manage resources efficiently, ensure compliance with financial regulations, and adapt to changing circumstances. Weak governance structures can lead to resource misallocation, corruption, and/or inefficiencies that undermine health spending effectiveness. Strengthening institutional capacity, particularly in the areas of financial management and oversight, is essential for improving health sector budget execution.

The case studies also shed light on budget execution challenges in decentralized health system contexts. Decentralization, while offering potential benefits such as increased responsiveness to local needs and greater accountability, can also complicate health budget execution. The division of responsibilities between central and local governments, financial management capacity variability across regions, and coordinating funding flow complexity can all pose significant challenges to effective budget execution. Addressing these challenges requires careful planning, clear role and responsibility delineation, and capacity building at all health system levels.

In addition to the technical and institutional budget execution challenges, this series recognizes the importance of political economy considerations. Health budget execution is often influenced by political dynamics, such as different stakeholder interests and priorities, power distribution within government—including at and between different government levels, and the broader economic and fiscal environment. Understanding these dynamics is crucial for anticipating potential budget execution obstacles and for designing strategies to navigate them.

The COVID-19 pandemic further underscored the importance of resilient health systems and the need for flexible and responsive budget execution. The pandemic brought to light the significant health financing disparities and challenges that many countries face in mobilizing and executing resources to respond to public health emergencies. The case studies in this series reflect on these lessons, emphasizing the need for budget execution processes that are flexible and responsive to crises, while maintaining a focus on long-term health system strengthening.

As you delve into the case studies, you will gain a deeper understanding of the multifaceted nature of budget execution in health. The examples from different countries and regions provide practical insights into what works and what does not, offering valuable guidance for improving budget execution in diverse contexts. Whether you are a policymaker seeking to enhance the efficiency of health spending, a health manager responsible for overseeing budget execution, or a researcher interested in the intricacies of health financing, this special series should serve as an invaluable resource.

Interesting examples of practices that have supported better budget execution include the Lao People's Democratic Republic's ringfencing of health sector expenditures, protecting them from being cut when government revenue is less than projected; the Lao PDR's amended State Budget Law, 2021 which allows provincial authorities to allocate any excess revenue to capital projects, leading to the highest capital budget execution rates across the case

studies; Pakistan's outsourcing of primary healthcare service delivery to the private sector, facilitating both high budget execution rates and evidence of resources reaching the facility level more effectively than under centrally-managed government systems; the Solomon Islands' decision to ensure that its essential medicines were entirely domestically financed which led to an increasingly robust domestically managed system for procuring drugs and medical supplies; and Ethiopia's high accuracy of payroll expenditure underpinned by rapid turnaround times for payroll changes.

The case studies also demonstrate commonalities in terms of the bottlenecks impacting the quality of budget execution. Key shared issues include limitations with the quality and credibility of budget preparation processes; rigidities in budget execution management; over-estimation of budget revenue to finance health budgets; inefficient and ineffective spending controls; and weaknesses with real-time and ex-post reporting and accountability, particularly in terms of the links from spending to the sector's strategic priorities.

In conclusion, budget execution in health is not merely a technical exercise; it is a critical determinant of the ability of health systems to deliver on their promises to the populations they serve. By ensuring that allocated resources are used efficiently, transparently, and effectively, we can move closer to achieving the goal of universal health coverage and ensuring that all people have access to the health services they need without suffering financial hardship. We hope this series will inspire and inform your efforts to strengthen budget execution in the health sector, contributing to the broader goal of building resilient, equitable, and sustainable health systems worldwide.

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BUDGET EXECUTION IN HEALTH: FROM BOTTLENECKS TO SOLUTIONS

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CASE STUDY SERIES

DEMOCRATIC REPUBLIC OF CONGO

WORLD BANK GROUP

Health, Nutrition and Population (HNP) Discussion Paper

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CASE STUDY SERIES

DEMOCRATIC REPUBLIC OF CONGO

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ABSTRACT:

The Democratic Republic of Congo is committed to achieving Universal Health Care by 2030. Progress toward this goal faces challenges due to limitations in the execution and allocation of the country's health budget. This contributes to health spending being predominantly financed by households and donors rather than the government. The only part of the government health budget that is consistently executed in line with allocations is for health worker payments. Execution rates for other spending categories are volatile and generally low. Many parts of the budget are not executed at all, while some activities are implemented without having been included in the budget. Budget execution within the Ministry of Health is influenced by both internal and external factors. Inconsistencies between strategic planning, budget preparation, and execution processes hinder effective financial management; inaccurate cost estimations; heavy reliance on exceptional procedures for spending and over-execution of specific budget lines to the detriment of otherwise planned activities. External challenges include a systematic over-estimation of national revenue; the highly centralized nature of budget execution processes; the dominance of health worker payments in budget allocations; the non-respect of budget management rules and cumbersome procurement and expenditure execution procedures.

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Budget execution in health: from bottlenecks to solutions

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Click on this square to return to the contents page

SECTION NAME

Click on this section to return to the beginning of the section

DEMOCRATIC REPUBLIC OF CONGO **CONTENTS**

LIST OF FIGURES

LIST OF TABLES

ACKNOWLEDGMENTS

This study is part of a broader analytical collaboration between the World Health Organization (WHO) and the World Bank to address budget execution problems in the health sector. The study's findings feed into a synthesis report, which is released concurrently: Budget Execution in Health: From Bottlenecks to Solutions.

This study was authored by the Democratic Republic of Congo (DRC) World Bank team, including Marion Jane Cros (Senior Health Specialist), Fatima El Kadiri El Yamani (Senior Economist), Michel Muvudi (Senior Health Specialist), and Aminata TOU Nana (Consultant). It follows a case study protocol developed by Hélène Barroy (Senior Health Finance Specialist, WHO), Moritz Piatti-Fünfkirchen (Senior Economist, World Bank), and Amna Silim (Senior Consultant). Quality assurance was provided by Hamish Colquhoun (Senior Consultant) and Moritz Piatti-Fünfkirchen (Senior Economist). Technical editing and communication support was provided by Zac Mills (Senior Consultant), Hamish Colquhoun (Senior Consultant), Clementine Murer (Program Analyst), and Alexandra Michele Beith (Senior Consultant). The study benefitted from management oversight by Agnès Couffinhal (Global Program Lead for Health Financing) and Monique Vledder (Practice Manager, HNP). It was made possible through generous financial support from the Global Financing Facility (GFF).

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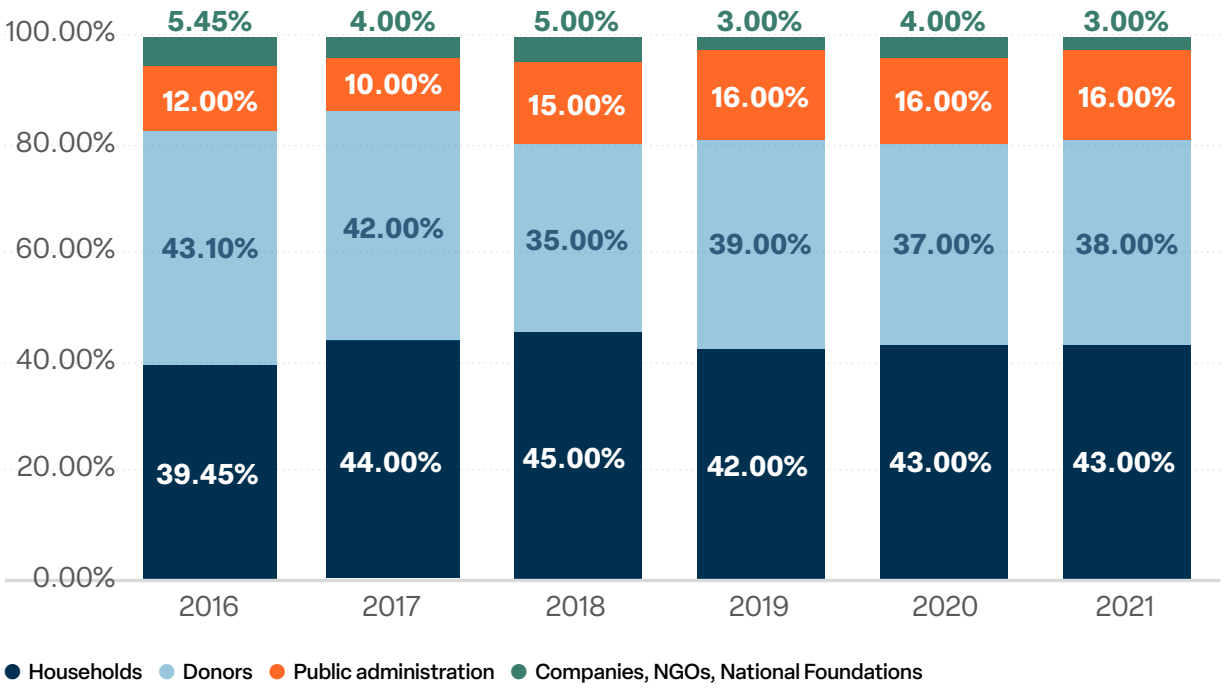
1.0 HEALTH FINANCING CONTEXT

The Democratic Republic of Congo (DRC) is committed to achieving Universal Health Coverage (UHC) by 2030. This target requires ensuring all people have access to quality healthcare without financial hardship. The government's strategic objectives for the sector are set out in the National Health Development Plan[1] 2019–2022. This plan is complemented by a 2019 Health Financing Strategy which defines the mechanisms for improving the mobilization and effective utilization of resources for the health sector.

Spending on health is predominantly financed by households and donors. Direct household payments are the main source of health facility income. Collectively, household payments and donor grants comprised over 80 percent of total health spending from 2016 to 2021 (see Figure 1). Government financing comprised 10-16 percent of total health spending in the same period.

Figure 1
Democratic Republic of Congo Health Financing Sources, 2016–21



Source: Ministry of Health: National Health Accounts Report 2021.

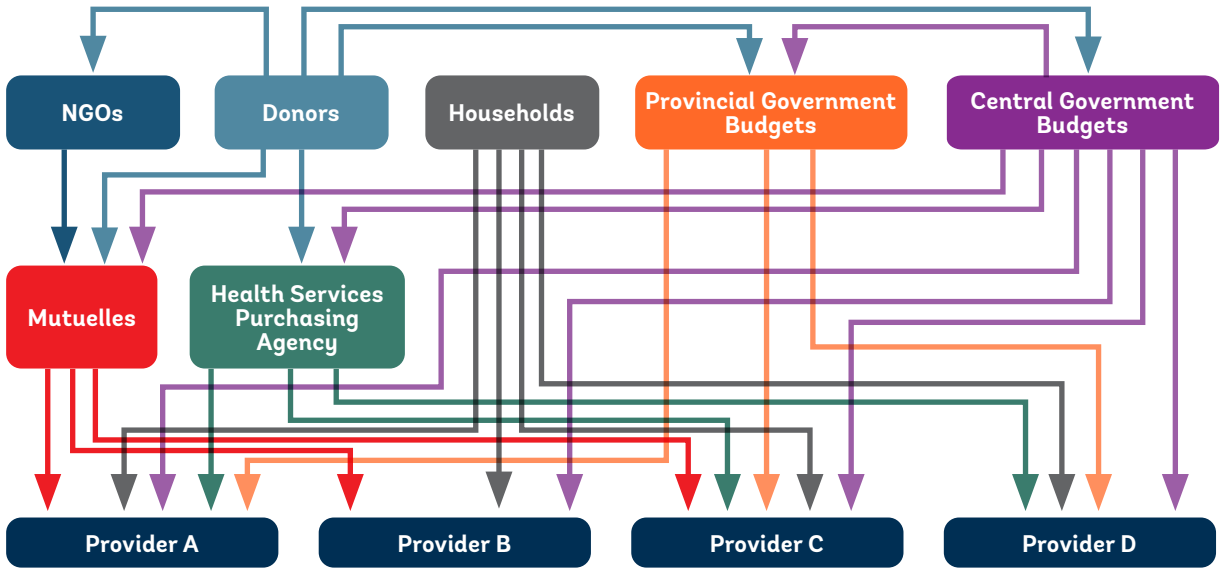
1 Plan National de Développement Sanitaire (PNDS).

Total spending on health is far below the estimated levels required to achieve UHC. Total health expenditure ranged from US$19 to US$22[2] from 2013 to 2019 and reached 3.65 percent of gross domestic product (GDP) in 2020. This is far below the US$86 per capita and 5 percent of GDP estimated by international studies to achieve UHC.[3]

While the health sector budget allocation has increased in recent years, the increase is primarily due to donor resources. Overall, the proportion of the government's total budget allocation that is earmarked for the health sector increased from 6.6 to 11 percent from 2016 to 2021. However, when considering only the government's own resources (i.e., excluding donor allocations captured in the budget), the allocation increase was more modest (from 6.6 to 7.4 percent over the same timeframe). Public resource allocation for health, therefore, remains below half the Abuja Declaration target of 15 percent. Gaps in resource mobilization are compounded by less-than-adequate budget execution: in 2019, only 57 percent of the health budget was spent.

Resource flows are fragmented (see Figure 2)**.** Households pay the service providers at hospitals and health centers out-of-pocket for consultations, medicines, tests, and hospitalization. Donor resources are channeled

Figure 2
Health Sector Financial Flows in Democratic Republic of Congo



Source: Ministry of Health: National Health Accounts Report 2021.

2 Government of the Democratic Republic of Congo. 2021. National Health Accounts Report 2021 (Comptes Nationaux de la Santé 2021). Kinshasa: Ministry of Health.

3 McIntyre and Meheus (2014) quoted in World Bank (2021) DRC Health Financing Reform for UHC: Fiscal Space Analysis. Note: US$86 in 2012 terms.

to providers through development projects (off-budget) or through central and provincial government structures (on-budget direct transfer payments for service providers of health centers[4] allocations). Government resources are transferred through multiple mechanisms both as financial flows (principally remunerations for health workers) and in-kind (including the provision of medicines). Private sector resources, nongovernmental resources, and a tiny portion of donor resources—collectively representing about 3 percent of total health expenditure—are transferred to public community-based insurance schemes (i.e., mutuelles), which in turn purchase health services from providers.

Public management of the health sector is decentralized in theory but remains highly centralized in practice. In theory, healthcare provision is the responsibility of the provinces. In practice, the management of resources for the sector remains almost entirely under the control of the central government. Health worker payments and other recurrent spending are made by the central government on behalf of the provinces. Large allocations are included in the annual budget for capital spending resources to be transferred to the provinces. In practice, most of these allocations are not released (or when partially executed, they again reflect capital spending implemented by the central government on behalf of the provinces).

Mechanisms have been established for linking on-budget donor financing to specific service delivery results, but gaps remain in terms of operationalization. In 2016, the government established a program-based budget, linking health budget allocations to the strategic health plan. Monitoring exercises are undertaken to assess the delivery of the strategic plan based on this reporting framework. However, budget execution processes do not yet utilize the program-based structure, so it currently serves a reporting function only. The World Bank and European Union also support public corporations that purchase health services in about 3,000 health facilities. The public corporations agree on service cost, sign provider purchase contracts, and pay based on negotiated rates and performance criteria such as the number of patients treated for certain preventive services.

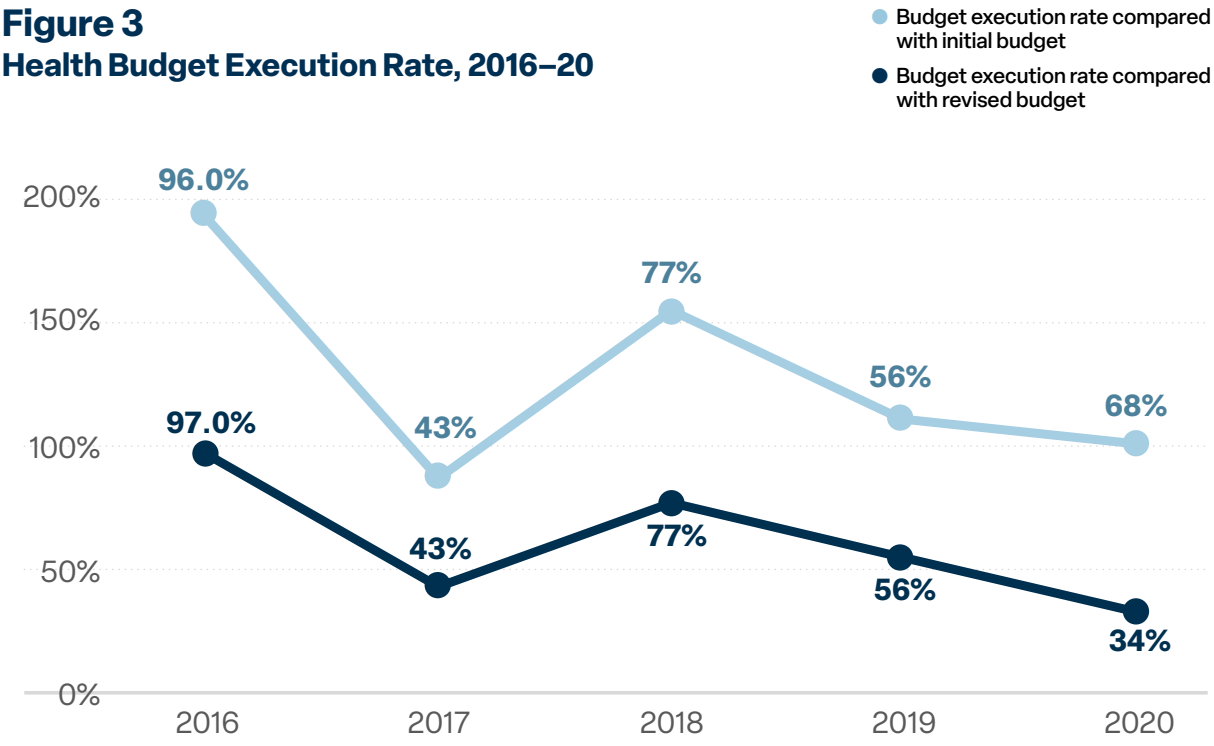
Discussions are ongoing to create a national health insurance scheme. The details of its implementation remain unclear, particularly whether it would subsidize the poorest in the informal sector. (In the formal sector, mutuelles cover the police, the army, and teachers, among others.) The government plans to create a National Health Solidarity Fund to purchase health services; yet, no institutional or financial feasibility study has been conducted to explore how to establish and manage the fund (e.g., health services to be offered, population to be covered—including mechanisms to exempt the poorest informal sector households).

4 Formations sanitaires (FOSA).

2.0 BUDGET EXECUTION IN HEALTH

The overall execution rate for the health budget is modest. Over 2016–20, the average health sector budget execution rate was 47.6 percent of initial budget allocations. The average execution rate was 68 percent when compared with the revised budget (see Figure 3). This health budget execution rate was considerably lower than for overall government spending, which averaged 80 percent.

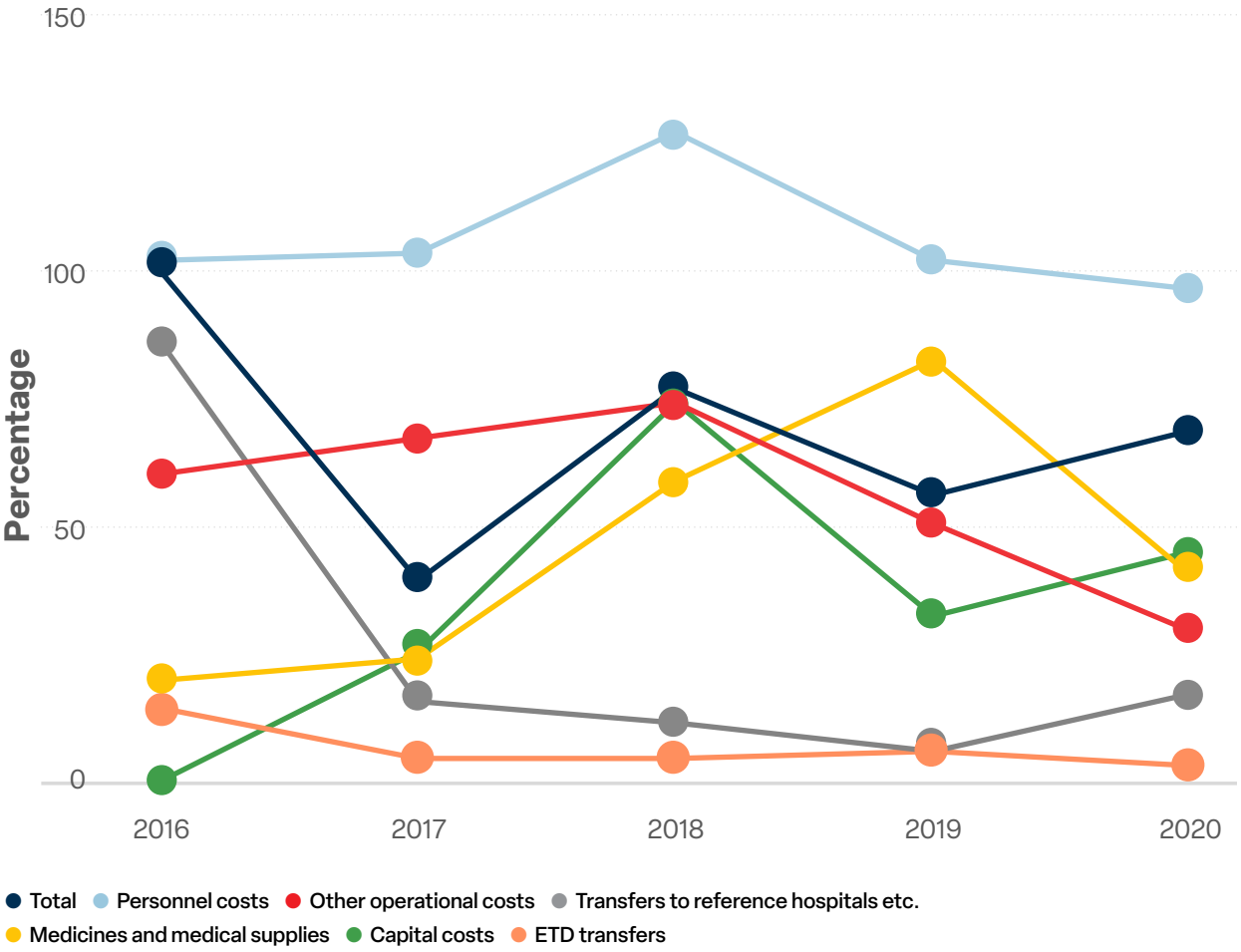
Figure 3
Health Budget Execution Rate, 2016–20



Source: World Bank 2025, based on General Directorate of Budget Policies and Programming: Budget Monitoring Statements 2016-2020 and Budget Execution Laws 2016-2020.

Execution rates differ substantially by budget category and by year. Health worker payments average a 103 percent execution rate. Execution rates for other spending categories decrease and vary significantly (see Figure 4). Notably the execution rates for transfers to provinces (consistently below 5 percent) and hospitals (consistently below 20 percent) are the least funded. The execution rate for other operational spending varied significantly, dropping to just 30 percent in 2020. The overall health budget execution rate with health worker payments excluded averaged 48 percent (relative to the revised budget allocation).

Figure 4
Execution by Health Expenditure Type, 2016–20

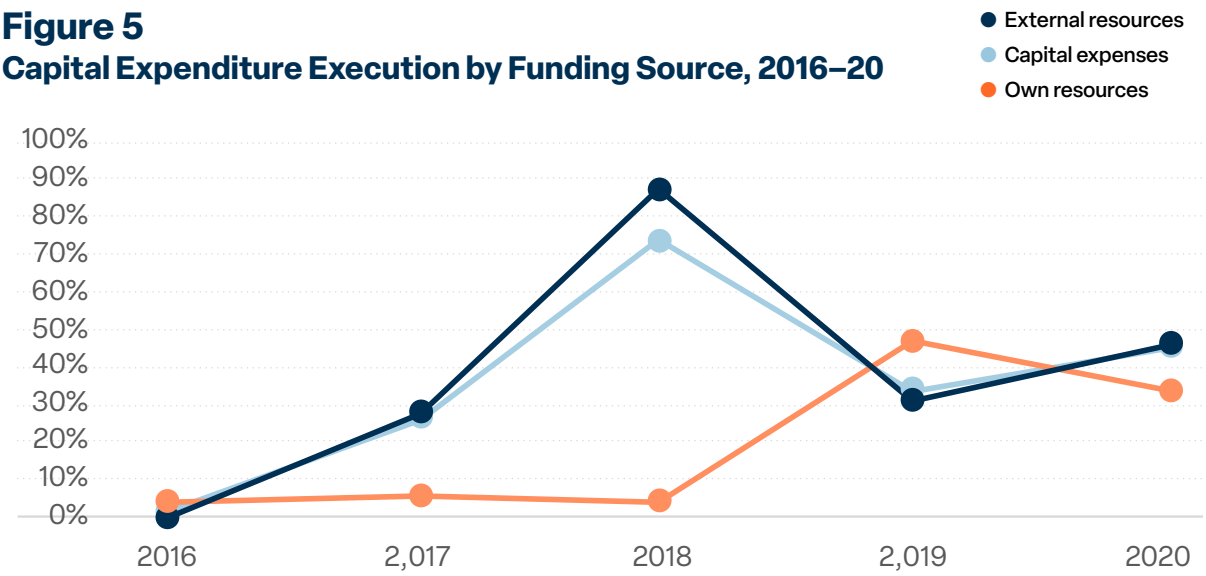


Source: World Bank 2025, based on General Directorate of Budget Policies and Programming: Budget Monitoring Statements 2016-2020 and Budget Execution Laws 2016-2020.

Variability in execution rates is even more extreme when considering more disaggregated budget categories. For example, in 2019, only six of the Ministry of Health's over 50 divisions and programs achieved any execution of their budgets for running costs. The Office of the Minister of Health, however, over-executed its budget with a rate of 205 percent. In the same year, the allocations for hospital running costs were not executed for a single hospital.

Capital spending is inadequately executed, with further variation if disaggregating between internal and external financing. The average execution rate for internally financed capital spending was just 19 percent but a slightly higher 38 percent for externally financed capital spending. From 2016 to 2018, domestic capital spending was close to zero executed, with the execution rate improving modestly in 2019 and 2020 (see Figure 5).

Figure 5
Capital Expenditure Execution by Funding Source, 2016–20



Source: World Bank 2025, based on General Directorate of Budget Policies and Programming: Budget Monitoring Statements 2016-2020 and Budget Execution Laws 2016-2020.

Budget controls are largely bypassed. Many areas of actual spending are for activities that were not included in the voted budget, while the majority of activities actually planned for are not executed. For example, in 2019, US$6.3 million was spent on purchasing vaccines and inputs for blood transfusions despite the lack of any budget allocation for this activity. Further, no retrospective exercise was undertaken to account for this spending in a revised budget.

A major part of the government health budget is externally financed, creating challenges for execution. Donor financing is included in the health budget in a non-exhaustive and, at times, inconsistent manner. The ineffective execution rate for external financing is explained by actual challenges in executing the resources and, given that most of the resources are executed outside of government systems, by the difficulty of accessing the data on execution. Donor execution varies and often differs from the government's own processes. Donor processes can be administratively heavy and beyond the available capacity within the Ministry of Health to manage efficiently, leading to delays and under-execution.

The root causes of poor health sector budget execution that are external to the Ministry of Health include:

- **Over-estimation of budget revenue.** Revenue projections in the budget are based on political considerations rather than on realistic economic and social assumptions or historical resource mobilization performance. They tend to be systematically overestimated, leading to low execution rates.
- **Highly centralized budget execution processes.** All phases of the budget execution process remain managed by the Ministry of Budget and the Ministry of Finance. The Ministry of Health has no delegated authority to execute its own budget. This reform has been legislated for but not yet implemented.

- **Dominance of health worker payments in budget allocations.** Health worker payments are prioritized in budget execution processes. These payments make up 60 percent of total health budget spending and, excluding donor resources, an even higher percentage of domestic financing. The prioritization of these payments in the execution process reduces the ability to execute other categories of expenditure.

- **Disregard for budget management rules.** Some government institutions systematically spend beyond their budget allocations. This reduces the resources available for the execution of the health budget.

- **Cumbersome procurement and expenditure procedures.** The process of executing budget items is highly burdensome and time-consuming, incurring long delays in procurement processes. Most spending is executed by bypassing these controls, contributing to other challenges of execution composition and quality.

Root causes of poor health sector budget execution that are internal to the Ministry of Health include:

- **Inadequate programming of the priorities in the budget.** The misalignment between the health planning cycle and the budget calendar is a major factor. Strategic health plans are not timed to feed into the budget preparation processes and (given the non-implementation of the program budget reform) their financing estimations are not fully integrated with the actual format of the government budget. This issue is exacerbated by the lack of consideration for aligning budget allocations to strategic priorities in response to requests. Budget allocations instead tend to be based on the previous year's allocations, with limited considerations of prior execution performance or changed priorities.

- **Budget credibility.** Costs for specific activities are inaccurately estimated, leading to challenges in execution as available resources differ from required resources.

- **Nonstandard budget execution procedures.** Given the challenges with executing spending through the standard budget procedures, most health spending is executed by bypassing these controls. The lack of control, however, means that such expenditure often does not align with programmed priorities and by using up the overall resources available for the sector, further reduces the possibility of executing originally planned activities.

- **Over-execution of the operating budget crowds out the operating expenses of other units.** Budget allocations for running costs are systematically over-executed, which results in most other departments within the ministry being unable to access their operational budgets.

- **Narrow health budget execution processes.** A narrow group oversees the resource execution processes, with minimal input from other health sector stakeholders. Budget allocations and resource execution processes are not well communicated to the impacted departments. Health sector stakeholders have minimal engagement in the execution of the health sector's budget.

3.0 PUBLIC FINANCIAL MANAGEMENT CONTROLS FOR HEALTH SPENDING

Health expenditures are subject to both ex-ante and ex-post controls. At a general level, ex-ante controls are performed by the government, including the Budget Control Directorate (Ministry of Budget), the Payment Authorization and Treasury Directorate (Ministry of Finance), and the Central Bank. These controls aim to ensure the legality, compliance, regularity, and timeliness of the expenditure. Ex-post control is carried out by the General Inspectorate of Finance, the Court of Auditors, and the Parliament. It takes place after the expenditure has been executed and is intended to ensure that the expenditure is genuine, legal, and consistent.

Specific controls vary for different types of health spending. Table 1 describes the main controls for each category of health spending and discusses their adequacy in practice. It also uses the example of the 2020 budget to show the proportion of spending for each category and the number of transactions executed in that year.

Table 1: Health Sector Expenditure Controls

Control Type	Total Spending (2020, %)	Control Description	Adequacy of Control
Wages and salaries	69.6%	■ Personnel monitoring in the quarterly payroll report by the Ministry of Health (MoH). ■ Compliance verification of the payroll directorate's database with that of the civil service. (12 transactions involved)	This control's objective is to identify fictitious workforce personnel, integrate omissions, and adjust salary levels in line with grade changes. The control is inadequate. however. The objectives cannot be achieved given the lack of interface between the civil service and budget software. It does not allow for real time assessments.

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Table 1: Health Sector Expenditure Controls

Control Type	Total Spending (2020, %)	Control Description	Adequacy of Control
Bulk purchase of drugs and medical supplies	0.8%	■ Procurement level control: specification verification, supplier certification, international ordering, and delivery. ■ Expenditure commitment control. ■ Verification of services rendered. ■ Control of appropriations availability before commitment, control of actual payment amount required, control at payment authorization level, and checking cash availability for payment. **(3 transactions involved)**	This process involves a fairly large number of checks, which lengthens the time and can lead to delays in essential drug provision to patients.
Health facility purchasing of drug and medical supplies	0.2%	At the health facility level, oversight is carried out at the: ■ Health zone level to monitor compliance with quantity and type of products ordered. ■ Provincial division level to check costs before placing orders. Following oversight, hospitals proceed with order and payment.	Drug procurement controls at the health facility level are light. The facilities are required to obtain supplies from approved suppliers in their geographical area. However, lighter control does not guarantee medicine availability, as the approved suppliers are subject to lengthy national-level procedures.

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Table 1: Health Sector Expenditure Controls

Control Type	Total Spending (2020, %)	Control Description	Adequacy of Control
Non-wage operating costs (other than bulk procure-ment)	2.6%	The control level varies depending on the expenditure execution procedure. For the exceptional process: checking that a budget line exists and that an amount is entered for post-implementation adjustment. For the normal public expenditure procedure, several levels of control exist, namely: ■ Appropriations submanager oversight: verifies procurement procedure compliance, appropriations availability, existence of all supporting documents, and expenditure veracity. ■ Budget controller level: reviews all controls already carried out by the submanagers before affixing a stamp of approval. ■ Ministry of Budget reviews all controls by the submanagers and the budget controller before committing the expenditure. ■ At the settlement level, the same checks are carried out before the file is forwarded for payment authorization. ■ Finally, for payment authorization and actual payment, the same controls are repeated. In addition, payment is subject to other controls, such as cash availability and priority to be given to said expenditure. **(48 transactions involved)**	The multiplicity of controls that are part of the normal procedure is not aligned with the objectives of improving health expenditure levels and ensuring healthcare establishment functioning. Instead, the numerous transactions become an incentive to use emergency procedures that result in significant extrabudgetary expenditures.

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Table 1: Health Sector Expenditure Controls

Control Type	Total Spending (2020, %)	Control Description	Adequacy of Control
Capital Expenditures	26.7%	Capital expenditure controls depend on the funding source and the nature of the expenditure. For expenditures financed from internal resources, national procurement rules are applied with various levels of control, such as: ■ Procurement procedure oversight by the Ministry of Health and the Ministry of Budget. ■ The expenditure procedure itself with repetition of the various phases of commitment, validation, payment authorization, and payment. Regarding external financing, requesting a procurement procedure "no objection" involves an additional level of control, which can lead to a long delay in execution. **(13 transactions involved)**	The cumbersome procurement procedure involving different levels of control and intervention by several actors from different ministries makes it difficult to achieve efficient execution.

Source: World Bank 2025, based on stakeholder discussions with the Ministry of Health and the Ministry of the Budget and data from the computerized expenditure chain system.

Payment arrears are large but not monitored. As of January 2021, Ministry of Health arrears for the 2020 budget were estimated at US$181 million. Budget management rules and procedures mandate that payment arrears recorded at the end of a fiscal year be recommitted in the following fiscal year for payment on a priority basis. This does not always happen, and many commitments appear not to ever be paid. Currently, the Ministry of Health lacks oversight, and the Ministry of Health and the Ministry of Budget do not have a joint mechanism to monitor incomplete expenditures and avoid accumulation of payment arrears.

The delays and incomplete payments to government suppliers are reflected in higher prices and challenges in securing timely procurement. Suppliers factor in their prices the risk of nonpayment and the costs of receiving late payments. Discussions with Ministry of Health officials suggest the premium can be as much as 50-70 percent compared to what a similar service would cost for the private sector. When there is a considerable stock of payment arrears, especially for drugs, the government waits to clear them before placing additional orders, since the sector is dominated by the same actors. This can impact drug and medical equipment availability.

Procedures expedited for COVID-19 were well intentioned but challenging. The government expedited some expenditures to support an urgent response to and curb the spread of COVID-19. Expedited procedures entailed simplified procurement procedures, particularly for certain categories of expenditure. There were challenges in managing pandemic-related expenditures, including the use of unregulated emergency procedures for disbursing COVID-19 response funds, instances of over-billing for goods and services, the involvement of unauthorized individuals in handling funds, and an insufficient justification of expenses by these individuals (see Table 2).

Table 2: Changes in Expenditure Controls during COVID-19

Expenditure	Change of Control for Each Type of Control	Change in Control Period
Wages and salaries	No change and in control for salaries	No change
Bulk purchase of drugs and medical supplies	Procedures streamlined and purchases made using direct contracting procedures	No changes in timelines for such procedures
Purchase of drugs and medical supplies from health facilities	No change	No change
Non-wage operating costs (other than bulk procurement)	Certain procurement expenditures made without requiring the budgetary controller's prior approval	Control period became zero days
Capital expenditures	Some fixed assets completed without the use of procurement controls or procedures	Turnaround time reduced by two months
Transfers to different levels of government when resources used to finance health expenditures	Resources made available directly to provincial governors without specifying the types of expenditures to be financed or the sectors to be financed	Transfer done in one week as compared to usual three months
Payments by purchasing agency to health facilities for their services	No change in controls	Payment delays lengthened because travel restrictions led to a delay in controls

Source: World Bank 2025.

4.0 GOOD PRACTICES AND BOTTLENECKS

Execution of the health budget has been highly problematic over the period of this case study's analysis. While health worker payments are well executed (albeit often over-executed), execution rates are much more volatile across all other areas of spending. There is often a limited link between what is spent and what was originally planned in the budget.

The government has made substantial effort to improve budget execution processes, with some foundations now in place. Yet, bottlenecks, including in the implementation of these good practices, remain the dominant feature of the system. These bottlenecks and good practices are set out in Table 3.

Table 3: Summary of Budget Execution Good Practices and Bottlenecks in Democratic Republic of Congo

Issue	Explanation
Good Practices	
The Department of Administration and Finance has been established within the Ministry of Health, such that the Ministry of Health will take on increasing responsibility for the execution of its own budget.	The centralized management of the health budget by the Ministry of Budget and the Ministry of Finance imposes additional execution challenges and makes it harder to ensure actual spending is based on the sector's own priorities. The 2011 Public Finance Reform requires this management to be decentralized to the sectoral level. While this reform has not yet been implemented, the Ministry of Health, in collaboration with the Ministry of Budget and the Ministry Finance, has made progress in establishing and operationalizing the necessary unit for managing the health sector budget.
A tripartite Health-Budget-Finance Committee has been established to monitor budget execution.	In the interim of the Ministry of Health becoming responsible for executing its own budget, an inter-ministerial committee has been established to bring together the main actors responsible for health budget execution. This committee periodically analyzes the execution situation in relation to forecasts and, if necessary, proposes and monitors urgent actions for improvement. This committee still needs to be made fully operational.

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Table 3: Summary of Budget Execution Good Practices and Bottlenecks in Democratic Republic of Congo

Issue	Explanation
Program budgets have been introduced to improve allocative efficiency by directing resources to defined priorities.	The Ministry of Health has increasingly prepared budget allocations and reported budget execution using a program-based format since this reform was included in the 2011 Public Finance Law. Although execution processes do not yet utilise this format, the reporting does increase the transparency of how execution challenges relate to the sector's priorities.
Bottlenecks (Central Government-level)	
Unrealistic revenue forecasts	Revenue forecasts are systematically over-estimated for political reasons. This causes both under-execution of the budget and leads to inconsistencies in how available resources are prioritized given the extent of the gap between the planned and actual financing available.
Highly centralized budget execution processes	Budget execution processes for the health sector are almost entirely managed by the Ministries of Finance and Budget. The 2010 Public Finance Law set out the process for this to be decentralized to the control of the Ministry of Health, but this reform has not yet been implemented. This centralization makes it harder for the health sector to ensure budget allocations and their in-year execution link as closely as possible to its strategic priorities. It also reduces the sector's accountability for delivery of its own strategic targets.
Non-respect of budget management rules	Certain institutions and departments systematically over-execute their budget allocations by avoiding the proper controls. This makes it even more difficult for other institutions to execute their own budgets.
Public procurement system inefficiencies	A public procurement system analysis conducted in 2018-2022 with World Bank support highlighted the inefficiencies in the system which need to be addressed. These actions are required to reduce procurement delays and should take into account the specific characteristics of the health sector.

...table continued next page

Table 3: Summary of Budget Execution Good Practices and Bottlenecks in Democratic Republic of Congo	
Issue	**Explanation**
Cumbersome and fragmented expenditure chain	There are excessive controls on spending which are disproportionately applied relative to transaction sizes. In practice most health spending simply avoids going through these controls. It would be more effective to have a streamlined system of controls which is less burdensome and hence more regularly utilized.
Bottlenecks (Ministry of Health-level)	
Lack of integration between strategic planning processes and actual budget allocations	Sector planning processes do not directly feed into budget preparation exercises. In-year processes determining actual execution also make limited or no reference to strategic priorities set out in longer term planning processes.
Weak estimation of costs	Many costs are now well estimated leading to inaccurate budget allocations and consequent challenges with execution.
Opaque or non-inclusive health budget preparation and execution processes	There is also a lack of transparency in budget preparation processes from the perspective of implementing departments and agencies, alongside limited communication on the amounts allocated and how structures should make spending requests in a timely and accurate manner.
Frequent recourse to emergency execution procedures	Most spending within the health sector bypasses the normal controls. Such expenditure often does not align with programmed priorities and makes the execution of planned activities more difficult.
Non-systematic tracking of external financing inputs	A large proportion of the government's health sector budget is based on assumptions of external financing amounts. Most of this external financing does not utilize government execution processes making reporting on its execution time-consuming and problematic. Where data cannot be collected, the execution rate is shown as zero even if funds may have been disbursed. This distorts overall reporting on the execution of the health budget.

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BUDGET EXECUTION IN HEALTH: FROM BOTTLENECKS TO SOLUTIONS

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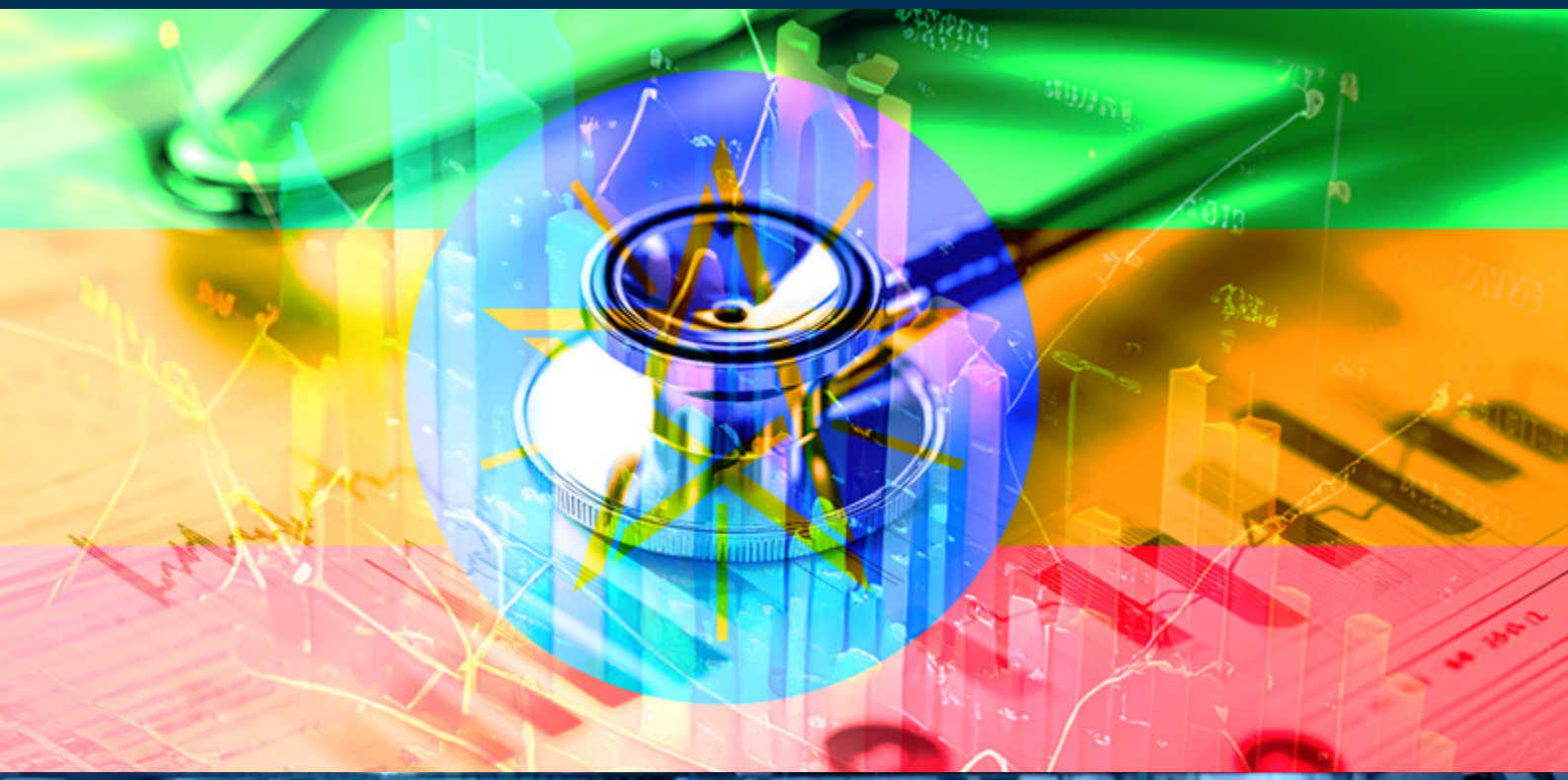
CASE STUDY SERIES

ETHIOPIA



WORLD BANK GROUP

Health, Nutrition and Population (HNP) Discussion Paper

BUDGET EXECUTION IN HEALTH: FROM BOTTLENECKS TO SOLUTIONS

CASE STUDY SERIES

ETHIOPIA

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ABSTRACT:

Ethiopia achieves a high overall rate of execution of its health budget. From 2016 to 2021 the health budget execution rate averaged 95 percent of the original budget allocation. The health budget execution rate was higher than the execution rates for overall government spending. The execution rate also increased each year (ultimately exceeding 100 percent in both 2019/20 and 2020/21 as a result of additional prioritisation to health spending during the pandemic). Nonetheless, the execution rate for regions was lower than for the federal government. The execution of the capital budget was also weaker, particularly at the regional and woreda levels. Data on execution rates for specific government programs are not available and may involve much more volatility than aggregated execution rates. Development partner spending managed outside of the federal Treasury also had much higher volatility in execution. Good practices that underpin Ethiopia's high execution rates include relatively low levels of arrears; reasonable turnaround times for payroll changes and high accuracy of payroll expenditures; timeliness and good communication of budgeting processes; and shortening of timeframes for transfers from federal to decentralized levels. Areas that hold back the quality of budget execution include limited transparency on execution data; capacity constraints at the facility and woreda levels; external resources being managed outside of government systems; limited flexibility of spending for health facilities; and overly simplified procurement processes that prioritise only the lowest price.

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Budget execution in health: from bottlenecks to solutions

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Click on this square to return to the contents page

SECTION NAME

Click on this section to return to the beginning of the section

ETHIOPIA **CONTENTS**

LIST OF FIGURES

LIST OF TABLES

ACKNOWLEDGMENTS

This study is part of a broader analytical collaboration between the World Health Organization (WHO) and the World Bank to address budget execution problems in the health sector. The study's findings feed into a synthesis report, which is released concurrently: Budget Execution in Health: From Bottlenecks to Solutions.

This study was authored by the Ethiopia World Bank team including Mideksa Adugna (Data Analyst Consultant), Marion Jane Cros (Senior Health Specialist), Tseganeh Amsalu Guracha (Senior Health Specialist), and Noemi Schramm (Lead Consultant). It follows a case study protocol developed by Hélène Barroy (Senior Health Finance Specialist, WHO), Moritz Piatti-Fünfkirchen (Senior Economist, World Bank), and Amna Silim (Senior Consultant). Quality assurance was provided by Hamish Colquhoun (Senior Consultant) and Moritz Piatti-Fünfkirchen (Senior Economist). Technical editing and communication support was provided by Zac Mills (Senior Consultant), Hamish Colquhoun (Senior Consultant), and Alexandra Michele Beith (Senior Consultant).
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1.0 HEALTH FINANCING CONTEXT

Ethiopia is administratively and fiscally decentralized. Administratively, the country is divided into 12 regional governments and two city administrations; each region is divided into woreda (district) governments, with nearly 1,060 woredas in the country. Fiscally, the regional and woreda governments are responsible for most health service delivery. While grants from federal government constitute 70-80 percent of regional revenues, the regions raise revenue through income taxes (personal, sales, corporate, profit, property, and other); fees on agricultural land, licensing, royalty, forest resources, water use, and other activities; and fees on health services, such as drugs.[1]

Ethiopia aims to achieve universal health care by 2035. Its twenty-year health sector strategy, Envisioning Ethiopia's Path to Universal Health Care through the Strengthening of Primary Health Care by 2035, focuses on improving access and equity, management information systems, woreda management, and person-centered care. Under the strategy, the Second Health Sector Transformation Plan 2020/21–2024/25 builds on the first plan (which revised the Essential Health Service Package to improve service availability, accessibility, acceptability, and affordability) and guides health spending and policies. The second plan focuses on accelerating progress toward universal health coverage, protecting people from health emergencies, transforming woredas, and improving health system responsiveness.

Health Administration

In 2007, the government established the Ethiopian Pharmaceutical Supply Agency (EPSA) under the Ministry of Health.[2] It has seven clusters and 19 branches throughout Ethiopia.[3] Its main objective is to procure affordable drugs, which are the main drivers of out-of-pocket expenditures for households (45 percent of outpatient spending and 43 percent of inpatient spending).[4] The drugs are procured with donor and MoH funds and are made available to facilities and pharmacies on a commercial basis. During fiscal 2018/19, total procurement was valued at close to USD 500 million (ETB 14.2 billion), with 55 percent coming from domestic sources and 45 percent from health program funds.[5]

In 2010, the government established the Ethiopian Health Insurance Agency (EHIA). Its primary responsibility has been to set up

1 Telila, H.F. 2024. Fiscal Decentralization and Regional Economic Growth in Ethiopia: A Spatial

2 Ministry of Health, Ethiopian Pharmaceuticals Supply Agency website: https://www.moh.gov.et/en/Ethiopian_Pharmaceuticals_Supply_Agency?language_content_entity=en#:~:text=Ethiopian%20Pharmaceutical%20Supply%20Agency%20(EPSA,553%2F2007

3 World Bank. November November 2019. Public Expenditure and Financial Accountability (PEFA) Performance Assessment Report 2019, Performance Assessment Report, Final Report. Washington DC.

4 Federal Democratic Republic of Ethiopia. September 2019. Ethiopia National Health Accounts Report 2016/17. Addis Ababa: Ministry of Health.

5 World Bank 2025, based on 2018/19 procurement data from the Ethiopian Pharmaceutical Supply Agency.

and manage the Community Based Health Insurance (CBHI) program. By June 2020, the CBHI program covered 6.9 million households in 70 percent of all woredas, a third of the total population.[6] CBHI membership is voluntary and is based on household-level enrolment to discourage adverse selection. Members receive an identification card with a photo that provides access to health facilities under contract with their respective CBHI program. The program reimburses facilities directly based on the claims submitted. Nonetheless, the Ethiopian Health Insurance Agency is not yet fully functional.

In 2019, the average annual CBHI member premium per household was USD 6 (300 ETB). The federal government subsidizes 10 percent of the member premiums, and the regional and woreda governments subsidize full member premiums for the poorest people (around 10 percent of the total population). The Treasury funds CBHI running costs, and woredas pool member contributions. Each woreda has a Health Insurance Board to govern their program; the governing board is led by the woreda administrator and includes members from relevant sectors. Each CBHI program holds an annual General Assembly to ensure community ownership and active participation in design and implementation.

As mentioned above, the regional and woreda governments are fiscally responsible for most health service delivery. While the Ministry of Health (MoH) is responsible for developing health policies, coordinating health program implementation and infrastructure expansion, and ensuring essential drugs; it is fiscally responsible for select agencies, including the Public Health Institute, Ethiopian Health Insurance Authority, Ethiopian Pharmaceutical Supply Agency, Research Institute, and Ethiopian Drug and Medicine Control Authority. The Ministry of Finance (MoF) is fiscally responsible for federal hospitals.

Health System

Ethiopia has three levels of health care: (i) primary care provided by health posts, health centers, and primary hospitals that serve up to 100,000 people; (ii) secondary care hospitals that serve 1-1.5 million people; and (iii) tertiary care (referral) hospitals that serve up to 5 million people. Within the three levels, Regional Health Bureaus focus on policy implementation, technical matters and regional priorities and the Woreda Health Office manages and coordinates health service delivery. Across the country, 17,550 health posts offer basic primary services; 3,735 health centers provide primary health services; and 353 hospitals offer various hospital-based care.

The health facilities have four major sources of income: government budgetary allocations, user fees, external resources, and CBHI reimbursements. Facilities prepare and submit a budget request for government resources, which is approved by the facility management and the facility governing board. The requested budget is consolidated at the woreda level within the broader budget envelope and then consolidated at the regional level and sent to the regional council for approval. Woredas are

6 Federal Democratic Republic of Ethiopia. April 2022. Ethiopia National Health Accounts Report 2019/20. Addis Ababa: Ministry of Health.

responsible for consolidating the budgets of the health posts and centers,[7] while regional governments are responsible for consolidating the budgets for hospitals.

Health Financing

Health funds flow through three channels (see Figure 1). Channel 1 funds originate from domestic funding (taxes and other revenues) and budget support from development partners, and they are managed by the MoF. Under Channel 1, the MoF allocates block grants to the region (Channel 1a) or sector earmarked funds (Channel 1b). Channel 1a funds are allocated through the Appropriation Act (the federal budget), while Channel 1b funds are earmarked for specific use in line with federal priorities and transferred to the implementing budget entity. These transactions are recorded in the Integrated Budget and Expenditures (IBEX) system.[8]

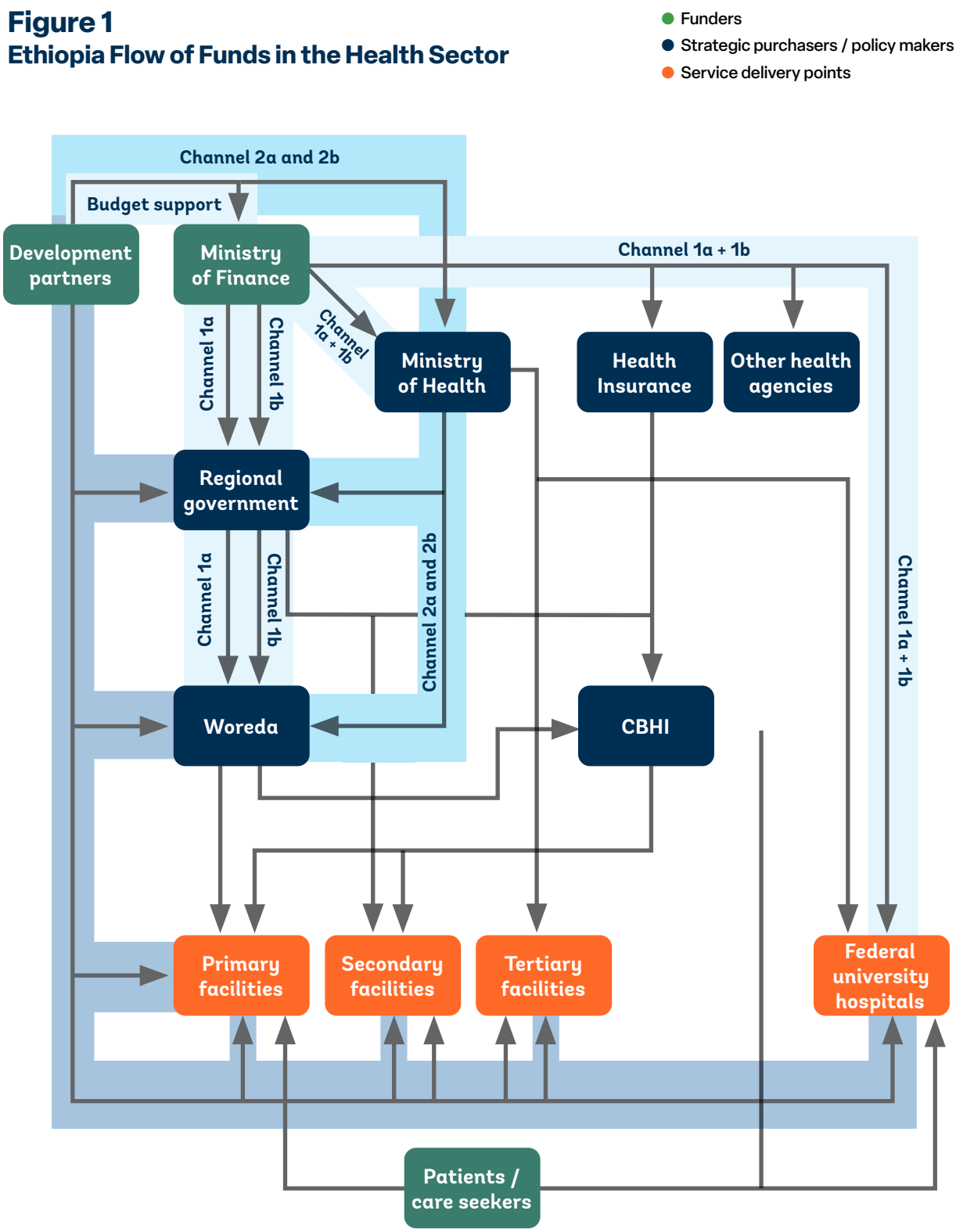
Channel 2 funds originate from development partners and are managed by the MoH. There are two subchannels: general funds (Channel 2a) and earmarked funds (Channel 2b). Channel 2a resources are planned for and executed in program-based budgets and are recorded as external resources under the federal capital budget. Most of these funds pass through the Sustainable Development Goal Performance Fund (SDG Fund), a pooled funding mechanism. The SDG Fund operates under a Joint Financing Agreement signed with 11 development partners in 2020; spending priorities are agreed every year at a Joint Consultative Forum between the MoH and development partners. SDG Funds cannot be used to pay salaries. Most of the Channel 2a funds are executed at the federal level, with goods and services transferred in-kind and in-cash to regional and woreda governments. These regional and woreda governments are required to adhere to the public financial management requirements outlined in the Financial Management Manual and to achieve the results in the performance contracts. These transactions are recorded in the (new) Integrated Financial Management Information System (iFMIS). Channel 2b resources are partially planned for and executed in program-based budgets and are recorded as external resources under the federal capital budget. Mostly of these funds pass through vertical programs (such as, Gavi or UN agencies). These transactions are recorded in the IFMIS.

Channel 3 funds are transferred directly from development partners to nongovernmental implementing partners. Channel 3 funds are not recorded in the federal capital budget but are tracked in an annual resource mapping exercise (which occurs outside of the government's systems) as part of the Health Sector Strategic Plan. Further, the mapping exercise tracks estimated expenditure (not actual expenditure) because of different government and development partner fiscal year-ends.

7 The woreda Finance and Economic Development Office is responsible for overseeing and strengthening the public financial management practices at the facility level.

8 In Ethiopia, there are two management information systems: Integrated Financial Management Information System (iFMIS) and Integrated Budget and Expenditure System (IBEX), both running concurrently. As of 2019, most users were still using IBEX, while iFMIS was gradually being introduced. IBEX is used for budget planning, execution, and reporting at both the federal and lower levels, whereas iFMIS is currently only used at the federal level. A notable feature of iFMIS is its integration of personnel and payroll records, an improvement over IBEX which does not have this capability.

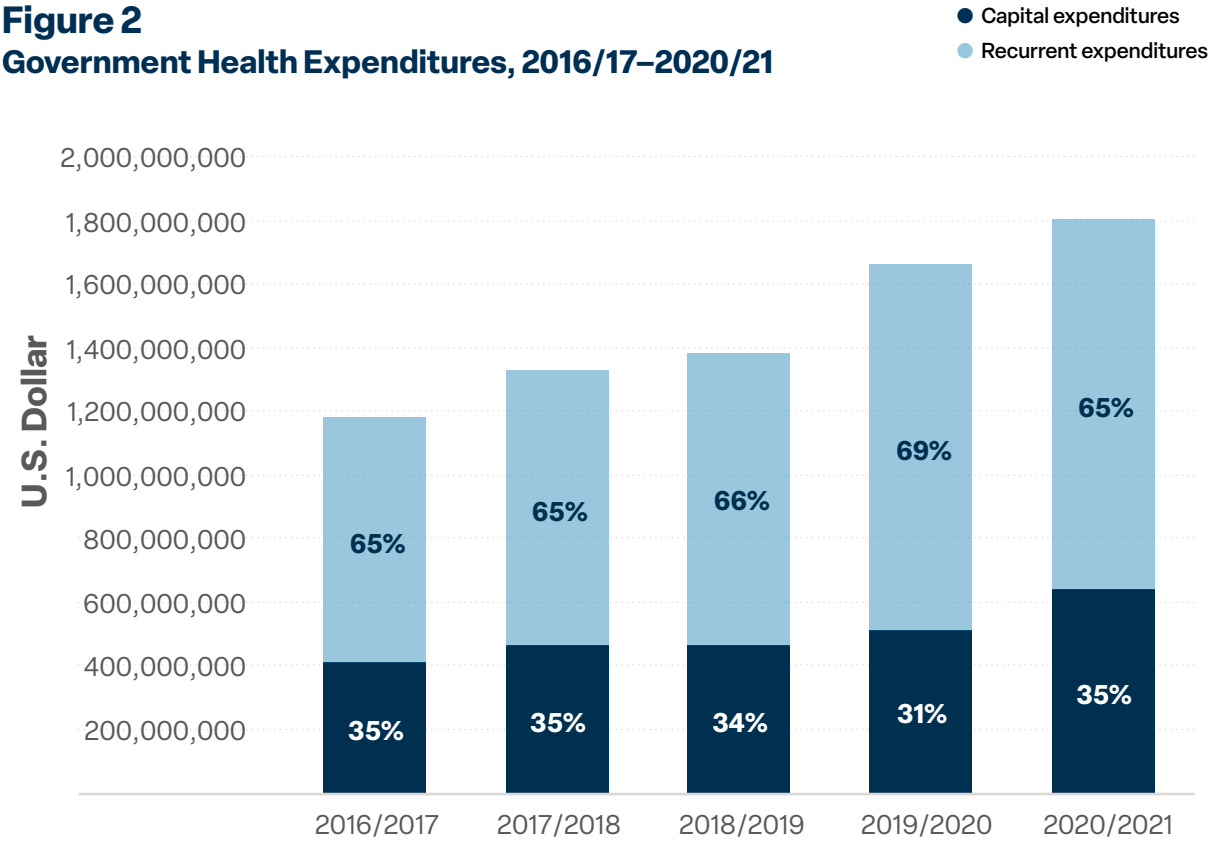
Figure 1
Ethiopia Flow of Funds in the Health Sector



Source: World Bank 2025, based on World Bank. November 2019. Public Expenditure and Financial Accountability (PEFA) Performance Assessment Report 2019, Performance Assessment Report, Final Report. Washington DC.

In 2019/20, Ethiopia's total health expenditure was reported at USD 3.62 billion (ETB 127 billion), or 6.3 percent of the total gross domestic product.[9] In real terms, government health spending increased by 52 percent from USD 1.1 billion (ETB 25.7 billion) in 2016/17 to USD 1.8 billion (ETB 62.9 billion) in 2020/21 (Figure 2). Two-thirds of this was executed on recurrent costs and one-third on capital costs.[10] As a share of total government expenditure, the health sector budget increased to 9.4 percent in 2020/21, below the Abuja target of 15 percent but higher than the average for low-income countries of 6.2 percent. The increase was driven significantly by external on-budget support.

Figure 2
Government Health Expenditures, 2016/17–2020/21



Source: World Bank 2025, based on National Bank of Ethiopia Quarterly Bulletins 2016/17–2020/21.

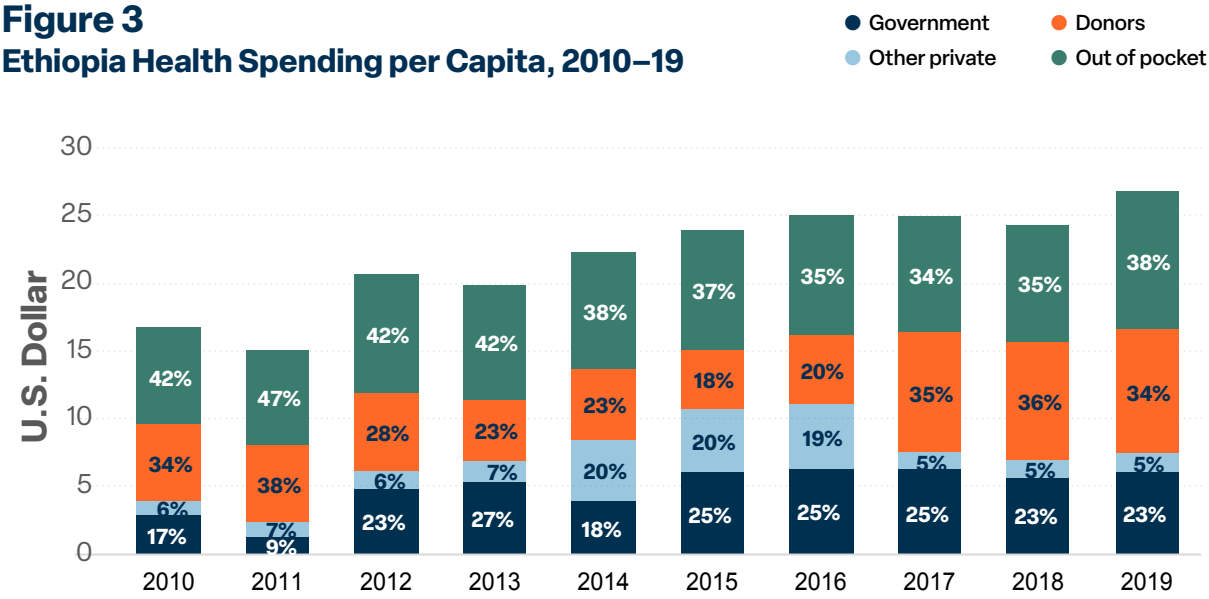
9 Federal Democratic Republic of Ethiopia. April 2022. Ethiopia National Health Accounts Report 2019/20. Addis Ababa: Ministry of Health.

10 World Bank 2025, Based on National Bank of Ethiopia Quarterly Bulletins 2016/17–2020/21.

Channel 1 and 2 disbursements averaged approximately USD 550 million (ETB 15.6 billion) per year 2011/12–2018/19, of which approximately USD 150 million (ETB 4.3 billion) was derived from the SDG Fund.[11] Channel 3 disbursements averaged USD 290 million (ETB 8.2 billion) per year during this period.[12] Overall, based on the NHA 2019/20 data, the MoF spent 35 percent of total government health funding, with the regions and woredas spending 65 percent. Other health agencies accounted for only 0.1 percent of spending. Channel 2 sources, in part driven by the SDG Fund, made up 64 percent of total external resources given to the health sector in the six years between 2012 and 2018, while the remaining 36 percent were channelled off-budget (Channel 3). The external resources executed outside of the government's budget were substantial, with just under USD 300 million (ETB 8.5 billion) a year spent directly by development partners on service providers and purchasers.

Over the last 10 years, out-of-pocket expenditures contributed around half the total health expenditure, with donors contributing around a third and government around a fourth (Figure 3)**.** Total health spending was USD 26 (ETB 582) per capita, significantly below the Sub-Saharan average of USD 79 per capita (ETB 1,770).[13] Between 2015 and 2019, total out-of-pocket expenditures were relatively consistent, while government per capita spending stagnated.

Figure 3
Ethiopia Health Spending per Capita, 2010–19



Source: World Health Organization Global Health Expenditure Database

11 Channel 1 figures are based on: World Bank BOOST Open Budget Portal Database and National Bank of Ethiopia Quarterly Bulletins 2016/17–2020/21.

12 Channel 3 figures are based on: World Bank. November November 2019. Public Expenditure and Financial Accountability (PEFA) Performance Assessment Report 2019, Performance Assessment Report, Final Report. Washington DC.

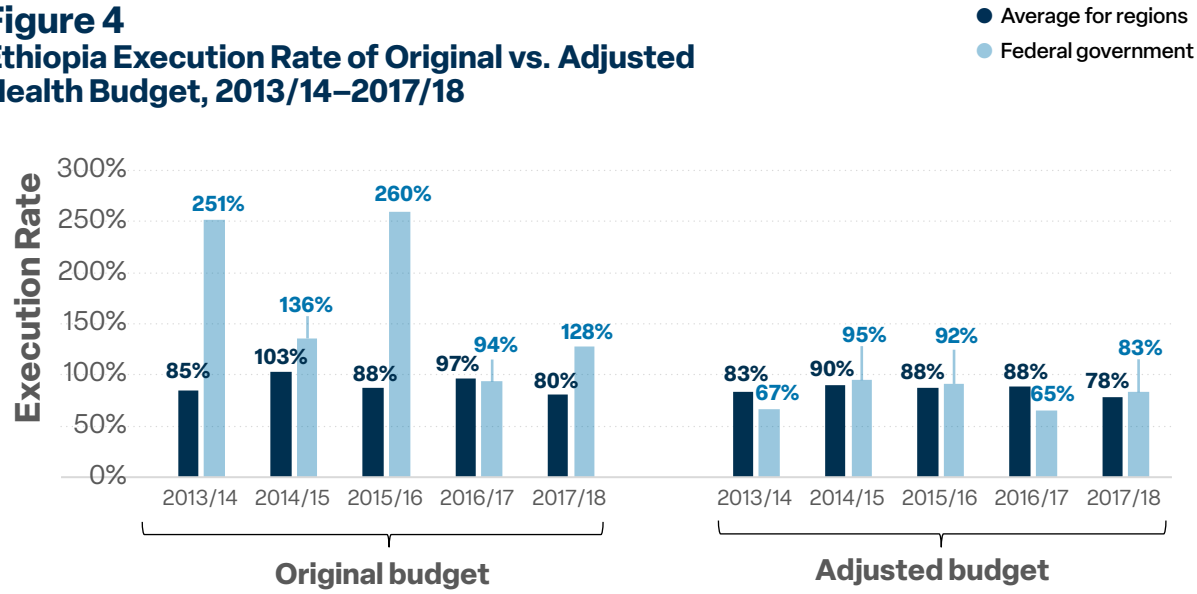
13 World Health Organization Global Health Expenditure Database.

2.0 BUDGET EXECUTION IN HEALTH

Ethiopia typically uses a mid-year supplementary budget which makes significant adjustments to health expenditure.14 Between fiscal 2013/14 and 2017/18, the federal government overspent the original health budget allocation.

However, the execution rates for the adjusted budget dropped below 100 percent (Figure 4). The adjusted allocations increased at the regional level although to a lesser extent than at the federal level.[15]

Figure 4
Ethiopia Execution Rate of Original vs. Adjusted Health Budget, 2013/14–2017/18



Source: World Bank 2025, based on World Bank BOOST Open Budget Database.
Note: Channel 1 and 2 only.

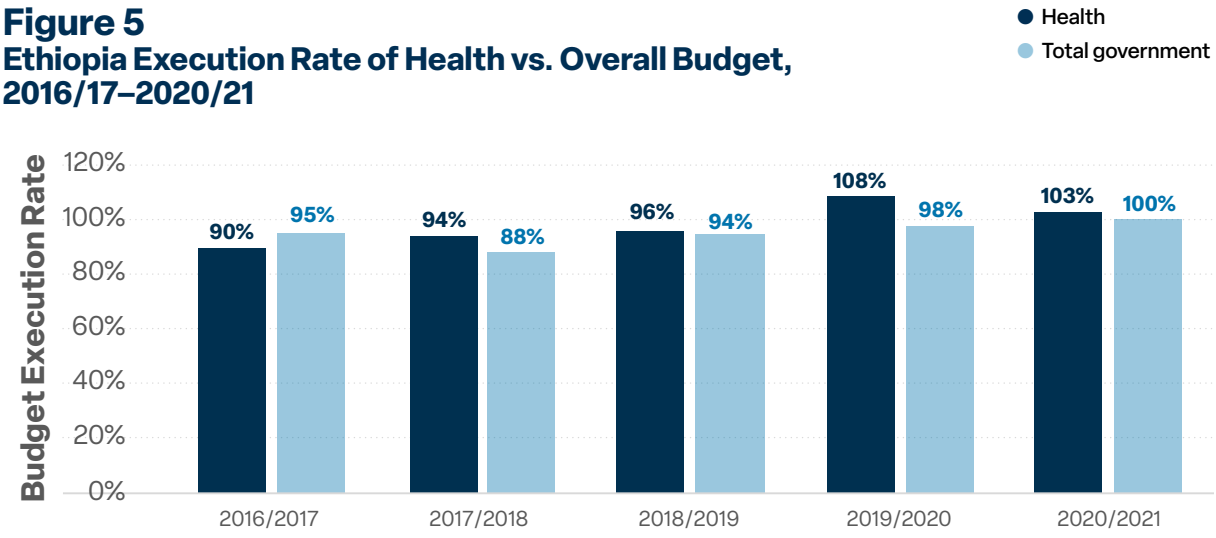
The execution rate of the health budget (Channels 1 and 2) was higher than the execution rate of the general budget between fiscal 2016/17 and 2020/21 (Figure 5)[15]**.** In this period, the adjusted health budget averaged a 98 percent execution rate.

In fiscal 2019/20 and 2020/21, the health budget execution rate eclipsed 100 percent, which reflected the relative priority given to health expenditures compared to other government expenditures during the Covid-19 pandemic.

14 The Ethiopian fiscal year runs from July 8 to July 7.

15 Primary data were obtained from the National Bank of Ethiopia through its quarterly bulletins for health budget and overall government budget execution, including breakdowns for capital and recurrent budgets. This covers 2016/17–2020/21. For breakdowns into different levels of government or different channels of spending, the World Bank BOOST Open Budget Database was used, which includes execution data until 2017/18.

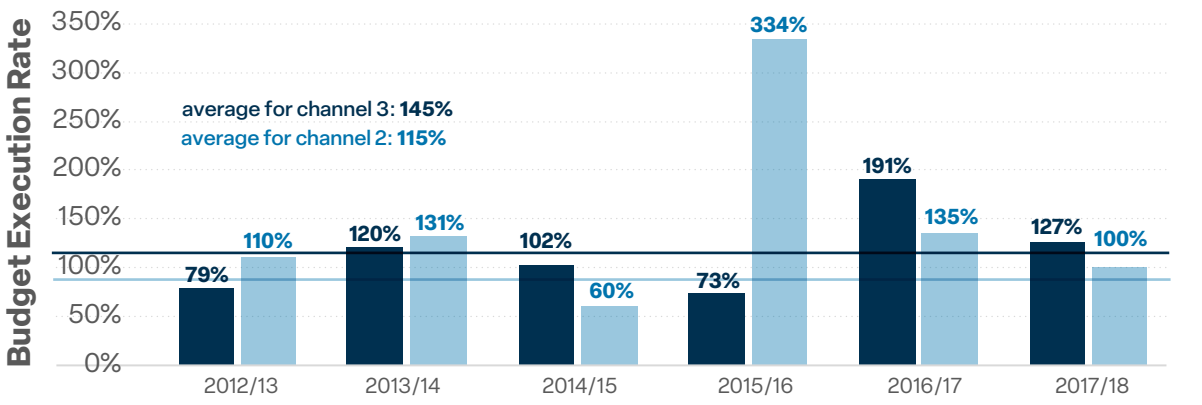
Figure 5
Ethiopia Execution Rate of Health vs. Overall Budget, 2016/17–2020/21



Source: National Bank of Ethiopia, Quarterly Bulletins 2016/17–2020/21. Addis Ababa.

The execution rate varied across Channels 2 and 3 between fiscal 2012/13 and 2017/18 (Figure 6).[16] Channel 2 had execution rates ranging from 73 percent to 191 percent, with an average of 115 percent. Channel 3 had execution rates between 60 percent and 334 percent, with an average of 145 percent. Both channels have limited budget credibility, as expenditure rates are volatile. The Health Sector Transformation Plan II 2020/21–2024/25 continues to estimate similarly high levels of total external resources (USD 1.06 billion (ETB 41.87 billion) a year for all three channels).

Figure 6
Ethiopia Budget Execution Rate by Channel, 2012/13–2017/18

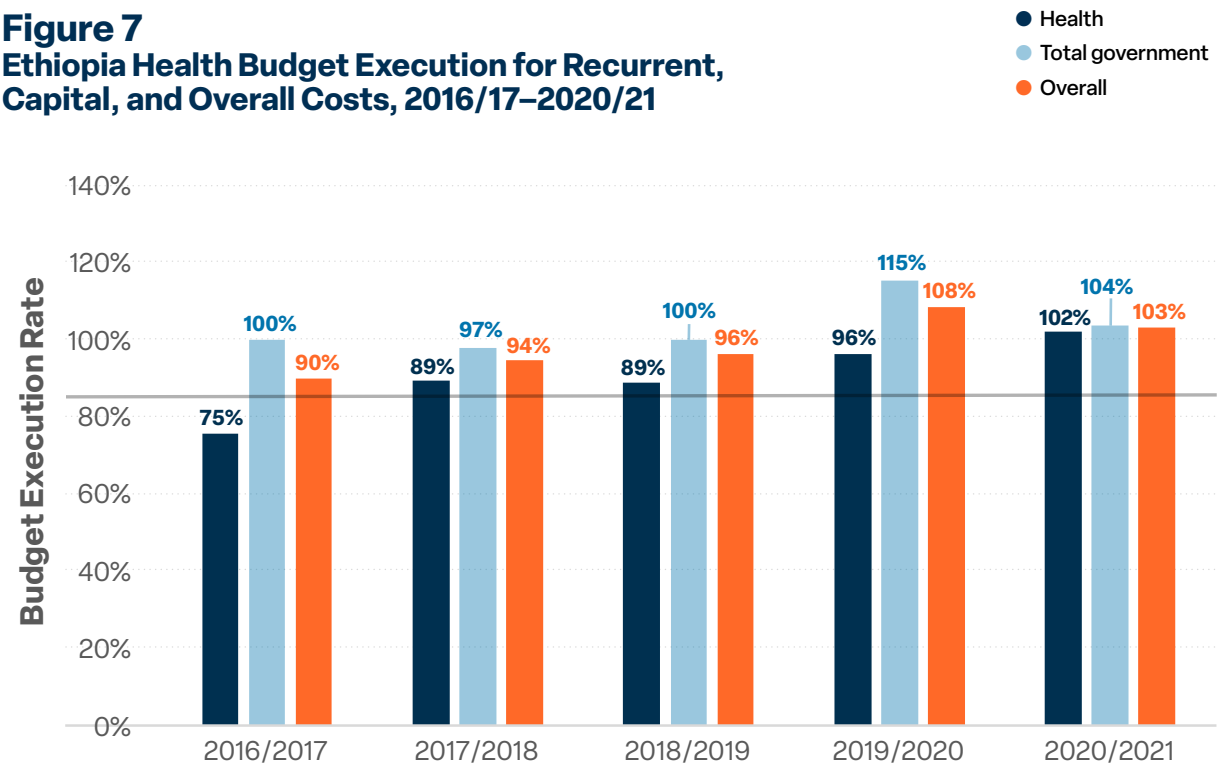


Source: National Bank of Ethiopia, Quarterly Bulletins 2016/17–2020/21. Addis Ababa.

16 Budget execution data on Channel 1 was not available.

The execution rate of the adjusted capital budget and adjusted recurrent budget was 90 and 103 percent, respectively, between 2016/17 and 2020/21 (Figure 7). These rates were slightly above the general adjusted average: on average, the execution rate of the adjusted health budget was 98 percent and the execution rate of the overall budget was 95 percent. In 2020/21, the capital budget was marginally over-executed. This probably related to the additional procurement for the Covid-19 pandemic. The federal government set up a Covid-19 task force, which included a subgroup responsible for resource mobilization and allocation. Around 91 percent of the total Covid-19 resources were managed by the federal government, with development partners managing around 9 percent.[17] This is despite the government only financing around 50 percent of the expenditure itself.[18] Public financial management rules were followed, though the MoH had greater allocation flexibility. The funds were allocated under a single cost center (Covid-19 response), which also covered procurement costs.

Figure 7
Ethiopia Health Budget Execution for Recurrent, Capital, and Overall Costs, 2016/17–2020/21



Source: World Bank 2025, based on National Bank of Ethiopia Quarterly Bulletins 2016/17–2020/21. Addis Ababa.
Note: Channel 1 and 2 only.

17 Federal Democratic Republic of Ethiopia. April 2022. Ethiopia National Health Accounts Report 2019/20. Addis Ababa: Ministry of Health.

18 Ibid.

Most facilities are not linked to the iFMIS, limiting data collection and accessibility. Table 1 shows a high average execution rate at health posts/centers and hospitals for the three funding sources, based on available data.

Table 1: Ethiopia Average Facility Budget Execution Rate, 2017/18–2019/20

	Treasury	Internal Revenue	Donor/External Resources
	Average of Fiscal 2017/18–2019/20		
Health Post and Center	93%	98%	100%
Hospital	95%	97%	89%

Source: Case study protocol information provided by the Ministry of Finance.

3.0 PUBLIC FINANCIAL MANAGEMENT CONTROLS FOR HEALTH SPENDING

Ethiopia has public financial management controls in place to ensure health care funds reach their intended beneficiaries. All receipts and payments flow through a Single Treasury Account with a few exceptions (mainly donor projects). Payroll and procurement are decentralized to the budget holders.

For payroll expenditures, a monthly list detailing payees and attendance is submitted to the Woreda Finance Office. Salaries are paid to the personnel accounts between the 25th and 30th of each month. Changes in personnel or payroll records are updated within 2 days for facilities linked to the iFMIS or within 4 weeks for facilities not linked to the iFMIS.[19] Only 0.7 percent of personnel changes were retroactive adjustments in the MoH,[20] indicating that payroll management is largely up to date. There were no significant issues with ghost workers recounted in the internal audit reports.

The Ethiopian Pharmaceutical Supply Agency procures most drugs and medical commodities. A 2018 situational analysis uncovered significant financial management challenges. Among the challenges, three stand out: first, the financial management system did not break down costs into specific line items, instead grouping costs into a limited number of cost centers; second, financial reports were not produced; and third, the procurement process was slow: (i) on average, taking a year to complete; requiring (time-consuming) internal and external approvals from the Ethiopian Food and Drug Administration; basing the winning bid solely on price (even after it passed through the initial approval and registration process). In 2018, the procurement process was manual; in 2020, the agency distributed drugs and medical commodities valued at almost USD 1 billion (ETB 34 billion.[21]

Across the three levels of health care, procurement, oversight, and compliance are opaque. Under public procurement law, hospital service providers can procure supplies, rental services, equipment maintenance, and generator services based on framework agreements. They submit annual budgets to the respective supervisory ministry (the MoH at the secondary level and MoF at the tertiary level). Generally, procurement bids are published in public newspapers and finance

19 According to the latest Public Expenditure and Financial Accountability data (2019), 67 public agencies use the iFMIS, while 145 public agencies use the IBEX.

20 World Bank. November November 2019. Public Expenditure and Financial Accountability (PEFA) Performance Assessment Report 2019, Performance Assessment Report, Final Report. Washington DC.

21 Federal Democratic Republic of Ethiopia. September 2018. Revised Pharmaceutical Supply Transformation Plan 2018–2020. Addis Ababa: Ethiopian Pharmaceutical Supplies Agency.

officers retain the bid evaluation outcomes on file.[22] However, the supervising ministry does not monitor the framework agreements and the procurement methods are not published in a public register.

Health facilities lack a uniform system to plan and monitor their spending and a connection to the Integrated Financial Management Information System (iFMIS) or the Integrated Budget and Expenditures (IBEX) system. The isolation of the health system makes it impossible to consolidate financial reports, such as comparing funds transferred to facilities with their actual expenditures. Guidelines for general financial management and the procurement processes seem to generally be available, according to a small sample of health facilities surveyed,[23] and nearly all facilities followed the guidelines. In comparison, ministries agencies, and departments use the iFMIS and IBEX to plan and monitor their spending.

The SDG Fund requires procurement over USD 25 million (ETB 575 million) to be submitted for "no objection" to the fund contributors. (A split into smaller amounts is not allowed.) This is an extra measure of accountability for high-value procurement but can also slow execution. Contributors are required to reply to the request within six weeks; thereafter, the MoH can proceed with the procurement.

In 2017, the U.K. Department for International Development reviewed and highlighted weaknesses in the management of public investment projects. Since then, a new public investment framework has been developed to strengthen project appraisal, selection, costing, and monitoring. It is now mandatory to include an economic analysis for a project to be approved in the capital budget.[24] This reform was ongoing at the end of 2019, and an assessment of the efficacy and implementation of this new framework for public investment is not yet available. For smaller capital expenditures, the control measures as described under non-salary expenditures apply.

There is no limit on the number of in-year budget reallocations.[25] This is beneficial for budget flexibility but can reduce the incentive to plan and budget. The MoF solely approves all reallocations, and the approval process can be tedious. The MoF can also delegate this power to other public bodies.

As mentioned above, CBHI member premiums are offset by federal and regional/ woreda subsidies.[26] These subsidies are usually paid based on bank statements submitted to the district CBHI scheme, showing the total amount and number of premiums collected for each CBHI. However, controls for premium collection are lacking. The Health Insurance

22 World Bank. November November 2019. Public Expenditure and Financial Accountability (PEFA) Performance Assessment Report 2019, Performance Assessment Report, Final Report. Washington DC.

23 World Bank. 2020. Assessment of Financial Management at the Health Facility Level, unpublished report.

24 World Bank. November November 2019. Public Expenditure and Financial Accountability (PEFA) Performance Assessment Report 2019, Performance Assessment Report, Final Report. Washington DC.

25 Under Ethiopian law, Financial Administration Proclamation No 648/2009 does not allow for transfers from the capital budget to the recurrent budget.

26 Federal Democratic Republic of Ethiopia. July 2020. Health Insurance Strategic Plan 2020/21–2024/25. Addis Ababa: Ethiopian Health Insurance Agency.

Agency instituted a 2 percent incentive for collectors to increase their motivation and improve the efficiency in collecting contributions. In practice, the incentive has not been uniformly applied across CBHI programs and there is no evidence yet of its effectiveness. Premiums paid are still not deposited promptly in the bank, and cash collection vouchers are not returned on time. There is also no verification of the amount collected and deposited. Where audits have revealed default or potential fraud, woredas have failed to take legal measures against collectors.[27] Recently, more regional and woreda finance offices have been integrated into the financial audit process and, as a result, the CBHI program audited increased from 38 percent in 2017/18 to 69 percent in 2019/20. Nonetheless, implementation is irregular, and the Ethiopian Health Insurance Service strategy mentions the low quality of audits.

CBHI programs mobilized ETB 3.2 billion (more than USD 105 million) and reimbursed ETB 2.12 billion (more than USD 70 million) to health facilities for services provided to beneficiaries between 2015/16 and 2018/19.[28] Despite the overall positive balance, some CBHI programs were in deficit. The process for facility reimbursement also changed in 2021. Prior to 2021, the CBHI program reimbursed 75 percent of the claimed costs, and the remaining 25 percent after clinical audits showed that the quality and administrative processes of the health facilities to be adequate. However, the budgeting for clinical audits was not adequate, resulting in irregular audits. The Ethiopian Health Insurance Service changed the rules in 2020: CBHI programs now reimburse 100 percent of the claimed costs and woredas conduct risk-based audits of the facilities.

Across the government, arrears are limited at fiscal year-end, and payment discipline is high with cash shortages being the primary challenge.[29] There were examples of tertiary hospitals that incurred arrears due to unpaid capital projects. Yet, those arrears represented less than 1 percent of actual annual expenditures for the fiscal year and resulted from the MoF having a cash shortage and not being able to approve payment. There were also incidences of hospitals owing cash to the Ethiopian Pharmaceutical Supply Agency for medical equipment and drugs where the stock of arrears is more than 12 months old.

Facilities maintain a cash register, a file for invoices and receipts of expenditures, a fixed asset register, and bank statements to execute their budget. A facility's governing board is charged with internal controls, although audit reports have highlighted that concrete controls are lacking.[30] One of the main challenges is that the facilities are not connected to the financial management system of higher administrative units. Unused government budget funds must be returned at the end of the fiscal year, while user fees, CBHI reimbursements, and other income (such as, in-kind contributions from donors through

27 World Bank. June 2021. Political Economy and Financial Sustainability of Social Health Insurance in Ethiopia. Washington DC.

28 Federal Democratic Republic of Ethiopia. July 2020. Health Insurance Strategic Plan 2020/21–2024/25. Addis Ababa: Ethiopian Health Insurance Agency.

29 World Bank. November November 2019. Public Expenditure and Financial Accountability (PEFA) Performance Assessment Report 2019, Performance Assessment Report, Final Report. Washington DC.

30 World Bank. June 2020. Assessment of Financial Management at the Health Facility Level, unpublished. 2020.

Channel 3) can be retained at the facility across fiscal years. If facility audits show (deliberate or indeliberate) fund mismanagement, the staff in charge can face consequences and penalties, ranging from fund repayment from personal assets to demotion, career non-progression, or criminal pursuit. An indirect consequence is that fear of punishment can hinder budget owners to implement the budgets, lowering execution rates.

4.0 GOOD PRACTICES AND BOTTLENECKS

The good practices and bottlenecks outlined in Table 2 should be analyzed in relation to their impact on budget execution—both in terms of improving expenditure efficiency and contributing to poor execution rates. When interpreting these factors, it is essential to consider how certain practices enhance budget execution, such as strengthening planning and financial management systems, timely requisition submissions, and improved reporting mechanisms. Conversely, bottlenecks such as limited transparency on execution, procurement inefficiencies, and capacity constraints within the health system can lead to low execution rates, preventing timely implementation of planned activities.

Table 2: Summary of Budget Execution Good Practices and Bottlenecks in Ethiopia

Issue	Explanation
Good Practices	
Relatively low levels of arrears.	The overall payment discipline of the government is high, with few arrears reported at the end of the fiscal year. The grace pe-riod of one month at the end of the fiscal year, and the regular reporting on arrears from various budget entities, has helped achieve this low level. These practices should be maintained and further strengthened to address the few examples of hospitals that committed to capital projects but have not fully paid given late-arriving transfers from the federal level due to cash flow constraints.

...table continued next page

Table 2: Summary of Budget Execution Good Practices and Bottlenecks in Ethiopia

Issue	Explanation
Reasonable turnaround times for payroll changes and high accuracy of pay-roll expenditures.	Payroll changes are responded to within days if the unit is linked to the iFMIS but delays more if the unit is not linked to the iFMIS. As a result, the payroll is largely accurate and up to date, which avoids ineligible expenditures.
Budgeting timelines are adhered to, and budgets are communicated in time across the government.	The budget calendar is adhered to and budgets for upcoming fiscal years, including details of transfers to region and woreda levels, are timely communicated to regions and woredas. This adherence helps the regions and woredas with their planning and commitment processes.
Payment delays have improved.	Payment delays from the federal level to the regions and woredas have shortened. However, further opportunity to reduce the delays all together, by improving cash management, would allow the regional and woreda governments more time to implement their budgets and increase their execution rates.
Bottlenecks	
Limited transparency on execution data.	Budget execution data are not publicly available, making accountability more difficult and decreasing transparency. Health stakeholders are involved in the annual planning session but have limited insights into budget execution progress.
Not all transactions recorded in iFMIS/IBEX.	Approximately 20 percent of woreda expenditures are not classi-fied in the IBEX.[33] Further, programs and subprograms are not codified in the IBEX at the woreda level. Seven standardized uniform codes are used across all levels of government. However, program-and subprogram-specific codes remain discretionary, making it difficult to track expenditures across priority needs.

...table continued next page

Table 2: Summary of Budget Execution Good Practices and Bottlenecks in Ethiopia

Issue	Explanation
Capacity constraints at the facility and woreda levels for overall financial man-agement, with a specific focus on a) adequate budgeting and b) pro-curement regulations.	Facilities and woredas tend to over-budget due to anticipated funding cuts that then may not materialize, which in turn leads to under-execution of budgets. In this case, the facilities have unplanned resources that are available without the necessary capacities to implement the budget in full. Capital budgets are more under-executed than recurrent budgets, partly due to ca-pacity and knowledge constraints about procurement rules and regulations. Recent reforms to public investment management are targeting improvements in the efficiency and efficacy of capi-tal expenditures, including the rates of budget execution.
External resources not captured in the government's financial management systems.	Channel 3 resources are tracked in the annual resource map-ping exercises, which occurs outside of the gov-ernment's systems. The information is a mix of actual spending and commit-ments, depending on the timing of the exercise and alignment of donor fiscal years with the government's fiscal year. The in-formation is also not shareable for the wider public, which undermines trans-parency and accountability.
Limited flexibility of spending at the health facility level.	Health facility levels have different rules and regulations at-tached to each funding source (fees collected, Trea-sury funds received, in-kind support, CBHI reimburse-ments). Giving greater flexibility in the use of the funds (within limits) could increase the availability of essential medicines and other recurrent commodi-ties.
Procured products are assessed solely based on the lowest price.	There may be a tendency toward lower quality products (shelf life, storage conditions, among other). Adjusting the procure-ment guidelines to include assessment crite-ria beyond pricing could increase the quality of products and overall efficiency gains.

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BUDGET EXECUTION IN HEALTH: FROM BOTTLENECKS TO SOLUTIONS

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BUDGET EXECUTION IN HEALTH: FROM BOTTLENECKS TO SOLUTIONS

CASE STUDY SERIES

LAO PDR

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ABSTRACT:

The Lao People's Democratic Republic has a high execution rate for its overall health budget, ranging from 89 to 104 percent from 2015 to 2019. Aggregated execution rates are generally high across the main categories of spending – wage, non-wage recurrent and capital – with only a couple of outliers during the period of analysis. Some of the public financial management practices employed that enable these high execution rates may, nonetheless, risk lowering the quality of spending. There is also greater variation in execution rates when considering more disaggregated levels of budget spending, including between the central and provincial level of government. Good practices that have helped budget execution include the ringfencing of spending on health and flexibility in budget laws enabling high execution of capital budgets. Key bottlenecks holding back budget execution performance include the lack of a mechanism linking spending to the delivery of outputs; weaknesses in how budget allocations are set for health worker payments; delays in payments reaching health facilities; a lack of transparency in disaggregated spending data, no publication of audits and no reporting on the stock of arrears; inefficiencies in the availability of resources for health facilities; and the widespread use of manual reporting which delays reporting processes and is prone to errors and inconsistencies.

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Budget execution in health: from bottlenecks to solutions

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This interactive document has been optimised for use on computers and tablets in portrait orientation.

Click on this square to return to the contents page

SECTION NAME

Click on this section to return to the beginning of the section

LAO PDR **CONTENTS**

LIST OF FIGURES

LIST OF TABLES

ACKNOWLEDGMENTS

This study is part of a broader analytical collaboration between the World Health Organization (WHO) and the World Bank to address budget execution problems in the health sector. The study's findings feed into a synthesis report, which is released concurrently: Budget Execution in Health: From Bottlenecks to Solutions.

This study was authored by the Lao PDR World Bank team including Grant Beveridge (Lead Consultant), Soulaxay Bounthideth (Health Financing Consultant), Emiko Masaki (Senior Health Economist, World Bank), and Chanhsy Samavong (Public Financial Management Consultant). It follows a case study protocol developed by Hélène Barroy (Senior Health Finance Specialist, WHO), Moritz Piatti-Fünfkirchen (Senior Economist, World Bank), and Amna Silim (Senior Consultant). Quality assurance was provided by Hamish Colquhoun (Senior Consultant) and Moritz Piatti-Fünfkirchen (Senior Economist). Technical editing and communication support was provided by Zac Mills (Senior Consultant), Hamish Colquhoun (Senior Consultant), and Alexandra Michele Beith (Senior Consultant). The study benefitted from management oversight by Agnès Couffinhal (Global Program Lead for Health Financing) and Monique Vledder (Practice Manager, HNP). It was made possible through generous financial support from the Global Financing Facility (GFF).

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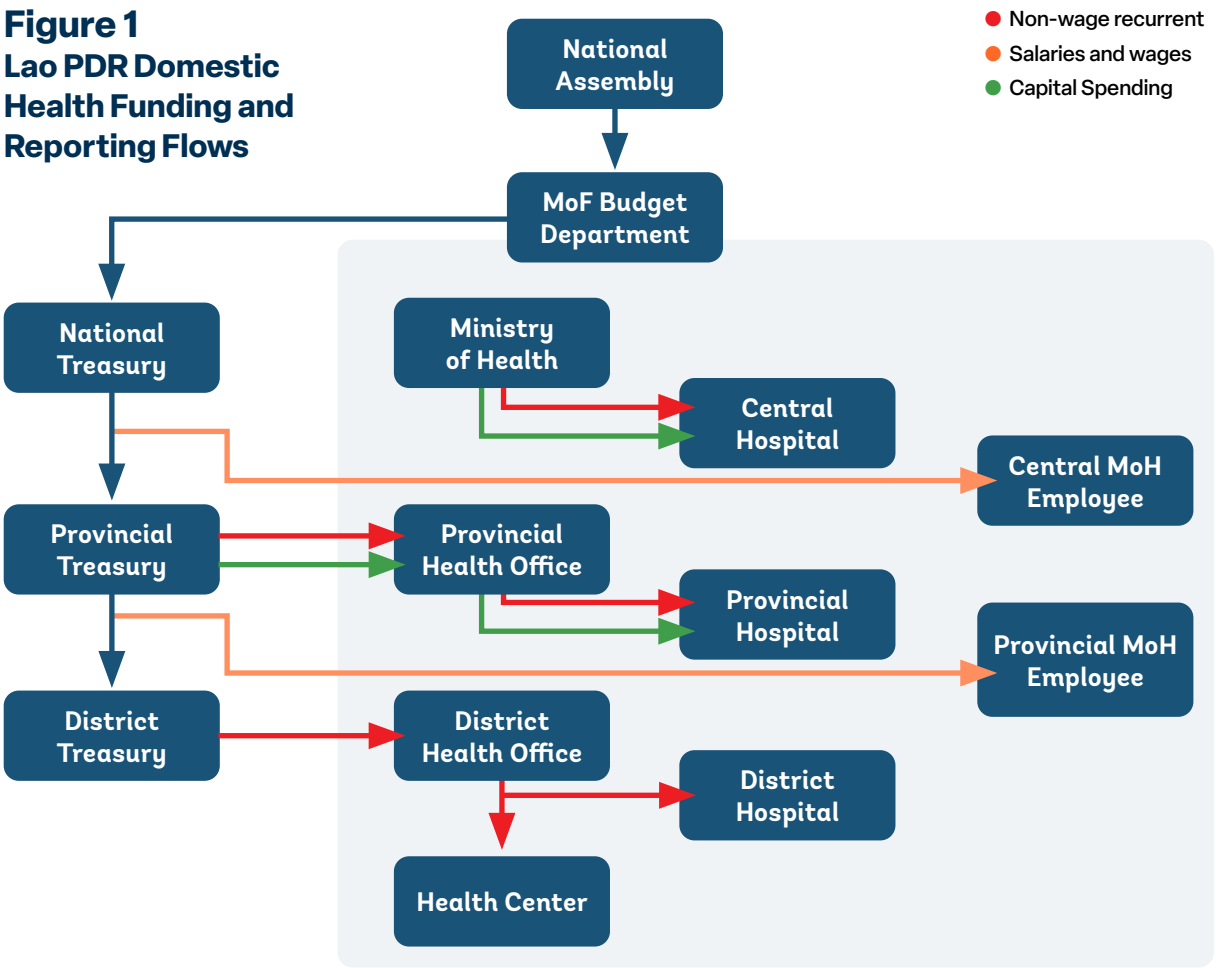
1.0 HEALTH FINANCING CONTEXT

In the Lao People's Democratic Republic (Lao PDR), the Ministry of Health (MOH) consists of central and line ministries. There are 12 departments at the central level, 10 divisions at the provincial level, and 10 units at the district level.1 The annual Budget Law, once approved, allows the National Treasury to release cash to the MOH and to the National Treasury at the provincial level (see Figure 1). Following the approval of the provincial budget, the provincial and district finance offices assign revenue and expenditure plans for departments and units.

Figure 1
Lao PDR Domestic Health Funding and Reporting Flows

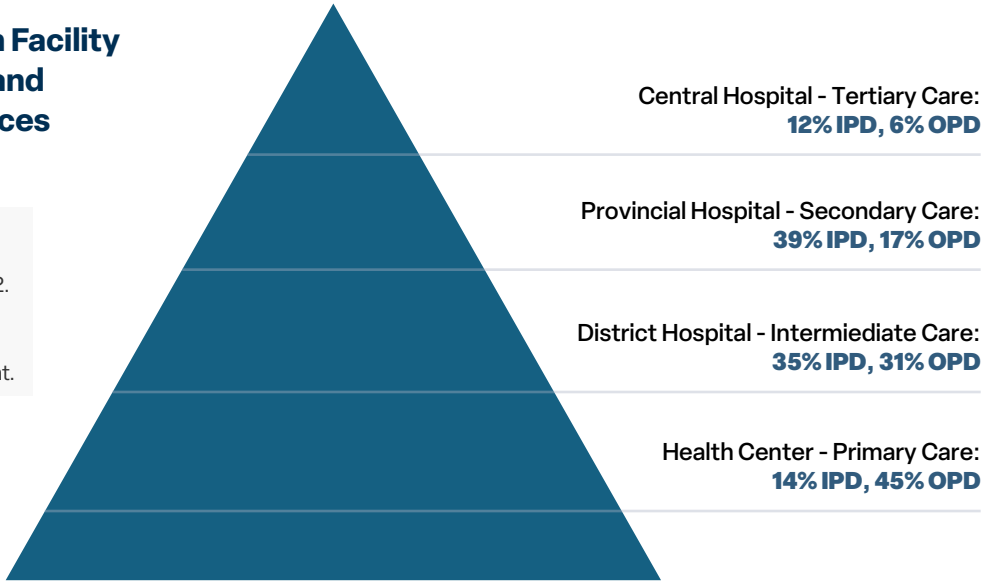


Source: World Bank 2025.

1 A minor restructuring of the Ministry of Health administration is underway, with recent approval to merge the Department of Finance with the Department of Planning and International Cooperation to become the Department of Planning and Finance. The Department of Health Personnel will also merge with the Department of Health Professional and Education or Department of Training and Research.

Lao PDR has four levels of public health facilities: health centers (sometimes referred to as small hospitals); district or community hospitals; provincial hospitals; and central hospitals located in the capital Vientiane. Figure 2 provides an overview of inpatient and outpatient utilization at the public health facilities.

Figure 2
Lao PDR Health Facility Classification and Available Services



Source: Lao PDR National Health Statistics Report, 2022.

Note: IPD- Inpatient Department; OPD- Outpatient Department.

- **Health Centers** are administered by district health offices and provide primary health care interventions, including examination, diagnosis, treatment, rehabilitation, hygiene promotion, disease prevention, and vaccination. There are two types of health centers: Type A are more than an hour away from the nearest hospital, cover a population of more than 7,000 people, and have at least five in-patient beds. Type B are less than an hour from the nearest hospital, cover a population of up to 7,000 people, and have no more than five in-patient beds. The Lao PDR has a total of 1,061 health centers.[2]

- **District, or community, hospitals** also are administered by district health offices. These hospitals receive referrals from health centers and offer intermediate care, including diagnostic services, treatment, and rehabilitative services. These hospitals are also subdivided into Type A hospitals, which can perform minor surgeries such as caesarean section deliveries, and Type B hospitals, which cannot perform surgeries. The Lao PDR has a total of 135 district hospitals.

2 Lao PDR, Ministry of Health. 2019. National Health Statistics Report 2019. Vientiane: Department of Planning and Cooperation, pp.5-16.

- **Provincial hospitals** are administered by a hospital director with supervision by the provincial health offices. Provincial hospitals offer a higher level of care than district hospitals and deliver research and capacity-building services. Each province has one provincial hospital for a total of 17 in the country; the capital, Vientiane, does not have a provincial hospital.
- **Central hospitals** include three general hospitals, two specialized hospitals, and three centers for ophthalmology, dermatology, and rehabilitation.[3]

Table 1: Lao PDR Budget by Type of Health Facility

Health Unit	Value	Health sector factors
	(Million kip)	(%)
Central Hospitals	312,342	11.2%
Provincial Hospitals	696,518	25.1%
District Hospitals	470,151	16.9%
Specialized Hospitals	18,271	0.7%
Health Centers	257,662	9.3%
Preventive Care Providers	405	0.0%
Government Health Administration Agencies	1,023,064	36.8%
Other Residential Long-Term Care Facilities	949	0.0%
Public Sector	**2,779,365**	**100%**

Source: Lao PDR National Health Accounts Report (2020 and 2021).

3 Lao PDR Health and Social Services, Ministry of Health presentation to Services Trade Forum, 27-28 November 2019.

The Health Sector Reform Strategy 2021–2023 aims to increase and sustain the level of domestic government financing for health to ensure the enhanced ability to eventually deliver universal health care coverage by:

- Improving the efficiency of existing health resource utilization; and
- Prioritizing additional government health expenditures on:
  - Improving the quality and enhancing the delivery of a core basic package of primary health care services focused on maternal, neonatal and child health (MNCH), nutrition, and 'Healthy Villages' [including water and sanitation and community engagement through district health services strategically managed by the Provincial Health Offices (PHOs)];
  - Scaling up free MNCH with an initial focus on rural and remote communities particularly in poor districts; and
  - Scaling up Health Equity Funds for the poor nationwide.

The management of both revenues and expenditure is heavily decentralized in the Lao PDR. In the fiscal 2020 State Budget, the provinces were responsible for 27 percent of expenditure, rising to 34 percent if foreign capital spending is excluded. Conversely, the provinces were estimated to raise 20 percent of total government revenues. Provincial governments rely on central government transfers to fund operations because their spending is higher than their revenues. The *Law on the State Budget 2006* makes provisions for the central government to support provincial governments where approved revenues are insufficient to cover approved expenditure. Both estimates and actual intergovernmental transfers are not publicly reported.

The National Health Insurance Fund is in the process of consolidating several public insurance schemes into one consolidated fund. Currently, the major health insurance schemes under the fund are as follows:

1. **National Health Insurance (NHI)** scheme has the objective to accelerate the achievement of universal health coverage by covering individuals in the informal sector who were not otherwise covered by health insurance. The scheme was rolled out in six of the 17 provinces by the end of 2016 and expanded to all 17 provinces (and excluded in the capital, Vientiane) in 2017. Currently, the government has funded the premiums for the NHI directly and has automatically enrolled the eligible population, leading to a large expansion in coverage. Under the NHI scheme, a fixed patient co-payment is payable to the provider at the time care is sought, while the remainder of the cost is reimbursed by the NHI scheme through a pre-payment. The pre-payment is based on expected demand and the estimated cost of services. NHI implementation has increased social health protection coverage from 32 percent in 2015 to 94.5 percent in 2021.[4] Currently, Vientiane remains outside of NHI coverage, although the NHI Strategy 2021-2025 states that expanding coverage to all provinces by 2025 is a strategic objective. NHI funding is expected to

4 Lao PDR, Ministry of Health. 2021. National Health Insurance Strategy 2021-2025. Vientiane.

make up to 14 percent of the health budget in fiscal 2022.[5]

2. **State Authority for Social Security (SASS)** is a public health insurance scheme for civil servants and their families that was established in 1995. Premiums for SSAS, the military, and the police are sourced from an 8.5 percent contribution paid on top of staff salaries by the government and an 8 percent deduction from staff salaries, which collectively total 16.5 percent of staff salaries.

3. **Social Security Organization (SSO)** is a health insurance scheme for those in private, formal sector employment. Established in 2001, all businesses with more than one employee are required to enroll their employees. Premium payments are set at 11.5 percent of an employee's total salary, with 6 percent to be paid by the employee and 5.5 percent paid by the employer.

The National Health Insurance Bureau (NHI Bureau), which is equivalent to a department under the MOH, is responsible for managing health insurance for members of the National Social Security Fund (NSSF). The NSSF is responsible for the registration of policy holders and for the collection of premiums for SASS and SSO.[6] Health facilities are required to estimate their expected demand for services, based on population and historical data. Health facilities also estimate the health service input costs. These data are then reviewed and consolidated to form the annual service contract. The service contract stipulates an agreement with the health contractor (NHI Bureau) to pay health providers for services to health insurance members. Funding for health services is paid to health facilities quarterly from NHI Bureau accounts, following approval from the relevant district, provincial, or NHI Bureau.[7] Discussions regarding the merger of the SSO and SASS schemes are ongoing between the two ministries and implementation is underway.

Overall, total health expenditure in the Lao PDR is low by international standards at an estimated 2.8 percent of gross domestic product in 2021.[8] In that year, donors contributed 39.6 percent of total health expenditure, followed by households at 29.5 percent, and the government at 24.1 percent (Figure 3). The National Health Insurance funding accounts for 180 billion kip or only 3.4 percent of the total health expenditure.

5 Based on data from the Ministry of Health, Budget Plan.

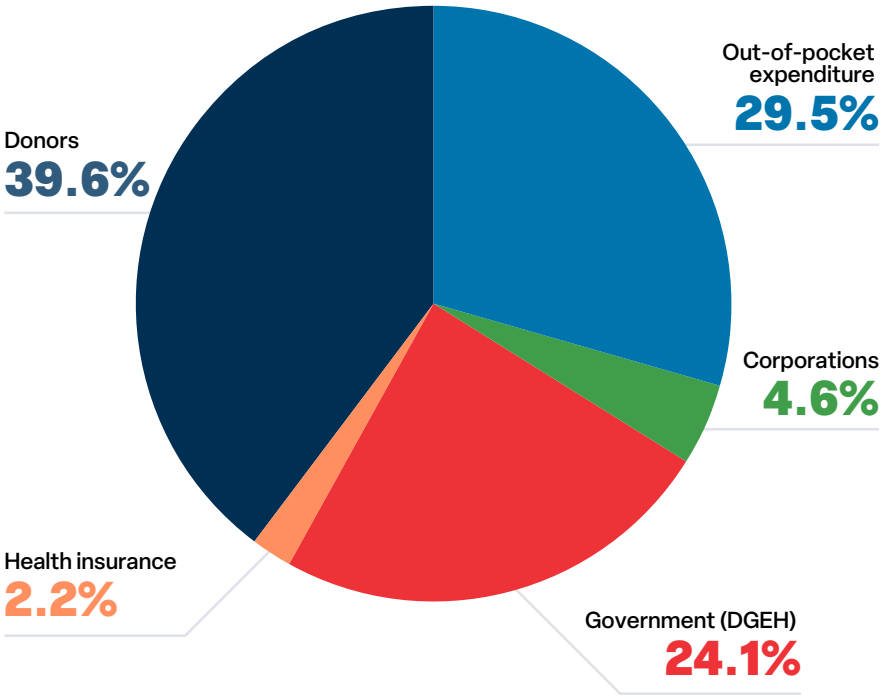
6 Lao PDR, Ministry of Health. 2021. Health Financing Strategy 2021-2025. Vientiane: Ministry of Health and World Health Organization, as cited in: World Bank. 2024. Budget Execution in the Health Sector in Lao PDR, Technical Note. Washington DC.

7 Funding is transferred to the health facilities sub-account for Chapter 63, Subsides and Contributions.

8 Lao PDR, Ministry of Health. 2023. National Health Accounts Report. Vientiane.

Figure 3
Lao PDR Domestic Health Sector Financing by Source

Sources: Lao PDR National Health Accounts Report (2020 and 2021).



From the 1980s, the Lao PDR health system transitioned from a government-funded public system that provided free services to a health financing system that relies partly on user fees-for-services delivered at public health facilities. As a result, out-of-pocket payments gradually increased to reach 48.6 percent of total health expenditures in fiscal 2011. More recently, the MOH implemented new policies to reduce financial access barriers, including the provision of free maternal, newborn, and child health services for mothers and children under the age of 5 as well as free access to health care for poor people as provided through Health Equity Funds. These free services are financed by pooled government funds and Official Development Assistance.

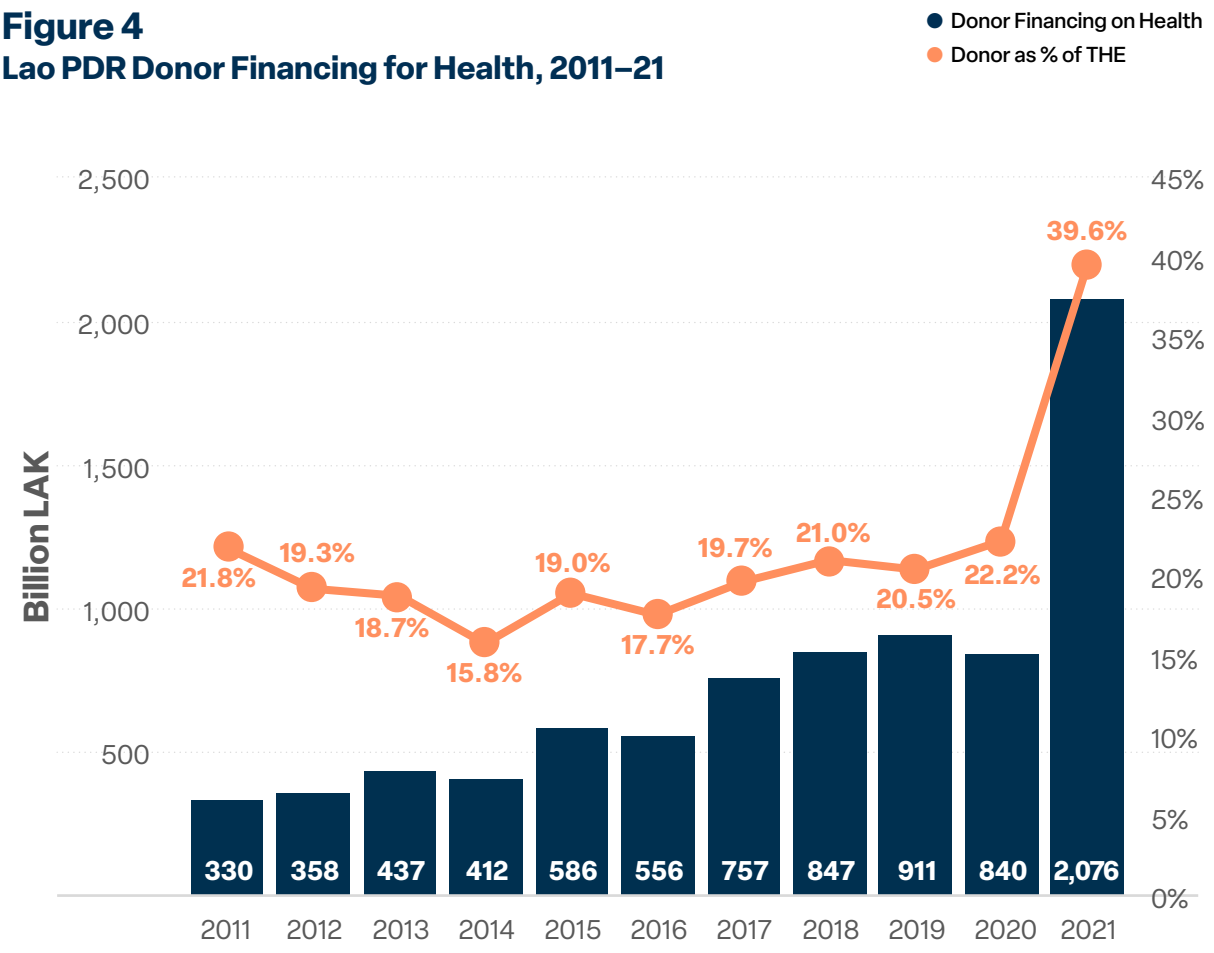
Donor financing is the biggest financing source for health expenditure, followed by out-of-pocket payment and government budget. Since 2011, the share of donor financing has been on an upward trend, increasing 20.2 percent per year on average (Figure 4). In 2021, donor financing totaled 2,075 billion kip, equivalent to 39.6 percent of total health expenditure.[9] Although donor financing increased significantly in 2021, it is expected to decline or stagnate as the Lao PDR nears the income eligibility thresholds for both GAVI and the Global Fund.[10]

9 Ibid.

10 The Institute for Health Metrics and Evaluation (2022) projects that the share of development assistance for health in total health expenditure will decline by 3.1 percentage points over the years 2019-2025. The transition policy of GAVI (https://www.gavi.org/sites/default/files/document/gavi-eligibility-and-transition-policypdf.pdf) and eligibility policy of the Global Fund (https://resources.theglobalfund.org/en/grant-life-cycle/applying-for-funding/understand-and-prepare/eligibility/). Reference: Global Burden of Disease 2020 Health Financing Collaborator Network. 2021. Tracking development assistance for health and for COVID-19: A Review of Development Assistance, Government, Out-of-Pocket, and Other Private Spending on Health for 204 Countries and Territories, 1990-2050, The Lancet, 398(10308):1317-1343.

Outside the usual government cash flows, specialized government bank accounts can be established to receive funding. Usually established by government decree, these accounts give additional accountability to ensure that funds raised are directed to their intended purpose. Where donor governments require additional procurement, accounting, or audit practices, the government may establish a separate account for receiving and disbursing funding. Alternatively, the government may establish an account by decree to receive donations from businesses and individuals. The government decree will outline the objective of the fund, administration and management of the fund, and controls on the use of funding.

Figure 4
Lao PDR Donor Financing for Health, 2011–21

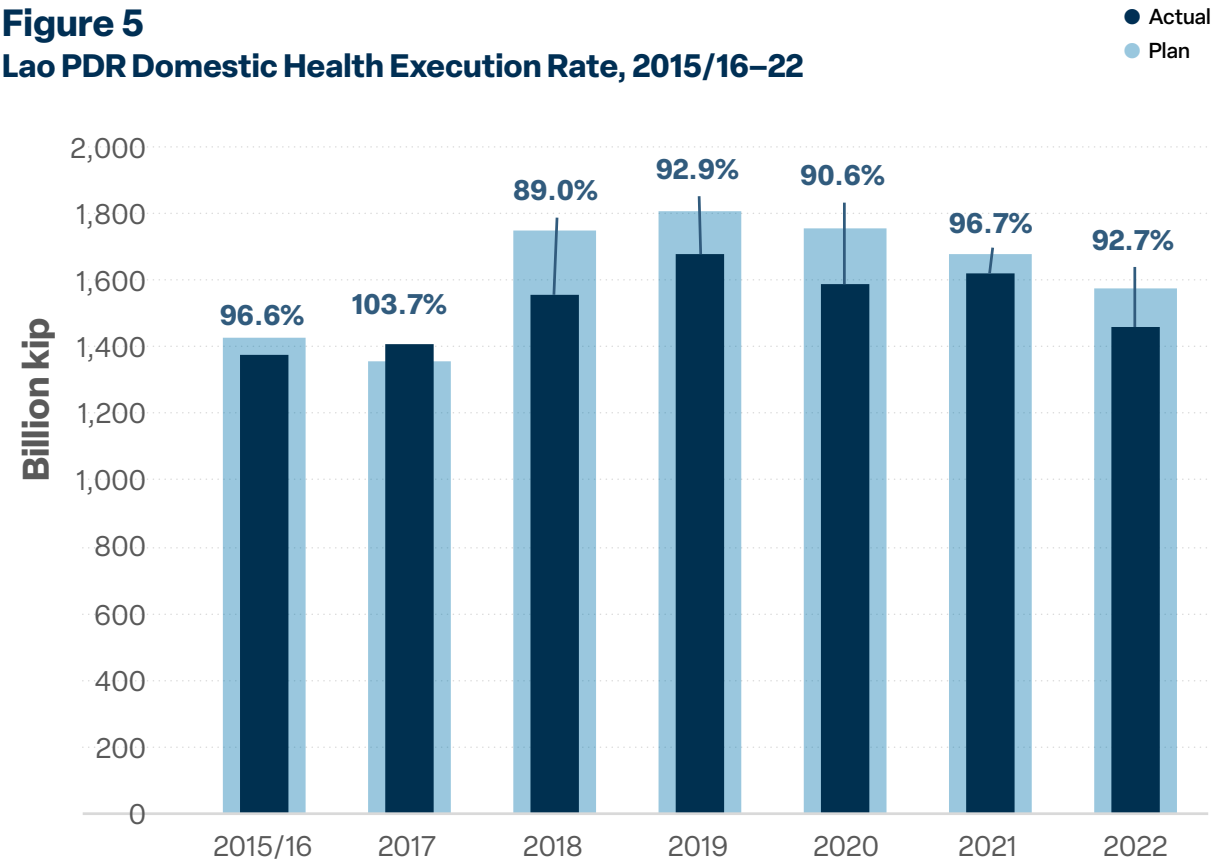


Source: Lao PDR National Health Accounts Report (2020 and 2021).

2.0 BUDGET EXECUTION IN HEALTH

From fiscal 2015/16 to fiscal 2022, the aggregate execution rate for the health budget averaged 94.2 percent (Figure 5). This execution rate excluded foreign financed capital spending, which was executed at 44 percent in fiscal 2018 (while not being included in the budget in the other years).

Figure 5
Lao PDR Domestic Health Execution Rate, 2015/16–22



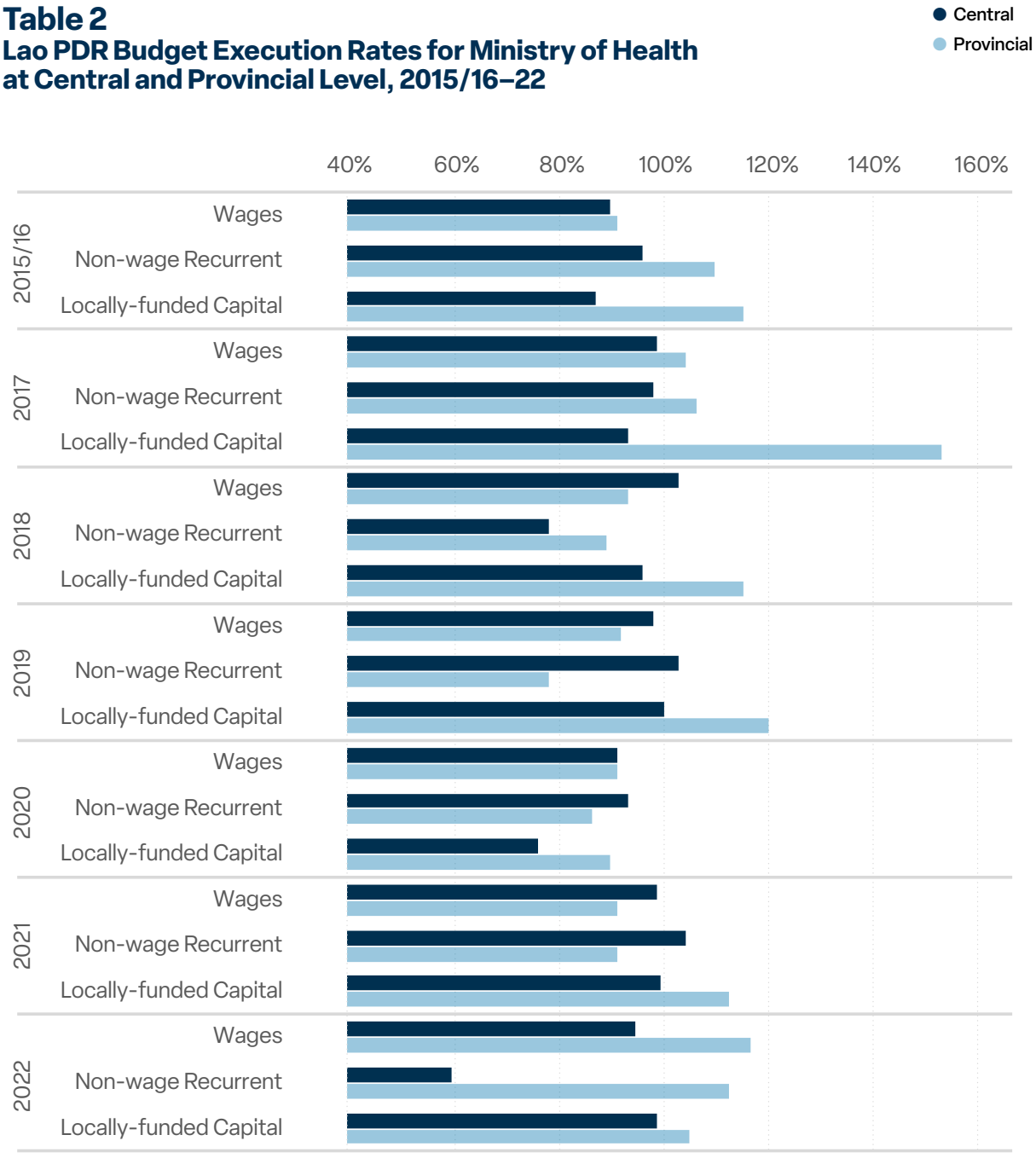
Source: Lao PDR State Budget Plan and State Budget Implementation reports, 2015/16–22.
Note: The Lao PDR budget changed from following an October-September fiscal year to following the calendar year in 2017 (World Bank, Lao PDR Economic Monitor, January 2019, p.23).

The central MOH budget execution outperforms the rest of government, while the provincial MOH budget execution performs similarly to the rest of government.

Across levels of government, the central level executed the health budget, on average, at a higher rate than the provincial level. The provincial level outperformed the

central level on wages by 1 percentage point in 2015/16 and on non-wage recurrent expenditure in 2018 (Table 2). In this instance, the low execution by the central MOH was due to a delayed scaling up of the National Health Insurance Fund.

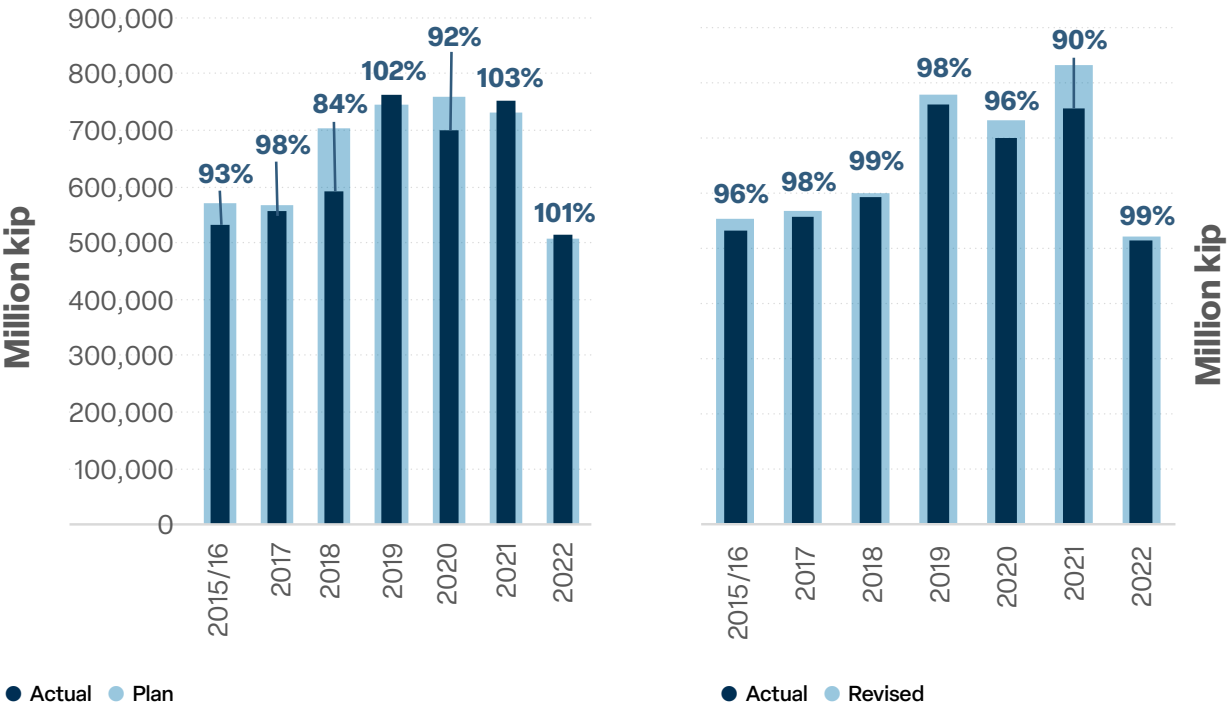
Table 2
Lao PDR Budget Execution Rates for Ministry of Health at Central and Provincial Level, 2015/16–22



Source: Lao PDR State Budget Plan and State Budget Implementation reports, 2015/16–22.

An established practice of preparing a revised budget is permissible under *Article 54 of the Amended Law on the State Budget 2022*. A revised budget is only permitted once a year, after the first six months of implementation, and recommended when major variations to revenue or expenditures are expected. However, during the Covid-19 pandemic, a second revised budget was prepared in fiscal 2020 due to a major downgrading of revenue projections. Revised budgets for the central MOH are more accurate than original planned budgets (Figure 6). From 2015 to 2022, the central MOH execution rate varied between -16 and +3 percent compared to the planned budget but -10 and -1 percent compared to the revised budget. The large variations in spending compared to the planned budget was due to in-year budget cuts stemming from the Ministry of Finance rather than systemic budget execution issues within the central MOH. The central MOH has demonstrated an ability to revise its budget in line with the more accurate budget and nearly achieve full execution.

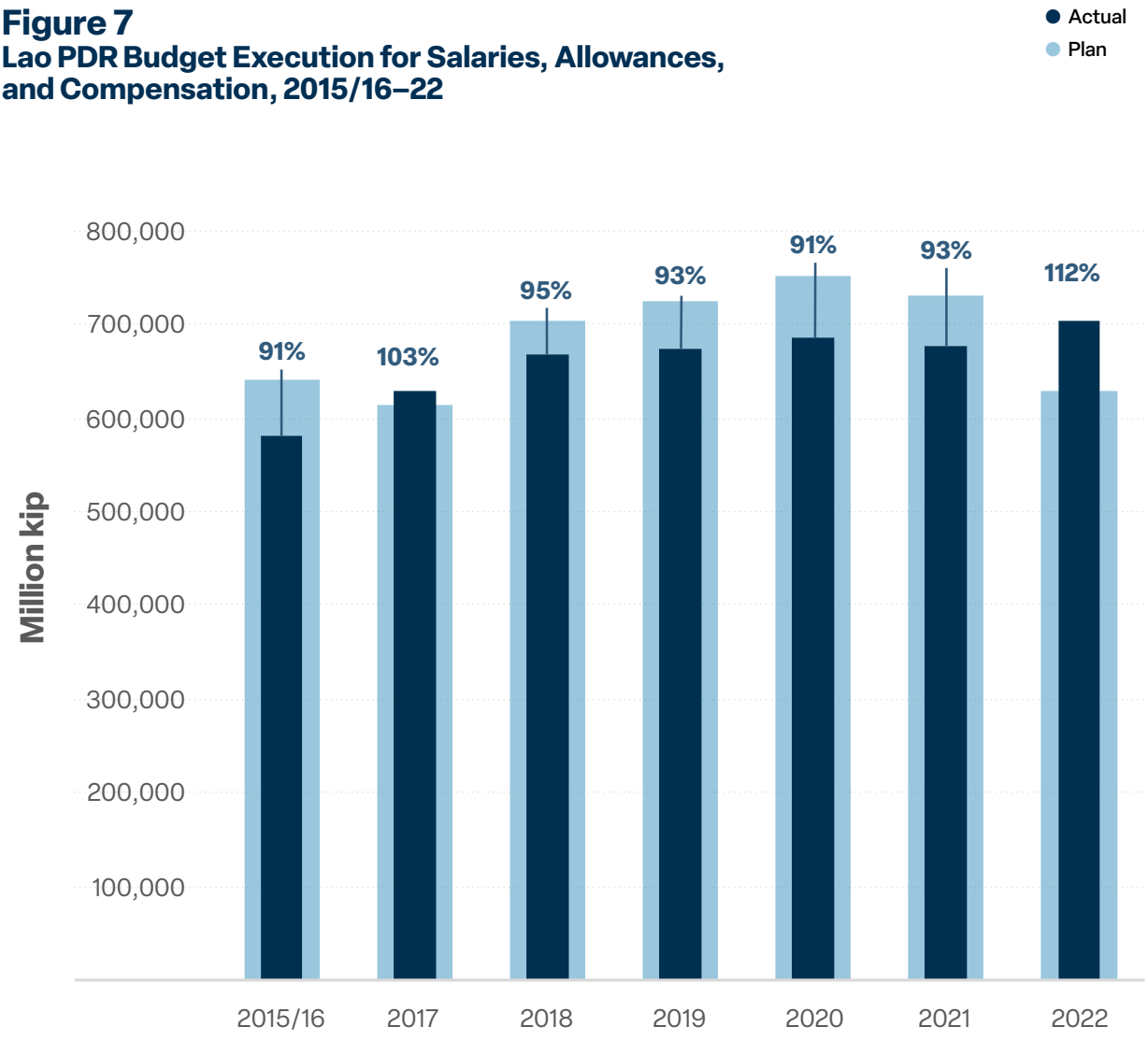
Figure 6
Lao PDR Central Ministry of Health Planned, Actual, and Revised Execution Rates, 2015/16–22



Source: Lao PDR State Budget Plan and State Budget Implementation reports, 2015/16–22.

Execution rates for MOH wages and salaries averaged 96.4 percent from 2015/16 to 2022 (Figure 7).[11] According to the state budget implementation report for 2022, the central and provincial MOH managed 18.9 and 81.1 percent of spending, respectively. The average absolute deviation from the initial plan was 4 and 3 percent for the central and provincial MOH, respectively (Table 3).

Figure 7
Lao PDR Budget Execution for Salaries, Allowances, and Compensation, 2015/16–22



Source: Lao PDR State Budget Plan and State Budget Implementation reports, 2015/16–22.

11 Health spending on wages and salaries can be tallied by adding Chapter 60 (Civil Servant Salaries and Subsidies) and Chapter 61 (Compensation and Allowances) in the Lao PDR Chart of Accounts.

Table 3: Lao PDR Budget Execution for Salaries and Wages, 2015/16–22

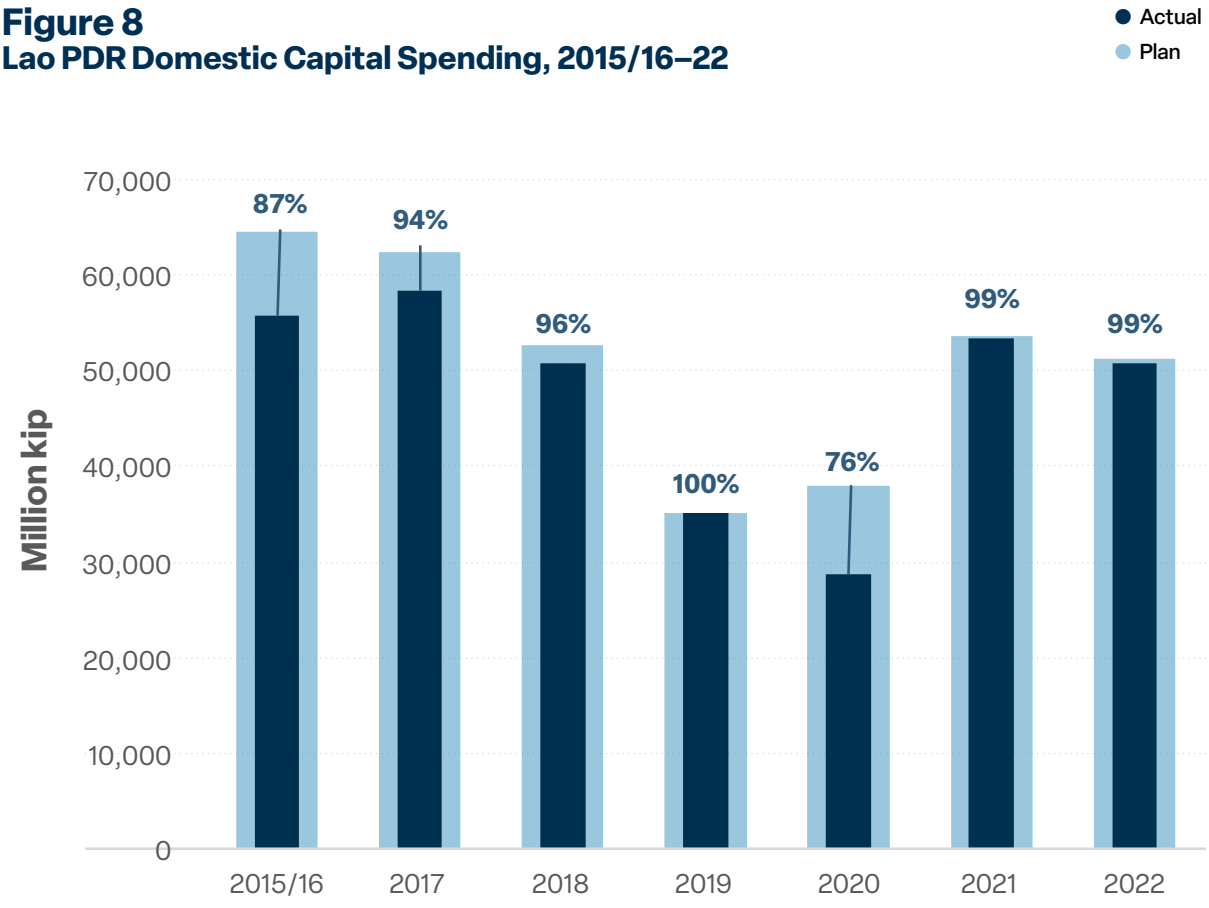
Administration	Fiscal	Plan	Actual	Variance	Execution
Ministry of Health	Year	Million kip	Million kip	Million kip	%
Central	2015/16	130,025	116,629	-13,396	90%
	2017	127,731	126,406	-1,325	99%
	2018	128,981	133,116	4,135	103%
	2019	132,153	130,046	-2,107	98%
	2020	142,244	130,227	-12,017	92%
	2021	136,948	135,063	-1,885	99%
	2022	139,928	132,688	-7,240	95%
Provincial	2015/16	509,648	462,744	-46,904	91%
	2017	484,384	503,369	18,985	104%
	2018	574,739	535,233	-39,506	93%
	2020	608,436	554,198	-54,238	91%
	2021	592,682	542,082	-50,600	91%
	2022	489,541	571,120	81,580	117%

Source: *Lao PDR State Budget Plan and State Budget Implementation reports, 2015/16–22.*

Capital spending averaged 93 percent from 2015/16 to 2022, and the execution rate improved each year (Figure 8). The central MOH slightly underspent its allocated capital budget each year, while the provincial MOHs overspent their capital budget each year (Table 4). The central MOH indicated the budget execution rate of 87 percent for central capital spending in fiscal 2015/16 may be due to lower-than-expected central revenues.

A possible explanation for the consistent over-execution of the capital budget at the provincial level is the *Amended Law on the State Budget, 2006*,[12] which allows provincial authorities to allocate any revenues beyond approved plans to capital expenditures. This provision creates an incentive for provinces to overspend their capital budgets when actual revenues exceed planned amounts.

Figure 8
Lao PDR Domestic Capital Spending, 2015/16–22



Source: Lao PDR State Budget Plan and State Budget Implementation reports, 2015/16–22.

12 See Article 6, paragraphs 4 and 5, and Article 32, paragraph 9.

Table 4: Lao PDR Central and Provincial Ministry of Health Capital Spending Execution, 2015/16–22

	2015/16	2017	2018	2019	2020	2021	2022
Ministry of Health	Difference (Million kip)						
Central	-8,639	-3,852	-1,941	-3	-9,157	-334	-596
Provincial	6,021	24,409	5,618	5,047	-2,371	3,383	1,904
Ministry of Health	Difference (%)						
Central	-13%	-6%	-4%	0%	-24%	-1%	-1%
Provincial	15%	105%	15%	20%	-10%	12%	5%

Source: Lao PDR State Budget Plan and State Budget Implementation reports, 2015/16–22.
Note: The figures for 2017 include only locally funded capital at the provincial level due to data availability.

Budget execution for medical equipment performed better than budget execution for medical drugs (see Figure 9 and Figure 10, next page). Budget execution for medical equipment performed well overall, but a planned increase in spending for fiscal 2021 (from 80 to 132 billion kip) was not fully realized. Budget execution for medical drugs exhibited a higher variation during this period, particularly in fiscal 2017. According to the state budget implementation report for 2022, the MOH was responsible for about 100 percent of the purchase of medical drugs and the purchase of medical equipment. The central MOH accounted for 79 percent of the spending on medical equipment, primarily because it is responsible for central and specialist hospitals, while the provinces are responsible for 65 percent of the spending on drugs due to greater provincial responsibility for managing health facilities.

Figure 9
Lao PDR Budget Execution for Medical Equipment

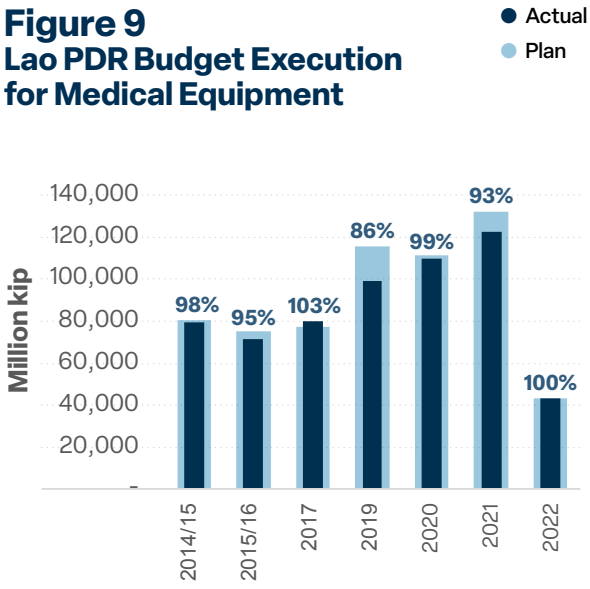
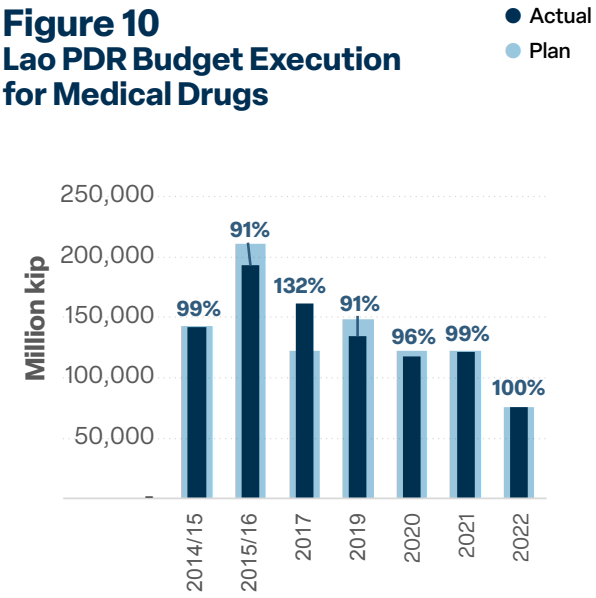


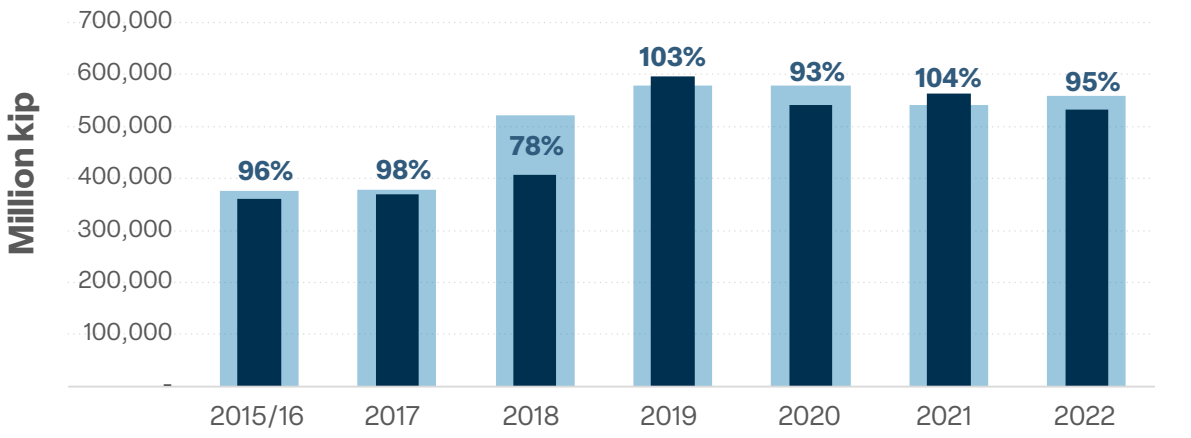
Figure 10
Lao PDR Budget Execution for Medical Drugs



Source: Lao PDR State Budget Plan and State Budget Implementation reports, 2014/15–22 (2018 data not available)

Non-wage recurrent spending[13] is generally well executed (Figure 11). For the fiscal years 2015/16, 2017, and 2022 budget execution was within 4 percent of the planned amount. The planned large expansion of non-wage recurrent spending to support the expansion of the NHI in fiscal 2018 was ultimately delayed, which led to a one-off lower execution rate of 78 percent.

Figure 11
Lao PDR Non-Wage Recurrent Budget Execution, 2015/16–22



13 Non-wage recurrent expenditure consists of Operations and Maintenance (Chapter 62), Subsidies and Contributions (Chapter 63), Financial Expenditure (Chapter 64), Other Expenditures (Chapter 65), and Fixed Assets for Administration (Chapter 66), though the bulk of spending derives from Chapters 62 and 63. More operational spending is allocated to the Ministry of Health at the central level compared with the provincial level.

3.0 PUBLIC FINANCIAL MANAGEMENT CONTROLS FOR HEALTH SPENDING

Budget preparation, execution, and reporting processes are set by the *Amended Law on the State Budget, 2021*. The law details the sources of revenue available to the central government and the provinces/capital city as well as the revenues to be apportioned between the two levels of government. Though both the budget for the central government and for the provincial and capital city governments are presented in one document, the budget preparation process for the two levels of government is sequential due to uncertainty around the total budget for the provinces. The National Assembly endorses the budget for the central government and provinces and then assigns revenue and expenditure plans to departments, sectors, and units within one and a half months.

Most health facilities and the funding for health services are managed at the provincial and district level. Provincial governors have the authority to allocate funding within their provincial government, with limiting constraints.[14] For example, all civil servants at the provincial level are employed by the central government and tend to show deference to the procedures and policies set by more senior officials at the central level.

Facilities prepare a revenue and expenditure plan based on the ceiling from the central or provincial Department of Finance. The most senior person at the health facility usually takes responsibility for managing and approving all expenditures within a health facility. Appointed authorities have a good deal of autonomy in how they manage a budget, though their ability to revise and reallocate budget between chapters of the Chart of Accounts and within the fiscal year is limited. Central and provincial hospitals prepare a budget, and the budget can include all chapters under the Chart of Accounts. Health centers prepare a more limited revenue and expenditure plan which only includes spending under Chapters 62 (Operation and Maintenance) and 63 (Subsidies and Contributions) of the Chart of Accounts.

Accounting practices are based on the Amended Accounting Law 2013. The law requires double entry bookkeeping, chronological transaction records, daily updates of the general ledger with validation by a trial balance, monthly financial reports, and a comprehensive annual financial report. Facility-level accounting follows the Chart of Accounts, which is input based. The MOH can add to the Chart of Accounts if procedures are documented in the MOH Accounting Procedure Manual. Records are kept in Microsoft Excel and the Government Financial

14 The Prime Minister has the authority to transfer funds between provinces per Article 65 of the Amended Law on State Budget, 2006.

Information System (GFIS).[15] Table 5 shows the information systems used by the MOH.

Financial and health performance information is tied to budget allocation. Inaccuracies, underreporting, and incomplete reporting are acknowledged in the National Health Statistics Report.[16] Long processes and inaccuracies can lead to poor budget allocation and delayed cash disbursements, which can affect budget execution. Currently, a minority of health budget units use a financial management system approved by the Ministry of Finance. A survey of four provinces in 2018 found that 40 percent of

Table 5: Lao PDR Ministry of Health Information Systems

Information System	Purpose
Government Financial Information System	Recording of financial transactions within the government
National Health Insurance Bureau Administer Transfer Discharge System	Recording and reconciliation of patient records with health insurance records and health services
Hospital Management Information System	Admission Patient ID Staff ID Staffing schedule Health records Diagnosis Prescription Nursing plan Lab results Imaging report
mSupply	Drug supply and logistics information

Source: Lao PDR, Ministry of Health. Health Insurance Information System Master Plan.

15 Perras, A. 2021. Lao PDR Health Insurance Information System Master Plan. Vientiane: Lao PDR Ministry of Health and International Labor Organization, as cited in: World Bank. 2024. Budget Execution in the Health Sector in Lao PDR, Technical Note. Washington DC.

16 Lao PDR, Ministry of Health. 2019. National Health Statistics Report 2019. Vientiane: Department of Planning and Cooperation.

provincial hospitals and half of health centers were not using the standard financial reporting forms required of all budget units.17 Health facilities and many MOH departments do not have access to the GFIS. Health facilities, divisions, and departments keep offline, and paper-based, financial records. Records must be consolidated at the district, provincial, and the central level. The recordkeeping system is prone to error, while the many layers of consolidation lead to reporting delays.

Department level revenues, planned expenditures, and actual expenditures are not reported on separately in the budget. The largest expense, the NHI premium payment, is included in Chapter 63 (Subsidies and Contributions) of the Chart of Accounts of the MOH central budget. The NHI Bureau produces an annual report titled Previous Year Implementation Report and Forward Year Plan, which provides analysis of recent budget implementation and future plans. The report also provides an overview of the Bureau's objectives, administrative structure, completed activities, outputs, and outcomes. However, the annual report does not include budget actuals; the administrative budget; links between budget, outputs, and objectives; or links to other government financial reports. In addition, the state budget plan and the state budget implementation reports often cannot be reconciled. In fiscal 2017, for example, the budget plan for the central MOH was reported to be 505.5 billion kip in the Budget Law and more than double that amount (1,271 billion kip) in the state budget implementation report. In several instances, figures within these documents were not internally consistent. There are also major discrepancies when comparing financial records provided by the Ministry of Finance to records held by MOH. Furthermore, the Ministry of Finance does not produce a public document detailing intergovernmental fiscal transfers, making it impossible to know the exact flow of funds between levels of government and government organizations. Overall, there is a lack of publicly available health sector reports (Table 6).

Provincial governments and health facilities can raise and retain revenue. Provincial governments prepare an expected revenue plan for review and approval by the provincial governor or municipal mayor. Health facilities prepare revenue and expenditure plans for review and approval by the relevant Department of Finance. Total own-sourced revenue is a significant proportion of expenditure. Between 2016 and 2022, own-sourced revenue was equivalent to 20-28 percent of total MOH expenditure (Figure 12). Revenues are collected by decentralized units (health centers and district, provincial, and central hospitals), which have special privileges in how these funds can be managed and used. Health facilities can utilize revenues as they are collected and have greater flexibility in the use of own-sourced revenues compared to funding received from central or provincial transfers. The source of financing does not impinge on the provincial governments' freedom to manage and allocate funding, as transfers from the central government do not carry restrictions on how they are managed. Funding from the central government and provincial

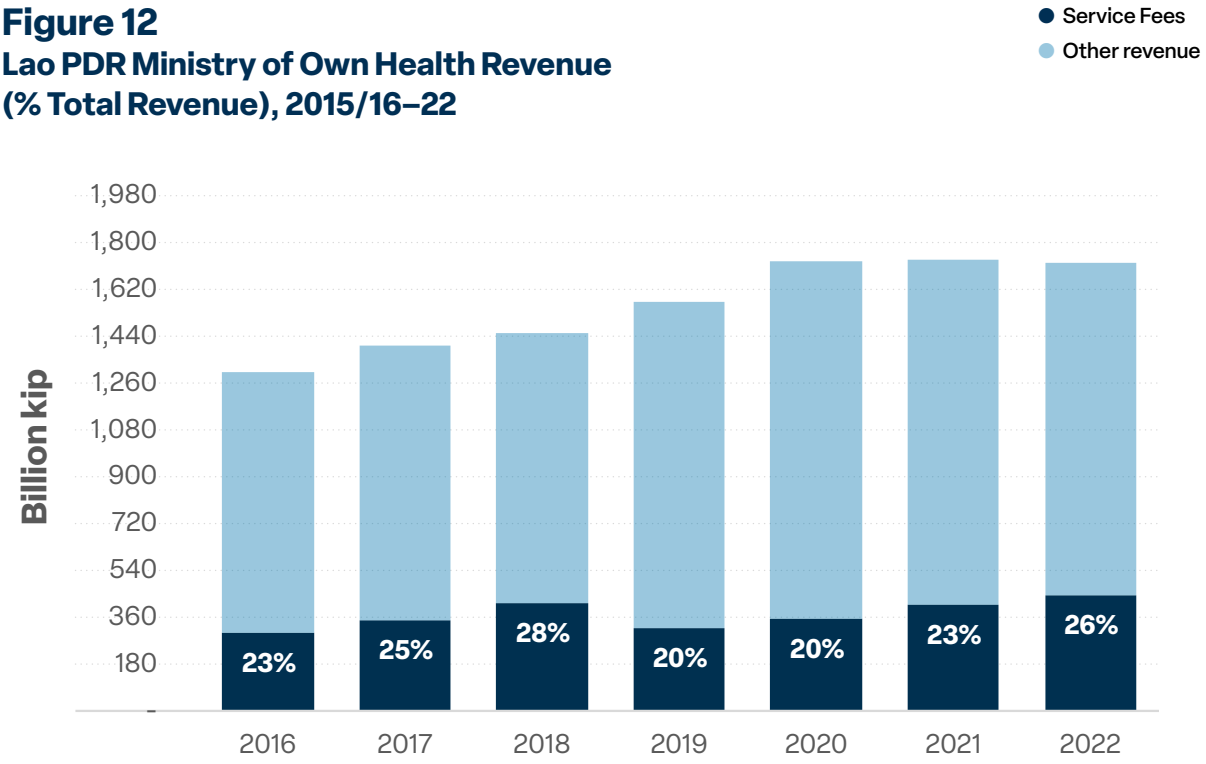
17 Lao PDR, Ministry of Health. 2020. National Health Insurance: An Assessment of Progress in 2016-2019 and Priorities for 2021-2025. Vientiane.

Table 6: Lao PDR Publicly Available Health Spending Reports

Key Health Financing Information	Plan	In-Year	End of Year
Total Health Expenditure	✔	✗	✔
Health Spending by...			
Central and Provincial Level	✔	✗	✔
Individual Provinces	✔	✗	✔
Administrative Unit	✗	✗	✗
Departments	✗	✗	✗
Economic Classification*	✔	✗	✔
Function or Program	✗	✗	✗
Total Health Revenue	✔	✗	✗
Revenue by Administrative Unit	✗	✗	✗
Intergovernmental Transfers	✗	✗	✗
Audit Report	✗	✗	✗

Source: World Bank 2025.
Note: *Economic Classification includes wages, goods and services, capital, and transfers

Figure 12
Lao PDR Ministry of Own Health Revenue (% Total Revenue), 2015/16–22



Source: Budget data provided by the Lao PDR Ministry of Health.

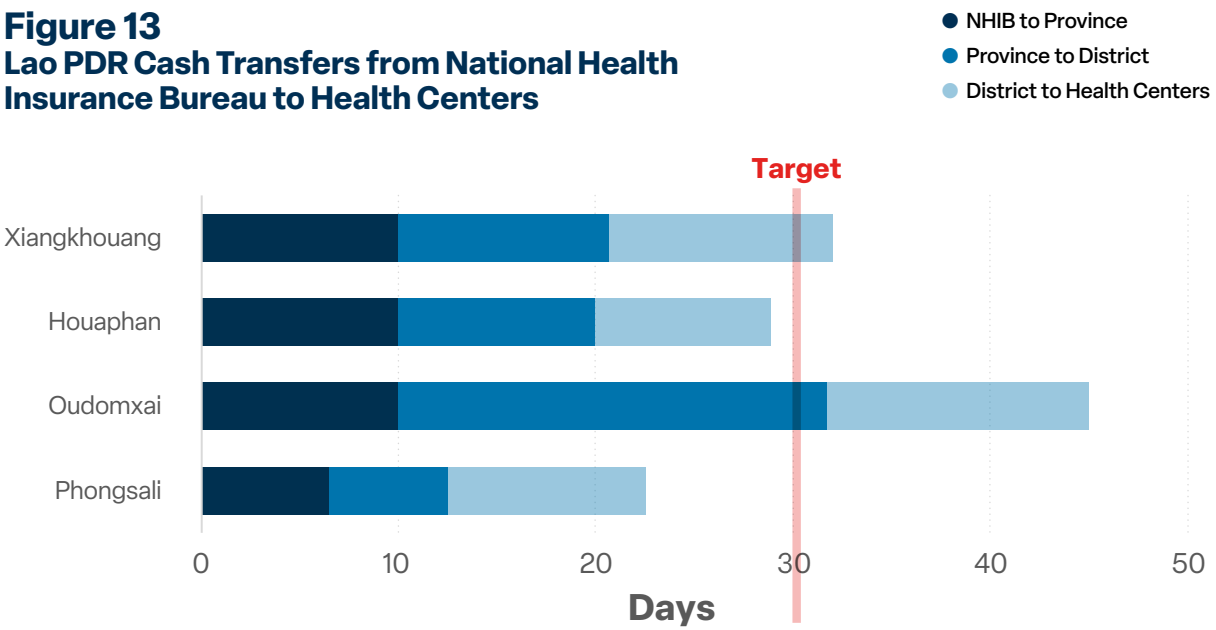
sources of revenue are held in the same account and are treated equally.[18]

The release of funds from the central NHI Bureau to health facilities is convoluted and not always timely. Figure 13 shows the average days required for cash to be released from the central NHI Bureau to the National Treasury at the provincial level, then from the National Treasury at the provincial level to the National Treasury at the district level, and finally, from the National Treasury at the district level to the health centers' bank accounts. A target of 30 days was set, based on the World Bank's Health and Nutrition Services Access Program's disbursement linked indicators. However, a sample of four provinces shows that in half the cases, the transfer of funds from the central NHI Bureau took longer than 30 days to reach the health centers.

The National Treasury and National Treasury at the provincial level disburse cash on a quarterly basis. Each budget unit maintains a bank account operated by the central bank,

18 The current government financial information system (GFIS) only allows for the classification of four types of revenue and cannot accommodate the complex accounting needs of the National Health Insurance Bureau (NHI Bureau) and the broader health system. As a stop-gap measure, the NHI Bureau has requested the central bank (Bank of the Lao PDR) to create sub-accounts for each insurance type to better manage revenue streams. As the GFIS and Treasury system do not accommodate the requirements of the NHI Bureau, this has pushed additional accounting responsibilities onto the NHI Bureau and health facilities. Much of this accounting work is paper based, thus time-consuming and error-prone.

Figure 13
Lao PDR Cash Transfers from National Health Insurance Bureau to Health Centers



Source: Data from the payment tracking system of the disbursement linked indicators in the World Bank Health and Nutrition Service Access Program.

Bank of the Lao PDR. The Bank of the Lao PDR19 also operates sub-accounts including those created at the request of the NHIB to manage insurance revenue streams more effectively, based on chapters of the Chart of Accounts. Cash is disbursed to the central budget units following approval by the National Treasury, while cash is disbursed to provincial and district budget units following approval by National Treasury at the provincial or district level. The provincial health offices submit a quarterly budget request to provincial finance offices and once approved, receive the budget amount credited to their dedicated account at the National Treasury at the provincial level. District health offices request their quarterly budget tranche of non-salary budget from provincial health offices and have their budgets remitted to the respective accounts with the National Treasury at the district level. Health facilities can maintain substantial cash balances, allowing for more independence from cash disbursements through the Treasury system.

Table 7 compares cash balances carried over from fiscal 2018 to total approved expenditure in fiscal 2019 for all health facilities managed by provincial MOH. In sum, provincial health facilities carried over 64 billion kip from fiscal 2018 against a total of almost 92 billion kip of expenditure in fiscal 2019. These funds are only permitted to be used for non-wage recurrent expenditure. The large cash balances may partly explain the relatively good performance of non-wage recurrent expenditure. At the same time, there is evidence that the demand for health services may not positively correspond to available cash balances.

19 NHIB has requested the Bank of the Lao PDR to create sub-accounts for each insurance type to better manage revenue streams.

Table 7: Lao PDR Cash Balances at Health Facilities, 2019

Administration	Plan	Actual	Variance
Provincial Hospitals	22,716,703,046	45,334,023,256	50%
District Hospitals	23,808,114,782	35,023,164,538	68%
Health Centers/Small Hospitals	17,565,645,836	11,480,385,128	153%
Total	64,090,463,664	91,837,572,922	70%

Source: Lao PDR, Ministry of Health. 2020. Implementation and Plan of the National Health Insurance Fund.

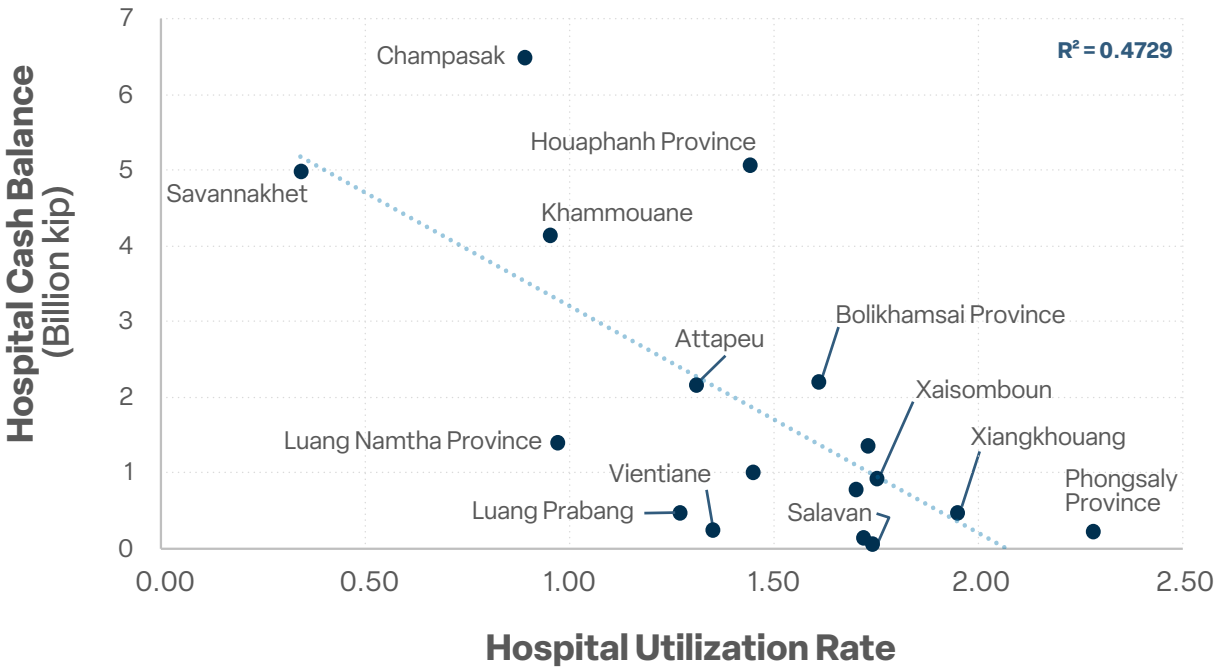
Figure 14 shows a strong relationship between high SASS utilization rates and low cash balances. This means that hospitals with high demand had low cash balances, while hospitals with low demand had high cash balances.

The *Amended Law on the State Budget 2021* and the Instructions on Revenue and Expenditure Management of Financially Self-Sufficient Administrative and Technical Units encourage provincial governments and health facilities to become financially self-sufficient. Currently, the MOH is piloting an initiative to make select central hospitals self-sufficient. The long-term aim of the NHI is to allow health facilities to be financially self-sufficient and to manage their resources, including personnel, operational, and capital expenditures. In 2021, the National Treasury issued instructions to update expenditure and revenue management for financially self-sufficient administrative and technical units. This triggers major changes in the financial management of health facilities, for example:

- **Central hospitals** can retain up to 20 percent of their monthly revenue in cash or a cash account, with the remaining 80 percent deposited in accounts at the National Treasury or the National Treasury at the provincial level.
- **Provincial hospitals, district hospitals, and health centers** can manage procurement up to 300 million kip for medical supplies and equipment or 500 million kip for repairs and maintenance.[20]

20 Lao PDR, Ministry of Finance. 2021. Instructions on Revenue and Expenditure Management of Financially Self-Sufficient Administrative and Technical Units, May 2021.

Figure 14
Lao PDR State Authority for Social Security Utilization Rate and Provincial Hospital Cash Balances, 2020



Sources: Lao PDR Implementation and Plan of National Health Insurance Fund 2020; Lao PDR National Health Statistics Report 2020.

The government does not publicly report the status of arrears. In 2019, a joint World Bank—IMF Debt Sustainability Analysis found the known stock of domestic payment arrears was 3 percent of gross domestic product. Contractor pre-financing of capital projects represents a risk of arrears accumulating in the health sector. Overall, however, the level of capital investment is low in the health sector, reducing the risk of arrears accumulation.

Capital spending is managed at the central and provincial level. Financing for approved capital projects (Chapter 67) flows from the central MOH to the central hospitals and from the provincial health office to the provincial hospitals. The consistent overspending of the provincial capital budget is likely due to a combination of factors. The budget law encourages spending units to prioritize capital spending in the event of revenue over-performance. In the event of cost overruns or revenue underperformance, cuts typically come from recurrent spending rather than capital. In addition, the links between internal reporting on capital projects and accounting are weak, creating possibilities for cost overruns. For example, the MOH may report

a project has been completed while payments for the project are still outstanding. If a project faces cost overruns, it may only be reported in subsequent years. This can lead to a provincial MOH exceeding its total capital budget.

Wages and salaries are directly transferred from the National Treasury or the National Treasury at the provincial level to the employee, under Chapters 60 and 61 of the Chart of Accounts. MOH employees working at district facilities are managed and paid through provincial systems. Since 2013, salary payments have been directly deposited into the government bank accounts of civil servants by the National Treasury or the National Treasury at the provincial level. In addition, civil servants are paid monthly rather than quarterly.

Health facilities have been able to smooth spending by delaying payments to private providers. In such instances, health facilities can report expenditures against their approved budget before payment has been received by the supplier, which helps health facilities to achieve high rates of budget execution in situations of delayed treasury disbursements or low cash balances. However, this practice has resulted in health facilities operating negative cash balances. For example, in fiscal 2020, two provincial hospitals had payable invoices totaling more than available cash and receivables combined. The provincial hospitals in Borikhamxay and Xaysomboun maintained negative balances of 26 and 3 percent of revenue, respectively. Though delaying payment to providers may help hospitals to achieve a high rate of budget execution, it creates a risk that the suppliers will increase their prices as delays in payment are costed into procurement.

4.0 GOOD PRACTICES AND BOTTLENECKS

The health sector's budget execution rate is relatively high, ranging from 89 to 104 percent from 2015 to 2019. Aggregated execution rates are generally high across the main categories of spending – wage, non-wage recurrent and capital – with only a couple of outliers during the period of analysis. Some public financial management practices that enable these high execution rates may, nonetheless, risk lowering the quality of budget execution. There is also greater variation in execution rates when considering more disaggregated levels of budget spending, including between the central and provincial level of government (Table 8).

Table 8: Summary of Budget Execution Good Practices and Bottlenecks in Lao PDR

Issue	Explanation
Good Practices	
Ringfenced health budget	While being forced to cut government spending due to increasing debt service costs, the government has committed to protecting the health budget. This assurance has ensured greater credibility of the Ministry of Health (MOH) budget allocations by reducing the chance of in-year budget cuts.
Relatively high capital budget execution rate	The overall capital budget has been consistently executed near 100 percent or in some cases, slightly beyond 100 percent. Generally, the central MOH capital budget is marginally under-executed, while the provincial MOH capital budgets are systematically over-executed. This is because of a budget law that allows provinces to spend excess collected revenue on capital projects. These additional capital projects are not necessarily well integrated with strategic plans.

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Table 8: Summary of Budget Execution Good Practices and Bottlenecks in Lao PDR

Issue	Explanation
Bottlenecks	
Limited oversight or link to activities or outputs	Activity plans are not linked to the budget, published,or subject to audit. This enables budget managers to allocate spending to activities with limited oversight, offering a great deal of budget flexibility and enabling high budget execution rates. However, this also means that executed spending may not align strongly with strategic objectives. More generally, there is no mechanism linking budget spending to the delivery of outputs.
Systematic under-execution of wages and salaries	Wages and salaries were under-executed by 9, 7, and 5 percent in three of the four reported years. This is because of weak budget preparation processes, particularly at the provincial level. Spending units prepare budgets for wages and salaries based on historical information plus a percentage increment. The submission is not linked to the number or type of positions, promotions, or allowances that it is intended to support.
Delays in payments reaching health facilities	Two of the four sampled health facilities reported that it took more than 30 days for National Heath Insurance funds to reach them after being disbursed from the National Treasury. Health facilities have reported payments being increasingly unpredictable and delayed, even being received in the following fiscal year.
Limited budget execution transparency	Disaggregated health budget execution data is not available at the administrative, departmental, or programmatic level. Reporting also is limited on revenue raised from health facilities and on intergovernmental transfers. There is no reporting on the stock of arrears or on any published audit of spending.

...table continued next page

Table 8: Summary of Budget Execution Good Practices and Bottlenecks in Lao PDR

Issue	Explanation
Cash management challenges	Health facilities can maintain substantial cash balances, allowing for more independence from cash disbursements through the Treasury system. The ability to hold large cash balances may explain the relatively high execution rates for non-wage recurrent expenditure. However, available evidence shows that health service demand may not positively correspond to available cash balances. On average, health facilities with a higher demand for health services had a lower stock of available cash compared to health facilities with a lower demand for health services.
Manual reporting processes	Health facilities and many MOH departments do not have access to the government financial information system (GFIS) and instead keep offline, paper-based financial records. These records are then manually consolidated at the district, provincial, and central level. This leads to delayed reporting processes as well as errors and inconsistencies.

Source: World Bank 2025.

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BUDGET EXECUTION IN HEALTH: FROM BOTTLENECKS TO SOLUTIONS

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CASE STUDY SERIES

PAKISTAN

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BUDGET EXECUTION IN HEALTH: FROM BOTTLENECKS TO SOLUTIONS

CASE STUDY SERIES

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ABSTRACT:

Pakistan's overall national health budget had a high rate of execution from 2016 to 2019, averaging 95 percent. However, execution rates between provinces as well as between categories of spending varied significantly. At the health facility level, execution of spending is notably challenging, particularly for non-wage expenditure. Good practices that facilitated better budget execution included strong integration of payroll and personnel records in most provinces as well as the contracting out of the provision of primary healthcare services to the private sector in Sindh, Baluchistan, and Punjab Provinces. This approach has facilitated more consistent budget execution rates and evidence of resources reaching the facility level. There remain challenges, however, with ensuring the accountability of how these resources are used. The main bottlenecks holding back the quality of budget execution include an inability to track primary, secondary, and tertiary healthcare budgets and their execution; systematic over-estimation of resources by the provinces; weaknesses in budget preparation processes; inefficiency in spending control processes; lack of autonomy for primary healthcare facilities; insufficient integration of vertical programs in local health systems; and lack of a process for capturing spending arrears.

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Budget execution in health: from bottlenecks to solutions

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Click on this square to return to the contents page

SECTION NAME

Click on this section to return to the beginning of the section

PAKISTAN **CONTENTS**

LIST OF FIGURES

LIST OF TABLES

ACKNOWLEDGMENTS

This study is part of a broader analytical collaboration between the World Health Organization (WHO) and the World Bank to address budget execution problems in the health sector. The study's findings feed into a synthesis report, which is released concurrently: Budget Execution in Health: From Bottlenecks to Solutions.

This study was authored by the Pakistan World Bank team, including Qurat ul Ain Hadi (Senior Financial Management Specialist, World Bank), Johan Verhaghe (Lead Consultant), and Hammad Yunus (Public Financial Management Consultant). The study was also benefitted from the review of Jahanzaib Sohail (Senior Health Specialist) and Hnin Hnin Pyne (Program Leader, HNP). It follows a case study protocol developed by Hélène Barroy (Senior Health Finance Specialist, WHO), Moritz Piatti-Fünfkirchen (Senior Economist, World Bank), and Amna Silim (Senior Consultant). Quality assurance was provided by Hamish Colquhoun (Senior Consultant) and Moritz Piatti-Fünfkirchen (Senior Economist). Technical editing and communication support was provided by Zac Mills (Senior Consultant), Hamish Colquhoun (Senior Consultant), and Alexandra Michele Beith (Senior Consultant). The study benefitted from management oversight by Agnès Couffinhal (Global Program Lead for Health Financing) and Monique Vledder (Practice Manager, HNP). It was made possible through generous financial support from the Global Financing Facility (GFF).

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1.0 HEALTH FINANCING CONTEXT

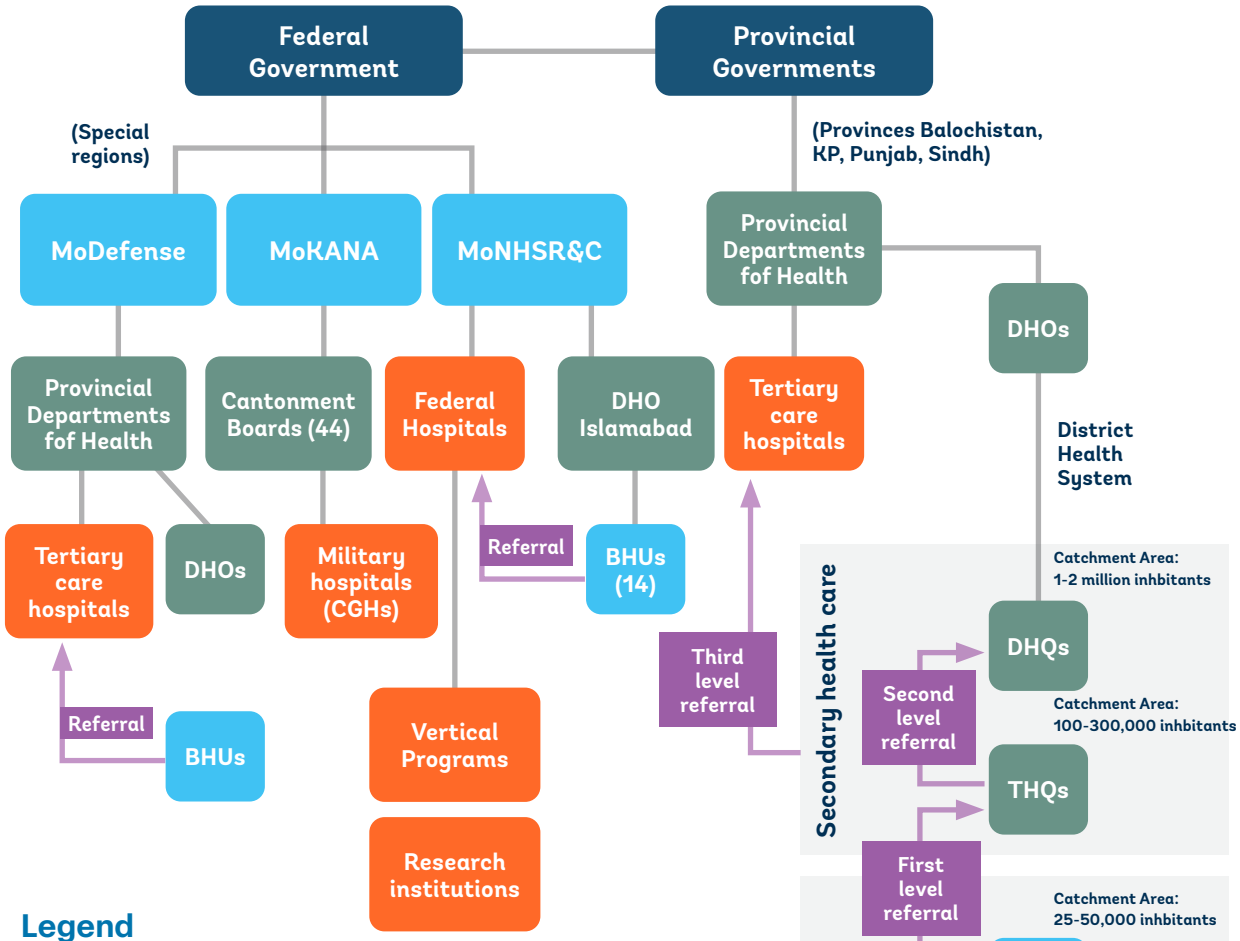
Health became a fully provincial mandate when the 18th Constitutional Amendment in 2010 removed the Concurrent Legislative List (i.e., the federal–provincial concurrent powers) from the Constitution. This change allowed provinces to pass local health laws (Punjab 2010, Sindh 2014, and Khyber Pakhtunkhwa (KP) 2015) and implement devolution at the district level. Despite weaknesses, the 18th Amendment is generally considered a milestone towards fiscal decentralization and provincial autonomy. In principle, the shift allows for the design of provincial and district Annual Development Plans, including priority-oriented health policies and relevant budgets.

The National Finance Commission makes a single-line budget transfer to the provinces from the federal divisible pool of revenues (see Figure 1). Provinces then decide on the intersectoral budget allocations. Based on a pre-established formula, the Provincial Finance Commission distributes available resources, including federal transfers and provincial-generated revenue, between the province and the districts. Before devolution, provincial health departments exercised direct administrative control over districts, including supervision and authority for allocating primary healthcare budgets. Today, tertiary healthcare remains under the provincial health department, but primary and secondary healthcare have been devolved to the districts.[1]

At the district level, Basic Health Units (BHUs), Rural Health Centers (RHCs), Maternal and Child Health Centers (MCHCs), and Dispensaries deliver primary healthcare. A Basic Health Unit has a catchment area of 10,000-15,000 inhabitants and mainly provides preventive and basic care, including maternal and child health services, immunization, diarrhea and malaria control, child spacing, mental health, school health services, prevention and control of locally endemic diseases, and provision of essential drugs. A Rural Health Center has a catchment area of 25,000-50,000 inhabitants and provides preventive and outpatient healthcare, mainly curative services for common diseases. Maternal and Child Health Centers are part of the integrated health system and focus on maternal and child health. Secondary care is provided in Tehsil Headquarter Hospitals (THQs), which cover 100,000-300,000 individuals, and District Headquarter Hospitals (DHQs), which cover 1-2 million individuals. Primary and secondary healthcare constitute the district health system. Major hospitals (with specialized facilities) provide tertiary healthcare and operate under the authority of Provincial Departments of Health (See Table 1. Size of the Health Sector, page 3).

1 A varying degree and different institutional arrangements of the health mandate are devolved to districts across the provinces; this is regulated in the Local Government Acts.

Figure 1
Public Health System Structure in Pakistan



Legend

MoNHSR&C = Ministry of National Health Services, Regulation & Coordination

MoKANA = Ministry of Kashmir Affairs and Gilgit Baltistan Region

KP = Khyber Pakhtunkhwa

CGH = Cantonment General Hospital

RHC = Rural Health Centre

MCHC = Maternal and Child Health Centre

BHU = Basic Health Unit

THQ = Tehsil Headquater Hospital

DHQ = District Headquater Hospital

LHW = Lady Health Workers

LHW = Lady Health Visitors

CMW = Community Midwives

Source: Pakistan Bureau of Statistics 2021.

Table 1: Size of the Health Sector

Locality	Pop.*	Hospitals	RHC	BHU	MCHC	Dispensaries	Beds
Federal	--	9			4	81	2,571
Punjab	114.7	389			284	1,286	60,387
Sindh	50.2	473			220	2,819	38,623
Khyber Pakhtunkhwa / Federally Administered Tribal Areas	37.5	277			153	983	24,329
Balochistan	13.2	134			95	574	7,797
Gilgit Baltistan	(na)	44			163	426	(na)
Azad Jammu and Kashmir	(na)	17			(na)	79	(na)
Total		**1,343**	**723**	**5,719**	**919**	**6,248**	**133,707**

Source: Pakistan Bureau of Statistics 2019.

Note: * Estimated population size, millions (2019); RHC–Regional Health Center; BHU–Basic Health Unit; MCHC–Maternal and Child Health Center.

The Sehat Sahulat Program is a micro-health insurance initiative of the Federal Government of Pakistan in partnership with the provinces. The Sehat Insaf Card (National Health Card) offers access to free inpatient healthcare, particularly for low-income households. Implemented in 2019-20, the program is now fully operational in Khyber Pakhtunkhwa (KP). The program signs local contracts with pre-selected hospitals, called panel hospitals. In KP, the National Health Card is accessible to all on condition of being a KP resident and having a computerized identification. Total coverage for treatment is PRs 1 million per annum per person and two dependents (USD 5,000 in 2022).[2] Benefit packages vary from province to province.[3] The program is financed by both the central government (USD 18 million in fiscal

2 See https://sehatinsafcard.com/

3 Benefits usually include emergencies, general surgeries, maternity care (including C-section), inpatient care and (particularly expensive) treatment for diabetes, cardiovascular disease, cancer, kidney transplant and liver disorders, HIV and hepatitis complications, burns, and road accidents.

2017-18) and provincial budgets. However, challenges have delayed the rollout to the whole country.[4]

Sindh and Baluchistan Provinces have contracted out the management of Basic Health Units to the private sector.[5] These companies operate under Section 42 of the Companies Act (2017)[6] and sign a partnership agreement with provincial health departments to provide services in contracted-out health facilities.[7] In Sindh, the private sector manages about 85 percent of primary healthcare facilities in 22 districts; in Baluchistan, the private sector manages 653 (73 percent of) primary healthcare facilities in 33 districts.[8] A 2011 independent evaluation indicated the need for improvements in staffing, drug availability, equipment, and the material condition of facilities, including the rehabilitation of dysfunctional Basic Health Units. However, recent research by Zaidi (2022, p.2) identified "*serious gaps in the continuum of care with essential services such as family planning, new-born care and child nutrition receiving less attention. Diagnostic services were only partially boosted, with private providers investing in more visible X-rays and ultrasounds imaging but overlooking low-cost laboratory testing required for routine disease management. Moreover, limiting the NGOs [non-governmental organizations] to facility control, without involvement in the health outreach programs, restricted the downstream community impacts*."[9]

Out-of-pocket spending totals more than 60 percent of the total health expenditure and an estimated 83 percent of patients use private health facilities[10] (see Figure 2).[11] This finding indicates that a large portion of the population seeks healthcare in private-run facilities rather than in public facilities. The primary reasons for choosing private facilities include overstretched public health facilities and most of the registered laboratories (X-ray, ultrasound, MRI, and CT-scans) operate in the private sector.

4 Issues with Insaf Sehar Card (National Health Card) have been reported in the press, such as resistance in hospitals to accept the card and identification of eligible beneficiaries. In Punjab, 5 million families received a card, but only 93,000 (2 percent) benefited from the Sehat Sahulat Program. The program reportedly targeted 7.2 million families, but 2.2 million could not be traced or registered (The Express Tribune 2020). Most private hospitals do not accept the card to treat diseases covered under the Sehat Sahulat Program or use delaying tactics (such as, waiting lists) to discourage patients. Both private and public hospitals (in Bahore) continue refusing treatment for patients under the Sehat Sahulat Program, while the government makes claims about its success (Dawn 2022).

5 KP stopped participating in 2016.

6 *The Companies Act* (2017) regulates how not-for-profit associations with charity activities are established.

7 Services include treatment/curative health services, emergency, outdoor/indoor, 24/7 services, mobile health services, community health education, health services at your doorstep, diagnostics, lab tests, radiology, X-ray and ultrasound, medicines, preventive healthcare, Tuberculosis dot, awareness and health education, nutrition advisory, public health-related education and advocacy; electronic medical record (EMR), and referral. The list may vary from province to province. (https://pphisindh.org/home/, https://pphib.org/pphi-b/). Contracted-out facilities comprise: dispensaries, Basic Health Units, Rural Health Centers, filter clinics, 24/7 health facilities, Maternal and Child Health Centers, mobile health units, Unani Tibi dispensaries, medical camps, community outreach activities (https://pphisindh.org/home/, https://pphib.org/pphi-b/).

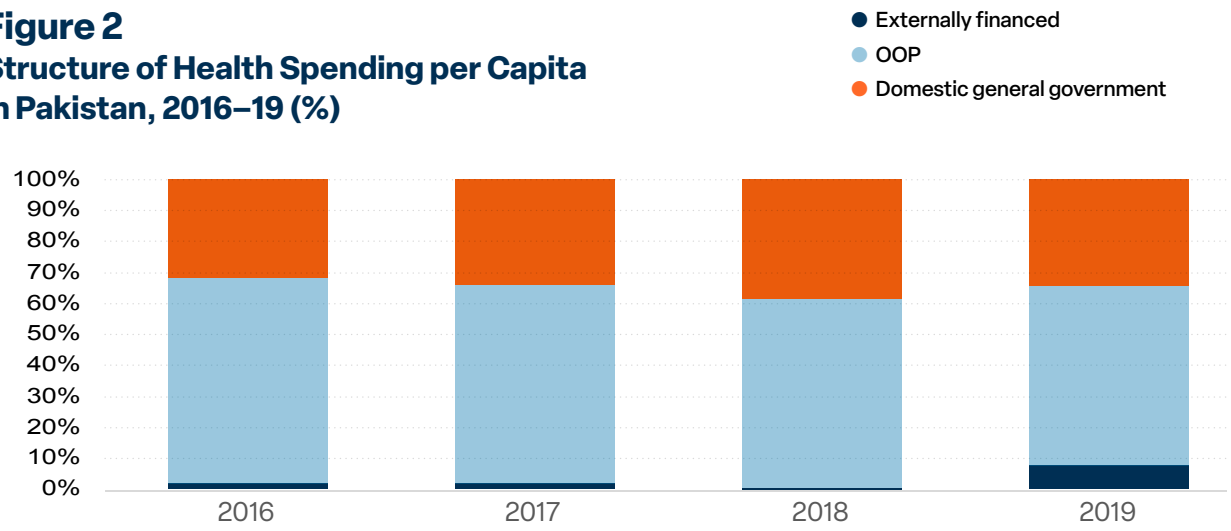
8 PPHI Sindh and Baluchistan, Sindh and Baluchistan Health Departments; Punjab Health Facilities Management Company (PHFMC) audited annual financial statements 2020-21.

9 Zaidi, S. 2022. Re-Imagining Public Private Partnerships for Better Health Coverage. Lahore: Consortium for Development Policy Research.

10 Figures were updated in the 2021/22 National Health Accounts but were unavailable at the time of writing.

11 Pakistan Bureau of Statistics. 2021. National Health Accounts 2017-18, p. 77. Islamabad: Government of Pakistan.

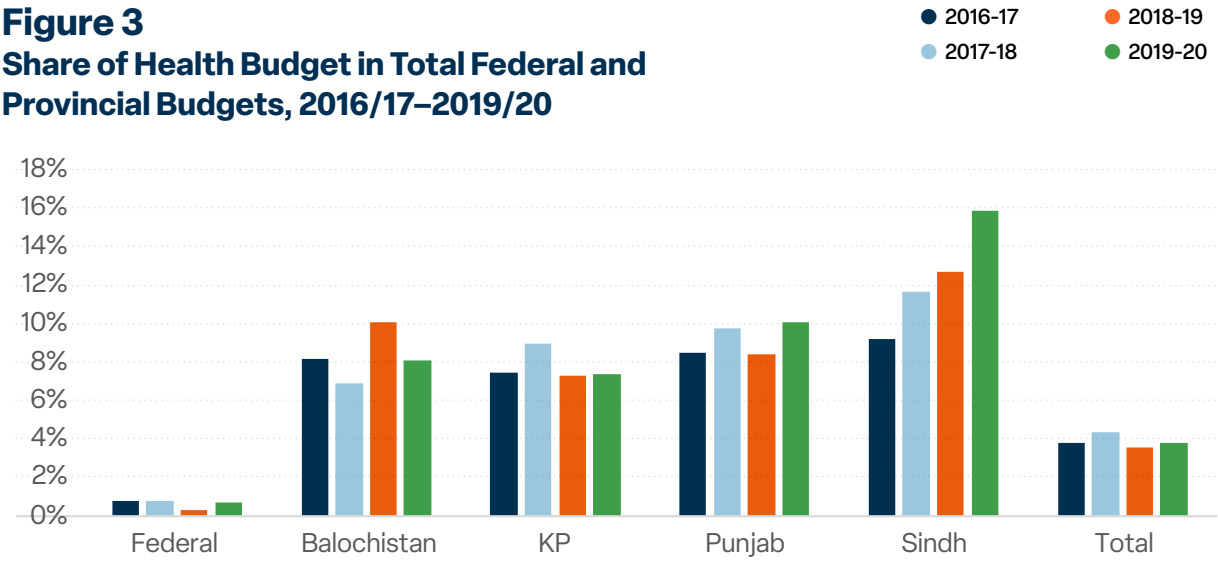
Figure 2
Structure of Health Spending per Capita in Pakistan, 2016–19 (%)



Source: World Bank 2025, based on World Bank data (data.worldbank.org/) and WHO Global Health expenditure database (apps.who.int/nha/database).

The total health budget allocation averaged 4 percent of the combined federal and provincial budgets (see Figure 3).[12] Provincial health budget allocations vary, and Punjab and Sindh Provinces exhibited the largest increase in share over the period. In Balochistan and KP Provinces, the share allocated in 2019/20 was less than the share in 2016/17.

Figure 3
Share of Health Budget in Total Federal and Provincial Budgets, 2016/17–2019/20



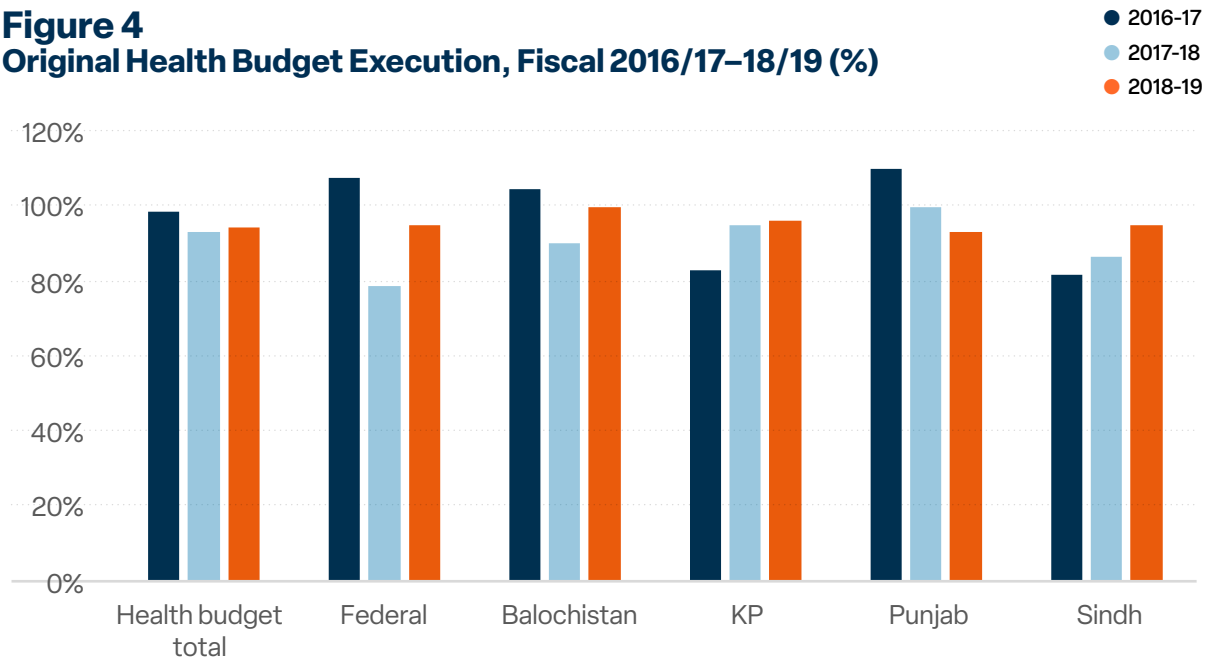
Source: Finance Division Annual Budget Statements 2016/17–2019/20.

12 Data were not available for the special regions of Kashmir and Gilgit Baltistan. Furthermore, the absence of reliable data prevented the inclusion of the Army Health Budget in the total health budget.

2.0 BUDGET EXECUTION IN HEALTH

In Pakistan, health budget execution rates averaged 95 percent for the original health budget and 104 percent for the revised budget estimates in the annual budget statement (see Figure 4).[13] However, there are significant variations across years and across provinces. Punjab Province averaged 100 percent budget execution but had the most variation year to year, while Sindh had the lowest execution rate among provinces.

Figure 4
Original Health Budget Execution, Fiscal 2016/17–18/19 (%)

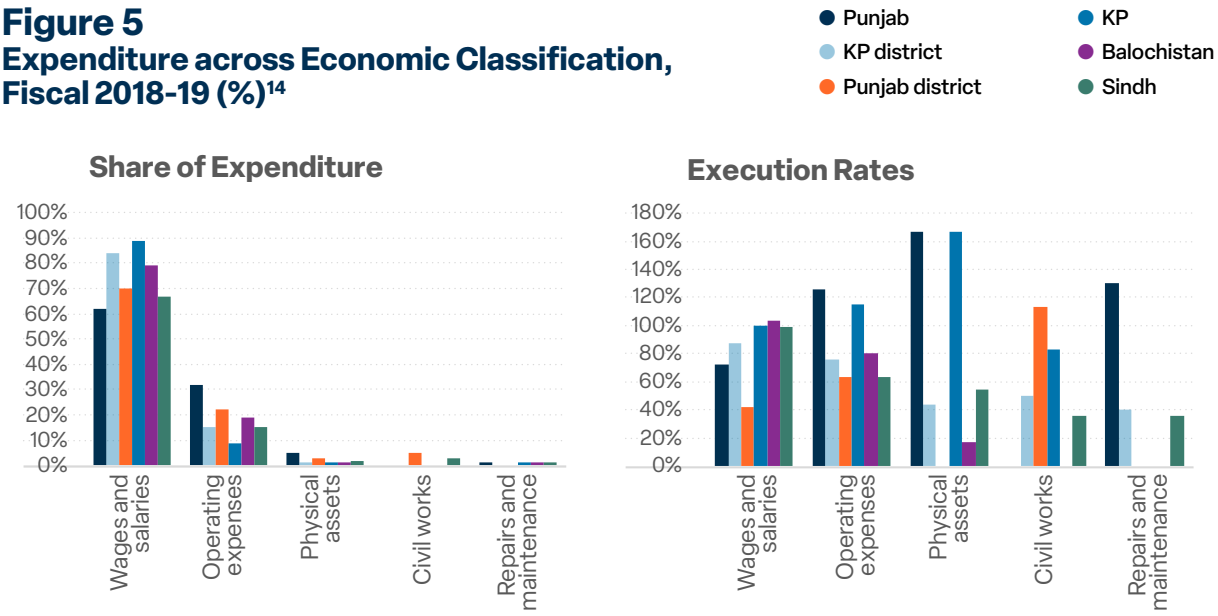


Source: Financial and Budgeting System 2016/17–2018/19.

Wages and salaries were the highest spending category, averaging 70 percent of expenditure at the provincial level; however, execution across provinces varied significantly (see Figure 5). KP and Punjab executed only 42 and 72 percent, respectively, of their wage bill, while Balochistan and Sindh had near perfect execution rates, 103 and 99 percent, respectively. The second largest budget line was operating expenses, which had even more execution variation. Very little was spent on physical assets, civil works, and repairs and maintenance, which collectively had volatile execution rates.

13 Financial and Budgeting System (FABS) is a Government Integrated Financial Management Information System (IFMIS) owned and operated by the Controller General of Accounts.

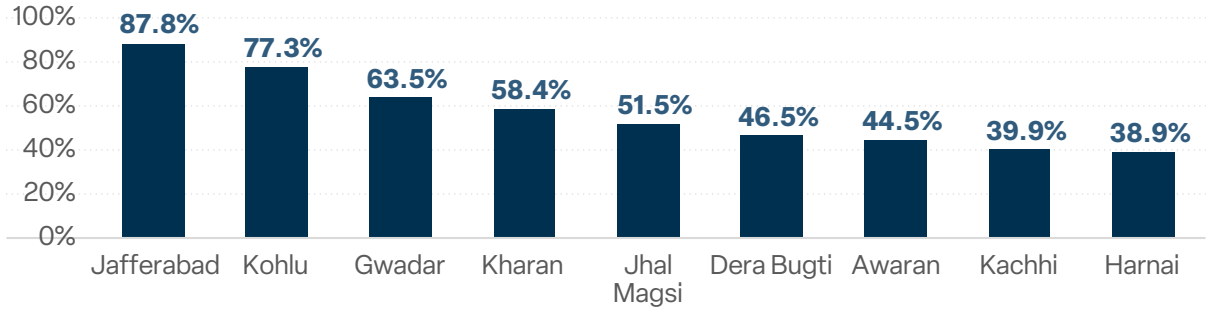
Figure 5
Expenditure across Economic Classification, Fiscal 2018-19 (%)[14]



Source: Financial and Budgeting System 2018/19.

Health facility budget execution rates vary significantly. From a random sample of nine hospitals in Balochistan Province, the average budget execution rate was only 56.5 percent (see Figure 6). At a lower level of care, by contrast, a random sample of a Basic Health Unit and a Regional Health Center in Punjab Province found high execution rates at the aggregate level (101 and 144 percent, respectively). For these two facilities, wages and salaries were over-executed; while drugs, operating expenses, repairs, and maintenance were all significantly under-executed. An in-depth investigation is needed to fully understand the underlying causes.

Figure 6
District Headquarter Hospital Budget Execution Levels, 2016



Source: Financial and Budgeting System Balochistan 2016.

14 Data are limited to fiscal 2018-19, including for Punjab and KP Districts, which are available in the Financial and Budgeting System.

3.0 PUBLIC FINANCIAL MANAGEMENT CONTROLS FOR HEALTH SPENDING

Pakistan has a unified public financial management (PFM) system[15] at all three levels of government (federal, provincial, and district). The PFM is structured as follows:[16]

- The Controller General of Accounts (CGA) is the premier accounting office of the government and produces financial statements for the federation.
- Accountant Generals (AGs), one for each province, operate under the authority of the Controller General of Accounts. Accountant Generals prepare and submit the annual provincial statements to the Controller General of Accounts.
- District Accounts Officers (DAOs) work under the authority of the Provincial Accountant General. District Accounts Officers are responsible for all accounting operations at the district level. They pre-audit bills, make payments (including salaries and pensions), and keep records of payments/receipts for federal and provincial transactions (in separate ledgers).
- Drawing and Disbursing Officers (DDOs), also called "cost centers," approve local spending. They are the lowest organizational level where budget control happens. All service delivery units, such as schools and health facilities, have their own Drawing and Disbursing Officer; however, depending upon the facility size, several facilities may be assigned to one Drawing and Disbursing Officer (as is the case of the Basic Health Units).

Tertiary hospitals are the only healthcare delivery unit with autonomy over their operating expenses. Primary Healthcare Centers (PHC) do not manage their budgets, are completely absent from the budgeting process (planning, allocation, and execution), and depend entirely on the District Health Office (DHO) for decision-making. Primary healthcare centers must submit requests and bills to the District Account Officer (DAO) for payment, which significantly affects the day-to-day management. (Basic Health Unit must submit requests and bills first to the District Health Office for approval, then to the District Account Officer for payment.) Tertiary care hospitals and large District Headquarter Hospitals can procure their own medicines.

Payroll is generally documented and checked against data from the previous

15 Directives are outlined in the System of Financial Control and Budgeting (Finance Division, 2006), the Public Financial Management Act (2019, Chapter IV, Art. 21-29), and the General Financial Rules (Finance Division, 2018). These are synthesized in the Budget Manual (Finance Division, 2020a). Procurement is regulated in the Public Procurement Rules (2004). If most documents are relevant for federal government, each province has (similar) own budget laws, Public Financial Management laws, and procurement rules. The Accounting Policies and Procedures Manual (1999) sets out detailed policies and procedures in accounting for public financial transactions and is applicable all over the country.

16 Main source: Fundamentals of Public Financial Management, A Training Handbook for Officials of the Sindh Government (2019).

month. Staff hiring requires budget availability. Changes in personnel records and payroll are clearly defined in the General Financial Rules (2018) and the *Accounting Policies and Procedures Manual* (1999, APPM): procedures for paying salaries and wages (pp. 4.37-4.46). Payments are transferred to employee bank accounts as per the pre-defined schedules and protocols. Provincial Public Expenditure and Financial Accountability undertaken from 2017 to 2020 found a strong integration of the payroll and personnel records in KP, Punjab, and Sindh Provinces. However, in Balochistan, manually kept staff files were not reconciled on a regular basis with the payroll system.

Non-wage expenditure controls involve several measures: expenditure sanction (as defined in the rules on the delegation of financial powers), administrative and technical approvals for works-related expenditure, fulfilment of responsibilities related to accounts maintenance, regular reconciliation of expenditure, and compliance with the different levels of controls on the Financial and Budgeting System. However, there are inefficiencies due to the controls applied to all transactions irrespective of value. For example, the APPM lists nine distinct controls for pre/post-audit and payment certification. Consequently, a bill of PRs 200 undergoes the same level of scrutiny as a bill of PRs millions and requires duplicate internal controls of six different officers in two different entities. The process is bureaucratic and requires supporting documents and multiple approvals.

Provinces procure drugs, vaccines, and health supplies centrally through the Procurement Committee at the Office of Health Secretary via a pooled procurement process, and these are distributed to PHC units via the DHO. Pooled procurement allows economies of scale and decision-making transparency. However, audit findings noted issues when procurement was conducted at the DHO level, including:

- Payment made to the Drawing and Disbursing Officers instead of directly to the vendor
- Cash withdrawn from the Drawing and Disbursing Officers account instead of issuing a crossed cheque to the supplier
- Non-transparent tendering for the purchase of medicine
- Irregular purchase of medicine, such as purchasing at rates higher than market rates, misreporting in stock registers, and purchasing medicine with a short shelf life
- Non-utilization of assets procured, such as ultrasound machines, in health facilities (RHCs, DHQs)
- Not maintaining proper books of accounts and non-availability of records.

The current Chart of Accounts is not aligned with healthcare services. There is no expenditure classification by level of healthcare, so it is not possible to track budget allocation or execution for primary, secondary, and tertiary healthcare through the Financial and Budgeting System. This also complicates the rollout of performance-based budgeting (which was mandated by the 2019 Public Financial Management Act but requires a modification of the Chart of Accounts to become practical).

Despite the decentralization reforms, the integration of federally supported vertical programs[17] into local health systems remains limited and faces challenges. These challenges include:[18]

- Vertical programs that operate in parallel and rely on different structures that cause duplication[19]
- Lack of coordination and disagreement on the new modus operandi between the federation and the provinces
- Outstanding public financial management concerns on future procurement, payment arrangements, and the availability of funds.

Arrears cannot be calculated separately, because there is no accrual accounting and no systemic way to calculate budget arrears for line departments. There is evidence of the accumulation of arrears, particularly for obligations like pensions and unpaid contractor invoices. However, none of the provinces have a system in place to monitor and record the stock of arrears. There is no operational commitment accounting in place.

17 The public health sector provides preventive healthcare services through vertical programs such as the Expanded Program on Immunization (EPI), the TB Control Program, the National Program for Family Planning and Primary Healthcare, the AIDS Control Program, the Malaria Control Program, the Nutrition Program, and the Reproductive Health Program. Fiscal decentralization significantly changed their modus operandi. Previously top-down financed, they are now the financial and institutional responsibility of the provinces.

18 Implementing PFM Reform for UHC in a Decentralized Service Delivery System: Lessons from the Pakistan National Immunization Support Program, 2021. https://documents1.worldbank.org/curated/en/099744306132234962/pdf/IDU049440c8b03be30429a0b46e0d6b552a4cfc5.pdf

19 In Punjab, PPHI tried to integrate vertical programs into their primary healthcare, but this did not happen systematically or on a large scale.

4.0 GOOD PRACTICES AND BOTTLENECKS

The overall national health budget was executed at an average of 95 percent over the period of analysis. However, the execution rates between provinces as well as between categories of spending varied significantly.

At the health facility level, execution of spending is notably challenging, particularly for non-wage expenditure. Table 2 provides a summary of key good practices and bottlenecks for executing health spending in Pakistan.

Table 2: Summary of Budget Execution Good Practices and Bottlenecks in Pakistan

Issue	Explanation
Good Practices	
Payroll	In most provinces, there is strong integration of payroll and personnel records.
Contracting out of health services to the private sector	Baluchistan, Punjab, and Sindh Provinces have contracted out the provision of many primary healthcare services to the private sector. This has facilitated more consistent budget execution rates as well as evidence of resources reaching the facility level. Ensuring accountability for resource use, however, remains a challenge.
Bottlenecks	
Inability to track primary, secondary, and tertiary healthcare budgets and their execution	The Chart of Accounts is not aligned with the care levels of the health system (i.e., primary, secondary, and tertiary healthcare) or the activities and programs within the sector more broadly. This makes it difficult to track budget allocations and their execution and to link spending to service delivery.

...table continued next page

Table 2: Summary of Budget Execution Good Practices and Bottlenecks in Pakistan

Issue	Explanation
Over-estimation of resource availability	The provinces systematically over-estimate their budget resources.
Weaknesses in budget preparation processes	Budget estimates are generally not based on costing studies, mean-ing allocations are often not aligned with needs. PHC facilities also generally are not involved in determining their budget allocations, contributing to a misalignment between needs and allocations. PHC budget allocations are also not based on the type, size, and catchment area (local demography) of the health facility. Rather, they are generated from historic allocation decisions.
Inefficient spending control processes	Expenditure commitment controls are not always followed. Excessive controls for operational expenses and inefficiencies prevail and are applied to all transactions irrespective of the value. For example, a bill of PRs 200 undergoes the same level of scrutiny as a bill of PRs millions and involves duplicate internal controls of six different offic-ers in two different entities.
Lack of autonomy for pri-mary healthcare centers	Primary healthcare facilities are entirely dependent on District Health Offices for their spending (with the exception of facilities managed through the contracting-out mechanism in Baluchistan, Punjab, and Sindh). District Health Offices can ignore, delay, or only partially pay spending requests. Reportedly, facilities are routinely unable to carry out core activities, including paying utility bills and carrying out basic repairs or maintenance, among other.

...table continued next page

Table 2: Summary of Budget Execution Good Practices and Bottlenecks in Pakistan

Issue	Explanation
Vertical programs are insufficiently integrated in the local health system	The recent decentralization of vertical programs, particularly those focused on preventive care (e.g., immunization, tuberculosis, and AIDS) from top-down federal management to the provinces contin-ues to face challenges, including incomplete integration of federally supported vertical programs into local health systems. There are also duplication and gaps in planning and oversight roles, which affect budget planning and execution processes.
Arrears cannot be tracked	There are no means to capture arrears in the Financial and Budgeting System (the Integrated Financial Management System).

Possible Solutions

- Revise the Chart of Accounts to allow expenditure tracking at the service delivery level
- Provide budget and spending autonomy to service delivery units
- Cost health services
- Devise a payment mechanism for the service providers
- Strengthen the accountability mechanism by introducing results-based financing.

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BUDGET EXECUTION IN HEALTH: FROM BOTTLENECKS TO SOLUTIONS

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CASE STUDY SERIES

SOLOMON ISLANDS

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Health, Nutrition and Population (HNP) Discussion Paper

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ABSTRACT:

Health spending in the Solomon Islands is primarily funded by the government and with external budget support, with minimal contributions from the private sector and household out-of-pocket expenses. The government consistently executes nearly 100 percent of its domestically funded recurrent budget, largely due to the non-discretionary nature of expenditures. However, while overall execution remains high, certain budget line items experience low utilization. Additionally, capital spending and donor-funded projects often face significant inconsistencies in budget execution.

Effective health budget execution relies on best practices, including strengthening annual operational plans and budgets, submitting requisitions promptly and timely processing of activities, timely accessing financial reports, and transitioning to a cloud-based financial management information system (FMIS). However, key challenges hinder efficient budget execution. These include inadequate planning coordination, unrealistic cost estimations, misalignment between capital spending and project timelines, contractor delays, a short annual budget cycle, lengthy compliance processes for donor funding, limited human resources capacity to manage large donor-funded programs, and discrepancies between FMIS systems used at the central and provincial levels.

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Budget execution in health: from bottlenecks to solutions

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This interactive document has been optimised for use on computers and tablets in portrait orientation.

Click on this square to return to the contents page

SECTION NAME

Click on this section to return to the beginning of the section

SOLOMON ISLANDS **CONTENTS**

LIST OF FIGURES

LIST OF TABLES

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This study was authored by the Solomon Islands World Bank health team, including Michael Mike (Health Finance Consultant, Lead), Wayne Jeremy Irava (Health Specialist), Maude Ruest (Consultant), and Richie Rummery (Consultant). It follows a case study protocol developed by Hélène Barroy (Senior Health Finance Specialist, WHO), Moritz Piatti-Fünfkirchen (Senior Economist, World Bank), and Amna Silim (Senior Consultant). Quality assurance was provided by Hamish Colquhoun (Senior Consultant) and Moritz Piatti-Fünfkirchen (Senior Economist). Technical editing and communication support was provided by Zac Mills (Senior Consultant), Hamish Colquhoun (Senior Consultant), and Alexandra Michele Beith (Senior Consultant). The study benefitted from management oversight by Agnès Couffinhal (Global Program Lead for Health Financing) and Monique Vledder (Practice Manager, HNP). It was made possible through generous financial support from the Global Financing Facility (GFF).

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1.0 HEALTH FINANCING CONTEXT

The Solomon Islands government plays key roles in the health sector, as a funder, regulator, and provider of nearly all health services. Health services are funded, managed, and delivered by the Ministry of Health and Medical Services (MHMS). The MHMS also allocates resources (such as funding, staff, and supplies) to its provincial health services, which are part of the MHMS rather than the provincial governments, to deliver health services in the provinces on behalf of the MHMS.[1] Most health facilities are government-owned, with a few operated by churches. However, church-owned facilities receive annual budget allocations, human resources, medical supplies, and capital investments from the government. There are privately owned outpatient facilities, but these are mainly found in urban areas. There is no social health insurance or separate agency for buying healthcare services.

There are 34 divisions under the MHMS:

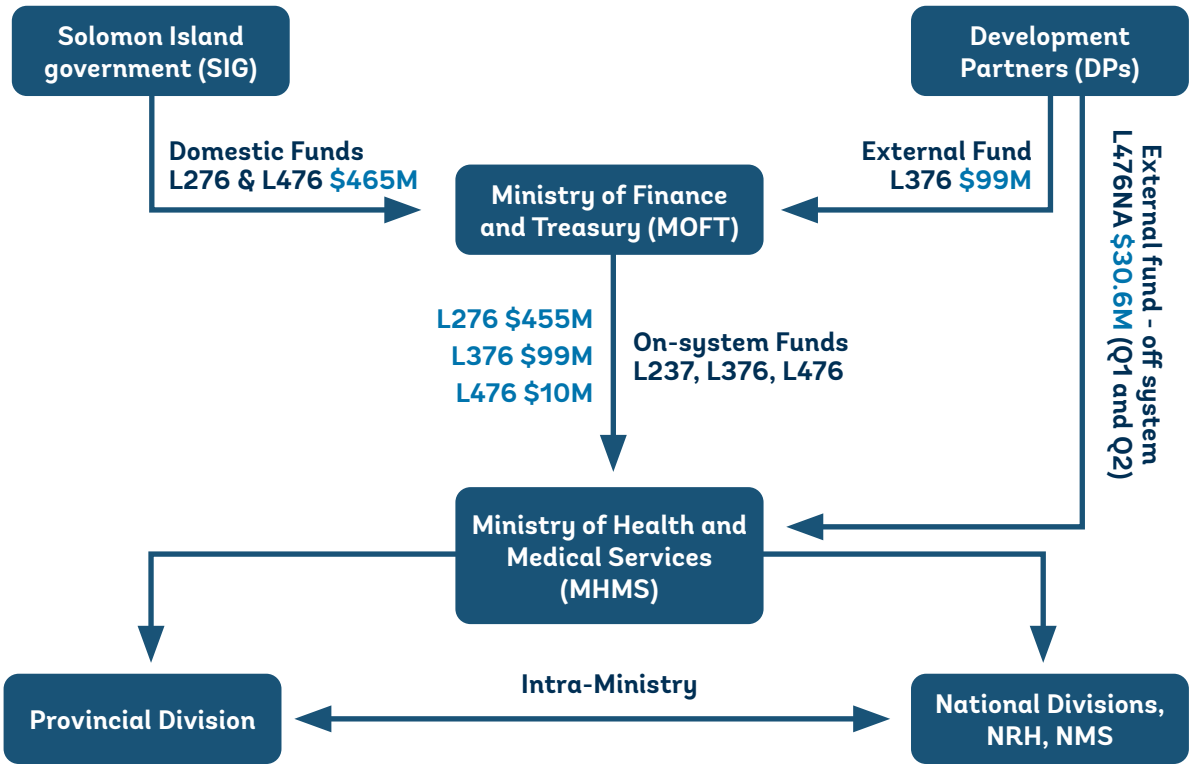
- Ten (10) Provincial Health Services authority manage the provincial hospitals and are responsible for all service implementation through the network of all public health facilities, including more than 300 lower level health facilities.
- Four (4) Corporate Services Units support all administrative roles, recruitment, and training for the National Divisions and Provincial **Health Services.**
- Eighteen (18) National Programs are related to public health or health services (such as, the National Vector Borne Disease Control Program or the National Dental Program).
- One (1) National Referral Hospital is the tertiary care or end point of the health system and offers all specialized services (such as, orthopedics, surgery, eyecare).
- One (1) National Medical Store procures, manages, and distributes all drugs and medical supplies for the Ministry of Health and Medical Services and its divisions.

The main health financing arrangement is a budgetary allocation from the Ministry of Finance and Treasury (MoFT) to the Ministry of Health and Medical Services. The MHMS budget follows the general Solomon Islands government budget format and is divided into the recurrent (which includes both payroll and other recurrent charges) and the development budgets (see Figure 1). The recurrent budget is fully appropriated,[2]

1 From time to time, provincial governments may spend on health by funding infrastructure, funding human resources, or providing funding for goods such as outboard motors for patient transfers. While consultation with the MHMS has not always been the norm, these ad-hoc investments in health are increasingly discussed with the provincial health office and the MHMS. (However, they are not currently recorded as health expenditure by the Solomon Islands government).

2 Appropriation is an authorization from the Parliament to the Executive arm of government to spend up to a limit, for a purpose, and within a period (the authority to spend lapses at the end of that period regardless of whether the funds have been spent or not). The non-appropriated budget identifies funds that are spent outside the Consolidated Fund on behalf of the government (for example, cash that does not come under the direct control of the government, largely from development partners and the private sector). The non-appropriated budget is recorded for sectoral information purposes under the development budget.

Figure 1
Solomon Islands Health Funding Flows, 2020



Source: World Bank 2025.

Note: A new Solomon Islands government (SIG) central financial management information system superseded the ledger codes in 2022. L276–SIG recurrent budget; L376–Development Partners recurrent budget; L476–SIG development budget; L476NA–Development Partners non-appropriated development budget; 576–Health Lifestyle Promotion Fund.

whereas the development budget has both an appropriated and a non-appropriated (NA)[3] side, which serves to track the contributions from development partners.

Healthcare expenditure in the Solomon Islands is largely public with a high reliance on external financing (22 percent of health expenditure in 2019 according to global data[4] or 20 percent according to national data[5]). The private sector plays a very minimal role within the health sector, with limited private practice in Honiara City Council (HCC) and in some of the hospitals. Non-governmental organizations do not provide substantive clinical services in the country and have had relatively limited engagement and integration with the MHMS. However, they do provide very limited and

3 The NA is not official coding, but it commonly is used to differentiate between the two 476 ledgers.

4 WHO Global Health Expenditure Database. https://apps.who.int/nha/database/Home/Index/en

5 This difference between global and national data highlights the ongoing challenge with recording in-kind contributions from development partners.

targeted public health services to provincial areas. Faith Based Organizations are also involved in the administration of four provincial hospitals, but with heavy reliance on government funds for operational and human resources.

Out-of-pocket payments are very small in the Solomon Islands, averaging 2 percent of health expenditure between 2015 and 2018.[6] **The fees are kept by the facility. A World Bank-led health facility costing exercise**[7] **(based on 2013 data) found the following:**

- The legislation allows for the collection of patients' contributions at any amount only at hospitals; however, the patient exit survey revealed contributions were collected at all facility levels except at the National Referral Hospital.
- Across all facility types, 35 percent of respondents to the patient exit survey reported they were asked to make a financial contribution and 37 percent of these reported that they made such a contribution.[8] The average contribution to see a health worker was SBD 3.35 (USD 0.40), significantly lower than the average cost of SBD 29 (USD 3.5) for transport to the health facility.

6 Source: Global Health Expenditure database. Unfortunately, more recent data are not available.

7 https://documents1.worldbank.org/curated/en/694001467998461830/pdf/101158-WP-P130475-PUBLIC-Box393259B-HFCS-Final-Report-August-2015-final.pdf.

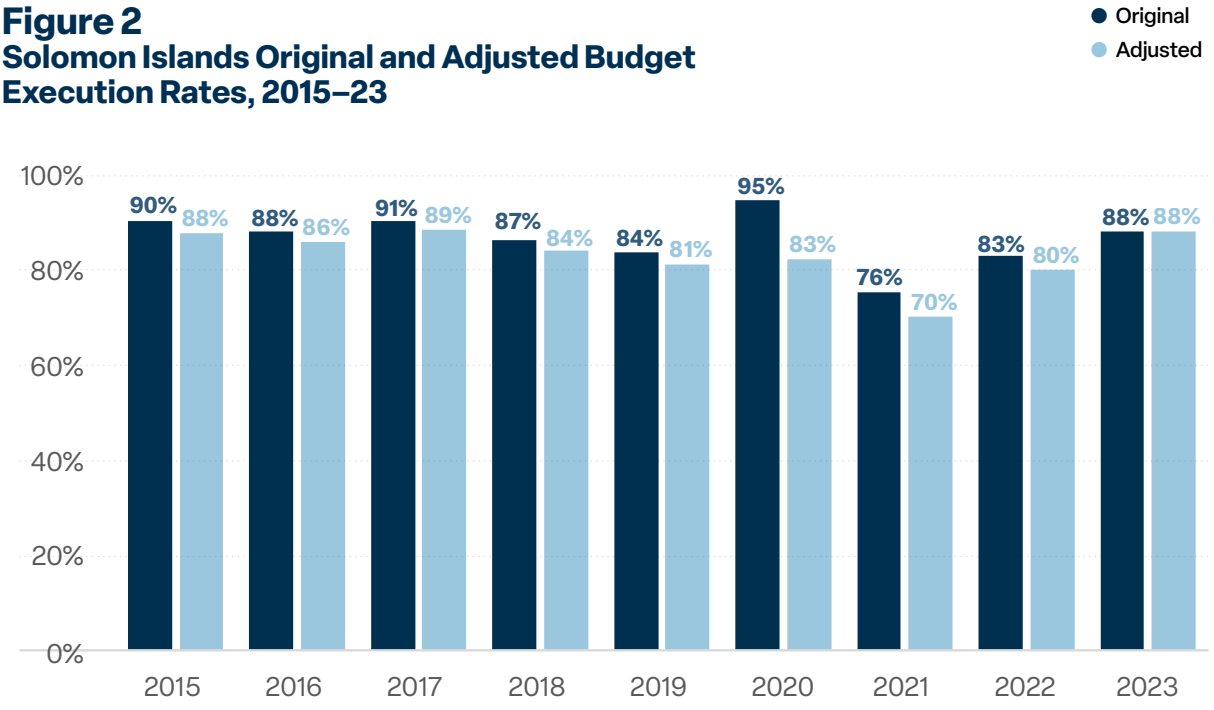
8 Facilities reported collecting contributions for outpatient services (55 percent of hospitals and 70 percent of lower level health facilities), inpatient services (36 percent of hospitals and 32 percent of lower level health facilities), and deliveries (27 percent of hospitals and 32 percent of lower level health facilities). A smaller number of hospitals collected contributions for immunization services and diagnostic tests. All hospitals and over 50 percent of lower level health facilities collected contributions for medical record books, mother's books, and baby's books, and a smaller proportion also charged for family planning books, antenatal cards, and sick leave requests. Of the facilities that did collect contributions for services or books, the average amount was higher at hospitals than at lower level health facilities, except for medical records, mother's books, and baby's books.

2.0 BUDGET EXECUTION IN HEALTH

The Ministry of Health and Medical Services tends to spend above 80 percent of its total health budget (see Figure 2).[9] Interestingly, the original budget has a higher execution rate than the adjusted budget.[10] Between 2015 and 2022, the original budget was always higher than the adjusted budget. This was the result of significant mid-year funding for adjusted budgets and short timelines for dispersing funds and implementing planned activities.

For example, in 2020, mid-year adjustment provided new funds for Covid-19 preparedness and response of SBD 32.8 million under general disaster relief and SBD 6.2 million for maintenance of facilities provided by the government to the MHMS through budget supplementary, however the ability to quickly implement the funds was limited due to lengthy process, timing of the funds, and poor absorption capacity within the Ministry of Health.

Figure 2
Solomon Islands Original and Adjusted Budget Execution Rates, 2015–23



Source: World Bank 2025, based on World Bank Health Budget and Expenditure Trend Analysis and Solomon Islands Ministry of Health and Medical Services Annual Report 2017.

9 Annex 1 contains a table with the raw data.

10 The original budget is the recurrent and development budget as appropriated by Parliament, usually at the end of each calendar (which is also the budget) year (November/December). The revised budget is the adjusted original budget with additions or reductions to the original budget (such as, SIG supplementary budget, donor funds, advance warrants, and virements). The revised budget is listed in the Budget Estimates Books published each year by the MoFT.

Execution rates vary significantly between the domestic and external recurrent budgets (L276 and L376) (see Figure 3). The SIG recurrent budget (L276) consistently achieves near-full execution, primarily because a significant portion is allocated to payroll and other non-discretionary expenditures.[11] The MHMS & Ministry of Finance and Treasury (MoFT) has processed these essential expenditures in a relatively timely manner, ensuring their effective utilization. The payroll component of the L276 is processed outside of the MHMS and because of the legal commitment related to executing payroll spending, expenditures are not restricted to the commitment process and are paid by the MoFT automatically whether the budget is appropriated or not.[12] Despite that, in 2019, 2021 and 2022 fall below 90 percent was due mass resignation of nurses that impact payroll budget and slow implementation due to introduction of COVID-19 pandemic. On the other hand, external recurrent budget support (L376) has consistently been poorly executed compared to domestic funding (L276). This is largely because most commitments in the original budget become available mid-year as they follow donors' calendar-year funding cycles. Moreover, our recent study revealed that both programs and development partners tend to allocate unrealistic budgets at the appropriation stage, which often do not align with the actual cash available for implementation. Additionally, the limited absorption capacity poses a challenge, as many partner funds are earmarked for specific program activities, requiring lengthy processes. The combined administrative requirements from both development partners and the Solomon Islands Government (SIG) further delay the timely processing and implementation of these funds.

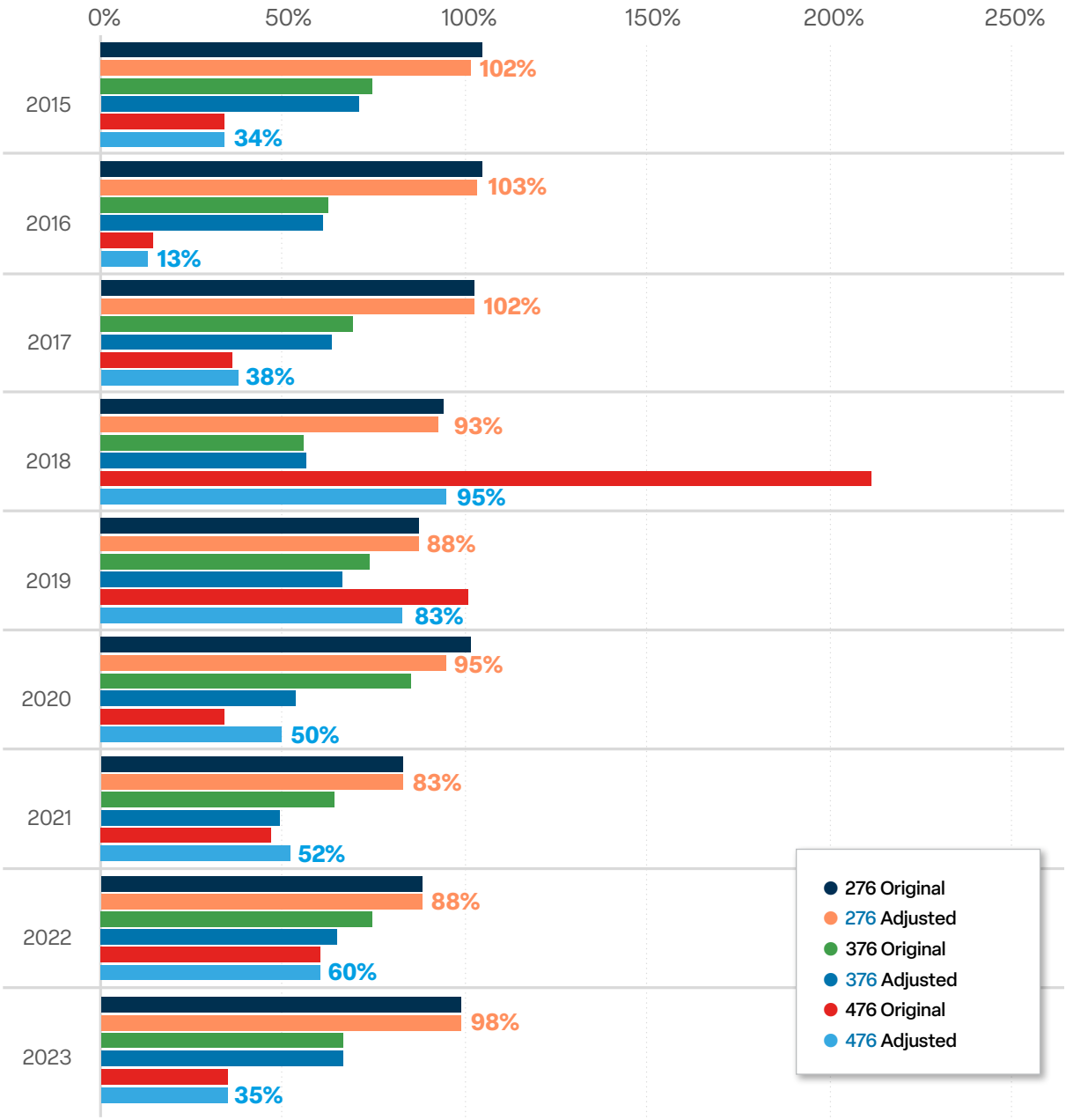
The development budget (L476) remains poorly executed. The development budget has faced persistent challenges over the years, primarily due to the capital-intensive nature of expenditures. While the average execution rate for the original budget stands at 64 percent, the adjusted budget sees a lower execution rate of 51 percent. In 2018, an execution rate of 211 percent was recorded due to accounting errors. Low execution rates are largely attributed to slow project implementation, as payments are milestone-based, meaning delays caused by contractors directly impact budget execution. Additionally, limited capacity within the MHMS to manage procurement processes and enforce contractor obligations further contributes to underperformance. A key structural issue is the misalignment between project timelines and the financial year. The L476 budget follows an annual appropriation cycle, whereas many projects span multiple years. Other critical factors affecting budget execution include cash availability constraints and lengthy compliance processes.

Across the MHMS divisions, execution rates vary significantly (see Table 1), though DP recurrent budgets (L376) and (L476) are consistently executed at a lower rate than the

11 Non-discretionary because the MHMS would stop functioning if invoices in these categories went unpaid (as opposed, for example, to other expenditures such as training). Examples include grants to the Provincial Health Services, drugs and medical supplies, housing rent, utilities, and annual leave, among other.

12 The Ministry of Public Service must approve all positions for all ministries, and it works with the Ministry of Finance and Treasury to determine the budget based on how many staff need to be paid in any given year.

Figure 3
Solomon Islands Original and Adjusted Budget Execution Rates By Ledgers, 2015–23



Source: World Bank 2025, based on World Bank Health Budget and Expenditure Trend Analysis and Solomon Islands Ministry of Health and Medical Services Annual Report 2017.

Note: A new Solomon Islands government (SIG) central financial management information system superseded the ledger codes in 2022. L276–SIG recurrent budget; L376–Development Partners recurrent budget; L476–SIG development budget; L476NA–Development Partners non-appropriated development budget; 576–Health Lifestyle Promotion Fund.

recurrent budget (L276). The execution rate across divisions is categorized into five groups:

- Corporate Services Units
- National Health Programs
- Provincial Health Services
- National Referral Hospital
- National Medical Store

Among these, only the Corporate Services Unit manages ledger L476. This means the Policy and Planning Unit, which operates within the Corporate Services Unit, oversees all capital projects for the MHMS.

L476 faced challenges in achieving full execution because, although budget allocations are earmarked annually, project timelines often span years. As a result, only a portion of the total L476 budget is utilized each year. In contrast, the execution rate for L276 remains high across all divisions, primarily due to the non-discretionary nature of expenditures.13 The execution rate for L376 remained consistently low across most divisions, except for the Provincial Health Services (PHS), which reported higher execution of external budget support. Low execution of external financing in the Corporate Services Unit, the National Health Programs, and the National Medical Store was primarily due to delays in cash availability and limited capacity within divisions to meet compliance requirements and process external financing before disbursement. Unlike national divisions, where spending approvals and compliance processes must go through the Ministry of Finance and Treasury, the PHS has greater flexibility. Spending approvals and compliance for the PHS are managed at the provincial level by health directors. Additionally, execution rates are based on disbursements recorded in the central financial management information system, rather than actual expenditures reported in provincial financial records. The PHS budget did not have major adjustments in the revised budget, as both the original and revised budget execution rates were identical. The National Referral Hospital is largely funded under L276, with some smaller support from L376.14 From 2015 to 2017, the National Referral Hospital overspent its L276 budget (mostly due to overspending of payroll and salaries); however, from 2018 to 2020, the L276 budget execution rate averaged 93 percent. The MNMS had weaknesses in budget execution in 2016 and 2018 but improved to 100 percent in 2020.

Payroll and salaries[15] for public servants are only paid through L276 budget and have exhibited significant variation in their execution (see Table 2). The public service payroll is funded under L276, with the payroll budget increasing annually in nominal terms. Between 2015–17 and 2022–23, the MHMS overspent its payroll budget, primarily due to a sharp rise in allowances. If left unchecked, this trend will become unsustainable, highlighting the need for stronger controls on allowance expenditures. From 2018, payroll and

13 The 2020 original budget execution of 139 percent was largely due to significant additional budget and expenditure throughout the year for Covid-19 preparedness and response, including SBD 30.5 million for disaster relief.

14 It should be noted that while the National Referral Hospital budget falls under the MHMS, responsibility for allocation, implementation, and oversight lie with the National Referral Hospital executive, the chief executive officer of which is directly appointed by the government.

15 Payroll and salary expenses are a mix of wages, allowances, and superannuation expenses.

Table 1: Solomon Islands Budget Execution Rates by Ministry of Health and Medical Services Divisions and Categories, 2016, 2018, 2020

Regrouped Divisions	Budget Ledger	Budget					
		2016		2018		2020	
		Original	Revised	Original	Revised	Original	Revised
Corporate Services Units	**SIG recurrent budget (L276)**	**97%**	**94%**	**92%**	**90%**	**130%**	**91%**
	DP recurrent budget (L376)	48%	46%	55%	54%	292%	39%
	SIG development budget (L476)	14%	13%	211%	95%	34%	50%
National Programs	SIG recurrent budget (L276)	107%	107%	102%	98%	91%	95%
	DP recurrent budget (L376)	46%	45%	41%	41%	52%	51%
Provincial Health Services	SIG recurrent budget (L276)	112%	112%	95%	95%	101%	101%
	DP recurrent budget (L376)	93%	93%	85%	85%	94%	94%
National Referral Hospital	SIG recurrent budget (L276)	112%	108%	99%	95%	87%	90%
	DP recurrent budget (L376)	n/a	n/a	47%	47%	0%	78%
National Medical Store	SIG recurrent budget (L276)	80%	80%	72%	74%	100%	100%
	DP recurrent budget (L376)	54%	54%	42%	47%	65%	65%

Source: World Bank 2025, based on World Bank Health Budget and Expenditure Trend Analysis and Solomon Islands Ministry of Health and Medical Services Annual Report 2017.

Note: n/a – There was no budget allocation that year.

Table 2: Solomon Islands Payroll and Salaries Budget Execution Rates, 2015–23

Year	Expenditure	Original Budget		Revised Budget	
	Amount (SBD)	Amount (SBD)	Execution Rate (%)	Amount (SBD)	Execution Rate (%)
2015	180,367,371	168,719,906	107%	168,773,756	107%
2016	201,369,301	172,713,298	117%	172,713,298	117%
2017	207,520,765	173,163,778	120%	173,163,778	120%
2018	222,066,398	226,425,877	98%	226,110,877	98%
2019	205,373,949	247,806,562	83%	248,132,562	83%
2020	254,618,443	256,771,744	99%	256,821,424	99%
2021	197,166,505	254,190,639	78%	254,189,981	78%
2022	289,328,743	278,026,459	104%	278,026,459	104%
2023	295,261,875	286,964,866	103%	286,964,866	103%

Source: World Bank 2025, based on World Bank Health Budget and Expenditure Trend Analysis and Solomon Islands Ministry of Health and Medical Services Annual Report 2017, SIG recurrent budget (L276).

salary budgets were adjusted to more realistic levels, keeping execution rates just below 100 percent. However, in 2019, the execution rate dropped to 83 percent (leaving SBD 42.7 million unspent). This was largely due to unfilled vacancies, significant reductions in allowances, and a mass resignation of nurses, many of whom left to join a nursing scheme in Vanuatu.

Drugs and dressings execution rates fluctuated under external financing, and domestic financing was low from 2016 to 2018 (see Table 3). The budget for drugs and dressings is funded through both external and domestic recurrent financing. Since 2019, external financing has been used exclusively for emergency procurement, leading to fluctuations in its execution over the years. The domestic recurrent budget generally maintains a high execution rate, except during 2016–2018, when internal procurement process changes within the MHMS led to disruptions, culminating in the 2018 drug stockout crisis. However, the high execution rate of domestic financing has led to drug and dressings procurement being driven by budget allocations rather than actual needs. This practice has resulted in the accumulation of outstanding bills for drugs and dressings over the years.

Table 3: Solomon Islands Drugs and Medical Supplies Revised Budget Execution Rates, 2015–23

Year	Budget Ledger	Revised Budget	Actual	Execution Rate
		SBD	SBD	%
2015	L276	23,230,801	22,521,853	97%
	L376	13,500,000	13,007,118	96%
2016	L276	29,700,000	22,879,830	77%
	L376	8,000,000	3,797,067	47%
2017	L276	28,327,690	20,476,727	72%
	L376	8,172,310	7,017,876	86%
2018	L276	30,221,486	21,046,771	70%
	L376	5,970,000	2,628,952	44%
2019	L276	39,290,000	38,982,312	99%
	L376	2,750,000	2,608,575	95%
2020	L276	35,275,000	35,275,000	100%
	L376	8,858,054	78,223	1%
2021	L276	27,353,781	26,041,759	95%
	L376	3,749,964	3,479,478	93%
2022	L276	31,000,000	31,623,257	102%
	L376	11,282,639	8,337,947	74%
2023	L276	30,992,582	30,917,253	100%
	L376	6,827,096	5,684,688	83%

Source: World Bank 2025, based on World Bank Health Budget and Expenditure Trend Analysis and Solomon Islands Ministry of Health and Medical Services Annual Report 2017.

Budget allocations to the provinces are by provincial health services and not by provincial hospitals and lower-level health facilities. Budgets and expenditures for provincial facilities are integrated within the Provincial Division budgets and expenditures. Lower level health facilities do not manage their own budgets but receive in-kind and petty cash from the provincial health division administration budget.

3.0 PUBLIC FINANCIAL MANAGEMENT CONTROLS FOR HEALTH SPENDING

SIG regulates all on-system public expenditure through the framework established under the Public Finance Management Act of 2014. Individual ministries are authorized to conduct procurements in-line with activities submitted annually to the MoFT as part of the government's budget and planning process. For the MHMS, procurement is conducted with a Ministry Tender Board that can approve the bidding documents and the contract award up to a certain threshold, beyond which the approval of the Central Tender Board must be sought. The MHMS raises the payment requisitions with supporting documentation and management authorization before submitting the paperwork to the MoFT (now is online with the new system in place), which in turn inputs the data into the SIG financial management information system,[16] verifies the budget allocation and authorization controls, and processes the payment.[17] Regardless of the source of funding, the internal controls remain similar. The only significant difference is that the payments raised under L376 require additional approval from partners. For the Provincial Health Services, procurement is governed by the same government Act and the procurement thresholds are the same as the national level. The only difference is that the Provincial Health directors authorized payments which do not require signoff from MHMS and MOFT.

As soon as L276 and L476 budgets are appropriated by Parliament, the MHMS can spend the funds. There are no quarterly spending limits, but due to the nature of MHMS's largest expenditure categories (such as payroll, housing rent, and grants transfers to the Provincial Health Services), spending is largely spread out evenly throughout the year. While MHMS is responsible for its budget execution, all transactions processed by the MHMS are submitted to the MoFT for final compliance and approval of spending. Budgets are appropriated by budget line items, and any move of funds between budget heads and new funds available must go through virement or advance warrant process and must have approval from the minister of Finance and the Cabinet under budget supplementary.

While the L376 budget is also appropriate, the MHMS must wait for funds to be available in the development partner bank account before they can start spending. Despite development partners theoretically being on on-system, there are ongoing complications and delays with accessing some development partner funds. External financing is planned on

16 This refers to old financial management information system; the government transitioned to a new financial management inform system as this report was finalizing.

17 As of 2022, the ministries are responsible for inputting data into the new SIG financial management information system.

Image © Australian Aid Photolibrary

an annual basis according to SIG annual budget process, but funds normally available mid-year due to difference in financial year. For example, SIG financial year ends December, while partners financial year ends June, this only leaves six months for implementation. Additional requirements such as delayed liquidation of funds transferred to the program impact next tranches of external funding to the programs.

More so, high staff turnover and limited absorption capacity within health programs further complicate the timely execution of available funds, thus has led to low and late activity implementation.

The presence of arrears remains an ongoing issue. Efforts to fully implement annual plans have been hindered by the accumulation of unpaid bills, which over the years have consumed a significant portion of the current year's budget. This has directly impacted on the effective execution of planned activities. Most of these outstanding bill's stem from specific budget line items, including drugs and dressings, utilities, freight, rations, and general store supplies. As a result, a portion of each year's budget is used to settle arrears, leaving current activities underfunded in the new financial year. In some cases, suppliers and vendors have suspended services to the MHMS until outstanding payments are cleared. A key limitation for the MHMS is that its annual budgetary allocation is beyond its control, meaning the budgetary allocation was prepared based on estimate from MoFT and not the budget needs estimated by MHMS. While the ministry continues to advocate for increased funding to meet its needs, the allocation ceiling is set by the MoFT based on historical spending patterns rather than the MHMS's actual estimated requirements.

4.0 GOOD PRACTICES AND BOTTLENECKS

The good practices and bottlenecks outlined in Table 4 should be analyzed in relation to their impact on budget execution—both in terms of improving expenditure efficiency and contributing to poor execution rates. When interpreting these factors, it is essential to consider how certain practices enhance budget execution, such as strengthening planning and financial management systems, timely requisition submissions, and improved reporting mechanisms. Conversely, bottlenecks such as delayed fund disbursement, procurement inefficiencies, and capacity constraints within health programs can lead to low execution rates, preventing timely implementation of planned activities.

Table 4: Summary of Budget Execution Good Practices and Bottlenecks in the Solomon Islands

Issue	Explanation
Good Practices	
Strengthening of the annual operational planning and budgeting (AOPB) process	Annually MHMS convenes the AOPB workshop, bringing together provincial health and national health division management, managers, and accountants. The event facilitates a comprehensive review of previous and current AOPB while setting the foundation for the new financial year. By enhancing collaborative planning and aligning resources with strategic outcomes, the workshop strengthens resource allocation and decision-making and ensures timely and effective delivery of health services.
Timely availability of financial report	Timely availability of financial report enables the Ministry Budget Committee to monitor and review all divisions' execution at the national level and put pressure on divisions or programs that are slow to implements their AOPB.
Timely submission of requisition	Some program managers timely submit the purchase requisition of their planned activities which results in timely availability of funds for spending.

...table continued next page

Table 4: Summary of Budget Execution Good Practices and Bottlenecks in the Solomon Islands

Issue	Explanation
Transition to cloud-based fi-nancial management information system (D365)	The SIG transitioned to a new cloud-based financial management information system (FMIS) "D365" in mid-2022. This improved the processing of transactions and reduced the heavy paperwork required in the old system. The FMIS has individual accounting codes for all donors unlike the previous system which combined all donor funding into one accounting code. This improved visibility of budget execution and monitoring.
Stable compliance process	The government compliance process for domestic funding has remained the same. This enables the program manager to master the process and requirements.
Bottlenecks	
Limited Coordination, capacity, and governance for managing donor financing	During the AOPB process, asymmetric communication can arise between development partners and the divisions. They both allocate funds to the other without prior knowledge. Further, donor funds have more complex pay-ment processes and their own modalities and fiscal time-lines; this places significant pressure on (and creates possi-ble bottlenecks in) public capacities.
Poor management of liquidation process	SIG has policy to safeguard the liquidation of funds, particularly for imprest, but weak enforcement. This has contributed to delay the release of external funds for timely execution. Because some external organizations disburse funds in tranches to the health programs, requiring prompt liquidation of funds. The timeliness of fund disbursement depends on the Ministry of Health's programs effectively and promptly liquidating received funds.

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Table 4: Summary of Budget Execution Good Practices and Bottlenecks in the Solomon Islands

Issue	Explanation
Insufficient management capacity, planning challenges, and misalignment of capital spending and project cycle	The complexity of the health infrastructure and larger capital projects, combined with gaps in the capacity of the MHMS infrastructure unit (with key senior positions vacant for several years), was a major contributor to low execution rates of the capital budget. There is also a mismatch between the multi-year nature of capital projects and the annual nature of the budgeting process. Broader SIG cashflow management, particularly a budget deficit in 2017, also contributed to low execution of capital spending as it is considered non-essential.
Budget submission timelines are often delayed.	These delays have often resulted in the MHMS not knowing its domestic budget ceilings until only a short time before it is required to submit its budget, which in turn, leads to poor planning and inevitably poor budget execution.
Lower level (health) facilities do not have a separate budget.	Lower-level health facilities are integrated into the Provincial Health Services budgets. and do not have the autonomy to manage their own resources. This can lead to a lack of flexibility to utilize resources in response to lower-level needs.
Excessive centralization of resource management processes	The Ministry of Health and Medical Services (MHMS) is a highly centralized organization; however, most health services are provided at the provincial level. The central processing of payments and allocation of staffing, transport, and logistics support can lead to inefficiencies and implementation delays, which contributes to poor budget execution.

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ANNEX: BUDGET EXECUTION IN HEALTH, 2015–23

Table 5: BUDGET EXECUTION IN HEALTH, 2015–23

Year	Budget Ledger	Budget		Actual Expenditure	Execution Rate	
		Original (SBD)	Revised (SBD)	SBD	Original (SBD)	Revised (SBD)
2015	SIG recurrent budget (L276)	306,456,743	314,562,043	320,042,078	104%	102%
	DP recurrent budget (L376)	123,407,925	129,207,408	91,878,592	74%	71%
	SIG development budget (L476)	41,191,145	41,191,145	14,079,625	34%	34%
	Total	**471,055,813**	**484,960,596**	**426,000,295**	**90%**	**88%**
2016	SIG recurrent budget (L276)	334,583,289	339,455,230	350,742,492	105%	103%
	DP recurrent budget (L376)	130,606,674	133,218,985	81,842,825	63%	61%
	SIG development budget (L476)	31,478,992	35,907,051	4,546,871	14%	13%
	Total	**496,668,955**	**508,581,266**	**437,132,188**	**88%**	**86%**
2017	SIG recurrent budget (L276)	338,008,769	339,008,769	347,141,576	103%	102%
	DP recurrent budget (L376)	120,034,274	130,716,755	83,270,180	69%	64%
	SIG development budget (L476)	29,000,000	28,000,000	10,558,658	36%	38%
	Total	**487,043,043**	**497,725,524**	**440,970,414**	**91%**	**89%**

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Table 5: BUDGET EXECUTION IN HEALTH, 2015–23

Year	Budget Ledger	Budget		Actual Expenditure	Execution Rate	
		Original (SBD)	Revised (SBD)	SBD	Original (SBD)	Revised (SBD)
2018	SIG recurrent budget (L276)	391,479,199	397,374,224	367,852,599	94%	93%
	DP recurrent budget (L376)	132,070,954	130,357,090	73,985,744	56%	57%
	SIG development budget (L476)	9,000,000	20,088,946	19,017,099	211%	95%
	Total	**532,550,153**	**547,820,260**	**460,855,442**	**87%**	**84%**
2019	SIG recurrent budget (L276)	428,497,433	428,547,433	375,948,256	88%	88%
	DP recurrent budget (L376)	134,675,641	149,150,547	99,140,060	74%	66%
	SIG development budget (L476)	23,000,000	27,950,750	23,182,023	101%	83%
	Total	**1,095,723,227**	**1,125,518,240**	**935,943,758**	**85%**	**83%**
2020	SIG recurrent budget (L276)	448,969,864	478,060,633	455,518,985	101%	95%
	DP recurrent budget (L376)	116,005,546	185,691,050	99,134,693	85%	53%
	SIG development budget (L476)	30,741,900	21,130,615	10,476,038	34%	50%
	Total	**595,717,310**	**684,882,298**	**565,129,716**	**95%**	**83%**
2021	SIG recurrent budget (L276)	427,640,690	427,540,032	355,120,301	83%	83%
	DP recurrent budget (L376)	166,274,165	218,493,978	106,425,669	64%	49%
	SIG development budget (L476)	44,800,000	39,800,000	20,870,424	47%	52%
	Total	**638,714,855**	**685,834,010**	**482,416,394**	**76%**	**70%**

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Table 5: BUDGET EXECUTION IN HEALTH, 2015–23

Year	Budget Ledger	Budget		Actual Expenditure	Execution Rate	
		Original (SBD)	Revised (SBD)	SBD	Original (SBD)	Revised (SBD)
2022	SIG recurrent budget (L276)	461,612,601	461,612,601	407,651,764	88%	88%
	DP recurrent budget (L376)	168,092,108	193,823,762	125,023,921	74%	65%
	SIG development budget (L476)	40,000,000	40,000,000	24,036,872	60%	60%
	Total	**669,704,709**	**695,436,363**	**556,712,557**	**83%**	**80%**
2023	SIG recurrent budget (L276)	472,684,917	472,684,917	465,161,785	98%	98%
	DP recurrent budget (L376)	110,076,157	110,076,157	73,475,915	67%	67%
	SIG development budget (L476)	44,500,000	44,500,000	15,360,983	35%	35%
	Total	**627,261,074**	**627,261,074**	**553,998,683**	**88%**	**88%**

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