Is Decentralisation Friend or Foe to Agile Public Financial Management in Health?

Findings from Burkina Faso, Indonesia, Kenya, Mozambique, Nigeria, the Philippines, Uganda, and the United Republic of Tanzania

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This synthesis report, which explores the relationship between decentralisation and PFM reforms and its implications for health financing, was conceptualised by Hélène Barroy (WHO/HGF) and Nirmala Ravishankar (ThinkWell) in 2020. The following individuals from ThinkWell authored case studies and contributed to the synthesis analysis: Marie-Jeanne Offosse N. for Burkina Faso; Paulina Limasalle, Prastuti Soewondo, Trihono, Halimah Mardani, Nadhila Adani, Nirwan Maulana, and Anooj Pattnaik for Indonesia; Nirmala Ravishankar and Boniface Mbuthia for Kenya; Ileana Vîlcu, Salomão Lourenço, Egidio Cueteia, Yara Cumbi, Federica Fabozzi, and Amandio Manuel for Mozambique; Michael Chaitkin for Nigeria; Christian Edward Nuevo, Jemar Anne Sigua, Mary Camille Samson, Pură Angela Co, and Maria Eufemia Yap for the Philippines; and Tapley Jordanwood, Michael Chaitkin, Angellah Nakyanzi, Ileana Vîlcu, Federica Margini, and Nirmala Ravishankar for Uganda.

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**ABBREVIATIONS**

<table>
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<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>BHCPF</td>
<td>Basic Health Care Provision Fund (Nigeria)</td>
</tr>
<tr>
<td>BLUD</td>
<td>Status of financial autonomy for certain public primary health care facilities in Indonesia</td>
</tr>
<tr>
<td>BPJS-K</td>
<td>Badan Penyelenggara Jaminan Sosial – Kesehatan (Social Insurance Administrating Body for Health) (Indonesia)</td>
</tr>
<tr>
<td>DBM</td>
<td>Department of Budget and Management (Philippines)</td>
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<tr>
<td>DFF</td>
<td>direct facility financing</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health (Philippines)</td>
</tr>
<tr>
<td>FMIS</td>
<td>financial management information system</td>
</tr>
<tr>
<td>FY</td>
<td>fiscal year</td>
</tr>
<tr>
<td>JKN</td>
<td>Jaminan Kesehatan Nasional (National Health Insurance Scheme) (Indonesia)</td>
</tr>
<tr>
<td>LGAs</td>
<td>local government areas (Nigeria)/authorities (United Republic of Tanzania)</td>
</tr>
<tr>
<td>LGUs</td>
<td>local government units (Philippines)</td>
</tr>
<tr>
<td>MOF</td>
<td>Ministry of Finance</td>
</tr>
<tr>
<td>MOFP</td>
<td>Ministry of Finance and Planning (United Republic of Tanzania)</td>
</tr>
<tr>
<td>MOFPED</td>
<td>Ministry of Finance, Planning and Economic Development (Uganda)</td>
</tr>
<tr>
<td>MOH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NHIF</td>
<td>National Health Insurance Fund</td>
</tr>
<tr>
<td>PBB</td>
<td>program-based budgeting</td>
</tr>
<tr>
<td>PFM</td>
<td>public financial management</td>
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<tr>
<td>PHC</td>
<td>primary health care</td>
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<tr>
<td>PhilHealth</td>
<td>Philippine Health Insurance Corporation</td>
</tr>
<tr>
<td>RBF</td>
<td>results-based financing</td>
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<tr>
<td>UHC</td>
<td>universal health coverage</td>
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<td>WHO</td>
<td>World Health Organization</td>
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**EXECUTIVE SUMMARY**

Most countries have decentralised aspects of health financing and service delivery, transferring responsibility from central governments to subnational public entities. How decentralisation affects the financing and delivery of health services depends, among other things, on how well it coheres to public financial management (PFM) reforms. This study describes how decentralisation has shaped PFM processes in health, identifies key challenges for the health sector emerging from the misalignment between decentralisation and PFM reforms, and offers policy lessons based on the experiences of eight low- and middle-income countries in Africa and Asia.

**Decentralisation has complicated health budgeting.** Disparate budget structures hinder collaboration across government levels, contributing to disjointed or duplicative sector plans and low budget prioritisation for health. Fragmented financing compounds these challenges, especially where subnational actors lack the capacity to develop rigorous and credible health budgets. To strengthen budget development, countries need to better align budget structures across levels, which will facilitate more coherent planning. They should also adopt and implement approaches that provide flexibility in health spending more consistently.

**Decentralisation does not necessarily enhance the managerial or spending autonomy of service providers.** While subnational entities exercise new decision-making powers and fiscal controls, these have not been systematically extended to providers themselves, and most often facilities cannot respond flexibly to evolving needs. Over time, countries have recognised these harms and introduced mechanisms to put more money under facilities’ direct control. Countries need to continue these efforts and consider shifting the balance between fiscal control and provider autonomy to support flexibility and accountability for service outputs and outcomes aligned to health policy goals.

**Due to lagging PFM reforms, decentralisation has not delivered on its promise of greater transparency and accountability for public spending on health.** Financial information systems remain weak and fragmented—often reflecting disparate sources and flows of funds—which hinders timely, efficient, and comprehensive reporting and analysis of health spending. The persistence of input-based budget structures at subnational levels also reinforces accountability for inputs rather than outputs or outcomes. Even without digitised and interoperable information systems, financial analysis and management across government levels can benefit greatly from harmonised budget and reporting structures and practices.

**There is considerable need for further research on the interplay among decentralisation, PFM, and health financing.** Key questions include identifying the most promising PFM and health financing approaches for different decentralisation models, the opportunities and constraints arising from the political economy of decentralisation, the advantages and drawbacks of extrabudgetary health financing approaches in decentralised settings, the integration of vertical programs into decentralised systems, and the experiences of other sectors that deliver services in decentralised contexts.

**As evidence on these and other important issues continues to emerge, countries can make considerable progress.** The varying needs and capabilities of health system actors will lead to different policy designs, though all countries should continually strive to align PFM reforms with other initiatives. Where the need for change has yet to gain traction, an urgent next step is raising awareness among national and subnational policymakers of the harmful PFM bottlenecks that can arise from decentralisation.
INTRODUCTION

Public funds lie at the heart of sustainable health financing policy for progressing towards universal health coverage (UHC) (1). Public financing for health accounted for approximately 60% of worldwide health spending in 2018, including 52% in low- and middle-income countries, and grew faster than any other source of health expenditure over the preceding decade (2,3). As low- and middle-income countries develop policies for financing progress towards UHC, there is increased emphasis on governments spending public funds more effectively, efficiently, and equitably. Specifically, public financial management (PFM) systems have been increasingly recognised as key to providing a supportive environment for effective health financing reforms for UHC (4,5).

In parallel, over the past five decades, most countries around the world have embarked on decentralisation processes that affect public services, including those for health (6). Decentralisation involves the redistribution of government functions and decision-making power between central and subnational authorities. It is often studied from a fiscal perspective focused on the levels, sources, and constraints of spending by subnational levels (7). There is also longstanding awareness that decentralisation can enhance or undermine service delivery. This depends both on the design and institutional arrangements underpinning these reforms and on how reforms reshape relationships among government bodies, service providers, citizens, and communities at various levels (8,9). Research on these dynamics with respect to the health sector show that there are mixed results from decentralisation in health (8–18). Recent studies have also drawn attention to the potential pitfalls of decentralisation for health and other complex public services (19).

How decentralisation affects the financing and delivery of health services depends on how well it coheres to the concurrent evolution in PFM systems and processes (20), and whether these changes align with health financing reforms (4). Numerous studies describe aspects of PFM in decentralised low- and middle-income countries, including Bangladesh (21), Brazil (22), Burkina Faso (23), Chile (24), Colombia (24), Democratic Republic of Congo (25), Ghana (26,27), Indonesia (28,29), Kenya (30–32), Lao People’s Democratic Republic (29,33), Mexico (34), Mozambique (5), Pakistan (35), the Philippines (36–38), Rwanda (5), South Africa (5), Tajikistan (4), Thailand (29), Uganda (5,39), the United Republic of Tanzania (5,40–45), and Zambia (41). Inconsistencies and lack of coordination between PFM and decentralisation reforms can lead to service inefficiencies, yet only recently have there been more focused efforts to systematically assess how decentralisation affects PFM processes, and ultimately service provision, in the health sector (46). Many health stakeholders lack understanding of how PFM operates and how functional and financial roles unfold in decentralised contexts. Consequently, to guide suitable policy responses, there is a need to further unpack PFM processes and identify bottlenecks affecting financing of health services.

Against this backdrop, ThinkWell and the World Health Organization (WHO) undertook a study to explore how decentralisation has shaped PFM processes in the health sector and to identify challenges arising from the misalignment of decentralisation and PFM reforms. It aims to answer the following questions:

- How has decentralisation shaped PFM processes in health, specifically budget development, budget approval, budget execution, and budget accountability?
- What are the main opportunities and bottlenecks that have emerged from decentralisation for PFM in health at central, subnational, and facility levels?
- How have misalignments between decentralisation and PFM reforms and the associated PFM bottlenecks affected the financing of health services?
- How have the identified bottlenecks been addressed? What remains unsolved? What are the possible ways forward?
METHODS & KEY CONCEPTS

For this study, ThinkWell and WHO synthesised information about decentralisation reforms, PFM practices, and health financing in eight countries in Africa and Asia: Burkina Faso, Indonesia, Kenya, Mozambique, Nigeria, the Philippines, Uganda, and the United Republic of Tanzania. ThinkWell conducted detailed case studies on seven of the countries (all except the United Republic of Tanzania) (47–53), and the synthesis analysis also leveraged recent work conducted by WHO in Burkina Faso (54), Kenya (55), and the United Republic of Tanzania (54,56). The countries were selected purposefully to include geographic diversity and different degrees of decentralisation and years of experience, as well as to leverage ongoing projects that ThinkWell implements through country-based teams. This report is a companion to another synthesis analysis focused on broader health financing issues in devolved contexts (57).

Information for each country was collected through a desk review supplemented by key informant interviews and informal consultations. Data collection was conducted from July 2020 to April 2021 using a structured questionnaire (Annex 1). Case authors reviewed publicly available documents and data, including those produced by central and subnational governments, international organisations, development assistance projects, and researchers. Government officials and other experts were consulted to validate findings and fill gaps. Each case author team then analysed its data and produced a country-specific report. Case authors also answered questions in a PFM-focused instrument that helped categorise findings according to stages of the budget cycle, unpack key bottlenecks, and catalog relevant reforms. That information was then analysed further for this synthesis.

Notably, the information presented here reflects prevailing PFM systems and processes before the COVID-19 pandemic that began in late 2019. Although many countries have adjusted and continue to adjust their PFM practices to respond to the pandemic (58), it is uncertain whether new modalities for budgeting and spending will be retained in the long run or applied to non-emergency health needs in the reviewed countries.

PUBLIC FINANCIAL MANAGEMENT SYSTEMS

The PFM system is the set of rules, institutions, policies, and processes that govern the allocation, use, and reporting of public funds (59–61). Its objectives are to ensure prudent fiscal decisions, credible budgets, reliable and efficient resource flows and transactions, and institutionalised accountability (62). The budget cycle is typically structured around an annual budget process with four main stages:

1. **Budget development**, in which the executive arm of government makes macroeconomic projections about revenue and debt as well as decisions about allocations to different levels of government (central versus subnational), division of funds between subnational units, and the allocation of funds to individual ministries, government departments, and other state agencies at all levels.

2. **Budget approval**, in which different actors negotiate over budgets and legislatures and then grant approval to final budgets, which can happen at multiple levels of government.

3. **Budget execution**, which first includes the release of funds to different levels of government and, within each level, to ministries, government departments, and other budgetary entities in accordance with the approved budget. Then, these entities spend on personnel, goods, and services. Payments by subnational governments to providers of health services, including public and private health facilities—that is, health purchasing—are part of this stage of the process, as is spending by public health facilities.

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*Authors and organisations have conceptualised the stages of the budget process in different ways. For current purposes, the stages have been adapted as described in (62).*
During this stage, spending agencies at different levels follow internal control processes and report their expenditure using government accounting and reporting procedures.

4. **Budget accountability**, the final phase, involves independent agencies auditing accounts and reporting findings to the legislature to inform future decisions.

**DECENTRALISATION**

Decentralisation refers to the transfer of authority and responsibility for public functions from the central government to other public entities. Decentralisation should not be confused with direct facility financing (DFF) or provider autonomy. Across countries, decentralisation is highly diverse and can occur in several ways (46). For example, three forms of decentralisation have been described as how much power the central government cedes and to whom (63):

- **De-concentration** to the central government’s own representative units or agents throughout the country (e.g., regional offices directed by and accountable to central ministries).
- **Delegation** to semi-autonomous organisations under the government’s partial or indirect control.
- **Devolution** to autonomous subnational governments.

Decentralisation requires the redistribution of different kinds of government functions, including:

- **Political**: Subnational governments have constitutionally or legislatively derived policymaking power.
- **Fiscal**: Subnational governments have the authority to raise, allocate, and spend public revenue.
- **Administrative**: Authority and responsibility for certain administrative functions are transferred to subnational authorities by the central government (64–66).

Most decentralisation reforms combine multiple types. De-concentration typically implies the transfer of administrative functions, while devolution also tends to include the decentralisation of political or fiscal functions or both.

**Within this study’s scope were countries whose reforms involved some degree of fiscal decentralisation to subnational levels of government.** The experiences of several countries also featured aspects of administrative and political decentralisation. In the case of federal systems, of greatest interest was the decentralisation of government functions to local governments from the central, state, or provincial level. Most countries have multiple levels of decentralised governance, for example, wards that are nested within districts that are grouped within provinces. Additionally, decentralisation has not generally been a one-off event. Instead, some countries have undertaken multiple reforms spanning several decades, creating new levels of government, changing the distribution of functions across levels, and even shifting between recentralisation and decentralisation (68–70).

Countries across the world have embraced decentralisation in their health systems for a range of reasons. These include better capturing citizen preferences, increasing accountability, improving quality of care, enhancing equity, and making spending more efficient. Decentralisation often follows the end of a conflict or a radical change in government. In practice, countries’ experiences have often been messier and the results less clear than the theories suggest (71).

For all dimensions of decentralisation, countries can choose whether, how, and to what extent different government levels will manage the financing of health services. Critically, changes along one dimension do not automatically entail movement along another. For example, assigning responsibility for health service delivery to

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b Federalism is an especially “durably institutionalised” form of devolution in which the authorities granted to subnational governments, often constitutionally, cannot be curtailed without their consent (67).
subnational authorities (via de-concentration or devolution) involves a separate set of decisions from those that grant managerial and operational autonomy to individual service providers (via delegation). Historically, increasing the autonomy of public service providers often followed other decentralisation efforts as part of reforms meant to improve government effectiveness. The “purchaser-provider split” paradigm underpinning these reforms, which draws inspiration from the “new public management” philosophy, unpacked the concept of delegation for service providers, placing them on a spectrum from budget units to autonomous, corporate, and ultimately private entities (72). The degree of provider autonomy matters greatly to health financing and systems design (73), and it can vary no matter the prevailing extent of de-concentrated or devolved health sector authorities.

The eight countries covered in this study have varying decentralisation arrangements that shape the organisation and financing of health services. They all have multiple levels of government involved in delivering health services and managing health financing functions, and they differ in the extent and nature of health facility autonomy. The countries also have significant and diverse histories of decentralisation reforms. Nigeria’s federal system emerged from the Biafran War in the late 1960s and has evolved over the subsequent decades. Devolution elsewhere also followed significant political upheaval, including in Indonesia (1999), Kenya (2013), and Uganda (1986). Other countries, such as Burkina Faso, Mozambique, the Philippines, and the United Republic of Tanzania, were part of the wave of countries that decentralised beginning in the 1990s. Within their decentralisation reforms, all the study countries have undertaken some form of devolution, in many cases following de-concentration that occurred decades earlier. Finally, the pace of decentralisation has varied across the countries, ranging from the rapid (or “big bang”) approaches in Indonesia and Kenya, to more incremental reforms elsewhere. Additional details about each country’s decentralisation history are summarised in Annex 2, and the health financing and service delivery roles played by subnational entities are detailed in Annex 3. The impact of devolution on the three health financing functions in each of the study countries is explored in detail in another report that ThinkWell and WHO developed (57).

The remainder of this report has three sections. Section 1 describes PFM processes with a specific focus on the health sector in the eight study countries, unpacking the roles and functions fulfilled by various actors across levels of government and stages of the budget cycle (development, approval, execution, and accountability). Section 2 delves into challenges resulting from misalignment between PFM and decentralisation processes and highlights their implications for the financing of health services. Finally, Section 3 offers policy options to address the identified challenges and suggests priorities for future research.

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5 This form of delegation has also been described as “marketisation” because when providers gain autonomy, they may be increasingly subject to market-based performance drivers (72). Arguably, privatisation goes beyond decentralisation because it implies complete divestiture by government of a previously public function.
SECTION 1. PFM PROCESSES FOR HEALTH IN DECENTRALISED Contexts

This section summarises findings related to the four main stages of the annual budget process: development, approval, execution, and accountability. First, an overview of subnational funding for health in the eight study countries is presented. Then, a sub-section for each budget stage describes prevailing PFM practices and trends in and across the countries.

SUBNATIONAL FUNDING FOR HEALTH

Subnational budgets rely heavily on transfers from central governments. Transfers account for more than 95% of revenue for Mozambique’s provinces and districts (74), Nigeria’s local government authorities (LGAs) (75), and Uganda’s districts (76). In fact, in some countries, including Mozambique and Uganda, central authorities claim some or all of locally generated funds, which can demotivate subnational revenue efforts (76,77).

Elsewhere, transfers represent a smaller but still predominant share of subnational revenue, including in Indonesia’s districts (67% in 2018) (78), Kenya’s counties (71% in fiscal year (FY) 2019/20) (79), Nigeria’s states (65% in 2019) (75), the Philippines (57% across all subnational units in 2020) (80), and the United Republic of Tanzania (89% in 2018/19) (81). Only Burkina Faso’s communes (82) and Indonesia’s provinces get a majority of their revenue—57% and 53%, respectively—from sources other than central transfers (78).

Most of the study countries blend unconditional and earmarked transfers that both feed into subnational health budgets (Table 1). In several cases, there is an unconditional transfer or block grant that subnational governments allocate at their discretion, combined with one or several conditional grants that are earmarked by central authorities for specific sectors, programs, or even individual projects, including in the health sector. Variations of this approach are implemented in Indonesia, Kenya, Mozambique, Nigeria, the Philippines, Uganda, and the United Republic of Tanzania. In some countries, conditional grants make up the largest share of subnational governments’ funding (e.g., 81% in FY 2019/20 in Uganda) (83). In others, the unconditional grants are the main source of subnational government financing for health (e.g., 66% in FY 2019/20 in Kenya [77], 65% for states in 2019 in Nigeria [75,84]), and subnational governments decide the health allocation that may be supplemented by conditional grants or other transfers. In Indonesia, the Philippines, and Uganda, subnational governments also receive equity-oriented development grants over which they exercise at least some discretion. In contrast, communes in Burkina Faso receive specific transfers for each devolved sector, including health. They also receive a predefined amount per health centre (1.2 million CFA in rural communes and 1.3 million CFA in urban communes). One of the conditional grants in Kenya requires counties to transfer funds to primary care facilities.

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*Additional details regarding revenue raising and intergovernmental fiscal arrangements in the study countries can be found in the companion report on health financing in devolved contexts (57) and the individual country cases (47–53).*

*Transfers to Nigeria’s LGAs include both the local share of federal revenue and allocations by state governments.*

*In Indonesia, lack of accountability is more likely to cause stagnant service delivery outcomes, not the design of the intergovernmental transfers systems or insufficient local funding. Therefore, performance grants seem the best option to improve service delivery outcomes (85).*
Table 1. Overview of intergovernmental transfers

<table>
<thead>
<tr>
<th>Country</th>
<th>Types of intergovernmental transfers</th>
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<tbody>
<tr>
<td>Burkina Faso (86)</td>
<td>Central government transfers for each devolved sector, including health&lt;br&gt;Central government grant for primary health centres (no matching requirements or conditions)</td>
</tr>
<tr>
<td>Indonesia (87)</td>
<td>Two unconditional grants from the central government to provinces and districts: revenue-sharing fund (called DBH), general allocation fund (called DAU)&lt;br&gt;One conditional grant from the central government to districts: special allocation fund (called DAK)</td>
</tr>
<tr>
<td>Kenya (30,79)</td>
<td>One block grant from the central government to counties to be allocated to any sector or purpose&lt;br&gt;Several conditional grants from the central government to counties, including for health</td>
</tr>
<tr>
<td>Mozambique (88,89)</td>
<td>Block grant from the central government to provinces&lt;br&gt;Block grants from the central government to districts&lt;br&gt;Health-sector specific grant (PROSAUDE) from the central government to provinces and districts&lt;sup&gt;g&lt;/sup&gt;</td>
</tr>
<tr>
<td>Nigeria (90–93)</td>
<td>Unconditional block grants from federally collected revenue (oil, value-added tax, Federation Account) to states&lt;br&gt;Health-specific transfers from the Basic Health Care Provision Fund (BHCPF)&lt;sup&gt;h&lt;/sup&gt; to states representing at least 1% of federal revenues</td>
</tr>
<tr>
<td>Philippines (94,95)</td>
<td>Internal Revenue Allocation block grant from the central government to local government units (LGUs) &lt;br&gt;LGUs also receive additional resources from government-funded programs and projects, official development assistance loans and grants, and off-budget funding</td>
</tr>
<tr>
<td>Uganda (96–98)</td>
<td>Equalisation grants&lt;sup&gt;i&lt;/sup&gt; from the central government to disadvantaged districts&lt;br&gt;Unconditional grants from the central government to districts&lt;br&gt;Three sector-conditional grants: wage (covers health workers’ salaries), non-wage recurrent (meant for health facilities), and development</td>
</tr>
<tr>
<td>United Republic of Tanzania</td>
<td>Block grants for personnel emolument, other charges, and development&lt;br&gt;Earmarked grants for health, education, etc.</td>
</tr>
</tbody>
</table>

<sup>g</sup> PROSAUDE was initially an unconditional grant that is progressively becoming a conditional grant.

<sup>h</sup> The BHCPF aims to bolster primary health care service quality and access by channeling more funds to health facilities. It is primarily financed by Nigeria’s federal government and is designed to attract co-financing from state governments and development partners. Forty-five percent of the Fund is meant for state primary health care development agencies to improve service readiness and quality, and 50% is meant to be managed by state social health insurance agencies and used to buy services on behalf of the poorest segments of each state’s population. The remaining 5% is meant for emergency medical services.

<sup>i</sup> These are discretionary development grants.
Rarely do countries require subnational governments to allocate a minimum share of their budgets to health. Among the study countries, only Indonesia legally requires subnational governments to allocate at least 10% of their budgets to health. However, the central government has not clearly defined what counts as health spending, and compliance has been weak historically. In 2013, only 4 of 44 assessed districts met or exceeded the 10% requirement, with health’s share of district budgets ranging from 3% to 18% (87). Central governments in other countries promote but cannot enforce targets for subnational allocations to health. For example, the Department of Health (DOH) in the Philippines encourages LGUs to allocate a certain portion of their budgets to health, nutrition, and environment—22% for provinces and highly urbanised cities, and 15% for other cities and municipalities—as part of a local government performance scorecard. However, LGUs generally do not follow these recommendations as there are neither penalties nor incentives (99). Kenya’s central government and Nigeria’s federal government have no legal authority to prescribe sectoral spending thresholds for counties and states, respectively, resulting in variable allocations to health across subnational units. To overcome these constraints, central governments and donors have attempted to use conditional grants to secure budget allocations for health, as is the case in Kenya, Uganda, and the United Republic of Tanzania. Some use “matching grants” to conditionalise access to certain transfers of subnational allocations or co-financing. For instance, districts are usually required to co-finance 10% of activities supported by Indonesia’s earmarked grants for disadvantaged areas (87). Likewise, by law, states’ access to Nigeria’s BHCPF is contingent on 25% co-funding, though this requirement has not yet been enforced (100). In Kenya, counties are required to allocate at least 20% of their budget to health and to increase these allocations annually to access Global Financing Facility funds (101).

In several of the study countries, health is prioritised more in subnational government spending than in spending by the central government (Table 2). This is the case in Kenya, Mozambique, the Philippines, Uganda, and the United Republic of Tanzania. In Indonesia, subnational government spending on health ranges widely, with some units allocating a greater share to health and some a lesser share than the central government. These patterns contrast with the previous finding that health does not get a higher share of spending at subnational levels than central ones in such countries as the Democratic Republic of Congo (25,102). Among the study countries, only in Nigeria does health claim a lower share of public spending subnationally than at the federal level; notably, public spending on health is low across all levels. The study pattern suggests that centrally imposed conditions on intergovernmental transfers may help to ensure higher spending on health within subnational spending.¹ There are limits, though. For example, although the Philippines’ Local Government Code (103) requires subnational authorities to prioritise devolved functions when they allocate transferred revenue, there is continued concern that LGUs do not allocate sufficient funds to health compared to other devolved sectors (104,105).

¹ Additional information from all study countries is needed to determine what share of funds fully controlled by subnational authorities is allocated to health versus earmarked transfers from the central level or funds accounted for under subnational spending but in practice controlled centrally.
Table 2. Health’s share of overall and subnational government spending

<table>
<thead>
<tr>
<th>Country</th>
<th>Overall</th>
<th>Subnational only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burkina Faso</td>
<td>10.3% (2016) (106)</td>
<td>Not available¹</td>
</tr>
<tr>
<td>Indonesia</td>
<td>5.7% (2014) (107)</td>
<td>3% to 18% – districts (2013) (87)</td>
</tr>
<tr>
<td>Kenya</td>
<td>8.5% (FY 2018/19) (108)</td>
<td>17% to 37%, 27% average (FY 2018/19) (108)</td>
</tr>
<tr>
<td>Mozambiquem</td>
<td>10% (2020)</td>
<td>13% (2020)</td>
</tr>
<tr>
<td>Nigeria</td>
<td>5.1% (2016) (110)</td>
<td>4.2% – state; 3.8% – local (2016) (110)</td>
</tr>
<tr>
<td>Philippinesn</td>
<td>6.6% (FY 2019)</td>
<td>10.1% – all LGUs (FY 2019)</td>
</tr>
<tr>
<td>Uganda</td>
<td>7.4 % (FY 2019/20) (115)</td>
<td>15.2% (FY 2019/20) (115)</td>
</tr>
<tr>
<td>United Republic of Tanzania</td>
<td>6.1% (2017) (116)</td>
<td>16.5% (2017) (116)⁰</td>
</tr>
</tbody>
</table>

Budget development refers to decisions about allocations of revenue between levels of government, across subnational units, and among individual ministries, departments, and other government agencies. For each country, information was gathered about the budgeting process, budget structure and classifications, and decision-making within and across levels of government, with a specific focus on health-related expenditure.

Central finance ministries generally set the key budgeting parameters. In all eight countries, planners rely on revenue projections from central finance ministries to guide budget development. These projections are taken directly as the basis for subnational budgeting in Burkina Faso (118), Indonesia (119), Mozambique (120), and Uganda (121). Elsewhere, the finance ministry’s forecasts inform additional revenue analysis by subnational authorities, including county treasuries in Kenya (122), state ministries of finance in Nigeria (123), local government units (LGUs) in the Philippines (124), and LGAs in the United Republic of Tanzania (125).

k Country sources were favoured over WHO’s Global Health Expenditure Database (GHED) for data on prioritisation of health in overall government spending because they were expected to provide a better comparator for the estimates of health’s share of subnational spending. For example, the GHED’s indicator for general government health expenditure as a share of general government expenditure includes spending from on-budget external sources in its denominator, while country sources may not do so.

l Subnational governments do not report health expenditure to the Ministry of Health.

m Estimates for Mozambique are based on authors’ calculations using data from the second table on page 7 (114) and Table 12 (109).

n Estimates for the Philippines are based on authors’ calculations. For the numerators, estimates of overall and subnational government health expenditure came from the National Health Accounts (111). Data from multiple sources were used to calculate government expenditure. Total LGU spending was found in Table E.1 of (112). Spending by the central government was found in Table 9 of (113). To avoid double counting, central government allotments to LGUs for both operating and capital expenses were subtracted out based on amounts in Table 10 of (113). Overall government spending was also assumed to include expenditure by Government-Owned and Controlled Corporations (GOCCs), for which total outlays were found in Table E.11 (114). Again, to avoid double counting, transfers to GOCCs from the central government were subtracted out based on amounts in Table E.11 of (114).

o The estimate for health’s share of subnational government spending in the United Republic of Tanzania is based on authors’ calculations using data on the subnational share of government spending (117) and health expenditure (116).

p An overview of intergovernmental transfers and rules for revenue sharing between central and subnational governments and across subnational governments is described in another report that ThinkWell and WHO developed (57).
Health budgeting unfolds in parallel across different levels of government. Subnational units participate in budgeting in all eight countries, with varying degrees of coordination and intersection between levels. Subnational budgeting is more independent in countries with greater subnational autonomy over the content of the budget, such as Kenya, Nigeria, and the Philippines. The parallel processes in the Philippines are further described in Box 1. Other countries orchestrate bottom-up planning—including at the health facility and sub-district levels (e.g., villages and wards)—that feeds into district, regional, provincial, and national plans. In Burkina Faso, Indonesia, Mozambique, and the United Republic of Tanzania, subnational units manage the budgeting process for eventual presentation to central authorities, while in Uganda, districts develop annual plans and budgets through iterative consultation with central planning authorities. Budgeting for health workers may differ from budgeting for other health system inputs or activities, and practices vary across the study countries (Box 2).

Box 1. Parallel budgeting processes at central and subnational levels: example of the Philippines

Numerous government functions are devolved to LGUs in the Philippines, including much of health service delivery. Each year, central agencies develop and submit their budget proposals for consolidation by the Department of Budget and Management into an executive proposal for enactment by Congress (126). For the DOH, a division of the Health Policy Development and Planning Bureau facilitates budgeting across individual units within the central office, including programs such as immunisation and family planning. Budget levels for personnel are largely fixed, while amounts for maintenance and other operating expenses are proposed based on estimated increases in target populations, inflation, and consultations with regional DOH program coordinators and civil society (127).

Concurrently, LGUs enact their budgets independently through annual local ordinances. They expect funds from all sources—block and earmarked intergovernmental transfers, local revenue, Philippine Health Insurance Corporation (PhilHealth) payments, locally generated revenue, and donor grants and loans—and allocate these according to priorities determined by local legislative councils and chief executives. Allocations within their health budget are determined autonomously by LGUs in consultation with publicly managed health facilities and local health boards. In general, the heads of public facilities prepare their own budgets to submit to the heads of their LGUs. This includes costs for staff, operations, and commodities, as needed. The budget is then approved by the local legislative council (128).

In some countries, information system weaknesses limit the effective use of data in the budget development process. For example, in Nigeria, data required for preparing good health budgets, including for coverage, utilisation, wastage, and costs, are not reliably available at federal, state, or local levels. In addition, inaccurate revenue forecasts lead to unrealistic budgets at federal and state levels (100,129). Poor revenue forecasts also hinder budget development (and undermine subsequent budget performance) in the United Republic of Tanzania (130). In Kenya, the financial management information system (FMIS) captures information according to budget lines but not the structure underpinning the program-based budgets produced by the central and county governments (131).

In the countries where health facilities are meant to participate in budgeting, they do so with varying awareness of their budget allocation and ownership of the planning process. For example, Kenya’s counties often fail to communicate with facilities about resource allocations or budget ceilings. Unaware of these constraints, facility management teams still develop annual budgets based on their needs, which are approved by hospital boards or health facility management committees and sent to the county (30). In contrast, health
facilities designated as budget units in Mozambique—central, provincial, and general hospitals—receive initial budget ceilings from the agencies to which they are subordinate (132). Practices in the United Republic of Tanzania have evolved significantly. Previously, facilities submitted their plans to LGAs, which adjusted the budgets to fit within ceilings that were set after the planning stage and without proper consultation with the health sector about priorities. Once budget ceilings were set, health facilities did not have the opportunity to prioritise their plans. Instead, LGAs made these decisions on their behalf. This has evolved since the introduction of DFF, with facilities now trained and responsible for planning and budgeting for all their funding (56).

Box 2. Models for employing and budgeting for health workers

There are three typical models for employing and budgeting for health workers in the study countries. The first model entails health workers mainly employed by the central government—either the Ministry of Health (MOH) or a public service commission—and deployed to facilities across levels of the health system. This is the approach used in Burkina Faso. The second model involves health workers employed and budgeted for by the government level or agency in whose facilities they work. This approach or a variant prevails in Indonesia, Mozambique, Nigeria, and Uganda. For example, Nigeria’s federal government employs all health workers in federally owned facilities, while the state governments employ and pay workers in state-owned hospitals. Through their Local Government Service Commissions, states also employ and control payments to skilled health workers in locally managed primary health care (PHC) facilities, while LGAs more directly manage unskilled workers in their facilities (133). Similarly, in Mozambique districts pay health worker salaries in facilities under their management. In Uganda, health sector personnel at all levels below regional referral hospitals are employed by the districts, which are empowered to appoint, promote, discipline, and remove most district employees.

However, the creation of new positions, terms of employment, and salaries are all controlled centrally (134). Kenya uses a blended approach, with most health workers in county-managed facilities employed by the counties, complemented by some personnel that the central MOH started paying and deploying to counties in the context of the UHC program scale-up. In addition, very few facilities hire and pay temporary staff (135). Similarly, in the Philippines, although most health workers are employed by their respective LGUs, the DOH also has several national health workforce deployment programs to augment the number of staff in needy areas (136,137). Finally, the third model involves health workers employed at the central level and budgeted by subnational governments, as in the case of the United Republic of Tanzania (138).

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q In Indonesia, subnational governments receive a specific intergovernmental transfer from the general allocation fund that is meant, in part, to cover civil servant salaries.

r Provincial hospitals are budget units, so they pay staff from their own budget.

s Uganda’s District Service Commissions can be understood as de-concentrated structures given that their leadership, composition, and policies are all subject to varying degrees of control by the central government’s Public Service Commission. Additionally, the chief and deputy chief administrative officers in districts, town clerks and deputy town clerks in cities, and town clerks of municipalities are all appointed directly by the Public Service Commission (134).

t The Government of Kenya has made a firm commitment to achieving UHC for all its citizens. In December 2018, it started pilot-testing the UHC program in four counties. The scale-up of the UHC program started in the second half of 2020.
In several countries, decentralisation has created space for public participation in health budgeting. For example, Indonesia’s National Development Planning Agency invites members of the public to consultations for the draft national budget, and similar meetings (Musrenbangs) are hosted at every level of subnational government to discuss local priorities and the financial performance of the previous year’s activities (107,119). Some government units in Nigeria conduct stakeholder meetings, including with traditional and community leaders (139). Kenya’s 2010 Constitution requires public participation in national and county budgeting (122). Budget hearings in Burkina Faso are open to the public, though community participation is low (140). In contrast, in the Philippines, local health boards must have a member of a nongovernmental organisation involved in health services who represents the community. However, direct consultations with the public are not common in the country (141).

Only three of the study countries (Kenya, Mozambique, and the United Republic of Tanzania) have a standard approach to budget structure across all levels of government. Table 3 summarises the main budget classifications used. While at central and county levels, Kenya uses both program-based budgeting (PBB) and economic classifications, but it implements PBB at the health facility level. In Mozambique, a mix of economic, administrative, and functional classifications are used across all levels, with PBB still only partially applied, despite its introduction in 2008. Similarly, the United Republic of Tanzania uses economic classifications at the central, local, and facility levels. Budget structure differs across levels in the other countries. For example, Burkina Faso uses PBB at the central level and economic- and activity-based classifications at the commune and facility levels, respectively. In the Philippines, the central DOH and its own facilities use PBB, while LGUs and local facilities tend to rely on economic classifications, in some cases with programmatic elements. Nigeria uses economic and administrative classifications at the central level and other approaches subnationally. Practices vary at the state level in Nigeria, and no documentation was found of LGA or facility budget practices. The lack of standardisation across LGUs in Philippines and states in Nigeria may create complexities for resource management and tracking. Finally, Uganda has partially implemented PBB at the central level, where the budget structure still also features economic, administrative, and functional classifications. Local governments use economic and functional classifications, while health facilities have input- and activity-based budgets.
Table 3. Main budget classifications used by country and level of government

<table>
<thead>
<tr>
<th>Country</th>
<th>Central</th>
<th>Subnational (region, province, state)</th>
<th>Local (commune, district, LGA, LGU)</th>
<th>Health facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burkina Faso (47)</td>
<td>Program</td>
<td>Not applicable&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Economic</td>
<td>Activity-based</td>
</tr>
<tr>
<td>Indonesia (119)</td>
<td>Program</td>
<td>Program</td>
<td>Program</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Administrative Economic</td>
<td>Administrative Economic</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Functional</td>
<td>Functional</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kenya (30)</td>
<td>Program</td>
<td>Program</td>
<td>Program</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(Economic)</td>
<td>(Economic)</td>
<td>(Economic)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Some budget lines are cross-cutting (human resources, administrative functions)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mozambique (120)</td>
<td>Economic</td>
<td>Economic</td>
<td>Economic</td>
<td>Economic</td>
</tr>
<tr>
<td></td>
<td>Administrative Functional</td>
<td>Administrative Functional</td>
<td>Administrative Functional</td>
<td>Functional</td>
</tr>
<tr>
<td></td>
<td>(Program introduced in 2008 but not yet fully applied)</td>
<td>(Program introduced in 2008 but not yet fully applied)</td>
<td>(Program introduced in 2008 but not yet fully applied)</td>
<td></td>
</tr>
<tr>
<td>Nigeria (100,129,142)</td>
<td>Economic</td>
<td>Varieties by state</td>
<td>(Documentation of LGA budgets not found)</td>
<td>(Not clear if local facilities have budgets)</td>
</tr>
<tr>
<td></td>
<td>Administrative</td>
<td>Lagos: functional, then organisational, then economic</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not consistently aligned with federal budget structure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Philippines (37)</td>
<td>Program</td>
<td>Economic with some programmatic elements (varies by subnational unit)</td>
<td>Economic with some programmatic elements (varies by subnational unit)</td>
<td>Program for DOH-owned facilities Economic for local facilities</td>
</tr>
<tr>
<td></td>
<td>(Administrative, Economic)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uganda (83,143,144)</td>
<td>Program (partial implementation)</td>
<td>Economic</td>
<td>Economic</td>
<td>Economic</td>
</tr>
<tr>
<td></td>
<td>Economic Administrative</td>
<td>Functional</td>
<td>Functional</td>
<td>Activity-based</td>
</tr>
<tr>
<td></td>
<td>Functional</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>United Republic of Tanzania (56)</td>
<td>Economic</td>
<td>Economic</td>
<td>Economic</td>
<td>Economic</td>
</tr>
</tbody>
</table>

<sup>a</sup> Regions do not receive any budget for the health sector.
**Budget Approval**

Budget approval is the stage at which different actors negotiate over budgets and legislatures grant approval to final budgets, both of which can happen at multiple levels of government. Information was gathered about the nature and the quality of the budget approval process and distribution of approval authorities within and across government levels in each study country, with key features summarised in Table 4.

**Table 4. Features of central and subnational budget approval processes**

<table>
<thead>
<tr>
<th>Country</th>
<th>Central budget approval</th>
<th>Subnational budget approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burkina Faso (118)</td>
<td>Ministry of Finance (MOF) proposes budget to Parliament, whose hearings and debate shape a final Finance Act that is signed by the president.</td>
<td>Local council reviews and approves budget, which is then submitted to MOF’s Regional Technical Committee. Following committee approval, budget is then submitted to the regional governor, MOF, and Ministry of Local Government for final approvals.</td>
</tr>
<tr>
<td>Indonesia (107,119)</td>
<td>National Parliament reviews and approves the national budget, including allocations to subnational units. The president signs to ratify.</td>
<td>Local parliaments approve local budgets.</td>
</tr>
<tr>
<td>Kenya (122)</td>
<td>National Treasury presents the Budget Policy Statement and budget proposal to the National Assembly and the Senate. Following review and public consultation, these are elaborated into the annual Division of Revenue Act, County Revenue Allocation Act, Appropriation Act, and Finance Act.</td>
<td>County treasuries submit County Fiscal Strategy Papers to their respective county assemblies, which then develop County Appropriation and County Finance Acts.</td>
</tr>
<tr>
<td>Mozambique (145,146)</td>
<td>MOF submits national economic and social plan and budget proposal to the national Parliament for discussion and approval.</td>
<td>Provincial directorate of planning and finance submits local economic and social plan and budget proposal to local government for approval before submission to local parliament. Following local approvals, local budget is submitted to MOF for review and inclusion in budget submission to the national Parliament.</td>
</tr>
<tr>
<td>Nigeria (139,147)</td>
<td>Federal Ministry of Budget and National Planning submits budget proposal to National Assembly, which reviews, refines, and develops the annual Appropriation Bill.</td>
<td>Practices may vary by state. In general, a state’s finance authorities submit a budget proposal to the House of Assembly, which reviews it and develops the state Appropriation Bill. An LGA’s budget is either approved by the Local Government Council or the state House of Assembly.</td>
</tr>
<tr>
<td>Philippines (128,148)</td>
<td>Department of Budget and Management (DBM) presents budget to the president and cabinet. Budget proposal is finalised, signed, and submitted by the president to Congress.</td>
<td>Local Finance Committee submits Executive Budget to local council (sanggunian) for approval and enactment of Appropriation Ordinance. The ordinance is then submitted to the National DBM for review.</td>
</tr>
</tbody>
</table>
Legislative bodies exercise budget approval authority in all eight countries. At the central level, it is common practice for executive agencies, typically ministries of finance, to lead budget development on behalf of the government and submit a budget proposal, sometimes accompanied by work plans, to the parliament or equivalent. In most of the study countries, a similar process unfolds at the subnational level, with local finance or planning authorities responsible for submitting budget proposals to the relevant legislative body. In fact, countries generally have formal, codified budget development approval processes at both the central and subnational levels.

Subnational legislatures exercise sole budget approval authority in some countries, while in others, local budgets require approval from one or more national bodies. In Indonesia (107), Kenya (122), Nigeria (139,147), and Uganda (151), subnational budgets only require approval from provincial, district, county, state, or local parliaments or councils. Budgets for decentralised bodies at the provincial level in Mozambique are scrutinised, debated, and approved by provincial assemblies, while the rest of the health budget, including that of districts, is subject to the national legislature’s approval (132,152). In contrast, in the United Republic of Tanzania, local budgets are included in the appropriations bills developed by the national Parliament (125). Finally, central executive agencies approve subnational budgets in the other countries, including the ministries of Finance and Local Government in Burkina Faso and the DBM in the Philippines.

Countries face different challenges during the budget approval process. Although budgets are approved by local councils in Uganda and the United Republic of Tanzania, the overall budget at the central level can still be adjusted. Therefore, local governments may not receive the funds they need to implement planned activities. In addition, delays in federal budget approval have become the norm in Nigeria over the last two decades (153), at times forestalling or jeopardising the flow of financial and in-kind resources from the central level to frontline service providers. Uganda also experienced delayed approvals in the mid-2010s (154), though none has been reported more recently. In Indonesia, there are discrepancies in data and interpretation between central and subnational governments that get used in budget decisions, which makes negotiations with central government officials difficult (119).

Approval practices often do not always conform to established guidelines, and there are generally capacity differences between central and subnational levels. Capacity deficits at subnational levels have been
documented elsewhere for three study countries—Kenya (5,155,156), the Philippines (36,199), and the United Republic of Tanzania (45)—and several others, including the Democratic Republic of Congo (5,155), Pakistan (35), South Africa (5,155), and Zambia (41). Budget approval processes at subnational levels have varying degrees of formalisation. Many of the study countries have regimented approaches to budget approval at subnational levels, including Burkina Faso (157), Indonesia (107), Kenya, the Philippines (158), and Uganda (76,144,159). In contrast, budgets are not produced and adopted in a systematic manner at the LGA level in Nigeria, where the nature of actors’ participation and influence in budgeting depends on state-level policies and practices. Consequently, LGA budget negotiations may be informal, with decisions made with minimal transparency or health sector input, as has been observed elsewhere (160).

**BUDGET EXECUTION**

Budget execution includes the release and control of funds to different levels of government and, in turn, spending by budgetary entities. Payments to health service providers are part of budget execution, as is spending by publicly owned facilities and expenditure reporting using government accounting and reporting procedures. Consequently, a wide range of information was gathered across the study countries, including the budget execution chain, flow of funds, provider payment, fiscal autonomy, management of supplemental budgets and unspent funds, and reporting.

Across the study countries, central governments follow similar procedures to execute their budgets. Following legislative budget approvals for the fiscal year, ministries of finance typically register anticipated expenditure in the country’s PFM system, in some cases alongside information about planned activities. They then release funds in quarterly or monthly tranches, allowing budget holders (e.g., ministries, departments, agencies, and other public entities) to spend against the released amount. Depending on the nature of the spending, budget holders may be bound to follow public procurement rules before committing or spending funds.

Intergovernmental transfers in the devolved countries are generally executed on fixed schedules. For example, Nigeria’s Federation Account Allocation Committee meets monthly to review the previous month’s revenue and distribute it across the three government tiers (161). Similarly, LGUs in the Philippines receive 80% of their internal revenue allotment by the eighth day of each month, with the remainder disbursed on the 24th (162).

In several countries, unpredictable timing and magnitude of fund releases delay subnational health spending. Over the last decade, delayed releases from central treasuries have been common in Burkina Faso (47) and Indonesia (163), compounded by late or incomplete donor disbursements in Mozambique (164) and the United Republic of Tanzania (130). Except for funds from the DOH’s Health Facility Enhancement Program, whose disbursements are often hampered by various management challenges (165), intergovernmental transfers are generally timelier in the Philippines (162,166). Transfers from the federal government to states are reliable in Nigeria (161), though less funding than expected reaches subnational budget holders due to poor revenue forecasts, and there is a history of multi-month payment delays to health workers (100,129). In contrast, despite delays in the release of funds in Uganda, allocations to districts are transferred in their entirety; the timeliness and accuracy of district transfers to individual facilities are more variable. Unreliable revenue projections are also problematic in the United Republic of Tanzania, where spending units make commitments based on approved budgets, only to accrue substantial arrears when they lack sufficient cash flow to pay suppliers and contractors (130). Central authorities are not the only culprits. In Kenya, health facilities on average wait about 90 days to receive the funds that counties allocate from their equitable share, roughly 40 days of which are due

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v In Kenya, the equitable share is the portion of centrally collected revenue that is distributed unconditionally to county governments, which then determine how to allocate it across sectors.
to delayed releases by county treasuries. Moreover, even though the National Treasury must disburse funds to county governments each quarter, counties are often late to submit the necessary requisitions to the Controller of Budget (167). In all these settings, late disbursements can lead to low budget execution rates and complicate cash flow management. When subnational authorities cannot pay suppliers, shortages or stock-outs of critical inputs such as drugs and supplies can also ensue.

The spending autonomy of subnational budget holders varies considerably across the study countries. The subnational governments in Burkina Faso (communes), Indonesia (provinces and districts), Kenya (counties), Mozambique (districts), Nigeria (states), the Philippines (provinces and municipalities), and Uganda (districts) do not require any authorisation from the central level to spend their funds. In contrast, Nigerian states often retain control over LGA spending and, in at least some states, LGAs can only spend money with state authorisation (133,147).

The central governments in Kenya, Mozambique, Nigeria, Philippines, and Uganda exclusively channel public funds to PHC facilities through subnational intermediaries. For example, in Mozambique, PHC facilities are not budget holders; funds flow to district health offices, which spend on behalf of the facilities (168). Central government funds for PHC facilities in Kenya are channeled through county governments (49). The only funds that flow directly from Uganda’s central government to PHC facilities are donor-funded, results-based financing (RBF) payments, whereas domestic PHC financing is disbursed to local governments, which then transfer funds to facility accounts (169). Health districts hold much of the PHC budget in Burkina Faso, and although payments to health centres from the MOH’s Free Care (Gratuité) program are earmarked exclusively for facilities’ use, they still pass through district special treasury accounts before reaching facilities (170). Finally, many facilities in Indonesia also receive central funds via a subnational level, though an increasing share of facilities have become semi-autonomous budgetary units that receive direct transfers (107).

Subnational levels in several countries receive a blend of unconditional and earmarked transfers. Indonesia’s provinces and districts, Nigeria’s states and LGAs, and the Philippines’ LGUs are all entitled to a share of national revenue, distributed by their respective central treasuries. Many of them also receive funds earmarked for health. Examples include disbursements from the BHCPF to state PHC development agencies and social health insurance schemes in Nigeria (171), and grants from the Health Facility Enhancement Program administered by the Philippines’ DOH (165). Previously, the central government in Kenya also made several conditional grants to county departments of health (55), though these were phased out in FY 2021/22 (172).

In all but one of the study countries, most or all publicly owned health facilities have their own bank accounts, which facilitate direct access to public funding. This is the case in Burkina Faso (173), Indonesia (174), Kenya (30), Nigeria (139,175), Uganda (144,176), and the United Republic of Tanzania (56). In Mozambique, the majority of PHC facilities do not have their own bank accounts, while the rest of health facilities do (177). In the Philippines, PhilHealth requires LGUs to maintain a separate bank account for the public health facilities they own for accounting purposes. However, the implementation of this policy has not been monitored (178).

Public facilities in most of the study countries collect user fees, though they are not always allowed by PFM rules to retain and spend the revenue. All facilities in Burkina Faso (47), Nigeria (133,175), and the United Republic of Tanzania (56) retain user fee revenue. Elsewhere, subsets of facilities may do so, including those that

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* In some countries, central finance authorities still exercise significant control over local spending. For example, through the warranting process in Uganda, the Ministry of Finance, Planning and Economic Development imposes strict quarterly expenditure limits that local governments cannot exceed (159).

* Officially, some states require PHC facilities to remit user fees to their local government for redistribution, but the revenue is not tracked, and state and local officials generally are unable to discover the fate of facility-collected revenue (133,175).
have been designated semi-autonomous budgetary units in Indonesia\textsuperscript{v} and DOH-owned hospitals in the Philippines. Other facilities must transfer revenue from user fees to local government accounts (107,179). In Kenya, only hospitals can collect user fees, but whether they can retain these revenues or not varies across counties. Under the 2012 PFM Act, counties can enact legislation to allow county government entities, including health facilities, to retain funds they raise. However, most counties have not enacted such legislation, instead requiring health facilities to remit these revenues to the County Revenue Account (30). In Mozambique, by law, health facilities cannot retain revenues from user fees. They must remit the revenues to the central government and then request to claim them; however, this rarely happens. Alone among the study countries, Uganda abolished user fees in all public facilities in 2001, although hospitals\textsuperscript{z} were permitted to create private wings where they charge user fees (180,181).

**Health facilities in some countries also collect insurance (or similar) payments, which are often off budget.** Among the study countries, Indonesia, Kenya, Nigeria, the Philippines, and the United Republic of Tanzania all have publicly financed, extrabudgetary health insurance schemes. Each of these funding sources has its own execution rules and protocols. In contrast, Burkina Faso’s budget-financed Gratuité scheme reimburses public facilities for operating costs associated with delivering a set of family planning, maternal, newborn, and child health services (182). Payments to districts and facilities from the donor-funded RBF scheme in Uganda are also on budget at the central level and more recently at the local level too.

**The ways health facilities spend their budgets and other revenue vary across countries.** Health facilities use their budgets to cover mainly operational costs. In Burkina Faso, own-source funds are used to pay for commodities and cover operating costs. In Nigeria, health facilities have discretion on how to use revenues from user fees; these usually supplement health workers’ income, complete minor repairs and upgrades, and purchase materials and supplies, including drugs (133,175). In the Philippines, DOH-managed facilities must use income from user fees and insurance reimbursements for capital and non-personnel operating expenses (183). Health facilities in the United Republic of Tanzania must spend revenues from user fees according to approved facility plans (56).

**Health facilities tend to have more flexibility than government agencies to carry funds over from one fiscal year to the next.** In several countries, including Kenya (49), Nigeria (100), and Uganda (76), most government agencies must remit any unspent funds to the relevant central or subnational finance authorities. In Indonesia, all government entities can retain unused funds if they conduct a satisfactory internal audit, but the excess funds will be deducted from the following year’s central government budget allocations (184).\textsuperscript{aa} In the United Republic of Tanzania, LGAs may carry over funds to the next year, but they are supposed to spend these funds during the first quarter of the next year. Facilities may assign surplus funds to incomplete or new activities (185). Kenya’s PFM regulations allow facilities to retain surplus with the approval of their county treasury, though in practice some counties permit fund retention while, in others, facilities remit their surplus to the county revenue fund (30). In Indonesia, only health facilities that have semi-autonomous budgetary units (BLUD) status can retain unused funds to use at their discretion, while other public health facilities need to give unused funds back to the local government entity that manages them. In Mozambique, facilities must remit any surplus to the national treasury, after which they may request to reclaim some of those funds. Finally, the Philippines is trying

\textsuperscript{v} Only a third of the Indonesian public primary health care facilities are semi-autonomous budgetary units; they collect user fees and receive national health insurance reimbursements directly in their bank account.

\textsuperscript{z} Although health centres are not included in the policy, the authors are anecdotally aware of at least one that operates a private wing that charges user fees.

\textsuperscript{aa} In the case of central government entities, an audit may also be conducted by the MOF’s inspectorate general.
to move away from planned budget carryovers and is transitioning towards an annual cash-based appropriation to promote faster implementation and better planning (186–188).

**Most of the study countries use a financial management information system (FMIS) to track spending by central government agencies, and in some the system is also used by subnational entities.** Central and subnational government ministries and departments use a common tracking system in Burkina Faso, Indonesia, Kenya, Mozambique, Uganda, and the United Republic of Tanzania. Nigeria has implemented an FMIS at the federal level, but there are no standard practices across states, nor do federal and state tracking systems interoperate. The Philippines is piloting an integrated system at the central level, while none exists subnationally.

**Health facilities less commonly use the FMIS.** In five of eight countries, at least some health facilities report directly through the integrated system, though not at the primary or secondary care levels in Mozambique. With the introduction of direct facility payments in the United Republic of Tanzania, a web-based system has been developed for facility accounting and reporting (5). In Kenya, health facilities do not have direct access to the FMIS. Instead, facility accountants compile the financial information and share it with the county treasury to enter it into the FMIS. Practices are similar in Burkina Faso and Uganda, where PHC facilities report to district authorities. Indonesia has several fragmented systems that extend to facilities (189,190), while Nigeria’s federal tracking system is not used at subnationally owned facilities, and in the Philippines, a new integrated system is so far only being piloted centrally.

**The FMIS in several countries lack attributes considered necessary for effective implementation in decentralised settings.** These include integration of systems at various levels; clear, consistent, and transparent reporting standards; strong institutional arrangements between the different government levels for coordination; a common chart of accounts; and sufficient capacity at all levels, both human and technological (191–193). Nigeria and the Philippines lack integrated systems, and deployment to subnational levels is only partial in Burkina Faso, Indonesia, and Mozambique. Kenya’s systems are relatively stronger. While Uganda is making progress towards fully integrated, standardised, and universally deployed reporting systems, the United Republic of Tanzania has made the most progress, though some capacity gaps remain at local levels (56). Nevertheless, full integration of systems should not hinder effective integration of reporting.

**The study countries are at varying stages of digitisation for their expenditure management systems.** Many have computerised systems at the central level, including Burkina Faso, Indonesia, Kenya, Mozambique, Nigeria, the Philippines (being piloted), and Uganda. However, extension of digital PFM systems to subnational levels and facilities is less common. Kenya’s systems are widely deployed, Burkina Faso’s extend to districts, and Mozambique’s to provinces, districts, and facilities that are budget units. Considerable effort has been made in recent years to make the United Republic of Tanzania’s PFM and health management information systems digital and interoperable, including the introduction of a financial accounting and reporting system to all facilities (56). Many of Uganda’s systems have been digitised but not deployed to PHC facilities. Following the rollout of the FMIS at the district level in Uganda, implementation and monitoring of activities were often difficult due to system instability, poor internet connections, and the fact that units below the districts (e.g., sub-counties, individual facilities) still report manually (194). Nigeria’s states generally lack mature PFM systems, instead relying on manually maintained records (139). In Indonesia, the nature of PFM system technologies varies by region, with Jakarta’s systems more advanced than those elsewhere (195).

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**bb** The central level enters information into the PFM system on behalf of communes.

**cc** Some states maintain computerised financial records using spreadsheet software like Microsoft Excel, but they generally lack more integrated or networked financial management systems.
Budget accountability, the final stage of the budget cycle, refers to independent agencies auditing government accounts and reporting findings to legislative authorities to inform future decisions. Information was gathered for the study countries about who monitors and accounts for health spending and with what information, the availability of routine and comprehensive budget and expenditure analyses, and the consequences and related decision-making processes associated with poor budget performance.

All the study countries have regular audit processes. Several have auditors general or similar offices responsible for scrutinising public spending at central and subnational levels, including Burkina Faso, Kenya, Mozambique, Uganda, and the United Republic of Tanzania. In the Philippines, the Commission on Audit, an independent constitutional body, plays this role (158). Likewise, Indonesia employs an external auditor (119,196). Auditors rely on a range of methods, including direct review of financial records and both routine and ad hoc site visits to verify spending. Nigeria’s Constitution requires annual audits of all public accounts (197), with specific rules and procedures defined separately at the federal and state levels.

Because they are extrabudgetary, publicly financed health insurance schemes often have separate accountability mechanisms. For example, Indonesia’s Social Insurance Administering Body for Health (BPJS-K) reports semi-annually to the president and National Social Security Council on the financial performance of the national health insurance scheme, Jaminan Kesehatan Nasional (JKN) (198). In the Philippines, spending by PhilHealth is monitored by its Board of Directors and chaired by the secretary of health and the Governance Commission for Government Owned and Controlled Corporations (158). There are analogous arrangements for Kenya’s National Hospital Insurance Fund (199) and the National and State Social Health Insurance Schemes in Nigeria (200,201).

Some of the study countries do not undertake comprehensive, consolidated analyses of health spending across government entities and levels. The data for conducting such analyses can be extracted from systems existing at different levels of the government, even if these are not integrated. Nevertheless, several countries leverage their FMIS to track health budget performance in a consolidated fashion. For instance, in the United Republic of Tanzania there is a consolidated budget execution report for the health sector, and Uganda’s Ministry of Finance, Planning, and Economic Development publishes an annual budget performance review that includes a detailed report on all health-related budget votes. In general, numerous institutions participate in budget monitoring and oversight across central and subnational levels (see Annex 4).

Transparency around public spending on health is gradually improving, though financial information for subnational levels is less readily available. Annual audit results are published in Indonesia (119) and the Philippines (158). Kenya’s auditor general publishes its reports with increasing reliability (122), and both federal and state governments in Nigeria publish audited financial statements, though sometimes with significant time lags (197,202–204). Uganda’s Ministry of Finance, Planning, and Economic Development maintains an online platform with budget information, including for local governments, dating back to FY 2009/10 (205). Subnational units are less likely to publish information online. For example, only a few of Kenya’s counties publish real-time financial data, in part because many of them, like local governments in Nigeria and the Philippines, lack their own websites (206). Similarly, in Burkina Faso, only two more developed communes publish a report that is available to everyone (157).
SECTION 2. CHALLENGES ARISING FROM MISALIGNED DECENTRALISATION AND PFM REFORMS

Building on the descriptions of PFM practices and processes above, this section identifies health financing challenges that have arisen in the study countries from misalignments between decentralisation and PFM reforms. These often stem from the reality that decentralisation, as a politically driven governance reform, outpaces PFM reforms and renders PFM rules and processes unsuited to the new distribution of public functions between central and subnational levels. This often translates into adverse and unmanaged implications for health and other sectors delivering public services at subnational levels. The consequences may be of special concern to health due to unavoidable uncertainty in population and individual health needs and the related need for flexibility at the service delivery level. In particular, the following three challenges are highlighted:

1. Decentralisation has led to mismatches between central and subnational planning processes and the resulting budgets for health.

2. Due to the maintenance of preexisting PFM rules, decentralisation has not been systematically associated with increased flexibility in health spending at the facility level.

3. Despite the strong push accompanying decentralisation for more transparency and accountability in health, countries still lack the PFM systems needed to support those aims.

MISMATCHED PLANNING AND BUDGETING

There is rarely perfect alignment between central and subnational plans and budgets in decentralised countries, often weakening prioritisation of activities in the health sector. Mismatches arise for numerous reasons. For example, the actors charged with planning are not always best positioned to discern needs or constraints at the service delivery level. Prior to reforms, LGAs in the United Republic of Tanzania developed and managed plans according to national directives on health priorities, but they also adjusted health facility plans to meet budget ceilings even though they were not familiar with facilities’ resource needs (40,41,45). Elsewhere, there is contention over whose priorities should prevail in planning, and efforts to increase budget allocations to health may be ineffective where national policy priorities are not reflected in the local budgeting process (5,7,207). In Kenya, counties do not always allocate resources in alignment with national health priorities, reflecting ongoing debates about the appropriateness of centrally defined priorities given the diversity of needs across counties. To promote alignment, the central government works through the Council of Governors and other intergovernmental forums, as well as increasingly using conditional grants to earmark county resources for specific health priorities. Nonetheless, there remain areas of overlap or contention, such as budgeting for family planning commodities at both central and county levels, or the perceived imbalance between the share of health resources controlled by counties and the scope of their implementation responsibilities (30).

Mismatches also arise when there is too little coordination, information flow, or support between central governments and subnational actors during budgeting. For instance, in the Philippines, uncertainty regarding in-kind transfers from DOH for priority programs hinders effective budgeting at the local level. In the mid-2000s, the Local Investment Plan for Health was introduced to help LGUs better plan and budget for health, facilitated by the DOH’s Bureau of Local Health Systems Development. LGUs now receive cash and in-kind incentives tied to their performance as measured by the DOH’s LGU scorecard. However, uncertainty about the timing and size of the incentive transfers means they are not factored into local budget preparation processes. LGUs' revenue from PhilHealth is also difficult to project and consider in the annual budgeting process. Indicative of insufficient coordination, the central DOH also provides capital financing for new facilities, with the local government expected, but not always willing, to provide funds to staff them (99,158). Additionally, central governments vary in their helpfulness to subnational counterparts. The central government in the Philippines provides templates
for annual work plans and organises trainings for LGU staff. In contrast, in Mozambique, planning guidelines are adjusted annually without sufficient training for local staff.

**Fragmented funding sources with varying conditionality make it difficult for subnational units to budget comprehensively.** In all study countries, subnational units receive funds through multiple channels, such as block and conditional grants from the central level, locally generated revenue, and donors. Funding amounts are often uncertain and subject to diverse conditions, limiting planners’ ability to foresee all available resources or use them flexibly to respond to local needs and priorities. For example, provincial and district health officials in Indonesia manage both unconditional transfers and several allocations earmarked for personnel and development programs in disadvantaged areas (87,107). In the Philippines, subnational governments also receive block grants plus allotments of central government revenue according to legislators’ priorities in their constituencies. These “Congressional insertions” can be hard to predict, so local planners often will not count on them to cover essential costs (158). In the United Republic of Tanzania, the government is working to mitigate some adverse effects of fragmentation by taking steps towards a harmonised PHC payment system across multiple sources of facility revenue, including DFF from the Health Basket Fund, Community Health Funds, the National Health Insurance Fund, and the RBF scheme (56).

**Decentralisation can exacerbate fragmentation** (208), **with consequences beyond planning and budgeting.** For example, as a later section of this study notes, decentralisation can make it more difficult to holistically track and analyse health spending due to the proliferation of budget and spending units. Additionally, fragmentation often results in facilities receiving multiple funding flows that lack coherence, clarity on who is paying for what services or inputs, or mutually reinforcing incentives. In these cases, facilities may change their behaviour in ways that undermine UHC objectives related to equity, efficiency, and quality (209). However, in some settings—including several of the study countries—decentralisation may also mitigate fragmentation’s adverse effects, such as where funds from disparate sources flow to a subnational entity that controls the bulk of disbursements payments to providers within its jurisdiction.

**Rapid decentralisation can pose additional challenges for subnational budgeting.** When Kenya transitioned to a devolved system of government, county officials responsible for planning and budgeting initially lacked a clear understanding of their roles and the skills to undertake them (32). Similarly, following the United Republic of Tanzania’s “decentralisation by devolution” reforms, LGAs were not always trained to develop budget plans (45). These dynamics have also been documented in other countries, such as the Democratic Republic of Congo and South Africa (5). Importantly, countries that decentralised more gradually were not immune to capacity challenges, which can vary between levels of government—for example, states fare better than local governments in Nigeria—and across subnational units, where some are more capable than others in Indonesia and the Philippines. Neglecting the capacity needs of different government levels in decentralised settings is unwise: several studies show that in countries with sufficient local capacity and accountability, decentralisation is more likely to have positive effects on health and service delivery outcomes (210).

**No guarantee of facility autonomy**

Decentralisation does not guarantee managerial or spending autonomy at the service delivery level. Across the study countries, early stages of decentralisation typically involved the transfer of additional decision-making power and fiscal controls to subnational levels—both devolved government tiers and de-concentrated extensions of central agencies—based on their new or strengthened service provision mandates. New authorities were rarely extended to service providers themselves, and in at least one country (Kenya), facilities’ prior autonomy was greatly curtailed. In essence, functions previously delegated by central governments to providers were shifted to subnational government bodies that did not immediately embrace sustaining or increasing provider autonomy. This limited the ability of frontline health facilities to flexibly use their resources (to the extent they had any) or to respond to the evolving health needs in their communities. The experiences in...
Kenya and the United Republic of Tanzania illustrate well how the distribution of authority and fiscal autonomy can evolve, due to both de- and recentralising forces, between the local government and service delivery levels (see Box 3 and Box 4, respectively).

**Box 3. The evolution of financial authority and control between counties and facilities in Kenya**

Prior to devolution in Kenya, public health facilities retained the revenue they received from user fees, insurance reimbursements, and other transfers from the government and used them to finance their operating budget. After devolution, which began in 2013, the newly formed counties required public facilities to remit all their revenue to the county treasury, either because of a narrow interpretation of the PFM Act (2012) or a desire to maximise county revenue, or both. The Act permits counties to enact legislation that would allow health facilities and other public entities to retain internally generated revenue (211), but not many have.

To increase health spending at the county level and provide frontline facilities with more discretionary funds, the central government and donors have channeled funds through conditional grants that counties are required to transfer to facilities (30,55,167), protecting them from other county priorities. However, in Kenya’s budget for FY 2021/22, the central government folded funds previously transferred through conditional grants back into the block grants, giving counties fuller discretion over their use (172). How this will affect financing for county-managed health facilities, including the extent to which frontline facilities control their resources, remains to be seen.

**Box 4. The evolution of financial authority and control between LGAs and facilities in the United Republic of Tanzania**

In 1998, the Government of Tanzania adopted a policy of decentralisation by devolution (D-by-D), giving LGAs greater authority and responsibility in health and other public service delivery. Under this policy, LGAs came to manage all funds for local health services, including from the Health Basket Fund and revenue collected by facilities. For example, the MOFP disbursed health sector basket funds to LGAs’ health sector bank accounts based on input-based line-item budgets. A portion of the funds was earmarked for PHC facilities, but there was no set allocation for each individual facility, and so not all facilities benefited equitably (or at all) from these disbursements. The concentration of funds and decision-making at the LGA level led to procurement delays, a sub-optimal inputs mix, and ultimately poor frontline services.

To overcome these challenges, the Government of Tanzania further delegated some decision-making and financial authorities to service providers, and in 2011 health facilities were permitted to open their own bank accounts. Over time, this enabled direct payments to facilities by a results-based financing scheme and the National Health Insurance Fund, and facilities developed stronger capacity to manage funds and procure inputs based on health needs. In 2017, the health sector formally adopted DFF, after which all health sector basket funds and insurance reimbursements were transferred directly to facilities’ bank accounts. Key enablers of the DFF reforms included the directives given to all health facilities to open standard bank accounts, the shift to output-based payments from the Health Basket Fund, the development of capable facility-level financial management, and a realignment of institutional roles and responsibilities across levels of the government—including the LGAs—to shift from day-to-day operations to support and oversee facilities.

Source: (56).
In many of the study countries, health facilities generally have no or limited flexibility to unilaterally repurpose budget funds during the fiscal year. PHC facilities and rural and district hospitals in Mozambique are not budget units and have no discretion to reallocate funds, while other hospitals can make a fixed number of midyear adjustments (212). In Uganda, PHC facilities and district health offices largely control their operating budgets but must rely on their district’s chief administrative officer to request adjustments across their grants for operating, wage, and capital expenses, which must be approved by central finance authorities (159). Similar constraints have been observed in Burkina Faso, Indonesia (except for facilities with BLUD status) (184), Kenya (213), the Philippines (128), and United Republic of Tanzania (41).

Earmarking at the central level has diverse impacts on how much discretion subnational units exercise over their health budgets and on facility-level spending autonomy. In some countries, conditional grants and similar transfer mechanisms limit subnational spending discretion. For example, conditional grants account for an increasing share of intergovernmental transfers in the United Republic of Tanzania and Uganda. The latter’s central government provides three conditional grants for health to local governments, and local health offices do not have the authority to reallocate funds across the grants (214). Conversely, conditional grants in Kenya are the key financing source for discretionary spending by facilities. Several grants are specifically intended to channel funds to facilities for their own use, including one for foregone user fee revenue (30,167) and another funded by the Danish International Development Agency (55). Deployed in this fashion, conditional grants can be mutually beneficial to a central government wanting to align subnational activities with national priorities, and to subnational governments seeking sufficient resources to carry out their mandates (55).

Whether and how autonomously facilities spend money also depends on their status in budgets and charts of accounts. In Burkina Faso, PHC facilities do not have their own sub-paymaster account at the treasury. Consequently, local authorities make spending decisions on their behalf, except with respect to Gratuité income, which passes through district sub-accounts and on to facilities. Similarly, although district health services, district hospitals, and rural hospitals all have budgets identified in Mozambique’s PFM system, they are not budget units and therefore must have their spending authorised by district secretariats (145). In contrast, facilities in Kenya are budget holders and, like other subnational health units, must obtain approvals from the county health and finance departments to spend money (167). Likewise, facilities in the United Republic of Tanzania were added to the chart of accounts as part of broader efforts to extend PFM systems to the service delivery level and impart greater spending autonomy to providers (56).

Over time, several study countries recognised shortcomings in their PFM systems and undertook reforms to put more money under the direct control of health facilities. For example, Burkina Faso’s Free Care (Gratuité) program introduced a direct financial flow from the MOH to PHC facilities, allowing facilities to spend funds flexibly to cover operating expenses (170). The implementation of DFF in the United Republic of Tanzania has also increased transfers directly to facility bank accounts, as well as granted facility managers greater authority and responsibility for planning and resource allocation. Spending flexibility could be further enhanced by allowing facilities to reallocate funds across activities or inputs at any time rather than only at the midpoint of the financial year, as well as harmonising spending guidelines across fund sources (56). Uganda introduced

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dd There is only one rural hospital that is a budget unit.

e° Adjustment types include supplementary allocations, virements (by which money is shifted from one budget line to another within a budget vote), and reallocation (by which money is shifted from one budget vote to another).

ff The health sector conditional grants are for wages, non-wage recurrent expenses, and development costs such as facility upgrades and major repairs.

gg The chart of accounts is a critical element of the PFM system that facilitates classification, recording, and reporting of information on financial transactions in a systematic and consistent manner.
grants to health facilities to cover non-wage recurrent costs. Technically these grants are appropriated to local
governments, but their allocation to individual facilities is determined centrally. Building on a donor-funded RBF
scheme, efforts are under way to incorporate output- and quality-linked payments into the grants
(169,215,216). Nigeria’s BHCPF similarly aims to increase the availability of funds for frontline providers, albeit
with more substantial involvement by state-level agencies (171). Finally, PHC centres (puskesmas) and hospitals
in Indonesia may seek to become semi-autonomous budgetary units (BLUD), which have enhanced control over
both allocated and internally generated funds (107).

INSUFFICIENT PFM SYSTEMS FOR TRANSPARENCY AND ACCOUNTABILITY

Subnational units and health facilities face what others have called “multiple and conflicting lines of
accountability” (46). To varying degrees, downstream actors in all eight study countries must manage and
account for financing from multiple sources, including a blend of discretionary and earmarked government
funds, on- and off-budget donor resources disbursed to different levels of the health system, and one or more
forms of private spending. Challenges are especially acute in Uganda, where the many substantial flows of off-
budget external funding hinder holistic reporting and accountability (46). Nigeria contends with similar
fragmentation, compounded by a federal system in which no central entity has the legal authority or sufficiently
robust coordination mandate to impose common accounting or reporting standards on all levels (100,139).

Subnational budget classifications promote accountability for inputs rather than service outputs or outcomes.
Economic classifications prevail in most subnational levels of the study countries (Table 3), and where program-
based budget principles have been incorporated, spending units are often still held accountable for adherence
to line-item allocations rather than programmatic achievements. Central reforms to increase flexibility are slow
to permeate subnational levels.

Some study countries still have limited capacity to ensure the transparency of subnational spending data.
There is no standardised process or system for public access to subnational budget documents in several study
countries, including Kenya, Nigeria, and the Philippines. In Kenya, some counties publish all their budget
information online, but others do not due to capacity constraints and poor connectivity. Elsewhere, subnational
governments lack channels for publishing key budget and expenditure data, thus limiting the public’s access to
expenditure information. For example, Nigeria’s FMIS tracks only federal spending, while subnational levels rely
on manual reporting processes. These constraints undermine the reliable, complete, and transparent
dissemination of public financial information, which is necessary to the accountability of subnational
governments to communities and their central counterparts.

Several of the study countries do not regularly consolidate and analyse health spending across all government
levels. No public entity in Nigeria has a mechanism or mandate to consolidate health spending information
across government tiers, geographies, or types of services (51). Similarly, expenditure information in the
Philippines is fragmented across the central DOH, PhilHealth, and LGUs (217). In Uganda, budget holders
produce biannual spending reports, but sector-specific spending is not systematically consolidated across the
central and local governments (53). In contrast, a consolidated picture of health spending is generated in other
study countries, including Burkina Faso (47), Indonesia (119), and Kenya (131).
SECTION 3. IMPLICATIONS FOR POLICY AND RESEARCH

Findings from the study countries provide a range of lessons for those seeking to improve the financing of health services amid decentralisation. This section distills the policy implications of the challenges that have resulted from the misalignments between PFM and decentralisation reforms, which resonate with findings of other recent studies that examine how challenges in subnational PFM affect service delivery (46). It also offers policy options for overcoming these challenges based on promising efforts in the study countries (summarised in Table 5 and elaborated below). The section concludes with suggested priorities for future research.

Table 5. Challenges and policy options in decentralised settings

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Policy options (aimed at central and/or subnational levels)</th>
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<tbody>
<tr>
<td>Mismatched planning and budgeting</td>
<td>Systematically train subnational government staff to handle the planning and budgeting process (central and subnational)</td>
</tr>
<tr>
<td></td>
<td>Improve intergovernmental coordination for planning and budgeting (central and subnational)</td>
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<tr>
<td></td>
<td>Strengthen incentives for subnational governments to increase spending on health (central)</td>
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<td></td>
<td>Strategically align budget structures across levels and funding sources (central and subnational)</td>
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<td></td>
<td>Adopt and fully implement approaches that enable spending flexibility, including but not limited to program-based budgeting (central and subnational)</td>
</tr>
<tr>
<td>No guarantee of facility autonomy</td>
<td>(Re-)extend financial autonomy to facilities through direct facility financing or similar mechanisms while allowing facilities to decide how to spend their funds (central and subnational)</td>
</tr>
<tr>
<td></td>
<td>Institutionalise these mechanisms and update PFM frameworks accordingly (central and subnational)</td>
</tr>
<tr>
<td>Insufficient transparency and accountability</td>
<td>Accelerate digitisation and interoperability of key financial, health, and operational information systems (central and subnational)</td>
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<tr>
<td></td>
<td>Extend systems to subnational and service delivery levels to enable evolving PFM frameworks (central and subnational)</td>
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<tr>
<td></td>
<td>Work towards a more unified payment system underpinned by more capable and interoperable information systems (central and subnational)</td>
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First, decentralisation has complicated health planning and budgeting, particularly where the sector is devolved to subnational levels. Disparate budget structures can hinder collaboration across government levels. At times, this contributes to disjointed or duplicative sector plans and low levels of budget prioritisation for health due to lack of willingness and interest of local officials to spend more. Fragmented financing compounds these challenges, especially where subnational actors lack the capacity to develop rigorous and credible health budgets. In addition, the continued reliance of subnational units on input-based budgeting constrains the responsiveness of resource allocations to population health needs and spending flexibility of subnational units.
Several of the study countries have taken steps to promote subnational prioritisation of health and better align planning and budgeting across levels. In Kenya, Nigeria, and Uganda, central governments have attempted to overcome the lack of local political will by earmarking funds or conditionalising intergovernmental transfers to ensure greater prioritisation of health in subnational spending. Elsewhere, including the Philippines and the United Republic of Tanzania, central authorities and development partners have invested in training and tools to improve subnational budgeting. Increasing levels and prioritisation of health spending subnationally in most of the study countries suggest these efforts to use earmarked or conditional grants and to improve capacity of subnational governments for planning and budgeting have succeeded to an extent.

To further strengthen budget development, countries need to continue reforming budget structures to better align across levels. This will facilitate more coherent planning and budgeting throughout the health system. Additionally, they should adopt—and fully implement—budgeting approaches that more consistently provide flexibility in health spending, such as program-based budgeting, or simpler processes or increased thresholds for virements (or both). Finally, to bolster prioritisation of health in public spending, central governments can consider strengthening incentives for subnational units to increase allocations to the sector. In fact, conditional and matching grants could ensure that a greater share of the overall subnational government budget is allocated to the health sector.

Second, decentralisation does not necessarily enhance the managerial or spending autonomy of service providers. In the study countries, reforms that bestowed public functions on subnational levels of government rarely extended new authorities to service providers, and in Kenya’s case, devolution caused a notable decrease in facility autonomy. Additionally, facilities’ status in budgets and charts of accounts varies considerably: in some countries they are budget holders and spending units recognised by PFM systems, while elsewhere their financing is managed by local governments. Consequently, frontline facilities in many countries lack managerial and spending autonomy so that they cannot respond flexibly to evolving community health needs or repurpose funds across budget lines throughout the financial year.

Several of the study countries have recognised the harms of these constraints and introduced diverse reforms to put more money under the direct control of health facilities. For example, Kenya and Uganda have relied on earmarked intergovernmental transfers to ensure a portion of funds voted to local governments ultimately reach frontline facilities. Elsewhere, reforms have focused on preparing facilities to receive direct payments or transfers, including requiring them to open bank accounts in the United Republic of Tanzania and allowing them to be designated as semi-autonomous budget units in Indonesia. Similar efforts are ongoing in Nigeria, where the federally financed Basic Health Care Provision Fund is designed to purchase services directly from facilities via state-level social health insurance schemes.

Moving forward, decentralised (and other) countries need to further develop and institutionalise mechanisms to give facilities more discretionary funding. Many countries continue to favour strict fiscal controls over facility autonomy, at the expense of service delivery. They should instead consider a different balance that would enable the health system to be more responsive to needs and empower service providers to improve productivity and quality. Related countries should update their PFM frameworks to accommodate, reinforce, and increase discretionary financing at the facility level. For example, fuller implementation of program-based budgeting can increase flexibility while shifting the focus of accountability away from inputs and towards service outputs and outcomes aligned with health policy goals. Additionally, central governments can encourage and

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10th However, in Kenya’s budget for FY 2021/22, the central government folded funds previously transferred through conditional grants back into block grants, giving counties fuller discretion over their use. How this will affect financing for county-managed health facilities, including the extent to which facilities control their resources, remains to be seen.

11th For further discussion, see the companion report on health financing in devolved settings.
support subnational governments to adopt more standardised and autonomy-enabling PFM practices.

**Third, decentralisation has not delivered on its promise of greater transparency and accountability for public spending on health.** In fact, financial management information systems remain weak and severely fragmented in many of the study countries, hindering timely, efficient, and comprehensive reporting and analysis of health spending. This is partly a symptom of subnational levels and frontline facilities having to manage and account for fragmented financing from disparate sources. Moreover, central governments in some countries are powerless or unable to ensure transparency or public availability of subnational health spending data. This undermines accountability and prevents the routine use of high-quality information in management and planning. Additionally, input-based budget structures have proliferated to subnational levels, reinforcing accountability and fiscal control practices centered on inputs rather than service outputs or outcomes.

**The countries included in this study are at varying stages of strengthening their health and financial information systems, including through digitisation.** While the United Republic of Tanzania has gone farthest towards integrating its systems and extension at the service provision level, other countries, including Burkina Faso, Indonesia, and Kenya, also generate, analyse, and consolidate health spending information across all government levels. Several countries are also undergoing budget reforms to encourage greater results in how government plans and accounts for spending, though these reforms have been slow to unfold.

**Countries should accelerate budget reform efforts and intensify investments to improve their information systems.** As countries continue to build foundational budgeting capacity and institutionalise existing systems, including FMIS, at subnational levels, modernising the information technologies used to capture and share budget and expenditure data can improve health system efficiency and accountability. Planning and performance can also benefit from connecting the FMIS to operational data systems, such as those for managing logistics, human resources, and service outputs and outcomes. While digitisation of systems can help to improve accountability, it is no panacea. Other efforts will also be critical, including strengthening institutional arrangements between the different government levels for monitoring, reporting, and analysis of health spending. Even where it will be many years until key information systems are universally deployed, interoperable, and computerised, financial analysis and management across government levels can benefit greatly from harmonised budget and reporting structures and practices, such as a uniform chart of accounts.

**Ultimately, decentralised countries need to continually scrutinise PFM challenges in their health systems and tailor politically feasible reforms to their context.** Decentralisation often follows the end of a conflict or a radical change in government, constituting a shock to public administration and financial management that subnational levels need years (sometimes decades) to adapt to. It is also highly political and goes well beyond the health sector; to improve public services, decentralised countries may need to confront an array of governance and even leadership challenges. Such efforts can be daunting. Nonetheless, examining previous and ongoing experiences, such as those in the study countries, can be instructive.

**This study and the underlying country case studies raise numerous questions to be addressed by future research.** First, given the health sector’s limited ability to influence the trajectory of decentralisation in many countries, which PFM and health financing reforms are likeliest to succeed under various models of decentralisation? Second, what opportunities and constraints for health financing arise from the political economy of decentralisation? Similarly, how does competition over authority and resources between levels of government affect efforts to increase funding and autonomy for frontline facilities? Third, what of the advantages and drawbacks of extrabudgetary health financing approaches—such as national health insurance schemes—in decentralised settings? Fourth, what are promising ways to integrate vertical programs, which are centrally (or externally) financed, into decentralised health systems without jeopardising their coverage? And finally, what financing lessons can health systems draw from other sectors that deliver services in decentralised contexts?
As evidence for these and other important issues continues to emerge, countries can make considerable progress. The varying needs and capabilities of health system actors, especially purchasers and providers, will suggest different options for aligning health financing and PFM from one decentralising country to another. Common among them will be the perpetual need to coordinate PFM reforms with other important health financing and management initiatives, including but not limited to transitioning to output- and outcome-based payment systems, improving supply-side readiness, and enhancing financial management capacity and accountability structures at the service delivery level. Where the need for reforms has yet to gain traction, as is the case in many of the countries reviewed for this study, building awareness and understanding of PFM issues among national and subnational policymakers is an urgent next step.
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ANNEX 1. STRUCTURED QUESTIONNAIRE

This annex outlines the questions that each of the country teams used to collect data.

OVERVIEW/COUNTRY CONTEXT

Health financing
1. List your country’s main health financing schemes—e.g., budget funding, national health insurance scheme, other national schemes, specific subnational schemes—and the eligible population groups.
2. Please provide the latest estimates of the following:
   - Domestic government spending for health as a share of (current) health spending.
   - Domestic government spending for health as a share of total government spending.
   - Out-of-pocket health spending as a share of (current) health spending.

Decentralisation
3. Provide a brief overview of the history of devolution in your country (consider using a time chart or diagram).
4. What is the current setup of devolved government?
   - De-concentration (no local government): administrative divisions at what level (provinces/regions, counties/districts/municipalities, sub-counties, ...)?
   - Devolution (local government): at what level, and is it political decentralisation, fiscal decentralisation, or both?
5. Fiscal decentralisation indicators (potential sources for information include Government Finance Statistics website and National Health Accounts reports):
   - What share of government revenue is from state and local levels?
   - What share of government expenditure occurs at state and local levels?
   - What share of government expenditure for health occurs at state and local levels?

PFM laws (or legal framework)
7. Did the legislation change post devolution? If yes, how?

BUDGET FORMULATION

Revenue raising and intergovernmental transfers
8. Is there clear division of authority on revenue raising between central and local levels, and revenue sharing rules?
9. Do subnational governments raise revenue? If yes, what are their main sources of revenue?
10. What share of the local budget is financed by intergovernmental transfers from the central/national government (payments from national health insurance agencies to their subnational branches are not categorised as intergovernmental transfers for the purposes of this exercise)?
11. What criteria are used to determine the amount of funds being transferred to each subnational unit? Are local needs considered (in terms of preferences, infrastructure upgrading needs), poverty levels, demographics, etc.?
12. What types of transfers are used (e.g., earmarked/conditional grant, block grant, matching versus non-matching grants)?
13. Are conditionalities tied to the funds that are transferred? What kind of conditionalities (e.g., pre-requisite like x% allocated to health, matching requirements, rules about how the funds can be spent, and/or performance indicators or targets)?

14. Are there any resource allocation formulas used for allocating funds across subnational units? Are there any mechanisms for equalising revenue or spending across subnational units?

Budget development process

15. Describe the budgeting process in terms of the key steps and associated calendar at the following levels:
   – National
   – Subnational/local
   – Health facility

   How has the budgeting process evolved over time as a result of devolution? Is there a gap between how the process is envisioned (de jure) and how it transpires in practice (de facto)? Are there aspects of new PFM laws or procedures introduced as part of the decentralisation process that have not been implemented?

16. What budget classifications are used at each level:
   – Administrative (by administrative unit, e.g., Ministry of Health, Ministry of Education, etc., based on country context)
   – Functional (by sector such as health, education, etc., following international guidelines from the International Monetary Fund)
   – Program-based (by programs like curative, preventive, administrative costs, etc.)
   – Economic (based on economic inputs, like salaries, commodities, etc.)

   Note that more than one classification may be used, with some nested within others. What is the budget classification used for spending/appropriation? Note that the budget can be formulated using one approach (for example, program-based budgeting) but spending is incurred following a different approach (for example, input-based budgeting).

17. What decisions about health spending priorities are made at each level?

18. Does the central government require the subnational government to allocate a certain minimum share of their budget to health?

19. Are public sector health workers employed by a national ministry (which one, e.g., MOH or ministry of public service) or the local government? Are salaries of health workers budgeted for by the central level or local levels?

20. What is the level of discretion that subnational governments have on various budget lines (personnel, drugs, operational costs, etc.)?

21. Does the local government budget for drugs and other health commodities?

22. To what extent can subnational governments combine funds from different grants or intergovernmental transfer mechanisms from the central government?

Budget negotiation

23. How has devolution impacted budget negotiation in the health sector?

24. Is the health budget scrutinised and debated by the national legislature? What about local legislative assemblies?
BUDGET EXECUTION

Flow of funds
25. What does the budget execution process look like? Briefly explain how funds flow from the national treasury to various ministries, subnational levels, down to health facilities. Consider both financial and in-kind transfers.
26. What are the main steps in the spending process at the local and facility level? Who authorises spending decisions, and how?
27. How has the flow of funds changed because of devolution?

Provider payment
28. What are the provider payment mechanisms used by the local government to pay health providers? Note, this can vary by type of provider (e.g., hospital versus PHC facility).
29. Can local government purchase health services from private providers? Do they? What are the contracting mechanisms in place?
30. Has devolution impacted provider payment methods? If yes, how?

Facility autonomy
31. Do public facilities collect user fees and insurance reimbursements? If yes, 
   – Can they retain those funds, or are they remitted to the local government?
   – Are they earmarked for health?
32. Do public facilities receive any direct financial transfers from the national government (e.g., under a PBF or user fee reimbursement scheme)?
33. Do public facilities receive any direct financial transfers from the local government or administration (beyond in-kind transfers for staffing, drugs, etc.)? What is the basis for these transfers? Are they linked to performance?
34. Can public facilities retain and use any surplus?
35. What kind of costs do facilities cover using their own budget (staff, drugs, operational costs, etc.)? What kind of approvals do they need to incur expenditure?
36. Do public facilities have their own bank account?
37. From existing literature and studies (e.g., Public Expenditure Tracking Surveys, health facility surveys), is it possible to estimate what share of the operating cost of public facilities is covered by the operating budget controlled by the facility?

Supplemental budgets and unspent funds
38. Is there any flexibility to reallocate the budget during the year? If yes, which levels have this flexibility? Has this changed post decentralisation?
39. Can the unspent funds be carried over to the next year?
40. Has the budget execution rate improved post devolution?

Budget reporting and monitoring
41. Is there an integrated financial management system for tracking spending? Which of the following use the system?
   – All national government ministries and departments
   – All local government ministries and departments
   – Health facilities
42. Briefly describe the existing mechanism to monitor health budget execution.
43. Which institution is responsible for monitoring the health budget at different levels (national versus local)? Is there a consolidated budget execution report for the health sector?

44. What data and information are used for budget monitoring? How?

45. Are there any consequences for underspending/overspending on the health budget? If yes, who makes that decision? What is the decision-making process?

46. Is there a government audit process? Briefly describe it.

47. Does the government publish the annual budget proposal and approved budget for the health sector, the budget execution report, audit reports etc.? 
## ANNEX 2. OVERVIEW OF DECENTRALISATION IN THE EIGHT STUDY COUNTRIES

<table>
<thead>
<tr>
<th>Country</th>
<th>Levels of government</th>
<th>Brief history of decentralisation</th>
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</thead>
<tbody>
<tr>
<td>Burkina Faso</td>
<td>Regions, provinces, districts, and communes</td>
<td>Between 1960 and 1991, Burkina Faso’s political administration changed between democratic governments and military regimes. The last two decades of this period were characterised by over-centralisation.</td>
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<td>The country made its first step towards decentralisation in 1991 when the new constitution was adopted and local governments were established.</td>
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<td>Regions and communes were introduced as the two levels of local government in 1993. Districts were created in 1994.</td>
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<td>In 1998, provinces were added as another level of the local government.</td>
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<td>Between 2009 and 2014, authority was transferred from the central government to local governments. However, the transfers were made only to communes and applied to 4 out of 11 areas of competencies, including health.</td>
</tr>
<tr>
<td>Indonesia</td>
<td>Provinces, districts/cities, sub-districts, and villages/municipalities</td>
<td>Since gaining independence in 1945, Indonesia was mostly managed by a central government.</td>
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<td>In 1974, administrative areas at the provincial, district, and municipal levels were formed; decision-making power remained at the central level.</td>
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<td>District governments gained political and fiscal autonomy in 1999. Eleven functions were transferred to provinces and districts.</td>
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<td></td>
<td>In 2004, provincial and district governments were responsible for five more functions.</td>
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<td>As of 2014, provincial governments oversee district and municipality levels and report to the central government. Provincial and district governments are responsible for 6 mandatory functions related to basic services and 18 mandatory functions related to non-basic services.</td>
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<tr>
<td>Kenya</td>
<td>Counties, sub-counties, and wards</td>
<td>Local authorities provided a range of services during the colonial period.</td>
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<td>In the post-independence period, the country became a highly centralised unitary state with 8 administrative provinces and districts.</td>
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<td>Reforms in 1980 de-concentrated a range of functions to the district level.</td>
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<td>The country adopted a new constitution in 2010 that introduced a new, devolved structure with 47 newly created counties. The new structures came into being following elections in 2013.</td>
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<td></td>
<td>Each county is divided into sub-counties and wards, which are nested administrative units.</td>
</tr>
<tr>
<td>Mozambique</td>
<td>Provinces, districts, and municipalities</td>
<td>When Mozambique gained independence in 1975, the Portuguese colonial administrative structures were replaced by a new system of governance at central, provincial, and local levels consisting of districts and cities.</td>
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<td>The 1990 constitution defined two additional types of local authority: municipalities in cities, and towns and village councils in rural areas.</td>
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<td>Thirty-three municipalities were established in 1997. The number of municipalities gradually increased to 43 in 2008 and to 53 in 2013.</td>
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<td>In 1998, the central government started implementation of the District Planning and Financing Project in Nampula Province to support efforts to decentralise planning and financing at the district level.</td>
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<td>In 2003, the structure and organisation of local state organs were defined, and districts became the planning and budgeting units. The autonomy of provinces and districts increased.</td>
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<tr>
<td>Country</td>
<td>Levels of government</td>
<td>Brief history of decentralisation</td>
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</tbody>
</table>
| Nigeria (129, 147, 235, 236)     | States and local governments | - In 2018, the constitution was amended to state the three levels of decentralisation with elected provincial, district, and municipal assemblies.  
- A decentralisation package was approved in 2019 and 2020.  
- The colonial constitution of 1951 introduced a degree of regional autonomy.  
- In the late 1960s, Nigeria's four regions were dissolved into 12 less powerful states under a stronger central government.  
- In 1976, 7 new states and the Federal Capital Territory were created, and local government areas were established as the third government tier. Two more states were created in 1986, and 15 between 1991 and 1995.  
- The 1999 constitution maintains the three-tier system that also prevails today, with power and resources distributed among the federal government, the Federal Capital Authority, 36 states, and 774 local government areas.  
- Political and fiscal authority is vested in the federal government or devolved to states. Local governments are subject to states’ willingness to delegate power and financial autonomy. |
| Philippines (237)                | Regions, provinces, cities, and municipalities | - With the enactment of the Local Government Code of 1991, a decentralised system was organised.  
- Local government units have full autonomy to finance and operate local health systems. |
| Uganda (238–241, 85, 242)        | Districts, counties, sub-counties, parishes, villages | - Political decentralisation was introduced in 1986.  
- In 1992, the government established the Decentralisation Secretariat, a semi-autonomous organisation embedded under the Ministry of Local Government to support the decentralisation process. The Decentralisation Secretariat was dissolved in 2004.  
- In 1995, the new constitution was adopted, which established 5 levels of the government (i.e., district, county, sub-county, parish, and village).  
- In 1997, the government passed the Local Government Act to devolve power and responsibility for public service delivery to local governments.  
- Between 1997 and 2000, the government introduced decentralisation of recurrent expenditures at the district level, and the central level started to provide 3 transfers.  
- In 2014, the government decentralised payroll management and salary processing. |
| United Republic of Tanzania (243)| Districts, wards, and villages | - Between 1961 and 1972, LGAs were introduced; LGAs were highly dependent on their own revenue sources.  
- The LGA system was abolished in 1972, when a de-concentrated system (*Madaraka Mikoani*) was adopted.  
- The LGA structure was reintroduced in 1982 through the Local Government Act (District and Urban Authorities) due to the lack of resources and weaknesses in governance structure.  
- In 1998, the Policy Paper on Government Reform introduced decentralisation by devolution, through the amendment of the Local Government Finance Act, which also involved the decentralised management of human and financial resources. LGAs were mandated to establish and maintain reliable sources of revenue and were allowed to contract with third parties. This mandate was furthered with the introduction of an electronic revenue collection system between 2002 and 2015. |

Note: Indonesia and Nigeria are federal states.
## ANNEX 3. ROLES OF SUBNATIONAL GOVERNMENTS IN HEALTH SERVICE DELIVERY AND FINANCING

<table>
<thead>
<tr>
<th>Country</th>
<th>Service delivery</th>
<th>Key roles of central and subnational levels</th>
<th>Health financing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Revenue raising</td>
<td>Pooling</td>
</tr>
<tr>
<td><strong>Burkina Faso</strong> (47)</td>
<td>MOH is responsible for policy and planning and steers policy implementation through regional and district health offices. The district health office oversees district hospital and PHC facilities. PHC centres alone also report to the communes where they are located. Regional health office oversees regional hospitals.</td>
<td>The central government raises the bulk of the revenue. Communes are responsible for local revenue raising.</td>
<td>Pooled at the national level.(^\text{ii})</td>
</tr>
<tr>
<td><strong>Indonesia</strong> (48)</td>
<td>The central government is responsible for overall health policy and overseeing centrally managed tertiary facilities. Provincial governments have the authority to develop regional/provincial policies and regulations. Provinces manage provincial hospitals, while districts operate district hospitals and PHC facilities.</td>
<td>Subnational governments can raise revenue but account for a small share. They rely heavily on transfers from the central government.</td>
<td>There is one national pool from the national budget, and several provincial and district pools. Districts and provinces also receive earmarked funds for specific health programs from the central government, which cannot be pooled with their general budget. The national health insurance scheme, JKN, pools resources at the central level.</td>
</tr>
<tr>
<td><strong>Kenya</strong> (49)</td>
<td>MOH sets policy and oversees tertiary care facilities. Counties directly manage service delivery in all primary and secondary care facilities in the public and regulate private providers in their jurisdiction.</td>
<td>The central government raises the bulk of the revenue. Counties generate local revenue, but in practice this remains a small share of the county budget.</td>
<td>The central government pools the bulk of tax revenue and allocates a share to counties. Counties pool these transfers with local revenue. The National Health Insurance Fund (NHIF) manages additional pools at the</td>
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\(^{\text{ii}}\) The national health insurance scheme is not yet operational. Therefore, pooling mechanisms for this scheme are not established.

\(^{\text{kk}}\) The institution was until recently called “National Hospital Insurance Fund.”
<table>
<thead>
<tr>
<th>Country</th>
<th>Service delivery</th>
<th>Key roles of central and subnational levels</th>
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<tbody>
<tr>
<td>Mozambique</td>
<td>MOH sets health sector policies and plans. Provinces are responsible for provincial sector plans and for operating provincial facilities. Districts manage health service delivery in their jurisdiction.</td>
<td>The central government mobilises and allocates the bulk of funds. Revenue generated by districts and provinces represents a small share of the total. Funds are pooled at the national level by MOH, the provincial level, and the district level. The central government purchases services from central and specialised hospitals. Provinces purchase services from provincial hospitals. District health offices purchase services from district and rural hospitals and health centres. All public facilities charge user fees.</td>
</tr>
<tr>
<td>Nigeria</td>
<td>The federal MOH oversees tertiary facilities and funds select health programs. States manage their own hospitals and oversee PHC services through PHC Boards. Local governments supervise PHC services.</td>
<td>The federal tier raises the bulk of government revenue. A large share is transferred to on federal transfers mostly managed on their behalf by states. The federal MOH and each state is a pool. Some states also operate health insurance schemes, but these are small, as is the federally administered National Health Insurance Scheme. There is minimal pooling at the local level. The federal government purchases services from tertiary facilities and pays for commodities for all levels. The state government covers the costs of state hospitals, as well as salaries of health workers in state-owned facilities and of skilled health workers in locally managed facilities. Some local governments pay for the operating costs of primary care facilities. Most public facilities charge user fees.</td>
</tr>
<tr>
<td>Philippines</td>
<td>DOH sets policies, regulates services, and continues to have direct oversight of some tertiary hospitals. LGUs (which include all levels listed in the previous table) are responsible for managing and implementing local health programs, facilities, and services.</td>
<td>The central government raises the bulk of government revenue. LGUs have the authority to raise their own revenue, but most continue to be highly dependent on fiscal transfers and allocations received from the central government. DOH and PhilHealth manage the biggest fund pools for health at the central level. LGUs pool funds received from central government and their own source revenue into the LGU budget. DOH purchases services from DOH-owned hospitals as line-item budgets and provides some inputs, including commodities and temporary staff for other facilities. LGUs purchase services from LGU-owned facilities as line-item budgets. PhilHealth purchases services from both public and private facilities. Hospitals can charge user fees, but public primary care facilities cannot charge user fees.</td>
</tr>
<tr>
<td>Uganda</td>
<td>MOH is responsible for policy development and supervision of the sector. Districts are responsible for overseeing delivery of health services.</td>
<td>The central government raises most of the revenue. Districts can generate local revenue, but the amount collected is negligible and must be remitted to the central consolidated fund. The central government pools all domestic resources. The central government purchases directly from tertiary facilities, and indirectly from primary and secondary public facilities through grants allocated to districts for wages (over which districts have limited control), capital projects (managed by the district), and operating expenses (transferred to facilities). There are no user charges in public facilities (except in private wings of hospitals, whose revenue is remitted to the central level).</td>
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<tr>
<td>Country</td>
<td>Service delivery</td>
<td>Health financing</td>
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<tr>
<td>United Republic of Tanzania</td>
<td>MOH sets health sector policies, strategies, and plans. Other central government</td>
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<td>agencies are responsible for specific health services. Regions, which are an</td>
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<td>administrative extension of the central government, provide regional health</td>
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<td>services and supervise delivery of health services at the LGA level. LGAs are</td>
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<td>responsible for delivery of local health services.</td>
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<td></td>
<td>The central government raises the bulk of government revenue. LGAs have the</td>
<td>Central pooling is by the MOH and NHIF. Community health funds are pooled at the</td>
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<td>authority to raise their own revenue, but the ability to raise revenue varies</td>
<td>regional level. LGAs allocate a portion of their funds to locally managed health</td>
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<td>across LGAs, and most of them have limited space to raise enough revenue. Locally</td>
<td>budgets.</td>
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<td>generated revenues cover less than 10% of expenditures.</td>
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<td>MOH and LGAs purchase from publicly owned facilities through line-item budgets.</td>
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<td>NHIF and community health funds contract with providers and mostly pay on a fee-for-service basis, though since 2018 community health funds have paid for PHC services on a capitation basis. Centrally managed health-sector basket-funding DFF makes output-based payments for priority services at frontline PHC facilities.</td>
</tr>
</tbody>
</table>
# ANNEX 4. INSTITUTIONS RESPONSIBLE FOR BUDGET MONITORING

<table>
<thead>
<tr>
<th>Country</th>
<th>Central level</th>
<th>Subnational level(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Burkina Faso (245)</td>
<td>PFM system allows the MOF, Ministry of Local Government, and line ministries, including the MOH, to monitor budget execution.</td>
<td>PFM system allows the MOF, Ministry of Local Government, and line ministries, including the MOH, to monitor budget execution.</td>
</tr>
<tr>
<td>Kenya (222)</td>
<td>Controller of Budget and the National Assembly</td>
<td>Controller of Budget and each County Assembly</td>
</tr>
<tr>
<td>Mozambique (247,248)</td>
<td>MOF and MOH</td>
<td>MOF, MOH, provincial directorates of health and finance, and district directorates of health</td>
</tr>
<tr>
<td>Nigeria (197,202)</td>
<td>Federal Ministry of Finance</td>
<td>State ministries of finance</td>
</tr>
<tr>
<td>Philippines (158)</td>
<td>Department of Finance and Department of Health monitor the national budget. PhilHealth’s budget is monitored by its board and the Government Commission for Government-Owned and Controlled Corporations.</td>
<td>Department of Finance, Department of Health, and Department of Interior and Local Government</td>
</tr>
<tr>
<td>Uganda (154)</td>
<td>MOH, MOF, Planning and Economic Development, Auditor General, and Parliament</td>
<td>District Technical Committee, District Senior Management Team, and District Council</td>
</tr>
<tr>
<td>United Republic of Tanzania (249,250)</td>
<td>MOFP and MOH</td>
<td>MOFP, MOH, and President’s Office, Regional Administration and Local Government (PORALG), Regional Administration and Council Management Team</td>
</tr>
</tbody>
</table>