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Diagnostic Study of Public Financial Management for Strengthening Health Financing and Service Delivery in Bangladesh

September 2018

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Acronyms

ADP	Annual Development Programme
AMC	Alternate Medical Care
ANC	Antenatal Care
BPL	Below Poverty Line
BOR	Bed Occupancy Rate
CAO	Chief Accounts Officer
C&AG	Comptroller and Auditor General
CBHC	Community Based Health Care
CCSD	Clinical Contraception Services Delivery
CDC	Communicable Diseases Control
CGA	Controller General of Accounts
CMSD	Central Medical Stores Depot
CPD	Centre for Policy Dialogue
CPTU	Central Procurement Technical Unit
CS	Civil Surgeon
CSC	Community Support Committee
DAO	District Accounts Officer
DDFP	Deputy Director Family Planning
DDO	Drawing and Disbursing Officer
DG	Director General
DGFP	Directorate General of Family Planning
DGHS	Directorate General of Health Services
DH	District Hospital
DP	Development Partner
DPA	Direct Project Aid
DPP	Development Project Proforma
DRM	Domestic Resource Mobilization
DRS	District Reserve Store
EDCL	Essential Drug Company Limited
ESD	Essential Services Delivery
FAPAD	Foreign Aided Project Audit Directorate
FD	Finance Division
FM	Financial Management
FMAU	Financial Management and Audit Unit
FMIS	Financial Management Information System
FPFSD	Family Planning Field Service Delivery
FWV	Family Welfare Visitor
FY	Fiscal Year
FYP	Five Year Plan
GDP	Gross Domestic Product
GFR	General Financial Rule
GOB	Government of Bangladesh
HCF	Health Care Financing
HCFS	Health Care Financing Strategy
HED	Health Engineering Department
HEF	Health Economics and Financing
HEP	Health Education and Promotion

HEU	Health Economics Unit
HIS-EH	Health Information Systems and E-Health
HNP	Health, Nutrition, and Population
HNPSP	Health, Nutrition, and Population Sector Programme
HPNSDP	Health, Population, and Nutrition Sector Development Programme
HPNSP	Health, Population, and Nutrition Sector Programme
HPSP	Health and Population Sector Programme
HNPSIP	Health, Nutrition, and Population Strategic Investment Plan
HR	Human Resources
HRM	Human Resources Management
HSD	Health Services Division
HSM	Hospital Services Management
iBAS	Integrated Budgeting and Accounting System
ICMAB	Institute of Cost and Management Accountants of Bangladesh
IEC	Information, Education and Communication
IFM	Improved Financial Management
IST	In-service Training
LD	Line Director
MBF	Ministry Budget Framework
MCH	Maternal and Child Health
MCRAH	Maternal, Child, Reproductive and Adolescent Health
MCWC	Mother and Child Welfare Centre
MEFWD	Medical Education and Family Welfare Division
MHVS	Maternal Health Voucher Scheme
MIS	Management Information System
MNCH	Maternal, Neonatal, and Child Health
MNCAH	Maternal, Neonatal, Child, and Adolescent Health
MOF	Ministry of Finance
MOHFW	Ministry of Health and Family Welfare
MSR	Medical and Surgical Requisites
MTBF	Medium-Term Budgetary Framework
MTMPS	Medium-Term Macroeconomic Policy Statement
MTSO	Medium-Term Strategic Objective
NASP	National AIDS and STD Program
NCD	Noncommunicable Disease
NEC	National Eye Care
NEMEW	National Electro-Medical Equipment Maintenance Workshop and Training Centre
NES	Nursing Education and Services
NGO	Nongovernmental Organization
NHSO	National Health Security Office
NIPORT	National Institute of Population Research and Training
NNS	National Nutrition Services
NSSS	National Social Security Strategy
ODI	Overseas Development Institute
OECD	Organisation for Economic Co-operation and Development
OOP	Out-of-pocket
OP	Operational Plan
OPD	Outpatient Department
PA	Project Aid

PD	Project Director
PER	Public Expenditure Review
PFD	Physical Facilities Development
PFM	Public Financial Management
PIP	Program Implementation Plan
PLSM	Procurement, Logistics, and Supplies Management
PME-FP	Planning, Monitoring, and Evaluation of Family Planning
PMMU	Program Management and Monitoring Unit
PMR	Planning, Monitoring, and Research
PNC	Postnatal Care
PPA	Public Procurement Act
PPR	Public Procurement Rule
PSE	Preservice Education
PSSM	Procurement, Storage, and Supplies Management
PWD	Public Works Department
RADP	Revised Annual Development Programme
RAF	Resource Allocation Formula
RMO	Resident Medical Officer
RPA	Reimbursable Project Aid
RPIP	Revised Program Implementation Plan
SDAM	Strengthening of Drug Administration and Management
SIP	Sector Investment Plan
SOE	Statement of Expenditure
SRO	Statutory Regulatory Order
SSK	*Shasthya Surokhsha Karmasuchi*
SWAp	Sector-wide Approach
SWPMM	Sector-wide Program Management and Monitoring
THE	Total Health Expenditure
TAPP	Technical Assistance Project Proforma
TB-LC	TB and Leprosy Control
TEMO	Transport & Equipment Maintenance Organization
ssTRD	Training, Research, and Development
UAO	*Upazila* Accounts Officer
UHC	Universal Health Coverage
UFPO	*Upazila* Family Planning Officer
UHFPO	*Upazila* Health and Family Planning Officer
UHFWC	Union Health and Family Welfare Center
UzHC	*Upazila* Health Complex
WHO	World Health Organization

Executive summary

1. **Inadequate and inequitable health financing is a major challenge toward achieving universal health coverage (UHC).** Total health expenditure (THE) per capita in nominal terms in Bangladesh was US$37 in 2015. When compared to other South Asian countries, this figure is quite low. This is less than two-thirds of the US$60 per capita per year estimated by the World Health Organization (WHO) to cover a basic package that includes interventions for noncommunicable disease (NCD) control and to attain a fully functional health system by 2015. The main sources of finance for THE is out-of-pocket (OOP) spending, 67 percent, followed by 23 percent government spending constituting less than 1 percent of gross domestic product (GDP). Although the wealthier people are able to afford high OOP payments to receive quality health care, the poor can afford less and thus receive poor quality health care, and those who cannot afford do not seek treatment at all.

2. **Effective Public Financial Management (PFM) is crucial for increasing public spending, strengthening financial protection, and extending service coverage toward achieving UHC.** With the realization that UHC needs a significant government budget, the PFM system of a country needs to be sound and flexible enough without compromising financial control to align government and development partner (DP) funding with defined priorities. An effective PFM system can lead to the formulation of realistic budgets and timely execution of budgets, fund allocations aligned with public priorities, and improve operational efficiency, with reduced waste, corruption, and other leakages. Efficient and equitable use of PFM-related inputs (for example, budget, health staff, diagnostic services, and drugs) would improve Health, Nutrition, and Population (HNP) service delivery.

3. **The Health Care Financing Strategy (HCFS) 2012–2032 of Bangladesh, adopted in 2012, aims at UHC with a goal to strengthen financial risk protection and extend health services and population coverage.** The strategy identified the key health financing challenges in Bangladesh. The challenges include inadequate financing resources, inequity in health financing and utilization, and inefficient use of existing resources. To address these key health financing challenges, the strategy proposed three strategic objectives: (a) generate more resources for effective health services, (b) enhance efficiency in resource allocation and utilization, and (c) improve equity and increase access especially for the poor and vulnerable. The HCFS outlines some strategic interventions under the three strategic objectives.

4. **The implementation of the proposed interventions in the HCFS has been slow since 2012.** PFM challenges are assumed to be one of the barriers to effective implementation of the HCFS. Some of the strategic interventions such as scaling up of the Maternal Health Voucher Scheme (MHVS), implementation of the Resource Allocation Formula (RAF), and retention of user fees at the facility cannot be implemented due to PFM challenges. Further, PFM challenges such as delay in fund availability, delay in procurement, and lack of provision for allocating operational funds at the facility level affect health service delivery.

5. **This diagnostic study intends to identify and document major concerns and issues of PFM in relation to the strategic interventions outlined in the HCFS 2012–2032 and health service delivery.** This study attempts to diagnose the most critical constraints the HCFS 2012–2032 and service delivery arrangements face to achieve the desired goals. The assumption is that removal of these constraints would yield higher welfare gains. The study also examines potential interventions to address some PFM challenges in service delivery (for example, delay in fund availability, delay in procurement, lack of operational funds at facility, and lack of diagnostic services at district-level public facilities).

6. **Delay in fund availability is a chronic problem causing poor execution of the Ministry of Health and Family Welfare (MOHFW) development budget that in turn adversely affects service delivery.** The recent introduction of the upgraded version of the Integrated Budgeting and Accounting System (iBAS), namely iBAS++, has accelerated budget distribution. However, delay in fund release is a major cause of underspending of development budget especially reimbursable project aid (RPA). The reasons for delay in fund release include (a) delay in sending the fund release request letter, (b) absence of necessary documents with the letter for fund release, (c) not providing the Chief Accounts Officer (CAO) a certified reconciled account with the request letter for the third and fourth quarters, (d) delay in sending the Statement of Expenditure by the Line Directors (LDs) for the third and fourth quarters, (e) lack of timely follow-up by the concerned Operational Plan (OP) Officer, (f) noncompliance with the donor conditions set for loan/grants, and (g) noncompliance with financial rules and regulations, even minor rules, which can be amended without delay.

7. **The fund release process for RPA is not well understood by all LDs and relevant officials.** Discussions with LDs and other relevant officials found that some of them are unaware that the fund for the first to third or first to fourth quarters can be released all at once if justifications are provided along with the request. As per current practice, the fund therefore becomes available toward the end of the period, leaving little time for spending the fund fully and efficiently. Training of LDs and relevant officials on fund disbursement processes would be useful to expedite fund release. Recently, the Ministry of Finance (MOF) decided that release of the first and the second quarter portions of the development budget of the Government of Bangladesh (GOB) would not require a fund release order. The same could be done for RPA to further simplify the process.

8. **The recent introduction of iBAS++ has accelerated budget distribution, and as it will contain all the execution data, the condition of submitting the Statement of Expenditure (SOE) should no longer be a requirement for the release of the third and fourth quarters of RPA.** Delinking the fund release from submission of SOE will improve the fund release process by significantly reducing the delay in fund release.

9. **The recent decision of the government brings a change in the fund release regime.** The first and the second quarters of the GOB portion of the development budget from now on will be automatically released, and the LDs/Project Directors (PDs) will be able to use the project/OP fund from July 1. This will make fund release easier to some extent, and this decision should be extended to the first two quarters of RPA.

10. **Delay in audit resolution has serious consequences for service delivery.** In some cases, this results in the suspension of fund disbursement by the DPs, delayed or no procurement of certain items, slow progress, or sometimes even abandonment of certain activities. Review of the Annual Program Implementation Report 2015 and independent review of responses to the audit observations by the LDs of respective OPs revealed that the status of audit resolution is still far from satisfactory in terms of compliance with deadlines and quality.

11. **Lack of adequate manpower skilled in planning and budgeting and PFM is a common and persistent problem at the operational level.** The study revealed that due to the lack of skilled manpower, planning and budgeting are often done by staff from the accounting or administrative unit with little or no knowledge about policy objectives and programs. On the other hand, the majority of the Program Managers and LDs are medical doctors and are not familiar with PFM functions. As a consequence, plans at the operational level often become a wish list and the budget fails to follow the plan. This results in delay in initiating the processes and completing the requirements of PFM. Capacity strengthening activities such as training on how to develop realistic plans and budgets and manual development, modernization of the PFM system, and integration of the Financial Management Information System (FMIS) could address these problems.

Initiatives outlined in HCFS

12. **The HCFS identified a need-based RAF as an intervention to improve the efficiency in resource allocation and public provision of health services.** The Health Economics Unit (HEU) of the MOHFW proposed a RAF for need-based budget allocation to districts/*upazilas*. This will help meet the needs of the population, mitigate interdistrict disparities, and make plans and resource allocation to be more effective. For successful implementation, it will require enhanced subdelegation of financial power to the district-level officials and strengthened capacity in planning and budgeting at the district level.

13. **The retention of user fees might enhance efficiency in service delivery.** In 2014–15, around BDT 1,445 million was collected from the users of the MOHFW facility services. The amount represented 2 percent of the MOHFW recurrent spending and 59 percent of the MOHFW spending on repair and maintenance in the same year. Retention of user fees at the facility would help improve efficiency and quality of care. For example, the money could supplement the allocation for repair and maintenance budget of the facility which is insufficient. Currently, facilities need to deposit the collected user fees to the treasury. To allow user fees to be retained and utilized at the MOHFW facilities, several regulations/acts need to be amended.

14. **The HCFS suggested scaling up of the MHVS as it has results-based financing elements and it could improve equity and access and enhance efficiency.** Mothers receive cash incentives for receiving maternal health services and travel. The MHVS is a demand-side intervention and is being implemented by the MOHFW in 53 *upazilas* of the country. There are persistent delays in the release of the MHVS fund at the ministry and *upazila* levels. The fund for the MHVS comes from the development budget. Arrangements of advance or 'Imprest fund' can be used for timely payment of cash incentives and travel allowances to beneficiaries. However, the Imprest fund is applicable for the nondevelopment budget. This could be solved if the financial rules are changed to allow the Imprest fund to be used for the development budget. Another option is for the MHVS to be financed through the nondevelopment budget like other social protection programs of other ministries, for example, allowance for poor lactating mothers under the Ministry of Women and Children Affairs.

15. ***Shasthya Suroksha Karmasuchi* (SSK), a social protection scheme for the below poverty line (BPL) population mentioned in the HCFS, is currently being piloted.** The HEU of the MOHFW is currently piloting the SSK in three *upazilas* (subdistricts) of Tangail district. The SSK aims to reduce OOP expenditure of the households, thereby protecting them from impoverishment in case of catastrophic illnesses. It is a government scheme to put away the premium for safeguarding the health care of the targeted families against a number of listed diseases. However, a health insurance scheme like the SSK cannot operate without a proper legal framework including financial rules and regulations. Currently, the SSK is running like a normal development function of the government guided by rules and regulations. A separate set of financial and business rules are required for a health insurance scheme.

16. **The National Health Security Office (NHSO) is proposed in the HCFS 2012–2032 to support the implementation of the proposed social health protection schemes.** This study suggests the prerequisites for establishing such an entity. Studies need to be undertaken to explore the possible structure, legal authority, functions, funding, PFM procedures, staffing, and management of the proposed NHSO. Establishing the NHSO as an autonomous authority under the MOHFW would remove the functional barriers of utilizing the health security fund for the benefits of underserved, poor, and vulnerable groups without encumbrance of financial rules and regulations and protocol applicable to a government entity as it would have a set of financial rules and regulations applicable to an autonomous body.

New initiatives, not proposed in the HCFS

17. **The Community Support Committee (CSC), a new domestic resource mobilization (DRM) initiative not mentioned in the HCFS, aims to generate local-level resources to improve health service delivery at the health facilities.** The CSC is supported by the HEU of the MOHFW in 11 districts. This committee provides support to the hospital authority for effective clinical service delivery and for ensuring nonclinical service provision and basic amenities and safety and security to the hospital property and users of the hospital services. The resource generation might not be substantial but would improve the quality of facility services by providing additional resources to supplement the government allocation. CSC members follow-up the CS supported activities on regular basis, which strengthen monitoring. To ensure transparency and accountability, the government should develop a comprehensive guideline for the CSC.

18. **A three-year framework contract for drug procurement has the potential to solve the problem of the delay in the procurement of drugs.** The existing weak procurement processes delay the transfer of drugs to the health facilities, causing frequent shortages of supplies at the health facilities. The time requirement for procuring and distributing drugs takes on average 9 months, however in practice, it takes 15–18 months for drugs to reach the *Upazila* Health Complex (UzHC) and below. A three- year framework contract for drug procurement could help reduce the annual procurement problems arising from the current bidding processes. The framework could also reduce the price of medicines by ensuring the lowest competitive price and would encourage drug manufacturing companies, especially well-reputed pharmaceutical companies, to participate in the bidding process directly.

19. **Introducing 'Flexible Cash at Facilities' can potentially solve the problem related to health facilities at the district level for not having funds for repair and maintenance of buildings, equipment, and ambulances at the right time.** Lack of operational funds for repair and maintenance affects the quality of services. This happens due to the low allocation of the fund and not having the required fund on time. It was found that sometimes responsible officials are not aware of processes and they do not initiate processes for receiving the fund in a timely manner. The capacity and responsiveness of the contracted agency responsible for repair and maintenance are also an issue. Health managers/providers need enhanced delegation of authority to expend money for repair and maintenance. 'Flexible Cash at Facilities' could be arranged if a permanent advance of BDT 200,000 and BDT 100,000, respectively, or a certain percentage of the respective facility budget is allocated to the District Hospital (DH) and UzHC by the DGHS with the approval of the Finance Division of the MOF.

20. **Contracting out certain health services under the existing procurement rule is possible where public facilities at *upazila* and district levels do not have the required diagnostic services.** For engaging the private sector at district hospitals and *upazila* health complexes, the government might allow superintendents of DHs and district civil surgeons to contract out these services within the framework of the Public Procurement Rule (PPR) by issuing a circular. This may also need relaxation of the Delegation of Financial Power within the framework of the General Financial Rules (GFRs) with the necessary budget support. However, introducing such a change would be a lengthy process.

1. Introduction: Why Public Financial Management is important

1. **Inadequate and inequitable health financing is a major problem toward achieving the goals set in the national policy documents**. According to a World Health Organization (WHO) estimate, low-income countries require US$60 per capita per year to attain a fully functioning health system that ensures a basic package of services including interventions targeting noncommunicable diseases (NCDs) by 2015 (WHO 2010). In Bangladesh, the Total health expenditure (THE) per capita in nominal terms was US$37 in 2015 (MOHFW 2018). This is less than two-thirds of the requirements. When compared to other South Asian countries, this figure is quite low (World Bank 2016a). Public health spending comprises less than 1 percent of gross domestic product (GDP). The main source of finance for THE is out-of-pocket (OOP) spending, 67 percent, followed by 23 percent government spending. Although the relatively wealthy people are able to afford these high OOP payments for quality health care, the poor can afford less and thus receive health care that lacks quality (GOB 2015a). Those who cannot afford it do not seek treatment at all.

2. **The Health Care Financing Strategy (HCFS) 2012–2032 of Bangladesh aims at achieving Universal Health Coverage (UHC) through addressing the key health financing challenges in Bangladesh.** The challenges include inadequate financing resources, inequity in health financing and utilization, and inefficient use of existing resources (GOB 2012). Health financing priority activities need to contribute to improving Health, Nutrition, and Population (HNP) outcomes, making the health system more efficient and equitable, and increasing the financial protection for health care. The following three strategic objectives have been proposed in the HCFS 2012–2032: (a) generate more resources for effective health services, (b) enhance efficiency in resource allocation and utilization, and (c) improve equity and increase access especially for the poor and vulnerable. The strategy also outlined a number of interventions to achieve these objectives.

3. **Effective Public Financial Management (PFM) in the HNP sector is crucial for increasing public spending and introducing a risk pooling prepayment mechanism toward achieving UHC.** The HNP sector budgeting process is unique as health needs are characterized by uncertainty and the expenditure for health is greatly affected by provider behavior. As UHC needs a significant government budget, the PFM system of a country should be sound and flexible enough without compromising financial control to align government and development partner (DP) funding with defined priorities. However, misalignments can happen at each stage of the budget cycle even if PFM rules are not a bottleneck for effective health spending (WHO 2017).

4. **In recent years, PFM in the health sector has become an increasingly prominent issue for governments of many developing countries (Cashin et al. 2017; GOB 2010; Hossain 2015; OECD 2006; World Bank 2014).** Appropriate allocation of funds under a strong PFM system ensuring efficient, transparent, and accountable use of resources can help the government achieve its desired goals. Weaknesses in PFM are a major cause of inefficiency in the sector. Poor resource allocation to sector priorities undermines the achievement of equity and access to essential services (Cashin et al 2017; Renzio and Dorotinsky 2007; World Bank 2006). Efficient use of funds from both the domestic resources and DPs depends on PFM (GOB 2010; Hossain 2015).

5. **This diagnostic study intends to identify and document major concerns and issues of PFM in relation to Bangladesh's HCFS 2012–2032 and health service delivery.** The implementation of the HCFS 2012–2032 has been underscored in the 7th Five Year Plan (FYP) (GOB 2015a) and the National Social Security Strategy (NSSS) (GOB 2015b) as a major priority. The implementation of the HCFS 2012–2032 has been slow, and it is hypothesized that PFM is one of the barriers. This study attempts to diagnose the most critical constraints of the HCFS 2012–2032 and service delivery arrangements in

achieving the desired goals. The assumption is that the removal of these constraints would yield the highest welfare gains.

6. **This diagnostic study has three objectives.** These are to (a) identify PFM-related bottlenecks to the HCFS 2012–2032 implementation, (b) examine the link between PFM and health service delivery, and (c) inform the Ministry of Health and Family Welfare (MOHFW) and the Ministry of Finance (MOF) and stakeholders on specific PFM barriers and inefficiencies in the Bangladesh HNP sector with possible options of addressing them. The study provides an understanding of what elements of PFM and health financing are considered critical to effective and efficient health service delivery. The study identifies health financing and common health sector service delivery constraints and opportunities, their underlying PFM-related factors, and possible resolutions.

7. **This study uses qualitative and quantitative methods of data collection and analysis within a diagnostic study approach.** Both qualitative structured key informant interviews and a documentary analysis were used to collect data on PFM barriers and options. The study team collected and reviewed key official documents such as the national health policy; health financing strategy; and laws, acts, and official reports of health, finance, and law ministries.

8. **The main sources of quantitative data were the MOF and MOHFW.** Data included budget, revised budget, and actual expenditure for both nondevelopment and development of the MOHFW. Additional data on fund release were collected from the Planning Wing and the Project Implementation Branch of the MOHFW. Fund release related data for one Operational Plan (OP) was tracked for each quarter of the five fiscal years (2011–12 to 2015–16) during the third HNP sector program. The MOHFW data on fund release are not computerized yet. Therefore, data were obtained by going through a number of files page by page for only one OP. Due to limited access and time constraints, it was not feasible to go through all the files for all OPs. Data from the MOF were obtained for seven financial years from 2009–10 to 2015–16, covering two years under the second HNP sector program and five years of the third HNP sector program.

9. **Key informant interviews were conducted with 55 policy makers and program managers at the national and subnational levels as well as officials involved in the implementation of health financing schemes.** Key informants were asked about their opinions and experiences concerning the implementation of Bangladesh HCFS 2012–2032 to accelerate UHC. Key informants were guaranteed anonymity to encourage an open expression of their views. Two field visits were conducted to collect data from district and *upazila* levels. The study team visited Jhenidaha and Tangail districts and Kalihati *upazila* of Tangail district. In these districts, *Shasthya Surokhsha Karmasuchi* (SSK), maternal health voucher scheme (MHVS), and Community Support Committee (CSC) funds are being implemented. The focus of data collection was to identify PFM barriers and potential sources of inefficiencies.

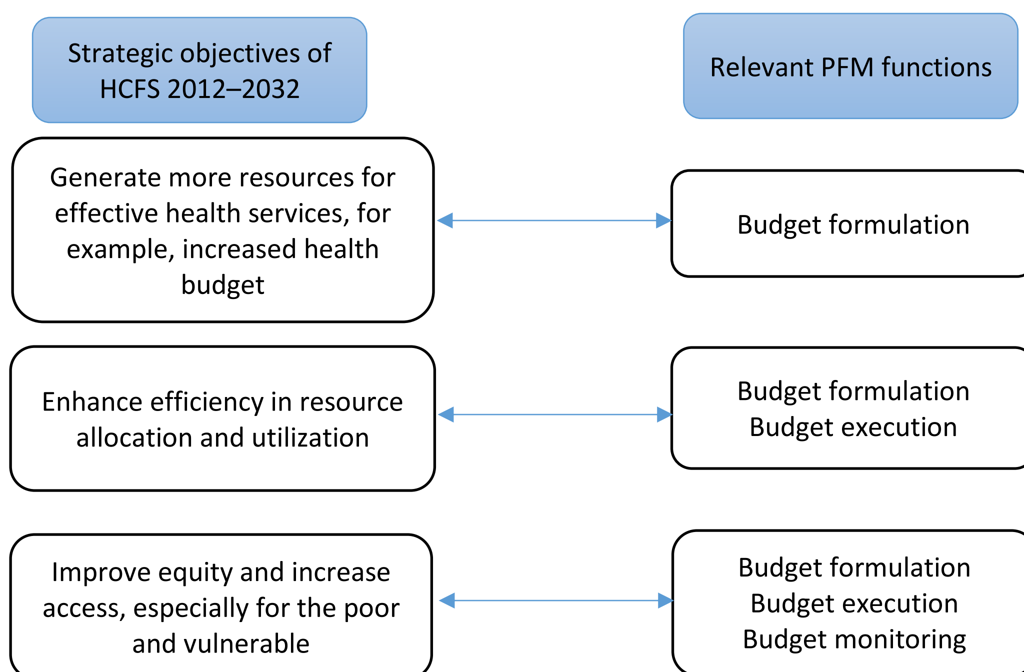
10. **This report is structured in the following manner.** The introductory section is followed by an analytical section on link between the HCFS 2012–2032 and PFM, with a focus on budget preparation and planning. The third section describes how PFM influences health service delivery in Bangladesh, with a focus on budget execution. Budget reporting for monitoring and accountability is discussed in the fourth section. The fifth section subsequently describes strengthening the capacity for PFM. Finally, the last section concludes the report by providing specific and general policy recommendations.

2. Linkages between the Health Care Financing Strategy and PFM

11. **The HCFS 2012–2032 combines funds from tax-based budgets with the proposed risk pooling prepayment schemes to provide financial protection to all segments of the population with an aim to achieve UHC.** Since public sector financing is the keystone of sustainable financing for UHC in most countries, the public financial management (PFM) system plays a crucial role (Cashin et at 2017). A better PFM system can lead to the formulation of realistic budgets and timely execution of budgets, fund allocations aligned with public priorities, and improved operational efficiency, with reduced waste, corruption, and other leakages (Fritz, Sweet, and Verhoeven 2014).

12. **The HCFS proposed strategic interventions and supporting actions to achieve the stated strategic objectives.** One of the supporting actions for strengthening national capacity outlined in the HCFS is strengthening financial management (FM) and accountability at all levels. This section discusses how PFM arrangements influence the three key strategic objectives of the HCFS 2012–2032.

Figure 1: Link between strategic objectives of HCFS 2012–2032 and relevant PFM functions



2.1 Generate more resources for effective health services

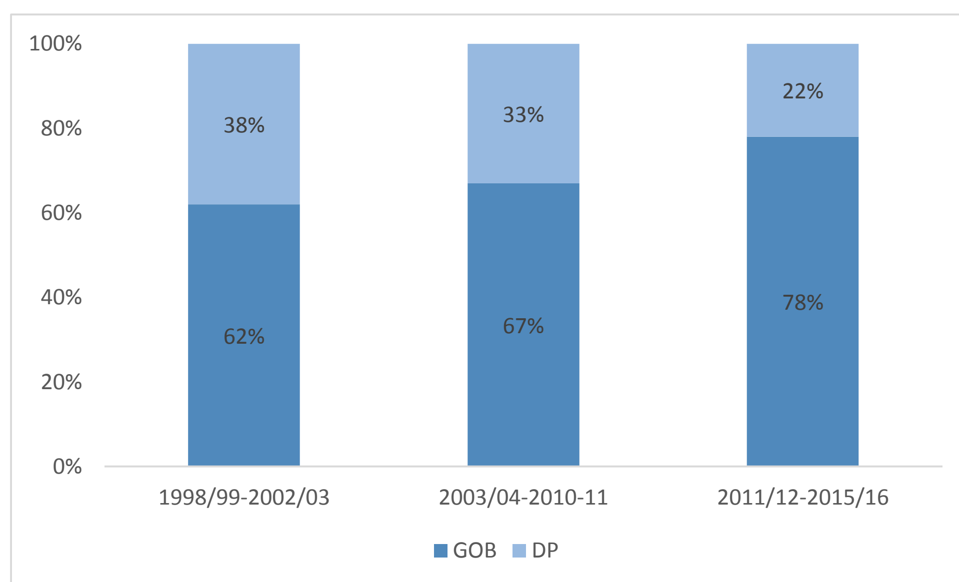
2.1.1 Domestic resource mobilization (DRM): Why and how

13. **The demands of the health sector are rising.** More resources are required to increase the coverage of basic health interventions as well as scale up new NCD services in the context of the rising burden of NCDs due to epidemiological and demographic transition. Further, in the context of high OOP burden on households, additional financing is also required to provide better financial protection to the population.

14. **Bangladesh is a low- and middle-income country and projected to become a middle-income country by 2021 and, as expected, grant aids are falling.** The share of DP financing in the health sector program dropped to 22 percent during the period between FY2012 and FY2016 from 38 percent during FY1999–FY2003 (Figure 2). Although some DPs providing development assistance have left the sector, some new initiatives are emerging (World Bank 2016a). However, it is likely that net DP assistance will decline steadily in the medium term (World Bank 2016a) as the country aspires to be a middle-income

country by 2021. Therefore, mobilizing domestic resources for the health sector should be the foremost policy priority. Financing health in Bangladesh over the short to medium term will require a combination of existing and additional domestic resources that result from economic growth, improved tax collection, and most significantly a moderate reprioritization of the budget in favor of the health sector. The World Bank (2016a) report highlighted that due to implementation challenges, insurance contributions, if introduced, are more likely to generate additional resources for the health sector only over a medium to long term.

Figure 2: Declining share of DP contribution to the health sector



Source: PMMU 2013.

2.1.1.1 Community Support Committee (CSC) Fund: A new DRM initiative, not proposed in the HCFS

15. **Local-level resource generation is an option through which health service delivery could be expanded and improved.** The Health Economics Unit (HEU) of the MOHFW formed a 'health management committee support' according to a government order.[1] The committee consists of 14 members, and the local Paurashava Mayor is the chairman of this committee. The committee is working in 11 districts of the country. This committee has taken a great opportunity to involve local authorities and representatives to combat the financial and other barriers associated with the provision of better quality of health care. Key responsibilities of the committee include:

- To ensure support to the hospital authority for effective clinical service delivery;
- To ensure the provision of all nonclinical services and other amenities including provision of drinking water and safety and security to the patients and their attendants;
- To provide assistance for proper supply/availability of required medicines, equipment, reagents, furniture, and other consumables like X-ray/ultrasonogram film, electrocardiography papers, and stationery;
- To provide support for implementation of all sanitary and hygienic measures including provision of cleanliness and toilet facilities for the patients and their attendants;

[1] Order issued on October 5, 2016 vide memo number 709, MOHFW.

- To provide assistance for timely maintenance of hospital buildings including premises and to encourage community participation in these activities;

- To utilize funds for timely maintenance and repair of hospital equipment, machinery, and other assets subject to the guidelines;

- To ensure the rights and responsibilities (health service responsiveness) of the service recipients through the installation of a public information system and signage system, display of the citizens' charter, display of referral maps and chains, and other mechanisms;

- To provide assistance for effective in-house and outside waste management; and

- To provide assistance for the introduction of patient-centered service.

16. **The committee members collect funds from private clinics, pharmaceutical companies, and community members who have the ability and interest to donate.** The committee deposits the collected fund in a local bank account. In most cases, individuals, companies, and entities directly pay the salary of security guards and cleaners from their accounts. They also directly finance the furnishing of rooms and toilets and donate equipment such as air conditioner according to the need and availability of funds.

17. **Receiving funds from private clinics and pharmaceutical companies raises a question on conflicts of interests.** Health care providers at health facilities prescribe drugs for inpatients and outpatients, and these patients often have to purchase drugs from pharmacies outside the health facilities. Private clinics attract patients from public clinics to generate income. The committee manages accounts and reviews account status at regular committee meetings. There is no audit on expenditures and no official guideline for addressing these conflict issues or managing and controlling the CSC fund by the committee. The committee expressed the need for a detailed guideline for the management of the fund without any contentious issues such as the fund of *Roggi Kallyan Samity* of the Social Welfare Department.

18. **Guidelines for implementation of CSC-supported activities at the health facilities are needed.** The guidelines should describe the possible sources of funds including financial sustainability, fund management and utilization, account management, audit, social audit, mitigation of conflicts of interest, and concurrence of the MOF where required. The guidelines would require the MOF's concurrence.

2.1.2 Government health budget - the largest source of potential fiscal space for health over the medium term

19. **In 2017-18, the MOHFW budget represented just 5 percent of the total government budget in Bangladesh, while in other South Asian and low-income countries, health sector budgets account for 8–10 percent of their total budgets.** Bangladesh needs to improve this ratio toward international benchmarks. The World Bank (2016a) report noted that over the short to medium term, reprioritization of the MOHFW budget within the national budget represents a significantly larger potential source of fiscal space for the Bangladesh health sector than economic growth and other sources of fiscal space.

2.1.2.1 Weak link between stated policies and MOHFW budget

20. **National policies and plans relevant to the HNP sector revolve around the principle of ensuring access to affordable and quality health care for all people of Bangladesh, with an emphasis on vulnerable groups.** The HNP-related policies and plans also bring to the forefront the issue of financing health care services particularly for the benefit of the poor and marginalized population. These policies also recognize the inadequacy of public sector financing for health and burden of OOP expenditures on the households. Two main strategies are needed to address these challenges: increasing the health budget and introduction of a risk-pooling prepayment mechanism. A strong PFM system is critical for both these strategies (Table 1).

Table 1: Summary of key policies and strategies relevant for health care financing (HCF) and PFM

National policy/plan/strategy	Strategies with links to HCF and PFM
National Health Policy 2011	• Increasing health budget every year • Ensuring free treatment for the poor also through the provision of q health card to the extreme poor in phases • Introducing health insurance to formal sector employees and other groups of population in the long term
7th FYP - 2016–2020	• Piloting risk-pooling mechanisms, such as health insurance • Implementation of the HCFS as a priority
NSSS 2015	• MHVS • Health insurance • Implementation of the HCFS 2012–2032 as complement to NSSS
Health, Nutrition and Population Strategic Investment Plan (HNPSIP) 2016–2021	• Advocacy for increased budget allocation • Exploring new and innovative financing sources • Advocacy for increased DP funding • Explore pooling mechanism • Pilot and implement resource allocation formula (RAF) • Promote results-based financing as a strategy to improve health systems efficiency
HCFS 2012–2032	• Strengthening of tax-based health system to fund essential health services for all people • Bringing formal and informal sectors and people living below the poverty line under the scope of prepayment mechanisms

21. **Five-Year Plan (FYP) resource projections for health have not been translated into reality.** The FYP is the most important policy document of the GOB for providing development policy guidelines to all sectors and sectoral allocations. Allocation for the MOHFW development budget has been lower than the original projection in FYPs (

22. Table 2). Although the total allocation for the MOHFW marked an increase in nominal terms, the allocation as a share of projected expenditure in the 6th FYP (2011/12–2015/16) shows a steady decline. Table 2 shows that during the entire 6th FYP, the development budget allocation to the MOHFW and actual expenditure fell short of the amount projected in the plan. This may have happened because of three reasons: (a) projects planned at the beginning of the FYP did not materialize, (b) fund flow from domestic/external sources fell short of expectation, or (c) the FYP projection was too ambitious. A more realistic FYP projection is necessary to overcome this problem.

Table 2: 6th FYP projections and MOHFW development budget (2011/12–2015/16)

	2011–12	2012–13	2013–14	2014–15	2015–16	5-year total
6th FYP projections for health sector in BDT, billions	35	45	54	68	84	286
MOHFW development budget in BDT, billions	36	38	36	43	53	207
MOHFW development budget as % of 6th FYP projection	103%	85%	67%	64%	64%	72%
MOHFW development expenditure in BDT, billions	26	33	34	37	40	170
MOHFW development actual spending as % of 6th FYP projection	75%	74%	63%	54%	48%	60%

Source: 6th FYP and integrated Budgeting and Accounting System (iBAS) data, MOF.

23. **One of the top policy priorities of the 7th FYP is to increase the allocation to the health sector to 1.2 percent of GDP by the end of FY2020.** In FY2016, BDT 53.3 billion (US$666 million) has been allocated in the MOHFW development budget, which is 100 percent of the budget projected in the 7th FYP. However, in the second year of the 7th FYP, the development budget is 92 percent of the 7th FYP projection.

24. **Despite the government's intentions expressed in the 6th FYP, the share of the MOHFW in the national budget remained around 5 percent or below.** It did not rise to 12 percent of the national budget as anticipated by the 6th FYP. Table 3 shows that the MOHFW budget as a share of the national budget has been a little above 5 percent during the first year of the 6th FYP and the second year of the 7th FYP.

Table 3: MOHFW budget and national budget, FY2011–12 to FY2017–18
(Figures in current BDT, billions)

Year	National budget	MOHFW budget (excluding pension)	MOHFW budget as percentage of national budget	Nominal growth in national budget	Nominal growth in MOHFW budget	Real growth in national budget	Real growth in MOHFW budget
2011–12	163,589	8,409	5.1%	—	—	—	—
2012–13	191,738	8,967	4.7%	17.2%	7%	9%	−1%
2013–14	222,491	9,074	4.1%	16.0%	1%	10%	−4%
2014–15	250,506	10,470	4.2%	12.6%	15%	6%	9%
2015–16	295,100	12,060	4.1%	17.8%	15%	10%	8%
2016–17	340,605	15,883	4.7%	15.4%	32%	9%	24%
2017–18	400,266	20,679	5.2%	18%	30%	—	—

Source: Budget brief of various years, MOF.
Note: Real growth rate estimated using 2015–16 constant price.

25. **The MOHFW budget experienced two-digit nominal growth rate since FY2015 in spite of its lower share in the national budget.** In 2017–18, the MOHFW budget grew at a faster pace than the national budget both in nominal and real terms. In the course of six years, the budget allocation has been more than doubled. During the three years between 2014–15 and 2016–17, the real growth rate of the MOHFW budget was impressive (Table 3). It was around 14 percent per year, reflecting high government commitment for the health sector. Despite this increase, the MOHFW does not have sufficient funds to fulfill its pledges made in the health policy documents.

26. **The Medium Term Macroeconomic Policy Statement (MTMPS) 2018–2020 projects the HNP sector's total spending to grow on average by around 19 percent annually by FY2020, and from the FY2017–18 budget allocation (39 percent growth), it can be said that the allocation is going in tandem with the MTMPS projection while exceeding the 7th FYP projection (MOF 2017).** The mission statements of the Health Services Division (HSD) and the Medical Education and Family Welfare Division (MEFWD) of the MOHFW incorporated in the Ministry Budget Frameworks (MBF) 2017–18 echo the MTMPS. The objectives of the HNP sector mentioned in the MTMPS from 2018 to 2020 is "to ensure quality and equitable health care for all citizens in Bangladesh by developing access and utilization of health, population and nutrition related services to improving the health status of the underserved – poor, women, children, elderly, marginalized and physically and psychologically challenged people" (MOF 2017a).

27. **The Medium-Term Strategic Objectives (MTSOs) of the MOHFW are a mere repetition of last year's narrative with few changes without assigning any value to the targeted work, although MTSOs are the specific objectives for attaining the overall goal of the ministry.** The main objective of the Medium-Term Budgetary Framework (MTBF) is to establish a clear link between budget allocation and the national policies and priorities and also a link between resource utilization and performance. Table 4 presents the MTSOs of two divisions of the MOHFW for FY2017–18. The MTSOs have been expressed in general terms, without specifying in real terms how much progress or improvement has been targeted with what resources. This is due to the weak capacity of personnel with little or no exposure to budget-setting procedures under the MTBF.

Table 4: MTSOs of two divisions of the MOHFW

	HSD	**MEFWD**
	Similar objectives	
1	Ensuring improved health care for mother and child	Ensuring improved health care for mother and child
2	Upgrading quality health care services for all	Upgrading quality health care services for all
3	Ensuring quality of specialized health care services	Ensuring quality specialized health care services
4	Increasing food safety with nutritional standards	Increasing food safety with nutritional standards
5	Development of efficient human resources in health, population, and nutrition sector	Development of efficient human resources in health, population, and nutrition sector
	Different objectives	
6	Control communicable and noncommunicable diseases and new diseases, arising out of climate change	Expansion of population control and improved reproductive health
7	Establishment of improved and efficient pharmaceutical sector	—

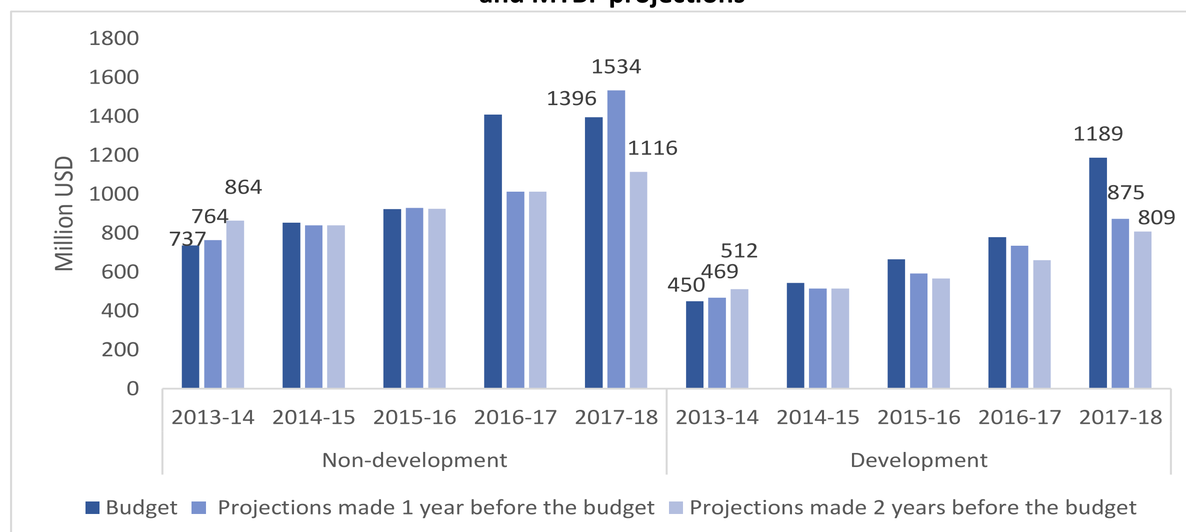
28. **Most of the time, the MOHFW budget cannot catch up with the projected amount in the MTBF.** The MTBF projections for development projects should be made based on the commitment of the DPs and the trend of government financing. The possible reasons could be change in government priorities, fall of revenue, and other unexpected causes. When this becomes a regular feature, it also indicates PFM problems such as weak capacity in planning and budgeting (for example, officials responsible for the MTBF budget preparation often have little or no exposure to budget-setting procedures under the MTBF), inability to complete a procurement plan, failure to obtain clearance from DPs for procurement, or failure to obtain release of fund in time.

29.

30. Figure 3 illustrates the unpredictability of the MOHFW budget. For example, both development and nondevelopment budget for FY2013–14 was lower than the projections made one year before the budget (that is, 2012–13) as well as two years before the budget (that is, 2011–12). In

contrast, the MOHFW development budget for FY2017–18 was higher than both projections. However, the nondevelopment budget for FY2017–18 was lower than the projection made one year before the budget but higher than the projection made two years before the budget.

Figure 3: Difference between MOHFW nondevelopment and development budgets and MTBF projections



Source: MBF FY2014–2018, MOHFW Budget Document, Finance Division, Ministry of Finance.

2.1.2.2 Dual budgeting - a leading cause of inefficiency in resource planning and utilization

31. **The national budget in Bangladesh is characterized by dual budgets titled as 'Non-Development Budget' (now named as 'Operating Budget') and 'Development Budget'.** The health budget is no exception. Health budget in this analysis refers to the MOHFW's budget although other ministries incur health-related expenditures.[2] The nondevelopment budget concerns recurrent expenditure of the government while the development budget is mainly the conversion of the Annual Development Programme (ADP) into the budget format. The two budgets have separate preparation, processing, documentation structure, management, and monitoring and reporting (Table 5).

Table 5: PFM functions and accountability arrangements

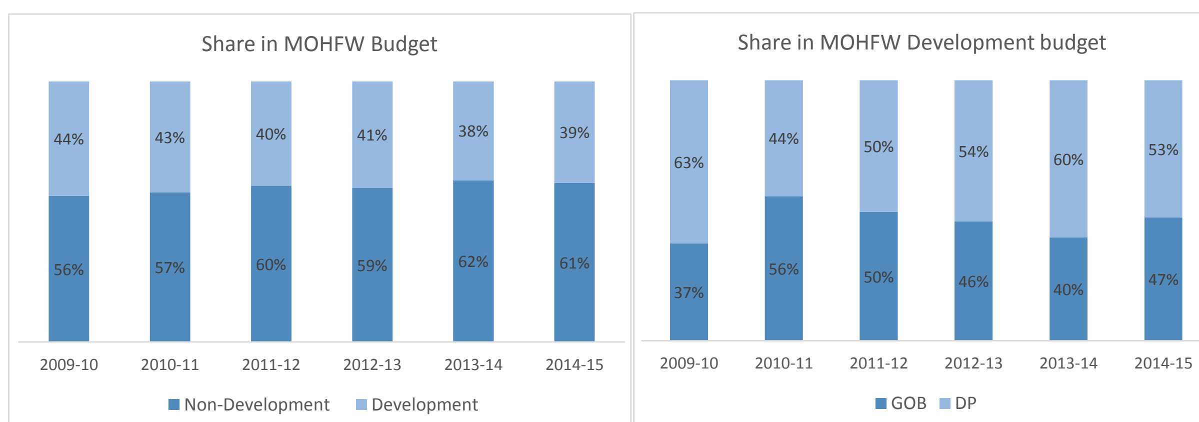
PFM functions	Nondevelopment budget	Development budget
Budget formulation		
Preparation	Ministry: Budget branch of FM wing, MOHFW Director General (DG) level: Director of Finance District level: Civil Surgeon (CS), Director/Superintendent of Hospitals and Deputy Director Family Planning (DDFP), and Medical Officer (Clinic), Mother and Child Welfare Center (MCWC) *Upazila* level: *Upazila* Health and Family Planning officer (UHFPO) and *Upazila* Family Planning Officer (UFPO) and Medical Officer (Maternal and Child Health-Family Planning)	Ministry level: Planning Wing, MOHFW DG level: Line Director (LD)/Director Planning District level: Limited Inputs and involvement *Upazila* level: No involvement in budget preparation except providing expenditure report where necessary
Estimation	Institution-wise/facility-wise allocation	Project/OP-wise allocation
Approval	MOF	Planning Commission through the ADP

[2] In FY2012, the MOHFW accounted for 91 percent of the government spending on health (HEU 2016).

PFM functions	Nondevelopment budget	Development budget
		Ministry of Finance - Development Programs not included in the ADP
Budget execution		
Fund release	Budget branch, FM wing, MOHFW DG level -Director Finance	Project implementation branch, FM Wing, MOHFW DG level-LD/ PD
Payment	Chief Accounts Officer (CAO)/District Accounts Officer (DAO)/*Upazila* Accounts Officer (UAO)→ Drawing and Disbursing Officer (DDO)	CAO/DAO/UAO→PD/DDO
Budget monitoring		
Expenditure monitoring	Ministry: Budget branch of FM wing DG level: Director of Finance	Ministry level: Planning Wing DG level: LD/Director Planning
Reporting	Audit branch, FM wing, MOHFW	Financial Management and Audit Unit (FMAU), MOHFW
Internal audit	Core audit teams (3), MOHFW	Outsourced to external audit firm by FMAU, MOHFW
External audit	DG Local Audit, DG Works Audit and Civil Audit	DG Foreign Aided Project Audit Directorate (FAPAD)

32. The nondevelopment budget is financed from the domestic resources while the development budget is financed from domestic and external resources (that is, Project Aid [PA]).[3] The development budget's share in the total MOHFW budget has been less than the nondevelopment budget's share and also on a declining trend during 2010–2015 (Figure 4). While the DPs' contribution to health sector through the development budget continued to vary (between 44 percent and 63 percent) during 2010–2015, the GOB maintained consistent overall funds to the health sector by adjusting its slice (Figure 4).

Figure 4: Composition of MOHFW total budget and MOHFW development budget



Source: Estimated from MOF budget data and Public Expenditure Review (PER) 1997–2014 (HEU 2016).

33. **The separate preparation of nondevelopment and development budgets results in the lack of coordination.** Coordination meetings between persons responsible for the preparation of the two budgets are not effective in terms of timing of the meetings, monitoring, and follow-up of budget

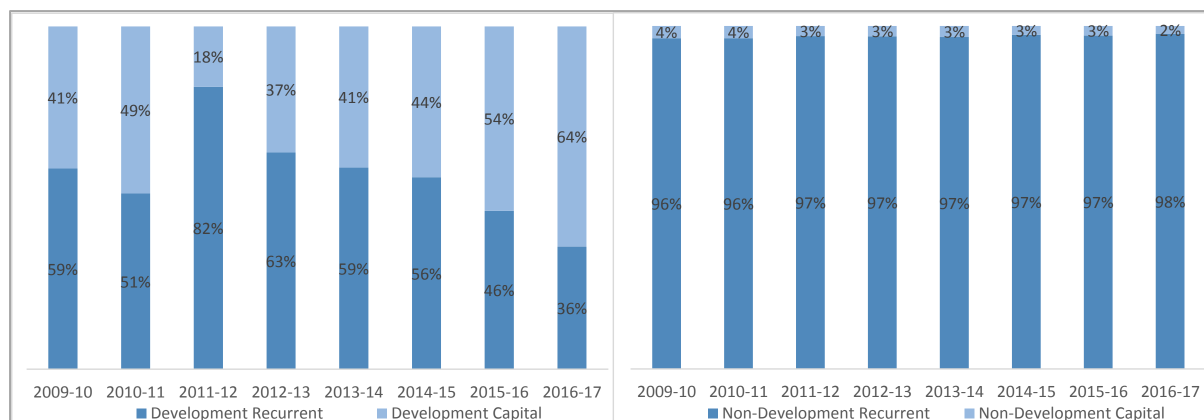
[3] PA is channeled through the RPA and Direct Project Aid (DPA). In the case of the RPA, DPs reimburse once the government spends the specified money as planned. The DPA is spent by the project or by the DP directly.

formulation. The tracking of the total budget at the central level to the lower level is difficult due to separate preparation of the two budgets.

34. **The recurrent cost implications of capital expenditure are not taken into consideration often due to the bifurcated budgeting process.** It happens when hospitals are upgraded without the MTBF/policy consideration. The expansion of hospital facilities (for example, increasing bed capacity) without making any provision in the nondevelopment budget for the payment of medical and surgical requisites (MSR) and diet makes it necessary to arrange payments from development/OP budget. For example, 31-bed *upazila* health complexes (UzHCs) have been upgraded to in-patient capacity of 50 beds and 50–100-bed District Hospitals (DHs) have been upgraded to 100 and 250 beds, respectively, in 2015 and 2016 without making any provision for MSR and diet for the additional beds in the nondevelopment budget. Hence, the diet and MSR charges for additional beds were left to the Essential Services Delivery (ESD) and Hospital Services Management (HSM) OPs. A similar practice was observed in 2007–2009 (GOB 2011). Though many of the additional hospital beds were later brought under the nondevelopment budget, the expenses of a significant number of beds in DHs are carried out by the HSM. The variation in the occupied bed number makes monitoring a difficult task. This problem could be resolved by holistic resource planning.

35. **Both nondevelopment and development segments finance recurrent and capital line items.** Expenditures for recurrent line items that occur on a regular basis (such as medical and surgical supplies, food for hospital inpatients, vaccines, and contraceptives) and capital line items (such as procurement of medical equipment, office equipment, other machineries, motor vehicles, and furniture and fixtures) are financed from both the nondevelopment and development budgets (Figure 5). This might lead to double budgeting for the same recurrent line item from separate sources.

Figure 5: Share of recurrent and capital line items in nondevelopment and development budgets 2009/10–2016/17



Source: Estimated from the MOF budget data.

36. **Dual budgeting deters the deepening of the MTBF**. The MTBF was introduced in the MOHFW in FY2007 with an aim of bringing the two budgets into one fold and joint programming of recurrent and capital expenditures gradually. However, the budgeting process of the MOHFW is still based on the formulation of the dual budgets with separate preparation and structure.

2.1.2.3 Sector-wide approach and a mixed PFM experience

37. **The MOHFW development budget[4] is characterized by the presence of the Sector-wide Approach (SWAp).** The HNP sector of the government has moved away from the traditional project approach to the SWAp since 1998 with the first SWAp Health and Population Sector Programme (HPSP). The integration of all HNP projects under one program aims at rendering cost-effective service delivery and the promotion of the involvement of private and nongovernmental organizations (NGOs) in essential health and family planning service delivery. The Health SWAp is implemented through different OPs. The advantage of a SWAp is that, as the resources are kept in a common pool fund and the services are divided by line items under different OPs fund flow, accounting and accountability of individual OPs are better ensured.

38. **The existence of parallel projects outside of the SWAp contradicts the main spirit of the SWAp.** The intention of the SWAp was to integrate HNP-related development expenditures, both recurrent and capital, under one umbrella program. At the beginning, there were only a few projects outside the SWAp. Presently, the number of development projects outside of the SWAp is on the rise. In FY2017–18, 24 projects outside OPs have been included in the ADP (Table 6). The advantage of projects outside the SWAp is that the PDs are not encumbered by the issue of delegation of authority. All expenditures are incurred centrally, and funds are released based on Development Project Proforma (DPP) or Technical Assistance Project Proforma (TAPP), subject to the conditions laid down there. The proliferation of projects outside OPs also belies the concept of the SWAp.

Table 6: Number of projects outside the Health SWAp

Sector programs	Period	Number of projects at start	Number of projects at completion
HPSP	1998/99–2002/03	0	2
Health, Nutrition, and Population Sector Programme (HNPSP)	2003/04–2010/11	9	11
Health, Population, and Nutrition Sector Development Programme (HPNSDP)	2011/12–2015/16	20	23
4th Health, Population, and Nutrition Sector Programme (4th HPNSP)	2016/17–2020/21	24	—

Source: ADP for various years.

39. **The Strategic Plan for the 4th HPNSP (2017–2022) includes a number of priorities in governance, including PFM.** The HNP Sector Investment Plan (SIP) 2016–2021 rightly adopted strengthening the capacity of the MOHFW's core systems encompassing FM, procurement, and institutional development as strategic objectives to be achieved in the five-year period between 2017 and 2022 (MOHFW 2016).

40. **During the SWAp period, the MOHFW experienced an improvement in FM strengthening and FM capacity building.** The improvement is reflected in the timely preparation of financial reports, the use of the government treasury system for the channeling of a substantial amount of DP funds, the formation of an audit committee and FM task force for monitoring FM actions, and capacity building of the MOHFW staff in FM activities (Ahsan et al 2015). Over the years under the SWAp, the budget execution capacity of the MOHFW also improved significantly (Ahsan et al 2015; HEU 2016).

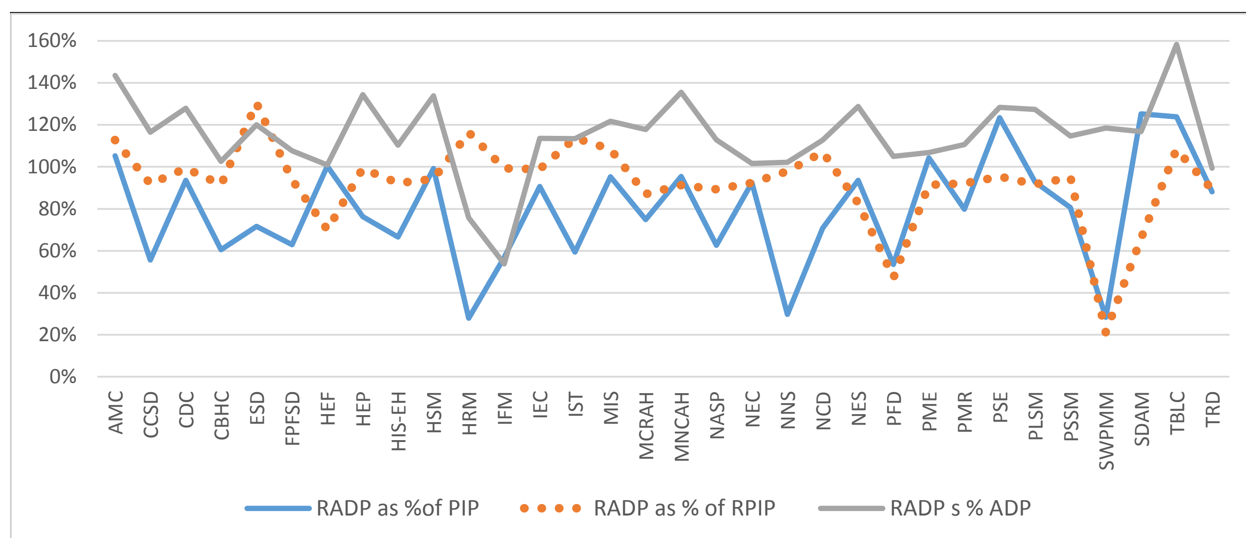
[4] The SWAp does not cover the whole development budget of the MOHFW as there are projects outside the SWAp.

41. **OP budgets are not prepared using the MTBF resource envelopes.** OPs are prepared for the total program period, that is, for five years. Usually, OPs are revised after midterm review of the sector program. However, there is scope for using the MTBF resource envelopes during the OP revision.

42. **There are mismatches between the ADP allocations and Program Implementation Plan (PIP) allocations to OPs.** This is also true for Revised Annual Development Programme (RADP) and Revised PIP (RPIP) allocations. The PIP budget under the SWAp is prepared for the total program period (that is, every five years) and includes the budget for individual OPs. On the other hand, the ADP, which also includes allocations to OPs, is prepared annually. During the third HNP sector program, the overall five-year (FY2012–FY2016) ADP allocation to 32 OPs was 60 percent of the PIP allocation. However, both the PIP and ADP underwent revision halfway through their implementation period considering the spending capacity of the respective OPs. The RADP was 81 percent of the RPIP, indicating some improvement (Annex 1). OP-wise comparison between the ADP and the RADP shows that, in most of the cases, the ADP allocation was revised upward (Figure 6) and the RADP allocation was underspent, indicating unrealistic revision and perhaps unnecessary as well (Table 11).

43. **A large number of OPs leads to a lack of coordination in planning and budgeting of OPs.** The number of OPs varied in different sector programs. The second health sector program was implemented through 38 OPs while the third sector program had 32 OPs and the fourth sector program includes 29 OPs. There are two OPs on maternal and child health[5]—one under the Directorate General of Health Services (DGHS) and the other under the Directorate General of Family Planning (DGFP). Ideally, there should be one OP for maternal and child health to be implemented by both directorates. Both OPs could have been planned jointly or at least in a coordinated manner. The budgeting of similar activities or procurement shown in these two OPs varied widely in some cases. This could have been avoided in joint planning and budgeting. Due to the large number of OPs, effective coordination centrally by the Planning Wing of the MOHFW becomes a daunting task.

Figure 6: ADP allocation to OPs significantly differs from both PIP and RPIP



44. **The large number of OPs also hinders effective monitoring.** The MOHFW holds monthly ADP review meetings to discuss the progress of activities and budget execution of OPs as well as other

[5] Maternal, Neonatal, Child, and Adolescent Health (MNCAH) OP under DGHS and Maternal, Child, Reproductive and Adolescent Health (MCRAH) OP under DGFP.

projects outside of the SWAp. These monitoring meetings could have been more effective if the number of OPs and projects was much less.

2.2 Enhance efficiency in resource allocation and utilization

2.2.1 Input-based budget causing inefficiency in resource allocation

45. **Both nondevelopment and development budgets follow input-based line item budgeting, that is, resources are allocated for specific line items or categories of expenditure (for example, pay, MSR, and diet).** The budget for the line item is based on the number of staff, facilities, and beds including the fund provided in the previous years. Line item budgeting provides little flexibility in managing and spending budget funds. The reallocation of budget funds between line items is not allowed although reallocation is allowed between different lines within the same broad economic category. For example, reallocation is permitted between lines within pay code but not between pay code and repair and maintenance code. This means unspent budget for pay cannot be reallocated to repair and maintenance even if it needs additional funds.

46. **The decisions concerning resource allocation are fragmented, centralized, and seldom need-based.** Table 7 shows that allocation decisions are taken either at the ministry level or directorate level or outside of the MOHFW (for example, for pay). Either capacity or historically determined normative governs the allocation basis. For example, the diet budget is based on per bed per day; however, the diet budget for a facility depends on the historic patient flow. Previously, the MSR allocation to hospitals was based on the number of beds without considering inpatient service utilization or patient load at the outpatient department (OPD). However, from FY2016/17, the DGHS has started considering service utilization while allocating the MSR budget to facilities. From FY2017/18, outpatient services have been considered while allocating the MSR budget to hospitals.

Table 7: Basis and decision of fund allocation to public facilities

Line items	Allocation basis	Allocation decision	District (hospital)	*Upazila* (hospital)	Union (health center)	Financial and management authority
Salary and allowances	Grade wise salary and allowances for staff up to the maximum approved position per facility	National pay scale, MOF	Approved positions of doctors, nurses, and other staff vary according to the number of beds	Approved positions of doctors, nurses, and other staff vary according to the number of beds	Approved positions	DG
MSR	Bed occupancy rate (BOR) per facility	Top-down decision from DG	Flat rate Taka	Flat rate Taka	Taka	CS supervises tender
Food (diet)	Per bed-day	Top-down decision from DG	Taka per bed-day (125 per bed-day)	Taka per bed-day (125 per bed-day)	Not applicable	CS supervises tender
Maintenance, fuel, etc.	Historic spending; Vehicle capacity utilization pattern; Political importance	Top-down decision from DG	Flat rate Taka (330,000 per year for all vehicles and <30,000 per vehicle)	Flat rate Taka (115,000 per year for all vehicles and <20,000 per vehicle)	Not applicable	CS supervises use of budget

Line items	Allocation basis	Allocation decision	District (hospital)	*Upazila* (hospital)	Union (health center)	Financial and management authority
Construction and infrastructure repair	Submission of demand note by facilities to DG; DG office sends prioritized list to PWD for facilities with >100 beds and HED facilities with <=100 beds	PWD for facilities with >100 beds and HED facilities with <=100 beds	—	—	—	PWD and HED

Source: Updated based on Ensor et al. 2001.
Note: PWD = Public Works Department; HED = Health Engineering Department.

47. **Resource allocation structure differs between the two budgets.** The development budget is allocated to OP/projects based on program/policy priorities while the nondevelopment budget is allocated to the institution or facility and not linked to policy priorities. As a result, it becomes difficult to track development expenditures at the facility level and match nondevelopment expenditures to OPs.

48. **The nondevelopment budget for construction, reconstruction, renovation, and repair of infrastructure of different facilities is not included in the respective facility budget.** Rather, the budget lies with two entities—HED for up to 100 bed facilities and PWD for facilities with more than 100 beds. Similarly, the SWAp budget for construction, reconstruction, renovation, and repair of infrastructure is allocated to the Physical Facilities Development (PFD) OP. Ideally, the budget for renovation, reconstruction, and repair of facilities should be included in the facility budget. The facility should place the budget to the HED or PWD similar to what is followed in case of drug procurement through the Central Medical Stores Depot (CMSD).

2.2.2 Resource Allocation Formula: A proposed need-based budget allocation

49. **The MOHFW currently allocates a public fund to geographic areas based on norms related to the size of the facilities.** For example, funding for the MSR is fixed according to the number of beds and salaries as well as according to the fixed numbers of staff per facility. Such allocations often do not reflect the population need of the areas since health facilities and staffing patterns often do not consider changing demographic and epidemiological requirements. Differences in population, poverty, and health status have little influence on the planning and allocation of the health resources to geographic areas. The MSR budget in FY2016–2017 was allocated according to the BORs of UzHCs and DHs. The MOF gave concurrence for allocating according to the BOR, although patient load does not play any role in determining the local needs and allocation required to meet the demand. These resulted in allocation inefficiency.

50. **The HEU of the MOHFW proposed to implement a RAF for efficient resource allocation for health services (Ensor and Begum 2013)**. The objective of the formula is to target resources toward geographic areas. There are three main components of geographic need: (a) population size, (b) demographic structure (proportion of the population in each age-sex group), and (c) need differences arising from other characteristics. The implementation of the RAF could help meet the needs of the population, mitigate interdistrict disparities, and make planning and allocation of resources more

effective. The RAF could be first used to allocate the development budget and then expanded to include the nondevelopment budget.

51. **The CS and DDFP need enhanced subdelegation of financial power to implement the RAF.** This would help utilize the required financial resources for different activities at district and *upazila* levels. For example, the current budget ceiling for ambulance repair is BDT 20,000. The repair budget could be increased if subdelegation was permitted. The MOHFW requires approval from the MOF to bring any changes in subdelegation of financial power which creates an additional bureaucratic layer in the allocation of resources.

52. **The capacity of the district-level health and family planning team needs to be strengthened to plan needs-based allocation of resources to *upazilas*.** The successful implementation of the RAF depends on many factors such as the capacity of local-level managers and budget officials of different levels (Offices of DGHS and DGFP, district, and *upazila*). The local-level capacity should be strengthened in a number of areas that include need-based planning and budgeting, better understanding of the formula, accessing and using updated information on different indicators used in the formula, and ability to apply the formula to allocate resources to *upazilas*.

53. **The successful implementation of the RAF will require additional financial resources.** At the start of the formula-based allocation, some areas will lose funding if need-based allocation is less than the current allocation. For smooth implementation, the MOHFW should ensure that no area loses funding but the areas currently receiving less than the need catch up.

2.2.3 Retention of user fees might enhance efficiency

54. **Public health facilities (50-bed hospitals at the primary level and all secondary- and tertiary-level health facilities) are collecting user fees according to the revised order issued by the MOHFW.[6]** Fees are collected for outdoor entrance, admission, and selected services such as laboratory and investigations, surgical and neuro-medicine services, private bed or room, and ambulance rent. The MOF approved the amount of these fees with certain terms and conditions. According to this approved order, certain proportion of the user fees are to be distributed among employees working in high-risk departments such as radiology, radiotherapy, and pathology. However, to date there has not been concurrence from the MOF to distribute user fees among employees according to the revised order issued by the MOHFW.[7] Therefore, according to the existing policy, all income from user fees should be deposited in the government treasury first. Therefore, employees are not receiving any incentives from user fees. The health facilities return the collected user fees to the government treasury.

55. **An estimated BDT 1,445 million (iBAS data on the MOHFW's revenue) was collected from users at the MOHFW facilities in 2014–15 for using various services (for example, outdoor ticket fee; inpatient admission fee; fees for selected diagnostic investigations, surgical procedures, private bed/room, and selected medicines/vaccines; and ambulance rent[8]).** This amount represents around 2 percent of the MOHFW recurrent expenditure (1.4 percent of the MOHFW total spending) in the same year. The MOHFW spent around 3 percent of the recurrent expenditure on repair and maintenance in 2014–15. The estimated user fees represent 59 percent of the repair and maintenance expenditure in that year. Hence, user fees if retained at the facility could be used as a supplement to the allocation for repair and maintenance budget of the facility which is not adequate.

[6] Vide memo no. 155 dated March 2, 2010, MOHFW.

[7] Vide memo no. 155 dated March 2, 2010, MOHFW.

[8] Income from use of government vehicles (Code 2037) includes ambulance rent. While estimating total user fees, it is assumed that 75 percent of that was from ambulance rent.

56. **Secondary- and tertiary-level public health facilities can only retain user fees collected for blood transfusion services.** These services include blood transfusion, blood grouping, and cross matching. The blood transfusion center takes the fees from patients staying at cabins, paying beds, and the general wards, as well as from private patients. The facilities are collecting fees according to existing rules of the country.[9] Table 8 presents how the collected user fees for blood transfusion services are allocated. The safe blood transfusion fund is created and managed along with the income and expenditure record, accounting, and audit according to present rules.[10]

Table 8: Distribution of collected user fees for providing blood transfusion related services

Distribution of Allocation	Officer - Employees	Claimed proportion (%)
Fund	Blood Transfusion Center Fund	45
	Fund of National Expert Committee of Blood Transfusion	5
Officer of blood transfusion center	Professors, in-charge, or same-level officers equally	12
	Associate Professor, Assistant Professor, or same-level officer equally	10
	Medical Officer or same-level officer equally	08
Employees	Class III employee equally	14
	Class IV employee equally	6

57. **Retention of user fees at the primary- (50 bed), secondary-, and tertiary-level health facilities could improve efficiency and quality of care.** It should be noted that primary health care should remain free of charge. Like the law and rules for collecting user fees for blood transfusion related services, legislative support is needed to retain user fees collected from other services at health facilities. Coverage of the rule should be extended to include all health care related services at *upazila*, secondary, and tertiary levels, specifying the proportion of user fees to be split between health facilities and health care providers as incentives. This would require concurrence of the Finance Division (FD), as the present rule covers all types of staff connected with diagnostic services. To introduce this change, an amendment of medical practice, private clinic, and laboratory (regulation) ordinance, 1982, and safe blood transfusion act 2002 (amended 2008) would be required.

2.3 Improve equity and increase health care access especially for the poor and vulnerable

58. **The HCFS 2012–2032 proposes social health protection schemes (including the poor and the formal sector) to ensure financial protection against health expenditures for all segments of the population, starting with the poorest (GOB 2012).** Presently, the MOHFW is implementing two social health protection schemes: SSK and MHVS in different *upazilas* of Bangladesh.

2.3.1 Shasthya Surokhsha Karmasuchi - a social health protection scheme for the poor

59. **The SSK aims to reduce OOP expenditure of the household members, thereby protecting them from impoverishment in case of catastrophic illnesses.** The government is subsidizing the premium for the below poverty line (BPL) beneficiaries. The scheme is being piloted in three *upazilas* of Tangail district. The sources of the SSK fund as outlined in the draft SSK Operational Manual[11] are a government grant, membership fees, a government subsidy in the form of premium, profit from the investment, and funds obtained from any other sources approved by the government. Although health care insurance for ultra-poor is at the core of SSK, the element of insurance policy is absent. It is rather

[9] Rule no. 12 of 2002 (Bangladesh Gazette, April 10, 2002) and Revised Statutory Regulatory Order (SRO) No. 145-Law/2008, rule no. 24 (Bangladesh Gazette, June 17, 2008).

[10] Rule numbers 25, 26, and 27 of SRO No. 145-Law/2008 (Bangladesh Gazette, June 17, 2008).

[11] Draft Operational Manual. *Shasthya Surokhsha Karmasuchi*. Dhaka: Health Economics Unit, MOHFW, Government of the People's Republic of Bangladesh.

a government scheme to put away the premium for safeguarding health care of the targeted families against a number of listed diseases. However, the goal is to introduce a premium-based insurance policy to higher-income groups gradually to support achievement of the UHC financing policy by 2032. It is, therefore, necessary to study PFM functions, weaknesses, and limitations of the SSK along with the suggestions for improvement.

60. **The availability of funds to pay the premium of the SSK cardholders needs to be ensured in three pilot *upazilas*.** Though the government was supposed to deposit BDT 1,000 (US$12.5) as premium for each BPL cardholder in a separate fund created for the purpose, no money was deposited in the first year of operation. The total cost of the project for the six-year period (January 2017–June 2022) is BDT 1.72 billion (US$21.5 million). The record from the Office of the CAO of the MOHFW shows the SSK cell made no claim to the government in FY2016–17 for the payment of the premium. In addition, the budget breakup[12] of the 4th SWAp for FY2016–17 forwarded to the CAO by the HEU shows no allocation for the premium payment. An amount of BDT 105 million (US$1.3 million) will be required per year for the payment of premium for the three piloted *upazilas'* BPL population (average 35,000 per *upazila*). Since it is a onetime payment, it may be managed from the government grant and development budget. However, health care financing through the SSK will not be possible unless efforts are made to ensure the availability of this fund.

61. **The fund requirements for scaling up and enhancement of the SSK scheme covering all 427 *upazilas* outside the district headquarters will be considerable.** An amount of BDT 10.67 billion (US$133.4 million) will be required for 427 *upazilas* every year only to pay the premium. During the 4th SWAp, the SSK is to be piloted in three *upazilas*; a total of minimum 105,000 BPL cardholders will then fall under the coverage of the SSK scheme. BDT 1.35 billion (US$16.9 million) out of the total BDT 1.72 billion (US$21.5 million) has been allocated in the 4th HPNSP for the payment of premium in the SSK pilot program (GOB 2017). This amount is insufficient for carrying out health care expenses of the targeted population for six years without any additional support. The HNP SWAp wants the SSK scheme to be self-sustained, but other avenues must be explored to find ways for generating income to make it sustainable. It is necessary to collect funds from different sources and invest it for generating more resources.

62. **A health insurance scheme like SSK cannot operate without a proper legal framework including financial rules and regulations.** Currently, the SSK cannot be considered sustainable as it is operating like a normal development function of the government guided by rules and regulations. It is also framed for the projects that are supported by the development budget. The draft Operation Manual of the SSK states that the fund should be deposited in any scheduled bank upon the approval of the SSK Cell and the fund or part of it may be invested in the SSK-related activities only. In the absence of formal approval of the manual, or adoption of rules regarding the creation of the fund and investment of the same, no method for escalating the SSK fund could be applied. A separate set of financial and business rules are required for a health insurance scheme. Before framing the financial rules and regulations, it is necessary to establish a fund titled '*Shasthya Surokhsha Karmasuchi* (SSK) Fund' and open a special account in any scheduled bank for its operation. The special account is necessary for exclusively handling the SSK investment. It was found from the draft SSK Operation Manual that the SSK Operation Manual needs certain modifications to accommodate commercial accounting principles for the smooth running of an investment scheme. Commercial accounting principles are general rules and concepts that govern the field of accounting (ICMAB 2014). Many of the government financial rules may not apply to an investment fund. The rules need to specify issues such as the possibility of fund transfer from one financial year to another financial year. The Scheme Manager will be able to bear risk and to invest reserves if applicable. For example, drawing money from the pool fund directly by the SSK may not be possible. This will be channeled through the HEU to

[12] Memo no. SwaPKoM/SwaSeBi/Health-Econ/HNSP/Finance Budget/2017-22/762/2017/342. Date: January 6, 2017.

the investment fund. Separate financial rules need to be outlined within the framework of investment procedures and profit sharing mechanisms. The SSK Operation Manual instructs the maintenance of financial accounting in line with the government chart of accounts. This is not necessary as it will follow commercial principles. For both accounting and auditing, it should follow international standards of best practices.

63. **The SSK needs a proper monitoring, accounting, and reporting backup to ensure accountability of the persons involved in the operation.** The scaling up of the SSK with an expansion of operation across the country will need a robust monitoring and accounting system in place. The draft SSK Operation Manual contains a few provisions for the maintenance of accounts and audit. These are more or less in line with the government accounting procedures. If the SSK is designed as an autonomous organization combining the character of a public-private enterprise, modification of the government rules will be necessary for its operation. Establishing a system for ensuring accountability of the persons responsible for the operation of the SSK insurance scheme is vital for a successful program. A mechanism should be set up for the control and oversight of financial operation of the SSK to protect the interest of the stakeholders.

2.3.2 Maternal Health Voucher Scheme: A demand- and supply-side financing intervention

64. **The MOHFW is now implementing the MHVS in 53 *upazilas* of the country.** Initially, the pilot scheme was adopted in 21 *upazilas* in 2007. The service components covered by the vouchers are three antenatal care (ANC) checkups, safe delivery at a facility including caesarean delivery or at home by skilled birth attendants, one postnatal care (PNC) checkup within six weeks of delivery, and management of complications including caesarean sections from designated providers. The beneficiaries are supposed to receive these services without any OOP expenses. Mothers receive cash incentives for safe deliveries either in a facility or at home for first and eligible second deliveries. They have to adopt family planning before the second delivery to receive incentive payments for the second delivery. Transportation costs provided through the system are for three ANC visits, institutional delivery, and one PNC visit. Pregnant women receive this money in cash after the completion of the five visits. These incentives are paid as part of the demand-side financing component.

65. **The supply-side component of the MHVS has a provision to provide payments to public and private providers.** Nongovernmental and private providers receive full reimbursement for the services they provide to the beneficiaries according to policy. Public sector health facilities at *upazila* level provide all needful maternal, neonatal, and child health (MNCH) services free of charge in Bangladesh. The incentive policy for the public providers was introduced to motivate them to participate in the program and to offer services to the beneficiaries. Government health care providers are reimbursed 50 percent of the voucher value as incentive payment, and the remaining 50 percent of the value is deposited in a seed fund account. An initial onetime payment of BDT 65,000 is provided to open a seed fund account in each *upazila*. The seed fund is used to procure medical and surgical supplies required to provide maternal health services. The signatory of the seed fund account is the UHFPO. Providers submit their claims to a Resident Medical Officer (RMO) who, after approval, forwards all claims to the bank for transferring the approved amount from the MHVS account to the seed fund account. The UHFPO draws money from the seed fund account and disburses that money between service providers and beneficiaries. Now, beneficiaries receive money through their respective bank accounts.

66. **The release of fund is delayed at the ministry and *upazila* levels.** The source of fund to support the MHVS implementation activities is the approved budget of the operational plan 'MNCAH', which is financed through the development budget. At the beginning of the financial year, the MOHFW releases a quarterly allotment in favor of the LD, MNCAH OP. The LD then sends an advance drawing request from the DGHS to the MOHFW. In most cases, it is revealed that the fund request exceeds the

amount (BDT 500,000) delegated to the Secretary of the MOHFW. Therefore, the MOHFW sends the fund request to the MOF for approval. The approval in turn is sent to the LD through the same steps. The MOHFW approves the advance request received from the LD on receipt of approval from the MOF. The LD submits the advanced bills to the CAO of the MOHFW to draw the fund. The MHVS account at the *upazila* receives the fund from the office of the LD. These ministry-level approval processes take 3–6 months and cause delay in receiving the fund in the MHVS account at the *upazila* level. The cycle repeats every financial year. The long delay in the flow of fund from the national level to the *upazila* level affects efficiency and effectiveness of program activities (Khan and Khan 2016). The processes of requesting the advance fund need to be simplified and ideally should not take more than one month.

67. **The situation is further aggravated at the *upazila* when the backlog of payment processes is created.** The UHFPO, RMO, and Account Officer are involved in the fund management. They have to work additional hours to complete these processes. Some of these positions are vacant, and the responsible officials are not available. Unspent money returns to the treasury at the end of the financial year according to the existing financial rules. As a consequence of the whole procedure, the MHVS program faces a fund crisis for almost half of the year. Khan and Khan (2016) recommended that arrangements of advance or an 'Imprest fund' could be used for timely payment of cash incentives and travel allowances to beneficiaries. However, the Imprest fund is currently applicable only for nondevelopment budgets, not for development budgets. One option to solve this problem is changing financial rules to allow the use of the Imprest fund for the development budget. The other option is financing the MHVS from the nondevelopment budget like similar social protection programs of other ministries, for example, allowance for poor lactating mothers under the Ministry of Women and Children Affairs.

68. **There is a governance issue arising from conflict of interests.** The UHFPO and RMO have a dual role in the MHVS. Both are managers of the MHVS fund and also the MHVS service providers at the UzHC. They receive incentives for providing services to the MHVS beneficiaries. Their role in fund management conflicts with their interest as receivers of incentives for service providers. This raises serious concerns for governance and accountability.

2.3.3 Design and implement the NHSO for social health protection schemes

69. **The main purpose of the proposed NHSO in Bangladesh is to support the implementation of social health protection schemes (for example, SSK) and strengthen health care services.** The HCFS 2012–2032 proposes the establishment of the NHSO. Establishing the NHSO as an autonomous authority under the MOHFW will remove the functional barriers of utilizing the health security fund for the benefits of underserved, poor, and vulnerable groups without encumbrance of financial rules, regulations, and protocol applicable to a government entity as it will have a set of financial rules and regulations applicable to an autonomous body. The ultimate objective of the HCFS 2012–2032 is to reach UHC by the year 2032 without being encumbered by procedural formalities. The NHSO will perform the following functions:

(a) Operate health social protection schemes for mother and child, adolescent girls, poor and vulnerable groups, and underserved people.

(b) Research and devise newer schemes for implementing National Health Policy 2011, Bangladesh Population Policy 2012, and Bangladesh National Nutrition Policy 2015.

(c) Arrange funds for implementing these policies.

(d) Manage contracted out health care providers.

(e) Coordinate and align activities of different national and international organizations/DPs active in the HNP sector in Bangladesh.

(f) Implement and manage the health insurance policy of the Bangladesh Government aiming at achieving UHC by 2032.

70. **The first and foremost barrier to setting up the NHSO is the absence of a policy directive from the government.** The establishment of the NHSO with full autonomy to arrange funds, prepare plans, formulate policies, and ensure smooth flow of service delivery under the MOHFW will need a policy directive from the government. The government may form a high-level committee with the Minister, MOHFW, in the chair to decide on the policy issues. Once this is approved by the policy makers, it will initiate the processes. The adoption of a policy to establish the NHSO may need a wide range of discussion with parliament members, DPs, health and social security workers, government employees, and NGOs to ensure their support and surmount probable resistance from any quarter.

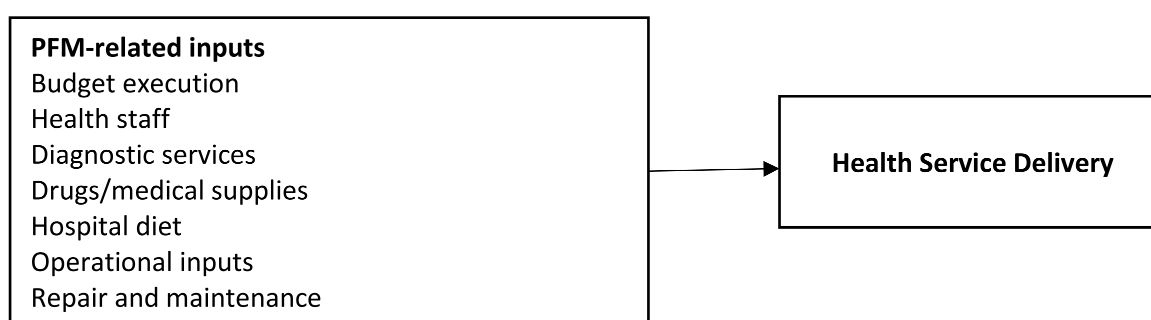
71. **Prerequisites for establishing the NHSO.** The formation of a high-level committee with the Additional Secretary of the HSD as convener and senior officers from Medical Education and Family Welfare Division, HSD, FD, Economic Relations Division, Ministry of Social Welfare, DGHS, and DGFP as members is one prerequisite. The committee could be composed according to the decision of the Minister, MOHFW. Discussion with the group of government employees will be needed, if the government considers the possibility of amalgamation of the government group insurance and benevolent fund with the proposed national health/social insurance policy under the NHSO. A study is needed to suggest structure, legal authority, functions, funding, PFM procedures, staffing, and management of the NHSO. State-owned and private insurance companies should participate in the discussion to consider the formation of a national health insurance policy. The status of the NHSO will be determined based on the business procedure of the NHSO. This may function as an autonomous board, for example, Bangladesh Rural Electrification Board or Bangladesh Rural Development Board with wider range of control, or it may work as a public company, with the major share being held by the government, registered under Companies Act 1994. The following prerequisites are necessary for the setting up of the NHSO:

- The formation of a high-level committee
- Approval of an outline by the government
- A task force would be formed to prepare a draft act
- A draft act defining the status of the office, functions, and area of activities with provision of rules relating to governance, FM, and audit modalities
- Draft examined and cleared by the MOF and the Ministry of Law
- The act placed before the Parliament by the Minister, MOHFWs

3. Linkages between PFM and health service delivery in Bangladesh

72. **The World Bank, WHO, Overseas Development Institute (ODI), and several studies highlighted the importance of sound PFM to health service delivery (Cashin et al. 2017; Welham et al. 2017; World Bank 2016b).** A comprehensive PFM leads to improved health service delivery through process and decision-making improvement. PFM-related inputs lead to the desired output: access to quality care. This section discusses how PFM issues affect service delivery in the health sector of Bangladesh to inform policy making. The study reveals that key PFM-related inputs affecting health service delivery at the district level in Bangladesh are health staff, diagnostic services, drugs/medical supplies, hospital diet, operational activities, and repair and maintenance of health facilities. The availability of resources for these inputs and the organization of their use determine the possibilities for health services delivery (Figure 7).

Figure 7: Link between PFM-related inputs and health service delivery



Source: Adapted from Welham, Krause, and Hedge 2013.

3.1 Enhance efficiency in budget execution to improve health service delivery

3.1.1 Fund availability without delay for efficient budget execution

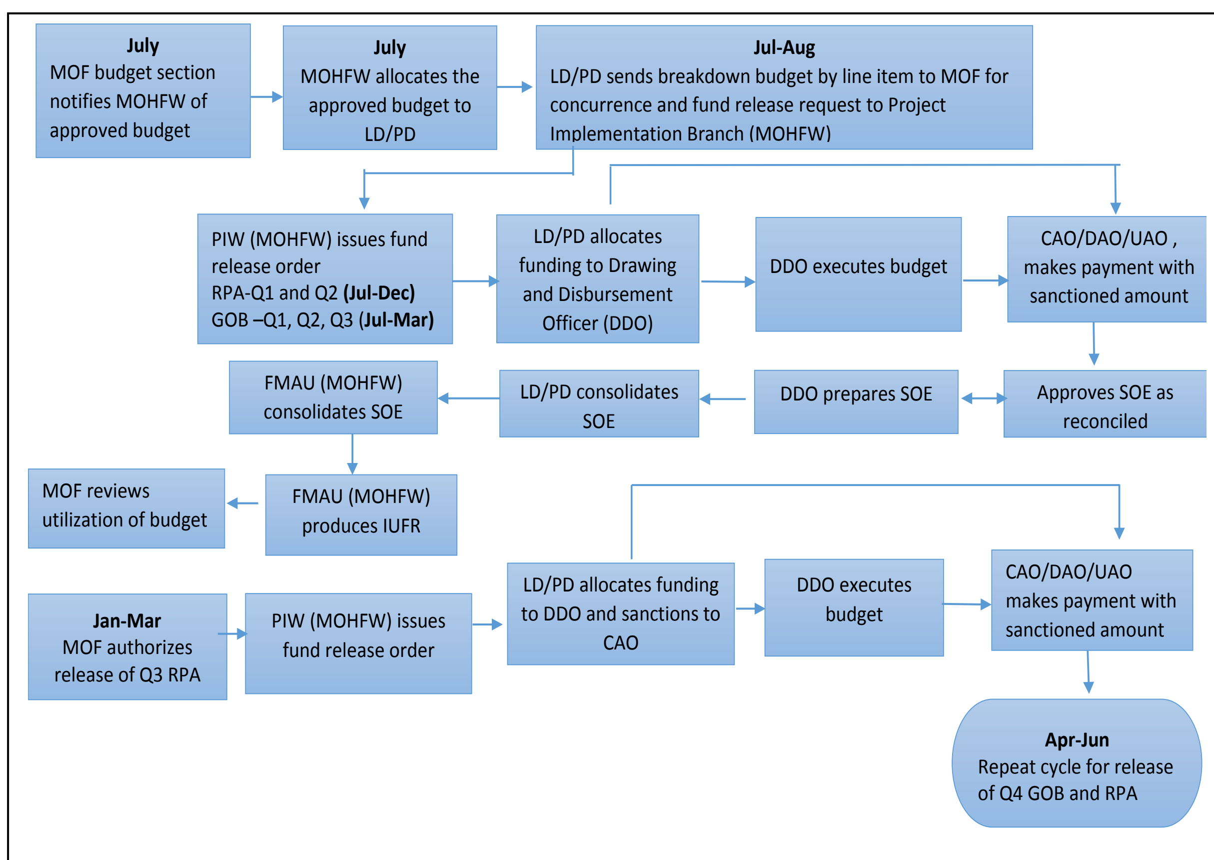
73. **The fund disbursement method differs between development and nondevelopment budgets.** The development budget is allocated from LDs/PDs to DDOs, who execute the budget through the treasury system. The development budget is released or disbursed in four quarters (Table 9). For the development budget, a fund release order from the MOHFW (Project Implementation Branch) is required. The order allows the fund disbursement to the DDOs[13] for the first three quarters of the GOB funds and first two quarters of the RPA funds. The fourth-quarter release of the fund requires endorsement from the FD. For release of third- and fourth-quarter installments of the RPA, the LDs/PDs need to submit the SOE reconciled and certified by the CAO, Health (Figure 8). In case of nondevelopment budget, a separate order for fund disbursement is not necessary. The nondevelopment budget fund can be spent against the budget allocation, and a quarterly fund release is not required except for the grant transfers to different agencies.

Table 9: Timeline for the development budget fund release

Quarter	Timeline for fund release
1st quarter	July–September
2nd quarter	October–December
3rd quarter	January–March
4th quarter	April–June

[13] Funds released and distributed to DDOs does not mean funds are distributed to all facilities under the respective DDOs. Some facilities have no DDOs.

Figure 8: Flow chart - Development budget disbursement and execution



74. **The fund disbursement starts with the circulation of notification from the FD on approval of the budget.** The Approved budget becomes available online through iBAS++[14] of the FD. The approval notification passes through the DGs to the Finance Director, LD, CS, DDFP, UHFPO, UFPO, and others. The Director, Finance, of the respective directorate (DGHS/DGFP) is responsible for the disbursement of the nondevelopment budget fund. Budget approval authorizes local officers to draw money from the treasury (DAO/UAO) up to the ceiling determined by the delegation of financial authority. LDs disburse cash/materials for executing OPs by field offices/cost centers.

75. **The delay in fund release is a major cause of underspending of the development budget especially RPA.** Discussions with the respective officials of the MOHFW and examination of fund release documents revealed the following reasons for delay:

- Delay in sending the fund release request letter
- Absence of necessary documents with the letter for fund release
- Not providing the CAO-certified reconciled account with request letter
- Delay in sending the SOE by LDs
- Lack of timely follow-up by the concerned OP officer
- Noncompliance with the donor conditions set for loan/grants
- Noncompliance with financial rules and regulations, even minor rules, which can be amended without delay

76. **The delay in sending the SOE by the LD/PD is often due to the delay in receiving expenditure reports from all units/facilities.** The LDs encounter this problem while integrating the expenditure

[14] Upgraded version of iBAS.

report from all units for preparing the consolidated SOE. The SOE is required for making the fund release request for the third and the fourth quarters of the RPA fund. The delay in preparing and sending the SOE from all the cost centers further delays the fund release.

77. **The fund release process is not well understood by all LDs and their colleagues.** Discussions with the LDs and other relevant officials found that some of them are unaware that funds for the first to third or first to fourth quarters can be released if justifications are provided along with the request. For example, OPs with a large procurement budget cannot execute it fully if funds are released quarterly. In such cases, the LDs can request for funds of three quarters or four quarters to be released all at once. Table 10 presents information from one large OP as an example and shows that the LD has not sent the fund release request on time, that is, at the beginning of a quarter. The first-quarter fund release request was sent in August in two out of four fiscal years. For the second-quarter fund release, the request was sent in November–December in three fiscal years. Therefore, the fund became available toward the end of the period leaving little time for spending the fund fully and efficiently.

78. **The separate disbursement of nondevelopment and development budgets results in the lack of coordination and accountability.** For example, lack of coordination of the entire financing operation at the directorate level characterizes the fund disbursement process. The Director, Finance, who controls the nondevelopment expenditure process, is not informed about the amount released from the development budget through the OP budget for the same line item such as MSR, diet, and so on. According to the job description,[15] the role of the Director, Finance, of the DGHS, is limited to the nondevelopment budget preparation and disbursement of funds from the nondevelopment budget. Her/his role does not include overall supervision/monitoring of financial activities. As a result, the Director, Finance, of the DGHS remains unaware of the latest position of diet and MSR allocation to the health facilities under the DGHS. The information is not available with the Director, Finance, of the DGHS as diet and MSR for added beds in upgraded facilities were borne by the LDs of HSM and ESD OPs. There is no one responsible in the DGHS and DGFP to track both nondevelopment and development budget allocations of the respective directorates, to prevent wastage, double payment, and pilferages. This indicates the necessity of an effective expenditure control and monitoring system in the DGHS to ensure accountability.

79. **The recent introduction of iBAS++ has accelerated budget distribution.** Discussions with Finance Directors and LDs of the DGHS and DGFP revealed that fund release is delayed till August as it starts after hard copies of budget books become available by the fourth week of July. However, the introduction of the improved iBAS++ in the current fiscal year accelerated the budget distribution online replacing the distribution of hard copies of budgets. In FY2017–18, the MOHFW budget was made available online by the first week of July. The processes will be further accelerated if the DGHS and DGFP are directly linked with iBAS++.

80. **The recent decision of the government brings a change in the fund release process.** The first and the second quarters of the GOB portion of the development budget from now on will be automatically released, and the LDs/PDs will be able to use the project/OP fund from July 1.[16] This will simplify the fund release process to some extent, and this decision should be extended to the first two quarters of the RPA.

81. **Since iBAS++ will contain all the execution data, the condition of submitting the SOE should no longer be a requirement for the release of third and fourth quarter of the RPA.** The delay in submission of the SOE is a major cause of the delay in fund release of the last two quarters of the RPA.

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[15] http://www.dghs.gov.bd/images/docs/Job_Description/Job_DESCRIPTION%20DGHS.pdf in Bangla.

[16] Budget speech 2018–19 of the Finance Minister, paragraph 190. https://mof.portal.gov.bd/sites/default/files/files/mof.portal.gov.bd/page/b29661b6_927f_4012_9f83_5ac47dbd6ebd/Speech_EN_18_19.pdf.

Delinking the fund release from the submission of the SOE will reduce the delay in fund release significantly and thereby improve fund availability.

3.1.2 Underspending indicating inefficiency in budget execution

82. **The MOHFW budget execution rate is higher for the nondevelopment budget than that for the development budget.** The execution rate of the revised nondevelopment budget varied ranging from 93 percent to 97 percent while the rate for the revised development budget varied between 78 percent and 93 percent during the last seven years. However, the original nondevelopment budget execution exceeded 100 percent in three years out of the seven-year period. This may raise questions about the necessity of budget revision in certain cases.

Table 10: Days taken to process the fund release request by the Project Implementation Wing

FY	GOB-financed/ RPA	Quarter(s)	Fund release request letter sent by the LD	Number of days between starting of the quarter and sending of fund release request (excluding weekends)	Request letter received by Project Implementation branch	Fund release order issued	Number of working days taken for fund release (excluding weekends)
2012–13	GOB and RPA	1	July 19, 2012	14	July 22, 2012	July 29, 2012	6
2012–13	GOB and RPA	2	October 15, 2012	10	October 18, 2012	October 25, 2012	6
2012–13	GOB and RPA	3	March 14, 2013 and March 25, 2013	52	March 20, 2013 and March 27, 2013	April 2, 2013	5
2012–13	GOB and RPA	4	May 9, 2013	28	May 12, 2013	May 26, 2013	10
2013–14	GOB and RPA	1	August 13, 2013	32	August 14, 2013	September 4, 2013	15
2013–14	GOB and RPA	2	November 18, 2013	34	November 19, 2013	November 27, 2013	7
2013–14	GOB and RPA	3	February 11, 2014	29	February 16, 2014	February 24, 2014	10
2013–14	GOB and RPA	4	May 4, 2014	23	May 6, 2014	June 1, 2014	19
2014–15	GOB	1	August 23, 2014	38	August 24, 2014	September 2, 2014	8
2014–15	GOB	2	November 24, 2014	38	November 26, 2014	December 10, 2014	11
2014–15	RPA	1 and 2	December 14, 2014	52	December 15, 2014	December 28, 2014	9
2014–15	GOB and RPA	3	March 1, 2015	42	March 4, 2015	March 11, 2015	6
2014–15	GOB and RPA	4	May 28, 2015	41	May 31, 2015	June 16, 2015	13
2015–16	GOB and RPA	1	July 26, 2015	17	July 28, 2015	August 11, 2015	11
2015–16	GOB	2	November 9, 2015	27	November 10, 2015	November 16, 2015	5

FY	GOB-financed/ RPA	Quarter(s)	Fund release request letter sent by the LD	Number of days between starting of the quarter and sending of fund release request (excluding weekends)	Request letter received by Project Implementation branch	Fund release order issued	Number of working days taken for fund release (excluding weekends)
2015–16	RPA	2	December 21, 2015	57	December 22, 2015	December 24, 2015	3
2015–16	GOB and RPA	3	February 14, 2016	30	February 15, 2016	February 28, 2016	9
2015–16	GOB and RPA	4	June 5, 2016	45	June 5, 2016	June 20, 2016	12

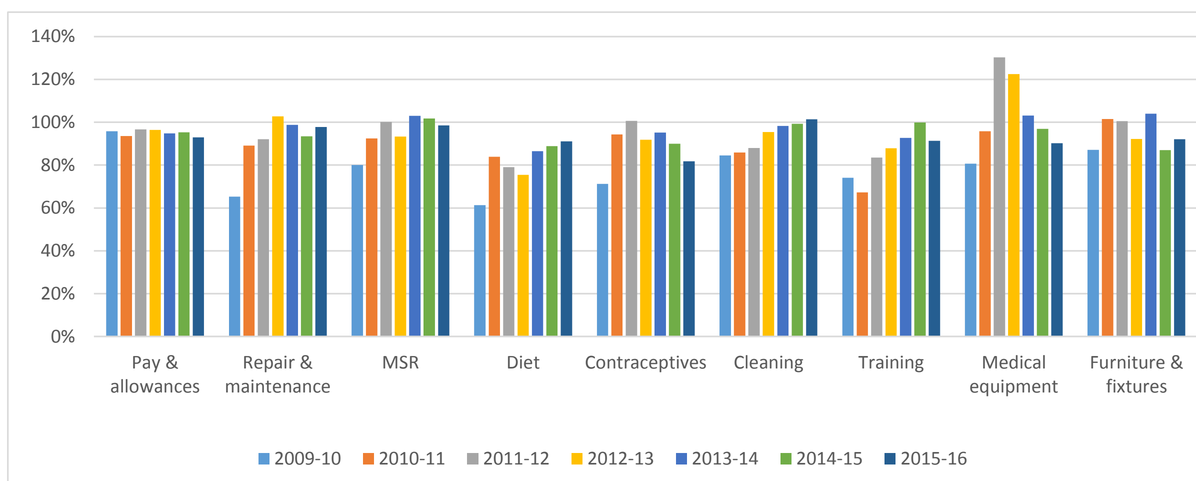
Source: Project Implementation Wing, MOHFW.
Note: This table is based on information of one OP.

83. **The nondevelopment budget execution fluctuates for almost all line items.** No line items show any uniform pattern in the execution of the revised nondevelopment budget (Figure 9). For example, the revised budget execution of pay and allowances varied between 93 percent and 97 percent. The budget for this line item includes pay and allowances for vacant positions; still variation is much less than other line items. The execution of the repair and maintenance budget[17] fluctuated between 65 percent and 103 percent during the last seven years. However, the execution rate improved substantially compared to the years before FY2012. Four separate entities are responsible for the repair and maintenance of infrastructure, vehicles, and equipment. These include the PWD, HED, Transport & Equipment Maintenance Organization (TEMO), and National Electro-Medical Equipment Maintenance Workshop and Training Centre (NEMEW). Recently, there has been increasing human resources (HR) capacity and budget for some of these entities.[18]

84. **Some line items show underspending of the revised nondevelopment budget in one year and overspending in another year indicating weak capacity in budgeting, also weak monitoring and reporting.** Recurrent line items such as repair and maintenance, MSR, and cleaning and capital line items such as medical equipment, furniture, and fixtures showed such a trend (Figure 9). Expenditures were more for some items than the revised budget allocation as reallocation/reappropriation[19] was done but was not reflected in the revised budget. It shows that both the original and revised budgets were far from realistic.

[17] Repair and maintenance budget includes repair and maintenance of infrastructure, furniture, fixtures, machineries, medical equipment, and vehicles.
[18] For example, NEMEW.
[19] In some instances the reallocation is done just before the fiscal year ends (on 30 June)

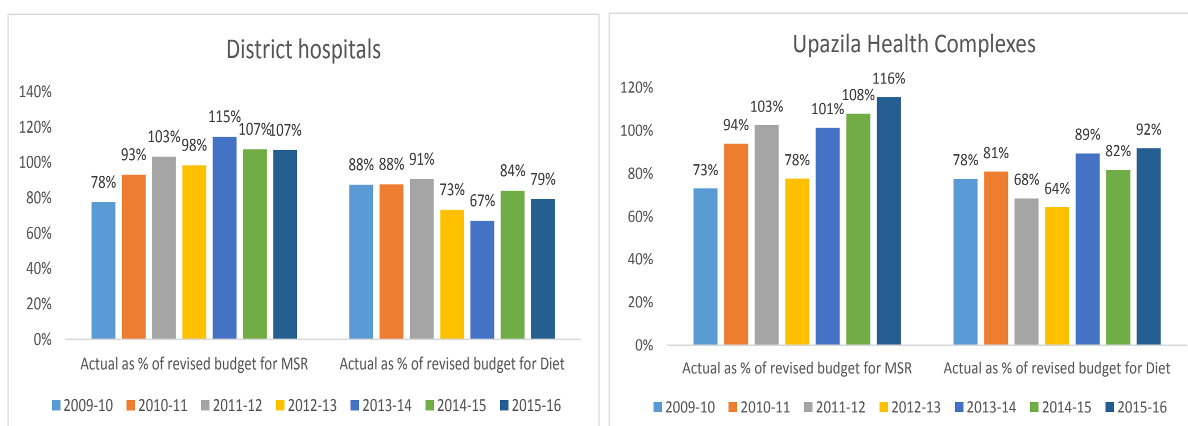
Figure 9: Revised nondevelopment budget execution for selected recurrent line items



85. **The nondevelopment budget for the MSR and diet[20] that are crucial for service delivery remained unspent at the facility level.** During the last seven years, the UzHC utilized on average 96 percent of the revised budget for the MSR. The DHs performed better in this regard (Figure 10). Diet is used for inpatients only; so, it is related to inpatient service utilization (for example, admission, bed occupancy, and duration of stay). The BOR at the DH was 137 percent in 2015 (GOB 2016). Surprisingly, utilization of the revised budget for diet was 84 percent in 2014–15 and 79 percent in 2015–16. On the contrary, the BOR was 78 percent in 2015 in the UzHC, but 82 percent and 92 percent of the revised nondevelopment budget for diet was spent in 2014–15 and 2015–16, respectively. The mismatch between the reported BOR and diet budget utilization warrants further examination.

86. **The performance of OPs in the development budget execution varies widely.** Table 11 shows the budget utilization level of different OPs. The average execution rate in five years was less than 50 percent for three OPs while it was over 100 percent for four OPs. Further analysis revealed the capital-intensive expenditure pattern of the highest performing OPs. It raises concern that half of the lowest 10 spenders are service delivery related OPs. Three OPs could not even spend half of their revised allocation.

Figure 10: Nondevelopment budget execution for the MSR and diet at DHs and UzHCs



[20] Food for inpatients.

Table 11: Revised Development budget execution by OPs (2011/12–2015/16)

Operation Plans	Type of OP	Trend	2011-12	2012-13	2013-14	2014-15	2015-16	Average
National Nutrition Services (NNS)	SD		61%	45%	74%	37%	19%	47%
Strengthening of Drug Administration and Management (SDAM	GS		75%	19%	40%	86%	19%	48%
Human Resources Management (HRM)	SS		21%	38%	61%	69%	53%	48%
Health Economics and Financing (HEF)	GS		80%	84%	45%	26%	22%	51%
Essential Services Delivery (ESD)	SD		31%	76%	80%	49%	24%	52%
Management Information Systems (MIS)	SS		81%	78%	47%	75%	33%	63%
Sector-Wide Program Management and Monitoring (SWPMM)	GS		53%	87%	75%	68%	37%	64%
TB and Leprosy Control (TB-LC)	SD		79%	88%	78%	82%	3%	66%
National AIDS And STD Program (NASP)	SD		41%	79%	114%	50%	58%	69%
Maternal, Neonatal, Child and Adolescent Health (MNCAH)	SD		86%	94%	84%	72%	16%	71%
Family Planning Field Services Delivery (FPFSD)	SD		99%	41%	87%	96%	32%	71%
Nursing Education and Services (NES)	SS		70%	91%	93%	78%	27%	72%
In-Service Training (IST)	SS		56%	84%	73%	72%	78%	73%
Non-Communicable Diseases (NCD)	SD		90%	95%	64%	65%	49%	73%
Community Based Health Care (CBHC)	SD		71%	88%	82%	59%	67%	74%
Training, Research and Development (TRD)	SS		73%	78%	94%	87%	35%	74%
Planning, Monitoring and Research (PMR)	GS		74%	91%	82%	72%	64%	77%
Maternal, Child, Reproductive and Adolescent Health (MCRAH)	SD		99%	96%	97%	28%	71%	78%
Improved Financial Management (IFM)	SS		52%	90%	87%	84%	81%	79%
Communicable Diseases Control (CDC)	SD		87%	96%	97%	33%	91%	81%
Clinical Contraception Services Delivery (CCSD)	SD		84%	88%	82%	90%	62%	81%
Information, Education and Communication (IEC)	SD		72%	98%	90%	71%	81%	82%
National Eye Care (NEC)	SD		80%	90%	95%	62%	90%	83%
Alternate Medical Care (AMC)	SD		89%	90%	83%	93%	75%	86%
Planning, Monitoring and Evaluation (PME)	GS		93%	93%	98%	91%	71%	89%
Health Education and Promotion (HEP)	SD		97%	96%	94%	100%	60%	89%
Procurement, Storage and Supplies Management (PSSM)	SS		84%	94%	140%	99%	73%	98%
Physical Facilities Development (PFD)	SS		97%	99%	92%	100%	106%	99%
Pre-Service Education (PSE)	SS		100%	105%	114%	99%	100%	104%
Hospital Services Management (HSM)	SD		98%	122%	106%	100%	104%	106%
Procurement, Logistics and Supplies Management (PLSM)	SS		89%	96%	99%	123%	125%	106%
Health Information Systems and E-Health	SS		96%	98%	56%	99%	678%	206%

Note: SD = Service Delivery; SS = System Strengthening; and GS = Governance and Stewardship.

87. **Inadequate PFM capacity at the local level is an issue.** The PFM skills of local-level officers, want of sufficient manpower, knowledge deficiency, and lack of effective on-the-job training contribute to the low efficiency in budget execution. For example, in FY2015–16, the ESD OP utilized only 37 percent of the recurrent and 19 percent of the capital budget allocation; the Clinical Contraception Services Delivery (CCSD) OP utilized 68 percent of the recurrent and 20 percent of the capital budget; and the Training, Research, and Development (TRD) OP spent 38 percent of the recurrent and 4 percent of the capital budget.[21] The situation of underspending in certain health care service line items of ESD OP and family planning line items, for example, Family Planning Field Service Delivery (FPFSD) and CCSD OPs, could have been avoided by arranging Flexible Cash at Facilities at a cost center.

88. **The frequent transfer of the main players of budget execution is another underlying reason that affects fund utilization efficiency of the directorate/OP.** Continuity in the Director/LD position makes budget preparation and execution easier. If a new Director/LD joins just before budget preparation, it makes the situation worse. On examination, it is revealed that five changes took place since December 2014 in the post of Director, Finance, of the DGHS. It is also revealed that changes occurred in the positions of the LDs. The LD of a large OP changed twice in a week after the sitting LD retired. Another Director position changed eight times during four years. This means the unit gets two new Directors every year, on average. By the time the Director becomes familiar with her/his responsibilities as a Director she/he is transferred. This also creates problems for other officials within that unit responsible for apprising the new Director. They need to repeat the same procedure twice or more in a year leaving less time for their own work.

[21] *Source:* CAO MOHFW Account available through iBAS.

3.2 Decentralization of budget: District budget - an unsuccessful pilot

89. **Budget distribution and expenditure are overly centralized under the two directorates of the MOHFW.** Delegation of Financial Authority of the government officers and other embargos often preclude officers at different levels of budget execution from using the budget placed under their disposal. For example, utility services like electricity charges or recurring expenditure like repair of ambulance beyond a limit has to be endorsed by the FD for incurring expenditures. This often obstructs/delays timely performance of the function vested on them.

90. **The district budget was initiated in FY2013–14 as a pilot program, and Tangail was selected as the intervention district.** However, it was 'not a district budget per se' (Budget speech, 2013–14),[22] rather an accounting exercise of allocations from both the development and nondevelopment budgets for the field offices of various ministries located in Tangail. It was a central-level exercise, and the district-level administration was not involved (Khan and Sabbih 2015). However, capacity constraints both at the district level and at the central level barred the full implementation of the district budget. There was lack of manpower and adequate financial authority delegated to the district officers, for example, CS, DDFP, and Hospital Superintendent, to implement the district budget. The preparation for developing a monitoring system and the distribution of budget and accounts-related functions between head offices and district offices was also not complete.

91. **Budget decentralization will not be fruitful without changes in the PFM modalities.** The PFM modalities include the expansion of the delegation of financial authority, strengthening the capacity of district authorities (district council/*Zila Parishad*), activating district-wise budget distribution, and accounting- and operation-level budget classification network. The issues of integration of the nondevelopment and development budgets and budget classification systems incorporating district budget operational codes mentioned in the concept paper 'Unified Budget and District Budget'[23] are still persisting. It necessitates certain local-level planning and budgeting or assessment of local requirements. Local-level planning and budgeting are not practicable under the present circumstances as the nondevelopment budget is allocated to institutions/facilities while the development budget is allocated to OPs and projects. Planning officers of the ministry start the planning process with specific knowledge of the expected fund, its source, and its need in different project/OP areas. Prior knowledge of the availability of resources at the local level and the amount expected from the center is essential for the preparation of local-level plans. At present, the district-level offices of the MOHFW lack this knowledge. Therefore, the enhancement of the capacity of the district health and family planning offices is necessary before the implementation of planning and budgeting at the local level.

3.3 PFM and Human Resources

92. **Staff in health care facilities are essential to enable the delivery of efficient and effective health services and to achieve patient satisfaction.** In many countries, the health workforce represents the single largest item in health budgets. In FY16, the total salary and allowances constituted 41 percent of the MOHFW total budget.[24] Availability, retention, and performance of health care providers in rural and neglected areas are important HR management functions. Sound HR management plays a key role in health services coverage. In Bangladesh, public health care providers are salaried staff. Challenges include recruitment, capacity, performance, poor retention in rural areas, absenteeism, and limits to accountability. It is not possible to allocate staff hired on the development budget to the nondevelopment budget. The Ministry of Public Administration with concurrence from the MOF can transfer posts from the development to nondevelopment functions

[22] https://www.mof.gov.bd/en/budget/13_14/budget_speech/speech_en.pdf.
[23] FD, MOF.
[24] MOF.

and then the people in those positions can be regularized. Recruitment, capacity development, and incentives for performance and retention need budget approval and policy support in place.

93. **The approval of the budget by the MOF is a key requirement to recruit additional health staff.** The Ministry of Health and MOF need to jointly identify and allocate additional financial resources to recruit additional health staff/new cadres for providing essential care. The recruitment process involves the approval of the required budget from the MOF. These processes take time, and the delay in the recruitment processes eventually affects the delivery of health care. Resources generated by the Community Support Group provide opportunities to recruit security guards and cleaners. As mentioned earlier in this report, there should be a guideline to use funds of CSC to recruit additional staff.

94. **Effective training courses and workshops are required for building capacity and skills of staff.** This may affect the overall production of services. Insufficient capacity can harm service delivery. Local trainings predominantly are 1–2 days long, which raises concerns on the quality and content of these trainings (PMMU 2015). A number of issues need to be addressed for making the training effective, which include among others training not being need based, lack of basic and refresher training for all clinical and technical staff, participants being selected on the basis of a personal connection or political considerations overlooking eligibility, some staff receiving multiple training while others not receiving any, and inadequate length of training (TIB 2014).

95. **Sufficient resources are not always available to conduct training courses and workshops.** Trainings are mostly dependent on the development budget, but some are also conducted using the nondevelopment budget. Around 17 percent of positions at the health facilities under the DGHS are vacant (GOB 2016). Reappropriation of the salary budget defined for vacant positions can create an avenue to receive additional financial resources for continuous professional development. Moreover, coordination between trainings financed by the two budgets is required for increasing effectiveness.

96. **Appropriately designed financial incentives and performance-based management might increase motivation and improve retention in rural areas and commitment of health care workers.** Linking payment to performance is an option. The PFM rules make it difficult to introduce financial incentive and performance-based management for health workers. An incentive is something given to an employee to motivate her/him to work for an organization and improve her/his performance as well as performance of the organization. This does not match with the service conditions of a permanent government servant who works for the government in exchange of a fixed remuneration and promotion prospect to attain an objective set by the government. There is no provision in the government financial rules and regulations for the payment of incentives to a permanent government employee to motivate her/him to work. This is also applicable for rural postings. As a part of their service conditions, the government servants are obliged to perform any work assigned to them.

97. **To add an incentive as a part of a regular payment and to give it a permanent structure, special rules should be framed and added to the Bangladesh Service Rules and the General Financial Rules (GFRs) defining incentives and determining rates.** The MOHFW can discuss this with the FD supported by plausible arguments and examples for the consideration of the proposal. The alternative of this proposal could be extending the definition of payment of honorarium to government servants for special or arduous types of work in connection with a development project. It helps to cover the payment of incentives and allows Secretaries of the line ministries/divisions to pay incentives up to an accepted limit. At present, this payment of honorarium to government staff is an item to be referred to the FD for approval.[25]

[25] Government Order No-ama/obi/u:go:sha/3/94/360 dated: June 2, 1994 - List of items to be referred to the FD.

98. **Private providers can provide public health services.** Public health facilities in Bangladesh need additional health workers to meet the demand for health care. In Bangladesh, private health care providers are increasingly acknowledged as a well-resourced provider of health care services. The motivation of collaboration with the private sector is to contribute services to supplement public sector services. Contracting arrangements with the private providers are currently advocated to make publicly funded services more accountable, transparent, and efficient. However, empirical evidence is limited to claim it. The PFM rules need flexibility to engage private providers in public facilities. The infrastructure of public health facilities in many locations of Bangladesh will be able to accommodate private providers. The PFM issues and implications have been discussed along with arranging private diagnostic services at public health facilities.

3.4 Availability of drugs and medical supplies - critical for service delivery

99. **Like HR, availability of sufficient drugs and medical supplies is affecting health service delivery.** Health care providers frequently face shortage of supply of drugs. Financial resources and procurement processes affect the availability of drugs and medical supplies. Health facilities receive insufficient funds on time, which leads to shortage of drugs and medical supplies. Weak procurement processes, delay in receiving drugs, and increase in the prices of drugs and medical supplies added to the problem of insufficiency of funds aggravate the situation.

100. **Facilities receive the MSR allocation (financed from the nondevelopment budget) from multiple sources.** The DHs and UzHCs receive the MSR budget from both the MOHFW and DGHS. In FY2016–17, the MOHFW allocated the budget to the DHs and UzHCs according to bed occupancy ratios. The DGHS allocated the MSR budget to the UzHC according to annual admissions and OPD visits and to the DH according to annual patient days and OPD visits.

101. **The MOHFW budget for the MSR allows the DH and UzHCs to purchase drugs locally.** Drugs is one of the components of the MSR. From the MOHFW budget, 35 percent of the total allocation for the DH and UzHC is mandated for purchasing medicine locally. Procurement of local drugs does not include drugs from Essential Drug Company Limited (EDCL). EDCL is a public drug company. The MSR budget allocation for the DHs and UzHCs goes to the CS Offices, but where the Superintendent is posted, the MSR budget allocation directly goes to the DH. The MOHFW and DGHS have guidelines for procuring the MSR. The UHFPO with the help of the RMO (UzHC), accountant, and storekeeper makes a requisition for the MSR and submits it to the CS Office before the beginning of the financial year. Respective departments (medicine/surgery/gynecology-obstetrics) of the DHs make a consolidated list of requisitions. There is a Selection and Specification Committee for the MSR in the CS Office/DH. The committee identifies and decides the amount of the MSR items according to the annual budget allocation. According to Table 12, the DHs and UzHCs purchase drugs directly from the EDCL, and it does not require initiating any procurement processes. These facilities also use the MSR budget allocation from the DGHS to purchase drugs through the CMSD. The DHs and UzHCs use 5 percent of the nondiscretionary budget for emergency purpose, along with other components of the MSR (gauze/bandage, linen, and gas/oxygen).

Table 12: MOHFW and DGHS budget allocation for drugs by district and *upazila*

Source	District	*Upazila*
The MOHFW budget for the MSR for local tender	35% of the total MSR budget of the MOHFW allocated to the district	35% of the total MSR budget of the MOHFW allocated to the *upazila*
The DGHS budget for the MSR	70% of the total MSR budget of the DGHS. Procurement guideline allows following distribution of 70% MSR budget	75% of the total MSR budget of the DGHS.

Source	District	*Upazila*
		Procurement guideline allows following distribution of 75% MSR budget
	75% EDCL	75% EDCL
	20% CMSD	20% CMSD
	5% local tender	5% local tender

102. **The DGHS sends budget allocation letters to the CMSD around November/December of each financial year.** In Bangladesh, the financial year starts on July 1 and ends on June 30. The budget allocation letters indicate the budget allocation for each district to purchase drugs from the CMSD. Around March/April of the next calendar year, the CMSD receives information on drug requirements from offices of the CS of all districts. Every year, the CS prepares these requisitions based on the needs of the DHs and UzHCs of her/his district. The CMSD has a list of enlisted drug suppliers and completes all procurement processes from these suppliers by May/June. The CMSD is capable of completing all drugs procurement processes by October/November of the financial year if its office receives the budget allocation letters from the DGHS and drug requirements letters from the CS Offices by September. The DGHS and CS Offices should send the letters to accelerate the procurement processes of the CMSD, and this would help ensure the availability of the CMSD-purchased drugs at the DHs and UzHCs on time.

103. **The tendering process at the district level can be open or limited following the Public Procurement Act (PPA) 2006 and Public Procurement Rule (PPR) 2008.** After the selection of the contractor, the procuring entity (CS/Superintendent) requires the administrative approval from the DGHS within December of each year. The contractor supplies the MSR items to the CS/Superintendent Office upon obtaining the approval from the DGHS office. There is a survey committee in each district. The survey committee checks the supplied MSR items whether these MSR items have been supplied according to the specification and sample that was approved and accepted by the specification committee. After certification given by the survey committee, the MSR are kept in a District Reserve Store (DRS)—a store room (inside the CS Office). Then, the CS/Superintendent sends all documents to the DGHS and MOHFW for expenditure approval by March 31. After obtaining the expenditure approval, payments are given to the contractor following the completion of all financial procedures and the CS releases the MSR to each of the health facilities under the respective district, according to the indent/request submitted by the UzHCs (for the UzHC and union subcenter together).

104. **In case of the DGFP, the source of fund for drug procurement is the operational budget.** The revenue budget has a small allocation to purchase medical supplies such as cotton, bandage, and catgut. The Director of Procurement, DGFP, is responsible for procuring all drug items at the DGFP level. There are no procurements of drugs at the district and *upazila* levels for the DGFP facilities. PPA 2006, PPR 2008, and open tendering processes are followed in purchasing drugs at the DGFP level in each year on receipt of the operational budget. Procured drugs are first stored in the Central Warehouse in Dhaka, and from there, drugs are distributed to regional Warehouses, MCWCs, *Sadar* Clinics, and MCH Units of UzHCs. The Union Health and Family Welfare Centers (UHFWCs) receive drugs from the regional Warehouses.

105. **Delay in the procurement of drugs also happens due to the delay in the release of the revenue budget from the MOHFW and DGHS.** CSs and the CMSD start the tendering process after receiving the fund from the MOHFW and DGHS. The time requirement for procuring drugs according to the above descriptions takes on average nine months, though in practice, it takes 15 to 18 months for the drugs to reach the UzHCs and below. The same cycle repeats in each financial year for following these procedures. These limitations could be overcome by putting in place a framework contract of three-year duration.

106. **A three-year framework contract for drug procurement has the potential to ensure regular and sufficient availability of drugs in the public facility on time.** This would also help avoid procurement hazards and going through the bidding process every year. The framework would reduce the price of medicine by ensuring the lowest competitive price and would encourage drug manufacturing companies, especially well-reputed pharmaceutical companies, to participate in the bidding process directly. Patients' demand for branded drugs will be expanded if many top brand companies participate in the bidding process.

107. **There is no framework contract for drug procurement.** Section 36 and Subsections 36(1), 36(2), and 36(3) of PPA 2006 and Rule 89 and Subrules 89(1), 89(2), 89(3), and 89(4) of PPR 2008 (Ministry of Law, Justice, and Parliamentary Affairs, September 2013) permit having a framework contract for procuring drugs by the CMSD (DGHS), DGFP, and CS at the district level.

108. **Resources are sometimes used inefficiently.** For example, the UHFWCs repeatedly receive more catgut, lignocaine, and snake venom than is actually needed. Wastage or leakage can occur when medical supplies are not in use. The inadequate mix of medical supplies likely hampers the quantity and quality of medical services. Appropriate planning and projection could help health care providers get the correct quantity of drugs, medical supplies, diet, and stationaries.

3.5 Flexible operational fund at facilities for timely repair and maintenance

109. **The operational fund is essential for the efficient functionality and provision of health services.** Health facilities need funds to cover operational costs such as transport cost for emergency purposes, replacement of minor electrical appliances, repair of water leakage, and ordering of an official seal. Availability of these funds on time strengthens service coverage and results in better quality of care. Health facility managers/health service providers face barriers to maintain or improve health service delivery performance due to the shortage of operational funds. User fee retention or flexible cash arrangements at the health facilities can help health center managers/health care providers improve functionality and provision of health services at the right time. DHs and subdistrict hospitals have bank accounts. User fees and flexible cash could be deposited in these accounts.

110. **Health facilities at the district level do not have funds for repair and maintenance of buildings, equipment, and ambulances at the right time.** Old facilities need constant maintenance. Maintenance gaps can adversely affect the quality of care services. This happens due to low allocation and lack of required funds on time. It was found that sometimes responsible officials are not aware of processes and do not initiate processes for receiving funds in time. The capacity and responsiveness of the contracted agency responsible for repair and maintenance are also an issue. Increased allocation of resources for repair and maintenance should be available at health facilities. Health managers/providers need enhanced delegation of authority to expend money for repair and maintenance. Like operational funds, flexible cash arrangements or user fee retention at health facilities can supplement the budget allocation for repair and maintenance. As mentioned earlier (section 2.2.3), the estimated user fees collected in 2014–15 represented 59 percent of the repair and maintenance expenditure.

111. **Performance of public-run facilities could be improved by granting them more financial autonomy and flexible cash management at the primary, secondary, and tertiary levels.** The DH and UzHCs should receive flexible cash each financial year. It is consistent with a common global trend toward flexible cash management by facilities. Such a measure may require supporting reforms to the PFM framework. Again, it would require broader support from outside the MOHFW. It would represent a shift away from the highly centralized budget process that has prevailed until now.

112. **Introducing 'Flexible Cash at Facilities' will require the insertion of a relevant clause in the GFRs.** Alternatively, this may be done by establishing an autonomous NHSO. 'Flexible Cash at Facilities' can be alternatively arranged if a permanent advance of BDT 200,000 and BDT 100,000, respectively, or a certain percentage of the facility budget is allocated to the DH and UzHC by the DGHS with the approval of the FD. Economic classification code '8501 - DDO's Advance', commonly known as 'imprest', is in use in other areas of the MOHFW; therefore, creation of a new code will not be necessary. Only the health facility managers need to submit documents to account officers as proof of fund use. However, for spending amounts more than BDT 100,000, the department would need authorization from the FD, MOF.[26]

3.6 Engaging the private sector at DHs and UzHCs for diagnostic services

113. **Public facilities at the *upazila* and district levels do not have the required diagnostic services.** In Bangladesh, the private sector is providing a large share of diagnostic services at different levels of the health system. Private services can be made available at public facilities to address this imbalance and equity gap. Public funds could be used to purchase private services for public facilities and to bring private providers into public health coverage.

114. **Contracting out certain health services by superintendents of DHs and district CSs under the existing procurement rule is possible.** This would provide an important avenue for setting flexible rules and improving efficiency, equity, and access. For engaging the private sector at the DHs and UzHCs, the government could allow superintendents of the DHs and the district CS to contract out these services within the framework of the PPR by issuing a circular. However, this would need budget allocation from both the nondevelopment and development budgets. At present, the CS and superintendents of hospitals are allowed to incur revenue expenditure only as the development budget (RPA) is centrally administered by the OP LDs. This may also require relaxation of Delegation of Financial Power to enable superintendents of DHs and district CSs to exercise financial power within the framework of GFRs with the necessary budget support. The government may decide to allow DHs and CSs to invite tenders within the threshold of request for quotation according to Rule 16 of PPR 2008 to hasten the process and avoid risk. Since it would be exercised under the PPR, GFRs, and Delegation of Financial Authority, no PFM issue would arise.

4. Budget reporting for monitoring and accountability

4.1 Fragmented reporting, weak monitoring, and accountability

115. **The two budgets (development and nondevelopment) require separate reporting systems.** Drawing and disbursement officers at health facilities and district offices who execute budgets are required to report expenditures separately to different offices. For example, a facility under the DGHS sends the nondevelopment expenditure report to the Finance unit of the DGHS while sending the development expenditure report to the relevant LD who allocated funds to that facility.

116. **The accounting system does not track resources provided to frontline delivery units such as primary health care facilities below the *upazila* level.** Expenditure is reported against the respective budget heads[27] of the MOHFW. For example, the budget for union-level health and family planning facilities below the *upazila* is included in the budget for the Upazila Health Offices, Upazila Family Planning Offices, and UzHCs. Therefore, the government accounting system captures the expenditure

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[26] *Source:* Delegation of Financial Powers, Development Projects, GOB, dated August 16, 2015 Sl.4 Imprest Approval.

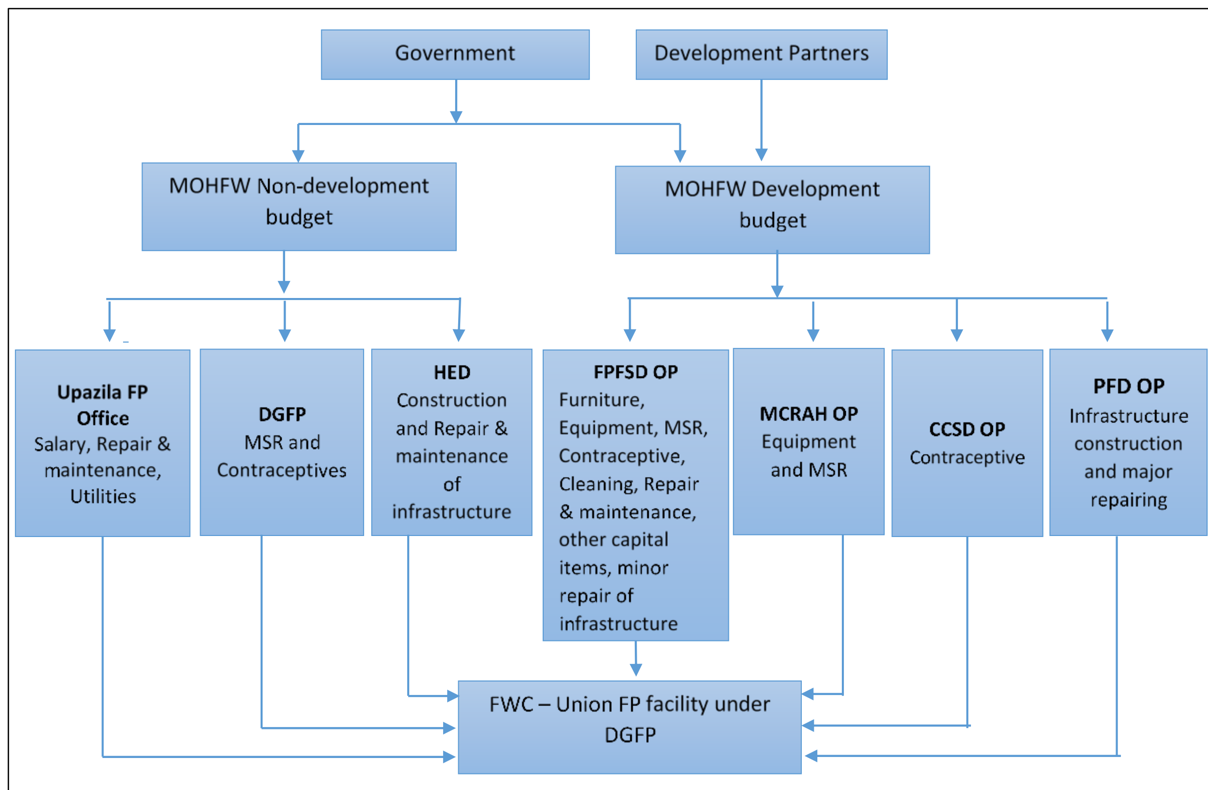
[27] Entities (function code or operation code in the accounting system) against which budget is allocated.

incurred by the *upazila*-level entities, not by union-level facilities. This has implications for transparency and accountability.

117. **There is no system to provide information on resources received by health facilities below the *upazila* level.** *Upazila*-level entities send a consolidated financial report to the higher level, that is, district/central (directorate) level. Therefore, the district level or central level does not know how much of the whole budgeted amount reached the union-level facilities. This leads to weak monitoring and poor accountability.

118. **A separate disbursement method is also an obstacle to monitoring individual line item expenditures from a single platform.** The nondevelopment budget is entity-wise and is distributed to different units of the MOHFW, including the district and *upazila* units. On the other hand, the development budget is OP-wise or project-wise and disbursed from the center directly to the facilities at the different levels, for example, the MCWC or UzHC without touching the ledger account of the district- or *upazila*-level health and family planning offices. The nondevelopment expenditure of the UzHC is directly incurred by the UHFPO. Although the MSR budget is placed at the disposal of the UHFPO, the procurement is made by the CS. The UHFPO may not have the full details of the MSR expenditure if the information on expenditure is not passed on to the UHFPO in time. The DDFP in the district is responsible only for expenditures of her/his own office. The UFPO in the *upazila* receives the fund directly from the center. The LDs of the DGFP send the MSR materials and cost of family planning operations and related expenditure directly to the cost centers (for example, *upazila* family planning office and MCWC). The LD/PD, therefore, has to encounter the problem of integrating expenditure report from all units during budget formulation and preparation of the consolidated SOE required for making the fund release request, which often gets delayed.

Figure 11: Flow of resources to the UHFWC facility under the DGFP



Note: Other capital items include tube wells and installation of electricity and solar panels.

119. **Tracking of the development budget allocated to different tiers of facilities under the DGHS and DGFP is not possible.** The OPs show how much is allocated to different activities but generally do not show how much is allocated to specific type of facilities to implement certain OP activities unless specific activities are directly related to a specific type of facility. For example, one OP shows training on a certain topic for doctors from district and *upazila* facilities without disaggregation. The same OP shows the budget for the MSR procurement but does not mention the MSR by the tiers of facilities. As a result, managers of facilities are not aware of the amount allocated from different OPs to their respective facilities. The OPs should show how much is allocated at least to each type of facility, if not to each facility. This will help improve transparency and accountability in budgeting.

120. **How much nondevelopment budget is allocated to facilities at different tiers under the DGFP is difficult to track.** For example, the budget for 'Hospitals and Dispensaries'[28] includes the budget for a large central-level maternity hospital, MCWC, MCH Units[29] at the *upazila* level, and Family Welfare Visitors (FWVs) training institutions. Similarly, the budget for the union-level facilities under the DGFP is included in the budget for the UFPO. To make tracking possible, all these different tiers of facilities should have at least operation codes if it is not possible to assign separate function codes. This is necessary for improving transparency and accountability in budgeting.

121. **Tracking of spending of 'Unallocated block allocation'- a subcategory under the line item of 'Block allocation' is not possible.** It is not possible to track unallocated block allocation spent on various activities, reflecting lack of transparency and accountability. This allocation is almost entirely financed from the development budget (less than 1 percent financed from the nondevelopment budget). In FY2015, the MOHFW spent BDT 4,950 million representing 6 percent of the MOHFW recurrent expenditure.[30]

122. **How much resources from the nondevelopment budget are spent to implement the sector program is not readily available as it cannot be tracked.** The PIP of the sector program shows the total nondevelopment budget at the aggregate level, but at the implementation level, the OP budget excludes the nondevelopment budget. Therefore, reporting of the OP implementation focuses only on the development budget. Monitoring of the OP implementation covers the development budget execution only.

4.2 Strengthening of Auditing

123. **Two separate audit directorates are responsible for the external audit of the financial activities financed from the two budgets.** Two directorates under the Comptroller and Auditor General (C&AG) of Bangladesh, namely, the Local and Revenue Audit Directorate and the FAPAD, are responsible for conducting the external audit of the nondevelopment- and development-related financial activities, respectively, of the departments/programs under the MOHFW.

124. **In addition, the OP Improved Financial Management (IFM) under the 3rd SWAp was responsible for improving the FM and audit system of OPs.** IFM is continuing under the 4th SWAp as an OP with a total allocation of BDT 282.8 million, aiming to improve the FM and audit handling capacity of the OPs. The FMAU is responsible for the overall coordination of FM and internal and external audit of all programs/projects under the MOHFW.

125. **Audit observations often lack quality.** Audit observations, in many cases, are not detailed enough to help take conclusive decisions based on them. This may be a result of a lack of qualified

[28] Currently, all these facilities belong to the function code 7489 (old code 2789) under only one operation code.
[29] This unit is under the DGFP but operates within the UzHC, which is under the DGHS.
[30] *Source:* Controller General of Accounts (CGA) data.

auditors and also absence of the scope of professional training for the auditors. There are also allegations of rent-seeking behavior of the auditors leading to inconclusive audit observations.

126. **Timeliness of audit resolution is an issue.** There are persistent delays in respect of audit resolution, which can be attributed to the negligence on the part of both the auditor and the auditee. The fewer number of auditors, overloaded with the task of resolving numerous observations, may be one of the reasons for the delays. At the same time, there are also delays caused by the auditee in responding to audit observations. Specially, in cases where the concerned staff are retired or transferred to a different position and location, there is no one else to respond to the audit observations.

127. **Delay in audit resolutions has serious consequences.** In some cases, this results in the suspension of the fund disbursement by the DPs affecting fund release by the GOB, delayed or no procurement of certain items, slow progress, or sometimes even abandonment of some planned activities. Review of the Annual Program Implementation Report 2015 and independent review of response to the audit by the LDs of respective OPs revealed that the status of audit resolution is still far from satisfactory in terms of meeting deadlines and quality.

5. Strengthening the capacity for PFM

128. **The lack of adequate manpower skilled in planning and budgeting is a common and persistent problem from the central level to service delivery level.** Interviews with officials at different levels revealed that due to the lack of skilled manpower, planning and budgeting is often done by the staff from the accounting or administrative unit with little or no knowledge about policy objectives and programs. Health workers at the facility level are burdened by the PFM reporting requirements. On the other hand, those who are aware of the policy objectives and programs often lack skills in planning and budgeting. As a consequence, plans at the operational level often become a wish list and the budget fails to follow plan. These result in a delay of initiating the processes and completing the requirements of PFM.

129. **A majority of the Program Managers and LDs working in the health sector are medical doctors, and they are not familiar with the PFM functions.** Managers and implementers of health projects/programs working at different levels of the health system need training on PFM in the health sector. While designing such training, it should be kept in mind that the same concepts might be understood differently by health experts and PFM experts. For example, service delivery as understood by PFM experts is the fund flow from the central to service delivery points. On the other hand, from the health sector perspective, service delivery means providing health services from service delivery points.[31] Adequate measures (for example, a handbook of glossary of PFM terms and health financing terms) should be taken to improve PFM literacy among public health professionals and also to remove the language barrier between PFM and health experts.

130. **The lack of effective on-the-job training is an important issue.** Interviews with relevant officials revealed that most of the officials had not received necessary training when they were given the responsibilities particularly in planning and budgeting and FM. This is also true for other staff.

131. **The PFM capacity strengthening activities for middle and senior managers in the health sector should aim at creating awareness and understanding of the PFM concepts, rules, and regulations and their implications.** These would help to develop an understanding of the basic concepts and principles necessary for sound PFM, comply with the requirements of the PFM rules and regulations, apply the performance requirements for FM, and apply the principles of effective reporting.

132. **The lack of necessary and relevant manuals makes the situation worse.** Budgeting needs proper understanding of what type of expenditure will be coded under which economic code classification. Often, line items are wrongly coded. For example, facilities do not use uniform coding for depositing the revenue collected from the different types of hospital services.[32] This is due to the lack of a detailed manual with adequate and appropriate examples and lack of adequate training.

133. **The modernization of PFM systems and defining the functional requirements and technology architecture for the implementation of PFM solutions should be based on best practices.** A framework for reporting of the PFM activities would be useful. It was found that replacement officials or newly appointed officials face challenges to find processes-oriented documents/reports. The proposed framework would be useful for institutional development and to carry out the PFM functions by the newly appointed officials. A coherent and consistent set of principles, rules, and

[31] Authors' discussions with PFM experts and health service providers.

[32] Some facilities deposit collected outdoor ticket and admission fees under Code 2024 ('User fees') while some facilities use Code 2023 ('Health and family planning services'); for depositing the collected surgery fees, some use Code 2024 ('User fees') while others use Code 2112 ('Hospital receipts').

instructions should be available to guide officials in the delivery of their PFM-related duties and responsibilities efficiently and effectively.

134. **The integration of the departmental system of the DGHS, DGFP, and HEU of the MOHFW with iBAS for the smooth operation of the departmental Financial Management Information System (FMIS) is needed.** This would facilitate real-time transfer of budget endorsement, fund release, and accounting information from the FD and CAO Health Office to the DGHS and DGFP and subsequently to the PDs and LDs.

135. **Many officials, mostly medical professionals, not familiarized with public financial rules and regulations are hesitant to act for fear of facing an audit.** An individual officer facing unresolved audit observations encounters many ordeals. The retiring or retired person's final payment including payment of pension is deferred till audit observations are settled.

Box 1. PFM and quality of health care

A range of PFM factors and non-PFM factors (behavior and attitude of providers) affect the quality of health care. Health care providers need adequate resources and mix of inputs on time to ensure quality of care. Providers face difficulties to reallocate funds according to their actual needs. Absence of quality elements such as timeliness of services can discourage patients from seeking health care services from health facilities. Factors likely to affect quality of care include late release of funds and delays in procurement processes. Budget flexibility between line items could allow providers to spend the allocated budget efficiently.

Financial and nonfinancial incentives motivate and encourage health care providers to perform well and improve their outcome. Poor career prospects and working locations and conditions are likely to discourage health care providers to provide quality of care. The assumption is that financial incentives will improve, motivate, and enhance providers to pursue aggressively and ultimately achieve the quality performance targets. The MOHFW budget is input based and not output based. An input-based budget does not encourage providers to perform better. As described earlier, the PFM rules in Bangladesh do not allow providers to receive financial incentives on a regular basis.

Allocating and channeling resources to health facilities at the district level and below helps promote quality in health service delivery and health financing. Insufficient non-salary funds at the health centers depicts poor access to health services coupled with low quality of services. Channeling funds to facilities could improve quality of care in a number of ways: better drug supply, improved staff morale, better equipped facilities, and improved maintenance.

6. Recommendations

136. **This section presents the identified PFM diagnostic issues from the analysis of quantitative and qualitative data collected by this study.** Attempts were made to 'diagnose' PFM barriers and concerns to facilitate the implementation of the Bangladesh HCFS 2012–2032 and strengthen health service delivery in Bangladesh. The issues were categorized under key PFM areas of the HCFS 2012–2032 and health service delivery. Short- (within one year), medium- (within one to three years), and long-term (more than three years) recommendations were made to address the PFM issues identified. Removing these barriers does not require many resources; rather, the understanding of these barriers and an administrative will are required. The findings and recommendations will facilitate rethinking to remove the PFM barriers. The GOB and DPs should jointly commit to addressing the barriers in order to accelerate the implementation of the HCFS 2012–2032 and improve health service delivery.

Recommendations: Policy level

Key areas	Identified PFM diagnostic issues	Recommendations	Term	Responsibility
Fund release process	Requirement of submission of SOE for the release of the third and the fourth quarters of the RPA significantly delays fund release.	Delink the fund release process from the submission of SOE.	Short	MOF
Sector program	Existence of parallel projects outside the SWAp contradicts the main spirit of the SWAp.	Consider limiting the number of parallel projects outside the SWAp.	Medium	MOHFW policy makers
Sector program	Large number of OPs leads to lack of coordination in planning and budgeting and also hinders effective monitoring.	Reduce the number of OPs in the next (5th) sector program.	Medium	MOHFW policy makers
Retention of user fees at secondary- and tertiary-level facilities	Public health facilities (50-bed hospitals at the primary level and all secondary- and tertiary-level health facilities) are collecting user fees and returning these fees to the government treasury according to the policy.	I. The MOHFW to negotiate with the MOF to have a law to retain user fees at the health facilities. II. Draft and place it for enactment after necessary vetting. III. Prepare guidelines for using the retained user fees once the law is enacted.	Medium to long term	MOHFW and FD, MOF
SSK	A health insurance scheme like the SSK cannot operate without a legal framework including financial rules and regulations.	Develop a legal framework including financial rules and regulations and approval by FD, MOF.	Medium	MOHFW and MOF
Need-based RAF	Initially according to plan, the nondevelopment budget will be used for applying the RAF and processes of spending the nondevelopment budget	I. Extend subdelegation of financial power to district managers. II. Send a proposal with details of such subdelegation to the FD, MOF, for approval.	Short	FM and Budget Wing, MOHFW, and MOF

Key areas	Identified PFM diagnostic issues	Recommendations	Term	Responsibility
	for this purpose may take time and hinders application.			
MHVS	The long delay in flow of funds from national level to *upazila* level affects efficiency and effectiveness of program activities.	II.a. Initiate dialogue with the MOF to allow Imprest fund for the development budget Or alternatively II.b. Initiate dialogue with the MOF to finance the MHVS from the nondevelopment budget like other social protection programs. III. Finance the MHVS through the nondevelopment budget IV. Make arrangements of advance or 'Imprest Fund' to be used for timely payment of cash incentives and travel allowances to beneficiaries if financed from the nondevelopment budget.	Medium to long term	MOHFW and MOF
NHSO	Absence of policy directive from the government for establishing NHSO for social health protection scheme	I. Initiate policy discussions and initiate processes to complete prerequisites for establishing the NHSO. II. Draft the Act and place it at the Parliament. III. Establish fully functional NHSO.	Short (I), medium (II), and long (III)	HEU, MOHFW, and MOF
Availability of drugs and medical supplies at service delivery points	Delay in procurement of drugs and medical supplies is affecting health service delivery at district and *upazila* levels.	I. Organize consultation with CPTU. II. Introduce a three-year framework contract for drug procurement for three years.	Medium	CMSD, CPTU, and MOHFW
Engaging private sector in public service provision	Public facilities at *upazila* and district levels lack required diagnostic services.	I. Initiate dialogue with the DGHS and MOF. II. Organize stakeholder consultations with district-level managers. III. Design detailed implementation plan. IV. Implement on a pilot basis.	Medium (I and II) and long (III and IV)	Planning Wing, Budget Wing, MOHFW, CPTU, FD, and MOF
Flexible operational fund at facilities for timely repair and maintenance	Health facilities at the district level do not have funds for repair and maintenance of buildings, equipment, and ambulance at the right time.	I. Initiate dialogue with the MOF and relevant stakeholders within the MOHFW and DGHS. II. Make changes in financial rules. III. Introduce 'Flexible Cash at Facilities'.	Medium (I) and long (II and III)	HEU, Budget Wing, MOHFW, FD, and MOF

Note: CPTU = Central Procurement Technical Unit.

Recommendations: Operational level

Key areas	Identified PFM diagnostic issues	Recommendations	Term	Lead responsibility
Governance, monitoring, and accountability	Tracking of budget allocated to different tiers of facilities under the DGHS and DGFP is not possible, which has implications for transparency and accountability.	I. Assign operation codes to facilities below *upazila* level. II. Assign operation codes to different tiers of facilities under the DGFP. III. Assign function codes to different tiers of facilities under the DGFP.	Short (I and II) and medium (III)	Budget Wing, DGHS, DGFP, MOHFW, and MOF
	Tracking of development budget allocated to different tiers of facilities under the DGHS and DGFP is not possible.	Relevant OPs show budget allocation provided to specific tier(s) of health facilities in the revised OP after Midterm Review.	Medium	Planning Wing, MOHFW
	Financing of recurrent and capital line items from both budgets might lead to duplication, pilferage, and wastage of resources	Finance the MSR and diet for the health facilities from the nondevelopment budget only.	Short to medium	Budget Wing, MOHFW
DRM: CSC fund	There is no guideline indicating possible sources of community funds including financial sustainability; fund management and utilization; managing of account, audit, and social audit; and mitigating conflicts of interest and concurrence of the MOF where required.	I. Develop a comprehensive guideline to implement community-supported activities at health facilities. II. Share with relevant stakeholders. III. Get concurrence from the MOF.	Short to medium	HEU, MOHFW, FD, and MOF
RAF: a proposed need-based budget allocation	Initially according to plan, the nondevelopment budget will be used for applying the RAF and processes of spending the nondevelopment budget for this purpose may take time and hinders application.	I. Include both the development and nondevelopment budgets. II. Make necessary changes in the delegation of financial authority. III. Start implementation with the development budget.	Medium	HEU, Budget and Planning Wings, MOHFW, FD, and MOF
SSK -a social health protection scheme	A health insurance scheme like the SSK cannot operate without an approved operational manual.	I. Develop a comprehensive operational manual of the SSK based on field experience and also consulting the stakeholders. II. Share with relevant stakeholders. III. Get approval of the MOHFW.	Short	HEU and MOHFW

Key areas	Identified PFM diagnostic issues	Recommendations	Term	Lead responsibility
Fund availability without delay	Delay in fund release is a major cause of underspending of the development budget and fund release processes are not understood well by the LDs and relevant officials.	I. Conduct effective training for the LDs and relevant officials on fund disbursement processes.	Short and medium	FMAU, DGHS, DGFP, and MOHFW
PFM capacity strengthening	Lack of adequate manpower skilled in planning and budgeting is a common and persistent problem from the central level to service delivery level.	I. Design appropriate training programs on planning and budgeting for each level. II. Develop comprehensive manuals on budgeting including coding with clear and adequate examples. III. Integrate FMIS with MIS.	Medium (I and II) and long (III)	Budget, FMAU, Planning Wing, DGHS, DGFP, and MOHFW
	Resources are sometimes used inefficiently.	I. Develop appropriate training programs for facility managers/providers to make realistic projections for quantity of drugs, medical supplies, diet, and stationaries.	Medium	HEU, Budget Wing, DGHS, DGFP, and MOHFW
Capacity building of service providers	Inadequate length of short training raises concerns for content and quality.	I. Reduce the number of 1–2-day training for professional development. II. Organize effective training programs with adequate duration and appropriate content with quality.	Medium	IST, NIPORT, Budget Wing, Planning Wing, and MOHFW
Audit	Noncompliance to audit observations have serious consequences.	Follow-up specific audit recommendations using internal control system.	Medium	FMAU and MOHFW

Note: IST = In-service training; MIS = Management information system; NIPORT = National Institute of Population Research and Training.

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Annex 1: OP budget and expenditure as a share of HPNSDP PIP and RPIP (FY2012–FY2016)

Name of the OP	ADP as % of		RADP as % of			OP expenditure as % of			
	PIP	RPIP	PIP	RPIP	ADP	PIP	RPIP	ADP	RADP
Alternate Medical Care (AMC)	73	79	105	113	143	88	94	119	83
Clinical Contraception Services Delivery (CCSD)	48	79	56	92	116	45	74	94	81
Communicable Diseases Control (CDC)	73	78	94	99	128	76	81	104	82
Community Based Health Care (CBHC)	59	89	61	92	103	41	62	69	68
Essential Services Delivery (ESD)	60	109	72	130	120	35	63	58	48
Family Planning Field Services Delivery (FPFSD)	58	87	63	94	108	47	71	81	75
Health Economics and Financing (HEF)	99	69	100	70	101	41	29	41	41
Health Education and Promotion (HEP)	57	74	76	99	134	66	86	116	86
Health Information Systems and E-Health (HIS-EH)	60	84	67	92	110	122	168	201	183
Hospital Services Management (HSM)	74	70	99	94	134	106	100	142	107
Human Resources Management (HRM)	37	153	28	116	76	12	51	34	44
Improved Financial Management (IFM)	106	184	57	99	54	46	80	44	81
Information, Education and Communication (IEC)	80	87	91	99	113	74	81	93	82
In-service Training (IST)	52	100	59	114	113	43	83	83	73
Management Information Systems (MISs)	78	89	95	108	122	60	69	77	63
Maternal, Child, Reproductive and Adolescent Health (MCRAH)	64	74	75	87	118	57	67	90	77
Maternal, Neonatal, Child and Adolescent Health (MNCAH)	70	67	95	91	136	66	63	94	69
National AIDS and STD Program (NASP)	56	79	63	89	113	42	60	76	67
National Eye Care (NEC)	91	91	92	92	102	76	76	83	82
National Nutrition Services (NNS)	29	96	30	98	102	13	44	46	45
Noncommunicable Diseases (NCDs)	63	95	71	107	113	55	83	87	78
Nursing Education and Services (NES)	73	64	94	83	129	65	57	89	69
Physical Facilities Development (PFD)	51	45	53	47	105	53	47	105	100
Planning, Monitoring, and Evaluation of Family Planning (PME-FP)	98	86	104	91	107	90	79	92	86
Planning, Monitoring, and Research (PMR-DGHS)	72	83	80	92	111	62	72	86	78
Preservice Education (PSE)	96	74	123	95	128	127	98	133	103
Procurement, Logistics and Supplies Management (PLSM-CMSD)	73	72	93	92	127	103	102	142	111
Procurement, Storage and Supplies Management (PSSM-FP)	70	83	81	95	115	74	87	105	92
Sector-wide Program Management and Monitoring (SWPMM)	24	18	28	21	118	17	13	73	62
Strengthening of Drug Administration and Management (SDAM)	107	57	125	66	117	68	36	64	55
TB and Leprosy Control (TB-LC)	78	68	124	108	158	69	60	88	56
Training, Research, and Development (TRD)	89	90	88	89	99	63	64	71	71