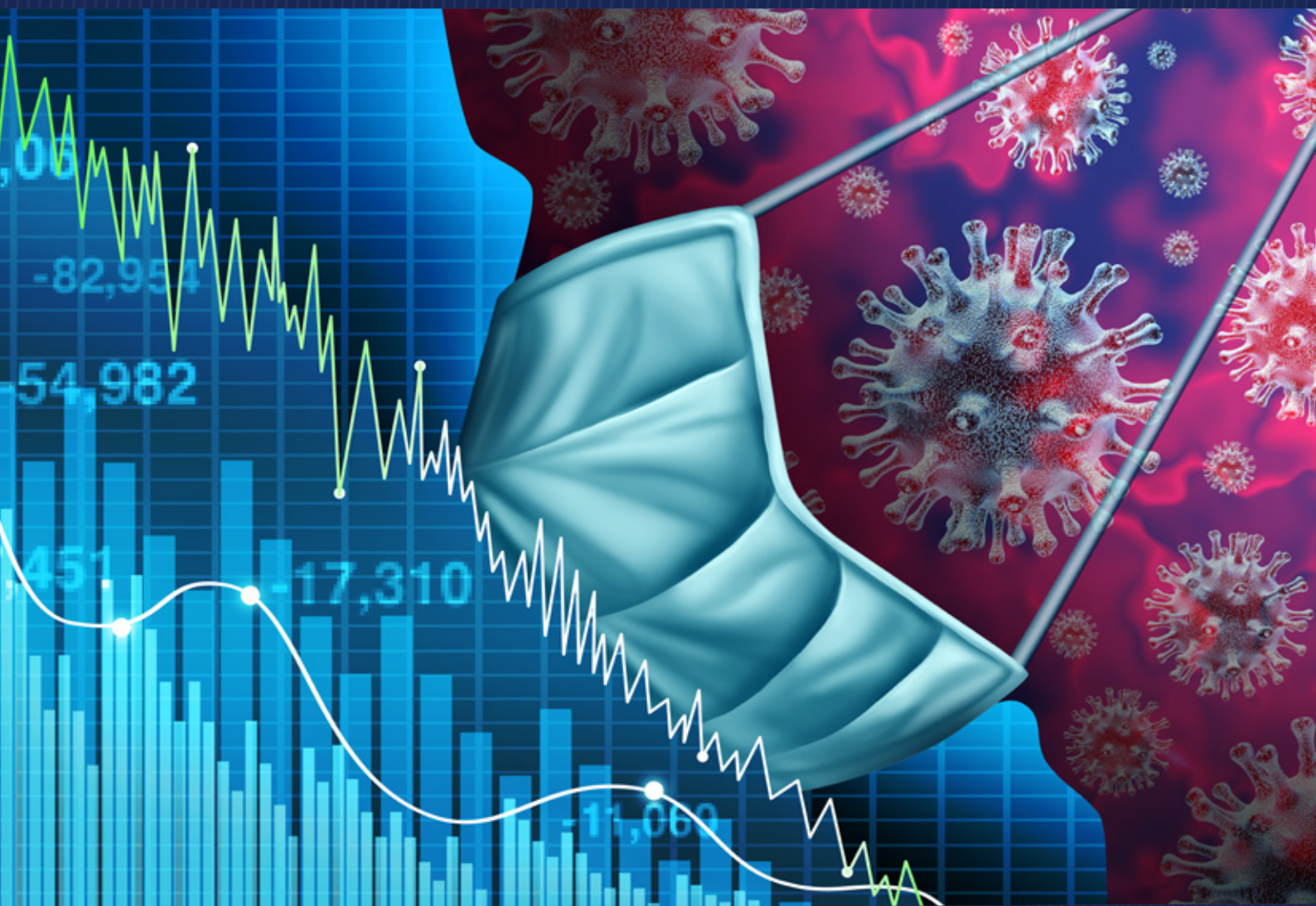


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# Public financial management for effective response to health emergencies

Key lessons from COVID-19 for balancing flexibility and accountability



World Health  
Organization



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Key lessons from COVID-19 for balancing flexibility  
and accountability

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# Key messages

- Public revenues are the cornerstone of funding for governments' response to health emergencies; as such, **public financial management (PFM)** – the rules and mechanisms governing the allocation, execution and reporting of public funds – has been **an integral part of the health response** to the COVID-19 pandemic.
- This rapid review highlights the importance of PFM for health emergencies, by analysing various countries' experiences of financing their national health response to COVID-19 and identifying some early lessons. This review can help countries to **enhance their understanding of good practices**, and key **requirements for adjustments to their PFM systems**.
- To be able to effectively adapt and quickly respond to health emergencies, PFM may need to be overhauled. Key PFM policy actions summarized in Table 1 include recommended **adjustments for each phase of the budget cycle (formulation, spending, and reporting), to ensure health financing is more agile**, flexible and responsive to emergency needs, while assuring transparency and accountability.
- One of the key PFM-related lessons emerging from the COVID-19 health response is **the need to shift from budgeting by line items to budgeting based on programmes**. Programme-based budgets are more readily structured to allow for more flexible allocations of public resources, and are thus more effective responses to health emergencies.
- The COVID-19 pandemic has shown the need to **prepare expenditure management systems** by updating emergency spending protocols and proactively **empowering frontline providers** to access, manage, and account for public funds in an agile way.
- The adoption of measures to balance speed and accountability is another key lesson. **Better equipping financial management information systems** to provide integrated reporting of emergency-related spending is a critical step to ensuring public trust for the response.
- Countries can better prepare for future health emergencies by **strengthening their regular PFM** mechanisms and capacities, while **limiting the proliferation of parallel mechanisms** which can exacerbate fragmentation of health financing and hinder alignment with national response plans. The use of extra-budgetary mechanisms without well-defined procedures is unlikely to result in the efficient use of public resources for health emergency response.

**TABLE 1.**

**Summary of key policy actions to enhance PFM preparedness for health emergencies**

<b>Budget cycle</b>	<b>PFM dimensions</b>	<b>Key policy actions</b>
<b>Budget allocation and formulation</b>	Emergency funding	Update activation protocols and related disbursement procedures for emergency funding (e.g., disaster/relief funds)
	Budget re-prioritization	Accelerate programme-based budgeting reforms to provide more flexibility and accountability in resource allocation and management for health emergencies (and routine health needs)
	Fund transfers to subnational entities and purchasers	Ensure transfer modalities are in place to facilitate access to funding for subnational entities and purchasers, and explore formula-based budget mechanisms
	Extra-budgetary funds	Develop standard operating procedures for extra-budgetary funds, if/when introduced, to ensure optimal effectiveness in resource allocation and use, and anticipate closure modalities
<b>Budget execution</b>	Fast-track spending authorization	Revise emergency spending protocols and ensure readiness for adherence across administrative levels
	Procurement	Update emergency procurement protocols, with a specific focus on the purchase of health products, and incorporate measures to balance flexibility and transparency
	Staff/provider hiring or contracting	Refine regulatory frameworks at central and/or subnational levels to ease staff hiring and private provider contracting to respond to emergencies
	Access to funding for service providers	Develop and test front-loading and/or transfer of funds directly to service providers through separate purchasers and/or regular budget system
	Service providers' financial management	Conduct a rapid assessment of service providers' financial management capacities and provide strengthening as needed
<b>Budget reporting</b>	Financial management information system (FMIS)	Ensure FMIS has the agility to report emergency-related health spending
	Public transparency	Plan for the development of open, online platforms to assure transparency and accountability in emergency-response spending, and to secure public trust



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# Introduction: why PFM matters for the response to health emergencies

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**Public revenues are the cornerstone of funding for the response to health emergencies.** While private financing can contribute to a country's response, public sources make up the largest share of the funding available for this purpose.<sup>1</sup> This has been exhibited during the current pandemic, with the health response to COVID-19 predominantly funded from public sources, even in countries facing revenue constraints [1,2]. For example, in Ghana, COVID-19-related health spending in 2020 was mostly funded through domestic government funds (83%) with external and private funding representing 10% and 7% of the total, and in Burkina Faso, domestic public funding represented 53% [2]. The predominance of public funding promotes consistency, efficiency and equity in the response [3].

**Given the importance of public finances, the ongoing COVID-19 pandemic has also shown that public financial management (PFM) should be an integral part of the response.** Effectiveness in financing the health response depends not only on the level of funding but also on the way public funds are allocated and spent. This is determined by the PFM rules<sup>2</sup> that guide how public funding is allocated, executed, and reported, and in turn how money flows to health service providers<sup>3</sup> [4,5]. Early assessments have shown that PFM systems ranged from being a fundamental enabler to acting as a roadblock in the COVID-19 health response [6,7].

**When the crisis hit, many countries' domestic PFM systems were not ready or agile enough to support an effective emergency response.** Challenges commonly faced by countries include [6,8-10]:

- i) estimating and formulating budget provisions to align with response needs;
- ii) tailoring spending modalities to ensure funds are quickly available for service delivery units and disbursed flexibly and on time;
- iii) adjusting tracking and reporting systems to ensure public funds for emergency response are accounted for effectively and transparently.

**While problems in service delivery have been extensively documented [11], the underlying PFM mechanisms of the response also merit attention.** To highlight the importance of PFM in health emergency contexts, this policy brief analyses various country PFM experiences and identifies early lessons emerging from the financing of the health response to COVID-19. The policy brief is focused on documenting lessons from the budgeting and spending mechanisms and processes; it does not discuss the sources of funding, nor the content of fiscal policies in response to COVID-19, which are covered extensively elsewhere [12]. The assessment is done by stages of the budget cycle: budget allocation, budget execution, and budget oversight. Identifying lessons from PFM modalities used to finance the health response to COVID-19 is fundamental both for health policy-makers and for finance authorities, to enhance PFM system preparedness to respond effectively to future health emergencies. It can help to enhance understanding of good practices, as well as key requirements for future system adjustments.

**The assessment is built on a non-systematic review of several activities initiated by WHO in 2020 to monitor countries' health response from a PFM perspective (see Table 2).** The evidence reviewed included a desk-based survey initiated in March 2020, which analysed budgeting, spending, and accounting modalities in financing of the health response in 183 countries. Technical consultations were conducted in 17 countries (Argentina, Australia, Brazil, Chile, China, Costa Rica, Dominican Republic, Ecuador, Indonesia, Lao People's Democratic Republic, Malawi, Mexico, Mongolia, Peru, Philippines, South Africa, Ukraine) between June and September 2020 by WHO to further the understanding of PFM modalities. Complementary analyses conducted in 2021 to unpack specific PFM aspects of the health response, including an analysis of 40 extra-budgetary funds used to channel resources for the response [13], a mapping of PFM issues related to COVID-19 vaccine roll-out [7], and an in-depth assessment of PFM modalities in selected countries, including Argentina, the Philippines and South Africa [14,15] were also reviewed. In late 2021, the emerging findings in this paper were further explored and validated during the 5th Meeting of the Montreux Collaborative, a virtual meeting that gathered over 900 participants and 50 speakers over 5 days to explore policy options to help countries rebuild and strengthen health financing and PFM systems to make them more responsive to future shocks and able to sustain efforts towards universal health coverage (UHC). Finally, in early 2022, to gather the latest information on the response, another non-systematic review of published literature and publicly

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1 To meet the demand for increased public funding, low and middle-income countries increased budgets by 13-36% in 2020 for COVID-19 health response, over and above already-approved budgets for health (<https://www.who.int/publications/i/item/9789240017788>, p. 57).

2 Cangiano M, Curristine T, Lazare M. Public financial management and its emerging architecture. Washington (DC): International Monetary Fund; 2013.

3 UHC 2030. Public financial management for universal health coverage: why and how it matters. Geneva: World Health Organization; 2020 (<https://www.uhc2030.org/blog-news-events/uhc2030-news/public-financial-management-for-universal-health-coverage-why-and-how-it-matters-555436/>, accessed 10 April 2022).

available audit reports on COVID-19-related expenditures was conducted to complement the understanding of the opportunities and risks associated with the use of emergency procedures.

**TABLE 2.**

**Key activities in WHO analyses of PFM in COVID-19 pandemic response, 2020-early 2022**

Timeline	Activity	Output
March 2020	Examination of how highly affected countries allocated budget funds in the early stage of the response	How to budget for COVID-19 response? A rapid scan of budgetary mechanisms in highly affected countries <sup>4</sup>
May 2020	Analysis of how PFM processes supported the allocation and utilization of public funds for the response, based on a rapid review of 183 countries	No calm after the storm: time to retool country PFM systems in the health sector <sup>5</sup>
August 2020	Analysis of the use of extra-budgetary funds to mobilize resources and streamline emergency spending measures, and their possible utility for the response (jointly with the International Monetary Fund)	COVID-19 funds in response to the pandemic <sup>6</sup>
October 2020	Lessons from the response from a PFM perspective, drawing on the 183-country review and consultations with 17 low and middle-income countries (jointly with World Bank, OECD, Public Expenditure and Financial Accountability [PEFA] program and others)	If you're not ready, you need to adapt: lessons for managing public finances from the COVID-19 response <sup>7</sup>
May 2021	Identification of PFM "stress points" in the roll-out of COVID-19 vaccines, and how to overcome these (see in Annex 1)	Why PFM is key for the effective roll out of COVID-19 vaccines <sup>8</sup> Mapping PFM for COVID-19 vaccine roll-out <sup>9</sup>
November 2021	5th Montreux Collaborative conference on Fiscal Space, PFM and Health Financing brought together perspectives from finance and health, identifying promising PFM practices that emerged in the COVID-19 response and opportunities to integrate these into regular budget processes	COVID-19 as an opportunity for PFM transformation in health <sup>10</sup>
February 2022	WHO-organized session at the African Health Economics Association (AfHEA)'s 6th scientific conference discussed key PFM lessons from the COVID-19 health response with researchers and policy-makers	AfHEA's 6th scientific conference: WHO health financing sessions <sup>11</sup>

4 <https://www.who.int/publications/m/item/how-to-budget-for-covid-19-response>

5 <https://p4h.world/en/who-wb-no-calm-after-the-storm-time-to-retool-country-pfm-systems-in-health-sector>; <https://blog-pfm.imf.org/pfmblog/2020/05/-no-calm-after-the-storm-retooling-pfm-in-the-health-sector-.html>

6 <https://blog-pfm.imf.org/pfmblog/2020/08/-covid-19-funds-in-response-to-the-pandemic.html>

7 <https://p4h.world/en/blog-lessons-for-managing-public-finances-from-COVID-19-response>

8 <https://p4h.world/en/PEFA-Key-for-Effective-Roll-Out-of-COVID-19-Vaccines>

9 [https://www.pfm4health.net/\\_files/ugd/18961e\\_b235b5ff61e148478386d157692124de.pdf](https://www.pfm4health.net/_files/ugd/18961e_b235b5ff61e148478386d157692124de.pdf)

10 <https://blog-pfm.imf.org/pfmblog/2022/02/-covid-19-as-an-opportunity-for-pfm-transformation-in-health-.html>

11 <https://www.who.int/news-room/events/detail/2022/03/07/default-calendar/afhea-6th-conference-WHO-health-financing-sessions>

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# 1. Aligned budget formulation and allocation

Aligning the formulation and allocation of budgets is a precondition for ensuring that budget funds can be mobilized promptly and serve priority needs for the response to health emergencies. In the case of COVID-19, countries have adopted various approaches to align funding with their national health strategies. The main budgetary mechanisms to prioritize the health response have thus far included: i) activating emergency funding through regulated mechanisms; ii) leveraging existing budget flexibilities to facilitate budget re-prioritization; iii) adopting supplementary budgets through simplified formulation and approval rules; and iv) leveraging existing inter-fiscal transfer mechanisms to facilitate the allocation of resources to front-line responders. These approaches are not mutually exclusive, with most countries combining several strategies to ensure sufficient funding.

## 1.1 Activating emergency funding through regulated mechanisms

**Pre-existing regulations that allow the government's executive to activate emergency funding have enabled the rapid mobilization of public funds for the response.** Emergency funding generally provides immediate funding for unanticipated issues on a limited timescale and can take various forms and designations depending on the country (e.g., emergency funds, disaster funds, contingency funds). The activation procedures are strictly regulated but generally do not require legislative approval. Before the pandemic, many countries already had laws in place that allowed the executive to access and use emergency funds. For example, in the United States of America, the declaration of a national emergency by the President allowed the administration to utilize the Stafford Act, a federal law governing disaster-relief efforts, making US\$ 50 billion in emergency funding immediately available to states and territories [10]. In South Africa, the existing Provincial Disaster Relief Grant (PDRG) was the first mechanism activated in March 2020 to fund the response. Activation of this mechanism required the declaration of a national or regional disaster; R466 million (around US\$ 29 million<sup>12</sup>) were then channelled to provincial health departments to fund immediate needs [16].

**While many countries have relied on the mobilization of emergency funding, COVID-19 has also exposed weaknesses in the protocols for activating this type of funding.** In most low and middle-income countries (LMICs), protocols were poorly defined or did not exist, and there was a lack of clarity on disbursement-related procedures [17,18]. As a result, where the activation procedures for emergency funds were not fully regulated, the process for allocating funds was often cumbersome and non-transparent. In some contexts, certain reserves and unregulated contingency funds were mobilized outside of regular PFM processes, with limited information provided on the level of funding and their deployment modalities [17].<sup>13</sup> This type of mobilization can reduce alignment between the emergency funding and the needs and response strategies, and may result in a response that is ad hoc, fragmented and non-transparent.

**Most countries have combined the activation of emergency public funding with the use of exceptional procedures to allow rapid reprioritization of approved budgets.** In half of the 183 countries surveyed, the executive was granted broader powers to use exceptional procedures to quickly re-prioritize budgets in response to the crisis. This type of rapid budget re-prioritization was generally conducted through executive decrees. For instance, in the Philippines, the Congress granted the President authority to exercise temporary budgetary measures to access and re-direct public funding from various sources to the COVID-19 response; this included redirecting funding from regular budget allocations (the General Appropriation Act [GAA]) as well as accessing funding from the National Disaster Risk Reduction and Management Funds and other contingency funds. This was mainly through the government's mandate to discontinue appropriations for at least 10% of the total unobligated allotments, allowing it to provide around ₱266.8 billion (US\$ 5.2 million) [15].<sup>14</sup> See Box 1 for an additional example.

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12 <https://www.oanda.com/currency-converter/en/> (18 May 2022)

13 E.g., the use of the President's personal reserves in Gabon, and of contingency funds in Papua New Guinea.

14 A total of ₱394.4 billion from the 2020 GAA (₱356.7 billion) and the 2019 Continuing Appropriations (₱37.7 billion) was converted into one lump-sum envelope from which the Executive was able to fund the first actions against COVID-19 (Congressional Policy and Budget Research

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**BOX 1.**

## Costa Rica: combining sources of emergency funding to respond to COVID-19

The declaration of the state of emergency due to COVID-19 on 16 March 2020 allowed the national government to use a series of existing financial arrangements within its National Risk Management System, which had been established in 2005 to respond to emergency situations. For instance, the National Emergency Fund, a contingency fund administered by the National Commission for Risk Prevention and Emergency, was replenished with resources transferred from various public institutions' ordinary budgets and released rapidly. From March 2020 to the end of 2021, around ₡38 949.3 million (around US\$ 56.8 million;<sup>15</sup> 0.14% of gross domestic product [GDP] 2020) from the National Emergency Fund were used to finance the country's response to the COVID-19 pandemic. Other resources used to finance health emergency measures include the Contingency Fund of the Costa Rican Social Security Fund, loans from international organizations, and donations from foreign governments, the private sector, and international organizations.

**Source:** OECD, 2022

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### 1.2 Leveraging existing budget flexibilities to facilitate budget re-prioritization

**Programme-based budgeting, which groups budget inputs around key policy goals and outputs, has supported rapid re-deployment of public funding to meet financial needs for the health response.**

The built-in flexibilities of programme-based budgets allowed for flexible virements<sup>16</sup> within programme envelopes without legislative approval [19]. In South Africa, for instance, flexible reallocations within three main budgetary programmes quickly freed up resources for the emergency response in the fiscal year (FY) 2020/21 budget that was tabled in February 2020 for the fiscal year starting in April 2020 (Figure 1). The design of the South African budget enabled the flexibility to augment budget allocations throughout the fiscal year for COVID-19 testing and treatment as needed, though some delays in funds disbursement have been observed [16]. In 2021, the government was also able to leverage budgetary flexibilities to facilitate allocations towards the vaccine purchase and deployment, even though the first budget proposal for FY 2021/22 had no provisions for that spending [16]. New Zealand also utilized its programme budgeting framework to effectively allocate COVID-19-related expenditures, providing a framework for the Department of Health to flexibly manage expenditure for the response within the approved envelope [20].

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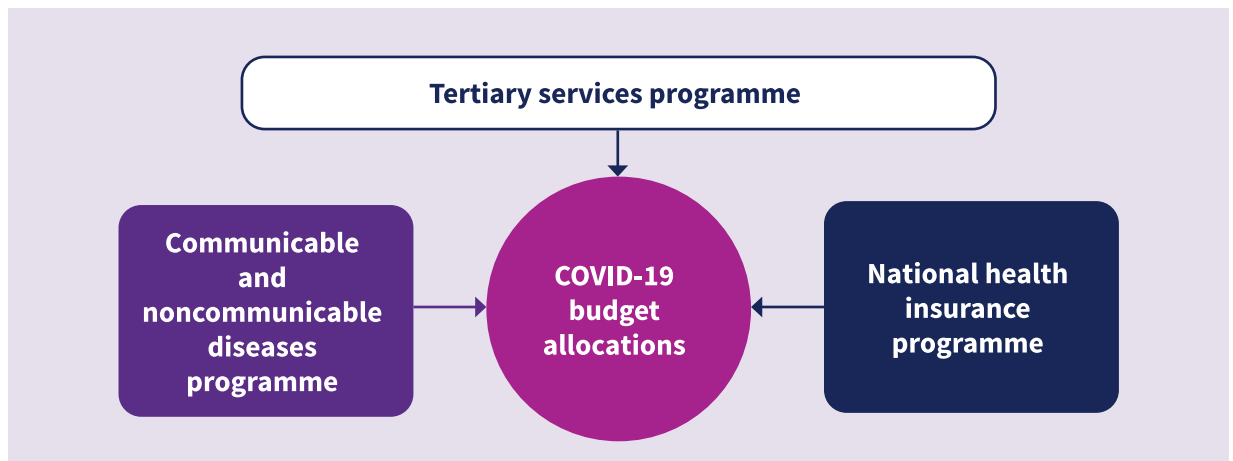
Department [CPBRD] 2021). ₡99.4 billion were tagged as unprogrammed appropriations mainly for the Department of Health. The rest was sourced from regular agency funds, including the National Disaster Risk Reduction and Management Fund and contingency funds [15].

15 <https://www.oanda.com/currency-converter/en/> (18 May 2022)

16 Virements are movements of budgetary resources between line ministries, programs, policy areas, expenditure categories or line items. Virements (a) take place after the budget has been authorized by the legislature, (b) do not affect the total level of budgeted expenditure, (c) should not fundamentally alter the composition of expenditure appropriated by the legislature, and (d) are carried out under the executive authority of the government and do not require legislative authorization (<https://www.imf.org/external/pubs/ft/tnm/2016/tnm1604.pdf>).

**FIGURE 1.**

**South Africa: Use of re-allocations within a programme-based budget to direct public funding to COVID-19 health response needs**



**In some countries where programme-based budgeting was already in place, COVID-19 programmes or sub-programmes have been added to the budget structure.** This has facilitated budget re-prioritization and simplified the tracking of public resources for the response. In France, where a programme-based budget structure was institutionalized in the late 1990s, it was possible to build onto that structure an *Emergency Programme for the Health Crisis* consisting of two sub-programmes and specific activity scopes, providing a single platform for allocating and tracking COVID-19 health expenditures. In Mexico, a COVID-19 sub-programme was added to the Department of Health (DoH) budget structure to cover additional spending for secondary and tertiary care. A budgetary sub-programme for individual and community-related support was also added to another existing budgetary programme, the Health Services Contributions Fund. These new budget programmes enabled Mexico's DoH to increase its spending by 61% in 2020 [6]. In Argentina, a new programmatic category within the existing National Immunization Programme was created to accommodate COVID-19 vaccines expenses. The programmatic framework within the ministry of health's budget also enabled the tracking of COVID-19-related expenditure [14].

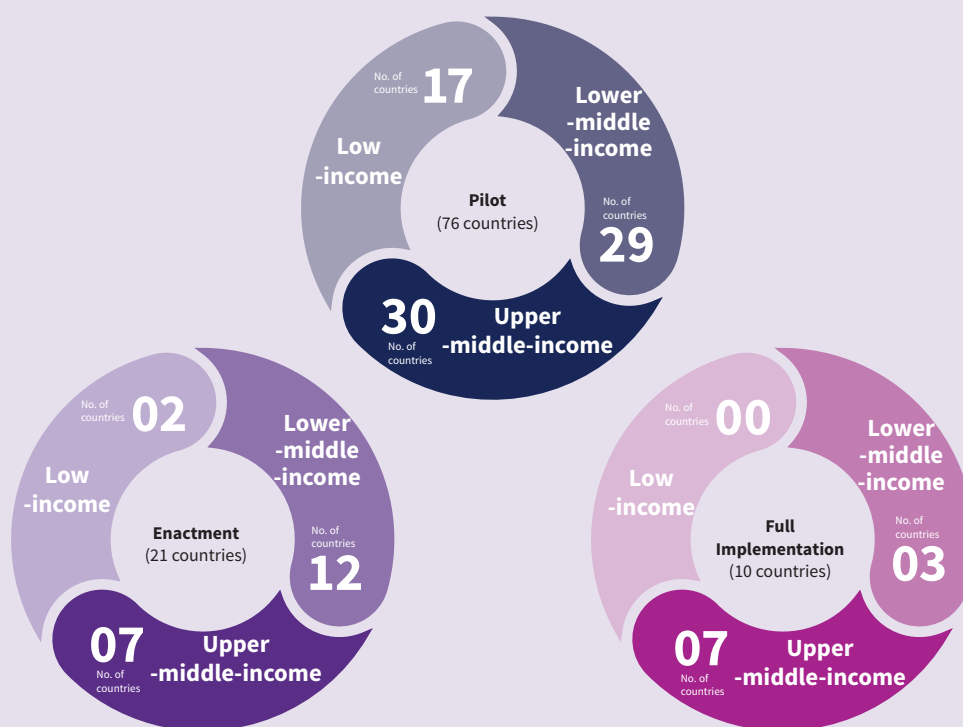
**The COVID-19 pandemic has highlighted the need for flexible and agile budgets, justifying a move away from budgets formulated by line items.** Countries with input-based budget structures that traditionally split allocations across different line items (e.g., for diagnostics and tests, for treatment, and for personal protective equipment [PPE] in the context of COVID-19) have found it more challenging to allocate and coordinate funding for the health response [21]. For COVID-19 vaccine deployment, having separate budget lines for vaccines, cold chain, support staff, and other operating costs has created complexities for budget management and the delivery of vaccines by front-line service providers [7]. Before COVID-19 hit, a majority of LMICs had initiated budget formulation reforms oriented toward more agile and flexible programme-based budgeting approaches, with the health sector often being the focus of a pilot. These reforms in some countries have benefited the response, but a scaling-up of that approach is needed to ensure budgets are better structured to respond to future health emergencies (Box 2).

**BOX 2.**

## Accelerating implementation of programme-based budgeting in health

The transition from line-item budgets to output-oriented budgeting is driven by the logic that expenditures should be grouped by and aligned with policy objectives or outputs, which are defined as budgetary programmes. The key distinction is how output-oriented budgeting is legislated, and the flexibility it allows for shifting of resources, rather than the forgoing of inputs or line-items in the budget-development process. The managers of budget programmes are held accountable for pre-defined outputs and assessed on the basis of what is achieved; at the same time they are granted flexibility to allocate and distribute funds to spending units.<sup>17</sup>

As of 2019, around 80% of LMICs – 107 countries out of 135 – had introduced some form of programme-based budgeting for health expenditure. However, just 10 of these countries had fully implemented a programme-based budget, with annual budgets that were formulated, adopted, released and monitored by budgetary programmes. The remaining 97 countries were in either the pilot phase (76) or the enactment phase (21); in these countries, the health ministry formulates budget proposals according to budgetary programmes and submits them to the executive and the legislature for approval [19].



17 The health sector's different departments and agencies can jointly contribute to defining a common and shared performance objective in health emergency response, even while bearing responsibility for distinct functions (e.g., disease surveillance, contact tracing, care, and treatment). Performance-based budgeting can be conducive to this type of coordination and shared accountability [21].

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### 1.3 Simplifying the development and approval of supplementary budgets to support transparent allocation

**When budget re-allocations were not sufficient to cover emerging needs, countries have developed and adopted supplementary budgets** to provide additional funding for the response.<sup>18</sup> Supplementary budgets are widely used to deal with unexpected funding issues but require a formal development and approval process, generally through the legislature. Where formally enacted, as in Estonia or the Philippines, supplementary budgets have helped safeguard public funding for, and provided a transparent and accountable platform for spending related to, the response (Box 3). However, only a small majority of the 183 countries surveyed by WHO adopted a supplementary budget to fund the response in 2020, while others exclusively used exceptional procedures without going through a formal budget approval process [10]. Generally, LMICs struggled to develop, cost, and approve supplementary spending plans in 2020. This was due to systemic weaknesses in various features of the budget development process and difficulties in quickly and efficiently mobilizing the legislature [22]. Instead, countries often relied on the systematized use of executive decrees. Although justified by the need for urgent action, this approach sidesteps the normal legislative approval process and limits public debate; it also reduces the opportunity to mobilize broader political support [17].

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#### BOX 3.

### Adopting supplementary budgets to mobilize additional funding for the health response: good practices from the Philippines and Estonia

The Philippines adopted a proactive, learning-by-doing approach to tackle public funding needs during the pandemic. As early as February 2020, the Department of Health (DoH) requested an additional ₱2 billion (around \$US 38.1 million<sup>19</sup>) for the COVID-19 response, but Congress delayed clearance. When community transmission of COVID-19 increased, the Congress held a special session to ratify the Bayanihan to Heal as One Act (Bayanihan 1), to provide additional funding to DoH and other national agencies. Under Bayanihan 1, the Government was able to mobilize ₱394.4 billion (around \$US 7.5 billion<sup>20</sup>) from 2020 and 2019 appropriations, mostly through re-prioritization of existing appropriations. This funding was directed to the DoH, local governments and cities (through the Department of Finance), and other ministries as well as the Department of Science and Technology (DOST) which was tasked with producing COVID-19 test kits. Specific provisions were included in Bayanihan 1 to ensure that weekly reports on COVID-19 response actions are sent to a Joint Congressional Oversight Committee that oversees implementation [15,17]. The Bayanihan to Recover as One Act (Bayanihan 2), legislated in September 2020 to augment COVID-19 response funds, took a more targeted approach – addressing specific gaps such as hiring and incentives for health care workers, supplementing various public health programmes, and advancing payments for COVID-19 vaccines.<sup>21</sup>

In 2020, Estonia adopted a supplementary budget to support funding for the COVID-19 response. An explanatory memorandum to the Estonian Supplementary Budget Act contained revised expenditure projections and ceilings for the 2020 budget. The memorandum also included revised expenditure and revenue projections and the updated budget position for the Estonian Health Insurance Fund. These projections included estimates on the loss in revenue from health insurance payments, and COVID-19-related costs for primary care, ambulance services, specialist care, hospital care, and pharmaceuticals [23].

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18 Supplementary budgets were often funded through deficit and/or debt financing (<https://www.imf.org/en/Publications/WEO/Issues/2020/06/24/WEOUpdateJune2020>).

19 <https://www.oanda.com/currency-converter/en/> (18 May 2022)

20 <https://www.oanda.com/currency-converter/en/> (18 May 2022)

21 <https://www.officialgazette.gov.ph/downloads/2020/09sep/20200911-RA-11494-RRD.pdf>. It should however be noted that extensions have been granted for the release, obligation and disbursement of the appropriated Bayanihan 2 funds, suggesting there may be challenges relating to spending (<https://www.congress.gov.ph/photojournal/zoom.php?photoid=3009>).



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**When supplementary budgets were requested, countries’ executives have used quick review and approval processes permitted by the regular finance laws.** For example, in France, the supplementary COVID-19 budget was adopted within two days in March 2020 – first by the National Assembly and then the Senate [10]. In the USA, the Families First Coronavirus Response Act was rapidly signed into law with bipartisan support and activated by 1 April 2020.<sup>22</sup> In Canada, the budget adoption process was streamlined – from a weeklong discussion to only a three-hour discussion [10]. However, owing to the rapid approvals, consultations with civil society and the public were neglected, particularly during the first phase of the response [24]. According to International Budget Partnership, Norway was the only country where in 2020 both the executive and the legislature carried out adequate consultations with key stakeholders – including various disadvantaged groups – both during the formulation and the implementation of the government’s response budget [17].

**Simplifying the adoption of supplementary budgets has also led to the integration of programmatic and flexible envelopes within budget structures.** While robust cost estimations and supportive explanations of planned activities are typically required when developing supplementary budget proposals, countries have generally approved supplementary funding for COVID-19 through “lump-sum” allocations. For example, several francophone sub-Saharan African countries (e.g., Chad, Côte d’Ivoire, and Mali) that typically use line-item planning and budgeting created temporary lump-sum budget lines for the COVID-19 health response, as a means of grouping budgetary inputs and facilitating budget implementation [25]. Similarly, Nigeria created temporary budget programmes in the supplementary budget law adopted in 2020 and used the same approach to facilitate the mobilization of supplementary funding for the COVID-19 vaccine roll-out in 2021. In Georgia, a temporary budgetary programme was introduced to make resource management more responsive to evolving needs, and to provide a clear audit trail for COVID-19 vaccine roll-out spending [7].

#### 1.4 Leveraging inter-fiscal transfer mechanisms to accelerate spending by service providers

**Another key component of effective financing for the COVID-19 health response has been the rapid transfer of additional resources to subnational levels.** While COVID-19 spending has been partially centralized to facilitate procurement in bulk, fiscal transfers to subnational entities (e.g., local government, province, or district depending on the degree of decentralization) have generally helped to accelerate access to funding for service delivery units to cover their operating costs. In general, having a pre-existing, robust, formula-based inter-fiscal transfer mechanism has been key to supporting access to efficient and equitable funding for the health response. For example, in Argentina, the pre-existing system of conditional grants to provincial governments has, with some adjustments, enabled a consistent and performance-oriented health response. The system was adapted to ease spending by providers (e.g., by removing the cap on human resources expenses) and enable health facilities to increase their capacity to provide necessary services (Box 4). Similarly, in the Philippines, the Bayanihan 1 Act used existing modalities to make transfers to local government units (LGUs)<sup>23</sup> and granted the LGUs some flexibility in reallocating their budgets for the COVID-19 response.<sup>24</sup> Although most of the 183 surveyed countries reported increased and tailored transfers to subnational entities [20,21], many countries continued to experience bottlenecks in the flow of funds between local entities and service providers (see next section).

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22 <https://www.dol.gov/agencies/whd/pandemic/ffcra-employee-paid-leave>

23 LGUs consist of three levels of local government: 1) provinces and independent cities, 2) component cities and municipalities, and 3) barangays.

24 The DOF calculated its grants to LGUs based on their existing Internal Revenue Allotment (IRA), the block grant used to support LGUs’ functioning which itself is based on a proportion of revenues from the Philippine national government. The Bayanihan Grant to Provinces was calculated as one-half of provinces’ one-month 2020 IRA, and the Bayanihan Grant to Cities and Municipalities was equivalent to one month of cities’ and municipalities’ 2020 IRA. These actions were provided for in the DBM’s Local Budget Circular No. 24 (<https://www.dbm.gov.ph/index.PHP/issuances/dbmissuances/local-budget-circulars/266-latest-issuances/local-budget-circular/local-budget-circular2020/1626-local-budget-circular-no-124>.), which describes how LGUs’ annual budgets can be adjusted via supplemental budgets or savings and augmentation. This Circular relaxed rules on the use of the local disaster risk reduction and management fund, enabling LGUs to utilize amounts larger than the 30% outlined in previous policies. Each LGU must reflect these additional sources of money in its Annual Investment Plan, with the approval of the local legislative council.

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**BOX 4.**

## Argentina: use of performance-based transfers to provinces to facilitate efficient and equitable financing for COVID-19 health response

Argentina's *Programa SUMAR*, introduced in 2012 as a national-scale successor to the Plan Nacer pilot project, shared the earlier programme's focus on providing health care services to uninsured populations and continued its use of results-based financing with provincial governments and health care providers.<sup>25</sup> The Federal Ministry of Health funds the provinces through capitation payments, based on performance as measured by a set of health output and outcome indicators. The provinces use fee-for-service payments to transfer funds to health care providers, for specified health services for the enrolled population. These transfers supplement the providers' regular budget allocations, incentivizing an increase in the quantity and quality of pre-defined health services delivered to the public. As of 2009, provinces were required to match a predefined share (15%) of the capita on transfers provided by the federal MoH to reimburse public health facilities within their jurisdiction [26].

When the COVID-19 pandemic was declared, Argentina used its existing inter-fiscal transfer mechanisms described above to accelerate access to funding and spending by the provinces and the service providers for its health response. Those mechanisms were the main channel through which the federal government offered early financial support to the provinces and to service delivery units.

To facilitate COVID-19 health response spending, some adjustments to the pre-existing transfer and payment mechanisms were introduced, including i) increasing the capitation rate for provinces, ii) expanding the health benefit package and enabling the contracting of private providers, iii) complementing the fee-for-service payment to providers with monthly capitation remuneration, iv) creating a National Health Equity Fund to guarantee the financing of COVID-19 inpatient services (intensive care unit beds) in public and private facilities, and v) eliminating the spending cap for Human Resources at the provider level.

Conditional transfers have also been used by other programmes, such as *Programa Redes de Salud*, to respond to COVID-19.<sup>26</sup> That programme has supported the Provincial Emergency Committees, financing the design of comprehensive provincial response plans, as well as the development of vaccine roll-out plans [14].

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**A few countries with separate purchasers<sup>27</sup> have leveraged existing transfer modalities to purchasing agencies as the main funding instrument to meet increased financial needs.** To compensate for expenditure pressures, the central government of Austria, for example, provided a flat-rate subsidy to the Austrian Health Insurance Fund of €60 million in 2020. Similarly, in Estonia, the state supplementary budget provided increased transfers to the Estonian Health Insurance Fund to cover COVID-19-related costs [20]. In the Philippines, although Bayanihan 1 mandated the Philippine Health Insurance Corporation (PhilHealth) to cover testing and treatment of COVID-19 patients, the agency did not initially receive additional funds to cover these costs since it was argued there had been a simultaneous decrease in service use by outpatients. Recognizing the increased need for 2021, the Congress increased funding in its General Appropriations Act to include contributions to PhilHealth to cover COVID-19 treatment for insured populations [15].

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25 *Plan Nacer*, initiated in 2004 in nine northern provinces and expanded in 2007 to the remaining 14 provinces and the Autonomous City of Buenos Aires, provided financing for a package of preventive maternal and child health care services for uninsured pregnant and lactating women and uninsured children under six, at primary care level. *Programa SUMAR* further included uninsured children aged 6 to 9 years, uninsured youth aged 10 to 19 years, and uninsured adults aged under 65, while adding cancer prevention, sexual health, and prevention of noncommunicable diseases, and support for the federal network for treatment of congenital heart disease (<https://www.argentina.gob.ar/salud/sumar>; <https://www.worldbank.org/en/results/2020/06/29/universal-health-coverage-sumar-program>).

26 <https://www.argentina.gob.ar/salud/redes>

27 Purchasing refers to the allocation of pooled funds to healthcare providers for the delivery of health services on behalf of certain groups or enrolled populations. Purchasing of health services is to be distinguished from the procurement of medicines and other medical supplies in bulk. Purchasing agencies can take many forms, such as the ministry of health, subnational authorities (e.g., at provincial or district levels), a mandatory or voluntary health insurance agency (or multiple insurance agencies), a community-based health insurance organization, or a nongovernmental organization [27].

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## 2. Flexible budget execution

After a budget is allocated, funds need to be disbursed in a timely manner, and service delivery units need to be empowered to access, manage, and account for the funding received. The litmus test for the PFM response to health emergencies is whether these funds can be deployed quickly and effectively to the service providers. In countries with weak and/or rigid PFM systems, governments had to find creative ways to rapidly deploy resources to service providers. Often this required substantial adjustments to existing spending modalities, including i) fast-tracking spending authorization and disbursement modalities; ii) streamlining procurement rules; iii) allowing service providers more flexibility in the use of resources; or iv) establishing extra-budgetary funds to overcome spending delays and rigidities.

### 2.1 Making good use of fast-track spending modalities to accelerate disbursements

**Most countries adopted fast-track procedures to accelerate the disbursement of funds for the health response.** Generally, budget execution systems consist of four main steps: appropriation, authorization, commitment, and payment [28]. Fast-track modalities introduced in most countries during COVID-19 enabled more rapid provision of approved funds to their final recipients, skipping several intermediate authorization steps in the expenditure chain. For example, early in the pandemic, China allowed fund managers to advance appropriations and fast-track disbursements across the various administrative levels to meet provincial and local spending needs [10]. France also adopted a centralized fast-track authorization process, removing one of the authorization steps to speed up disbursement and make funds available immediately after budget approval [10]. In South Africa, typically no expenditures are allowed until the budget is formally enacted, a process that can take several months. However, regulations in place (section 29 of the PFM Act) allowed spending before formal enactment, helping to make funding available more quickly. This provision was used to enable expenditure during the period prior to formal enactment and was used both in FY 2020/21 for the initial COVID-19 health response and in FY 2021/22 for the procurement of vaccines [16].

**As part of agile PFM, having or introducing regulations for hiring supplementary personnel and contracting private providers has helped to increase response capacities.** Fast vaccine roll-out has increased the need, in many countries, to contract private providers. However, without a clear regulatory and contracting framework, it has been difficult to do so quickly enough to meet immediate needs. The Philippines had legal mechanisms in place for the purchaser, PhilHealth, to do such contracting. These mechanisms allowed the contracting of more than 700 additional facilities (both public and private) to deliver health services, helping with COVID-19 response including vaccine roll-out. In 2021, Estonia updated its contracting modalities for providers, simplifying the procedure for inclusion of new private providers and providing financial incentives to deliver additional services related to the COVID-19 response. In several countries, caps on hiring health personnel were also lifted. For example, in the Philippines, LGUs were permitted to hire more emergency health care workers [15]. Argentina also removed pre-existing personnel caps at the facility level at the beginning of the pandemic [14].

### 2.2 Providing more flexibility in resource use for service providers

**COVID-19 has necessitated better and more flexible access to funding for front-line providers.** Generally, PFM systems with no separate purchaser do not allow service providers to access public funding directly, as service providers are not recognized as spending units [33,34]. This situation has often created unnecessary rigidities in the expenditure chain, while diminishing the effectiveness of facility-level performance incentives. One of the learnings from COVID-19 is to provide health facilities with greater autonomy (ideally not only during a health emergency), as this allows service providers to respond more quickly to health needs. In Indonesia, health facilities known as *Badan Layanan Umum Daerah* (BLUD or Local Public Service Agency) – accounting for around 20% of the country's more than 10 000 public primary health care facilities – have special autonomous status. During the COVID-19 pandemic, the BLUD facilities have used national health insurance (*Jaminan Kesehatan Nasional*) capitation funds for both routine essential health services and emergency service provision, in contrast to regular non-autonomous public providers which could not

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immediately access the increased public funds, hindering their ability to provide services.<sup>28</sup> In Australia, the federal government was able to swiftly provide supplementary budget allocations directly to primary health care units to set up respiratory clinics. However, examples such as these tend to represent the exception rather than the rule, particularly in LMIC contexts.

**Front-loaded funding has been shown to enable more agile spending for providers.** While introducing a new cash-advance system in pandemic times may be challenging, some countries have leveraged and tailored existing mechanisms to facilitate direct access to funding for providers and help mitigate facilities' financial risks. In the Philippines, the purchasing agency (PhilHealth) instituted a new payment mechanism in May 2021 called the Debit-Credit Payment Method (DCPM) to fast-track payments to facilities. Through the DCPM, PhilHealth immediately pays 60% of the total amount of applicable receivables while the remaining 40% are paid following compliance with existing claims-processing requirements and procedures (Box 5). A similar approach that builds on existing regulations has been introduced in the Republic of Korea. To ensure cash flow to health care providers, the government adjusted the National Insurance Enforcement Rules by shortening the reimbursement process from 22 to 10 days. For health facilities facing financial difficulties owing to COVID-19, funding equivalent to 90-100% of the monthly average insurance benefit claim cost (for the same period in the previous year) was provided in advance to meet these additional costs [35].

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**BOX 5.**

## Front-loading payments to facilities during COVID-19: benefits and issues in the Philippines

PhilHealth had an existing policy for “front-loading” funds to health care providers called the Interim Reimbursement Mechanism (IRM), whereby three months' worth of claims payments based on historical data is provided in advance to health facilities during natural calamities and fortuitous events to secure substantial financial aid for health facilities. PhilHealth applied this policy during the COVID-19 emergency response, advancing around ₱15 billion (around \$US 285.9 million<sup>29</sup>) worth of funds to public and private hospitals, dialysis centres, and maternity clinics. The special provision for emergencies extends the period for claims submission from 60 days to 120 days and exempts facilities from the 45 days benefit limit. All valid claims during this period will be deducted from the IRM fund until fully liquidated.

In July 2020, PhilHealth came under scrutiny because of alleged anomalies surrounding the IRM. During the joint Senate and Congressional inquiry, concerns were raised about the IRM's design (e.g., the purpose of the fund and mechanisms for utilization, method for calculation, selection of facilities, and mechanism for monitoring, accounting, and liquidation). In response to these probes, PhilHealth suspended the implementation of the IRM. To address this challenge, PhilHealth instituted a new payment mechanism in May 2021 called the Debit-Credit Payment Method (DCPM) to fast-track payments to facilities. Through the DCPM, PhilHealth will immediately pay 60% of the total amount of applicable receivables, while the remaining 40% will be paid following compliance with existing claims processing requirements and procedures.

The pandemic highlighted that facilities and health care workers need to be provided with sufficient resources and better incentives during an emergency, and mechanisms need to be developed to ensure that those resources reach public and private providers quickly. PhilHealth has demonstrated a capacity to channel resources directly and rapidly to front-line service providers; however, its design and execution require strengthening – as of September 2021, it had paid only a portion of COVID-19 claims, while a majority were denied, returned to the hospital, or were in process. For isolation and inpatient-related benefits, just under a quarter of claims were paid, while for COVID-19 testing-related benefits only 40% had been paid. The DCPM continues to be a promising mechanism to ensure that facilities are adequately financed during an emergency but there is a need to refine its ability to transfer funds to facilities [15].

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28 <https://p4h.world/en/blog/Public-financial-management-in-a-pandemic>

29 <https://www.oanda.com/currency-converter/en/> (18 May 2022)

## 2.3 Streamlining procurement rules

**As the COVID-19 pandemic placed governments under extreme procurement pressure, most countries relaxed procurement rules** to accelerate the purchase of COVID-19 diagnostics, testing, and treatment tools [17,18]. Effectiveness in procurement is a critical enabler for the response, as evidenced in previous health emergencies, and to secure public trust [29,30]. Common measures taken in the context of COVID-19 purchasing included i) negotiating directly with suppliers, ii) lifting the requirement for prior publication of bids, iii) lifting the time and due-diligence constraints on opening of bids, iv) lifting the requirement for a minimum number of candidates, and v) making advance payments. In most countries, the centralization of procurement has been the preferred method for COVID-19-related purchases, on the rationale that a centralized process could enable economies of scale, reduce transaction costs, strengthen purchasing power, and improve capacity and expertise [29].

**As countries activated emergency protocols for procurement, the need to develop or update procedures has also become apparent.** Although emergency procedures for procurement generally simplify and streamline processes, the need to purchase COVID-19-related supplies revealed modalities that were still cumbersome, unclear, inconsistent, and sometimes conflicting across administrative levels. Cumbersome procedures included multiple layers of authorization or procedures that did not readily adapt to market constraints, requiring governments to issue further detailed orders for COVID-19-related emergency purchases. For example, the purchase of COVID-19 vaccines in a very concentrated market has been particularly challenging and has required measures to allow for sole-sourcing and an accelerated process. Many sub-Saharan African countries lacked comprehensive or easily actionable provisions for emergency procurement [29,31].

**Lack of transparency in the procurement process, contract provisions, and pricing for COVID-19 tools has increased integrity risks and exacerbated inequality in access to supplies across countries.** Although good practices have emerged,<sup>30</sup> data on countries' emergency purchases are often not disclosed in open data formats or are only partially published [32]. As emergency purchases are more vulnerable to corruption or fraud, emergency protocols need to be refined to strengthen transparency and accountability. Emergency measures put in place and the scaling-up of e-procurement for COVID-19-related purchases have been marred by alleged corruption in several countries, across income levels.<sup>31</sup> In addition, a lack of transparency in COVID-19 vaccine purchasing contracts has put lower-income countries in a weak negotiating position vis-à-vis the suppliers, escalated purchase costs, and prevented countries from knowing contract details that could enable more effective budgeting and operational preparations for vaccine roll-out.<sup>32</sup>

## 2.4 Setting-up extra-budgetary mechanisms to overcome PFM weaknesses

**Where existing spending modalities were considered unsuitable to channel resources for the COVID-19 health response, more than 40 countries have created extra-budgetary funds (EBFs)** to facilitate emergency spending measures, with a view to simplifying financial management procedures and accelerating spending. Additional reasons include the need for high-level control (often located in the President's or Prime Minister's office), to pool public and private resources, to coordinate interventions across different sectors and levels of government, or to ring-fence COVID-19-related spending from external resources. EBFs are generally established outside the regular PFM processes, through separate banking arrangements, financial transactions, and institutional governance, and are not included in the annual state

30 For example, in Ecuador, the procurement agency's emergency procurement platform provides open access to data on all COVID-19-related procurement contracts (<https://internationalbudget.org/covid/>).

31 For African countries, CABRI reports: "Despite all these transparency and accountability measures, there were still instances of alleged corruption reported in the news in respect of the COVID-19 emergency procurement processes in Botswana, DRC, Lesotho, Mauritius, Mozambique, Namibia, South Africa, Zimbabwe (Heywood et al. Daily Maverick, 2020) and Senegal (Baudin et al., 2020)" (<https://www.cabri-sbo.org/en/publications/streamlining-public-procurement-processes-during-covid-19-balancing-efficiency-and-accountability>).

Also see publicly available audit reports for Kenya (<https://www.oagkenya.go.ke/wp-content/uploads/2021/09/UTILIZATION-OF-COVID-19-FUNDS-BY-KEMSA-2020.pdf>), Sierra Leone (<https://www.audit-service.gov.sl/wp-content/uploads/2020/12/Report-on-the-Audit-of-Funds-managed-by-NaCOVERC-and-other-MDAs.-March-June-2020.pdf>), and South Africa (<https://www.agsa.co.za/Reporting/SpecialAuditReports/COVID-19AuditReport.aspx>).

For Brazil, the United Kingdom of Great Britain and Northern Ireland, and the USA, see: <https://www.transparency.org.uk/covid-19-has-created-conditions-which-corruption-health-procurement-can-flourish-heres-how-open>

32 "Contracts contain information not just about prices, dates, and quantities—they can have clauses about liability, conditions on who else a manufacturer is allowed to sell to and when, and intellectual property and licensing. All of those contracting details will allow for improved preparation for vaccination drives and budgeting for vaccines and vaccination programs" (<https://www.cgdev.org/blog/release-covid-19-vaccine-contracts>).

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budget law. While most countries introduced EBFs for the early phase of the response, some other countries, such as Mauritius through the creation of its National COVID-19 vaccination fund, also implemented EBFs to facilitate the COVID-19 vaccine roll-out [13].

**Yet, for good reasons, EBFs are often regarded as suboptimal.** While such funds can accelerate spending in some emergency contexts, they can also create significant governance vulnerabilities, particularly when the funds operate outside government systems, are managed by officials not familiar with basic principles of financial management, and are not subject to robust transparency and reporting standards. In the absence of strong safeguards, funds with independent spending authority that bypass normal budgetary and expenditure controls can dilute accountability and weaken fiscal control, creating significant fiscal risks and corruption vulnerabilities. In addition, they further fragment spending in the health sector where multiple funding streams and rules already exist [13].

**The COVID-19 pandemic has heightened many of the inherent risks of EBFs.** In sub-Saharan African countries, where EBFs for COVID-19 have been popular, lessons from these experiences have been mixed. The rush to set up funds has in many cases led to a legal vacuum, in which the EBFs' purpose, management, and oversight were insufficiently defined. Legal provisions were often vague on important governance arrangements, including the funds' objectives and scope, procedures for spending decisions, or the interplay with government bodies and the budget system. While operating modalities vary across countries, most funds have operated through separate banking, financial management, and reporting arrangements. Reporting modalities have often bypassed the government's financial management information system and provided limited information on spending. Often, purchases have been processed outside of regular procurement systems and associated with integrity issues [36,37]. Countries and development partners need to learn from the COVID-19 pandemic to avoid further proliferation of fragile EBFs in future health emergency situations (Box 6).

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**BOX 6.**

## Extra-budgetary funds for emergency pandemic response: getting it right

While exceptional situations may justify the use of EBFs, they should be designed and managed carefully:

**Legal mandate.** Legislation is essential to clarify the purpose of the fund and its sources of finance, its management and oversight structure, the business processes governing its activities and operations, its reporting standards, and its accounting and auditing requirements. Any law, regulation or decree needs to strike a balance between conciseness, which speeds up the approval of new funds, and detail, which is needed to codify important institutional and governance arrangements. To ensure that these funds do not outlive their purpose, the law should also stipulate a sunset clause and how the remaining balances should be used.

**Purpose of the funds and sources of finance.** To avoid duplication, limit fragmentation, and ensure coordination across activities, the areas of the fund's operations and revenue sources should be defined in consultation with the relevant government ministries, development partners, and nongovernmental organizations. The fund's mandate should be commensurate with the resources that it has, or is likely to have, at its disposal. Careful thought should be given to how public and private sources of finance could be aligned to deliver effective emergency responses.

**Management and oversight.** If the fund is a legal entity as well as a set of bank accounts, a sound management structure could comprise an independent management committee or board responsible for making strategic decisions, and a chief administrator to manage the fund's day-to-day activities. To ensure that the fiduciary team has sufficient PFM expertise, its membership should ideally include strong representation from the ministry of finance and the national procurement authority.

**Standard operating procedures (SOPs).** The fund's efficiency and performance will rely primarily on how swiftly interventions can be rolled out on the ground while ensuring full transparency and accountability. Interactions with existing PFM systems and procedures should be specified in SOPs. In cases where the regular PFM channels are being bypassed, these SOPs should also carefully clarify the respective roles and responsibilities of the fund itself, the finance ministry, and implementing agencies such as health and internal security. The SOPs should also prevent potential duplication of approvals and controls, and hence the risk of delays in making transactions.

**Transactions.** COVID-19-related funds should be required to make transactions electronically, where possible. e-transactions will improve speed and accuracy in the transfer of funds to identified beneficiaries, simplify the maintenance of transaction records, and reduce operating costs. Similar considerations apply to the procurement process, which should also be conducted electronically as far as possible.

**Transparency.** Governments should disclose the existence of COVID-19-related funds on their websites and describe the funds' key characteristics, including their legal mandate, objectives and policy rationale, sources of revenue, governance and management arrangements, and operating rules and procedures. The funds' revenue and expenditures should be reported monthly or quarterly on a gross basis [13].<sup>33</sup>

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33 In Sierra Leone, real-time auditing approaches honed during the Ebola crisis were used to monitor the use of funds (including EBFs) by the National COVID-19 Emergency Response Centre (NaCOVERC) and other parts of the government. The audit was conducted from March-June 2020, and focused on procurement, disbursement including payment of allowances, cash and bank, and asset and donations management, and information system management (<https://www.audit-service.gov.sl/wp-content/uploads/2020/12/Report-on-the-Audit-of-Funds-managed-by-NaCOVERC-and-other-MDAs.-March-June-2020.pdf>).

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# 3. Trackable expenditure for better accountability and transparency

Governments responded to the onset of the COVID-19 pandemic with increases in public spending of exceptional scale and speed [38], challenging traditional approaches to ensuring transparency and the safeguarding of public accountability. Advice from the International Monetary Fund (IMF) was to “do whatever it takes but keep the receipt” [38]. Broadly, policy-makers and development partners have agreed on the importance of monitoring and reporting on the use of these funds. Maintaining reporting is necessary to assure adequate monitoring of fiscal risks, and “keeping the receipt” is essential to build public trust in the response. Countries have adopted various measures to balance the demands of an urgent budgetary response with a high degree of accountability and transparency. Those adaptations have served to manage the emergency, and can also help to improve accountability systems for the longer term, including in the health sector.

## 3.1 Leveraging programme-based structures to facilitate expenditure tracking

### **The structure of programme-based budgets has facilitated the tracking of COVID-19 health spending.**

When COVID-19-related programmes were inserted in ministry of health budget structures either as programmes, as in France, or sub-programmes, as in Mexico, the programme-based structure has both facilitated the allocation of resources and enabled sound reporting of these expenditures. Through this structure, budgetary inputs for the pandemic response have been grouped, and expenses are monitored as an earmarked and consolidated envelope. As a result, data can easily be retrieved providing real-time information on the actual level of spending. These experiences provide practical insights on how to combine flexibility in spending (within a programme-based approach) with strong accountability. In the example below from Burkina Faso (see Table 3), a sub-programme entitled “Fight against COVID-19” (002.1) was created in the second main budgetary programme (“Access to health services,” 002). The sub-programme was sub-divided into two COVID-19 envelopes, one managed by the National Public Health Directorate (27105007410) and the second funded by external resources (271060074). The approach offered a consolidated platform for tracking COVID-19-related health expenditure from both domestic and external resources, channelled through the government.



TABLE 3.

## Tracking COVID-19 health spending in budgetary programmes: an example from Burkina Faso

Section	Programme	Action	Libellé Action	Chapitre : Service/ localisation/fonction	Article/ Paragraphe (PCE)	Libellé	Montant
71	Ministère de la Santé						
	002	Programme accès aux soins de santé					
		002.1	Lutte contre le COVID-19				
			27105007410	Direction Nationale de la Santé Publique			
					2440	Matériel Technique	5 000 000 000
			271060074	(Projet) Appui lutte contre le COVID-19			
					6180	Frais Formation	1 500 000 000

Chapitre regroupant le type de service (2 administration contreale), le service ou projet et son numéro (7105/7106 direction/projet), la localisation géographique (0) pour la capitale et la fonction (074 santé).

Source: IMF<sup>34</sup>

**Having a programme-based structure is not however a guarantee of budget transparency and sound accountability.** Even a programme-based structure requires basic allocation and financial management mechanisms to function effectively. In Kenya, for example, the government used its existing programme-based structure to allocate and disburse funding for the COVID-19 health response, but the tracking system did not allow for clear and transparent reporting of expenditures. Most of the country's health response funds were allocated to the "Health policy, Standards and Regulation" budgetary programme but, according to the International Budget Partnership (IBP), execution of the allocated COVID-19 envelope remained opaque [39].<sup>35</sup> A performance monitoring framework and associated reporting and accountability mechanisms are necessary complements for tracking financial and non-financial outputs under a programme-based budget structure [21].

**Expenditure tagging is another useful approach that has been adopted to monitor COVID-19-related health spending.** During the pandemic, some governments opted to mainstream COVID-19 health spending in their existing budget structures, without creating a specific budgetary programme. Instead, they included COVID-19 within existing budget categories and "tagged" related spending. As observed in Estonia, this approach has allowed COVID-19 health spending to be identified and monitored across budgets of various entities (including health, social protection, and finance). A similar approach has been used by some countries to specifically monitor gender-oriented spending related to COVID-19. A few advanced PFM systems have used gender budget tagging to track how allocations for COVID-19 programmes and activities supported gender equality objectives.<sup>36</sup>

**Countries with an already robust public expenditure tracking system, a Financial Management Information System (FMIS) or similar,<sup>37</sup> have been able to provide a comprehensive picture of health spending on COVID-19.**<sup>38</sup> South Africa has a solid and transparent public expenditure tracking and reporting system, with an online platform reporting on the financial and non-financial performance of health

34 <https://www.africacquest.org/servlet/servlet.FileDownload?file=00P3h000004iIFFEA2>

35 [https://internationalbudget.org/covid/wp-content/uploads/2021/08/Kenya-Brief-Managing-COVID-Funds\\_Paper.pdf](https://internationalbudget.org/covid/wp-content/uploads/2021/08/Kenya-Brief-Managing-COVID-Funds_Paper.pdf)

36 In Iceland where gender budgeting has been embedded as a tool in the budget process since 2015, the government used this tool to ensure key measures of a pandemic budget bill were gender-inclusive (<https://www.government.is/government/covid-19/#Tab5>). Canada has implemented a gender-based analysis plus (GBA+) tool for COVID-19 and recovery spending. This has enabled the identification of gender-specific needs, mental health needs and gender-based violence responses ([https://read.oecd-ilibrary.org/view/?ref=1094\\_1094692-vsm1fnncha&title=Towards-gender-inclusive-recovery;](https://read.oecd-ilibrary.org/view/?ref=1094_1094692-vsm1fnncha&title=Towards-gender-inclusive-recovery;)).

37 "automated solutions that enable governments to plan, execute and monitor the budget, by assisting in the prioritization, execution and reporting of expenditures [...] and revenues" (<https://elibrary.worldbank.org/doi/abs/10.1596/978-0-8213-8750-4>).

38 This also requires an electronic information management system and data that are readily digitized.

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spending.<sup>39</sup> Using existing real-time expenditure reporting, the country has been able to draw COVID-19 health spending data, typically with a lag of just one day, and locate where and how these funds have been spent [16]. While only limited system updates were necessary to enable reporting on COVID-19-related spending, some challenges were still experienced in ensuring consistent and accurate use of the budget codes by the provinces. The latter required increased coordination between the National Treasury, national DoH, and their provincial counterparts, to correct and increase the reliability of the expenditure reports [16].

**Several countries have adapted their FMIS to monitor COVID-19-related health spending in an integrated way.** Best practice requires the FMIS to be in alignment with the budget structure and the chart of accounts. In a programme-based budget structure, when COVID-19-related spending is included at the programme level,<sup>40</sup> new categories should subsequently be added to the FMIS.<sup>41</sup> In Ghana, for example, the new coding reflects the addition of the Coronavirus Alleviation Program in the budget. FMIS reporting capabilities have also been enhanced to configure and generate required reports on COVID-19 in some countries, such as Gambia which adjusted its FMIS reporting capabilities to report COVID-19-related spending in a timely manner. The country's reports included all COVID-19-related activities, including those financed by development partners, even where these activities are executed either directly by those partners or through project implementation units that are outside the government's public sector information systems. Where the COVID-19-related activities were financed by loans or grants to the government, both the disbursements and corresponding expenditure were recorded in the FMIS.

**Some countries have seized the opportunity to accelerate FMIS reforms and simplify recording processes.** Procedures and controls embedded in manual information systems are generally not designed to deal with rapid increases in the volume of transactions that can result from the response to emergencies. In the case of the COVID-19 pandemic, an FMIS may prove a stumbling block if it does not facilitate adequate flexibility and timely responses [40]. To address this problem, Rwanda simplified and shifted its financial information system to a fully electronic approach. The reform was under development at the start of the COVID-19 pandemic, and physical distancing policies prompted the upgrading of the system to be accelerated (Figure 2). In other countries where the FMIS was not fully operational, governments have accelerated the use of paperless procedures to facilitate disbursement and reporting of COVID-19-related spending [40].

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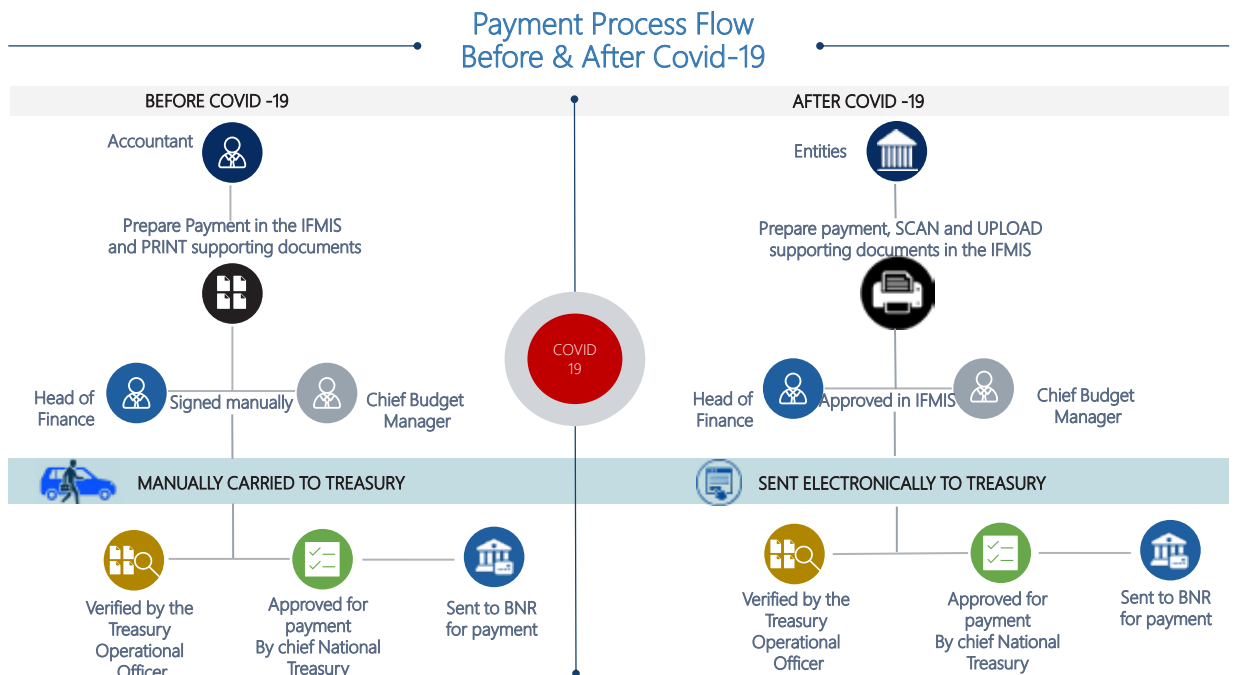
39 <http://www.treasury.gov.za/publications/guidelines/2015-16/FMPI.pdf>

40 Typically, a programme-based budget structure has three levels: programme, sub-programme, and actions/activities/projects.

41 <https://blog-pfm.imf.org/pfmblog/2020/09/-tracking-covid-19-operations-in-francophone-africa-.html#more>

**FIGURE 2.**

**FMIS upgrading during the response to COVID-19: an example from Rwanda**



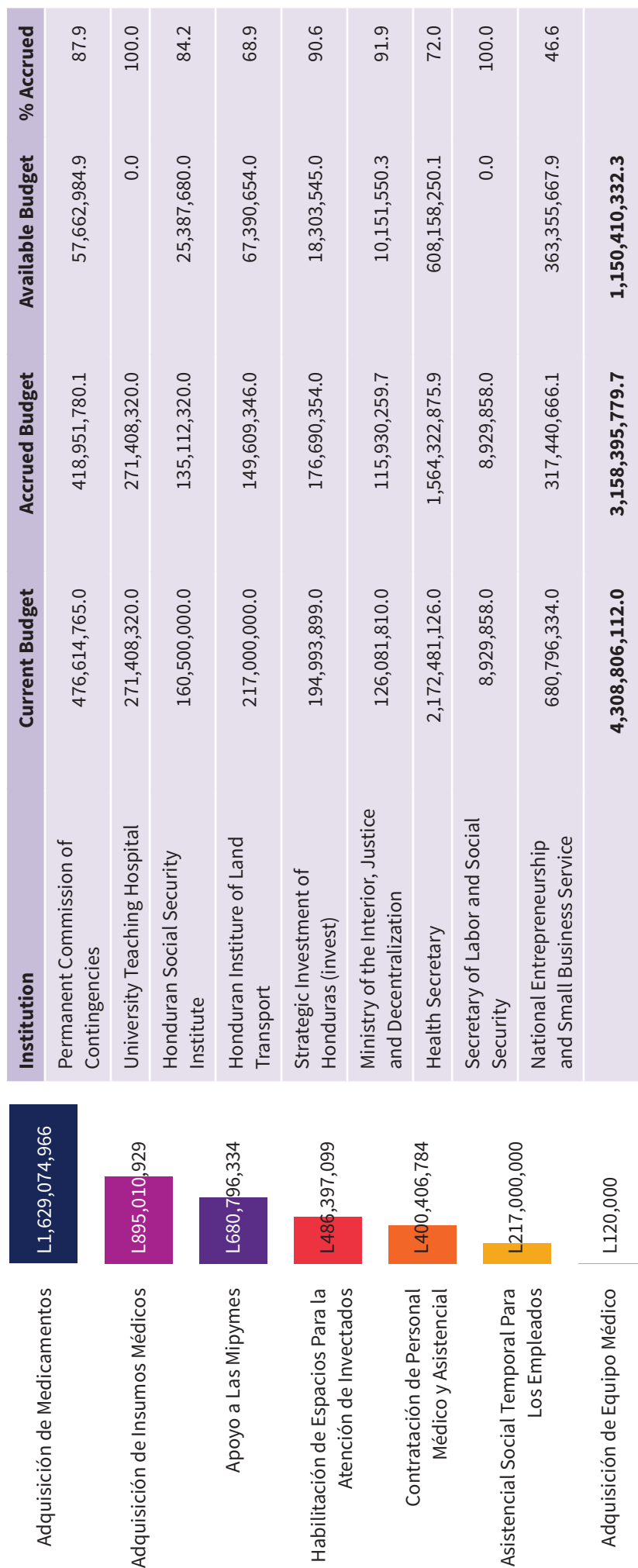
Source: CABRI<sup>42</sup>

**Publicly accessible portals have facilitated public visibility into spending on the response.** Several countries have implemented online portals to provide the public with access to the national FMIS database and for reports to be run and data analytics to be conducted. In Estonia, for example, the *Riigiraha* open data portal provides users with the facility to search the government’s financial database, generate reports, and prepare highly disaggregated analyses of the government’s financial flows. Similarly, in Brazil, the portal *Monitoramento dos Gastos da União com Combate à COVID-19* was developed through a Business Intelligence (BI) application on the FMIS database, and allows for real-time monitoring of crisis-related expenditures and the comparison of outturns with budgeted amounts [40]. Where existing government platforms were weaker, countries have set up separate portals. For instance, the Republic of Honduras has implemented a dedicated COVID-19 spending platform that provides disaggregated health spending data to the public (Figure 3), building transparency and public confidence in the response.

42 <https://www.cabri-sbo.org/en/events/financial-management-information-systems-balancing-flexibility-and-accountability-during-a-crisis>

**FIGURE 3.**

**Enhancing public transparency through digital technology: Honduras's e-platform for COVID-19 health spending data**



Source: Ministry of Finance, Honduras: <https://covid19.sefin.gob.hn/>

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**Real-time auditing can be an important tool for managing and accounting for emergency funding.**

This form of audit enables the auditing of transactions as the government receives and spends funds, providing an extra layer of assurance that money is being used for its intended purposes as it is being spent. This is particularly important during emergencies where money is rapidly mobilized and deployed, often outside of normal procedures, leaving room for irregularities and mismanagement. In Sierra Leone, real-time audits were conducted both during the Ebola outbreak and the COVID-19 response. In early 2020, at the onset of the COVID-19 pandemic, the government's Supreme Audit Institution announced the real-time audit of emergency funding to provide independent assurance that money was being spent as intended. This was of particular relevance as the emergency funds were not subject to the regular PFM rules and were managed as an EBF, until new legislation was introduced in August 2020. As of 2021, the audit had uncovered irregularities and mismanagement of funds such as unauthorized spending and inflated prices. The audit has also launched investigations into instances of corruption. Successful real-time audits require a strong legal mandate alongside strong institutional leadership, as was the case in Sierra Leone [41].

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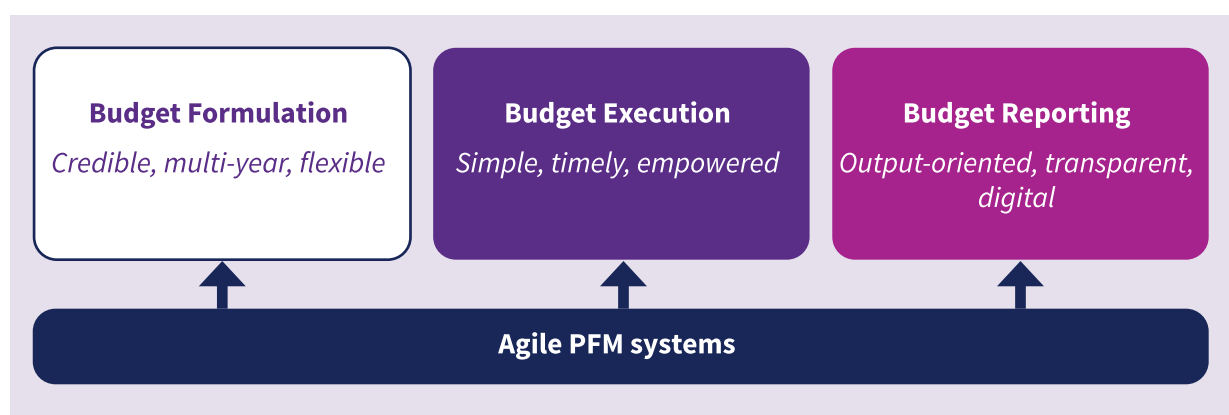
# 4. Moving forward: how to enhance PFM preparedness for health emergencies

**To be able to effectively adapt and respond quickly to health emergencies, PFM requires a comprehensive overhaul.** While key aspects of functioning PFM systems are common to all sectors, there are some specificities in health that require adjusting the PFM system to make it more agile and responsive to emergency needs. The health sector requires both predictable budget allocations and the ability to make in-year adjustments to meet evolving service needs [4], particularly during emergencies. PFM must be agile in deploying resources to spending units in a reliable and timely manner while also empowering service providers to access and use resources according to emerging needs [6]. Output-oriented accountability is another key requirement, shifting the focus from controlling the use of inputs to being accountable for outputs. This type of accountability is essential to building public trust, especially in an emergency context (Figure 4).

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**FIGURE 4.**

## Agile PFM for health



**There is a need to accelerate programme-based budgeting reforms to facilitate the alignment of budgets with priority needs and emergency contexts.** The COVID-19 pandemic has shown the need for built-in flexibilities in budgeting to allow budget allocation to respond more effectively to unforeseen events. Countries with programme-based budgets generally were able to quickly reallocate budgetary resources and respond to evolving COVID-19-related funding needs. Flexible re-allocation mechanisms within budgetary programme envelopes combined with fast-track spending modalities facilitated the management and reporting of funds for the health response. In contrast, countries with rigid line-item budget and disbursement structures found it much harder to redeploy resources quickly and effectively. By launching or accelerating their programme-based budgeting reforms, which can increase agility in allocation processes and promote strong accountability, countries will better be able to align budget and disbursement structures with the funding needs for the response to health emergencies.

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**Another key PFM reform to be anticipated is the revision of regulatory frameworks to enable front-line service providers to draw on financial resources in response to evolving circumstances.** Streamlined budget execution procedures have enabled governments to quickly disburse COVID-19-related funds to subnational entities and purchasers, but inefficiencies elsewhere in the PFM system have impeded some health service providers from receiving the funds they need in a timely fashion. Several governments have tested providing direct access to funding and/or front-loading funds, in replacement of or in combination with retrospective payments to enable more agile spending by these providers. Countries' demonstrations, under emergency conditions, provided helpful lessons on how to "engineer" those approaches with a combination of systems to ensure sound financial management by the service providers, while allowing those providers the flexibility to choose the right mix of inputs in response to service needs. These adjustments introduced during COVID-19 should be mainstreamed into regular budget processes.

**Increased flexibility for health facilities to draw on and expend financial resources must be accompanied by sound financial management and accountability.** Countries have adopted various measures to balance the demands of an urgent budgetary response with a high degree of accountability and transparency. Those adaptations, including real-time auditing, adjustments to FMIS, and transparency portals, have served to manage the COVID-19 pandemic and can also help to build longer-term improvements in accountability systems, including in the health sector. Recent efforts to mainstream PFM into global monitoring tools for pandemic preparedness and response (PPR) can also help to prepare financing systems to prepare for and respond to future infectious disease outbreaks and other health emergencies (see Annex 2 for details).

**Emergency procurement protocols should be updated.** Although in most countries these protocols are simplified and streamlined, the need to rapidly purchase COVID-19-related supplies revealed modalities that are cumbersome, unclear, or inconsistent with the specificities of health products, requiring governments to issue further detailed orders for those purchases. Refining and updating emergency procurement rules and procedures is critical for readying systems to handle future health emergencies. The response to the COVID-19 pandemic offers lessons for countries seeking to develop adaptive procurement rules that balance flexibility and transparency.

**Change and innovation should be focused on regular PFM systems.** Many countries with weak PFM systems have channelled COVID-19-related funding through extra-budgetary funds and mechanisms. While it may seem a good idea to cope with urgent funding needs by allowing spending flexibility outside of regular budget guidelines, the use of parallel mechanisms without well-defined standard operating procedures has generally not resulted in better targeting or faster disbursement for the health response. Governments can better prepare for the budgetary response to future health emergencies by strengthening their regular PFM capacities, while reducing fragmentation in spending and accounting modalities.

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# Annexes

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# PFM for COVID-19 vaccine roll-out: WHO mapping of key issues and policy options

Mapping how to channel necessary funds toward the COVID-19 vaccine roll-out is a key step alongside determining its cost. As vaccination is predominantly publicly funded and managed, efficiency and flexibility in PFM are critical. Preliminary country evidence indicates that PFM bottlenecks, regularly encountered in the health sector during normal times, are also affecting COVID-19 vaccination plans.<sup>43</sup> The key issues include: How are vaccines and vaccination delivery costs formulated in budget structures? How will funds flow to health service providers to cover operational costs? What are the rules for hiring and contracting temporary vaccinators? How will providers be incentivized for vaccination services? How can reporting mechanisms ensure financial accountability for vaccination-related expenditures? The below mapping (see Fig. A1.1, A1.2 and A1.3) identifies PFM “stress points” in each phase of the budget cycle (budget formulation, budget execution and budget reporting) that may arise throughout the vaccine roll-out. It also illustrates possible ways to overcome these barriers. This mapping is designed to help countries identify their own bottlenecks and practical solutions.

**FIG. A1.1.**

## Key PFM issues and possible policy options for COVID-19 vaccine roll-out in budget planning and formulation

BUDGET CYCLE STAGE	PFM ISSUES	POLICY OPTIONS
 <b>BUDGET PLANNING AND FORMULATION</b>	<b>Budget estimates</b> <ul style="list-style-type: none"> <li>• Disconnect between costing for COVID-19 vaccination and budgeting processes</li> <li>• Under-estimated costs for non-vaccine items and delivery costs</li> </ul>	<ul style="list-style-type: none"> <li>• Updating cost estimates and budget proposals to include comprehensive spending needs for vaccination plans</li> <li>• Protecting spending needs for essential health services</li> </ul>
	<b>Budget planning</b> <ul style="list-style-type: none"> <li>• Lack of vision over the medium term for budget planning and for aligning allocations with longer-term vaccination deployment needs</li> <li>• Fragmented budget planning and budget provisions (e.g. provisions in a health ministry budget, and an extra-budgetary fund.)</li> </ul>	<ul style="list-style-type: none"> <li>• Revising multi-year expenditure frameworks to provide a rolling horizon over two to three years and a consolidated vision on spending needs</li> <li>• Ensuring budgetary coordination across several ministries and/or entities, and between central and subnational levels</li> </ul>
	<b>Budget structure</b> <ul style="list-style-type: none"> <li>• Rigidities in resource allocation due to input-based budgeting (e.g. vaccine, cold chain, and other immunization support services all exist as separate line items)</li> </ul>	<ul style="list-style-type: none"> <li>• Creating temporary programme-type lines within a budget</li> <li>• Exploring extra-budgetary funds and their potential pros and cons</li> <li>• Accelerating the transition to programme-based budgeting to improve priority-setting and accountability and to make allocations more flexible</li> </ul>
	<b>Budget holders</b> <ul style="list-style-type: none"> <li>• Uncoordinated allocations to multiple budget holders</li> <li>• Complex execution and poor tracking system</li> </ul>	<ul style="list-style-type: none"> <li>• Transparent budget split between budget holders involved in COVID-19 vaccination</li> <li>• Consolidated operational and performance plan</li> </ul>

43 <https://p4h.world/en/PFM-Key-for-Effective-Roll-Out-of-COVID-19-Vaccines>

FIG. A1.2.

## Key PFM issues and possible policy options for COVID-19 vaccine roll-out in budget execution


BUDGET CYCLE STAGE	PFM ISSUES	POLICY OPTIONS
 BUDGET EXECUTION AND SPENDING MODALITIES	<b>Spending authorisation rules</b> <ul style="list-style-type: none"> <li>Cumbersome and multilayered spending authorization processes</li> <li>Delayed transfers to sub-national levels and purchasing agencies</li> </ul>	<ul style="list-style-type: none"> <li>Adjusting modalities to allow funds to be disbursed more easily upon appropriation (e.g. fast-track authorization for vaccine-related expenditures)</li> <li>Simplify spending procedures for budgetary transfers to entities in charge on vaccination delivery</li> <li>Adjusting and/or introducing budget formulas to account for variations in regional or community health needs</li> </ul>
	<b>Procurement rules</b> <ul style="list-style-type: none"> <li>Cumbersome procurement procedures</li> <li>Insufficient provisions in emergency procurement rules to allow direct contracting and advance payment to manufacturers for COVID-19 vaccines</li> </ul>	<ul style="list-style-type: none"> <li>Refining regulation to allow fast-track procurements procedures for the purchase of vaccines and non-vaccine items</li> <li>Maintain financial transparency requirements</li> </ul>
	<b>Provider contracting modalities</b> <ul style="list-style-type: none"> <li>Rigid personnel recruitment and contracting policies (eg for temporary vaccinators)</li> <li>Rigid or non-existent frameworks for contracting private providers</li> </ul>	<ul style="list-style-type: none"> <li>Revising regulatory frameworks to make it easier to contract temporary and/or private providers for vaccine deployment and to ensure that private providers are held accountable for outputs</li> </ul>
	<b>Payment and incentives to providers</b> <ul style="list-style-type: none"> <li>Inconsistent incentives to providers for effective vaccine roll-out</li> </ul>	<ul style="list-style-type: none"> <li>Revising payment methods to support effective service delivery (eg. introducing an additional fee to capitation payment rate)</li> </ul>
	<b>Rules for resource use by health service providers</b> <ul style="list-style-type: none"> <li>Lack of access by front-line workers to operational funds</li> <li>Cumbersome authorization and reporting rules against resource use</li> </ul>	<ul style="list-style-type: none"> <li>Updating PFM frameworks to allow front-line workers to receive and manage public funds directly (e.g. for operational costs linked to the vaccine roll-out)</li> </ul>

FIG. A1.3.

## Key PFM issues and possible policy options for COVID-19 vaccine roll-out in budget reporting

BUDGET CYCLE STAGE	PFM ISSUES	POLICY OPTIONS
EXPENDITURE REPORTING AND ACCOUNTABILITY	<b>Tracking expenditure</b> <ul style="list-style-type: none"> <li>Weak reporting systems</li> <li>Multiple reporting processes</li> <li>Narrow or incomplete view of spending</li> </ul>	<ul style="list-style-type: none"> <li>Adjusting FMIS to include new codes for COVID-19 expenditure related to vaccinations</li> <li>Introducing a budget tagging system within an existing programme structure, where relevant</li> <li>Considering the introduction of output-based tracking mechanisms</li> <li>Publicly releasing expenditure and performance data on vaccinations</li> </ul>
	<b>Large volume of spending not accounted for in Financial Management Information Systems (FMIS)</b> <ul style="list-style-type: none"> <li>Spending on external resources monitored through separate processes, verification systems and audits</li> </ul>	<ul style="list-style-type: none"> <li>Streamlining reporting modalities to avoid duplications and parallel reporting processes</li> <li>Strengthening domestic financial information systems and audit functions</li> </ul>
	<b>Lack of incentives for accountability by health service providers</b> <ul style="list-style-type: none"> <li>Poor accountability systems</li> <li>Tracking the consumption of inputs instead of performance</li> </ul>	<ul style="list-style-type: none"> <li>Refining contracts with service providers and performance agreements</li> </ul>

Source: WHO: <https://www.who.int/news/item/04-03-2021-resources-portal-on-pfm-for-health>

# WHO guidance for monitoring of health financing and PFM for pandemic preparedness and response

As of April 2022, 196 countries, including all WHO Member States, are parties to the International Health Regulations (IHR) (2005) treaty,<sup>44</sup> whose purpose is “to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.” Countries are required to “develop, strengthen and maintain [...] the capacity to detect, assess, notify and report events”. Financing is identified as a core capacity for pandemic preparedness and response (PPR) within two of the tools constituting the IHR (2005)’s Monitoring and Evaluation Framework: the State Party Self-Assessment Annual Report (SPAR) which countries are required to complete annually,<sup>45</sup> and the Joint External Evaluation (JEE) which is voluntary and recommended to take place every 4-5 years.

Each of these tools defines capacities or technical areas, and indicators – 15 capacities with 35 indicators for the SPAR (2021), and 19 technical areas with 49 indicators for the JEE (2018). The SPAR’s “Financing” capacity (C3)<sup>46</sup> includes indicators on “Financing for IHR implementation” (C3.1) and “Financing for public health emergency response” (C3.2) (see Fig. A2.1).

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44 [https://www.who.int/health-topics/international-health-regulations#tab=tab\\_1](https://www.who.int/health-topics/international-health-regulations#tab=tab_1)

45 Countries may report via the e-SPAR online platform, <https://extranet.who.int/e-spar>

46 “States Parties should ensure provision of adequate funding for the implementation of IHR capacities through the national budgetary process. Budget is an itemized summary of expected income and expenditure of a country over a specified period, usually a financial year, whereas financing and funding refers to money which a government or organization provides for a particular purpose.”

**FIG. A2.1.**

**Financing-related indicators within International Health Regulations (2005)’s mandatory State Party Self-Assessment Annual Reporting Tool (second edition, 2021)**

Indicators		
Level	C3.1. Financing for IHR implementation	
Level 1	There is no financial planning, budget line or budgetary allocation available to finance IHR implementation, and is handled through extrabudgetary <sup>17</sup> means	<input type="checkbox"/>
Level 2	Financial planning is limited with a budgetary allocation or substantial external financing <sup>18</sup> made for some of the relevant sectors <sup>19</sup> and their respective ministries to support the IHR implementation at the national level	<input type="checkbox"/>
Level 3	Financial planning based on identified gaps and estimated resource needs with a budgetary allocation and/or substantial external financing made for relevant sectors is available to support IHR implementation at national level and some monitoring and accountability mechanisms are in place	<input type="checkbox"/>
Level 4	Financial planning based on identified gaps and estimated resource needs with sufficient budgetary allocation for IHR implementation, that may include external financing. The budget is predictable, flexible, and distributed in a timely manner at the national and intermediate levels in all relevant ministries or sectors, with monitoring and accountability mechanisms in place to measure implementation and effectiveness	<input type="checkbox"/>
Level 5	Financial planning with sufficient budgetary allocation for IHR implementation, that may include external financing is available at national, intermediate and local levels and all sectors; with predictable and flexible budget, distributed in a timely manner. The country is able to collaborate and provide financial support to other countries considering regional priorities, needs and global threats  The budget is monitored against objectives, and accountability mechanisms are in place at each level for transparent and effective use of funds	<input type="checkbox"/>

Indicators		
Level	C3.2. Financing for public health emergency response	
Level 1	Public financing for responding to public health emergencies is not identified and funds are allocated and distributed in an ad hoc manner	<input type="checkbox"/>
Level 2	Public financing exists that allows for structured reception, rapid distribution and use of funds for responding to public health emergencies	<input type="checkbox"/>
Level 3	Public financing for responding to public health emergencies is identified for immediate mobilization when needed, at the national level for all the relevant sectors in advance of a public health emergency	<input type="checkbox"/>
Level 4	Public financing for responding to public health emergencies is in place at national and intermediate levels and allows for the timely execution of funds <sup>20</sup> by all relevant sectors during a public health emergency	<input type="checkbox"/>
Level 5	Public financing for responding to public health emergencies is in place, with an appropriate emergency contingency, at national intermediate and local levels, that allows for the timely execution of funds by all relevant sectors during a public health emergency. The country is able to collaborate and provide financial support to other countries during a public health emergency	<input type="checkbox"/>

Source: World Health Organization: <https://www.who.int/publications/i/item/9789240040120>

The JEE addresses financing as part of its “National Legislation, Policy and Financing” technical area, within the “Prevent” core area.<sup>47</sup> The relevant indicators, which were newly added for the second (2018) edition, are “Financing is available for the implementation of IHR capacities” (P.1.2), and “A financing mechanism and funds are available for timely response to public health emergencies» (P.1.3) (see Fig. A2.2).

47 The other technical areas in this core area are IHR coordination, communication and advocacy; Antimicrobial resistance; Zoonotic disease; Food safety; Biosafety and biosecurity; and Immunization.

**FIG. A2.2.**

**Financing-related indicators within International Health Regulations (2005)’s voluntary Joint External Evaluation Tool (second edition, 2018)**

Score	Indicators: National legislation, policy and financing		
	P.1.1 The State has assessed, adjusted and aligned its domestic legislation, policies and administrative arrangements in all relevant sectors, <sup>4,5</sup> to enable compliance with the IHR	P.1.2 Financing <sup>6</sup> is available for the implementation of IHR capacities	P.1.3 A financing mechanism and funds are available for timely response to public health emergencies <sup>8</sup>
<b>No capacity - 1</b>	Assessment of relevant legislation, regulations, administrative requirements and other government instruments not undertaken for the implementation of IHR	There is no budget line or budgetary allocation <sup>9</sup> available to finance the implementation of IHR capacities, and financing for implementation of IHR capacities is handled through extra-budgetary means <sup>10</sup>	Financing for responding to public health emergencies is not identified and funds are allocated and distributed in an ad hoc manner during a public health emergency
<b>Limited capacity - 2</b>	Assessment of relevant legislation, regulations, administrative requirements and other government instruments for IHR implementation has been carried out and required adjustments have been identified	A budgetary allocation or substantial external financing <sup>11</sup> is made for some of the relevant sectors <sup>12</sup> and their respective ministries to support the implementation of IHR capacities for biological hazards <sup>14</sup> at the national level	An emergency public financing mechanism exists <sup>15</sup> that allows for structured reception and rapid distribution of funds for responding to public health emergencies
<b>Developed capacity - 3</b>	The country can demonstrate the existence and use of relevant legislation in all relevant sectors involved in the implementation of the IHR <sup>16</sup>	A budgetary allocation or substantial external financing is made for human health, veterinary public health, agriculture, and all other relevant ministries or sectors, to support the implementation of all <sup>17</sup> IHR capacities at the national level	Financing for response is identified <sup>18</sup> for immediate mobilization when needed, at the national, state, province and regional levels for all the relevant sectors <sup>19</sup> in advance of a public health emergency
<b>Demonstrated capacity - 4</b>	The country has legislation references and/or administrative requirements for specific areas (such as current legislation that specifically addresses National IHR Focal Point designation and operations)	A sufficient budget <sup>20</sup> is allocated with timely distribution <sup>21</sup> at the national and subnational level(s) in all relevant ministries or sectors for the implementation of all IHR capacities	The emergency public financing mechanism in place allows for the timely execution <sup>22</sup> of funds <sup>23</sup> by all relevant sectors, during a public health emergency
<b>Sustainable capacity - 5</b>	The country has legislation references and/or administrative requirements for all areas related to IHR implementation	A sufficient budget that is distributed in a timely manner at the national and subnational level(s) in all relevant ministries or sectors is well coordinated in its execution <sup>24</sup> , for the implementation of all IHR capacities	Financing can be executed and monitored <sup>25</sup> in a timely and coordinated manner at all levels and for all relevant sectors, with an emergency contingency fund <sup>26</sup> in place, for response to an acute public health emergency

Source: World Health Organization: <https://extranet.who.int/sph/sites/default/files/document-library/document/9789241550222-eng.pdf>

Regular use by countries of these monitoring tools will give them and their partners a clearer picture of the availability of funding, and the efficacy of funding mechanisms, both to ensure routine adherence to IHR (2005) requirements and to detect and respond to health emergencies as they arise – as well as areas needing strengthening or improvement.

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# References

1. Global spending on health 2020: weathering the storm. Geneva: World Health Organization; 2020 (<https://www.who.int/publications/i/item/9789240017788>, accessed 10 April 2022).
2. Global expenditure on health: public spending on the rise? Geneva: World Health Organization; 2021 (<https://www.who.int/publications/i/item/9789240041219>, accessed 10 April 2022).
3. Health financing for the COVID-19 response: process guide for national budgetary dialogue. ACT-A Health Systems Connector. Geneva: World Health Organization; 2021 (<https://www.who.int/publications/i/item/9789240030527>, accessed 10 April 2022).
4. Barroy H, Dale E, Sparkes S, Kutzin J. Budget matters for health: key formulation and classification issues. Geneva: World Health Organization; 2018 (Health financing policy brief, No. 4; Budgeting in health; <https://apps.who.int/iris/handle/10665/273000>, accessed 10 April 2022).
5. Piatti-Fünfkirchen M, Barroy H, Pivodic F, Margini F. Budget execution in health: concepts, trends and policy issues. Washington, DC: World Bank Group; 2021 (<http://hdl.handle.net/10986/36583>, accessed 10 April 2022).
6. Barroy H et al. If you're not ready, you need to adapt: lessons for managing public finances from the COVID-19 response. P4H blog; 26 October 2020 (<https://p4h.world/en/blog-lessons-for-managing-public-finances-from-COVID-19-response>, accessed 10 April 2022).
7. Barroy H et al. Why PFM is key for effective roll out of COVID-19 vaccines. P4H blog; 12 May 2021 (<https://p4h.world/en/PFM-Key-for-Effective-Roll-Out-of-COVID-19-Vaccines>, accessed 10 April 2022).
8. Saxena S, Stone M. Preparing public financial management systems to meet Covid-19 challenges. International Monetary Fund Public Financial Management blog; 13 March 2020 (<https://blog-pfm.imf.org/pfmblog/2020/03/preparing-public-financial-management-systems-to-meet-covid-19-challenges.html>, accessed 10 April 2022).
9. Allen R. How budgeting systems can prepare better for health emergencies: six lessons from the COVID-19 crisis. Unpublished communication for the 5<sup>th</sup> WHO Montreux Collaborative meeting on fiscal space, public financial management and health financing. 2021.
10. Barroy H, Wang D, Pescetto C, Kutzin J. How to budget for COVID-19 response? A rapid scan of budgetary mechanisms in highly affected countries. Geneva: World Health Organization; 2020 (<https://www.who.int/publications/m/item/how-to-budget-for-covid-19-response>, accessed 10 April 2022).
11. Third round of the global pulse survey on continuity of essential health services during the COVID-19 pandemic: November-December 2021. Interim report. Geneva: World Health Organization; 2022 ([https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS\\_continuity-survey-2022.1](https://www.who.int/publications/i/item/WHO-2019-nCoV-EHS_continuity-survey-2022.1), accessed 10 April 2022).
12. Fiscal Monitor, October 2021: Strengthening the credibility of public finances. Washington (DC): International Monetary Fund; 2021 (<https://www.imf.org/en/Publications/FM/Issues/2021/10/13/fiscal-monitor-october-2021>, accessed 10 April 2022).
13. Rahim F, Allen R, Barroy H, Gores L, Kutzin J. COVID-19 funds in response to the pandemic. International Monetary Fund Public Financial Management blog; 27 August 2020 (<https://blog-pfm.imf.org/pfmblog/2020/08/-covid-19-funds-in-response-to-the-pandemic-.html>, accessed 10 April 2022).
14. Sabignoso M. Public financial management and strategic purchasing review of COVID-19 response in Argentina. Unpublished communication for the 5<sup>th</sup> WHO Montreux Collaborative meeting on fiscal space, public financial management and health financing; 2021.
15. Wee-Co PA, Apostol V, Ravishankar N. Strengthening public financial management systems and practices for health in response to COVID-19: a perspective from the Philippines. Manila: ThinkWell; 2022 ([https://thinkwell.global/wp-content/uploads/2022/02/PFM-COVID-in-Philippines\\_Report-2.7.22-FINAL-1.pdf](https://thinkwell.global/wp-content/uploads/2022/02/PFM-COVID-in-Philippines_Report-2.7.22-FINAL-1.pdf), accessed 10 April 2022).

- 
16. Davén J, Thokoa R, Gaarekwe O, Blecher M. Public finance management mechanisms and practices used in South Africa's health response to COVID-19. Unpublished communication for the 5th WHO Montreux Collaborative meeting on fiscal space, public financial management and health financing; 2021.
  17. Managing COVID funds: the accountability gap. Washington, DC: International Budget Partnership; 2021 ([https://internationalbudget.org/covid/wp-content/uploads/2021/05/Report\\_English-2.pdf](https://internationalbudget.org/covid/wp-content/uploads/2021/05/Report_English-2.pdf), accessed 10 April 2022).
  18. Budgeting in the context of COVID-19: Trends and tools of reallocations. Collaborative Africa Budget Reform Initiative; 2021 (COVID-19 Africa Public Finance Response Monitor; <https://www.cabri-sbo.org/en/publications/budgeting-in-the-context-of-covid-19-trends-and-tools-of-reallocations>, accessed 10 April 2022).
  19. Barroy H, Blecher M, Lakin J. How to make budgets work for health? A practical guide to designing, implementing and monitoring programme budgets in health. Geneva: World Health Organization; 2022.
  20. Government financial management and reporting in times of crisis. Paris: Organisation for Economic Co-operation and Development; 2020 (OECD Policy Responses to Coronavirus (COVID-19); <https://www.oecd.org/coronavirus/policy-responses/government-financial-management-and-reporting-in-times-of-crisis-3f87c7d8/>, accessed 10 April 2022).
  21. Barroy H, Gurazada S, Piatti-Fünfkirchen M, Kutzin J. No calm after the storm: time to retool country PFM systems in the health sector. P4H blog; 21 May 2020 (<https://p4h.world/en/who-wb-no-calm-after-the-storm-time-to-retool-country-pfm-systems-in-health-sector>, accessed 10 April 2022).
  22. Barroy H, Kabaniha G, Boudreaux C, Cammack T, Bain N. Leveraging PFM for better health in Africa: key bottlenecks and opportunities for reform. Geneva: World Health Organization; 2019 (Health financing working paper, No. 14; <https://apps.who.int/iris/handle/10665/339297>, accessed 10 April 2022).
  23. Ministry of Finance, Estonia; 2020 (<https://www.fin.ee/>).
  24. Rajan D et al. "Build forward better" must include heavy investment in government capacities to engage with communities and civil society. Eurohealth. 2021;27:1 (<http://apps.who.int/iris/bitstream/handle/10665/344952/Eurohealth-27-1-54-59-eng.pdf>, accessed 10 April 2022).
  25. Barroy H, Kutzin J. COVID-19 as an opportunity for PFM transformation in health. International Monetary Fund Public Financial Management blog; 14 February 2022 (<https://blog-pfm.imf.org/pfmblog/2022/02/-covid-19-as-an-opportunity-for-pfm-transformation-in-health.html>, accessed 10 April 2022).
  26. Sabignoso M, Zanassi L, Sparkes S, Mathauer I. Strengthening the purchasing function through results-based financing in a federal setting: lessons from Argentina's Programa Sumar. Geneva: World Health Organization; 2020 (Health financing working paper, No. 15; <https://www.who.int/publications/item/9789240003651>, accessed 28 April 2022).
  27. Mathauer I, Dale E, Jowett M, Kutzin J. Purchasing health services for universal health coverage: How to make it more strategic? Geneva: World Health Organization; 2019 (Health financing policy brief, No. 6; <https://apps.who.int/iris/bitstream/handle/10665/311387/WHO-UCH-HGF-PolicyBrief-19.6-eng.pdf?sequence=1&isAllowed=y>, accessed 18 May 2022).
  28. Potter BH, Diamond J. Guidelines for public expenditure management. Washington (DC): International Monetary Fund; 1999 (<https://www.imf.org/external/pubs/ft/extend/index.htm>, accessed 10 April 2022).
  29. COVID-19 vaccine financing, procurement and distribution in African ministries of finance and health. Collaborative Africa Budget Reform Initiative; 2021 (COVID-19 Africa Public Finance Response Monitor; <https://www.cabri-sbo.org/en/publications/covid-19-vaccine-financing-procurement-and-distribution-in-african-ministries-of-finance-and-health>, accessed 10 April 2022).
  30. Torbert S. A call to action on open budgets during the COVID-19 response. Oxfam From Poverty to Power blog; 20 May 2020 (<https://oxfamapps.org/fp2p/a-call-to-action-on-open-budgets-during-the-covid-19-response/>, accessed 10 April 2022).

- 
31. Cocciolo S, Di Maro V, Samaddar S. Global survey highlights challenges and opportunities for public procurement during the Covid-19 pandemic. World Bank Governance for Development blog; 12 August 2020 (<https://blogs.worldbank.org/governance/global-survey-highlights-challenges-and-opportunities-public-procurement-during-covid-19>, accessed 10 April 2022).
  32. Lessons from the COVID-19 pandemic: findings and recommendations for better emergency procurement. Open Contracting Partnership; 2020 (<https://www.open-contracting.org/wp-content/uploads/2020/10/OCP2020-Action-Research-COVID19.pdf>, accessed 10 April 2022).
  33. Direct facility financing: concept and role for UHC. Geneva: World Health Organization; 2022 (<https://www.who.int/publications/i/item/9789240043374>, accessed 10 April 2022).
  34. Barroy H et al. Let managers manage, a health service provider's perspective on public financial management. World Bank Investing in Health blog; 9 September 2019 (<https://blogs.worldbank.org/health/let-managers-manage-health-service-providers-perspective-public-financial-management>, accessed 10 April 2022).
  35. Kang H, Kwon S, Kim E. COVID-19 health system response monitor: Republic of Korea. World Health Organization. Regional Office for South-East Asia; 2020 (<https://apps.who.int/iris/handle/10665/337371>, accessed 10 April 2022).
  36. Audit Service Sierra Leone. Report on the Audit of Funds managed by the National COVID-19 Emergency Response Centre and other Ministries Departments and Agencies. 2020. <https://www.auditservice.gov.sl/wp-content/uploads/2020/12/Report-on-the-Audit-of-Funds-managed-by-NaCOVERC-and-other-MDAs.-March-June-2020.pdf>
  37. Office of the Auditor General. Utilization of COVID-19 funds by Kenya Medical Supplies Authority (KEMSA). 2020. OAG, Kenya. <https://www.oagkenya.go.ke/wp-content/uploads/2021/09/UTILIZATION-OF-COVID-19-FUNDS-BY-KEMSA-2020.pdf>
  38. Fouad M, Schwartz G, Wendling C. “Do whatever it takes but keep the receipts”—the public financial management challenges. International Monetary Fund Public Financial Management blog; 22 April 2020 (<https://blog-pfm.imf.org/pfmblog/2020/04/-do-whatever-it-takes-but-keep-the-receiptsthe-public-financial-management-challenges-.html>, accessed 10 April 2022).
  39. Kinyanjui F, Ochieng A, Rugo A, Kinuthia J. Hits and misses: budget credibility in the context of COVID-19 in Kenya. International Budget Partnership Kenya; 2021 ([https://internationalbudget.org/covid/wp-content/uploads/2021/08/Kenya-Brief-Managing-COVID-Funds\\_Paper.pdf](https://internationalbudget.org/covid/wp-content/uploads/2021/08/Kenya-Brief-Managing-COVID-Funds_Paper.pdf), accessed 1 May 2022).
  40. Una G, van Eden H, Singh A, Bardella F, Verma A. Enhancing digital solutions to implement emergency responses. Fiscal Affairs. Washington (DC): International Monetary Fund; 2020 (Special Series on COVID-19; [https://socialprotection.org/sites/default/files/publications\\_files/en-special-series-on-covid-19-enhancing-digital-solutions-to-implement-emergency-responses.pdf](https://socialprotection.org/sites/default/files/publications_files/en-special-series-on-covid-19-enhancing-digital-solutions-to-implement-emergency-responses.pdf), accessed 10 April 2022).
  41. Mills L. Closing the COVID Accountability Gap: Leveraging Ebola's Auditing Lessons in Sierra Leone. International Budget Partnership; [no date] (<https://internationalbudget.org/wp-content/uploads/IBP-Leveraging-Ebolas-Auditing-Lessons-in-Sierra-Leone.pdf>, accessed 1 May 2022).





