Public Disclosure Authorized

DIAGNOSTIC STUDY OF PUBLIC FINANCIAL MANAGEMENT:

TO STRENGTHEN HEALTH FINANCING AND SERVICE DELIVERY IN BANGLADESH

Public Disclosure Authorized

DISCUSSION PAPER April 2019

Shakil Ahmed
Tahmina Begum
Owen Smith

Public Disclosure Authorized

WORLD BANK GROUP
Health, Nutrition & Population

DIAGNOSTIC STUDY OF PUBLIC FINANCIAL MANAGEMENT:

To Strengthen Health Financing and Service Delivery in Bangladesh

Shakil Ahmed, Tahmina Begum, and Owen Smith

April 2019

Health, Nutrition, and Population (HNP) Discussion Paper

This series is produced by the Health, Nutrition, and Population Global Practice of the World Bank. The papers in this series aim to provide a vehicle for publishing preliminary results on HNP topics to encourage discussion and debate. The findings, interpretations, and conclusions expressed in this paper are entirely those of the author(s) and should not be attributed in any manner to the World Bank, to its affiliated organizations, or to members of its Board of Executive Directors or the countries they represent. Citation and the use of material presented in this series should take into account this provisional character.

The World Bank does not guarantee the accuracy of the data included in this work. The boundaries, colors, denominations, and other information shown on any map in this work do not imply any judgment on the part of the World Bank concerning the legal status of any territory or the endorsement or acceptance of such boundaries.

For information regarding the HNP Discussion Paper Series, please contact the Editor, Martin Lutalo, at mlutalo@worldbank.org or Erika Yanick at eyanick@worldbank.org.

Rights and Permissions

The material in this work is subject to copyright. Because the World Bank encourages dissemination of its knowledge, this work may be reproduced, in whole or in part, for noncommercial purposes as long as full attribution to this work is given.

Any queries on rights and licenses, including subsidiary rights, should be addressed to World Bank Publications, The World Bank Group, 1818 H Street, NW, Washington, DC 20433, USA; fax: 202-522-2625; e-mail: pubrights@worldbank.org.

© 2019 The International Bank for Reconstruction and Development / The World Bank
1818 H Street, NW, Washington, DC 20433
All rights reserved.

Health, Nutrition, and Population (HNP) Discussion Paper

Diagnostic Study of Public Financial Management:
To Strengthen Health Financing and Service Delivery in Bangladesh

Shakil Ahmed,[a] Tahmina Begum,[b] and Owen Smith[c]

a. Senior Economist (Health), Health, Nutrition, and Population Global Practice, World Bank, Dhaka, Bangladesh.
b. Consultant, Health, Nutrition, and Population Global Practice, World Bank, Dhaka, Bangladesh.
c. Senior Economist, Health, Nutrition, and Population Global Practice, New Delhi, India.

Abstract:

Robust public financial management (PFM) systems are crucial to ensure the efficacy and integrity of public health spending, thereby contributing to improved service coverage and financial protection, as required for achieving universal health coverage. A weak PFM system has impeded implementation of the Bangladesh Health Care Financing Strategy 2012–2032. This paper aims to identify and document major PFM challenges in relation to the interventions outlined in this strategy document, on the grounds that relaxing these constraints would strengthen implementation. Further, the study examines PFM barriers in service delivery, such as delays in fund availability and procurement and the lack of operational funds at the facility level. The paper points to a number of obstacles, including the absence of a legal framework for implementing a social health protection scheme, no laws to retain user fees at health facilities or to change financial rules to introduce "Flexible Cash at Facilities," district health managers without delegated financial power, noncompliance with audit observations, and need for PFM capacity strengthening. Short-, medium- and long-term actions are proposed to address these PFM issues. Removing these barriers would not require significant additional resources, but would offer the potential to significantly enhance value for money for Bangladesh's government health budget.

Keywords: Public financial management, health financing strategy, health service delivery.

Disclaimer: The findings, interpretations, and conclusions expressed in the paper are entirely those of the authors, and do not represent the views of the World Bank, its Executive Directors, or the countries they represent.

Correspondence Details: Shakil Ahmed (sahmed35@worldbank.org), Dhaka, Bangladesh.

Table of Contents

ACRONYMS ..... **V**

ACKNOWLEDGMENTS ..... **IX**

INTRODUCTION **1**

LINKAGES BETWEEN THE HEALTH CARE FINANCING STRATEGY AND PUBLIC FINANCIAL MANAGEMENT **3**

- GENERATE MORE RESOURCES FOR EFFECTIVE HEALTH SERVICES 3
- ENHANCE EFFICIENCY IN RESOURCE ALLOCATION AND UTILIZATION 15
- IMPROVE EQUITY AND INCREASE HEALTH CARE ACCESS ESPECIALLY FOR THE POOR AND VULNERABLE 18

LINKAGES BETWEEN PFM AND HEALTH SERVICE DELIVERY IN BANGLADESH **23**

- ENHANCE EFFICIENCY IN BUDGET EXECUTION TO IMPROVE HEALTH SERVICE DELIVERY 23
- BUDGET REPORTING FOR MONITORING AND ACCOUNTABILITY 37

STRENGTHENING THE CAPACITY FOR PFM **41**

RECOMMENDATIONS **43**

REFERENCES **47**

ANNEX 1: **51**

- ANNEX TABLE: OPERATIONAL PLAN BUDGET AND EXPENDITURE AS A SHARE OF HPNSDP PROGRAM IMPLEMENTATION PLAN AND REVISED PROGRAM IMPLEMENTATION PLAN (FY2012–FY2016) 51

ACRONYMS

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

HCF	Health Care Financing
HCFS	Health Care Financing Strategy
HED	Health Engineering Department
HEF	Health Economics and Financing
HEP	Health Education and Promotion
HEU	Health Economics Unit
HIS-EH	Health Information Systems and E-Health
HNP	Health, Nutrition, and Population
HNPSP	Health, Nutrition, and Population Sector Programme
HPNSDP	Health, Population, and Nutrition Sector Development Programme
HPNSP	Health, Population, and Nutrition Sector Programme
HPSP	Health and Population Sector Programme
HNPSIP	Health, Nutrition, and Population Strategic Investment Plan
HR	Human Resources
HRM	Human Resources Management
HSD	Health Services Division
HSM	Hospital Services Management
iBAS	Integrated Budgeting and Accounting System
ICMAB	Institute of Cost and Management Accountants of Bangladesh
IEC	Information, Education, and Communication
IFM	Improved Financial Management
IST	In-Service Training
LD	Line Director
MBF	Ministry Budget Framework
MCH	Maternal and Child Health
MCRAH	Maternal, Child, Reproductive, and Adolescent Health
MCWC	Mother and Child Welfare Centre
MEFWD	Medical Education and Family Welfare Division
MHVS	Maternal Health Voucher Scheme
MIS	Management Information System
MNCH	Maternal, Neonatal, and Child Health
MNCAH	Maternal, Neonatal, Child, and Adolescent Health
MOF	Ministry of Finance
MOHFW	Ministry of Health and Family Welfare
MSR	Medical and Surgical Requisites
MTBF	Medium-Term Budgetary Framework
MTMPS	Medium-Term Macroeconomic Policy Statement
MTSO	Medium-Term Strategic Objective
NASP	National AIDS and STD Program
NCD	Noncommunicable disease
NEC	National Eye Care
NEMEMW	National Electro-Medical Equipment Maintenance Workshop and Training Center
NES	Nursing Education and Services
NGO	Nongovernmental Organization

NHSO	National Health Security Office
NIPORT	National Institute of Population Research and Training
NNS	National Nutrition Services
NSSS	National Social Security Strategy
ODI	Overseas Development Institute
OECD	Organisation for Economic Co-operation and Development
OOP	Out-of-pocket
OP	Operational Plan
OPD	Outpatient Department
PA	Project Aid
PD	Project Director
PER	Public Expenditure Review
PFD	Physical Facilities Development
PFM	Public financial management
PIP	Program Implementation Plan
PLSM	Procurement, Logistics, and Supplies Management
PME-FP	Planning, Monitoring, and Evaluation of Family Planning
PMMU	Program Management and Monitoring Unit
PMR	Planning, Monitoring, and Research
PNC	Postnatal Care
PPA	Public Procurement Act
PPR	Public Procurement Rule
PSE	Preservice Education
PSSM	Procurement, Storage, and Supplies Management
PWD	Public Works Department
RADP	Revised Annual Development Programme
RAF	Resource Allocation Formula
RMO	Resident Medical Officer
RPA	Reimbursable Project Aid
RPIP	Revised Program Implementation Plan
SDAM	Strengthening of Drug Administration and Management
SIP	Sector Investment Plan
SOE	Statement of Expenditure
SRO	Statutory Regulatory Order
SSK	Shasthya Surokhsha Karmasuchi
SWAp	Sector-wide Approach
SWPMM	Sector-wide Program Management and Monitoring
THE	Total Health Expenditure
TAPP	Technical Assistance Project Proforma
TB-LC	TB and Leprosy Control
TEMO	Transport & Equipment Maintenance Organization
ssTRD	Training, Research, and Development
UAO	Upazila Accounts Officer
UHC	Universal Health Coverage

UFPO	Upazila Family Planning Officer
UHFPO	Upazila Health and Family Planning Officer
UHFWC	Union Health and Family Welfare Center
UzHC	Upazila Health Complex
WHO	World Health Organization

ACKNOWLEDGMENTS

The authors acknowledge the valuable contribution of Rezauddin Muhammad Chowdhury and Dr Saidur Rahman Bhuiyan (Consultants, World Bank) in the collection and documentation of data from various ministries.

The authors are deeply appreciative of the guidance they received from Md. Ashadul Islam, former Director General, Health Economics Unit, Ministry of Health and Family Welfare, Government of Bangladesh. E. Gail Richardson (Practice Manager, World Bank) provided valuable guidance and feedback. Suraiya Zannath (Lead Financial Management Specialist, World Bank), Zahid Hussain (Lead Economist, World Bank), and Hasib Ehsan Chowdhury (Financial Management Specialist, World Bank) provided important input. The authors also acknowledge the valuable information provided by Tekabe Ayalew Belay (Program Leader, World Bank). Finally, the authors would like to thank World Bank peer reviewers Furqan Ahmad Saleem and David W. Wachira for their comments.

The authors are grateful to the World Bank for publishing this report as an HNP Discussion Paper.

INTRODUCTION

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

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

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

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

This diagnostic study intends to identify and document major PFM concerns and issues in relation to Bangladesh's HCFS 2012–2032 and its health service delivery. Implementation of the HCFS 2012–2032 has been underscored in the Seventh Five Year Plan (FYP) (GOB 2015a) and in the National Social Security Strategy (NSSS) (GOB 2015b) as a major priority. Implementation of the HCFS 2012–2032 has been slow, and PFM appears to be one of the barriers. This study attempts to diagnose the most critical constraints to

implementation of the HCFS 2012–2032 and service delivery arrangements in achieving the desired goals. The assumption is that the removal of these constraints would yield the highest welfare gains.

This diagnostic study has three objectives: (i) identify PFM-related bottlenecks to HCFS 2012–2032 implementation, (ii) examine the link between PFM and health service delivery, and (iii) inform the Ministry of Health and Family Welfare (MOHFW), the Ministry of Finance (MOF), and relevant stakeholders on specific PFM barriers and inefficiencies in the Bangladesh HNP sector with possible options for addressing them. The study examines elements of PFM and health financing considered critical to effective and efficient health service delivery. Further, It identifies health financing and common health sector service delivery constraints and opportunities, their underlying PFM-related factors, and possible resolutions.

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

The MOF and MOHFW were the main sources of quantitative data. Data included budget, revised budget, and actual MOHFW expenditure for both nondevelopment and development from the Integrated Budget and Accounting System (iBAS). One caveat of the iBAS data is that it does not include expenditure of Direct Project Aid (DPA) under the development budget. Additional data on fund release were collected from the Planning Wing and the MOHFW's Project Implementation Branch. Fund release–related data for one Operational Plan (OP) was tracked for each quarter of the five fiscal years (2011–12 to 2015–16) during the third HNP sector program. Since MOHFW fund release data are not yet computerized, data were obtained by going through several files page by page for only one OP. Due to limited access and time constraints, it was not feasible to go through all the files for all OPs. Data from the MOF were obtained for seven financial years from 2009–10 to 2015–16, covering two years of the second HNP sector program and five years of the third HNP sector program.

Key informant interviews were conducted with 55 policy makers and program managers at the national and subnational levels, as well as with officials involved in the implementation of health financing schemes. Key informants were asked about their opinions and experiences concerning the implementation of Bangladesh HCFS 2012–2032 to accelerate UHC. Key informants were guaranteed anonymity to encourage open discourse. Two field visits were conducted to collect data from district and *upazila* (subdistrict) levels. The study team visited Jhenidaha and Tangail Districts and Kalihati Upazila of Tangail District. These districts are implementing Shasthya Surokhsha Karmasuchi (SSK), Maternal Health Voucher Scheme (MHVS), and Community Support Committee (CSC) funds. The focus of data collection was to identify PFM barriers and potential sources of inefficiencies.

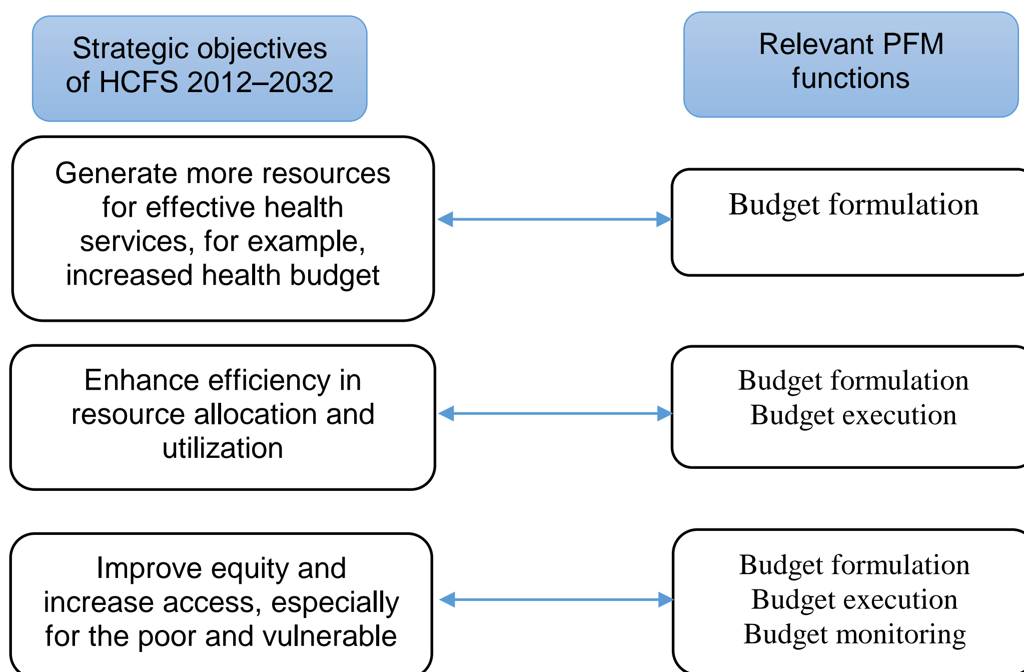
This report is structured in the following manner: The introduction is followed by an analytical section on the link between the HCFS 2012–2032 and PFM, with a focus on budget preparation and planning. The third section describes how PFM influences health service delivery in Bangladesh, with a focus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

LINKAGES BETWEEN THE HEALTH CARE FINANCING STRATEGY AND PUBLIC FINANCIAL MANAGEMENT

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

The HCFS has proposed interventions and supporting actions to achieve stated strategic objectives; for instance, HCFS outlines how strengthening financial management (FM) and accountability at all levels will strengthen national capacity. This section discusses how PFM arrangements influence the three key strategic objectives of the HCFS 2012–2032.

Figure 1: Link between Strategic Objectives of Health Care Financing Strategy 2012–2032 and Relevant Public Financial Management Functions



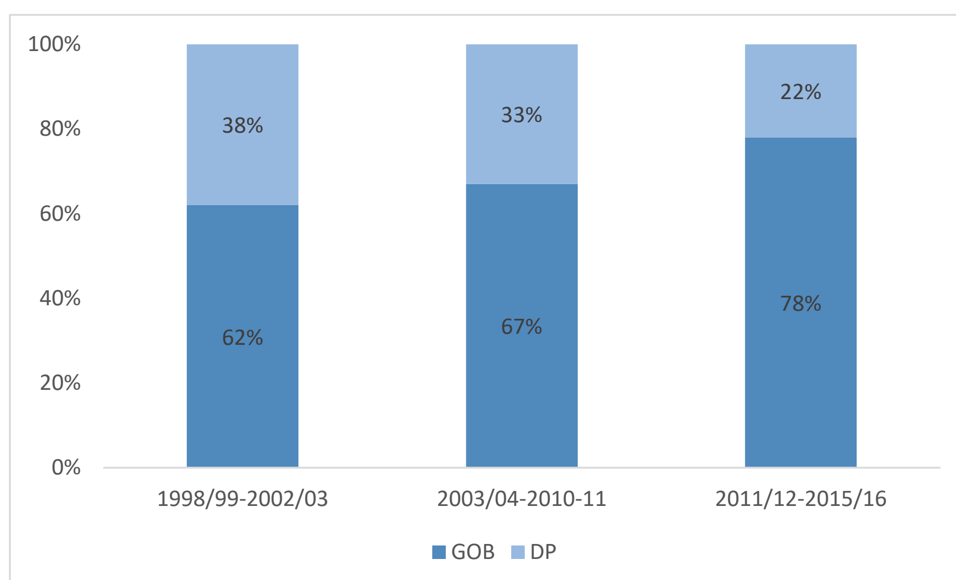
GENERATE MORE RESOURCES FOR EFFECTIVE HEALTH SERVICES

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

Bangladesh is projected to become a middle-income country by 2021, and, as expected, grant aid is falling. The share of DP financing in the health sector dropped from 38 percent during FY1999 to FY2003 to 22 percent during the period between FY2012 to FY2016

(Figure 2). Although some DPs providing development assistance have left the sector, some new initiatives are emerging (World Bank 2016a). However, it is likely that net DP assistance will decline steadily in the medium term (World Bank 2016a) as the country aspires to middle-income–country status by 2021. Therefore, mobilizing domestic resources for the health sector should be the foremost policy priority. Financing health in Bangladesh over the short to medium term will require a combination of existing as well as additional domestic resources that accrue from economic growth, improved tax collection, and, most significantly, moderate reprioritization of the budget in favor of the health sector. A World Bank (2016a) report highlighted that if insurance contributions are introduced—given implementation challenges—they are more likely to generate additional resources for the health sector only over a medium to long term.

Figure 2: Declining Share of Development Partner Contribution to the Health Sector



Source: PMMU 2013.

The Community Support Committee (CSC) Fund is a new Domestic Resource Mobilization (DRM) initiative, which was not proposed in the HCFS. Local-level resource generation is an option for expanding and improving health service delivery. The Health Economics Unit (HEU) of the MOHFW formed a Community Support Committee as stipulated by a government order.[1] The committee consists of 14 members; the local municipality mayor serves as its chairman. Separate 11 committees are working in 11 districts of the country. Crucially, these committees have involved local authorities and representatives to combat financial and other barriers associated with the provision of better quality health care. The committees' responsibilities include the following:

- To ensure support to the hospital authority for effective clinical service delivery
- To ensure provision of all nonclinical services and other amenities, including provision of drinking water as well as the safety and security of patients and their attendants

1. Order issued on October 5, 2016, MOHFW, Memo No. 709.

- To ensure supply/availability of required medicines, reagents, equipment, furniture, and other inputs and supplies (X-ray/ultrasonogram film, electrocardiography papers, and stationery)

- To implement sanitary and hygienic measures, including for clean toilet facilities for patients and their attendants

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

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

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

- To ensure effective in-house and outside waste management

- To introduce patient-centered services

Committee members collect funds from private clinics, pharmaceutical companies, and wealthier and more responsive community members. The committee deposits the collected funds in a local bank account. In most cases, individuals, companies, and entities directly pay the salary of security guards and cleaners from their own accounts. They also directly finance the furnishing of rooms and toilets and donate equipment, such as air conditioners, according to the needs and the availability of funds.

Receiving funds from private clinics and pharmaceutical companies raises the issue of conflict of interest. Health care providers at health facilities prescribe drugs for inpatients and outpatients, and these patients often have to purchase drugs from pharmacies outside the health facilities. Private clinics attract patients from public clinics to generate income. The committee manages accounts and reviews accounts' status at regular committee meetings. There are no audits on expenditures and no official guidelines for the committee to address these issues or to manage and control the CSC fund. The committee requested detailed guidelines for the management of funds where there is no conflict of interest, such as for the Social Welfare Department's Roggi Kallyan Samity Fund.

Guidelines for implementation of CSC-supported activities at health facilities are needed. The guidelines should describe the possible sources of funds, as well as financial sustainability, fund management and utilization, account management, audit, social audit, mitigation of conflicts of interest, and concurrence of the MOF as required.

The government health budget is the largest source of potential fiscal space for health over the medium term. In FY2017–18, the MOHFW budget represented just 5 percent of the total government budget in Bangladesh, while in other South Asian and low-income countries, health sector budgets account for 8 to10 percent of total budgets. Bangladesh needs to improve this ratio toward international benchmarks. A World Bank (2016a) report noted that for the Bangladesh health sector over the short to medium term, reprioritization of the MOHFW budget within the national budget represents a significantly larger potential source of fiscal space than economic growth or other sources of fiscal space.

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

Table 1: Summary of Key Policies and Strategies Relevant for Health Care Financing and Public Financial Management

National policy/plan/strategy	Strategies with links to HCF and PFM
National Health Policy 2011	• Increase health budget every year • Ensure free treatment for the extreme poor through the provision of a health card in phases • Introduce health insurance to formal sector employees and to other population groups in the long term
7th Five-Year Plan - 2016–2020	• Pilot risk-pooling mechanisms, such as health insurance • Implement HCFS as a priority
National Social Security Strategy (NSSS) 2015	• Maternal Health Voucher Scheme (MHVS) • Health insurance • Implement HCFS 2012–2032 as a complement to NSSS
Health, Nutrition, and Population Strategic Investment Plan (HNPSIP) 2016–2021	• Advocate for increased budget allocation • Explore new and innovative financing sources • Advocate for increased Development Partner (DP) funding • Explore pooling mechanisms • Pilot and implement Resource Allocation Formula (RAF) • Promote results-based financing as a strategy to improve health systems efficiency
Health Care Financing Strategy (HCFS) 2012–2032	• Strengthen tax-based health system to fund essential health services for all people • Bring formal and informal sectors and people living below the poverty line under the scope of prepayment mechanisms

Sources: GOB 2012, GOB 2015a, GOB 2015b, MOHFW 2012b, MOHFW 2017

Five-Year Plan (FYP) resource projections for health have not been translated into reality. The FYP is the Government of Bangladesh's (GOB) most important policy document for providing development policy guidelines for all sectors and sectoral allocations. Allocation for the MOHFW development budget has been lower than the original projection in FYP (Table 2). Although the total allocation for the MOHFW marked an increase in nominal terms, the allocation as a share of projected expenditure in the Sixth FYP (2011/12–2015/16) shows a steady decline. Table 2 illustrates that during the entire Sixth FYP, the development budget allocation to the MOHFW and the actual expenditure fell short of the amount projected in the plan. There are three possible reasons for this shortfall: (i) projects planned at the beginning of the FYP did not materialize, (ii) fund flow from domestic and external sources fell short of expectation, or (iii) the FYP projection was too ambitious. A more realistic FYP projection is needed to overcome this problem.

Table 2: Sixth FYP Projections and Ministry of Health and Family Welfare Development Budget (2011/12–2015/16)

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

Source: GOB 2012a and iBAS data, MOF.

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

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

Table 3: MOHFW Budget and National Budget, FY2011–12 to FY2017–18 (Figures in current Tk, billions)

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

Source: Budget brief of various years, MOF.2011-12 to 2017-18
Note: Real growth rate estimated using 2015–16 constant price; — = Not available.

The MOHFW budget experienced two-digit nominal growth since FY2015 in spite of its lower share in the national budget. In 2017–18, the MOHFW budget grew at a faster pace than the national budget both in nominal and real terms. In the course of six years, the budget allocation has more than doubled. During the three years between 2014–15 and 2016–17, the MOHFW budget's real growth rate was impressive (Table 3). It was close to 14 percent per year, reflecting high government commitment to the health sector. Despite

this increase, the MOHFW does not have sufficient funds to fulfill the pledges made in the health policy documents.

The Medium-Term Macroeconomic Policy Statement (MTMPS) 2018–2020 (MOF 2017) projects that by FY2020, the HNP sector's total spending will grow on average by about 19 percent annually to Tk 249 billion in FY 2020. From the FY2017–18 budget allocation (with 39 percent growth) appears to be following the MTMPS projection but exceeds the Seventh FYP projection (MOF 2017). The mission statements of MOHFW's Health Services Division (HSD) and Medical Education and Family Welfare Division (MEFWD) incorporated in the Ministry Budget Frameworks (MBF) 2017–18 echo the MTMPS. The objective of the HNP sector mentioned in the MTMPS from 2018 to 2020 is "to ensure quality and equitable health care for all citizens in Bangladesh by developing access and utilization of health, population, and nutrition related services to improving the health status of the underserved—poor, women, children, elderly, marginalized and physically and psychologically challenged people" (MOF 2017a).

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

Table 4: Medium-Term Strategic Objectives of Two Divisions of the MOHFW, FY2017–FY2018

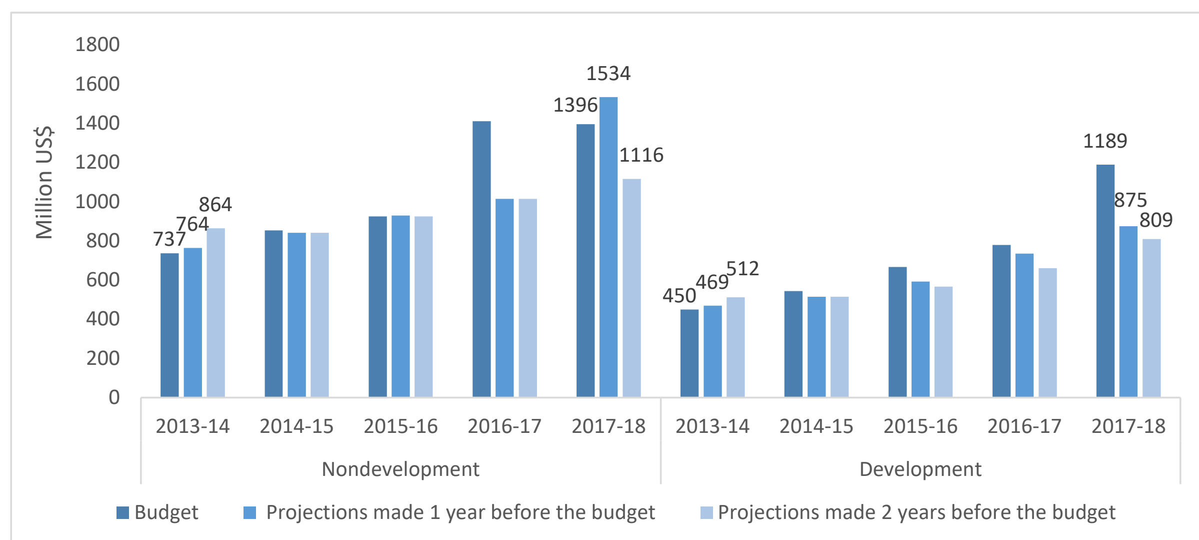
	Health Services Division	**Medical Education and Family Welfare Division**
	Similar objectives	
1	Ensure improved health care for mother and child	Ensure improved health care for mother and child
2	Upgrade quality health care services for all	Upgrade quality health care services for all
3	Ensure quality of specialized health care services	Ensure quality of specialized health care services
4	Increase food safety with nutritional standards	Increase food safety with nutritional standards
5	Develop efficient human resources in the Health, Population, and Nutrition sector	Develop efficient human resources in health, population, and nutrition sector
	Different objectives	
6	Control communicable and noncommunicable diseases and new diseases arising from climate change	Expand population control and improve reproductive health
7	Establish an improved and efficient pharmaceutical sector	

Source: MOF 2017a

Most of the time, the MOHFW budget is less than the MTBF projected amount. The MTBF projections for development projects should be made based on DPs' commitments and government financing trends. Possible reasons for shortfall could be change in government priorities, decrease in revenue, and other unexpected causes. When this becomes a regular feature, it also indicates PFM problems such as weak capacity in planning and budgeting (for example, officials responsible for MTBF preparation often have little or no exposure to medium-term budget-setting procedures), inability to complete a procurement plan, failure to obtain clearance from DPs for procurement, or inability to obtain release of funds in time.

Figure 3 illustrates the unpredictability of the MOHFW budget. For example, both development and nondevelopment budgets for FY2013–14 were lower than the projections made one year before the budget (that is, 2012–13) as well as two years before the budget (that is, 2011–12). In contrast, the MOHFW development budget for FY2017–18 was higher than both projections. However, the nondevelopment budget for FY2017–18 was lower than the projection made one year before, but higher than the projection made two years before the budget.

Figure 3: Difference between MOHFW Nondevelopment and Development Budgets and Medium-Term Budgetary Framework Projections



Sources: MBF FY2014–FY2018, MOHFW Budget Document, Finance Division; Ministry of Finance.

Dual budgeting appears to be a leading cause of inefficiency in resource planning and utilization. Bangladesh's national budget is characterized by dual budgets—"nondevelopment budget" (now the "operating budget") and "development budget." The health budget is no exception. The health budget in this analysis refers to the MOHFW's budget, although other ministries incur health-related expenditures as well.[2] The nondevelopment budget concerns recurrent government expenditure, while the development budget is mainly the conversion of the Annual Development Programme (ADP) into the budget format. The two budgets undergo separate preparation, processing, documentation structure, management, and monitoring and reporting (
Table 5).

Table 5: Public Financial Management Functions and Accountability Arrangements

PFM functions	Nondevelopment budget	Development budget
Budget formulation		
Preparation	Ministry level: Budget branch of Financial Management (FM) wing, MOHFW Director General (DG) level: Director of Finance District level: Civil Surgeon (CS),	Ministry level: Planning wing, MOHFW DG level: Line Director (LD)/Director of Planning District level: Limited Inputs and involvement

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

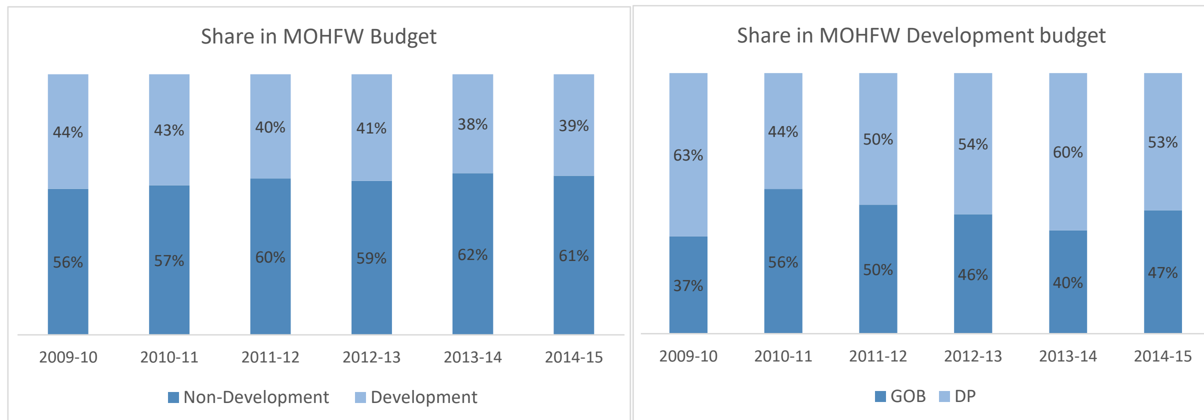
PFM functions	Nondevelopment budget	Development budget
	Director/Superintendent of Hospitals and Deputy Director Family Planning (DDFP), and Medical Officer (Clinic), Mother and Child Welfare Center (MCWC) Upazila level: Upazila Health and Family Planning officer (UHFPO) and Upazila Family Planning Officer (UFPO) and Medical Officer (Maternal and Child Health-Family Planning)	Upazila level: No involvement in budget preparation except to provide expenditure report where necessary
Estimation	Institution-wise/facility-wise allocation	Project/Operational Plan (OP)-wise allocation
Approval	Ministry of Finance (MOF)	Planning Commission through the Annual Development Programme (ADP) MOF—Development Programs not included in the ADP
Budget execution		
Fund release	Budget branch, FM wing, MOHFW DG level—Director of Finance	Project implementation branch, FM Wing, MOHFW DG level-LD/ Project Director (PD)
Payment	Chief Accounts Officer (CAO)/District Accounts Officer (DAO)/Upazila Accounts Officer (UAO)→ Drawing and Disbursing Officer (DDO)	CAO/DAO/UAO→PD/DDO
Budget monitoring		
Expenditure monitoring	Ministry: Budget branch of FM wing DG level: Director of Finance	Ministry level: Planning Wing DG level: LD/Director of Planning
Reporting	Audit branch, FM wing, MOHFW	Financial Management and Audit Unit (FMAU), MOHFW
Internal audit	Core audit teams (3), MOHFW	Outsourced to external audit firm by FMAU, MOHFW
External audit	DG Local Audit, DG Works Audit, and Civil Audit	DG Foreign-Aided Project Audit Directorate (FAPAD)

Source: Adapted from Bhagat J (2016)

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

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

Figure 4: Composition of MOHFW Total Budget and MOHFW Development Budget, 2009/10 - 2014/15



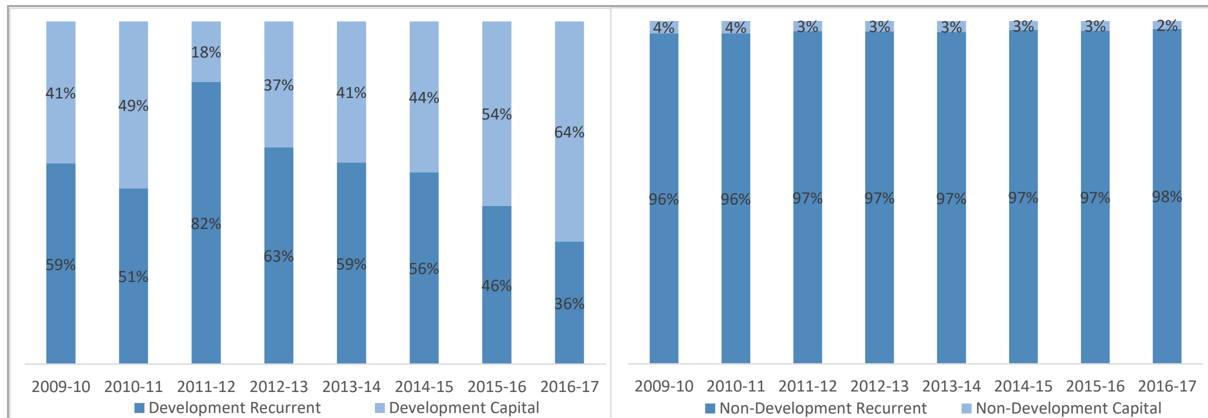
Sources: Estimated from MOF budget data and Public Expenditure Review (PER) 1997–2014 (HEU 2016).

The separate preparation of nondevelopment and development budgets results in lack of coordination. Coordination meetings between those responsible for the preparation of the two budgets are not effective in terms of timings of the meetings, monitoring, and follow-up of budget formulation. Tracking of the total budget from the central level to the lower level is difficult as the two budgets are prepared separately.

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

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

Figure 5: Share of Recurrent and Capital Line Items in Nondevelopment and Development Budgets 2009/10–2016/17



Source: Estimated from the MOF budget data, 2009/10-2016/17.

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

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

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

4. The SWAp does not cover MOHFW's entire development budget, as there are projects outside the SWAp.

Table 6: Number of Projects Outside the Health Sector-wide Approach

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

Source: ADP for various years, 1998/99-2016/17.
Note: n.a. Not applicable.

The Strategic Plan for the fourth HPNSP (2017–2022) includes several priorities in governance, including PFM. The HNP Sector Investment Plan (SIP) 2016–2021 rightly adopted capacity strengthening of MOHFW's core systems, encompassing financial management, procurement, and institutional development as strategic objectives for the five-year period between 2017 and 2022 (MOHFW 2016).

During the SWAp period, MOHFW saw an improvement in FM strengthening and FM capacity building. That improvement is reflected in the timely preparation of financial reports, use of the government treasury system to channel substantial DP funds, formation of an audit committee and FM task force to monitor FM actions, and capacity building of the MOHFW staff in FM activities (Ahsan et al 2016). Over the years under the SWAp, the MOHFW's budget execution capacity also improved significantly (Ahsan et al 2016; HEU 2016).

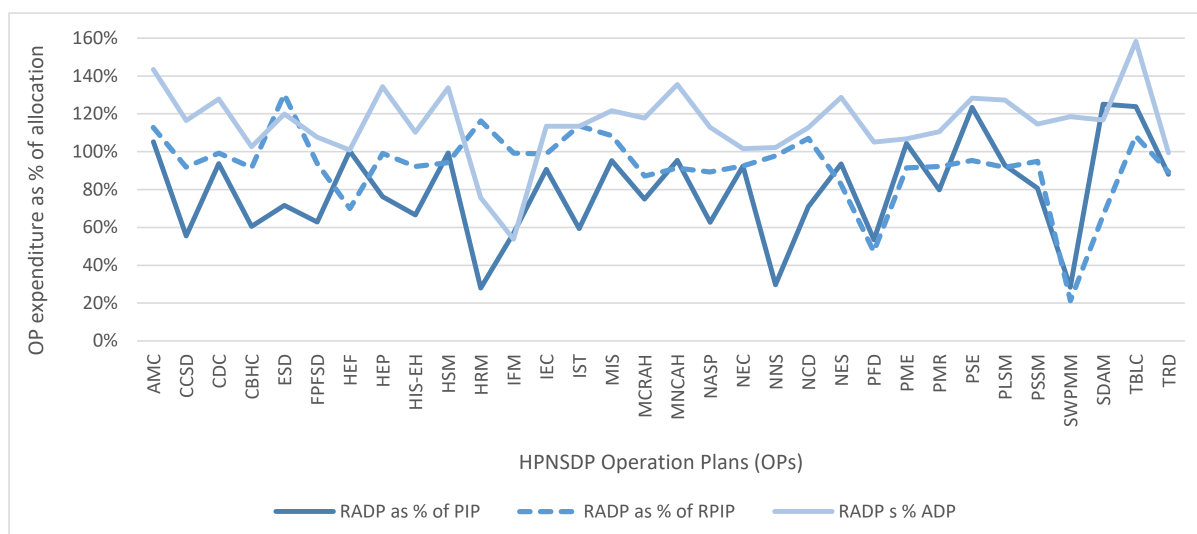
Operational Plan budgets are not prepared using the MTBF resource envelopes; they are prepared for the total five-year program period. Usually, OPs are revised after midterm review of the sector program. However, there is scope for using the MTBF resource envelopes during the OP revision.

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

Having a large number of OPs leads to lack of coordination in their planning and budgeting. The number of OPs varied in different sector programs. The second health sector program was implemented through 38 OPs, while the third had 32, and the fourth 29 OPs. There are

two OPs on maternal and child health[5]—one under the Directorate General of Health Services (DGHS) and the other under the Directorate General of Family Planning (DGFP). Ideally, there should be one OP for maternal and child health to be implemented by both directorates. Both OPs could have been planned jointly or at least in a coordinated manner. The budgeting of similar activities or procurement shown in these two OPs varied widely in some cases. This could have been avoided in joint planning and budgeting. Due to the large number of OPs, effective central coordination by the MOHFW's Planning Wing becomes a daunting task.

Figure 6: Annual Development Programme Allocation to HPNSDP OPs Significantly Differs from Both the Programme Implementation Plan and the Revised Programme Implementation Plan



Sources: iBAS data, MOF, ADP 2011/12_2016/17, RADP 2011/12-2016/17, MOHFW 2011, MOHFW 2014

Notes: HPNSDP=Health, Population and Nutrition Sector Development Program, OP=Operational Plan, ADP = Annual Development Programme, RADP = Revised Annual Development Programme, PIP = Program Implementation Plan, RPIP = Revised Program Implementation Plan.
AMC=Alternative Medical Care, CCSD=Clinical Contraception Service Delivery, CC=Communicable Disease Control, CBHC=Community Based Health Care, FPFSD=Family Planning Field Service Delivery, HEF= Health Economics and Financing, HEP= Health Education Promotion, HIS-EH= Health Information System-E Health, HSM= Hospital Services Management, HRM = Humana Resources Management, IFM=Improved Financial Management, IEC=Information, Education and Communication, IST=In service Training, MIS= Management Information System, MCRAH=Maternal, Child, Reproductive and Adolescent Health, MNCAH=Maternal Neonatal, Child and Adolescent Health, NASP=National AIDS and STD Program, NEC=National Eye Care, NNS=National Nutrition Services, NCD=Non-communicable Disease, NES=Nursing Education and Services, PFD=Physical Facilities Development, PME=Planning, Monitoring and Evaluation, PMR=Planning Monitoring and Research, PSE=Pre Service Education, PLSM= Procurement, Logistics and Supplies Management, PSSM= Procurement, Storage and Supplies Management, SWPMM= Sector-Wide Program Management and Monitoring, SDAM= Sector-Wide Program Management and Monitoring, TBLC=TB and Leprosy Control, TRD= Training, Research and Development

The large number of OPs also hinders effective monitoring. The MOHFW holds monthly ADP review meetings to discuss the progress of activities and budget execution of OPs as well as other projects outside the SWAp. These monitoring meetings would be more effective if the number of OPs and projects were reduced.

---

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

ENHANCE EFFICIENCY IN RESOURCE ALLOCATION AND UTILIZATION

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

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

Table 7: Basis and Decision of Fund Allocation to Public Facilities

Line items	Allocation basis	Allocation decision	District (hospital)	Upazila (hospital)	Union (health center)	Financial and management authority
Salary and allowances	Grade-wise salary and allowances for staff, up to the maximum approved position per facility	National pay scale, MOF	Approved positions of doctors, nurses, and other staff vary according to the number of beds	Approved positions of doctors, nurses, and other staff vary according to the number of beds	Approved positions	DG
MSR	Bed occupancy rate (BOR) per facility for inpatient facility and lumpsum for outpatient facility	Top-down decision from DG	No fixed rate	No fixed rate	No fixed amount	CS supervises tender
Food (diet)	Per bed-day	Top-down decision from DG	Tk per bed-day (175 per bed-day)	Tk per bed-day (175 per bed-day)	n.a.	CS supervises tender
Maintenance, fuel, etc.	Historic spending; Vehicle capacity utilization	Top-down decision from DG	Flat rate Tk (330,000 per year for all vehicles and	Flat rate Tk (115,000 per year for all vehicles	n.a.	CS supervises use of budget

Line items	Allocation basis	Allocation decision	District (hospital)	Upazila (hospital)	Union (health center)	Financial and management authority
	pattern; Political importance		<30,000 per vehicle)	and <20,000 per vehicle)		
Construction and infrastructure repair	Submission of demand note by facilities to DG; DG office sends prioritized list to PWD for facilities with >100 beds and HED facilities with <=100 beds	PWD for facilities with >100 beds and HED facilities with <=100 beds	—	—	—	PWD and HED

Source: Updated based on Ensor et al. 2001.
Note: MOF = Ministry of Finance, DG = Director General, MSR = Medical and Surgical Requisites, CS = Civil Surgeon, PWD = Public Works Department, HED = Health Engineering Department, n.a. = Not applicable, — = Not available.

The two budgets have different resource allocation structures. The development budget is allocated to OP/projects based on program/policy priorities, while the nondevelopment budget is allocated to the institution or facility and is not linked to policy priorities. Thus, it is difficult to track development expenditures at the facility level and match nondevelopment expenditures to OPs.

The nondevelopment budget for construction, reconstruction, renovation, and repair of infrastructure of different facilities is not included in the facility budget. Rather, the budget lies with two entities—the Health Engineering Department (HED) for up to 100-bed facilities and the Public Works Department (PWD) for facilities with more than 100 beds. Similarly, the SWAp budget for construction, reconstruction, renovation, and repair of infrastructure is allocated to the Physical Facilities Development (PFD) OP. Ideally, the budget for renovation, reconstruction, and repair of facilities should be included in the facility budget.

The MOHFW currently allocates a public fund to geographic areas based on norms related to the size of facilities. For example, funding for MSR is fixed according to the number of beds and salaries as well as to the fixed number of staff per facility. Such allocations often do not reflect the population needs of the area since health facilities and staffing patterns do not always consider changing demographic and epidemiological requirements. Differences in population, poverty, and health status have little influence on the planning and allocation of health resources to geographic areas. The MSR budget in FY2016–17 was allocated according to the BORs of UzHCs and DHs. The MOF concurred with such allocations, even though patient load is irrelevant in determining local needs or the allocation necessary to meet demand—thus, creating allocation inefficiency.

The MOHFW's Health Economics Unit proposed implementation of a Resource Allocation Formula (RAF) for efficient resource allocation in health services (Ensor and Begum 2013). The formula's objective is to target resources toward geographic areas. There are three main components of geographic need: (i) population size, (ii) demographic structure (proportion of the population in each age-sex group), and (iii) need differences arising from other characteristics. Implementation of the RAF could help meet the needs of the

population, mitigate interdistrict disparities, and make planning and allocation of resources more effective. The RAF could first be used to allocate the development budget and then expanded to include the nondevelopment budget.

The Civil Surgeon (CS) and Deputy Director Family Planning (DDFP) need enhanced subdelegation of financial power to implement the RAF. This would help utilize the required financial resources for different activities at district and upazila levels. For example, the current budget ceiling for ambulance repair is Tk 20,000. The repair budget could be increased if subdelegation were permitted. The MOHFW requires approval from the MOF to bring any changes in subdelegation of financial power, creating an additional bureaucratic layer in the allocation of resources.

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

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

Public health facilities (50-bed hospitals at the primary level and all secondary- and tertiary-level health facilities) are collecting user fees according to the revised order issued by the MOHFW (MOHFW 2010). Fees are collected for outdoor entrance, admission, and selected services, such as laboratory and investigations, surgical and neuro-medicine services, private bed or room, and ambulance rent. The MOF approved the amount of these fees with certain terms and conditions. According to this approved order, a certain proportion of user fees is to be distributed among employees working in high-risk departments (radiology, radiotherapy, and pathology). However, to date there has been no MOF concurrence for distribution of user fees among employees according to the revised order issued by the MOHFW (MOHFW 2010). Therefore, as per the existing policy, all income from user fees should first be deposited in the government treasury. As health facilities return collected user fees to the government treasury, employees receive no incentive from user fees.

An estimated Tk 1,445 million (iBAS data on MOHFW's revenue) was collected from users at MOHFW facilities in 2014–15 for using various services (outdoor ticket fee; inpatient admission fee; fees for selected diagnostic investigations, surgical procedures, private bed/room, selected medicines/vaccines; and ambulance rent[6]). This amount represents approximately 2 percent of the MOHFW recurrent expenditure (1.4 percent of the MOHFW total spending) in the same year. The MOHFW spent about 3 percent of recurrent expenditure on repair and maintenance in 2014–15. The estimated user fees represent 59 percent of the repair and maintenance expenditure in that year. Hence, user fees if retained at the facility could be used to supplement the repair and maintenance budget allocation, which is not adequate.

---

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

Secondary- and tertiary-level public health facilities can only retain user fees collected for blood transfusion services. These services include blood transfusion, blood grouping, and cross matching. The blood transfusion center collects fees from patients staying at cabins, paying beds, and the general wards, as well as from private patients. The facilities collect fees according to the country's existing rules (GOB 2002 and 2008). Table 8 below presents allocation of the collected user fees for blood transfusion services. The Safe Blood Transfusion Fund is created and managed along with the income and expenditure record, accounting, and audit, according to current rules (GOB 2008a).

Table 8: Distribution of Collected User Fees to Provide Blood Transfusion-related Services

Distribution of allocation	Officer—Employees	Claimed proportion (%)
Fund	Blood Transfusion Center Fund	45
	National Expert Committee of Blood Transfusion Fund	5
Officer of blood transfusion center	Professors, in-charge, or same-level officers	12
	Associate Professor, Assistant Professor, or same-level officer equally	10
	Medical Officer or same-level officer equally	8
Employees	Class III employee	14
	Class IV employee	6

Sources: GOB 2002, GOB 2008, GOB 2008a

Retention of user fees at the primary- (50 bed), secondary-, and tertiary-level health facilities could improve efficiency and quality of care. It should be noted that primary health care should remain free of charge. Like the law and rules for collecting user fees for blood transfusion–related services, legislative support is needed to retain user fees collected from other services at health facilities. The purview of the rule should be extended to include all health care–related services at upazila, secondary, and tertiary levels, specifying the proportion of user fees to be split between health facilities and health care providers as incentives. This would require the Finance Division's (FD) concurrence, as the present rule covers all types of staff connected with diagnostic services. To introduce this change, an amendment to Medical Practice, Private Clinic, and Laboratory (Regulation) Ordinance (1982), and Safe Blood Transfusion Act (2002 and amended 2008) would be required.

IMPROVE EQUITY AND INCREASE HEALTH CARE ACCESS ESPECIALLY FOR THE POOR AND VULNERABLE

The HCFS 2012–2032 proposes social health protection schemes (including the poor and the formal sector) to ensure financial protection against health expenditures for all segments of the population, starting with the poorest (GOB 2012b). Presently, the MOHFW is implementing two social health protection schemes: Shasthya Surokhsha Karmasuchi (SSK) and Maternal Health Voucher Scheme (MHVS) in various upazilas.

The SSK—a social health protection scheme for the poor—aims to reduce OOP expenditure of household members, thereby protecting them from impoverishment in case of catastrophic illness. The government is subsidizing the premium for the below poverty line (BPL) beneficiaries. The scheme is being piloted in three upazilas of Tangail District. The sources of the SSK fund as outlined in the draft SSK Operational Manual[7] are a government grant, membership fees, a government subsidy in the form of a premium, profit from the

7. Draft Operational Manual. *Shasthya Surokhsha Karmasuchi*. Dhaka: Health Economics Unit, MOHFW, Government of Bangladesh

investment, and funds obtained from any other government-approved sources. Although health care insurance for the ultra poor is at the core of SSK, the element of insurance policy is absent. Rather, it is a government scheme to put away the premium for safeguarding health care of targeted families against a number of listed diseases. However, the goal is to gradually introduce a premium-based insurance policy to higher-income groups to achieve the UHC financing policy by 2032. It is, therefore, necessary to study PFM functions and weaknesses of the SSK along with the suggestions for improvement.

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

Fund requirements for scaling up and enhancing the SSK scheme covering all 427 upazilas outside district headquarters will be considerable. An amount of Tk 10.67 billion (US$133.4 million) will be required for 427 upazilas each year just to pay the premium. During the Fourth SWAp, the SSK is to be piloted in three upazilas; a minimum total of 105,000 BPL cardholders will be covered by the SSK scheme. Tk 1.35 billion (US$16.9 million) out of total Tk 1.72 billion (US$21.5 million) has been allocated in the Fourth HPNSP for payment of the premium in the SSK pilot program (MOHFW 2017). Without additional support, this amount is insufficient in meeting health care expenses of the targeted population over six years. The HNP SWAp wants the SSK scheme to be self-sustained, but other avenues for income generation must be explored to make it sustainable. It is necessary to collect funds from different sources and invest them toward generating greater resources.

A health insurance scheme like SSK cannot operate without a proper legal framework that includes financial rules and regulations. Currently, the SSK is not considered sustainable as it is operated like a pilot project of the MOHFW guided by rules and regulations. It is also framed for the projects that are supported by the development budget. The SSK's draft Operation Manual states that the fund should be deposited in any scheduled bank upon the approval of the SSK Cell, and the fund or part of it may be invested in SSK-related activities only. In the absence of formal approval of the manual, or adoption of rules regarding the creation of the fund and investment of the same, no method for escalating the SSK fund could be applied.

A separate set of financial and business rules are required for a health insurance scheme. Before framing these, it is necessary to establish a fund entitled "the Shasthya Surokhsha Karmasuchi Fund" and open a special account in any scheduled bank for its operation. The special account is necessary to exclusively handle the SSK investment. It was found from the draft SSK Operation Manual that certain modifications are needed to the SSK Operation Manual to accommodate commercial accounting principles for the smooth running of an investment scheme. Commercial accounting principles are general rules and concepts that govern the field of accounting (ICMAB 2014). Many government financial rules may not apply to an investment fund. The rules need to specify issues, such as the possibility of fund

transfer from one financial year to another. The Scheme Manager will be able to bear risk and to invest reserves if applicable. For example, drawing money from the pool fund directly by the SSK may not be possible. This will be channeled through the HEU to the investment fund. Separate financial rules need to be outlined within the framework of investment procedures and profit-sharing mechanisms. The SSK Operation Manual provides instructions on the maintenance of financial accounting in line with the government chart of accounts. This is not necessary as SSK will follow commercial principles. Both accounting and auditing should follow international standards of best practices.

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

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

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

The release of funds is delayed at the ministry and upazila levels. The source of funds to support MHVS implementation activities is the approved budget of the operational plan "MNCAH," which is financed through the development budget. At the beginning of the financial year, the MOHFW releases a quarterly allotment in favor of the Line Director (LD),

Maternal, Neonatal, Child, and Adolescent Health (MNCAH) OP. The LD then sends an advance drawing request from the DGHS to the MOHFW. In most cases, this reveals that the fund request exceeds the amount (Tk 500,000) delegated to the Secretary of the MOHFW. Therefore, the MOHFW sends the fund request to the MOF for approval. The approval in turn is sent to the LD through the same steps. The MOHFW approves the advance request from the LD on receipt of approval from the MOF. The LD submits the advanced bills to the MOHFW's CAO to draw the fund. The MHVS account at the upazila receives the fund from the Office of the LD. These ministry-level approval processes take three to six months and delay receiving the fund in the MHVS account at the upazila level. The cycle repeats every financial year. The long delay in the flow of funds from the national to the upazila level affects efficiency and effectiveness of program activities (Khan and Khan 2016). The process of requesting the advance fund need to be simplified and, ideally, should not take more than one month.

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

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

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

- Operate health social protection schemes for mother and child, adolescent girls, poor and vulnerable groups, and underserved people.
- Research and devise newer schemes for implementing National Health Policy 2011, Bangladesh Population Policy 2012, and Bangladesh National Nutrition Policy 2015.
- Arrange funds for implementing these policies.
- Manage contracted out health care providers.

- Coordinate and align activities of different national and international organizations/DPs active in the HNP sector in Bangladesh.
- Implement and manage the health insurance policy of the Bangladesh Government with the aim of achieving UHC by 2032.

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

Prerequisites for establishing the NHSO include the formation of a high-level committee with the additional secretary of the HSD as convener, and members to include senior officers from Medical Education and Family Welfare Division, Health Services Division, Finance Division, Economic Relations Division, Ministry of Social Welfare, Directorate General of Health Services, and Directorate General of Family Planning. The committee may be composed by the minister of MOHFW. Discussion with the group of government employees must occur, if the government considers the amalgamation of the government group insurance and benevolent fund with the proposed national health/social insurance policy under the NHSO. A study is needed to suggest structure, legal authority, functions, funding, PFM procedures, staffing, and management of the NHSO. State-owned and private insurance companies should participate in the discussion to consider the formation of a national health insurance policy. The status of the NHSO will be determined based on the NHSO business procedure. This may function as an autonomous board, for example, Bangladesh Rural Electrification Board or Bangladesh Rural Development Board with wider range of control; or it may work as a public company, with the major share being held by the government and registered under the Companies Act 1994.

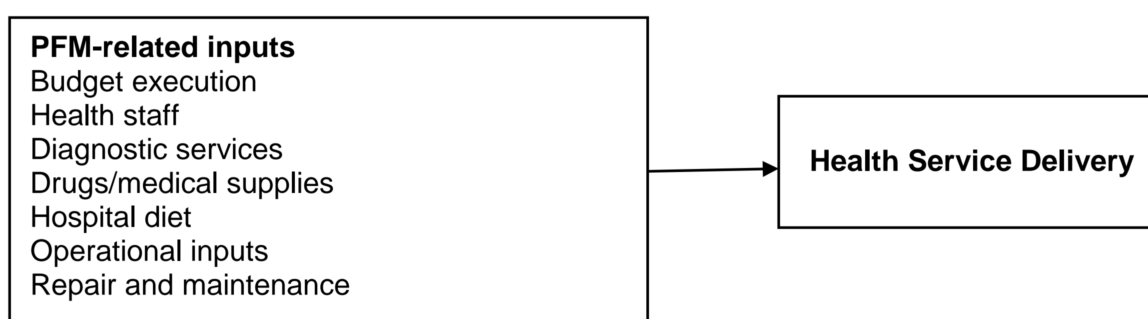
Prerequisites for the setting-up of the NHSO include the following:

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

LINKAGES BETWEEN PFM AND HEALTH SERVICE DELIVERY IN BANGLADESH

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

Figure 7: Link between PFM-related Inputs and Health Service Delivery



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

ENHANCE EFFICIENCY IN BUDGET EXECUTION TO IMPROVE HEALTH SERVICE DELIVERY

The fund disbursement method differs between development and nondevelopment budgets. The development budget is allocated from Line Directors/Project Directors to Drawing and Disbursing Officers, who execute the budget through the treasury system. The development budget is released or disbursed in four quarters (Table 9). For the development budget, a fund release order from the MOHFW (Project Implementation Branch) is required. The order allows the fund disbursement to the Drawing and Disbursing Officers (DDOs)[8] for the first three quarters of the GOB funds and first two quarters of the Reimbursable Project Aid (RPA) funds. The fourth-quarter release of the fund requires endorsement from the Finance Division. For release of third- and fourth-quarter installments of the RPA, the LDs/PDs need to submit the Statement of Expenditure (SOE) reconciled and certified by the Chief Accounts Officer, Health (

(Figure **8**). In case of nondevelopment budget, a separate order for fund disbursement is not necessary. The nondevelopment budget fund can be spent against the budget allocation, and a quarterly fund release is not required except for grant transfers to different agencies.

---

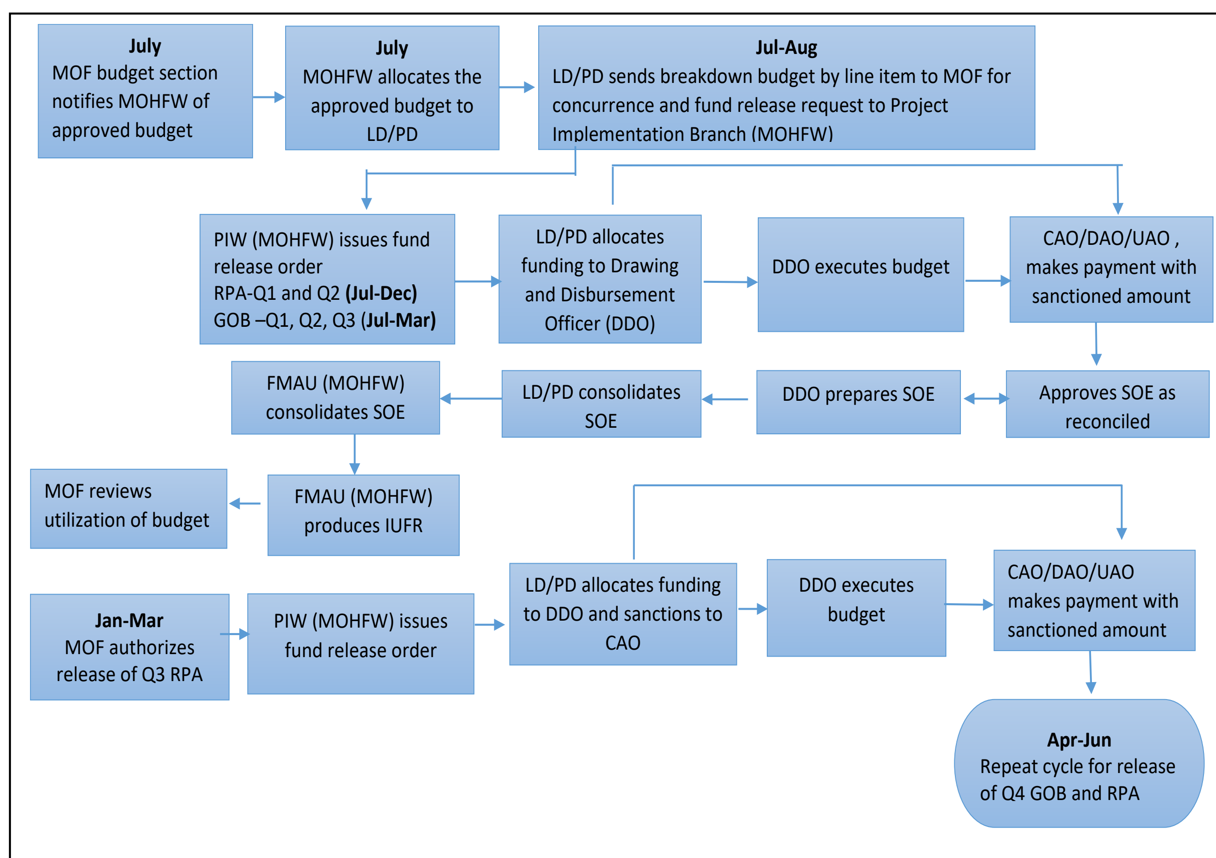
8. Funds released and distributed to DDOs does not mean funds are distributed to all facilities under the respective DDOs. Some facilities have no DDOs.

Table 9: Timeline for the Development Budget Fund Release

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

Source: Key informant interview

Figure 8: Flow Chart—Development Budget Disbursement and Execution



Source: Updated from World Bank 2010.

The fund disbursement starts with notification from the FD on approval of the budget. The approved budget becomes available online through iBAS++[9] of the FD. The approval notification passes through the DGs to the Finance Director, Line Director, Civil Surgeon, Deputy Director Family Planning, Upazila Health and Family Planning Officer, Upazila Family Planning Officer, and others. The Finance Director of the directorate (DGHS/DGFP) is responsible for the disbursement of the nondevelopment budget fund. Budget approval authorizes local officers to draw money from the treasury (District Accounts Officer/Upazila Accounts Officer) up to the ceiling determined by the delegation of financial authority. LDs disburse cash/materials to execute OPs by field offices/cost centers.

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

---

9. Upgraded version of iBAS.

- Delay in sending the fund release request letter
- Failure to send in necessary accompanying documents with the fund release request letter
- Failure to provide CAO-certified reconciled account with request letter
- Line Director's delay in sending the SOE
- Lack of timely follow-up by relevant OP officer
- Noncompliance with donor conditions for loan/grants
- Noncompliance with financial rules and regulations—even minor rules—which could be amended without delay

The LD/PD's delay in sending the SOE is often due to the delay in receiving expenditure reports from all units/facilities. The LDs encounter this problem while integrating expenditure reports from all units to prepare the consolidated SOE. The SOE is a prerequisite for the fund release request for the third and fourth quarters of the RPA fund. The delay in preparing and sending the SOE from all the cost centers further postpones the fund release.

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

The separate disbursement of nondevelopment and development budgets results in lack of coordination and accountability. For example, lack of coordination of the entire financing operation at the directorate level characterizes the fund disbursement process. The Finance Director, who controls the nondevelopment expenditure process, is not informed about the amount released from the development for the same line item—such as MSR, diet, and so on. According to the job description,[10] the role of the Finance Director of the DGHS is limited to preparation of the nondevelopment budget and disbursement of funds from the nondevelopment budget. Her/his role does not include overall supervision/monitoring of financial activities. As a result, DGHS' Finance Director remains unaware of the latest allocation figures for diet and MSR to health facilities under the DGHS. The information is not available to the FD as diet and MSR for added beds in upgraded facilities were borne by the LDs of Hospital Services Management and Essential Services Delivery OPs. There is no one responsible in the DGHS and DGFP to track both nondevelopment and development budget allocations of the respective directorates, to prevent wastage, double payments, and pilferages. This disconnect indicates the need for an effective expenditure control and monitoring system in the DGHS to ensure accountability.

The recent introduction of iBAS++ has accelerated budget distribution. Discussions with Finance Directors and LDs of the DGHS and DGFP revealed that fund release is delayed until August as it starts after hard copies of budget books become available by the fourth week of July. However, the introduction of the improved iBAS++ in the current fiscal year

10. http://www.dghs.gov.bd/images/docs/Job_Description/Job_DESCRIPTION%20DGHS.pdf in Bengali

accelerated the budget distribution online replacing the distribution of hard copies of budgets. In FY2017–18, the MOHFW budget was made available online by the first week of July. The processes will be further accelerated if the DGHS and DGFP are directly linked with iBAS++.

The government's recent decision brings a change in the fund release process. The first and second quarters of the GOB portion of the development budget henceforth will be released automatically, and the LDs/PDs will be able to use the project/OP fund from July 1.[11] This will simplify the fund release process to some extent, and this decision should be extended to the first two quarters of the RPA.

Since iBAS++ will contain all the execution data, submission of the SOE should no longer be a requirement for release of RPA's third and fourth quarter. The delay in submission of the SOE is a major cause of delay in fund release of the last two quarters of the RPA. Delinking fund release from submission of the SOE will reduce the delay in fund release significantly and thereby improve fund availability.

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

Table 10: Number of Days to Process Fund Release Request by the Project Implementation Wing

Fiscal Year	Government of Bangladesh (GOB)-financed/ Reimbursable Project Aid (RPA)	Quarter	Fund release request letter sent by the LD	Number of days between start of quarter and sending of fund release request,	Request letter received by Project Implementation branch	Fund release order issued	Number of working days taken for fund release
2012–13	GOB and RPA	1	July 19, 2012	14	July 22, 2012	July 29, 2012	6
2012–13	GOB and RPA	2	October 15, 2012	10	October 18, 2012	October 25, 2012	6
2012–13	GOB and RPA	3	March 14, 2013, and March 25, 2013	52	March 20, 2013, and March 27, 2013	April 2, 2013	5
2012–13	GOB and RPA	4	May 9, 2013	28	May 12, 2013	May 26, 2013	10
2013–14	GOB and RPA	1	August 13, 2013	32	August 14, 2013	September 4, 2013	15
2013–14	GOB and RPA	2	November 18, 2013	34	November 19, 2013	November 27, 2013	7
2013–14	GOB and RPA	3	February 11, 2014	29	February 16, 2014	February 24, 2014	10

11. Finance minister's Budget Speech 2018–19, Paragraph 190. https://mof.portal.gov.bd/sites/default/files/files/mof.portal.gov.bd/page/b29661b6_927f_4012_9f83_5ac47dbd6ebd/Speech_EN_18_19.pdf.

Fiscal Year	Government of Bangladesh (GOB)-financed/ Reimbursable Project Aid (RPA)	Quarter	Fund release request letter sent by the LD	Number of days between start of quarter and sending of fund release request,	Request letter received by Project Implementation branch	Fund release order issued	Number of working days taken for fund release
2013–14	GOB and RPA	4	May 4, 2014	23	May 6, 2014	June 1, 2014	19
2014–15	GOB	1	August 23, 2014	38	August 24, 2014	September 2, 2014	8
2014–15	GOB	2	November 24, 2014	38	November 26, 2014	December 10, 2014	11
2014–15	RPA	1 and 2	December 14, 2014	52	December 15, 2014	December 28, 2014	9
2014–15	GOB and RPA	3	March 1, 2015	42	March 4, 2015	March 11, 2015	6
2014–15	GOB and RPA	4	May 28, 2015	41	May 31, 2015	June 16, 2015	13
2015–16	GOB and RPA	1	July 26, 2015	17	July 28, 2015	August 11, 2015	11
2015–16	GOB	2	November 9, 2015	27	November 10, 2015	November 16, 2015	5
2015–16	RPA	2	December 21, 2015	57	December 22, 2015	December 24, 2015	3
2015–16	GOB and RPA	3	February 14, 2016	30	February 15, 2016	February 28, 2016	9
2015–16	GOB and RPA	4	June 5, 2016	45	June 5, 2016	June 20, 2016	12

Source: Based on documents of the Project Implementation Branch, 2014-15 and 2015-16, MOHFW.
Note: This table is based on information of one Operational Plan.

Nondevelopment budget execution fluctuates for almost all line items. No line items show any uniform pattern in the execution of the revised nondevelopment budget (Figure 9). For example, the revised budget execution of pay and allowances varied between 93 percent and 97 percent. The budget for this line item includes pay and allowances for vacant positions; still variation is much less than for other line items. Execution of the repair and maintenance budget[12] fluctuated between 65 and 103 percent during the last seven years. However, the execution rate improved substantially compared to the years before FY2012. Four separate entities are responsible for the repair and maintenance of infrastructure, vehicles, and equipment: the Public Works Department (PWD), Health Engineering Department (HED), Transport and Equipment Maintenance Organization (TEMO), and National Electro-Medical Equipment Maintenance Workshop and Training Center (NEMEMW). Recently, there has been increasing human resources (HR) capacity and budget for some of these entities.[13]

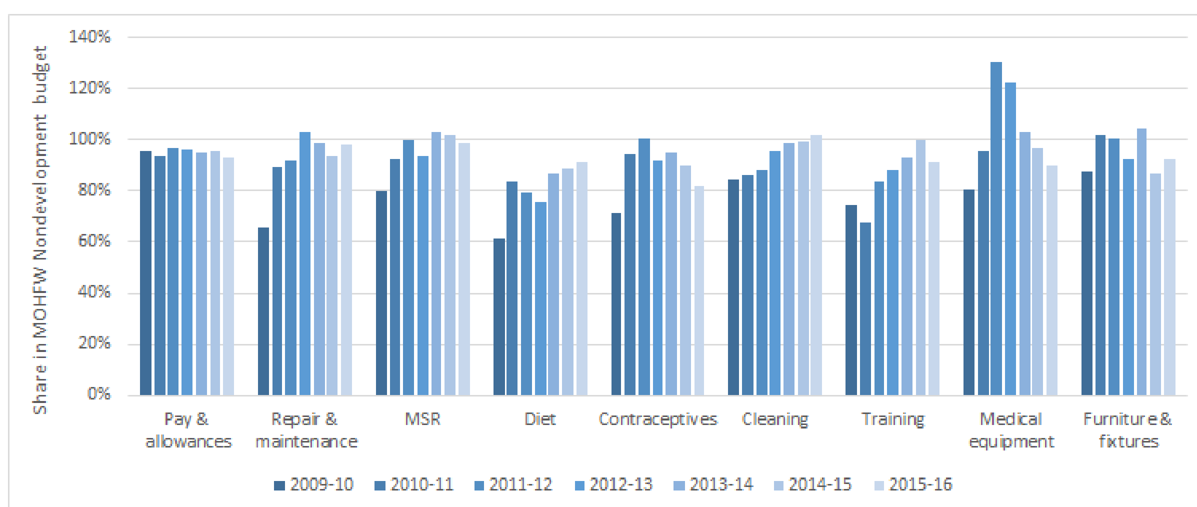
Underspending of some line items in the revised nondevelopment budget in one year and overspending of the same line items in another year indicates weak capacity in budgeting, as well as in monitoring and reporting. Recurrent line items such as repair and maintenance,

12. Repair and maintenance budget includes repair and maintenance of infrastructure, furniture, fixtures, machinery, medical equipment, and vehicles.

13. For example, NEMEMW.

MSR, and cleaning, and capital line items such as medical equipment, furniture, and fixtures showed such a trend (Figure 9) although the budget is revised halfway through the fiscal year. This shows that both the original and revised budgets were far from realistic. Expenditures for some line items were more than the revised budget allocation as reallocation/reappropriation was done, but revised budget figures for those line items were not updated accordingly. In some instances the reallocation is made just before the fiscal year ends (on June 30). As a result the execution rate against the initial revised allocation shows an inflated budget execution rate (Figures 9 and 10), indicating both poor reporting and poor monitoring. However, introduction of iBAS++ should solve this problem.

Figure 9: Revised Nondevelopment Budget Execution for Selected Recurrent Line items



Source: iBAS data, MOF

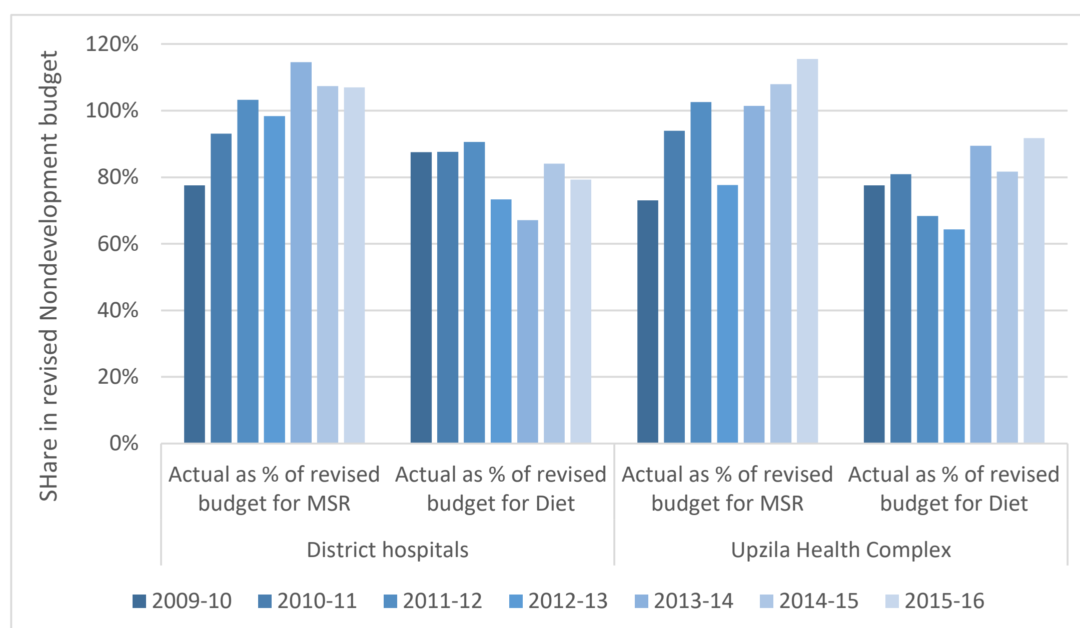
The nondevelopment budget for MSR and diet,[14] which are crucial for service delivery, remained unspent at the facility level. During the last seven years, the UzHC utilized on average 96 percent of the revised budget for the MSR. The district hospitals performed better in this regard (Figure 10). Diet is used for inpatients only; so, it is related to inpatient service utilization (for example, admission, bed occupancy, and duration of stay). The BOR at the DH was 137 percent in 2015 (DGHS 2016). Surprisingly, utilization of the revised budget for diet was 84 percent in 2014–15 and 79 percent in 2015–16. On the contrary, the BOR was 78 percent in 2015 in the UzHC, but 82 percent and 92 percent of the revised nondevelopment budget for diet was spent in 2014–15 and 2015–16, respectively. The mismatch between the reported BOR and diet budget utilization warrants further examination.

The performance of OPs in development budget execution varies widely. Table 11 shows the budget utilization level of different OPs. The average execution rate in five years was less than 50 percent for three OPs, while it was over 100 percent for four OPs.[15] Further analysis revealed the capital-intensive expenditure pattern of the highest-performing OPs. It is concerning that half of the lowest 10 spenders are service delivery–related OPs. Three OPs could not even spend half of their revised allocation.

14. Food for inpatients.

15. As explained earlier, sometimes the revised budget figure is not updated to include the reallocation/reappropriation, especially toward the end of the fiscal year.

Figure 10: Nondevelopment Budget Execution for Medical and Surgical Requisites and Diet at District Hospitals and Upazila Health Complexes



Source: iBAS data, MOF

Table 11: Revised Development Budget Execution by Operational Plans (2011/12–2015/16)

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

Sources: iBAS data, MOF

Note: The figures do not include the Direct Project Aid (DPA) part of the revised development budget, as iBAS does not capture DPA.

SD = Service Delivery, SS = System Strengthening, GS = Governance and Stewardship.

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

The frequent transfer of the main players of budget execution is another factor affecting the directorate/OP's fund utilization efficiency. Continuity in the director/LD position makes budget preparation and execution easier. Five changes took place since December 2014 in the post of Finance Director of the DGHS. Moreover, changes occurred in the positions of the LDs: the LD of a large OP changed twice in one week after the sitting LD retired. Another director position changed eight times during four years. Such flux means the unit gets two new directors every year, on average. By the time the director becomes familiar with her/his responsibilities, she/he is transferred. This also creates problems for the unit's other officials, who must apprise the new director, as they must repeat the same procedure twice or more each year, leaving less time for their own work.

Decentralization of budget: District budget—an unsuccessful pilot

Budget distribution and expenditure are overly centralized under the MOHFW's two directorates. The structure of delegation of financial authority among government officers and other constraints often preclude officers at different levels of budget execution from using the budget placed under their disposal. For example, utility services like electricity charges or recurring expenditure like repair of ambulance beyond a certain limit must be endorsed by the FD. This often obstructs/delays timely performance.

The district budget was initiated in FY2013–14 as a pilot program, and Tangail was selected as the intervention district. However, it was "not a district budget per se" (Budget speech, 2013–14),[17] but rather an accounting exercise of allocations from both the development and nondevelopment budgets for the field offices of various ministries located in Tangail. This was a central-level exercise, and the district-level administration was not involved (Khan and Sabbih 2015). However, capacity constraints both at the district and at the central level barred the full implementation of the district budget. There was lack of manpower and inadequate financial authority delegated to district officers—for example, the Civil Surgeon, Deputy Director of Family Planning, and Hospital Superintendent—to implement the district budget. Preparations to develop a monitoring system and to distribute budget and accounts-related functions between head offices and district offices were also not complete.

Budget decentralization will not be successful without changes in PFM modalities, such as expanded delegation of financial authority, capacity building of district authorities (district council/*zila parishad*), district-wise budget distribution, and an accounting- and operation-level budget classification network. The issues of nondevelopment and development budget

16. CAO, MOHFW Account available through iBAS.

17. https://www.mof.gov.bd/en/budget/13_14/budget_speech/speech_en.pdf.

integration and of budget classification systems incorporating district budget operational codes, mentioned in the concept paper "Unified Budget and District Budget" (MOF 2010) continue to persist. This necessitates local-level planning and budgeting or at least an assessment of local requirements. Local-level planning and budgeting are not practicable at present, as the nondevelopment budget is allocated to institutions/facilities, while the development budget is allocated to OPs and projects. MOHFW's officers start the planning process with specific knowledge of the expected fund, its source, and its need in different project/OP areas. Prior knowledge of the availability of resources at the local level and the amount expected from the center are essential for the preparation of local-level plans. At present, MOHFW's district-level offices lack this knowledge. Therefore, capacity building of the district health and family planning offices is necessary before the implementation of planning and budgeting at the local level.

PFM and Human Resources

Staff in health care facilities are essential to enable the delivery of efficient and effective health services and to achieve patient satisfaction. In many countries, the health workforce represents the single largest item in health budgets. In FY2016, total salary and allowances constituted 45 percent of MOHFW's total recurrent budget (MOF 2015). Availability, retention, and performance of health care providers in rural and neglected areas are important human resources (HR) management functions. Sound HR management plays a key role in health services coverage. In Bangladesh, public health care providers are salaried staff. Challenges include recruitment, capacity, performance, poor retention in rural areas, absenteeism, and limited accountability. It is not possible to allocate staff hired on the development budget to the nondevelopment budget. The Ministry of Public Administration with concurrence from the MOF can transfer posts from the development to nondevelopment functions, and then the people in those positions can be regularized. Recruitment, capacity development, and incentives for performance and retention need budget approval and policy support.

MOF's approval of the budget is a key requirement to recruit additional health staff. MOHFW and MOF must jointly identify and allocate additional financial resources to recruit additional health staff/new cadres to provide essential care. The recruitment process involves MOF approval of the required budget. All this takes time, and the delay in the recruitment processes eventually affects the delivery of health care. Resources generated by the Community Support Group provide opportunities to recruit security guards and cleaners. As mentioned earlier in this report, there should be guidelines for using CSC funds to recruit additional health staff.

Effective training courses and workshops are required for building skills and capacity among staff. This may affect the overall production of services. Local trainings are one- to two-days long, which raises concerns on the quality and content of these trainings (PMMU 2015). A number of issues must be addressed to make the training effective; for instance, training is not need-based, lack of basic and refresher training for all clinical and technical staff, participant selection based on personal connection or political consideration, some staff receiving multiple training while others receive none, and inadequate length of training (TIB 2014).

Sufficient resources are not always available to conduct training courses and workshops, depending on the development budget, but some trainings are conducted using the nondevelopment budget. Approximately 17 percent of health facilities' positions under the DGHS are vacant (DGHS 2016). Reappropriation of the salary budget defined for vacant positions provides an avenue to receive additional financial resources for continuous

professional development. Moreover, there must be coordination between trainings financed by the two budgets to increase effectiveness.

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

To add an incentive as a part of a regular payment and to give it a permanent structure, special rules would have to be framed and added to the Bangladesh Service Rules and the General Financial Rules (GFRs), defining incentives and determining rates. The MOHFW can discuss this with the FD, supporting its case with plausible arguments and examples. An alternative could be to extend the definition of an honorarium payment to government servants for special or arduous work in connection with a development project. This option helps to cover the incentive payments and allows secretaries of the line ministries/divisions to pay incentives up to an accepted limit. At present, this honorarium payment to government staff is an item that is to be referred to the FD for approval.[18]

Private providers can also supply public health services. Public health facilities in Bangladesh need additional health workers to meet the demand for health care. In Bangladesh, private health care providers are increasingly acknowledged as well-resourced providers of health care services. At present, there is support for contracting arrangements with private providers, with a view to making publicly funded services more accountable, transparent, and efficient. However, empirical evidence in this regard is limited. The PFM rules need flexibility to engage private providers in public facilities. Many public health facilities across Bangladesh will be able to accommodate private providers. Discussions have been held on PFM issues and implications as well as on necessary arrangements for providing private diagnostic services at public health facilities.

Availability of drugs and medical supplies that are critical for service delivery

Like HR, Lack of availability of drugs and medical supplies is affecting health service delivery. Health care providers frequently face shortages in drug supplies. Financial resources and procurement processes affect the availability of drugs and medical supplies. Health facilities receive insufficient funds, which leads to shortages of drugs and medical supplies. Weak procurement processes, delays in receiving drugs, and increased drug and medical supply prices aggravate the situation.

Facilities receive the MSR allocation (financed from the nondevelopment budget) from multiple sources. The DHs and UzHCs receive the MSR budget from both the MOHFW and the DGHS. In FY2016–17, the MOHFW allocated a budget to the DHs and UzHCs according to bed occupancy rates. The DGHS allocated the MSR budget to the UzHC

18. Government Order No-ama/obi/u:go:sha/3/94/360, June 2, 1994—list of items to be referred to the FD.

according to annual admissions and Outpatient Department visits, and to the DH according to annual patient days and OPD visits.

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

Table 12: Ministry of Health and Family Welfare and Directorate General of Health Services Budget Allocation for Drugs by District and Upazila

Source	District	Upazila
The MOHFW budget for MSR for local tender	35% of the total MSR budget of the MOHFW allocated to the district	35% of the total MSR budget of the MOHFW allocated to the upazila
The DGHS budget for MSR	70% of the total MSR budget of the DGHS. Procurement guidelines permit the following distribution of 70% of the MSR budget	75% of the total MSR budget of the DGHS. Procurement guidelines permit the following distribution of 75% of the MSR budget
	75% EDCL	75% EDCL
	20% CMSD	20% CMSD
	5% local tender	5% local tender

Source: Based on Key informant interviews.
Note: MOHFW = Ministry of Health and Family Welfare, MSR = Medical and Surgical Requisites, DGHS = Directorate General of Health, EDCL = Essential Drug Company Limited, CMSD = Central Medical Stores Depot.

The Directorate General of Health Services sends budget allocation letters to the Central Medical Stores Depot around November/December of each financial year. In Bangladesh, the financial year starts on July 1 and ends the following June 30. The budget allocation letters indicate the allocation for each district to purchase drugs from the CMSD. Around March/April of the next calendar year, the CMSD receives information on drug requirements from CS offices of all districts. Every year, the CS prepares these requisitions based on the needs of the DHs and UzHCs of her/his district. The CMSD has a list of enlisted drug suppliers and completes all procurement processes from these suppliers by May/June. The CMSD can complete all drugs procurement processes by October/November of the financial year if its office receives the budget allocation letters from the DGHS and drug requirements letters from the CS Offices by September. The DGHS and CS Offices should send the

letters to accelerate the procurement processes of the CMSD without delay; this would help ensure the timely availability of CMSD-purchased drugs at the DHs and UzHCs.

The tendering process at the district level can be either open or limited following the Public Procurement Act (PPA) 2006 (GOB 2006) and Public Procurement Rule (PPR) 2008 (GOB 2008c) respectively. After selection of the contractor, the procuring entity (CS/Superintendent) requires administrative approval from the DGHS by December of each year. The contractor supplies the MSR items to the CS/Superintendent Office upon obtaining DGHS approval. Each district has its own Survey Committee, which checks whether MSR items have been supplied according to the specifications and sample approved and accepted by the Specification Committee. After receiving certification from the Survey Committee, MSR items are kept in a District Reserve Store (DRS)—a storeroom (inside the CS Office). Then, the CS/Superintendent sends all documents to the DGHS and MOHFW for expenditure approval by March 31. After obtaining expenditure approval, and following the completion of all financial procedures, payments are given to the contractor, and the CS releases the MSR to each of the district health facilities, according to the request submitted by the UzHCs (for the UzHC and union subcenter together).

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

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

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

There is no framework contract for drug procurement. Section 36 and Subsections 36(1), 36(2), and 36(3) of PPA 2006 (GOB 2006), and Rule 89 and Subrules 89(1), 89(2), 89(3), and 89(4) of PPR 2008 (GOB 2008c) permit a framework contract for CMSD (DGHS), DGFP, and CS to procure drugs at the district level.

Resources are sometimes used inefficiently. For example, the UHFWCs repeatedly receive more catgut, lignocaine, and snake venom than is actually needed. Wastage or leakage can occur when medical supplies are not in use. The inadequate mix of medical supplies likely

hampers the quantity and quality of medical services. Appropriate planning and projection could help health care providers get the correct quantity of drugs, medical supplies, diet, and stationery.

Flexible operational fund at facilities for timely repair and maintenance

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

District-level health facilities do not have funds for timely repair and maintenance of buildings, equipment, and ambulances. Old facilities need constant maintenance; maintenance gaps can adversely affect the quality of care services. The shortfall happens due to low allocation and to the nondelivery of funds in a timely manner. It appears that sometimes responsible officials are unaware of requisite processes to receive funds and thus do not initiate these processes in time. The capacity and responsiveness of the contracted agency responsible for repair and maintenance are also issues. Increased allocation of resources for repair and maintenance should be available to health facilities. Health managers/providers need enhanced delegation of authority to expend money for repair and maintenance. Like operational funds, flexible cash arrangements or user fee retention at health facilities can supplement the budget allocation for repair and maintenance. As mentioned earlier, the estimated user fees collected in FY2014–15 represented 59 percent of total repair and maintenance expenditure.

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

Introducing “Flexible Cash at Facilities” will require the insertion of a relevant clause in the General Financial Rules (GFRs) or, alternatively, establishment of an autonomous NHSO. “Flexible Cash at Facilities” can be arranged if a permanent advance of Tk 200,000 and Tk 100,000, respectively, or a certain percentage of the facility budget is allocated to the DH and UzHC by the DGHS with approval of the FD. Economic classification code “8501-DDO's Advance,” commonly known as “imprest,” is in use in other areas of the MOHFW; therefore, a new code need not be created. Health facility managers need only submit documents to account officers as proof of fund use; unless spending amounts are greater than Tk 100,000, in which case the department would require FD, MOF authorization (GOB 2015).

Engaging the private sector at DHs and UzHCs for diagnostic services

Public facilities at the upazila and district levels do not offer essential diagnostic services. In Bangladesh, the private sector provides a large share of diagnostic services at different levels of the health system. Private services can be made available at public facilities to

address this imbalance and equity gap. Public funds could be used to purchase private services for public facilities and to bring private providers into public health coverage.

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

Budget Reporting for Monitoring and Accountability

Fragmented reporting, weak monitoring, and accountability

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

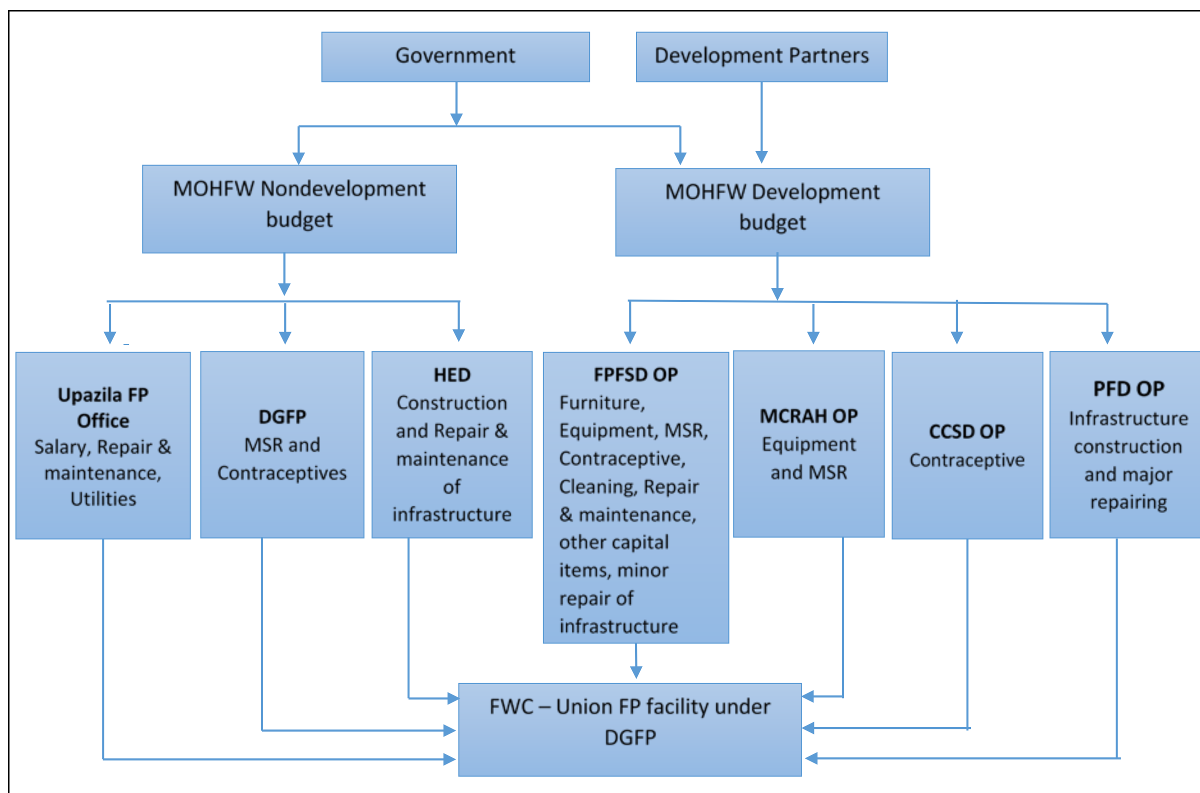
The accounting system does not track resources provided to frontline delivery units such as primary health care facilities below the upazila level. Expenditure is reported against the respective budget heads[19] of the MOHFW. For example, the budget for union-level health and family planning facilities below the upazila is included in the budget for the Upazila Health Offices, Upazila Family Planning Offices, and Upazila Health Complexes. Therefore, the government accounting system captures the expenditure incurred by the upazila-level entities, but not by union-level facilities. This has implications for transparency and accountability.

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

The separate disbursement method is also an obstacle to monitoring individual line item expenditures from a single platform. The nondevelopment budget is entity-wise and is distributed to different units of the MOHFW, including district and upazila units. On the other hand, the development budget is OP-wise or project-wise and disbursed from the center directly to facilities at the different levels, for example, the MCWC or UzHC without touching the ledger account of the district- or upazila-level health and family planning offices. The nondevelopment expenditure of the UzHC is directly incurred by the Upazila Health and Family Planning Officer. Although the Medical Surgical Requisites budget is placed at the disposal of the UHFPO, the procurement is made by the CS. The UHFPO may not have full details of the MSR expenditure if information on expenditure is not relayed to the UHFPO in time. The district's Deputy Director Family Planning is responsible only for expenditures of her/his own office. The Upazila Family Planning Officer receives the fund directly from the center. The LDs of the Directorate General of Family Planning send the MSR materials, and cost of family planning operations and related expenditure directly to the cost centers (for example, Upazila Family Planning Office and Mother and Child Welfare Centre). The LD/PD, therefore, must integrate expenditure reports from all units during budget formulation and preparation of the consolidated SOE, which is required for the fund release request—which is hence often delayed.

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

Figure 11: Flow of Resources to the Union Health and Family Welfare Center Facility under the Directorate General of Family Planning



Note: Other capital items include tube wells and installation of electricity and solar panels. MOHFW = Ministry of Health and Family Welfare, FP = Family Planning, DGFP = Directorate General of Family Planning, MSR = Medical and Surgical Requisites, HED = Health Engineering Department, FPFSD OP = Family Planning Field Service Delivery Operational Plan, MCRAH = Maternal, Child, Reproductive, and Adolescent Health, CCSD = Clinical Contraception Services Delivery, PFD = Physical Facilities Development, FWC = Family Welfare Center.

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

It is difficult to track how much nondevelopment budget is allocated to facilities at different tiers under the DGFP. For example, the budget for "Hospitals and Dispensaries"[20] includes the budget for a large central-level maternity hospital, Mother and Child Welfare Center,

20. Currently, all these facilities belong to the Function Code 7489 (old code 2789) under only one operation code.

Maternal and Child Health units[21] at the upazila level, and Family Welfare Visitors (FWVs) training institutions. Similarly, the budget for union-level facilities under the DGFP is included in the budget for UFPO. To enable tracking, all these different tiers of facilities should at least have operation codes if separate function codes are not possible. This is necessary for improving transparency and accountability in budgeting.

It is not possible to track expenditure of “unallocated block allocation”—a subcategory under the line item “block allocation.” It is also not possible to track unallocated block allocation spent on various activities, reflecting lack of transparency and accountability. This allocation is almost entirely financed from the development budget (less than 1 percent is financed from the nondevelopment budget). In FY2015, the MOHFW spent Tk 4,950 million, representing 6 percent of MOHFW recurrent expenditure.[22]

The proportion of nondevelopment budget resources spent to implement the sector program is not easily calculated, as this cannot be tracked. The sector program’s PIP shows the total nondevelopment budget at the aggregate level; however, at the implementation level, the OP budget excludes the nondevelopment budget. Therefore, reporting of OP implementation focuses only on the development budget, and monitoring of OP implementation covers development budget execution only.

Strengthening of Auditing

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

In addition, the OP Improved Financial Management (IFM) under the third SWAp was responsible for improving financial management and OP audit systems. IFM continues under the Fourth SWAp as an OP with a total allocation of Tk 282.8 million, aiming to improve the FM and audit handling capacity of the OPs. The Financial Management and Audit Unit (FMAU) oversees overall coordination of FM and internal and external audit of all programs/projects under the MOHFW.

Audit observations often lack quality. In many cases, these are not detailed enough for conclusive decision-making. This may be due to a lack of qualified auditors as well as to insufficient professional training for the auditors. There are also allegations of auditors engaging in rent-seeking behavior, leading to inconclusive audit observations.

Persistent delays in audit resolution is an issue. These can be attributed to negligence on the part of both the auditor and the auditee. The fewer number of auditors, overloaded with the task of resolving numerous observations, may be one reason for the delays. At the same time, delays are also caused by the auditee in responding to audit observations. In cases where the concerned staff are retired or transferred, there is no one to respond to the audit observations.

Delay in audit resolutions has serious consequences. In some cases, this results in the suspension of fund disbursement by the DPs, affecting fund release by the Government of

21. This unit is under the DGFP but operates within the UzHC, which is under the DGHS.

22. Controller General of Accounts (CGA) data.

Bangladesh, delayed or no procurement of certain items, slow progress, and sometimes even abandonment of planned activities. Review of the Annual Program Implementation Report 2015 and independent review of response to the audit by the LDs of OPs revealed that the status of audit resolution is still far from satisfactory in terms of meeting deadlines and quality.

STRENGTHENING THE CAPACITY FOR PFM

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

Most Program Managers and LDs in the health sector are medical doctors, who are not familiar with PFM functions. Managers and implementers of health projects/programs working at different levels of the health system need training on PFM in the health sector. While designing such training, it should be kept in mind that the same concept might be understood differently by health experts than by PFM experts. For example, service delivery as understood by PFM experts is the fund flow from the central to service delivery points. On the other hand, from the health sector perspective, service delivery means providing health services from service delivery points.[23] Adequate measures (for example, provision of a glossary handbook of PFM and health financing terms) should be taken to improve PFM literacy among public health professionals and also to remove the language barrier between PFM and health experts.

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

PFM capacity-strengthening activities for middle and senior managers in the health sector should aim to create awareness and understanding of PFM concepts, rules, and regulations and their implications. This would develop an understanding of basic concepts and principles necessary for sound PFM, comply with PFM rules and regulations, apply performance requirements for FM, and exercise the principles of effective reporting.

The lack of necessary and relevant manuals makes the situation worse. Budgeting needs proper understanding of what type of expenditure will be coded under which economic code classification. Often, line items are wrongly coded. For example, facilities do not use uniform coding for depositing the revenue collected from the different types of hospital services.[24] This is because there is no detailed manual with appropriate examples.

Modernization of PFM systems and defining the functional requirements and technology architecture for implementation of PFM solutions should be based on best practices. A framework for reporting PFM activities would be useful. It was found that replacement or newly appointed officials face challenges in finding process-oriented documents/reports. The proposed framework would be useful for institutional development and for newly appointed officials to correctly perform PFM functions. A coherent and consistent set of

---

23. Authors' discussions with PFM experts and health service providers.

24. Some facilities deposit collected outdoor ticket and admission fees under Code 2024 ("user fees") while some facilities use Code 2023 ("health and family planning services"); for depositing the collected surgery fees, some use Code 2024 ("user fees") while others use Code 2112 ("hospital receipts").

principles, rules, and instructions should be available to guide officials to efficiently and effectively deliver their PFM-related duties and responsibilities.

The departmental system of the MOHFW's Directorate General of Health Services, Directorate General of Family Planning, and Health Economics Unit must be integrated with iBAS for smooth operation of the departmental Financial Management Information System (FMIS). This would facilitate real-time transfer of budget endorsement, fund release, and accounting information from the FD and CAO Health Office to the DGHS and DGFP and subsequently to the PDs and LDs.

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

Box 1. PFM and quality of health care

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

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

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

RECOMMENDATIONS

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

Recommendations: Policy level

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

Key areas	Identified PFM diagnostic issues	Recommendations	Term	Responsibility
MHVS	The long delay in flow of funds from national to upazila level affects efficiency and effectiveness of program activities.	II.a. Initiate dialogue with the MOF to allow Imprest Fund for the development budget Or alternatively II.b. Initiate dialogue with the MOF to finance the MHVS from the nondevelopment budget as for other social protection programs. III. Finance MHVS through the nondevelopment budget IV. Make arrangements of advance or Imprest Fund to be used for timely payment of cash incentives and travel allowances to beneficiaries, if financed from the nondevelopment budget.	Medium to long term	MOHFW and MOF
NHSO	No policy directive from the government for establishing NHSO for social health protection scheme	I. Initiate policy discussions and initiate processes to complete prerequisites for establishing the NHSO. II. Draft the Act and place it at the Parliament. III. Establish fully functional NHSO.	Short (I), medium (II), and long (III)	HEU, MOHFW, and MOF
Availability of drugs and medical supplies at service delivery points	Delay in procurement of drugs and medical supplies is affecting health service delivery at district and upazila levels.	I. Organize consultation with CPTU. II. Introduce a three-year framework contract for drug procurement.	Medium	CMSD, CPTU, and MOHFW
Engage private sector in public service provision	Public facilities at upazila and district levels lack required diagnostic services.	I. Initiate dialogue with the DGHS and MOF. II. Organize stakeholder consultations with district-level managers. III. Design detailed implementation plan. IV. Implement on a pilot basis.	Medium (I and II) and long (III and IV)	Planning Wing, Budget Wing, MOHFW, CPTU, FD, and MOF
Flexible operational fund at facilities for timely repair and maintenance	Health facilities at the district level do not have funds for timely repair and maintenance of buildings, equipment, and ambulance.	I. Initiate dialogue with the MOF and relevant stakeholders within the MOHFW and DGHS. II. Make changes in financial rules. III. Introduce "Flexible Cash at Facilities."	Medium (I) and long (II and III)	HEU, Budget Wing, MOHFW, FD, and MOF

Source: Authors

Note: SOE = Statement of Expenditure, RPA = Reimbursable Project Aid, MOF = Ministry of Finance, SWAp = Sector-wide Approach, MOHFW = Ministry of Health and Family Welfare, OP = Operational Plan, FD = Finance Division, SSK = Shasthya Surokhsha Karmasuchi, RAF = Resource Allocation Formula, MHVS = Maternal Health Voucher Scheme, NHSO = National Health Security Office, HEU = Health Economics Unit, CPTU = Central Procurement Technical Unit, CMSD = Central Medical Stores Depot, DGHS = Directorate General of Health Services.

Recommendations: Operational level

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

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

Note: DGHS = Directorate General of Health Services, DGFP = Directorate General of Family Planning, MOHFW = Ministry of Health and Family Welfare, MOF = Ministry of Finance, DRM = Domestic Resource Mobilization, CSC = Community Support Committee, HEU = Health Economics Unit, FD = Finance Division, RAF = Resource Allocation Formula, SSK = Shasthya Surokhsha Karmasuchi, FMAU = Financial Management and Audit Unit, PFM = Public Financial Management, FMIS = Financial Management Information System, MIS = Management Information System, IST = In-Service Training, NIPORT = National Institute of Population Research and Training.

REFERENCES

Ahsan, K., P. Streatfield, Rashida -E- Ijdi, G. Escudero, A. Khan, and M. Reza. 2016. "Fifteen Years of Sector-wide Approach (SWAp) in Bangladesh Health Sector: An Assessment of Progress." *Health Policy and Planning* 31(5): 612-623.

Bhagat, J. 2016. *Budget Note*. An internal note developed for the HNP GP team, The World Bank Office Dhaka

Cashin, C., D. Bloom, S. Sparkes, H. Barroy, J. Kutzin and S. O'Dougherty. 2017. "Aligning Public Financial Management and Health Financing: Sustaining Progress toward Universal Health Coverage." Health Financing Working Paper No. 17.4. Geneva: World Health Organization. License: CC BY-NC-SA 3.0 IGO. http://apps.who.int/iris/bitstream/10665/254680/1/9789241512039-eng.pdf.

DGHS (Directorate General of Health Services).2016. *Health Bulletin 2016*. Dhaka: MIS, DGHS, Ministry of Health and Family Welfare

Ensor, T., A. Hossain, Q. Ali, S. Begum, and A. Moral. 2001. "Geographic Resource Allocation Bangladesh." Health Economics Unit Research Paper 21. Dhaka: Health Economics Unit (HEU), Ministry of Health and Family Welfare (MOHFW), Government of the People's Republic of Bangladesh.

Ensor, T., and T. Begum. 2013. *Needs-based Geographic Resource Allocation in the Health Sector of Bangladesh: Moving towards Formula Funding*. Dhaka: Oxford Policy Management.

Fritz, V., S. Sweet, and M. Verhoeven. 2014. "Strengthening Public Financial Management: Exploring Drivers and Effects." World Bank Policy Research Working Paper (WPS7084). Washington, DC: World Bank.

GOB (Government of Bangladesh).1994. Government Order No-ama/obi/u:go:sha/3/94/360, June 2, 1994.

______.2002. Rule No. 12 of 2002 (Bangladesh Gazette, April 10, 2002)

______.2006. Public Procurement Act 2006. Ministry of Law, Justice and Parliamentary Affairs, Government of People's Republic of Bangladesh http://bdlaws.minlaw.gov.bd/bangla_all_sections.php?id=942

(Bangladesh Gazette June 2013)

______.2008. Revised Statutory Regulatory Order (SRO) No. 145-Law/2008

______.2008a. Rule No. 24 (Bangladesh Gazette, June 17, 2008).

______.2008b. Rule Nos. 25, 26, and 27 of SRO No. 145-Law/2008 (Bangladesh Gazette, June 17, 2008

______.2008c. Public Procurement Rule (PPR) 2008. (Bangladesh Gazette, January 8, 2008)

______.2010. "Bangladesh: Public Expenditure and Financial Accountability Assessment." Dhaka: Government of Bangladesh and Strengthening Public Expenditure Management Program (SPEMP). http://www.pefa.org/en/assessment/bd-dec10-pfmpr-public-en. Last consulted: December 23, 2017.

______.2012. National Health Policy 2011

______.2012a. *Sixth Five Year Plan FY 2011- FY2016: Accelerating Growth and Reducing Poverty.* Dhaka: General Economic Division, Bangladesh Planning Commission

______.2012b. *Expanding Social Protection for Health towards Universal Health Coverage: Health Care Financing Strategy 2012–2032*. Dhaka: Health Economics Unit (HEU). MOHFW, Government of the People's Republic of Bangladesh

______.2015. *Delegation of Financial Powers, Development Projects.*,GOB, August 16, 2015, Sl.4 Imprest Approval

———.2015a. *Seventh Five Year Plan FY2016–FY2020: Accelerating Growth, Empowering Citizens.* Dhaka: General Economic Division, Bangladesh Planning Commission

———.2015b. *National Social Security Strategy (NSSS) of Bangladesh*. Dhaka: General Economic Division, Planning Commission

HEU (Health Economics Unit). 2011. *Public Expenditure Review of the Health Sector 2007/08 and 2008/09*. Health Economics Unit Research Paper 40. Dhaka: HEU, Ministry of Health and Family Welfare (MOHFW), Government of the People's Republic of Bangladesh with GIZ support.

______. 2016. *Public Expenditure Review 1997–2014*. Dhaka: Health Economics Unit (HEU), Ministry of Health and Family Welfare (MOHFW).

______. *Draft Operational Manual. Shasthya Surokhsha Karmasuchi*. Dhaka: Health Economics Unit, MOHFW, Government of Bangladesh

______.2017. Memo No. SwaPKoM/SwaSeBi/Health-Econ/HNSP/Finance Budget/2017-22/762/2017/342. January 6, 2017.

Hossain, S.S. 2015. "Quality of Public Financial Management in Bangladesh: An Analysis from PEFA Framework Perspective." *Journal of Humanities and Social Science* 20 (6): 43–55.

ICMAB (Institute of Cost and Management Accountants of Bangladesh). 2014. *Bangladesh Cost Accounting Standards.* Vol. 1. Dhaka: ICMAB.

Khan, M., and A. Khan. 2016. *Report on the Diagnostic Study of Demand Side Financing—Maternal Health Voucher Scheme of Bangladesh*. Dhaka: Maxwell Stamp PLC.

Khan, T., and M. Sabbih. 2015. "District Budget Experience in Bangladesh: The Case of Tangail." Dhaka: Centre for Policy Dialogue (CPD). http://cpd.org.bd/wp-content/uploads/2015/03/District-Budget-Experience-in-Bangladesh_Tangail.pdf

MOF (Ministry of Finance). 2010. Unified Budget and District Budget- a Concept Paper, Finance Division, MOF, Government of the People's Republic of Bangladesh.

______.2015. *Medium Term Budget Framework for Ministry of Health and Family Welfare 2015-16*

______.2017. *Medium-Term Macroeconomic Policy Statement (MTMPS) 2017–18 to 2019–20*. Finance Division, MOF, Government of the People's Republic of Bangladesh. https://mof.gov.bd/en/budget1/17_18/mtmps/en/MTMPS%20EN_comp.pdf.

_____.2017a. *Medium-Term Budgetary Framework -MTBF- 2017-18 to 2019-20*, Finance Division, Ministry of Finance (MOF), Government of the People's Republic of Bangladesh. https://mof.gov.bd/en/index.php?option=com_content&view=article&id=397&Itemid=1

MOHFW (Ministry of Health and Family Welfare). 2010. Memo No. 155, March 2, 2010, MOHFW.

_____.2011. Revised *Programme Implementation Plan (RPIP), Health, Population and Nutrition Sector Development Programme (HPNSDP) 2011-16*. Dhaka: Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh

_____.2014. Revised *Programme Implementation Plan (RPIP), Health, Population and Nutrition Sector Development Programme (HPNSDP) 2011-16*. Dhaka: Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh

_____. 2016. *Health, Nutrition, and Population Strategic Investment Plan (HNPSIP) 2016–21: Better Health for a Prosperous Society.* Dhaka: Planning Wing, Ministry of Health and Family Welfare (MOHFW), Government of the People's Republic of Bangladesh.

_____.2016a. *Memo No. 709. Order issued on October 5, 2016, MOHFW*

———.2017. *Programme Implementation Plan, 4th Health, Population and Nutrition Sector Programme*. Dhaka: Ministry of Health and Family Welfare, Government of the People's Republic of Bangladesh

_____.2018. *Bangladesh National Health Accounts 1997–2015.* Dhaka: Health Economics Unit, Health Services Division. MOHFW, Government of the People's Republic of Bangladesh.

OCED (Organisation for Economic Co-operation and Development). 2006. *Harmonizing Donor Practices for Effective Aid Delivery*. Organisation for Economic Co-operation (OECD): Paris: OECD publication service

PMMU (Program Management and Monitoring Unit). 2013. *Annual Program Implementation Report (APIR) 2013*. Dhaka: PMMU, Planning Wing, Ministry of Health and Family Welfare (MOHFW), Government of the People's Republic of Bangladesh.

———. 2015. *Annual Program Implementation Report (APIR) 2015*. Dhaka: PMMU, Planning Wing, Ministry of Health and Family Welfare (MOHFW), Government of the People's Republic of Bangladesh.

Renzio, P., and W. Dorotinsky. 2007. *Tracking Progress in the Quality of PFM Systems in HIPCs*. Washington, DC: PEFA Secretariat. http://www.pefa.org/report_studies_file/HIPC-PEFA%20Tracking%20Progress%20Paper%20FINAL_1207944117.pdf.

TIB (Transparency International Bangladesh). 2014. *Shasthya Khatay Shushashoner Challenge O Uttoroner Upay (Good Governance Challenges in Health Sector and Ways to Overcome).* Dhaka: TIB.

Welham, B., P. Krause, and E. Hedge. 2013. "Linking PFM Dimensions to Development Priorities." London: Overseas Development Institute (ODI).

Welham, B., T. Hart, S. Mustapha, and S. Hadley. 2017. “Public Financial Management and Health Service Delivery, Necessary, but Not Sufficient.” London: Overseas Development Institute (ODI).

WHO (World Health Organization). 2010. *The World Health Report: Health System Financing: The Path to Universal Coverage*. Geneva: WHO.

———. 2017. “Public Financial Management within Health Financing.” *UHC Technical Brief*. Geneva: WHO South East Asia Regional Office http://www.searo.who.int/entity/health_situation_trends/public_finance_management.pdf.

World Bank. 2006. *Bangladesh Country Assistance Strategy 2006–2009*. Washington DC: The World Bank Group. http://siteresources.worldbank.org/BANGLADESHEXTN/Resources/CAS_MAIN_BOOK_FINAL.pdf.

———.2010. *Bangladesh Health Sector Profile*. Dhaka: World Bank in collaboration with Government of Bangladesh and WHO.

———. 2014. *Bangladesh Governance in Health Sector: A Systematic Literature Review*. Dhaka: World Bank.

———. 2016a. *Fiscal Space for Health in Bangladesh: Towards Universal Health Coverage*. Washington DC: The World Bank Group.

———. 2016b. *PFM in Health. Conceptual Framework*. Draft Report. Washington, DC: World Bank.

ANNEX 1:

ANNEX TABLE: OPERATIONAL PLAN BUDGET AND EXPENDITURE AS A SHARE OF HPNSDP PROGRAM IMPLEMENTATION PLAN AND REVISED PROGRAM IMPLEMENTATION PLAN (FY2012–FY2016)

Name of the HPNSDP Operational Plan (OP)	ADP as % of		RADP as % of			OP expenditure as % of			
	PIP	RPIP	PIP	RPIP	ADP	PIP	RPIP	ADP	RADP
Alternate Medical Care (AMC)	73	79	105	113	143	88	94	119	83
Clinical Contraception Services Delivery (CCSD)	48	79	56	92	116	45	74	94	81
Communicable Diseases Control (CDC)	73	78	94	99	128	76	81	104	82
Community-based Health Care (CBHC)	59	89	61	92	103	41	62	69	68
Essential Services Delivery (ESD)	60	109	72	130	120	35	63	58	48
Family Planning Field Services Delivery (FPFSD)	58	87	63	94	108	47	71	81	75
Health Economics and Financing (HEF)	99	69	100	70	101	41	29	41	41
Health Education and Promotion (HEP)	57	74	76	99	134	66	86	116	86
Health Information Systems and E-Health (HIS-EH)	60	84	67	92	110	122	168	201	183
Hospital Services Management (HSM)	74	70	99	94	134	106	100	142	107
Human Resources Management (HRM)	37	153	28	116	76	12	51	34	44
Improved Financial Management (IFM)	106	184	57	99	54	46	80	44	81
Information, Education, and Communication (IEC)	80	87	91	99	113	74	81	93	82
In-Service Training (IST)	52	100	59	114	113	43	83	83	73

Name of the HPNSDP Operational Plan (OP)	ADP as % of		RADP as % of			OP expenditure as % of			
	PIP	RPIP	PIP	RPIP	ADP	PIP	RPIP	ADP	RADP
Management Information System (MIS)	78	89	95	108	122	60	69	77	63
Maternal, Child, Reproductive, and Adolescent Health (MCRAH)	64	74	75	87	118	57	67	90	77
Maternal, Neonatal, Child, and Adolescent Health (MNCAH)	70	67	95	91	136	66	63	94	69
National AIDS and STD Program (NASP)	56	79	63	89	113	42	60	76	67
National Eye Care (NEC)	91	91	92	92	102	76	76	83	82
National Nutrition Services (NNS)	29	96	30	98	102	13	44	46	45
Noncommunicable Diseases (NCDs)	63	95	71	107	113	55	83	87	78
Nursing Education and Services (NES)	73	64	94	83	129	65	57	89	69
Physical Facilities Development (PFD)	51	45	53	47	105	53	47	105	100
Planning, Monitoring, and Evaluation of Family Planning (PME-FP)	98	86	104	91	107	90	79	92	86
Planning, Monitoring, and Research (PMR-DGHS)	72	83	80	92	111	62	72	86	78
Preservice Education (PSE)	96	74	123	95	128	127	98	133	103
Procurement, Logistics, and Supplies Management (PLSM-CMSD)	73	72	93	92	127	103	102	142	111
Procurement, Storage, and Supplies Management (PSSM-FP)	70	83	81	95	115	74	87	105	92
Sector-wide Program Management and Monitoring (SWPMM)	24	18	28	21	118	17	13	73	62
Strengthening of Drug Administration and Management (SDAM)	107	57	125	66	117	68	36	64	55
TB and Leprosy Control (TB-LC)	78	68	124	108	158	69	60	88	56

Name of the HPNSDP Operational Plan (OP)	ADP as % of		RADP as % of			OP expenditure as % of			
	PIP	**RPIP**	**PIP**	**RPIP**	**ADP**	**PIP**	**RPIP**	**ADP**	**RADP**
Training, Research, and Development (TRD)	89	90	88	89	99	63	64	71	71

Source: ADP 2011/12-2016-17, RADP 2011/12-2016/17, MOHFW 2011, MOHFW 2014

Note: HPNSDP=Health, Population and Nutrition Sector Development Programme, PIP = Programme Implementation Plan, RPIP = Revised Programmme Implementation Plan, ADP = Annual Development Programme, RADP = Revised Annual Development Programme

Robust public financial management (PFM) systems are crucial to ensure the efficacy and integrity of public health spending, thereby contributing to improved service coverage and financial protection, as required for achieving universal health coverage. A weak PFM system has impeded implementation of the Bangladesh Health Care Financing Strategy 2012–2032. This paper aims to identify and document major PFM challenges in relation to the interventions outlined in this strategy document, on the grounds that relaxing these constraints would strengthen implementation. Further, the study examines PFM barriers in service delivery, such as delays in fund availability and procurement and the lack of operational funds at the facility level. The paper points to a number of obstacles, including the absence of a legal framework for implementing a social health protection scheme, no laws to retain user fees at health facilities or to change financial rules to introduce "Flexible Cash at Facilities," district health managers without delegated financial power, noncompliance with audit observations, and need for PFM capacity strengthening. Short-, medium- and long-term actions are proposed to address these PFM issues. Removing these barriers would not require significant additional resources but would offer the potential to significantly enhance value for money for Bangladesh's government health budget.

ABOUT THIS SERIES:

This series is produced by the Health, Nutrition, and Population Global Practice of the World Bank. The papers in this series aim to provide a vehicle for publishing preliminary results on HNP topics to encourage discussion and debate. The findings, interpretations, and conclusions expressed in this paper are entirely those of the author(s) and should not be attributed in any manner to the World Bank, to its affiliated organizations or to members of its Board of Executive Directors or the countries they represent. Citation and the use of material presented in this series should take into account this provisional character. For free copies of papers in this series please contact the individual author/s whose name appears on the paper. Enquiries about the series and submissions should be made directly to the Editor Martin Lutalo (mlutalo@worldbank.org) or HNP Advisory Service (askhnp@worldbank.org, tel 202 473-2256).

For more information, see also www.worldbank.org/hnppublications.

1818 H Street, NW
Washington, DC USA 20433

Telephone: 202 473 1000
Facsimile: 202 477 6391
Internet: www.worldbank.org
E-mail: feedback@worldbank.org