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An Intergovernmental Perspective on Managing Public Finances for Service Delivery

Assessing Neglected Challenges in the Health Sector and Beyond

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List of Acronyms

CDOH	County Department of Health (Kenya)
CIDP	County Integrated Development Plan (Kenya)
DHO	District Health Office (Uganda)
FMOH	Federal Ministry of Health (Ethiopia)
GDP	Gross Domestic Product
MOF	Ministry of Finance (Ethiopia and Kenya)
MOFPED	Ministry of Finance, Planning, and Economic Development (Uganda)
MOH	Ministry of Health (Kenya and Uganda)
NDOH	National Department of Health (South Africa)
NYU	New York University
OECD	Organization for Economic Co-operation and Development
PBB	Program-Based Budgeting
PDOH	Provincial Department of Health (South Africa)
PEFA	Public Expenditure and Financial Accountability
PFM	Public Financial Management
PPP	Purchasing Power Parity
RHB	Regional Health Bureau (Ethiopia)
SDGPF	Sustainable Development Goals Performance Fund (Ethiopia)
UCLG	United Cities and Local Governments
UN	United Nations
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

Abstract

Improving service delivery outcomes has long been at the top of the agenda in international development. The urgency for action has intensified in the face of a global pandemic, climate change, and worsening inequality. Despite a shared agenda, approaches to attaining this goal have been fragmented across different fields of public sector expertise, including sector financing, public financial management, and decentralization. Progress is slow, but some barriers are breaking down. One area that has received particularly limited attention is how sector finances are managed in diverse multilevel systems of government, and how these arrangements may affect service delivery. This paper starts to fill that gap by looking across the relevant literature and applying an intergovernmental lens to health sector financing arrangements in four African countries with different intergovernmental systems—Ethiopia, Kenya, South Africa, and Uganda. While generalization is elusive, the paper demonstrates the value of more purposefully incorporating intergovernmental structures and dynamics into the analysis of sector financing and service delivery. An exploratory analytical framework is proposed as a means of building knowledge and generating practical ideas for improvement. The paper concludes by setting out an agenda for further work at the intersection of decentralization, public finance/financial management, and sector financing.

An Intergovernmental Perspective on Managing Public Finances for Service Delivery:

Assessing Neglected Challenges in the Health Sector and Beyond

I. Introduction

Improving service delivery and sector outcomes is rapidly becoming a top demand on those who manage public finances. This imperative is even more pressing as public servants around the world struggle with a global pandemic, confront climate change, and grapple with growing inequality.[1] But exactly how to manage public resources in support of better and more inclusive public services eludes clear guidance. The academic and practitioner literatures identify many deficiencies in how resources are generated and managed in order to meet public objectives, but there is less strong systematic evidence on the upside.

Multiple elements of public sector operations—the sectoral policies that determine service delivery parameters and resource needs; the mobilization, allocation, and management of public finances; and the roles and relationships among levels of government in multilevel systems—play a vital role in the delivery of public services.[2] These elements and others, however, are often developed and considered separately despite the critical linkages among them. The premise of this paper is that they should instead be understood and treated as a set of interactive components in a complex system by those trying to improve the use of public resources for service delivery.

The divides in public sector operations and reform reflect the core priorities of different lead actors.[3] A typical finance ministry charged with the stewardship of a nation's public finances is principally concerned with ensuring the optimal use of these resources. A sector ministry is concerned chiefly with outcomes relevant to its mandate (such as educational attainment or health status) and with the delivery of public services to support those objectives (such as schooling or health care services). A typical ministry responsible for intergovernmental relations, decentralization, or local government is charged with enhancing and supporting the role and performance of subnational governments.[4] Despite clear linkages among these goals in relation to service delivery, finding a way for the ministries to work together requires dedicated collaborative effort and often involves challenging and contested tradeoffs in system design and implementation.

Recent research, reviewed below, has made progress in bridging the divides in public sector reform by examining how public financial management (PFM) can more effectively support service delivery. There has been comparative work on the distinctive needs and challenges faced by particular service

[1] This is a pervasive theme in the development literature, a major area of development partner support, and a central focus of global development agendas, such as the Sustainable Development Goals (https://sdgs.un.org/goals).
[2] There are, of course, other important aspects of public sector operations, such as human resource management, that are not considered in detail in this paper.
[3] This point is raised in both the public sector reform and decentralization literatures. A concise summary of the issues and consequences of fragmented public sector reforms is presented in Eaton et al. (2011).
[4] Not all ministries, of course, do what they are supposed to do—some local government ministries, for example, behave in a controlling fashion that can constrain subnational government action.

sectors,[5] and specific work has been conducted on decentralization and health.[6] The existing literature has paid much less attention, however, to how sector finance and PFM play out in diverse intergovernmental systems and how this may affect service delivery.[7] This paper intends to help fill that gap by raising awareness about the value of more deliberately incorporating intergovernmental relations in the analysis of sector financing and by presenting an exploratory framework to support such analysis. Although the paper considers issues that are generally relevant for service delivery, the health sector is used to illustrate the nature and potential importance of arrangements, relationships, and dynamics that are often underappreciated.[8]

The more limited treatment of intergovernmental concerns in work on managing finances for service delivery may occur because central governments are expected to lead in the definition of national development policies and the systems and procedures that support the pursuit of those policies. At the same time, there is extensive literature and experience to demonstrate the valuable role that subnational governments and other local actors can play in improving the efficiency, effectiveness, and equity of public resource use in service delivery.[9] Moreover, decentralization has been adopted or deepened in many developing countries in recent decades.[10] A critical point for this paper is that decentralization is highly diverse, ranging from centralized systems that manage local operations through deconcentrated field offices of national ministries to devolved systems with empowered subnational governments that are accountable to elected councils. Many countries have hybrid approaches that combine elements of both systems and other mechanisms, and there is great variation in the number of levels and roles of subnational government. Countries' diverse intergovernmental structures are often reflected in some way in their sector policies and processes, and in their resource allocation and financial management mechanisms. A full analysis of service delivery financing therefore needs to include the intergovernmental system.[11]

The rest of the paper is organized as follows.

- **Section II provides additional context to frame the main analysis.** This section includes a brief discussion of how this work is situated in the broader process of moving from the elaboration of government policy priorities to the delivery of public services. It concisely reviews current thinking about the relationship between PFM and service delivery in the context of varying institutional structures.
- **Section III further considers the nature and role of decentralization and intergovernmental relations in sector finance**, using intergovernmental fiscal principles to frame how resources

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[5] See, for example, Batley and Mcloughlin (2015), Mcloughlin and Batley (2012), and Wild et al. (2012).

[6] See, for example, Bossert (1998), Mitchell and Bossert (2010), Sheshadri et al. (2016), Liwang and Wyss (2019), and Sumah and Baatiema (2019).

[7] The PFM–decentralization relationship is discussed in Boex and Kelly (2013), Fedelino and Smoke (2013), Smoke (2015b), and Mills (2017). Boex (2020) and Cook (2020) also incorporate the service delivery dimension.

[8] The importance of an integrated approach is recognized in the broader health decision space framework developed by Bossert (1998) and used in many case studies.

[9] Much has been written on this topic over the past three decades. Recent synthetic treatments include Faguet and Pöschl (2015), Smoke (2015a), Bahl and Bird (2018), Kim and Dougherty (2019), and Rodden and Wibbels (2019).

[10] Intergovernmental system diversity is challenging to document systematically, but there are a number of broad global overviews, such as UCLG and World Bank (2009), UCLG (2010), and OECD/UCLG (2016/2019), and attempts to compare selected regions or countries, such as World Bank (2005), Ellis & Roberts (2016), Boex (2013), and Smoke (2013, 2019).

[11] Alternatively, it may be possible to modify intergovernmental structures in cases where they create insurmountable challenges for the effective performance of public functions.

for service delivery are organized and managed in different intergovernmental environments.

- **Section IV uses the framing outlined in section III to examine the sources, flow, and management of finances in the health sector in four African countries**—Ethiopia, Kenya, South Africa, and Uganda. The countries' overall intergovernmental systems are outlined briefly, with a specific focus on institutional responsibilities for health services, available sources of finance, and the intergovernmental management and flow of funds in the sector.
- **Section V presents key challenges in subnational health financing and PFM that are reported to affect service delivery in the countries under consideration**. Unlike the system assessments in section IV, the challenges discussed here are not based on a systematic conceptual framework—instead, this section organizes the challenges reported in relevant secondary materials into categories to facilitate presentation.
- **Section VI reviews the factors and dynamics that generate or contribute to the health financing and PFM challenges observed in the cases.** These include both immediate contributors (termed here *proximate determinants*), such as system design flaws and failure to follow established procedures, as well as more fundamental underlying forces (termed here *causal factors*) that drive the proximate determinants, such as political economy and institutional capacity. An understanding of these realities provides a basis for identifying potential responses and assessing their likely feasibility.
- **Section VII presents a preliminary analytical framework** to assist reformers in documenting relevant intergovernmental considerations and identifying specific PFM and sector financing problems that affect service delivery. The diagnostic builds on the literature review, reported experiences in case countries, and the factors and forces behind the challenges experienced in sector financing.
- **Section VIII concludes and offers selected recommendations for further work**. This includes ideas for building directly on this paper and for additional investigation of case experiences and consequential intergovernmental issues in service delivery financing that are insufficiently documented and understood.

II. Some Background Basics: From Policy Priorities to Financing Service Delivery

The question of how public resources relate to service delivery and sector outcomes has multiple dimensions. Three are reviewed in this section to clarify the scope of the paper and lay a foundation for subsequent sections. The first consideration is the overall framework within which government policy choices are translated into government actions and then into policy impacts (including development results). The second is the role of PFM processes in raising, prioritizing, allocating, executing, evaluating, and accounting for public resources at the sector level. The third is the institutional and intergovernmental setting in which public policy, PFM, and sector processes play out, which can vary considerably across countries.

1. The Positioning and Pathway of Funding in the Public Policy Framework

The provision of public resources for service delivery in principle broadly follows a well-recognized path. In the simplest terms, government policy choices create the basis for government actions, including service delivery, which in turn are expected to lead to desired policy impacts (Figure 1, Column A) (NYU International Working Group, 2020). Policy choices, or priorities, include fiscal policy, sector policy, and decentralization policy, among others. These policies provide parameters for budgeting, for service delivery and other government actions, and for functional responsibilities among different public sector entities. While the attribution thereafter of government actions to policy impacts is empirically challenging, the intention and expectation are clear.

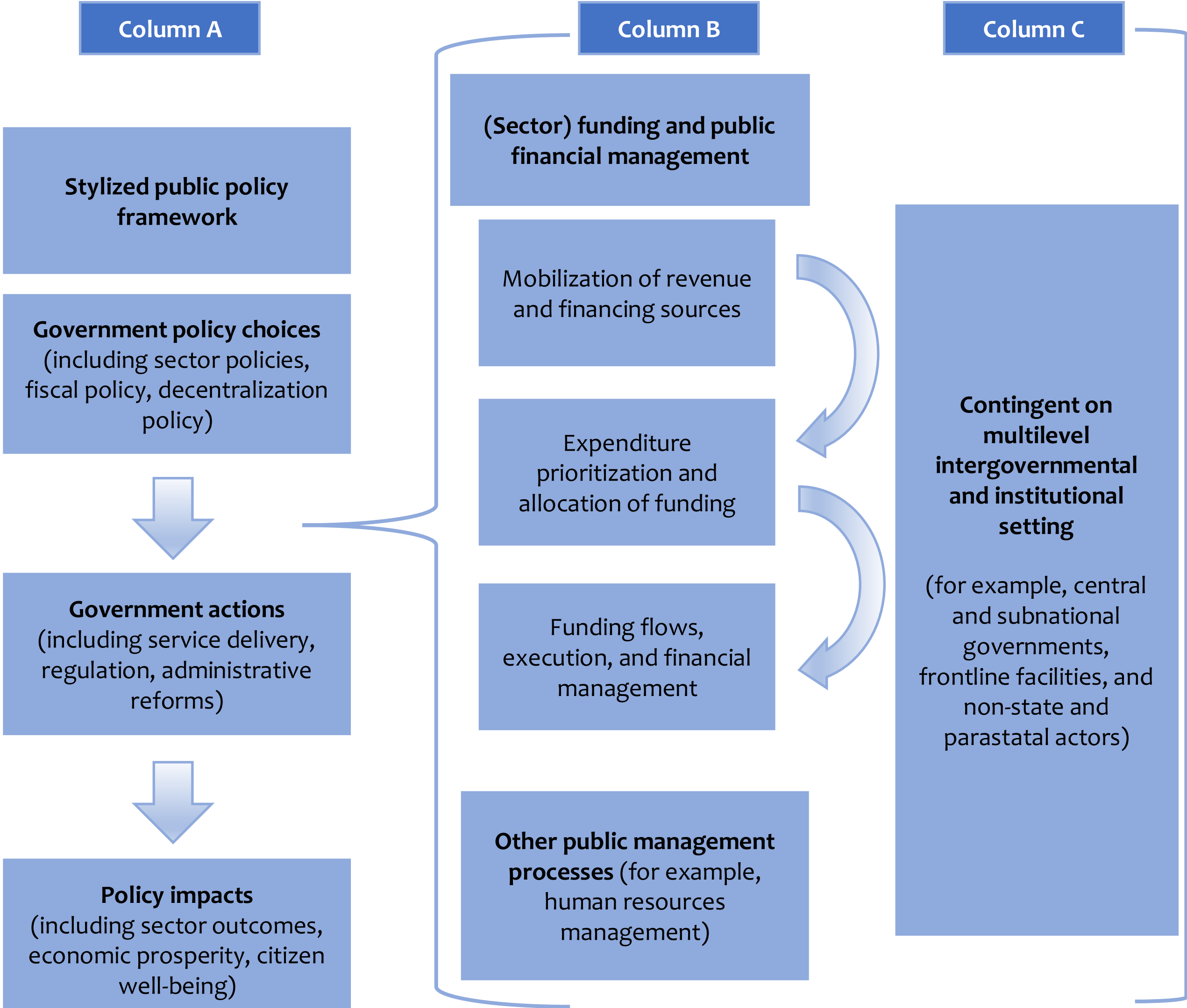
This paper is not primarily about how government policy choices are determined, which has both political and technical dimensions. This is obviously a foundational step in the process of delivering public services, but how such decisions are made and the attendant debates about policymaking are beyond the scope of this paper. Moreover, the paper is not focused on policy impacts such as sector outcomes, economic prosperity, and citizen well-being, although there are, of course, major difficulties in measuring how, and to what distinctive extent, public services contribute to these outcomes. Equally challenging and inconclusive is the empirical question of how PFM contributes specifically to service delivery (De Lay et al., 2015).

The primary emphasis of the paper is on selected aspects of the process by which policy choices are translated into service delivery. Specifically, it focuses on sector funding and on the functioning of PFM in relation to service delivery—both *within* intergovernmental systems and *across* multilevel institutional settings (Figure 1, Columns B and C). Three aspects of funding and PFM are considered: mobilization of revenue and financing sources; expenditure prioritization and the allocation of funding; and funding flows, execution, and financial management. While other public management systems, such as human resource management, are important and closely connected (World Bank, 1998), those are not addressed directly in this paper.

Although the actors involved in making choices and taking actions may vary according to the type of intergovernmental system in which they operate, many of the basic issues regarding sources, flows, and management of funding for service delivery are relevant for centralized systems with deconcentrated field administrations, for devolved systems with empowered local governments, and for mixed systems. Other organizational entities, such as dedicated service delivery boards and frontline service facilities, to varying degrees receive revenues, keep accounts, and manage (aspects of) delivery in all intergovernmental and institutional settings. Finally, there are complex accountability

relationships for service delivery that condition incentives, and which may vary across settings (Miller et al., 2021).

Figure 1: Public finance, sectors, and decentralized governance in the public policy framework



Source: Adapted and further developed from NYU International Working Group (2020), pp. 82-87.

2. Public Financial Management and Service Delivery

The path from government policy choices to government actions, including service delivery, relies heavily on the PFM system, which raises, allocates, organizes, and accounts for public resources. This system's interaction with sector practices and preferences for the financing and delivery of public services—in other words, "PFM and service delivery"—has become a prominent area of debate, research, and action in international development. One feature of that is a nascent joint agenda on the part of sector financing specialists and PFM specialists to look for areas of convergence and investigate the tensions or trade-offs that may be inherent.

An ODI paper (Miller et al., 2021) explores the extent and nature of these common or differing perspectives. ODI's findings reveal a strong shared reliance on established PFM frameworks and principles. Although some experts have challenged the conventional technical framing of PFM as principally involving the formulation, approval, execution, and evaluation of budgets, this perspective still has strong influence and traction.[12] A central focus is the control and administration of public spending—that is, the rules, procedures, and processes of PFM and the incentives they produce for effective use of resources in delivering public services. Spending limits, output costing, program budgeting, strategic purchasing, and carryover limits, for example, are viewed as potential means of better connecting PFM and service delivery for this purpose (Gupta & Barroy, 2020). Nonetheless, the conventional wisdom among PFM practitioners is that "basic" elements of the PFM system, together with an emphasis on accountability, should be prioritized (Welham et al., 2017).

There is a growing field of inquiry into PFM "bottlenecks," obstacles, or binding constraints to service delivery (Cammack et al., 2020; Chukwuma et al., 2020; Barroy et al., 2019a; Choudhury & Mohanty, 2018; Krause et al., 2013). A synthesis of key issues produced by ODI points to weak links between plans and budgets, lack of credibility of budget allocations, erratic and unreliable funding flows, and poor timeliness and integrity of procurement (Miller et al., 2021), all of which are observed in the cases reviewed in the present paper. A recent stocktaking by the World Health Organization focused on the health sector in African countries (Barroy et al., 2019a). Consistent with the anchoring of many analyses around the budget cycle, it analyzed findings in relation to budget formulation (including approval), execution, and accountability (Table 1).

Beyond the mechanics of PFM, there is a recognition that multiple organizations and actors are involved in the various dimensions of PFM for service delivery. That cast expands beyond the "central finance agencies" (Dressel & Brumby, 2012) to sector ministries and agencies, as well as frontline facilities. The service provider perspective has notably led to calls for facilities to hold their own budgets, with more autonomy over spending decisions (Barroy et al., 2019b). There are divergent approaches to accountability as well, which in the education sector has contributed to incoherent systems and incentives (Pritchett, 2015). Whereas PFM typically emphasizes centralized, top-down systems and incentives aimed at probity and control (for example, a treasury single account or an integrated financial management information system), a sector view is more attuned and responsive to the public, who are the end users of services, as the object of accountability. This orientation leads to a push for flexibility and responsiveness in the management of financial resources in order to reflect the changing needs and demands of those users.

Although this paper is not concerned primarily with how PFM systems operate, nor with sector policy and management processes, both interact closely with the intergovernmental setting in a country. The intergovernmental institutional structures and practices that are the focus of the paper affect and are affected by both PFM and sector processes. The simple presumption of a centralized and unitary system is seldom accurate or instructive. The way that public resources for service delivery are mobilized, allocated, disbursed, and managed through an intergovernmental system will self-evidently have a material impact on how—and how effectively—those services are delivered.

[12] The IMF provides an authoritative summary: "PFM in the narrowest, and perhaps most traditional, sense is concerned with how governments manage the budget in its established phases—formulation, approval, and execution. It deals with the set of processes and procedures that cover all aspects of expenditure management in government" (Cangiano et al., 2013, p. 1).

Table 1: Common PFM obstacles to health service delivery in African countries

Budget cycle stages	PFM-related issues affecting service delivery in the health sector
Budget formulation (and approval)	• Weak approaches to priority setting and costing cause a disconnect between budget allocations and needs. • Multiple sources of funds, funding schemes, and funding flows complicate budgeting if they are not pooled and are subject to different allocation rules. • Certain public expenditures (such as personnel spending, capital expenditure, and supplies) are often programmed and controlled separately, causing fragmentation. • Input-based budget structures create rigidities and constrain effective matching of the budget to sector priorities and outputs. • Weak skills, limited influence on the finance ministry, and poor implementation of rules and calendars contribute to ineffective negotiation by sectors.
Budget execution	• Cash management systems are inadequate, with liquidity problems leading to late, inconsistent, or insufficient disbursement of funds. • Cash budgeting practices cause total releases to be matched to the revenues raised in the previous month, which can result in unexpected funding shortfalls. • Delays in disbursement, blockages at the district level, and constraints on accessing transfer funds mean that frontline facilities do not receive, or are not able to use, the funds intended for their use. • Requirement that within-year savings be returned to the central budget eliminates incentives to spend more effectively and efficiently in the sector. This applies particularly if the savings cannot be reallocated within the year.
Budget accountability	• Multiple funding flows to the sector, with associated rules and systems for financial management and reporting, impose fragmentation and administrative burdens. • Information on sector performance is not consolidated with financial performance information. • Multiple audit reports (often two to three years after the events to which they relate) are produced for different audiences, making it difficult to identify systemic weaknesses and to monitor follow-up of recommendations across the sector.

Source: Adapted from Barroy et al. (2019a).

3. Service Delivery Financing in Intergovernmental and Institutional Context

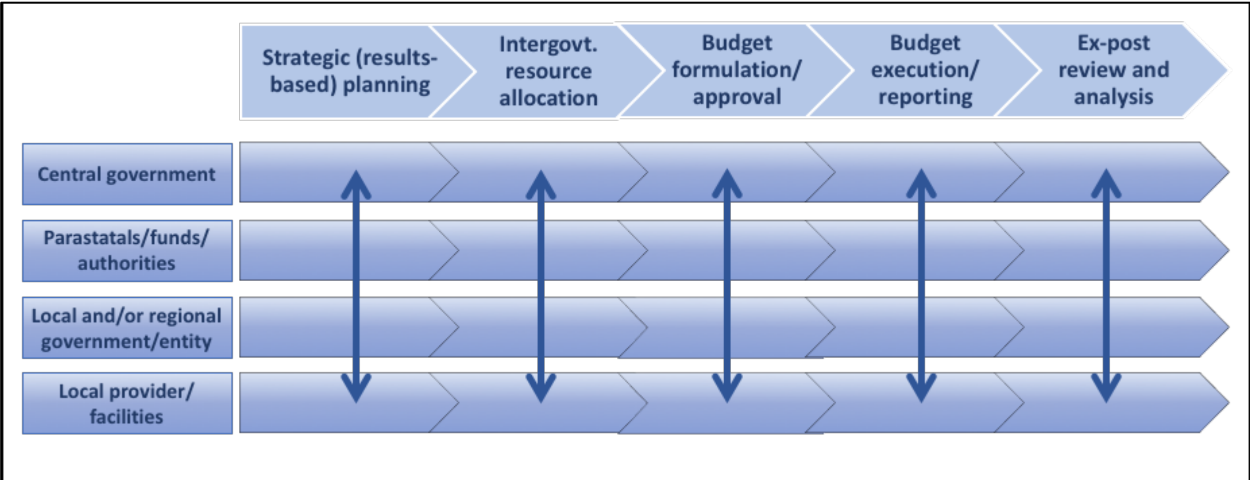
In considering the intergovernmental landscape, the decentralization literature increasingly recognizes that different modes of decentralized financing and service delivery are used simultaneously, even within a country or a sector (Charbit, 2011; OECD, 2019). Different government ministries or departments deliver frontline services through different mechanisms: some spend most of their budget directly or operate through arms-length public bodies, while others support subnational governments in delivering frontline services (often providing them with intergovernmental grants), and still other ministries may have contracting arrangements with various providers (Miller et al. 2021). Even within a given sector, many countries rely on a combination of devolution, deconcentration, delegation (of the functions of one actor to another), and centralized (direct) service delivery at the same time (Boex & Edwards, 2015).

The complexity of the intersection between public finances, PFM, and service delivery increases exponentially if the functional responsibility for a service does not fall within the domain of any single government unit or level. In those cases, responsibilities are divided across a multilevel public sector with stakeholders at different levels of government contributing to different aspects of service provision. In this intergovernmental context, if PFM is viewed as the formulation, execution, and accountability of budgets, a concrete question arises: whose budget and whose finances ought to be considered? Should the focus of analysis be the budget of the responsible sector ministry or central government, or that of the subnational governments with statutory responsibility for specific public services?

The obvious answer is that any perspective on decentralized service delivery requires consideration of the budget processes of both the sector ministry and the subnational government. In addition, there is a need to analyze and ensure the effectiveness of the connection between central and subnational budget processes. This analysis often requires considering intergovernmental (fiscal) systems that extend beyond the purview of either the relevant sector ministry or subnational governments. For instance, consideration of intergovernmental aspects of PFM must include the allocation of intergovernmental fiscal transfers and their complete, reliable, and timely disbursement. Special attention may need to be paid to intergovernmental accountability processes when intergovernmental fiscal transfers flow from the national budget to local facility accounts (which appears to be an increasingly common practice), rather than from the central government treasury into the consolidated local government account.

A more complete perspective requires full consideration of the budgets and finances of all stakeholders—at all government levels—involved in service delivery (Figure 2). Local service providers may have their own budgets, institutionally or administratively separate from a central or subnational government that established or operates it. If so, these providers require dedicated attention in exploring the connection between decentralized service delivery, financial flows, and PFM. Traditional decentralized finance metrics focus on local or regional government budgets alone, typically overlooking the budgets of frontline service providers, such as school committees, health facilities, or local water providers (of various institutional types). Such entities may collect (sometimes considerable) tariffs or user fees from local residents and may receive funds from other sources (Boex & Vaillancourt, 2014).

Figure 2: PFM in a multilevel governance context



Naturally, the budgetary status of subnational service delivery units may vary from country to country, and even within a country and/or sector. At one extreme, the budget of a local service delivery unit (including all revenues and expenditures) may be integrated fully into the budget and PFM processes of the parent government. At the other extreme, the unit could be a fully autonomous legal and/or budgetary entity, with its own revenues and expenditures and empowered to manage its finances through its own accounts.[13] In between are cases in which service providers have some, but less, financial autonomy—for example, in the health sector, salaries for local health facility staff may be reflected in the local or regional government budget, while these facilities may maintain their own bank accounts (or petty cash boxes) for the collection and spending of user fees and/or insurance payments at the facility level.

A final type of public service delivery entity that is often overlooked includes parastatal organizations, state-owned enterprises, and other funds or authorities controlled by higher-level governments. The exact nature and role of these entities again varies across countries and between sectors. In many cases, national parastatals or similar authorities play a direct role in at least some frontline services. It is not unusual, for example, for a medical stores department to be set up as a parastatal entity responsible for providing critical drugs and medical supplies to local health facilities. In other countries, a national roads fund or regional water board may be involved in sectoral functions for which a subnational government is legally responsible. In still other cases, parastatal or quasi-parastatal financing institutions controlled by higher-level governments may play an important role in the funding or financing local public services, as in the case of a municipal development bank or a national health insurance fund that may or may not be reflected in subnational government budget accounts.

Two preconditions must be met for PFM to contribute to better service delivery in an intergovernmental, multi-actor context. First, public finances should be managed effectively during the budget process by all levels of government, special entities, and frontline service delivery units. Second, it is critical to recognize that these entities are not cogs in a monolithic machine; instead, each manages, often with some autonomy, an aspect of service delivery and faces different institutional incentives and constraints. Adequate alignment of funding and PFM systems among all relevant actors is therefore also needed for effective management of service delivery. Currently, few, if any, tools—within either the PFM, decentralization, or service delivery financing communities—are available to assess such alignment and coordination.

Having provided this background to situate the present paper in the broader field, the next section examines the financing sources, allocation, and flow of funds for service delivery in the intergovernmental context. This is followed by an exploration of these considerations with respect to the health sector in the case countries reviewed here.

[13] In fact, "local" entities may not be owned or controlled by the local government at all, even in devolved countries. It is not unusual for local water authorities, local development corporations, and other local bodies to be established and operated by central line ministries, mostly or fully outside the view of local government officials.

III. Managing Finances for Service Delivery in the Intergovernmental Context

Some of the most fundamental challenges involved in financing service delivery in developing countries—both generally and in the health sector—reflect the design of the national institutional and fiscal framework.[14] Certain issues are not health-specific; many countries face challenges in securing sufficient stable sources of public funding, and this may to some extent affect all service sectors depending on their relative national priority. Resource constraints can be even more challenging to manage when service responsibilities are decentralized or shared across levels of government.

Even in the most decentralized countries, there is an imbalance between the service delivery burdens placed on subnational governments and the funds available to them for use in meeting those obligations. Since subnational governments tend to have limited revenue-generating powers and capacity, they rely heavily on the central government to ensure an adequate and reliable stream of resources for subnational public service delivery. This section briefly summarizes a few basic points about the volume and reliability of funding for subnational services from the national perspective, followed by a discussion of subnational sources of funding. Although not a primary concern of this paper, these funding sources shape the flow of resources for local service delivery. This section then turns to a review of how service financing operates in different intergovernmental systems.

1. Volume and Reliability of Funding for Subnational Services

The funding available for a particular service in a developing country—whatever level of government delivers it—is largely a function of the resources available from the national budget and those from external sources, such as loans and grants from development partners. Although subnational governments raise revenues, these tend to be modest outside of regional governments in large countries and some major urban areas. As such, therefore, the volume and reliability of funding are primarily a matter for national government agencies, with finance and external affairs ministries taking the lead and potentially important roles for sectoral agencies with a national policy mandate for specific public services. There are four key points on this. First, the volume of funds in the national budget is rarely adequate to meet all service delivery needs. Second, the amount of funding allocated to a particular sector depends on technical inputs and political decisions at the national level that determine the relative priority of the sector. Third, the volume of resources from external sources depends on the specific priorities of development agencies, requests from national agencies, and the relationship between them. Fourth, the stability and responsiveness of resources from both the national budget and external sources depends on national and external priorities and relations.

The relevance of volume and stability is obvious—a steady stream of a sufficient funding is needed to support effective and sustainable subnational service delivery. If budget allocations and external resources do not keep up with increases in service needs or costs for a particular sector, or if they are unstable from year to year (with increases in some years and decrease in others), national and

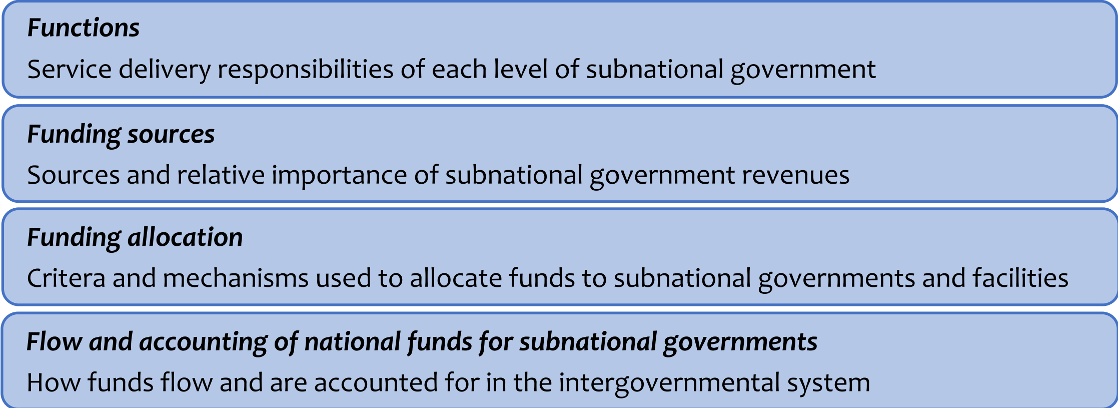
[14] Reviews of the literature on fiscal decentralization in developing countries are provided in Bahl and Bird (2008); Bahl et al. (2013); Bird and Slack (2014); Mascagni et al. (2014); Smoke (2014); Ahmad and Brosio (2015); Fretes Cibils and Ter-Minassian (2015); UN-Habitat (2015); and Bahl and Bird (2018).

subnational governments will face challenges in providing services to the citizens in their jurisdictions and in planning for such services over a reasonable time horizon.

2. Intergovernmental Considerations in Service Delivery Financing

The elements and processes involved in financing service delivery may play out differently in different intergovernmental systems where responsibilities across levels of government vary. There are also considerable differences in the sources and mix of funding for particular services, how funds are allocated, and the precise channels and processes through which these funds flow in the national government–regional government–local government–service facility landscape. The elements and processes covered here are summarized in Figure 3.

Figure 3: Subnational service delivery functions and financing



A. Sectoral functional responsibilities of subnational governments

The number of government levels, and the extent to which they are empowered, varies across countries. Some public services are exclusive to a particular level, while others have shared responsibilities in that different types of health facilities, schools, or roads, for example, are managed by different levels. There may also be varied relationships among levels—in some countries each level may have autonomy over its designated functions, and in other cases the relationship may be hierarchical, such that a lower-level government or service facility needs approval from a higher level to make fiscal decisions. Particularly in federal systems, state/regional/provincial governments often have more control over local governments than the federal/central government does. Except for the most local services, such as trash collection, streetlights, parks, and the like, central governments tend to issue national standards or regulations to ensure minimum levels of priority services for all.

In some cases, the assignment of service functions to levels of government is imprecise or ambiguous. Even a clear legal framework may violate normative principles by assigning a service incorrectly (to the wrong level) or may not be adhered to in practice. Insufficient clarity in or non-compliance with functional assignments complicates accountability because national governments and citizens will not be sure which subnational actor to hold properly accountable for performance. Issues in functional assignment are quite common in intergovernmental fiscal systems.

B. Sources of funding for subnational governments

In most developing countries in which there is some form of decentralization, intergovernmental fiscal transfers from the central government dominate the financing of public services, including health.[15] Subnational governments may have their own sources, including tax and non-tax revenues, as well as the power to impose user charges for certain services. User charges can be important for some services, but general local taxes and non-tax revenues would not often be used for the delivery of services that can be financed by other means, especially since these sources are often modest in volume compared to transfers. In some countries other sources, such as national health insurance payments, are important for service delivery, but they may go to providers rather than to subnational governments.

Intergovernmental fiscal transfers can be unconditional (with no restrictions on use) or conditional. In the former case, subnational governments may choose whether or not to spend the funds in a particular sector, although there may be pressures to spend if a national sectoral ministry has specific mandates/guidelines and a means to enforce subnational government compliance. Conditions may be broad, as in the case of a simple requirement that the funds be spent on a particular sector, or highly specific, as when detailed budget specifications mandate that certain shares be spent on investment in facilities, salaries and wages, particular types of supplies, and so on. Some countries have primarily unconditional transfers, while other transfer systems are largely conditional or mixed. A finance ministry is often in overall charge of transfers and almost invariably manages transfers that share national revenues unconditionally with subnational governments. Other ministries, however, may be involved to various degrees in sector-specific transfers. External development partners often provide resources for service delivery through national ministries or parallel mechanisms.

C. Allocation of national funding to subnational governments

Some national resources that are shared with subnational governments are allocated on a derivation basis (for example, a portion of national income taxes collected in a particular subnational government is returned to that jurisdiction). Such funds are not typically earmarked for specific services and primarily benefit wealthier jurisdictions whose residents pay more national taxes. Transfers more commonly use funds pooled from multiple national revenue sources and allocated to specific subnational governments on the basis of criteria captured in a formula. This type of approach helps to channel national resources transparently and objectively to subnational governments and provides a means to direct more resources toward poorer jurisdictions, as well as to meet other high-priority national policy goals.

The criteria used to allocate transfers may vary considerably.[16] They can be based on measures of general service demand (such as population) or in service-specific terms (like the number of school-aged children); they can depend on input requirements (such as the cost of specific staff needed in a health facility) or on some aspect of output or performance (for example, number of patients seen, school enrollment, test scores, reduction of morbidity and mortality rates, and so on). There may also be specific targets, such as those related to poverty reduction, women's empowerment, or support for disadvantaged groups. Different approaches serve different purposes, so the choice and mix of

[15] Literature on intergovernmental fiscal transfers is reviewed from various perspectives in Boadway and Shah (2007), Martinez-Vazquez and Searle (2007), Martinez-Vazquez and Sepulveda (2012), Shah (2013), Alam (2014), Osiolo (2017), and Bahl and Bird (2018).

[16] https://www.who.int/health_financing/topics/purchasing/payment-mechanisms/en/

transfers can vary. These approaches have varying implications for the level and distribution of resources allocated to subnational governments, the freedom with which those subnational governments can spend funds, and, in some cases, how compliance or performance would be measured to determine future allocations.[17] Subnational governments may be required to apply for national funds for specific service delivery purposes, most typically to finance development expenditures, for example to build a hospital, a school, water infrastructure, and so on.

D. Flow and accounting of national funding to subnational governments

The resources transferred to subnational governments—whatever their source and however the allocation to a particular recipient is determined—may use different systems and follow varied institutional paths. This raises at least two important considerations for financing service delivery.

First, funds that flow through the national budget would generally be captured in subnational budgets, with the exception of some donor program funds. This is comparatively straightforward if a standardized PFM system is in force. But not all subnational budgeting and financial management systems are fully integrated into the national budgeting and PFM system. If subnational governments have their own budgeting and financial management systems, these may not be organized in a way that corresponds neatly to the budget categories or uses all of the standards and processes—or even the same calendar—followed by the national system.

Second, the institutional path through which resources flow can vary. Funds may flow directly to local governments, which then make allocations (based on national requirements or local discretion) to service delivery units (such as health clinics) or individual staff members for salaries and wages. In other cases, the funds flow first to a state/provincial/regional government, which makes allocations (as per national guidelines or according to intermediate-level government preferences) to lower levels of government before the funds are provided to service delivery units. In still other cases, national ministries or empowered intermediate-tier governments bypass local governments and make transfers directly to service delivery facilities or staff. The latter approach is normally justified by the granting entity based on concerns that subnational governments will not get resources to service delivery units in an appropriate and timely way. In addition, transfers from special-purpose funds managed separately through parallel systems (such as government funds or entities managed by donor agencies) may go through the government budget or be off-budget, and they may flow directly to subnational governments or service delivery units. Transfers may even go directly to agencies that perform certain functions for subnational governments or service facilities, as is often the case with drug procurement.

E. Mapping the intergovernmental system and financial flows in a sector

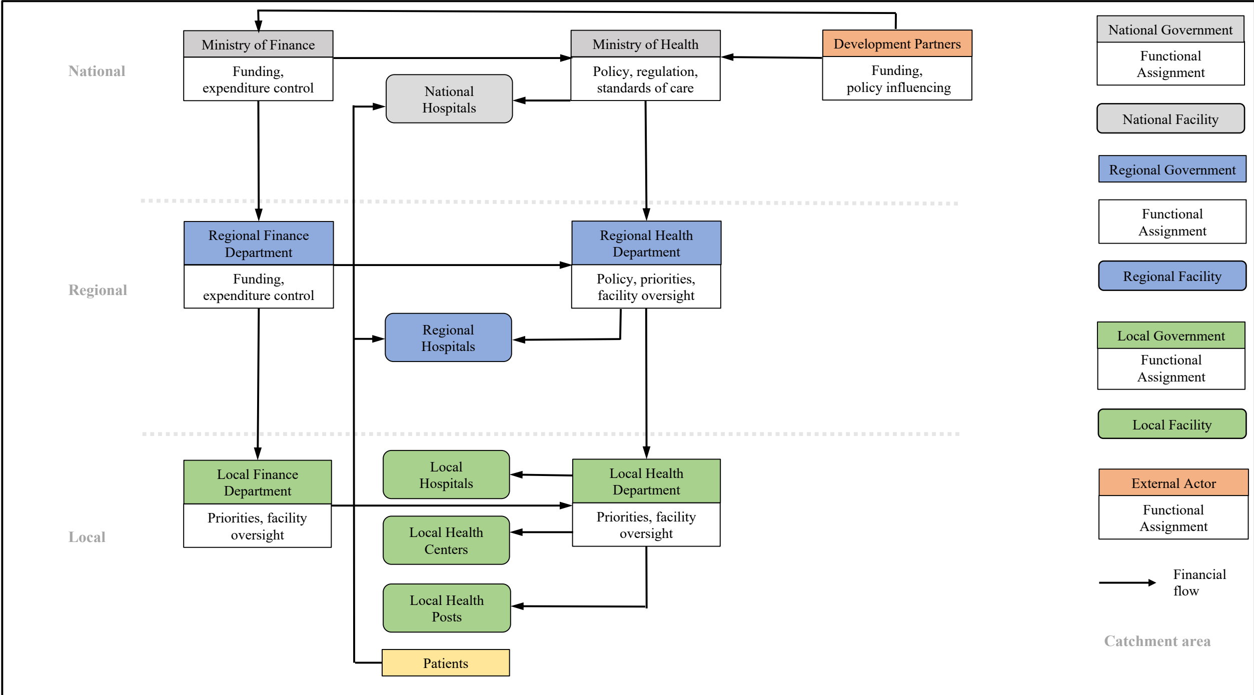
A first step in understanding the actors and elements involved in financing service delivery is to map the structure in a particular country. This mapping will vary to some extent by sector, even if overarching financial management systems and procedures are uniform. There will invariably be a ministry of finance or treasury and a sectoral ministry involved at the national level, but there may be others in charge of planning, public works, local governments, and so on, which may play a role in service delivery financing. Development partners normally channel their funding through the national government, although not always. There will also be one or more lower levels of government or

[17] Performance-based transfers (general and/or sector-specific) are discussed, for example, in Shah (2010), Steffensen (2010), Lewis and Smoke (2012), Shah (2013), Mukherjee (2014), and Fan et al. (2018).

administration. Each level may have responsibility for specific types of services or facilities, and they may have relationships with each other. For example, a provincial government may have oversight over local government budgeting and may control or influence one or more types of funding that flow to local governments or service providers.

Using the health sector as an example, Figure 4 provides a simplified generic map of the actors and financial flows that may be involved in service delivery. Of course, details about specific revenue allocations and how they flow will also need to be documented.

Figure 4: Intergovernmental structure for managing service delivery and finances



F. Implications for subnational service delivery and financial accountability

The intergovernmental structure of subnational financing has important implications for service delivery. Heavy reliance on fiscal transfers may be inevitable, but how transfers are designed affects subnational government discretion and may create incentives that affect fiscal behavior. Managing subnational service delivery resources for a particular sector can be especially challenging under certain scenarios, including if funds originate from multiple sources and are allocated in varied ways that are not adequately coordinated by a finance or sectoral ministry; if they include significant unconditional resources that are not required to be spent on particular sectors; if some funds are raised directly by subnational governments or service delivery units and are not properly recorded; or if some funds are channeled off-budget and not reflected in the PFM system at all. In some cases, more than one of these conditions may apply at the same time.

Depending on the mix and extent of these conditions, there may also be challenges for accurate and transparent monitoring of the sources, flow, and use of the full set of resources allocated to a particular sector, including the extent to which national service delivery standards are met. The

structure of the intergovernmental fiscal system can thus have a significant impact on the volume, use, and management of resources for service delivery, and thereby the quality, distribution, and outcomes of service delivery, as well as the ability of governments at any level to properly report on and be held accountable for how public resources are used to deliver services.

Given its prominence in debates about financial allocations and budgeting in intergovernmental systems, one additional point must be raised here: the degree of discretion that subnational actors should have in using resources for service delivery. Disagreement on this issue is reflected in the varied use of conditional transfers and budgeting rules. Few would argue that subnational governments or frontline service providers should have full spending discretion or that there is any fixed rule for how much is appropriate or whether/how it should vary across expenditure categories.[18] There is a need to balance legitimate national mandates and standards against the potentially superior ability of subnational actors to make certain decisions that deal with immediate needs on the ground.[19] The preferred arrangements depend in part on contextual factors, such as the specific services being delivered, subnational capacity, and logistical considerations such as whether facilities have bank accounts or a system for managing cash. It would be valuable to know how discretion affects service delivery performance, but this is difficult to measure and there is limited hard evidence. Ultimately the appropriate degree of discretion needs to be settled in a particular country based on principles, prevailing conditions, and performance.

[18] Piatti-Fünfkirchen et al. (2019) propose an interesting approach to thinking about how to balance control and flexibility in public expenditure management.

[19] This issue is covered in much of the synthetic literature cited in footnote 9, as well as comparative studies, evaluations, and guidelines, including Bossuyt et al. (2007); European Commission (2016); World Bank (2008, forthcoming); Local Development International (2013); USAID (2013); and Rao et al. (2014). A specific discussion of facility autonomy is presented in Broadbent (2010).

IV. Intergovernmental Systems and the Health Sector: Selected Country Experience

Having reviewed how intergovernmental systems may differ in terms of the sources, flow, and management of finances for service delivery, this section introduces the country cases covered here—Ethiopia, Kenya, South Africa, and Uganda. It first offers a succinct overview of key country characteristics and intergovernmental systems, including assignment of functions and finances to subnational governments, the structure of subnational PFM (whether integrated into national PFM structures or separate), and other selected factors related to the role of subnational governments.[20] Second, this section offers details on the institutional and fiscal structure of the health sector in each country.[21] Following the features outlined in section III.2, it summarizes functional assignments, health financing sources, and how funds for health flow to subnational actors. This review is largely descriptive, comparing how the systems are set up according to legal frameworks and, where possible, when this legal guidance is not followed in practice. Some of the challenges faced by subnational governments and providers are previewed here, with more detail in the following section.

1. Basic Country Characteristics and Intergovernmental Systems

The countries covered here are diverse in terms of basic characteristics (Table 2). Ethiopia has roughly twice the population of each of the other countries, which are similar to each other in population size. Ethiopia and Uganda have only half the per-capita gross domestic product (GDP) of Kenya, which has only about a third of South Africa's per-capita GDP. Kenya covers only about half as much territory as Ethiopia and South Africa but has more than twice the land area of Uganda. The lower-income countries have higher population densities but lower urbanization levels, and South Africa has the lowest population density but the highest urbanization rate.

Table 2: Basic country characteristics (2020)

Country	Population (millions)	Per-capita GDP (PPP US$ 2019)	Land area (sq. km. 000)	Population density	Urbanization level (%)
Ethiopia	114.9	2,312	1,000	115	21
Kenya	53.8	4,509	569	94	28
South Africa	59.3	12,999	1,213	49	67
Uganda	45.7	2,272	200	229	26

Source: per-capita GDP data: https://data.worldbank.org/indicator/NY.GDP.PCAP.PP.CD; other data: https://www.worldometers.info/world-population/population-by-country/

[20] The team selected four countries in Africa for which relevant secondary information was available, as fieldwork was precluded by the Covid pandemic. These countries are diverse (Table 2), have different intergovernmental structures (Table 3), and organized their intergovernmental health care sectors differently (section IV.2). At the same time, however, they are not broadly representative of developing countries.

[21] Many sources were consulted on each country. Primary sources include: **Ethiopia**: Kelly et al. (2020), Fagan et al. (2019), FISCUS (2019), and Lawson, personal interview (2020); **Kenya**: Barasa et al. (2017), Dauda and Taveras (2020), Dutta et al. (2018), Mbau et al. (2018), World Health Organization (2017), and unpublished work commissioned by the World Bank (2020); **South Africa**: James et al. (2018), Schreiber (2018), and Moeti and Padarath (2019); **Uganda**: Fagan and Lang (2019), ODI (2018), ODI-BSI (2019), and Wabwire, personal interview (2020). Additional citations on specific points are provided in in-text references.

These characteristics are relevant because they affect the nature, costs, and distribution of the public services to be delivered. For example, health service requirements and delivery modalities generally differ in areas with disparate population densities or between urban and rural areas. Moreover, these characteristics influence the structure of intergovernmental systems (in that larger and more populous countries tend to have a greater number of subnational levels, and urban local governments tend to have more service responsibilities and better access to public finances than rural areas).

The basic intergovernmental structures of the four countries do indeed vary (Table 3). The larger countries, Ethiopia and South Africa, have multiple subnational tiers, while Kenya and Uganda only have only one main level (although with sub-tiers of various significance). All of the countries have legally devolved services, but generally with non-trivial intergovernmental co-sharing of functions, and in Uganda there is strong higher-level control over legally devolved services. All of the countries allow subnational government own-source revenues, but with considerable variation and heavy reliance on intergovernmental transfers, particularly in the lower-income countries and within countries outside of the more urbanized areas. None of the countries have subnational PFM systems that are entirely distinct from the national system.

Table 3: Intergovernmental system structure and functions

Country/ system type	Subnational government levels	Subnational government functions	Revenue	PFM	Comments
Ethiopia (federal)	• Regions (9) • Cities (2) • Zones (68) • Woreda (770) • Kebelle (> 30K)	• Devolution of major service functions • Regions empowered more than lower levels, but not full legal clarity	• Federal tax shares/block grants, own-source revenue in regions/cities • Regional transfers to lower tiers	• National PFM system under Ministry of Finance	• Regional governments have significant control and oversight over lower tiers
Kenya (unitary with some federal features)	• Counties (47) • Lower tiers of administration (sub-county/ward) and urban boards	• Devolution of many service functions to county governments that manage lower administrative tiers	• Unconditional transfer dominates • Modest conditional transfers • Modest own-source revenues	• National PFM law • Some county variations in executing PFM functions	• Counties fairly autonomous • Can deconcentrate functions to lower tiers
South Africa (unitary with some federal features)	• Provinces (8) • Municipalities – metro (8) – local (205) – district (44)	• Devolution of major functions to provinces and municipalities • Many concurrent functions	• Unconditional and conditional transfer blend • Own-source revenues stronger in urban areas	• PFM system under national treasury with standard reporting from all levels	• Metropolitan municipalities have stronger functions and resource bases
Uganda (unitary)	• Administrative regions (4) • Districts (146) • City (1) • Municipality (41) • Multiple lower tiers	• Devolution of major functions by law • Control by central government of local functions similar to deconcentration	• Conditional transfers dominate • Own-source revenues relatively limited	• Ministry of Finance, Planning, and Economic Development manages PFM	• Districts and municipalities are main entities with minor lower-tier roles • Regions not empowered

In short, the countries share certain intergovernmental system features, including some degree of devolution (at least officially), established standardized PFM systems with oversight at the national level, and considerable or dominant dependence on intergovernmental fiscal transfers (sometimes less so in major urban areas). There are also important distinctions, however, in the number of levels of subnational government levels, their respective degrees of empowerment, and the nature and strength of relationships among them. These variations in institutional structures and financing mechanisms have important implications for the delivery of health services, as documented below.

2. Structure and Financing of the Health Sector

Using the categories outlined in section III.2 (Figure 3)—functions, funding sources, funding allocation, and funding flows—this section briefly considers how the health sector is structured in the four case countries. This review is not comprehensive and does not provide individual case studies, but rather identifies the main features of each system to the extent that they could be determined from secondary sources and compares them as background on the types of challenges said to be faced by subnational actors in financing health service delivery (section V).

Drawing on the general health sector schematic in Figure 4, Figures 5-8 illustrate the intergovernmental institutional setup of the sector in each of the case countries and depict the financial flows among government levels and entities. These figures are not individually explained in the text but are provided for the reader to refer back to as needed in reading about specific features of the systems covered as the paper progresses. The figures highlight the complexity of health sector institutional architecture and funding flows, and of their diversity across different country contexts.

A. Health service delivery responsibilities of subnational governments

Functional assignments in the health sector vary across the case countries. In Ethiopia and South Africa, health functions are divided across multiple subnational levels, with a significant role for intermediate tiers, while in Kenya and Uganda they are more concentrated at the primary level of local government. Responsibilities and decision-making power for health in Ethiopia are shared at different levels, with the Federal Ministry of Health (FMOH) and Regional Health Bureaus (RHBs) managing policy matters and setting guidelines for adoption by subnational levels. The more basic level one health facilities, which include primary hospitals, health centers, and satellite health posts, fall under the jurisdiction of the *woredas* (districts). Regional governments are responsible for level two facilities, which include general/referral hospitals whose operations and staffing are managed by RHBs. The FMOH manages level three facilities, which include specialized federal hospitals (Argaw et al., 2019).

The current intergovernmental architecture of the public health system in South Africa includes the National Department of Health (NDOH), Provincial Departments of Health (PDOHs), and District Departments of Health, with governing bodies in the form of councils and committees spread across the levels. Health is primarily a provincial function, although environmental health is a municipal function, and a few metropolitan municipalities manage limited health services. Most primary health services are delivered through 52 district health systems run locally by district health management teams and accountable to PDOHs. The lowest level includes community health clinics, centers, or facilities, each of which offer a mix of first- and second-contact care services (such as 24-hour maternity services and emergency care). South Africa's community health model involves a variety of non-governmental organizations that are contracted to provide community-based services, especially for HIV/AIDS and tuberculosis prevention.

Figure 5: Ethiopia's intergovernmental health sector structure

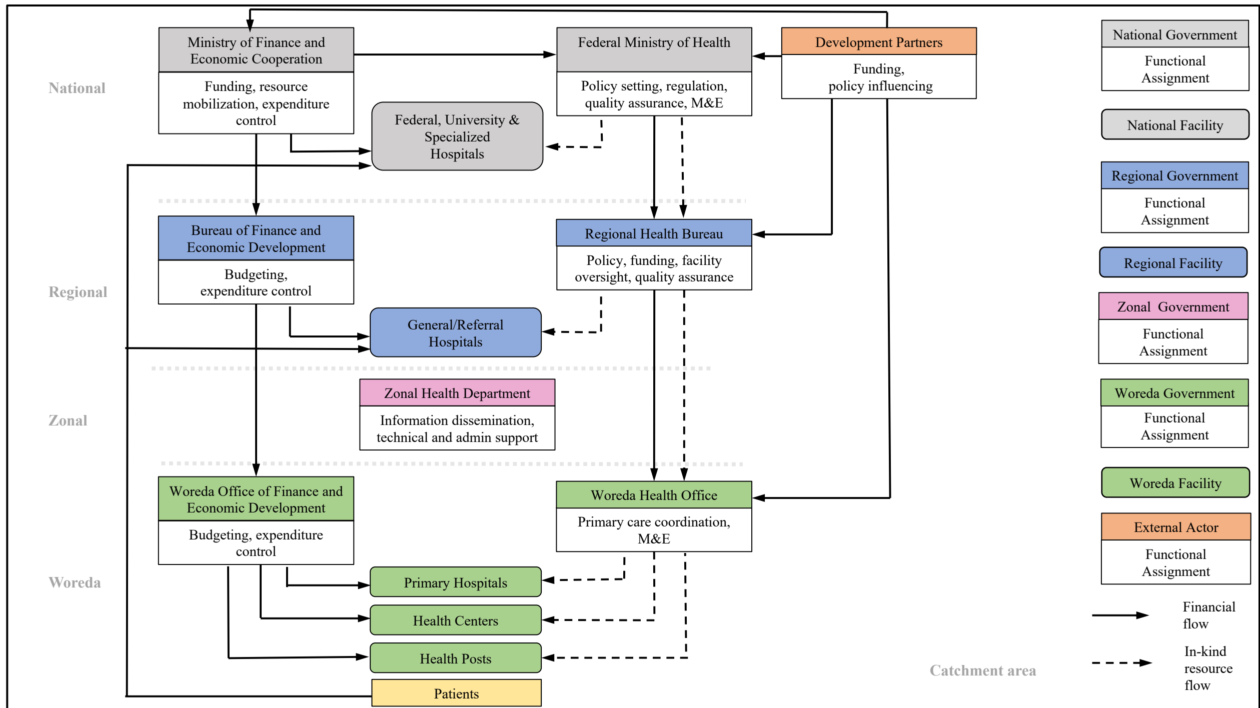


Figure 6: Kenya's intergovernmental health sector structure

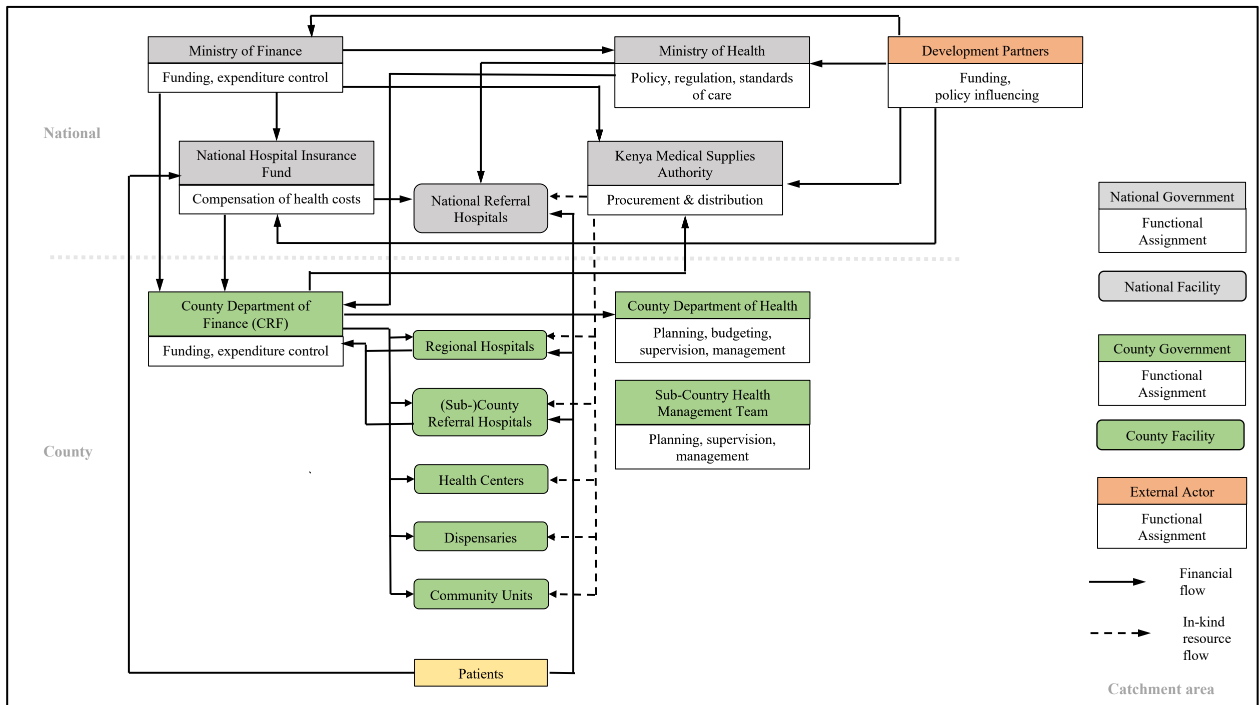


Figure 7: South Africa's intergovernmental health sector structure

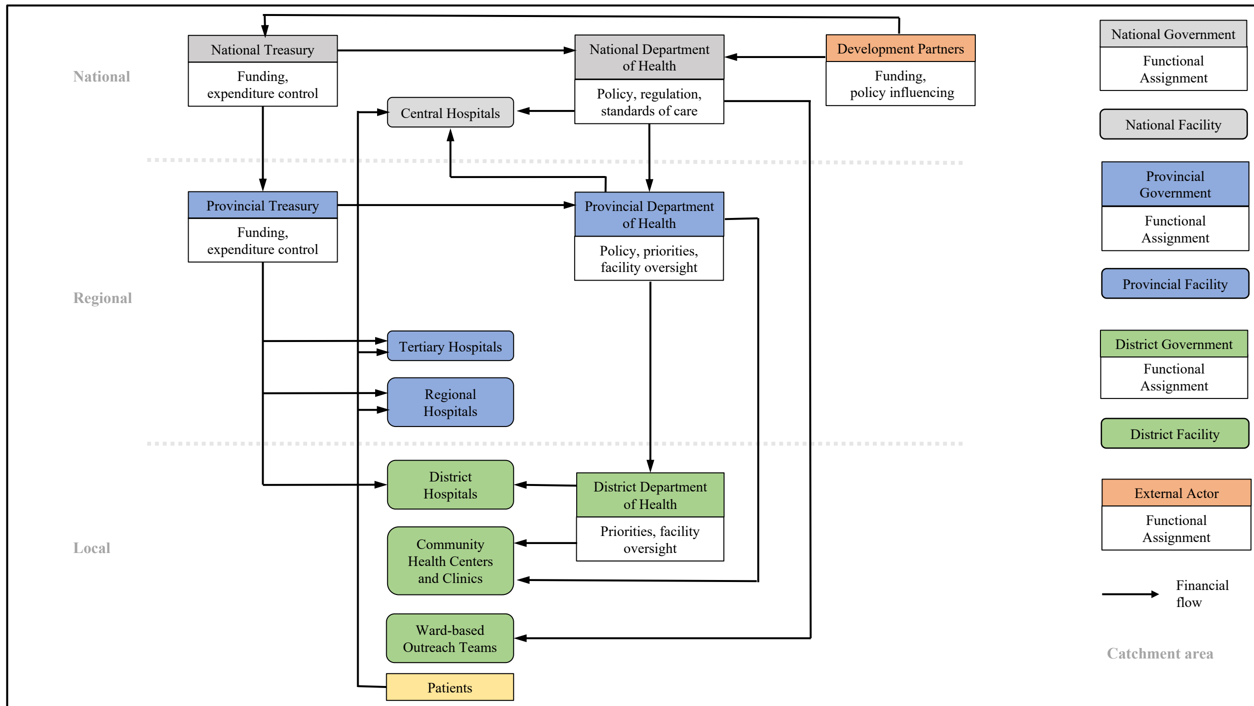
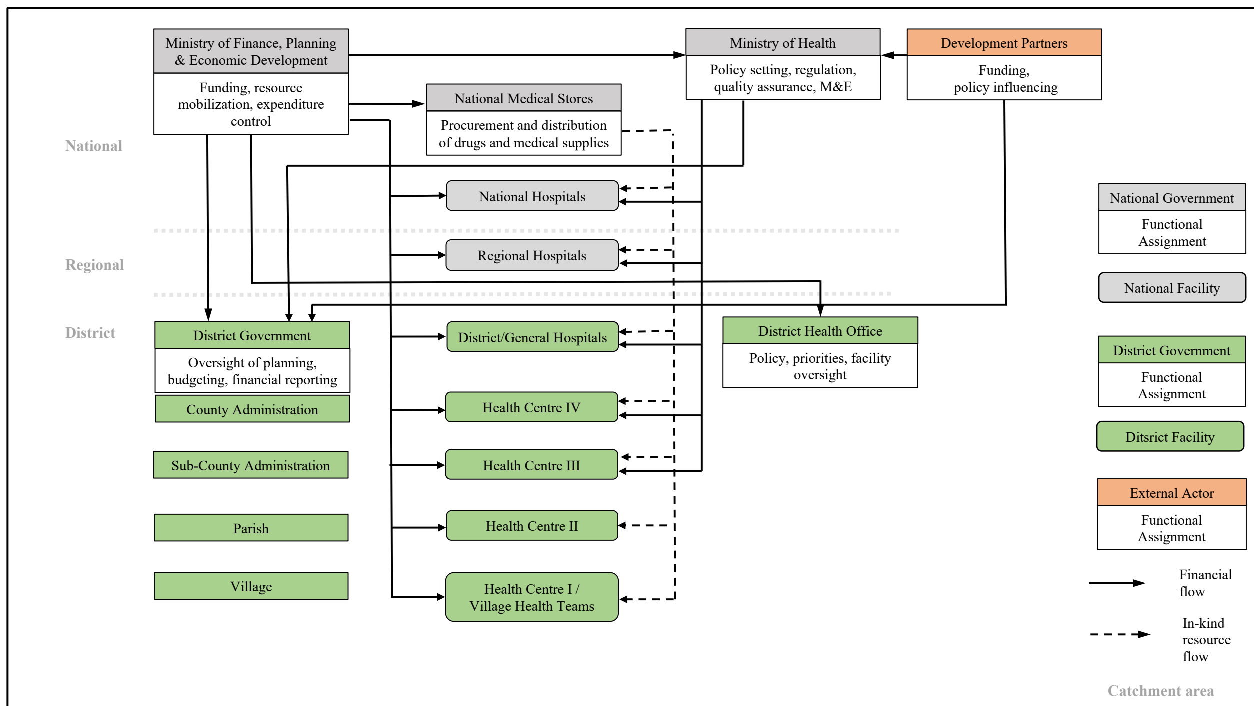


Figure 8: Uganda's intergovernmental health sector structure



In Kenya, primary responsibility for the majority of health services lies with the county governments, although some remain with the national Ministry of Health (MOH). County responsibilities carried out by the County Department of Health (CDOH) include the planning and implementation of community health, primary care, and county referral services, including managing all level 1 to level 5 health

facilities. The MOH is in charge of policy formulation, providing technical assistance to counties and managing the national referral hospitals. The counties implement their service delivery functions by means of deconcentrated administrative structures at the sub-county and ward levels, particularly the sub-county health management teams that oversee most county health facilities.

In Uganda, the Ministry of Health oversees the sector, focusing on policy formulation and standard setting for subnational implementation. Local governments are legally responsible for health care services within their jurisdiction, although this is not true in practice. The sector was formerly more decentralized, but core parts of the health system, such as procurement and distribution of drugs and medical supplies, have been recentralized in recent years. The Ministry of Finance, Planning, and Economic Development (MOFPED) and MOH increasingly work directly with service delivery facilities, using local governments primarily to perform routine managerial and reporting roles (Wabwire, personal interview, 2020). The two highest tiers of service delivery are national referral hospitals and regional referral hospitals, which have semi-autonomous status with MOH oversight. At the district level, health systems consist of general hospitals and health center levels II-IV. Health center level I operates through village health teams, which represent a collaboration between health facilities and the community (Lukwago, 2016). These lower-level health center teams typically do not have a physical facility. Uganda also uses private not-for-profit facilities that are partially funded by transfers.

Overall, in the case countries, a national health ministry typically defines policy and oversees lower levels and even health facilities, but in most cases, lower-level governments or administrations have some oversight responsibility. In some cases, there are mobile community or village health services or private sector facilities involved in delivering services.

B. Mix and sources of funding for subnational health services

There is a range of practice regarding the mix and sources of health funding and how these resources are managed (Table 4). In Kenya, the main county funding is unconditional, flowing through the equitable-share intergovernmental fiscal transfer managed by the Ministry of Finance (MOF). The estimates used to determine devolved health financial needs are based on historical service delivery costs that do not account for gaps in subnational service delivery (due to lack of facilities, resources, or capacity). Moreover, counties need not spend unconditional transfers on specific sectors—they decide how much to devote to health. Several conditional health transfers were created to deal with underspending on key health line items, although critics argue that they are fragmented and driven by specific MOH or donor interests, and some are off-budget. Beyond traditional transfers, other funding channels support health, most notably the National Hospital Insurance Fund, which compensates health facilities through provider payment mechanisms, including case-based payments, outpatient capitation grants, fee-for-service payments, and inpatient per-diems (Mbau et al., 2018).[22] User fees for basic primary care were abolished in Kenya, with grants established to offset the loss, but there are charges for other services unless patients have insurance or are deemed exempt according to specific criteria. Kenya is currently piloting universal health coverage in some counties, which, if adopted nationwide, will eventually lead to the complete abolition of user charges (Barasa et al., 2017).

Uganda's health transfers, by contrast, are largely conditional. In recent years, health transfers have increasingly bypassed district governments, going directly to health facilities in an effort to improve service delivery performance and facilitate oversight. District Health Offices (DHOs) remain tasked

[22] The National Hospital Insurance Fund is replenished through membership contributions as well as allocations from the national budget for particular programs, such as free maternity care.

with budgeting for health facilities, as well as reporting on and accounting for fund use to MOFPED. Although districts no longer receive transfers to distribute to health facilities, DHOs receive a share of conditional grants to cover their management and supervision costs (Wabwire, personal interview, 2020). Development grants are transferred to districts and managed by DHOs, although they are conditional. A more recent donor approach is the introduction of performance-based transfers. Donors provide a significant share of health funds, many of which go through the MOH but remain off-budget. The heavy role of donor funding raises concerns about funding sustainability, especially since health allocations have been declining as a share of the national budget and donor allocations vary over time. User fees for health services were abolished in 2001, but due to chronic facility funding gaps, fees were reinstated, accounting for an estimated 41 percent of health spending (Lang & Fagan, 2019). Fees are said to impose significant out-of-pocket costs on users.

Table 4: Summary of health financing sources

Country	Fiscal transfers	User fees	Donor funds	Health insurance
Ethiopia	• Major transfer is unconditional (non-health specific) • Multiple significant conditional transfers	• Health care fees are charged • However, criteria-based exemptions for primary care	• Considerable donor funds • Significant share off-budget	• Community Based Health Insurance (informal sector) piloted but low enrollment • Social Health Insurance for formal sector planned
Kenya	• Main transfer is unconditional (non-health specific) • Range of ad hoc conditional transfers	• Primary care fees abolished • Fees for other services, with some exemptions	• Multiple donor funds for general county health, types of facilities, specific purposes	• National Hospital Insurance Fund makes provider payments • Universal health coverage being piloted in selected counties
South Africa	• Main transfer is unconditional (non-health specific) • Conditional transfers for priority diseases and facility infrastructure	• Fees for primary and maternal care abolished for most users • Fees for some other services	• Donor funds comparatively limited • Some remain important for specific diseases (HIV/AIDS, TB)	• Pilot national health insurance scheme will fundamentally modify health funding and spending arrangements when adopted
Uganda	• Mostly conditional transfers (wage, non-wage, development and various funds for specific purposes)	• Fees officially abolished • Fees used in practice due to health funding shortfalls	• Donor funds are substantial • Many managed by MOH, but some off-budget	• National health insurance bill awaiting review • <1% of population has community-based health insurance

Ethiopia has a mix of unconditional and conditional transfers. There are three major channels of health financial flows. The first channel consists of unearmarked donor and government funds flowing from the MOF. The second channel is managed by the FMOH and includes both relatively unearmarked donor basket funds, such as the Sustainable Development Goals Performance Fund (SDGPF), and funds earmarked for donor programs, including GAVI, The Global Fund, and some United Nations agencies. The third channel covers other off-budget funds from multiple donors (Kelly et al., 2020). A large share of donor funds flows through the SDGPF, which alleviates some of the coordination challenges and administrative burdens that are often generated by separately managed programs. Many donor programs remain off-budget, however, and continue to be managed separately though

donor-preferred arrangements. Health facilities charge user fees for all services, but there are criteria-based exemptions, mostly for primary health care. The user fee schedule is usually set by RHBs, although some regions permit health facilities to set and revise their own user fees, which they may retain and use for operational expenses (Fagan et al., 2019).

South Africa has the most streamlined health funding system of the four countries. An important share of health funding flows through the national unconditional transfer program, as in Kenya, but the national government also operates a set of targeted conditional programs for HIV/AIDS, tuberculosis, community health, and other specific uses. There used to be a more fragmented set of donor-funded programs, but these have been phased out and consolidated into a more integrated system that fills some funding gaps created by donor withdrawals. There are specific efforts to finance health infrastructure and maintenance, particularly the health facility revitalization grant allocated by the NDOH to the PDOH, with execution managed by the provincial Department of Public Works. In addition to this transfer, the National Health Insurance Grant consolidated various conditional grants into a single grant that supports health facility development. Health user fees are not significant after being abolished for basic preventive and maternal services at primary clinics for most of the population, but they are used for some services.

In summary, health services in the case countries are funded largely by transfers, but the mix and sources vary. In Kenya and South Africa, unconditional transfers provide significant funds, giving county and provincial governments, respectively, more control over what to spend on health. Uganda's health transfers are mostly conditional and given in large part directly to facilities, ensuring that certain resources are spent on health but limiting the budget authority of subnational governments and service providers. Ethiopia has a mixed transfer system, with both unconditional and conditional elements playing a major role. Fragmentation of funding sources exists to some extent in all of the countries. Each has taken steps to consolidate fragmented funding streams that complicate PFM effectiveness in ways that are discussed below. Still, this fragmentation remains significant to varying degrees, least of all in South Africa. All of the countries still have some—often significant—degree of off-budget health spending.

C. Allocation of national funding for subnational health services

Many of the intergovernmental fiscal transfers (unconditional and health-specific) in the four case countries are allocated using a defined formula or criteria based on some underlying policy logic (Table 5). The types of fiscal transfers and resource flows that support health service delivery in these countries are not necessarily allocated in a way that recognizes how other sources are distributed. Effective allocation is also constrained by inadequate data.

In Kenya, the dominant unconditional transfer is funded by a vertical share of national resources based on clear estimates (subject to the above-noted caveats). Until recently, however, the pool has been allocated to specific county governments through a formula based on general territorial, socioeconomic, and fiscal characteristics such as population, land area, and poverty. In the future a revised formula will incorporate sector needs, including health. Once allocated, however, the national government cannot control how counties distribute these funds across sectors. In practice, the formula has favored historically neglected counties, reflecting redistribution. Some of these counties, however, do not have the facilities or the capacity to use the funds, while others with facilities and capacity are underfunded, which can affect delivery of health and other services. Beyond the equitable share, each of the various conditional health transfers is allocated according to its own ad hoc criteria.

There has not yet been a careful mapping of how unconditional and conditional resources separately and collectively support county health expenditures and service delivery, and the effects of the forthcoming main transfer formula remain to be seen.

Table 5: Summary of health funding allocations

Country	Unconditional transfer allocations (non-health-specific)	Conditional transfer allocations (health)	Donor funds allocations (health)
Ethiopia	• Formula allocation to regions (managed by MOF) based on population, service (including health) needs, and revenue generation • Regions allocate to *woredas* according to criteria that vary across regions	• Conditional transfers from federal government are heavily funded by donors • Allocation criteria vary • Managed either by FMOH or a special mechanism	• Major donor pool (SDGPF) uses common allocation • Other funds are separate, with assorted targeted levels and purposes
Kenya	• Formula allocation (managed by national treasury) to counties based mainly on developmental and service delivery criteria • Allocation to sectors determined by counties	• Increasing conditional transfers for specific types of spending allocated individually using ad hoc criteria • These still account for modest share of spending	• More donor funds on-budget or considered in county budgeting, but still use donor allocation criteria
South Africa	• Formula allocation to provinces (managed by national treasury) based on socioeconomic/fiscal indicators and sector-specific needs, including health • Provinces oversee allocations to districts and facilities	• Major conditional transfer (priority diseases) and a few others under NDOH • Allocation based on measures of health needs, input costs, or other specific criteria and conditions	• Donor funds for specific purposes are mostly managed by NDOH as conditional transfers and allocated on the basis of agreed criteria
Uganda	• Not applicable: no significant fully unconditional transfers	• Criteria-based recurrent wage and non-wage transfers (district share of facility allocation) and development transfers from MOFPED • Others under MOH	• Donor criteria allocate funds • In most cases MOH or MOFPED manages • Increasingly go directly to health facilities

In Ethiopia, the main unconditional transfer is allocated to regions using a formula based on population; resources to provide equal access to health, education, clean water, agricultural development, and accessible roads; and local revenue-generation potential (MOF, 2009). Allocations to regional sector offices that manage health spending are based on the previous year's expenditure and new recurrent or investment needs. These allocations must be approved by the Regional Cabinet and Council and are subject to change each year (Fagan et al., 2019). Each region uses a formula to allocate transfers to *woredas*, but design and implementation vary. Some RHBs provide block health grants to *woredas*, while others are conditional. There are variations in the criteria used in *woreda* allocations to facilities. Donor funds are often managed separately and allocated to different actors at specific levels. SDGPF resources, for example, are allocated to *woredas* according to work plans based on the *woreda* planning process. Funds are generally earmarked, but the specific basis for transfers varies considerably (Kelly et al., 2020).

In South Africa, the unconditional equitable share transfer is allocated to provinces based on a range of economic, social, and fiscal indicators, incorporating variables that measure need in specific public

service sectors, including health. Provinces determine how to use these funds for health, leaving the national government with limited influence over the extent to which they prioritize health. On average, these funds cover 80 percent of health expenditures (James et al., 2018). The more structured conditional transfers that are dedicated to certain health priorities are allocated according to health-specific measures of need, input costs, and so on. These vary by type or are based on other specific criteria and conditions. For instance, the health facilities revitalization grant allocations are based on a mixture of health infrastructure, project preparation, and performance criteria, and a portion of the funds can be used to cover human resources costs in provincial infrastructure units as per national treasury guidelines.

As noted above, Uganda has the largest share of conditional transfers among countries reviewed here. MOFPED pays salaries directly to subnational health staff rather than through local governments (ODI, 2018). The conditional primary health care non-wage recurrent grant is allocated to facilities, with 15 percent of district allocations reserved for DHOs' management and supervision costs. Criteria for allocation to the district level are primarily formula-based, and then based on the type of individual facility after that. Despite the use of formulas, major variations persist in per-capita transfer allocations across subregions. They are not related systematically to income, poverty, health, or other measures of need, and the resources provided are often insufficient to cover basic operating costs. Additional conditional transfers and donor programs are allocated based on ad hoc criteria, and it is not clear that they consistently help service providers to cover gaps in specific types of health expenditure (ODI-BSI, 2019).

In summary, unconditional transfers provide discretionary resources to subnational actors, but funds may not be based on health sector needs, and there is no mandate on their use for health. Conditional transfers allocated using sound criteria help cover particular costs (sometimes for specific groups), and they may create incentives for subnational actors to use some discretionary funds to complement costs covered by conditional funds. Allocation mechanisms for multiple conditional transfers may be uncoordinated, raising the possibility that some health expenditures will be under- or overfunded and that complementary expenditures will not be covered.

D. Flow and accounting of funding for subnational health services

Subnational governments generally use a standard PFM system managed by the finance ministry or its equivalent in the countries covered here. None of them has a separate subnational government PFM system that is incompatible with the national system. In most cases, although probably to the smallest degree in South Africa, there are issues with the extent to which standardized PFM practices have been adopted and used appropriately, as discussed in section V.

The funds flow through different paths in different countries (Table 6). In Kenya, all government funds intended for service delivery are expected, in principle, to flow through the County Revenue Fund and the county budget. At the same time, counties take different approaches in providing funds to service delivery facilities, and as noted above, there are other fund flows to the health sector, including from uncoordinated donor programs. In Uganda, transfers come from different ministries and donors. Following the above-mentioned dramatic shift in funding arrangements, these funds now bypass local governments and are instead channeled directly to health facilities, although local governments retain responsibility for budgeting and reporting.

Table 6: Summary of health financing flows

Country	To intermediate tiers	To local governments	To health facilities
Ethiopia	• Unconditional revenue sharing to regions • Some donor funds to regions	• Regions send transfers to *woredas* • Some types of donor funds flow to *woredas*	• Most funds for local facilities flow through one or more subnational government level
Kenya	• Not applicable: no intermediate tier	• Unconditional equitable share to counties • All funds must flow by law through Country Revenue Fund (not all do, but there is progress)	• Counties fund health facilities through transfers and in-kind • Sometimes through sub-counties • Practices vary across counties
South Africa	• Unconditional equitable share/some conditional transfers to provinces	• PDOHs manage flow of transfer funds for health services to districts	• Districts (with PDOH) manage flow of transfer funds to health facilities
Uganda	• Not applicable: no intermediate tier	• MOFPED sends recurrent wage transfers directly to district staff • Non-wage transfers go to facilities with a 15% share to districts for administrative costs • Development transfers go to districts	• MOFPED sends recurrent wage transfers directly to facility staff and 85% of recurrent non-wage transfers to facilities • Some donor funds for health facilities but flow through government

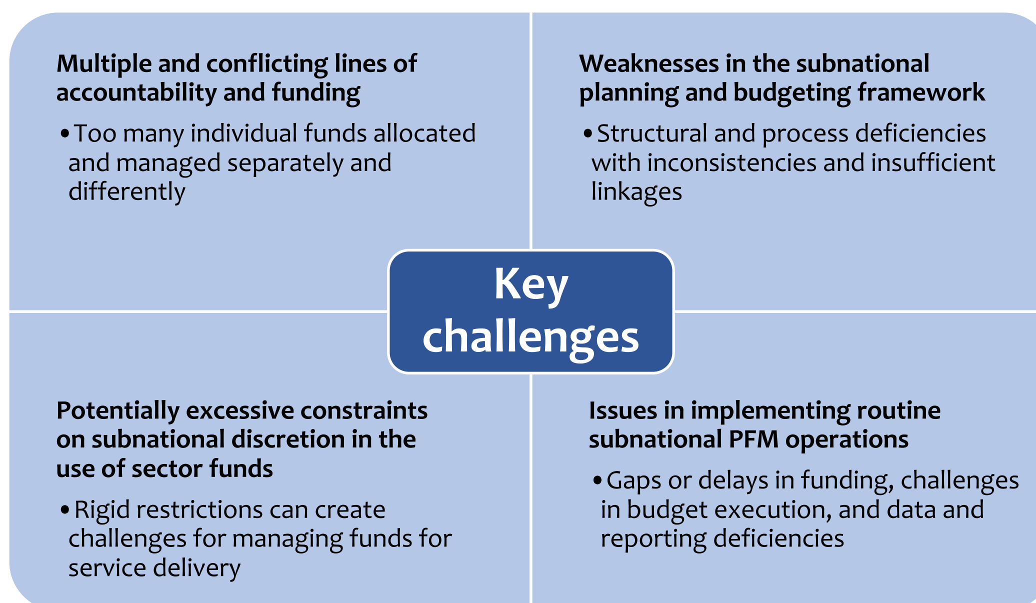
In Ethiopia and South Africa, most health transfers flow to regional/provincial governments and then to lower levels of government and facilities. In both cases, there is more clarity and standardization in how funds are allocated to the intermediate tier than in how regions and provinces in turn allocate funds to lower levels and health facilities. Such variations provide more discretion to the main subnational tier in charge of health, but there are reports that these arrangements make it difficult to determine the adequacy of funds for health services, create space for inequities and inefficiencies in funds allocation, generate disruptions or delays in funding flows, and complicate monitoring of how funds are used. In Ethiopia, significant funds provided by fragmented donor programs that do not flow through the formal transfer system follow different routes, with some funds going to RHBs and others to *woredas*.

In short, the paths through which funds flow vary considerably in the four countries, in some cases with different processes at different levels, and there are varied paths to the health facilities that ultimately provide services. The other major concern is the considerable off-budget activity in most of these countries, although this is a less significant issue in South Africa. A substantial share of off-budget funds flow to local governments and health facilities in Ethiopia and Uganda; some of them are coordinated through a national ministry, but others are managed on a separate ad hoc basis. Kenya has some off-budget funding, but more of it is reported to be passing through the county budget compared to several years ago (Dutta et al., 2018).

V. Health Finance Management Challenges Affecting Subnational Governments and Frontline Service Delivery Facilities

Having used a simple framework to outline the intergovernmental structure of the health sector and summarize the sources, allocation, and flow of sector funding in the four countries under consideration, this section reviews selected constraints to the effective management of health service delivery financing that reportedly affect subnational governments and service facilities. These are not based on an underlying conceptual framework or standardized assessment process, but on issues that stood out in reviewing secondary materials on the case countries. To facilitate presentation, the issues have been classified into four categories: multiple and conflicting lines of accountability and funding; weaknesses in subnational planning and budgeting frameworks; excessive constraints on subnational discretion over service delivery; and issues in implementing subnational PFM operations (Figure 9). Although the categories are not conceptually driven, a few subsections include brief reference to conceptually or empirically based principles in the relevant literature to help frame the discussion of these challenges. It is important to note that these categories are interrelated, so they often exist simultaneously and interact. Moreover, not every country is discussed under every category—a country is covered only if relevant information was available from the sources consulted.

Figure 9: Reported challenges in managing subnational health sector finances



1. Multiple and Conflicting Lines of Accountability and Funding

The blend and behavior of the various actors involved in health financing and financial management for health service delivery—including national ministries and agencies, subnational departments, external donors, and frontline facility staff—can create challenges for downstream players who deliver health services. First, fragmented funding may be targeted for the same or different purposes. Without overall coordination and management of the various sources, there may be fund shortages and/or redundancies for particular categories of expenditure, a situation that proves even more challenging if some funding sources for service delivery are off-budget. Second, even if funding sources are complementary for budgetary purposes, separate reporting channels to different

providers may impose significant administrative burdens on subnational service delivery staff and complicate efforts to keep proper track of resource flows.

Multiple channels of health funding exist in all of the case countries reviewed here, but to different degrees. In Ethiopia, health funding (much of it from donors) flows through numerous channels, as noted above. There has been some consolidation, as with the common-pool SDGPF, but considerable fragmentation persists in terms of sources, allocation mechanisms, reporting modalities, and recipient entities. The challenges this situation creates for mobilizing, allocating, and monitoring health sector finances are clear. Consolidated planning and budgeting may even be virtually impossible given the large number of funding sources, varied time frames and reporting requirements, and shifting levels of commitment and, in some cases, conditions.

In Uganda, health funding is also substantially fragmented, with a large share coming from external donors and weak harmonization of channeling and reporting mechanisms. As explained above, some funds go through MOFPED and others through MOH; some go to local governments, but more go to facilities; and some are on-budget, while others are off-budget and managed by MOH or parallel mechanisms. Despite the role of donor resources in offsetting health sector funding deficiencies, off-budget funding (estimated to comprise over 50 percent of donor contributions) is not all included in official PFM records, which complicates a full reporting of available resources and weakens accountability (Wabwire, personal interview, 2020). Previous attempts to coordinate aid and government funds for health were derailed by reported or documented problems in funding use, including corruption. Donors then reverted to disbursing funds in highly conditional ways through separately managed programs that could be supervised more closely.

Fragmentation is less of a problem, although not entirely absent, in Kenya and South Africa. There are a number of funding flows in Kenya in addition to the transfers reported above. The recent mandate that funds be reflected in the consolidated budget helps to reduce fragmentation, but issues persist. County referral and sub-county hospitals, for example, are financed from as many as ten different funding flows (Mbau et al., 2018). Although the share of external funding in Kenya's health sector has declined in recent years, it still plays a major role in programs targeting specific diseases, such as HIV/AIDS, tuberculosis, or malaria. Moreover, much external funding continues to flow off-budget, generating challenges for health sector strategic planning and budgeting and complicating monitoring and accountability (Dutta et al., 2018).

In South Africa, public health financing is comparatively well integrated and delivered through national and provincial budgets to frontline facilities through the unconditional and conditional transfers outlined above. In addition, there are programs intended to accelerate the adoption of new local health provision models under national health insurance reforms and to fund the construction and upgrading of health facilities. Management of these funds creates some challenges, but these are not related primarily to fragmentation. Several donor programs continue to target specific diseases, as noted above, but they are not as numerous as in the past, although that may change in response to the current novel coronavirus pandemic.[23] Despite the more favorable situation, subnational actors still face difficulties in allocating, managing, and reporting on health finances from varied sources.

The documented fragmentation of funding can impose onerous managerial burdens on subnational governments and health facilities. The absence of a streamlined mechanism for managing health

[23] https://www.reuters.com/article/us-health-coronavirus-safrica/south-africa-seeking-5-billion-from-multilateral-lenders-to-fight-virus-treasury-official-idUSKCN22808B.

sector resources allows the proliferation of separate funds and associated administrative and reporting requirements. This is of particularly concern in Ethiopia and Uganda, where large shares of health funding come from multiple donors and are managed off-budget. In Kenya, anecdotal evidence suggests that lower-level health facility workers have been overwhelmed with additional administrative responsibilities since the devolution of functions (Dauda and Taveras, 2020).

2. Weaknesses in the Subnational Planning and Budgeting Framework

A critical public sector management issue in developing countries is the quality of development planning and budgeting systems and the relationship between them. For the purposes of this paper, development planning refers to subnational planning for public infrastructure and capital investments, whereas budgeting refers to the allocation of resources. There are two main types of budgeting: recurrent (for funding routine administration and operations) and capital (for financing development projects—ideally those provided for in the development plan).

Some concerns with planning and budgeting are general, and others may relate specifically to the health sector. Two challenges tend to be particularly problematic, although they manifest in different ways. First, planning and/or budgeting processes may suffer from design flaws. These can range from how plans and budgets are constructed to how they are implemented and which actors are involved. Second, subnational development planning and budgeting systems are often inadequately linked. In particular, development projects that receive high priority in plans might not be provided for in the capital budget, and those that are financed may not be allocated annual budget funds for operations and maintenance.

The four case countries have generally sound subnational planning and budgeting processes, at least in terms of formal system structures and guidelines. In Ethiopia, all federal ministries officially adopted conceptually sound program-based budgeting (PBB) in 2012, but its rollout in the health sector has encountered difficulties. The original idea was to introduce a standard program structure that FMOH could use to report to MOF, ensuring consistent accounting and expenditure management. The ministries, however, have not fully clarified the basis for the programs, and most regions have yet to adopt PBB, continuing instead to plan and budget based on organizational structure/directorates (Lawson, personal interview, 2020). This situation is exacerbated by donor use of unique budget classifications. The lack of consistent budget categories across government levels and donor programs generates risks of duplication and/or gaps in funding.

In Kenya, counties are expected to follow a comprehensive county planning and budgeting framework outlined under the Public Financial Management Act. Counties develop sectoral plans for health and other sectors for a ten-year period that create the basis for budgeting and performance management in each sector. These are supposed to feed into the County Integrated Development Plans (CIDPs), which are developed with systematic input from the public and are intended to articulate all known projects and programs to be implemented within the county by any organ of state over a five-year period. The CIDPs are expected to serve as the basis for county governments to prepare both their annual development plans and their annual budgets.

The basic planning and budgeting processes are considered sound, but poor coordination with national programs results in considerable waste of resources. The Managed Medical Equipment Scheme, for example, procures capital equipment for health facilities without consulting them or county health management teams about their needs, resulting in the purchase of expensive

equipment that remains unused. Furthermore, since the CIDP and county PFM systems are relatively new, they are still being rolled out and refined, and counties have somewhat different approaches to implementing them. On balance Kenyan local governments have a reasonably well-integrated and consistent system, although there are additional challenges in how this system functions, discussed below.

In South Africa, integrated development plans are prepared at the provincial and municipal levels, but they are not always well coordinated. Subnational PFM is fairly well established, with relatively sound processes. There are health-specific subnational plans, but these are not necessarily well linked to broader plans to provide for the complementary infrastructure (for example, in water, sanitation, and roads) needed to serve health facilities. This challenge is heightened by the fact that health is a provincial function (district health plans are under provincial supervision), while some of the infrastructure needed to serve health facilities falls under municipal responsibility.

There are, moreover, potential concerns about the underlying logic of certain budgeting rules and conventions. Provincial allocations to district health facilities, for example, tend to be made on the basis of historical budgets, but district budgets use a zero-based budgeting approach and are tied to annual district health plans (Wolvaardt et al., 2014). Budget ceilings for frontline health facilities are generally set based on patient load but are not adjusted for patient case-mix. In some cases, these frontline health service providers and the provincial health department do not coordinate sufficiently to help ensure that annual budget ceilings are consistent with local needs/requests and that local officials understand provincial resource envelopes.

Other issues can arise when new programs are not adequately provided for in the budget. For example, South Africa adopted ward-based outreach teams in 2012 as part of an NDOH strategy to re-engineer and expand community primary health services. These services are an add-on to primary care clinics and have a unique cost structure that creates new management and reporting burdens. The PFM processes covering these costs have not been well anchored in local planning and budgeting instruments and institutions (Jinabhai et al., 2015). The primary care staff in these ward-based outreach teams lack access to appropriately sized and equipped facilities, adequate transport, and communications infrastructure needed by community health workers performing duties in wards. There was apparently an assumption that the costs of these outreach teams could be covered by existing conditional grants or through the reallocation of other funding (Marcus et al., 2017).

Beyond general concerns about planning and budgeting processes, weak linkages between subnational planning and budgeting systems is a concern in a number of the cases. In Ethiopia, the large number of funding agencies involved, with decision makers spread across different entities, together with the proliferation of unique budget classifications, the volume of ad hoc off-budget flows, and decentralized management create considerable challenges for health planning and budgeting (FISCUS, 2019). Under the right conditions, the fluidity of the system's functioning could potentially give motivated and capable providers some flexibility to better meet health sector needs, but it is still important to develop a more stable and sustainable system.

Kenyan county governments, in line with their CIDPs, invest heavily in new health posts and nurseries, but corresponding operating costs are often not fully provided for in the recurrent budget. Without budgeting for the staff required to operate new facilities and the needed medicines and supplies, facilities remain largely non-operational. Other factors can disrupt CIDPs and budgets as well. For example, members of the national assembly can access the Constituency Development Fund

to secure resources for development projects in their constituencies, even in service delivery sectors that fall under the legal jurisdiction of county governments. The fund has financed the construction of many health facilities, but not necessarily based on clear criteria, in line with CIDP priorities, or linked to budgeting that provides recurrent funds for operations and maintenance.

In South Africa, the disconnect between planning and budgeting is not a major problem given the relatively robust district health planning and monitoring framework. There are some potential challenges, however, including insufficient clarity and some disagreement about how to finance facility costs. Health facility revitalization grants can cover maintenance, but the national government position is that provinces should prioritize maintenance out of their own revenues (including unconditional transfers) and not rely on national funds. In addition, there are concerns that inadequate information on capital needs weakens effective planning and budgeting. According to the South African Health Facilities Association, the government does not have an updated centralized physical asset management database for health facilities.[24]

Although Uganda used to have an unconditional development grant (not health-specific) to finance high-priority facilities, this grant was not clearly linked to the recurrent budget for operating expenses. Local development grants have become more conditional in recent years. In health there have been efforts to ensure that every sub-county has at least one health center level III facility, but recurrent grants often lack the resources needed to operate new facilities. To temper expectations and adjust bottom-up planning to match available funds, local governments and facilities are now supposed to be informed of anticipated allocations for the following fiscal year, which in principle allows better budgeting for facility costs if followed in practice (Wabwire, personal interview, 2020).

3. Potentially Excessive Constraints on Subnational Discretion in the Use of Sector Funds

Many of the institutional and funding factors discussed above can enable or constrain the ability of actors at different levels—intermediate governments, local governments, and frontline service delivery units—to make sufficiently independent decisions that potentially capture the prospective benefits of decentralization and make the best possible local use of resources to deliver services. Debates about the pros and cons of discretion were outlined in section III.2.F, and the divergent views on this front are reflected clearly in the varying practices of countries considered here. In all cases there are some claims that lack of autonomy hinders the ability of one or more subnational actors to use resources for health service delivery effectively.

In Kenya, counties have relatively strong autonomy by virtue of powers enshrined in the legal framework and supported by large unconditional transfers. There is unevenness, however, across the financing chain. The PFM Act, for example, gives counties considerable budgeting power and requires all funds to run through the County Revenue Fund, which in principle limits the challenges emanating from fragmented and off-budget financing. This framework, to the extent that it is followed, may strengthen coordination of health resources, since for the most part separate funds do not flow directly to facilities. At the same time, this "centralization" at county level is said to hinder frontline service delivery. There is some evidence that, since devolution, county governments have significantly reduced the autonomy of county hospitals, hindering their ability to deliver services

[24] https://www.hfassociation.co.za/images/docs/PresidentialHealthSummit2018/commission-3-resources-infrast-181019.pdf

(Barasa et al., 2017). There is variation across counties, however, with some granting more autonomy to their health service delivery units than others.

In the majority of Kenyan counties, higher-level health facilities keep bank accounts but do not receive funds directly from national or county governments. All health facility staff are CDOH employees and must request funds for goods and services from CDOH (or in some cases through the sub-county). Facilities cannot procure medicines directly from the Kenya Medical Supplies Authority or any supplier; instead, they submit requests to CDOH for procurement and payment. Facilities deposit funds into bank accounts but cannot use them independently, as transactions require both facility and county signatories. They also cannot retain user fees, which are deposited to the County Revenue Fund. Some county governments concerned about such constraints have passed laws to increase hospital autonomy, for example by giving them access to user fees and National Hospital Insurance Fund resources and allowing them to spend at the source (Barasa et al., 2017).

South Africa's mix of conditional and unconditional transfers allows considerable subnational discretion, but largely for the provinces in allocating unconditional resources to districts and health facilities. Lower-level actors have less fund management autonomy (Wishnia & Goudge, 2020). The provinces also have more scope to modify allocations. The national treasury uses a two-step budget ceiling approach to facilitate PDOH planning within the annual budgeting process. District Departments of Health and district health management teams, however, have almost no scope to revise spending targets in the district health plan (Wolvaardt et al., 2014). The lack of meaningful local autonomy, exacerbated by fragmentation in higher-level authority over allocations from unconditional transfers and conditional funding, prevents frontline service providers from determining how best to meet stated national health priorities while adequately tailoring spending to local needs (Lince-Deroche et al., 2016).

Subnational health sector actors at the local government and facility levels in Uganda have limited discretion. As noted above, wages are set and paid directly to staff by the MOFPED, while non-wage recurrent and development grants must be spent, respectively, at facility and district government levels following MOH guidelines (Wabwire, personal interview, 2020). Donor funding is almost invariably accompanied by conditions that local governments and/or health facilities must follow. On balance, therefore, local governments and health facilities in Uganda have rather low flexibility over the use of resources transferred to them for the purpose of delivering health services.

4. Issues in Implementing Routine Subnational PFM Operations

Adequately smooth PFM operations are essential for effective and sustainable service delivery, as discussed in section II. At the most basic level, promised funding amounts should be received by subnational actors in a timely manner. Once funds arrive the budget is expected to be executed as planned within PFM guidelines. In some cases, though, available resources in total or budgeted for a specific purpose are not spent as intended at the subnational government and/or health facility level. Instances of insufficient adherence to expenditure management protocols and incomplete and/or delayed compliance with reporting are common. In addition, off-budget funds may not be captured in official reporting, meaning that government records do not reflect all health funding flows, and in some cases these account for a significant share of sector financing. Other elements of PFM—such as procurement, asset management, auditing, and so on—-may suffer from delays or weaknesses in execution.

The budget execution challenges faced by the case countries reviewed here vary widely, although not all types of challenges are documented, and hard evidence is limited. Budget execution issues can be general or affect specific areas. In Uganda, budgeting—subject to the caveats noted above—functions generally according to regulations and meets deadlines, but there are indications that local governments and facilities, despite funding shortages, suffer from budget absorption deficiencies. A few years ago, for example, the Auditor General found that local government budget absorption was 85 percent overall, but only 70 percent in health (USAID, 2016). It is not clear whether this has changed recently, with more funding going directly to health facilities.

Although there is limited information about budget execution challenges in South Africa, it appears that these pertain to particular programs or specific funds. There are, for example, reports of underspending in the Health Facilities Management Program, under which the above-mentioned health facility revitalization grant falls (James et al., 2018). There are claims that this direct grant is underspent (UNICEF, 2019), although more recent data seem to suggest that the situation is improving. There is more consistent evidence of underspending of the health facility component of the National Health Insurance Program (Blecher et al., 2017, p. 33).

In Ethiopia, available documentation indicates that budget execution is particularly challenging on the investment side of the budget. The federal government overspent its capital budget by an estimated 43 percent over the period from 2011 to 2017, which is thought to be linked to poorly planned and hastily executed expenditure (FISCUS, 2019). At subnational (regional and *woreda*) levels, however, capital expenditure disbursement is often low and slow—especially in disadvantaged areas. The funding fragmentation and program classification issues discussed above seem to be contributing factors, as are deficiencies in project selection, fund management, and procurement.

Budget execution can be affected by delays in releasing funds. In Kenya, for example, salary disbursement delays, while less problematic than when devolution began, persist. This is due in part to delays in disbursement of the equitable share from the treasury to the County Revenue Fund. Moreover, some donor funds reach health facilities with long delays. Anecdotal evidence from Nyeri County, for example, suggests that some health facilities had not received installments of donor funding on which they rely to cover operational costs. The donor involved admitted to disbursement delays, which it attributed to how funds flow down to county governments (Dauda & Taveras, 2020).

County governments in Kenya have substantial pending bills, particularly in the development budget, but it is not clear if these result from arrears or commitments. Large arrears create challenges for counties, which must find a way to finance them, for example by deferring other spending or covering them in subsequent financial years. A high level of commitments, on the other hand, is more likely to reflect delays in public investment management, such that payments for signed contracts are not due because works have not been undertaken, completed, or verified. This issue is not specific to health but does affect the sector.

Kenyan frontline health staff face delays related to procurement requirements. County health departments, for example, are in charge of procuring medicines and other supplies from the Kenya Medical Supplies Authority and other suppliers on behalf of health facilities. The process requires multiple approvals to ensure the availability of funds and authorize payment by the CDOH. This process delays the delivery of supplies, resulting in stockouts of essential medicines, in part because suppliers withhold deliveries due to payment delays (Barasa et al., 2017). There are claims that some counties make inefficient purchases, such as procuring small batches of medicines at higher prices from third-

party suppliers instead of the Kenya Medical Supplies Authority, which offers lower prices due to high-volume orders. Such activity can open the door for potential corruption in the procurement process. Some counties do not even have procurement plans for medical supplies and medicines in place.

Weaknesses in procurement and contract management in Uganda are reported to contribute to challenges in executing the budget (ODI, 2018). In particular, procurement planning is inadequately integrated with budgeting, and restrictive procurement regulations are reported to hinder budget execution. For example, a good or service cannot be procured until the resources required to finance it are available. Although it is prudent not to commit funds that are not yet in hand, this can create excessive delays and subsequent challenges for service delivery.

5. Summary of Selected Issues in Managing Subnational Health Financing

The countries under review have experienced to varying degrees the types of health funding and PFM challenges introduced in section II.2 and illustrated here. These include fragmentation of funding and accountability, flaws in planning and budgeting, lack of adequate expenditure discretion, and weaknesses in the implementation of budgets and PFM functions more broadly. Clearly, these are not entirely distinct categories, and there are important linkages among them. For example, issues with expenditure discretion and budget execution are often related to fragmentation in funding channels and deficiencies in the structure of planning and budgeting systems.

The discussion provided here is incomplete, as owing to the travel restrictions imposed by the global pandemic, it is based on issues that emerge from available secondary materials rather than comparative primary research using a standardized methodology in the case countries. It is not possible to prioritize the relative importance of the various challenges identified without further investigation. As such, there is not sufficient information to make strong recommendations for specific reforms in any of the four countries, much less to offer more generalizable advice. Nevertheless, the following sections consider how to more systematically assess challenges in managing health funding, how to determine the factors underlying these challenges, and how to consider feasible actions to improve on the status quo.

VI. Assessing the Factors and Dynamics behind Challenges in Service Delivery Financing

The first step in understand what enables and generates the challenges outlined above is to identify the factors most immediately related to specific problems—referred to here as *proximate determinants.* These include, for example, institutional and procedural design and implementation flaws and other systemic and operational considerations that affect the flow and management of funds for service delivery. These proximate determinants of the observed challenges provide a useful initial basis for considering solutions, such as how to modify system design and implementation flaws. Proposed remedies, however, are often technical fixes that, even if sound in principle, may not succeed in practice without taking the broader context into account and accepting compromises.

The second step thus involves determining *underlying causal factors* that drive and sustain the proximate determinants. These include, for example, political economy considerations and capacity constraints that influence the design and operation of intergovernmental structures and processes—and may hinder adoption of seemingly good solutions. Public sector reforms tend to do well at identifying proximate determinants, if not necessarily in the context of intergovernmental considerations. Underlying causal factors, however, except for relatively common attention to capacity constraints, tend not to be given the level of attention required to develop realistic and sustainable reforms.

This section explains the analytical process being proposed by providing examples of proximate determinants of selected intergovernmental health finance issues in the countries covered here and the types of first-order solutions commonly suggested to address them. This is followed by an overview of underlying causal factors and their potential implications for pursuing these recommended solutions. A summary visual of the process is provided in Figure 10. The discussion also highlights the types of tradeoffs that must often be navigated in crafting strategic and pragmatic approaches to reforming health finance systems.

1. Proximate Determinants of Subnational Service Delivery Financing Challenges

The proximate determinants of the financing challenges experienced by the entities charged with delivering subnational health services fall into multiple categories. Some common examples illustrated in the cases include flaws in the design of the institutional and legal framework, gaps in implementation of the framework, and insufficient collaborative action among relevant actors.

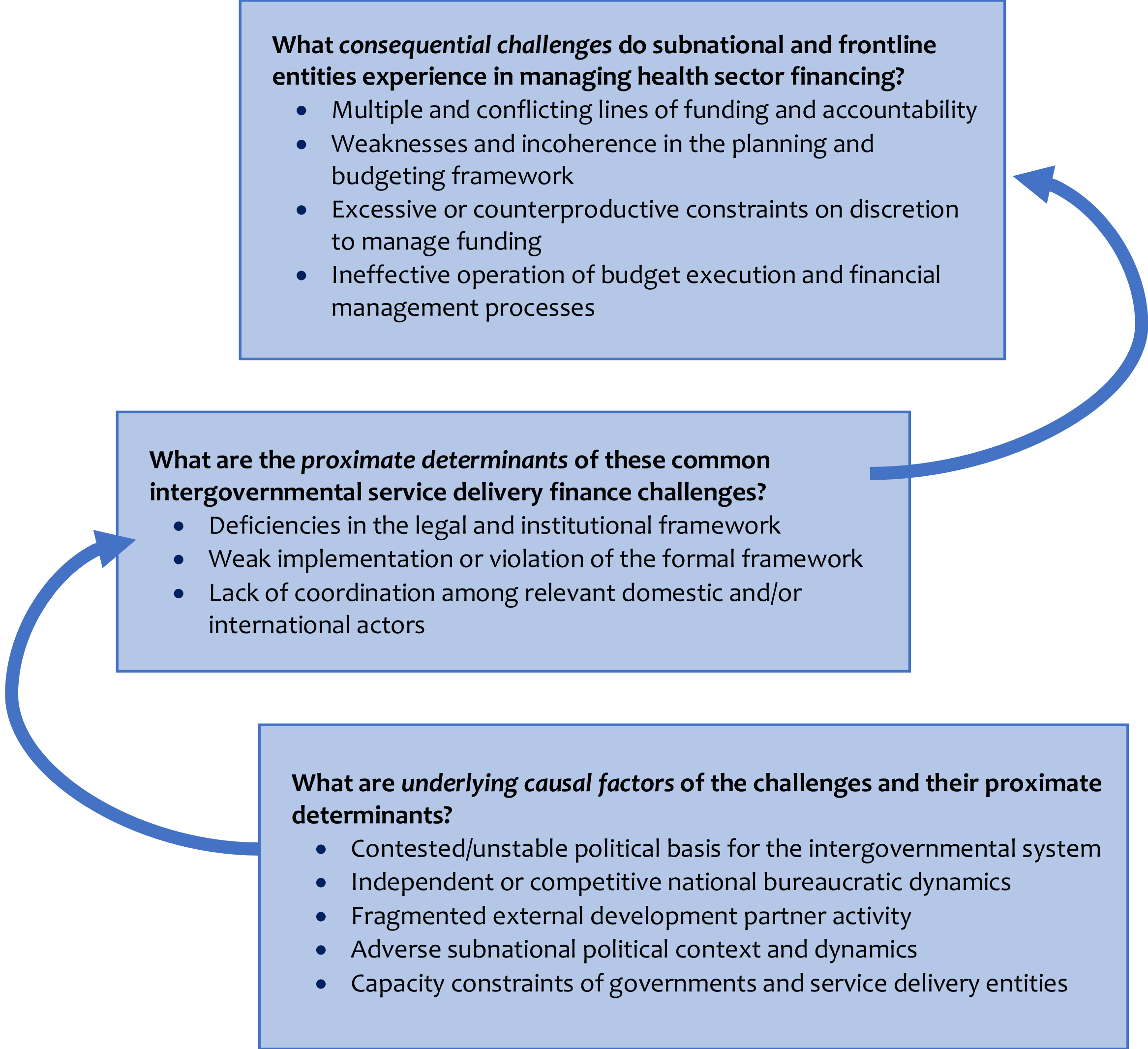
A. Deficiencies in the institutional and legal framework

Deficiencies in the institutional and legal framework for service delivery (both general and health-specific) in intergovernmental systems exist in many countries and are an immediate determinant of some of the operational health service issues discussed above. These include a lack clarity in functional responsibilities across levels of government, insufficient provision for subnational revenues (through transfers and/or local sources), weaknesses in fiscal transfer design, and underdeveloped or inappropriate PFM procedures and accountability mechanisms. The countries covered here exhibit a number of these issues in varying ways and to varying degrees.

All of the country cases lack full clarity or have experienced some consequential shifting in the responsibilities of specific actors, and concerns have been raised about the extent, design, and use

of user charges in the health sector. Intergovernmental transfers available for health are generally significant, but there are potential design issues across the board, including with the way transferred funds are allocated to specific subnational governments and facilities and the extent to which their use is subject to restrictions. In Uganda, for example, there are concerns that intergovernmental transfers have become too conditional. In contrast, the main transfers in Kenya, South Africa and Ethiopia are highly unconditional, raising uncertainties about whether initial recipients allocate enough funds for health service delivery.

Figure 10: Unpacking the drivers of intergovernmental sector finance challenges



The path that funding follows may be too complicated or too long in some cases, allowing for unwarranted inconsistencies and delays in resource flows for subnational health services. In Ethiopia and South Africa, for example, transfers flow from the national to intermediate-tier governments before going to lower tiers and health facilities. Transfers to intermediate tiers generally follow clear allocation criteria (not always related to health) and are unconditional, while policies guiding transfers to lower levels are determined by regions or provinces and may differ. The greater authority of lead subnational governments to target specific needs in their jurisdictions is attractive to decentralization proponents, but how this power is used may create space for major variations in how funds are allocated among subregional governments and health facilities. This is a concern from a national policy perspective because the variations may introduce inequities and inefficiencies, constrain even capable lower tiers and facilities from delivering services well, and complicate compliance with accountability requirements.

The case countries face multiple planning and budgeting challenges. In Ethiopia, South Africa, and Uganda, for example, development planning and budgeting systems are not designed in such a way that they link together appropriately. The criteria on which budget formulation is based are not always clearly defined. Even if budget formulation standards are well specified and seem generally appropriate, there are concerns that subnational health departments and facilities are not adequately consulted about their needs and experiences in constructing budgets and that the resulting top-down budgets do not serve them well. Concerns along these lines came up in various ways in all of the countries considered here.

B. Weak implementation or violation of the formal framework

Even if there is a strong and well-designed *de jure* intergovernmental fiscal and administrative system, it may not be implemented as designed. For example, higher levels of government can unduly interfere beyond their official mandate in functions that are legally assigned to subnational governments, or they may fail to exercise proper oversight or provide adequate support to subnational governments as is often required by law. Similarly, subnational governments may not meet their service delivery or revenue generation mandates, and/or they may fail to follow PFM requirements and other regulatory provisions in the subnational framework.

The countries reviewed here offer some examples of weak implementation. In most cases, planning and budgeting systems do not fully operate as designed, at least not uniformly across the country. There have been gaps, for example, in adopting PBB reforms in Ethiopia. Moreover, there are multiple issues with linking facility-level planning and budgeting even where this is provided for in the legal framework. Kenyan county governments, for example, are required by law to include development projects (including for health facilities) in their five-year CIDPs, which in turn must provide a basis for annual development plans and budgets. Yet there are documented instances in which neither of these requirements has been met. The situation can be complicated further if national parliamentarians use resources from the Constituency Development Fund to build health facilities in their local area without linking them to CIDPs and budgets, including failing to provide for operations and maintenance.

Other common implementation weaknesses include delays in transfer disbursements, budget execution, and financial reporting. Some of these problems are due to steps taken (or not taken) by higher levels of government in moving funds and in issuing implementation guidance, such as the failure of the federal government to standardize PBB budget classifications in Ethiopia. In other cases, designers of new health programs assume that existing elements of the system will be able to support

their efforts, such as the presumption that certain expenses associated with the expansion of ward-based outreach teams in South Africa would be covered by regular transfers. In most of the cases, there are general and specific instances of weak PFM performance, particularly with underspending of budgeted capital expenditures and the failure of subnational governments to comply with basic financial reporting requirements in a timely manner.

C. Poor coordination among relevant actors

It is not uncommon for individual actors—governmental and external—who are involved in various aspects of service delivery to independently develop policies, programs, and procedures when it would likely be more effective to undertake these efforts collaboratively. Some countries and/or sectors may lack an official coordination mechanism, or if one exists (either in the form of an integrated planning and budgeting system, covered above, or a dedicated sectoral coordination body) it may not be used effectively. As a result, different ministries or donor agencies may develop dedicated sources of funding or support for specific purposes without considering how they are related, and there may be insufficient sharing of relevant information that could be used to improve operations and performance. Experimentation and some competition in piloting new approaches may be valuable and should not be discouraged, but without creating an effective mechanism to identify best practices and ultimately harmonize common regulations, activities, and programs to support the health sector, persistent fragmentation may waste resources and even generate conflicting or incomplete approaches to health service delivery in different parts of the country.

Such coordination deficiencies were identified in all of the cases. In some countries, such as Ethiopia and Uganda, the finance and health ministries manage different financial flows from both government and donor sources. Other agencies are involved in various ways in other countries, including the Ministry of Devolution and Planning in Kenya and the Ministry of Public Works and Infrastructure in South Africa. The extent to which diverse initiatives and funding flows are harmonized is not clear, but there are some indications that they do not often operate synergistically, at least in a systematic way. Although some mechanisms to pool fragmented donor resources and coordinate donor and government resources are in place at least nominally in all of the countries, donors continue to varying degrees—particularly in Ethiopia and Uganda—to operate separate programs and funds that are not well synchronized to meet subnational health budget needs, are off-budget, and generate the administrative burdens discussed above.

D. Linkages among proximate determinants

Although some of the proximate determinants noted above can be standalone or dominant factors in affecting the functioning of intergovernmental finances and financial management in the health sector, they often manifest in related ways. If, for example, designation of responsibility is not sufficiently specific in the legal framework (a design flaw), this may open up space for different national and subnational government actors to independently interpret their roles and make decisions that lead them to act in inconsistent ways (generating a coordination problem).

Coordination weaknesses can also result from design flaws, even if functional responsibilities are clear in the sense that provision for appropriate coordination should be built into system design. It may be the case, for example, that one ministry is legally responsible for wages and salaries for health services and one or more different agencies for managing other funding flows. One level of government may have the main role in facility planning and financing, while another is responsible for

operations and maintenance. Individual health facilities may be required to determine supply needs, but then they must rely on a parent subnational government for procurement. Even if such functional separations can be justified, lack of provision in system design for adequately calibrated action can be problematic, especially if separately responsible entities do not recognize the need or face incentives to take action to coordinate. To respond to the challenges created by such arrangements and behaviors, it is necessary to understand how elements of the problem are related, and whether one of the determinants plays the primary role in generating the problem.

It is also worth noting that the interrelated nature of proximate determinants offers a potential advantage, in that taking measures to alleviate the effects of one proximate determinant may make it easier to deal with others. For example, improvements in planning, budgeting, and reporting systems through design modifications or more careful attention to implementation bottlenecks can concurrently help improve coordination among actors involved in health service delivery.

2. From Proximate Determinants to Pragmatic Solutions: Assessing Underlying Causal Factors

As noted above, the proximate determinants of subnational health service delivery challenges tend to point to specific types of solutions. Logical remedies for issues with the design of intergovernmental and health service delivery systems, for example, might include reassigning functions to different actors, changing the institutional path through which funds for the health sector flow, modifying the criteria used to transfer funds and the degree of conditionality placed on their use, increasing the role of subnational actors in formulating health budgets, and so on. Similarly, challenges in coordinating the roles of different actors in health service delivery and the flow of funds from different sources could in principle be alleviated by adopting or improving coordination mechanisms, laying them out clearly, and creating incentives for them to be used effectively.

Reforms based on sound analysis of factors that affect health service delivery are the bread and butter of development assistance, but they may not be practical, as evidenced by their uneven and often weak performance. More fundamental underlying causal forces shape the structure of intergovernmental systems and influence the feasibility of normatively desirable reforms. These include, for example, the political basis for the intergovernmental system, national bureaucratic dynamics, development partner influence, subnational government dynamics, and government (national and subnational) and health facility capacity constraints. Wider appreciation for the value of such analysis has emerged in recent years in the literature on the political economy of development assistance and on "doing development differently," but not to the extent that reform approaches have been modified significantly on a broad scale.[25]

A. Contested/unstable political basis for the intergovernmental system

In many countries, deficient intergovernmental and sectoral frameworks, weak implementation of even sound frameworks, and poor coordination among actors at least partly reflect weak consensus on the role that subnational actors should play, in general and in health. Political forces that motivate decentralization—often crises—may result in a formal system based on unworkable compromises negotiated among political actors with different perspectives. Alternatively, strong decentralization

[25] See, for example: Andrews et al. (2013); Booth and Unsworth (2014); Fritz et al. (2014); and Rocha Menocal (2014). See also: http://doingdevelopmentdifferently.com.

may be adopted, but without appreciation of the transformational implications, for example on national actors that lose power and local actors asked to assume a great deal of responsibility. Once structures and broad powers are defined legally, politics influence the specific functions and resources that are decentralized, the degree of local autonomy, and the processes and support mechanisms needed to enable subnational governments to perform their functions. Some framework features, such as institutional structures, tend to be durable even if they are problematic, while others are more easily manipulated to conform to changing political winds.

These considerations affect the viability of reforms that may seem to be logical responses to alleviate the proximate determinants of specific problems. For example, in Ethiopia and South Africa, where considerable unconditional funding is granted to regions/provinces, some reformers see value in issuing guidelines or mandates on how funds should be shared with lower tiers and service facilities. In those political environments, however, this proposed solution may not be feasible (at least not without negotiation with intermediate tiers). Ethiopia created a federal system to unify the country in a post-conflict period by giving ethnically identified regions more control over shared federal resources. South Africa's system is based on a post-apartheid commitment to separate spheres of government constitutionally entitled to an unconditional share of national resources. Imposing central conditions on block transfers in such cases may be politically difficult (or even unconstitutional), although both countries have shown that creating additional transfers allocated on a conditional basis to ensure funding for nationally prioritized services is a possible compromise.

Kenya and Uganda centered their intergovernmental system on local governments, avoiding a role for intermediate tiers because regions are associated with ethnic groups/traditional kingdoms and related political dynamics. Some reformers recommend empowering regional governments to streamline service delivery funding and management and to provide a pool of higher-capacity staff on whom lower-tier governments and facilities could draw without the funds needed to hire full-time experts. Such a reform seems unlikely, however, due to the political forces at play. There are also differences in how Kenya and Uganda provide resources to the health sector, with Kenyan counties receiving large unconditional transfers to share with health facilities while Uganda relies heavily on conditional transfers that are directed increasingly toward health facilities. Even if some reformers want to standardize the health financing chain more fully in Kenya or offer more flexibility in Uganda, such reforms could be difficult given prevailing political conditions. And even if they are legally adopted, they may not be faithfully implemented.

B. Independent or competitive national bureaucratic dynamics

In addition to the role of political realities in shaping intergovernmental financing and service delivery systems, strong bureaucratic dynamics may be at play. Some national actors may resist decentralization because it would require them to relinquish powers and resources to subnational governments. Equally important, as noted in sections I and II, are the different perspectives and priorities of national actors, with finance ministries focused on managing public resources (and reluctant, perhaps, to fiscally empower subnational governments or to provide a level of resources commensurate with health sector needs out of concern for national fiscal effects); health ministries focused on service delivery (perhaps without considering the legal role of subnational governments and with different priorities than the finance ministry on allocating and managing funds); and local government ministries that oversee subnational governments (oriented perhaps toward local autonomy or exerting their own authority over subnational governments regarding the protocols and

standards that finance and health ministries consider essential for resource management and service delivery).

These bureaucratic dynamics can create or worsen the coordination challenges discussed above. If a ministry with a particular mission independently develops and implements policies and processes that affect service delivery, their actions may not be consistent with sector-relevant policies and processes under the purview of different ministries with other primary goals. Such divergent priorities, agendas, and actions can not only stifle interest in collaboration, but they can also generate resistance on the part of some actors to participate in even well-conceived coordination mechanisms and thereby weaken the ability of these mechanisms to meet their objectives.

A reading of the secondary material on the cases suggests that such tensions may exist to varying degrees in some of the countries. In Ethiopia there were indications that the FMOH and MOF managed different, not particularly well harmonized programs and funds for subnational health services, and insufficient action had been taken to develop a consistent set of budgeting categories for PBB. The MOH and MOFPED manage different elements of the allocations for local health services in Uganda, and in Kenya the main transfer is managed by the MOF, but other mechanisms are managed separately, such as the Constituency Development Fund managed by the Ministry of Devolution and Planning. There is not enough secondary information on the cases to be certain how much these differences in approach represent overt insistence on following different priorities versus ad hoc arrangements to manage specific resources and programs, but it is equally unclear that the managers of these various functions and funds make enough of a concerted effort to work effectively together.

C. Fragmented external development partner activity

As is evident from previous discussions, international development agencies can be prominent and productive actors in the subnational health sector. In practice, however—and despite efforts to create commonly managed funding pools that may even be on-budget—independently managed donor programs have proliferated, with limited or ineffective coordination despite commitments made under the 2005 Paris Declaration and other aid effectiveness agreements. As a result, countries may be unable to pursue more synchronized donor support with greater prospects of collectively improving health service delivery. Since so many instances of donor fragmentation in the case countries and their proven and potential implications for the health sector have been covered above, there is no need to repeat them here.

The reasons why aid fragmentation persists are well known. Many donors face strong incentives to work independently and to promote their specific priorities using their own modalities. This is a matter of establishing the value and comparative advantage of their approaches to improving health services and demonstrating their specific impact. Donors' resolve to use their own reporting formats facilitates their own institutional accountability requirements, but also signals mistrust of the PFM and reporting systems of partner countries. Fragmentation can sometimes reflect individual donor partnerships with specific government agencies—finance, health, or local government—that share their interests and priorities. Such arrangements can reinforce the above-noted inconsistencies in measures taken by competing and/or uncoordinated government agencies.

On the one hand, these justifications may have some validity in terms of donor interests, and they may be under pressure from their headquarters to operate in this way, risking the loss of funds if they fail to do so. On the other hand, this *modus operandi* poses challenges for improving inherently

related elements of health financing and management systems in countries that the donors claim they are committed to supporting. One reform recommendation that emerges most prominently from reviewing the country materials is the need, in most cases, for better cooperation among government agencies, levels of government, and donor support mechanisms. Given the behaviors and incentives summarized here, dramatic overarching reform on this front may not be a realistic goal. It may be more feasible, then, to develop more modest experimental measures that could potentially be scaled up later if proven effective.

D. Adverse subnational political context and dynamics

Health service delivery is inherently embedded in local context, and in decentralized or decentralizing environments, the role of subnational governments is important to varying degrees. The case was made earlier for assigning suitable health responsibilities and resources to subnational governments along with enough discretion to allow them to respond to specific local needs and changing conditions. One of the issues arising from the case reviews is that subnational governments and health facility managers in some countries do not believe they have sufficient autonomy to do their jobs as effectively as they could with more authority.

In reality, however, the health functions assigned, and the degree of discretion allowed over the use of resources needs to fit the local context. In some cases, subnational actors can responsibly manage more functions and autonomy, as seems to be the case in South Africa. Under other scenarios, strong local autonomy over service delivery may lead to elite capture or uneven service delivery across areas or population groups, which seems to have been a strong motivating factor behind weakening the role of Ugandan local governments in health. Without adequate development and enforcement of a coherent subnational government framework and cultivation of appropriate accountability relationships, local residents may not be well served by strong local discretion, and greater higher-level control and oversight may be warranted.

At the same time, central authorities may allege that subnational governments are unreliable and corrupt as a way to justify gratuitous controls that may be detrimental to health service delivery, including overly restrictive budgetary conditions and excessive, direct higher-level control of individual health facilities. Understanding relevant local political and administrative conditions is important to assess the extent to which subnational governments and health facilities can deliver, improve, and sustain local health services. It is also clear that conditions can change over time, and that the relationship between higher levels and lower levels can evolve accordingly.

E. Capacity constraints of governments and service delivery entities

It is hardly news that actors at all levels of government in the health sector, and more generally, may face capacity constraints. Flawed design and/or implementation of intergovernmental arrangements for financing the delivery health services may result from a lack of expertise on the part of national actors who designed the system, and delays or deficiencies in implementing the system as designed might be due to insufficient capacity at any level of government or even at the facility level, however well-intentioned they may be. In Kenya, for example, nurses in charge of lower-tier health facilities report struggling with financial management and with requirements for reporting to the county. Although capacity is a serious issue and evident in the cases, it can, as with claims that subnational governments are untrustworthy and corrupt, be used as an excuse for higher levels of government to

overly control the financing and delivery of health services that are legally decentralized or in which local governments and health service facilities could play a stronger role.

Capacity certainly needs to be considered in determining the extent to which subnational actors are given control over resources, but such decisions need not be uniform since the capacity of individual local governments and health facilities may vary greatly. Those that meet certain capacity and performance criteria could be given more functions and discretion over resources. Moreover, as the capacities of local governments and facilities improve, their role in managing health finance can be expanded accordingly.

Where needed, capacity development can play a role in enabling less qualified local governments and health facilities to meet their responsibilities more effectively. Although capacity building receives much attention, there are concerns that it is dominated by "supply-driven" approaches (by national governments and donors), which tend to privilege standardized training in the technical skills needed to manage finances and service delivery. Attention has increasingly been given to fostering more "demand-driven" (requested by subnational governments and facility managers) and "on-the-job" approaches that deal with the immediate technical and managerial problems being experienced on the ground. Both are clearly valuable, but they need to be designed in a way that recognizes the fundamental underlying incentives and dynamics that could inhibit the use of new skills.

3. Significance of Proximate Determinants and Underlying Causal Factors

The proximate determinants of intergovernmental health finance challenges and the causal factors that underlie them should be understood and factored into reform deliberations if constructive action is to be crafted and implemented. It is often reasonably straightforward to use quantitative indicators and qualitative assessments to identify issues in how funds for health service delivery are raised, allocated, and managed in an intergovernmental system. The specific path to remedying or alleviating such issues, however, is often less clear. Seemingly sound technical solutions may be more or less feasible in different contexts, but their specific entry point and application may require distinctive approaches, depending on whether the problem reflects a flawed legal framework; weak implementation; poor coordination among some mix of national and/or subnational government actors, frontline service providers, and international development partners; and/or various other considerations.

Even if proximate determinants can be readily identified, the feasibility of addressing them and the most effective reform path depend on recognizing underlying causal drivers of the observed determinants. These include the degree of political commitment to correct the issue (at national and/or subnational level), explicit (or less visible) conflicts between specific actors that hinder coordination and remediation, pressure from external funders on government agencies to proceed in a specific way, insufficient capacity to do what needs to be done, and a range of other factors. Multiple of these elements may be present simultaneously and with varying importance. This is complex territory that this paper cannot explore comprehensively, but as a start the next section maps out an exploratory framework intended to help analysts think about bringing an intergovernmental relations perspective into the process of assessing challenges, defining potential solutions, and crafting reform strategies in this field.

VII. Intergovernmental Considerations in Strengthening Resource Use for Health Service Delivery: A Preliminary Analytical Framework

This section draws on lessons from the literature and the countries covered here to outline two different approaches to identifying challenges in the health sector–intergovernmental finance–PFM nexus that can affect service delivery.

The first approach is to conduct a more broad-based assessment of health financing in the larger intergovernmental context, which involves tracking a standard set of system features and what they might imply for health service delivery. Such an approach would include the intergovernmental health financing system features covered in section III.2—subnational government health responsibilities, the mix and sources of health funding, the allocation of national funding for subnational health services, and the flow of and accounting for national fund transfers. It could also cover non-fiscal issues as needed, depending on context and the scope of the analysis being undertaken. This type of broader analysis would be indicated when an overall assessment of the system is desired.

The second approach is to build out from a specific problem in health financing and financial management that has been identified as having a negative impact on service delivery. The target challenge could, for example, fall into a category reviewed in section V—multiple/conflicting lines of funding and accountability, weaknesses in subnational planning and budgeting frameworks, excessive constraints on discretion over subnational health service delivery, or issues in implementing routine subnational PFM functions. It is likely that this analysis would focus on a specific high-profile sub-problem within these broader categories—for example, a disconnect between facility development financing and recurrent financing for operations and maintenance, rigid line-item budget allocations that preclude budget flexibility for facility managers, or delays in intergovernmental health transfers reaching service facilities.

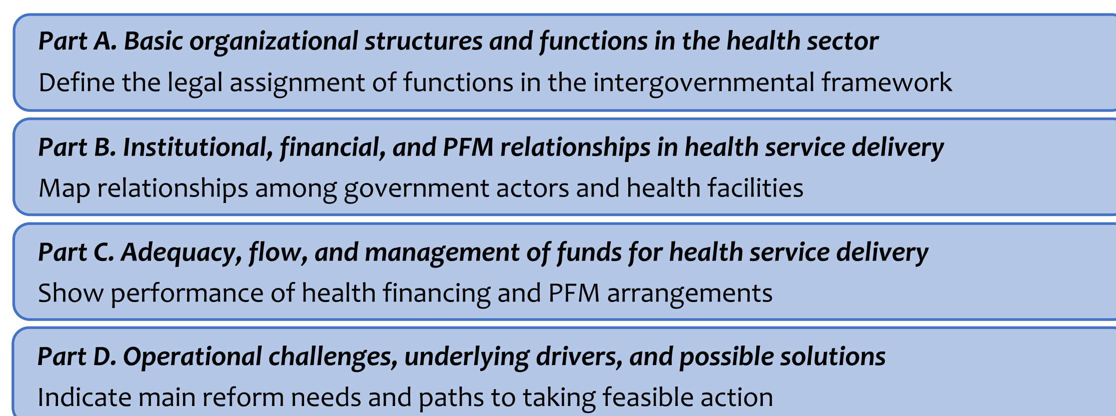
Ultimately, these two approaches are interrelated. The more broad-based approach will likely identify multiple specific problems that require deeper attention. The more targeted approach will typically require going back to intergovernmental structural and financing considerations—many of which are proximate determinants of health funding and financial management challenges—because one must pay attention to them in dealing with the specific challenge of interest. Analysis in a particular case may often include a blend of broader and narrower assessments. Moreover, as discussed in section VI, there may be clear technical fixes to structural and financial problems, but they may not be feasible. A diagnostic exercise is therefore incomplete without incorporating the underlying causal factors—political economy, bureaucratic dynamics, local context, the role of donors, and capacity—outlined in section VI.2.

Since relevant literature is thin and this paper covers only selected countries using secondary material, and given that intergovernmental systems are extremely diverse, what is presented here is necessarily exploratory. Although this paper cannot offer a generalizable policy matrix that neatly prescribes how to improve the finance–health service delivery relationship under specific intergovernmental systems, it does outline **basic diagnostic questions** that can help to assess the management of health sector financing in intergovernmental context and to look for pragmatic reform opportunities. The framework does not directly employ quantitative indicators, but relevant examples and a discussion of how they can be used are provided in section VII.1.E.

1. The Intergovernmental Health Finance Landscape: A Broad-Based Assessment Framework

Although a comprehensive assessment of the health sector financing system is not always necessary, it is useful to have a framework available. In some cases, a broader approach will prove useful even if an effort initially targets a specific problem. The framework presented here covers four interrelated categories (Figure 11) that document how health sector financing operates in the intergovernmental system: organizational structures and functions; institutional, financial, and PFM relationships; the adequacy, flow, and management of funds; and challenges, underlying drivers, and possible solutions. These categories and the questions posed under each are not truly comprehensive, but they provide a basic overview of relevant concerns and serve as a basis for more extensive investigation as needed. Box 1 summarizes how to use the broad-based assessment framework.

Figure 11: Mapping the intergovernmental health finance system, challenges, and options



This subsection enumerates a set of questions and concerns for each of the four categories, then summarizes the key issues (Boxes 2-5). Many of the points of interest require qualitative assessment. There may be different perspectives about, for example, the effects of fragmented funding sources, the value of specific mechanisms for allocating funds, appropriate levels of subnational spending discretion, and so on. Some discrepancies may be resolved by more careful examination of indicators and available documentation (including records of funding levels and timing of flows), while others will require additional exploration, judgment calls (based on guiding principles), or negotiation with key parties holding different views.

A. Basic organizational structures and functions in the health sector

The first set of basic informational questions aim for the most part to provide descriptive characterizations of the health sector system structure (Box 2)—for example, what does the legal framework have to say about the general provisions of the intergovernmental system (including PFM) and the role of subnational governments in the sector? These basics are important in understanding how finances are managed.

Box 1
Using the broad-based analytical framework

- ***Different users will have different needs***
  - ✓ Those less familiar with the country and the sector will need to use the analytical framework more fully (even starting with part A).
  - ✓ Those with greater familiarity may be able to start with a specific section, including jumping straight to identifying the challenges (even starting with part D).
  - ✓ Those familiar with some aspects of the system but not others, for example who know facility financing arrangements but not how funds flow to the parent government, can start with what they know and build backward and forward.
- ***Different questions will require different sources of information***
  - ✓ The answers to some questions may be well documented in readily available public sources, such as government, agency, or development partner materials and records.
  - ✓ Certain information can be obtained from quantitative indicators; others will require qualitative assessments.
  - ✓ Certain questions will require consulting directly with sector, finance, or intergovernmental experts at the policy or practitioner level, and in some cases people at the facility level.
  - ✓ It may often be valuable to consult people in multiple positions given different perspectives and levels of familiarity with relevant information.
- ***Different means of reporting findings and recommendations will differ depending on the target audience and the purpose***
  - ✓ Where there is a need for a broader assessment of sector finance, well documented with details, a full report on the overall system may be warranted.
  - ✓ Where well-defined, narrower information is needed by specific actors (such as government officials in a particular role, facility managers, or development partners), a more focused output would serve the purpose.
  - ✓ Even where a more focused output is needed, it is important to make sure that relevant information and relationships in the larger framework are considered; -shortcuts can lead to inaccurate findings and inappropriate recommendations.

Key questions on basic organizational structures and functions include:

i. **Which level (s) of government has (have) responsibility for health service delivery?** The center is typically responsible for developing policy frameworks and may lead on delivery in some cases, but primary responsibility for the delivery of specific services, including oversight of certain types of facilities (such as national hospitals, regional hospitals, local clinics, and community health centers) may be assigned to other levels.

ii. **Which types of entities are involved in service delivery?** These may include general-purpose governments, special-purpose governmental or quasi-governmental agencies, private sector entities, and so on. Any are possible, regardless of which government level has primary legal responsibility. In some countries, for example, subnational governments form service-specific agencies or contract the private sector or nongovernmental organizations to perform functions just as central governments can, and subnational service-specific entities that are delegated functions by the center may partner with government agencies or private

actors. These entities can be involved directly in health service delivery or in only some specific function, such as drug procurement.

iii. **How are health services financed?** Subnational health services may be financed through different combinations of funding, including transfers from national revenues (allocated by derivation or formula, conditional or unconditional, automatic, or performance-based, in-kind); subnational tax and non-tax revenues not specific to health; and health insurance payments and/or user charges. Development partner funds may be managed by different ministries or separate entities and may be on-budget or off-budget. The specific mix of resources has implications for the operations of subnational service providers and the ability of higher-level monitoring mechanisms to trace the use of specific resources on specific health services.

iv. **How is the PFM system for the health sector organized?** Whether health functions are devolved, deconcentrated, or delegated, a subnational government or special entity budget may or may not be integrated into the national budget and use the same PFM system, including the same IT software and infrastructure, as the central government. There may be varying involvement of national sectoral agencies (relative to the finance ministry role) and subnational entities in budget formulation, fund management, budget execution, reporting, and monitoring.

Box 2
Part A. Basic organizational structures and functions in the health sector

1. **Level(s) of government assigned responsibilities for health services** (oversight, specific services, different types of facilities, and so on)—some functions may be shared by multiple levels
2. **Types of entities involved in service delivery** (government departments, special agencies, or nongovernmental organizations; may vary across levels)
3. **Health service delivery financing system** (intergovernmental transfers, user fees, insurance payments)
4. **Organization of health sector PFM system** (uniform PFM system across government levels and providers or more fragmented arrangements)

B. Institutional, financial, and PFM relationships in health service delivery

Beyond basic system parameters, the second set of questions intends to document in more detail how various actors work together to operate the system (Box 3). This includes the service delivery responsibility chain and how key elements of sector operations that affect service delivery—planning and budgeting, revenue generation, staffing—are managed. Key questions include:

i. **What is the specific chain of responsibility and accountability among levels and entities involved in the delivery of health services?** Building on the information gathered on basic functional responsibilities under part A of the framework, documentation of the chain of service delivery roles indicates how various actors operate in the flow of service delivery to consumers. In health, there may be a regional health department that has some authority over local governments, which in turn may interact directly with service delivery units or a subdistrict office that immediately supervises local health clinics. Actors at each level may

play a role (hierarchically, collaboratively, or independently) in managing health revenues, expenditures, and staffing, and this can substantially impact service delivery.

ii. **What roles and authority do the different levels of government and frontline service delivery units have in planning and budgeting?** Which level of government has official responsibility for planning and budgeting recurrent and development funding in health? Planning and budgeting sometimes take place at different levels. Even if subnational governments or health facilities lack strong authority, do they provide information and submit requests to help shape national or regional sector planning and budgeting (in the expectation that this may support better resource use)? Ultimately, it is important to understand the roles that each level of government and service delivery units play in influencing and determining plans and budgets, and what this implies for health service delivery.

iii. **What roles and authority do subnational entities have in revenue generation and use?** Main transfer programs are defined and managed by the central government, so the relevant considerations here are the allocation criteria and the degree of conditionality on subnational use of funds. Intermediate tiers may also control how resources are allocated to local governments, which in turn may control allocation to lower tiers and/or health service facilities. In some cases, central or intermediate tiers may directly control allocation to health facilities. If subnational revenues are generated for health, to what extent do specific actors at different subnational levels have the authority to make decisions about the setting of user fees for health services and how to use the fees that are collected? These revenue arrangements are obviously central to health service delivery.

iv. **What roles and authority do subnational entities have in staffing and human resource management?** Subnational health staff are most likely regulated and may also be managed by the central government. Do subnational governments have any authority to make decisions about the level and configuration of health service delivery staff, the individuals hired and fired, and the compensation and advancement of staff? Do health service facility managers have any role on these matters? The key issue here is to understand the balance between sufficient local autonomy to determine staffing needs/expenses (and to hold staff accountable for performance) and the need to ensure staffing quality/standards and protect against unnecessary staffing expenditures.

v. **What might the chain of responsibility/accountability and roles/degrees of authority of different subnational actors imply for service delivery accountability?** National actors have a responsibility to set national priorities, determine national processes and standards, and ensure productive use of national resources. At the same time, meaningful subnational (government or health facility) input into resource allocation decisions can improve the relevance and efficiency of planning and budgeting, and some authority over spending decisions and staffing make them (in principle) better able to locally tailor, control, and monitor service delivery performance. There must be a balance—appropriate to the specific context—between upward accountability for meeting national priorities, standards, and procedural requirements and downward accountability for performance to subnational government constituents and the consumers of services provided by health facilities. How does that balance look in the case under consideration?

Box 3
Part B. Institutional, financial, and PFM relationships in health service delivery

1. **Chain of responsibility for health service delivery** (health departments and entities at various levels and their relationship with each other and service facilities)
2. **Planning and budgeting** (roles, degree of autonomy, and relationships among national and subnational levels and facility managers)
3. **Revenue generation and use** (degree of control over transferred funds and user fees by subnational governments and facility managers)
4. **Staffing and human resource management** (role of subnational entities in staffing and human resource management)
5. **Implication of roles/relationships for accountability** (balance of upward and downward accountability given the roles and autonomy of different actors)

C. Health service delivery fund adequacy, flows, and management

Beyond the basic parameters of the system and roles/relationships in health finances covered thus far, this third set of questions is intended to document in more detail the adequacy, flow, and extent of absorption of funds for health service delivery in the PFM process (Box 4). Key questions include:

i. **Are the total resources available for health service delivery adequate, transparently recorded, and stable?** Adequacy is, of course, primarily a national consideration since subnational health funding is normally dominated by intergovernmental fiscal transfers. In assessing budgeting, it is important to have a sense of the extent to which resources are sufficient in the aggregate to cover the expected (according to specific input or output cost guidelines) requirements or budgeted expenditures (which may or may not fully meet policy guidelines). Equally important is the extent to which these funds are transparently reported (on-budget versus off-budget) and relatively stable across fiscal years (both in terms of national domestic revenue sources and donor funds).

ii. **To what extent are resource flows linked to subnational (government and facility) health budgetary needs?** In some cases where total transferred resources are highly unconditional, this is more difficult to document without detailed analysis of subnational budget preparation down to the facility level. Still, some resources are in many cases linked directly to specific budgetary requirements, as with intergovernmental transfers to cover staff salaries, conditional grants for medicines, user charges or insurance fund payments for certain types of health services and diagnostic procedures, and so on. Are such linkages evident and appropriate in policy guidelines, budgets, and financial reporting practices?

iii. **Are promised health resource flows honored and received on schedule?** For example, do specific intergovernmental transfer payments arrive at scheduled times during the year and at all levels (including from central to subnational governments, intermediate tiers to lower levels, and/or from any government level to health facilities)? Are any dedicated tax or non-tax revenues received reasonably in line with expenditure demands, or is there lumpiness in accrual (in that some revenue proceeds may come due once or twice a year rather than on a schedule that coincides with committed outflows)? Are user charges for specific services collected according to guidelines and in a timely manner?

iv. **Are budgets executed fully and appropriately?** Are subnational governments and health facilities able to absorb the full amount of funds allocated to them and raised by them? To what extent are health budgets executed as planned (allowing for reasonable modifications across line items as provided for in budgeting regulations)? Are certain types of budget expenditures more or less likely to be fully executed (for example, capital expenditures or medicines) than others? Is there overspending on any budget categories (such as salaries and wages) and, if so, are there implications for other budget categories (for example, if funds for medical supplies are being used to pay staff, resulting in insufficient funding for supplies)?

v. **Is there a sensible degree of flexibility in routine budget management?** To what extent do specific actors in the service delivery chain (from the sector department to frontline service delivery facilities) have appropriate discretion to reallocate budgeted funds as needed? What is the basis for such flexibility? For example, there could be general budget authority in force, funds under certain line items could be allowed to be allocated flexibly, specific rules could permit a certain percentage of funds to move across the full range of line items, or performance indicators could be used to determine budgetary discretion. To what extent do the different entities involved in health service delivery financing make reasonable use of their discretion? Are there instances in which flexibility provisions are exceeded (as in the above example of using funds budgeted for supplies to pay staff) and what are the consequences?

vi. **Have any other subnational PFM issues been identified?** A range of other PFM-related considerations could affect the ability of subnational governments and health service facilities to effectively manage resource use. Data availability and quality may hinder effective PFM operations, and there may be delays and quality issues in financial reporting. Deficiencies in other relevant processes, such a procurement, contracting, and auditing, among others, may also occur. Have these or other challenges and their effects been documented?

Box 4
Part C. Adequacy, flows, and management of funds for health service delivery

1. **Adequacy, transparency, and stability** (extent to which funding sources are broadly sufficient, transparently reported, and reliably regular)
2. **Linkage of resource flows to subnational budgetary needs** (extent to which the mix and terms of conditional and unconditional transfers and other sources is consistent with the expenditure requirements of subnational governments and facilities)
3. **Receipt and timing of transfers** (extent to which committed resource flows are received and in a timely manner by subnational governments and facilities)
4. **Budget execution** (extent to which subnational government and facility budgets are executed as planned and if there are particular areas of weak performance)
5. **Flexibility in routine budget management** (extent to which subnational government and facility managers have and use budget flexibility powers)

D. Managing intergovernmental health financing: challenges, drivers, and solutions

The final set of questions in the overview diagnostic focus on determining, based on the assessments conducted in parts A, B, and C of the framework, the relative importance of health finance management challenges that might be expected to affect service delivery (Box 5). These cover the specific nature of the challenges, system features that seem to generate or contribute to them (the proximate determinants covered in section VI.1), types of responses that might help to resolve or alleviate them, and how more fundamental underlying drivers (the causal factors discussed in section VI.2) influence the feasibility of desired institutional or procedural solutions. Key questions include:

i. **What are the key challenges to health financing and financial management uncovered in parts A, B, and C of the framework, and how/why might they negatively affect service delivery?** Examples that may emerge in the system assessment (discussed in section V) include multiple and conflicting lines of accountability and funding, issues with service delivery planning and budgeting, lack of appropriate discretion among subnational governments and facility managers, and challenges in PFM implementation. There may not be an easy way to prioritize these challenges without more evidence on their effects, so it is possible that additional investigations will have to be conducted before selecting the focal challenges.

ii. **What are the proximate determinants of the specific challenges identified?** To what extent are they related to deficiencies in the institutional and legal framework that defines responsibilities and relationships among health sector actors, as well as fund allocations and processes required to manage finances (sections IV.2 and VI.1)? Other issues include deficient system implementation and poor coordination among actors involved in the sector—including within national agencies, between external donor agencies and government actors, between national and subnational governments, among subnational actors at the same and different levels, and between governments and health service delivery facilities.

iii. **What types of solutions might be considered to alleviate the specific challenges identified?** Remedies to problems, as discussed in section VI, often seem to flow logically from documented challenges and the proximate determinants that are their immediate trigger. Flaws in institutional and legal frameworks, for example, should technically be correctable through commonly recommended reforms, and efforts can be undertaken to improve poor implementation of constructive elements of the framework. Similarly, coordination should in principle improved as a result of better use of coordination mechanisms (for example, to enhance sharing of budgeting input and monitoring budget performance) or creation of new mechanisms as needed to deal with issues that are not subject to coordination provisions (such as to consolidate fragmented donor funding for the health sector under a basket fund managed through common procedures and accounted for in national and subnational planning and budgeting, even if the funds are channeled off-budget to meet donor requirements).

iv. **Are the more fundamental causal factors that generate or motivate the proximate determinants of identified challenges likely to be conducive to successful implementation of desirable solutions?** Proposed solutions may not always be feasible because the proximate determinants of the challenges they target are shaped by powerful and durable factors that may preclude or obstruct desired reform (section VI.2). These might include, for example, political economy dynamics (national or subnational), resistance from government agencies or external development partners whose specific interests may not be well served

by the desired reforms, and capacity deficiencies among subnational government or health facility staff that make it difficult to effectively implement and sustain proposed modifications in responsibilities, funding allocations, or operational procedures.

v. **What do the underlying causal factors suggest about the types of reforms that are likely to be feasible?** Understanding how these causal factors affect health financing and service delivery may assist reformers in identifying (perhaps more modest) policies and mechanisms with genuine potential to (perhaps incrementally) improve funding and use of PFM for better service delivery under prevailing or modifiable governmental arrangements. Although it may not be realistic, for example, to increase the role of subnational governments and health facilities in making direct budget decisions, it may be possible for them to formally provide information on needs and feedback on past allocations. This information could meaningfully influence future budget allocations and provide insights on defining provisions for selected degrees of discretion in fund management. Similarly, while it may not be feasible to increase the conditionality of a main intergovernmental transfer program to target health services more specifically, there may be scope for negotiating guidelines to allocate a specific share of unconditional block transfers for health services or to create new conditional transfers for specific health needs that may even incorporate innovative design features, as in the case of performance-based transfers. Decisions on how to proceed would need to be negotiated with various actors whose cooperation would be required for reforms to succeed.

Box 5
Part D. Intergovernmental health finance challenges, drivers, and solutions

1. **Identify priority challenges** (determine the most important challenges from among those identified, ideally in terms of their effects on service delivery)
2. **Identify proximate determinants** (challenges may result from flaws in service delivery, PFM, or intergovernmental frameworks; poor compliance with system requirements; lack of cooperation among key actors; and the like)
3. **Determine possible solutions to determinants** (for example, correcting system flaws, improving adherence to requirements, or promoting greater collaboration)
4. **Check for underlying causal factors** (political economy considerations, capacity constraints, and other factors may limit or preclude adoption of desired solutions)
5. **Consider implications for reform feasibility** (if causal factors create obstacles, examine options that may be more limited than desired measures but can proceed in spite of obstacles to move the system in a productive direction)

E. Using quantitative assessment

In analyzing any public management issue, it is valuable to collect objective quantitative indicators as evidence. Much of the information required to do the type of assessment outlined here, however, requires qualitative investigation and informed judgment. As mentioned above, there are constraints on numerically measuring some attributes of the intergovernmental fiscal and financial management system, both in general and for the health sector. It is particularly challenging to directly ascribe health service delivery performance to particular aspects of the system, even if logic and anecdotal evidence can create the basis for reaching informed conclusions on this issue.

Table 7: Selected quantitative indicators of intergovernmental health financing

Indicator	Relevance	Interpretation	Framework category/ diagnostic question
1. % total public health spending at subnational level	Indicates relative role of subnational governments in health; may exclude off-budget funds	Health spending can be divided among subnational government levels and facilities under different rules	1.A.i 1.A.iv
2. % subnational health budgets funded	Indicates if approved budget is properly funded	Mismatch may result from poor budgeting or unrealistic funding expectations	1.C.i 1.C.ii
3. % total subnational health expenditures from fiscal transfers	Indicates dependence of subnational health sector on funding from higher-level government	Effects of dependence depend on reliability of funds and how transfers are allocated and accounted for	1.A.iv 1.C.i
4. % total subnational health expenditures funded by user fees	Indicates ability of subnational governments and/or health facilities to generate funds for health services	User fees provide funds; may have discretion or equity implications depending on regulations	1.A.iv 1.B.iii
5. % of total fiscal transfers that are unconditional	Indicates subnational government flexibility to program resources for health services	Discretion can be positive or problematic depending on policy objectives and context	1.A.iv 1.B.ii
6. Number of conditional fiscal transfer programs	Indicates fragmentation of conditional transfers for health services	Fragmentation only works if separate streams are properly allocated and coordinated	1.A.iv I.B.iii
7. % budgeted fiscal transfers disbursed and % on time	Indicates if higher-level commitments to subnational governments/ health facilities are met	Gaps and/or delays can reflect issues with source of funds or management at any level	1.C.iii
8. % subnational government and health facility budget spent (total and on specific purposes)	Inadequate budget execution can affect the level and quality of health services	Gaps and delays can be due to issues with funding flows, various management issues, or capacity, among others	1.C.iv
9. % subnational government health funding from development partners	Donors provide needed resources but may distort health spending and be subject to variation	Instability or fragmentation of donor funds may hinder subnational government and health facility performance and sustainability	1.A.iv 1.C.i
10. % of development partner health funding that is off-budget	Off-budget resources provide needed funds but may not be coordinated with health budgets	Productive use of off-budget funds requires a means to program funding in conjunction with health budgets	1.A.iv 1.C.i

Nevertheless, quantitative indicators provide useful information for analysts trying to assess how the health sector is affected by the intergovernmental fiscal and financial management system, and they can often be used as a starting point for deeper analysis. Table 7 provides an illustrative list of ten measurable indicators that can provide a useful starting point for such analysis. These indicators, however, may be difficult to measure in some developing countries due to data deficiencies. Even

where they can be measured, they need to be understood in context. The table provides some guidance on the relevance of each indicator and how it can be interpreted, as well as an indication of its link to particular questions in parts A, B, and C of the framework presented above. The indicators have relevance to other diagnostic questions, but they are more directly related to those indicated in the table.

A few examples from Table 7 illustrate how such indicators might be interpreted. The share of health expenditure at the subnational level (indicator 1), for example, is a general marker of the relative role of subnational actors in health, but this role can be shared in varying ways across levels of government and types of facilities, so the indicator needs to be considered in institutional context. Similarly, the extent to which fiscal transfers for health are conditional or unconditional (indicator 5) says something about the degree of subnational discretion in health service delivery. It does not, however, help to determine, for example, if there is too much or too little conditionality given priority policy objectives and the country context; whether the criteria used to allocate the transfers are appropriate; or the extent to which multiple conditional transfers for specific expenditures are designed to work together productively to support health service delivery. Ultimately, quantitative indicators must be interpreted in situational context, and robust analysis of the intergovernmental fiscal and financial management system for health requires an appropriate balance and synergistic use of quantitative and qualitative assessments.

2. The Intergovernmental Health Financing Landscape: A Problem-Driven Approach

When a more broad-based assessment of health sector finances, as outlined above, is not desired or feasible, assessment of a specific problem or challenge and how it relates to intergovernmental structures and relations may be productive. It is more difficult to define a standardized framework for such analyses because the varying nature of problems will require different starting points and different information and questions. this subsection thus provides only examples of the type of tailored investigative approach that might be taken in considering three specific problems—fragmentation of health funding sources, a disconnect between health facility planning and budgeting, and delays in health funding flows. Box 6 summarizes how to use this problem-driven approach.

A. Fragmentation of health funding sources

One of the health financing challenges that emerges in the literature and in a number of the countries covered in this paper is that funding sources are not uncommonly fragmented and inflexible. Subnational governments and health facility managers may complain that the large number of diverse funding sources hinders their ability to effectively manage the resources they have available to deliver health services. To better understand the problem, it would be necessary to examine the details.

i. **What is the specific nature of the fragmentation and how is it affecting health finances and service delivery?** In some cases, fragmentation may be due to a large number of separate intergovernmental transfers. In other cases, transfers may be adequately coordinated, but there may be various uncoordinated donor-funded programs managed through independent mechanisms. In still other cases, a range of funds from both government and donor sources may be administered too separately. This fragmentation can create severe imbalances in the allocation of funds, such that, for example, certain types of health facilities or jurisdictions are adequately covered but others are not. Separate conditional funds may over allocate for

certain purposes, such as medicines, and provide insufficient funds for staff expenses or other basic operating costs such as electricity or supplies. Different funding sources can be productive if they can be programmed and managed in a sufficiently integrated way through the PFM system and through efforts to link off-budget funds to the budgeting process; otherwise, serious challenges may be created for the relevance and effectiveness of budget composition and service delivery. In addition, major management burdens may result if many funding streams have separate reporting requirements.

Box 6
Using the problem-driven analytical approach

- ***All users start by identifying a specific problem***
  - ✓ The problem may be known to the user or come from another source.
  - ✓ The problem may be framed as generally applicable or occurring in specific locations.
  - ✓ If there is uncertainty about the extent or importance of a reported problem, this could be investigated prior to undertaking the analysis or as part of it.
  - ✓ The exact source(s) of information and the people who need to be consulted will depend on the problem.
- ***Although the particular scope and details of the analysis may differ, there are some common elements typically considered by all users***
  - ✓ Users need to document the specific details of the problem in order to be able to investigate it appropriately.
  - ✓ Users need to identify the source of the problem and trace the actors and actions involved in the path to its occurrence.
  - ✓ Users need to identify the proximate determinants and underlying causes of the problem (part D of the broad-based analytical framework) in order to develop and determine the feasibility of potential solutions.
- ***Different means of reporting findings and recommendations will differ depending on the purpose***
  - ✓ If the nature of the problem and the chain of actions that lead to it are relative clear, the findings may not need further investigation or detailed reporting.
  - ✓ If the problem is more complex and linked to other problems in the system, the analysis might be more involved (going into certain elements covered in the broad-based analytical framework) and require more detailed reporting
  - ✓ Ultimately, the findings and recommendations will need to be tailored to the audience (government official in a particular role, facility manager, development partner) and the main purpose (targeted policy action, broader system reform, donor project scoping memo).

ii. **What is the institutional or procedural source of the fragmentation?** Separate pools of funding may come from restrictions placed on funds from the original sources, whether earmarked funding from government revenues or conditional aid from donors. Fragmentation may also result from independent management of various transfers by different ministries—including finance, planning, health, and local government—if the PFM system does not capture them appropriately. In still other cases, funds may flow directly from donor programs managed through parallel mechanisms and even channeled off-

budget. Each of the actors providing funding may face specific constraints and incentives that hinder a more integrated approach.

iii. **What causal factors/dynamics are driving the fragmentation?** If the issue is purely a matter of mistakes made in system or procedural design, it may be easier to adopt corrective measures. If, however, the fragmentation is based on more challenging factors discussed above—including reluctance to take measures that empower subnational actors due to mistrust or concerns about capacity, or competitive relationships among ministries with different perspectives about how subnational health finance and service delivery should be managed—it may be more difficult to undertake what seem like obvious reforms. Similarly, where development partners need visibility to claim credit and/or feel they need to meet their own institutional accountability requirements outside of partner government systems about which they have reservations, correcting fragmentation may be less feasible, although there may be ways to reduce it with willing partners.

B. Disconnect between subnational planning and budgeting for health services

Another challenge that emerges in the literature and in a few of the countries covered in this paper is the lack of operational linkages between subnational development (infrastructure) planning and the budgeting process. The specific nature and consequences of the challenge need to be identified if it is to be addressed.

i. **What is the specific nature and impact of the planning and budgeting disconnect?** In some cases, the disconnect may exist primarily between the subnational development plan and the annual budget, such that the most highly ranked projects reflected in a subnational government development plan are not funded in the capital budget and priority health facilities are not built. In other cases, the health facilities are funded and built, but there is no connection between the development budget and the recurrent budget, such that insufficient resources are provided for the operation and maintenance of the new facilities.

ii. **Why does the disconnect between health planning and budgeting occur?** In some cases, the problem may be that there is no officially specified relationship between the subnational planning and budgeting processes, or the integration process that is mandated is not followed. Subnational development planning is sometimes framed as a standalone, aspirational exercise rather than one that links formally to the capital investment budget. Integrated territorial development planning may be less well considered in the budgeting process than facility plans prepared by the health ministry or subnational health departments (which poses the risk that health facilities will not be served by critical supportive public infrastructure, such as water and roads, included in other plans). More generally, planning and budgeting may be managed by separate planning and finance ministries—or plans and budgets may be managed by different levels of government and/or be financed by uncoordinated funding sources (government or external donors). Clearly the determinants that create the disconnect need to be understood in order to determine their significance and develop possible solutions.

iii. **What causal factors/dynamics underlie the disconnect between planning and budgeting procedures?** In some cases, the disconnect may simply reflect the separate development of planning and budgeting systems (general and health specific) by different ministries (perhaps with support from different development partners) and the resulting lack of attention in the design process to the linkages between them. Technical reforms can remedy

these problems if the parties involved are willing. In other cases, however, fundamentally different perspectives and inclinations of different ministries and development partners (and power imbalances among them) may be at play, and this can make resolving the problem more challenging. There are also potential political considerations—politicians seeking visibility and re-election are known to privilege using funds for visible infrastructure projects over those for operating facilities—and this is reflected in budgeting decisions. Another example is where special funds that allow national politicians to build local health facilities for their constituents without following subnational territorial planning and budgeting processes contribute to the disconnect. Finding solutions for such issues can be difficult.

C. Gaps and delays in health funding flows

It is not uncommon for subnational governments and health facility managers to report that the resources to which a local government or service delivery unit is entitled according to approved budgets are not flowing as expected. Taking steps to correct this issue requires more detailed information on the specific nature of the problem and the factors that generate it.

i. **What is the specific issue or blockage in the flow of funds process?** In some cases, the full amount of funding allocated in the budget may not be received by the subnational government or facility. This may occur for a specific type of transfer or more generally. In other cases, there may be significant delays in receiving committed funds. These gaps and delays can occur at only one level of the financial flow chain, or at multiple levels leading down to the health facility. Such gaps and delays obviously hinder health service delivery.

ii. **What is the nature of the funding flow obstacle(s) and which level(s) of government is (are) the source?** In some cases, there may be delays at higher levels in collecting or disbursing revenues that fund the transfer pool from which health allocations are made. Often, the PFM process requires layers of approval that slow down the flow of funds. A local government that receives transfer funds on time from the center, for example, may not be passing them on to the service delivery units as per mandated regulations. In a multitier system in which the funds pass through a state or regional government, the higher tier may fail to pass funds on to the local governments that legally oversee health facilities. Other delays can be caused if subnational governments or facility managers fail to file the reports needed for funds to be released. Information inadequacy can also be important, as in cases where the expenditure data needed for required reporting are lacking or unreliable (unacceptable to higher-level approvers) or if there are delays in generating them. Some of these issues can be remedied by procedural changes or enforcement of existing procedures if the source of the delays is accurately identified.

iii. **What causal factors/dynamics are responsible for delays in health funding flows?** Although there may be obvious technical measures to improve the flow of health resources, more fundamental causal factors may hinder their implementation. If government or development partner funds are being delayed for fiscal or political reasons, technical and procedural system reforms to facilitate smoother flows are unlikely to help much. If delays at various levels—whether related to management transferring funds or recipient compliance with reporting requirements for fund release—result from political maneuvering, bureaucratic obstruction (that is, the failure of an actor to provide the data needed by another actor), or capacity constraints, then streamlining or simplifying procedures may not solve the problem, at least not without concurrent attention to the other underlying constraints.

D. Concluding comments on assessing specific health financing issues and challenges

The illustrations in this section do not offer detailed assessments. They only present simplified vignettes intended to illustrate how to investigate specific issues and challenges if the problem-driven approach is preferred to the broad-based approach for analyzing health sector financing and financial management in an intergovernmental context. Some such assessments can result in conceiving narrow actions that target specific issues, while others may ultimately require more thorough investigation of the broader parameters of the system (section VII.1).

The two types of assessments recommended here share two common foundational assumptions. First, there is value in considering intergovernmental institutional issues more carefully before designing reforms to improve health sector financing and financial management based exclusively on PFM or sectoral considerations. Since these intergovernmental systems and how health and PFM are organized within them vary significantly, there is not a neatly standardized approach to this type of work. Whether the preferred initial approach is broader or more specific, the analysis required to correctly identify health financing challenges is essentially a form of detective work, although it should be framed and executed as systematically as possible. Second, and equally important, is to re-emphasize the need to identify causal factors underlying observed challenges and their proximate institutional and procedural determinants (sections VI.2 and in VII.1.D). Understanding these forces offers a more complete basis for judging the feasibility, sustainability, and design of reforms. In many cases, the analysis may point to modest initial steps that can help launch a more gradual strategic reform process. Although this may be less substantial and slower than desired, in some cases it may provide the best possible foundation a more viable, and thus ultimately transformative and sustainable, reform trajectory.

VIII. Concluding Observations and Recommendations for Further Work

This paper has investigated how the sources, allocation, and flow of public financing for service delivery are structured and managed in an intergovernmental context. Existing literature, although limited, was used to take stock of general considerations and to frame case explorations of the health sector in Ethiopia, Kenya, South Africa, and Uganda. Findings from the literature and cases provided the basis for a preliminary analytical framework intended to document how health sector financing is situated in the intergovernmental system and to consider how identified structures and dynamics may support or hinder service delivery. Although the focus is on the health sector, the analytical framework can be adapted for use in other sectors.

There are two principal caveats to the analysis and findings. First, reliance on literature reviews and secondary materials led to gaps and uncertainties in the country assessments. Without field research it was not possible to examine fully how health financing operates across levels of government and types of facilities. Building the assessment around intergovernmental concerns nevertheless provides a more in-depth perspective on how public service delivery is financed. Second, some findings that emerge prominently from the work, such as fragmented funding sources and budget execution challenges, are quite familiar to those who work in service delivery financing. Yet they are often not considered sufficiently in the intergovernmental context and with a necessary level of detail, and this angle is not well incorporated in existing diagnostic tools.

The overarching conclusion is that much of the published analytical work on service delivery financing does not consider sufficiently and systematically the roles of subnational entities. Those actors include subnational governments, quasi-governmental agencies, and frontline facilities. There are exceptions, such as the increased attention to finance at the facility level in health and education. However, the multilevel institutional paths through which funds flow for service delivery—as well as how they are affected by national and sector-level policies and practices—are not routinely considered. Specialists in PFM, sector financing, and intergovernmental fiscal relations tend to approach these issues narrowly from their own perspectives. There has been some progress on bridging PFM and sector perspectives. Incorporating the roles of subnational actors more systematically and comprehensively would further enrich the understanding of how public finance relates to service delivery.

1. Main Findings and Approaches

Funding sources for the health sector are diverse and unevenly reliable, and they often follow different institutional paths to providers. They are raised and allocated through multiple means (including transfers, in-kind, local collection, and health insurance) and have different restrictions (from fully unconditional to highly conditional) based on varied criteria (general socioeconomic characteristics or health-related criteria based on inputs, outputs, or other factors). Funds may flow to service providers differently (either directly to facilities or indirectly through one or more subnational governments or sector-specific entities and programs), and they may or may not be included in a government budget. There can also be difficulties in managing resources to deliver services on the ground. For example, committed funds may not be received or may arrive late, funds received may not be fully spent, and supplies requiring approval or procurement by other actors may be delayed. Such challenges can impede service delivery and efficient use of sector resources.

Documenting the observed impediments to service delivery and acknowledging their significance are necessary first steps. Immediate triggers of problems may be traced to their *proximate determinants*, such as flaws in the revenue, PFM, or intergovernmental system; lack of adherence to the legal requirements of even well-designed systems; and weak cooperation among actors who must work together for effective service delivery. Proximate determinants—and typical reforms to alleviate them—are often relatively easy to identify. *Underlying causal factors*, however, may create obstacles to successful adoption of obviously justified reforms. Those include national and subnational political economy forces, the behavior of international development partners, and capacity constraints. Understanding both the proximate determinants and the underlying causal factors is necessary to craft productive and feasible reforms, and the process of doing so may involve difficult trade-offs and negotiated compromises.

The exploratory analytical framework outlined in this paper can help to identify challenges, document the factors that produce them, and develop pragmatic paths to reform. The framework outlines two possible diagnostic approaches—one comprehensive, and the other narrower. The broad-based diagnostic, which involves a fuller assessment of how the sector functions, can be useful but may not always be necessary or feasible. The more targeted analysis, which starts with a specific problem (such as excessive fragmentation of funds or delays in funds transfers to service providers) and works backward to identify why the problem exists and what might be done about it, may be sufficient, although it may ultimately lead back to considering additional elements covered in the more broad-based approach.

2. Recommendations for Further Work

Additional work is needed to achieve a better understanding of the funding and PFM processes for service delivery in an intergovernmental context. Some of the recommended follow-up work would build directly on the findings and diagnostics in this paper. Other work would examine issues that are not dealt with or are only covered superficially here.

A. Expanding the current work

The analytical framework presented in the paper has not yet been tested in the field. Doing so would provide additional insights, more robust findings, and a basis for refining and streamlining the approach. Three actions are recommended for the broad-based version of the assessment.

- **Apply the framework using systematic fieldwork to one or more of the cases already covered in the paper.** This would confirm or correct the findings drawn from secondary materials and fill in important gaps in the assessment and observations.
- **Apply the framework to the health sector in additional countries.** This paper covers only four African countries that are diverse in multiple ways, but do not provide a fully representative picture.
- **Expand the application of the framework to one or more additional service delivery sectors.** Sectors have different characteristics and needs. Water, for example, is a highly capital-intensive infrastructure sector that relies on service delivery arrangements, financing mixes, and funding flows that tend to differ from those in health.

Analyzing additional countries and sectors would test the broader applicability of the more comprehensive analytical framework and offer insights about how to streamline it. Such efforts would indicate the extent to which more specific diagnostics, or "add-ons," to the general analytical framework would be useful to understand how finances are managed in different intergovernmental systems and for different sectors.

A final recommendation for building directly on the current work is to further develop the problem-driven approach outlined and illustrated in the paper. Although problem-driven analysis is far from new, there is little documented use of it for assessing specific problems of service delivery financing in an intergovernmental context. Since potential problems are numerous and can differ substantially in nature, different questions may be needed to analyze why a specific problem exists and what might be done to alleviate it. Additional examples of how common problems might be analyzed would deepen the pool of information and support efforts to develop a better-refined and more flexible approach to problem-driven assessment.

B. Specific sector financing issues recommended for additional investigation

It is evident that more work is needed to understand the complex intergovernmental landscape in which sector financing and PFM interact with service delivery. A few issues that have emerged prominently in this effort are presented here for further consideration. They are certainly not new to specialists in PFM and sector finance, but how they manifest in the intergovernmental context has not been well explored or documented. That is the distinctive additional perspective advocated in this paper and illustrated by the preliminary analysis.

Issue 1: Budget formulation in intergovernmental systems

Budgeting is a shared concern of finance ministries, sector entities, and all levels of government, and it has received a great deal of attention with respect to service delivery. The role and engagement of subnational governments in the national budgetary process, however, is often unclear and reportedly mistimed when practiced, even if there are well-defined formal procedures. Some literature and the cases suggest that, despite official recognition of the value of bottom-up input, budgeting processes tend to remain dominated by top-down approaches and national-level actors, even if subnational input is solicited. The concern is that top-down approaches may allocate resources using criteria that are insufficiently tailored to different types of jurisdiction and to the needs of different facilities.

A foundational step is to document in greater depth how subnational governments and frontline service providers, who are familiar with local conditions and needs, do and could participate in the budget process and influence budget formulation. This is relevant beyond the national budget. In multilevel systems with empowered intermediate tiers that oversee the budgets of entities under them, there are non-trivial variations in how they allocate budget resources to lower tiers and service delivery facilities. If the variations are not carefully planned to deal with lower-level needs, there may be spatial disparities and inequities in service delivery. These concerns raise questions about the quality of budgets. Budgetary control will not serve the best interests of service delivery if the budget is poorly formulated in the first place.

Issue 2: Budget execution and discretion in intergovernmental systems

Claims of insufficient discretion in the use of funds for service delivery by subnational governments and frontline facilities are prominent. The debates about discretion in the context of decentralization

are well known. Certain sector expenditures may require standardized quantities and costs for budgeting and transfer purposes. In some settings, there may be legitimate concerns that funds needed for these essential line items would be diverted for other, less critical purposes if not protected by restrictions on their use. On the other hand, excessive rigidity may prevent subnational governments from allocating funds efficiently within their jurisdictions and may constrain the ability of service delivery managers to use those funds effectively. Some instances of poor budget execution, for example, may result from multiple separate transfers being restricted to the same type of expenditure. If the targeted expenditure does not require the full amount of conditional funding available, and if service managers are prohibited from reallocating excess funds, service delivery may suffer.

A first step is to try to gain a better understanding of how much discretion local governments and service delivery facilities enjoy and whether it is in place for legitimate reasons. Intimately related is an understanding of the effects that discretion has on the ability of subnational governments and facility managers to manage funds effectively. This type of enhanced analysis and the evidence base it generates will help to stimulate more innovative thinking about how to deal with what is a contentious and consequential aspect of managing public funds, including through the possible relaxation of restrictions that do not seem to serve a legitimate purpose and policy experimentation with other restrictions that need to be explored more fully.

Issue 3: Managing fragmented funding in intergovernmental systems

The pervasive problem of multiple separate sources of funding for public functions is well recognized and has long been criticized by PFM and sector specialists alike. Efforts to remedy it, including by addressing the typically significant role of international development agencies, have met with limited success. The problem is usually framed in terms of separate sources of sector funding originating in, or being channeled through, different ministries and parallel mechanisms. These various sources and flows of funds may or may not be reflected in government and service provider budgets. In multilevel systems, the situation can be even more complicated. Funds (with or without restrictions on use) may come from, pass through, or go to any level of government. The funds may remain at their first stop, or they may be passed on to a lower tier of government or a facility, either on- or off-budget. If efforts to consolidate these flows are ineffective, the question is whether there are alternative ways to better manage the funds.

There is little evidence on the extent to which disparate funding sources are collectively and systematically considered in expenditure decisions, that is by using an informal overarching "budget" that includes all sources whether or not they are captured in the official budget. If it were possible to know all sources and amounts in advance, a subnational government or service provider could use the resources more strategically. A budget manager, for example, could apply unconditional transfers to pay for expenses not covered by off-budget funds that come with restrictions. There are risks in such an approach. If on-budget funds are highly conditional or subnational finance managers do not have much discretion, such an approach may not be feasible. There may be compliance complications with formal budget execution and reporting requirements if funds in the official budget are being used in ways that seem out of line, even if they actually lead to better overall use of funds. Nevertheless, there is clear value in understanding more about actual practices and possibilities for managing more strategically the full set of available sector funds in a way that best supports service delivery.

Considering the three issues together, different national, sectoral, and subnational actors will doubtless have different perspectives on their relative importance for service delivery. There will be differing views about who should be involved in budget formulation, how much autonomy subnational levels of government should have in allocating resources to health services or facilities, how much discretion facility managers should have in budget execution, and whether it is desirable and feasible to manage all sources of sector funding in a more strategic integrated manner—and if it is seen as potentially productive, how to do it. Some interested parties may believe that other issues are more pressing and merit more immediate attention. International development partners will have opinions on all of these matters, too.

Structured and evidence-informed discussions of intergovernmental challenges in service delivery among specialists in PFM, sector financing, and intergovernmental fiscal relations would be a valuable first step. The starting point for advancing this agenda would be to debate these ideas with those who work in service delivery financing and are already interested in incorporating an intergovernmental perspective into their agenda. At the same time, it would be desirable to involve others who may not be convinced but are nonetheless willing to engage. Everyone would benefit from increasing the sphere of expertise and experience, and from collecting and sharing richer and more relevant data and evidence.

The overall aim of future efforts is to broaden and enrich the analysis and policy discussion, not to generate universal or generalizable prescriptions. That is impractical given the differences in perspectives and priorities and not even appropriate given the diverse structures of intergovernmental systems. The purpose instead is to provide a broader and more informed basis for considering reform options in service delivery financing and for negotiating strategic and productive paths to improvement within an intergovernmental context.

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