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"Can PFM Systems be Better Prepared for Health Emergencies: Six Lessons from the COVID-19 Crisis"

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This policy note discusses how PFM systems can be better prepared for national (and global) emergencies such as COVID-19. What are the lessons learned from the various spending modalities and flexibilities introduced during the pandemic to provide emergency financing, and should they be sustained beyond the pandemic?

Introduction

Global emergencies such as the Asian Financial Crisis, 1997-1998, the Global Financial Crisis (GFC), 2008-2009 and the COVID-19 pandemic can create huge pressures on public finances. In the aftermath of the GFC, global public debt increased by more than 20 percentage points of GDP. Standing at 83 percent of global GDP in 2018, before the pandemic, it rose to 100 percent of GDP at the end of 2020 because of the forceful response of governments around the World (IMF Fiscal Monitor 2021a and b).

Data from the IMF indicate that countries have provided substantial discretionary fiscal support to member countries during the COVID-19 crisis: up to 35 percent of GDP for advanced economies, up to 14 percent of GDP for emerging markets, and up to 6.5 percent of GDP for low-income developing countries.[2] The size of emergency financing provided to the health sector in OECD countries ranges from 5 percent of GDP to more than 20 percent of GDP (James, et. al., 2021; IMF Fiscal Monitor, 2020a and 2020b). This massive support is not surprising given that the COVID-19 crisis was a health crisis first and foremost. It was thus different in nature from other crises, such as the GFC. But sectors other than health have faced similar challenges during the COVID-19 crisis, e.g., adjusting spending priorities, maintaining accountability and transparency, releasing emergency funds fast (ACCA Survey, 2021).[3]

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[2] IMF Fiscal Monitor Database, July 2021. Data on financial support includes additional spending and foregone revenues, equity, loans, and guarantees.

[3] According to the ACCA survey, the most important challenges faced by the public sector during the COVID-19 pandemic include adequately responding to the financial needs of businesses and individuals (44 percent of respondents); having adequate IT capacity to respond to the crisis (42 percent); maintaining accountability and transparency in the reporting of emergency spending (41 percent); formulating innovative policy responses to the crisis (40 percent); adjusting spending allocations (38 percent); reducing and detecting corruption and fraud related to emergency financing (32 percent); and releasing emergency financing fast enough (30 percent).

As Heller (2006) noted in a classic article, in emerging and developing countries especially there are limited opportunities and financing to create additional "fiscal space"[4] to meet the competing demands for scarce public resources that arise during crises. Heller sets out a framework for assessing the available options. Raising more revenue as a share of GDP against the backdrop of economic difficulties may be challenging and counterproductive. Earmarking revenue towards health (e.g., through off-budget funds) may reduce resources for other equally important government priorities. Options for reprioritizing spending may require politically difficult trade-offs such as cutbacks in social assistance, spending on law and order, and government payroll, External grants may provide fiscal space (in contrast to borrowing which increases future debt service payments and have a bearing on fiscal sustainability) but few donors are prepared to make commitments beyond one or two years. Grants can be volatile and reduce the incentives for the government to generate revenue. A further constraint is that emergency spending programs or projects need to be fiscally sustainable over several years and viewed within the context of a comprehensive and forward looking fiscal and budgetary framework.

The Heller framework has been updated for the health sector (Tandon and Cashin, 2010) and by adding a PFM perspective. Barroy and Gupta (2021) unpack ways in which overall PFM improvements can increase budgetary space for health by improving spending efficiency and other means. Examples include the development of multi-year spending plans, realistic cost estimates, improved cash forecasting and planning, effective management of public procurement, and a tailored internal control and accountability framework. Such reforms are important but tend to be slow acting and depend critically on the available financial capacity and capability in the health authorities, especially in their central finance or budget departments. Lack of capacity may restrict the ability of health authorities to engage in an effective budget dialog with their counterparts in the finance ministry.

There are several ways to change spending modalities and measures to respond to a crisis. These include implementing existing laws that cater for national emergencies, having recourse to flexibilities that already exist in PFM laws and regulations (such as in-year adjustments to spending allocations, supplementary budgets, and contingency funds or reserves), and adopting additional measures through legislation or administrative orders.

The effectiveness of emergency spending is not only a matter of funding levels. The quality of PFM systems and processes is also a critical enabler of fast, well-directed spending while maintaining adequate control and accountability.

Key questions considered in this note are:

- What have been the main spending modalities introduced during the COVID-19 pandemic to provide emergency funding for health-related spending?
- What are the emerging lessons from these modalities?
- What can be sustained/refined in the future to enhance preparedness and responsiveness?

[4] Defined by Heller (2006) as "room in a government's budget that allows it to provide resources for a desired purpose without jeopardizing the sustainability of its financial position or the stability of the economy."

In considering these questions, the goals and objectives of the health community need to be balanced against those of the central financing authorities, namely the Ministry of Finance, the Central Budget Office (CBO) and the National Treasury.[5] It is well known that the policy and operational objectives of these "two communities" are different and to some extent conflicting (Chakrabarty, et. al., 2010). The CBO's focus is on a unitary system of centralized rules and procedures from which flexibilities and divergences are tolerated to a limited extent. The health community's focus is on the decentralization of functions from the finance ministry, increased flexibility, and the need to manage public revenues – revenue collection, pooling of resources and purchasing – in ways that vary widely from country to country (Cashin, et. al., 2017; Chakrabarty et. al., 2010; Kutzin, 2001).

The effectiveness of emergency financing may have been affected by the extent to which responsibilities for health budgeting have been devolved within government. There are two kinds of devolution in the health sector: from ministries of finance to health ministries and from health ministries to subnational governments (SNGs) or to health insurance funds and the private sector. Devolution can bring substantial benefits where the environment is favorable, and where health ministries, SNGs or insurance funds have sufficient capacity and skills to undertake efficient and effective oversight of their budgetary operations.

Unfortunately, in many low- and middle-income countries (LMICs), such conditions do not exist. In some countries, finance ministries have not yet relinquished control of budget execution and internal control mechanisms to line ministries where capacities only extend to basic accounting functions and where resources devoted to financial policy issues related to resource planning and management are very limited. In Francophone countries, accounting and control functions in principle are already devolved to line ministries through the system of public accountants and financial controllers but, in practice, these functions remain under the tight supervision of the finance ministry who are the employers of the accountants and controllers. Capacities and capabilities for undertaking efficient PFM functions appear to be especially low in health ministries in which significant functions are devolved to off-budget entities such as health insurance funds, and the private sector (Barroy, et. al., 2019; Krause, et. al., 2016).[6] The "lessons from COVID" should take account of these different practices and experiences regarding the devolution of core PFM functions.

Spending Modalities Used to Address the COVID-19 Crisis

The first step in many countries was to carry out a rapid response assessment, to prepare possible options and modalities for emergency financing and, as appropriate, have these options considered and approved by the government. The approved funding modalities for emergency spending fall into several broad categories (James, et. al., 2021; IMF Fiscal Monitor, 2021; see blogs[7] for LMICs)

[5] The CBO and the National Treasury are frequently departments of the finance ministry, but in some countries are separate entities with ministerial rank.

[6] A similar story arises with respect to devolution from central to subnational governments in the health sector. Often due to donor funding constraints or other types of expenditure earmarking, the discretionary fiscal space that is available at subnational level for reallocations is quite limited.

[7] For example: https://p4h.world/index.php/en/blog-lessons-for-managing-public-finances-from-COVID-19-response; https://p4h.world/index.php/en/who-adjustments-health-purchasing-part-of-covid-19-health-response-survey-results-lessons-future; https://p4h.world/index.php/en/who-wb-no-calm-after-the-storm-time-to-retool-country-pfm-systems-in-health-sector

listed below. Additional sources of funds, not considered here, were provided in some countries through new borrowing or the rescheduling of existing loans, emergency funding programs agreed with the IMF and other lending institutions, capital injections, and government guarantees.

(i) Use of existing budgetary instruments and modalities:

- Approving new budgetary allocations for emergency health financing through the issuance of supplementary budgets which are provided for in many countries' PFM law in addition to the annual budget.
- Activating existing legislation on contingency funds or reserves to provide emergency and temporary financing for natural disasters or serious economic or social shocks. These funds are typically equivalent to about 1-2 percent of the budget and thus insufficient in most countries to meet the full cost of COVID-19-related emergency spending.
- Reprioritizing budgetary allocations in the existing annual budget to create fiscal space for COVID-19 responses. These adjustments could include temporary postponement of low-priority activities, boosting the health workforce in hospitals and health centers, and prioritizing the purchase of health infrastructure and equipment.

(ii) Use of special instruments and spending modalities which include:

- Accelerating transfers of spending authorizations to sub-national levels.
- Frontloading funds to service providers such as hospitals and health centers.
- Contracting out the delivery of health-related goods and services to private providers.
- Accelerating procurement processes balanced by attention to the possibility of fraud and financial misreporting.
- Creating targeted extra-budgetary funds to manage COVID-19 related transactions financed through the budget or external sources.
- Creating new programs and budgetary codes to deliver emergency spending.

The final item in this list is also helpful in ensuring that timely reports are prepared on the execution of the emergency spending and to monitor and audit its economic and social impacts.

Lessons Learned

The following six lessons can be learned from the experience of countries that have adopted the policies, instruments and modalities described above.

Lesson 1. *Effective health financing systems and effective emergency responses require critical PFM fundamentals to be in place.*

These fundamentals include reliable interfaces between planning and budgeting systems (Allen, et. al., 2020), medium-term expenditure frameworks that provide predictability in the allocation of resources (Allen, et. al., 2017), performance budgeting systems that focus on outputs and outcomes not (only) inputs, and reliable internal controls and cash management (International Health Partnership, 2017). However, sound PFM systems are lacking in many LMICs, as underscored by a recent WHO study of 51 countries in sub-Saharan African countries (Barroy, et. al. 2019). This study shows, for example, that 13 of 26 African countries on average underspent their annual health

budget allocations by more than 15 percent in 2016 and that the trend had deteriorated since 2008. The latest global report of the Public Expenditure and Financial Accountability (PEFA) Program shows that, based on an analysis of 549 assessments carried out to the end of 2019, many LMICs have improved (slightly) their PFM performance since the mid-2000s but in others performance has deteriorated (PEFA, 2020).

The need for LMICs to implement effective PFM reform strategies is thus paramount, but such reforms tend to slow moving and institutionally constrained. Some countries, however, have demonstrated progress during the COVID-19 pandemic. Rwanda, for example, put in place good budget execution mechanisms (a financial management information system (FMIS), a chart of accounts) that helped their emergency responses. Jordan and Papua New Guinea have published information on procurement contracts, including beneficial ownership. Countries such as Ecuador, Kenya, Kyrgyz Republic, and Nicaragua amended their legal framework for procurement and require the collection of data on beneficial ownership. Colombia, Honduras, and Ukraine have added a module to their e-procurement platforms presenting detailed information on all emergency procurement (IMF Fiscal Monitor, 2021).

Lesson 2. *Ministries of finance should build an analytical framework for assessing the appropriateness of emergency funding mechanisms, and whether they are sustainable beyond the crisis and, if not, consider terminating the mechanisms.*

Some CBOs may have established formal procedures and criteria for evaluating the instruments and modalities proposed by health authorities to deliver emergency financing, but most rely on ad hoc discussions between these two entities. Key criteria from a finance ministry perspective would include the following:
(i) whether the proposed spending modalities are covered by existing legislation or emergency legislation;
(ii) if not, what legal instrument the health authorities are proposing;
(iii) a fiscal/economic justification for why the proposed mechanism is required, its expected impact, and the cost of implementation;
(iv) whether the spending will be covered by existing budget allocations or will require a supplementary budget;
(v) if the health authorities propose to set up a special fund, the justification for this as opposed to alternative mechanisms (e.g., establishing a new spending program or additional budget lines);
(vi) arrangements for reporting the spending to the ministry of finance and the legislature;
(vii) how the economic/fiscal/social impact of the spending will be measured and monitored;
(viii) mechanisms for auditing the spending; and
(ix) arrangements for winding up the mechanism after the crisis is over and, if required, returning any surplus funds to the treasury.

Table 1 indicates areas where a dialog would be required between the finance ministry and the health authorities to demonstrate that a particular spending modality was justified economically and financially. Boxes marked in red are those likely to be critical from the finance ministry perspective. All new spending proposals related to the COVID-19 pandemic should be reviewed against the nine criteria listed above. In addition, at the end of the crisis, finance ministries should review the measures taken by health authorities to provide emergency support, consider which measures might

be justified to sustain beyond the crisis, and institutionalize elements of the analytical framework for application in future crises. Where key criteria have not been satisfied, health ministries should consider what capacity building efforts may be needed to respond more efficiently and effectively to future crises.

Table 1. Assessment of Emergency Spending Modalities: Key Requirements

Spending scheme/initiative	Does the scheme require a new legal mandate?	Does it require a full economic and fiscal justification?	Are there alternative delivery mechanisms	Does it require reprioritization of existing budget allocations?	Does it require additional reporting arrangements?	Is it covered by existing external audit provisions?	Should the scheme be terminated at end of crisis?
Rapid response assessments	No	No	Not relevant	No	No	Not relevant	Not relevant
Use of supplementary budgets and contingency reserves	Probably, no	Yes	Not relevant	Yes	No	Yes	No
Accelerated transfers to SNGs	Yes	Yes	Probably yes	Probably, yes	Yes	No	Probably, yes
Front loaded funds to service providers	Yes	Yes	Probably, yes	Probably, yes	Yes	No	Probably, yes
Contracting our services to private sector	Yes	Yes	Possibly, yes	Probably, yes	Yes	No	No
Accelerated procurement procedures	Yes	Yes	No	Probably, yes	Yes	No	Probably, yes
Creation of new programs and/or budget codes	No	No	No	No	No	Yes	No
Creation of extra-budgetary funds	Yes	Yes	Probably, yes	Yes	Yes	No	Probably, yes

Source. Author.

Note: Cells marked in orange indicate areas where a substantive dialog between the finance ministry and the health authorities is likely to be required. Cells marked in red are areas where the finance ministry may challenge the health authorities most strongly.

Lesson 3. *Balancing flexibility and speed of response against transparency and accountability is key.*

Countries such as Australia, Belgium, Ghana, and India have tried different approaches to balance these requirements. The approaches include fast-track spending authorizations at the central level, accelerated procedures for fiscal transfers to subnational levels, and advanced payments to health service provided as a complement to retrospective reimbursements (Barroy et. al., 2020b). In some countries, COVID-19-rerlated spending is included in regular budget execution reports; the Maldives has prepared dedicated reports; other countries such as Colombia, France, Honduras, and Peru have published data on dedicated transparency portals (IMF Fiscal Monitor, 2021).

Many of these emergency procedures or the related budgetary transactions, however, have not yet been evaluated or audited by national audit institutions or other independent entities. Countries may also be politically constrained in making comprehensive disclosures of information on emergency financing (as well as other fiscal transactions) and may lack an efficient FMIS. Where audits have taken place, they show mixed results. Audits from the Ebola and COVID-19 crises in Sierra Leone and South Africa suggest cases of financial irregularity and fraud arising from weak PFM and procurement systems (Auditor General of Sierra Leone, 2014 and 2020; Auditor General of South Africa, 2020a and 2020b). Some countries have stepped up the audit functions during COVID-19 (Rahim et. al., 2020; IMF Fiscal Monitor, 2021) with the use of interim audits (e.g., Honduras, Peru, Sierra Leone, and South Africa) and concurrent controls (e.g., Honduras and Peru). But creating an enhanced internal and external audit function that also exhibits financial and political independence remains a key challenge in many LMICs. Weak governance systems and endemic corruption are other constraining factors (IMF, 2020).

It should be noted that more than half of OECD countries and many LMICs operate a compulsory health insurance fund which is characteristically an extra-budgetary entity outside the normal budget process (James, et. al. 2021). These funds are normally regulated by rules on reporting, audit, etc., set in a country's organic budget law or equivalent, but may not conform with good practice requirements of accountability and transparency, as well as operational efficiency. Nevertheless, they can also be vehicles through which funds can be expedited because they operate outside normal, and typically slow moving, budget processes.

Lesson 4. *Extra-budgetary funds have been useful in some cases but can create large fiscal risks and a potential accountability deficit.*

More than 40 countries (advanced countries and LMICs alike) have set up special funds during the pandemic for managing emergency spending (including on health). In most cases, these funds operate outside the normal budget process. They have created opportunities for flexible health-related responses (e.g., a better capability for managing external sources of financing) and better coordination across different sectors affected by the pandemic. Botswana, for example, made use of its fund to combine and track public and private support, and Sierra Leone's external audit authority carried out a real-time audit on the use of emergency funds (IMF Fiscal Monitor, 2021).

The establishment of extra-budgetary funds or entities may create serious risks, especially of transparency and accountability (Rahim, et. al., 2020; Allen and Rahim, 2021 forthcoming). The funds may increase fragmentation in the provision of health services, a sector that is often already

characterized by multiple funding flows (Barroy, et. al., 2020a). It has been argued that they should not be regarded as permanent features of the fiscal regime for health services, should be wound up after the pandemic, based on clearly defined sunset clauses, and any surplus revenues returned to the treasury (Rahim, et. al., 2020).

Lesson 5. *Program budgeting can help facilitate emergency financing of COVID-19 responses.*

Good examples of this practice are mainly confined to OECD countries or emerging markets with advanced PFM practices. For example, several countries across different income levels leveraged existing program-based budgeting approaches by adding a COVID-19 budgetary program to their health budgets or using existing programmatic envelopes to redirect expenditure toward the emergency response (Barroy, et.al., 2020b). The use of existing program structures may be more cost effective than setting up an extra-budgetary fund (see Lesson 4). Examples include Burkina Faso and France, while Honduras and Rwanda have tagged COVID-19 spending in their information systems (IMF Fiscal Monitor, 2021). In these examples, COVID-19 targets were defined within a country's existing performance monitoring frameworks to ensure good expenditure tracking. In Mexico, New Zealand, and South Africa, where program budgeting has long been standard practice, this approach clearly enabled an agile response to the crisis, as well as the tracking of emergency spending (Barroy et. al., 2020b). However, only 18 SSA countries had introduced some form of programmatic classification to present their health budgets in 2017, while only one country in the Africa region uses programs as the unit for budget appropriation in health (Barroy, et. al. 2019). Thus, the extent to which program budgeting can be used to support emergency financing initiatives remains limited in many countries.

Lesson 6. *Capacity constraints in finance departments often limit the ability of LMICs to manage health-related resources efficiently and effectively.*

Anecdotal evidence (for example, on Argentina[8]) suggests that CBOs and health authorities in some advanced countries and LMICs managed efficiently the process of taking decisions on emergency funding allocations and the mechanisms for disbursing these funds to beneficiaries. But in many LMICs, there are huge remaining constraints in human resources and finance skills, and lack of an effective dialog between the CBO and health services on budget related issues. Some CBOs are unable to exercise an effective "challenge" function when faced with new spending proposals put forward by spending ministries such as health. Krause, et. al., (2016) define four core "capabilities" of finance ministries (analytical, delivery, coordination, and regulation) of which the last - which includes setting the financial framework for spending ministries and overseeing their financial performance - is the most important in the present context. For most LMICs good internal control of spending is also a key requirement, and indeed is often the main role of finance ministries. As PFM systems mature, CBOs can move away from control into analytical, coordination and regulatory functions.

In the finance departments of health ministries, staff capabilities are typically weak, comprising a few accountants but extremely limited capacity to analyse budgets. For decentralized health functions, capabilities of SNGs are typically even less than the centralized finance departments, but some health

[8] See a PowerPoint presentation by Martin Sabignoso on "Public Financial Management Adoption to Support the COVID-19 Response in Argentina". July 2021.

insurance funds may be more professionally managed. Barroy et. al (2019) emphasise the need for "an institutional and cultural shift in health ministries [in undertaking PFM functions] ….health ministries should pay attention to improving] people's skills, responsibilities, accountabilities, motivation and rewards." More positively, some countries were able to harness digital technologies to deliver emergency health services and cash transfers efficiently (Una, et. al., 2020a and 2020b) which should represent a permanent benefit for the health sector.

Summary and Conclusions

1. Fiscal space is heavily constrained during periods of national emergency in LMICs and the health sector will not always be the primary recipient of emergency financing, as it was during the COVID-19 pandemic. Improving PFM functions to increase the efficiency of health services is one mechanism for expanding fiscal space, but many such reforms take a long time to implement and mature.

2. Flexibilities need to be fully justified and balanced by accountability. Some of the spending modalities proposed by health authorities to deal with the pandemic may not be affordable, create fiscal risks, and may undermine fiscal sustainability. They should be rigorously assessed by the finance ministry before being approved by the government and adopted by the health authorities. The criteria adopted by the finance ministry to assess the viability of new spending modalities should be reviewed after the crisis and lessons drawn on their applicability in future crises.

3. Some spending modalities proposed by health authorities, notably most special COVID-19 funds, can only be economically and financially justified to the extent that the pandemic persists. Most of these funds should then be abolished based on clearly defined sunset clauses, and any surplus funds returned to the treasury.

4. Most LMICs need to focus attention on improving the basic features of PFM that are fundamental to financing critical spending, including health. Weak capacity and capabilities of finance staff working in health ministries (and also CBOs) is another serious constraint in many LMICs and should be a focal point for future capacity development support.

5. Some budget flexibilities (e.g., in-year virement of budgetary resources, supplementary budgets, end-year carryover of unspent funds, contingency reserves, single-source procurement, etc.) already exist in the PFM systems of many countries to deal with national emergencies. Many countries also have special laws and emergency procedures that can be automatically triggered during an emergency. These provisions may need to be supplemented by other spending modalities to deal with specific issues raised by the crisis, e.g., shortages of medical supplies, slow and inefficient contracting processes.

6. Countries should focus resources on improving the quality of their institutions and governance arrangements without which spending on health and other core public service will remain vulnerable to risks of corruption and financial mismanagement. National audit offices and anti-corruption agencies have an important role to play in that process.

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