

# Health Financing and Public Financial Management during the Covid-19 Pandemic: evidence from Pakistan as low income country

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## **Abstract:**

**Purpose:** This article aims to explore the areas of misalignment between the PFM and health financing during the COVID-19 pandemic in Pakistan.

**Originality/Value:** To the best of our knowledge, it is the first study on South Asian countries to adopt a (Cashin et al., 2017) framework and bring forward the dominant themes that cause the misalignment between PFM and health financing. The timing of the research was excellent as the world was facing the biggest health challenge in the form of COVID-19 which has put pressure on the PFM and has seriously hampered health service delivery. Therefore, the findings of the study are helpful for the ministry of health to draft policies to improve health allocations and move toward Universal Health Coverage (UHC).

**Design/Methodology/Approach:** In-depth semi-structured interviews of 15 participants were used to explore the areas of misalignment between PFM and health financing. Based on qualitative data, thematic content analysis has been carried out.

**Findings:** The findings of the study can be divided into five clusters and their explanations. First overall budget allocation has an impact on the health sector budget. For example the budget for priority health interventions is not reflected in the budget allocation process. Further, the budget is classified by inputs rather than disease and finally, the budget is not released by the health priorities. The second cluster was devolution of health to provinces which is unfinished agenda. Under this cluster fiscal decentralization has found to cause problems for the provinces as they have not provided fiscal autonomy to spend the money and there is a lack of coordination between the federal and provincial authorities. Third cluster was donor funding and it was observed that it

is not aligned with the government policies and priorities. Forth cluster was procurement and it was discovered that it is a lengthy process and caused delays in procuring the essential health equipment. Fifth cluster was organizational culture which is not conducive to the health sector. Under this cluster the attitude, knowledge, and practices of departments responsible for the health sector require complete revamping.

**Keywords:** Health Financing, Public Financial Management, Budgeting for health, Universal Health Coverage, Covid-19, Pakistan.

**Paper type:** Research paper

**Highlights:**

1. The government budget is not allocated to the health sector by priority health interventions mainly because of input-based budgeting and could be improved substantially if output-based budgeting is adopted.
2. Fiscal decentralization as a part of devolution has not worked because of inadequate coordination among federal and provincial governments. The coordination should be improved.
3. Size of the fiscal envelope for health is not measurable because of fragmented revenue streams.
4. Cultural misalignments between the finance ministry and health departments exist.

**"Ethic statement - Not applicable"**

## **1. Introduction**

Universal Health Security (UHS) aims to achieve a preparedness level where every person in society is protected from threats to their health. True health security cannot be reached unless everyone is safe from infectious disease without facing financial hardships. To safeguard individuals from financial hardships, the Public Financial Management (PFM) of the country must be working in harmony with health financing [1]. PFM ensures sustainable financing for preparedness (by providing the funds when, where, and by whom needed) whereas health financing mobilizes the available funds for health needs. Both complement each other to achieve UHS and ultimately accomplish the goal of Universal Health Coverage [2]. Thus far the alignment between public financial management and health financing to achieve UHS has rarely been discussed. We believe that this is an important area that needs to be explored as the COVID-19 pandemic has already exposed the misalignment between PFM and the health financing of developed and developing countries.

Public Financial Management (PFM) is the cornerstone of health financing. The role of health financing is to generate sustainable revenues, pool risk to save individuals from financial austerities, and purchase health services efficiently and effectively [3]. Whereas the PFM is

concerned about the budget formulation, budget execution, and budget monitoring. Practically every aspect of the PFM corresponds to health financing [4]. When health financing work on sustainable revenues; the PFM ensures that the budget is allocated to provide sustainability. When the health financing emphasized domestic resource mobilization, the PFM support it through budget formulation. The procurement function of health financing; what to purchase, how to finance it, and the payment mechanisms are being taken care of by the budget execution and payment function of PFM. Therefore, is not possible to achieve -UHC unless both systems are working together in conformity.

PFM and health financing should work together to achieve UHC yet at times misalignment exists. Cashin et al has identified areas of misalignment between PFM and the health financing that could impact health service delivery [5]. Some of the critical areas of misalignments identified are input based budgets, fragmented revenue streams and procurement issues. A major area of misalignment is budget classification by inputs. When allocating the budget, the PFM allocate expenditure by organization units rather than services. This creates misalignment between the budget allocation and the policy objective of the organization. In Pakistan for example, budget is classified by inputs (entity element, fund element, and functional elements) however identification of expenditure by policy objectives (like International Health Regulations -IHR) is not possible [6]. Consequently, it is difficult to ascertain how much has been spent on IHR core capacities and to judge the progress towards UHS. A fragmented revenue stream i.e. money for health is coming through different sources can also create problems for health financing. At times a health intervention is funded from public funds as well as from the donor fund. This creates duplication and inefficiencies in the allocation of funds to priority health interventions. Moreover often the donor support is off-budget which is not part of the government budgetary process. [7]. In this way the off-budget support is not significantly contributing towards the country's priority services and interventions [8]. Similarly, the complex and lengthy procurement procedure could seriously hamper service delivery during health emergencies.

Cashin et al., 2017 has define a framework to explore the areas of misalignment between the PFM and health financing during the COVID-19 pandemic [5]. This paper has used the same framework to explore the areas of misalignments between the PFM and the health financing in the context of Pakistan, as a developing economy. To date very little work has been done to find the relationship between PFM and health financing [1] and [30]. To fill this research gap, the need to explore this area is derived from the fact that the COVID-19 has made the world redefine its financial system to cope with health financing. Therefore, this article aims to explore the phenomena through a qualitative research method that would be the first attempt to unleash the anomalies between PFM and health financing in Pakistan. The findings will help government authorities develop policies to address health financing issues in general and health financing during emergencies in particular.

## **2. Literature review & theoretical underpinning**

Public Financial management is a broader concept and entails the management of public funds. It includes how the funds are raised, the mechanisms through which the funds are spent and the fiscal capacity of the government in the short and long term [9]. Therefore, each intervention government

plans is, directly and indirectly, related to the PFM [10]. Proper functioning of the PFM means that taxpayers' money is managed properly, and the government financial system is working to provide the allocative and operational efficiencies in the spending.

The working of the PFM for the health sector becomes more important as the health sector across the world is primarily the responsibility of the government [3]. During the budgeting process, the budget is allocated for health and the money is provided to the purchasing agents to procure health care services for the general public. The harmony between the PFM and health financing means that each step of the budgeting is working towards the provision of better health care to the end-user that is the general public [11]. The better the PFM, the better the delivery of health care to the general public.

The current study has adopted the Cashin et al., 2017 framework that defines the role of PFM to achieve Universal Health Coverage [5]. Although the PFM – the mechanism, policies, and procedure to govern the public funds – is a standard mechanism sometimes it is not compatible with health financing. The health systems have unique dynamics and sometimes need flexibility from the PFM like making direct payment during health emergencies, swift procurement of essential health services output-based budgeting etc. In such cases, there rises a misalignment between the PFM and the health financing. The framework by [5] has identified various areas of misalignment between the PFM and health financing but some areas are particularly important for developing countries like Pakistan. Taking support from the literature four areas of misalignment has been selected for the current study these are 1) impact of the budget cycle on health allocations 2) devolution 3) fragmented revenue streams and 4) procurement through central approval.

Adopting the [5]framework to Pakistan has justifications. First of all, during COVID-19 it was observed that the PFM of the country was not in harmony with the health financing [12], [13]. The funds raised for the pandemic remained unspent during the first two quarters. There was no budget allocation for unseen emergencies like COVID-19 and this shows the impact of the budget cycle on budget allocations (the first variable chosen for the study). Secondly, the health system of Pakistan operates under the devolved setup and the provinces have the financial and administrative autonomy to deal with health-related issues. However, the devolution has not been properly implemented and there remain some administrative issues between the federal and provincial governments. This was apparent during COVID-19 where the health service delivery was adversely affected as a result of devolution. Hence the second variable chosen from [5] framework was devolution. Third, health in Pakistan is mainly financed through the development and recurrent budget [14] but there is a great variation in the budget approval for development programs and the recurrent budget. This creates a fragmented revenue stream (third variable of the study). Lastly, the procurement issues have always been a problem as it follows rigid procurement rules which are not suitable for emergency procurements (fourth variable of the study). [5] framework was most suitable as it addresses all the issues faced by the government of Pakistan that works as a barrier between the PFM and health financing. Literature support for the variable chosen is given below.

### ***2.1 Impact of the budget cycle on health allocations***

The way the health sector received its allocation throughout the budget cycle is an important area for many countries. A strong commitment and stewardship from the Ministry of Health [14] have a major impact on their budget allocations. Vis-à-vis weak commitments and institutionalized separation within the health ministry create a misalignment between the budget cycle and the health sector budget allocations for priority interventions [15]. Another issue that arises in the budget cycle is in-year adjustments – when an additional budget is demanded by the MoH outside the normal budget cycle [16], [17]. It is therefore mandatory that the MoH actively participate throughout the budget process with the ministry of finance to minimize misalignment between the PFM and health financing. Therefore, in the context of Pakistan, it is necessary to add this variable, as previous studies have documented the relationship between health allocation and the budget cycle [8], [18].

### ***2.2 Devolution***

Fiscal decentralization is a part of devolution and shows how PFM functions and health financing roles are moving at the lower levels to provinces and districts [19]. Fiscal decentralization helps provinces increase health revenues, establish the health budget, and align health needs with the available budget. Literature shows that fiscal decentralization has a positive impact on various sectors of the country including health [20]. However, the evidence is mixed. In Tajikistan, fiscal decentralization has worked against the health system and in China, the health service delivery has improved [21]. Devolution is debated by many researchers to see how it affects the PFM and how the health financing respond to this [22], [23]. Keeping in mind the literature this variable is selected for the current study. This variable will help to identify the issues and challenges of devolution in the health sector of Pakistan.

### ***2.3 Fragmented revenue streams***

A problem reported by many lower- and middle-income countries in raising pooling for health is fragmented revenue streams – money is coming through different sources and not part of the government system [24]. Donors off-budget support also creates fragmented revenue streams for the health sector as most of the support is off-budget and is not aligned with the government PFM. This put pressure on the domestic PFM [10], [25]–[27]. Vietnam and Thailand have also faced the issues of fragmented revenue streams for the health sector [28]. In the current study, this variable is selected as the literature shows that for the health sector contribution from the donors is significant but most of this contribution is coming through off-budget support. This variable will help identify the issues of donor support for the health sector in Pakistan.

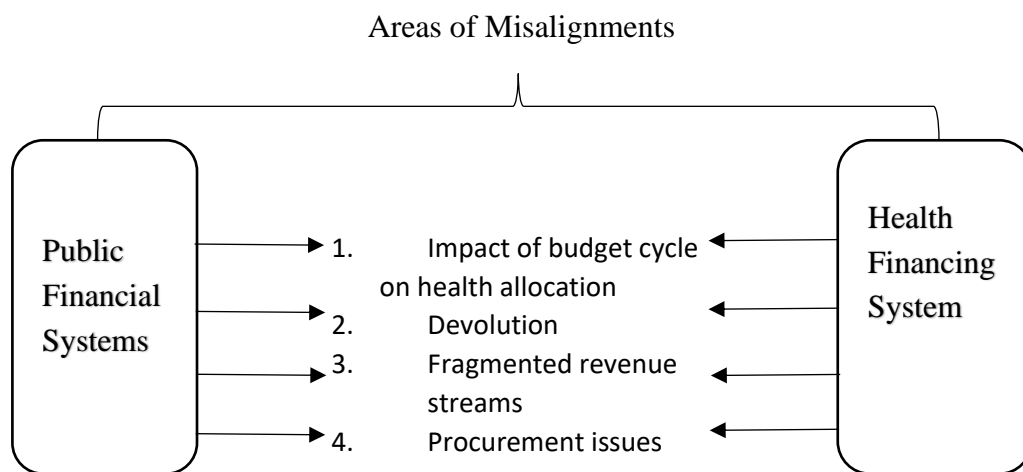
### ***2.3 Procurement issues***

A common PFM challenge across the lower- and middle-income countries are the procurement rules [29]. Procurement rules refer to the PFM process where the portion of the health budget is used to procure goods and essential health services for the public. The process includes how the government structure their procurement – tendering, choosing vendor, monitoring the delivery and final payment to the vendor [4], [30]. The latest research shows that for many low- and middle-

income countries procurement rules are usually centralized and are not flexible [29], [31]. This issue has been flagged as one of the key issues that create the misalignment between the PFM and health financing in the country [5], [11]. The current study has chosen this variable because it fits the context well. The health subject in Pakistan has been devolved to the provinces after the 18<sup>th</sup> amendment to the constitution. Every province is now responsible to manage the finances and procurement issues. However, centralized procurement is still in practice as the main procurement authority is at the federal level and provinces sometimes must take the final approval from the federal level ministry.

Based on the literature the theoretical framework has been given in the figure below:

**Figure 1. Areas of Misalignments**



*Source: Authors*

Although the literature and (Cashin et al., 2017) framework<sup>1</sup> has highlighted many anomalies between the PFM and the health financing yet not many studies have applied this framework to the devolved health setup like Pakistan. To the best of our knowledge, this is the first study where the Cashin framework is tested in a developing country like Pakistan. The general framework has been tested to see if all of the proposed misalignments between the PFM and the health financing exist or if only a few are applicable or if new information can be generated through this framework to contribute to the growing body of knowledge. Secondly, there are many studies where the issues of budgeting have been discussed in Pakistan [32] & [33] but how these issues are affecting the health sector are largely unknown. This study fills this gap by conducting in-depth interviews with the relevant authorities to bring the actual issues forward. One of the most important contributions

<sup>1</sup> The framework provided by Cashin has highlighted a few areas of misalignment between health financing and PFM functions. These areas can be broadly classified under three heads i.e. revenue raising, pooling, and purchasing. Under the head of revenue raising the areas of misalignment are budget classification, budget ceiling, revenue forecasting, and tax collection. The pooling head covers the areas like fiscal decentralization, fragmented revenue streams, fragmented donor support, and management issues. Finally, the purchasing function includes areas like different purchasing arrangements, lack of fiscal autonomy, delay in fund release, and information system.

of this study is that the framework has been tested during the COVID-19 pandemic to see how the PFM respond to the health emergency and do we need to align the PFM and health financing.

### 3. Research Methodology

The qualitative research paradigm is selected for the current study and involve the analysis of qualitative data collected from the federal level ministries and provincial line departments. As the information required from the interviews was technical and require specific knowledge of the subject, purposive sampling was used. It was part of the selection criteria that the respondent has good knowledge of public financial management and has been part of the budgeting process. The respondents were asked to share their experience of financial management during the COVID-19 pandemic. The data gathering took place between March 2021 to August 2021.

#### 3.1 Sampling

The health subject was devolved to the provinces after the 18<sup>th</sup> amendment to the constitution of Pakistan in 2010. This led to the shared responsibility of health between the federal level ministries including Ministry of Nation Health Services Regulation and Coordination (M/o NHR&C), Ministry of Climate Change (M/o CC) and Ministry of National Food Security & Research (M/o NSFR). Collectively all these three ministries are now looking to health sector issues at the federal level. M/o NHR&C being the lead ministry is responsible for the coordination between the federal and provincial levels. Therefore, the unit of analysis for the current study is the federal level ministries and the provincial health departments. The respondents were selected from all three federal level ministries. The list of respondents, their departments and other information is given in the table below:

**Table 1: Summary Table of respondents and attached departments for the current study**

Category	Percentage
<i>Gender</i>	
Male	67%
Female	33%
<i>Education</i>	
Bachleor	53%
Masters	33%
Doctor	13%
<i>Year of Experience</i>	
More than 3 years	47%
More 5 years	33%
More than 10 years	20%
<i>Ministry</i>	
KPK Health Department	7%
Sindh Health Department	7%
Punjab Health Department	7%
M/o CC	27%
M/o NSFR	27%
M/o NHR&C	27%

*Source: Authors*

After the sample was finalized one to one and online meetings were conducted with the participants. A total of 15 in-person and online interviews were conducted. The sample selected fulfils the requirement of the study as various studies has recommended a sample size of five [34] six [35] and less than 10 [36].

### ***3.2 Designing the questionnaire***

Keeping in mind the scope of the study and referring to the literature and conceptual framework a semi-structured questionnaire was developed with the help of M/o NHR&C. The questionnaire has five different parts based on the conceptual framework with open-ended questions to assess the efficacy of PFM during the COVID-19 pandemic. As the PFM incorporate the budgeting processes, four sets of questions were designed to refer to each type of budget process that is 1) budget formulation, 2) approval, 3) execution, and 4) monitoring. The fifth part of the questionnaire was related to the functioning of PFM during health emergencies like COVID-19.

### ***3.3 Data analysis***

The data were analysed using the thematic matrix (see table 2 below). The matrix was a result of many steps including reading the transcripts, annotating the transcripts, conceptualization and establishing the relationships. The final report summarizes the key findings, how the categories defined are linked, their relationship with the objective of the study, etc.

**Table 2. Thematic matrix and coding information**

<b>Themes</b>	<b>Sub-themes</b>	<b>Codes</b>
<b>1. Impact of budget cycle health allocations</b>	Delink between budget allocations and policy deter health priority setting	Health priorities Budget allocations Policy Decision
	Budget classification by inputs is major deterrent to priority health interventions.	Disease-specific budget Limited budget classification Input based budgeting Health priorities Non-suitable for health allocation
	Fragmented input budgets limit the estimation of fiscal envelop for health	Different budget allocation cycles Formula-based budget for current Lack of coordination PFM and health allocations Misalignment between budgets
	Budget releases - delay in the release of funds prevent rapid procurement of essential health equipment	Budget release policy The formula Inappropriate for emergency procurement Budget Autonomy in releasing funds COVID-19
<b>2. Devolution</b>	Fiscal decentralization is still an unfinished agenda between federal and provincial departments.	The hybrid system of funds Decentralization Autonomy Provincial dependency Multilayer approval COVID-19
	Lack of coordination between provinces caused duplication of activities	Central communication mechanism Roles and responsibilities. Coordination Health security Donor support COVID-19
<b>3. Fragmented revenue streams</b>	Donor funding is not aligned with government priorities	Donor Partners Foreign funding Pooling for health Dashboard Priority health interventions In-kind donor support Pandemic
	The link between LMIS and PFMS is weak	LMIS Medical equipment and facilities Pandemic Equipment recording
<b>4. Procurement issues</b>	Procurement through federal approval is subject to multiple approvals and caused delays	Approval Procurement rules Emergency procurement COVID-19 Internal Delays in procurements

<b>5. Organizational culture</b>	Knowledge about health financing and PFM is limited	Limited knowledge Understanding Less training No facts Less experience
	The attitude between departments is not conducive to PFM practices	Final authority Attitude problems Emotional attachment Previous experience Behavior
	PFM practices are not helpful for health emergencies	Old practices Comfortable with the existing practices Part of organizational culture

*Source: Authors*

## 4. Findings

**Table 2** shows the thematic metrics that emerged as a result of in-depth interviews with the respondents at the ministry of health and the provincial line departments. The matrix provides the framework to assess the efficacy of PFM during the health emergency i.e., COVID-19 pandemic. The themes, sub-themes and codes developed through the interviews helped to answer the research question of the study. Five dominant themes captured are (1) Impact of the budget cycle on health allocations (2) devolution (3) fragmented revenue streams (4) procurement issues and (5) organization culture.

### 4.1 Theme 1 - Impact of the budget cycle on health allocations

The in-depth interviews lead towards the derivation of sub-themes that gave insight on budget cycle and health allocations.

#### 4.1.1 Delink between budget allocations and policy deter health priority setting

Delink between the budget cycle and health allocation was found to be a major barrier for setting health priorities. The respondents were on the opinion that as the ministry of finance has the final decision on the health budget allocations, they do not usually listen to ministry of health. As a result the health budget allocated to ministry of health is less than required.

*“Health priorities on which ministry is working are not usually reflected in the budget process” R-3*

*“Policies are made here (ministry of health) but the budget is allocated somewhere else” R-4*

*“Ministry of health and ministry of finance don’t talk to each other during the budget cycle although it is imperative for successful health budget allocations” R-7*

*“The major issues for health allocation are that the final decision on health allocations rests with the ministry of finance, not us” R-11*

*“We never get what we want – ministry of finance always gave us less allocation than we asked for” R-12*

The respondents believe that allocations for health could substantially improve if the ministry of health and the ministry of finance work closely to achieve some common objective that is more money for health and achieving universal health coverage.

#### **4.1.2 Budget classification by inputs is a major deterrent to priority health interventions.**

The respondents believe that budget classification by inputs is a major deterrent to increasing the budget allocations for health. In this classification health budget cannot be allocated by specific disease (immunization, HIV) or by program (malaria, TB etc.) rather the health budget is allocated by line items including salaries, office expenses, maintenance costs etc. Because of this ministry of health cannot allocated or spend the money by outputs (disease or programs) and has limited autonomy to spend the budget.

*“We want to track the health expenditure by disease, but the current budgeting system is not designed in this way” R-2*

*“Because of unavailability of disease-specific codes, we can only ask health budget by inputs” R-9*

*“The budget classification is limited because the financial system records the health allocation by functional and object codes. Sometimes this is very annoying as we cannot spend the budget by outputs” R-8*

*“Budget classification by inputs limits the ability to get health allocation by priority health interventions” R-5*

*“Health is different than other sectors. There is great uncertainty in health spending, especially after COVID-19. Health allocation should be by the health sector dynamics” R-6*

Respondents were of the view that budget classification by inputs has a direct impact on health sector budget allocations. The current classifications of budget codes are rigid and not very helpful for the health sector allocations as well as spending.

#### **4.1.3 Fragmented input budgets limit the estimation of fiscal envelop for health**

The interviewee believes that a fragmented input budget is a barrier to health allocations. A fragmented budget occurs when the money for health is allocated at two different places that are two different ministries. In Pakistan, the current budget and the development budget are two different streams for health allocation. Unfortunately, both budgets are approved and managed in different ways are significantly different. Consequently, at times, it is difficult to ascertain the overall fiscal envelope for the health sector. Further, the release of money from both budgets is managed differently which creates a problem.

*“The current budget is part of the normal budget cycle, but the planning budget is approved and managed by the planning commission. They are two different budget cycles and processes that create fragmentation” R-1*

*“Because of the fragmented budget streams, it is sometimes difficult to assess which part of the budget is working more for the health sector priorities” R-6*

*“The current budget allocations are usually tied with the historical patterns of spending - you spend more you get more in next year. At least there is some formula for current budget allocations. For the development budget, there is no allocation formula. To get the budget release we have to face not only the finance division but also the planning commission” R-3*

*“The two different streams of current and development budget always create coordination problems between the ministry of health, planning commission and the ministry of finance” R-11*

*“There seems a misalignment between health sector allocations and health priorities” R-9*

*“Surely there is a visible misalignment between the budget cycle - especially the PFM structure and the health financing policy objected” R-13*

The response from the participants is pointing that for the swift distribution of the health budget different organizations working during the budget cycle must be working in harmony. There should be some formula for both the development and current budget which is used to define how much budget is allocated to the ministry of health at the start of the year.

#### ***4.1.4 Budget releases - delay in the release of funds prevent rapid procurement of essential health equipment***

Participants commented on the budget release policy and its impact on health allocations. Most of the participants believe that for the smooth working of the health sector during emergencies and even in normal conditions the budget release is a crucial factor. They believe that the current budget release policy is not conducive for emergency health procurement where the money is required in a lump sum. Moreover, the release of the budget is a cumbersome process with multiple checks at the release stage rather than at the allocation stage. They believe that in absence of a budget release policy consistent with the health sector requirements the allocation process is just a paper exercise.

*“The cash release policy of the ministry of finance seems to be working against us, not in favor of us. How can we spend if the cash releases are delayed?” Participant-2*

*“The 30,30 and 40 formula of budget release is insane. We get only 30% of funds in the first quarter, 30% in second and 40% in the last quarter” R-5*

*“In many cases, payments for procurement to be made cannot be done in peace meal. For instance, where the whole equipment is required to be purchased in one go, then the invoice is to be processed together for the whole of the equipment. In such cases, the procuring agencies are not authorized to spend the whole of the budget of the physical asset in the first quarter. If it opts to wait two or three quarters, this will reduce its utilization of budget, which will attract objection to the non-release of funds due to non-utilization by MoF” R-6*

*“Due to this cumbersome release process, some of the procuring agencies prefer not to go for procurement by the time the release is available” R-7*

*“During COVID-19 we need to procure essential health equipment on an urgent basis, but owing to the limitation of cash release policy we were unable to procure most of the basic supplies” R-11*

*“A considerable sum was allocated to fight the pandemic's adverse effect, but funds earmarked for some high-priority interventions were never released. In the first six months of the pandemic, only 34% of funds were -released, which seriously jeopardize the preventive measures to deal with the emergency” R-12*

*“Allocation alone cannot guarantee that we will get the money. It is just a way of earmarking funds. Most of the funds released were less than the health sector allocations” R-6*

*“For health emergencies, the allocations, as well as the cash release policies, should be revisited” R-3*

The budget release policy during Covid-19 was tagged as a barrier to health allocations by participants. The health emergency demands that the funds are not only allocated quickly to priority health interventions, but the release process is also working accordingly.

## **4.2 Theme 2 – Devolution**

In this theme, the factors that affect the health service delivery during COVID-19 were highlighted. Fiscal decentralization (transfer of financial and administrative powers to the provinces from the federal government) and lack of coordination between provinces appeared as the sub-themes.

### **4.2.1 Fiscal decentralization is still an unfinished agenda between federal and provincial departments.**

Respondents mentioned that fiscal decentralization was meant to increase the efficiency of provinces in general and for the health sector in particular. However, the desired benefits of fiscal autonomy were yet to achieve for various reasons. First provinces are not fully independent financially and need to seek approval from the federal to spend the money. This creates additional work and wastes time. Second, all the funds released are subject to pre-audit at the provincial and federal levels. Hence an urgent procurement may be delayed because of multiple audit processes.

*“The hybrid system of fund flow has not been worked out properly after the devolution. Fiscal decentralization in true sense is still not in practice” R-6*

*“Decentralization was supposed to increase the provincial autonomy, but we are still dependent on the federal approval to spend. As such the fund flows between the federal and provincial levels are still in the pre-devolution stage” R-8*

*“You need to understand the mechanism of approval and fund flows. All of the expenditure of the provincial government is meted through the consolidated fund. Each province has an Accountant General, who is the custodian/signatory of the consolidated fund and keeps the checkbook of the said account maintained with the State Bank of Pakistan. The health departments of the provincial government route all its payments through the Accountant General office. However, the Accountant General (AG) offices are governed under the Federal Legislation of Controller General Accounts Act,*

*2001 and this function continues to remain with the Federal Government. As a result, provinces are still dependent on the federal to get approval for spending” R-5*

*“How can you imagine the swift flow of funds when there is a multilayer approval process between federal and provincial levels? The whole process is cumbersome and time-consuming. Further, such a process has inherent delays that do not go well with the health emergency like COVID-19 where funds are required on an urgent basis for the priority interventions” R-4*

*“For COVID-19 funds were required urgently but the fund flow mechanism was so lengthy that the fiscal decentralization looks like a futile exercise” R-2*

*“To initiate the procurement, the health departments of provincial governments have to first seek the budget and its release from the provincial finance department. Then comply with the respective provincial rules for procurements, and then comply with complex federally issued instructions and orders during pre-audit check applied by the AG office at the time of payments for any goods or services. All these procedures are very complex and lengthy and are not suitable to deal with emergency procurements, especially during health emergencies” R-3*

In Pakistan, fiscal decentralization because of devolution has not worked as expected. The 18<sup>th</sup> amendment to the constitution delegated most of the public service delivery functions to the provincial governments. As a consequence, PFM became a hybrid system of rules, regulations, and procedures for the federal as well as the provincial government. This system involves multiple layers of checks and numerous officials in budget execution, implementation, release processes, etc.

#### ***4.2.2 Lack of coordination between provinces caused duplication of activities***

The second factor addressing the issues of devolution was the lack of coordination among provinces. During COVID-19 need for coordination was imperative, however, it was observed that the provinces were not clear about their roles as no one was leading from the front. There existed a coordination mechanism (IHR taskforce) but its functionality was limited. Donor coordination for health emergencies was also not harmonized with the government efforts.

*“The COVID-19 was a national emergency and there was no formal mechanism to address it. Although the government departments like National Health Emergency Preparedness & Response Network (NHEPRN) was working to respond to emergency preparedness, it was underfunded to deal with such situations” R-11*

*“Fiscal decentralization is not easy to implement. It’s only possible if the provincial and national governments are clear about their roles and responsibilities. During COVID-19 the provincial governments have the funds but the lack of coordination between the federal and provincial governments makes it difficult to decide who is doing what” R-12*

*“Lack of coordination was obvious during COVID-19. When the coordination between federal and provincial should have been optimal, there was no formal authority to lead it. Although it was under the mandate of M/o NHR&C to lead, they*

*were falling short to manage it. Resultantly the National Command and Control Centre (NCOC) was established to harmonize the operational response on COVID-19 at the federal and provincial levels” R-2*

*“Devolution has its demerits if not managed properly. COVID-19 is an example of that. We became an IHR signatory in 2005 to build strong capacities in implementing preparedness activities including coordination. But to date, we are far behind in achieving this. In the last 5 years (2017-2021) we only have had one IHR task force meeting to discuss the issue of health security like COVID-19. During these last five years, the coordination between the federal and provincial government are not exemplary” R-4*

*“Lack of coordination was apparent during COVID-19. Donors were contributing generously to fight the pandemic at the federal and provincial levels. However, it was difficult to track who is doing what and where. It is therefore imperative to enhance governance and coordination mechanisms and work on M & E framework to reduce duplication of activities between different donors” R-5*

Lack of coordination between the federal and provincial governments is found an area of improvement. Decentralization has given autonomy to the provinces yet the role of coordination with the provinces is still with the federal ministry of health. The federal ministry needs to make sure that the coordination mechanism not only exists but is active to deal with an emergency like COVID-19.

### **4.3 Theme 3- Fragmented revenue streams**

Fragmented revenue streams were another dominant theme that emerged during the interview. This is one of the challenges of PFM that leads to an unrealistic estimation of funds availability for the health sector. Fragmented revenue happens when the donor and private out-of-pocket funding is used to buy the health services. This creates fragmentation in revenue sources and ultimately creates a forecasting error in estimation. The two prominent sub-themes were donor funding and the link between the LMIS and PFMS.

#### **4.3.1 Donor funding is not aligned with government priorities**

Donor funding not coming through the government channel can create a fragmentation problem. At times it is difficult to assess the size of the fiscal envelope for health because the revenues are not easily traceable from the government financial system. The respondents believe that multiple donors were giving money for COVID-19 but their donations were not visible i.e. who is doing what because the donor were giving money through off-budget support.

*“If we know exactly where the money is coming from, we can plan correctly. Currently, we manage the health service delivery mainly through the government budget. But usually, the government gave us less money than we require. Donors and health development partners are also contributing to purchasing health care services, but their contribution is largely off-budget, and we don’t have visibility of their funds. This creates the fragmentation in revenues for health” R-1*

*“Foreign funding is not usually coming through the government channel. They gave a lot of off-budget support to purchase the health service, but they provide this*

*support directly to health service providers. This creates confusion about the revenue streams. Further, this support is not traceable from the government financial system” R-5*

*“Creating the pooling for health is important so that the funds can be used from the pool in case of health emergency like COVID-19. However, because of fragmented revenue streams, we cannot assess how much money is available for health. For example, the pool created for COVID-19 consists of government funds and donor funds. Further, there were out-of-pocket health expenditures. This creates the problem of estimation for total revenues available for health” R-6*

*“During COVID-19 government created a dashboard to see how much has been allocated to COVID-19 related activities. However, the dashboard did not have any information on who is providing how much. Donors were giving grants and loans to fight the pandemic, but their contribution was not traceable from the PFM of the country” R-8*

*“The problem with the off-budget support is it is often allocated to the programs or some projects. The problem is these programs and projects are not equitable i.e., they are not designed to serve the country’s priority population. In this sense, this donor funding create fragmentation as well as create inequity in providing the health services” R-12*

*“In-kind donor support is a major type of donor support, but it is not reflected in the government PFM system. During COVID-19 we receive the ventilators and other essential supplies to fight the pandemic but the same was not reflected in the PFM system. Maybe some government departments have the information, but it is surely not part of the government financial system” R-4*

Fragmented revenue streams put pressure on the PFM of the country to assess how much money is available for health and what are the sources. This ultimately makes the policymaking to the health ministry correctly forecast the revenues against the expenditure.

#### **4.3.2 The link between LMIS and PFMS is weak**

The logistic management system of the country should be working in harmony with the public financial management system of the country. This is especially important during pandemics like COVID-19 where huge in-kind grants were coming from the government systems. Currently, The PFM as discussed in detail is not designed to record, track, and report physical assets received in-kind from the federal government or any other donor agency. This shows a delink between the LMIS and PFMS of the country. The respondent argue that they did not know whether the in-kind support from the donors is available or not.

*‘During COVID-19 the ministry of health does not have visibility of the in-kind grant from the donors. We knew that donors have given the ventilators, but the PFM does not have a record of it. There is some delink between the LMIS and PFM” R-5*

*“Pooling for health involves that all the stakeholders take an active part and contribute their resources. But during COVID-19 we feel the there was a problem of fragmentation and the medical equipment given by the donors was not recorded in the financial system of the government” R-7*

*“I strongly believe that The PFM in our country is not designed to record, track, and report physical assets received in-kind from the federal government or any other donor agency” R-3*

Harmonization between the financial system of the country with the logistic management system is crucial to avoid fragmented revenue streams. The government and all the stakeholders should have the knowledge and visibility of what has been given through in-kind support to the government and how this resource has been utilized.

#### **4.4 Theme 4 - Procurement issues**

The in-depth interviews lead to the derivation of a sub-theme that gave insight into procurement issues.

##### ***4.4.1 Procurement through federal approval is subject to multiple approvals and caused delays***

Respondents commented that the multi-layered procurement cycle is a consequence of devolution. The ideal situation could have been that the provincial government is free to procure essential supplies during COVID-19. However, complex, and time-consuming procurement procedures brought it closer to completion. The respondents stated that procurement was the biggest challenge during COVID-19.

*“Provincial officers (Drawing and disbursement officers) were not authorized to invoke an emergency procurement clause without getting approval from the federal level. This approval process makes the procurement during COVID-19 complex and cumbersome” R-2*

*“Currently there exists an emergency clause in Provincial procurement rules 2004, however, the same does not cover the outbreak of the epidemic” R-6*

*“In case of emergency procurement over Rs. 500 million Drawing and disbursement officers (DDOs) must apply for foreign exchange for the purchase of imported items. This application is to be routed from the health department to the finance department and from the provincial finance department to the Ministry of Finance at the federal government level to approve the purchase of imported goods. This whole process alone requires many months if not years. In this context, the devolution is not helping as expected” R-9*

*“The result for these non-procurements (say for instance PPE) is that the health care community was widely affected by the virus and was hit first during COVID-19. Besides many doctors who died, the hospital was not able to perform their duties on a routine basis” R-11*

*“The devolution has created extra work for us. We already have internal delays while procuring items because of time taking procurement rules. Add to our misery was taking the federal approval for procuring essential items during Covid-19. This created procurement emergency during health emergency” R-12*

#### 4.4.1 Theme 5 – Organizational Culture

The new theme i.e., organizational culture emerged from the interview data based on the codes that were knowledge, attitude, and practice.

##### 4.4.2 *The attitude between departments is not conducive to PFM practices*

The respondents believe that one of the major causes that creates a delink between the PFM and health financing arrangements is the attitude of various departments. The finance department thinks that they are the final authority in the decision-making about budgets as they have the money. The respondents remarked that there is a wide gap in the understanding of health issues between the ministry of finance and the ministry of health. He former did not understand the dynamics of health and made unilateral decisions about health allocations.

*“The final decision about the budget allocation indeed rests with the ministry of finance, but they have attitude problems. They think they know better than us and have supreme authority” R-2*

*“The finance department is strictly attached to their way of doing things. They don’t listen and at the time make a one-sided decision about the budget allocations for the health departments” R-15*

*“The organization culture plays a crucial role in budget cycle and health allocations. The Ministry of finance has different organisational culture than ours (ministry of health), we are always confronted with new health challenges like COVID-19. We have no previous experience of handling such a pandemic and our demand for budget allocation was different. Contrary to this ministry of finance allocate budget based on their previous experiences and seldom keep the context in mind” R-12*

Respondents believe that attitude plays a vital role in implementing the PFM practice. If the attitude of MoF is positive and cooperative, then it is much easier for both ministries to work together. This will reduce the misalignment between PFM practices and financing for health.

##### 4.4.3 *Knowledge about health financing and PFM is limited*

It was observed during the interviews that there was a lack of knowledge on both sides of ministries. The ministry of finance does not have in-depth knowledge of how the health ministry works and at the same time ministry of health has little idea about the fiscal envelope under which MoF operates. The respondents record their views in the words:

*“The dynamics of health ministry are different than other ministries. We don’t know how much money we need in the coming year as we are perusing different interventions to achieve Universal Health Coverage. But the ministry of finance does not understand this context” R-9*

*“We have competing priorities here (Ministry of Finance). We must allocate the budget to all the ministries and not only to health, moreover they don’t understand that we are working with constrained resources. In the last ten years, we have fiscal deficit, and our debt is soaring. They (ministry of health) have no idea how we manage the funds” R-4*

*“There is a lack of training at both ends. Both the ministry should be trained on cross-cutting issues like PFM issues, efficiency savings, budgeting for health, and fiscal space for health. Only then we will be able to move forward, and this will create the organizational culture of working in harmony” R-8*

*“There is a gap of knowledge at every level. The decisions are made not based on the facts but based on the organization's culture. We (MoH) never get the budget we want and it's not only us, but all the other ministries that face the same issues when working with the ministry of finance. They have some issues when it comes to budget release” R-7*

*“Lack of experience staff is also a problem at both ministries. Most of the senior staff have retired or shifted to other departments and the current staff has limited capacity to advocate for the health budget” R-6*

#### **4.4.4 PFM Practice are not helpful for health emergencies**

One sub-theme that emerged under the organization culture was practised. Respondents believe that the PFM practices at the ministry of health are not conducive for the health ministry as there are many areas of misalignments that need attention. Respondents say:

*“The PFM rules and practices are old and need to be updated. It is evident that the COVID-19 has exposed the old PFM practices, the procurement rules are outdated, there is no specific PFM rule that caters the budgeting for health emergency and there is also no mechanism to release funds quickly for emergency response” R-9*

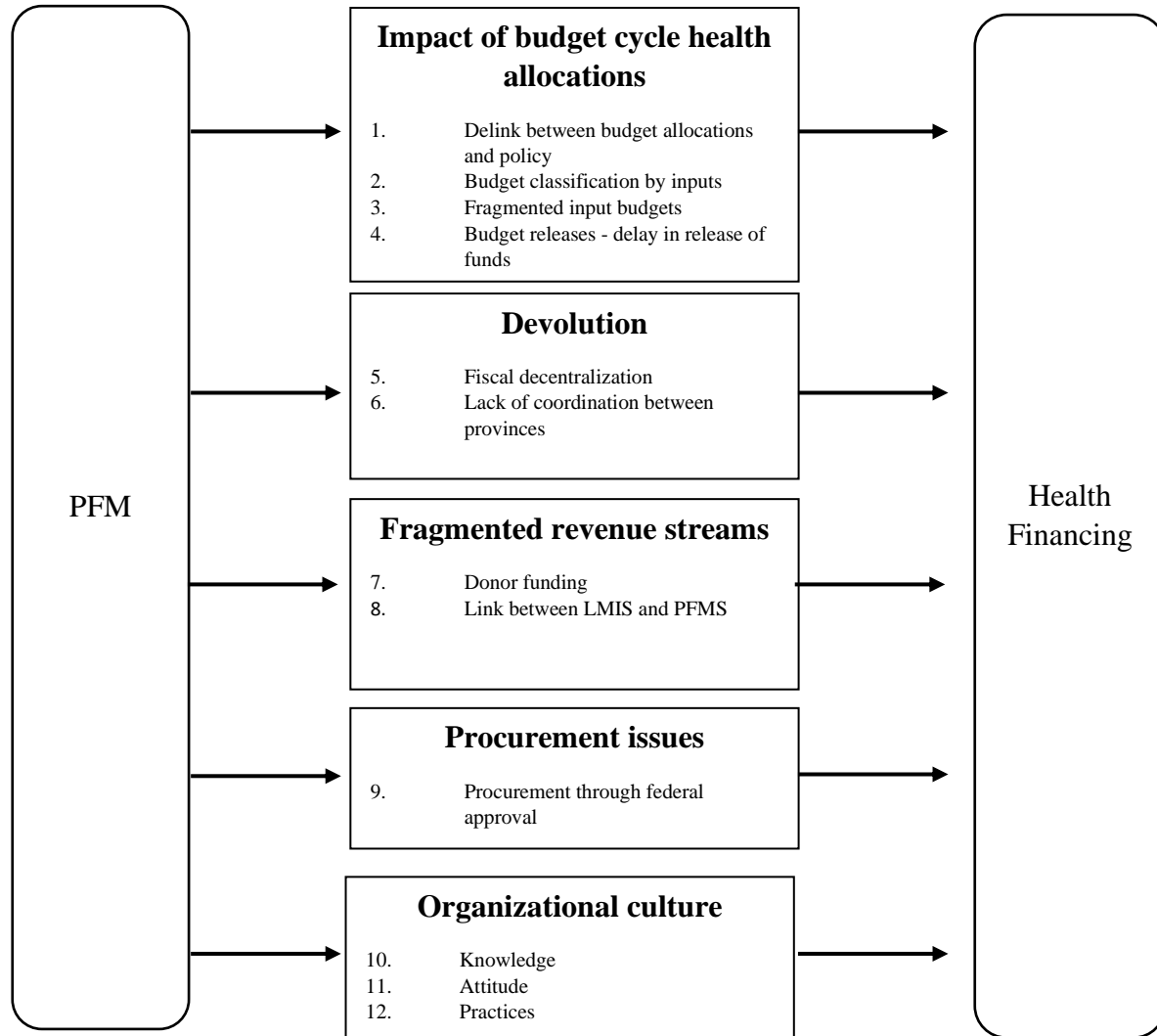
*“The Finance Ministry wants to stick with their old practices irrespective these are working or not” R-4*

*“The organizational culture at the ministry is rigid, in a sense that does not listen and usually has made the decision beforehand about the budget allocation” R-15*

## **5. Discussion**

Five themes have emerged as a result of in-depth interviews with the staff at the ministry of health and provincial line departments. These themes are shown in Figure 2 and provide a deeper insight into the areas of misalignments between the PFM and health financing of the country.

**Figure 2. Misalignments between the PFM and health financing**



*Source: Authors*

The first theme discusses the impact of the budget cycle on health allocations and contains four sub-themes. That is delinked between budget allocations and policy, budget classification by inputs, fragmented input budgets, budget releases - delays in the release of funds. The findings of our study confirm the work done in previous empirical studies in different contexts. In African developing countries the PFM assessment has shown that the input-based budget reduces the capacity of recording the disease-specific health expenditure [37]. In turn, it reduces the government's ability to correctly forecast the health budget against priority health interventions. In Pakistan, this is also the case that input-based budgeting has limited the capacity of the government to allocate the budget against key health interventions like IHR, RMNCH, etc. Similarly, the WHO report has documented that fragmented input budgets hamper the government's ability to plan correctly [38]. This is because the budget approval is done at two different places like the planning

budget and the development budget goes through different process and implementation procedures. This creates a delink between budget planning and execution. A fragmented budget is also a major problem for health allocation in Pakistan. The interview with the respondents at the federal and provincial levels shows that almost all the priority health interventions are perused through the development budget however the approval of the development budget is not in the hand of the ministry of health, hence which creates inefficiencies in resource planning. Finally, the budget release is found to be a major barrier between the PFM and health financing in Pakistan. This problem is not new for many low- and middle-income countries [29], [39] and can seriously reduce the flexibility of government agencies to procure essential health supplies for the general public.

The second theme in this study was devolution – the transfer of financial and administrative power to the lower level i.e., provincial and district level – from the federal government. Two sub-themes were derived from it namely fiscal decentralization and lack of coordination among the federal and provincial levels. Fiscal decentralization aims to transfer the financial power from the federal government to the provincial and district governments [23]. This in turn provides autonomy to the lower level in performing health financing functions including revenue-raising, pooling, and purchasing for health services. Misalignment between the PFM and health financing functions exists as a result of devolution as the federal ministry fears losing financial control over the provincial budget. Globally the evidence in favor of devolution is strong and shows that devolution has a positive impact on the PFM cycle [20], [40]. However, our study found that in Pakistan the desired benefits of devolution have not been met so far [41]. This is mainly because of a lack of stewardship at the federal level ministries, federal level autonomy, unclear roles between the federal and provincial ministries ad line departments, etc. The respondents in this study further believe that many functions that should have been devolved to the provincial level are still in the hands of the federal government like the release of payments, procurement fund flow mechanism, and audit. This situation works as a barrier to health financing.

The second sub-theme under the devolution was the lack of coordination between provinces. The literature has shown that devolution is a time taking process and the procedures, systems, and people take time to get familiar with it [23], [42]. However, in Pakistan, although the devolution has taken place in 2010 yet the coordination between the federal and provincial is still not exemplary to help the transition. The respondents in this study mentioned that during COVID-19 the roles and responsibilities were not clear between the federal level ministry and the provincial governments. As a result, the health service delivery was badly affected.

The third theme this study explored was the fragmented revenue stream – the health sector is financed through different sources including government, donors, and other funds. Research has shown that fragmented revenue can work with or against health financing [43]. In Turkey, the insurance program was highly subsidized and successful even though there were multiple revenue streams [44]. Contrary to this Vietnam has faced problems when working with the fragmented pooling and their social security fund was highly inequitable [24]. However, this study found that one of the crucial factors that work against policy development is off-budget support. A major portion of the donor support for health is off-budget and creates a big problem for the government.

During the COVID-19 pandemic Government of Pakistan raised (the US \$ 74.92 billion) in March 2020 to fight the pandemic [12]. The revenue for the pandemic was raised through different sources including foreign funding. A dashboard was also created to monitor the allocation and spending for the pandemic fund. The dashboard developed by the Ministry of information technology and communications shows the expenditure however the bifurcation between domestic and foreign funding cannot be traced from the dashboard. It was not clear how much money is available through the foreign funding neither the spending was traceable against it.

The fourth theme in this study was procurement issues. Under this theme, the sub-theme was procurement through federal approval. Literature shows that in much lower- and middle-income countries centralized procurement limits the flexibility to purchase essential health supplies in the right quantity and at the right time [29]. In an emergency, the procurement of health supplies rapidly is essential to meet the service delivery needs. The misalignment between the PFM and health financing exists if the services are not procured within the given time and at a lower cost [39]. Our study found that in Pakistan procurement is found a major issue when dealing with health emergencies like COVID-19. Procurement is another area that was not aligned with the situation like COVID-19. During the pandemic, procurements were carried out under the public procurement rules of the provincial governments (PPR). The PPRs are designed to have value for money and cost-effective procurements. However, several checks are built-in these rules for proper advertisements of bids, receiving of tendering, and award of contract for the supply of goods, whether these are to be financed by development expenditure or non-development expenditure.

The fifth theme in this study was organizational culture. This study uses the [5] framework to check the areas of misalignment between the PFM and health financing. Most of the misalignments mentioned by the Cashin framework were present in Pakistan and were supported by the literature. However, during the in-depth interviews, a new theme emerged that gave further insight into the cause of the misalignment between the PFM and health financing in Pakistan. It is found that during the PFM cycle that is budget planning, formulation, approval, and execution organization culture is a key area that cannot be ignored. Especially the knowledge, attitude, and practices of staff working at the ministry of finance are crucial for the PFM to work in harmony with health financing. Although these three variables also known as (KAP) have been used in Pakistan before but in a diffident context. KAP has been applied in the banking sector of Pakistan [45], [46]. [47] has used the KAP model to see the financial management practices, but there are rarely any studies that have seen the application of KAP during the budget cycle or applying to see the application on PFM practices. The theoretical contribution of this study is hence applying the KAP in Pakistan and bringing forward issues of budget execution. This study found that knowledge, attitude, and practices play a vital role during the PFM cycle. The limited knowledge of the ministry of finance staff on budgeting for health workers is a barrier to budget allocation. Similarly, both ministries i.e., Finance and Health are comfortable using their old practices and did not want to change. Therefore, there is an urgent need to train staff on the theory of change and to challenge old working practices.

## 6. Conclusions

The paper aimed to highlight the issues of PFM when working with the health financing functions. These issues can be grouped under five headings i.e. impact of the budget cycle on health allocations, devolution, fragmented revenue streams, procurement issues, and organizational culture. Subheadings under each subgroup further shed light on the issues between PFM and health financing.

Under the head of the impact of the budget cycle on health allocations four subheadings were identified that are areas of concern for the government. First, it was found that the health budget did not get the due attention in the budgetary cycle, as a consequence budget allocation to the health sector is usually done on an incremental basis rather than a need basis. The second budget cannot be allocated by priority health interventions or by a program rather it is done by line items which limit the expenditure tracking. Third, the development and the current budget are approved differently hence it is difficult to understand the overall size of the fiscal envelop for the health sector. Lastly, the budget release in general and for the health sector is a cumbersome process and at times essential health equipment cannot be procured.

Health is a devolved subject but it is still in transition. The health was devolved to the provinces but there are issues. For example, fiscal decentralization which was part of devolution is an unfinished agenda. Although the provinces are now responsible for their health allocation but getting approval from the federal authorities is still required which is time taking process. There is also a lack of coordination among provinces and there is duplication of activities.

Fragmented revenue streams were found third major issue between PFM and health financing. Under this heading, two main areas were donor funding and LMIS and PFMS. It was observed that the donor funding is not linked with the government priorities stated in the health vision and provincial health strategies as a result sometimes there is duplication of activities by the donors on some health-related issues. Secondly, it was found that there is delink between LMIS and PFMS.

Procurement is also a weak link between the PFM and health financing. The procurement at the provincial level is subject to multiple checks and formalities. During emergencies, essential health equipment could not be procured because it takes two to three months to procure the equipment and such lengthy procedure are not suitable for the health sector.

The organization's culture was also identified as a major theme. Attitude, knowledge, and practice are the three areas that need immediate attention by the government. The attitude of non-cooperation between departments exists because of a lack of knowledge on health financing.

### ***6.1 Contributions***

The theoretical contribution of the study is that it has adopted and extended the [5] framework on the developing country like Pakistan. With an extensive theoretical framework, this research has deepened our understanding of the factors that create the misalignments between the PFM and health financing in the devolved health setup. To the best of our knowledge, it is the first study on South Asian countries to check this framework and bring forward the dominant themes that cause the misalignment. The timing of the research was excellent as the world was facing the biggest health challenge in the form of COVID-19 which has not only put pressure on the PFM but has seriously hampered the health service delivery.

The study concludes that besides the apparent cause of misalignment between the PFM and health financing which are devolution, fragmented revenue streams, procurement issues, and budget cycle there is another dimension. This study found that the organizational culture plays a vital role to bring alignment between the PFM and health financing. Knowledge, attitude, and practice are the factors that need to be addressed besides the other factors. In this way, this study has extended the (Cashin et al., 2017) framework by adding the evidence-based variable.

### ***6.2 Implications***

There are several implications based on the findings. 1) The capacity of the ministry of health should be built so they could take an active part during the PFM-budget cycle as currently the role of the ministry is limited to budget formulation, and implementation. 2) There should be some emergency funds that both the federal government and provinces should contribute. These accumulated funds can be used in emergencies and the mechanism to draw funds from that fund should be made. Either equity base disbursement or the burden of a disease based formula should be applied to withdraw funds from that account. 3) Transparent distribution of funds and timely release of the same, preferably the DDOs at major healthcare facilities should have access to direct payment option through the already existing mechanism of assignment account under the PFM Act 2019 and Single Treasury Accounts rules, 2020 4) A mechanism should be developed to bring donor support into the government system. All the off-budget cash and in-kind support must be identifiable from the PFM and, 5) A mechanism for Improved federal-provincial PFM coordination in case of emergencies. Where necessary, the Government, Auditor General of Pakistan, and Accountant Generals must act proactively to give a blanket exemption from applicable rules in emergencies dealing with numerous issues. The rules must cover all issues including foreign exchange requirements clearance from the federal government, need to get PC1 approved in case of procurements of assets relating to COVID-19.

### ***6.3 Limitations and future research agenda***

There were certain limitations of the research. First, the sample size was confined to 15 respondents from three provinces and the federal only. There was no representation from Federally Administrated Tribal Areas (FATA) and Azad Jammu Kashmir (AJK). Another limitation was that only four variables from the Cashin framework were taken as they were pertinent to the country context. Lastly, a pure qualitative technique was adopted to explore the objective of the study i.e.,

areas of misalignment between PFM and health financing. Going forward the research can be expanded by adding more variables to the study, increasing the number of respondents, or taking interviews in other provinces. To see if the research finding is replicable to other South Asian countries a quantitative research paradigm can be considered.

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