

BUDGET EXECUTION IN HEALTH: FROM BOTTLENECKS TO SOLUTIONS

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CASE STUDY SERIES

DEMOCRATIC REPUBLIC OF CONGO



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ABSTRACT:

The Democratic Republic of Congo is committed to achieving Universal Health Care by 2030. Progress toward this goal faces challenges due to limitations in the execution and allocation of the country's health budget. This contributes to health spending being predominantly financed by households and donors rather than the government. The only part of the government health budget that is consistently executed in line with allocations is for health worker payments. Execution rates for other spending categories are volatile and generally low. Many parts of the budget are not executed at all, while some activities are implemented without having been included in the budget. Budget execution within the Ministry of Health is influenced by both internal and external factors. Inconsistencies between strategic planning, budget preparation, and execution processes hinder effective financial management; inaccurate cost estimations; heavy reliance on exceptional procedures for spending and over-execution of specific budget lines to the detriment of otherwise planned activities. External challenges include a systematic over-estimation of national revenue; the highly centralized nature of budget execution processes; the dominance of health worker payments in budget allocations; the non-respect of budget management rules and cumbersome procurement and expenditure execution procedures.

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This study was authored by the Democratic Republic of Congo (DRC) World Bank team, including Marion Jane Cros (Senior Health Specialist), Fatima El Kadiri El Yamani (Senior Economist), Michel Muvudi (Senior Health Specialist), and Aminata TOU Nana (Consultant). It follows a case study protocol developed by H el ene Barroy (Senior Health Finance Specialist, WHO), Moritz Piatti-F unfkirchen (Senior Economist, World Bank), and Amna Silim (Senior Consultant). Quality assurance was provided by Hamish Colquhoun (Senior Consultant) and Moritz Piatti-F unfkirchen (Senior Economist). Technical editing and communication support was provided by Zac Mills (Senior Consultant), Hamish Colquhoun (Senior Consultant), Clementine Murer (Program Analyst), and Alexandra Michele Beith (Senior Consultant). The study benefitted from management oversight by Agn es Couffinhal (Global Program Lead for Health Financing) and Monique Vledder (Practice Manager, HNP). It was made possible through generous financial support from the Global Financing Facility (GFF).

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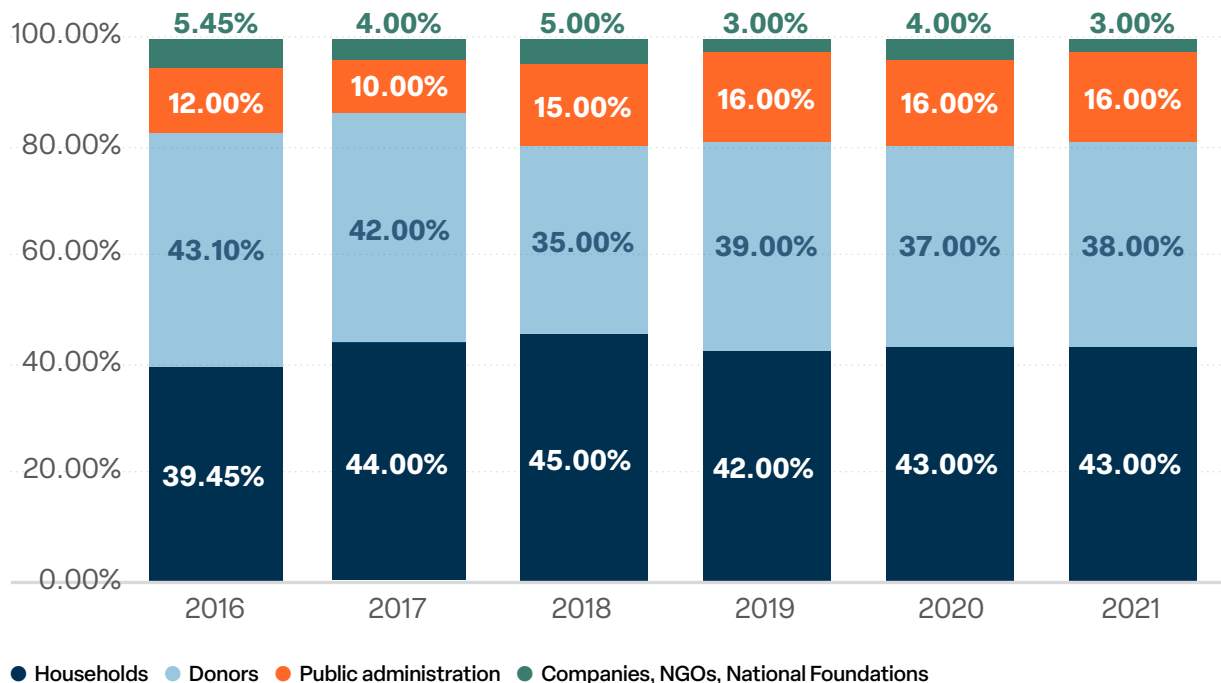
1.0 HEALTH FINANCING CONTEXT

The Democratic Republic of Congo (DRC) is committed to achieving Universal Health Coverage (UHC) by 2030. This target requires ensuring all people have access to quality healthcare without financial hardship. The government’s strategic objectives for the sector are set out in the National Health Development Plan¹ 2019–2022. This plan is complemented by a 2019 Health Financing Strategy which defines the mechanisms for improving the mobilization and effective utilization of resources for the health sector.

Spending on health is predominantly financed by households and donors.

Direct household payments are the main source of health facility income. Collectively, household payments and donor grants comprised over 80 percent of total health spending from 2016 to 2021 (see Figure 1). Government financing comprised 10-16 percent of total health spending in the same period.

Figure 1
Democratic Republic of Congo Health Financing Sources, 2016–21



Source: Ministry of Health: National Health Accounts Report 2021.

1 Plan National de Développement Sanitaire (PNDS).



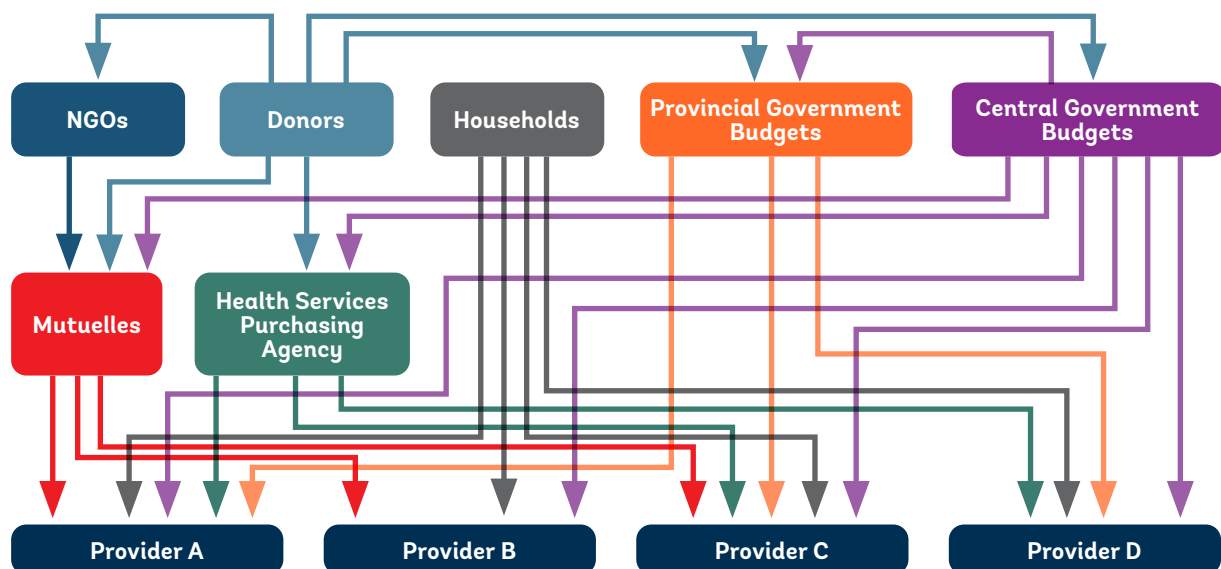
Total spending on health is far below the estimated levels required to achieve UHC. Total health expenditure ranged from US\$19 to US\$22² from 2013 to 2019 and reached 3.65 percent of gross domestic product (GDP) in 2020. This is far below the US\$86 per capita and 5 percent of GDP estimated by international studies to achieve UHC.³

While the health sector budget allocation has increased in recent years, the increase is primarily due to donor resources. Overall, the proportion of the government’s total budget allocation that is earmarked for the health sector increased from 6.6 to 11 percent from 2016 to 2021.

However, when considering only the government’s own resources (i.e., excluding donor allocations captured in the budget), the allocation increase was more modest (from 6.6 to 7.4 percent over the same timeframe). Public resource allocation for health, therefore, remains below half the Abuja Declaration target of 15 percent. Gaps in resource mobilization are compounded by less-than-adequate budget execution: in 2019, only 57 percent of the health budget was spent.

Resource flows are fragmented (see Figure 2). Households pay the service providers at hospitals and health centers out-of-pocket for consultations, medicines, tests, and hospitalization. Donor resources are channeled

Figure 2
Health Sector Financial Flows in Democratic Republic of Congo



Source: Ministry of Health: National Health Accounts Report 2021.

2 Government of the Democratic Republic of Congo. 2021. National Health Accounts Report 2021 (Comptes Nationaux de la Santé 2021). Kinshasa: Ministry of Health.

3 McIntyre and Meheus (2014) quoted in World Bank (2021) DRC Health Financing Reform for UHC: Fiscal Space Analysis. Note: US\$86 in 2012 terms.



to providers through development projects (off-budget) or through central and provincial government structures (on-budget direct transfer payments for service providers of health centers⁴ allocations). Government resources are transferred through multiple mechanisms both as financial flows (principally remunerations for health workers) and in-kind (including the provision of medicines). Private sector resources, nongovernmental resources, and a tiny portion of donor resources—collectively representing about 3 percent of total health expenditure—are transferred to public community-based insurance schemes (i.e., *mutuelles*), which in turn purchase health services from providers.

Public management of the health sector is decentralized in theory but remains highly centralized in practice. In theory, healthcare provision is the responsibility of the provinces. In practice, the management of resources for the sector remains almost entirely under the control of the central government. Health worker payments and other recurrent spending are made by the central government on behalf of the provinces. Large allocations are included in the annual budget for capital spending resources to be transferred to the provinces. In practice, most of these allocations are not

released (or when partially executed, they again reflect capital spending implemented by the central government on behalf of the provinces).

Mechanisms have been established for linking on-budget donor financing to specific service delivery results, but gaps remain in terms of operationalization. In 2016, the government established a program-based budget, linking health budget allocations to the strategic health plan. Monitoring exercises are undertaken to assess the delivery of the strategic plan based on this reporting framework. However, budget execution processes do not yet utilize the program-based structure, so it currently serves a reporting function only. The World Bank and European Union also support public corporations that purchase health services in about 3,000 health facilities. The public corporations agree on service cost, sign provider purchase contracts, and pay based on negotiated rates and performance criteria such as the number of patients treated for certain preventive services.

Discussions are ongoing to create a national health insurance scheme. The details of its implementation remain unclear, particularly whether it would subsidize the poorest in the informal sector. (In the formal sector, *mutuelles* cover the police, the army, and teachers, among others.) The government plans to create a National Health Solidarity Fund to purchase health services; yet, no institutional or financial feasibility study has been conducted to explore how to establish and manage the fund (e.g., health services to be offered, population to be covered—including mechanisms to exempt the poorest informal sector households).

4 Formations sanitaires (FOSA).

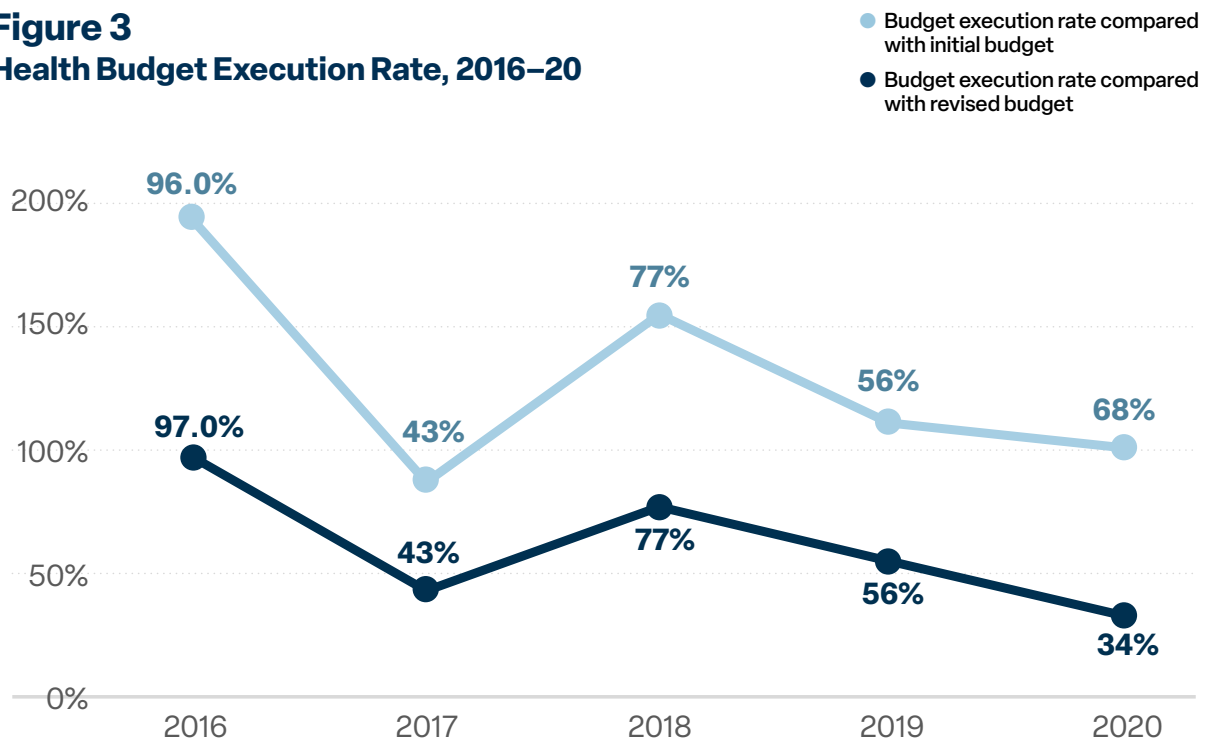


2.0 BUDGET EXECUTION IN HEALTH

The overall execution rate for the health budget is modest. Over 2016–20, the average health sector budget execution rate was 47.6 percent of initial budget allocations. The average execution rate was 68 percent

when compared with the revised budget (see Figure 3). This health budget execution rate was considerably lower than for overall government spending, which averaged 80 percent.

Figure 3
Health Budget Execution Rate, 2016–20



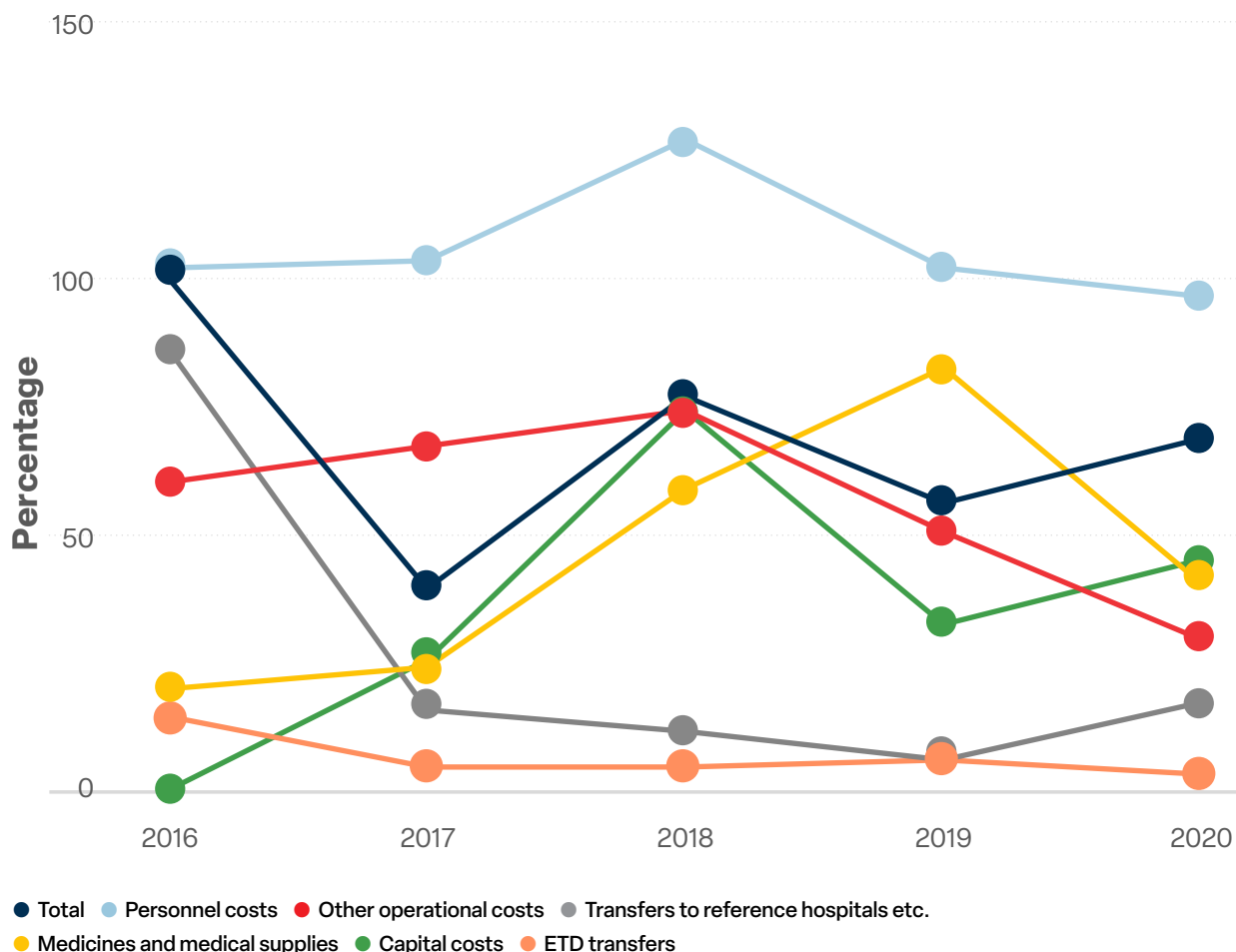
Source: World Bank 2025, based on General Directorate of Budget Policies and Programming: Budget Monitoring Statements 2016–2020 and Budget Execution Laws 2016–2020.

Execution rates differ substantially by budget category and by year. Health worker payments average a 103 percent execution rate. Execution rates for other spending categories decrease and vary significantly (see Figure 4). Notably the execution rates for transfers to provinces (consistently below 5 percent) and hospitals

(consistently below 20 percent) are the least funded. The execution rate for other operational spending varied significantly, dropping to just 30 percent in 2020. The overall health budget execution rate with health worker payments excluded averaged 48 percent (relative to the revised budget allocation).



Figure 4
Execution by Health Expenditure Type, 2016–20



Source: World Bank 2025, based on General Directorate of Budget Policies and Programming: Budget Monitoring Statements 2016-2020 and Budget Execution Laws 2016-2020.

Variability in execution rates is even more extreme when considering more disaggregated budget categories.

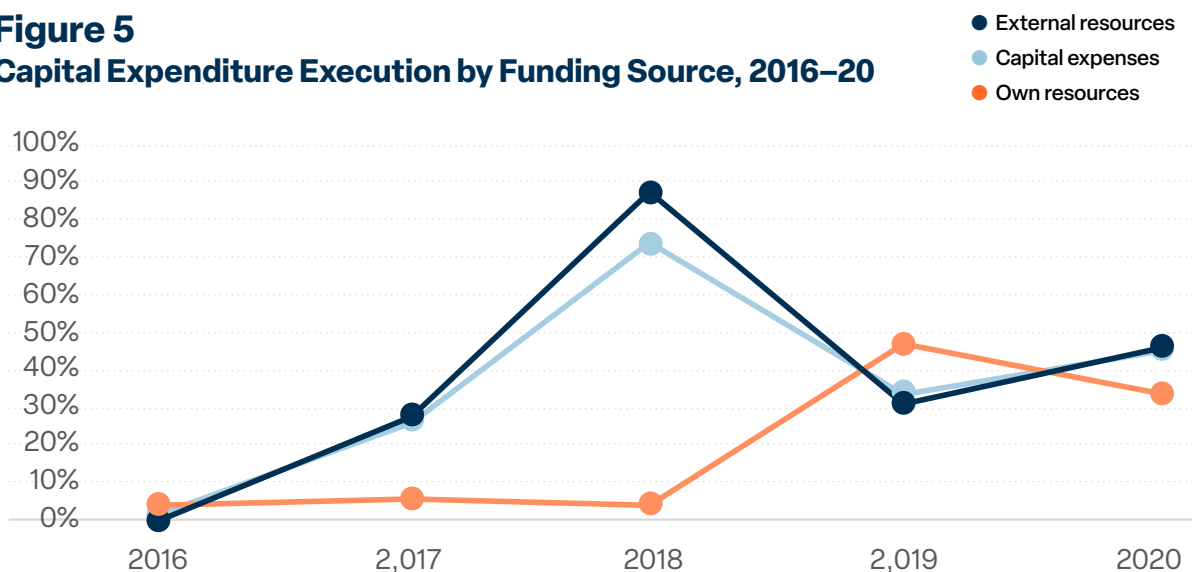
For example, in 2019, only six of the Ministry of Health’s over 50 divisions and programs achieved any execution of their budgets for running costs. The Office of the Minister of Health, however, over-executed its budget with a rate of 205 percent. In the same year, the allocations for hospital running costs were not executed for a single hospital.

Capital spending is inadequately executed, with further variation if disaggregating between internal and external financing.

The average execution rate for internally financed capital spending was just 19 percent but a slightly higher 38 percent for externally financed capital spending. From 2016 to 2018, domestic capital spending was close to zero executed, with the execution rate improving modestly in 2019 and 2020 (see Figure 5).



Figure 5
Capital Expenditure Execution by Funding Source, 2016–20



Source: World Bank 2025, based on General Directorate of Budget Policies and Programming: Budget Monitoring Statements 2016-2020 and Budget Execution Laws 2016-2020.

Budget controls are largely bypassed. Many areas of actual spending are for activities that were not included in the voted budget, while the majority of activities actually planned for are not executed. For example, in 2019, US\$6.3 million was spent on purchasing vaccines and inputs for blood transfusions despite the lack of any budget allocation for this activity. Further, no retrospective exercise was undertaken to account for this spending in a revised budget.

A major part of the government health budget is externally financed, creating challenges for execution. Donor financing is included in the health budget in a non-exhaustive and, at times, inconsistent manner. The ineffective execution rate for external financing is explained by actual challenges in executing the resources and, given that most of the resources are executed outside of government systems, by the difficulty of accessing the data on execution. Donor execution varies and often differs from the government's own processes. Donor processes can be administratively heavy and beyond the available

capacity within the Ministry of Health to manage efficiently, leading to delays and under-execution.

The root causes of poor health sector budget execution that are external to the Ministry of Health include:

- **Over-estimation of budget revenue.** Revenue projections in the budget are based on political considerations rather than on realistic economic and social assumptions or historical resource mobilization performance. They tend to be systematically overestimated, leading to low execution rates.
- **Highly centralized budget execution processes.** All phases of the budget execution process remain managed by the Ministry of Budget and the Ministry of Finance. The Ministry of Health has no delegated authority to execute its own budget. This reform has been legislated for but not yet implemented.



- **Dominance of health worker payments in budget allocations.** Health worker payments are prioritized in budget execution processes. These payments make up 60 percent of total health budget spending and, excluding donor resources, an even higher percentage of domestic financing. The prioritization of these payments in the execution process reduces the ability to execute other categories of expenditure.

- **Disregard for budget management rules.** Some government institutions systematically spend beyond their budget allocations. This reduces the resources available for the execution of the health budget.

- **Cumbersome procurement and expenditure procedures.** The process of executing budget items is highly burdensome and time-consuming, incurring long delays in procurement processes. Most spending is executed by bypassing these controls, contributing to other challenges of execution composition and quality.

Root causes of poor health sector budget execution that are internal to the Ministry of Health include:

- **Inadequate programming of the priorities in the budget.** The misalignment between the health planning cycle and the budget calendar is a major factor. Strategic health plans are not timed to feed into the budget preparation processes and (given the non-implementation of the program budget reform) their financing estimations are not fully integrated with the actual format of the government budget. This issue is exacerbated by the lack of consideration

for aligning budget allocations to strategic priorities in response to requests. Budget allocations instead tend to be based on the previous year's allocations, with limited considerations of prior execution performance or changed priorities.

- **Budget credibility.** Costs for specific activities are inaccurately estimated, leading to challenges in execution as available resources differ from required resources.

- **Nonstandard budget execution procedures.** Given the challenges with executing spending through the standard budget procedures, most health spending is executed by bypassing these controls. The lack of control, however, means that such expenditure often does not align with programmed priorities and by using up the overall resources available for the sector, further reduces the possibility of executing originally planned activities.

- **Over-execution of the operating budget crowds out the operating expenses of other units.** Budget allocations for running costs are systematically over-executed, which results in most other departments within the ministry being unable to access their operational budgets.

- **Narrow health budget execution processes.** A narrow group oversees the resource execution processes, with minimal input from other health sector stakeholders. Budget allocations and resource execution processes are not well communicated to the impacted departments. Health sector stakeholders have minimal engagement in the execution of the health sector's budget.



3.0 PUBLIC FINANCIAL MANAGEMENT CONTROLS FOR HEALTH SPENDING

Health expenditures are subject to both ex-ante and ex-post controls. At a general level, ex-ante controls are performed by the government, including the Budget Control Directorate (Ministry of Budget), the Payment Authorization and Treasury Directorate (Ministry of Finance), and the Central Bank. These controls aim to ensure the legality, compliance, regularity, and timeliness of the expenditure. Ex-post control is carried out by the General Inspectorate of Finance, the Court of Auditors, and the Parliament. It takes place

after the expenditure has been executed and is intended to ensure that the expenditure is genuine, legal, and consistent.

Specific controls vary for different types of health spending. Table 1 describes the main controls for each category of health spending and discusses their adequacy in practice. It also uses the example of the 2020 budget to show the proportion of spending for each category and the number of transactions executed in that year.

Table 1: Health Sector Expenditure Controls

| Control Type | Total Spending (2020, %) | Control Description | Adequacy of Control |
|---------------------------|--------------------------|---|---|
| Wages and salaries | 69.6% | <ul style="list-style-type: none"> Personnel monitoring in the quarterly payroll report by the Ministry of Health (MoH). Compliance verification of the payroll directorate's database with that of the civil service. <p>(12 transactions involved)</p> | <p>This control's objective is to identify fictitious workforce personnel, integrate omissions, and adjust salary levels in line with grade changes. The control is inadequate. however.</p> <p>The objectives cannot be achieved given the lack of interface between the civil service and budget software. It does not allow for real time assessments.</p> |

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Table 1: Health Sector Expenditure Controls

| Control Type | Total Spending (2020, %) | Control Description | Adequacy of Control |
|--|--------------------------|---|---|
| Bulk purchase of drugs and medical supplies | 0.8% | <ul style="list-style-type: none"> ■ Procurement level control: specification verification, supplier certification, international ordering, and delivery. ■ Expenditure commitment control. ■ Verification of services rendered. ■ Control of appropriations availability before commitment, control of actual payment amount required, control at payment authorization level, and checking cash availability for payment. <p>(3 transactions involved)</p> | This process involves a fairly large number of checks, which lengthens the time and can lead to delays in essential drug provision to patients. |
| Health facility purchasing of drug and medical supplies | 0.2% | <p>At the health facility level, oversight is carried out at the:</p> <ul style="list-style-type: none"> ■ Health zone level to monitor compliance with quantity and type of products ordered. ■ Provincial division level to check costs before placing orders. <p>Following oversight, hospitals proceed with order and payment.</p> | Drug procurement controls at the health facility level are light. The facilities are required to obtain supplies from approved suppliers in their geographical area. However, lighter control does not guarantee medicine availability, as the approved suppliers are subject to lengthy national-level procedures. |

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Table 1: Health Sector Expenditure Controls

| Control Type | Total Spending (2020, %) | Control Description | Adequacy of Control |
|---|--------------------------|---|---|
| Non-wage operating costs (other than bulk procurement) | 2.6% | <p>The control level varies depending on the expenditure execution procedure. For the exceptional process: checking that a budget line exists and that an amount is entered for post-implementation adjustment. For the normal public expenditure procedure, several levels of control exist, namely:</p> <ul style="list-style-type: none"> ■ Appropriations submanager oversight: verifies procurement procedure compliance, appropriations availability, existence of all supporting documents, and expenditure veracity. ■ Budget controller level: reviews all controls already carried out by the submanagers before affixing a stamp of approval. ■ Ministry of Budget reviews all controls by the submanagers and the budget controller before committing the expenditure. ■ At the settlement level, the same checks are carried out before the file is forwarded for payment authorization. ■ Finally, for payment authorization and actual payment, the same controls are repeated. In addition, payment is subject to other controls, such as cash availability and priority to be given to said expenditure. <p>(48 transactions involved)</p> | <p>The multiplicity of controls that are part of the normal procedure is not aligned with the objectives of improving health expenditure levels and ensuring healthcare establishment functioning. Instead, the numerous transactions become an incentive to use emergency procedures that result in significant extrabudgetary expenditures.</p> |

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Table 1: Health Sector Expenditure Controls

| Control Type | Total Spending (2020, %) | Control Description | Adequacy of Control |
|-----------------------------|--------------------------|---|--|
| Capital Expenditures | 26.7% | <p>Capital expenditure controls depend on the funding source and the nature of the expenditure. For expenditures financed from internal resources, national procurement rules are applied with various levels of control, such as:</p> <ul style="list-style-type: none"> ■ Procurement procedure oversight by the Ministry of Health and the Ministry of Budget. ■ The expenditure procedure itself with repetition of the various phases of commitment, validation, payment authorization, and payment. <p>Regarding external financing, requesting a procurement procedure “no objection” involves an additional level of control, which can lead to a long delay in execution.</p> <p>(13 transactions involved)</p> | The cumbersome procurement procedure involving different levels of control and intervention by several actors from different ministries makes it difficult to achieve efficient execution. |

Source: World Bank 2025, based on stakeholder discussions with the Ministry of Health and the Ministry of the Budget and data from the computerized expenditure chain system.

Payment arrears are large but not monitored.

As of January 2021, Ministry of Health arrears for the 2020 budget were estimated at US\$181 million. Budget management rules and procedures mandate that payment arrears recorded at the end of a fiscal year be recommitted in the following fiscal year for payment on a priority basis. This does not always happen, and many commitments appear not to ever be paid. Currently, the Ministry of Health lacks oversight, and the Ministry of Health and the Ministry of Budget do not have a joint mechanism to monitor incomplete expenditures and avoid accumulation of payment arrears.

The delays and incomplete payments to government suppliers are reflected in higher prices and challenges in securing timely procurement.

Suppliers factor in their prices the risk of nonpayment and the costs of receiving late payments. Discussions with Ministry of Health officials suggest the premium can be as much as 50-70 percent compared to what a similar service would cost for the private sector. When there is a considerable stock of payment arrears, especially for drugs, the government waits to clear them before placing additional orders, since the sector is dominated by the same actors. This can impact drug and medical equipment availability.



Procedures expedited for COVID-19 were well intentioned but challenging. The government expedited some expenditures to support an urgent response to and curb the spread of COVID-19. Expedited procedures entailed simplified procurement procedures, particularly for certain categories of expenditure. There were challenges in

managing pandemic-related expenditures, including the use of unregulated emergency procedures for disbursing COVID-19 response funds, instances of over-billing for goods and services, the involvement of unauthorized individuals in handling funds, and an insufficient justification of expenses by these individuals (see Table 2).

Table 2: Changes in Expenditure Controls during COVID-19

| Expenditure | Change of Control for Each Type of Control | Change in Control Period |
|---|---|--|
| Wages and salaries | No change and in control for salaries | No change |
| Bulk purchase of drugs and medical supplies | Procedures streamlined and purchases made using direct contracting procedures | No changes in timelines for such procedures |
| Purchase of drugs and medical supplies from health facilities | No change | No change |
| Non-wage operating costs (other than bulk procurement) | Certain procurement expenditures made without requiring the budgetary controller's prior approval | Control period became zero days |
| Capital expenditures | Some fixed assets completed without the use of procurement controls or procedures | Turnaround time reduced by two months |
| Transfers to different levels of government when resources used to finance health expenditures | Resources made available directly to provincial governors without specifying the types of expenditures to be financed or the sectors to be financed | Transfer done in one week as compared to usual three months |
| Payments by purchasing agency to health facilities for their services | No change in controls | Payment delays lengthened because travel restrictions led to a delay in controls |

Source: World Bank 2025.



4.0 GOOD PRACTICES AND BOTTLENECKS

Execution of the health budget has been highly problematic over the period of this case study’s analysis. While health worker payments are well executed (albeit often over-executed), execution rates are much more volatile across all other areas of spending. There is often a limited link between what is spent and what was originally planned in the budget.

The government has made substantial effort to improve budget execution processes, with some foundations now in place. Yet, bottlenecks, including in the implementation of these good practices, remain the dominant feature of the system. These bottlenecks and good practices are set out in Table 3.

Table 3: Summary of Budget Execution Good Practices and Bottlenecks in Democratic Republic of Congo

| Issue | Explanation |
|---|--|
| Good Practices | |
| <p>The Department of Administration and Finance has been established within the Ministry of Health, such that the Ministry of Health will take on increasing responsibility for the execution of its own budget.</p> | <p>The centralized management of the health budget by the Ministry of Budget and the Ministry of Finance imposes additional execution challenges and makes it harder to ensure actual spending is based on the sector’s own priorities. The 2011 Public Finance Reform requires this management to be decentralized to the sectoral level. While this reform has not yet been implemented, the Ministry of Health, in collaboration with the Ministry of Budget and the Ministry Finance, has made progress in establishing and operationalizing the necessary unit for managing the health sector budget.</p> |
| <p>A tripartite Health-Budget-Finance Committee has been established to monitor budget execution.</p> | <p>In the interim of the Ministry of Health becoming responsible for executing its own budget, an inter-ministerial committee has been established to bring together the main actors responsible for health budget execution. This committee periodically analyzes the execution situation in relation to forecasts and, if necessary, proposes and monitors urgent actions for improvement. This committee still needs to be made fully operational.</p> |

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**Table 3: Summary of Budget Execution Good Practices and Bottlenecks in Democratic Republic of Congo**

| Issue | Explanation |
|---|--|
| <p>Program budgets have been introduced to improve allocative efficiency by directing resources to defined priorities.</p> | <p>The Ministry of Health has increasingly prepared budget allocations and reported budget execution using a program-based format since this reform was included in the 2011 Public Finance Law. Although execution processes do not yet utilise this format, the reporting does increase the transparency of how execution challenges relate to the sector’s priorities.</p> |
| <p>Bottlenecks (Central Government-level)</p> | |
| <p>Unrealistic revenue forecasts</p> | <p>Revenue forecasts are systematically over-estimated for political reasons. This causes both under-execution of the budget and leads to inconsistencies in how available resources are prioritized given the extent of the gap between the planned and actual financing available.</p> |
| <p>Highly centralized budget execution processes</p> | <p>Budget execution processes for the health sector are almost entirely managed by the Ministries of Finance and Budget. The 2010 Public Finance Law set out the process for this to be decentralized to the control of the Ministry of Health, but this reform has not yet been implemented. This centralization makes it harder for the health sector to ensure budget allocations and their in-year execution link as closely as possible to its strategic priorities. It also reduces the sector’s accountability for delivery of its own strategic targets.</p> |
| <p>Non-respect of budget management rules</p> | <p>Certain institutions and departments systematically over-execute their budget allocations by avoiding the proper controls. This makes it even more difficult for other institutions to execute their own budgets.</p> |
| <p>Public procurement system inefficiencies</p> | <p>A public procurement system analysis conducted in 2018-2022 with World Bank support highlighted the inefficiencies in the system which need to be addressed. These actions are required to reduce procurement delays and should take into account the specific characteristics of the health sector.</p> |

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Table 3: Summary of Budget Execution Good Practices and Bottlenecks in Democratic Republic of Congo

| Issue | Explanation |
|--|---|
| <p>Cumbersome and fragmented expenditure chain</p> | <p>There are excessive controls on spending which are disproportionately applied relative to transaction sizes. In practice most health spending simply avoids going through these controls. It would be more effective to have a streamlined system of controls which is less burdensome and hence more regularly utilized.</p> |
| <p>Bottlenecks (Ministry of Health-level)</p> | |
| <p>Lack of integration between strategic planning processes and actual budget allocations</p> | <p>Sector planning processes do not directly feed into budget preparation exercises. In-year processes determining actual execution also make limited or no reference to strategic priorities set out in longer term planning processes.</p> |
| <p>Weak estimation of costs</p> | <p>Many costs are now well estimated leading to inaccurate budget allocations and consequent challenges with execution.</p> |
| <p>Opaque or non-inclusive health budget preparation and execution processes</p> | <p>There is also a lack of transparency in budget preparation processes from the perspective of implementing departments and agencies, alongside limited communication on the amounts allocated and how structures should make spending requests in a timely and accurate manner.</p> |
| <p>Frequent recourse to emergency execution procedures</p> | <p>Most spending within the health sector bypasses the normal controls. Such expenditure often does not align with programmed priorities and makes the execution of planned activities more difficult.</p> |
| <p>Non-systematic tracking of external financing inputs</p> | <p>A large proportion of the government's health sector budget is based on assumptions of external financing amounts. Most of this external financing does not utilize government execution processes making reporting on its execution time-consuming and problematic. Where data cannot be collected, the execution rate is shown as zero even if funds may have been disbursed. This distorts overall reporting on the execution of the health budget.</p> |



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