HF & PHC WEBINARS

Financial autonomy of health facilities : arguments, constraints and courses of action

GLOBAL FINANCING FACILITY

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WEBINARS

HEALTH FINANCING & PRIMARY HEALTH CARE

From theory to practice

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Speakers :

HF & PHC WEBINARS

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Towards a typology of financial autonomy of PHC facilities in LMICs

Prof. Sophie Witter, Queen Margaret University, Edinburgh & ReBUILD for Resilience research consortium

December 4th 2024

World Health Organization

Queen Margaret University
INSTITUTE FOR GLOBAL HEALTH AND DEVELOPMENT

ReBUILD FOR RESILIENCE

What is provider autonomy?

- Refers to the overall ability of health providers to exert influence and control over the delivery of services.

- Essentially represents a transfer of decision-making rights to facility managers.

- Can have different dimensions, e.g.:
  - human resource management (e.g. decisions over personnel, staffing mix, compensation);
  - facility management (e.g. decisions over infrastructure and equipment);
  - clinical management (decisions over patient care);
  - **financial management** (e.g. decisions over allocating and spending funds)

  These dimensions are often inter-related

Unpacking financial autonomy

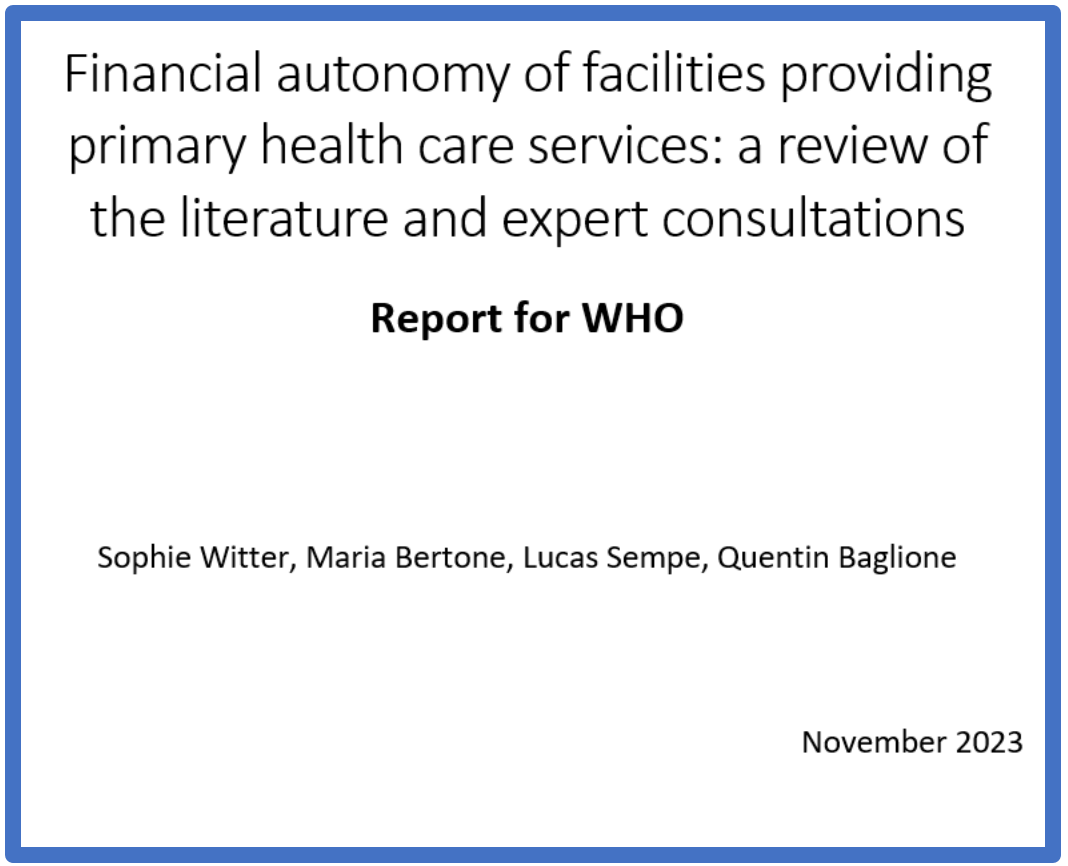
- Financial autonomy can be defined as “level of control and influence that health facility managers have to mobilise, allocate and spend financial resources” (Barasa et al. 2022)
- Decision rights across budget cycle
- Autonomy is not a dichotomy but rather a spectrum – the interest is on the *level* of autonomy in the various decision rights, adapted to context

Why does this topic matter

It's not a new topic but continues to be a challenge and is highly relevant for:

- **Strategic purchasing reforms:**
  - for providers to achieve efficiency gains and improve performance, they need a certain level of autonomy
- **Provider payment reforms:** specific payment methods assume/require a certain degree of financial autonomy to respond to incentives set by the payment methods
- **RBF/PBF:** provider autonomy is one of the premises
- **Financing facilities directly:** facility autonomy is one of the three key principles
- **Public financial management (PFM) reforms:** PFM reforms might trigger or inhibit facility autonomy
- **Decentralization reforms:** may lead to increased or decreased level of provider autonomy

COVID-19 has also put the spotlight on the importance of financial autonomy for service provision



- Scoping literature review (n=91)
- Extraction from HFPM data (n=25 countries)
- Expert interviews (n=12)
- Team's own insights
- Revised after discussions with PFM and HF experts at Montreux

Rationale for this work

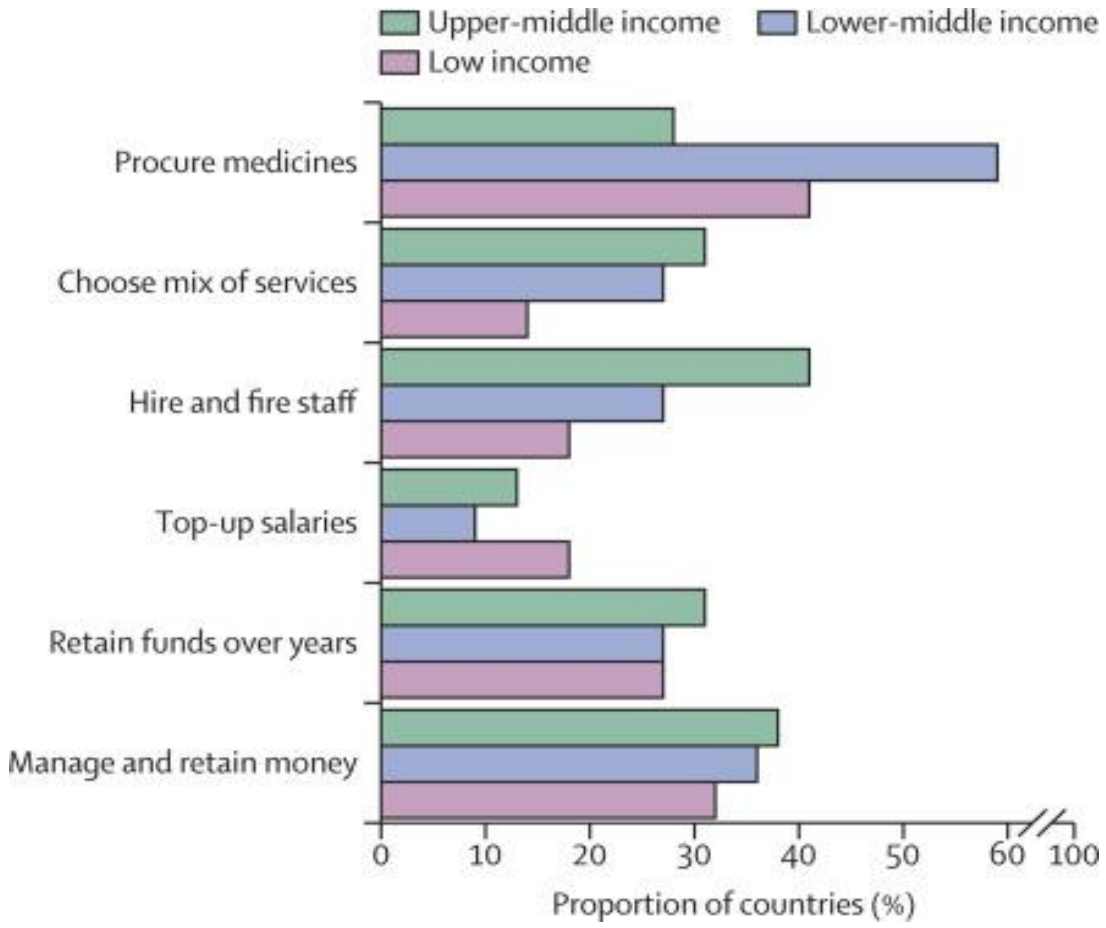
- Relatively little unpacking of financial autonomy of primary care providers

Key study questions

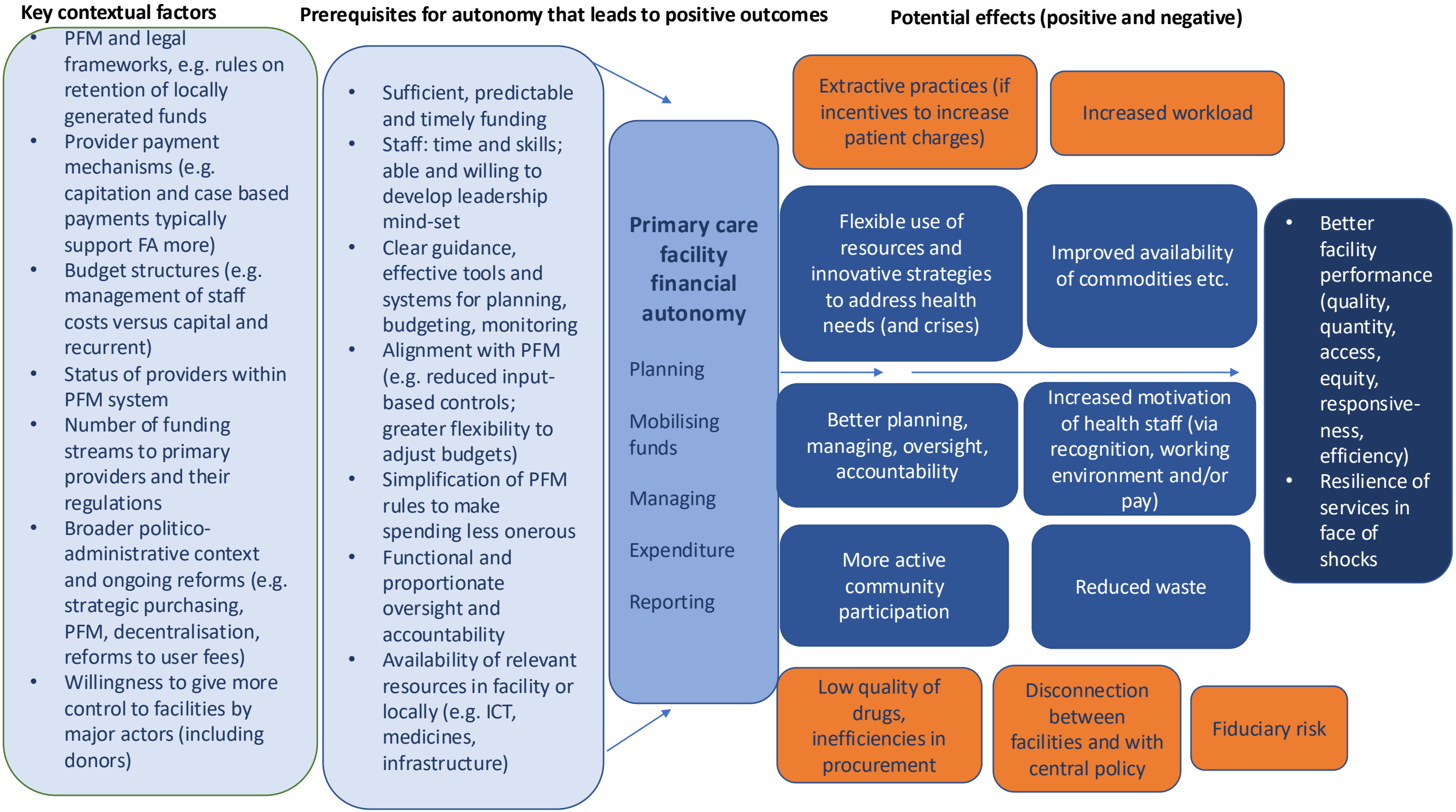
- How is FA conceptualised and what kinds of reforms have triggered changes in it?
- How much FA do primary providers have and over what?
- What are the key design and implementation issues for financial autonomy?
- What are (positive and negative) impacts of financial autonomy for primary care providers?
- What are the key (pre-)requirements for financial autonomy? What factors affect financial autonomy?
- What lessons should we draw for moving towards an adequate level of financial autonomy for primary providers?

How much autonomy do primary providers have?

- Varies by area, but low autonomy in general, including for finance (c. 1/3 in general can retain and manage funds)
- Somewhat of gradient by economic level, but not large differences



Source: Hanson et al. 2022


Key contextual factors
PFM and legal frameworks, e.g. rules on retention of locally generated funds
Provider payment mechanisms (e.g. capitation and case based payments typically support FA more)
Budget structures (e.g. management of staff costs versus capital and recurrent)
Status of providers within PFM system
Number of funding streams to primary providers and their regulations
Broader politico-administrative context and ongoing reforms (e.g. strategic purchasing, PFM, decentralisation, reforms to user fees)
Willingness to give more control to facilities by major actors (including donors)
Prerequisites for autonomy that leads to positive outcomes
Sufficient, predictable and timely funding
Staff: time and skills; able and willing to develop leadership mind-set
Clear guidance, effective tools and systems for planning, budgeting, monitoring
Alignment with PFM (e.g. reduced input-based controls; greater flexibility to adjust budgets)
Simplification of PFM rules to make spending less onerous
Functional and proportionate oversight and accountability
Availability of relevant resources in facility or locally (e.g. ICT, medicines, infrastructure)
Primary care facility financial autonomy
Planning
Mobilising funds
Managing
Expenditure
Reporting
Potential effects (positive and negative)
Extractive practices (if incentives to increase patient charges)
Increased workload
Flexible use of resources and innovative strategies to address health needs (and crises)
Improved availability of commodities etc.
Better planning, managing, oversight, accountability
Increased motivation of health staff (via recognition, working environment and/or pay)
More active community participation
Reduced waste
Low quality of drugs, inefficiencies in procurement
Disconnection between facilities and with central policy
Fiduciary risk
Better facility performance (quality, quantity, access, equity, responsive-ness, efficiency)
Resilience of services in face of shocks

Budget cycle	Low financial autonomy scenario	Medium financial autonomy scenario	High financial autonomy scenario
Mobilising funds	Funds are fixed externally; no ability to mobilise additional funds at facility level; funds remitted to Treasury or district/higher level. All funds spent within financial year	Most funds are fixed; some small (marginal) additional fund mobilisation is permitted and retained at facility level, with rest remitted to higher levels. One part of revenues can be retained (e.g. use of user fee or PBF income) across years	Able to raise funds independently from multiple sources, as available, without restrictions. All funds raised are retained at facility level. All funds can be retained across years, if unspent
Planning	Budgets are allocated from above with no scope for facilities to influence them	Facilities make inputs into budget process but can only influence the final budget in limited ways	Facilities structure own budgets according to their identified activities and needs
Management, including reallocation	Budgets are fixed (often by line item) and changes across them are very cumbersome and limited. Most of expenditure is ring-fenced. Where multiple revenue sources exist, there are strict rules about how they can be used	Some in-year changes in budget are possible, with higher authorisation. There is some flexibility around deployment of different revenue streams according to facility needs	Facilities can shift funds across budget lines within clear and agreed parameters, drawing flexibly from the different funding streams that they can access
Expenditure	Most expenditure is made at higher levels (on behalf of the facilities), with inputs provided in kind. Facilities do not need or have bank accounts	Facilities have access to limited funds to use for small costs (often minor operational costs, such as cleaning and maintenance). They may have bank accounts but can also operate through petty cash	Facilities can actively manage their major expenditure items, including for staffing, medicines and supplies and operational costs. They all have bank accounts
Reporting	Facilities have no financial reporting requirements as they are not recognised within the PFM system	Facilities report on expenditure via higher level (such as districts) for funds released by them to the facilities	Facilities are spending units, accounting within the PFM system for their expenditure

Financial autonomy typology, by budget cycle

- Note that these are descriptive, more than normative; the context is critical
- Low FA is however generally undesirable (aim for medium at least)

Public financial management as enabler of health facility autonomy

Danielle Serebro
Programme Manager: Public Finance and Service Delivery

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The Collaborative Africa Budget Reform Initiative (CABRI)

An intergovernmental organisation providing peer-learning and capability building for African finance and sector ministries

CABRI Policy Dialogue

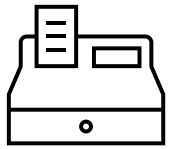
PFM as enabler of greater health facility autonomy

27-29 August, 2024

Lessons from Policy Dialogue: PFM as enabler of autonomy

Finance ministries lack insight into the benefits of autonomy. Health officials are unclear how PFM can be a help or hindrance.

Ministries of finance are open to increasing facility autonomy, but will require a bit more convincing.



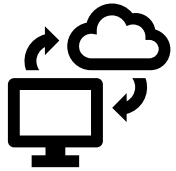
Selling this reform to the finance ministry requires illustrating that facility managers can manage their resources.

Facility managers' financial responsibilities can increase gradually through carefully sequencing the costs under their control.

Lessons from Policy Dialogue: PFM as enabler of autonomy

Spending controls cannot be conflated with accountability.

How facility financing is approached should be driven by an understanding of problems to be solved.



There is a long way to go to understand how digital tools can support health facility autonomy.

Country experience :

Uganda

Richard Kabagambe

OUTLINE OF THE PRESENTATION

- Brief Purpose of PFM reforms in Uganda
- Some of the reforms that have helped the implementation of financial autonomy in Uganda
- Key enablers for financial autonomy
- Reviewing the Autonomy across the budget cycle
- Key Take Away (lessons)

BRIEF OVERVIEW OF PFM REFORMS IN UGANDA

- Government of Uganda rolled out Public Finance Management (PFM) amendments in 2015 to streamline government practices and support decentralization program.
- These reforms aimed at improving resource allocation, adequacy, equity & aggregate control, prioritization, accountability and efficiency.
- Key feature of the reform: strengthened inter-governmental fiscal transfers with direct transfer of funds to the facilities on their bank accounts.

SOME OF THE BROADER PFM REFORMS THAT MATTERED FOR THE FINANCIAL AUTONOMY OF HEALTH FACILITIES IN UGANDA

- Fiscal Decentralization reform in Local Governments to strengthen the process of decentralization in Uganda through increasing **Local Governments**' autonomy
- IFMS (2004) - as a commitment control system to ensure spending is within the approved budgets and work plans
- Treasury Single Account (TSA-2013) for easy monitoring of cash management and enhance transparency, budget execution and absorption of resources
- Program Based Budgeting (FY2017/18) for improving efficiency, effectiveness and equity of government expenditure.

Some of these reforms include IFMS, TSA,PBS,IPPS,P4R,RBF, DFF),etc

Autonomy across the budget cycle

	Traits	Scenario
Mobilizing funds	Operational funds are fixed. No user fees. Result Based Financing (RBF) funds are tagged to performance measurements. There is ability to mobilize additional funds from donors and NGOs. Funds are spent within a financial year.	Middle
Planning	Indicative planning figures (IPFS) are allocated to HF from above based on available resource envelope. Facilities make inputs into the budget process by presenting their priorities.	Middle
Management including reallocation	There is some flexibility around deployment of funds according to facility needs. There is some flexibility on expenditure line items after authority is thought to change workplans with justification	Middle
Expenditure	Salaries and medicines are handled at district level and National Medical Stores. HF manage minor budgets for operational costs for the public money (= operational funds + RBF) that they received on their bank accounts.	High
Reporting	Facilities are required to do financial reporting/ accountability based on workplans on quarterly basis (3 months) through IFMS and Manual reporting which ever is applicable.	Middle

HEALTH CENTRE PERSPECTIVE ON THE FINANCIAL AUTONOMY AND INSTITUTIONALISATION OF RBF

- Timely release of funds leading to more clients
- Improved service quality
- Improve planning and budgeting
- improved infrastructure and mantainance

"I have seen that the infrastructure has been stepped up and its, and buildings at the health facilities."

- Improved capacity of health management committee in financial management
- More regular and timely referrals
- Better reporting and data management
- Strengthened financial planning and management

"Health facility in-charges have learnt and now understand how to plan and account for money. Previously this capacity was weak."

KEY ENABLERS-UGANDA CASE

- **Political interest** at both Central and Local Governments to relinquish control over resources
- Government and **donor support** to the decentralization reform in Uganda since 1992
- PFM (2015) reforms supported by flexible **legal frameworks that support operational systems**
- Both **ownership and alignment** through bottom-up planning and budgeting for Local Govts and lower health facilities (during the budget process every Financial Year)
- **Frequent trainings** to strengthen the management capabilities of the HF Management Committees

KEY TAKE AWAYS (LESSONS)

- **Financial autonomy may not necessarily result into improved performance.**
- It is critical that local government in decentralized settings are supported to develop PFM capacity. This includes the translation of overarching PFM laws into operational systems.
- Periodic audits of PFM processes to establish and resolve implementation bottlenecks that impinge on public health facility autonomy should be part of efforts to address health facility autonomy issues.
- Lastly, a part from the legal and structural issues, public health facility financing is influenced by the complex interactions of multiple factors that include ***sense-making, political interests, health facility capacity, PFM bottlenecks and broader operational autonomy.***

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