"COUNTRY EXPERIENCE OF INCREASING FACILITY AUTONOMY"

IMPLEMENTING DIRECT FACILITY FINANCING IN UGANDA

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OVERVIEW OF THE PRESENTATION

- Context of Decentralization of Health Care Services
- Brief Overview of PFM Reforms in Uganda
- PHC Allocation Formula
- Why DFF Reform was introduced?.
- Health Facility Financial Management Mechanisms
- Achievements of DFF
- Results Based Financing (RBF)
- KEY TAKEAWAYS

CONTEXT OF DECENTRALISATION IN UGANDA

Decentralization in Uganda was adopted in1990 and its main objectives were:

- The transfer of **Political Power to the LGs from the Centre**
- Bringing **Political and Administrative control** over services at the point where they are actually delivered
- Improving **Accountability and Responsibility**
- Improving the **Capacity of Local** authorities to plan, finance and manage the delivery of services to citizens.

Health care services in Uganda are decentralized with hierarchical referral structure from Village/community level to the national level. Service delivery is at grassroots while the Centre provides support supervision and policy direction

BRIEF OVERVIEW OF PFM REFORMS IN UGANDA

- Government of Uganda (GoU) rolled out Public Finance Management (PFM) reforms to streamline government practices and support decentralization program.
- These Reforms aimed at improving resource allocation, Adequacy, equity & aggregate control, prioritization, accountability and efficiency.
- Strengthened inter-governmental fiscal transfers (e.g. decentralization of the pay-roll system, streamlining of the grant allocation criteria for LGs
- Some of these reforms include; IFMS, TSA,PBS,IPPS,P4R,RBF, DFF),etc

PRIMARY HEALTH CARE GRANT RESOURCE ALLOCATION FORMULA

Applies to Conditional Grants namely Wage, NWR, Development and RBF

The allocations to Local Government (LG) facilities are based on allocation formulae with variables

- Population - 60%
- Infant Mortality Rate - 10%
- Poverty Headcount Rate - 20%
- Population in hard-to-reach - 10%

The budgeting process is bottom-up from Facility to LGs, MoFPED and Parliament. MoH provides guidelines and IPFs on an annual basis.

WHY THE DFF REFORM?.

The reform was spearheaded by MoFPED with support from MOH, and other line Ministries. The reform was meant to address challenges faced by health facilities namely:

- **Major delays** in many local governments taking an average of **2 months into the financial year** and intermittent in-year delays before facilities receive operational funds.
- **Limited ownership** of activities by the Health Facilities as all financial decisions were controlled by the respective local government.
- **Poor service delivery** to communities.

HEALTH FACILITIES FINANCIAL MANAGEMENT MECHANISMS

- The facility prepares an annual plan and budget with agreed upon costs within predetermined allocations. This is included as part of the Local Government Budget (**bottom-up planning &budgeting process).**
- Funds for every HF are disbursed quarterly by MOFPED directly to approved facility bank accounts as advised by MoH.
- The facilities' bank accounts are managed by the Facility in-charge & HUMC.
- Funds received must be spent by the facility in line with the guidelines issued by MoH
- Accountability is provided on quarterly basis.
- Quarterly financial and physical reports by the health facilities are tracked through the local government performance reports.
- Internal control reviews are done by the Internal Audit department of the respective local governments.
- Audits done by the Office of the Auditor General annually to enforce accountability.
- All unspent funds must be returned to MoFPED at the end of the financial year.

ACHIEVEMENTS OF THE DIRECT FACILITY FINANCING REFORM

- Direct facility financing has transformed the way in which health facilities receive, manage, and account for funds to deliver health services.
- Health facilities operate more **equitably** and e**fficiently, improves accountability, and creates an environment in** which facilities are more likely to respond to financial incentives e.g. RBF

***Note*: Direct facility financing should not be considered a scheme or project but rather a set of attributes and actions that can help strengthen domestic health systems and support progress towards universal health coverage (UHC).**

OVERVIEW OF RBF IN UGANDA.

- Uganda Reproductive Maternal Child Services Improvement Project (URMCHIP) July 2017 – June 2021, supported by the World Bank loan, Global Financing Facility and Sida Grants in few HFs

- The RBF projects implemented in Uganda provided several lessons that guided the development of the National RBF Framework and Implementation Manual.
- Demonstrated that RBF can be implemented in both public and private facilities
- Currently RBF has been integrated or mainstreamed into PHC in 80% of the facilities

RBF'S IMPACT ON PHC AND ITS ENABLERS

- Increased client volumes
- Improved service quality
- Increased availability of essential medicines, equipment, and supplies
- Upgraded infrastructure
- Invigorated health workforce
- More regular and timely referrals
- Better reporting and data management
- Strengthened financial planning and management

"I have seen that the infrastructure has been stepped up and its, and buildings at the health facilities. All of that is because of the RBF funds."

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

RBF NEGATIVE CONSEQUENCES

- Falsification of evidence or manipulation of data to receive more funds
- Supplier induced demand of services that are remunerated
- Services that are not rewarded being neglected
- Spending shorter time on the patients or delegating to unqualified staff due to increased workload
- Irrational referral of costly patients to minimize expenses.

KEY TAKEAWAYS FROM THE IMPLEMENTATION OF DFF& RBF IN UGANDA

- DFF provides small but essential flexible resources which support integrated health care packages,
- DFF has also contributed to the strengthening the health system on long term operational constraints(skill gaps, rigidities etc)
- RBF significantly increased discretionary revenue, and Autonomy for health facilities,
- Facilities spend most of their RBF revenue on staff incentives, medicines and supplies, and infrastructure which are critical in health care.