POLICY DIALOGUE: PFM AS ENABLER OF GREATER HEALTH FACILITY AUTONOMY

SESSION 2: STATUS OF FACILITY AUTONOMY AND DIRECT FINANCING IN LMICS
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Status of Facility Autonomy in Burkina Faso, Philippines, Kenya, Pakistan, Uganda and Indonesia

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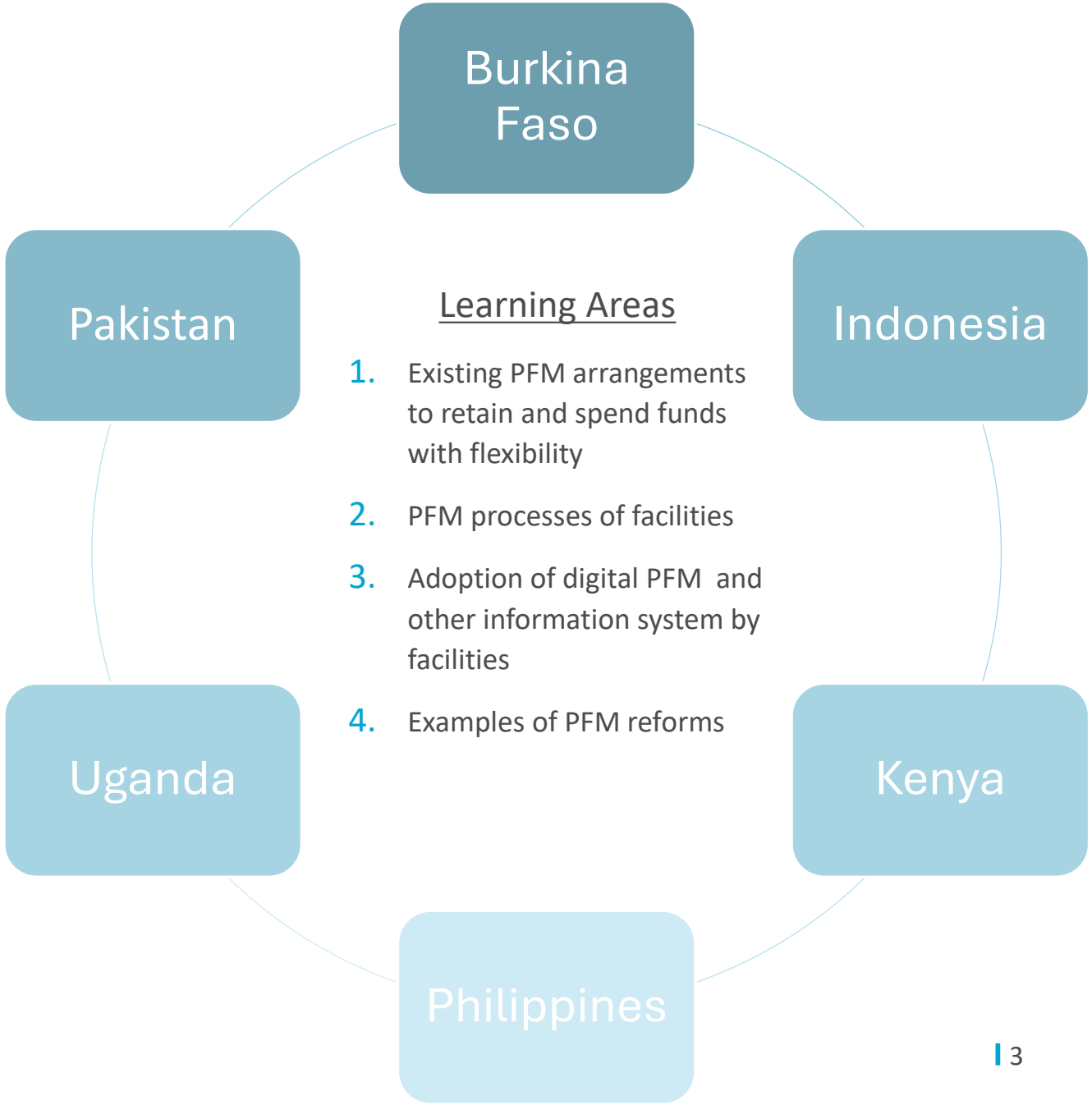
AGENDA

1. Background
2. Health Financing Country Snapshots
3. Resources received by Facilities
4. PFM Systems in Place
5. What Facilities Purchase
6. Key Messages

BACKGROUND

— **To inform the growing consensus towards ensuring that facilities need to be directly financed or receive and manage funds directly, we conducted this research to:**

1. Determine the current extent to which some health facilities retain and spend funds with flexibility;
2. Document the capacity of health facilities to budget for, use, and account for the funds they control;
3. Generate recommendations that will enable public facilities to receive, spend, and account for public funds.



HEALTH FINANCING COUNTRY SNAPSHOTS

- **GGHE-D:** 9.8%
- **Health Purchasers:** MOH Commune, Community mutuals, Employment-based health insurance, CNAMU, OOP

Burkina Faso

- **GGHE-D:** 8.5%
- **Health Purchasers:** DOH, Local Government Units, PhilHealth (National Health Insurance), PHI, OOP

Philippines

- **GGHE-D:** 9.3%
- **Health Purchasers:** MOH, 47 Counties, NHIF (National Health insurance), Donors, OOP

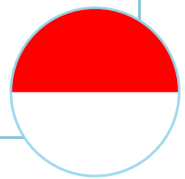
Kenya

- **GGHE-D:** 4.9%
- **Health Purchasers:** MOH, Subnational Government, Donors, PHI, OOP

Uganda

- **GGHE-D:** 12%
- **Health Purchasers:** MOH (4.3%), Subnational Government (22.8%), BPJSK (National Health Insurance) (23.1%), PHI (14.6%), OOP (32.1%)

Indonesia

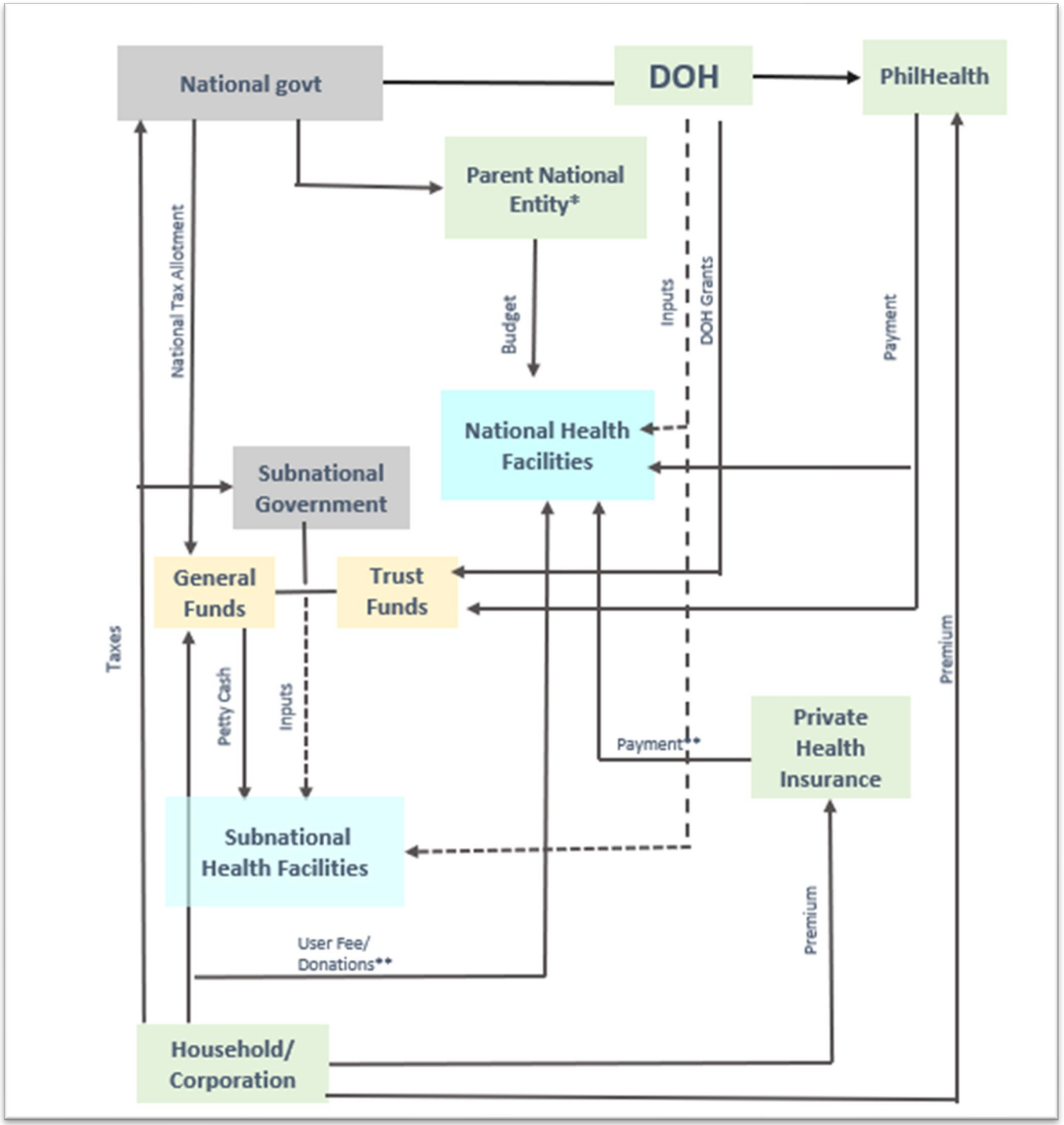


- **GGHE-D:** 4.6%
- **Health Purchasers:** MOH, Subnational Government, Sehat Sahulat Program (National Health insurance), OOP

Pakistan

PHILIPPINE FUND FLOW

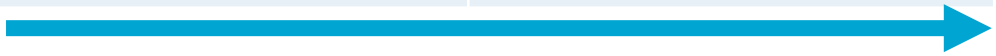
- Multiple purchasers and sources of funds and other resources for facilities
- Subnational government plays a role in receiving and executing funds for facilities within its purview
- Facilities had differing mechanisms and capacities to receive, retain and spend financial resources



TYPE OF RESOURCES RECEIVED BY THE FACILITIES

Table 1: Financial Resources Received by Facilities Directly

Country Examples	Primary Care and Lower-Level Facilities	National Hospitals
Philippines	Petty Cash	Budget from parent owner, PhilHealth, PHI, User Fees
Kenya	Financial Transfers (County), NHIF (variable), Grants	Financial Transfers (County), NHIF (variable), User Fees (variable)
Pakistan	PCMC Grant, User fees (90%)	HCMC Grants, Health Insurance Payments, Operational Budget
Burkina Faso	Salaries, Gratuite, PHI, OOP, External resources	Salaries, Gratuite, PHI, OOP, External resources, State Budget
Uganda	PHC NWR (HC II-IV), External Partner Funds	PHC NWR, Funds from External Partners, User fees, PHI
Indonesia	Global Budget, SHI, P4P (local government), User fees (BLUD only)	Global Budget, SHI, Donor funding, User fees

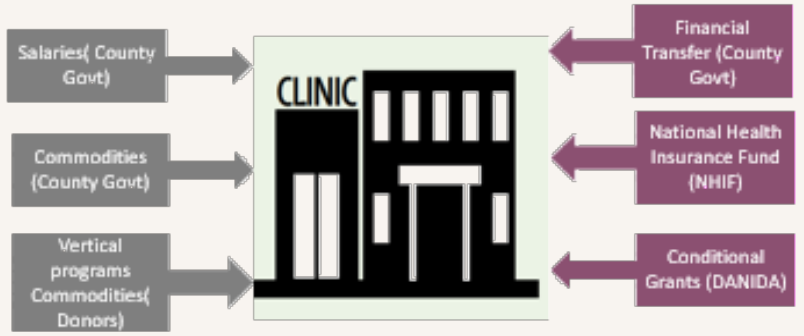


Increasing Level of Autonomy

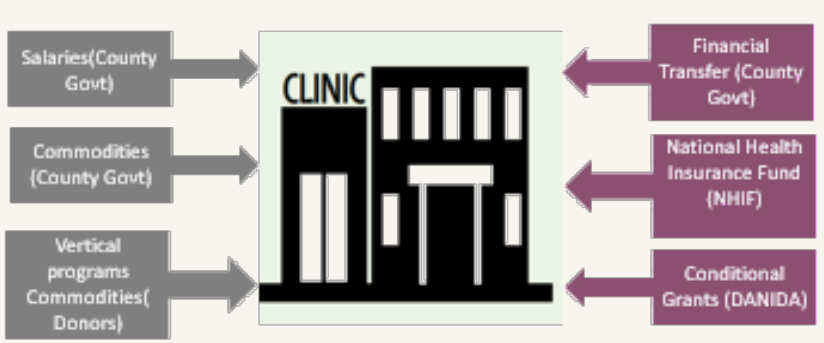
- **Public health service delivery organization is diverse in each country**
  - Different public owners (MOH, other national government entity, subnational government)
  - Differing standards of services
- **All facilities in each study country had a mechanism to directly receive monetary resources**
  - Different mechanism to transfer funds for each facility
  - Primary care and lower-level facilities generally receive smaller amount of monetary resources directly

RESOURCES RECEIVED BY KENYAN HEALTH FACILITIES

Funds → In-kind →



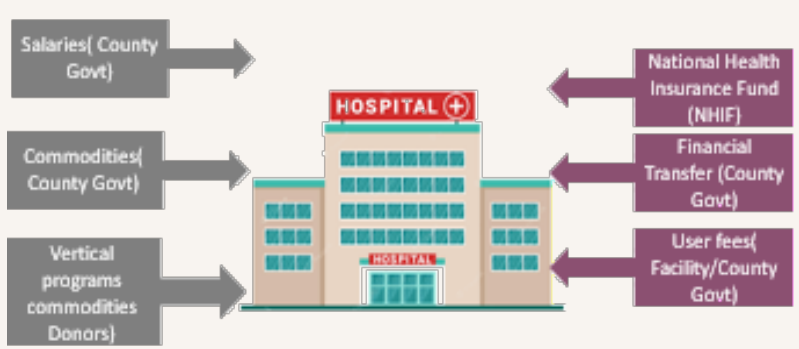
Dispensary



Health Center

Primary Care Facilities

Type of source	Can the facility retain these funds	Approx % of budget
Financial Transfer- County Government	Yes.	5%*
NHIF	Some Yes & Some No. New FIF law standardizes retention	60%
Conditional Grants (Donor- DANIDA)	Yes. Expenditure approved upon receipt	35%



Sub-County Hospital

County Referral Hospital

Hospitals

Type of source	Can the facility retain these funds	Approx % of budget
Financial Transfer- County Government	Yes.	10%*
NHIF**	Yes & No. New FIF Act standardizes funds retention	60%
User fees	Yes & No. New FIF Act standardizes funds retention	30%

Funds → In-kind

INDONESIAN BLUD AND NON-BLUD FACILITIES

Badan Layanan Umum Daerah (BLUD) facilities is defined as a regional government public service agency that is statutorily defined (UU No.28/2009) to fulfill certain administrative, financial, and substantive criteria

Puskesmas Tongas with Autonomy (BLUD)

Type of flow	Retained by Facility in its Accounts?	Roll-over to the next FY?	% of facility operational budget
Global budget (local govt)	Yes	No	Depends on the facility planning request. Payment system are at cost depending on request
SHI payments (NHI agency)	Yes	Yes	40%, where the Capitation fund will be accounted for by the BPJS and used for next month FY
User fees (households)	Yes	Yes	Depends on the facility regulation, roughly 60%
P4P (local govt)	Yes	No	The budget is using BOK for incentive performance, that is paid at cost

Puskesmas Klabang without Autonomy (Non-BLUD status)

Type of flow	Retained by Facility in its Accounts?	Roll-over the funds to the next FY?	Approx share of facility operational budget
Global budget (local govt)	Yes	No	Paid at cost based on activity
SHI payments (NHI agency)	Yes	No	Sent back to the DHO and accounted as local govt fund
User fees (households)	No	No	No authority to retain or manage the user fee. Sent back to the DHO
P4P (local govt)	Yes	No	Paid at cost based on activity and for HW' incentives

Funds → In-kind

PAKISTAN'S EXPERIENCE WITH THE PCMC GRANTS

- **Primary Care Management Committee (PCMC) -** committees are responsible for maintaining the efficacy of Primary Health Care and resource utilization including planning, resource generation, monitoring and improvement in service delivery.
- **PCMC Grants –** placed in a bank account with chairman and secretary of PCMC as signatories. These are used to pay for casual workers, emergency purchase of medicines, non-health supplies and facility maintenance. It has minimal accountability mechanisms in place.

Type of flow	Can the facility retain these funds in its accounts (or do they remit funds to a parent govt)?	Can the facility roll-over the funds to the next FY?	Approx share of facility operational budget
PCMC Grant	Yes	Yes	Depends on size and Coverage of the facility
User fee	Yes	Yes	Negligible

PFM SYSTEMS IN PLACE

Bank Account

- (National) Hospitals have bank accounts
- Lower-level facilities have bank accounts, but signatories are with subnational government

Presence in Chart of Accounts

- (National) Hospitals are present in the chart of accounts
- Lower-level facilities (primary care) are not in the chart of accounts

IFMIS

- Hospitals have access to IFMIS
- Lower-level facilities generally do not have access to IFMIS

Participation in Budgeting Processes

- (National) Hospitals have more autonomy in their budgeting and PFM processes
- Lower-level facilities are more dependent on subnational government

Certain emerging prerequisites must be met to ensure facilities can receive, manage, and be accountable for their funds. One requirement is having a bank account to receive payments. Another is having a code in the chart of accounts as one of the means to ensure authorization, which delegates rights, responsibilities, and accountability for public financing. In the meantime, having access to financial management information systems facilitates certain PFM processes, including execution and reporting.

UGANDA PFM SYSTEMS FOR FACILITIES

Facility type	Budgeting processes at the facility level for funds held by the facility.		
	Who approves spending against the budget? How often is this approval sought (e.g. each transaction, per quarter, per year)	**Who approves budget adjustments/virements?**	**Who are budget reports made to?**
HCII-HCIV	At **HC II**, the chairperson of HUMC approves the budget. At **HC III**, budgets are approved by the Chairperson of HUMC and by DHOs in some districts. At **HC IVs**, budget approval is done by the Medical Officer, the Chairperson of HUMC and the DHO	At **HC II** level, budget adjustments are approved by the *Subcounty accountant*. At **HC III** level, budget adjustments are approved by *HUMC* for public facilities and by the *Board of Governors* for PNFP facilities. At **HC IV** level, budget adjustments are approved by the Public Accounts Committee (PAC), DHO, CAO, and HUMC.	Reports are submitted to the DHO, CFO and CAO.
District Hospital	Budgets are approved by the DHO and HUMC and Board of Governors for PNFPs	Budget adjustments are approved by the PAC, DHO, CAO and hospital board.	District hospitals submit their budget reports to the DHO, CFOs and CAO.
RRH	Budgets are approved by the Hospital Director for public hospitals and the Board of Governors for PNFPs.	Budget adjustments are approved by the Hospital Director for the public and the Board of Governors for PNFPs.	Budget reports are made to Ministry of Finance Planning and Economic Development

STEPS OF EXECUTION OF EXPENDITURE AT FACILITY LEVEL IN BURKINA FASO

FACILITY FUNDS

STATE BUDGET

INTERGOVERNMENTAL TRANSFERS

★ CSPS/CM ★★ CMA ★★★ Regional/National hospital

WHAT FACILITIES PURCHASE

Table 2: The Role of Facilities In Purchasing Inputs With Retained Funds

	Primary Care and other Lower-Level Facilities	Nationally-Owned Hospitals
HRH	Generally, retained funds can be used to hire casual workers	Facility maintains payroll
Medicines	Generally, retained funds can be used for emergency purchases of medicines	Facility procures medicine whether through the market or through a central medical store
Operational Cost	Retained funds can be used to pay for utilities and minor repairs	Facility pays for operational cost
Infrastructure	None	Facility have more role in directly or working with other national agencies to contract out of infrastructure projects

Increasing Level of Autonomy

- **Generally, primary care and lower-level facilities had less autonomy in purchasing inputs including human resource, medicines, operational cost and infrastructure.**
- **Differing systems and policies in place in each country affected how each country purchased these inputs**
  - Some countries purchase medicines through a central medical store. Facilities are given a budget, but funds flow directly to these agencies

KEY MESSAGES

- **To be able to respond to purchasing signals, it is important to ensure that facilities are effectively and efficiently financed and resourced**
- **Systems to directly finance facilities already exist in the study countries. However:**
  - There is a need to strengthen these mechanisms apt to the country context
  - With differing understanding/language of some of these mechanisms, it may be important to build a clear taxonomy of these different mechanisms to be able to compare, measure, understand and eventually guide the reforms in these complex systems
- **Within countries, there are also differences in the maturity and nature of the autonomy in each level of the health system (eg national, subnational) and type of facilities (eg primary care, inpatient facilities)**
  - The focus on primary health care necessitates the need to improve facility financing systems apt for its context
  - It is important not to create systems that will not overburden these facilities (appropriate to type and amount of resources)
  - We must work within PFM systems to balance flexibility and accountability

Thank you!