Session 8: Perspectives of facility manager on financial management capacity and PFM bottlenecks

Sequencing of autonomy and financial capacity constraints and needs of facilities

CABRI policy dialogue: PFM as enabler of greater health facility autonomy

Sheila O'Dougherty

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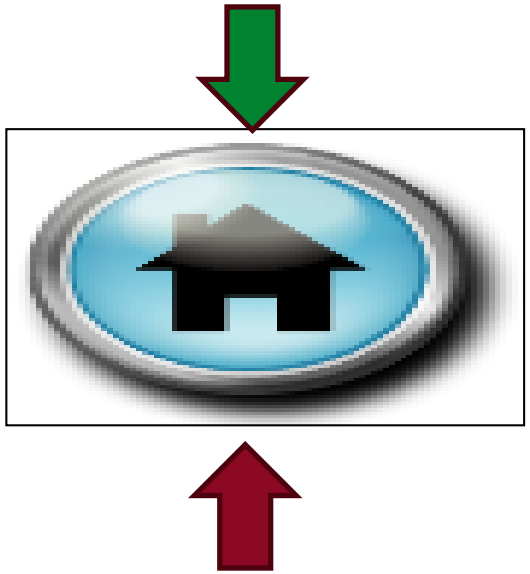
Changing perspective on health facility financial management including PHC centers

1) Strategic purchasing and output-based payment delegates rights and autonomy to health facilities



2) Bottom-up facility **financial management** and accountability with systems and rules like any small business entity

1. Driven by top-down or trickle-down health purchasing
   - Pooling and purchasing with some general revenue (not just private user fees at facilities)
2. Separate but closely related interventions for purchasing and bottom-up facility financial management
   - PFM supports service delivery

- Leads to facility autonomy AND accountability

Two sides of the same autonomy and accountability coin…

- Health purchasing/output-based payment
  - Leans towards health, health authority responsibility
  - Enables **facility autonomy** as it is required for facilities to plan, budget, and procure best mix of inputs to produce and deliver service outputs
- Facility level financial management
  - Leans towards PFM, finance authority responsibility
  - Enables **facility accountability** as improves management of both finances and service delivery

Impact of changing perspective on health facility financial management

- Increased focus on bottom-up facility view vs. top-down government view
  - Improve management vs. monitoring and tracking
- Aspects of facility financial management:
  - Relationship and sequencing purchasing/provider payment
  - Financial management (public/PFM or private) systems, rules and processes
  - Staffing
  - Capacity building and expectations

Relationship purchasing/provider payment

- Defined service outputs in national plans and budgets?
  - Facilities know exactly what service being paid to produce, enables management of service delivery
- Payment matched to these service outputs?
  - Facilities know what amount is paid for what service, output-based payment increases transparency and motivation
- Does fragmentation create issues?
  - Facilities see different funds flows/payment systems--creates confusion and conflicting or perverse incentives
  - Facilities must use different PFM systems and rules for different funds flows, increases facility administrative burden
- Aligning institutional structure, roles and relationships

Sequencing of purchasing/provider payment

- Dilemma:
  - On the one hand, global lessons learned from programs financing facilities directly are generally positive
  - On the other hand, probably not good PFM to throw entire health budget at health facilities and expect a good result
- How to segment and sequence the types of costs in output-based payment to facilities including PHC centers
  - Probably never include: capital over a threshold
  - Not include in first step: health professional salaries (note dynamic or issue of LMIC seeing civil servant salaries as separate program)
  - Maintain a balance of national and facility financing/ payment: drugs, possibly other clinical supplies
  - Focus of financing facilities directly: remaining operational costs. Follows 80/20 rule of number of transactions vs. amount of cost

Financial management (public/PFM or private)

Improving how PFM systems, rules, and processes hamper or support facility financial and service delivery management and enable facility autonomy and accountability:

- Are facilities involved in **planning and budget formation**? Are there different rules across programs or sources of funds?
- Does fragmentation creep into planning and budgeting including for national vertical health programs (e.g. MNCH, NCD, malaria, HIV, TB, other)?
- Can have both a facility level plan and budget and national health program plans.

Financial management (public/PFM or private)

- **Budget execution** including provider payment, spending guidelines
  - If facilities are paid directly, are there different budget execution or spending guidelines that fragment funds flows or payment systems?
  - If not paid directly, how do facilities have financial info to manage?
- Procurement processes, internal controls?
  - Transparency, better separate functions?
- Facility level accounting and reporting systems?
- Connection to country internal and external audit?

Example of Tanzania Facility Financial Accounting and Reporting System (FFARS)

- National implementation extending planning and budgeting (PlanRep) and FFARS to service provider level (health facilities, schools, villages)
- Cross-sectoral is game-changer for efficiency and management, local governments use one system that doesn't vary by sector
- Web-based PlanRep and FFARS also game changer as can aggregate across government levels and reduce admin costs
  - Three versions of FFARS: web-based, smart phone app, manual

Example of Tanzania Facility Financial Accounting and Reporting System (FFARS)

- Simple such that facility staff including nurses able to use, but some accountants hired to support a group of facilities
- Health facilities and schools quickly adapted and began using FFARS (99+% use) including for their own financial analysis and decisions
- Direct link to facility autonomy including bank account, country chart of accounts for visibility and transparency at facility level, and interoperable finance and health systems

PHC center financial management staffing

- Bit of a dilemma…but not that complicated
- Yes, need some health facility staff level of effort for financial management
  - But it is not separate from good health service delivery management, rather inherent in it
  - Administrative burden may increase but should assess all burden including health statistics, vertical programs
  - Counterfactual of PHC centers without autonomy or direct payment where the norm is often low utilization, efficiency, and poor staff motivation (desire to serve community)
- Practical middle ground can emerge that includes a role for existing facility staff and adding accounting expertise

Capacity building for facility autonomy and accountability

- Is multi-faceted. Be practical.
- To be clear, capacity building for what?
  - Understanding top-down purchasing/payment
  - Mechanisms of autonomy including bank account, country chart of accounts, etc.
  - Design, introduction and use of bottom-up facility financial management and accountability systems, rules and processes

Systems, roles, and mentoring

- Reduce fragmentation and keep it simple: one accounting system, cash vs. accrual basis
- Establish roles across levels of government
  - Local government roles in oversight and support
- Focus on practical and continuous on-the-job training, mentoring
- System support
  - Tutorials built into systems, productive use of AI
  - System user support for facility level (IT tickets)

Expectations, Motivation

- Perspectives when talking with PHC centers about autonomy (view through their eyes)
  - Ready to go
  - Uncertainty, don't know what to expect
  - Don't trust that someone won't blame them
  - Don't want to be bothered
- Strong motivation to serve clients and community
  - Understanding that need resources to do it

More sequencing…chicken or egg?

- Which comes first?
  - Facility autonomy and shift to output-based payment? Risk: facilities lack financial management systems and capacity
  - Facility financial management? Risk: if no autonomy, increase admin burden and demotivate facilities.
- Tanzania did both together….on facility FM systems:
  - MOF recognized good PFM roles, better separation of functions, suggested extend internal audit, etc.
  - Helped overcome facility and local government reluctance
    - Facilities embraced doing analysis, making decisions and managing
    - Local government supported as fewer complaints and reports on time
  - Management entity, not just monitoring and tracking