CABRI Policy Dialogue

PFM as enabler of greater health facility autonomy

27-29 August, 2024

BACKGROUND PAPER

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Acknowledgements

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Acronyms

CoA	Chart of accounts
DFF	Direct facility financing
FFS	Fee-for-service
FMIS	Financial management information system
PHC	Primary healthcare
PPM	Provider-payment mechanism
PFM	Public financial management
LMIC	Low- and middle-income countries
TSA	Treasury single account
RBF	Results-based financing

Glossary of terms

Term	Definition
Accounting officer	An individual charged with accounting for services in respect of which funds have been appropriated.
Capital expenditure	Costs associated with purchasing an asset such as land, equipment, or a building.
Capitation-based payment	A payment method in which providers in are paid, in advance, a predetermined fixed rate to provide a defined set of services for each individual enrolled with them for a fixed period.
Chart of Accounts (CoA)	The CoA is an organised and coded listing of all budget entities and financial transactions enabling standardisation in financial management and reporting across government.
Cost centre	An administrative unit or function that uses public funds and is identified in financial reporting for accounting purposes by a specific code.
Direct facility financing	Providing financial resources, which are at least partly funded by government revenues, directly to providers, often by depositing the funds into their bank accounts.
Economic classification	Structures the budget by the type of expenditure incurred, for example, salaries, goods and services, or capital. It is usually associated with an input-based line-item budget.
Expenditure controls	Processes that enforce the budget law approved by the legislature ensuring that public funds are spent as intended, within authorised limits, and according to public financial management rules.
Facility allocation ceiling	The fixed amount that the health purchaser commits to pay the provider at the start of a period, which serves as the foundation for preparing the budget.
Facility in-charge	The facility manager. In many cases this will be a nurse.
Fee-for-service (FFS)	Payment method reimbursing providers for each individual service they deliver.
Financial autonomy	The degree of control that a spending unit exercises over the mobilisation, allocation, and spending of resources.
Financial management information system (FMIS)	Information technology supporting the automation and digitalisation of public financial management processes.
Global budget	Fixed allocation given to a healthcare provider to cover a specified set of services over a certain period. This budget can be based on either the resources used, the services provided, or both. Providers usually have the flexibility to decide how to distribute these funds across different expenses.
Health facility	Places that provide health care, including hospitals, clinics, and outpatient care centres.
Health provider	An individual health professional or a health facility licensed to provide healthcare diagnosis and treatment.
Health purchaser	An entity that transfers health care resources to providers to pay for health services.
Input-based line-item budget	Budget structure where resources are appropriated at a detailed level of inputs.

Input-based provider payment mechanism	The payment of a fixed amount to a health care provider to cover specific input costs (such as personnel, utilities, medicines, and supplies) for a certain period.
Operational autonomy	Facility control over financial management, administration, procurement, human resources and strategic management.
Output-based provider payment mechanism	Payment to a healthcare provider based on the outputs provided over a certain period. The outputs forming the base of the reimbursements can be healthcare services provided, diagnoses, days of treatment, or the patients enrolled. The payment can be done prospectively or retrospectively.
Pooling	The accumulation of prepaid funding on behalf of a population to increase financial risk protection through greater income- and risk-subsidisation.
Primary healthcare (PHC)	As defined in the Alma Ata declaration: "Essential health care…made universally available to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain…"
Primary healthcare facility	Typically a clinic or community care centre providing essential services such as immunisation, family planning, anti-natal care, and treatment of common diseases. PHC centres may also offer emergency care, casualty and a short-stay ward.
Programme-based budget	A budget organisation structure grouping programmes with similar objectives and linking funding more closely to results than inputs.
Prospective payment	Payments made prior to services being delivered.
Provider payment method (PPM)	The method used to allocate and transfer funds directly to providers.
Public facility registry	The authoritative list of government-owned facilities, managed by a specific agency, usually the ministry responsible for accreditation.
Public financial management (PFM)	Set of rules, processes, and procedures, designed to support the development and implementation of fiscal policies, with the final goals of maintaining a sustainable fiscal position, ensuring the effective allocation of resources, and efficiently delivering public goods and services.
Recurrent expenditure	Any ongoing or repeated costs, typically associated with goods, services, wages, salaries, and basic maintenance.
Retrospective payment	A payment or reimbursement transferred after service are delivered.
Spending unit	A government unit, smaller than a ministry or a department, responsible for delivering public services, and reporting to a line ministry or to the ministry of finance.
Strategic purchasing	Purchasing that links fund allocations with the performance of healthcare providers and the health needs of the population.
Treasury single account	A unified structure of government bank accounts, providing a consolidated perspective on government's cash position.

Introduction

Financial autonomy refers to the degree of control that facilities have to raise, allocate and spend resources (Barasa et al. 2022). It typically implies allowing PHC facilities to receive funds directly; retain at least a portion of the funds they generate; influence budget allocations; conduct virements (up to a reasonable threshold) when needs change; and, cover, at least, routine operational costs without overly restrictive approval and accounting processes. Financial autonomy is just one feature of facility operational autonomy, which includes control over administration, procurement, human resources and strategic management (Barasa et al. 2022).

Increasing financial autonomy is a gradual process, operating on an "autonomisation" spectrum, with a first step often to provide facilities with direct financing. Direct facility financing (DFF) or financing facilities directly involves providing financial resources directly to a facility, usually to a facility's own bank account, rather than to an entity acting on their behalf such as the ministry of health or a local government authority. In most instances, facility financing concerns only recurrent operational expenditure, rather than financing for capital development, salaries, or even drugs and medical supplies (WHO 2022b).

There is growing consensus that financial autonomy is important for improving health service delivery. Evidence suggests that financial autonomy enhances efficiency in the flow of funds, strengthens transparency and accountability, improves responsiveness to local needs, and results in better and more equitable health outcomes (Kuwawenaruwa et al. 2018; WHO 2022; Barroy et al. 2019). In Nigeria, for instance, a small amount (USD 1.74 per patient) of funding disbursed directly to providers led to a 20 percentage point increase in immunisation coverage (Gatome-Munyua et al. 2022). Even a minimal amount of operational funding available for direct use by the facility can facilitate responsiveness to rudimentary needs like changing a light bulb or purchasing soap.

In most African countries, PHC facilities are granted minimal financial and operational autonomy. This is in contrast to higher levels facilities such as hospitals which often receive direct funding and have much greater autonomy (Piatti-Fünfkirchen et al. 2021a; Kuwawenaruwa et al. 2019). The *Lancet Global Health* Commission on Financing Primary Health Care found that fewer than 40 percent of low- and middle-income countries (LMICs) allow public PHC facilities to retain and manage their own funds (Hanson et al. 2022a). Typically, these facilities are included within the local government budget provision and depend on in-kind resources , such as drugs and commodities and human resources (Piatti-Fünfkirchen et al. 2021; Barroy et al. 2022). At best, this leaves only a small facility budget to cover basic running costs, and often PHC facilities do not even receive this operational funding directly.

The public financial management (PFM) system is often viewed as a bottleneck to increasing health facility autonomy. In the initial stages of facility financing reforms, health stakeholders may lack a comprehensive understanding of how PFM arrangements can help or hinder direct financing and increased financial autonomy for public facilities. Conversely, finance authorities may not fully appreciate the importance of granting autonomy to service providers or the need to adjust PFM regulations to facilitate this shift.

On 27-29 August, the Collaborative Africa Budget Reform Initiative's (CABRI) Policy Dialogue on Public Financial Management (PFM) as Enabler of Health Facility Autonomy, will bring together ministries of finance, ministries of health, and local government representatives, to reach a shared understanding of how each can contribute to increasing facility financial autonomy and improving health outcomes. This background note aims to familiarise the policy dialogue participants, who come from different technical backgrounds, with key concepts to be discussed at the event. It aims to provide a shared understanding and common language of what facility financing and financial autonomy involve, and where the PFM system may serve as a bottleneck or enabler.

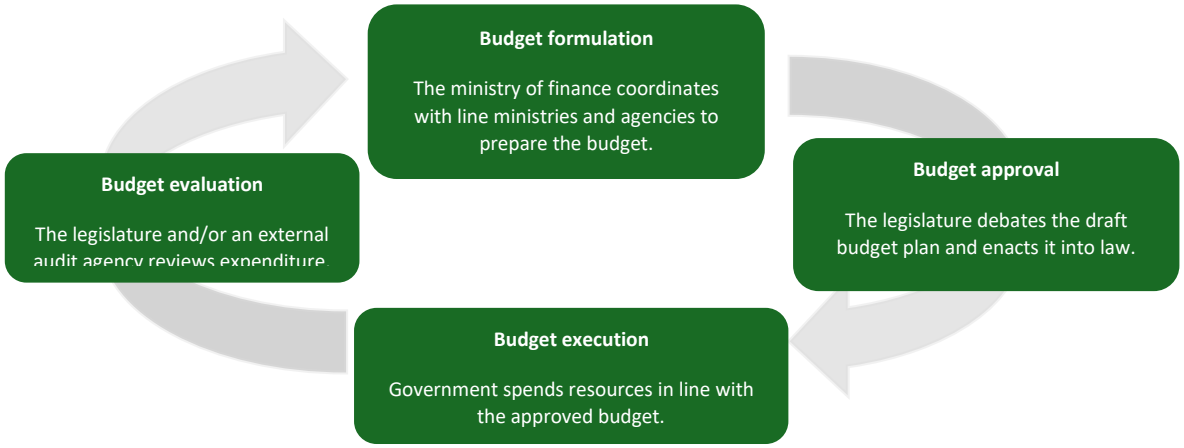
The background paper is structured as follows:

- Section 1 provides a general overview of how PFM and health financing intersect.
- Section 2 offers a brief discussion of how funds flow through levels and structures of government to the facility and the impact of decentralisation on facility autonomy.
- Section 3 covers some of the common requirements for granting facilities the status to receive public resources through the PFM system.
- Section 4 reflects the cost categories, i.e. inputs such as salaries, capital, drugs, and operational expenditure, over which providers may or may not receive control.
- Section 5 covers how providers are paid through input-based or output-based payment mechanisms and the relationship between these and the existing budget appropriation structure.
- Section 6 illustrates how execution flexibility can be achieved in input-based budgeting systems - either through controlling spending at higher levels, adjusting virement rules or exempting low-value transactions from rigid controls.
- Section 7 indicates how better data processes and digital PFM can support facility autonomy.
- Section 8 discusses the importance of facility-level financial management capacity and how this can be supported by local authorities and ministries of finance and health.

1 The intersection of PFM and the health financing functions: revenue raising, pooling and purchasing

PFM relates to how governments manage public resources through the established phases of the PFM cycle (illustrated in Figure 1) - budget formulation, budget approval, execution, and evaluation - to achieve aggregate fiscal discipline, allocative efficiency and operational efficiency. PFM plays a key role in the success or failure of health financing reforms, as it directly influences the three health financing functions, i.e., revenue raising, pooling and purchasing.

FIGURE 1: STAGES OF THE BUDGET CYCLE



Source: Authors

Revenue raising considers how health services are funded from government budgets, user fees, insurance funds or external aid. Revenue raising relies on a robust budget formulation process ensuring that allocations are sufficient and commensurate with health sector objectives (Cashin et al. 2017). It also depends on accurate revenue forecasting to support the in-year predictability of resources for health.

Pooling involves the accumulation of prepaid funding on behalf of a population to increase financial risk protection through greater income- and risk-subsidisation. Risk pooling is supported by a budget formulation structure that prevents the fragmentation of funding flows across administrative levels and financing schemes.

Purchasing considers which interventions should be purchased, how funds should be allocated to providers, and from which providers. It is the health financing function most explicitly connected to increasing facility financial autonomy. Purchasing becomes more strategic when allocation decisions are based on information about provider behaviour and population health needs. Strategic purchasing relies on a budget formulation process that supports the equitable and strategic allocation of resources to providers. It also depends on budget classification and execution rules that allow providers sufficient spending flexibility to efficiently deliver the services purchased and adjust their input mix in response to changing demand. Budget execution processes must also ensure the timely release of funds to providers. Finally, effective reporting, accounting, and auditing processes allow purchasing decisions to be made based on evidence of the effectiveness of fund use.

2 How do funds flow to facilities?

How funds flow from the health purchaser – the entity responsible for managing and transferring pooled healthcare resources, - to facilities, is often shaped by the decentralisation system in place (ThinkWell and World Health Organization 2022a). In centralised countries, such as Tanzania, funds are typically transferred directly from central agencies, either the ministry of finance or health, to the facility level. In countries that have decentralised PHC service delivery, but where central authorities retain significant policy responsibilities, the ministry of health will establish facility ceilings or set tariffs, while local authorities manage the actual transfer of funds. This is the case in Uganda, Burkina Faso and Burundi (Offosse 2022; Hélène Barroy et al. 2022b; ThinkWell and ODI Forthcoming; WHO 2022b). In highly decentralised countries, such as South Africa, Nigeria and Ethiopia, local governments determine facility budgets and are responsible for the transfers or payments to those facilities (ThinkWell and World Health Organization 2022a).

Some evidence suggests that providing funding from the central level can improve the predictability of funds to frontline providers. Substantial leakage and delays often occur when funds are disbursed from the finance ministry to health ministry, then to the regional authorities, local governments, and, finally, to facilities (Gauthier 2020; Hanson et al. 2022b). There is often more predictability and standardisation in how funds flow from central level than from sub-national governments. This is the case in both Ethiopia and South Africa (NYU Wagner-ODI 2021). Furthermore, when purchasing responsibilities are fragmented across administrative levels and providers receive funds through multiple channels, the resulting amounts can become highly variable and difficult to predict (Cashin et al. 2017).

Decentralisation has been found to be at odds with the goals of increasing PHC financing and facility autonomy. While it is generally expected that decentralisation would increase autonomy down to the facility level, this has not consistenly materialised. In Kenya, for instance, decentralisation resulted in a "recentralisation" of financial autonomy from health facilities to counties (Barasa et al. 2022). Decentralisation can also create a misalignment between local and central priorities (ThinkWell and World Health Organization 2022). If local authorities do not prioritise PHC adequately, health providers may not receive sufficient resources to meet the national PHC financing goals set by the ministry of health.

3 What are the common PFM requirements to allow facilities to receive funding directly?

The PFM requirements for facilities to receive funding directly will vary across countries. This section presents some of the common requirements, including receiving the legal status of cost centre or spending unit, which is typically associated with inclusion in the chart of accounts and FMIS; having a qualified accountant onsite; and access to a bank account.

In most instances, to receive funding directly, facilities must be designated as spending units or cost centres under a spending unit. Having an approved budget may not be a sufficient criteria for qualifying as a spending unit or cost center. For example, although district health services in Mozambique have budgets included in the national budget, they are not classified as budget units and require expenditure authorization by district secretariats (the same applies for district and rural hospitals) (ThinkWell and World Health Organization 2022b). In Malawi, a facility must have a high-grade accounting officer with an accounting qualification, to become a cost centre – a requirement that is likely unfeasible in the short term, as most facilities are managed by nursing staff and there is a shortage of qualified accounting personnel, even for shared positions across facilities. Cost centres in Malawi also need to have access to the FMIS. Until significant funds flow to facilities, the requirements for becoming a cost centre may need to be relaxed, or government could consider the provision of conditional grants, discussed below (Serebro and Hart Forthcoming).

Including facilities in the chart of accounts (CoA) is a transparent way to fund facilities directly. In most instances, receiving the legal status of budget entity or cost centre is synonymous with being included in the CoA. The CoA is an organised and coded listing of all budget entities and financial transactions, enabling standardisation in financial management and reporting across government. Depending on the organisational structure of the country, facilities may be sub-segments under a local government or directly under the ministry of health (Serebro and Hart Forthcoming). As discussed in section 7, making facilities more visible through the CoA supports reporting, accountability and budget policymaking. It may also attenuate difficulties in tracking PHC spending and raise its profile.

Financial autonomy typically requires that facilities have access to cash, usually through a bank account. Governments globally have introduced treasury single accounts to enable a consolidated view of government's cash position and limit cash lying idle that could be used productively by other government entities. Ideally facilities are able to maintain transactional sub-accounts linked to the main treasury single account (TSA), as is the practice in South Africa. In many LMICs, however, the existing banking infrastructure may make it impossible for facilities, particularly those in remote areas, to hold bank accounts within the TSA structure. The ministry of finance may need to revise its rules or allow deviations from rules preventing use of commercial bank accounts outside the TSA, as has happened in Benin, Togo and Uganda (Piatti-Fünfkirchen, Hadley, and Mathivet 2021). Where commercial bank accounts are opened outside the TSA, new oversight structures and audit capacity may be required to ensure that funds are being used appropriately (Piatti-Fünfkirchen, Hadley, and Mathivet 2021).

However, having a facility bank account is not always required. In Niger, as most PHC facilities do not have a bank account, funds are transferred to district bank accounts, with earmarking for facilities based on submitted claims (Hélène Barroy et al. 2022b). In Burkina Faso, cheques have also been used to provide cash to facilities. Digital money solutions, such as mobile money, also offer another viable alternative as mobile wallets can be integrated into the treasury single account.

Full autonomy implies that facilities can retain efficiency savings and the funds they generate, however this process must be transparent. Allowing facilities to retain revenue they generate through user fees, sales of drugs and insurance reimbursements can enhance their flexibility toallocate these resources according to their needs. For a purchaser-provider split to incentivise better service provision, facilities must be able to retain and spend against payments from national health insurance schemes. In Rwanda, public facilities have financial autonomy for internally generated revenues. A persistent challenge, however, has been determining how much facilities earn through user fees and ensuring full accountability for these funds. It is therefore important for the ministry of finance to set standards for and support in the development of systems and capacity to track and account for all resources at the facility level.

Providing funding to providers may also require setting up an independent governance structure in charge of scrutinising and voting the budget, while monitoring its execution. These boards or committees should include representatives from the facility, as well as members not involved in its day-to-day management, such as government officers and members of the community. Community representation is often seen as crucial for ensuring public participation in the delivery of public services. Facility committees are, for instance, in charge of voting the facility budgets in Uganda, Tanzania and Burkina Faso (ThinkWell and ODI Forthcoming). These committees are usually also responsible for overseeing the budget's execution, and in some cases, such as Tanzania or Uganda, a representative from the committee carries out internal controls.

4 Over what cost categories do facilities have financial autonomy?

In the early stages of increasing facility financial autonomy, facilities are likely to only receive funding to cover recurrent operational costs, rather than financing for capital development, salaries, or even drugs and medical supplies. Allowing facilities control over smaller sums of money initially can support their financial management capacity development and provide reassurance that they can manage larger expense categories with greater fiduciary risk. While the devolution of procurement responsibilities should increase in line with providers' financial management capacity, some cost categories, such as capital expenditure, may never be fully devolved to the facility level.

In Africa, drug procurement is typically managed centrally, with public PHC providers having limited responsibility. Increased procurement responsibility for PHC providers has been shown to improve availability of drugs and reduce the frequency of stockouts (World Bank 2018; Ruhago et al. 2023). However, public procurement regulations often limit the procurement of health supplies and medicines to central procurement units, usually under the ministry of health (Hélène Barroy et al. 2022b; ThinkWell and ODI forthcoming). Resistance to devolving procurement responsibilities can stem from concerns over providers fraudulently inflating drug invoices or reducing the central purchaser's procurement monopoly. Additionally, allowing facilities to procure drugs independently on the open market poses a risk of inefficiency. Individual facilities lack the purchasing power of central agencies, or they may also lack knowledge of correct drug prices, increasing the risk of inefficient spending. However, it is possible to grant providers greater procurement responsibilities while mitigating the risks of inefficiency. For instance, providers can be given responsibility for ordering but not tendering as seen in Tanzania, South Africa or Burkina Faso, where PHC facilities are allowed to pay for drugs using their own resources, but are not in charge of the tendering process (ThinkWell and ODI Forthcoming). In Tanzania, public PHC providers must purchase drugs through the Prime Vendor System at pre-negotiated tariffs. In South Africa, facilities buy supplies from the central purchasing entity, while in Burkina Faso facilities reimburse drugs received from the National Medical Store.

Civil service rules are likely to prohibit facilities from recruiting health workers directly or paying their salaries. While the ability to hire and fire staff is an important aspect of facility autonomy, there are risks associated with providing this responsibility to facilities in the early stages of the "autonomisation" process. It risks exacerbating the inequitable allocation of human resources for health. However, employing contract staff or community health workers on an annual basis can address short-term staff shortages without long-term liabilities. Such annual commitments are likely to be preferred by the ministry of finance to expenditure commitments that extend across the annual budget cycle. Similarly, bonuses, key to motivating staff, are best managed by facility managers familiar with their staff's performance. Recruitment and payment of contract staff for both non-health and health positions are allowed both in Kenya (ThinkWell and ODI Forthcoming) and Tanzania. In Uganda, recruitment of contract staff by PHC facilities is also allowed but must be approved by the local government health office.

Capital or development expenditures are rarely devolved to PHC facilities. Procuring large equipment or undertaking infrastructure projects typically demands specialised procurement, tasks that are often better handled by higher administrative levels. In addition, in decentralised settings, this can be politically sensitive as it reduces the portion of the budget being implemented by local authorities. Furthermore, the ability to procure expensive equipment or undertake infrastructure projects will ultimately demand substantial increases in government transfers to providers.

5 Incentivising provider efficiency and enabling in-year flexibility through output-based payments and spending controls

Government entities and insurance agencies use two types of provider-payment mechanisms (PPMs) to allocate and transfer funds to providers: input-based and output-based. Input-based PPMs allow for greater control over resources and are generally easier to implement They are typically favored by finance ministries and are the most prevalent method for budgeting for and paying PHC providers across Africa (Barroy et al. 2019). However, input-based PPMs can create execution rigidities and do not necessarily incentivise efficiency-seeking behaviour. In the past decade, several African countries, including Burkina Faso, Tanzania, or Uganda, have begun transitioning from input-based budgets towards more strategic purchasing or allocation methods by adopting output-based PPMs (ThinkWell and ODI Forthcoming). While these output-based mechanisms support a focus on health outputs, can incentivise providers in line with health sector priorities, and encourage efficiency, they are often more complicated to roll out and are data intensive. They are also more feasible in an output-oriented budgeting and expenditure control system, which remain uncommon in Africa.

Input-based provider payment mechanisms

Input-based budgets cover the costs of inputs used to provide services. Input-based payments are in most cases determined prospectively, as part of budget formulation, through the computation of provider-budget ceilings. With input-based PPMs, resources are often allocated based on historical trends, and so may not reflect current needs. They do not incentivise the provision of a higher volume of health services. Nor do they encourage efficiency seeking behaviour on the part of providers, given that they limit opportunities for providers to adjust their input mix to achieve a desired output level.

Input-based payments are typically associated with the economic classification budget appropriation structure, commonly used in African countries. Under this appropriation structure, the budget is formulated by detailed input-based line items, such as salaries, goods, services and capital expenditure. If this appropriation structure is mirrored during budget execution, and detailed input-based line items are used as the basis of spending control, it presents a significant source of rigidity during execution. It limits the possibility of adjusting the input mix throughout the year (Cashin et al. 2017; Barroy et al. 2019; Piatti-Fünfkirchen et al. 2021a). This is a significant concern given the high uncertainty of health needs (Cashin et al. 2017). Input-based budgets may also impede linkages between policy priorities or programme objectives and financial resources.

However, input-based allocations are easier to implement and may provide more expenditure control. Input-based payments can be more appealing in low-capacity contexts because it often relies on readily available administrative data. In an input-based system, facilities typically receive a fixed amount based on the facility type, sometimes informed by an estimated costing of the essential inputs a typical facility needs to procure. Equity considerations can be easily included by adjusting the fixed allocations based on socio-economic factors, without requiring advanced information systems, as done in Uganda (ThinkWell and ODI Forthcoming). Additionally, input-based allocation can serve as a base allocation, which can be complemented with a more strategic allocation mechanism. In Uganda, facilities receive a base allocation based on their facility type to cover essential operational input needs. This is supplemented by fee-for-service allocations, incentivising provision of priority services. Mixed payment systems are particularly useful when transitioning from input-based to output-based PPMs.

Output-based provider-payment mechanisms

Instead of concentrating on the inputs required to deliver services, output-based allocation or payment mechanisms focus on the services to be provided. They aim to incentivise providers to deliver more services, or specific types of services to specific population groups, by minimising their inputs and optimising their input mix (Cashin, Langenbrunner, and O'Dougherty 2009). There are various types of output-based payment mechanisms, which create different incentives for the treatments that providers offer. Common output-based payments for PHC include fee-for-service and capitation (Cashin, Langenbrunner, and O'Dougherty 2009). Facility autonomy is a prerequisite for leveraging the incentivising properties of both payment mechanisms. To use resources more efficiently, providers must have the flexibility to optimise the input mix used to deliver more services.

Fee-for-service is a common output-based payment method, however it can lead to escalating costs and its retrospective payments may imply more fiscal risk. Under fee-for-service, providers are reimbursed based on a fixed rate for services delivered in the previous period, as seen in Burkina Faso's Gratuité programme (Offosse 2022). However, in countries with cash rationing systems or countries possessing rigid execution rules to enforce budget reliability, retrospective fee-for-service payments may not be feasible due to the fiscal risks involved. For example, retrospective payments were not allowed by the Ministry of Finance, Planning and Economic Development in Uganda for the mainstreaming of the Results-Based Financing (RBF) programme (ThinkWell and ODI Forthcoming). Instead, tariffs are adjusted to ensure allocations for the coming year fit within the budget set by the Ministry of Finance. Hence, providers do not know in advance the exact reimbursement they will receive for their services.

A capitation-based mixed provider payment model has been advocated for paying for PHC services by the Lancet Commission for Financing Primary Healthcare (Hanson et al. 2022b). Under a capitation system, providers are paid a fixed amount prospectively to provide a defined set of services for each individual registered at their facility for a fixed time (Cashin, Langenbrunner, and O'Dougherty 2009). The Lancet Commission argues that by directly linking the population with health services, capitation puts people at the heart of health financing and achieves equity objectives. However, as recognised by the Commission, most LMIC lack features of PHC arrangements that are a pre-requisite for population-based payment strategies (including empanelment, registration, and gatekeeping) (Hanson et al. 2022b). This reflects broader concerns with introducing output-based payments in low-capacity settings as discussed in Textbox 1.

TEXTBOX 1: DATA CHALLENGES IMPEDING OUTPUT-BASED PPMS

Output-based payments rely on advanced data systems, making them a challenge in low-capacity contexts, regardless of PFM system design. The effectiveness of these payment system depends on the availability and accuracy of provider performance data. Collecting health output data from all government-funded facilities nationwide requires implementing either facility or patient-level information systems. Ensuring the quality of the output data entered into these systems is time-consuming and requires recruiting a large number of bio-statisticians at the local level. Resource-intensive quality audits might have to be implemented to control and incentivise facility managers. Lastly, using healthcare data for payment purposes generally requires integration between financial and health information systems, a challenge in most African countries.

Source: Authors

Output-based payments are most feasible if the budget is also structured and spending controlled on an output basis, in line with a programmatic budget structure. Under programme-based budgeting, expenditure is grouped based on policy objectives and outcome targets. Compared to input-based controls, PBB should reduce the number of approvals needed for in-year budget amendments, thereby increasing flexibility (Robinson 2007; Helene Barroy, Blecher, and Lakin 2022). However, PBB is complex to implement and there has been limited success in rolling out this reform in Africa. In most countries that have committed to introducing PBB and have made progress in defining programmes in the health sector, budgets continue to be appropriated and executed by economic classification. In other countries that have begun to appropriate by programmes, including Gabon and Ghana, most budget funds are still disbursed and spending controlled by input (Helene Barroy, Blecher, and Lakin 2022).

Regardless of the PPMs used, the chosen mechanisms should be transparent, and the resources transferred to providers must be predictable to enable effective budgeting and planning. To accurately plan for the resources needed to deliver PHC services, providers require clarity on the funding they will receive at the start of the financial year. This depends on the purchaser's ability to inform providers about the allocations to be received or tariffs that will determine reimbursements, as well as the reliability of the grant ceilings provided by the ministry of finance (Cashin et al. 2017). Budget ceilings or fee schedule should be communicated during the facility budget preparation phase and before the start of the financial year.

6 Increasing execution flexibility while mitigating fiduciary risk

Execution flexibility for PHC providers operating in an expenditure control regime based on inputs can still be achieved. This can be done either by (1) controlling spending at a higher level of grouped inputs, (2) relaxing the conditions for reallocations or virement across budget lines, or (3) adjusting controls for lower-risk transactions. As flexibility increases, control and accountability will still be required. However, the nature of control should be commensurate with the very low value of most facility transactions, which, even on aggregate, would not threaten a country's fiscal discipline (Piatti-Fünfkirchen, Hashim, and Farooq 2019).

Transitioning from a line-item to an output- or programme-level appropriation structure is a significant budget reform with far-reaching implications throughout the administration. Increased execution autonomy for PHC providers can be more easily achieved through controlling spending at a higher level of fewer line items (Hart et al. 2021). In line with this, countries should ensure they are not requiring approval for adjustments between line items at an inappropriately granular level (Hart et al. 2021).

Virements, reallocations which do not affect the overall expenditure ceiling, do not fundamentally alter the budget's composition, and remain solely under the control of the executive, are commonly used to enable some in-year flexibility for spending agents. However, they are quite restrictive, often limiting reallocations above 10% or from one economic category to another. In Kenya, South Africa, Tanzania and Zambia, for example, virements are not allowed between wage and capital budget lines towards non-wage recurrent budget lines. Restrictions also commonly apply to their timing - some countries prohibit virements during the initial or final months of the financial year (Lacroix and Serebro Forthcoming).

Virement rules can be made more flexible for health facilities. Uganda has relaxed expenditure rules for PHC providers, allowing managers to revise budgets within approved ceilings. Managers can therefore easily reallocate funds from one budget line to another if they face an unexpected expense. Increases or decreases to the total budget ceiling are also allowed upon approval from the Health Unit Management Committee or hospital board (ThinkWell and ODI Forthcoming). However, in most countries national execution rules apply to facilities. In Tanzania, no adjustment has been made and facilities must adhere to same execution rules as other government entities.

A certain level of control remains necessary to ensure compliance with PFM regulations and support devolution of additional spending responsibility. Because PHC providers are not central agencies, like national hospitals, and usually do not have access to a financial management information system, their transactions are generally not controlled and authorised by ministry of finance officers. Instead, controls, when they exist, are usually performed by officers from local authorities and/or representatives from the facility committee. For instance, payments initiated by accounting officers in PHC facilities in Tanzania and Kenya, as well as district hospitals in Uganda, must be authorised by local government officers (ThinkWell and ODI forthcoming). In Burkina Faso, transactions initiated by dispensaries require approval only from the Facility Management Committee. In Uganda, transactions from lower-level facilities need authorisation from both the chair of the Facility Management Committee and the sub-county chief.

However, while accountability is critical, payment approval processes and controls should not unnecessarily burden medical staff or prevent them from performing their duties (Piatti-Fünfkirchen et al. 2021a). Piatti-Fünfkirchen, Hashim, and Farooq (2019a) argue that a balance between prudent fiscal management and provider responsiveness can be achieved by subjecting high-value transactions to rigorous ex-ante controls, while relaxing controls for low-value transactions (which constitute most of PHC facilities' expenses). They propose using digital banking innovations, such as smart cards or mobile money, for advance payments and subsequently reporting this through the FMIS. This allows for integration of spending and reporting and leaves a credible audit trail without unduly restricting facility-level execution.

Facility accounts should be audited both internally and externally. Given the number of facilities, auditing all providers is often unfeasible. However, partial audits are crucial for ensuring accountability. For instance, in Uganda, local government officers internally audit all facility accounts quarterly and some health facilities are randomly selected annually for external audits by the supreme audit institution (ThinkWell and ODI forthcoming).

7 Data governance and digital PFM for improved facility budgeting and reporting

A lack of robust data governance processes creates significant bottlenecks at every stage of the PFM cycle. Budgeting is often hindered by poorly maintained registries of PHC providers (Long et al. 2023a). The absence of processes to ensure the integration of various registries used by different systems also complicates the use of sectoral data for planning purposes. Additionally, the lack of reporting standards and report consolidation processes prevents effective monitoring of provider budgets and expenditures. In fact, in many African countries, PHC health facilities record their budgets and expenditures manually on paper forms, which are not consolidated in centralised financial reports (ODI and TW, forthcoming). Facility financial information is typically used only for compliance audits, with limited use for analysis and monitoring by local or central authorities.

Data governance processes for improved planning and budgeting

Budgeting for health facilities requires an up-to-date and reliable registry of facilities (Long et al. 2023a). Clear responsibilities for maintaining the registry should be assigned to a custodian agency. Processes should be established to ensure that providers included are operational and their data are accurate. The registry of PHC providers, typically maintained by the ministry of health, should be authoritative, and be used by any agency dealing with PHC service providers. For instance, in Uganda, a registry of PHC service providers is maintained by the Ministry of Health and used by the Ministry of Finance, Planning and Economic Development for budgeting (ThinkWell and ODI forthcoming). The accuracy of facility registries enables planning and budgeting and can help prevent the misappropriation of resources through the creation of ghost facilities. Inaccurate registries can result in some facilities being excluded from the planning and budgeting process, which may require in-year adjustments.

To use health outputs and performance data in provider payment systems and integrate ceilings into financial management information systems, common IDs must be used across all systems. Each system should include a foreign key referring to the authoritative provider registry to ensure data linkage. For example, to mainstream Result-Based Financing into the government system in Uganda, the facility registries in the health management information system and the Ministry of Finance, Planning and Economic Development's budgeting system were reconciled, and their IDs linked to enable the use of health outputs for budgeting. The use of common data standards requires strengthening coordination between entities (Long et al., 2023; Rivero del Paso, et al. 2023).

Data governance processes for improved reporting and monitoring

The lack of common reporting standards and consolidated financial reports at the provider level often prevents access to provider budgets and expenditures. Providers generally report manually, and these performance reports are usually only used for compliance audits, rarely being utilised by local or central authorities for monitoring (ThinkWell and ODI forthcoming). Poor reporting systems can also undermine efforts to increase expenditure responsibilities, as ministries of finance may hesitate to grant autonomy to service providers if they lack confidence in the proper use of funds (Piatti-Fünfkirchen et al. 2021a). PHC facilities in Burkina Faso, Uganda and Kenya, for instance, complete their financial reporting through paper-based forms, without any consolidation.

Introducing a Chart of Accounts (CoA) for providers, or integrating them into the local government CoA, can help standardise reporting and pave the way for introducing an accounting or payment system at the facility level. A provider CoA will lay the foundation for consolidating financial information from facilities. It will enable monitoring of the amounts of funds received by providers, as well as how they budget and use these funds. Such a CoA was developed in Tanzania to consolidate provider financial reports through the Facility Financial Accounting and Reporting System (Mtei 2020). Alternatively, facilities can be introduced as cost centres in the local government CoA, as in South Africa.

However, rolling out an accounting or payment system at the facility level requires significant IT and capacity investment. Since most government PHC facilities are situated in rural areas with limited internet connectivity or access, rolling out a financial management information system at the PHC facility level might prove difficult, as these systems are challenging to use offline (Piatti-Fünfkirchen, Hashim, and Farooq 2019). Such systems tend to be used in countries with mature IT infrastructure at the local level, suchas in South Africa. In countries lacking the required connectivity, a separate accounting system can be used, allowing providers to report their expenditures, after they have been incurred. For facility staff to input their financial information, a web-based system must be developed to allow staff to sync their data when internet access is available. For this approach to be effective, all facility in-charges or accountants across the country would need access to specific tools and occasional connectivity. Additionally, they would require extensive training on how to use the accounting system.

8 Facility financial management: the make or break of facility financing reforms

Success in increasing facility autonomy depends on how it is exercised by managers and clinicians. Few facilities would turn down the opportunity to increase their autonomy. However, with greater financial decision-making responsibility comes a need for strong PFM processes and staff capacity. Better financial management will directly contribute to improving management of service delivery for clients and communities. Managers may not embrace autonomy if they fear punitive consequences for potential failures or if the additional workload interferes with their clinical duties.

Direct transfer of funds to providers may or may not be accompanied with the full devolution of accounting officer responsibilities to facility managers. For instance, in Uganda and Tanzania, since the implementation of direct facility transfer, managers are responsible for ensuring that public funds received by facilities are budgeted, executed, and reported according to PFM regulations. In other countries, the authority in charge of paying facilities – often a local authority – is solely accountable for the use of the funds, like an imprest system. The full devolution of accounting officer duties to managers is likely to add significant administrative and legal responsibilities to managers, who are already responsible for reporting a large amount of clinical and performance indicators.

In cases where facility managers are to take on full accounting officer responsibilities, it is crucial that the PFM regulations they must follow are well-defined and clearly communicated. Clear regulations, rules, and processes can increase acceptance by providing support and guidance for managers in fulfilling their duties. For example, in Tanzania, the Facility Financial Accounting and Reporting System was instrumental in formalising and enforcing PFM rules and processes to be followed (Mtei, 2020). In Uganda, guidelines have been developed to clearly outline the relevant regulations applying to providers, with detailed descriptions of all PFM processes to be followed by facility staffs. However, no information technology system has been implemented to support them in completing these tasks (TW and ODI, forthcoming).

Because facility managers are clinicians without financial management background, it is crucial for them to receive adequate support. In larger facilities, such as district hospitals or health centre in charge of inpatient care, managers are unlikely to have the time to oversee accounting duties and should be supported by a financial staff or an accountant. However, it might not make sense or be feasible to hire an accountant in small facilities. Small dispensaries, often headed by a nurse, can be assisted by local authority officers or accountants from larger facilities. For example, in Uganda, facility managers in Health Centres II and III are supported by the sub-county accountant (ThinkWell and ODI forthcoming). This accountant helps them during both the budgeting and reporting process. They ensure that all supporting documents are collected, expenses are recorded, and accounts are reconciled with financial statements at the end of the reporting period. It is important that the devolution of PFM responsibilities be gradual and aligned with the capacity of the facilities. In the first stage, full devolution of responsibilities can be granted only to the largest facilities, with the option to extend it to others later once the necessary support systems are in place.

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