Towards a typology of financial autonomy of PHC facilities in LMICs

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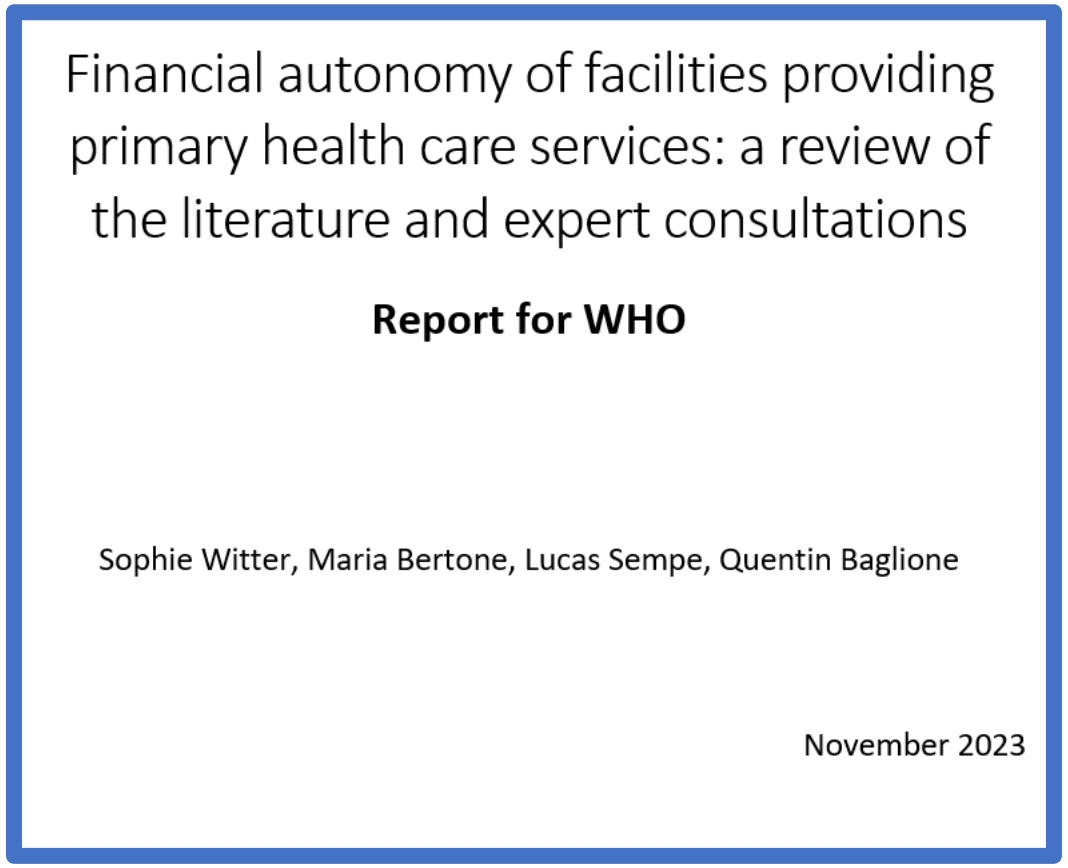
August 2024, CABRI meeting

World Health Organization

Queen Margaret University
INSTITUTE FOR GLOBAL HEALTH AND DEVELOPMENT

ReBUILD FOR RESILIENCE



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

Rationale for this work

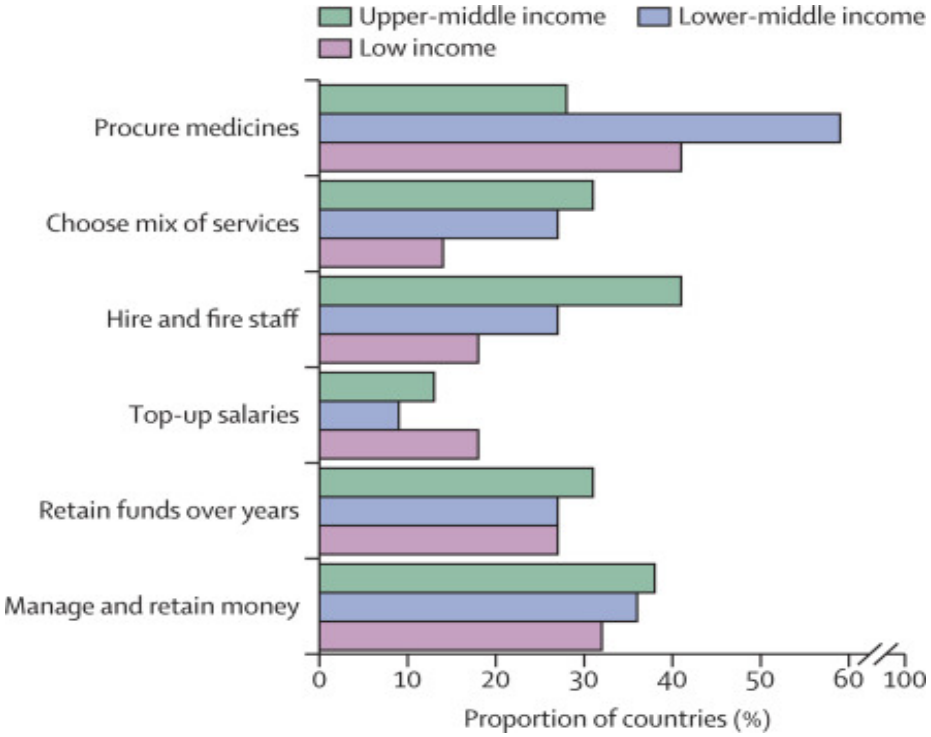
- Relatively little unpacking of financial autonomy of primary care providers

Key study questions

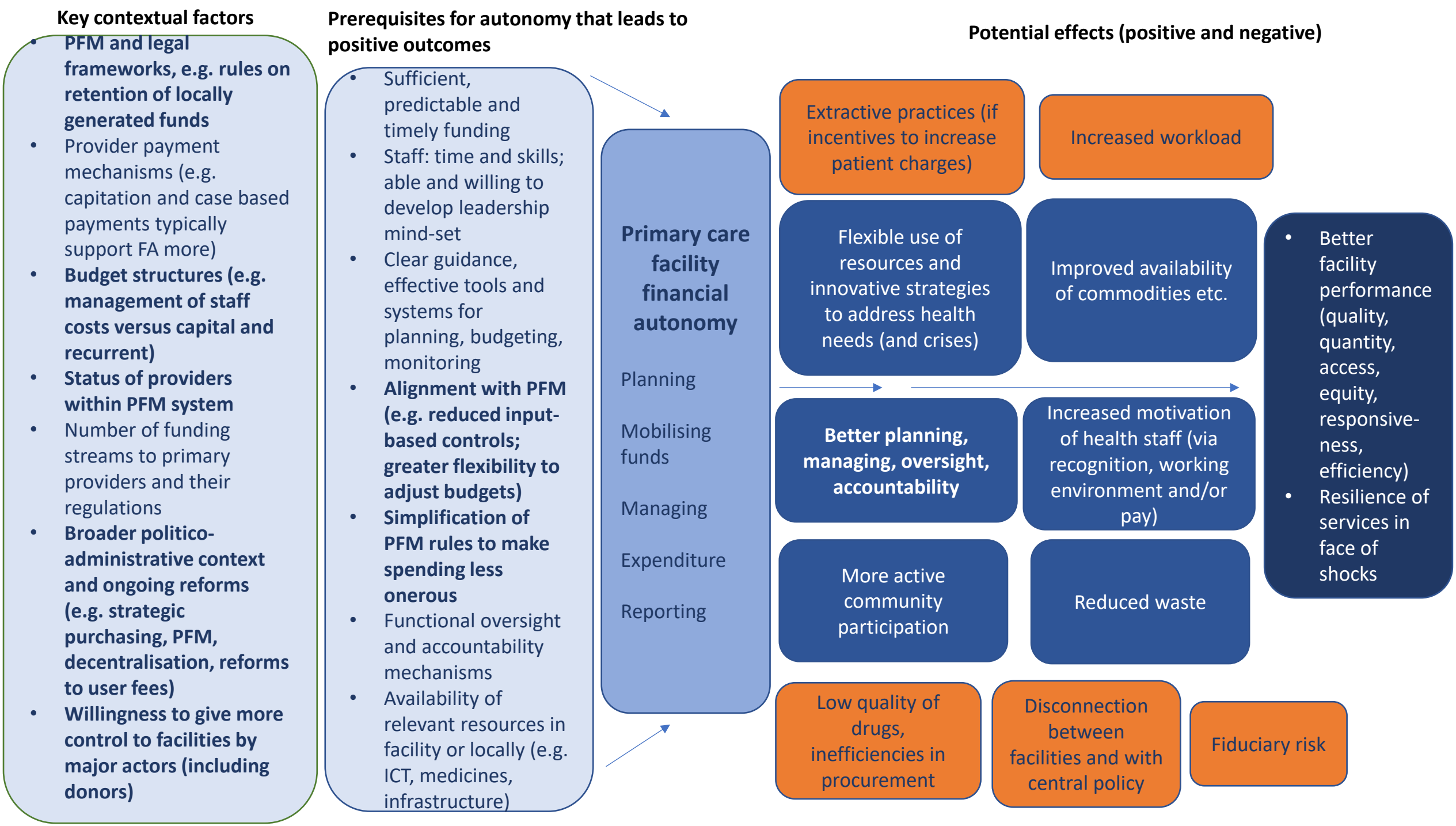
- What are the key design and implementation issues of financial autonomy?
- What are (positive and negative) impacts of financial autonomy for primary care providers?
- What are the key (pre-)requirements for financial autonomy? What factors affect financial autonomy?
- What are the lessons learned in terms of aligning the various (pre-)requirements as to design and implementation for an adequate level of financial autonomy of 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 consistently



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 oversight and accountability mechanisms
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)

Key findings on financial autonomy and PFM

PFM systems are key to FA and to the success and sustainability of changes to FA

- **Frequent misalignment** between the PFM system and health financing arrangements is common, e.g. lack of autonomy for facilities determined by PFM rules is a major constraint to strategic purchasing reforms.
  - E.g. Cameroon, Cote d'Ivoire – tension between PBF and PFM on fund retention at facilities and flexible use of funds.
  - In Kenya, in order to address the reduced facility autonomy after the decentralisation reform, some counties have developed parallel PFM rules, leading to a patchwork of legal frameworks.
  - In addition, everyday PFM bottlenecks *de facto* constrained autonomy in Kenya – for example, county health department budget ceilings are not always transparent and not communicated to public health facilities.
- In addition, **rigid line-item budgets** do not allow for decisions to reallocate funds according to needs.
  - Economic classification used by both the Ministry of Health (MoH) and public primary care providers can result in providers being restricted to the same historical input mix, with limited room for optimizing resources and planning investments and no autonomy to reallocate funds to changing needs during the year.
- In contrast, **programme budgeting** allows the identification of primary care clearly in the national budget and would allow more flexibility for primary care facilities if ex-ante input-based controls were eliminated.
  - However, the empirical experience points to the fact that, in practice, even when programme budgeting is adopted, it is often applied in addition to the historical economic classification, and/or is used only for budget formulation, but not for the monitoring of budget execution, so that only inputs that were explicitly budgeted for can be procured – e.g. in Zambia, Tanzania

Summary message 1: presumption in favour but not effective in isolation

- There should be a **presumption in favour** of at least minimum autonomy
- But financial autonomy alone does not guarantee improved performance efforts at addressing financial autonomy should **also resolve operational autonomy issues**
  - there are numerous other (pre)conditions that need to be carefully considered and tailored to the context (administrative, PFM, provider payment mix, etc.) such as skills, knowledge, organisational culture, and willingness to actively manage resources)
- What matters here is **how systems work in practice**, rather than in theory – PBB, for example, is meant to give greater flexibility in budget use for providers, but when combined (as it often is) with line-item rigidities, the effect is very controlling

Message 2: key features of financial autonomy

Reflecting on our typology, some elements appear to be particularly important to support autonomy, including:

1) **ability to retain at least some funds generated;**
2) **ability to influence budgets that apply to their level;**
3) **ability to vire across budget lines within reasonable limits;**
4) **Ability to address at minimum routine operational costs without prohibitive approvals and accounting**

Message 3: Alignment

- To achieve FA, it is essential to **manage the alignment** between strategic purchasing and PFM arrangements
- And to **move out of "project" logic** towards systemic and integrated primary care funding, which strengthens the health system in the longer term and has a better chance of being sustained

Key message 4: Respecting functional differences for expenditure types

- **C**ertain elements lend themselves more to central control, most obviously **capital costs** (being multi-year and requiring special planning across primary care boundaries)
- **Staffing budgets** are more complex – typically, staff are centrally funded, linked to wider civil service employment, however, this does impact on local managerial influence over staffing mix, which is a major input to services.
  - Bonus schemes tend to be nationally regulated for reasons of smoothing the labour market.
  - In many systems there is more flexibility at facility level over hiring of contractual staff.
- **Medicines and supplies** are also usually hybrid, with some central procurement but allowances for 'emergency' top ups at facility level.
- Most autonomous are **operating costs**, which should be determined by facilities, whether expended directly by them or by a district or equivalent authority.

Key message 5: Understanding risks

- The **risks of increasing autonomy** are less in terms of fiduciary risks (primary care centres usually handle small amounts of money), but more in terms of increased workload, inefficiencies and missed opportunities due to other constraints
  - such as complexity or other restrictions that stop autonomy from being exercised in reality
- Although **accountability** is important, the country data suggests that accountability measures (to control financial risks) may be squeezing out autonomy, although this topic needs more attention