phcpi PRIMARY HEALTH CARE PERFORMANCE INITIATIVE

IMPROVEMENT STRATEGIES MODEL: FUNDS

[This module is under final review by the PHCPI Partnership and may be subject to change.]

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CORE PRINCIPLES OF FUNDS

The "Funds" strategy addresses the availability and management of funds at health facilities to meet the recurrent and fixed costs associated with delivering health services. It discusses a range of public financial management processes, from budget formation to budget execution, that influence facility-level funds availability and management. It focuses on facilities that receive government funds (or a combination of government and other funds, such as private or donor funds) to manage operations and provide services.* In addition to discussing facility-level financial management issues, this strategy acknowledges the reality that many financial processes influencing the facility level take place at higher levels of the system.

The availability of funds and how funds reach facilities can shape the supply, accessibility, and quality of services, resulting in flexibility or constraints for primary care providers. Facility managers' ability to budget, manage, and track funds at the facility level can impact health care providers' ability to be responsive to changing disease burdens and patient needs.

HOW ARE FACILITY BUDGETS SET?

Facility budgets provide an outline for how a given amount of money received from a particular source is intended to be spent. Ideally, budgets should be a tool to proactively plan for future activities and track the use of funds in real time. Budget preparation exercises help facilities estimate how much funding they will have available and how they will use that funding. In larger PHC facilities with authority to manage their own finances, budget preparation is an essential component of planning (such as what kinds and how many medicines and supplies to buy, which staff to hire, and how to meet the evolving needs of the patients and communities the facility serves). Many smaller government-owned PHC facilities may not have this authority – staff allocations may be decided at a higher level and medicines provided in-kind – and their budgets may cover only on facility operational costs or use of internally generated funds.

Challenges with health sector budget formulation that affect funds availability at facilities

In many contexts, facility budgets are determined as part of a broader or national health sector budget formulation process. National health budgets may be set by referring to historical spending levels – what was the budget last year and did that money get spent? – and often focus on determining the funds required for service inputs like personnel, medicines, and supplies. However, historical budgets may not accurately reflect optimal spending patterns or current population health needs. Focusing on *inputs* or line items may distract from what *outputs and outcomes* are being achieved with funds allocated.

Common challenges in health budget formulation processes that can impact funds availability at the facility level include [1]:

- Variability in annual amounts allocated to the health sector by Ministries of Finance or legislatures

* Most facilities that receive government funds also receive funds from other sources, such as out-of-pocket payments by households or contributions from international donors. This section does not focus on purely privately funded health facilities.

- Weak evidence on actual costs and unrealistic revenue projections, leading to lack of health budget credibility
- Budgets developed from historical spending patterns with little connection to annual operational plans, making it challenging to translate health sector priorities into budget allocations.

Improving how budgets are set

Health sector budget allocations should be set utilizing need-based, empirical factors, including population size, demographic characteristics like age and fertility rates, and the burden of disease and associated treatment costs. Countries can improve the budgeting process by moving to a combination of top-down (where the central budgeting authority determines resource allocations based on revenues available) and bottom-up budgeting (where facilities estimate the budget needed to meet local service delivery needs). Easy-to-understand allocation formulas with a system of financial transfers for poorer areas are recommended [1]. To develop evidence-based allocation criteria, countries can use benefit incidence analysis to understand how much poor areas benefit from government spending, relative to wealthier groups [2]. (For further reading on benefit incidence analysis and when it can be utilized, see How to do (or not to do) a benefit incidence analysis.)

Using output-based budgeting (also known as "performance budgeting", "performance-based budgeting", "program-based budgeting" and "budgeting for results" [3]) may also improve the responsiveness of budgets to changing local health needs. Output- or program-based budgets are oriented around achieving specific results and the anticipated resources needed to achieve those results. This type of budget orientation can help hold facilities accountable for delivering outputs (such as successful prevention, diagnosis and treatment of patient conditions), rather than simply spending inputs [4]. It shows elected officials "what will be accomplished with the money, as opposed to merely showing that it has been used for the purchase of approved input" [3].

For further information on budgets and how they can impact performance, see **Budgeting for Health**.

HOW DO FUNDS GET TO FRONTLINE FACILITIES?

To support high-quality primary health care delivery, funds need to reach frontline facilities in a timely and predictable fashion, and in full. But in many LMICs, challenges with getting public funds to lower-level facilities are common. Personnel, operational, and capital funds often reach facilities in different ways and have different challenges associated with disbursement.

Challenges with getting funds to frontline facilities

Common challenges to getting funds to facilities include leakage in funds transfers along the chain from central, regional, and local levels of government to facilities; and delays in disbursement [5]Public expenditure tracking surveys (PETS), which carefully triangulate what proportion of disbursed public funds are received by lower-level facilities, often reveal delays and leakages that prevent facilities from receiving operational funds. In Chad, for example, only 18% of the non-wage recurrent budget reached the regional level, and front-line providers received less than 1% of funds [1]. In Ghana, a survey found that only 20% of non-salary funds reached health facilities, and in Tanzania, the estimated leakage rate – meaning funds either disappeared or were not used as budgeted – of non-salary funds was 41% [5]. (For a brief overview of PETS and how to conduct one, see: Economic and Social Tools for Poverty and Social Impact Analysis: PETS.)

Budget transfer systems that require multiple steps in the payment process between the Ministry of Finance and facilities can create delays in funds reaching facilities, whether due to complex administrative procedures or leakage as funds move through the system. Such delays can translate into seemingly low budget execution rates (the proportion of budgeted funds which are spent by the end of the fiscal year) for the health sector. In Nepal, for example, approximately 20% of the overall 2012 health budget was disbursed in the final quarter of the year, resulting in District Health Officers under-utilizing funds by 20% [2]. Low budget execution rates, in turn, can jeopardize future allocations from the Ministry of Finance, which might blame the underspend on inefficient facility management rather than on late disbursements.

Delayed or irregular payments also have a negative impact on health workers and can lead to demotivation, mistrust, and absenteeism. If providers are not paid, they may charge informal payments to patients or refer patients in public facilities to their own private clinic in an effort to make up for lost wages [5]. Over the long term, remuneration challenges can make health workers less interested in taking a government-funded health care position in the first place, contributing to staffing shortages in the public sector.

Improving the flow of funds

Successful budget execution entails coordinating and streamlining the processes that lead to effective funds transfers from the national treasury to the Ministry of Health and then to districts and health providers. Simplifying payment systems by reducing the number of layers through which disbursements must flow can increase the timeliness of payments and reduce leakages. Establishing facility bank accounts and making direct payments to facilities can more efficiently move funds to front-line providers (see further discussion below). This will require increasing facilities' financial management capacities to manage, track, and report on funds provided.

Addressing central-level cash management problems may also be necessary. Countries that use cash budgeting processes (meaning cash must be available before the budget is disbursed) often experience unpredictable funds availability. If the central budget is unrealistic due to limited cash at hand, Ministries of Finance often engage in cash rationing. Remuneration can be delayed for many months due to liquidity problems and then is often disbursed in larger sums towards the end of the fiscal year [5]. Improvements in timely, regular health worker payments are likely to require budget process strengthening and improvement in budget execution at the central level.

HOW ARE FUNDS MANAGED AT FACILITIES?

Facility financial management refers to systems and processes at the health facility level to track and manage revenues (funds received from government transfers, insurance payments, and patient fees) and expenditures (outlays on personnel and other inputs). Strong financial management systems allow facilities and the health system overall to manage and track funds effectively, comparing spending to estimated budget allocations and adjusting as needed. They also help identify when underperformance is due to inefficiency or insufficient funding and plan for future spending needs.

Common components that health facilities need to manage include personnel, operations, and capital spending.

- **Personnel** (also called remuneration) includes staff salaries and fringe benefits. Staff who are government employees may be hired and paid directly by the central or subnational government. Sometimes the civil service is entirely administered by another ministry outside the health sector – for example, a Ministry of Labor – and their costs will not be handled by the facility at all. In some

contexts, health facility managers can hire additional contract staff to cover for staff shortages or fill specific positions (e.g. laboratory services). These costs would be managed directly by the facility.

- **Operations** include the non-personnel inputs required to run the facility and can include:
    - Medicines, supplies and equipment. These are either procured centrally and distributed in-kind, or facilities may receive funds directly and manage their own procurement.
    - Community outreach activities. These would include allocations for vehicles and fuel costs, educational supplies, etc.
    - Maintenance, utilities, and sanitation.
- **Capital** spending includes infrastructure improvements. These may also be managed centrally, sometimes by a separate public works ministry.

Challenges with facility financial management

Many primary care facilities have only limited authority to manage their own funds. They may not have a facility bank account that they can access directly; their staff may be managed and paid centrally and they may have little ability to hire and fire staff locally. Medicines and supplies may be provided in kind, and facility managers may not have the ability to procure them directly or adjust quantities based on patient needs. If they do have direct access to funds, there may be strict regulations about use of those funds and little flexibility in their allocation. Clinical staff might lack training in financial management, and the information infrastructure necessary for good accounting may be limited.

In addition to public funds, internally generated funds – including user fees and other revenues collected directly by facilities – may constitute a pool of discretionary funds at the facility. In some contexts, internally generated funds are controlled by facilities, while in others, facilities are required to return them to the district or central treasury. If controlled by facilities, these funds are sometimes "off-budget" (not included in the official budget) and have weak or absent reporting requirements [1]. In many contexts, different sources of funding are intended for different portions of the facility budget, but facilities often have difficulties managing and accounting for these fragmented funds.

Increasing facilities' autonomy to manage funds

"Provider autonomy" refers to the extent to which frontline facility managers have the authority to function as funds managers and to change the mix of inputs and services they provide based on their patients' needs (e.g. to respond to an unexpected outbreak of disease or to adapt to a change in drug pricing). When health facilities have strong financial management capacity and authority to make some financial management decisions, they are more likely to adjust service provision and deploy inputs based on the needs of the population [2].

Introducing greater provider autonomy in funds management at the facility level typically requires reforms to a country's public financial management (PFM) regulations [6]. PFM regulations aim to promote transparent, effective, accountable management of government finances [1]. They touch upon all phases of the budget cycle, including the preparation of the budget, internal control and audit, procurement, monitoring and reporting arrangements, and external audit. However, some PFM rules – intended to ensure predictability of spending and careful fiscal control -- can create inefficiencies in the health sector, where health care needs are unpredictable and quick responses to crises are essential.

Changes to PFM regulations may be needed to increase the authority of lower-level spending units (including health facilities) to flexibly move funds across budget lines. This can improve PHC performance by enabling facilities to respond to changes in population needs and provider payment incentives more

nimbly [1]. (In general, these changes should be integrated into broader health system reforms [7], including but not limited to primary care, and must be closely coordinated by the Ministry of Finance.)

Budget officials may consider disbursing some cash income directly to primary care facilities, rather than only in-kind inputs. This can provide facility managers more flexibility to reallocate funds as needed. Recognizing that most medicines and supplies will be bulk-procured centrally, allowing facilities to procure small amounts of medicines and supplies with their funds may reduce both wastage and stock-outs and improve responsiveness to short-term local needs. Dedicated facility bank accounts are necessary for facilities to receive direct funds transfers, and allowing them to receive cash income and open bank accounts may require changing their legal status; this can be a serious bottleneck in some contexts. Facility bank accounts can also help expedite disbursements and increase budget execution rates.

Ensuring alignment between how facilities receive funds and public financial management regulations on how funds are used and accounted for is critically important. In many countries, the beneficial impacts of provider payment reforms (see the Health Financing improvement strategy) have been muted by a lack of provider autonomy to allocate funds at the facility level, sometimes due to strict PFM rules. At the primary level, greater provider autonomy has been most commonly introduced through performance-based or results-based financing programs (e.g. Zambia, Rwanda, Nigeria, Democratic Republic of the Congo, Burundi) [8]. Similar "direct facility financing" interventions, where cash funds are directly transferred to primary care facilities and they are granted autonomy in the planning, management, and use of those funds to improve service delivery, are underway in Kenya [9] and Tanzania [10].

Strengthening financial management capacity

Of course, facilities with increased autonomy to manage some of their own funds still require overall guidance on how funds can be utilized, with monitoring to ensure appropriate use and prevent leakage. In order to effectively manage facility budgets, managers must have the capacity to engage in proactive planning and forecasting, and to account for and report on expenditures incurred at the facility level. Health system leaders should provide training and financial management guidelines to support facility managers in the forecasting and reporting processes. At the primary care level, training in management of a cash book can support day-to-day expenditure management, while larger facilities often require dedicated accounting and/or financial management staff [6]. In larger facilities, managers should have the capacity to develop and negotiate facility business plans to guide spending. Adequate financial management information systems are essential to track expenditures and report on cash income.

In addition to training, under systems with increased provider autonomy health system managers must also employ new or strengthened accountability systems to ensure that facilities are utilizing funds for their intended purpose [6, 9]. Improved recordkeeping at the facility level can increase the accuracy of public expenditure tracking surveys, which can be utilized to monitor improvements in funding flows to facilities over time.

KEY TERMS

Budget: a document that outlines forecasted revenue and planned expenditure for an entity (government, subnational unit, or health facility) over a defined period of time. Budgets indicate how funds are meant to be allocated to achieve certain objectives.

Financial management: systems and processes at the facility level to track revenues and expenditures, ensure that resources are not wasted, and ensure that desired results are achieved

Public financial management (PFM): the rules and regulations established to ensure transparent, effective, accountable management of public (government) finances. PFM includes all phases of the budget cycle, including the preparation of the budget, budget execution, internal control and audit, procurement, monitoring and reporting arrangements, and external audit.

Program-based budgeting (also known as **output-based budgeting)**: developing budgets based on the resources needed to achieve program objectives (or produce desired outputs or results).

Performance-based financing: providing financial incentives to providers based on the achievement of pre-defined, measurable, and agreed-upon performance targets.

Direct facility financing: the practice of directly transferring funds to health facilities for their management and use.

Top-down budgeting: Budgeting process in which a central (national) authority determines resource allocations based on revenues available.

Bottom-up budgeting: Budgeting process in which health facilities or other subnational units estimate the budget needed to meet local service delivery needs.

WHAT HAS BEEN DONE ELSEWHERE TO IMPROVE FUNDS

ARGENTINA: IMPROVING FUNDING AND FINANCIAL MANAGEMENT FOR PRIMARY CARE

Brief overview

Argentina's Plan Nacer created new payment incentives for provincial governments and frontline providers, resulting in increased service utilization and improved health outcomes

Why reforms were needed

- Overburdened and under-funded public primary care facilities
- Poor maternal and child health outcomes in northern provinces **Tanzania's approach**

Argentina's approach

- Central government transfers to provinces are linked to coverage and utilization of priority MNCH services
- Provinces transfer operating budgets directly to frontline providers

Background

Argentina's constitution guarantees universal health coverage (UHC) for its citizens. Prior to 2004, free health care services were provided through public clinics, but these were chronically underfunded. Provincial governments were responsible for allocating and managing up to 70% of health funding, with little regulation from the Ministry of Health [11]. In parallel, many people with employer-sponsored insurance received care from private providers.

In 1998, Argentina was hit with a depression that drove many private patients to seek care in the government-run health system, overburdening primary care facilities and exacerbating challenges in providing maternal health services to underserved populations. This shift led the central and provincial governments to agree that increased coordination across levels of government was needed to improve equity and efficiency in the public system. The central government, in partnership with nine provincial governments and the World Bank, launched *Plan Nacer* in 2004 to cover pregnant women and children under five. The program (now called *Programa Sumar*) has since scaled nationwide and covers the general population. A full overview of the program is found here.

Improving budget allocations, funds transfers, and financial management for primary care

Under *Plan Nacer*, the central government established a new approach to setting provincial budgets [12]. Sixty percent of the budget allocation from central to provincial level was tied directly to the number of people enrolled in the program by the provinces; provinces were allocated a fixed amount per person in exchange for providing a specific benefit package to enrollees. The remainder of the allocation to provinces was conditional, based on results each province achieved on a set of tracer indicators for maternal and child health service use (see here). The provinces in turn transferred operating budgets to public primary care facilities and reimbursed them on a fee-for-service basis for primary care services included in the mandatory benefit package.

This payment arrangement incentivized provinces to increase the number of people enrolled in the program. It also incentivized provinces to efficiently transfer funds to front-line providers, because provinces would receive the conditional central government payments based on the utilization of prioritized services at those primary-level facilities. Finally, reimbursing providers for each service provided under the benefit package incentivized providers to increase provision of priority services [13.].

The central government set overarching guidelines for the use of funds at facilities, and provinces could add additional guidelines to suit their context. Within the guidelines, providers were given autonomy to invest in improving their facilities [13]. Permitted expenditures include supplies, maintenance, infrastructure and equipment, staff recruitment, and staff incentives [14]. Local health authorities retained decision-making authority for full-time staff management, procurement, and service mix at the facility [13.].

Outcomes

The conditional, results-based payments led to an increase in use of services linked to the tracer indicators. According to the Center for Global Development, *Plan Nacer* averted "approximately 773 neonatal deaths, 1,071 low birth-weight babies, and 25,401 total disability adjusted life years" between 2005 and 2008 [16]. A survey of participating providers found that direct payments to facilities improved provider motivation, thereby increasing coverage and quality of services. This has translated to increased patient satisfaction among enrollees [12].

Implementation of the program required new or strengthened financial management, disbursement processes, budget implementation, accounting, and monitoring. Providers were required to report to provinces on the number of enrolled patients and health outcomes, and auditing and verification of clinical records for the conditional payments improved record keeping and data quality [11]. *Plan Nacer* providers were given extensive training to ensure managerial competency and independent firms were engaged for quarterly audits [13.]. The monitoring and continuous updating of tracer indicators promoted dialogue between central and provincial governments, rather than top-down control [13]. Provincial governments provided support with health planning and ensured that providers had the tools to manage the program effectively [14].

UGANDA: ENSURING ADEQUATE FUNDING FLOWS TO PRIMARY CARE FACILITIES

Brief overview

Primary health care facilities in Uganda face challenges in having sufficient funds available to deliver a comprehensive set of PHC services. Analyzing the flow of primary care funds from national to facility level helped to reveal some root causes of these challenges.

Why reforms were needed

- Funding for PHC at the facility level is often insufficient to regularly provide comprehensive primary care services
- Districts and facilities often lack adequate funds to make needed improvements to PHC infrastructure

Uganda's approach

- Analysis of funding flows from national to facility levels to identify strengths and opportunities for improving facility-level primary care financing
- Adoption of budgeting process that is oriented around outputs and increases accountability for public health expenditures

Background

In Uganda, district and municipal governments provide most public sector health services. Three government ministries -- the Ministry of Health; Ministry of Finance, Planning and Economic Development; and Ministry of Local Government -- jointly allocate funds to local governments based on a resource allocation formula, which incorporates variables such as population, child mortality, topography, and poverty. These budgets are intended to support district health teams and publicly owned facilities to provide a minimum package of primary and secondary health care services [15].

How funding flows to health facilities

Grants for primary health care are transferred quarterly to local governments. The grants are intended to cover non-discretionary spending on wages and some non-wage costs, like conducting immunization outreach. Some local governments also receive discretionary development grants for infrastructure construction or rehabilitation. During an annual planning and budgeting process, individual facilities—with support from district health management teams—estimate the non-wage resources they will need to deliver priority services.[†] They are also required to make their budgets publicly available to all patients to improve transparency [16].

Unfortunately, the budgets allocated are often insufficient to deliver quality services [17]. Facilities have limited decision-making power on how they spend their budgets [18], and the non-discretionary grants are not flexible enough for health facilities to adequately address specific local needs. Furthermore, there

[†] For most primary-level facilities, drugs are not part of the non-wage grant but are handled separately through a line of credit with the National Medical Stores. The lowest two levels of facilities receive drugs and supplies based on a push system, while the highest primary care level before a district hospital completes its own drug and supply ordering with the National Medical Stores with the line of credit serving as a spending cap.

are often delays in the release of funds as well as discrepancies between the expected facility budget and the amount disbursed [18].

Diagnosing challenges in availability and flow of funds for primary care

To better diagnose these problems, the MCSP project conducted a funding flow analysis in 2019 [17]. This revealed that 39% of the national health sector budget in 2018 was allocated to primary health care grants (including district level hospitals). The vast majority of that budget (81%) was devoted to personnel costs. Forty percent of districts received a small amount of funding for infrastructure development [17]. Excluding salaries and drug-related costs, this translated to an average annual facility budget of $9,000 to $13,700. Qualitative interviews with a sample of health facility managers confirmed that these amounts were insufficient to deliver the full set of essential services, and that the funding shortage was exacerbated by challenges with stock-outs of key child health commodities, like amoxicillin dispersible tablets. There was a divergence between top-down budget decision-making processes and bottom-up planning processes by local governments and communities [19].

The analysis informed recommendations for strengthening national and sub-national financial planning processes and public financial management systems to improve the availability of funds to deliver essential primary care services. Uganda is moving towards developing budgets around clearly articulated outputs for each program [17]. This should help improve alignment between national and local resource needs, strengthen resource mobilization efforts, and improve accountability by linking financing to program-based outputs.

NIGERIA: IMPROVING PRIMARY CARE PERFORMANCE BY ENHANCING PROVIDER AUTONOMY FOR FUNDS

Brief overview

The Nigeria Health Investment Program – which provided operating funds directly to frontline providers to spend as needed – has improved quality and coverage in three states in Nigeria. The approach is now being scaled nation-wide.

Why reforms were needed

- Limited budget allocation, poor execution, and financial management challenges meant funds were not available at the primary care level
- Low quality at primary care facilities
- Poor maternal and child health outcomes

Nigeria's approach

The Nigeria Health Investment Program improved quality and coverage by

- Directly providing funds to frontline providers, reducing delays and leakages
- Giving providers autonomy to allocate funds based on needs at the facility, improving responsiveness
- Strengthening management and governance of primary care including systematic use of quality improvement scorecards

Background

Nigeria has some of the highest rates of maternal, infant, and child mortality in the world [20]. The primary care system suffers from low utilization, inefficiency, and insufficient quality of care, contributing to poor health outcomes.

Getting adequate funds to front-line providers is an underlying contributor to these challenges. For example, a 2018 public expenditure review found that Ekiti State's total primary care budget was $8.68 per capita, with $4.67 per capita actually disbursed. In Niger State, of the $6.47 per capita primary care budget, only $4.16 per capita was disbursed. Only 66% and 72% of personnel budgets were executed in Ekiti and in Niger states respectively. When personnel costs are excluded from the primary care budget, the review found that an estimated $0.07 per capita in Ekiti and $0.04 per capita in Niger reached primary care facilities. Low levels of budget execution and a retention of those resources at each level of government are common reasons why facilities do not receive budgeted funds. This drives facilities towards depending on user fee revenue to cover their expenses, exacerbating access challenges for patients who cannot pay. [21]

Getting funds to frontline providers [22]

In 2011, the Nigeria State Health Investment Project (NSHIP) – a partnership between the Government of Nigeria and the World Bank – began testing new ways to get funds to front-line providers to improve primary care performance. NSHIP changed how primary care funds were allocated, delivered, managed, and reported on in participating public facilities. Prior to NSHIP, facilities received inputs in-kind with few or no additional operating funds. They did not have the ability to manage facility budgets or make decisions about procuring additional inputs. Under NSHIP, facilities began receiving quarterly grant transfers for operational costs, disbursed directly to facility bank accounts that could be accessed by the facility manager. Some facilities received funds as a block grant. To test the effect of performance-based

payments, some facilities also received additional performance grants tied to the quality and quantity of services provided.

Providers now had more autonomy to allocate and spend funds on allowable costs within the facility, such as maintenance, procuring additional medicines and supplies, and hiring contract staff. Facility managers had to develop business plans to guide this spending and were required to report on how they utilized the funds. The performance-based financing (PBF) facilities could use up to 50% of their quarterly payment for staff performance bonuses.

Facility development committees at the community level, along with state primary health care development agencies, worked to ensure that funds were spent appropriately and reflected the needs of patients. While financial management and record keeping were a challenge in primary care facilities and few facilities had dedicated financial officers that were trained in record keeping, nonetheless a financial review found that funds were generally utilized for approved operational expenses [23].

Outcomes

The NSHIP program had a measurable impact on primary health care in participating facilities, including improvements in quality (availability of drugs and supplies, waste management, and hand washing), and coverage (curative care for children under 5, antenatal care utilization, and modern contraceptive prevalence). Improvements were also seen in facility infrastructure. Finally, the timeliness's of NSHIP payments was correlated with increases in the quantities of services provided [23]. An evaluation of the program concluded "providing operating budgets to health facilities, allowing them to spend the funds on their perceived priorities, systematic supervision using a QSC [quality score card] and strengthened management and governance at LGA [local government], state and federal levels were the main reasons for the success of NSHIP" [23]. Interestingly, the PBF facilities achieved similar results, suggesting that providing additional, performance-based bonuses to providers was not the main driver of observed improvements.

Initially operating in Ondo, Adamawa, and Nasarawa States in 2014, NSHIP has since expanded to an additional six states in Northern Nigeria. Many of NSHIP's approaches have now been institutionalized in Nigeria's Basic Health Care Provision Fund, a nationwide initiative funded from 1% of Nigeria's consolidated federal revenue.

WHAT QUESTIONS SHOULD BE CONSIDERED TO BEGIN IMPROVEMENTS?

The questions below may be a useful starting place for assessing funds in your context and how one might begin to plan and enact reforms.

WHAT PERCENTAGE OF THE HEALTH BUDGET REACHES PRIMARY CARE FACILITIES?

In many contexts, only a small percentage of the overall health sector budget reaches primary care facilities. Facilities often have little funding available to meet operational costs aside from health worker salaries, including budgets for outreach services in communities. Understanding the percentage of funding reaching facilities is the first step in diagnosing potential challenges and working towards improvement. A public expenditure tracking survey can unpack how funding flows through the health system, what percentage of funds reach frontline providers, and potential sources of inefficiencies and/or leakages.

HOW ARE FUNDS ALLOCATED ACROSS PRIMARY CARE FACILITIES?

Budget allocation for primary care facilities should be need-based, rather than based on historical spending levels. Many countries have adopted resource allocation formulas that combine population size, geography, disease burden, poverty, and other equity indicators relevant in the context (see Building Strong Public Financial Management Systems Towards Universal Health Coverage for country examples). Others have tied resource allocations to utilization of priority services (see Argentina case study).

WHAT IS THE CAPACITY OF FRONTLINE MANAGERS TO MANAGE FUNDS EFFECTIVELY AT THE FACILITY LEVEL?

Introducing some provider autonomy allows providers to be responsive to changing patient needs by changing inputs used or the mix of services provided, increasing efficiency and improving responsiveness to patient needs. Depending on the country's provider payment systems, increasing provider autonomy may also be required to ensure providers can respond to appropriate incentives to improve efficiency and increase quality (see Health Financing strategy).

This may require building greater capacity for financial management at the facility level. Completing a diagnostic of providers' capacity for financial management can inform policymaking on whether and how to increase providers' autonomy. Policymakers will need to understand existing financial management systems, human resource capacities (both skills and workload), current management practices for facility-generated revenues, and facilities' forecasting abilities. Public financial management guidelines frequently must also be revised to enable facilities legally to open their own bank accounts and keep internally generated revenues for use at the facility.

IS REMUNERATION FOR HEALTH CARE PROVIDERS TIMELY AND PREDICTABLE?

Examining the timeliness and predictability of salary payments to health care providers can identify challenges related to low motivation, absenteeism, and/or the presence of informal payments at the primary care level. Delays in payment are often related to weakness in public financial management and/or challenges with cash flow at the central level. Increased advocacy to Ministry of Finance, coupled with support in overall financial management reforms, is likely to be critical.

RELEVANT TOOLS & RESOURCES

Tags: financial management, business plans, budgets, performance-based financing, provider autonomy, budget formulation, budget accounting, public financial management, health financing, output-based budgets

ALIGNING PUBLIC FINANCING MANAGEMENT AND HEALTH FINANCING: SUSTAINING PROGRESS TOWARD UNIVERSAL HEALTH COVERAGE (WHO, 2017)

Overview: This report illustrates various misalignments that can emerge between health financing objectives and the systems and policies governing public financial management in a country. A range of options are presented to achieve greater alignment between public financial management rules and health financing needs (pp 33–41), including with respect to facility-level budget structure, management systems, and remuneration. The resource also outlines the importance of provider autonomy.

Tags: budget formulation, budget accounting, public financial management, health financing

ALIGNING PUBLIC FINANCING MANAGEMENT AND HEALTH FINANCING (HEALTH FINANCING GUIDANCE SERIES NO. 4) (WHO, 2017)

Overview: This is a practical guide to diagnose misalignments between a country's health financing and public financial management systems. The guide is designed for use by policymakers, budget officials, health care providers, and other stakeholders and can support collaborative processes across these stakeholders. Modules 3-5 include an assessment of budget formulation, budget execution, and accounting/reporting.

Tags: public financial management, health financing

BUDGETING FOR HEALTH (WHO, 2016)

Overview: This document provides an overview of the health budget process across countries, including insights on budget formulation, approval, execution, and evaluation. Section 8.6 highlights operational considerations for the health budget process. This document can be a useful foundation for non-finance practitioners to understand how budget process reforms could improve funds availability and management.

Tags: budget formulation, budget accounting, public financial management, output-based budgets

BUDGET MATTERS FOR HEALTH: KEY FORMULATION AND CLASSIFICATION ISSUES (WHO, 2018)

Overview: This document provides a review of various approaches to budget structure and how they link to planning and decision-making at facility as well as higher levels of the health system. This resource provides a useful conceptual framing on the importance of budgets in the health sector, the potential value of program-based budgets, and linking budgets to payment. Page 13 provides considerations for health ministries when implementing budget classification reforms for health.

Tags: budget formulation, public financial management, output-based budgets

BUILDING STRONG PUBLIC FINANCIAL MANAGEMENT SYSTEMS TOWARDS UNIVERSAL HEALTH COVERAGE: KEY BOTTLENECKS AND LESSONS LEARNT FROM COUNTRY REFORMS IN AFRICA (WHO, 2018)

Overview: This resource provides an outline of common public financial management challenges, potential improvement strategies, and practical country examples, including the introduction of provider autonomy and increased financial management by frontline providers. Chapter 3 provides health policymakers with a range of reform options to consider, with country implementation examples.

Tags: budget formulation, budget accounting, public financial management, health financing, Africa

PERFORMANCE-BASED FINANCING TOOLKIT (THE WORLD BANK, 2014)

Overview: This toolkit provides guidance on health facility autonomy and financial management. Chapter 6 makes the case for provider autonomy, details the main components and preconditions, and relates autonomy to needed accountability mechanisms. Chapter 7 outlines potential sources of funds for facilities and recommended processes for processing, verifying, and accounting for funds at facilities.

Tags: financial management, business plans, budgets, performance-based financing, provider autonomy

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