Wednesday, June 14-16, 2022

Financing Primary Health Care: Opportunities at the Boundaries
Format: Hybrid

In-Person Participants
Preston Auditorium

Virtual Participants
Welcome to the 6th Annual Health Financing Financing

healthfinancingforum@worldbankgroup.org

Jun 10, 2022, 5:31 PM (1 day ago)

Hello Yohanis,

Get ahead of the game and prepare for the 6th Annual Health Financing Forum (AHFF) to save yourself time and get the most out of your event.

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Are you ready to join your event community?

LET'S GET STARTED!
Session Link for Virtual Participants

PS2
Funding PHC in the time of COVID-19
10:00-11:30 EST | Tuesday, June 14th

Information
At the onset of the COVID-19 crisis, almost all countries faced reductions in government revenues and, as a result, many low- and lower-middle-income countries also decreased government spending. Those that increased government spending did so at the cost of greater public debt. Recent IMF and World Bank projections show that government per capita spending will remain below pre-COVID-19 levels for the next five years in 48 out of 78 countries, and stagnant in 39. Twenty-two out

Connect to the session

Add to your personal schedule

 groceries

Speakers
David Evans
Consultant
World Bank

Iryna Postolovska
Senior Economist, Health
World Bank

Prof. Mariana Mazzucato
Chair of the WEF Council/Professor in the Economics of Innovation and...
Economics of Health for All/University College London /UCL Institute for...

Honorable GILBERT MOKOKI
Minister of Health and Population
Ministry of Health and Population, Republic of Congo

ZOOM link to session

Tuesday, June 14, 2022 10:00 AM to 11:30 AM
Washington DC/Virtual
Hybrid
Primary Health Care Financing
COVID-19
Health Spending

ADD TO MY SCHEDULE
Access to relevant documents for the session
Interactions & Questions: Virtual Participants

*Join Audio: Select how you want to join the call; either by phone or through your computer.

Always muted and video off
Select your language

Mute the original language audio.
Interactions & Questions: In-Person Participants

Ask question directly to the panelists!
Covid Protocols: In-Person Participants

• Visitors attending meetings must attest to being fully vaccinated on entry.

• Masks are required in shared spaces and during meetings.

• Masks can ONLY be removed for eating and drinking, and this should be undertaken in a separate area.
Session 3
Making output and population-based financing work in national PFM systems
June 14-16, 2022
Plenary Session 3

Sarah Byakika
Commissioner Planning, Financing and Policy, Ministry of Health, Uganda.

Mark Blecher
Chief Director, South African National Treasury

Edwine Barasa
Director, Nairobi Programme, & Head, Health Economics Research Unit (HERU), KEMRI-Wellcome Trust Research Programme. Kenya

Pichenda Koeut
Director of Payment Certification Agency, Cambodia

Moritz Piatti
Senior Economist, World Bank.

Tim Williamson
Senior Governance and Public Sector Specialist, World Bank.
PHC: making output/population-based financing work *through* national PFM systems

1. How much should each facility receive?

2. How do we send these funds to facilities through the national PFM system?

3. What degree of autonomy and capability to facilities have to manage their output-based budget?
...you may find it’s more complicated than that

<table>
<thead>
<tr>
<th>Institutional environment</th>
<th>Budgeting systems</th>
<th>Execution systems</th>
<th>Oversight systems</th>
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<tr>
<td>Legal environment</td>
<td>Determining the budget of the facility</td>
<td>Cash management / in-year funding</td>
<td>Financial reporting</td>
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<tr>
<td>Unitary / federal structure</td>
<td></td>
<td>Accounting systems and rules</td>
<td>Audit</td>
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<tr>
<td>Legal status of PHC facility</td>
<td></td>
<td>Other finance flows (insurance, OOP fees)</td>
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<tr>
<td>PHC capability to manage money</td>
<td></td>
<td>Relationship to IFMIS</td>
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<tr>
<td>MoF attitude towards PHC autonomy</td>
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What options do I have?

<table>
<thead>
<tr>
<th>Approach 1: Health facility as a government spending entity receives funding within national standard PFM controls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approach 2: Health facility as a government spending entity receiving funding outside national PFM controls</td>
</tr>
<tr>
<td>Approach 3: Health facility as a non-government institution (private or not-for-profit provider)</td>
</tr>
</tbody>
</table>

1.1: Formal spending unit within the budget
1.2: Formal cost center within the budget

Even within these approaches there are numerous ways of structuring how the PHC operates the three PFM elements of budgeting, execution, and oversight.

Each of these have different strengths and weaknesses in terms of sending an output/population-based budget to PHC facilities.
South Africa: Reimbursement for PHC (Public) How much?

• Current
  • Global budgets to PHC facilities allocated from District/Sub-district/metro budget
  • Facility budget is dependent on workload (e.g. personnel, medicines must correspond to workload or great inequities) but quite management dependent, not fixed rule
  • Workloads for PHC: headcounts, community services, need to find more measures
  • Too much reliance on historical budgeting
  • Monitoring and evaluation e.g. cost per headcount/visit, patients per nurse/doctor, etc.

• Future (NHI)
  • Blended reimbursement
  • Risk based capitation (population registration)
  • Elements of, pay-for-performance, bonus payments (e.g. quality), FFS (e.g. particular procedures)
How do funds get to PHC facilities?

- Budgeting: Combination of top-down and bottom-up
- Drawings / cash-flow: Agreed by day up-front at start of year, so immediately available
- One main Departmental PMG account but 1000s of cost centres on FMIS including majority of PHC centres
- Most PHC centres have a budget and can see spending on their budget
- Sub-district offices and larger PHC facilities have access to FMIS (BAS) but varying levels of admin staff and authorisation/access to system
- Besides ordering off systems (e.g. PERSAL/LOGIS), can make other expenditures
- Petty cash availability increased ++ during COVID
- In some cases, facilities order from depot or sub-district and spending is journalised to their cost centre
What are advantages and disadvantages?

• Trade-off between facility flexibility, autonomy and economies of scale (admin staff, strategic procurement)
  • Strategic and bulk sourcing requires economies of scale
• More decentralised gives more control, but requires a lot more work on supply chain, finance
• More centralised often associated with multiple levels of sign-off and delays
• S21 schools in SA do have own bank accounts and school governing bodies
• In many cases, it is not having own bank account that is critical but degree of delegation in making authorizations on system for expenditure/procurement/hiring staff
• In SA, although facilities order and have budget, often bulk of procurement and finance work done at sub-district office
Uganda: How are facilities being paid?

- IFMIS was introduced in 2008 and has since been rolled out nationally for budget preparation, execution, accounting and reporting.

- Prior to this there were persistent delays at LGs in transferring PHC grants to health facilities, reallocation within health facilities or diversion to other LG priorities

- Annual health facility PHC Grant allocations are made by MoH using an agreed formula to ensure equity and uploaded on the OTIMS

- Annual health facility workplans and budgets are developed by the Health Facility Managers, approved by the Health Facility Management Committees, consolidated into the LG workplan & budget on the PBS and uploaded on the IFMIS

- On quarterly basis, Ministry of Finance (MoFPED) issues cash limits to LG votes, MoH issues release advises with breakdown for each health facility, LGs warrant to different cost centres and submit to MoFPED for loading on IFMIS, then LG Accounting Officers approve invoicing for direct transfer of funds to health facility accounts by MoFPED.

- Signatories to health facility accounts include a Representative of the LG AO, LG Health Officer and Health Facility Manager
What are advantages and disadvantages

Advantages
• Grants reach every public and contracted PNFP PHC facility
• Higher geographic coverage, predictability and fungibility that is not matched by other funding mechanisms.
• Allows flexibility in addressing local priorities through facility workplans
• Involvement of the relevant stakeholders bridges the knowledge gap, improves transparency in resource allocation and accountability.
• Direct transfers enhance timely service delivery.
• Reduced absenteeism of health facility in-charges.

Disadvantages
• e-System challenges in terms of connectivity, upgrade of servers and software. This leads to user frustration during budgeting and delays in warranting and reporting.
• Knowledge gap by some officers on the use of the system thus delays in transfer of funds to health facility accounts. Need for continuous capacity building.
• Bank charges levied on the health facilities not well thought through and catered for.
Kenya: Health financing pre and post devolution

Pre-devolution (<2013)
• Health sector decentralized
• Hospitals and PHC facilities funded through budget allocation, user fees, and donor funds
• Hospitals and PHC facilities had financial autonomy

Post-devolution (national government & 47 county governments)
• Counties are responsible for service delivery
• User fees in PHC facilities abolished
• Coming into effect of PFM act (2012)
• Hospitals lost financial autonomy
• PHC facilities lost autonomy over county budget allocations, have varied autonomy over other funds
Public PHC Facility Financing in Kenya

Several strategies used to achieve flow of funds and to, and facility autonomy
- For conditional grants – ringfencing & creation of special purpose account
- Using PFM act provision for facilities to retain funds
- Development of county laws to allow health facilities to retain funds

<table>
<thead>
<tr>
<th>Source of funds</th>
<th>Counties with autonomy over funds</th>
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<tbody>
<tr>
<td>DANIDA Funds</td>
<td>All</td>
</tr>
<tr>
<td>World Bank THS</td>
<td>All</td>
</tr>
<tr>
<td>User fee foregone</td>
<td>All</td>
</tr>
<tr>
<td>County budget allocation</td>
<td>Some</td>
</tr>
<tr>
<td>Other-NHIF</td>
<td>some</td>
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What worked, what did not work

What worked well?
• Where counties have allowed facilities to have autonomy, PHC facilities are functional
• Conditional grants, ringfencing, creation of special purpose accounts facilitated autonomy
• Engagement between national and county governments has led to progressive granting of autonomy
• Counties developing laws to facilitate autonomy

What did not work well?
• Where counties did not allow autonomy
  • Compromised service delivery
  • Delays in procurement
  • Staff demotivation
  • Compromised leadership and governance of health facilities
  • Compromised accountability of health facilities
• Conditional grants abolished in 2020 – user fee forgone withdrawn
• Donor dependence – DANIDA & World Bank THS are transitioning out
Bottlenecks and intervention targets along the entire PHC system (and outside)
Cambodia: Financing PHC through the budget

- Service delivery grants allocated to health centers from general budget
  - Fixed lump sum grants
  - Performance based grants

- Are facilities government owned?
  - All public health facilities manage the fund by themselves (Majority of the hospital is autonomous)

- How do facilities account for spending and report on resource use?
  - Health facilities make the quarterly report (Health center to operational district)

- What are health equity funds?
  - Health Equity fund allocated the budget to the health facility to support coverage of the poor
Advantages and disadvantages

**Advantages**
- Financial protection
- Health facilities can make their own decision
- Health facilities respond to their needs
- Accountability: accountable for services delivery and financial management

**Disadvantages**
- Workload for the health service provider (PHC)
- A lot of capacity needed
- ICT investment
- Sometime uncomplete reporting