

Draft Version for the 5th Meeting of the Montreux Collaborative, November 2021

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# Direct Facility Financing: Concept and role for UHC

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# TABLE OF CONTENTS

<b>Acknowledgment</b> .....	<b>iv</b>
<b>Executive summary</b> .....	<b>v</b>
<b>Introduction</b> .....	<b>1</b>
<b>Definition and key principles</b> .....	<b>1</b>
1. Facility autonomy .....	2
2. Purchase health services using output-based payment .....	3
3. Sound facility financial management .....	5
<b>Country implementation example: the United Republic of Tanzania</b> .....	<b>7</b>
The United Republic of Tanzania .....	7
Burkina Faso .....	9
<b>Conclusion</b> .....	<b>11</b>
<b>References</b> .....	<b>13</b>

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# EXECUTIVE SUMMARY

Direct facility financing transforms the way in which health facilities and their broader provider and community networks receive, manage, and account for funds to deliver health services. The approach establishes health facilities as autonomous management entities, able to receive many types of funds directly and manage them independently to meet the needs of beneficiaries. When implemented successfully, direct facility financing helps health facilities operate more equitably and efficiently, improves accountability, and creates an environment in which facilities are more likely to respond to financial incentives.

Three principles guide direct facility financing: facility autonomy, in which facilities can determine how to use funds to deliver the highest quality services possible; output-based payments, in which funds are allocated to facilities based on service outputs as opposed to rigid line items or inputs; and sound facility financial management, in which facilities have the systems and capacity to carry out appropriate financial management, accounting and reporting practices. Direct facility financing is not to be considered a single scheme or project but rather a set of attributes and actions that can help strengthen domestic health systems and support progress towards universal health coverage (UHC).

The success of direct facility financing depends on the extent to which implementation of the approach reflects each of the three guiding principles. Thanks to evidence generated through country experiences, there is an emerging understanding of how the relationships and synergies among each of the three principles leads to success, as well as the importance of an implementation strategy that recognizes the different dynamics and interventions needed to strengthen the two separate but related sides of health purchasing and facility financial management. In addition, the sequencing or order and timing of interventions is a factor that contributes to success through implementation of institutionalized and sustainable steps suiting unique country environments.

Four key themes around direct facility financing have emerged over time. First, by elevating government health facilities to the status of autonomous management entities, financing facilities directly deepens the intersection of health purchasing and public financial management (PFM). With direct facility financing, PFM systems support facility level management and service delivery, and purchasing reforms are embedded in PFM systems and applied to general revenue budget funding. By extending cross-sectoral PFM systems to the service provider level, a new management platform for planning, budgeting, spending/procurement, accounting and reporting is created, which can increase equity and efficiency, improve transparency, and enable multi-sectoral activities and services across health, social welfare, nutrition, education, and other sectors. Direct facility financing recognizes that governance and management are different functions or disciplines. The national or local government apparatus that

owns and oversees health facilities does not eliminate the need for basic management to produce any product or deliver any service.

Second, direct facility financing helps avoid the false dichotomy, separation or siloing that can arise with different approaches to health financing, purchasing and provider payment. Direct facility financing is not inherently different than social health insurance or performance-based financing approaches<sup>1</sup> but rather a systemic generalization of all these schemes that emphasizes a fundamental and flexible approach to provider payment and management. Direct facility financing contains a general shift from fee-for-service (FFS) to formula-based systems while empowering countries to choose the optimal payment system(s) to finance facilities based on their own unique environment, with corresponding facility autonomy, accountability, and institutional arrangements.

Third, fragmented revenue sources or flows of funds can reduce operational efficiency and increase the administrative burden on facilities. This can occur if government or donor funds are tied to separate provider payment systems with conflicting financial incentives (e.g. health facilities are incentivized by different levels of government or different donors for different actions or results); if direct facility financing principles are only applied to one of many sets of funds; or if each source or flow of funds is tied to its own financial management system and procedures (i.e. planning and budgeting processes, spending guidelines, accounting systems). Fragmentation can be reduced by pooling government or donor funds<sup>2</sup> but that approach may not be appropriate for all countries. Purposefully designing a unified provider payment system that applies to all sources and flows of funds will ensure all facilities receive the same financial incentives and mitigate the risks associated with fragmented sources of funding. A unified provider payment system can be achieved through incremental reforms to streamline budget formation, payment formulas, budget execution or spending guidelines, and financial management, reporting, and monitoring systems and processes.

Finally, direct facility financing can be a powerful approach to help countries achieve UHC. Efficiency gains and reduced administrative costs can increase coverage of health services, and inclusion of government general revenue can drive improvements in equity and financial risk protection. Giving frontline health facilities, particularly at the primary care level, the authority to manage their own funds has many benefits, including igniting facility management to improve delivery of services to their clients and communities, and increasing transparency, accountability, and responsiveness. Countries should consider placing direct facility financing at the heart of public health budgets; channelling funds from both domestic and international sources directly to health facilities can help target resources to priority services, improve harmonization and performance of all fund flows to facilities, and ensure that facilities use government PFM systems to improve financial management.

As with all reforms, the package of interventions required to finance facilities directly will not automatically or immediately generate results; design and implementation matters,

<sup>1</sup> Programmes or labels including performance-based financing (PBF), results-based financing (RBF) or pay-for-performance (P4P).

<sup>2</sup> The health financing function of pooling is the accumulation of prepaid revenues on behalf of a population.



as do other complementary actions across the health system, such as workforce development and drug supply management. Direct facility financing has the potential to dramatically alter the landscape for government health facilities and pave the way for greater autonomy, accountability, equity, and efficiency across health systems.

# INTRODUCTION

The aim of this brief is to highlight how direct facility financing contributes to national health financing reforms. The definition of direct facility financing contains mandatory elements while the principles are intended to be indicative of how to implement it well. The principles and related actions are fundamental and universal to improving health financing systems (Jowett et al 2020). They can illuminate and mainstream the relationship between good health purchasing and sound financial management. (Piatti, O'Dougherty & Ally 2020).

The brief explains both global relevance and how countries can flexibly shape implementation to the needs of their unique environments. The authors avoid a survey of a range of countries. Instead, they use examples – The United Republic of Tanzania and Burkina – to explain principles. The next sections define direct facility financing and describes three key principles, followed by two country examples and conclusions.

## DEFINITION AND KEY PRINCIPLES

Direct facility financing is money received in facility bank accounts including some government general revenue, to purchase benefits or health services through output-based provider payment. All revenues received and retained by facilities from government, donor, business, or individual sources finance them directly. However, a portion of facility funding is required to be general revenue funds.<sup>3</sup> These funds, managed through government systems, can be used to cross-subsidise or make facility level exemptions work for non-contributory, poor, or underserved populations, to support priority public health interventions such as the response to COVID-19, and to drive progress towards UHC. General revenue transfers to intermediate entities such as national insurance or purchasing agencies and local governments are included in the direct facility financing definition if they eventually transit to facilities through output-based payments.

A service provider is defined as any type of public or private entity authorized to deliver health services to patients and communities. This definition does not include individuals unless they have the legal and operational structures to perform fundamental management functions required by all management entities. These

<sup>3</sup> General revenue funds are defined as funds from either government revenue not earmarked for a specific purpose or DP budget support funds flowing through country PFM systems.

functions include planning, budgeting, procurement, accounting, reporting, human resource management, and monitoring and evaluation (Mathauer, Dale & Meessen, 2017). This policy brief uses the term facility as the entity receiving direct facility financing. Community health affiliates, provider networks and other service delivery configurations are included in the definition.

Building on the direct facility financing definition, three principles guide country implementation.

## **1. Facility autonomy**

The principle of facility autonomy ensures a health facility has the status to receive, manage and account for funds from any legal source or funds flow. Autonomy includes both operational and legal status. Stakeholders may view facility autonomy differently, for example, equating autonomy with the functioning of a distinct management entity rather than regarding a facility as a spending unit of a government institution. In addition, facility autonomy and decentralization to local government are separate interventions; levels of government apparatus and service providers are not the same type of institutions. These distinctions should be considered in all countries with special attempts made to enable health facilities to develop as autonomous and sustainable management entities. Facility autonomy should gradually be enshrined in law and regulatory frameworks to ensure that changes in governance do not recast the health system and, consequently, the legal status and operations of facilities.

At one end of a facility autonomy spectrum is the minimum operational requirements of facility bank accounts and the right to procure inputs. A health facility should have a bank account at a government-approved financial institution, including transparent and accessible sub-accounts in treasury systems, and should be able to receive all types of payments for services through these accounts. Administrative issues hampering transfer of funds to a large number of health facilities in the past have been resolved by information technology. Those financed directly should use their bank accounts to manage their funds and keep petty cash on hand only to cover small expenditures. Health facilities are delegated the right to determine and procure the best mix of inputs to produce and deliver health service outputs to their patients and communities. Health financing initiatives or interventions including performance-based financing (PBF) have been instrumental in setting the stage for increased facility autonomy and flexible spending in many countries including the right of facilities to procure the best mix of inputs (Meessen, Soucat & Sekabaraga 2011; Piatti, Hadley & Mathivet, forthcoming).

A facet of increasing facility autonomy is inclusion in the country chart of accounts or administrative classification identifying entities that can receive and expend funds. A code in the chart of accounts for each government health facility serves as authorization for direct facility financing and identifies health facilities in government systems. The inclusion in the chart of accounts is a regulatory action that is not easily reversed. It delegates rights, responsibilities, and accountability to facilities. They must follow government PFM requirements to build trust with the Ministry of Finance (MoF), enable the development and aggregation of plans and budgets to the national level, and to facilitate forecasting, cash management, and financial reporting.

A country's legal and regulatory framework should define the legal status of health facilities. Laws and regulations should clarify the roles of all types of facilities, organizations, and business management entities. The legal status of both health facilities and the medicine supply chain ranges from fully public to quasi-public with additional enterprise rights to fully private.

Private providers are situated at the other end of the health facility autonomy spectrum. Those in countries where PFM rules permit funds to flow to private facilities have licenses, accreditation, or other mechanisms that allow them to contract to receive and manage public funds. The privatization of health facilities is not encouraged. Still, private providers often play a vital role either at the core of the health delivery system or by filling service gaps in public health systems. Their right to receive public funds should be formal and explicit.

Increasing facility autonomy requires strengthening governance including realigning institutional roles and relationships across all levels of government. For example, if local governments own or finance health facilities that are granted increased autonomy, they can shift from a focus on day-to-day operations to policy, oversight and support. Roles and relationships surrounding facility autonomy are complex, and in some countries instead of shifting from operations to oversight, local governments have viewed facilities as revenue generators and retained funds rather than transferred them to facilities (Chaitkin et al, forthcoming). This is usually not optimal for facility autonomy and management of health service delivery. Facility autonomy can help to establish or invigorate the governance structure of facilities through the separation of financial management responsibilities such as authorization and payments. Increased community participation in planning can create new civic space to enhance transparency, accountability and engagement.

## **2. Purchase health services using output-based payment**

The output-based payment principle enables health purchasers to “buy the right thing” and better match payment to prioritized services (Mathauer, Dale & Meessen, 2017). In the conditions or contracts of provider payment systems, the health purchaser (e.g. a state, a local government, a national health insurance fund) defines the benefit package or service outputs to be purchased and the types of costs on which facilities are allowed to spend funds. Output-based payment permits health facilities to determine and procure the best mix of inputs to produce and deliver service outputs to clients and communities. Input-based payment often contains PFM rigidities including line-item restrictions that undermine facility autonomy (Cashin et al 2017; Barroy, Dale, Sparkes & Kutzin 2018). Therefore, extending input-based payments including block grants or global budgets based on inputs to the facility level is inconsistent with output-based payment principle and facility autonomy.

Provider payment systems vary by many factors including who sets the payment rates, definition of service outputs including level of service bundling, and use of flat fees or formula-based systems. A purchaser should establish an output-based provider payment system that pays standard rates to a group of service providers delivering

the same type of services incorporating the same types of costs. These payment rates should reflect average cost across service providers which provides the financial incentive to increase efficiency. Similar problems will develop if country donors use different payment rates across funds flows for the same services.

A consideration of output-based provider payment systems is how the unit of service or service output is defined. Payment for unbundled service outputs such as consultations with or without a drug prescription, diagnostic tests or surgical procedures tends to drive supplier-induced demand and escalate costs in the health sector. Such payment also increases the risk to the purchaser of exceeding their budget when providers submit greater than expected claims. This type of payment system is usually called fee-for-service (FFS).<sup>4</sup> Payment for more bundled service outputs such as primary health care (PHC) services for one person for one year or for a discharged hospital patient may contribute to underserving individual patients. It increases the risk to the service provider of service costs exceeding payments, often due to factors beyond their control, and may reduce financial risk protection and access for very sick patients with catastrophic health expenditures. This type of payment includes PHC per capita and case-based hospital payment systems including diagnostic-related groups (DRGs).

A second consideration in the specification of a provider payment system is whether output-based payment uses an absolute flat fee or a payment formula. A flat fee pays the same rate for all services for all people in a category and does not vary payment for either cost factors differentiating the service or for desired policy objectives. A formula-based approach has the advantage of incorporating both budget neutrality and payment adjustors for facility or individual level cost differences or other desired policy objectives. Most payment formulas are specified as base rate per unit of service\*number of service units\*payment adjustors. Base rate\*service units will set the total budget ceiling for the defined services across all health facilities paid using the system. Payment adjustors and their corresponding relative payment weights adjust payment to reflect need, equity, performance, or other policy objectives in payment systems including PHC per capita and case-based hospital payment systems. Relative payment weights reflect the relative difference in cost per unit of service and are calibrated to 1.0 to avoid total payment exceeding the budget ceiling.

The choice of a provider payment system to purchase health services should be consistent across all health financing and PFM functions, policies and systems. Pooling of funds is a health financing function closely related to health purchasing. Direct facility financing can exist within a variety of fund pooling options for both domestic and international funds. However, the transaction of payment to service providers must be transparent and observable. For example, local governments can serve as purchasers in decentralized governance structures, but payment should be output-based and made directly to health facilities.

Challenges that direct facility financing can help mitigate are funds flow fragmentation and PFM barriers or rigidities. A key health financing and PFM challenge is fragmentation

<sup>4</sup> FFS is often the underlying provider payment system in PBF mechanisms, programmes or projects with some variation in the level of bundling, depending on the programme. Countries should aim for a level of bundling and sharing of purchaser and provider financial risk that suits their context and environment.

of either domestic or international funds flows as it contributes to decreases in efficiency and equity and poor facility service delivery management. Use of a uniform provider payment system across funds flows can reduce the negative consequences of fragmentation by providing consistent financial incentives to facilities delivering the same health service to patients with similar characteristics. PFM barriers or rigidities can hamper output-based payment, related efficiency gains, and management and service delivery improvements for general revenue funds. Examples include input-based budget formation, line-item restrictions on budgeting or payment, and individual facility level rather than program level expenditure caps.

### **3. Sound facility financial management**

The autonomy to directly receive funds paid for outputs and the flexibility to manage procurement of inputs to produce and deliver desired services must be underpinned by sound health facility financial management and accountability (Barroy et al 2019). Establishment of good financial management systems and processes at provider level enables facilities to diligently account for the inputs procured, report on the use of funds and provide an audit trail to facilitate financial accountability. Health facilities, including both hospitals and PHC providers, can function as businesses or management entities when they take advantage of these robust financial management systems and processes. Stronger and more coordinated dialogue between the health sector and public finance reform specialists<sup>5</sup> can emerge if PFM is approached from the perspective of health facilities. Finance authorities may grow more confident in these facilities and grant them greater autonomy.

The definition of direct facility financing maintains that government systems be used to manage public funds. Consequently, existing financial management systems should be extended to facility level or new systems developed and implemented in government health facilities. Planning and budgeting systems used by health facilities should be integrated or made interoperable to automatically feed data into national plans and budgets. Budgets should be developed for service outputs or programmes even if input-based budgets are still contained in government systems (Barroy, Blecher, Lakin, forthcoming). Budgeting should allow funds to be carried over from one year to the next. The process should be flexible enough to allow adaptation of facility plans and budgets to changing circumstances.

Government or donor fragmentation requiring separate accounting systems and financial reporting processes for each funds flow causes duplication and inefficiency. This problem is exacerbated when small or remote health facilities with limited human resources are burdened with different systems and administrative requirements. Therefore, a standard accounting and financial reporting system should be used for all revenue sources or funds flows. Accounting for revenue and expenditures in both public and private entities is globally standardized. A good facility accounting system can receive funds, manage expenditures, report on multiple funds flows, and interact with other systems including integrated financial management information systems

<sup>5</sup> [https://blogs.worldbank.org/health/let-managers-manage-health-service-providers-perspective-public-financial-management?cid=SHR\\_BlogSiteEmail\\_EN\\_EXT](https://blogs.worldbank.org/health/let-managers-manage-health-service-providers-perspective-public-financial-management?cid=SHR_BlogSiteEmail_EN_EXT)

(IFMIS). Such systems remove PFM barriers to funds transfer to all health facilities. Introducing facility accounting and financial reporting systems would mitigate fragmentation, decrease administrative costs, maximize efficiency and ensure healthy financial management (Hashim & Piatti 2018)

Procurement is a complicated financial management task with elements of it contained in all three principles. The autonomy principle delegates to health facilities the right to procure inputs to produce and deliver outputs, the output-based payment (financing) principle determines what facilities can procure, and the good financial management principle sets the guidelines for how facilities procure with associated internal controls. Specifics of procurement can be complex and include aspects such as consideration of market price and quality for specific inputs including drugs, access to government systems, and the right to contract with private vendors.

To procure inputs to the services they deliver to clients, health facilities should follow country procurement laws, regulations, systems, and procedures to obtain bids, select vendors, authorize purchases, pay for goods and acknowledge receipt of those goods. Direct facility financing is not exempt from procurement regulations, but it does not require more restrictive rules. Separating duties such as authorization and payment for goods and services can be done through either facility management and governing boards or through facilities and local government apparatus. Facilities can procure some inputs such as supplies and fuel on the open market. Procurement of other inputs such as staff allowances and drugs may be regulated to manage cost or quality issues.

Direct facility financing focuses on the recurrent costs of health services. Most health facility expenditures should be low cost, high volume recurrent operating transactions with few procurements above the threshold separating operational and capital expenditures. Facility use of direct financing for major capital investments such as buildings and equipment could frustrate capital master planning, hamper infrastructure development, and increase costs. In most countries, public worker salaries are covered by separate line items or civil service programmes although facilities may be able to hire or contract categories of workers or temporary staff (e.g. cleaners) and pay staff allowances.

Good facility management also requires delivering services consistent with clinical protocols, drug supply processes, and other practices to improve service quality. Drug procurement and supply chain management is a difficult health policy, financing, and management task. Unique policy, market, financing, and management considerations should be taken into account in finding the best country-specific balance of facilities procuring drugs directly and central procurement and distribution mechanisms. The management of human resources is critical to efficient and effective service delivery. Direct facility financing allows health facilities to enhance their staff management role as they can review performance, motivate staff, and enable continuing education.

The integration of PFM and health information systems improves facility management. Health information such as the type of clinical procedure or drugs required by patients is intertwined with financial information such as the procurement of supplies or drugs. Access to and the use of high-quality information will improve facility and country

management, monitoring, analysis and decision-making. Most facilities monitor performance in these ways: 1) financial reporting including responses to country audits to rectify deficiencies in external audits and implement recommendations in internal audits; and 2) programme reporting including monitoring results on health indicators and feeding data into national health statistics.

The argument that health providers need extensive capacity building before facilities are financed directly is often raised during the dialogue on implementation (Barroy et al 2019). Health facility capacity varies by country, but if facilities have bank accounts or are legally able to manage user fees or other funds, they usually have the capability to carry out a range of financial management functions. This capability includes PHC facilities critical to equitable frontline service delivery in remote and underserved areas. Financing PHC facilities directly can also drive the shift from inpatient to outpatient care thus increasing utilization, efficiency and value for money. Capacity building can consist of on-the-job training and mentoring to fill gaps in management functions, to educate staff on new manual or automated systems, and to teach personnel how to better use their data for analysis and decision-making.

The importance of using data for monitoring, analysis and decision-making cannot be overstated, not only for policy purposes but also for day-to-day management decisions to improve the delivery of services. These practices build confidence and reassure facility managers that they can operate systems and use information to function as a management entity that assembles inputs into high quality service outputs for patients and communities.

# COUNTRY IMPLEMENTATION EXAMPLES

## The United Republic of Tanzania

Many countries have expressed interest in financing facilities directly, but only a few have implemented reforms consistent with all three principles. The United Republic of Tanzania built its implementation of health financing and PFM interventions on the foundation of all three principles. In 2017, the Government of the United Republic of Tanzania added direct health facility financing to pre-existing direct school financing and extended national planning, budgeting, accounting and reporting systems to more than 24 000 public health facilities and schools on the mainland. Two assumptions drove the implementation strategy: 1) sufficient human and financial resources are required



to improve service delivery; and 2) facility autonomy in managing information, plans, finances, staff, service outputs and outcomes strengthens service delivery.

All health facilities and schools opened or transferred existing bank accounts to the national bank for their funding. The MoF added individual health facility and school codes to the country chart of accounts to ensure facilities are visible in national systems and can participate in all planning and financial processes. These actions satisfy the autonomy principle.

Output-based provider payment disburses government general revenue comprised of DP health basket fund or budget support flowing to facilities through government PFM systems. A PHC per capita payment system is used with a payment formula consisting of base rate per health facility calculated from the total budget, and simple payment adjusters for catchment population (need), distance from local government center (equity), and utilization (performance). Facilities receiving payments to deliver health services can expend their revenue on all types of recurrent operating costs except civil servant salaries (staff allowances can be paid). Drugs are procured both directly by facilities and with national budget funds. Small capital expenditures for equipment or building renovations can be made by facilities. This system meets the second principle of purchasing health services through output-based payment. Other facility fund flows and their corresponding payment systems include the national health insurance payroll tax, community health fund private premiums, PBF, other donor funds and user fees.

To meet the third principle of facility financial management, the President's Office Regional and Local Government and MoF invested in nationwide extension of two systems to the health facility and school level. The standalone planning, budgeting, and reporting system called PlanRep was redesigned to create a cross-sectoral, web-based, interoperable system. PlanRep includes service outputs, allowing facilities to plan and budget based on the services they provide as opposed to the rigid requirements of input-based line-item budgets. Facility Financial Accounting and Reporting System (FFARS) is a new accounting system used by facilities to receive revenue, spend funds to procure inputs, enter financial transactions, reconcile bank accounts, produce reports, and use data to improve financial management. FFARS has a mobile app and manual versions for facilities without computers or connectivity. The use of PlanRep and FFARS builds a financial management platform for facilities, increases efficiency, and reduces system and administrative fragmentation across sectors and levels of government. The systems also enable facility level governance improvements by reinvigorating facility governing boards, separating financial functions to increase transparency and accountability and engaging citizens to ensure plans are responsive to community needs.

Direct facility financing was introduced nationwide. Synergies were created between top-down national level purchasing/output-based payment and bottom-up facility level autonomy and financial management. To start implementation, national and regional governments together with DPs provided training and mentoring to local governments and health facilities. To deepen and sustain implementation, President's Office Regional and Local Government established a new help desk for continuous user support, and local governments trained and mentored health facilities to support the use and institutionalization of systems. Accountants were hired for financial management

in larger health centres. Health staff, nurses in particular, performed accounting functions in smaller dispensaries. Courses on financial management, including the use of the PlanRep and FFARS systems, were integrated into undergraduate and graduate university curricula. A Ministry of Health and DP Joint Field Visit for the Annual Health Sector Review documented positive changes in health financing and service delivery in terms of transparency, management, availability of health commodities, infrastructure improvement and effective ways of engaging community structures at local government and facility levels (United Republic of Tanzania, 2018).

The United Republic of Tanzania has challenges to address in the next generation of reform including clarifying roles and responsibilities in facility level procurement and addressing funds flow fragmentation. National and local governments can create or exacerbate fragmentation by separating budget and funds flows by type of revenue source or by type of health programme. DPs increase fragmentation unless funds are pooled or processes to explicitly coordinate funding are in place. This country example demonstrates how direct facility financing can unify provider payment systems to harmonize fragmented funds flows and mitigate problems with pooling and conflicting facility level incentives. The example also shows how to establish the foundation of provider payment, facility management, and governance roles and relationships needed to move towards national health financing reform including health insurance, with the increased pooling and reduced fragmentation of domestic and international funds that comes with strengthening domestic health financing.

## **Burkina Faso**

Burkina Faso has demonstrated a commitment to financing facilities directly by transferring funds to facilities in the context of user fee removal (Barroy, et al forthcoming). After the introduction of the Bamako Initiative, most operational costs for health facilities were covered through user fees. The removal, in 2016, of user fees for women and children under five left PHC facilities without the ability to cover operational costs for these services. Policymakers decided to compensate facilities for their loss of funding using general revenue with a provider payment system linked to utilization of health services. Facilities are paid fees based on the number of consultations provided for exempted services. Fees are the same as those in place before the policy decision. Since 2017, facilities submit claims documenting the number of consultations and the national treasury makes direct payments to health centers or freehealth care sub-accounts of the health districts when facility bank accounts are not operational. Health districts support the channelling of funds by paying PHC facilities in the form of a bank cheque. However, they do not play a role in determining allocation to individual facilities as the central level system determines the payment amounts.

Procurement delays did not allow facilities to purchase drugs in a timely manner. Consequently, the first refinement to the system was made in late 2017 to address drug stock-outs. Allocations for facilities were split between operating costs paid directly to facilities and subsidies for drug purchases, which were deposited into regional stores accounts. The payment system effectively translated into increased funding and flexibility in the use of public general revenue funds for PHC facilities. The policy entailed a major change in budget transfer methods. The system shifted from an input-based

model to one that is output-based. Facilities are no longer controlled on the use of line items but compensated for delivering a volume of defined service outputs.

The Burkina Faso programme meets the facility autonomy principle and that of purchasing health services using output-based payment. In addition, it is an example of the value of envisioning the evolution of provider payment systems. The FFS payment could lead to escalating costs and challenges with efficiency and equity. Facilities will be motivated to increase the number of consultations, whether they are necessary or not. Further, some patients require more resources than others. Both issues can be addressed by shifting to a formula-based provider payment system where the fee or base rate is supplemented by elements of the formula, called relative payment weights, that adjust payment for factors affecting patient level need and costs. The same policy rationale will exist to fund frontline services and reduce user fees. However, payments will be more likely to stay within budget and will be more likely to address the needs of individual patients. For example, the formula-based amount for a consultation in a remote facility may be higher to reflect both higher costs, such as those for transport, and equity concerns.

Implementation sequencing establishes incremental steps to put into practice the guidance in the three direct facility financing principles and to create relationships, linkages and synergies between them. Optimally, a step-by-step approach includes separate but related interventions for health purchasing and facility financial management. Burkina Faso has not introduced the facility level systems embodied in the third principle, that of sound financial management. Facilities that strengthen fundamental business management will be able to inform authorities about their spending plans then account and report on revenues and expenditures. This would help to avoid the risk, for facilities and government and DP programme managers, of an adverse audit.

# CONCLUSION

Direct facility financing is a clear first step towards UHC and improving frontline service delivery. All developing countries, including those with less mature PFM systems, can adopt direct facility financing principles, implement its methodologies and benefit from its lessons learned. At its core, direct facility financing reflects the right of health facilities to receive, manage and account for their funds. Investments in systems and capacity are needed to strengthen the two separate but related sides of health purchasing and facility financial management. Establishing health facilities as functioning management entities will improve service delivery and accountability in concert with the autonomy and financial incentives trickling down from output-based payment.

This policy brief encourages developing countries to use the definitions and principles of direct facility financing to consider how the disciplines of health financing and PFM interact in purchasing health services and managing health facilities. PFM and health finance practitioners should engage in reforms that are mutually supportive to reach shared goals of equitable, efficient, and high-quality public services for the benefit of citizens and communities. A solid, institutionalized, and sustainable intersection of health purchasing and PFM incorporates government general revenue into output-based payment to facility bank accounts, is explicit about the right of facilities to determine and procure the best mix of inputs to deliver services and emphasizes sound facility financial management including use of efficient government systems.

Facility autonomy, provider payment and facility financial management complement each other and create synergies to help reduce fragmentation, improve service delivery and health outcomes, and increase efficiency, access, equity, financial risk protection, transparency and accountability. Enhancing the relationships and synergies between the three principles can increase the probability of successfully financing facilities directly. Facility autonomy tends to be based on discrete policy decisions, laws or regulations. The financing side of purchasing health services through output-based payment and the management side of good facility financial management are more continuous in nature and dependent on the relationships and synergies between them for success. Payment to facilities without systems and processes to ensure good facility financial management will undermine both autonomy and accountability and will challenge the trust and transparency vital to direct facility financing. Introducing more rigid facility level systems and administrative procedures or controls without financing facilities directly will also disconnect autonomy and accountability, undermine fundamental business and financial management and demoralize facility managers.

From a country point of view, the principles are both definitive and flexible enough to spark policy dialogue and trigger improvements in design, development, and implementation of systems and management. From a DP point of view, the focus is not establishing minimum criteria applicable to all countries but rather creating the best possible balance of global principles and country level space to enable design specifics to match unique country environments.

A forthcoming manual will foster improvements to technical methodology and country implementation. This paper will assist countries in using these principles to support health purchasing, PFM and facility management choices suited to their environment. At country level, an assessment can help determine: 1) how a country can best introduce direct facility financing; 2) whether implementation is consistent with the three principles and how to refine systems and processes; and 3) how to design and implement continuous improvements in provider payment or facility financial management systems. Country experience can demonstrate how to adapt the three principles to any setting and how to refine implementation consistent with the three principles.

# REFERENCES

- Barroy H, Coulibaly S, Bigeard A, Yaméogo P, Caremel JF, Korachais C, Kutzin J: User Fee Removal and Public Financial Management: A Silent Revolution, accepted for publication by Health Systems and Reform on 16 August 2021, Ref: KHSR-2021-0076
- Barroy H, Blecher M, Lakin J: How to make budgets work for health: a practical guide to designing, implementing and monitoring programme budgets, WHO. Geneva. Forthcoming
- Barroy H, Piatti M, Sergent F, Dale E, O'Dougherty S, Mtei G, Kabaniha G, Lakin J: Let managers manage: a health service provider's perspective on public financial management, World Bank blog, published in Investing in Health, 9 September 2019, <https://blogs.worldbank.org/health/let-managers-manage-health-service-providers-perspective-public-financial-management>
- Barroy, H., Dale, E., Sparkes, S. & Kutzin, J. Budget matters for health: key formulation and classification issues. World Health Organization. 2018 (<https://apps.who.int/iris/handle/10665/273000>).
- Cashin C, Bloom D, Sparkes S, Barroy H, O'Dougherty S, Kutzin J: Aligning public financial management and health financing: a process guide for identifying issues and fostering dialogue (Health Financing Guidance Series No. 4). 2017. ISBN 978-92-4-151307-4 (<https://www.who.int/publications/i/item/9789241513074>)
- Chaitkin M, Vilcu I, Ravinshankar N, Barroy H. Implications of decentralization and public financial management reforms for health systems: Lessons from Burkina Faso, Kenya, Indonesia, Mozambique, Nigeria, the Philippines, Tanzania, and Uganda. ThinkWell; Washington DC; forthcoming
- Hashim A, Piatti-Fünfkirchen, M. Lessons from Reforming Financial Management Information Systems: A Review of the Evidence. Policy Research Working Paper;No. 8312. World Bank, Washington, DC. 2018. (<https://openknowledge.worldbank.org/handle/10986/29222>)
- Jowett M, Kutzin J, Kwon S, Hsu J, Sallaku J, Solano JG. Assessing country health financing systems: the health financing progress matrix. Geneva: World Health Organization; 2020 (Health financing guidance, no. 8). Licence: CC BY-NC-SA 3.0 IGO (<https://www.who.int/publications/i/item/9789240017405>)
- Mathauer I, Dale E, Meessen B. Strategic purchasing for universal health coverage: key policy issues and questions: a summary from expert and practitioners' discussions. World Health Organization. 2017. (<https://apps.who.int/iris/handle/10665/259423>).

- Meessen B, Soucat A, Sekabaraga C. Performance-based financing: just a donor fad or a catalyst towards comprehensive health-care reform?. *Bulletin of the World Health Organization*, 89 (12); 153 - 156. World Health Organization (<http://dx.doi.org/10.2471/BLT.10.077339>)
- Piatti M, Hadley S, Mathivet B: Alignment of Performance-Based Financing in Health with the Government Budget: A Principle Based Approach. World Bank, Washington DC, forthcoming
- Piatti M, O'Dougherty S, Ally Mariam. Why strategic purchasing in health and public financial management are two sides of the same coin. World Bank blog, published in *Investing in Health*, 12 August 2020 (<https://blogs.worldbank.org/health/why-strategic-purchasing-health-and-public-financial-management-are-two-sides-same-coin>)
- United Republic of Tanzania: Ministry of Health, Community Development, Gender, Elderly and Children: Field Visit Report, 2018 in *Joint Annual Health Sector Review: Direct Health Facility Financing: Are we on the right track?*, unpublished
- USAID/Abt Associates Tanzania Public Sector Systems Strengthening (PS3) project: Final Report (2015–2020), unpublished.

