2020

Direct Facility Financing: Tanzania Health Sector Experience

Gemini Mtei

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List of Abbreviations

CCHP	Comprehensive Council Health Plan
CHF	Community Health Fund
COA	Chart of Accounts
D by D	Decentralization by Devolution
DFF	Direct Facility Financing
DMOs	District Medical Officers
eLMIS	Electronic Logistic Management Information System
FFARS	Facility Financial Accounting and Reporting System
GePG	Government Electronic Payment Gateway
GOT	Government of Tanzania
GOTHOMIS	Government of Tanzania Health Operations Management Information System
HBF	Health Basket Fund
HFGC	Health Facility Governing Committee
LAN	Local Area Network
LGAs	Local Government Authorities
MOHCDGEC	Ministry of Health, Community Development, Gender, Elderly and Children
MSD	Medical Store Department
NHIF	National Health Insurance Fund
PFM	Public finance management
PHC	Primary Health Care
PlanRep	Planning, Budgeting and Reporting System
PORALG	President's Office, Regional Administration and Local Government
RBF	Result Based Financing
SNHI	Single National Health Insurance
UHC	Universal Health Coverage

1 Introduction

International experience indicates that investing in primary health care (PHC) is the most efficient and effective way of managing population health because it is the most cost-effective health service and a large segment of the population (particularly the underserved) depends on this level of service provision to be their first health care access point. Evidence is growing that a new intersection of public finance management (PFM) and health purchasing can contribute to increased efficiency and improved management of health service delivery. This new intersection includes a shift to output-based payment to better match payment to priority services, and increased provider autonomy and accountability as the management entity procuring the best mix of inputs to deliver service outputs to clients. Strategic purchasing through output-based provider payment systems is at the core of the relationship between health financing and service delivery. They can encompass general revenue budget funding and directly target it to underserved populations and the health services they need the most.

Direct Facility Financing (DFF) initiatives create the opportunity to introduce strategic purchasing, especially in central general revenue budget allocations to PHC providers. Improving the quantity and quality of service delivered at PHC level requires direct payment to facilities, a shift to output-based payment, better unifying or harmonizing payment system incentives for fragmented funds flows from different public and private sources, and empowered providers capable of both financial and service management.

1.1 Direct facility financing implementation in Tanzania

The Government of Tanzania (GOT) is committed to accelerate progress towards achieving universal health coverage (UHC) and to improve delivery of equitable quality health services across all levels of service delivery, with special attention to PHC. GOT has put a number of initiatives in place to fulfill this commitment including health sector strategies and decentralization by devolution (D-by-D). Adopted in 1999, the D-by-D initiative gave Local Government Authorities (LGAs) more authority and responsibility to manage delivery of health care and other public services to the community.

The LGA management team was responsible to develop plans and budgets for health facilities and manage expenditures including procuring inputs for service providers (dispensaries, health centres and district hospitals). Revenues collected at service provider level were supposed to be deposited at the LGA health sector bank accounts (Council Comprehensive Health Plan (CCHP) guideline 2011). Facilities were supposed to identify their input needs and submit to LGA management through District Medical Officer's (DMO) department which was responsible to procure the inputs (Figure 1). The challenges with this approach included delays in procurement of inputs, a less than optimal mix of inputs for individual facilities and their patients, and imbalances in the distribution of inputs across service providers. Further, health facility staff and communities surrounding these facilities had limited knowledge and ownership of facility plans, budgets and expenditure decisions

because most of these decisions were done at the central LGA management level and often not fully communicated to facilities making it harder to deliver front-line services to patients and serve their communities.

Recognizing these challenges and their substantial impact on public service provision especially for the poor and underserved, the GOT decided to further delegate decision-making processes and management to service provider level in health and education for some inputs critical to front-line service delivery to beneficiaries. This was done by improving funds flow to service providers to make them more visible in systems, increase transparency, autonomy and accountability, and improve alignment between limited resources and priority service outputs.

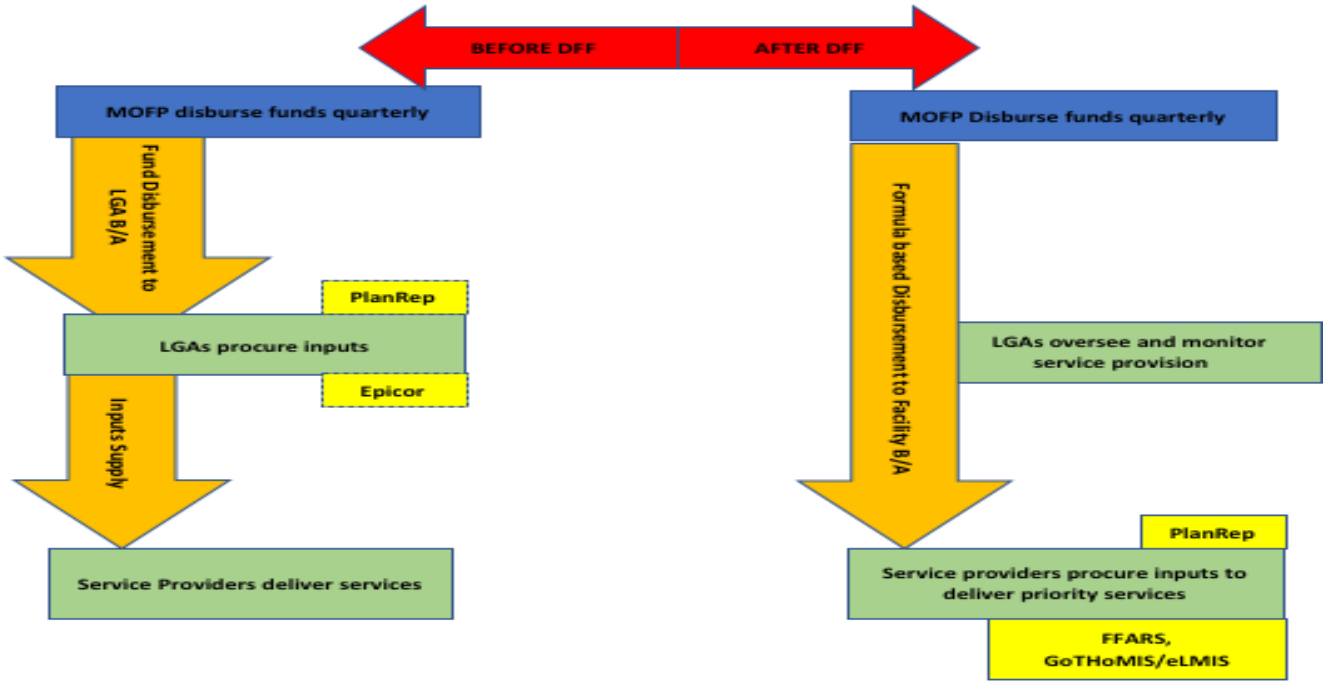
From 2011, health facilities were allowed to open facility bank accounts and service providers gradually responded to new incentives and management processes, especially district hospitals. The pay-for-performance programme introduced in Pwani in 2011 shed light on the increasing ability of health facilities to manage funds and procure inputs based on priority population needs. More facilities opened facility bank accounts following the introduction of result-based financing (RBF) in 2015 as having a bank account was a pre-condition for a facility to receive quarterly RBF payments. During that time, NHIF[1] also started to reimburse public facilities[2], especially hospitals, directly to their facility bank account. However, NHIF reimbursements for facilities that did not have bank accounts continued to be deposited at the LGA health sector account.

In 2017, the entire health sector formally adopted Direct Health Facility Financing (DFF). All health facilities were mandated to open a facility bank account as a condition for receiving health basket fund (HBF) payments. Incorporating HBF into DFF was a key step for many reasons, not least because it is general revenue funds (development partner budget support) flowing through country PFM systems. A review was done of the facilities that already had bank accounts to make sure they all complied toPFM rules and regulations. It was during this time that the terminology 'Direct Facility Financing (DFF)' was formally adopted in the health sector to recognize the policy and its implementation, despite the fact that some facilities had previously managed funds in their bank accounts. While the driving force of DFF in Tanzania was HBF, DFF quickly became generic terminology referring to all funds flowing directly to facility bank accounts. The shift of HBF to DFF modality was a major revolution in PFM systems in Tanzania as it proved that it is possible to improve the alignment between health sector financing and PFM rules and regulations for the purpose of improving efficiency, equity and service delivery by introducing more strategic purchasing in the central budgetary system of the country.

[1] NHIF is a public sector mandatory contributory public insurance scheme targeting the public sector workers. Private employees and individuals are free to join this scheme on voluntary basis

[2] Private facilities were reimbursed directly to their facility bank account the moment they entered into a contract with NHIF and started to provide services and submit claims

Figure 1: Flow of Health Basket Funds before and after Direct Facility Financing



Prior to DFF, HBF was disbursed by the Ministry of Finance and Planning (MOFP) to LGA health sector bank accounts on an input-based budget line item basis. There was an earmarked block allocation proportion for dispensaries and health centres but no set allocation for each individual facility, hence less than optimal transparency and not all facilities benefited from HBF. DFF and a shift to output-based payment moved together in Tanzania. Following adoption of DFF policy to disburse HBF, a budget neutral payment formula was developed which moved HBF allocation and direct payment to facilities from input-based budget line item to an output-based provider payment system. A PHC per capita payment formula and system was developed which included a base rate and three adjustors reflecting three key policy objectives: catchment population for need, number of visits for performance, and distance from LGA center for equity. An explicit objective was to start simple including clear payment adjustors based on existing data, and then refine over time as data and its analysis and use improved. The first disbursement of HBF DFF from Treasury to facility bank accounts was in fiscal year (FY) 2017/2018. DFF was officially or formally recognized as a country health sector initiative in 2017 following the adoption of DFF in disbursement of HBF.

The Community Health Fund (CHF) or Tanzania's version of community-based health insurance is also included in the definition of DFF. Health financing policy and implementation emphasized proactive linkages between all funds flow to facilities to reduce fragmentation, increase efficiency, and help ensure consistent financial incentives at the health facility level. In 2018, improvements in CHF design created more seamless linkages across facility funds flows by use of the same bank

account and CHF introduction of PHC capitation with a harmonized payment formula to unify payment systems and reduce conflicting financial incentives. Currently all public health facilities have a uniform bank account and all were opened under the National Microfinance Bank with support from the Bank of Tanzania.

All facilities are now getting their NHIF reimbursement and CHF payments directly to their bank accounts on top of out-of-pocket payment collected at facility level and HBF disbursed from the MOFP[3]. Facilities are supposed to book revenue by source. Effective implementation of DFF is anticipated to increase service providers' visibility, autonomy and accountability in planning, budgeting and expenditure prioritization, improve transparency in fund use, improve management of service delivery, and increase community ownership, all of which are anticipated to improve PHC health care service delivery especially for the poor and underserved, improve health outcomes and accelerate progress towards UHC.

2 DFF Preconditions

There are a few standard pre-conditions for DFF meaning requirements for implementation that do not vary across country environments and can be used in global sharing of lessons learned and provision of technical assistance. They include:

a) **A health facility bank account:** This is a basic requirement to facilitate transfer of funds to service providers.
b) **Output-based payment to facilities:** Inherent in DFF is increased health facility autonomy and accountability to determine the best mix of inputs to produce and deliver service outputs. Therefore, it is a challenge for DFF to realize the desired efficiency, equity, and service delivery improvements if it does not include a shift from input-based to output-based provider payment.
c) **Establishing facility level financial management:** The new intersection of health purchasing and PFM created by DFF requires good facility level financial management including accounting and reporting. Prior to adopting DFF, it is important to put in place a simple but effective financial accounting and reporting system to ensure that facilities are able to manage receipt and expenditure of funds, and financial reports on fund use will be generated and shared with the health purchaser and/or Central Treasury.
d) **Realignment of institutional roles and relationships:** The implementation of DFF comes with changes in institutional roles and relationships. Through DFF, service providers will be more hands on in planning service delivery priorities and also actual spending of their funds (execution of their budgets) including procurement of their inputs. In this case, other institutions will also need to realign their roles, for example local governments will focus more on support and oversight than day-to-day operational management and control.

[3] It is important to note that DFF definition does not include funds that are paid as salary to staff working at service provider level because such funds are paid directly to individual staff bank account

3 Provider Payment and Purchaser Role

Introducing DFF in Tanzania required a decision on the modality to use to disburse funds to service provider bank accounts, and the financial incentives to be contained in these provider payment systems. Delegation of at least some functions to service provider level with corresponding autonomy and accountability was viewed as inherent in DFF. Therefore, retaining rigid input-based budget line-item payment was not viewed as a viable conceptual or practical option and the shift to output-based payment rose to the level of DFF pre-condition (see Section 2). DFF through output-based payment increases transparency and predictability of funds availability at facility level, flexibility in using funds and autonomy to prioritize service provision based on population needs. The decision on how service providers are paid is a core strategic purchasing policy decision that ministries responsible for policy formulation need to make.

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Before the introduction of DFF for Health Basket Fund (HBF) or development partner budget support flowing through country PFM systems, fee-for-service (FFS) payment was the only output-based provider payment system used in Tanzania (NHIF, CHF, user fees). DFF implementation led the shift from FFS to budget neutral formula driven output-based payment, specifically PHC per capita payment. The PHC per capita payment system bundles services to stimulate more efficient and effective service delivery and lower administrative costs, and uses a formula including a base rate enabling budget neutrality (staying within budget ceiling) and policy-based payment adjustors. Although there is no perfect provider payment system, there is an optimal choice of payment system to achieve specific objectives in a specific environment at a specific point in time. PHC per capita payment disbursing DFF funds to facility bank accounts suited the Tanzania environment as it better matched payment to priority service outputs, increased transparency, introduced financial incentives to increase equity and improve performance, and ignited PHC facilities to step up to improve management and cost-effective PHC service delivery especially for poor and remote populations.

The first DFF HBF PHC per capita payment system formula comprised a base rate or fee per person adjustments to the base rate for need, equity, and performance. Policy dialogue resulted in an explicit strategy or tactic of starting simple in defining payment adjustors and then refining over time as health facilities began to manage to their financial incentives and data availability and quality improved. Service area catchment population is used as an adjustor for need carrying a weight of 30 percent (health facilities are the unit in the formula, in essence, this adjustor converts to per capita); utilization as defined by outpatient visits is used as an adjustor for performance carrying a weight of 50%, and distance from facility to LGA headquarters is used as an adjustor for equity carrying a weight of 20%. The adjustors and the weights attached to them was a policy decision made by the Ministry of Health Community Development Gender Elderly and Children

(MOHCDGEC) as health purchaser in collaboration with the Presidents' Office Regional Administration and Local Government (PORALG) which is the ministry responsible for managing policy implementation.

Two key experiences and lessons learned from introduction of new output-based provider payment systems in Tanzania: how to establish a continuous payment system refinement process and institutionalize for sustainability (also see Section 6 Implementation Sequencing), and how to use health purchasing and provider payment to reduce funds flow fragmentation (mitigate pooling problems). Tanzania established an explicit strategy of starting with simple payment formula adjustors, developing experience and better data, and then refining over time to improve fairness and targeting of payment and also continuously adapt to evolving purchaser-provider dynamics. For example, initial policy dialogue on payment adjustors resulted in consensus that facility need would first be defined as catchment population number and age-sex adjustors would be considered in the future, and equity would first be defined as facility distance from LGA center or headquarters and a facility level poverty index (food poor and social welfare) would be considered in the future.

Following the revision of Comprehensive Council Health Planning Guideline (CCHP) early 2020, refinement of the payment adjustors in the DFF formula were proposed. The revised adjusters are as follows:

- Catchment Population carrying the payment weight of 40%
- Distance of the individual dispensary/health centre to the LGA headquarters carrying the payment weight of 10%
- Service utilization carrying the payment weight of 40% with addition disaggregation as follows;
    - Outpatient visits (weight 0.87%)
    - Antenatal visits (weight 0.87%)
    - Postnatal visits (weight 0.87%)
    - Admissions (weight 8.70%)
    - Institutional deliveries (weight 5.22%)
    - C-sections (weight 23.48%)
- Performance carrying the payment weight of 10% with the following disaggregation;
    - Use of modern family planning methods (weight 5%)
    - Availability of 30 tracer medicines (weight 5%)

These new adjusters started to be used to disburse DFF funds to health facilities from the October-December 2020 quarter. A lesson learned from this process is that policy dialogue

between financial specialists and program, service delivery or clinical specialists does not always result in complete consensus thus requiring experimentation, data collection and analysis, development of evidence and further refinement. For example, clinicians may believe additional payment for C-sections is justified due to its complexity while financial specialists may believe it creates financial incentives to increase C-sections. The "game" of continuous purchaser-provider and financial-clinical adaptation can be productive and lead to continuous efficiency, equity, and service delivery quality improvements. This is also true of the relationship between health financing and PFM specialists. The Tanzanian experience is contributing to the global knowledge base on creation of a new intersection of health purchasing and PFM whereby financing and purchasing of health services from health providers is not only about financial control but also about "buying the right thing" and increasing efficiency by reducing unnecessary services and waste.

Unifying or harmonizing provider payment across funds flows can reduce fragmentation (mitigate pooling problems) by reducing conflicting financial incentives and their unintended consequences. An element of Tanzania DFF implementation strategy was unifying PHC per capita payment system across iCHF and NHIF funds flows. In addition, complementarity of RBF FFS payment and HBF PHC per capita payment was an explicit part of DFF implementation strategy. DFF HBF and RBF payment maximize impact through a mixed payment model whereby RBF (FFS) leverages performance of all DFF funds and conversely HBF (PHC per capita) serves as a core payment foundation mitigating potential perverse RBF FFS incentives.

A similar PHC capitation payment formula with minor differences in payment adjustors was adopted to disburse improved community health funds (iCHF) to service providers. The formula uses catchment/service population as a measure of need carrying the payment weight of 20% and two adjusters for performance, namely, utilization among CHF members with the payment weight of 70% and population enrolled to CHF in the catchment area with the payment weight of 10%. The population enrolled to CHF was added to motivate health providers to encourage community members to enroll with CHF.

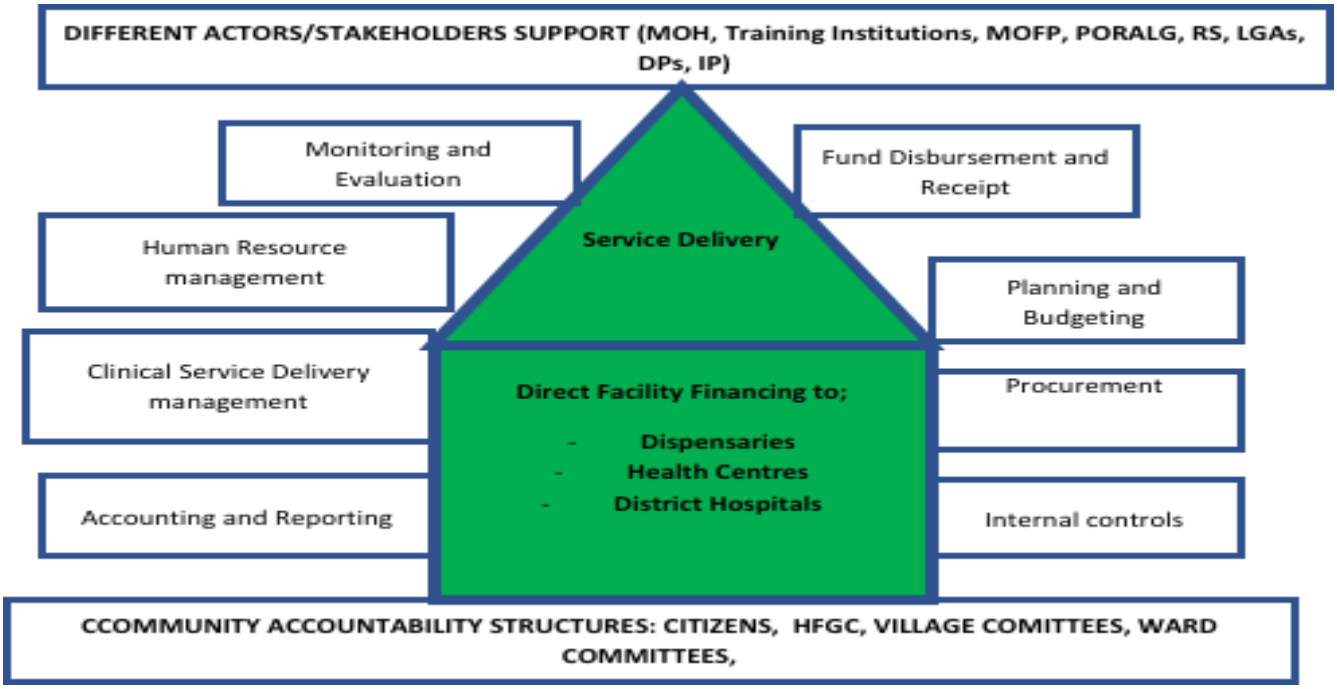
Currently, public facilities that are contracted under NHIF are reimbursed on a fee-for-service basis. However, discussions are ongoing to explore the possibility of improving NHIF provider payment systems to adopt PHC per capita payment system harmonized across funds flows and to improve hospital payment system. It is important to note that, while the ministry responsible for health policy formulation should take the lead in specifying provider payment systems and their corresponding financial incentives, evidence on the ground shows that this is a process that requires a significant level of consultation with wider stakeholders, including development partners who are supporting health sector financing together with other local finance and health experts. Further, for easy implementation and management of DFF, especially from service provider perspective, it is important to harmonize DFF payment mechanisms across different fund sources or funds flows.

4 DFF Management and Provider Role

The introduction of DFF across sectors formally recognizes public service providers as fund managers and spending entities with decision making space and responsibility to prioritize the use of financial resources. However, these service providers including health facilities being public entities, their planning decisions to prioritize use of funds and making expenditures are guided by public financial management (PFM) rules and regulations. These PFM rules and regulations are tailored around three key processes and their corresponding health financing functions: plan and budget formulation and approval, budget execution (health pooling and purchasing arrangements) and budget accounting, reporting and evaluation.

Public health facilities need to have the systems and capacity to effectively implement these processes, especially when financing direct to facilities involves funds that flow through the central treasury/exchequer system including HBF. As a first step, core country PFM systems including planning and budgeting, accounting and reporting (Figure 2) need to be extended to service provider level to enable performance of PFM tasks and processes, build the capacity of service providers to manage funds, and build the confidence and trust of the central treasury in provider management thus increasing their support for implementation of DFF. The following sections present these key DFF implementation systems and processes (Figure 2) in detail with reference to the Tanzania experience.

Figure 2: Direct Facility Financing Implementation Systems and Processes



Source: Draft DFF Management Framework

Improving health purchasing and provider payment as described in Section 3 and extending core PFM systems to service provider level will not realize the expected benefits of DFF if there are insufficient or underqualified facility human resources and ineffective system and processes to manage delivery of clinical services. In addition, it is necessary to put in place a strong monitoring and evaluation (M&E) system to help assess whether DFF implementation is achieving the expected improvements in transparency, equity and service delivery, and also identify blockages that require removal or improvement for successful realization of the benefits of DFF. At the same time (and discussed throughout this paper), institutional roles and relationships need to be aligned in order to match changes that are accompanying the implementation of DFF. Other governance improvements including investing in community accountability structures are also an important aspect enabling realization of the intended objectives of DFF.

4.1 Fund disbursement and receipt

One of the DFF pre-conditions is health facility bank accounts. DHFF management includes three aspects of health facility bank accounts and fund disbursement and receipt. First is opening and use of a single bank account. Health facilities should maintain a single bank account to manage all different fund sources or flows in order to avoid the administrative complications, increased cost or PFM risks that might arise from managing multiple bank accounts. Secondly, public health facility bank accounts should be contained within the country PFM structure (e.g. treasury system, national bank) and be standardized to increase efficiency and ease of administrative operations. All 5,539 health facilities under DFF in Tanzania have established a standard bank account in the national microfinance bank. A third aspect of health facility DFF funds disbursement and receipt is transparent and consistent rules for actual transfer of funds to facilities based on invoices or amounts calculated by provider payment systems (see Section 3 on provider payment above and Section 5 on information systems below) for each funds flow. Following transfer of any type of funds or payments, health facilities book them as revenue in their facility level accounting system.

4.2 Planning and Budgeting

Four of the systems or processes in the DFF management chart in Figure 2 extend core PFM systems to service providers (also a pre-condition especially for accounting for use of DFF funds). In Tanzania, the PlanRep system extends planning and budgeting to service provider level in health and education sectors (health facilities and schools), the Facility Financial Accounting and Reporting System (FFARS) extends accounting and reporting to service provider level in health and education sectors, and procurement systems and processes together with internal controls are also extended to service provider level.

Prior to initiating any spending, all public entities are supposed to develop plans and budgets indicating how their funds will be spent and for what priorities. Service providers that have been recognized as formal fund managing and public spending entities through DFF are also expected to follow the planning and budgeting process. However, many if not most countries do not

recognize service providers as independent spending entities in their treasury systems meaning they do not receive their own individual budget ceiling allowing them to independently develop their own plans and budgets during the budget formulation process. Functioning as public spending entities usually requires inclusion in the country finance structure or chart of accounts (COA) and service providers normally do not exist in the COA (often called economic classification).

In Tanzania, the COA that is used in both local government planning and budgeting and expenditure management systems was re-programmed to include individual service provider codes. The inclusion of service provider codes in the COA created room or a place to enter budget or expenditure ceilings by fund source for each individual service provider. Through inclusion of service provider codes in the COA, service providers can now plan and budget for all funds that they receive or are allocated to them.

Delegating functions (increasing autonomy and accountability) and extending planning and budgeting systems to service provider level by including provider codes will not realize the intended DFF results if facilities do not have the capacity to develop plans and budgets that match their client and community needs or if facilities do not know the specific health services that need to be produced and delivered. In line-item budgeting systems, more focus is normally placed on planning for inputs with less emphasis on how such inputs will translate or be assembled into service outputs. Recognizing this gap, the Tanzanian COA was further strengthened to include 'service output' codes that are used to specify the service output that is expected to be produced upon execution of plans and budgets, and also to connect inputs to them. These improvements helped to create a link between how DFF funds are expected to be used and what are the expected outputs upon expenditure of DFF funds, hence slowly service providers are starting to shift their mentality from input-based line-item budgeting towards output-based budgeting. The bottom-up, community-oriented planning and budgeting enabled and ignited by extension of PlanRep planning and budgeting system to service providers was accompanied by capacity building to facility staff in order to equip them with the ability to develop plans and budgets that match priority community needs.

4.3 Procurement

Parallel to extending planning, budgeting and financial accounting and reporting systems to service provider level, adapting and introducing a sound facility level procurement system is necessary for successful implementation of DFF. Sending money to service providers is necessary but not sufficient to realize the benefits of DFF. Clear procurement systems and procedures and an effective supply chain will help ensure that both general operating inputs (general supplies, utilities, transport, allowances) and health-specific inputs (drugs, other medical commodities and supplies) can easily be procured by service providers using DFF resources. In addition, procurement rules and regulations need to be simplified so they will not act as a barrier to facility staff to procure needed inputs for service delivery. Tanzanian experience to date is that adapting

and extending systems and procedures for procurement of general operating inputs required by all sectors and service providers or business management entities does not present major barriers or obstacles for health facilities.

Procurement of health-specific inputs especially drugs is complicated. In Tanzania, health facilities have two channels to access drugs and other medical commodities/supplies. The first one is through central budget disbursed to the Medical Store Department (MSD) and then used to procure drugs for LGAs and health facilities. MSD procures and directly supplies drugs and other medical commodities based on a combination of health facility need and the budget that has been allocated for each facility. The second channel is through procurement using facility funds that are deposited into their bank accounts. DFF plays an important role and has significantly expanded facility procurement of drugs.

Health facilities procuring drugs directly are supposed to always first try to order drugs from MSD. However, at times MSD is out of stock and service providers experience related stockouts. To address this challenge, the government introduced a Prime Vendor system whereby one entity is competitively selected as an alternative source to buy drugs and medical supplies in case MSD is out of stock. Early analysis has shown the introduction of the Prime Vendor system has complemented MSD and helped increase availability of drugs and medical supplies.

Both health information and PFM systems are key to improvements in both MSD and direct facility drug procurement (see Section 5). The electronic Logistic Management Information System (eLMIS) used by MSD to monitor stock of drugs and medical supplies and process procurement has been extended to service provider level, including PHC facilities. eLMIS has been made interoperable or integrated with GOT Health Operations Management Information System (GOTHOMIS), the system used for patient management at dispensaries, health centres and hospitals, hence facilitating timely information sharing from central MSD to service provider level. In addition, MSD Epicor accounting system and FFARS for facility level accounting have been made interoperable which enables facilities to see their MSD drug account balance and efficiently manage both MSD central budget and facility DFF to improve drug procurement for their patients.

4.4 Internal Controls

This is another PFM function that needs to be extended to service provider level to support DFF implementation. Facilities will establish internal controls including separation of functions and authorization procedures to establish proper spending approval processes and avoid misuse of DFF funds. In Tanzania, health facility governing committees (HFGC) are an important governance structure that helps ensure that DFF funds are used properly and responsibly to deliver priority health services. HFGCs contribute to development and review of plans and budgets, review financial reports, and one member approves all payments to suppliers. In addition, Tanzania plans to extend conduction of internal audits will be to service provider level to ensure that facilities are using funds according to needed regulations and they are getting needed support.

4.5 Facility Accounting and Reporting

Financial accounting and reporting is an important function of financial management in both public facilities and private for profit firms. When public service provider autonomy and accountability is increased health facilities have more flexibility to adapt plans and budgets to spend funds to deliver priority service outputs based on emerging and evolving population needs.

This degree of service provider autonomy and flexibility in prioritizing spending without being constrained by requirements to rigidly follow previously approved plans and budgets (rather than adapt them to changing environments) is deemed essential in the health sector due to the difficult in predicting population health needs with certainty. Managers of autonomous service providers in both public and private sectors are keen to have information to guide their expenditure of funds and also to know and analyze how funds have been used to deliver services. Similarly, sound financial accounting and reporting systems and processes are necessary for DFF implementation. It is difficult to build trust with the Ministry of Finance and other government institutions and public officials on the ability of public health facilities to independently manage funds through DFF without an effective financial accounting and reporting. Hence its designation as a DFF pre-condition along with facility bank accounts, shift to output-based payment and realignment of roles and relationships. In addition, a sound financial management system is necessary to facilitate national level consolidation of financial reports from different public entities, including frontline service providers.

In Tanzania, health facilities did not have a standard system for financial accounting and reporting prior to the introduction of DFF. Health facilities were using their own initiative to do manual accounting including receiving revenue, ensuring expenditures were consistent with their own plans and budgets, documenting procurement paperwork, filing receipts, and reconciling bank accounts. This was the case even after the introduction of user fees whereby facilities were allowed to retain and use such revenue at its collection point.

Following the adaptation of DFF to disburse HBF that flows through the Treasury system, one of the first steps was to develop a service provider level accounting and reporting system that will improve financial management and help guarantee accountability in the use of funds. The simple Facility Financial Account and Reporting System (FFARS) was developed to serve this purpose. FFARS was initially created as a manual system whereby standardized templates and instructions were developed and distributed to health facilities to facilitate recording of facility revenue and expenditure, and also produce reports. Through this initiative, all health facilities were developing standard financial reports.

The next step in the sequencing of FFARS implementation was to program the manual templates into an electronic system that could be accessed at any locality from central, region or local government level. This step was partially driven by internal government dialogue revealing the intent and urgency of capturing all public expenditures in automated systems. Currently, all health

facilities and schools in Mainland Tanzania are using electronic FFARS (25,000+ facilities with a 99%+ system use rate), and all responsible ministries can access information on how facilities are spending funds on a daily basis. The commitment of health facilities and schools to use FFARS and improve their financial management was reflected in the effort of facilities without connectivity to travel to a connected site to enter their FFARS data into the system. To address this connectivity problem, a mobile FFARS version was developed to facilitate ease of use especially in remote areas where there is no or limited computers and internet connectivity or local area network (LAN).

Currently FFARS is being used by all health facilities and schools to book revenue and expenditures, process procurements, reconcile bank accounts, and produce financial reports. FFARS is interoperable with other accounting and financial management systems at LGA and central government level to facilitate generation of national level consolidated financial reports. FFARS system is also interoperable with PlanRep system hence plans and budgets are automatically exported from PlanRep to FFARS for their execution.

4.6 Clinical service delivery management

The ultimate objectives of DFF are improvement of equity/financial risk protection and quality of services, especially primary health care level. Hence an element of DFF management is enabling health services to be delivered according to standard clinical practice guidelines and incentives to introduce quality improvement methods and mechanisms. Health facilities must integrate use of DFF funds into their day-to-day delivery of clinical services including procuring inputs needed to provide services. With support from LGA management, facilities should put in place quality improvement plans to ensure that service providers are continuously investing in providing quality health services to the population. Successful DFF implementation requires a partnership between finance and clinical specialists, and facility staff need to be frequently oriented to make sure they use DFF funds to increase adherence to standard clinical practice guidelines including prescription of drugs, and adopt changes in service delivery technology in a timely manner.

4.7 Human resource management system

Successful implementation of DFF also depends on availability of quality health workforce, especially at PHC level. It is therefore important to make sure that health worker distribution is based on variation in need across service providers. Tanzania designed and implemented a simplified Workload Indicators of Staffing Need (WISN) plus Prioritization and Optimization Analysis (POA) system to improve distribution of staff across health facilities. WISN plus POA takes into consideration variation in need across facilities and gives higher priority to facilities that have few staff of certain cadres as compared to facility workload. While it is a challenge to fulfill the need for human resources in all health facilities, the system helps to reduce gaps in human resource across facilities and complements DFF which better distributes money according to facility need.

Tanzania DFF implementation generated experience related to staffing financial management functions and tasks: 1) nurses or other dispensary staff were able to perform the relatively simple accounting processes using FFARS for small front-line service providers especially after deployment of FFARS mobile app reduced travel requirements to enter data; and 2) HBF-funded accountants at larger health centers were an important aspect of DFF introduction and also helped mentor dispensary level staff. Continuous capacity building for facility staff is necessary to make sure that they have required managerial capacity to managed delivery of health services under DFF.

Retention of staff at PHC facilities serving poor and remote populations is also a major human resources problem. Early results of DFF implementation indicate that it helps to improve staff motivation, for example, 76% of staff believe there have been positive changes over the last year, and 56% of respondents reported that drug and teaching material availability together with paying staff allowances improves staff motivation and retention.[4] In addition, evidence is accumulating on linkages between DFF and community health workers (CHWs) that can play a pivotal role in assisting with clinic and outreach services. A health facility in-charge explained: "We have used some of the additional funding received quarterly to share with CHWs who have done a very good job of community outreach that has nearly doubled our health center's service users."

4.8 Monitoring and evaluation

Establishing an effective monitoring and evaluation (M&E) system is another important factor contributing to successful DFF implementation. M&E is necessary to ensure that other DFF functions or processes (i.e. fund disbursement, planning and budgeting, procurement, internal control, financial accounting and reporting, clinical services delivery management, and human resource management) are implemented in the right direction in order to facilitate realization of the expected DFF objectives of increasing transparency, efficiency, equity, and financial risk protection and improving management and quality of service delivery, especially for underserved populations. M&E will also help to identify DFF implementation challenges, including capacity building needs so that appropriate financial and technical resources could be mobilized in time. GOT is in the final stages of development of M&E function under DFF management framework with both processes and indicators such as disbursement time, production of financial reports, and specific service delivery indicators.

5 Information management systems to support DFF implementation

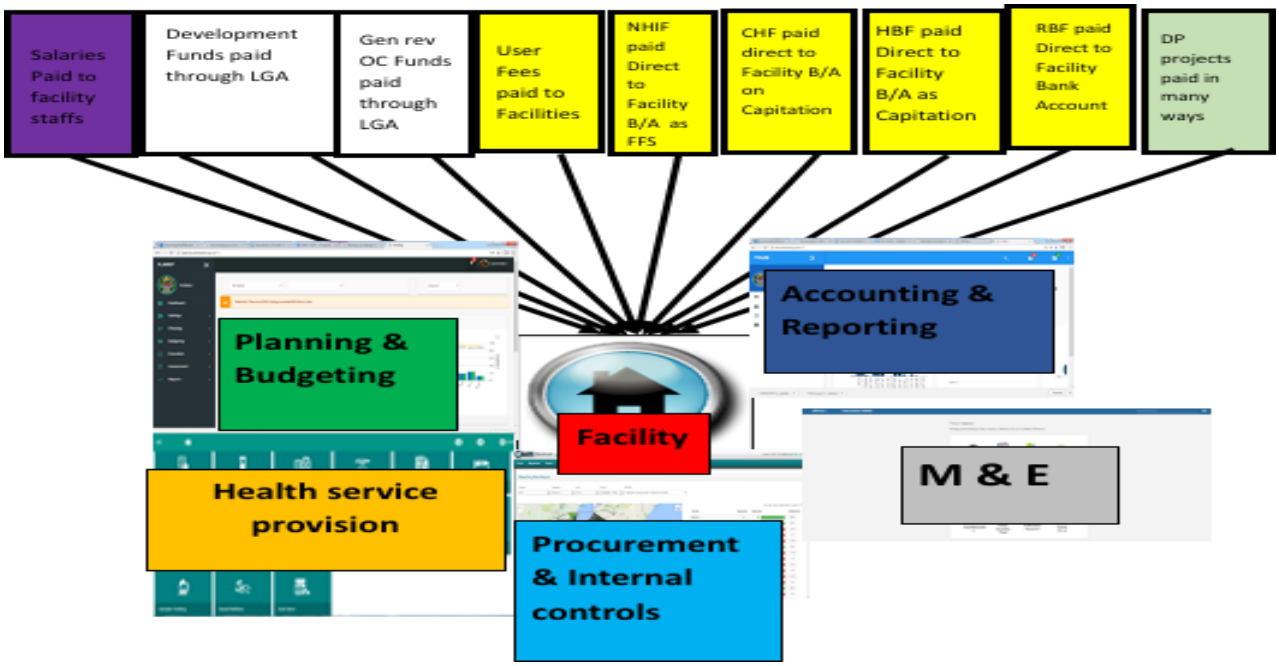
DFF implementation has increased the type and volume of information management requirements at the service provider level. Strengthening service provider PFM and health systems increases the flow of data to and from facilities and generates information to ignite and support improved service provider management.

[4] Reference USAID PS3 facility OR study

Since 2017, a number of systems have been extended to health facility level (Figure 3) including planning and budgeting system (PLANREP), facility financial accounting and financing reporting system (FFARS), health service and patient management system (GOTHOMIS) and the Integrated Monitoring and Evaluation System (iMES). The government in collaboration with development partners has provided training, mentoring and technical support every time a new system is developed or refined and extended to facility level. These systems improve efficiency, transparency, and management of service delivery and as a result support effective implementation of DFF. While DFF is an important initiative to improve equity and service delivery especially at primary health care level, the degree of information that facilities are required to manage and submit to a variety of different government institutions could undermine the gains from DFF, especially when such information is produced by different standalone systems. Capacity building initiatives on their own cannot eliminate the inefficiencies that arise from standalone or fragmented operation of these systems. Realizing this challenge, the GOT took deliberate initiative to make sure that the extended information systems are automated and interoperable to allow information sharing across systems.

The automation of PFM and health systems reduces the degree of manual work health facility staff have to do to generate required information and reports for institutions across levels of government, and also enables better data analysis and management at health facility level. The interoperability of PFM and health information systems reduces administrative costs and creates time savings by providing timely and seamless portability and sharing of information across systems to increase efficiency and improve management and service delivery for citizens and communities. The use of electronic mediums of data interchange without human interventions reduces the possibility of the occurrence of human induced errors. It has also reduced the related potential for performing erroneous reporting which could result in poor management and decision-making. The sections below describe specifics of system interoperability and examples of the functioning of automated interoperable PFM and health information systems that manage DFF funds in Tanzania.

Figure 3: Information systems extended to health facility level to manage DFF implementation



Source: PORALG

5.1 Systems interoperability

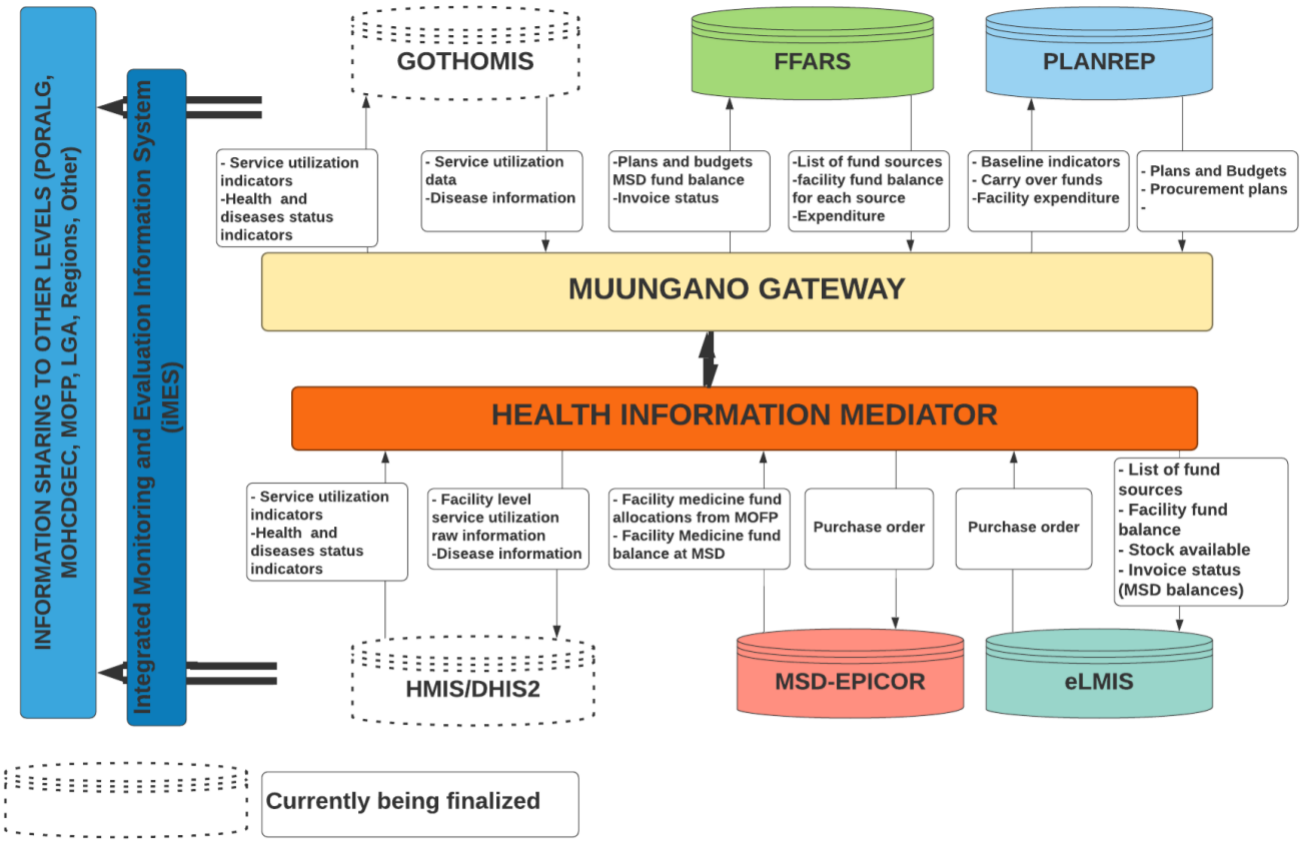
The PORALG Muungano Gateway information mediator and the MOHCDGEC Health Information Mediator (HIM) are the mechanisms used to facilitate interoperability or sharing of information between all local government systems hosted at PORALG and all health systems hosted at MOHCDGEC. In addition, MOFP operates an information mediator sharing information both within its systems and across other government systems, and President's Office Public Service Management and Good Governance/eGovernment Agency (POPSMGG/eGA) is responsible for all government information sharing and mediators.

Muungano Gateway and HIM enable central management of the way systems exchange data and operate processes including transaction logs where the success or failure of data exchange can be viewed, maintained, and continuously improved. In addition, PORALG Information,

Communication and Technology (ICT) Department has established a national Help Desk to structure, organize, manage, maintain and refine information systems, and also ensure a strong focus on support and mentoring for system users at local government and service provider levels. Figure 4 illustrates the systems connected to the Muungano Gateway and HIM and the types of transactions exchanged by them.

The integrated monitoring and evaluation system (iMES) is the new cross-sectoral web-based system or database built on District Health Information System 2 (DHIS2) platform to export data from Muungano Gateway, Health Information Mediator, and other government information mediators. It is a key to realizing the potential of system interoperability by maximizing access, use, and analysis of information, and also to production of timely and relevant reports contributing to improved management and service delivery. Selected information from cross-sectoral and sector-specific interoperable systems is exported and stored in iMES. It contains a public portal enabling access to information for Tanzanian citizens, development partners and other stakeholders.

Figure 4: Facility Level Systems Interoperability



5.2 Systems that share information through Muungano Gateway and Health Information Mediator (HIM)

a) The interoperability of the PFM and health systems of hosted at PORALG and MOHCDGEC relies on the presence of Muungano Gateway and HIM. PFM systems managed by PORALG and interoperable and sharing information with each other through Muungano Gateway include Facility Financial Accounting and Reporting System (FFARS), Planning, Budgeting and Reporting System (PlanRep), and Government of Tanzania Health Operations Management Information System (GOTHOMIS). Health systems managed at by MOHCEGEC and interoperable and sharing information with each other through HIM include Electronic Logistic Management Information System (eLMIS), Medical Stores Department financial management system (MSD Epicor 9) and Health Management Information System (HMIS). In addition, the presence of Muungano Gateway and HIM information mediators produces interoperability and sharing information across PFM and health sector systems. The three sub-sections below describe interoperability of PFM and health systems particularly important to DFF implementation.

PlanRep and FFARS

PlanRep is the planning, budgeting and reporting system used by LGAs, health facilities and schools. The system is interoperable with financial management systems (FFARS at facility level and Epicor at LGA level) and is used by LGAs as the core reporting system. FFARs captures funds received and expenditures made at the facility level, generates reports to Local Government Authorities (LGAs), Regional Secretariats (RS), PORALG, sector ministries, and other government institutions. Facilities are using this system to manage execution of their plans and budgets, including processing procurement and payment to vendors. Through interoperability, plans and budgets that have been prepared and approved in PlanRep are automatically exported to FFARS for execution. To complete the reporting process, FFARS exports back to PlanRep information on facility revenue, expenditures and fund balance for automatic generation of quarterly and annual financial and program implementation reports.

b) FFARS vs MSD Epicor Accounting System

As described in Section 4.3 Procurement, there are two types of disbursements or funds flows used to procure drugs for health facilities: DFF funds that are deposited and managed through facility bank accounts and Ministry of Finance and Planning (MOFP) allocation of central budget funds to MSD for procurement of drugs and other medical supplies for each facility. For central budget funds, health facilities will be sending their request for medicine and other medical supplies to MSD based on each facility allocated ceiling.

MSD uses Epicor accounting system to manage expenditures for drug procurements from central budget funds. FFARS and MSD Epicor have been made interoperable and health facilities are now able to monitor their funds managed by MSD as information on how much has been spent and

remaining MSD balance is automatically sent to FFARS (rather than requesting this information from MSD, a process that took a long time). Health facilities benefit from this interoperability between FFARS and MSD Epicor as they are able to comprehensively plan, budget, and manage drug procurement using both their own facility funds (DFF) and their MSD account funds. MSD also benefits from FFARS and MSD Epicor interoperability as they can easily track facility fund balances in facility bank accounts when facilities are placing health commodity orders and can supply them with confidence that facilities have the ability to pay.

c) Health Information Systems: GOTHOMIS, HMIS2 and eLMIS

The GOT Health Operations Management Information System hosted by PORALG is used to manage patient information at public dispensaries, health centers and district hospitals. The system has different modules including registration, diagnosis, prescription, lab, pharmacy, and user fee payment. A simplified mobile version of GOTHOMIS has been developed for frontline primary health care (PHC) facilities, particularly dispensaries and health centers. Its interface has been streamlined and can be used in parallel with the mobile version of FFARS.

GOTHOMIS is interoperable with MOHCDGEC Health Management Information System (HMIS) on District Health Information System 2 (DHIS2) platform thus facilitating automatic aggregation of facility level disease, service utilization and other health information that is required at the national level. Prior to the introduction of GOTHOMIS, facility staff were required to manually fill in registers, tally sheets and HMIS monthly summary forms, which were submitted to the district HMIS focal person, who entered the data into HMIS/DHIS2. Extension of GOTHOMIS to facility level and interoperability with HMIS allows all information to be automatically generated from the system and easily accessible across different levels.

The interoperability of health information systems has also eased patient management and the availability of patient records. Health facility staff are able to use GOTHOMIS to manage inventory of drugs including ordering of new stock, collect revenue and submit health insurance claims to the National Health Insurance Fund (NHIF) because of its interoperability with MSD electronic logistic management information system (eLMIS) and NHIF claims management. The establishment of GOTHOMIS and its interoperability with HMIS, eLMIS and NHIF has improved the following:

1. **Reporting:** A key to performance of information systems is improving the availability of data and quick reporting. With patient -level clinical data in place, GOTHOMIS becomes a tool to production of easily available HMIS Reports as opposed to the tedious and inconsistent paper-based ones (e.g. utilization and other health statistics, practitioner performance reports, medical supplies usage reports, revenue collection reports and other service delivery reports). The development of functionality to automatically generate HMIS data in the facility level GOTHOMIS system and use system interoperability to automatically feed this data into the national HMIS system on DHIS2 platform to automatically produce reports has been

completed and the MOHCDGEC is expected to beginning official use of this functionality soon.

2. **Electronic Medical Record:** GOTHOMIS contains powerful features for capturing, storing and disseminating patient level clinical data. The system captures registration (regular/emergency), clinical and investigations data across patient visit episodes. With a centralized repository of the data at the national level, GOTHOMIS makes it possible to have a complete patient profile and medical record whenever a patient visits any health facility across the country. Availability of centralized data is also an indispensable ingredient for data analysis, research and decision-making at facility, LGA, regional and national levels. In addition, patient-level data collected through GOTHOMIS links clinical and financial information to increase efficiency by feeding into the claims management system of insurance systems in the country, including the National Health Insurance Fund (NHIF) and the forthcoming Single National Health Insurance System (SNHI).
3. **Inventory and Supply Tracking:** GOTHOMIS also provides information for tracking medicines and other medical commodities supplies as they trickle down and are used by the final consumer at health facilities. Within facilities, the system records medicines as received at the main pharmacy and the distribution and use across various departments/sections in the facility. Correct recording of usage enables a health facility to better manage inventory and estimate requisitions for medicines and supplies stock. The system is interoperable with eLMIS for ordering medicines from MSD. Managing and tracking inventory helps reduce stock outs, overstocking, lost items and counterfeit goods. Managers can also improve their cost and planning estimates and reduce waste in the system thus increasing efficiency and extending service coverage. GOTHOMIS and eLMIS interoperability also allows MSD to better plan and procure medicines and other medical commodities to meet the needs of all health facilities as information on facilities' stock is readily accessible to MSD. MSD can monitor utilization of these health commodities across service providers and can project future needs based on trends across facilities. Facilities can place their order on eLMIS and they can also get information on drugs that are out of stock at MSD so that they can proceed procuring such items from prime vendors or other private pharmacies.
4. **Billing and Revenue:** GOTHOMIS also incorporates billing and revenue collection functionality in the service delivery chain. This feature increases transparency and prevents dishonesty in cash handling, ensures correct billing and provides for correct and quick reporting of revenue. The system also incorporates handling of insured clients and exemptions as per policy which together with DFF help make exemptions work and increase access for the poor and underserved. With the advent of the Government Electronic Payment Gateway (GePG), GOTHOMIS has laid the groundwork for a cashless environment for revenue collection at health facilities.

6 Institutional roles and relationships and implementation sequencing

As emphasized throughout this paper, successful DFF implementation depends on realigning and strengthening institutional roles and relationships. It encompasses increased provider autonomy and corresponding realignment of roles and relationships vertically across levels of government, and the horizontal roles and relationships between national ministries. DFF increases health provider autonomy and accountability and kindles management improvement by shifting some decision-making to facilities on planning, budgeting, and procurement of inputs to deliver service outputs based on individual and community need. Health facilities have a key role in management and governance of service delivery processes and in response to DFF they quickly and proactively stepped up although they require additional training and mentoring to increase capacity and confidence (see Section 7). The realignment of LGA roles are particularly critical to DFF implementation as they shift from day-to-day operations to support and oversight of service providers.

DFF implementation also triggered realignment of national ministry roles and relationships particularly related to health service purchasing, payment and provision or management. DFF HBF roles included MOHCDGEC as purchaser deciding on what and how to purchase health services (benefits package and provider payment system), Ministry of Finance and Planning serving as lead ministry in planning and budgeting and payer transferring funds to service providers (this role may shift to MOHCDGEC/NHIF under national health insurance), and PORALG role in service provision and establishing DFF management framework to guide health facilities in use of funds including procurement, accounting and reporting. Clearly defining and realigning roles and relationships of all actors and stakeholders (e.g government institutions, citizens, private sector, development partners) is imperative and ongoing to support DFF implementation, avoid inefficiency and duplication of functions, and sustainably improve equity and management of service delivery..

DFF implementation in Tanzania provides an example of how to use implementation sequencing as an explicit strategy to start simple, develop experience and better data, and then refine systems and processes over time to both improve and continuously adapt to evolving purchaser-provider dynamics. DFF was also used to unify fragmented funds flows (reduce pooling problems) and reduce conflicting financial incentives and their unintended consequences.

Stakeholder dialogue on implementation was extensive particularly related to geographic phasing: should DFF be implemented nationwide or start smaller in pilot or Phase I regions and then scale-up? Tanzania's strong preference was for nationwide implementation for reasons including equity and fairness, and this option was selected. While difficult to analyze or compare without a baseline (see Section 7 for findings from field visits and operations research studies), an overall assessment of the geographic phasing choice is that any loss of targeted capacity building was countered and overwhelmed by the gains from immediate institutionalization into GOT systems, high level of

ownership across all levels of government, and extensive and focused GOT and DP PFM system installation, training and mentoring using PORALG Help Desk and other communication mechanisms (WhatsApp Groups, e-mails, phone).

Other segmentation options and choices considered during development of DFF sequencing strategy and implementation plans were type of funds, type of costs and type of facility. It was decided to begin with HBF flowing through country PFM systems and contribute domestic other charges (OC) funding as a next step. Type of costs were focused on operating not labor or capital costs to shift prioritizing expenditures for relatively small but direct costs of patient care to the facilities serving their communities. Starting with only hospitals and health centers was considered but GOT decided to include all health facilities in DFF implementation to support and strengthen front-line PHC especially for underserved populations. Again, findings from dialogue, field visits, and operations research studies (see Section 7) demonstrated that inclusion of all dispensaries helped feed the facility management and service delivery transformation as this massive PHC front-line responded quickly to financial incentives and showed themselves able to manage their funds using PlanRep and FFARS extended to facility level.

Several complementary positive dynamics contributing to the global knowledge base emerged from DFF and its corresponding extension of PFM systems to service provider level. Two examples are facility and LGA planning by service output strengthening the PFM and health purchasing intersection, and improvements in multi-sectoral planning. Stimulated by GOT intent to ensure that DFF plans and procurements better match priority services, service outputs were added to PlanRep for all public sectors and services. Although they were still converted to input-based planning and budgets for aggregation to the national level, it was immediately clear that planning by service outputs stimulated LGAs and facilities to better define and plan their services to clients and communities. The impact of planning by service outputs on multi-sectoral planning was large and immediate. Nutrition, social welfare, and gender-based violence all documented better plans and increased budgets when all public sectors were able to clearly define and plan their contributions to these multi-sectoral priorities.

7 DFF implementation successes and remaining improvement needs

A detailed facility operations research study was conducted under the USAID Abt Associates Public Sector Systems Strengthening Project (PS3)[5] project in 2020 to understand the effect of DFF and extension of PFM systems on facility management and governance. This study was conducted in both health facilities and schools and involved 72 facilities (36 schools and 36 health

[5] PS3 is an abbreviation for Public Sector Systems Strengthening, the project that was funded by USAID to support the Government of Tanzania to support its public sector systems in four areas; Information Systems, Public Financing, Human Resource and Governance and Citizens Engagement.

facilities) in nine LGAs. The study revealed a number of successes and challenges associated with implementation of the important DFF initiative.

The study documented that DFF has ignited changes in the way facilities manage and operate to serve their citizens and communities. Coupled with stronger PFM systems at the facility level, including the PlanRep system for planning and budgeting and FFFARS for accounting and financial management, there has been an increase in transparency, autonomy, and accountability at the facility level. With the power to directly receive funds, and the systems to better plan and account for those funds, health facilities and their governing committees are beginning to strengthen their own management processes and more actively engage communities to improve public sector service delivery. DFF also establishes the health financing foundation required to implement national health insurance moving towards universal health coverage by ensuring that health facilities are prepared to receive and manage insurance payments. A summary of study findings is represented in the following quote from a Dispensary In-Charge:

> *"Our ability to provide services has improved significantly, we are now able to purchase goods based on needs of the facility and thus provide good and quality services. Previously, we used to receive drugs that we were not in need of or not relevant. Supply of drugs has improved by more than 65%."*

Specific successes and challenges are described below:

7.1 DFF successes

DFF implementation across facilities helped to improve predictability of funds availability at service provider level, improve facility planning and budgeting, improve facility procurement and facility governance, and better align roles and relationships. These successes are briefly elaborated below.

7.1.1 Improved predictability of fund flows

The findings from the study documented that a majority of facility in-charges reported a major benefit of DFF was helping to improve predictability of funds receipt in terms of both timing and amount. Out of 71 facility in-charges interviewed during the study, 51% said that the timing of funds transfer has become predictable. A significant number of respondents (45%) reported that the revenue (payment) formula was "good." The implication is that facilities are now able to better organize and make arrangements for procurement of inputs needed to provide priority health services. In addition, due to improved understanding of the formula used to determine the level of payment to them, facilities are now more able to develop strategies to increase revenue based on the financial incentives contained in the DFF payment formula.

7.1.2 DFF promotes results-based planning

As implemented in Tanzania, a key aspect of DFF is the shift from input-based to output-based payment. This shift also enabled and drove output or results-based planning and budgeting, requiring health facilities to better plan and budget inputs to better deliver priority service outputs. Evidence shows that shortly after planning and budgeting systems were extended to service provider level, facility staff felt they have increased responsibility and flexibility to prioritize how their funds are allocated to deliver priority services based on community needs. Both facility staff and health facility governing committee members acknowledge that the introduction of DFF and the extension of core PFM systems (PlanRep and FFARS) to the facility level have made decision-making more evidence based.

7.1.3 Improvements in facility procurement

Through introduction of DFF, facilities can now procure with certainty the priority inputs that they needed to deliver services at the right mix. Of the procured items listed, 48% were related to direct inputs for service delivery (e.g. drugs, supplies, teaching materials, stationary, consumables), 29% were related to infrastructure, 9% was staff allowances, and 5% was to pay for utilities. These findings suggest that when facilities receive funds directly, they have the ability to prioritize and manage procurement of inputs according to what they need most to deliver health services. In addition, with funds available in facility bank accounts, facility management can more easily and quickly react to evolving or emerging service delivery procurement needs. For example they can manage emergence of periodic outbreaks such as typhoid or respond to the COVID-19 pandemic and buy necessary protective gears such as masks and sanitizers.

7.1.4 DFF helps to strengthen governance at facility level

Following the introduction of DFF and extension of strengthened systems to service provider level, health facility governing committee (FGC) members acknowledge that the situation has changed for the better. FGC meetings are now being held more often and engagement with communities using both formal and informal processes has increased. Respondents explained that they now have more to bring to citizens and communities. Similar findings were observed during a joint field visit[6] involving development partners who have interest in the health sector and GOT representatives, who noted that there is a realized positive change in health service delivery in terms of transparency, management, availability of health commodities, infrastructure improvement, and effective ways of engaging community structures in health planning and implementation at district level and lower local government and facility levels

[6] Joint Field Visits Report Direct Health Facility Financing – Are we on the right track? Joint Annual Health Sector Review 2018

7.1.5 DFF promotes better alignment of roles

The study found that a significant number of health facility in-charges believe and appreciate that DFF has allowed them to better perform their respective roles in delivering services to beneficiaries by enabling them to procure drugs, equipment, and learning materials. Facility in-charges further reported seeing improved relationships with FGCs and their staff because having funds available allows them to pay staff allowances on time, as well as FGC transport allowances to attend meetings. Moreover, staff reported enhanced involvement in making decisions on spending facility funds - they initiate the procurement of inputs and together with the FGC verify the delivery of ordered inputs. Staff and FGCs members confirmed they can better manage financial resources through FFARS, and they frequently give feedback to community members through village meetings. Staff were feeling more motivated due to availability of inputs enabling them to perform their roles better. All FGC members reported they are engaging well with the facility management team, there is good collaboration between FGCs, and facility management, and together they are now able to better respond to citizen and community needs.

7.2 Remaining DFF improvement needs

Although DFF has demonstrated important beneficial effects as discussed above, there are a number of issues or challenges that must be addressed to reap the full benefits of the initiative with two examples described below.

7.2.1 Continuous investing in capacity building

Successful DFF implementation requires financial management systems and skills at the service provider or facility level. Not all health facilities had the required skills to use FFARS and other systems that have been extended to service provider level hence they frequently asked for LGA support to produce the required financial reports. Facility level proficiency in use of PFM systems is an area that requires continuous capacity building especially due to facility staff turnover including transfers and also the need to build capacity of newly hired staff. Further, investment is still required in computers, internet connectivity, computer skills, and analytical skills for better use of data in order to realize the full benefits of DFF. Comparable to accounting and financial management investment in planning, budgeting and program implementation capacity building is needed so that facilities will be able to deliver required priority service outputs. In addition to capacity building on use of systems, there is a need to provide support on IT infrastructure including procurement of computers and extension of network to facilities especially for facilities located in remote areas.

7.2.2 Balancing flexibility and financial risk in budgeting and procurement

The overall suggestion from health facility managers and staff is to introduce more flexibility in budgeting and procurement systems and processes. Specifically, to allow facilities the flexibility to adapt to unforeseen events (e.g. disease outbreaks) including procuring inputs that were not

initially budgeted in their approved plans or reallocate funds from one activity to another at any time. PFM rules and regulations still need to be adjusted to allow this flexibility with appropriate accountability and internal controls to manage any potential financial risks that may arise. Currently, health facilities can reallocate funds across activities or inputs only at the mid-point of the financial year and the processes are often administratively burdensome. Greater flexibility will eanble facilities to react to any unforeseen needs at any time, bearing in mind that facilities may fail to plan and budget for all necessary priorities due to the unpredictable nature of health care needs. Further, there are spending rules and guidance for each funding source or funds flow. A key next step is to harmonize spending guidelines across fund sources to increase efficiency, reduce administrative costs, improve management at service provider level, and mitigate pooling problems until implementation of single national health insurance as planned.

8 Conclusions and DFF lessons from Tanzania implementation experience

a) Introducing DFF is an important step towards creating a new intersection improving the alignment between PFM and health sector financing and purchasing. The shift to output-based payment inherent in DFF helps realize this improved alignment of PFM and health purchasing systems, rules and regulations.
b) Harmonizing provider payment systems and their corresponding spending guidelines across different fund sources flowing directly to service provider simplifies management of funds at service provider level, increases efficiency and reduces administrative costs.
c) DFF is not only about disbursing funds to facility bank accounts but also improvements in PFM systems and processes (e.g. extending planning, budgeting, accounting, reporting systems to facility level, DFF management framework) that will help health facilities to better use DFF funds to improve health service delivery and ensure financial accountability.
d) While there are a number of systems and management processes that need to be in place for successful DFF implementation, the following are the priority first steps. To reiterate, the Tanzania DFF implementation experience led to the conclusion that globally relevant pre-conditions can be identified, supplemented by step-by-step introduction of country-specific systems and processes.
    - ✓ Establish facility bank account
    - ✓ Clearly defined provider payment system including shift to output-based payment to enable service providers to better match available resources to priority health services
    - ✓ Extend PFM systems to service provider level, especially financial accounting and reporting system to build capability and trust that health facilities will manage spending well and be accountable for use of funds.
    - ✓ Improve alignment of institutional roles and relationship to match the changes accompanying the introduction of DFF, and also ensure all players have a clear understanding of their roles in DFF implementation

- ✓ Establish an effective monitoring and evaluation system that will be used as a feedback mechanism to understand whether DFF is producing the intended results and/or identify the gaps that need improvement to realize such expected results

e) Invest in infrastructure and building capacity of health facility staff in order to equip them with the knowledge and skills to manage all aspects of DFF implementation including planning and budgeting, procurement, and financial accounting and reporting.