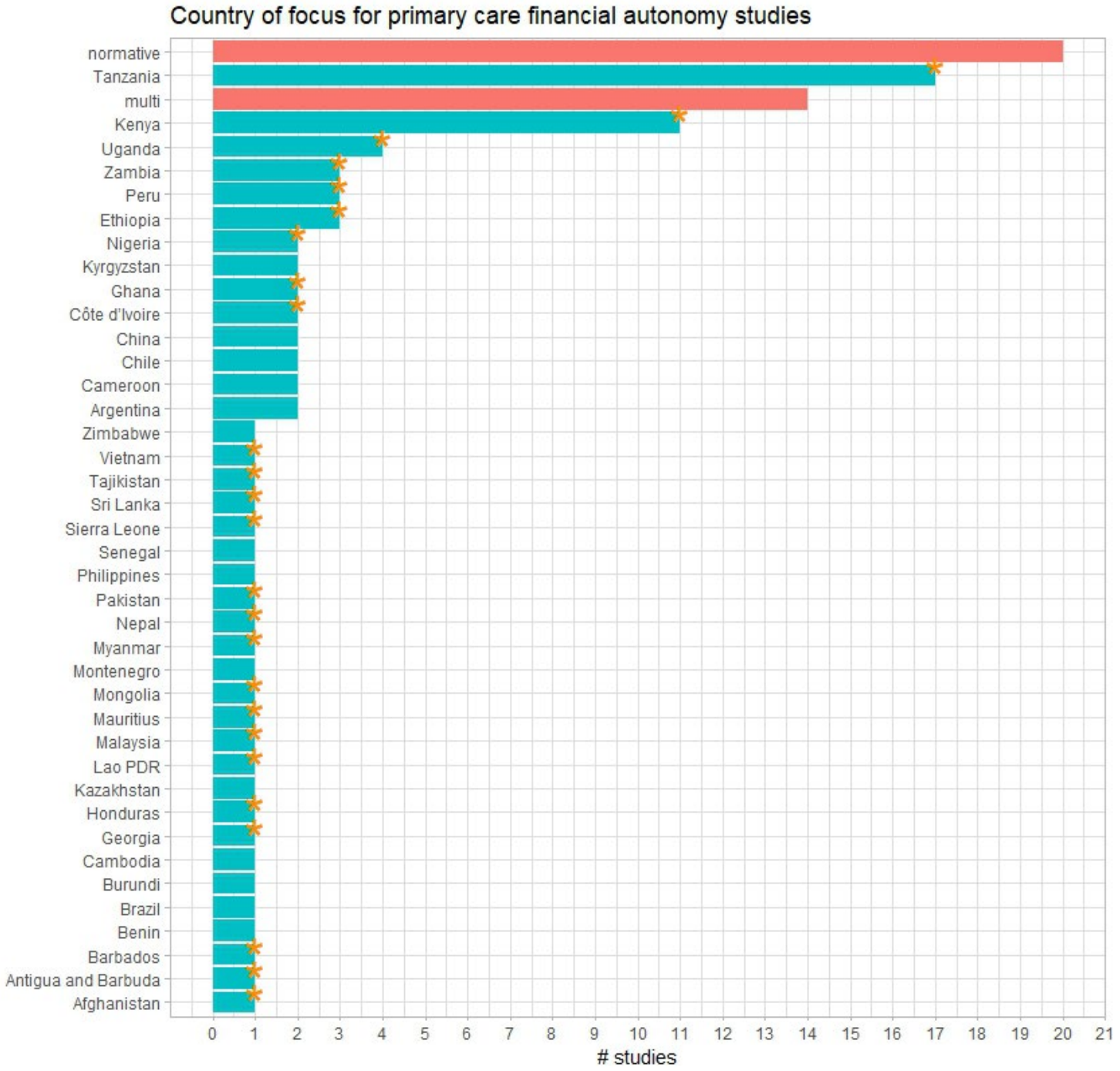
Exploratory review of financial autonomy at primary care level

Sophie Witter, Maria Bertone, Lucas Sempe, Quentin Baglione

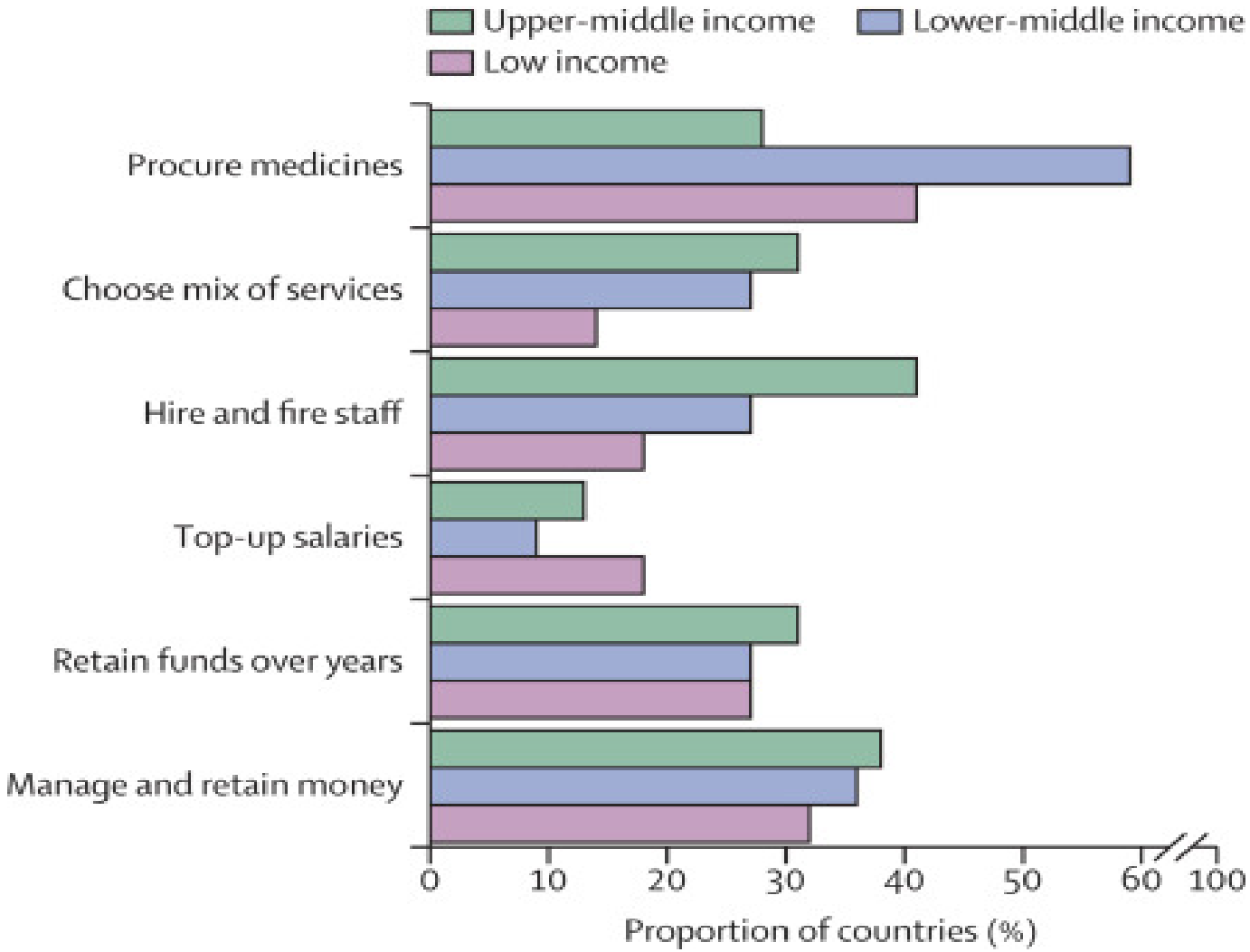
Methods

- Scoping literature review (n=91)
- Extraction from HFPM data (n=25 countries)
- Expert interviews (n=12)
- Team's own insights
- Formal literature is limited in depth
- But combined methods yielded insights across wide geographies (c. 40 countries)



How much autonomy do primary providers have?

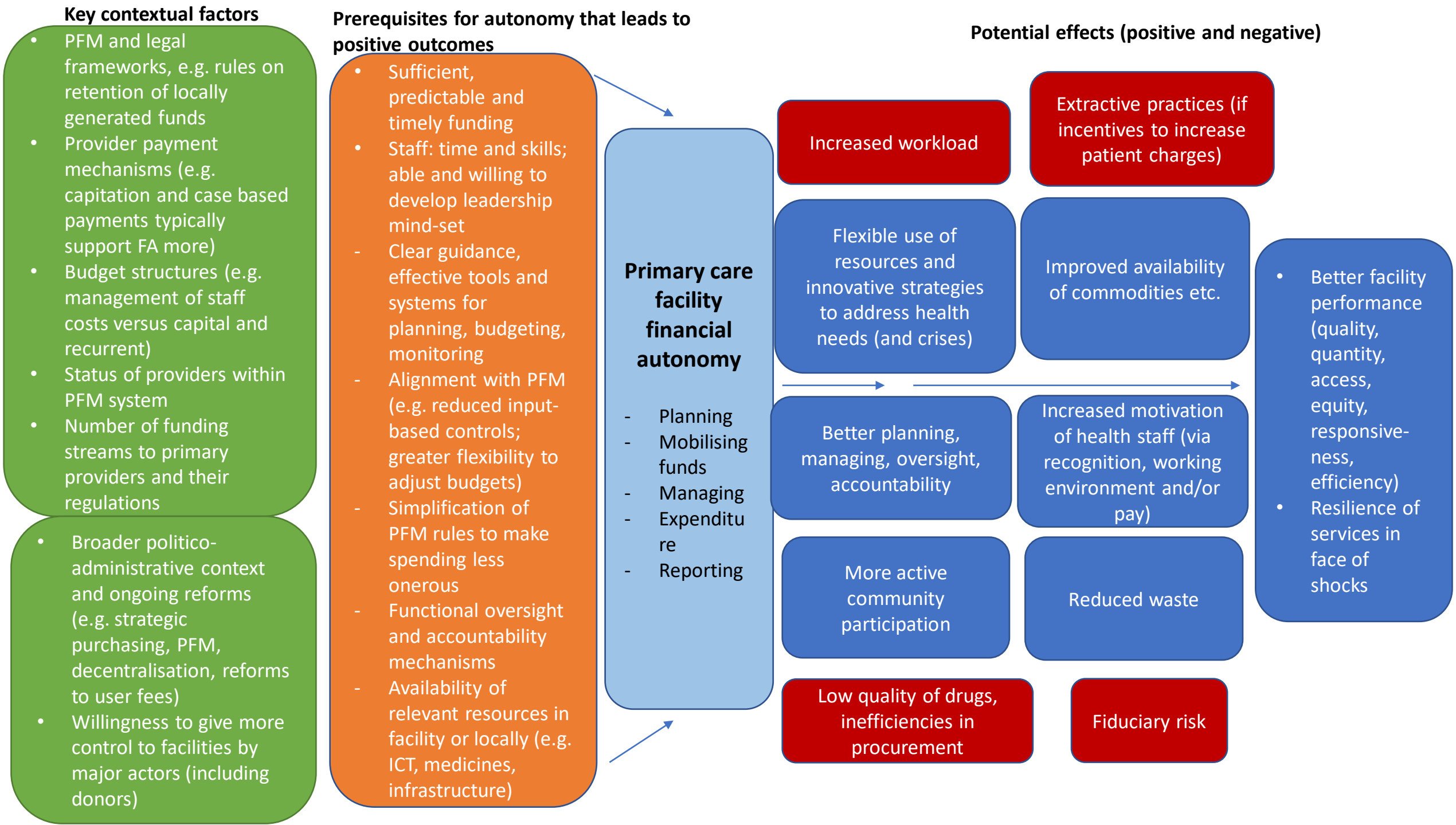
- Varies by area, by low autonomy in general (<40% manage and retain funds)
- Somewhat of gradient by economic level, but not consistently



Source: Hanson et al. 2022; data from 75 LMICs

Financial autonomy scenarios, by budget cycle

	Low financial autonomy scenario	Medium financial autonomy scenario	High financial autonomy scenario
Planning of budget	Budgets are allocated from above with no scope for facilities to influence them	Facilities make inputs into budget process but can only influence the final budget in limited ways	Facilities structure own budgets according to their identified activities and needs
Mobilising and retention of additional funds	Funds are fixed externally; no ability to mobilise additional funds at facility level. Funds remitted to Treasury or district/higher level. All funds spent within financial year	Most funds are fixed; some small (marginal) additional fund mobilisation is permitted and retained at facility level, with rest remitted to higher levels. One part of revenues can be retained (e.g. use of user fee or PBF income) across years	Able to raise funds independently from multiple sources, as available, without restrictions. All funds raised are retained at facility level. All funds can be retained across years, if unspent
Management, including reallocation	Budgets are fixed (often by line item) and changes across them are very cumbersome and limited (or not possible). Most of expenditure is ring-fenced. Where multiple revenue sources exist, there are strict rules about how they can be used	Some in-year changes in budget are possible, with higher authorisation. There is some flexibility around deployment of different revenue streams according to facility needs	Facilities can shift funds across budget lines within clear parameters set out in advance (with simple approval procedures where this threshold is exceeded), drawing flexibly from the different funding streams that they can access
Expenditure	Most expenditure is made at higher levels (on behalf of the facilities), with inputs provided in kind. Facilities do not need or have bank accounts	Facilities have access to limited funds to use for small costs (often minor operational costs, such as cleaning and maintenance). They may have bank accounts but can also operate through petty cash	Facilities can actively manage their major expenditure items, including for locally hired staffing, medicines and supplies and operational costs. They all have bank accounts
Reporting	Facilities have no financial reporting requirements as they are not recognised within the PFM system	Facilities report on expenditure via higher level (such as districts) for funds released by them to the facilities	Facilities are spending units, accounting within the PFM system for their expenditure


Key contextual factors
PFM and legal frameworks, e.g. rules on retention of locally generated funds
Provider payment mechanisms (e.g. capitation and case based payments typically support FA more)
Budget structures (e.g. management of staff costs versus capital and recurrent)
Status of providers within PFM system
Number of funding streams to primary providers and their regulations
Broader politico-administrative context and ongoing reforms (e.g. strategic purchasing, PFM, decentralisation, reforms to user fees)
Willingness to give more control to facilities by major actors (including donors)
Prerequisites for autonomy that leads to positive outcomes
Sufficient, predictable and timely funding
Staff: time and skills; able and willing to develop leadership mind-set
- Clear guidance, effective tools and systems for planning, budgeting, monitoring
- Alignment with PFM (e.g. reduced input-based controls; greater flexibility to adjust budgets)
- Simplification of PFM rules to make spending less onerous
- Functional oversight and accountability mechanisms
- Availability of relevant resources in facility or locally (e.g. ICT, medicines, infrastructure)
Primary care facility financial autonomy
- Planning
- Mobilising funds
- Managing
- Expenditure
- Reporting
Potential effects (positive and negative)
Increased workload
Extractive practices (if incentives to increase patient charges)
Flexible use of resources and innovative strategies to address health needs (and crises)
Improved availability of commodities etc.
Better planning, managing, oversight, accountability
Increased motivation of health staff (via recognition, working environment and/or pay)
More active community participation
Reduced waste
Low quality of drugs, inefficiencies in procurement
Fiduciary risk
Better facility performance (quality, quantity, access, equity, responsive-ness, efficiency)
Resilience of services in face of shocks

Key message 1: better conceptualisation

- Autonomy has many aspects, which need more detailed unpicking, potentially along the lines of the typology which we have developed here
  - Facilities may have considerable autonomy in one aspect but not another, and their interaction is important
  - Equally, autonomy often varies according to funding sources and expenditure types, which can be a complex mix at facility level.

- It is not a binary choice (autonomous or not)
  - Nor is it a simple continuum (with more autonomy always being better - the arrangements need to follow the contextual needs)

Key message 2: raise the profile of the issue

- Autonomy at primary care level has not received as much attention as that at hospital level
  - likely reflects the fact that in most health care systems, public primary care facilities have had limited funds and limited autonomy over them (as highlighted in our analysis of the HFPM data)

- Need for more focus on this issue, including in-depth case studies to elaborate the nature and strength of the relationships in the preliminary conceptual framework

- Areas to explore include:
  - different ways of increasing primary care financial autonomy without high transaction costs;
  - better documenting the role of multiple funding streams at primary care level, and their interaction with financial autonomy;
  - understanding the role of different types of expenditure (e.g. management of staffing budgets) and different facility characteristics, and how these interact with financial autonomy;
  - implications for PFM and other system components (e.g. accountability systems)
  - role of new digital technologies in relation to financial autonomy
  - cost (e.g. investment in capacity) and benefits (e.g. improved performance) of increasing financial autonomy

Key message 3: key features

The data is not strong enough to draw firm conclusions on optimal design (which also needs to fit to context in any case).

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

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

Key message 4: put it in context

- Autonomy alone does not guarantee improved performance
  - efforts at addressing financial autonomy should also resolve operational autonomy issues
  - there are numerous other (pre)conditions that need to be carefully considered and tailored to the context (administrative, PFM, provider payment mix, etc.) such as skills, knowledge, organisational culture, and willingness to actively manage resources)
  - what matters here is how systems work in practice, rather than in theory

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

Key message 5: consider functional aspects

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

Key message 6: pay attention to drivers and management of change

- Managing the political economy of change should also not be underestimated, especially as increased financial autonomy at primary care level can be threatening to other actors

- Some reform processes, such as decentralisation, have been detrimental to provider financial autonomy.

- Many of the changes have come from reforms to purchasing and provider payments, with varying degrees of external support.

- The cost of system changes which affect a large primary care sector are significant, if capacity and infrastructure need to be built, as is likely.

Key message 7: understand risks

- The risks of increasing autonomy are less in terms of fiduciary risks (primary care centres usually handle small amounts of money), but more in terms of increased workload, inefficiencies and missed opportunities due to other constraints
  - such as complexity or other restrictions that stop autonomy from being exercised in reality

- Although accountability is important, the country data suggests that accountability measures (to control financial risks) may be squeezing out autonomy, although this topic needs more attention

Key message 8: keep an outcome focus

- Autonomy is not a goal in its own right, but a means to an end (of better performance of primary care facilities and better health outcomes, including preventative)

- Reforms should be monitored to track these important outcomes