Foundational Reforms for Financing and Delivery of PHC Collaborative
2nd In-Person Meeting
April 23-24, 2025 – Accra, Ghana

MEETING REPORT

The Primary Health Care (PHC) Foundational Reforms Collaborative brings together practitioners from 14 member countries of the Joint Learning Network for Universal Health Coverage (JLN)[1] to share lessons and problem-solve how to transfer resources directly to PHC facilities and ensure effective use of these resources. Between April and July 2024, the practitioners distilled three learning topics to tackle the pressing needs of the countries represented in the collaborative: resource allocation, provider payment mechanisms and provider autonomy. Over the remaining period of the collaborative, practitioners will explore how to allocate sufficient resources for PHC, design effective provider payment systems, and provide adequate decision-making authority for PHC managers to effectively utilise resources to meet their community's health needs.

26 members of the Provider Autonomy sub-group met in Accra, from April 23-24. Participants were implementers and policy makers from Burkina Faso, Ethiopia, Ghana, Indonesia, Kenya, Malaysia, Mongolia, Nigeria and Philippines. The meeting delved into countries practices as relates to decision making for PHC resources, the level of provider

[1] Botswana, Burkina Faso, Colombia, Ghana, Ethiopia, Indonesia, Kenya, Liberia, Lebanon, Malaysia, Mongolia, Nigeria, Philippines, Vietnam

autonomy and the accountability mechanisms applied along the continuum. The meeting deliberations will contribute to inputs in the Collaborative's knowledge products.

Meeting Objectives

- Validate the provider autonomy continuum at the PHC level, identify where countries are on the continuum and the practical steps to increasing autonomy
- Identify the accountability arrangements in place for PHC financial resources and inputs and the practical approaches to balancing autonomy and accountability

The case for expanding decision space for PHC resources for PHC providers

Provider autonomy refers to the decision rights that PHC providers have to allocate and use resources at the facility level, and to allow providers to respond to signals in provider payment. Provider autonomy may be considered as a spectrum that extends to some or all decision rights over resources such as financial (budgeting, financial management, internal (re)allocation of funds, assets and investments, retention, and use of surplus), personnel (staffing levels and mix, hiring/firing, compensation), and service delivery (partnerships or networking with other providers).

Provider autonomy enables providers to get the right mix of services and inputs -- medicines, staffing, community outreaches, equipment and supplies based on what is needed at the facility. A challenge for all countries is finding the sweet spot between autonomy and accountability. The benefits of autonomy may outweigh the risks of misappropriation of public resources, and the general perception among the countries at the meeting, was PHC providers are not likely to misuse funds. Benefits can be gained from letting PHC providers manage resources and decide the best way to serve their communities with appropriate accountability measures. Figure 1 below presents a theory of change adapted by the technical facilitation team from a WHO report on "Financial autonomy of facilities providing primary health care services: a review of the literature and expert consultations".

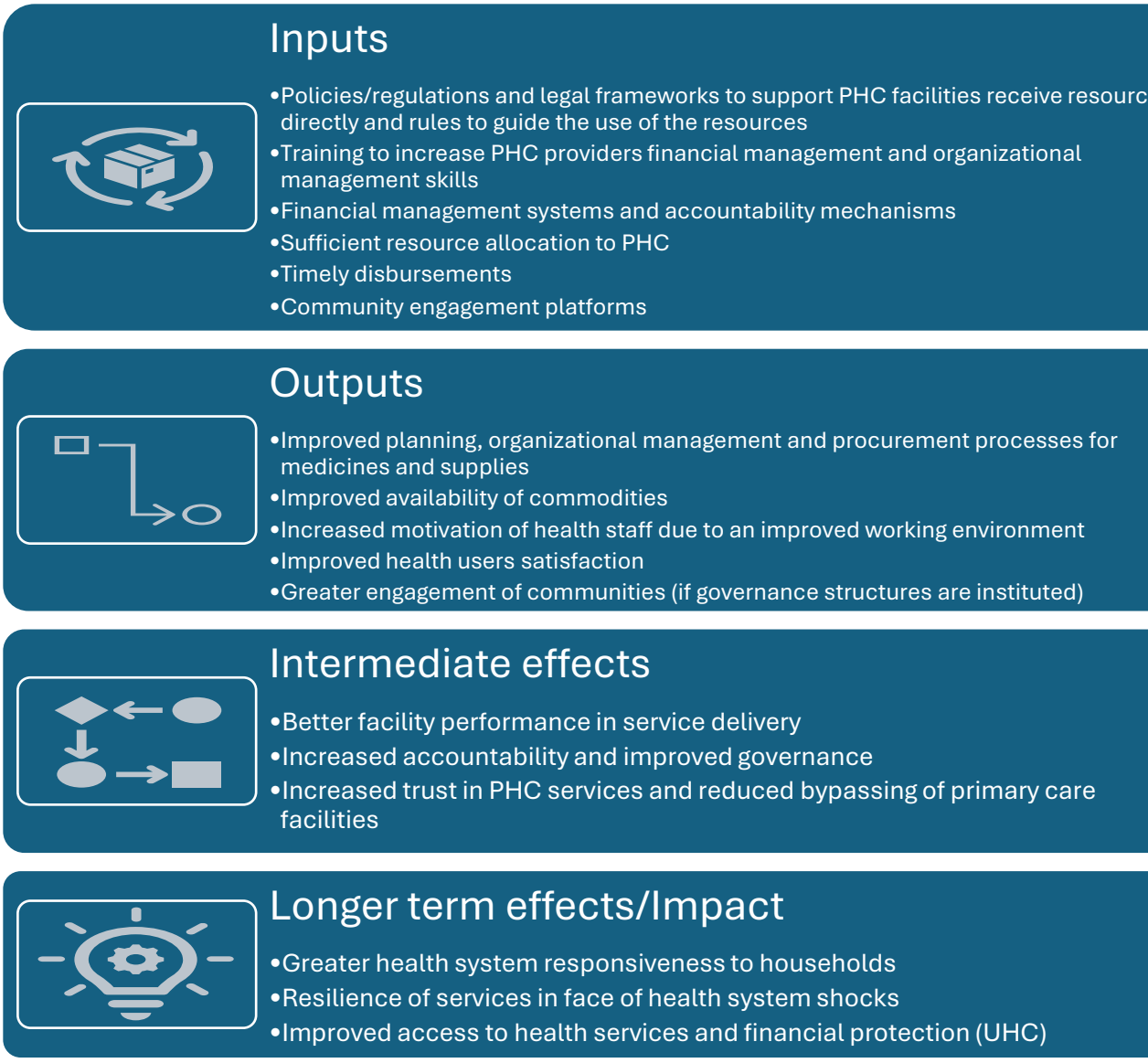

Figure 1: Proposed theory of change on provider autonomy for PHC providers and impact on UHC[2]

The theory of change recognizes that there are specific contextual factors required for provider autonomy to work well:

- Political will to implement supporting legislation to allow PHC providers receive funds directly
- Willingness to give more control to facilities
- PHC providers included in PFM system/chart of accounts

[2] Adapted from a 2024 WHO Report "Financial autonomy of facilities providing primary health care services: a review of the literature and expert consultations"

- Most funding streams channelled to the facility directly

Day 1 Summary

The kick-off session summarised the outputs from pre-meeting webinars, scoping calls and included a spotlight presentation of the primary care networks of the host country Ghana. Government officials from the Ghana Health Service and Ministry of Health opened the meeting and shared successes in PHC and how Ghana is addressing the challenges in PHC financing and service delivery.

Participants reviewed the provider autonomy continuum developed during the first in-person meeting in April 2024. Participants had detailed discussions in groups on the sources of funds for PHC, the financial management and budget allocation rules across line items for each source.

The summary of Day 1 is described below:

Ghana's scale up of the networks of practice presents new opportunities for patient-centred care

Ghana is implementing primary care networks in the network of practice model to strengthen sub-district management and oversight on service delivery. The main challenge in the scale up is re-orienting the sub-district structure and managers away from an individual facility-focus to a networked system of service delivery. The networks of practise will need more collaboration and shared responsibility within networked facilities to attain health outcomes. Some challenges to be overcome include changing quality assurance, contracting and appraisal mechanisms from the facility to a network of facilities; and providing funds and resources to networks, rather than individual facilities.

As Ghana prepares for national scale up, there is need for change management at all levels for buy-in and ownership of the network to foster better coordination in the management of the network to meet the needs of the population. There is also a shift needed from disease orientation to holistic patient-oriented care. Ghana will require systems to track progress and scale learnings and best practices across the country.

Getting on the same page about what provider 'autonomy' is.

In the context of the collaborative, we refer to financial autonomy as the decision space for primary health care facility managers to influence how they use their PHC resources to respond to the needs of their communities. In this collaborative, we also explore the decision space in settings where PHC providers do not directly receive or manage funds, but there is the decision space to influence planning and budgeting and consider the needs

of their communities within those processes. For example, in Ethiopia and the Philippines where PHC providers have limited autonomy and the subnational level manages PHC resources, facility managers are being engaged in the planning process, providing inputs into budgeting for funds allocated to the PHC facilities.

As private providers have autonomy to use their revenue, we focused discussions on the autonomy of public PHC providers for whom their arrangements are more varied and complex. In breakout and plenary sessions, participants validated the provider autonomy continuum presented in Figure 2 and outlined accountability mechanisms in place to ensure resources are used well.

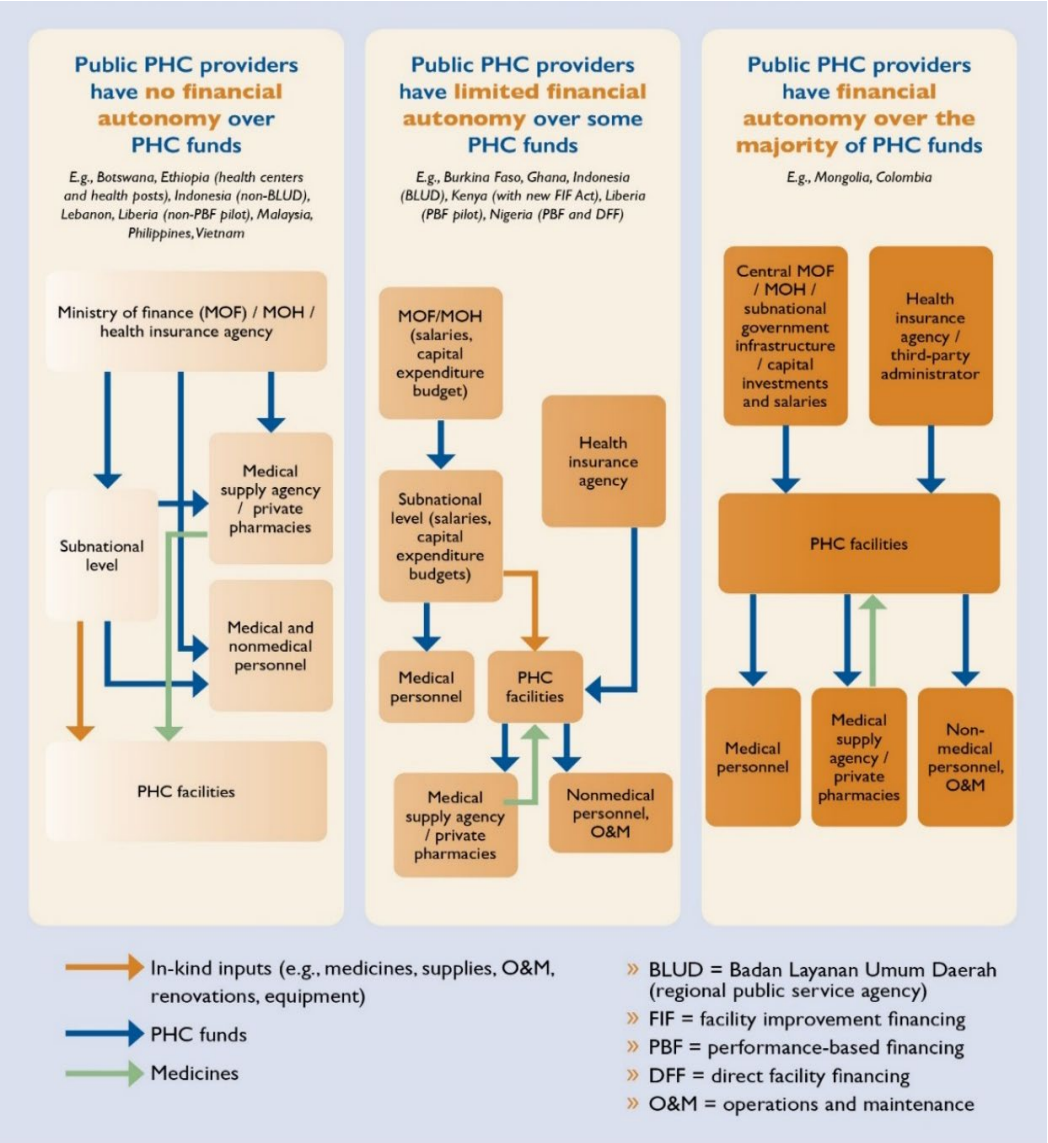

Figure 2: Main types of PHC funding flows to public PHC providers

- All countries have **diverse and varied sources of funds for PHC** including the government budget, donor funds, donations from philanthropies, insurance reimbursements and out of pocket spending. Government budgets including on-budget donor support, are allocated for specific activities such as capital investments, health workforce compensation or goods and services. If well-coordinated, multiple channels of funds can ensure all inputs for PHC services are covered. However, countries should be aware of the risks that a high level of fragmentation, with limited coordination, can present, and the administrative and reporting burden that it can pose to PHC managers.
    - Indonesia and Mongolia have two predominant sources of PHC funds from the **local government** and from the **health insurance fund** (*Jaminan Kesehatan Nasiona*l – JKN and Health Insurance General Office – HIGO respectively) to the Puskesmas and Soum Health Centres respectively. Both sources have different financial management rules and are remitted to facilities through different payment methods. However in both countries, these funds are received in a single bank account and providers are able to plan and budget for these funds as a single pot which improves allocation of these resources at the provider level to the priorities at the PHC facility level.
- In countries where providers generate and retain internal revenue, they are allowed to use **internally generated funds for medicines and operation and maintenance costs** most commonly. The medicines are procured from different channels (1) central medical stores funded through the government budget (2) private wholesalers and retailers with government budget funds or facility generated revenue.
    - In Burkina Faso, *Gratuité* funds are allocated to the medical stores – *Centrale d'Achat de Médicaments Essentiels* (**CAME**) for medicines. PHC facilities draw down from their allocation as needed.
    - PHC facilities in Kenya can purchase directly from the Kenya Medical Supplies Authority (**KEMSA**) or from the Mission for Essential Drugs and Supplies (**MEDS**) and the **private market**, when commodities are unavailable at KEMSA or MEDS.
    - Malaysia operates a more **centralized procurement process** with central negotiations for the best prices. Districts procure with the negotiated prices for the facilities.
- At the end of the financial year, PHC managers in most countries are unable to retain unused funds from the government budget for the following year but they may be able to retain unused funds from user fees and insurance reimbursements.

  - For example in Ethiopia, unused funds are returned by the regional Bureau of Finance to the Ministry of Finance but the reimbursements for Community Based Health Insurance are retained for the next financial year.
- There is a **gamut of tools to guide PHC provider's stewardship** and serve as guardrails for resources and to account for allocated funds. They range from national/sub-national budget execution reports, routine internal and external financial audits, facility management committees, Civil Society monitoring and community engagement.
  - In Nigeria, facility management committees approve budgets and make improvement plans through quarterly meetings.
  - Community engagements are used in Ghana through the community score card which is integrated into the service delivery reporting platform, DHIS2.
  - The quality improvement committees at Ethiopia's Woreda level provide accountability guidelines to PHC facilities.

Key Takeaways

- At least half of the collaborative members use some form of strategic provider payment mechanism which is essential to allow providers to respond effectively to incentives to provide high quality PHC services that meet the populations needs.
- Private providers generally have autonomy, and the mix of public and private providers in most member countries requires that we level the playing field to give public PHC providers the space to make decisions and respond quickly to community needs.
- Increased autonomy requires accountability and systems like community involvement, audit visits, and oversight already exist in many settings. Shifting from punitive accountability measures to incentive-based reward systems can encourage providers to respond positively.
- There is a need to assess whether the level of accountability is proportional to the size of funding being managed and to aim for a balance between autonomy and accountability that minimizes the administrative burden on providers.
- PHC managers need to demonstrate the benefits of PHC clearly to policymakers and fund holders, such as Ministries of Finance, and highlight the effects of PHC autonomy on response to community needs to improve health outcomes.

Day 2 Summary

Provider autonomy and accountability in practice: site visits to three PHC facilities.

The Collaborative participants visited three primary healthcare facilities in the Lekma and La Districts within Accra: La Polyclinic, Lekma Polyclinic and Lekma District Hospital. The participants experienced the management of mid-sized hospitals in an urban setting in Ghana. The facilities were higher level PHC facilities with a wide range of autonomy for managing finances, commodities, drugs and non-clinical staff. The observations and interactions are described in Annex 1. The summary of day 2 discussions are described below:

What does balance look like between autonomy and accountability? How can countries prevent too much autonomy/accountability or too little autonomy/accountability?

In many countries, PHC public facilities have minimal autonomy and in settings where autonomy is being expanded, there is a tendency to introduce a wide variety of accountability which can increase the administrative burden for PHC providers. Countries should assess the level of autonomy being granted to PHC facilities and take steps to achieve the right balance keeping in mind the value of transactions taking place at this PHC level – especially for high frequency but low value transactions.

- In Ghana, once the regional directors approve their budgets, PHC facilities which are recognized as budget management centres have the autonomy to spend their resources in line with their approved budgets and implementation plans. The facilities prepare financial reports and have finance officers to support financial management.

Clearly defining indicators to measure accountability is an important step to help countries to strike the right balance to track the health outcomes that autonomy is expected to deliver. Most systems already have checks and accountability measures in place, and these can be sufficient to guide autonomy. Accountability without sufficient guardrails may also incentivize providers to prioritize expansion of services and profit over providing quality PHC services to the community.

- Capitation rates within Mongolia have increased four times since 2019, but the outcomes achieved were not commensurate to the increase in capitation funds. Mongolia is continuing to review regulations to better align provider behavior to achieve expected health outcomes.

There was a consensus that providers must be set up for success by retooling them and building their capacity for managing all aspects of autonomy (including planning and budgeting, financial management) for which they can account for their stewardship.

Key Takeaways

- Autonomy is the decision-making space for health workers to influence how they use their resources to meet the needs of their communities. In contexts where health workers do not manage funds, they can have a measure of autonomy when they are involved in planning and budgeting and can influence how the funds are allocated to their facilities.
- Autonomy is a continuum, and countries have the flexibility to define the process and take steps to achieve the right balance for their context. Countries can take practical steps to assess their current situation around autonomy to identify the opportunities inherent within their systems.
- Accountability mechanisms and tools are important to guide autonomy and ensure that objectives for which autonomy was granted are being met. Accountability can occur both ex ante – before funds and resources are released to set expectations – and ex poste – stewardship to account for the use of the funds and resources.
- Community engagement is important for accountability, to ensure the decisions facilities are making align with the needs of the communities they serve.
- Most systems already have accountability measures in place which provides the space to implement autonomy within those guardrails.
- Clearly defining indicators to measure the objectives for autonomy is an important step. This can require bringing together both financial and service delivery data to help define appropriate indicators.
- Countries must guard against the situation where both accountability and responsibility are shifted to PHC facilities. This can be a difficult space to operate effectively and might incentivize the shift from community needs to profit.

Country takeaways and actions

The meeting deliberations will serve as inputs into the final Provider Autonomy knowledge product from the collaborative. In addition, participants summarized their key takeaways and actions they are taking to adapt the learnings from the meeting:

Burkina Faso: Examine the PHC system to understand how funds flow, how funds get to providers. Document the opportunities to build capacity for management of resources to increase autonomy and improve health outcomes.
Ethiopia: Advocate for increasing capacity for planning and managing PHC services and to increase participation of PHC facilities in the planning process.
Ghana: Examine the decision space for district health management teams to increase spending towards promotion and prevention services, utilizing uncapped health insurance levy.
Indonesia: The key takeaway from the tour of PHC facilities is the importance of increased capacity in financial and operational management for PHC facilities managers to enable them to operate fully within the autonomy space they are granted.

Kenya: Emphasized the importance of uniformity and standards across counties, enabled through capacity building on financial management. The key takeaway or recommendation from the facility tour are the e-learning modules implemented for health worker capacity building.
Malaysia: There's limited opportunity to expand autonomy for public providers in Malaysia. There's an opportunity to use the PeKa B40 initiative via the special purchasing vehicle (PHCorp) to expand NCD management services beyond screening for further reduction of congestion at public facilities.
Mongolia: The separation of provider bank accounts for medicines and services, to act as guardrails for autonomous facilities is a notable practice from the site visits. Recommend further study on the community score card concept and community engagement in PHC decision making.
Nigeria: Health workers need capacity building in project and financial management as operational tools to enable guided autonomy. This can also foster advocacy to streamline the number of accountability mechanisms in operations.
Philippines: Will advocate for leadership and management capacity for the Local Government and Municipal Health Officers to enhance ability to manage resources and engage facilities in the process. PhilHealth can set guidelines for providers on utilizing resources to achieve targeted outcomes.

ACKNOWLEDGEMENTS

This document summarizes discussions at the second in-person meeting of the Foundational Reforms for Financing and Delivery of Primary Healthcare (PHC) Collaborative facilitated by the Joint Learning Network for Universal Health Coverage (JLN). JLN is an innovative network of practitioners and policymakers from around the world who collaboratively solve implementation challenges and develop practical tools to help countries work toward universal health coverage. More information is available at www.jointlearningnetwork.org

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Annex 1: Site visit observations and interactions:

La Polyclinic	Lekma Polyclinic	Lekma District Hospital
○ Sources of funds include subsidies from social protection programs, NHIS health insurance claims, out of pocket payments and civil society contributions. ○ More than 90% of resources are from public sources. ○ More than 59% of consultations are from National Health Insurance Scheme (NHIS) members. ○ The facility implements client exit interviews, staff satisfaction surveys and peer reviews to identify areas to improve quality of service. ○ There's a banking system on site, to collect payments and limit cash transfer between patients and providers ○ Strong community collaboration through bi-annual meetings.	○ Autonomy to provide services beyond the NHIS benefits package ○ High level of autonomy in service delivery, including managing and procuring commodities and medicines. ○ Strong community involvement through a Stakeholder Advisory Group. ○ Has a partnership with a bank on site, to collect payments to limit cash transfer between patients and providers and minimize cash losses.	○ Has multiple sources of funds: health insurance, government transfers, corporate donations. ○ 80% of revenue is from user fees, despite 73% of patients being NHIS members. ○ Have the autonomy to use up to 15% of internally generated funds to hire non-clinical personal. ○ There's a banking system on site, to collect payments and limit cash transfer between patients and providers ○ It's a large hospital in an urban setting that presents unique challenges with reaching and engaging community members. This limits the level of collaboration they have with the community.