Primary Care Provider Autonomy and Accountability Arrangements

A Learning Report from the JLN Foundational Reforms for Financing and Delivery of Primary Health Care (PHC) Collaborative

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Joint Learning Network
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Contributors

The Foundational Reforms for Financing and Delivery of Primary Health Care (PHC) Collaborative, a peer-to-peer learning collaborative of the Joint Learning Network for Universal Health Coverage (October 2023 to October 2025), explored ways to improve the flow of resources to the primary care level to enhance service delivery and be more responsive to local needs. The representatives of the 14 participating countries—Botswana, Burkina Faso, Colombia, Ethiopia, Ghana, Indonesia, Kenya, Lebanon, Liberia, Malaysia, Mongolia, Nigeria, the Philippines, and Vietnam—and the collaborative's JLN facilitators are listed below.

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Introduction

Many countries, including members of the Joint Learning Network for Universal Health Coverage (JLN), share the goal of achieving universal health coverage (UHC)—giving the entire population access to high-quality services without risk of financial hardship. Primary health care (PHC) has been identified as a pillar of UHC, as described in the 2018 Astana Declaration on Primary Health Care. PHC serves as the first level of care in a community and consists of preventive, promotive, curative, and rehabilitative services. It includes a range of cost-effective interventions, such as immunizations, guidance on nutrition and hygiene, and family planning services. PHC is the foundation of an equitable, efficient, and people-centered health system, so it must be well funded in order to contribute to achieving UHC goals.

PHC is often under-resourced, however, in favor of curative care provided in more expensive hospitals. The reasons may include low public spending on PHC and overreliance on out-of-pocket spending on PHC, especially for medicines. In addition, PHC resources in the government budget are often allocated and spent inefficiently and in a way that is difficult to track. Countries also frequently rely on historically based line-item budgeting rather than on population-based allocation criteria.

Awareness of the challenges of PHC financing is growing. The *Lancet Global Health* Commission on Financing PHC recommends steps that countries can take to improve PHC resource allocation, including ensuring that PHC resources reach primary care providers and using per capita resource allocation approaches and blended provider payment systems based on capitation. Once PHC resources are flowing to primary care providers in a timely manner, the next step is to ensure that the providers can use the funds to address specific local priorities and needs. This might involve disbursing funds to the providers' bank accounts accompanied by well-defined rules governing how the funds should be used and accounted for. A clear process is also needed for identifying and articulating local priorities and needs, in a work plan or a business plan.

Over a two-year period, the JLN's Foundational Reforms for Financing and Delivery of Primary Health Care (PHC) Collaborative explored country experiences with enabling the flow of PHC resources to primary care providers and ways to overcome common obstacles and bottlenecks to the flow and use of PHC funds at the primary care level. From October 2023 to October 2025, representatives from 14 countries—Botswana, Burkina Faso, Colombia, Ethiopia, Ghana, Indonesia, Kenya, Lebanon, Liberia, Malaysia, Mongolia, Nigeria, the Philippines, and Vietnam—gathered for in-person and virtual meetings to discuss how funds flowed to primary care providers in their contexts, explore provider autonomy in the use of PHC funds, and document existing accountability arrangements to ensure appropriate use of PHC funds.

What This Report Covers

This report describes the experiences of the 14 country members of the collaborative in the following areas:

- PHC resource flows to primary care providers for various inputs: human resources, medicines, capital expenditure, and operations and maintenance
- Strategies for, and experiences with, expanding provider autonomy in the use of PHC resources
- Mechanisms to ensure accountability for providers' use of PHC resources

The 14 countries differ in how PHC resources flow. This report places them along a continuum based on the level of budget execution/spending and the types of inputs over which primary care providers have discretionary spending authority. In drafting this report, the technical facilitation team reviewed existing gray and published literature on the topic of provider autonomy and built on it by linking primary care provider autonomy with accountability arrangements that enable effective and efficient use of PHC funds.

This report is relevant to practitioners interested in realigning how funds flow to primary care providers for patient-centered PHC and learning from the practical experiences of other countries in implementing PHC financing reforms.

What Is Primary Care Provider Autonomy?

This report defines *primary care providers* as the lowest level of care facility in a community and the first point of care at which PHC services are provided. Some countries have a range of primary care providers, including public and private clinics, health centers, and hospitals. *Primary care provider autonomy* refers to primary care facility managers having decision-making authority over budgeting and financial management, procurement, staffing, and spending across service delivery domains.[1]

Some countries grant autonomy to providers in nearly all of these domains, but most give providers decision-making power over only certain funds for operational costs and/or procurement of medicines, keeping staff salaries and capital or development expenditures centrally managed at the national or subnational level.

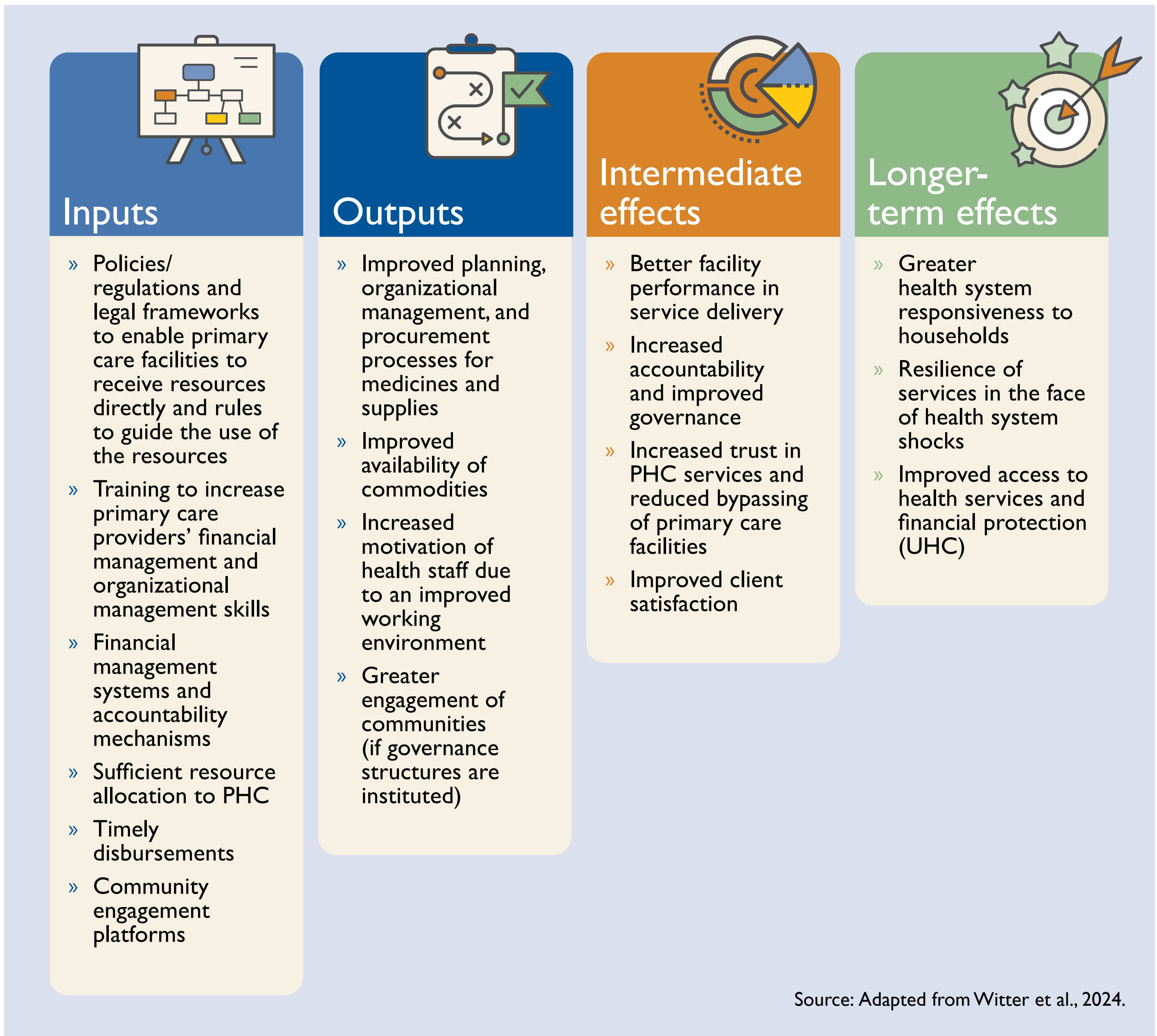
In most of the countries participating in the collaborative, private facilities and public hospitals have significant autonomy in how they can use the PHC funds they receive. This report focuses largely on the degree of autonomy granted to facility managers at smaller public clinics, dispensaries, and health centers and the rules and processes that govern how they can use PHC funds.

[1] Budgeting and financial management can include internal allocation and reallocation of funds, assets and investments, funds retention, and use of surpluses. Procurement can include selecting vendors, raising purchase requisitions, and paying vendors. Staffing can include setting the levels and mix of staffing, hiring and firing, and compensation. Service delivery can include partnerships/networking with other providers.

Provider Autonomy: A Theory of Change

Provider autonomy allows providers to respond to signals in provider payment. It enables them to determine the right mix of services and inputs—including medicines, staffing, community outreach, equipment, and supplies—based on what is needed at their facility. Figure 1 presents a theory of change adapted by the collaborative's technical facilitation team from a 2024 World Health Organization report on financial autonomy for PHC facilities.

Figure 1. Primary Care Provider Autonomy: A Theory of Change



Source: Adapted from Witter et al., 2024.

Potential Benefits of Expanding Provider Autonomy

Expanding provider autonomy is not without risks, but when paired with public financial management rules that facilitate the flow of resources, accountability mechanisms that are not burdensome, capacity development of primary care facility managers, and supportive supervision systems, it can play a transformative role in strengthening PHC.

Potential benefits include:

» **Improved responsiveness to local needs.** Facility managers who have adequate skills and training can make quick decisions based on real-time information and specific community health needs. Facilities can tailor services, purchase essential medicines, and adjust staffing more effectively than if they have to wait for approval from higher administrative levels. This can lead to better service delivery and improved patient satisfaction.

» **Greater efficiency in allocation and use of resources.** When facility managers control their own budgets and have sufficient guidance to use resources, they can use their local insights to allocate resources to the most pressing priorities, which might include repairs, outreach programs, or staff incentives.

» **Enhanced staff ownership and motivation.** Greater autonomy accompanied by sufficient and timely resources can give facility managers and staff a greater sense of responsibility and control over outcomes. This can boost morale, encourage innovation, and foster a culture of problem-solving. When providers can see the results of their decisions, they feel more accountable and invested in performance.

» **Greater transparency.** Greater autonomy coupled with accountability mechanisms—financial reporting, performance monitoring, and community oversight—increases transparency and trust within the health system and among the public.

» **Better alignment with the objectives of decentralization.** In countries pursuing decentralization, expanded provider autonomy complements broader governance reforms. It aligns with efforts to bring decision-making closer to the point of service delivery and improves coordination with subnational authorities and community stakeholders.

The literature on provider autonomy has been mixed. Evidence from Colombia, Kenya, and Tanzania has shown improved service delivery, improved availability of medicines, and structural upgrades / rehabilitation of infrastructure. At the same time, concerns have emerged about weak implementation in India, Kenya, and Tanzania. Issues include national or subnational governments not relinquishing enough control or not granting facilities enough decision-making authority; unclear rules on spending of funds; facility managers not being adequately trained for their financial management roles; and inadequate funds or funds not being received in a timely manner. (Annex 1 summarizes the experiences of selected low- and middle-income countries.)

Prerequisites for Provider Autonomy to Work Well

The theory of change recognizes that certain factors must be present for provider autonomy to work well and translate into more efficient use of PHC resources. These include the political will to implement supporting legislation that allows public primary care providers to receive funds directly and a willingness on the part of national and local leaders and officials to grant more control to these facilities. Generally, primary care providers must also be included or recognized in public financial management (PFM) information systems or charts of accounts so they can receive public funds. For PHC providers to have coherent incentives to use PHC funds well, most PHC funding streams must be channeled directly to the facilities and be guided by similar rules about the use of the funds. Finally, autonomy without sufficient and predictable resources will have little impact because providers will not be able to meaningfully address local priorities.

Table 1 summarizes these prerequisites by category.

Table 1. Prerequisites for Granting Increased Provider Autonomy

Category	Prerequisites
Legal and policy frameworks	» National or subnational government establishes legal authority for facilities to retain and manage revenue from user fees, insurance reimbursements, and/or government budget transfers. » Local political leaders, finance officials, and district health managers support the transfer of PHC funds and financial responsibilities to primary care facilities. » Well-defined boundaries govern how much autonomy facilities have over budgeting, procurement, and hiring decisions. » Reforms to PFM regulations allow facilities to receive PHC funds directly and reduce required expenditure approvals to ease the administrative burden on providers.
Financial management capacity	» Facility managers and community oversight committees are trained in financial management, budgeting, procurement, and reporting.
Effective accountability and oversight mechanisms	» Supportive institutional arrangements provide clear rules on the use of PHC funds, without restrictive or burdensome approval and reporting requirements. » A financial management information system provides timely information for decision-making and improves transparency and accountability for the use of resources. » Regular audits and reporting to local governments or ministries of health are established. » Community health committees or boards provide social accountability. » Performance monitoring frameworks (e.g., performance-based indicators or service readiness scores) are in place.

In summary, provider autonomy works best when primary care facilities are empowered with clear legislative frameworks, are adequately funded, have well-developed financial management capacities, and are held accountable through transparent reporting and performance monitoring. Without these prerequisites, autonomy can result in mismanagement and inefficiency rather than improved service delivery.

Provider Autonomy Among the Collaborative Members: A Continuum

The 14 countries in the collaborative differ in how they organize their PHC financing, how resources flow to primary care providers, and the degree to which providers can receive funds directly and decide how to use them. The financial autonomy granted to providers falls along a continuum from no autonomy to limited autonomy to substantial autonomy. Note that some countries (e.g., Indonesia, Kenya, and Liberia) have a mix of rules for autonomy for the same type of providers. (See Figure 2 and Table 2.)

- **No financial autonomy.** Eight countries—Botswana, Ethiopia, Indonesia, Liberia, Lebanon, Malaysia, the Philippines, and Vietnam—have primary care providers that do not receive PHC funds directly. The subnational (e.g., district) level manages PHC funds for providers and is responsible for planning and budgeting, although providers may participate in the planning and budgeting process.
- **Limited financial autonomy.** Seven countries—Burkina Faso, Ethiopia, Ghana, Indonesia, Kenya, Liberia, and Nigeria—have primary care providers that receive some PHC funds directly and have the authority to plan, budget, and use these funds. The funds are usually small amounts for operations, maintenance, and procurement of commodities and exclude health worker salaries, emoluments, and capital expenditure. In Ghana, some primary care providers pay the salaries of nonclinical personnel (such as cleaning staff and accountants) and clinical personnel (such as part-time doctors and physician assistants) that are not on the government payroll. Providers can initiate procurement, but expenditures may require authorization from a subnational official. Some countries, including Liberia, have defined thresholds (such as US$500) below which the provider can procure inputs directly, without seeking approval from the county.
- **Substantial financial autonomy.** In two countries, Colombia and Mongolia, primary care providers receive the majority of PHC funds and have autonomy in planning, budgeting, and using those funds. They are responsible for a wider variety of financial management functions, including procurement of medicines, payment of health worker salaries and emoluments, and facility operations and maintenance. However, capital expenditures for infrastructure development and large equipment are managed at the national or subnational level.

Indonesia, Kenya, and Liberia are testing, or have recently introduced, changes to legislation to increase autonomy for some facilities. For example, in 2021 the Indonesian government introduced a change in status to qualifying community health centers (*puskesmas*), granting them semi-autonomous regional public service agency (*Badan Layanan Umum Daerah*, or BLUD) status that allows them to retain and manage their own revenue. In Kenya, the Facilities Improvement Financing (FIF) legislation passed in 2023 enables primary care facilities to retain and use their internally generated revenue (IGR) and any additional public funds allocated. Implementation of the FIF Act has been patchy, however—some subnational governments (counties) allow primary care facilities to retain all funds, others allow facilities to retain some of the funds, and still others do not allow facilities to retain any funds. Liberia has been implementing performance-based financing (PBF) since 2008 and in 2018 began expanding provider autonomy in some primary care facilities, allowing them to have their own bank accounts.

Figure 2.
How PHC Funds Flow to Primary Care Providers Along the Continuum of Autonomy

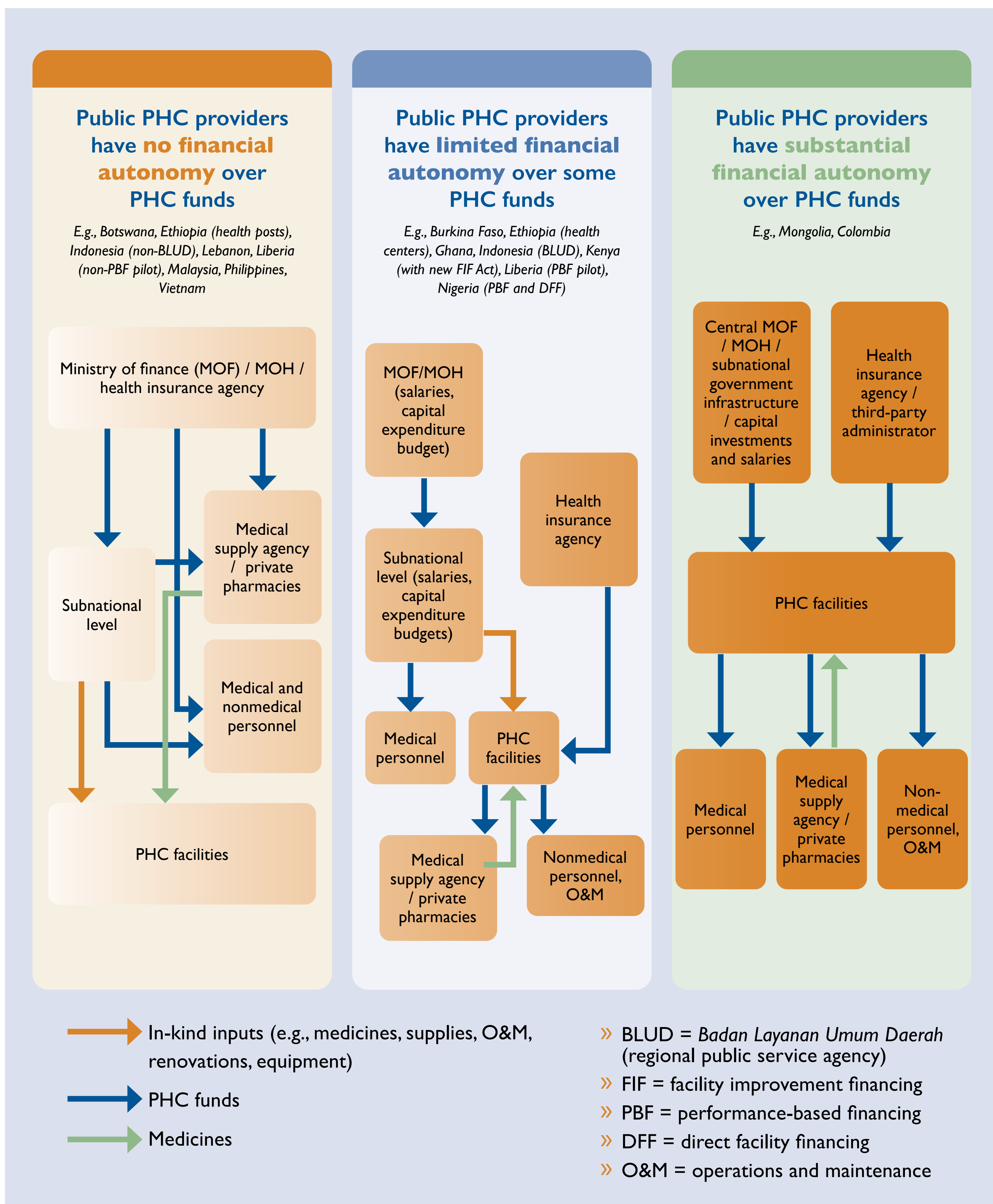


Table 2. Typical Attributes Along the Continuum of Provider Autonomy

	No Autonomy	Limited Autonomy	Substantial Autonomy
Countries	Botswana, Ethiopia (health posts), Indonesia (non-BLUD), Liberia (non-PBF), Lebanon, Malaysia, Philippines, Vietnam	Burkina Faso, Ethiopia (health centers), Ghana, Indonesia (BLUD), Kenya (with new FIF Act), Liberia (PBF), Nigeria (PBF and direct facility financing)	Colombia, Mongolia
Are primary care facilities included in PFM systems?	No	Yes, they are included in the chart of account as spending units or budget management centers	Yes, they are included in the chart of account as spending units or budget management centers
Do primary care facilities have bank accounts?	No	Yes	Yes
How is IGR managed?	IGR from insurance payments and/or user fees is channeled to the subnational level (e.g., the district for non-BLUD *puskesmas* in Indonesia, non-PBF facilities in Liberia and Malaysia, local government units in the Philippines, communes in Vietnam, and *woredas* (districts) in Ethiopia.	IGR from insurance payments and user fees is retained for procurement of medicines and supplies, operational expenses, minor renovations, and clinical and nonclinical personnel not on the government payroll (Ghana and Kenya).	IGR from insurance payments and user fees is retained for nonclinical and clinical personnel salaries, procurement of medicines and supplies, operational expenses, and minor renovations. (Medicines are also provided at separate pharmacies.)
Which financial functions are centrally managed?	Infrastructure/capital investments, salaries, procurement of medicines and supplies, operations, and maintenance are managed by the central government and/or subnational authority.	Infrastructure/capital investments are managed by a subnational authority or central ministry of health (MOH). Clinical and nonclinical personnel salaries are paid centrally by the MOH or a public service agency or subnational authority.	Infrastructure/capital investments and some salaries are paid by local governments or the central MOH.

How Countries Structure Provider Autonomy and Accountability Arrangements

For provider autonomy to work well and lead to effective use of PHC funds, clear reporting and accountability arrangements are essential. This section provides examples of the decision-making authority granted to primary care providers and the financial management and accountability arrangements in place along the continuum of provider autonomy, focusing on public PHC providers and particularly smaller frontline primary care providers.

Table 3 lists typical attributes of accountability arrangements across the 14 countries.

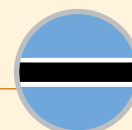
Table 3. Common Attributes of Provider Autonomy Along the Continuum

Provider Attribute	No Autonomy	Limited Autonomy	Substantial Autonomy
Recognized in the chart of accounts and treasury system	Usually no	Yes	Yes
Develop their own plans and budgets	May have an advisory role in the planning and budgeting process	Yes	Yes
Implement/spend their own budgets	No (subnational authority manages PHC spending)	Yes, on a limited range of inputs or line items (e.g., medicines and supplies, nonclinical personnel salaries, operations and maintenance costs)	Yes, on a broader range of inputs (e.g., medicines and supplies, clinical and nonclinical personnel salaries, operations and maintenance costs)
Bank account	Usually no	Usually yes, for receiving IGR and/or public funds	Yes, for receiving IGR and/ or public funds
Health facility governance structure	Sometimes	Usually (and may include community participation)	Usually (and may include community participation)
Accounting and financial reporting systems	No (reporting is done on providers' behalf by the subnational or national authority)	Yes, for funds spent directly, via the subnational or national reporting system	Yes, for funds spent directly, via the subnational or national reporting system

Group 1. No Provider Autonomy

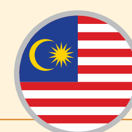
In countries with no primary care provider autonomy, providers focus on providing services and have limited or no financial management role. Subnational authorities manage planning and budgeting for primary care facilities within their jurisdiction, although they may consult with facility managers on prioritization and planning.

Botswana



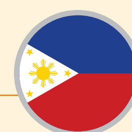
Primary care providers	Public health facilities (primary hospitals, clinics, health posts, and mobile stops).
Decision-making authority of facility managers	Primary hospitals are overseen by the Ministry of Health (MOH); clinics, health posts, and mobile stops are overseen by the Ministry of Local Government and Traditional Affairs (MLGTA). Facility managers of clinics, health posts, and mobile stops have no financial decision-making role beyond budget preparation and advising on the purchase of inputs by the subnational authority (district council).
Who is responsible for budget formulation, execution, and reporting	Public primary care facilities prepare their own budgets, which are consolidated and rationalized by the MLGTA and the MOH before submission to the Ministry of Finance (MOF).
What PHC funds are used for	The MOH and district councils under the MLGTA are responsible for procuring medicines and supplies from the Medical Supplies Agency. Health worker salaries and emoluments are currently paid centrally by the MOH, but at clinics and lower levels they will be moved to the district councils under the MLGTA in fiscal year 2025. Capital investments and infrastructure development are managed centrally at the MOH and the MLGTA.
Who provides authority to incur expenditure	The MOH provides authority to incur expenditure for hospitals, and district councils provide authority to incur expenditure and execute the budgets for clinics, health posts, and mobile stops.
Use of funds across fiscal years	Public funds for the MOH recurrent budget cannot be retained across fiscal years—unused funds are returned to the national treasury at the end of every fiscal year. But MOH development budget funds are ring-fenced and thus retained until the project is completed. As part of fiscal decentralization, district councils are allowed to retain their funds across fiscal years.
Financial management systems	The MOH and MLTGA use an integrated financial management system for reconciling and reporting on financial expenses to the treasury.
Accountability measures	» **Internal controls:** Facilities have controls for managing medicine stock levels and a management committee. » **External controls:** The government has an internal and external auditing function for all public agencies, including the district. Primary care facilities are included in the district auditing process.

Malaysia



Primary care providers	Public medical clinics.
Decision-making authority of facility managers	Primary care facilities receive inputs funded by central government. Primary care facilities have no autonomy to use PHC funds. User fees are pooled in the district consolidated fund.
Who is responsible for budget formulation, execution, and reporting	The district health office is responsible for budgeting and planning for public primary care facilities. It may consult with primary care facilities about local priorities during the budgeting and planning process.
What PHC funds are used for	The district budget is used to procure medicines and supplies and pay for operation and maintenance of the primary care facilities. Health worker salaries and emoluments are paid based on the specified emolument line item set by the MOH. Capital investments and infrastructure development are managed centrally by the MOH, which might consult with the district, state, and facility levels.
Who provides authority to incur expenditure	The district level provides authority to incur expenditure and executes the budget against specific approved line items for each facility or program.
Use of funds across fiscal years	Public funds allocated to the district cannot be retained across fiscal years and must be returned to the national treasury.
Financial management systems	The district uses an integrated financial management system for reconciling and reporting on financial expenses to the MOH and treasury.
Accountability measures	» **Internal controls:** Facilities have controls for managing medicine stock levels and have cash handling procedures for user fees, which are pooled in the consolidated fund. » **External controls:** The government has an internal and external auditing function for all public agencies, including at the district level. Primary care facilities are included in the district auditing process.

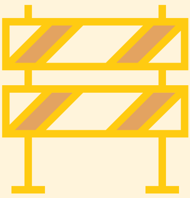
Philippines



Primary care providers	Public providers (rural health units, urban health centers, and *barangay* health stations).
Decision-making authority of facility managers	Facility managers receive inputs purchased by the national and regional department of health (DOH) and local government units (LGUs)—provincial, municipal, and city. Facility managers receive IGR from PhilHealth (national health insurance) reimbursements and user fees. These funds are surrendered to the municipal and city LGUs for banking. Facility managers lead planning and budgeting and provide recommendations on the use of resources, service delivery, program implementation, and technical supervision.
Who is responsible for budget formulation, execution, and reporting	The Department of Budget and Management, Commission on Audit, DOH, LGUs, and/or specific funding agencies issue rules and guidelines on budget preparation, budget execution, and financial reporting. Municipal and city health offices are responsible for budgeting and planning for public primary care facilities. They also develop local investment plans for health (LIPHs)—in consultation with facility managers on local priorities—and consolidate them into province-wide and citywide LIPHs.
What PHC funds are used for	Municipal and city budgets pay for building and/or upgrading health infrastructure, procuring medicines and supplies, operation and maintenance of primary care facilities, health worker salaries, and honoraria for *barangay* health workers (who are volunteers). The DOH augments the LGUs by deploying health workers to priority municipalities/cities through the National Health Workforce Support System, providing centrally procured commodities, and building/upgrading health infrastructure based on the Philippine Health Facility Development Plan.
Who provides authority to incur expenditure	Municipal and city health offices execute budgets against plans and budgets approved by the legislative body (*sangguniang bayan/panlungsod*) and chief executives of the LGUs.
Use of funds across fiscal years	IGR from user fees and PhilHealth can be retained and used across fiscal years. Funds allocated from the DOH and other national government agencies cannot be retained across fiscal years and must be returned to the national treasury after their one- or two-year validity expires, depending on what is approved in the general appropriations act.
Financial management systems	Municipality and city boards use an integrated financial management system for reconciling and reporting on financial expenses to the Department of Finance. The system has a built-in performance monitoring system for financial indicators such as revenue generation, expenditure management, debt management, and investment management and is used for all sectors and expenditures of the LGUs. Primary care providers enter their LIPHs in the LIPH Information System, which consolidates them at the regional and national levels for consideration in DOH budgets.
Accountability measures	» **Internal controls:** Facilities have controls for managing medicine stock levels. Primary care providers submit regular financial reports to the LGU and/or the DOH, depending on the source of the funds. » **External controls:** The government has an internal and external auditing function for all public agencies, including LGUs (municipalities and cities). Primary care facilities are included in the local government auditing process. PhilHealth has separate monitoring and reporting systems. Audits may be conducted by the Commission on Audit to ensure that funds are spent according to regulations.

Insights and lessons learned:

- In this group of countries, financial management is consolidated at the subnational level, which reduces the burden of financial management on primary care providers.
- Countries with weak financial management systems may find it beneficial to consolidate financial management at the subnational level because PHC funds are not fragmented in separate bank accounts and financial management and reporting are therefore easier. This approach may also make funds transfers (virements) and reallocations across facilities and regions easier and enable more equitable allocation of resources.
- When facilities are allowed to contribute to the budgeting and planning process, local priorities may be considered in the planning for PHC funds.



Challenges:

- Providers may face bureaucratic obstacles and delays in obtaining approvals for procurement, operational expenses, or facility maintenance/repairs. This can be particularly problematic during crises such as disease outbreaks, which require quick action at the local level. Health personnel may feel disempowered and disengaged, lowering morale and ownership over service delivery.
- Every community has unique health priorities, but without autonomy, facilities cannot tailor services or reallocate resources based on what patients actually need. Instead, they must follow rigid budgets that were set centrally. This can result in inefficient service delivery, including overstocking of items that are not in demand and shortages of essential items.
- When financial decisions are made at higher levels, it is difficult to hold local providers responsible for poor outcomes or underperformance because they have little control.

Group 2. Limited Provider Autonomy

Limited provider autonomy usually means that primary care providers have autonomy over a small portion of PHC funds, usually IGR from user fees or insurance reimbursements. In some countries, they also receive public funds allocated by the national or subnational authority. Public primary care facilities that receive public funds are guided by PFM rules articulated in PFM legislation or PFM guidelines. These facilities usually have their own bank accounts and are included in the country's chart of accounts as spending units or budget management centers.

Burkina Faso

Primary care providers	Health and social promotion centers (*Centres de Santé et de Promotion Sociale*) and medical centers (*Centres Médicaux*).
Decision-making authority of facility managers	Primary care facilities receive public funds through the *Gratuité* program to deliver a defined package of maternal and child health services. They also collect user fees for other services. Facility managers manage a single bank account for the *Gratuité* funds and user fees.
Who is responsible for budget formulation, execution, and reporting	Facility managers develop an annual plan and budget for funds received from *Gratuité* and user fees. Once the budget and plan are approved by the district, the facility manager can use the budget. Reallocation across line items within the budget requires approval from the district. Facility managers provide monthly financial reports to the district.
What PHC funds are used for	The facility manager can use IGR from user fees and *Gratuité* payments for medicines and consumables, operational costs, and maintenance. For medicines, a portion of *Gratuité* funds is transferred to the national medical stores (*Centrale d'achats des médicaments essentiels génériques et des consommables médicaux*), where facilities can procure medicines directly. Health worker salaries and emoluments are paid centrally by the MOH through the MOF. Capital investments and infrastructure development are managed centrally by the MOH.
Who provides authority to incur expenditure	The district provides authority to incur expenditure against the approved plan and budget. The facility manager raises purchase requisitions, which must be approved by the district health office.
Use of funds across fiscal years	IGR from user fees and *Gratuité* can be retained and used across fiscal years. In line with the principle of annual budgeting, these funds are carried over to the following year's budget before being used.
Financial management systems	The facility is incorporated into the PFM system and uses the integrated financial management system for reconciling and reporting on financial expenses to the MOH and treasury.
Accountability measures	» **Internal controls:** Facilities reconcile financial records with bank statements and have controls for managing medicine stock levels, cash handling procedures, procurement controls, and facility committee boards. » **External controls:** The government has an internal and external auditing function for all public agencies, including the district and public health facilities. For the *Gratuité* program, civil society organizations review claims from the facilities to verify audit claims and adjust payments based on their audit.

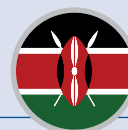
Ethiopia

Primary care providers	Primary hospitals, health centers, and health posts. Primary hospitals and health centers have autonomy to raise, retain, and use revenue; health posts do not.
Decision-making authority of facility managers	Primary health centers are mandated to generate, retain, and use internal revenues from community-based health insurance provider payment (fee-for-service and capitation), PBF, and other sources. Primary health centers oversee the management of health posts in their catchment, including all their financial and operational needs. Primary hospitals and health centers use their IGR based on the pre-approved budget authorized by the health facility board. This internal revenue is stored in the health facility's dedicated internal revenue account.
Who is responsible for budget formulation, execution, and reporting	The *woreda* (district) is responsible for budgeting and planning for the public primary care facilities in its jurisdiction. Primary care facilities are included in the *woreda* budgeting and planning process so their priorities can be considered.
What PHC funds are used for	PHC funds include budget line items allocated from the *woreda* and IGR. Health facilities use IGR to procure medicines and supplies and for operation and maintenance of primary care facilities. Health worker salaries and emoluments are paid centrally by the regional health bureau and MOH through line-item budgeting. Capital investments and infrastructure development are managed centrally at the MOH and regional health bureau.
Who provides authority to incur expenditure	Facilities use PHC funds based on the budget preapproved by the facility governing board and *woreda* cabinet.
Use of funds across fiscal years	Approved IGR from user fees, capitation, PBF, and community-based health insurance can be retained and used across fiscal years. Funds allocated from the *woreda* or regional health bureau cannot be retained across fiscal years and must be returned to the national treasury.
Financial management systems	The *woreda* uses paper-based and automated processes for reconciling and reporting on financial expenses to the regional health bureau. Facilities use the Integrated Budget and Expenditure financial management information system to report against the approved budget. They also use DHIS2 to report some key financial indicators and health service indicators.
Accountability measures	Accountability arrangements for PHC funds at the facility level are managed by the health facility governing board, health facility management committee, and health facility finance staff. The Woreda Office of Finance and Economic Development (WoFED) is responsible for health center audits. » **Internal controls:** Segregation of financial management duties, procurement controls, facility record-keeping and ledgers, approval thresholds, management of medicines and supplies inventories, and health facility management committees. » **External controls:** Audits are conducted by WoFEDs.

Ghana

Primary care providers	Public health centers, Community-Based Health Planning and Services (CHPS) compounds, and maternity homes. Ghana introduced a new service delivery model in 2017: hub-and-spoke networks of practice that connect CHPS compounds and maternity homes (spokes) to a health center (hub). Financial management is not integrated at the network level, however, because individual health facilities operate independently.
Decision-making authority of facility managers	Managers of primary health facilities that are recognized as budget management centers have autonomy to use IGR, including reimbursements from the National Health Insurance Authority (NHIA) and user fees from out-of-pocket payments. Facilities not recognized as budget management centers are managed by the district health directorate and do not have autonomy over PHC funds.
Who is responsible for budget formulation, execution, and reporting	Facility managers prepare annual and quarterly implementation plans and budgets, which must be approved by the district and regional health directorates. The plans and budgets incorporate all sources of revenue—NHIA reimbursements, user fees, and the national budget.
What PHC funds are used for	PHC funds are used for operational and maintenance costs, procurement of medicines and supplies, community health services, salaries of clinical and nonclinical staff that are not on government payroll, and district health directorate administrative expenses. Health worker salaries are paid through Ghana Health Service.
Who provides authority to incur expenditure	The regional health directorate.
Use of funds across fiscal years	Unspent IGR can be carried over to the next fiscal year after rebudgeting for the affected activities. Unspent funds from the national budget are returned to the treasury after year end, and health facilities are required to rebudget for those activities.
Financial management systems	The facility accountant prepares quarterly financial statements, which are reviewed by the facility manager and district and regional health directorates.
Accountability measures	» **Internal controls:** Internal controls at the facility level include separate functions (e.g., budget planning, budget execution, reporting, and financial management) for the facility manager, accountant, pharmacists, procurement managers, and supply officers. Internal auditors check compliance with established controls and relevant laws. Controls are implemented for procurement, cash handling procedures, and reconciliation of financial reports and bank statements. » **External controls:** Facilities are subject to external auditing by the Ghana Audit Service, and facility managers are accountable for any adverse findings, through public hearings conducted by the Public Accounts Committee of the national parliament. The NHIA has defined claims processing and claims reconciliation processes.

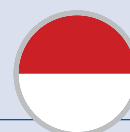
Kenya



Primary care providers	Public dispensaries and health centers. Kenya introduced a new service delivery model in 2019: hub-and-spoke primary care networks that connect dispensaries and health centers (spokes) to a county hospital (hub). Financial management is not integrated at the network level, however, and individual facilities operate independently.
Decision-making authority of facility managers	With the new FIF Act, facility managers can retain all funding they receive from the three funds managed by the Social Health Authority—the Social Health Insurance fund; Emergency, Chronic and Critical Illness Fund; and PHC Fund. Not all counties have implemented the FIF Act, so provider autonomy for IGR varies from county to county. Twenty-one of the 47 counties allow full retention of IGR, 22 counties allow retention of a portion of IGR (with the rest consolidated in the county revenue fund), and four counties do not allow any retention of IGR (so all funds are consolidated in the county revenue fund).[2]
Who is responsible for budget formulation, execution, and reporting	Facility managers prepare annual work plans and budgets, which are reviewed by the health facility management committee before submission to the county health management team for approval. After facilities receive funds from Social Health Authority reimbursements and any other grants or IGR, they submit a budget request to county health management to spend the funds. The plans and budget incorporate all sources of revenue (IGR from insurance reimbursements and any funds from the county or donors). The facility manager submits reports on facility expenditure to the county chief officer of health.
What PHC funds are used for	PHC funds can be used for operational and maintenance costs, procurement of medicines and supplies, community health services, and ambulance referrals. Health worker salaries are paid directly by the county.
Who provides authority to incur expenditure	The county chief officer of health provides authority to incur expenditure against the facility budget.
Use of funds across fiscal years	Unspent funds can be carried over to and used in the next fiscal year, but in some counties unspent funds must be submitted to the county revenue fund account.
Financial management systems	The facility manager prepares quarterly and annual financial statements, which are reviewed by the facility committee and county accountant.
Accountability measures	» **Internal controls:** Facilities have controls for managing medicine stock levels. The facility, facility committee, and county have separate functions for budgeting, budget execution, reporting, and financial management. » **External controls:** Facilities are subject to auditing by the county and national levels. The facility health management committee, which includes community representatives, oversees planning and budgeting, budgeting execution, and financial reporting.

[2] Data based on a webinar presentation by the Kenya country team on October 31, 2024.

Indonesia



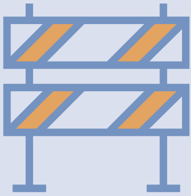
Primary care providers	*Puskesmas* (community health centers), which are designated as semi-autonomous (BLUD) or non-autonomous (non-BLUD).
Decision-making authority of facility managers	BLUD *puskesmas* can receive and retain capitation and non-capitation reimbursements from the social health insurance fund (*Jaminan Kesehatan Nasional*, or JKN), national funds transfers from vertical programs, district budget allocations, and user fees. The PHC funds are received in different bank accounts and are subject to different guidelines for use, depending on the source of the funds. Non-BLUD *puskesmas* do not have autonomy to manage PHC funds and are under the oversight of the regional administration.
Who is responsible for budget formulation, execution, and reporting	BLUD *puskesmas* facility managers are responsible for developing an annual plan and budget, which must be approved by the district. Facility managers can spend on defined line items in the annual budget, including procurement of medicines and operations and maintenance. Each source of funds has a separate reporting platform.
What PHC funds are used for	The capitation and non-capitation funds paid by *Badan Penyelenggara Jaminan Sosial Kesehatan* (BPJS-K) for JKN members and user fees are the only flexible funds that BLUD *puskesmas* can directly manage for paying nongovernment clinical and nonclinical workers, procuring medicines and supplies, providing community health services, and paying operational and maintenance expenses. The other sources of funds have defined spending guidelines. Regional governments manage PHC funds for non-BLUD *puskesmas*.
Who provides authority to incur expenditure	The district health office provides authority to incur expenditure against the facility budget.
Use of funds across fiscal years	BLUD *puskesmas* can retain funds from user fees and BPJS-K capitation and non-capitation reimbursements but not from district budget allocations.
Financial management systems	Each source of PHC funds has a separate financial management system.
Accountability measures	» **Internal controls:** Financial management functions within the facility are separate from those of the internal auditing unit. Other internal controls include cash handling procedures and bank reconciliations. » **External controls:** Facility managers prepare service utilization and financial reports for each source of funds. They also send monthly financial reports to the provincial and district health offices. *Puskesmas* are included in provincial-level audits. JKN reporting to the insurer, BPJS-K, is separate.

Nigeria

Primary care providers	Public primary health centers.
Decision-making authority of facility managers	Primary health center managers can receive PHC funds from health insurance reimbursements as capitation and operational funds as direct facility financing from the Basic Health Care Provision Fund's National Primary Healthcare Development Agency gateway, the National Health Insurance Agency and state social health insurance agencies, and user fees.
Who is responsible for budget formulation, execution, and reporting	Facility managers, in collaboration with community members, prepare annual plans and quarterly budgets (business plans), which must be approved by the district-level health authority and state MOH through the state PHC board. The plans and budgets incorporate all sources of revenue (IGR, insurance reimbursements, direct facility financing, and user fees).
What PHC funds are used for	PHC funds can be used for operational and maintenance costs; purchasing supplies, medicines, commodities, and equipment; ad hoc staff hiring; and providing community health services.
Who provides authority to incur expenditure	The state primary health care board.
Use of funds across fiscal years	Unspent funds can be carried over and used in the next fiscal year.
Financial management systems	The facility management team prepares financial statements for review by the local government health authority and then the state PHC board.
Accountability measures	» **Internal controls:** Controls include segregation of financial management roles, procurement controls, cash handling procedures, and bank reconciliations. The facility management committee, which approves budgets, holds quarterly meetings. » **External controls:** The Performance Management officers verify records, validate expenditures, and enforce timely and accurate financial reporting. Audits are conducted by health authorities at the federal, state, and local levels.

Insights and lessons learned:

- Granting providers autonomy over some funds enables facility managers to make real-time decisions, such as procuring emergency supplies or repairing broken equipment, without waiting for approval from higher authorities. This improves service continuity and ensures that patients receive timely care, especially in urgent situations such as drug stockouts or infrastructure breakdowns.
- When facility managers and staff have a say in budgeting, planning, and incentives, they feel more empowered and accountable. This boosts morale, job satisfaction, and motivation to improve service quality. Staff members become problem-solvers rather than passive implementers of top-down decisions.
- Strengthening facility managers' financial management capacity empowers them to carry out their roles and reduces the risk of mismanagement of PHC funds.
- When facility management committees include community representatives (as in Kenya) and civil society organizations conduct auditing (as in Burkina Faso), communities are engaged in accountability mechanisms.



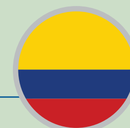
Challenges:

- Burdensome ex ante controls (e.g., preapprovals required from multiple officials before funds can be spent), can be time-consuming and expensive for facility managers (e.g., when they have to travel to district or county offices far from the facility to get preapprovals).
- There is always a risk of financial mismanagement, but strengthening the capacity of facility managers can mitigate that risk. Accountability systems that call for regular reporting and auditing with supportive supervision of facility managers can further reduce the risk.
- Facility managers are often clinicians, not trained managers. Giving them financial and administrative responsibilities without support can distract them from their clinical roles and reduce their effectiveness as health providers. Countries have addressed this challenge by hiring or contracting with facility accountants to create a separation of duties and to support facility managers. If it is not feasible to contract with an accountant for each facility, an accountant can be shared across multiple facilities.

Group 3. Substantial Provider Autonomy

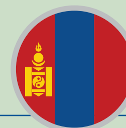
In two countries in the collaborative, Colombia and Mongolia, primary care providers have autonomy over most PHC funds. The providers receive and independently manage revenue for most inputs, although capital and infrastructure expenditures are centralized within the national or subnational authority.

Colombia



Primary care providers	PHC posts and PHC centers. Colombia has standalone primary care facilities as well as integrated care networks in which PHC posts (spokes) are linked to a PHC center (hub).
Decision-making authority of facility managers	The primary care facility manager or the hub facility manager (in the case of a network) has a high level of autonomy over PHC resources received from public and private sources. Sources of PHC funds include the MOH, local secretariats of health, insurance, and user fees.
Who is responsible for budget formulation, execution, and reporting	The standalone primary care facility or the network hub is responsible for developing a budget and a plan for the facility or the PHC post in the network, respectively. These must be approved by the facility board. The facility manager uses funds in alignment with the approved budget and plan and prepares financial reports for the facility board.
What PHC funds are used for	PHC inputs include staff salaries and emoluments, medicines and supplies, operational expenses, equipment maintenance, and infrastructure renovations.
Who provides authority to incur expenditure	After approval of the facility plan and budget by the facility board, the facility manager or hub manager can use PHC funds as designated in the budget.
Use of funds across fiscal years	Facilities can retain funds from public and private sources across fiscal years and spend the funds in line with the approved budget.
Financial management systems	Facility managers prepare financial reports to submit to the MOH, insurers, and local authorities.
Accountability measures	» **Internal controls:** Primary care networks conduct routine internal audits of the hubs and spokes. Facility boards of public facilities and public primary care networks, which comprise community and government representatives, approve annual budgets and oversee financial controls. » **External controls:** Standalone primary care facilities and hubs report financial and service delivery indicators and outcomes to the MOH, insurers, local authorities, and communities.

Mongolia

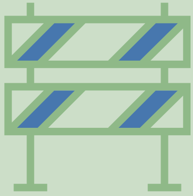


Primary care providers	Public *soum* (district) health centers.
Decision-making authority of facility managers	*Soum* health centers have autonomy over funds received from the health insurance fund managed by the Health Insurance General Authority (HIGA), using a blended provider payment system—capitation and performance-based payment.
Who is responsible for budget formulation, execution, and reporting	HIGA formulates a budget based on the payment method and expected service utilization and disburses monthly advance capitation payments and performance-based incentives that are tied to key performance indicators. The facility receives PHC funds based on the assigned population and its progress against performance indicators and spends the funds based on economic classifications, with transactions executed under strict oversight through the national treasury account. The treasury prepares monthly, semi-annual, and annual financial statements, and each year the General Audit Office conducts an official evaluation. If it finds liabilities or misuse of funds, it enforces legal accountability.
What PHC funds are used for	The health facility's management allocates expenditures based on economic classifications, which include salaries, medicines, and operational costs. Outpatient medicines are not dispensed by the health facility; patients receive prescriptions and obtain medications from pharmacies. *Soum* health centers in remote areas provide emergency care, ambulance services, and some inpatient services, which results in expenditures on medicines and meals. Such costs are not incurred by family health centers in urban areas.
Who provides authority to incur expenditure	All transactions are executed through the treasury system, which ensures oversight and control. A monthly and quarterly disbursement schedule is approved in advance, and monthly spending limits are authorized accordingly. These allocations are based on revenue generated and the budget request of the facility. This mechanism is implemented to ensure that the allocated budget is used for its intended purposes and to prevent liabilities or misappropriation of funds.
Use of funds across fiscal years	PHC funds from the Health Insurance Fund can be retained and used in the next fiscal year.
Financial management systems	*Soum* health centers generate financial reports using an electronic financial system. All treasury transactions and payments are processed electronically. Only primary financial documents are archived in physical form, for the purposes of auditing and verification.
Accountability measures	Health facilities operate under strict government oversight because they are financed by the state budget and the Health Insurance Fund. » **Internal controls:** Controls include separation of financial management functions, cash handling procedures and bank reconciliations, procurement controls, and asset registers. » **External controls:** Authorities monitor spending limits for day-to-day expenditures and budget execution in line with the country's Budget Law and monitor compliance with procurement procedures in line with the Law on Procurement—and in both cases also in line with other relevant rules and regulations for financial transactions. The State Audit Office conducts financial audits and validates facility reports, and it takes legal measures if it discovers misappropriation or criminal misconduct. The latter might include recovering funds or dismissing individuals, as prescribed by law, but provisions under the Budget Law allow for exemptions and provide settlement mechanisms in the case of liability.

Insights and lessons learned:

» In Colombia, the hub has been used to support financial management of the spokes, allowing for shared bulk procurement of medical supplies and economies of scale.

» Both countries rely more on ex post controls (e.g., post-spending audits) rather than ex ante controls to facilitate budget execution.



Challenges:

» Autonomy requires guardrails to ensure that PHC funds are used effectively. For example, Mongolia is revising rules for *soum* health centers to include how PHC funds can be used, in order to avoid misallocation of resources to high-cost equipment such as ambulances and CT scanners and encourage use of low-cost, high-impact interventions such as immunizations.

Overall Lessons and Insights

Generally speaking, there is no "good" or "bad" level of provider autonomy because the appropriate amount of autonomy granted to providers depends on the context, the preparedness of financial management systems, and the capacity of primary care facilities to take on financial management roles. Below is a summary of insights on provider autonomy from the 14 countries in the collaborative.

» **Improvement is possible at every level of provider autonomy.** There is no one-size-fits-all solution, and countries can determine how much autonomy to grant primary care providers based on the local context. Although a consensus is forming that facility autonomy can enhance responsiveness to local needs and improve efficiency in how resources are allocated, it may not be possible for all countries to expand provider autonomy due to system capacity limits and other factors. But despite these constraints, most countries have room to increase opportunities for facility managers to contribute to decision-making on resource allocation during the planning and budgeting process, where they can emphasize local priorities.

» **Provider autonomy can improve responsiveness and efficiency.** When primary care providers have control over financial and operational decisions, they can respond more quickly to local needs, adjust services, and manage resources more efficiently. This autonomy allows them to reallocate budgets, procure needed supplies, and address urgent issues without waiting for approval from subnational or central authorities. This can lead to faster service delivery, better management of resources, and improved operational efficiency. For example, facilities with financial decision-making authority can quickly replace broken equipment, restock essential drugs, or adjust staffing based on seasonal health trends. These timely actions can improve patient outcomes and overall facility performance.

» **Provider autonomy requires strengthening facility managers' financial management capacity along with continuous oversight.** Facility managers who are trained as clinicians may lack training in budgeting, procurement, and/or financial reporting. When autonomy is granted to providers without adequate training, facility managers may struggle to manage budgets, comply with regulations, or produce required financial reports. This can lead to underperformance or even financial mismanagement, undermining the goals of decentralization. Countries that implement autonomy reforms must therefore invest in continuous capacity-building for facility managers and health facility committees. With stronger leadership, planning, and financial skills, they can exercise their autonomy effectively and responsibly. Countries that overlook this step often face implementation failures or uneven performance across facilities.

» **Provider autonomy requires clear guardrails.** With greater autonomy, providers should have greater accountability for outcomes. To ensure that autonomy leads to improved service delivery rather than mismanagement, robust accountability mechanisms are essential. These include regular financial audits, transparent reporting systems, supervision by subnational health teams, and active community involvement through health facility committees. Without accountability, autonomy can open the door to inefficient spending or misappropriation. When designed well, autonomy paired with accountability can create a system that improves both trust and performance. A careful balance is needed to avoid burdensome ex ante controls that create barriers to spending while also allowing for sufficient ex post controls to avoid misappropriation of resources.

» **Reformers must manage complex political dynamics to change the flow of resources.** Expanding provider autonomy requires organizational shifts across all levels of the health system, including the adoption of supportive laws and institutional frameworks that provide legal authority for facilities to retain funds, open bank accounts, and/or directly receive government transfers. When resources that previously flowed to subnational authorities flow directly to facilities, roles and power dynamics will change. New roles must be clearly defined, with a clear change management plan and capacity strengthening to overcome resistance to change.

- **Provider autonomy can worsen inequity if poorly designed.** Provider autonomy has the potential to improve health service delivery, but it can also widen disparities in access to quality care if not implemented carefully. Facilities in wealthier, better-managed areas might benefit more from autonomy because they may have stronger leadership, infrastructure, and local resources, while under-resourced facilities might lack the capacity to fully exercise their autonomy. The resulting inconsistencies in service quality across regions can deepen health inequities. To address this, governments must ensure equitable distribution of resources, offer targeted capacity support to weaker facilities, and maintain a level of centralized oversight to ensure that national health priorities and quality standards are maintained across all regions.

Conclusion

Provider autonomy can improve the efficiency, responsiveness, and quality of primary health care, but it is not without challenges. When frontline health facilities have more control over financial and operational decisions, they can better tailor services to meet local needs, respond more quickly to emergencies, and make better use of limited resources. Autonomy also has the potential to increase staff motivation, improve community trust, and strengthen accountability, especially when supported by strong oversight mechanisms.

If implemented well, provider autonomy can empower providers to deliver better, more equitable care and further UHC goals. If poorly implemented, it can expose the system to risks such as poor financial management and misallocation and misappropriation of funds. Facilities that lack the necessary skills or resources may struggle to use their autonomy effectively, and weak accountability structures can lead to misuse of funds or inconsistent service quality. Political resistance and rigid PFM systems can also compromise implementation.

Ultimately, greater provider autonomy works best when carefully designed, supported by legal and institutional reforms, matched with capacity-building efforts, and balanced by clear accountability mechanisms, including well-established governance and monitoring and evaluation frameworks. Provider autonomy reforms should not be implemented in isolation, but rather as one component of a broader strategy to strengthen PHC financing. Service delivery norms, standards, and performance benchmarks can facilitate data-driven improvements in service delivery and resource management.

Beyond this report, which focuses on describing the provider autonomy and accountability arrangements across the 14 JLN collaborative countries, more can be done to explore this topic in depth, in particular to address the following questions:

- **Which levels should financial autonomy be devolved to?**
- **How can systemwide resource allocation priorities be maintained while allowing for autonomy at the facility level?**
- **How can facilities be assessed for their readiness for more autonomy?**
- **Are there minimum qualifications that a country must meet before greater autonomy is feasible?**
- **Which accountability arrangements work better than others, depending on the level of autonomy and the context?**

Answers to these questions can inform a research agenda that helps countries select which mechanisms to invest in that will deliver better health system performance and further progress toward UHC.

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Annex 1. Country Experiences with Provider Autonomy

The following table summarizes the benefits and challenges of greater provider autonomy in several low- and middle-income countries, drawing from the technical facilitation team's literature review.

Country	Benefits and Successes	Challenges and Risks	Key References
Colombia	» Hospital autonomy has improved managerial flexibility and efficiency. » Local innovations in service delivery and contracting have been allowed.	» Service fragmentation and inequities between rich and poor regions have been seen. » There are risks of profit-driven decision-making over equitable access. » Quality control has been inconsistent.	Castano and Mills, 2013; World Bank, 2020.
Ethiopia	» Reforms have expanded the autonomy of primary health care units over facility-level funds. » Results-based financing (RBF) pilots have given facilities flexibility to use bonus payments for priorities such as equipment and repairs.	» Autonomy has been restricted by central control of procurement and staffing. » Discretionary funding has been limited by ex ante controls, with facilities often waiting for approval from districts. » Community oversight structures have been weak.	Maiba et al., 2024; World Bank, 2009.
Ghana	» Facility-level RBF and National Health Insurance Scheme (NHIS) reimbursement have created opportunities for performance-linked autonomy. » Some districts have used autonomy to improve quality improvement plans.	» Delayed NHIS reimbursements have undermined autonomy. » Facilities have struggled with planning due to unpredictable funds. » Local accountability has remained weak.	World Bank, 2009.
Kenya	» The Health Sector Services Fund and later Facility Improvement Fund have allowed facilities to retain user fees and operational grants. » Facility maintenance, responsiveness, and community oversight through health committees have improved. » Public display of financial information has enhanced accountability.	» County treasuries have regained control over funds after devolution, limiting provider autonomy. » Facilities have faced delays in funds release and lack of clarity on expenditure authority. » PFM alignment has been weak, and reporting systems have been inconsistent. » Political interference in fund management has been seen at the county level.	Waweru et al., 2014; Mbuthia et al., 2023; Musiega et al., 2024; Wawer et al., 2013.

Country	Benefits and Successes	Challenges and Risks	Key References
Nigeria	» The Basic Health Care Provision Fund aims to channel funds directly to PHC facilities. » Transparency and local participation in budgeting have been enhanced in pilot states.	» Implementation has been slowed by bureaucratic delays and state-level bottlenecks. » Many facilities have lacked bank accounts or financial staff. » Weak coordination between federal, state, and local authorities has limited the impact of greater autonomy.	World Bank, 2004; Government of Kenya, 2023.
Philippines	» Decentralization has given local governments greater control over health financing and provider management. » Some municipalities have demonstrated improved resource use and staff motivation.	» Autonomy has been inconsistently implemented across municipalities. » Weak coordination between local and national levels has caused confusion in roles and financing. » Service quality has varied across regions.	World Bank, 2004.
Tanzania	» Direct facility financing has allowed facilities to open bank accounts and receive funds directly. » The availability of drugs and supplies has improved, along with the ability to make small repairs. » Community participation has been strengthened through facility committees. » Transparency and accountability in the use of funds have increased.	» Delays in fund disbursement from councils and the central government have been persistent. » Financial management capacity in rural facilities has been weak. » Heavy reporting and auditing requirements have strained staff time. » Some inequity has been seen between stronger and weaker districts.	Mæstad et al., 2021; Maiba et al., 2024; Binyaruka et al., 2021.
Uganda	» Decentralization has given district and facility managers greater ability to address local priorities. » Facilities with more autonomy have had better drug availability and more flexible service delivery. » Participation of communities in health management committees has enhanced local ownership.	» Low managerial capacity and limited financial training for health workers have been seen. » Weak auditing and accountability systems have led to inefficiencies. » Funding flow interruptions have constrained provider autonomy.	Waweru et al., 2020; World Bank, 2004.

Annex 2. Accountability Arrangements Used by Countries

Internal controls	External controls
Budgeting and planning » Annual or quarterly budgets prepared by facilities to plan and monitor the use of funds against health priorities	**Audits (financial and performance)** » Independent reviews by national audit offices, donors, or external firms to assess use of funds
Segregation of duties » To reduce fraud risk, having different staff handle authorization, record-keeping, and cash management	**Compliance inspections** » Visits by subnational health or finance officers to check adherence to financial rules and guidelines
Cash-handling procedures » Rules for collecting, storing, and depositing patient fees or other revenues	**Reporting requirements** » Regular financial reports submitted by facilities to the MOH or MOF, for oversight purposes
Procurement controls » Clear procedures for ordering, verifying, and paying for drugs, equipment, and supplies	**National treasury/finance regulations** » PFM rules on how funds are disbursed, banked, or accounted for in public financial systems
Record-keeping and ledgers » Accurate documentation of all transactions (e.g., receipts, invoices, and vouchers) to track expenditures	**Performance contracts/scorecards** » External evaluation of how facilities use resources relative to service delivery outcomes
Approval and authorization » Approval required from the facility manager or committee for spending above certain thresholds	**Community oversight/accountability forums** » Public hearings, citizen report cards, or social audits that hold providers accountable externally
Asset registers » Tracking of equipment, drugs, and supplies to prevent loss, theft, and misallocation	**National health insurance agency monitoring** » Oversight linked to payment mechanisms (e.g., capitation, fee-for-service, case-based payments, diagnosis-related groups, results-based payment / pay for performance)
Reconciliation » Regular cross-checking of financial records against bank statements or cash balances	**Donor oversight mechanisms** » Additional financial tracking, auditing, and reporting requirements imposed by donor-funded programs
Stock management systems » Monitoring of medicines and consumables to ensure availability and prevent stockouts and pilferage	**Anti-corruption agencies** » Agencies that conduct investigations and enforcement in cases of suspected fraud or mismanagement
Health facility committees/boards » Community or staff-based committees that review and approve financial decisions, for transparency	**External procurement oversight** » Centralized procurement agencies or boards that review large purchases to ensure value for money

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