

A balancing act: Evolving health financing in devolved settings

Conference copy

July 2021

ACKNOWLEDGEMENTS

This report is the product of a collaboration between ThinkWell and the World Health Organization's (WHO) Department of Health Systems Governance and Financing (HGF). It was prepared by Nirmala Ravishankar (ThinkWell), Inke Mathauer (WHO/HGF), Ileana Vîlcu (ThinkWell), and Michael Chaitkin (ThinkWell). This report draws on information from seven country case studies developed by ThinkWell as follows: Marie-Jeanne Offosse (Burkina Faso); Nirmala Ravishankar and Boniface Mbutia (Kenya); Ileana Vîlcu, Salomão Lourenco, Egidio Cueteia, Yara Cumbi, Federica Fabozzi, Aurora Milice and Amandio Manuel (Mozambique); Michael Chaitkin (Nigeria); Federica Margini and Tapley Jordanwood (Uganda); Paulina Limasalle, Prastuti Soewondo, Trihono Trihono, Halimah Mardani, Nadhila Adani, Nirwan Maulana, and Anooj Pattnaik (Indonesia); and Christian Nuevo, Jemar Anne Sigua, Mary Camille Samson, Pura Angela Co and Marife Yap (Philippines).

The authors of the case studies and this report would like to thank key informants and country experts for their inputs. The authors also gratefully acknowledge very valuable comments from Fahdi Dkhimi (WHO/HGF), Susan Sparkes (WHO/HGF), Ding Wang (WHO Western Pacific Regional Office), Leo Sunnar (WHO Indonesia), and H  l  ne Barroy (WHO/HGF).

This report and the case studies were produced with support from the Bill & Melinda Gates Foundation to ThinkWell. WHO gratefully acknowledges financial support received from the German International Cooperation through the Sector Initiative Universal Health Coverage.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS	2
TABLE OF CONTENTS	3
ABBREVIATIONS	4
EXECUTIVE SUMMARY	5
INTRODUCTION	7
CONCEPTUAL FRAMEWORK AND METHODOLOGY	8
KEY CONCEPTS	8
STUDY OBJECTIVES	10
COUNTRY CASE STUDIES	10
KEY FINDINGS	11
REVENUE RAISING	15
<i>The importance of intergovernmental transfers</i>	15
<i>Institutional design aspects and factors that influence health sector spending at local level</i>	17
POOLING	20
<i>Effects of horizontal revenue sharing formulas and equalization measures</i>	21
<i>The role of health insurance schemes in the context of devolved settings</i>	24
PURCHASING	27
<i>Purchasing activities and payment methods of subnational governments</i>	27
<i>Flow and use of facility funds</i>	31
DISCUSSION	34
<i>How does devolution impact revenue raising for health?</i>	34
<i>What are the implications of devolution for the pooling function and equitable resource distribution?</i>	35
<i>How has devolution affected the ability of purchasers to be more strategic?</i>	36
CONCLUSION	36
REFERENCES	38
ANNEX 1. ANALYTICAL FRAMEWORK TO ASSESS HEALTH FINANCING IN DEVOLVED SETTINGS	42
ANNEX 2. OVERVIEW OF DECENTRALISATION IN THE SEVEN STUDY COUNTRIES	49

ABBREVIATIONS

BHCPF	Basic Health Care Provision Fund (Nigeria)
“BLUD” status	Status of financial autonomy for certain public primary health care facilities in Indonesia
CFA	West African Franc (Communauté financière d'Afrique)
CHE	Current health expenditure
DAK	Dana Alokasi Khusus (Special Allocation Fund in Indonesia)
DAU	Dana Alokasi Umum (General Allocation Fund in Indonesia)
DBH	Dana Bagi Hasil (Revenue Sharing Fund in Indonesia)
DOH	Department of Health (Philippines)
FP	Family planning
GDP	Gross domestic product
GGHE-D	Domestic general government health expenditure
IRA	Internal revenue allocation (Philippines)
JKN	Jaminan Kesehatan Nasional (Health Insurance in Indonesia)
LGA	Local government authorities (Nigeria)
LGU	Local government units (Philippines)
MNCH	Maternal, newborn, and child health
MOH	Ministry of Health
NA	not applicable
NHIF	National Hospital Insurance Fund (Kenya)
OOPE	Out-of-pocket expenditure
PHC	Primary health care
PhilHealth	Philippine Health Insurance Corporation
PROSAUDE	Health sector specific grant (Mozambique)
UHC	Universal health coverage
USD	U.S. Dollar
VAT	Value-added tax
WHO	World Health Organization

EXECUTIVE SUMMARY

Many low- and middle-income countries are undertaking reforms to make progress towards the goal of universal health coverage (UHC) against a backdrop of devolved government systems. Some of them have federal systems of government, and many have devolved government functions to local levels of government. Concurrently, most of these countries have embraced health financing reforms as part of their UHC strategy. Devolution in the health sector has been explored at length. There is also a large body of literature describing health financing reforms. However, there remains a gap in terms of analysis of the linkages between health financing arrangements and devolution, and how health financing functions are organised in and affected by devolved settings.

This report summarises findings from a multi-country study by the World Health Organization (WHO) and ThinkWell to analyse the implications of devolution for health financing, with a focus on health spending at the subnational level. Using a common analytical framework, we developed seven case studies exploring how the three health financing functions of revenue raising, pooling, and purchasing are affected by a devolved system of government in Burkina Faso, Indonesia, Kenya, Mozambique, Nigeria, the Philippines, and Uganda. We then analysed the case studies to identify common themes and generate hypotheses about how devolution impacts government health financing arrangements.

Revenue raising in devolved settings: issues and policy options

Local governments in all cases rely extensively on transfers from central governments to build their budgets. While the local government's share of total government health expenditure varies considerably from 20% to 75% in the seven countries, transfers from central government account for between 43% to 71% of the government budget at the subnational level. There is a vertical fiscal gap between the expenditure functions local governments are required to perform and the resources they have. Block grants serve to transfer non-sector specific resources along a formula in six countries. However, local governments have discretion over how they use these funds and may not sufficiently prioritize health in their budget allocations. In five of the seven countries, central governments use earmarked grants for health to increase and influence local government health spending.

Based on analysis of the seven countries, we hypothesize that central governments will likely need to drive increases in government health spending as part of UHC strategies. Policy options at their disposal include transferring earmarked or conditional grants to subnational governments, as well as increasing subsidies for health insurance coverage for the poor. Earmarked grants for health could be a way to reconcile devolution with the goal of enhanced resource allocation to health. Local government spending could also be increased by revising vertical revenue sharing rules to grant a higher share of national revenue to subnational units.

Pooling in devolved settings: issues and policy options

Devolution contributes to fragmentation of the pooling function, making equitable distribution of resources across subnational units more difficult. Subnational territories differ in terms of their fiscal capacity relative to their needs, thereby requiring fiscal equalization arrangements (e.g., formula-based block grants in six countries, earmarked grants for health in five countries, and special grants for disadvantaged areas in three countries). Yet the intergovernmental grant transfers were not found to equalise these differences across territorial units. Indeed, horizontal revenue sharing formulas are complex by design, and it is challenging to strike a balance between multiple considerations informing their design (such as the needs of the health versus other sectors, allocating resources according to fiscal need while also incentivizing fiscal effort etc.).

Given that devolution may consolidate or even increase inequalities, there is need for national governments to improve fiscal equalisation arrangements. When revising horizontal revenue sharing or resource allocation formulas, indicators measuring health needs ought to be used rather than solely relying on measures of health infrastructure, which is biased against more disadvantage areas. Conditional grants earmarked for health also offer a targeted way to redistribute health funds between subnational units. Matching requirements can incentivise greater investments in health by subnational units and link financing for local governments to performance. National subsidies for health insurance coverage for the poor could also increase revenues for health facilities, and as such indirectly contribute to equalisation across subnational territories.

Purchasing in devolved settings: issues and policy options

There is limited discretion and capacity of sub-national governments to function as strategic purchasers of health services. Line-item budget allocations is the dominant mode of purchasing for subnational governments in all seven countries. Moreover, a large share of the health budget at the subnational level is “locked in” for health worker salaries in five out of seven countries (in the remaining two, the national government covers salaries costs). Even where subnational governments have the authority to purchase services from private providers, they rarely do.

There continues to be limited financial autonomy for most primary and secondary care facilities under the jurisdiction of subnational governments. In all but one country in this study, public facilities generate revenue from user fees as well as reimbursements from health insurance or other purchasing arrangements. However, the ability of facilities to retain and spend these funds varies across the countries as well as within countries by level of care or subnational unit. In three of the four countries with national health insurance, reimbursements for certain types of public facilities do not remain at the facility, but flow back to the subnational government that continues to finance facilities through line-item budgets.

Streamlining of health financing and service delivery responsibilities can help reduce duplication and fragmentation as well as clarify purchasing roles. Granting facilities greater autonomy through legislation as well as changes to public financial management systems can make purchasing reforms effective. Facilities need to be able to manage the funds they receive from separate purchasing agencies (e.g., health insurance schemes) for the potential of strategic purchasing to be achieved.

Future research

Our exploration of health financing in devolved settings – a hitherto under-explored topic – generated many questions that warrant further examination. What kind of conditions work for earmarked health grants? What kind of institutional arrangements are needed for them to succeed? Are there opportunities to document and diffuse best practices in purchasing across sub-national units within a country? These are just some examples of areas for further research. To make progress in this area, more granular data will certainly be needed. Hence, it is important for both country and global data sources on health spending to provide more details on subnational spending. Another research topics include gaps between legislation and the actual practice of devolution, subnational capacity to undertake health financing reforms, and how the political economy of devolution affects implementation of health financing reforms. Further research and policy practice that specifically focuses on the linkages between health financing in devolved settings will be critical to enhance effective health financing reform implementation.

INTRODUCTION

The health financing reforms that many low- and middle-income countries in Asia and Africa are undertaking to make progress towards the goal of universal health coverage (UHC) are happening against a backdrop of decentralised government systems. Some countries like India, Indonesia, Nigeria, and South Africa adopted a federal system of government in the post-colonial era in the mid-20th century. As decentralisation gained popularity as governance reform, driven in part by donors, many more countries devolved government functions to subnational government units starting in the 1970s and have continued to reform these arrangements, some as recently as the 2010s. Concurrently, most of these countries have also embraced health financing reforms, such as designing intergovernmental transfers that are earmarked for health, enacting user fee removal policies, and introducing new purchasing and payment arrangements, including performance-based financing. Several have also introduced or expanded national health insurance. These reforms collectively aim to mobilise more resources for health, reduce financial barriers to access and increase financial protection, and ensure optimal use of available funds to maximise health impact as part of a broader UHC strategy.

Decentralisation reforms typically involve the transfer of decision-making powers, public finances, and service delivery responsibilities to lower levels of government. The conventional argument in favour of decentralisation is grounded in theories of democratisation, good governance, increased responsiveness, and improved alignment of public services to local contexts, with ultimately more effective service delivery (1). By bringing government “closer to the people,” decentralisation—in particular devolution—is believed to enhance direct participation of citizens in decision-making and increase their ability to monitor what governments are doing and hold them accountable (2).¹ The case for decentralisation is also linked to theories of fiscal federalism or financial decentralisation in the public finance literature, which is focused on determining which revenue and expenditure functions are best centralised and which are best given to lower levels of government (3).

While decentralisation in health care has received a lot of attention in both conceptual and country-specific work, health financing in such settings remains relatively under-explored. Since early work by Bossert (4) offering an approach for analysing decentralisation of health systems, a range of studies have described ongoing decentralisation reforms and assessed their effect on health outcomes (4–7). There is also a separate body of literature describing and analysing health financing arrangements within country health systems (8–10) and how they contribute to progress towards UHC (11). Despite these two rich bodies of literature, there remains a gap in terms of detailed exploration of how health financing functions are organised in devolved settings. Health financing is typically described in terms of three core functions: revenue raising, pooling, and purchasing (8). Low- and middle-income countries are designing and testing changes to these core health financing functions as they implement reforms to further the UHC objectives of all people obtaining the health services they need whilst being financially protected and the services being of sufficient quality to be effective (12). The nature of decentralisation—particularly, the devolution of substantive decision-making powers and government spending functions to subnational units—inevitably impacts the design, the process of implementation, and the performance of such health financing arrangements, the UHC reforms more broadly, and ultimately health outcomes. Devolution of health financing functions has the potential to enhance efficiency and equity in access to care, while also increasing transparency, accountability, and the equitable distribution of health resources. However, it could also have the opposite impact, exacerbating underlying problems within the health financing system or creating new distributional challenges and distortions. It is therefore important for country health

¹ We discuss definitions of decentralisation, devolution etc. in the next section.

financing strategies for making progress towards the goal of UHC to be informed by a thorough understanding of how devolution shapes specific design features and implementation issues around each health financing function.

The World Health Organization (WHO) and ThinkWell launched a study to analyse the implications of devolution for health financing, with a focus on government health spending, building on seven country cases.

Using a common analytical framework, we explored how the three health financing functions of revenue raising, pooling, and purchasing are affected by a devolved system of government in a country, and the implications of this for progress towards UHC. We developed case studies for the following countries: Burkina Faso, Indonesia, Kenya, Mozambique, Nigeria, the Philippines, and Uganda. We then analysed the case studies to identify common trends as well as stark differences to inductively generate hypotheses about how devolution impacts government health financing arrangements.

This report synthesises the findings from the country case studies. The first section on methodology describes the key definitions used to guide this work, country selection, and the analytical framework. The next section summarises key findings from across the seven cases on how devolution influences health financing functions. In the discussion section, we further explore how this affects progress towards the UHC objectives and offer some concluding remarks in the final section.

CONCEPTUAL FRAMEWORK AND METHODOLOGY

KEY CONCEPTS

For the purposes of this work, we define decentralisation to mean the transfer of authority and responsibility for public functions from the central government to subnational government authorities. The literature offers several typologies to distinguish between different forms of decentralisation. One approach is to differentiate between de-concentration and devolution (1,13,14). The former refers to the transfer of authority over specific resources and management functions to regional or local offices of central government ministries or departments. In such an arrangement, authority remains with the central level even as some functional responsibilities and financial or in-kind resources are transferred to the local level. In contrast, devolution implies the transfer of considerable decision-making authority to subnational governments that enjoy a degree of autonomy, often stipulated by the constitution (especially in federal systems) or through other legislation.

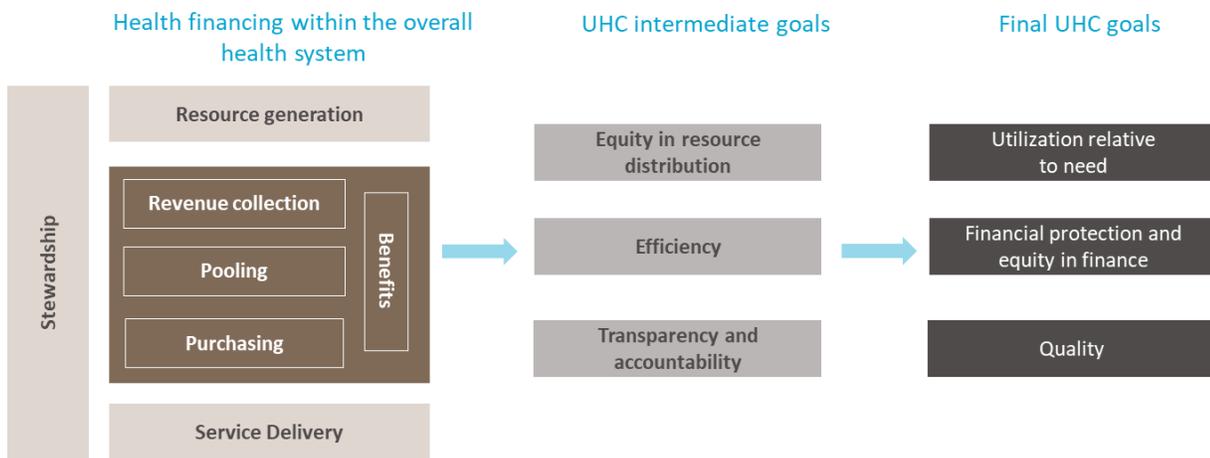
Another way of distinguishing between different forms of decentralisation focuses on the type of functions that have been transferred (15–17). This results in three types:

- *Administrative decentralisation:* authority and responsibility over certain administrative functions are transferred to subnational authorities by the central government.
- *Fiscal decentralisation:* subnational governments have decision-making power, authorised by the constitution or legislation, to raise revenues and take spending decisions.
- *Political decentralisation:* subnational governments are elected and have independent power for decision-making over local matters by constitutional ruling or legislation.

Administrative decentralisation without fiscal and political decentralisation is comparable to de-concentration. Administrative decentralisation combined with political and/or fiscal decentralisation (which often go together) are frequently referred to as devolution. Federalism implies subnational governments with elected representatives and independent powers.

The three core health financing functions are revenue raising, pooling, and purchasing. Revenue raising refers to the way funds are raised across the whole system to finance health care provision and other health promotion activities. Pooling refers to the arrangements for accumulating pre-paid funds such that the financial risk of seeking health care is spread across the population and no individual carries the full burden of paying for health care. The purchasing function characterises how pooled funds are allocated by agencies like national ministries of health, local health departments, and health insurance agencies to providers of health services. Purchasing is strategic if key decisions about what services are to be purchased with the pooled funds, which providers are contracted, and how providers are paid is linked to information about provider behaviour and population health needs in order to maximise health system goals (8,11). As outlined in Figure 1, health financing is one of four health system functions – along with stewardship, resource generation, and service delivery – that must come together to achieve intermediate UHC objectives of equitable distribution of resources, efficiency, and transparency and accountability. These contribute to the final UHC objectives, namely equitable access to health services, quality health services, fair financing and financial protection (12). This in turn leads to the achievement of the ultimate health system goals of responsiveness, equity, and overall health (18).

Figure 1. Health system functions and goals



Source: (12)

While most countries have two or more levels of decentralised government (e.g., states, provinces or regions followed by districts, counties, municipalities, wards, etc.), we prioritised assessing those subnational levels of government that exercise power over health financing decisions in the country studies. More specifically, we focused on levels that control pooled government funds (typically in the form of a subnational government budget) and use them to purchase health services. In some countries, multiple levels of government are involved in performing the health financing functions; for example, both states and local governments share responsibilities in the health financing functions in federal Nigeria. In others, only one level was selected for closer examination because other levels play a more administrative role, passing funds down to lower levels (e.g., regions in the Philippines) or executing funds received from higher levels without much decision-making powers (e.g., sub-counties in Kenya). It is worth noting that the same action can represent different functions for different levels of government. For example, the division of revenue across different subnational units is a

resource allocation function for the central government. However, the same act represents a revenue raising function for the subnational unit.

STUDY OBJECTIVES

WHO and ThinkWell developed an analytical framework to guide the development of the country cases. The framework is designed to explore the role of subnational governments in each of the three health financing functions and related governance functions; more specifically, it explores the following three questions:

- How does devolution impact revenue raising for health?
- What are the implications of devolution for pooling and equitable resource distribution?
- How has devolution affected the purchasers' ability to engage in strategic purchasing?

The framework provides a series of questions, organized by function (which can be found in Annex 1). The analytical framework was also informed by a draft policy brief on health financing in devolved settings developed by WHO and a session with that focus during the Montreux conference on public finance in 2019 (19).

The focus of the study is on the government health budget as the key health financing scheme in most countries. We touch upon national health insurance, but do not further explore performance-based financing arrangements, as this would deserve its own analysis. Moreover, the country studies have not looked at related health sector governance issues in devolved settings that may also affect how health financing reforms are implemented. In many countries, devolution implied the creation or strengthening of a ministry of local government. This requires additional coordination efforts with the health sector but can also be a cause of conflict and competition between different ministries. Neither do we explore human resource management arrangements in devolved setting, such as whether the decision-making authority over staff placement, remuneration, and supervision are held at the central or subnational levels even though decisions about how staff are assigned and managed at different government levels can have a significant impact on how health financing reforms are implemented.

Another important aspect influencing implementation of health financing reforms at subnational levels is the political dynamics of devolved settings, including political party affiliation of local governments and political capture. This can be quite complicated particularly when there is a disconnect between the central ruling party and the subnational government ruling party. This may also explain variations in health expenditure and priority setting across different subnational units. However, this paper does not explore these issues, as it would require a comparative analysis of the differences in the ruling parties at subnational levels and deserves its own paper.

COUNTRY CASE STUDIES

ThinkWell developed seven country case studies (20–26) based on the analytical framework, following which WHO and ThinkWell jointly wrote this synthesis report. The countries were selected purposefully to cover a range of different countries across Asia and Africa, with different degrees of devolution and years of experience with it, as well as to leverage ongoing projects that ThinkWell is implementing through country-based teams. Table 1 summarises some key statistics, including basic health financing indicators, for the seven countries. In each country, the case study authors undertook an extensive review of the peer-reviewed literature, government documents, and other publications from international organizations, implementing partners, and civil society organizations. The authors also interviewed 5-10 experts in each country to gather additional

insights and validate conclusions from the desk research. Next, WHO and ThinkWell analysed the case studies to identify common themes and issues across them, also drawing from the global literature on devolution in the health sector. Insights from that analysis are presented in this synthesis report.

Table 1. Summary of key statistics

	Burkina Faso	Kenya	Mozambique	Nigeria	Uganda	Indonesia	Philippines
Gross domestic product (GDP) per capita in current USD (2019)	786.9	1,816.5	503.6	2,229.9	794.3	4,135.6	3,485.1
Population (million, 2019)	20.3	52.6	30.4	200.7	44.3	270.6	108.1
Income level (2019)	Low	Lower-middle	Low	Lower-middle	Low	Upper-middle	Lower-middle
Current health expenditure (CHE) per capita in USD (2018)	40.2	88.4	40.3	83.8	43.1	111.7	136.5
Domestic general government health expenditure (GGHE-D) as % of CHE (2018)	42.5%	42.1%	21.2%	14.9%	15.8%	49.3%	32.7%
External assistance as % of CHE (2018)	15.2%	15.5%	62.9%	7.9%	43.1%	0.4%	0.8%
Out-of-pocket expenditure (OOPE) as % of CHE (2018)	35.8%	23.6%	9.7%	76.6%	38.4%	34.9%	53.9%
Social health insurance as % of CHE (2018)	0%	9.9%	0%	0.8%	0%	24.6%	12.7%
GGHE-D as % of general government expenditure (2018)	8.8%	8.5%	5.6%	4.4%	5.1%	8.5%	6.6%

Sources: (27–29)

KEY FINDINGS

All seven countries covered by this study have multiple levels of government which play a role in revenue raising, pooling, and purchasing to varying degrees. Table 2 provides an overview of the devolved system of government across the seven countries as well as the role of the subnational governments in terms of health financing and service delivery. Among the study countries, Indonesia and Nigeria are federal while all the rest are unitary states. However, without exception, they all have multiple levels of government. Each of them also has a history of undertaking decentralisation reforms that date back several decades, which is summarised in Annex 2. In the sections below, we explore how devolution has impacted each of the three health financing functions.

Table 2. Role of subnational governments in health service delivery and financing

Country Subnational levels	Service delivery	Key role of each with respect to health financing		
		Revenue raising	Pooling	Purchasing
Burkina Faso (Unitary) Regions and communes (devolution); provinces and districts (de-concentration)	Ministry of Health (MOH) is responsible for policy and planning, and steers policy implementation through regional and district health offices. The district health office oversees district hospital and primary health care (PHC) facilities. PHC centres alone also report into the communes where they are located. Regional health office oversees regional hospitals.	Central government raises the bulk of the revenue. Communes are responsible for local revenue raising.	Pooled at the national level ²	MOH is the main purchaser of services from all levels of public facilities. Some of its funds are channelled through district health offices. Communes allocate funds in their budget to cover operating costs at primary health centres. Public facilities levy user fees except for select maternal, newborn, and child health (MNCH) and family planning (FP) services under the Gratuité scheme, for which they receive reimbursement from MOH (via the district health office in the case of PHC centres).
Kenya (Unitary) Counties, sub-counties, and wards	MOH sets policy and manages tertiary care facilities. Counties directly manage service delivery in all primary and secondary care facilities in the public sector and regulate private providers in their jurisdiction.	Central government raises the bulk of the revenue. Counties generate local revenue, but in practice this remains a small share of the county budget.	Central government pools bulk of tax revenue and allocates a share to counties. Counties pool these transfers with local revenue. The National Hospital Insurance Fund (NHIF) manages additional pools (covering 26% of the population).	MOH purchases services from tertiary facilities in the public sector. Counties purchase primary and secondary care from public facilities within their jurisdiction. NHIF purchases services from both public and private providers. Secondary and tertiary hospitals in the public sector charge user fees, while services at the primary level are free.

² The national health insurance scheme is not yet operational. Therefore, pooling mechanisms for this scheme are not established.

Country Subnational levels	Service delivery	Key role of each with respect to health financing		
		Revenue raising	Pooling	Purchasing
Mozambique (Unitary) Provinces, districts, and municipalities	MOH sets health sector policies and plans. Provinces are responsible for provincial sector plans and operating provincial facilities. Districts manage health service delivery in their jurisdiction.	Central government mobilizes and allocates the bulk of funds. Revenue generated by districts and provinces represents a small share of the total.	Funds are pooled at the national level by MOH, provincial level, and the district level.	Central government purchases services from central and specialized hospitals. Provinces purchase services from provincial hospitals. District health offices purchase services from district and rural hospitals and health centres. All public facilities charge user fees.
Nigeria (Federal) States, and local governments	Federal MOH oversees tertiary facilities and funds select health programmes. States manage their own hospitals and oversee PHC services through PHC Boards. Local governments supervise PHC services.	Federal tier raises bulk of government revenue. A large share is transferred to subnational levels. A fifth of state revenue is internally generated, while local governments rely overwhelmingly on federal transfers.	Federal MOH and each state is a pool. Some states also operate health insurance schemes, but these are small, as is the federally administered National Health Insurance Scheme. There is minimal pooling at the local level.	Federal government purchases services from tertiary facilities and pays for commodities for all levels. The state government covers costs of state hospitals, as well as salaries of health workers at state and local levels. Some local governments pay for a share of operating costs of primary care facilities. Most public facilities charge user fees.
Uganda (Unitary) Districts	MOH is responsible for policy development and supervision of the sector. Districts are responsible for overseeing delivery of health services.	Central government raises most of the revenue. Districts can generate local revenue, but the amount collected is negligible and must be remitted to the central consolidated fund.	Central government pools all domestic resources.	The central government purchases directly from tertiary facilities, and indirectly from primary and secondary public facilities through conditional grants that are allocated to districts but flow directly to facilities. There are similar limited purchasing arrangements with private not-for-profit providers. Districts control financing for community health programmes. There are no user charges in public facilities (except in private wings of public hospitals; this revenue remitted to the central level).

Country Subnational levels	Service delivery	Key role of each with respect to health financing		
		Revenue raising	Pooling	Purchasing
Indonesia (Federal) Provinces, districts/cities, sub-districts, and villages	<p>Central government is responsible for overall health policy and overseeing centrally managed tertiary facilities. Provincial governments have authority to develop provincial policies and regulations. They manage provincial hospitals while districts operate district hospitals and PHC facilities.</p>	<p>Subnational units can raise revenue, but account for a small share. They rely heavily on transfers from the central government.</p>	<p>There is one national pool from the national budget, and several provincial and district pools. Districts and provinces also receive earmarked funds for specific health programmes from the central government, which cannot be pooled with their general budget. The national health insurance scheme, JKN, pools resources at the central level.</p>	<p>Provincial government purchases services from provincial hospitals, while district governments purchase services from district hospitals and PHC centres. The central government controls tertiary hospitals in the public sector. JKN purchases services from public and private providers. There are user charges at all private and public facilities for non-JKN members (or members who do not identify as such).</p>
Philippines (Unitary) Regions, provinces, cities, and municipalities	<p>The Department of Health (DOH) sets policies, regulates services, and continues to have direct oversight of some tertiary-level hospitals. Local government units (LGUs) (which includes all levels listed in the previous column) are responsible for managing and implementing local health programmes, facilities, and services.</p>	<p>Central government raises bulk of government revenue. LGUs have the authority to raise their own revenue, but most continue to be highly dependent on the fiscal transfers and allocations received from the central government.</p>	<p>DOH and Philippine Health Insurance Corporation (PhilHealth) manage the biggest fund pools for health at the central level. LGUs pool funds received from central government and their own source revenue into the LGU budget.</p>	<p>DOH purchases services from DOH-owned hospitals as line-item budgets and provides some inputs including commodities and temporary staff for other public facilities. LGUs purchase services from LGU-owned facilities as line-item budgets. PhilHealth purchases services from both public and private facilities. Hospitals can charge user fees, but public primary care facilities cannot charge user fees.</p>

REVENUE RAISING

The importance of intergovernmental transfers

Local governments rely extensively on intergovernmental transfers from the central government for their revenues. In all seven countries, local governments can raise own-source revenue through local taxes, issuing licenses and permits, and fees for services. However, revenue raised by local governments as a share of total government revenue was small across the board; for example, the local and state levels account for 0.3% and 7% of revenue respectively in Nigeria (30) and districts account for 4% of revenue in Indonesia (31). In view of these small shares, inter-municipal or inter-district fiscal equalisation mechanisms are of little relevance and are not found in these countries. Central governments transfer resources to local governments in all countries on the basis of vertical and horizontal revenue sharing arrangements. Transfers from the central government accounted for 57% of local government spending in the case of the Philippines (32), 67% of district government budgets in Indonesia (33), nearly 71% of county budgets in Kenya (34), and 99% of local spending in Mozambique (35).

In all countries except Burkina Faso, subnational governments receive block grants from the central government that are not earmarked for health or any specific sector (see Tables 3 and 4 for an overview).

While the constitution in Kenya stipulates that at least 15% of national revenue must be allocated to counties, there are no such thresholds in other countries. In the Philippines and Kenya, the vertical revenue sharing formula between levels is governed by criteria stipulated in the constitution. In the case of Nigeria, there are established formulas to allocate federally collected revenue (oil, value-added tax or VAT, and Federation Account) between the federal government, states, and local governments. In contrast, Indonesia and Uganda do not have a formula based on which the national revenue is divided between central and subnational governments.

Table 3. Overview of intergovernmental transfers

Country	Types of intergovernmental transfers
Burkina Faso	Central government transfers for each devolved sector, including health Central government grant for primary health centres (no matching requirements or conditions)
Kenya	One block grant from the central government to counties to be allocated to any sector or purpose Several conditional grants from the central government to counties, including for health
Mozambique	Block grant from the central government to provinces Block grants from the central government to districts Health sector specific grant (PROSAUDE) from the central government to provinces and districts ³
Nigeria	Unconditional block grants from federally collected revenue (oil, VAT, Federation Account) to states

³ PROSAUDE was initially an unconditional grant which is progressively becoming a conditional grant.

Country	Types of intergovernmental transfers
	Health-specific transfers from the Basic Health Care Provision Fund (BHCPF) ⁴ to states representing at least 1% of federal revenues
Uganda	Equalisation grants ⁵ from the central government to disadvantaged districts Unconditional grants from the central government to districts Three sector-conditional grants: wage (covers health workers salaries), non-wage (meant for health facilities), and development
Indonesia	Two unconditional grants from the central government to provinces and districts: revenue sharing fund (called DBH), general allocation fund (called DAU) One conditional grant from the central government to districts: special allocation fund (called DAK)
Philippines	Internal Revenue Allocation (IRA) block grant from the central government to LGUs LGUs also receive additional resources from Priority Development Assistance Funds, government-funded programmes and projects, official development assistance loans and grants, and off-budget funding

Note: In the tables, we present the terminology used in the respective country. In the text, we generally refer to block grants versus earmarked grants.

Table 4. Overview of rules for revenue sharing between central and subnational governments

Country	Rules for revenue sharing between central and subnational governments
Burkina Faso	NA
Kenya	As per the constitution, at least 15% of national revenue must be allocated to counties ⁶
Mozambique	Not clear PROSAUDE: 20% goes to central government, 80% to provinces and districts
Nigeria	Oil revenue: 13% goes to oil-producing states and 87% to the Federation Account VAT revenue: 15% of VAT goes to the federal government, 50% to the states, and 35% to local governments Federation Account: 54.7% goes to the federal government, 24.7% to states, and 20.7% to local governments ⁷

⁴ BHCPF aims to bolster PHC service quality and access by channelling more funds to health facilities. Forty-five percent of the BHCPF is meant for state PHC Boards to improve service readiness and quality, and 50% is meant to be managed by state social health insurance agencies and used to buy services on behalf of the poorest segments of each state’s population. The remaining 5% is meant for emergency medical services.

⁵ These are discretionary development grants.

⁶ The exact share in a given year is based on the recommendation of the Commission on Revenue Allocation, an independent government institution in charge of proposing how revenue raised nationally should be shared between the central and county government and among the county governments and enacted by the central government.

⁷ The local government share is largely controlled by LGAs’ respective states.

Country	Rules for revenue sharing between central and subnational governments
Uganda	No formula
Indonesia	5% of national budget and 10% of subnational budgets (after excluding salaries) must go towards health spending
Philippines	IRA: 23% to provinces, 23% to cities, 34% to municipalities, and 20% to barangays Own criteria for other funds

Institutional design aspects and factors that influence health sector spending at local level

Central governments also use earmarked grants to increase revenues for health at the subnational level or to influence health spending by subnational units, or both. Funds can be earmarked for the health sector in general, or for specific types of health expenditures (e.g., facility operating costs or specific health activities), with or without “conditions” such as requirements for matching funds. For example, while the bulk of funds the central government transfers to counties in Kenya is in the form of block grants, it is increasingly using conditional grants to earmark some central government resources for the health sector. Most of these conditional grants in Kenya do not require matching contributions from the counties, but they do have conditions (e.g., annual increases in the annual percentage of budget allocated for health, prioritisation of reproductive, maternal, newborn, child, and adolescent health, and the requirement that counties transfer funds to PHC facilities). In Burkina Faso, communes also receive a grant for health centres but without any matching requirements or conditions. In Uganda, the national transfers to subnational units are both disaggregated into different grants by purpose and are accompanied by strict guidelines about how districts may use the funds. In Indonesia, the central government provides earmarked funding to support disadvantaged districts (called DAK grants) to invest more in health. These districts are usually required to co-finance 10% of activities. The MOH also provides direct budget transfers to the subnational level to support health service delivery, including funds to districts for specific health programmes. In the case of Nigeria, states receiving funds from the BHCPF are supposed to provide 25% counterpart funding, but this has not been enforced so far. In fact, in Nigeria there is limited use of matching requirements for conditional grants compared to what is seen in other federal systems, including in Argentina (36), India (37), South Africa (38), and the United States (39).

Local governments in Kenya, Indonesia, the Philippines, and Nigeria enjoy discretion over how much of the block grants and their budget they allocate to health. This is especially apparent in the case of Kenya and the Philippines, where the central government cannot influence local budget allocation decisions as per the constitution. However, in the Philippines, the DOH encourages local governments to allocate a considerable proportion of their budgets to health, nutrition, and environments (22% for provinces and highly urbanised cities, and 15% for municipalities and cities) as part of a local government performance scorecard. Nevertheless, DOH’s influence is minimal due to the lack of incentives and penalties. Districts in Indonesia are encouraged to use general allocation funds (called DAU) to provide basic essential services and 10% of their budgets must go towards health spending.⁸ In practice, districts use DAU funds to cover salaries and administrative costs and their budget allocation to health varies from 3% to 18%. In Nigeria, the federal government cannot control the states’ allocation decisions, but state governments themselves do heavily influence budgeting at the local level. In contrast, block grants to districts in Uganda are small and rarely used to cover health sector costs. Most

⁸ However, what constitutes as health spending is not clearly defined and expenditure earmarks are often not fully met.

health spending at the local level is financed through conditional grants to districts and health facilities, which limit district government discretion over allocation decisions. In Mozambique, the Ministry of Economy and Finance influences provinces and districts’ block grant allocation to health as it communicates guidelines and budget ceilings for the preparation of plans and proposed budget.

The arrangements for revenue-sharing across subnational governments vary across the seven countries (see Table 5). Kenya, Mozambique, Nigeria, and the Philippines employ a formula to divide funds between subnational governments. The formula in Kenya has evolved over time and takes into account factors like geographical size, poverty level, population, and health needs. The final shares allocated to counties are approved by parliament. Similarly, the subnational governments in Mozambique and the Philippines receive funds based on factors such as population, area, fiscal effort, or poverty level. In the case of Nigeria, the funds for the local governments flow via their state. While there are vertical revenue sharing rules for determining the total funds for local governments within a state, how funds are divided among local units varies by state. Moreover, states do not always share the funds for local governments with them. In c Uganda, the equalisation and non-wage grants are guided by socio-demographic and health criteria.

Table 5. Overview of rules for revenue sharing across subnational governments

Country	Formula and/or and criteria for revenue sharing across subnational governments
Burkina Faso	Transfers for the health sector based on the number of health facilities in the catchment area and the type of setting (rural vs. urban) Predefined amount per health centre in rural communes and urban communes (1.2 million CFA and 1.3 million CFA, respectively)
Kenya	Formula for block grant developed by the Commission on Revenue Allocation, taking into account factors like geographical size, poverty level, population, and health needs; final shares approved by parliament
Mozambique	Block grant to provinces distributed based on population size and poverty index Block grants to districts allocated based on population size, surface areas, own revenue collection, and poverty level PROSAUDE funds further distributed to provinces (16% going to subnational governments) and districts (64% going to subnational governments), determined by population (25%), activity (30%), beds per inhabitant (20%), acute child malnutrition (15%), and reverse population density (10%)
Nigeria	Oil revenue: 13% distributed to oil-producing states in proportion to their contributions VAT revenue: 50% distributed to states in proportion to derivation and 10% in proportion to population, and 40% equally divided among states Federation Account funds determined by population (25.6%), population density (1.45%), internal revenue effort (8.31%), landmass (share of national territory) (5.35%), terrain (5.35%), rural roads and inland waterways (1.21%), potable water (1.5%), education (3%), and health (3%); the other 45.23% divided equally among states
Uganda	Equalisation grant allocated based on a formula that considers population, education and health needs, and poverty measures There is a formula for unconditional grants in the constitution, but its application remains inconsistent

Country	Formula and/or and criteria for revenue sharing across subnational governments
	<p>Non-wage conditional grant allocated based on a formula that considers population, infant mortality, poverty headcount, population in hard to reach and hard to stay areas.</p> <p>Development conditional grants: (1) facility component follows the basic allocation criteria (80% of the total), and (2) performance components based on the results of the local government performance assessment (20% of total); squared local government performance assessment scores are used (these are weighted by 50% and 50% respectively of the basic formula component)</p>
Indonesia	<p>DBH funds allocated to provinces and districts proportionally by amount of revenue collected per geography⁹</p> <p>DAU funds: total salary of subnational civil servants and the difference between fiscal requirements¹⁰ and fiscal capacity¹¹</p> <p>DAK funds: support disadvantaged districts¹²</p>
Philippines	IRA further distributed to LGUs based on population (50%), land area (25%), and equal sharing (25%)

The share of total government health expenditure going through the local governments varies considerably across the seven countries (Table 6). Uganda, the Philippines, and Nigeria are at the lower end (with 39%, 20%, and 29% respectively). In contrast, local governments accounted for a larger proportion of government health spending in Burkina Faso, Kenya, Indonesia, and Mozambique. Altogether, there is a vertical imbalance between revenue raising capacity and spending responsibilities across levels of government in all seven countries. Subnational governments rely heavily on transfers from the central level to fund their budgets regardless of the extent of discretion they may enjoy over allocation decisions.

Table 6. Subnational role in health spending

Country	Transfers from central government as a share of total subnational budget	Share of total government health spending that occurs at the subnational level ¹³	Share of local budget that is for health
Burkina Faso (40)	43% of revenue for communes came from transfers by central government, 39% came from local revenue, 12% from donors, and 6% other (2018)	75% of government health spending went through the subnational level while 15% was by MOH (2017)	NA (local government budget classifications does not allow for such analysis)

⁹ Revenue collected at subnational level through unique fees/taxes at that level do not get pooled at central level.

¹⁰ Fiscal requirement calculations are based on population count, geographic area, and index on “construction expensiveness”, human development index estimates, and gross regional domestic product.

¹¹ Fiscal capacity is determined by DBH revenues and own-source revenue totals.

¹² There are two types of DAK: (1) physical DAK that is meant to finance infrastructure activities or to purchase equipment, and (2) non-physical DAK that is used for public health programmes.

¹³ The numbers in this column refer to the share of total government health spending that occurs at the subnational level as of general government health expenditure, including compulsory health insurance.

Country	Transfers from central government as a share of total subnational budget	Share of total government health spending that occurs at the subnational level ¹³	Share of local budget that is for health
Kenya (34,41)	71% (FY 2019/20)	50% (FY 2019/20)	27% on average (FY 2018/19)
Mozambique	NA	NA	NA
Nigeria (30,42)	60% for states and 95% for LGAs (including federal transfers and state allocations) (2019)	29% at state-level, 8% at local level (not including federal programmes that provide support to PHC facilities) (2016)	4% at state-level and local level (2016)
Uganda (43–46)	100%	39% (between FY 2015/16 and 2018/19)	15% (FY 2019/20)
Philippines (47,48)	External revenue sources, including IRA, accounted for 61 percent (P478.86 billion) of the operating income of LGUs (2019)	LGUs account for 20% of total government spending, compared to 39% by DOH and 41% by PhilHealth	Provinces spent 23% of their budget on health compared to 13% for cities and 8% for municipalities (2019)
Indonesia (31,49,50)	47% at the provincial level and 67% at the district level (2018)	Districts and provinces accounted for 36% and 10% of government health expenditure respectively. In contrast, central government ministries and JKN accounted for 12% and 42% of government health spending (2018)	It is meant to be at least 10% of district budgets; in reality it ranges from 3% to 18%

Unpredictability and delays in the flow of funds from the central government to subnational units is a common challenge in several countries. As in Kenya and Burkina Faso, this can happen due to a paucity of funds at the central level. It is also triggered by lower levels of government not preparing budget and expenditure documents on time and based on national guidelines, as is the case in both Kenya and Indonesia. Regardless, this can contribute to low execution of the budget at the local level, including delays in payments to health workers and poor execution of infrastructure projects and health programmes. In contrast, in Nigeria, transfers from the federal government to states are reliable.¹⁴ Similarly, block grant funds in the Philippines are usually released on time.

POOLING

Subnational governments receive revenues transferred by the central government and raise revenue locally and subsequently, parts of the pooling function and purchasing function are transferred to the local government; this leads to the creation of multiple pools and could result in fragmentation. Subnational pools should ideally be large in terms of the number of people covered to avoid the pools being financially precarious, inefficient, or having limited administrative capacity (51). If resources are not equitably redistributed, multiple

¹⁴ Transfers are made according to a set monthly schedule. However, the amounts may not be reliable due to poor and/or uncertain revenue forecasts. This means that states receive funds on time but not necessarily the expected amount based on their budget.

pools can lead to fragmentation, which is undesirable from a health financing policy perspective; the redistributive capacity of multiple smaller pools is usually less than that of one single large pool and varies across the pools given different health risks and available health funds in each pool. Fragmentation may be further aggravated by territorial overlap in population and service coverage in urban centres when higher level facilities co-exist with lower-level facilities for PHC (52). Redistributive capacity would be equal if per capita expenditure adjusted for the health risks of the population in each territory is equal across each pool. The way the revenue raising function is organized in a devolved setting including the horizontal revenue sharing rules and local revenue raising capacity is thus decisive for redistributive capacity within the multiple pools. Table 7 provides an overview of the horizontal revenue sharing rules and the nature of intergovernmental transfers.

Effects of horizontal revenue sharing formulas and equalization measures

Given that subnational governments represent territorial pools, it is important to assess the extent to which intergovernmental transfers and horizontal revenue-sharing rules attain equitable average per capita health expenditure adjusted for health risks across the multiple pools. As shown in Table 7, all countries except Burkina Faso and Uganda use formula-based block grants to transfer revenues to subnational levels of government. In several countries, parts of the funds are evenly distributed across subnational units (for example, states in Nigeria) or a portion of the total revenue raised by states is transferred back to the states in proportion to their contribution (which leads to oil-producing states in Nigeria receiving back a large part of their revenues from oil). There is no equalizing effect for the part of inter-governmental transfers that is evenly distributed across subnational units or that is transferred back to subnational units in proportion to what they raised (see Tables 5 and 7). There are alternative approaches to achieving a more equitable distribution of general government resources per capita across subnational pools. One way is to use population size as a criterion, which is indeed applied in all countries for some part of the funds. This is more needs-oriented than just evenly distributing the resources though it disadvantages (geographically large) subnational units that are sparsely populated that may have special needs to overcome distance, remoteness, and associated challenges. On the other hand, size of land area may also be an insufficient indicator. To bring together those two aspects, Mozambique allocates 10% of PROSAUDE funds based on a reversed population density indicator. A stronger equalisation effect can be achieved by considering more specific needs-oriented indicators, such as poverty head count or health indicators (such as infant or maternal mortality). Kenya, Mozambique, and Uganda do so. In contrast, using the number of health facilities, hospital beds or health workers may not have an equalisation effect, as these are often not distributed equally across subnational units. Kenya is now considering a revised revenue sharing formula that will better factor in health needs of individual counties.

Despite these formula-based distribution rules, per capita expenditure across subnational units is reported to be very unequal in the study countries. For example, in Mozambique, this ranges from about 800 to 2,100 Metical across provinces. The difference is even much larger in Nigeria, where state revenue per capita spans from 10,000 Naira in Bauchi to 95,000 Naira in Bayelsa state, which seems unlikely to be a mere reflection of different needs across these states. Instead, it shows that the revenue sharing formula for dividing resources across states favours the oil-producing states. More detailed data for all countries will be important to reveal these inequities and bias in the formula used for the distribution of national revenues. However, the country evidence suggests that the criteria to distribute funds across subnational units appear to be insufficient to lead to more equitable distribution of resources.

Table 7. Assessment of horizontal revenue sharing formulas and equalization measures

Country	Do the formulas for sharing centrally pooled revenues across subnational units <i>attempt</i> to equalise fiscal resources across subnational units?	Do the formulas actually equalise fiscal resources across subnational units?	Does the revenue sharing formula for block grants include any health-related indicators?	Are there any special grants for poorer/less developed states/regions?
Burkina Faso	Unclear: Depending on whether the number of health facilities is in line with population numbers and population density	Partially: Depends on whether infrastructure/norms or whether health needs are used as criteria to determine facility grants.	NA	No
Kenya	Partially: Formula takes into account geographical size, poverty level, population, health needs (17%) (based on a health index)	Partially	Yes: 17% of allocations guided by the health index	0.5% of national revenues allocated to equalisation fund and reserved for marginalised counties. Multiple conditional grants for health to give counties funds to compensate them for various user fee removal policies and for the new UHC programme.
Mozambique	Partially: Block grant from central government to provinces based on Population size, and poverty index. Block grants from central government to districts based on population size, surface area, own revenue collection, poverty level. Health sector specific grant (PROSAUDE) allocated based on population (25%), activity (30%), beds per inhabitant (20%), acute child malnutrition (15%), and reverse population density (10%).	No: Per capita expenditure across provinces varies from around 800 to 2,100 Metical	Multidimensional poverty indicators which include water (15%), sanitation (15%), health, (20%) sanitation, administration and socio-economic infrastructure, and population.	
Nigeria	Minimally: Needs-oriented criteria, such as population, population density, terrain, and the availability of potable water only factor modestly in how federally collected revenue is distributed across states. The health-related criterion considers	No: State per capita expenditure ranges from 10,000 Naira (Bauchi) to 95,000 Naira (Bayelsa).	Yes: 3% of Federation Account for health (number of hospital beds).	Use of resources from the BHCPF is meant to prioritise the health needs of the poorest people in each state, though not necessarily only for poorer states; in principle with 25% state matching.

Country	Do the formulas for sharing centrally pooled revenues across subnational units <i>attempt</i> to equalise fiscal resources across subnational units?	Do the formulas actually equalise fiscal resources across subnational units?	Does the revenue sharing formula for block grants include any health-related indicators?	Are there any special grants for poorer/less developed states/regions?
	the number of hospital beds.			No information on how the BHCPF is distributed across states and within states across LGAs.
Uganda	Yes. Non-wage conditional grant allocation is partly needs-based, but 60% is based on population. Development conditional grant: 80% is based on previous grant allocation. Discretionary development grants are allocated based on population, education and health needs, and poverty levels.	To a limited extent. But wage based conditional grants are the largest part and are based on existing staff numbers, not related to actual need. Data shows that discrepancies are very large.	Yes: - Infant mortality - Number of health facilities - poverty head count (partly capturing health needs)	Yes: Discretionary development grants
Indonesia	Partially: Larger proportion of revenues going to resource-rich districts from where the revenues originated, but DAU and DAK have an equalization purpose	No	No: General allocation transfer includes civil servants' salaries in calculation.	Special allocation funds provide additional resources to underdeveloped and vulnerable districts with low financial capacity.
Philippines	Partially: The distribution of IRA among LGUs is weighed based geographical and population sizes.	No	No	No

Even with a revenue allocation formula that is designed to achieve a more equitable distribution of block grants or reflect health needs, there is no guarantee this will lead to equitable health spending across subnational units. This is because subnational governments may not prioritize health as envisioned. This is especially true in countries where subnational units have complete discretion over how much they allocate towards health versus other priorities (refer to revenue raising section for more discussion of this).

Given the limitations of block grants, conditional grants for health are another way to address disparities in health needs or spending levels. The distinction between revenue sharing rules for block grants versus conditional grants earmarked for the health sector is worth noting. The former may factor in variables related to health and non-health sectors and may envisage an equitable allocation of resources based on the range of variables measuring needs across sectors. But this may not look equitable when viewed just through the lens of health needs. In contrast, it is easier to optimise the distribution of resources through conditional grants that are earmarked for health. For that matter, it is important for conditional grants to be oriented along health needs rather than existing health infrastructure or health worker numbers, since the existing infrastructure may only

reflect current inequities. In the study countries, conditional grants are provided in Uganda (partly needs-based, partly based on existing health workers), Burkina Faso (a grant per facility) and Kenya (compensation for user fee removal policies, thus rather needs-based). However, data in Uganda shows that there remain huge differences in the per capita PHC allocations, i.e., the sum of the earmarked health allocations going to districts. Sixteen local governments receive less than 2 USD per capita, another sixteen get more than 7 USD and four local governments receive more than 10 USD per capita for the delivery of PHC services (53).

As another measure to address existing inequalities and inequities, several countries provide specific funds for poorer subnational units, such as Indonesia (special allocation grants), Uganda (equalisation grant); Kenya (equalisation fund for marginalised counties); or for poorer people (BHCPF for poorer people in Nigeria, with implementation still in nascent stages). For Nigeria, it is so far unclear how the funds will be distributed across states and within states and hence to what extent they can have a redistributive effect. Moreover, states must meet various statutory requirements to receive funds. Hence, the actual distribution of these funds may ultimately depend on how ready states are to receive these funds.

Despite the specific provision of conditional grants for health or special grants, the average per capita health expenditure across subnational units reveals stark differences. In other words, the horizontal revenue sharing rules combined with the provision of conditional grants turn out to be insufficient to equalise resource allocation for health. Across all seven case study countries, it appeared that the central government could make better use of their share of health spending to achieve greater equity in health spending across subnational units. Central governments typically use their health budgets to fund tertiary health facilities, as a result of which tertiary care often seems to get higher priority and relatively more funds compared to PHC. While these tertiary facilities are a common resource for all subnational units, they can disproportionately benefit people living closer to them. To reduce fragmentation and to increase redistributive capacity, some communes in Burkina Faso are pooling funds within their community (“communauté”) of communes, i.e., communes within a geographic area. As such, communes share transfers and own resources to increase equity in the distribution of resources. In the Philippines, according to the UHC Act, resources will be pooled at provincial or city levels in a special health fund to reduce fragmentation and earmark funds for health from various sources. However, any attempt to merge subnational health pools at the national level can be politically fraught. For example, in Kenya, discussions about counties contributing to a common national social health insurance fund from their own coffers has often been viewed as a backdoor attempt to recentralise health funds even as counties would welcome the central government committing more resources to a common fund.

The role of health insurance schemes in the context of devolved settings

Among the study countries, Kenya, Nigeria, the Philippines, and Indonesia have a national health insurance scheme. Table 8 provides an overview of their specific arrangements. In the case of Nigeria and Kenya, there are also health insurance schemes at the state and county levels, respectively. The existence of a health insurance scheme increases the need for coordination across subnational units and may add to the existing fragmentation, particularly when subnational schemes exist. Indonesia and the Philippines each have large national health insurance schemes that covered over 83% in 2020 (54) and 98% in 2018 (55) of the country’s population. In contrast, Kenya has a national social health insurance that only covers 26% of the population (56). While not geographically fragmented, these schemes can have sub-pools by population groups. In Kenya, for example, there is one pool for public sector employees, a second pool for other formal sector employees, and a third pool for paying members from the informal sector, and yet another separate pool for households subsidised by the government. Some counties in Kenya have also launched either their own county-based health insurance programmes or are paying premiums for households under NHIF in their county. There is also a variation across

counties in terms of how beneficiaries are identified. In Nigeria, there are both a federal health insurance scheme for federal employees and state social health insurance schemes, leading to an even more complex pooling architecture and high level of fragmentation; however, they collectively covered only 4.2% of the population as of 2016. Burkina Faso has passed legislation to establish a social health insurance scheme, but not yet operationalised it. Uganda has passed legislation for a national health insurance scheme, which is awaiting presidential signature. Health insurance is still nascent in Mozambique. Discussions to build a national insurance scheme based on the existing scheme for civil servants are ongoing.

In the four countries with a national health insurance scheme, membership has historically been biased towards formal sector employees more generally or government employees more specifically, but the central government has in recent years started providing budget transfers to either partially or fully pay for coverage for poor or vulnerable population groups. For formal sector employees, governments as employers typically pay a part of the civil servants' contributions and may also subsidize contributions of private sector employees. Many of these members are based in the capital or in other urban settings such that reimbursements for health services they consume go to health facilities in those areas. Thus, health facilities in marginalized areas do not benefit from insurance reimbursements. As part of UHC reforms, governments in these countries have introduced subsidies to extend health insurance cover to the poor. In Philippines, the central government uses general government revenue from a sin tax to subsidise health insurance coverage for an estimated 40% of the population (55). In Indonesia, insurance coverage is subsidised for approximately 46% of the population (57,58), though there may be a risk for duplicative subsidies since subnational governments must verify poor households and there needs to be better coordination with central government databases. In Nigeria, 50% of the BHCPF is supposed to be used by state social health insurance agencies to buy health services for poor and vulnerable people. In Kenya, the central government is preparing to cover an estimated 10% of the population (1 million households country-wide) and gradually expanding that to cover the third of the national population that is poor.

The distribution of central government subsidies for health insurance coverage of poor and vulnerable people can have an indirect redistributive effect. When Kenya first piloted a health insurance scheme, the government provided subsidies to an equal number of poor households in each county. In the current plans for covering one million poor households from across the country, subsidies are divided in proportion to county population shares. This new approach is more equitable than an even amount per county, but less equitable than apportioning subsidies according to actual county poverty levels. In both the Philippines and Indonesia, the budget transfers follow the number of eligible households. While the budget transfers are sent to PhilHealth, their spending would largely occur in accredited health facilities where the subsidised people live, supposing they seek care and do so within their subnational unit.¹⁵ In principle, no quota in place implies a more equitable spending of funds across subnational units. Such a direct distribution of funds per subsidised individual provides an explicit amount of funding for a person and can lead to more equitable distribution of funds and spending than the existing allocation criteria for central government allocations to local governments, even if they are based on health (needs) indicators. Nonetheless, if access to services is challenging (transport, financial barriers due to still existing cost-sharing mechanisms, etc.) and health care supply is weak in remote areas where we find more poorer people living, then this more equitable resource distribution is still not going to translate in utilisation being in line with health care need. In conclusion, it is unclear to what extent central government transfers to subsidise health insurance coverage of poor and vulnerable people contribute to equalise per capita

¹⁵ However, for example in the Philippines, accredited government health facilities are more often found in urban areas.

health expenditure across subnational units. This extent is more so unclear as health insurance payments for health services from formal sector employees are largely channelled to the capital and urban centres, assumingly with little indirect redistributive effect across subnational units.¹⁶

Table 8. Overview of health insurance subsidy arrangements and potential redistributive effects

Country	Is a national health insurance scheme in place?	Are there local/subnational government health insurance type schemes?	Does the central government subsidise health insurance coverage for the poor?	Does subnational government subsidise health insurance coverage for the poor? Is there a common policy for this?	Do (central government) budget transfers to health insurance schemes lead to redistribution across territorial units? Are subsidies in line with poverty headcounts of each territorial unit?
Burkina Faso	No, under development and yet to be operationalised	NA	It is planned	No, this is not planned	No information
Kenya	Yes	Yes ¹⁷	Yes	Some counties do, based on a county-based policy, while others use pooled resources to pay NHIF contributions for eligible persons under NHIF	Each county receives a share in proportion to its population size.
Mozambique	No, under discussion	NA	NA	NA	NA
Nigeria	Yes (federal scheme for federal employees)	Yes, under development ¹⁸	Envisaged (not yet implemented) 50% of BHCPF (federal funding) to be used via the state social health insurance agencies to provide health insurance coverage for the Basic Minimum Package of Health services, to which all Nigerians, including the poor, are entitled	Envisaged (not yet implemented): states to provide 2% counterpart funding	No quotas per state

¹⁶ A higher disease burden of poor and vulnerable people would have to be considered when setting the subsidy amount per person.

¹⁷ The county-based schemes are budget-funded, no payroll-based contributions are collected.

¹⁸ So far, 16 states enrol members, and in 10 of these, benefits are provided.

Country	Is a national health insurance scheme in place?	Are there local/subnational government health insurance type schemes?	Does the central government subsidise health insurance coverage for the poor?	Does subnational government subsidise health insurance coverage for the poor? Is there a common policy for this?	Do (central government) budget transfers to health insurance schemes lead to redistribution across territorial units? Are subsidies in line with poverty headcounts of each territorial unit?
Uganda	No, under discussion	NA	NA	NA	NA
Indonesia	Yes	No (the different national and local schemes were merged after 2016)	Both the central and subnational governments subsidise JKN premiums for poor households.	Yes The Bureau of Statistics and Poverty Reduction Team determines the number of subsidised. The MOH sets premium rate for the subsidised.	No quotas for subnational units from central government ¹⁹
Philippines	Yes	No	Yes	No	No quota for subnational units from central government; no data to assess the extent of redistribution

PURCHASING

Purchasing activities and payment methods of subnational governments

Subnational governments pay for all or parts of PHC services and, in some cases, secondary services from public facilities in all seven countries. While central governments retain the responsibility of determining the core set of health services that will be available through the public delivery system as well as control over tertiary care facilities in the public sector, subnational governments pay to varying degrees for the delivery of primary and secondary care through public hospitals and health centres, as well as community outreach programmes. Table 9 below provides an overview of the division of purchasing responsibilities.

In Mozambique, Indonesia, Nigeria, and the Philippines, the costs of service delivery in the public sector are shared between three levels of government: the national MOH, an intermediate level such as state, region or province, and local governments. In the Philippines, Mozambique, and Indonesia, local governments pay for the bulk of the costs incurred at primary care facilities and local hospitals in the public sector, including staff salaries and operating costs. In contrast, Nigerian states pay for health worker salaries at all public facilities within its jurisdiction, while local governments sometimes contribute to the operating costs of primary care facilities. Subnational governments also budget for commodities for public sector facilities in the Philippines and

¹⁹ However, if utilization rates are low in a district (e.g., due to geographical or other barriers), the funds for the subsidized (called PBI) may have to be transferred to districts with higher utilization rates where the funds are needed.

Indonesia, while many commodities are supplied by the federal government in both Nigeria and Mozambique, the intermediate level operates provincial or regional hospitals, although some regional hospitals are managed by DOH in the Philippines.

In Kenya, Burkina Faso, and Uganda there is only one level of devolved government that plays a role in purchasing in addition to national MOH, but the extent of their purchasing power varies considerably. At one extreme is Kenya, where counties are the main purchasers of primary and secondary services from public facilities and, as such, they budget and pay for staff salaries, commodities, and the operating costs of health facilities. In contrast, communes in Burkina Faso only pay for some the operating costs of PHC facilities while staff salaries are covered by the central government and commodities are financed through user fees collected by facilities as well as through in-kind contributions from national programmes. Local governments play the least significant role in purchasing decisions in Uganda. While districts in Uganda oversee the delivery of health services at health centres in their jurisdiction, the finances are allocated by the national MOH through a series of conditional grants. Even though these funds are reflected in district votes in the national budget, the districts have no control over fund allocations for staff salaries or commodities that are determined by MOH, or the operating funds for health facilities that are also allocated by MOH and transferred directly from the central level to facility accounts.

Table 9. Division of purchasing responsibilities

Country	What services do local governments purchase?	Are there other purchasers who also pay for government health services?
Burkina Faso	By providing some funds, communes are purchasers for a range of health services from PHC facilities in the public sector. They pay for operations costs as well as the salary costs for ancillary staff and community health workers through input-based budgets.	MOH pays staff salaries and district health offices (which are administrative branches of MOH) cover additional costs.
Kenya	Counties purchase primary and secondary health services in the public sector, largely through input-based budgets covering staff salaries, commodities, and operating costs. This includes community health workers, as well as prevention and promotion programmes.	NHIF pays public facilities for services consumed by its members. NHIF payments to public providers are a “top-up” over supply-side financing received by the facilities from the country government. NHIF uses a variety of provider payment mechanisms (e.g., case-based payments, per diem and capitation) with both public and private health facilities.
Mozambique	Provinces purchase services from provincial hospitals, paying for health worker salaries and other costs through input-based budgets. Districts purchase services from district hospitals and PHC facilities, paying largely for health worker salaries and operating costs. Districts also pay for community health workers, and they both undertake public health programmes.	The national MOH pays for commodities and capital investments.
Nigeria	States purchase primary and secondary care from hospitals and PHC facilities, largely through input-based budgets that cover health worker salaries.	The federal government buys a range of commodities, often for priority programmes and with support from donors. It also directly funds

Country	What services do local governments purchase?	Are there other purchasers who also pay for government health services?
	Local governments may pay for some operating costs of health centres. Additionally, some states operate social health insurance schemes wherein they purchase a range of services from contracted providers.	portions of the PHC workforce, such as covering the salaries of midwives and community health extension workers.
Uganda	Districts receive conditional grants from the central government to pay for capital costs associated with infrastructure upgrades for health facilities as well as local community health programmes. They do not pay for any facility costs.	The central government pays for health worker salaries (though the funds are allocated to districts, the local administration has limited control over the funds) and commodities. It allocates and transfers funds directly to public facilities to cover operating costs.
Indonesia	Provinces purchase secondary services from provincial hospitals. Districts purchase primary and secondary services from district hospitals and public PHC units. Both fund preventive and promotive health services and receive funds to implement vertical health programmes. They largely finance these services through input-based budgets, paying for staff salaries, commodities, and operations costs.	Under the JKN national health insurance scheme, public and private facilities are paid for services access by scheme members.
Philippines	LGUs purchase services from public facilities within their remit (provincial hospitals in the case of provinces, local hospitals, and health centres in the case of cities and municipalities). They each use input-based budgets to pay for health worker costs, commodities, etc.	Under the national health insurance scheme, PhilHealth pays for primary health care services through a mix of capitation and case-based payments, while inpatient services are through case-based payments. PhilHealth purchases services from both public and private providers. DOH continues to provide inputs including commodities, health human resource, and capital outlay for select public facilities.

In all seven countries, local governments play an important role in paying for and managing community health services. Local governments are responsible for paying for at least some cadres of community health workers in all countries except Nigeria where the state government covers those costs, in some cases with support from the federal government or donors (or both). In all seven countries, local governments are responsible for undertaking public health programmes and community outreach activities.

Input-based budgets are the dominant resource allocation approach for all subnational governments in the case study countries. Even though many of the case study countries – most notably Burkina Faso, Kenya, the Philippines, Mozambique, and Indonesia – have introduced program-based budgets, subnational governments have either not transitioned to producing program-based budgets or continue to allocate resources according to

economic classifications while also producing program-based budgets.²⁰ More important from a purchasing point of view is the fact that they pay directly for various inputs – health workers, commodities, and operating costs – instead of transferring funds to facilities using grants or provider payment methods like global budgets or capitation. There are some small exceptions; counties in Kenya for example receive conditional grants from the central government (some of which are financed by donors) which they are required to transfer to PHC facilities.

Subnational governments do not pay providers based on outputs even when they have the authority to do so.

Counties in Kenya, states in Nigeria, and provinces and districts in Indonesia have the authority to introduce alternative ways to pay health facilities in the public sector, but they by and large do not exercise this authority to pay facilities based on outputs. Districts in Mozambique, LGUs in the Philippines, and communes in Burkina Faso are not authorized to alter payment methods. In Uganda, the bulk of service delivery in the public sector is financed through conditional grants from the central government; some of those budget allocations flow directly to facilities but are not linked to performance. Burkina Faso, Kenya, Mozambique, Nigeria, and Uganda have experimented with performance-based financing to health facilities, primarily with donor support. These programmes have been centrally managed by MOH in Uganda, Burkina Faso, and Mozambique, whereas in Nigeria and Kenya, they have been managed by states and counties, respectively. In Kenya, some counties are starting to embrace performance-based payment approaches with their own resources as well as engaging in active discussions about how more funds can be channelled directly to facilities that are also empowered with greater financial autonomy.²¹ There is also one county that uses general revenue to operate a health insurance scheme whereby it reimburses public hospitals for user fees.

Subnational governments rarely use their funds to purchase health services from private providers in any of the case study countries. Private sector health providers constitute a large share of the service delivery capacity in several of the study countries, notably Kenya, Nigeria, the Philippines, and Indonesia. They also account for a high share of services consumed in these countries. While national and subnational health insurance schemes are set up to contract private providers in all these countries, there are very few examples of subnational governments out-sourcing or in-sourcing private providers for health services. Subnational units in the Philippines, Mozambique, and Kenya can contract private providers, but rarely do. Both states and local governments in Nigeria are similarly permitted to contract non-state providers but have shown little appetite for this. In Uganda, there is a long-standing history of public resources flowing to private not-for-profit facilities for the delivery of services in areas where the coverage of public facilities is poor. But these arrangements are more by custom than contracts. Moreover, the allocations are stipulated by MOH, even though the money passes through the district budget.

Overall, local governments are not engaged as strategic purchasers. This is because of limited discretionary space for purchasing decisions due not only to limited funds, but also due to limited use of the available purchasing authority. As certain types of health facilities are unable to retain their revenue from health coverage programmes, provider payment incentives, another element of strategic purchasing, cannot have their intended effect.

²⁰ For more on this, please refer to a companion report on devolution and public financial management processes in the health sector.

²¹ For more on this as well as information about direct facility financing in Tanzania, please refer to the companion report on devolution and public financial management in health.

Flow and use of facility funds

Public facilities generate revenue from user fees, health insurance reimbursements, or other payment arrangements in all countries. Table 10 outlines the flow and use of such facility funds. In Indonesia, Mozambique, Nigeria, and Burkina Faso, public facilities at all levels charge fees. In Kenya and the Philippines, only public hospitals charge fees while services at the PHC-level are free in government facilities. In Uganda, patients are charged fees only when using “private wings” in public hospitals; all other services are free at public facilities. In Kenya, Indonesia, Nigeria, and the Philippines, there are health insurance schemes that channel resources to facilities. Both Burkina Faso and Kenya have user fee removal policies for high priority and MNCH and FP services wherein facilities are reimbursed by MOH (NHIF manages the actual payments in Kenya) for maternal health and FP services accessed by women.

The ability of facilities to retain and spend these funds varies across the countries as well as within countries by level of care or subnational unit. The case of Kenya is most stark in terms of underscoring how facilities have lost financial autonomy because of devolution. Before devolution reforms in 2013, facilities could retain any funds they generated from user fees, reimbursements from the national health insurance agency as well as direct facility payment schemes initiated by the central government with support from donors. They spent the funds on their operating costs. Since devolution, they are required to remit these funds to the county government unless the county authorises them to retain these funds, partially or fully. This lack of autonomy is also an issue in Indonesia, where only a third of public primary health care facilities have financial autonomy (“BLUD” status) and can receive funds from JKN. Payments from health insurer to facilities without that status flow instead directly to the district, which continues to pay facilities through input-based budget allocations. The same is also the case in the Philippines; although there have been efforts to allow facilities controlled by DOH to retain revenue, most public facilities that fall under the purview of local governments and provinces still pool their funds with the general revenue. In Mozambique, facilities are required to transfer revenues from user fees to the central government, but this rarely happens in practice. Notably, the overall amount of user fees collected is very little and, although it represents a small share of the total budget, it is an important source of revenue for facilities. In contrast, in Burkina Faso, user charges can be retained and spent by health facilities. Likewise, under the Gratuité user fee removal policy for MNCH and FP services, a portion of the payments from MOH flow to the health facility bank account while the rest flows to the central medical store for commodities.

The fact that public facilities are unable to retain and spend payments from national health insurance schemes can dilute the “signals” that these separate purchasers are attempting to send facilities. Philippines and Indonesia have initiated health financing reforms to establish large-scale national health insurance schemes that already cover most of the population. Kenya aspires to do the same by expanding the social health insurance scheme that currently covers a fifth of the population. That funds from these health insurance agencies do not actually reach public facilities that by and large continue to receive budget allocations for inputs like health worker salaries, commodities, etc., severely hampers the ability of these health insurance agencies to purchase services strategically. However, there is limited disaggregated information in local budget documents about user fees and other revenue generated by public facilities.

Table 10. Flow and use of facility funds

Country	Do public facilities collect user fees? If yes, can they retain and spend them?	If there is national health insurance or other output-based purchasing arrangements, do those reimbursements flow to facilities? Can the facility retain the funds received?	Is revenue generated by health facilities “earmarked” for use in the health sector?
Burkina Faso	Yes, except for FP and MNCH services covered by the Gratuité user fee reimbursement policy. These funds are retained and spent by facilities.	A portion of Gratuité payments flow to the health facility bank account to cover operations cost. While hospitals receive money directly in their bank account, payments for PHC facilities are first transferred to districts and then to the facility bank account. Some payments flow to the central medical store for commodities.	The funds are retained and spent by the health facilities and, as such, are “earmarked” for health. Gratuité reimbursements are also used for health purposes.
Kenya	Public hospitals charge user fees, while services are free at health centres and dispensaries. Counties dictate whether hospitals can retain and spend the user fees they collect.	NHIF reimburses facilities under its health insurance programmes as well as other purchasing arrangements (e.g., for maternity services). In most counties, hospitals are required to transfer those funds to the county government (while a minority of counties have authorized facilities to retain and spend those funds). PHC facilities receive less from NHIF, but can retain and spend the funds	It varies across counties, depending on county legislation. Some counties have passed legislation authorizing facilities to retain the funds. Others have created a special “facility improvement fund” into which all funds are remitted and then earmarked for use by facilities. In a majority of counties, the funds flow to the county government which can allocate it towards any purpose.
Mozambique	All public facilities collect user fees but cannot retain it. The funds are remitted to the central government. Facilities designated as budget units receive their money back. The revenues from health centres, rural and district hospitals are sent to the district health office.	No national health insurance.	Revenue from user fees is meant to be used to support operating costs of facilities. There is considerable variation in how the funds are used.
Nigeria	Yes. Whether they can retain and spend the funds varies	Varies by state.	No consistent practice.

Country	Do public facilities collect user fees? If yes, can they retain and spend them?	If there is national health insurance or other output-based purchasing arrangements, do those reimbursements flow to facilities? Can the facility retain the funds received?	Is revenue generated by health facilities “earmarked” for use in the health sector?
	across states. User fees are not well-tracked.		
Uganda	Most services in public facilities are free. User fees are charged in private wings of hospitals.	Public facilities receive direct grants from the central government for their operating costs. They also receive payments under a donor-funded performance-based financing programme.	Revenue generated by private wings in public facilities is remitted back to the central level for reprogramming through the annual budget process.
Indonesia	All public sector facilities charge user fees for non-JKN members and members who do not use their benefits. Hospitals and some PHC units designated as semi-autonomous budgetary units have financial autonomy to retain and spend their revenue. Revenue from PHC units without autonomous status accrues to the local government.	For non-BLUD facilities, JKN payments for public facilities flow to local governments. Public facilities with BLUD status have financial autonomy.	There are general guidelines for local governments to allocate 10% of their budget to health. This is not consistently followed. Many local governments use revenue from facilities to meet this threshold.
Philippines	Public hospitals charge fees while PHC facilities generally do not. DOH-managed hospitals can retain revenue (they are required to use 25% of the funds for upgrading hospital equipment and the remaining for operating expenses and capital outlays). In general, all other LGU-controlled facilities cannot retain their revenue.	Yes, public health facilities can receive and retain PhilHealth reimbursements. But in practice this varies. In some instances, all funds are remitted to the LGU. On the other hand, some local governments allow their facilities to get their full PhilHealth payments and retain all their income streams.	Varies a lot across LGUs based on whether they allow health facilities to retain any revenue since all funds remitted to the LGU are treated as general revenue.

DISCUSSION

In this section, we return to the original questions that we set out to answer through this study. We use both the patterns observed across the seven country cases as well as other global evidence to offer some reflections.

How does devolution impact revenue raising for health?

Based on what we observe of revenue raising arrangements in devolved settings, it seems far more likely that additional health spending for UHC will come from central governments than from subnational governments.

Subnational governments rely heavily on transfers from central governments while their capacity to raise local revenue remains limited. This is certainly the case in the seven countries covered by this study. Such vertical fiscal imbalance between the share of revenue raised by subnational governments versus their share of government spending is not uncommon in many countries including federal systems like the United States, Australia, South Africa, and India. What is problematic, however, is when there is a vertical fiscal gap between the expenditure functions a level of government is required to perform and the resources it has, inclusive of vertical transfers. A common manifestation of this – which we also observe in several of the study countries -- is that the funds controlled by subnational governments are inadequate to cover the range of services they are meant to deliver. This is further aggravated by unreliable or delayed transfers of funds, which makes it difficult for local governments to meet their objectives and be accountable to their citizens. These observations suggest that in devolved countries registering steady rises in government health spending, the increases may be primarily driven by central governments dedicating more funds to health, either through conditional grants (as is the case in Kenya and Nigeria as well as other countries like India) or through subsidies for health insurance coverage for the poor (which is the case in the Philippines and Indonesia and in progress in Kenya and Nigeria), or both. More analysis with a wider set of countries and historical data is no doubt warranted to check this hypothesis.

These findings also suggest that countries should revisit vertical revenue sharing rules to grant a higher share of national revenue to subnational units that bear the brunt of the costs of delivering services, coupled with conditional transfers for health (not general block grants for all sectors). In fact, conditional grants could be a way to reconcile devolution with the goal of enhanced resource allocation to health. This may range from more rigid instructions of how to allocate these funds (for central governments to keep close control) to conditionalities and performance requirements to rather influence local government prioritization processes. Similarly, performance-based financing serves this purpose of providing earmarked funds for health directly to the facilities, thus increasing available resources at facility level, when coupled with sufficient facility autonomy.

The fact that funds from national health insurance agencies flow to local governments instead of facilities poses an interesting challenge for health accounting exercises. Typically, these flows are counted as spending by the health insurance agency. However, they are also revenue for local governments, who then use some or all of it to finance their health spending. When local government spending is also included in the estimation of total health spending, there is the need to make corrections for the amount of revenue received through insurance reimbursements in order to avoid that the same flow will be counted twice – once as spending by the health insurance agency, and one as spending by the local government body. The same could also be true for user fees collected by health facilities, which could be counted under OOPE and local government health spending.

What are the implications of devolution for the pooling function and equitable resource distribution?

While the decentralisation literature underscores the benefits of moving decision-making closer to citizens, devolution in the health sector creates multiple pools resulting in fragmentation. This calls for fiscal equalisation measures, yet it is challenging to achieve equitable resource distribution. The intergovernmental block grant transfers were not found to equalise these differences across territorial units. The formulas used kept disadvantaged areas even further behind and did not allow them to catch up in their capacity to offer more and better health services. This is especially the case when a significant share of subnational revenues remains at the subnational level, as is the case in Nigeria for oil revenues. In fact, devolution may increase inequalities and inequities, because the subnational territories are bound to differ in terms of their fiscal capacity relative to their needs, thereby requiring fiscal equalisation arrangements to redistribute resources. Achieving this while also recognising fiscal effort – lest regions are disincentivised to raise own-source revenue – and factoring in other considerations like absorption rates, budget transparency and accountability, etc., is no easy task (1).

In most devolved settings, the bulk of funds for subnational governments are distributed through block grants. The allocations are based on horizontal revenue sharing formulas that are complex by design as they (try to) strike a balance between multiple considerations including fiscal need, fiscal effort, and fiscal performance. While some countries use health indicators to capture service delivery needs in these formulas, there is a limit to how much these formulas can be aligned with nuanced measures of health delivery capacity, health needs, and health risks. Moreover, subnational governments have discretion over how much of these funds they allocate for health.

In contrast, conditional grants earmarked for health offer a targeted way to redistribute funds for the health sector between subnational units. Conditional grants for health are a more promising mechanism for redistributing national funds according to health needs and risks. They also give the central government the opportunity to use matching requirements to incentivize greater investments in health by subnational units, and link financing for local governments to performance. Ideally, the central government should monitor the effect of block grant formulae and local government health budgets on per capita expenditure on health, and then follow up with conditional grants to address imbalances in spending and further assessment of the effect of the conditional grants on per capita health expenditure across subnational units. National subsidies for health insurance coverage for the poor could have a similar effect on increasing revenues for health facilities and/or equalization across subnational territories, in that they are also directly linked to health and will have the net effect of channelling funds to places with more poor people with higher health risks, under the assumption that poor people use health services.²²

While several countries are turning to health insurance mechanisms as the vehicle for UHC, there are greater coordination needs in a devolved setup, for both national as well as subnational health insurance schemes. Coordination serves to ensure equitable distribution of resources across the country and equitable access. From a technical point of view, a single national pool has a greater redistributive capacity than subnational pools. It may also have other benefits, including cross-border portability across subnational units, greater administrative efficiency, etc.

²² A frequent challenge is that poor people may use health services at much lower rates due to both supply side constraint (less facilities where they live) as well as demand-side factors.

How has devolution affected the ability of purchasers to be more strategic?

In terms of purchasing, the first challenge that devolution poses for UHC plans is the division of purchasing responsibilities for different levels of care across different levels of government. In many countries, central government controls tertiary facilities, while lower levels of government control primary and secondary facilities (e.g., provinces or states control hospitals while local governments oversee health centres). This complicates any attempt to move to integrated care models, or to coordinate care between the primary and secondary level. Moreover, in Burkina Faso for example, there are overlaps and hence duplications in responsibilities for primary care facilities in that both the central MOH as well as local governments are in charge for similar aspects. This is also displayed in terms of conflicts between national and subnational levels on responsibilities and amounts of resources shared between them for health. Moreover, the fragmentation of the purchasing function across multiple pools may also increase overall administration costs due to duplication and the loss of economies of scale. More detailed studies in each country are needed to understand the actual extent of inefficiencies created by fragmentation versus efficiency gains due to more precise responses to citizen needs.

A second issue confirmed by these country case studies is that local governments are highly dependent on central government transfers to undertake the decentralised or even devolved purchasing tasks. But as taxing and purchasing authority are not aligned and not in the same institutional hands, one of the main arguments for decentralisation, namely enhanced accountability of the local government, is undermined (59). Heavy reliance on transfers from national government results in ineffective collection of own source revenues and delays in transfers from the national governments negatively affects the delivery of quality health services,

A third concern is the limited discretion and capacity of subnational governments to function as strategic purchasers of health services. In several study countries, notably Kenya, Indonesia, and the Philippines, local governments are the principal purchasers of PHC services. However, their purchasing approach is largely limited to line-item budget allocations for inputs and a large share of their health budget is “locked” into paying for health worker salaries, leaving little room to pay public providers based on outputs. Moreover, in several countries like Uganda and Indonesia, funds for subnational units flow through multiple channels including conditional grants with matching requirements, donor grants and in-kind transfer for vertical programmes, each with its own set of accountability and reporting requirements. This limits the ability of subnational units to use the funds effectively to respond to local needs. As such, there is practically limited leeway for matching services with citizen preferences, and as such another key argument in favour of decentralisation, namely realizing efficiency gains, is undermined.

A fourth common concern about purchasing arrangements in devolved settings relates to the continued limited health facility autonomy. In Kenya, the Philippines, Indonesia, and Uganda, tertiary facilities that are typically overseen by the central government enjoy a high degree of autonomy through global budgets. In contrast, most primary and secondary care facilities that fall within the jurisdiction of subnational government continue having far less financial autonomy (in both central as well as decentralised contexts). Most troubling is the fact that in several countries – notably Kenya, the Philippines, and Indonesia – user charges collected or payments from national health insurance agencies for health services delivered by public facilities must flow back to the local government (either directly or via the facility). In some countries, devolution led to even greater restrictions in facility autonomy.

CONCLUSION

The nature of decentralised governance in a country has profound consequences for any strategies or plans ministries of health and other health sector stakeholders develop to make progress towards UHC. It impacts

the design choices available to reformers, the politics of agreeing on any health system reform agenda, the implementation process, and ultimately the results.

Our “deep dive” into the health financing arrangements as part of UHC reforms against the backdrop of devolution highlights many challenges. With respect to revenue raising, we found that vertical revenue sharing rules favour the central level, resulting in resource shortage at the local level, particularly for PHC. Moreover, allocation formulas to distribute funds among subnational territories are complex and do not reduce existing inequities, they often exacerbate them. In terms of the pooling function, devolution has increased fragmentation, creating multiple territorial pools as well as territorial overlap in terms of service and population coverage across different levels (e.g., regions, districts, etc.). In some countries, the health insurance system is also territorially organised, making coordination with local health authorities even more complex. This implies multiple packages and multiple payment methods, increasing inefficient allocation and spending as well as inequities across territories and also between urban versus rural populations. Regarding purchasing, local health authorities have limited discretion to take purchasing decisions, as local resources – which are scarce to begin with -- are tied to personnel and medicines costs. Government health facilities can often not retain their revenues from user charges and other purchasers such as health insurance schemes and must remit the funds to local governments instead.

The main question remains around the level(s) of pooling and how best to realize maximum redistributive capacity. To ensure equal per capita health expenditure (adjusted for health risks), a government may consider to keep the majority of funds in a national health pool, with funds being allocated based on demand, health needs and requirements for infrastructure upgrading and larger number of health workers in underserved areas.

The country cases as well as global best practices point to some policy recommendations for addressing these challenges. This includes the following options:

- revising revenue sharing rules in favour of subnational levels;
- revising horizontal resource allocation formula across subnational units;
- reviewing and potentially shifting pooling levels upwards;
- ensuring timely, transparent and accountable fund flows to local governments and facilities;
- enabling and incentivising local governments to act as strategic purchasers;
- addressing lack of financial and managerial autonomy in public health facilities;
- streamlining health financing and service delivery responsibilities to reduce duplication and fragmentation and to clarify purchasing roles;
- granting facilities greater autonomy through legislation; and
- changing public financial management systems.

REFERENCES

1. Hart T, Welham B. Fiscal decentralization. A public financial management introductory guide [Internet]. Overseas Development Institute; 2016. Available from: <https://www.odi.org/sites/odi.org.uk/files/resource-documents/11063.pdf>
2. Treisman D. The architecture of government: rethinking political decentralization. Cambridge University Press; 2007.
3. Oates WE. An Essay on Fiscal Federalism. *Journal of Economic Literature*. 1999;37(3).
4. Bossert T. Analyzing the decentralization of health systems in developing countries: decision space, innovation and performance. *Soc Sci Med* 1982. 1998 Nov;47(10):1513–27.
5. Bossert TJ, Beauvais JC. Decentralization of health systems in Ghana, Zambia, Uganda and the Philippines: a comparative analysis of decision space. *Health Policy Plan*. 2002 Mar 1;17(1):14–31.
6. Marchildon GP, Bossert TJ. Federalism and decentralization in health care: a decision space approach. University of Toronto Press; 2018.
7. Abimbola S, Baatiema L, Bigdeli M. The impacts of decentralization on health system equity, efficiency and resilience: a realist synthesis of the evidence. *Health Policy Plan*. 2019 Oct 1;34(8):605–17.
8. Kutzin J. A descriptive framework for country-level analysis of health care financing arrangements. *Health Policy*. 2001 Jun 1;56(3):171–204.
9. Gottret P, Schieber G. *Health Financing Revisited: A Practitioner’s Guide*. Washington DC: World Bank; 2006.
10. Asante A, Wasike WSK, Ataguba JE. Health Financing in Sub-Saharan Africa: From Analytical Frameworks to Empirical Evaluation. *Appl Health Econ Health Policy*. 2020 Dec;18(6):743–6.
11. WHO. *The World Health Report: Health Systems Financing: The Path to Universal Coverage*. Geneva: World Health Organization; 2010.
12. Kutzin J. Health financing for universal coverage and health system performance: concepts and implications for policy. *Bull World Health Organ*. 2013 Aug 1;91(8):602–11.
13. Rondinelli D, Cheema S. *Implementing decentralization policies: an introduction. Decentralization and development: policy implementation in developing countries*. Beverly Hills: Sage; 1983.
14. Prud’homme R. *On the dangers of decentralization*. Policy, Research working paper no. WPS 1252. Washington, DC: World Bank; 1994.
15. Manor J. *The political economy of democratic decentralization*. Washington, DC: World Bank; 1999.
16. Cai H, Treisman D. *Did government decentralization cause China’s economic miracle?* Cambridge University Press; 2006.
17. Kim A. *Decentralization and the provision of public services: framework and implementation*. Washington, DC: World Bank; 2008.
18. WHO. *Everybody’s business: Strengthening health systems to improve health outcomes*. Geneva: World Health Organization; 2007.

19. WHO Symposium on Health Financing for UHC 2019 [Internet]. [cited 2021 Jul 8]. Available from: <https://www.who.int/news-room/events/detail/2019/11/12/default-calendar/collaborative-agenda-on-fiscal-space-pfm-and-health-financing-2019>
20. Offosse M-J. How decentralization has shaped health financing arrangements and PFM practices in the health sector in Burkina Faso. ThinkWell; Forthcoming.
21. Limasalle P, Soewondo P, Trihono T, Mardani H, Adani N, Maulana N, et al. How decentralization has shaped health financing arrangements and PFM practices in the health sector in Indonesia. ThinkWell; Forthcoming.
22. Ravishankar N, Mbutia B. How decentralization has shaped health financing arrangements and PFM practices in the health sector in Kenya. ThinkWell; Forthcoming.
23. Vilcu I, Lourenco S, Cueteia E, Cumbi Y, Fabozzi F. How decentralization has shaped health financing arrangements and PFM practices in the health sector in Mozambique. ThinkWell; Forthcoming.
24. Chaitkin M. How decentralization has shaped health financing arrangements and PFM practices in the health sector in Nigeria. ThinkWell; Forthcoming.
25. Nuevo C, Sigua JA, Samson MC, Co PA, Yap M. How decentralization has shaped health financing arrangements and PFM practices in the health sector in the Philippines. ThinkWell; Forthcoming.
26. Margini F, Jordanwood T. How decentralization has shaped health financing arrangements and PFM practices in the health sector in Uganda. ThinkWell; Forthcoming.
27. World Health Organization. Global Health Expenditure Database [Internet]. [cited 2019 Jun 17]. Available from: <https://apps.who.int/nha/database/Select/Indicators/en>
28. World Bank. World Bank Country and Lending Groups – World Bank Data Help Desk [Internet]. n.d. [cited 2019 Jun 17]. Available from: <https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups>
29. World Bank. World Development Indicators | DataBank [Internet]. 2020 [cited 2019 Jun 17]. Available from: <https://databank.worldbank.org/reports.aspx?source=world-development-indicators>
30. Central Bank of Nigeria. 2019 Statistical Bulletin: Public Finance Statistics [Internet]. 2020. Available from: <https://www.cbn.gov.ng/documents/Statbulletin.asp>
31. World Bank. Indonesia: Health Financing System Assessment [Internet]. World Bank Group; 2016. Available from: <https://pubdocs.worldbank.org/en/841891492102642178/110298-HFSA-Indonesia-Published.pdf>
32. DBM. FY 2021 Budget Forum Presentations [Internet]. Department of Budget and Management; 2020. Available from: <https://www.dbm.gov.ph/index.php/news-update/budget-forum-presentations/fy-2021-budget-forum-presentations>
33. Director General of Fiscal Balance. Summary of 2018 Regional Expenditure and Revenue Budget.
34. Office of the Controller of Budget. County Governments Budget Implementation Review Report FY 2019/20. Nairobi: Office of the Controller of Budget, Republic of Kenya; 2020.
35. Republic of Mozambique. General State Account. Year 2019. Volume I (Portuguese) [Internet]. Maputo, Mozambique: Republic of Mozambique; 2020. Available from:

<https://www.mef.gov.mz/index.php/documentos/instrumentos-de-gestao/-21/conta-geral-do-estado-cge/cge-2019/899-Conta-geral-do-estado-2019-anexos-informativos-volume-i/file>

36. Sabignoso M, Zanazzi L, Sparkes S, Mathauer I. Strengthening the purchasing function through results-based financing in a federal setting: lessons from Argentina’s Programa Sumar. Geneva: World Health Organization; 2020.
37. Sengupta A, Sharma A, Gupta S, Ravindran S, Sengupta S. Examination of the legal basis for conditional transfers to states and issues relating to performance-based incentives for states. Report to the Fifteenth Finance Commission. Vidhi Centre for Legal Policy; 2018.
38. Makube T. The Performance of Conditional Fiscal Transfers in the South African Intergovernmental Fiscal RELations System. Government of South Africa; 2012.
39. Digler RJ, Cecire MH. Federal Grants to State and Local Government: A Historical perspective on Contemporary Issues. Congressional Research Service; 2019.
40. Ministry of Local Government records.
41. Mbutia B, Vilcu I, Ravishankar N, Ondera J. Purchasing at the county level in Kenya. Washington DC: ThinkWell; 2019.
42. Federal Ministry of Health. National Health Accounts 2010–2016 [Internet]. Abuja, Federal Republic of Nigeria; 2017. Available from: https://www.health.gov.ng/doc/National-Health-Account-2010-2016_21032019.pdf
43. Republic of Uganda. Annual budget performance report FY 2015/16. Kampala; 2016.
44. Republic of Uganda. Annual budget performance report FY 2016/17. Kampala; 2017.
45. Republic of Uganda. Annual budget performance report FY 2017/18. Kampala; 2018.
46. Republic of Uganda. Annual budget performance report FY 2018/19. Kampala; 2019.
47. DOF. 2019 annual report: Bridging fiscal & social reforms for a better nation. Manila: Department of Finance; 2020.
48. DOH. Administrative Order No. 2012-0018: Guidelines on Contracting Province-Wide and City-Wide Health Systems. Manila: Department of Health; 2020.
49. Ministry of Finance. Summary of Regional Revenue and Expenditure Budget 2018 [Internet]. Jakarta; 2019. Available from: <http://www.djpk.kemenkeu.go.id/wp-content/uploads/2019/06/Ringkasan-APBD-TA-2018.pdf>
50. Ministry of Health Republic of Indonesia. National Health Accounts Indonesia 2018. Ministry of Health Republic of Indonesia; 2020.
51. Mathauer I, Saksena P, Kutzin J. Pooling arrangements in health financing systems: a proposed classification. Int J Equity Health [Internet]. 2019 Dec [cited 2021 Jun 15];18(1). Available from: <https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1088-x>
52. Mathauer I, Vinyals Torres L, Kutzin J, Jakab M, Hanson K. Pooling financial resources for universal health coverage: options for reform. Bull World Health Organ. 2020 Feb 1;98(2):132–9.

53. Margini F, Jordanwood T, Walimbwa A. Overview of Health Financing Flows in Uganda. Washington, DC: ThinkWell; 2021.
54. Herewati FR, Chrisnahutama A. Universal Health Coverage: Tracking Indonesia's Progress. Jakarta: Perkumpulan PRAKARSA; 2020.
55. Soria F. Getting All Filipinos into the PhilHealth Database. Presented at the 4th National Health Sector Meeting, The Oriental Hotel, Legazpi City, Albay 25-27 June 2019. 2019.
56. MOH. Health Sector Report. Medium Term Expenditure Framework for the Period 2021/22-2023/24. Nairobi: Ministry of Health; 2020.
57. ThinkWell Strategic Purchasing for Primary Health Care. Country factsheet: Indonesia 2020. Washington, DC: ThinkWell; 2020.
58. World Bank. Population, total - Indonesia | Data [Internet]. [cited 2021 Jul 9]. Available from: <https://data.worldbank.org/indicator/SP.POP.TOTL?locations=ID>
59. Saltman RB, Bankauskaite V, Vrangbaek K. Decentralization in Health Care. Strategies and outcomes. World Health Organization on behalf of the European Observatory on Health Systems and Policies; 2007.

ANNEX 1. ANALYTICAL FRAMEWORK TO ASSESS HEALTH FINANCING IN DEVOLVED SETTINGS

This annex outlines the guiding questions that each of the country teams used to develop their respective country cases.

1. Overall setup

Organization of health financing and devolution/decentralisation	
Mapping the health financing system	<p>1.1. List your country’s main health financing schemes – e.g., budget funding, national health insurance scheme, other national schemes, specific subnational schemes – and the eligible population groups.</p> <p>1.2. Please provide the latest estimates of the following:</p> <ul style="list-style-type: none"> • Domestic government spending for health as a share of (current) health spending • Domestic government spending for health as a share of total government spending • Out-of-pocket health spending as a share of (current) health spending
Setup of decentralised system	<p>1.3. Provide a <u>brief</u> overview of the history of devolution in your country (consider using a time chart or diagram).</p> <p>1.4. What is the current setup of devolved government?</p> <ul style="list-style-type: none"> • De-concentration (no local government): administrative divisions at what level (provinces/regions, counties/districts/municipalities, sub-counties,)? • Devolution (local government): at what level, and is it political decentralisation, fiscal decentralisation or both? <p>1.5. Which subnational levels seem to be the most critical ones for further analysis for this exercise (i.e., most relevant for health financing)?</p>

2. Revenue raising

<u>Revenue raising</u> The way revenues are raised by the subnational level to fund health care provision and promotion activities.	
Revenue raising and collection	<p>2.1. Is there clear division of authority on revenue raising between central and local levels and revenue sharing rules?</p> <p><u>Locally raised revenues:</u></p> <p>2.2. Can local governments introduce new local taxes?</p>

Revenue raising	
The way revenues are raised by the subnational level to fund health care provision and promotion activities.	
	<p>2.3. Do local governments raise revenues?</p> <p>2.4. If yes: what are the sources of local revenues? (property taxes, licenses and fees, local taxes, aid, user fees, etc.)</p> <p>2.5. Do local government budgets present information about the amount of revenue generated by health facilities (collected from various sources including user fees and insurance reimbursements)?</p> <p>2.6. Are user fees and insurance reimbursements collected by health facilities earmarked for health?</p>
<p>Intergovernmental transfers</p> <ul style="list-style-type: none"> - Type of transfers - Criteria/formula 	<p>2.7. What share of the local budget is financed by intergovernmental transfers from the central/national government (payments from national health insurance agencies to their subnational branches are not categorised as intergovernmental transfers for the purposes of this exercise)?</p> <p>Question 2.8 to 2.11 apply to each mechanism or funding stream:</p> <p>2.8. What criteria are used to determine the amount of funds being transferred to each subnational unit? Are local needs considered (in terms of preferences, infrastructure upgrading needs), poverty levels, demographics, etc.?</p> <p>2.9. What type of transfer is used (e.g., capitation, formula-based, earmarked, block grant)?</p> <p>2.10. Which entity receives/manages funds from the central level (e.g., local government, provincial/district health administration, hospitals, health centres)?</p> <p>2.11. Are conditionalities tied to the budgets that are allocated? What kind of conditionalities? (e.g., 25% allocated to health, or matching fund requirements/ grants to incentivise a higher level of funding by local units or meet targets, related to performance indicators)</p> <p>2.12. Is there a mandate or mechanism to reallocate funds across subnational entities to ensure equity in the distribution of resources (e.g., central fund or inter-municipal transfer mechanism in place)?</p>
<p>Budget formulation (national and local levels)</p>	<p>2.13. At national- and local- levels, is the budget formed through input-oriented line items or through program budgeting, or both?</p> <p>2.14. Is the local level involved in the national budget formulation process?</p> <p>2.15. At what level are health spending priorities decided?</p> <p>2.16. Are there separate budgets formulated for different activities or care levels, such as for vertical programmes?</p>

Revenue raising	
The way revenues are raised by the subnational level to fund health care provision and promotion activities.	
	<p>2.17. Does the central government require the subnational government to allocate a certain minimum share of their budget to health?</p> <p>2.18. Are there pre-defined allocations to the sector or sub-sector (conditional) or is the budget formation a local government decision?</p>
Effects of devolution on revenue raising	2.19. Has there been an increase in health expenditures per capita at devolved level over the years? (or since devolution was introduced?)
Implementation issues	<p>2.20. Are intergovernmental transfers rules/processes implemented and followed as prescribed or are there implementation gaps? (due to politics, lack of capacity/lack of understanding, lack of clarity in rules, etc.)</p> <p>2.21. How often are central funds transferred? Are they transferred on time?</p>

3. Pooling

Pooling	
Arrangements (location, mechanism, organization) for accumulating pre-paid funds that are raised (all funds other than out-of-pocket payment).	
Pooling arrangements at local level	3.1. Is there one or are there several (sub-) pools at the local level and which resources do they pool? Who are the pooling entities at local level?
Risk equalisation/ adjustment	<p>3.2. Does the resource allocation process from the national to subnational levels lead to equitable revenues per capita across subnational units as well as between different population groups?</p> <p>3.3 In the case of locally raised revenues, is there a mechanism of risk-adjusted re-allocation in place across subnational entities? How does it work? Which part of the revenues raised are considered for the risk equalisation mechanism across subnational units?</p>
When there is a separate pooling/purchasing agency (e.g., health insurance fund or other health coverage programme)	<p>3.4. Does pooling by separate pooling/purchasing agencies take place at the central or subnational levels?</p> <p>3.5. Do budget transfers for subsidised population groups come from central or subnational sources?</p> <p>3.6. If budget transfers are financed from local budgets/local revenues, what incentives does this set to identify families for subsidisation in health coverage schemes?</p> <p>3.7. What are other implications?</p>

<u>Pooling</u>	
Arrangements (location, mechanism, organization) for accumulating pre-paid funds that are raised (all funds other than out-of-pocket payment).	
Effects of devolution on pooling	3.8. In case of inequitable revenues/expenditure per capita across subnational territories/units: What are the core reasons for this? (e.g., inadequate formula and risk adjustment or inadequate risk equalisation, inadequate fund transfer)
Implementation issues	3.9. Are rules/processes implemented and followed as prescribed above or are there implementation gaps (due to politics, lack of capacity/lack of understanding, lack of clarity in rules, etc.)? 3.10. Provide a brief discussion about the geographic differences in implementation stemming from capacity, politics etc.?

4. Purchasing

<u>Purchasing</u>	
How are the funds allocated to providers and used to pay for services?	
Purchasing responsibilities and division of labour	4.1. Is there a clear division of expenditure authority and purchasing responsibilities between central and local levels, considering economies of scale, externalities, capacity (e.g., central government purchasers from tertiary facilities while local governments purchaser services from primary and secondary facilities)? 4.2. What services does the local entity purchase (e.g., primary care, secondary care, etc.)? 4.3. How does the local entity coordinate and align its purchasing decisions with that of the subnational branches of a national health insurance agency (whether these have their own purchasing responsibility or not)?
Autonomy of the purchasing agency	4.4. What is the level of autonomy of the local purchasing actor (local government or local health administration) vis-à-vis the central government (e.g., ministry of health)? 4.5. What is the level of discretion it has on various budget lines (personnel, drugs, operational costs, etc.)? How much discretion does it have to contract private facilities (for-profit and non-profit)? 4.6. Are purchasing entities allowed to use surplus or keep reserves? What are the rules around the use of surplus?

Purchasing	
How are the funds allocated to providers and used to pay for services?	
Provider payment mechanisms	<p>4.7. What are the provider payment mechanisms used by the local government to purchase services (e.g., budget funding, standalone scheme, performance-based financing payment)?</p> <p>4.8. Can the local purchasing agency (or agencies) decide on and determine payment methods and rates, or are these centrally determined?</p> <p>4.9. Are public sector health workers employed by a national ministry (which one, e.g., ministry of health or ministry of public service) or the local government? Are salaries of health workers paid by the central level or local levels?</p> <p>4.10. Does the local government purchase drugs and other health commodities? If yes, can they procure from any source or must they use a central medical store? Does the central government pay for any commodities used by local governments (e.g., “strategic commodities” through vertical programmes)?</p>
Benefit package design	<p>4.11. Which level (central or subnational)/which entity determines the benefit package?</p> <p>4.12. Are local entities allowed to determine and provide additional services? Who decides what additional services to provide?</p> <p>4.13. What degree of discretion do local entities have regarding benefit package specification?</p>
Expenditure monitoring and accounting	<p>4.14. What is the budget execution rate at the national and local levels? (where possible, to be differentiated for external funds and domestic funds)</p> <p>4.15. What reporting systems have been put in place to account on activities to the central level and the local government council, where this exists?</p> <p>4.16. What information is reported from local to central levels? How frequently does this reporting take place?</p> <p>4.17. Does the national-level monitor how local entities spend any conditional grants or ear-marked spending for health?</p>
Contracting	<p>4.18. Is there a “purchaser-provider split” between local purchasing actor and the facilities they purchase services from (this could vary across different local schemes)?</p> <p>4.19. Does the local purchasing actor contract with individual providers or facilities? If yes, can it develop its contracts or are all contracts managed and/or prescribed centrally?</p> <p>4.20. Are the local purchasers allowed to contract out services to private providers or NGOs? If so, 1-2 examples?</p>

Purchasing	
How are the funds allocated to providers and used to pay for services?	
Provider autonomy	<p>4.21. What is the level of autonomy of health facilities?</p> <p>4.22. Do public health facilities charge user fees? If yes, are user fees retained, partially or in full, at the facility or transferred to local authorities?</p> <p>4.23. Do public health facilities receive reimbursements from any health insurance scheme(s) or other types of purchasers (e.g., user fee reimbursement)? Can they retain those funds, or do they have to transfer them to local authorities?</p> <p>4.24. Do public facilities receive any direct financial transfers from the central government (e.g., under a PBF or user fee reimbursement scheme)?</p> <p>4.25. Do public facilities receive any direct financial transfers from the local government or administration (beyond in-kind transfers for staffing, drugs, etc.)? What is the basis for these transfers? Are they linked to performance?</p> <p>4.26. Can public facilities retain and use any surplus?</p> <p>4.27. Can public facilities determine their facility budget? What kind of costs do they cover (staff, drugs, operational costs, etc.)? What kind of approvals do they need in order to incur expenditure?</p> <p>4.28. Do public facilities have their own bank account?</p>
Effects of devolution on purchasing	<p>4.29. Has health remained or become a local political priority since the introduction of devolution? (as reflected in the evolution of the share of the health budget as of total local government budget)</p> <p>4.30. Is there coherence and alignment in purchasing arrangements (e.g., in relation to contracting, payment methods and rates) between the centre and the subnational levels?</p> <p>4.31. Has local purchasing improved or worsened overall efficiency (regarding administrative costs, purchasing power, etc.) since the introduction of devolution?</p> <p>4.32. Has devolution led to increased or reduced spending on public health, health promotion/prevention?</p> <p>4.33. Has the devolved budget for personnel costs, medicines, and medical supplies, etc. led to shortages or could the subnational entity respond better and quicker on local needs?</p> <p>4.34. Has devolution improved or worsened inequities across different population groups with respect to benefit entitlements?</p> <p>4.35. Has access to services improved through better catering to people's needs? (e.g., adjustment to local needs and conditions? Access to private providers included through contracting)</p>

<u>Purchasing</u>	
How are the funds allocated to providers and used to pay for services?	
Implementation issues	<p>4.36. Are centrally allocated funds for health being spent as planned/prescribed? (overspending or underspending?)</p> <p>4.37. Are rules/processes implemented and followed as prescribed or are there implementation gaps? (due to politics, lack of capacity/lack of understanding, lack of clarity in rules, etc.)</p>

5. Oversight and accountability

<u>Oversight and accountability:</u>	
The oversight and accountability mechanisms in place to monitor and evaluate financing functions at the devolved level	
Oversight and accountability mechanisms	<p>5.1. What oversight/supervision mechanisms from the central level are in place? How effective are these accountability mechanisms?</p> <p>5.2. What mechanisms are in place to make local units accountable to the local population with respect to health financing decisions? How effective are these mechanisms?</p> <p>5.3. Are there effective mechanisms to coordinate health financing policies and tasks/responsibilities between the central and subnational levels?</p>
Capacities for devolved HF functions	5.4. Is there capacity for budget formation, forecasting, purchasing, etc.?
Implementation issues	5.5. Are rules/processes implemented and followed as prescribed or are there implementation gaps? (due to politics, lack of capacity/lack of understanding, lack of clarity in rules, etc.)

ANNEX 2. OVERVIEW OF DECENTRALISATION IN THE SEVEN STUDY COUNTRIES

Table A2: Overview of decentralisation in the seven study countries

Country	Levels of government	Brief history
Burkina Faso	Regions, provinces and communes	<ul style="list-style-type: none"> • Between 1960 and 1991, Burkina Faso’s political administration changed between democratic governments and military regimes. The last two decades of this period were characterized by over centralization. • The country made its first step towards decentralisation in 1991 when the new constitution was adopted, and local governments were established. • Regions and communes were introduced as the two levels of local government in 1993. • In 1998, provinces were added as the third level of the local government. • Between 2009 and 2014, authority was transferred from the central government to local governments. However, the transfers were only made to communes and applied to four out of eleven areas of competencies, including health.
Kenya	Counties, sub-counties and wards.	<ul style="list-style-type: none"> • Local authorities provided a range of services during the colonial period • In the post-independence period, the country became a highly centralised unitary state with 8 administrative provinces and districts • Reforms in 1980 deconcentrated a range of functions to the district-level • Adopted a new constitution in 2010 that introduced a new, devolved structure with 47 newly created counties. The new structures came into being following elections in 2013. • Each county is divided into sub-counties and wards, which are nested administrative units.
Mozambique	Provinces, districts, municipalities	<ul style="list-style-type: none"> • When Mozambique gained independence in 1975, the Portuguese colonial administrative structures were replaced by a new system of governance at national, provincial, and local levels consisting of districts and cities. • The 1990 constitution defined two additional types of local authority: municipalities in cities and towns and village councils in rural areas. • In 1997, thirty-three municipalities were established in 1997. The number of municipalities gradually increased to 43 in 2008 and to 53 in 2013. • In 1998, the central government started implementation of the District Planning and Financing Project in Nampula province to support efforts to decentralise planning and financing at district level. • In 2003, the structure and organization of local state organs were defined, and districts became the planning and budgeting units; autonomy of provinces and districts increased. • As of 2005, each district received an investment budget of 7 million meticaís under the Local Initiative Investment Budget, later known as the District Development Fund. • The procedures through which functions and competencies are transferred from state bodies to municipalities were defined in 2006. • In 2018, the constitution was amended to state the three levels of decentralisation with elected provincial, district, and municipal assemblies. • A decentralisation package was approved in 2019 and 2020.

Country	Levels of government	Brief history
Nigeria	States, local governments	<ul style="list-style-type: none"> • The colonial constitution of 1951 introduced a degree of regional autonomy. • In the late 1960, Nigeria’s four regions were dissolved into 12 less powerful states under a stronger central government. • In 1976, seven new states and the Federal Capital Territory were created, and local government areas were established as the third government tier. Two more states were created in 1986, and 15 between 1991 and 1995. • The 1999 constitution maintains the three-tier system that also prevails today, with power and resources distributed among the federal government, the Federal Capital Authority, 36 states and 774 local governments areas. • Political and fiscal authority is vested in the federal government or devolved to states. Local government are subject to states’ willingness to delegate power and financial autonomy.
Uganda	Districts, counties, sub-counties, parishes, villages	<ul style="list-style-type: none"> • Political decentralisation was introduced in 1986. • In 1992, the government established the Decentralisation Secretariat, a semi-autonomous organization embedded under the Ministry of Local Government to support the decentralisation process. The Decentralisation Secretariat was dissolved in 2004. • The decentralisation process was accelerated in 1993. • In 1995, the new constitution was adopted, which established five levels of the government, i.e., district, county, subcounty, parish, and village. • In 1997, the government passed the Local Government Act to devolve power and responsibility for public service delivery to local governments. • Between 1997 and 2000, the government introduced decentralisation of recurrent expenditures at district level and the central level started to provide three transfers. • In 2014, the government decentralised payroll management and salary processing. • New districts were created over the last two decades.
Indonesia	Provinces, districts, municipalities	<ul style="list-style-type: none"> • Since gaining independence in 1945, Indonesia was mostly managed by the central government. • In 1974, administrative areas at the provincial, district, and municipal levels were formed; decision-making power remained at the national level. • District governments gained political and fiscal autonomy in 1999. Eleven functions were transferred to provinces and districts. • In 2004, provincial and district government were responsible for five more functions. • As of 2014, provincial governments oversee district and municipality levels, and report to the central government. Provincial and district governments are responsible for 6 mandatory functions related to basic services, and 18 mandatory functions related to non-basic services.
Philippines	Regions, provinces,	<ul style="list-style-type: none"> • With the enactment of the Local Government Code of 1991, a decentralised system was organised. Local government units have full autonomy to finance and operate local health systems.

Country	Levels of government	Brief history
	cities, municipalities	