Health Financing and Public Financial Management in Decentralised Settings:

What Can We Learn from Country Experiences to Date?

Summary report from a virtual knowledge exchange organised by ThinkWell and the World Health Organization, July 12–13, 2022

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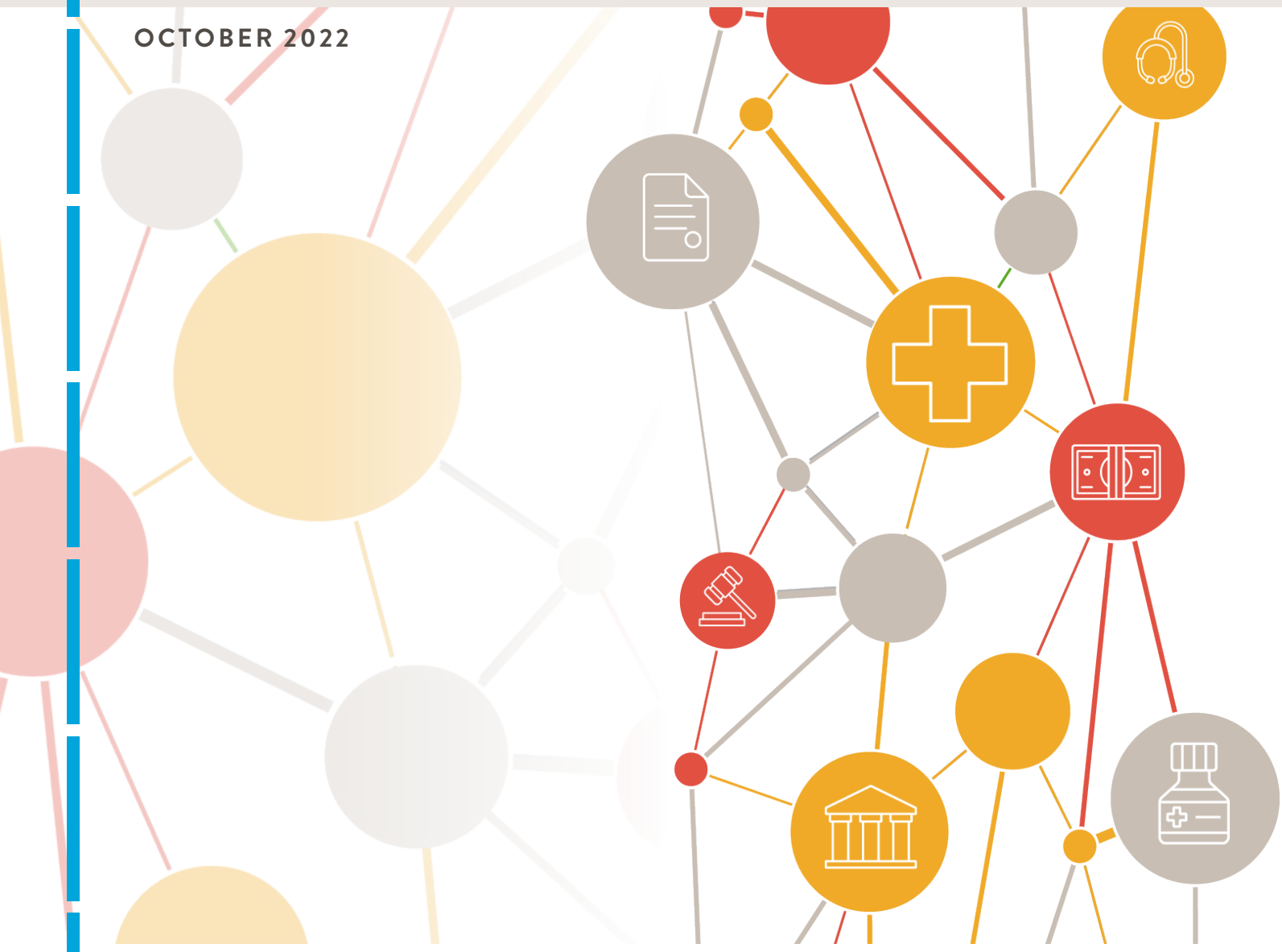

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ThinkWell and the World Health Organization's (WHO) Health Financing Team launched a learning collaboration in 2019 to explore the interplay among decentralisation, public financial management (PFM), and health financing. The collaboration yielded case studies on seven countries—Burkina Faso, Indonesia, Kenya, Mozambique, Nigeria, the Philippines, and Uganda—and two synthesis reports based on the country cases and other published literature. All contributors to the synthesis reports and case studies are listed at left.

Based on the findings of the learning collaboration, ThinkWell and WHO organised a two-day virtual knowledge exchange in July 2022, convening government officials, practitioners, scholars, and other stakeholders from numerous countries for detailed discussions about the implications of decentralisation for PFM and the financing of health services. This meeting report summarises the technical presentations and group discussions from the knowledge exchange. It was developed by Michael Chaitkin, Nirmala Ravishankar, and Ileana Vîlcu of ThinkWell and Hélène Barroy and Inke Mathauer of WHO.

ThinkWell and WHO also thank the numerous colleagues without whom the virtual knowledge exchange could not have happened, including Gabriela Alvarado, Kimaya Dixit, Meaghan Koudelka, Boniface Mbuthia, Angellah Nakyanzi, Marie-Jeanne Offosse N., Camille Samson, Edward Sutanto, Trihono, and Maria Eufemia Yap from ThinkWell; and Justine Hsu and Joe Kutzin from WHO. The team is indebted to Valérie Dossogne for her heroic organisational efforts, and to the WHO IT and interpretation teams for ensuring all participants could be seen, heard, and understood.

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For more information about SP4PHC, please visit **https://thinkwell.global/projects/sp4phc/**.
For questions, please write to ThinkWell at **sp4phc@thinkwell.global**.

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I. INTRODUCTION

BACKGROUND

With growing recognition that public financing needs to drive countries' progress towards universal health coverage (UHC), there is ever more emphasis on how effectively, efficiently, and equitably governments spend public money on health. Many countries have decentralised health systems and financing functions from central governments to subnational authorities. Some of these decentralisation processes include devolution, the transfer of considerable decision-making powers and autonomy to subnational governments stipulated and protected by the constitution or through legislation. As a result, subnational governments manage a large share of public financing for health, governed by public financial management (PFM) rules and processes. How decentralisation coheres with health financing arrangements and PFM in the health sector impacts health system performance and UHC objectives.

Exploring the nexus between decentralisation, health financing arrangements, and PFM in the health sector was the focus of a multi-country learning collaboration implemented by ThinkWell and the World Health Organization (WHO). Using a jointly developed analytical framework and approach, ThinkWell examined the state of play in seven countries: Burkina Faso, Indonesia, Kenya, Mozambique, Nigeria, the Philippines, and Uganda. ThinkWell and WHO then produced two synthesis reports analysing how devolution influences health financing arrangements and how decentralisation has shaped PFM processes in the health sector.[1] **Annex 1** contains links to the synthesis reports and seven country cases.

As the learning collaboration came to an end, ThinkWell and WHO organised a two-day, virtual knowledge exchange to share findings and stimulate discussion and debate among policymakers, scholars, and other key stakeholders. More than 130 individuals from 27 countries[2] participated in the exchange, which occurred July 12–13, 2022 (see **Annex 2** for the agenda).

The event was organised around two main themes—revenue sharing between levels of government and subnational government health spending—which are described further below. For each theme, ThinkWell and WHO provided a short technical presentation based on the two synthesis reports, after which a panel of experts from three of the study countries offered lessons and reflections. Following each panel, participants divided into smaller groups to discuss aspects of that day's topic in more detail.

This event report summarises the technical presentations, panels, and breakout group discussions from the virtual knowledge exchange. Links to all the presentations can be found in **Annex 3**.

REVENUE SHARING BETWEEN LEVELS OF GOVERNMENT

The framing slides for this theme can be accessed **here**.

The first day focused on revenue sharing between levels of government. The day's discussion was framed with the following summary points extracted from the two ThinkWell-WHO synthesis reports:

— The vertical imbalance between the revenue raising capacity and spending responsibilities across government levels is a common issue observed in all study countries.

[1] The PFM-focused synthesis report included an eighth country, the United Republic of Tanzania, thanks to recent WHO work there covering similar issues as this learning initiative.

[2] Participants were from Argentina, Belgium, Burkina Faso, Cambodia, China, Congo, France, India, Indonesia, Kenya, Lao People's Democratic Republic, Liberia, Malaysia, Mongolia, Mozambique, Niger, Nigeria, Philippines, Senegal, Sri Lanka, Switzerland, Uganda, United Republic of Tanzania, the United Kingdom, the United States, Viet Nam, and Zimbabwe.

- The revenue raised by subnational governments as a share of their total revenue is small across the board. So subnational governments rely extensively on intergovernmental transfers from the central government for their revenues, which account for 43% to 100% of the subnational government budgets.
- Most of the study countries blend unconditional and earmarked transfers that both feed into subnational health budgets. 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. Central governments use earmarked grants to increase the 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, with or without conditions, such as requirements for matching funds.
- Decentralisation has complicated health budgeting. There is rarely perfect alignment between central and subnational plans and budgets in decentralised settings.
- Disparate budget structures hinder collaboration across government levels. At times, this contributes to disjointed or duplicative sector plans and low budget prioritisation for health due to the lack of interest and willingness of local officials to spend more.
- Local governments in most of the study countries enjoy discretion over how much of the block grants and their budget they allocate to health, which often translates into insufficient prioritisation of health in local government budget.
- Based on the analysis of the study countries, central governments will likely need to drive increases in local health spending. There are several policy options for this:
    - Earmarked grants or matching grant arrangements for health could be a way to reconcile devolution with the goal of enhanced resource allocation to health.
    - Subnational government spending could also be increased by revising vertical revenue sharing rule to grant a higher share of national revenue to subnational units.
    - Central government subsidies going directly to and being retained by facilities from health insurance or other coverage schemes can help expand coverage for the poor.
    - To strengthen budget development, countries need to continue reforming budget structures to better align across levels. This will facilitate more coherent planning and budgeting throughout the health system. In addition, countries should adopt—and fully implement—budgeting approaches that more consistently provide flexibility in health spending, such as programme-based budgeting.
- Decentralisation contributes to fragmentation of the pooling function, creating barriers to equitable distribution of resources across subnational units.
- Subnational territories differ in terms of their fiscal capacity relative to their needs, thus requiring fiscal equalisation arrangements. Yet, the existing intergovernmental grant transfers are often inadequate to equalise the differences across territorial units.
- Horizontal revenue sharing formulas are complex by design, and they must strike a balance between multiple considerations informing their design, such as the needs of the health sector versus other sectors or fiscal need versus incentivising fiscal effort.
- There is need to redesign intergovernmental grant transfers to increase their equalisation effect across territorial units and use pooling arrangements at higher levels. There are several policy options for this:
    - Revise horizontal revenue sharing rules, i.e., the resource allocation formula, to consider health (needs) indicators rather than (only) health infrastructure-related criteria.
    - Target conditional grants earmarked for health to those subnational units with particular needs.
    - Review and potentially shift pooling levels upward from lower administrative levels to higher levels to increase pool size and reduce pool fragmentation in the health sector.
    - Use budget transfers for health coverage expansion of the poor to contribute indirectly to resource equalisation across subnational territories.

SUBNATIONAL GOVERNMENT HEALTH SPENDING

The framing slides for this theme can be accessed **here**.

The second day focused on subnational government health spending, including the associated challenges and potential policy remedies. Like on the previous day, the discussion was framed with several summary points extracted from the two ThinkWell-WHO synthesis reports:

- Challenges abound for subnational spending, which is complicated by a range of factors—including subnational entities' heavy reliance on transfers from central governments—that contribute to spending volatility, cash flow management problems, and low budget execution rates for subnational spending units, including both local governments and health facilities.
- Decentralisation has not delivered on its promise of greater transparency and accountability in public spending on health. Weak and fragmented information systems, both within and across government levels, make it difficult to systematically account for funds use. Subnational units must also account for funds from numerous sources: discretionary and earmarked government funds, on- and off-budget donor funding, health insurance payments, user fees, and more.
- Subnational governments are not very engaged as strategic purchasers. Many are constrained by funding earmarked for inputs. In fact, input-based budgets predominate at subnational levels, even in countries that have introduced programme-based budgeting. Subnational units often lack the authority, capacity, or willingness to introduce output-based payments or be selective about which providers to fund.
- On the health care provider side, decentralisation does not automatically translate into enhanced facility autonomy. Across the study countries, early stages of decentralisation sometimes involved transferring decision-making power and fiscal controls from health facilities to subnational levels, but new authority or provider autonomy were rarely extended to health facilities themselves.
- In many countries, frontline facilities are not visible in key PFM systems or the chart of accounts,[3] making it difficult to channel funds to them or account for their spending. Additionally, not all facilities are permitted to retain revenue, and their financial management is lacking, which means they struggle to respond to purchasing incentives.
- Facilities' weak financial management also creates a vicious cycle because it becomes the justification for central authorities or local governments to withhold greater autonomy.
- Promising reform efforts to address PFM bottlenecks at the subnational and facility levels include simplifying budget execution procedures; channelling funds directly from central governments to frontline facilities, sometimes bypassing subnational intermediaries; enhancing financial information systems to generate more, better, and timelier insights into fund flows and use; and strengthening local accountability for health spending.
- To succeed, these reforms need to be combined with other well-known enablers of strategic purchasing, such as defining clear and non-duplicative purchasing roles across levels of government; granting facilities greater autonomy, provider payment through output-based payments, including to retain revenue from these payments; and bolstering facilities' capacity to manage and account for funds.

II. COUNTRY EXPERIENCES

For each theme, a panel of experts from the study countries offered key findings and reflections from their respective case studies. This section distils their contributions to the knowledge exchange.

[3] The chart of accounts is a critical element of the PFM system that facilitates classification, recording, and reporting of information on financial transactions in a systematic and consistent manner.

PANEL 1: REVENUE SHARING BETWEEN LEVELS OF GOVERNMENT

The first panel, focused on revenue sharing between levels of government, included Mr. Boniface Mbuthia (Kenya), Dr. Maria Eufemia Yap (Philippines), and Ms. Angellah Nakyanzi (Uganda).

Kenya

The Kenya case study can be accessed **here**.

Kenya embarked on a process of devolution in 2013, transferring planning, budgeting, and management responsibilities for a range of services including health to 47 newly created counties.

- The health budget has increased over the past two decades. Since devolution, counties control a larger share of the government health budget than the Ministry of Health.
- Counties rely extensively on central government transfers. As per the Constitution, the central government must transfer a minimum of 15% of national revenue to counties, referred to as the equitable share. The Commission on Revenue Allocation is responsible for recommending the equitable share in any year and dividing the funds between counties taking into account various factors. Transfers from the central government to counties are often delayed and this contributes to counties not executing the complete budget allocation and carry-overs to the next year.
- Counties also generate own-source revenue from local taxes and fees, including revenue generated by health facilities. The funds generated by health facilities are among the top sources of own-source revenue for counties, so counties tend to overprescribe public financial management laws and limit the ability of health facilities to retain and spend the funds they generate. Nevertheless, the level of own-source revenue generated by counties is generally low.
- Counties also receive conditional grants from the central government and development partners; however, some development partners are phasing out or reducing their support, putting pressure on counties to increase funding from own-source revenues.

Philippines

The Philippines case study can be accessed **here**.

Devolution of the health system in the Philippines began 31 years ago with the adoption of the 1991 Local Government Code transferring control and responsibility of delivering basic services to local government units (LGUs). Thus, different levels of LGUs were granted fiscal and administrative autonomy over delivery of basic services, including health, while the central Department of Health became responsible for policy and standards setting, stewardship, and providing technical and financial assistance.

- According to the Local Government Code, LGUs receive an Internal Revenue Allotment (IRA) annually. IRA is a block grant through which 40% of national internal revenue is transferred to LGUs to fund the devolved functions. In 2022, Executive Order 138 mandated full devolution of certain functions of the Executive Branch to the LGUs. This has the potential to result in increased budget allocations to LGUs, which can translate into a wider fiscal space to allow LGUs to allocate more funds to finance health services.
- LGUs rely on fiscal transfers from the national government; IRA represents between 60% and 95% of LGUs' total budgets. While IRA transfers increased over the years, this has not necessarily translated into more spending on health, as evidenced by low LGU health expenditure and persistently high out-of-pocket expenditure for households.
- Pooling of funds to achieve better efficiency and economies of scale remains a challenge. Devolution to the municipal level has resulted in inequitable resource distribution and inefficient purchasing. It also impeded provision of a comprehensive spectrum of care given that (1) populated

urban areas receive a higher IRA compared to rural areas, and (2) a small number of PhilHealth-accredited facilities are located in rural areas.

- The implementation of the 2019 UHC Act is an opportunity to (i) increase revenue for the social health insurance scheme, PhilHealth, to finance a more comprehensive benefit package and complement LGU spending through service level agreements; (ii) pool resources into a special health fund at the provincial level to reduce fragmentation and consolidate funds for better economies of scale while earmarking these funds for health; (iii) delineate health financing roles to help improve governance, accountability, efficient resource use, and more secure financing for health; and (iv) move from LGUs' discretionary budget processes to performance-based payments.

Uganda

The Uganda case study can be accessed **here**.

Uganda's political and fiscal decentralisation was undertaken to promote democratic participation, increase the autonomy of Local Governments (LGs), and bring service delivery closer to the people. The number of districts has more than quadrupled, from 30 in 1986 to 139 in 2020, and other subnational units (cities and municipalities) have emerged. Consequently, the number of subnational budget votes has increased significantly, and their health funding comes mainly from conditional grants for PHC.

- Wage grants cover salaries for all civil servants, including in the LG health office and public facilities. Staff are paid via transfer to their bank accounts. Wage grant funds are allocated based on the number of staff employed, not need, and amounts are set in the public service pay scales.
- Operational ("non-wage recurrent") grants for LGs and health facilities are transferred quarterly using a formula that includes both input- and need-based parameters, including population, infant mortality, poverty headcount, population in hard-to-reach areas, facility type, and ownership.
- There are four types of development grants: (1) funds for facility construction and upgrading, allocated based on population and infrastructure needs; (2) infrastructural grants to construct, maintain, and upgrade infrastructure and purchase equipment, allocated based on the number of facilities, population, and LG performance; (3) transitional ad hoc grants for targeted investment in selected LGs based on Ministry of Health guidance; and (4) sanitation grants.
- Facilities also receive centrally appropriated budget subventions from specific donor initiatives, and qualified facilities benefit from credit lines at the National Medical Stores and Joint Medical Store.
- Despite the use of need-based criteria, the horizontal revenue sharing approach does not achieve an equitable allocation of resources across LGs. Funding mainly follows inputs, especially wages.
- LGs are dependent on conditional grants for health, even where they can generate revenue locally because it gets remitted to the consolidated fund. Health's share of the central budget has declined.
- Public facilities have little flexibility in fund use because of earmarking; they only control operational funds, which are minimal in per capita terms though growing. Purchasing reforms have been proposed to increase financing for health and improve how equitably it is distributed across LGs.

PANEL 2: SUBNATIONAL GOVERNMENT HEALTH SPENDING

The second panel, focused on subnational government health spending, included Ms. Marie-Jeanne Offosse (Burkina Faso), Dr. Trihono (Indonesia), and Dr. Gemini Mtei (United Republic of Tanzania).

Burkina Faso

The Burkina Faso case study can be accessed **here**.

In Burkina Faso, decentralisation began 30 years ago. Today, the central and local governments share authority and responsibility over six social sectors, including health.

- In Burkina Faso, challenges arise from the fact that decentralised entities have overlapping mandates, with lack of coherence in their operating procedures.
- Health financing is devolved to the communes, but they only control 3% of government health expenditure and rely extensively on transfers from the national government. The Ministry of Health continues to play a dominant role in health spending, including for health worker salaries.
- Planning and budget structure issues, plus constrained technical capacity (e.g., for basic financial management), also limit communes' ability to effectively support the delivery of priority services.
- The case study recommends to first work with what is in place and improve effectiveness of the existing governance arrangements, before deepening decentralisation processes in health. For instance, the National Agency for Primary Care is not yet operational at the decentralised level.

Indonesia

The Indonesia case study can be accessed **here**.

Decentralisation began in 1999, allowing subnational governments to raise and pool funds to provide local services, including health services; however, subnational governments still rely heavily on transfers from the central government.

- In the health sector, these transfers do not automatically translate into improved service delivery. There are numerous budget execution challenges, including delays in transfers, rigid spending guidelines, and divergent planning, disbursement, and reporting requirements for the various funding mechanisms. Likewise, monitoring and evaluation have been challenging compared to before decentralisation because each subnational unit now has their specific innovative health programmes.
- The national health insurance scheme (JKN)[4] began in 2014 and focused more on curative and rehabilitative care and less on health promotion and prevention. JKN-funded service provision operates alongside the government funded health services. Health funds transferred by the national government to BPJSK,[5] the agency operating JKN, are pooled with member contributions to pay for health services and the administration of JKN.
- Capitation payments for primary care providers are transferred directly from BPJSK's account to the provider's account every month, given that the provider is semi-autonomous (BLUD), otherwise transfers are made to the District Health Office, who will then transfer to non-BLUD providers. One overall implication and concern is that JKN funds constitute a more predictable source of funding, crowding out districts' budget allocations.
- There are several opportunities to improve the health financing system. For example, incentives are being introduced, in the form of additional operational funding, for public primary care facilities to meet the new Minimum Standard of Service. Additionally, more facilities should be encouraged to

[4] *Jaminan Kesehatan Nasional*

[5] *Badan Penyelenggara Jaminan Sosial Kesehatan* (Social Security Administering Body for Health)

become semi-autonomous service delivery units. Finally, there is a need to strengthen subnational governments' PFM capacity, including through improved systems and guidelines.

United Republic of Tanzania

Decentralisation started in the 1980s and deepened in the 1990s, transferring decision-making from the central level to local government authorities (LGAs). At that time, little was done in terms of shifting duties to service providers. Funding for frontline facilities was embedded in LGA's budgets, and local governments were responsible for procuring inputs for facilities. Many challenges arose from these arrangements, including delays in inputs provision, resource allocation misaligned with needs, and limited consideration for remote facilities.

- A range of reforms were pursued to improve the health financing system. Starting in fiscal year 2010-11, some pilot facilities were allowed to retain locally generated revenue, including facilities that were receiving results-based financing funds. A more major shift came in 2017, when all facilities were authorised to open a bank account.
- Health Basket Fund—a pool of funds from donors who have interest to finance the health sector managed by the Treasury—started to flow to facilities. Funds were disbursed based on a capitation formula that accounted for variations in needs, equity, and performance across facilities.
- Those changes were made within the PFM system, starting with recognising facilities as planning and spending entities in the expenditure management system—facilities were inserted into the chart of accounts with their own codes. This allowed them to be assigned annual budget ceilings, which has transformed the whole process of budgeting, whereby facilities are aware and fully engaged in the planning and budgeting process.
- Facilities were also given autonomy to prioritise services that needed to be delivered according to client needs. At the same time, a robust facility financial management system was set up to ensure reporting and accountability from the lowest levels.
- In this entire process, Tanzania had to take into consideration and address political economy challenges, working with the Ministry of Finance and Planning to change the perception that facilities had minimal capacity to manage funds. This involves local governments in defining the capitation formula, which radically shifted power, and empowers communities to participate more actively in the management and oversight of facilities.

III. REFLECTIONS FROM BREAKOUT GROUP DISCUSSIONS

Following each panel, participants divided into facilitated groups to discuss aspects of that day's main topic in more detail. This section presents key points from the discussions.

REVENUE SHARING BETWEEN LEVELS OF GOVERNMENT

On day one, groups addressed four themes related to revenue sharing between levels of government: 1) subnational prioritisation of health; 2) criteria for conditional grants; 3) coordination between government budget roles and public health insurance; and 4) the political economy of redistribution.

Subnational prioritisation of health

Discussion prompt: How could one ensure prioritisation of the health sector by subnational authorities in view of their enhanced decision-making power?

Key points from the discussion:

- Challenges related to health sector prioritisation vary depending on the nature of decentralisation in a health system, including whether health is a devolved function. Numerous factors influence the extent to which health is prioritised at the subnational level, including the formal rules and incentives for resource allocation; national and subnational policy goals; politics and the expectation of key stakeholders; the capabilities of decision-makers, technical experts, and advocates; and the quality and timeliness of information available to them.
- Advocacy that emphasises the economic and cross-sectoral benefits of investing more funds in health, including at the local level, are more likely to succeed than those relying solely on emotional appeals. In Kenya, it has been helpful to highlight the benefits of health investment to agricultural productivity and education outcomes. Multi-sectoral coalitions can be especially powerful for advocacy—they can be fostered through joint budget analysis and allocation exercises.
- When there are numerous budget holders in the health sector—including subnational government entities and individual health facilities—even though this is not negative per se, budgeting and prioritisation are more complex given that each holder is responsible for preparing, spending, and tracking funds.
- Centrally defined policies and guidelines can have a powerful influence where subnational governments are highly dependent on revenue transfers.
- Some central governments set explicit benchmarks for subnational prioritisation for health. For example, districts in Indonesia are expected to allocate at least 10% of their budgets to health. There are no punishments for falling short, rather, the Ministry of Health encourages districts to make evidence-informed decisions, such as by supporting them to produce district health accounts.

Criteria for conditional grants

Discussion prompt: How should one determine the amount transferred through conditional grants, and what criteria could one use?

Key points from the discussion:

- A broad and overarching principle could be that health grants need to be sufficient to guarantee the availability of essential services in all subnational territories. Yet, the details need to be country specific.
- Criteria can be guided by key health policy goals, such as access and equity. For example, Uganda allocates its conditional grants in part based on the different needs across districts.
- In some countries, national or social health insurance payments are an important additional transfer from the central to subnational governments. In the Philippines, PhilHealth payments to local government units are meant to cover contractually defined deliverables. The UHC Law now requires

those payments to be pooled in a Special Health Fund that will be used solely for health investments.

- Counterpart arrangements can also encourage subnational investment when the central government makes in-kind transfers of key inputs, such as infrastructure, human resources, and commodities. In the Philippines, the Department of Health negotiates such arrangements with local governments, who make their own commitments (e.g., to provide land for new facilities, to absorb new health workers into the local government wage bill after a defined period, etc.).
- In some cases, grants from the central government for capital investment are not well aligned with local government budgets, leading to confusion about who covers what costs. In this case, it is important to clarify responsibilities and align across the different levels.

Coordination between government budget roles and public health insurance

Discussion prompt: How could one establish a complementary and efficient mix of devolved government budget roles and (national) health coverage schemes for more equitable resource distribution across subnational units?

Key points from the discussion:

- Information sharing and joint planning among relevant entities are key to establishing a complementary and efficient mix of roles for devolved governments and (national) health coverage schemes, ideally leading to more equitable resource distribution across subnational units. It is important to recognise that national priorities are in principle not different from local priorities, but that the latter feed into and be reflected in national priorities.
- Various institutional arrangements can serve this purpose. A multi-year plan of priorities that is evidence based can jointly consider the problems and needs of local entities and propose locally adjusted measures (such as in the Philippines). Regular stakeholder meetings among ministries of health, local governments, and health insurance managers—will equally be needed to review revenue and expenditure and jointly plan and set priorities.
- Certain health financing functions can remain centralised. For instance, in Burkina Faso, although the financing of health services is devolved to the communes, it is envisioned that specific a payment mechanism using budget funds and health insurance funds will remain centrally operated.
- While it is desirable that health facilities can retain the revenue from a (national) health coverage scheme, it will be important to assess and anticipate the resulting incentives, including how to address their effects on efficiency and equity stemming from resource and service shifting. An analysis of mixed provider payment, multiple funding flows, and ways to align these, is an important supportive measure.
- Capacity issues were widely flagged. For example, subnational financial management capacity is often limited among leaders of local governments or local authorities.
- More capacity (e.g., for data generation and analysis) is needed to enhance information sharing, especially at subnational levels, to overcome implementation and data integration hurdles. In particular, this concerns the generation of detailed local-level health spending data.
- Finally, a separate, national health coverage scheme may also consider providing financial allocations to local governments to support infrastructure funding beyond covering the direct operational costs.

Political economy of redistribution

Discussion prompt: How much potential for redistribution for the health sector across unequal subnational units is politically feasible (and acceptable) in (ethnically or economically) diverse societies?

Key points from the discussion:

- Decentralisation is a wide government reform. On the one hand, it empowers local stakeholders, but on the other hand, it can create conflicts between the different government levels. Therefore, it is critical to understand why countries embark on a process of decentralisation (e.g., improve efficiency or increase local democracy) and what powers and resources are available for each government level.
- For example, in Kenya, devolution empowered local leaders to decide how to allocate their budgets. Prior to devolution, some areas were marginalised.
- In the Philippines, there were tensions between local governments and health facilities due to lack of trust and lack of a robust reporting mechanisms. When the country devolved, there was minimal capacity within local governments to manage their budget, and the health sector was not necessarily a priority. Therefore, the Department of Health continued to fund and provide a considerable number of health services. Recent reforms include better integration between the various levels of local government which can result in improved budget allocation for the health sector.

SUBNATIONAL GOVERNMENT HEALTH SPENDING

On day two, groups discussed four themes related to subnational government health spending: 1) PFM bottlenecks; 2) the purchasing roles of subnational governments; 3) provider autonomy; and 4) financial management information systems.

PFM bottlenecks

Discussion prompt: What are the key PFM bottlenecks hindering effective subnational spending on health, including at the local government and facility levels? How should they be overcome?

Key points from the discussion:

- Countries face various PFM challenges at the lowest levels of their health systems. Many of them are common and require adaptations to meet the requirements of effective and accountable spending.
- In Burkina Faso, health worker salaries continue to be paid by the central level, and communes cannot hire and pay health workers. There are also challenges from how decentralisation was sequenced—it should be implemented step-by-step and take into account differences in technical and financial capacities across communes.
- In Kenya, the interpretation of PFM laws is often flawed or divergent across counties. Additionally, there is a need to balance technical capacity and political power when devolving decision-making.
- In India, there are numerous non-interoperable digital systems, with different standards. This limits visibility in fund flows to the facility level.
- Sri Lanka experiences delays in the release of funds to subnational levels. It also relies on historical budgeting; as a result, the inequitable distribution of health grants across subnational units persists.
- In Uganda, subnational spending is hampered by the limited autonomy accorded to local government entities.

Role of subnational governments in purchasing

Discussion prompt: How can subnational governments become more strategic purchasers of health services?

Key points from the discussion:

- As a first step, there is need to reduce the asymmetric availability of data and thus provide adequate and real-time information to subnational governments and frontline facilities on objectives, plans, targets, and available funding. Smooth information flow, upwards and downwards, in the health system and across subnational units, will be key.

- Each government level's functions, roles, and responsibilities need to be clear and sufficiently resourced. Often, capacity will need to be strengthened, such as improving skills needed for subnational governments' administrative functions, which affect purchasing (e.g., weaknesses lead to disbursement delays).
- To enhance identification of and responsiveness to local priorities, planning and budgeting should involve all stakeholders, including civil society actors, as well as development partners where relevant. Joint monitoring is also key to ensuring accountability.
- Subnational governments can achieve economies of scale by pooling their resources, for example, for procurement. In some cases, this will require legal reforms to increase subnational autonomy.
- Systems thinking can help to situate subnational governments within the whole health system and promote more consistent collaboration and coordination across levels, coupled with some flexibility to adapt and shift responsibilities where needed. Systems thinking can also help to identify opportunities for synergies (especially within budgeting and scaling) and reduce conflicts, such as those arising in relation to timely disbursements and revenue sharing.

Increasing provider autonomy

Discussion prompt: What reforms and capabilities are needed for facilities to have more managerial and financial flexibility? How can supportive arguments or evidence best be framed to secure political agreement to increase provider autonomy?

Key points from the discussion:

- In Uganda, autonomy of local government is considerably limited in practice. The local and central governments could revise the current frameworks so that funds are allocated to match local needs and ensure that local leaders have sufficient funding for identified priorities. Currently, funds not used by local governments must be remitted to the central government, so there is the need to improve budget execution but also give more flexibility to reallocate funds to other areas related to health. In addition, capacity of local governments and health facility managers to manage their own resources should continue to be built.
- Counties in Kenya can enact legislation to allow health facilities to retain and spend the funds they generate. Currently, there is a push for counties to enact such legislation given that providers know best the needs of the population in their catchment area. This requires political goodwill. In addition, this should be corroborated with improved budget transparency.
- It is critical to enhance facilities' managerial and financial flexibility while improving the skills needed to handle such flexibility. This will ultimately allow health facilities to be more responsive to needs and improve quality of services.

Improving financial management information systems

Discussion prompt: How should financial management information systems be improved to enable more effective subnational health spending and accountability?

Key points from the discussion:

- Sobriety is warranted about what financial management information systems can and cannot do. Their primary purpose is to enable budgetary and expenditure control and generate a complete and timely record of financial transactions. Although they can contribute to other aims, such as budget execution and accountability, other systems, policies, and practices may matter more.
- Balancing access to and control of financial information systems is important. In some places, such as Kenya, budget holders cannot fully exploit technically capable systems because user rights are

centrally controlled. Elsewhere, such as in the Philippines, each local government unit has its own systems, hindering aggregation or comparison across subnational territories.

- A key objective is for financial information systems to enable the aggregation and comparison of health spending across subnational units—a technically capable system is necessary but insufficient without a compatible coding structure for the chart of accounts.
- Links and interoperability with other databases and systems, such as those for personnel management and health information, can enable better analysis of subnational spending and outputs. Harmonised codes for local governments and facilities across systems are critical. Giving each facility its own cost code can also enable facility autonomy.
- By means of a financial information system, multiple (and often fragmented) funding flows could be better captured. Yet, often, existing systems do not log health insurance payments or transactions involving off-budget donor funding or locally generated revenue, such as from user fees collected by facilities.

IV. CONCLUSIONS AND NEXT STEPS

In the final session of the event, we discussed key messages and policy recommendations emerging from the learning exchange, which are summarised below; the slides can be found **here**.

With respect to revenue raising in decentralised settings, the key messages are as follows:

- Countries need to address the vertical fiscal imbalance by revisiting revenue sharing rules to grant a higher share of revenue to subnational units and increasing conditional grants for health.
- National governments should consider incentivising greater investment in health by subnational governments, link financing to lower levels of government to performance, and align priorities across levels.

With respect to pooling, the key recommendations are as follows:

- Since devolution contributes to fragmentation, countries should increase and improve intergovernmental transfers and include different criteria that favour disadvantaged areas. If feasible, countries should shift pooling levels upwards to reduce fragmentation.
- Budget transfers to health coverage schemes for the poor may affect how equitably resources are distributed. Greater coherence across supply- and demand-side financing through a "systems-perspective" can enhance equity.

In terms of budgeting in decentralised settings, the key take-aways are as follows:

- Countries need to harmonise and coordinate budget development across levels to enhance efficiency.
- Seeing that budget structures are often inconsistent across levels and input-based budgeting prevails, countries should transition to programme-based budgeting at the subnational level and harmonise structures across levels.
- Updating PFM frameworks with an eye to enhancing flexible spending by subnational units, as well as their accountability for expenditure.

On purchasing, the main messages are as follows:

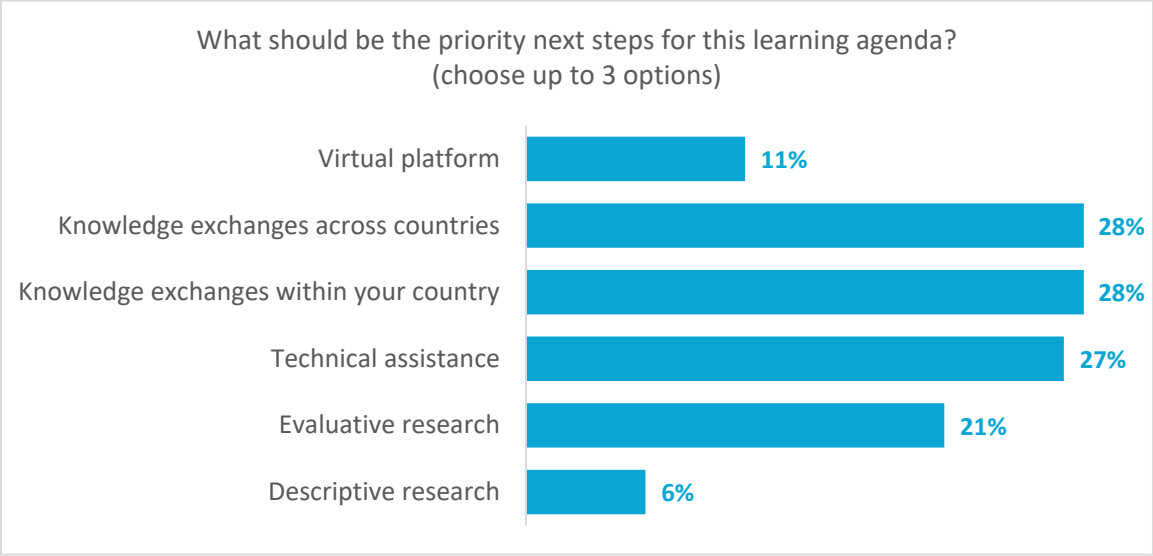
- Countries need to enhance the purchasing function at the subnational level, increasing the discretion of subnational governments to spend health funds as per local needs and priorities.
- It is critical that countries explore ways to ensure that more funds reach public facilities promptly and directly, including updating PFM rules. Moving away from line-item allocations to output-based payments, allowing facilities greater autonomy to retain and spend funds flexibly, and strengthening financial management and accountability for outputs will enhance and align facility incentives to deliver high-quality services efficiently.
- There is much work to be done to enhance the capacity of subnational governments to purchase services from private providers.

Finally, the discussion also yielded insights on the following cross-cutting domains:

- **Governance**: Formalising planning and budgeting processes is critical for ensuring continued prioritisation of health and effective spending. Purchasing arrangements through health care coverage schemes like national health insurance and "free care programmes" offer another avenue for enhancing equity across subnational units.
- **Information**: Much more investment is needed in strengthening systems and tools for generating information on subnational health allocation, budget execution, and health spending.

— **Capacity**: There is a need to strengthen capacity at all levels, both at the central as well as at the subnational levels.
— **Communication**: Greater information sharing between levels of government is critical for improved budgeting and expenditure. Additionally, the exchange of ideas and experience between subnational governments and across countries can enhance benchmarking and policy diffusion.

An audience poll soliciting views on priority areas for further learning reiterated the need for greater knowledge exchange within and across countries. The participants also favoured greater investment in technical assistance to streamline health financing arrangements in the context of decentralised governance structures. The graph below shows the full results.



Indeed, the discussions over the course of the two days yielded many open questions about which there is still little evidence; they are listed below. They constitute a large research agenda that would benefit from collaborative exploration within and across countries. Creating more and better opportunities to showcase countries' experiences and lessons both domestically and globally can both enhance this research agenda and the translation of knowledge to policy and practice.

- Does giving more money to subnational levels (e.g., a greater share of national revenue) lead to more spending on health? What are the factors to determine a **conducive balance between conditional and block grants**?
- For horizontal revenue sharing formulas: Which **combination of criteria** (poverty indicators, population, health needs, health infrastructure, local government fiscal effort) has the **best equalisation effect**?
- How have (a few) countries managed to **shift the level of pooling** for health from smaller subnational units to a **higher level**?
- What role do or should **budget transfers to health coverage schemes** (e.g., "health insurance subsidies") and provider payments play **to achieve equitable resource distribution** across subnational territories?
- What are promising institutional arrangements for coordination and alignment between subnational units and health coverage schemes or other health programmes?
- What is or should be the **(governance) role of the central government** to ensure **coherence and (information) exchange** across subnational units?

- What **adjustments to PFM frameworks** contribute to more effective **programme-based budgeting** and spending at subnational levels?
- What are effective approaches to **enhancing provider autonomy** and facilitating more agile spending at the facility level?
- Under what circumstances do **subnational governments selectively contract providers**, including in the private sector?
- How can **(digital) financial management information systems** most effectively improve the **visibility of fund flows and spending**?
- What is the **political economy** of implementing health financing reforms that **cohere with decentralisation**?
- What are promising ways to **integrate centrally (or externally) financed vertical programmes** into decentralised health systems without jeopardising their coverage?
- What lessons on financing can health systems **learn from other sectors** that deliver local services?

We encourage participants to continue sharing their experiences based on technical assistance, as well as their research findings, and establish a vibrant community of practice on decentralisation, health financing, and PFM. There may be opportunities to connect with and build upon other relevant forums and platforms, including the several health financing-related communities on Collectivity (**https://www.thecollectivity.org/en/communities**) and the Local Public Sector Alliance (**https://decentralization.net/**).

ANNEX 1: LEARNING COLLABORATION PUBLICATIONS LIST

This annex lists all the publications produced during the ThinkWell-WHO learning collaboration exploring the interplay among decentralisation, PFM, and health financing. These products can be accessed using the links below or by visiting the pages dedicated to the learning collaboration on the **ThinkWell** and **WHO** websites.

Synthesis reports	
Synthesis #1	**A Balancing Act: Health Financing in Devolved Settings**
Synthesis #2	**Is Decentralisation Friend or Foe to Agile Public Financial Management in Health? Findings from Burkina Faso, Indonesia, Kenya, Mozambique, Nigeria, the Philippines, Uganda, and the United Republic of Tanzania**
Country case studies	
Burkina Faso	**Devolution of the Health Sector to Communes: A Misfit in the National Health System Governance Framework and Management Shortfalls in Burkina Faso**
Indonesia	**Subnational Government's Autonomy vs. Capacity: The Need for Stronger Management Systems for Health Financing in Indonesia**
Kenya	**How Decentralization Has Shaped Health Financing Arrangements and PFM Practices in the Health Sector in Kenya**
Mozambique	**Decentralization Reforms in Mozambique: How This Has Shaped Health Financing Arrangements and Public Financial Management Practices in the Health Sector**
Nigeria	**Intergovernmental Rivalry and Fragmentation: How Federalism Shapes Public Financial Management and Health Financing in Nigeria**
The Philippines	**Three Decades of Devolution in the Philippines: How This Has Shaped Health Financing and Public Financial Management Reforms**
Uganda	**The Pendulum of Power in Uganda: How Decentralization has Shaped the Role of Local Governments, Public Financial Management, and Health Financing**

ANNEX 2: AGENDA FOR VIRTUAL KNOWLEDGE EXCHANGE

This annex contains the agenda for the virtual knowledge exchange organised by ThinkWell and WHO, which took place July 12–13, 2022.

Day 1 – July 12, 2022 (Tuesday)

Time	Session
1:00 – 1:10	**Opening remarks & framing of topic** Mr. Joseph Kutzin, Head, Health Financing Unit, WHO Switzerland
1:10 – 1:20	**Overview of WHO-ThinkWell initiative & housekeeping** Dr. Nirmala Ravishankar, Senior Fellow, ThinkWell India
1:20 – 2:20	**Panel 1: Revenue sharing between levels of government** *Moderators* • Dr. Inke Mathauer, Senior Health Financing Specialist, WHO Switzerland • Ms. Ileana Vîlcu, Program Manager, ThinkWell Switzerland *Panelists* • Mr. Boniface Mbuthia, Technical Advisor, ThinkWell Kenya • Dr. Maria Eufemia Yap, Senior Technical Advisor, ThinkWell Philippines • Ms. Angellah Nakyanzi, Country Manager, ThinkWell Uganda
2:20 – 2:30	**Comfort break**
2:30 – 3:15	**Breakout group discussions** *Facilitators* ThinkWell and WHO staff
3:15 – 3:45	**Reporting out** Rapporteurs from breakout groups
3:45 – 4:00	**Closing + preview of day 2** Dr. Nirmala Ravishankar, Senior Fellow, ThinkWell India

Day 2 – July 13, 2022 (Wednesday)

Time	Session
1:00 – 1:05	**Welcome + recap of day 1** Dr. Nirmala Ravishankar, Senior Fellow, ThinkWell India
1:05 – 2:00	**Panel 2: Sub-national government spending** *Moderators* • Dr. Hélène Barroy, Senior Public Finance Expert, WHO Switzerland • Mr. Michael Chaitkin, Technical Advisor, ThinkWell Uganda *Panelists* • Ms. Marie-Jeanne Offosse, Country Director, ThinkWell Burkina Faso • Dr. Trihono, Technical Advisor, ThinkWell Indonesia • Dr. Gemini Mtei, Senior Director, Abt Associates Tanzania
2:00 – 2:05	**Comfort break**
2:05 – 2:50	**Breakout group discussions** *Facilitators* ThinkWell and WHO staff
2:50 – 3:20	**Reporting out** Rapporteurs from breakout groups
3:20 – 3:30	**Comfort break**
3:30 – 4:00	**Key messages and next steps** ThinkWell and WHO organising team

ANNEX 3: SLIDES FROM THE VIRTUAL KNOWLEDGE EXCHANGE

Day 1: Revenue sharing between government levels

Day 2: Subnational government health spending

Day 2: Key messages and next steps