Performance-based Financing through Government Systems

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PBF: Popular but challenging to institutionalize

- PBF is popular among CMUs and donors
  - Money to frontline
  - Results/outcomes oriented
  - Accountable and transparent

- Currently implemented in 28 countries around the world, 21 in Africa; Total WB commitment ~ US$1.6 billion

- However, the **engagement modality** of PBF projects has mostly been **outside of gov't budgetary processes.** This poses a **sustainability challenge**

Context matters: PBF in different country settings

- Systems with **statutory funds** or purchasing agency that operates outside the budget

  Rwanda

- **Fiscally decentralized** countries

  Kenya, Nigeria

- Countries allocating public budgets to **local government administration** for service delivery

  Cameroon, Zambia

- Countries that allocate budgets **directly to service providers**

  Tanzania

- Countries that rely on **NGO contracting** for delivery of a minimum benefits package

  Afghanistan, CAR

There are 5 main challenges.

- Challenge 1: What is the legal status of health facilities?
- Challenge 2: Bank accounts or not, that is the question.
- Challenge 3: How much control is really necessary?
- Challenge 4: Should the facility budget be output-oriented?
- Challenge 5: How do we verify?

Challenge 1: What is the legal status of health facilities?

- **Typical PBF process**

  Facility is spending unit.

- **Typical PFM process**

  District is spending unit.

- **What this means**

  PBF requires facilities to manage their own funds but in most countries the lowest cost center is at the district level.

Challenge 2: Bank accounts or not, that is the question.

- **Typical PBF process**

  Facilities have bank accounts.

- **Typical PFM process**

  Country pursues treasury single account.

- **What this means**

  With PBF, facilities have financial sovereignty and require banking services. This is often in conflict with treasury single account reforms.

Challenge 3: How much control is really necessary?

- **Typical PBF process**

  Large flexibility of spending

- **Typical PFM process**

  Subject to annual budget law and enforced by ex-ante commitment control.

- **What this means**

  PBF facilities execute budget against business plan, with flexibility to adjust to changing priorities with approval from governance committee. Districts execute against annual budget law.

Challenge 4: Should the facility budget be output-oriented?

- **Typical PBF process**

  Facilities get reimbursed against performance.

- **Typical PFM process**

  Districts request expenditures against budget.

- **What this means**

  PBF budget ceiling is a function of previous' quarter performance. District budget depends on annual budget law.

Challenge 5: How do we verify?

- **Typical PBF process**

  Rigorous verification

- **Typical PFM process**

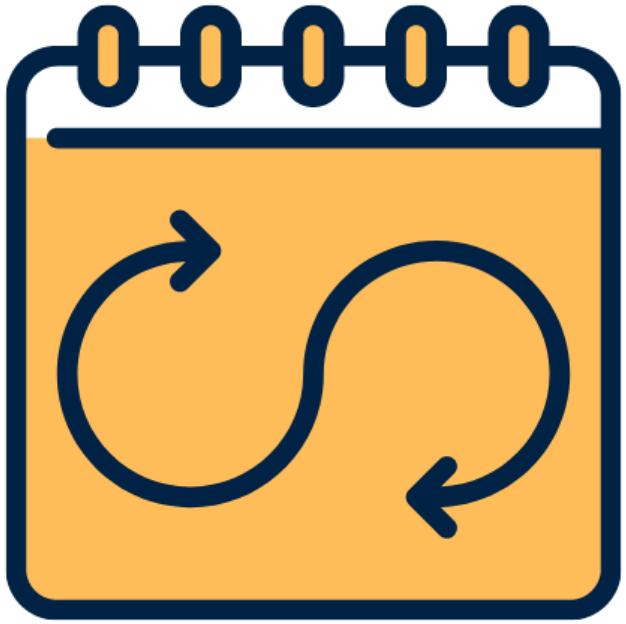
  Internal audit

- **What this means**

  PBF facilities must evidence progress against indicators, which are verified by a third party. Districts undergo rigid internal control, but transactions are approved based on appropriation and budget availability.

Pillar I: Autonomy and flexibility of spending

- What is the legal status of facilities?
- Are they spending units in the chart of accounts?
- Can they receive and spend money? Retain across fiscal years?
- Do they have access to banking services?
- How rigid are rules for the use of funds (e.g. Input-based controls? Bonus payments allowed?)



Pillar II: Financial management capacity

- If facilities receive funds, how are these accounted for?
- How is the use of funds reported and against what?
- Is there adequate financial accountability?
- Is there periodic bank reconciliation?
- What type of controls (for example, appropriations control or budget controls) are applied to facilities' spending? Are these adhered to? Adequate?

Pillar III: Unified payment system

- Is there fragmentation amongst revenue sources to facilities?
- Are revenue sources captured in budget?
- Do these follow the government financial year?
- Do execution protocols vary among these different financing sources?
- Do reporting requirements differ by financing source?

- Does the payment system support strategic purchasing and efficient facility management?

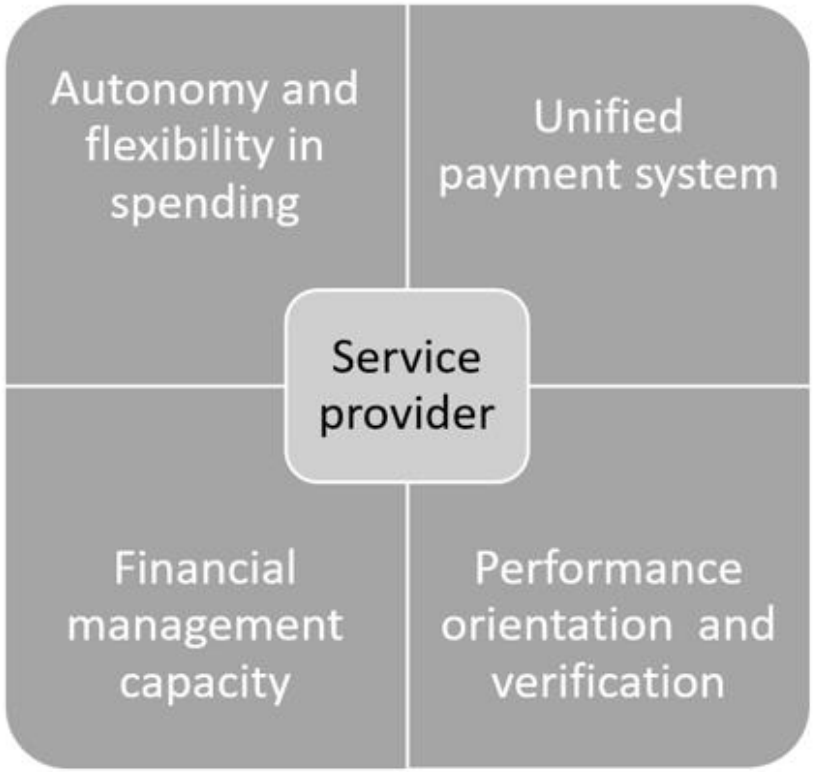
Pillar IV: Performance orientation and verification

- How is the budget evaluated?
- Are there compliance and performance evaluations? How credible are these?
- Is the budget allocation for facilities informed by their performance during the previous year?
- Is the performance of facilities monitored and verified?

Thinking about mainstreaming

Budget Cycle

Facility Financing Pillars



Service Delivery Goals

- Efficiency
- Equity
- Quality
- Accountability

What options do I have?

- Develop a game plan → where are we today and how do we get to greater use of govt systems?
- Diagnostic and building consensus (external & internal)
- Collaborate with the GGP!
  - Is there PFM for Service Delivery Project?
  - Buy GGP staff time through G4GFF TF.
- Make use of budget support operations for policy reform. (e.g. change in flow of funds, provider autonomy, etc.)
- Consider performance-based conditions in IPFs.
- Work with DLIs in PforRs.

Application to Zimbabwe

- Zimbabwe has just completed PFM reforms, which directly affect health service delivery.
  - Reforms relate mainly to **program-based budgeting**, **expansion of the IFMIS**, and **enhanced financial reporting**.
  - Mainstreaming PBF is undertaken in this context—with MoFED onboard.

- **What has worked for Zimbabwe?**
  - ✓ A **strong IFMIS** that goes down to district level
  - ✓ A robust policy framework that is the basis of the well-defined institutions underpinning government operations
  - ✓ Has started implementing **program-based budgeting (PBB)** and is in the process of rolling this out to districts; this links allocations to government priorities
  - ✓ Has a demand-side functional accountability framework, which is underpinned by an internal control support system

Application to Zimbabwe

» However, some gaps remain that would need to be addressed to allow for enhanced effectiveness of mainstreaming PBF:

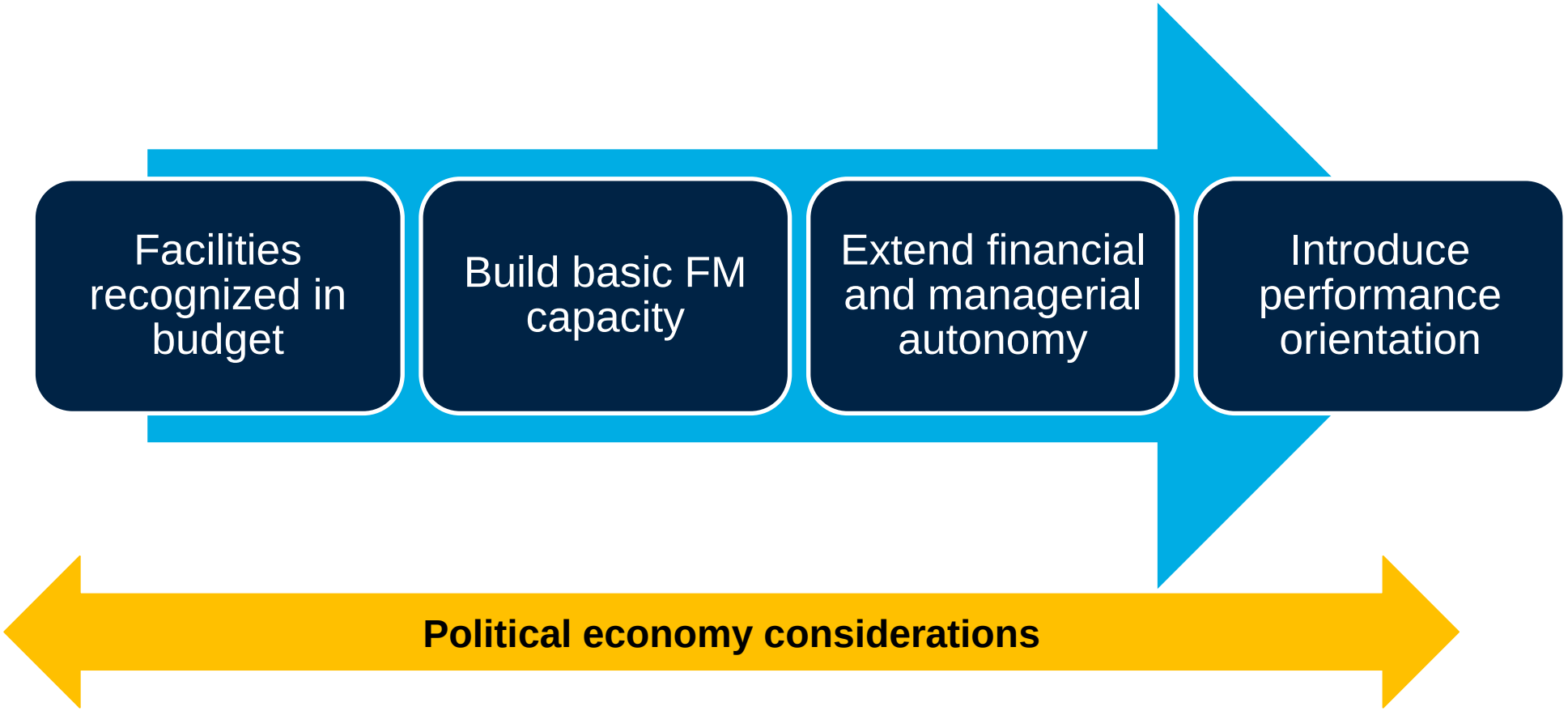
- **Budgeting autonomy is low.** Budgets are controlled at the district level. Under PBB, HCs have little control over outputs.
- **Spending by HCs is recorded manually** because the Public Finance Management System does not go beyond the level of the district. Input-based budgeting is practised.

- **Compromised resource control**: Possible delays in cash resource availability from MoFED due to cash rationing
- There is **no major accounting done at the clinic level**.
- **Low FM capacity, in general, at HCs**
- Appropriation funds are reported through IFMIS – at the district level – since **HCs are *not* cost centres in the PFMS**.
- **Granular HC financial information for RBF may not find its way into consolidated government reports**.
- Districts and Provinces largely purchase on behalf of the health facilities. There is **high risk of losing transparency** due to this.

Lessons learned for successful PBF

- Successful and sustainable PBF requires a gradual approach and alignment to national PFM scheme (STA)
- Flexibility to adapt to the PFM system in the PBF reform is key in terms of budgeting, fund flow, control and reporting
- Capacity building at central, regional and HC levels should be consistent and follow a change management approach
- Simple FM procedures/protocols at HC level supported by a well-tailored FM information system

Developing a reform program



Thank you!

ANNEX

Assessment criteria

PBF pillar	*Budget formulation*	*Budget execution*	*Budget evaluation*
Provider autonomy	Criteria 1-3 (D1)	Criteria 4-7 (D2)	Criteria 8 (D3)
Unified budget provision / payment system	Criteria 9 (D4)	Criteria 10-11 (D5)	Criteria 12 (D6)
Financial management capacity	Criteria 13 (D7)	Criteria 14-21 (D8)	Criteria 22-23 (D9)
Performance orientation and verification	Criteria 24 (D10)	Criteria 25-26 (D11)	Criteria 27-29 (D12)