DIRECT FACILITY FUNDING (SUMMARY)

A. Definition

1. Direct facility funding (DFF) is defined as the direct provision of government or external funds to a health facility to meet the operational requirements of the health facility. The facility will prepare a budget and, once it is approved, spending by facilities will not be subject to pre-approval or pre-audit of transactions, but will rather rely on post control through, in particular, the budget and expenditure control as part of the liquidation process.

B. Scope

2. A “facility” will be a community health post (CHP), health center, or subcenter. It will not apply to aid posts, which will be considered as part of their supervising CHP. DFF will apply to both government- and church-operated facilities.

C. Problems DFF Intends to Address

3. Public funding is not reaching frontline health facilities. Instead, most facilities rely on collection of user fees to fund their operations. Church-run facilities are in a similar situation. Funds move very slowly through the government system, and provincial governments appear to give priority to spending on costs of health administration, rather than operation of facilities and patrols.

4. Second, when funds are released, there are major delays before they can be used. In many districts it takes 4 months into the financial year before approval is granted for operational expenditures, due to the long process individual expenditure items take. This process adds little value to the quality of the purchasing, and effectively handicaps facility activity for a substantial part of the year, limiting the achievement of health goals.

5. Third, there is reduced ownership of facility activity at the local level, as all financial decisions are controlled more centrally. Increasing the local ownership and connecting planning at the local level with the available resources is expected to bring benefits, enabling local facility staff to be responsive.

6. Last, the unreliability of operational support has fostered a wide variety of user fee regimes. These have low levels of accountability, and at times impede access for priority conditions such as maternity care.

D. Description of Progress

7. The DFF approach has already been widely applied in the education sector in Papua New Guinea, and is currently being piloted in the Autonomous Region of Bougainville (ARB). A number of the provinces within the project have also indicated that they are in the process of implementing DFF schemes.

8. In the ARB pilot, the funds being used are external funds, through the Health Sector Improvement Program rather than government funds more directly. Part of the intention of the ARB pilot is to explore the issues that will need to be addressed to allow the flow of government funds through this mechanism.

9. Continual monitoring of the ARB pilot is recommended so that experience learned in this setting is applied.

E. Key Elements of DFF

10. The key elements are as follows:

(i) The DFF funds are managed through a separate provincial government bank account.
(ii) Bank accounts are established for the individual facilities under the signature of the officer-in-charge and the Health Committee chair.
(iii) The facility prepares an annual plan and budget with agreed upon costs within predetermined allocations.
(iv) The budgets are endorsed by the health committees and approved by the province before funds transfers can take place.
(v) The funds are released quarterly to the facilities' bank accounts by electronic transfer.

11. Release of funds to a facility will be subject to satisfactory liquidations. Funds will, however, be released automatically for the 1st and 2nd quarter, while release of the 3rd quarter will depend on satisfactory liquidation for the 1st quarter, etc., in order to ensure that facilities are not caught without cash during the period between liquidation and release of subsequent funds. Funds will be released quarterly to each facility as one quarter of the facility's annual allocation. Facilities will submit liquidations to the health division. Spending by facilities will not be subject to pre-approval or pre-audit of transactions, but will rely on post control through, in particular, the budget and expenditure control as part of the liquidation process.

F. Financial Management Framework

12. A facility accounting system has been developed comprising as the main elements:

(i) the annual facility budget summarized along the government expenditure items;
(ii) a combined cashbook (same expenditure categories as budget);
(iii) combined payment and expenditure vouchers; and
(iv) Liquidation documents submitted; copy of combined cashbook showing the cashbook balances with analysis of itemized expenditures (and thus financial reporting for the period), vouchers for payments and expenditure, and copy of bank statement.

13. Rules about facility bank accounts and the procedures for approving expenditures will need to be established. The Provincial Health Authority Chief Executive Officer or Provincial Administrator (CEO/PA) will open the facility bank accounts to ensure that the accounts are established with the required set of signatories for each facility representing the officer-in-charge and the health committee chair. Internet banking facilities will be established with the bank to enable electronic transfer of the quarterly facility funds to the individual facility bank accounts and so that the provincial health authority CEO or provincial administrator can monitor the facility bank accounts. Expenditure vouchers will be authorized by the same signatories as the bank account.

G. Use of Funds

14. National Economic Fiscal Commission (NEFC) unit cost estimates can be used to determine the total facility cost requirements for facility operations, including outreach. Facility cost responsibilities will be assigned to determine which costs should be borne by the facilities – and thus covered by funds released directly to the facilities – and which costs will remain at the provincial level. The amount allocated for each individual health facility will then be worked out by using a combined set of allocation criteria (outpatients, number of aid posts, and patient transfers related to number of outpatients).

15. In line with the assignment of facility cost responsibilities, facilities are permitted to use funds for nonmedical supplies, utilities, nonmedical equipment/furniture (minor), building maintenance (minor), transport (fuel and maintenance), camping allowances, casual staff, etc. The costs of medical supplies, purchase/replacement of vehicles and boats, refrigerators for storing vaccines, and medical equipment as well as major infrastructure upgrading or expansion, etc., remain the responsibility of the province.

H. Rules on Charging Fees

16. The funds allocated to facilities should be set at a level intended to cover the full costs of facility operations and outreach. It should be agreed from the outset that facilities will abolish whatever fees and costs have been hitherto charged to patients, including transfer of patients for referral treatment.

I. Roles and Responsibilities of Health Committees

17. All health centers involved will require functioning health committees. The overall functions of the committee will be to oversee the management of the health facility and to support health facility operations and programs, and more specifically

(i) approve work plans and the budget of the facility;
(ii) approve the expenditures, including signatories to the facility fund bank account; and
(iii) approve financial reports submitted by the officer-in-charge.

18. Committee allowances will not be permitted. This is in line with the policy in the education sector.

J. Roles and Responsibilities of Provincial Health Office

19. The PHA CEO/PA is overall responsible for health administration and thus for managing the accountability of the DFF scheme. The district coordinators will be involved in oversight of facility fund management and accountability. Apart from determining facility fund allocations and approving facility budgets, the PHA CEO/PA will ensure that the following functions are carried out:

(i) transfers to facility bank accounts,
(ii) receipt of liquidation documents and reports,
(iii) addressing problems with accounts,
(iv) monitoring performance,
(v) management response to performance issues,

(vi) decision to withhold funds,
(vii) support and training to facility staff, and
(viii) provision of medical supplies and capital items not included in the facility fund.

K. Monitoring of Performance

20. Provision of the facility fund directly to health facilities is in general expected to improve overall service delivery, and, more specifically, to improve facility operations and outreach services (patrols). Performance will be measured on general service provision with special focus on outreach services — monitoring of planned versus actual outreach — and facility fund budget execution through regular and timely submission of facility fund liquidation/reports reflecting expenditure in compliance with facility budgets.

21. Key indicators that should be monitored include:

(i) number of facilities with DFF,
(ii) satisfactory submission of liquidation/disbursement documents,
(iii) number of outreach patrols,
(iv) immunization coverage,
(v) elimination of user charges,
(vi) facility staff and community satisfaction levels,
(vii) increased facility productivity, and
(viii) officer-in-charge time commitment to DFF issues.

L. Risks

22. DFF is one of a number of initiatives in this project, and it arrives on an already crowded provincial and district agenda. Care will need to be taken to plan sufficient time and resources for training and implementation, in the context of the other demands for time of key personnel.

23. DFF will, on occasion, be abused. Provinces need to develop an appropriate audit plan to ensure the integrity of transactions, and a management plan when problems are identified. The most common problem is likely to be late or absent liquidation. A mechanism of incentivizing this activity should be considered.

24. The DFF may increase transaction costs and involve frontline staff in additional paperwork. This needs to be monitored and the system kept as simple as possible.

M. Training Requirements

25. A facility training program will need to include two training sessions for each batch of Health committees. The first session will cover the introduction and context of the scheme, allocations to each facility, and facility planning and budgeting (templates, microplans, etc.), followed about a month later, when facilities will be expected to have finalized their plans and budgets for approval, by a second session covering facility accounting and reporting immediately before release of operational funds. The officer-in-charge as well as the chairman of the facility committee will participate in the training.

N. Cost Involved

26. The following costs are involved (note: these items are already included in the proposed project budget): (i) training costs, and (ii) supervision costs.