
Report on the WHO Global Learning Event

*Financing facilities directly: how can it
transform public budgets into services?*



World Health
Organization

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BACKGROUND OF THE GLOBAL LEARNING EVENT

Hélène Barroy, WHO, introduced the event, providing a first definition of the approach, highlighting the objectives of the discussions, and providing an outline of the different sessions.

Definition

‘Financing facilities directly’ establish primary care facilities, as management entities able to receive budget funds directly, manage them flexibly to deliver services meeting the population’s health needs, and perform good financial management for output-oriented accountability.’

‘Financing facilities directly’ is a concept; it is not a project or new scheme but should be viewed as a set of key adjustments within existing public financial management systems. Financing facilities directly is really an opportunity for countries to transform and align the public budgets to deliver priority health services.

Financing facilities can transform the way in which health facilities receive, manage, and account for funds to deliver health services. Financing facilities directly has generated strong interest from countries and development partners in recent years as a mechanism to empower health-service providers and contribute to expanding coverage. However, evidence sharing has been limited so far, and there is a need for dialogue on the key principles to generate a deeper understanding of what is needed from health financing and public financial management systems to enable the approach to be implemented nationally.

This work builds on a joint WHO and World Bank briefing entitled Direct Facility Financing: concept and role for UHC, which sets out the guiding principles for financing facilities directly¹.

Objectives of the event and target audience

The main objectives of the global learning event were:

- To frame **key questions/considerations** for enabling facilities to access, manage and account for funding directly
- To unpack **good practices** and understand key requirements for a successful transition
- To identify remaining **knowledge gaps** and needs for future cross-country learning and support.

¹ <https://www.who.int/publications/i/item/9789240043374>

Overall, the Global Learning Event was an opportunity to discuss how to apply foundational principles to enact step-by-step reforms in country environments, with a focus on low-and-middle-income countries. It is designed to benefit the Ministry of Health, Ministry of Finance, and subnational government officials, as well as service providers, who are involved in practical aspects of health purchasing, public finance management, and service delivery. Development partners supporting the sustainable management of equitable patient-centred health services may also be interested in joining the discussions.

The Global Learning Event was structured around the below three themes, with a dedicated discussion for each objective. The dialogues included a mix of panel discussions, technical presentations by subject-matter experts and country representatives, interactive discussions in breakout groups on a set of questions, reporting in plenary from the breakout groups, and final reflections by a subject-matter expert. The event provided an opportunity to use peer learning to identify best practices, discuss challenges and how to address these potential hurdles.

Session 1: Key principles

Session 2: Provider payment

Session 3: Facility financial management

Participation

The Global Learning Event was attended by more than 194 unique participants, which included the organizers of the event (the background staff as well as the presenters). Approximately two-thirds of the external participants were country officials including representatives of ministries of health and finance and the rest were representatives of international organizations.

ACKNOWLEDGEMENTS

This report takes stock of a WHO Global Learning Event organized virtually on 10 November 2022 on ‘Financing facilities directly: how can it transform public budgets into services?’. This report was developed by the event’s organizing team, including H  l  ne Barroy (Senior Public Finance Expert, WHO), Amna Silim (PFM consultant), Sheila O’Dougherty (consultant), Val  rie Dossogne (Web Manager), and Joseph Kutzin (Team Head, Health Financing, WHO).

DISCUSSION AREA 1:

Financing facilities directly: definition and key requirements

The first session of the global learning event focused on the definition, rationale, and fundamentals for implementing financing facilities directly.

Joe Kutzin, WHO, began the session by offering a definition of financing facilities directly, and setting out the importance of this approach for UHC and expanding coverage. This was followed by Sheila O'Dougherty, an independent consultant, delivering a brief overview of the key fundamentals for financing facilities directly, of which, the themes brought up in this presentation underpinned many further discussions during the global learning event. Finally, a panel discussion of three technical experts closed the session by offering their insights based on their country experiences including how well the definitions and key requirements brought up in the first half of the session relate to the on-the-ground experience.

Why it matters for UHC? Joe Kutzin, WHO

Joe Kutzin started the session by explaining how financing facilities directly is not a scheme or a project or an acronym but it is about changes to the underlying engineering of public finance systems. Fundamentally, financing facilities directly focuses on domestic policy and ensuring that the right underlying engineering is in place to enable sustainable change in health financing.

This approach exists to different degrees in different countries (e.g. Burkina Faso or Indonesia); however, this global event focuses on country experiences where implementation has been most advanced such as Tanzania, where the approach has come under the label of direct facility financing.

Overall, Joe stressed that financing facilities directly enables facilities to directly receive, flexibly manage and account for funds. It is an opportunity to make public budgets more flexible, which can then facilitate progress towards UHC (e.g. enables the pooling of funds more centrally, and the ability to purchase services strategically including on an output basis or using a needs-adjusted payment formula). It is also an opportunity to extend coverage through use of general revenue funds or non-contributory entitlement thereby providing an alternative to contributory insurance schemes. This is particularly important in LMIC contexts with high degrees of participation in the informal economy. Joe also highlighted that this approach does not have to be uniform across countries or an all-or-nothing approach but can be adapted to unique country environments and focus on gradual stepwise implementation. Finally, Joe highlighted that WHO is working collaboratively with others to further define this concept and to produce a how-to manual for financing facilities directly.

Unpacking key principles, Sheila O'Dougherty

Sheila started the session by describing what financing facilities directly is not:

- Not a new application but rather a fundamental and foundational health financing approach with attributes and actions to strengthen domestic health systems
- Not outside of country PFM systems but rather feasible within and even supported by PFM systems
- Not intended to reflect lessons learned from only a few countries but rather to establish overarching principles and guidance that create space for adaptation in all country environments

Overall, the definition of financing facilities directly provided in this session is that money is received in facility bank accounts (including some government general revenue) to purchase benefits or health services through output-based provider payments. Sheila specified that the term facility reflects a management entity, not individuals unless incorporated, and includes networks or community-level affiliations.

Funding can include all revenues however, a portion of facility funding is required to be general revenue funds. General revenue is key to cross-subsidization, serving the poor and vulnerable, equity and financial risk protection, moving closer towards attaining UHC. In addition, investing general revenue in financing facilities directly by definition requires the use of country PFM systems thus increasing efficiency, reducing fragmentation and administrative costs and enabling service delivery support.

Sheila went on to describe the three key principles of financing facilities directly.

Principle 1 is facility autonomy, which is also a precondition. Under this principle, health facilities should have the legal and operational status to receive, manage and account for funds from any source. This also requires entities to have their own bank account and their inclusion in the country chart of accounts. Facility autonomy recognizes that facilities are management entities with the requisite management platform and the ability to perform financial management functions. Sheila stressed that autonomy requires financial management systems and the accountability that goes with these systems and processes. Without this, extending autonomy is a non-starter and sets facilities up to fail. Autonomy and accountability go hand in hand.

Principle 2 is output-based provider payment. Output-based payment permits health facilities to determine and procure the best mix of inputs to deliver service outputs. This principle doesn't include extending input-based payments to the facility level as this approach gives facilities the responsibility, but not the authority to better manage the assembling of inputs to deliver outputs. Sheila outlined the key technical considerations under this principle, which were covered in more detail Session 2 and its break-out groups.

Technical considerations for provider payment

- Specifics of output-based payment including how the unit of service or output is defined and the level of bundling (risk); payment of average cost across a group of facilities; flat fees vs. formula-based payment
- How to include drugs in output and payment rate, this can be tied to drug supply mechanisms such as framework contracts or prime vendors
- A variety of pooling options can be used although payment transactions must be transparent and observable (local governments can be the purchaser if payment is output-based and made to facilities)

Principle 3, the last principle discussed, is sound facility financial management.

Health facilities including PHC providers should function as management entities, which requires existing or new financial management systems to be extended to the facility level. One standard accounting system can be used to account for revenue and expenditures for all domestic and external funds. The focus of this principle is on empowering facilities to manage their funds, which can also drive a shift in mentality. Financing facilities directly with the requisite systems and practical learning by doing can enable facility managers to manage their funds well and shift the external perception of facility managers from apathetic to capable and motivated, and this kind of change in mentality can happen surprisingly quickly.

Sheila went on to discuss the parameters for successful implementation, which include realigning institutional roles and relationships, capacity building encompassing both training and user support, and understanding the importance of both sequencing and timing within a broader reform process. Sheila noted that possible entry points include using financing facilities directly to reduce funds flow fragmentation or strengthen service provider systems and capacity. Overall, implementation should be bottom-up and focused on creating a functioning management entity with financial management systems and processes.

In conclusion financing facilities directly transforms the way health facilities, and their broader community networks receive, manage, and account for funds to deliver health services. This shift requires recognizing the level of management that is required to assemble inputs and deliver outputs. Sheila noted throughout the presentation that PFM systems should support not hamper service delivery, and that PFM should not be viewed as a bottleneck or a rigidity but as an enabler.

Panel Discussion

Professor Edwine Barasa, KEMRI-Wellcome Trust Research Programme, Kenya

Q: Reflecting on the principles raised in the first discussion how does this resonate with the experience in Kenya particularly given the decentralization context?

Edwine discussed the impact of devolution in Kenya on the autonomy of health service providers. Following devolution, most health functions moved to the county level and funds were transferred to the county treasury. As a result, many health facilities, namely hospitals, lost their autonomy and access to public funds. However, at the primary healthcare level, there was a push to have conditional grants allocated to primary facilities, and therefore health centres and dispensaries continued to receive funding directly into their bank accounts. Edwine discussed how evaluations have shown that facilities that received direct funding witnessed improvements in service delivery and that the loss of autonomy for certain health facilities has compromised service delivery. Edwine also discussed the importance of output-based payments, while also noting that more work is needed to unpack how to operationalize this mechanism successfully. Finally, Edwine closed by highlighting the importance of sound financial management and accountability in Kenya, which requires requisite skills, training and support. However, Edwine also flagged that there is the risk of overburdening staff with accountability and reporting. To illustrate this point he highlighted an early assessment that revealed that staff spend 20 per cent of their time doing accounting and reporting which can distract them from core responsibilities.

Oluwole Odutolu, Polywonk Ltd

Q: Regarding financing facilities directly in Nigeria, could you kindly share some key lessons from this experience and highlight the underlying requirements and key principles for making this work effectively?

Oluwole began his remarks by explaining his role in the design and implementation of financing facilities directly in Nigeria between 2010 to 2019. In Nigeria there was an allocative inefficiency challenge, with primary health care receiving minimal funding. Nigeria then introduced a basic care provision, which included supplementary financing for primary care. Aside from the allocative efficiency challenge, Nigeria also faced an operational efficiency challenge and this was largely due to fragmentation of financing, multiple institutions responsible for primary health care, and leaky bucket issues as money flowed down multiple levels, often leaving very little left at the facility level.

With the introduction of financing facilities directly, which required some adaptations to the PFM system, an evaluation showed that this approach incentivized workers, with improvement witnessed in the quality of care and coverage among other indicators. Autonomy, building accountability and providing sufficient supervision, Oluwole noted, are all critically important in financing facilities directly. Finally, Oluwole highlighted some challenges faced in the scale-up of financing facilities directly including political economy challenges such as the issue of the redistribution of roles and relationships, working within the federal system with multiple layers, and the importance of defining the right allocation formula to meet the needs of facilities and communities.

Aneta Wierzynska, The Global Fund

Q: How do you navigate the tension between more flexibility and ensuring there is a good level of accountability, especially in a context such as Democratic Republic of Congo (DRC) facing fragility and governance challenges?

Aneta's contribution focused on fiduciary risk management, governance and audit consequences. Her discussion aimed to answer whether financing facilities directly makes sense from both programmatic and fiduciary risk management perspectives. Overall, the takeaway is yes, financing facilities directly can be a win-win as it can provide better accountability, better risk management, and better governance – all while delivering better services to the population and achieving better outcomes. As a programmatic intervention, financing facilities directly assumes that the management and functioning of facilities is critical to service delivery, and facilities are better placed than others to make decisions on their needs. In terms of governance and accountability, financing facilities directly is about increasing transparency, improving management at all levels of the system, and better separating financial functions including shifting some autonomy and accountability for making decisions to the facility and its community. In addition, this intervention from a corruption or fraud risk angle can be viewed as a mitigation measure because the fewer steps money flows through, the fewer the leaky buckets, although this message is not always intuitive. Aneta also addressed the role of the donor in financing facilities directly.

The Global Fund worked with DRC to design financing facilities directly. The Global Fund project will not fully integrate into the existing PFM systems, however, the expectation is that it will happen step-by-step over time. Another consideration when working with donors is the need to account for the money, however, Aneta noted that the effort to meet fragmented and burdensome financial management requirements outside of domestic PFM systems and processes may set facilities up for failure. The key is to continuously strengthen financial management including audit processes to ensure a balance of program and financial risk management priorities and set facilities up for success.

DISCUSSION AREA 2:

Financing facilities directly and provider payment

Cheryl Cashin, R4D

The Global Learning Event's second session focused on provider payment systems. The objectives of this session were to lay out the guiding principles, and technical considerations of provider payment systems, followed by breakout group discussions to identify what we know, what is missing, and what is truly country-specific.

Cheryl began the discussion by highlighting how provider payment systems are one of the most powerful elements of financing facilities directly. Provider payments are a transaction or a mechanism to get money into the hands of providers, but key to financing facilities directly success is specification of payment systems containing levers, that are appropriate for the environment, to support meeting broader objectives for example strengthening primary health care, equity and UHC.

The following guiding principles were discussed:

- Provider payment should be linked to service delivery outputs (not inputs)
- Provider payment needs to be embedded in the PFM system
- Provider payment should be used to reduce not increase fragmentation

In the design of provider payment systems, it is important that the specification of payment system matches priority objectives, and addresses system problems. It is also critical to consider the factors that can dilute payment incentives, for example, lack of provider autonomy, conflicting systems, high administrative burden, and payment delays. These must be addressed upfront otherwise they can create perverse incentives. Cheryl also highlighted the wide variations in impact on services of different types of provider payment systems as they might divert funds away from the front line (i.e. fee for service) but they can also be a tool to protect funds for PHC and achieve equity, for example, capitation payments can help extend equity and flexibility among other broader objectives.

The discussion included highlighting some of the technical considerations in the design and implementation of payment mechanisms.

Policy questions	What do we know?
Which payment method(s) will be used	• It depends on the objectives and capacity of the system • Adaptations may be needed in the PFM system • It is more effective to start simpler and move toward blended models
Will a performance component be included?	• Targeted incentives have limited impact on provider behavior but may be useful as a complementary payment component to communicate priorities, improve data systems, and improve accountability
Which inputs will be included?	• Including more inputs (e.g. drugs and eventually labor) increases the power of the payment system • Supporting systems and guidelines are needed for how those inputs (especially drugs) are procured
How will payment rates be set?	• Formula-based payment provides more policy levers than flat-rate tariffs • Closed-ended payment systems offer more control by the purchaser over resource allocation and budget management than open-ended payment
How will the payment system be implemented?	• Streamlined implementation arrangements reduce payment delays and increase transparency • The "right" entity to receive payment depends on the context but should facilitate management of funds at the lowest feasible level

Breakout Group Discussion

Group 1: Describe the characteristics of different types of provider payment systems

- What are the trade-offs between formula-based vs. flat fees/tariffs?
- Whether and how to add a performance payment?

The breakout group discussion emphasized country level issues with the complexities of fragmented funds flows and noted that any provider payment interventions reducing fragmentation are likely to improve health financing and PFM. Participants also discussed the need for a deeper understanding of formula-based systems. The discussion also highlighted the ability of results-based financing (RBF) to create inroads into improving autonomy, although RBF increases fragmentation and can be integrated into overall provider payment framework. The report out also included how to incorporate HR into payment and facility management, and the benefits associated with its integration into payment mechanisms. The importance of health purchaser or system level financial management was also highlighted, including the need to integrate capacity building and accountants to support the financial management of output-based payment systems, and the importance of interoperability of financial management systems with general country PFM systems. Finally, the report out concluded by reflecting on the importance of adopting a step-by-step approach, and that implementation should always try to take advantage of existing PFM systems.

Group 2: Relationship between health financing and PFM

- How to adapt PFM to output-based payment granting providers autonomy to procure inputs?
- How to adapt and strengthen PFM systems to incorporate service providers into financial operations and internal and external audits?

To successfully adapt PFM to output-based payment granting providers autonomy to procure inputs, the breakout group report out discussed the importance of context. How to adapt requires an understanding of what existing country level PFM systems look like, and the need to adopt an iterative approach and to recognise the importance of sequencing. The reform can be broken into component parts and addressed using a step-by-step process. In addition, the participants highlighted the impact of output-based payments on forecasting methods, and the importance of facilities having access to their own bank account which requires engaging the Treasury and Ministry of Finance. The experience of Rwanda was shared as an example of incorporating service providers into financial operations, here, primary care providers get funds from the budget as well as community-based health insurance funds. This is reflected in the budget, but while these entities use the PFM system it is not as on-budget entities or service units without autonomy.

Group 3: Drugs incorporated into the payment system

- What drugs can be procured by facilities financed directly?
- Where can facilities financed directly buy drugs from? (central medical stores, prime vendor, private wholesalers, retail pharmacies, other)?

The key message reported out from this breakout group was that drugs should be included in financing facilities directly, with most of the discussion focused on the mechanics of including drugs. Experiences from Nigeria, Tanzania and Ghana were shared during the breakout group. In Nigeria incorporating drugs in financing facilities directly improved drug availability and reduced stockouts by allowing facilities to purchase drugs from the private sector that were certified by the National Agency for Food and Drug Administration. Donors can play role in facilitation, enabling the flow of drugs through the supply chain and its systems to certified providers or providing guarantees to the private sector. However, the discussants also noted that for its success a few issues must be addressed, including assuring the quality of drugs, and acknowledging that payment systems must be strengthened as the private sector does not allow provisions for arrears. Finally, there is a need to smooth out procurement and price challenges in a way that balances the advantages of central procurement and inclusion of drug costs in financing facilities directly.

Concluding remarks, Matt Jowett, WHO

Matt Jowett discussed how the policy space on health financing is often dominated by how to establish new agencies and health insurance schemes in LICs. This approach channels public funds outside the system, whereas the proposition of this Global Learning Event is a distinct shift towards working within the existing PFM system.

Financing facilities directly is an alternative way of expanding coverage however Matt highlighted the need for clearer examples of how to operationalise this approach and the need to reflect these discussions in country budget dialogues. Matt summarised the key considerations for implementing output-based payment to providers, the service delivery level flexibility that this approach can provide, and the importance of providing autonomy with regulation for accountability. Finally, caution was raised, Matt highlighted the need to ensure step-by-step approaches are well specified, reflect variation in capacity and avoid creating geographical inequities.

DISCUSSION AREA 3:

Financing facilities directly: facility financial management and accountability

The third session of the Global Learning Event consisted of three sections with a specific focus on facility financial management. First, Gemini Mtei, Abt Associates, delivered a technical presentation on the Tanzania experience of implementing financing facilities directly, followed by a breakout group discussion focused on facility financial management and accountability and finally Benjamin Loevinsohn, GAVI, closed out the session by reflecting on the evidence available.

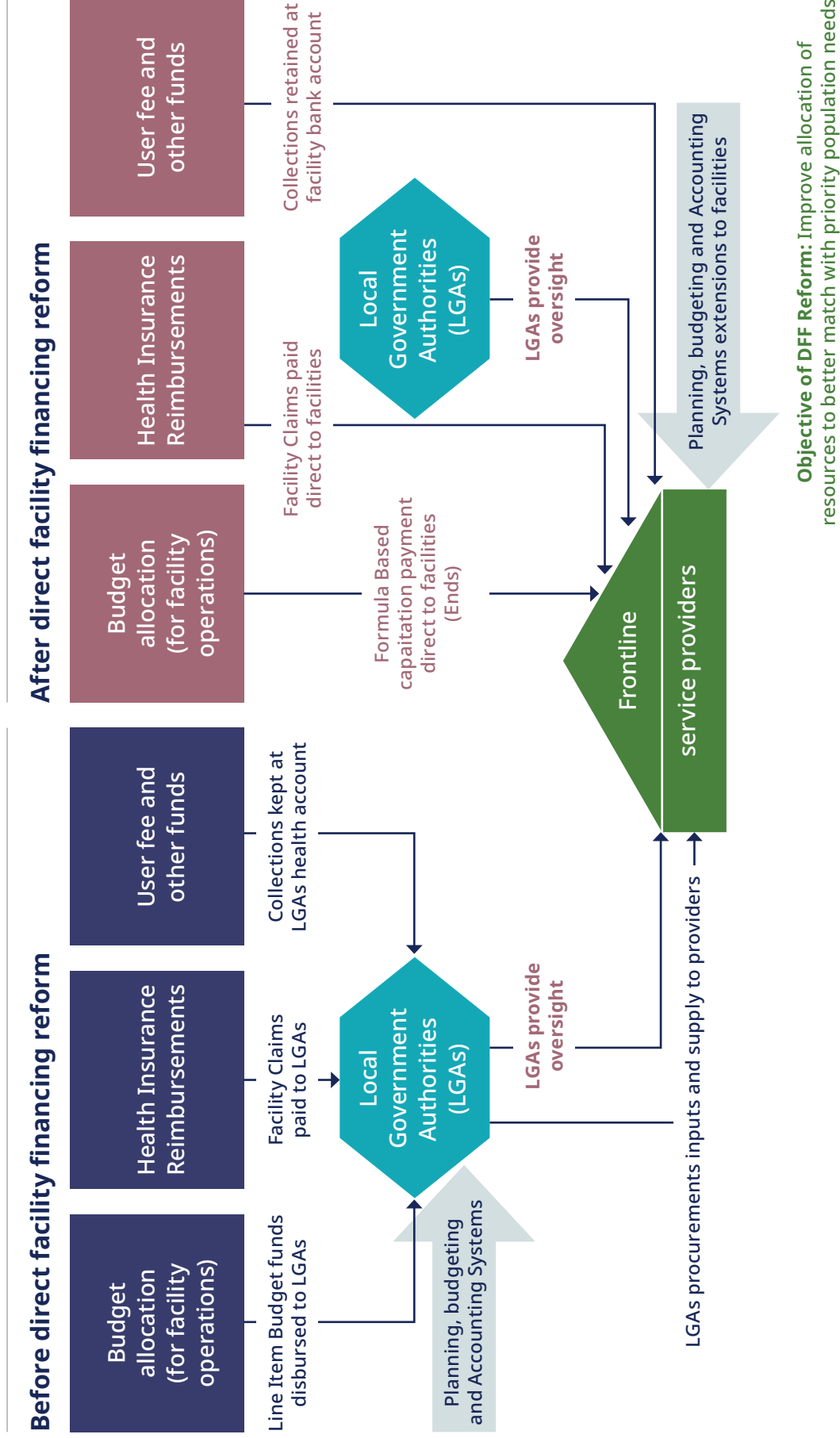
Technical introduction, Gemini Mtei, Abt Associates

Gemini Mtei introduced the session by providing a comprehensive overview of how Tanzania implemented financing facilities directly. This presentation largely focused on the extension of financial management systems to the provider level.

Before financing facilities directly, most health funds in Tanzania would flow from the central budget (including donor budget support), health insurance, and other sources to local government authorities. In addition, planning and budgeting responsibilities ended at the local government level. As a result, front-line providers were not visible within the PFM system and local governments were responsible for procuring inputs which often led to mismatches between priorities and need, a lack of transparency, and delays in delivery.

In 2017, Tanzania adopted financing facilities directly for general revenue budget funds, starting with the education sector and then moving to the health sector. This created autonomy to receive funds at the facility level which opened the door to improving both the system level purchasing function through the introduction of output-based payment systems, and provider management by extending financial management systems to the facility level. Direct facility financing in Tanzania was a cross-sectoral whole system intervention across service providers in both health and education sectors. The first entry point for implementation included formally recognizing service providers in the country chart of accounts, ensuring facilities were acknowledged as fund managers and spending agents. This led to the mandate of facilities to open a bank account and extension of financial management systems to the facility level.

As part of the implementation, the existing PFM planning, budgeting, and reporting system PlanRep was redesigned for use by all public sectors, converted to web-based, and then extended to each facility, enabling providers to develop their own plans and budgets and increasing their visibility within the PFM system. Using this system, facilities are required to align their plans and budgets with a menu of pre-defined service output options in the system. This also integrated accountability into the process, as facilities are only allocated financing if they produce a plan and budget that is reviewed and approved by higher levels of government.



Alongside extending PFM systems, the reform also included developing and extending Facility Financial Accounting and Reporting System (FFARS), a new accounting system. This accounting system was simple, with one system used across the health sector to account for all funds and the use of standardised templates. This system was rolled out to approximately 25,000 facilities (schools and health facilities), and later a mobile application was developed to enable facilities to use accounting systems in remote areas or places with limited interconnectivity. Important to this rollout was the interoperability of PlanRep and FFARS as it reduced the burden on the service provider by removing the need to work with multiple systems.

Gemini also highlighted the importance of a participatory approach during the development process, including involving system developers and end users from the beginning. He also discussed the need for extensive and continuous capacity building and operational user support, and also the importance of the interoperability of systems to increase efficiency, improve management and build trust in the system functionality across central government, local government and providers.

Breakout group discussions

Group 1: Overall governance and HR management

- How to strengthen and empower service provider governance and financial and HR management?
- How to realign roles and relationships of local government/entities (eg districts) and service providers?

Financing facilities directly requires a redistribution of the roles between central government and its ministries, agencies and departments, local government, and service providers. In Group 1 the discussion focused on how to resolve tensions that are potentially implied by the change in health financing and PFM functions and corresponding redistribution of roles and realignment of relationships. Based on country experiences the proposals included creating or redesigning a trust compact with all stakeholders, or a joint agreement on shared goals and ambitions around financing facilities directly. Another proposal was to integrate civil society into health facility committees to strengthen governance and support the dynamic process of redistributing roles and responsibilities. During this process, the group also identified the need to clearly define training requirements associated with the new roles.

Group 2: Facility level planning and budgeting:

- How to extend planning and budgeting systems to the provider level?
- How to support and build the capacity of provider management in planning and budgeting?

In Group 2, two key issues were raised, the first was the need for simple systems with minimal fragmentation and the second was stressing the importance of context when extending systems including extension to areas and facilities with limited information technology (IT) infrastructure access. The need for stewardship from the Treasury or the Ministry of Finance was discussed, examples from India were highlighted where the central treasury prioritises Integrated Financial Management Information Systems

(IFMIS) systems, meanwhile different planning systems exist across the country which can create fragmentation and challenges. It is therefore important for the Treasury to prioritise adopting a standardized or harmonized system that can speak to the facility level. This avoids creating challenges when consolidating planning and budgeting data and processes. Finally, the discussion highlighted the importance of capacity building particularly as the capacity to plan and budget is limited for many facilities.

Group 3: Facility level accounting and financial reporting:

- How to extend accounting and financial reporting systems to the provider level?
- How to support and build the capacity of provider management in accounting and financial reporting?

Group 3 stressed the need to take financial accounting for revenues and expenditures seriously as it is key to both financial management and service delivery. However systems can be simple and adapted to facility capacity and processes don't have to be fragmented, complicated or burdensome. In addition, there is evidence that facilities are motivated and able to use their money well even if accounting systems are still developing. Overall, for the success of extending these systems, there needs to be a mentality shift and to acknowledge that day-to-day operational issues will emerge, however, this is true for most organisations. The focus should be on continuous improvement, ensuring that the extension of accounting and financial reporting is moving forward, and that facilities are using data to improve their internal management as well as for external financial reporting. As part of the process, it is important to understand the financial management skills required for provider management.

The discussion stressed the need to recognise that facilities are capable of undertaking these financial management systems and roles which then leads to a shift in the role of higher government levels from day-to-day control to user support and oversight. The topic of facility staff workload is complex and should be unpacked in each environment to assess the existing administrative and financial management level of effort, increases in workload of extending financial management to facility level in the context of service delivery improvements, staff capacity, and efficiency gains or productivity improvements including those resulting from strengthened and interoperable systems.

Concluding remarks, Benjamin Loevinsohn, Gavi

Benjamin Loevinsohn, Gavi, closed the third session by highlighting the results financing facilities directly can achieve. The purpose of his remarks was to bring forward the benefits demonstrated through evaluations. The first takeaway, based on randomised trials, is that facilities that received direct financing were distinctly different from those that were not financed through this approach. Facilities that received financing directly experienced improvements in patient utilization, increased quality of care, increased outreach activities, and improved physical infrastructure of facilities. However, other randomised control trials, for example, Health Results Innovation Trust Fund (HRITF) reviews showed more mixed results, so more work is required to understand the impacts. There are other experiences to draw from which may be useful as these conversations progress, including the large-scale experience in India.

The remarks also highlighted the health worker's perspective, which can be lost. Financing facilities directly enables health workers to decide how money gets spent, thereby increasing their autonomy and decision space. This autonomy can help to improve health workers' morale leading to improved service delivery.

Benjamin also discussed how accountability and related mechanisms change as part of the shift to financing facilities directly. Previously at the facility level, it was easier for providers to push back on assessments of poor performance given their little control over resources, however, under this approach the discussion can shift from a blame game to a more productive conversation on accountability and outputs. Furthermore, community engagement, particularly facility health committees, is strengthened as now resources are tied to the conversation which generates more interest from the community.

FINAL CONCLUDING REMARKS

Hélène Barroy provided some final remarks summarizing her 5 key takeaways from the Global Learning Event.

Takeaway 1: **Financing facilities directly breaks with traditional practice** as it requires a foundational transformation of existing PFM systems and a shift in mentality. Before financing facilities directly, the local government received funding and facilities were not visible in the PFM systems, leaving minimal decision space for facilities.

Takeaway 2: **This approach is where strategic purchasing and PFM intersect.** Traditionally strategic purchasing was conceptualised as something outside national domestic PFM systems, however, through this approach, financing facilities directly is now a purchasing mechanism operating within PFM systems to use public funding to purchase services, expand coverage, and move towards UHC.

Takeaway 3: **The focus is not on changing the legal status of facilities, but instead to work within the existing PFM systems and rules to adapt the level or the degree of operational autonomy** and flexibility of providers, together with improvements in financial management and accountability.

Takeaway 4: **Financing facilities directly can be good for the balance of service/program improvement and financial risk management.** This approach reduces the number of layers and steps in the expenditure chain which can reduce the misuse of funds. In some countries, there is a need for further dialogue between finance and health to reach this consensus, develop explicit steps (e.g. revise guidelines, incorporate service providers in internal and external audit), and build trust before seeing risk management benefits. But overall, financing facilities directly can support the shift from input controls to output-based accountability, and fiduciary risk management.

Takeaway 5: **This is about domestic systems, in some instances, donors can help support and be a catalyst for this change** but this process is focused on domestic systems, and the approach is embedded within PFM rules.

Joe Kutzin provided final thoughts to close the Global Learning event. First, Joe highlighted (as others did), that this is not a radical idea, in practice, it is an approach to widen the service delivery decision-making space of facilities and to re-emphasise Sheila's point of letting managers manage. Therefore, financial facilities directly does not need to be overly complicated, and Joe stressed that it is best to start with relatively easy implementation steps or adaptations. Overall, financing facilities directly is not a magic bullet, but it is about facilitating the direction of travel away from rigid controls and towards flexibility and accountability for service delivery management and making better use of budget funds for effective change.

