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ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/khsr20

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To cite this article: Peter Binyaruka, John Maiba, Dastan Mshana, Agnes Gatome-Munyua & Gemini Mtei (2024) Does Provider Autonomy Work Well in Tanzania? Perspectives of Primary Care Facilities on Budget Execution under Direct Facility Financing and Factors Affecting Provider Autonomy in Singida Region, Health Systems & Reform, 10:3, 2432043, DOI: 10.1080/23288604.2024.2432043

To link to this article: https://doi.org/10.1080/23288604.2024.2432043

Published online: 09 Dec 2024.

HEALTH SYSTEMS & REFORM
2024, VOL. 10, NO. 3, 2432043
https://doi.org/10.1080/23288604.2024.2432043

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COUNTRY EXPERIENCES IMPLEMENTING OBJECTIVE-ORIENTED REFORMS

Does Provider Autonomy Work Well in Tanzania? Perspectives of Primary Care Facilities on Budget Execution under Direct Facility Financing and Factors Affecting Provider Autonomy in Singida Region

Peter Binyaruka[a], John Maiba[a], Dastan Mshana[b], Agnes Gatome-Munyua[c], and Gemini Mtei[d]

[a]Department of Health System, Impact Evaluation, and Policy, Ifakara Health Institute, Dar es Salaam, Tanzania; [b]Health Services, President's Office - Regional Administration and Local Government (PORALG), Dodoma, Tanzania; [c]Health Portfolio, Results for Development (R4D), Nairobi, Kenya; [d]Abt Global (Formally Abt Associates), USAID Public Sector Systems Strengthening Plus (PS3+), Dar es Salaam, Tanzania

ABSTRACT

Primary care facilities' autonomy and the factors that influence it are understudied. Direct facility financing (DFF) is gaining popularity in low- and middle-income countries as a modality to finance primary care facilities. Tanzania has introduced DFF with the objectives of streamlining resource allocation, fostering fiscal decentralization, and granting autonomy to health facilities for enhanced service readiness and responsiveness. This study aims to contribute evidence on primary care facilities' autonomy to execute DFF funds and the factors influencing this autonomy.

Qualitative interviews and group discussions were conducted with health workers, managers, and community representatives from two councils to understand their perceptions of the autonomy of primary care facilities under DFF and remaining bottlenecks to effective budget execution. Data were analyzed using thematic content analysis to explore factors that influence facility autonomy to execute DFF funds.

Primary care facilities are well informed on financial management and have adequate autonomy to execute DFF funds. However, several factors constrain their autonomy, including delays in funds disbursement, complex procurement and approval processes, rigid spending caps, restrictions on reallocations, and weaknesses in financial management capacity.

DFF is a promising modality for health financing that supports health system goals. However, various challenges continue to hinder the autonomy of frontline service providers to fully execute DFF funds. To improve DFF budget execution, policy makers in Tanzania and elsewhere should consider reforms to better align public financial management and health financing.

ARTICLE HISTORY
Received 4 June 2024
Revised 13 November 2024
Accepted 15 November 2024

KEYWORDS
Budget execution; DFF; facility financing; provider autonomy; Tanzania

Introduction

Assuring public access to primary health care (PHC) is a cornerstone of universal health coverage (UHC) policies in many low-income countries (LICs) and lower-middle-income countries (LMICs).[1] PHC encompasses a range of cost-effective interventions delivered close to the community. Despite many stated commitments to PHC, it remains chronically underfunded, often superseded by hospital care.[1,2] Policy makers in LICs and LMICs have explored various financing models and strategies to facilitate the flow of resources to primary care facilities to enhance the provision of PHC services.

One such strategy is direct facility financing (DFF), which involves transferring funds directly to health facilities to overcome bureaucratic bottlenecks at the subnational level.[3] This approach expands PHC providers' financial autonomy by enabling them to select and procure the optimal mix of resources needed to provide health services for their communities. The expectation is that financial autonomy should thereby enhance service readiness, responsiveness, and overall delivery of PHC.[1,4,5]

While DFF has been implemented in different ways in various LICs and LMICs, all DFF strategies are built on similar principles: (1) facilitate the flow of resources, (2) expand provider autonomy to allocate and use public funds, (3) use output-based payments to link resources to services, and (4) improve facility financial management.[4,6–8] Implementing DFF usually requires other policy reforms to public financial management (PFM) systems to allow the direct transfer of public funds into health facilities' bank accounts. This entails including health facilities as accounting units in order to receive public resources directly, and strengthening their capacity to manage and account for public funds and adhere to PFM rules.[6] Facilities may receive funding

CONTACT Gemini Mtei gemini.mtei@gmail.com

This article has been corrected with minor changes. These changes do not impact the academic content of the article.

directly from centralized or decentralized operational grants from the government budget (which may or may not include pooled on-budget donor funds).[8–12]

Evidence shows that effective and efficient use of health resources to deliver priority services requires both strong alignment between health financing policies and PFM rules and providing financial autonomy for facilities, so they can make decisions on how to use resources to meet local priorities.[13,14] DFF is intended to reduce administrative delays and inefficiencies in resource allocation while fostering fiscal decentralization.[4,6,8,15] However, simply sending money directly to facility bank accounts does not lead to improved service delivery if facilities do not have enough authority to make decisions on executing the allocated financial resources.

In Tanzania, an East African LMIC, DFF was introduced as a system-wide intervention to address bottlenecks that impeded resources from reaching frontline primary care facilities and to expand primary care facilities' decision space to execute (or use) these resources effectively. Budget execution refers to the rules and processes that govern how the budget is implemented.[16] Typically, underspending or overspending by 15% or more of the allocated budget is considered poor execution.[16] Provider autonomy in budget *execution* is thus a key principle for DFF in Tanzania.[3] Giving primary care facilities the authority to manage their financial resources has the potential to increase transparency, reinforce accountability, and foster greater responsiveness to the needs and preferences of patients and communities.

Primary care facilities' perceptions of financial autonomy and the factors that influence it are understudied. This study aimed to begin filling this evidence gap. The objective of this study was to understand the perceptions of primary care facilities' regarding the factors that constrain provider autonomy in the implementation of DFF in Tanzania. As part of the special issue on "objective-oriented health system reforms," it sought to assess whether provider autonomy is sufficient to attain the objectives of Tanzania's DFF. These were to: (1) improve the structural quality of maternal and child health services; (2) increase accountability and improve governance in the health system at the primary care facility level; (3) increase health system responsiveness for patients who receive health care at health facilities; and, (4) improve health-seeking behavior and service utilization at primary care facilities, to avoid bypassing primary care.[12,17,18]

According to the theory of change proposed by Kapologwe et al.,[10] shown in Figure 1, increasing facility financial autonomy was an important intermediate objective to realizing the intended outcomes for DFF.[12] By providing PHC facilities with direct financial resources and autonomy to manage and use funds, DFF is a "means" to reach the objectives of efficient allocation of resources and procurement of required inputs to deliver health services needed by the population.[4,6]

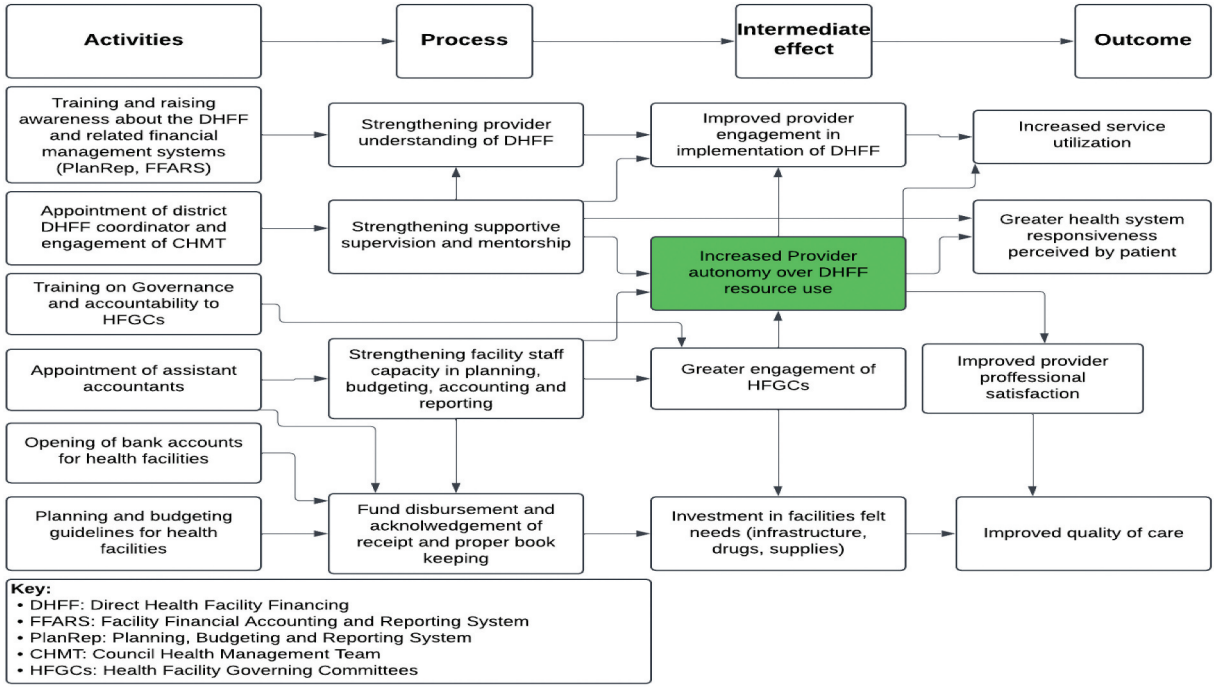


Figure 1. Theory of change for the DFF program in Tanzania. Source: Adapted from Kapologwe, et al.[10]

Bottlenecks to resources flowing to primary care facilities and inadequate provider autonomy are health system underperformance challenges being faced by many LMICs. While this paper focuses on Tanzania's experiences, it provides evidence that can inform policy design and implementation for more efficient use of health resources in many places.

Direct Facility Financing in Tanzania

Tanzania introduced DFF in fiscal year 2017/18 to ensure timely disbursement of funds to frontline primary care facilities and empower them with the autonomy to improve performance and service delivery.[6] Before DFF, budgeting, planning, and execution of primary care facilities funds in Tanzania was implemented by council-level administrations (shown on the left side of Figure 2).[15,19] Under that system, primary care facilities lacked direct access to financial resources and lacked autonomy to decide how to use available resources.[20] Revenue collected at primary care facilities from user fees and insurance reimbursements were all channeled into the council bank account. In practice, minimal resources reached primary care facilities, often after delays. In addition, the resources that were disbursed often failed to match individual facilities' needs, causing further delays in the implementation of health interventions and significantly contributing to poor quality in health service delivery.[15]

Tanzania initiated the DFF modality nationwide by transferring on-budget donor funds pooled in the Health Basket Funds (HBF) and reimbursements from the National Health Insurance Fund (NHIF) and improved Community Health Fund (iCHF) directly to health facilities' bank accounts (shown on the right side of Figure 2).[18,19,21] DFF was utilized only for funds used to cover facility operating expenses, accounting for about 15–20% of total facility expenditure. It excluded salaries (accounting for about 80% of total facility expenditure)[22] and funds earmarked for capital investments.

There is a growing body of literature demonstrating the positive effects of DFF in Tanzania in several areas, including financial management, service utilization, accountability and functioning of health facility governing committees (HFGCs), availability of health commodities, strengthening financial management systems, and overall health system performance.[5,7,20,21,23–25] Studies have also assessed the political economy of introducing DFF, how DFF aligns with strategic purchasing principles, implementation progress, and the acceptability of DFF in Tanzania.[18,26–28] Outside Tanzania, the evidence base regarding the impact of DFF on various dimensions of health systems remains limited,[4,9,10,19] although a few studies have compared DFF with performance-based financing.[4,7,8,29] The current evidence based on DFF lacks assessments of two key topics: facility performance on budget execution, and

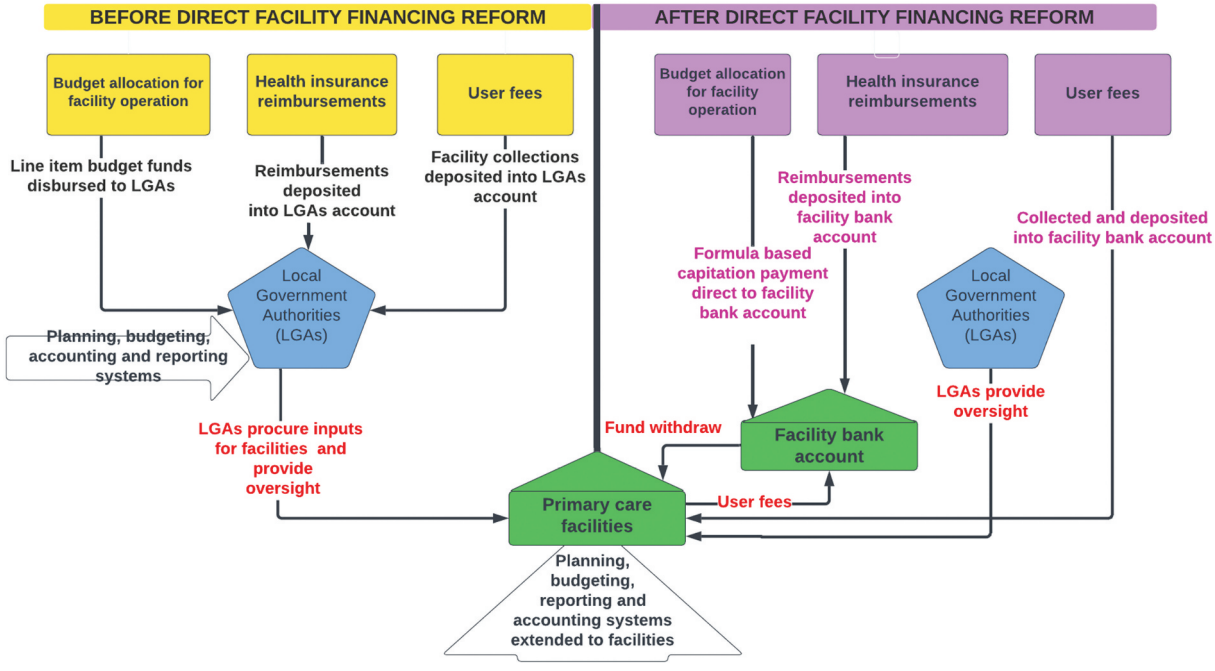


Figure 2. Fund flows to primary care facilities before and after the introduction of direct facility financing.

whether facilities have enough autonomy to execute DFF funds as a necessary principle for the effective implementation of DFF.

Evidence from other contexts shows that effective and efficient use of health financing resources requires health financing policies and PFM rules and regulations to be well aligned in order to provide space for facilities to make decisions.[13,14] Simply disbursing funds directly to a facility's bank account does not lead to improved service delivery if the facility lacks sufficient decision space to prioritize how to utilize the funds based on local needs. Hence, facility autonomy is key to better functioning DFF reform.[30,31] This study makes the linkage that budget execution is facilitated by provider autonomy, defined as having the decision space to receive, manage, and make independent decisions to use funds, without being unduly constrained by financial management and procurement rules. The definition of autonomy used in this study goes beyond financial autonomy (i.e. the level of control that facilities have to mobilize, allocate, and spend funds)—it also extends to include the levels of control and influence that facilities have over key functions, including financial management and procurement.[32]

The objectives of this study were: (1) to assess primary care facilities' autonomy in decision-making for executing DFF funds, and (2) to identify factors influencing their autonomy to execute the DFF funds disbursed to their bank accounts. Primary care facilities were defined as dispensaries, health centers, and council hospitals. The main questions that this study explored were: (1) What are the general perceptions of provider autonomy under DFF? (2) What are the factors that influence primary care facilities' ability to fully execute DFF funds? As background, this study also presents trends in DFF budget execution across primary care facilities in the study region between 2017 and 2023—this data provides a basis for assessing whether budget execution improved.

Methodology

The study was conducted in Singida region of central Tanzania. Singida was selected because it is similar to most Tanzanian regions (beyond the capital and a few other large cities). It has a mix of rural and urban councils, allowing the study to capture perspectives from health facility managers in various contexts. Singida has had relatively few donor-led interventions compared with other regions, enabling the study to focus on DFF implementation.

Study Design and Data Collection

This qualitative study sought to understand health facility and council managers' general perceptions of provider autonomy under DFF and to explore factors that influence the autonomy of primary care facilities to fully execute DFF funds. Data were collected from two purposively selected district councils: the urban Singida Municipal Council and the rural Singida District Council. In collaboration with council health managers, three public primary care facilities were sampled in each council: a council hospital (which are considered primary care facilities in Tanzania), a health center, and a dispensary. Qualitative data were collected through in-depth interviews (IDIs) and focus group discussions (FGDs) (Table 1). The IDIs were conducted with 16 stakeholders with professional experience of DFF implementation at either council or facility level. The FGDs were conducted with the members of four HFGCs.

Semi-structured interview guides were used to focus data collection on the respondents' perceptions of facilities' autonomy to execute DFF funds and the factors that affect it. The interviews and group discussions were conducted in Swahili by two researchers (one serving as interviewer and one as note-taker). All interviews and discussions were conducted in January 2024, and all participants provided informed consent.

Table 1. Study participants at municipal, district, and PHC facility levels.

Method	Study participants	Singida Municipal Council	Singida District Council	Sample (n)
In-depth Interview (IDI)	District Health Secretary (DHS)	1	1	2
	District Medical Officer (DMOs)	1	1	2
	DFF coordinator	1	1	2
	District pharmacist	1	1	2
	Facility in-charge (3 facilities)	3	3	6
	Facility accountant	1	1	2
				n = 16
Focus Group Discussion (FGD)	Health Facility Governing Committee (HFGC)	2	2	4
				n = 4
	Total (IDIs + FGDs)	**10**	**10**	**N = 20**

Data Analysis

Each IDI and FGD was audio recorded. The audio recordings from the IDIs and FGDs were transcribed by research assistants and then translated into English. A senior investigator cross-checked the translated transcripts against both the recordings and the Swahili transcripts to ensure accuracy and consistency. The data were then analyzed thematically. Coding involved reading all transcripts and aligning text within pre-identified themes. The qualitative analysis was conducted using NVivo, version 14.

Limitations

The study's geographical focus on two councils may limit generalizability. However, the sample of primary care facilities in Singida likely reflects those in most Tanzanian regions, as they all utilize the same disbursement and coordination mechanisms. The study was not able to identify the reasons for HBF fluctuations or trends in budget execution rates—these could be areas for future studies.

Results

Direct Facility Financing Implementation in Singida Region

Singida, one of the 26 regions in mainland Tanzania, has a population of 2,008,058.[33] The region has 282 public and private health facilities, including 229 dispensaries, 30 health centers, and 23 hospitals. The region's performance on health service delivery indicators is similar to the national average; for example, 78% of women delivered in health facilities (compared to 81% nationally) and 59.7% attended at least four antenatal care visits (compared to 65% nationally).[34]

In terms of health financing, the HBF accounts for the largest proportion of health facilities' revenue in Singida region, accounting for approximately 61% of total revenue (Figure 3). The share of HBF increased from 62.5% in 2017/18 to 68.1% 2019/20, followed by a decline to 50.7% in 2022/23. This decrease in Singida region is consistent with the national trend in total donor financing to the health sector: the share of donor financing in current health expenditure (CHE) decreased from 34% in 2017/18 to 23% in 2021/22.[35,36] The decreases in HBF are larger compared to those from other sources of external donor health budget support. As the share of HBF revenue declines, facilities are increasingly depending on direct out-of-pocket payments as a source of revenue. The proportion of revenue from user fees in Singida region increased over the period under consideration, from 4.7% in 2017/18 to 27.6% in 2022/23. The increase in the share of out-of-pocket payments is also related to decreases in iCHF coverage during the period; membership in the health insurance program decreased, from 25% in 2017/18 to 5% in 2022, as a result of the iCHF redesign and increased premium contributions.[37]

The absolute budget amounts for DFF-HBF disbursed to health facilities' bank accounts in Singida region also declined over time, from USD 996,032 in FY 2017/18 to USD 837,302 in FY 2022/23 (Figure 4). Overall facility spending decreased as well, from USD 936,508 in 2017/18 to USD 686,508

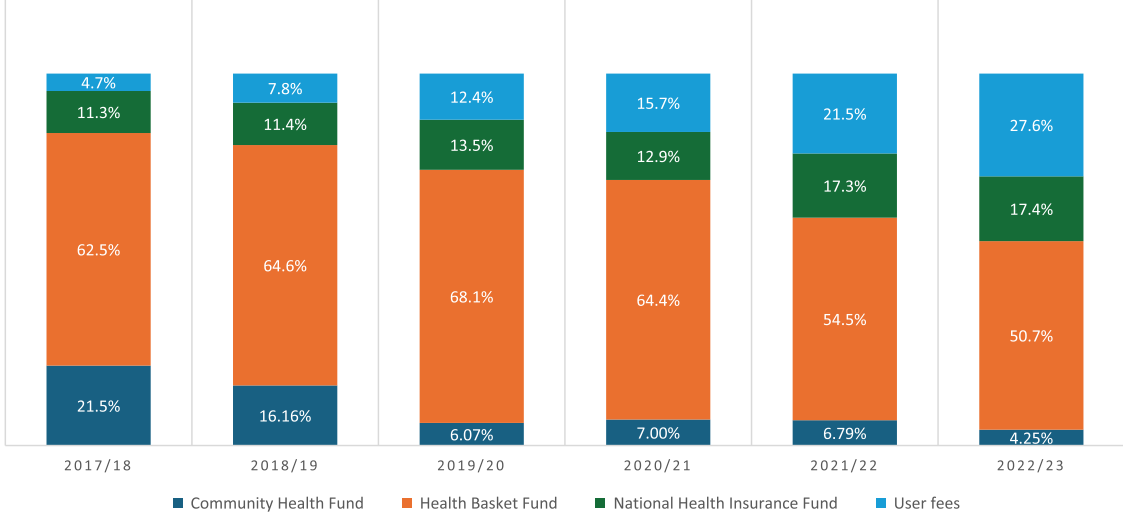
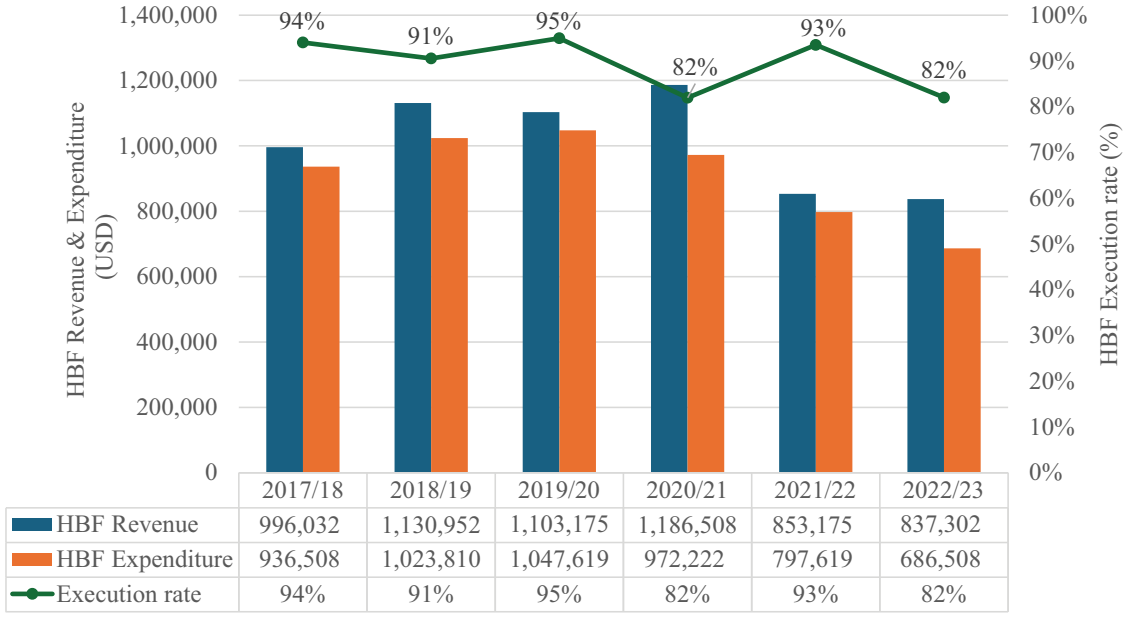


Figure 3. Composition of facility revenue in Singida region, FYs 2017/18-2022/23.



	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
HBF Revenue	996,032	1,130,952	1,103,175	1,186,508	853,175	837,302
HBF Expenditure	936,508	1,023,810	1,047,619	972,222	797,619	686,508
Execution rate	94%	91%	95%	82%	93%	82%

Figure 4. Budget execution of DFF-HBF in Singida Region, FYs 2017/18-2022/23.

in FY 2022/23. The budget execution rates fluctuated during this period, with a high of 95% in FY 2019/20 and a low of 82% in FYs 2020/21 and 2022/23.

Budget execution varied across facilities, as well as over time. In FY 2022/23, for example, it ranged from 24% to 100% (Figure 5). The variation in budget execution across the 282 facilities, indicates that some facilities struggle to utilize their autonomy to access and fully execute the disbursed budget funds.

The execution rate of DFF-HBF funds by council hospitals, average of 95% (range: 81–100%) during

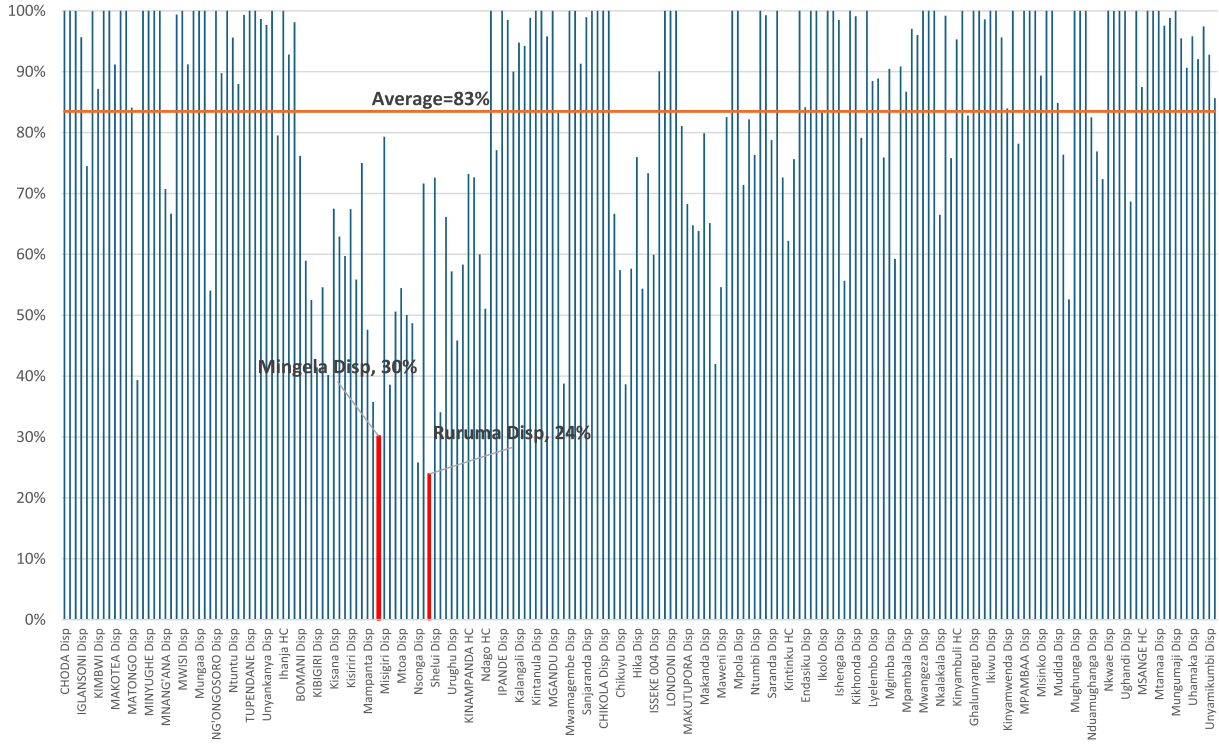
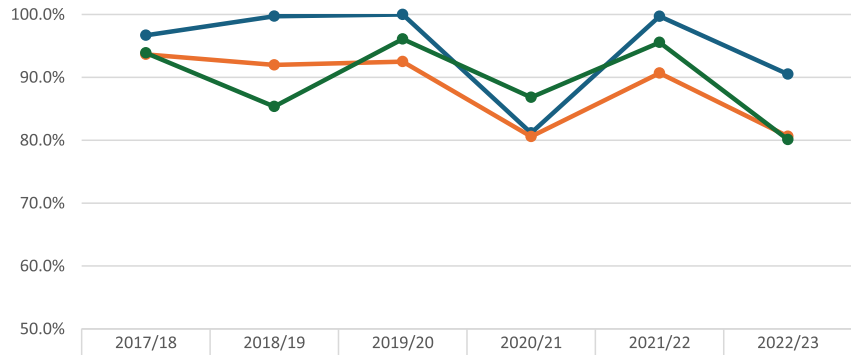


Figure 5. Budget execution rates at Singida region primary care facilities, FY 2022/23.



	2017/18	2018/19	2019/20	2020/21	2021/22	2022/23
Council Hospitals	96.7%	99.7%	100.0%	81.2%	99.7%	90.5%
Dispensaries	93.7%	92.0%	92.5%	80.6%	90.7%	80.6%
Health Centers	93.9%	85.4%	96.1%	86.8%	95.6%	80.1%

Figure 6. DFF-HBF execution rates by type of facility, FYs 2017/18-2022/23.

the analyzed period, was higher than in health centers, with an average of 90% (range: 80–96%), and dispensaries, with an average of 88% (range: 80–93%) (see Figure 6).

General Perceptions of Provider Autonomy Under DFF

The DFF approach of sending funds directly to primary care facilities' accounts was generally perceived positively by most interviewees. DFF is seen as a tool that empowers health care providers to set priorities and make decisions based on their specific local needs. Council health managers and facility in-charges reported that they have more control over resources and the decision space required to be able to respond to the needs of the populations they serve.

> DFF has facilitated the provision of services by allowing us to respond to health needs quickly and effectively without various bureaucratic processes. Before, we were supposed to request resources from the council, which made the process to be lengthy. [Facility in-charge]

> Currently, there is more control over drug procurement, which has addressed the issue of non-existing purchases of medicine. Previously, providers may have ordered medicine and received something different from what they requested. [DFF Coordinator]

Prior to DFF, a Council Health Management Team (CHMT) was solely in charge of procurement and distribution of medicines and supplies to facilities within the council area. Almost all interviewees reported procurement processes had improved under DFF. Enhanced provider autonomy enables facilities to procure what is needed in their local context with available funds—this has improved services, by reducing medicine stock outs.

> In the past, we solely relied on the District Council. There were periods when a facility could go for almost six months without receiving any drugs. Sometimes, facilities received drugs that were about to expire. With the introduction of the DFF, the situation has significantly improved. Funds are now allocated directly to the facility, enabling us to plan and order drugs independently. With our budget, we can procure medicines externally. [Facility in-charge]

> There are changes in the intervals for ordering medicines compared to before, as you used to order medicines for a specific month. Now, at least every two months, we request medicines, anticipating the depletion of our stock. The orders are timelier, and there has been a significant improvement. [Facility in-charge]

However, others reported different experiences. For instance, one council health manager said that implementation of DFF had been rushed and that implementation was weak due to lack of staff capacity to manage the funds.

> Facilities may face a scarcity of staff, and when funds arrive it increases the workload to available staff. This situation forces the facility in-charge to focus on financial issues rather than providing treatment. [District Medical Officer, DMO]

Factors Affecting Primary Care facilities' Autonomy to Execute DFF Funds

Most council health managers and facility in-charges considered DFF to be a beneficial initiative that has increased their autonomy to make decisions on use of funds. However, five main challenges were identified, which curtail provider autonomy to fully execute funds that are deposited into their facility bank accounts: (1) delays in DFF funds disbursement; (2) complex procurement and spending approval processes; (3) rigid spending caps for some budget items; (4) restrictions

on reallocations (within and between budgets); and (5) financial management capacity among health workers. These five complex and overlapping factors constrain smooth and comprehensive budget execution at facilities receiving HBF funds through DFF:

Delays in DFF Funds Disbursement

Almost all council managers and facility in-charges interviewed reported that they had experienced delays in the disbursements of HBF funds from the Central Treasury—this resulted in the facilities' failure to fully spend funds that had been deposited into the bank accounts within the financial year. In some cases, these delays had extended for more than a quarter.

> For example, the HBF was supposed to be disbursed in December, but it has been delayed. As a result, it came for two quarters instead of just one, hence some of the planned activities will be delayed. [Facility in-charge]

Delays in DFF fund disbursement exert pressure on fund utilization, particularly toward the end of the financial year. This can limit the execution of planned activities and impose constraints on service delivery.

> You may find that there's only one or two weeks left before the year ends, and that's when you find the funds for two quarters coming in. What happens there: facilities are told that the funds should not overflow. It means they have to struggle to finish those funds before they expire, which adds significant pressure to spend those funds. [District Pharmacist]

> Delays in disbursement of DFF funds affects us by almost 70%... the delay in funds largely inhibits the procurement of drugs, leading to shortage of drugs in some quarters. [Facility in-charge]

Complex Procurement and Spending Approval Processes

Interviewees reported the procurement process has significantly improved with DFF but is still a lengthy process. The procurement guidelines for medicines, for example, require that facilities must procure drugs and medical supplies from the national Medical Stores Department (MSD). Facilities only have the autonomy to procure from outside MSD if the requested materials are out of stock and MSD has issued out-of-stock notifications to facilities. Interviewees reported that MSD frequently delays issuing its out-of-stock notifications, constraining facilities' capacity to procure medicines from elsewhere using DFF funds.

> We often delay getting out-of-stock notifications from the MSD, exceeding the standard fourteen-day waiting period, which creates some challenges in timely procurement from other source (e.g., Prime Vendor). [Facility in-charge]

> Sometimes, even if you submit the order to MSD, they may not have the items (out of stock), where they can either provide an "out of stock" notification or ask you to wait for some items. According to the law, you should wait for fourteen days. However, even after those fourteen days, [MSD] might not have procured the items because they are still in the process of sourcing them. So, the challenge is that you have the money to procure outside MSD, but you cannot use for drug procurement in the absence of an "out of stock" notification from the MSD. [Facility in-charge]

Primary care facilities follow a structured approval process for budget execution. Before any expenditures can occur, the facility in-charge organizes a meeting with the HFGC to inform them of the amount of funding received and review a list of proposed items for purchase. Once the HFGC approves the list, but before initiating the procurement, the facility in-charge must travel to the council headquarters to discuss the list with the council procurement officer. Once the council procurement officer agrees, the facility in-charge prepares payment vouchers. Procurement above certain threshold amounts requires approval from the council health manager or council executive director prior to spending. The thresholds are set at: one million Tanzanian Shillings (TZS) (USD 397) for dispensaries, TZS two million (USD 794) for health centers, and TZS three million (USD 1,190) for hospitals (n.b., the exchange rate at the time of data collection in January 2024, was 1 USD = 2,520 TZS).

> Things related to procurement require me to go to the district council and meet with the procurement officer to discuss and guide me. Although I am aware of what needs to be done, I must approach the procurement officer because some pre-approved suppliers are in systems, and not every supplier is government-approved. I can't just initiate the process myself. Therefore, I have to leave here and go to the district council, which costs time and makes me absent at work. [Facility in-charge]

Rigid Spending Caps Imposed by Predefined Spending Ceilings

Currently, facilities are required to spend up to 35% of HBF on medicines and other medical supplies and use the remaining funds to cover facility operational activities (such as outreach, utilities, or allowances). Facilities do not have the flexibility to independently reallocate funds beyond predefined ceilings. Most respondents were aware of the established spending guidelines, especially for health commodities.

> The guidelines state that 35% of the health basket funds should be allocated for the procurement of health commodities. . .out of this, 50% should be spent on medicine, 15% on equipment, 10% on supplies, 10% on dental supplies, 10% on laboratory reagents, and 5% on items for planned preventive maintenance. [DFF Coordinator]

Respondents raised concerns that these guidelines limit facilities' autonomy.

> You may find that when the ceiling is reached, it restricts spending any amount beyond the pre-stated spending guidelines until reallocation (at the mid-year) is done. It does control finances, but it restricts meeting any additional or emerging needs that you have. [Facility in-charge]

The inflexibility created both by the restrictions and by the bureaucratic approval processes required for reallocation limit facilities' ability to respond promptly to emerging needs and utilize additional resources efficiently.

Restrictions on Reallocation within and Between Budgets

Most participants agreed that reallocation within a budget was quicker than between different budgets. Budget reallocation within approved budget-line items is permitted upon approval by CHMT and the President's Office Regional Administration and Local Government (PORALG). Reallocation between budgets, on the other hand, is conducted in the middle of the financial year and requires additional approvals for supplementary budgets by CHMT and the Ministry of Finance.

Facility in-charges viewed this policy as a potential constraint to responding to emergencies.

> Reallocation is a challenge sometimes. For instance, we did it in December (after six months). But if you encounter an emergency within six months, you can't do anything, you have to wait until the six months are over. So, that is a significant challenge. [Facility in-charge]

On the other hand, CHMT representatives viewed reallocation requests as indicative of poor planning, except in cases when reallocation is requested for supplementary budgets for additional funds received outside the approved budget. Health managers at council level also saw requests for reallocation as an indication of poor planning.

> Re-allocation has its implications. Why should I engage in re-allocation? Perhaps my planning is poor, unless there is an ad hoc opportunity that has emerged. Your line budget may also be small, or you may reallocate funds from one budget line to another because of the overestimation or underestimation. If you find yourself frequently carrying out re-allocations, it suggests poor planning. [DFF Coordinator]

Interviewees called for more training and targeted supervision on planning and budgeting for health facility in-charges.

Financial Management Capacity

The tasks involved in financial management and procurement are perceived to be a burden for health workers who lack accounting skills. Council health managers and health facility in-charges acknowledged the critical role of the few health accountants who have been placed in health centers and council hospitals: they assist with both financial management and navigating bureaucratic procedures.

Facility in-charges highlighted the importance of receiving capacity building in financial management so that they can efficiently and effectively use the facility financial management system to manage their budgets and procurement. Health workers who lack knowledge and skill in financial management expressed their concerns making errors that further prolong approval and procurement processes.

> We also lack enough knowledge in many aspects of accounting, and we need assistance on how to deal with accounting issues to reduce delays due to errors and procedural challenges. [Facility in-charge]

Discussion

This study explored factors that constrain the autonomy of primary care facilities in Singida region to execute DFF funds. The DFF modality is generally considered acceptable by multiple stakeholders[27] and has been implemented as planned to ensure the direct transfer of funds from multiple sources to frontline primary care providers.[7] The underlying assumption of this study was that even when health facilities have the autonomy to receive funds in their bank accounts and to prioritize planning and budgeting according to population needs, their autonomy may not be fully realized if other barriers to utilization of DFF funds persist.

Findings from this study affirm that the introduction of DFF in Tanzania has reduced bureaucratic barriers in accessing funds and has created decision space for facilities to prioritize delivery of health services based on community needs. Generally, having autonomy to execute DFF funds has been shown to empower health care providers.[32] The experiences from Singida region documented in this study suggest that there have indeed been notable improvements since the introduction of DFF,

particularly in drug procurement using facility resources.[10] These intended effects of DFF are consistent with other studies in Tanzania, Burkina Faso, Kenya and Nigeria.[7,21] In Kenya, the initiative to disburse funds directly to facility bank accounts through the previous health-sector service funds (HSSF) helped to promote transparency, participation of communities in decision-making, and better accountability for funds and results[1–3,38]

This analysis does show some fluctuation in the budget execution rate, and while it was generally stable over time, a negative trend has emerged in recent years. If this trend persists, and especially if the rates fall lower than the required threshold of spending at least 85% of allocated budgets, it may undermine the effectiveness of the DFF modality.[16] Policy makers are advised to carefully track execution rates and to intervene if they fall further.

This study also identified several factors that are still hindering the autonomy of facilities to execute DFF funds: delays in DFF fund disbursement, long and complicated procurement and spending approval processes, low spending caps, the restrictions on reallocation within and between budgets, and the added burden that dealing with financial management and procurement places on health care workers.

Disbursement delays as a constraint on effective facility autonomy is well documented in studies from Tanzania and other countries, including Kenya[11,39] and Ghana.[40] The delays create critical challenges to meeting primary care facilities' needs and executing planned activities as scheduled. The ability of health facilities to execute funds is also affected by complex and inflexible bureaucratic processes in spending or procurement,[31,41] and poor revenue forecasting during the budget process. Previous studies in Tanzania documented lengthy bureaucratic processes required for spending down budgets, including multiple approvals for drug procurement.[42,43] The spending guidelines were generally well known among this study's respondents—this is different from the DFF experience in Kenya,[9] where there was confusion regarding guidelines.

Another positive policy feature in Tanzania is the minimum spending thresholds under which primary care facilities are not required to undergo complex approval processes. However, the requirement to procure medicines and supplies from MSD has created challenges, especially when MSD experiences stockouts but delays issuing out-of-stock notifications. Thus, the availability of medicines remains an ongoing challenge.

Although ceilings, guidelines, and multiple approvals are good practices in budget control and PFM,[44,45] the health facility and council managers interviewed in this study raised concerns about the inflexibility created by these practices. They are perceived as limiting health facilities' ability to respond promptly to emerging needs and to utilize additional resources efficiently. Tanzania's Budget Act requires facilities to spend according to approved line items, only allowing within-budget reallocation to be done once a year upon approval by the Ministry of Finance or its delegated entities. Better alignment between financial management and health financing rules and regulations could facilitate flexibility and autonomy of providers to reallocate funds to address emergent population needs.[13]

The study findings also suggest that Tanzania needs to invest more in building the capacity of PHC facility staff to accurately project budget requirements during planning and budgeting processes (to minimize the need for frequent reallocations), and to manage and execute budgets. Evidence from this and other studies shows limited knowledge on financial management among health care providers in the region.[9,11,21] Before the introduction of DFF, health workers and managers were trained in budgeting, planning, financial management, and using financial and planning systems.[7,28] The current finding that health care providers need additional skills in financial management may be indicative of the limitations of the earlier training or the need for continuous retraining—or both. Finally, while facility in-charges acknowledge that DFF has improved their responsiveness to population health care needs, they need additional financial management capacity to effectively use financial management systems to execute their facilities' budgets.

Policy and Research Implications

DFF has been an important and largely successful reform. However, to fully meet its objectives in Tanzania, providers need even more flexibility to allocate and reallocate resources to address heterogeneous health care needs. This study suggests that immediate policy interventions are needed to bolster the autonomy of primary care facilities to use DFF funds appropriately and in a timely manner. In addition to continuous capacity building in budgeting and financial management skills for health personnel, these efforts should focus on improving the alignment between PFM rules and regulations and the health financing system. Priorities should include simplifying the fund use and approval processes, simplifying the procurement process, and ensuring timely disbursement of funds to reduce pressure in spending at the end of the financial year. Further research is needed to identify

which interventions effectively optimize budget execution and streamline procurement processes to enable improved health care delivery.

Conclusion

This study provides valuable insights into the complexities of DFF design and implementation in Tanzanian health care settings. It affirms that DFF goals remain relevant in Tanzania and offer potential benefits to other LICs and LMICs. However, it also indicates a need to streamline the effectiveness of DFF funds flow and further expand autonomy in budget execution. The study's findings underscore the need for various and multifaceted interventions to enhance adaptive financial management practices and streamline processes to address delays and bureaucratic obstacles to budget execution. Addressing these DFF implementation challenges is crucial for advancing health care delivery and achieving optimal health outcomes in Tanzania.

Acknowledgments

We would like to thank the guest editors of the special issue on objective-oriented health reform for providing valuable inputs to the manuscript. We also thank the officials from PORALG and MOH, all the respondents, and various government officials for their support, which allowed the successful conduct of the research. The authors appreciate the inputs and feedback made by participants in satellite sessions during the Seventh Global Symposium on Health Systems Research, the 15th IHEA World Congress on Health Economics, and a writing workshop held in Nanyuki, Kenya, in February 2024. Further comments and insights on earlier drafts provided by Hélène Barroy, Susan Sparkes, Martin Sabignoso have added greatly to the final product. Additionally, the authors gratefully acknowledge Anya Levy Guyer for her efforts in editing this article.

Disclosure Statement

The author(s) reported that there is no funding associated with the work featured in this article.

Funding

This work was supported by INV-006213 SG001 from Amref Health Africa to Results for Development. Additional funding was provided by the Bill & Melinda Gates Foundation [Grant number: INV-065757] to World Health Organization (WHO). The funding bodies had no role in the study design, data collection and analysis, decision to publish, or preparation of the manuscript.

Author Contributions

GM and AGM conceived and designed the study. PB and JM participated in data collection, extraction and analysis. PB drafted the manuscript. PB, JM, AGM, DM and GM participated in data interpretation and reviewed and approved the final manuscript.

Ethical Approval

Ethical approval was obtained from both an institutional and a national ethics committee in Tanzania. The institutional ethical approval is from the Ifakara Health Institute (IHI) Ethical Review Board (IHI/IRB/No: 36–2023), and the national ethical permit is from the National Institute for Medical Research (NIMR) Ethical Review Board (NIMR/HQ/R.8a/Vol.IX.4416).

ORCID

Agnes Gatome-Munyua http://orcid.org/0000-0001-8910-4989
Gemini Mtei http://orcid.org/0000-0002-8695-8820

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