Direct facility funding as a potential tool in user fee removal in Kenya

Antony Opwora, Margaret Kabare, Sassy Molyneux, Catherine Goodman
KEMRI-Wellcome Trust

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Introduction

Health user fees damage children's health

The Guardian Newspaper reports that the British government is right to highlight the highly damaging consequences of health user fees.

Although these fees are not the only barrier to accessing healthcare, a wealth of research evidence shows that, when they are introduced, poor people's demand for primary health services falls, and when they are abolished, it

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Gordon Brown leads push to bring free healthcare to tens of millions

Killer bills - Make child poverty history - abolish user fees

world will be given access to free healthcare for the first time under plans to be launched by Britain this

- User fees are a barrier to access, especially for poorer groups, and raise very little revenue (<5%)

- Calls for their removal from both researchers and politicians have led to their abolition or reduction in several countries

Background

- Kenyan government reduced user fees in 2004
- Concerns that the policy reduced facility level funds and involvement of health facility committee (HFC)

Direct Facility Funding (DFF)

- Piloted in Coast Province since 2005 with DANIDA funding, plans underway for nationwide rollout
- Funds transferred directly into facility accounts, administered by HFCs
- Funds can cover operations and maintenance, casual staff, allowances (but not drugs)
- Communities should be empowered to monitor use of funds, e.g. accounts displayed on public notice boards

Aim

- To evaluate DFF implementation and its perceived effects on health facility operations

Methodological Challenges

- No baseline data collected prior to pilot
- HMIS data incomplete & unreliable

Challenges addressed through:

- Focus quantitative analysis on intermediate and process outcomes
- Qualitative methods to explore perceived impact on quality of care and utilization

Methods

- **Data collection in 2007/8, in two districts of Coast Province**

- **Structured survey at 30 government health centres and dispensaries**
  - Interview with facility in-charge
  - Record reviews
  - Exit interviews
- **In-depth interviews in sub-set of 12 facilities**
  - Facility in-charge
  - HFC members
- **In-depth interviews with managers and stakeholders**
  - District level staff
  - Provincial level accountants and health admin staff

Results

Setup and Implementation

- Bank accounts opened by each facility and money transferred regularly
- HFCs met more regularly, produced & implemented work plans
- Accounting procedures followed

DFF Role in Facility Funding

- DFF equivalent to only 13% of total recurrent costs in dispensaries and 2% in health centres
- However, DFF makes up a large share of facility cash income

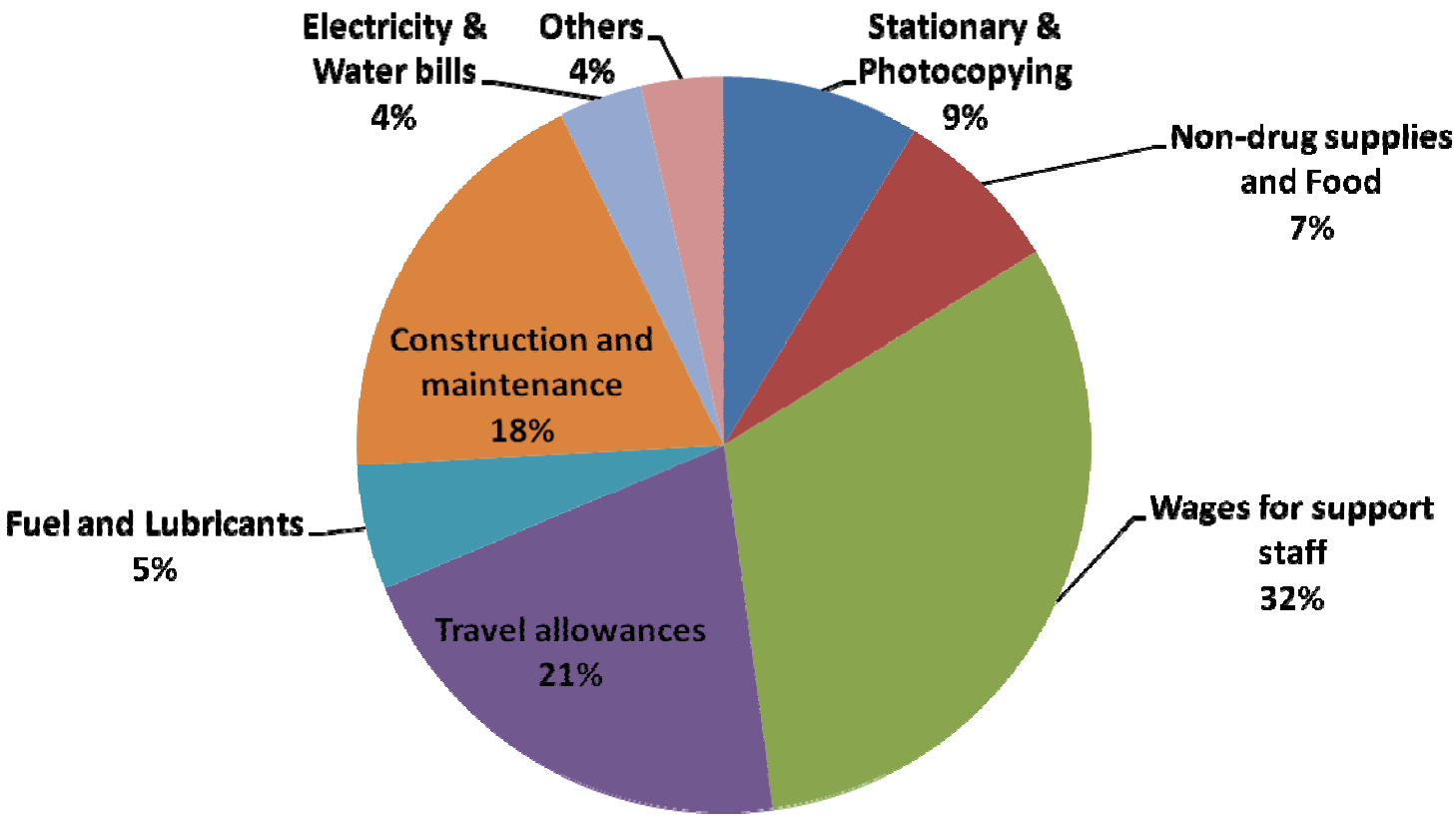
Average annual cash income by source†

Level	DFF	User fees	Other s‡	Total
Dispensary	2,802	959	737	4,498
	62%	22%	16%	100%
Health Centre	4,720	4,838	324	9,882
	47%	49%	4%	100%
All facilities	3,392	2,092	575	6,061
	56%	34%	10%	100%

† July 2006 – June 2007, Figures in US$

‡ Include sale of ITNs, Income generating activities, donations

Expenditure of DFF Income



Achievements of DFF

- DFF perceived by district and local stakeholders to have improved facility utilization, quality of care and staff morale through:

  - Outreach activities
  - Extra support staff: safer and cleaner working environment
  - Improved supplies and drugs availability
  - Payment of staff incentives

" *…. in case of emergency the health worker can hire a vehicle to transport the patient to the district hospital and also get some night out allowance…"* - HFC Member

Challenges

- Inadequate training for HFC members, especially in financial management
- Lack of reference guidelines at facility level
- Community awareness of DFF low
- Tensions between health workers and members of HFCs

"*The chairman and treasurer act as if they are watchdogs of the facility staff. They are stubborn, and are always in the compound monitoring what is happening, thus they are a nuisance"* – Health worker

Incomplete adherence to user fee policy

Health worker reports of fees charged for specific cases (n=30)

Case	Adherent (exc. lab costs)
Child with malaria	22
Adult with malaria	5
Child with pneumonia	20
Adult with pneumonia	23
Adult with TB	22
Adult with gonorrhoea	3
Woman at first ANC visit	28
Mother requiring delivery	30
All above cases	0

Implications for policy and practice

- Small increases in funding controlled at the periphery may have a significant impact on quality of care with the potential to increase utilization
- Training of HFCs is paramount and should include simple and clear manual for HFC members
- DFF can be considered a potential mechanism to compensate facilities if user fees are abolished or reduced
- Must be linked to strategies to ensure adherence to user fee policy