

INTRODUCTION

There is increasing debate over the appropriate way to finance health facilities in developing countries in order to increase quality and utilization. While several countries are experimenting with “pay for performance” mechanisms, they have been criticized for their administrative burden and potential for perverse incentives.

In Kenya an alternative approach has been piloted, termed direct facility funding (DFF), which links funding levels to general indicators of facility size and workload rather than specific output targets. The funds are transferred directly into the facility’s bank account, and a workplan and budget are prepared by the Health Facility Committee (HFC). With the HFC made up of community members and the facility in-charge, DFF has the additional potential advantage of strengthening community involvement in health delivery.

RESEARCH QUESTION

The research evaluates the DFF pilot scheme in the Kenyan Coast Province. It aims to explore the implementation and perceived impact of DFF at health centres and dispensaries.

The focus is on these types of facilities because they are most used by poor rural households, and direct funding mechanisms have not been used before at this level.

METHODS

- Data collection in 2 purposefully selected coast districts
 - Kwale and Tana River
- Structured survey at 30 randomly selected health centres and dispensaries
 - Interviews with the facility in-charge, record reviews and exit interviews (292)
- In depth interviews in a sub-set of 12 purposefully selected facilities
 - Interviews with the facility in-charge and health facility committee members
- In depth interviews with managers and stakeholders
 - Interviews with district staff and other stakeholders



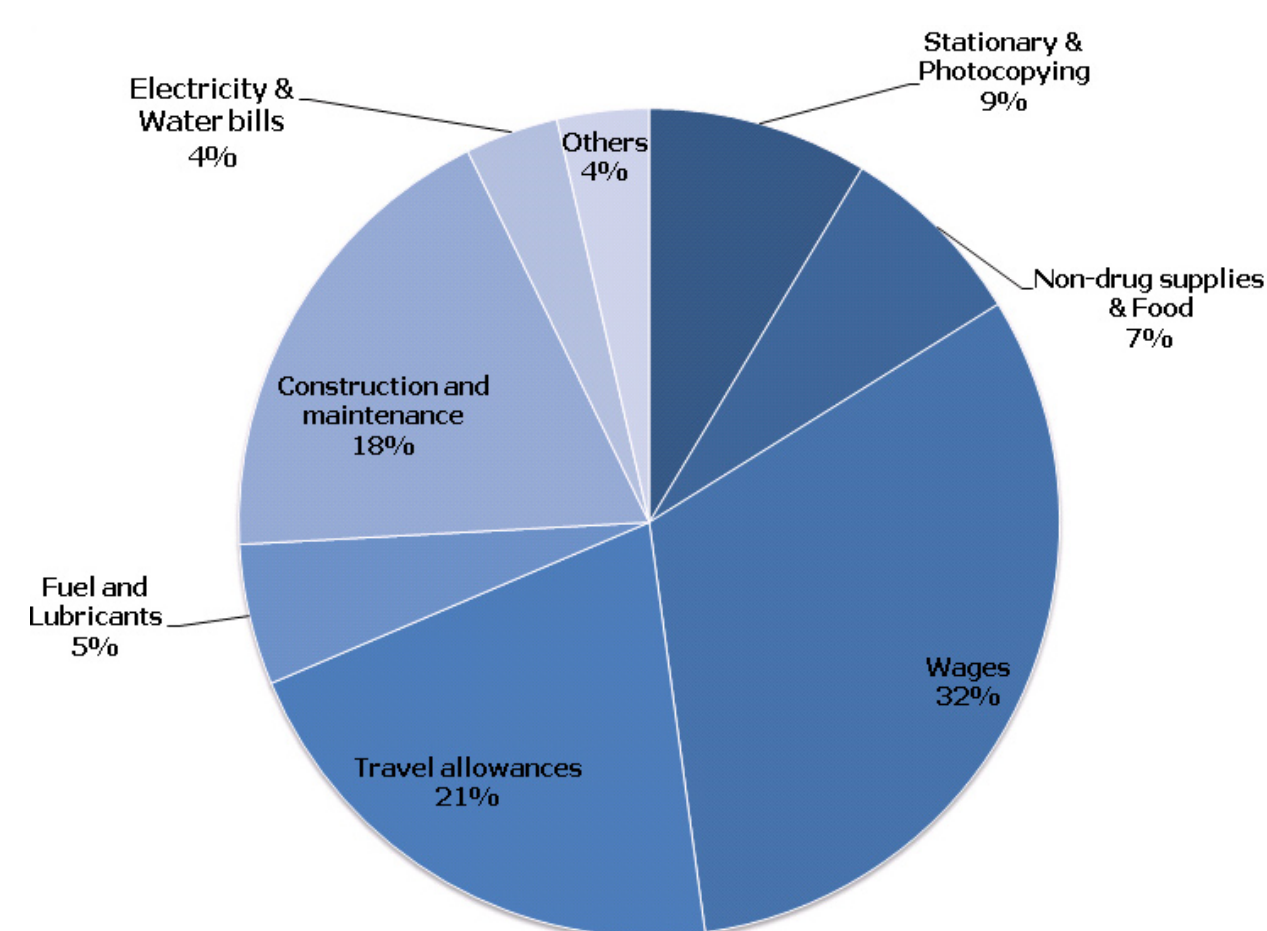
Members of a health facility committee discuss their roles

KEY FINDINGS

DFF EXPENDITURE

- The average annual income from DFF was US\$4,720 and US\$2,802 per health centre and dispensary, respectively. This accounted for an average of 56% of the facilities’ annual income (the remainder being from user fees, insecticide treated nets, income generating activities and donations).
- However, DFF represented a small fraction of the total costs, being equivalent to only 2% and 13% of the recurrent costs at health centres and dispensaries, respectively.
- The main categories of DFF expenditure were wages, travel allowances and construction and maintenance.

DFF expenditure in health centres and dispensaries



IMPACT OF DIRECT FACILITY FUNDING

Achievements

- DFF procedures were well established, HFCs met regularly, and accounting procedures were broadly followed.
- DFF was perceived to have a highly positive impact through funding support staff; outreach activities for immunization and antenatal care; building renovations; patient referrals and increasing the activity of HFCs.
- Employment of extra support staff and payment of staff incentives in the form of allowances, has reportedly improved health worker motivation, the safety and cleanliness of facilities, and led to reduced waiting time.
- District managers, health facility staff and HFC members felt that DFF has had a positive impact on utilisation and quality of care.



An example of DFF funded maintenance: fixing a gutter to collect rain water

Challenges

- Problems with DFF implementation include: inadequate training for members of the HFC, especially in the area of financial management, and a lack of relevant guidelines at the facility level.
- The operation of the HFC has improved since the introduction of DFF. However, community members are largely not aware of DFF funds, the identify of their HFC representatives or official user fee policies.
- Despite the DFF funds, many facilities are not adhering to the user fee policy. They continue to levy charges above the prescribed fees and fail to exempt groups of patients such as children under 5 years old.

POLICY RECOMMENDATIONS

For the Kenyan government

- The positive findings from the provincial-level pilot indicate that scaling up of the current DFF system is warranted. The amount of funds could be increased because facilities currently show good absorptive capacity and have several ideas about how additional resources could be used.
- To replicate successes in the Coast province, other provinces may require additional support such as strengthened drug delivery systems, infrastructure, and support to facility managers.
- DFF implementation and operations should be strengthened. This will require comprehensive training for HFC members and health workers, and a clear manual which covers the HFC roles, procedures for elections and rules on how funds can be used.
- The policy on user fees should be clarified with a document from the Ministry of Health that lists all applicable fees, and this should be displayed at all health facilities. Adherence to the user fee policy should be made a key part of DFF training, and the receipt of DFF money should be conditional on user fees adherence.

For policymakers in other countries and development partners involved in advising on health financing policy

- Direct funding offers an opportunity to compensate health facilities for loss of user fee revenue where these are removed or reduced. Although user fee removal can improve equity, it also removes an important source of discretionary funds which, though small in absolute amount, can have an important impact on facility performance.
- Direct funding can be implemented successfully at health centres and dispensaries, but requires an effective mechanism for transferring funds to the lower levels of the health system. In many contexts, this means circumventing the bureaucracy and corruption problems that have been identified in expenditure tracking surveys.
- Performance based financing mechanisms are being increasingly discussed, but have potential disadvantages including administrative burden, fraud and perverse incentives. This study indicates that even without performance targets, an increase in funding at peripheral level may have a positive impact on utilization and quality.

The research presented in this poster was conducted by Antony Opwora, Margaret Kabare, Sassy Molyneux and Catherine Goodman.

This forms part of the CREHS research theme on financial risk protection. For more information about this research project contact Antony Opwora, email: aopwora@nairobi.kemri-wellcome.org