

Examining multiple funding flows to public healthcare facilities in Kenya

Key points

- Multiple funding flows occur when there are several purchasers within a health system, requiring healthcare providers to manage multiple sources of funds and different payment mechanisms.
- Research in Kenya has found that county and sub-county public hospitals had ten funding flows from purchasers who included the national government, county government, National Hospital Insurance Fund (NHIF) and households.
- Multiple funding flows were beneficial to hospitals as they improved the stability of funding; inadequate funding from one source could be compensated for by others.
- Differences in the sufficiency and predictability of separate funding flows led to undesired provider behaviour including inequitable allocation of resources in favour of members of the NHIF managed scheme, compromising access to and quality of care for the uninsured.



Introduction

Healthcare purchasing is high on global health financing agenda as it is recognized that achieving universal health coverage (UHC) requires more than increased spending: how funds are allocated to obtain health services from healthcare providers is an important influence on the equity, quality, and efficiency of health service delivery. In Kenya, like many low and middle-income countries, multiple purchasers operate within the health system. Healthcare providers are often required to engage with many, or all, of these purchasers resulting in multiple funding flows.

KEMRI-Wellcome Trust conducted research to examine the characteristics of different funding flows to public county hospitals in Kenya and how they influenced provider behaviour. This was an in-depth qualitative study carried out in sub-county and county public hospitals in Kenya. The key findings from the research are outlined in this brief as well as recommendations to policy makers.

What are multiple funding flows?

A funding flow refers to any transfer of funds from a purchaser to a healthcare provider that is characterised by a distinct combination of arrangements including: services purchased, population group covered, provider payment mechanism, provider payment rate, accountability mechanism and any other contractual arrangement. It is possible that providers receive several funding flows from one purchaser, for example when different payment mechanisms are used for inpatient and outpatient services.

Funding flows vary in terms of

- How much they contribute to health care providers' total resources
- The relative sufficiency of provider payment rates (i.e. the extent to which the payment amount covers the costs of care provided by health facilities)
- Their predictability - in terms of timing and quantity
- How much flexibility health care providers have to access and use funds at their discretion
- The burden and complexity of accountability
- Performance requirements

The interaction of these characteristics sends signals to healthcare providers that may lead to desired or undesired behaviours.

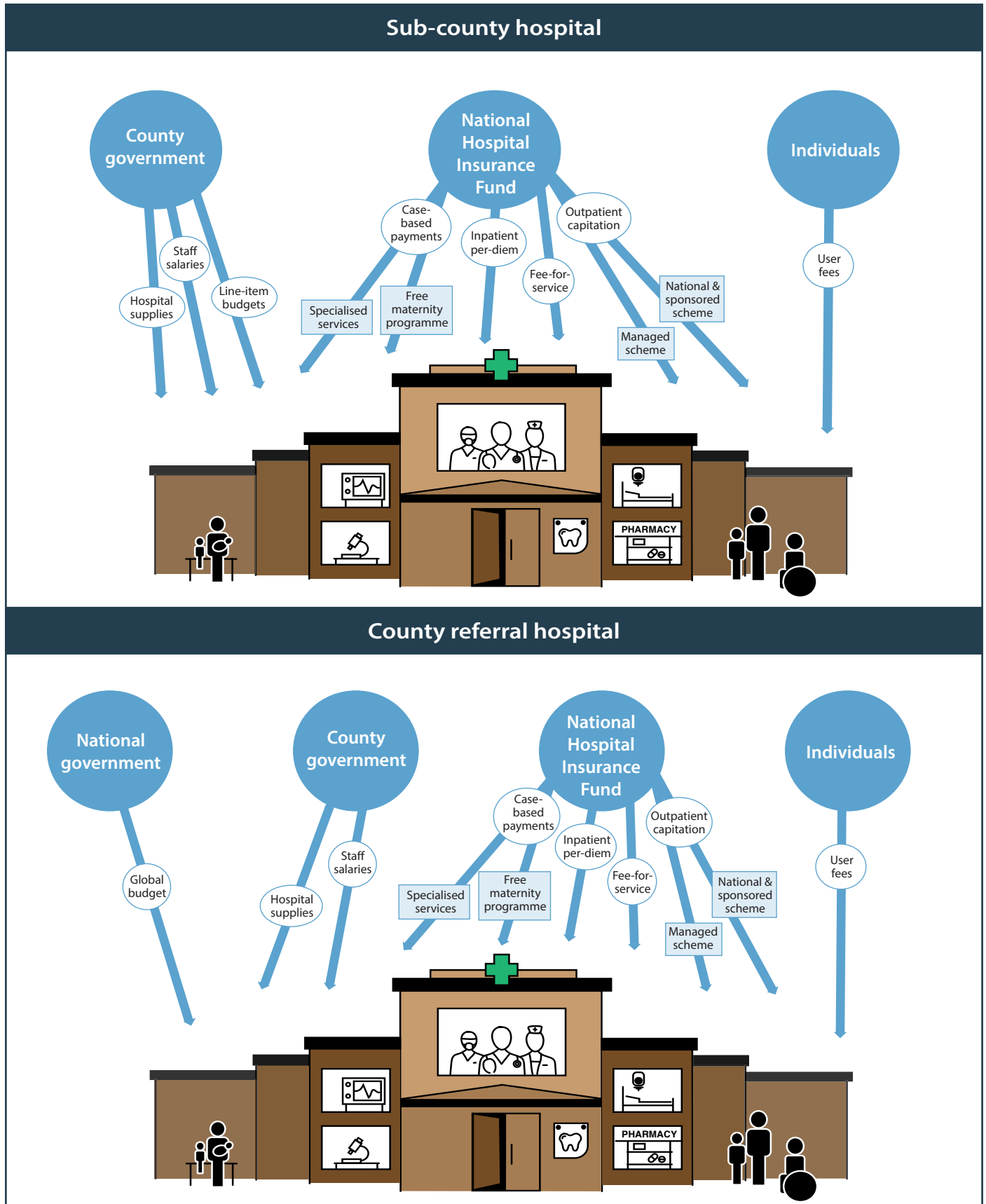
Key findings

1. County hospitals experienced ten funding flows

Hospitals received financial resources from up to four purchasers: the national government, county government,

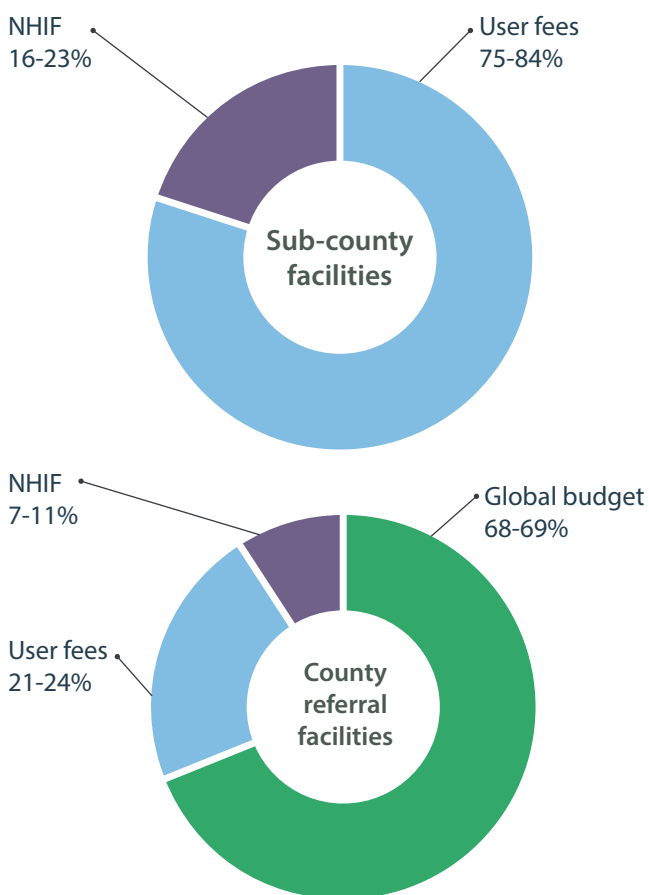
NHIF and individuals. Different payment mechanisms through the NHIF, e.g. case-based payments for maternity care, and capitation for outpatient services, resulted in ten identifiable funding flows for sub-county and county referral facilities.

Figure 1: Funding flows to sub-county and county referral hospitals



In the sub-county facilities that were surveyed, user fees made up approximately 80% of the total share of funding, followed by NHIF reimbursements. For county referral facilities, global budget from the national government made up the greatest share of funding, followed by user fees then NHIF reimbursements.

Figure 2: Relative contribution of funding flows to providers



2. Multiple funding flows improved the amount and predictability of financial resources

Having multiple funding flows benefited public hospitals by improving the overall level of financial resources that the hospitals had access to. Managers also reported that multiple funding flows provided them with greater stability by ensuring consistent availability of financial resources. This is because gaps created by irregular or insufficient disbursements from one funding flow were compensated for by another.

3. Differences between funding flows led to shifting of resources and discrimination

Despite higher total revenue generated from user fees, hospitals prioritized allocation of resources and gave preferential treatment to patients enrolled in the NHIF. This is because the NHIF funding flows were considered more sufficient and predictable compared to user fees. User fees were often affected by waivers (where certain groups are exempted from paying), particularly for inpatient care.

Civil servants, who are covered through the NHIF Managed Scheme, received markedly preferential treatment: special clinics with dedicated staff were set up for civil servants, and where these did not exist, civil servants were allowed to jump queues. Healthcare providers entered into private arrangements with private pharmacies to ensure that drugs were available for civil servants in case of drug stock outs in hospitals, and civil servants were given private wards and rooms in hospitals with special meals and dedicated staff.

This resulted in perceptions of unfairness in access to care for uninsured people, and compromised the quality of care they received due to long waiting times and low doctor-patient ratios.



“There is an NHIF civil servants’ clinic where civil servants and the ones who are working here are taken care of. The privilege is that they are seen quicker than others. And you know they are the biggest clients who have NHIF. In fact, every civil servant is an NHIF registered person... So, we felt it was good to have a place whereby all civil servants would be taken care of”

Mid-level health facility manager

4. Some healthcare providers sought to shift patients between funding flows

In some hospitals, uninsured patients who required protracted inpatient care or elective surgical operations were encouraged to enrol into the NHIF. Some hospitals employed clerks to identify and enrol such patients to reduce waivers on inpatient care. This behaviour was driven by the higher amounts paid by the NHIF, and the greater likelihood of receiving full reimbursements for services compared to user fees. Uninsured patients requiring long inpatient or surgical care often required waivers which undermined the predictability of amount service providers received following service delivery.

“We usually encourage people to do the cards because we consider them more important ... and we get higher return. [NHIF clerks] usually go around trying to encourage people to take the NHIF cards”

Accounts staff

Conclusion

Multiple funding flows to public hospitals can be beneficial as they provide alternative funding pathways that increase the financial resilience of county and sub-county facilities. However, differences in the characteristics of these funding flows, such as relative sufficiency and predictability, influenced the behaviour of service providers with potential equity and quality implications for uninsured groups.

Recommendations to county governments

Put in place mechanisms to reimburse public hospitals for revenues lost from waiving user fees

When revenues from user fee waivers are not reimbursed to health facilities, it reduces the predictability of expected hospital resources. Introducing a user fee waiver reimbursement mechanism may mitigate against resource shifting, preferential treatment of insured patients and patient shifting.

Prohibit the creation of special clinics or wards within public health facilities

County governments should promote equity in resource allocation and service delivery by outlawing the creation of special clinics or wards in public health facilities. Such clinics or wards create a two-tier system in public health facilities that could compromise equity and quality of service delivery.

Recommendations to National Hospital Insurance Fund

Engage healthcare providers in the development of provider payment rates

This will help to demystify the notion that capitation rates are insufficient to cover the cost of care to patients and reduce unnecessary prioritization of resources towards certain population groups.

Strengthen monitoring and accountability mechanisms for healthcare facilities

Both the NHIF and county government should put in place monitoring mechanisms with sanctions to guard against patient discrimination. For example, strengthening patient feedback mechanisms, regularly reviewing patient and community feedback about service experience, and acting on the feedback.

Recommendations to public hospitals

Institute a systematic priority setting and resource allocation mechanism

Public hospitals should develop and implement a systematic process, with explicit criteria, for allocating hospital resources such as staff, medical supplies, and funds, to guard against unfair or inequitable allocation of resources across departments and patient groups within the hospital.

About the brief

References and related resources

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