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policy

EFFECTIVE IMPLEMENTATION OF THE NEW HEALTH FINANCING POLICIES

Brief

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Health Policy and Abolition of User Fees at Public Primary Healthcare Facilities

What can we learn from PETS-Plus 2012 evidence?

Introduction

Inadequate financing for health services in low-income countries and the reliance on out-of-pocket spending to supplement government resources have been described as key challenges to the achievement of key health development goals (James, Saul, Keith, and Taylor, 2005; Borghi, et al., 2006). In the mid-1980s, many low- and middle-income countries introduced user fees as an instrument to help improve the quality of services through local retention of generated revenue in the wake of dwindling national health budgets (McPake et al., 2011). Kenya introduced user fees in 1989 with a waiver and exemption policy to buffer the poor and the vulnerable. In an effort to increase access to essential services by these groups, in 2004 the government reduced user fees at primary healthcare facilities, setting the maximum amounts at 10 and 20 Kenya Shillings (KSh) for dispensaries and health centers, respectively.

In the last decade, evidence has emerged that user fees are regressive and undermine equitable access to essential health services, particularly for women and children. The large body of evidence has compelled countries to implement waiver and exemption mechanisms, and partially reduce or abolish user fees altogether to help improve access to healthcare by the poor and vulnerable (Witter, 2010; Campbell, Oulton, McPake, and Buchan, 2011; Yates, 2009).

It is against this background that the government of Kenya took decisive action to remove user fees in dispensaries and health centers and to provide free maternal health services at all public health facilities in an effort to increase access to essential health services and reduce maternal mortality (see Box 1). It is envisioned that these two policies will improve access

to essential health services for the poor and vulnerable, in line with Vision 2030 and the National Health Sector Strategic Plan (NHSSP) III that is currently under development. The 2010 Constitution assigned all health service delivery functions to county governments, except for national referral services. This means that counties are responsible for planning, financing, and coordinating and monitoring the delivery of health services to fulfill the citizens' right to "the highest attainable standard of health," as prescribed by the Constitution. Counties are expected to implement all national initiatives aimed at increasing access to high-quality care, including abolishing user fees and providing free maternal healthcare.

With the support of the USAID- and PEPFAR-funded Health Policy Project (HPP) and the World Bank, the Ministry of Health implemented the Public Expenditure Tracking Survey (PETS-Plus), a nationally representative survey of public and faith-based facilities, in 2012. The study had two components: a tracking component, to assess the effectiveness of key policies that resulted from previous PETS studies including the 10/20 user fee policy, Health Sector Service Fund (HSSF), Hospital Management Service Fund (HMSF), and the pull system for medical supplies; and a service delivery component to assess the availability of key inputs (basic infrastructure and medical equipment, priority medicines for mothers and children), providers' clinical knowledge of management of key diseases, and the level of absenteeism.

It is anticipated that the abolition of user fees at primary-level facilities and the provision of free maternal healthcare services in all public health facilities will lead to improved access to health services, especially for the poor and vulnerable. However, these benefits can be maximized only if the mechanisms used to channel funds to health facilities are effective, if the reimbursed funds are used efficiently, if health facilities provide free services, and if tools are provided for monitoring, accounting, and management of the funds.

This brief presents data from the PETS-Plus 2012 on resource flows; awareness and compliance with the 10/20 user fee policy; effectiveness of the disbursement mechanisms (HSSF and HMSF); utilization of user fees, HSSF, and HMSF funds; and availability and use of accounting and financial management tools. The study also considers what these data indicate about making the resource flows and use, related to the two health financing policies, work for the benefit of all Kenyans.

Box 1. New Health Financing Policies

Abolition of User Fees: All user fees in public health centers and dispensaries are abolished to promote equity in access to essential healthcare services.

Free Maternal Health Services: President Kenyatta announced abolishment of maternity charges in public health facilities on June 1, 2013. The purpose of the free maternal services is to remove financial barriers to using maternity services, with the goals of reducing maternal and neonatal mortality rates, contributing to poverty reduction, and therefore moving toward realization of Millennium Development Goal 5.

Source: MOH Circular on Abolition of User Fees and Provision of Free Maternal Health Care, June 2013

Methods

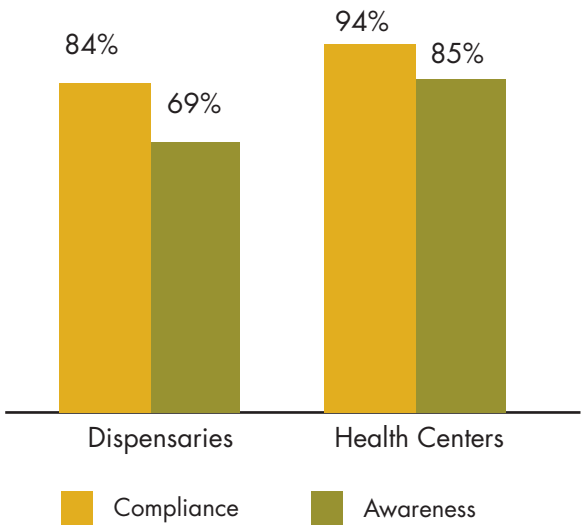
The data presented and analyzed here were extracted from the PETS-Plus 2012, which covered 294 public and faith-based facilities in Kenya. The survey had two components: a public expenditure tracking component and a service delivery component. The detailed methodology can be obtained from the published report.[1]

Results

Awareness of the policy

Although awareness of the 10/20 policy among all the respondents was high (72%), it was higher among staff in health centers than staff in dispensaries (see Figure 1).

Figure 1: Level of self-reported awareness and compliance with 10/20 policy



Adherence to the 10/20 user fee policy

Under the 10/20 policy, dispensaries and health centers are allowed to charge only KSh 10 and KSh 20, respectively, as registration fees. Adherence to this policy is critical because it ensures that clients' access to healthcare services improves. PETS-Plus 2012 examined facility compliance using a set of questions to establish awareness of the policy itself (self-reported), implementation (also self-reported), and collection and analysis of data on fees for a series of age and illness groups (for example, children under five with malaria). These data were compared with the MOH policy, which also requires full exemptions for specific services, including treatment for malaria, tuberculosis, and sexually transmitted diseases.

Ninety-four percent of health centers and 84 percent of dispensaries were found to be implementing the policy. However, when self-reported compliance was compared with actual data collected from the facilities during the survey, a different picture emerged. While 86 percent of facilities reported implementing the policy, facility data showed that over 50 percent were not complying with the policy. The discrepancy was higher among dispensaries: examination of actual data showed that 39 percent were not complying although 84 percent had self-reported compliance. Figure 2 confirms that fees were charged for health conditions that should have been exempt from payment.

Figure 2: Average user fee charges for selected services

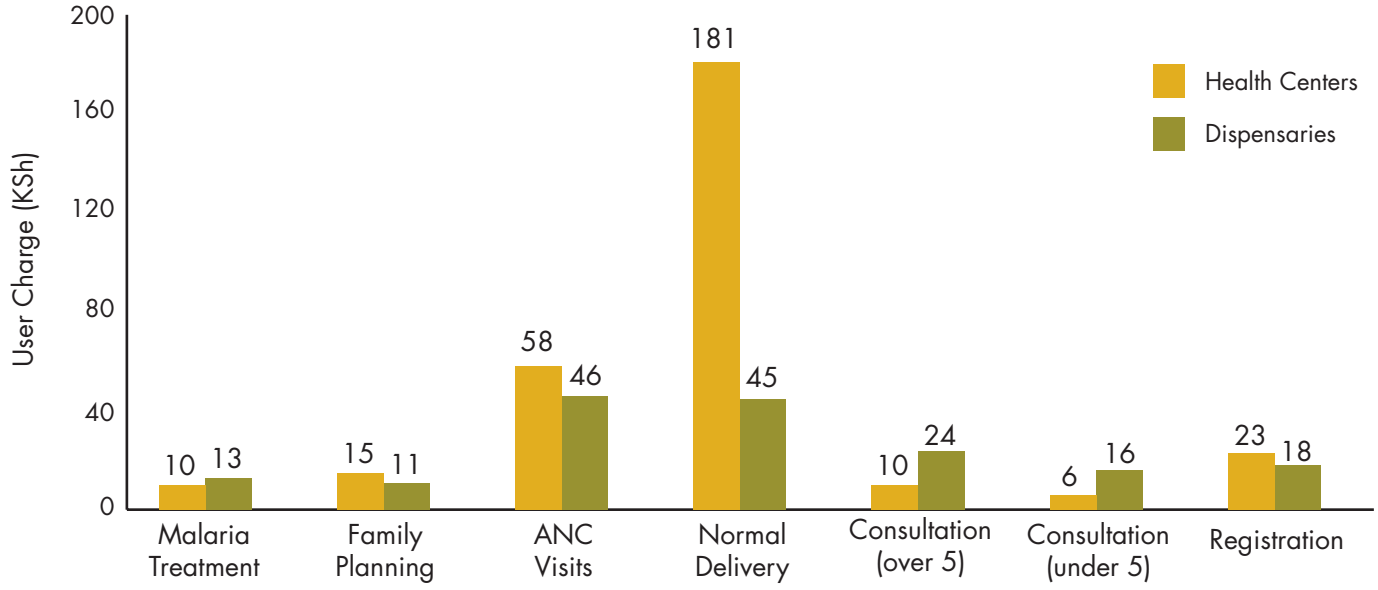
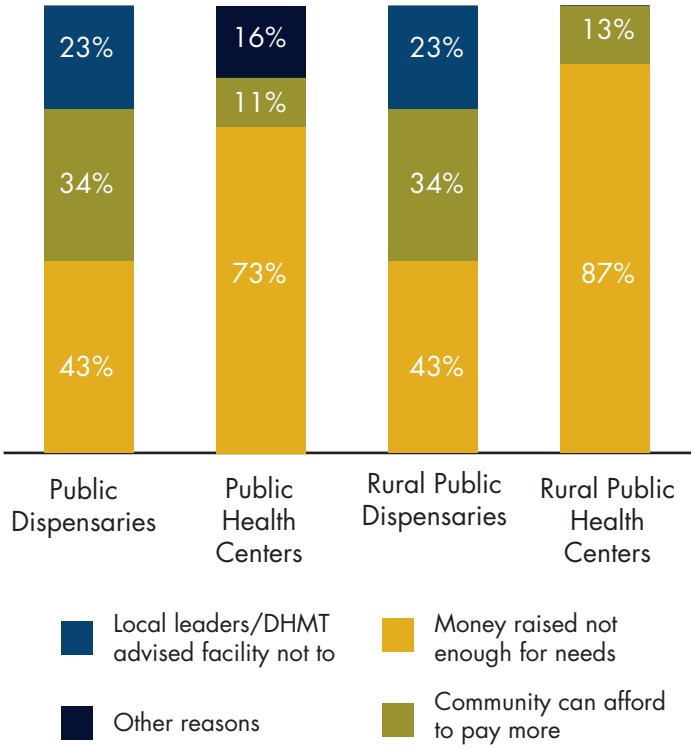


Figure 3: Reasons for not implementing the 10/20 Policy



Reasons given for noncompliance were diverse, with inadequate resources being most frequently reported (43% of dispensaries, 73% of health centers, and 87% of rural health centers) (see Figure 3).

Utilization of user fees, HSSF, and HMSF at facilities

International evidence emphasizes the important role of user fees in supporting service delivery. In Zambia for instance, incomes from user fees accounted for up to one third of the total resources available to some health facilities (Cheelo et al., 2010). The PETS-Plus findings showed that user fees accounted for about 53 percent of health centers' and dispensaries' annual income and 70 percent of hospitals' annual income (see Figure 4). Public facilities in Kenya also receive allocated funds through the Hospital Management Services Fund (HMSF) and Health Sector Services Fund (HSSF) (see Box 2). The findings showed that HSSF funds accounted for 31 percent and 40 percent of health center and dispensary annual income, respectively. The contribution of HSMF (17%) in financing hospital care was limited because only the recurrent budget covering operation and maintenance was transferred directly to public hospitals through the fund (see Figure 4).

Box 2. Objectives of HSSF and HMSF Funds

HSSF and HSMF are health financing tools that were set up by the government as a direct response to the operational challenges that previously undermined funding flows to public health facilities.

The mechanisms were meant to pool both public and donor resources and directly transfer the same to health facilities based on allocation criteria and therefore circumventing the bureaucratic decision points associated with the previous flow of funds system.

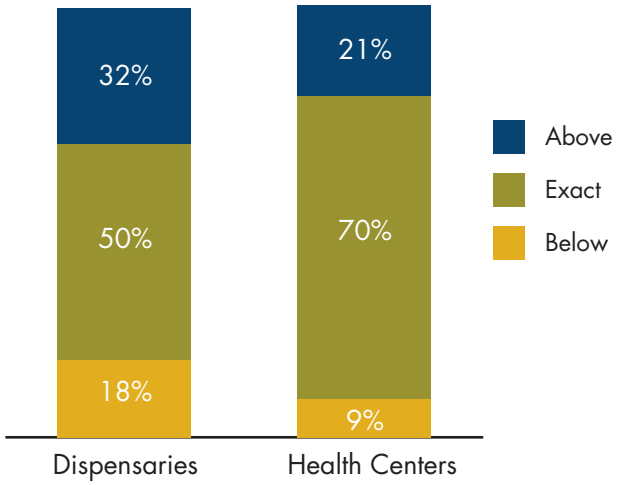
The two mechanisms are intended to improve access to health services by addressing the operational weaknesses associated with the health systems.

The mechanisms aim to improve financial management, efficiency, and effectiveness of facility management committees by reducing the bureaucratic challenges that previously undermined the flow of resources to facilities.

Source: MOH HSSF/HMSF guidelines

The user fees generated at the facility level are used to pay for temporary staff (cleaners, security, laboratory technicians, etc.). They also cover travel allowances for staff, and pay for outreach services, and operation and maintenance of the health facilities, among other things. Salaries for health workers and medical commodities are paid through a central budget managed by the Ministry of Health.

Figure 4. Comparing user fees and HSSF/HMSF revenues in public facilities, 2011–2012

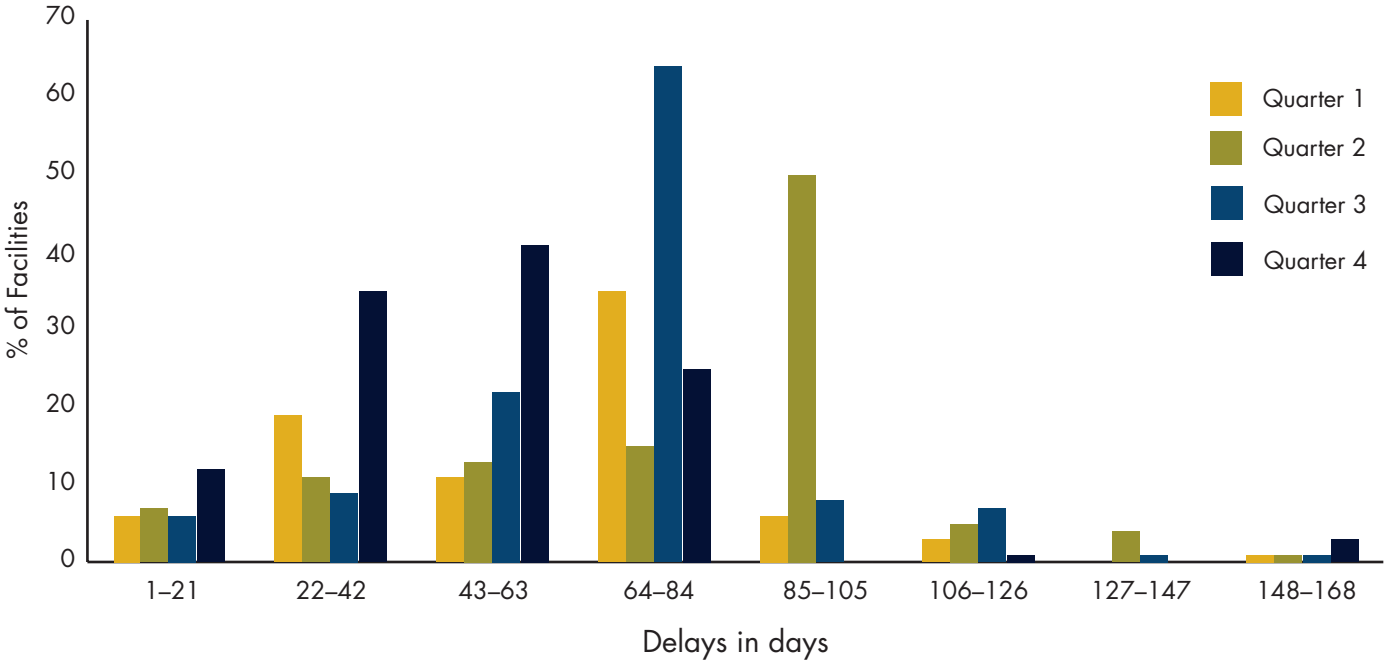


Timeliness in disbursement of HSSF and HMSF funds

User fees, though small in absolute terms, are an important source of discretionary funds for health facilities and have played a critical role in improving the quality of health services provided by public facilities. The timely disbursement of compensation to health facilities for loss of revenue is important when facilities have no other source of income, because it ensures that facilities can continue to deliver high-quality healthcare.

Evidence from Zambia indicated that facilities suffered a huge gap in finances due to slow disbursement of compensation funds when user fees were abolished—in some cases the delays were up to eight months. The lack of funds led many facilities to scale down the services provided, and some services were completely discontinued. In Kenya, the PETS-Plus 2012 found erratic disbursement of HSSF and HMSF funds, with most of the surveyed facilities experiencing delays of between two and three months (Figure 5).

Figure 5: Distribution of delayed receipt of HSSF resources 2011/12



Expenditure pattern of user fees revenue, HSSF and HMSF funds

HSSF and HSMF guidelines provide information on how funds from the two mechanisms are supposed to be spent. Ideally, the funds should not be used to cover wages, drugs, or pharmaceutical supplies, which are paid for by the government through other channels.

A close look at the PETS-Plus evidence provided insight on the efficiency of spending, and whether facilities were spending on items stipulated by the respective guidelines. The pattern of HSSF/HMSF spending also indicated how funds channeled to health facilities could be used as compensation for providing free essential health services under the two health financing policies.

Figures 6 and 7 show how user fees, HSSF, and HMSF were spent on different items, and items on which facilities spent more money. The largest proportion of HMSF spending by hospitals was on food and rations (17%), maintenance of vehicles (14%), and training (11%), while user fees were spent on medical and laboratory supplies (20%), food and rations (18%), drug supplies (11%), and casual labor (10%).

Health centers mainly spent user fee revenue on medical drugs (37%) and casual labor (13%). Similarly, dispensaries spent user fee revenue on casual labor (20%) and food and rations (16%). HSSF spending in health centers was primarily on training (13%); maintenance of plant, machinery, and equipment (12%); medical supplies (12%); and food and rations (11%).

Figure 6: Top five user fees expenditures for 2011–2012

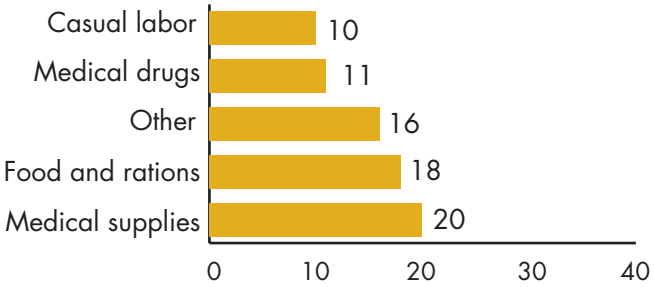


Figure 7: Top five HSSF and HMSF expenditures for 2011–2012

In dispensaries, about a third HSSF spending was for maintenance (33%) and 22 percent was spent on casual labor.

The high level of spending on drug supplies, medical and laboratory supplies, and food and rations implies that funding for these items is inadequate and the MOH should prioritize funds for them to improve access to health services for women and children. The level of spending on these items also suggests that funds from the two health financing policies are likely to be used to cover the same type of expenses.

Discussion and recommendations

Smooth flow of HSSF/HMSF funds; adherence to the 10/20 policy; appropriate use of user fees, HSSF, and HMSF; and the availability and use of monitoring, accounting, and management tools are critical in ensuring access to high-quality healthcare services. The findings of this study can inform the successful implementation of the new policies on abolition of user fees at health centers and dispensaries, and provision of free maternal health services.

These findings show that a substantial number of facilities were unaware of the 10/20 user fee policy and that many facilities that were aware of the policy were not implementing it, which suggests a deliberate disregard for the policy. Facilities cited inadequate resources as a reason for noncompliance, and this is a genuine concern that the government should address. The level of noncompliance also points to weak supervision of health facilities, which could undermine successful implementation of the recent policies.

The fact that almost one-third of health centers and dispensaries were unaware of the 10/20 policy eight years after it was implemented also indicates serious flaws in the MOH's policy dissemination system. The MOH may not convey national-level policy changes to facilities, or they are not well understood at the facility level. Initial spot checks by the MOH following the introduction of the policies abolishing user fees and providing free maternal health services revealed confusion about the circular that was distributed. Facilities did not have a clear understanding of which services should be free and which should be charged, particularly maternal health services.

The experience of the Zambian Ministry of Health is particularly informative for Kenya (Masive, Chitah, and McIntyre, 2010; Masive, Chitah, Chanda, and Simeo, 2008). The Zambia MOH had less than three months to develop and disseminate clear guidelines that spelled out the change in policy on user fees at the primary healthcare level, including which specific services would be exempted. This led to confusion at facilities. Some facilities discontinued all charges, while others only stopped charging a consultation fee.

The facilities surveyed in Kenya reported that they did not adhere to the 10/20 policy because the resources available to them did not meet their needs. The fact that the government's current contributions to public health facilities through HSSF or HMSF are not the dominant source of revenue for any of the facility types surveyed implies that the resources are inadequate to meet the needs of health facilities. Therefore, facilities may hesitate to cut user fees or may scale down services. Patterns in expenditures reveal that some specific areas lack sufficient funding, including drugs, non-pharmaceuticals and laboratory supplies, and patient food and rations, among others.

Compensation for the abolition of user fees and free maternal health policies is being channeled to the respective facilities through the HSSF and HMSF mechanisms. This study found that there the two funds had operational and systemic weaknesses, including delays in disbursement and lack of monitoring, accounting, and management tools. This provides a valuable lesson for the successful implementation of the two new health financing policies: delays in the disbursement of compensatory funds will render them irrelevant and may lead to scaling down of services as facilities attempt to rationalize health services due to limited funding.

Policy recommendations

The following recommendations can be made based on the findings of this study. They require the urgent attention of the Ministry of Health in implementing the policies:

- **Provide guidelines on the abolition of user fees and free maternal health policies:** The Ministry of Health should provide clear guidelines to steer the implementation of the two health financing policies.

The government must describe the categories of the population that should receive free healthcare services (e.g., female/male, children under age five, women of reproductive age, etc.). Clarification is also needed on how the policies affect health centers/dispensaries under other government departments, such as prisons. This information is best conveyed through definitive guidelines that are widely disseminated.

The guidelines must define the package of services that will be provided for free. This will ensure that confusion, such as that experienced when the 10/20 policy was introduced, is eliminated. The MOH can use innovative formats and tools, such as flowcharts, to explain changes in user fees to the lower-level health facilities that are supposed to implement the policy.

- **Increase awareness of the new policies and monitoring of facilities:** It is important to put measures in place to ensure that facilities adhere to the new policies. Without these, and without close supervision, non-adherence rates will remain high.
- **Ensure timely and accurate disbursement of compensatory funds:** Facilities reported delays in fund receipt and inaccurate amounts being disbursed. The MOH should work with the treasury to address exchequer-related delays.
- **Identify the funding gaps that exist at facilities:** Facilities reported that they did not adhere to the 10/20 policy because the resources available to them did not meet their needs. A comprehensive costing study can provide information on how much it would cost to provide free maternal health services.

Note

[1]Onsomu, E., D. Muthaka, G. Mwabu, O. Nyanjom, A. Dutta, T. M. Maina, C. Barker, and S. Muchiri. 2014. *Public Expenditure Tracking in Kenya, 2012 (PETS-Plus)*. Washington, DC: Futures Group, Health Policy Project, and Nairobi, Kenya: Kenya Institute for Public Policy Research and Analysis.

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