Direct facility financing: rationale, concepts & evidence

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Section 1

BACKGROUND, RATIONALE & CORE CONCEPTS

Background and problem statement

1. Funds are not getting to frontline providers, especially in primary care

2. This pushes costs onto users

3. Primary care is underfunded, seen as poor quality, bypassed by users

Driven largely by:

- resource shortages
- political economy (favouring higher level facilities)
- system failures (weak PFM, capacity gaps)
- low levels of trust in managers

Funding source	% of total		
	Budget	User fees	Other
4 regional hospitals	62	37	1
6 district health centres	57	42	1
9 health posts	5	95	0

Source: my PhD fieldwork in Senegal, 2005

So why DFF?

DFF not only approach to these challenges but tries to address some of these root causes. Works on the principle that:

1. Funds should be concentrated where they are needed most – i.e. health facility levels
2. District and provincial level involvement in fund administration creates unnecessary transaction costs and payment delays, compromising the abilities of facilities to effectively and efficiently deliver quality health care
3. Needs to be complemented by addressing systemic challenges (ensuring facilities have flexibility and autonomy and skills to manage etc.)
4. Trust will be built by addressing iteratively addressing blockages and demonstrating results; at present no accountability can be enforced as resources are not made available; DFF also usually accompanied by attempts to decrease formal and informal user fees

Core concept

Direct facility financing (DFF) = direct provision of funds to health facilities to enable facilities to meet operational requirements

Basis for payments can vary but commonly prospective (e.g. capitation or budgets-based)

The main differentiating feature is that funds are directly channelled from national levels to health facilities, and that facilities are given managerial autonomy their use.

- Once districts have approved budgets, funds are transferred from national purchasers directly into facility accounts and facilities can proceed to use funds as agreed, without need for further approvals
- Auditing of transaction and expenditure records, as well as usual monitoring and supervision of health facility activity, are the main verification mechanisms

Pre-requisites

DFF requires health facilities to set up independent bank accounts, as well as to have the autonomy (and capacity) to manage the funds

- So willingness to decentralise must be present to some degree

Introduction may be accompanied by:

- additional support for budgeting, auditing and accounting, both at district and facility levels (tools + training + supervision)
- specific guidelines and rules for how/when funds obtained via DFF may be spent (e.g. in some countries purchase of medicines and supplies is excluded to ensure cost-savings and quality control via pooled procurement mechanisms)
- capacity building on community engagement to provide oversight on budgets and fund use

Section 2

EVIDENCE ON DFF IMPLEMENTATION AND EFFECTS

Implementation issues

Growing interest but still limited published literature

Studies in Papua New Guinea, Kenya, Tanzania

Kenya: overall spending across the program was high with only few isolated occasions of mismanagement (e.g. facility fake receipts, in charge absconding with funds)

However, some areas of challenge:

- Delays in disbursement

  e.g. in Kenya, districts only sent off budgets for approval to national levels once all facilities had submitted budgets and all funding agreements had to be signed off in Nairobi prior to funds being made available
- Some districts not willing to allow facilities to set budgets
- Additional accountancy training needed

Impacts

Studies ongoing in Tanzania but preliminary evidence (from Kenya and PNG) suggests:

1. Increased utilisation (though may be due to increased funding)
2. User fees – no strong evidence of reduction

In Kenya, also:

1. Improvements in clinic working environment at facilities (including equipment and consumables)
2. Increases in staff attendance and outreach services provided
3. Patient-reported improvements in facility cleanliness, waiting times and treatment quality, including staff courtesy

Section 3

FINAL REFLECTIONS

Supportive components

DFF sometimes portrayed as simple but **requires considerable groundwork** in terms of:

- design and implementation of system strengthening components (such as reinforcing management skills at facility level, access to banking, improved supervision and health information systems);
- a broader supportive environment and adequate funding;
- programme design and implementation components, such as:
  - estimating funding amounts which are required at facility level;
  - determining reporting, verification and performance review approaches;
  - agreeing, monitoring and enforcing policies on charges to users;
  - determining and enforcing any rules on staff benefits from the funds, and on how funds can be used more generally.

Many of these require changes outside health sector,e.g. by MoF

DFF can be system strengthening

DFF should be seen as a **health system strengthening intervention** (not just health financing intervention), as it impacts on all system areas and should in principle be coherent with arrangements in them

- e.g. health worker remuneration, drug supply systems, governance, public financial management (PFM) systems, health information systems, service packages, infrastructure quality and distribution, and measures to address community access barriers

DFF **mechanisms of change are also more complex** than the label implies: the label focuses on finance, and resources are indeed important to effects observed. However, there are many other components which are important

- including feedback on effort, signaling of priorities, support for planning, more focus on data and results and greater autonomy for facility managers, among others

Conclusion

- It is **not a new approach** – similar features to approaches used previously (e.g. for reimbursing lost fees in fee exemption policies) and in other sectors (e.g. capitated payments to schools in Uganda)
- As a **system strengthening intervention**, DFF has promise if designed with good fit to the context and its blockages.
  - It can provide the small but essential flexible resources which are needed at facility level to support integrated care packages
  - It can contribute to strengthening the system through encouraging focus on long-term operational constraints at facility level (skill gaps, rigidities etc.)
- It requires **complementary interventions at community level** given that it focuses on facility-based services.

Questions for panel

1. Do we have a consensus on the definition of DFF?
2. What do grounded experiences tell us about how it is working and lessons arising, particularly for PFM systems?
3. Where do we need further testing and evidence?

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