Nature and effects of multiple funding flows to public healthcare facilities: a case study from Nigeria

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Background

- Health financing functions are: mobilizing funds; pooling and managing fund; and purchasing services.
- Purchasing is the process through which purchasers, on behalf of the population, transfer pooled resources to healthcare providers to deliver healthcare services to the people (RESYST, 2016).
- Purchasers act as agents for the citizens and government in the purchase of healthcare services (Buse, 2012).

Purchasing in health in Nigeria

- Undertaken by: government at all levels through the Ministries of Health and LG HA, the National Health Insurance Scheme (NHIS), NPHCDA, Health Maintenance Organizations (HMOs), Private Health insurance (PHI), Community based health insurance (CBHI), development partners, non-governmental organizations (NGO) and households.
- The purchasers transfer funds to healthcare providers for the provision of services.
- Each funding flow is characterized by different payment mechanism, provider payment rates, contractual agreement, reporting requirement and decision space.

Funding flows to health facilities in Nigeria

A funding flow refers to any transfer of funds, in cash or in kind, from a purchaser to a healthcare provider (RESYST, 2017). Examples in Nigeria are:

1. Insurance capitations
2. Insurance fee-for-service
3. Out-of-pocket payments from user fees
4. Donor/philanthrophy
5. In kind
6. Others

Rationale

- Discussions about purchasing often focus on the activities of a single funding flow (Eboh et al, 2016).
- In reality, most public health facilities are funded through multiple financing mechanisms or financial flows
- Implementing parallel funding mechanisms may create signals to which providers respond in both intended and unintended ways and could aide or bring about an improved health financing.
- These mixed systems need to be better understood assessing the combined (complementary or contradictory) effects of different payment methods applied in a country (Mohammed et al, 2014).

Objectives

STUDY AIM

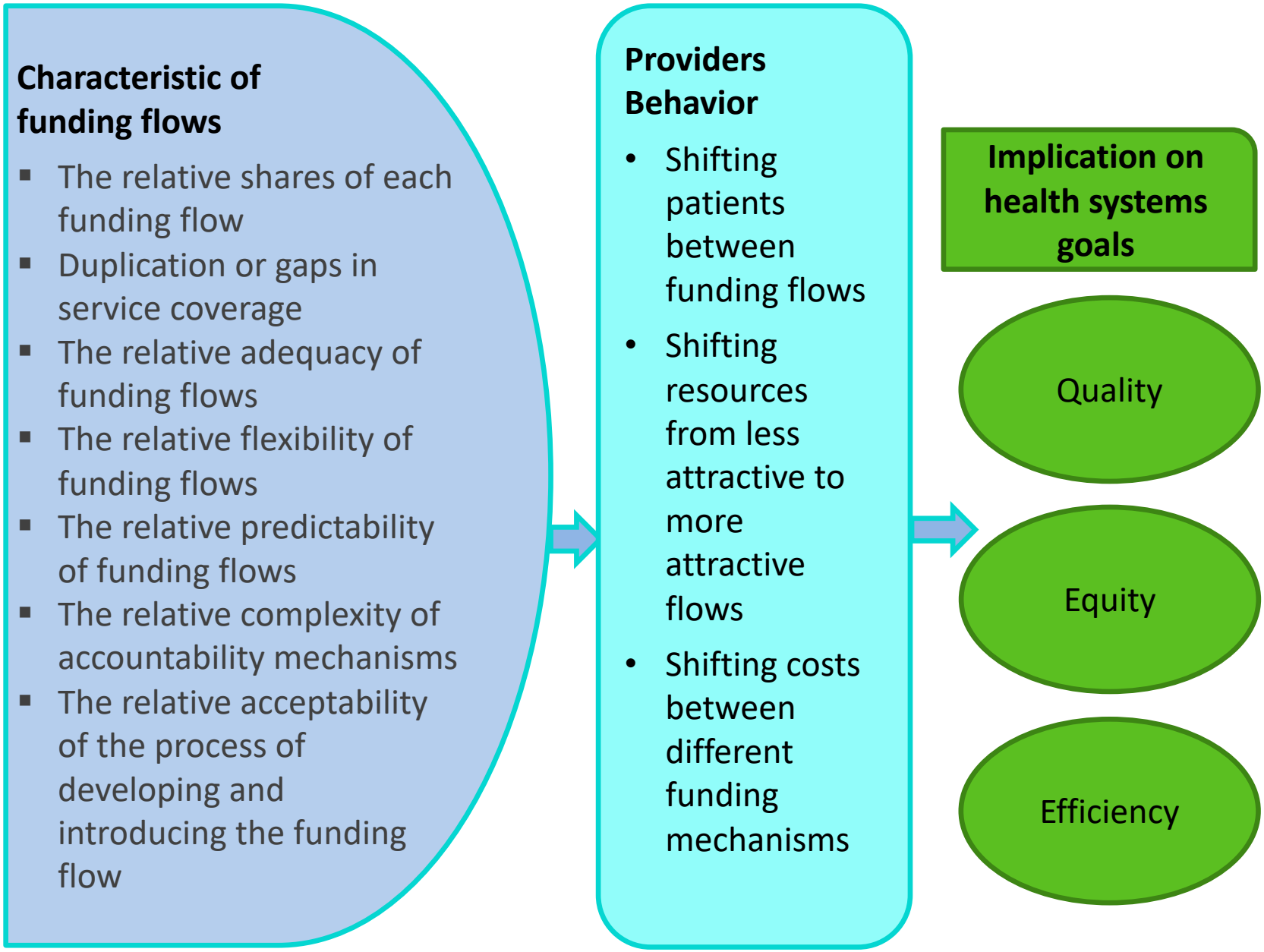
- To examine how healthcare providers respond to multiple funding flows and the implications of such flows for achieving the health systems goals of equity, efficiency and quality

Characteristics: The mix of funding creates a set of attributes which influence healthcare provider behaviour

- Duplication or gaps in service coverage across multiple funding flows.
- Contribution each funding flow makes to the total provider resource envelope (as a share of total)
- Relative adequacy or sufficiency of each of the funding flow to cover the costs of services purchased
- Relative flexibility of the funding flows
- Accountability mechanisms associated with each of the flows
- Predictability of the funding flows
- Incentives generated by the provider payment mechanisms

Providers responses due to the resultant interactions of the funding flows

- Shifting patients between funding flows
- Shifting resources from less attractive to more attractive flows
- Shifting costs between different funding mechanisms


Characteristic of funding flows
The relative shares of each funding flow
Duplication or gaps in service coverage
The relative adequacy of funding flows
The relative flexibility of funding flows
The relative predictability of funding flows
The relative complexity of accountability mechanisms
The relative acceptability of the process of developing and introducing the funding flow
Providers Behavior
Shifting patients between funding flows
Shifting resources from less attractive to more attractive flows
Shifting costs between different funding mechanisms
Implication on health systems goals
Quality
Equity
Efficiency

Study methods

- STUDY AREAS

  Two(2) tertiary healthcare facilities and;

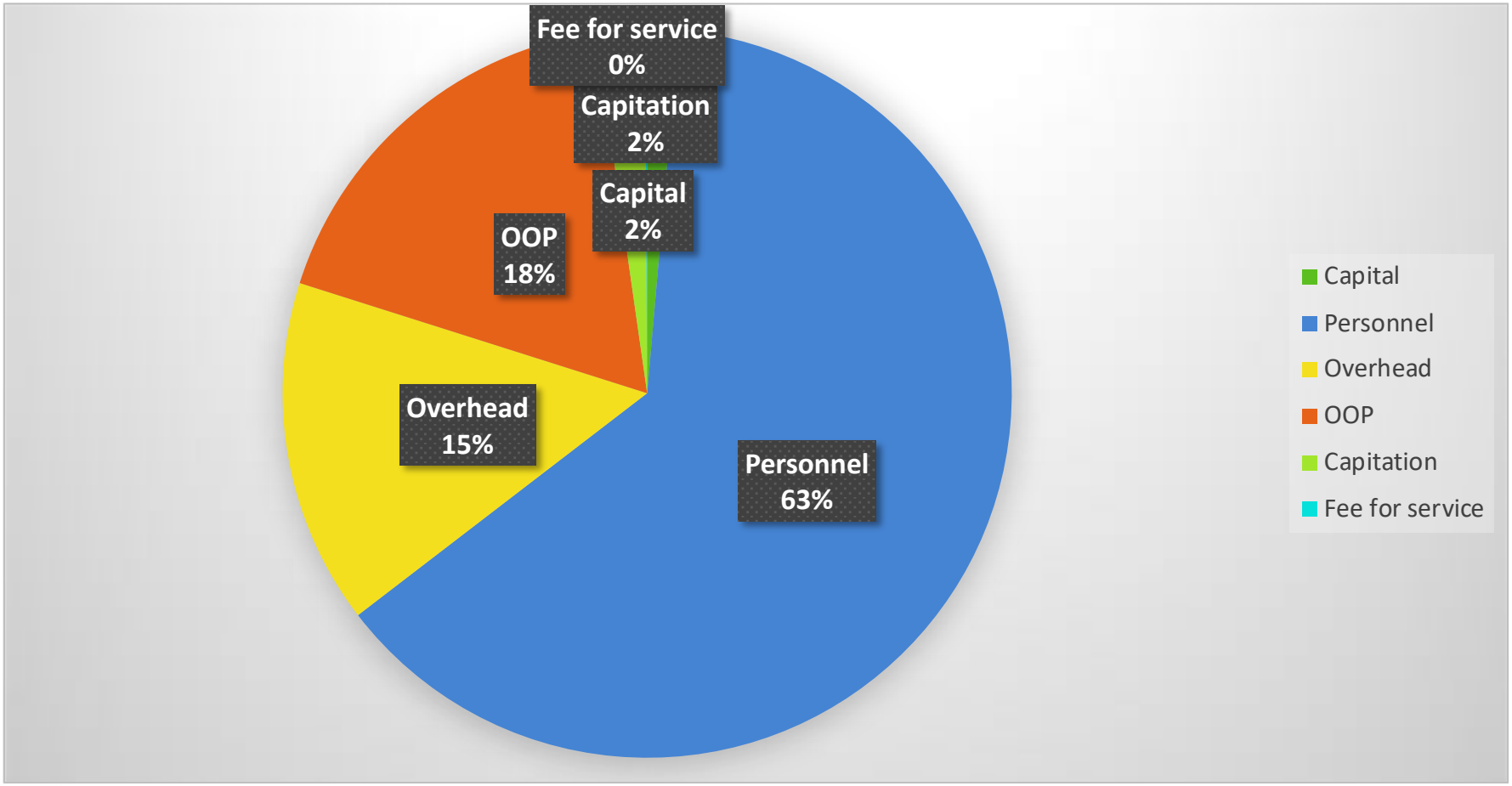
  Two(2) secondary hospitals in Enugu state, Nigeria.

- HEALTHCARE PROVIDER refers to organizations that provide healthcare services (e.g. hospitals), rather than individual healthcare workers working in these organizations or independently (e.g. doctors).

Study methods (2)

- Sixty-six (66) Key Informant interviews (KII) and Eight(8) Focused Group Discussion (FGD) were conducted.
- KII respondents included key officials of public facilities, State Ministry of Health (SMoH), State Health Board (SHB), National Health Insurance Scheme (NHIS) and Health Maintenance Organizations (HMOs) etc.
- FGD participants were facility users covered by different funding flows

Findings: Characteristics (1)
Size of funding from different flows



Attributes (2)

Characteristics	Government funding (GF)	Out of pocket payment	NHIS	Donor funds
Duplication or gaps in service coverage	Gaps exist	Gaps	Gaps - NHIS drug formulary is restrictive	Duplication – donors run parallel programs
Relative adequacy of funds	Personnel: ++ Overhead: - -	Some: - - Others: + +	Capitation, FFS are inadequate	For earmarked services: + +
Relative flexibility	Not flexible	Flexible in tertiary hospitals but not so in secondary hospitals	Mostly flexible in use. Minority: - - in TH.	Some flexibility
KEYS:	+++ = High ++ = moderate + = low (positive)		- - - = High - = moderate - = low (negative)	

Characteristics (3)

Characteristics	Government funding (GF)	Out of pocket payment	NHIS	Donor funds
Relative predictability	Personnel: + + + Overhead: - - - Reimbursement for FMCH: - - -	Varied opinion Majority: + + + Minority: +	Capitation: Amount: + + + Timing: + FFS : Amount &Timing: +	Services covered: - - - Depends on donors whim
Relative complexity of accountability mechanisms	Less complex compared to OOP.	Most complex. Requires extra vigilance of accounting staff.	Less complex than OOP but more than GF.	Not complex. Funds are earmarked.
Acceptability of process of developing and introducing funding sources	Not acceptable. Decided by government Lacks fairness and transparency. FMCH is politically motivated.	More acceptable. FFS rates were decided by a representative committee	Not acceptable. Current design and rates were decided at the national level. Benefit package is not robust.	Not so acceptable. Decision is made by donors.

Provider behaviour & implications for health systems goals: Resource shifting (1)

Types of provider behaviour	Evidence of provider behaviour	Related characteristic	Implications for health system goals
Resource shifting from other flows to NHIS patients	"Like the NHIS people are being given preference ...in the out patients' unit. We have the doctors that are assigned to be seeing the NHIS patients when they come... despite the crowd or whatever." (FP/KII /R23) "We pay more attention to NHIS patients, because they are special patients. ……But for those NHIS patients, they must get them here, and if you don't treat them well, they may start asking their HMOs to change, so you need to give them that special attention..." (FP/KII/R32)	Relative share of funding	Inequity

Resource shifting (2)

Provider behaviour	Evidence of provider behaviour	Related characteristic	Implications for health system goals
Resource shifting from DRF for all patients to NHIS patients	*"The kind of money they* (NHIS) *owe us, if they pay us that money, it will not only revive our DRFs, because they have contributed in the depletion of our DRFs,…. But many a time, because we don't want NHIS patients to leave the hospital without drugs, we still bring money from DRFs to buy drugs and put for national health insurance, … …Nothing is coming through NHIS to us. They are still taking from us"* (FP/KII/R08)	Relative predictability of funding, adequacy, flexibility	Inequity, inefficiency

Resource shifting (3)

Provider behaviour	Evidence of provider behaviour	Related characteristic	Implications for health system goals
Shifting resources to a PPP lab or to special interventions	Private lab is provided with better resources. Because the private laboratory charges higher rates and generates more revenue for the hospital.	Flexibility	Inequity, quality
	"Well, I think like the cardiothoracic unit, …. people are coming from outside the country to come and conduct open heart surgery, and when they come here, you cannot say you don't have light or water; and they have limited time to stay. So they give priority to that area to make sure that the place is really functional" (FP/KII/R08)		Poor quality of care for some patients.

Patient shifting

Provider behaviour	Evidence of provider behaviour	Related characteristic	Implications for health system goals
To ensure that clients get the quality of services they require by shifting NHIS patients to OOP	"There are some drugs that are not in the list of NHIS approved for their enrolees, so if you have a case like that you are going to go beyond the circle of NHIS, you have to go and buy the drugs by yourself and pay... At the moment what we actually do is to subtract the amount. For instance, for a brand of Ceftriaxone that is sold at ₦3,600, if the price [on NHIS drug list] is ₦600, we subtract the ₦600 and work out its 10% percent which is ₦60. So, the patient pays ₦60. The remaining ₦3,000 the person has to go to the other bank and pay. (FP/KII/R32)	Relative, adequacy Accountability	Quality, equity and efficiency

Patient shifting (2)

Provider behaviour	Evidence of provider behaviour	Characteristics	Implications for health system goals
NHIS enrollees pay out of pocket but later get reimbursed	"When it comes to fee-for-service, there is communication gap between us (HMO) and the hospital (Service provider), and they end up making the enrollees to pay from their pockets. Definitely at the end of the day, we refund the enrollees the money they paid. You know, when someone pays out-of-pocket, the charges are a lot because they don't do mark-up. Normally they do mark-up on us on fee-for-service especially when it comes to drugs. So really, it affects them (hospital), because what we would have paid them would have been higher than when we do refund" (PHA /KII /R11)	Accountability Predictability adequacy	Efficiency (cost escalation) Equity (poorer people will not be able to access)

Cost shifting (Price discrimination)

Types of provider behaviour	Evidence of provider behaviour	Related attribute	Implications for health system goals
Cost shifting	Different fees are charged to out-of-pocket paying clients for the same laboratory tests depending on whether they use the commercialized (privately-owned) labs or the non-commercialized (public-owned) labs in the hospital	Relative adequacy of funding flows	Improves quality of care for those that can afford but creates inequities in access
	NHIS is charged higher rates than out-of-pocket payment for the same laboratory investigations in a TH (R10)		

Conclusion

- Multiple funding flows improve overall predictability of funding for health facilities
- Multiple flows are good for financial resilience of hospitals
- They have Negative implications if there is maladaptation from patients' perspectives OR unnecessary purchasing from perspective of purchasers
- Providers do not understand how capitation works
- The burden of patient shifting from capitation to fee for service for insured clients (NHIS) is borne by the clients.
- There are negative effects on efficiency, equity and quality of services if multiple flows are mismanaged

Recommendations

- Purchasers and providers need standard operating procedures on how to administer multiple funding flows so that all their clients are equitably financially protected
- NHIS should engage providers in discussions on how capitation works will modify the signal it sends to them (improve 'acceptability') and modify their behavior.
- Minimize losses. Providers should set payment rates that do not expose them to deficits. This could address the problem of adequacy of resources and modify the signal it sends to providers.
- Minimize patient/cost/resource shifting

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