

Purchasing at the county level in Kenya

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BREAKING NEW GROUND





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ABBREVIATIONS

BMGF	Bill & Melinda Gates Foundation
CDOH	County Department of Health
CHV	community health volunteers
CRF	County Revenue Fund
DANIDA	Danish International Development Agency
FMS	free maternity scheme
FP	family planning
FY	fiscal year
GFF	Global Financing Facility
HMSF	Hospital Management Support Fund
HSSF	Health Sector Support Fund
KEMSA	Kenya Medical Supplies Authority
KEPH	Kenya Essential Package for Health
MEDS	Mission for Essential Drugs and Supplies
MNCH	maternal, newborn, and child health
MOH	Ministry of Health
NHIF	National Hospital Insurance Fund
PETS	Public Expenditure Tracking Survey
PFM	public financial management
PHC	primary health care
RMNCAH	reproductive, maternal, newborn, child, and adolescent health
SP4PHC	Strategic Purchasing for Primary Health Care
THS-UC	Transforming Health System for Universal Care
UHC	universal health coverage

EXECUTIVE SUMMARY

Strategic Purchasing for Primary Health Care (SP4PHC) project aims to improve how governments purchase primary health care (PHC) services, with a focus on family planning (FP) and maternal, newborn, and child health (MNCH). The project is supported by the Bill & Melinda Gates Foundation and is being implemented by ThinkWell in five countries, including Kenya. In collaboration with the Ministry of Health (MOH), the Council of Governors, the National Hospital Insurance Fund (NHIF), and county governments, the SP4PHC team in Kenya is pursuing a program of work that combines strategies at the national and county levels to improve how public funds are used to pay for PHC services.

The team undertook a rapid situation analysis to understand county-level purchasing practices to inform the development of project activities. The study drew from an extensive desk review of the available literature and key informant interviews in Isiolo, Kilifi, and Makueni counties, which are among the project's focus counties.

The purchasing landscape in Kenya

There are 49 public purchasers in Kenya today: the MOH, 47 county governments, and NHIF. Understanding their respective roles requires an appreciation for Kenya's devolved system of government, the history of social health insurance, and the evolution of user fee policies in the country. The devolution process started in 2013. Prior to that, the national MOH operated a public integrated delivery system, where it paid for the costs of inputs for a network of public providers through its budget. After devolution, the responsibility for financing all primary and secondary public providers shifted to 47 newly formed county governments. The MOH is the purchaser for tertiary hospitals and implements various vertical disease programs. The second element involves NHIF, the sole social health insurance agency in Kenya with the mandate to offer a comprehensive benefit package to all Kenyans. While NHIF is mandatory for everyone by law, in practice informal sector household enrollment is voluntary. Hence NHIF coverage is currently estimated at 20%. The third part of the story relates to the evolution of user fee policies in Kenya. Between 1965 and 1988, all services were free in public facilities. With the introduction of user fees, public facilities would collect and retain user charges to cover their operating costs. While a range of exemptions for high-priority health services were introduced in the 1990s and 2000s, none of them was accompanied by a reimbursement to the facility for the loss of user fees. In 2009, the MOH set up a mechanism to channel funds directly to public providers with donor support. In 2013, the national government removed all user fees at government-owned primary care facilities as well as user fees for deliveries at all public facilities. The MOH initially started channeling funds directly to public facilities to compensate them for the loss of user fees, but later shifted to transferring the funds to the county governments in the form of conditional grants. In 2017, responsibility for the management of the free maternity scheme shifted to NHIF, which uses MOH funds to purchase maternal health services from both public and private providers.

County health purchasing arrangements

Counties are the main purchasers of PHC services and, per national laws, can grant public facilities the authority to retain and spend own-source revenue. Counties derive revenue from four sources: their share of national revenue, which they receive as a block grant from the national government; local revenue; and conditional grants from the national government and donors. Local revenue includes funds that health facilities in the public sector generate from user fees and NHIF reimbursements. As per the country's public financial management (PFM) regulations, county governments have the authority to decide if public providers can retain and spend the funds they collect.

County departments of health (CDOHs) allocate resources to public facilities using multiple arrangements. CDOHs directly pay for some costs associated with health care delivery in the public sector, including staff salaries, commodities, facility maintenance, and so on. All counties receive two conditional grants from the

national government that are meant to compensate PHC facilities for user fees foregone. The first is funded by the national government and the second by a donor, and the counties transfer these funds to health centers and dispensaries (it is a financial transfer and not an in-kind payment to the facility). Under the universal health coverage (UHC) pilot, four counties have abolished user fees at hospitals and are receiving additional funds from the national government to compensate them for the lost revenue. Makueni County has initiated its own user fee reimbursement scheme, whereby the county reimburses public hospitals on a fee-for-service basis for services to households who have paid to register for the scheme.

The nature of the flow of funds to providers is complex and varies across counties as well as types of public providers. Before devolution, there was relative consistency in how purchasing was organized across the country; the national government paid directly for basic facility costs, including salaries and drugs, while public facilities used user fees and other revenue to cover their operating costs. The nature of funding flows in Isiolo, Kilifi, and Makueni captures the variation in purchasing policies and practices post devolution. Primary care facilities in all three counties retain and spend funds they receive from NHIF and receive funds from the county government for user fees foregone. In contrast, hospitals in Kilifi and Isiolo do not receive a financial transfer from the county government; all their costs are covered by the county government directly. Makueni has given public hospitals financial autonomy to retain and spend funds they collect. Kilifi has passed legislation with similar intent, but the law is not being applied. Isiolo has not passed any such law.

Opportunities for strengthening strategic purchasing at the county level

Some purchasing arrangements offer immediate opportunities for strengthening strategic purchasing of PHC, FP, and MNCH services, while others may prove harder to reform in the near term. The bulk of county spending for health flows via budgetary allocations for salaries. Linking these payments to performance has obvious appeal, but it is one of the most challenging reforms as it requires changes to the civil service rules. In contrast, it may be easier to improve how counties manage the conditional grant to reimburse health centers and dispensaries for user fees foregone, convince counties to commit additional funds (including financing from the Transforming Health System for Universal Care project funded by the Global Financing Facility, or GFF) to this mechanism, and link the payments to performance metrics, including specific FP and MNCH indicators.

Several counties are now exploring ways to give health facilities greater autonomy, which also represents a key opportunity for making purchasing more effective. Counties like Kiambu and Makueni have already implemented legislation or executive orders to this effect. Documenting and sharing their experience with other counties seems like an obvious place to start. The team also needs to explore and understand the conditions under which giving facilities greater autonomy works. After all, health facilities including hospitals had more financial autonomy prior to devolution, but that did not guarantee high performance. To be successful, reforms to grant facility autonomy may need to go hand in glove with reforms to link payments to health priorities, improve supply-side readiness, and enhance management capacity and accountability structures.

Finally, there is a need for timely and detailed information and analysis on the flow of funds to health facilities, which is essential for making purchasing more strategic. At present, county budget documents do not clearly record how much revenue different facilities generate and retain. Nor do they specify any specific budget allocation for health facilities. There is limited systematic analysis of annual budget and expenditure information at the county level. NHIF does not offer disaggregated financial reports on how much was disbursed to different counties, let alone to specific health facilities under different schemes. Improving the production and use of these data is essential for improving the purchasing relationship between county governments and health facilities.

I. INTRODUCTION

In 2013, Kenya transitioned to a devolved system of government under which 47 newly created counties became the main purchasers of primary and secondary health care services. The counties own and operate an integrated public health care delivery system where they pay for services provided by a network of public facilities through budgetary allocations that cover health worker salaries, the costs of medicines, and so on. They also implement financing schemes financed by the national government or donors. As per the country's PFM regulations, county governments also have the authority to decide if health facilities in the public sector can retain and spend funds they generate from user fees and payments from the NHIF.

Prior to devolution, health facilities derived revenue from different sources that they could retain and use, but this has changed since devolution. In 2012, just before the devolution process started, user fees accounted for half of the operating budget¹ of primary care facilities and slightly over two-thirds of hospitals' operating budgets. Public hospitals also received reimbursements from NHIF and direct financial transfers from the MOH (Onsomu et al. 2014). Studies since then have documented that even as public spending was devolved from the national government to the counties in 2013, public sector hospitals have less financial autonomy now than they had prior to devolution (Barasa et al. 2017). Some counties have implemented legislation allowing health facilities to retain self-generated revenue, but the way these laws have been applied and how well they are working is poorly documented. Some reports have suggested that the way counties manage finances for primary care facilities differs from their approach toward hospitals (MANI Project, Options, and Marie Stopes International 2018).

Supporting county governments to test approaches to strengthen health purchasing and sharing best practices with respect to county purchasing are among the objectives of the Strategic Purchasing for Primary Health Care (SP4PHC) project in Kenya. Supported by the Bill & Melinda Gates Foundation (BMGF) and implemented by ThinkWell, SP4PHC aims to improve how governments purchase PHC services, with a focus on FP and MNCH. Purchasing refers to the allocation of pooled funds to health care providers, and making purchasing *strategic* involves linking decisions about those allocations to information about provider behavior as well as population needs (World Health Organization et al. 2010). The SP4PHC project supports strategic purchasing reforms in five focus countries: Burkina Faso, Indonesia, Kenya, the Philippines, and Uganda. The SP4PHC team in Kenya is pursuing a program of work to support national- and county-level government agencies to make the purchasing of PHC services—including FP and MNCH interventions—more strategic to improve health outcomes. This includes targeted technical support to county governments in Isiolo, Kilifi, and Makueni counties.²

Strengthening how county governments purchase health services from public facilities is critical for improving FP and MNCH outcomes. Public sector facilities account for the majority of PHC services consumed, which applies also to FP and MNCH services. According to the 2013 Household Health Expenditure and Utilization Survey, public facilities accounted for 58% of outpatient services (Ministry of Health, Government of Kenya 2014), while data from the 2016 Kenya Integrated Household Budget Survey show that 74% of

¹ While salary, drugs, equipment, and maintenance costs were budgeted and paid for by the MOH, facilities maintained an operating budget that covered day-to-day running costs.

² In late 2018, the SP4PHC team had extensive discussions with the MOH and the Council of Governors, an intergovernmental relations body established through Kenyan law, to select the five project counties. The Council of Governors provided the initial introduction to the project, after which the team started engaging with the county governments. Isiolo, Kilifi, and Makueni were the first three to respond, and the project team worked closely to recruit county program officers for each county in early 2019. The project hopes to extend to two additional counties in mid to late 2019.

respondents who reported seeking care for an illness or injury visited a public facility (Kenya National Bureau of Statistics [KNBS] 2018). According to the 2014 Demographic and Health Survey, government health facilities were the major source of modern contraception methods, providing contraception to 60% of users in Kenya. They also accounted for 75% of births taking place at a health facility. As mentioned before, county governments are the main purchasers of primary and secondary health care services in the country, and they purchase these services from public facilities.

This report synthesizes findings from a landscaping exercise the SP4PHC team conducted to understand how county governments allocate and manage resources for PHC service delivery in public facilities based on a review of the literature and key informant interviews in three project counties. Section 2 describes the main topics the team set out to explore and the methods used. Section 3 provides an overview of the purchasing landscape in Kenya. Sections 4 and 5 explore the county budgeting process and the evolution of user fees and user-fee policies in Kenya, respectively. These two features of the health system influence the nature of county purchasing arrangements and the flow of funds to public facilities, which are described in section 6. Section 7 explores opportunities for improving county purchasing policies and practice, and section 8 provides concluding remarks.

II. STUDY OBJECTIVE AND METHODOLOGY

The goal of the landscaping study was to understand purchasing policies and practices at the county level. The SP4PHC project plans to provide technical support to each of the five county governments to strengthen their capacity as purchasers of health services. Hence, the SP4PHC team set out to synthesize information about the following topics:

1. County governments as purchasers of health services
2. The flow of funds to public facilities at the county level
3. Opportunities to strengthen county government purchasing policies and practices

To explore these themes, the team conducted a detailed desk review of the existing literature and interviewed key stakeholders in Isiolo, Kilifi, and Makueni counties. The desk review focused on all known publications on county health financing from the academic and grey literature. Specifically, in Google, the first five pages with 10 results per page were screened. In Science Direct, the first two pages with 25 results per page were screened. In PubMed, the first page with 50 results per page was screened. The following search term combinations were used: (*public financial management OR planning and budgeting OR financial flows OR budget execution OR strategic purchasing OR Linda Mama OR autonomy OR decentralization*) AND (*health sector OR health facility*) AND (*Kenya AND/OR county name*).³ In addition, the websites of institutions/projects such as The London School of Hygiene & Tropical Medicine (LSHTM) Resilient & Responsive Health Systems (RESYST), KEMRI Wellcome Trust Research Programme, Health Policy Plus (HP+), and more were screened. Between November 2018 and March 2019, the team also undertook 65 key informant interviews with health workers and key representatives of the County Department of Health (CDOH) in Isiolo, Kilifi, and Makueni counties (14, 26, and 25 key informant interviews, respectively). Furthermore, the team consulted 9 and 41 key representatives of the County Health Management Team and sub-County Health Management Teams in Isiolo and Kilifi, respectively. Information was gathered from 25 health facilities (7 in Isiolo, 10 in Kilifi, and 8 in Makueni).

³ Given the multiple search term combinations, the same publication was retrieved several times, thus the limit on the number of pages screened.

The project has adopted a conceptual framework for analyzing health purchasing that draws upon the existing literature. Purchasing refers to how agencies that pool health resources allocate resources to health care providers for the provision of services (World Health Organization et al. 2010; Mathauer 2016). There are two broad models for purchasing: contract and integrated delivery (RESYST 2014; Docteur and Oxley 2003). Under the contract model, the purchaser is distinct from the provider in terms of organization (often referred to as a purchaser-provider split), and the purchaser contracts providers to deliver services. Social health insurance and private insurance are both examples of a contract model. In an integrated delivery model, the purchaser and the providers belong to the same organization. A government department in charge of health services providing on-budget support to a network of public facilities that it owns and operates is an example of a public integrated model. There can also be private models for integrated delivery. For the purposes of this project, the team is interested in public purchasing arrangements, that is, both public integrated delivery and contract models involving a public purchaser. Strategic purchasing is any purchasing arrangement where decisions about the allocation of funds to health care providers are linked to information about population health needs and provider performance to maximize health system goals of equitable access, efficiency, financial risk protection, and quality.

III. THE PURCHASING LANDSCAPE IN KENYA

Kenya has a mix of public and private provision of services. While 49% of facilities in the country are government owned, 16% are private not-for-profit and 33% are private for-profit (Government of Kenya, Ministry of Health 2013). Public sector provision is organized into four tiers that include facilities of different “levels” (Box 1): community health care (through level 1 community health units⁴), primary health care (level 2 dispensaries and level 3 health centers), secondary care (levels 4 and 5 county hospitals), and tertiary care (level 6 national referral and specialty hospitals) (Ministry of Health 2014). These facilities provide health services in accordance with the Kenya Essential Package for Health (KEPH) (Ministry of Health 2005).

Under Kenya’s devolved system of government, counties oversee all health service provision except for tertiary and specialized care. Prior to devolution in 2013, Kenya was organized into provinces and districts, but these were primarily administrative units. The MOH at the national level was responsible for coordinating all health functions and held the entire budget for the health sector, and drew upon provincial and district health management teams for program implementation (Tsofa, Molyneux, and Goodman 2016). Since devolution in 2013, the 47 newly formed county governments oversee delivery of health care services at levels 1 to 5. CDOHs, which are in charge of coordinating and implementing health sector activities within counties (Waithaka et al. 2018), manage resources for all public sector health facilities as well as community health and

Box 1. Levels of health care providers

- *Level 1: Community health units*
- *Level 2: Dispensaries*
- *Level 3: Health centers*
- *Level 4: Primary hospitals (previously district hospitals)*
- *Level 5: County referral hospitals (previously provincial hospitals)*
- *Level 6: National referral hospitals*

Providers in levels 1-5 fall under the purview of county governments, while level 6 is managed by the national government. The levels also apply to private providers, but they are not listed here.

⁴ Each community health unit is linked to a public health facility and consists of two salaried community health extension workers who oversee a maximum of 20 community health volunteers receiving non-financial incentives/rewards for their efforts (Farnham Egan, Devlin, and Pandit-Rajani 2017).

other non-facility-based public health programs (Waithaka et al. 2018; Barasa et al. 2017; Nyikuri et al. 2017). The MOH oversees tertiary care facilities and is responsible for developing national policies and plans.

Counties control a larger share of the health sector budget than the MOH (Figure 1⁵). The county’s share of the total health budget increased from 53.8% in the 2013/14 fiscal year (FY)⁶—the first year of devolution—to 62.8% in FY 2017/18, and then dipped back down to 56.5% in FY 2018/19 (how counties spend this budget is discussed below). The government’s health budget as a share of the total budget was lower in the four years after devolution compared to the year immediately preceding it, but there has been a marked increase in the last two years.

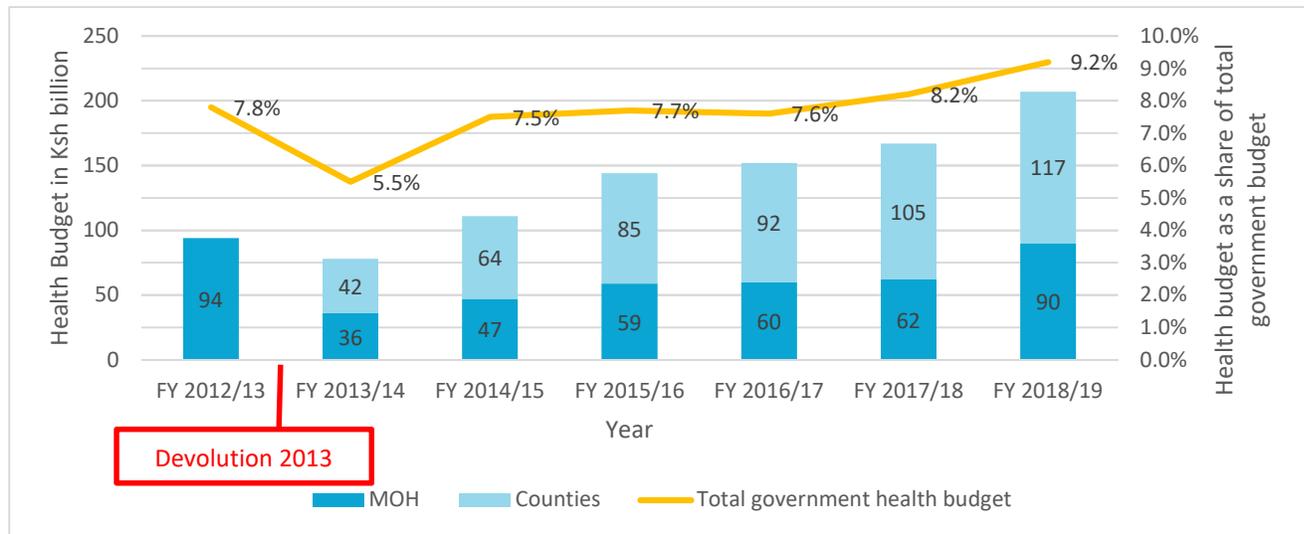


Figure 1. Pre- and post-devolution budget allocations to health

Source: Ministry of Health 2019

As a result of devolution, there are 49 public purchasers in Kenya. This includes the MOH and NHIF at the national level, and 47 CDOHs at the county-level. Besides these public purchasers, there are both commercial and community-based voluntary health insurance schemes in Kenya, but they cover approximately 3% of the population (Ministry of Health 2018). Purchasing by the MOH and the CDOHs follows a public integrated delivery model, while NHIF is a public contract model (Mbau et al. 2018). Each of the public purchasers implements multiple financing schemes. Below, purchasing arrangements by the MOH and NHIF (also summarized in Table 1) and are also described, before a turn to county government health purchasing in section 4.

Ministry of Health

The MOH as purchaser allocates funds to tertiary and specialty care facilities. As shown in Table 1, the MOH purchases tertiary care services provided by the country’s referral hospitals (which are semi-autonomous entities and receive grants from the MOH) and specialty medical facilities. While all citizens are eligible to

⁵ Estimates of county budget allocation and actual spending for health seem to vary between government agencies, specifically the MOH, the Controller of the Budget, and the Commission on Revenue Allocation. While the MOH’s estimates have been used for this report, the team calls upon these three agencies to explore the causes for this and address any accounting discrepancies.

⁶ The Kenyan FY, following the practice in East Africa, runs from June 1 to July 30 of the next calendar year.

access these services, they may have to pay out of pocket depending on whether they have insurance coverage or not.

Table 1. Overview of public purchasing arrangements in Kenya

Purchaser	Financing scheme/arrangement	Source of financing	People covered	Benefit package	Providers	Payment to providers
MOH	Tax-funded health care delivery	National government allocation, reflected in MOH budget	All	KEPH	Level 6 referral and specialized care facilities, public only	Grants to semi-autonomous tertiary hospitals; line-item budget to specialty care facilities
NHIF	General Scheme	Member contributions, national government allocation to cover sponsored members	Formal sector employees, informal sector enrollees, sponsored members (and all their families)	Inpatient, outpatient, chronic disease treatment, surgery, maternity and FP, ambulance, optical care, foreign care	Contracted public and private providers	Capitation for outpatient, combination of fixed fee and per diems for inpatient
	Civil Servants Scheme	Member contributions, government contribution as employer	Civil servants (and their families)	Same as general + fertility services, dental, vision, last expenses	Contracted public and private providers	Capitation for outpatient, combination of fixed fee and per diems for inpatient
	Linda Mama	National government allocation reflected in MOH budget	Pregnant women who register with NHIF	Antenatal care, deliveries, and postnatal care	Contracted public and private providers	Fixed fee for deliveries, antenatal care, and postnatal care
	EduAfya	National government allocation via Ministry of Education	Students registered in public secondary schools	Same as general + fertility services, dental, vision, last expenses	Contracted public and private providers	Fixed fee per visit

Purchaser	Financing scheme/arrangement	Source of financing	People covered	Benefit package	Providers	Payment to providers
CDOH			Refer to Table 2			

Source: Ministry of Health 2019; Dutta et al. 2018; Barasa et al. 2018; Mbau et al. 2018; program brochures on NHIF website

In addition, the MOH manages a range of vertical health programs. They are implemented by units within the MOH (e.g., for FP, malaria, and immunization) or semi-autonomous government agencies (e.g., for HIV/AIDS), and typically involve developing policies and plans and managing donor-funded programs implemented by the national government. The MOH also pays directly for priority commodities (discussed in the context of FP in section 4).

The MOH also finances several schemes that are implemented by other public purchasers. This includes the Linda Mama free maternity program, which is implemented by NHIF, as well as a range of conditional grants to the county governments (more details about both in sections 4 and 5 below).

The National Hospital Insurance Fund

NHIF, the sole public health insurance agency in Kenya, is meant to provide social health insurance to all Kenyans but currently covers approximately a fifth of the population. It was established in 1966 as a department within the MOH to provide inpatient coverage to formal sector employees. Kenyans employed in the formal sector (both public and private) make mandatory contributions to the NHIF through automatic payroll deductions. Following reforms in 1972, NHIF made the inpatient scheme available to informal sector households on a voluntary basis (Abuya, Maina, and Chuma 2015). The 1998 NHIF Act reconstituted NHIF as a parastatal, gave NHIF the mandate to cover both inpatient and outpatient services, and—most notably—made NHIF insurance mandatory for all Kenyans (National Council for Law Reporting 2012b). In practice, however, NHIF is only mandatory for salaried employees, whose employers remit the monthly premium (set on a graduated scale linked to salary levels) to NHIF. The insurer does not have a way to automatically collect contributions from those who are self-employed or work in the informal sector. For such households, membership is therefore effectively voluntary and involves a flat premium (currently set at KES 500 or \$5 per month for a household). In 2014, the national government launched the Health Insurance Subsidy Program, which pays the premiums for poor and vulnerable households (Barasa et al. 2018). Currently an estimated 20% of the population is actively enrolled in NHIF, compared to 3% with private health insurance (Ministry of Health 2018). However, NHIF only accounts for 4.6% of current health spending, compared to 10.7% by private insurance (World Health Organization n.d.).

NHIF covers a range of inpatient and outpatient services, which it purchases from contracted public and private providers. It introduced an outpatient package for civil servants in 2012, which it extended to all members in 2015 along with an increase in premiums. Currently, NHIF offers two main insurance schemes: the civil servant scheme for government employees, and a general scheme that covers everyone else, which includes all formal sector employees not employed by the government, informal sector members, and households sponsored by the government. It pays primary care facilities for outpatient services using a capitation method, and hospitals for inpatient services through a mix of case-based rates, fee-for-service, and per diems (Barasa et al. 2018). As per the NHIF Act, all payments are made directly to health facilities. Notably, the ability of facilities to retain and spend those funds has changed as a result of devolution, explored further in section 4 below.

Beyond its insurance schemes, NHIF also serves as the purchaser for national government schemes targeting high-priority health areas or vulnerable population groups. This includes Linda Mama, the free maternity

scheme that NHIF started managing in 2017 (discussed in section 5) and the EduAfya scheme for adolescents studying in public sector secondary schools, which is financed by the Ministry of Education (NHIF 2019).

County departments of health

The CDOHs in the 47 counties are the main purchasers of primary and secondary services in Kenya. They receive funds from different sources, which they allocate to public providers from levels 1 to 5 using a mix of input-based financing (where the county pays directly for such inputs as health workers, drugs and supplies, equipment, and other activity implementation costs) and financial transfers.

To analyze health purchasing by county governments requires an understanding of how counties generate and spend funds, as well as national- and county-level policies for user fees and user-fee reimbursements in the public sector. An overview of the sources of revenue for the county government and the budget allocation process is provided in section 4 below. In section 5, the evolution of user fee policies in Kenya is described. Section 6 draws on sections 4 and 5 to explore the full range of county purchasing arrangements and the flow of funds to public facilities.

IV. COUNTY REVENUE AND EXPENDITURE FOR HEALTH

Sources of financing for county governments

Each county operates a County Revenue Fund (CRF) where it pools funds from different sources. The 2010 Constitution and the 2012 PFM Act mandated the creation of the CRF in each county. By default, all funds raised or received by county governments are meant to be held in this account, which is controlled by the county treasury (Box 2). There are four main sources of county funds: a block grant⁷ from the national government, own-source revenue, conditional grants from the national government, and loans and grants from development partners.

The first and main source of county funds is a block grant from the equitable share of national revenue. The national government is required to transfer a minimum of 15% of national revenue to counties, which is referred to as the equitable share. The Commission on Revenue Allocation, a constitutionally mandated body, develops the revenue allocation formula that determines how much each county gets from the equitable share based on several factors, including county population, geographical size, and poverty level. Counties receive these funds as block grants and have full control over how they allocate the resources to different sectors and activities. Across all counties, the equitable share block grant accounted for 78% of revenue for counties in FY 2017/18⁸ (Office of the Controller of Budget n.d.).

Locally generated funds are the second biggest source of county revenue, including funds generated by public health facilities. The counties collect revenue from local taxes (mainly property and entertainment taxes) and fees for goods and services provided by the

Box 2. Language in the 2012 PFM Act about facility funds

“The County Treasury for each county government shall ensure that all money raised or received on behalf of the county government is paid into the County Revenue Fund, except money that ... may, in accordance with other legislation, this Act or County legislation, be retained by the county government entity which received it for the purposes of defraying its expenses...”

⁷ In public finance, a distinction is made between two types of intergovernmental transfers: block grants that can be used for any purpose decided upon by the county, state, or city receiving the funds, and conditional grants that the recipient must use for a specific purpose stipulated by the level of government making the grant.

⁸ This section refers mainly to FY 2017/18 as it is the last fiscal year for which a full budget implementation report from the Controller of Budgets is available.

county. The latter includes funds generated by public facilities through user fees or reimbursements from NHIF. Counties have struggled to meet their own targets for own-source revenue; in FY 2017/18, they collected only 66% of the targeted amount. The funds they collected accounted for 8% of their total revenue in that year (Office of the Controller of Budget n.d.). Collections from hospitals are among the top sources of own-source revenue for counties, especially in rural counties that do not have much to raise in property taxes or parking fees (IBP Kenya 2017).

Under the 2012 PFM Act (Box 2), county governments can enact legislation to allow any county government entity, including public health facilities, to retain funds they raise to cover their own expenses (The Republic of Kenya n.d.). Indeed, public facilities in Kenya have collected revenue from user fees and health insurance reimbursements for decades (refer to section 5). There is variation in how counties have interpreted and applied this provision, discussed under section 6.

Conditional grants from the national government are the third main source of financing for the counties.

While the equitable share is a block grant that counties can allocate freely (along with locally generated revenue), the counties also receive conditional grants from the national government that are pegged to specific purposes. The national government has initiated several conditional grants related to health; in FY 2017/18, county governments received a user fee foregone grant (to compensate levels 2 and 3 facilities for user fee removal; more details can be found in section 5), a conditional grant for level 5 county referral hospitals (which serve a catchment population that often extends beyond the county where they are located; see more about this in section 5), and a medical equipment leasing grant.⁹ Across all counties, conditional grants from the national government accounted for 4% of total county revenue in FY 2017/18 (Office of the Controller of Budget n.d.).

Conditional loans and grants from external partners are the fourth main source of financing. A range of development partners give on-budget support to Kenya. Some of the support is meant for the counties, and this is typically structured in the form of conditional loans and grants to county governments. These transfers accounted for 2% of total county revenue in FY 2017/18 (Office of the Controller of Budget n.d.). For health, this includes a conditional grant from the Danish International Development Agency (DANIDA) that flows to levels 2 and 3 facilities and a conditional grant from the World Bank under the Transforming Health Systems for Universal Care (THS-UC) program for improving reproductive, maternal, newborn, child, and adolescent health (RMNCAH) financed by the Global Financing Facility (GFF). The recently launched universal health coverage (UHC) pilot program targeting selected counties, which receive donor support, is also structured as a conditional grant to the county governments (the THS-UC conditional grant and the other conditional grants in section 5 are discussed below). Some of these donor-funded loans and grants flow through a special purpose account, where they are ring-fenced for specific uses.

How counties allocate their budget

The four main sources of revenue described above form the basis for the county budget, which county governments develop using a process that mirrors the national budget process. The budget cycle at the county level consists of four key phases—budget formulation, budget approval, budget execution, and auditing—that are aligned with the national budget cycle. In the budget formulation stage, which starts a full year before the FY begins (e.g., in July 2019, planning starts for FY 2020/21), CDOH reviews the health sectors' performance in the previous year and determines priorities for the next year as well as their cost. Then, CDOH

⁹ A public-private partnership scheme initiated by the national government whereby county governments receive specialized medical equipment from private companies for use in county hospitals. This is beyond the scope of this report as it does not meet the definition of purchasing (which is about allocations to providers of services rather than producers of facility inputs such as equipment).

develops a budget proposal for health investments, which includes the plan for using resources as well as the required funding to achieve commitments. The CDOH is supposed to consider the plans and budgets prepared by health facilities, but the experience around this has been mixed (an issue explored in section 6). This proposal is examined together with proposals from other sectors during the process of allocating available resources (Health Policy Project 2016). Next starts the approval phase, typically six months before the start of the actual FY. The County Assembly reviews and approves budget estimates and passes the legislation, which allows CDOH to spend funds. Next comes the budget execution phase with the start of the actual FY. At the end of each quarter, the county government is meant to account for budget execution to date. The final phase is auditing, which starts once the FY has ended. County governments have to comply with the legal requirements related to accounting and reporting against past spending (Waithaka et al. 2018; Health Policy Project 2016). At any given point in time, the county will be in a different phase of the budget cycle for different FYs; for example, in the July to December timeframe, the county is accounting for its spending for the last FY, executing its budget for the current FY, and starting to prepare its budget for the next FY.

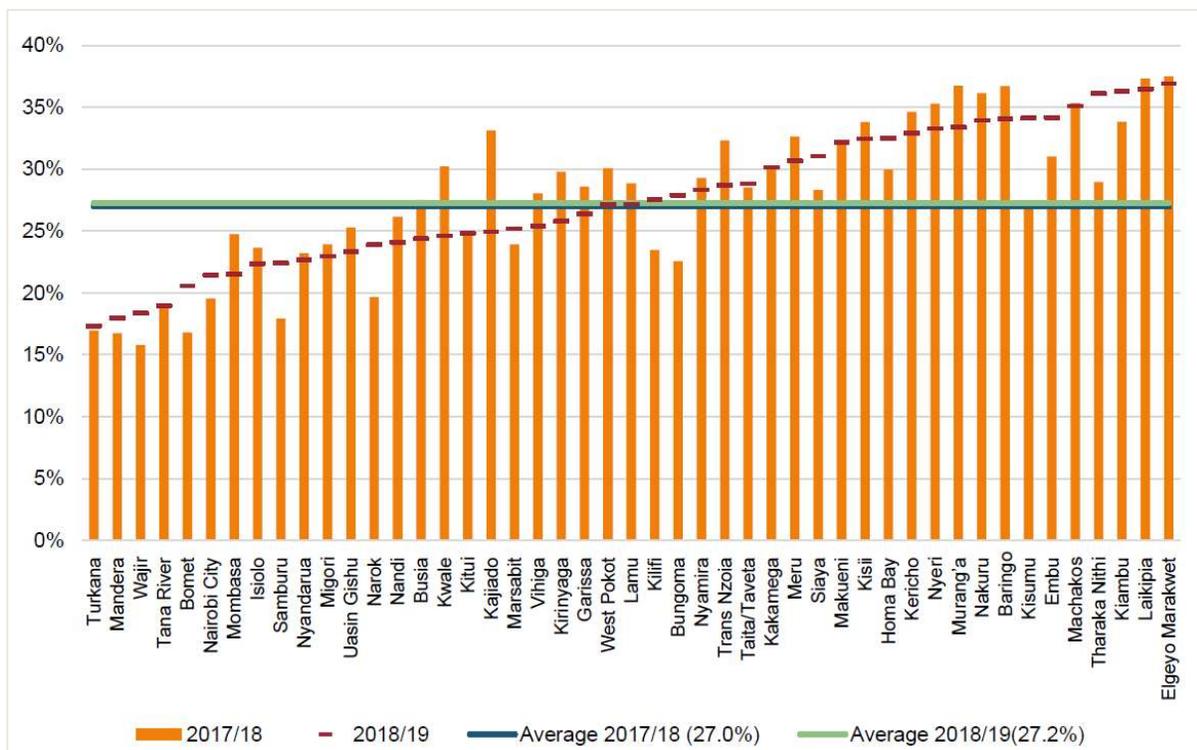


Figure 2. County health budget as a percentage of total county budget FY 2017/18 and FY 2018/19

Source: Ministry of Health 2019

The share of the county budget that is for health averaged across counties has been steadily increasing over the past few years, from 23.4% in FY 2015/16 (Ministry of Health, Republic of Kenya n.d.) to 27.2% in FY 2018/19 (Ministry of Health 2019). However, the budget allocations for health vary considerably across counties (Figure 2). The absorption rate (or the share of the county overall budget that was spent) was 74% in FY 2017/18, and this also varied from a low of 48.5% to a high of 85.5% across counties (Office of the Controller of Budget n.d.).

Recurrent health spending accounts for the bulk of county health spending. According to the 2012 PFM Act, counties are supposed to allocate 70% of their budget to recurrent expenditure and 30% to development expenditure. This allocation is meant to be reflected in the sector budgets (Ministry of Health, Republic of

Kenya n.d.). However, the allocation for recurrent spending has been higher than this threshold in most counties (including the focus counties); the average across counties reduced from 83% in FY 2017/18 to 79% in FY 2018/19 (Ministry of Health 2019).

The CDOH pays directly for a range of provider costs in the public sector, including health worker salaries, medical supplies, and facility operating expenses. These allocations are principally based on past patterns of expenditure (Mbau et al. 2018). Personnel emoluments for health workers accounted for 75.8% of counties’ recurrent budget for health in FY 2018/19, up from 70.6% and 71.9% in FY 2016/17 and FY 2017/18. Spending on medical supplies and facility operations costs accounted for 6.9% and 9.7% of the recurrent health budget for counties in FY 2018/19 (Ministry of Health 2019). Figure 3 shows the wide variation across counties in these shares. These costs are paid directly by the county and represent “in-kind” transfers to the facilities, as opposed to a flow of funds to the facility. The CDOH also pays for non-facility-based health care provision (community outreach, health promotion activities, and so on), as well as other health functions (general administration, policy and planning, in-service trainings, regulation, and quality assurance, etc.).¹⁰

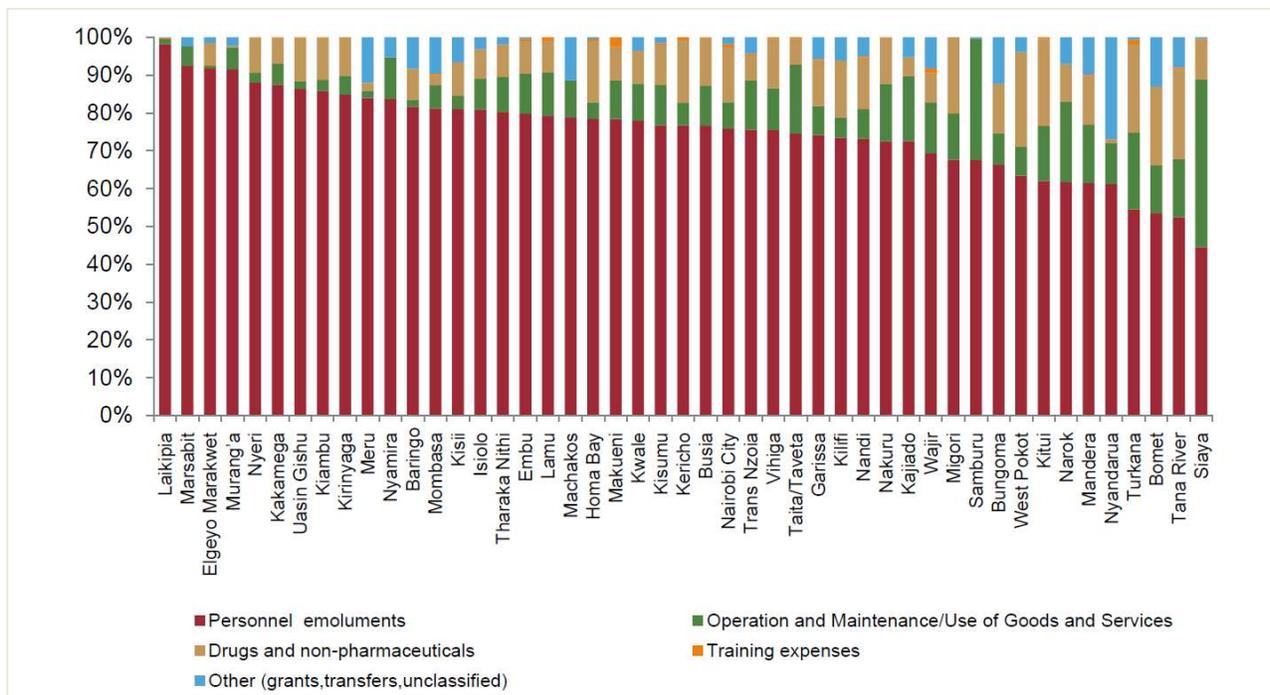


Figure 3. County recurrent health budget by economic classification in FY 2018/19

Source: Ministry of Health 2019

County governments make key decisions regarding the health workforce employed in public facilities. Prior to devolution, the national government employed and paid for all health workers serving in public facilities. In late 2013, the national government transferred all responsibilities for managing and paying health workers to the county governments. More than half of county employees work in the health sector. Their recruitment is managed by the CDOH and the County Public Service Board (Ministry of Health 2015a). In the immediate

¹⁰ A distinction is drawn here between purchasing and other forms of health spending that purchasing entities may incur. This is most relevant for ministries of health and other government departments, which pay for health care delivery through public providers and a range of other functions that support health care delivery (such as those listed above).

aftermath of this transition, inadequate capacity and weak structures at the county level caused major delays and discrepancies in staff salary payments as well as confusion around management of health workers, including in-service training, career progression, and so on (Tsofa, Goodman, et al. 2017). While some of the initial challenges with counties managing health workers have been addressed, perceptions of low pay and infrequent promotions have caused industrial action in the sector (Mbau et al. 2018). There is some evidence that counties have started adopting different strategies to address their unique health workforce needs. This includes actively recruiting significant numbers of health workers and, in some instances, offering more remuneration (e.g., Bomet County); increasing staff motivation through promotions, trainings, and awards (e.g., Samburu and Elgeyo Marakwet counties); and offering health workers housing and transport in hard-to-reach areas (West Pokot County) (Nyagaka 2018). Overall, health workers are paid based on their job groups, and not based on performance (Mbau et al. 2018).

County governments hold the budget for drugs and medical supplies, and aggregate and submit orders from public facilities to commodity procurement agencies. Essential medicines and supplies are procured through Kenya Medical Supplies Authority (KEMSA) and Mission for Essential Drugs and Supplies (MEDS). The former is a state corporation under the MOH, and the latter is a faith-based, not-for-profit organization. Both are responsible for procurement and distribution of medicines and medical supplies. The procurement process starts at the health facility level, where needs are determined. Health facilities submit a request to CDOH, which analyzes and consolidates all orders, prepares the purchase orders, and submits them to the County Treasury (Tsofa, Goodman, et al. 2017). However, given limited communication and consultations between CDOH and the Department of Finance within the county government, purchasing of goods and services for the health sector is not adequately prioritized and funded (Mbau et al. 2018). Some studies indicate that at the primary health facility level, patients receive a prescription and are asked to purchase drugs from the private sector (Nyikuri et al. 2015). Evidence also shows that hospitals are facing shortages of essential medical supplies due to delayed payments (Barasa et al. 2017; Mbau et al. 2008).

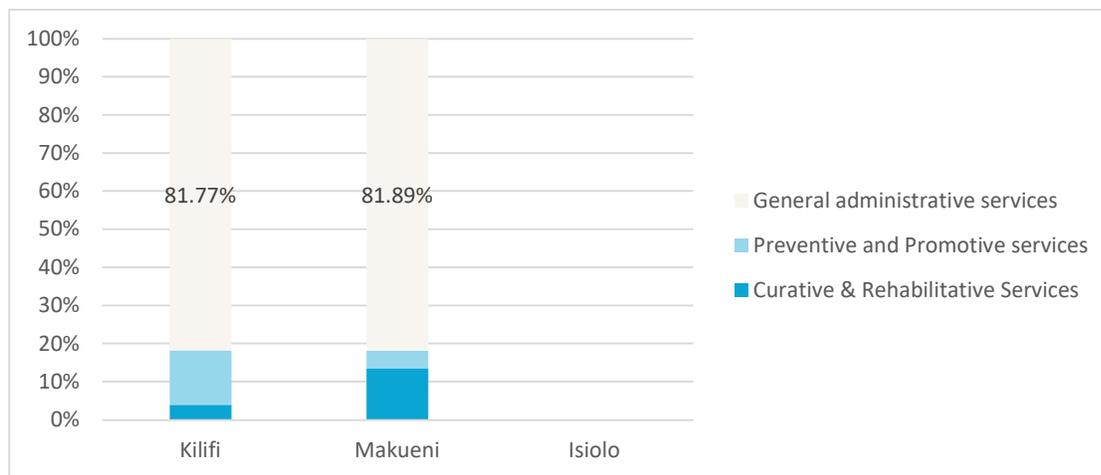


Figure 4. Program-based budget for Makueni and Kilifi, FY 2019/20

Source: Authors' calculations from county program-based budgets; Isiolo's program-based budget is not available at this time.

While counties have adopted program-based budgeting following guidelines from the national government, the bulk of their health spending is categorized under general administration. Kenya adopted program-based budgeting in 2007, which was integrated into the 2012 PFM Act. Following guidelines from the MOH, counties categorize their health spending into three main programs: curative and rehabilitative services, preventive and promotive services, and general administration. These budgets are heavily skewed toward general

administration in most counties, given that all costs associated with salaries, drugs, and facility maintenance are included under this category (Figure 4). While there are now guidelines for counties to disaggregate each of the three main categories into sub-categories, including a line for reproductive, maternal, newborn, and child health under preventive and promotive services, these have not been implemented consistently.

County government financing for FP and MNCH

CDOH directly pays for a significant share of the costs associated with the delivery of FP and MNCH in public facilities. As shown in Figure 3 and discussed above, CDOH allocates and spends funds to cover staff salaries, commodities, and operating costs of public providers that offer FP and MNCH services as part of a broad package. CDOHs also pay for other FP- and MNCH-related activities, such as community outreach through community health volunteers (CHV), supportive supervision, social and behavior change communication, school-based programs, and so on. Recent analysis by the Clinton Health Access Initiative suggests that counties have typically not been budgeting for FP commodities (CHAI 2019). The national government was paying for FP commodities until FY 2012/13 but stopped in subsequent years with the expectation that county governments would budget for commodities. This however did not happen, resulting in donor programs becoming the sole financiers of FP commodities since then. This includes significant financing from the GFF-funded THS-UC program, which accounted for three quarters of total commodity financing in FY 2016/17 and approximately half of the total in FY 2017/18 and FY 2018/19. In the current fiscal year, the national government has once again committed resources for FP commodities, financing approximately 41% of the total, while GFF covers another 41% and other donors finance the rest.

Financing for commodities represents a small share of THS-UC funds; the bulk of funding under the program is structured as results-based financing from the national government to counties in the form of conditional grants. The program places some broad conditions on the use of the funds: they are earmarked for RMNCAH activities, the counties cannot use the funds to augment health worker salaries, and the funds must be held in a special purpose account at the county level. Beyond that, the counties have discretion over how they allocate the funds, what share is for direct service provision versus supportive functions like trainings, and whether the county pays for inputs such as commodities and pays facilities based on services delivered.

V. EVOLUTION OF USER FEE POLICIES

User fees in the pre-devolution era

Public health facilities have generated funds for the health sector since user fees were introduced three decades ago. All health services were free in post-colonial Kenya until 1989 (Figure 5), when user fees were introduced to raise additional revenue for the health sector (Chuma and Thomas 2013; Mwabu and Mwangi 1986). User charges started being levied at all public facilities, including levels 2 and 3 facilities (which correspond to dispensaries and health centers; see Box 2) that provide primary care services. The rates were set locally by the facilities and included charges for individual items such as drugs, injections, and laboratory services. The charges varied across facilities and regions. Most of the revenue was retained at the district level and used for health service delivery at the facility and other public health programs in the district (Chuma et al. 2009; Owino 1998).

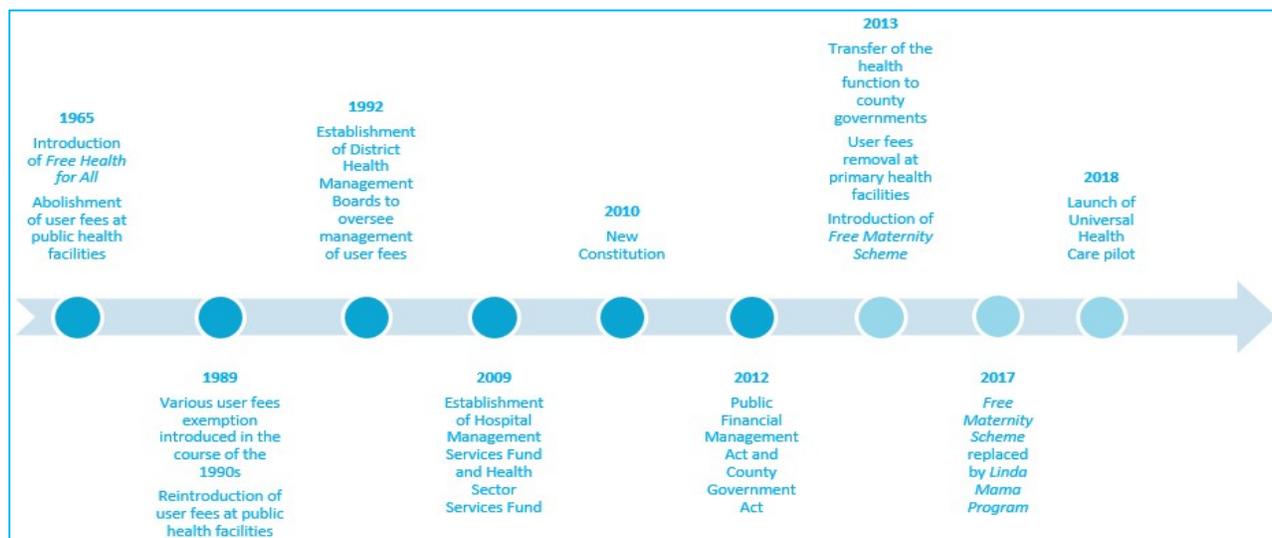


Figure 5. Key reforms in the health sector in Kenya

Source: Based on Waweru et al. 2016; Tsofa, Molyneux, et al. 2017; MANI Project, Options, and Marie Stopes International 2018

Early attempts to either cap or remove user fees had limited success because facilities were not reimbursed for the loss of user fees. In the course of the 1990s, the Government of Kenya introduced waivers and exemptions for high-priority health areas such as services for children under the age of five. Regardless, evidence from this period suggests that user fees introduced a significant financial barrier to access, depressing health care utilization (Mwabu, Mwanzia, and Liambila 1995; Moses et al. 1992). In 2004, the government abolished user charges for primary care, and instead adopted a single flat registration fee of 10 and 20 Kenyan shillings at government-owned dispensaries (level 2) and health centers (level 3), respectively, in what came to be known as the 10/20 policy (Chuma et al. 2009). An early evaluation of the policy reported high adherence to the new rates on the part of health facilities and a 70% increase in utilization (Kenya Ministry of Health 2005). However, Chuma and coauthors (2009) found that three years after the implementation of the policy, patients' understanding of the policy and facility adherence to the policy both were limited.

In 2009, the Government of Kenya and development partners jointly set up a mechanism to channel funds directly to health facilities in the public sector. The World Bank and DANIDA financed the Health Sector Support Fund (HSSF) to compensate levels 2 and 3 facilities for the loss of user fees due to the 10/20 policy (Ramana, Chepkoech, and Workie 2013). A fixed amount of money was sent directly to the facilities' bank accounts from the national treasury (Tsofa, Molyneux, et al. 2017; Nyikuri et al. 2015). These funds were received on a quarterly basis and managed by the health facility's management committees. HSSF is credited for improving service delivery in health centers and dispensaries, as well as for improving accounting of facility finances (Ramana, Chepkoech, and Workie 2013), strengthening transparency and community involvement, and improving health workers' motivation and patients' satisfaction (Waweru et al. 2016). In 2009, a similar mechanism was established for hospitals under the name of the Hospital Management Support Fund (HMSF) (Tama et al. 2017).

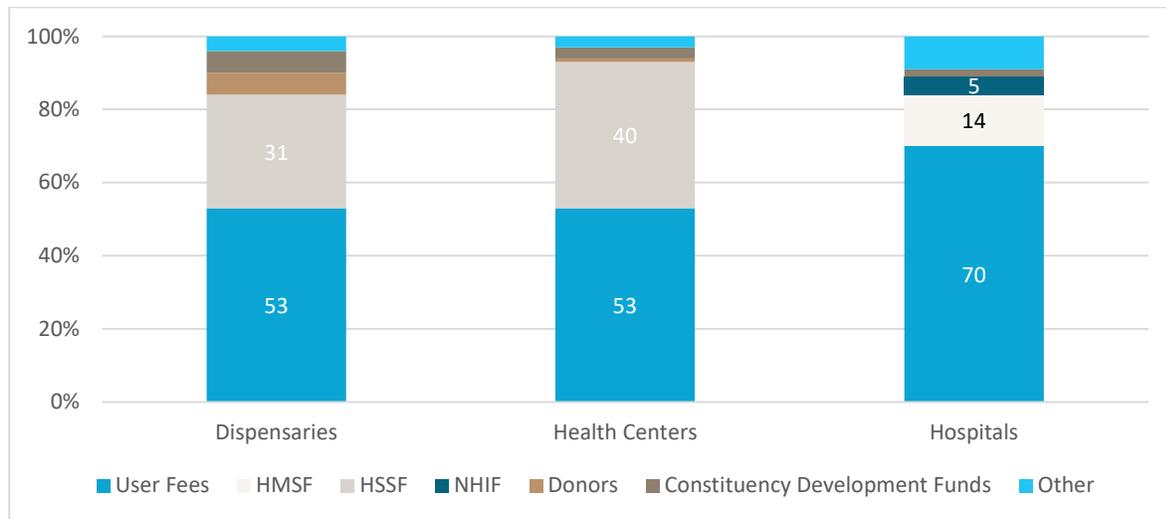


Figure 6. Sources of revenue for facility operating budgets, FY2011/12

Source: Onsomu et al. 2014

Even with the financial transfers to facilities, user fees remained the largest source of financing for the operating costs of health facilities in the public sector prior to devolution. Before 2013, the MOH paid for staff salaries and drugs through the national budget, while facilities maintained a separate operating budget financed through funds collected and retained by the facility from user fees, transfers from HSSF or HMSF, and reimbursements from insurance. The Public Expenditure Tracking Survey (PETS) completed for FY 2011/12, which included a nationally representative sample of facilities, found that on average user fees accounted for 53% of the operating budget of health centers and dispensaries (Figure 6). In the case of hospitals, user fees accounted for 70% of the operating budget (Onsomu, et al., 2012). In contrast, HSSF accounted for 31% and 40% of the operating costs of dispensaries and health centers, respectively, while HMSF accounted for 14% of the operating budget of hospitals. NHIF only accounted for 5% of hospital revenue. Since this study predates the expansion of NHIF to cover outpatient services at primary care facilities, health centers and dispensaries received no revenue from NHIF.

The operating budget—while small compared to total facility expenditure—was controlled by the facilities, which used the funds to pay for a range of things. The operating budget as a share of total facility costs was no doubt small even though a precise estimate is not available. A 2012 facility survey estimated that spending on personnel accounted for 70 to 80% of the total costs of running a public-sector hospital. The share was 80 to 90% in the case of health centers and dispensaries. Drugs and supplies accounted for another 10%, 5%, and 15% of total costs in hospitals, health centers, and dispensaries, respectively (IHME 2014). These were largely paid by the MOH directly, though facilities did use their operating budget to procure commodities and casual labor, as described above. The FY 2011/12 PETS shows that hospitals spent nearly a third of the user fees they collected to pay for drugs, medical supplies, and laboratory materials; the other main uses were food and rations (18%), casual labor (10%), and utilities (5%).

Evolution of user fee reimbursement schemes since 2013

In 2013, alongside the transition to a devolved system of government, the Government of Kenya abolished all user fees at government-owned primary care facilities as well as user fees for deliveries at all government-owned health facilities. The two user fee policies were designed to remove financial barriers to access (Chuma and Thomas 2013). Under the first policy, all services at public sector dispensaries (level 2; see

Box 2) and health centers (level 3) were made free at the point of use. Under the free maternity scheme (FMS), women delivering at any public facility were able to do so without any charges. The national government set aside funds to compensate levels 2 and 3 facilities for the loss of revenue from user fees for PHC services and to reimburse all public facilities for deliveries. The reimbursements to levels 2 and 3 facilities were based on historical data of revenue collected from user fees reported by each health facility. For FMS, the reimbursement was based on births reported to the health management information system.

After initially paying the facilities directly, the MOH started transferring the reimbursements to the counties in the form of conditional grants. When the two user fee removal policies were initially announced, the MOH started reimbursing health facilities directly using the HSSF mechanism set up by the World Bank and DANIDA. However, given the constitutional requirement for national funds to be transferred into the CRF, the reimbursement for user fees foregone by levels 2 and 3 facilities as well as FMS reimbursements were converted into conditional grants to the county in FY 2015/16 (Office of the Controller of Budget n.d.). The user fee reimbursement has remained a conditional grant ever since. The national government releases the conditional grant for user fees foregone to counties with instructions on how much should be transferred to specific levels 2 and 3 facilities based on service utilization data from the district health information system. The HSSF mechanism was discontinued, and DANIDA changed its support to a conditional grant where county governments are required to channel the funds to primary care facilities (levels 2 and 3).

In 2013, the national government also started giving counties a conditional grant for level 5 facilities. Prior to devolution, each province had a level 5 referral hospital. Counties that inherited these hospitals receive a conditional grant from the government in recognition of the fact that these facilities serve a population area that extends beyond the county where the hospital is located. The national government allocates funds across the hospitals based on a formula that considers factors like bed capacity and bed occupancy rates (National Council for Law Reporting 2019). These funds are transferred to the county government where the hospital is located as a conditional grant.

In 2017, the MOH transferred FMS to NHIF, at which point it was renamed Linda Mama. Early evaluations of FMS, while it was still controlled by the MOH, documented several challenges, including delays in payment and overcrowding in public facilities (Maina and Kirigia 2015; Ministry of Health 2015b). To address these issues, the MOH decided to transfer management of the scheme to NHIF. In mid-2017, NHIF started contracting and paying private and faith-based health facilities for deliveries by women who registered with NHIF for the scheme. The MOH continued to pay public providers. By late 2017, NHIF was managing reimbursements for all facilities. In March 2018, the benefit package was expanded to include antenatal care and postnatal care. Reimbursements rates under Linda Mama vary according to facility type (hospital versus levels 2 and 3 facilities, and public versus private ownership), but are below NHIF rates for the maternity package under its general scheme (Appleford and Mbuthia 2018). All pregnant women who are Kenyan citizens are eligible to become members of Linda Mama and can benefit from services for a period of one year. They can register through mobile phone, NHIF registration portal, contracted health care providers, NHIF service centers, or other public service centers. A membership card is issued once registration is completed (NHIF n.d.).

The latest iteration of a user fee reimbursement scheme is the UHC pilot, which the national government is financing in four counties. In December 2018, the national government launched Afya Care or the UHC pilot in Isiolo, Kisumu, Nyeri, and Machakos. Under the scheme, registered households can access services free of charge at levels 4 and 5 county hospitals (former district and provincial hospitals, respectively). The national government reimburses the counties for the lost revenue from user fees through a conditional grant, which is financed with support from the World Bank and the Government of Japan.

The largest share of funds under the UHC pilot flow to Kenya's central medical supplies procurement agency to pay for essential drugs and commodities. Funds under the UHC pilot conditional grant are dispersed in four

tranches: basic and specialized services (72%), community health (12%), health system strengthening (15%), and public health (1%). Of the funds set aside for basic and specialized services, the national government transfers 70% directly to KEMSA, a state corporation overseen by the MOH, to pay for essential drugs and commodities. Counties have “draw down” rights against their allocation. County governments can use the balance of 30% for operations and maintenance at levels 4 and 5 facilities (Dutta et al. 2018).

The county government of Makueni has its own version of user fee reimbursement for public hospitals.¹¹

Under Makueni Care, all bills incurred by patients at county hospitals are reimbursed by the county government. The scheme is open to all residents of the county, who are required to register for the scheme and pay an annual non-refundable registration fee of KES 500 per household. The county pays the facilities on a fee-for-service basis for inpatient care, outpatient consultations, emergency transport to the county hospital, laboratory services, and so on (Kibwana, n.d.). The county does not appear to have adjusted its supply-side financing for public facilities to account for the output-based payment.

These user fee reimbursements schemes in Kenya result in a complex set of funding flows to public facilities. These are covered in the section below.

VI. COUNTY HEALTH PURCHASING

County government purchasing arrangements

The CDOH as purchaser allocates resources to public facilities using multiple arrangements. In Table 2, each is described according to the people covered, the benefit package, the providers, and the payment methods. First and foremost, CDOHs directly pay for costs associated with health care delivery at levels 1 to 5, including staff salaries, commodities, facility maintenance, and activities under vertical programs (this includes health promotion and prevention activities that are implemented outside of facilities). These are financed through the county’s health budget, drawing from the equitable share grant, own-source revenue, and donor funds, including the THS-UC grant. Second, all counties receive two conditional grants that are specifically earmarked for covering facility costs: user fee reimbursement for levels 2 and 3 facilities, and the DANIDA conditional grant for levels 2 and 3 facilities (which is a continuation of the HSSF mechanism described in section 5). Counties transfer these funds as a financial payment (as opposed to in-kind transfers) to primary care facilities. Third, counties that have level 5 hospitals receive a conditional grant to defray their operating costs. These funds are transferred to the hospitals, but there remain concerns about facility autonomy, capacity, and accountability.

In addition to these payment arrangements, county governments decide whether facilities can retain and spend revenue from user fees and other purchasers, such as NHIF. Early studies of facility financing in the post-devolution period noted that hospitals lost financial autonomy after 2013 because county governments started requiring them to remit all funds they collected to the CRF (Barasa et al. 2017; Mbau et al. 2018). The review of purchasing arrangements in Kilifi, Isiolo, and Makueni shows that there is considerable variation across counties in how they manage funds raised by facilities. Through an executive order, Makueni has allowed public hospitals to retain and spend the funds they collect (from user fees in the case of households not registered for Makueni Care and NHIF reimbursements). Kilifi has enacted legislation allowing for the creation of facility improvement funds for hospitals, but is not implementing the law. Isiolo has made no provision for facilities to retain funds. Hence in both Kilifi and Isiolo, hospitals transfer all funds they collect to

¹¹ The authors are not aware of any other county launching its own user free reimbursement scheme.

the CRF, and the county government pays directly for any expenses (National Council for Law Reporting 2012a; The Republic of Kenya 2015).

Table 2. Overview of county purchasing arrangements

Purchaser/ county	Financing scheme/ arrangement	Source of financing	People covered	Benefit package	Providers	Provider payment method
CDOH in all counties	Tax-funded health care delivery	County funds (including equitable share grant, own- source revenue, and THS-UC funds)	All	KEPH	Levels 1-5, public only	Input-based financing for salaries, commodities, and other operating costs
	User fee foregone conditional grant	National government	All	KEPH	Levels 2 and 3, public only	Grant to each facility based on historical utilization rates
	DANIDA conditional grant	DANIDA	All	KEPH	Levels 2 and 3, public only	Grant to each facility based on its level
CDOH in 12 counties with level 5 facilities	Level 5 conditional grant	National government	All	KEPH	Level 5 facilities	Grant given based on allocation criteria: poverty levels, bed utilization, outpatient cases, accident rates, and fuel price
CDOH in UHC pilot counties only	UHC pilot	World Bank and Government of Japan	Registered households	KEPH	Levels 4 and 5, public only	Input-based financing for commodities, and facility operations and maintenance costs
CDOH in Makueni County	Makueni Care	County funds from equitable share and own- source revenue	Registered households	KEPH	Levels 4 and 5, public only	Fee for service

Source: Authors' assessment based on key-informant interviews

The existing purchasing arrangements suffer from several challenges. A recent study by Mbau and colleagues (2018) used qualitative information from 10 counties to examine the nature of a range of “purchasing actions” grouped under three sets of relationships: purchaser and the government, purchaser and providers, and government and citizens. Along the government-purchaser axis, the study found that government (national and county) does not provide adequate stewardship. It fails to enforce existing laws and policies to form an enabling environment for strategic purchasing, provide adequate financing to CDOHs, and hold them

accountable for their performance. Along the purchase-provider axis, the authors noted that CDOHs do not selectively contract providers based on any performance or quality criteria or sign an explicit contract with any providers. Acknowledging that selective contracting may be difficult to implement within an integrated delivery model, the study recommends strengthening health information systems to allow the purchaser to allocate resources effectively and monitor provider performance. Provider payment through input-based budgeting and limited provider autonomy limits provider incentives to improve performance. Along the final government-citizen axis, the study documents poor public participation and the lack of bottom-up accountability.

Flow of funds to health facilities

Taking stock of the combination of provider payment methods and the nature of funding flows to providers is critical for understanding provider incentives and behavior (Mathauer and Dkhimi 2018; KEMRI Wellcome Trust 2018). Table 1 summarizes various schemes operated by NHIF that pay public and private providers for delivering services to NHIF beneficiaries. Table 2 provides an overview of how CDOH allocates resources to levels 1-5 public providers. As discussed above, county governments can grant these public providers the authority to retain the funds they collect from user fees and NHIF. These system features in combination create a complex set of resource flows to and from health facilities, which are described here.

There is currently no standard source of information about how much revenue public facilities generates, how much they can retain, how much they transfer to the CRF, and how much is spent by the county on their behalf. Kenya has not conducted a PETS exercise since the last one done in 2013 for FY 2011/12; in other words, not since devolution. The national and county budget documents do not provide detailed, disaggregated information about how much revenue health facilities generate and retain. Nor are county budgets set up in a way to see how much was allocated from the county budget for each health facility. In this section, the qualitative information collected is used as part of this landscaping exercise to describe these dynamics in Makueni, Isiolo, and Kilifi counties.

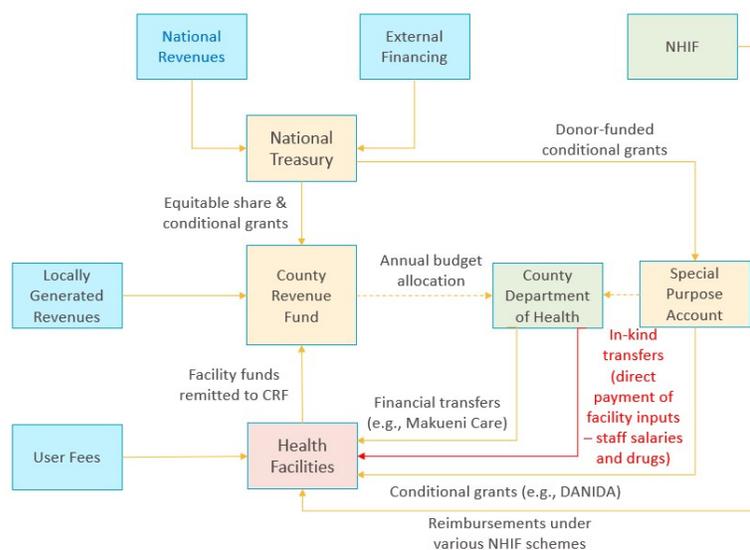
While prior to devolution it was relatively easy to describe how public facilities were financed, the landscape post-devolution is complex and varies across counties and levels of care. Before 2013, the national government paid directly for basic facility costs, including salaries and drugs. As described in section 4 above, facilities collected funds from different sources (see Figure 6) and used that to cover their operating costs. In contrast, the flow of funds in the post-devolution period is complicated (Box 3). While the county governments finance basic facility costs, including salaries, drugs, and maintenance, from the county budget across all counties (shown in Box 3 as in-kind transfers), the similarity between counties stops there. There are both variations across counties in what funds facilities collect, retain, and spend, and between primary care facilities (levels 2 and 3) and hospitals (levels 4 and 5). Table 3 provides an overview of these features in Makueni, Isiolo, and Kilifi counties.

Primary care facilities in Isiolo, Kilifi, and Makueni can both retain and spend the funds they collect. In all three counties, levels 2 and 3 facilities receive funds from three key sources: payments from NHIF under various schemes, funds from the county governments under the user fees foregone conditional grant, and funds from a conditional grant from DANIDA that is earmarked for primary care facilities (as a continuation of HSSF funding). The facilities spend the funds according to investment plans they develop. On a quarterly basis, they receive approval to incur expenditure from the Chief Officer within CDOH.

Hospitals in all three counties receive funds from NHIF through various schemes, but user fee policy is different in each of the three counties. Under NHIF's general scheme as well as special purchasing schemes like Linda Mama, NHIF pays public hospitals directly for services for NHIF members and program beneficiaries. This is a common source of funding for hospitals in all three counties. In contrast, the counties have three different ways of managing user fees. As one of four UHC pilot counties, Isiolo has discontinued all user fees at

Box 3. Flow of funds at the county level

The diagram below shows funding flows in the post-devolution period. A solid yellow line denotes a financial transfer, while a solid red line shows in-kind transfers to health facilities. A dotted yellow line is used to depict control over budget allocation decisions. The National Treasury transfers the equitable share and conditional grants financed from general taxation to the County Revenue Fund, which also draws resources from local taxes and revenue generated by public facilities from user fees and claims reimbursements (unless the county has authorized facilities to retain fees collected, as in Makueni). Donor-funded conditional grants are typically channeled to a special purpose account at the county level. The CDOH develops the county's health budget, drawing from both the CRF and donor-funded conditional grants. In all counties, the county governments pay directly for a range of facility costs, including staff salaries, drugs, and so on, and disburse funds from conditional grants to levels 2 and 3 facilities.



hospitals since January 2019. In Makueni, where the county government operates its own user fee reimbursement scheme, households that pay an annual membership and register for Makueni Care are exempt from paying user fees at hospitals, but other households are still required to pay. In Kilifi, hospitals continue to charge user fees for patients and services not covered by NHIF.

Table 3. Financial flows at health facility level in Isiolo, Kilifi, and Makueni

County	Facility level	Own-source revenue		Transfer own-source funds to CRF	Receive financial transfers from county government**	Facility has funds it can spend directly
		User fees	Payments from NHIF*			
Isiolo	Health centers and dispensaries (2&3)	No	Yes	No	Yes (user fee foregone conditional grant; DANIDA conditional grant)	Yes (NHIF payments, transfers from CDOH for conditional grants)
	Hospitals (4 & 5)	Yes, until December 2018; discontinued since then under UHC pilot	Yes	Yes	No	No
Kilifi	Health centers and dispensaries (2 & 3)	No	Yes	No	Yes (user fee foregone conditional grant; DANIDA conditional grant)	Yes (NHIF payments, transfers from CDOH for conditional grants)
	Hospitals (4 & 5)	Yes	Yes	Yes	No	No
Makueni	Health centers and dispensaries (2 & 3)	No	Yes	No	Yes (user fee foregone conditional grant; DANIDA conditional grant)	Yes (NHIF payments, transfers from CDOH for conditional grants)
	Hospitals (4 & 5)	Yes (households registered under Makueni Care do not have to pay)	Yes	No	Yes, receive reimbursements under Makueni Care	Yes (NHIF, user fees; payments from county government)

* NHIF pays capitation for outpatient services to all facilities, a combination of per diem and case-based rates for inpatient; and fixed fees for special schemes such as Linda Mama and EduAfya.

** All facilities receive supply-side financing for staff salaries, drugs, etc. These represent in-kind transfers from the county to the facilities.

Hospitals cannot retain the funds they collect in either Isiolo or Kilifi counties but have the authority to do so in Makueni. Hospitals in Isiolo transfer all funds they collect from the facility’s bank account to the CRF. While Kilifi has passed legislation to allow all health facilities including hospitals to retain and spend funds (Kilifi County Government 2016), the law has not been implemented, and hospitals continue to remit their revenue to the CRF. In Makueni, an executive order allows all hospitals to retain and spend their revenue from user fees and NHIF payments.

In the case of facilities that can retain and spend funds—namely, levels 2 and 3 facilities in all three counties and hospitals in Makueni—the process for spending the funds is similar. The health management team develops quarterly implementation plans and associated budgets, which are then approved by the health facility management committee. These are forwarded to the chief officers for health, who can issue an authority to incur expenditure. The facility in charge can then spend the amounts according to facility plans, and file returns with the county accountant. In Makueni there is an additional step, where the county has a committee at the county level that evaluates the proposals for each facility before they are finally approved by the chief officer for health.

For facilities that cannot retain and spend funds directly—namely hospitals in Isiolo and Kilifi—the county governments are meant to pay directly for all operating costs. These facilities are required to place requests to the CDOH, which then pays for the costs directly. Key informants interviewed in both counties spoke of considerable delays in this process. In contrast, hospitals in Makueni can retain and spend funds directly.

All public facilities in all counties are meant to prepare plans that feed into the county budgeting process; however, the implementation of this bottom-up budgeting process faces numerous challenges, and facilities are routinely not aware of their budget allocation from the county. The executive expenditure committee of the health facility management committee and board is generally responsible for developing the facility budget (Barasa et al. 2016). It is then sent to the CDOH, which then develops the county’s health budget. It should be noted that when health facilities develop their budgets, they are not aware of a budget ceiling. While the budgeting process is open to all stakeholders in Makueni and health priorities are determined in an appropriate manner, the budgeting process for the health sector in Isiolo and Kilifi is characterized by a lack of communication and transparency. Hospitals in both counties indicated they are not aware of their allocated resource envelope due to limited communication with CDOH. Ultimately, planned activities are often not implemented due both to a lack of enough funds and of control over funds. Given these challenges, there is some anecdotal evidence that hospitals illegally spend revenues from user fees.

The fact that hospitals cannot retain funds they receive from NHIF in Kilifi and Isiolo reduces their incentive to attract NHIF beneficiaries and offer them high-quality services. While health centers and dispensaries are able to retain the funds they receive from NHIF under various schemes, hospitals are required to remit these funds to the CRF. The allocation that the facility receives from the CDOH is unrelated to the volume of services delivered to NHIF clients, which is part of a broader problem of the CDOH as purchaser not linking its payment to public providers to performance.

VII. OPPORTUNITIES FOR STRENGTHENING STRATEGIC PURCHASING

In this final section, strategies for strengthening county government purchasing are explored. Table 4 below takes a closer look at the purchasing arrangements, identifies key challenges and opportunities for addressing them, and proposes actions categorized into three groups: (1) **analyze** through additional

research and learning activities, (2) **discuss** options with key stakeholders, and (3) **test** new approaches and/policies. Recommendations that are within scope for the SP4PHC to support are shown in **bold**.

VIII. CONCLUSION

The Government of Kenya has made a firm commitment to achieving UHC for all its citizens and has launched a range of health financing initiatives to achieve this goal. There is ongoing discussion about the UHC pilot that the national government initiated in December 2018 being scaled to all counties in FY 2019/20. The MOH has convened a high-level task force to advise on NHIF reforms. At their core, these reforms are about how the Government of Kenya allocates resources to providers of health services, such as purchasing.

In the post-devolution era, CDOHs are the main purchasers of PHC services, including priority FP and MNCH interventions, and do so using a range of purchasing arrangements. They control the government budget for health services in all public facilities except for tertiary hospitals. Even for schemes managed by NHIF, county governments have the authority to decide whether public facilities can retain and use the reimbursements they receive from NHIF. CDOH receives and allocates the user fee foregone, level 5 hospital, and UHC pilot conditional grants from the national government. They also are the main recipients of donor-funded conditional grants, including financing under the GFF/THS-UC mechanisms, which is earmarked for RMNCAH services. Strengthening how counties allocate these monies to providers—making them more strategic in their decision-making—is critical for improving health system performance in Kenya.

Some of the purchasing arrangements offer immediate opportunities for strengthening strategic purchasing of PHC services, while others may prove harder to reform in the near term. The bulk of county spending for health flows via budgetary allocations for salaries. Making this more strategic is critical but one of the most challenging reforms to undertake as it requires changes to the civil service rules. In contrast, it may be easier to improve how user fee reimbursements for levels 2 and 3 facilities are allocated and potentially convince counties to channel more resources from THS-UC into this mechanism and link the payments to specific FP and MNCH indicators.

Several counties are now exploring ways to give health facilities greater autonomy, which also represents a key opportunity for making purchasing more effective. Counties like Kiambu and Makueni have already implemented legislation or executive orders to this effect. Documenting their experience and sharing that with other counties seems like an obvious place to start. It's important to explore and understand the conditions under which giving facilities greater autonomy works. After all, health facilities including hospitals had more financial autonomy prior to devolution, but that did not guarantee high performance. To be successful, reforms to grant facility autonomy may need to go hand in glove with reforms to enhance management capacity and accountability structures, both upward and downward.

Finally, there is a need for timely and detailed information on the flow of funds to health facilities from different sources, which is essential for making purchasing more strategic. There are limited data on resource flows at the county level. At present, county budget documents do not clearly record how much revenue was generated (and retained) by different facilities. Nor do they specify any specific budget allocation for health facilities. NHIF, the purchaser for the Linda Mama scheme, does not offer disaggregated financial reports on how much was disbursed to different counties, let alone to specific health facilities. Improving the production and use of these data are essential for improving the purchasing relationship between county governments and health facilities.

Table 4. Recommendations for strengthening county purchasing policies and practices

Purchasing mechanism/ provider payment	Challenge	Potential for change	Recommendations		
			Analyze	Discuss	Test
County in-kind financing for salaries	Payments are unrelated to performance	Usually requires civil service reforms, which is not easy; however, since 2013, counties have authority to recruit, promote, train, and offer higher remuneration and awards, which offers an opportunity for exploration. Counties are using THS-UC funds to undertake a range of activities to improve RMNCAH services; this flexible financing stream could be used to test performance incentives for CHVs.	Document existing county arrangements to offer health workers monetary and non-monetary incentives	Explore feasibility of changing from fixed salaries to other payment terms with county stakeholders in focus counties	Counties design and test new ways to pay health workers/CHVs
County in-kind financing for commodities	Delays and stock-outs as a result of county procurement processes; financing is delinked from performance	Allow hospitals and potentially health centers to act as autonomous purchasing units (pre-devolution, facilities would use their operating budget to procure drugs)	Document experience from any county that has done this	Share with other counties as an example	Test new approach for direct facility procurement
NHIF reimbursements	Previously hospitals could collect and spend NHIF reimbursements; post-devolution in many counties require them to remit to the CRF While PHC facilities are able to retain funds they collect from NHIF, they are not fully utilizing this opportunity by registering beneficiaries to schemes like Linda Mama and	In the case of hospitals, allow them to retain a share of their collections from NHIF reimbursements and spend on their immediate costs In the case of dispensaries and health centers, work with CDOH to help facilities attract more clients under the Linda Mama scheme, provide them the full range of benefits, submit claims, and track payments by NHIF	Document experience from counties that have implemented laws to achieve this (e.g., Makueni, Kiambu)	Share with other counties through county learning platforms	Through staff embedded within county governments, provide technical support for implementation of facility improvement funds, strengthen CDOH support to PHC facilities to register more mothers to Linda Mama, deliver

<i>Purchasing mechanism/ provider payment</i>	<i>Challenge</i>	<i>Potential for change</i>	<i>Recommendations</i>		
			<i>Analyze</i>	<i>Discuss</i>	<i>Test</i>
	submitting claims for reimbursement				high-quality services, and submit claims
Conditional grants for user fee foregone at levels 2 and 3 facilities and THS-UC	Extent to which facility allocation under the user fee foregone grant is linked to facility performance is unclear. Most counties are not using THS-UC funds to pay facilities based on the delivery of priority FP and MNCH services.	In dialogue with MOH, the allocation for specific facilities could be linked more explicitly to performance. This fund flow mechanism could be used to channel more THS-UC funds to levels 2 and 3 facilities in a way that is linked to FP and MNCH performance metrics.	Document how counties are allocating these funds (policy versus practice) as well as how national government is enforcing the conditionalities	Discuss potential to change allocation method to make it more performance-based, as well as using this method to pay levels 2 and 3 facilities for FP and MNCH services with THS-UC funds	Test the use of this mechanism for priority health areas like FP and MNCH
UHC pilot	Link to facility performance is unclear; runs the danger of de-prioritizing PHC as a result of its focus on hospitals	The scheme is very new; more information is needed to identify best opportunities for improvement.	Undertake documentation of Isiolo's experience using program officer in the county		
Makueni Care	The scheme reimburses hospitals on a fee-for-service basis. There are concerns about sustainability of the scheme, how it will interact with other UHC related schemes, and whether it draws people (and therefore	Support county to analyze current patterns of utilization and then develop and test approaches to prioritize PHC (e.g., a gate-keeping function).	Study patient pathways	Discuss policy options with county government	Test appropriate solutions

<i>Purchasing mechanism/ provider payment</i>	<i>Challenge</i>	<i>Potential for change</i>	<i>Recommendations</i>		
			<i>Analyze</i>	<i>Discuss</i>	<i>Test</i>
	government funds) away from PHC providers.				
All schemes	There is no study offering recent data on how much public providers receive from different sources and whether these flows are harmonized.	A PETS exercise is planned but may take several months to conclude.	Collect data about funding flows in focus counties	Engage county and national stakeholders about findings and explore options for improving coherence across funding streams	

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