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PERSPECTIVES ON IMPLEMENTING OBJECTIVE-ORIENTED HEALTH REFORMS

Health Reforms in Pursuit of Universal Health Coverage: Lessons from Kenyan Bureaucrats

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ABSTRACT

In this commentary, two members of the technical teams that led Kenyan health reforms reflect on progress made in the country's journey toward universal health coverage during President Uhuru Kenyatta's second term (2017 to 2022). The authors discuss how key decisions were made while balancing multiple considerations such as: maintaining the technical fidelity of the reforms to achieve objectives, accounting for the context of previous reforms, and making necessary trade-offs between technical and political pressures. They share three lessons, contextualized with African proverbs, for others implementing health reforms. First: "The person who does not seize today's opportunity will also be unable to seize tomorrow's opportunity"—that is, act quickly when opportunities arise. Second: "The person who cannot dance will say, 'The drum is bad!'" This implies that naysayers, especially those who are not part of technical teams, may not understand the reasons behind certain decisions or trade-offs. Reformers must balance different needs, including responding to varied opinions, taking urgent action, generating timely results, making technically sound decisions, and getting the design right. And third: "A bird that flies from the ground onto an anthill does not know that it is still on the ground." This proverb reminds us to not mistake short-term gains for the achievement of long-term goals. Kenya continues to enjoy unprecedented political will to pursue health reforms. For other reformers lucky enough to have political support, the final advice to the technical teams in the driver's seat is to design for delivery . . . and then start!

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Many countries with governance based on democratic principles experience regular political cycles and upheavals. Political appointees lead and steward government ministries, departments, and agencies temporarily—in Kenya, they remain in office for an average of only two years. Meanwhile bureaucrats in the civil service serve as custodians of ministerial policies and over time amass significant sector-specific experience and expertise. An important role for government bureaucrats is to help to steer policy despite changes in political cycles. We view it as a counterbalance between a longstanding civil service and a transitory, politically appointed cohort.

Two coauthors of this commentary served in the Kenyan civil service for 13 years, under the stewardship of seven Ministers of Health, in a period that straddled the two terms of President Uhuru Kenyatta. The points made in this commentary come from personal perspectives from our time in government. We draw on our experiences serving in the Ministry of Health (MOH) and the Executive Office of the President to offer these lessons learned on balancing technical and political imperatives when driving health reforms from inside government.

Straddling the Political and Policy Ecosystems in Kenya's Universal Health Coverage (UHC) Journey

During President Kenyatta's first term (2012–2017), the implementation of his political party's manifesto to provide "affordable health care" began. At the same time, there was a unique set of circumstances: a new constitution was being implemented, bringing forth a raft of new governance structures. Most notably, the new constitution devolved various functions to autonomous, sub-national county governments, including significant responsibilities for financing and delivery of health services. The implementation of the new government's manifesto therefore required a delicate dance, progressing policy co-creation and implementation with both a new administration and the new devolved units. They lacked a reference blueprint and were, in essence, building "affordable health systems" de novo.

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Over the first year, bureaucrats at the national and sub-national levels began building devolved systems and facilitating the transition of health service delivery to county governments. At the same time, they were trying to translate the manifesto's aspirations of affordable health care into policy. The Presidency was eager—and under increasing pressure from the citizenry and political advocates—to deliver on its promise of affordable health care. The administration surreptitiously did away with the constitutionally prescribed two-year period for transitioning from national to county government health services. Instead, the President's Office effected an immediate transition of country-level health services to the county governments, declaring that maternity services were free and abolishing user fees for primary health care (PHC). Without any preparation, bureaucrats implemented the free maternity policy (a universal scheme facilitating access to free delivery services in all public hospitals) overnight—with mixed success.[1]

This commentary considers what happened next, in President Kenyatta's second term from 2017 to 2022. We describe how the next set of health sector objectives were articulated, how reforms were designed to achieve the objectives, and the importance of learning and evolving over time. The commentary concludes with three lessons—each captured in an African proverb—for our fellow technocrats who are charged with carrying out politically driven health reforms.

Kenya's Health Sector Reforms in the Context of the Big 4 Agenda

In 2017, President Kenyatta was reelected as President, for a final five-year term, and he launched a transformative development blueprint called The Big 4 Agenda. It comprised four key issues: 1) food security, 2) affordable housing, 3) enhancing manufacturing to address unemployment, and 4) achieving universal health insurance to guarantee quality and affordable health care. The fourth objective was then refined to achieving universal health coverage (UHC) by 2022, to broaden the policy options beyond health insurance. This change was made following a WHO Mission that the MOH invited to the country early in President Kenyatta's second term.

Visioning for, and stewardship of, the Big 4 Agenda was overseen by the Presidency; while responsibility for execution fell under the purviews of political and technical teams at various national ministries—most notably the MOH and its UHC secretariat, along with other departments, agencies, and 47 sub-national county governments.

The Big 4 Agenda generated new momentum for reaching ambitious health targets. This objective aligned with Kenyans' constitutional right to the highest attainable standard of health.[1] The Big 4 Agenda galvanized both public- and private-sector stakeholders to reimagine how they could address the challenges to further progress toward UHC in Kenya. This was not an entirely new goal. In fact, the Big 4 Agenda for health was able to build on the many health financing reforms undertaken over the past 20 years, shown in Table 1, as well as the affordable health care agenda from President Kenyatta's first term.

Various health reforms had occurred during the first term to strengthen organizational performance of the National Health Insurance Fund (NHIF, previously known as the National Hospital Insurance Fund), and expansion of NHIF benefits. NHIF was repealed in 2023 and replaced by a new Social Health Authority (SHA) put in place through the 2023 Social Health Insurance Act. Finally, the MOH in its stewardship role developed a Health Financing Strategy 2020–2030 and a Kenya UHC Policy 2020–2030. These policies defined the architecture for adequate, efficient, and fair financing of health services through a health insurance fund to guarantee all Kenyans access to essential, high-quality health services.[2,3]

The Big 4: Seizing Opportunities to Solidify the UHC Objective

Many of the foundational reforms from before and during President Kenyatta's first term were designed and implemented piecemeal. The health reforms designed between 2017 and 2022 built on key lessons learned about the underperformance of these earlier reforms:[1,4–16,18–22]

- The free maternity and Linda Mama policies increased the number of assisted deliveries—but lacked stakeholder engagement and were plagued with challenges, including stock outs and levying of "informal" charges.
- Resources were consolidated at county treasuries—but did not flow to the health facilities in most counties. This starved facilities of critical resources, worsening undersupply of inputs e.g. medicines and health workers.
- NHIF's fragmented risk pools contributed to allocative, technical, and administrative inefficiencies, and limited its ability to be a strategic purchaser.
- Having multiple benefit packages accessed by citizens under different schemes (including NHIF,

Table 1. Key health financing reforms in Kenya over the last two decades.

Presidential Administration	Year	Reform
President Mwai Kibaki	2004	"10/20" policy abolished user fees at dispensaries and health centers; registration fees were set at KES 10 at dispensaries/Level 2 facilities and KES 20 at health centers/Level 3 facilities
	2004	Unsuccessful bid to introduce a National Social Health Insurance Fund
	2010	Replaced user fees at Levels 2 and 3 PHC facilities (foregone with the 10/20 policy) through the Health Sector Services Fund
	2010	New Constitution devolved several health functions from the national level to newly formed county government health services (including management of county health facilities and pharmacies, ambulance services, and PHC promotion)
	2012	NHIF introduced a Comprehensive Medical Insurance Scheme for Civil Servants and Disciplined Services (and their dependents)
First term of President Uhuru Kenyatta	2013	Most counties enacted a requirement to transfer all county revenues, including from health facilities, to a county revenue fund
	2013	All health service user fees and registration fees abolished
	2013	MOH launched the free maternity policy, providing free delivery services at health centers and dispensaries; conditional grants are transferred to counties to cover the services
	2014	Funded by the World Bank, NHIF piloted a health insurance subsidy targeting indigent households
	2015	MOH launched the managed equipment scheme to increase access to diagnostic, imaging, and radiology services at county level
	2015	NHIF expanded the "SupaCover" benefit package to include outpatient benefits for members and dependents at their preferred outpatient facilities
	2016	MOH transferred the free maternity policy to NHIF. The program, dubbed "Linda Mama," expanded the package of benefits for women during the antenatal and postnatal period and newborns up to 28 days old. It covered services offered by participating private providers. Payments to providers were made via output-based payment. However, many counties consolidated the funds at the county treasury and did not fully disburse them to health facilities for services rendered.
Second term of President Uhuru Kenyatta	2017	The president launched the Big 4 Agenda, which included achieving UHC by 2022
	2018	MOH launched a one-year UHC pilot in four counties. Supply-side grants were provided to the four county governments to finance: medicines from Kenya Medical Supplies Agency; recruitment of additional health workers; and supervision of county health services. User fees were discontinued at all public health facilities in the four counties during the pilot period.
	2019	The Health Financing Reforms Expert Panel issued its report on transforming and repositioning the NHIF as a strategic purchaser of health services for the attainment of UHC by 2022
	2020	The Health Benefits Package Advisory Panel defined criteria for inclusion of services in the benefit package and the UHC Essential Benefits Package
	2020	MOH launched a new UHC scheme design with health insurance subsidies providing coverage through NHIF for one million poor households
	2022	The national government signed Inter-Governmental Agreements with county governments to facilitate the identification of indigent households for coverage; foster opportunities for cost-share of the health insurance subsidy; and facilitate implementation of the health insurance subsidy program.

private insurance, government-funded services) exacerbated inequitable access to health services.

To pursue this ambitious agenda to achieve UHC by 2022, technocrats in the Executive Office of the President and the MOH collaborated on several reform options. Previous reforms had increased access but were marred by various inefficiencies and inequities that ultimately watered down the impact of the interventions. The well-documented health system underperformance areas included, among others: duplication, misalignment, and fragmentation of coordination structures; lack of and maldistribution of health workers; weak management; weak budget formulation, execution, and monitoring; misalignment with public financial management (PFM) systems; and misappropriation of resources.[23–28]

In the second term, there was a concerted effort to be deliberate in learning from past experiences in order to develop technically-sound strategies to address health system underperformance. The technical teams built on principles outlined in several policy documents, including the 2010 Constitution of Kenya, the 2017 Kenya Health Act, the Health Financing Strategy, and the Kenya UHC Roadmap.[3,4,29,30] Due to the multi-sectoral nature of the reforms, implementation required collaborative efforts by the MOH, county governments, Kenya Medical Supplies Agency, NHIF, and the Social Protection Secretariat, among others. Later, the national government, through the MOH, put in place Inter-Governmental Agreements with each individual county government. These agreements defined the roles and responsibilities of each level of government in implementing a core set of health financing and service delivery reforms, including co-financing of the health insurance subsidy program in 2022. Policy documents and the agreements were used to align the objective—of UHC by 2022—with normative frameworks and best practices.

Identifying Effective Means to Reach the UHC Ends

The second term became a period where the "north star"—that is, the unmoving marker that allows sailors to navigate the way to their intended destination—was achieving UHC. The experiences of the Kenyan bureaucrats and technocrats who designed and implemented health policy reforms, particularly during President Kenyatta's second term, generated insights for future health reform efforts. Successful reform efforts require both a clear destination—such as "UHC by 2022"—and a series of stages or steps that present clear guideposts along the way. The Kenyan technocrats working in President Kenyatta's administration recognized that reforms intended to address health system underperformance required consideration of best practice, technical fidelity of the reforms to achieve objectives, and logical sequencing of reforms, to test and evaluate potential solutions and to create incremental changes.

These health reforms grappled with various inefficiencies in the health system. NHIF did expand coverage (from 9.7% of the population in 2003, to 17% in 2013, and to 24.1% in 2022). However, many challenges remained in NHIF's design. First, beneficiaries did not have a guaranteed health benefits package. Additionally, there were gross inefficiencies in various NHIF administrative and logistical arrangements, including its pooling and purchasing functions, identification of beneficiaries, and provider payment mechanisms.

In a bid to maintain technical fidelity and coherently structure reforms that would address some of the health system underperformance issues identified, the MOH convened two panels of experts: the Health Benefits Package Advisory Panel to define a costed explicit benefits package; and the Health Financing Reforms Experts' Panel to review NHIF organizational and business processes and liquidity challenges. Both panels developed outputs applied in the redesign of benefit packages and in the design of the new Social Health Insurance Fund (SHIF). While these outputs were designed through rigorous processes, they took almost two years to complete, losing implementation time and frustrating politicians eager for quick wins.

Technical excellence may be achieved through incremental change, but policy reforms do not take place in a vacuum.[31–34] Instead, they face a significant counterweight: time, which on the political clock is marked against upcoming elections.[35] This creates tension between the goals of the technical bureaucrats and the politicians by pitting the "best" design against the time-limited aspirations of politicians. In these cases, the technocratic focus (on time-consuming processes to assure technical fidelity, normative standards, and best practices) risks losing political "windows of opportunity" to enact reforms quickly to meet political objectives.[35] However, technical and political objectives need not be mutually exclusive when technocrats prepare in advance to exploit rare political windows.

Objectives Evolve as Progress is Made

Implementing reforms incrementally creates opportunities to identify policy successes and failures along the way, and then change strategies or courses of action. Furthermore, changes in objectives may also occur due to external influences and changes in the operating environment. For example, Kenya's original Big 4 Agenda for health was defined as affordable care through universal health insurance. This was changed, from universal health *insurance* to universal health *coverage*, after input from a WHO Mission. The original focus on universal health insurance as the objective limited the available policy instruments (or means); the change to UHC opened up various possible policy approaches.[36] In this instance, changing the objective has proved to be a positive decision, but in other cases in Kenya and elsewhere, changes driven by the influence of local and global actors have not always resulted in beneficial outcomes.[37–42]

Another example of an external force driving changes in reform objectives is the effects of the COVID-19 pandemic, which began during the second term. The Kenyan health sector was forced to reprioritize its ongoing efforts to address the pandemic's many health and non-health impacts. The UHC objective was placed on the "back burner," while the MOH was thrust into the limelight to coordinate across sectors and create new COVID-19 management platforms.

Once the most urgent pressures of the COVID-19 pandemic abated, the MOH and the presidential administration were able to refocus on the UHC reforms. Ultimately, President Kenyatta's second term (which spanned the 2017–2022 period) resulted in: a costed health benefits package; recommendations on repositioning the NHIF to become a strategic purchaser for health;[43] a supply-side subsidy pilot conducted in four counties in 2018; and in 2022, a full NHIF premium subsidy for one million households across 47 counties. These developments were anchored by several key policies developed by the MOH: the Kenya Health Financing Strategy, Kenya UHC Policy, the PHC Strategy, Primary Care Network Guidelines, and the NHIF Amendment Act.[3,4,44–46]

Successes, Failures, and Lessons Learned from the Big 4 Agenda for Health

What constitutes success for the Big 4's health objective? One possible definition is the literal attainment of the stated objective: UHC by 2022, but "attainment" of UHC is not a static end point. Other interpretations could include improvements in health outcomes or the sustainability of the reform's interventions. Success could also be considered as expanding the capacity of the health system to address areas of underperformance, such as weaknesses in pooling and purchasing at the public health insurer or PFM bottlenecks that hamper the availability and quality of services provided by facilities.

In fact, the reforms carried out during President Kenyatta's two terms are credited with increasing access to priority services *and* improving some health outcomes. Attendance by skilled birth attendants increased to 89% (from 66%) between 2014 and 2022, largely credited to the free maternity program and Linda Mama. The 2022 Kenya Demographic and Health Surveys (KDHS) calculated that Linda Mama is averting the deaths of 2,000 women and 30,000 children annually.[47] The KDHS 2022 also showed a modest reduction in the infant mortality rates, from 39 to 32 deaths per 1,000 live births, between 2014 and 2022.[47] There was also an increase in contraceptive prevalence and decreasing trends in the total fertility rate. Evidence to assess health system improvements is scanty, because the supply side pilot conducted in the second term was implemented for only one year and only in four counties;[48] similarly, the health subsidy pilot was only initiated toward the end of the second term. An evaluation of the supply side subsidy pilot demonstrated an increase in utilization over the year, but also noted that the pilot was plagued by challenges in implementation, disruption of Linda Mama reimbursements, high workload, and medicine stockouts.[48–50] As the pilot was terminated with no transition plan, any gains at the county level may not have been sustained. Other metrics showed less progress. Out-of-pocket spending on health remains high, at 26.6% of total health expenditure (in 2018/19), and NHIF coverage has stagnated at 24.1% (2022).[47,51] Quality of health care remains a perennial problem, as does lack of inputs and medicines.[17,51]

The successes achieved—particularly of the free maternity and Linda Mama programs—cannot be solely attributed to health reforms. They are also inextricably linked to other social and economic reforms instituted during the prior administration and President Kenyatta's terms, including: free primary and day secondary school education, compulsory transition from primary to secondary school, conditional cash transfer programs, increased access to clean water, electricity, and roads, and the decentralization of service delivery.

Indeed, for the President's Office, the key metrics of success used were broader than health sector metrics (such as access to health services or financial protection). They also sought to ensure the political resilience of the Big 4 Agenda, as well as foster multisectoral coordination to continue to drive all goals, including UHC, forward. From a health advocacy standpoint, we argue that one of the biggest achievements of the Big 4 Agenda was to elevate the UHC discourse to a national discussion. Its inclusion in the Big 4 Agenda galvanized action for UHC among stakeholders, increased citizen awareness of, and expectations for, access to health care, and engaged the media in new ways on the topic of UHC. The latter is important because regular reporting keeps the topic in the public eye and holds policymakers and politicians accountable for their promises to citizens.

President Kenyatta appointed bureaucrats to consistently further Big 4 Agenda reforms; they learned from past reforms, quickly redesigning as needed, while pursuing evidence-based changes to the health system. Despite the COVID-19 pandemic, they tested and learned from the supply-side pilot programs, and designed and rolled out a demand-side health insurance subsidy program to increase coverage for one million poor households.

Lessons Learned—In Proverbs

The health reforms pursued during President Kenyatta's two terms had clearly specified objectives to achieve UHC. The objective was distinct from the means designed to create a pathway for change, and address areas of health system underperformance. Regular tracking was conducted to measure and evaluate whether the reforms were achieving their stated goals.[37] As we reviewed Kenya's recent experiences with health reform, three African proverbs came to mind that capture our key lessons learned:

The Person Who Does Not Seize Today's Opportunity Will Also Be Unable to Seize Tomorrow's Opportunity

Some aspects of Kenya's health reforms have been delayed due to initial concerns about the complexity of sectoral transformation and sustainability. For example, early on technocrats considered a range of policy options to achieve the big-picture objective of UHC, including an insurance-focused reform through NHIF

or a supply-side subsidy reform to address shortages of health workers and medicines. An NHIF-driven reform was complicated by, among other things, the lack of a unique identification system. This hampered the accurate identification of beneficiaries, raising doubts about the validity and equity of household selection. As unique identification systems fall outside the purview of the health sector, the technical team worried that addressing it would require lengthy and complex interventions from the social and internal security agencies. However, the technical team had a duty to deliver on the promised health reform, and thus opted to extend user fee waivers to county hospitals, and increase access to funding for inputs (health commodities, supplies, operations, and maintenance costs) and for community health services. This pilot was implemented for a year but reported few successes.[52]

In 2020, the technical team went ahead and designed a health insurance subsidy program, despite the country still lacking a unique identifier system. Ultimately, they ended up using less-than-perfect National Civil Registration databases (births and national identification systems), while building biometric identification systems within NHIF. If health technocrats had made a different decision early on—to engage with other sectors to develop a unique identifier system—it would have facilitated the implementation of the 2020 health insurance subsidy. They could have directed the resources (a loan from the World Bank) spent on the supply-side pilot (with limited impact) to facilitate the reform that they suspected all along would eventually be needed.

One may opine that the reformers should not have sacrificed their preferred reform due to the existence of the obstacle—the lack of a unique identification system. Because they failed to pursue one early effort, they missed an opportunity to make changes needed to facilitate future reform efforts and lost valuable time in the process.

The Person Who Cannot Dance Will Say, "The Drum is Bad!"

Technocrats who had been engaged in Kenya's health reform journey before President Kenyatta took office expressed concerns that the early UHC pilot reforms were overly simplistic, given their experiences with previous health financing reforms. They saw the supply-side-focused pilot reforms as dodging away from the critical reforms needed at the NHIF.

However, the earlier reforms in the first term had not ameliorated the root causes of health system underperformance (such as constrained autonomy at the point of service delivery, barriers to commodity availability, and problems with facility operations). Furthermore, some reformers considered the existence of the NHIF to be the objective, rather than the means, of health reform. This cohort argued against reforms that pursued the objective of UHC through any other means. We equate this with the proverbial poor dancer blaming their bad performance on the drum. In this case, the drum is the reform chosen, whether a supply side or NHIF reform.

Health reforms should not be constrained by false dichotomies. Narratives about sophisticated versus simple reforms, primary versus higher levels of care, or longer-term technical solutions versus political expediency and "quick-wins" have been exceedingly unhelpful in Kenya. Instead, reformers must balance the need for urgent action and timely results on the one hand, with making technically sound decisions and getting the design right on the other. Naysayers, especially those who are not part of the technical team, may not understand the reasons behind certain decisions or the trade-offs being made. Time and opportunities get lost when technocrats engage in technical debates with opponents and the majority (who "just want better health care") while the political window is open. In fact, the magic lies somewhere in between all these seemingly antagonistic choices and aided by speed while the "political window" is open.

A Bird That Flies from the Ground onto an Anthill Does Not Know that it is Still on the Ground

A bird that has flown a great height to the top of an anthill may be pleased with its new vantage point, but it is still on the ground. Similarly, Kenya has undergone many cycles of health reforms and learned many lessons in the process to take forward. But it is, in many respects, still "on the ground." Health system performance faces many entrenched and profound challenges, including inequitable access, poor quality of health services, and weak financial protection for majority of the population. To date, only 24.1% of Kenyans have coverage through NHIF.[47] This is progress—but is insufficient to meet the need for accessible, affordable, high quality health care for all. Reformers should steer toward their objectives but must avoid mistaking short-term gains for achievement of long-term goals. However, Kenya can continue to build on its incremental successes and avoid repeating mistakes.

Conclusion

In conclusion, Kenya's health sector is on a continuous improvement journey that offers lessons for its own and

other countries' reform efforts. The UHC goal remains a key aspiration, with sustained political support from the subsequent presidential administration. Recently, the new government passed new legislation to address areas of health system underperformance. The Facility Improvement Fund Act confers more autonomy on health providers to address the challenge of county-level resources being redirected away from health. The PHC Act recognizes community health promoters (making them eligible for remuneration from county public service boards) and provides for new primary health care networks. A new SHA replaces the NHIF, and oversees a PHC Fund, a SHIF, and an Emergency Services and Chronic Illness Fund.

The technocrats now engaged in health reform face strong headwinds as they undertake the next part of Kenya's journey toward UHC, within fiscal constraints. However, they also enjoy unprecedented levels of political and public support, providing a critically important political window of opportunity to institute lasting reforms. Our advice to these technical teams is: design for delivery and just start! Avoid "analysis paralysis"—that is, getting stuck in time-consuming technical processes, such as highly detailed costing and actuarial studies that are not clearly linked to specific implementation decisions. Instead, focus on building capacity for continuous and adaptive learning, generating monitoring data useful for health reform improvement, and continuous communication with diverse stakeholders.

Technocrats in Kenya and elsewhere need political savviness and technical skills to take advantage of windows of opportunity to implement technically sound health reforms in pursuit of UHC. In addition, technocrats must learn to communicate better on upcoming health reforms and achievements, beyond their sectoral "echo chambers," to engage with multisectoral stakeholders with influence on social determinants of health. Finally, technical teams do need not need to achieve perfection when implementing reforms, as there are opportunities to course-correct on their pursuit toward UHC.

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Data Availability Statement

The authors confirm that the data supporting the findings of this study are available within the article and/or its supplementary materials.

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