REPUBLIC OF KENYA

Ministry of Health

Kenya Health Financing Strategy 2016 - 2030

May 2016

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1 INTRODUCTION

The Government of Kenya (GoK) is committed towards achieving Universal Health Coverage (UHC), as a means of realizing the "Right to Health" as enshrined in the Constitution of Kenya 2010, as well as the long term development blueprint, Vision 2030.

UHC will enable Kenyans access quality promotive, preventive, curative, rehabilitative and palliative health services based on need and not ability to pay. This ensures that use of health services does not expose users to financial risk[1].

Movement towards UHC calls for an adequate policy, legal and institutional frameworks.

1.1 Health as a right in the Constitution of Kenya 2010 and Vision 2030

By recognizing Health as a Right, the Constitution of Kenya 2010 provides the overarching legal framework for UHC. The Bill of Rights (BoR) – which is a chapter in the Constitution -- *"gives all persons the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health"*. The BoR also states that no person shall be denied emergency medical treatment and the state shall provide for social security to persons unable to support themselves and their dependents. In applying the BoR, the constitution recognizes that the state will deliver services within the resources available, giving priority to *"ensuring the widest possible enjoyment of the right or fundamental freedom, having regard to prevailing circumstances, including the vulnerability of particular groups or individuals"*. The Constitution further obligates the State and every State organ to observe, respect, protect, promote, and fulfill the rights in the Constitution and to take "legislative, policy and other measures, including setting of standards to achieve the progressive realization of the rights guaranteed in Article 43." Table 1 summarizes some of the major clauses of the BoR relevant to the health sector.

Table 1: Summary BoR clauses relevant to the health sector

Article	Right to:
43	1) Every person has the right to— (a) the highest attainable standard of health, which includes the right to healthcare services, including reproductive healthcare; (b) reasonable standards of sanitation; (c) be free from hunger and have adequate food of acceptable quality; and (d) clean and safe water in adequate quantities. 2) A person shall not be denied emergency medical treatment

[1] World Health Organization (2005). The 58th World Health Assembly

43 (1 e)	Right to social security
43 (3)	The state shall provide appropriate social security to persons who are unable to support themselves and their defendants
46 (1 b)	Consumers have the right to the protection of their health and safety
53 (1 c)	Every child has a right to basic nutrition and health care
56 (e)	Minorities and marginalized groups have the right to reasonable access to health services

The Kenya Health Financing Strategy (KHFS) provides a framework that enables Kenya to move towards UHC, and therefore guarantee health entitlements as a means of realizing the constitutional right to health, within the context of available resources. The KHFS identifies the key challenges in the current health financing arrangements and proposes practical solutions to address them. It also focuses on key design features of the health financing system required to deliver an affordable Essential Package of Health (EPH) services for all Kenyans and demonstrates how this goal will be achieved progressively by 2030.

1.2 Historical experiences with health financing reforms

The Government of Kenya (GoK), through the Ministry of Health (MoH), has implemented several interventions to provide financial risk protection. The National Hospital Insurance Fund (NHIF), the sole social health insurer, has been in existence since 1966. Initially designed to provide health insurance for formal employees, the fund was re-structured in 1998 to include contributors from the informal sector.

Following the unsuccessful attempt to introduce social health insurance through an elaborate legal framework, The National Social health Insurance Bill 2004, the GoK has focused on health financing initiatives that target the poor and vulnerable members of the population, with different levels of success, albeit in a fragmented way.

These initiatives include removal of user fees removal of user fees in primary health care facilities and maternity fees all public health facilities in June 2013..For the first time in history, the GoK provided a budgetary allocation to compensate facilities for lost revenue arising from user fees removal for primary health care and maternity services. In addition, the GoK is also sponsoring health insurance programmes that target the poor and vulnerable populations, namely Health Insurance Subsidy Programme for the poor (HISP) and the health

insurance programme for elderly people and persons with severe disabilities; all administered by NHIF.

Table 2 below is a chronology of key milestones that defines the evolution of the health financing architecture in Kenya.

Table 2: Overview of key milestones in the evolution of the health financing architecture in Kenya

Year	Policy Reform
1966	National Hospital Insurance Fund formed to provide health insurance cover for formal employees. Contributions mandatory from payroll.
1998	NHIF Act amended to provide for members from informal sector. The Act obligated all Kenyans above age of 18 years and with income to contribute to the fund.
2003	National Social Health Insurance Bill (NSHI) passed in parliament but not enacted.
2004	User fees abolished in public dispensaries and health centres, and instead a registration fees of Kenyan Shillings 10 and 20 respectively were introduced (10/20 Policy). Women and children under five were exempted, with waiver mechanisms for the poor and vulnerable. However, implementation of the policy could not be sustained.
2007	All fees for deliveries at public health facilities were abolished, but the implementation failed as facilities were not compensated for lost revenue.
2010	A Health Sector Services Fund (HSSF) was established. The HSSF was designed to address delays and leakages in flow of funds from the Ministry of Health to primary care health facilities through the district treasuries. Prior to the HSSF, less than half of funds earmarked for such facilities actually reached them. With the introduction of the HSSF, the primary care health facilities received funding for operations and maintenance directly into their commercial bank accounts from the Ministry of Health, thus bypassing the district treasury.
2012	A comprehensive health insurance scheme for civil servants (including the military) was introduced. The civil servant scheme is implemented by the NHIF.
2013	The GoK removed user fees in all public dispensaries and health centres. A total of Kenya Shillings 700 million was allocated to compensate these facilities for lost revenue. During the same period, maternity services were declared free in all government facilities and Kenya Shillings 4.5 billion allocated to compensate facilities for lost revenue.
2014	A Health Insurance Subsidy Programme for the Poor (HISP) was launched on a pilot basis. The HISP provides a comprehensive package of outpatient and inpatient services to 21,500 households (approximately 500 households in each county) and their dependents. The HISP is implemented by the NHIF and HISP beneficiaries can access outpatient and inpatient services without paying out-of-pocket.
2015	The GoK introduced a health insurance programme for the elderly people (above 65 years) and persons with severe disabilities. A budgetary allocation of Kenya Shillings 500 million was provided to purchase health insurance cover through the NHIF. The beneficiaries are entitled to a benefit package similar to the one for formal employees.

2 Health financing situation analysis

2.1 Introduction

This analysis provides an assessment of Kenya's health system relative to UHC goals, with a particular focus on the financing system. The analysis has been conducted using guidelines developed by McIntyre and Kutzin (2014)[2] and a "Core Health Financing System Assessment Protocol" being developed by the World Bank Group[3]. Section 2.2 considers contextual factors that influence what has been achieved and what can be implemented in relation to health financing. Section 2.3 considers health expenditure patterns and their implications. The third section analyzes the financing system by function i.e. resource mobilization, pooling, purchasing and provider payment mechanisms. The fourth section assesses achievements relative to health financing goals; namely, financial protection and equity, health service quality, equity in utilization of health care services, and health system efficiency.

2.2 Overview of country context

2.2.1 Economic context

In 2014, the rebasing of Kenya's national accounts, which involved changing the base year from 2001 to 2009, resulted in an upwards revision of the GDP per capita and reclassification of Kenya as a lower middle income country[4]. The rate of economic growth in Kenya was 5.3% in 2014 with a Gross Domestic Product (GDP) per capita estimated as US$ 1,417. Kenya is a center for trade and finance in the East Africa region and is considered to be one of sub-Saharan Africa's (SSA) most developed economies. The country is classified as the 5th largest economy in sub-Saharan Africa behind South Africa, Nigeria, Angola and Sudan.

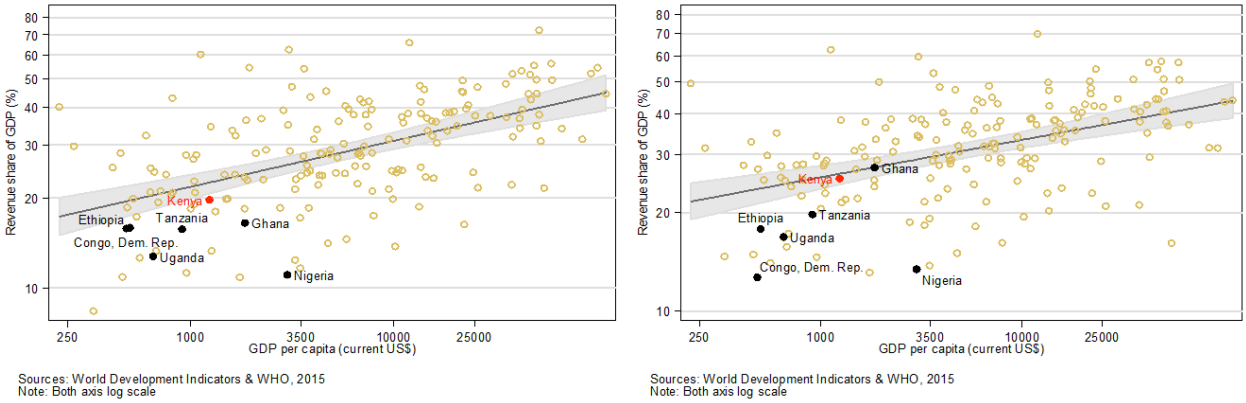
The informal sector has the largest share of employment accounting for 83 percent of the total jobs, with agricultural sector accounting for 17 percent of all the jobs in the private sector. However agriculture (including forestry, hunting and fishing) accounted for only 30% of GDP in 2014. This was second to the service sector (dominated by tourism) which accounted for 50% of GDP in 2014.

[2] McIntyre, D and Kutzin J (2014).Guidance on conducting a situation analysis of health financing for universal coverage. World Health Organization, Geneva.
[3] World Bank Group (2015). Core Health Financing System Assessment Protocol: DRAFT. WBG, Washington DC.
[4] http://www.worldbank.org/en/news/feature/2014/09/30/kenya-a-bigger-better-economy

Despite its relatively diverse economy, Kenya's economic growth over the past decade has been hindered by challenges in accountability, the 2008 post-electoral violence, extreme weather conditions in form of droughts, and weak investment[5].

The GoK raises revenues largely from taxes. Figure 1 shows the Kenya revenue and expenditures relative to other countries in the region and countries with similar GDP.

Figure 1: Government revenue and expenditure (share of GDP) versus GDP per capita, 2013



Tax revenue relative to GDP has remained relatively constant at 16% as at 2012. Levels of government spending are higher than revenue generation, with government spending of approximately 30% of GDP and a budget deficit of approximately 5% of GDP. The accumulated debt is estimated to be about 45% - 50%. The International Monetary Fund (IMF) recommends that a "prudent" debt to GDP ratio is 60% for high-income or developed countries and 40% for low-and middle-income or developing countries.

[5]Luoma, M., J. Doherty, et al. (2010).Kenya Health System Assessment 2010. Bethesda, MD, Health Systems 20/20 project, Abt Associates Inc.

In the last decade, the country has achieved mixed results in reducing poverty levels and other social determinants of health. Although there have been improvements in GDP and reduction in population living in absolute poverty, especially in urban areas, absolute poverty levels still remained high with 33.6% of households living on less than $1.90/day (2011 PPP) in 2005)[6]. The national GINI index, estimated by the World Bank for 2005, was 48.51[7]. Literacy levels remained good at 78.1%, though inequities in age and geographical distribution persist. Gender disparities too were significant, though showed improvements particularly after 2003, a reflection of better opportunities for women.

2.2.2 Socio-demographic and health context

Kenya's 2015 population is estimated to be 46.6 million people with an average life expectancy of 60 years (**Table 3**). The population growth rate has remained high at 2.4% per year, with a large large number of young and dependent populations that is increasingly urbanized.

On key health indicators, the country has made significant improvements in reducing infant and under five mortality rates, though maternal mortality ratio remains high (**Figure 2**). Infant mortality rate (IMR) declined from 61 to 39 deaths per 1,000 live births in 2003 and 2014, respectively, while under-five mortality rate (UMR) declined from 90 to 52 deaths per 1,000 live births in the same period[8]. While the gains related to child mortality are remarkable, neonatal mortality remains high and contributes about 60% of IMR[9].

Table 3: Health Outcomes and Demographics

Indicator	**Time (Year)**		
	1990	**2000**	**2010**
Life Expectancy	59	53	60
Crude Mortality rate	9.9	12.3	9.2
Infant Mortality Rate (IMR)	63.9	68.6	52.0
Under-5 Mortality Rate (U5MR)	98.7	110.9	79.5
Maternal mortality ratio (modeled estimate, per 100,000 live births)	490.0	570.0	460.0

[6] World Bank Group, Development Goals in an Era of Demographic Change, http://pubdocs.worldbank.org/pubdocs/publicdoc/2015/10/503001444058224597/Global-Monitoring-Report-2015.pdf

[7] World Bank Indicators: http://data.worldbank.org/country/kenya (Accessed 21 October, 2015)

[8] Republic of Kenya (2014), Kenya Demographic and Health Survey 2014: Key Indicators (p. 23)

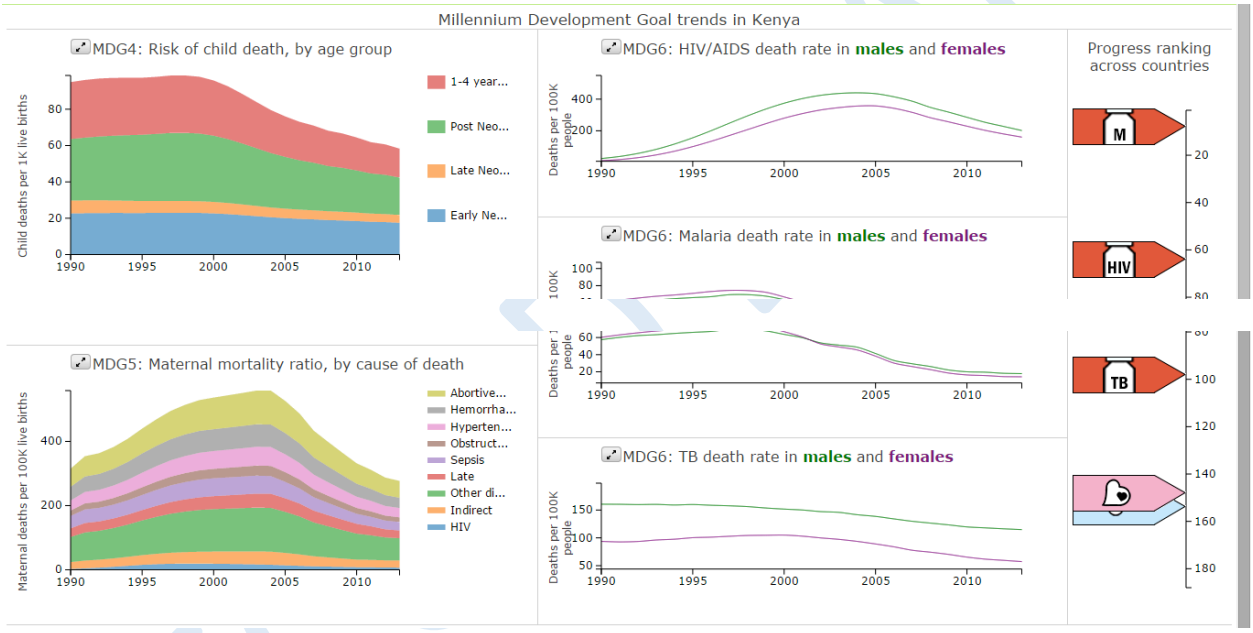
[9] DHS 2014, p. 22. Infant mortality in the five-year period preceding the 2014 survey was 39 per 1,000 live births while neonatal mortality was 22 per 1,000 live births.

Population Size (millions)	23.4	31.3	40.9
Population Growth Rate	3.4	2.6	2.7
Age-Dependency Ratio	106.9	88.4	82.4

Source: World Development Indicators 2015.

Maternal Mortality Rate (MMR) declined from 418 per 100,000 live births in 209/10 to in 362 in 2014. Utilization of maternal health services has shown some signs of improvement with women receiving skilled care at child birth rising from 44% in 2008 to 62% in 2014, while the proportion of women making at least four antenatal visits increased from 47% in 2008 to 58% in 2014 and, reversing the declining trend reported between 1993 and 2008[10].

Figure 2. MDG Development Goal trends in Kenya[11]



With promulgation of a new Constitution in 2010, the country is now implementing a devolved system of government. The Constitution created a National government and 47 County governments; the latter being responsible for devolved functions. The new system of government presents opportunities and challenges for the health sector, as health service provision is largely a devolved function. The political decentralization associated with devolution now grants autonomy to County governments in the implementation of health policies with funding from equitable share allocations and local taxes. From

[10] Republic of Kenya (2014), Kenya Demographic and Health Survey 2014: Key Indicators (p. 26)
[11] *Source:* http://vizhub.healthdata.org/mdg/

these sources, the County governments decide on the share of resources to allocate to the health sector. While this poses challenges in advocating for increased resource allocation to health, preliminary analysis suggests that on average, counties allocated an average of 22% of their budgets to health[12]. However, close to 80% of these funds are spent on personnel emoluments, leaving very little for other critical service delivery inputs such as essential medicines and medical supplies and health facility operational costs.

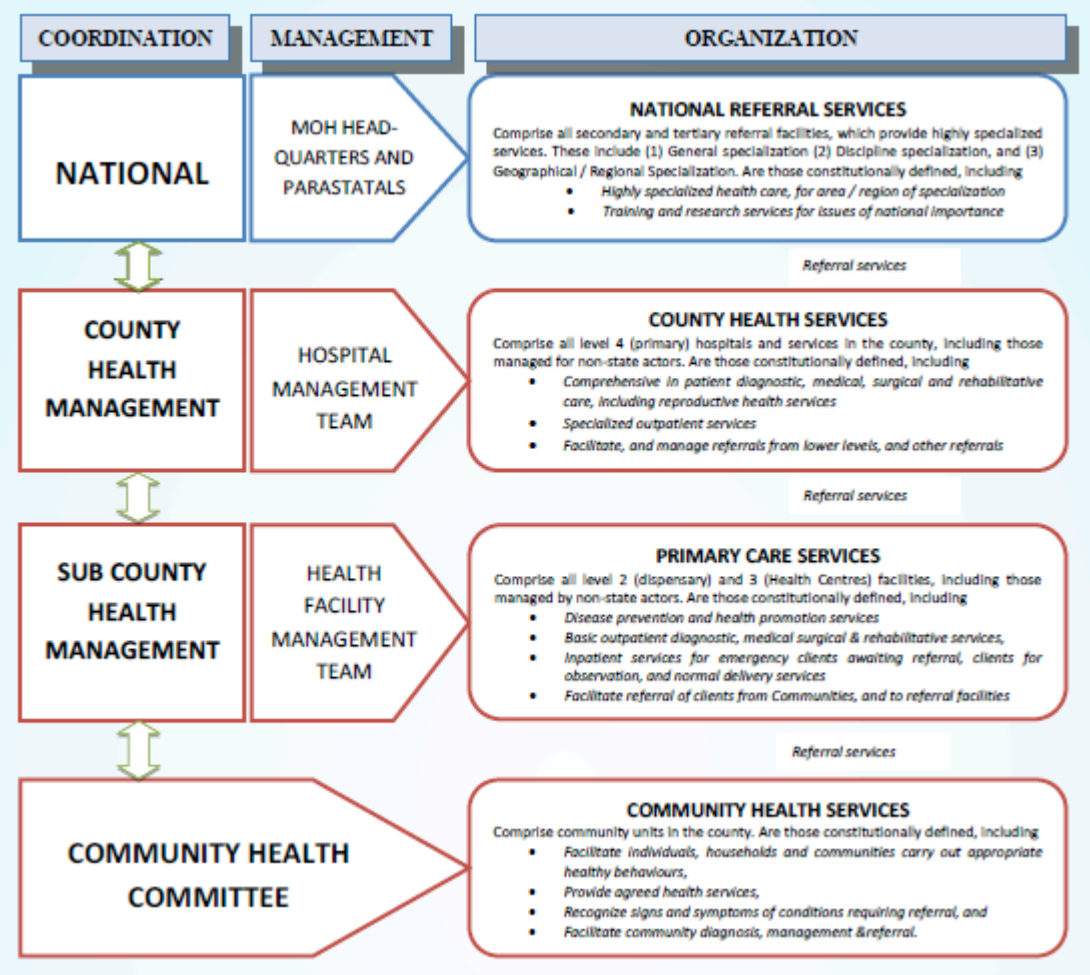
2.3 Health service organization

Health services in Kenya are provided by both public and private providers, with the latter comprised of both not-for-profit and for-profit providers. The government (county, national and other government entities) operates about 51% of the nearly 8,500 health facilities, with the rest being operated by private-for-profit providers (34.2%) and private-not for-profit (14.8%). In total, the government operates 191 hospitals, 465 health centres and 2122 dispensaries; majority of these being operated by County governments. **Figure 3** provides an overview of the current organization of public health service delivery[13].

Figure 3.Organization of public health services delivery system

[12]Ministry of Health (2015).National and County health budget analysis report.

[13] This figure is taken directly from: Ministry of Medical Services (MOMS) and Ministry of Public Health and Sanitation (MOPHS) (2012), Kenya Health Policy 2012 – 2030. (p. 22)



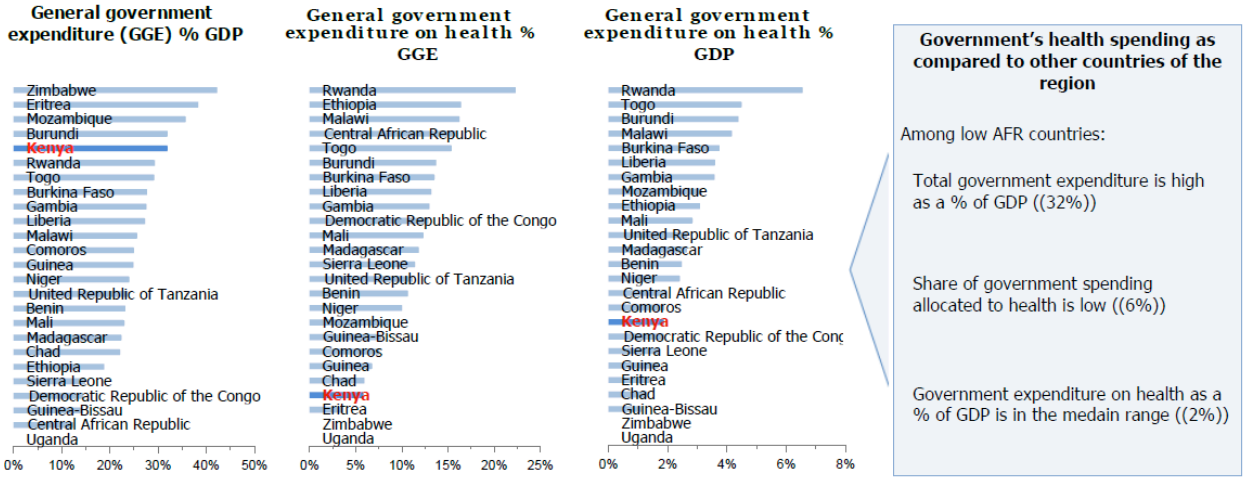
2.4 Review of health financing arrangements

2.4.1 Revenue contribution and collection mechanisms

As shown in Figure 4 below, government budgetary allocation to health has remained low relative to other countries. The Government expenditures on the health sector stood at about 6.1% of total government expenditure in 2012/13; Total Health Expenditure (THE) amounted to about 6.8% of the GDP. It is known that countries that have made progress towards UHC spend public funds (both tax and social health insurance) at around 5% of GDP, which is way above the 0.6% spent in Kenya in 2012/13.

In absolute values, the countries' health sector budget allocations increased by 60 percent from Kenya Shillings (KES) 69 billion in 2013/14 to KES 110 billion in 2014/15. The average allocation to health by the counties increased from 13 percent of the county budget in 2013/14 to 22 percent in 2014/15. As indicated in the previous section, about 80% of these funds are personnel emoluments.

Figure 4: Government health spending compared to other countries of the region.



Source: (http://apps.who.int/nha/database/Key_Indicators/Index/en)).

As repeatedly reported in National Health Accounts reports, direct out of pocket payments (OOPs) are a major source of financing for health services in Kenya. The direct OOPs[12] are charged for health services in both the public (cost-sharing, user fees) and private sector. The OOPs accounted for 32% of Total Health Expenditure (THE) in 2012/13, an increase from 29.6% reported in 2009/10. Direct OOP places the burden of bearing the costs of illness to the sick person and their families, and is therefore a major contributor to horizontal and vertical inequities. In 2012/13, 6.2% of households who utilized healthcare services experienced catastrophic expenditures.

Health insurance coverage is low with about 17.1% of households reported to be in some some prepayment health schemes in 2013. 88.4% of such households are covered through NHIF. This form of social health insurance contributed about 5% of THE in 2012/13. Health insurance coverage amongst the poorest income quintile was 3%, compared to 42% in the richest income quintile.

The level of donor funding is relatively high, with a significant share of this funding being 'off-budget'. A considerable share of Official Development Assistance (ODA) that is flowing through government has reduced from 40% in 2009 to 25% in 2012.

External financing for the health sector accounted for 25.6% of THE in 2012/13 up from 16.4% in 2001/02, but down from 34.5% in 2009/10. The period 2009 to 2015 has been characterized by a steady increase in donor support; this funding is expected to decline in the near future.

A significant share of the donor funding is for key programmes such HIV/AIDS, TB, malaria, reproductive health and immunization.

2.4.2 Risk and fund pooling arrangements

Characteristically, the Kenyan health system has not given adequate attention to the need to establish and promote efficient financial risk pooling arrangements for the two potential risk pools; namely general tax revenues allocated to health and social health insurance premiums. The NHIF is the only public insurer in Kenya. As a social insurer, the NHIF collects revenue, pools and purchases health services for its members. The NHIF is fraught with several governance and efficiency challenges. A strategic review conducted in 2011 identified key institutional weaknesses and made recommendations on how these can be addressed. A Task Force set up in 2013, made similar observations and identified several short-term and medium-term recommendations to make the NHIF a credible institution. Although some recommendations have been implemented (for example, the NHIF publishes quarterly financial reports online for accountability), progress has been extremely slow.

Commercial insurance companies are pooling about 9% of THE and are covering about 800,000 Kenyan's. However, these companies target the rich and primarily the formal sector employees. In the recent years, the commercial insurance companies have started to package medical insurance covers to attract the large informal sector clientele.

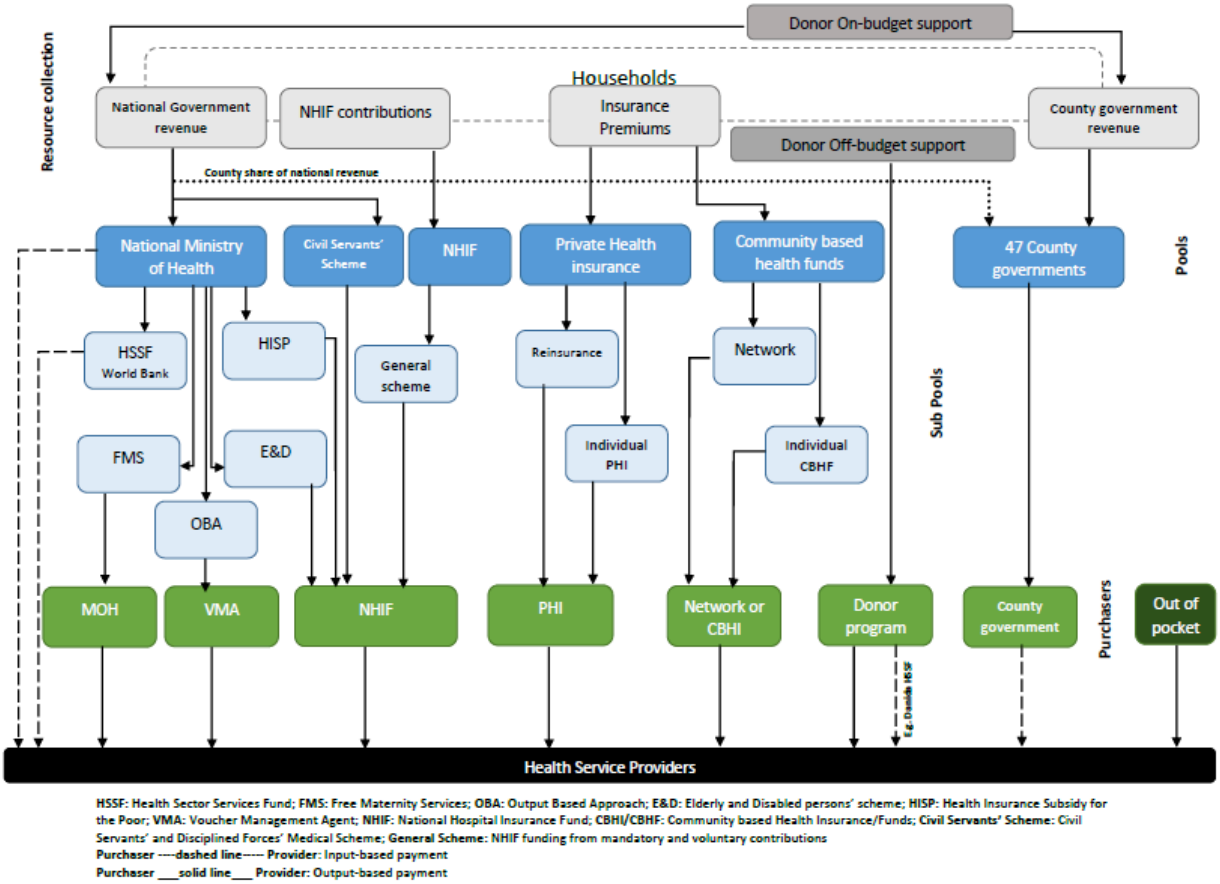
Figure 4 illustrates (in light blue) the various pools in which resources and risks are pooled. Government budgetary allocations, mainly from general tax revenues are held in forty eight (48) "risk" pools, i.e. the national pool, for services purchased through the Ministry of Health (including other Government agencies such as Defence, Education etc.) and 47 pools at the county governments' level. At both levels of government, there are no clear guidelines on minimum budgetary allocations to the health sector for purposes of predictability of resources available at any one time. In the contrary, this has been left to the annual budgeting cycle processes. In addition, the administrative arrangements of the risk pools promote further fragmentation in form of line budget items, rather than consolidation. A framework to guide consolidation of the 48 risk pools is not in place.

International experiences suggest that UHC is best achieved with less fragmentation. However, the devolved system of government comes with challenges of high degree of fragmentation[14], since the 48 governments have autonomy to decide on the amounts to allocate to health sector.

Similarly, the social health insurance pool within NHIF is split into three sub-pools targeting different populations with varying benefit packages namely, the general scheme comprising of the mandatory contributions from the formal sector, the voluntary members from the from the informal sector and government sponsored insurance programme for elderly people and persons with severe disabilities; the civil servants scheme, an add-on to the general scheme with a more comprehensive benefit package; and the Health Insurance Subsidy Programme for the poor which provides for outpatient and inpatient care to indigent members of the population. Neither the general scheme nor the civil servants scheme receives government subsidies – i.e. premiums fully cover benefits paid to enrollees and the operating costs of the schemes. The HISP scheme, meanwhile, is a fully subsidized pilot scheme. Experiences from Thailand and elsewhere have demonstrated the difficulties of harmonizing covers targeting different populations once introduced, particularly where this amounts to reducing the benefits of one group to equalize the benefit packages.

Figure 4: Illustration of the current source of funds and risk pooling arrangements

[14] For example, 10 counties have a population of less than 400,000, which is too small for a social health insurance pool.



HSSF: Health Sector Services Fund; FMS: Free Maternity Services; OBA: Output Based Approach; E&D: Elderly and Disabled persons' scheme; HISP: Health Insurance Subsidy for the Poor; VMA: Voucher Management Agent; NHIF: National Hospital Insurance Fund; CBHI/CBHF: Community based Health Insurance/Funds; Civil Servants' Scheme: Civil Servants' and Disciplined Forces' Medical Scheme; General Scheme: NHIF funding from mandatory and voluntary contributions
Purchaser ----dashed line----- Provider: Input-based payment
Purchaser ___solid line___ Provider: Output-based payment

2.4.3 Resource allocation and purchasing health care services

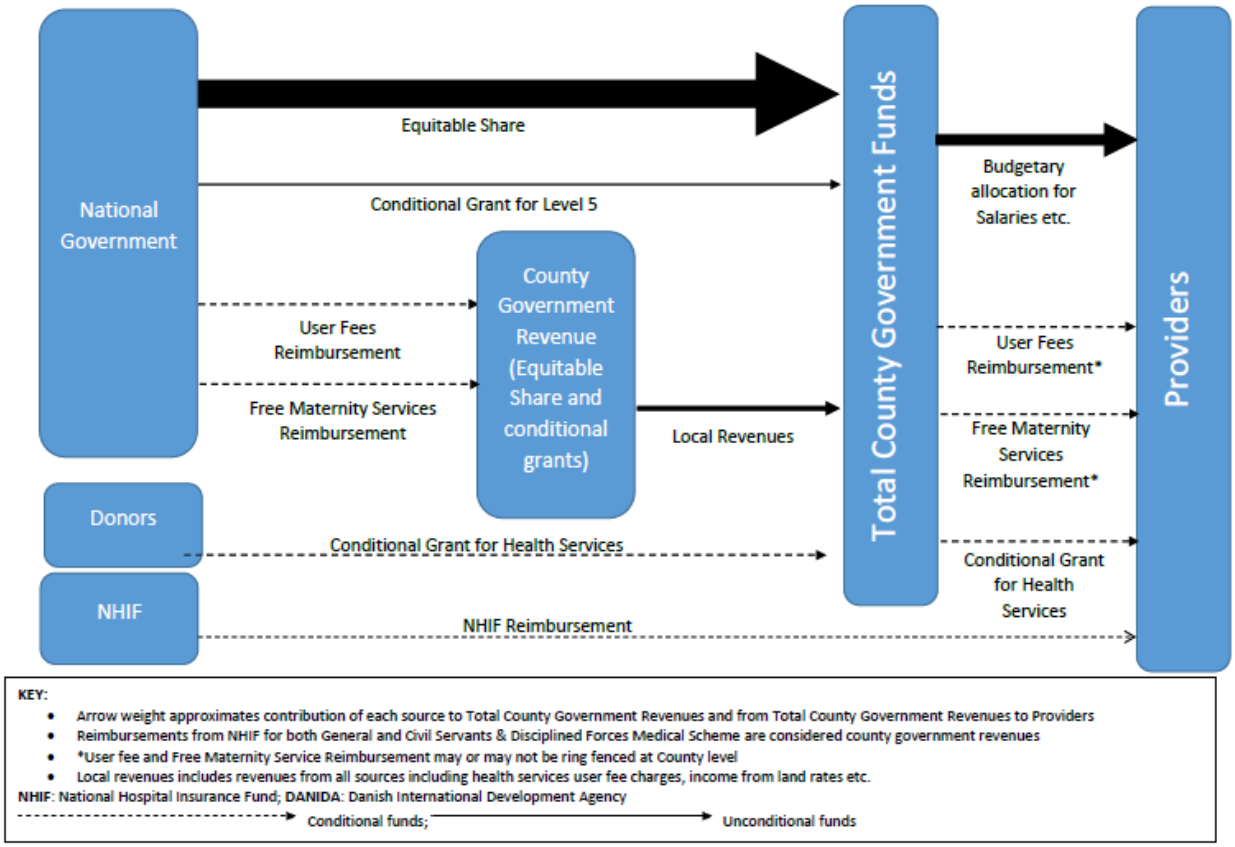
The MoH and County Governments are the major purchasers of packages of health services provided through the public sector, and nearly all tax revenue funds flow via the two financing intermediaries (Figure 5). However, there is no clear purchaser-provider split, and provider payment mechanisms are ill-defined. While health workers are paid salaries, payment for other costs is input based through predetermined line-item budgets. This form of purchasing mechanism is thus passive with no focus of which health care services should be purchased, how and from whom. Lack of strategic purchasing arrangements is a major cause of sub-optimal health system performance characterized by inefficiencies, poor quality of services and low staff productivity.

As a purchaser, the NHIF conducts some form of 'strategic' purchasing by accrediting health providers for a defined benefit package. As at 2015, he Fund

had contracted 1,128 health facilities national wide. The Fund has negotiated fixed reimbursement rates for in-patient in private facilities, while inpatient services in public facilities are paid on a fee for service basis. Outpatient services are paid on a capitation basis, but private facilities receive a higher capitation rate compared to the public facilities.

However, access to facilities contracted by NHIF is limited as most of them are urban based. In addition, there are no mechanisms for continous monitoring and engagement with providers to ensure that quality is maintained. Private health insurance providers contract hospitals on the basis of pre-negotiated contracts. Different insurance providers use different criteria to identify and contract health facilities. However, the health insurance regulatory environment remains inadequate to the disadvantage of all parties involved; namely the insurance providers, the health providers and contributors.

Figure 5: Resource flow arrangements



2.5 Health system performance in relation to UHC goals and intermediate objectives

2.5.1 Financial protection and equity in finance

Health care costs push about 3% (1.5 million) of Kenyans[15] into poverty each year and many poor people are trapped in poverty as a result of paying for health care. Each year, close to 6.2%[16] of Kenyan households are tipped or pushed further into extreme poverty because of the high cost of direct out of pocket health spending. In addition, 13% of sick Kenyans do not seek care when they are ill due to affordability barriers[17]. Average service utilization rates in Kenya are below international standards and are particularly worse for the poorest population. On average Kenyans make about 3.1 visits per capita for out-patient services, but the poorest 20 percent make less than two visits per capita.

[15] Chuma and Maina (2012). Catastrophic health spending and impoverishment in Kenya
[16] Kenya Household Expenditure and Utilization Survey, 2013
[17] Kenya Household Expenditure and Utilization Survey, 2007

In summary, the health financing arrangements in Kenya remain largely regressive. The relative progressivity of direct and indirect taxes was 0.15 and was dominated by the regressivity of out-of-pocket payments (Kakwani index -0.47). The distribution of indirect taxes was also regressive, with fuel levy being the most regressive (Kakwani index -0.41).

2.5.2 Health service quality

Ensuring adherence to quality standards in the health sector is largely a responsibility of the Ministry of Health, with some responsibility shared by county departments of health. Defined standards are enforced by independent regulatory bodies comprising of boards and councils. County Departments for Health play a facilitative role in the registration, licensing and accreditation of providers and health facilities respectively"[18].

The Kenya Service Availability and Readiness Assessment Mapping 2013 (SARAM), a national census involving all health providers (public and private), conducted in 2013 to assess the sector readiness to provide the Kenya Essential Package for Health, (KEPH) concluded that on average, only 41% of KEPH services are available across the country; however, only 7% of facilities were providing all the KEPH services[19].

Many factors are known to contribute to the poor quality of health care. Among these are weak mechanisms that would enable government as purchasers of health care to influence the behavior of the health providers and weak institutions, including:

- The lack of clearly defined national quality assurance standards;
- Weak quality assurance systems, including critical processes and structures for licensing, certification and accreditation. The processes are carried out by multiple bodies, occasionally uncoordinated. In nearly all instances, public health facilities have been excluded from requirements to comply with minimum standards for licensure;
- Lack of other processes and structures (e.g. personnel and management information systems) that would allow for continuous quality improvement (CQI) at facilities; and

[18] Health Bill, 2015, section 20d)
[19] Ministry of Health, Kenya (2013).Kenya Service Availability and Readiness Assessment Mapping (SARAM).

- Absence of financial incentives for providers and facilities to improve on quality. For example, the NHIF only reimburses facilities based on compliance to minimum quality standards and there is no link between reimbursements and the level of quality of services provided.

Quality health care is entrenched in the Kenyan Constitution and in the draft Health Bill, 2015. A health sector policy on quality assurance and standards has recently been approved and a Kenya Health Improvement Policy (HIP) has been drafted[20]. Nonetheless, strategic approaches to improve the quality of health care must be part of the Health Financing Strategy, taking into consideration the fact that ensuring quality of health care is key to achieving efficient use of resources.

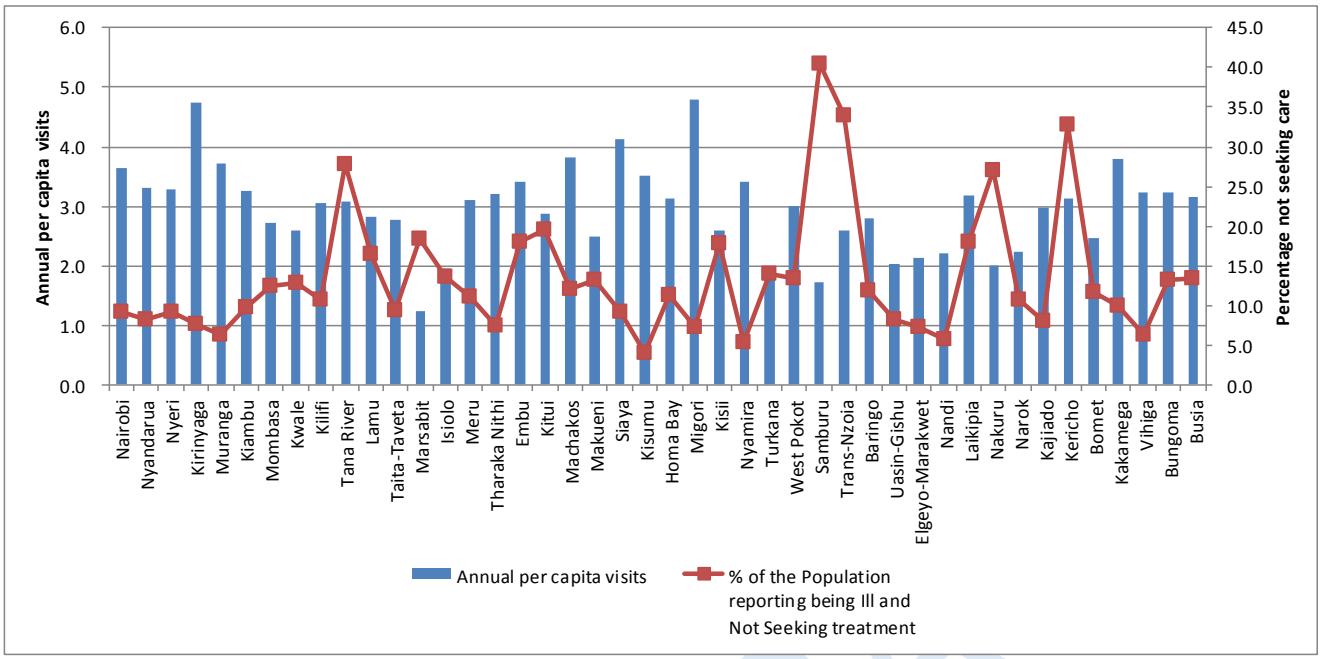
2.5.3 Equity in utilization of health care services

Public health services in Kenya remain the main source of outpatient and inpatient care for two thirds of the population. About 12.7% [21] of the sick do not seek care when they are ill due to affordability barriers. Inequities in access to health care services are high. Utilization of health care services is on the increase, reflecting the large investment and provision of free primary health care services. Kenyans made an average of 3.1 outpatient visits per capita in 2013, an increase from 2.6 visits in 2009. As expected, utilization is highest among children aged below five years (7.6 per capita visits) and the elderly 4.7 per capita visits Figure 6 and 7 show inequities in utilization of health care services in Kenya by geographical region and wealth status.

Figure 6: Utilization of outpatient services by county (2012-2013 FY)

[20] Priority 1 is that "National and County governments lead quality improvement by example and ensure

[21] Ministry of Health (2013) Kenya Health Expenditure and Utilization Survey



The public primary health care facilities and public hospitals remain the main providers of outpatient services, accounting for 40.1% and 18.3% of outpatient visits respectively. Private-for-profit facilities accounted for 17%, while private-not-for-profit accounted for 8.7% of outpatient visits. Notably, self-treatment through over-the counter medicines account for 15.9% of outpatient visits.

Available data show that primary health care services benefit the poorest populations, while hospital care largely benefits the highest income quintiles[22]. Within both the public and private sector, outpatient and inpatient benefits are inequitably distributed, and the pattern of distribution is more inequitable the higher the level of care. For example, a benefit incidence analysis showed that the richest quintile received 63.5%, 23.5% and 26.0% share of outpatient benefits for tertiary hospitals, secondary hospitals and primary hospitals respectively. In contrast, the poorest quintile received 2.5%, 4.7% and 14.8% share of tertiary, secondary and primary hospital outpatient benefits respectively[23]. However, primary health care services have remained pro-poor, benefiting the poorest in society more than the wealthy population.

[22]Chuma et al (2012). Does the distribution of health care benefits in Kenya meet the principles of universal coverage? BMC Public Health.
[23]Chuma et al., (2012). Does the distribution of healthcare benefits in Kenya meet the principles of Universal Coverage?

2.5.4 Health system efficiency

Overall, aggregate outcomes suggest that even at the current levels of spending, the country can achieve better health outcomes. Public spending is skewed in favour of high-end curative care which is inefficient and inequitable[24]. Before the devolved system of government, more than 20% of MoH budget transfers were to two referral hospitals; Kenyatta National Hospital (KNH) and Moi Teaching and Referral Hospital (MTRF). Currently, this stands at about 25% of the MoH budget; and about 13% of total government allocations to health including county governments. However, budgetary allocations at county level are still heavily skewed towards curative care.

An efficient health system would allocate a significant share of funds to primary care due to widespread coverage of public primary health facilities and equity considerations, while maintaining lower but sufficient transfers to the national referral hospitals as they are important for offering specialized care.

The absence of a gate-keeping function at primary care level is a major source of inefficiency. Available data indicate that KNH and MTRH are involved in management of patients who can be treated at lower level facilities. Patients usually walk in and out of these referral hospitals without any referral from lower level providers. The result is that specialists spend their time attending to basic ailments, which can be treated at lower levels of care. A similar pattern is observed at level 5 hospitals, the regional referral facilities.

On technical efficiency, available data suggests that hospitals are relatively more efficient compared to health centres and dispensaries[16]However, it is not clear whether this is due to better management or simply the fact that health centres and dispensaries service have smaller catchment areas with less dense populations.

Personnel costs account for 70-80% of total recurrent budget for health[25].There is a tremendous variation in the density of health personnel suggesting an

[24]World Bank Group (2014). Laying the foundation for a robust health care system in kenya: Kenya public expenditure review, The Macroeconomics & Fiscal Management, and Health Nutrition & Population Global Practices Africa Region, the World Bank Group
[25] Ministry of Health (2015). 2014/15 National and County health budget analysis report.

inefficient spatial allocation[26]. In Mandera County, for example, there is one health personnel and four hospital beds for every ten thousand people. This is in stark contrast to a county like Isiolo, where there are 17 health personnel and 35 beds for every 10,000 people.

The devolved system of government has introduced some other health workforce related inefficiencies. The greatest challenge that the counties have encountered since devolution has been the management of the health workforce. The constitution, under the fifth schedule article 190 calls for support for county governments in implementing their roles and gave a timeline of three years from the inception of devolution until full assumption of responsibilities by the counties. However, this process was fast-tracked, and as a result health workforce concerns are the most recurring issues. The main grievances by health workers include:

- Lack of clear human resource management guidelines for health workers employed on contract before devolution;
- Lack of clarity in the process for the transfer of health care workers in between counties;
- Addressing Human Resources for Health (HRH) shortages due to budgetary constraints;
- HRH career progression including promotions and professional trainings;
- Lack of harmonized salary structures between the mainstream seconded MOH staff and former local government staff working in counties.

The above issues have resulted in a frustrated and demotivated workforce, this often manifesting in form of absenteeism, strikes and mass resignations from public service; all with negative consequences on productivity and quality of care.

The pricing and spending of essential medicines and medical supplies in the public and private-not-for profit sector are known to be efficient, but inefficient in the private sector. Public sector procurement prices for the lowest priced generic medicines were found to be 0.61 times international reference prices[27], while the prices charged to in the private sector for the lowest priced generics were found to be 3.33 times the international reference price. Despite past

[26] World Bank Group (2014). Laying the foundation for a robust health care system in Kenya: Kenya public expenditure review, The Macroeconomics & Fiscal Management, and Health Nutrition & Population Global Practices Africa Region, the World Bank Group.
[27] HAI and World Health Organization (2004).

efforts to regulate the medicines and medical supplies, there is no policy of generic prescribing and restriction of procurement to purchasing quality generics. Worse still, the Public Expenditure Tracking Survey (PETS) findings in 2012 found that essential drugs availability was 67.2% across all facilities, with private and rural facilities marginally edging public and urban facilities. For the 10 essential drugs for children and 16 for mothers, availability was 77.9% and 59.2%, respectively[28].

2.6 Governance and regulatory framework for health financing

Health service delivery is largely a devolved function under the Constitution of Kenya. The MoH is largely responsible for policy, norms and standards, capacity building and technical assistance to the counties. It is also responsible for national teaching and referral hospitals.

In the past, health financing systems in Kenya have not received adequate attention. Consequently, governance and coordination structures have remained weak. Key issues related to existing governance structures are:

- Weak regulation of both public and private insurers. The NHIF is regulated through the NHIF Act (CAP 255, 1998), while private health insurance is regulated through the Insurance Act (CAP 487, 1985). These acts will need to be reviewed to make them appropriate for the proposed health financing reforms. For the NHIF, the governance structures including the board composition, selection of the CEO and the role of the NHIF in accreditation are some of the aspects that require revision. For private health insurance, the Insurance Act is not explicit about how to regulate the different aspect of health insurance and the Insurance Regulatory Authority (IRA), the body responsible for regulating insurance in Kenya largely focuses on matters related to financial accountability. There are no formal mechanisms to promote transparency and accountability to the public for both the NHIF and private health insurers.

[28] Kenya Institute for Public Policy Research and Analysis (KIPPRA), Health Service Delivery Indicators and Public Expenditure Tracking in Kenya (2012).

- Mechanisms to promote accountability exist at the county level, but the extent to which this functions remains unclear. At the county level, there exists the County Department of Health responsible for ensuring that health policies are implemented and regulations and standards are adhered to within the county. Both hospitals and primary health care facilities are governed through hospital boards and health facility committees (HFCs) respectively, both with representation from the population they serve. These boards and committees have been shown to play a critical role in managing health funds and representing the views of communities

At national level, the coordinating structures for health financing initiatives are largely un-institutionalized. In addition, there is limited understanding of UHC within the MOH. Engagement of stakeholders in UHC reforms is weak. There is a health financing interagency coordinating committee (HF-ICC), a forum which brings together all stakeholders interested in health financing. The HF-ICC provides a platform for public dialogue on all aspects related to UHC. There lacks clear coordination framework among development partners which limits their potential to align activities to national priorities.

3 Vision, Goals and Objectives

3.1 Health financing challenges in Kenya

Section 2 has identified several health financing systems challenges, which the KHFS aims to address, namely:

1. Lack of an explicitly defined essential package of health services that Kenyans are entitled to;
2. Inadequate government funding on health;
3. Overreliance on OOP payments, which creates a major barrier to access and pushes close to two million Kenyans into poverty;
4. Inequities in financing and delivery of health care services. The poorest benefit least from public health spending and contributions to health funding do not reflect ability to pay.
5. Low health insurance coverage of approximately 17% of the population. The majority of those with health insurance cover work in the formal sector and comprise the richest 20% of the population;
6. Fragmented health financing arrangements, which creates challenges for pooling, increases costs of administration and creates incentives for inefficiencies;
7. Allocative and technical inefficiencies in both public and private sectors;
8. Suboptimal quality of health services;
9. Weak health financing governance and regulation.

3.2 Vision

Quality health care services are available to all Kenyans based on need.

3.3 Goal

To ensure adequate health financing arrangements that guarantee Kenyans access to a defined package of essential health services without the risk of financial hardship.

3.4 Specific objectives

Specifically, the objectives of the KHFS are:

1. To elaborate an essential package of health services which all Kenyans are entitled to at any one time.
2. To mobilize adequate resources to fund delivery of EPH.
3. To strengthen financial risk protection with a focus on the poor and vulnerable.
4. To promote efficient allocation and equitable use of resources for health.
5. To facilitate provision of quality health services.
6. To ensure an effective governance and regulatory framework for a sustainable health financing system.

3.5 Guiding principles

The KHFS is guided by principles drawn from health, economic, social and political goals, highlighted in the Kenyan constitution, national policy documents and international declarations. These include:

- **The right to health:** The Kenyan constitution, gives all Kenyans a right to the highest attainable standards of health, including reproductive health and emergency treatment. The design of the health financing system is an important step towards realization of these rights.

- **Social solidarity***:* The establishment and operationalization of financial risk protection mechanisms for the population, which ensures sufficient funding for health and risk cross-subsidization between the rich and the poor, and the healthy and sick.

- **Equity:** Health financing and delivery models should ensure that contributions are made on the basis of ability to pay, while everyone benefits based on their need for care. Resource collection, pooling and purchasing arrangements will be designed to ensure equity in access to quality services for all.

- **Effectiveness and Efficiency:** Effectiveness will be achieved through evidence based interventions and strong health management systems; while efficiency will be achieved by reducing fragmentation and duplication across different levels, as well as promoting better performance of the health care systems.

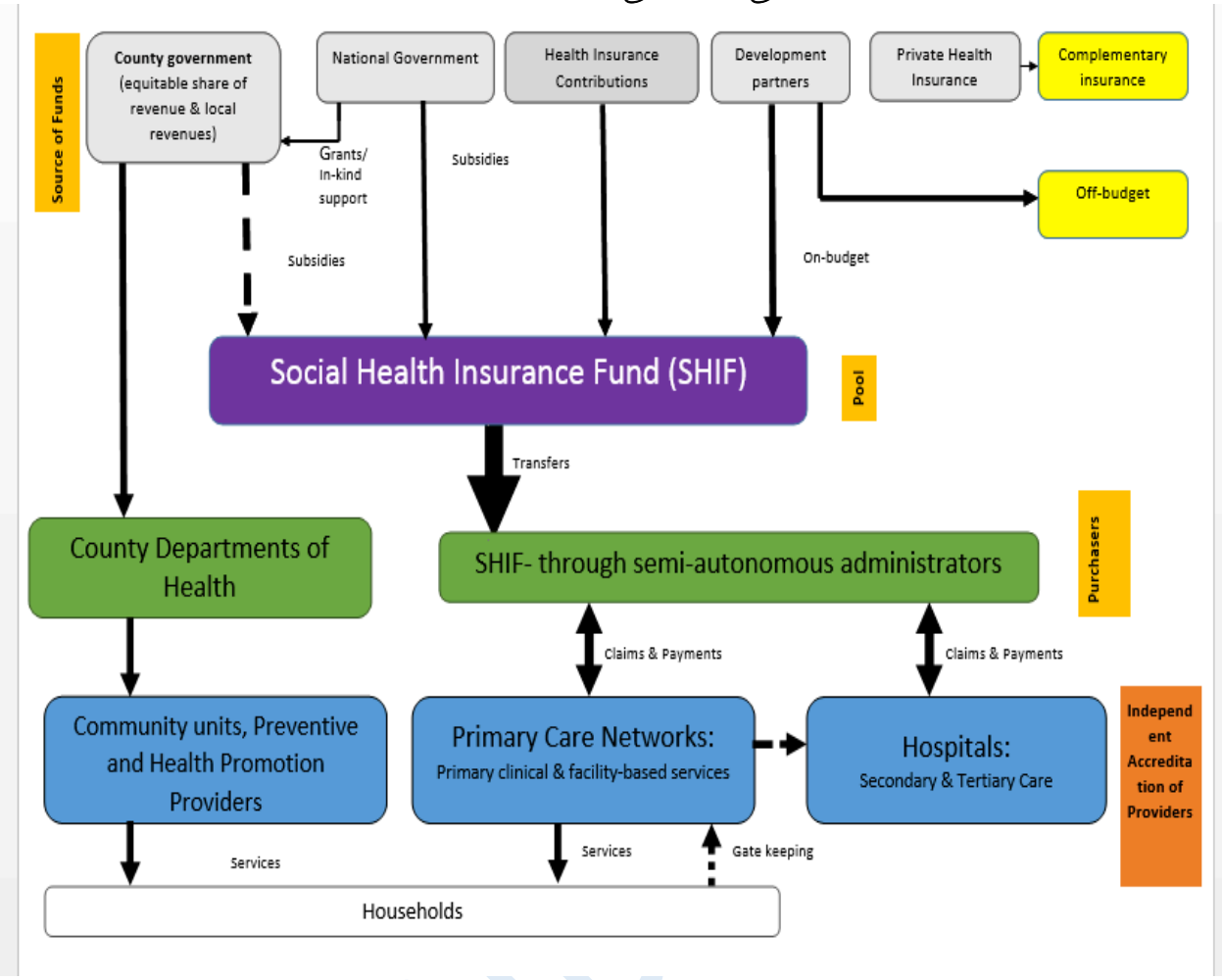
- **Appropriateness and responsiveness:** The adoption of new and innovative health service delivery models that take account of the local context and acceptability and tailored to local health needs. The health system will be responsive to population needs, ensuring provision of timely and continuous care.

- **Transparency and Accountability:** Social accountability is key to the successful implementation of the KHFS. Strong governance and regulation structures will be put in place for organizations and institutions responsible for revenue collection, pooling and purchasing. Community participation will be promoted at all levels of the health system.

4 Strategic Interventions

The strategic interventions focus on strengthening the Kenya health financing system described in Figure 4. The new health financing system aims at reducing fragmentation, increasing efficiency in resources use and delivering quality services. A single health insurance fund (SHIF), that will perform the pooling and purchasing function will be established, with plans to pool tax funds and mandatory health insurance contributions by 2030.

Figure 4: Proposed health financing architecture for UHC in Kenya



5 Strategic Objective I: To elaborate an essential package of health services as an entitlement for all Kenyans

The Kenya Health Sector Strategic and Investment Plan 2014 – 2018 (KHSSP) identifies the KEPH as the set of entitlements, which should be accessible to all Kenyans by 2030. The KEPH as defined is not affordable in the short and medium term, and thus the KHSSP states that KEPH services and population coverage will be realized progressively on the basis of disease burden, cost-effectiveness, equity and affordability. It is therefore necessary to define an

affordable essential package of health services, which all Kenyans will have access to at any one time, targeting universal coverage for comprehensive KEPH by 2030. Strategic approaches to enable the health system deliver the health entitlements for Kenyans are summarized in Box 2.

5.1.1 Strategic approaches to deliver on health service entitlements – the Essential Package of Health (EPH)

Box 2: Strategic approaches to deliver an affordable, essential package of health services to all Kenyans

1. Deliver a set of priority affordable health service interventions constituting the EPH, within the context of the constitutional right to health.
2. Define a framework for reviewing the EPH taking into account the burden of disease, epidemiological patterns and availability of resources.

5.1.1.1 Deliver a set of priority affordable health service interventions, within the context of the constitutional right to health

The EPH will constitute a set of priority health services that the State guarantees its citizens within the context of the constitutional right to health. The EPH will be derived from the KEPH and will be defined and updated on the basis of the current burden of disease, epidemiological patterns, cost-effectiveness, equity and affordability. Table 3 outlines the preliminary categorization of EPH services to be used for purposes of constituting the health service entitlement package:

Table 3: Categorization of EPH services

Categorization	Indicative health interventions	Priority for health impact	Complexity for service delivery
1A: Public health services, community based	health promotion, food safety and hygiene, water safety, environmental sanitation, vector control	High	Basic
1B: Public health services, health institution based	Immunization, family planning, nutrition programmes, disease screening programmes, communicable disease control programmes (HIV/AIDS, TB, Malaria, Childhood diarrhea etc.)	High	Basic

2A: Clinical services, primary health care	Maternal and newborn care, management of common illnesses and conditions; including HIV/AIDS,TB and Malaria (primary care consultations), emergency treatment	High	Basic
2B – 1: Clinical services, secondary health care (Hospital based services)	Emergency treatment (first contacts and referrals from primary care)	High	Medium and high)
2B – 2: Clinical services, secondary health care (Hospital based services)	Management of common illnesses and conditions (referrals from primary care)	High	Medium and high
2B – 3: Clinical services, secondary health services (Hospital based services)	Other conditions (referrals from primary care)	Medium and low	Medium and high
2C – 1: Clinical services, specialized / tertiary care	Emergency treatment (first contacts and referrals from primary and secondary care)	Medium and high	Medium and high
2C – 2: Clinical services, specialized / tertiary care	Essential referral from secondary care	Medium and low	High
2C – 3: Clinical services, specialized / tertiary	Other conditions (referrals from primary or secondary care)	Medium and low	High
3: Rehabilitative services	Long term and palliative care	Medium and low	Medium and basic

The initial EPH shall comprise of universal coverage for high priority interventions (1A, 1B, 2A, 2B-1 and 2B-2) summarised as follows:

1. Community and health facility based public health services
2. Maternal and new-born care
3. Screening, detection and management of common illnesses and conditions (first and secondary contacts), including TB and HIV/AIDS
4. Emergency treatment
5. Selected medium priority and medium complexity interventions

The EPH will be reviewed periodically.

5.1.1.2 Define a framework for revising the EPH

The MoH shall provide leadership for the regular updating of the EPH based on an explicit and evidence based criteria, targeting expansion of service and population coverage as resources become available. An independent health benefits expert committee, comprising of experts in different areas (e.g. epidemiologists, demographers, medical practitioners, health economists, service users etc.) will be established, and given the mandate to review the EPH. Health Technology Assessments (HTA) to examine the medical, economic, social and ethical implications of use of health technology will also inform the review of

the EPH. Stakeholder consultation, including public consultation will be a central part of the EPH review process.

The KHFS proposes three phases of implementation. In Phase I (2016-2017), the focus will be on defining, strengthening and aligning the health system to deliver EPH as defined, and establishing the legal and regulatory framework. Phase II (2018-2022) will focus on increasing population and service coverage for EPH. During this phase, delivery of the initial EPH will be strengthened. The EPH will be reviewed in phase III (2023-2030) and further expanded to include additional interventions, subject to resource availability.

Figures 5a to 5c illustrate the increase in population coverage, and expansion of the range of services covered by the EPH, with time. In **Figure 5a**, the x-axis represents the population, from poorest to wealthiest. The-y axis represents levels of service delivery. In 2016, the informal sector has variable access to existing public services, and very few have access to the services set out in the KEPH. The blue bar represents the small percentage of the informal sector that is able to purchase health insurance. The green, yellow, orange and red bars together represent the formal sector. All are required to have insurance – some are insured with the NHIF, and others are with private-for-profit insurers. **Figure 5b** illustrates that by 2022, the focus will be on strengthening the health system in order to provide an 'initial EPH' to the entire population. Between 2023 and 2030, the focus will be on expanding the benefits that are universally available (**Figure 5c**).

Figure 5a: Current situation

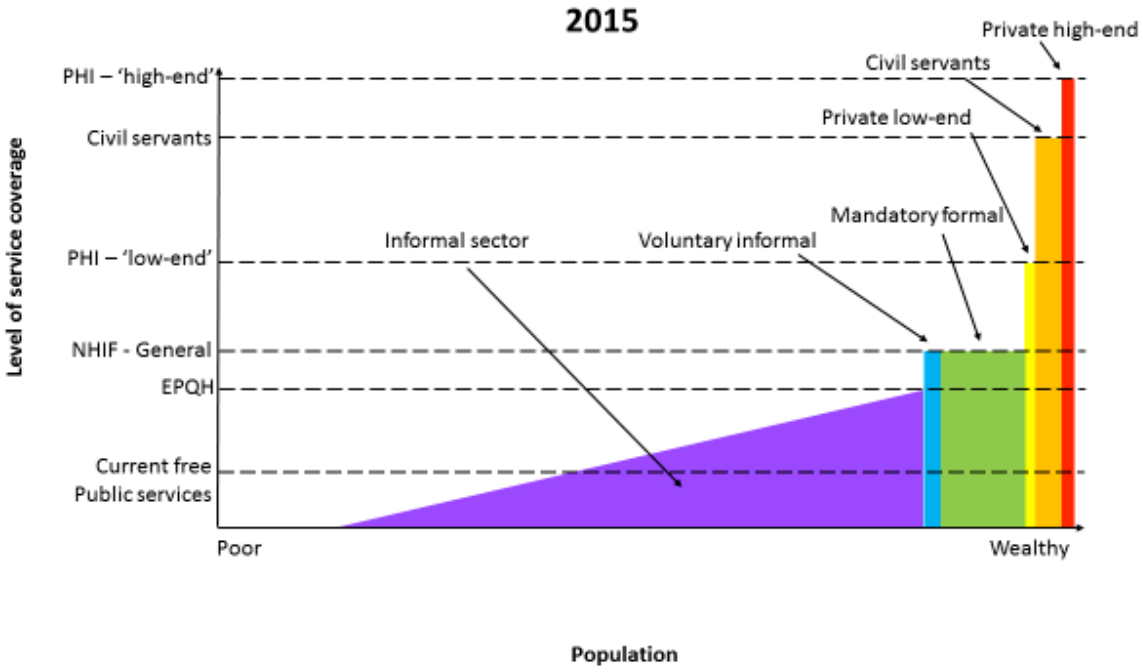


Figure 5b: Phase 1: Expanded breadth of EPH coverage by 2022

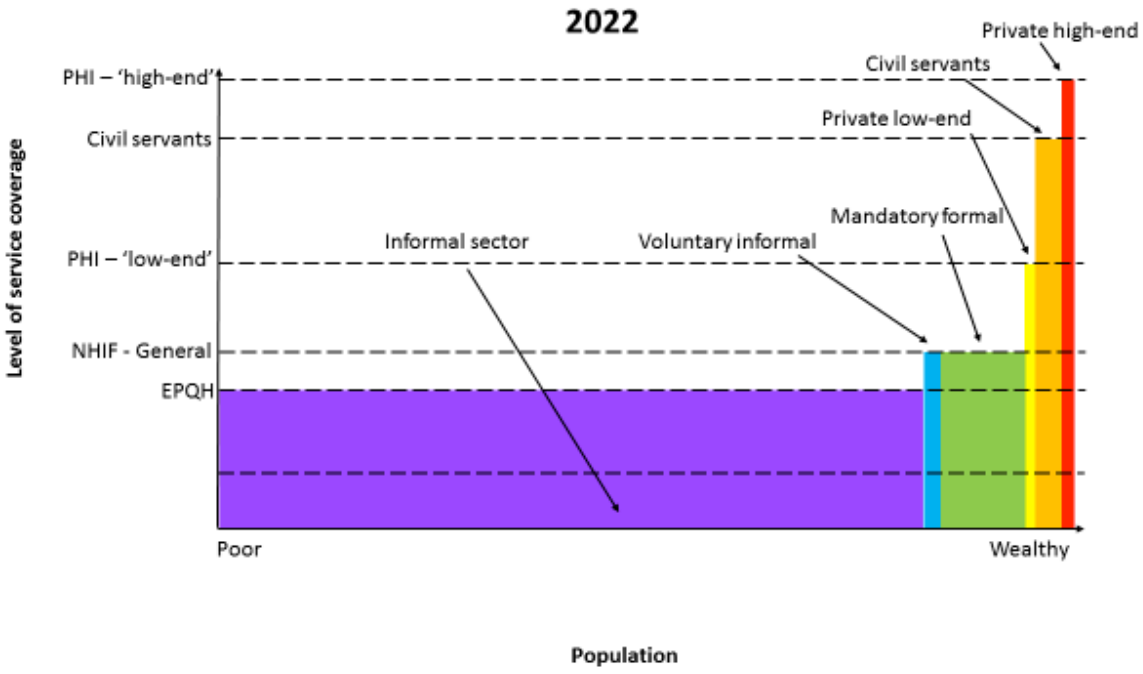
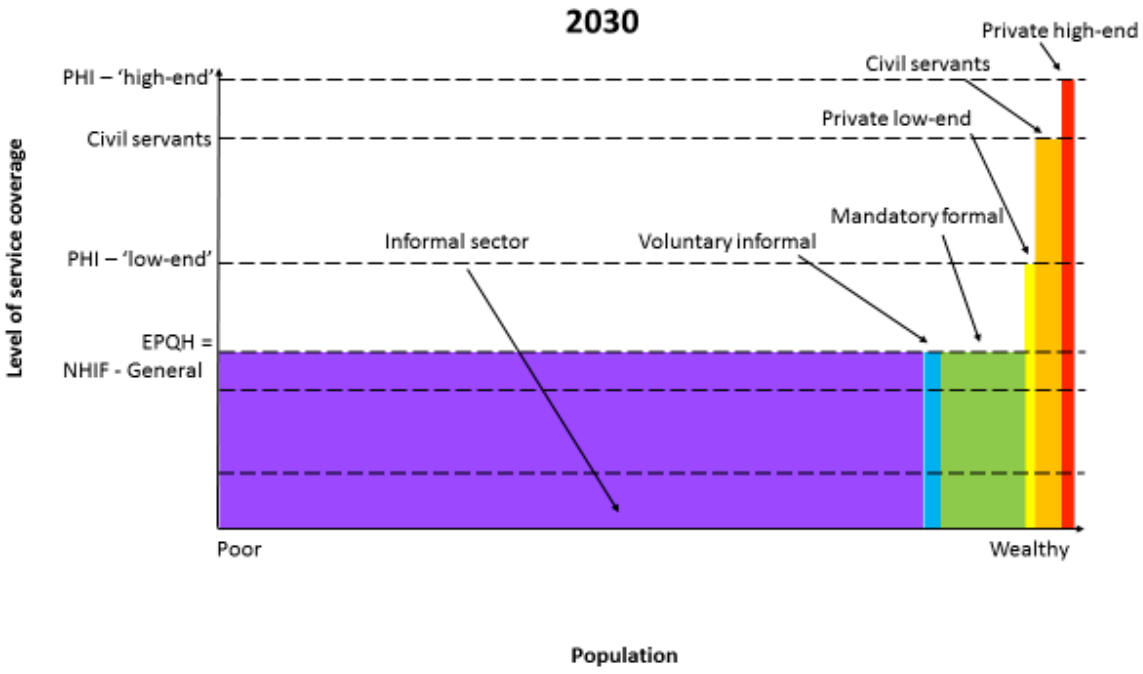


Figure 5 c: Phase 2: Expanded depth of coverage by 2030



5.1.1.2.1 Resource requirements for the delivery of EPH

When exploring potentials sources of funding the EPH, the starting point is an estimate of how much resources are needed to deliver the EPH and the potential sources of funding by 2030.

Figure 6 projects government health spending to the year 2030 and incremental costs of delivering the EPH. In 2015, the GoK spent approximately US$ 27.25 per capita[29]. Through inflation alone, government health spending is expected to increase from US$ 27.25 per capita in 2015 to US$ 49.25 in 2030[30]. The incremental costs of the EPH between 2016 and2022[31] show that an additional US$15.5 per capita is required in 2016, with slightly more each year, reaching US$ 29.4 in 2019. In Phase I and II, a significant share (75%) of incremental resources would be devoted to health systems strengthening. Of the US$3.4 billion needed for health systems strengthening, almost half is for infrastructure and equipment, and the other third goes for personnel emoluments. This gap can be complemented by resources from the private sector, development partners and other public sources of funding.

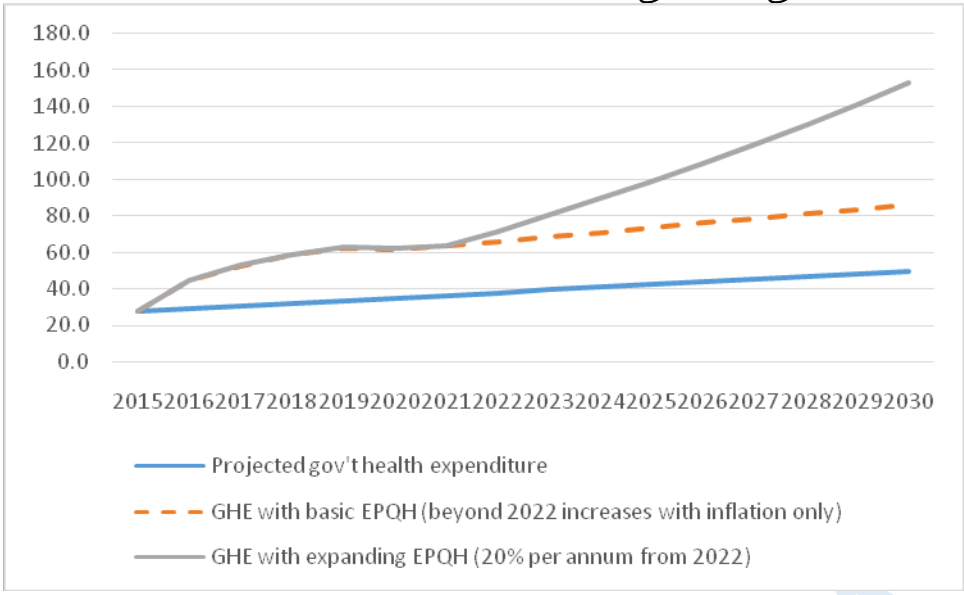
In Phase III the focus is on gradually increasing the benefits under the EPH. The incremental cost of the package is increased by 20% each year to allow for gradual expansion of the benefits package. Thus, the incremental cost of the EPH reaches US$ 104.1 by 2030. By 2030, the GOK will need to spend US$ 153.3 per capita to deliver an expanded EPH.

Figure 6. Government health spending and incremental costs of the EPH

[29] These estimates are based the NHA 2012/13.

[30] THE was projected to 2030 using GDP deflators (http://data.worldbank.org/indicator/NY.GDP.DEFL.ZS?page=1). It was assumed that the public share of THE would remain constant at 33.5%. The government health spending each year was converted to US$ using the 2015 exchange rate (US$ 1 = 103 KSh). All figures are in 2015 US$.]

[31] Costs are estimated based on data from the Taskforce on Innovative International Financing for Health Systems. The HLTF estimate (based on the WHO normative costing) includes the cost of medicines for this broader range of diseases and services as well as costs related to expanding facility and equipment infrastructure, higher staffing levels and other components of health system strengthening.



6 Strategic Objective II: Increase resources for effectively delivery of the EPH

6.1.1 Strategic approaches to increase resources for health

Domestic resources, both tax funding and health insurance premiums, will play a key role in making the EPH accessible to all Kenyans. However, donor funds will still be required to supplement government resources in the short and medium term. Three core strategic approaches to increase domestic resources are presented in Box 3.

Box 3: Strategic approaches to increase domestic resources for health

1. Gradually increase government budget allocation (national and county-including locally generated revenue) to health and promote efficient use of these resources.
2. Mandatory health insurance for all Kenyans.
3. Manage donor support to ensure continued harmonization and alignment in the short to medium term

6.1.1.1 Gradually increase government budget allocation (national and county level) to health and promote efficient use of resources

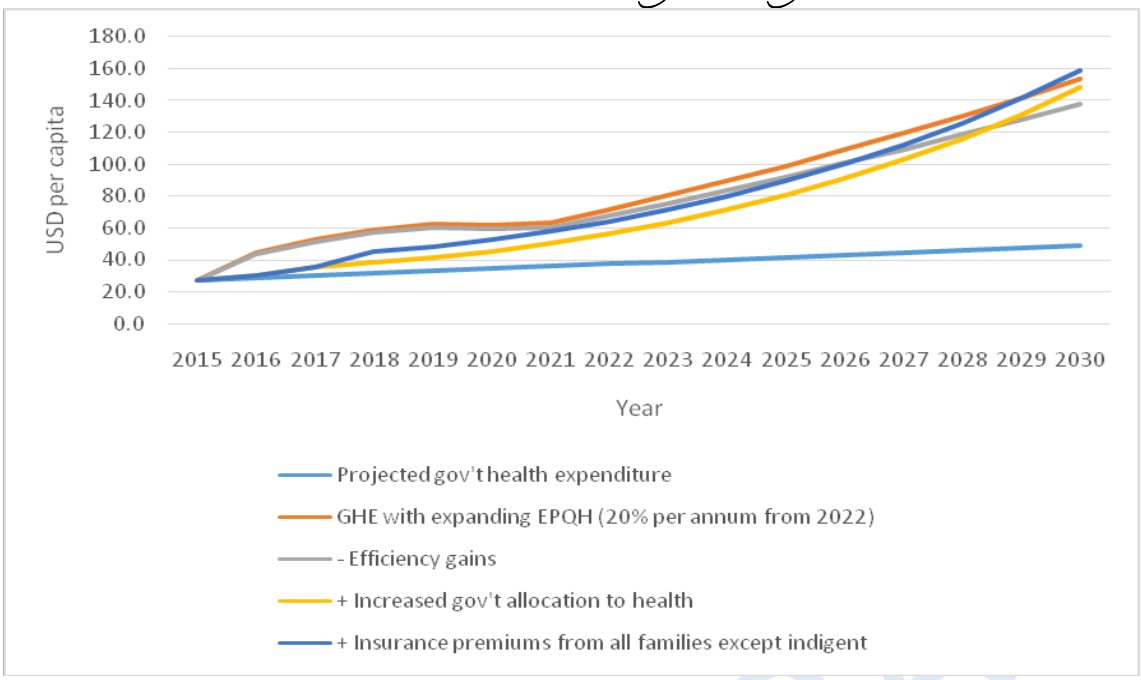
Section 4.1 showed that Kenya will need to spend US$ 153.3 per capita to deliver the EPH by 2030, which is approximately six times the current level of government health expenditure. Clearly, both national and county governments will need to increase budgetary allocations to health, for the delivery of the EPH to be met. Over the long term, it is anticipated that total health system expenses will be covered through three 'sources':

- Efficiency gains, arising from better allocation and use of funds at the national and county level;
- Increased government budgetary allocation to health from both general and local tax revenues;
- Mandatory health insurance premiums targeting both formal and informal sector.

The estimated total revenue mobilized through the different sources are presented in Figure 7[32].

Figure 7: Addressing the financing gap with efficiency gains, increased allocation to health and increased enrolment in national health insurance

[32] **These calculations are very preliminary and require correcting and refinement.**
Of particular note, the EPH (based on the Taskforce package) does include anti-retroviral treatment – but the costs are based on averages across many low-income countries, which do not take into account individual country's disease burden. The cost of anti-retrovirals is likely to be much more expensive in Kenya given its disease burden.
So far, all of these figures take into consideration government spending only (including on-budget donor spending) but they do not take into consideration private spending and off-budget donor spending on health.

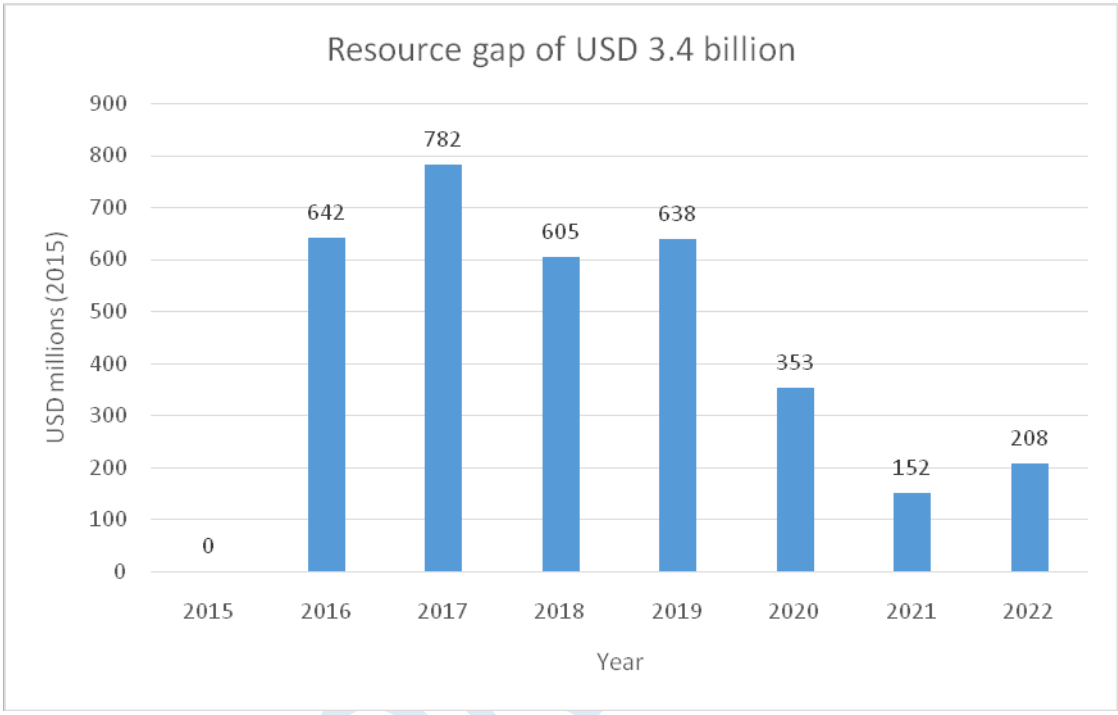


First, assuming very modest efficiency gains, of 0.625% per year, with an additional 0.625% added each year, total efficiency gains are expected to be 10% by 2030. This results in efficiency gains of USD 15.3 per capita by the year 2030. These efficiency gains are subtracted from the line illustrating resources required to pay for expanding the EPH. Second, it is assumed that government allocation to health will increase, linearly, from 1.82% of GDP to 3% in 2030. This modest increase in allocation to health would result in an increase in government spending of US$ 100 per capita in the year 2030. Third, as the country moves towards a system of social health insurance, it there will be additional revenues generated through health insurance premiums. It is assumed that 80% of Kenyan households (excepting the 20% of households that are indigent) would contribute 300 Kenya Shillings per month, per household, starting in the year 2017. These premiums have been projected to 2030 using GDP deflators.

What is clear from Figure 7 is that even with efficiency gains and mobilization of domestic resources, there will remain a significant resource gap as Kenya strengthens its health system and begins to deliver the EPH. This gap is especially evident between 2016 and 2022 (Figure 8). During this time, the total resource gap sums to approximately US$ 3.4 billion, largely due to the

initial investment in health system strengthening. Domestic resources alone will not be sufficient to fill this gap. Coordinated donor support, preferably through on-budget, will be needed to strengthen the system for delivery of the EPH as Kenya transitions off of external support.

Figure 8: Estimated resource gap (2015-2030)



6.1.1.2 Mandatory health insurance for all Kenyans

The health system will be funded predominantly through tax funding and health insurance contributions, while OOP payment will be kept at a minimum. Considering that close to 80% of economically active Kenyans work in the informal sector, it is important that revenue collection mechanisms are designed in the most efficient way possible. Besides increasing revenue for health care, health insurance contributions from informal sector ensure financial risk protection, equitable access, and foster a sense of ownership and solidarity.

Overall, the population will be classified in seven categories:

- **Category 1:** Salaried employees and employers and their dependents to be registered by employers. The premium will be shared proportionately between the insured and the employer.
- **Category 2:** Self-employed, including independent professionals and technical specialists and their dependents to register through the identified channels.
- **Category 3:** Wage earners (occupational union members) and dependents to be registered through the unions they belong.
- **Category 4:** Organized occupation groups and their dependents (e.g farmers, fishermen, pastoralists etc. to be registered by associations and cooperative societies).
- **Category 5:** Inmates at correctional facilities (no dependents) to be registered by the correctional facilities. The premium will be paid by the government.
- **Category 6:** Indigents and population minorities without incomes to be registered by local administrative offices (for example chiefs' offices).
- **Category 7:** Others e.g. Heroes and dependents to be registered by local administrative offices (chiefs' offices). For Heroes, premium will be paid by government. However, premium for dependents will be shared between the insured and government.

Contribution from formal sector workers will be income rated and will be in the form of statutory deductions. A flat contribution rate contribution will be charged to the informal sector (category 2-5), with partial subsidy from the government. Contributions for category 5-7 will be fully met by the government. Possible approaches to collecting revenue from the informal sector include organized groups like cooperative societies, linking contributions to issuance of business licenses (including driving licenses and Personal Identification Numbers) and Civil Registration and Vital Statistics (CRVS).

6.1.1.3 Align donor funding to domestic resources in the short to medium term

Development Partners will be encouraged to continue supporting the development of the health sector in line with sector priorities at both County and National levels within the tenets of the Paris Declaration on Aid effectiveness. This partnership in the implementation of the KHFS is a unique opportunity for maximizing aid effectiveness in the health sector; but will require flexibility on the part of both government and donors.

7 Strategic Objective III: Improving financial risk protection, with a focus on the poor and vulnerable

7.1.1 Strategic approaches to increase financial risk protection

In order to ensure financial risk protection for all, provision of EPH will be funded primarily through prepayment mechanisms, while reducing OOP payments to a very minimum. The long-term goal is to ensure that Kenyans have equitable access to the EPH, without the risk of financial impoverishment.

Box 4: Strategic approaches to increase financial risk protection

1. Establish a Social Health Insurance Fund (SHIF) to cover all Kenyans.
2. Provide budgetary allocations for health insurance subsidies for the poor and other targeted beneficiaries.
3. Align all social security programs with the SHIF.

7.1.1.1 Establish a Social Health Insurance Fund.

In order to implement the KHFS, there will be restructuring, reorganization and strengthening of institutions and organizations involved in revenue collection, pooling and purchasing. The legal and regulatory framework will be revised and enforced to make health insurance mandatory for all Kenyans.

(a) *Establish the SHIF as the main pooling and purchasing agency*

A single Social Health Insurance Fund (SHIF) will be established. The SHIF will be the main pooling and purchasing agency for clinic –based EPH services (described in 8.1.1.2).

- During the first and second phase of the KHFS implementation (2017-2022), the national and county governments will remit health insurance subsidies to the SHIF (Figure 3). Development partners will also remit funds to the SHIF to support the government efforts to reach the poor. Individual contributions will also be remitted to the SHIF by the collecting agencies.
- County governments with directly purchase population based (as well as facility based) preventive and promotive services
- Towards the end of the third phase of KHFS implementation (2023-2030), the focus will be gradually channelling as much tax funding as possible into the SHIF, thus separating service provision from purchasing to the extent possible (section 8.1.1.2).

(b) Registering the population

The first phase of the KHFS implementation will focus on developing infrastructure to register and collect revenue; and community sensitisation in preparation for 2018 roll-out. Kenyans will be required to register with the SHIF and pay a premium based on the categories (section 6.1.1.2), which will enable them to access the EPH. Both levels of government will pay full subsidies for the indigents and partial subsidies for informal sector workers (Section 7.1.1.3). All the registered members will be issued with cards that will enable them to use services from accredited services providers. Both formal and informal sector health insurance contributions will be collected by the Kenya Revenue Authority (KRA) and transferred to the SHIF.

(c) Role of Private Health Insurers

Membership to the SHIF will be mandatory for all Kenyans. However, the services provided through the SHIF membership will be limited to the EPH and will only be provided by accredited health care providers. This recognition that no government can provide all health services to all people all the time clearly calls on private health insurance to supplement government initiatives. Therefore private health insurers will continue to exist alongside the SHIF on a voluntary basis, to purchase additional cover for services not covered through the SHIF. However, individuals with private health insurance cannot opt out of the SHIF and will be legally required to remit contributions, which they can draw from to access the EPH.

7.1.1.2 Establish a system for identifying target beneficiaries for health insurance subsidies.

About half of Kenyans live below the international poverty line. Ideally, the government should fully subsidize health insurance contributions for those living below the poverty line, but doing so will not be affordable in the short term. Rather the government will prioritize the poorest of the poor (indigents) and other vulnerable groups, for example, orphans and vulnerable children, the elderly and people living with disabilities. For this to be done effectively, an accurate data base for the poor and vulnerable is required. The Ministry of Labour, Social Security and Services (MoLSSS) currently operates a cash transfer program for OVCs, the elderly and disabled, and has a data base developed in 2005. This data base will be updated and expanded to include other target beneficiaries. The data base will be reviewed and updated periodically, and linked to CRVS to timely capture births and deaths in the target population.

7.1.1.3 Align social security programs with the SHIF.

The MoLSSS operates three social security programmes namely: cash transfer programs to OVCs; cash transfer programs to the elderly and the National Social Security Fund (NSSF) provides social security protection to all workers in their retirement. All formal and informal sector workers are mandated by law to

contribute to the NSSF, but contributions are only enforced in the formal sector. Under the NSSF Act 2014, both employees and employers contribute to the scheme and members can only access their benefits when they reach the age of 55, or when they ultimately retire from regular paid employment. Private pension plans also exist. A shortcoming of existing social security schemes is that they do not offer health related financial risk protection to the beneficiaries upon retirement. All social security programs will be aligned with the SHIF, to ensure that beneficiaries (OVCs, elderly, disabled and pensioners) have health insurance cover, purchased by the respective social security/retirement fund.

Table 4: Summary of activities needed to increase financial risk protection

Strategic area	Key activities		
	2016-2017	2018-2022	2022-2030
Establish a SHIF legislative framework	Development and enactment of SHIF Act Revise the IRA Act Develop infrastructure for registration of all Kenyans Community sensitization of the SHIF policy	Mandatory enrollment of informal sector workers into the SHIF	Expand SHIF coverage to 100% of population
Provide health insurance for the poor	Develop systems for identifying the poor, jointly with the Ministry of Labor, Social Security and Services	Enroll the poor into NHI using 100% subsidy from national government	Expand health insurance subsidy for the poor to100% of eligible population
Harmonize social security programmes	Link social security programmes under the MLSSS with the NHI	All social security benefits to include health insurance cover for the EPH	

8 Strategic Objective IV: Ensuring maximum health benefit from existing and future resources

8.1.1 Strategic approaches to improve purchasing and efficiency in service delivery

Strategic purchasing will be adopted and providers reimbursed based on the most efficient provider payment mechanisms. The national government will ensure that SHIF has the authority, information and instruments needed for strategic purchasing and will create a transparent and stable environment within which strategic purchasing can flourish. Strategic interventions to improve purchasing are summarized in Box 5.

Box 5: Strategic approaches to improve purchasing and efficiency in service delivery

1. Adopt a client centred primary care service delivery model to deliver the EPH.
2. Separate service provision from purchasing of curative services
3. Establish mechanisms to support health system strengthening, for delivery of high quality services.

8.1.1.1 Adopt a client centred primary care service delivery model to deliver the EPH

The EPH will require adoption of appropriate strategic approaches for its effective delivery. Such approaches include client-centred service delivery models, re-engineering primary health care and strengthening the referral system among others. Available information suggests that 70 – 80% of health problems can be handled at primary care level. A client centred delivery model built around a strong primary health care system will be developed. The primary care service model will require that the current service delivery model gradually moves from stand-alone clinics and hospitals to a network of facilities that are well linked and equipped to provide all services associated with that level.

A PCN will comprise of 30 to 40 providers (dispensaries, health centres, OPD units-primary care units in hospitals, medical laboratories, and individual clinics operated by physicians or other health workers such as nurses, clinical officers, pharmacists, from both the public and private sector). The PCNs will be established at the county level in order to organize for continuous professional development, to refer patients among each other according to specific competence, and to act as the contracting unit for the SHIF. Each PCN will be linked to level 4 and 5 hospitals for effective referral.

A key goal of adopting a PCN service delivery model is to maintain continuity of care for clients. Good linkages and referrals within and outside the PCN will thus be required. It is estimated that the country will need approximately 10,000 PCNs to effectively deliver primary care services. Each PCN will be accredited by the national accrediting body (section 9.1.1.3). SHIF members will register with a PCN, which is linked to their SHIF contribution. A system of referral across the PCNs and to hospitals and back to primary service level will be guided by the national referral policy, with a strong gatekeeping function. Penalties will be imposed by-passers of the referral system, except for emergency cases, which will be clearly defined in law. A prerequisite for this system to function is appropriate investment by the national and county governments in strengthening the system to deliver quality health services (section 8.1.1.3).

Box 5: Key elements of the PCN service delivery model

- The PCNs will be assigned to deliver primary health care (including curative and facility based preventive)
- Will comprise 30 to 40 single primary care providers , and may (or not) be defined by the boundaries of sub-counties
- Will register the target population within their boundaries
- Will serve as contracting units of the SHIF
- Will be allocated capitation budget to provide comprehensive primary care services to its registered population
- Referral within the network for primary health care services will be done at no additional cost
- Will have a well-established and formalized relationship with hospitals (level 4, 5 and 6) for 'referrals'

8.1.1.2 Separate service provision from purchasing

a. County governments as purchasers of preventive and promotive services

The county governments are responsible for county health facilities and are currently involved in direct purchasing of health services. This dual role does not provide incentives for service improvements, cost-containment and efficiency, and there is no competition between public service providers. With separation of purchasing from service delivery function, direct purchasing of health care will be limited to preventive and promotive health services with public externalities,

largely delivered at population level. In addition, county governments will be responsible for personnel emoluments, capital investments and infrastructure and equipment maintenance.

Full implementation of the KHFS will see the funding for human resources for health and maintenance factored into the provider re-imbursements and therefore channeled through the SHIF. This approach will mark the full shift from input based financing towards out-based funding that rewards performance by 2030.

b. The SHIF as the main purchaser.

The SHIF will be the main purchaser of health services. Contracts will be developed to guide the relationship between service providers; namely Counties, PCNs and Hospitals, and the SHIF. To promote equity and to encourage private providers to operate in remote areas, the accreditation process will take into account the need for particular providers within an area and incentives provided by the government and SHIF to encourage private investments in underserved regions. Financial incentives related to empanelment and level of reimbursement will be developed to encourage providers to improve quality of care.

To promote cost-containment and future sustainability of UHC in Kenya, the most efficient PPMs will be used. Risk-adjusted capitation system will be used to pay for primary health care services, offered through the PCNs. The annual capitation fees will be determined on the basis of the epidemiological profile, target utilization and cost levels. Hospitals will be reimbursed on the basis of diagnosis related groups (DRGs), where providers are paid a fixed rate per discharge based on diagnosis and treatment and fee-for service for outpatient services.

c. SHIF semi-autonomous administrators

SHIF will carry out its purchasing function through semi-autonomous administrators country-wide, with at least one SHIF administrator per county. The administrators will be the operational arm of the SHIF, and will ensure that

services are available closer to the people. They will consult, partner and coordinate as needed with county governments within their regions to ensure successful implementation of the KHFS. The SHIF administrators will also negotiate contracts with service providers on behalf of SHIF, process, review and pay claims and sensitize the population on SHIF.

8.1.1.3 Establish funding mechanisms to strengthen the health system to deliver high quality services.

Effective delivery of the EPH requires that health facilities have adequate capacity to deliver quality services. Significant investment in health system strengthening will be required to empanel health facilities in the first and second phase of the KHFS and ensure they meet the required standards for EPH delivery. The national government will establish mechanisms to support health systems strengthening at the county level. Development partners will also contribute to the health system strengthening, through conditional grants channeled through on-budget support as much as possible.

Each county will develop a comprehensive health system strengthening plan, clearly documenting how they will revamp their system to deliver quality health services through a PCN model, with clear linkages to hospitals. Counties will receive investment grants from the national government, conditional to primary care network strengthening to address identified gaps, which may include increasing the quantity and quality of human resources, availability of medical and non-medical commodities, equipment, and infrastructure among others. National quality standards for health care providers at all tiers will be developed to guide county health system strengthening plans (section9.1.1.2).

Table 5: Summary of activities needed to improve strategic purchasing

Strategic area	Key activities		
	2016-2017	**2018-2022**	**2022-2030**
Develop a health service delivery model for EPH delivery	Develop guidelines for establishing PCNs in each county Assess capacity to deliver EPH in each county Counties establish PCN linked to a strong referral system, including gate keeping	Implement the PCN service delivery model in each county Register and issue all Kenyans with an EPH health cared	Implement the PCN service delivery model in each county Register and issue all Kenyans with an EPH health cared

	Develop infrastructure for registering all Kenyans		
Establish mechanisms to fund health system strengthening	Counties develop and start implementation health system strengthening plans National government develops mechanisms to fund county health system strengthening	Continue implementation of HSS plans	Continue implementation of HSS plans
Separate service provision from purchasing	Develop legislation to support purchaser-provider split at both national and county level. Technical support and capacity building for new institutions/organizations	Implement separation of purchaser-provider split Continue technical support and capacity building	Complete separation of purchasing from provision

9 Strategic Objective V: To facilitate provision of quality health services

9.1.1 Strategic approaches to ensure the best quality of health care

Good quality services are integral component of UHC. Box 6 summarizes strategic approaches to improve quality of care in the Kenyan health sector.

Box 6: Strategic approaches to improve quality of care

1. Develop national quality standards for health care providers at all tiers
2. Develop and implement processes and structures for assessing quality and for continuous quality improvement (CQI).
3. Establish an independent national accreditation agency.
4. Link financial incentives and reimbursements to quality of care.

9.1.1.1 Develop national quality standards for health care providers at all tiers.

National quality standards that can be implemented in health care facilities to improve quality in health care (with or without certification) are lacking. These standards are being developed under the stewardship of the Ministry of Health and the national and county governments will use the standards as a tool to measure performance of health care providers against the quality standards.

9.1.1.2 Develop processes and structures for assessing quality.

Licensure will be the entry point for facilities into the CQI and certification processes. There will be regular post-licensure inspection of providers to ensure that only those that meet the basic minimum practice requirements are allowed to continue operating. The main reform to drive this is the Joint Health Inspections Checklist (JHIC), and promoting coordination between regulatory agencies and SHIF administrators, the strategic purchasers of health care services. The JHIC aims to streamline the process of inspections, make more transparent assessment criteria, and enhance communication and accountability between inspectors and health facilities. Facilities that fail to achieve the lowest allowable score through the JHIC process will not be eligible for CQI and will not be certified or accepted as providers for accreditation purposes.

9.1.1.3 Establish an independent national accreditation system.

An independent national accreditation agency will be established to assess and accredit PCNs and hospitals based on prescribed criteria and standards. The accreditation process will take into recognition the challenges of the current health system and will be built upon a CQI and certification process. PCNs and hospitals will develop and implement comprehensive quality improvement plans. Facilities that fail to achieve the lowest allowable score through the national accreditation process will not be contracted under SHIF.

9.1.1.4 Link financial incentives and reimbursements to quality of care.

Strategic purchasing that links reimbursement to quality improvement creates incentives to improve quality of care. The SHIF will define financial incentives to promote quality improvement, and encourage providers to meet accreditation standards for EPH. In addition, the MOH, county governments and the SHIF will require evidence of quality improvement systems as a condition for funding purchaser contracts with health care providers. The level of reimbursement will be structured so as to motivate individuals and facilities to provide care of the highest quality.

Table 6: Summary of activities needed to improve quality of care

Strategic area	Key activities		
	2016-2017	**2018-2022**	**2022-2030**
Develop national quality standards for health care provision at all levels	Develop national quality standards for health care providers at all levels	Implement national quality standards	Monitor
Develop processes and structures for assessing quality	Develop processes and structures for assessing quality Develop a quality monitoring framework Facilities develop CQI plans Initiate regular inspections	Implement processes for assessing quality	
Establish a national quality standards and accreditation system	Develop legislation to form a the national accreditation body Establish the national accreditation body	Embark on accreditation process Support PCNs to develop and implement quality improvement plans (QIP)	Monitor quality improvement for PCNs and hospitals and review accreditation status
Link financial incentives and reimbursements to quality of care	Design system for categorizing providers on different levels of quality Design PPMs that pay higher reimbursement rates to facilities ranked high on quality	Implement PPMs Regularly review the quality grading to keep the providers incentivised	

10 Strategic area VI: Strengthening health financing governance and institutions

10.1.1 Strategic approaches to strengthen health financing governance and institutions

The institutional and regulatory arrangements for the establishment of the NHI are critical for Kenya's progress to UHC. A strong governance and regulatory framework, coordination, leadership, transparency and accountability are important for the successful implementation of the proposed reforms. This section outlines roles of organizations at county and national level, laws needed to support the reforms and mechanisms to promote transparency and accountability. Strategic approaches for strengthening health governance are shown in Box 6.

Box 6: Strategic approaches to strengthen health financing governance

1. Develop a legal and regulatory framework to guide the implementation of health financing reforms.
2. Strengthening the capacity of the Insurance Regulatory Authority
3. Strengthening UHC leadership at national and county levels.
4. Improve transparency and accountability in health financing and delivery at all levels
5. Strengthen coordination between all stakeholders at national and county levels
6. Develop a strong pubic financial management system in the health sector

10.1.1.1 Develop a legal and regulatory framework to guide the delivery of all strategic interventions.

Section 7 and 8 describe the pooling and purchasing agencies, which will be established as part of the health financing reforms. For these organizations to function adequately, and enable Kenyans to realize the right to health, a clear legal and regulatory framework is required. Some of the legal requirements include mandatory social health insurance; EPH entitlements; creating framework to guide the participation of private provider in delivering the EPH on behalf of the GOK.

10.1.1.2 Strengthen the capacity of the Insurance Regulatory Authority (IRA)

A strong regulatory framework to guide the SHIF will be developed. Currently the IRA is mandated to regulate the insurance sector in Kenya, including health. However, the IRA Act is not explicit on how the health insurance should be regulated and the IRA has limited capacity to regulate the health sector. Rather the IRA regulatory function for health insurance largely focuses on financial accountability; there are no mechanisms to promote transparency and accountability for the NHIF and private health insurance. The IRA Act will be reviewed to make health insurance regulation explicitly and capacity developed within IRA to regulate the health insurance market. Both the SHIF and private health insurance will be regulated by the IRA.

10.1.1.3 Leadership for UHC

High level commitment and leadership for UHC within the MOH is a critical driver of the KHFS implementation. Three coordination structures will be put in place to spearhead the implementation of this strategy:

a. *Internal UHC coordinating committee responsible for driving the UHC agenda*

A UHC coordinating committee will established with clear Terms of Reference to drive the UHC agenda. It will be chaired by the CS, Health, with the Principal Secretary as the vice chair. Membership will comprise of the Director of Medical Service (DMS), all heads of departments and one technical officer from each department. By involving the top leadership at the MOH, it is envisaged that UHC will feature predominantly within and across all MOH departments and that the stewardship role of the MOH will be strengthened. The UHC coordinating committee will liase with other arms of national and county government, the private sectors, development partners and other stakeholders on all matters related to UHC.

b. *Strengthen capacity of the Division responsible for coordinating health financing reforms*

Delivering UHC is the responsibility of all five MOH departments. However, to ensure that all key aspects from the different departments are aligned to UHC and to follow up on any implementation plans, the capacity of the Division of Health Care Financing will be strengthened. The DHCF will be responsible for: (a) liaising with all departments on a day-to-day basis to ensure that implementation is on track. This may include for example following up with Monitoring and Evaluation Unit that all data are up-to-date, plan for annual progress and process evaluations and work closely with academic organization(s) and partners to ensure that these evaluations are conducted on time and to the highest standards; (b) resource mobilization-both domestic and from donors (c) advocacy, lobbying and communication. The DHCF also have an analytical role and will be responsible for identifying gaps in evidence and drawing on data from M&E to generate evidence on health financing and presenting this to the UHC coordinating committee for discussion and dissemination to the national and county governments. To conduct these roles effectively, the DHCF will require expertise in policy and planning, health financing and economics, monitoring and evaluation, among others. At the initial stages, the DHCF may require technical assistance from DPs on key areas with limited expertise like health economics, data analysis and epidemiologist, but there must be clear commitment from the MOH to continuously invest in these technical areas in the medium term.

10.1.1.4 Strengthen transparency and accountability for all health financing functions and levels service provision delivery

There will be several structures to promote transparency and accountability at all levels of the system:

- **The SHIF**: The SHIF will be governed by a Board of Directors (BODs). The composition of this Board will clearly be spelt out in law and will be aligned to the relevant aspects of the Kenya constitution. The SHIF will

operate an independent 24 hour hotline where all grievances will be registered and analysed independently.

- **Semi-autonomous SHIF administrators:** The SHIF will have semi-autonomous administrators in counties, managed by committees representative of stakeholders, including providers and consumers of health services. Membership to the SHIF committees will be defined by law.
- **PCNs:** All PCNs will have an oversight committee with representation from county governments, SHIF, service providers and users.
- **Service Providers:** All public health facilities will be governed by health committees (for primary care facilities), and boards (for hospitals), are components of governance and management structures. The composition of these committees and boards will be clearly defined. The teaching and referral hospitals will continue to be governed by boards.

  Communities will play an active role in the selection of committee members to ensure that they represent the diverse views of the populations they serve. Legislation will be developed to ensure that public health facilities have sufficient mandates to operate effectively. In addition to committees, there will be clear mechanisms for clients to hold service providers accountable. PCNs will be required to operate a 24 hour hotline, where the public can call free of charge to raise grievances experienced during their interactions with service providers. All calls will be recorded for the purposes of security and quality and a detailed analytical report forwarded to the SHIF on a quarterly basis. Independent analysis of the hotline calls will be conducted once every six months to ensure that actions are taken where needed.
- **Consumer engagement and stakeholder consultations:** Consumer satisfaction surveys will be conducted annually by an independent firm at the initial stages of implementation to solicit the views of the population on their interaction with service providers and the health financing system. The frequency of these surveys will reduce as the implementation progresses. A forum to discuss these findings at the county level will be held each year, where service users, providers and purchasers are invited listen, deliberate and make recommendations on areas for improvements. These county annual forums will also serve as an avenue for PCN

committees, hospitals and SHIF staff and BOD to interact with the people they represent and respond to their questions and concerns and where providers can also discuss issues of concerns with their clients.

10.1.1.5 Develop a strong pubic financial management system and strengthen financial management capacity at all levels.

The entire health financing system will require strong financial management systems for transparency and accountability. Specifically, the SHIF will require strong financial management systems to manage contracting and payment to providers. The financial management systems should will be integrated from the provider level up to the SHIF and linked to non-financial data including service utilization for both outpatient and inpatient services.

11 Implementation of the HFS

11.1.1 Developing a costed implementation plan

An implementation plan describing in detail the processes and mechanisms needed to achieve the vision, goals and objectives outlined in the KHFS will be developed. The costed implementation plan will sequence planned reforms depending on priority, feasibility and resource availability. It will be necessary to implement some aspects from the very beginning (for example establishing organizations and institutional arrangements), and these will require a large upfront investments. Other aspects like the EPH and PPMs will be regularly reviewed to reflect the implementation lessons and resource availability.

11.1.2 Develop and implement a clear communication plan

Public awareness and understanding of the KHFS is important for the successful implementation of proposed reforms. The public is the main beneficiary of the reforms and it is important that changes are understood and supported by all

key stakeholders. Timely and accurate communication of key messages tailored to specific individuals and group is prerequisite for any change process. A health financing communication plan will be developed to guide the communication to all stakeholders, create a public debate of UHC and ensure continuous flow of information on the KHFS implementation. The communication plan and its implementation will also be subject to continuous monitoring and evaluation and will be an ongoing process and the plan will be updated as necessary to respond to emerging information gaps.

12 Implementation framework for the KHFS

12.1.1 Institutional arrangements for implementation

The implementation plan will outline in details key activities to be conducted each year. Annual operational action plans will be developed to coordinate activities of all actors and to realize the objectives of the KHFS**.** The implementation of the KHFS will adopt a multi-sectoral approach, involving different stakeholders. The role of different stakeholder is described below and summarized in Table 7.

- **National Treasury**: The NT will be responsible for allocation sufficient public resources to health (for national level services under the MOH) and health insurance subsidies for the poor, other vulnerable groups and informal sector workers.
- **Kenya Revenue Authority (KRA):** will collect health insurance premiums from both formal and informal sector, and transfer these revenues to the SHIF.
- **Ministry of Health:** The MoH will remain responsible for policy direction, and will play the oversight role in the implementation of the KHFS. The Department of Policy, Planning and Health care financing will take lead on aspects related to financing reforms (including monitoring and evaluation), while the Department of Quality and Standards will work closely with national accreditation body, regulatory bodies and providers

to ensure that services delivered are meet set standards. To ensure effective coordination of reforms, a UHC technical coordination unit will be established (4.5.1.2).

- **Ministry of Labour, Social Security and Services:** Jointly with counties, the MoLSSS will oversee the identification of indigents, elderly and vulnerable population. The MoLSSS will update the database, which will be shared with the SHIF, county and national government to ensure that everyone in that database has a health insurance cover.

- **Social Security and Pension Funds:** The NSSF and all private pension funds will provide SHIF will a data base of the pensioners they server. They will be required to remit health insurance premium for their members to the SHIF.
- **County Governments:** Counties will be direct purchasers of population based preventive and promotive health services offered outside PCNs. In addition, they will ensure optimum operations of county health facilities by providing inputs critical for quality service delivery, including infrastructure, equipments and human resources for health through budgetary provisions.
- **SHIF:** The SHIF will be the risk pooling agency and main purchaser of EPH. The SHIF will be responsible for registering beneficiaries and sensitizing them on their entitlements. It will also contract PCNs and hospitals to provide services to the registered members there SHIF administrators.

- **Semi-autonomous SHIF administrators:** The SHIF administrators will be the operational arm of the SHIF. These administrators will have operational autonomy and will be the point of contact with the service providers and users. They will be responsible for claim management in their respective regions and will work closely with county governments and service providers to enforce contracts with PCNs and hospitals.

- **The National Accreditation Agency:** The NAA will accredit PCNs and hospitals to provide health services, including the EPH to be purchased by SHIF.

- **Primary Care Networks:** The PCNs will be the first point of contact for services provision. The PCNs will ensure that services provided to the population are available and are of high quality, as stipulated in the contract entered between them and SHIF.

- **Hospitals:** Hospitals will provide secondary care to patients referred through PCNs. They will enforce the gate keeping function and ensure that only those patients with referral documents are attended to, except for emergency cases, which will be clearly defined. Any individual who by passes the referral system will be required to pay the full cost of care out-of-pocket, regardless of their SHIF membership status.

- **Donors:** Donors will support the strengthening of the health system by providing financial resources to fill the resource gap.

- **Communities:** Communities will participate in the management of health facilities through health committees at health centre level and hospital boards.

Table 7: Summary of stakeholders' roles and responsibilities

Stakeholder	Roles and responsibilities
National Treasury	Allocation resources to the health system strengthening investment fund Allocation resources to provide full health insurance subsidies for the poor Collecting and pooling health insurance premiums from the formal sector and informal sector, through the Kenya Revenue Authority
Ministry of Health	Overall policy design Support counties in implementation Quality and regulation Overall UCH stewardship Resource mobilisation Monitoring and Evaluation Invest in infrastructure at the National level and support county governments when needed

County Government	Equitable allocation of sufficient funds to provide the EPH Develop and implement county health system strengthening plans Invest in health system strengthening and ensure facilities have the required resources (infrastructure, human resources, supplies and commodities) to provide EPH Reorganise the facilities into PCNs Community sensitization Together with MLoSSS, identify indigents for health insurance subsidies
Health benefits Expert Committee	Reviewing the EPH every five years
Service providers (PCNs and hospitals)	Provide quality services to all registered members
National Quality Standards and Accrediting body	Accrediting health service providers including PCNs and hospitals
Insurance Regulatory Authority	Regulate NHI and private health insurance
SHIF	Register members Contract PCNs and hospitals Purchase services for members
Private Health Insurance	Provide complementary health insurance cover to those who can afford to pay
Public and private service providers	Provide quality health services as defined in the EPH
Donors	Align donor funds to the KHFS Technical Assistance to the UHC coordinating unit Health system strengthening though contributions to the national fund

12.1.2 Phasing in of the KHFS implementation

The KHFS outlines a 14 year path to enabling Kenyans realize their constitutional right to health. Implementation will be done in a sequential manner, to allow for adequate preparation, including developing the legal and regulatory framework, strengthening service deliver and resource mobilization. The phasing of the reforms is summarized under each strategic area, but generally there reforms will be sequenced in three phases:

- Phase I (2016-2017)- the preparatory phase will focus on developing the legal and regulatory framework, mobilizing resources for health system strengthening, developing the PCN service delivery model and building capacity for implementation.

- Phase II (2018-2022) will mark the start of implementation. During this period, the strengthening of the system will continue. Other activities during this phase will include registration and issuance of health cards to beneficiaries, contracting of facilities among others

- In phase III (2023-2030), implementation will continue and will be strengthened based lessons learnt in Phase II.

13 Monitoring and evaluation

Monitoring and Evaluation (M&E) will be integral in the KHFS implementation. A strong M&E framework will enable continuous learning and refinement of reforms. Priorities for M& E will focus on two key areas: (i) strengthening the information system and capacity for health data use and (ii) strengthening capacity for health financing analysis.

13.1.1 Strengthen the information system and capacity for data use

Successful implementation of the KHFS will largely depend on availability of good quality data. Accurate data are needed across the entire health system. Currently, Kenya uses the DHIS2 as the health management information system (HMIS), but reporting levels are low and quality of data is questionable. The country also has very rich data on health financing, with several National Health Accounts and Health Expenditure and Utilization surveys, public expenditure reviews and public expenditure tracking surveys. These data have been extremely useful for informing policy and practice, however few of this information is accurately captured through the HMIS and the capacity to interpret and use these data at the national and county level is limited.

As the country moves towards a SHIF model, it is important that there is an integrated information system, which links the SHIF data to DHIS2, social

protection and CRVS data bases. Such a system will provide essential data for determining the population health needs and linking health insurance contribution to service utilization. An integrated health information system will be developed in the first two years of the KHFS. The development of the integrated health information system will go hand in hand with capacity building for data generation and use at the county and national level.

In addition to routine monitoring, operation research studies and evaluations will be conducted to inform implementation.

13.1.2 Strengthen capacity for health financing analysis.

There is very limited capacity for health financing analysis and evidence based planning at the national and county level. While there are adequate economists and public health experts in Kenya, their health economics and health financing analysis capacity is limited. Investment in capacity to develop both junior and senior staff within the MOH and county level will be prioritised and collaborations developed with local universities and research institutions to mentor and support MOH and county staff working in these areas.

13.1.3 Results Framework

Indicator	2016	2017	2022	2027	2030
Objective 1: To define an essential package of health services for which all Kenyans are entitled to at any one time, on the basis of burden of disease, equity, affordability and cost-effectiveness					
Define the EPH and framework for revising it	0	Initial EPH clearly defined	-	EPH revised once every two years	-
Percent of population with access to full EPH	NA	NA	50%	80%	100%
Objective 2: To mobilize adequate domestic resources to deliver the EPH					
Government spending on health as % of total government spending	6.8%	8%	11%	13%	15%
Government spending on health as % of total health spending	33%	-	-	-	50%
Government spending on health as percentage of GDP	2%	2.5%	3%	4%	5%
Public per capita health spending	20.8				153.3

% of population enrolled in health insurance of any kind	17%	50%	70%	80%	100%
% of donor support on-budget or pooled in a fund	15%	20%	30%	40%	50%
Objective 3: To improve financial risk protection, with a focus on the poor and vulnerable					
% of the indigent population identified and issued with SHIF	1%	5%	60%	80%	100%
Out-of-pocket payment (% of THE)	32%	30%	25%	20%	15%
% of population incurring catastrophic expenditure	6.21	5%	3%	2%	0
% of population impoverished due to health care	1.48 million				0
Objective 4: To promote efficient allocation and use of resources for health care services.					
% of all health problems address addressed at primary care level					
% of all gov't spending through results based financing					
% of gov't spending that goes to tertiary-level care	50% (??)				25% (??)
% of gov't spending on services that are not part of EPH					
Objective 6: To ensure effective governance and regulatory framework for a sustainable health financing system					
A functional UHC coordinating committee					

14 Conclusions

The development of the KHFS is marks an important step towards the realization of the constitutional right to health for all Kenyans

15 Annex

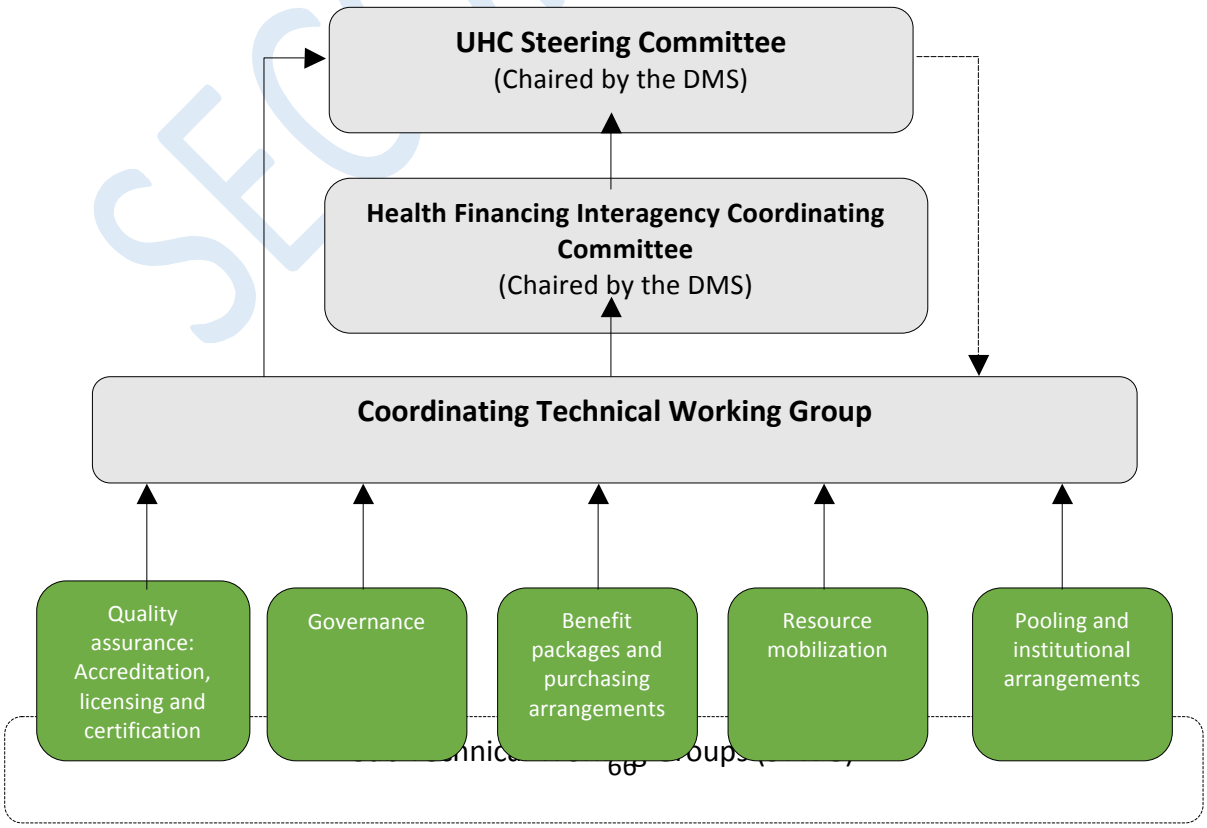
Annex I: Process of developing the KHFS

Kenya embarked on a process to develop a health financing strategy in 2006, when the MoH established a taskforce comprising representatives of key stakeholders to develop the KHFS. A draft strategy was completed in 2009 but this was not finalized due to various challenges including lack of effective linkage processes in different social security sectors; limited involvement and coordination of GoK stakeholders; lack of explicit and systematic stakeholder analysis, leading to exclusion of key stakeholders; poor communication; and limited public debate. Preparation on the finalization of the strategy was again initiated in 2012, when the MoH commissioned a review of the draft financing

strategy by the Providing for Health (P4H). Following the recommendations of the P4H review, the MoH put in place coordination mechanisms to engage all key stakeholders. The health financing interagency coordinating committee was revived and a UHC steering committee established.

In May 2015, the MOH embarked on the process to finalize the health financing strategy. The process was led by the MoH and involved all key stakeholders to ensure ownership and buy in. The UHC steering committee provided leadership and guidance on the overall process. Five sub-technical working groups on key thematic areas namely: resource mobilization; pooling and institutional arrangements; quality assurance and; governance were formed to deliberate on current arrangements and make proposals for reforms. The UHC steering committee was supported by a coordinating Technical Working Group (cTWG), whose main role was to coordinate the entire process and provide a platform for the sub-TWGs to discuss emerging issues. A health financing interagency coordinating committee comprising of over 100 members met on a monthly basis to deliberate on proposed reforms and potential implications.

Figure 1: The KHFS development process



Annex II: List of health interventions for the EPH (costed in WHO normative approach)

Interventions	Model	Service delivery Model
Communication and behavior change		
Condom promotion and distribution		
Control of tobacco use		
Counselling for improved complementary feeding		
Counselling for promotion of exclusive and continued breast feeding		
Family planning interventions: oral contraceptives, injectable, condom-male and female, intrauterine devices (IUDs), implants, sterilization (male and female)		
Harm reduction among intravenous drug users	HIV	
HIV prevention: mass media	HIV	
HIV prevention among female sex workers	HIV	
HIV prevention among male sex workers	HIV	
Male circumcision	HIV	

Post-exposure prophylaxis	HIV	
Voluntary counselling and testing	HIV	
Social marketing	HIV	
STI management	HIV	
Immunizations (all routine immunizations including BCG, DPT, OPV, Hid, pneumococcus, 2-dose measles, hepatitis B, yellow fever, rubella, rotavirus, etc)	Immunizations	
Long-lasting insecticides mosquito nets and other malaria vector control intervention	Malaria, children under 5, maternal health (people living in endemic areas)	
Intermittent preventive malaria therapy	Malaria, Maternal health	
Newborn care, routine (immediate postnatal care ,breastfeeding support, resuscitation, small baby care and kangaroo mother care, care for minor problems, presumptive sepsis care, eye prophylaxis, presumptive treatment for syphilis, pre-referral care for seriously ill neonate)	Neonatal health	
Postnatal care	Neonatal health	
Postpartum administration of anti-D immunoglobulin to rhesus negative women with a rhesus positive foetus	Maternal health	
Postpartum care in the maternity ward, routine (examination of the mother, information and counselling, recording and reporting, administration of iron and folate supplements, administration of vitamin A supplements)	Maternal health	
Postpartum care, follow-up visit (postpartum examination of the mother, information and counselling on home care, care seeking, counselling on family planning methods)	Maternal health	
Postpartum counselling on family planning (counselling on family planning methods, voluntary tubal ligation (female sterilization), intrauterine device, combined oral contraceptives, combined injectables)	Maternal health	
Prevention and control of malaria epidemics	Malaria	
Prevention of mother-to-child transmission of HIV by antiretroviral prophylaxis and infant feeding counselling	Children U5, maternal health, HIV	

Salt reduction in processed foods	Chronic diseases	
Screening all pregnant women for blood group isoimmunization	Maternal health	
Vitamin A supplementation to children under five, routine	Children U5	
Antibiotic treatment for dysentery	Children U5	
Antiretroviral therapy	HIV	
Antiretroviral therapy and co-trimoxazole therapy for HIV+ TB patients	TB/HIV	
Basica care package for HIV+ people		
Case management for diarrhea	Children U5	
Case management for malaria	Children U5	
Case management for pneumonia	Children U5	
Case management for severe malnutrition	Children U5	
Case management of neonatal infection	Children U5	
Co-trimoxazole preventive therapy for HIV+ TB patients	TB/HIV	
Diagnostic testing (HIV)	HIV	
HIV care and support in TB patients	TB/HIV	
HIV surveillance in TB patients tested	TB/HIV	
HIV testing and counselling of TB patients	TB/HIV	
Home-based care for people living with HIV/AIDS	HIV	
Isoniazid preventive therapy, following tuberculin skin test	TB/HIV	
Isoniazid preventive therapy, no tuberculin skin test	TB/HIV	
Management of breathing difficulty	Neonatal health	
Management of congenital syphilis	Neonatal health	
Management of convulsions	Neonatal health	
Management of mastitis	Maternal health	
Management of neonatal tetanus	Neonatal health	
Management of postpartum depression	Maternal health	
Management of severe hypothermia	Neonatal health	
Management of severe jaundice	Neonatal health	
Multidrug-resistant tuberculosis treatment	TB	
Nutritional support	HIV	
Palliative care for people living with HIV/AIDS	HIV	
Prophylaxis for opportunistic infections	HIV	
Regular deworming	Children U5	
Routine offer of counselling and testing	HIV	

Safe abortions/management of abortion complications (where legal)	Neonatal health	
Sepsis management	Neonatal health	
Severe and complicated malaria, case management	Malaria	
Special general care for seriously ill neonate	Neonatal health	
Supporting breastfeeding (maternal stay for baby care)	Neonatal health	
TB smear positive/ negative/ extrapulmonary treatment	TB	
TB screening among people living with HIV/AIDS	TB/HIV	
Treatment of bacterial vaginosis or trichomoniasis infection in pregnancy	Maternal health	
Treatment of chlamydia in pregnancy	Maternal health	
Treatment of chronic diseases including asthma, cardiovascular disease, mental illness and neglected tropical diseases and symptomatic treatment	Chronic disease	
Treatment of complications during childbirth (ultrasound, promote foetal maturation before preterm delivery, management of pre-labor rupture of membranes or infection, management of antepartum hemorrhage, management of puerperal sepsis, management of obstructed labor, management of prolonged labor, management of foetal distress, episiotomy, avoid breech presentation at birth (with external cephalic version), vaginal breech delivery, craniotomy or embryotomy, management of postpartum hemorrhage, management of perineal infection, repair of vaginal or perineal tear, repair of cervical tear, symphysiotomy)	Maternal health	
Treatment of eclampsia	Maternal health	
Treatment of gonorrhoea in pregnancy	Maternal health	
Treatment of hookworm infection (antenatal care)	Maternal health	
Treatment of lower urinary tract infection		
Treatment of measles and measles complications		
Treatment of moderate anaemia in pregnancy		
Treatment of opportunistic infections		
Treatment of severe anaemia		
Treatment of severe hypertension in pregnancy		
Treatment of severe pre-eclampsia		
Treatment of syphilis in pregnancy		

Treatment of upper urinary tract infection		
Treatment of upper urinary tract infection in pregnancy		
Treatment of vaginal candida infection in pregnancy		
Very small baby care and kangaroo mother care		
Antenatal care, routine (assessment of maternal and foetal well-being, information and counselling, recording and reporting, screening for hypertensive disorders of pregnancy (pre-eclampsia), screening for anaemia, prevention of anaemia, specialist care for pregnant women with diabetes, syphilis testing, tetanus toxoid immunization)		
Childbirth care, routine (initial assessment and recognition of delivery complications, surveillance and regular monitoring of labour and delivery, social support throughout labour and delivery, prevention and control of infections, assistance during childbirth, active management of the third stage of labour, care and support for the mother)		

Source: Adopted from the taskforce on innovative international financing for health systems