

PURCHASING ARRANGEMENTS AT COUNTY LEVEL IN KENYA

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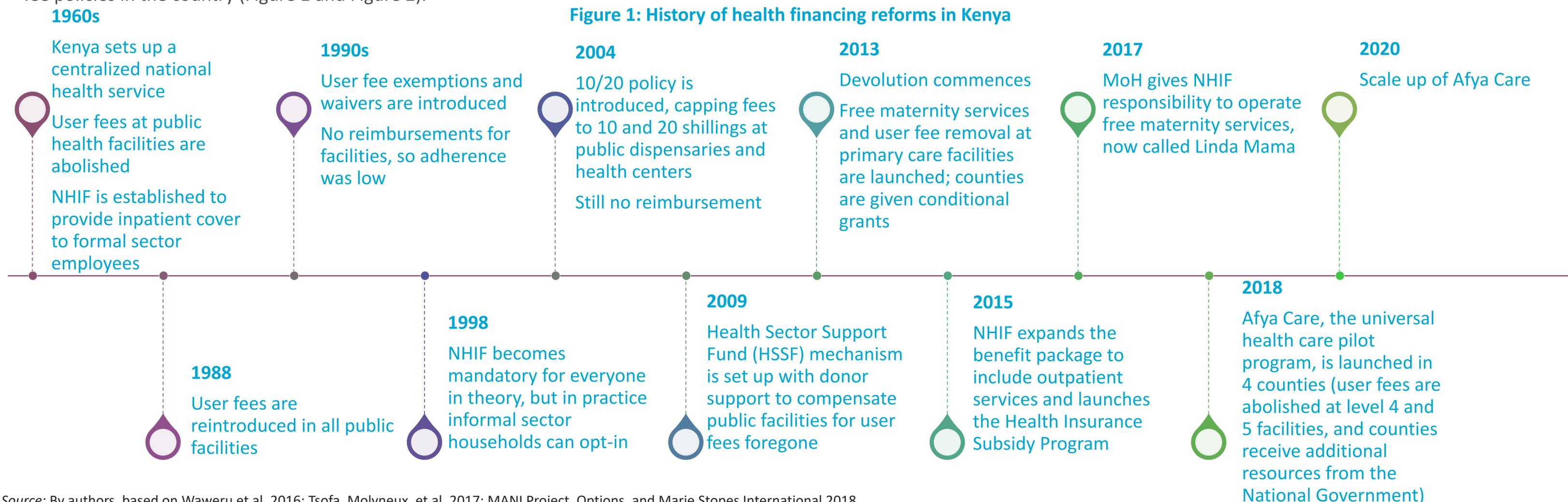
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Introduction

- Kenya embarked on a process of devolution in 2013, transferring planning, budgeting, and management responsibilities for a range of services including health to 47 newly-created counties.
- As a result, there are 49 public purchasers in Kenya today: the Ministry of Health (MoH), 47 county departments of health (CDOH), and the National Hospital Insurance Fund (NHIF). Understanding their respective roles requires an appreciation of Kenya's devolved system of the government, the history of social insurance, and the evolution of user fee policies in the country (Figure 1 and Figure 2).



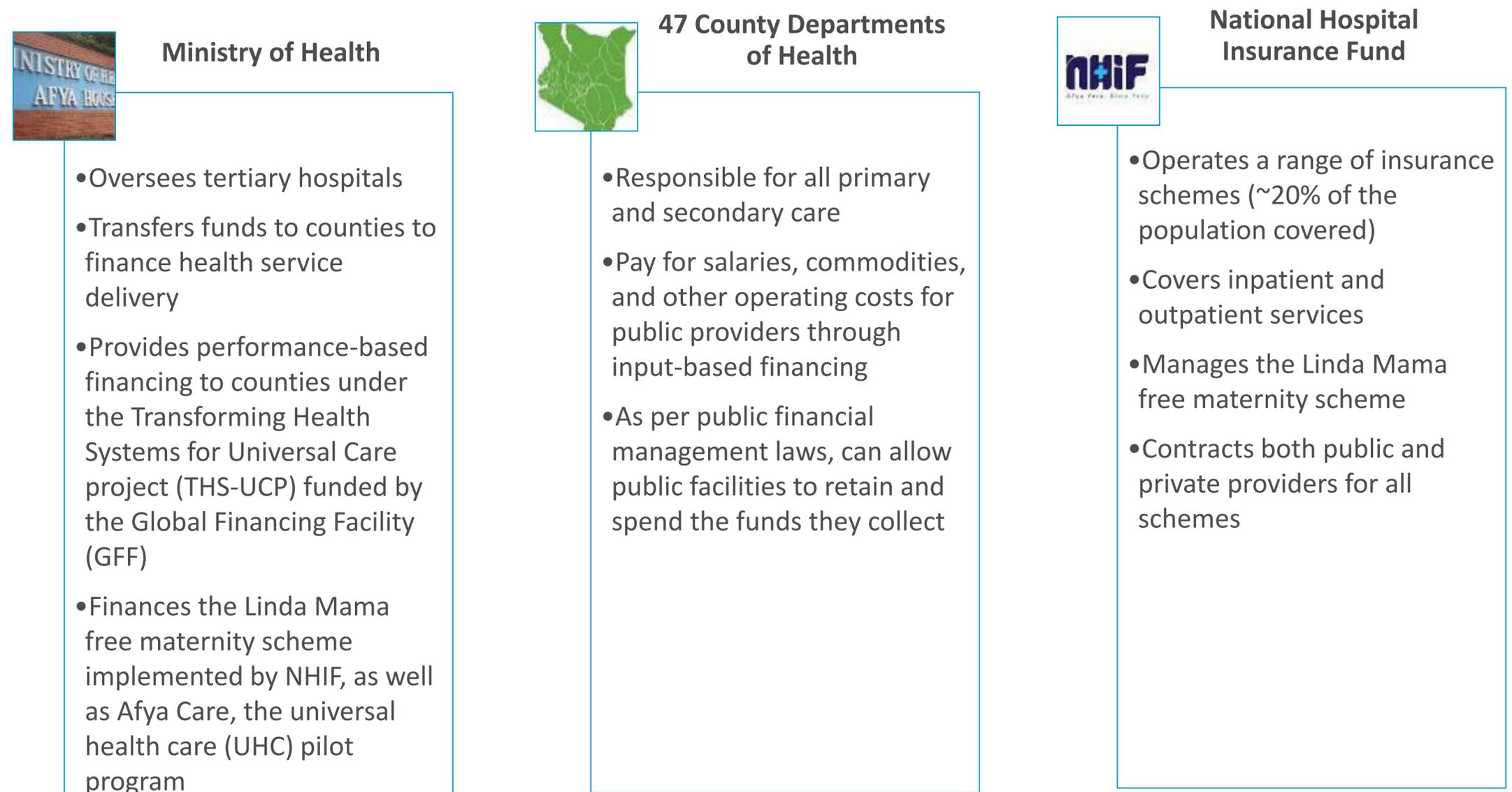
Figure 1: History of health financing reforms in Kenya



Methods

- The team conducted a detailed review of publications on county health financing from both the academic and grey literature. In addition the websites of institutions/projects were screened.
- Between November 2018 and March 2019, the team also undertook 65 key informant interviews with health workers and key representatives of the Isiolo, Kilifi, and Makueni CDOH (14, 26, and 25 key informant interviews, respectively).
- Furthermore, the team consulted 9 and 41 key representatives of the County and Sub-county Health Management Teams in Isiolo and Kilifi, respectively. Information was gathered from 25 health facilities (7 in Isiolo, 10 in Kilifi, and 8 in Makueni).

Figure 2: Purchasing landscape in Kenya: fragmented roles



Results

- Counties derive revenue from four main sources (Figure 3):
 - Counties' share of national revenue** in the form of a block grant from the National Government, which is referred to as the equitable share and counties can allocate these funds at their discretion
 - Local revenue** that includes funds that public health facilities generate from user fees and health insurance reimbursements
 - Conditional grants from the National Government** that are earmarked for certain purposes
 - Conditional grants from donors**, for example under the GFF-funded THS-UCP program.
- According to the 2012 Public Finance Management Act, each county established a County Revenue Fund into which all money raised or received by or on behalf of the county government is collected.
- Donor-funded conditional grants are typically channeled to a special purpose account at the county level.
- County government use these funds to finance service delivery through a network of public providers as well as other population health services.

- CDOH directly pay for costs associated with health care delivery at levels 1 to 5, including staff salaries, commodities, facility maintenance, and activities under vertical programs (this includes health promotion and prevention activities that are implemented outside of facilities).
- All counties receive two conditional grants (one from domestic finances and the other funded by a donor) that are specifically earmarked for covering facility costs at level 2 and 3 primary care facilities. Counties transfer these funds as a financial payment (as opposed to in-kind transfers) to the facilities.
- Counties that have level 5 hospitals receive a conditional grant to defray their operating costs. These funds are transferred to the hospitals, but there remain concerns about facility autonomy, capacity, and accountability.
- Beyond these conditional grants, counties have the discretion to authorize public facilities to retain and spend any funds they generate from user fees and health insurance reimbursements. While some counties have granted financial autonomy to health facilities (e.g. Makueni), most counties have not.
- This is especially challenging for level 4 and 5 hospitals that have less financial autonomy than they had before devolution.

Levels of health care provision

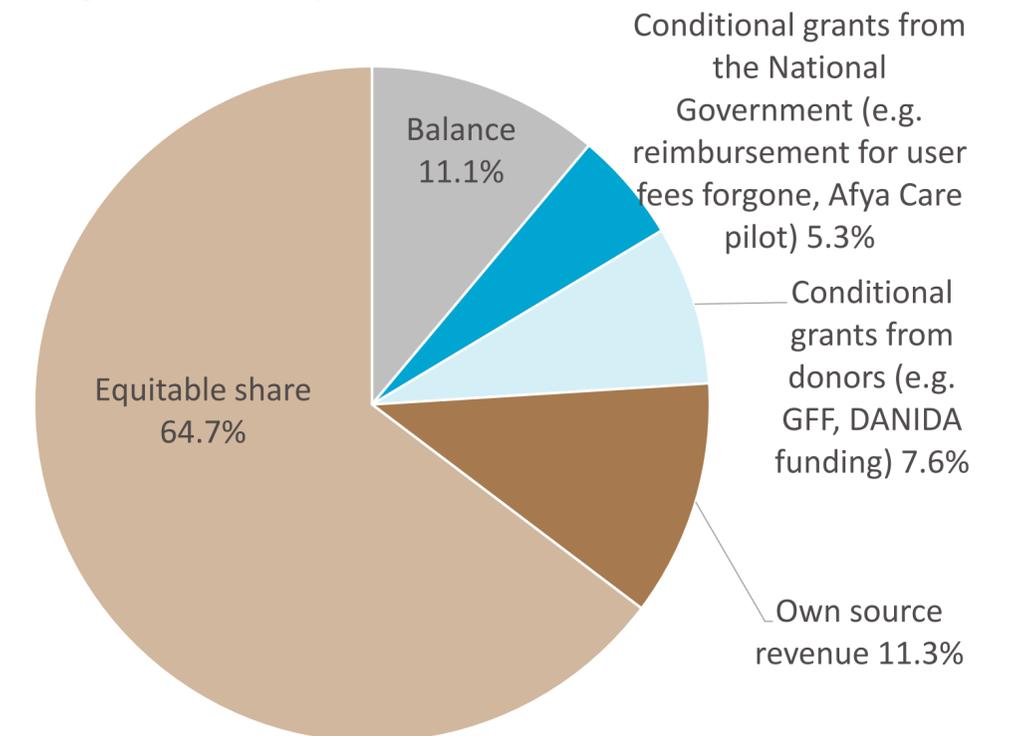
- Level 1: Community health units
- Level 2: Dispensaries
- Level 3: Health centers
- Level 4: Primary hospitals (previously district hospitals)
- Level 5: County referral hospitals (previously provincial hospitals)
- Level 6: National referral hospitals

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

Number of public and private health facilities by level, 2019	
Level 2	10,671
Level 3	2,313
Level 4	782
Level 5	18
Level 6	6
Total	13,790

Source: Kenya National Bureau of Statistics 2020

Figure 3: County revenue, FY 2018/19

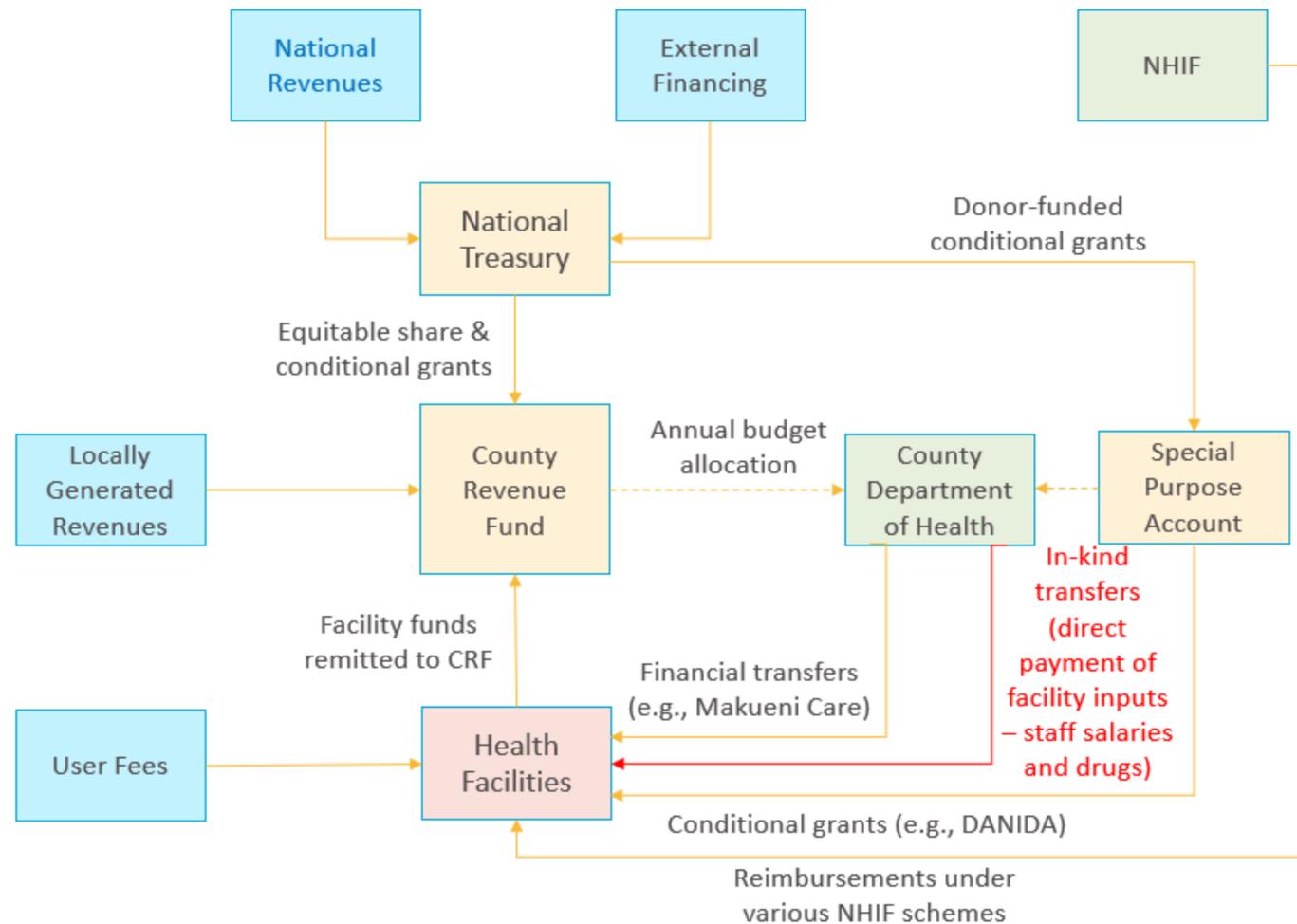


Source: Controller of Budgets FY 2018/19

Results

- Figure 4 shows funding flows in the post-devolution period. A solid yellow line denotes a financial transfer, while a solid red line shows in-kind transfers to health facilities. A dotted yellow line is used to depict control over budget allocation decisions.
- There are considerable variations across counties in what funds facilities collect, retain, and spend, and between primary care facilities (levels 2 and 3) and hospitals (levels 4 and 5), as shown in Figure 5.
- There is currently no standard source of information about how much revenue public facilities generates, how much they can retain, how much they transfer to the County Revenue Fund, and how much is spent by the county on their behalf.

Figure 4: Flow of funds at the county level



Primary care facilities in Isiolo, Kilifi, and Makueni receive conditional grants from the National Government and donors and reimbursements from NHIF.

Primary care facilities in Isiolo, Kilifi, and Makueni can retain and spend the funds they collect (i.e. payments from NHIF).

Hospitals in Isiolo and Kilifi cannot retain the funds they collect (i.e. payments from NHIF and user fees) but they have the authority to do so in Makueni.

Hospitals in Isiolo transfer all funds they collect from the facility's bank account to the County Revenue Fund.

While Kilifi has passed legislation to allow all health facilities including hospitals to retain and spend funds, the law has not been implemented, and hospitals continue to remit their revenue to the County Revenue Fund.

In Makueni, an executive order allows all hospitals to retain and spend their revenue from user fees and NHIF payments.

Figure 5: Variation in flow of funds to health facilities across 3 focus counties

Key Findings

- CDOH are the main purchasers of primary and secondary care services and do so using a range of purchasing arrangements.
- CDOH can grant public facilities the authority to retain and spend own source revenue; in practice few have, which limits the potential for strategic purchasing.
- The nature of flow of funds to providers is complex and varies across counties as well as types of public providers.

Conclusion



- Some purchasing arrangements offer immediate opportunities for strengthening strategic purchasing of primary health care, while others may prove harder to reform in the near term.
- Several counties are now exploring ways to give health facilities greater autonomy, a key opportunity to make purchasing more effective.
- There is a need for timely and detailed information on the flow of funds to health facilities from different sources which is essential for making purchasing more strategic.

Read the full report [here](#).



Photo credit: Shano Guyo

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