How Decentralization Has Shaped Health Financing Arrangements and PFM Practices in the Health Sector in Kenya

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For more information, please visit our website at https://thinkwell.global/projects/sp4phc/.

For questions, please write to us at sp4phc@thinkwell.global.
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ABBREVIATIONS

CHE  current health expenditure
CDOH  County Department of Health
COB  Controller of Budget
CRA  Commission on Revenue Allocation
CRF  County Revenue Fund
DANIDA  Danish International Development Assistance
FMS  Free Maternity Scheme
FY  fiscal year
GFF  Global Financing Facility
GOK  Government of Kenya
HMSF  Hospital Management Support Fund
HSSF  Health Sector Support Fund
IFMIS  Integrated Financial Management Information System
KEMSA  Kenya Medical Supplies Authority
KEPH  The Kenya Essential Package for Health
KSH  Kenyan shilling
MOH  Ministry of Health
NHIF  National Hospital Insurance Fund
OOPs  out-of-pocket spending
PETS  Public Expenditure Tracking Survey
PFM  public financial management
SP4PHC  Strategic Purchasing for Primary Health Care
THS-UCP  Transforming Health Systems for Universal Care project
UHC  universal health coverage
WHO  World Health Organization
INTRODUCTION

Over the past five decades, sub-national government units in most countries around the world have assumed some extent of decision-making authority (Cheema and Rondinelli 2007). This often occurs through devolution, a reform that typically involves the transfer of different government functions related to sectors, such as health, from the central government to sub-national units. Devolution often entails changes to public financial management (PFM) rules, systems, and processes. In parallel, countries have also initiated health financing reforms, such as expanding publicly managed health insurance, eliminating user fees, and introducing performance-based payments to move closer to the goal of achieving universal health coverage (UHC). While national governments exercise a high degree of control over the design of health financing reforms, their implementation in devolved contexts is heavily influenced by local politics, policies, and processes. Sub-national government units are often the main purchasers of primary health care services, exercising considerable control over the funds flowing to public facilities, including from user fees or insurance reimbursements.

Public funds lie at the heart of sustainable health financing policy for achieving UHC (Kutzin, Yip, and Cashin 2016). Globally, public financing accounted for approximately 60% of health spending in 2017 and increased faster than any other source of health expenditure over the preceding decade (World Health Organization 2019). Given public funding’s growing role, governments and development partners increasingly recognize the importance of PFM to effective, efficient, and equitable health spending (Cashin et al. 2017; Barroy et al. 2019). Therefore, devolution and related PFM reforms can affect how public funds are allocated, used, and reported in the health sector.

The World Health Organization (WHO) and ThinkWell jointly developed a series of case studies to explore the implications of devolution for health financing, with a deep dive into PFM issues. The cases shed light on how health financing functions are organized within and impacted by each country’s devolved system of government. They also explore how devolution has shaped PFM processes in the health sector, including budget development, approval, execution, and accountability.

This case study focuses on Kenya, which transitioned to a devolved system of government in 2013. The national government transferred a range of government functions to 47 newly created county governments, and health was one of the main sectors to be devolved. County governments own and operate all primary and secondary care health facilities in the public sector, while the national government overseas public facilities provide tertiary and specialized care. The national government leads the development of health policies and plans, but county governments drive much of their implementation. This case study explores how decentralization has affected health financing arrangements, with a focus on PFM processes in the health sector in Kenya.

METHODOLOGY

WHO and ThinkWell developed a set of questions to guide data collection in the selected countries to answer the following overarching questions:

- How are the three health financing functions— revenue raising, pooling, and purchasing—and related governance functions organized and affected by a devolved system of government in a country?

1 The literature offers several typologies to distinguish between different forms of decentralization (devolution vs. de-concentration, administrative, fiscal vs. political decentralization), which are discussed in a separate methodology document.
What challenges related to devolved health financing exist and how do these affect progress toward UHC?

How do PFM processes unfold across government levels, and what is the role of sub-national governments in allocating, spending, and reporting public funds for health?

What is the role of health facilities in PFM processes?

Information for Kenya was mainly collected through a desk review of the existing literature and analysis of budget documents. The desk review entailed a purposeful review of the peer-reviewed literature, government budget documents, and other online publications from national and county governments, international organizations, implementing partners, and civil society organizations. Kenya is a focus country for the Strategic Purchasing for Primary Health Care (SP4PHC) project, which ThinkWell is implementing with support from the Bill & Melinda Gates Foundation. The project is working to improve county-level purchasing policies and practices, including providing targeted support to the three county governments of Isiolo, Kilifi, and Makueni and sharing information and best practices across a range of counties. This case study draws heavily from a previous study conducted by the project team in 2019 to understand the county health purchasing landscape based on key informant interviews with county officials and health facility managers in the three SP4PHC focus counties.

There is considerable variation in policies and practices across Kenya’s 47 counties which are not comprehensively captured here. Instead, available evidence from the literature and examples from SP4PHC focus counties are used to describe the overall landscape, calling out common themes and significant points of divergence across the country.

**COUNTRY CONTEXT**

Local authorities played an important role in delivering services in Kenya during the colonial period, but many of these functions were centralized within a unitary state after independence. Kenya transitioned from British colonial rule to being an independent country in 1963. Local authorities, including city, municipal, town, and county councils provided a wide range of services during the colonial period (Patrick, Els, and Wanyama 2003; Smoke 1993; World Bank n.d.). Kenya’s founding constitution provided for a decentralized structure that granted these local authorities considerable autonomy. However, a series of constitutional amendments and laws passed in the succeeding decade shifted revenue-raising and decision-making powers away from the local level to the national level (T. Barasa and Eising 2010; Smoke 1993). The Government of Kenya (GOK) concentrated control over government functions within national ministries and parastatals as a centralized planning approach (Cohen and Hook 1987).

Kenya had a parallel system of de-concentrated government administration through provinces and districts, which assumed greater significance in the 1980s. Eight administrative provinces were subdivided into districts, which were then sub-divided further into locations and sub-locations (Smoke 1993). Recognizing the limitations of a centralized, top-down developmental approach, GOK launched the District Focus for Rural Development initiative in the 1980s to “de-concentrate” government functions to the regional arms of the central government. The district emerged as the locus for planning, budgeting, and service delivery (World Bank n.d.; Oyaya and Rifkin 2003). Within the health sector, GOK transferred a range of functions to the districts in the 1980s. District health management teams were set up to undertake planning, budgeting, and monitoring activities in the late 1980s. District health management boards and health facility boards were introduced in 1992 to oversee the
management of user fees, which were introduced in public health facilities in 1989 (O’Meara et al. 2011; Tsofa et al. 2017). While the Ministry of Health (MOH) was responsible for coordinating all health functions and held the entire budget for the health sector, it drew upon district health management teams and provincial authorities for program implementation (Tsofa, Molyneux, and Goodman 2016).

Kenya’s 2010 Constitution enshrines the principle of devolution based on two levels of government—national and county. Promulgated in August 2010 after ratification by public referendum, it called for the creation of 47 new counties and recognized national and county governments as “distinct and inter-dependent” (National Council for Law Reporting 2010). The Constitution lists self-governance, the decentralization of state organs, functions, and services away from the center, and equitable sharing of national and local resources among the objectives for devolution. It also stipulates that county governments shall have reliable sources of revenue to deliver services effectively. The County Government Act of 2012 further elaborates on the principles and processes outlined in the Constitution. The counties cannot be abolished easily, and the newly established bicameral legislature with a Senate that draws representation from the counties re-enforces the devolved system of government. The Intergovernmental Relations Act of 2012 also mandated the creation of a Council of Governors, consisting of the elected governors of all 47 counties and advocates representing the counties.

Kenya transitioned to a devolved system of government in 2013. Forty-seven county governments were formed after the country held elections in 2013. As per the 2010 Constitution, each county government consists of an executive branch and a legislative branch (Figure 1). An elected governor leads the executive who appoints a deputy and the county executive committee members akin to a cabinet at the county-level. An elected county assembly constitutes the legislative arm of the county government.

Figure 1: Overview of the county government structure

Source: Adapted from Mwenda n.d.
The 2012 PFM Act provides the implementation framework for how public resources are raised, shared between levels of government, and spent. Anchored on the public finance principles stated in article 201 of the Constitution, the 2012 PFM Act seeks to promote good financial management at both levels of government and ensure efficient use of public resources. Consolidating and replacing a range of PFM statutes that predated devolution (e.g., the 2004 Government Financial Management Act and the 2009 Fiscal Management Act), it articulates the budgeting process and the roles and responsibilities of different actors. Kenya also passed a range of supportive legislation to complement the Constitution and the 2012 PFM Act, such as the Intergovernmental Relations Act of 2012, the Controller of Budget (COB) Act of 2016, the Public Audit Law of 2015, and the Public Procurement and Asset Disposal Act of 2015.

Under the devolved system of government, counties bear the bulk of the responsibility for the delivery of healthcare. Schedule 4 of the Constitution lists the functions of the national government versus the counties. Most social sectors fall within the remit of the county’s responsibility and health was one of the main sectors to be devolved (Tsofa et al. 2017). The county governments oversee delivery of community-level, primary, and secondary health care services. They do this through the county departments of health (CDOH), which manage resources for all public sector health facilities and providers (Waithaka et al. 2018; E. Barasa et al. 2017; Nyikuri et al. 2017). The national MOH is responsible for developing national health policies and plans, and overseeing tertiary care facilities and national health programs for priority health areas. The 2017 Health Act further elaborates the roles and responsibilities of different actors at the national and county levels within a unified health system.

HEALTH FINANCING LANDSCAPE IN THE CONTEXT OF DECENTRALIZATION

Kenya has a complex and evolving health financing system. Figure 2 depicts the flow of resources from government, private, and donor sources to intermediaries that pool these funds and from those intermediaries to the ultimate providers of health services. A mix of public and private facilities manage health provision in Kenya. The public sector accounts for 49% of facilities in the country. In comparison, private not-for-profit and private for-profit facilities represent 16% and 33% of facilities, respectively (Government of Kenya, Ministry of Health 2013).
Public sector provision is organized into 6 levels of care, ranging from community health care (level 1), up to primary health care (level 2 dispensaries and level 3 health centers), secondary care (levels 4 and 5 county hospitals), and tertiary care (level 6 national referral and specialty hospitals); see Box 1. Private providers are also categorized into these levels.

Box 1. Levels of health care providers

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

Below, we describe how devolution has impacted the health financing functions, focusing on PFM policies and processes. The first function is revenue raising, which refers to the generation of revenue for the health sector from different sources. The second is pooling, whereby funds are collected and managed by agencies on behalf of the population. The final function is purchasing, which refers to how agencies that pool funds pay for health services. We discuss each from the perspective of the county government in the next three sub-sections. A final sub-section examines reporting, oversight, and accountability for health financing. Findings related to PFM processes are integrated into these sections.
Revenue Raising

Sources of Health Spending

The share of health spending that is financed by government revenue has increased over the past two decades. Figure 3 disaggregates current health expenditure (CHE) by the following sources: government revenue in black (this includes mandatory health insurance), out-of-pocket spending (OOPs) in dark blue, other private health spending in light blue (this includes voluntary private health insurance spending by households as well as spending by private companies), and external financing in gray. Government health expenditure as a percentage of CHE increased from 29% in 2000 to 43% in 2017, while OOPs decreased from 47% to 24% over this period. The share of spending financed by donors first increased from 12% in 2000 to 29% in 2010 and then declined to 18% by 2017.

Figure 3: Health spending by source


Since devolution, counties control a larger percentage of government health spending than MOH. As shown in Figure 4, the county’s share of the total health budget increased from 54% in the 2013/14 fiscal year (FY) — the first year of devolution — to 63% in FY 2017/18, and then dipped back down to 57% in FY 2018/19. The government’s health budget as a share of the total government budget was lower in the four years after devolution compared to the year immediately preceding it, but there has been a marked increase since FY 2017/18.
Country Revenues

Counties derive their revenue from four main sources: a block grant from the national government, own-source revenue, conditional grants from the national government, and conditional grants from development partners. Figure 5 shows the relative shares of financing from these different sources. Each county operates a County Revenue Fund (CRF) mandated by the 2012 PFM Act, where it pools these funds. By default, all funds raised or received by county governments are meant to be held in this account, which the county treasury controls.

Figure 5: County budgets disaggregated by source of revenue, FY 2019/20

Source: Office of the Controller of Budget 2020

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We use the term block grants to refer to transfers that can be used for any purpose by the sub-national government receiving the funds. In contrast, conditional grants allow the level of government transferring the funds to stipulate how the funds can be used by the recipient.
Counties generate own-source revenue from local taxes and fees, including property taxes, business permits, trade and building permits, parking fees and revenue generated by health facilities. Funds generated by health facilities from user fees and health insurance reimbursements are among the top sources of own-source revenue for counties (International Budget Partnership Kenya 2017) (we discuss user fee policies in the following sub-section).

**Counties are entitled to a portion of national revenue, referred to as the equitable share.** As per the Constitution, the national government must transfer a minimum of 15% of national revenue to the counties. The Commission on Revenue Allocation (CRA), a constitutionally mandated body, that is responsible for recommending the equitable share in any year and dividing the funds between counties based on a revenue-sharing formula that includes factors like geographical size, poverty level, population, and health needs (CRA 2020). The National Treasury draws on these recommendations when developing budget legislation—specifically, the Division of Revenue Bill that stipulates the share of the national government versus the counties and the County Allocation of Revenue Bill that details each county’s allocation—which are ultimately debated and approved by Parliament (Muthuri 2019). As Table 1 shows, county allocation as a share of the total budget was on average 17% between FY 2013/14 to FY 2017/18 and has dropped to 11% in recent years. Counties receive these funds as block grants and have full control over allocation of resources to different sectors and activities. The equitable share block grant accounted for 66% of the total revenue for county budgets in FY 2019/20, as shown in Figure 5.

### Table 1: County allocation as a share of the total national budget

<table>
<thead>
<tr>
<th>Year</th>
<th>County allocation (KSH Billion)</th>
<th>Total budget (KSH Billion)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013/14</td>
<td>190</td>
<td>1,136</td>
<td>17%</td>
</tr>
<tr>
<td>2014/15</td>
<td>227</td>
<td>1,433</td>
<td>16%</td>
</tr>
<tr>
<td>2015/16</td>
<td>260</td>
<td>1,493</td>
<td>17%</td>
</tr>
<tr>
<td>2016/17</td>
<td>280</td>
<td>1,806</td>
<td>16%</td>
</tr>
<tr>
<td>2017/18</td>
<td>302</td>
<td>1,578</td>
<td>19%</td>
</tr>
<tr>
<td>2018/19</td>
<td>314</td>
<td>2,557</td>
<td>12%</td>
</tr>
<tr>
<td>2019/20</td>
<td>316</td>
<td>2,800</td>
<td>11%</td>
</tr>
<tr>
<td>2020/21</td>
<td>316</td>
<td>2,790</td>
<td>11%</td>
</tr>
</tbody>
</table>

*Source: National Treasury 2020*

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3 The 15% constitutional floor applies to revenue collected in the last audited and approved fiscal year, which is usually 2 years prior to the current FY. Given that the total budget has been growing every year, 12% of the current FY’s budget still exceeds 15% of the revenue from two fiscal years prior.
Counties also receive conditional grants from external partners as well as the national government. On-budget support from development partners that flows via the national government to the counties is typically structured as conditional grants. In the health sector, this includes grants from the Danish International Development Agency (DANIDA) as well as from World Bank’s Transforming Health Systems for Universal Care project (THS-UCP), which Global Financing Facility (GFF) supports. Counties also receive conditional grants from the national government. While counties have complete discretion over the allocation of own-source revenue and funds from the equitable share, the conditional grants are earmarked for specific purposes by the funder. In FY 2019/20, county governments received a user fee foregone grant to compensate levels 2 and 3 facilities for user fee removal (more details on that below), a conditional grant for level 5 county referral hospitals, and a medical equipment leasing grant. As shown in Figure 5, conditional grants from donors and the national government accounted for 8% and 5% of total county revenue in FY 2019/20, respectively.

There is significant variation in the functioning of conditional grants from donors versus the national government. Donor-funded conditional grants typically feature detailed contractual documents, and adherence to the conditions is monitored. The funds flow from the CRF into a special purpose account, where they are ring-fenced for use as per the conditions of the grant. In contrast, conditional grants from the national government flow to the CRF, where they are combined with other county funds. Counties exercise more discretion over the use of those funds (Sabignoso and Kwesiga 2009).

User Fees in the Public Sector

Health facilities in Kenya have collected user fees for nearly three decades. All health services were free in post-colonial Kenya until 1989 when user fees were introduced in all public facilities to raise additional revenue for the health sector (Chuma and Thomas 2013; Mwabu and Mwangi 1986). Facilities set the rates, and the revenue was retained at the local level, used by the facility to improve health service delivery and the district for public health programs (Chuma et al. 2009; Owino 1998). GOK has enacted several policies to limit user fees over the years. In the 1990s, GOK introduced waivers and exemptions for high-priority health areas such as child health services, but user fees continued to pose a significant financial barrier to access (Mwabu, Mwanzia, and Liambila 1995; Moses et al. 1992). In 2004, GOK adopted the 10/20 policy, capping user charges at primary care facilities to a flat registration fee of 10 and 20 Kenyan shillings at dispensaries (level 2) and health centers (level 3), respectively (Chuma et al. 2009). While the policy had the immediate effect of increasing service utilization (Kenya Ministry of Health 2005), patients’ understanding of the policy and facility adherence to the policy remains limited in the long run (Chuma et al. 2009).

In 2009, GOK and development partners set up a mechanism to channel funds directly to government-owned health facilities to compensate them for the loss of user fees. The World Bank and DANIDA financed the Health Sector Support Fund (HSSF), whereby a fixed amount of money was sent directly to the facilities’ bank accounts from the National Treasury (Ramana, Chepkoech, and Workie 2013; Tsofa et al. 2017; Nyikuri et al. 2015). These funds were received quarterly and managed by the health facility management committees. The Hospital Management Support Fund (HMSF) was a similar mechanism for hospitals (Tama et al. 2017).

Despite these transfers, user fees remained the largest source of financing for the operating costs of health facilities in the public sector before devolution. While MOH paid for staff salaries and drugs through the national budget, health facilities financed their operating expenses through the revenue they generated from user fees, transfers from HSSF or HMSF, and reimbursements from insurance. User fees accounted for 53% of the operating budget of health centers and dispensaries, compared to 31% from HSSF according to the Public Expenditure Tracking Survey (PETS) for FY 2011/12 (Onsomu et
User fees accounted for 70% of the operating budget in hospitals compared to 14% from HMSF.

Along with transitioning to a devolved system of government in 2013, GOK abolished user fees for primary health care services and facility births in the public sector. Under the user fee removal scheme, all services at level 2 government dispensaries and level 3 government health centers were made free at the point of use. The national government started transferring funds to the facilities to compensate them for the loss of revenue. Under the free maternity scheme (FMS), women delivering at any public facility could do so without any charges.

MOH initially reimbursed the facilities directly but eventually transferred the funds as conditional grants to the county governments. For the first two years after devolution, MOH used the HSSF mechanism to transfer funds into health facility accounts. The reimbursement for FMS was based on births reported to the health management information system, which reimbursements for level 2 and 3 facilities were based on historical data on user fee collections (Maina and Kirigia 2015). However, given the constitutional requirement for national funds to be transferred into the CRF, the reimbursement for user fees foregone by levels 2 and 3 facilities as well as FMS reimbursements were converted into conditional grants to the county in FY 2015/16 (Office of the Controller of Budget n.d.). The funds started flowing to the counties with instructions on how much should be transferred to levels 2 and 3 facilities. The original HSSF transfers to health facilities also ended, and DANIDA shifted to giving conditional grants to counties with the stipulation that the county government transfers the funds to level 2 and 3 facilities.

In 2017, the MOH shifted the management of FMS to the National Hospital Insurance Fund (NHIF), Kenya’s sole public health insurance agency, and renamed it Linda Mama. Delays in payment and overcrowding in public facilities were a recurring challenge during the early years of FMS when MOH was managing it (Maina and Kirigia 2015; Ministry of Health 2015b). MOH transferred the scheme to NHIF to address these challenges (additional details about Linda Mama can be found in the purchasing section).

Under the 2012 PFM Act, county governments can enact legislation to allow county government entities like health facilities to retain funds they raise (The Republic of Kenya n.d.). However, most counties have not enacted legislation to allow appropriation-in-aid for public facilities, instead requiring them to remit all revenue they generate from user fees and reimbursements from NHIF to the CRF. This has severely limited facility autonomy, which is explored further below.

Budget Development Process

For these case studies, we analyze the budget cycle in terms of four stages: budget formulation, budget approval, budget execution, and budget accountability. The first two stages of budget formulation and approval are described here, while execution and accountability are discussed under the purchasing and reporting sections, respectively. The FY in Kenya runs from July 1 to June 30 of the following year, and the budget cycle for a sample FY is available in Figure 6.
Figure 6: Main phases of the budget cycle for FY 2021–22

<table>
<thead>
<tr>
<th>Month</th>
<th>Past FY</th>
<th>Current FY</th>
<th>Next FY</th>
<th>Role of CDOH</th>
</tr>
</thead>
<tbody>
<tr>
<td>July</td>
<td>Counties publish Q4 implementation report</td>
<td>Current fiscal year begins</td>
<td></td>
<td></td>
</tr>
<tr>
<td>August</td>
<td>National government publishes Q4 implementation report</td>
<td>National Treasury and county treasuries release budget circulars defining timelines, policy priorities, and framework for public participation</td>
<td>National Treasury and county treasuries release budget circulars defining timelines, policy priorities, and framework for public participation</td>
<td>National Treasury and county treasuries release budget circulars defining timelines, policy priorities, and framework for public participation</td>
</tr>
</tbody>
</table>

Source: Adapted from International Budget Partnership Kenya 2015

The budget formulation stage involves the executive arm of the county government, while the approval phase largely involves the legislative arm. Table 2 provides a more detailed monthly breakdown of the budget cycle and key milestones, as well as the role of CDOH at each stage. The budget formulation takes place the year before the fiscal year starts. It begins with the County Treasury releasing a budget circular describing timelines and key policy issues to be considered in preparing the budget, followed by an Annual Development Plan that is aligned with the 5-year County Integrated Development Plan, the County Budget Review Outlook Paper that provides a three-year review in line with the Medium-Term Expenditure Framework and the County Fiscal Strategy Paper that provides initial budget ceilings. All these products are subjected to public participation and approval by the County Assembly by the end of February. Next, the County Executive Committee Member for health presents the estimates to the County Assembly and, upon approval, shares with sectors to prepare annual workplans, cashflow projections, and procurement plans. During the approval phase, county assemblies first pass the Appropriation Bill that details spending, followed by the County Finance Bill that describes revenue sources.

Counties have been allocating an increasing share of their budget to health, but there is marked variation across counties. The average health share increased from 23.4% in FY 2015/16 (Ministry of Health, Republic of Kenya, n.d.) to 27.2% in FY 2018/19 (Ministry of Health 2019). It ranged from 15% to 35% in FY 2018/19 across counties. Though the national government cannot require counties to allocate a certain share of their budget to health, they can use conditional grants to encourage counties to increase their health allocations. This type of conditionality has been tried under the GFF-funded THS-UCP project; counties are required to meet a minimum threshold and increase their health budget annually to receive funding (Sabignoso and Kwesiga 2009).
<table>
<thead>
<tr>
<th>Month</th>
<th>Past FY</th>
<th>Current FY</th>
<th>Next FY</th>
<th>Role of CDOH</th>
</tr>
</thead>
<tbody>
<tr>
<td>September</td>
<td>Counties publish Annual Performance Review about sector performance in the last FY</td>
<td>Counties release an Annual Development Plan that describes annual priorities in line with the published 5-year County Integrated Budget Development Plan</td>
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<tr>
<td>October</td>
<td>Counties publish 1st quarter implementation reports</td>
<td>National and county governments submit Budget Review and Outlook Papers to the National Parliament and county assemblies respectively; these documents review performance of the previous FY, plans for the current FY, and the outlook for the next FY in line with the Medium-Term Expenditure Framework and set provisional ceilings for each sector. County government launches sector working groups and public participation hearings.</td>
<td>Advocate to the County Treasury for higher allocations as provisional ceilings are being set in the outlook papers Leads health sector working group Review funds allocated verses used and performance in current FY</td>
<td></td>
</tr>
<tr>
<td>November</td>
<td>National government publishes Q4 implementation report</td>
<td>County government completes all sector working group reports.</td>
<td>CDOH submits sector working group report to the County Treasury</td>
<td></td>
</tr>
<tr>
<td>December</td>
<td>Audit reports released by Auditor General</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>January</td>
<td>Counties publish Q2 implementation reports</td>
<td>CRA submits recommendations for the Division of Revenue</td>
<td>Review funds allocated verses used and performance in current FY</td>
<td></td>
</tr>
<tr>
<td>February</td>
<td>National government publishes Q2 implementation reports</td>
<td>Treasury submits Budget Policy Statement to Parliament for approval by the end of the month. Division of Revenue and County Allocation of Revenue bills also submitted to Parliament, and Debt Management Strategy Paper tabled.</td>
<td>Review health sector request and align it with the ceilings set in the County Fiscal Strategy Paper Develop of the Annual Work-plan</td>
<td></td>
</tr>
<tr>
<td>Month</td>
<td>Past FY</td>
<td>Current FY</td>
<td>Next FY</td>
<td>Role of CDOH</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>County Treasury submits County Fiscal Strategy Paper to County Assembly, and tables Debt Management Strategy Paper and Program Based Budget estimates</td>
<td></td>
<td></td>
</tr>
<tr>
<td>March</td>
<td>County Fiscal Strategy Approved by County Assembly.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>April</td>
<td>Counties publish Q3 implementation reports National budget proposal and county budget proposals submitted to Parliament and County Assemblies, respectively by the end of the month Review funds allocated verses used and performance in current FY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>May</td>
<td>National government publishes Q3 implementation reports</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>June</td>
<td>National Appropriation Bill passed by Parliament, and County Appropriation Bills approved by County Assemblies. Finance Bills at the national and county-levels are tabled in June before approval of the budget. They must be approved within 90 days of the Appropriation Act. Obtain the final copies of the Appropriation Act and other budget laws from the County Assembly and align in case of any amendments</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Adapted from IBP Kenya 2015

The health budget includes allocations for health worker salaries, medical supplies, and facility operating expenses. These allocations are principally based on past patterns of expenditure (Mbau et al. 2018). On average, health worker salaries accounted for 75.8% of counties’ recurrent budget for health in FY 2018/19 while allocations for medical supplies and facility operations costs comprised 6.9% and 9.7% of the recurrent health budget, respectively (Ministry of Health 2019).

Countries produce budgets according to economic classifications as well as program-based budgets. The county budget is divided into votes that correspond to various government departments. It is then structured by economic classifications such as employee compensation, use of goods and services, etc. Counties also produce a program-based budget, which the 2012 PFM Act requires. Following guidelines from the MOH, counties categorize their health spending into three main programs: curative and rehabilitative services, preventive and promotive services, and general administration. These budgets are heavily skewed toward general administration in most counties, given that all costs associated with salaries, drugs, and facility maintenance are included under this category; see Figure 7 for the program-based allocation for the three SP4PHC counties. While there are now guidelines for counties to disaggregate each of the three main categories into sub-categories, these have not been
implemented consistently (Mbuthia et al. 2019).

**Figure 7. Program-based budget for Makueni and Kilifi, FY 2019/20**

<table>
<thead>
<tr>
<th>County</th>
<th>Curative &amp; Rehabilitative</th>
<th>Preventive &amp; Promotive</th>
<th>General Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isiolo</td>
<td>67%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Makueni</td>
<td>82%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kilifi</td>
<td>82%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Authors’ calculations based on Office of the Controller of Budget n.d.

While public facilities are meant to participate in a bottom-up budgeting process, facilities are routinely not aware of their budget allocation from the county. Health facility management teams develop annual budgets based on their needs, approved by hospitals boards or health facility management committees. These are then sent to the Chief Officer for Health within CDOH. Health facilities are often unaware of a budget ceiling when developing their budgets or informed of their allocated resource envelope due to limited communication with CDOH (Mbuthia et al. 2019).

**POOLING**

**MOH controls the single largest pool of health funds in Kenya.** At the national level, the MOH, NHIF, and various private health insurers pool health funds. Each county represents a pool at the sub-national level. As shown in Figure 4 above, MOH’s share of the total government health budget was 43% in FY 2018/19, while the remaining 57% was distributed into 47 county pools. MOH uses these funds to finance its operations and a range of vertical health programs and purchase services from tertiary health care facilities.

**NHIF, the sole public health insurance agency in Kenya, is meant to provide social health insurance to all Kenyans but currently covers approximately a fifth of the population.** It was formed in 1966 to provide inpatient coverage to formal sector employees (both public and private) and extended to include informal sector households in 1972 (Abuya, Maina, and Chuma 2015). The 1998 NHIF Act reconstituted NHIF as a parastatal with the mandate to cover both inpatient and outpatient services. It also made NHIF insurance mandatory for all Kenyans (National Council for Law Reporting 2012b). In practice, however, NHIF is only mandatory for salaried employees, who contribute through automatic payroll deductions following a graduated scale. For Kenyans who are self-employed or work in the informal sector, membership is voluntary and involves a flat premium. NHIF operates two main pools: the civil servant scheme for government employees and a general scheme that covers everyone else, including all formal sector employees not employed by the government, informal sector members, and households sponsored by the government. GOK subsidizes premiums for some poor and vulnerable households, for example through the Health Insurance Subsidy Program launched in 2014 (E. Barasa et al. 2018). Discussions about expanding on that as part of Kenya’s UHC policy are ongoing, which we discuss more below. Currently, an estimated 20% of the population is actively enrolled in NHIF, compared to 3% with private health insurance (Ministry of Health 2018). However, NHIF only accounts
At the county-level, pooled funds for the health sector are managed by CDOHs. Each of the 47 counties pools funds from own-source revenue (which includes revenue generated by public facilities), the equitable share block grant from the national government, and conditional grants from the national government and donors. They allocate these funds through the budgetary process described above. The CDOH controls the health sector budget. County governments can also set up separate schemes, which pool resources for healthcare beyond what is reflected by the county’s health budget. Only a few counties have done this in practice. In Makueni, the county government operates a scheme called Makueni Care to cover hospital charges in the public sector. Residents of the county can register for the scheme by paying an annual non-refundable registration fee of KSH 500 per household. The county government adds additional funding, which is used to cover user fees incurred by any scheme members seeking care at public hospitals in the county (Murira and Vilcu 2019). Some county governments (for example, Kisumu, Kajiado, and Tharaka-Nithi) have launched schemes to purchase NHIF cover for poor households (Alal 2020; Komu 2020; Kenya News Agency 2018).

PU B U R C H A S I N G

Purchasing captures how pooled funds are allocated to providers and used to pay for services. There are multiple health purchasers across Kenya’s two government tiers. Below, we describe the purchasing landscape, followed by a more in-depth look at how county governments pay providers during the execution phase of the budget cycle and account for that expenditure.

Purchasing Landscape

There are 49 public purchasers in Kenya; this corresponds with how health funds are pooled, as described above. Figure 8 provides a broad overview of these purchasers. Kenya also has commercial and community-based voluntary health insurance schemes that involve private purchasers beyond the 49 public purchasers described here. Collectively, these private schemes cover approximately 3% of the population (Ministry of Health 2018).

MOH purchases health care services provided by the country’s referral hospitals and specialty medical facilities. Many of these facilities are classified as semi-autonomous government agencies and, as such, receive a global budget allocation within MOH’s budget. Treasury transfers these funds to the entities directly, which have considerable autonomy over how they are spent. While all citizens are eligible to access these services, they may have to pay out of pocket depending on whether they have insurance coverage or not. MOH also manages a range of health programs that are implemented by units within the MOH (e.g., family planning, malaria, and immunization) or semi-autonomous government agencies (e.g., HIV/AIDS). The MOH also pays for some priority health commodities such as vaccines and contraception.

NHIF purchases a range of inpatient and outpatient services from contracted public and private providers. It pays primary care facilities for outpatient services using a capitation method and hospitals for inpatient services through a mix of case-based rates, fee-for-service, and per diems (E. Barasa et al. 2018). While all payments are made directly to health facilities, the ability of facilities to retain and spend those funds has changed because of devolution (we discuss this further in the sub-section on the flow of funds to facilities). Beyond its insurance schemes, NHIF also serves as the purchaser for national government schemes targeting high-priority health areas or vulnerable population groups. This includes Linda Mama, the FMS scheme that NHIF started managing in 2017. All pregnant women can
register to participate in Linda Mama through mobile phone, the NHIF registration portal, contracted health care providers, NHIF service centers, or other public service centers. Their membership allows them to draw benefits for one year, specifically free delivery, antenatal care, and postnatal care services. NHIF contracts with private and faith-based health facilities and public facilities for the scheme (Murira 2020). NHIF also operates the EduAfya scheme for adolescents studying in public sector secondary schools, financed by the Ministry of Education (Appleford and Mbuthia 2020).

**Figure 8: Public purchasers in Kenya**

![Figure showing public purchasers]

Source: Authors based on Mbuthia et al. 2019

The remaining public purchasers are the CDOHs in each of the country’s 47 counties. As described above, they are the main purchasers of primary and secondary services in Kenya. They receive funds from different sources, which they use to purchase services from public providers through input-based financing whereby the county pays directly for such inputs as health workers, drugs and supplies, equipment, and other activity implementation costs as well as some financial transfers (we discuss both in the next sub-section on county health purchasing).

The Kenya Essential Package for Health (KEPH) forms the basis for healthcare delivery in public facilities and purchasing by public purchasers in Kenya (Ministry of Health 2005). The package is comprehensive, including the full range of preventive and curative health services. Public providers from level 1 to 6 are collectively meant to deliver KEPH. Therefore, it forms the basis for MOH and county government purchasing. The NHIF benefit package for its main insurance scheme references KEPH, while other schemes like Linda Mama and Edu Afya have their own, more narrow benefit packages.

**County Health Purchasing**

Most CDOH funds for health are paid to public providers through input-based budgets in an integrated public delivery model with no “purchaser-provider” split. County governments own the network of public dispensaries, health centers and, hospitals and pay directly for staff salaries, commodities, facility operations, and maintenance. Before 2013, the national government employed all health workers in the public sector. After devolution, the county government assumed this responsibility for health workers working at public facilities within their remit. Presently, CDOH recruits the workers in conjunction with the County Public Service Board (Ministry of Health 2015a). Health
workers are paid based on their job groups and not on performance (Mbau et al. 2018). CDOH receives requests from health facilities for medical commodities. They consolidate and pass on to County Treasury that places the order for commodities to the Kenya Medical Supplies Authority (KEMSA), the state-owned central medical procurement agency (Tsofa et al. 2017). The counties also receive some commodities for priority health areas like immunization and family planning without having to budget and pay for them, as their costs are covered either by the national government, donors, or both (Mbuthia et al. 2019).

**Counties transfer some funds to facilities for discretionary spending, all financed by conditional grants.** First is the DANIDA conditional grant for level 2 and 3 facilities, which is a continuation of the HSSF mechanism. DANIDA requires that these funds flow to health facilities and monitors conditions (Sabignoso and Kwesiga 2009). Second, counties receive funds from the national government through the conditional grant for user fees forgone at level 2 and 3 facilities, which they, by and large, seem to transfer to health facilities (Mbuthia et al. 2019, MOH 2020). Third, counties with level 5 hospitals receive a conditional grant to defray their operating costs, which the county should transfer to the hospital. Some counties transfer these funds to the hospitals, while others pay in-kind for hospital costs (Sabignoso and Kwesiga 2009; MOH 2020).

**A few counties have introduced their own purchasing arrangements or payment methods to pay public providers based on outputs.** Under Makueni Care, the county government of Makueni reimburses public hospitals for user fees for scheme members (Murira and Vilcu 2019). Some counties – like Kwale – have used THS-UCP funds to offer performance-based payments to health facilities. Counties that are using such output-based methods for paying health facilities are, however, a small minority among Kenya’s 47 counties.

**Though counties can purchase services from private providers, these arrangements have primarily been for specialized services.** Several counties have leasing agreements and other contractual arrangements for ambulance services, laboratory services and equipment, specialist medical equipment, etc. (Ravishankar and Lehmann 2015; Ravishankar et al. 2016). They have largely eschewed contractual arrangements for the delivery of essential health services.

**Budget Execution**

**The start of the fiscal year marks the commencement of the budget execution phase.** The County Appropriation Act and the County Finance Act passed by the County Assembly represent the final approved budget for county expenditure and revenue, respectively. The county’s annual development plans and procurement plans also guide expenditure decisions. Counties can pass supplementary budgets during the fiscal year to make budget adjustments, typically in January or February.

**Counties are meant to receive funds from the national government in four quarterly installments, but these transfers are often delayed.** MOH recently concluded a PETS exercise that shows that while counties received 100% of their equitable share allocation in FY 2017/18 and FY 2018/19, there were considerable delays in releasing funds. Fund shortages at the National Treasury and delays in submitting budget documents by the county to the national government cause the delays. While counties typically receive their allocations under conditional grants funded by GOK, there was greater variability for donor-funded conditional grants (MOH 2020). These delays contribute to counties not executing the complete budget allocation. **Figure 9** compares budget execution rates for the national government versus the county governments. Unspent funds roll over to the following year. The PETS results show that in the health sector, the execution rate was 94 percent of the recurrent budget in 2018/19, but only 59% for the development budget.
**CDOH and the County Treasury jointly approve all spending against the health budget.** County units—which includes health facilities—raise requisitions for expenditure from the finance team at CDOH, which are sent to the Chief Officer for Health for approval. All approved requisitions are then forwarded to the County Treasury for further approvals by the Chief Officer for Finance. County officers or facility managers are then given the green light to carry out the activity and issued the “authority to incur expenditure” either on credit or based on a cash advance.

**Figure 9. Budget execution rates, county versus national government**

![Budget execution rates graph]


**Flow of Funds to Public Health Facilities**

The flow of funds to public facilities was relatively simple to describe before devolution. The national government paid directly for salaries and drugs. Public facilities collected funds from user fees and mechanisms like the HSSF and NHIF and used them to cover their operating costs.

In contrast, the flow of funds in the post-devolution period varies across counties and levels of care (Mbuthia et al. 2019; MOH 2020). **Table 3** provides an overview of the flow of funds for facilities in the three SP4PHC focus counties of Isiolo, Makueni, and Kilifi. Across all three counties, primary care facilities receive payments from NHIF under various schemes and funds from the county governments under the user fees foregone conditional grant and the DANIDA conditional grant. The facilities spend the funds according to the investment plans they develop. The nature of flows to hospitals varies significantly across counties.

**Hospitals have lost financial autonomy in most counties.** Early studies of facility financing in the post-devolution period noted that hospitals lost financial autonomy after 2013 because county governments started requiring them to remit all funds they collected to the CRF (E. Barasa et al. 2017; Mbau et al. 2018). Some counties like Makueni have since allowed public hospitals to retain and spend their funds from user fees and NHIF reimbursements. Makueni also reimburses public facilities for user fees incurred by members of the Makueni Care scheme. In contrast, Kilifi county has passed legislation to set up a facility improvement fund (FIF) where revenue from public facilities would be collected and
redistributed back to the facilities. Still, the county has yet to operationalize it. Isiolo county is currently passing similar legislation (Mbuthia et al. 2019).

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

<table>
<thead>
<tr>
<th>Facility level</th>
<th>Own-source revenue</th>
<th>Transfer own-source funds to CRF</th>
<th>Receive financial transfers from county government**</th>
<th>Facility has funds it can spend directly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dispensaries and health centers, all three counties</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>Yes (user fee foregone &amp; DANIDA conditional grant)</td>
</tr>
<tr>
<td>Hospitals in Isiolo</td>
<td>Yes, until December 2018***</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hospitals in Kilifi</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hospitals in Makueni</td>
<td>Yes (households registered under Makueni Care do not have to pay)</td>
<td>Yes</td>
<td>No</td>
<td>Yes, receive reimbursements under MakueniCare</td>
</tr>
</tbody>
</table>

* NHIF pays capitation for outpatient services to all facilities, a combination of per diem and case-based rates for inpatient; and fixed fees for special schemes such as Linda Mama and EduAfya.
** All facilities receive supply-side financing for staff salaries, drugs, etc. These represent in-kind transfers from the county to the facilities.
*** Kenya launched a UHC pilot program called Afya Care in late 2018. Isiolo was one of the pilot counties. As part of the program, the county discontinued user fees at public hospitals and received additional funds from the national government. We discuss the UHC scale up plans in the discussion section.

Source: Mbuthia et al. 2019

**Reporting, Oversight, and Accountability**

The Constitution grants county governments full discretion over how they allocate and spend their resources, limiting the ability of national government to oversee the counties. The county governments—the executive arm headed by the Governor and the county assembly—derive their powers from the people who elect them. Under the County Government Act of 2012 (National Council for Law Reporting 2012a), the County Executive Committee is required to provide the county assembly full and regular reports on matters relating to the county. These reports are shared with the relevant committees, including the health committee, the budget appropriation committee, etc. The national government sets overarching health policies and plans, typically led by MOH in collaboration with key national government institutions. The National Assembly and Senate monitor the implementation of these policies through their health committees. However, neither MOH nor the National Assembly provides any direct oversight over county health plans or budgets. The one exception to this is the extra funds provided by the national government to the counties through conditional grants.
national government can stipulate how these funds can be used and ensure that those conditions are met. In practice, the national government has exercised greater oversight over donor-funded conditional grants than the conditional grants it has financed from domestic resources (Sabignoso and Kwesiga 2009).

The Constitution mandates statutory bodies at the national level to monitor and audit how national and county governments spend public funds. The Controller of Budget (COB) is a statutory body that oversees the budget implementation at the national and county levels. The COB must confirm that each county has an approved budget before releasing funds to the county government. Each county is required to submit a quarterly budget implementation report no later than the last day of the month after completing the quarter to the National Treasury. The reports are meant to document revenues collected, expenditure by department, and performance against targets. The COB aggregates these county reports into composite county implementation reports quarterly. The Auditor General releases audit reports covering national and county spending within six months of the end of the fiscal year.

Counties must account for all their spending through Kenya's integrated financial management information system (IFMIS). First launched in 2003, the system has been re-engineered and expanded since 2011. It is designed to support all financial operations, collect accurate financial data for all public entities, provide adequate management reporting, and produce auditable financial statements. It currently includes modules for accounts receivable and payable, purchasing, cash management, and e-procurement. All county departments, including CDOH and county government units including health facilities must liaise with Country Treasury to ensure that all transactions are recording within IFMIS (Cisa 2016). Centralization of operations at Treasury can result in bureaucratic delays. Capacity constraints and poor connectivity pose additional challenges (IPSAS workshop 2017).

Despite counties' detailed reporting, there is a need for a more timely analysis of county health budgeting and expenditure. Counties must produce a range of documents as part of the budget cycle detailing their revenue and expenditure projections and performance (see Table 2). They also produce annual health sector plans and undertake annual health sector performance reviews. While these documents capture a range of information about the county health sector, some vital pieces of information remain missing. None of these documents contain disaggregated information about how much revenue health facilities generate. At the same time, counties report how much own-source revenue they generate from different sources including, from health facilities; the facility does not disaggregate these figures. Nor do their quarterly expenditure reports disaggregate spending by the county on behalf of different facilities or enumerate transfers to specific facilities. Finally, counties do not collect or report any detailed information about how facilities spend the funds they receive through various conditional grants.

While the 2010 Constitution provides a strong legal framework for promoting citizen participation, downward accountability structures in Kenya remain weak. The principle of public participation and accountability runs through numerous articles in the Constitution, including, for example, a guaranteed right to information and the requirements that national and county governments must solicit public participation. The 2012 PFM Act and the 2012 County Government Act echo the same principle, which provides for public participation in the budget-making and county planning processes. County practices fall short of these ideals. Although budget documents are meant to be published on county websites for public access, only a few counties publish real-time financial data. There is considerable room to improve the quality of public participation fora.
DISCUSSION

Kenya’s transition to a devolved system of government in 2013 fundamentally transformed the organization of health financing functions and, within that, PFM policies and practices in the health sector. While the national government continues to mobilize and pool the bulk of public funds for health, county governments exercise direct control over half of government health spending. They undertake a budgeting process that mirrors the national cycle, and the national government has limited ability to influence the spending decisions they make. Moreover, counties are the main purchasers of primary and secondary care services in the country, and they own and operate most public facilities in the country. They also have the mandate to grant public facilities the authority to retain and spend own-source revenue from user fees and insurance reimbursements. This case study also garners the following findings:

1. **The new devolved structure is less than ten years old and, as such, still nascent.** While PFM systems, processes, and capacities have matured considerably since 2013, both the national and the county governments have room to grow. For example, the national government is increasingly using conditional grants to channel earmarked resources to counties in the health sector to finance activities that align with national health policies and plans. MOH can more effectively use the “carrots” and the “sticks” that the mechanism of conditional grants affords them to influence county government policies and practices by improving formulas for the allocation of the conditional grants, testing and improving the conditionalities incrementally, stating the conditions more explicitly in agreement documents with county governments, and more closely monitoring whether counties are applying the conditions.

2. **For their part, county governments can stand to improve many of their budgeting practices.** This includes improving how their program-based budgets are structured and developed to create more flexibility for implementing units and yield more meaningful information about whether spending aligns with stated health priorities and improves performance. There is a need for a more timely and detailed accounting of county financing for public facilities. At present, county budget documents do not provide information about how much revenue was generated by different facilities, any appropriation-in-aid for public facilities, amount of funds transferred by county government to public facilities, county spending on various inputs disaggregated by facility, or how facilities used any of the funds that were available to them.

3. **County governments would also be well served by testing approaches to become more strategic purchasers of health services.** Presently, the bulk of county spending for health flows via budgetary allocations for salaries, commodities, and facility maintenance. County governments use resources from conditional grants to transfer funds to primary care facilities. Augmenting these transfers to facilities and linking them more explicitly to outcomes would be a step toward making purchasing more strategic. Several counties are now exploring ways to give health facilities the authority to receive, retain, and use revenue from user fees and NHIF reimbursements. Enhancing health facility autonomy with concomitant measures to enhance management capacity and accountability structures within public facilities is a precondition for strategic purchasing by county governments and a national purchaser like the NHIF.

4. **Such reforms will determine the success of GOK’s plan for achieving UHC, which it launched recently.** In 2018, GOK initiated a new UHC pilot called Afya Care in four counties. All user fees at county public hospitals were discontinued, and the national government transferred additional resources in the form of conditional grants to the counties (Shano and Vilcu 2020).
In recent weeks, the national government has announced a plan to scale up the scheme country-wide. In addition to channelling funds to county governments, the national government will sponsor NHIF cover for a million poor households from across the country. The implementation of this plan calls for greater coordination between national and county governments. Its success hinges on timely and transparent intergovernmental transfers and improved county PFM policies and practices, especially with the use of conditional grants to enhance service delivery and facility autonomy in the public sector.


**ANNEX 1: LIST OF INTERVIEWED INDIVIDUALS**

This annex contains a list of individuals interviewed by the authors between July 13 and August 25, 2020. For each interview, a semi-structured questionnaire was prepared based on the subject’s expertise and information gaps following the desk review.

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
<th>Interview date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alamin Adan (Dr.)</td>
<td>County Deputy Director of Health, County Government of Isiolo</td>
<td>August 21, 2020</td>
</tr>
<tr>
<td>Mulewa David (Dr.)</td>
<td>County Director of Health, County Government of Kilifi</td>
<td>July 13, 2020</td>
</tr>
<tr>
<td>Kiuluku David (Mr.)</td>
<td>Director of Health Planning, County Government of Machakos</td>
<td>August 17, 2020</td>
</tr>
<tr>
<td>Ziro Christopher (Mr.)</td>
<td>Head of Planning, Monitoring, and Evaluation, County Government of Kilifi</td>
<td>August 25, 2020</td>
</tr>
</tbody>
</table>