SP4PHC
Strategic Purchasing for Primary Health Care

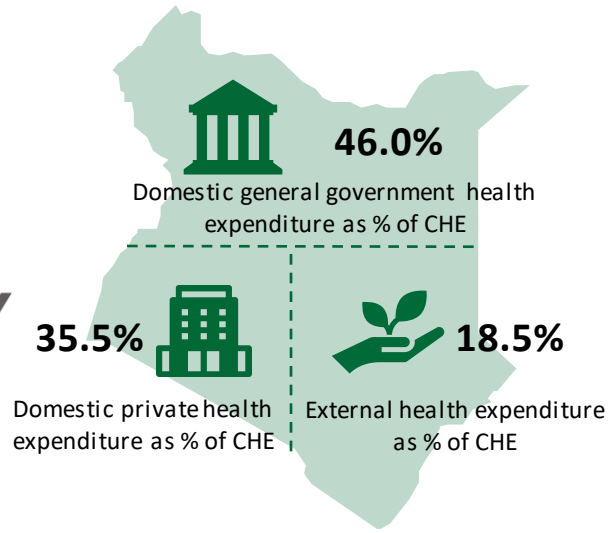
Kenya Health Purchasing Factsheet

August 2022

Under Kenya's devolved system of government, counties are the main purchasers of primary health care (PHC) services. They not only control the bulk of government funds for delivery of PHC services through public facilities, but they also determine whether public facilities can retain and spend any funds the latter collect from user fees or reimbursements from the National Health Insurance Fund (NHIF). Under the SP4PHC project, ThinkWell is collaborating with key government stakeholders at the national level as well as in three focus counties (Isiolo, Kilifi, and Makueni) to strengthen purchasing policies and practices that can improve PHC delivery. Below are general health financing statistics to better understand the health financing profile in Kenya.

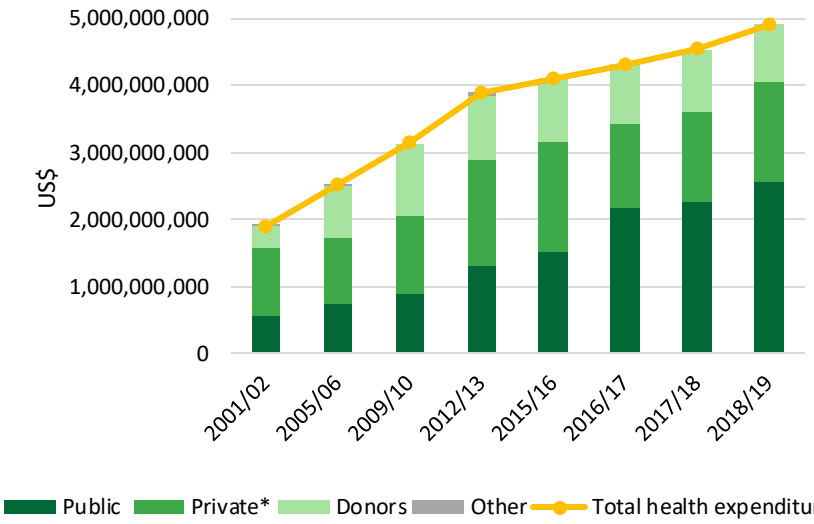
Kenya's Current Health Expenditure (CHE) (2019)

Source: Global Health Expenditure Database 2022



Trends in Total Health Expenditure

Source: Kenya National Health Account Fiscal Year 2016/17-2018/19

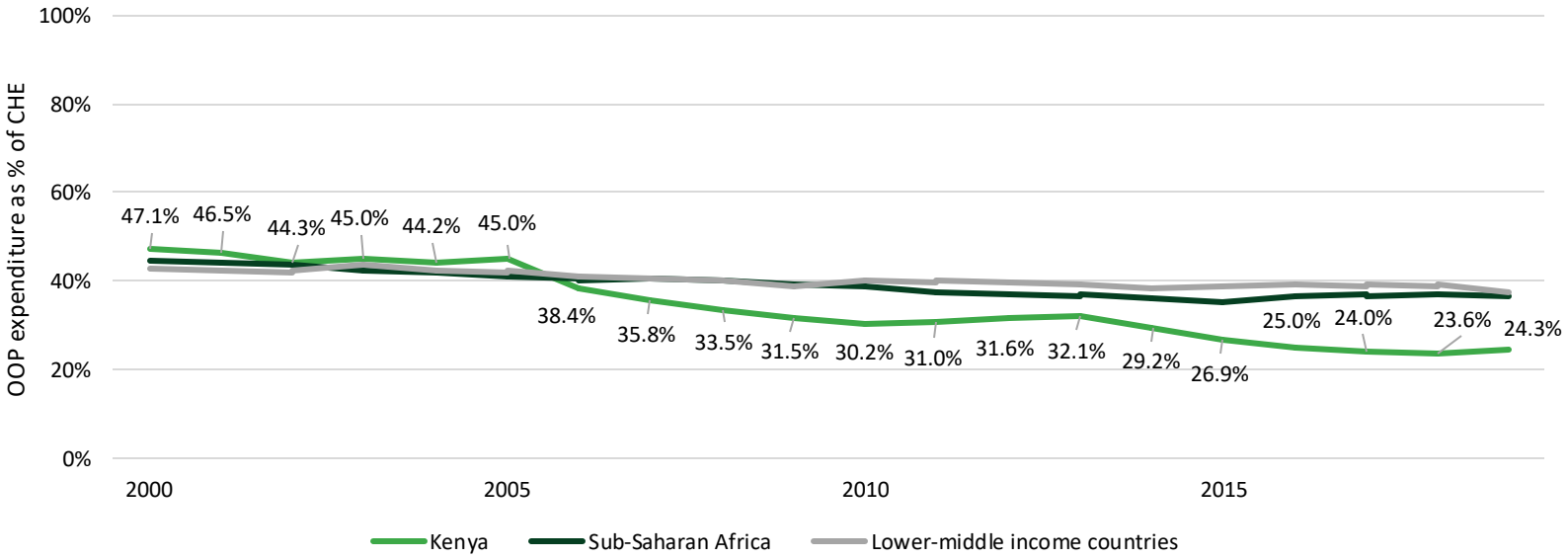


*Private expenditure comprises households' (i.e., OOP) and private firms' expenditure.

Trends in Out-of-Pocket (OOP) Expenditure as a Percentage of CHE

Source: Global Health Expenditure Database 2022

OOP expenditure as share of CHE decreased considerably over the last decade. It is much lower than the average OOP expenditure for Sub-Saharan Africa and lower-middle income countries.



Strategic Purchasing for Primary Health Care (SP4PHC) is a project that ThinkWell is implementing in partnership with government agencies and local research institutions in five countries (Burkina Faso, Indonesia, Kenya, the Philippines, and Uganda), with support from the Bill & Melinda Gates Foundation.

Goal of Strategic Purchasing

Source: World Health Report 2000; World Health Report 2010

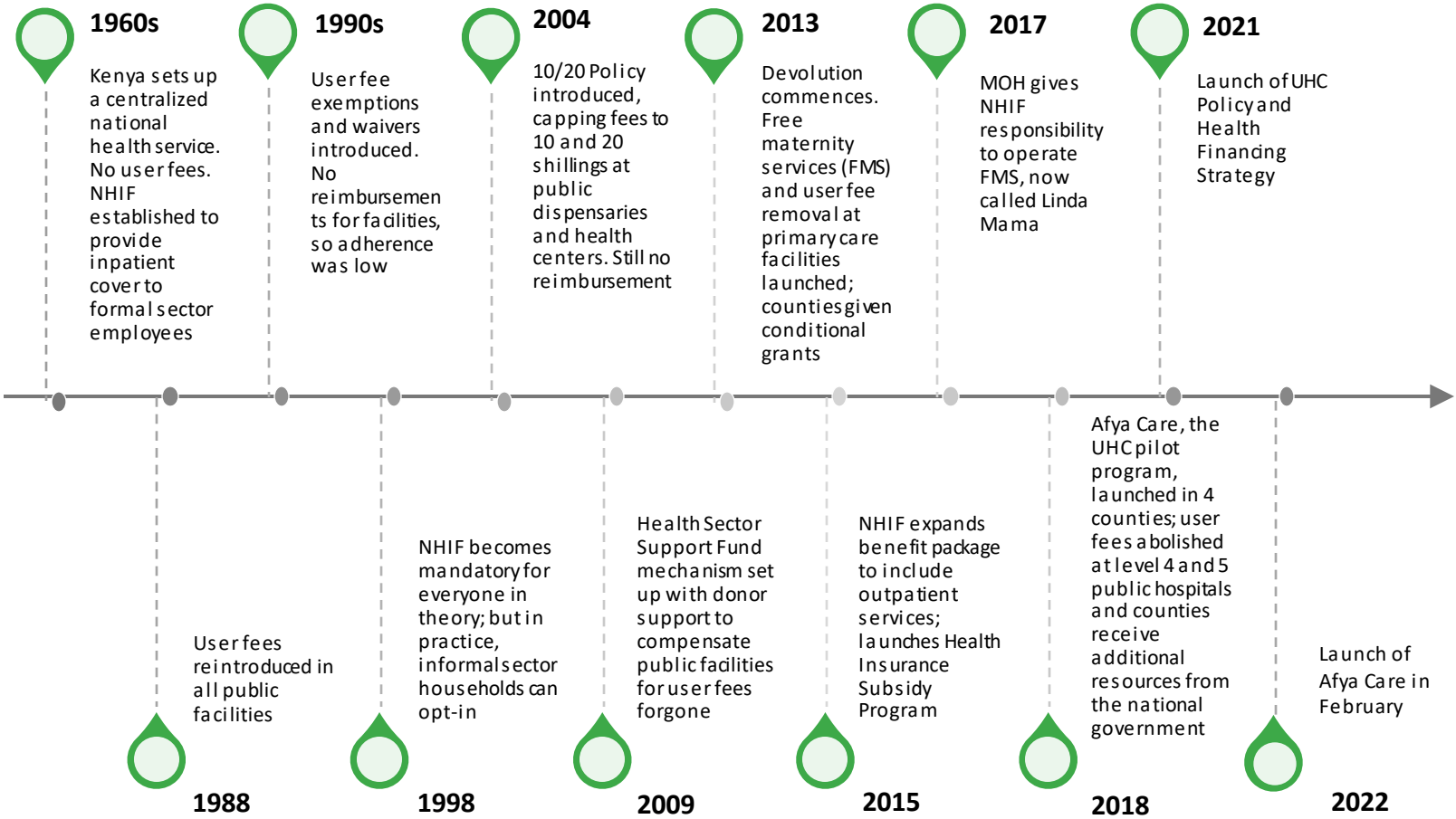
As countries such as Kenya implement strategies to achieve universal health coverage (UHC), they are undertaking health financing reforms to mobilize more financing for health and ensure that available funds for health are used optimally and equitably. Strategic purchasing is linked to the second objective. Making purchasing strategic involves basing purchasing decisions on information about provider behavior and population health needs. However, most countries have multiple purchasers and purchasing schemes and these reforms are often overlaid on existing systems, risking further fragmentation and mixed signals to health providers.

Under SP4PHC, ThinkWell is working with individual purchasers critical for the delivery of PHC, especially family planning (FP) and maternal, newborn and child health (MNCH) services and assisting governments to improve coherence between purchasing arrangements at the system-level.

History of Health Financing Reforms in Kenya

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

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, and NHIF. Understanding their respective roles requires an appreciation of Kenya's devolved system of government, the history of social insurance, and the evolution of user fee policies. The Government of Kenya has made a firm commitment to achieving UHC for all its citizens. In December 2018, it started pilot-testing the Afya Care UHC program in four counties. The scale-up of Afya Care started in the second half of 2020 with the registration of 1 million poor households. The program, officially launched in February 2022, uses public funds to pay NHIF premiums for poor households, entitling them to a defined package of services free of charge.

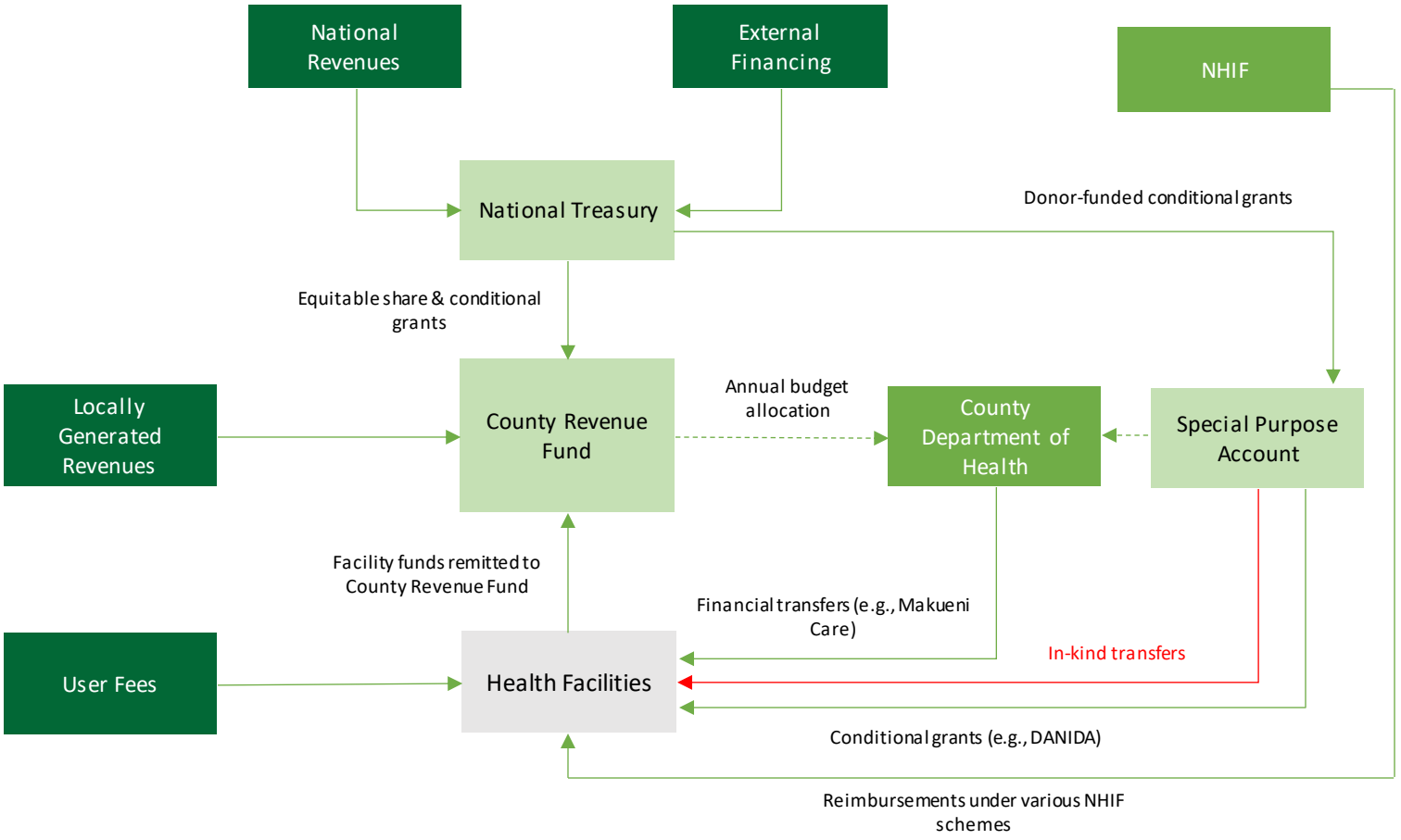


Fund Flow for Health Services

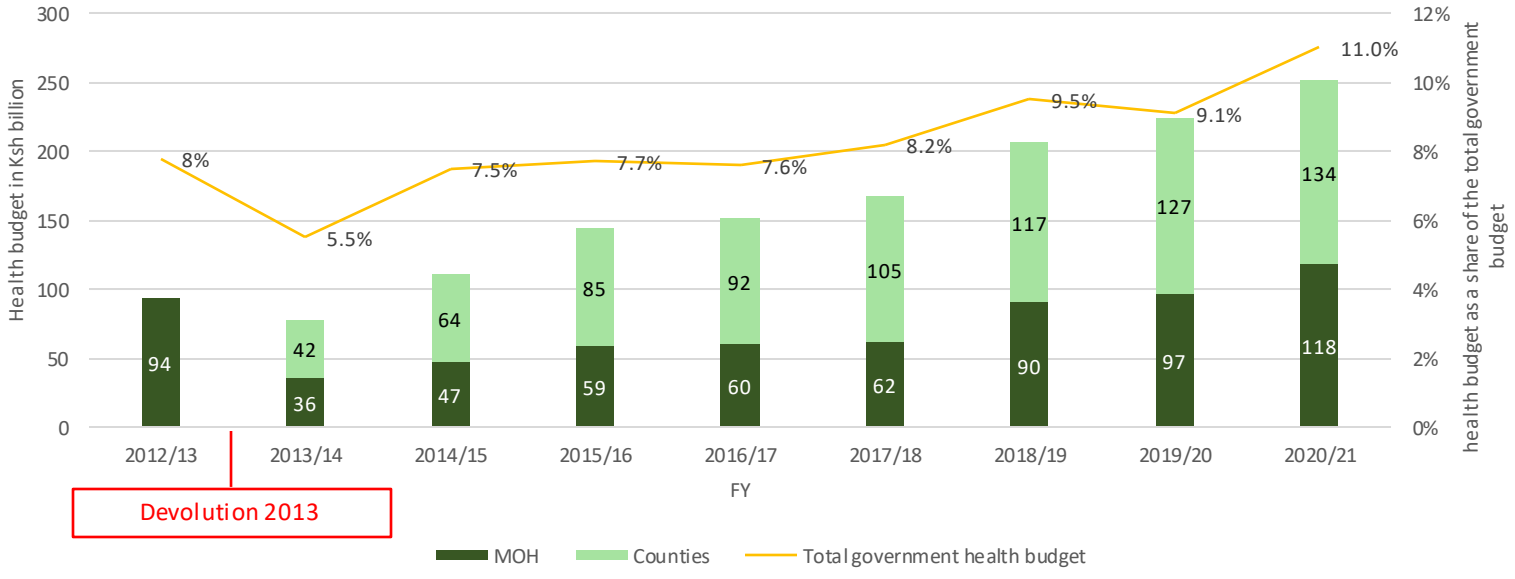
Source: Mbuthia, Vîlcu, Ravishankar et al. 2019

The diagram below shows funding flows in the post-devolution period. A solid green line denotes a financial transfer, while a solid red line shows in-kind transfers to health facilities. A dotted green line is used to depict control over budget allocation decisions.

- The National Treasury transfers the equitable share and conditional grants financed from general taxation to the County Revenue Fund, which also draws resources from local taxes and revenues generated by public facilities.
- Donor-funded conditional grants are typically channeled to a Special Purpose Account at the county level.
- County governments pay directly for a range of facility costs, including staff salaries, drugs, and so on, and disburse funds from conditional grants dispensaries and health centers.



Since devolution, counties control a larger share of government health budget than the MOH. The counties' share of the total health budget increased from 54% in fiscal year (FY) 2013/14 to 63% in FY 2017/18 and then it decreased to 53% in FY 2020/21 as the MOH budget increased to respond to the COVID-19 pandemic.



Types of Purchasing Schemes

The purchasing landscape in Kenya is fragmented as there are 49 public purchasers of health services. The remainder of this factsheet focuses on Linda Mama, a publicly-funded scheme managed by NHIF, aiming to ensure that all Kenyan pregnant women and their infants have access to quality and affordable health services.

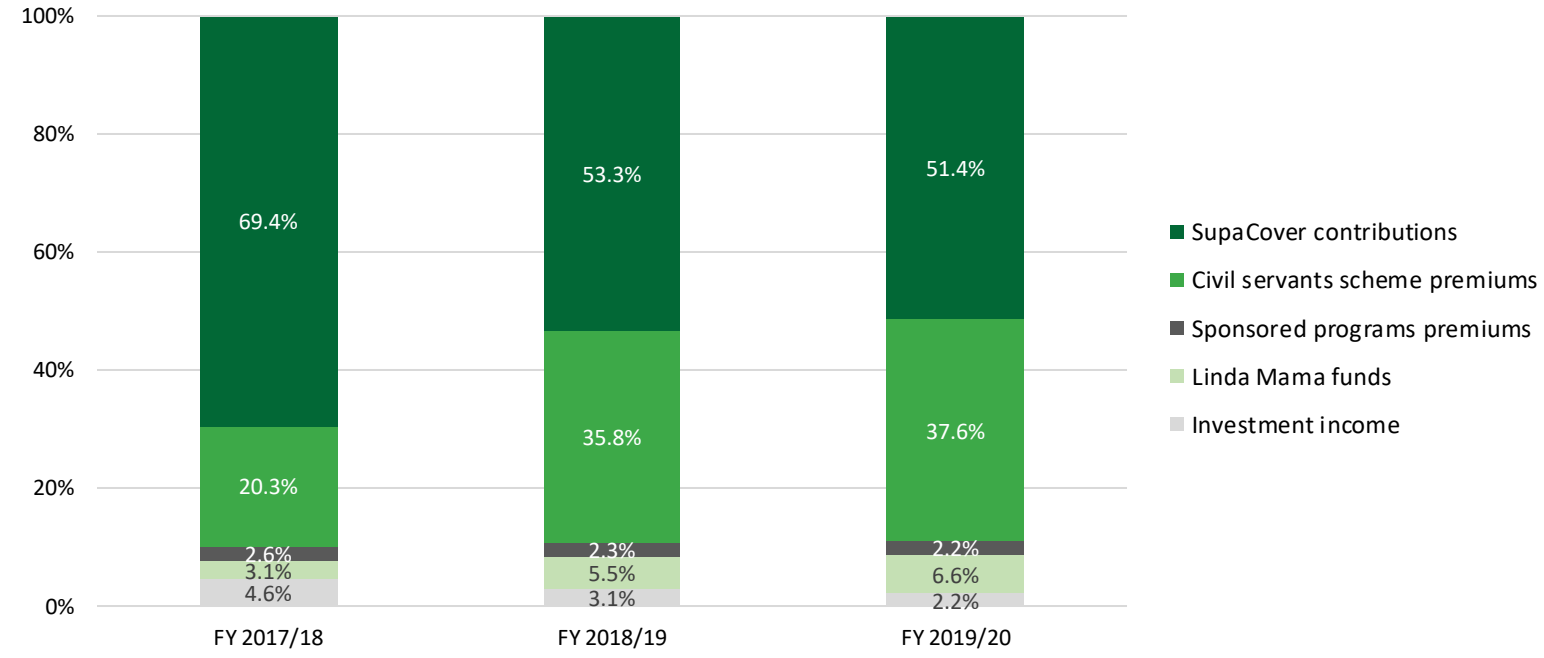
Purchaser attributes	Ministry of Health (MOH)	County Department of Health	National Hospital Insurance Fund (NHIF)			Private Health Insurance
			SupaCover	Afya Care	Linda Mama Scheme	
Sources of revenue (e.g., taxes, premiums)	National government allocation	County funds, including "equitable share" block grant and conditional grants from the national government, as well as own-source revenue	Member contributions (including payroll deductions for formal sector employees) and national government allocation for low-income households	MOH allocation	National government allocation	Member and employer contributions/ premiums
Population covered (e.g., poor, formal sector)	All Kenyan citizens	All residents of the county	Formal private sector employees, contributing informal sector workers, sponsored members (poor and most vulnerable); and all their families	1 million poor households (coverage to be gradually expanded)	Pregnant and postpartum women and their infants	Those able to pay premiums; most plans target formal sector workers and wealthier groups
Benefits/services covered (e.g., PHC, hospitalization, inpatient, outpatient, etc.)	Kenya Essential Package for Health - inpatient and outpatient tertiary services; FP products are free, but in the case of stock-outs patients purchase from private shops; no costs on short acting FP methods; normal deliveries, caesarean sections, postpartum care, management of complicated pregnancies	Same benefits covered as MOH	Inpatient and outpatient services, chronic disease treatment, surgery, maternal services, FP services and methods, ambulance, optical services, foreign care (for services not locally available)	Same as SupaCover	Antenatal care (ANC), postnatal care (PNC), normal delivery, and caesarean sections, conditions and complications during pregnancy, care for infant; postpartum FP	Benefit packages vary; Typically cover inpatient and outpatient services and "top-up" services (e.g., dental)
Types of facilities included (e.g., referral hospitals, health centers, health posts, etc.)	Level 6: national referral hospitals (only public)	Only public: Level 1: community health units; Level 2: dispensaries; Level 3: health centers; Level 4: primary hospitals; Level 5: county referral hospitals	Public and private: Levels 3-6	Public and faith-based: Levels 2-6 (private facilities are likely to be included in the future)	Public and private: Levels 2-6	Typically, private facilities (but in principle public facilities can also be included)
Payment methods (with FP and MNCH specifics)	Grants to semi-autonomous tertiary hospitals; Line-item budget to specialty care facilities; Input-based budgeting (commodities, salaries, equipment) for FP and MNCH services	Input-based budgeting	Case-based rates for specific services (e.g., permanent FP methods, MNCH services, "package" for renal care, cancer treatment, maternity etc.), capitation for all remaining outpatient services (including other FP methods and consultation) and per diem "bed rates" for inpatient services	Capitation	Case-based payment for ANC, delivery, and PNC	Benefit packages have financial caps per member

Note: A small number of corporate companies or groups contract private health facilities to offer health services to their staff.

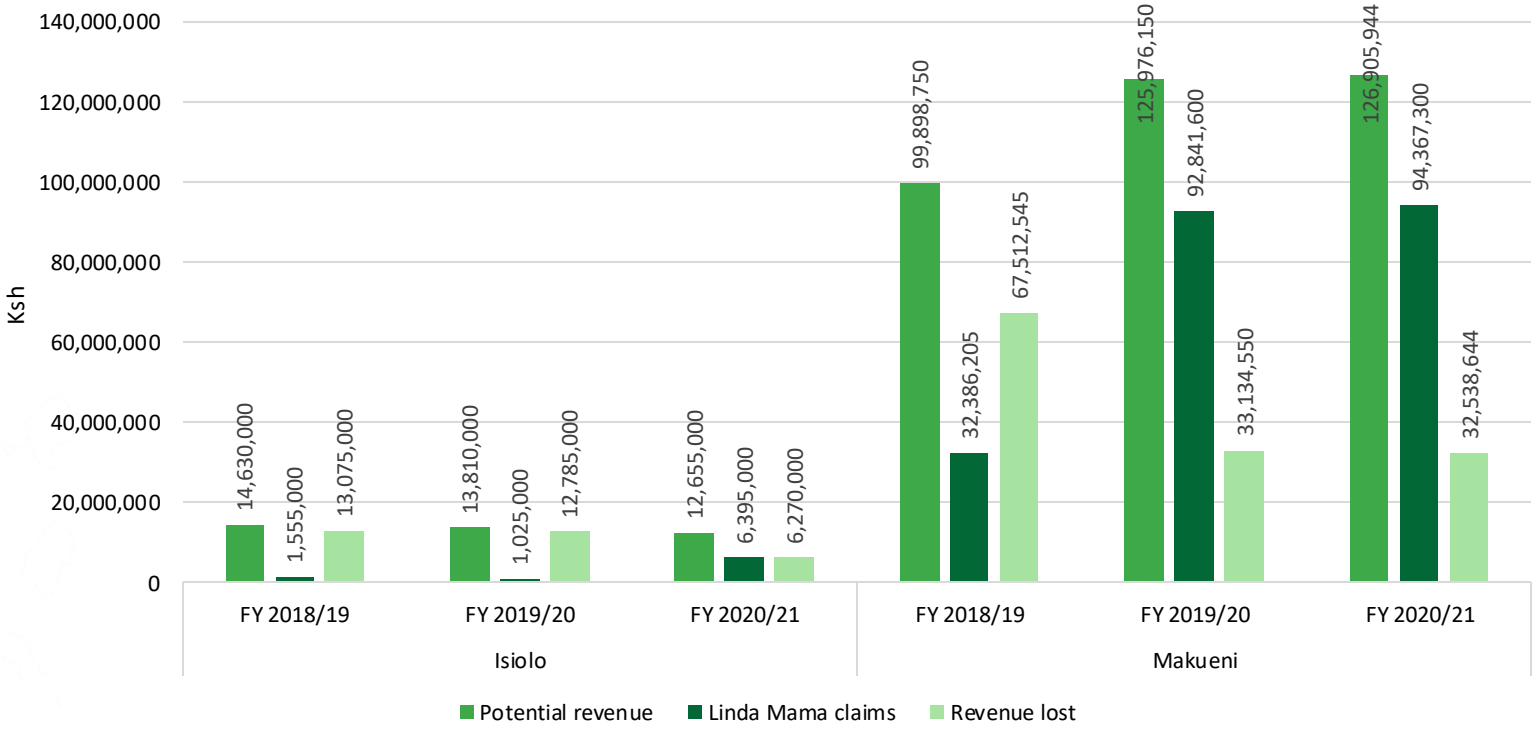
NHIF Revenue Collection

Source: MOH Health Sector Report 2020 and MOH Health Sector Report 2021

As NHIF membership has grown over the years, now reaching 43% of the population, revenue collection has also increased from Ksh 45 billion in FY 2017/18 to Ksh 60 billion in FY 2020/21. The funds NHIF received from MOH to operate the Linda Mama scheme have increased from Ksh 1.5 billion in FY 2017/18 to Ksh 4 billion in FY 2019/20 and represented approximately 7% of NHIF's revenues in FY 2019/20.



At the same time, the revenue collected by health facilities by submitting Linda Mama claims in the SP4PHC project counties has increased. ThinkWell's support has contributed to progress made by Isiolo and Makueni counties, where public facilities are submitting more claims, and tracking whether claims have been paid or not.



Source: Isiolo and Makueni County Departments of Health

Recommended Citation: ThinkWell Strategic Purchasing for Primary Health Care. 2022. "Kenya Health Purchasing Factsheet – August 2022." Washington, DC: ThinkWell
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