Sustainable Financing for Universal Health Coverage (UHC) in Kenya: Policy Priorities for the county governments

BACKGROUND AND CONTEXT

Healthcare financing relates to the mobilization, accumulation, and allocation of money to cover the health needs of the people, individually and collectively. Ideally, a good health financing system should be able to play a key role in achieving universal health coverage (UHC) by raising adequate funds for health in ways that ensure people can use needed services and are protected from the financial risk associated with having to pay for health services [1]. This policy brief explores how the counties can obtain adequate and sustainable health financing and advocate for equitable and effective health care financing to obtain better health outcomes. The recommendations are meant to guide counties in ensuring that health budgets are better aligned with Government of Kenya and County commitments and that the health sector receives enough funds to deliver quality healthcare services.

KEY POLICY ISSUES

As counties continue to allocate more resources for health, health care costs continue to create a huge financial risk to the citizens making the need to protect the more than 1 million Kenyan households from being impoverished as a result of catastrophic health expenditures challenging. Given that health is a devolved function, it requires that counties offer practical solutions to aggressively attack the crushing burden of health care costs. Issues of concern are as follows: -

Inadequate investments in health by national and county governments

Overall, the total government budget allocated to health as a percentage of total for both national and county increased to 11.5% in FY 2020/2021 up from 7.8% in FY 2012/2013. In absolute terms, the combined health budget allocation was Ksh 217 billion in 2019/20, nearly three times compared to pre-devolution (FY 2013/14). County health budgetary allocations almost doubled in nominal terms between 14/15 FY and 2020/21 and, as a proportion of total county government expenditures, grew by 5.3%. Even then, most counties still fall below the recommended 30% allocation as recommended by the 2012 Public Financial management Act (PFMA). Only **20 counties**[1] have an allocation of 30% or more to health in FY 2020/2021. Despite the increases in budget allocations, on average counties are spending between 70-75 percent of their recurrent health budgets on personnel emoluments leaving insignificant amounts for other equally important inputs thus compromising on quality and access.

The growth in equitable shares in absolute terms, has not kept pace with the growth in national tax revenues and nominal gross domestic product (GDP)

Despite the equitable share revenue/transfers by the national treasury to the counties increasing from Ksh. 190 billion in 2014/15 to Ksh. 370 billion (2021/22), the rate of growth of the equitable share has been on a decline except for 2021/22 and, largely, lower than the growth of national tax revenues and nominal gross domestic product (GDP). Similarly, it has not kept pace with population and inflation growth, eroding the capacity of country governments to deliver consistent level of services on a per-capita basis.

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[1] These include: Baringo, Elgeyo Marakwet, Embu, Homa bay, Kericho, Kisii, Kiambu, Kilifi, Kisumu, Lamu, Kirinyaga, Murang'a, Makueni, Meru, Nakuru, Nandi, Narok, Nyamira, Nyeri and Tharaka Nithi

Late disbursement of the equitable share of revenue by the national treasury to the counties

In as much as the Public Financial Management Act (PFMA) provides for the disbursement of the equitable share revenue by the National Treasury to the counties by the 15th day of every month, these funds are often disbursed late, with occasioned extension of the cut-off date of closure of the Financial Year (FY). Also, Facility Improvement Funds (FIF) raised and transferred to the County Revenue Fund (CRF) as per PFMA regulations are more often been reallocated to other activities rather than being ploughed back to the facilities to improve on service delivery.

High reliance on development partners assistance adversely affecting sustainability

With the country obtaining a lower-middle income country status in 2014, donor financial support to the health sector that currently stands at 18% of health budget (NHA 2016-2019) with donors contributing as much as 69% for HIV is set to decline and, both levels of government anticipated to take on increased responsibility for funding the sector.

Fragmented and disjointed government support in the health care delivery system leading to inefficiencies

With multiple funding flows risk pooling remains fragmented, compromising financial risk protection. The fragmentation in the sector is alarming with separate funding pools such as the numerous individual county government and/or corporate institutions negotiated enhanced schemes with the insurer; promising, yet non-insurance based county health financing initiative such as Makueni care;, pools for identified vulnerable groups such as pregnant mothers under Linda Mama, Health insurance subsidy schemes for the elderly, people living with severe disability and the indigents, and Edu-afya program for school going children; independent, strategic programs that have persisted with little or no effort to consolidate them into the UHC health insurance benefit package, including the management of COVID-19 treatment; and, coupled with the ongoing parallel input financing for the health sector. The schemes are small and fragmented with wide gaps in the levels of benefit packages for scheme members and with different provider payment rates for similar services which are not linked to quality improvement. Fragmentation brings about inefficiencies in utilization of limited public resources as seen in the high administrative costs of NHIF (17% in 2018) against an average 4.7% for reviewed health insurance schemes in 58 countries (HEFREP report); but also, inequities as experienced by county governments who provide healthcare to these covered, partially covered, and uncovered groups.

Glaring gaps in public financial management

For many counties**, t**here is – lack of clear interlinkage of 10 – year planning frameworks to the 5 – year County Integrated Development Plans (CIDPs) to annual Medium Term Expenditure Framework (MTEF) budgeting processes; lack of evidenced based budgeting in health sector; non – compliance in budget execution due to limited capacity; weak human resource enforcement and, limited capacity among county assemblies to scrutinize budget execution processes; and lack of operational public participation operational legislation and, citizen engagement in planning and budgeting cycle and, operational audit function at the County.

Limited financial protection

There exists inequities in the health financing system especially in the absence of a strong social financial protection system. About 21.4% of sick Kenyans do not seek healthcare due to high costs. Still, while the proportion of Kenyans with health insurance increased from 17% (2013) to 20% (2018), [2]

[2] Ministry of Health. *2014 & 2018 Kenya household expenditure and utilization survey.* Nairobi, Kenya 2014 & 2018.

health insurance mobilizes only 5% of current health expenditure pointing to low depth of coverage.[3] In general, health insurance coverage rates remain low in Kenya (19.9%)[4] with wide disparities between rural (12%) and urban (27%) areas and income quintiles (42% highest income quintiles and 2.9% lowest quintile). Limited financial risk protection leads to high OOPs expenditures (5 percent of Kenyans incur catastrophic expenditures from OOPs due to health care costs) thus, limiting access to essential health care services especially by the poor and vulnerable groups.

Worse still, out of pocket payments (OOP) remain high (27.7 per cent of total county health expenditure and 7.1% of Kenyans incur catastrophic health payments [5]. As part of financial protection, the government operates a health insurance subsidy program for the poorest covering both inpatient and outpatient care in public and private health facilities. To date, the NHIF scheme covers 920,325 indigent and vulnerable households of the targeted 1 million households across the country. The dismal competitiveness of the NHIF, is due to weak regulatory and enforcement environment coupled with a parallel input financing system. To-date, no policy document has clearly addressed a clear pathway on how County Governments can reorganize resources in the shift towards an output based financed health system.

OPPORTUNITIES TO OBTAIN SUSTAINABLE FINANCING FOR UNIVERSAL HEALTH COVERAGE

Moving forward, the county governments should place emphasis on mobilizing additional domestic resources for the health sector as well as increasing efficient and effective allocation and use of health budgets to safeguard the health system and to maximize on the health outcomes. The following proposals are provided for consideration: -

County negotiations with the Treasury/MOH/NHIF for increased funding and timely disbursements

As the third-generation formula prioritizes health -- determined by number of primary health care visits to Level 2 and 3 facilities and number of in-patient days in level 4 and 5 hospitals, the counties need to take advantage of this opportunity to undertake advocacy with the national government to increase allocations to county governments through annual negotiation on the division of revenue process.

Consolidate and expand exiting financial risk pooling schemes: NHIF reforms should be guided by the Kenya health financing strategy. Senate's failure to assent to mandatory NHIF enrollment which would have brought over KES. 120 billion to NHIF notwithstanding, this proposal remains the most feasible and sustainable strategy to attain UHC. Additionally, counties need to negotiate with the government (MOH / Treasury) for targeted subsidies to be earmarked towards UHC to cover indigents.

Ringfence health funds: The COG has been developing a Model Law aligned with 2021 PFMA (Section 109 (2) read together with Section 116, to create county special purpose accounts (CSPA) to protect health funds from diversion to non-health sectors. This Law which is to be annexed to the *Facility Improvement Funds (FIF) and Health Facilities Management Committee (HFMC) Guidelines*

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[3] Barasa EW, Maina T, Ravishankar N. Assessing the impoverishing effects, and factors associated with the incidence of catastrophic health care payments in Kenya. *International journal for equity in health.* 2017;16(1):1-14.

[4] The Kenya Integrated Household Budget Survey 2015, KNBS, 2018

[5] Ministry of Health. *2018 Kenya household health expenditure and utilization survey.* Nairobi, Kenya2018.

for Health Facilities, provides clarity on sources of funds to be ring fenced for health services and key actors, procedures and accounting procedures and processes. On finalization, the counties need to support its implementation to improve the financial flow of health funds to the health facilities.

Increase county health budgetary allocations: Counties could consider increasing their health budgetary allocations by 10% annually while also ensuring efficient use of the resources, allocating at least 5% of the yearly budgets to strategic programs, depending on county disease burden. An assessment of county fiscal space will be critical to inform county resource mobilization strategies. To increase Own Source Revenue (OSR) that currently stands at 10 per cent, the counties should adopt more efficient/low-cost tax collection systems guided by the fiscal assessments; re-evaluate properties after every 10 years and, enhance staff capacities in tax administration. Deliberate efforts should also be taken to increase the population covered by insurance or any other pre-payment schemes.

Obtain seamless transition of donor programs: To ensure sustainability of the vertical programs including HIV, TB, Immunizations, and malaria which are overly dependent on donor-support, county governments should progressively make provisions for these programs in their annual budgets (i.e. HRH and supervisions) . This is in addition to an increased commitment at the national level as guided by the Kenya Health Finance Transition Road Map[6].

Enhance technical and allocative efficiency: The developments in the health fiscal space call for more prudent use of the limited public health sector resources to ensure better value for money in the context of health finance transition period and to deliver on the UHC agenda. To obtain this objective, this brief calls for,

Streamlining flow of funding to the counties through responsive pooling arrangements: In line with the health financing strategy, Policy actions to reduce fragmentation of the existing health financing landscape will entail (i) restructuring and consolidating current public budgets and health insurance to align to the pooling arrangements, (ii) consolidation of budgetary allocations at both national and county levels. Kenya health finance strategy[7] proposes the creation of four major risk pools, namely, Social Health Insurance Fund- , County Health Funds (CHFs), National Health Fund (NHF) and, complementary private health insurance. *V*irtual pooling of the fragmented health pooling schemes will also be required to harmonize the benefit packages, consolidate and expand existing pools to maximize on efficiency gains. Mandatory NHIF enrollment which will bring over KES. 120 billion to NHIF remains the most feasible and sustainable strategy to attain UHC. Additionally, counties need to negotiate with the government (MOH / Treasury) for targeted subsidies to be earmarked towards UHC to cover indigents.

Establishment of county health planning units (CHPU) to enhance health planning, budgeting and programming: Building on lessons learned from such counties as Kisumu, Makueni, Mombasa and Kitui, counties need to establish CHPU as a framework for coordinating planning and budgeting functions of the county health department and interface with the county treasury.

Strengthen the purchasing function: The counties need to work with NHIF and MOH to establish a minimum benefit package entitled to beneficiaries. The package should be oriented towards

[6] Ministry of Health, Kenya Health Sector Transition Roadmap: In the Context of Universal Health Coverage Sustainability Financing 2022-2030, September 2021 (Draft)

[7] Ministry of Health, 2021. Kenya Health Financing Strategy 2020–2030, Republic of Kenya, July

preventive and primary health care and, be provided through the provider care networks (PCNs) to enhance efficiency and referral care systems. Payment mechanisms also need to change from passive to strategic purchasing of health services pegged on quality of services offered that include a standard benefit package and harmonization of provider payment rates for the package (i.e a standard fee regime which does not discriminate between private, FBO and public health facilities.) in addition to reviewing and/or expanding the definition of health providers to include private chemists, diagnostic services, X-ray, lab etc.

Leverage on private sector support through public-private sector partnership (PPP): The counties through the Council of Governors (COG) should increasingly support enactment of laws and instruments that support increased and efficient private sector participation in health financing. Options to this end include collaborating with Treasury to channel funds from environmental impact assessments infrastructure development towards health sector priorities (eg. up to 2% of all capital (infrastructure) projects and, providing fiscal and monetary policy incentives (such as tax breaks and low interest financing) to manufacturers producing quality assured products in the respective counties. Both levels of government can also ring-fence at least 10% of health sector budgets to be implemented by non-state actors to deliver and improve quality of health services within difficult and hard to reach areas; maintain infrastructure and equipment; implement critical prevention and care interventions for key and vulnerable populations, among others.

Need to ensure Social Health Protection for vulnerable groups as per the Constitution: Financial protection schemes at both levels of government need to be progressively consolidated to enhance efficiency without losing entitlements). Kisumu, for instance, implements health solidarity cover dubbed MARWA that covers to 41,800 households (approx. 136,000 lives) – indigents under NHIF Super Cover on a partner/county matching contribution. MARWA which is semi-autonomous and administered by NHIF, acts as the aggregator, enabler and innovator of the social health insurance for the county, bringing in critical players in the UHC ecosystem. In addition to the Government's health insurance subsidy program, the counties need to consolidate and expand the schemes and ensure that the benefits packages are harmonized and payment rates standardized across facilities (private, FBO, public).

Strengthen Public Financial Management: This will be through (i) development of Health Sectoral Plans and, integration of Sectoral Plans with County Integrated Development Plans (CIDPs), (ii) budget execution specifically in procurement, reporting and performance management and, (iii) supporting system reviews on budget execution systems. There is also a need to limit the growth in the proportion of wages as a per cent of recurrent expenditure that crowds out much-needed resources for key and priority health inputs. Guidelines by the Senate recommends 50-60 percent, while PFMA (35 percent). Lastly, at least 30 percent of county governments' budgets should go to development expenditures as per 2012 PFMA guidelines

Promote evidence-based decision making: Counties need to invest in technical and operational efficiency analyses for more effective decision making aligned with the PFMA and, to enhance the ability of the public health facilities to deliver quality and affordable healthcare services. Priority areas could include costing, budget absorption, payroll cleansing and staff rationalization analysis, performance-based financing.

CONCLUSION

This Policy brief recognizes that, success of the county governments to obtain sustainable financing for UHC will depend on a multitude of factors that need to be addressed in addition to the proposed health financing reforms. Further, comprehensive, and integrated health care

financing initiatives through the support COG will be required as well as close partnership and coordination with the other actors including National Treasury and Ministry of Health.

CALL FOR ACTION BY THE KEY ACTORS

1. **Senate:** Review of the recommendation No 7 and 11 allowing voluntary contributions under the Senate report on the NHIF Act (amendment) Bill 2021.
2. **National assembly and the Senate**: Consider COG memorandum on 2021 NHIF Act amendment Bill that calls for separation NHIF functions and, advocate for implementation of county led financial protection schemes.
3. **Parliament and Senate (health committees):** Legislate for mandatory enrollment to risk pooling schemes for sustainability of UHC roll out- including consolidation and expansion of existing risk pooling schemes towards equitable access to health services and efficiency enhancement.
4. **National Ministry of Health**: Ensure NHIF reforms are guided by KHFS; disseminate KHFS to key stakeholders, notably, Senate, CECs health, Parliamentary Health Committees, counties
5. **National and County Governments**: Take care of the poor and vulnerable for sustainability of UHC and, enforce mandatory social health insurance; ensure health finance reforms are aligned with the Kenya Health Financing Strategy (KHFS); increase budgetary allocations for health and strategic programs (HIV/AIDS, TB,FP/RMNCAH)while ensuring efficient use of the available and future resources; HIV commodities are included in the EMS and, HIV/TB care treatment services incorporated in the essential benefit package towards sustainability; NHIF reforms-separate pooling and purchasing functions in line with KHFS

COG/Counties: Deliberate shift from input to results based financing; obtain seamless health finance transition starting with commodities security, HRH, supervision and capacity building; increase allocations to primary health care and, pre-payment schemes; ring-fence funds for health guided by the new Facility Improvement Funds (FIF) Guidelines and accompanying Model law and undertake rapid assessment of county health fiscal spaces to inform health finance transition