COUNCIL OF GOVERNORS

Final Assessment Report on The Status of Implementation of Facility Improvement Fund at the County Level

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1. Background

Cost sharing is not a new phenomenon in Kenya. The practice was introduced in December 1989 to help address challenges of increased demand for quality health services and education sectors. The education sector pioneered this practice of funds being ploughed back into the parent institutions. In the pre-devolution context, health centers and dispensaries were already collecting and retaining user fees within laid down structures and systems. of service delivery. To ensure that the poor and vulnerable populations were not disadvantaged, an elaborate waiver system was established that included a criterion of identifying those who cannot pay through engagements of the social workers, exemptions for priority population cohorts e.g., expectant mothers, children below 5 years, strategic programs such as Malaria, HIV/Aids and Tuberculosis among others.

The demand for quality and affordable health care services has continued to increase over the years, and this hasn't been matched with adequate financing to meet all healthcare demands. Kenyans are entitled to the highest attainable standard of health, which includes the right to reproductive health care services and emergency medical treatment.[1] Cost sharing thus was seen as a supplementary mechanism on health care financing to solve the perennial problem of availability and predictability of funds for hospitals to finance health service delivery. Cash payments and reimbursements from public health insurance such as the National Health Insurance Fund (NHIF) were to be raised, retained and used at the health facilities account while the government supplemented with additional direct financing to help facilities respond to meet the health needs of the population through quality health service delivery. This was what came to be known as the facility improvement funds (FIF).

By applying the FIF model, between 1999- 2001, some of the facilities tripled their revenue. Some of the factors that contributed to this good performance included:

- Good management practices that included better prioritization and use of available resources
- Active involvement of the in-charge and facility staff
- Setting targets (aggregate facility and respective units) and
- Rigorous monitoring performance (to keep track of the gaps between targets and achievements)

Out of the total collections, 75% of the revenue was retained for use by the generating facility and the balance was used to finance primary and preventive health care activities in the district where the money was collected. This resulted in improved health services. At the time less than 4% was allocated to the health sector and that justified the need for sharing some of the revenue to support primary health services.

[1] Article 43 of the Constitution of Kenya

In 2002, the Ministry of Health provided an operational manual for health centers and dispensaries. This manual was meant to support health facility improve collection, use of the funds and enhance patients and staff's satisfaction with services. [2] The new constitution (2010) resulted to devolution with 47 county governments. Key among sectors that was devolved was health with the County mandated to allocate resources to health facilities and delivery health services at both primary and secondary health facilities. With the inception of devolution, Counties re-centralized revenue collections from hospitals and health facilities under the County Revenue Fund account (CRF). This meant facilities lost the revenues they collect and loss of incentives on the part of health managers since the operational responsibility shifted from the health facility to county treasury. On the other hand, disbursements from the CRF were delayed, and because of competing priorities, facilities got far less than they had collected; the net effect was low revenue collections way below the pre-devolution period. With unpredictable resources, and far less amounts when finally disbursed, services delivery was impacted negatively. In some Counties health services almost became non-existent or witnessed deterioration of quality of health services offered.

Some Counties tried to solve the challenges resulting from complicated funds flow because of all the revenues being transferred to the CRF. While some of the counties tried by developing legislation, there were mixed results and hence failed to solve the funding flow challenges. Counties like Nakuru allowed the Nakuru referral hospital and level 4 hospitals through a legal notice, to raise, retain and use revenue. Coupled with administrative support, the hospital superintendent and management team were allowed to operate as an entity (by employing the accountants and procurement officers) in FY 2014/15. Over the years they have also implemented key reforms to strengthen revenue management and hence positively affecting delivery of quality health services with very impressive results. Other Counties established fund accounts at the County Departments of Health hence all revenue received at the health facility first was transferred to this fund account. As part of the requirement of the Public Finance Management Act (2012) the Fund accounts must engage a fund administrator and an independent board to provide oversight. However, the use of the fund account and administrator has not exactly resolved the complicated funds flow mechanisms and has resulted to the same delays as those experienced with the CRF and hence not positively improved health services.

It is against this backdrop that this assessment was undertaken to confirm the status of implementation of FIF, document success stories into a compendium and develop a policy brief that can guide the counties towards successful implementation of financing model for health services.

Suffice to note, the health care system is a continuum from the referral hospitals to the community. The community plays a major role in advocating for preventive and promotive health care to reduce incidences of illness that would require medical treatment. While Kenya has a very strong public health policy and legislation, recent years has seen public health being relegated behind curative care.

[2] FIF Operational manual – Health Centers MoH December 2002

The community health services has also focused more on primary health care than preventive and promotive services. A strong link between public health at community level, primary and curative services through health facilities will enhance the continuum of health services from the community to all other levels of health care. Public health cuts across all these levels. It is in this regard that this assessment recommend the renaming financing model from facility Improvement Fund to County Health Facility and County Public Health Improvement Financing to integrate public health as an important component of this financing model to facilitate support for public health activities at the community level.

2. The Assessment Context

2.1 Assignment Rationale

The Council of Governors (CoG) in partnership with AMREF commissioned this assignment to deliver an assessment report of FIF implementation at County level. This assessment will thereafter inform the development of a policy brief on the implementation of FIF in Counties and also feed into the generation of a compendium on the good/best practices on FIF in Counties.

The work included assessing the different mechanisms Counties developed on the FIF and how these are working to ensure resources raised by hospitals, health facilities and public health units are managed and accounted for. The assessment examined the existing systems, processes and structures, experiences and lessons learned, including challenges faced by the funding models adopted. The study also identifies the successes in FIF implementation and these are reflected in the recommendations for consideration.

This assessment was coordinated through the Maarifa Centre - the CoG knowledge sharing and learning platform. The lessons highlighted in this report are intended to strengthen FIF implementation and public health in the Counties. The FIF success stories will be deposited in the Maarifa Centre e-platform and will be utilized for peer to peer learning on matters FIF.

2.2 Scope of work

In order to achieve the objectives of the assessment, the terms of reference provided detailed scope of work. The Terms of Reference (ToRs) provided clear description of the task, areas to be covered and elaborated on the process to be followed. The scope of work included the following:

- Examining the implementation of different models of Facility Improvement Fund (FIF) implementation in the Counties- (an assessment); and.
- Generating a policy brief and key recommendations for FIF implementation in focus Counties.
- Documenting best practices and lessons learnt by examining the process of developing FIF andpolicies, legal and institutional frameworks, implementation.

The key findings confirm that FIF is indeed being implemented through various models across the Counties and mixed results can be seen from the different models.

2.3 Methodology

The assessment applied two methods:

i. Review of secondary data (policies, national and County laws, regulations, FIF manuals and FIF reports); and
ii. Primary data collected through individual interviews with County officials and selected partners working on FIF.

2.3.1 Documentary review/ secondary data

As part of the assessment, the following documents were examined:

- FIF policies, laws, regulations and guidelines from the 15 focus Counties;
- FIF evaluation reports;
- Existing operational manuals (at the national and County levels); and
- Reports from the Ministry of Health on FIF.

Review of the above materials was an integral part of understanding FIF practices before and after the inception of devolution. Analysis of the secondary data was useful in teasing out what has worked and what has not worked in FIF implementation.

2.3.2 Primary data

Interviews were conducted with the following:

i. County officials from six (6) Counties namely Makueni, Kilifi, Mombasa, Meru, Kisumu and Nakuru. Virtual meetings were held with two (2) Counties- Garrisa and Narok.
ii. Officers from CoG, AMREF, Thinkwell and other relevant partners.

The selection of the Counties was purposely done in consultation with CoG. The purpose of the County visits was two-fold:

- To engage one on one with County officials who are directly implementing FIF; and
- To observe how the FIF structures and systems work.
- To identify lessons learnt and document best practices

The County visits helped to confirm the information provided by the documents and enabled the consultant to experience the actual implementation of FIF. Interviews with County officials provided an opportunity to discuss how actual implementation deviates from what is provided in the County laws or regulations. Where there are no laws or regulations, the visits helped the consultant to understand how FIF is being implemented.

3. Objective and Principles of FIF

The need for County health facilities to apply sustainable financing mechanisms for improved service delivery is a priority for all County Governments. This assessment was guided by the knowledge that section 5 (1) of the Public Finance Management Act enables the County Executive Committee Member for Finance, with the approval of the County

Executive Committee and County Assembly, by order in the Gazette, declare a body to be a County Government entity. This is meant to:

(a) allow the entities retain revenue collected to finance operational and maintenance costs guided by section 109 (2) (b) of the Public Finance Management Act, 2012; and
(b) facilitate the governance structures and accountability measures to support county hospitals, health centers and public health units manage FIF.

3.1 Principles of FIF

FIF implementation should be guided by the following principles, that:

(a) health services are available, accessible, acceptable, affordable and of good quality and standard;
(b) health facilities are well funded to offer quality health care to all patients;
(c) public health services are well funded to ensure that quality promotive and preventive services are provided at the community level;
(d) accountability, transparency and integrity is upheld, observed and protected in the collection, management and use of revenue; and
(e) revenue generated by the entities are considered to be additional to the budgets appropriated to the entities by the County Assembly or Parliament and not a substitute.

3.2 FIF revenue

From the County visits, it emerged that FIF monies include the following:

I. monies received as user fees and charges;
II. monies received as capitation from the National Hospital Insurance Fund (NHIF);
III. monies received from the National Hospital Insurance Fund as reimbursement for services prescribed in the National Hospital Insurance Fund Act;
IV. voluntary contributions from public officers and private persons;
V. grants and donations from other county public entities such as the municipalities and water companies;
VI. in-kind donations from well-wishers such as medical equipment and supplies, pharmaceutical and non-pharmaceutical supplies and relief foods;
VII. monies appropriated by the County Treasury; and
VIII. monies from any other source approved by the County Treasury.

3.3 Benefits of FIF

For the Counties that are implementing FIF, the following benefits can be traced:

(i) financing the operational and management costs for the health facilities has been made possible;
(ii) more readily available funds leading to improved daily operations;
(iii) procurement of health commodities and products for the health facilities has been made easier and predictable; and
(iv) the ability of the facilities to have a level of autonomy in budgeting for the funds that are ploughed back to its operations.

3.4 Current implementation of FIF

Currently, FIF is collected by the following facilities:

i) County Referral hospital; and
ii) Sub-county hospital.
iii) Primary level facilities – especially from reimbursements from health insurance and direct government transfers

Public health units also collect revenues charged for services provided. All revenues collected are transferred to the CRF. This means that revenues from public health have been un-available to the public health unit. Health centers and dispensaries provide services for free following the removal of user fees policy in 2013 but receive revenue reimbursement for the free maternal health services from Linda Mama program under NHIF. Health centers and dispensaries have also relied on donor funding – especially Danida and World Bank to finance their operations. FIF will support the public health units and health centers and dispensaries to access reliable predictable and sustainable resources to improve their services.

4. Governance structures supporting FIF

4.1 Organisation and Management

4.1.1 County Department of health

All County hospitals, health centers dispensaries and public health units are oversighted by the County health department through the office of the County Executive Committee Member (CECM) Health. The CECM provides oversight in planning, budgeting and implementation of the devolved health functions. The accounting officer is the Chief Officer (CO) for Health. The County Director of Health is head of technical issues in the CDoH providing technical support to the CO and CECM Health The role of the CO in providing oversight of the FIF includes:

(i) ensuring that the annual work plans and budgets from all county health facilities and public health units are reflected in the consolidated county annual budget;
(ii) approves all quarterly budgets;
(iii) issue quarterly AIEs to all facility in-charges and the public health officer aimed to cover operations and development of the facilities,
(iv) approve all county appropriation for county health facilities and public health units
(v) receive form county health facilities and public health units monthly, quarterly and annual financial reports and forwards them to County Treasury;
(vi) monitor performance of all county health facilities and public health units.

4.1.2 County Hospitals, health facilities and public health Units

The Kenya Health Policy (2014-2030) identifies the health facilities as follows: a) Level 6 – Tertiary Hospitals (Level 6), b) Level 4 and 5 – as county hospitals, c) Level 3 and 4 as primary health facilities and d) Level 1 – community units. These differences further dictate how their management structure is established. To ensure that they are effectively managed and deliver quality health services, they all have oversight by the Hospital Boards and Health Facility Management Committees (HFMCs) that comprise members of the

community and also team members from the facility departments heads (Hospital/Health Facility Management Team (HMTs).

The County hospitals and health centers are managed different because of the difference in services they offer. Hospitals are big institutions offering specialised services and managing a large amount of money. They have a board at the apex of their decision making process.

The Hospital Management Team has the primary responsibility of running the hospital and is made up of the following (this team may vary from County to County);

(i) the Medical superintendent who is in charge of the hospital;
(ii) the hospital administrator;
(iii) the nurse in-charge;
(iv) the hospital accountant;
(v) the pharmacist; and
(vi) the hospital procurement officer.

Findings show that the Hospital Management Team prepares and presents the annual work plans and budgets for approval to the hospital board. Indeed, these bodies play a very important role in the implementation of FIF.

4.1.2.1 Role of the hospital board

This study found that the hospital boards provide oversight in the management of the hospital by approving the hospital annual work plans and budgets; ensuring that the hospital is delivering services efficiently and effectively; and ensuring that the financial and procurement rules are being followed.

This is a key governance organ in the management of FIF by the hospitals.

4.1.2.2 Health Centers and Dispensaries

Health centers and dispensaries are small institutions managed by either a clinical officer or a nurse in-charge. The facility committees include members of the community they work in.

The committee has 8 community members three of whom must be women from the catchment area. The main role of health facility committee is to support the decision making process of the facility in-charge, especially the financial and general management of the dispensary and health center. The committee also ensures accountability to the community they operate in.

4.1.2.3 Public health units

Public health officers operate in the health facilities and at the community level. Those working in communities are organized within units comprising of 10 community health units. Their roles include promotive and preventive health services. They also support addressing determinants of health relating to water and environmental issues at households.

Public health works closely with community health volunteers to create awareness at community level on health issues and promote health seeking behaviours.

5. Key Findings

5.1 County Facility Improvement Financing

Cost sharing or charges for services in public hospitals as mentioned in the background started in 1989 as part of the economic structural adjustments the country was implementing at the time. In 2002, the FIF guidelines were provided and structures established to allow accountants in health departments. In 2009, health facilities were allowed to charge 10 shillings for dispensaries per patient and 20 shillings for health centers. Health facilities including the primary facilities were allowed to raise, retain and use revenues but account to the district treasury.

The introduction and establishment of County Governments through devolution, has revolutionised service delivery in the country. In accordance with the Fourth Schedule of the 2010 Constitution, health sector functions were shared between national and counties, while County Governments are responsible for implementing and delivering health services, the national Ministry of Health is mainly responsible for policy formulation, national referral hospitals and capacity building. This means all health services from community units (Level 1) to level 5 hospitals are under the County Governments.

Counties inherited hospital structures that existed before devolution. Counties also took over the responsibility of managing facilities and their functions. The County health management teams (CHMTs) have replaced the district and provincial health teams. The CHMTs provide supportive supervision to the health facilities management teams. The community level structures have remained unchanged mainly with community health volunteers (CHVs) and the public health.

The Public Finance Management 2012 at section 17(6) defines the financial systems that deliver funds to the County departments including health facilities. Counties have been using the systems since their establishment in 2013. Transfer of funds and reporting of expenditures is done through the Integrated Financial Management Information System (IFMIS). IFMIS is connected across all Counties. It is a legal requirement that all government entities use this system for all public financial planning, budgeting, transactions and reporting in compliance with the Act.

How counties interpreted and implemented the PFM Act (2012) affected the way hospitals – levels 4 and 5 operated especially in relations to the raising, retaining and use of health facility revenues. Prior to the devolved system of governance, hospitals had been allowed to collect, retain, plan and spend the revenues. The PFMA was enacted and it was expected that all revenues collected by hospitals would be deposited into the County Revenue Fund account (CRF)- which is the consolidated account for County revenues under the control of the County treasury as mandated by the PFMA. This requirement in effect re-centralised all hospital and public health collected funds and would always result in commingling of collected health facility revenues with all other County revenues. Eventually, the facility revenues would be planned and budgeted for as part of the larger CRF kitty and this distribution would be dependent on County preserved priorities.

As a result, monies transferred by hospitals to CRF would not be ploughed back to the hospitals. The allocation to hospitals would be much less than contributed and it would be irregular and sometimes occasioned by undue delays. As a result, health services became severely affected with poor or non-existent supplies. Consequently, the quality of care deteriorated and in some Counties almost collapsed.

A few Counties like Nakuru used legal notice that allowed hospitals to retain revenues collected especially by the level 5- County referral and level 4- sub-county hospitals. This decision triggered the evolution of the Facility Improvement Fund (FIF) that has now taken various forms in different Counties.

Suffice to note that this assessment concludes that the use of the word "fund" in reference to the FIF has been mis-interpreted differently by Counties. Some Counties have proceeded to establish a fund with a fund manager/administrator appointed by County Treasury yet section 109 (2) (b) of the PFMA can be invoked to allow County health facilities to be treated as entities to allow them retain and account for revenues they have collected.

Nakuru level 5 continued to provide services because the County leadership and hospital management decided to allow the hospital to run its hospital account and continue retaining the revenues collected for services offered. The system of revenue collection that existed before devolution continued and improved under the County management- making Nakuru level 5 hospital a leading institution from which other Counties can learn.

6. Different Practices

There exists two systems of the FIF (in this context meaning facility improvement financing), namely:

1) the fund approach where a County enacts a law establishing a fund with a fund manager; and
2) the ''old system" approach where a County operates under the pre-devolution system by utilizing a facility account established through a legal notice, an Executive Order or guidelines.

6.1 Counties with FIF Laws

The first question that guided the consultations and interviews with County officials and partners that are supporting Counties, was the regulatory and institutional framework guiding implementation of FIF. Even though the assessment focused on 15 Counties, interviews especially with partners confirmed that there are many Counties that have established a law to guide them in the implementation of the FIF.

The table below shows Counties with FIF legislation and those either with draft bill or are yet to start the process.

Counties with a legislation on FIF		Counties that have not established any law
• Kilifi • Laikipia • Nyeri	• Busia • Vihiga • Nandi	• Kirinyaga • Embu (draft bill)

• Kiambu • Turkana • Kisumu • Isiolo • Bungoma	• Trans Nzoia • Kericho • Kisii • Nyamira	• Homa-bay (draft bill that was never passed in the county assembly) • Kitui • Wajir • Garrisa • Meru (developed a bill that was never passed by the county assembly) • Nakuru is using a legal notice (gazetting the hospital account)

Most of the Counties that have enacted a law have provided for setting up of a Fund with a fund manager/administrator. Except for Laikipia, Meru, Kiambu and Nyeri Counties that have similar laws, majority of the rest of the Counties have laws that differ at the operational level. Some of the differences include amounts in terms of percentages that is ploughed back to the hospitals through the fund manager/administrator. For example Kilifi County returns 70% of the amount the facility has collected, 20% goes to lower level facilities- dispensaries and health centers that do not charge a fee for services. 7% is provided to go to the County health management teams for supportive supervision while 3% pays the fund manager.

Busia County ploughs back to hospitals 70% of the amounts the facility has collected, 27% goes to CHMT while 3% is provided to the fund manager.

Siaya County allows hospitals to spend 75% , while 25% is sent to another County account that is operated by the CHMT. The Embu County FIF Bill proposes 80% to hospitals, 15% provided for waste management while 5% is sent to CHMTs. Makueni and Nakuru Counties allow facilities to retain 100% of the hospital collection. The best practice is where the facilities can retain 100% of the revenue while the County takes care of all other health systems costs including financing of primary health care and CHMTs/supervision costs, because FIF is supplementary financing and does not cover all hospital running costs.

Additionally, the structures and flow of funds differ from one County to another. For example, Kilifi hospitals transfer all collected monies to the CRF. Every quarter, the CRF transfers the hospital collected revenue back to the Fund and after the approval of the plans, the fund manager gives the hospitals authority to incur expenditure (AIEs). This means the fund manager assumes the responsibility of accounting officer. Some of the risks that come with this mode of operation include the possibility of operational conflicts, bureaucratic processes leading to delay in access of the funds by the facilities.

In Makueni County, all the monies are banked into the hospital account. The funds are available to the facilities for use after the plans are approved by the budget committee constituted by the CO for health. This committee include officials from the County treasury. The purpose of including representatives from the County treasury in the budget committee is to ensure the County treasury is involved in the approval of the hospital plans and financial decision making process. This involvement emphasises on department of health and County treasury oversight role in the management of FIF in Makueni,

6.2 Counties that have established FIF with a Fund Manager.

During interviews with partners supporting health financing in Counties, it was confirmed that there are many Counties that have adopted the ‘’fund management’’ model. Examples of these are Kilifi and Kisumu Counties that have passed respective County laws anchoring this model. While the reasons advanced on the creation of a fund and appointment of a fund manager is accountability, observations from all the counties that have established the FIF Fund Account point to a) bureaucratic process – delays in either appointing the fund manager, b) possibility of operational conflicts and reporting mechanisms, c) the fund has not necessarily strengthened the operational management of the own source revenue. The negatives created by the fund and fund management to the health facilities accessing the resources exceed the benefits it creates.

At the beginning, the Kisumu County FIF law did not include a Fund with a manager. It had foreseen the operationalisation of the FIF through an account similar to the hospital account before devolution. But before the draft was approved by the County Assembly, it was revised to include a fund with the fund manager/administrator. The fund manager/administrator would be appointed by the County Executive Committee Member (CECM) for finance. To date the manager/administrator is yet to be appointed, hence the fund is not operational. Further, regulations to guide FIF operations have been passed. However, these regulations reflect the original intent of the FIF- of managing the FIF through a hospital accounts. Thus the regulations and the law passed by the County Assembly are not aligned. This points to the fact that there should be consistency in the legislations that are presented before the house for approval.

Despite this, Kisumu County hospitals are collecting revenues and banking them in hospital accounts. The account that receives the collection is also used for expenditure. Reconciliation is done every three (3) months. Authority to Incur Expenditure (AIE) is issued by the CO of health and financial reports are provided to the County Treasury. These reports have both totals of revenue collection data and expenditure data. Collection and banking is done manually. However, the hospital uses banking agents for banking directly into the hospital account. The cashier only issues receipts on cash paid for services and the bank agent issues a banking receipt showing money received. This initiative has reduced leakage to a good extent.

Kilifi County on the other hand with a total of 9 collecting hospitals has operationalised the Health Services Fund (HSF) guided by its law. The fund is managed by a fund manager appointed by the CEC Treasury for a period of three years. All revenues collected by the hospitals are deposited with CRF and then transferred to the FIF Fund.

All collecting hospitals have a board – a health Improvement facility board. The hospital also has a hospital management team made up of the hospital medical superintendent, hospital administrator, hospital pharmacist and a nursing officer. The team compiles the hospital plans for approval by the hospital board and submits the same to the fund manager. The fund manager working with a Fund management committee reviews all hospital plans and budgets and forwards them to the Fund County board for final approval before AIEs are issued by the Fund manager. Every quarter, the Fund manager transfers amounts approved by the Fund County Board back to the hospitals. Expenditure reports

are made every quarter. The entire process takes about a month to finalise. The approval processes cause delays although they are not chronic.

Counties that have taken the fund management approach have applied the PFMA section 109 (2) (a) instead of (2) (b). Unfortunately, this model is still faced with a myriad of challenges including:

- Delayed disbursement of funds to hospitals caused especially by the approval requirement of the Fund County board whose members take time to sit to approve the hospital budgets.
- Facilities receive about 70% of the collected funds.
- Accessing the funds for other uses other than for health service delivery through inter-departmental borrowing without returning the moneys into the Fund. This means that sometimes hospitals receive less than the 70% they are entitled to. Money borrowed by other departments is not returned hence less money for hospitals. This opens the fund to abuse as it is not insulated- funds are not completely ring-fenced for hospitals only.
- The fund introduces additional bureaucratic levels of approval that result in delayed disbursement of funds to hospitals.
- The Fund manager takes over the accounting officer's functions. This is despite the fact that the CO is responsible for financial accountability of all the funds under the health department as provided by PMFA.

In Kilifi county, inter- departmental borrowing from the Fund not only exposes the fund to risk of abuse, but also reduces the money available to hospitals thereby defeating the purpose of setting up the fund. Additionally, the Fund Manager office is vulnerable to political manipulation because it operates at the mercy of the County leadership. Kisumu County is a good example of how this problem has manifested itself where the office of the administrator is yet to be established to operationalize the Fund despite the same being embedded in law.

6.3 Counties that operate FIF with hospital/health facility account

Nakuru and Makueni Counties provide examples of Counties operating FIF using the hospital account. After devolution, the County health department and the management of Nakuru level 5 hospitals formerly the Provincial General Hospital-PGH) agreed to retain the hospital account that the hospital operated before devolution. The County leadership allowed the hospital to collect, retain, plan and manage the revenues collected for services provided by the hospital. The hospital management team lead by the hospital superintendent is responsible for planning and budgeting for the collected revenues. The hospital board is responsible for approving the plans and budgets before submitting the same to the CO for health. Once the CO approves the plans and budgets, an AIE is issued to the hospital to spend. Nakuru's FIF management is straight forward and avoids many bureaucratic processes that may result in delays. Disbursements are immediate because the revenues are held in the hospital account.

An accountant is attached to the health facility to facilitate reviews of the budget and ensure each activity that is planned for has a budget line and that there are sufficient funds

for expenditure. By allowing the hospitals to retain and use 100% of collected revenues, quality of service has improved and revenue collection has also increased steadily.

Makueni County manages FIF in a similar manner like Nakuru County. Most of the Counties visited managing their FIF through hospital accounts keep 100% of the collection.

7. Observations

(i) A general observation is that Counties that have established funds with a fund manager/administrator have not been able to plough back the funds into the facilities easily and efficiently. The problem was to reduce delays in disbursement of funds from CRF and ensure hospitals got in a timely manner the revenues they have collected. The establishment of the fund manager added a bureaucratic layer that delays approvals of work plans and budgets. However, flow of funds to facilities is much improved than before.

(ii) Not all funds collected from facilities are ploughed back 100% in Counties managing FIF from a fund. Facilities are getting at least 75% of their collection which is also a much improved allocation than before.

(iii) The fund managers are working at the discretion of the current leadership therefore opening up the fund management to risk if the fund managers does not agree with County leadership. The managers in Counties with a FIF Fund have three-year contract and no office tenure.

(iv) The inter-department borrowing, though allowed, poses a risk to the Fund. It was confirmed in Counties experiencing this kind of borrowing that the money is not refunded. This means money meant for health services is not completely ring-fenced. This opens the fund to fiduciary risks.

(v) Some Counties like Kisumu and Meru each have a law that remains inoperable. Kisumu specifically, has developed regulations that are in contradiction with the law (the law established a fund with a fund manager). The regulations confirm that funds collected by the hospitals are managed from the hospital account not by a fund manager as envisaged in the parent law. Currently, Kisumu County is relying on the regulations to implement FIF.

(vi) Apparently, Counties like Makueni, Nakuru and Mombasa that are operating their FIF through hospital accounts do not face the mentioned common problems. Their hospitals are receiving 100% of the funds they have collected.

(vii) All Counties with FIF have the hospital boards and facility committees that mirror the institutions that had been created by the pre-devolution Ministry of Health guidelines. The composition of the boards and the committees has not changed.

(viii) However, practice differs from one County to the other. Makueni and Meru Counties, for example, has added an ad hoc expenditure committee that is constituted by the Chief officer for health and includes the County treasury officials.

This committee reviews all the quarterly workplans and budgets for the hospitals. All hospital budgets approved by this committee are issued with AIEs. Makueni County has perfected the budget approval process starting from the hospital management teams, to the hospital board and finally to the ad hoc expenditure committee. The different committees work seamlessly to avoid delays, taking a maximum of one week to the issuance of the AIE. As a result, hospitals in Makueni have no financial problems as they receive money at the beginning of every quarter.

(ix) The predictability and availability of the funds has facilitated County hospitals to plan for operations as well as development. In Makueni County for example, Wote hospitals have been able to build and equip a casualty and buy other hospital equipment in the last five years. Staff motivation has also been addressed by providing training and locums for doctors. In addition, all health committees have been trained on their roles and responsibilities.

(x) The process of the approval in Nakuru County starts one month before the end of the quarter, ensures AIEs are issued at the beginning of every quarter. The health accountant validates all the hospitals' quarterly budget to confirm there is money in the budget specific votes, before the CO issues AIE. The health accountant also approves all the hospital payment vouchers and cheques. This is likely to be cumbersome if the lower health facilities are brought on board.

(xi) Regarding use of IFMIS and special purpose account (SPA) to ringfence the hospital funds, most of the Counties especially the health accountants confirmed they would be open to embrace use of IFMIS because this would increase transparency. Nakuru County specifically confirmed that adopting IFMIS would ease the accounting work including processing payments currently being done manually. Kilifi County on the other is open to using SPA to facilitate ring-fencing of money in the Fund. SPA would also ensure funds are managed through IFMIS and inter-departmental borrowing without refunding would reduce.

(xii) On reporting both for financial and technical performance, all Counties visited reported no delays in submitting of performance (technical and financial) reports.

(xiii) County health facilities are not comfortable providing information with respect to the total revenues collected. It is assumed that they fear this disclosure may lead to reduction of their County appropriation to the hospitals. The original intention of was allowing health facilities to supplement health services financing with their revenues but not preventing any additional allocations that must be appropriated by government. Revenue collected by health facilities should be treated as appropriation in aid and they are not sufficient to cover all hospital costs.

8. Public Health Units

Public health units collect levies and fees for services offered at the community level yet no county has focused on how to strengthen the public health services and strongly link them to the community health services- yet the two work at the same level addressing same health issues.

Focusing on this revenue stream can be reliable to support community health activities at Level 1 related to preventive and promotive services. However, since 2013 all funds are transferred to CRF making the revenues unavailable to the health system. In many counties, the public health activities have stalled or irregular due to lack of funding, yet revenues collected and retained by public health units can be used to provide the basic funding as the county health systems provide additional complementary funding. Nakuru for instance, has been collecting at least Ksh. 500m annually making it a significant source of revenue for the health sector. Integrating public health as part of the county health facility and public health improvement financing, will also center the community health service under the public health and provide supportive supervision to the community health volunteers.

9. Recommendations

From the findings, the report recommends the following:

(i) Counties to apply section 109 (2)(b) of the PFMA.

The perennial problem of delayed financing of County health care services can be addressed by Counties allowing hospitals, health facilities and public health units to collect, retain, manage and account revenues from services rendered. Implementation of the facility improvement financing guided by the PFMA 109 (2) (b) will enable Counties to declare these facilities as entities. Counties will support health facilities build the right capacity for accountability and transparency.

This action will provide a semi-autonomous privilege to the facilities hence allowing the hospital superintendents, health facility in-charges and public health officials to be responsible for the revenues they collect in their facilities. The semi-autonomous privilege does not remove the oversight role of the CO for health and County treasury on the financial management of the FIF, rather, this resolves the delay of disbursement of funds, ensures what the facilities collect is ploughed back to improve the facility. This also ensures predictability and reliability of resources that will facilitate planning for supplies of commodities thus increasing the quality of care to the majority of Kenyans.

(ii) Renaming this finance mechanism to 'County Health Facility and County Public Health Improvement Financing" and move away from the use of the word "Fund".

Majority of the Counties have mis-interpreted the word " Fund" to mean establishing a Fund with a fund manager instead of "financing health care services." It is recommended that the term "Fund" is replaced with "financing" to emphasize that this is a financing mechanism that does not require the establishment of the Fund with elaborate, bureaucratic fund management.

These Counties face increased bureaucratic processes that have not solved the problem of delayed disbursement. The creation of the office of Fund manager has also taken away the role of the CO of health to provide the AIEs to hospitals, removing the check and balances provided by the County department of health over the funds. The office of the

Fund manager also increases the administrative cost hence reducing the amount of money going back to the hospitals.

Counties using the "old way" of managing the financing through a hospital account entrust the responsibility of management of the revenues to the hospital and health facility management with strong oversight from the health department and County treasury.

Counties like Nakuru, Makueni and Mombasa present best practices of operationalising the financing without establishing a Fund and instead operating hospital accounts that are both collecting and expenditure accounts. This has ensured County hospitals are semi-autonomous with strong oversight both from the hospital boards and facility committees and county health leadership.

In addition, the renaming of the financing model will include public health revenue collected, retained, planned for and used by county health facilities and county public health units will avail revenues to defray costs of operations and maintenance of health service from levels 5 to level 1 community health service. This will also ensure public health units support the community health services both from a promotive, preventive and primary health care services.

(iii) **Counties to facilitate inclusion of dispensaries and health centers into financing model because the facilities are collecting funds from NHIF and Linda Mama programme.**

This will prepare them to collect funds from the scaled up UHC program that has been rolled out since February 2022. This will encourage these facilities to register more clients for Linda Mama and other services especially under NHIF.

(iv) **Counties to facilitate inclusion of public health units into renamed financing model with a view to retaining at least 50% of revenues collected.**

These funds, however, must be invested towards promotive and preventive and primary health activities at the community level.

(v) **Counties to include financing model in their health policies and support use of hospital accounts for managing FIF.**

Annex 1: The questions guiding the Interviews:

General questions:

1. Does the county have a health policy? What are the provisions in the policy on funds mobilisation- from:
    a) County Treasury to the health facilities
    b) Generated by the facility
    c) From partners?
2. What is the estimated amounts of funds available from the county treasury to each level of the facility? Are the funds adequate to cover the improvement of facility activities included in the annual workplans?
3. When country treasury delay disbursement, what happens to service delivery at each level of facility?
4. What needs to be done to facilitate health facilities retain the facility generate funds:
    a) Defining levels of responsibilities between the county's treasury and department of health- separation of roles and duties
    b) Are governance and financial structures and systems adequate to support the management and accountability of the funds by the health department
    c) Flow of funds systems- How are the systems and what needs to change under FIF?
    d) Do facilities have comprehensive annual workplans and budgets to facilitate use of the facility funds?

Specific questions to counties with FIF experience

5. Confirm estimated amount of cash each level of facility is able to raise since establishment of FIF
6. What is the county experience with management of FIF?
7. What has been the experience of facilities managing FIF in terms of capacity to manage and account for the funds?
8. What structures and systems already exist for smooth funds flow for facility improvement?
    a) Are they well understood
    b) What are the bottlenecks in the flow of funds and what needs to be done to address them?
9. What has the county done differently- for those who have succeeded either with health financing policy, law/ regulations or without?
10. What lessons can we learn from the counties that have successfully ringfenced funds generated by health facilities

Annex 2: List of people interviewed

Name and Title	County
Khatra Ali	Director- Health COG

Rosemary Njaramba – Strategic Planning- Head of Maarifa Center- COG	COG
Zahra Hassan	COG
George Mitana Apiyo- Project Coordinator HSS- AMREF Health Africa in Kenya	COG
Robert Rapando- Health Department/ FIF/CHS -COG	COG
Catherine Mwongeli Ngave	
Jane Kimbwarata, KM Consultant,	Maarifa Centre COG
Boniface Mbuthia- technical Advisor PFM, Kenya	ThinkWell
Isaac Ntwiga - technical Advisor AMREF	AMREF
Dr. Okello - Consultant National Assembly	
Jemimah Kuta	
Dr. Sam Nyingi	
Dr Kennedy Otieno- Director and FIF Focal person	Kisumu County
Dr. Elizabeth Kitoo, Medical Director, Department of health services	Nakuru County
Mburu Dominic Gitau, County Health Administration Officer, Department of health services	Nakuru County
Mary Wangari, Health Department Accountant	Nakuru County
Rita Ochola, Community Health Services Focal Person	Nakuru County
Christopher Maitha Muthama, Focal Person for Community Health Strategy,	Makueni County
Jopha Kitonga, County Health Administration Officer	Makueni County
Dr Shem Patta, Director of Health,	Mombasa County
Nancy Mukui, FIF Manager,	Mombasa County
Catherine Munywoki, Head of Preventive & Promotive Health Services,	Kilifi County
Dr. Cecilia Wamalwa FIF Focal Person	Kilifi
Kilifi Fund manager	Kilifi
Dr. Koome Muthuri Director Medical Services	Meru
Benjamin Kobia, CHS Coordinator,	Meru
CPA Henry Gatobu- Health Department Accountant - FIF Manger	Meru
Chief Officer	Garrisa County