Policy Brief on the Implementation of Improvement Financing (HIF) in Counties.

Background of the FIF

Prior to devolution, Public health facilities were allowed by law to raise, retain and use revenues collected (from cash and NHIF reimbursements). This was recognized in the budget as appropriation in Aid (AiA). Out of total collected, 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. Between 1999 and 2001, some of the hospitals tripled their cost sharing revenues and resulted in improved health services across the different levels.

The legal notices (401 of 2009 that created the HSSF for primary health facilities and 155 of 2009 created the HMSF for hospitals) provided the legal framework for bypassing the Consolidated Fund. During this process, there was an acknowledgment that revenue collected by health facilities was not adequate to meet all the needs of the facilities and hence the government supplemented this revenue through grants that were transferred directly to health facilities.

Post devolution, health facilities, as any county entity remit their monies to CRF account. The basis of health facilities remitting their collections to the County Treasury has been the PFM Act (2012) which centralized the county financial management. However, the PFM Act also states instances in which county entities are allowed to retain user fees for purposes of defraying their expenses in line with PFM Act, Part III Section 109 (2) (a, b & c). The cost sharing referred to as facility Improvement financing (FIF) and previously known as facility improvement fund - is the subject of this policy brief.

The finances that make up the FIF include:

The following are the sources of revenues that make up FIF:

(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 or any other health insurance;
(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 Assembly and monies from any other source approved by the County Treasury.

The benefit of FIF to health facilities

Health facilities have easy access to predictable sources of money to:

(i) finance the respective health facilities operational and management costs;
(ii) provide readily available financial resources for optimal operations of the county health facilities all year round;
(iii) improve daily operations to ensure improved access to health services to all county residents;

(iv) establish the county health facilities as procurement entities in line with the Public Procurement and Asset Disposal Act of 2015 and the Public Procurement and Asset Disposal Regulations of 2020;

(v) ensure accessibility and predictability of finances for procurement of essential products, commodities and technologies; and

(vi) enable county health facilities to budget and utilize collected revenue in line with the Public Finance Management Act (2012).

Understanding the Legal Remedies Provided for on the PFM Act (2012)

The PFM Act (2012) allows counties to adopt any of the three options below to enact FIF legislation;

Options	Advantages	Disadvantage
Sec 109 (2) (a) of PFM **Creation of a fund Account**	• May prevent funds from going to the CRF	• Bureaucratic (does not address the real problems and has similar constraints as CRF) • Introduces a parallel management structure • Introduces complex funds flow mechanism.
Sec 109 (2) (b) of PFM **County legislation that allows public entities to raise, retain and use revenues (Best practice)**	• Allows health facility autonomy; • Relies on existing structures (HFMCs); • Tests and improves facility capacity • CDoH and Treasury regain supervisory powers to strengthen accountability • Best approach (done in the past and at Level 6 hospitals)	• Effectiveness may be affected by misinterpretation of the PFM Act; • May be open to abuse if no effective oversight and regulations
Sec 109 (2) (c) of PFM **National Assembly passes an Act of Parliament**	• Can allow uniform application.	• Can be misinterpreted to mean that the national level is interfering with devolution • Politically charged

Lessons Learnt

1. Despite enacting FIF legislations, some counties are not able to address perennial funds flow challenges to health facilities. The Counties that have established a fund (complete with a fund management structure) in line with Section 109 (2) (a) of PFM Act continue to experience operational and implementation challenges.

2. The Counties that sustained the “old system” by operationalising FIF in line with Section 109 (2) (b) and Section 5(1) of the Public Finance Management Act (2012) have better funds flow, increased revenue generation and better service outcomes.

3. Implementation of FIF legislation by counties requires leadership commitment and capacity strengthening for governance structures in the health system.

Conclusion

Most county health facilities including those that enacted laws to establish a fund are faced by the perennial problem of weak financing, delays and unpredictable funds flow. Implementation of the facility improvement financing guided by Section 109 (2) (b) of the Public Finance Management Act bestows operational and financial autonomy to health facilities since they are recognized as 'entities.'

The designation of health facilities as entities with operation and financial autonomy enhances the oversight role of the Chief Officer for Health and County Treasury on health facilities and resolves the delay of disbursement of funds. It ensures that revenue generated by health facilities is ploughed back for continuous improvement of the health services thus addressing predictability and reliability of commodities and supplies.

Main Recommendations

1) That Counties prioritize the enactment and full implementation of Health Improvement Financing (HIF) law as envisaged in Section 109 (2) (b) of the PFM Act (2012).

2) That granting of operational and financial authority to health facilities is a pre-requisite for the attainment of UHC.

3) Counties continue funding to health facilities (Level 2-5) to allow them to respond to the health needs of their catchment population. This is especially in the wake of reduced funding due to transitions experienced on grants that are appropriated directly to health facilities.

   That the term "Fund" is replaced with "financing" to emphasize that HIF is a financing mechanism that does not necessarily require the establishment of the Fund with elaborate fund management structure.

Specific Asks

1) The Members of County Assemblies to enact the Health Improvement Financing (HIF) legislation.

2) That the County Treasury declares health facilities and public health unts as entity

3) Strengthen governance structures across the proposed entities to ensure effective implementation of the Health Improvement legislation.