POLICY BRIEF

Strategic Health Purchasing in Kenya

A Summary of Progress, Challenges, and Opportunities

MAY 2021

STRATEGIC HEALTH PURCHASING FOR UNIVERSAL HEALTH COVERAGE IN SUB-SAHARAN AFRICA

The Strategic Purchasing Africa Resource Center (SPARC), a resource hub hosted by Amref Health Africa with technical support from Results for Development (R4D), aims to generate evidence and strengthen strategic health purchasing in sub-Saharan Africa to enable better use of health resources. SPARC and its technical partners created a framework for tracking progress in strategic health purchasing and are applying it in countries across sub-Saharan Africa to facilitate dialogue on what drives progress and to promote regional learning.

KENYA AT A GLANCE

- Population (2019): **52.6 million**
- GDP per capita (2019): **US$1,817**
- Poverty headcount at $1.90/day (2016): **37%**
- Life expectancy (2018): **66 years**
- Current health expenditure (CHE) per capita (2018): **US$88**
- Domestic government expenditure as % of CHE (2018): **42%**
- Out-of-pocket expenditure as % of CHE (2018): **24%**
- External expenditure as % of CHE (2018): **16%**

Source: World Bank Databank

Health Financing Schemes in Kenya

Kenya, a lower-middle-income country, is commited to achieving universal health coverage (UHC) and improving strategic health purchasing, as set forth in the Kenya UHC Roadmap 2018-2022. The roadmap defines strategies to achieve these goals, including a unified health benefit package, a national accreditation system for providers, and performance-based provider payment.

The main types of health financing arrangements in Kenya include:

- **GOVERNMENT BUDGET FINANCING THROUGH THE MINISTRY OF HEALTH (MOH) AND COUNTY DEPARTMENTS OF HEALTH (CDOHs).** The government guarantees the entire population access to essential health services and medicines, as defined in the Kenya Essential Package for Health (KEPH). Funding comes mostly from taxes at the national level. CDOHs are responsible for service provision, while the MOH is responsible for policy and transfer of funds to health-related semi-autonomous government agencies (SAGAs) such as tertiary hospitals and research institutions.
- **NATIONAL HOSPITAL INSURANCE FUND (NHIF).** NHIF is the country's national health insurance scheme and covers approximately 20% of the population. It has eight major schemes, with multiple sub-schemes. Each scheme has a different benefit package, and benefit packages vary within sub-schemes. NHIF revenues are 95% from enrollee premiums (mandatory for formal-sector workers and voluntary for all others) and 5% from government disbursements for special schemes that provide free or subsidized care for specific populations, such as orphans and vulnerable children, secondary school students, pregnant women, elderly people, and people living with severe disabilities.

Kenya also has private voluntary insurance and community-based health insurance schemes that together cover less than 3% of the population.

Table 1 compares the purchasing functions in three schemes.

Table 1. **Purchasing Functions in Kenya's Health Financing Schemes**

	Ministry of Health (MOH)	County Departments of Health (CDOHs)	National Hospital Insurance Fund (NHIF)
% of Total Health Expenditure (2015/16)*	18.7%	18.2%	4.6%
Main Purchaser(s)	Ministry of Finance (MOF), MOH	County treasuries, CDOHs	NHIF
Governance	MOH and MOF are central government entities led by cabinet secretaries. MOF collects tax revenue and channels it to MOH, whose mandate is policy and oversight of tertiary hospitals, which are SAGAs. MOH defines the benefit package and transfers resources to SAGAs. MOH does not have a role in service delivery at the county level. SAGAs have financial autonomy to allocate funds according to MOF public financial management guidelines for the use of public funds.	Counties are led by a county executive committee member (political role) and a county director of health (technical role). Counties have a constitutional mandate to provide health services at the county level under MOH policy direction. Most county public facilities do not have financial autonomy.	NHIF is a SAGA under MOH. It is headed by a board representative of key stakeholders that makes strategic decisions on the benefit package, contracting, and provider payment. Private facilities have autonomy to use NHIF revenues, but most county public facilities do not. SAGAs and some county public facilities have financial autonomy to allocate funds according to MOF public financial management guidelines for the use of public funds.
Financial Management	The annual budget is based on the MOF circular that provides guidance on preparing the MOH budget and the budget formulation calendar, the Medium Term Expenditure Framework, and historical expenditures and is approved by Parliament. Budget overruns are corrected by supplementary budgets passed by Parliament.	The annual budget is based on a circular from the County Executive Member for Finance that provides budget formulation guidance and the budget formulation calendar; the County Annual Development Plan; and historical expenditures. The budget is approved by the County Assembly. Budget overruns are corrected by supplementary budgets passed by the county legislative assembly.	The annual budget is based on projected revenue and member contributions. Budget overruns are covered by surpluses accumulated over the years.
Benefits Specification	KEPH (the main benefit package) includes a wide range of population and individual health services and is applied along with a list of essential medicines, supplies, and diagnostics. The UHC benefit package focuses on primary health care services.	KEPH includes a wide range of population and individual health services and is applied along with a list of essential medicines, supplies, and diagnostics.	The different scheme categories have varying benefit packages, which generally include a wide range of outpatient services, inpatient services, specialized services (e.g., renal dialysis, specialized diagnostics), and treatment outside of Kenya.
Contracting Arrangements	Loose agreements with public providers; memorandums of understanding (MOUs) with private providers	Loose agreements with public providers; MOUs with private providers in some counties	Selective contracting with private providers; all public providers included
Provider Payment	Global budget transfers to tertiary hospitals by SAGAs; in-kind inputs (e.g., commodities, human resources) to private facilities	Line-item budgets, salaries for public facilities, and in-kind inputs (e.g., commodities, human resources) for private facilities	Capitation for outpatient services, per diem for inpatient services, fee-for-service and case-based payments for selected services
Performance Monitoring	Monthly facility activity reporting on DHIS2; MOH performance management	Monthly facility activity reporting on DHIS2, supportive supervision by CDOHs, CDOH performance management	Quality assurance officers, claims submission medical audits, and financial reporting by NHIF

** National Health Accounts 2015/16*

Progress and Challenges in Strategic Health Purchasing

Kenya's progress in strategic health purchasing includes developing criteria for reviewing benefit packages, enhancing links between financial resources and services received, and a review of NHIF to reposition the institution as a strategic purchaser. Output-based payment systems have been introduced, particularly at NHIF, but lack of financial autonomy for public providers means they cannot respond effectively to financial and quality incentives.

Highlights of progress and remaining challenges in each of the purchasing functions are described below.

GOVERNANCE. All of the schemes have designated agencies with responsibility for carrying out most or all purchasing functions, but their capacities, particularly at the county level, require strengthening. The MOH and CDOHs draw their mandates from Kenya's constitution, which defines the roles of the central and county governments. Initial steps have been taken to enhance county-level strategic purchasing, including through conditional grants and embedded technical assistance. NHIF and the Kenya Medical Supplies Agency (KEMSA) draw their mandate through acts of Parliament. NHIF and KEMSA have recently undergone a comprehensive review aimed at improving their performance and repositioning NHIF as a strategic purchaser of health services. While NHIF has increased its outreach to beneficiaries, more effort is needed to inform Kenyans about entitlements and key processes. The MOH and counties also lack effective communications approaches, which has hampered progress in the recently launched UHC pilots.

FINANCIAL MANAGEMENT. All of the schemes have a defined process for setting the purchaser's budget. They also have mechanisms to track budget execution/spending, which are enforced, but budget overruns occur frequently. NHIF draws on surpluses from previous years, while the MOH and CDOHs use supplementary budgets passed through the national and county-level legislative assemblies to adjust the budget.

BENEFITS SPECIFICATION. Benefit packages are defined for all of the schemes and reflect health priorities, but there is significant fragmentation, with various packages on offer through the various schemes. A recent review of benefit packages in Kenya led to the development of the UHC benefit package, which strengthened linkages to disease burden, equity goals, financial resources, and services received. The UHC benefit package is expected to be the minimum benefit package offered by all schemes and is being tested in the UHC pilots. Meanwhile, KEPH remains the dominant benefit package and covers a range of basic services and medicines that should be provided at all levels of the health system. NHIF has multiple schemes with different benefit packages targeting different population groups. Most NHIF members access Supa Cover, which provides a wide range of outpatient, inpatient, and specialized services, as well as treatment outside Kenya. NHIF processes used to determine benefit packages lack transparency and are not sufficiently informed by evidence.

CONTRACTING ARRANGEMENTS. All of the schemes use loose agreements with public providers, and only NHIF has selective contracting with private providers based on some definition of quality standards. The MOH and CDOHs are testing new primary care networks as contracting units, in which the county hospital acts as the clinical and administrative hub for a geographically defined set of primary care providers, regardless of ownership type. The primary care networks aim to increase the focus on primary care and more integrated care.

Engagement of private providers, particularly by national and county governments, remains weak. NHIF publishes a list of public and private providers where beneficiaries can access health services. NHIF uses a checklist that includes quality criteria for accreditation and contracting, but the checklist is mostly based on inputs.

PROVIDER PAYMENT. The MOH uses a mix of output-based payment and line-item budgets, NHIF uses output-based payment, and CDOHs use line-item budgets. Payment methods used by CDOHs do not incentivize quality and efficiency, and they lack mechanisms for monitoring provider behavior. NHIF uses a mix of output-based payment, capitation, per diem payment, case-based group payment, and fee-for-service for diagnostic procedures. These payment mechanisms are not well harmonized, however, and there is some evidence that the use of capitation with open-ended payment at higher levels of care has increased admissions as providers shift patients across levels of care to avoid costs. Mechanisms for reviewing and adapting payment systems are lacking at the MOH, CDOHs, and NHIF.

PERFORMANCE MONITORING. Each scheme has a system to monitor provider activity, but because of fragmentation of systems, that information cannot be used consistently to inform purchasing decisions. All public and private facilities are expected to report facility activity using MOH registers. However, the quality and accuracy of reporting vary widely. The MOH and CDOHs have systems for budgeting, tracking, reporting, and performance management at the facility and health system levels. NHIF uses separate information systems for claims submission, tracking, and financial reporting. The various information systems have different reporting requirements, which burdens facilities and leads to reporting delays, poor accuracy, and lack of consistent data to inform strategic purchasing.

Table 2 summarizes progress made in strategic purchasing functions along the dimensions of progress defined by SPARC for the main schemes in Kenya. (See the annex for a detailed explanation of how the levels of progress are indicated using ○, ● ●, and ● ● ●.)

Table 2. **Progress Made Across Purchasing Functions in Kenya**

Purchasing Function	Indicators of Strategic Purchasing	MOH	CDOHs	NHIF
Governance	Purchasing functions have an institutional home that has a clear mandate and allocation of functions.	○	○	●●
	Providers have autonomy in managerial and financial decision-making and are held accountable.	○*	○*	○*
Financial Management	Purchasing arrangements incorporate mechanisms to ensure budgetary control.	●●	●●	●●
Benefits Specification	A benefit package is specified and aligned with purchasing arrangements.	○	○	●●
	The purchasing agency further defines service delivery standards when contracting with providers.	○	○	●●●
Contracting Arrangements	Contracts are in place and are used to achieve objectives.	○	○	●●
	Selective contracting specifies service quality standards.	○	○	●●
Provider Payment	Provider payment systems are linked to health system objectives.	○		●●
	Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation.	○	○	●●
Performance Monitoring	Monitoring information is generated and used at the provider level.	○	○	○
	Information and analysis are used for system-level monitoring and purchasing decisions.	○	○	●●

** Private facilities and SAGA hospitals have financial autonomy, but most county public facilities do not.*

Kenya's health purchasing arrangements have weaknesses and limitations that constrain progress toward strategic purchasing. The three schemes manage approximately 42% of health funds, and while NHIF is being positioned as the strategic purchaser, it manages less than 5% of health funds, which reduces its leverage to create effective incentives to providers. Policies and laws in support of strategic purchasing are lacking despite the existence of key plans, roadmaps, and strategy documents. Some of these documents have misaligned content or are still in draft form. In other cases, implementation challenges have hindered progress. Lack of a purchaser-provider split hinders strategic purchasing by county governments because they own and operate the health facilities they purchase from. Rigid public financial management (PFM) requirements and lack of autonomy for public health facilities in spending decisions (excluding SAGAs) compound this problem.

Opportunities to Improve Health Purchasing

Kenya's president has called for achieving UHC by 2022 as part of his Big 4 Agenda, which has informed the development of a UHC Roadmap by the MOH. Strategic purchasing can be a powerful lever to advance progress toward this goal if a number of critical actions are taken.

In terms of governance, the roles of the MOH, CDOHs, and NHIF as envisioned in the UHC Roadmap should be better harmonized to reduce fragmentation and consolidate purchasing power. Overall governance structures need to be strengthened, and public facilities may be granted more financial autonomy to enhance their responsiveness to incentives. Some counties have granted financial autonomy to some or all public health facilities, but most public facilities remain constrained by PFM rigidities. Mechanisms are needed for citizens and other stakeholders to provide feedback and participate in health system governance and oversight. NHIF is highly fragmented, with more than 85 different schemes and different benefit packages, which increases the administrative burden of managing these schemes. Some functions are decentralized to the 90 branches, with overlaps and duplication in areas such as accreditation, contracting, authorization, claims payment, and reconciliation processes, which leads to increased administration costs and less efficient operations. These processes require harmonization between the head office and branch offices.

The process to develop the UHC benefit package based on explicit criteria related to population need and health system goals could be formalized with future revisions made through a transparent process. Rolling out this unified package nationwide, with clear communication to beneficiaries and providers on their entitlements and obligations, would strengthen this important cornerstone of strategic purchasing.

Going forward, strategic purchasing can be strengthened through clear service delivery standards for contracting with all types of providers and robust enforcement mechanisms. Payment systems and methods can be better coordinated and aligned with health system goals, with mechanisms for review and revision that are transparent and promote accountability. Provider payment rates can be aligned with system needs and available resources using actuarial and costing evidence, taking into account the different cost structures of public and private facilities to create better incentives for efficiency and quality. NHIF may consider setting a budget ceiling at some level (e.g., facility or geographic area) for open-ended provider payment mechanisms (per diem, case-based payment, and fee-for-service) and require preauthorization to exceed those ceilings, in order to manage costs and improve financial sustainability.

Strategic purchasing can also be improved by strengthening information systems and performance monitoring of providers across all levels of care and closely linking purchasing decisions to service quality. Standardized patient data across all health facilities and schemes can enable better clinical decision-making, facility- and system-level performance monitoring, and evidence-informed purchasing policies for all schemes.

SPARC and its technical partners view strategic purchasing as a way to improve resource allocation, provide coherent incentives to providers, and improve accountability for health resources. As next steps, SPARC's partner in Kenya—the KEMRI Wellcome Trust Research Programme—will validate the SPARC findings with Kenyan stakeholders and determine appropriate actions to make further progress in strategic purchasing as a way to achieve UHC in Kenya.

This policy brief is based on a strategic purchasing progress assessment whose details are reported in the following publication: Kazungu J, Kabia E, Munge K, Barasa E. Assessing the progress and gaps in strategic health purchasing in Kenya. Wellcome Open Research. Vol 6. Issue 81. https://wellcomeopenresearch.org/articles/6-81

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Annex. **Strategic Purchasing Progress Indicators**

Governance	**Purchasing functions have an institutional home that has a clear mandate and allocation of functions.**	○	An agency or agencies have responsibility for carrying out one or more purchasing functions, but mandates are not clearly defined and capacity is weak.
		●●	An agency or agencies have responsibility for carrying out most or all purchasing functions and capacity is improving, but some overlaps and gaps in responsibilities remain. Mechanisms are in place for stakeholder engagement.
		●●●	An agency or agencies have responsibility for carrying out all purchasing functions, capacity is strong, and there are no overlaps or gaps in responsibilities. There is inclusive and meaningful stakeholder engagement.
	Providers have autonomy in managerial and financial decision-making and are held accountable.	○	Public providers have no autonomy or extremely limited autonomy to carry out financial and managerial functions, and they have limited ability to respond to financial incentives created by provider payment systems.
		●●	Public providers are given a larger degree of financial and managerial autonomy, but accountability mechanisms are weak.
		●●●	Public providers are given a large degree of financial and managerial autonomy, and accountability mechanisms are effective.
Financial Management	**Purchasing arrangements incorporate mechanisms to ensure budgetary control.**	○	A defined process is used to set the purchaser's budget, and mechanisms are in place to track budget execution/spending, but these mechanisms are not well enforced.
		●●	A defined process is used to set the purchaser's budget, and mechanisms are in place to track budget execution/spending. These mechanisms are enforced, but budget overruns routinely occur.
		●●●	A defined process is used to set the purchaser's budget, and mechanisms are in place to track budget execution/spending. These mechanisms are enforced, and budget overruns rarely occur.
Benefits Specification	**A benefit package is specified and aligned with purchasing arrangements.**	○	A benefit or service package is defined and reflects health priorities, but it is not well specified, is not a commitment, and/or is not aligned with purchasing mechanisms.
		●●	A benefit or service package is defined, reflects health priorities, and is a commitment, but it is not well specified and/or not aligned with purchasing mechanisms.
		●●●	A benefit or service package is defined, reflects health priorities, is a commitment, is well specified, and is aligned with purchasing mechanisms, and a transparent process for revision is specified.
	The purchasing agency further defines service delivery standards when contracting with providers.	○	The purchaser defines some general standards for delivering services in the package (e.g., for gatekeeping), but enforcement through contracts is weak.
		●●	The purchaser defines some general service delivery standards and some specific service delivery standards (e.g., number of prenatal care visits) that are enforced through contracts.
		●●●	The purchaser defines general service delivery standards and specific service delivery standards in line with national service delivery policies and clinical protocols, and service delivery standards are enforced through contracts.
Contracting Arrangements	**Contracts are in place and are used to achieve objectives.**	○	Loose agreements are in place between the purchaser and public providers for specified services in exchange for payment instead of or in addition to input-based budgets. Formal agreements may be in place with some private providers.
		●●	Formal agreements are in place between the purchaser and public providers for specified services in exchange for payment or in addition to input-based budgets. Formal agreements may be in place with some private providers.
		●●●	Formal agreements are in place between the purchaser and public and private providers to help achieve specific objectives, and they are linked to performance.
	Selective contracting specifies service quality standards.	○	The purchaser has loose, nonselective agreements or contracts with all public providers and selective contracts with some private providers based on some definition of quality standards.
		●●	The purchaser contracts at least somewhat selectively with public and private providers based on accreditation or some other definition of quality standards.
		●●●	The purchaser contracts selectively with public and private providers based on uniformly applied quality standards.
Provider Payment	**Provider payment systems are linked to health system objectives.**	○	Some output-based payment is used.
		●●	Output-based payment is used, and payment systems are linked to specific service delivery objectives.
		●●●	Output-based payment is used and is linked to specific service delivery objectives; payment systems are harmonized across levels of care, and they allow purchaser budget management.
	Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation.	○	Provider payment rates are determined based only on the purchaser's available budget.
		●●	Provider payment rates are determined based on the purchaser's available budget and at least one other factor (e.g., cost information, priorities, or negotiation with providers).
		●●●	Payment rates are based on a combination of cost information, available resources, policy priorities, and negotiation.
Performance Monitoring	**Monitoring information is generated and used at the provider level.**	○	Some form of monitoring happens at the health provider level (e.g., supportive supervision visits, monthly activity reporting, claims audits, quality audits).
		●●	Provider-level monitoring is at least partially automated and is used for purchasing decisions.
		●●●	Provider-level information is automated, fed back to providers, and used for purchasing decisions.
	Information and analysis are used for system-level monitoring and purchasing decisions.	○	Some form of analysis is carried out at the system level (e.g., service utilization, medicines prescribed, total claims by service type).
		●●	System-level analysis is automated and carried out routinely.
		●●●	Information and analysis are used for system-level monitoring and purchasing decisions.