HERU
HEALTH ECONOMICS RESEARCH UNIT

KEMRI | Wellcome Trust

POLICY BRIEF

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Implementation Experience of Health Facility Autonomy Reforms in Kenya

Summary Findings

- Health facility autonomy reforms in Kenya were enabled by political support, institutional memory and capacity of staff at the county department of health, support from county treasuries, and a robust legislative framework
- Barriers to health facility autonomy reforms included resistance by county treasuries because of concerns over the capacity of health facilities to manage funds and accountability, and limited technical capacity of county staff to develop health facility autonomy legislation
- Health facility autonomy empowered health facility managers to problem-solve, improved the timeliness of payments to health facility suppliers, the availability of medicines and other health commodities, and the maintenance of health facility infrastructure
- Unintended consequences of health facility autonomy reforms included reduced budgetary allocation to county health facilities, deprioritized funding to primary healthcare facilities and low revenue generating services, and increased financial barriers among the poor
- To strengthen health facility autonomy reforms, counties should guarantee budgetary allocation to health facilities, implement priority setting guidelines that ensure that PHC facilities and services are prioritized, and implement user fee exemption mechanisms for the poor and vulnerable
- The national government should scale-up prepayment health financing mechanism to the population, to reduce the exposure of individuals, and reliance of health facilities on user fees
- National and county government should monitor potential unintended effects of health facility autonomy and intervene to mitigate them

Introduction

Kenya devolved its governance arrangements in 2013, guided by the coming into effect of the 2010 Constitution. Devolution was accompanied by the introduction of a new Public Finance Management (PFM) law (PFM act 2012), which required that all funds mobilized by county governments are pooled in the County Revenue Fund (CRF) account. The interpretation of this law by counties led to the loss of health facility financial autonomy. Public health facilities were required to transfer funds mobilized from all sources to the CRF, meaning that health facility managers could not spend funds at source, and could not directly access funds to address health facility needs.

The loss of health facility autonomy negatively impacted on health facility performance, by compromising the capacity of health facility managers to solve problems. This resulted in delays in the procurement, supply, and availability of essential medical supplies such as medicines and medical devices, and the maintenance of health facilities. These challenges contributed to the demotivation of health workers. The experience of these challenges led to progressive reforms by counties to re-introduce health facility autonomy. These reforms aimed to give the public health facility the authority to retain and spend funds at source and were labelled facility improvement financing (FIF) reforms to signal the intentions to use these funds to improve the capacity of health facilities to deliver health services.

Between 2013 and 2023, some county governments progressively introduced health facility reforms guided by county specific legislation, while other counties did not. The council of governors (COG) developed a model FIF law to guide the development of county specific FIF laws. In 2023, the national government passed a law, the Facilities Improvement Financing (FIF) act 2023, that requires all counties to give public health facilities financial autonomy. KEMRI-Wellcome Trust, in collaboration with Thinkwell conducted a study to examine the implementation experience of health facility autonomy (FIF) reforms in Kenya. The study collected qualitative data using document reviews and in-depth interviews (n=48) with health sector stakeholders at the national level and in six purposely selected counties between February and June 2024. We further collected quantitative data using health facility surveys (in 261 health facilities) in counties 4 counties implementing health facility autonomy, and 4 counties that had not implemented health facility autonomy. This policy brief presents key findings from the research as well as recommendations on how to strengthen health facility autonomy reforms implementation in Kenya.

Enablers of Health Facility Autonomy Reforms

The implementation of health facility autonomy reforms in Kenya was enabled by the following factors:

1. **Experience of the lack of health facility autonomy:** The motivation to introduce health facility autonomy was informed by the experience of the negative effects of the lack of health facility autonomy. This included compromised service delivery because of delays in, or inability to procure medicines and other health commodities, and to maintain health facilities. The lack of health facility autonomy was consistently identified by health sector technocrats at the national and county level, as a key challenge of the health sector post-devolution.
2. **Political support:** The implementation of health facility autonomy reforms has received substantial political support both by the National and County governments. Political support by the national government was symbolized by the inclusion of health facility autonomy as one of the health system reform agenda in the current government's election campaign manifesto, and the passing of the Facilities Improvement Financing (FIF) act 2023. At the County level, health facility autonomy reforms also formed part of the election campaign promises of several governors and received support from members of county assemblies (MCAs) signaled by the passing of county specific health facility autonomy laws.
3. **Robust legislative and policy framework:** Health facility autonomy reforms in Kenya have been facilitated by a robust legislative framework. At the county level, several counties that introduced health facility autonomy anchored these reforms to county specific health facility autonomy legislation. The Council of governors (COG) develop a model health facility autonomy law to guide the development of county specific laws. The passing of the facility improvement financing (FIF) act 2023 consolidated the legal guidance for the design and implementation of health facility autonomy reforms nationally.
4. **Institutional memory and technical capacity:** The reintroduction, design, and implementation of health facility autonomy reforms was enabled by the experience and knowledge of staff at the counties departments of health with institutional memory of the benefits and implementation arrangements of health facility autonomy reforms in the pre-devolution period.
5. **Support from the County treasuries:** Counties that introduced health facility autonomy reforms were characterized by support of these reforms by the County treasuries. This was crucial given that the country treasury was the department with the role of providing guidance on the management of public funds at the county level.

Barriers of Health Facility Autonomy

The introduction and implementation of health facility autonomy reform was challenged by the following factors:

1. **Resistance by county treasuries:** A challenge to introducing health facility autonomy in counties that delayed introduction was resistance from county treasuries. Key concerns by county treasuries were the capacity of health facilities to manage funds, and to be accountable for the funds that they would have authority over.
2. **County technical capacity to develop FIF regulations:** The limited capacity of county level staff to develop health facility autonomy regulations slowed down health facility autonomy in some counties.

Positive Effects of Health Facility Autonomy

Health facility autonomy reforms led to several positive effects:

1. **Empowered health facility managers:** Health facility autonomy empowered health facility managers to respond to emergent health facility needs in a timely fashion. It also facilitated the capacity of health facility managers to address the challenges faced by health facilities.
2. **Timely payment of health facility service providers:** Health facility autonomy reduced the timelines for payments to health facility service providers and health commodity suppliers.
3. **Improved health facility revenue collection:** The authority to retain and spend funds at source incentivized health facilities to improve their revenue mobilization efforts. This included the strengthening of revenue collection mechanisms such as the collection of fees, and the placing of claims for health insurance reimbursements.
4. **Improved availability of health products:** Increased access to funds at the health facility level improved the availability of medicines and other health products. Health facilities with financial autonomy procured health commodities in a timely manner improving their availability.
5. **Improved health facility infrastructure:** The availability and direct access to funds at the health facility level facilitated timely and prioritized investments in the maintenance of health facility infrastructure. This improved the infrastructural capacity of health facilities to provide healthcare services to clients.

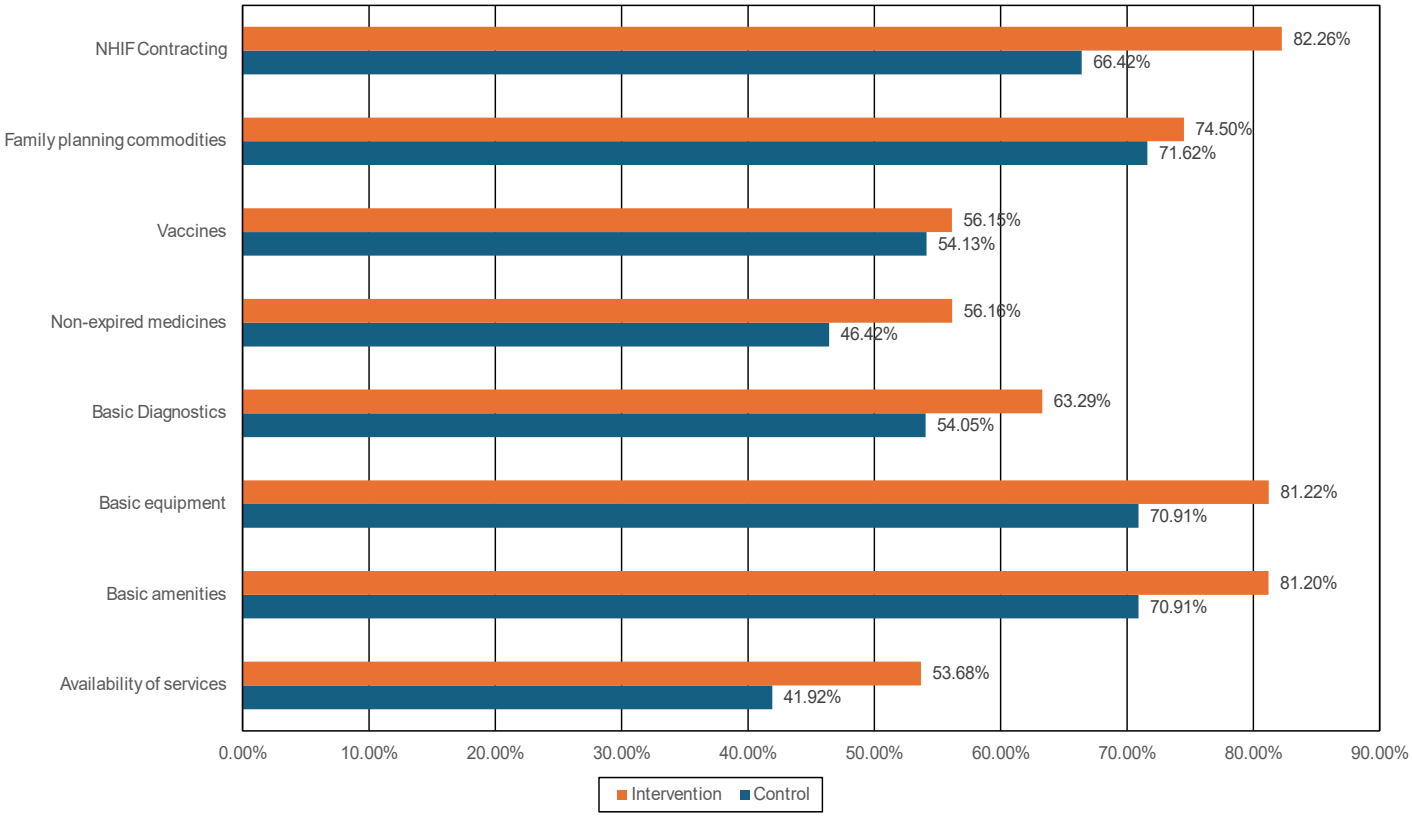

Figure 1: Impact of health facility autonomy of health facility readiness

Negative effects of Health Facility Autonomy

The introduction of health facility autonomy was associated with some unintended effects:

1. **Reduced budgetary allocation to County Health facilities:** County governments tended to reduce budgetary allocations to health facilities that had autonomy. This was because county governments expected these facilities to mobilize revenues though user fee charges and other sources to supplement county government budget allocations. This led to increased health facility reliance on out-of-pocket payments by clients.
2. **Deprioritized funding to Primary Healthcare Facilities:** When counties allocated budgets to health facilities, they prioritized county hospitals over primary healthcare facilities. This was because county hospitals had a higher income generating potential through user fee collections while primary healthcare facilities did not charge user fees.
3. **Deprioritized funding for low revenue generating activities:** Counties that had health facility autonomy were incentivized to prioritize health services that had revenue generating potential. These counties allocated healthcare resources to such services, which were often expensive, secondary care services, and neglected services (often primary healthcare services) that had low revenue generating potential.
4. **Increased financial barriers among the poor:** Counties that implemented health facility autonomy reforms did not have mechanisms for exempting the poor and vulnerable from user fee charges. This, coupled with intensified efforts by health facilities in these counties to improve user fee collections, presented financial barriers to access to the poor and vulnerable.

Recommendations

This study found that health facility autonomy has the potential to improve health facility performance in Kenya. However, the implementation of health facility autonomy could also result in unintended effects. The following recommendations should be considered to enhance the implementation of health facility autonomy, promote its positive effects, while mitigating against its potential unintended effects:

1. The introduction of health facility autonomy should involve the engagement of both county departments of health and county treasuries to align interests and address potential concerns from both departments.
2. Counties guarantee budgetary allocation to health facilities with facility autonomy to avoid dependence on user fees and ensure that health facilities are adequately resourced.
3. County departments of health should develop and enforce priority setting guidelines and that ensure that resources are allocated by counties and health facilities based on a broader set of criteria rather than just the revenue generating potential of health facilities, and health service areas.
4. Counties should develop and implement user fee exemption mechanisms for the poor and vulnerable to reduce financial barriers to access.
5. The national government should scale-up prepayment health financing to the population, to reduce the exposure of individuals, and reliance of health facilities on user fees.
6. National and county government should monitor potential unintended effects of health facility autonomy and intervene to mitigate them.

About this brief

This brief was developed by the Health Economics Research Unit (HERU), KEMRI-Wellcome Trust Research Programme, and Thinkwell Global. The Brief is based on research work that was funded by the Bill and Melinda Gates Foundation.

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