Health Financing Progress Matrix assessment

Kenya 2023

Summary of findings and recommendations

REPUBLIC OF KENYA
MINISTRY OF HEALTH
World Health Organization

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Foreword

Kenya is currently going through a pivotal moment in the journey towards Universal Health Coverage (UHC), with the introduction of transformative health financing reforms. The Health Financing Progress Matrix (HFPM) is an instrument developed by the World Health Organization (WHO) Department of Health Financing & Economics. It assesses a country's health financing system against a set of evidence-based benchmarks that were identified as being key in making progress towards UHC. Thus, the HFPM signals the direction in which the various aspects of the health financing system need to be developed.

This comprehensive HPFM report thoroughly explores Kenya's health financing landscape. It provides an in-depth analysis of the current state of affairs and sheds light on required strategic changes in health financing. The report points out the need to improve public financial management within the health sector, for more efficient financial systems. It focuses on better resource-raising and utilization mechanisms. The matrix highlights the need for consolidation of fragmented health financing arrangements, for a more efficient health system. It also emphasizes the need for enhancing strategic purchasing of health services, to improve the overall efficiency and quality of care. Additionally, the report stresses the critical role of leveraging data and information systems for more evidence-based informed decision-making. These recommendations are crucial for advancing Kenya's health financing system and moving closer to the UHC goal.

The Ministry of Health is thankful to the staff, county government, development and implementing partners, and other health stakeholders, especially in the health financing space, who contributed to various aspects of developing this report. The successful implementation of the recommendations is vital for the matrix to translate into tangible benefits for our population. Implementation will be achieved through a collaborative effort from all stakeholders to contribute to our goal of accessible, affordable, and quality health care for all.

Dr. Deborah M. Barasa

CABINET SECRETARY
MINISTRY OF HEALTH

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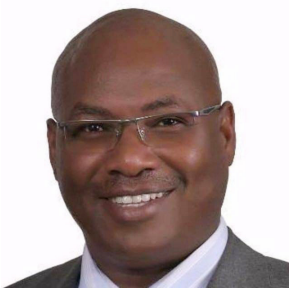
The contributions of Mr Eric Tama, Doctoral Fellow, Strathmore University Business School, Kenya, who acted as the Principal Investigator both conducting the assessment itself, and writing of this report, are greatly appreciated.

Gratitude is also extended to the following for their contributions and guidance: Evalyne Chagina and Mona Almudhwahi (WHO Country office in Kenya, Nairobi), Christabel Abewe (WHO Country office in Uganda, Kampala), Georgina Bonet Arroyo (WHO/AFRO Multicountry Assessment Team, Kenya, Nairobi), Dr Ogochukwu Chukwujekwu (WHO Regional Office for Africa, Brazzavile, Congo), Dr Matthew Jowett and Inke Mathauer (Department of Health Financing and Economics, WHO headquarters), Joseph Kutzin (Independent Consultant), and Brendan Kwesiga (formerly of WHO Country office in Kenya, Nairobi).

Special thanks are due to Dr Daniel Mwai (Advisor to the Presidential Economic Transformation Team on Health, Kenya) and Professor Sophie Witter (Queen Margaret University) who performed the external peer review and provided further input to the report. Special thanks also go to Mr Juan Gregorio Solano (WHO headquarters) who compiled and analysed data from official sources to generate all charts and diagrams used in the report.

This work was prepared in the context of the Country Cooperation Strategy between the Ministry of Health and the WHO Country Office in Kenya and was made possible thanks to the funding from WHO's core funders, with additional support from Global Fund for HIV, TB and Malaria, under the Special Initiative grant.



Mr. Harry Kimtai, CBS
Principal Secretary State Department for Medical Services

Abbreviations

AFRO	WHO Regional Office for Africa
AMREF	Africa Medical Research Foundation
ANC	antenatal care
AWP	Annual Work Plan
CHE	Current Health Expenditure
CIDP	County Integrated Development Plan
DPs	Development Partners
ECCF	Emergency, Chronic & Critical Illness Fund
FBO	Faith Based Organization
FFS	fee for service
FIF	Facility Improvement Financing
GDP	Gross Domestic Product
GGHE-D	General Government Health Expenditure from Domestic sources
GHE	Government Health Expenditure
GHO	Global Health Observatory
HBAP	Health Benefits Advisory Panel
HEFREP	Health Financing Expert Panel Report
HFPM	Health Financing Progress Matrix
HISP	Health Insurance Subsidy Programme
HIV	Human Immunodeficiency Virus
HTA	Health Technologies Assessment
ICC	Inter-Agency Coordinating Committee
IHR	International Health Regulations
JHI	Joint Health Inspection
KDHS	Kenya Demographic Health Survey
KEPH	Kenya Essential Package for Health
KHF	Kenya Health Federation
KHFS	Kenya Health Financing Strategy
KHSSP	Kenya Health Sector Strategic Plan
KQMH	Kenya Quality Model for Health
LMIC	lower middle-income country
MTEF	Medium Term Expenditure Framework
MTP	Medium Term Plan
NCD	noncommunicable disease
NGO	nongovernmental organization
NHIF	National Health Insurance Fund
OOP	out-of-pocket payment
PBB	programme-based budget
PEFA	Public Expenditure and Financial Accountability
PER	Public Expenditure Review
PFM	public financial management
PHC	primary health care
PPM	provider payment mechanism
SHA	Social Health Authority
SHI	Social Health Insurance
SHIF	Social Health Insurance Fund
SDG	Sustainable Development Goals
TB	tuberculosis
TGE	Total Government Expenditure
THE	Total Health Expenditure
TWG	Technical Working Group
UHC	universal health coverage
UNHCR	United Nations High Commissioner for Refugees
VAT	Value Added Tax
WHO	World Health Organization

Executive Summary

Kenya introduced new health financing legislation in late 2023, the final design and implementation of which will determine whether key shortcomings of the health system will be addressed. The Health Financing Progress Matrix (HFPM) Kenya assessment, based on the situation in 2023, identified several areas where further progress is required to accelerate progress to UHC. Priorities for attention include addressing or mitigating the consequences of fragmentation, for example across the numerous health coverage schemes, making more effective use of data and information systems, and improving public financial management within the health sector.

The extent to which the Social Health Insurance Act, the Primary Health Care Act, the Digital Health Act, and the Facility Improvement Financing Act will address current health system performance weaknesses depends on both the details of policy design, and the effectiveness of implementation. Given the context of devolved decision-making for a substantial part of overall government health spending, a realistic health reform implementation roadmap should suggest mechanisms to bring about greater overall coherence in the system, identifying those features which can be established nationally while recognizing the limits of what can be imposed centrally. The Health Financing Progress Matrix assessment provides guidance to policy-makers, building on international experience and evidence, whilst at the same time reflecting the unique features and context of the Kenyan health system.

Recommended priorities for policy attention

1. Address fragmentation directly or mitigate its consequences

Financing arrangements are fragmented in multiple ways in Kenya: by level of public administration (devolution); through disease-specific health programme funding, often donor-supported; between the insured (public and private) and uninsured; and within the National Health Insurance Fund (NHIF), via multiple contributory and non-contributory schemes. Most countries face major challenges to reduce fragmentation directly because of the political dimension of doing so. However, the new legislation adopted in Kenya will partially address this by consolidating some of the current schemes/funding pools within the Social Health Authority (SHA), which supplants the NHIF. As further detailed below, important directions for reform are to (a) make different funding sources more explicitly complementary in terms of the way providers are paid, and (b) unify underlying data systems on health service use under public management, regardless of coverage scheme or programme.

A foundational step for this is to develop a unified benefits framework for the entire population, within which the different coverage programmes can be embedded, aiming to minimize gaps and overlaps while ensuring universal service guarantees. The new legislation offers this possibility but requires getting certain key design elements right to ensure the necessary foundation for the ongoing process of coverage expansion. In particular, it means taking forward an implementation roadmap for the new legislation with the following two key directions in mind:

a) Ensure that the 3 "funds" (PHC, SHI, and Chronic Illness and Emergency) under the management of the SHA use, one common information platform on patient contacts which serves each of these coverage programmes. The unified authority would manage the data on behalf of the entire system, for multiple purposes ranging from routine operations to informing policy development, more specifically to: (1) enable the purchasing of services by the SHA to become more strategic over time; (2) simulate the financial implications of various coverage expansion options based on historical utilization patterns; (3) inform wider health policy challenges and strategies, particularly for quality improvement; (4) improve tracking and monitoring of performance, as well as public reporting and accountability. In other words, the data of the provider payment system is about much more than the payment of claims. Data are at the core of creating a learning, adaptive system, and need to be under the direct management of the government, with arrangements that facilitate co-utilization of the data by the SHA and the Ministry of Health. This unified approach to data management should also be used as the foundation for donor-related funds, including disease-specific programming. These funds remain uncoordinated and lack transparency, which has clear efficiency and sustainability concerns, particularly in light of diminishing donor resources.

Priority actions to enable unified and dynamic governance of health financing:

- Analyse existing patient contact and population data as basis for creating unified reporting forms (national standards) and platform to serve all schemes and programmes.
- In concert with the Ministry of Health, develop an overall performance monitoring and tracking strategy, drawing as much as possible on routine financial, service use, and population data, and that incorporates donor-related accountability processes.
- Develop governance arrangements for SHA so that it can best fulfil its function as an executing agency for health financing policy, including its role relative to the Ministry of Health, county representation, and public reporting and accountability requirements. For the latter, review good practice examples to inform decisions on what can be included in Kenya's annual SHA performance report.

b) Universalize PHC services through non-contributory entitlement for the entire population. This would be defined by specific levels of service delivery to enable population understanding. The SHI fund would be contributory, though with some population groups or services fully subsidized to provide the foundation for future pro-poor policy choices as more funding becomes available. Although the international evidence on the limits of contributory-based entitlement in contexts of high labour force informality is clear, current fiscal constraints mean that not all the coverage programmes can be fully funded from general revenues. Framing the benefits as one programme with different entitlements, rather than several distinct programmes, offers the potential to support decisions on how to make different funding streams more explicitly complementary. In a context of, at best, slow growth in public spending on health and the risks inherent in dependence on external funding, moving towards explicit complementarity in the detailed design and funding arrangements for these schemes and programmes would enable progress on both levels and inequalities of service coverage and financial protection to be sustained.

Universal non-contributory benefits would provide the foundation for a unified, more efficient system from which there would be, broadly speaking, three directions for expansion of coverage (and reduction of financial barriers and out-of-pocket spending) over time:

i. increase the scope of PHC services (and medicines) for all
ii. increase the scope of the chronic illness and emergency services and medicines covered explicitly, for all
iii. expand population affiliation to the SHI programme through expanded subsidies for defined vulnerable groups as well as any contribution collections, though expectations about what can be raised through contributions should be tempered, given extensive international evidence that this does not work well in contexts of high informality

Real planning for complementarity must also consider the disease control programmes and the financial role of county governments. This unified benefits framework can be used to bring coherence to currently fragmented donor funds and how they support service delivery. Additionally, it can harmonize the currently disconnected and uneven approach to user fees. All future options would be facilitated by the data on service use patterns (from point i) above) and fiscal scenarios.

Priority actions to enable complementarity and positive dynamic through a unified benefits framework:

- decision on the universal, non-contributory nature of core PHC and chronic and emergency benefits, in line with global evidence and the specific experience of Kenya
- develop a strategy for explicit complementarity based on a detailed review of funding flows and sources for specific services, and for inputs (e.g. salaries) funded from different sources (national Ministry of Health, disease programmes including external flows, county governments, NHIF contributions)
- develop an agreement or framework on the role (e.g. what services or facilities) that direct funding by county governments will play
- design the scope of services, or the facility level, to be covered by the universal PHC fund with estimated budgetary requirements
- define an initial set of explicit services to be included in the Chronic Illness and Emergency Fund and develop regulations which require cost–effectiveness and budget impact analysis (HTA) for any future proposed changes or additions to that package.
- develop the means to communicate in simple terms the various benefits of the coverage programmes, including whether they are free of charge, or otherwise that there are explicit limits on any co-payments for services or medicines, and that these are defined in fixed amounts, rather than as a percent of the bill.

2. Make health budgets work better for UHC by addressing PFM challenges

Any meaningful health financing reform will be driven by an improved ability to match government budget revenues to priority services and populations (as reflected in a benefits package), to create incentives for counties to spend more and better on health, and to enable public sector providers to directly receive, manage, and account for funds. The HFPM identifies specific aspects of public financial management (PFM) in the health sector where Kenya can drive improvements, including the alignment of more flexible budget execution processes with the structure of programme budgets, improving the predictability and transparency of fund flows from centre to county to health facilities, and increasing managerial flexibility for public sector health facilities. The Facility Improvement Financing Act offers the potential to address the managerial flexibility aspect of this, and this could also improve budget execution and the flow of funds, but only if it results in real PFM changes in county health facilities.

Priority actions to align PFM and health financing reforms:

- Identify the PFM changes, as well as the guidance and support (e.g. facility financial management tools) that need to accompany the Act so that providers, as well as county and sub-country governments, have the ability to directly receive, manage and account for funds. Managers should be progressively freed from line-item controls (beginning with non-salary items). Aim for unified financial accounting at provider level so that they have one system to report on all funding sources and coverage programmes, with tagging as needed. Develop standard reporting formats.
- Use existing intergovernmental consultative forums for engaging with county governments and CECs to develop a joint implementation roadmap for these changes, linking to broader discussions of the flow of central government funds to counties, including but not limited to health-specific grants.
- Set benchmarks for the gradual extension of financial flexibility ("autonomy") to more non-salary budget lines. Monitor implementation to identify any problematic issues.
- Review programme budget structure to determine if changes are needed to align with the "three funds" of the benefits package managed by the SHA.

3. Create enabling environment for harmonizing national health policy implementation in the context of devolution

A current challenge to development and implementation of coherent national health reform strategy is devolution: the centre cannot dictate the actions of the counties. At the same time, there are instruments available that some countries in similar contexts have used to enable greater coherence through a collaborative approach. These are important for Kenya to consider, as it will be difficult to realize the benefits of the planned reforms if there is only limited buy-in from the counties (or if only a few counties align). In particular, making better use of information and data analysis to support ongoing communication and engagement will be central to the approach. Common standards for performance monitoring will be especially valuable given the likelihood that counties do not all move at the same pace or implement the same way.

Priority actions to enable greater harmonization of county and central government approaches:

- develop a standardized health system performance assessment reporting framework through a collaborative effort of the national Ministry of Health and the county health authorities, that also considers external funding priorities.
- bring a more systematic approach to existing intergovernmental consultative fora to review performance on key indicators, and to exchange experiences with respect to addressing key challenges and the implementation of reforms. Build on and use administrative data from the new provider payment systems as well as other analyses (e.g. National Health Accounts, household survey analyses, Public Expenditure Tracking surveys) to provide the data analysis required for the comparative performance assessment and learning across counties.

Dr. Patrick Amoth, EBS
Director General, Ministry of Health

About the Health Financing Progress Matrix

The Health Financing Progress Matrix (HFPM) is WHO's standardized qualitative assessment of a country's health financing system. The assessment builds on an extensive body of conceptual and empirical work and summarizes "what matters in health financing for Universal Health Coverage (UHC)" into nineteen desirable attributes, which form the basis of this assessment.

The report identifies areas of strength and weakness in Kenya's current health financing system, in relation to the desirable attributes, and based on this recommends where relevant shifts in health financing policy directions, specific to the context of Kenya, which can help to accelerate progress to UHC.

The qualitative nature of the analysis, but with supporting quantitative metrics, allows close-to-real time performance information to be provided to policy-makers. In addition, the structured nature of the HFPM lends itself to the systematic monitoring of progress in the development and implementation of health financing policies. Country assessments are implemented in four phases as outlined in Fig. 1; given that no primary research is required, assessments can be implemented within a relatively short time-period.

Fig. 1: Four phases of HFPM implementation

Phase 2 of the HFPM consists of two stages of analysis:

- Stage 1: a mapping of the health financing landscape consisting of a description of the key health coverage schemes in a country. For each, the key design elements are mapped, such as the basis for entitlement, benefits, and provider payment mechanisms, providing an initial picture of the extent of fragmentation in the health system.

- Stage 2: a detailed assessment based on thirty-three questions of health financing policy. Each question builds on one or more desirable attribute of health financing and is linked to relevant intermediate objectives and the final goals of UHC.

Countries are using the HFPM findings and recommendations to feed into policy processes including the development of new health financing strategies, the review of existing strategies, and for routine monitoring of policy development and implementation over time. HFPM assessments also support technical alignment across stakeholders, both domestic and international.

Further details about the HFPM are available online: https://www.who.int/teams/health-systems-governance-and-financing/health-financing/diagnostics/health-financing-progress-matrix

About this report

This report provides a concise summary of the Health Financing Progress Matrix assessment in Kenya, identifying strengths and weaknesses in the health financing system, and priority areas of health financing which need to be addressed to drive progress towards Universal Health Coverage (UHC). Findings are presented in several different summary tables, based on the seven assessment areas, and the nineteen desirable attributes of health financing. By focusing both on the current situation, as well as priority directions for future reforms, this report provides an agenda for priority analytical work and related technical support. The latest information on Kenya's performance in terms of UHC and key health expenditure indicators, are also presented. Detailed responses to individual questions are available on the WHO HFPM database of country assessments or upon request.

This HFPM assessment was conducted during 2023 (see Methodology and timeline section) and hence reflects the situation during that time. This Report is, however, published following new legislation relating to health insurance, passed in late September 2023. Whilst the high-level findings and recommendations recognize the intentions and potential implications of the legislation, they are based on and reflect the actual situation in 2023. As such this assessment provides a pre-reform baseline and can be updated to monitor the effects of the new legislation.

For additional information about this report, please contact the Ministry of Health, Department of Health Financing:

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Methodology and timeline

Kenya planned and initiated the Health Financing Progress Matrix (HFPM) assessment jointly with the African Union Health Financing Tracker, a complementary assessment which compiles a number of indicators related to health financing.

The HFPM assessment followed the methodology and technical guidance provided in WHO"s HFPM Country Assessment Guide. The assessment involved the review of key policy documents as well as health financing legislation. In Stage 1 of the assessment, the consultant together with the Health Financing Technical Working Group developed a landscape of the major health coverage arrangements or schemes in the country using the criteria provided on pages 11-13 of the Country Assessment Guide. Stage 2 of the assessment was based on 33 questions as outlined on pages 16 and 17 of same guide.

The bulk of the assessment was carried out at a workshop held from 11th to 14th April 2023. The first validation workshop was held on 1st August 2023 and a second validation workshop held from 25th to 29th September 2023.

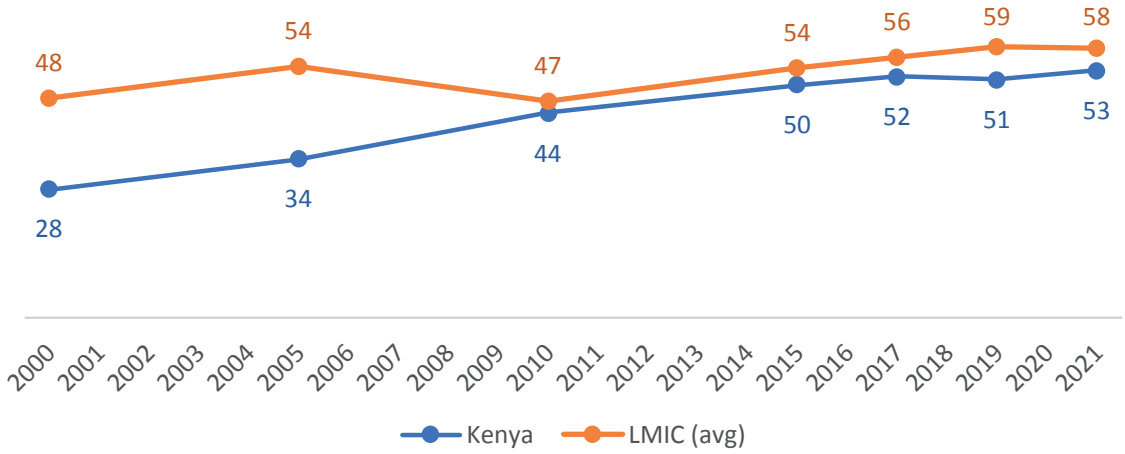
The Principal Investigator was Mr Eric Tama, MPH, health economist and lecturer at Strathmore University, Nairobi, Kenya. Hired as an external consultant through a WHO procurement contract, the relevant declaration of conflict of interest was managed as part of the processes related to this contract.

The external review process was conducted through November 2023; two health financing experts, Professor Sophie Witter and Dr Daniel Mwai, who were not involved in conducting the assessment, independently reviewed the question responses and proposed scores, consolidated their feedback and discussed with the Principal Investigator. As a results of the external review, further clarifications to the assessment have been made, and scores were revised for four questions.

Universal health coverage (UHC) performance in Kenya

Sustainable Development Goal (SDG) indicator 3.8.1 relates to the coverage of essential health services. It is a service coverage index (SCI) with a score between 0 and 100 defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, and services for noncommunicable diseases, as well as indicators of service capacity and access. A low score means high unmet need. In Kenya, the UHC coverage index has been on an upward trend from a score of 28 in 2000 to a score of 53 in 2021. However, the country is still lagging below the average for lower middle-income countries which stands at 58.

Fig. 2: Service coverage index trend in Kenya 2000 – 2021



Source: Global Health Observatory (https://data.who.int/indicators/i/9A706FD, accessed 1 May 2023)

For some service components of the index, it is possible to obtain disaggregated information, as shown in Fig. 3, to get a picture of inequalities in access, which have decreased over time.

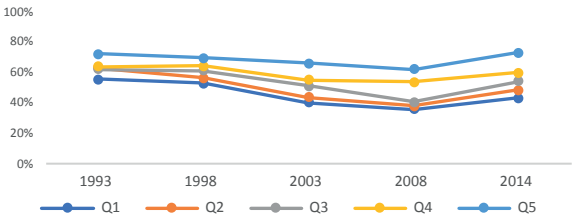
Fig. 3: Antenatal care and DPT3 coverage by quintile in 2014

Antenatal care +4 visits

National average (2014): 57.1%

Value by quintile – 2014

Q1 (poorest)	Q2	Q3	Q4	Q5 (richest)
45.0%	55.4%	65.0%	73.3%	82.0%

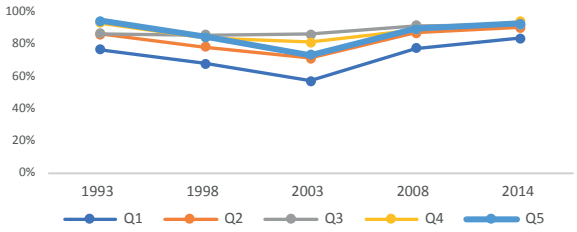


DTP3 coverage 1 year

National average (2014): 90.1%

Value by quintile – 2014

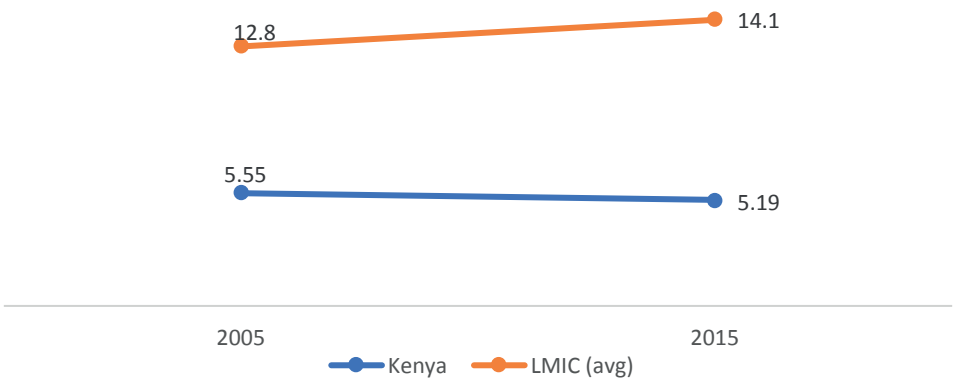
Q1 (poorest)	Q2	Q3	Q4	Q5 (richest)
88.9%	90.2%	89.6%	85.9%	77.9%



Source: WHO Global Health Observatory indicators (GHO | By indicator (who.int), accessed 25 May 2022)

SDG indicator 3.8.2 relates to financial protection, measured in terms of catastrophic spending defined as the "proportion of the population with large household expenditure on health as a share of total household expenditure or income". It is calculated using two thresholds: household expenditure on health greater than 10% of household budget or greater than 25% of the household budget. Using the 10% of household expenditure threshold, the proportion of the population that incurred catastrophic expenditure declined from 5.6% in 2005 to 5.2 in 2015. Also, the percentage of the population pushed below the $2.15 a day poverty line as a result of household out-of-pocket spending on health fell from 1.6% in 2005 to 1.3% in 2015. These numbers indicate that Kenya is doing better than the LMIC average, as indicated in the graph below.

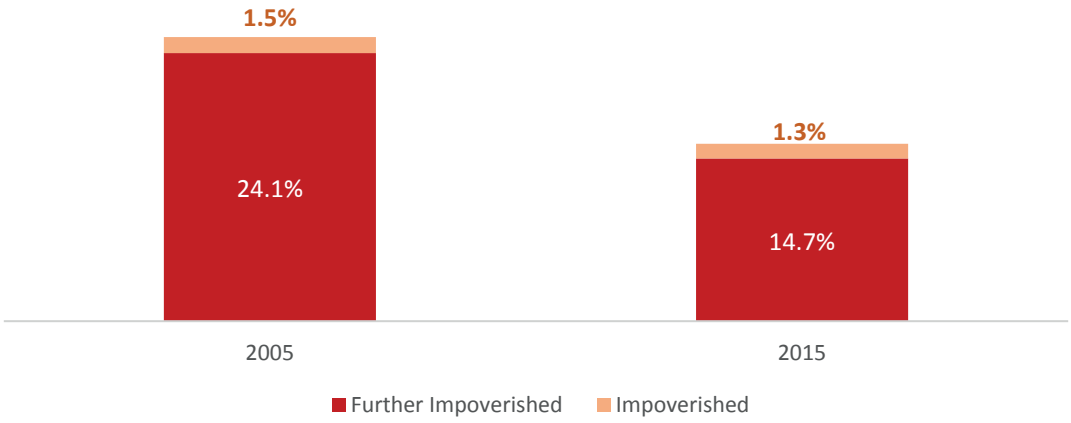
Fig. 4: Percent of population with household out-of-pocket health spending on health greater than 10% of household budget



Source: SDG 3.8.2 Catastrophic health spending (and related indicators) [online database]. Global Health Observatory. Geneva: World Health Organization; 2023 (https://www.who.int/data/gho/data/themes/topics/financial-protection, accessed 19 Jun 2023).

Though not an official SDG indicator, an additional metric of financial protection looks at out-of-pocket health spending which leads to impoverishment. Indicators are defined as the proportion of the population pushed into, or further into, poverty as a result of out-of-pocket health spending. The poverty line used is the extreme poverty line, defined as 2017 PPP US$ 2.15[1] per person per day and where even the most basic standard of living is not guaranteed. In Kenya, the level of impoverishment due to out-of-pocket health spending has reduced over the years as depicted in Fig. 5.

Fig. 5: Percent of the population pushed below the $1.90 poverty line by household health expenditures



Source: SDG 3.8.2 Catastrophic health spending (and related indicators) [online database]. Global Health Observatory. Geneva: World Health Organization; 2023 (https://www.who.int/data/gho/data/themes/topics/financial-protection accessed 24 March 2023).

1 Purchasing Power Parity

Summary of findings and recommendations by assessment area

This section of the report presents a summary of the responses to each of the 33 questions in Stage 2 of the assessment, including the ratings for each against the four progress levels as outlined in Annex 1. These results reflect the discussions of the TWG workshop held in April 2023, that brought together various stakeholders to assess the country's progress on each of the questions. The results were then presented back to the TWG for validation on 1st August 2023 and have been revised to reflect the changes as proposed by the workshop participants.

HEALTH FINANCING POLICY, PROCESS & GOVERNANCE

Kenya has launched the Kenya Health Financing Strategy 2020-2030 (KHFS) to guide the country towards UHC and focuses on ensuring there is adequacy, efficiency and fairness in financing of health services. The President has recently signed a number of important health bills into law. The Social Health Insurance Act, 2023 that establishes a Social Health Authority to replace NHIF. The Act also creates three new funds. A Primary Health Care Fund, a Social Health Insurance Fund and a Chronic Illness and Emergency Fund. The Primary Health Care Act, 2023 that aims to strengthen preventive health services by co-opting 100,000 community health promoters. The Digital Health Act, 2023 that aims to digitize health services and establish an Integrated Health Information System that is designed to manage health and health-related system data that provides the foundation for decision-making. This would improve data sharing, set standards for e-health, and personalize patient care, ultimately leading to enhanced health care quality and the empowerment of communities through telemedicine. And finally, the Facility Improvement Financing Act, 2023 aims to enhance the financial and managerial autonomy of public health facilities, and to ensure better resource management, service quality, and community involvement.

Governance arrangements are in place, but accountability mechanisms remain unclear. There is need to have contractual arrangements instead of MoUs that do not have clear mandates on accountability. There are forums that are intended to bring various stakeholders in the health sector together, but the meetings do not take place as scheduled.

Ministry of Health is implementing a digital health platform to harmonize data on health statistics and health expenditure to provide a mechanism of monitoring and evaluation of the health systems performance from a health systems integration view. The system has been piloted and is ready for national rollout. However, there is need to establish a health financing dashboard for clear indication of the health financing indicators across counties. The Digital Health Act, 2023 will improve data sharing and enhance monitoring and tracking of a variety of health indicators.

The Ministry of Health needs to strengthen the mechanism to monitor and evaluate the implementation of the health care financing strategy. This will allow it to reflect on the policy implications by actions expected from the different stakeholders. Future NHAs, PET surveys, KHHEUS, annual and periodic Ministry of Health Reports, Annual Health Sector Working Group Reports, should be aligned to help strengthen tracking and evidence generation on the implementation status of the health financing strategy at both the national and county levels of government.

Development of the draft road map on domestic resource mobilization for health plus the declarations from the National Health Financing Dialogue and from the recent push for UHC emphasize the importance of shifting to domestic sources of funds and reducing reliance on external sources of funding for health.

REVENUE RAISING

- The country has been making steady progress in increasing allocations to health but there is still room for improvement. Government expenditure on health has been increasing as donor funding has been falling indicating a commitment by the government to transition to domestic funding. Out-of-pocket share of current health expenditure has been increasing marginally indicating the need for increasing financial risk protection with OOPs still contributing over 25% of CHE which is higher than recommended, but relatively good for levels of public spending on health.
- Alignment of plans with expenditure is a big challenge at the county level which compromises the predictability and stability of funding for health facilities. Occasional delays in the disbursement of funds to the counties from the national treasury remains a major challenge. However, the Facility Improvement Financing Act, 2023 is intended to increase both operational and financial autonomy of public health facilities. If well implemented, this can contribute to improved fund flow and service delivery.
- The impact of existing health taxes (on alcoholic products, tobacco products and soft drinks) on behaviour change has not been significant with consumers opting for cheaper alternatives whose production is not regulated and sometimes are harmful to their health. This suggests that the government should consider their re-design with the aim of improving health impact.
- Kenya has a large informal sector whose contributions to the NHIF are voluntary and not income-rated hence making them regressive for many. This leads to low revenues, increases the risk of adverse selection and worsens inequity. Addressing this is one of the intentions of the Social Health Insurance Act, 2023, which has made contributions mandatory for all Kenyan with exemptions for the indigent and vulnerable groups of the population. The new Act proposes the use of a means testing approach to assess income on which contributions will be based.

POOLING REVENUES

- The country's pooling arrangements are fragmented due to the many schemes (including health programme funding) with different entitlements across the schemes. This has reduced the redistributive ability of the pools due to the relatively small and non-diverse pools. The non-harmonized benefits enhance inequity in access to services due to different entitlements across different pools.
- Fragmentation in pooling has also led to high administrative costs leaving less funds for actual provision of health services. Consolidation of pools and harmonization of benefits is expected to increase the ability for risk and financial cross-subsidization and enhance financial protection and equity. The Social Health Insurance Act, 2023 establishes a Social Health Authority to replace NHIF.
- In order to address the problem of fragmentation in pooling, the Act has consolidated all the public pools currently managed by the NHIF into three new funds. A Primary Health Care Fund, a Social Health Insurance Fund and a Chronic Illness and Emergency Fund. When fully implemented, the intent is that this will reduce

fragmentation, enhance equity in entitlements and improve efficiency. Under this new Act, the government will provide coverage for the indigent and vulnerable persons, with the aim of enhancing equity in financial risk protection.

PURCHASING & PROVIDER PAYMENT

- There has been progress in moving away from passive purchasing towards strategic purchasing but the use PPMs has not been optimized to improve efficiency and quality of care. While various PPMs have been employed, the tracking and monitoring of performance indicators against which providers are paid is not done effectively. Contracting and empanelment of providers can be improved to ensure providers meet certain quality and efficiency standards. There is an opportunity for using data and information systems to improve tracking and monitoring of performance. Public facilities have less autonomy compared to private facilities which have more flexibility in use and management of resources and are better placed to improve their performance. The Facility Improvement Financing Act, 2023, is intended to give public facilities more autonomy and the Digital Health Act, 2023, and intends to enhance the use and sharing of data to improve quality monitoring and tracking.
- To ensure that the elements of quality of care and care coordination are efficiently and effectively implemented, there is need to align all policy documents that promote quality of care. Such documents include the Joint Health Inspection (JHI) checklist guidelines, Infection Prevention and Control guidelines, the Kenya Quality Model for Health (KQMH) Checklist guidelines. More effort is needed to align these metrics to the purchasing arrangements.

BENEFITS & CONDITIONS OF ACCESS

- A Health Benefits Advisory Panel (HBAP) was established in 2018 to define and cost an essential benefit package and the process involved wide consultations with relevant stakeholders. The panel developed a criterion to be used to prioritize interventions to be included in the benefit package, and this criterion was later expanded and used by the NHIF. However, this criterion has not been well communicated to the public and their involvement was limited. The defined benefits were not aligned with the available revenues, available health services and purchasing mechanisms.
- The current NHIF benefit package is costing more than what is pooled as suggested by the level of deficit. The SHI Act 2023 aims to address this on the revenue side by making contributions mandatory for every adult Kenyan and with the new contributions for the formal sector being based on a percentage of income. Means testing will be used to determine the contributions for those in the informal sector. It is hoped that the increased revenues arising from these efforts will be greater than the administrative costs of implementing them, thereby enhancing the resource envelope for the provision of the new UHC benefit package. A costing exercise has been conducted recently to determine the resource requirements of the new UHC benefits package.
- It is critical that the resource requirement needs of the benefit package are matched to revenues taking into account the prevailing macroeconomic climate to ensure that service delivery and quality is not compromised, and financial risk protection is provided as intended. There are plans to institutionalize a HTA body which will have an elaborate process of determining future revisions to health services and products in the benefit package.

PUBLIC FINANCIAL MANAGEMENT

- A general PFM diagnostic analysis was completed in the last three to five years including a comprehensive Public Expenditure Review (PER) 2018 and a Public Expenditure and Financial Accountability (PEFA) assessment done in 2019. The PEFA assessment though is not sector specific. The country has adopted the use of program-based budgets but there are challenges in budget execution. Predictability of funds is limited by delays in funds disbursement to the devolved units of government and by limited autonomy of health facilities.
- The budgeting process is clear and there is optimal engagement between national and county governments but implementation and execution at the county level is not ideal. The Facility Improvement Financing Act, 2023, seeks to enhance the financial and managerial autonomy of public health facilities for the purpose of ensuring better resource management and budget execution. Effective public participation and engagement is suboptimal due to limited access to resource tracking reports. There is need for increased sharing of such reports accompanied by awareness creation among the public on the importance and value of such engagements.

PUBLIC HEALTH FUNCTIONS AND PROGRAMMES

- Many health programmes are donor supported but this support has started to decline as a result of Kenya attaining LMIC classification. These health programmes are characterized by multiple programme-specific funding streams, with different payment mechanisms that fragment policy and complicate operations all the to service delivery level.
- Most of the donor support is off budget that does not align to the government annual work programme (AWP) and the budget cycle, and rather have their own, disconnected and misaligned AWPs. The lack of transparency and ring-fencing of these external funding flows poses clear sustainability concerns as donor funds reduce.
- The uncoordinated and fragmented funding flows for disease programmes contribute to clear duplications and misalignments with respect to how these programmes operate within the context of Kenya's overall health system. While there are plans to move towards a more integrated system, several structural issues will need to be addressed. As efforts are made to better coordinate and pool funding flows, priority areas for investment and integration across programmes include supply chains, human resource distribution and contractual arrangements, data and information systems, capacity of country governments to manage programmes, and overall service delivery coherence and integration.
- There is budgetary allocation to IHR at different levels of government and sectors, though the resources set aside are inadequate and multisectoral coordination for budget execution is limited. Limited flexibility also hinders the rapid deployment of funds to the frontline in case of an emergency especially at the county level.

Summary of findings and recommendations

Assessment area	Summary findings	Status
Health Financing Policy Process & Governance	• Kenya has launched a health financing strategy that will guide the country towards UHC and focuses on how to ensure adequacy, efficiency and fairness in financing of health services. • The regulatory and legal frameworks (the SHI Act 2023 and FIF Act 2023) are now in place to help in the implementation of the health financing strategy. • Ministry of Health needs to strengthen the mechanism to monitor and evaluate the implementation of the health care financing strategy. • The draft road map on domestic resource mobilization for health should be fast racked and finalized to ensure government utility and ownership.	Established
Revenue raising	• Government expenditure on health has been increasing as donor funding has been falling indicating a commitment by the government to transition to domestic funding. • Out-of-pocket share of current health expenditure, though declining, still contribute over 25% of CHE. • Alignment of plans with expenditure is a big challenge which compromises the predictability and stability of funding for health facilities. • The SHI Act 2023 makes contributions mandatory for all Kenyans with exemptions for vulnerable groups of the population. If well implemented, this should lead to an increase in revenues and enhance equity in access to services. • Health taxes are in place, but they have had minimal impact on behaviour change with people opting for cheaper alternatives.	Established
Pooling revenues	• There is a high degree of fragmentation leading to reduced redistributive capacity and suboptimal financial risk protection. • The non-harmonized benefits enhance inequity in access to services due to different entitlements across different pools. • Fragmentation in pooling has also led to high administrative costs leaving less funds for actual provision of health services. • If recently approved legislation leads to consolidation of pools and harmonization of benefits, it should increase the ability for risk and financial cross-subsidization and thus enhance financial protection and equity.	Progressing
Purchasing and Provider Payment	• There has been progress in moving away from passive purchasing and strategic purchasing but the use PPMs has not been optimized to improve efficiency and quality of care. • Payment methods remain disjointed and fragmented across health programmes, which requires greater coherence to better coordinate incentives. • Tracking and monitoring of performance indicators is not done effectively. Contracting and empanelment of providers can be improved to ensure providers meet certain quality and efficiency standards. • To ensure that the elements of quality of care and care coordination are efficiently and effectively implemented, there is need to align all policy documents that promote quality of care.	Progressing
Benefits and conditions of access	• Benefits are well defined and there is an elaborate process used to prioritize interventions to be included in the benefit package for UHC. However, this criterion has not been well communicated to the public and their involvement in the benefit design process has been limited. • There is need for more effort in educating beneficiaries about their entitlements and obligations under these new reforms.	Progressing

Summary of findings and recommendations

Assessment area	Summary findings	Status
Public financial management	• A general PFM diagnostic assessment has been conducted in the last 3 to 5 years. The country has adopted the use of program-based budgets but there are challenges in budget execution. • The current Standard Chartered of Accounts (SCoA) is undergoing review to ensure standardization of codes used in the implementation of PBB by the National Treasury and partners. • Predictability of funds is limited by delays in funds disbursement to the devolved units of government and by limited autonomy of health facilities. • The budgeting process is clear and there is engagement at national and county levels but engagement with the public is limited. • There is need for increased sharing of public expenditure reports accompanied by awareness creation among the public on the importance and value of such engagements.	Progressing 
Public Health Functions and Programmes	• Many health programmes are donor supported but this support has been declining. Most of the donor support is off budget and does not align with the overall government AWP. This funding is uncoordinated and highly fragmented across all levels of the health system. • The multiple, uncoordinated financing flows for health programmes drive many duplications and inefficiencies in how the disease programmes are structured within the context of the overall health system. While there are plans to create greater coherence and integration, there remains an implementation gap. • There is budgetary allocation to IHR at different levels of government and sectors though the resources set aside are inadequate and multisectoral coordination for budget execution is limited. Limited flexibility also hinders the rapid deployment of funds to the frontline in case of an emergency.	Progressing 

Summary of findings and recommendations by desirable attributes of health financing

Policy process and governance

Desirable attribute GV1	Health financing policies are guided by UHC goals, take a system-wide perspective and prioritize and sequence strategies for both individual- and population-based services
Key areas of strength and weakness in Kenya	Kenya has launched the Kenya Health Financing Strategy (KHFS) that will guide the country towards UHC and focuses on ensuring there is adequacy, efficiency and fairness in financing of health services. The President has recently signed a number of important health bills into law. The Social Health Insurance Act, 2023 that establishes a Social Health Authority to replace NHIF. The Act also creates three new funds. A Primary Health Care Fund, a Social Health Insurance Fund and a Chronic Illness and Emergency Fund. The Primary Health Care Act, 2023 that aims to strengthen preventive health services by co-opting 100,000 community health promoters. The Digital Health Act, 2023 that aims to digitize health services is expected to improve data sharing, set standards for e-health, and personalize patient care, ultimately leading to enhanced health care quality and the empowerment of communities through telemedicine. And finally, the Facility Improvement Financing Act, 2023, aims to enhance the financial and managerial autonomy of public health facilities to create an enabling environment for better resource management, service quality, and community involvement.
Recommended priority actions	The recent health financing reforms need to be well implemented for the benefits to be realized. There is also a need to use data and information more effectively to monitor the implementation of the KHFS.
Desirable attribute GV2	**There is transparent, financial and non-financial accountability in relation to public spending on health**
Key areas of strength and weakness in Kenya	Accountability mechanisms exist but these are not very clear, and the public is not sufficiently empowered to hold financing agencies accountable. The Digital Health Act 2023 will enhance information sharing improving monitoring and performance tracking. The FIF Act 2023 aims to improve financial and operational autonomy of health facility and provide an opportunity for increased accountability from the health facilities.
Recommended priority actions	There is need to have contractual agreements on accountability rather than having MOUs that do not have very clear mandates on accountability. Financial reports on public spending on health should be made publicly available and civic education done on the role and importance of the public in financial accountability.
Desirable attribute GV3	**International evidence and system-wide data and evaluations are actively used to inform implementation and policy adjustments**
Key areas of strength and weakness in Kenya	The country conducts national surveys and assessments that generate crucial data. These include NHAs, KHHEUS, KDHS, PET surveys. The Digital Health Act, 2023 seeks to digitize health services and improve data sharing which can be used in monitoring and tracking policy implementation.
Recommended priority actions	Future NHAs, PET surveys, KHHEUS, annual and periodic Ministry of Health Reports, Annual Health Sector Working Group Reports should be aligned to help strengthen evidence generation on the implementation status of the health financing strategy at both the national and county levels of government.

Revenue raising

Desirable attribute RR1	Health expenditure is based predominantly on public/compulsory funding sources
Key areas of strength and weakness in Kenya	Government spending on health has been increasing over the years, however out-of-pocket payments are still a significant source of funding. The Kenya Health Financing Strategy targets to reduce the contribution of OOP payments to 10% by 2030 (KHFS 2020-2030). Currently, the country's out-of-pocket expenditure stands at 20.9% of THE.
Recommended priority actions	Implementation of the KHFS and the recent health financing reforms should be monitored effectively to take early lessons that may be needed to inform any adjustments.

Revenue raising

Desirable attribute RR2	The level of public (and external) funding is predictable over a period of years
Key areas of strength and weakness in Kenya	Kenya executes the Medium-Term Expenditure Framework (MTEF) planning and budgeting process every 3 yrs. Funding from partners providing on-budget support is predictable but that from partners providing off-budget support is unpredictable and not tracked. Delays in the release of funds to county governments coupled with the lack of autonomy in public health facilities, compromises predictability.
Recommended priority actions	Reduce or ideally eliminate the delays in releasing funds to county governments. Implementation of the FIF Act should be closely monitored to identify progress and challenges with regard to the financial autonomy of public health facilities.
Desirable attribute RR3	**The flow of public (and external) funds is stable and budget execution is high**
Key areas of strength and weakness in Kenya	There are significant delays in disbursement of funds across levels. Delays in the release of funds to county governments coupled with the lack of autonomy in public health facilities, compromises stability and leads to low budget execution.
Recommended priority actions	Timely disbursement of funds from the national treasury and from county treasury. Implementation of the FIF Act, 2023, should be assessed in terms of its effects on budget execution.
Desirable attribute RR4	**Fiscal measures are in place that create incentives for healthier behaviour by individuals and firms**
Key areas of strength and weakness in Kenya	There are sin taxes in place but their impact on behaviour change has not been significant. The impact of these taxes on behaviour change has however not been significant with consumers opting for cheaper alternatives whose production is not regulated and sometimes are harmful to their health.
Recommended priority actions	The government should consider re-design of health taxes with the aim of improving health impact through behaviour change.

Pooling revenues

Desirable attribute PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds
Key areas of strength and weakness in Kenya	The country's pooling arrangements are fragmented due to the many schemes with different entitlements across the schemes. This has reduced the redistributive ability of the pools due to the relatively small and non-diverse pools. The non-harmonized benefits enhance inequity in access to services due to different entitlements across different pools. Fragmentation in pooling has also led to high administrative costs leaving less funds for actual provision of health services.
Recommended priority actions	Implementation of actions to consolidate or harmonize pools (as per recently adopted legislation) should move forward with close monitoring of implementation across programme and schemes and levels of government.
Desirable attribute PR2	**Health system and financing functions are integrated or coordinated across schemes and programmes**
Key areas of strength and weakness in Kenya	The many schemes in place have led to non-harmonized benefits with different schemes having different benefits which are tied to contributions. This has led to inequities in service utilization.
Recommended priority actions	Actions to integrate or coordinate the various functions across health financing schemes or programmes should move forward, with ongoing analysis and feedback on the implementation process.

Purchasing health services

Desirable attribute PS1	Resource allocation to providers reflects population health needs, provider performance or a combination
Key areas of strength and weakness in Kenya	Over the years, there has been significant progress in the allocation of public funds to providers, and to some degree, reflecting population health needs. The has been progress in moving away from passive purchasing towards strategic purchasing but the use PPMs has not been optimized to improve efficiency and quality of care. While various PPMs have been employed, the tracking and monitoring of performance indicators against which providers are paid is not done effectively.
Recommended priority actions	Contracting and empanelment of providers can be improved to ensure providers meet certain quality and efficiency standards. There is an opportunity for using data and information systems to improve tracking and monitoring of performance.
Desirable attribute PS2	**Purchasing arrangements are tailored in support of service delivery objectives**
Key areas of strength and weakness in Kenya	The has been progress in moving away from passive purchasing to strategic purchasing but the use of contracting and PPMs has not been optimized to improve efficiency and quality of care. While various PPMs have been employed, the tracking and monitoring of performance indicators against which providers are paid is not done effectively.
Recommended priority actions	Contracting and empanelment of providers can be improved to ensure providers meet certain quality and efficiency standards. There is an opportunity for using data and information systems to improve tracking and monitoring of performance.
Desirable attribute PS3	**Purchasing arrangements incorporate mechanisms to ensure budgetary control**
Key areas of strength and weakness in Kenya	The has been progress in moving away from passive purchasing to strategic purchasing but the use of contracting and PPMs has not been optimized to improve efficiency and quality of care. While various PPMs have been employed, the tracking and monitoring of performance indicators against which providers are paid is not done effectively.
Recommended priority actions	Contracting and empanelment of providers can be improved to ensure providers meet certain quality and efficiency standards. There is an opportunity for using data and information systems to improve tracking and monitoring of performance.

Benefits and entitlements

Desirable attribute BR1	Entitlements and obligations are clearly understood by the population
Key areas of strength and weakness in Kenya	While benefits are clearly defined, there has not been adequate public awareness campaigns to educate the public on their entitlements and obligations.
Recommended priority actions	Increase efforts to raise awareness amongst the public drawing of successful experience in other sectors.
Desirable attribute BR2	**A set of priority health service benefits within a unified framework is implemented for the entire population**
Key areas of strength and weakness in Kenya	The benefit package only caters for NHIF members who constitute about 50% of the entire population but only 24% are active contributors. This largely includes Kenyans in the formal sector, a small proportion of the informal sector workers who are contributors and the sponsored population (through health insurance subsidies). This leaves out a significant population in the informal sector and the indigents who are currently unsponsored.
Recommended priority actions	The government should develop a unified benefits framework, inclusive of the entire population, within which certain services defined as priorities (e.g. primary care, HIV/AIDS, TB) are made available to all who need them.

Benefits and entitlements

Desirable attribute BR3	Prior to adoption, service benefit changes are subject to cost–effectiveness and budgetary impact assessments
Key areas of strength and weakness in Kenya	While costing has been done for service benefits, information on budgetary impact has not been effectively utilized to inform roll-out.
Recommended priority actions	The institutionalization of a HTA body will ensure there is a transparent process of assessing proposed changes to benefit packages that is informed by evidence on cost–effectiveness and impact on budget.
Desirable attribute BR4	**Defined benefits are aligned with available revenues, health services, and mechanisms to allocate funds to providers**
Key areas of strength and weakness in Kenya	The defined benefits are not aligned with the available revenues, available health services and purchasing mechanisms. The current NHIF benefit package costs more than what is pooled as evidenced by the loss ratios (expenditures exceeding revenues) in recent years.
Recommended priority actions	Address imbalances through actions to enhance revenues and to reduce inefficiencies.
Desirable attribute BR5	**Benefit design includes explicit limits on user charges and protects access for vulnerable groups**
Key areas of strength and weakness in Kenya	Determination of user fees is not based on assessments of vulnerability nor capacity to pay e.g. indicators for socioeconomic status, chronic illnesses amongst others. For the lower facility levels (2&3), the government policy is that health services are provided for free to increase access and enhance financial protection. Despite services being free, some patients are required to make unofficial payments to receive services. This is attributed to lack of essential inputs such as drugs and supplies. The NHIF co-payments in accredited facilities are not clear and create room for exploitation, especially where the limits set are exceeded or approvals for cases are not made.
Recommended priority actions	The entitlements and obligations within the benefits package should be made clear to the beneficiaries and providers.

Public financial management

Desirable attribute PF1	Health budget formulation and structure support flexible spending and are aligned with sector priorities
Key areas of strength and weakness in Kenya	The country has made progress in budget formulation and adopted the use of programme-based budget at all levels (National, County). The current Standard Chart of Accounts (SCoA) is undergoing review to ensure standardization of codes used in the implementation of PBB by the National Treasury and partners. Although County Governments are autonomous, they are expected to be aligned with the national health goals but there are still misalignments. Some challenges still exist including: • Limited flexibility of the budget structure and budget execution. • Limited alignment to health priorities at provider level e.g. different facilities are supplied the same commodities program structure. • A challenge in alignment between the program-based structure and provider payment mechanisms. • A challenge with predictability of flow of funds especially at County level as well as the flow from the purchaser (NHIF) to the providers. At the facility level managers have limited authority to retain or use funds.
Recommended priority actions	The revision of SCoA to be completed to enhance the implementation of program-based budgets. Introduce actions to enhance the autonomy of public health facilities.
Desirable attribute PF2	**Providers can directly receive revenues, flexibly manage them, and report on spending and outputs**
Key areas of strength and weakness in Kenya	There is limited financial and operational autonomy in public levels 2,3 and 4 facilities as opposed to levels 5 and 6 facilities and private facilities. Overall, the extent of autonomy granted to managers varies considerably by county.
Recommended priority actions	Deepen engagement with county governments to enable greater financial management flexibility for specific levels of government health facilities.

Public health functions and programmes

Desirable attribute GV1	Health financing policies are guided by UHC goals, take a system-wide perspective, and prioritize and sequence strategies for both individual and population-based services
Key areas of strength and weakness in Kenya	Kenya is committed to making meaningful progress towards Universal Health Coverage (UHC). The current Kenya Health Financing Strategy outlines a clear path to align with the UHC goals of financial protection and equitable access by addressing policy gaps and challenges from a system-wide perspective, particularly targeting vulnerable populations. However, its implementation has not been fully realized: • Expanding fiscal space is challenging, especially as donor support to the health sector is declining. However, additional funds will be necessary to fill the gap left by donors. There is scope to reduce this resource gap by restructuring the health system, particularly for vertical donor-funded programs, in a manner that eliminates unnecessary duplication, redundancies, and other sources of inefficiency. • The multiple program-based funding streams, each characterized by different payment mechanisms, has contributed to fragment the policy vision and complicated operations. • There is a need to put in place improved redistributive mechanisms and the prudent use of public resources to achieve the Kenya HFS objectives and UHC goals. Currently, the Government of Kenya is working to implement a National Social Health Insurance set to start in 2024. Several acts have been enacted, introducing the legal framework to key reforms aimed at addressing the fragmentation of funding schemes, improving and harmonizing purchasing mechanisms for health facilities, and enhancing access to a uniform benefit health package framework for all citizens.
Recommended priority actions	The recent health financing reforms need to be well implemented for the benefits to be realized. The health financing reforms and policies to be developed must ensure system-wide approaches and actions as opposed to focusing on specific programs goals, to enable strengthening the system components to deliver the expected health services equitably, according to the population needs, protecting the most vulnerable from financial hardship.
Desirable attribute PR1	**Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds**
Key areas of strength and weakness in Kenya	Limited risk pooling mechanisms as a consequence of the existence of multiple funds without a specific scheme for accumulating prepaid revenues, with the exception of the Linda Mama scheme funded by the government through the NHIF. The NHIF currently manages over 74 schemes, which present significant management challenges due to the differing functions and symbolisms of each pool. This fragmentation in pooling has led to various inefficiencies within the health system, including limiting the redistributive capacity of available prepaid funds and duplicating the agencies required to manage the pools, especially through the NHIF. Additionally, multiple pools entail higher administrative costs when compared to a single pooling and purchasing agency, which could raise system-wide costs. Furthermore, the existence of multiple information systems linked to each pool, or purchaser, necessitates additional administrative staff at the provider level.
Recommended priority actions	The SHI Act, 2023 should be effectively implemented by creating the three national funds under the management of the Social Health Authority to finance a unified health benefit package framework. Donors' funds could be channelled through the SHI (PHC fund or Emergency fund) to sustain the financing of the Social Health Insurance at the PHC level, and to promote integrated service delivery. Alternatively, external funding could be pooled under the counties management accounts to finance the APW county plans, promoting "One Plan, One budget, and One M&E framework".
Desirable attribute PR2	**Health system and financing functions are integrated or coordinated across schemes and programmes**
Key areas of strength and weakness in Kenya	Multiple program specific funding streams with funding flows characterized by different payment mechanisms, fragmenting the policy vision and complicate operations. Uncoordinated purchasing arrangements that apply different aims, approaches and incentives even when the policy objectives are the same. Misalignments of partner plans with government Annual Work Plans (AWPs), with differences in program priorities. Unsynchronized donor-govt financial cycles that lead to unpredictability in financial flows. Inconsistencies in the application of user fee policy at the service delivery points across counties in relation to health programmes.
Recommended priority actions	The SHI Act, 2023 should be effectively implemented to realize the benefits of harmonization of benefits, with specific consideration of how to harmonizes health programme funds. Efforts should be made to adopt a "one policy, one strategy and one M&E plan" across the AWP process to enable alignment and harmonization of external and conditional grant funds with the overall health financing arrangements.

Public health functions and programmes

Desirable attribute PS2	Purchasing arrangements are tailored in support of service delivery objectives
Key areas of strength and weakness in Kenya	Although there has been some progress in moving away from passive purchasing to strategic purchasing, the existing multiple purchasers use different payment methods and rates to pay the same providers in an uncoordinated way. This has weakened the potential gains from using purchasing as an instrument to influence provider's behaviour to improve the service delivery. For the national and county governments, the purchaser mechanisms continue to be passive, irrespective of performance, with no efforts to influence the quantity or quality of the services delivery.
Recommended priority actions	Under the county stewardship, update and harmonize provider payment methods and mechanisms to health facilities using existing legal provisions, ensuring alignment of incentives. Additionally, align health information systems, supervisory, and monitoring mechanisms across all funding streams.
Desirable attribute PF1	**Purchasing arrangements are tailored in support of service delivery objectives**
Key areas of strength and weakness in Kenya	Health budget formulation manifest misalignments. Partners supporting specific programs do not necessarily align their APW to the county's APW and priorities, leading to lack of clarity on determination of total resources envelope available to contribute to the counties' objectives and targets. Besides, donors support does not align to the Government budgeting cycle and partners do not participate to the MTEF process. This unsynchronised approach leads to unpredictability in financial flows from partners, adversely affecting the planning and budgeting formulation and priority setting. Additionally, development health partners rarely declare the total resources available to support counties and the funds are managed directly by them, limiting the re-distribution to other less resourced programs to align with sector priorities.
Recommended priority actions	• Enhance the PFM capacity of community, county, sub-county and health facility management teams, by developing strategies to increase the capacity for planning, budgeting, accounting and financial analysis with the overall objective of transparency and accountability. • Enhance partner's coordination with county's governments to adopt the principle of "One Policy, One Strategy, and One M&E Plan" though a join APW process. • Support the operationalization of the FIF Act 2023, while strengthening CSOs and citizen groups through budget analysis trainings.

Stage 1 assessment

The health coverage schemes included in Stage 1 were selected according to the criteria outlined in the HFPM Country Assessment Guide. The aim is not to conduct an inventory, but rather to describe the main health schemes and programmes which make up the health system, and around which health financing and other policies are made, and through which money flows to health facilities.

A total of 9 schemes were identified in Kenya, out of which five are under the NHIF and the remaining four are managed separately. We included the devolved units of government as a scheme due to the health budgets they control and because they own and run all levels 2, 3, 4 and 5 facilities in the country. The national government health budget was considered a separate scheme due to its role in policy design and running and management of level 6 facilities. The following are the schemes identified in stage 1 and Table 1 below outlines the objectives and key design features of each scheme.

Coverage schemes:

1. National Government Health Budget
2. The National Insurance Scheme
3. The Civil Servants scheme
4. EDU Afya
5. Linda Mama Programme
6. Other Public Servants scheme
7. County schemes (Equitable share disbursed to county governments)
8. Private Health Insurance schemes
9. Strategic Public Health Programmes (TB, HIV, Malaria)

Stage 1. Health coverage schemes in Kenya: health financing arrangement

Key design feature	National Government Health Budget	National Insurance Scheme	Civil Servants scheme	NHIF – EDU AFYA	Linda Mama Program	Other public servants	County Schemes (Equitable share)	Private Health Insurance Schemes	Strategic Public Health Programs (TB, HIV, MALARIA)
A) Focus of the scheme	Policy Technical assistance Capacity building, National referral, Service delivery	All Kenyan Residents who contribute to the scheme from the Formal sector, Informal sector, refugees, sponsored indigents	All employees of the National Government.	All students enrolled to a public secondary school	All pregnant mothers without any form of insurance	Employees of the County Governments & Ministerial department Agencies (MDA''s)	Service provision for all Kenyan citizens.	Medical cover for corporates and individuals. Government entities e.g county governments	Disease programmes (HIV, TB Malaria) including FP, Immunization, KEMSA, Cancer Program
B) Target population	All Kenyans	51 million Kenyans	131,000 employees, 300,000 dependants	3 million students	1.2 million deliveries	Approximately 800,000	All Kenyans	All Kenyans	General population
C) Population covered	All Kenyans	16,028,321 (only 44% are active)	All	All	760,000 deliveries	All	53 million,	1 million	HIV/TB-1.2 million, Malaria; 4.9 million cases annually Vaccines; 86%of the total population. Cancer; 40000 cases annually. FP: WRA
D) Basis for entitlement/ coverage	Automatic	• Scheme is contributory • Mandatory for Formal sector members • Voluntary for members of the informal sector (Though Act has changed for informal sector to be mandatory in Jan 2023 but not yet implemented) • Automatic for indigents and special groups registered for cash transfer programmes where govt. contributes for them.	Automatic enrolment once in service	Automatic enrolment once enrolled to a public secondary school	• Non-contributory scheme • Automatic for all pregnant mothers without an insurance scheme • National Government sets a Fund	Automatic enrolment once in service	Automatic	Voluntary contributory	Automatic

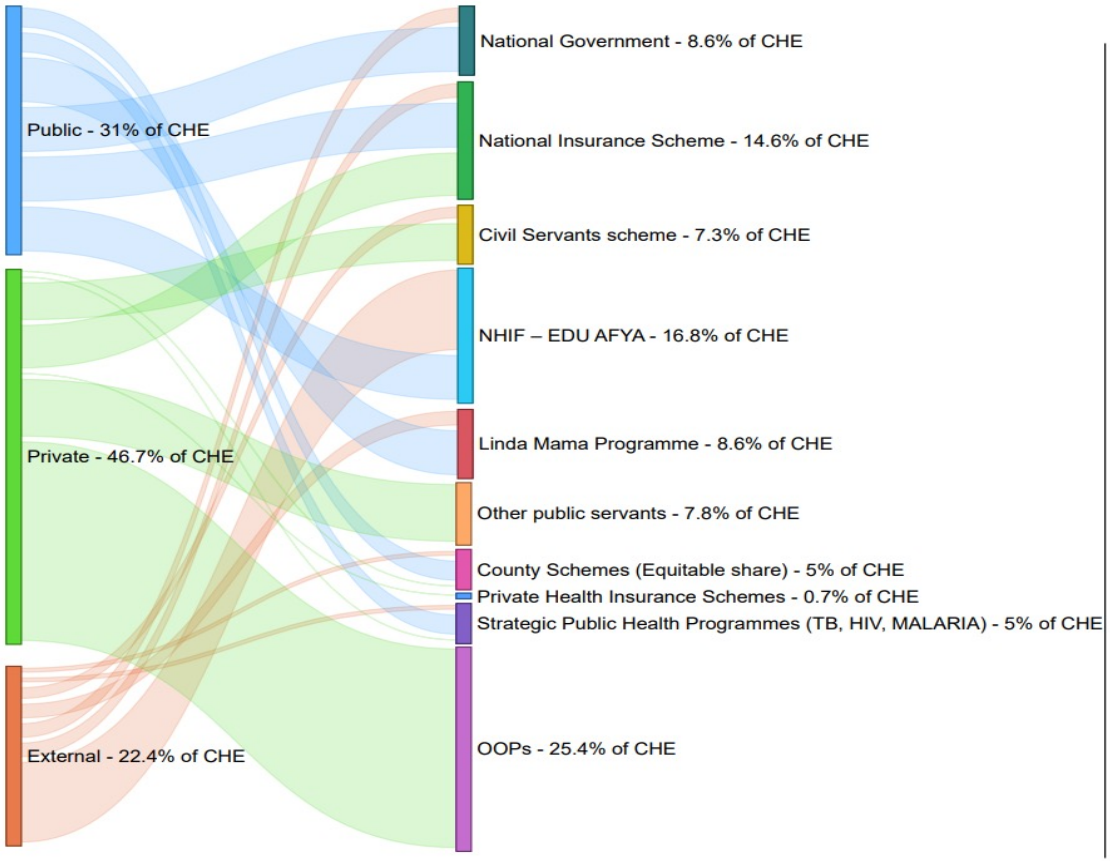
Key design feature	National Government Health Budget	National Insurance Scheme	Civil Servants scheme	NHIF – EDU AFYA	Linda Mama Program	Other public servants	County Schemes (Equitable share)	Private Health Insurance Schemes	Strategic Public Health Programs (TB, HIV, MALARIA)
E) Benefit entitlements	Based on need	1. There is the UHC benefit package for health (2022) that covers services in primary, secondary and tertiary health facilities (, inpatient care is covered for a maximum of 180 days per year) Note 3. 2. Exclusions include; cosmetic surgeries, self-prescriptions, herbal medicines, supplements, dental services and correction of refractive errors, critical care admissions, medical devices, screening, annual medical check-ups etc. NB: Dental and eye surgeries are covered.	1. Services covered are negotiated by the employer and includes all services in primary, secondary and tertiary health facilities Note 4. 2. Exclusions include; cosmetic surgeries, self-prescriptions, herbal medicines,	1. Services covered. are negotiated by the employer and includes all services in primary, secondary and tertiary health facilities Note 4. 2. Exclusions include; cosmetic surgeries, self-prescriptions, herbal medicines, maternal health services	1. Antenatal services 2. Deliveries 3. Post-natal services 4. Complications arising out of pregnancy and delivery	Employer chooses to insure wither through the NHIF or private insurance. For those who choose NHIF, they get benefits similar to Civil servants. For those who choose Private Insurance get similar benefits to the private insurance schemes	Essential inpatient and outpatient services subject to availability.	Inpatient, outpatient, overseas treatment (can be ring-fenced by some) but depth of cover will depend on the scheme.	Community health services, curative, and rehabilitative services
F) Co-payments (user fees)	No Co-payments but there is user fees	Co-payment exists as the benefits are limited to frequency per card. The amount is not structured as the hospital billing is not standardized. Beneficiaries accessing Health facilities contracted as non-comprehensive co-pay almost 90% of their medical bills apart from dialysis services.	No co-payments within benefit limits. Limits are allocated per member for Outpatient, Inpatient and maternity services	No co-payments within benefit limits. Limits are allocated per member for Outpatient and inpatient services	There is no co-payment unless for: Management of complications requiring surgeries and ultrasounds	Limits are allocated per member for Outpatient, Inpatient and maternity services	Subsidized user fee for levels 4, 5 and 6	Co-payment based on the agreement of entitlements.	Co-payment applies in some cases e.g cancer and private sector.

Key design feature	National Government Health Budget	National Insurance Scheme	Civil Servants scheme	NHIF – EDU AFYA	Linda Mama Program	Other public servants	County Schemes (Equitable share)	Private Health Insurance Schemes	Strategic Public Health Programs (TB, HIV, MALARIA)
G) Other conditions of access	Kenyan Citizen access services at the public health facilities	Access to health services is available across all health facility ownership types including government, private and faith based.	Access to health services is available across all health facility ownership types including government, private and faith based.	Access to health services is available across all health facility ownership types including government, private and faith based.	Kenyan citizenship. Access to health services is available across all health facility ownership types including government, private and faith based.	Access to health services is available across all health facility ownership types including government, private and faith based.	Services are accessed at public facilities.	some require pre-assessment, some ring-fenced outpatient services, some ring-fenced access of services especially for chronic conditions	Specific partner agreements
H) Revenue sources	Donor loans and Grants, Taxes	• Formal Sector – statutory contributions • Informal sector – voluntary contributions • Refugees – contributions paid by UNHCR • Indigents, vulnerable groups (PWD"s, Orphans, elderly) – Health insurance subsidy Programs by the National & County Governments health budgets	Employer pays premiums	Ministry of Education allocates funds from their budget.	Ministry of Health allocated Funds from their budget	Employer pays premiums	User fee, National treasury-health budget (sharable revenue), partners	Employers, Members, employee-organization co-funding, Kenya Re	Donor Government of Kenya Co-funding County Program based Government User Fees
I) Pooling	National Govt through treasury	Single pool	Single pool	Single pool	A fund operated on reducing balance	No pooling	Multiple pools	Multiple pools.	Multiple pools (national, county, donors
J) Governance of health financing	Treasury, Ministry of Health, SAGAs, Level 6 Referral Health Facilities, NHIF	NHIF Board, Ministry of Health	Ministry of Public Service, Gender and Affirmative action, National Treasury	Ministry of Education, National Treasury	Ministry of Health, National treasury	County Governments	County executive, county assembly, Ministry of Health, Controller of budget.	IRA. AKI, and private health insurance schemes. Association of Kenya Professional Insurance Agents – AKPIA, Association of Insurance Brokers of Kenya – AIBK	Ministry of Health, National treasury, donors and county government, Health Sector partnership & Coordination structures

Key design feature	National Government Health Budget	National Insurance Scheme	Civil Servants scheme	NHIF – EDU AFYA	Linda Mama Program	Other public servants	County Schemes (Equitable share)	Private Health Insurance Schemes	Strategic Public Health Programs (TB, HIV, MALARIA)
K) Provider payment	Global Budget	Capitation, per-diem, Case based	Fee for Service, Case based	Fee for Service, Case based	Case based	Fee for Service, Case based	Global budget, input based, User fees	Fixed fee-for-service, case-based, capitation, fee-for-service	Global budget, input budget, Line items
L) Service delivery & contracting	All Government of Kenya facilities	• Public, Private-for-profit and private-non-profit • The Kenya Health Professions Oversight Authority accredits all health facilities • Kenya Medical Practitioners and Dentists Board licenses all Private-for-profit and private-not-for profit facilities • Ministry of health and County Government Health Units manages the government facilities • NHIF empanels these facilities who meet the set quality standard threshold	• Public, Private-for-profit and private-non-profit • The Kenya Health Professions Oversight Authority accredits all health facilities • Kenya Medical Practitioners and Dentists Board licenses all Private-for-profit and private-not-for profit facilities, • Ministry of health and County Government Health Units manages the government facilities • NHIF empanels these facilities who meet the set quality standard threshold	• Public, Private-for-profit and private-non-profit • The Kenya Health Professions Oversight Authority accredits all health facilities • Kenya Medical Practitioners and Dentists Board licenses all Private-for-profit and private-not-for profit facilities, • Ministry of health and County Government Health Units manages the government facilities • NHIF empanels these facilities who meet the set quality standard threshold	• Public, Private-for-profit and private-non-profit • The Kenya Health Professions Oversight Authority accredits all health facilities • Kenya Medical Practitioners and Dentists Board licenses all Private-for-profit and private-not-for profit facilities, • Ministry of health and County Government Health Units manages the government facilities • NHIF empanels these facilities who meet the set quality standard threshold	• Public, Private-for-profit and private-non-profit • The Kenya Health Professions Oversight Authority accredits all health facilities • Kenya Medical Practitioners and Dentists Board licenses all Private-for-profit and private-not-for profit facilities, • Ministry of health and County Government Health Units manages the government facilities • NHIF empanels and contracts these facilities who meet the set quality standard threshold	Services are accessed at public facilities.	Private health facilities, FBO – Brokers who act as an intermediary e.g Medical Administrators Kenya Limited (MAKL) for teachers and police schemes	Commodity & service level contracting

Health expenditure by Stage 1 coverage schemes

Fig. 6: Expenditure flows by scheme (Sankey diagram)



WHERE DO SCHEMES/PROGRAMMES REVENUES COME FROM?

Stage 1 Schemes	Public	Private	External	Total
National Government	71.9%	-	28.1%	100%
National Insurance Scheme	42.3%	41.1%	16.5%	100%
Civil Servants scheme	-	72.0%	27.9%	100%
NHIF – EDU AFYA	36.8%	-	63.2%	100%
Linda Mama Programme	71.9%	-	28.1%	100%
Other public servants	-	100%	-	100%
County Schemes (Equitable share)	61.6%	14.3%	24.1%	100%
Private Health Insurance Schemes	-	100%	-	100%
Strategic Public Health Programmes (TB, HIV, MALARIA)	61.6%	14.3%	24.1%	100%
OOPs	-	100%	-	100%

HOW ARE REVENUE SOURCES DISTRIBUTED ACROS SCHEMES/PROGRAMMES?

Stage 1 Schemes	Public	Private	External
National Government	20.0%	-	10.8%
National Insurance Scheme	20.0%	12.9%	10.8%
Civil Servants scheme	-	11.3%	9.2%
NHIF – EDU AFYA	20.0%	-	47.5%
Linda Mama Programme	20.0%	-	10.8%
Other public servants	-	16.7%	-
County Schemes (Equitable share)	10.0%	1.5%	5.4%
Private Health Insurance Schemes	-	1.5%	-
Strategic Public Health Programmes (TB, HIV, MALARIA)	10.0%	1.5%	5.4%
OOPs	-	54.5%	-
Total	100%	100%	100%

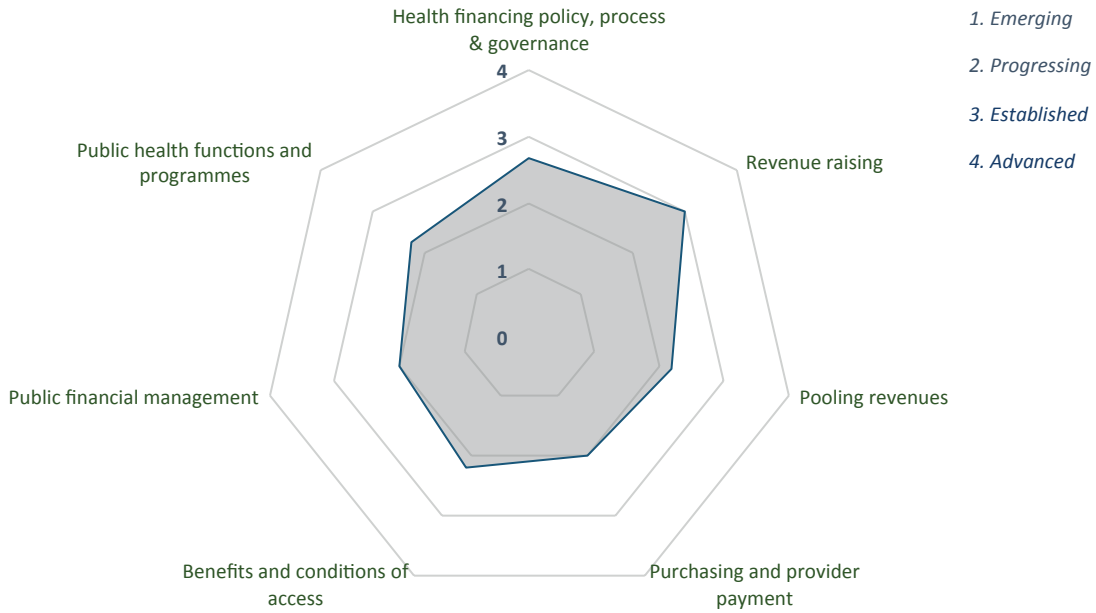
Source: Author estimates based on the HF x FS breakdown available using Health Accounts 2016 (Ministry of Health, Kenya), supplemented by the most recent expenditure estimates for the schemes identified in Stage 1.

Stage 2 assessment

Stage 2 takes a close look at health financing policies in the country, based on thirty-three questions organized into seven assessment areas. For each question a rating between 1 and 4 is indicated, based on extensive discussion and validation; this signals the current situation in Kenya on each specific area of policy, relative to global best practice.

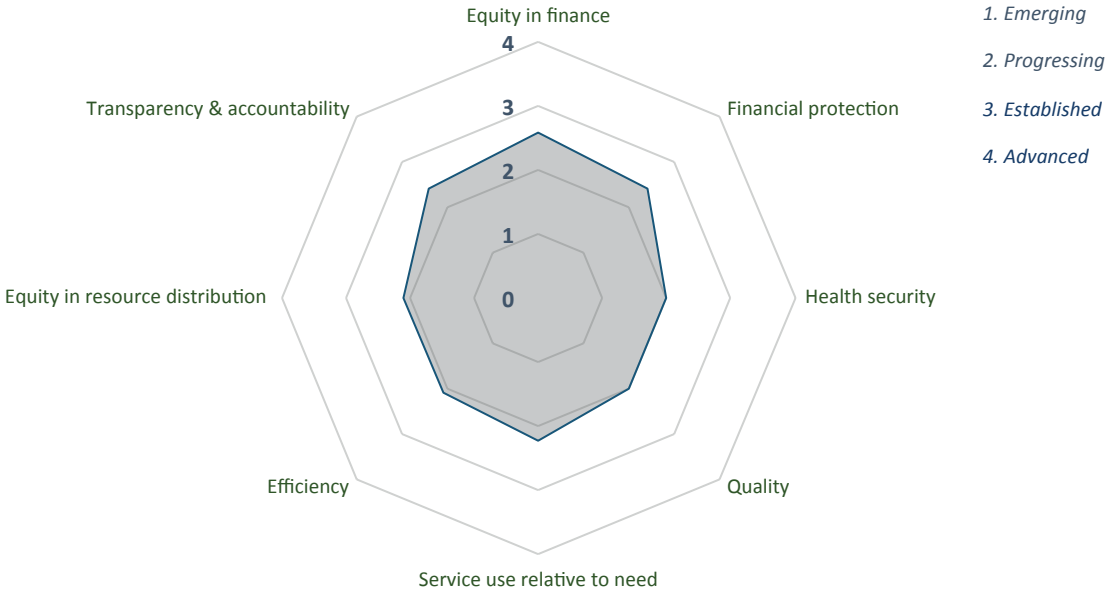
Summary of ratings by assessment area

Fig. 7: Average rating by assessment area (spider diagram)



Source: Based on HFPM data collection template v2.0, Kenya 2023

Fig. 8: Average rating by goals and objectives (spider diagram)

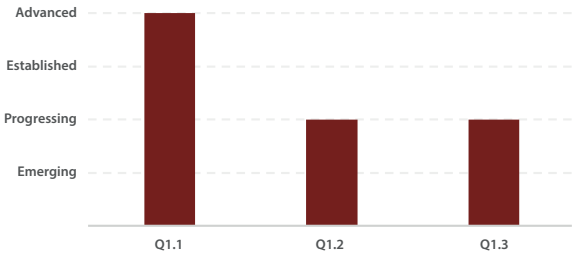


Source: Based on HFPM data collection template v2.0, Kenya 2023

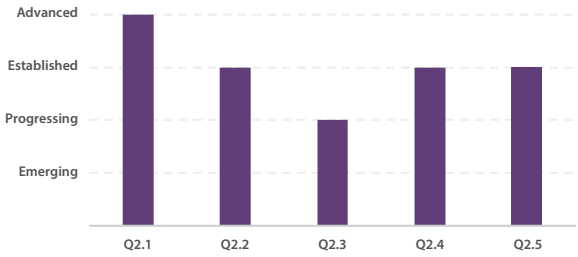
Assessment rating by individual question

Fig. 9: Assessment rating by intermediate objective and final coverage goals

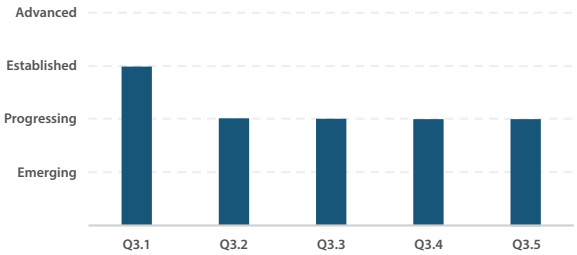
1. Health financing policy, process & governance



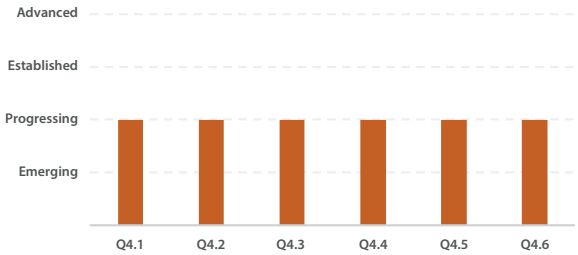
2. Revenue raising



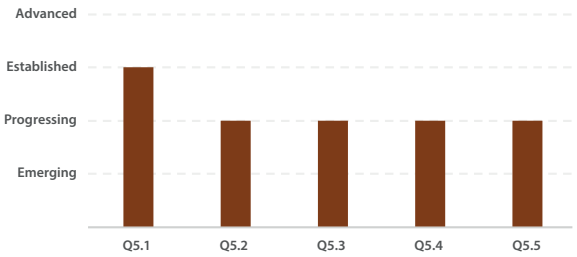
3. Pooling revenues



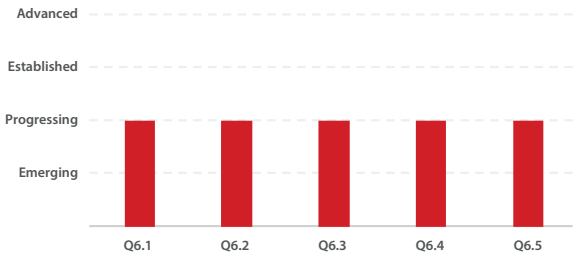
4. Purchasing and provider payment



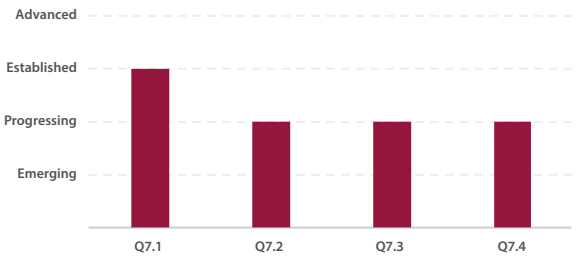
5. Benefit and conditions of access



6. Public financial management



7. Public health functions and programmes

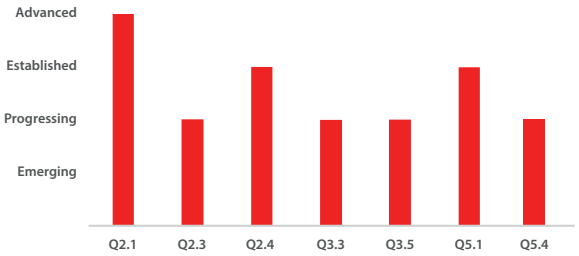


See Annex 3 for question details

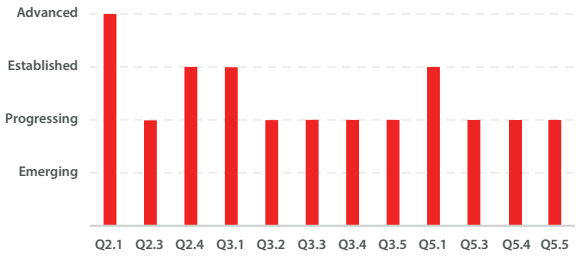
Assessment rating by UHC goals

Fig. 10: Assessment rating by intermediate objective and final coverage goals

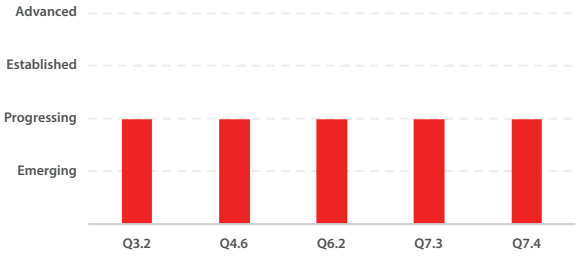
Equity in finance



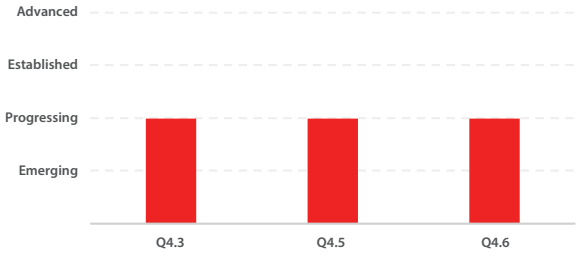
Financial protection



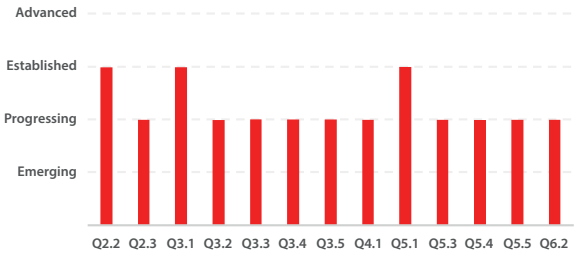
Health security



Quality



Service use relative to need

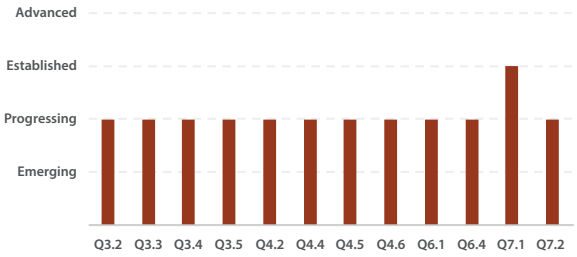


See Annex 3 for question details

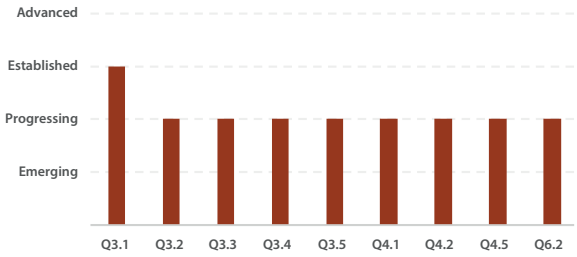
Assessment rating by intermediate objective

Fig. 10 (continued): Assessment rating by intermediate objective and final coverage goals

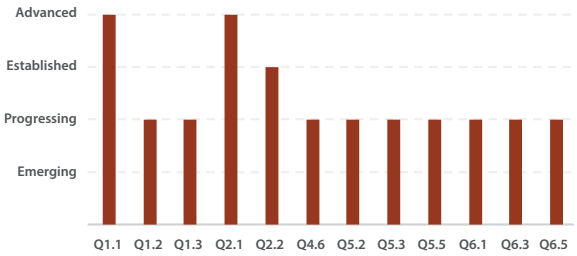
Efficiency



Equity in resource distribution



Transparency & accountability



See Annex 3 for question details

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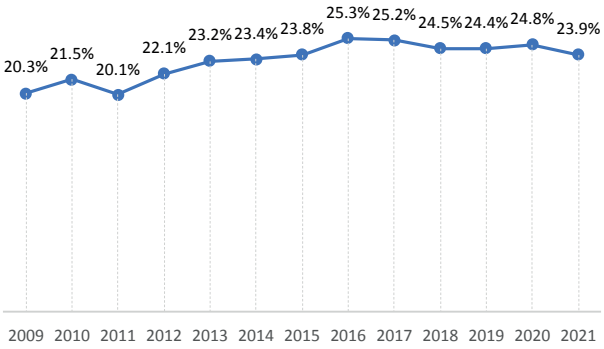
Annexes

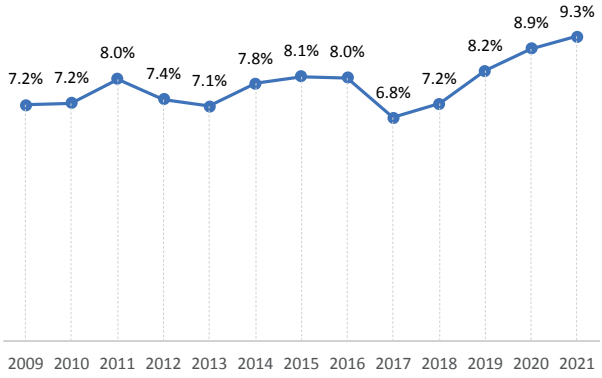
Annex 1: Selected contextual indicators

Fig. A1.1: Health expenditure indicators for Kenya

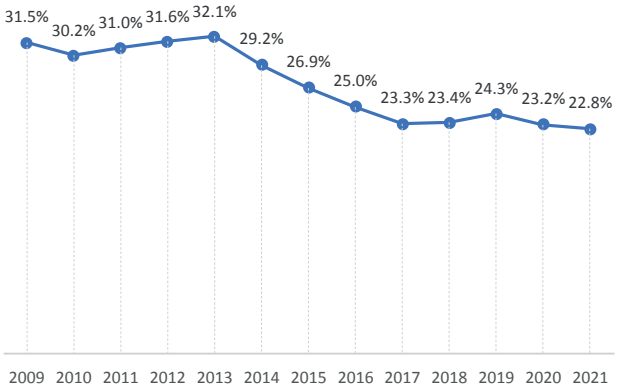
General Government Expenditure (GGE) as % Gross Domestic Product (GDP)



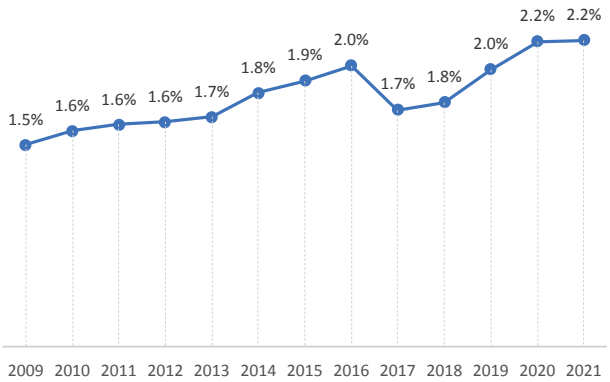
Domestic General goverment health expenditure (GGHE-D) as % General Government Expenditure (GGE)



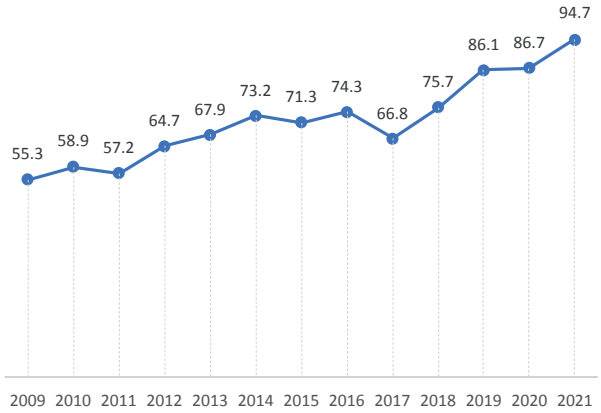
Out-of-pocket spending as % Current health expenditure (OOPS % CHE)



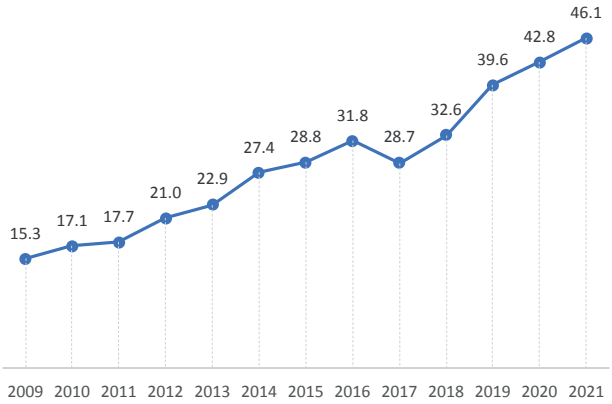
Domestic General goverment health expenditure (GGHE-D) as % Gross Domestic Product (GDP)



Current Health Expenditure (CHE) per Capita in US$

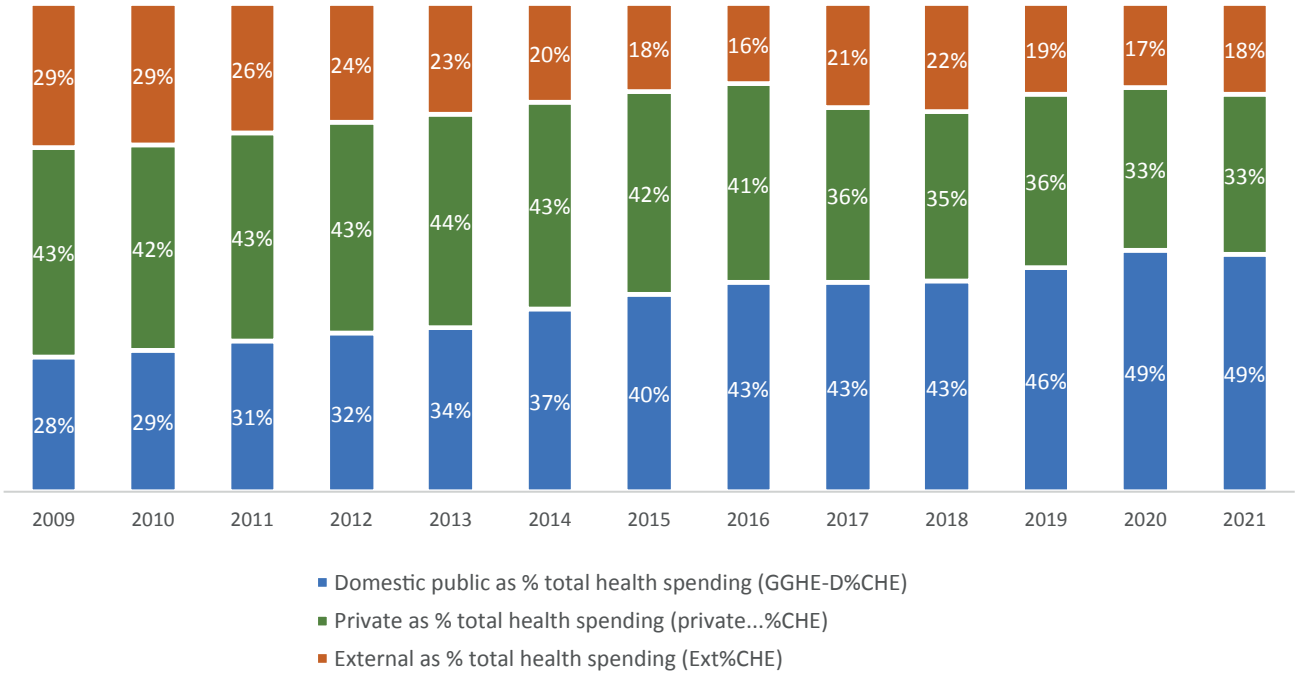


Domestic General Government Health Expenditure (GGHE-D) per Capita in US$



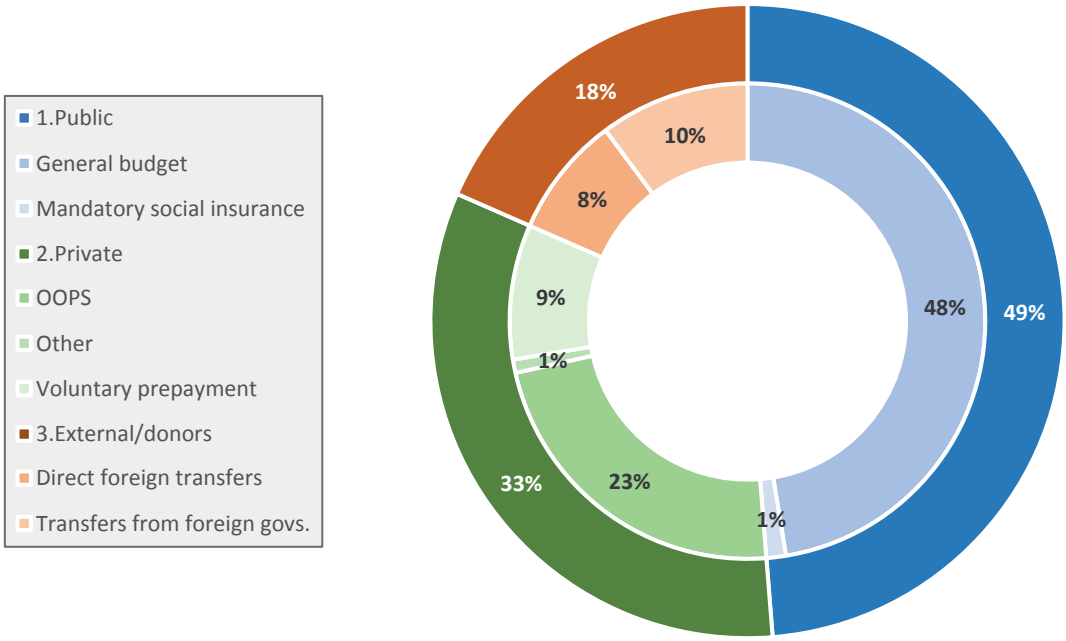
Source: WHO Global Health Expenditure 2023 (https://apps.who.int/nha/database/Home/Index/en, accessed 1 January 2024)

Fig. A1.2: Revenue sources for health in Kenya



Source: WHO Global Health Expenditure 2023 (https://apps.who.int/nha/database/Home/Index/en, accessed 1 January 2024)

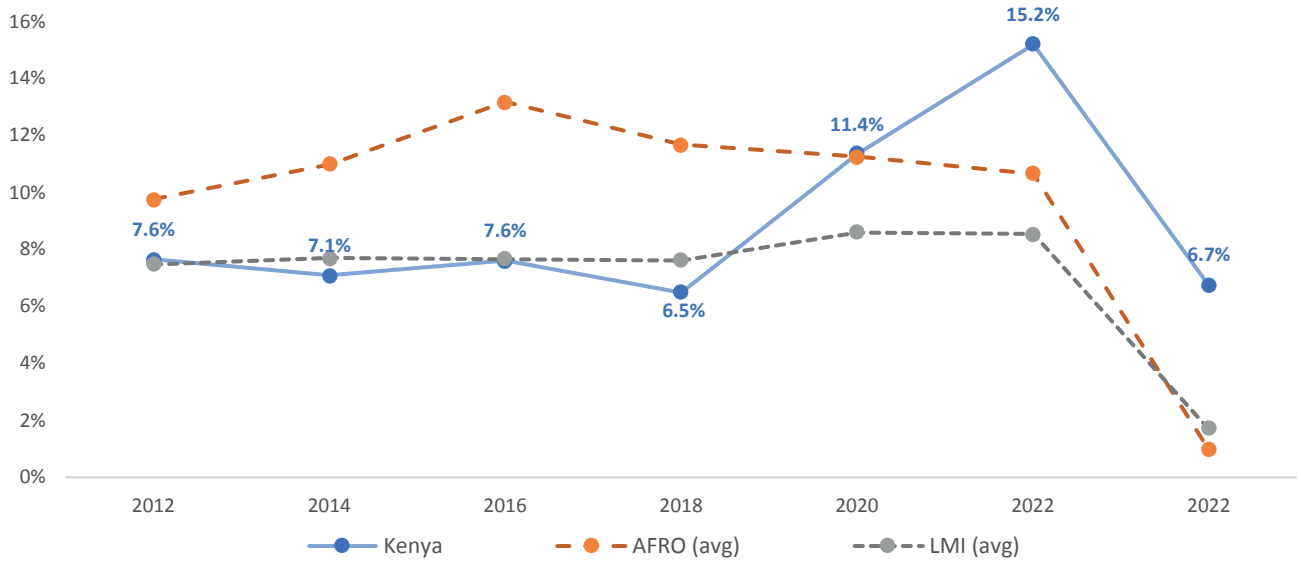
Fig. A1.3: Revenue sources disaggregated 2021



Source: WHO Global Health Expenditure 2023 (https://apps.who.int/nha/database/Home/Index/en, accessed 1 January 2024)

Fig. A1.4: Cigarette affordability in Kenya

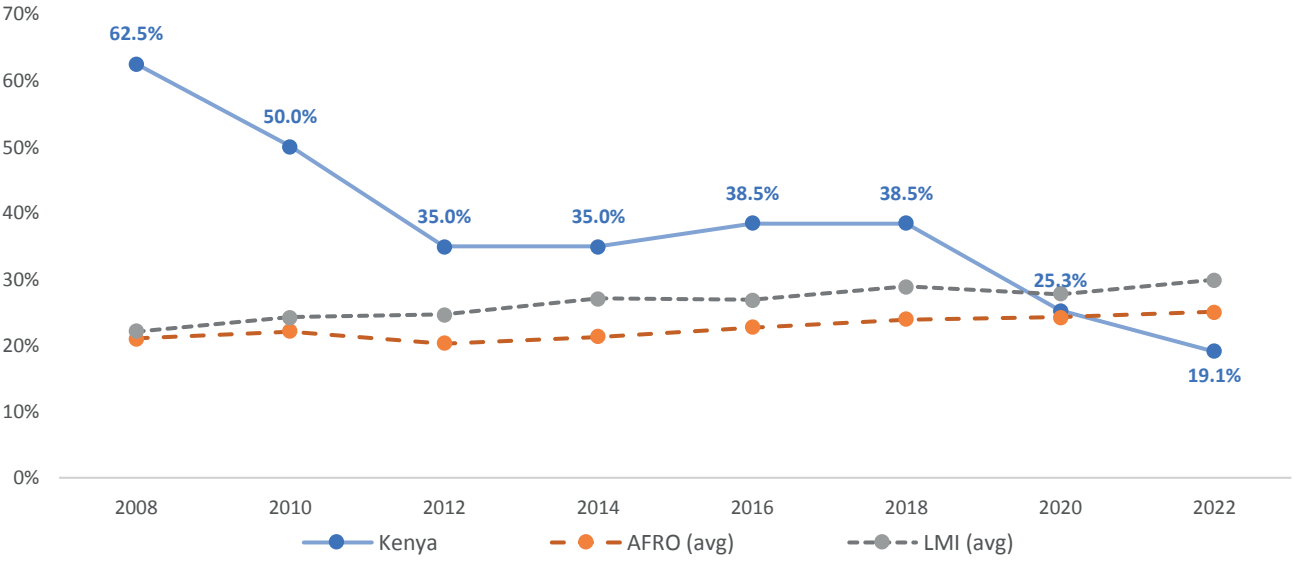
Reducing affordability is an important measure of the success of tobacco tax policy. In the longer term, a positive, higher measure means cigarettes are becoming less affordable. Short term changes in affordability are also presented.



Source: WHO report on the global tobacco epidemic 2023 (https://www.who.int/teams/health-promotion/tobacco-control/global-tobacco-report-2023, accessed 30 July 2023)

Fig. A1.5: Excise tax share in Kenya

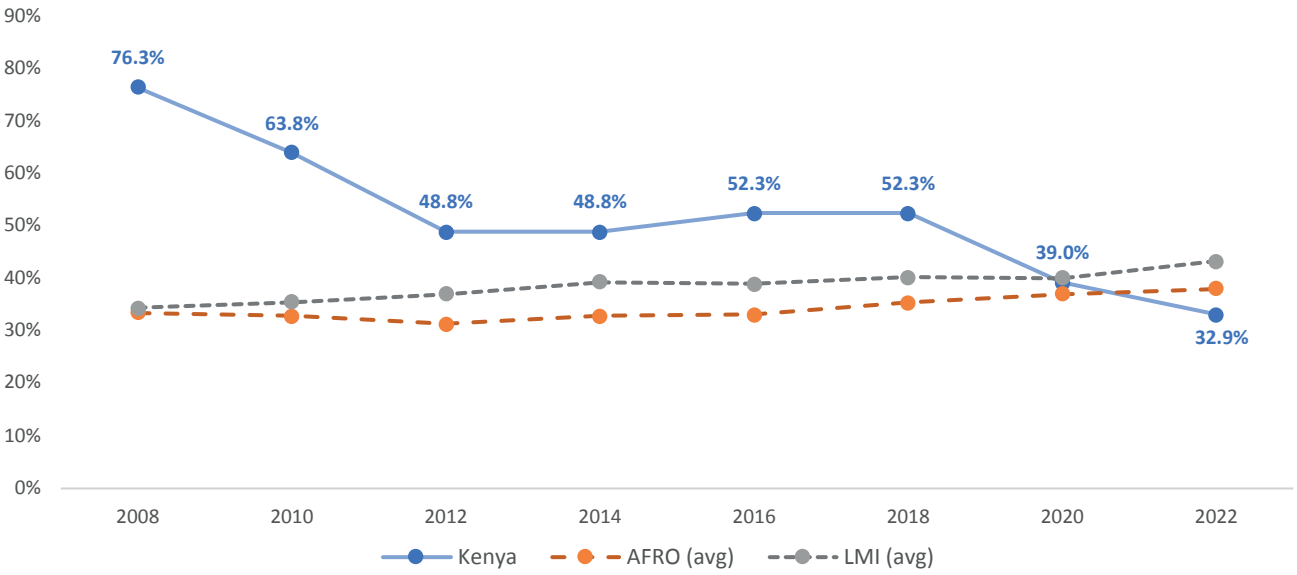
WHO recommends an excise tax share of 70%. Total tax share includes import duties and levies.



Source: WHO report on the global tobacco epidemic 2023 ((https://www.who.int/teams/health-promotion/tobacco-control/global-tobacco-report-2023, accessed 30 July 2023)

Fig. A1.6: Total tax share in Kenya

This indicator represents the best comparable measure of the magnitude of total tobacco taxes relative to the price of a pack of the most widely sold brand of cigarettes in the country. Total taxes include excise taxes, VAT/sales taxes and, where relevant, import duties and/or any other indirect tax applied in a country.



Source: WHO report on the global tobacco epidemic 2023 ((https://www.who.int/teams/health-promotion/tobacco-control/global-tobacco-report-2023, accessed 30 July 2023)

Annex 2: Desirable attribute of health financing

Policies which help to drive progress to UHC are summarized n terms of nineteen desirable attributes of health financing policy. For further information see: https://www.who.int /publications/i/item/9789240017405

Desirable attributes of health financing systems		
Health financing policy, process & governance	GV1	Health financing policies are guided by UHC goals, take a system-wide perspective and prioritize and sequence strategies for both individual and population-based services
	GV2	There is transparent, financial and non-financial accountability, in relation to public spending on health
	GV3	International evidence and system-wide data and evaluations are actively used to inform implementation and policy adjustments
Revenue raising	RR1	Health expenditure is based predominantly on public/compulsory funding sources
	RR2	The level of public (and external) funding is predictable over a period of years
	RR3	The flow of public (and external) funds is stable and budget execution is high
	RR4	Fiscal measures are in place that create incentives for healthier behaviour by individuals and firms
Pooling revenues	PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds
	PR2	Health system and financing functions are integrated or coordinated across schemes and programmes
Purchasing & provider payment	PS1	Resource allocation to providers reflects population health needs, provider performance or a combination
	PS2	Purchasing arrangements are tailored in support of service delivery objectives
	PS3	Purchasing arrangements incorporate mechanisms to ensure budgetary control
Benefits & conditions of access	BR1	Entitlements and obligations are clearly understood by the population
	BR2	A set of priority health service benefits within a unified framework is implemented for the entire population
	BR3	Prior to adoption, service benefit changes are subject to cost–effectiveness and budgetary impact assessments
	BR4	Defined benefits are aligned with available revenues, health services and mechanisms to allocate funds to providers
	BR5	Benefit design includes explicit limits on user charges and protects access for vulnerable groups
Public financial management	PF1	Health budget formulation and structure support flexible spending and are aligned with sector priorities
	PF2	Providers can directly receive revenues, flexibly manage them and report on spending and output

Desirable attributes of health financing systems		
Public health functions & programmes[3]	GV1	Health financing policies are guided by UHC goals, take a system-wide perspective and prioritize and sequence strategies
	PR1	Pooling structure and mechanisms across the health system enhance the potential to redistribute available prepaid funds
	PR2	Health system and financing functions are integrated or coordinated across schemes and programmes
	PS2	Purchasing arrangements are tailored in support of service delivery objectives
	PF1	Health budget formulation and structure supports flexible spending and is aligned with sector priorities

Annex 3. HFPM assessment questions

Assessment	Question number code	Question text
1) Health financing policy, process & governance	Q1.1	Is there an up-to-date health financing policy statement guided by goals and based on evidence?
	Q1.2	Are health financing agencies held accountable through appropriate governance arrangements and processes?
	Q1.3	Is health financing information systemically used to monitor, evaluate and improve policy development and implementation?
2) Revenue raising	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.2	How predictable is public funding for health in your country over a number of years?
	Q2.3	How stable is the flow of public funds to health providers?
	Q2.4	To what extent are the different revenue sources raised in a progressive way?
	Q2.5	To what extent does government use taxes and subsidies as instruments to affect health behaviours?
3) Pooling revenues	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
4) Purchasing & provider payment	Q4.1	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	Q4.2	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q4.3	Do purchasing arrangements promote quality of care?
	Q4.4	Do provider payment methods and complementary administrative mechanisms address potential over- or under-provision of services?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?

Assessment area	Question number code	Question text
5) Benefits & conditions of access	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.2	Are decisions on those services to be publicly funded made transparently using explicit processes and criteria?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
6) Public financial management	Q6.1	Is there an up-to-date assessment of key public financial management bottlenecks in health?
	Q6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
	Q6.3	Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?
	Q6.4	Are there measures to address problems arising from both under- and over-budget spending in health?
	Q6.5	Is health expenditure reporting comprehensive, timely, and publicly available?
7) Public health functions & programmes	Q7.1	Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?
	Q7.2	Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?
	Q7.3	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?
	Q7.4	Are public financial management systems in place to enable a timely response to public health emergencies?

Annex 4: Questions mapped to objectives and goals

Each question represents an area of health financing policy, selected given its influence on UHC intermediate objectives and goals, as explicitly defined below.

Objective / goal	Question number code	Question text
Equity in resource distribution	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q4.1	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	Q4.2	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
Efficiency	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q4.2	Are provider payments harmonized within and across purchasers to ensure coherent incentives for providers?
	Q4.4	Do provider payment methods and complementary administrative mechanisms address potential over- or under-provision of services?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?
	Q6.1	Is there an up-to-date assessment of key public financial management bottlenecks in health?
	Q6.4	Are there measures to address problems arising from both under- and over- budget spending in health?
	Q7.1	Are specific health programmes aligned with, or integrated into, overall health financing strategies and policies?
	Q7.2	Do pooling arrangements promote coordination and integration across health programmes and with the broader health system?

Objective / goal	Question number code	Question text
Transparency & accountability	Q1.1	Is there an up-to-date health financing policy statement guided by goals and based on evidence?
	Q1.2	Are health financing agencies held accountable through appropriate governance arrangements and processes?
	Q1.3	Is health financing information systemically used to monitor, evaluate and improve policy development and implementation?
	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.2	How predictable is public funding for health in your country over a number of years?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?
	Q5.2	Are decisions on those services to be publicly funded made transparently using explicit processes and criteria?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
	Q6.1	Is there an up-to-date assessment of key public financial management bottlenecks in health?
	Q6.3	Are processes in place for health authorities to engage in overall budget planning and multi-year budgeting?
	Q6.5	Is health expenditure reporting comprehensive, timely, and publicly available?
Service use relative to need	Q2.2	How predictable is public funding for health in your country over a number of years?
	Q2.3	How stable is the flow of public funds to health providers?
	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q4.1	To what extent is the payment of providers driven by information on the health needs of the population they serve?
	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
	Q6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?

Objective / goal	Question number code	Question text
Financial protection	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.3	How stable is the flow of public funds to health providers?
	Q2.4	To what extent are the different revenue sources raised in a progressive way?
	Q3.1	Does your country's strategy for pooling revenues reflect international experience and evidence?
	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.4	Are multiple revenue sources and funding streams organized in a complementary manner, in support of a common set of benefits?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.3	To what extent are population entitlements and conditions of access defined explicitly and in easy-to-understand terms?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
	Q5.5	Are defined benefits aligned with available revenues, available health services, and purchasing mechanisms?
Equity in finance	Q2.1	Does your country's strategy for domestic resource mobilization reflect international experience and evidence?
	Q2.3	How stable is the flow of public funds to health providers?
	Q2.4	To what extent are the different revenue sources raised in a progressive way?
	Q3.3	What measures are in place to address problems arising from multiple fragmented pools?
	Q3.5	What is the role and scale of voluntary health insurance in financing health care?
	Q5.1	Is there a set of explicitly defined benefits for the entire population?
	Q5.4	Are user charges designed to ensure financial obligations are clear and have functioning protection mechanisms for patients?
Quality	Q4.3	Do purchasing arrangements promote quality of care?
	Q4.5	Is the information on providers' activities captured by purchasers adequate to guide purchasing decisions?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?
Health security	Q3.2	To what extent is the capacity of the health system to re-distribute prepaid funds limited?
	Q4.6	To what extent do providers have financial autonomy and are held accountable?
	Q6.2	Do health budget formulation and implementation support alignment with sector priorities and flexible resource use?
	Q7.3	Do financing arrangements support the implementation of IHR capacities to enable emergency preparedness?
	Q7.4	Are public financial management systems in place to enable a timely response to public health emergencies?

For additional information, please contact:

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