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FACILITY AUTONOMY IN THE AGE OF DEVOLUTION: COUNTY-LEVEL ARRANGEMENTS FOR MANAGING HEALTH FACILITY REVENUE IN KENYA

SP4PHC
Strategic Purchasing for Primary Health Care

THINKWELL

In Kenya, government-owned health facilities could retain the revenue they collected from user fees, health insurance reimbursements, and government transfers prior to devolution in 2013. Facilities would spend these funds to address their immediate needs, including sourcing for commodities, hiring casual workers, and paying for other operating costs. After devolution, their ability to retain and use own-source revenue became dependent on how the newly formed county governments interpreted the 2012 Public Finance Management Act. Most counties started requiring facilities to transfer all own-source revenue to the county treasury. Some have since put in place arrangements to grant financial autonomy to health facilities. Under the Strategic Purchasing for Primary Health Care (SP4PHC) project, ThinkWell reviewed facility financing arrangements in Kenya's 47 counties. This brief summarizes the findings and offers reflections on potential implications for service readiness.

INTRODUCTION

The topic of autonomy for health facilities has garnered considerable attention lately. The principle of facility autonomy ensures that a public health facility can generate, receive, spend, and account for funds from any legal source (World Health Organization 2022). Autonomy is not just about the amount of money that facilities have, but also about the kinds of decisions they can make with it (Barasa et al. 2022). Several health financing interventions have been critical in setting the stage for increased facility autonomy and flexible spending (Piatti-Fuenfkirchen, Hadley, and Mathivet 2021). Although greater autonomy at the primary health care level resulted in improved services delivery in many cases (Cashin et al. 2017), the *Lancet Global Health* Commission on financing primary health care emphasizes that public facilities still have little autonomy over their spending. Specifically, facilities in fewer than 40% of the low- and middle-income countries have autonomy to retain and manage income, which ultimately affects their ability to deliver services and respond to local needs (Hanson et al. 2022).

In Kenya, the transition to a devolved system of government in 2013 has shifted the decision-making power over how most public facilities are managed and financed to the 47 county governments. This has led to different arrangements regarding facility financial autonomy across counties. To date, there is no review and categorization of such arrangements across the 47 Kenyan counties.

In this brief, ThinkWell reports findings from a study to review how county governments in Kenya are setting up arrangements to enhance financial autonomy of health facilities. Under the SP4PHC project, ThinkWell has been supporting several county governments to improve financing for primary health care, which includes reforming how those funds flow to health facilities. This study builds on this ongoing work. Below, the methodology describes the one first followed for the review. Next, the financing arrangements in public health facilities are described, including the evolution of public financial management laws pertaining to facility financial autonomy and an overview of the status of facility financial autonomy across Kenya's 47 counties. Finally, the potential pros and cons of the different arrangements pertaining to facility financial autonomy at the county level are discussed.

METHODOLOGY

The study adopted a mixed methods approach. The team reviewed the status of facility financial autonomy

in Kenya's 47 counties (as of January 2023) (Annex 1). The review was based on county government documents, the 2012 Public Finance Management Act, advisories from the Ministry of Health (MOH) and the National Treasury, and information obtained during 22 key informant interviews conducted with selected county departments of health and facility managers. The team also analyzed source revenue collected by health facilities using data from the records of the county departments of health and finance in the four purposively selected counties.

FINDINGS

Revenue sources for public health facilities

Before 2013, public health facilities controlled their operating budget and used revenues from user fees and other sources to pay for a range of things. While the government paid directly for several inputs, health facilities generated revenue from user fees and payments from the government and donors (see Box 1 for more details on the evolution of user fee policies in Kenya). They used these own-source revenues to purchase commodities when they faced stock-outs, hired casual labor, and paid for other operating costs. The district—an administrative unit that predated devolution–received a share of these funds to finance its activities (more details on this are available in the next section).

With the transition to a devolved system of government in 2013, user fees for all services at health centers and dispensaries as well as fees for deliveries at all public facilities were abolished. To compensate facilities for the missing user fees, the national government initially paid the facilities directly. Later, it converted the payments for health centers and dispensaries for general user fees forgone into conditional grants to counties. It also transitioned the

Box 1. Evolution of user fee policies

All services in public health facilities were free of charge until 1989, when the Government of Kenya (GOK) introduced user fees to raise additional revenue for the health sector (Chuma and Maina 2013; Mwabu and Mwangi 1986). Districts retained the revenue generated and used it for health service delivery and various public health programs (Chuma et al. 2009; Owino 1998). During the 1990s, the GOK introduced several waivers and exemptions for certain services, but user fees continued to be a barrier to access (Mwabu, Mwanzia, and Liambila 1995; Moses et al. 1992).

In 2004, the GOK abolished user fees for primary care and adopted a single flat registration fee of 10 and 20 Kenyan shillings (KSh) at dispensaries and health centers, respectively (Chuma et al. 2009). To compensate for the loss of user fees, the GOK and development partners jointly set up mechanisms to channel money directly to public health facilities in 2009: the Health Sector Support Fund for dispensaries and health centers and the Hospital Management Support Fund for hospitals (Tama et al. 2017; Ramana, Chepkoech, and Workie 2013). Even so, according to the 2012 Public Expenditure Tracking Survey (PETS), revenues from user fees accounted for 70% and 53% of the operating budget of public hospitals, and health centers and dispensaries, respectively. Hospitals spent their own-source revenue on medical supplies and laboratory materials (20%), food and rations (18%), and drugs (11%). Health centers spent their income on drugs (37%) and casual labor (13%). Of the operating budget's dispensaries, 20%, 16%, and 13% was spent on casual labor, food and rations, and drugs, respectively (Onsomu et al. 2014).

In 2013, the GOK abolished all user fees at health centers and dispensaries in the public sector, as well as user fees for deliveries at all public facilities (Chuma and Thomas 2013). Initially, the MOH started reimbursing the facilities directly; however, given the newly devolved system of government, the direct transfers were deemed unconstitutional and the reimbursements for user fees forgone were converted into conditional grants to the county in FY 2015/16 (Office of the Controller of Budget n.d.). The GOK released the conditional grants—some of which were funded by partners—to counties with instructions on how much should be transferred to the facilities based on service utilization data from the health information system. In 2017, the free maternity program was transferred to NHIF. (A more detailed description of the evolution of user fee policies in Kenya can be found in Mbuthia et al. 2019.)

In the FY 2021/22 budget, the national government discontinued various conditional grants, including the one for user fees forgone. The funds were converted into block grants, giving counties fuller discretion over their use (The National Treasury 2021). How this will affect financing of health facilities remains to be seen.

free maternity program to the National Hospital Insurance Fund (NHIF).

Public sector health facilities have several sources of revenue. The common sources of revenue are user fees, reimbursements from NHIF, donor-funded grants, and donations. Other sources of revenue include reimbursements from private insurance schemes to public facilities or funds as appropriated by county assemblies or the national government. A few county governments transfer other grants to facilities to meet their recurrent expenditures.

Evolution of public financial management laws pertaining to facility financial autonomy

Over the years, the GOK developed guidelines or manuals to guide the collection and use of facility revenues. The GOK provided such guidelines in 1989, when public hospitals and health centers started to collect user fees (MOH 2014a). In 2002, the GOK updated the manuals to improve the existing practices. Specifically, the updates stated that the revenues generated from user fees and health insurance reimbursements from NHIF were supposed to be deposited into the health care service fund at the district level. The health care service fund, also known as the facility improvement fund, health services fund, health fund, or health services improvement fund, is an instrument to ring-fence revenue from health facilities for use by health facilities. Health facilities received 75% of the deposited revenues, which they could use to improve service delivery, according to the plan the facility developed, and the district health management team approved. The remaining 25% of funds supported district-level preventive and promotive health care services (Ministry of Health 2002); however, the 2008 public expenditure tracking (PETS) showed that the transfer of the 75% portion of funds back to the facilities that collected it did not always happen, often due to bureaucratic challenges at the district level. With the establishment of the Health Sector Support Fund and the Hospital Management Support Fund in 2009, the MOH issued legal notices that not only allowed funds to flow directly to public health facilities, but also allowed facilities to retain and use the revenues they raise without having to transfer these revenues to the district treasury accounts (Health Rights Advocacy Forum 2011).

In 2013, Kenya transitioned to a devolved system of government under which 47 newly formed counties started operating their own central funds. As per the 2010 Constitution, counties receive a share of revenue collected by the national government and can also raise their own revenue, which includes fees and reimbursements collected by health facilities. Counties allocate funds to public health providers, including dispensaries, health centers, and hospitals through input-based financing (for health worker salaries, commodities, and other operating costs) and financial transfers (Mbuthia et al. 2019). Under the 2010 Constitution and 2012 Public Finance Management Act, each county operates a county revenue fund (CRF) where it pools funds from a block grant from the national government, own-source revenue (including funds generated by public health facilities from user fees and health insurance reimbursements from NHIF), and conditional grants from the national government and donors (Mbuthia et al. 2019); however, the 2012 Public Finance Management Act allows counties to authorize any county entity—including health facilities—to retain the funds it generates (Box 2) (The Republic of Kenya n.d.; Kairu et al. 2021).

Box 2. Language in section 109, part 2 of the 2012 Public Finance Management Act about facility funds

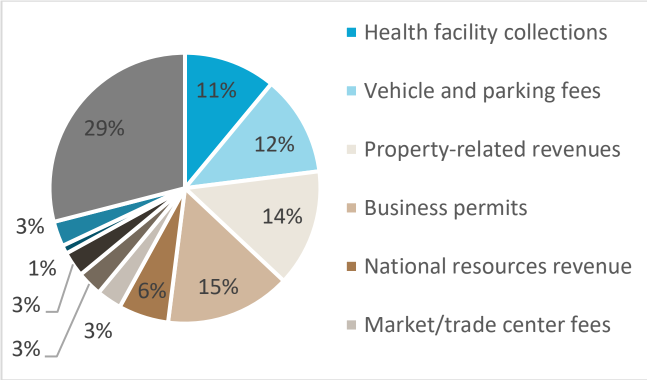
"The County Treasury for each county government shall ensure that all money raised or received on behalf of the county government is paid into the County Revenue Fund, except money that:

(a) is excluded from payment into that Fund because of a provision of this Act or another Act of Parliament, and is payable into another county public fund established for a specific purpose;
(b) may, in accordance with other legislation, this Act or County legislation, be retained by the county government entity which received it for the purposes of defraying its expenses; or
(c) is reasonably excluded by an Act of Parliament as provided in Article 2017 of the Constitution."

Fees and reimbursements collected by facilities are both a significant and a reliable source of revenue for counties. Counties collect revenue from local taxes and fees for goods and services they provide. The latter includes funds generated by public health facilities

(Mbuthia et al. 2019). In 2019, health facilities' collections from user fees and NHIF reimbursements represented 11% of county governments' total locally generated revenues (Figure 1). Collections from hospitals are among the top sources of counties' own-source revenues, particularly in rural counties, which do not have much to raise from property taxes or parking fees (International Budget Partnership Kenya 2017). Therefore, county governments have a strong incentive to collect and retain these revenues, especially given delays in the release of funds from the national government. The most recent PETS exercise showed that while counties received 100% of the block grant from the national government in FY 2017/18 and FY 2018/19, there was considerable delay in its release (MOH 2020a).

Figure 1. Sources of local revenue at the county level, 2019



Source: Commission on Revenue Allocation 2019

There has been growing concern that health facilities in the public sector have lost financial autonomy in the aftermath of devolution. Early studies have documented the "recentralization" of funds within the county, where the county government controls funds that government hospitals could previously retain and spend (Barasa et al. 2017; Kairu et al. 2021). The county governments allocate those funds to different purposes, which no doubt includes paying for the costs of operating health facilities; however, the facilities have little control over how these funds are allocated and spent. More important, they have lost the ability to allocate and spend the funds themselves with ease, based on their immediate needs and priorities.

Recognizing the negative impact devolution has had on facility autonomy, the MOH issued guidelines advising counties to enhance facility financial autonomy. The MOH's goal was to encourage county governments to preserve the gains made in facility autonomy prior to devolution. The 2012 Public Finance Management Act stipulates that revenues raised by public health facilities and other government entities should be recognized as appropriation-in-aid and that their utilization is still subject to the public financial management framework. Thus, retention of funds in the government entity's bank account must be accompanied by a framework that allows regular declaration of revenues raised in a prescribed format to the treasury for accountability without transferring funds from one account to another. Public health facilities must have established governance structures such as hospital boards and health facility management committees to provide additional accountability structures. In addition, the MOH consulted with the national treasury and the Attorney General about the need to develop a law at the national level to ensure that counties allow public facilities to retain and use the funds they generate. This level of autonomy in health facilities would be similar to how the education sector allows schools to retain revenues collected both from own-source revenues like school fees and grants from government; however, both institutions emphasized that the 2012 Public Finance Management Act allows counties to develop such legislation, and therefore there would be no need for the national government to develop additional legislation. Therefore, the MOH continued to issue advisories to guide counties to develop their own legislation and allow public facilities to retain and use the funds they generate (MOH 2014b; 2019; 2020b; 2021). As stated in the MOH's advisories, such legislation would facilitate simplified and direct flow of funds to health facilities (MOH 2020b; 2021). Some counties have implemented such legislation, allowing health facilities to retain the revenues they generate. The way these laws have been applied and how well they are working are described in the next section.

Status of facility financial autonomy in Kenya's 47 counties

This section presents findings from the review of the facility autonomy arrangements that ThinkWell conducted in each of Kenya's 47 counties.

There is variation in how Kenya's 47 counties have interpreted and applied the provisions of the 2012

Public Finance Management Act pertaining to facility financial autonomy. As a result, counties can be categorized into three broad groups: (1) those where public facilities must remit all own-source revenue to the CRF to be allocated by the county through the budget process, (2) counties where facilities can retain 100% of their own-source revenue in their bank accounts, or (3) counties where facilities have access to a portion of their own-source revenue (Table 1). The situation in each of the 47 counties is detailed in Annex 1. It should be noted that there could be variation regarding the facility financial autonomy arrangements within a county. The remainder of this brief and Annex 1 provide information about the general practice in a county.

Table 1. Status of facility financial autonomy in the 47 Kenyan counties

Category	Number of counties	%
Counties where facilities must remit all own-source revenue to the CRF to be allocated by the county through the budget process	21	44%
Counties where facilities retain 100% of own-source revenue	10	21%
Counties where facilities have access to a portion of own-source revenue	16	34%

Source: Authors

In 21 out of the 47 counties in Kenya, public facilities must remit all own-source revenue to the CRF to be allocated by the county through the budgeting process. Of these 21, 18 counties require public facilities to remit all own-source revenue to the CRF as per the provisions of the 2012 Public Finance Management Act. The remaining three counties enacted legislation allowing facilities to retain own-source revenue in their bank accounts, but they are not implementing it. Based on ThinkWell's consultations, this may be attributed to the lack of oversight by both the county executive and the county assembly on laws that have been passed or treasury's insistence that all revenue must be deposited into the CRF.

Public facilities in these 21 counties rely primarily on the county government to directly pay for various inputs and have limited means to cover their operating costs. In all counties, lower-level facilities receive grants from the county governments through the budget process, financed typically from conditional grants received by the county from the national

Box 3. Excerpts from legal documents allowing health facilities to retain and use own-source revenue to defray their costs

2010 Constitution of Kenya, Article 176 (2): *"Every county government shall decentralize its functions and provision of its services to the extent that is efficient and practicable to do so."*

2012 County Government Act, Section 116 (2): *"A county shall deliver services while observing the principles of equity, efficiency, accessibility, non-discrimination, transparency, accountability, sharing of data and information and subsidiarity."*

Section 6(2): *"Without prejudice to the generality of subsection (1) a county government may delegate any of its functions to its officers, decentralized units, or other entities within the county."*

Section 31(c): *"The governor may appoint an accounting officer for each department entity or decentralization unit of the county government."*

2012 Public Financial Management Act, Section 148 (1): *"A County Executive Member for Finance shall, except otherwise provided by law, in writing designate accounting officers to be responsible for managing finances of the county government entities as is specified in the designation."*

2012 Public Financial Management Act-2013 County Government Regulations

Section 23(1): *"The Accounting Officer of a county government entity may delegate to a public officer, in writing, any of the Accounting Officer's powers or functions under the Act or these Regulations."*

Section (3): *"The delegation in this regulation may include the authority to incur expenditure in accordance with any limits prescribed by the Accounting Officer."*

Section 24(1): *"An accounting officer may authorize a public officer under their county government entity to be an Authority to Incur Expenses Holder."*

government and development partners; however, according to several key informants, these funds from the county are inadequate to cover the operational needs of facilities, are often delayed, and are unreliable. These allocations are also unrelated to current facility revenue and performance in contrast to revenue from either user fees or NHIF reimbursements, which are both linked to facility outputs. The key informants also noted that losing the autonomy to retain their own revenue, which these facilities had before devolution, has reduced the motivation for facility managers to submit claims and collect funds from NHIF. On the other hand, this arrangement, where all facility revenue is transferred to the CRF, improves the County Treasury's visibility over the revenues generated by health facilities. It also allows the County Treasury to measure and report these funds as local revenue to the national government more easily, which is beneficial for the county since the revenue allocation formula used by the national government to divide revenue across counties includes fiscal effort. While technically counties can reflect revenue retained by facilities as appropriations-in-aid, many of them do not have the systems to capture this information and the country's integrated financial management system does not extend down to the level of PHC facilities.

Public health facilities in 10 out of the 47 Kenyan counties are allowed to retain all own-source revenue. These county governments have granted facilities financial autonomy to retain and use the revenue they raise from either user charges of NHIF reimbursements, either by enacting legislation stating this (six counties), or by authorizing them to do so through a cabinet memo or executive order (four counties). The enacted legislation is in line with the provisions of the 2012 Public Finance Management Act (Box 2) and other legal documents (Box 3) and clearly states that health facilities should keep their own-source revenue in their bank accounts and use it to defray their expenses.

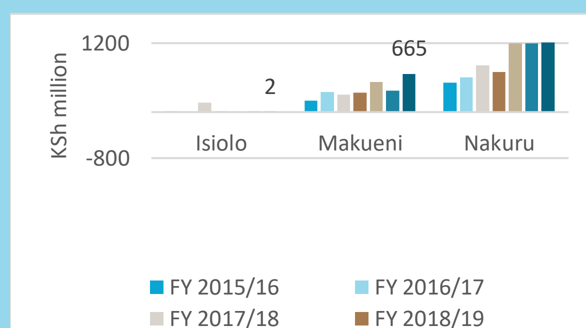
Facilities in these counties are increasing the amount of funds they raise and using the funds to address a range of immediate needs. Having the authority to retain their revenue appears to be incentivizing facilities in these counties to increase revenue collection, especially from NHIF's insurance schemes and free maternity program (see Box 4). According to key informants, facilities use these funds to pay for operations and maintenance costs, purchase medical supplies and small-scale equipment, and contract and

Box 4. Health facilities' own-source revenue in selected counties

The level of own-source revenue collected by health facilities varied considerably across Isiolo, Makueni, and Nakuru counties between FY 2015/16 and FY 2020/21. Makueni and Nakuru county governments allow health facilities to retain their own-source revenue. Therefore, facilities' collection in Nakuru County more than doubled during the analyzed period. Despite fluctuations, Makueni County performed well too. High facility own-source revenue in Nakuru and Makueni performance is attributable to the fact that health facilities submitted more claims to get reimbursed by NHIF for all the services they provided. This is likely because they know that they can retain these funds and decide how to invest them to improve service delivery. In addition, Makueni and Nakuru county governments are constantly making efforts to improve revenue collection from own-sources for all sectors, not just health. In contrast, health facilities in Isiolo were required to remit funds to the CRF and lacked the incentive to raise their own revenues; however, this situation is improving with the enactment and implementation of legislation in early 2022.

Overall, NHIF reimbursements to health facilities across the entire country have increased over the years from KSh 9.5 billion in FY 2013/14 to KSh 71 billion in FY 2021/22, highlighting the potential of this source of revenue for health facilities.

Figure 2. Own-source revenue collected by health facilities in Isiolo, Makueni, and Nakuru counties, FY 2015/16 – FY 2020/21 (KSh million)



Source: Authors based on records from the county departments of health and finance of Isiolo, Makueni, and Nakuru

remunerate support staff or give allowances to health facility staff. On a quarterly basis, facility in-charges work in collaboration with their teams to identify facility priorities and develop a request for authority to incur expenditure against their annual budget, both of which need to be approved by the Health Facility Management Committee. They send the request to the county with a copy of the bank statement to confirm available resources and other documentation. The county governments continue to cover larger expenses, including those related to salaries of health facility staff, drugs, and capital investments. Respondents further reported that effective use of this arrangement allows counties to further trust public health facilities due to better capacity to manage public resources with additional resources through county grants. This is useful to supplement revenues available at the facility level. In some counties, we observed that the county had seconded accountants and procurement officers to the health facilities to strengthen their capacity to manage finances and the procurement process. This strengthened management functions at the facility level and enabled them to be more accountable to the county.

In the remaining 16 counties in Kenya, public facilities can access a portion of the own-source revenue while the rest goes to the county. How this is operationalized varies in terms of the nature of the arrangement with the county, as well as the type and amount of funds facilities can retain. The different arrangements are described below.

In 5 of the 16 counties, facilities are authorized to retain a portion of their revenue and remit the rest to the CRF (Figure 3a). In 3 of the 16 counties, facilities must remit cash received from user charges to the CRF but can retain other revenue, principally from NHIF. In the remaining two, the exact split was not clear. Once in the CRF, these funds are controlled by the county government and allocated as part of the main budget process. Some of these funds likely make it back to the facilities, either as cash or in-kind transfers; however, those allocations are not linked in any direct way with revenue generation by the facility. In some of these counties, county officials noted that the funds collected from the facilities are redistributed across health facilities from the CRF; however, how this happens in practice is not documented.

County governments in 10 of the 16 counties have passed legislation creating a county health fund to hold revenue from health facilities. The legal basis for such accounts to ring-fence facility revenue stems from the Public Financial Management Act that allows counties to establish "funds for special purposes" (see Box 3). The county health funds are managed by county departments of health and overseen by boards (see Box 5). They are often referred to as "facility improvement funds" or FIF, which is a reference to similar accounts held at the district level before devolution; however, the term also refers to funds retained by facilities in their own accounts and as shorthand for the issue of facility autonomy more generally. Given these different meanings of the term "FIF," ThinkWell opted to use the

Box 5. Governance of county health funds

Ten counties in Kenya have implemented legislation creating a county health fund account to ring-fence revenue from health facilities. The funds are managed by the county departments of health as per section 109, part 2a of the 2012 Public Finance Management Act (Box 2). The money transferred in this fund account by public health facilities is earmarked for use in the health sector. According to the 2012 Public Finance Management Act, counties are allowed to retain an administration fee of up to 3% for the management of a fund account. Counties transfer the rest of the money from the county health fund account to the facilities that remitted them or across all facilities in the county, the county, and/or sub-county management teams.

The county health fund is typically overseen by a board. The composition and number of board members varies from county to county. The board typically includes the health county executive committee member and the chief officer in addition to other representatives of the county departments of health or facilities. In general, the board (1) oversees management and administration of the county health fund, (2) advises the county executive committee member on the appropriate guidelines and procedures for better management of the county health fund, (3) approves the workplan and budgets prepared by health facilities' committees, and (4) monitors the performance of the county health fund. The board represents another layer of governance in addition to the leadership structures of the county departments of health.

term “county health fund” instead to refer to special purpose accounts created by the county to ring-fence revenue from health facilities.

Facilities in 6 of the 10 counties that created county health funds must directly transfer all own-source revenue to that account. The county retains an amount to cover the administration costs of the county health fund account, and either transfers the rest of the money to the facilities that remitted them or redistributes the money across all public facilities in the county (including dispensaries and health centers), county, or sub-county health management teams (Figure 3b).

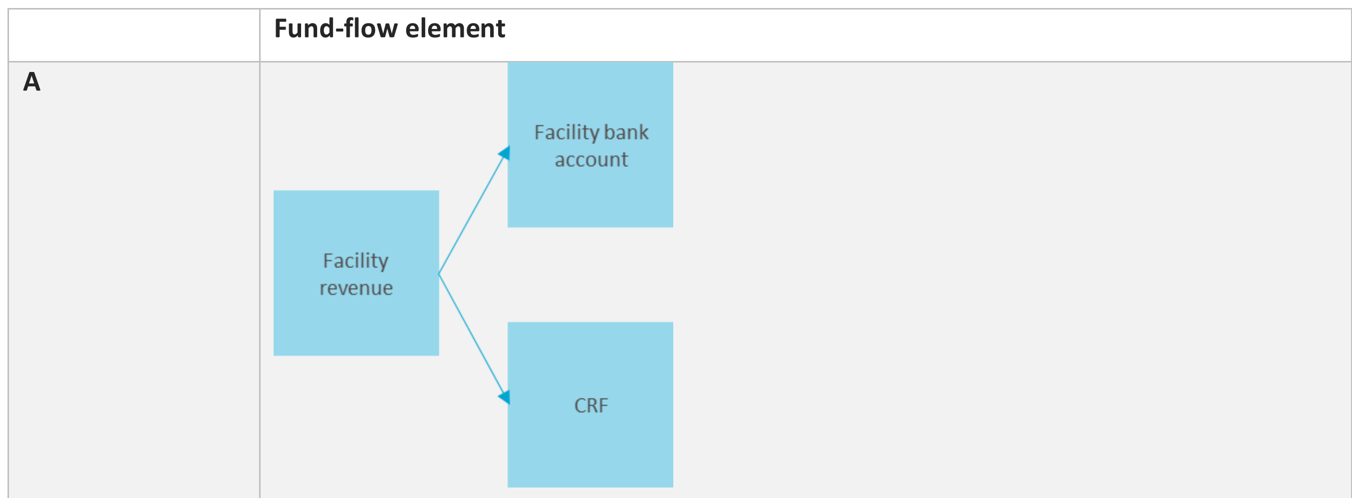
Public facilities in 3 of the 10 counties must first remit all the funds they generate to the CRF, which are then transferred to the county health fund account. The county retains an administration fee for the management of the county health fund account and transfers the money left in the account to the facilities that generated them or redistributes the money across all public health facilities in the county, including dispensaries and health centers (Figure 3c).

In one of the 10 counties in this category, facilities remit some funds to the CRF and some to a county health fund. Revenue collected in cash, typically from user fees, goes to the CRF. Other own-source revenue, which is NHIF reimbursements, is remitted to the county health fund account. The county retains an administration fee for the management of the county health fund and transfers the rest of the money to the facilities that generated the funds (Figure 3d).

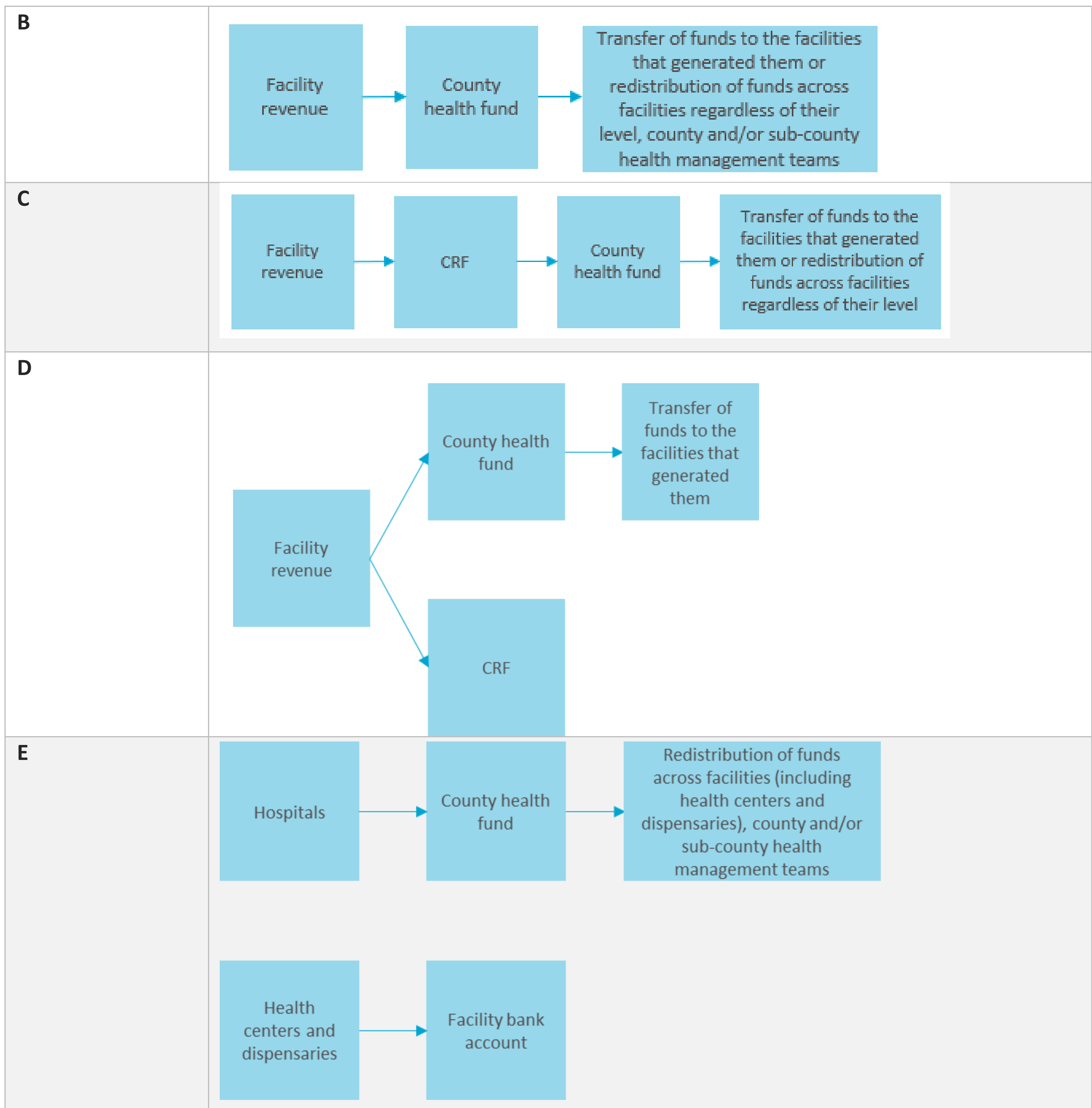
One county of the 16 requires hospitals to remit all revenue to a county health fund while lower-level facilities can retain their revenue. The county redistributes the revenue from hospitals across facilities, including lower-level health centers and dispensaries, the county, and/or sub-county health management teams (Figure 3e).

The flow of funds[1] to facilities in this group of 16 counties is more complicated than the second category of counties where facilities can retain all the revenue they generate. The establishment of county health funds involves creating additional administrative and governance structures including a county health fund board and a fund administrator. Key informants noted that these additional layers of bureaucracy typically result in delays in facilities accessing the funds they need. In addition, facilities do not have access to all the revenues they raised and are sometimes in similar operational dilemmas to when funds are transferred to the CRF.

Figure 3. Flow of funds in counties where facilities retain or receive from the county a portion of own-source revenue



[1] The flow of funds at the county level is described in detail in another report developed by ThinkWell.



Source: Authors

DISCUSSION

The topic of facility autonomy has garnered much attention in Kenya. Several recent studies have highlighted how devolution led to facilities losing autonomy and, in turn, not having resources and recourse to pay for various operating costs that allow them to deliver services effectively (Barasa et al. 2017; Kairu et al. 2021). Key health sector stakeholders and development partners including ThinkWell have been bringing greater attention to this issue in policy discussions at the national and county levels (Ravishankar et al. 2022). The MOH in turn has been exhorting counties to enable facility autonomy, as evidenced by recent guidelines it has issued on this topic and in the issuance of multiple advisory notes to counties. The Council of Governors has similarly been

advocating for this change, and various governors have agreed to develop legislation allowing health facilities to retain and use own-source revenues.

Despite all the discussion about counties granting greater autonomy to health facilities, there has been no systematic attempt to document the state of play across Kenya's 47 counties, a gap that is filled with this study. The existing literature offers evidence from samples of counties. The MOH and different partners often reference selected counties during policy discussions. Yet there have been no attempts to systematically document the legal and public financial management arrangements that counties are putting in place to manage revenue from health facilities. This study set out to understand the current lay of the land with respect to financial autonomy at the facility level, and how it varies across the counties. Through reviews of legal and budget documents as well as interviews with key informants, ThinkWell has compiled information about what laws or executive orders (if any) counties have enacted related to facility revenue, whether they have been implemented, and the current arrangement for managing facility funds.

The findings show that counties fall into three broad categories. Category 1 includes 21 counties where facilities remit all own-source revenue to the CRF, a central account at the county level from where funds are allocated by the county through the annual budget process. Category 2 includes 10 counties where facilities retain 100% of their own-source revenue in their own bank accounts. Category 3 includes 16 counties where facilities can access a portion of their own-source revenue based on different revenue-sharing arrangements between the county and facilities.

While this study does not offer a rigorous assessment of the effect of each arrangement on service readiness or delivery metrics at the facility level, it points to certain patterns. ThinkWell asked key informants about challenges with current arrangements, how they compare to what existed prior to devolution, and what is known to be the case in other counties. This information offers some insight into the potential benefits and disadvantages of the three diverse types of arrangements.

The arrangement in category 1—where facilities are required to remit all their revenue to the CRF—likely hurts service readiness and quality but ensures better financial control over public funds. Once in the CRF, the revenue from facilities co-mingles with other county funds and is no longer ring-fenced or earmarked for health. Some of these resources may flow back to facilities, either as cash or in-kind transfers, but these transfers are unpredictable and often delayed, which likely hurts service readiness and quality. The allocation to facilities is not linked to the revenue generated by the facility. As a result, facilities are unlikely to feel incentivized to increase the uptake of national schemes such as the free maternity program since they do not retain any of the output-based payments received from NHIF. This arrangement in most cases lowers the decision space and the participation of health facility managers in decision-making. Further, it denies opportunities for counties to strengthen the capacity of health facilities with respect to financial management. On the flip side, this arrangement is advantageous for the county, given that it improves the visibility that the County Treasury has over the revenues generated by health facilities and the ease with which it can track and account for these public funds. It also allows it to count these funds as local revenue, which is factored into the division of revenue formula at the national level.

The arrangement in category 2—where facilities retain and spend all their revenue—likely enables them to respond to local needs more quickly and incentivizes them to deliver more services. In this group, all revenue raised by facilities is earmarked for health, seeing that it is spent by the health facilities directly. Facilities use these funds to access inputs they need to deliver health services. Financial autonomy also motivates facilities to participate in NHIF schemes that offer output-based payments. In addition, the arrangement to manage facility revenue is simple and does not involve funds flowing to the county and then back to the facility (as is the case in counties in category 3 that have set up county health funds to hold facility revenue). Counties can also strengthen the capacity of health facilities to manage public funds in line with the PFM Act (2012) and the public procurement and disposal act (2012). ThinkWell further noted an increase in revenue at public health facilities (see Figure 2). In this arrangement, counties can further explore new

ways of purchasing health services where allocations can be linked with health outcomes, such as additional grants or payments to supplement the own source revenue raised at the facility.

However, this arrangement is not without some potential challenges. Counties may reduce their budgetary allocations for facilities, if they perceive that facilities are able to cover their costs through own-source revenue. The success of this arrangement depends on facilities having the capacity to manage and account for their funds, which is a concern for county treasuries. Indeed, the evidence from global literature on the effect of hospital autonomy on quality, efficiency, and accountability of facilities as well as household out-of-pocket spending is mixed (Ravaghi et al. 2018).

The remaining 16 counties in category 3 have more complicated arrangements where facilities have access to some of the funds they generate. A majority have set up a county health fund to collect revenue from all health facilities where all facility revenue is pooled. Some funds are retained by the county to cover administrative costs, but the rest flows back to the facilities. In many others, facilities retain a portion of their revenue and remit the rest to the CRF.

Setting up a county health fund in turn has its own pros and cons. On the one hand, the arrangement ring-fences revenue from health facilities for the sector (compared to category 1, where the funds are held in the CRF). The fund also makes it possible for the county to redistribute revenue across facilities. While this can be a disincentive for facilities that make efforts to maximize collections, this allows facilities that do not collect a lot of own-source revenue—due to remoteness of location, for example—or have poorer infrastructure to access more funds. On the other hand, the flow of funds from the facility to the county and then back to the facility seems complex and bureaucratic, and likely introduces delays.

The arrangement where the facility retains some revenue and remits the rest to the CRF seems administratively simpler than the county health fund but limits the funds available to the facility. This practice—followed by five counties—allows some facility revenue to be earmarked for health (namely the part that stays with the facility). It also ensures that facilities have an incentive to care about own-source revenue, which is absent in category 1; however, it reduces the amount of funds the facility can access when compared to category 2.

The findings from this study point to several recommendations. First, based on the qualitative information we collected for this study we recommend that all counties consider enabling facilities to retain own-source revenue. Poor service readiness and low motivation appeared to be the norm in facilities located in counties where all facility revenue flows to the CRF. Counties are operationalizing facility autonomy in a variety of ways. Hence, our second recommendation is for more rigorous research to understand each of these arrangements in detail and test their effect on service readiness and service delivery. More platforms for inter-county dialogue and knowledge exchange will pave the way for the diffusion of successful practices. Third, in counties that are granting greater financial autonomy to health facilities, more investment and support is needed from county governments and partners to build facility systems and capacity for managing their revenue. Data systems that would allow facilities and counties to have greater visibility over facility revenue and expenditure in addition to enhancing the ability of counties to measure and report these funds as appropriation-in-aid would be beneficial to both the county and health facilities. Counties have a critical role to play in enabling public health facilities to participate in NHIF schemes and advocating on their behalf when claims are not settled.

Streamlining county-level arrangements for managing facility revenue is critical for the success of Kenya's plans for progressing toward universal health coverage. Key policies in the sector including the Kenya Health Policy 2014-2030 and the Health Financing Strategy 2020-2030 talk about scaling up a national health insurance scheme. In early 2022, Kenya initiated an ambitious new program to subsidize NHIF cover for poor households from public funds. How motivated public facilities are to serve clients and their ability to deliver quality services is linked to facility autonomy. Indeed, even as GOK channels more public resources to NHIF, which it has identified as the vehicle to expand coverage and progress towards the goals of UHC, improving the financial and managerial capacities of health facilities will allow them to optimize revenues

from NHIF's schemes and use the funds to deliver high-quality services.

ThinkWell supports efforts at the national and county levels to enhance facility financial autonomy in line with the provisions of the 2012 Public Finance Management Act. At the national level, the team works with the MOH to provide clear guidelines to counties on the options they have at their disposal to grant facilities financial autonomy. The team also contributes to policy discussions to make sure that these options facilitate health facilities' active participation in the universal health care program and other NHIF programs. At the request of county governments, ThinkWell continues to support selected counties as they develop, revise, enact, and track implementation of policies pertaining to facility financial autonomy.

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ANNEX 1. STATUS OF FACILITY FINANCIAL AUTONOMY

Note: Counties have been grouped according to the categories and sub-categories described below.

1. Counties where facilities must remit all own-source revenue to the CRF to be allocated by the county through the budget process
    - 1.1. In line with the provisions of the 2012 Public Finance Management Act
    - 1.2. Despite county legislation allowing facilities to retain all own-source revenue
2. Counties where facilities retain 100% of own-source revenue
    - 2.1. Through county legislation stating this
    - 2.2. As per county authorization through a cabinet memo and/or executive order
3. Counties where facilities retain/receive from the county a portion of own-source revenue
    - 3.1. Countries authorize facilities to retain a portion of own-source revenue in their bank account and to remit the rest to the CRF
    - 3.2. Counties that have passed legislation creating a county health fund
        - 3.2.1. Facilities transfer own-source revenue to the county health fund. The country retains an administration fee for the management of the county health fund and (a) transfers the rest of the funds to the facilities that generated them or (b) redistributes the funds across facilities, including lower-level facilities, county, and/or sub-county health management teams.
        - 3.2.2. Facilities remit own-source revenue to the CRF, which is then transferred to the county health fund. The county retains an administration fee for the management of the county health fund and (a) transfers the rest of the funds to the facilities that generated them or (b) redistributes the funds across facilities, including lower-level facilities.
        - 3.2.3. Facilities remit a portion of funds to the CRF and the rest to the county health fund. The county retains an administration fee for the management of the county health fund and transfers the rest of the funds to the facilities that generated them.
    - 3.3. Counties require public hospitals to transfer own-source revenue to the county health fund to be redistributed across facilities (including lower-level facilities, county, and/or sub-county health management teams) but allow lower-level facilities to retain own-source revenue in their bank accounts

*Table 2. Status of facility financial autonomy in the 47 Kenyan counties**

County	Legislation status	Content of the latest draft/enacted/developed/revised/implemented legislation			Notes	Category***	Sub-category***
		Facilities retain own-source revenue in their accounts	Facilities transfer own-source revenue to the CRF	Facilities transfer own-source revenue to the county health fund**			
Baringo	Legislation enacted (2021) and implemented	No	No	Yes	Facilities transfer own-source revenue to the county health fund. County retains an administration fee for the management of the county health fund and transfers the rest of the funds to facilities.	3	3.2.1
Bomet	Legislation not available	NA	NA	NA	Facilities transfer own-source revenue to the CRF.	1	1.1
Bungoma	Legislation enacted (2019) and implemented	Yes	No	No		2	2.1
Busia	Legislation enacted (2014) but not implemented	No	No	Yes	According to the legislation, facilities should transfer own-source revenue to the county health fund. County should retain an administration fee for the management of the county health fund and transfer the rest of the funds to facilities. In practice, facilities remit own-source revenue to the CRF.	1	1.1
Elgeyo Marakwet	Legislation not available	NA	NA	NA	Facilities transfer own-source revenue to the CRF.	1	1.1

County	Legislation status	Content of the latest draft/enacted/developed/revised/implemented legislation			Notes	Category***	Sub-category***
		Facilities retain own-source revenue in their accounts	Facilities transfer own-source revenue to the CRF	Facilities transfer own-source revenue to the county health fund**			
Embu	Legislation under development	No	Yes	Yes	According to the draft legislation, facilities should remit own-source revenue to the CRF, which should be transferred to the county health fund. The county should retain an administration fee for the management of the county health fund and transfer the rest of the funds to facilities. In practice, facilities remit own-source revenue to the CRF and the county health fund is not operational.	1	1.1
Garissa	Legislation not available	NA	NA	NA	Facilities are allowed to retain own-source revenue in their accounts.	2	2.2
Homa-Bay	Legislation under development (2020)	No	No	Yes	According to draft legislation, facilities are supposed to transfer own-source revenue to the county health fund. County is supposed to retain an administration fee for the management of the county health fund and transfer the rest of the funds to facilities. In practice, facilities transfer all revenue collected in cash to the CRF. Facilities retain NHIF reimbursements in their accounts.	3	3.1

County	Legislation status	Content of the latest draft/enacted/developed/revised/implemented legislation			Notes	Category***	Sub-category***
		Facilities retain own-source revenue in their accounts	Facilities transfer own-source revenue to the CRF	Facilities transfer own-source revenue to the county health fund**			
Isiolo	Legislation developed (2021), enacted, and implemented (2022)	Yes	No	No		2	2.1
Kajiado	Legislation enacted (2020), and implemented	Yes	No	No		2	2.1
Kakamega	Legislation enacted (2020), implemented, repealed, revised, enacted (2021), implemented (2022), revised, enacted (2022) and to be implemented	Yes	No	No	In practice, facilities remit own-source revenue to the CRF, which is transferred to the county health fund. County retains an administration fee for the management of the county health fund and transfers the rest of the funds to facilities (through the sub-county health account).	1	1.2
Kericho	Legislation enacted (2022), and implemented	No	No	Yes	Facilities transfer own-source revenue to the county health fund account. The county retains an administration fee for the management of the county health fund and transfers the rest of the funds as follows: 75% to hospitals, 20% to health centers and dispensaries, and 5% to the County Health Management Team.	3	3.2.1

County	Legislation status	Content of the latest draft/enacted/developed/revised/implemented legislation			Notes	Category***	Sub-category***
		Facilities retain own-source revenue in their accounts	Facilities transfer own-source revenue to the CRF	Facilities transfer own-source revenue to the county health fund**			
Kirinyaga	Legislation not available	NA	NA	NA	Facilities remit own-source revenue to the CRF and receive in-kind or cash transfers.	1	1.1
Kiambu	Legislation not enacted (2014), revised and enacted (2019), and implemented	No	No	Yes	According to legislation drafted in 2014, facilities were supposed to be allowed to retain own-source revenue in their accounts. According to the legislation enacted in 2019, a county health fund was created. Facilities remit all own-source revenue to the county health fund. The county retains an administration fee for the management of the county health fund and transfers the rest of the funds as follows: 80% to hospitals and 20% to the County Health Management Team.	3	3.2.1
Kilifi	Legislation enacted (2016), not implemented due to inconsistencies with the 2012 Public Finance Management Act, under revision	No	Yes	Yes	According to the legislation enacted in 2016, a county health fund was supposed to be created. Facilities were supposed to remit all own-source revenue to the CRF to be transferred to the county health fund. Funds were supposed to be distributed as follows: 75% to hospitals, 20% to health centers and dispensaries, 5% to the County Health Management Team (which	3	3.3

County	Legislation status	Content of the latest draft/enacted/developed/revised/implemented legislation			Notes	Category***	Sub-category***
		Facilities retain own-source revenue in their accounts	Facilities transfer own-source revenue to the CRF	Facilities transfer own-source revenue to the county health fund**			
					includes the administration fee for the management of the county health fund). The revised legislation is supposed to allow facilities to retain own-source revenue in their accounts. In the meantime, hospitals remit all own-source revenue to the county health fund which is distributed as described above. Health centers and dispensaries retain own-source revenue (NHIF reimbursements) in their accounts.		
Kisii	Legislation enacted (2015), and implemented	No	No	Yes	Facilities transfer own-source revenue to the county health fund. County retains an administration fee for the management of the county health fund and transfers the rest of the funds to facilities as follows: 75% to hospitals and 25% to health centers and dispensaries.	3	3.2.1
Kisumu	Legislation not enacted (2019)	No	No	Yes	According to draft legislation, facilities were supposed to transfer own-source revenue to the county health fund. County was supposed to retain an administration fee for the management of the county health fund and transfer the rest of the funds to facilities.	2	2.2

County	Legislation status	Content of the latest draft/enacted/developed/revised/implemented legislation			Notes	Category***	Sub-category***
		Facilities retain own-source revenue in their accounts	Facilities transfer own-source revenue to the CRF	Facilities transfer own-source revenue to the county health fund**			
					In practice, through an executive order, facilities retain own-source revenue in their accounts.		
Kitui	Legislation not enacted (2020)	No	No	Yes	According to draft legislation, facilities were supposed to transfer own-source revenue to the county health fund. County was supposed to retain an administration fee for the management of the county health fund and transfer the rest of the funds to facilities. In practice, facilities remit own-source revenue to the CRF.	1	1.1
Kwale	Legislation not available	NA	NA	NA	Facilities remit own-source revenue to the CRF.	1	1.1
Laikipia	Legislation enacted (2016) and not implemented	Yes	No	No	In practice, facilities remit own-source revenue to the CRF.	1	1.2
Lamu	Legislation under development	Yes	No	No	In practice, facilities remit own-source revenue to the CRF and receive it back in its entirety.	1	1.1
Machakos	Legislation not passed (2020)	No	No	Yes	According to draft legislation, facilities were supposed to transfer own-source	3	3.1

County	Legislation status	Content of the latest draft/enacted/developed/revised/implemented legislation			Notes	Category***	Sub-category***
		Facilities retain own-source revenue in their accounts	Facilities transfer own-source revenue to the CRF	Facilities transfer own-source revenue to the county health fund**			
					revenue to the county health fund. County was supposed to retain an administration fee for the management of the county health fund and transfer the rest of the funds to facilities. In practice, facilities transfer all revenue collected in cash to the CRF. Facilities retain NHIF reimbursements in their accounts.		
Makueni	Legislation enacted (2016), regulations formulated (2021), implemented	Yes	No	No	NA	2	2.1
Mandera	Legislation not available	NA	NA	NA	Facilities remit own-source revenue to the CRF.	1	1.1
Marsabit	Legislation enacted (2016) and implemented	Yes	No	No		2	2.1
Meru	Legislation not passed (2016)	Yes	No	No	In practice, facilities remit own-source revenue to the CRF.	1	1.2

County	Legislation status	Content of the latest draft/enacted/developed/revised/implemented legislation			Notes	Category***	Sub-category***
		Facilities retain own-source revenue in their accounts	Facilities transfer own-source revenue to the CRF	Facilities transfer own-source revenue to the county health fund**			
Migori	Legislation enacted (2022), but not implemented	No	No	Yes	According to the legislation enacted in 2022, facilities are supposed to transfer own-source revenue to the county health fund. County is supposed to retain an administration fee for the management of the county health fund and transfer the rest of the funds to facilities. In practice, facilities remit own-source revenue to the CRF. Sometimes they receive back the funds, but not necessarily in their entirety.	1	1.1
Mombasa	Legislation under development	Yes	No	No	In practice, facilities retain the own-source revenue.	2	2.2
Murang'a	Legislation not available	NA	NA	NA	In practice, facilities remit own-source revenue to the CRF.	1	1.1
Nairobi	Legislation not available	NA	NA	NA	In practice, facilities retain the own-source revenue in their accounts.	2	2.2
Nakuru	Legislation enacted (2014) and implemented	Yes	No	No	NA	2	2.1

County	Legislation status	Content of the latest draft/enacted/developed/revised/implemented legislation			Notes	Category***	Sub-category***
		Facilities retain own-source revenue in their accounts	Facilities transfer own-source revenue to the CRF	Facilities transfer own-source revenue to the county health fund**			
Nandi	Legislation enacted (2021), and implemented	No	No	Yes	Facilities transfer own-source revenue to the county health fund. County retains an administration fee for the management of the county health fund and transfers the rest of the funds to facilities.	3	3.2.1
Narok	Legislation enacted (2017), and implemented	Yes	Yes	No	Facilities receive and retain NHIF reimbursements in their accounts, but they transfer all revenue collected in cash to the CRF. The funds transferred to the CRF are distributed as follows: 75% to hospitals and 25% to health centers and dispensaries.	3	3.1
Nyandarua	Legislation not available	NA	NA	NA	Facilities remit own-source revenue to the CRF.	1	1.1
Nyamira	Legislation enacted (2019), and implemented	No	Yes	Yes	Facilities remit own-source revenue to the CRF, which is then transferred to the county health fund. County retains an administration fee for the management of the county health fund and transfers the rest of the funds to facilities.	3	3.2.2
Nyeri	Legislation enacted, and implemented (2021)	No	No	Yes	Facilities remit own-source revenue to the county health fund. County retains an administration fee for the management of the county health fund and transfers the	3	3.2.1

County	Legislation status	Content of the latest draft/enacted/developed/revised/implemented legislation			Notes	Category***	Sub-category***
		Facilities retain own-source revenue in their accounts	**Facilities transfer own-source revenue to the CRF**	**Facilities transfer own-source revenue to the county health fund****			
					rest of the funds to facilities as follows: 75% to hospitals and 25% to health centers and dispensaries.		
Samburu	Legislation enacted (2021), not implemented	No	No	Yes	According to the legislation enacted in 2021, facilities are supposed to transfer own-source revenue to the county health fund. County is supposed to retain an administration fee for the management of the county health fund and transfer the rest of the funds to facilities. In practice, facilities remit own-source revenue to the CRF. Sometimes they receive back the funds, but not necessarily in their entirety.	1	1.1
Siaya	Legislation not enacted (2019)	No	No	Yes	According to draft legislation, facilities were supposed to transfer own-source revenue to the county health fund. County was supposed to retain an administration fee for the management of the county health fund and transfer the rest of the funds to facilities. In practice, facilities transfer all revenue collected in cash to the CRF. Facilities retain NHIF reimbursements in their accounts.	3	3.1

County	Legislation status	Content of the latest draft/enacted/developed/revised/implemented legislation			Notes	Category***	Sub-category***
		Facilities retain own-source revenue in their accounts	Facilities transfer own-source revenue to the CRF	Facilities transfer own-source revenue to the county health fund**			
Taita-Taveta	Legislation enacted (2015), and implemented	Yes	No	No	In practice, facilities retain 75% of own-source revenue in their accounts. They transfer the remaining 25% of funds to the CRF, which is distributed to health centers and dispensaries.	3	3.1
Tana River	Legislation not available	NA	NA	NA	Facilities transfer own-source revenue to the CRF and receive in-kind and cash transfers.	1	1.1
Tharaka Nthi	Legislation not available	NA	NA	NA	Facilities transfer own-source revenue to the CRF and receive in-kind and cash transfers.	1	1.1
Trans Nzoia	Legislation enacted (2021), but not implemented	No	No	Yes	According to the legislation enacted in 2021, facilities were supposed to remit own-source revenue to the county health fund. County was supposed to retain an administration fee for the management of the county health fund and transfer the rest of the funds to facilities. In practice, facilities remit own-source revenue to the CRF.	1	1.1
Turkana	Legislation enacted (2020), but not fully implemented	No	Yes	Yes	Facilities remit own-source revenue to the CRF, which is then transferred to the county health fund accounts. County	3	3.2.2

County	Legislation status	Content of the latest draft/enacted/developed/revised/implemented legislation			Notes	Category***	Sub-category***
		Facilities retain own-source revenue in their accounts	Facilities transfer own-source revenue to the CRF	Facilities transfer own-source revenue to the county health fund**			
					retains an administration fee for the management of the county health fund and transfers the rest of the funds to facilities.		
Uasin Gishu	Legislation not available	NA	NA	NA	Facilities transfer own-source revenue to CRF and receive in-kind and cash transfers.	1	1.1
Vihiga	Legislation enacted (2019), and implemented	No	Yes	Yes	Facilities receive NHIF reimbursements in their accounts and transfer these to the county health fund. County retains an administration fee for the management of the county health fund and transfers the rest of the funds to facilities. Facilities transfer all revenue collected in cash to the CRF accounts.	3	3.2.3
Wajir	Legislation not available	NA	NA	NA	Facilities transfer own-source revenue to the CRF.	1	1.1
West Pokot	Legislation enacted (2019), and implemented	No	Yes	Yes	Facilities remit own-source revenue to the CRF, which is then transferred to the county health fund. County retains an administration fee for the management of the county health fund and transfers the rest of the funds to facilities as follows:	3	3.2.2

County	Legislation status	Content of the latest draft/enacted/developed/revised/implemented legislation			Notes	Category***	Sub-category***
		Facilities retain own-source revenue in their accounts	**Facilities transfer own-source revenue to the CRF**	**Facilities transfer own-source revenue to the county health fund****			
					70% to hospitals and 30% to health centers and dispensaries.		

* As of January 2023

** According to the 2012 Public Finance Management Act, counties are allowed to retain a fund management administration fee that should not exceed 3% of the transferred funds.

*** As per what is happening in practice

Source: Authors