

Kenya National Health Financing

Domestic Resource Mobilization for Health: National Health Financing Dialogue for Implementation of the Health Sector Domestic Financing Sustainability Plan

Co-financing Commitments and Strategy: The HIV, TB and Malaria Replacement Challenge

Issue Paper

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This Issue Paper takes stock of Kenya's financing landscape for health and the three diseases (HIV, TB and Malaria) with the aim of prioritizing opportunities and challenges as government scales up its domestic investments for attaining UHC by 2022. The time for a government-led process in incorporating sustainability and transition issues into routine health planning and dialogue among ministries of health and finance is now. Economic growth, greater prioritization of health in government spending, and better budget execution will provide more money for health. Meanwhile, improving planning and implementation processes will help to produce more health for the money, including correcting information asymmetries and clarifying responsibilities across national and county actors; eliminating delays in procurement and supply chain processes; streamlining and bolstering health information systems; and devising an appropriate regulatory framework for contracting private providers with public funds.

Background

Kenya's response to the ill health of its population has seen great achievements and still faces significant challenges. To sustain these gains and further strengthen epidemic control, the government is increasingly exploring strategies for eventual transition away from external funding and programmatic support for health and ongoing sustainable progress, including for the three diseases. Our country's disease responses faces a triple transition challenge: replacing donor funding; closing the resource gap that would exist even with donor funding and more efficiently delivering on our health program objectives. With several priority HIV, TB and Malaria interventions heavily supported by donor funding, concerted action is needed to increase government funding for the three diseases and to improve efficiency of resource use.

Meeting the replacement challenge and our country's overall health sector needs will require a combination of mobilizing new revenue for health and efficiency gains; neither alone will suffice. New funding for health will largely depend on macro-fiscal conditions, the government's overall effort to collect revenue and the extent to which policy makers prioritize health within government budgets at the national and county levels. To sustain current programmatic outcomes for the three diseases, the government will need to look to efficiency gains that can be reinvested in the health sector. Ultimately, the sustainability and the successful transition of externally supported programs will require prolonged commitment from national and county levels, buttressed by strategic investments from development partners- to collaboratively address the three diseases through recurrent processes to planning, implementation and monitoring of finances for health.

Key Concerns

1. Without external funding, Kenya's unmet funding need for HIV, TB and Malaria would total KES 84 billion annually over the next 3 years. In reality, the Global Fund, US Government and other donors invest KES 77 billion per year in the three diseases meeting 92% of that need. This represents a significant fiscal challenge as we aim to achieve UHC by 2022.
2. For the 2018-2020 funding cycle, the Global Fund will account for 18% of total external funding for HIV, TB and Malaria while majority (81%) will come from US government. The HIV response will attract more than 80% of external funding and will be predominantly supplied by the US Government. Global Fund will be the leading partner for TB, the smallest of the three programs, the two donors will play a more balanced role for malaria. However, the pilot for the UHC benefits package does not include HIV and TB
3. Donors mainly invest in (1) treatment and prevention programs including commodities and (2) programs for priority and vulnerable populations. Most HIV money flows to ART, TB funding focuses on addressing MDR-TB and LLINs and IRS are the priority for malaria funding. Overall, there is very minimal focus on prevention activities for the three and other diseases by donors.
4. Counties want to be more involved in the planning and budgeting for HIV, TB and Malaria activities but do not feel equipped with sufficient information to do so. Information asymmetry

between the national and county levels continue to constrain counties' ability to sufficiently plan for any future assumption of responsibilities.

5. There is uncertainty on which program components the national or county governments would be responsible for financing and which level of government and sector (public vs private) would implement activities in the context of devolution and declining donor funds. Off- budget funding may not be sufficiently visible to inform strategic planning and resource mobilization in the wake of dwindling donor funding.
6. The Public Procurement and asset Disposal act 2015 provides a favorable legislative foundation that allows the government to outsource services. However, in a situation where government assumes financial but not programmatic responsibilities in various program areas, there is uncertainty around the political appetite to engage in PPPs to support delivery of essential services including for key populations.
7. Skepticism exists around costing of HIV, TB, Malaria and other diseases resource needs. A contributory factor is that program Based Budgeting has not yet been implemented in a way that sufficiently monitors actual spending against programmatic objectives. The centralized governance structure of HIV, TB and Malaria diseases programs negatively affects the perception of efficiency.
8. Siloed planning between disease programs and lack of effective coordination among donors continues to impact negatively on the plans for an integrated primary health care system hence further limiting opportunities to realize efficiency gains.
9. Budget execution for procurement continues to be hindered by a series of bureaucratic delays related to approval of the procurements, specifications for the commodities, nominations to tender committees and delayed delivery. Accountability measures for the three diseases are not yet sufficient to ensure availability of complete, on-time , quality data which limits the ability to structure budgets accurately according to needs of priority populations , programs and services and further limits the compilation of data needed to support strategic, data –informed purchasing of services.

Recommendations

1. Continue to advocate for compulsory revenue options like taxes and mandatory social health insurance contributions as core of future health financing. Meeting the replacement challenge will require a combination of new revenue for health and efficiency gains.
2. Accelerate progress towards our goal of allocating 13% of government expenditure to health so as to mobilize an additional KES 36 billion annually for the 3 diseases by 2022.
3. National Treasury to review budget trends for health and see whether new spending at county level is enabling greater service delivery outputs, outcomes, increasing wages or both so as to effectively guide country dialogue on prioritizing health within government budget.
4. Closer integration of siloed health programs into broader financing, management and service delivery systems so as to consolidate shared health sector inputs (e.g. program management, human resources, health information systems). Reforms in the sector to enable broader efficiency gains must be instituted in the immediate.
5. Integrate sustainability and transition issues into routine health financing discussions among health and treasury officials as well as embracing a spirit of 'urgent incrementalism' to tackle donor financing transition challenges over time.
6. Institute an elaborate information management system for both the services and the finances (National Health Observatory)