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Financing universal coverage in Kenya – A case study

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Abstract

Introduction: One of the challenges to maintain an agenda for universal coverage and equitable health system is to develop effective structuring and management of health financing. Global experiences with different systems of health financing suggest that a strong public role in health financing is essential for health systems to protect the poor. Health systems with the strongest state role are likely to be more equitable and achieve better aggregate health outcomes. Using Kenya as a case study, this paper seeks to evaluate the progress and capacity of a middle income country in terms of health financing for universal coverage, and also to highlight some of the key underlying health systems challenges.

Methodology: *The World Health Report 2010: Health Systems Financing: The Path to Universal Coverage* was used as the framework to evaluate the Kenyan healthcare financing system in terms of the provision of universal coverage for the population, and the Kenyan National Health Sector Services Fund Accounts (2011) provided the latest Kenyan data on health spending. Measuring against the four target indicators outlined, Kenya fared modestly with total health expenditure close to 4.5% of its GDP (3.75%), out-of-pocket payment below 40% of total health expenditure (30.7%), comprehensive social safety nets for vulnerable populations, and a tax-based financing system that fundamentally poses as a national risk-pooled scheme for the population.

Results: Nonetheless, within a holistic systems framework, the financing component interacts synergistically with other health system spheres. In Kenya, out-migration from public to private of public health workers particularly specialist doctors remains an issue and financing strategies needs to incorporate a comprehensive workforce compensation strategy to improve the health workforce skill mix. Health expenditure information is systematically collated, but feedback from the private sector remains a challenge.

Conclusion: As far as Service delivery is concerned, there is a need to enhance financing capacity to expand preventive care, in better managing escalating healthcare costs associated with the increasing trend of non-communicable diseases. Additionally, health financing policies need to instill the element of cost-effectiveness to better manage the purchasing of new medical supplies and equipment. Good governance and leadership are needed to ensure adequate public spending on health and maintain the focus on the attainment of universal coverage, as well as making healthcare financing more accountable to the public, particularly in regards to inefficiencies and better utilization of public funds and resources.

Keywords: Universal Coverage, Health care Financing, Primary health care, Health Insurance

1. Introduction

Universal coverage and access to quality health care requires human capital, infrastructure and material resources [1].

Resources, however, are Limited. With advances in medical technology, an emerging ageing population, disease transitions, and a more demanding population, healthcare costs in middle-income countries like Kenya generally outpace the national inflation rate [2]. With the current economic downturn, the stress on national health care budgets

is significant and this places people at risk of greater impoverishment due to health. To maintain an agenda for universal coverage and an equitable health system, therefore, the challenge is to develop effective structuring and management of health financing.

Kenya has a mixed healthcare financing system. Within the private sector, private health insurance is voluntary, with variable premiums charged based on the individual's financial and health

status, the type of health insurance, and the level of coverage. Private sector employers may elect to offer welfare and health benefits and typically negotiates packages with Health care Organizations (HCOs) like AAR, Resolution Health Kenya etc. and private insurance companies to provide medical insurance cover for their employees. Public health care services are funded through general taxation, with annual health budgets allocated by Ministry of Finance to the Ministry of Health. The proportion of general revenue allocated for Ministry of Health functions in the National Budget is decided annually [3]. In addition, the formally employed workforce makes monthly contributions to an Employee Fund (NHIF), a compulsory savings scheme that provides a measure of security in retirement, and disburses supplementary benefits to members for medical expenses. All private sector formal workers earning more than Ksh10,954.70 (USD104) a month make a minimum contribution to the Social Security Fund (NSSF), a scheme that provides medical benefits for work related injuries of members. Payments through NHIF and NSSF, however, do not constitute a significant proportion of healthcare expenditure because the contribution and the coverage provided are minimal. Public sector employees and their families enjoy free access to primary medical services provided by the public sector (level 1-3), and some of them have private insurance or private medical care benefits.

Most significantly, out-of-pocket expenses incurred at the point of utilization by patients, at both public and private health facilities increasingly constitute a substantial proportion of health care financing. Given the role as the custodian of health, with the responsibility to pursue universal coverage of affordable health services through an equitable and efficient health system, the Ministry of Health faces mounting pressures both internally and externally as it strives to fulfil its mandates. Similar to many countries, the Kenyan Ministry of Health has a tripartite role as a funder, provider, and regulator. Public healthcare is heavily subsidized with very low user fee with revenue collection is estimated to be around 2% against its spending [4]. Provision-wise, an extensive range of care is provided in the public setting with a fairly high level of geographical coverage. In terms of regulation, there is a multitude of laws, directives, and clinical practice guidelines overseeing the medical profession that also regulate medical insurance, treatment fees schedule, and the operations of private healthcare practice.

Evidences generated through global experience with different systems of health financing

suggests that a strong public role in health financing, whether through payroll or general taxes, is essential for health systems to protect the poor and demonstrates that health systems with the strongest state role are likely to be more equitable and achieve better aggregate health outcomes [5,6]. Health equity, in this sense, relates to the value of fairness and justice in health distribution and incorporates elements of ethics and human rights [7-11]. For health systems to function equitably towards universal coverage, financing allocations should reflect the three dimensions of coverage; the depth, breadth, and proportion of health cost covered [12]. Using Kenya as a case study, this paper seeks to evaluate the progress and capacity of a middle income country in terms of health financing for universal coverage, and also to highlight some of the key underlying health systems challenges.

2. Methods

The World Health (WHO) Report 2010: Health Systems Financing: The Path to Universal Coverage was used as the framework to evaluate the Kenyan healthcare financing system in terms of the provision of universal coverage for the population. In the absence of a set of comprehensive and internationally recognized indicators for evaluating healthcare financing for universal coverage, the WHO strategy presents the most robust basis for evaluation as it was developed in consultation with national governments and on the basis of regional health financing reviews. It is also strongly informed by growing body of global research and evidence. This regional strategy includes target indicators and strategic areas to help focus attention on key health financing issues. In addition to target indicators and strategic areas, the strategy provides more detailed and specific information on the health financing situation in the Africa region.

Specifically, the four target indicators proposed by WHO to monitor and evaluate overall progress in attaining universal coverage in countries and in the African region are:

- Total health expenditure should be at least 4%-5% of the gross domestic product;
- Out of pocket spending should not exceed 30-40 % of total health expenditure;
- Over 90% of the population is covered by prepayment and risk pooling schemes; and
- Close to 100 % coverage of vulnerable populations with social assistance and safety net programs.

While the indicators are developed for an overall regional perspective, they are nonetheless useful in providing baseline criteria for low and

middle income countries in general, to measure their progress in terms of financing for universal coverage.

Global data suggested total health expenditure within the range of 5% of GDP to be the minimum level for governments to provide adequate public infrastructure and health service delivery that could reduce catastrophic and impoverishing health expenditures [13]. Out-of-pocket payments create substantial financial barriers in accessing health care, and low-income households frequently face catastrophic health costs when out-of-pocket payments are more than 30% of total health expenditures [14]. Public financing, mainly through taxation or social health insurance or a combination of the two, is the dominant form of prepayment financing in countries that have achieved near universal coverage. Tax-based and social health insurance financing have comparative advantages and disadvantages, but both provide the risk pooling and cross-subsidization which are essential for universal coverage, access and financial protection [15]. Social safety-net mechanisms aim to increase social protection by reducing barriers (economic, political, social and cultural) that can exclude the poor and vulnerable from accessing health services. Health financing oriented towards the poor can eliminate financial barriers to care by reducing out-of-pocket payments and promoting pooling that provides subsidized access for the poor.

The core source of health financing data was drawn from the most recent Kenyan National Health Sector Services Accounts Report (2011) to measure up against the WHO indicators. The report follows the framework used by the Organization of Economic Cooperation and Development countries and conforms to the International Classification of Health Accounts. The System of Health Accounts (OECD, 2000 Version 1.0) has been adopted by the World Health Organization as a basis for international data collection and comparison. It proposes an integrated system of comprehensive and inter-nationally comparable accounts and provides a uniform framework of basic accounting rules and a set of standard tables for reporting health expenditure data. The Kenyan Health Sector Services National Health Accounts framework was based on the System of Health Accounts (OECD, 2000 Version 1.0) classification with some modifications to suit local needs. In this context, sources of financing included the public sector consisting of the National government, local authorities, and social security funds, and the private sector consisting of private health insurance, managed care organizations, household out-of-pocket expenditure, non-profit

institutions (Faith Based Organization Facilities), and corporations.

3. Results

The WHO recommends that for universal coverage to be achieved in African countries, one of the key criteria is to have adequate spending on health; a minimum total health expenditure of 4%-5% of the gross domestic product is set as the benchmark. Kenya's health expenditure was at 1.9 % in 2011, and has been on an upward trend. It is important to note however that private expenditure overtook public expenditure in 2004, and in 2008 private health expenditure accounted for 53.8% compared to government health spending of 46.2%. Higher government spending is widely promoted and regarded as a means to lessen the consumption of private healthcare services that could lead to high out-of-pocket payment (OOP), as it generally relates to the provision of adequate public infrastructure and health service delivery at subsidized cost. Nevertheless, Kenya's relatively higher spending on health per capita GDP at USD 45 (in 2013) is modest within the developing country context, and has catered for the provision of comprehensive care with broad access and social safety nets.

Another concern to universal access to healthcare services are the reliance of direct payments such as user fees to providers. This is normally done through OOP which may lead to impoverishment when the payment is catastrophic. The WHO strategy recommends OOP spending to be less than 40% of the total health expenditure for its Africa region, and for Kenya, OOP accounted for 30 % of the total healthcare expenditure in 2011.

A closer examination of the Kenyan OOP shows that the nearly 55.0 % of the expenditure is for ambulatory care as shown in the Table 1. The expenditure incurred was for services ranging from general practitioners, specialist care, and purchase of pharmaceutical and other medical related products. Expenditures on these ambulatory care services are generally not catastrophic and they may also be reimbursed by employers (as part of staff health benefits) and private insurance. The category of OOP that raises the most concern is expenses for secondary care and hospitalization services, but this accounted for only 37.0% of the total OOP spent or 9.6% of the total health expenditure in 2010. OOPs spent in private hospitals are typically for both specialist inpatient and outpatient care, and in general are patronized by the richer class who can afford it or those who can claim reimbursements from their employers and private insurance. Nonetheless,

frequent appeals in the mass media requesting for public donation for private healthcare treatment is also indicative of the existing inadequacies of public hospitals such as the lack of treatment facilities and doctors, overcrowding, and long waiting lists.

Table 1: Cross-classification of household out-of-pocket expenditure by provider of health services in 2011

Providers	Amount	Percentage
Hospitals	3,388.2	31.4
Offices of Doctors	1,914.8	17.7
Office of Dentists	201.1	1.9
Other Professions	431.4	4.0
Office of other Providers	3,385.0	31.3
Dispensing Chemist	618.2	5.7
All other sales of medical goods	746.3	6.9
All other industries as secondary producers of Healthcare	117.1	1.1
Total	10,803.0	100

Source: Kenya National Health Accounts Unit: Health Expenditure Report (2009-2010)

The third indicator used by the WHO to monitor and evaluate universal coverage is whether over 90% of the population is covered by prepayment and risk pooling schemes.

In Kenya, citizens and residents are able to access the subsidized healthcare services provided by the Ministry of Health, parastatal hospitals, and local authorities. The public sector healthcare services (MOH) can be considered as a national health service with its tax-based financing and heavy subsidies. In 2010, there were about 2.3 million admissions in public hospitals which accounted for about 73.2 % of the total number of admissions. Public health facilities registered about 19.2 million outpatient attendances or 87 % of the total attendances, and only a nominal sum of Ksh 20 (approximately USD 0.20) is charged which is inclusive of medication [18]. The maximum amount that can be billed to a patient in a general ward is Ksh15, 000 (USD156) inclusive of all procedures, medication, diagnostic services and ward charges. Exemptions are also provided to those who cannot afford to pay the fees. In addition, all patients are exempted from any charges for infectious diseases.

The fourth recommended indicator relates to whether vulnerable populations are provided with social assistance and safety-net-programs. Kenya's public healthcare system provides access to all Kenyans at a highly subsidized rate as well as geographical access to a health facility within an average 10kilometer radius [20].

For those in need of emergency funds for acute complex and expensive treatments, it is left largely for the individual families to manage. Non-governmental organizations and even politicians also provide support to access these services either by providing some of these services (e.g. dialysis services), subsidizing part of the payment, or assist in appealing for public donations. In expanding the coverage of public outpatient services to underserved low income groups in densely populated areas, many health centers and dispensaries have been set up nationwide and operated by clinical officers and nurses offering basic outpatient care [22]. The rate is fixed similar to outpatient services in other public health facilities (Ksh 20) for both consultation and medication.

4. Discussion

Measuring up against WHO Africa's 4 key proposed indicators for financing universal coverage, Kenya has performed modestly. This can be reflected through notable health outcomes in mortality and morbidity which are improving. National vital statistics in 2010 revealed maternal mortality rate to be at 360 per 100,000 live births, infant mortality at 39.0 per 1,000 live births, and expected life expectancy to be 60.0 and 63.1 years for men and women respectively [18]. These outcomes are to be achieved through a comprehensive primary healthcare infrastructure that consists of an extensive rural health service, a referral system that integrates primary care clinics as the gatekeeper to secondary and tertiary care services linking County, National, and general hospitals, as well as heavy government subsidy on public healthcare service provision.

Nonetheless, in moving towards attaining and maintaining a comprehensive universal coverage, various aspects beyond the health financing component needs to be taken into account. Health financing is only but one component of the overall health system strengthening framework that functions inter-connectedly with other key parts to be truly effective in delivering universal coverage and improving health outcomes. Under the WHO framework for action for strengthening health systems, five other building blocks were identified including health workforce, health information, medical products and technologies, leadership and governance, and service delivery; and all these blocks link and interact dynamically with health financing [24].

In relation to health workforce, compensation of health workers comprises a large part of health expenditures, and various provider

payment methods incorporated in financing mechanisms need to be effectively used to increase health workforce motivation. The public health sector in Kenya has always been plagued with issues of low wages and overwhelming patient loads, which has spurred the brain drain of doctors and health workers to the private sector and also outmigration [25,26]. Numerous schemes have been introduced to incentivize public health workers particularly doctors such as allowing locums, establishment of private wings, and direct salary increments but the difference with private sector remuneration benefits remains significant. In addition, unlike the public sector, there is no referral system in the private sector to screen out patients, leading to the underutilization of specialist expertise [27]. The quality of internship training can also be affected by the medical brain drain due to the fact that most teaching hospitals in Kenya are run by the public sector. Nonetheless, in the last few years, the government has made inroads in developing compensation strategies which could influence and improve the health workforce skill mix to deliver priority health services, deployment, retention and performance in underserved areas.

In terms of health information, data on health expenditure that is reliably disaggregated alongside epidemiological and health outcomes data is critical to support policies and technical reviews. The collation of health information in Kenya has been vigorous and consistent both in terms of expenditure and vital health statistics. The establishment of the National Health Accounts unit has led to the systematic documentation and production of quality health expenditure data in accordance to international standards, and these data has been instrumental in supporting evidence-based policy making. While there are known shortcomings in the lack of data from the private healthcare sector, continuous efforts have also been made to approach private sector providers to provide key information such as admission rates and expenditure levels [2]. A focused policy intervention on data sharing coupled with the development of a robust national database management system would be a viable strategy in the medium and long term to collate key missing data from the expanding private healthcare sector that would enable effective policy planning and optimization of healthcare resources.

In service delivery, health financing policies need to secure an agreed benefit package to address national health needs, especially those of the poor and including all types of care from preventive and promotive to curative and rehabilitative. While Kenya has fared modestly in terms of curative care,

there is a critical need to allocate more financing capacity to expand preventive care, in better managing escalating healthcare costs associated with the shifting of disease burden towards chronic non-communicable diseases (NCD). With NCDs starting to appear in the top ten principal causes of death at government hospitals in 2010 [18] and also the alarming increase in the prevalence of NCDs (i.e. diabetes, obesity, stroke) [28], the effective management of chronic diseases at the population level could significantly affect the sustainability of the existing tax-based financing system. Allocative, technical and distributional efficiencies in health financing could contribute significantly to systems gains from better structure, organization and management, as well as cost-effectiveness of service delivery. Data from the Health Service Provision in Kenya: Assessing Facility Capacity, Costs of Care, and Patient Perspectives 2014 revealed that medicines and medical products constitute a significant share of out-of-pocket payments that contributed to driving the overall increase in total health expenditure. The acquisition of high-end medical equipment and new drugs should take into consideration the overall impact to the national healthcare expenditure, and purchasing decisions should be based on sound economic evaluation on population usage and cost effectiveness rather than market competition. The glut of medical equipment available in the private healthcare setting has been one of the factors that led to the increase in private health expenditure [29] where competition promotes the duplication of expensive services and equipment [26]. Issues of irrational drug use can be addressed through sound health financing policies in relation to drug procurement and distribution, alongside public education and clinical practice management. Health financing policies need to infuse the element of cost-effectiveness to better manage the purchasing of new medical supplies and equipment both in the private and public sector.

Lastly, health financing policy towards universal coverage is not isolated from the politics, pressure groups and lobbies at country level [30]. Improving the health financing system would require the critical role of the government in interacting with stakeholders and guiding the overall public interest. Good governance and leadership are needed to ensure adequate public spending on health and maintain the focus on the attainment of universal coverage, which will need to be supported by legislative and regulatory frameworks that promote prepayment and risk pooling arrangements, and rationalize health spending both in the public and private sectors. Every

year, the Kenyan Auditor-General report consistently highlighted discrepancies in the management of funds and resource management of the MOH both at the National and County level [31]. In this aspect, leadership is needed to make health care financing more accountable to the public, particularly in regards to inefficiencies and better utilization of public funds and resources.

5. Conclusion

The Member States of WHO have endorsed universal coverage as an important goal for the development of health financing systems but in order to achieve this long-term solution, flexible short-term responses are also needed. Measuring against WHO's four target indicators for financing universal coverage, the case of Kenya exemplifies the ways in which within a two-tier health system, notable achievements in terms of health outcomes and coverage can be attained through a mix financing system, with the government continuing to be the major financier and for those who can afford it to patronize private health services. One of the salient features of the Kenyan health system that lower income countries as well as those in the region can infer from is the critical importance of having a strong public role in health financing in protecting the poor and reaching for universal coverage.

Nonetheless, common challenges in developing countries in terms of escalating healthcare costs and expanding private healthcare continue to pose imminent risk to health equity and universal coverage. While the tax-funded public system is functioning credibly within a well-developed policy and operational framework (e.g. the civil service system), a critical systemic gap lies in the second tier, i.e. the private healthcare sector. The private realm operates in a more liberal setting and is funded by OOP, private medical insurance, and individual savings (NHIF); apart from the standard laws and regulations governing medical practice and medical products, the private sector functions primarily through market mechanisms and competition. Unlike the public sector, there is no referral system in the private sector, registration of private sector specialists is voluntary, and apart from information on communicable diseases and statutory compliance for outbreaks (e.g. reporting of infectious admissions) there is no formal obligation to share health data such as daily admission rates, expenditure levels, and clinical performance.

This presents a systemic disparity in the two-tier health system which may potentially weaken the case for universal coverage on whether current

achievements can be maintained in the future when uncontrolled pressures (e.g. market competition, liberalized trade, monetary incentives) in the private system start to negatively influence coverage particularly in relation to the three dimensions of universal coverage i.e. breadth and depth of coverage, and the proportion of costs covered (levels of financial risk protection). Additional prepayment financing mechanisms have been considered for the past two decades in the form of a social health insurance structure to supplement the financing of escalating healthcare costs but until today, this has not taken solid form. Health system strengthening strategies are currently underway under the ongoing devolution of health services to the County level albeit with a lot of challenges.

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Competing interests

The authors declare that they have no competing interests.

References

- [1] Latko B, *et al*: The growing movement for universal health coverage. *The Lancet* 2010, 377:2161-2163.
- [2] MOF: The 2012 Budget Speech. Ministry of Finance Kenya; 2009.
- [3] Options for Kenya's health financing system A P4H Policy Brief: 2014
- [4] Chai Yu, David K Whyne, Tracey H Sach.
- [5] Equity in health care financing: The case of Malaysia. *International Journal for Equity in Health* 2008, 7(15).
- [6] Gilson L, *et al*: Challenging inequity through health systems: final report.
- [7] Knowledge Network on Health Systems, WHO Commission on the Social Determinants of Health, Geneva; 2007.
- [8] Kenya National Health Accounts 2009/10.
- [9] Rannan-Eliya R, Somanathan A: Equity in health and health care systems in Asia. In *The Elgar companion to health economics*. Cheltenham: Edward Elgar; Jones AM 2008.
- [10] Whitehead M: The concepts and principles of equity and health. *Health Promotion International* 1991; 6(3):217-228.

- [11] Graham H: Unequal lives: Health and Socioeconomic Inequalities. Maidenhead: Open University Press; 2007.
- [12] Maidenhead: Open University Press; 2007.
- [13] Leon D, et al: International perspectives on health inequalities and policy. *BMJ* 2001; 322:591-594.
- [14] Braveman P: Health Disparities and Health Equity: Concepts and Measurement. *Annual Review of Public Health* 2006, 27:167-194.
- [15] Daniels N, et al: Why justice is good for our health: the social determinants of health inequalities. *Daedalus* 1999, 128(4): 215-251.
- [16] WHO: The World Health Report: Health systems financing, the path to universal coverage. World Health Organization, Geneva; 2010.
- [17] World Health Organization, Geneva; 2009.
- [18] Xu K, et al: Protecting households from catastrophic health spending. *Health Affairs* 2007; 26(4): 972-983.
- [19] WHO: Technical Briefs for Policy-Makers. Achieving Universal Health Coverage: Developing Health Financing Systems. World Health Organization, Geneva; 2009.
- [20] World Bank: World Development Indicators Database. Accessed on 20 March 2012. Available at: <http://databank.worldbank.org/ddp/editReport?>
- [21] Health Financing Reform in Kenya | Management Sciences Available at URL: <https://www.msh.org/resources>.
- [22] Health Service Provision in Kenya: Assessing Facility Capacity, Costs of Care, and Patient Perspectives 2014
- [23] The progressivity of health-care financing in Kenya heapol. Available at URL: <http://oxfordjournals.org/content/early/2013/10/08/heapol.czt073> Oct 8, 2013
- [24] Health Financing in Kenya DSW. Available at URL: www.dsw.org/uploads/tx.../2011_HealthyAction_BudgetStudy_Kenya.p.
- [25] London: Routledge; Chee HL. and Barraclough S 2007.
- [26] Bernama: Foreign workers with insurance may enter hospital without deposit. The BERNAMA news portal website; [<http://www.bernama.com>], (Accessed on 28 November 2011).
- [27] WHO: Everybody business: strengthening health systems to improve health outcome: WHO's framework for action. World Health Organization, Geneva; 2007.
- [28] Restructuring health services: changing contexts and comparative perspective. London: Zed Books; Sen K 2003.
- [29] Carrin, et al: Universal coverage of health services: tailoring its implementation. *Bulletin of the WHO* 2008, 86(11):857-863.
- [30] National Audit Department: Auditor General's report for the year 2010: synopsis. National Audit Office Kenya; 2011.