Unlocking Access to Healthcare in Kenya

Avenues and stumbling blocks

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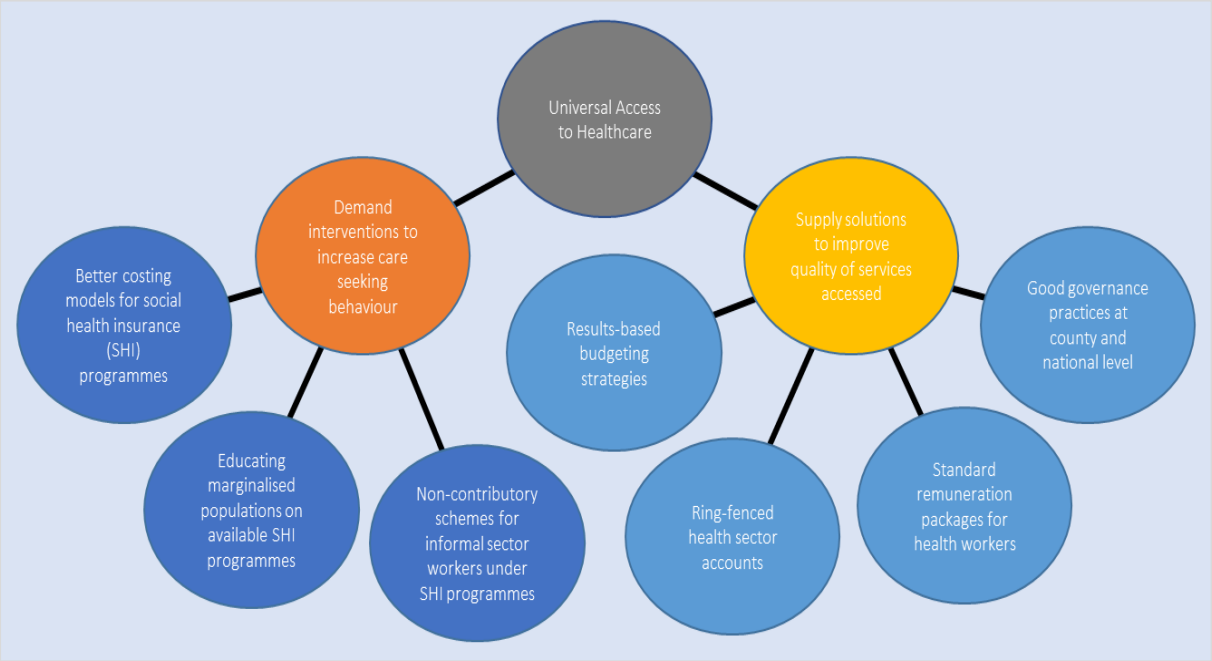
Executive Summary

In investigating the barriers to accessing quality healthcare in Kenya, inefficiencies in service delivery and economic exclusion emerged as the main deterrents to attaining universal access to health services. Though the ongoing interventions under the universal health coverage umbrella are a step in the right direction; demand side policies, through social insurance programmes, have so far proved insufficient in stimulating health seeking behaviour particularly in impoverished communities. Further, supply side gaps threaten the sustainability of the UHC framework as a result of ineffective financing strategies and the politicisation of health policy choices.

This paper argues that better investments in the health sector, good governance and a people-centred policy approach to economic growth will pave the way for economic recovery in Kenya and other African economies, once the health effects of the COVID-19 pandemic have been subdued. In this regard, the steps taken by the incumbent, Kenya's 4th president Uhuru Kenyatta, in seeing the UHC promise to completion; will not only determine his legacy, but also set the stage for his successor in the upcoming 2022 elections.

Figure 1: Recommendations



Introduction

Singapore, during the early 1960s, suffered from similar socio-economic challenges experienced in developing countries today. Running water and electricity as well as basic necessities pertaining to health and education was a privilege only enjoyed by elites. Fast forward to 2021 and the story is quite different. With a current life expectancy of about 84 years and per capita income of $88,155, the country placed eleventh worldwide, in the most recent Human Development Index rankings.

What caused this drastic shift in economic stature?

One of the critical push factors that enabled Singapore to realise such gains in productivity was the country's investment in human capital.

In curating the sustainable development blueprint, the United Nations selected health and education as key priority areas, with good reason. The development of human capital and economic growth are complementary, if not dependent, on each other. Productivity gains that emerge with strategic investments in human capital are as extensive as they are exponential. Economic growth must account for the human element, if it is to yield the intended economic transformation.

Over the past decade, investments in health and education have remained dismally low in Sub-Saharan Africa. Funding allocated to both health and education in the region have averaged at about 5% of GDP.[1] This misalignment of development objectives and policy choices has greatly impacted the trajectory of economic growth on the continent. Alluding to the post pandemic recovery period, Mukhisa Kituyi, UNCTAD Secretary-General[I] aptly stated that governments will face "a stark choice: continue misguided policy choices or collectively chart a new path that leads from recovery to a more resilient, more equal and more environmentally sustainable world".

Since the onset of the pandemic, the health sector has become the central feature of economic debate and policy rhetoric. Globally, the World Health Organization has pressed for more investments in the health sector to enhance preparedness for the next health crises. While Africa is no stranger to disease outbreaks, the continent still faces a long road ahead when it comes to building more formidable health systems.

As a continent, the challenges facing the health sector are deeply rooted in scarcity. Of health workers, financing and effective governance structures. In Kenya, the story is no different. Insufficient government funding, unequal distribution of health personnel and scanty distribution of medical equipment, impede the process of providing accessible and quality healthcare.

The government's Vision 2030 focuses on the "Big Four" agenda, which in part, aims to provide universal health coverage (UHC). However, the extent of coverage is yet to materialise, despite the impending 2022 deadline. UHC, perceived more as an altruistic government pledge to its citizens, is geared toward expanding access to quality healthcare for the marginalised and economically ostracised in Kenya.

The current approach to UHC provision is bipartite: reduce the ratio of out-of-pocket (OOP) expenditure to total household expenditure and fully subsidise the cost of essential services. But, funding gaps of up

[I] See United Nations Conference on Trade and Development. (2020). Trade and Development Report.

to 39% reported in the health sector hint at some inefficiencies in the disbursement and utilisation of current financing.[2]

Although unlocking access to healthcare lies in reducing financial barriers to demand, care cannot be delivered if the supply is ill-equipped or grossly overburdened. If the root causes of service delivery inefficiencies on the supply side are not corrected, the attainment of UHC will remain an aspiration with little proximity to reality. Focusing on both demand and supply side challenges, this discussion underscores inefficiencies in Kenya's health sector and provides a set of pragmatic recommendations which are instructive to the larger African context.

Health Financing in Kenya – High Stakes or Penny Ante?

Eight years after the decentralisation of government services in Kenya, county health budgets have systematically increased whereas national health budgets have declined. Although the devolution of health services can explain the shift in expenditure at the national level, the utilisation of disbursed funding at both county and national level remains uncoordinated and inconsistent.

At the national level, the health sector receives about one fifth of the funding allocated to education (Figure 2). Grants and transfers take up between 60-70% of the recurrent budget while a larger proportion of the development budget is allotted to the leasing of medical equipment and the free maternity health programme.[3]

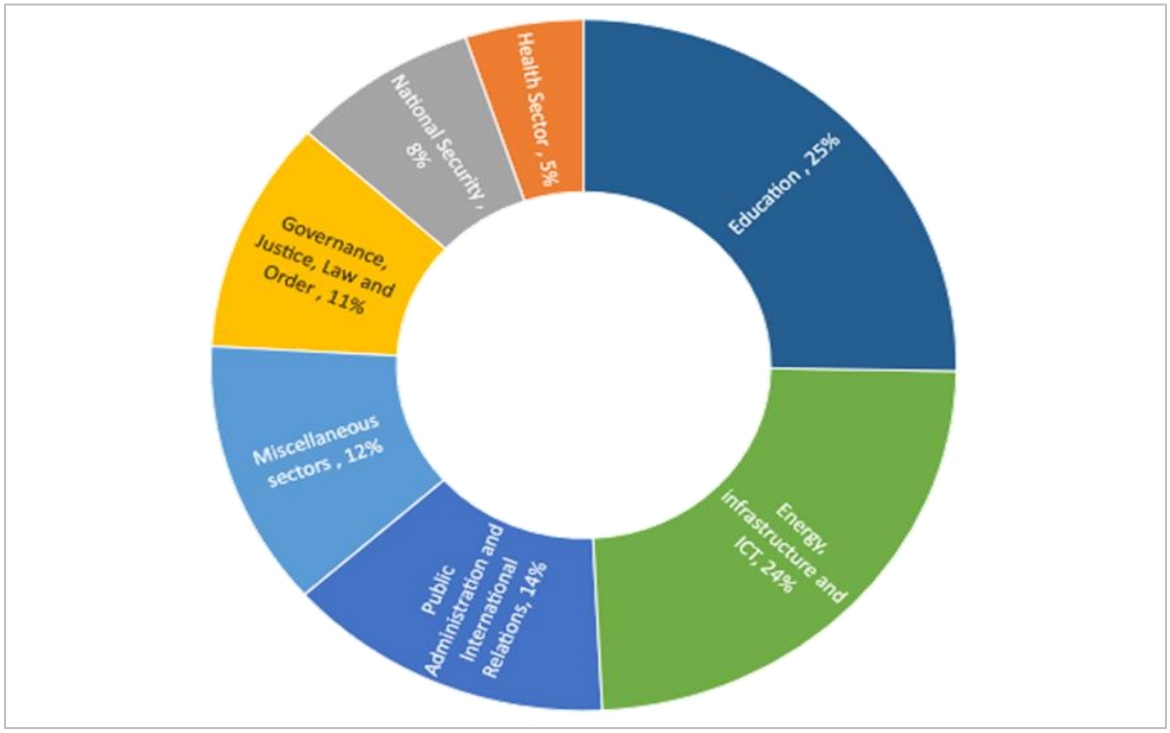
At county level, construction projects combined with grants and transfers take up more than half of the development budget, whereas 70% of the recurrent expenditure is distributed as personnel remuneration[4].

These dissimilar budgetary allocation strategies in the national and county health departments are not only inefficient but they are also counterintuitive to the attainment of UHC. Aside from the lack of cohesion in implemented health financing strategies, international aid dependence also provides a false sense of financial security as it is often politically volatile and to some extent, unreliable. The United States, one of Kenya's closest allies, allocates about $1 billion annually in development assistance to Kenya, two thirds of these funds are directed toward the health sector.[II]

Although such support is fundamental to the attainment of UHC, the unpredictability of donor funding results in fragmented and short term value delivery to local communities[5]. For example, after the re-enactment of the controversial anti-abortion "gag rule"[III] under the Trump administration in 2017, some reproductive health programmes pertaining to abortion were suspended in Kenya. Without local government backing, this disruption resulted in the closure of reproductive community health facilities which no longer qualified to receive funding from the United States government. In the context of UHC, pronounced donor dependency obscures the true cost of quality healthcare provision and creates falsity in available social safety nets.

[II] See Prakash *et al.* (2020). Investing in Kenya's people: Valuing the benefits of the U.S.-Kenya relationship.
[III] Requires non-governmental organisations based outside the US which receive US government global health assistance to certify that they will not use any funding to provide legal abortion services, referrals, or information to clients, or to advocate for the liberalisation of a country's abortion law.

Figure 2: Government expenditure by sector 2018/2019



Source: National Treasury

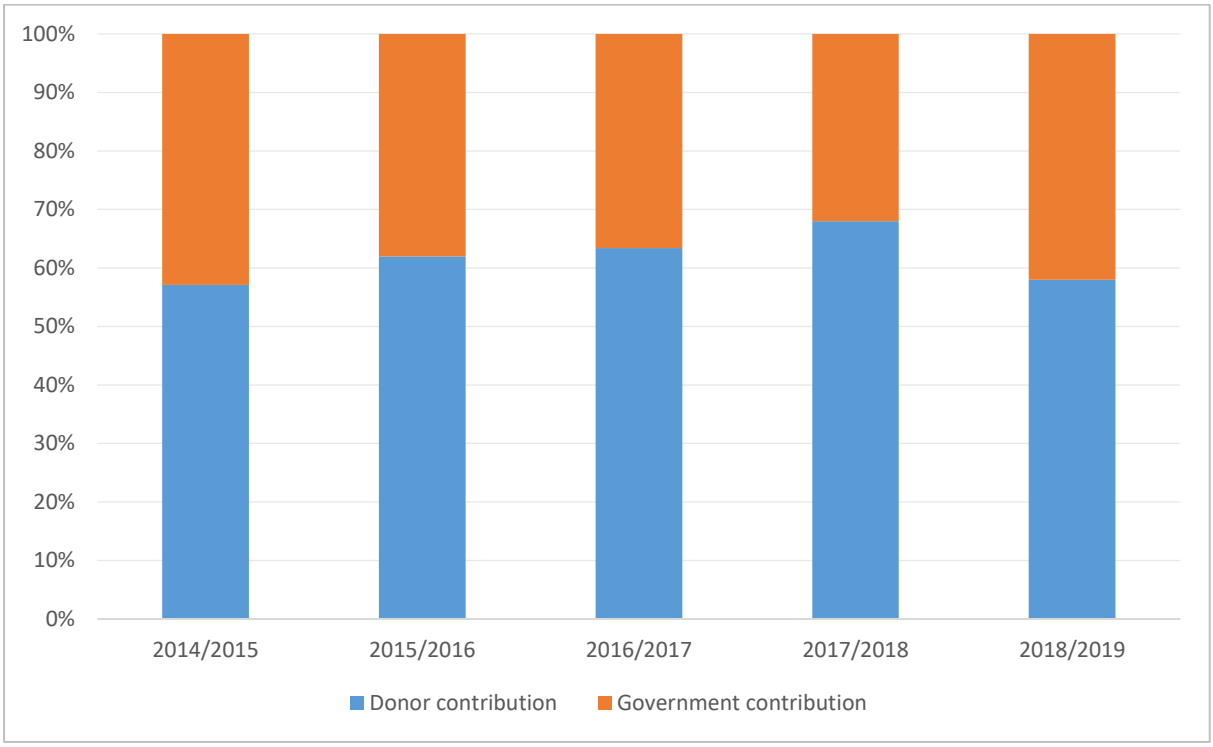
Over the past five years, the Kenyan government's financial contribution to the health sector has been on the lower side, despite its efforts to promote the UHC (Figure 3). With anticipated post pandemic reductions in donor funding, the government needs to up the ante, financially speaking, to prove its commitment to the Kenyan people. In any case, when development expenditure in the health sector is predominantly driven by donor contributions, how can Kenyans trust the government's pledge to provide universal health coverage?

Contrary to national accounts, county-level health expenditure is financed primarily by household OOP payments and county governments, with some donor funding to a lesser extent[6]. That said, there is a bias toward recurrent expenditure (Figure 4) at county-level, exceeding the legally mandated ceiling of 70%.[7] Although county governments could simply restructure their budgets to lean more toward development, increasing funding is only part of the equation.

In the absence of allocative efficiency, focusing on funding alone is a misdirected strategy which does not translate to increased coverage or improved service delivery. For example, counties with high per capita health expenditure performed poorly in critical health indicators pertaining to the quality of neonatal care provision.[8]

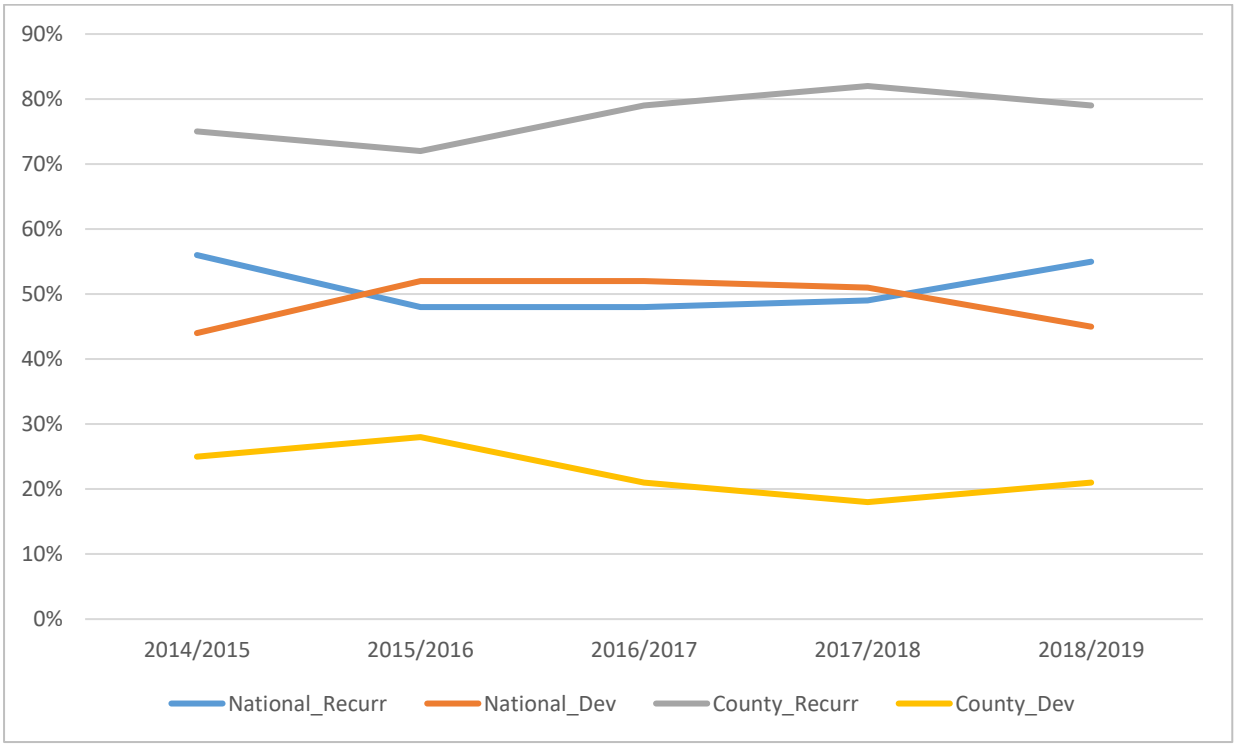
Though such distinct inefficiencies could be as a result of limited data availability in these counties, it is also indicative of the need for greater intermediary solutions beyond financial interventions. Given the contribution of health sector to economic growth, the stakes are high and low sectoral investments will not serve Kenyans, or the economy, in the long run.

Figure 3: Donor funding as % of total development budget



Source: Ministry of Health National and County Health Budget Analysis 2014-2019

Figure 4: Recurrent and development expenditure at national and county level



Source: MOH National and County Health Budget Analysis 2014-2019

Social Health Insurance Programmes

Social health insurance (SHI) programmes target the poor and vulnerable populations[IV] who would otherwise bear the brunt of superfluous insurance premiums charged for accessing basic healthcare services. These SHI programmes, which are central to the UHC framework, if properly enacted, would provide access to quality healthcare for the whole population independent of income bracket.

Despite the purported benefits, the uptake of SHI programmes varies depending on economic and political context. For example, less than 40% of the Ghanaian population was covered by the national health insurance during 2015, on the other hand, about 80% of the Rwandese population had insurance cover during the same period.[9] With both countries' economies relatively stable, political differences provide a better explanation for the deviation in coverage of their respective SHI programmes.

Politically engineered reforms in the health sector only subsist to the extent that the instigators stay in power. Such was the case in Ghana, where a significant subset of the population was excluded from accessing insurance cover as a result of regime changes and poor governance which curtailed the implementation of the country's national health insurance scheme. Conversely, sustained political will and regime stability create an environment where SHI programmes can thrive. In Rwanda, the community-based health insurance scheme, *mutuelles de santé*, has become a UHC exemplar in Africa. Rwanda's community model worked and continues to do so, because of the political push toward UHC and adaptation of the scheme to suit the country's context of communal ownership.

Disparities in coverage also come about as a result of the mismatch of goals between insurance providers and the target population. Insurance premiums, which are primarily based on anticipated levels of risk, disadvantage the vulnerable population, whose employment is for the most part in the informal sector. But, informal sector insurance models pose challenges to providers.

They are not only difficult to build due to income ambiguity but they are also costly to implement as a result of high administrative overheads.[10] Setting high premiums to match these incremental costs and risk leads to burdensome contributions and high attrition rates in the target population, as is the case under Kenya's National Hospital Insurance Fund (NHIF).

From a governance standpoint, the financing of Kenya's health-related programmes is reliant on politics limiting the extent of their reliability[5]. Added to this, the absence of a clear-financing strategy places implementation restraints on the UHC agenda and will continue to do so unless expenditure adjustments and resource utilisation reforms take place.[11]

Although Rwanda's UHC success is one to be marvelled, the country still struggles with infrastructure and human resource capacity constraints. Proof that long term cross-subsidisation of risk and income can only be attained through SHI programmes, if there is stable financing on the demand side and a functional health infrastructure to facilitate the resulting increase in supply. Further, if SHI programmes truly provide the roadmap to attaining UHC,

[IV] Also referred to in this paper as target population

political support cannot be optional, it must be absolute.

Does Kenya's NHIF Complete the UHC Puzzle?

Over 50 years since the establishment of Kenya's NHIF, its coverage rates, by population, are still inadequate.[12] In recent years, the NHIF has reformed its structures to include the Health Insurance Subsidy for the Poor (HISP) and the expansion of the membership benefit package aimed at escalating their reach into the informal sector. Some of these efforts have come to fruition.

More than 50% of the NHIF membership base is from the informal sector.[13] Cost subsidisation programmes, along with other factors such as the use of mobile application technology and cheaper premiums, have proved useful in attracting the informal sector to the NHIF.

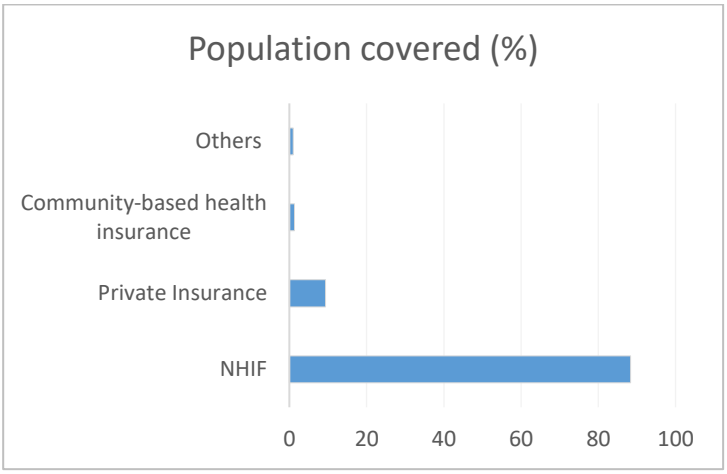
Despite the significant informal base in its membership, the NHIF is yet to considerably raise the bar when it comes to the retention of informal sector workers. The increase in coverage and health-seeking behaviour has been much slower than initially anticipated[12] and justifiably so. Uncertainty regarding the duration of funding and the exclusion of some of the target population from the subsidisation schemes, have led to the slow uptake of government driven initiatives. Such was the case in the subsidy programme for the elderly and persons with severe disabilities, whereby a 50% budget cut resulted in an 80% decrease in the number of subsidy recipients who had benefited from the programme since 2014.

Poor selection mechanisms also compound the discrepancies between the beneficiaries of the target population covered by the health insurance subsidy program and the actual number of poor and marginalised population in the country[12]. By 2018, the HISP had supported approximately 178,186 households. In terms of coverage, this represented about an eighth of the targeted 1.5 million households.[14]

Even with the highest membership base (Figure 5), the true extent of insurance cover under the NHIF is ambiguous at best. Findings from the Kenya Household Health Expenditure and Utilisation Survey indicated coverage rates of about 20% from the survey respondents, of which 88% were under NHIF, an effective population coverage rate of about 17.6%[15]. In contrast, the NHIF reported coverage of about 7.6 million principal members and by extension, 27.2 million members (including dependants) resulting in a coverage rate of about 50%.[16]

Without consistent and reliable data on NHIF coverage rates under various interventions, monitoring the progress and effectiveness of implemented strategies over time will not only be difficult, but it will also result in obsolete policy choices.

Figure 5: Insurance providers in Kenya



Source: Kenya Household Health Expenditure and Utilisation Survey

So far, the efficacy of the strategies implemented by the NHIF in scaling UHC, are debatable. Revenue leakages stemming from weak accountability structures within the NHIF and fraud among health providers could only add to the financial black holes that must be plugged before any serious reforms begin to materialise in its coverage utility.[17] Given the anticipated increases pay-out ratios for beneficiaries, and the inflated administrative remunerations paid by NHIF in the past,[18] better management strategies for the fund's capital are both requisite and mandatory.

UHC: Roadblocks and Missing Puzzle Pieces

Kenya's average annual population growth rate is estimated to be approximately 3%. By 2050, Kenya's population is projected at 95 million, almost double the figure recorded in 2017.[19] At this rate, the rising population levels alone, will place considerable strain in healthcare capacity long after the effects of the pandemic wane. Longer term solutions to healthcare infrastructure and human resource bottlenecks are necessary, but they are also urgent. If investments in human capital development are not made now, Kenya will fail to realise the potential benefits that its demographic dividend has to offer in the not so distant future.

Thus far, the demand financing strategies employed in the country have been ineffectual in substance and inconsistent in execution. On the supply side, the availability of health workers as well as the adequacy and geographic distribution of health infrastructure is lacking. These capacity constraints have limited the range of services accessed even after subsidisation programs have been implemented. By focusing on filling the gaps in the demand financing framework as well as the blockades on the supply side, the Kenyan government can start meeting the future health needs of its people today.

> "The healthier Africa's population is, the more robust the future global workforce will be."
>
> Abebe Aemro Selassie, Director, IMF African Department

Individual Cover at Universal Cost, Demand Financing Alone Won't Work

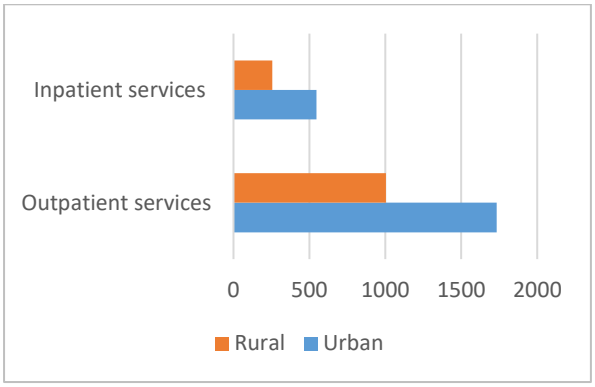
Economic and geographic disparity have been highlighted as the leading indicators of healthcare access exclusion. Both cross-county and intra-county income inequalities are positively associated with incidences of access exclusion.[20] In terms of spending, the poorest households bear the brunt of OOP and have the highest incidence of catastrophic health expenditure. Although rural populations have a lower per capita health expenditure relative to urban areas (Figure 6), the cause of the lower expenditure is both a symptom and result of poor access.

Economically, both direct medical and non-medical costs associated with the acquisition of health services factor into the prevalence of catastrophic health expenditure(CHE)[V] among the target population. After accounting for direct costs, the probability of CHE increases by about 2%.[21] Further, outpatient services are more likely to increase the incidence of CHE relative to inpatient services, with a widening disparity after adjusting for

[V] Health expenditure exceeding 10% of total expenditure and 40% of non-food related expenditure

income levels.[22] While these findings do not exclude the unambiguous medical costs pertaining to access, they are also indicative of high direct non-medical costs attributable to transportation and inefficient outpatient service delivery systems associated with costly medicines and diagnostic testing.

Figure 6: Per capita health expenditure (Kshs)



Source: Kenya Household Health Expenditure and Utilisation Survey

Aside from explicit financial barriers to access, the target population is affected by covert factors pertaining to discrimination by healthcare care providers along with poor grievance structures in place to address such malpractices.[23] Reforms instigated by the NHIF to alleviate the financial burden of the target population in accessing healthcare, is further encumbered by poor adherence to the user fee eradication scheme in public health centres and inadequate follow up of delayed insurance reimbursements to health facilities that fall under NHIF cover.

If solving the access problem were as simple as financing demand through the subsidisation of medical costs, UHC would not be as elusive as it currently is. Both systemic and localised solutions are needed to solve the UHC financing puzzle.

The scaling up of NHIF cover alone may help in increasing short term coverage, but financial hardship will still persist if the root causes of specific healthcare costs are not addressed in the long run. Tailored solutions, driven by county governments and coordinated at the national level, provide a better chance of attaining UHC in each county as opposed to the current 'do as you see fit' approach.

Remuneration, Representation and Recourse

The inadequate and poor distribution of health personnel or expertise to address medical needs is a priority area that has been side lined for far too long (Box 1). Since devolution, poor coordination between the national and county governance structures have contributed to inefficient health systems at county level, which are riddled with both management and staff-related challenges.[24]

On top of that, the distribution and expertise of health sector workers is both inadequate and inequitable across the different counties.[25] With incidences of staff attrition being higher in rural health facilities[26]. This is partly due to unreliable county government funding, which has not only resulted in perennial staff redundancies but also in low technical capacity improvements. In effect, at both national and county level, there is a lack of technical response and skills capacity during public health emergencies.

Remuneration has been a point of discourse and discontent among varying cadres of public health professionals in Kenya. Although county governments spend over 70% on administrative remuneration, it appears that the funds do not trickle down to those at the lower

levels of the personnel pyramid. It was not surprising that, despite the ongoing pandemic, health worker unrest in Kenya escalated during 2020 and subsequently spilled over into 2021. With the government threatening layoffs for those striking and the health workers unions teetering between the national and county governments, little progress will be made in ensuring the negotiations are substantive.

During the 2017-2018 period, the government's response to health worker unrest was to rent the services of Cuban doctors. If outsourcing medical care is the government's reaction to the plight of healthcare workers, attaining UHC will be as expensive as it is infeasible. The segmented representation of health professionals, particularly those working in the public sector, makes it harder to attain the upper hand in government negotiations. A more harmonized approach from the various representative agencies of health professionals would ensure that their recurrent demands are met, if not at least heard.

Infrastructural Cracks

While increasing coverage to essential healthcare is of paramount prominence within the UHC delivery context, the quality of the services accessed should be matched in tow.

Presently, health facilities in public hospitals are both inadequate and poorly equipped to handle medical emergencies (see Box 1 below). While the public sector, through the government and NHIF, plays a distinct role in the purchasing and provision of health services, the private sector's role is becoming increasingly significant, particularly in delivering low-cost solutions in healthcare provision.

The private sector outperforms the public sector in both capacity and preparedness, despite the fact that public hospitals are more accessible to a larger subset of the population. During life-threatening emergencies, private health centres are 40% more likely to have access to a four-wheeled vehicle than public health centres, similar findings are reported in diagnostic equipment.

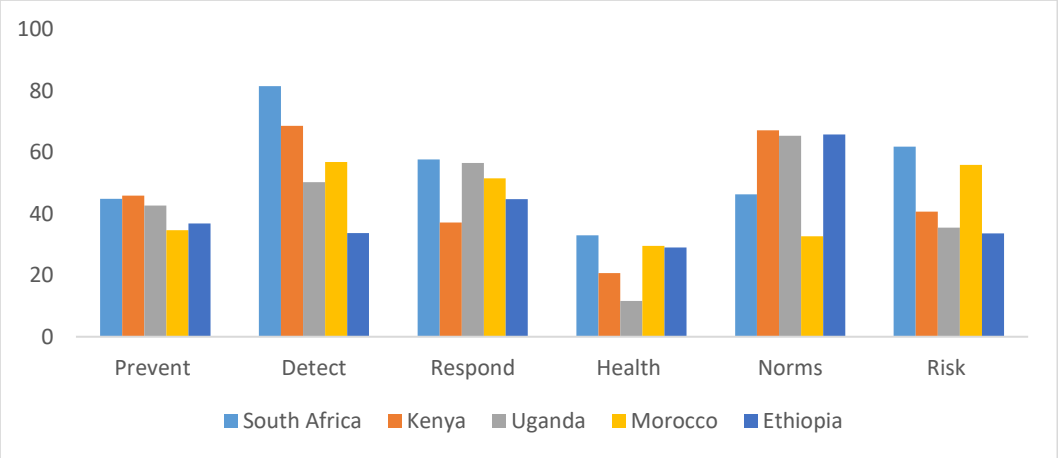
Medical equipment scarcity coupled with limited communication infrastructure during life-threatening emergencies, exacerbate access exclusion and impede effective delivery of health services in public hospitals. The funding allocated to the public health emergency operations centre in the country is so low, that it was classified under International Health Regulations standards as limited in its utility during a public health emergency.

Although Kenya ranks higher than most of its Sub-Saharan counterparts in managing its health systems, more strategic investments in critical technologies are necessary to attain infrastructural capacity. Currently, infrastructural investments, at both county and national level, appear to be uncoordinated.[27] For instance, there is currently no decentralised staff database which would improve the response capacity during public health emergencies in the country.

On a smaller scale, the use of in-patient electronic health record (EHR) systems lags behind the more prevalent administrative data management systems used in public hospitals.[28] This reduces the detection capacity of real or perceived health risks whilst limiting reliable data sharing across geographically alienated hospitals.

Box 1: International benchmarks - How is Kenya faring?

Health standards provide a way of monitoring the progress and performance of countries in meeting the most equitable level of quality healthcare provision. In terms of the recommended WHO guidelines on functional health infrastructure, Kenya has a long road ahead. For instance, between 2006 and 2014, there were, on average, 14 hospital beds per 10,000 population in Kenya.[I] By 2018, the density of health professionals was approximately 11 per 10,000 population[I], a figure below the recommended SDG index goal of 44.5 skilled health workers per 10,000 population.[I] In terms of health financing, Kenya's health expenditure, to date, is below the 15% set out in the 2001 Abuja Declaration. Geographically, Kenya is faring better than its African counterparts and came 2nd to South Africa on the continent in the Global Health Security index.[I] As anticipated, the health systems indicator had the worst performance not only in Kenya, but also globally. In a world where health tends to take a back seat in economic policy, perhaps the global pandemic was the most ruthless and expedient wakeup call needed to create a human-centred approach to economic development.



Source: GHS index[I]

Conclusion

Economist and Nobel Laureate Amartya Sen was not wrong when he postulated that "economic growth without investment in human development is unsustainable – and unethical". A country's long-term economic growth is rooted in the productivity of its people as

derived from investments in its human capital. With Kenya's population rising along with its economic disparities, investments in social safety nets will greatly reduce the number of people pushed into poverty in the aftermath of the pandemic.

As the UHC deadline draws closer, the country is still battling with the effects of the health crisis and an ensuing economic crisis. Valiant as the efforts to increase health coverage might be, the gaping holes in personnel scarcity, funding and resource allocation depict systemic disorganisation that must be addressed beyond the 2022 deadline. Even so, some bold moves are needed, if quality healthcare is to be

attained under UHC. Kenya must adopt a UHC delivery model that fits its socio-economic context and geopolitical landscape. Demand side deficiencies and supply side barriers must be addressed simultaneously.

On the demand side, economic interventions are simply not enough. Geographical exclusion affects large sections of the country living in inaccessible areas. Given that enhancing the distribution of health centres and transportation networks may only be addressed over time, short term solutions could be adopted to enable health seeking behaviour. These include the subsidisation of transportation costs as part of the UHC costing model, scaling the use of mobile technology to facilitate consultations in arid and semi-arid areas of the country as well as better collaboration with community health workers who are more adept at providing efficient channels of accessing healthcare in geographically remote areas. Additionally, educating the target population via community health workers on the importance of insurance and the different programmes accessible to them under UHC, could also stimulate care seeking behaviour at household level.

On the supply side, service delivery is severely inadequate. Both national and county governments should work concurrently with organisations which represent health workers' interests so as to address grievances rather than threatening retrenchments as recourse for the persistent health worker unrest. At the national level, the creation of ring-fenced health sector accounts that direct funding toward counties which meet the pre-planned performance targets in terms of service provision or infrastructural development should be used to improve budgetary allocative efficiencies.

Moreover, due to limited resources and sectoral opportunity costs, results-based financing systems should be used to mitigate escalating recurrent expenditure with little benefit to healthcare provision, particularly at county level.

When it comes to financing social health insurance programmes, racking up debt to fund UHC poses long term sustainability risks. With the current levels of debt, health-related financial shocks would prove detrimental to the Kenyan economy. Some debt management and financial ingenuity will be needed to dig the country out of the mounting external debt which currently stands at 32% of its GDP.[29]

Despite these challenges, UHC might yet be within reach.

Social health insurance models which are non-contributory have been found to offer longer term feasibility relative to the current contributory model.[30] Thailand used such a non-contributory framework to provide cover for 78% of its population whilst recovering from the 1997 financial crisis. A change of this magnitude cannot occur overnight, it must be contextualised to match the country's socio-economic constraints.

Prior to the adoption of such a nationwide non-contributory health financing system, a multi-stakeholder revision of formal and informal contributions should be conducted to ensure equitable, sustainable and reasonable premium rates.[31] As a result of COVID-19, the number of Kenyans absorbed into the informal sector is bound to increase making the attraction and retention of informal workers under NHIF paramount. In this regard, the government can supplement premium increases for informal sector workers subscribed to the NHIF, improving retention rates.

One way to fund such a system would be through sin tax[VI]. In Korea, just as in Thailand, the government supplemented healthcare financing via tax revenues derived from levies on commodities such as alcohol and tobacco. Even if such taxes would result in some revenue flow, allocative efficiencies must take precedence to maximise value per shilling spent. Recurrent expenditure must be directed toward improving the distribution of personnel and subsidisation of medicine costs whereas development spending should be directed toward expanding health infrastructure across counties.

The government receipt of $50 million for the COVID-19 health emergency response project, if utilised for the intended purpose, should also aid in closing some of the infrastructural cracks, mandated as part of the project's objectives.[32] Aside from financing expenditure, better tracking of the utilisation rates of health facilities at county and national levels should also be employed for cost analysis and budget control.

Lastly, the longevity of the UHC plan is very reliant on good governance. Without the coordination of cohesive health strategies at national and county level, the current segmented strategy will only aggravate the pre-existing inequalities arising from health access exclusion across counties. If the Kenyan government prioritises its people over politics and focuses on long term systems augmentation as opposed to short term fixes in the health sector, UHC will not only be achievable but also sustainable.

[VI] Taxes levied on products or services perceived as harmful to society such as alcohol and tobacco

Endnotes

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