

Alternative Sustainable Financing of Public Health Care in Kenya

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Abstract

The pursuit of quality health care has been the concern of Kenya government in collaboration with key stakeholders including donors, NGOs, CBOs among others. To realize this, government has continued to develop and implement various national health policies and strategies necessary for enhancing financing of a well-functioning health system. Due to the economic reforms and performance experienced in the 1980s, the Kenyan government forced to cut down on public expenditure contributing towards the abolition of free and subsidized public goods including healthcare. In the process, the government introduced user charges, which has however contributed to limited utilization of health services as well as deterioration in quality of care and catastrophe in household expenditure. Similarly, government budgetary allocation as well as donor support has been dwindling over years. In order to enhance access to quality health care in the country, various suggestions are made to facilitate financing of health care. Among these include prioritization of healthcare financing as a target for fundamental reforms through enhanced allocation by the government in line with Abuja Declaration. Other supportive reforms that are necessary and particularly urgent include strengthening health infrastructure and human resources; increased autonomy for public health facilities to allow them to manage their resources in the best possible way while enhancing their capacities at all levels. Alternative financing mechanisms are equally suggested including dedicated taxes, risk-pooling mechanisms and infrastructure bond amongst others. Finally, necessary policies need to be put in place to enhance joint financing agreements as well as the sector-wide approaches to minimize duplication of effort and skeweness in implementation of health projects meant to enhance access to quality care.

Key words: Health Care Financing, Dedicated Tax Funds, Risk-Pooling, Infrastructure Bond, Universal coverage

1.0 Background of the Problem

The health sector has been recognized as an important pillar in the world economy as well as a key component in delivering the social component necessary for economic growth (GoK, 2009). The pursuit of good health has been a critical focus for many stakeholders including governments, multilateral institutions, NGOs as well as CBOs. To ensure access to quality health care, governments through various stakeholders worldwide have continued to develop and implement national health policies and strategies necessary for enhancing financing of a well-functioning health system. These have been earmarked towards the promotion, prevention, treatment and rehabilitation. Due to the economic reforms and performance experienced in the 1980s, many countries including Kenya were forced to cut down on public expenditure contributing towards the abolition of free and subsidized public goods including healthcare. Similarly, the health sector became too large for the line ministry to manage accordingly. It soon however, became evident that the available government resources were insufficient to fully finance a basic package of cost-effective services.

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With increasing budgetary pressure, it became a reality that the health sector was financially unstable as the governments could not fully support the health sector single-handedly. This led to the development of alternative financing mechanisms, including user charges/fees, whose main objective was cost recovery, from users of public health facilities to generate additional revenue and augment the financing of the under-funded non-wage recurrent expenditure items, reduce excessive use of services. The new policy change was viewed as being pro-poor if used to improve the access to quality health care, and help reorient public financing towards serving poor and other vulnerables. They were however concerns that the fees could limit access to services particularly by the poor thus argued that the charges should be accompanied by appropriate systems of waivers for the poor, exemptions for preventive and some primary health care (PHC) services as well as other mechanisms of financial protection including cash transfers to the poor.

In terms of financing, user charges through out-of-pocket (OOP) expenditure represent a major source of health care financing in low-income countries (LICs) of total health care expenditure (THE). In the country for instance, OOP expenditure remains, in general, the principal method of financing healthcare services and contributes towards at least 36% of all health expenditures. It is estimated that this leads to the impoverishment of an estimated 1 million households, while a further 39% of sick people fail to seek treatment (Gitahi, 2011). For instance, in 2007/08 financial year, 36% of total health expenditure (THE) was financed by households, mainly through out of pocket spending. This was way above the recommended level of 15-20% of the total health expenditure, a level at which the incidence of financial catastrophe and impoverishment falls to negligible levels (National Health Accounts (NHA), 2009; Chris and William, 2010; WHR, 2010). Such systems of health financing make it impossible to spread costs over the life-cycle: paying contributions when one is young and healthy and drawing on them in the event of illness later in life. Consequently, the risk of financial catastrophe and impoverishment is expected to worsen making the realization of universal coverage a dream. Based on the foregoing discussion, the study reviewed literature on alternatives sustainable financing of health care, their practicability and implementation in the Kenya's context.

Although the government and development partners contribute to about 30% of all health expenditures, studies show that this is implemented without strict adherence to the objectives of aid effectiveness or in the context of long-term strategies for sustainability. The Public Expenditure Tracking Survey of 2008 shows that an average of 30% (range 0%-65%) of earmarked financial resources from government sources do not reach health centres and dispensaries notwithstanding the late disbursement. Risk-pooling through health insurance on the other hand, is responsible for only a minor component of all health expenditures and only for a small section of households in the country. Generating public revenue through increased taxation is often advocated as a solution but the potential for increased tax revenue in the country remains elusive given the poverty levels and economic growth. Similarly, the external funding and risk pooling are limited and underdeveloped, respectively. Further, the financing is ineffective and inequity of public spending.

There is also extensive evidence that public financing benefit the rich more therefore replacing charges by public financing may not improve equity as would be expected. Reports show that out of Kshs 236.6 billion allocated to social services in 2009/2010 the Ministry of Education received 73.8% while the Health Sector received only 16.0% of the allocation (GoK, 2010). This allocation compares to sector's requirement of Kshs 386.4 billion against an allocation of 191.2 billion between 2008-2012. An estimated funding gap in equipment, drugs, non-pharmaceuticals, human resource and infrastructure is Kshs 195.2 billions. The total health sector spending was however projected to increase by 5% for 2010/2011 and 10.1% by 2011/2012. This allocation is considered insignificant compared to economy's growth rate reported over the same period (GoK, 2010).

Additionally, despite an increased growth in Kenya's economy from stagnation in 2002, when it grew by only 0.5%, to a high rate of 7.0 in 2007, resulting to an increase of per capita income from 2.5% in 2002 to 3.3% in 2006 and the expansion of the real GDP by 6.1% in 2006, compared with a revised growth of 5.7% in 2005, the total expenditure on health as a percentage of gross domestic product (GDP) increased by a small proportion from 4.5 in 2000 to 4.7 in 2007, excluding external values (GoK, 2008; WHS, 2010). Although in nominal terms, the overall government expenditure on health increased in the last seven years, from 16.4 billion in 2003/04 to 39.9 billion in 2009/10 (USD 13.6 per capita), health financing in Kenya continues to pose a major challenge in health care delivery.

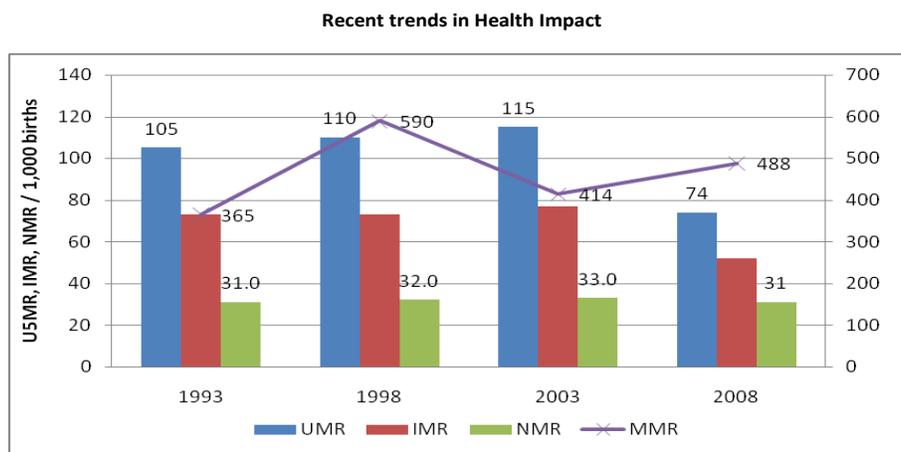
This level of funding is well below the Abuja declaration target of 15%, the Economic Recovery Strategy of 12% and the WHO Taskforce on Innovative International Financing for Health Systems (TIIFHS) recommended level of US\$ 44 per capita on average (unweighted) in 2009, rising to a little more than US\$ 60 per capita by 2015 for low income countries (NHA, 2009, WHR, 2010). This trend continues to be realized despite the government's commitment in Vision 2030 wherein the government of Kenya has reiterated revitalization of health care infrastructure, strengthening health care service delivery and developing equitable health care financing mechanisms (GoK, 2008; GoK, 2010). A key question that merit consideration has been given the high OOP with its negative effects to the poor and other vulnerables, what would be the desired mechanisms of financing health care in the country

2.0 Situational Analysis

2.1 Health Indicators

The trends in health indicators in Kenya since the 1960s shows a strong downward trend until the 1990s, thereafter, a deceleration, and finally, a momentary reversal in some of the indicators, particularly infant and child mortality rates. During the period, life expectancy rose from about 43.4 years (1960) to 62 years (1990), before declining and stabilising at about 52 years (2006). Similarly, infant mortality dropped from 122 per 1,000 live births (1960) to 63 in 1990, before rising to 83 in the year 2000, followed by a drop to the current level of 52 (GoK, 2010). The estimates for the under-five-year mortality rate at similar periods were 204 per 1,000 live births, 93, 134 and 77 respectively. Finally, maternal mortality rates still remain high at 414 per 100,000 live births, 650 in 1990 and 1,000 in the year 2000. Evidently, these rates are far above the targets set for the MDGs for the country.

Life expectancy (LE) at birth in Kenya had reduced to a low of 45.2 years during the previous policy period, but was estimated to have risen, up to 60 years by 2009². This trend was reflected across all age groups, with stagnation / worsening of the health situation seen across all age – specific impact indicator trends. By the beginning of this policy, however, some evidence of improvements for specific age cohorts was emerging, particularly for Adult, Infant and Child mortality.



Source: Respective Demographic and Health Surveys

Geographical and sex differences in age – specific impacts persist in the country. In addition, the country still faces a significant burden due to all disease domains especially communicable conditions, non communicable conditions, and injuries / violence.

The level and distribution of health in the country has been affected by the following contextual factors. The population growth rate has remained high estimated at 2.4% with a high young, and dependent population.

² WHO 2010 World Health Statistics

The period showed improvements in GDP and reduction in population living in absolute poverty, though more in urban areas, and absolute poverty levels still remained very high (46%). Literacy levels remained good at 78.1%, though inequities in age and geographical distribution persist. Gender disparities too are significant, though showing improvements particularly after 2003, a reflection of better opportunities for women. However, disparities exist and persist, with the GDI ranging from 0.628 (Central province) to 0.401 (North Eastern province). Finally, security concerns still persist in some areas of the country, making it difficult for the communities to access and use existing services. Gender related crime is also reported in urban areas, particularly in the informal settlements.

2.2 Leading causes of deaths and disabilities in Kenya

Table 2.1 provides a summary of the leading causes of deaths and disabilities in the country in order of magnitude.

Table 2.1: Leading causes of deaths, and disabilities in Kenya

<i>Causes of death</i>			<i>Causes of DALY's</i>		
Ran		% total	Ran		%
k	Disease or injury	deaths	k	Disease or injury	total
					DALY's
1	HIV/AIDS	29.3	1	HIV/AIDS	24.2
2	Conditions arising during perinatal period	9.0	2	Conditions arising during perinatal period	10.7
3	Lower respiratory infections	8.1	3	Malaria	7.2
4	Tuberculosis	6.3	4	Lower respiratory infections	7.1
5	Diarrheal diseases	6.0	5	Diarrhoeal diseases	6.0
6	Malaria	5.8	6	Tuberculosis	4.8
7	Cerebrovascular disease	3.3	7	Road traffic accidents	2.0
8	Ischemic heart disease	2.8	8	Congenital anomalies	1.7
9	Road traffic accidents	1.9	9	Violence	1.6
10	Violence	1.6	10	Unipolar depressive disorders	1.5

DALY's = Disability Adjusted Life Years

As indicated in the table, HIV/AIDS constitutes the highest cause of deaths in the country followed by conditions arising during perinatal period, tuberculosis, diarrheal diseases and malaria in that order. In terms of disabilities, again HIV/AIDS is rated the leading cause followed by conditions arising during perinatal period, malaria and lower respiratory infections. Other causes of disabilities include diarrheal diseases, tuberculosis, road traffic accidents among others.

2.3 Health Sector Reforms

To respond to the demands of the health sector, particularly the need to reform its systems and operations, various policies and strategies have been initiated over time. Among these include Health Policy Framework Paper, National Health Sector Strategic Plan I & II, Vision 2030. In this sub-section, a brief overview of the reforms is discussed.

2.3.1 Health Policy Framework 1994-2010

The Health Policy Framework 1994 and successive 5-year National Health Sector Strategic Plans (1999-2004 and 2009-10) set the targets and processes driving the health sector development, as well as healthcare service delivery. The aim of the policy was to introduce reforms, specifically in the way the healthcare services are not only organized but also financed, delivered and evaluated. Key to the realization of these was equitable allocation of government resources to reduce disparities in health status; increased cost-effectiveness and efficiency of resource allocation and use; and manage population growth. Others were enhanced regulatory role of the government in health care provision; creation of an enabling environment for increased private sector and community involvement in service provision and financing; and increase and diversify per capita financial flows to the health sector.

Important approaches and innovations of the health policy especially in NHSSP II were the concept of Kenya Essential Package of Health (KEPH), the Community Strategy, the Joint Framework of Work and Financing (JPWF) an essential element for entrenching the Kenya Health Sector-Wide Approaches (KHSWAp), and finally, the Annual Operational Planning process. These approaches are increasingly becoming a feature of the health sector necessary to enhance financing of health care in the country.

In 1994, the Government of Kenya (GOK) initiated and implemented the Kenya Health Policy Framework (KHPPF) as a blueprint for developing and managing health services. It spelt out the long-term strategic vitals and the agenda for Kenya's health sector. To operationalize the policy document, the Ministry of Health (MOH) developed the Kenya Health Policy Framework Implementation Action Plan and established the Health Sector Reform Secretariat (HSRS) in 1996 under a Ministerial Reform Committee (MRC) in 1997 to spearhead and oversee the implementation process. A rationalisation programme within the MOH was also initiated. These policy initiatives aimed at responding to i) the decline in health sector expenditure, inefficient utilisation of resources; ii) centralized decision making; iii) inequitable management information systems and outdated health laws; iv) inadequate management skills at the district level, worsening poverty levels; and v) increasing burden of disease, and rapid population growth.

The Healthcare Policy Framework of 1993 aimed at reversing the downward trends in health indicators through fundamental changes in healthcare financing systems, increasing the number and diversity of healthcare providers, particularly through the use of the public private partnerships strategies. As a means of increasing financial access, the National Hospital Insurance Fund Act was repealed and new legislation enacted in 1998. The new Act provided for the expansion of the benefit package to, among others, cover out-patient healthcare services, expand coverage to include the informal sector, and provisions for improving governance. However, NHIF service coverage was not expanded at that time, and the population continued to experience even greater constraints in affording the user-fees applicable in the public sector, while the prospects of meeting any of the health goals, including MDGs, remained remote. The situation became critical in 2002, forcing the Ministry of Health to drastically rethink the user-fees policy, abolishing these in the health centres and dispensaries, leaving only the registration fees of KSh 20 and KSh 10 respectively (10/20 Policy).

2.3.2 Kenya Vision (KV) 2030

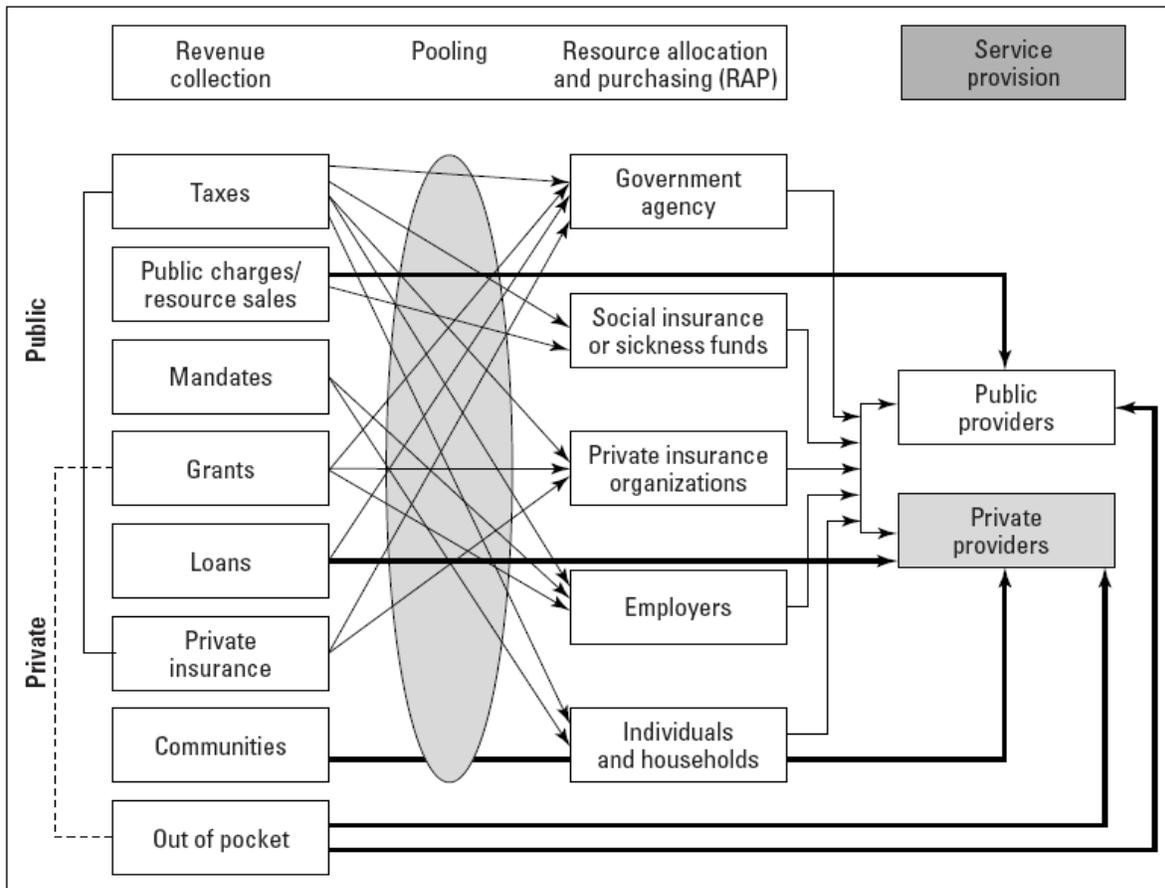
In the blue-print, the central role of health as a key pillar in driving Kenya to be a globally competitive and prosperous nation with a high quality of life equal to that of a middle income country, by 2030 is emphasized. Within the social pillar, Kenya's vision for health is to provide "equitable and affordable healthcare at the highest affordable standard" to its citizens. The stated goal for health under Vision 2030 is that Kenya *will restructure the health delivery system and also shift the emphasis to "promotive" care in order to lower the nation's disease burden*. The key areas of focus include i) access including actual availability of services and financial access - targeting affordability; ii) equity and quality; and iii) institutional capacity. The goals reiterated in the KV by the government include revitalizing the health infrastructure; strengthening health service delivery (especially through human resource strategies); development of equitable financing mechanisms with an emphasis on preventive healthcare; and finally creation of fiscal space through efficient use resources and expansion of health insurance schemes.

3.0 Health Financing in Kenya

2.1 Models for Financing Health Care

There are various models of financing health care in any economy however, these models and the various attempts to classify health financing functions in a more detailed manner provide useful information on the linkages with the rest of the health system and macro economy. The models also provide the frameworks for a better understanding of the incentives at play. Figure 2.1 provides a summary of a general model of financing by various sources in an economy.

Figure 2.1: Interactions among revenue raising, risk pooling, resource allocation, and service provision



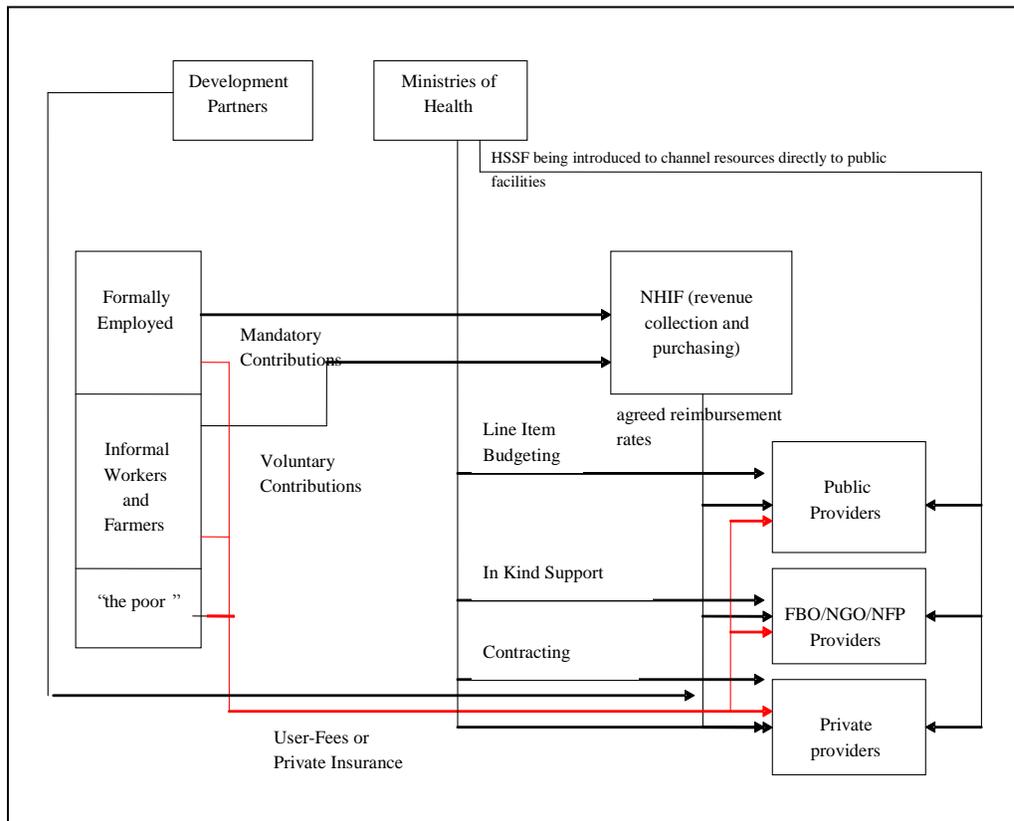
Source: Schieber *et al.* 2006

The figure shows Interactions among revenue raising, risk pooling, resource allocation, and service provision in an economy. As shown, there are various revenue sources including taxes, public charges/resource sales, mandates, grants and loans. Others include private insurance, community contributions and out of pocket. These sources of funds are pooled together through government agency, social insurance/or sickness funds, employers and individuals or households towards both public and private providers to enhance service provision.

2.2 Health Financing in Kenya

The healthcare financing system is complex and fragmented with respect to how revenues are raised, managed, its payment mechanisms and availability of healthcare services.

Figure 2.2: Healthcare Financing in Kenya



Source: MoH, 2010

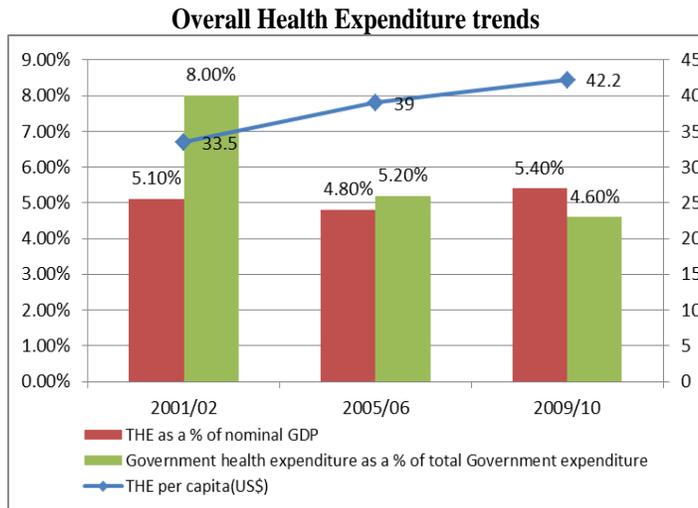
Key: --- Private funds
 --- Public funds

The GOK funds the health sector through budgetary allocations to the MOH and related government departments. However, tax revenues are unreliable sources of health finance, because of macroeconomic conditions such as poor growth, national debt, and inflation, which often affect health allocations. A manifestation of the health budget shortfalls is the widespread lack of adequate drugs and pharmaceuticals, staff shortages, and poor maintenance of equipment, transport, and facilities. Over the past two decades, the GOK has pursued a policy of cost sharing to bridge the gap between actual budgets and the level of resources needed to fund public health sector activities. The revenue from the cost-sharing programme has continued to grow in absolute terms and as a percentage of the recurrent government budget. In 2002-03, cost sharing contributed over 8 percent of the recurrent expenditure and about 21 percent of the non-wage recurrent budget of the MOH.

Over the past decade, real financing allocations to the public sector have declined or remained constant. Reviews of public expenditures and budgets in Kenya show that total health spending constitutes about 8 percent of the total government expenditure and that recurrent expenditures have been consistently higher than the development expenditures, both in absolute terms, and as a percentage of the GDP. Per capita total health spending stands at about Ksh. 500 (US\$6.2), far below the WHO’s recommended level of US\$34 per capita. The per capita expenditure falls short of the Government of Kenya’s commitment to spend 15 percent of its total budget on health, as agreed in the Abuja Declaration. The under-financing of the health sector has thus reduced its ability to ensure an adequate level of service provision to the population. Most of the budgetary allocation goes towards financing recurrent expenditure especially salaries and wages, program management including transportation leaving meager resources for drugs, and other medical supplies.

2.2.3 Health Investments

Investments made in the health system represent the only investments primarily made to improve health, and so



are the only ones analyzed in terms of their contribution to overall health goals. Overall health system expenditure has significantly increased in nominal terms, from 17 US\$ per capita, to an estimated 40US\$ by 2010 (GoK, 2010). This expenditure increase is primarily driven by Government and donor resource increases, with proportion of household expenditures reducing as a proportion of the total expenditures.

There is, however, no real increase in health system resources, with health expenditures as a proportion of GDP, and public expenditures as a proportion of general government expenditures remaining stagnant during the policy period. Additionally, health expenditures exhibit movement towards fairness in financing for health in absolute terms,

with contribution to total expenditures increasing by amount of wealth.

2.2.4 Ministry of Health Total Health Expenditures

Budgetary allocations to the MOH between 2000 and 2005 have increased steadily (Ksh. 12 billion in 2000-01 to Ksh. 23 billion in 2004-05) in absolute terms. Table 1.2 shows MOH expenditures for both the Recurrent Account (RA) and the Development Account (DA). Recurrent expenditures have increased both in absolute terms and as a proportion of total GOK spending and GDP, while development expenditures are somewhat variable, reflecting fluctuations in donor spending (GoK, 2005b). The current NHIF Act number 9 of 1998 provides for the provision of both in-patient and out-patient care. Currently the Fund has successfully offered in-patient cover by providing comprehensive cover through GoK hospitals, faith-based hospitals and low-cost private owned hospitals, whereas paying specific rebates to high cost private hospitals. The maternity benefit package has also been enhanced to cover both normal and caesarean delivery, with no additional cost.

Although the government health budget has increased in absolute terms - from KSh 15.3 billion in 2003/4 to KSh 34.4 billion in 2007/08³ (MPER, 2009) - it has declined significantly as a share of government spending from 7.66% in 2004/05 to 7.3% in 2007/08 (including on budget donor funding), and from 8.0% in 2002 to 5.2% in 2006 (focusing solely on government financing). This suggests that, as on budget donor funding has increased, domestic funding has been withdrawn. These levels remain well below the Abuja Declaration commitment figure of 15% and the Economic Recovery Strategy target of spending 12% of the budget on health. Per capita government spending remained at less than US\$ 8 - well below the average for sub-Saharan Africa, with total health expenditure, as a percentage of GDP, at just 4.8%.

Prospects for increasing public funding appear weak, although successive Budget Outlook Papers (BOPA) focused on increasing the share of resources earmarked for the core poverty areas namely education, health, agriculture, and physical infrastructure -- this has not, to date, been translated into an increase in the share of resources for health. The 2007 BOPA projected a small increase in the allocation to the health sector from 7.66% of total government expenditures in 2006/07 to 7.59% in 2008/09, and 8.53% in 2009/10. However, these figures are actually much lower than those set out in BOPA 2006 (from 9.0% in 2006/07 to 9.4% in 2008/09). Perceptions about the relative efficiency and effectiveness of existing spending, the budget execution issues mentioned above and the feeling that the sector is already well catered for by donors, is likely to have had an impact on the reluctance of the government to substantially increase health funding.

³ Of this recurrent expenditures accounted for some KSh 23.5 billion

Scope for increases from other sources is limited, with little room for government to incur additional debt to finance public borrowing. Given the current global financial crisis, it appears unlikely that significant additional external resources will be available, and there may even be some reductions in allocations by some donors. This underscores the need to improve aid effectiveness and ensure closer coordination of external and domestic funding resources. Since FY1999/2000, there have been attempts to develop a longer-term budgetary perspective through the establishment of a Medium-Term Expenditure Framework (MTEF), a rolling three-year budget. Its key aims are to link policy making to planning and budgeting; maintain aggregate fiscal discipline; improve inter- and intra-sectoral resource allocation based on cost of priority programmes and projects to increase effectiveness of public expenditure; and increase efficiency by achieving desired outcomes in a cost effective manner. However, because of the worsening poverty situation in the country, the MOH has changed its cost sharing policy and replaced it with a “10/20” policy, in which dispensaries and health centres are not to charge user fees for curative care other than Ksh.10 or 20 or client cards. In addition, the MOH is planning to introduce a National Social Health Insurance Fund (NSHIF) where everyone would contribute without exemption. For administrative purposes, it is envisaged that contributions should be per head and not per family, although current entitlements in the National Hospital Insurance Fund also include family members of the insured. For those too poor to pay, it is proposed that the government would pay for them. In its tenth year of phased implementation, the scheme would be targeted to give comprehensive health care to 80 percent of the population. The sources of funding would include payroll harmonization, general taxation, informed sector contributions, donations and grants. The scheme is outlined in Sessional Paper No. 2 of 2004 (GoK, 2004a).

Notwithstanding the allocation to the ministry by the central government, the actual spending is skewed in favour of tertiary and secondary care facilities, which absorb 70 percent of health expenditures. Yet primary care units, being the first line of contact with the population, provide the bulk of health services and are cost effective in dealing with the disease conditions prevalent in communities. Health personnel expenditures on the other hand are high, compared to expenditures on drugs, pharmaceuticals, and other medical inputs such as medical equipment and supplies an indication that budgetary allocation is skewed towards program management and as opposed to preventive and curative. Recent estimates reveal that personnel spending accounts for about 50 percent of the budget, leaving 30 percent for drugs and medical supplies, 11 percent for operations and maintenance (O&M) at the facility level and 10 percent for other recurrent expenses. Expenditures for curative care constitute more than 48 percent of the total MOH budget. The GOK works closely with development partners to raise money for the health sector. Donor contributions to the health sector have been on the increase, rising from 8 percent of the health budget in 1994-95 to 16 percent in the fiscal 2001-2002. In some years, donor contributions accounted for over 90 percent of the development budget of the MOH. In summary, the Ministry of Health Public Expenditure Review (GoK, 2004b) reported that the flow of funding to health facilities, especially at the primary care level as being poor with high incidences of leakage estimated at 22 of the user fee revenue collected.

NHIF accounts for around 10% of public health spending. Services are purchased from a total of 501 accredited hospitals totaling over 44,000 beds, of which 65% are derived from government hospitals and 35% from faith-based, private and community-based hospitals. NHIF has accumulated large surpluses due under-utilization of the contributions. This trend is attributed to i) the narrow benefit package (which has not been expanded despite the legal changes of 1998), and ii) lack of incentives for public sector providers to seek reimbursements. Although the share of contributions devoted to providing benefits has increased in recent years in 2007/08, it was only 45%, and in view of NHIF's wide network, administration costs account for a large share of revenue. Efforts to replace the NHIF with the National Social Health Insurance Fund (NSHIF) in 2006/07 were unsuccessful when the Act failed to receive presidential assent. The fund is in the process of piloting out-patient cover with the intention of rolling over to the entire membership.

2.3 Current Sources of Health Care Financing

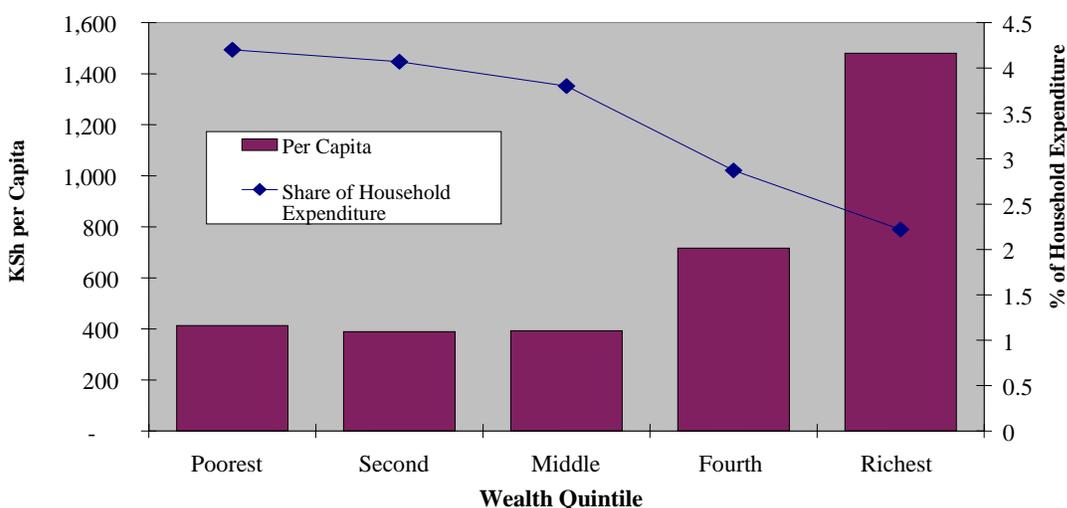
2.3.1 Out-of-Pocket Spending

In the country, out-of-pocket (OOP) spending generates the largest proportion of the revenue used to access healthcare services. This source contributed 52% and 36% of all the health expenditures in the country in 2002 and 2005, respectively. These funds are used directly at the point of accessing healthcare and are therefore subject to their actual availability at the time of illness, and the cost of the services. At least 65% of these funds are destined for use in the private sector.

The Ministry of Health is the second most important source of funding, contributing to about 30% of all health expenditures in the country (almost exclusively for use in the public sector). Resources from development partners are principally channeled to support direct expenditures in programmes and projects, particularly those of a non-curative nature. A small proportion of Kenyans have their health resources channelled into the system through the National Health Insurance Fund and private health insurance. The principal feature of the collection process is that it is fragmentary, unpredictable and except for NHIF, there is no legal or formal provision for how much may be contributed from any of these sources. Consequently the poor are not assured of accessing healthcare services when they are sick, government has not been consistent in meeting its commitments to increase allocations to the health sector, nor are most development partner funds on budget, or on-account. Heavy Reliance on Out-of-Pocket Spending as a Source of Healthcare Financing – Cost Remains a Major Barrier to Access, Often Purchasing Poor Quality Services

The majority of Kenyans do not have access to affordable healthcare due to poverty, which is currently estimated at 42 percent. According to the *Household Health Expenditure Report* of 2008, by KNBS, 44% of Kenyans who fall sick do not seek healthcare services, due to lack of finances. The report also indicates that over 40% of the poor undertake self-diagnosis when sick. Levels of self-diagnosis and/or self-treatment among the poor in Nyanza of 44%, 51% in Western and 42% in Eastern Provinces, respectively, are mainly due to lack of money. Private spending accounts for a large share of total health expenditure. Most of this takes the form of un-pooled, out-of-pocket spending, which is well recognised as an inequitable and inefficient means of funding healthcare (WHO, 2000) although the poor spend less in absolute terms than the better-off, a larger share of their household expenditure is devoted to meeting their healthcare needs. Figure 2.3 provides a summary of out-of-pocket spending by wealth quintile.

Figure 2.3: Out-of-Pocket Expenditure by Wealth Quintile in Kenya



Source: Kenya Household Health Expenditure and Utilisation Survey Report 2007

It is far from clear that such spending offers value for money since 69% of private spending on out-patient care is for drugs, with little or no evidence on whether this follows the practices of rational use of drugs. The share of private financing, especially out-of-pocket spending, has declined rapidly in both relative and absolute terms. According to the latest National Health Accounts, the share of private financing fell from 54% in 2002 to 39.3% in 2006, with much of this due to the increase in the share accounted for by donor support. Private spending declined in real terms by 9.8% from KSh 30.8 to KSh 27.8 billion over said period. Household spending dropped from 51% to 36% of total health expenditures⁴, and spending per capita (inflation adjusted) declined from KSh 770 to KSh 713.

⁴ This expenditure is in the form of direct payments, payment into an insurance scheme, or by purchase of a “health card” that gives access to services for a defined period of time

Perhaps more importantly, direct out-of-pocket spending decreased by 29% from KSh 819 to KSh 578. This huge drop in household spending mirrored a significant increase in flow of development partner funds, especially from PEPFAR, to the sector, which is however expected to suffer given the current funding schedule to developing countries including Kenya.

2.3.2 Overreliance on User-Fees Public Facilities to Fund Services

In 2007/08, reported cost sharing revenues amounted to some KSh 1.57 billion (*MoH*). Revenues have increased dramatically from around KSh 28m in 1990/91 and KSh 720m in 2000/01. District hospitals accounted for just below 60 percent of total revenues and provincial hospitals almost 30%. Collections in Central Province were more than 10 times greater than those in North Eastern Province. Although small, in absolute terms, they are significant at the operational level, accounting for 61%, 50% and 19% of the provincial, district and rural health facility operational budgets (excluding salaries), respectively. There has been a system of waivers and exemptions to cover children under five, TB treatment, malaria drugs, HIV/AIDS treatment and the poor, but this system is not well defined and is complex to administer, since there are no clear criteria to determine the patients who qualify. The important role for user-fees, as a mechanism for healthcare financing, is curtailed largely due to lack of third party payment for the cost of waivers and exemptions instituted to protect and guarantee access by the needy. As a result, the fee levels have been kept low, thereby undermining its revenue generating potential, and consequently its ability to support increased provision and availability of quality services.

2.3.3 Risk-Pooling and Purchasing

Less than 4% of all the health funds are subjected to risk-pooling by the NHIF or private health insurance. As a result, there is insufficient cross-subsidy from among the different income, as well as socio-economic, groups in the country. Similarly, the purchasing of healthcare services is predominantly personalised (fee-for-service), or input-based (as line item budgets) in the public sector. Only NHIF, private health insurance and a few demand-side financing agencies benefit from output-based purchasing. As noted before, the public sector is not, therefore, able to channel a significant proportion of health funding to the point of neither use, nor can the low income groups afford healthcare when they are sick.

3.0 Alternatives Financing Mechanisms for Health Care

In this sub-section, various financing mechanisms are reviewed. These include risk-pooling, dedicated tax funds, infrastructure bonds for construction of health facilities among others.

3.1 Risk-Pooling and Prepayment Approach

Risk pooling and prepayment approach is of fundamental importance of improving domestic health financing policy to meet the health MDGs in an equitable way. People contribute to a pool that they, or others, can draw on in the event of illness. In some years, they may receive services that cost more than their contributions, and in some years, less. According to World Health Report (WHR) of 2010, the funds are effective especially since they can cover prescription medicines, ambulatory care, hospitalization, disease prevention and health promotion. With these arrangements, the incidence of financial catastrophe and impoverishment falls to negligible levels especially among the vulnerables including the poor (Chris and William, 2010).

According to WHR (2010), the past three decades have provided lessons on the failure of direct payments such as user fees in financing health systems. As a result, many countries have embraced a system of prepayment and pooling, sharing the financial risks of ill health and to ensure that efforts to contain the growth of expenditures do not, in fact, extend the reliance on direct payments and to become more efficient and equitable in the use of resources. These have been pilot-tested in Rwanda and they seem to be successful. On average studies show that people appear willing to cover closer to one-half of the costs of healthcare for the poor. Although this seem to work in various world economies, there will be need to caution the poor who may not be able to pay the necessary premiums. The success of these mechanisms will however depend on how the public conceives the idea and the ability to minimize the embedded transaction costs.

In terms of implementation, WHR (2010) identifies three broad areas to be considered when implementing a redistributive pooling system. First, the policy makers must determine which proportion of the population is poor and may not be able to contribute through income taxes or insurance premiums.

This group will need to be subsidized from pooled funds, generally government revenues. Such assistance can take the form of direct access to government-financed services or through subsidies on their insurance premiums. Those countries whose entire populations have access to a set of services usually have relatively high levels of pooled funds estimated at between 5–6% of gross domestic product (GDP). Second, the contributions need to be compulsory, otherwise the rich and healthy will opt out leading to insufficient funding to cover the needs of the poor and sick (WHR, 2010). Longer-term plans for expanding prepayment and incorporating community and micro-insurance into the broader pool are important. De La Cruz *et al.* (2009) points out that microfinance institutions offer a unique opportunity, admittedly with challenges, to employ this global infrastructure for delivery of health-related services to those most in need. In deed an increasing number of microfinance institutions in Africa, Asia and Latin America already successfully offer health-related services, such as education, clinical care, health financing (loans, savings and health insurance) and establishing linkages to public and private health providers in facilitating access to health care.

Third, pools that protect the health needs of a small number of people are not viable in the long run since a few episodes of expensive illness will wipe them out. Multiple pools, each with their own administrations and information systems, are also inefficient and make it difficult to achieve equity. Sheila and Christopher (2010) argues that usually, one of the pools will provide high benefits to relatively wealthy people, who will not want to cross-subsidize the costs of poorer and those perceived to be less healthy. Community health schemes and insurance schemes should therefore be consolidated into national risk pools, which have higher levels of financial risk protection.

3.2 Establishing Dedicated Funds

Dedicated tax fund is another promising alternative of innovative financing in the health sector. This is because the mechanism has the capacity to generate adequate financial resources and has relatively low administration costs (Prakongsai and Patcharanarumol, 2008). In the US for instance, an additional US\$ 10 billion annually for global health is raised through this method (TIIFHS, 2009) through introduction of a tax on air tickets, foreign exchange transactions, as well as tobacco and alcohol consumption. Other sources of solidarity levies include a range of products and services, such as mobile phone calls (Musango and Aboubacar, 2010; Stenberg *et al.*, 2010) as well as sugary drinks and foods high in salt or trans fats (Leonhardt, 2010; Holt, 2010).

Some of the earliest developments in this area occurred Australia and California. An increase in tobacco taxes in states in Australia in 1983, resulted in a considerable injection of funds for health promotion which resulted in generation of US\$ 1.2 million which was directed to the ‘Tobacco Tax Trust Fund’ (Holman *et al.*, 1984) while in 1988, Californian voters approved 25 cents per package increase on cigarette tax, a quarter of which was earmarked for anti-smoking education and tobacco-related research (Bal *et al.*, 1990). The last two decade has seen a number of other states and countries establish dedicated funds for health. Although there have been some increases since 2000, there is great scope for revenue raising in this area, as advocated by the WHO Framework Convention on Tobacco Control (Prakongsai *et al.*, 2008). Analysis on the consumption, taxation and pricing of alcoholic beverages shows that, if excise taxes were raised to at least 40% of the retail price, substantial additional revenue could be generated and the harmful effects of drinking alcohol reduced. In Stenberg *et al.* (2010), it is estimated that will lead a reduction in consumption of alcohol by more than 10%, while tax revenues would more than triple to a level amounting to 38% of total health spending in especially in low income countries (LICs).

In practice, LICs have a large informal sector and quite often tend to focus on taxes that are relatively easy to collect, such as those on formal-sector employees and corporations, import or export duties of various types and value added tax (VAT). Ghana, for example, covers 70–75% of funding needs for its National Health Insurance Scheme with general tax funding, notably through a 2.5% national health insurance levy on VAT estimated at 12.5 % (Witter and Garshong, 2009). Chile on the other hand introduced a 1% increase in VAT in 2003 to finance public health. The VAT-based National Health Insurance Scheme has been able to support an increase in total health expenditure through domestically generated pooled funds. At the same time it has lessened the system’s dependence on direct payments such as user fees as a source of finance (Tsounta, 2009).

According to WHR (2010), the potential to increase solidarity taxes on specific goods and services exists in many countries.

An analysis carried out by WHO on the potential gains from increasing taxes on tobacco in 22 of the 49 LICs shows that an excise taxes in these countries range from 11% to 52% of the retail price of the most popular brand of cigarettes, representing a nominal range of US\$ 0.03–0.51 per pack of 20. If these are considered, a 50% increase in tobacco excise taxes would generate US\$ 1.42 billion in additional funds in these countries. These taxes are however not universal and therefore governments will need to implement those that best suit their economies. Additionally, there is need for political commitment for the success of these taxes (WHR, 2010). For instance, India has a significant foreign exchange market, with daily turnover of US\$ 34 billion (Bank for International Settlements, 2007) while Gabon imposed a 1.5% levy on the post-tax profits of companies that handle remittances and a 10% tax on mobile phone operators raising an equivalent of US\$ 30 million for health in 2009 (Musango and Aboubacar, 2010; Stenberg *et al.*, 2010). Similarly, the Pakistan government has been taxing the profits of pharmaceutical companies to finance part of its health spending for many years (Nishtar, 2010).

It is noteworthy that governments and ministries of finance in particular, are generally not enthusiastic about earmarking taxes for specific purposes. Busse (2007), points out that a more positive outcome may result from first earmarking products that are targeted for tax increase. This should be carefully done because earmarking some products can be politically sensitive and will invariably be resisted by particular interest groups. A tax on foreign exchange transactions, for example, may be perceived as a brake on the banking sector or as a disincentive to exporters/importers. When Gabon introduced a tax on money transfers in 2009 to raise funds to subsidize health care for low-income groups, some people protested that it constituted an exchange restriction. However a 1.5% levy on the post-tax profits of companies that handle remittances and a 10% tax on mobile phone operators in Gabon the same year were successful (Musango and Aboubacar, 2010; Stenberg *et al.*, 2010).

The second step should be seeking an increase in taxes of earmarked products. Every tax has some type of distortionary effect on an economy and will be opposed by those with vested interests. Lobbying for support from politicians, the media, health professionals, key opinion leaders and the general community is vital step in campaigning for tax increases. Advocates for dedicated taxes must be able to present a clear and firm vision, not only of the uses to which the funds are to be directed, but also of the mechanisms by which the funds will be allocated (Ritthiphakdee, 2002). The government with the necessary political support may need to consider implementing those that best suit their economy in consultation with key stakeholders. For instance, in 1983 Western Australia increased tax on tobacco resulting in a considerable injection of US\$ 1.2 million in the treasury (Holman *et al.*, 1984). In 1988, Californian voters approved 25 cents per package increase on cigarette tax. (Bal *et al.*, 1990)

The third step should be making a case for part of that increase being earmarked for specific health programmes. As pointed out by Glantz (1997), it is important to institute the necessary legal framework to legitimize the move. The legislation will also ensure that all or a reasonable proportion of the tax is dedicated to health care financing. For instance, the passing of the Tobacco Act in the Australian State of Victoria followed in 1987. This, not only led to tobacco taxes being directed to health promotion and tobacco control programmes, but also brought into being a specific organization, the Victorian Health Promotion Foundation, to administer the funding as one of institution set up to administer the dedicated tobacco taxes (Holman *et al.*, 1984). Persuading government to take this step is both a complex and challenging task, requiring much preparation and planning. In Malaysia, where relevant legislation is about to be introduced, and Thailand, which legislated in 2001, the process took around 10 years of hard work before success was achieved (Taskforce on Innovative International Financing for Health Systems, 2009).

Whether the two stages described above should occur simultaneously, or the increase in tax should be achieved prior to the case being made for funding for health promotion, is a matter for debate. In some places, like the State of Victoria, which has been successful in achieving these outcomes, negotiations took place at the same time (Holman *et al.*, 1984). In California the tax increase and quaranting of a quarter of the current tax revenue for anti-smoking education and tobacco-related research took place simultaneously (Bal *et al.*, 1990). In countries, like Thailand, two separate negotiations occurred, one to have the tax raised and the second to have part of it dedicated for health promotion initiatives, which would be administered by an organization set up specifically for that purpose (Moodie *et al.*, 2000).

3.2.3 Issuance of Infrastructure Bonds

With loans difficult access credit, bonds provide debt financing over long periods, which may cater for the long time investment expenditures such as expansion or construction of health facilities. There are two types of bonds that are commonly used namely general bond and municipal bonds. General bonds are issued and guaranteed by the central government. Traditionally, governments issue Treasury Bonds to finance public expenditure. For instance in 2009, the Kenyan government launched the first infrastructure bond (a 12-year bond) worth Kshs. 18.5 billion to finance water, sewerage and irrigation, roads and energy projects (Central Bank of Kenya, 2009). To attract investors, the government included incentives withholding tax exemption on interest income and listing at the Nairobi Stock Exchange – this would increase the bond’s liquidity.

Municipal bonds on the other hand, offers a way of helping local governments, particularly urban governments to finance critically infrastructure with domestic private capital, rather than sovereign borrowing by national governments (The Bond Market Association, 2008). These bonds are usually exempted from taxes. There are two types of municipal bonds depending on the source of debt service namely revenue bond and general obligation bonds. Revenue bonds are a type of municipal bonds, whose debt service is normally payable from identified sources of revenue generated from the financed project. On the other hand, general obligation bonds are a type of municipal bonds, whose debt service is payable from general revenues of the issuer of such municipal bonds. Although health care projects in developing countries have not tapped into the bond market, the sale of bonds in international bonds market has mostly been available to large projects by donor countries where issuance of these bonds has raised more than US\$ 2 billion since 2006 [International Financing Facility for Immunization (IFFIm), 2010]. These funds are channeled to the International Financing Facility for Vaccines, linked to the GAVI Alliance.

In order to implement this mechanism, it is important that a legal framework is put in place to ensure the success of infrastructure bond issues. For instance, in 2001, the Polish legislature made amendments made to the Polish Law on Bonds. The amendments opened a new window to a new class of investors, such as pension funds, to finance infrastructure for the first time in Poland (Hyun, *et al.*, 2008). Another factor that determines the success of a bond is the presence of a financial institution that is willing to issue a letter of credit to the issuer of the bond. This is a commitment by the bank to forward funds to the trustee representing the bondholders in the event the issuer is unable to service the debt. The corporation generally utilizes its credit rating to obtain the tax-exempt financing since it protects it from default. In the United States, the amendment of the Housing and Economic Recovery Act in 2008 supports Federal Home Loan Banks (FHLBanks) to issue highly rated Letters of Credit in support of tax- exempt bonds, those used to finance construction of health care facilities. This new funding mechanisms drove the costs of bonds down, giving the hospitals a new opportunities to raise the much needed funds for renovation, expansions and purchase of modern equipments (Craig, 2010).

Presence of an anchor investor whose role is to help build confidence in the new market is another factor that determined the success of an infrastructure bond in Poland, when the Miejskie Wodociągi i Kanalizacja w Bydgoszczy Sp. Z.o.o. (MWiK), a water company owned by and servicing Poland’s eighth-largest city Bydgoszcz, issued the first revenue bond of EUR 100 million, 40% of the issue was purchased by European Bank for Reconstruction and Development (EBRD) and 60% by the local pension funds and other institutional investors. EBRD played the role of an anchor investor (Hyun, *et al.*, 2008). The city of Johannesburg (South Africa) has since 2004, successfully launched four municipal bonds with the first bond receiving an overwhelming, positive response. The R1-billion (US\$153mn equivalent), launched in 2004, won the coveted Bond of the Year Award from Besa in that year. In the same year, another bond with a maturity of 12 years, worth R1-billion was issued. It was the first structured and longest maturity municipal bond in South Africa. It was partially guaranteed by partial credit guarantee for 40% of principal shared equally by IFC and the Development Bank of Southern Africa (DBSA). The bond achieved a national scale rating of double-A minus, three notches above the City’s stand-alone rating. This is an important factor in issuing bonds as improved credit ratings help in reducing debt-servicing costs as a percentage of overall expenditure. Johannesburg uses most of the funds raised by the bond issues to finance its capital expenditure backlog.

Bond debt can present a number of problems including the inability to settle resulting payment obligations. An example of this is the Denver-area (US) toll project.

The project had performed below expectations following its launch in 2003. This was attributed to the slow ramp-up period to the economic downturn that hit Colorado in 2001 and lasted nearly four years (The Bond Buyer, 2007). Another problem posed by the bond debt is the complex portfolio of collateralized debt obligations. For instance, in 2006, investors lost \$91.5 million when the bond value collapsed. The bond had been issued by the Cayman Islands-registered Credit Sails Ltd and arranged by the French investment bank Credit Agricole through a subsidiary company- Calyon. The funds raised from the investors were then used as collateral to raise further funds from banks loans (Fernandes, 2010).

4.0 Conclusion

From the analyses various inferences can be made. First, Kenya still has a high and rising burden of disease (double epidemic of communicable and non-communicable diseases) while the healthcare reforms to date have been fragmentary and feeble. Similarly, less funds have over the years been allocated and timely disbursed towards the financing of health care. Various policy documents including Health Policy Framework, Vision 2030 and MTP 2008-12, prioritise healthcare financing as a target for fundamental reforms, given the past trend, chances are that this may not be realized. Political commitment to reforming the healthcare financing system could yield immediate results such as access to health care, improved health infrastructure, provider incentives and affordability of health care by the poor. In this regard, it is recommended that i) desired healthcare financing reform should also address the qualitative issues in the system including exploring alternative financing mechanisms; ii) universal coverage (social health protection) to quality healthcare services should be the overall goal of the financing reforms.

Healthcare financing reforms on their own cannot solve all the problems of the healthcare systems, but need to be supplemented by reforms in other related areas necessary in enhancing provision of affordable quality health care. Other supportive reforms that are necessary and particularly urgent include strengthening health infrastructure and human resources; increased autonomy for public health facilities, to allow them to manage their resources in the best possible way and hold them accountable for doing so; and creating a healthcare system that is responsive to the needs of the population. The priority focus for the healthcare financing system should be the vulnerable including the poor, the underserved and hard-to-reach of the population. These should include actions and system changes, with the greatest impact on disease prevention/reducing the burden of disease.

Experience elsewhere suggests that successful healthcare financing models must i) have in-built mechanisms for protecting the poor and improve efficiency of revenue collection, resource allocation, and service delivery; ii) utilise the benefits of risk-pooling and in-built systems to allow for change; iii) built on a high degree of transparency, good governance, and effective institutional arrangements, including greater autonomy to public sector providers; iv) provide adequate incentives for making service providers responsive to quality and efficiency; and v) invest resources for generating adequate data and evidence for decision-making. Within the context of Kenya, the system must accommodate and integrate resources from various sources, including those from bi-lateral and multi-lateral partners through joint financing agreement (JFA) and SWAp arrangements.

In addition, the government in collaboration with key stakeholders needs to develop solutions, which reflect its own unique situation and needs. At the same time, it will be important to draw, as appropriate, from international experience with healthcare financing reform including shifting from out-of-pocket payments to tax financing and or social health insurance as well as community based health insurance (CBHI); consider reducing user-fees on essential services and where possible eliminated. Further, all links in the financing chain need to be reviewed including: collection, pooling, purchasing and provision. Taken together, they need to align with national objectives. Finally, capacity building need to be prioritized to minimize overreliance on foreign expert with the associated high transaction costs.

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