Systematic Review of Kenya's Programmatic Progress towards Universal Coverage and Its Effect on Health Equity

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Abstract

Over the years, the Government of Kenya with support from sectoral partners has continued to initiate and implement various policy reforms earmarked towards enhancing health equity. The purpose of this paper was to critically review the various initiatives that the government of Kenya has over the years initiated towards enhancement of universal coverage in terms of policy reforms including health care financing. For purposes of the analysis, data was largely collected through in-depth review of government policy documents including draft health care financing strategy, health policy framework, Ministry of Health strategic plans, Vision 2030, commissioned studies by the Ministry, among others. Notable findings include existence of multiple sources of revenue with government revenue showing an upward trend over the years in absolute terms though still lagging behind the Abuja Declaration of 2001, and existence of high levels of out-of-pocket spending which has continued to contribute towards catastrophic health expenditures. Other findings include existence of significant contribution by the development partners which is however, off-budget and skewed in favor of some regions notwithstanding its sustainability given the global trends. Similarly, though there exist a number of organizational entities that provide risk pooling options, the nature of resource pooling has limited cross-subsidization. Various recommendations have been suggested including sufficient funding for the health system through risk pooling mechanisms, earmarking some taxes for health care; improved revenue collection approaches, continued political commitment by government and development partners while enhancing efficiency in the management of health funds.

Keywords: Health Reforms, Universal health coverage, catastrophic health expenditure, Equity

1.0 Introduction

1.1 Background

Universal Health Coverage (UHC) has continued to dominate global agenda for health and carries with it the goal of ensuring that all people obtain the health services they need without suffering financial hardship when paying for them. According to World Health Organizaion (WHO), four key elements namely a strong, efficient, well-run health system; a system for financing health services; access to essential medicines and technologies; and a sufficient capacity of well-trained, motivated health workers are necessary. The Kenya government has over the years taken steps aimed at laying a firm foundation towards universal coverage. Some of these steps include the development of Kenya Health Policy Framework (KHPF 1994 - 2010), launching of the Vision 2030 and the enactment of the Constitution 2010, fast tracking of the actions necessary to the achievement of the Millennium Development Goals (MDGs) by 2015, and finally the President's declaration of free maternal care starting June 2013.

Within the broader government framework enshrined in the Vision 2030, the central role of health as a key pillar driving Kenya to becoming a globally competitive and prosperous nation within a high quality of life equal to that of middle-income country by 2030 cannot be underestimated. In addition, the Constitution provides an overarching conducive legal framework for ensuring a more comprehensive and people driven health services delivery. The Constitution introduces a devolved system of government meant to enhance access to services including health care by all Kenyans, especially those in the rural and hard to reach areas.

1.2 Health Situational

Kenya's health indicators though showing a mixed trend since independence in 1963, they continue to lag behind those of the rest of world including sub-Saharan Africa (SSA). Life expectancy rose from about 43.4 years (1960) to 62 years (1990), before declining and stabilizing at about 52 years (2006). Infant mortality, on the other hand 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 under-five-year mortality rates over the same period 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 though estimated at a low of 45.2 years in the 1990s, it rose up to 60 years by 2009 (World Health Statistics, 2009). This trend was reflected across all age groups, with stagnation/worsening of the health situation seen across all age. In terms of diseases, malaria is considered to account for almost half of morbidity in the country and currently ranked the third cause of death.

Table 1.1 Leading Causes of Deaths and Disabilities in Kenya

Causes of deaths				***Causes of DALY's***		
Rank	**Disease/ injury**	***% total deaths***		**Rank**	**Disease or injury**	***% total DALYs***
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

Source: GoK, 2010; Draft Health Policy, 2012, Okech, 2012

1.3 The Health Services Delivery

The availability and comprehensiveness of health services offered at a health facility as part of UHC depends, in large part, on the number of health workers at that facility. Available statistics reveals that, there are overall staff shortages with 47,247 personnel, against an estimated minimum requirement of about 72,234. Since 2005, concerted efforts have been made to increase the number of skilled health workers available at the lower levels of the health system with the intention of enhancing access to primary health care (PHC). These efforts have however, not produced the desired impact in terms of realizing desired health outcome as well as moving towards the realization of MDGs to which Kenya government is a signatory. The situation is likely to worsen based on the recent media reports of exodus of doctors from counties to private hospitals and private practice.

Like in many low income countries (LICs), health personnel in public health facilities in the country are heavily skewed in favor of urban centres. Part of the overall problem may be attributed to difficulties in recruitment and retention of the workers. This is attributed primarily to lack of incentives for locating in hard-to-reach places, general motivation and incentives, working conditions (including infrastructure and equipment) and human resources management. Studies reveal that many public hospitals are dilapidated and do not have access to appropriate equipment. Similarly, cases of significant gaps in essential specialized care capacity exists forcing individuals to seek these services abroad when required.

To circumvent resource flow bottlenecks and to devolve financing in the country, parliament introduced the Constituency Development Fund (CDF) in 2005, through which earmarked government funds are allocated to constituencies on the basis of a formula that is heavily weighted on poverty levels. The use of CDF resources has also added to the infrastructure in an ad hoc way, with facilities developed with little reference to outstanding needs, or the ability to meet on-going recurrent requirements, which must however, be met from MoH resources.

Efforts have further been made by devolving health services to county governments as enshrined in the Constitution albeit lack of health policy considered key in managing the devolution process.

1.4 Critical Analysis of Health Care Policy Initiative in Kenya

The pursuit of health equity has been one of the major tenets of the Kenyan government with support from sectoral stakeholders. This is evident in the development and implementation of national health policies and strategies necessary for enhancing access to quality health care by ensuring that there is a robust and well-functioning health system. The efforts in terms of reforms are contained in the various policy documents including Health Policy Framework, National Health Sector Strategic Plans, Vision 2030 and the constitution, and the recent declaration by the government on free maternal health care services in public health facilities. A brief overview of the reforms is discussed.

1.4.1 Post-independent Era

Since attaining independence, the government of Kenya in recognition of good health as a prerequisite to socioeconomic development prioritized the improvement of the health status of citizens. A number of government policy documents and successive national development plans prioritized the provision of health services to meet the basic needs of the population and placed health services within easy reach of Kenyans. As a result of these policies, both infant mortality and life expectancy at birth, improved significantly (Ngigi and Macharia, 2006). As observed by Nyarang'o (2010), the approval by parliament of Sessional Paper No. 10 in 1965, eighteen months after attainment of independence, was the defining moment in economic political and social development in Kenya. Dubbed "African Socialism and its Application to Economic Development," the Paper paved way for subsequent policy frameworks that have continued to shape the government's agenda for the health of its populace.

Key concern in the policy paper was the structural inequity in the country that favored the white minority compared to the blacks who were the majority. First, the government reiterated its commitment towards the progressive elimination of fees in public health facilities. Overtime, the health sector in Kenya has operated in the context of a number of policy frameworks and within a policy environment that was subject to both internal and external influences. The policies included domestication of the 1977 World Health Assembly declaration dubbed "Health for all by the year 2000'' which resulted in decentralization of facilities and community participation in 1986. In 1980's the policy shift from purely government provision of services to costs sharing was followed by the 1993 institutional and structural reforms and market orientation of the health services following the publication of the World Development Reports dubbed ''Investing in Health'' and later the Poverty Reduction Strategy of 1999 which aimed at reducing poverty in Kenya with improved healthcare as one of the strategies.

In 1994, the government developed the Health Policy Framework of 1994 and two successive 5-year National Health Sector Strategic Plans of 1999-2004 and 2005-10 that set the targets and processes driving the health sector development, as well as healthcare service delivery. In the Health Policy Framework of 1994, the aim was to introduce reforms, in relation to the way the healthcare services are organized, financed, delivered and evaluated. Key to the realization of these goals was equitable allocation of government resources to reduce disparities in health status; increased cost-effectiveness and efficiency of resource allocation and use. Others were enhanced regulatory role of the government in health care provision; creation of an enabling environment for increased private sector as well as community involvement in service provision and financing; and increase and diversify per capita financial flows to the health sector.

In the NHSSP II, important approaches and innovations such as the 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 were emphasized. To operationalize the Health Policy Framework, the ministry developed the Kenya Health Policy Framework Implementation Action Plan, while at the same time established the Health Sector Reform Secretariat (HSRS) in 1996 under a Ministerial Reform Committee (MRC) to spearhead and oversee the implementation process.

Similarly, a rationalization programme within the MOH was also initiated aimed at responding to among others, the financing of the public health sector as a bold step towards enhancing access to quality health care amongst the poor and other vulnerables.

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 about the user-fees policy. In the process, user fees were abolished in the health centres and dispensaries and introduced the10/20 Policy where health centres and dispensaries charged KSh 20 and KSh 10, respectively for registration.

1.4.2 The Vision 2030, MTEF and Health Financing Strategy

Further commitments by the Kenyan government in pursuing reforms earmarked towards UHC are contained in the Kenya Vision 2030 and operationalized in the Medium Term Expenditure Framework (MTEF) of 2010. In the policy documents, the central role of health as a key pillar in driving Kenya to becoming a globally competitive and prosperous nation with a high quality of life equal to that of a middle-income country, by 2030 was emphasized. The government further affirmed its commitment of providing "equitable and affordable healthcare at the highest affordable standard" to its citizens in the MTEF. These were to be realized mainly through the provision of robust health infrastructure; strengthening health service delivery (especially through human resource development strategies); development of risk pooling financing mechanisms, while at the same time ensure AID effectiveness and harnessing the informal sector financing potential through voluntary contributions to the NHIF as well as enhancing revenue collection and broadening the benefit package.

Finally, in the draft Health Financing Strategy of 2010, the government further outlined the pillars for health care services in the country. These included social health protection to all Kenyans by introducing social solidarity mechanisms founded on complementary principles of social health insurance and tax financing to mitigate against catastrophic health expenditures, while at the same time eliminate barriers to access (geographical, financial or cultural). In order to achieve the objective, the government reiterated its intention of taking the necessary measures to amend the NHIF Act of 1998, in particular to provide for coverage of the poor, accelerating coverage of the formal sector, and ensuring viability of NHIF and improving governance and efficiency. To date, this is yet to be realized primarily due to lack of political will. These changes were viewed necessary to enhance health financing functions namely revenue collection, pooling of funds and purchasing of health services.

1.4.3 The New Constitution

The Constitution of Kenya provides an overarching conducive legal framework for ensuring a more comprehensive and people driven health services delivery. It also seeks to ensure that a right based approach to health is adopted and applied in the delivery of health services. The Constitution provides that every person has the right to the highest attainable standard of health. It further outlines that a person shall not be denied emergency medical treatment and that the State shall provide appropriate social security to persons who are unable to support themselves and their dependents. The Constitution introduces a devolved system of government meant to enhance access to services including health care by all Kenyans especially those in the rural and hard to reach areas. The Constitution further singles out health care for specific groups such as children and persons living with disabilities as key areas of focus in health services delivery. The underlying determinants of the right to health such as adequate housing, food, clean safe water, social security and education, are also guaranteed in the Constitution. At the moment, health services have been developed, however media reports show exodus of health workers especially doctors from public health facilities, disjointed purchase of drugs and medical supplies, lack of policy guidelines as well as lack of leadership at county level to manage health care. The situation seems to worsen given lack of health policy that was envisaged in the constitution to guide the devolution of health functions from the national to county government.

1.4.4 Recent Reforms

In June, 2013, the Government abolished user fees at primary health care facilities and introduced free maternal health care services in public health facilities with the aim of improving access to essential health services by the poor and vulnerable. The thrust of the free maternal and abolition of user fee policy was to improve uptake, quality and financial and geographic access to essential health services including maternal health.

The government channels the reimbursement to participating health facilities through existing disbursement mechanisms – Health Sector Services Fund (HSSF) for primary health care facilities and Hospital Management Sector Fund (HMSF) for public hospitals. A study by Ministry of Health in 2012 noted existence of operational and systemic weaknesses associated with the HSSF and HSMF. These include delays in disbursements of funds and lack of and use of monitoring, accounting and management tools provides a valuable lesson to the successful implementation of the two policies. Delays in the disbursement of funds to counter the abolition of user fees and free maternal health policies continue to render the two policies irrelevant and may even lead to scaling down of services provided as facilities attempt to rationalize health services given the limitations in funding.

The Constitution of Kenya (2010) has also assigned the larger portion of delivery of health services to counties, with the exception of National Referral Services. This implies that salaries of health workers, allocation of funds and the management of hospitals, health centres and dispensaries are under the county governments. In this regard, counties are expected to bear overall responsibilities for planning, financing, coordinating delivery and monitoring of health services toward the fulfillment of right to '*the highest attainable standard of health'* as prescribed in the constitution.

1.5 Methodology

A mix of both qualitative and quantitative methodological techniques were used to review and analyze data and information on health care reforms relating to universal health coverage by focusing on revenue collection and risk pooling. Specifically, data was largely collected through in-depth review of relevant literature on key issues in the field of health financing. The information was obtained largely from key Ministry of Health documents such as the draft Kenya National Health Sector Strategic Plans, draft Health Policy Framework for 2012 - 2030, draft Health Care Financing Strategy, the Vision 2030, the Constitution, among others. Additional data was collected from both published and unpublished Ministry of Health commissioned studies.

2.0 Health Care Financing and Universal Coverage

2.1 Introduction

Equity in health care requires sustainable financing of health care and efficiency in the utilization of the funds collected. This will not only ensure provision of quality care but also financial protection of the poor and cross-subsidization. Although health financing systems have three inter-related functions to the achievement of health equity and finally, universal coverage, the focus of this report is on revenue collection and pooling.

2.2 Revenue Collection

Health resources in Kenya come from two broad sources namely public sources and private sources. Public sources include: government through general taxes (general taxes include personal income tax, company tax, VAT and Fuel tax and Import and exercise duty), loans from bilateral and multilateral agencies, external grants (includes charitable donations by foreign governments or organizations); and social insurance (mandatory insurance payments by employers and employees). Private sources include: households (direct out-of-pocket payments by consumers of health care to health providers), employers (firms paying for or directly providing health services for their employees), private prepaid health insurance plans (households make voluntary payments to private health insurance companies in return for coverage of pre-specified health service costs); donations (charitable contributions made in cash or kind) and voluntary organizations or non-governmental organizations (Chuma et al., 2012).

Revenue from tax has increased over time, from Kshs. 323,574 million in 2006/07 to Kshs. 826,186 million in 2012/13. There has also been a steady increase in tax revenue as a percent of Gross Domestic Product (GDP) from 15.9 percent in 2002 to 22.8 percent in 2012. Despite the increase, the country still depends heavily on donor funding which has however, continued to deepen with 35 percent of health resources coming from the partners in 2009/10, compared to 16 percent reported in 2001/02. The estimates for Appropriation in Account (AIA) in terms of both grants and loans for 2011/2012 amounted to Kshs 16.8 billion or 33.4 percent of the total health budget most of which was towards the Development (MoH, 2012). Notwithstanding this, not all development partners' resources for health in Kenya pass through the government budgetary system. For instance in 2011/2012, 75 percent of the total health sector resources were in the form of off-budget which has various equity related issues.

In terms of user fee revenues, the revenues increased from around Kshs. 28 millions in 1990/91 and Kshs. 720 millions in 2000/01 to Kshs. 3.5 billion in 2011/12 (MoH, 2010). The increase was attributed to the health care financing reforms by the Ministry including the introduction HSSF and HMSF. Reports show that district hospitals accounts for about 60 percent of total user fees revenues, while provincial hospitals account for almost 30 percent of the total revenues. Despite accounting for less than 10 percent of the total recurrent budget excluding salaries, user fee revenues play a critical role in meeting the operation and maintenance expenses in the public health facilities. For instance, the money generated is used to pay for temporary staff, travel allowances of staff, outreach services, operation and maintenance of the health facilities, among others (MoH, 2012). Most if not all the user fees revenue is from out-of-pocket spending which implies that a significant portion of health resources is not subjected to risk pooling. Lack of pooling of health resources makes it difficult in ensuring effective purchase of health services, that is, directing health funds to the most cost effective health interventions or services and to those in great need as well as channeling resources in a manner that creates incentive for health providers to improve performance.

Regarding health spending, reports show that in 2009/10, approximately Kshs 122.9 billion ($1,620 million) was spent on health, representing a 20 percent increase compared to what was reported in 2005/06. The estimated total health expenditure (THE) in 2009/10 was 5.4 percent of GDP, compared to 5.1 percent in 2001/02. Per capita health spending was estimated at Kshs 3,203 ($42.2) in 2009/10 representing about 8 percent increase from what was reported in 2005/06 - Kshs. 2,861 ($39). The overall allocations (recurrent and development) for the Ministry of Health has however, continued to fluctuate from a base of about 7 percent in 2001/02 to 8.6 percent in 2002/03 and to about 6.4 percent in 2013/14. This is however way below the Abuja declaration of 15 percent to which the Kenya government is signatory.

The under-financing of the health sector means that a significant proportion of health financing is from the private sector and mostly households. This is supported by various studies which show that households' out of pocket spending account for 29.5 per cent of the total health spending, down from 35.9 percent and 51.1 percent in 2005/06 and 2001/02, respectively. If not checked, this situation will continue to impact negatively on the poor and other vulnerable on their ability to access quality health care which in the process will continue to contribute towards catastrophic health expenditures and access among the poor. According to the latest report by Kenya National Bureau of Statistics (KNBS), on average, only 6.4 percent of people in Kenya can reach a health facility within one kilometre of their residence with almost 48 percent of the population travelling a minimum of 5km to reach the nearest health facility, with marked regional variations (KNBS, 2013).

Overall health system expenditure has significantly increased in nominal terms, from 17 US$ per capita, to an estimated 40US$ by 2010 (GoK, 2010). The 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 (GoK, 2010). In spite of the budgetary allocation to the ministry, studies reveal existence of inefficiencies in terms of actual allocation, expenditures on health personnel and leakage of revenue. For instance in the PETS study of 2012, actual spending was noted to be skewed in favor of tertiary and secondary care facilities, which absorbed 70 percent of health expenditures despite the physical access concerns by the poor (MOH, 2012). The issue of physical access also means that a certain segment of the population is not able to access the KEPH even if it is available in health facilities mainly because of the long distance to the nearest health facility. Health personnel expenditures, on the other hand accounts for about 50 percent of the budget, leaving 30 percent for drugs and medical supplies, 11 percent for operations and maintenance at the facility level and 10 percent for other recurrent expenses. The flow of funding to health facilities, especially at the primary care level exhibits high incidences of leakage estimated at 22 of the user fee revenue collected.

NHIF resources on the other hand accounts for about 10% of public health spending with services purchased from a few facilities with government hospitals constituting 65%, while the remaining 35% constitute faith-based, private and community-based hospitals (GoK, 2010). There have been concerns on the accreditation process of these facilities with reports indicating incidences of political interference and court cases regarding a few of the facilities. NHIF has also been reported to have continued to accumulate huge surpluses due to under-utilization of the contributions attributed to many factors.

These include: the narrow benefit package (which has not been expanded despite the legal changes of 1998); lack of incentives for public sector providers to seek reimbursements; and finally bureaucracy and sloppy management of the funds. Although the share of contributions devoted to providing benefits has increased in recent years, administration costs continue to account for a large share of revenue. Similarly, incidences of poor performance have continued to rock NHIF riddled with political intrudes in management of NHIF and patronage in hiring of staff which in the process continue to exert pressure on administrative expenses (Okech, 2014).

The public under-financing of the health sector has therefore impacted negatively on service delivery with frequent stock outs of essential medicine and staff shortages, and poor maintenance of equipment, transport, and medical facilities (MoH, 2012). The introduction of the free services at the lower level facilities and free maternal health services was designed to improve access to essential health services by the poor and vulnerable, however, given the nature of its introduction, the objective may not be realized notwithstanding the fact that NHIF and private health insurance schemes only cover a small proportion of the population estimated at less than 25 percent. This is an indication that even though the government with support from its sectoral partners has made initiatives to realize the universal coverage, the country is far from realizing the objective of UHC.

2.3 Risk-Pooling Mechanisms

Risk pooling refers to the spreading of financial risk across a population or a subgroup of the population through the accumulation of prepaid health care revenue (Chuma *et al*. 2012). It facilitates the pooling of financial risk across the population (or a subgroup), allowing the contributions of healthy individuals to be used to cover the costs of those who need health care. A number of organizational entities exist in Kenya that can provide risk pooling options. These include tax-based financing, health insurance including public, private health insurance and community health insurance, among others. Public resources for health in Kenya can be considered to have a degree of cross –subsidization. As earlier noted, with the coming in of the current Government which assumed power in March, 2013, health services in Kenya were made free at the lower level facilities (health centres and dispensaries), while maternal health services were also made free in all public health facilities.

Whereas the removal of user fees and providing free maternal health care is a good idea for equity purposes, the poor quality of services experienced in public health facilities (in terms of sharing of beds, long queues, lack of drugs, among others) imply a system where poor will seek treatment in public health facilities, while the rich will seek the same in private health facilities. Public pooling of funds has been dodged with cases of delays in the disbursement of HSSF and HMSF funds as well as leakages of the disbursed funds. For instance, the PETS Plus survey of 2012 reported delays of between two to three months, while not all the disbursed funds were received. The report as noted in Okech (2014), indicated that the government's current contributions to run public health facilities through HSSF or HMSF are not adequate in meeting all the needs of facilities especially on areas like drugs, non-pharmaceuticals and laboratory supplies, patient food and rations among others. In addition, there are delays in the disbursement of the funds with cases of leakage of the funds also reported. Media reports show that facilities have resorted to continue charging user fees, while others reported scaling-down services to patients. The implication is continued out-of-pocket spending by households on drug supplies, medical and laboratory supplies, food and ration further contributing towards catastrophic health expenditure by the poor who in most cases seek care and treatment in public health facilities. This is supported in recent studies where it has been estimated that about 1.48 million Kenyans are pushed below the national poverty line due to OOP (Chuma and Maina, 2012).

In terms of NHIF, the Act requires compulsory membership for all salaried employees with premium contributions automatically deducted through payroll with contributions calculated on a graduated scale based on income, with a majority contributing between Kshs. 30 to Kshs. 320 per month. For the self-employed and others in the informal sector, membership is voluntary and is available for a fixed rate of Kshs. 160 per month. The contributions rates do not however, reflect ability to pay especially for the informal sector since the sector comprise of both rich and poor households with both groups expected to contribute a fix rate of Kshs. 160. Overall, the contributions have remained low for a long time and the recent attempt by NHIF to introduce higher rates were meant with opposition leading to a court case still pending at the High Court of Kenya.

Kenya at the moment has a vibrant private voluntary health insurance, and in all cases, flat contributions are charged based on a pre-determined benefit package rather than income levels, except in a small number of closed schemes that are only open to employees of a specific company. Contributions to private health insurance are however not regulated and different companies charge different rates based on their risk assessment. These rates are unlikely to be progressive. For individual membership, private health insurance firms often cream skim and in most cases fail to cover people with chronic conditions or when they do, the premiums are unaffordable (Okech, 2014). In the end, poor households are more likely to opt for more basic and, hence, cheaper packages. As part of risk pooling, Community Based Health Schemes (CBHIs) have been in operation mainly in rural and informal population in Kenya. Their operations have however, been limited in nature and differ significantly from one scheme to another. CBHI schemes charge a single flat contribution, either per person or per household. This way, they are considered regressive with poor households subsiding the rich households. Similarly, there is no policy governing the operations of CBHIs in Kenya in terms of operation, quality and benefit package (IFC/Dolloitte, 2012; Okech, 2014).

3.0 Conclusion and Way Forward

3.1 Conclusion

The availability of adequate government – tax funding – is critical if problems associated with equity in access to health care in Kenya are to be addressed. For example, tax funded health budgets are critical in promoting an equitable geographical allocation of resources. In particular, general tax revenue and most cases combined with donor funding (on-budget) is the only funding source that can be actively be redistributed between geographic regions in order to promote equity in access to health care services. Increased tax funding coupled with significant reduction in out of pocket payments can significantly reduce financial access barriers and hence minimize incidences of catastrophic health expenditures. This is supported in various studies wherein it has been documented that in a number of African countries where there is increased government resources devoted to the health sector, the burden of out-of-pocket payments is kept at minimal levels.

Government spending on health as a percentage of total government expenditure is way below the Abuja target of 15 percent and has been declining over time to a low of 6.4 percent in 2013, while public health spending as a percentage of GDP has also stagnated at below 2% in the last 10 years. With this trend, the country is unlikely to make significant progress towards achieving universal health coverage. Similarly, although public health services have been made free at the primary health facilities level and also free maternal health services, the poor quality of services, lack of essential medicines in health centres and dispensaries continues to drive more households into poverty trap. In many of the facilities, removal of user fees has led to scaling down of services provided and in some cases, some services completely discontinued. This was occasioned by the delays, of up to eight months, in disbursing compensations to health facilities for loss of revenue. OOP spending is one of the most regressive funding mechanisms, because contributions are not made based on ability to pay, and those who cannot afford are excluded from accessing services. In addition, funds from OOP spending are not pooled and hence limited cross subsidization. On the other hand, most of the donor funds are off-budget through programmes which most cases are not aligned to meet the government health priorities.

This notwithstanding, health insurance is still relatively under developed in country with less than 25 percent of the population covered. The private voluntary insurance schemes for formal sector workers currently operate closed schemes with a number of exclusions in terms of benefit package. Most of these schemes have very limited coverage levels, exhibit fragmented risk pools coupled with rapid and uncontrolled operating and administrative costs. On the other hand, NHIF has continued to face several challenges including capacity and governance in efficiently and transparently in the management of the funds collected from contributors. These challenges have prevented the fund from pooling resources necessary to finance health care in Kenya while at the same time ensure financial protection.

3.2 Way Forward

In most world economies, no country has attained universal health coverage by relying mainly on either government funding or voluntary contributions. While public funding can come from general government revenues or compulsory health insurance contributions (payroll taxes), general government revenues are essential for universal health coverage in the country.

This requires an increase in government allocation through budgetary process as well as earmarking some tax revenues (such as air time, mobile money transfers, international remittances etc), towards health care. UHC goals of equitable access with financial protection require pooling of resources that redistribute prepaid resources to individuals with the greatest health service needs, while ensuring minimal fragmentation. To sustain progress on UHC, issues of efficiency and accountability in the use of health resources must be prioritized. This will ensure that the resources are put to proper use and that there are no delays in disbursement of the funds supported with minimal leakages of resources in the system. Enhancing risk pooling will also be critical by for instance, strengthening initiatives like sector wide approaches (SWAp) where all health resources are put into one 'basket' to boost sectoral planning and budgeting. This will in the process reduce incidences off-budget spending and acquisition of economies of scale which in the process will boost health equity.

Although health insurance schemes improve health service utilization and financial protection, implementation of these schemes require careful consideration because a scheme can benefit its members at the expense of the rest of the population. There will be need to identify the indigents in the society who may not be able to afford the premiums and where possible funds set aside to cater for their contributions. This will require enhancing the capacity and governance at the various institutions involved in the process. Mechanisms need to be put in place to enhance revenue collection as well as efficiency in the use of the generated revenue. Political commitment is important for sustained increase in the financing of health sector in line with the Abuja declaration of 2001. As noted elsewhere, however, increased funding will require efficiency and accountability mechanisms in the use of the funds.

Similarly, policies need to supported by necessary technical empirical evidence otherwise the initiatives may compromise equity intentions. For instance, the country's political leadership announced user fee removal policies for the public health sector out of the blue, without providing sufficient time to technicians to design, prepare and implement the reform which based on the media reports has compromised equity in terms of quality, waiting time, stock-outs, among others. As noted by Massen *et al* (2011), public health includes three major fields: policy, practice and research. In Kenya, each of them is organized as an ecological niche and thus characterized by specific ideologies, norms, jargon, internal orientations, communication channels, internal codes of behavior, self-directed learning processes, autonomy and the desire to protect their way of functioning against the outside world. The disconnection between scientists (in charge of producing evidence), top officials (who have the required knowledge for policy making) and practitioners (who have the operational experience) largely explains the research-to-policy and the policy-to-implementation gaps: each party ignores or even despises the knowledge held by the other

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