

## Kenya National Health Financing

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

#### UHC Delivery for Kenya – Issue Paper

September 2018

This Issue Paper proposes a set of actions for the Kenyan health sector and stakeholders involved in the UHC process. It is intended to stimulate action by demonstrating that the process towards achieving UHC in Kenya is not only possible but essential and requires commitments by:- i) the government in expanding domestic resources; ii) effective development partners assistance; iii) equitable and quality health services; iv) increased financial protection.

#### Background

Investment in Kenya's health system is key to inclusive and sustainable growth. Kenya's economy has shown a steady growth of 5.7 % in the first quarter of 2018. The proportion of Kenyans living on less than international poverty line (US\$1.90 per day in 2011 PPP) has declined from 43.6% in 2005/06 to 35.6% in 2015/16. Yet as Kenya's population expands –it is estimated to reach 60 million by 2030- the country faces a critical challenge of creating the foundations for long-term inclusive growth. Currently only 17 % of Kenyan households are covered by health insurance of any type, while the rest of the population relies either on donor aid, government spending or out of pocket spending for accessing health care. This makes the ambition to provide universal quality health care to all those in need, regardless of their ability to pay, a major undertaking that will require a major shift in the mechanisms and systems through which health is governed, financed and delivered.

Our health system is not able to deal effectively with the growing epidemics and the growing burden of chronic diseases. Kenya is facing an epidemiological as well as a demographic transition with a steep increase among non-communicable diseases (NCDs). For example, while HIV contribution to the burden of disease has decreased by 61% in the period 2005-2016, the combined contribution of ischaemic heart disease and cerebrovascular disease has increased by 57% in the same time period.

This calls for renewed commitments. His Excellency, the President of the Republic of Kenya, has identified affordable health care for all as one of the pillars of his Big4 agenda. Subsequently the Government of Kenya has committed to achieving Universal Health Coverage (UHC) by 2022. The Ministry of Health has therefore integrated UHC as a goal in the Health Sector Strategy and believe that by achieving UHC, Kenya will eliminate preventable maternal and child deaths, strengthen resilience to public health emergencies, reduce financial hardship linked to illness and strengthen foundations for long –term economic growth.

#### Key Concerns

It is morally unacceptable that some members of the Kenyan society should face death, disability, ill health or impoverished for reasons that could be addressed at limited cost. There has been significant growth in development assistance for health more in particular, development partners have committed substantial amounts for the UHC 4 pilot counties. This raises concerns on the effectiveness and long term sustainability of the development assistance funded priorities for UHC.

As a country, what should we do, in the next five years to address these challenges while building the foundations for future progress in UHC? We need to look at the specific ways that make the health system underperform. Notable challenges include:-

1. Devolution has brought both risks and opportunities for the health system in terms of greater responsiveness, local accountability and more scope for local tailoring of services given the diversity of contexts across the country. The share of health in county government spending has increased on average during the past 3 years. With each of the 47 counties having authority over public resource allocation, prioritizing health and what is prioritized within health is up to them and thus the UHC reform agenda must take this into consideration.
2. Inappropriate prioritization from a public health perspective - a tendency to invest in specialized referral services and new facilities and a relative lack of attention to 'basic' services. Investments in new facilities and services have longer-term recurrent cost implications that will place a strain on future capacity to sustain improved performance in health. Performance on some core indicators such as immunization coverage has fallen and there are also problems with water (reflected in cholera outbreaks), sanitation and nutrition.

3. The perception of the general public is that with the rebasing of the Kenyan economy to a low Middle Income Country, primary care or 'basic services' are viewed as being for low income countries –difference between 'what the public wants' and 'what the public needs'. This conversation needs to change
4. Management of the HIV, TB conditions is not included within the National Hospital Insurance Scheme, for reasons such as the main source of funding being off-budget donor support, and the high annual and lifetime cost liability of antiretroviral therapy. For example, leaving HIV interventions outside the essential benefits package will leave 1.5 million PLWHIV outside universal health coverage reach, challenging the universality principle and affecting the governments' ability to reach its UHC coverage targets.
5. The actual total spending on health is USD 76 per capita. The projected resource needs for covering 80% of the population with an essential benefits package call for a total health expenditure of USD 357 per capita. The resulting funding gap will not be addressed if HIV funding (from both donor and government contributions) is left outside the UHC funding pool
6. Wages constituted about 70% of public spending on health in 2015-16 and with the long strikes last year, the share now could be closer to 80%. There remains concerns about productivity, absenteeism and dual practice of the health work force.
7. There is an urgent need to change the role and 'operating philosophy' of the NHIF. NHIF continues to operate with a market –oriented approach similar to a private insurer. It offers differentiated packages that reflect an approach based on segmentation with no policy guidance from MOH. In addition there are many administrative barriers that insured persons have to navigate casting doubt as to whether NHIF is ready, willing and able to play the role that it needs to in the context of UHC.
8. Coverage with private voluntary health insurance is only about 1% but it accounts for 10% of total health spending. This means that a lot of money is serving a small number of people and if this grows, it could be a source of internal brain drain from public to private sector. The Kenya health financing model has not carved out some space for private sector in a way that limits this potentially harmful impact.

## Recommendations

1. Recognizing that NHIF has been in existence for more than 50 years, a conceptual approach that divides the package rather than the population. A universal, budget –funded entitlement for the entire county population and a complimentary benefit based on contributory entitlement. The space for private financing to be mainly outside of this publicly defined service package, apart from possible co-payments for complimentary benefits for those who do not have complimentary insurance coverage.
2. Finalize on the content of the essential and complimentary service package that is fiscally affordable. At a minimum the essential package should include all 'county level' health services that are currently offered free of charge as well as the fully subsidized services funded via national programs such as HIV/AIDS and TB.
3. Initiate development of longer-term institutional arrangements for package refinement over time including the function of health technology assessment, budget impact analysis and citizen participation.
4. Include health indicators in the new formula for CRA that is being developed for implementation in 2019-20 as well as use the processes of CRA to incentivize efficiency and monitor performance in the health sector at county level including working on PFM issues.
5. Develop 'matching conditional grants' for counties to invest in prevention, promotion and 'health enabling' interventions. Funding from the central government would be triggered to 'match' and reinforce these investments. This approach will be complimented with a strong monitoring framework to minimize gaming and ensure that the intent of the UHC policy is realized in practice.
6. Have a single pooled grant in place rather than broken into various programs such as sanitation, nutrition and immunization to encourage inter-sectoral dialogue at county level while enabling counties to develop tailored solutions to their particular UHC implementation challenges.
7. There is need for an institutional setup at county level (a county platform) that is resourced and staffed to analyze and tailor service delivery arrangements that adapt to local needs while still ensuring adherence to national standards and performance criteria.
8. Production of a multi-year 'county health access plan' with annual adjustments and with Technical Assistance support from the MOH as needed ,

is a valuable instrument for strengthening the reach of health services around the country.

9. Create an improved and unified universal data platform on patient activity and beyond while ensuring that MOH has full access to the database. A unified national provider payment database can enable analyses to inform policy and not just purchasing decisions.
10. Harmonize the plans for the patient activity database with other ongoing developments in information systems, notably DHIS-2. Getting the data platforms 'right' and developing the skills to ask policy relevant questions of the data and feed this back into decision making , can be the 'make or break' element of our delivery on the UHC delivery.





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