

A Case for Increasing Public Investments in Health *Raising Public Commitments to Kenya's Health Sector*

Author ~ Njuguna David and Pepela Wanjala

Executive Statement

In Kenya, 12.7 percent of sick Kenyans do not seek health care when they are ill with high cost of services being one of the major barriers that accounted for upto 21 percent of those who did not seek care in 2013. Further, 2.6 million Kenyans (6.2 percent) of households were at risk of impoverishment as a consequence of expenditure on health care depleting household savings and were at a risk of falling into poverty (Republic of Kenya 2015b).



Key Messages:

The main challenge of healthcare access in Kenya lies primarily in the acute scarcity of resources, and inadequate resource allocation. In the past few decades, the out-of-pocket (OOP) expenditure has been increasing since the introduction of user fees in the health sector. Moreover, to limit the rising publicly-financed health expenditures, OOP expenditures have continued to be implemented in the

country consequently leading to burdening social subgroups unequally.

To address these barriers, this brief calls for the Kenyan government to:

- Seize this period of strong economic growth to prioritize investments in health, particularly key areas such as maternal and child health that are fundamental to a healthy population;
- Reduce the burden on

poor households of out-of-pocket spending on health by expanding alternative financing sources such as health insurance subsidies and vouchers for key services and by partnering with the private health sector;

- Address missed opportunities in implementing high impact preventive interventions.
- Strengthen community-based care and address gaps in human resources for health.

Introduction

The general aspiration of the Kenya vision 2030 is to transform the country into a globally competitive and prosperous industrialized, middle-income country. In line with Vision 2030 and the Constitution of Kenya 2010, the government is committed to implementing strategic interventions aimed at accelerating the attainment of Universal Health Coverage (UHC) for all Kenyans.

Kenyan health sector has an articulate and elaborate Kenya Health Policy (KHP 2014 -2030) to assist the sector realign to new emerging issues to enable the country attain its long term Health goal sought by the country as outlined in the Kenya's vision 2030 and the Kenyan Constitution 2010.

Over the last decade, Kenya's strong economic growth has led to tripling of government expenditures across all sectors. With continued projected economic growth of above 5 percent, Kenya has an opportunity to reform its health sector (Economic Survey 2017). However, government expenditures on health as a percentage of total government expenditures has stagnated around 6 percent (Kenya NHA Reports year). This puts Kenya farther from its goal of increasing health expenditures to 12 percent of total government expenditures as set in the Kenya Health Sector Strategic and Investment Plan (KHSSP) 2014-2018.

WHO 2010, points out that for a country to achieve Universal health Coverage, then it should dedicate more resources to health. While raising more money for health is crucial in supporting the UHC agenda, it is just as important to get the most out of the resources available. In order to ensure financial risk protection for all, provision of essential package of health should be funded primarily through prepayment mechanisms, while reducing OOP payments to a very minimum.

The lack of adequate financial protection is attributed to low funding, fragmentation of resources and low insurance coverage. Direct OOP places the burden of bearing the costs of illness to the sick person and

their families, and is therefore a major contributor to inequities. According to WHO (2010), incidence of financial catastrophe and impoverishment falls to negligible levels only when direct OOP falls between 15-20 percent of Total Health Expenditure (THE).

This brief addresses Kenya's health care financing, based on evidence generated by the Kenya National Health Account (NHA) estimation of 2015/16. NHA is an international methodology that tracks flow of resources in a country's health system including volume of expenditures, sources of financing, types and levels of care provided, as well as the providers who deliver services. NHA findings are intended to inform the decisions of policymakers seeking to



improve health system efficiency.

Background

The average life expectancy in 2016 was 62.2 years, up from 51 years in 2004¹. The population growth rate has remained high at 2.7% per year, with a large number of young and dependent population that is increasingly urbanized.

Kenyans in the economically productive age-group (15–64 years), were estimated at about 53.5 percent of the population according to the Economic Survey 2017. In absolute numbers, this amounts to 23.65 million Kenyans. The total labor workforce stood at 15 million Kenyans, with the balance of about 8 million not in employment.

In 2016, employment increased by 5.3 per cent to 16.0 million persons. Informal sector employment increased by 5.9 per cent to 13.3 million persons, and accounted for 83.1 percent of total persons engaged during the review period. Migration from rural to urban areas, most noted among people ages 20–34 years, has contributed to an increase in the urban population and their associated health risks mostly affecting the urban informal settlements in the country.

The rebasing of the country's economy to lower middle-income country has necessitated some development partners to drastically reduce their support as per international benchmarks related to such support. The country is now expected to contribute above 20 per cent for basic commodities such as vaccines, Malaria, TB, Family Planning and ARVs instead of a minimum of 5 per cent previously.

Coverage of critical interventions related to maternal and child health have shown signs of improvement, as shown by trends in the Demographic and Health Surveys. Although Kenya did not achieve the health Millennium Development Goals (MDGs) by end of 2015, the health sector has recorded significant progress in improving maternal and child health indicators.

Infant Mortality Rate (IMR) reduced from 77 per 1,000 live births in 2003 to 39 in 2014 and Under-

five Mortality Rate (UMR) reduced to 115 per 1000 live births in 2003 to 52 in 2014. However, neonatal mortality remained high contributing about 35% of the Infant mortality rate.

On maternal health, the Maternal Mortality Ratio (MMR) remained high at 362 deaths per 100,000 live births against a global trend of declining MMR from 400 to 210 deaths per 100,000 live births in 1990 and 2010 respectively. The causes of maternal deaths are well known and manageable, when women access timely care from skilled providers. Maternal deaths not only affect families, but have serious negative impacts on the country's economic development.

Justification

The Total Health Expenditure (THE) in Kenya was KSh 346 billion (USD 3,476 million) in 2015/16, up from KSh 271 billion (USD 3,188 million) in 2012/13. Total health spending in 2015/16 accounted for 5.2% of GDP down from 6.8% in 2012/13.

The government budgetary allocation to health has remained low relative to global commitments like the Abuja declaration of 15 percent allocation of the total government allocation to health. The government expenditure on health as a percent of total government expenditure increased from 6.1% in 2012/13 to 6.7 % in 2015/16.

Similarly, the level of external funding has been relatively high, with a significant share of such funding being 'off-budget'. The external financing for the health sector accounted for 22 percent of Current Health Expenditures (CHE) in 2015/16 down from 32 percent in 2009/10.

In net present values, the per capita expenditure in USD has increased from KSh 6,602 (USD 77.4) in 2012/13 to KSh 7,822 (USD 78.6) in 2015/16. The per capita expenditure, government health expenditure as a percent of THE and the proportion of GDP spent on health has been increasing since 2001/02 estimates.²

According to the 2010 World Health Report on financing for UHC "Countries whose entire populations have access to a set of services usually have relatively high levels of [mandatory] pooled

funds – in the range of 5–6% of gross domestic product (GDP).” Kenya spent 2.5 % of pooled funds in 2015/16 on health.

Overall, the population having access to health insurance averages 17 percent. However, the rate of insurance coverage is higher for urban population (27 percent) compared with rural population (12 percent). Health insurance coverage is positively correlated to wealth in that insurance coverage is higher in the richest wealth quintiles at 42 percent compared with those in the poorest quintile at 3 percent (Republic of Kenya, 2015b).

There has been an increase in government investment in new initiatives as the country moves towards universal coverage. One being the introduction of new mechanisms of financing and reducing financial burden of the poor and vulnerable groups. Examples of these are the abolishing of user fees, free maternity, managed equipment and Health Insurance Subsidy Programme (HISP). Success stories include counties like Makueni county where fees have been abolished in all public health facilities making it free for their citizen. TB drugs have are 70% financed by government as a means to cover the cost from external financing.

Additionally, NHIF has expanded the benefit coverage with new rates for, leading to an additional 2 million additional members recruited, expanded benefit package that includes outpatient services, chronic diseases such as NCDs (cancer, diabetes and hypertension), and increased access to health services through subsidies (social health protection)

to the current 219,200 beneficiaries for the poor households and 21,000 elderly. There are also plans to increase subsidy program for the poor from 21000 HHs to 160,000 next year while administration cost that was at 29% in June 2016 and target to reduce it to 16% this year.

Piloting of the different performance based grants (RBF, OBF and others) has been done as well as scaling up RBF from 3 to 21 counties.

Government allocated more than budgeted in KHSSP midterm (109%), while 53% of the total financing of KHSSP (public) was financed by county governments. However the government allocation to health still remains low at 6% below international benchmarks.

About 4% of the all PBB funding comes to the health sector; curative care taking most of the resources of the PBB resources in the MOH allocations. Curative care took about 40% of the Total Health PBB allocations. Research and development as well as General administrative, planning and support services are getting more resources. Preventive and promotive share reduced and disaster management is no longer one of the programmes.

The MoH approved budget increased from the lows of KSh. 16 Billion in 2002/03 FY to the highs of KSh. 155 Billion in 2017/18 FY representing an overall growth rate of 867% in the same period. Figure 1 shows the trends in Health sector budget allocations.

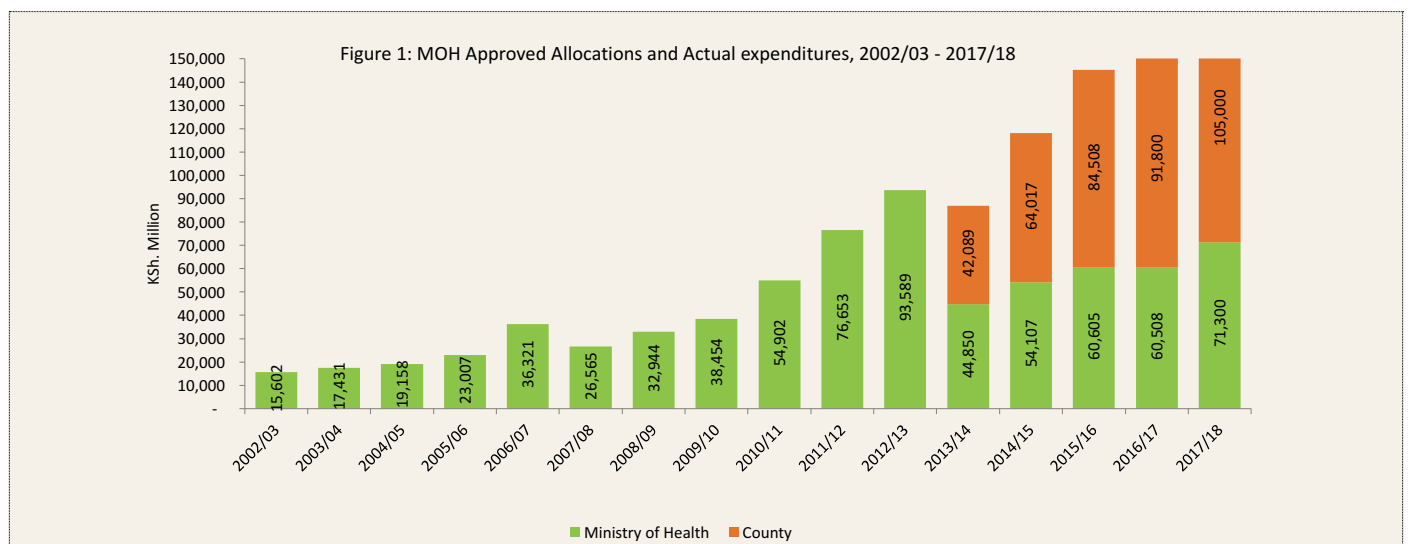


Figure 2 shows the breakdown of allocation at the county level. Globally, counties increased the proportion of their total budgets allocated to health, from 22 percent in FY 2014/15 to 30 percent in FY 2017/18, indicating the continued county governments’ increasing prioritization of health despite competing needs with other sectors.

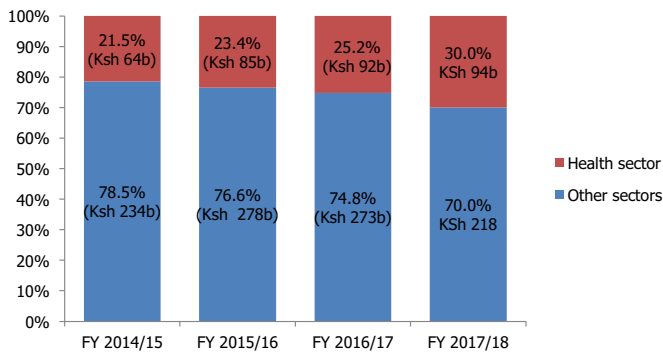


Figure 2: Breakdown of County Health Allocations, 2014/15 – 2017/18

High out of Pocket Expenditure on health continues to be major issue in Kenya constituting about 32 percent of total health expenditure (when all sources are considered: government, private and development partners). As a result, close to 6.2 per cent of Kenyans spend over 40 percent of their non-food expenditure on health (catastrophic health expenditure) – hence pushing close to 2.6 million poor people to the poverty. This situation is partly contributed by low government expenditure in health as public health services remain the main source of outpatient and inpatient care for

two thirds of the population. At present, total government health expenditure as a proportion of the total budget (both national and county budget) is about 6.7 per cent.

Public spending has been skewed towards high-end curative services which is both inefficient and inequitable. Furthermore, on aggregate personnel costs account for 70-80 percent of total recurrent budget for health both national and county levels.

Prioritize investments in health particularly among neglected areas

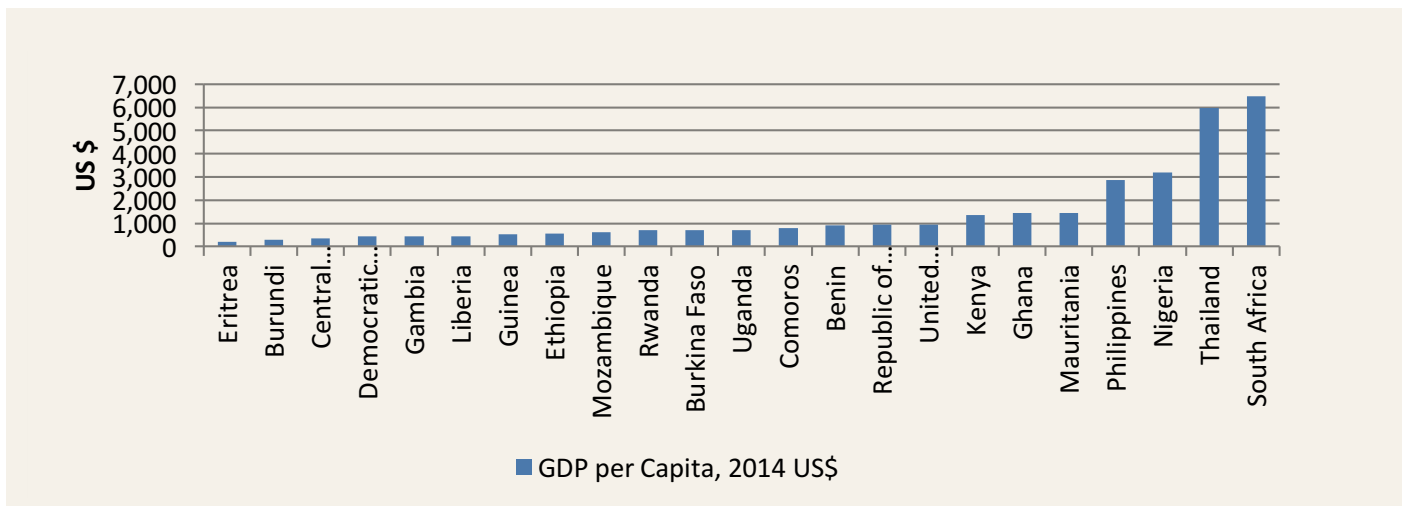
In 2001, the Heads of State and Government of African countries adopted the “Abuja target” which states that member states should allocate 15 percent of government expenditures to health. With just 6 percent of its 2015/16 budget allocated to health, Kenya has not lived up to this commitment. Nor has it achieved the most recent KHSSP target of 12 percent nor above commitment of 15 percent.

The country is classified as the 5th largest economy in sub-Saharan Africa behind South Africa, Nigeria, Angola and Sudan. The country’s economic development status in relation to other countries in the region is illustrated in Figure 3 below.

Levels of government spending are higher than revenue generation, with government spending of approximately 25% of GDP in 2016.

Insufficient expenditures on health compromise the quality of care delivered in the public health

Figure 3: GDP Per Capita, 2014



Source: World Health Organization Data (2016)

sector, as evidenced by shortages in medical supplies, inadequate human resources, and poorly maintained infrastructure.

Addressing gaps in human resources for health, quality of community-level health services, and other components of the health care delivery system will increase availability and affordability of services, especially for the poor.

Explore new methods to reduce out-of-pocket expenditures among the poor

The health system will be funded predominantly through tax funding and health insurance contributions, that intend to translate direct household payments into prepayment. As a result, OOP payment will be kept at a minimum. Considering that close to 80% of economically active Kenyans work in the informal sector, it is important that revenue collection mechanisms are designed in the most efficient way possible.

As repeatedly reported in National Health Accounts reports, direct Out of Pocket Expenditure (OOPs) is a major source of financing for health services in Kenya. The direct fees are charged for health care services in both public (cost-sharing) and private health institutions. The Out of Pocket Expenditure has been high and accounted for 27.7% of Total Health Expenditure (THE) in 2015/16. These out-of-pocket expenditures impede health seeking for these basic priority health areas. 6.2% of Kenyans spend 40% of their non-food expenditure on health (catastrophic health expenditures). The need to educate our people to buy medical insurance cover as opposed to relying on out-of-pocket payments becomes even more important.

The KDHS 2014 reported inability to afford care as one of the biggest barriers to women delivering in a health facility. Cost is not a burden just for deliveries; it also reduces use of medical care in general.

To remove this financial barrier to health care utilization, policymakers should increase government expenditure on health. They should also increase availability of services by scaling up

health financing innovations such as output-based aid, by partnering with the private health sector, and by abolishing maternal and child health user fees. Out-of-pocket expenditures can also be reduced by expanding the National Health Insurance Scheme to include more basic, essential services, including those who work in the informal sector and by offering subsidized premiums for those unable to pay the full price. Partnering with the private health sector to improve use of vouchers can further increase uptake of essential services.

Address missed opportunities by expanding access to high-impact preventive interventions

Vision 2030 prioritizes preventive health care¹, and NHA 2015/16 found that health financing has begun to shift in this direction. Government hospitals utilized 20.5 percent of Current Health Expenditure (CHE) in 2015/16 down from 35 percent in 2009/10. The role of provider of preventive health programmes remained at 14 percent in the study period while that of providers of health administration increased from 8 percent in 2009/10 to 20 percent of CHE in 2015/16. These less-expensive clinics and dispensaries should be used as a cost-effective avenue for service provision and prevention among communities. Of course, these facilities must be fully equipped and staffed to provide family planning, antenatal and postpartum care, and other essential preventive and curative services.

The amount of CHE spent on inpatient care decreased from 22.7 percent in 2009/10 to 20 percent in 2015/16, while that for outpatient curative care reduced from 40.5 percent to 37 percent respectively. Prevention and public health programmes utilized less of CHE at 16 percent in 2015/16 compared to 23.6 percent in 2009/10. A notable increase was the amount of CHE spent on Health administration which more than doubled to 20% in 2015/16 compared to 9 percent in 2009/10 levels.

Policy Recommendations

To address these barriers, this brief calls for the Kenyan government to:

- Seize this period of strong economic growth to prioritize investments in health, particularly among neglected areas such as maternal health and family planning
- Reduce the burden on poor households of out-of-pocket spending on health by expanding alternative financing sources such as health insurance and vouchers for key services and by partnering with the private health sector
- Address missed opportunities in implementing high impact preventive interventions
- Strengthen community-based care and address gaps in human resources for health.

Given Kenya's consistent economic growth since 2013, the government can expand financing of the health system to care for its population (Economic Survey, 2017). This will be an investment in a healthier society that will contribute to the nation's productivity and prosperity.

Conclusion

Kenya's current economic growth enables it to give greater priority to provision of health services, and thus realize the objectives laid out in its Vision 2030 Development Plan. Increasing government expenditures on health to 15 percent of overall government expenditures would make available to the health sector an additional funds. With this funding, Kenya could address gaps in preventive services, make progress on neglected areas such as maternal health and family planning, and make strategic investments in community-based health, national health insurance, and human resources that will benefit the country for years to come.

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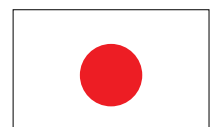
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