

# The GLOCEPS

## Policy Paper

Research and Analysis in Development Pillar

### Financing universal health coverage for Kenya's informal population

Michael Owuor



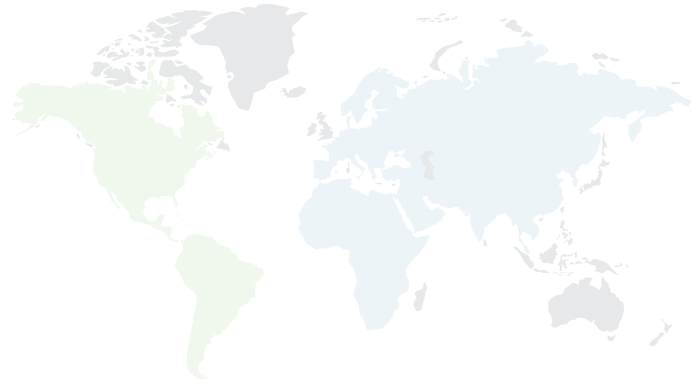
Photo credit: Good-Governance-Africa

#### Executive Summary

Unlocking the predicament of equitable health financing in developing countries is exigent to achieving health security for their populations. The colossal challenge of an uninsured population largely engaged in the informal sector thwarts the enforcement of the current voluntary health insurance contributions. Similar to other sub-Saharan African countries, Kenya is faced with a projected unprecedented spike in urban-poor populations and non-communicable diseases. These realities, in addition to the country's transition to a lower middle-income economy, further curtail donor financing for health programs. This paper advances germane policy discussions and options drawing from the expertise of health economists, social protection practitioners and scholars. The paper takes cognizance of the new development in the Kenya's national health insurance fund of 2021. These includes the repositioning of the fund as a strategic health

purchaser, and the expansion of health finances through mandatory contribution by all Kenya adult. These insights are supplemented by evidence from secondary data that address key issues on sustainable, fair and enforceable financing of UHC programs in developing countries. The paper concludes that a national mandatory insurance scheme for health should be pursued. Key recommendations include compulsory contributions for affluent households as the vulnerable are covered through government funding; enhancing transparency in NHIF management to increase public trust; expanding representation in the NHIF board to include county governments; adoption of a comprehensive and uniform healthcare package to guarantee universal access by all; and contracting only health providers offering quality standardized health services at capped costs, for the fiscal sustainability of the health fund.





## Introduction

The chronology of universal health coverage (UHC) stems from the Astana declaration on primary health care, Alma-Ata declaration of 1978 and the United Nations (UN) sustainable development goals (SDGs) of 2015. These global declarations are indicative of the convergence of vision and purpose around equitable and universal health care. The domestication of the international declarations by the UN member states espouse the mantra of “health care that is available and affordable to everyone, everywhere”. The universal adoption of SDGs cemented the rights of marginalized and vulnerable populations to essential health care without exposure to financial ruin. Empirical evidence substantiates that investment in robust and universal health system are beneficial to national and global economies. Nations like Kenya have thus been proactive in protecting UHC initiatives and benefits in legislation and development programs.

However, despite global consensus by policy-makers on the cornerstone role of UHC, resolving the equitable health financing conundrum is inexorable. As a result, experts portend that the SDG deadline of 2030 will elapse without achieving the goals of UHC. As of 2019, about 3.6 billion people globally were unable to access the most essential health services. Additionally, over 100 million were pushed to financial ruin through the disproportionate out of pocket payments (OOP) for healthcare.

Without predominant public health financing and service provision supplemented by mandatory health insurance contributions, UHC programs in developing economies will precariously tether to failure. Emerging economies will continue to suffer the adverse effects of large and resource-poor populations impeded from equitably accessing health care or UHC benefits. Moreover, health security and health systems

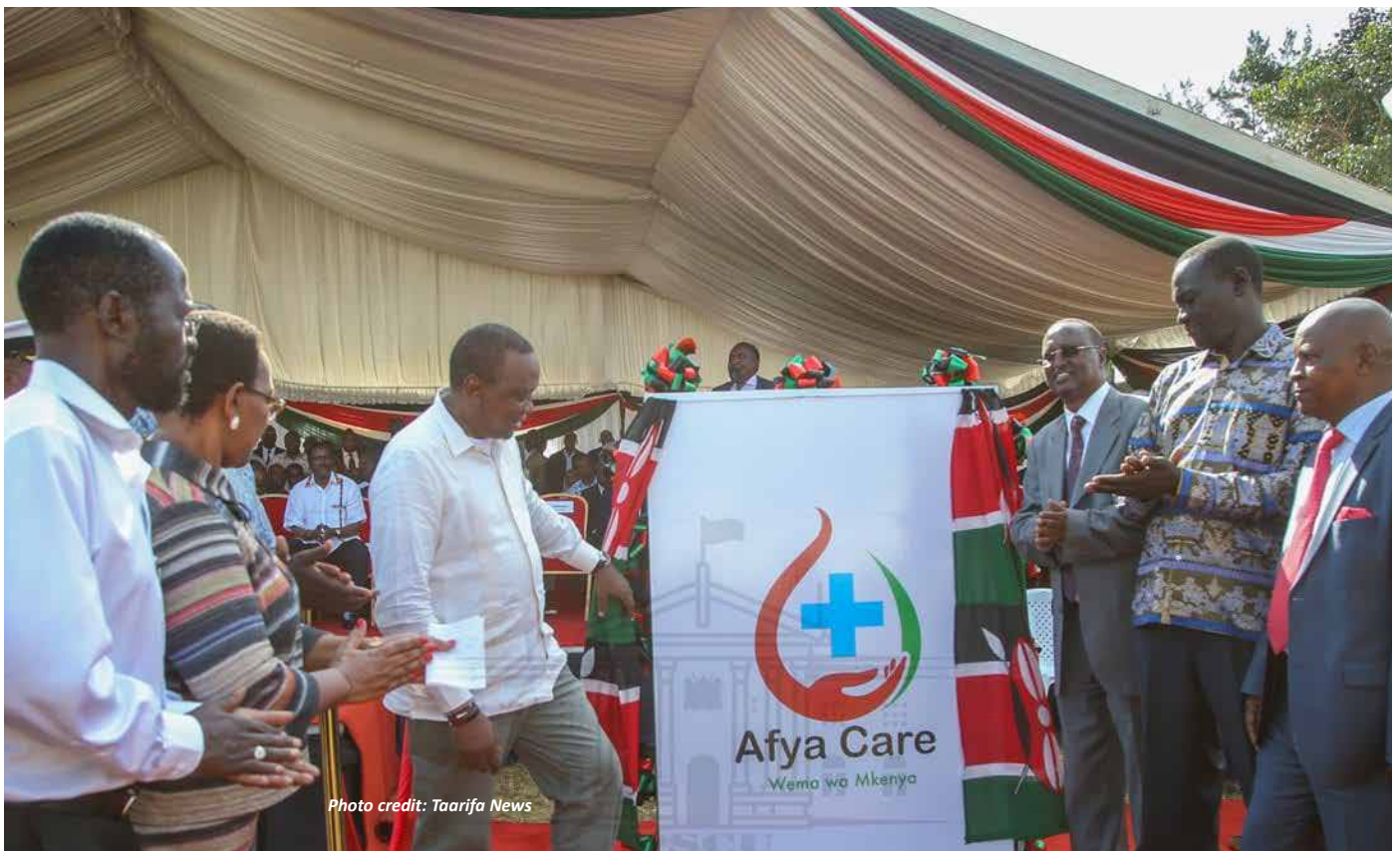


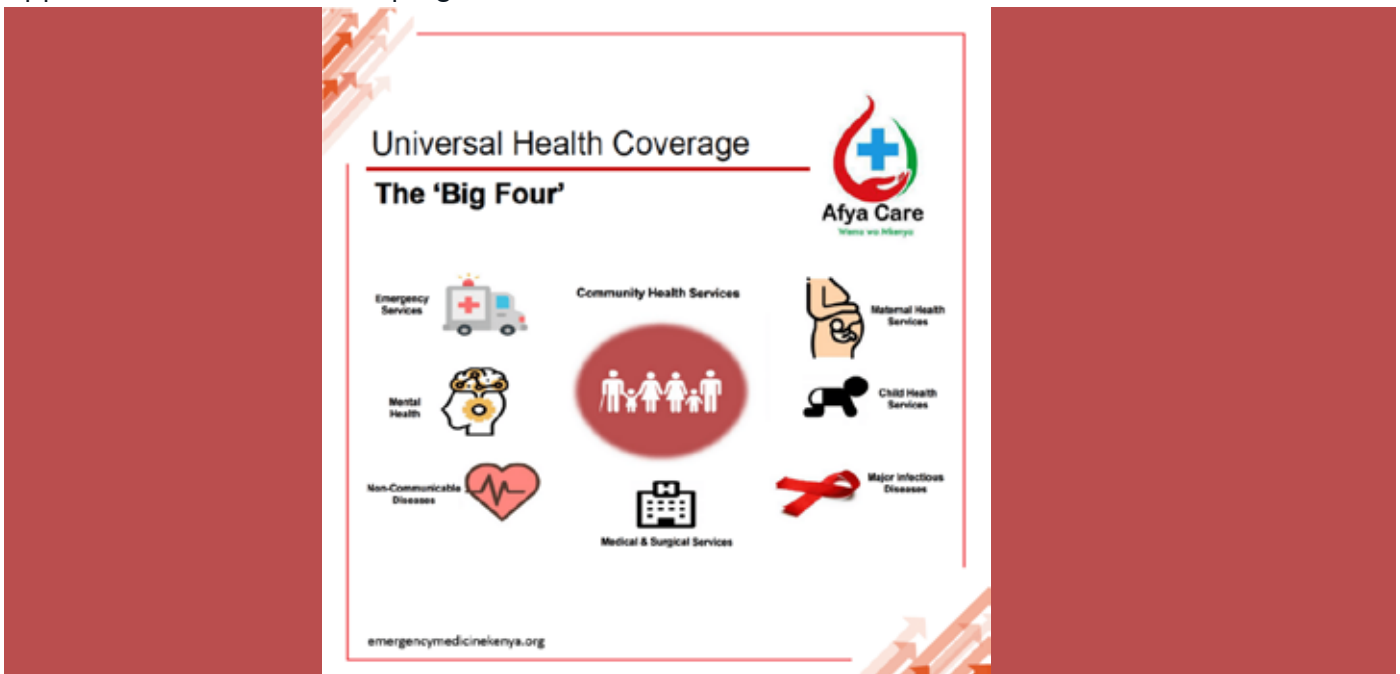
Photo credit: Taarifa News





resilience and sustainability will remain compromised. While different resource mobilization models have provided varied results, studies indicate that countries that expedited and sustainably managed their UHC programs have relied on taxes and mandatory contributions. They include the United Kingdom, Brazil, Mexico, Switzerland, Cuba and Thailand. Experiences from these nations provide learning opportunities for developing countries in

advancing their UHC programs. This paper examines the health financing landscape in the context of equitable health financing, optimal package of healthcare, the devolution of the health function, and prospects and impediments arising from the NHIF (Amendment) Bill of 2021. Conclusions advance policy discourses for robust health financing models that are equitable, enforceable and sustainable.



## Background

Access to the highest attainable standards of health without the risk of financial ruin is a fundamental human right. There is concurrence between states and intergovernmental organizations around quality, affordable and accessible health care through UHC. This has evolved into a political priority espoused in varied legal and policy frameworks that safeguard and advance the object of UHC. For instance, Target 3.8 of the Sustainable Development Goal (SDGs) and World Health Organization constitution, are in convergence with the UN’s high level declaration on UHC. In Kenya, the legal and institutional platforms such as Article 43 (1) (a) of the Constitution of Kenya (2010), the Kenya Health Sector Strategic Plan (2021-2023) appreciate

the need to increase public financing of health to 13% of the budget in tandem with the Abuja declaration; maximizing the availability of resources; and strategic purchasing. However, the country remains challenged in realizing the goal of a healthy population, predominantly due to health financing predicaments and the aforementioned commitments.

Social health insurance financing through the NHIF is an augmenting financing avenue. Nevertheless, inadequate health resources have exacerbated the current disproportionate out of pocket (OOP) expenditure on health, while curtailing health access. These challenges predispose the vast majority of the poor and





vulnerable to ill health and poverty. Developing economies are disadvantaged in this regard as they are exposed to demographic and economic challenges of high unemployment and strained national budgets. With the paucity of models that guarantee the financial sustainability of UHC and opportunities for tax-funded health-care equally obscure, a combination of tax and mandatory social health insurance appear indispensable.

Moreover, the rise in both communicable and non-communicable ailments on already strained health systems in most sub-Saharan countries support the urgency of robust and adequate investments in the health sector. Consequently, the political economy has to be cognizant of these emerging trends. This is in congruence with policy options that upscale and safeguard prerequisite investments in public health while advancing health security and economic progress.



Photo credit: Daily Active

## Methodology

Primary data was collected from experts and scholars with in-depth knowledge and understanding of social health protection, health economics and public health. This has been supplemented with secondary data from relevant literature and analyzed thematically. Consequently, the following key findings and recommendations are advanced.

## Key Issues

This section analyses key topical issues around equitable public financing of the UHC program and the optimal package of health service necessary to advance the goals of UHC. Additionally, the section examines the streamlining and safeguarding of health financing in Kenya's devolved system. The analysis of issues is informed by expert responses and documented literature from multiple jurisdictions overseeing various phases of UHC planning and implementation.





## Equitable UHC is premised on public and mandatory financing

A consummate health system is linked to the availability and adequacy of resources. They enable the procurement of health services and products while delivering health care in accordance with the fundamental needs of the target populations. However, public healthcare in developing countries such as Kenya occupy precarious positions. The prevailing poverty situation in a predominantly informal economy accentuates the health financing predicament. The current predilection with voluntary contribution and donor dependency have proved insufficient in covering the health finance deficits. With forecasts indicative of high OOP health spending and declining donor support, policymakers have to embrace robust resource mobilization approaches to safeguard UHC.

Equally, equitable and optimal health financing remains a huge challenge facing developing economies. The total per capita health spending remains predictably low when compared with those of richer nations. It is estimated that

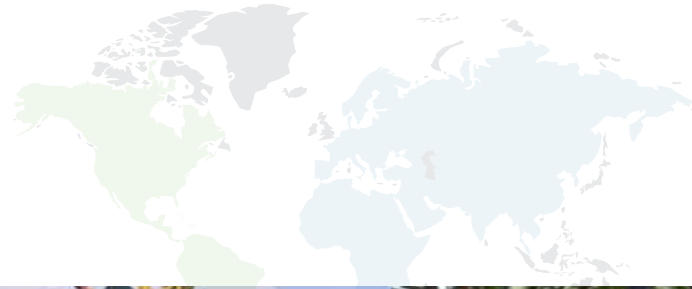
low-income countries' annual average per capita health spending stands at \$40. On the other hand, lower middle-income countries (LMICs), the upper middle-income countries (UMICs) and the higher income countries (HICs) averagely spend \$135, \$477 and \$3153, respectively. The pattern of low government spending on healthcare arises from low capacity of developing countries to mobilize resources from predominantly informal economies. As such, they fall foul of the recommended domestic general government health expenditure (GGHE) of \$101 (adjusted for inflation) necessary to promote and sustain UHC.

Therefore, achieving a holistic and equitable health financing model will require both political goodwill and supportive legislation. Commendably, Kenya boasts of a fairly robust legal framework that still lags in implementation. UHC is underpinned in the 2010 Constitution of Kenya, Article 43 (1) (a), the adoption of the Sustainable Development Goals (SDGs), especially



Photo Credit: CBS News





Target 3.8 and the World Health Organization constitution. The Kenyan government has prioritized UHC as a major building block for development under the Big 4 agenda and the Vision 2030 socio-economic development blueprint. The legal and policy framework provide the mainstay to UHC. They safeguard political commitments on fundamental health rights while promoting financial protection and access to the highest attainable standards of health.

These legislative undertakings and political commitments are in congruence with empirical studies from other jurisdictions. For instance, Cuba which is lauded for her robust health system, adopted a universal focus on public health. Though classified as a low-income country, her health indicators are among the best globally. The country's 1976 Constitution and Articles 1 and 72 of the Cuban Public Health Law (Law No. 41) delineates that the regulation, financing and guaranteed access to free, quality health care for the citizenry is the exclusive responsibility of the state. The Cuban health system is averagely financed by 6% of the national budget. Equally,

the United Kingdom operates a publicly funded health care system. Her National Health Service (NHS) is predominantly funded by general taxation, averaging 10% of the country's gross domestic product (GDP) or 30% of the national budget. Insurance payments and the copayment for health is miniscule. They are estimated to contribute less than 1% of the NHS budget. With assured funding, NHS concentrates on providing universal and comprehensive health care.

Another jurisdiction with devolved yet predominantly publicly funded health system is Brazil. She has a highly decentralized system with equally complex funding and service provision patterns involving the federal, state and municipal governments. Under its unified publicly funded health system (Sistema Unico de Saude, SUS), citizens access a full range of healthcare service from public and private health insurance providers. User fee, co-payments or out-of-pocket (OOP) financial contribution are not required except for the pharmacy program. The SUS program derives 50% of its funding from the federal government while state and municipal governments contribute a further 25%





each. Similar to Britain and Cuba, Brazil's Total Health Expenditure (THE) average 10% of GDP.

Evidence from the aforementioned jurisdictions are indicative of the succeeding global trends in health financing. Thailand and Mexico offer comparable evidence. The health sector is increasingly being publicly financed and complimented by common pools and less from OOP expenditures. Alternate financing models that are dependent on donor support, user fees, OOP payments or voluntary contributions remain transient and regressive. Lessons from Rwanda, Ethiopia, Ghana and Nigeria indicate that attainment of health financing devoid of considerable public financing are momentary. Progressively, they predispose populations to catastrophic health expenditures (CHE), preventable morbidity and mortality. The current predisposition with private health financing coupled with structurally weak health systems engender the prevailing and pernicious health outcomes.

As such, Kenya should transition its financing model to public funding and mandatory health insurance. Kenya's exposure to the reduction in donor funding due to its reclassification as a lower middle income economy and the huge drop-out of contributors from the NHIF program attests to the transience and unreliability of external funding and voluntary financing. This corroborates experiences from the aforementioned jurisdictions where equitable, sustainable and enforceable health are successful. In the UK, the health outlay from payroll tax is huge. Despite this, public discontent is minimal. The thought that all British get quality and comprehensive health care regardless of their financial status dissuades politicians and policymakers against considerations to privatize NHS. Put succinctly, such a move would be electoral poison. The high patriotism and deference to the NHS should assuage policymakers in developing countries to pursue UHC financing and mandatory contribution. NHS is the closest thing to religion among UK citizens. By comparison, it is more popular than the Queen.

## SUSTAINABLE FINANCING FOR UHC

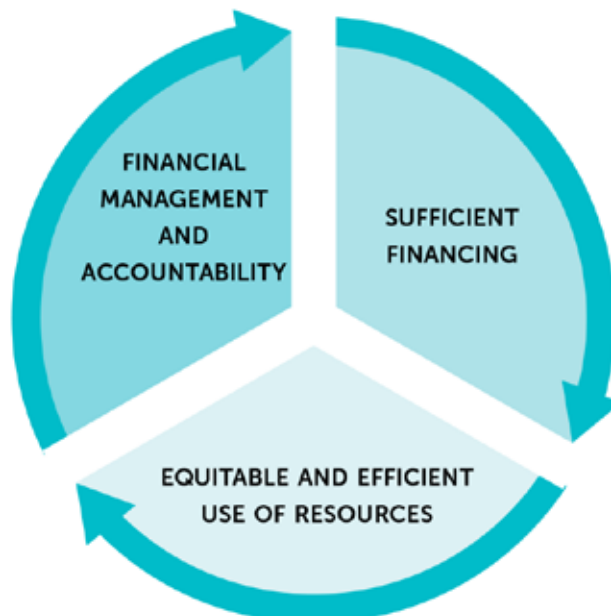


Photo Credit: Capacity Development for Health





*Photo Credit: Society for Public Health Education*

## Securing optimal UHC service package

Justification for optimal healthcare package is premised on disease profile and the cost-benefit of proposed health interventions. With epidemiological evidence revealing an upsurge in ageing populations, multiple chronic and non-communicable diseases (NCDs), these trends simultaneously point at the biggest contributors to CHE. Similar patterns are evident in Kenya where the transition from infectious ailments to NCDs is rampant. The NCDs account for over 40% of hospital admissions and mortality as disease burden among children remains high.

The profiles and trends of diseases have renewed interests around the prioritization of primary health care (PHC) in UHC. The escalation of NCDs in emerging economies and their impoverishing effect on households, can be placated by PHC interventions, which are efficacious in prevention and control of

long-term and pricier NDCs. Moreover, PHC is advantageous for developing economies as it delivers desirable health outcomes, health efficiency, and safety at lower costs.

Empirical evidence on Kenya show that the present health policy prioritization is aberrant to evidence. Resource allocation on PHC, preventive and promotive health services, has been on the decline from 2015/16 to 2018/19. Through the four years, expenditure on PHC has varied from 31%, 14%, 21% and 11% respectively. While improving hygiene facilities are beneficial to reduction of preventable mortality among under 5-year olds, investment in these interventions are low. The same is replicated in preventive and early detection interventions such as cancer screening and hypertensive diagnosis. These actions point to a persisting policy trend despite evidence that prevention and health promotion interventions inhibit the growing







# HEALTH FOR ALL

## UNIVERSAL HEALTH COVERAGE COALITION

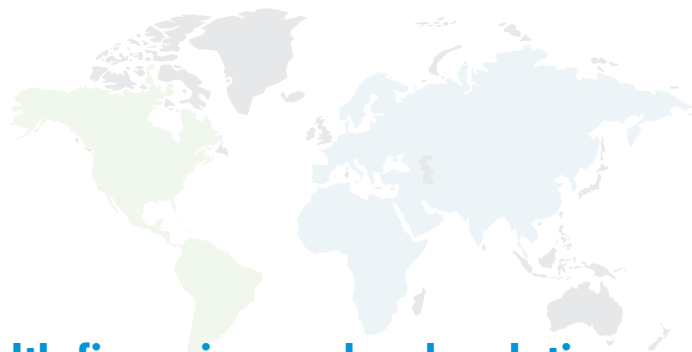
*Photo credit: Foreign IFSBH*

NCD burden.

In order to curtail CHE from derailing UHC, there is need to redouble policy action on PHC. They are beneficial in addressing current and future surges in NCDs, the overutilization of health services and hence higher health expenses. Learning from Cuba, policy interventions should reengineer the health system in line with the causal path of health-disease process. Likewise, the National Health Insurance Fund (NHIF) should be strategic in its health financing approach. The current strategy that prioritizes curative and rehabilitative packages including dialysis, chemotherapy, radiotherapy and theatre services while being apathetic to preventive and promotive services is regressive. The fiscal neglect and under-resourcing of health centers and dispensaries encourage the self-referrals (walk-in health clients) into the costlier, albeit better resourced country and

national referral facilities. This philosophy will guarantee unsustainable financial outlays both in the present and future. Moreover, the lower level facilities that serve the vast population with PHC (over 70% immunizations and over 94% skilled delivery), are incapacitated to offer critical and cost-saving interventions. Such interventions include routine cancer and blood pressure screening, antenatal care, preventive and other promotive health programs. These benefits of PHC transcend their level of healthcare. They are crucial in the reduction of prevalent NCDs. Their prioritization contributes to considerable financial savings that are necessary to the sustainability of UHC. Thus, comprehensive healthcare package under UHC should be uniform for all insured households including essential packages of health. NHIF should prioritize these healthcare interventions: reproductive, maternal, newborn, and child health; primary and preventive health; and non-communicable diseases.





## Streamlining health financing under devolution

The Kenyan health system is multifaceted with responsibilities assigned between national and county governments. The management of health facilities, pharmacies and the promotion of PHC are under the purview of county governments. Concurrently, the national government provides leadership on health policy, management of national referral health facilities and health commodities procurement. These roles are anchored in the 2010 Kenya constitution and formalized in the Health Act of 2017. The Act makes operational the relationship between national and county governments on health matters.

The Health Act and the Public Finance Management Act (PFMA) are the guiding framework for health financing including UHC. In particular, the Health Act provides safeguards for social health protection under Article 86 (1a and 2a) and 87 (1). They espouse health financing through an integrated national health insurance system and public health financing of county governments through National Treasury. Public

health allocations include disbursements, conditional grants, donations and other designated funds. The Act under Article 87 (2) mandates taxpayer health funds to only be used for the designated health functions.

As Kenya ascends to a lower middle-income country, the implications of this reclassification of the national economy on UHC financing needs conscious assessment. Reducing donor dependence in the financing of the health system is inevitable. Donor funding is consistently declining, though reliance on external support is unsustainably high. Over 25% of public health financing is donor-supported. In some critical health programs, donor dependence is colossal accounting for more than 50% funding for immunizations, tuberculosis (TB) and HIV. Low funding for these interventions exacerbates the strained primary health system that serves poor populations.

In order to moderate this situation, policymakers should proactively prepare for the transition,



Photo Credit: Amref Health Africa

Health Stakeholders renew momentum towards UNC





*Joint meeting between Health CS Mutahi Kagwe and Council of Governors*

increase domestic resources for health, address health system inefficiencies and shield the allocated funds from misappropriations. These policy actions advance the progress and achievement of UHC. There is an exigent need to buffer tax-funded health revenue and resources from being redirected and utilized away from the health sector. National and county governments are provided the leeway to deviate from financial objectives of the PFMA. This need curbing by the Senate under the provision of Article 8. Without resolute safeguards on public health financing, county governments will continue to spend less than 5% of their budgets on health, directly impacting UHC delivery and quality.

Equally, there is need to address the current imbalance where level 4 and 5 health facilities receive most funding under the Health Sector Services Fund (HSSF) compared to level 1 to 3 facilities. This is despite the lower level facilities providing health services to most of the poor clients whom they are proximal to. Implementa-

tion of HSSF need to be streamlined to address delays in disbursement of funds and onerous financial reporting requirements. There is also need to resolve adverse user fee even where direct facility funding under HSSF is implemented. These affect health service procurements and exacerbates health inequalities, especially in low-income settings.

Consolidating and protecting health resources in the legislative and policy framework will advance the procurement and delivery of quality healthcare service. Currently, most health facilities are encumbered in this regard. They are not allowed to utilize user fees that they collect in purchasing healthcare for their target communities. These funds collated by county and national governments and redistributed to non-health programs. Under Article 86 (1a and 2b), the two levels of government are at liberty to appropriate these funds away from the health system into other government functions. This insidious practice inhibits the achievement of UHC among the vast majority of vulnerable populations.





## NHIF (Amendment) 2021 Bill and UHC financing: prospects and impediments

The amended NHIF Bill (2021) has repositioned the NHIF as the strategic health purchaser. This implies that NHIF is obligated to buy healthcare services and medicine on behalf of the population. The Fund has the prospect to leverage its prodigious negotiating and purchasing power for cost effective purchases. Similarly, this healthy financing should motivate health providers and the insured to be more efficient in healthcare provision and utilization.

The amended Bill reorients the NHIF's focus on the prudent management of the legislated health financing mandate. For instance, Sections 15 (1), 16 (1) and 19 (1) provide a wider resource pool to insure a larger section of the population, with compulsory standard contributions by Kenya residents aged over 18 years. However, the Fund need to manage the impediment of the enforcement of mandatory contributions in Kenya's largely informal economy. Policymakers would need to consider rolling out strategies that

link the attainment of other services to the possession of updated NHIF cover. This should be judiciously undertaken so as not to disadvantage the indigent who are yet to be enrolled in the public financing programs.

The indigent question remains crucial since the basis for the UHC was to provide healthcare based on need and not ability to pay. With the existent poverty levels, policymakers should devise and streamline UHC social programs to cover all indigent households. Therefore, the pledge by the national government to pay the premium of 1 million indigent households to NHIF is still inadequate. It is estimated that the indigents consist of 20% of the population, approximately 5 million households. They lack any form of health insurance. This will require collaboration and public finance contributions by the national and county governments as well as stakeholders. Otherwise, the noble goal of UHC will be short-term.



*Photo Credit: MediaRoni*





Photo Credit: [airobiminibloggers.com](http://airobiminibloggers.com)

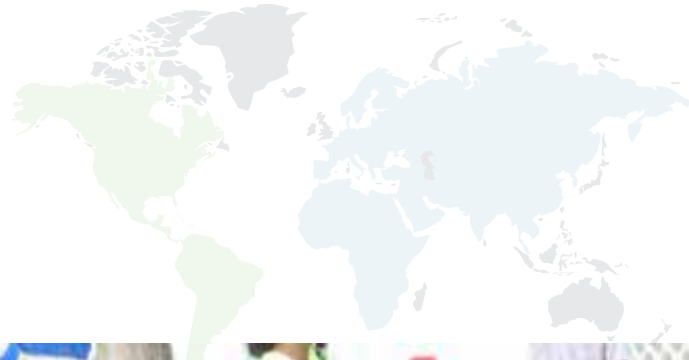
The amended legislation remains silent on the package of care available to the population. The possibility of arbitrary health package and the transience of resultant health benefits exposes the Fund to negative publicity and erosion of public trust which has previously bedeviled it. As it currently stands, the benefits described under Section 22 (3) of the amended Bill are ambiguous. In addition, they are not based on the disease profile and the long-term cost-benefit of health interventions. Moreover, the Bill is silent on PHC, an important health intervention to curtailing the rise of non-communicable ailments and associated catastrophic health costs. The description and communication of the comprehensive package of health should be clearly articulated in relevant policies.

Fraud on claims have proved detrimental to the welfare of the NHIF. With the amended Bill requiring private health plans to incur the first charge for beneficiaries, this will go a long way in improving the financial health of the Fund. For

its successful implementation, the NHIF needs to invest in a robust system that verifies claims sent by health providers. This includes biometric captures and real time alert to the beneficiaries who can authenticate these claims. More importantly, the Fund should utilize its power as a strategic purchaser to negotiate for the best rates and quality of care so as to boost the morale and trust of the public on the mandatory health program.

In essence, the success of the NHIF as a health purchaser will be determined by its ability to make difficult decisions. The Board should be inclusive of important stakeholders like the devolved governments in order to proactively curtail the prevalence of scandals around the NHIF. The Fund has to cultivate and utilize its political and technical skillsets to improve its public image. This is through prudent fiscal management, provision of comprehensive and quality health coverage and improving access to healthcare.





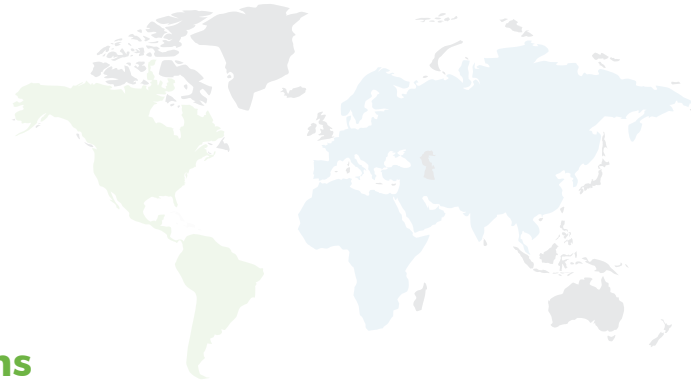
*Photo credit: Bright Kenya News*

*Registration at health facility using biometric*

## Conclusion

Kenya's health security is dependent on the prioritization of UHC and resolving the health financing debate. As the nation transitions into a lower middle-income economy, reliance on internal resources will take increased precedence and importance. This shift will require the health system at national and county levels to be weaned from donor reliance and out-of-pocket expenditure. The voluntary contributions to the national health insurance fund have proven unreliable as tough economic conditions escalate high dropout rate and default. This portends a dire situation that necessitates the mandatory NHIF contribution by those in formal employment and the affluent households. It must be supplemented by government contribution for indigent population and public investment in quality healthcare. At an estimated annual contribution of \$60 per household to the NHIF, the proposed \$300 million (Kshs 30 billion) annual allocation will advance health coverage to 5 million vulnerable households. This added to a combined budgetary allocation of 10% by both levels of government and mandated insurance contributions, UHC financing will be at a more secure footing. Policy interventions should be undertaken in tandem with the legislative buttressing of health resources, safeguard of comprehensive healthcare package, and the capping of healthcare costs by contracted healthcare providers.





## Recommendations

The following recommendations are geared towards enabling Kenya to maintain her geopolitical relevance during this transition.

1. The county and national governments should;
  - a) Develop and implement robust systems for enforcing transparency in NHIF fund management and quality comprehensive health service provision by empaneled and contracted health providers. This will enhance public trust in the program.
  - b) Increase national and county government budgetary allocation to health for UHC financing from the current 5% to at least 10% in accordance with the Abuja declaration.
  - c) Collaborate with NHIF to promote and expedite resource allocation and disbursement to public health care facilities to avert the visit to referral health facilities as a first point of services.
  - d) Work with stakeholders, to expedite roll-out of the UHC nationwide.
2. The National Assembly and Senate to;
  - a) oversee the implementation of the NHIF amendment mandating compulsory health insurance contribution by formally employed and well-to-do households while covering the unemployed youth, vulnerable and poor households through tax funded social welfare programs.



Photo credit: Capital News Kenya

Polio vaccination drive





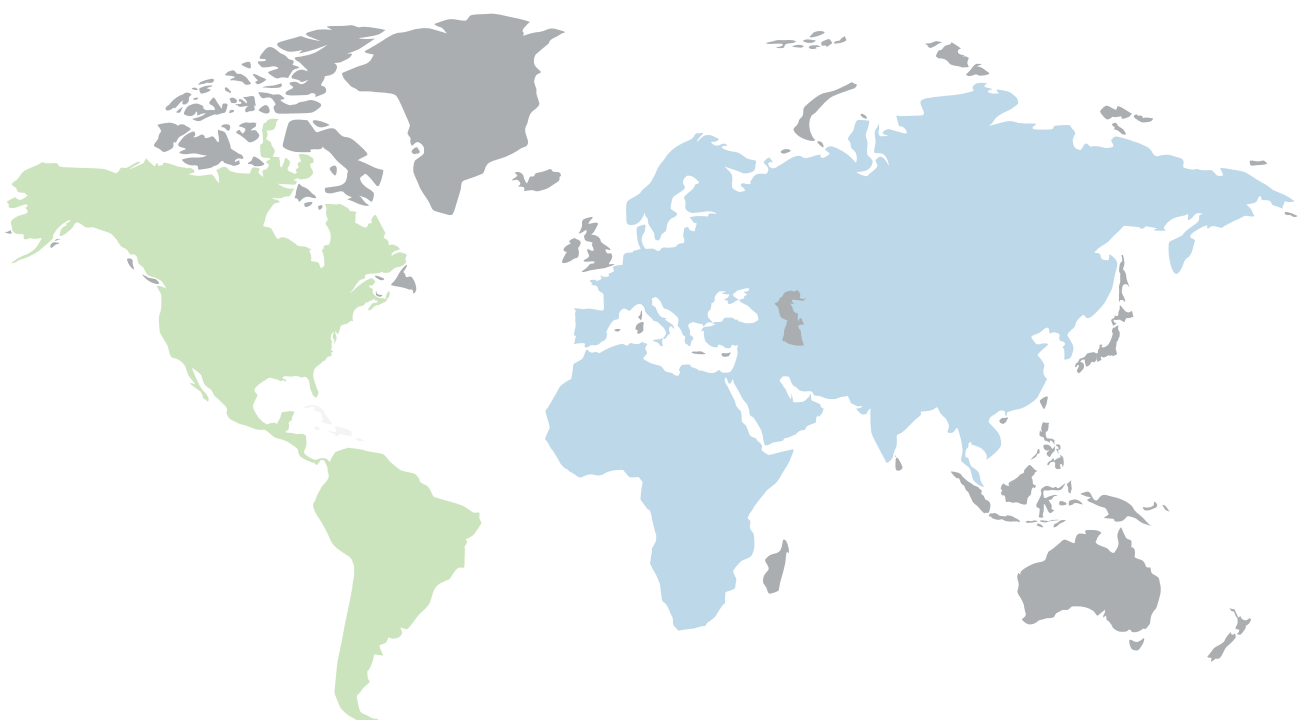
- c) Amend the Health Act and PFM Act and ring-fence health revenue and resources from being redirected and utilized in non-health sector and development programs. The laws should mandate public health facilities to utilize resources collected from health services provided at these facilities.
3. The NHIF Board should ensure equitable and expedited disbursement of health finance to level 1 to 3 facilities in addition to the disbursement to referral facilities where curative and rehabilitative services are provided. This will boost health financing of preventive and promotive health interventions as well as primary health care.
4. The NHIF Board should develop and implement policies to standardize health cost for comprehensive package of health services provided by empaneled and contracted health providers.
5. The NHIF Board should invest more in fund inspectors to mitigate fraudulent billings and poor quality of health services. This include investment in biometric capture systems and real-time message alerts to beneficiaries who can authenticate the bills.
6. The NHIF should expand representation at the Board to include county governments to enhance effective management of the fund.
7. The NHIF Board should prioritize investments on all-round and real time customer care and transparent billing system in order to improve public trust in the Fund and confidence in quality of service.







**Mr Michael Owuor** is GLOCEPS Research Fellow for Development Pillar. He has over ten years' experience in running multidisciplinary development programs and research with international public benefit organizations, universities and government agencies for policy action. His research priorities include business strategies, economic development and political economy. He holds Bachelor's degree in Business Management; a Master of Business Administration and MSc in Health Systems Management.



*The GLOCEPS, Policy Paper brings to policy makers precise incisive analyses of policy issues and events locally, regionally and globally. The priority is on topics that have a bearing on Kenya and beyond and are themed on defence and security; diplomacy and foreign policy; public policy, ethics and governance; strategic interests and transnational crimes; and development. We invite contributions from experts with policy opinions centred on any of the five pillars. Give us your thoughts and feedback through [info@gloceps.org](mailto:info@gloceps.org)*



**THE GLOBAL CENTRE FOR POLICY AND STRATEGY  
(GLOCEPS)**

**Research | Knowledge | Influence**

Off Kiambu Road, Nairobi Kenya  
P.O. Box 27023-00100, Nairobi.  
Telephone: 0112401331  
Mobile: +254 700 279635  
Email: [info@gloceps.org](mailto:info@gloceps.org)  
Web: <https://www.gloceps.org>

