

TOWARDS UNIVERSAL HEALTH COVERAGE IN KENYA: ARE WE ON THE RIGHT PATH?



Introduction

Universal Health Coverage (UHC) has become a policy priority at both the national and global level. The goal of UHC is to ensure that every citizen has access to quality healthcare services that they need without getting into financial difficulties or, worse, pushed into poverty. To progress towards UHC countries must advance along at least three lines of action. They must expand priority services, include more people, and reduce out-of-pocket payments (figure 1).

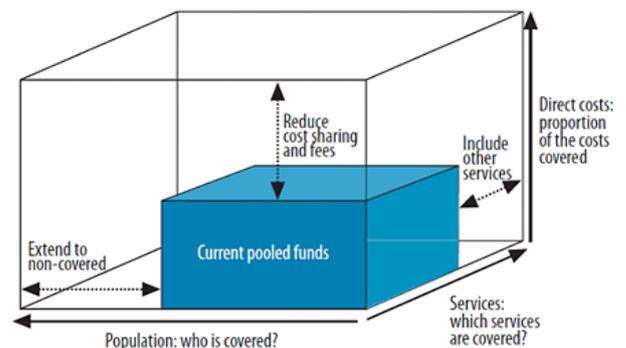


Figure 1: Universal Health Coverage Cube

The Kenyan government has made a commitment to achieve UHC by the year 2022. The country's strong political commitment to UHC is embodied in the government's big 4 agenda that include healthcare for all as one of the key development priorities. The installation of UHC as a global and country health policy goal has highlighted the need to measure it, and to track progress over time.

KEMRI-Wellcome Trust has conducted research to develop a summary measure of UHC for Kenya, and measure Kenya's progress towards UHC between 2003 and 2014. This work involved the analysis of three waves of the Kenya household expenditure and utilization survey, and the Kenya demographic and health survey. The key findings from this research are set out in this brief, as well as recommendations to support policy makers in designing and implementing UHC reforms.

Key Messages

- 6 out of 10 Kenyans did not have access to essential healthcare services in 2014.
- 4 out of 10 Kenyans were at risk of getting into financial hardship or poverty because of out of pocket healthcare payments in 2014.
- The Universal Health Coverage index for Kenya was 52% in 2014. This means that about half of Kenyans had coverage with both essential healthcare services and mechanisms to protect them from financial hardship or poverty because of out of pocket healthcare payments.
- Even though there was improvement in coverage between 2003 and 2014, inequalities in both service coverage and financial risk protection persist
- The Kenyan government should increase public financing of the health sector from the current 2.2% to at least 5% of the country's gross domestic product, and leverage this to scale up prepayment financing while reducing reliance on out-of-pocket payments. Kenya needs to move away from passive purchasing, and adopt strategic purchasing practices to enhance the equity, efficiency and quality of healthcare service delivery.

Main findings

Service Coverage

Data for Service Coverage was collected from two domains of indicators, measures of preventive and promotive health; and treatment indicators, as recommended by the World Health Organization (Table 1).

| Prevention/promotive indicators | Treatment Indicators |
|---|--|
| <ul style="list-style-type: none"> Family planning needs satisfied At least four antenatal visits Full immunization in children Condom use among men/women who had 2+ sexual partners | <ul style="list-style-type: none"> Skilled birth attendance; Appropriate treatment for diarrhea in children Access to treatment for acute respiratory infections Hospital admissions per 100 individuals |

Table 1: Service coverage indicators

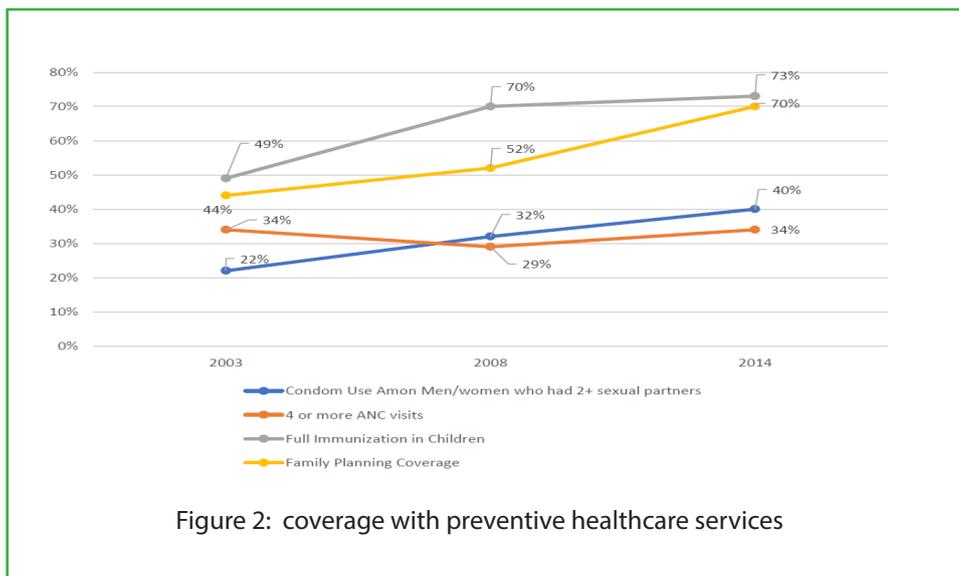


Figure 2: coverage with preventive healthcare services

While some indicators of service coverage like full immunization of children and family planning services recorded improvements between 2003 to 2013, others like condom use and antenatal visits remained very low (figure 2). Access to preventive services was characterized by inequalities, where the rich accessed more services compared to the poor except for condom use.

All indicators for treatment service coverage recorded improvements, except the appropriate treatment for diarrhea in children (figure 3). Skilled delivery, hospital admissions, and treatment of acute respiratory infections in children were accessed more by the rich compared to the poor signaling inequalities in service coverage.

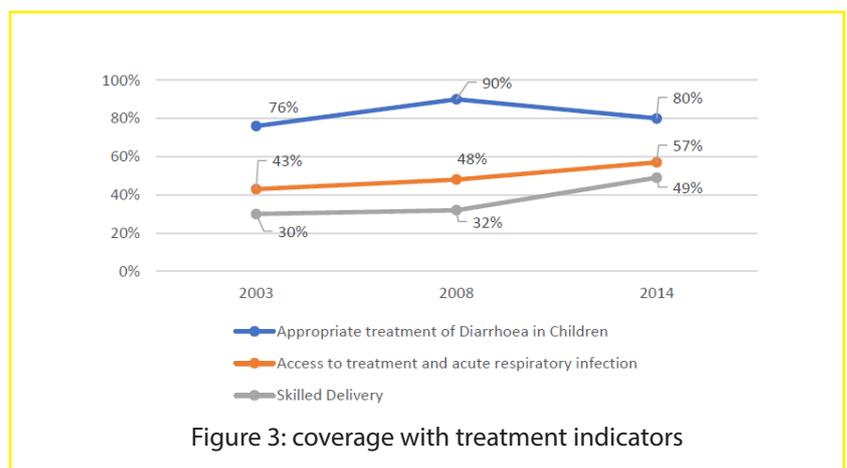


Figure 3: coverage with treatment indicators

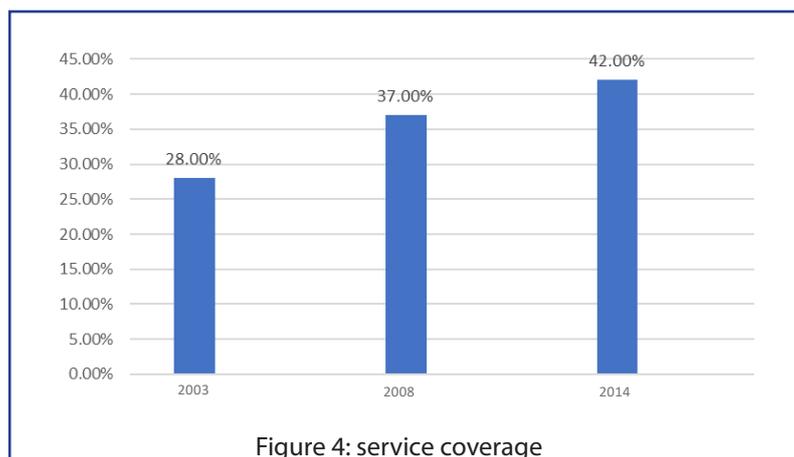
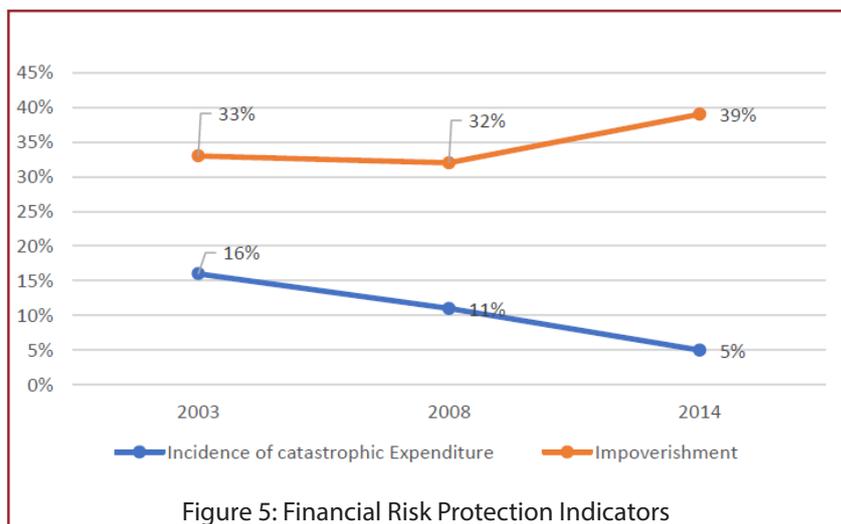


Figure 4: service coverage

The overall measure of service coverage increased from 28% in 2003 to 42% in 2014 (figure 4). This means that about 60% of Kenyans still did not have access to essential healthcare services in 2014.

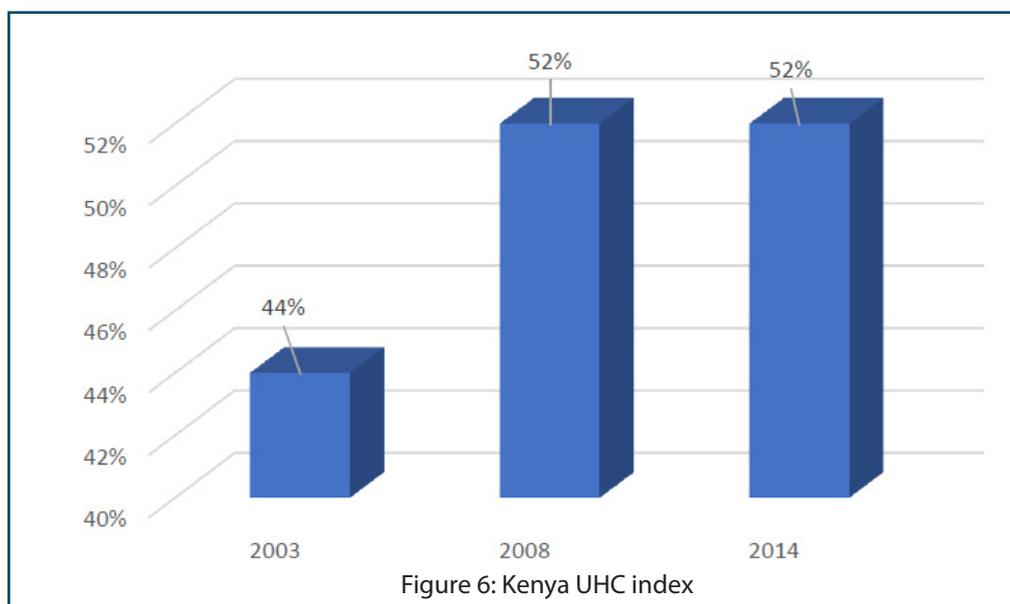
Financial Risk Protection

Two indicators were used to track the extent to which out of pocket healthcare payments present households with financial difficulties or push them into poverty. The first, is the percentage of households that did not incur catastrophic health care expenditure. Catastrophic healthcare expenditure refers to levels of out of pocket healthcare payments that present financial difficulties to households. The second, is the percentage of households that become poor because of out of pocket healthcare payments.



While the percentage of households facing catastrophic healthcare payments reduced between 2003 and 2014, the percentage of individuals that became poor or poorer as a result of out of pocket expenditures increased (figure 5).

Overall Measure of UHC



The overall measure of UHC, that combines measures of service coverage, and measures of financial risk protection, increased from 44% in 2003 to 53% in 2014 (figure 6).

Conclusions and policy recommendations

Kenya has made progress in increasing population coverage with both healthcare services, and financial risk protection. This implies that government efforts to expand access to priority healthcare services and reduce financial barriers are bearing fruits. These include policies such as the user fee removal and free maternity policies of 2013. However, population coverage is still low and characterized by inequalities where the rich have better coverage than the poor. About half of Kenyans (24 million) did not have access to essential healthcare services, and a third of Kenyans (14 million) were not protected from the harmful effects of out of pocket healthcare payments in 2013. Kenya was therefore halfway through (52%) its UHC journey in 2014 and still has a long way to go to achieve 100% population coverage with both needed healthcare services and financial risk protection mechanisms. While the slow progress towards UHC is perhaps symptomatic of weaknesses in all health system functions, we highlight here weakness of the health financing function (table 2).

- The Kenyan government has consistently underfunded the health sector.
- Kenya's health system is heavily reliant on donor funds and out of pocket payments
- Kenya's reliance on voluntary payments to the NHIF as a pathway to UHC is contributing to the country's slow UHC progress
- The overall structure of health financing contributions in Kenya has been shown to be regressive
- Healthcare purchasing in Kenya has been shown not to be strategic and hence compromises equity, quality and efficiency

Policy recommendations

- The Kenyan government should increase public financing of the health sector. Specifically, the level of public funding for healthcare in Kenya should double, if the threshold (5% of GDP) recommended by McIntyre et al (2017) it to be reached.
- The increase in public spending should be leveraged to scale up prepayment financing while reducing reliance on out of pocket payments. While user fees have been abolished in public health centers and dispensaries, accessing care in public hospitals, as well as private healthcare facilities still requires out of pocket payments.
- Kenya should reorient its health financing strategy away from a focus on contributory, voluntary health insurance, and instead recognize that increased tax funding is critical.
- Kenya should move away from passive purchasing, and adopt strategic purchasing practices to enhance the equity, efficiency and quality of healthcare service delivery.
- While several recommendations have been offered regarding improving purchasing in Kenya, we highlight here the need for Kenya to institute a systematic process for the development and regular updating of a harmonized benefit package that all Kenyans are entitled to.
- Such a benefit package should be evidence based, based on the needs of the Kenyan society, and developed using a procedure that is deemed legitimate and fair.

| Health financing indicators | 2002-2003 | 2005-2006 | 2008-2009 | 2013-2014 | 2015-2016 |
|---|-----------|-----------|-----------|-----------|-----------|
| Percentage of population with health insurance | 9.7 | n/a | 10.0 | 17.1 | 19 |
| Percentage of total health expenditure financed by public sources | 29.6 | 29.3 | 28.8 | 33.5 | 37 |
| Percentage of total health expenditure financed by donors | 16.4 | 31.0 | 34.5 | 24.7 | 23.4 |
| Percentage of total health expenditure financed by private sources | 54.0 | 39.3 | 36.7 | 40.6 | 39.6 |
| Percentage of total health expenditure paid for through out-of-pocket expenditure | n/a | n/a | 25.1 | 26.6 | 26.1 |
| Total health expenditure per capita (USD) | 51.2 | 59.5 | 66.3 | 77.4 | 78.6 |
| Government health expenditure % as percentage of total government expenditure | 7.9 | 5.1 | 4.8 | 6.1 | 6.7 |
| Total health expenditure as % of gross domestic product | 5.1 | 4.7 | 5.4 | 6.8 | 5.2 |
| Public expenditure on health | 1.5 | 1.4 | 1.6 | 2.3 | 2.2 |

Table 2 : selected health financing indicators for Kenya

About the Research

Related publications

This brief is adapted from a research paper published under the title, "Measuring Progress towards Development Goal 3.8 on universal health coverage in Kenya." <https://gh.bmj.com/content/3/3/e000904>

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