

# What is equity in health, and are Kenyans accessing equitable healthcare?

## 1. What does equity in health mean?

Equity refers to the absence of avoidable or correctable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically [1]. Equity in health has three broad measures, equal access to healthcare services for equal need; equal utilization for equal need; and equal quality of care for all [2].

## 2. Why does health equity matter?

As part of the Sustainable Development Goals, Target 3.8 on Universal Health Coverage (UHC), countries around the world have committed themselves to ensuring that every person has equal access to quality health services with protection from financial risk. Crucially, pursuing UHC means ensuring that no one is left behind; particularly the poor and vulnerable.

For Kenya, this aligns with Article 43 (1) (a) of the Constitution of Kenya which provides that every person has the right to the highest attainable standard of health. In fact, the President has committed, as part of the “Big Four Agenda”, to achieve Universal Health Coverage (UHC) by 2022.

## 3. What do we know about health equity in Kenya?

There exist avoidable disparities to both access to health services and the level of financial risk protection between Kenyans based on their level on wealth and other markers of their social status.

### a. Equity in access to protection from financial risk through insurance

Research carried out by KEMRI Wellcome Trust Research Programme shows that wealthier Kenyans are better protected than their poorer compatriots. Only 3% of the Kenyan poor have access to any health insurance coverage; compared to 38% among the rich. Put another way; even though only 19% of Kenyans are covered by any form of health insurance, only one out of every 12 of these people will be from the poorest part of the population. In fact, although there have been slight increases in the overall number of people with health insurance coverage between 2009 and 2014, most of this increase has been in the formal sector; characterised by people who are more likely to be well off.

Other research we have carried out suggests that the following features of the public health insurance – the National Hospital Insurance Fund (NHIF) may be working to increase the gap between the rich and the poor:

- Since membership is based on contribution of monthly premiums, those in the informal sector cannot contribute since they are poor or do not have consistent income flow to pay regular monthly premiums [3].
- Even though the contribution from members from the informal sector may seem low, it is based on a flat rate of KES 500 (\$5) per month [4], people from informal sector end up contributing a larger proportion of their income to the NHIF than those who are better-off. This is because the highest contribution rates for the NHIF are set at a maximum of KES 1,700 (\$17) per month meaning that a very wealthy person would not feel much of a pinch from this payment
- Key NHIF reforms have benefited the well-off. For instance, in a bid to expand health insurance coverage in Kenya, NHIF first expanded coverage to civil servants, who represent a sizeable number of the well-off population. This perpetuates inequity as a majority of Kenyans are in the informal sector.



**Figure 1: Health Insurance Coverage by Wealth, Employment and Education Status**

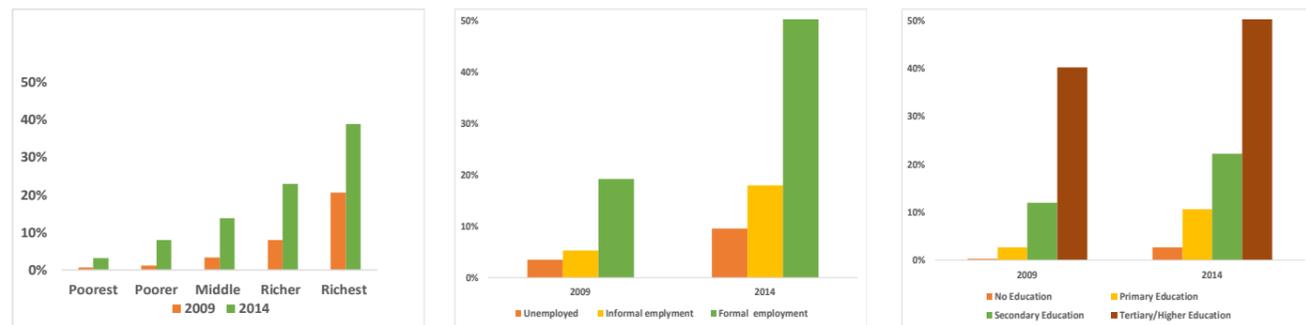


Figure 1.1: Health Coverage by wealth status

Figure 1.1: Health Coverage by employment status

Figure 1.1: Health Coverage by level of education

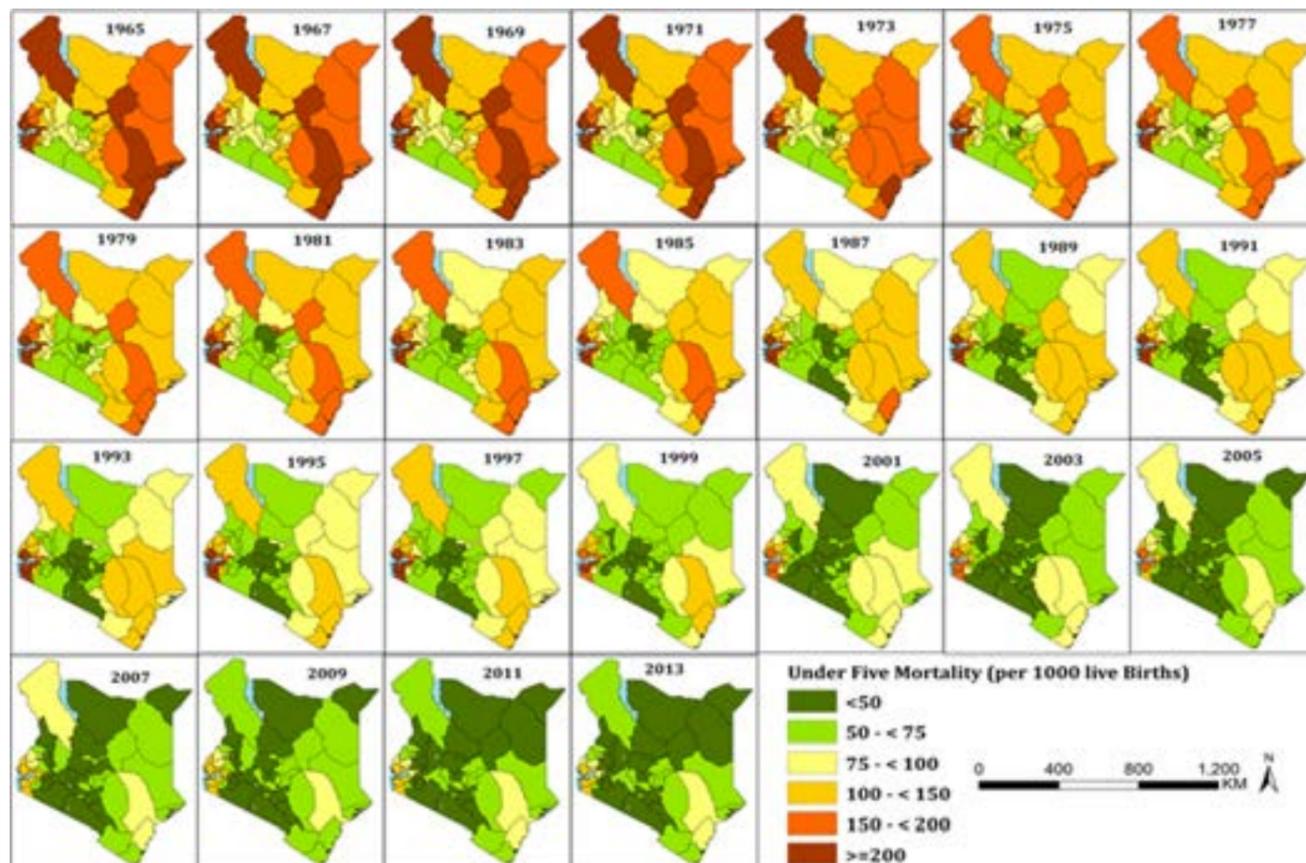
Source: Kazungu & Barasa (2017) [3]

**b. Equity in access to health services**

We have gathered and analysed data that show that there are avoidable differences in access to needed health services among Kenyans of different wealth status and even geographical location. Some of these data looks at the consequences of not accessing care when it is needed; i.e. that people, and especially children, may die. In the case of children, a commonly used measure is the number of children who die before they reach their fifth birthday; ‘the under-five mortality rate.’

We obtained data on deaths among children below the age of 5 (the under-five mortality rate) and mapped these to geographical areas of Kenya from 1965 – 2013 (Figure 2). Historically, (as indicated in the map by brown and orange coloured areas), the highest mortality rates are those in the coastal areas, the arid and semi-arid areas around Lake Turkana and those around the Lake Victoria region.

**Figure 2: Mean under five mortality per 1000 live births (U5M) at each of the 47 counties of Kenya every two years between 1965 and 2013**



Source: Macharia (2019)[5]

We identified that there were differences by region not only in the rate at which under-5s die, but also in factors that we think are linked to these deaths such as maternal education levels, stunting (children who are too short for their age) and the burden of diseases such as malaria. The data suggests that these factors also contribute to the avoidable differences in under-5 mortality that we observed. Figure 3 shows maps of these drivers of under-five mortality in Busia, Kakamega, Bungoma, Vihiga, Kisumu, Homa Bay, Migori, Kisii, Nyamira and Siaya counties.

**Figure 3: Under-Five Mortality and Selected Drivers in Western Kenya Counties**

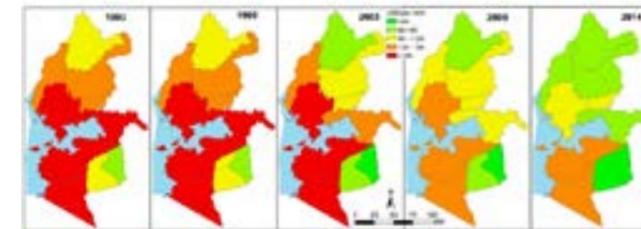


Figure 3.1: Western Kenya: U5M per 1000 live births

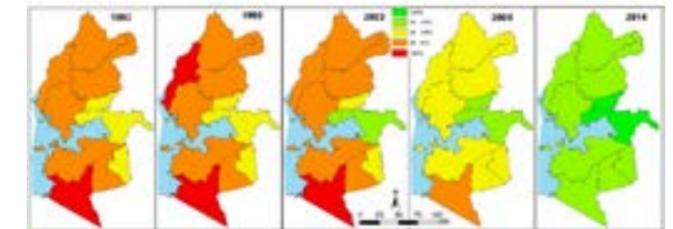


Figure 3.2: Stunting in Children in Western Kenya

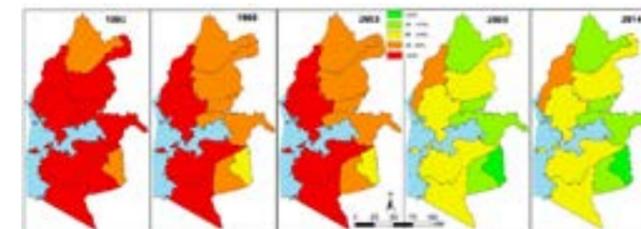


Figure 3.3: Maternal education: those with Less than primary school education

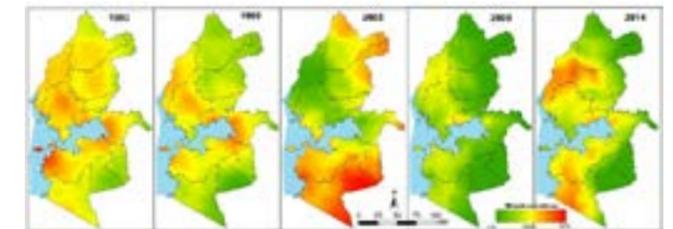


Figure 3.4: Malaria Prevalence in Western Kenya

Source: Macharia (2019)[5]; Macharia (2018)[6]

**4. What is the Government of Kenya doing to address these problems?**

In an effort to reduce such health inequities especially among the poor, the government introduced free maternity services and removed user fees in primary health facilities, dispensaries and health centres in 2013. The government also introduced the health insurance subsidy program (HISP) for the poor in 2014 (Text Box 1).

KEMRI Wellcome Trust Research Programme, and other agencies, have tracked the implementation of these programmes to inform the Government of their successes, to ensure that any challenges are addressed and to gain lessons for the future.

In terms of successes, these programs have reduced some of the financial barriers and improved access to health services which the poor would have previously gone without due to inability to pay [7,8].

**Text Box 1: The health insurance subsidy programme for the poor (HISP)**  
 HISP was introduced to improve access to protection from financial risk through provision of health insurance to the poorest households in Kenya. Under HISP, the National Hospital Insurance Fund (NHIF) premiums are fully subsidized by the government and through donor support. HISP beneficiaries access outpatient and inpatient care at NHIF accredited public, faith-based and low-cost private health facilities.

“Before [ free maternity services] people were fearful of delivering in hospitals because they were afraid that they could not be discharged because they didn’t have money. Therefore, they could just deliver at home”...

**Rural resident**

“When we didn’t have this card (HISP), it was a burden.... This card has helped many people. People used to suffer and they couldn’t go to the hospital, where would you get the money?”

**HISP beneficiary**

These programmes have also faced some challenges such as [7,8]:

- Informal payments (bribes) requested at health facilities and continued charging of user fees at primary healthcare facilities despite their removal.

*"It shouldn't be that when someone goes there it's written that it's free on the outside but when you enter the health center you are charged,"*

#### Urban resident

- Healthcare worker strikes at some of the public health facilities that the poor often sought care at which limited access and the quality of healthcare they received.

*"I am waiting for them [nurses] to go back to work [after the strike] and I will go to public a hospital. Isn't it lack of money that has made me not go to a private hospital? If I could afford, I would have been treated a long time ago,"*

#### Rural resident

- Delayed insurance disbursements for HISP beneficiaries
- Difficulty in accessing health facilities e.g. due to long distances, poor road networks and costly transport.
- Lack of drugs and other essential services at health facilities such as safe drinking water, sanitation facilities and access for disabled persons.

These challenges led the poor to continue making payments from their pockets e.g. for transport or to access medications or to pay bribes. In addition, difficulties accessing health facilities and discrimination by healthcare providers stopped some of the poor people from seeking care.

Discrimination by healthcare providers was a particular problem for poor people who had other challenges such as disability, as illustrated by Neema's story below.



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## Neema's Story

**Neema is 60 years old, she lives in an urban informal settlement and makes a living from selling groceries. She developed a physical disability when she was a one year old that left her paralysed on one of her lower limbs.**

She gave birth at home to her first three children because neither she nor her parents could afford to pay for a health facility delivery. She experienced difficulty while giving birth because she needed someone to support her weak limbs to enable her to deliver successfully.

*"I didn't have anyone who could take me to the hospital... My parents could not afford it...some women in the village helped me deliver."*

During her fourth and last pregnancy, she gave birth in a health facility, where she also decided to get her tubes tied. Her decision to go for a permanent method of family planning was based on the physical and verbal abuse she endured from her husband.

*"They (healthcare workers) told me because my husband has been beating me too much, the pregnancy is becoming smaller [retarded] instead of the baby growing well in the abdomen...I decided I will not give birth again...I decided to get my tubes tied"*

Neema eventually got divorced and moved back to her parent's house because her husband did not want a wife with disability.

*"My husband told me he doesn't want a disabled wife... he wants someone who can fetch water quickly...one who can go to the posho mill quickly...and then my marriage ended that way and I told myself I will not try to get married again"*

Neema was left largely dependent on her parents but after they died and having been divorced, she was left with no family support.

**Being a poor person living with a disability, Neema was selected to become a beneficiary of the government cash transfer program and later on the health insurance subsidy program for the poor (HISP).**

However, despite having a HISP card that enabled her to access free health services, she did not use it

to access care even after experiencing longstanding abdominal pains.

She feared she would be asked to pay to access care indicating that she didn't really understand that with the HISP card, she was entitled to free services at her chosen health facility.

*"I tell myself that even if I go (to the hospital), maybe they will ask me for money and sometimes I don't have money...it's good that now I am aware, I just used to stay with the card"*

She was also worried about healthcare worker's negative attitudes towards people with disabilities and this also prevented her from seeking care. Neema was concerned she would have to wait for a long period of time before being attended to.

*"I feel that we people with disabilities don't have someone who will attend to you quickly [at the hospital] and I tell myself I will leave there at night and what will my grandchildren eat?... I just stay at home"*

Neema also felt that the time seeking care could be better spent finding ways to provide and care for her family since she was the sole provider for her grandchildren.

*"If I go to the hospital if I leave the market, what will my grandchildren eat? Personally, what will I eat? Just that! Because I don't have anyone else who can help me...am just the way you are seeing me now"*

Neema felt excluded within the HISP programme itself. She felt that the program had negative stereotypes concerning her ability to participate in meetings and this limited her awareness about her entitlements under HISP.

*"They have never taken me for the awareness raising forums [for HISP]. They say they want someone who is educated and they leave me behind... They say we are selecting people who can talk and those who answer questions the right way... I wonder, 'Why don't they take me for the meeting one of these days and then they will find out if I will not answer [the questions?]'"*

*\*Neema's Story is adapted from research work carried by the KEMRI-Wellcome Trust Research Programme to assess experiences of the poor with free government health programmes that target the poor [7,8]. A composite character "Neema" was developed to protect the anonymity and confidentiality of study participants.*

## 5. What more needs to be done to ensure equity in health in Kenya?

Our research, and experiences from other settings, suggests that the following steps could reduce these avoidable differences.

- **Policy coherence:** The Government should look to make its policies on protecting the poor and vulnerable more coherent. This includes ensuring that policies speak to each other, encouraging more collaboration and coordination between national and county levels, and ensuring that everyone is clear about their responsibilities and their role.
- **Improve financial protection through more and better public spending:** The Kenyan government can ensure better protection from financial risk by taking steps to spend existing resources better, and increasing the level of public spending on health. These resources could be spent in ensuring that every Kenyan, including those who cannot afford it, are covered by the NHIF. These resources could also be spent in ensuring that services are available where needed e.g. ensuring that drugs and medical supplies are available or making sure that health workers offer the best quality care. There is also value in ensuring that resources at county and national level are allocated in a way that seeks to reduce these avoidable gaps.
- **Address the other factors that influence health:** Factors such as poor road access, poverty, low levels of education and poor access to safe drinking water also influence health. Many of these factors lie outside the health sector but remain within the control of the Government. Addressing these factors would influence key health outcomes such as the number of children who die before age 5.
- **Focus on the most vulnerable:** Ensuring the health system remains focussed on the most vulnerable is a useful way of ensuring that the poorest and other minority groups are never left behind. This includes implementing a range of measures such as ensuring health facilities are designed to accommodate persons with disability, as well as ensuring their participation in developing solutions to the challenges that they may face.

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### **About KEMRI-Wellcome Trust Research Programme**

The KEMRI-Wellcome Trust Research Programme (KWTRP) has delivered internationally competitive research and capacity building for the last 30 years. Established in 1989 as a partnership between Kenya Medical Research Institute (KEMRI), the University of Oxford, and the Wellcome Trust, the programme has two hubs in Kenya (Kilifi and Nairobi) and one in Uganda (Mbale).

The Nairobi Programme of KWTRP coordinates clinical, health services, health systems, and population health research, with results feeding directly into local and international health policy, and also aims at enhancing the country's capacity to conduct internationally competitive health research.

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