



# KENYA HEALTH FINANCING SYSTEM ASSESSMENT, 2018

## TIME TO PICK THE BEST PATH

## Kenya Health Financing System Assessment, 2018

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# ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ART	antiretroviral therapy
ARV	antiretroviral
BCTA	Business Call to Action
CHE	catastrophic health expenditure
COMESA	Common Market for Eastern and Southern Africa
CRF	county revenue fund
CT	computed tomography
FBO	faith-based organization
FY	fiscal year
GDP	gross domestic product
GOK	Government of Kenya
HIV	human immunodeficiency virus
HP+	Health Policy Plus
HSSF	Health Sector Service Fund
IMF	International Monetary Fund
IRA	Insurance Regulatory Authority
IUD	intrauterine device
KDHS	Kenya Demographic and Health Survey
KEMSA	Kenya Medical Supplies Authority
KEPH	Kenya Essential Package for Health
KHFS	Kenya Health Financing Strategy 2016–2030
KHHEUS	Kenya Household Health Expenditure and Utilisation Survey
KIHBS	Kenya Integrated Household Budget Survey
KNBS	Kenya National Bureau of Statistics
MDG	Millennium Development Goal
MEDS	Mission for Essential Drugs and Supplies
MES	Managed Equipment Services

MOH	Ministry of Health
MRI	magnetic resonance imaging
NACC	National AIDS Control Council
NASCOP	Kenya National AIDS and STI Control Programme
NCD	noncommunicable disease
NGO	nongovernmental organization
NHIF	National Hospital Insurance Fund
OOP	out-of-pocket
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
RMNCAH	reproductive, maternal, neonatal, child, and adolescent health
SARA	Service and Readiness Assessment
SARAM	Service Availability and Readiness Mapping
SDGs	Sustainable Development Goals
SHI	social health insurance
SHIF	Social Health Insurance Fund
TB	tuberculosis
THE	total health expenditure
UHC	universal health coverage
UHC-EBP	Universal Health Coverage Essential Benefits Package
USAID	U.S. Agency for International Development
VAT	value-added tax
WHO	World Health Organization



*Photo courtesy of White Ribbon Alliance*

## EXECUTIVE SUMMARY

### Introduction

This report assesses the Kenyan health financing system in light of ongoing reforms and the Government of Kenya's (GOK's) ambitious commitments to achieve universal health coverage (UHC) through multiple initiatives. International experience suggests that effective health financing reforms can advance UHC by mobilizing sufficient resources to provide the services necessary for good health and by ensuring that these resources are pooled and spent equitably, protecting citizens from financial burden when seeking healthcare. Whether Kenya succeeds in this endeavor will depend on congruent actions across national and county governments. These joint goals include increasing insurance coverage, strengthening the financing of primary care, increasing domestic spending for essential programs, and improving the efficiency of budget allocation, while engaging the private sector to enhance supply and choice. Current trends suggest that the health sector has built on an evolving maturity of political and fiscal devolution that began in 2012, with the county governments consolidating resources in county-level funding pools and increasingly spending on efforts to improve access and quality. However, there is still considerable inequality across counties in health resources and policy effectiveness. Across levels of government, there is emerging consensus on an eventual move toward single-payer health insurance evolving from the current National Hospital Insurance Fund (NHIF), though in this regard the actions of counties and the national government will need to harmonize better, since the insurance system as a whole requires major improvements in process and performance to drive population-level coverage of essential interventions. There is a need to pick a path in terms of the overall mechanism that will yield UHC. Currently, Kenya is experimenting with removal of user fees at a large scale, married to new supply-side spending to reimburse facilities and improve access to services. These are the basis of recent county-level Afya Care pilots and the county-led MakueniCare scheme, hinged on tax-funded and input-based financing of healthcare. The links from current user fee removal efforts and a long-term vision of an insurance-led model of guaranteeing and purchasing an essential package of services need to be better forged. Overall, Kenya shows a willingness for policy experimentation and is also a source of private market digital and financial innovation which, if harnessed, can accelerate key future health system solutions.

## Government Vision for UHC and Health Financing Reform

The GOK has committed to achieving UHC by 2022, as part of the current administration’s “Big Four” development agenda. While Kenya has made significant progress toward UHC across the usual dimensions, this ambitious goal still requires considerable additional resources and effort. In line with this, the *Roadmap Towards Universal Health Coverage (2018–2022)* details key objectives for advancing UHC in the next four years. Further, the government is strengthening the health financing system to underpin these UHC efforts, as articulated in the draft *Kenya Health Financing Strategy 2016–2030* (KHFS). As stated in these critical policy documents, expanding health insurance through NHIF is central to the UHC strategy. NHIF is at its core a social health insurance (SHI) institution, financing health insurance coverage for formal sector employees through payroll deductions. Kenya envisions expanding from this foundation and achieving universal insurance coverage across formal and informal sectors, with formal sector employers and employees sharing in the contribution amounts. In this vision, different levels of government will participate in subsidizing membership for the poor and vulnerable. Achieving high insurance coverage alone, however, will not be sufficient for UHC in Kenya. Covered benefits need to be more clearly defined, meet emerging population needs given Kenya’s epidemiological transition, and be purchased more efficiently and equitably than they are currently. Kenya has made major investments in its public health workforce, supplies, and infrastructure, as well as removing user fees for primary care, and these continue to be primarily resourced through tax-based funds. The country will increasingly need to ask if these initiatives in the health system are fit-for-purpose, given how the health financing structure will evolve and health needs will shift.

## Main Focus of This Assessment

This report is based on work conducted by the Health Policy Plus project, funded by the U.S. Agency for International Development. It assesses the current health financing system with a view toward informing future reforms. It especially takes stock of recent NHIF performance and trends in public financing of healthcare, given the growing role of county governments under the devolved system. Four key themes are explored throughout the report:

1. The impact of devolution on health financing trends and prospects
2. The evolving role of NHIF and its readiness to lead expansion toward universal health insurance
3. The expanding role of the private sector in service provision
4. Transition away from external financing and the basis for increased government spending on health

## Findings

**Kenya’s health outcomes have improved significantly, though some health areas lag behind.** Kenya’s Vision 2030 development agenda sets ambitious targets toward UHC in terms of financial protection, health service utilization, health service availability, and ultimately, health impact. Kenya has made significant progress in improving health outcomes. Overall, its 2015 UHC “service coverage index” was 57, based on a composite of different service delivery indicators analyzed by the World Health Organization. This is relatively high for the region. Under-five mortality in 2014, for example, was 30 percent lower than in 2008. Infant mortality fell 25 percent over the same period. However, Kenya is still far from its targets. Under-five mortality, for example, decreased by nearly half from the 1990 baseline of 98 deaths per 1,000 births to 52 in



2014, but this is still well above the target of 32 deaths per 1,000 births. These numbers also mask geographic disparities. The under-five mortality rate is 82 in Nyanza Province and 72 in Nairobi. North Eastern and Central Provinces, on the other hand, have under-five mortality rates of 44 and 42, respectively.

**Kenya has made significant progress in expanding health access, but disparities continue.** Access to essential services has improved. The longstanding Kenya Essential Package for Health (KEPH) is a package of key services defined along six health areas and was not previously guaranteed through financing reforms. Since 2018, a process to define an explicit benefits package to be covered under NHIF, drawing from KEPH, has garnered support. A guaranteed package may be more feasible than before, since between 2013 and 2016, there was an increase of 14 percentage points in the mean availability index of all KEPH services. Despite this overall improvement, the availability of services varies significantly across health area and geography. In 2016, for example, two-thirds of the facilities provided the full scope of essential health services, while no facilities offered the full range of services, including emergency and trauma services and services for all noncommunicable conditions. There are also wide inter-county variations. For example, about half of the 47 counties report health utilization rates above the national average (2.5 per capita per year), while nine counties report utilization rates of 30 percent or more below the national average.

**Kenya has taken individual policy actions toward financial protection that need to be integrated in a broader vision.** Kenya's recent history of deliberate pro-poor user fee policies has helped to improve use of health services among the poor to some extent, though the long-term vision for continuing these should be weighed against plans to expand health insurance coverage as a mechanism for financial protection. Two policies have been central to this effort. Linda Mama provides free maternal healthcare for mothers and children through the first year of life. A second policy abolished user fees for primary healthcare at public facilities. Despite evidence of the impact of these policies, persistent disparities in utilization continue across socioeconomic status and utilization, which suggests that removal of user fees without other investments in the availability and quality of services may not be sufficient. "Afyra Care" in four counties from 2018 to 2020 expands free services to the secondary care sector and provides additional reimbursements and investments into healthcare inputs to compensate facilities and plan for increased utilization.

**The ability to mobilize resources for health is continually increasing, with improved government revenue raising and prioritization of health, but limits to growth are on the horizon.** Expanded insurance contributions from the entire formal sector and the able-to-pay portion of the informal sector will contribute to a growing pool of resources in time that will cross-subsidize care for the poor if NHIF is reformed and a single payer and pool formed. It is necessary to realize this vision with milestones. The other perennial pool of resources for healthcare is general taxation, which will be needed for some time since the GOK will continue to invest in the availability, quality, and affordability of primary and secondary care. Kenya's current macroeconomic trend suggests that the government's capacity to mobilize resources and transfer them to counties will increase. The Kenyan economy has grown rapidly in recent years and is projected to continue to grow in the medium term. The national government's tax collection and the tax compliance rate are improving. Mobilizing sufficient resources for health will require continued effort for all levels of government. As in other sub-Saharan countries, the level of public debt continues to grow very rapidly, approaching 60 percent of the gross domestic product. Kenya's need to control public debt will restrain growth in social sector spending, especially with continuing security threats. Notionally, growth in government revenue mobilization has a ceiling imposed by structural factors such as the country's limited natural resource and commodity export base, significant and increasing informality in the economy, and limited manufacturing and modern services sectors. Counties have limited revenue-raising authority, and local tax capacity

and efforts vary widely. County revenues are highly dependent on national resource transfers. Few counties have a significant local tax base or collection capability, so the availability of resources for health will continue to depend largely on levels of national government resource mobilization and development partner spending. However, county spending on health is also a reflection of county government priorities. Overall, county spending on health is increasing; health was 25 percent of total county budgets in 2016/17, compared to 13 percent following devolution (2013/14). Nonetheless, national averages mask considerable inter-county disparities. Nyeri, for example, spent 39 percent of total county government expenditures on health in 2014/15, whereas Tharaka Nithi spent 9.7 percent.

**Processes allocating and executing resources for health have improved.** Increasing government revenue mobilization and budgetary allocation will not guarantee predictable resources for health unless funds are released and executed, on time and as per plan. Under devolution, public funds for health are mobilized at both the national and county levels. Total government budget allocations to health have increased in absolute terms but stagnated between 7 percent and 8 percent of total budget across levels for the last six years. Since devolution, Ministry of Health (MOH) expenditures have declined in absolute terms, reflecting the reduced role of the MOH in terms of retained functions. At the same time, the MOH's budget execution capacity has also declined; only 68 percent of the total budget was spent in 2015/16.

**General trends in total health expenditure suggest a continuing role for out-of-pocket (OOP) spending.** The amount of total health expenditure pooled through insurance has increased, but over half of health expenditure is still financed by households and external funders. Household spending is dominated by expenditures at the point of care, creating financial barriers and threatening the financial security of households. Despite policies like Linda Mama and free primary healthcare and efforts to increase prepayment through the NHIF, only a fraction of household spending on health is pooled. OOP spending accounts for almost one-third of total health expenditure. The continued health system and political relevance of OOP spending has motivated key national schemes and policy action.

**Health funds are increasingly pooled at the local level and contain resource transfers for new user fee removal schemes.** Devolution fundamentally changed the way resources flow through the health system, giving far greater control and discretion for health spending to county governments. Counties have autonomy in managing their finances, and all resources from the national level must flow through county revenue funds (CRFs). All federal funds, including those administered by the County MOH and some through NHIF, are allocated through the CRF. There are resources that flow into CRFs as conditional grants, earmarked for certain purposes. Prior to the Afya Care or "UHC pilots" in four counties beginning in 2018, these conditional funds primarily concerned funding the both free primary healthcare and Linda Mama user fee schemes. Free primary health services are reimbursed directly from CRFs to public primary health facilities. Linda Mama has been administered as a reimbursement model through NHIF since 2016. NHIF receives funds from the national government to largely pass through the CRF to reimburse public facilities, as well as contracted private facilities, for a benefits package of antenatal, delivery, postnatal, and newborn care.

**Current insurance coverage is low, though there are challenges to measurement.** According to data from the recent Kenya Household Health Expenditure and Utilisation Survey (KHHEUS), approximately 20 percent of individual Kenyans reported having some form of insurance coverage; 89 percent of those insured were covered under NHIF (MOH, 2018). These coverage rates vary significantly across geography and socioeconomic status. For example, approximately 41 percent of Kenyans in Nairobi reported having insurance coverage, while in Nyeri and Embu, about 32 percent were covered. In contrast, Wajir, West Pokot, Marsabit, Mander, and

Garissa all have coverage below 3 percent. Insurance coverage is also significantly higher among the wealthy. Only 2.9 percent of the lowest quintile report health insurance coverage, compared to 42 percent of the wealthiest. There are discrepancies, however, between KHHEUS coverage estimates, which are driven by individual responses, and NHIF-reported coverage data. In 2018, NHIF reported that based on primary membership of 7.66 million, it insures about 25 million Kenyans, or about 49 percent of the population. There are many possible explanations for the difference in coverage estimates. In dual-income households, for example, both earners contribute from their payroll. These families may be overcounted by NHIF estimation methods that multiply primary members by household size. This report explores these issues in more detail, but reliable data on true coverage rates will be critical for Kenya to develop and implement effective targets and scale-up strategies.

### **The shared roles of enhanced insurance coverage alongside tax-based health**

**spending need further clarity.** As NHIF coverage increases, inherently public health functions will continue to require public financing at both the national and county levels. The GOK will need to mobilize greater resources for health based on the assumption of continuing increased tax collection and compliance and better budget execution, as well as through public-private partnerships. County governments will need to finance their increasing responsibility for reaching and enrolling informal sector members in NHIF, including subsidizing premiums for the poor and vulnerable. This is particularly important given ambitious NHIF scale-up targets. As articulated in the *Roadmap Towards Universal Health Coverage*, Kenya intends to achieve universal coverage of mandatory SHI by 2022. Expanding outwards from inherently social health insurance is a possible mechanism for advancing UHC, as discussed in the conclusion of this assessment, and a current four-county Afya Care pilot program is valuable for learning. As of December 1, 2018, citizens in Isiolo, Kisumu, Machakos, and Nyeri could access a defined package of services at public facilities free of charge. True universal coverage, however, will require considerably more effort; current NHIF coverage by one measurement standard is less than one-fifth of the population. Therefore, there is a role for the expanding private insurance sector. The roadmap notes that voluntary insurance, like private or community-based schemes, can supplement services and benefits, particularly while the benefits package is still being defined and expanded. Through the MOH, the government can improve regulations, and coordination with the private market complements NHIF expansion and provides high-quality services.

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**GOK targets for growth in insurance coverage are extremely ambitious and may need rationalization.** NHIF is approaching near-saturation in formal sector enrollment, and future expansion will depend on its ability to reach and retain informal sector members. Membership is compulsory for the formal sector, and contributions are reliably deducted from their payroll by their employers; participation is voluntary for informal sector workers. Enrolling informal sector members with the ability to pay for insurance is difficult, and demand creation can be costly and of variable efficacy. It can also be more challenging to collect premiums from informal sector workers. Voluntary informal sector members are more likely to join when they are in need of services and to stop contributing when they are well, contributing to adverse selection. Kenya is employing a range of tactics to increase enrollment of the harder-to-reach informal sector. Cellphone-enabled platforms like the NHIF Mobile App, for example, are making it easier for informal sector

participants to save for and make contributions using M-PESA, the ubiquitous mobile money standard in Kenya. There are also significant county-level efforts to drive enrollment. Under the ongoing NHIF enrollment drives, for example, each county is responsible for targeting and enrolling a certain number of informal sector workers. The GOK is also targeting poor and vulnerable groups, subsidizing their enrollment. This includes Kenyans over the age of 70 and not receiving pensions, as well as individuals with severe disabilities. In addition, the GOK intends to target public secondary school students and continue enrollment of poor households.

**Familiar challenges in enrolling and retaining informal sector members in insurance exist, as do Kenyan innovations to address them.** The common challenges in enrolling the informal sector in Kenya, as seen elsewhere, go beyond enrollment and include raising contributions that allow high-quality services by mobilizing appropriate levels of revenue. Alongside efforts by county governments and nongovernment partners, NHIF is aiming at success in reaching the informal sector, much of which has some ability to pay, though re-enrollment and premium collectability are additional challenges. Utilizing mobile-based financial services and payments, which are universal in Kenya, NHIF and other financial services offerors can minimize barriers to re-enrollment and consistent contributions. While previous small micro-insurance providers using mobile technology have struggled to become financially sustainable, a few of these platforms have generated promise in introducing informal sector households to saving for future healthcare needs, and through a tie-up, act as a gateway for membership in NHIF. PharmAccess-supported M-TIBA, for example, is a mobile health wallet app which had enrolled 1.4 million users and paid out US\$4.6 million (KSh 476 million) in health benefits through late 2018. Through M-TIBA's NHIF Bora promotion, participants in the scheme can make contributions toward NHIF monthly premiums. Innovations such as the M-TIBA app may benefit future contributory system expansion, as they allow health-related contributions from both the individual as well as a sponsor, such as an employer, in both the general m-health wallet as well as in the NHIF promotion.

**There is a need to rationally expand and deepen benefits under existing health insurance and create fiscal space to afford an increase in subsequent utilization.** As NHIF works to expand coverage across these populations, it is also working to expand the services it offers its members. It initially included covered inpatient services, primarily “hotel costs” of care, such as fees for hospital stays. Benefits have grown over time, with the most significant expansion following the increase in contribution rates in 2015. The primary national benefits package, SupaCover, now covers an inclusive list of inpatient, outpatient, and ambulatory services, including for certain noncommunicable diseases, but actual provision and stated availability of these services at providers for clients bearing SupaCover continue to be below expectation. An expert panel was constituted in 2018 to recommend a revised benefits package for reaching UHC, and it made its recommendations. The GOK will need to consider repeated cost and actuarial analyses around guaranteeing such a package; initial cost estimates appear to suggest that it will be expensive. It will be critical for NHIF to define the appropriate mechanisms to pay for any expansion of its guaranteed benefits, designing and implementing effective contracting mechanisms and determining appropriate reimbursement mechanisms to compensate providers, ensure quality, offer financial protection to members, and control costs. NHIF's estimates of affording the expanded benefit package at an average cost per capita should be generated. Kenya will also need to work toward integrating the various schemes to reduce fragmentation and more effectively pool risk, which will require harmonizing the services covered under each scheme. National and county governments will also have to continue to invest in addressing the supply-side constraints to providing high-quality health services.

**A transition in external support to the health sector is gathering speed, and the GOK has responded adequately.** External funding is declining as a percentage of total health expenditure, though with a continuing role in financing key vertical programs. Much of external

spending on health is off-budget; for example, 73 percent of external funds were off-budget in 2015/16. This funding is increasingly targeted toward disease-specific programs such as HIV, tuberculosis, malaria, and maternal health. Off-budget support is more challenging for health sector strategic planning, as it is not captured in government budgets and may not easily adapt to shifting priorities at the county level. It may also not lead to local accountability by aligning better to government's setting of priorities, whether these are epidemiologically and programmatically correct or not. In light of these trends, it is promising that government spending on health now exceeds external funding. Domestic resource mobilization will be critical both to reducing the burden of OOP expenditure and closing the gaps left by declining donor funds. Further, even though off-budget support remains high, it is declining as a proportion of overall external resources. This offers the opportunity for increased government ownership and better coordination across domestic and external funders.

**Contracting levels with the private sector to expand access and choice do not sufficiently reflect where citizens prefer to receive services or the opportunity to reduce service loads at public health facilities.** The GOK is the primary provider and purchaser of health services, followed by NHIF. These purchasers do not sufficiently leverage a private health sector, which is playing a large role. The number of private facilities has been growing across all ownership types for providers, and together private health spending had a sixfold increase between 2009/10 and 2015/16. The extent to which Kenyans seek and access care from private providers varies across health domains. Family planning, for example, is nearly universally available at private clinics, and clients often prefer these providers due to perceived higher quality, faster service, geographical proximity, or greater privacy. HIV services, on the other hand, are less available in the private sector, likely because private for-profit providers cannot access subsidized HIV commodities or do not have the proper equipment or training. The government can increase access and choice by promoting an enabling environment, effective regulation, and strategic purchasing mechanisms that incentivize higher affordability, quality, and scale of private sector services.

**There are openings to expand the private sector's role in delivery of essential services, though well-designed purchasing systems are required.** The NHIF has been contracting with an increasing number of private providers for some of its schemes. With such providers, the right contracting and purchasing mechanisms can create incentives to increase availability of high-quality, low-cost services. They can also avoid unanticipated effects. For example, when the Marie Stopes Kenya's Amua network of providers was contracted with NHIF, capitation payments reduced incentives for providers to offer family planning services. Without better structured payments, family planning was seen as an additional cost, and provider-initiated family planning counseling declined. Similarly, without appropriate incentives and oversight, there is opportunity for fraud. The balance between necessary oversight and timely payments has led to tension between the NHIF and private providers. Strategies for tailored claims and medical information systems and rapid verification could assist in scaling key services through the private sector in partnership with the NHIF.

**Health financing reforms, as designed, currently do not sufficiently incentivize expansion in broader private health market activity.** There is opportunity for growth in the private pharmaceutical and medical device sectors in Kenya, but current market conditions and regulations are not supporting this growth. Over half of pharmaceuticals are procured through the public sector Kenya Medical Supplies Authority or through Mission for Essential Drugs and Supplies, a faith-based nonprofit system. For many commodities of public health importance, these mechanisms rely on external funds and are required to purchase from accredited manufacturers—and only one out of 34 Kenyan manufacturers is qualified. A major GOK policy to lease major medical equipment from international medical device manufacturers requires further evaluation to

understand its impact on service availability and cost efficiency. Government reforms that gradually favor local production, including investment in manufacturing capacity toward international standards, will allow the government to procure high-quality, locally manufactured pharmaceuticals and for Kenya to become a competitor in the regional pharmaceutical market. Further, there is an opportunity for increased public-private partnerships to leverage private sector resources and capacity for health. Current public-private partnership mechanisms are limited primarily to build-and-operate models that do not take full advantage of opportunities to incentivize efficient, high-quality service delivery. New partnerships are needed that can engage multiple stakeholders across the health sector to collaboratively develop and implement new models.

**The NHIF expansion framework has pro-equity dimensions; however, resources for subsidizing coverage for a significant share of the poor and vulnerable must still be found.** Many countries planning for an SHI base to expand UHC have adopted “progressive universalism,” i.e., first prioritizing coverage of the poor and vulnerable. Currently, civil servants and formal sector workers, both of whom typically belong to higher wealth quintiles in Kenya, enjoy benefits packages that are superior to sponsored programs for needier members. The financial protection principles inherent in Kenya’s Afya Care/UHC pilots of 2018–2019, as well as county-led initiatives such as MakeniCare, removing user fees around more services and the parallel drives to enroll more poor and vulnerable households in NHIF, are laudable, though not easily mutually reinforcing. The GOK should follow NHIF enrollment growth with a long-term plan for harmonization of benefits across the segments and required investment in the supply side of the health system to allow effectively equal access to health services. The total resources to pay a fair premium for these subsidized groups in the future, sufficient to sustain payments to providers of possibly expanded benefits as well as utilization, will require a financial commitment from the national treasury, as well as a plan for partial contribution from county governments.

**Deepening of benefits and expansion of coverage may lead to challenges in the sustainability of NHIF.** Given recently revised provider payment rates and alongside any expanded benefits package, there may be increased stress on NHIF’s financial sustainability. These issues, particularly from adverse selection in initial waves of voluntary members, as seen in other countries (e.g., Indonesia), can be managed if Kenya learns from best practices elsewhere when following an SHI-led model of insurance expansion. Efficiency improvements in its revenue collection, payments, and other processes are one necessary step. Here, the NHIF can also look to other country examples in improving quality assurance, claims management, and patient-oriented accountability, and in reducing voluntary members’ attrition through improved collection efforts. These challenges have been addressed in other schemes by first implementing a more robust social security governance structure that allows thoughtful and multi-sectoral stewardship of the expanded insurance scheme. In Kenya, as NHIF increases enrollment overall, especially in areas now implementing enrollment drives, these process and governance reforms need to be accelerated.

**Kenya’s plan for a consolidated, single-payer insurance model, building from the current NHIF schemes, can be a viable model of insurance expansion if challenges are addressed.** Success will depend on a consolidated scheme’s ability to pool resources from a large and diverse enrolled population with varying levels of contribution, as well as on tax revenue injected by the government. At present, this process must contend with the following key challenges:

- Multiple, fragmented pools formed by separated insurance schemes limit cross-subsidy and risk adjustment; these need to be consolidated, which faces resistance from existing members.

- The NHIF has limited ability to increase its revenue given the feasibility of premium and contribution reform.
- Benefits offered in terms of the package of interventions and limits are not harmonized across schemes.
- Several user fee removal and provider reimbursement schemes exist, like Linda Mama, the management of which has been added to NHIF's mandate, fragmenting its operations and the overall policy vision for financial protection.
- Despite county government efforts, there is continuing difficulty in sufficiently enrolling and retaining the subset of the informal sector with the ability to pay, and in targeting and increasing healthcare utilization of subsidized members (i.e., poor households, the elderly).
- Due to a lack of prioritization, provider payment processes and strategic purchasing orientation remain weak.

## Conclusion

There is skepticism that countries can truly advance UHC by scaling up to universal levels of insurance coverage through a “top-down” approach that began, as it has in Kenya, with mandatory enrollment and better benefits for wealthier socioeconomic groups. However, with pragmatic incrementalism and fiscal planning, Kenya's approach can succeed, as it has in a few countries, and may be feasible. The health system will very likely proceed through several phases, which are also suggested in the *Roadmap Towards Universal Health Coverage (2018–2022)*. These are highlighted in Annex B. In the immediate phase, resources for subsidizing healthcare and NHIF membership for a large portion of the poor and vulnerable must be allocated and effectively targeted. The currently proposed essential benefits package for UHC, or UHC-EBP, needs to be subjected to repeated financial sustainability analysis, further prioritized according to Kenya's disease burden, and made universally available to all beneficiaries if it is to attract more voluntary enrollment. In this transitional, interim phase up to the effective formation of SHIF—i.e., until universal insurance-based benefits are defined and purchased from a broad mix of providers for most of the population—public, tax-funded, free and subsidized healthcare will be critical in protecting against the costs of ill health and in continuing the progress in improved health outcomes. A focus on NHIF expansion does not obviate the need for strong public spending on primary healthcare across levels of government, especially for strengthening health system resources for commodities, equipment, and the workforce. Other countries that have achieved high insurance coverage, as well as financial protection and improved health outcomes, have first prioritized these investments, and Kenya should accelerate its progress in the same manner.



Photo courtesy of Espen Faugstad

## 1. INTRODUCTION

**The Government of Kenya (GOK) is committed to achieving universal health coverage (UHC) by 2022.** The 2010 Constitution provides for the right to health and aims to ensure that all Kenyans have access to quality, equitable healthcare without suffering financial hardship. This commitment is reflected in *Kenya Vision 2030*, the long-term national development blueprint, which states the country’s goal to create an efficient, high-quality healthcare system to improve the well-being of all Kenyans (GOK, 2007). Most recently, the GOK has committed to achieving UHC by 2022. Improved health for the population is one of the government’s “big four” development priorities, which are affordable housing, economic growth, food security, and universal access to affordable healthcare. From 2018, the government has launched pilot mechanisms that work through devolved levels of government and aim to reduce out-of-pocket (OOP) spending for health among households, and it has finalized a financing strategy for raising health insurance coverage. The government’s *Roadmap Towards Universal Health Coverage (2018–2022)*, details nine key objectives for achieving UHC over the next four years (see Box 1) (GOK, 2018).

**This report, based on work conducted by the Health Policy Plus project and funded by the U.S. Agency for International Development, assesses the state of the country’s health financing system in the context of this ambitious commitment to achieve UHC by 2022, as well as given devolution and ongoing health financing reforms.** Since the 2010 Constitution wrote devolution into law and related implementation began after the 2013 elections, the Kenyan health system has evolved to incorporate the role of county governments and new national initiatives removing user fees, with both benefits and challenges for health service delivery. At the same time, the GOK is strengthening the institutions that can deliver UHC, and these goals are articulated in the KHFS (MOH, forthcoming). The proposed reforms to health financing arrangements, as stated in the KHFS, are intended to better mobilize and pool funds for healthcare, and as a part of this process, to raise insurance coverage—with the result that better access to health services will be achieved, utilization of health services will rise, and financial protection from the costs of ill health for vulnerable families will be provided.



### Box 1. Key objectives for advancing UHC outlined in the *Roadmap Towards Universal Health Coverage (2018–2022)*

1. Universal coverage of health insurance
2. Universal access to an explicit unified progressive health benefits package
3. Increased availability and coverage of quality essential interventions
4. Financial risk protection for all Kenyans, particularly poor and vulnerable populations
5. Mobilizing adequate resources for delivery of health services
6. Efficiency in allocation and use of existing resources
7. Equity in distribution of services and resources
8. Effective regulation and collaboration with private medical insurance companies focused on UHC
9. Strengthened health sector leadership and governance for UHC

Source: GOK, 2018

**As of November 2018, both the roadmap and the KHFS identify the creation and expansion of the single-payer Social Health Insurance Fund (SHIF) as a key health financing reform.** Both documents envision the existing National Hospital Insurance Fund (NHIF), which until now has acted primarily as a social health insurance institution, as evolving into the SHIF by achieving high coverage in both formal and informal employment sectors, with different levels of government subsidizing membership for the poor and vulnerable (MOH, forthcoming). Annex A suggests the roles of different actors in this long-term development. Achieving high insurance coverage will not be sufficient for UHC in itself if the covered benefits package is inappropriate or inadequate for Kenya's disease burden, and if resources for the public health workforce, supplies, and infrastructure, which continue to be primarily resourced through tax-based funds, remain insufficient or poorly allocated. In 2018, the GOK began the process of defining a benefits package aligned with the roles of NHIF and county governments. It also began "UHC pilots," termed Afya Care, in four counties.<sup>1</sup> This report provides a summary of all these actions against the backdrop of the recent trends in financing healthcare through the public health system and the recent performance of NHIF. The chapters in this report summarize and discuss key aspects of the health financing system, with a view toward the potential of current reforms to advance UHC.

**Health financing reforms can advance UHC by mobilizing sufficient resources to provide the necessary services for good health and by pooling and distributing those resources in an equitable manner that ensures that everyone can access care without financial burden.** This relationship of health sector reform to UHC goals can be viewed through the lens of the World Health Organization's (WHO's) UHC cube showing the three dimensions of population coverage (breadth), quality and adequacy of the package of services provided (depth), and level of financial protection (height). The health financing system should not only be able to

<sup>1</sup> Beginning in December 1, 2018, citizens in four counties are able to access a defined package of services at public facilities free of charge with some funds flowing through the NHIF. The Afya Care pilots are intended to test the system's ability to handle provision of the expanded package and inform national expansion of such a program. The pilots are described further in Chapter 5 of this report. They are separate from wholly county-led efforts, such as the MakeniCare scheme in Makeni County. MakeniCare is also discussed in Chapter 5.

mobilize adequate resources to fill as much as possible of this cube, but it should also manage funds in a manner that creates the largest pools possible, yielding the benefits of cross-subsidy across the poor and the rich, the healthy and the sick, as well as greater efficiency in procurement. Institutions in the system should use these pooled funds to purchase services from a diversity of providers in a way that ensures equity, efficiency in allocations, and technical efficiency. Health financing reforms can directly impact the dimensions of the cube by changing the extent of financial protection in terms of the share of healthcare costs incurred at the point of consuming care that is covered by a health financing scheme, especially schemes offering prepayment and subsidies for the poor, and the extent of the population covered and the health services included under health financing schemes, such as insurance or free tax-funded public provision. The way resources are raised for paying for healthcare matters, much depends on the ability of the public taxation system to mobilize revenue, as well as the underlying growth in the population's average incomes and ability to pay for some proportion of its own healthcare. This report will assess the trends in Kenya on these fronts.

**Government-directed health financing reforms to raise health insurance coverage are critical to achieve UHC, but they are insufficient on their own.** Box 1 suggests the magnitude of the changes desired by the GOK for UHC in Kenya. It is clear that health financing reforms focused on the NHIF and on national-level policies related to user fees for health at public facilities must be complemented by other measures to strengthen the overall health system, such as ensuring an adequate health workforce and infrastructure and involving the private sector in health service delivery and financing (GOK, 2018). Achieving UHC would also require raising awareness among citizens of their health-related rights, the available health financing options and, more generally, on behaviors that promote better health. These issues related to health communication and behavior change are outside the main scope of this report. However, this report does look beyond the currently highlighted health insurance reforms and includes discussion of trends in financing public health systems from tax-based sources and the evolving role of different levels of government in Kenya after devolution.

**In assessing how far the country has to go, Kenya has made significant progress in improving the health outcomes of its citizens and advancing on all three dimensions of the UHC cube, but progress remains incomplete and inconsistent.** In an example of overall outcomes, Kenya reduced under-five mortality in 2014 by 30 percent from its 2008 level. Infant mortality fell by nearly 25 percent in the same period (KNBS et al., 2014). These values for the indicators are above the Millennium Development Goal targets for Kenya for 2015 (see Chapter 3). The country's UHC service coverage index, computed by WHO, was 57, which was relatively high in the context of sub-Saharan Africa (World Bank, 2017). The health system still faces significant supply-side constraints to meeting overall health outcome goals, particularly with insufficient and unequally distributed human resources and health facilities that limit the country's ability to expand service coverage. The GOK has responded with investment in facility equipment, and the health sector workforce has grown, accompanied by the financial pressures resulting from paying for wages. Financing roles in this context of supply-side needs have shifted since devolution toward county governments. Later chapters in this report will provide further assessment of the trends in these areas. In a devolved system, national and county governments will have to act together to resolve significant disparities in access and health outcomes persisting across counties and household income levels.

**Though declining, the Kenyan health system continues to feature a high share of OOP expenditure in health spending, which has implications for healthcare access and financial protection.** Since financial year 2009/10, OOP expenditure has consistently accounted for at least 25 percent of the total national health expenditure in periodic national health account analyses (MOH, forthcoming). In 2015/16, this share was higher than resources from external

fundes (i.e., development partners), which also signifies an overall transition. Such OOP spending places a significant burden on poor and vulnerable households and acts as a barrier to care; in 2018, one-fifth (19.4 percent) of households cited high cost as a primary reason for not accessing health services at a facility, a figure relatively unchanged from a previous measurement in 2013 (MOH, 2018). These statistics worsen for poor households, reflected in lower per capita healthcare utilization rates, lower service access, and higher likelihood of foregoing facility-based healthcare. Further, the continued trend for OOP spending threatens the poorest Kenyan households with catastrophic health expenditure (CHE). Incidence of CHE, measured as OOP spending exceeding 40 percent of total non-food expenditure, declined between 2013 and 2018, though at 4.9 percent it is still higher than the regional estimate of 3.3 percent for Africa in 2010 (Barasa et al., 2017; MOH, 2018). Strategies the GOK is currently exploring are to expand prepayment scheme coverage and target government subsidies to vulnerable populations.

**The current macroeconomic and fiscal environment suggests opportunities for the Kenyan government to invest more in health, though this sector must compete with others for budgetary allocations.** Gross domestic product (GDP) has been growing between 5 and 6 percent a year since 2014 and is forecasted to continue to grow at 6 percent to 6.5 percent annually in the medium term (The National Treasury, 2017). Tax reforms in recent history increased government revenue, particularly through direct taxes, though recently revenues have underperformed compared to targets. In comparison, government expenditures, both at the national and county levels, are increasing, and overall, the public sector remains heavily indebted with a significant ratio of interest payments to total non-grant revenue. The opportunities presented by overall economic growth and stable tax revenues, however, will not necessarily translate into increased health spending without a desire to allocate to the sector at all levels. In this report, we consider the nature of devolved responsibilities for the social sector, especially health, and how county governments must allocate more from their share of a growing national revenue.

**Kenya is now fiscally devolved, and primary responsibility for delivering primary and secondary health services falls to the counties.** Post-devolution, most funds for primary and secondary healthcare, along with those for other needs under county jurisdiction, must be derived from the pool represented by the county revenue funds (CRFs), which in turn operationalize the concept of county revenue funds. These accounts receive general transfers from the national treasury, locally generated tax revenues, and for health, conditional grants as transfers from the national level for special programs such as those for user fee removal, and NHIF payments to county-operated facilities. These mechanisms, which were established under the Public Financial Management Act of 2012 (revised 2015), force pooling through the CRFs. This gives counties greater control over funding their annual development plans, but it may or may not lead to prioritization of health spending. Recent trends in county-level allocations to health are discussed in Chapter 4 of this report. Inefficiencies remain, and funds flowing into the CRF, i.e., from development partners and national government sources, are sometimes not spent as intended. The amount allocated to health is a question of county priorities. National institutions and their partners will have to consider what support counties need to allocate resources to health appropriately, such as further institutionalization of program-based budgeting at the county level.

**The KHFS articulates a pathway toward Kenya's ambitious goals for universal health insurance that is also outlined in the roadmap.** The draft KHFS attempts to align key features of Kenya's health financing system around recently stated UHC objectives, such as ensuring access to quality services for the whole population without financial hardship. Although its centerpiece is the reformulation of NHIF as a single-payer system in the eventual form of the SHIF, this strategy has to contend with the existing effectiveness of NHIF in mobilizing revenue as a social health insurer, purchasing services from public and private providers enrolling members

and serving their healthcare needs. In the last few years, NHIF has undertaken considerable reforms and made a major effort to appeal to potential voluntary enrollees in the informal sector. Still, the prospect of major growth in NHIF's mandate will also require the GOK to assign a benefits package appropriate for SHIF, and for NHIF to anticipate the financing requirements to effectively cover those benefits. The latter will also involve addressing systemic weaknesses and inefficiencies, including reforms to NHIF governance and internal processes across purchasing, claims management, quality assurance, and other key areas (Barasa et al., 2018; MOH, forthcoming).

**Overall, this report assesses the current health financing system with an eye toward future reforms in support of Kenya's progress toward UHC.** It first presents a brief assessment of Kenya's progress toward UHC on key indicators, with particular attention to indicators of equity across counties and wealth quintiles (Chapter 3). It then assesses government resources for health at both the national and county levels, with consideration of the current macroeconomic and fiscal context (Chapter 4). Chapter 5 presents the current state of insurance schemes in Kenya, including government-supported social health insurance and private schemes. The report then discusses other sources of financing for health, namely external and OOP spending, and how these sources of funds are evolving (Chapter 6). The report also highlights opportunities for sustainability and efficiency in the health financing system through new, innovative practices, and the role of the private health sector (Chapters 7 and 8).

**The analysis concludes with discussion of prospects of health financing reform for advancing UHC, given Kenya's current landscape and goals.** This discussion includes four key themes, explored throughout the report:

- The impact of devolution on health financing trends and prospects
- The evolving role of NHIF and its readiness to lead expansion toward universal health insurance
- The expanding role of the private sector in service provision
- Transition in external financing and the basis for increased government spending on health



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## 2. METHODOLOGY

**This assessment builds upon current and past approaches to health financing system assessments to provide a comprehensive, forward-looking assessment of the system's role in advancing progress toward UHC.** The core methods for health financing system assessments have evolved in recent years, along with the purpose of such analyses. Health financing was one of the six health system modules in the Health System Assessment Approach developed with support from the U.S. Agency for International Development (USAID) in 2008–2012 (Health Systems 20/20, 2012). The World Bank has also proposed a new approach, which emphasizes similar areas: country context, health and UHC outcomes, health financing functions, and the health system in general (Health Financing Global Solutions Group, 2016). Current thinking suggests that assessments in the domain of health financing must go beyond focusing only on insurance or public financial management issues and instead comprehensively identify where the strengths and weaknesses lie in the context of a country's overall efforts to achieve UHC (see, for example, Cavanaugh et al., 2015).

**This assessment aims to gather all the available data on the status and functioning of health financing mechanisms as a basis for designing and assessing health financing reforms to advance progress toward UHC in Kenya.** It examines the challenges and the opportunities to advance UHC within this context, particularly through the expansion of Kenya's NHIF, given the central importance of this institution in the KHFS. This document serves as a companion to proposed reforms, including those in the KHFS, and for understanding their potential for success in advancing UHC.

### Data Collection

**Data were collected around key modules to capture a comprehensive picture of both the health financing and broader health system context in Kenya.** These modules guided the process of defining the scope of this health financing systems assessment, as well as to target the data collection process. Table 1 provides an overview of the key areas of data collection for this assessment. It does not reflect the ultimate organization of the report, but rather the overall approach to the assessment, in line with evolving approaches to assessing health finance systems. The four key themes listed in the introductory chapter informed the interpretation of the data collected and summarized in this report.

Table 1. Data collection structure informing the HFSA

Modules	Key Topics
1. Country context	<ul style="list-style-type: none"> <li>▪ Demographics and poverty</li> <li>▪ Macroeconomics</li> <li>▪ Fiscal policy and taxes</li> <li>▪ Government budget</li> </ul>
2. Current health outcomes	<ul style="list-style-type: none"> <li>▪ Key population trends</li> <li>▪ Mortality rates</li> <li>▪ Reproductive, maternal, newborn, and child health, HIV, malaria, and tuberculosis indicators</li> </ul>
3. Health system context	<ul style="list-style-type: none"> <li>▪ Health policies</li> <li>▪ Health infrastructure</li> <li>▪ Health workforce</li> <li>▪ Logistics and supply chain</li> <li>▪ Fiscal decentralization in health</li> <li>▪ Dimensions of total health expenditure</li> </ul>
4. Health financing institutions and functions	<ul style="list-style-type: none"> <li>▪ National and county budget and expenditure</li> <li>▪ External funding for health</li> <li>▪ Health insurance (NHIF)</li> <li>▪ Purchasing mechanisms</li> <li>▪ Health benefits package(s)</li> </ul>
5. Household behavior and financing outcomes	<ul style="list-style-type: none"> <li>▪ Where is care sought</li> <li>▪ Sources for commodity purchase</li> <li>▪ OOP and financial protection</li> <li>▪ Asset ownership, banking</li> </ul>
6. Key health financing interventions	<ul style="list-style-type: none"> <li>▪ Results-based financing</li> <li>▪ Vouchers</li> <li>▪ Other demand-side interventions</li> </ul>
7. The health market	<ul style="list-style-type: none"> <li>▪ Private actors in service provision</li> <li>▪ Pharmaceutical sector</li> <li>▪ Private health insurers and/or health maintenance organizations (HMOs)</li> <li>▪ Social marketing and franchises</li> <li>▪ Regulation and stewardship</li> </ul>

**For this national-level systematic assessment, the study team conducted a synthesis of existing studies and analysis of secondary data on the Kenyan health sector (Table 1), using a wide range of data sources.** The MOH, Ministry of Finance, Kenya National Bureau of Statistics (KNBS), NHIF, and Kenya Insurance Regulatory Authority (IRA) data were reviewed. The datasets included macroeconomic indicators, demographic data, health expenditure and utilization, and the results of various recent household surveys, including the 2014 Kenya Demographic and Health Survey. Both the report of the 2015 Kenya Integrated Household Budget Survey (KIHBS) and the report for the 2018 Kenya Household Health Expenditure and Utilisation Survey (KHHEUS) were used, as raw datasets for these surveys are not yet available, which prevented further customized analysis of key indicators. The assessment also comprised review of data and findings from peer-reviewed literature, as well as publications from the GOK and international organizations involved in the health financing and public financing systems of Kenya, such as the World Bank, International Monetary Fund (IMF), and WHO. As appropriate, to ensure that the most recent and accurate data were used, the assessment team referenced results of

surveys and analyses on which the USAID-funded Health Policy Plus project is currently collaborating with the GOK (e.g., the *Kenya National Health Accounts 2015/16* [MOH, 2017b], and the 2015/16 to 2017/18 National and County Health Budget Analyses). For market-based data, news articles and press releases from various private companies were reviewed.



Photo courtesy of SIM USA

### 3. MONITORING PROGRESS ON UNIVERSAL HEALTH COVERAGE IN KENYA

**Kenya's health financing system will play a critical role in moving the country toward UHC.** Its progress on key health and UHC indicators can signal the extent to which the health financing system has advanced this goal thus far (see Table 2). This chapter examines Kenya's recent improvements in key health outcomes and the availability, coverage, and utilization of health services. While Kenya has made significant progress toward UHC, the progress is incomplete against national goals, and inequities across counties and among wealth quintiles remain. Balancing investments into resolving supply-side barriers to access and demand-side financial barriers to utilization will be key on Kenya's journey toward UHC, with a role for both national and county governments.

**The GOK is committed to achieving UHC.** The 2010 constitution commits to providing equitable, affordable, and high-quality healthcare to all Kenyans. This commitment is reflected in *Kenya Vision 2030*, a long-term national development framework, as well as the *Kenya Health Sector Strategic Development Plan (KHSSP) 2014–2018*, which sets medium-term targets for key health indicators, “accelerating progress towards UHC” (MOH, 2014c). Kenya's goals for achieving UHC are in line with its commitment to the Sustainable Development Goals (SDGs), in particular Goal 3, to “ensure healthy lives and promote well-being for all at all ages.” More recently, UHC is a pillar of the government's “Big Four” development agenda; through this agenda, the government has pledged to reach UHC by 2022. The *Roadmap Towards Achieving Universal Health Coverage (2018–2022)* outlines how Kenya intends to reach these commitments and to ultimately improve health outcomes across disease areas, geography, and socioeconomic status.

**Kenya's 2030 development agenda sets ambitious targets for key indicators measuring progress toward UHC in terms of financial protection, health service utilization, health service availability and, ultimately, impact.** Although there is no single formal UHC framework, these targets are included throughout several key national policy and health strategy documents. The National Health Policy 2014–2030, for example, has clear impact-level indicators related to essential healthcare (MOH, 2014a). The KHSSP mid-term targets include reducing infant, neonatal, and maternal mortality by at least half and reducing CHE by 30 percent (WHO, 2015). The *Reproductive, Maternal, Neonatal, Child, and Adolescent Health (RMNCAH)*



Table 2. Kenya's progress toward key UHC-related targets

	Indicator	Most Recent Value (Year)	2030 Target
Health Financing <sup>i</sup>	THE per capita (USD)	US\$78.6 (2015/16)	US\$357
	Government expenditure on health as percentage of general government spending	6.7% (2015/16)	13%
	Government (public) spending on health as percentage of THE	37% (2015/16)	51%
	Public spending on health as percentage of GDP	5.2% (2015/16)	15% (Abuja Declaration)
	Public health spending per capita (USD)	US\$25.6 (2015/16)	US\$310
Financial Protection <sup>i</sup>	Percentage of population enrolled in some form of health insurance (MOH, 2018)	19.9% (2017/18)	85%
	OOP spending as percentage of THE	26.1% (2015/16)	15%
	Percentage of population incurring CHE (MOH, 2018)	4.9% (2018)	2%
	Percentage of indigent population benefitting from subsidies (MOH, forthcoming)	2% (2017)	2%
Health Service Availability <sup>ii</sup>	Percentage of population within 5 km of a health facility	80% (2014)	100%
Health Outcomes <sup>iii</sup>	Life expectancy	58 (2014)	72
	Neonatal mortality rate (per 1,000 births)	22 (2014)	13
	Infant mortality rate (per 1,000 births)	39 (2014)	20
	Under-five mortality rate (per 1,000 births)	52 (2014)	24
	Maternal mortality rate (per 100,000 births)	362 (2014)	113

Source: <sup>i</sup> *National Health Account 2015/16* (except where otherwise noted) (MOH, 2017b); <sup>ii</sup> *KHSSP 2013–2017* (MOH, 2014c); <sup>iii</sup> *KDHS 2014* (current status) (KNBS et al., 2014) and *Kenya Health Policy 2014–2030* (2030 target) (MOH, 2014a)

*Investment Framework* pushes Kenya toward attainment of the SDGs by setting ambitious goals for RMNCAH service coverage, including increasing skilled deliveries to 87 percent and the contraceptive prevalence rate to 73 percent by 2020 (MOH, 2016b). The KHFS has set clear goals toward sustainable health financing and financial protection (MOH, forthcoming). These policies set 2030 goals for dimensions of UHC, including financial protection, health service utilization, health service availability and, ultimately, impact, such as reducing maternal mortality to 113 per 100,000 live births, under-five mortality to 24 per 1,000, and HIV incidence by 80 percent (MOH, 2014a; NASCOP and NACC, 2014).

**The GOK has enacted several policies dedicating government resources to advance progress in these key health areas.** In 2013, for example, the government instituted free maternal healthcare and abolished user fees for primary healthcare at public facilities (see Box 2). These policies are intended to advance UHC by lowering financial barriers and promoting increased use of key services, particularly while Kenya works to expand health insurance coverage. Following their implementation, both policies have shown initial indications of improving

utilization. However, initial implementation faced challenges in timely disbursement of funds, lack of clarity around what and whom the policies covered, and supply-side constraints (Maina and Kirigia, 2015). Further assessment is also needed to understand their ability to serve poorer, marginalized populations and their implications for equity. Box 2 discusses these policies in more detail.

## Box 2. User fee removal policies initiated in 2013

### Abolishing User Fees at the Primary Healthcare Level

- Services covered: Primary healthcare
- Facilities included: Public primary healthcare facilities, including public dispensaries and health centers
- Cost reimbursed: Historical value of user fees, adjusted annually for expected increases in use of services

Kenya removed most user fees at public facilities in 2004, except for a registration fee of either KSh 10 or KSh 20. Commonly referred to as the 10/20 Policy, this was intended to reduce barriers to healthcare for the poor and vulnerable. In reality, adherence was mixed, and facilities continued to charge more for services (Onsomu et al., 2014). In 2013, the government responded by completely abolishing fees in public dispensaries and health centers. The 2013/14 budget allocated a budget of KSh 700 million to compensate facilities for the loss of revenue from user fees with funds transferred through the Health Sector Service Fund (HSSF) (Maina and Kirigia, 2015).

Initial analysis two years after implementation indicates that the policy did, in fact, increase utilization of health services. Total outpatient services for children under five, for example, increased by 25 percent. The same study implied some pro-poor benefits, such as an increase in the use of public facilities by lowest quintile patients, but further study is required to determine the equity impacts more conclusively (Maina and Kirigia, 2015).

The policy's initial rollout faced challenges in implementation and funding. There was a lack of clarity around who was covered by the policy and for what services (Maina and Kirigia, 2015). Further, the funds administered through the HSSF often saw delays in disbursement, and interviews conducted shortly after the implementation of the policy suggested that facilities found the compensation insufficient (Onsomu et al., 2014; Maina and Kirigia, 2015). Under the devolved system, funds now flow directly through county revenue accounts to health facilities, with the intention of increasing efficiency and county ownership. This is discussed further in Chapter 4.

### Free Maternal Healthcare (Linda Mama)

- Services covered: Package of benefits for women and newborns through the first year, including antenatal care, delivery, and postnatal care
- Facilities included: Contracted public and private facilities
- Costs reimbursed: Capitation payment for outpatient services (KSh 1200); fee-for-service for deliveries and inpatient services

In 2013, the Kenyan government implemented a policy of free maternity health services in all public health facilities. Similar to removing user fees, the intention was to remove financial barriers to accessing health services. The government hoped to increase utilization of maternal health services and, as a result, improve health outcomes. The government committed KSh 3.8 billion in the first fiscal year, transferred through the HSSF, to compensate facilities for free services provided under the policy. This fund was intended to reimburse the full cost of these services (unlike the KSh 700 million allocated in 2013/14 to compensate solely for the loss of user fee revenue).

Evidence suggests that this policy has had success. In the first month after it was implemented, the Kenyan Director of Public Health and Sanitation estimated a 10 percent increase in institutional visits (PSI Impact Blog, 2013). An initial study evaluating the impact of the policy indicated that the mean number of deliveries increased by 64 percent at Kakamega County Referral Hospital and confirmed a significant increase in national utilization of delivery services (Asule et al., 2017).

Initially, however, the policy faced many implementation challenges, including funding and supply-side resource constraints. One hospital reported, for example, that it previously charged KSh 5,000 per normal delivery and KSh 10,000 per caesarean. The policy had a flat reimbursement rate of KSh 5,000, creating a significant financial gap (Bourbonnais, 2013). Further, like the user fee reimbursement, these funds were administered through the HSSF, which saw frequent delays.

The government relaunched the program in 2017 under the name Linda Mama. Under the new program, reimbursement is managed by the NHIF (MOH, 2016d). These reimbursement mechanisms are discussed further in Chapter 4. Service delivery points were also expanded to include 2,700 private sector and faith-based facilities. It now also offers a broader benefits package including outpatient and inpatient services for mothers and newborns (Munge et al., 2017; Star Reporter, 2018). These reforms are intended to more efficiently and rationally reimburse facilities to improve sustainability and further expand access to free services. While the package of services covered by the scheme has expanded, however, the actual provision of services beyond deliveries is still being implemented. As insurance coverage expands, Linda Mama is expected to play a growing role as a bridge to cover, and ultimately enroll, uninsured women in the national NHIF scheme (GOK, 2018).

**Comparing current health indicators to national targets suggests that Kenya has more work to do to reach its ambitious targets.** There are gaps between the current status and 2030 targets for several indicators, including for government health spending, access to care, financial protection, and the maternal mortality ratio (Table 3). Meeting these targets will require improved health financing combined with reorganization of service delivery, as well as efforts to increase demand and utilization of health services. Health-seeking behavior, stigma against certain populations, and other demand-side barriers will also need to be addressed.

**Kenya made considerable progress toward the health-related targets of the Millennium Development Goals (MDGs), but it still faces significant gaps.** Overall, Kenya's 2015 UHC "service coverage index" was 57, based on a composite of different service delivery indicators analyzed by WHO (WHO, 2017). This is relatively high for its region. For example, the 2014 Kenya Demographic and Health Survey (KDHS) reports that nearly 90 percent of children are fully immunized against measles, and 95.5 percent of women receive at least one antenatal care visit (KNBS et al., 2014). Other indicators, however, fall further from their targets.

For example, maternal mortality remains high. Over the 2007–2014 survey period, it was 362 deaths per 100,000 live births, against the MDG target of 147 (although well below the 1990 baseline of 590 deaths) (KNBS et al., 2014; Ministry of Devolution and Planning, 2014). Under-five mortality nearly halved from the 1990 baseline of 98 deaths per 1,000 births to 52, but it is still well above the target of 32 (KNBS et al., 2014; Ministry of Devolution and Planning, 2014). These numbers also mask geographic disparities. The under-five mortality rate in Nyanza Province is 82, and in Nairobi it is 72. North Eastern and Central Provinces, in contrast, have under-five mortality rates of 44 and 42, respectively (KNBS et al., 2014).

**Table 3. Snapshot of key macroeconomic, health, and health financing indicators**

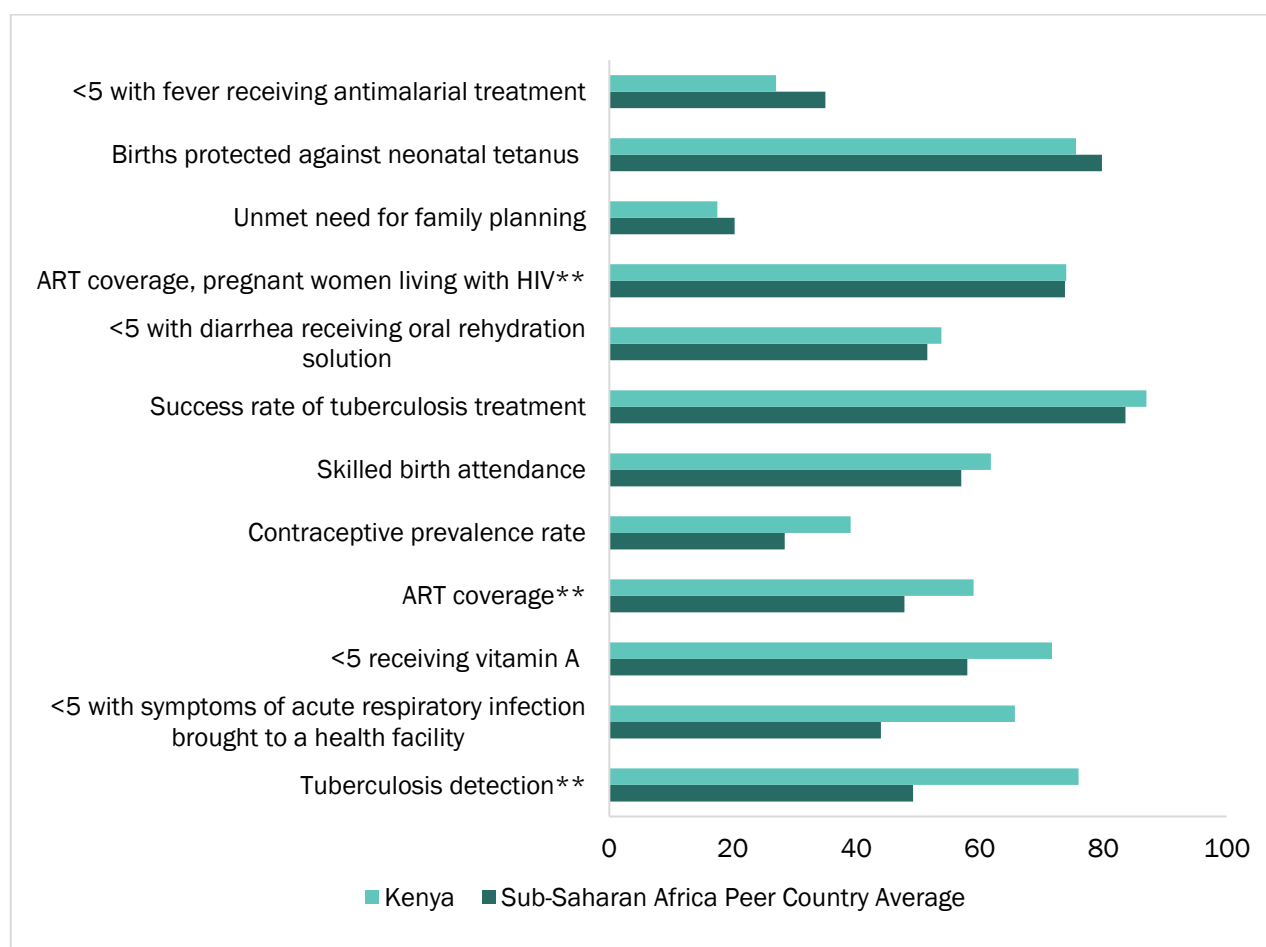
Indicator	Data
Gross domestic product (GDP) growth rate (IMF, 2016)	5.7%
Government expenditures (MOH, 2017b)	KSh 2.3 trillion
Government health expenditure as percentage of total government expenditure (MOH, 2017b)	6.7%
Total health expenditure (THE) per capita (MOH, 2017b)	US\$78.6
Out-of-pocket (OOP) as percentage of THE (MOH, 2017b)	27.7%
Percentage of population covered by insurance, 2018 (MOH, 2018)	19.9%
Infant mortality rate per 1,000 live births, 2014 (KNBS et al., 2014)	39
Under-five mortality rate per 1,000 live births, 2014 (KNBS et al., 2014)	52

## Access to UHC-related Tracer Primary Healthcare Indicators

### **Closing the gaps in progress toward Kenya’s health goals will require expanding access to key interventions, particularly around RMNCAH and infectious diseases.**

The WHO and World Bank UHC monitoring framework includes key health service coverage indicators (WHO, 2015). Distinct from MDG health outcome indicators, this framework includes a broad set of intervention indicators for preventive and promotive services across different levels of the health system. Figure 1 shows Kenya’s progress in providing these services, relative to a group of economic peer countries in sub-Saharan Africa. Kenya shows strong performance across key tracer indicators and generally has higher levels of coverage than its peers. However, low coverage of certain services such as antimalarial treatment among children under five (27 percent) indicates that Kenya faces some remaining challenges in reaching the population with comprehensive basic health services (Figure 1).

**Figure 1. Comparison of UHC indicators between Kenya and sub-Saharan Africa peer countries, 2014\***



\* Peer countries defined by the World Bank as those at a similar level of development with Kenya a decade ago.

\*\*2015 data; ART=antiretroviral therapy

Source: KDHS, 2014; WHO 2015; UNAIDS 2015 (aidsdataonline portal)

## Availability of Essential Services

**The Kenya Essential Package for Health (KEPH) has formed the basis of a newly defined package of key benefits in line with the country's long-term health goals, as well as goals for financing and essential service availability.** The original KEPH was aligned with six objectives: to eliminate communicable diseases, combat the rising burden of noncommunicable diseases (NCDs), reduce the burden of violence and injuries, provide essential services, minimize exposure to risk factors, and strengthen collaboration among health-related sectors (MOH, 2013b). In 2012, the KHSSP defined the services to be included in the KEPH, but these services were never formally procured or guaranteed by the GOK and actual coverage has been variable. The *Roadmap Towards Universal Health Coverage (2018–2022)* notes, however, that the KEPH was the basis for the UHC-Essential Benefits Package (UHC-EBP) determined by an advisory panel formed in June 2018, where the UHC-EBP is the package to which all Kenyans will be guaranteed access under UHC-oriented schemes. This package was not formally released and was subjected to an initial costing. The UHC pilots/Afya Care program, described in Chapter 5, is being used to test the provision of such a package in four counties representative of varying populations and disease burdens. The four counties—Nyeri, Kisumu, Machako, and Isiolo—have high proportions of NCDs, infectious diseases, injuries, and nomadic populations, respectively.

This basic package is intended to expand progressively over time and ultimately to be purchased by NHIF (see Chapter 5) (GOK, 2018). The ability of the system to deliver the UHC-EBP will likely follow similar recent trends seen in Kenya's ability to deliver the KEPH.

**Expanding coverage of key interventions requires that health facilities be equipped to provide an adequate package of essential services.** The services included in the KEPH were well defined by the KHSSP in 2012, but the extent to which they were actually being delivered was less clear. To measure the extent to which facilities were delivering KEPH services, the 2013 Service Availability and Readiness Assessment Mapping (SARAM) assessed the availability of services along a set of tracer indicators on the availability of inputs and the readiness of health facilities to provide defined interventions at all facilities and management units (MOH, 2013b). More recently, the 2016 Service and Readiness Assessment (SARA) assessed a regionally and nationally representative sample of facilities across the same indicators to measure progress (MOH, 2016e).

**Overall, the two assessments showed improvement in coverage of KEPH interventions.** Figures 2a and 2b show that between 2013 and 2016, there was a 14 percentage-point increase in the mean availability index of the full KEPH (from 41 percent to 55 percent). Health facilities providing the full range of essential services improved from 27 percent to 67 percent, and services for the elimination of communicable conditions rose from 2 percent to 23 percent. Additional specific services linked to key health programs improved significantly. The number of health facilities providing immunization services increased by 21 percentage points, and the number of facilities offering maternity services doubled. Two-thirds of facilities were screening for NCDs in 2016, compared to 28 percent in 2013. Integrated maternal and family planning services rose by 20 percentage points (MOH, 2013b, 2016e).

**While there have been overall improvements, availability of services varies significantly across health areas.** For example, in 2016, services addressing communicable disease elimination were the most available (71 percent), while services aimed at reducing violence and injuries were the least available (48 percent). More than two-thirds of the facilities had the full scope of services aimed at providing essential health services, while no facilities had the full range of services linked to violence and injuries, noncommunicable conditions, or exposure to risk factors (MOH, 2016e).

**The availability of some essential medicines has improved since 2013, but Kenya still struggles to insure availability across facilities and conditions.** The availability of medicines is considered one of the most important elements of quality by healthcare users, and the absence or stock-out of medicines is a key factor in the underutilization of public health services. At the time of the SARA survey in 2016, 69 percent of the facilities had some essential medicines available, but only 16 percent had all of them. Availability of different tracer essential medicines varies across condition types. Essential medicines for acute conditions were more available across facilities (more than 70 percent), compared with those of chronic conditions (30 percent to 68 percent) (MOH, 2016e). Amoxicillin was available in 69 percent of facilities in 2013 and 89 percent in 2016 (MOH, 2013b, 2016e). In 2016, the mean availability for tracer maternal health medicines was 64 percent for all facilities. However, availability of metronidazole (28 percent) and calcium gluconate injectable (41 percent) was low (MOH, 2016e).

Figure 2a. Mean availability of services by policy objective, 2013 and 2016

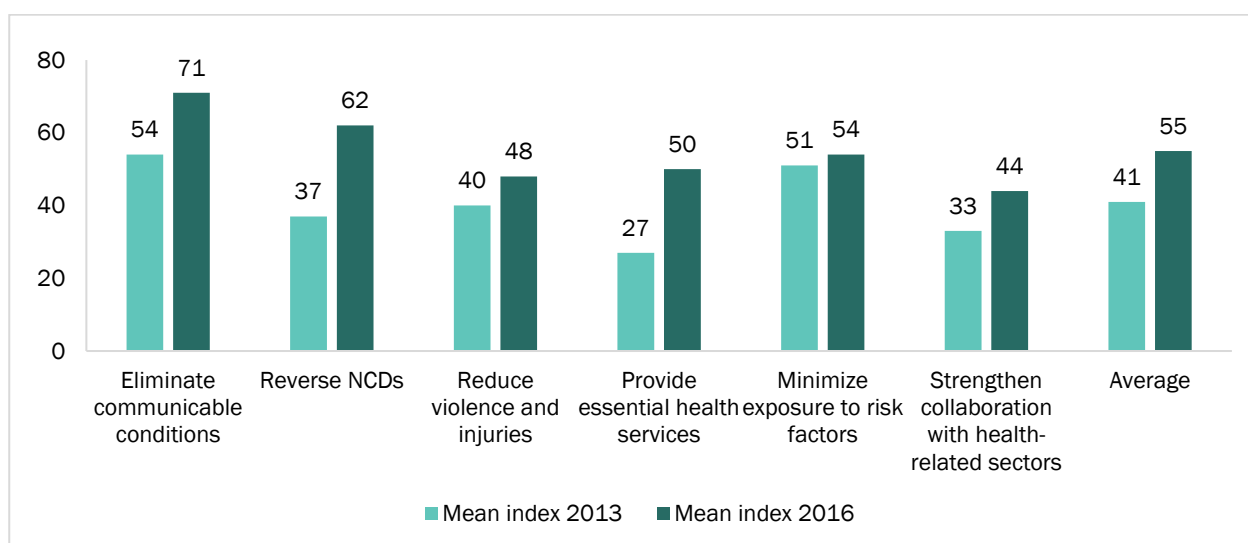
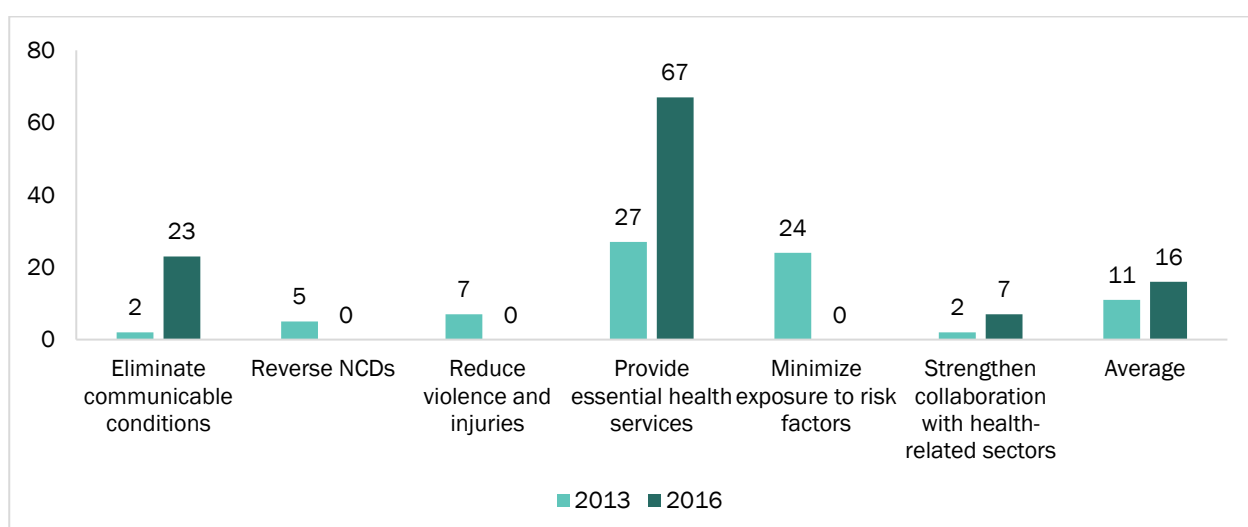


Figure 2b. Percentage of health facilities offering all services by policy objective, 2013 and 2016



Sources: SARAM, 2013; SARA 2016

### There are also substantial differences in service availability at the county level.

Although the more recent SARA, conducted with a nationally representative sample of facilities, does not report service availability by county, the 2013 SARAM shows these data (MOH, 2013b, 2016e). Table 4 highlights counties with the highest and lowest availability of select key services at primary care facilities. Mombasa and Nairobi, for example, reported the lowest availability for services related to immunization, child health, antenatal care, and prevention of mother-to-child transmission of HIV, whereas Kisii, Nyamira, and Isiolo reported the highest availability of these services (MOH, 2013b).

**Table 4. Percentage of primary care facilities providing select KEPH services (counties representing highest and lowest service availability)**

County	Number of Primary Healthcare Facilities	Immunization	Child Health	Antenatal Care	Prevention of Mother-to-Child Transmission of HIV
Bomet	106	92%	93%	96%	90%
Isiolo	38	95%	98%	95%	90%
Kisii	122	93%	93%	94%	93%
Nyamira	106	94%	97%	97%	93%
Mombasa	278	27%	37%	40%	23%
Nairobi	790	34%	44%	40%	30%

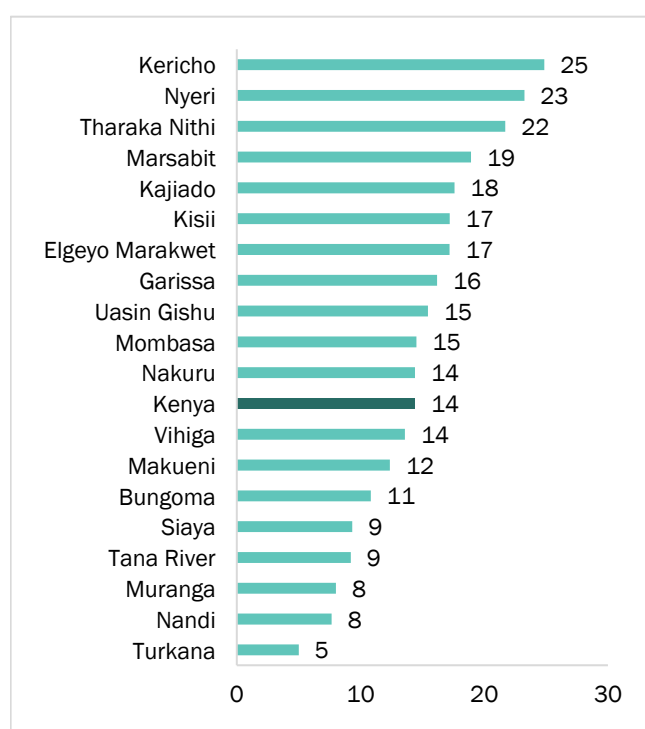
Source: MOH, 2013b

## Geographic Distribution of Health Infrastructure and Workforce

**National estimates obscure significant inter-county disparities for key indicators of supply-side availability.** The bed-to-population ratio provides a key infrastructure indicator of the capacity of health facilities to accommodate and provide services to the patients. The national average is 14 inpatient beds per 10,000, which is unchanged since 2013. There are large disparities across counties, with bed population ratios as low as five inpatient beds per 10,000 population in Turkana and as high as 25 inpatient beds per 10,000 in Kericho (Figure 3).

**Similar disparities are evident in the distribution of health facilities.** The 2017 master facility list identified a total of 8,854 health facilities, approximately two per 10,000 people nationally. At the county level, the average facility density is approximately 2.13 per 10,000 (MOH, 2013b). Figure 4 highlights the disparity in distribution across counties. Eight counties have an average facility ratio of more than 40 percent above the average. Twelve have an average facility ratio more than 25 percent below the national average. Wajir has the lowest facility density, at just over 1.1 facilities per 10,000. Nyeri and Nyandarua both have more than four facilities per 10,000.

**Figure 3. Beds per 10,000 people, select counties**

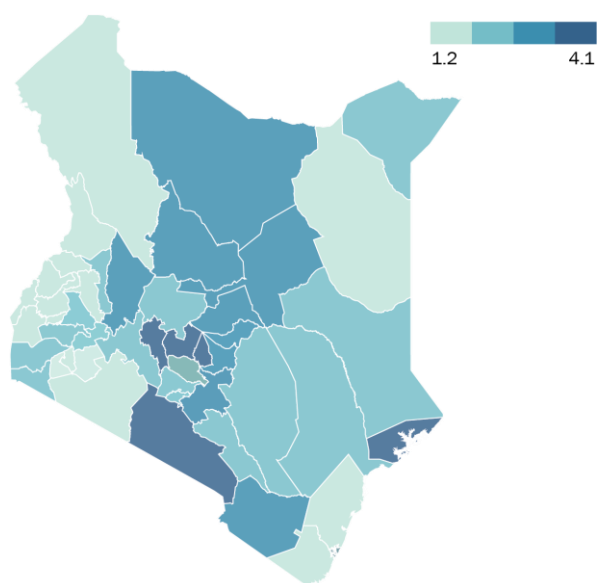


Source: SARA, 2016



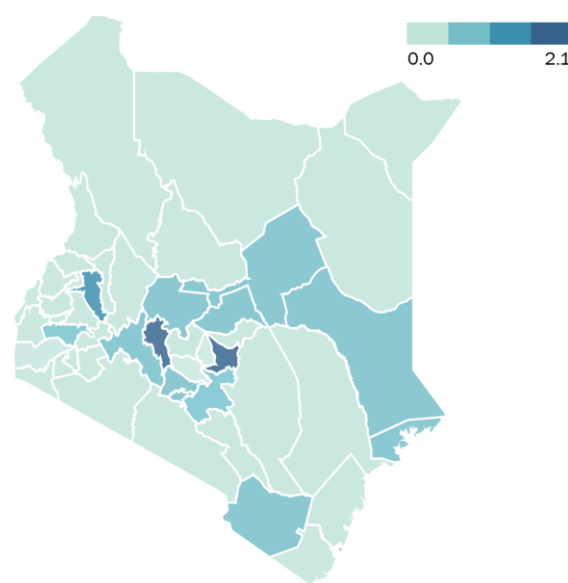
**Disparities also exist in the density of health workers across counties.**<sup>2</sup> In 2013, the SARAM reported a national average number of doctors (excluding dentists and clinical officers) of 5.1 per 100,000 people. That number has improved over the last few years, to almost 5.3 in 2016. Despite progress, there is considerable variation across counties, as seen in Figure 5. Turkana and Marena, for example, have less than one doctor per 100,000; Kisumu, Nairobi, Nyandarua, Embu, and Garissa all have more than 10 (GOK, 2018).<sup>3</sup>

**Figure 4. Health facilities per 10,000 population, 2017**



Source: Master facility list, 2017

**Figure 5. Doctors per 10,000 population, 2013**



Source: MOH, 2013b

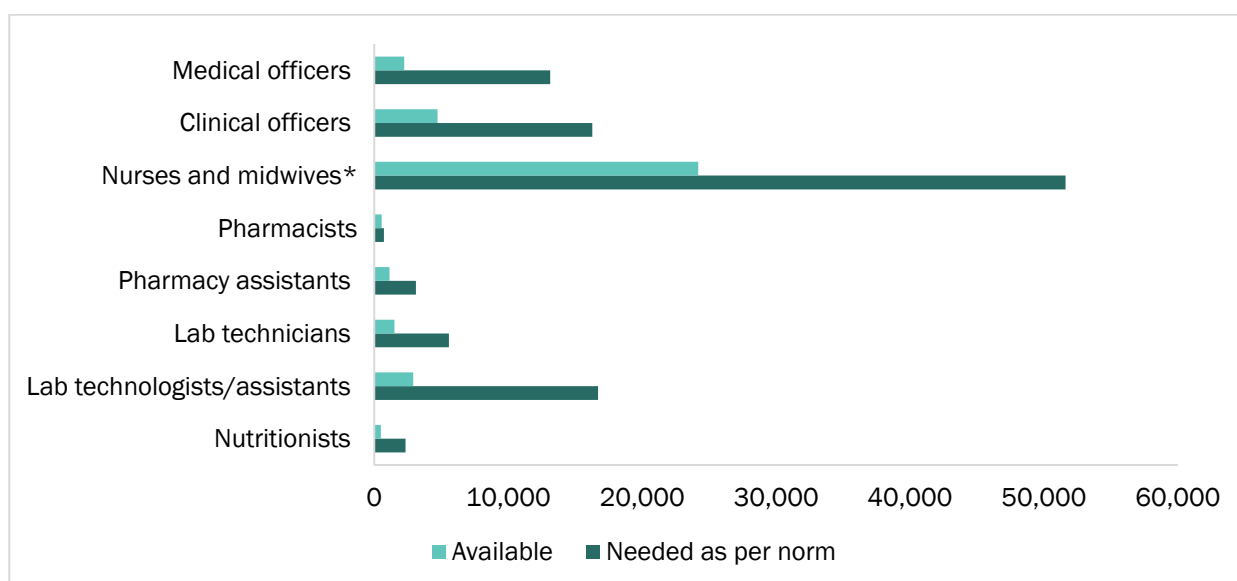
**Facility staffing gaps in Kenya remain high.** Figure 6 shows significant gaps in staffing between the actual and required levels set by the 2014 guidelines for human resources for health norms and standards for the KHSSP. These staffing levels were estimated based on prioritization of a minimum number of health workers in each facility, based on expected services to be delivered as defined in the KEPH. These data, however, may not reflect recent improvements. In-country stakeholders note that since devolution, counties have made significant efforts to fill these gaps. More recent data are necessary to assess whether these efforts have been successful in closing human resource gaps.

**Geographic accessibility has significant implications for utilization, and the 2014 KDHS indicates that this has improved.** For example, 89 percent fewer respondents reported distance to health facilities as a reason for not seeking care in 2013 than in 2003 (KNBS et al., 2014). However, the 2018 KHHEUS found that the percentage of people who reported distance to health facilities as a reason for not seeking care increased from 1.8 percent in 2013 to 3 percent in 2018, though this was still an 80 percent decline from 15.1 percent in 2003. In addition, according to the 2013 KHHEUS, the average time taken to reach a health facility for outpatient services was 46 minutes (East Central and Southern Africa Health Community, n.d.; MOH, 2013a).

<sup>2</sup> Data disaggregated by county and type of health worker other than doctors (medical officers) are not available.

<sup>3</sup> County-level population data came from the Kenya National Bureau of Statistics 2015 *County Statistical Abstracts*. These are projections based on 2009 census data. Since there are not county-level population data available for each of the relevant years for facility and human resource data, county densities may not be exact but still provide a useful illustration of the relative availability of health resources across counties.

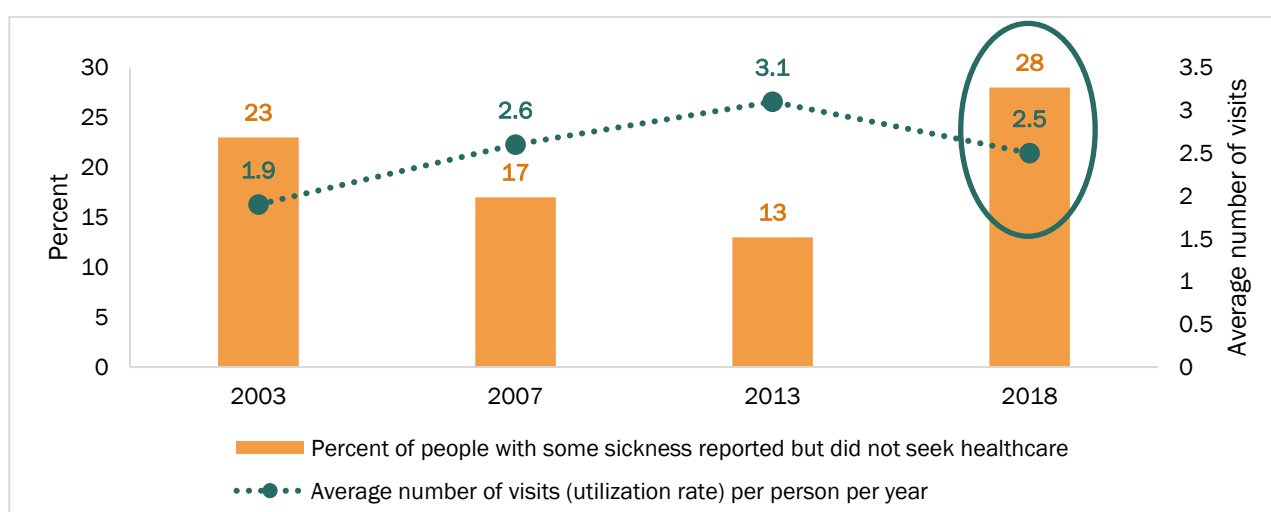
Figure 6. Human resources for health available vs. needed, 2013 (SARAM vs. KHSSP)



\* Includes, as available: BSc nursing, Kenya registered community health nurses, Kenya enrolled community health nurse, midwives, nurse assistant, enrolled nurse, registered nurse, BSn nurse, and specialized nurse.

**Healthcare utilization rates have generally increased over the last 10 years.** According to the KHHEUS 2018, the volume of outpatient services increased by 90 percent, from 4.8 million to 9.1 million from 2003 to 2018. The average number of visits per person increased from 1.9 to 3.1 from 2003 to 2015, but it fell to 2.5 in 2018. Simultaneously, the share of respondents who reported a sickness but did not seek care increased (Figure 7). While there has not been rigorous analysis to explain this decline, the 2018 KHHEUS report posits that it could be the result of a health workers' strike that took place before the survey was conducted, on the one hand, and on the other, an increase in self-medication, which increased from 30.7 percent in 2013 to 45.2 percent in 2018 as a reported reason for not seeking care (MOH, 2018).

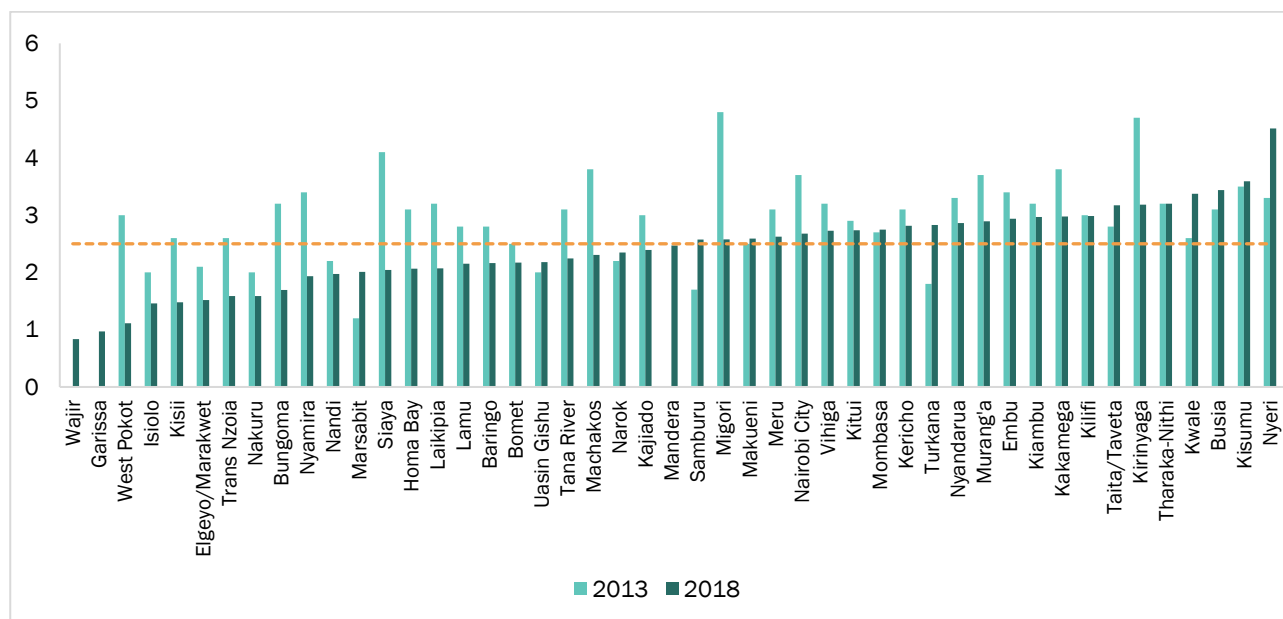
Figure 7. Trends in healthcare-seeking behavior in Kenya, 2003–2018



**Despite overall progress, wide inter-county variations in per capita utilization and inpatient admission rates remain.** Figure 8 shows that 23 counties report utilization rates above the national average (2.5 per capita per year). Nine counties report utilization rates of 30 percent or more below the national average (MOH, 2013a; KNBS, 2018). In Wajir, per capita

utilization is only 0.8, whereas 10 counties have per capita utilization rates of at least 3.0. Inpatient admissions increased by 153 percent between 2003 and 2013, reaching 38 per 1,000 population. The admission rate dropped slightly to 35 per 1,000 population in 2018. A regional UHC benchmark of 70 per 1,000 will require a 100 percent increase of admissions from the KHHEUS 2018 number by 2030 (East Central and Southern Africa Health Community, n.d.; MOH, 2013a, 2018). Figure 9 shows wide inter-county variation between counties, as five counties reported a per capita admission rate of 40 percent or more below the national average and 10 others reported a per capita admission rate of 30 percent or more above the national average (MOH, 2013a).

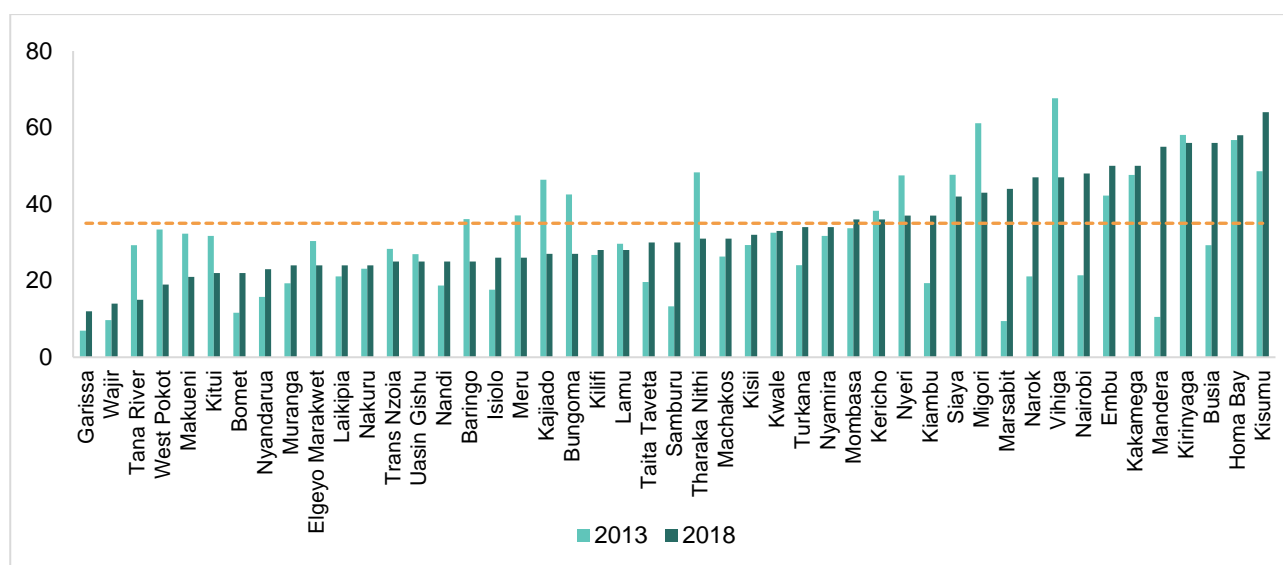
Figure 8. Per capita utilization of outpatient services by county



Note: The 2013 survey did not cover Garissa, Mandera, or Wajir Counties. The dashed horizontal line represents the national average.

Source: MOH, 2013a, 2018

Figure 9. Admissions per 1,000 population by county



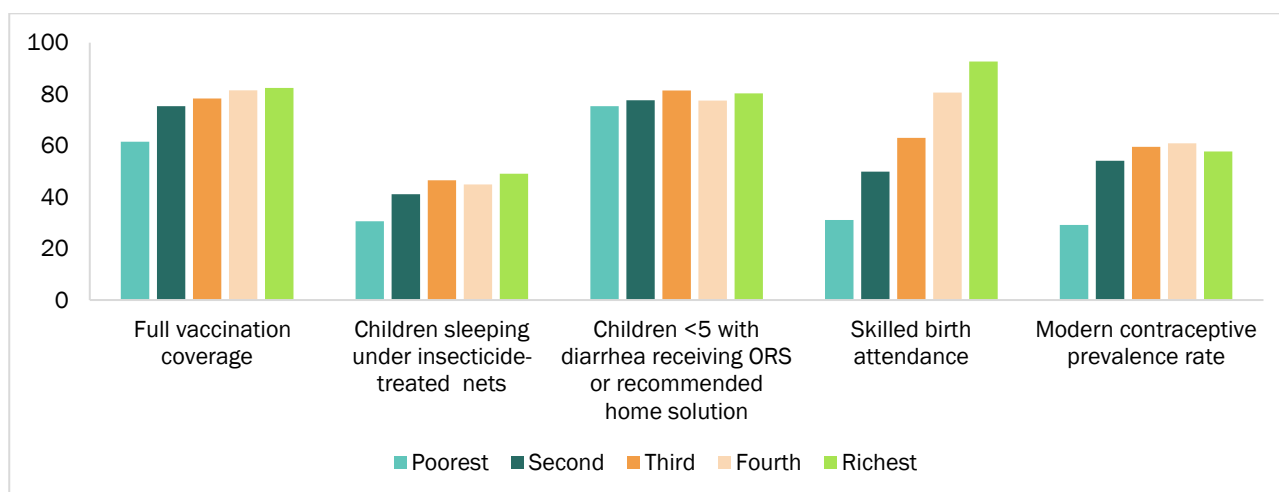
Note: The dashed horizontal line represents the national average.

Source: MOH, 2018

## Equity of Access across Socioeconomic Strata

**Overall, availability of and access to services have increased over the last 10 years, but inequities remain a challenge when considering socioeconomic groups.** Figure 10 shows that coverage of key tracer interventions varies significantly across wealth quintiles. The lowest wealth quintile had significantly less access to four out of six key interventions when compared to the top quintile, with gaps in intervention coverage ranging from 60.5 percent to 80.4 percent between 2014 and 2015 (KNBS et al., 2014).

**Figure 10. Access to healthcare by wealth quintile, 2014**



\* ORS=oral rehydration solution

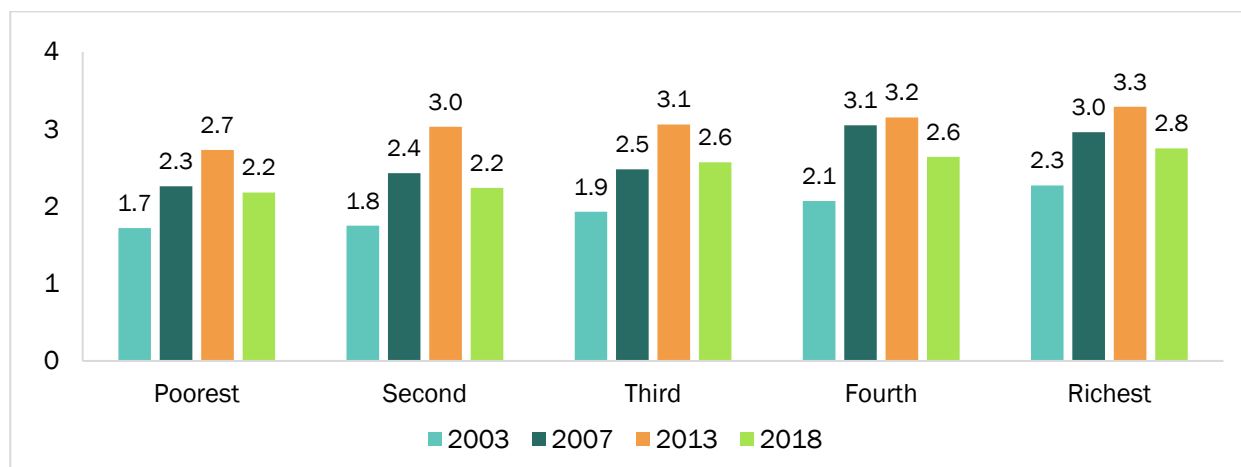
Source: KNBS et al., 2014

**Deliberate pro-poor policies have increased the use of health services among the poor, but they nonetheless lag behind higher-income groups.** KHHEUS 2013 data showed an overall increase in outpatient utilization rates between 2003 and 2013, with rates increasing more quickly among the poor; the three lowest quintiles increased 64 percent on average, compared to 48 percent on average for non-poor populations (Figure 11) (MOH, 2013a). However, KHHEUS 2018 data showed that outpatient utilization rates have fallen since 2013; the three lowest quintiles decreased by 21 percent on average, compared to a decrease of 16 percent on average for non-poor populations. The government is the largest provider of outpatient and inpatient services, and this is especially true for the poor. Public health facilities accounted for 59 percent of all outpatient visits; among the poorest quintile, public facilities accounted for 63 percent of admissions, compared to 37.2 percent for the wealthiest (MOH, 2013a, 2018).

**According to the KHHEUS 2013, unmet healthcare needs decreased by 44 percent between 2003 and 2013, reflecting improvements in access to healthcare.** However, according to the KHHEUS 2018, unmet healthcare needs are now above 2007 levels, having increased by 120 percent between 2013 and 2018 (MOH 2013a, 2018). The survey defines unmet need as the proportion of individuals who reported illness in the four weeks preceding the survey but did not seek healthcare. Unmet need fell from 22.8 percent to 12.7 percent from 2003 to 2013, but it rose to 28 percent in 2018. Like the decrease in the utilization rate from 2013 to 2018, possible explanations for this increase in unmet need include a national health worker strike that took place prior to the survey and an increase in self-medication. However, significant variations exist across counties, with rates as high as 40 percent above the national average. This suggests that underlying economic, social, and cultural conditions affect access to care. In 2013, Tana River, Samburu, Trans Nzoia, Nakuru, and Kericho all reported high levels of unmet need (28 percent, 40

percent, 34 percent, 27 percent, and 33 percent, respectively) (MOH, 2013a). Four out of five of these counties (except Samburu) had a facility density below the estimated national average, and three out of five had a medical personnel density below the national average.

**Figure 11. Per capita utilization rates by wealth quintile**



Source: MOH, 2018

## Financial Protection against the Costs of Ill Health

**Kenya has made progress in reducing OOP healthcare costs, but more progress is needed to ensure financial protection for households against the costs of seeking healthcare.** The KHFS aims to improve financial protection, reducing the burden of OOP health expenditures on households (MOH, forthcoming). OOP trends and patterns can be used as a measure of the level of financial protection provided to citizens by the health system. OOP health expenses place households at higher risk of incurring catastrophic expenditures, directly affecting living standards and sometimes pushing individuals below the poverty line. According to the preliminary results of the Kenya National Health Accounts 2015–2016, household OOP as a percent of total health expenditure decreased by 5 percent, from 25 percent to 24 percent, between 2010 and 2016. More progress is needed; however, the country is progressing toward its target of 15 percent of total health expenditure (MOH, forthcoming).

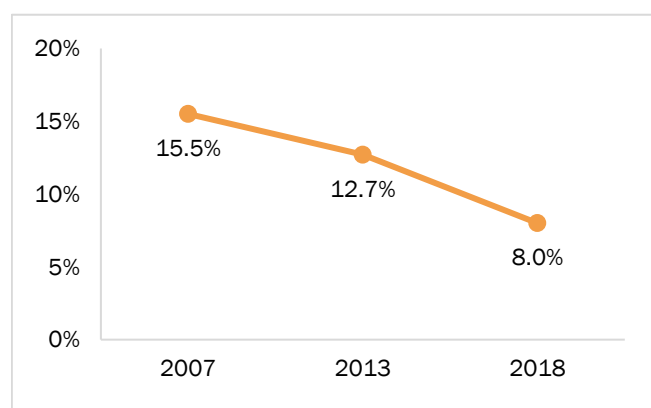
**Financial access to health services remains a barrier to use of care despite noteworthy improvements between 2003 and 2018, indicating a need for greater effort from the government to increase financial protection.** The KHHEUS 2018 data show that the percentage of households declaring high cost of healthcare as the main reason for not accessing health services fell from 36.3 percent to 19.4 percent (MOH, 2018). Although this is a 47 percent decrease, it still indicates that a significant demand-side barrier remains.

**The poorest households, who have greater health needs, are less likely to seek care, and they spend significantly less on health.** The highest burden of poverty is in rural areas. Among rural households, self-reported illness is 3.2 times higher for the bottom two wealth quintiles compared with households in the top two quintiles (MOH, 2018). This same part of the population, however, is also the least likely to seek care. Also, among rural households, the poorest two quintiles are 44 percent as likely not to seek care compared with their wealthier counterparts (MOH, 2018). Despite the higher disease burden, the average annual total per capita spending on outpatient and inpatient care is 2.29 times less among individuals in the bottom two wealth quintiles compared to the top two.

**Catastrophic health expenditure pushes more than half a million Kenyans annually into poverty.** Data from the 2007 KHHEUS show that 16 percent of households incurred OOP payments at the threshold of 10 percent of household budget. The poorest households were 66 percent more likely to incur catastrophic health expenditure (CHE) compared to the richest households (Chuma and Maina, 2012).

Based on this threshold, there has been a steady decline in the proportion of households assessed as facing such CHE (Figure 12) from 2007 to 2018, the year of the most recent survey. However, trends across socioeconomic groups suggest underlying inequity in these outcomes. A recent multivariate analysis by Barasa et al. in 2017, based on data from the 2013 KHHEUS, found that among households in the poorest quintile, households were 6.53 times more likely to incur CHE compared to the richest households when using a different threshold for CHE (OOP health spending exceeding 40 percent of total household non-food expenditures). The differences were also stark comparing rural, under-resourced counties such as Turkana, compared to others such as Makeni and Lamu. When looking at the impoverishment effect of CHE, the study found that nearly 620,000 Kenyans in 2013 were pushed into poverty by OOP payments for healthcare (Barasa et al., 2017). There is also significant regional variation, with the likelihood of catastrophic health expenditure 80 percent higher in rural areas than in urban ones.

**Figure 12. Trend in incidence of household-level catastrophic health expenditures\* in Kenya**



Source: KHHEUS 2007, 2013, 2018 (MOH 2013a, 2018)

\* Indicator: Proportion of households spending more than 10 percent of total expenditures on OOP healthcare costs.

## Discussion

**Kenya has made significant progress in improving access to healthcare and health outcomes in recent years.** The use of outpatient services increased by 32 percent between 2003 and 2018 (MOH 2013a, 2018). Mean availability of services increased across health areas over the same period, and Kenya outperformed its peers in several key UHC indicators, including antiretroviral therapy (ART) coverage, contraceptive prevalence rate, and skilled birth attendance.

**Progress, however, is still incomplete against national goals, and there are persistent disparities across geography and socioeconomic status.** For example, in Kenya, maternal and under-five mortality, for example, have fallen nearly 40 and 50 percent, respectively, from 1990 baseline levels. Yet, they still remain well above the country's 2015 MDG targets. Access to health services varies by county, as seen in the range of facility and human resource densities presented above, further reflected in the wide range of healthcare utilization rates. Poor Kenyans are also far less likely to access health services than their wealthier counterparts, in part a reflection of the high burden of OOP expenditures.

**Kenya will have to continue to invest public funds to improve the availability, quality, and distribution of health system resources, but structural inflexibility in health spending may be a constraint.** The investment needs in health are highlighted in the *Roadmap Towards Universal Health Coverage (2018–2022)*, with a particular focus on investing in quality primary healthcare services, facilities, and equipment, as well as in human resources (GOK, 2018). If Kenya is to ultimately guarantee universal access to an expanding package of basic services,

counties must be able to invest in underlying health infrastructure, service preparedness, and improved health worker competence. Under devolution, counties are responsible for the majority of direct service delivery. Counties receive the majority of their revenue from the national Treasury and have discretion over how to spend it. Much health spending is recurrent, and at least 71 percent in total at the county level is focused on wages. Improving the availability of services and health outcomes will require that counties raise sufficient overall revenue for the sector, prioritize health, and target their specific supply-side barriers to care, including what is lacking in capital infrastructure and essential commodities. However, investing in public facilities is only one modality to affect access to services. Counties can also explore contracting out or otherwise purchasing services from private providers, which is currently infrequently done.

**Kenya wants to advance an ambitious UHC agenda under fiscal constraint, which requires it to simultaneously balance resolving demand- and supply-side barriers affecting healthcare utilization of the poor.** Effective health insurance coverage can help reduce financial and other demand-side barriers to care and may raise healthcare utilization among the poor. The success here is dependent on NHIF's ability to enroll and subsidize the poor and vulnerable. Anticipating increases in insurance coverage, government resources will be critical to preparing public health facilities to meet any future expansion in utilization of services, which may have recently plateaued or even declined. It is unclear if private for-profit and not-for-profit facilities will be similarly incentivized to make the investments for service improvement, even if this improvement is made a prerequisite to contracting under an expanded insurance scheme. County governments, with increasing responsibility for health under the devolved system, will have to shoulder most of this infrastructure and health system input-related financial obligation for public facilities. The ongoing Afya Care pilot programs for UHC in a few counties (intended to expand nationally), is one modality to push new resources through county systems and enhance service availability at public facilities (Afya Care is described further in Chapter 5). The pilots may provide valuable insight in county governments' ability to successfully use such new incremental per-capita financial flows to expand access and quality. However, beyond understanding if the county hospital system can cope with rising demand, it is unclear how the pilots' lessons will inform a future where reducing financial barriers and purchasing of care are driven more through an insurance model. In this context, Chapter 4 discusses the financial flows for health between the national and county levels in more detail. Chapter 5 presents NHIF plans for scale-up, including efforts to expand coverage of poorer populations.



Photo courtesy of DFID - UK Department for International Development

## 4. MOBILIZING AND DEPLOYING GOVERNMENT RESOURCES FOR HEALTH

**Current and future macroeconomic and fiscal conditions in Kenya have important implications for the government's role in advancing UHC.** They directly affect the government's ability to mobilize and pool resources for health. This chapter examines the macroeconomic and fiscal context, its implication for resource mobilization for health, and how these resources currently flow through the devolved system.

### Macroeconomic and Fiscal Context

**The current economic forecast suggests that the Kenyan economy will expand in the medium term, spurred by government investment in infrastructure, consumer demand, and private investment (Kiringai and Kristensen, 2016).** After a period of poor economic performance in 2008–2009, Kenya has registered strong economic growth since 2010. While growth has not consistently hit targets (projected growth rates for 2010, 2011, and 2012 were 6.2 percent, 8.3 percent, and 9.1 percent, respectively with actual rates of 3.3 percent, 8.4 percent, and 6.1 percent, respectively), the economy has continued to grow (GOK, 2012). Under a newly elected government in 2013, the Kenyan economy recorded significant growth despite a general global economic slowdown (5.7 percent in 2016 compared to 4.3 percent in 2013).<sup>4</sup> This compares well with other countries in the region (Figure 13) (IMF, 2016).

**The economy is projected to further expand by 6.1 percent in 2017 and approximately 6.5 annually over the next four years** (The National Treasury, 2017). This is supported by strong private consumption and output in agriculture with a stable weather outlook, as well as

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<sup>4</sup> Kenya revised its GDP computation methodology (rebasings) by using 2009 as the base year in place of 2001. The rebasing resulted in an upward revision of the nominal GDP by 25 percent from USD 44.1 billion to USD 55.2 billion. After the country's GDP was rebased, the growth rate for 2013 was revised upwards to 7.2 percent from 4.3 percent.

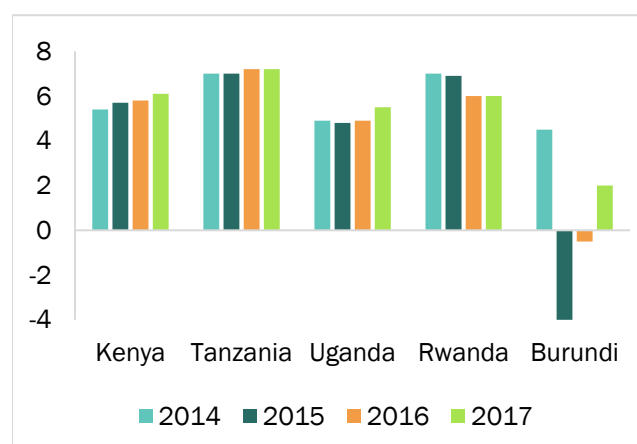


completion of key public projects in roads, rail, and energy generation. Consumer demand, private sector investment, and a generally stable macroeconomic environment will help reinforce the projected growth. Other key macroeconomic indicators have remained stable for the last 10 years. For instance, the annual average inflation has been contained by the Central Bank of Kenya at below seven percent for the last 10 years. While the economic outlook is favorable, the Kenyan economy does remain vulnerable to risks such as potential security threats, drought conditions, and global market volatility (IMF, 2014).

**From 2010–2016, the GOK’s total revenue averaged 25 percent of GDP.** After rebasing the GDP in 2014, the ratio of revenue to GDP fell from 25 to 19 percent due to the increase in measured GDP. Total revenue, however, increased from KSh 651 billion (US\$7.75 billion) in 2010/11 to KSh 1.24 trillion in 2015/16 (US\$12.4 billion). Tax revenue increased from 20 percent of GDP in 2010/11 to about 27 percent in 2015/16. When compared with other low- to middle-income economies whose tax revenue to GDP ratios are between 8.5 percent and 35 percent, Kenya performs notably well (Figure 14). Income and value-added taxes have contributed revenue of at least 12 percent of the GDP since 2000/01. The country’s positive revenue performance provides a fiscal environment conducive both in short- and long-term growth objectives (Ministry of Devolution and Planning, 2013).

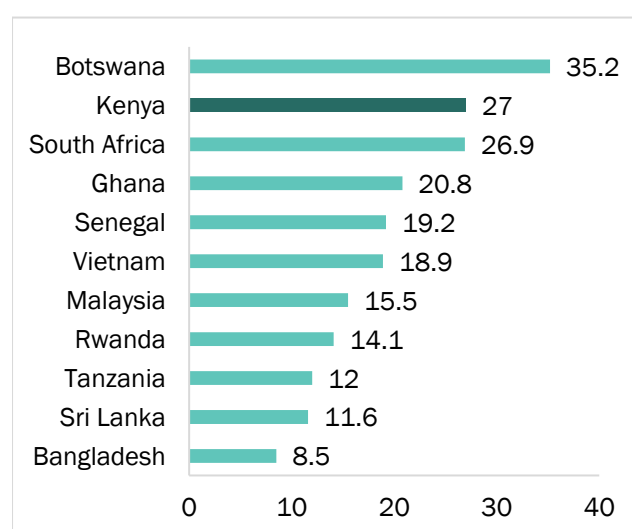
**Recent significant tax reforms have increased tax revenues, particularly from income taxes.** The increase in total tax revenue is largely attributed to significant increases in income tax revenue, which increased from KSh 272 billion in 2010/11 to KSh 570 billion in 2015/16 (The National Treasury, 2017). From 2010 to 2016, taxes contributed about 91 percent of total revenue (KNBS, 2015, 2016, 2017). The improved performance of income taxes is largely attributed to higher tax compliance. The Kenya Budget Statement of 2016/17 announced tax amnesty, which is intended to increase foreign income declared in Kenya (KPMG, 2017). Coupled with the use of personal identification numbers for tax assessment, income tax revenue is expected to increase further in the future. Tax revenues are projected to expand to about KSh 1.83 trillion 2019/20 (The National Treasury, 2017).

Figure 13. East African Community country GDP growth rates, 2014–2017



Source: IMF, 2016

Figure 14. Tax revenue as percentage of GDP among peer countries, 2015



Source: World Bank, 2015

**Despite increasing trends in tax collection, the GOK has not met its revenue targets.** For instance, by the end of March 2017, Kenya's total revenues amounted to KSh 984.6 billion against a target of KSh 1.05 trillion, falling below the target by 7 percent (Anyanzwa, 2017). As the country moves toward UHC and also aims to support implementation of capital-intensive development projects in a bid to achieve middle-income status, Kenya needs to strengthen its capacity to raise revenue. Mobilization is limited by structural factors such as low per capita income, a large informal sector, and small manufacturing and modern services sectors. Kenya's tax revenue is also largely dependent on income taxes, which accounted for approximately half of total tax revenue in 2015/16 (Figure 15). The IMF, however, noted significant improvements in the first quarter of 2016/17 in revenue collection from value-added tax (VAT) and excise taxes from improvements in the *i*-Tax and Excise Goods Management Systems, as well as VAT withholding (IMF, 2017).

**Growth in government expenditures has outpaced growth in revenue, contributing to a need for deficit financing with debt.** Total government expenditure increased from KSh 1.5 trillion in fiscal year (FY) 2013/14 to KSh 2.5 trillion in FY 2016/17. This was largely driven by ongoing infrastructure investment in roads and energy, security expenditure, and a rising civil servant wage bill (KNBS, 2017). In absolute terms, both recurrent and development expenditures have increased at the national level, but recurrent expenditure has declined as a percentage of total expenditure (Figure 16). The aggregate fiscal envelope has increased over the last 10 years, and public expenditure now stands at about 27 percent of GDP in 2016. The current level of government expenditure as a share of GDP puts Kenya on par with or above other countries in the region (Figure 17). Between 2010 and 2016, revenue growth rates fell 1.4 percentage points down from 19.8 percent of GDP to 18.4 percent.

Figure 15. Average composition of tax revenue, 2013–2017

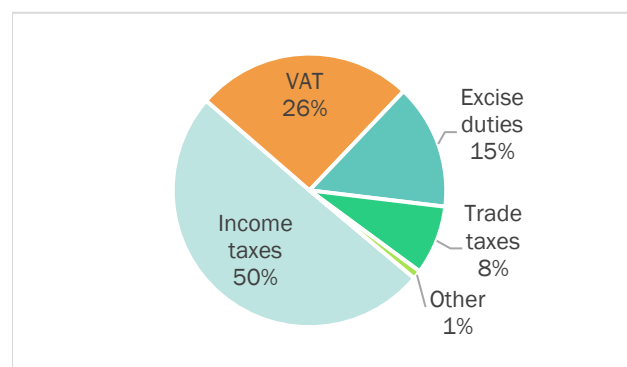
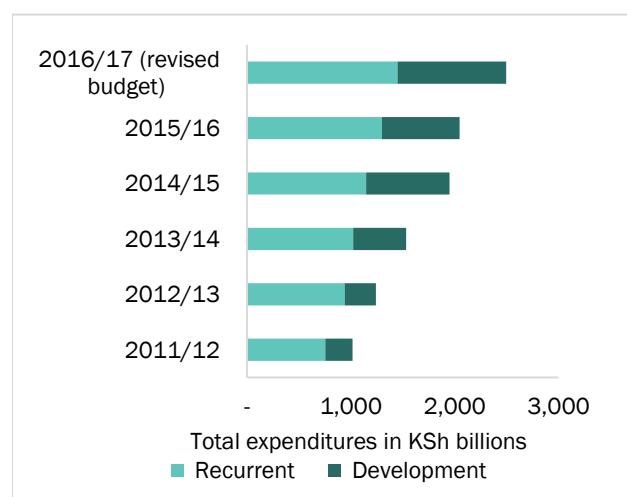


Figure 16. Government of Kenya expenditures



Source: KNBS, 2017

Figure 17. Government expenditures as share of GDP among peer countries

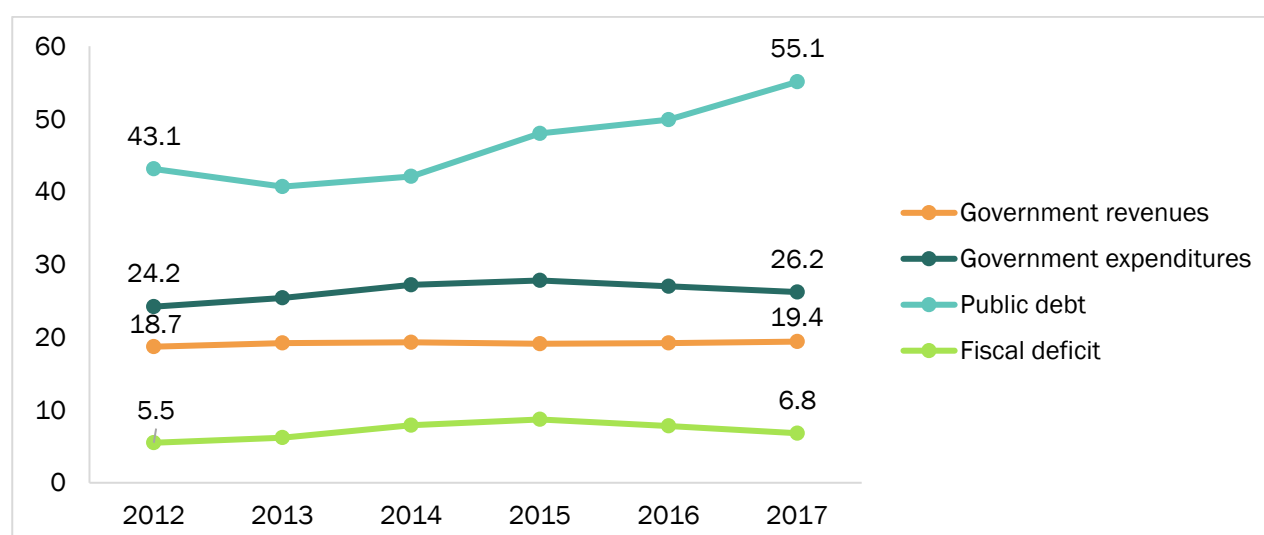


Source: IMF, 2016

Expenditures increased by 5.8 percent points during the same period, which pushed the government to borrow to finance the budget deficit (KNBS, 2015, 2016; The National Treasury, 2016).

**Kenya's public debt has increased in the past six years.** At the end of financial year 2015/16, total public debt amounted to KSh 3.62 trillion compared to KSh 1.49 trillion in 2010/11, a twofold increase when accounting for exchange rate fluctuations (Figure 18). As a percentage of GDP, total public debt increased from 43 percent in 2010/11 to 58 percent in 2017/18 (IMF, 2018). Trends suggest that it may continue to increase to 63 percent by FY 2019, thereafter declining if the GOK takes adjustment actions. Domestic debt increased from KSh 764.2 billion in 2010/11 to KSh 1.95 trillion in 2015/16. On the other hand, external debt increased from KSh 723 billion in 2010/11 to KSh 1.80 trillion in 2015/16 (KNBS, 2015, 2016, 2017; The National Treasury, 2016). With no change in government fiscal policies, public debt is, however, expected to stabilize at around 66 percent of GDP in 2020/21 and gradually decline thereafter (The National Treasury, 2017; IMF, 2018). Half of Kenya's public debt is owed to external creditors (The National Treasury, 2016, 2017). Reducing the fiscal deficit over the medium term is essential to limit and eventually reverse the rise in public debt ratio.

**Figure 18. Government revenues, expenditures, deficit, and public debt as percentage of GDP**

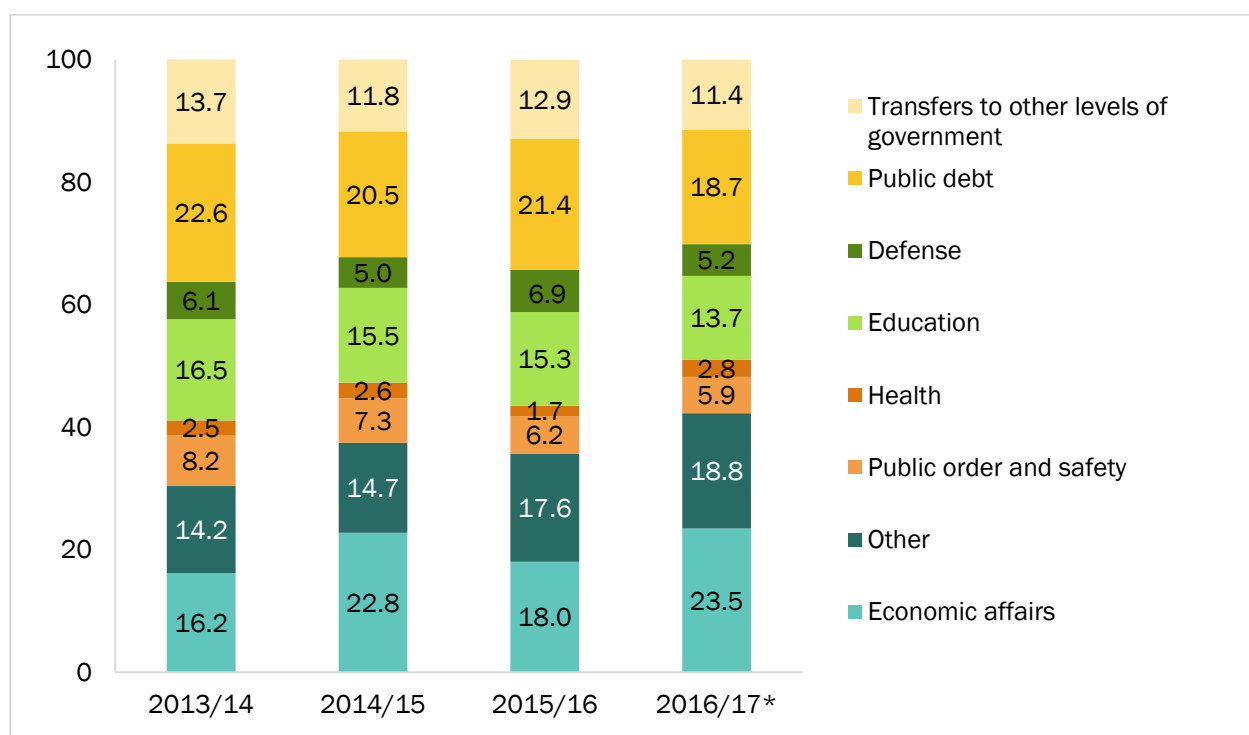


**The central government has increased spending on economic affairs,<sup>5</sup> general public services, and debt repayments, while reducing the proportion of spending on social services.<sup>6</sup>** The proportion of spending on economic affairs increased from 16 percent of total government spending in 2013/14 to 25 percent in 2015/16. Spending on functions like public debt, transfers between levels of governments, grants, and general public services were significant, although spending has been decreasing. Spending on education fell from 17 percent of total spending in 2013/14 to 14 percent in 2015/16. Health sector spending has remained almost the same at 2.6 percent since 2013/14 (Figure 19). By economic classification, national government spending has concentrated on compensation of employees (20.3 percent in 2016), grants (22.3 percent), public debt redemption (11 percent), capital grants to state owned enterprises (10.8 percent), and interest on both domestic and external loans (10.6 percent).

<sup>5</sup> Including general economic, commercial, and labor affairs; agriculture, forestry, fishing, and hunting; fuel and energy; mining, manufacturing and construction; transport; communication; and other industries.

<sup>6</sup> Including health, education, and social protection.

Figure 19. Government expenditure by function as percentage of total government spending



\* Provisional; Source: KNBS, 2017

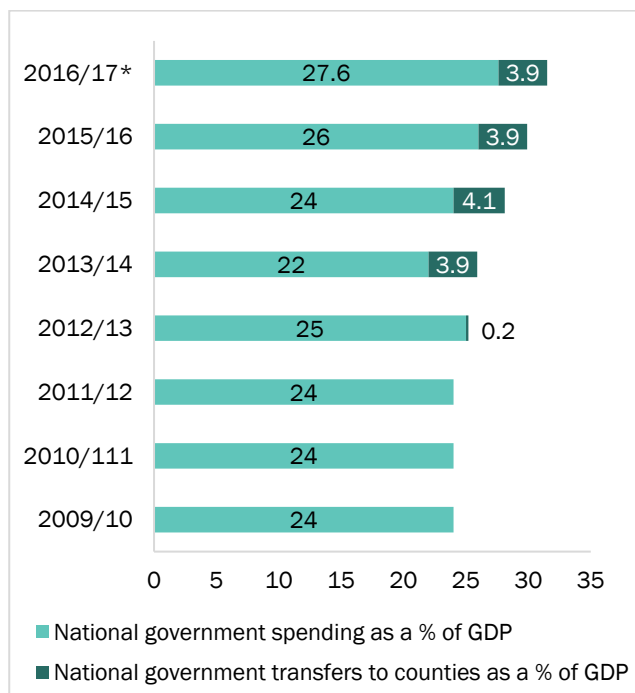
**Kenya is now fiscally devolved, and counties have significant responsibility for public service delivery.** Counties and the national level subdivide discretionary budget expenditures.<sup>7</sup> In line with the 2010 Constitution, the national government provides resources and support to counties to ensure effective delivery of public goods and services. In time, the national government expenditure was expected to decline as county governments took over certain public services. However, this has yet to be the case. As Figure 20 shows, national-level transfers to counties in form of sharable revenue equaled about 3.9 percent of GDP in 2013/14, 4.1 percent in 2014/15, and 3.9 percent in 2015/16. In absolute terms, in 2013/14, county governments were allocated KSh 236.3 billion as part of the sharable revenue (World Bank, 2014a). This amount increased to KSh 361.5 billion in 2016/17, an increase of about 53 percent (Figure 21). The total allocations to county governments consisted of sharable revenue,<sup>8</sup> conditional grants, and locally generated revenues. Sharable revenues accounted for an average of 82 percent of the total allocations, conditional grants (5 percent), and annual local revenues (13 percent). Most counties have limited capacity to locally generate revenues, which have been low. In 2013, for example, county governments targeted collecting about 1.2 percent of GDP as locally generated resources but only collected 0.5 percent (World Bank, 2014a).<sup>9</sup>

<sup>7</sup> The national budget includes Consolidated Fund Services, which covers servicing the national debt, pensions, and international commitments. This is nondiscretionary spending. Discretionary spending “is comprised of the spending on national-level institutions (like the Executive branch), the Parliamentary Service Commission, the Judiciary, the total transfers to counties, and the smaller amounts allocated to the Contingency Fund and Equalization Fund” (Dutta and Maina, 2014).

<sup>8</sup> Shareable revenue is anticipated national revenue collected from income taxes, VAT, excise and import duties, and other revenues. It is shared among counties based according to a formula that considers factors like population, land share, and poverty.

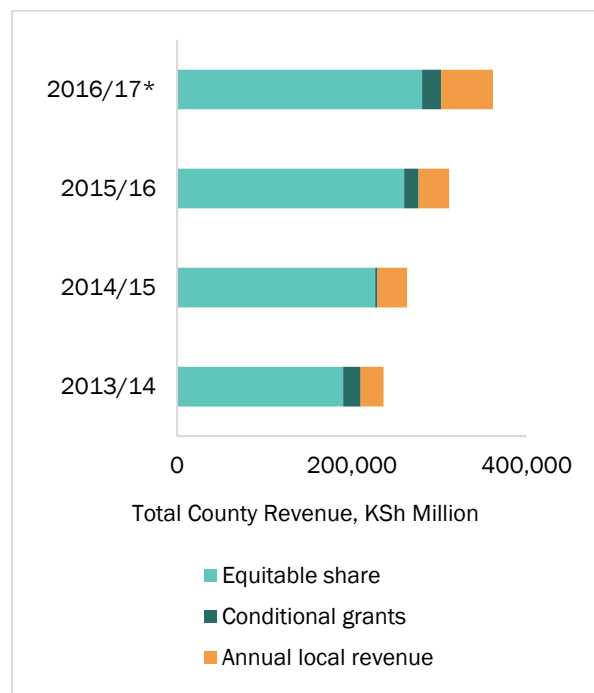
<sup>9</sup> Article 209 (3) of the Constitution empowers the county governments to impose two types of taxes: property rates and entertainment taxes. The county governments can also impose charges for any services they provide, in accordance with the stipulated laws.

**Figure 20. National government spending vs. county transfers as percentage of GDP**



\* Provisional; Source: KNBS, 2017

**Figure 21. Sources of annual county revenues**



\* Provisional; Source: KNBS, 2017

**With increased revenue, primarily from the national level, county expenditures have been increasing, especially on recurring expenditures.** In the first year of devolution (2013/14), counties spent around KSh 161.4 billion from all sources (about 5.4 percent of the GDP). County expenditure grew by 96 percent to stand at KSh 317 billion in 2015/16. Total county expenditures are expected to grow by 14 percent to KSh 370 billion in 2016/17 (KNBS, 2015, 2016). In 2015/16, county spending was equivalent to 4.8 percent of the GDP, an increase from 3.2 percent of the GDP in 2013/14. County recurrent expenditures are significantly greater than development expenditures, reflecting to some extent the start-up costs associated with establishing new administrative structures. This difference has been declining, however, and development expenditure is expected to increase to about 39 percent of total county spending in 2016/17, although there are significant variations across counties (Table 5). The composition of expenditure by economic classification shows that the majority of expenditure is consumed by wages and salaries, 40 percent in both 2014/15 and 2015/16 financial years. As a percentage of total recurrent expenditures, wages and salaries accounted for about 60 percent during the three financial years under review. Further, as discussed in greater detail below, this may actually underestimate the true proportion of spending on wages; grants to semi-autonomous agencies, including research and medical supply institutions and

**Table 5. Breakdown of county expenditures**

	2014/15	2015/16	2016/17 (projected)
<i>Recurrent vs. development</i>			
Recurrent	64.9%	65%	60.8%
Development	35.1%	35%	39.2%
<i>By economic classification</i>			
Personnel	40%	40%	—
Development	35%	35%	—
Operations and maintenance	25%	25%	—

Source: KNBS, 2017

referral hospitals like Kenyatta National Hospital, are classified separately, but also cover the costs of employee wages.

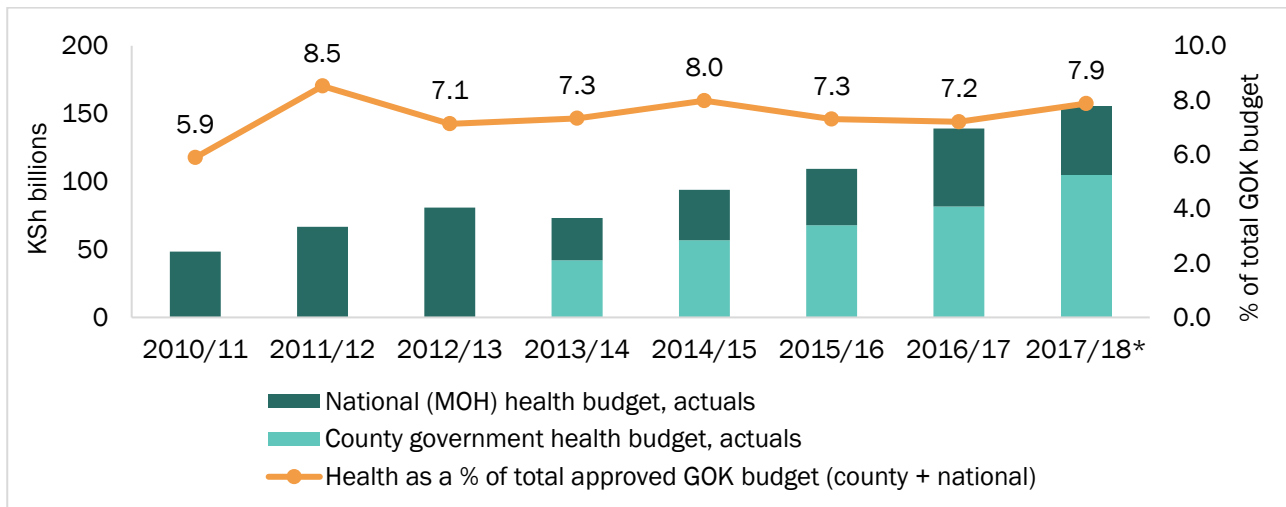
## Trends in Public Health Expenditure

**Under devolution, the national government (through the MOH) and county governments split the provision and management of healthcare.** Counties are now responsible for the majority of service delivery, while the national government maintains responsibility for overall governance and policy, as well management of national referral hospitals and certain vertical programs such as HIV. Once resources have been distributed between the two levels, each makes allocations to the health sector through a planning and budgeting process stipulated by the Public Financial Management Act, 2012. Any analysis of public financing of healthcare must be done at both the national and county levels.

**Government budgetary spending on health (both national and county) has increased in absolute terms from before to after devolution, but it has stagnated as a percentage of total approved government budgets.** Figure 22 shows the government's actual budgetary spending on health in absolute values, as well as a percentage of total approved government budgets across both levels. Budget allocations are revised and re-revised before being reported in the following year in terms of actual spending, which is often considerably lower than the target due to absorption and budget execution issues. In 2010/11, health, which was then an entirely national function, accounted for about 5.9 percent of total government budgets. This proportion peaked in 2011/12, but it has since remained stagnant between 7 percent to 8 percent for the last six years. Health as a percentage of the government budget has remained below the 15 percent target set by Africa heads of states in Abuja in 2000, of which Kenya is signatory. As an average for the period between 2010 and 2015, the Kenya government general health expenditure of 1.78 percent, as a percentage of GDP, was third lowest in a peer group of sub-Saharan African countries (Figure 23) (World Bank, 2010–2016). However, such international comparison as indicative of actual public sector commitment to health must be interpreted with caution, as many of the countries that have returned impressive rates receive large amounts of on-budget donor funding which is considered as part of government spending. The net effect is to inflate the role of government in financing health. Overall, Kenya's total general health expenditure as a share of GDP has remained below 2 percent in the last decade, which is low compared to the targets of closer to 5 percent set by WHO and other bodies (Figure 23).

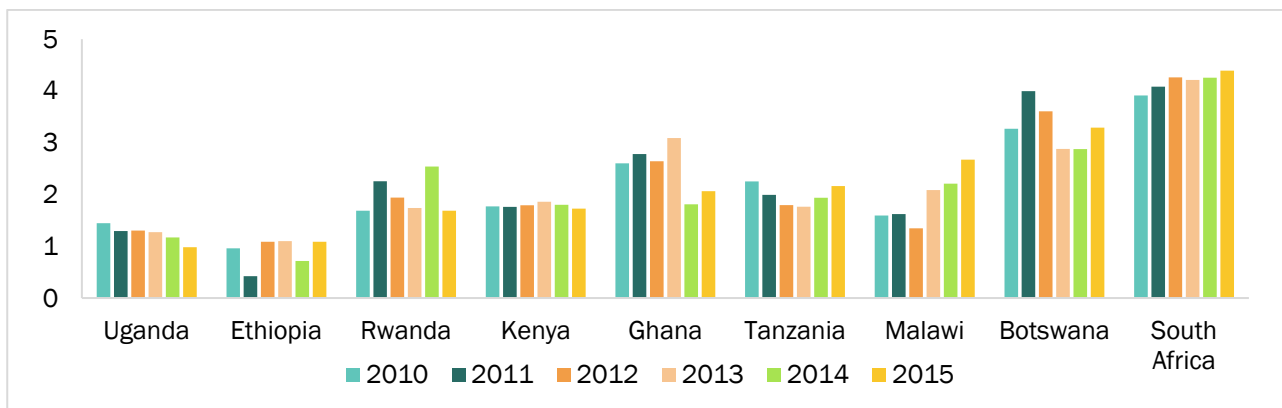
**Since devolution, total MOH budgets and expenditures have declined in absolute terms.** Devolution transferred significant functions and resources to the county governments, and the decline is in part a reflection of the reduced role of the MOH in terms of functions retained. The decline in recurrent spending after devolution was particularly significant, with a decline of about 60 percent from KSh 56 billion in 2012/13 to KSh 24 billion in 2013/14. The development budget has declined significantly, but actual expenditures have increased slightly (Figure 24).

**Figure 22. GOK actual budgetary spending on health, and health as a percentage of total approved GOK budget**



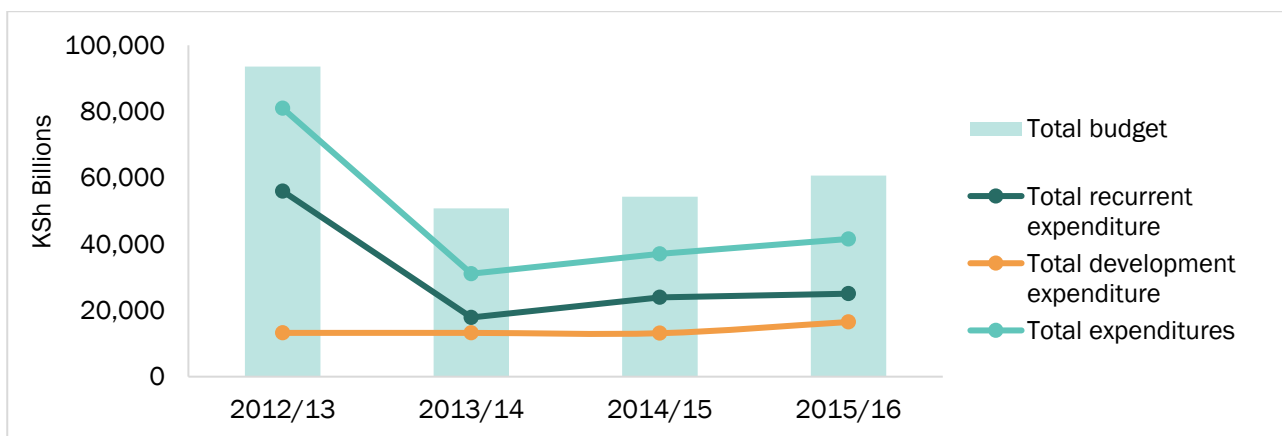
\* Provisional actuals; Source: Treasury, GOK (Health Sector Reports & Budget Statements FY2010–2018); Republic of Kenya, 2018; National and County Health Budget Analyses (2016–2018)

**Figure 23. General health expenditure as percentage of GDP among selected sub-Saharan countries, 2010–15**



Source: WHO, 2017

**Figure 24. National recurrent and development health expenditure vs. total health budget since devolution**



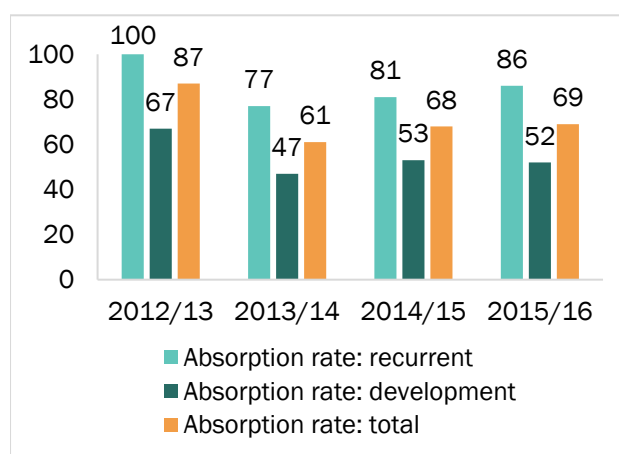
**The MOH's budget execution capacity has declined in recent years, as seen in the decreasing development expenditure.**

The MOH spent about 87 percent of the resources it was allocated by the national government in 2012/13. Interestingly, as Figure 25 shows, after devolution, the budget execution rate, also called the absorption rate, dropped to 69 percent in 2015/16. The trend is even more pronounced for development expenditure, with the MOH spending only 52 percent of the allocated funds in 2015/16. Recurrent spending, on the other hand declined to only about 86 percent in 2015/16 (from 100 percent in 2012/13). Some of this may be a result of increased fragmentation in health spending; there is weak coordination of external funding (discussed further in Chapter 6) and an increasing number of separate conditional grants for health that flow to counties (GOK, 2018).

**After implementation of the two-tier government structure, grants and transfers replaced employee compensation as the highest MOH expenditure.** With devolution, functions previously managed by the MOH are now under county governments, including paying salaries for county-level service delivery. Grants and transfers to semi-autonomous agencies now consume the largest share of MOH resources, followed by operations and maintenance.<sup>10</sup> Allocation to semi-autonomous agencies increased from KSh 19 billion in 2012/13 to KSh 27 billion in 2015/16. A significant share of the resources allocated to semi-autonomous agencies is spent paying the employees of these institutions. These salary and wage expenses are not captured under the economic classification for personnel expenses. Thus, as noted above, economic classifications actually underestimate the proportion of MOH resources spent on salaries and wages (MOH, 2016a).

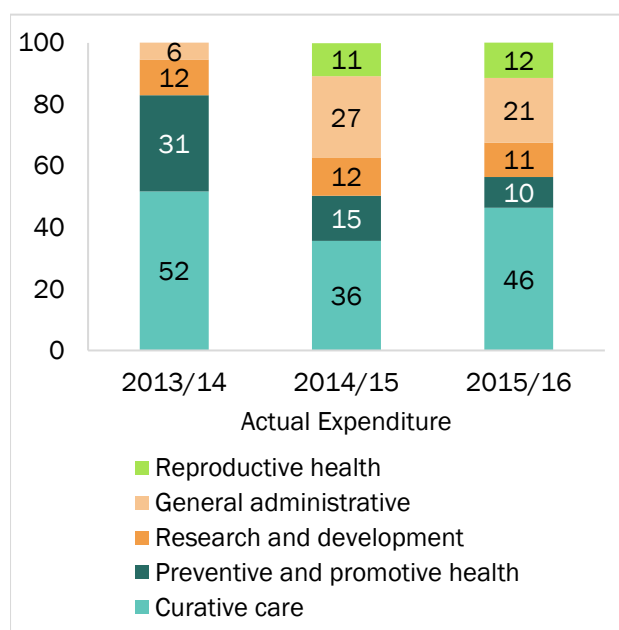
**National-level spending on health is dominated by curative services.** This is inconsistent with the stated MOH policy of shifting more resources to preventive and promotive health services. In FY 2013/14, curative services accounted for about 52 percent of the MOH's total spending, with preventive and promotive services accounting for 32 percent (see Figure 26). MOH spending on

Figure 25. MOH budget absorption rates



Source: MOH, 2016a

Figure 26. Breakdown of MOH expenditures by program



Source: MOH, 2016a

<sup>10</sup> Semi-autonomous agencies include Kenya Medical Training College, Kenya Medical Supplies Authority, Kenya Medical Research Institute, Kenyatta National Hospital, and Moi Teaching and Referral Hospital.



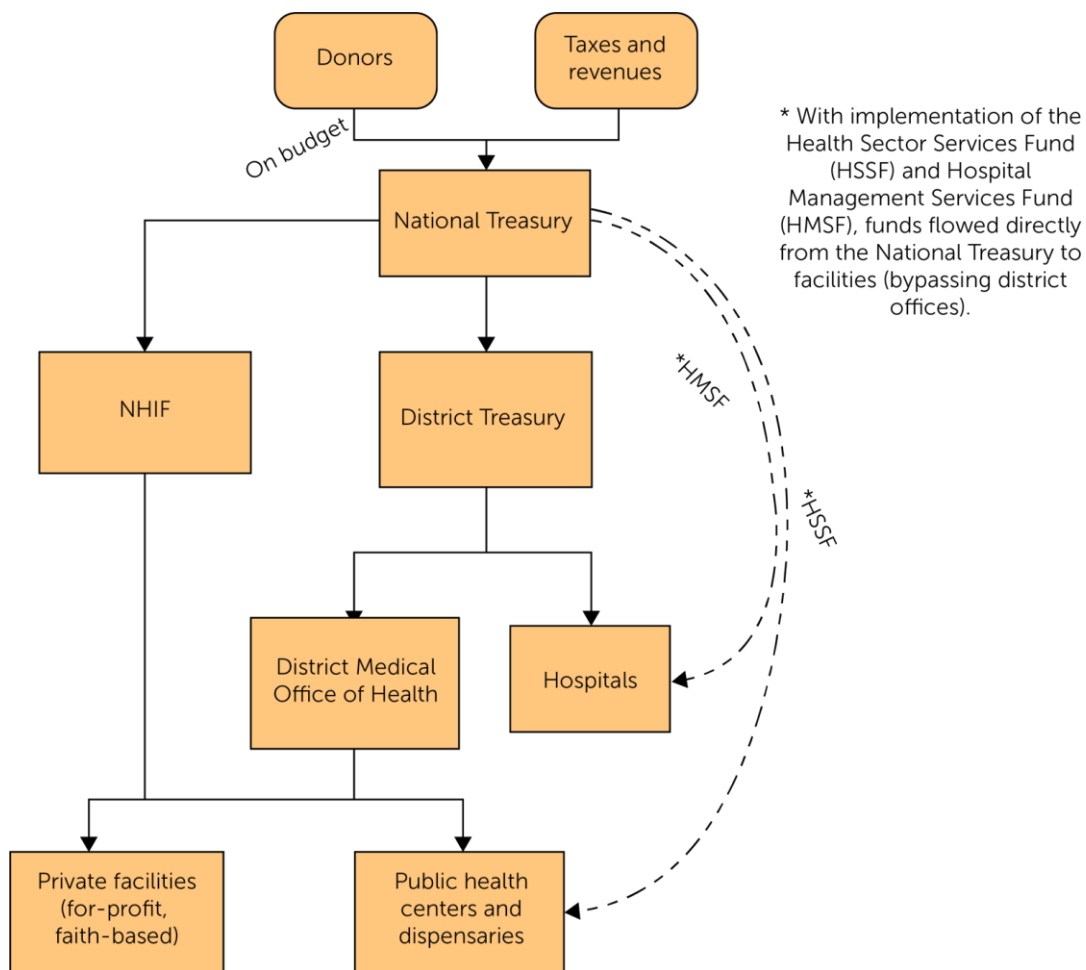
preventive and promotive programming has fallen to about 10 percent from 15 percent in 2014/15, and from nearly a third of total MOH spending in 2013/14 (MOH, 2016a).

## Devolved Resources for Health

**Devolution fundamentally changed the way resources flow through the health system, giving far greater control and discretion for health spending to county governments.** Prior to devolution, national health funds bypassed county treasuries. Some national resources flowed directly to county health departments. Others flowed through the Health Sector Service Fund and Hospital Management Services Fund, which transferred funds directly to hospitals and lower-level facilities, including reimbursement for the free primary healthcare and maternal healthcare programs. Box 3 discusses the government financing of these two programs in more detail. Following devolution, counties have autonomy in managing their finances and, in line with the 2012 Public Financial Management Act, all resources from the national level must flow through CRFs. All federal funds, including those administered through the County MOH and NHIF, are allocated through the CRF (see Figure 27 for illustrations of funding flows). There is wide variation in the prioritization of health needs (Figure 28), though the overall trend, comparing FY 2015/16 to FY 2016/17 is upward in terms of the share allocated to health.

**Figure 27. National- and county-level flow of health funds pre- and post-devolution**

*Pre-devolution*



Post-devolution

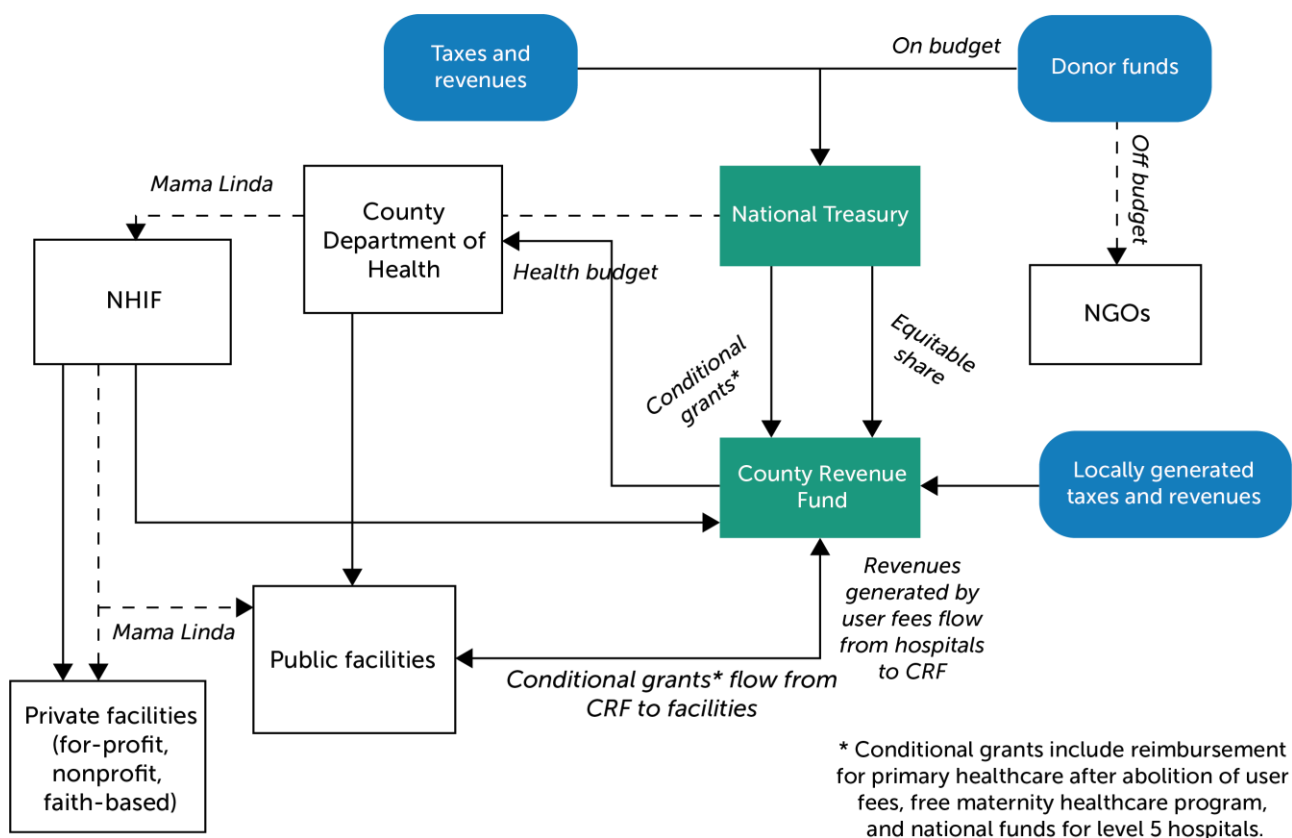
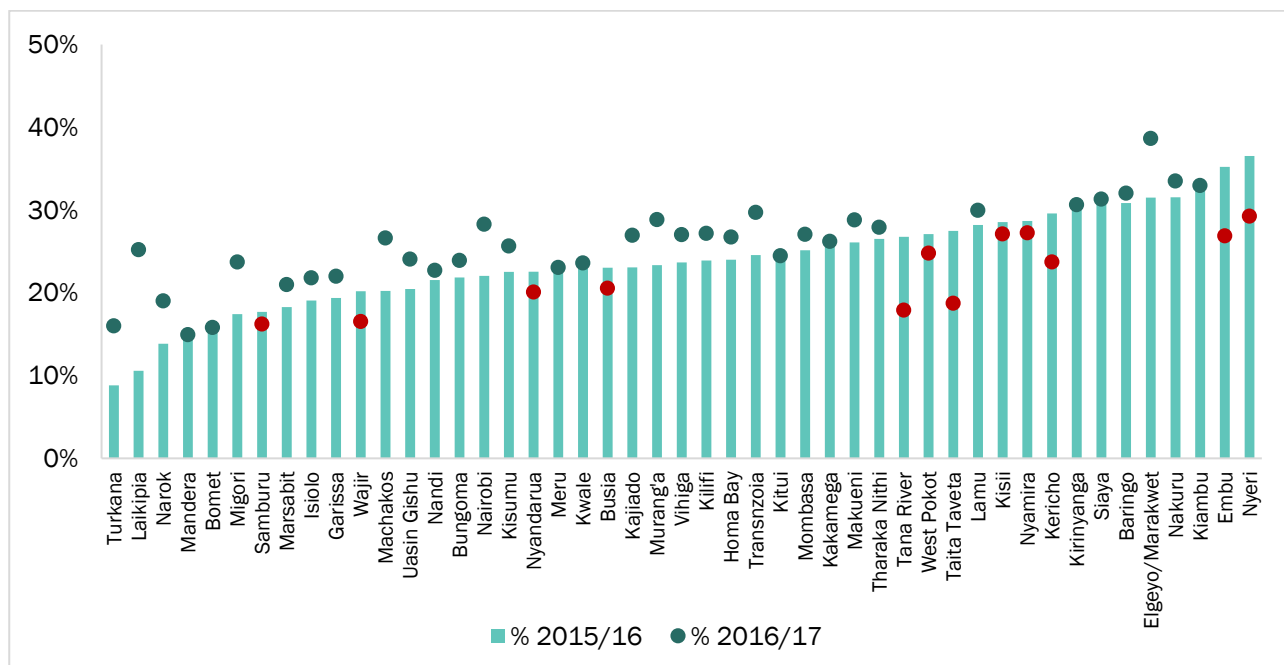


Figure 28. Percentage of county budgets allocated to health, FY 2015/16–FY 2016/17



### Box 3. Financing free primary healthcare and free maternity care (Linda Mama)

As discussed in Chapter 3, in 2013, the Kenyan government abolished user fees at public primary healthcare facilities and introduced free maternal health services in all public facilities. In the first year of the policies, the government allocated KSh 700 million and KSh 3.8 billion, respectively, to compensate facilities for the loss of user fee revenue and the cost of the maternal health services. Table 6 shows allocations for the two policies in Kenyan shillings (and the value in US dollars based on historical exchange rates).

**Table 6. Allocations for free primary healthcare and free maternity (Linda Mama) policies**

	FY 2013/14	FY 2014/15	FY 2015/16	FY 2016/17	Total
Free primary healthcare (millions)	KSh 700 (US\$8.06)	KSh 900 (US\$8.63)	KSh 900 (US\$8.02)	KSh 900 (US\$7.8)	KSh 3,400 (US\$32.9)
Free maternity (Linda Mama) (millions)	KSh 3,800 (US\$43.7)	KSh 4,000 (US\$42.9)	KSh 4,300 (US\$43.1)	KSh 3,800 (US\$37.1)	KSh 15,950 (US\$154.5)

These funds initially flowed through the Health Sector Service Fund and the Hospital Management Services Fund. As noted in Chapter 3, however, this posed challenges in terms of efficiency and timeliness of disbursement of funds. Under the devolved system, free primary health services are now reimbursed directly from the CRF to public primary health facilities, including health facilities and dispensaries. Funds flow from the National Treasury as a conditional grant to the CRFs, where they are then disbursed to the facility level (Figure 27).

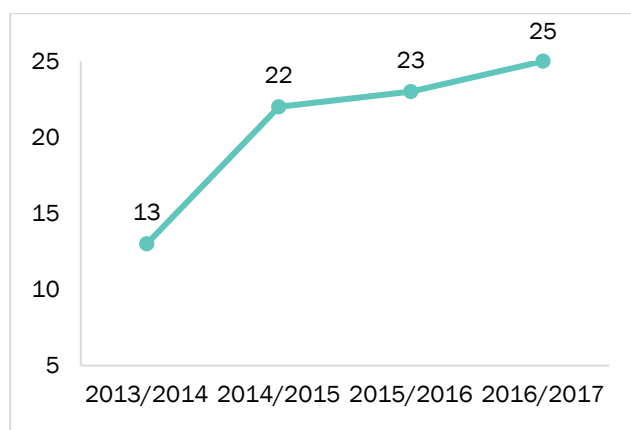
The government relaunched the free maternity healthcare program under the name Linda Mama as a reimbursement model administered by the NHIF in 2016 (MOH, 2016d). The NHIF will reimburse both public facilities and hospitals, as well as contracted private facilities for a benefits package of antenatal, delivery, postnatal, and newborn care (through the first year). The NHIF receives funds from the national government to finance the reimbursements as conditional grants flowing through the CRF (Figure 27). Reimbursement is based on quantity of services provided, determined through a combination of capitation and fee-for-service arrangements (MOH, 2016d). Outpatient services are paid through capitation and rates pegged to the NHIF's national scheme, currently KSh 1,200 per beneficiary (MOH, 2016d). Delivery reimbursement rates are currently KSh 2,500 and 5,000 for public facilities and hospitals, respectively. Private facilities are reimbursed at a negotiated rate between KSh 3,500 and KSh 6,500. All other inpatient services are reimbursed based on NHIF rates (MOH, 2016d).

**Under this system, counties have discretionary power on how to distribute resources between sectors, and the amount of resources for health depend on whether the sector is a priority.** County department development plans are consolidated into the Annual Development Plan. The latter articulates county priorities, forming the basis of the budgeting process. The County Budget Outlook Paper and the County Fiscal Strategy Paper outline the resources available and how they will be allocated to reach the priority sectors. The resources available are dependent on allocations from national government plus locally generated revenues. In many counties, however, fiscal space is limited by the scope for generating local revenues, and the majority of resources come from federal allocations.

**County allocations to health have been increasing since devolution.** Immediately after devolution, county budget allocations to health were insufficient relative to the counties' new responsibilities. A review of devolved functions estimated that health accounted for 36 percent of the functions newly under county control (World Bank, 2014a). However, total county allocations to health only amounted to KSh 42 billion, or 13 percent of total county budgets. Since then, counties have steadily increased allocations to the health sector (Figure 29). County governments' health allocation more than doubled from KSh 42 billion reported in 2013/14 to about KSh 92 billion in 2016/17. County health budgets in 2014/15, 2015/16, and 2016/17 were approximately 22 percent, 23 percent, and 25 percent of total county budgets, respectively. There are, however, huge county variations in budget allocations to the health sector. Nyeri, for example, spent 39 percent of total county government expenditures on health in 2014/15, while Tharaka Nithi spent 9.7 percent (Nyeri County Health Services, 2016; Tharaka Nithi County Health Services, 2016).

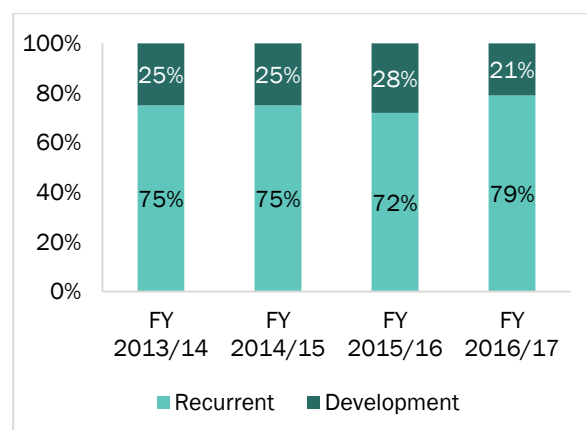
**County health sectors have inherited the national-level spending pattern in which the budget for recurrent expenditures far exceeds development.** On average, three-quarters of the county budget is allocated to cover recurrent expenditures (Figure 30). The increase in health budget for this is driven by the expanding budget for wages and salaries, which crowds out other recurrent inputs critical to achieving technical and operational efficiency in service delivery. Between 2014 and 2017, personnel emoluments received the largest share of counties' recurrent health budget, at around 70 percent. On average, drugs have received about 9 percent of the recurrent budget while operations and maintenance has received about 12 percent (Figure 31). Slowly, the development budget allocation is increasing, with investments in facility construction and rehabilitation. As Figure 32 shows, these two items consumed about half of the development budget since financial year 2013/14 and increased to 57 percent by 2016/17, reflecting counties investment in health infrastructure.

**Figure 29. County allocations to health as percentage of total county budget**



Source: National and County Health Budget Analyses

**Figure 30. County recurrent and development budget breakdown**



Source: National and County Health Budget Analyses

Figure 31. Composition of county-level health budget: recurrent

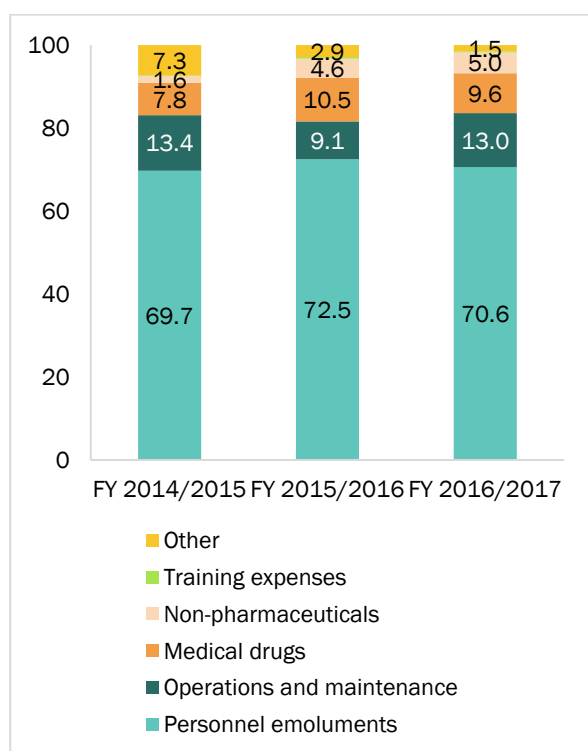
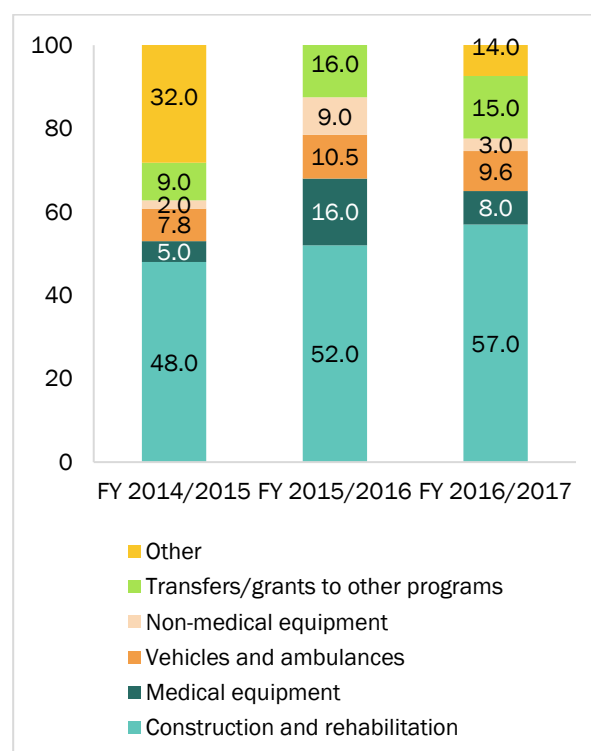


Figure 32. Composition of county-level health budget: development



## Discussion

**Kenya's current macroeconomic forecast suggests the government's ability to mobilize resources for health will continue to grow, subject to an ability to manage competing priorities and the need to control total public debt.** The Kenyan economy has grown rapidly in recent years and is projected to continue to grow in the medium term. The national government's tax collection and the tax compliance rate are improving. Mobilizing sufficient resources for health will require continued effort for all levels of government. As in other sub-Saharan countries, the level of public debt continues to grow very rapidly, approaching 60 percent of GDP, and may grow further if not checked by prudent fiscal policies. Kenya's need to control public debt has the potential to restrain growth in social sector spending, especially with continuing security threats. Still, growing public sector revenue presents an opportunity for the GOK to spend more on key social sectors to meet development and political demands, and this includes health at both the national and county levels. Nominal spending for health across both levels of government has indeed increased. It has not increased, however, as a proportion of the total government budget. Although the overall macroeconomic climate is promising for the health financing system, it will not necessarily translate into gains for the sector without continued effort and prioritization of health in the face of critical competing priorities and fiscal pressures.

**Devolution has given far more health financing control directly to county decision makers, yet their actions may be constrained due to a high share of wages and salaries in their health spending.** The new financial flow structures pool resources for counties in the CRFs, giving counties decision-making power over how to use them. This decentralized health financing system is intended to allow counties to disburse and administer funds more efficiently and to be more responsive to population health needs. This also means that county-level spending on health reflects county priorities, not just available resources; there are wide disparities among the counties in terms of proportional budget allocations to health. Further,

as discussed above, not all counties have dedicated sufficient resources to health to meet the totality of their responsibilities under devolved government functions. Increasing the potential for government revenue is not guaranteed to translate into increased county-level health spending. Much health spending is recurrent, and at least 71 percent in total at the county level is focused on wages. There has, however, been an increase in conditional grants to counties over the last three years. Unlike national resources allocated to counties under their formula-based share, conditional grants can be marked for special purposes. This growth is in part a reflection of increasing health expenditures through Linda Mama and the free primary healthcare programs. This trend will likely continue as the GOK continues to expand financial protection in health through user fee removal programs implemented at the county level.

**Overall, county revenues are highly dependent on national resources devolved based on the formula.** There is limited capacity from county governments to mobilize locally generated revenues, through county-level taxes or other mechanisms, which is unlikely to change in the immediate future. Therefore, even though the majority of direct health spending now takes place at the county level, the availability of resources for health will continue to depend largely on national resource mobilization driven primarily by national tax revenues.

**County government resources will play a critical role in the future successful scale-up of NHIF coverage.** As discussed further in Chapter 5, county governments will have increasing responsibility for reaching and enrolling informal sector members in NHIF. Under the ongoing enrollment drives for NHIF, for example, many counties have a target enrollment number to reach. Enrollment drives require resources, as will any long-term future role in subsidizing the membership of the poor and vulnerable in their borders. County governments will also have to allocate sufficient resources to support premium subsidies for the poor, which they currently do only at a relatively small scale (see Chapter 5).

**Particularly in light of declining external financing for health, Kenya will need to mobilize more domestic resources for health to finance its ambitious health agenda but also spend them efficiently.** As Chapter 6 discusses in more detail, external health financing is in long-term decline in Kenya. Public resources will be critical to ensuring improvements in service delivery, meeting the challenge of rising noncommunicable diseases, as well preventing an increased burden of OOP health expenditures for the poor and vulnerable. In the long term, as NHIF coverage increases and can more adequately mobilize funds from contributor segments, both mandatory and voluntary, inherently public health functions will become the main focus of public tax-based health financing. In the short to medium term, the GOK faces the challenge of balancing a need to mobilize greater resources for a variety of health needs, which it can only do through a limited set of mechanisms, including from tax revenue, with a need to restrain overall government spending to control the public debt. Maximizing efficient targeting and full execution of health resources is the minimum requirement; in addition, as average per capita incomes rise, finding equitable, progressive ways to raise health-related resources from middle- and upper-class Kenyans is needed. However, current efforts to remove user fees for an increasing share of health services for an increasing share of the population suggest that such targeting is still a plan for the future.



Photo courtesy of Direct-Relief

## 5. CURRENT STATE OF HEALTH INSURANCE SCHEMES

**Expanding health insurance coverage through a social health insurance model is central to Kenya’s strategy for achieving UHC targets.** As articulated in the *Roadmap Towards Universal Health Coverage (2018–2022)*, Kenya intends to achieve universal coverage through a Social Health Insurance Fund (SHIF) as single-payer by 2022. Although current NHIF coverage is a promising base from which to expand purchasing of a guaranteed benefits package, and while current plans to raise enrollment are important, this target is ambitious. Current NHIF coverage by most measures is less than one-fifth of the population. Achieving universal insurance coverage will require considerable effort to scale up enrollment, particularly of informal workers and the poor, as well as to strengthen the NHIF systems and purchasing mechanisms. This chapter assesses the current state of health insurance coverage, including NHIF and private schemes, in light of these ambitious plans for scale-up and for using NHIF as a vehicle to advance UHC.

**Health insurance coverage in Kenya is increasing and compares favorably to its neighbors, but overall coverage is hard to confirm due to differences across survey and administrative data.** According to recent KHHEUS data, 19.9 percent of individuals surveyed in mid-2018 had some form of health insurance,<sup>11</sup> an increase from 17 percent in the 2013 KHHEUS data (MOH, 2018) (Figure 33). This is also broadly in agreement with the findings of the KIHBS 2015 (KNBS, 2018). As a point of comparison, in FY 2016/17, the National Health Insurance Fund in Tanzania covered approximately 6 percent of the population (Lee, 2018).<sup>12</sup> In

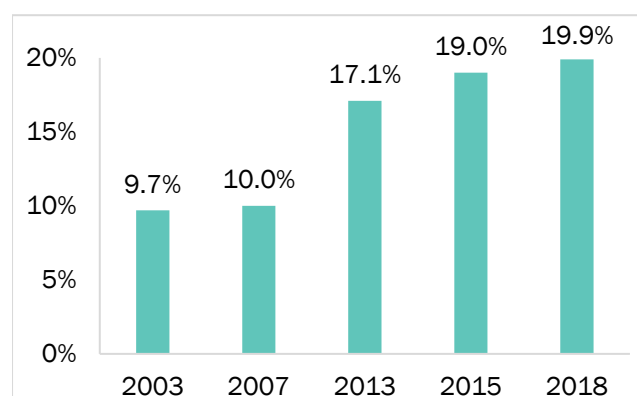
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<sup>11</sup> The KHHEUS survey question is, “Is there any member of the household who is covered by any form of health insurance?” The enumerators are then expected to probe and list the household members covered and the forms of health insurance held by each person. Household members may be covered by more than one form of insurance. In the KIHBS survey, the question asks, “In the last 12 months was [NAME] covered by any health insurance?” Each household member is to be listed, and the enumerator further records the source of insurance for each.

<sup>12</sup> An ineffectively implemented community health insurance scheme, the Community Health Fund, could claim about 2.1 million households, or about 12.6 million total beneficiaries, representing 23 percent of the population (Lee, 2018).

Ethiopia, social health insurance is still nascent, but about 16 percent of the population had access to community-based health insurance at the end of 2017 (McGaugh, 2018). While there has been some growth in private insurance, NHIF covers the vast majority of insured Kenyans; in the KHHEUS 2018, 89.4 percent of respondents with insurance were covered by NHIF, marginally up from the 88.4 percent reported in the 2013 KHHEUS (KNBS, 2018). In comparison to these statistics from the KHHEUS, the KIHBS 2015 reported that 94 percent of all the insured were covered by NHIF (KNBS, 2018). Therefore, there is variability in the role of the insurer across surveys. In sharp contrast, the recent NHIF *Strategic Plan 2018–2022* states that based on its principal membership count of 7.66 million Kenyans at the end of FY 2017/18, it had an overall membership, including dependents, of 27.2 million (Table 7) (NHIF, 2018b). This would imply coverage of over 50 percent of the population. Hence, there appears to be a large discrepancy with the survey data cited above, which may be rooted in interpretation of the survey data and on specific assumptions; this is discussed in Box 4.

**Figure 33. Individuals reporting some form of health insurance coverage**



Sources: KIHBS, 2015-16; KHHEUS, 2018

#### Box 4. Proportion of the population covered by NHIF

**Discordance in estimates.** The KHHEUS 2018 suggests that 17.8 percent of Kenyans are insured by NHIF (about 89 percent of the 20 percent with any insurance), which translates to about 8.8 million individuals (MOH, 2018). In contrast, NHIF stated in 2018 that based on its membership of 7.66 million at the end of FY 2017/18, it insures about 25 million Kenyans, or about 49 percent of the population. Which is correct?

**Based on the principle of family enrollment, NHIF's coverage estimate is plausible as a theoretical ceiling of coverage.** NHIF membership covers a nuclear household, and in Kenya, the average household size in urban areas is 3.4 and in rural areas 4.6 (as averages of estimates from KHHEUS 2018 [MOH, 2018] and KIHBS 2015 [KNBS, 2018]). NHIF's stated population-level coverage for 2017/18 suggests that it uses a household size of 3.3. This lower figure may account for the presence of some factors that cause coverage to be overstated, but it is not clear if it does so sufficiently. For example, NHIF's total membership (principal plus dependents) would be overstated if:

1. Some households in the formal sector are dual-income, where both earners contribute on their payroll; therefore, membership in the formal sector cannot accurately be multiplied by household size without accounting for such families—the estimate for which is unknown.
2. NHIF members who have died or stopped paying their dues are not removed from the rolls in time for the estimates. This is also unknown.
3. There may be families whose principal member failed to register all children on the NHIF enrollment form, which is also unknown.



**Survey-based estimates of insurance coverage may require further analysis.** The questions in the KIHBS and KHHEUS surveys are oriented toward the detection of household members with insurance, followed by identification of the type of insurance each individual carries. However, the enumerators' probing of the insurance status of individuals beyond the household head was not clear and requires clarification. The following are illustrative reasons why NHIF coverage may be underreported:

1. If the household head being interviewed is not aware of the nature of their benefits and the derivative insurance status of children, the children's insurances status may not be reported.
2. Some aspects of the adolescent children's status may connote that they do not have access to insurance under their parent's coverage, e.g., in the common scenario where they attend secondary school away from home.

**Table 7. Baseline membership, start of FY 2017/18**

Segment	Membership
Formal sector	3,870,400
Informal sector	2,934,000
Indigent (Health Insurance Subsidy Program) households	180,000
Other*	41,660
Total	7,026,060

\* Elderly and people living with severe disabilities; Source: NHIF, 2018b; KNBS, 2018

**Note on family enrollment:**

- NHIF membership can extend from the primary member and their declared immediate nuclear family (all children, up to 10 in total, can be registered on a single form). In the formal sector, a family may have more than one contributing member registered separately. There is no provision to register parents or other relatives (siblings) as dependents on the form.
- Since there is no additional cost to doing so, informal sector members can also register their immediate family (spouse and children) for the same flat rate of KSh 500, which is likely being done.
- In the Health Insurance Subsidy Program, entire vulnerable households, such as those in the GOK Cash Transfer Program for orphans and vulnerable children, are registered.

Given that NHIF does not provide statistics showing why its coverage may be overestimated, the 2018 estimate of nearly 50 percent of the population covered should be taken **only as a theoretical maximum**.

**There are geographic disparities in health insurance coverage.** Health insurance coverage is higher among urban Kenyans. Nearly 30 percent of people in urban areas have some form of health insurance, while coverage is only about 14 percent in rural areas (KNBS, 2018). This may be a reflection of the higher levels of informal sector employment in rural areas and less awareness of insurance options. One study using 2014 KDHS data suggests that these differences are explained by socioeconomic status, with higher poverty rates in rural areas and poorer individuals less likely to be insured, especially through private insurance (Kazungu and Barasa, 2017). According to KHHEUS data, there is also marked variation in coverage across counties (Figure 34) (MOH, 2018). Approximately 41 percent of Kenyans in Nairobi reported having insurance coverage, about 32 percent were covered in Nyeri and Embu, and in Wajir, less than 1 percent of the respondents were covered; West Pokot, Marsabit, Mander, and Garissa all had coverage below 3 percent (MOH, 2018).

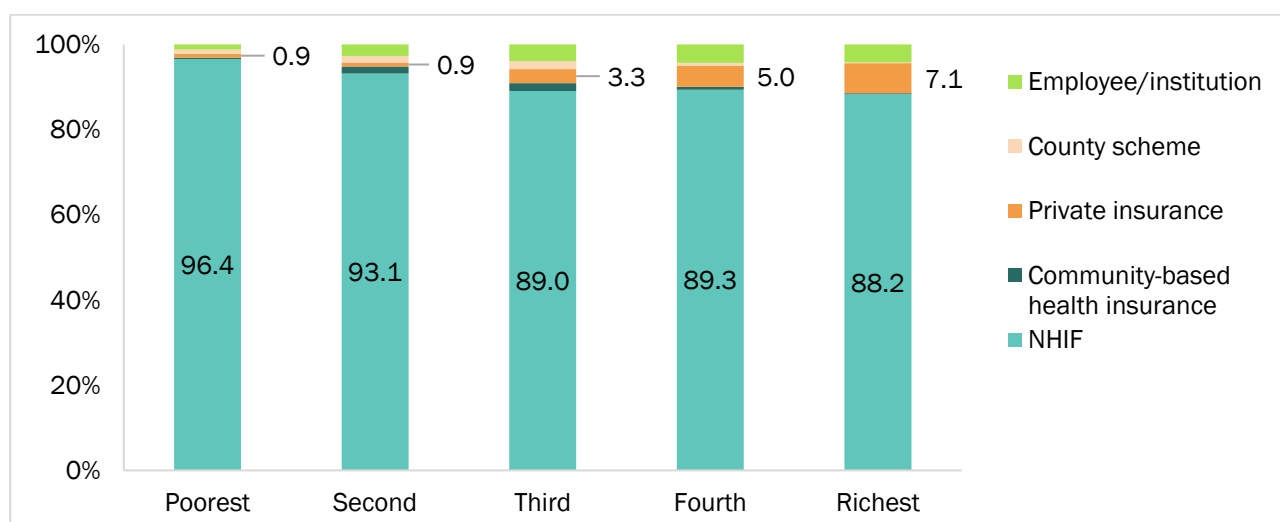
**Figure 34. Insurance coverage by county (percentage of population)**

County	%	County	%	County	%
Wajir	0.2	Trans Nzoia	10.9	Laikipia	21.4
Mandera	1.3	Homa Bay	11.3	Kisii	22.1
Marsabit	1.7	Makueni	13.5	Nakuru	22.9
Garissa	2.7	Migori	13.7	Muranga	23.1
West Pokot	2.9	Vihiga	14.3	Taita Taveta	23.4
Tana River	3.1	Kakamega	14.9	Kericho	23.9
Turkana	5.0	Tharaka Nithi	15.7	Uasin Gishu	25.2
Busia	6.1	Meru	17.4	Bomet	25.6
Samburu	6.4	Kilifi	17.9	Kiambu	25.6
Bungoma	6.5	Nyandarua	18.0	Kisumu	27.1
Siaya	7.7	Mombasa	18.1	Kajiado	28.4
Isiolo	7.7	Machakos	18.5	Kirinyaga	29.1
Lamu	7.9	Nandi	18.6	Nyeri	32.2
Kitui	8.6	Nyamira	20.1	Embu	32.7
Kwale	9.2	Baringo	20.4	Nairobi	41.0
Narok	9.3	Elgeyo Marakwet	20.8		

Source: MOH, 2018

**Insurance coverage is significantly higher among the wealthy across all types of health insurance.** According to the KHHEUS 2018, only 2.9 percent of the lowest quintile has health insurance, compared to 42 percent of the wealthiest. The vast majority of all quintiles are covered through NHIF, but NHIF coverage is highest among the poor (as a proportion of those insured). Private insurance coverage increases with wealth quintile. Private coverage is virtually nonexistent among the poorest members of the population but reaches 7 percent among the wealthiest (Figure 35). Community-based health insurance coverage, on the other hand, is highest among the poor. Kazungu and Barasa (2017) found similar differentials in their study; individuals from wealthy households were 12 times more likely to be covered by health insurance than the poor (Kazungu and Barasa, 2017). While the uninsured can access free primary and maternal healthcare services through the government-financed user-fee removal schemes like Linda Mama, they are not protected against the financial impact of hospital costs, leaving them vulnerable to CHE.

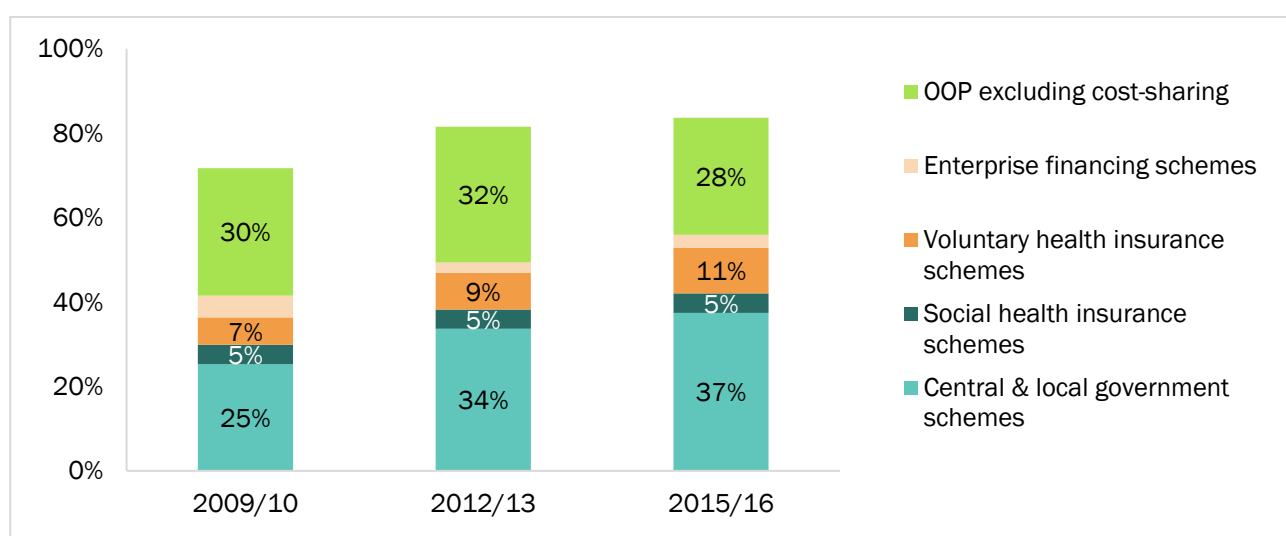
Figure 35. Sources of health insurance coverage for the insured, by wealth quintile



Source: MOH, 2018

**The overall proportion of total health expenditure from health insurance has been relatively stable in recent years** (Figure 36). Since 2009, total health expenditure (THE) pooled through NHIF (social health insurance schemes) has remained constant at around 5 percent, although it has increased in absolute terms from about KSh 9 billion in 2009/10 to KSh 15.1 billion in 2015/16 (MOH, 2017b). Enterprise financing schemes (i.e., employer-provided healthcare or insurance) across the same time points accounted for a constant amount of THE, around KSh 10 billion, but it declined from 6 percent to 3 percent as a proportion of overall health expenditures (MOH, 2017b). Voluntary health insurance schemes, including private and community-based schemes, have increased significantly from 7 to 11 percent of THE, accounting for KSh 35 billion in 2015/16 (from 13 billion in 2009/10). Despite representing a larger share of the total health funding, however, voluntary health insurance schemes cover a relatively small share of the population, at less than five percent (MOH, 2017b).

Figure 36. Total health expenditure (THE) by domestic sources

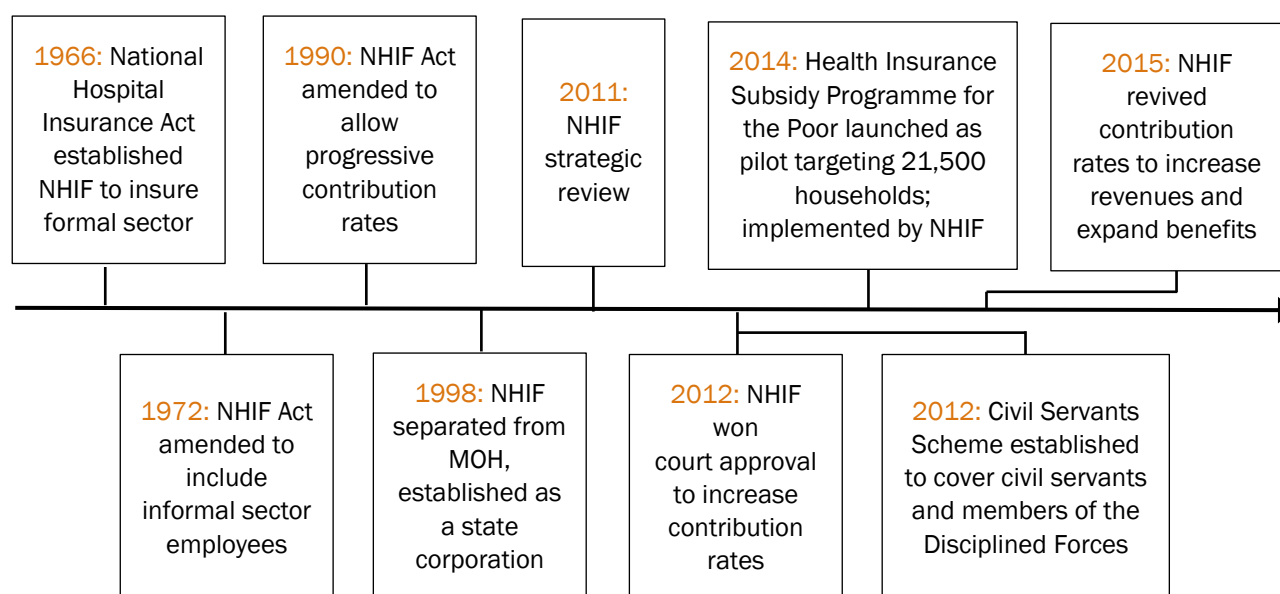


Source: MOH, 2017b

## National Hospital Insurance Fund (NHIF)

**NHIF is the primary provider of health insurance in Kenya and the primary vehicle through which Kenya intends to expand insurance coverage.** It was established through the National Hospital Insurance Act of 1966 to provide insurance coverage for formal sector employees, but the populations covered, the number and types of schemes available, and contribution rates have evolved since then (Figure 37). In the formal sector, only employees make contributions, with no employer share, which is unlike other contributory mechanisms for social health insurance in middle-income countries. Until the rates were revised in 2015, they had remained unchanged for decades. They ranged from KSh 30 to KSh 160 per month, according to income, while informal sector members paid a flat rate of KSh 160. Low rates limited the package of inpatient benefits NHIF could cover, and in 2015, it significantly increased contribution rates for the first time (Deloitte, 2011; Ongiri, 2015). Rates now range from KSh 150 to KSh 1,700, with informal sector members contributing a flat rate of KSh 500 (Box 5) (NHIF, 2017b). Membership is compulsory for formal sector employees, and contributions are deducted by their employers; participation is voluntary for informal sector workers. Further increases to the payroll-based contribution rates have been deemed unfeasible in the short-term due to popular opposition to higher premiums.

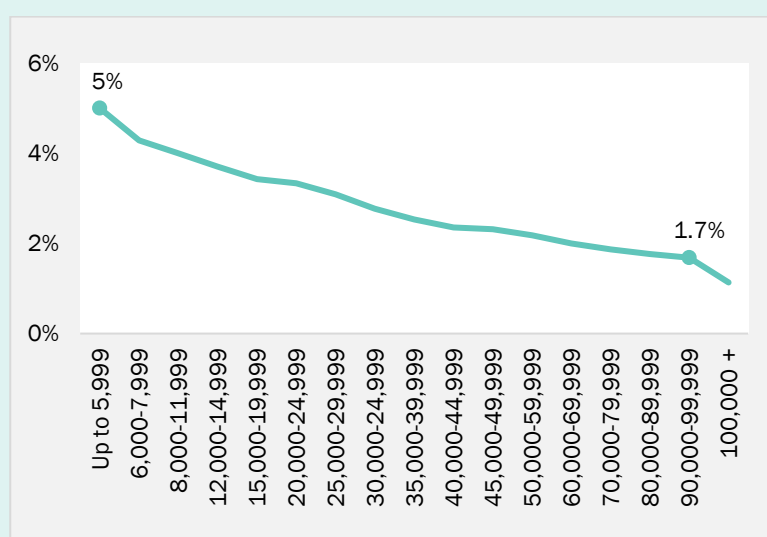
**Figure 37. Key milestones in the history of NHIF**



### Box 5. Understanding NHIF contribution rates

In the formal sector, NHIF contributions are paid by the employee only, in contrast to the shared burden with employers in most other contributory social health insurance schemes. For example, in Indonesia, the total payroll contribution for the National Health Insurance Scheme is 5 percent, with a cap on the maximum taxable monthly income. In Kenya, the average contribution rate across salary bands is closer to 3 percent (Table 8). Of the 5 percent in Indonesia, public sector employers are responsible for 3 percent and employees pay 2 percent. In the private formal sector, employers pay more—4 percent. For NHIF, the proportional contribution pattern is also regressive. As seen in Figure 38, lower-income earners pay more as a share of their wages. Even a flat proportional rate would be more progressive. In April 2018, the Kenyan parliament considered an amendment to the NHIF Act of 1998 that would require employers to contribute. However, as of late 2018, this was yet to become law, and it faces significant opposition from employer groups.

**Figure 38. NHIF contribution as percentage of salary band midpoint**



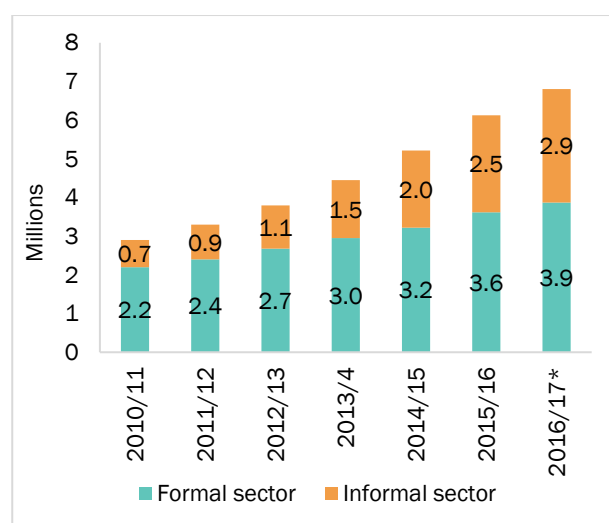
**Table 8. Employee contribution to NHIF**

Gross Monthly Income Band	Monthly Contribution (KSh)
Up to 5,999	150
6,000–7,999	300
8,000–11,999	400
12,000–14,999	500
15,000–19,999	600
20,000–24,999	750
25,000–29,999	850
30,000–34,999	900
35,000–39,999	950
40,000–44,999	1000
45,000–49,999	1,100
50,000–59,999	1,200
60,000–69,999	1,300
70,000–79,999	1,400
80,000–89,999	1,500
90,000–99,999	1,600
100,000+	1,700
Self-employed	500

**NHIF membership has expanded over the last five years, with a higher informal sector growth rate than among the formal sector.** According to the KNBS Economic Surveys, NHIF membership, including both the formal and informal sectors, which may include indigent sponsored members and other smaller groups, grew by 79 percent between 2012/13 and 2016/17, increasing by an average of 15 percent annually over the period since 2010/11 (KNBS, 2011, 2013, 2017). Total membership in the employed sectors increased from 6.1 to 6.8 million between 2015/16 and 2016/17. The formal sector's share in primary membership across the two sectors has been dropping and accounted for 57 percent in 2016/17, down from 76 percent in 2010/11. Informal sector membership growth annually outpaced formal sector enrollment growth

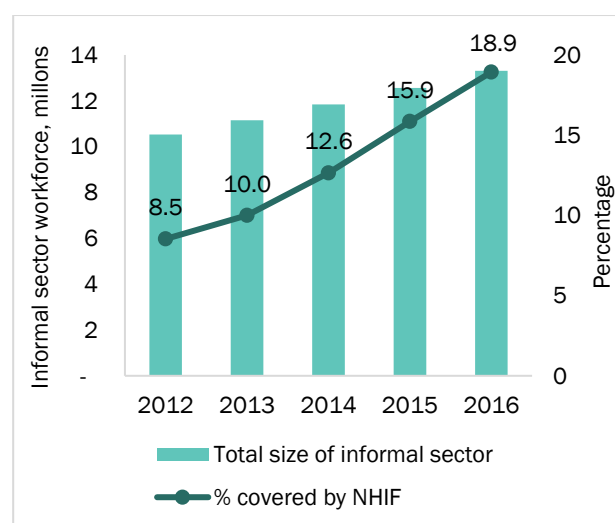
throughout the period, but it has slowed since its peak in 2013/14. Informal sector membership grew 17 percent in 2016/17, compared with 7 percent growth in the formal sector. Figure 39 shows total NHIF membership by employment group, while Figure 40 shows NHIF membership as a percentage of the total estimated size of the informal sector workforce. NHIF and other partners are making concerted efforts to increase informal sector enrollment beyond these levels (KNBS, 2017). Different enrollment drives are currently being conducted, including with the assistance of county governments and employing the organization Amref Health Africa, which was conducting door-to-door recruitment using community health volunteers in several counties in late 2018. The ongoing NHIF enrollment drives are also focused on informal sector membership, with some county governments taking on responsibility for hitting certain membership targets.

**Figure 39. Historical NHIF principal membership by employment sector**



\* Excludes indigent (sponsored) households and other small segments; Source: KNBS Economic Surveys 2011–2017

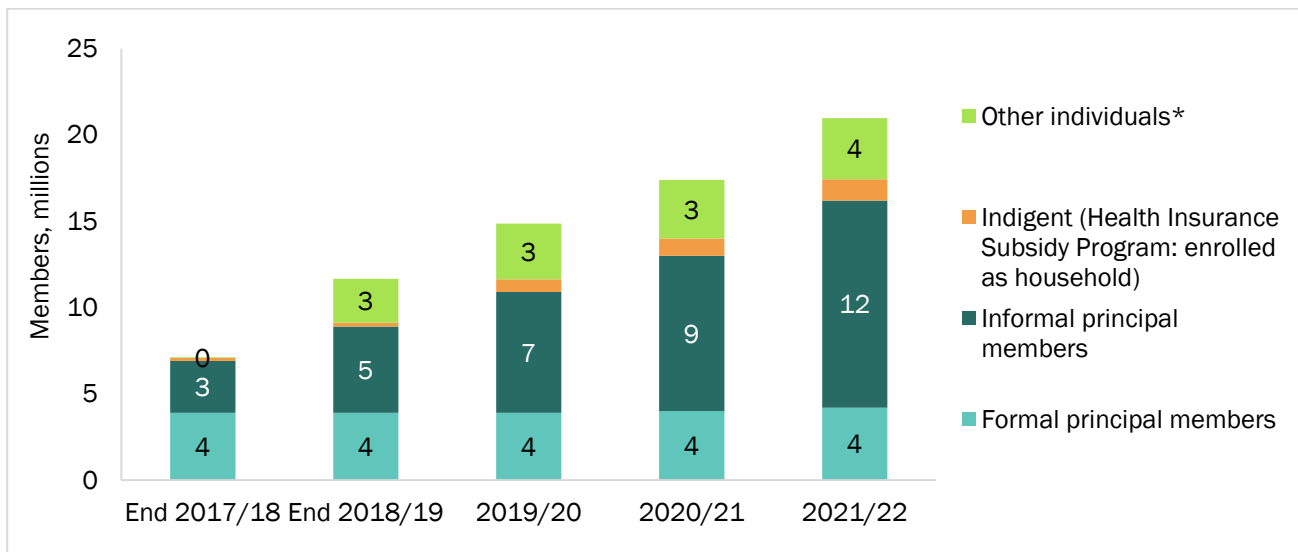
**Figure 40. Proportion of the informal sector workforce that are NHIF members**



Source: KNBS, 2017

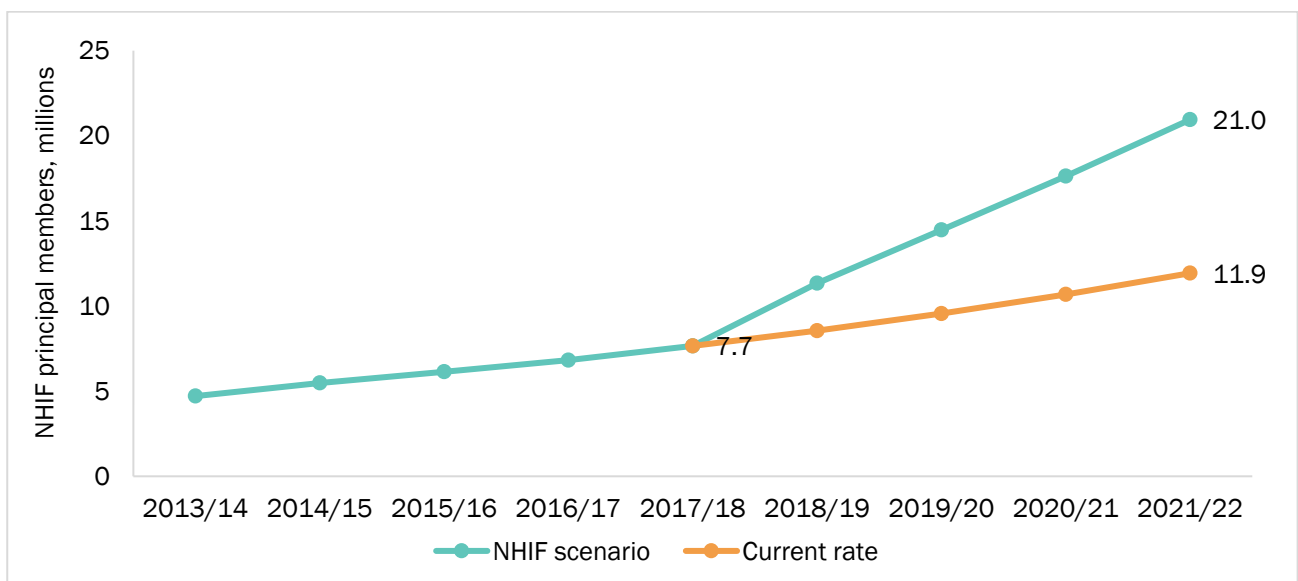
**The GOK has set ambitious scale-up targets in the *Roadmap Towards Universal Health Coverage (2018–2022)* to achieve universal coverage of health insurance by 2022.** By 2020, it intends to triple the number of primary NHIF members from the informal sector as of the end of FY 2017/18, which would require also tripling the recent rate of enrollment growth from this sector. The targets from the roadmap, which are also repeated in the *NHIF Strategic Plan 2018–22*, are shown in Figure 41. They include ambitious targets to enroll secondary students and the elderly. Overall, these targets for new members would represent a steep acceleration to the past rate of growth, as shown in Figure 42. Though there is substantial disagreement and confusion about the share of the overall population these NHIF membership targets may represent, as a theoretical maximum, we estimate that meeting these targets would get the country close to high or near-universal insurance coverage, but the overlap between some of the segments in the targets, e.g., for secondary school students as independent members versus dependents, has not been resolved (GOK, 2018; NHIF, 2018b).

Figure 41. Targets for growth in members by segment, NHIF Strategy



\* Elderly and secondary school—secondary students are a substantial element of this proposed segment. Overlap as dependents has not been clarified. Source: NHIF, 2018b

Figure 42. Growth paths for NHIF primary membership



**Kenya is employing a range of potential tactics to scale coverage of the harder-to-reach informal sector in NHIF.** In 2017, for example, it first partnered with mobile wallet platform M-TIBA, which is a partnership of PharmAccess Foundation, CarePay, and mobile network operators, to enroll 2,000 households from informal settlements into NHIF, as well as 4,600 workers of the horticulture company Oserian (Macharia, 2017). M-TIBA has since grown independently, and its tie-up with NHIF through the NHIF Bora promotion is driving individual as well as employer-driven enrollment into SupaCover. NHIF has also created the NHIF Mobile app that allows users to deposit small amounts of money as they are able, until they reach the KSh 500 informal sector premium. This is intended to make it easier for informal sector members to both save for and actually pay their contributions (*Daily Nation*, 2017). The roadmap also outlines broader, country-wide efforts to drive this enrollment. Some of the responsibility for these strategies lies with county governments, which are expected to devise targeted strategies for their populations. Currently, four counties are implementing Afya Care pilot programs to further

eliminate user fees up to the secondary care level. These pilots are discussed in detail in Box 7. The government is also proposing incentivizing county enrollment and premium collection through results-based transfers from the central level. NHIF also intends to use bank agents, rewarded with commission, and community health workers, including those organized through its partnership with Amref, to drive informal sector enrollment (GOK, 2018).

**Box 6. MakueniCare: Example of county-led innovation or further fragmentation in health financing?**

Makueni is a mainly rural county in southeast Kenya, with a population of approximately 1 million (2018 estimate). From May to September 2016, the County Government of Makueni initiated a pilot program under the title MakueniCare. The focus of MakueniCare was senior citizens over 65 years of age for whom it reimbursed expenses incurred for care at county hospitals. Since 2018, the County Government of Makueni expanded this to cover all residents and has adopted a plan target of spending 30 percent of its budget on health, which allows for financing the scheme. Allocations increased from KSh 200 million in FY 2016/17 to KSh 300 million in FY 2018/19 (Kibwana, 2018). MakueniCare has the stated objective to address financial barriers to access to services. Under this model, the county government guarantees and provides a set of essential curative, promotive, and rehabilitative healthcare services within county facilities, free of charge at the point of care. Residents must register as a principal beneficiary or as a spouse or dependent (below 18 years, except if school-going, then up to 24 years), and pay KSh 500 per household annually as a “registration fee.”

**Table 9. Stated scheme characteristics**

Benefits	Specifics	Provider Reimbursement
Inpatient free of charge	Nursing care, daily bed fee (range KSh 500–600), ward consumables, physician daily consultation, side-room procedures, last office procedures, laboratory and radiological investigations, blood transfusion	Fee-for-service
Outpatient free of charge	Outpatient department consultation, dental services, minor procedures, ambulance transport from community to county hospital, laboratory tests, occupational and other therapies, routine orthopedics, pharmacy services, X-ray imaging	Fee-for-service
Services with patient co-pay	Prosthetic devices, surgical implants, post-mortem, specialized imaging (CT scan), intensive care unit services, dialysis, non-routine medical reports	N/A

By August 2018, MakueniCare had 45,000 households enrolled (approximately 18 percent of the population). As per a report from a single facility (Muasya, 2018), inpatient utilization increased by 70 percent and outpatient by 40 percent. A larger evaluation of the model is under way, led by HP+. Critical questions remain: How will the scheme harmonize with the larger vision to expand NHIF across counties? How does the scheme currently manage any overlap in benefits with NHIF for households? Will MakueniCare merge into a local expansion of NHIF and adopt the larger benefits package NHIF currently offers? Will Makueni residents be willing to pay the charges as SupaCover requires? County schemes such as Makueni’s offer important lessons and show the willingness of county governments to invest in financial protection. However, the scheme raises questions of appropriate targeting of public resources and long-term sustainability.



### Box 7. Afya Care: A four-county pilot program to remove user fees for an expanded package of health services and test the system's response

As a step toward its commitment to reach UHC by 2022, the Kenyan Government launched Afya Care pilots in four counties on December 1, 2018, covering 7 percent of the Kenyan population. Key objectives are to test the ability to scale up population coverage of an expanded benefits package, especially covering services at county level 4 and 5 facilities (former district and provincial hospitals). It is also a key attempt to learn what works to reduce OOP spending and increase utilization of services and financial protection, all using government supply-side financing. Participants in the scheme will be attached to a specific public health facility and receive special Afya Care cards that will entitle them to free services at public facilities, paid for through NHIF.

Each of the four counties is representative of a different specific population or epidemiological profile, intended to test the appropriateness of the initiative and proposed benefits in different contexts. The pilot is being financed through a KSh 3.2 billion (US\$31.6 million) conditional grant from the national government divided across the four counties (Table 10). Funding will flow from the national Treasury to the national MOH and then be disbursed to county UHC fund accounts, except for the funds that will flow to KEMSA.

**Table 10. Afya Care pilot funding allocations and population**

County	Population	Allocation (KSh)	Allocation per capita (KSh)	County population type and epidemiology
Isiolo	184,768	725,719,086	3,928	Large nomadic and migrant populations
Kisumu	1,182,320	876,121,179	741	High infectious disease burden, including HIV
Machakos	1,216,120	787,524,789	648	High prevalence of injuries and accidents
Nyeri	830,296	780,801,105	940	High noncommunicable disease burden, including diabetes
Total	3,413,504	3,170,166,160	—	—

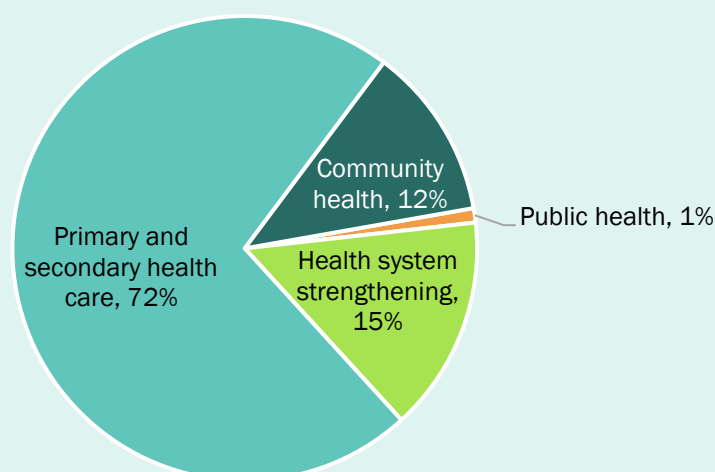
Counties will allocate the funds across four areas (Figure 43):

1. Public health services: resources allocated to County Health Management Teams for public health functions such as services quality control, data collection, and surveillance.
2. Community health services: funds to be used for community health worker training and supplies.
3. Basic and specialized services: 70 percent of these funds will flow through KEMSA for drugs and other supplies; the remaining 30 percent will be used for health facility operations and maintenance (levels 4 and 5).
4. Health system strengthening: 30 percent of these funds will be used for medical equipment in health facilities; the remainder will be used for general health system strengthening activities, including human resources and monitoring and evaluation. At least 5 percent must be used for performance-based financing at the facility level.

The intention of the pilot is to use specific national “top-up” funds over and above regular county spending, to enable entirely free services up to level 5 facilities. The ability of the system to meet the enhanced demand will be a key learning objective.

An additional fund will be established to pay for specialized care from tertiary facilities and national teaching hospitals outside the county boundaries. Managed by NHIF, the fund will pay for the poor from each of the pilot counties to access services at such referral hospitals. Counties are expected to match this money with their own resources.

**Figure 43. Planned Afya Care spending**



**Expanded coverage will also target specific vulnerable population groups with subsidized premiums.** For any Kenyans over the age of 70 not receiving pensions, the national government will subsidize health insurance coverage. The targets shown in Figure 41 include significant estimates of growth for this segment. Along with the elderly, the national government will also pay for coverage for individuals with severe disabilities. In addition, the GOK intends to target public secondary school students and continue the enrollment of poor (indigent) households, scaling this target to 1.5 million households by 2022. The *Roadmap Towards Universal Health Coverage (2018–2022)* identifies a budgetary need of KSh 6.3 billion for enrolling targets from these three sponsored segments in FY 2018/19, for which resources have not yet been identified or allocated. The Linda Mama program, which covers pregnant women (see Chapters 3 and 4), will also be used as a mechanism to ensure universal coverage, covering approximately 1.3 million additional women each year. Any pregnant women not covered by other insurance will be enrolled in Linda Mama whenever they make contact with the health system, covering them with basic maternal and neonatal services through the first year of life (GOK, 2018). This is an intermediary step, however, and intended ultimately to be integrated into the broader NHIF membership growth strategy.

**NHIF currently operates three, separately pooled schemes covering different subsets of the population.** The general, national NHIF scheme, or SupaCover, includes the mandatory contributing population from the formal sector, voluntary informal membership, and government-sponsored insurance for the elderly and for individuals with severe disabilities (MOH, forthcoming). The Civil Servants and Disciplined Services Scheme and County Public Servant Scheme are more comprehensive packages paid for through contributions from civil servants and members of uniformed services (MOH, forthcoming). The Health Insurance Subsidy Program is a

fully subsidized pilot program targeting poor and vulnerable households. Administered through NHIF, the program is currently supported by the World Bank, including a grant of US\$20 million for the pilot phase (World Bank, 2014b). The goal is to reduce financial barriers to care and also to increase healthcare utilization among the poor (NHIF, 2016a). Table 11 summarizes these scheme variants in greater detail.

**Table 11. Existing NHIF schemes**

Dimension	National Plan (SupaCover)		Health Insurance Subsidy Program—Indigents	Civil Servants Scheme	Police and Prison (Disciplined Services)
	Formal Private Sector	Informal Sector			
Estimated membership: June 2018	About 3.6 million (primary members, excludes civil servants and uniformed services) (NHIF, 2016a)	2.93 million (primary members)	181,400 households (Njoroge, 2017) (estimate does not include elderly and severely disabled)	241,316 primary beneficiaries; 346,843 secondary beneficiaries (NHIF, 2016a) (breakdown as of June 2016)	Same as civil servants scheme
Population segment served	Salaried private formal sector employees Minimum income of KSh 1,000/month; 18 years of age	Self-employed and others in non-salaried workforce Minimum income of KSh 1,000/month; 18 years of age	Mostly the indigent and most vulnerable; identified from GOK-developed lists such as those for the orphans and vulnerable children cash transfer program	Salaried public sector employees, excluding police, prison, and armed forces*	National Police Service and Kenya Prison Service
Enrollment type	Mandatory	Voluntary	Voluntary (subsidized)	Mandatory	Mandatory
Collection method	Payroll deduction	Fixed voluntary contribution	Government subsidized	Payroll deduction	Payroll deduction
Monthly premium range	KSh 150–1,700/month	500 KSh	N/A	NHIF receives medical allowances previously paid directly to civil servants by GOK	Coverage provided in lieu of previous KSh 5,000 monthly risk allowance
Benefits package: General inclusions	<ul style="list-style-type: none"> <li>▪ Inpatient</li> <li>▪ Outpatient</li> <li>▪ Chronic disease treatment (i.e., MRI, oncology, dialysis)</li> <li>▪ Surgery</li> <li>▪ Maternity health + family planning</li> <li>▪ Ambulance</li> <li>▪ Optical services</li> <li>▪ Foreign care (for services not available locally)</li> </ul>	Same as formal private sector	Same as SupaCover	Same as SupaCover + <ul style="list-style-type: none"> <li>▪ Fertility services</li> <li>▪ Dental</li> <li>▪ Vision</li> <li>▪ Last expenses</li> </ul>	Same as SupaCover + <ul style="list-style-type: none"> <li>▪ Fertility services</li> <li>▪ Dental</li> <li>▪ Vision</li> <li>▪ Last expenses</li> <li>▪ Job-related injury, including prosthetics</li> </ul>

Dimension	National Plan (SupaCover)		Health Insurance Subsidy Program—Indigents	Civil Servants Scheme	Police and Prison (Disciplined Services)
	Formal Private Sector	Informal Sector			
Benefits package: Key exclusions	<ul style="list-style-type: none"> <li>NHIF pre-approval required for many chronic disease services, including oncology</li> <li>Fertility treatment</li> <li>Dental</li> <li>HIV treatment</li> </ul>	Same as formal private sector	Same as SupaCover	—	—
Benefits package: Key limits— inpatient	<ul style="list-style-type: none"> <li>Cardiac care: KSh 500,000 per patient</li> <li>Foreign coverage: KSh 500,000 per patient</li> <li>Surgery: Up to KSh 500,000 per procedure</li> <li>Oncology: Chemotherapy up to KSh 600,000 per patient (6 sessions); radiology up to KSh 70,000</li> </ul>	Same as formal private sector	Same as SupaCover	Depends on job category: <ul style="list-style-type: none"> <li>A–L: unlimited</li> <li>M–T: KSh 2.75–3.5 million</li> </ul>	Depends on job category: <ul style="list-style-type: none"> <li>PG1–PG8: unlimited</li> <li>PG9–PG15: KSh 2.75–3.5 million</li> </ul>
Benefits package: Key limits— outpatient	Must register and seek care at designated facility	Same as formal private sector	Same as SupaCover	Depends on job category: <ul style="list-style-type: none"> <li>A–L: unlimited</li> <li>M–T: KSh 300,000–500,000</li> </ul>	Depends on job category: <ul style="list-style-type: none"> <li>PG1–PG8: unlimited</li> <li>PG9–PG15: KSh 2.75–3.5 million</li> </ul>
Provider payment mechanism: Outpatient (Barasa et al., 2018)	Capitation, KSh 1,400 per year per beneficiary	Same as formal private sector	Capitation, KSh 1,400 per year per beneficiary	Capitation, KSh 1,500 for public facilities, KSh 2,850 for private facilities per year per beneficiary (job category L and above use fee-for-service)	Capitation, KSh 1,500 for public facilities, KSh 2,850 for private facilities per year per beneficiary
Provider payment mechanism: Maternity (Barasa et al., 2018)	Case-based payment: KSh 10,000 for normal delivery; KSh 30,000 for caesarean  For patients covered under Linda Mama, normal delivery and caesarean reimbursement rates are KSh 5,000 and 10,000, respectively	Same as formal private sector	Same as SupaCover	Fee-for-service, capped at KSh 200,000	Same as civil servants scheme
Provider payment mechanism: Chronic disease care (Barasa et al., 2018)	Case-based payment: Renal dialysis (KSh 9,500 per session)  Fee-for-service: Radiology	Same as formal private sector	Same as SupaCover	Same as SupaCover	Same as SupaCover

Dimension	National Plan (SupaCover)		Health Insurance Subsidy Program—Indigents	Civil Servants Scheme	Police and Prison (Disciplined Services)
	Formal Private Sector	Informal Sector			
Provider payment mechanism: Surgery (Barasa et al., 2018)	Case-based payment: <ul style="list-style-type: none"> <li>▪ Major surgery: KSh 80,000 (levels 3 and 4); KSh 130,000 (levels 5 and 6)</li> <li>▪ Minor surgeries: KSh 30,000 (levels 3 and 4); KSh 40,000 (levels 5 and 6)</li> </ul> Per diem: KSh 2,000–4,000 per day; public facilities do not require co-payments	Same as formal private sector	Same as SupaCover	Same as SupaCover	Same as SupaCover
Additional comments	Informal sector may not use services for two months after enrollment	See formal private sector	—	—	—

Source: NHIF scheme and benefits documentation unless otherwise indicated

**NHIF’s benefits package has expanded to include a comprehensive package of inpatient and outpatient services.** It initially included only inpatient services, primarily covering “hotel costs” of care such as fees for overnight hospital stays. These benefits have grown over time, with the most significant expansion following the increase in contribution rates in 2015 (Githinji, 2016). NHIF now covers an inclusive list of inpatient, outpatient, and ambulatory services, including certain NCDs. It expanded the number of services covered but also increased the amount of expenses covered and reimbursement rates paid to providers for certain services, including deliveries and Caesarians (MyGov, 2016).

**NHIF accredits and contracts public as well as private nonprofit and for-profit facilities.** It requires accreditation before contracting with facilities. Accreditation covers the range of health services provided by the facility, the number and type of health personnel, bed capacity, infrastructure, and equipment (NHIF, 2005).

**After accreditation, facilities are contracted as one of three categories—A, B, or C—depending on the type of facility.** Category A includes government hospitals where all services, including maternity services and surgery, are fully paid by NHIF. At Category B facilities (private and mission hospitals, generally in rural or underserved areas), members also receive a full range of covered services but may have to pay a co-pay for surgical services (NHIF, 2017a). Members are also limited to KSh 432,000 at Category B facilities annually (Ndung’u, 2015). Category C includes private hospitals, where NHIF covers only a specified daily rebate (NHIF, 2017a).

**NHIF employs a variety of provider payment mechanisms, including fixed reimbursement, capitation, and fee-for-service payments, depending on the services provided.** Inpatient services are paid for through fixed reimbursement, while outpatient services are covered under capitation. Deliveries (both vaginal and caesarean) are paid for on a fee-for-service basis, as is NCD treatment like dialysis and chemotherapy. The amounts paid depend on the type of facility and the service provided. Private providers, for example, are paid slightly higher capitation rates for outpatient services than public facilities (MOH, forthcoming). The same is true

for inpatient reimbursement rates, all of which increased in 2016 (Koech, 2016); Category A facilities receive KSh 1,200, Category B facilities receive KSh 3,500, and the rate for Category C hospitals is KSh 4,000.

**NHIF has also increased coverage for services paid on a fee-for-service basis.** The rate for normal deliveries is now KSh 10,000 (increased from KSh 6,000), and caesarian rates have increased from KSh 18,000 to 30,000. Kidney dialysis is paid up to KSh 10,000 per session, up from KSh 2,500, and transplants are covered up to KSh 500,000 (an increase from KSh 200,000). Expanded services covered by fee-for-service also include chemotherapy (KSh 25,000 per session) and radiology (KSh 18,000 per session) (Koech, 2016).

**While the contracting process and payment mechanisms are clear, the execution of these agreements is more challenging.** Contracts between NHIF as the purchaser and service provider define the provider's obligations and the reimbursement rates to be paid for services. The objective of the various purchasing mechanisms is to incentivize quality, reduce wastage, and allow patients to choose their provider. The extent to which these agreements are enforced—including monitoring performance of health facilities, quality of services, and legitimacy of claims—is less clear. There are no mechanisms to monitor quality, and NHIF reimburses facilities based on compliance with minimum quality standards at the time of empanelment. There is no link between payment and service quality to incentivize higher standards (MOH, forthcoming). Cases of NHIF clients being unable to access necessary services and medicines from accredited facilities have been documented, and investigating and curbing fraud have been challenging (Chuma and Okungu, 2011; Murage, 2017; Oketch 2017b; Otieno, 2017a ).

**In particular, there have been disagreements between NHIF and contracted facilities, especially private facilities, over the need for a balance between issuing timely payments and performing the checks necessary to prevent fraud.** In reaction to late NHIF reimbursements, some hospitals have threatened to refuse NHIF cards or to require patients to pay cash up front. From the perspective of NHIF, however, delays in payment have been a result of the additional scrutiny required to weed out the growing number of fraudulent claims (Oketch, 2017b). NHIF has taken measures to combat fraud, including freezing reimbursements for diagnostic services at certain private hospitals in September 2017 (Otuki, 2017a). Shortly thereafter, NHIF implemented a new policy that requires pre-authorization for specialized services like MRIs and CT scans (Oketch, 2017a). As NHIF expands service coverage through a growing number of contracted facilities, it will need to refine payment mechanisms to limit fraud while meeting the needs of providers and patients.

**As Kenya uses NHIF to expand universal coverage of social health insurance, it is working to articulate a guaranteed package of health essential health services, the UHC-Essential Benefits Package (UHC-EBP).** Functionally, NHIF's current package for most of its membership is defined by the SupaCover benefits (see Table 11). The benefits are expressed in terms of an overall list that is very generally defined, with few specifics on levels or limits to care available. However, the GOK intends to more clearly define what is and is not covered under NHIF to improve accountability for providing these services. Therefore, the UHC-EBP package will be defined for progressive expansion—first covering the most essential services and then expanding to cover all major disease areas in line with KEPH. Once this package is established, the GOK also intends to have a technical review committee regularly evaluate and revise it, as needed, based on the current epidemiological burden and available health technologies and services (GOK, 2018). As the GOK defines these services, it will also be critical for NHIF to define the appropriate mechanisms to pay for them. There are ongoing policy discussions in Kenya on how best to reform the current purchasing and payment mechanism in place.

## Exhibit 1. NHIF SupaCover web infographic



**Benefits Package:**

- + Outpatient Services
- + Maternal Care
- + Renal Dialysis
- + Cancer treatment
- + Rehabilitation for drug & substance abuse
- + All surgical procedures including transplants
- + Emergency Road Evacuation Services
- + Inpatient Services
- + Reproductive Health Services
- + Overseas treatment
- + Radiology Imaging Services

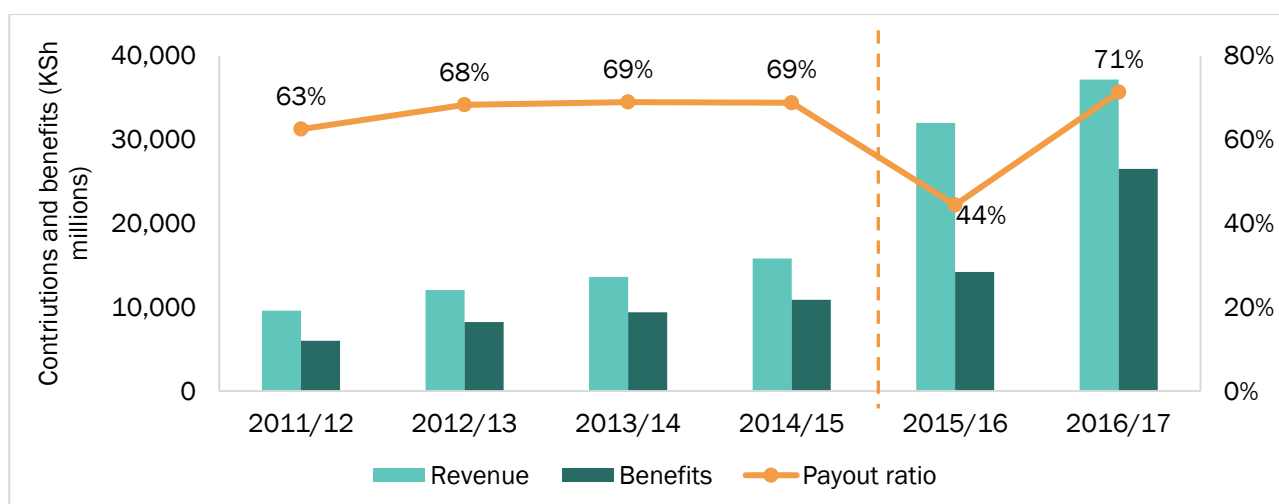
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**NHIF**  
Alya Yetu. Simu Yetu

Source: NHIF, 2018

**As NHIF increases contribution rates and expands its benefits package, it must strike a balance between revenues, claims, and administrative expenses to ensure financial sustainability.** Total membership contributions doubled between 2014/15 and 2015/16—from KSh 15.8 billion to KSh 32 billion—largely due to the revised contribution rates, as well as to an increase in membership (NHIF, 2016b; KNBS, 2017). Benefit expenses also increased in absolute terms, from KSh 5.8 to KSh 10.3 billion.<sup>13</sup> The payout ratio declined in the first year after the rise in contributions, but it has since increased from approximately 44 percent to 71 percent (Figure 44) (KNBS, 2017).<sup>14</sup> Preliminary, unaudited results for 2017/18 suggest that the payout (claims) ratio climbed to 78 percent (NHIF, 2018a).

Figure 44. NHIF revenues vs. benefits payouts, payout ratio



Dashed line shows the point of revision of contribution rates.

Source: KNBS Economic Surveys 2011–2018; NHIF 2018b

<sup>13</sup> Benefit expenses refer to medical benefits paid to healthcare facilities for providing outpatient and inpatient services. Includes capitation and fee-for-service payments.

<sup>14</sup> The payout ratio, also called the claims or medical loss ratio, refers to the amount paid for member services relative to the amount collected in premiums.

**A well-functioning insurance scheme should spend a large share of contributions on benefits, but until recently, NHIF has struggled to do this** (Lakin and Magero, 2012). The scheme has seen improvements, however. In 2005, the payout ratio was only 22 percent; by 2009/10, the payout ratio had increased to 52 percent, and in 2011/12, it had reached 63 percent (Lakin and Magero, 2012; KNBS, 2017). As Figure 44 shows, the payout ratio has fluctuated since 2015/16. Overall, NHIF has enjoyed annual operating surpluses for several years, for example, amounting to KSh 2.35 billion (US\$23 million) in 2016/17 based on its audited results (NHIF, 2016a). The recently expanded benefits package and increased reimbursement rates, however, should improve this ratio in the future. Among the other NHIF-administered schemes, the elderly/disabled and Health Insurance Subsidy Program schemes have recent payout ratios of 50 percent and 45 percent, respectively, in 2016/17, which is a decline from 2015/16 (NHIF, 2016a, 2016b). The County Public Servant Scheme payout ratio, on the other hand, was only 23 percent in 2015/16, down from 52 percent the previous year (NHIF, 2016a). These declines in payout ratios are problematic and could be attributed to utilization concerns, given the fact that the schemes are still in stages of development and expansion and that new members may have issues with communication and comprehension of benefits.

**One of the challenges to achieving a higher payout ratio is NHIF's relatively high administrative costs.** NHIF has previously come under criticism for spending a persistently high proportion of revenues on administrative expenses (Munge et al., 2017). In 2005, administrative costs consumed over half of the fund's revenues (Lakin and Magero, 2012). This improved over time, but administrative costs still accounted for approximately one-third of revenues from 2012–2014 (Munge et al., 2017). According to NHIF's 2016/17 Audited Financial Statement, however, this proportion fell considerably to about 22 percent; this is still considered high by international standards, with a proportion of 5 percent to 10 percent considered more feasible (NHIF, 2016b). This drop is also partially a function of the large increase in revenues; in absolute terms, administrative expenses continued to increase from KSh 3.76 billion in 2013/14 to KSh 8.3 billion in 2016/17 (NHIF, 2014, 2016b). NHIF will have to contain operating costs under the new revenue collection scheme in order to sustain this positive trend in the proportion of revenue spent on administration and to support a higher payout ratio for beneficiaries.

## Private Health Insurance

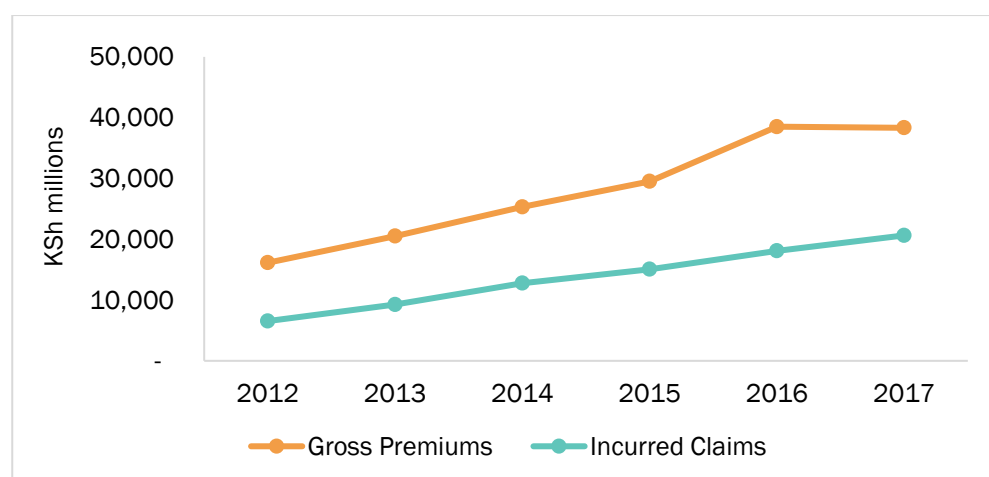
**The private health insurance market in Kenya has grown over the last 20 years.** In 2016, approximately 1.5 million Kenyans were covered by private health insurance, up from 600,000 in 2009 (Barnes et al., 2009). Private health insurance is also accounting for an increasing proportion of THE, growing from 7 to 11 percent between 2009/10 and 2015/16 (see Figure 25). The private insurance sector is still relatively small, however, covering only about 3 percent of the population, with 9.4 percent of the insured covered by private insurance and more than 88 percent covered through NHIF. Micro health insurance and mobile health wallets such as M-TIBA are discussed separately in Chapter 8.

**Private insurance is provided through two vehicles—medical insurance providers and insurance companies.** Medical insurance providers are equivalent to managed care organizations, while insurance companies providing health insurance are general insurance companies authorized to underwrite medical insurance. Both are regulated by the Insurance Regulatory Authority (IRA). According to the IRA, as of February 2017, there were 29 medical insurance providers and 11 insurance companies offering health insurance products (IRA, 2017a, 2017b).



**Private premium revenues have been steadily increasing, but profits have been fairly minimal.** Gross premium revenue was over KSh 38 billion in 2016, more than quadrupling from KSh 9 billion in 2011 and outpacing the growth of the general insurance market (Insurance Regulatory Authority, 2018). Benefit expenses have also increased, implying that the industry claims ratio has increased (Figure 45). Despite the high premium revenues, profits are low. In 2016, the average loss ratio was nearly 75 percent, and the entire industry (medical insurance providers and insurance companies) recorded profits of only KSh 350 million (IRA, 2016).

**Figure 45. Private medical insurance sector growth in Kenya**



Source: Kenya Insurance Regulatory Authority, 2018

**Most private plans target formal sector workers and wealthier socioeconomic groups, with varying levels of service coverage.** Private insurance is commonly offered to formal sector employees and their dependents, largely in urban areas (Munge et al., 2016). Plans vary significantly in terms of premium, benefits, and claim limits. Most benefits packages are divided into inpatient and outpatient services (which can be purchased together or separately) and “top-up” packages like dental (Munge et al., 2016). Private insurance benefits packages all have financial caps per member (inpatient caps are typically lower than outpatient), as well as waiting periods for coverage, such as a 10-month waiting period for maternity coverage under some schemes (Munge et al., 2016).

**There is no industry-wide standard for accreditation, contracting, and quality assurance mechanisms, making administration costly and reimbursement rates and quality variable.** There are no explicit regulations governing whom private insurers can contract to provide services, including public, private, and international providers. Insurers negotiate reimbursement rates with providers based on average historical costs, and reimbursement is typically on a fee-for-service basis. Inpatient reimbursements are paid at a rate less than NHIF reimbursements. There may also be co-payment requirements, to limit beneficiaries’ use of more expensive providers (Munge et al., 2016). Quality monitoring is generally minimal, except in response to specific complaints, as insurers are more concerned with monitoring costs. Access, quality, and quantity of health services for Kenyans with private health insurance coverage are most often influenced by the type of scheme, premium, location of the member, and in many cases, the medical budget of their employer. There is, however, evidence to suggest that stronger regulation through bodies like the IRA can improve the quality and accountability of providers through private insurers (Munge et al., 2016).

**As Kenya attempts to expand coverage of insurance through NHIF, there is a continued role for the expanding private insurance sector.** The *Roadmap Towards Universal Health Coverage (2018–2022)* notes that voluntary insurance, like private or community-based schemes, can supplement the services and levels of benefits covered by the UHC-BBP. The ability of the private insurance market to co-exist alongside national or social health insurance schemes as complementary or supplementary coverage is documented in many countries. This offers additional choice for those who, through their own resources or employment, have the ability to pay for additional services, pharmaceuticals including branded drugs, and higher hospital inpatient care levels. It is the role of the GOK, through the MOH, to improve regulations and coordination with the private market to ensure that private insurance complements or supplements the UHC-EBP or even the current NHIF benefits and expansion path, offers viable products, and provides members with high-quality services.

## Discussion

Previous chapters have already discussed general points related to expanding insurance coverage alongside a need to continue public sector, tax-based financing for key health needs for the medium term. The following points relate specifically to NHIF and its future expansion and reform.

**Kenya has made significant progress in expanding coverage under NHIF.** Overall membership has been increasing, and targeted efforts to increase enrollment among the informal sector and the poor have shown promise. NHIF is also making progress in expanding the benefits package to attract and meet the needs of its members. As the GOK considers the NHIF reform agenda with the recently formed Task Force (Box 8), it needs to contend with some key trends and re-evaluate the sustainability of the scheme in light of the ambition.

**Effective targets and scale-up strategies for NHIF will require reliable data on true current coverage rates.** As discussed above, there are considerable discrepancies between survey-based and NHIF membership estimates. Reliable data on population coverage are critical to targeting enrollment strategies and also to tracking progress toward universal coverage. NHIF will have to improve record keeping and information systems. Members who have died, for example, should be promptly removed from membership. It must also accurately count families with two formal sector employees, both of whom are counted as primary members; it cannot multiply both of these members by the average family size. There must also be communication across enrollment pathways to ensure that members are not double counted, such as secondary students who might already be claimed as dependents under NHIF. If NHIF is to be the vehicle for UHC, it must first accurately count the number of Kenyans that it covers.

**It is clear, however, that NHIF is approaching near saturation of formal sector enrollment and that future expansion will depend on its ability to reach and retain informal sector members.** As discussed above, it is more challenging to enroll and collect premiums from informal sector workers without regular paychecks from which to deduct contributions. Because enrollment is voluntary, informal sector members are more likely to join

### Box 8. 2019 GOK NHIF Task Force: Repositioning and reforming NHIF

Task force objectives:

- Realign, reorganize and reposition NHIF as the central medium through which to make progress towards SHIF
- Analyze legal and regulatory reforms needed and process and governance changes for NHIF to act as a strategic purchaser
- Review NHIF Act and proposals for the future national social health insurance fund bill

when they are in need of services and to stop paying when they are well, contributing to adverse selection. Brief waiting periods, such as the two months that informal sector members must currently wait to use NHIF benefits after enrolling, can help deter this. NHIF will also need to continue its efforts to make contributing easier for informal sector households through platforms like NHIF Mobile and M-TIBA. Promising examples of these kinds of platforms are discussed further in Chapter 8.

**As NHIF continues to expand in terms of both population coverage and the benefits package, it must carefully consider both equity and financial sustainability in establishing appropriate premium rates.** The government will need to subsidize premiums for the poor and vulnerable, requiring continued investment of public resources, as discussed in Chapter 4. For members with the ability to pay, in both the formal and informal sector, premiums should be progressive and actuarially determined to pay for the current benefits package. SupaCover includes a comprehensive package of services that NHIF will have to ensure that it can sustainably pay for, including offering sufficient compensation to providers to incentivize quality as well as to incentivize private providers to contract with NHIF. While increasing premium rates may be politically challenging, if actuarially necessary, NHIF will have better success if it can demonstrate the value to members in terms of the range, quality, and accessibility of services covered.

**The proposed NHIF expansion framework has pro-equity dimensions; however, resources for subsidizing coverage for a significant share of the poor and vulnerable must still be found.** Currently, civil servants and formal sector workers, both of whom typically belong to higher wealth quintiles in Kenya, enjoy superior benefits packages to sponsored programs for needier members. The GOK should follow NHIF enrollment growth with a long-term plan for harmonization of benefits across the segments and required investment in the supply side of the health system to allow effectively equal access to health services. The total resources to pay a fair premium for these subsidized groups in the future, sufficient to sustain payments to providers of possibly expanded benefits and utilization, will require a financial commitment from the national Treasury, as well as a plan for partial contribution from county governments.

**Achieving universal health coverage (UHC) through expanded health insurance membership, driven by a model based on NHIF, will also require considerable effort to strengthen the systems necessary to effectively purchase health services.** As it expands coverage of different populations, Kenya should work toward integrating the various schemes to reduce fragmentation and more effectively pool risk. Covering this broader population will also require clearer definition of the services to be purchased. Further defining and adopting the UHC-EPB will be an important step, and adoption must consider cost as well as quality and equity of services. The Afya Care pilots will provide valuable information on the ability of the system to respond to increased demand for secondary care, which can inform future prepayment reforms. NHIF must also continue its efforts to strengthen and reform purchasing and provider payment mechanisms to ensure that it is paying for services efficiently, with sufficient incentives for quality.



Photo courtesy of USAID Kenya

## 6. OTHER HEALTH FINANCING SOURCES AND THEIR ROLE

**Over half of health expenditures in Kenya are financed by households and external funders, which has important implications for long-term sustainability and financial protection.** External funders are a significant source of resources for health, particularly for key health programs like HIV. Further, as discussed in Chapter 3, households account for a substantial portion of total health spending, nearly all of which is OOP. Particularly as external funds are likely to decline, health financing reforms must consider how to mobilize sufficient domestic resources for health while protecting households from the burden of OOP expenditures.

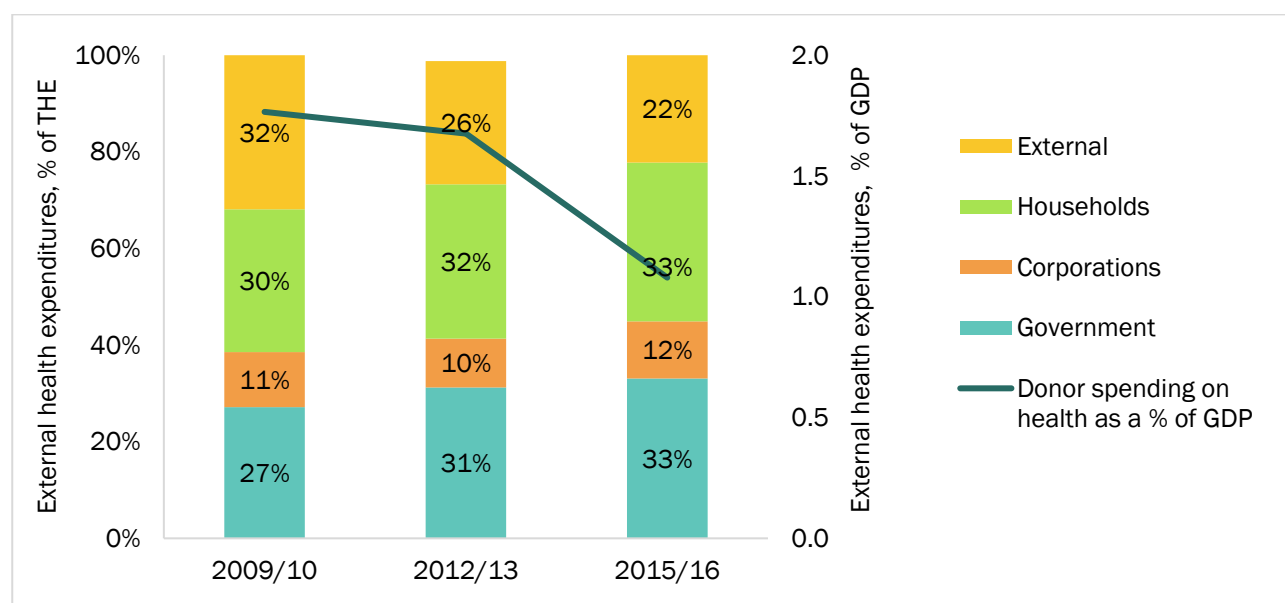
### Trends in External Resources

**External funding from donor governments and multilateral organizations has been an important resource for health financing in sub-Saharan Africa, particularly for specific, priority interventions and disease areas, including HIV, tuberculosis, malaria, and reproductive health.** From 2002 to 2010, external funds for health increased each year, especially in the second half of the decade, reflecting the scale-up of large global health initiatives like the Global Fund and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). Since the beginning of the current decade, however, this rapid growth in external resources for health has started to decline (Wexler et al., 2013). External resources in Kenya have followed a similar trend.

**In Kenya, external resources are declining as a percentage of THE, but they continue to play a significant role in financing healthcare.** In 2009/10, external funds from development partners accounted for 32 percent of THE. By 2015/16, this had declined by 10 percentage points to 22 percent of THE. As a percentage of GDP, development partners' funding for health declined from 1.8 percent to 1.1 percent. Over the same period, the government

contribution to THE increased from 27 to 34 percent, surpassing external funds as a share of THE (Figure 46). External funding has also fallen in absolute terms since 2012/14, from KSh 64.1 billion to KSh 53.2 billion in 2015/16 (MOH, 2017b).

**Figure 46. External spending as percentage of THE and GDP**



Source: MOH, 2017b

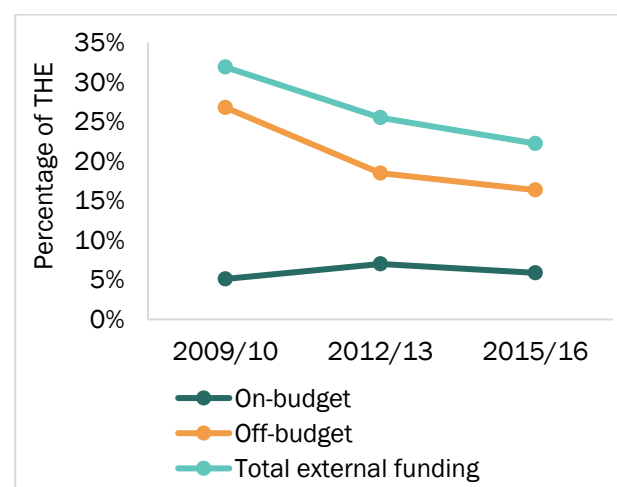
**External financing as a share of total resources for key health programs is also declining in Kenya.** The shares of HIV, tuberculosis, and malaria programming funded by external sources all fell between 2012/13 and 2015/16, from 72 percent, 37 percent, and 39 percent to 62 percent, 28 percent, and 27 percent, respectively (Table 12). NCDs are the only health area to be more heavily externally funded than in 2013, increasing slightly from 17.1 percent to 19.5 percent of total resources (MOH, 2017b). This is reflective of increasing attention to NCDs among donor governments and multilateral organizations as the disease burden in low- and middle-income countries grows (Table 12) (Kaiser Family Foundation, 2017).

**A significant share of external spending on health is off-budget, which can pose challenges to domestic strategic planning for health.** In 2009/10, 83 percent of donor funding was off-budget, equivalent to 27 percent of total health expenditure. The share of off-budget resources declined but remains the bulk of external funding; 73 percent of external funds were off-budget in 2015/16. Off-budget support has fallen further as a percentage of THE, to 16.4 percent, but is still a significant share of health expenditures (see Figure 47) (MOH, 2017b). Off-budget support is mainly earmarked as project support specific to disease or intervention and is channeled through nongovernmental organizations (NGOs). These resources play an important role in financing healthcare but are not captured in government budgets and may not necessarily align with country or county health priorities.

**Table 12. Proportion of health area expenditures financed by external funders**

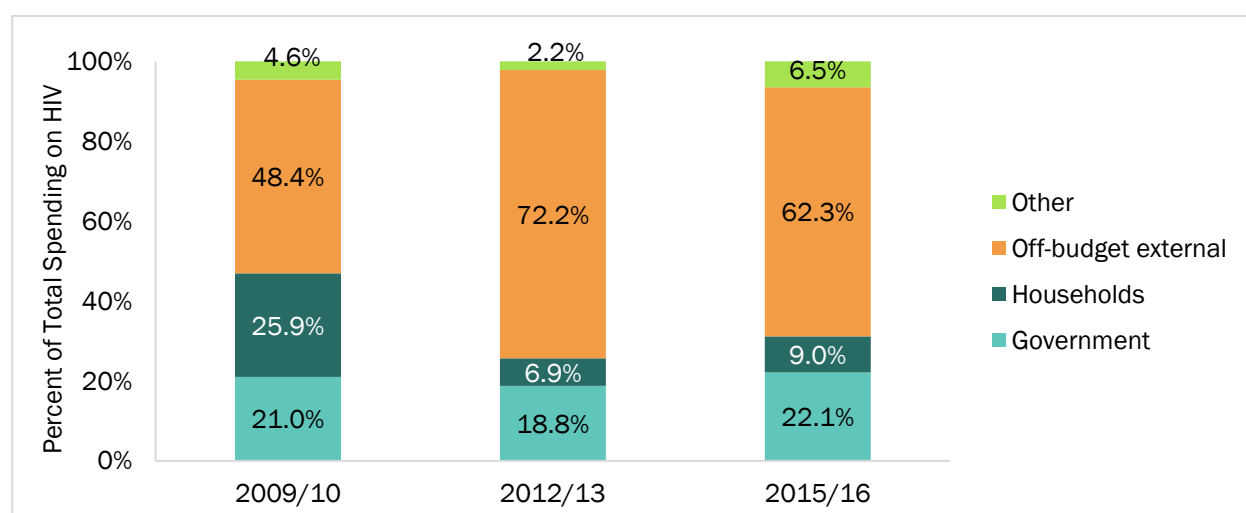
Health Area	2012/13	2014/15	Change
HIV	72.6%	62.3%	↓
Tuberculosis	36.4%	27.7%	↓
Reproductive health	19.1%	14%	↓
Malaria	38.7%	26.7%	↓
NCDs	17.1%	19.5%	↑
Nutritional deficiency	52.1%	48.4%	↓
Diarrheal diseases	40.2%	16.8%	↓

Source: MOH, 2017b

**Figure 47. On- and off-budget external funding as a percentage of THE**

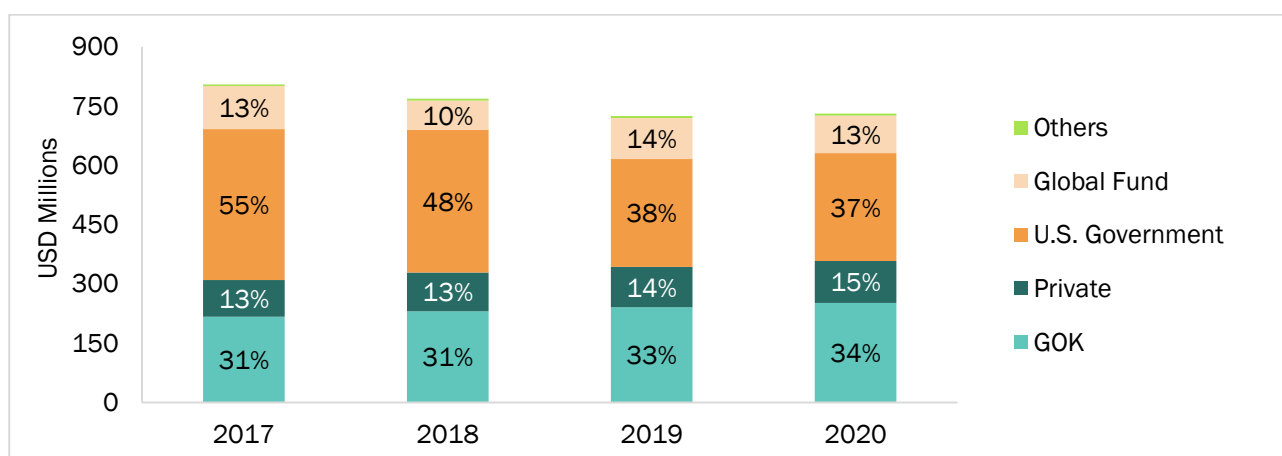
Source: MOH, 2017b

**All of these trends, in terms of the share of total resources and off-budget support, can be seen in the HIV response.** The bulk of HIV expenditures are financed through external sources, largely through PEPFAR and Global Fund, although this proportion has declined in recent years. In 2012/13, 73 percent of total spending on HIV was financed through off-budget external sources; off-budget external sources accounted for 62 percent in 2015/16 (Figure 48). In absolute terms, however, off-budget funding has increased from approximately KSh 34.8 billion to KSh 42.6 billion over the same period. These resources do not include on-budget external support spent through the government budget. Much of Global Fund support, for example, is spent directly through the MOH. Thus, the actual share of HIV financing from the government is even less relative to external funds. In 2015/16, the government financed 22 percent of HIV spending, but this figure captures some external resources (MOH, 2017b). This domestic share for HIV and tuberculosis (TB) is likely to continue to increase (Figure 49), although reliable estimates of true domestic, government tax-financed spending on programs across all uses are not available.

**Figure 48. Historical sources of HIV expenditures**

Source: MOH, 2017b

Figure 49. Planned funding sources, HIV and TB



Note: GOK HIV spending assumes flat 18.3 percent of need based on National Health Accounts estimate; TB based on National Strategic Plan. Private reflects flat 7.8 percent of need; TB varies; based on National Health Accounts estimates. U.G. Government HIV reflects PEPFAR expenditures for 2017–2018, minus program management; planned for 2019, flat-lined to 2020. Global Fund reflects actual disbursements for 2017–2018; approved within allocation budget 2019–2020; based on National Health Accounts 2015/16. Sources: MOH, 2017b; data.pepfar.net (accessed March 2019); Global Fund (accessed March 2019)

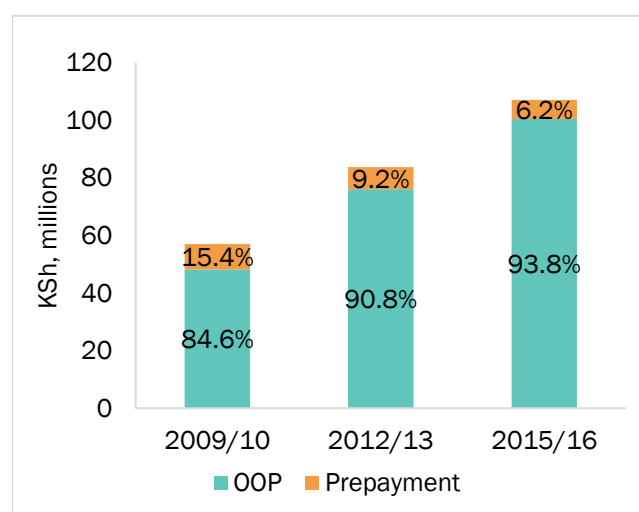
## Trends in Household Spending on Health

**Households are a significant source of health spending in Kenya, and the vast majority of this spending continues to come from OOP expenditures at the point of care, placing households at risk of incurring CHE.** Having to pay for healthcare OOP creates financial barriers to care and threatens the financial security of households. OOP spending can be used as a measure of financial protection provided by the health system, a key dimension of UHC (see Chapter 3 for further discussion of OOP and financial protection).

**Including both OOP expenditures and insurance premiums, household spending has consistently accounted for nearly one-third of THE since 2001/02.** Households accounted for 32 percent of health expenditures in 2012/13 and 33 percent in 2015/16 (MOH, 2017b).

**Nearly all household spending is OOP; only a marginal amount is pooled through prepayment schemes** (Figure 50). Prepayment schemes, such as NHIF and private or community-based health insurance schemes, accounted for only 6 percent of household spending in 2015/16, a decline from 15 percent in 2009/10. (MOH, 2017b). Prepayment allows households to pay for health in a predictable way, protecting from financial burden. Low enrollment in these schemes places households at greater risk of CHE.

Figure 50. Household health expenditures through prepayment and OOP spending



Source: MOH, 2017b

### Overall, private health expenditure in Kenya is dominated by OOP household spending.

Private health expenditures predominately come from two sources—private firms (i.e., through purchasing insurance or operating health facilities for employees) and household OOP payments. Over the last five years, on average, OOP expenditure has accounted for nearly three-quarters of private health expenditure (MOH, 2017b). It has declined, though, as a share of private spending since 2001 (Figure 51), in part reflecting the increase in private insurance coverage (see Chapter 5 for discussion of insurance coverage). Comparatively, however, Kenya has consistently had a significantly higher proportion of private health expenditure from OOP than its neighbors (Figure 52).

Figure 51. Private spending on health

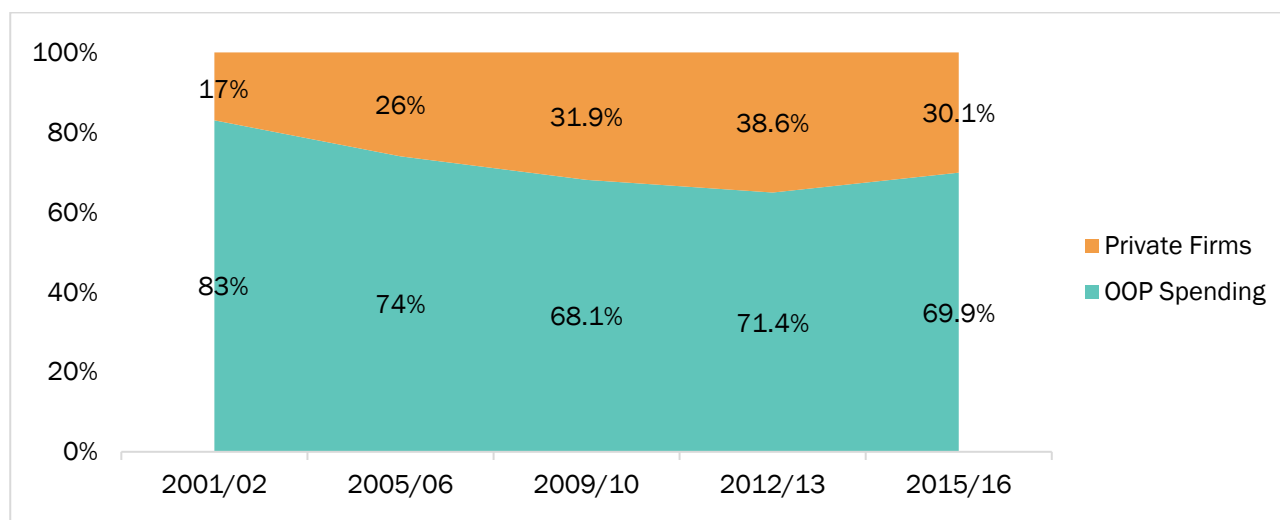
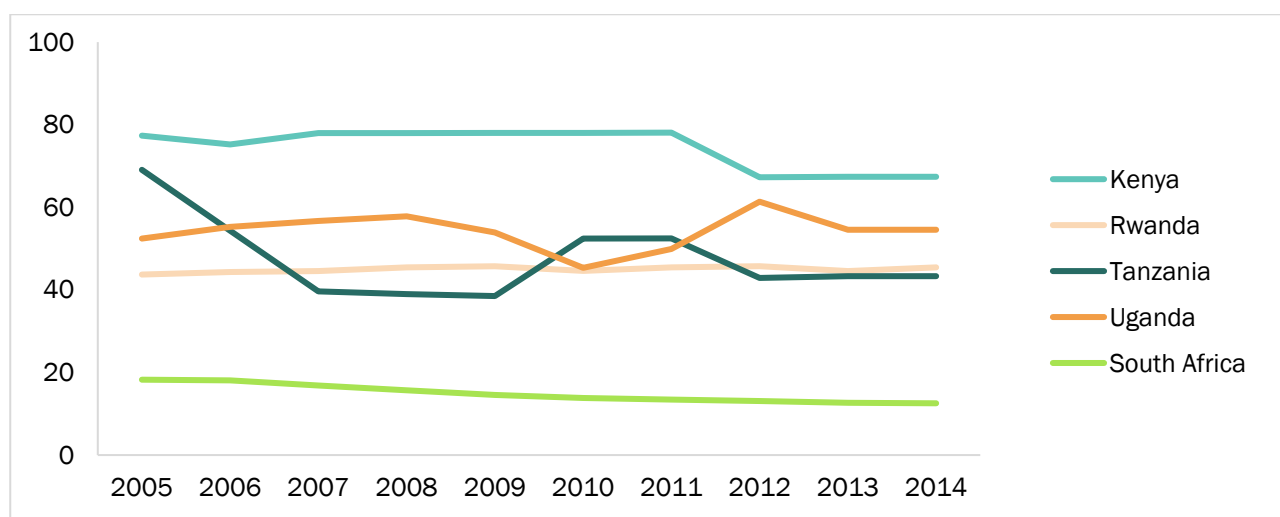


Figure 52. OOP as proportion of total private health sector spending, regional comparison



## Discussion

### External resources were significant for health in Kenya but are likely to continue declining in the future.

Kenya is progressing on its journey to self-reliance, but it needs to do more to increase long-term sustainability, particularly for key disease areas and for related health system strengthening. External financing accounts for over a fifth of THE and is largely off-budget and targeted toward disease-specific responses. Historically, external financing has been a prime source of scale-up and health system strengthening spending for HIV, TB, and malaria, as well as a



few other key programs, and has had a profound impact on health facilities and community-based programs. However, the burden for some of these diseases or health needs is more concentrated in certain counties. As these funds reduce, the county governments in question will need to step up, using diverse domestic sources. A future with lower levels of external financing more acutely focused on the highest-burden counties bodes complex sustainability issues for counties across spectrums of disease burden, devolved national resources per capita, and local financing capability. Counties previously receiving higher amounts of external funding may have both accrued health system benefits not available to other counties, as well as higher dependency, which in the future may contribute to inter-county health disparities.

**Despite these challenges, it is promising that government spending on health has surpassed external funds, and at the same time, off-budget support is declining as a proportion of overall external funding.**

Increased domestic resources for health will be critical to addressing the burden of OOP and the dependency on external funds. The increased proportion of on-budget support also indicates opportunity for increased GOK ownership and better coordination across domestic and external funds, allowing for better long-term strategic planning. The current macroeconomic climate (discussed in Chapter 4) suggests that the GOK will have the capacity to raise additional funds for health, with some constraints. The extent to which these resources are channeled to health, however, is a question of prioritization. For key vertical programs, the additional challenge to maintain prioritization from the Treasury is to execute the allocated funds within each fiscal year to meet the next budgetary cycle (see Box 9 for the HIV case). Both levels of government will have to ensure efficient and well-utilized investments in health.

**The high proportion of OOP spending poses a key equity challenge for the health financing system in Kenya.**

Despite policy efforts to reduce financial barriers to care, like Linda Mama and the free primary healthcare program, and the increase in prepayment scheme coverage through NHIF, OOP spending has consistently accounted for nearly 30 percent of THE. Only a fraction of household health spending is pooled. As discussed in Chapter 3, OOP expenditures leave the bottom two quintiles of Kenyans vulnerable. The current user fee removal programs, including Afya Care pilots, are critical experiments in increasing financial protection, but they do not cover all services nor all of the population. In the long term, against an SHIF vision, Kenya aims to increase its efforts to enroll Kenyans under NHIF as the main prepayment mechanism, allowing households to plan for the costs of healthcare. The GOK will also need to work on NHIF reform to adopt the UHC-EBP sustainably and design reimbursement mechanisms that sufficiently cover the costs of service provision for providers so that they do not have incentives to charge informal or illegal payment.

**To successfully address the twin challenges posed by high OOP expenditures and declining external resources, integration of vertical programs into the emerging**

**Box 9. Successes and challenges in allocating from domestic sources to a key national program: HIV**

- Successes: Counties allocating more to HIV in their budgets
- Challenge: Fully executing GOK allocation to commodity procurements and consistently maintaining the level of allocation or increasing it in line with program coverage
- Challenge: Long-term vision for vertical programs integrated into NHIF or UHC-EBP still missing

	FY 2015–18	FY 2019–22
GOK budget for HIV commodities	US\$68 million	US\$85 million (expected)
Execution rate (%)	79% (estimated)	90%–100% (goal)

Source: HP+ estimates

**health financing reform vision is necessary.** As external resources decline, public spending will have to fill the gaps and ensure that that key health programs like HIV, TB, and malaria are both sustained and scaled. County governments, with responsibility over primary and secondary care, are required to step up, but many may face a challenge in doing so. This then requires attention to where and how external funding flows are changing—geographically and across health system needs—so that additional national resources can be properly targeted. There is also risk that declining external resources will increase the financial burden on certain types of households, especially if pressure on facilities or community programs increases; GOK efforts via various schemes will be needed to mitigate this. In the long term, if widespread enrollment in NHIF and other prepayment schemes is a desired outcome, subsidized membership for the poor and vulnerable will be corollary, and at least some element of programs previously dependent on external resources should be integrated into these schemes.



Photo courtesy of MCSP

## 7. EVOLVING ROLE OF THE PRIVATE HEALTH SECTOR

**From service provision to pharmaceutical manufacturing to raising capital investible in the health sector, Kenya's health financing system both impacts and is impacted by trends in the private health sector.** Kenya has a vibrant private health sector that is taking up a larger share of THE. Ensuring an enabling environment, regulations, and strategic purchasing mechanisms that increase affordability and quality of private sector services and products will harness the sector to achieve the country's UHC goals. While a comprehensive review of the emerging trends in the private sector is beyond the scope of this chapter, the chapter does focus on the most pertinent issues connected to financing private healthcare, especially as it relates to the issues around reducing OOP expenditures, addressing the challenges and opportunities in decentralization, and the intersection of private providers with NHIF. This chapter is grouped by the key sector components: (1) providers, (2) pharmaceuticals, and (3) a new framework for private sector engagement to realize public sector goals. The private health sector includes not only the faith-based organizations (FBOs) and NGOs that have been providing healthcare to Kenyans for decades, but also the private commercial sector that is progressively becoming more organized to provide efficient, profit-making, high-quality services and products to the Kenyan population as well as to medical tourists. The Kenya pharmaceutical market is perceived as one of the most investible markets in sub-Saharan Africa, and private investment is expected to continue to grow. For the Kenyan government to achieve its national goals more efficiently, it needs to effectively leverage private sector human resources, infrastructure, and capital.

### Private Sector Service Delivery Capacity and Demand

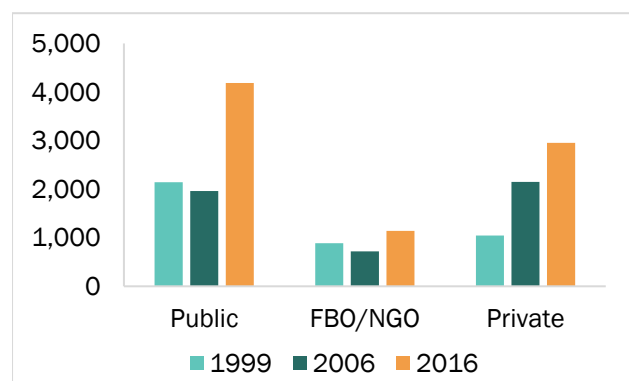
**Private sector facilities are increasingly significant in terms of available health infrastructure and THE.** The private sector across for-profit and FBO/NGO subsectors operates almost half of the health facilities in the country. The private sector, especially the for-profit or commercial sector, has grown significantly (Figures 53 and 54), potentially in response to the needs

and demands of the population. In parallel, the proportion of THE represented by private providers has grown over the years (Figure 55). As THE has grown by 63 percent, the health expenditure channeled through private providers has grown at more than 150 percent every three years. Most notably, private clinics saw a more than sixfold increase in their share of THE between 2009/10 and 2015/16.

**Private providers often provide services that match or surpass those offered within the public sector.** A 2017 study sampling public and private facilities across six counties found that across seven essential outpatient services, private and public sector providers often offered similar sets of services (Chakraborty et al., 2017). Family planning services were almost universally offered at all facilities, regardless of type. In the case of post-abortion care, private non-FBO providers were most likely to offer the service (58 percent) compared to public facilities (32 percent) or FBO facilities (18 percent).

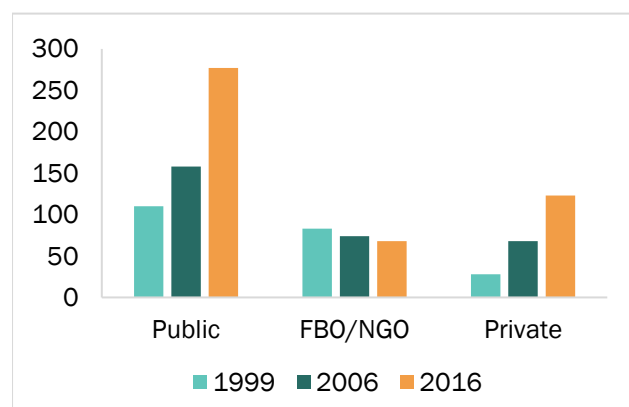
**That said, the lack of key commodities, specialized skills, and incentives can limit access to certain services through the private sector.** Predominantly, HIV care and treatment services were less likely to be available through the private sector, especially within the independent commercial sector. It is likely that these private providers were not able to access HIV tests and treatment commodities and drugs at an affordable rate, and/or access training to provide these services. Access to maternal and child health services was also inconsistent; compared to 92 percent of the public facilities offering these services, only 65 percent of the FBOs and 77 percent of private providers that were part of social franchises offered the service. On the other hand, 96 percent of commercial private providers offered this service. This discrepancy may highlight the difference in response by private commercial providers to perceived client demand for this service, compared to social

**Figure 53. Number of primary health clinics, by sector**



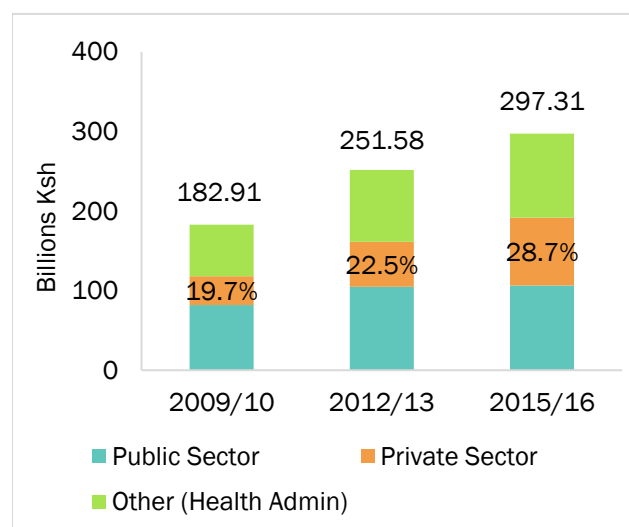
Source: Barnes et al., 2010; MOH, 2017c (sourced June 2017)

**Figure 54. Number of hospitals, by sector**



Source: Barnes et al., 2010; MOH, 2017c (sourced June 2017)

**Figure 55. Growth trends in private providers receiving proportion of THE**



Source: MOH, 2017b, preliminary findings

franchisees, which must limit their services to the interventions targeted and supported by the original franchise operator.

**As demand for essential reproductive and maternal health services has grown, the preference for private sector services has increased.** Modern contraceptive prevalence in Kenya has recently increased from 39 percent in 2008/09 to 53.2 percent in 2014, while the share of facility-based births increased from 43 percent to 61 percent over the same period, based on the KDHS. As a proportion of all live births, births at a private sector facility increased from 10.3 percent in 2008/09 to 15.2 percent by 2014. Delivery in a private sector facility is more common for women of higher socioeconomic status. The 2014 KDHS estimated that 34 percent of modern methods of contraception were supplied by the private sector, similar to the level from the 2008/09 KDHS (36 percent). In addition to condoms and pills, which usually have high access through the private sector, a significant number of users of intrauterine devices (IUDs) (35 percent) and injectables (36 percent) accessed their services from private providers in 2014 (KNBS et al., 2014).

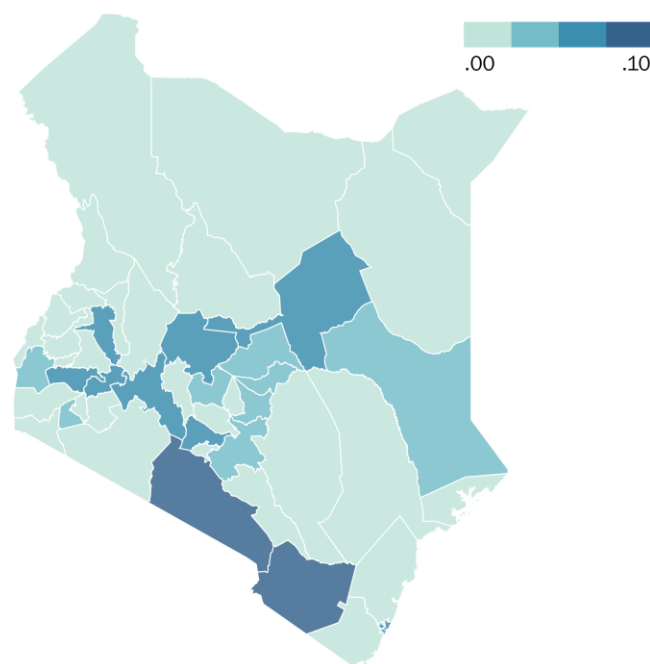
**Whether clients seek services from the private sector varies significantly across health areas.** In 2013, 52 percent of the urban population visited a private provider (across nonprofits, for-profits, pharmacies, and retail shops) for their outpatient visit, as did 32 percent in the rural areas, where ability to pay is lower (MOH, 2016a). Clients also often preferred the private sector for family planning (Chakraborty et al., 2017). However, for treatment of children under-five with fever, the public sector was the dominant point of call. Preliminary results from 2015/16 Kenya National Health Accounts indicate that expenditures for general outpatient curative services tend to skew slightly toward the public sector, but private sector (especially the nonprofit sector) provides the lion's share of specialized care, such as optometry and dentistry, long-term care, or preventative services (MOH, 2017b).

**After initially contracting only public facilities under Linda Mama, NHIF now contracts both public and private facilities to provide free maternal healthcare, but the impact on use of private sector services is still unclear.** Initially, both the free primary and maternal healthcare policies applied only to public facilities. Evidence from KDHS analysis after this initial, public-facility-based policy rollout suggested that the policy reduced deliveries in private facilities. There was a general increase in the proportion of public facility births. Some of this came from a decline in home births, but in rural settings, there was a greater shift away from private facilities (Obare et al., 2016). DHIS analysis also found a decline in both faith-based and for-profit facilities, representing a net shift to public facilities; the same analysis also found a reversal in the previous overall trend toward private deliveries (Wang and Dutta, forthcoming). Since 2016, however, NHIF has expanded free maternal health services to include both nonprofit, faith-based, and for-profit private facilities. These analyses do not include any data after the inclusion of private facilities, and the trends identified may not hold as more private facilities are contracted by NHIF.

**Private health sector services outside of essential primary healthcare that are affordable to the poor remain a distant vision, unless prepayment schemes scale up significantly and contract these providers.** While there are many private service secondary and tertiary facilities across the country, most services remain out of reach for poor and rural populations (Figure 56). NHIF partnership with some of the premier tertiary private hospitals has reduced the burden on specialized treatments such as cardiac surgery and chemotherapy from the public sector's Kenyatta Hospital (Otuki, 2017b, 2017c). Compared to 2016, NHIF notes that patients waiting for cardiac treatment have decreased by 262 patients to 1,173 in 2017 (Otieno, 2017b). However, the lack of specialists remains a bottleneck for both the public and private sectors to expand more complex care (MOH, 2015). Many facilities lack the medical equipment for NCDs,

such as electrocardiography machines (Institute of Health Metrics and Evaluation, 2014). Where they are available, NCD services such as dialysis, renal transplant, and heart surgery remain cost-prohibitive for most populations to access through the private sector (MOH, 2016c). NHIF reimbursements do not fully cover the cost of care. The NHIF benefits package limits cardiac surgery reimbursement to KSh 500,000, while typical private hospitals charge KSh 1.2 million for cardiac surgery, including stays in intensive care post-surgery (Otuki, 2017c). Despite increasing demand, there has not been significant investment in scaling up such service offerings in peri-urban areas or even increasing availability in Nairobi and Mombasa. Several public sector facilities have benefited from the GOK Managed Equipment Services (MES) project (discussed further in Chapter 8), which has installed specialized equipment such as for radiology and specialized surgery. However, there are few such partnerships benefitting private hospital operators.

**Figure 56. Density of private commercial hospitals, per 10,000 population**



Source: MOH, 2017c

**Kenya should explore the expansion of the private sector to provide key services in order to supplement overburdened public health facilities.** Services such as ART for HIV that could be provided by general practitioners in private clinics, with additional training, are an example where public-private partnerships are needed. A recent study on HIV services provided through the private commercial sector showed that it already provides an equal share of HIV testing and counseling as the public sector (MOH, 2017a). The study also found that the primary barrier to providing high-quality HIV care and treatment through the private sector was lack of access to affordable antiretrovirals (ARVs). Due to limited options for ARVs available through the private market (i.e., private importers and distributors), private providers were likewise limited in their ability to offer appropriate treatment for patients. If such barriers for private providers to access affordable, quality-assured ARVs were reduced and providers aligned with national treatment guidelines, these providers could offer paid services for patients with the ability to pay and a desire for personalized ART services which they perceive as more discreet. This can help reduce the strain on public sector financial and human resources. Based on a recent survey, private sector providers were willing to expand such treatment services to clients whom they diagnose as HIV positive (MOH, 2017a).

**Homegrown social franchises that organize private providers and ensure high-quality services and products could be an entry point for the government to expand access to essential health services for lower-income populations through the private sector.** Marie Stopes International and PSI, for example, have established global social franchise networks in recent years. Local professional associations followed these models and have successfully built local social franchises with strong brand recognition and the reputation for high-quality products. For example, PharmNet pharmaceutical chain, established by the Kenya

Pharmaceutical Association, built a membership of more than 300 pharmacists as part of the franchise and was self-funded by 2016 (PSP4H, 2016b). The LabNet social franchise, which built off of the experiences of PharmNet, quickly scaled up and is now expanding beyond Kenya. In addition, DocNet, a network of consulting physicians, is expected to be launched soon. These networks have become cost-efficient by using economies of scale in procurement and maintaining high quality (PSP4H, 2016b). The focus on quality is inherent in the process of building the social franchise brand, with the technical assistance of the franchisor—in the case of these networks, professional associations which already have internal capabilities around regulatory functions and training. For these reasons, and because these networks unite the fragmented private sector to make it easier for the public sector to regulate and partner with them, the trend toward franchising can be a positive step toward expanding health services through NHIF (see Chapter 8 for a discussion of the experience of the Amua franchise in NHIF empanelment).

**Payment schemes such as NHIF can increase availability of high-quality, low-cost services and products across the private sector by offering right incentives.** Issues related to accessing high-quality, low-cost commodities are further addressed in the sections below. In the case of services, empanelment with NHIF can be a motivator or a deterrent to providing services depending on the structure of the payment mechanisms. For example, under Marie Stopes Kenya’s Amua network, providers were empaneled with NHIF (see Chapter 8). The capitation payment scheme, however, reduced the incentive for the providers to offer family planning services. Since there were no additional case-based payments associated with family planning, this service was merely seen as a cost, and thus provider-initiated family planning family planning counseling decreased (Mackay, 2017). NHIF is currently reviewing whether case-based payments should be made for primary care outpatient clinics for family planning. Similarly, without appropriate incentives and oversight, fraud such as upcoding and claims for services never provided may proliferate. Already, these cases have led to contention between NHIF and the contracted private providers (Otuki, 2017a). Given that private providers are keenly sensitive to payment rates and to what is included in the benefits package, strategies such as better health information systems and rapid verification systems aided by information technologies could assist with continued scale-up of key services through the private sector, in partnership with NHIF.

**As another alternative to reaching the fragmented informal sector, NHIF could incentivize uptake of insurance by empaneling private sector providers known to target this population.** The Marie Stopes Amua social franchise program, for example, includes 420 mid-level providers offering reproductive health services throughout Kenya. Most of these providers have not worked with NHIF and perceive NHIF rates to be low. Recently, Amua has been working with NHIF and its franchisee clinics to contract with around 150 clinics as primary care providers, which are paid through capitation payments by NHIF. These clinics were selected based on provider motivation, level of quality of care (assessed using the SafeCare model), and geographical fit in reaching populations further away from public sector clinics (Mackay, 2017). The initial rollout has seen some challenges, such as the length of time it takes for contracting, the cost required to improve the facility to meet quality standards, and the lack of capacity for the clinics to manage costs within the capitation payment (Mackay, 2017). It has also, however, shown promise in supporting scale-up of NHIF coverage. Large, organized provider networks enable more strategic purchasing. Further, providers must promote their services to attract potential clients and, as more clients choose the clinic as care provider, more clients are exposed to and reached by NHIF. There are also new opportunities being tested whereby the Amua facilities are partnering with community health volunteers to sign up community members for NHIF and be part of the capitation group served by the health facility, further expanding NHIF’s reach (Mackay, 2017).

## Expansion of the Pharmaceutical Sector in Response to Health Financing Shifts

**The pharmaceutical manufacturing and sales sectors have seen robust growth as demand for healthcare grows.** In 2016, the pharmaceutical sector reached approximately KSh 81 billion (Marcopolis, 2016) and was projected to grow to KSh 122 billion by 2020 (International Trade Administration, 2016). The majority of the drugs are procured through the public sector's Kenya Medical Supplies Authority (KEMSA) or through the Mission for Essential Drugs and Supplies (MEDS), the faith-based drug procurement system. According to the most recent National Health Accounts data, as much as 53 percent of the pharmaceuticals are procured through these two mechanisms (MOH, 2017b). Although there is a significant number of private for-profit service providers who also procure drugs and commodities, due to the fragmentation of this market there have been no specific mechanisms created to serve it, nor is this subsector of the pharmaceutical market able to achieve competitiveness and efficiency (Chakraborty et al., 2017). Accordingly, the purchasing power is significantly consolidated by the government (through KEMSA) and MEDS. While the drug procurement budget has shifted toward the county through devolution, procurement guidelines specify that the counties should primarily procure drugs through KEMSA. Thus, the majority of pharmaceutical manufacturers focus on responding to procurements from these two large clients and do not invest significantly in marketing and sales for private for-profit providers. This means that the selection of drugs is limited within the commercial market, and prices are often high due to lack of competition and buying power among the private providers (PSP4H, 2014a). Ultimately, this leads to lower-quality and high-cost services for the patients in the private sector. MEDS is starting to allow private commercial providers who serve the lower-income population to access their commodities; similarly, consolidation and organization of the private sector could reverse this trend.

**Current purchasing preferences of KEMSA and MEDS do not necessarily encourage growth in local pharmaceutical manufacturing, and they result in lower-quality drugs being pushed to lower-income rural markets.** KEMSA and MEDS, both significantly reliant on donor funding to procure drugs, are often required to purchase from WHO-certified manufacturers. Of the 34 local manufacturers in Kenya, only one has successfully received WHO certification for Good Manufacturing Practices (Marcopolis, 2016). Thus, most local manufacturers are excluded from KEMSA and MEDS procurement, and they operate only within the fragmented private market, where it is costly to market and distribute the drugs. Indeed, local manufacturers enjoy only 28 percent of the total share of pharmaceutical revenues (UNIDO, 2010). At the same, due to poor regulation and limited post-market surveillance, low-quality drugs are able to enter the market. While penetration of low-quality drugs can be a problem throughout public and private sectors (Wafula et al., 2016), the highly fragmented retail sector has a higher risk of being flooded by cheaper and lower-quality drugs. The rural markets are often served by informal pharmaceutical retailers with several layers of middlemen along the way; as price is the primary competitive factor, this poorer, rural segment of the population is disproportionately at risk of accessing lower-quality drugs (PSP4H, 2014a).

**Despite local market dynamics, there is the expectation of growth for Kenyan pharmaceutical manufacturers by serving the region, and this scale could benefit the Kenyan market by increasing quality while reducing cost.** Notably, the Public Procurement and Asset Disposal Act of 2015 should give preference to local manufacturers if they are able to meet quality standards. Should local manufacturing firms meet WHO certification requirements, there will be significant market opportunity within the public procurement system. In addition, investors are seeing both domestic and international opportunities, as Kenya is a hub in the East African region, with free-trade agreements being established across the Common



Market for Eastern and Southern Africa (COMESA). Already, Kenya is a major net exporter with their East African continent partners, exporting US\$254 million worth of chemicals and related substances, while importing only US\$5.1 million from the region (COMESA, 2016). The size of the South African pharmaceutical exports to the region shows the potential growth that Kenyan manufacturers could gain, and investors acknowledge that Kenya is geographically better placed than South Africa to serve this market. That said, at least for the near future, these local pharmaceutical manufacturing firms must import the raw ingredients necessary to produce the final products. The Value Added Tax (Amendment) Act of 2014 added inputs or raw materials for pharmaceutical products to the exemption list, thereby benefitting local manufacturing firms. However, imports of finished pharmaceutical products have always been on the exemption list, countering the benefits of the amendment. Local manufacturing will, in the long run, achieve lower cost and improved efficiency in the health system. Government reform in its path toward UHC will require the cyclical approach of gradually shifting regulations to further favor local production and facilitate investments in local manufacturing capacity; in this way, the government will be able to progressively procure high-quality, locally manufactured pharmaceuticals.

## Partnerships to Harness the Private Sector

**The regulatory environment in Kenya has not fully shifted toward leveraging the resources and capacity that the private sector could bring to the table.** Current public-private partnership procurement mechanisms have been limited primarily to “build and operate” projects, both in health and other sectors. In 2014, there were four potential health public-private partnership projects in incubation (Box 10) (The National Treasury, 2014). The Public Private Partnership Act established a public-private partnership mechanism that is only used to procure tangible services. None of the projects aimed to make payment on a performance basis, leaving behind an opportunity to incentivize efficient and high-quality service delivery. Currently, only one equipment lease and infrastructure development project (the Managed Equipment Services project) is up and running (discussed further in Chapter 8). This is a public-private partnership structure where the public sector is buying a service from the private sector, and there is minimal “leveraging” of private sector resources. That said, for a cash-strapped public sector, reducing upfront costs while increasing valuable, high-end equipment is a good strategy. Opportunities 2 and 4 from Box 11, which are “build and operate” projects, could have a higher potential to mobilize resources in that private investors could provide up-front capital to upgrade and set up a system, with a small incremental cost to the public sector.

**New economic and trade policies could further incentivize private sector capital to enter the Kenyan healthcare market, especially in the**

### Box 10. Public-private partnerships for health

1. Equipment lease and infrastructure improvement: Equip level 4 and 5 hospitals with specialized diagnostic equipment in partnership with General Electric
2. 300-bed hospital at Kenyatta National Hospital private wing: Build-operate-transfer public-private partnership to establish state-of-the-art specialty hospital
3. Information and communication technology services at Kenyatta National Hospital: Develop and deploy platform to manage finance, procurement, drug supply, health records, and patient management
4. Oxygen plant: Install-operate-transfer public-private partnership of 22 oxygen-generating plants in 11 hospitals

**pharmaceutical and medical device manufacturing subsectors.** In addition to the local content law highlighted in the previous section, the Special Economic Zones (SEZ) Act of 2015 is an opportunity for multinational companies interested in entering the growing Kenyan and East African market. The act puts tax incentives into place, provides preferential customs and excise tax arrangements, and puts no restrictions on foreign direct investments into the companies based in these zones. This is seen as a prime opportunity for medical device manufacturers, as currently there are no local manufacturers of medical equipment (Task Force Health Care and the Kenya Healthcare Federation, 2016).

**Public-private partnerships of the future should look at how multiple stakeholders across the health sector and beyond can bring together their resources and capabilities to collaboratively develop and implement a solution.** In the last five years, multi-stakeholder partnerships to address specific health issues have emerged (Box 11) (WEF, 2016b). The model piloted by Novo Nordisk with support from the World Economic Forum in 2013 is gaining traction—in September 2017, Safaricom, Huawei, Philips, MSD/Merck, Unilever, and Glaxo Smith Klein contributed to the Every Woman Every Child initiative by supporting various complementary efforts to improve maternal health in six counties (Koigi, 2017). This new way of building partnerships across public and private sectors, both local and international, ensures alignment of objectives across all players. At the same time that the consumer or payer is able to get access to cheap but high-quality products and service providers are able to adequately serve their patients because of readily available drugs, the private commercial sector is able to grow its revenue by expanding its target market to the “base of the pyramid.”

## Discussion

**Kenya’s private health sector, especially the private provider and pharmaceutical manufacturing sector, is growing in proportion to the population’s demand for health services.** The number of providers is increasing, and the types of services being offered are becoming more robust and competitive with the public sector. Often, Kenyans prefer to access private providers due to perceived higher quality, increased privacy, and faster or more convenient service. Even in poorer segments of the population or more rural areas, private providers (including FBOs and NGOs) are often the first point of call for illness. The general tendency for the

### Box 11. Multi-stakeholder partnerships for health

#### Novo Nordisk and Diabetes

Novo Nordisk, a multinational pharmaceutical company, is working with public and NGO partners to improve diabetes care in the lower-income population. By working with providers that serve this population (public sector, Christian Health Association of Kenya, and the Kenya Conference of Catholic Bishops), Novo Nordisk supported a full review of the diabetes medication distribution chain to identify and address bottlenecks and set up a monitoring system to ensure that an appropriate supply of diabetes medication is cost-effectively distributed to the necessary health facility. Through this streamlined process, the program was able to reduce the price of insulin from US\$17 to US\$5 between 2013 and 2015.

#### e-Health Initiative by Safaricom and Huawei

The telecom giant Safaricom and electronics manufacturer Huawei are using their information technology and mobile technology platform to design and test digital health solutions to connect primary clinics with referral hospitals, especially to reduce maternal mortality and morbidity.

private sector to pay higher salaries for healthcare providers makes the sector more capable of responding to client demands compared to the public sector, which more frequently has staff turnover and strikes. Pharmaceutical sales have also grown, primarily through increased purchases through KEMSA and MEDS. Increasing numbers of multinational pharmaceutical and medical equipment companies, especially from India and China, are flocking to serve these two purchasers, thereby increasing healthy competition and choice for the two purchasers.

**However, gaps in geographic coverage and availability of services still exist, and access to high-quality, affordable medicines through the private providers and pharmacies are still inconsistent.** Services that do not require specialized skills or equipment are often available through the private sector. Specialized services and medical products, especially to address NCDs, are still not accessible to most of the population. The strengthened procurement practices and increased budget allocation by the GOK for pharmaceutical products, combined with local content laws that prefer local manufacturing, could fuel further investment and growth in the pharmaceutical sector. However, there is a lack of regulation and quality assurance for the private pharmaceutical distribution subsector, which will continue to limit quality of care at lower-level private health facilities.

**Scale-up of NHIF and expansion of the benefits package will likely continue to drive growth in the private sector.** The progressive empanelment of private providers to NHIF for outpatient and inpatient care is improving access. Furthermore, NHIF is attempting to deepen its benefits package and is starting to get large private providers to the table to offer more complex services at a lower price. While there has yet to be an analysis of private providers' motivations and the business case to join NHIF, it is likely that the scheme is finally reaching some level of scale with sufficient numbers of members and government financing support to make joining worthwhile. While the payment rates may be significantly lower than what is typically charged for clients paying OOP or through private health insurance, the volume achieved through NHIF may compensate for the lower margin.

**A more streamlined process for claims processing and validation, along with continued frank dialogue between the public and private sectors, is necessary to ensure that affordable, high-quality services expand through the private sector.** For every positive expansion of coverage by NHIF to the private sector, there are also persistent reports of fraudulent claims by the private sector and unnecessary withholding of reimbursements by NHIF. This challenge places patients at risk of inconsistent healthcare coverage as NHIF-covered services are halted, and of CHE as patients attempt to bridge care. An improved claims process, for example, linked with a more robust health information system, could speed up the verification process, improving NHIF's ability to find fraudulent claims, while reducing wait time for reimbursements. Understanding that such systems and regulations require buy-in across public and private sectors, the stakeholders must engage in frank dialogue to collaboratively address these issues.



Photo courtesy of Direct Relief

## 8. PROMISING PRACTICES

**As Kenya implements ongoing health financing reforms, it is facing challenges common across countries in similar situations of enrolling the informal sector in prepayment schemes, ensuring quality, and mobilizing domestic resources for priority health areas.** Insurance coverage, especially through NHIF, is increasing, but reaching and enrolling members of the informal sector who have the ability to pay into these schemes is difficult. Further, as NHIF scales up, covering more members and providing more benefits, the scheme will need mechanisms to pay for performance to ensure sufficient availability of quality services. At the same time, even as prepayment coverage increases, the government must continue to mobilize resources for key health programs like maternal and child health and HIV. This chapter highlights promising, innovative practices and initiatives that present opportunities to address these challenges, as well as preliminary lessons that can be built upon for more sustainable financing of healthcare in Kenya.

### Reaching the Informal Sector with Digital Financial Services in Health Financing

**A sizable share of the informal sector in Kenya may have the ability to pay NHIF's SupaCover charges, and successful scale-up will require convincing them to pay** (see Chapter 5 for discussion of NHIF coverage). The informal sector is highly fragmented, meaning that there are no single unified messaging strategies to capture their attention. They lack strong ties to public services and expect an attractive package of services at the cost they are willing to pay. This combination of traits, needs, and constraints makes providing healthcare access through traditional methods less effective. At the same time, this working poor population has some ability to pay for healthcare, though it is limited. Disposable income among this population is estimated at approximately KSh 100 per day for the rural population and KSh 300 per day for the urban one. Average OOP health expenditure of approximately KSh 50 per day fits within their budget (SupaCover is KSh 500 monthly), but the challenge of tapping into and collecting these resources remains (PSP4H, 2014b). Emerging innovations are targeting this population and aiming to attract

them with digital financial services in health, allowing for predictable prepayment, among other benefits, which can protect the population from the burden of paying at the point of care.

**Over the last decade, numerous mobile health insurance and health savings account products have emerged, promoting the ability to reach the unbanked informal sector.**

With near-universal adoption of M-PESA in Kenya (Suri, 2015), mobile money—and by extension any digital financial services with health payments tie-in leveraging mobile money—can lower transaction costs, increase the ease of saving for health and paying for insurance, and improve equity in healthcare access by providing affordable access to healthcare to the poor and near-poor (BCTA, 2016). Table 13 captures some better-known digital financial services platforms in health in Kenya and their characteristics, while excluding the NHIF Mobile app. Collectively, these five platforms active in Kenya cover approximately 1.5 million people, primarily from the informal sector. KNBS recorded 13.3 million informal, non-agricultural workers in 2016 (83 percent of the non-agricultural workforce) (KNBS, 2017), which means that there is still significant room for growth in this sector. Between its inception in September 2016 to late 2018, the market leader, M-TIBA, had paid out KSh 476 million for 273,282 clinical visits (M-TIBA, 2018).

**Table 13. Mobile-based health insurance and health savings account platforms in Kenya, 2016–2018**

Scheme Name/Operator	Type and Number of Users	Notes
M-TIBA/various, with Safaricom (M-TIBA, 2018)	Type: Health savings account Number of users: 1,400,000 (late 2018)	Partnership of PharmAccess and CarePay with mobile network operator Safaricom to offer mobile health savings and provider payment. The platform enables users to access health savings accounts and pay for NHIF or other insurance scheme premiums via mobile phone. M-TIBA is currently working on other services, such as an emergency loan for major medical expenses. M-TIBA can also be used by its members to learn the care that can be accessed and the price. In addition, M-TIBA is used by providers to submit medical claims digitally, allowing insurers to review and pay out fast. The enrollment, financial, and medical data from M-TIBA are shared with high-level users in customized dashboards and reports.
Airtel Insurance–Kenya/ MicroEnsure with AirTel (BCTA, 2016)	Type: Hybrid Number of users: 50,000 (2016) Not in operation (2019)	Underwritten by PanAfrica Life and designed/distributed by MicroEnsure, this service was unique, as the beneficiary did not directly pay for any premiums. It is currently discontinued in Kenya, though similar offerings are available through MicroEnsure elsewhere. Designed as a customer loyalty program, coverage was awarded based on the amount of individual airtime used each month. Covering death, accidental permanent disability, and hospitalization for any medical reason, up to a defined cash payout, it was at its time one of the more generous benefits offered on the mobile health market.
Afya Poa/Jawabu Ltd. with Kenya Jua Kali Association (PSP4H, 2016a)	Type: Health insurance/ health savings account Number of users: 15,000 (target for 2016) Not in operation (2019)	Afya Poa targeted the informal jua kali sector, working with existing networks of informal sector entrepreneurs to enroll. Premium payments were automatically deducted from mobile phone credit. It acted as insurance for inpatient care and other additional services costs (e.g., funeral, property insurance), while simultaneously being a health savings account for outpatient services. Launched in November 2015, it aimed to have 15,000 members by 2016, but it was discontinued by 2018.

Scheme Name/Operator	Type and Number of Users	Notes
Mamakiba/ Jacaranda Health (Jacaranda Health, 2015)	Type: Health savings account Number of users: 923 (2015) Not in operation (2019)	Built on the M-PESA platform, Mamakiba intended to set up an automatic savings target and account on a pregnant woman's phone to prepay for maternity services. While initial uptake was positive, it only applied to the two Jacaranda Health facilities, limiting its scalability and impact. It is currently discontinued.
m-Kadi Maternity and Family Health/ Changamaka MicroHealth (BCTA, 2016)	Type: Health savings account Number of users: 9,500 (2016) In operation (2019)	A maternity or family health savings account built on the M-PESA platform to top up funds after a one-time KSh 100 fee is paid. The family health product offers discounted services up to 50 percent and discounted medicines at partner providers up to 10 percent, with the specialized product for maternity care offered separately (no fee) with a 10 percent discount on delivery expenses.

**Mobile-based digital financial services for health show promise in expanding prepayment coverage, particularly among near-poor informal populations, but many fail to become financially viable.** Providing low-cost services at massive scale is typically not viable for traditional private insurance providers, which skews their offerings toward more expensive products. Mobile platforms ostensibly reduce the per-user costs of marketing, collecting contributions and disbursing cash-based payments, therefore increasing the spectrum of financially viable products (BCTA, 2016). While there have not been many rigorous evaluations of mobile insurance and health savings digital financial services platforms in Kenya, the cases in Table 13 suggest their potential. A series of case studies of mobile money platforms by Business Call to Action (BCTA), for example, found that they can increase access to health services and insurance, as well as savings for health among “bottom-of-the-pyramid” populations, or those living on less than US\$8.4 per day (BCTA, 2016). The same study also indicated that they could be more efficient and rapid payment mechanisms for providers, resulting in less leakage. Despite these benefits, however, operational costs are still significant, the market is competitive, and it is challenging to profitably serve and pool resources and risk in a crowded market in which clients have low incomes and a lack of credit history. Some of the cases in Table 13 are currently defunct. An older example not in the table is that of Changamaka Micro-Insurance Limited, which in 2012 partnered with British American Insurance Kenya (Britam) and Safaricom to offer Linda Jamii, a low-cost mobile insurance product. It originally targeted individuals, but in 2015 shifted its approach to groups, i.e., religious organizations and cooperatives, among other groups, in an attempt to broaden the risk pool and counter adverse selection. Yet, the product was discontinued two months later. While it had been useful for its 22,000 clients, it was not financially sustainable for the implementing companies (BCTA, 2016). In comparison, M-TIBA, which is backed by the PharmAccess Foundation, has continued to grow (Table 13).

**The successes and challenges facing mobile insurance and savings providers offer lessons for the potential of scaling up coverage through these platforms in the future.** Despite growing pains, more of these platforms continue to emerge. Experience has shown that successful mobile platforms offer diverse, customizable products. They also partner with a range of organizations to combine resources, information, and infrastructure (BCTA, 2016). Most mobile-based digital health payment or microinsurance services in Kenya did not scale up significantly, though M-TIBA may be breaking this trend. BCTA, for example, notes that there are opportunities to increase collaboration and information sharing across service providers, including with NHIF, to reduce information asymmetry and expand the client base of risk pooling. Market segmentation and offering adaptable, hybrid products will help yield more desirable products, again increasing the potential client base. There are also opportunities to expand the capabilities of mobile

platforms to include the full range of claims and reimbursement, increasing their value and attractiveness to healthcare providers (BCTA, 2016).

## Paying for Performance

**In Kenya, efficient resource allocation through vouchers and other demand-side interventions has helped shift the provider mindset and facility operations and is relevant for NHIF learning.** In Kenya, the

Reproductive Health Voucher Program implemented from 2006 supported over 500,000 women to deliver at a qualified health facility (Box 12) (Bellows, 2012). The scheme helped train the providers to work within the structure of a claims-based, fixed-price scheme, where they have to manage their service costs to stay within the reimbursement rate while also meeting the quality-of-care standards set by the scheme. The voucher program was progressively transferred to the government beginning in 2011. In Kenya, there was effort to build financing, financial management, and quality assurance within the government's Program Management Unit (Grainger et al., 2014). Vouchers are part of Kenya's Vision 2030 and have informed the rollout of the Linda Mama policy. Administering the voucher schemes requires capacity for accreditation, quality assurance, claims and reimbursement processing, and engaging the private sector (Janisch et al., 2010). They served as a useful intermediary step toward increased coverage of pre-payment schemes like NHIF, by strengthening the underlying systems, mechanisms, and attitudes necessary for scale.

**Performance-based financing schemes were piloted in several counties in Kenya and may inform purchasing of higher-quality services, particularly in poorly performing or low-access areas.** A performance-based financing scheme was initially piloted by the Health Results Innovation Trust Fund under the World Bank in 2011–2012 in Samburu County. Under this scheme, health facilities that met pre-determined, measurable service targets received additional compensation for health worker bonuses and facility improvements. Essential services like family planning, antenatal visits, and immunization showed significant improvements among the target population because of increased incentives to provide these services. In the year following implementation, for example, vaccination rates increased by 28 percent (RBFHealth, 2012). Based on the success of performance-based financing in Samburu County, the Health Results Innovation Trust Fund scaled up the scheme to 21 arid and semi-arid counties with US\$25 million from the World Bank's International Development Association (World Bank, 2013). Scale-up began in January 2016 with a KSh 508 million disbursement to CRFs. This required creating a national framework for the transfer of conditional grants, which requires a ring-fenced special-purpose account for the performance-based financing funds. Under the scheme, county departments of health that met agreed-upon performance targets for the maternal and child health services received additional funds. These funds were then disbursed to contracted facilities that provide these services. These funds could be used for either facility improvements (40 percent) or health worker compensation (60 percent) (MOH, 2014b).

**Through other performance-based financing initiatives, development partners are further incentivizing public sector programs to improve quality as well as encourage greater domestic resources for health.** This is the premise of the World Bank-supported

### Box 12. Characteristics of Kenya's Reproductive Health Voucher Program

Voucher price to the beneficiary: KSh 200

Voucher reimbursement rates:

- Prenatal Care: US\$13
- Normal delivery: US\$66
- Complicated delivery (including caesarian): US\$276

Source: Bellows, 2012

Transforming Health Systems for Universal Care Project. Its overall goal is to increase the use of quality primary healthcare services at the county level with a focus on reproductive, maternal, neonatal, child, and adolescent health, particularly among vulnerable populations. This includes increasing access and demand for services through, for example, facility improvements and demand creation. Further, it aims to improve institutional capacity to ensure high-quality services, including support for inspections, licensure, quality assurance, monitoring, evaluation, and reporting (MOH, 2016f). The project will approve grant funding allocation beyond the first year based on counties' achievement of health systems, service delivery, and quality metrics. In this way, these performance-based financing initiatives can strengthen the inherent government structures and health systems to achieve long-term outcomes.

## Mobilizing Resources for Priority Health Areas

**Along with incentivizing quality, external funders for health are using new financing mechanisms to promote greater domestic resource allocations for key health programs.** The US\$191 million Transforming Health Systems for Universal Care Project, for example, is funded by a US\$40 million grant from the Global Financing Facility of the World Bank. Another US\$150 million is coming from a World Bank International Development Association credit—a long-term, low-interest concessional loan. The Global Financing Facility uses relatively small grants to leverage larger investments in country-led maternal, child, and adolescent health, in this case in the form of International Development Association credit for county expenditures (World Bank, 2016). Another example, the Challenge Initiative, administered by the Bill & Melinda Gates Institute for Population and Reproductive Health at Johns Hopkins University, funds innovative approaches to reaching the urban poor with reproductive health services, contingent on local government first committing their own resources. In Kericho County, the government has committed US\$130,000 to improving family planning access; the Challenge Initiative is meeting that commitment with US\$130,000, as well as access to technical assistance and support in implementation (Mbugua, 2017).

**HIV funding earmarked in infrastructure projects is an innovative way Kenya is exploring to mobilize resources for priority health areas.** Some health issues, like HIV, have a particularly high burden among the productive, working-age population, resulting in a double burden to society in terms of healthcare costs and lost productivity. Certain sectors and professions expose individuals to a higher risk of HIV. The GOK recognizes, for example, that working in road transport professions can be a major risk factor for the spread of HIV, both for construction workers building roads as well as truckers and transport professionals using them. HIV can be regarded as an occupational health issue, and thus, road construction and rehabilitation contracts can include provisions for HIV care and treatment of the workers and local community. A 2017 study by the National AIDS Control Council (pending publication) showed that a sample of 32 road projects by the Kenyan National Highway Authority and the Kenyan Rural Roads Authority had allocated a total of KSh 387 billion for HIV. On average, approximately 0.44 percent of total budgets was allocated to HIV programming, although this varied significantly across projects. The allocation of HIV funds, however, was not determined in consultation with HIV experts, and so may or may not have been used for high-priority or high-impact investments. There can be significant resource mobilization in these types of earmarks through infrastructure and other sector projects. Better cross-sector and cross-ministry communication and collaboration could help maximize the impact of these resources.



**The Managed Equipment Service (MES) project offers an example of mobilizing resources for secondary healthcare improvement through partnership with the private sector.** Initially, the vision was that leasing rather than outright purchase would be a more efficient use of existing resources. Under MES, the GOK has partnered with General Electric, which provides specialized medical equipment (i.e., radiology and surgical equipment) on a pay-for-service plan that covers both use of the equipment as well as training and maintenance (Patolawala and World Bank, 2017). While this allows the government to upgrade facilities and expand specialized services beyond referral hospitals without requiring large up-front capital investment, without an increase in trained health workers and client utilization, the investment may need more time to provide value (Box 13). At the same time, the arrangement is designed to increase the likelihood that the equipment continues to function and that there will eventually be trained staff to use it. According to the manufacturer, the project initially reduced radiology referrals by 30 percent and reduced the cost of scans by 30 percent by making services more accessible across facilities (GE, 2017). When operating as per its design, the model should allow the government to budget its capital expenditure over a longer period of time and, through pay-for-service contracts, get more value for its money.

### Box 13. Summary of GOK Managed Equipment Services project

- Partnership with General Electric, which provides specialized medical equipment on a pay-for-service plan (cost for use of equipment, training, and maintenance)
- Aim is to improve access to specialized health services countrywide
- By June 2018, the MOH had fully equipped 94 of 98 targeted hospitals
- Utilization of equipment is still reported to be low due to shortage of trained staff
- Counties must pay a flat annual sum of KSh 200 million, regardless of utilization

## Discussion

**This chapter presents promising approaches to solving some of the key challenges Kenya faces in advancing UHC, particularly enrolling the informal sector in NHIF, ensuring the provision of high-quality services, and mobilizing domestic resources for health.** These practices are not silver bullets for any of the challenges, nor have they all been scaled to a national level. Their successes and failures, however, can provide useful insight and potential policy options to inform future reforms and policies moving toward UHC. The GOK, along with NHIF and private sector actors, should consider and explore how innovative approaches to financing health fit into broader national strategies.

**As discussed in Chapter 5, NHIF has a major task ahead to enroll and retain the informal sector, in line with the experiences of many countries when trying to expand coverage through a social health insurance model.** Mobile platforms offer a valuable tool to reach these populations. Many informal sector workers have some ability to pay into health insurance, but given that they are without a regular paycheck, collecting premiums is more difficult and more costly to the insurer. Further, reliance on voluntary contributions can contribute to adverse selection, as members pay for premiums only when they know they will need services. Mobile-based payment and saving is becoming near universal in Kenya and has the potential to minimize barriers to enrolling in and paying for insurance. This should be NHIF's objective for the informal sector—it should be as easy as possible for informal sector members to regularly contribute. While individual mobile insurance providers have struggled to be financially sustainable, these platforms show promise in terms of enrolling members, as well as reducing the

transaction costs of collecting premiums. They also have the ability to meet clients according to their ability to pay by allowing, for example, small, ongoing deposits contributing toward a monthly premium. NHIF has already entered into promising partnerships with these kinds of providers. M-TIBA, for example, has reached significant scale and has a partnership with NHIF, and NHIF's own mobile app allows informal sector members to make incremental mobile contributions toward their premium of KSh 500. It should continue to integrate these kinds of platforms and approaches even more into its scale-up strategies. The health saving accounts on mobile devices and other innovations increasingly introduce the concept of prepayment for healthcare and can make paying for insurance eventually seem more acceptable.

**As NHIF scales up coverage, it will need to ensure that there are adequate quality controls and incentives to provide high-quality care.** Kenya's Reproductive Health Voucher Program offered useful experiences in building capacity for accreditation, quality assurance, and reimbursement. This type of program helps build the underlying mechanisms that will be necessary to ensure quality as insurance coverage is scaled. Kenya has also had successes with larger, public sector performance-based financing schemes, such as that piloted by the World Bank. While this kind of mechanism is outside of NHIF, NHIF can look to experience with performance-based financing schemes to inform its development of paying providers for desired outcomes rather than reimbursing the underlying cost of care, building in appropriate incentives for desirable quality and cost control.

**Even as insurance coverage through NHIF increases, Kenya will need to mobilize increasing domestic resources for health, particularly as external funds decline.** Health in Kenya is primarily tax funded and, as discussed in Chapter 4, economic growth and improved tax collection should increase Kenya's ability to mobilize potential resources to health. This is contingent on a continued favorable economic climate, which is not guaranteed, as well as political will to allocate new resources to health. Further, Kenya will need to mobilize even greater resources as external funding declines and to reduce the burden of OOP (see Chapter 6). Tapping into private sector resources will be critical. The HIV infrastructure earmark discussed above is one particularly promising approach for the GOK to consider using more effectively, alongside a spectrum of blended finance and public-private partnership mechanisms. In this case, the government's authority can establish parameters requiring certain private sector contributions to health as part of the business process. The private actor can then factor these requirements, and any incentives, into its decision as part of the process. In this way, the arrangement may be transparent to private actors and also allows the government to exercise some degree of authority. There is opportunity for Kenya to further explore these kinds of mechanisms, along with the other public-private partnership models discussed in Chapter 7, to improve the sustainability of financing for health.



*Photo courtesy of USAID Kenya*

## 9. DISCUSSION AND RECOMMENDATIONS

As Kenya moves toward UHC, including both expanded access to services and financial protection from the costs of using them, the health financing system must be reformed. This report has given a detailed picture of the health financing system with particular attention to the evolving role of NHIF, the GOK's current experimentation with user fee removal, and the impact of devolution alongside declining external resources. Along these key themes, this chapter discusses their potential implications for future health financing policy options in Kenya. Given the current situation, trends, and future directions discussed above, we consider how Kenya is performing along the key functions of the health financing system. For example, to what extent is Kenya mobilizing sufficient resources for health and pooling them to efficiently purchase services for the population? This chapter concludes by highlighting important findings and suggesting an emerging timescale for achieving the vision across the key themes of this report. Annex B illustrates potential phases in Kenya's health financing transition toward 2030, while Annex C summarizes findings across the familiar domains of health financing functions.

**Kenya's advance toward universal insurance coverage under an eventual SHIF requires a difficult expansion outward from NHIF's social health insurance core.** This has been achieved elsewhere, and success will depend on the ability to pool resources across currently fragmented NHIF schemes that do not pool risk nor offer harmonized benefits. It is probable that an SHIF offering harmonized benefits, driving utilization increases, yet without major increase in contributions, will require support from Treasury for its sustainability, i.e., tax-funded cash injections by the GOK to finance deficits. It is unclear whether long-term fiscal space can be planned now for this contingency. To successfully increase the pool of resources and political consensus around SHIF, the current NHIF will have to begin expanding coverage of the informal sector, as it has already enrolled the majority of the formal sector. Informality also affects the size of government tax revenue as the underlying pool of funding for the social sector. The informal sector dominates the Kenyan economy, accounting for 78 percent of total employment and a third of GDP. Tapping into this sector for public resources, however, is challenging. As is well-known, since informal sector employees do not have a regularized salary, even if they may draw wages, it is difficult for the government to collect direct taxes on this income. The informal sector has the highest concentration of income tax non-compliance (Budget Information Program, 2012). The same challenges exist for collecting mandatory payroll contributions, yet either collecting from or subsidizing contributions for the non-poor informal sector will be critical to any viable single-payer SHIF. Annex A presents the roles of different actors in the formation and continuation of the SHIF, based on national documents.

**NHIF efforts to increase voluntary enrollment among the non-poor informal sector may need to be matched with another revision of the contributory structure.** Outreach, household sensitization, and increased use of digital services can contribute to growing informal membership. In 2012, only 8.5 percent of the informal sector was covered by NHIF. Coverage grew to almost 19 percent in 2016. While this growth is promising, a viable transition to SHIF will have to involve considerably more of the informal sector. Kenya must also pay careful attention to potential threats of adverse selection and to promoting equity in its growth of coverage. For example, initial voluntary adopters of insurance may be higher risk individuals. NHIF has also faced challenges retaining informal sector members, who temporarily pay premiums when they are ill and cease payments when they no longer need services. This makes the membership and revenue structure volatile. Further, there is a wide range of ability to pay in the informal sector. NHIF currently uses a fixed contribution for informal sector members. There are opportunities to mobilize more resources from wealthier informal sector individuals and from the formal sector, and to reduce financial burdens on the poor. The political feasibility of these contribution changes will require high-level political vision and stakeholder consensus.

**In order to cover the poor, Kenya will need resources from both levels of government in the long term to subsidize those who cannot afford to pay into NHIF's schemes.**

Currently, some of the poor are being covered through the Health Insurance Subsidy Program on a pilot basis, financed by the national government and the World Bank. Under devolution, counties are expected to make increasing contributions to NHIF from their budgets in order to cover poor and elderly populations. In Nairobi, for example, the county government is proposing coverage of 3 million poor residents through NHIF. Members would be expected to pay KSh 200 per month for coverage at public facilities. The county government will subsidize the rest of the SupaCover premiums (Thiong'o, 2017). Without tapping into local funds for counties with more resources, expanding coverage to poor populations through payments from the national Treasury may not be sustainable. Under this vision, national resources can be targeted toward the poor and vulnerable in more resource-poor counties.

**As it expands coverage of NHIF, Kenya can look to past global experiences for lessons and approaches to scaling up social health insurance schemes toward UHC.** Global experience suggests that enrolling the informal sector is a long process and that it will be difficult to quickly mobilize resources from or for this sector. Box 14 summarizes this and other key considerations in the context of NHIF reform.

#### **Box 14. Can Kenya reach universal insurance coverage by growing from a social health insurance program?**

**Need for pro-equity expansion.** The current NHIF revenue and expenditure framework is not sufficiently pro-equity, and this must change for the UHC expansion path to be effective. Some countries that expanded population coverage from an SHI core scheme adopted principles of “progressive universalism” favoring coverage of the needs of the poor and vulnerable first. Benefits for NHIF voluntary members who have an ability to pay have improved, though they still lag behind civil servants—and both categories belong to higher wealth quintiles. In contrast, for the sponsored categories of the neediest (e.g., Health Insurance Subsidy Program households, the elderly), benefit use and impact on financial protection are both assessed as low (Barasa et al., 2018). The financial protection and learning principles inherent in Kenya's Afya Care pilots of 2018–20, and the drive to enroll more poor and vulnerable households in NHIF, are laudable, though the specific links between these policies are unclear.

**Need for policy coherence.** With no clear decision on the UHC-EBP to be adopted by NHIF on the path to SHIF, and with independent county-led schemes such as MakeniCare forging their own vision for covering the population, there is uncertainty around the path forward. Policy coherence and a singular vision for sustained county and national government investment are required. Even if NHIF coverage expands, without spending on the supply-side of the health system, newly enrolled households across geographic and socioeconomic segments will not be able to access effective quality of health services.

**Need for major process and governance changes.** NHIF's current weaknesses across quality assurance, claims management, patient accountability, and reducing voluntary members' attrition are key process challenges. They can be resolved through improved effort at the management level. They have also been reduced elsewhere as schemes garnered a higher policy mandate and were put under a more robust social security governance structure. As NHIF is advancing on the enrollment growth path now, and in the context of the *Roadmap Towards Universal Health Coverage (2018–2022)*, the legal and regulatory reforms to be finalized by the GOK NHIF Task Force need to be agreed upon and implemented on an accelerated timeframe.

**Need for financial planning and mitigating shocks.** As suggested in a review by Barasa et al. (2018), the additional membership envisaged by the roadmap—with the recently revised provider payment rates and the expanded benefits package—may begin to stress NHIF's previously experienced financial sustainability. Across two scenarios of an additional 1 million members, the authors find that the primary deficit in terms of the excess of total benefit and moderate administrative expenses over revenues ranged from 29 to 59 percent (Barasa et al., 2018). These concerns resulting from adverse selection in initial waves of voluntary members have been seen previously, e.g., in Indonesia.

**Need for optimism and political will.** On paper, the theoretical maximum coverage based on achieving the membership numbers may lead to high insurance coverage on the family enrollment principle, but without utilization of services and quality of care, this coverage will not be meaningful for UHC. There is skepticism internationally that countries can achieve high insurance coverage and make a dent toward universal insurance coverage, especially with enrollment growth via mostly voluntary membership in the informal sector, and using a “top-down” approach that began with better benefits and coverage of richer socioeconomic segments (Dutta and Ginivan, 2018). However, Kenya's approach, even if aligned with this characterization, has prior precedent and may be feasible if resources for subsidizing a larger share of the poor and vulnerable than currently envisioned are allocated and appropriately targeted. In addition, the benefits carefully selected for Kenya's health conditions must be made universally made available (Dutta and Ginivan, 2018). Innovations in enrollment as currently being practiced also show promise.

#### **Key challenges for NHIF on the path of UHC-related expansion:**

- Fragmented contribution pools limit cross-subsidy and risk adjustment
- Limited ability to increase revenue
- Benefits not harmonized across schemes, limiting use and enrollment
- Several user-fee-removal and provider-reimbursement schemes, added to the NHIF mandate, fragment operations and policy vision
- Challenges in voluntary enrollment
- Targeting issues for free (sponsored) members, e.g., Health Insurance Subsidy Program, the elderly

**Even as NHIF coverage expands, certain inherently public health functions require extensive supply-side effort.** These areas will continue to require government resources, especially at county levels. Beyond subsidizing insurance coverage for the poor, the government will have to mobilize sufficient resources to address supply-side constraints. Kenya needs to invest in improving the quality, availability, and distribution of health services and commodities. There are continuing disparities across counties in key supply-side indicators, including health workforce and density of health facilities. Expanding NHIF coverage will increase financial protection and health-seeking behavior, yet it will fail in advancing UHC if facilities, equipment, and medical products are insufficient to meet rising demand. County budgets are dominated by recurrent spending. Counties will need to increase the resources available for health, including resources for capital expenditures, to improve availability and quality of health service delivery.

**As external funding for health declines, Kenya will also face the challenge of integrating donor-financed vertical programs into domestically financed schemes.**

The contribution of external resources to total health expenditure is still considerable. Kenya has not yet reached the point where it can transition entirely from external support, yet external resources are declining and will only continue to do so as the country matures as a middle-income economy. The government should begin planning for greater transition now, with integration of vertical programs into devolved service delivery and financing, with a role for NHIF as the future dominant purchaser. Integrating HIV, TB, and other vertical program interventions into NHIF requires that its risk pool be significantly large and diverse, that it cover the related populations at risk, and that the scheme establishes the provider linkages and purchasing models necessary to deliver the related care and to remain financially viable. Linkage with NHIF, however, can ultimately help ensure sustainable financing for these services as external resources decline. Previous cost and financial assessments of integration of vertical programs have not moved past the analysis stage. The *Kenya Health Financing Strategy* proposes financing most aspects of these vertical programs through national and county government budgets. Currently, the national government plays a central role in these vertical programs; it will continue to procure and distribute key commodities. National allocations to health will have to increase in order to ensure these functions continue with the diminution of external resources. County governments will also have to ensure adequate resources for financing and strengthening service delivery through public facilities, and also increasingly contracting community organizations.

**Kenya is in an ongoing transition phase during which universally affordable, efficiently procured, and effectively delivered health benefits are not yet widely available, although the framework for this is being put in place—see Annex B for our framework of phases.** During the transition, public tax-funded free and subsidized healthcare for the poor, increasingly the responsibility of counties, will be critical for financial protection and to deliver improving health outcomes. Therefore, emphasis in this chapter on NHIF reform is not meant to downplay the need for strong public spending on primary healthcare, especially for strengthening health system resource availability for commodities, equipment, and workforce. Countries that achieved high insurance coverage alongside financial protection and improving health outcomes not only used hybrid approaches to effectively cover the population, they also prioritized investments in the supply-side first.

**The transition from the current transitional phase to one of consolidation around SHIF will require several policy movements.** The first is to apply learning from the Afya Care pilots, and even county-led initiatives such as MakueniCare, toward the health system's judged ability to respond to an increase in demand for healthcare and to reduce OOP, especially at secondary care levels. Based on this judgment, stakeholders should make appropriate decisions on what secondary and tertiary services can be scaled-up, and when. Second, stakeholders should link this learning specifically to a rational and appropriately targeted iteration of the UHC-EBP, which

NHIF is willing to guarantee and deliver at affordable cost and quality; and around which actuarial and financial modeling can provide the GOK with a reasonable estimate of its future fiscal obligations. The third task is for national and county levels, government and the private sector, and employers and laborers to agree on the vision of SHIF-oriented universal enrollment as well as the costs and benefits of achieving this vision, which will require increased efforts from all. Key evidence needs across these and related policy movements are summarized in Table 14.

**Table 14. Areas of evidence need based on key themes of this report**

Policy Issues and Decision Points	Selected Evidence Requirements
<p>Enhancing health insurance coverage:</p> <ul style="list-style-type: none"> <li>▪ Strengthen processes and governance at NHIF</li> <li>▪ Prepare the final UHC-EBP for adoption</li> <li>▪ Understand which enrollment strategies work</li> <li>▪ Enact legal/regulatory changes (NHIF Act, draft the future national social health insurance fund bill)</li> </ul>	<p>Enhancing health insurance coverage:</p> <ul style="list-style-type: none"> <li>▪ Conduct actuarial analysis of revised UHC-EBP package with enrollment projections and cost</li> <li>▪ Conduct legal and regulatory analysis (under NHIF Taskforce) and cross-country comparisons/best practices</li> <li>▪ Conduct analysis of current NHIF enrollment successes and further targeted options by socioeconomic group</li> </ul>
<p>Deepening county role in health financing:</p> <ul style="list-style-type: none"> <li>▪ Strengthen and consolidate county procurement systems for commodities</li> <li>▪ Improve management of CRF for healthcare spending</li> <li>▪ Assess capability for contracting-out and paying for performance for public facilities</li> <li>▪ Increase utilization of critical health infrastructure</li> </ul>	<p>Deepening county role in health financing:</p> <ul style="list-style-type: none"> <li>▪ Scale-up costs for UHC pilots (phase II) and sustainability analysis</li> <li>▪ Conduct analysis of ongoing county budget commitments alongside national programs/conditional transfers</li> <li>▪ Develop scenarios for county contracting-out to the private sector</li> <li>▪ Conduct analysis of options for enhanced county commodity and medical equipment procurement</li> </ul>
<p>Expanding the role of the private sector:</p> <ul style="list-style-type: none"> <li>▪ Improve contracting through NHIF</li> <li>▪ Explore contracted involvement in delivery of critical programs, such as HIV and RMNCAH</li> <li>▪ Agree on long-term vision for inclusion in SHIF</li> <li>▪ Improve access to pooled price commodities</li> </ul>	<p>Expanding the role of the private sector:</p> <ul style="list-style-type: none"> <li>▪ Develop public-private partnerships for private facility networking and contracting with the GOK and NHIF</li> <li>▪ Implement financing models to provide subsidized commodities for vertical programs through private outlets</li> <li>▪ Explore options for enhancing private investment in affordable secondary care</li> </ul>

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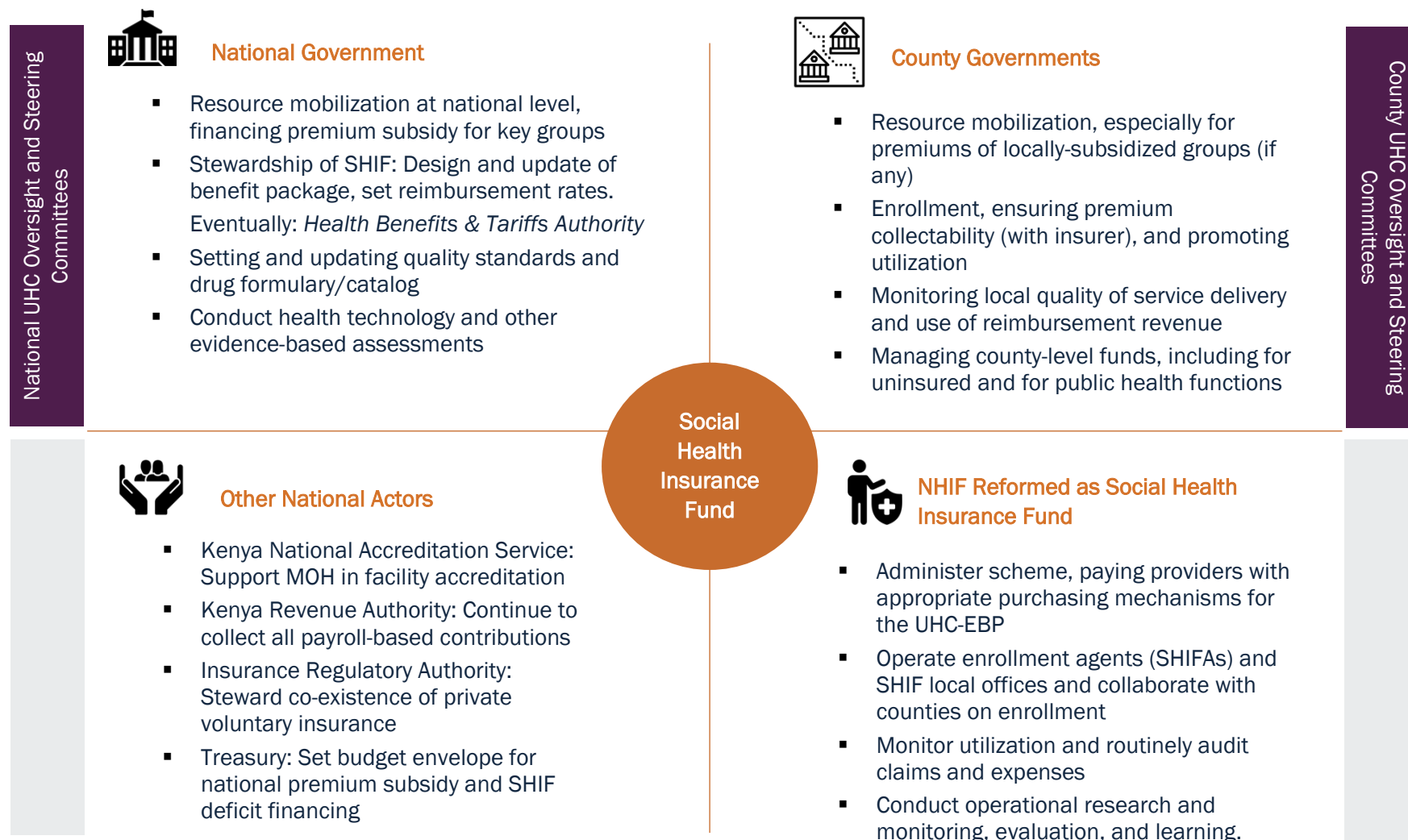
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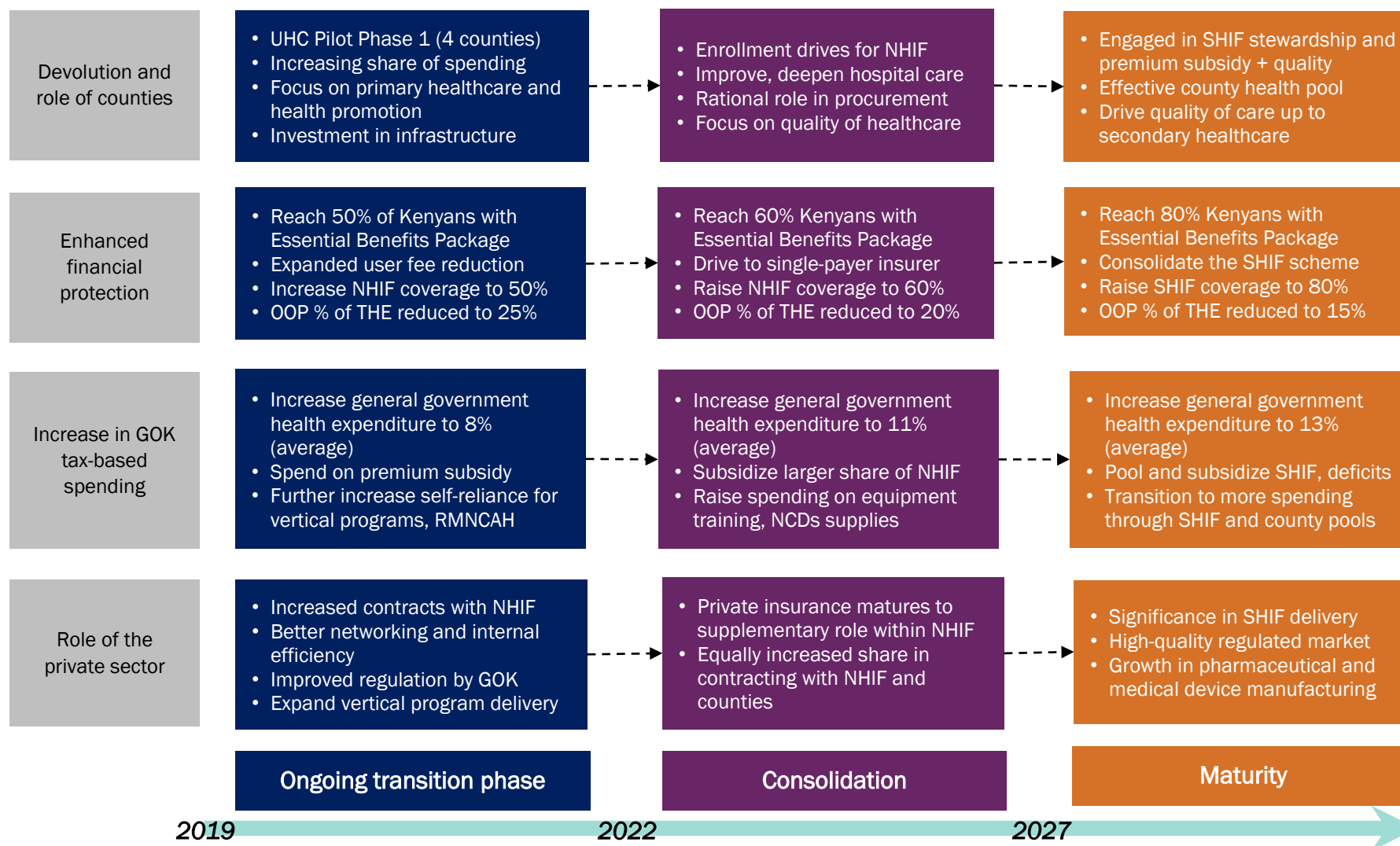
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# ANNEX A. ROLES IN THE DEVELOPMENT OF THE SOCIAL HEALTH INSURANCE FUND



## ANNEX B. POTENTIAL PHASES IN KENYA'S HEALTH FINANCING TRANSITION TOWARD 2030



# ANNEX C. REVIEW BY HEALTH FINANCING FUNCTIONS

## Resource Mobilization

### Findings:

- Tax-financed services are the largest source of funding for health in Kenya; thus, the GOK's ability to raise tax revenues directly impacts the amount of resources mobilized for health.
- External funding for health is declining as a proportion of THE, from 32 percent to 22 percent since 2010. Some of this decline is being filled by increased government spending, but OOP expenditure has also increased.
- One-third of health expenditures come from OOP spending, placing a high burden on households.
- The majority of resources for health are generated at the national level, but all resources for service delivery flow to county governments from the national level through the CRF. The amount of shareable revenue counties receive depends on available revenue and county characteristics, such as population size and poverty level.
- Allocation of these resources to health is at the discretion of the counties. There is considerable variation across counties and from year-to-year.

### Recommendations:

- The GOK should continue to improve overall tax revenue collection. Strategic tax amnesties, such as the one announced in 2016/17, can help encourage Kenyans to declare more foreign income. Ongoing support for improvements to electronic excise and VAT systems will also help capture more non-income tax revenue. The government should also develop county capacity to collect locally generated tax revenues.
- The GOK should consider giving some consideration to health in mobilizing resources as shareable revenue at the county level to ensure that counties have enough resources to meet specific health and service delivery needs.
- County governments should allocate more resources to health, with a clear understanding of exactly what the resource needs are. Nascent program-based budgeting reforms should be supported and expanded to ensure that resources are linked to intended outcomes and that sufficient resources are allocated to achieve those outcomes.

## Pooling

### Findings:

- Resources for health are pooled at three levels: national Treasury, CRFs, and insurance schemes, primarily through NHIF
- The CRF pools all resources for health at the county level, including national shareable revenue, conditional grants (i.e., for Mama Linda and free primary healthcare), and internally generated revenues.

- Health insurance in Kenya pools government and private resources.
- Approximately one-fifth of Kenyans are insured. The vast majority (approximately 88 percent) of these are covered through NHIF, with the remainder covered by private and community-based schemes.
- There are disparities in insurance coverage. Urban populations and higher wealth quintiles are far more likely to be insured than rural and poorer Kenyans.
- The GOK aims to increasingly pool resources for health through expanded coverage of NHIF.

#### Recommendations:

- CRFs are functioning as a pool, but county decisions on allocation are critical to ensuring that pooled resources for health are sufficient. Counties must allocate sufficient resources to health and effectively target resources to poor and vulnerable populations to ensure cross-subsidization.
- To sustainably and effectively pool risk and resources through NHIF, the scheme must increase the size and diversity of the pool. NHIF should increase enrollment, with particular effort to enroll the informal sector. It should also reduce fragmentation by pooling resources across schemes covering different populations.

## Purchasing

#### Findings:

- National and county governments are the primary purchasers of health services.
- Households primarily purchase services OOP from a range of public and private providers, with an increasing percentage of THE going to private providers. More data, like the Kenya Integrated Household Budget Survey, is important for a more detailed understanding of whom households are purchasing services from and their cost.
- Government purchasing is largely passive, based on input-based, line-item budgeting.
- At the national level, efforts to move toward more strategic purchasing are centered on shifting increasing purchasing responsibility to NHIF.
- Efforts to introduce program-based budgeting and performance-based financing schemes are helping to move counties toward more strategic purchasing, but current purchasing is still dominated by passive mechanisms.
- NHIF accredits and purchases services from both public and private providers. It pays for services through a mix of mechanisms, including fixed reimbursement, fee-for-service, and capitation, depending on the type of service. There are challenges in actual implementation of these mechanisms, including insufficient links between payment volume and quality of outcomes, the potential for fraud, and timeliness of payments.
- NHIF is expanding the package of services it purchases to cover an inclusive list of inpatient, outpatient, and ambulatory services. While the list of covered services has grown, it is not clear that all of these services are actually being procured.

## Recommendations:

- At both the national and county levels, the government should move away from line-item, input-based budgeting and accelerate program-based budgeting reforms.
- County governments should begin incorporating more performance-based financing schemes to move toward more strategic purchasing of services.
- NHIF should clearly define and communicate the benefits package to both members and providers. Patients need to know what services they are entitled to receive, and providers need to know the services for which they will be reimbursed. This will help ensure that covered services are actually procured.
- NHIF can improve its payment mechanisms to better control both cost and quality. Moving away from fee-for-service, for example, toward more case-based payments, can help encourage efficient use of services. It should also increase ongoing monitoring of provider quality, particularly for capitation payments, and link payment to the quality of services.

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