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Report to the World Bank on the Kenyan UHC
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Introduction:

The Kenyan Government has clearly declared its health policy goals. Its Vision 2030 stated that Kenya aims to achieve Universal Health Coverage (UHC) by that year. Kenya has planned the initial steps toward UHC and sets the priority for the next five years. The government's Second Medium Term Plan (2013-2017) listed several specific strategic steps to attain UHC in its major provisions for health development:

- Provision of free maternal services in all public health facilities;
- Expanding coverage of health benefits for all the indigents;
- Progressively remove user fees, especially for the poor and near poor.
- Reforming National Hospital Insurance Fund (NHIF) to effectively act as a vehicle to implement the UHC;
- Ensuring efficient allocation and utilization of resources.

Kenya is in a unique situation currently. The new Constitution recognizes the importance of devolution by establishing forty-seven new county governments. Budget, power, and responsibilities are being devolved to counties. The nation is in the midst of going through devolution where counties are creating their own legislatures, governmental operations and recruiting personnel. Meanwhile, the management/operation of public health services (staff and facilities)are being devolved to the counties. Each county receives a share of the national revenue, based on a new formula using equity criteria that determine the amount each county would receive. The aggregate amount of the equitable share given to the counties comes from the sectoral budgets the national government was allocating in the past for various programs such as health care, agriculture, water and sanitation, etc. The most important implication for health care is simple and stark: the equitable share allocated to counties does *NOT* ring-fence any amount for health care. The counties will set their own priorities to spend the equitable share received from the national government and revenues generated through local taxes/sources.

Objectives of my visit:

The World Bank (WB), Kenya Office invited me to review the strategy and implementation of the Kenyan UHC. The World Bank team particularly asked me to assess the design of a social health insurance for the indigents, the capability of NHIF to be an effective and efficient purchaser and to manage and administer an expansion of health insurance to cover the indigents. Furthermore, I was asked to assess the financial resources needed for UHC for the indigents, and the adequacy of supply of basic services to ensure indigents have access. I was requested to ensure that my assessments are based on evidence and my recommendations are *practical and implementable,* based on international experience. At the end of my visit, I shared my key findings and recommendations with the Cabinet Secretary for Health, Mr. James Macharia and the Parliamentary Committee on Health.

To prepare me for my assignment, the WB, Kenya Office sent several background documents and some preliminary working papers to me in advance, briefed me upon my arrival about the latest situation in Kenya, and organized an extensive briefing and discussion with the NHIF executives. In addition, WB, Kenya arranged for me to meet with the Technical Working Groups on Health Care Financing, organized by the Ministry of Health (MoH). These Working Groups were to investigate in depth the current situation in Kenya on health care financing and work is still at the preliminary stage. I also participated at the Interagency Coordination Committee for Healthcare Financing. On my own, I also interviewed Kenyan experts such as professors, researchers and former government officials.

Principal findings

Kenya has made significant improvements in prevention and primary care that resulted in impressive reduction in infant mortality and controlling HIV/AIDS. Health centers staffed by nurses are widely available throughout Kenya, except in Northern Kenya and in some poor counties. However, Kenya still suffers from high maternal mortality rate and high prevalence of preventive diseases such as malaria, pneumonia, diarrhea, and malnutrition. Clean water and sanitation are still lacking in many communities. The disparity in health status and health services among counties and between the rich and the poor are large. For example, there were 4 times of difference in maternal mortality by region. While Kenya's total spending for health from public and private sources is relatively reasonable for its socioeconomic stage of development, the public spending is relatively low. Patients' out-of-pocket payments seem to be high. The health system seems to under-perform with the resources it has. For example, one recent study found that the average staff absentee rate in public facilities has been as high as one-third. Despite relatively high levels of health provider's knowledge, there is large gap between how this knowledge was used for patient care. Further, the huge portion of the NHIF fund is spent on administration.

The consultant is deeply impressed by the commitments made by the top Kenyan political leaders for UHC. They have chosen to prioritize the coverage of the indigents and maternal health care first. Their goals also focus on improving efficiency and quality of health care. Based on worldwide experience, *the consultant found that the Kenyan Government has set the correct direction, policy goals and prioritizing the coverage of the indigents and maternal care.*

The critical challenges confronting Kenya is how to implement this policy effectively and efficiently. It faces at least the following major barriers:

- MoH can set policies and holds the responsibility and accountability for enhancing people's access to quality health care and improving their health status. However, it's not clear how MoH can implement its policy. For example, it does not have the power to control and allocate the health budget, and hire/fire/promote health executives or the health staff in the counties. These powers are now devolved to counties. Moreover, the consultant found that MoH requires additional technical capability to do policy planning and analysis to effectively play its new role.
- A few decades ago, Kenya had established a compulsory national health insurance plan for its formal sector workers and a new scheme was recently introduced for the civil servants providing a more comprehensive care. Both formal sector employees and civil servants are the middle or upper middle income households mostly living in urban areas. Social Health Insurance (SHI) mobilizes funds for the health care of these selected population groups. As a result, human resources have been drawn to the medical facilities in urban areas to serve these groups of people. This has promoted the disparities between the rich and poor as well as disparities between urban and rural population.

- NHIF has been expanded to enroll informal sector workers on a voluntary basis. But only a limited number of informal sector workers have enrolled, many are the high health risk population.
- Under its plan to expand coverage to the indigents, Kenya needs an organization to serve as the insurance agency and as a purchaser of services. Presently, Kenya only has NHIF that possesses the technical know-how to enroll people and purchase services from public and private facilities on a nationwide basis. Kenya's private insurance companies are small and they do not have the capacity to enroll people or purchase services on a nationwide basis.
- Historically, NHIF has had a poor performance record. Until recently, a majority of its revenue was spent on administrative expenses. Despite some improvement, the latest figure is still 40% the highest in the world. Kenya has a faulty governance structure for NHIF. Politics intrudes in the management of NHIF and patronage hiring seems to be widespread. In the past, huge amount of NHIF assets for insurance reserves were lost to corruptive investments. Besides its poor governance structure and its past dissatisfactory performance, NHIF has not been an effective purchaser of services for its beneficiaries nor an effective negotiator with the service providers to obtain "value for money" for its beneficiaries.
- Nevertheless, there is good news about NHIF. Recently, the organization is changing and improving. Most Kenyan political leaders and the public having learned about the poor performance of NHIF have prompted a push for its reform. Facing intense criticism, the current executives of NHIF have accepted the necessity for a major reform of its governance, organization and management. The organizational culture of its top executives seems to be changing from a bureaucracy serving political interests to one that is dedicated to serve its beneficiaries. More qualified professional staff have also been recruited.
- Kenya does not have a robust structure to assure quality of health services. The NHIF has ended up performing this role by accrediting facilities. Accreditation standards have been weak, service quality standards needs to be vastly strengthened, monitored and enforced. However, recently NHIF has embarked on an internationally recognized stepwise quality improvement program in its accreditation of facilities which helps to address some of these constraints..
- Supply of qualified primary care providers and drugs are inadequate at some geographical locations, particularly in sparsely populated arid and semi-arid communities where a sizable number of indigents live.

Recommendations

Context: Kenya is still a low-income nation with less than US$1,000 GDP per person. Accordingly, its domestic revenues are very limited. Kenya has to be realistic about its fiscal capacity to finance the initial coverage of the indigents, then expand the cover for the poor and near poor, and finally move to cover other informal workers and their families. Moreover, Kenya is currently relying on donors to finance most of its high cost HIV/AIDS program. These donor funds may gradually decline over the next decade, creating contingent liabilities that require Kenya to provide its own domestic funds to continue the HIV/AIDS program.

On the supply side, Kenya has to seriously consider the availability of the covered services and drugs under its benefit package of UHC. Otherwise, its UHC will be an empty promise. This consideration means the supply of basic services and essential drugs has to be expanded in many rural communities.

1) **Select a modest Benefit Package:** Because of the fiscal and supply constraints, Kenya faces a policy choice of giving a comprehensive benefit package to a narrow group of its citizens, or a modest benefit package for a larger group of citizens. The consultant recommends the latter choice for the following reasons:
   - A modest benefit package covering preventive and primary care cost and selected secondary services would be the most cost-effective approach to improve the health status of Kenyan people.
   - Modest benefit package but broad population coverage is more equitable for the entire population and would also be more affordable.
   - A comprehensive benefit package would include the tertiary medical services. It takes a long time to develop an adequate supply of qualified physicians and specialists to deliver the tertiary services. Moreover, it is unlikely that Kenya can attract and retain qualified specialists to the communities where the indigents, poor and near poor live.
   - As the Kenyan economy grows and better trained health personnel become available, Kenya can expand the benefit package for all.

2) **Drastically Reform NHIF**: This organization must be reformed; otherwise it can't serve as an effective and efficient purchaser for the interest of the beneficiaries. The consultant recommends the following five actions as the minimum measures:
   - Enact new laws to establish NHIF as an independent organization, divorced and insulated from politics. The organization should be managed by a Board where the majority of the Board members truly represent the interest of the grassroots beneficiaries, not only the governmental ministries or unions. The chairman should be an eminent civic leader who has a strong record serving the public interest.
   - Legislate and cap the administrative expenses of NHIF. It should NOT exceed 15% of its revenue three years after the law's enactment. Then the percentage should be gradually reduced down to 10%.
   - Select and appoint a CEO of NHIF by open listing and competition.
   - Alter the governance structure of NHIF where the CEO has power over financial affairs and human resources. Managers and staff should be selected based on their professional knowledge and competence. NHIF operation and its performance must be made transparent to the public. The CEO should be held accountable for the performance.
   - Pool the risk of civil servants, workers in formal and informal sectors, and indigents, investigate how other nations with similar fragmented insurance pools have moved toward national risk pooling such as Rwanda and Colombia.

3) **Do piloting:** Kenya has no experience on how to cover and provide adequate services to the indigents. NHIF and private insurance have not dealt with this population before. Only some Community-Based Health Insurance (CBHI) plans have some experience. Piloting is a wise and realistic approach to proceed. The consultant whole heartedly supports the pilot study that the WB plans to fund. The consultant would recommend that the WB and MoH modify its current plan and make the following changes for the reasons cited in recommendation #1 above:
   - Reduce the comprehensive benefit package proposed in the current plan to a modest one. The current benefit package proposed by MoH follows the comprehensive benefit package that the civil servants enjoy. Its cost would be very high. Equally important, many promised benefits could not be realized because the supply of many secondary and tertiary medical services would not be available for the indigents.

- Expand the pilot by contracting selected capable Community-Based Health Insurance Plans to be the administrators and purchasers for rural population. These selected CBHI must have demonstrated the know-how and capability to deal with the conditions in the rural communities. By expanding the pilot to include a few CBHI pilots, it would create competition for NHIF and also give the WB and MoH comparative information to make final policy decisions.

4) **Harmonize the responsibility and accountability of MoH for the health of the citizens with devolution**. The consultant recommends the following remedies:
   - MoH sets outcome performance standards and hold the counties accountable for results. The standards could include improvement in health status and volume of supply of public health services.
   - The MoH would publicize the county performance on a nationwide basis and hold national meetings with county leaders to discuss the results. This would create competition among the counties.
   - Conditional grants and other awards can be given to the high performing counties.

5) **Supply of preventive and primary care services:** Some Kenyan communities lack adequate supply of preventive and primary care services, particularly in rural communities. The consultant recommends that Kenya needs to make it's community strategy more efficient and affordable in order to serve the preventive and basic health needs of the communities relevant for the Kenyan context by taking in to account diversities among the counties. Counties should also be encouraged to select and incentivize qualified young rural residents for training as midwives and nurses to serve these rural communities.