Ministry of Health

Health Financing Reforms for Universal Health Coverage in Kenya

A Technical Concept Note

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Es konnten keine Einträge für ein Abbildungsverzeichnis gefunden werden.

SECTION 1.0: BACKGROUND AND CONTEXT

The 58th World Health Assembly of 2005 (WHA, 2005) encouraged member countries to aim at providing affordable and quality health care, accessible by all citizens on the basis of equity and solidarity. Following this declaration, many countries including Kenya are currently considering how to reform their Health Financing Systems with the aim of achieving Universal Health Coverage (UHC[1]).

The Constitution of Kenya (COK, 2010) through the Bill of Rights (BOR) puts a heavy responsibility on the health sector to ensure realization of right to health. Citizen's expectations have been raised by the provisions under this BOR particularly the right to highest attainable standards of health including Reproductive Health and Emergency Treatment. In addition, the goal of Kenya's Vision 2030 and that for the health sector is to provide equitable and affordable health care of the highest standards to Kenyans. Arising from this, the Government recognizes that access to health care not only entails the physical availability of services, but also the protection of its citizens from financial hardship. Developed against this background, this Concept note provides recommendations on key health financing reforms required to fast track the movement towards Universal Health Coverage. The note has been informed by various studies and relevant background papers on UHC and consolidated into an "Options for Kenya's Health Financing System" by the Providers for Health (P4H) group.

The recommendations pay attention to the role of Counties in a devolved Government system, equity in access, efficiency in service delivery and to the importance of health service quality assurance and improvement. It starts by examining health financing situation in the country in section 2 followed by conclusions and implications in section 3. Section 4 highlights the specific policy recommendations for the respective areas of reform followed by other required supporting reforms in section 5. The Concept note does not go into administrative and managerial details but concentrates on concepts and strategies to be developed.

SECTION 2.0: HEALTH FINANCING SITUATION IN KENYA

2.1 UHC Related Indicators on Health Sector Performance

Kenya has struggled to build a health system that can effectively deliver quality health services to its population. Among the key health indicators, the overall under-five child mortality rate and maternal mortality ratio remains high at 74 per 1000 live births and 488 deaths per 100,000 live births respectively (KDHS 2008/09) .

Access to health care varies widely throughout the country and major disparities exist between rural and urban communities and between the rich and poor. According to NHA 2009/10, individuals carry a huge burden of health care expenditures at 24% in form of direct out of pocket payments (OOP). Other sources of funds for health comprise of government 29%, Donors 35% and other private sources accounting for 13% of THE. The per capital health

[1] UHC requires that financing systems be specifically designed to provide all people with access to needed health services of sufficient quality to be effective and ensure that the use of these services does not expose the user to financial hardship (WHO report, 2010)

spending was estimated at USD 42.2 against the recommended WHO requirement of USD 60, indicating a general underfunding of about 30 percent. In addition, long distance to health facilities, unavailability of services and poor functionality are major factors that hinder access to health services. There is therefore need for a revamped health financing structure that can increase funding to the health sector and reduce direct OOP spending on health.

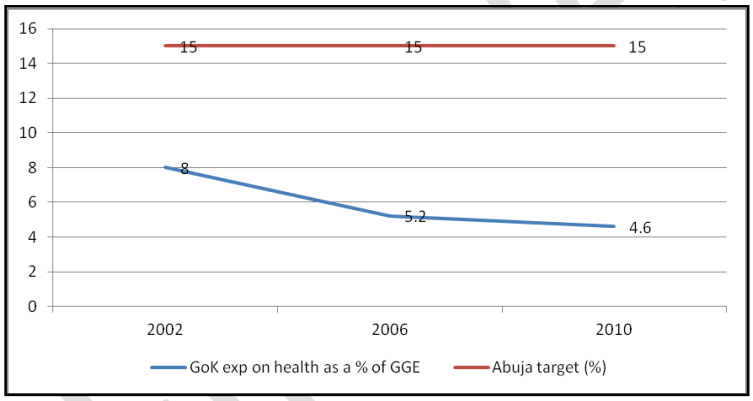
The key health policy concerns are not whether the government uses general revenues or payroll taxes, but whether the actual amounts of revenues raised are sufficient and the extent to which they are used in an efficient, equitable and sustainable manner.

2.2 Key Issues in Health Financing In Kenya

2.2.1 Raising Funds For Health Spending

The health sector is generally underfunded with only 70% of expected funding available from all sources. This is inclusive of direct out of pocket payment (OOP). The bigger challenge, however, is the insufficient amount of domestic public funds in the health system. In 2010, health resources from domestic public health expenditures accounted for only 29% (or approximately USD 12 per capita) of Total Health Expenditure (THE) (NHA 2010). This amounted to about 5% of the General Government Expenditure (GGE) which is way below the Abuja target of 15%. This figure has not been estimated in the devolved system of governance. Figure 2.1 provides information on Government expenditure on health as a % of general Government expenditure.

Figure 2.1 GOK Expenditure on Health As A % of General Government Expenditure.



It is estimated that nearly 15% of Kenyans spend more than 40% of non-food expenditure on health care which is a major source of financial distress in a context of high poverty levels, and leads to catastrophic health expenditures.

2.2.2. Financial Risk Pooling

Financial risk pooling of resources is the accumulation and management of funds contributed by individuals or households and possibly by employers, government and others, in a way that insures the individual contributor or defined beneficiary against the risk of having to pay the full cost of care out of pocket in the event of illness. Tax based health financing and health insurance both involve pooling, while fee for service user payments do not involve pooling.

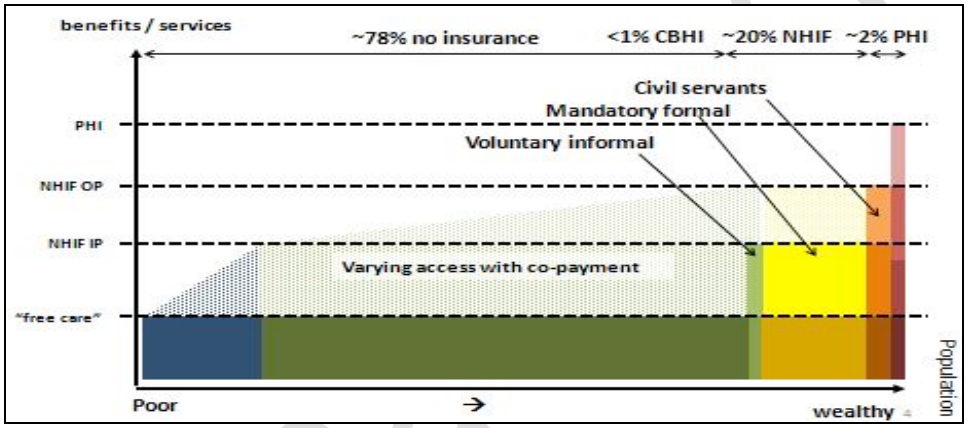
Currently, within the domestic sources the main financing pools are government budgetary allocations (29%), health insurance (6 %), and small community based prepayment schemes. These pools are isolated and not connected through financial risk equalization mechanisms. The

generally low insurance coverage is largely limited to formal sector employees (mandatory) and a small number of informal sector voluntary contributors. In all, about 20% of Kenya's population is insured.

The two main pools are characterized by further fragmentation. For example, within the government budgetary allocation pool, access to services for individuals and households is fragmented by coverage schemes which include general budget lines for GOK subsidized services, Free Maternity Initiative, Free Primary Health care etc. Devolution adds to the complexity in pooling, as Counties are purchasing health services from their block grant allocation from general tax revenue. This further fragments the system and therefore hinders equal access to care for all.

Figure 2.2 provides an overview of the current coverage among the population (ranked by wealth on the X-axis) and across different service categories included in different benefit packages (on the Y-axis). It simplifies the scheme coverage by wealth categories i.e. some wealthier Kenyans may not be covered by NHIF or PHI, while some less wealthy are, but by and large this principle does hold.

Figure 2.2 Population and Service Coverage by Health Financing Scheme



Access to health services is unequal and the poor are currently financially excluded from access to many services mainly, secondary and tertiary care.

2.2.3. Purchasing of Healthcare Services

In practice, purchasing of health services is done by public or private agencies that spend money either to provide services directly or to purchase services for their beneficiaries. In many cases, the purchaser of health services is also the agent that pools the financial resources. In Kenya, the main purchasers of health services are the government through the Ministry of Health, other government departments and agencies, County governments, National Hospital Insurance Fund (NHIF), Private Health Insurance and households.

Purchasing from government budgetary allocations pool is mainly passive and dependent on a pre-determined budget as opposed to strategic purchasing which requires deliberate approaches to seeking better quality services at low cost via selective contracting of providers and their services while reviewing the actual performance of the contracted providers. In Kenya, this passive purchasing is associated with high levels of wastage due to inefficiencies as

demonstrated by the 50 – 60% wastage levels in public hospitals, 10 – 20% for health centers and 20 – 50% for dispensaries. This implies that the facilities are using more inputs than required and could potentially reduce their current input endowments while leaving their output levels constant. For NHIF, administrative costs account for over 30% of total expenditures thus, denying resources for actual service provision.

2.2.4 Provider Payment Mechanisms

Pooled funding in Kenya, which is predominantly from general tax revenue, mainly benefits public providers. The payment mechanism is effected through input based line item budgets (e.g. salaries, supplies, equipments and other investments). The mechanism provides no incentive for increasing efficiency and productivity; and generally restricts the emergence of internal markets.

In addition, input based financing provides incentives for unnecessary referrals if costs can be avoided by referring patients to another "budget". For example, County facilities may refer patients to tertiary hospitals since these are not financed by the County, but by the MOH.

Where different funding sources are involved in data collection, the flow of health information is often inhibited. This can have obvious negative impacts on reporting of health outcomes and on the financial and general governance of the health sector.

SECTION 3.0: CONCLUSIONS AND IMPLICATIONS

Kenya's' health financing system, like for other low income countries is facing numerous challenges. Key among them include inter-alia absolute underfunding, high direct out of pocket payments for services, high dependency on external sources, low insurance coverage, and inefficiencies in the use of available limited resources. Over fragmented financial risk pools without adequate regulatory framework have negative consequences on cross subsidization.

Despite these challenges the Government is committed to achieve UHC by 2030. However, this calls for key reforms to be made in the health financing system focussing on mobilization of additional financial resources, improved financial risk pooling arrangements, strategic purchasing from public and private providers and provider payment mechanisms; as well as giving attention to other health system issues including but not limited to strengthening of institutional capacity, sector governance, supply chain management, information system and service delivery in particular.

SECTION 4: PROPOSED MODEL FOR HEALTH FINANCING REFORMS IN KENYA

The goal of this financing model is to ensure improved health status of Kenya's population, satisfaction with services and confer financial risk protection for all Kenyans. The intermediate objectives are to ensure equitable access to quality and affordable health care for the population. The proposed preferred health financing model is characterized by the following salient features:

4.1. Raising Funds for Health Spending

It is suggested that the model will optimize on the mixed sources of funding from both general tax revenues and health insurance premiums. This approach will ensure that Kenyans are not over-taxed in case of a solely general tax revenue based system or over-burdened with high

insurance premiums in a situation where the system is entirely public health insurance based. This in turn implies expanding of inclusive pre-paid risk-pooling schemes including increases in total government funding available and social health insurance coverage; and thus reducing the direct out of pocket payments for services. Only when the healthy and wealthy contribute via taxes or premiums according to their economic ability, can the sick and poor benefit according to their need. Against this background, the proposed strategies for consideration include:

a. Maximize on efficiency gains by reducing wastage at all levels of the health system

b. Gradual increase of government funding from the current 4.6 percent of General Government Expenditure (GGE) to a minimum of 15 percent (Abuja target);

c. Expanding pre-paid insurance funding from the current 6 percent to about 40 percent of THE by mobilizing mandatory contributions from the informal sector, but excluding indigents and the vulnerable groups;

d. Mobilizing additional resources from external sources while at the same time paying attention to the objects of the Paris declaration on Aid effectiveness;

e. Allocating additional funds to the health sector from the County level locally raised revenues and;

f. Co-payments of up to 10 percent of THE to counteract consumer moral hazard.

4.2 Financial Risk Pooling

The pooling objective is to minimize the fragmentation of the existing pools by progressively consolidating towards a single pool from which all the inputs into the health system will be financed. It is preferred that the government budgetary allocation to health be consolidated and pooled at National level, to be administered by a single agency that is independent of both MOH and Counties. The fragmentation within insurance pools will be eliminated to allow for cross-subsidization and uniformity of the insurance financed benefit package.

4.3. Purchasing Arrangements

There is need to change from passive to strategic purchasing of health services. This calls for promotion of internal health care markets characterized by purchaser-provider split, defining interventions to be purchased in response to population needs and national health priorities, how they should be purchased and from whom and in which volumes to purchase.

4.4. Provider Payment Mechanisms

A payment mechanism that provides incentives for efficiency and productivity is recommended. Towards this end, several methods on provider payment mechanisms are proposed. Such mechanisms advocate for progressive movement away from line-item budget mechanism towards a fee-for-service (FFS) system, including capitation-based budgets, Global budgets and Diagnostic related Groups (DRG).

Payments based on fee-for-service are useful in low-productivity settings and provides incentives for providers to improve performance, including reporting. The latter is extremely useful for quality assurance and financial and health services planning.

On the other hand, a capitation budget can be used, where calculating the expected average expenses of a provider for a disease episode will allow for determining the budget needed for e.g. 3 months and advance it to the health facilities. This way, the health care provider has a guaranteed income, which allows organizing health services efficiently. Such a system of capitation-based advanced budgets is usually accompanied by a system of quality control; and litigation and complaint management.

SECTION 5.0: OTHER REQUIRED REFORMS FOR THE FINANCING MODEL

The movement towards UHC calls for further health system reforms beyond financing:

5.1. Definition of a Benefit Package

Due to limitation of resources, universal health coverage can only be progressively achieved through incremental financing for defined health service packages moving from a minimum package of essential health care to a more comprehensive package, with each defined package being non-excludable, taking into consideration the fact that fragmentation of the population into too many target groups may lead to inequality and higher administrative costs. Additional services are included, as funds become available while individuals remain free to enroll in duplicative, supplementary or complementary private insurance.

The three key steps of implementation should be 1) Define the minimum package of essential health care within the principles of integrality of care (continuous set of preventive, promotive and curative care, individual and collective, actions and services required at all levels of complexity of care of the system), 2) Determine the criteria for referral and other conditions for access to care, 3) Estimate the cost of providing this minimum package of essential health care services and 4) Biennial review of benefit expenditures to possibly adjust the package or its funding level.

5.2. Standardized Quality Assurance System

Services will only be purchased from accredited providers. Accreditation[2] standards need to be defined by the Ministry of Health for all public and private service providers at all service levels. Standards, review processes and quality improvement activities will be developed via a participatory approach with both levels of government, health insurance agencies and service providers.

5.3. Legal and Regulatory Framework

There will be need for reforms as the MOH embarks on the movement towards UHC. Among key targets for legal reforms include:

[2] Accreditation can be defined as *"A self-assessment and external peer assessment process used by health care organisations to accurately assess their level of performance in relation to established standards and to implement ways to continuously improve". It can be voluntary or mandatory, implemented by MOH, an independent government agency or a private body recongnized by purchasers as authority of which the review results and accreditation status is used in their contracting policies.*

a. Legislation of laws that support earmarking funds for health at the National and County Governments;

b. Hospital operational autonomy and governance structures for all public health facilities;

c. Establishment of a health tariffs forums or body, which includes representatives of key stakeholders;

d. Strengthen Insurance Regulatory Authority (IRA) in order to support and oversee the proposed health-financing model including NHIF reforms and;

e. Establishment of a health facilities accreditation body for external quality assessment and continuous quality improvement

5.4. Managerial Considerations

Success of this complex reform process depends on political will and the right management approach. The strategies and management principles recommended include:

a. Advocacy for the importance of the reform and its implications;

b. Analyzing the interests of the main stakeholders;

c. Informing all stakeholders and actors on the proposed reforms for ownership;

d. Developing a 5-year implementation plan based on a logical framework with a solid component for internal and external monitoring, as part of the UHC roadmap;

e. Avoid fragmentation of the approach by accommodating donors and external experts with preferences to specific target groups and strategies and;

f. Give the process time to grow organically with full support from all stakeholders while staying the course towards UHC