Transparency and Accountability in Kenya's Health Financing Models

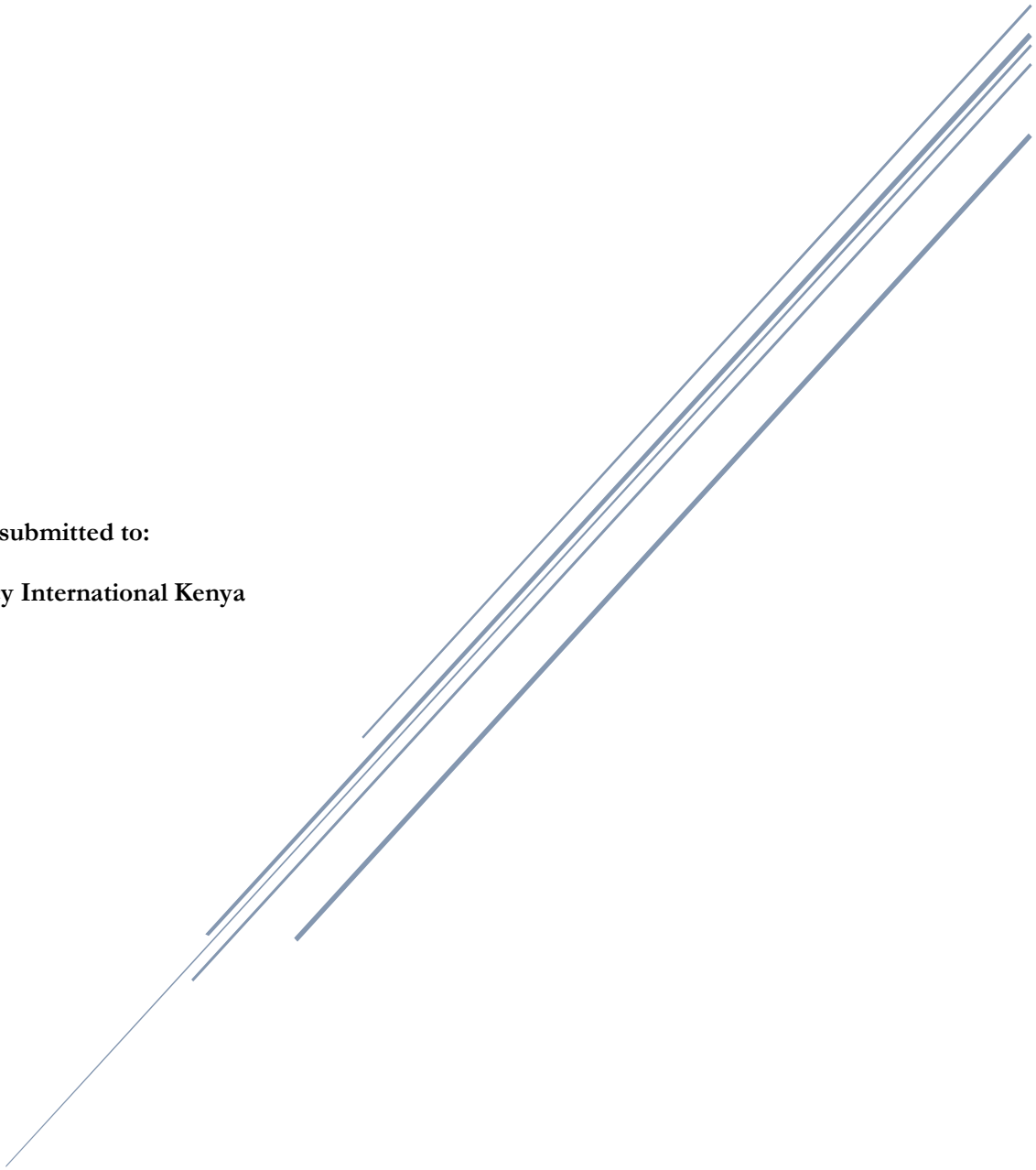

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Table of Contents

1 List of Tables and Figures

1.1 Tables

1.2 Figures

2 List of Acronyms And Abbreviations

CBHI	Community Based Health Insurance.
HISP	Health Insurance Subsidies Program
HSSF	Health Sector Services Fund
IFMIS	Integrated Financial Management Information System
KEML	Kenya Essential Medicines List
KEMSA	Kenya Medical Supplies Authority
KEPH	Kenya Essential Package for Health
MDGs	Millenium Development Goals
MES	Medical Equipment Scheme
MOH	Ministry of Health
NHIF	National Hospital Insurance Fund
NHA	National Health Accounts
OBA	Output Based Approach
OOP	Out-of-Pocket Payments
PHI	Private Health Insurance
SDGs	Sustainable Development Goals
SHI	Social Health Insurance
UHC	Universal health Coverage
UHC-EBP	Universal Health Coverage Essentail Benefits Package
WHO	World Health Organisation

3 Acknowledgements

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Finally, I wish thank all those who contributed directly or indirectly to the development of this study report.

4 Executive Summary

In August 2010, Kenya adopted a new constitution that created a devolved system of governance that consists of National Government and 47 County (sub-national) Governments. Under the new dispensation, health is a devolved function that is shared across the two levels. The responsibility for health service delivery is assigned to the Counties while policy, quality assurance, capacity building and management of national referral hospitals remain the national's government responsibility. In 2017, the government of Kenya made a commitment of accelerating its progress to achieving Universal Health Coverage (UHC) by 2022 and has taken a number of steps to reform the healthcare system towards achieving this goal.

Globally, the United Nations 2030 Agenda for Sustainable Development identified 17 Sustainable Development Goals (SDGs), to succeed the Millennium Development Goals (MDGs) and to be achieved by 2030. Attainment of good health and well-being is SDG 3, with target 3.8 spelling out the need to achieve Universal Health Coverage (UHC), including financial risk protection, access to quality essential health services, and medicines and vaccines for all.

The Constitution, under the Bill of Rights puts a responsibility on the State to ensure equitable, affordable and quality health care to all Kenyans. Despite these Constitutional requirements and safeguards for the right to health services, there continues to be persistent inadequacies in the health sector that have faced Kenya since independence largely due to stagnant or declining budgets for health, system inefficiencies, human resource deficiencies, and unaffordable quality health services. Transparency and Accountability especially on resources for the Health sector has also been wanting. It is in view of these shortcomings that the need to assess the effectiveness of health financing models in Kenya was necessary.

There are six major sources of financing health care in Kenya:

1. Tax-based financing: Financing of healthcare using tax revenues through the ministry of health.
2. Social health insurance (NHIF): Pay roll-based contributions by the formally employed and voluntary contributions by those in the informal sector. The government also provides funds to NHIF to provide coverage for different population groups.
3. Private health insurance: Voluntary contributions as well as employer-based groups
4. Community-based health insurance
5. Donor funding
6. Out-of-pocket payments: payments made at the point of care.

Some of the key findings of the study are:

1. Allocation to health by the government has been declining with an average of 4.5% in the last 3 years, way below the proposed 15% in the Abuja Declaration.
2. Despite legal requirements for the different health sector players to enhance mechanisms to ensure ease of access to information by the public, most institutions and counties do not have core information such as funds allocations, disbursements and expenditures accessible to the public. There is very little information on NHIF reimbursements for claims available to the public. This applies to institutions such as KEMSA that are tasked with providing core services to the health sector.
3. A number of health policy interventions in Kenya are largely driven by policymakers with very little public participation. One such example is the Medical Equipment Scheme (MES)

which was designed and executed by the National Government with very little particpation by the counties and the public in general. This has resulted in very low utilization of the leased equipments largely due to lack of required infrastructure and human resource.

4. Both NHIF and private health insurance companies have registered higher reimbursements to Private facilities and very low reimbursements to public facilities. This has served to increase inequity in access to healthcare in Kenya largely due to low financial flows to public facilities which are there primary source of care for majority of the Kenyan poor. Moreover, the services in Private facilities are more expensive compared to pubic facilities. This to a large extent raises sustainability concerns especially as the government moves to ensure coverage for all.

Based on the findings of this review, there is no perfect model of financing healthcare in Kenya so far. Most countries use a mix of two or more financing models to fund healthcare. To develop a sustainable health financing model for Kenya, there is need to work on an essential benefit package of health services while putting in place strategies to cushion the poor through subsidy programs. There is also need to ensure that public funds are primarily invested in public goods. This can be achieved through establishment of an enabling environment, enhanced public participation and access to information to enhance oversight mechanisms and value for money. It is important for the government to invest more in preventive and promotive healthcare interventions as they derive more value for money. Financing healthcare should always be viewed as an investment towards a healthy and productive population who provide the human capital towards economic growth of a nation.

5 Background

The World Health Organization (WHO) recognizes good governance as one of the six pillars of a health system. The 2010 World Health Report estimated that about 20–40% of potential health gains from health spending are lost through inefficiencies, such as losses from the health system due to waste, corruption and fraud. The sustainable development goals (SDGs), moreso SDG 16 highlight the critical role of governance across all sectors, including health through (i) promoting the rule of law; (ii) preventing corrupt practices; (iii) developing accountable and transparent institutions; (iv) ensuring responsive, inclusive and participatory decision-making processes; and (v) ensuring public access to information. Transparency and accountability can curb corruption and other unethical practices, leading to improve public trust in institutions.

In August 2010, Kenya adopted a new constitution, which among other provisions, entrenched the Bill of Rights that puts a responsibility on the State to ensure equitable, affordable and quality health care to all Kenyans. The government is therefore obliged to ensure access to the highest attainable standards of health to all while ensuring a people-driven, rights–based approach to health. The Constitution in article 10 entrenches citizen participation an integral part of Kenya's governance system. As entrenched in Article 174(c), devolution serves to to "enhance the participation of people in the exercise of the powers of the State and in making decisions affecting them."

The constitution created a devolved system of governance that consists of National Government and 47 County (sub-national) Governments. Under the new dispensation, health is a devolved function that is shared across the two levels. The responsibility for health service delivery is assigned to the Counties while policy, quality assurance, capacity building and management of national referral hospitals remain the national's government responsibility.

Despite these Constitutional requirements and safeguards for the right to health services, the highest attainable health standards and public participation, there continues to be persistent inadequacies in the health sector that have faced Kenya since independence. The Health Sector in Kenya has struggled with stagnant or declining budgets for health, system inefficiencies, human resource deficiencies, and unaffordable quality health services.

Transparency and Accountability especially on resources for the Health sector has also been wanting. In 2017 for instance, the Health Sector witnessed major challenges flowing from industrial unrests by health practitioners, corruption and poor service delivery leading to wastage of public funds. The U.S. Embassy to Kenya on May 9, 2017 reported the suspension of approximately $21 million (2.1 billion KSH) in assistance to the Kenyan Ministry of Health. According to the U.S government, these drastic measures resulted due to ongoing concerns about reports of corruption and weak accounting procedures at the Ministry of Health.

It is in view of these shortcomings identified in achieving Kenyans' health goals as set out in the Constitution and other policy and legal frameworks that the need to assess the effectiveness of health financing models in Kenya was necessary. This study therefore served to review the various health financing models in existence including through the Kenya National and County Budgets, the National Health Insurance Fund (NHIF), Private Health Insurance Companies, Development Partners (Including Donors, Faith Based and Non-Governmental Organisations) and Public Private Partnerships. The study also sought to determine how each of the models and avenues for health financing respond to Transparency and Accountability principles as elucidated in the Constitution including: access to information, public participation and value for money

6 Methodology

6.1 Study Design

The study adopted a qualitative approach mainly through document reviews. The information gathered was triangulated through an engagement with stakeholders in a validation workshop.

6.2 Overall Objective

To conduct study and develop a research paper on transparency and accountability in Kenya's health financing models.

6.3 Specific Objectives

1. Identify and explain the various health financing models in use in Kenya.
2. Evaluate the feasibility and attractiveness of the various models according to the following categories:
    a. **Enabling Environment:** any laws, policies, rules, or regulations, at both a national and county-level, that might impede the effectiveness of the various health financing models.
    b. **Access to Information:** the extent to which the public and private health institutions have published and publicized any important information relating to health financing with a view of promoting transparency and accountability.
    c. **Public participation:** the extent to which public health financing models allow for effective public participation in their formation and implementation including transparency, accountability and feedback mechanisms.
    d. **Value for money:** how the various health financing models respond to the need to ensure value for money in provision of services and health resources.
3. Recommend the most appropriate model(s), if any, with workable strategies identified to enhance people centered transparency and accountability principles in the health financing models.

6.4 Data Collection

Data collection was conducted between December 2018 and February 2019.

The data collection process involved the following:

1. A comprehensive literature review of available materials on the transparency and accountability of Kenya's health financing models. This involved desk reviews of peer-reviewed publications as well as reports and publications from key institutions in health financing in Kenya and globally.
2. Validation Workshop: A half-day workshop held, bringing together key stakeholders in the health sector. The workshop served as a platform to present results and receive feedback on the information gathered in activity 1 and 2.

7 Health Financing Models in Kenya

7.1 The Historical Overview of healthcare financing in Kenya

Since independence in 1963, Kenya has had a predominantly tax-funded health system, but gradually introduced a series of health financing policy changes as highlighted in Table 1 below. In 1989, user fees, or 'cost-sharing' model was introduced (G, 1991). User fees were abolished for outpatient care in 1990, inspired by concerns about social justice, but re-introduced in 1992 because of budgetary constraints (Guy, et al., 2007). Public health facilities instituted a waiving mechanism to protect the very poor that could not afford the user fees. Children under five years of age were exempted from all charges.

In 2004, an attempt to establish a universal social health insurance scheme failed after the government deemed it to be too expensive and unsustainable (Kimani et al. 2012). Below is a table outlining the historical chronology of the evolving nature of health financing in Kenya

Year	Policy	Implications
Pre-Colonial to 1965	User Fees in all public facilities	Inequity in access and utilization of healthcare
1965	User fees removed at all public health facilities. Health services provided for free and funded predominantly through tax revenue	Enhanced access to healthcare for all.
1989	User fees introduced in all levels of care.	Negatively impacted demand for health care especially among the poorest population
1990	User fees suspended in all public health facilities. Waivers and exemption put in place to protect the poor and vulnerable.	Increase in utilisation of healthcare
1991-2003	User fees were re-introduced in 1991, through a phased implementation approach stating from hospital level. Children under five, special conditions/services like immunisation and tuberculosis were exempted from payment.	This presented major barrier to access coupled with high out-of-pocket payment.
2004	User fees abolished at dispensaries and health centres (the lowest level of care), and instead a registration fees of Kenya shillings 10 and 20 respectively was introduced. Children under five, the poor, special conditions/services like malaria and tuberculosis were exempted from payment.	Utilisation increased by 70%; the large increased was not sustained, although in general utilisations was 30% higher than before user fee removal. Adherence to the policy was low, due to cash shortages
2007	All fees for deliveries at public health facilities were abolished	No data on extent to which policy was implemented and no evaluation has taken place.
2010	A health sector services fund (HSSF) that compensates facilities for lost revenue associated with user fee removal introduced. Dispensaries and health centre receive funds directly into their bank accounts from the treasury.	Possible positive impacts on adherence to fee removal policy and equity.

2013	Decentralization of healthcare begins. Free maternity services administered by MOH	Increased utilization of maternity services
2015	Enhanced NHIF premiums and benefits. Free maternity services funds transferred to NHIF as "Linda Mama" program. Health Insurance subsidies program (HISP)	Increased access to services. Regressive contributory mechanism for the informal sector
2016	County health financing initiatives such as Makueni UHC and "OparanyaCare" in Kakamega County	Triggered similar initiatives across other counties
2017	The government declares attainment of UHC by 2022 as one of the main agenda	Increased focus on health as well as funding by the government
2018	Pilot for Universal Health Coverage across 4 counties (Machakos, Isiolo, Nyeri and Kisumu)	Improved access to primary care by populations in the pilot counties.

Table 1: The historical chronology of the evolving nature of health financing in Kenya

In recent years Kenya has experienced a series of health financing reforms aimed at advancing financial risk protection against different segments of the population. Some of the notable initiatives are: 1) Free maternity services (Linda mama program) that covers ante natal care, safe delivery services as well as post-natal care, 2) Health insurance subsidies program for the poor that provides insurance coverage for the indigents and 3) NHIF cover for all secondary school students. Recently, the Government of Kenya committed to achieving Universal Health Coverage (UHC) by 2022 as one of the pillars of the Big Four Agenda.

7.2 Moving towards Universal Health Coverage in Kenya

World Health Organisation (WHO) defines Universal Health Coverage (UHC) as ensuring that all people have access to needed health services of sufficient quality while also ensuring that the use of these services does not expose the user the financial hardship. UHC has therefore become a major goal for health reform in many countries including Kenya (World Health Report 2010). The United Nations 2030 Agenda for Sustainable Development identified 17 Sustainable Development Goals (SDGs), to succeed the Millennium Development Goals (MDGs) and to be achieved by 2030. Attainment of good health and well-being is SDG 3, with target 3.8 spelling out the need to achieve Universal Health Coverage (UHC), including financial risk protection, access to quality essential health services, and medicines and vaccines for all.

In 2017, the President of the Republic of Kenya, listed affordable health care for all as one of the pillars of his Big 4 agenda. Subsequently the Government of Kenya has committed to achieving Universal Health Coverage (UHC) by 2022 and has taken a number of steps to reform its healthcare system, to put it on the path to realizing this goal. A key policy direction by the government of Kenya has been to abolish user fees as a mechanism for achieving UHC. In December 2018, the government kicked off the UHC pilot in 4 counties (Nyeri, Isiolo, Machakos and Kisumu) with the aim of scaling it up after one year.

A key initial step towards UHC is defining an explicit benefit package for implementation of UHC that is informed by the Kenya Essential Package for Health (KEPH) which focuses on meeting the needs of an individual through the entire life cycle. To Achieve this, the government gazetted

an Essential Benefits Package for UHC (UHC-EBP) Advisory Panel in 2018 with the key mandate to define and cost the package of health services to be funded under the UHC agenda.

7.3 Health Financing Models in Kenya

There are three major sources of financing health care in Kenya: private, public and donor financing. Public financing is either taxation-based or through subsidies to the National Hospital Insirance Fund (NHIF) while private financing is mainly through private health insurance, contributions to NHIF or OOP payments at the point of care. Public financing has the advantage of having a pooling mechanism of both income and health risks while private financing lacks pooling of neither risks nor benefits resulting in inequity in health care use (Kwon S. 2011)

The 6 models of financing healthcare in Kenya:

7. Tax-based financing: Financing of healthcare through the ministry of health.
8. Social health insurance (NHIF): Pay roll-based contributions by the formally employed and voluntary contributions by those in the informal sector. The government also provides funds to NHIF to provide coverage for different population groups.
9. Private health insurance: Voluntary contributions as well as employer-based groups
10. Community-based health insurance
11. Donor funding
12. Out-of-pocket payments: payments made at the point of care.

Table 2: Summary of the characteristics of key health financing models

Model	Revenue Source	Groups Covered	Pooling Organization	Care Provision
Tax-based (Publicly funded) model	General revenues	Entire population	Central government	Public providers
Social Health Insurance	Payroll contributions and voluntary contributions	Specific groups	Semi-autonomous organizations	Own, public, or private facilities
Community-based Health Insurance	Private voluntary contributions	Contributing members	Non-profit plans	NGOs or private facilities
Private (Voluntary) Health Insurance	Private voluntary contributions	Contributing members	For- and non-profit insurance organizations	Private and public facilities
Donor Funding	Bilateral and multi-lateral donor agencies	Mainly focussed on vertical disease programs	Mainly channeled through National Treasury or NGOs/CSOs	NGOs and Public facilities
Out-of-Pocket Payments (including public user fees)	Individual payments to providers	Individuals	None	Public and private facilities (public facilities)

7.3.1 Social Health Insurance Model

Social health insurance systems are generally characterized by independent or quasi-independent insurance funds, a reliance on mandatory earmarked payroll contributions (usually from individuals and employers), and a clear link between these contributions and the right to a defined package of health benefits. In many countries, coverage has been progressively extended to subpopulations and then to the whole population. The state generally defines the main attributes of the system, although funds are generally nonprofit and supervised by the government (Pablo Gottret, George Schieber, 2006). However, SHI may worsen inequity particularly in Low and Middle Income countries that may lack the enabling conditions for successful implementation ((Pablo Gottret, George Schieber, 2006; Yazbeck, 2018)

The National Hospital Insurance Fund (NHIF), a semi- autonomous state corporation, provides the social health insurance in Kenya that was established in 1966. The scheme gets its revenue through mandatory payroll deductions for the formal sector and voluntary payments at designated centers for members who are in the informal sector. By 2017, NHIF was estmated to cover about 20% of the Kenyan population.

7.3.2 Tax Based Financing Models in Kenya.

Tax-based health financing systems generally have three main features. First, their primary funding comes from general revenues. Second, they provide medical coverage to the country's entire population. Third, their services are delivered through a network of public providers. In most low- and middle-income countries, this model generally exists alongside other risk pooling arrangements. Therefore, they are not the sole source of coverage for the entire population. This model has the potential to ensure equity and efficiency but suffer the risk of inefficiencies, corruption and negative political influence such as low budget allocation (Pablo Gottret, George Schieber, 2006).

Universal Health Coverage as envisioned by the current government of Kenya, has adopted this model as a way of financing access to healthcare in Kenya. The tax-funded model will provide a defined package of health services to the whole population through public health facilities. With the existing investment in infrastructure and human resource, the government aims to strengthen commodity supplies through direct funding to Kenya Medical Supplies Authority (KEMSA). KEMSA will in turn supply all public facilities with a defined package of commodities as listed on the Kenya Essential Medicines List (KEML).

7.3.3 Private Health Insurance (PHI)

Private Health Insurance (PHI) is characterised by voluntary premiums (not tax or social security contributions). There are several roles that private/voluntary health insurance play in financing healthcare in Kenya:

- **Primary**: As the main source of coverage for a population or subpopulation
- **Duplicate**: Covering the same services or benefits as public coverage, but differing in the providers, time of access, quality, and amenities.
- **Complementary**: Complements coverage of publicly insured services or services, by covering all or part of the residual costs (e.g. co-payments).
- **Supplementary**: Covering additional health services not covered by the publicly funded systems or NHIF.

In Kenya, there are 19 private health insurance providers registered by the Insurance Regulatory Authority in Kenya and private insurance accounted for 2-4% (Health Financing Project, 2016; Barasa Edwine, Rogo Khama, Mwaura Njeri, Chuma Jane, 2016; Pablo Gottret, George Schieber, 2006)

7.3.4 Out Of Pocket Payments.

Many health systems in Africa are funded primarily through Out-Of-Pocket payments. In Kenya, OOPs are estimated to be 26% according to the 2016 National Health Accounts (NHA). Further, poor-rich differences are larger for inpatient compared to outpatient care, indicating that inpatient care is unaffordable to most poor households (Maina J. C., 2012).

Out-of-pocket payments, mainly in the form of user fees, prevent people from seeking care, can result to catastrophic health spending and lead to impoverishment. Catastrophic health care payments occur in both rich and poor countries, but over 90% of the people affected reside in low-income countries. (8) Unfortunately, the OOPs known to be the most inequitable source of health financing predominate in low and middle-income countries (Pablo Gottret, George Schieber, 2006).

Each year, Kenyan households spend close to a tenth of their budget on OOP health care payments. About 16% and 5% of households incurred health expenditure that exceeded 10% and 40% of total household budget respectively. The poorest households spent five times more of their budget on health care payments compared to the richest population. OOPs have no pooling of risks and resources hence no redistributive efficiency, no financial protection and no equity borne through these financing models (Maina J. C., 2012).

7.3.5 Community Based Insurance(CBHI)

These are not-for-profit prepayment plans for health care that are controlled by a community that has voluntary membership. Most community-based health insurance schemes operate according to core social values and cover beneficiaries excluded from other health coverage. These principally target low income earners who are excluded from mainstream commercial and social insurance schemes due to high premiums (Pablo Gottret, George Schieber, 2006).

Individuals within the organized body/community contribute to the premiums levied within the CBI schemes for the guarantee of a limited benefit package. The government and donor entities may also contribute to the resources. With financial support from the German government, the Ministry of Health implemented the Output Based Approach(OBA) voucher project since the year 2006. The project was aimed at providing subsidized vouchers to poor populations in the counties of Kisumu, Kilifi, Kiambu, Kitui and Nairobi's informal settlements of Korogocho and Viwandani (Ministry of Health, 2016).

7.3.6 Donor Funding for Health in Kenya

This refers to financing for health derived from external partners. Donor funding accounts for 23.4-26% of the Total Health Expenditure in Kenya (Health Financing Project, 2016; Barasa Edwine, Rogo Khama, Mwaura Njeri, Chuma Jane, 2016). Global programs, generally focused on specific diseases or interventions account for the bulk of the recent increases in external health assistance, representing 15–20 percent of development assistance for health globally.

Large increases in development assistance for health to low-income countries raise questions about whether countries can make effective use of new aid flows. Absorptive capacity has macroeconomic, budgetary, management, and service delivery dimensions. It also rests on critical macro conditions: good governance, lack of corruption, sound financial institutions, and human resources for public sector management and for service delivery (Pablo Gottret, George Schieber, 2006).

Local fund-raising initiatives such as the Beyond Zero Campaign have been widely seen as top-down with very little community engagement. This has largely seen lots of wastage where the donated mobile clinics lack the human resources and county support to deliver maternal health services to those in need. Entrenching public participation in such initiatives could serve to derive more value and improve the healthcare delivery system.

Donor funds in Kenya are mainly channeled through the National Treasury, Ministry of Health or the respective health ministries at the county level. In 2017-18, many donors (USAID, GAVI, GIZ etc.) withdrew or cut their funding for health in Kenya due to corruption allegations.

The table below provides a summary of selected health expenditure indicators in Kenya in according to the National Health Accounts (NHA) published by WHO in 2016:

Table 3: Selected Health Expenditure indicators (WHO National Health Accounts 2016)

Indicator	Value
Total population	44.2 Million
Total GDP	6.7 Trillion
Total Health Expenditure (THE) in KES	346 Billion
THE per capita in KES	7,822
Government Health Expenditure (GHE) as a % of Total Government Expenditure (TGE)	6.7%
Household OOPs as % of THE	26.1%
NGOs and Donors as a % of THE	17.9%

7.4 Financial Flows in the Health sector in kenya

Government revenues are collected by the Kenya Revenue Authority, pooled at national level (National Treasury) and then distributed to the 47 county governments. The Commission on Revenue Allocation (CRA), is an independent Commission set up under Article 215 of the Constitution of Kenya 2010. Its core mandate is to recommend the basis for equitable sharing of revenues raised nationally between the national and the county governments, and among the county governments.

The Public Finance Management Act No.18 of 2012; 12 (2a) tasks the National Treasury with the responsibility to promote transparency, effective management and accountability with regard to public finances in the national government. Chapter 12, Part 6, Article 229 of the Constitution of Kenya 2010 establishes the Office of the Auditor General whose mandate is to offer financial

oversight on all public finances. In pursuit of its mandate, the Office of The Auditor General has shown that, only 1.25% (Ksh.12.58B) in 2013/14, 1.05% (Ksh. 12.8B) in 2014/15, and 3.45% (Ksh. 43.45B)in 2015/16, of the total national expenditures between 2013 and 2016, had an unqualified opinion (clean bill of health) from the auditor general as shown in the chart below.

The Government in partnership with the World Bank has been offering coverage to the indigent, the elderly and those with disabilities through the Health Insurance Subsidy Program (HISP) since 2015. Further, the Government has cumulatively disbursed over US$7 million to the 47 counties to fund the provision of free primary healthcare and removal of user fees at the in dispensaries and health centers since 2013 (Health Financing Project, 2016; Ministry Of Health, 2017). The GOK also implemented a free maternity care policy, committing approximately US$38 and US$40 million for free maternal health services in FYs 2013/14 and 2014/15, respectively (Health Financing Project, 2016).

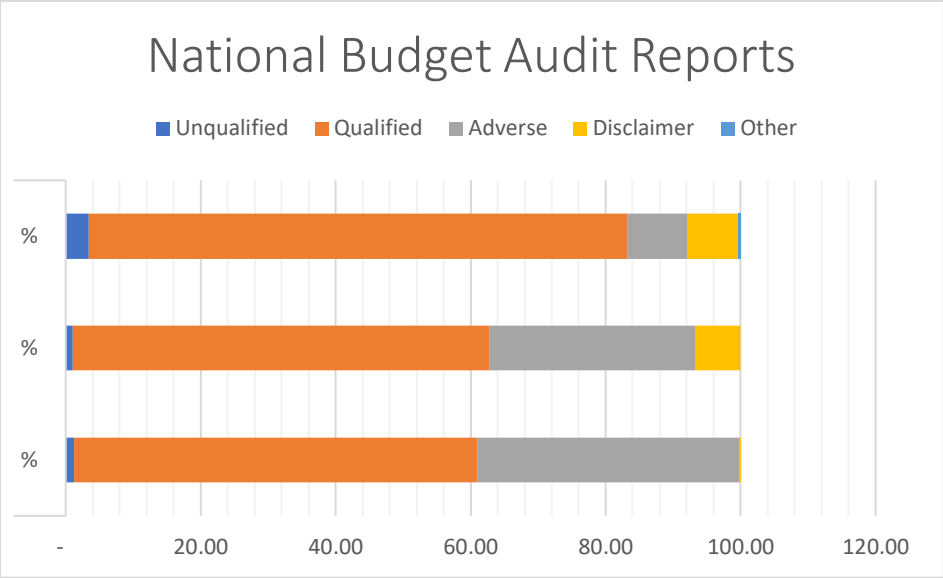

Figure 1: National Budget Audit Summary

Allocation of funds to counties is based on a resource allocation formula developed by the Commission for Revenue Allocation (Commission for Revenue Allocation, 2015). This formula includes seven weighted parameters: population 45%, basic equal share 25%, poverty 20%, land area 8% and fiscal responsibility 2%. Two new parameters were included in the revised formula to be used between 2015 and 2018: development and personnel emolument factor. Following devolution of health services after 2013, the county governments have also had to finance their healthcare alongside the funding drawn from the national treasury.

Figure 2 below outlines the complexity of funds flow in the health system in Kenya. The National Treasury plays a central funds flow in the Public health financing. This is largely defined in the Public Finance Management (PFM) Act.

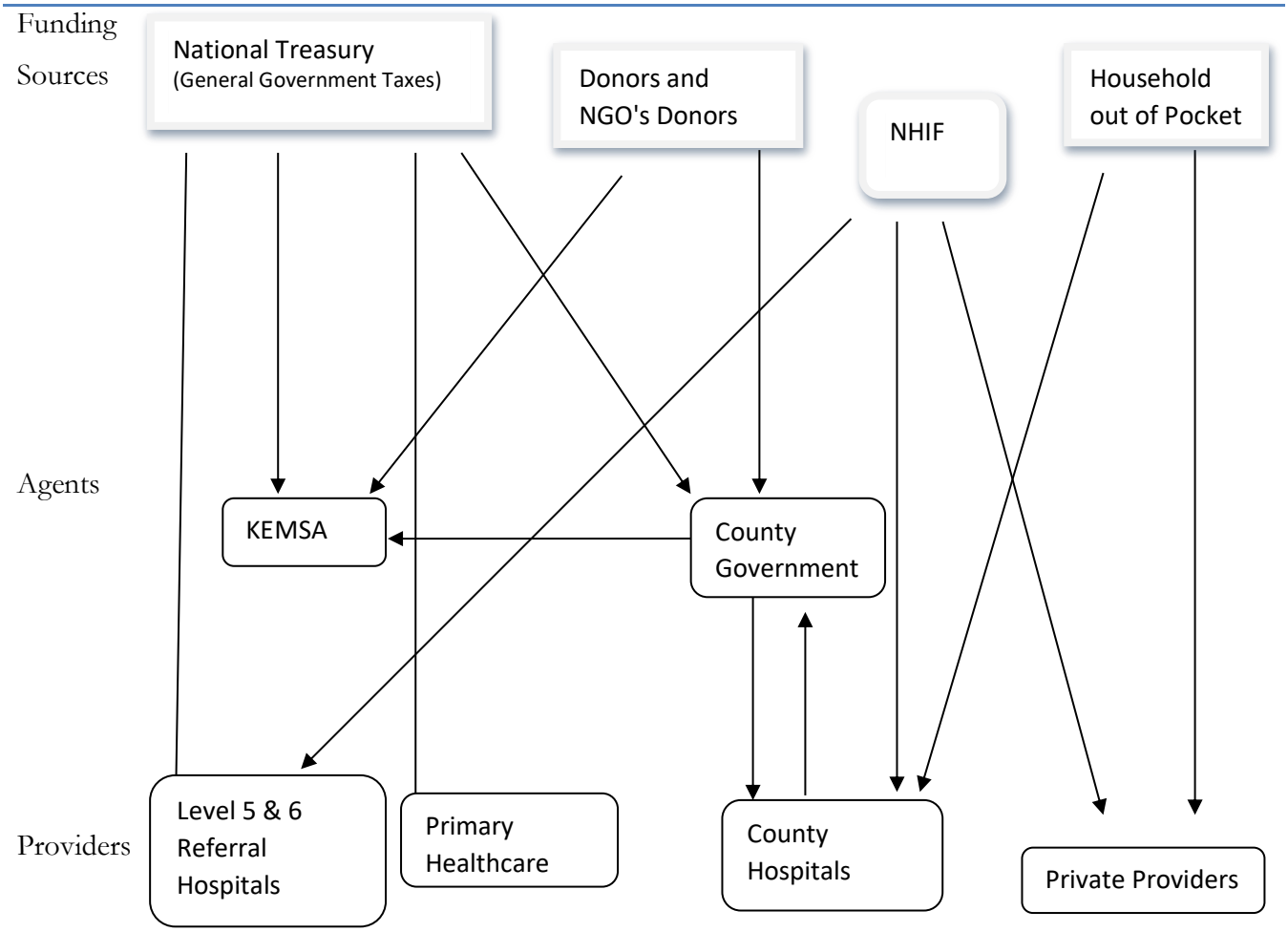

Figure 2: Schematic diagram showing finacial flows in the health sector in Kenya

NHIF relies on mandatory payroll contributions (usually from individuals and employers) as well as government funds to aimed at providing coverage for sub-populations such as pregnant women, indigents and students. Its main membership is drawn from the formally employed and some self-employed/ informal sector members. Between 2014 and 2017, the NHIF revenues grew from Ksh 13.3 B, to Ksh 30.2B and ultimately Ksh 37.1B. The benefits expenses for the same period grew from Ksh 5.9B, to Ksh 10.3B and Ksh 26.1B yielding a payout ratio of 46.5%, 35.9% and 74.7% respectively. The administrative expenses relative to the contributions for the same period were 33.4%, 19.5% and 23.7%. See graphs below:

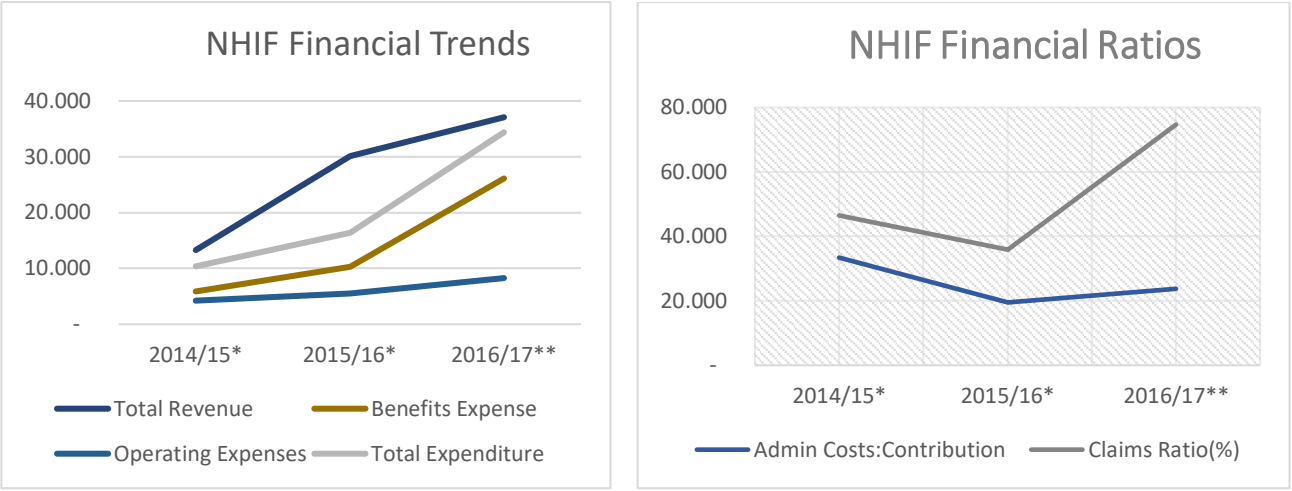

Figure 3: Summary of NHIF Financial trends

8 Findings in Relation to Transparency and Accountability in the Health Financing Models

8.1 Enabling legal and policy environment

In April 2001, the African Union countries including Kenya, met and pledged to set a target of allocating at least 15% of their annual budget to improve the health sector and urged donor countries to scale up support. The graph below shows the trend of government financing of health relative to the national budget. This trend (4-5.1%) falls short of the Abuja Declaration recommendation of 15%.

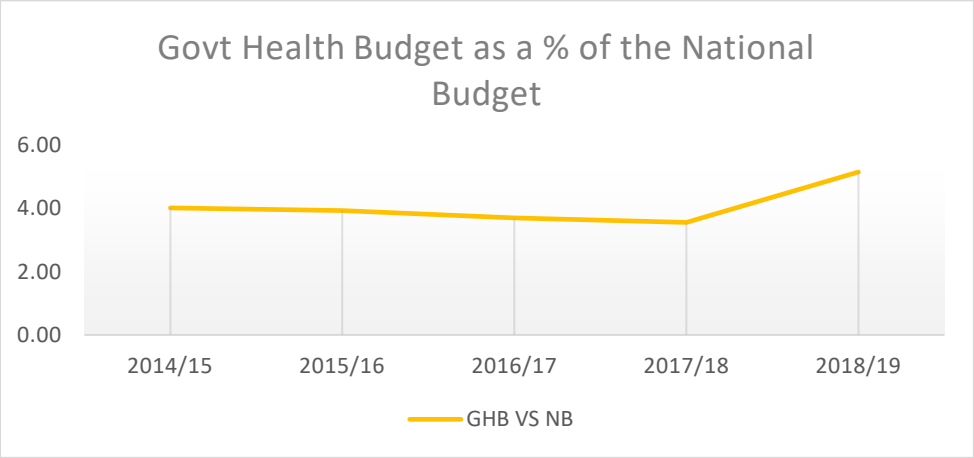

Figure 4: Trend in budgetary allocation to health as a proportion of the National Budget (Source: Report of the Auditor-General for the Year 2014/15, 2015/16 & Treasury Reports 2016/17 & 2017/18)

The government of Kenya is a signatory to a number of international treaties and agreements that directly impact healthcare financing policies in the country. This is in addition to the national laws and obligations as enshrined in the constitution and other national aspirations.

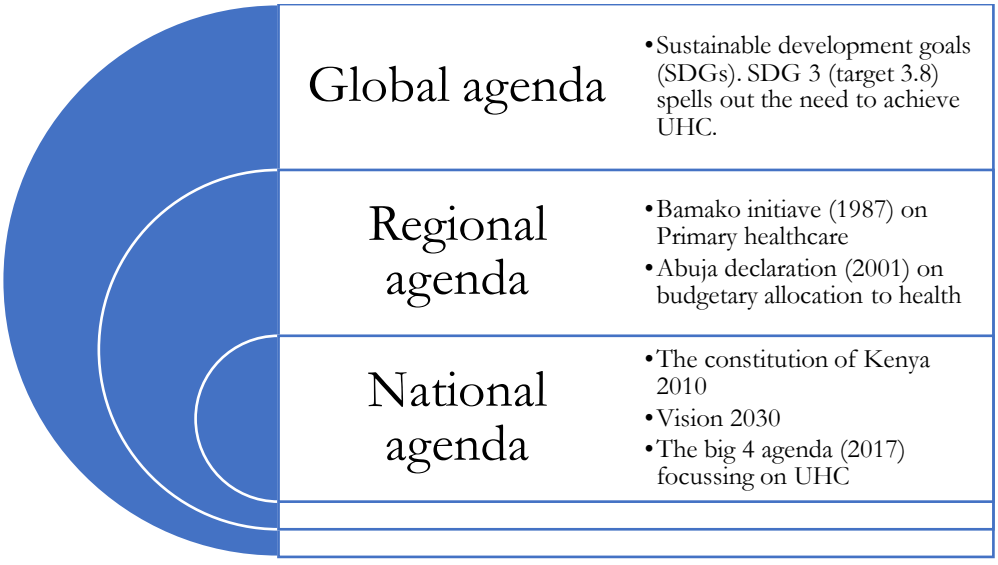

Figure 5: Global, regional and national agenda and aspirations on financing of healthcare

The Constitution of Kenya (2010) entrenches the right to access to healthcare with an emphasis on children and marginalised groups (Republic of Kenya, 2010). It also provides for the national government to build capacity and provide technical assistance, and for county governments to provide health services including promoting primary health care. CAP 4; 43 (1a) further affords all citizens the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care.

The Health Act 2017 clause 86 outlines the need for an established health insurance mechanism that ensures access to healthcare for all. There have been previous attempts to revamp NHIF as the key vehicle towards universal health coverage (UHC). However, the current approach by the government towards UHC is not aligned with the aspirations of the Act as it largely focusses on eliminating user fees at health facility level without by directly providing funds for commodities. Moreover, there still lacks a policy coherence on which financing models should be adopted across the counties. This is evidenced by the various health financing initiatives such as the Makueni UHC in Makueni county and "Oparanya Care" in Kakamega County.

The Public-Private Partnerships (PPP) Act, 2013 provides for the participation of the private sector in the financing, construction, development, operation, or maintenance of infrastructure or development projects of the Government through concession or other contractual arrangements. This has seen a growing interest of private sector players in the public health sector. A more controversial PPP arrangement has been the Medical Equipment Scheme which involved a leasing agreement between the National government and medical equipment manufacturers such as Philips and General Electric (GE) to equip county hospitals. It has been noted that the counties were not fully involved in the design stage of the PPP agreement and therefore were not ready to fully utilize the leased equipment. This has led to underutilization of the equipment with a number of them yet to be commissioned either due to lack of human resources or infrastructure.

Effective accountability requires a legal and political environment that encourages the same to thrive. These may encompass financial, performance and political accountability with the requisite enabling laws, policies and regulations (Brinkerhoff, 2004). The table in annex 3 outlines the performance of Kenyan system in the provision of an enabling environment for an accountable and transparent financing of healthcare.

Table 4: Legal provisions and structures that enforce transparency and accountability in public health financing

Accountability mechanism	Structures and initiatives in place
1. Financial accountability	• Office of The Auditor General, Internal & External Auditors. • Integrated Financial Management Information System (IFMIS). • Public Finance Management Act (2012), • Public Procurement and Asset Disposal Act, • Finance Act, • Appropriations Act 2016 • Select legislative committees (Parliament & Senate). • Controller of Budget • Commission of Revenue allocation • Treasury • County Assemblies • Development partners

2. Performance accountability	• Respective healthcare professionals' licencing and accreditation boards conduct inspections, registration, licencing and accreditation for respective professionals and facilities in keeping with their guiding laws e.g. Medical Practitioners' and Dentists' Board Act Cap 253, Clinical Officers' Act Cap 260, Nurses Act Cap 257 inter alia. • Ministry of health • County Executives • Health Management committees • Health workers' Unions • Citizens • Civil Society organizations
3. Political accountability	• National and county Executives • Parliament • Citizens • UHC Agenda • Linda Mama currently administered through NHIF & Free maternity care. • Removal of user fees at medical facilities. • Health Insurance Subsidy Programme (Elderly & Disabled)

Generally, the Kenyan laws as well as International agreements provide an enabling environment towards accountable and transparent financing of healthcare in Kenya. The challenge still remains the extent to which the laws are followed and adhered to.

8.2 Access to Information

Accountability demands that all engaging parties are fully agreeable to and aware of their obligations, rights and expectations and believe that each will act accordingly (Andrea Cornwall, 2000). Access to information is key for several functions such as:

- Increasing awareness of rights, alternative priorities inter alia
- Improving and providing judgement on available options.
- Problem identification.
- Decision making.
- Providing evidence.
- Identifying responsible persons/institutions.

Article 35 of the Constitution for Kenya (2010) and the Access to information Act (2016) provides for the right of public access to information. Some of the key information in health financing is on allocation of funds, disbursements and expenditures. Currently, access to this information on institutions tasked with financing healthcare is limited. For example, information on reimbursements by NHIF to health facilities is not publicly available. There is also very little information on packages and benefits entitlements by the members. Moreover, most counties do not post financial allocations, disbursements or expenditures on their websites.

Public health institutions have not been consistent in publishing important information relating to health financing with a view of promoting transparency and accountability. The lack of timely access to such crucial information pertaining the health funds impairs public participation in

decision making and prioritization. This further curtails their ability to hold those charged with the management of the institutions accountable.

8.3 Public participation

A major limitation to most of the past and present policy developments in Kenya is the failure to involve the public in the identification and implementation of policy interventions (Okungu, 2011). Public engagement would enhance ownership, provider and payer accountability and effective implementation (DeMaio, 1993). However, it is argued that public participation is best when earned by the communities rather than given to them if they are to make any meaningful contribution in the financing and implementation of healthcare policies (Andrea Cornwall, 2000).

A number of health policy interventions in Kenya are largely driven by policymakers with very little public participation. One such example is the Medical Equipment Scheme (MES) which was designed and executed by the National Government with very little particpation by the counties and the public in general. This has resulted in very low utilization of the leased equipments largely due to lack of required infrastructure and human resource. Another example is the mobile clinics purchased by the Ministry of Health. The clinincs have not been utilized, two years since they were procured. This is mainly due to the fact that they had not been identified as a need by the counties.

Donor-funded health programs are largely defined by the donors with little participation by the beneficiaries in most cases. This has led to low integration of health programs hence a fragmented health system. Public participation in the design of programs can serve to build a sense of ownership and sustainable people-centred programs.

NHIF provides for some form of engagement with stakeholders through workshops, technical working groups inter alia in its policy development and implementation process. These have included hospital owners, professional regulators and representatives. There are however concerns on the extent to which NHIF engages public health facilities compared to private healthcare providers.

8.4 Value for money

Deriving value for money in public health within a context of scarce resources demands priority setting by identifying and supporting cost-effective and equity-enhancing interventions fairly, transparently, and on the basis of evidence. Many developing countries do this in any of the following forms: essential medicines lists, health benefit plans, and health technology assessment agencies. Unfortunately, all suffer from a shortage of quality data, inadequate local capacity, lack of legal frameworks, limited formal institutional structures, incapacity to revise and update benefits on the basis of new data or products, minimal stakeholder involvement, and sometimes limited connection to decisions on the uses of available resources.

There has been effort to enhance efficiency and equity in the Kenyan health sector through establishment of the Kenya Essencial Medicines List (KEML) as well as health benefit plans through the NHIF such as *Supa Cover* and *Linda Mama*. There are however concerns that this initiatives have not been well cordinated to ensure access to healthcare for all. Morever, some public hospitals have established amenity wards (private wings) for those are able to pay more. This has in effect led to the rich being able to access better services quicker than the poor in the same public hospitals.

Recent reports indicate that NHIF favours private facilities in its reimbursement model. It has been noted that Private facilities receive disproportionately higher reimbursements than public hospitals for providing similar services. For example cataract surgery in Private hospital is reimbursed on average about KES 75,000 while public hospitals are reimbursed an average of about KES 7,000. Such a reimbursement models raises equity and sustainability concerns. Directing more funds to the public sector could in the long term support infrastructural development of public health facilities which have a wider reach in order to enhance access to healthcare to all Kenyans. Generally, investing in public health facilities has a long term public good.

As outlined above, NHIF is tasked with playing a key role in financing healthcare in Kenya. However, there are concerns in the approaches taken by NHIF in executing its mandate, which may affect the way the public derives value. Table 4 below provides highlights on key concerns on NHIF approaches.

Table 5: Highlight of Key concerns in NHIF approaches

Key purchasing decision points	NHIF approach	Key concerns
1. Range of services (benefit package) covered by NHIF	○ NHIF has a different package for different schemes	○ Differential access to NHIF benefits introduces inequity in access care in Kenya
2. Designing of the benefit package	○ NHIF has no established transparent health teachnology assessment mechanism to design benefit package	○ The process of designing the benefit package at NHIF is not transparent
3. Identification and contracting of providers	○ NHIF has an empanelment tool used in to contract providers ○ NHIF does not select providers based on desired patient outcomes or cost of care	○ Contracting of facilities favours big private facilities which are placed in category C giving access to high reimbursement rates
4. Payment of providers	○ Fee for service is main mode used by NHIF to pay providers	○ Media reports indicate disproportionate reimbursements between pubic and private facilities.
5. Curbing fraud and wastage	○ NHIF has weak systems to measures to curb fraud and theft of resources from fraudulent claims, contracting and procurement	○ Media reports indicate high levels of fraadulent claims
6. Assessment of quality and provider performance	○ NHIF has an quality assessment tool as well as a network of quality assurance officers who assess facilities regularly	○ NHIF has no mechanism to encourage use of medicines and technologies that offer the best care at the lowest cost to their membership.

According to Chalkidou et al, there are 6 key conderations when towards systematic priority setting in a public health system (Chalkidou, 2012): The table in Annex 1 outlines how the health financing models in Kenya compare with the global best practice.

The Paris Declaration on Aid Effectiveness outlines the need by all donor agencies to strengthen measures aimed at improving the value for money of services delivered. However, most donor agencies have adopted vertical programming with little investments in integrated approaches which could achieve a better value for money and serve to address the sustainablity concerns.

9 Limitations of the Study

This study was largely a desk review with inputs of key stakholders through a validation workshop. Therefore, the information provided is limited to the data and reports that are publicly available, and the number of stakeholders that made contribution during the validation workshop. A comprehensive study involving primary data collection from the key institutions and stakeholders could play a key role in enriching this or future studies on transparency and accountability in health financing models in Kenya.

10 Research and Advocacy areas.

1. **Claims processing at NHIF**

A digital alert platform (application) programmed to alert members whenever there NHIF card is utilized to access any service. This can serve to cut the rising cases of fraudulent claims at NHIF.

2. **NHIF capitation model**

There is need to carry out a study on efficiency of the NHIF capitation model currently being undertaken by NHIF to provide evidence on fraud and wastage as well as recommend measures to curb these.

3. **NHIF reimbursements to Private and public health facilities**

There is need for the NHIF to address the fairness and equity concerns in its current premiums and reimbursement models. Measures to be put in place to ensure fair reimbursements for public facilities by NHIF.

4. **Itemized medical claims by NHIF and private health insurance underwriters**

Make public information on their itemized healthcare expenditures e.g. pharmaceutical costs, Doctors fees, diagnostics and procedures in both NHIF and private health insurance.

5. **Value for money**

There is need for establishment of a Health Technology Assessment agency/team to help inform product and health benefits selection with a view to maximizing value for money

6. **Access to information**

NHIF and MOH need to open up channels for direct access to its financial information e.g. through its website in keeping with the constitutional right and related laws

7. **Public participation**

MOH and NHIF need to entrench public participation and patient-centeredness in the development of health benefit packages as well as other health policies

8. **Monitoring UHC financial flows**

UHC agenda will attract lots of government investments in healthcare. Therefore there is need to put in mechanisms to ensure transparency and accountability.

11 Conclusion

Based on the findings of this review, there is no perfect model of financing healthcare in Kenya so far. Most countries use a mix of two or more financing models to fund healthcare. To develop a sustainable health financing model for Kenya, there is need to work on an essential benefit package of health services while putting in place strategies to cushion the poor through subsidy programs. There is also need to ensure that public funds are primarily invested in public goods. This can be achieved through establishment of an enabling environment, enhanced public participation and access to information to enhance oversight mechanisms and value for money. It is important for the government to invest more in preventive and promotive healthcare interventions as they derive more value for money. Financing healthcare should always be viewed as an investment towards a healthy and productive population who provide the human capital towards economic growth of a nation.

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11.1 Annex 1: Assesing value for money considerations in the Kenyan health financing models

Steps	Global best practice	Kenyan Context
1. Registration	Done to assure safety and efficacy of new products and provides a gateway for considering a technology for funding.	○ The Pharmacy and Poisons' Board (PPB) does product registration for products to be used for both public and private health sectors.
2. Scoping	Identifies and selects technologies (broadly defined as policies, interventions, drugs, diagnostics, and other products) for evaluation depending on a country's priority-setting goals.	The Ministry of Health champions scoping in concert with other SAGAS like PPB. This has yielded the National Drug Policy as well as the Kenya Essential Medicines List. The GoK has recently established a team to review and propose an essential benefit package for the Universal Healthcare Coverage that was launched in December, 2018.
3. Cost-effectiveness analysis	Analyzes technologies using widely accepted economic evaluation methods, tools, and systematic evidence reviews, building on defined priority-setting criteria, including health impact, equity, financial protection, and others, as relevant.	This is hardly done in Kenya but mainly done by some donors for their respective programs within the health sector.
4. Budget impact analysis	Analyzes and projects the potential financial and fiscal impact of the adoption and diffusion of a technology.	This is hardly done in Kenya but mainly done by some donors for their respective programs within the health sector.

5. Deliberative process	Considers the results of cost-effectiveness analysis and budget impact analysis as well as more subjective decision-making criteria depending on national values and context to inform a recommendation for public or donor funding.	This is hardly done in Kenya but mainly done by some donors for their respective programs within the health sector. This is also done for public health through the Ministry of Health but may not be based on CEA and Budget Impact Analysis.
6. Decision	Assesses recommendations and makes decisions to include a technology in budgets.	The Ministry of Health does the same whilst private players may vary the same dependent on their financial capacities and service needs.

11.2 Annex 2: Guiding principles to improving access to information

Aspect	**Global Best Practice**	**Kenyan Context**
Right of public access to information	Provided and Implemented.	○ Provided for in Article 35 of the Constitution of Kenya (2010) and the Access to information Act (2016).
Availability of information at each level of interested stakeholders	Provided and Implemented.	○ Access to financial information at NHIF is reserved despite its being a state corporation. ○ Latest available financial information is courtesy of the Office of the Auditor General for the financial year 2015/16.
Availability of information at every level of relevant decision making.	Provided and Implemented.	○ Guarded information provided on benefit packages and and other services that memebers are entitled to.
Right to present and a responsibility to feedback information	Provided and Implemented.	○ Provided for in Article 35 of the Constitution of Kenya (2010) and the Access to information Act (2016). ○ No clear mechanisms for feedback presentation

11.3 Annex 3: Assessing how the financing models are providing an enabling environment towards transparency and accountability

Form of Accountability	Global best practice	Kenyan context
1. Financial accountability	Ensure tracking and reporting on allocation, disbursement and utilization of financial resources, using the tools of auditing, budgeting and accounting via: • Internal agency financial systems that comply to norms and standards. ability of health facilities to track and report on budgets, collection of fees, pharmaceutical purchases and supply inventories, vehicles and equipment etc. • Oversight and control guidelines by related ministries (Health, Planning, Finance) • Public Procurement and Contracting policies. • Budget Laws by legislature on health expenditures. • Legislative accountability sanctions for ministries of health	The office of the auditor general conducts audits for ministry of health, county government as well as state corporations like NHIF, KEMSA, KNH and MTRH. Most providers (public and private) have internal or external auditors. The public sector has Integrated Financial Management Information System (IFMIS) to help streamline public procurement with a view to enhancing transparency and accountability from planning, requisition, sourcing and provider payment. There are laws and regulations governing public finance e.g. Public Finance Management Act (2012), Public Procurement and Asset Disposal Act, Finance Act, Appropriations Act 2016 inter alia. Select legislative committees (Parliament & Senate) exist to ensure accountability in the use of public funds at ministry and provider levels.
2. Performance accountability	Demonstrating and accounting for performance in light of agreed-upon performance targets hence: • Quality of care • Resource allocation • Service provider behavior • Regulation by professional bodies	NHIF has accreditation officers who conduct quality assessment of facilities intent on or actually providing care to its clients and approvals are made by the board. NHIF has mandatory preauthorizations for services such as surgeries, dialysis, and diagnostics before it commits to paying for the said services for its beneficiaries.

		The respective healthcare professionals' licencing and accreditation boards conduct inspections, registration, licencing and accreditation for respective professionals and facilities in keeping with their guiding laws e.g Medical Practitioners' and Dentists' Board Act Cap 253, Clinical Officers' Act Cap 260, Nurses Act Cap 257 inter alia.
3. Political accountability	Ensuring that the entity delivers on electoral promises, fulfils the public trust, aggregates and represents citizens' interests, and responds to ongoing and emerging societal needs and concerns. These include: • Service delivery equity and fairness • Responsiveness to citizens • Service User Trust • Dispute resolution.	NHIF has some progressivity in its graduated premiums for the employed contributors but the premiums for the informal sector, being fixed, are regressive. Varied reimbursements for similar services across the private and public healthcare providers do not espouse fairness and financial protection. NHIF has feedback channels for its clients through their digital platforms. NHIF packages e.g surgical, diagnostic, dialysis packages are responsive to existing citizen needs and have improved access to respective services.

11.4 Annex 4: List of participants

Participant	Institution/Organization
1. Caroline Giathi	TI Kenya
2. Mike Mulongo	Health specialist
3. Opiyo Geoffrey	OSIEA
4. Duncan Wilson	OSIEA
5. Gabrida Deluca	OSIEA
6. Linda Kroega	KELIN
7. Caroline Kituku	KELIN
8. George Githinji	TISA Kenya
9. Eric Namungalu	GI-ESCR
10. Linda Oduor	EACHRights
11. S. Gullberg	FOJO
12. A. Wood	FOJO
13. Santana Simiyu	ICJ Kenya
14. Aggrey Aluso	OSIEA
15. Mebo Mugotitsa	A4T
16. Thomas Isaac	A4T
17. Judith Adhiambo	A4T
18. Elizabeth Wala	Amref
19. Ouma Oluga	KMPDU
20. George Oketch	KMPDU

21. Abraham Marita	TI-Kenya
22. Harriet Wachira	TI Kenya