

What Kenya can do to achieve Universal Health Coverage

1. Key Messages

Explicitly define an Essential Package of Health Services and cost it as fundamental first steps to move forward with Universal Health Coverage (UHC)

UHC is intrinsically country-owned. To work well, it must be home grown in line with each country's culture, domestic political institutions, the legacy of the existing health system, and citizen expectations

Overall health system strengthening should precede introduction of UHC. The Government should lead in investing in the health sector and mobilise the efforts of other stakeholders

Greater depth of public engagement, including public education should go hand-in-hand with the introduction of UHC guided by the principles of equity and public participation

A hybrid financing plan can help achieve greater coverage, reduce the risks of relying on one source of funding such as taxes and provide an opportunity for sustainability

2. Background

Universal health coverage (UHC) refers to access to needed health services and financial risk protection within a health system¹. UHC remains one of the key global health community commitments whose goal is to ensure all people obtain the health services they need without suffering financial hardship when paying for them. During the 58th World Health Assembly of 2005, World Health Organisation (WHO) member states committed to provide affordable universal coverage and access for all citizens on the basis of equity and solidarity. The drive for UHC is evidence-based: global evidence suggests that well-functioning and inclusive health systems contribute to social cohesion, equity and stability as well as holding societies together thereby helping reduce social tensions². The opposite is true: catastrophic health expenditures can drive families and communities into poverty. Among many policy options, UHC is one of the most powerful social equalisers available to overcome challenges of access to health care³.

Yet, achieving UHC is not a walk in the park. Available evidence shows that most countries are struggling to make progress perhaps because UHC requires a strong, efficient, well-run health system, an investment that most countries are unable or unwilling to make. It also requires a system for financing health services, access to essential medicines and technologies and sufficient capacity of well-trained, motivated health workers. While most literature on UHC has focused on the health financing aspect of UHC, the other three components (political commitment, economic environment and human resources) are equally important and underscore the renewed interest on a health systems thinking to health system challenges⁵. Even more critical, achieving UHC requires deliberate policy changes and leadership - as evidenced in countries such as Singapore and UK - where significant progress has been reported. This brief review draws together evidence on UHC and provides some suggestions on how Kenya can use the principle of UHC to support efforts for realising the constitutional provision of the right to health under the bill of rights in the Constitution of Kenya (COK, 2010).

3. Kenya and Universal Health Coverage - The Context

The Constitution of Kenya (COK, 2010) through the Bill of Rights recognises health as a primary right and tasks the health sector with the responsibility to realise this right. The right to health is also captured in other policy documents such as Vision 2030 and the Kenya Health Policy 2015 – 2030, which aim to provide equitable and affordable health care of the highest standards to Kenyans. These legal and policy documents, among others, signal the government's commitment to ensure that Kenyans have access to quality, affordable health care. Yet, despite these commitments, significant disparities in access to care persist mainly driven by residence (urban vs rural), wealth index (rich vs poor), sex (male vs female) and regional variations.

For instance, according to the National Health Accounts (NHA) 2009/10, individuals carry a huge burden of health care expenditures at 24 percent in the form of direct out-of-pocket payments (OOP). Other sources of funds for health comprise government (29 percent), and donors (35 percent). Other private sources account for 13 percent of the national health expenditure. The per capital health spending was estimated at USD 42.2 against the recommended WHO requirement of USD 60, indicating a general underfunding of about 20 percent. Major factors that hinder access to health services include long distance to health facilities, unavailability of services, poor functionality and high cost of services. The need for revamping of the health system especially the financing architecture is urgent to cushion Kenyans and the economy from catastrophic expenditures.

4. Evidence on UHC

Although evidence on the most promising UHC architecture that Kenya can learn from is scarce perhaps because there is 'no-one-size-fit-all', available evidence points to various promising reforms and emphasises the need to understand the health system context because UHC is 'intrinsically country-owned. To work well, it must be home grown in line with each country's culture, domestic political institutions, the legacy of the existing health system, and the expectations of citizens.'⁶ Below, we highlight the evidence and ways in which Kenya can learn from this evidence.

Financing – use of hybrid financing options provides better results

Evidence on UHC points to the efficacy of a country adopting mixed/hybrid healthcare financing options. This enables governments to cushion citizens against the risks of relying on one or two main options such as taxes and employer driven insurance. Of all financing mechanisms, insurance (particularly state driven national social health insurance schemes) are considered the most promising means for achieving UHC. This is because they offer robust cover to counteract the detrimental effects of out of pocket payments (OOPs) which inhibit care utilisation, particularly for marginalised populations, and can lead to catastrophic health expenditures⁷. Although the evidence on how social health insurance schemes affect fund mobilisation is limited, countries like the Philippines and Thailand have used insurance schemes to reach vulnerable segments of the population. The Singaporean hybrid UHC financing version have been lauded for its ability to balance the advantages of competitiveness and other market forces with the need for state intervention to steer these forces in the right direction (freedom to choose providers, services, and facilities with an obligatory health savings account, the MediSave plan, with emphasis on individual responsibility)⁸.

In Africa, the Ghana National Health Insurance Scheme (NHIS) offers a good case study of a national insurance scheme that provide a standardised, nearly comprehensive package of health benefits to all residents⁹. In the scheme, accredited public and private providers deliver services to scheme members and are reimbursed from a single national fund with no fees at the point of service. The scheme collects 90 percent of its revenues from dedicated taxes (portions of value-added tax (VAT) and payroll)¹⁰. However, like most UHC programmes, the programme faces major challenges of financial sustainability, quality, equity, and—still—basic coverage for the remaining two-thirds of Ghana's 25 million people^{11,12}.

For Kenya to achieve UHC given the poverty levels and disease burden, a key message from the literature is that the government must lead in investing in the health sector and mobilise the efforts of other stakeholders to complement these efforts. A starting point could be the reform of NHIF to expand coverage, reduce administrative inefficiencies and make the premiums affordable to the majority of poor Kenyans. Currently, NHIF membership is mandatory for all employees and their dependents but voluntary for the self-employed. With this arrangement, membership and access to health services is lower in poorer, more remote geographical counties and access in premium private facilities limited.

Target the poorest and those bearing the highest burden of disease

Evidence on successfully UHC show that countries ought to prioritise the poor by providing them with financial protection against catastrophic expenditure as well as engaging them fully to ensure buy-in in these efforts. Various schemes can be used to achieve this with mixed results – exceptions schemes, prepayment vouchers, national health covers that provide free care for the poor and in some cases, incentives to the private sector to reach those sections of the community not reached by the government or a mixed of these schemes¹³. In the case of Morocco for instance, the government instituted a Medical Assistance Scheme (RAMED), which provides benefits to the poorest who are exonerated from any payment for a large set of interventions such as vaccination, reproductive, maternal, new-born and child health among others (ibid). Similar schemes have been reported in China, Brazil and India with some indication of expanded Medicare¹⁴.

Implementation - a phased-out approach driven by evidence can sustain progress

The call to UHC and the commitment can be enticing such that the government is attracted to full scale implementation without due consideration to the limitation of such a policy move. Evidence suggests that a stepwise approach guided by carefully designed and evidenced-driven investment in the health system could yield better results. For instance, Singapore – one of the highest ranked country globally as having the most efficient health care, with excellent performance indicators key health indicators, especially maternal and infant mortality – developed UHC strategies guided by research and tailored to individual needs. The scheme put major emphasis on individual responsibility in access and use of services¹⁵. Similarly, South Africa, with considerable disparities in health status across race groups and also geographical areas and little mandatory prepayment funding or tax based funding (just over 40 percent of total funding), has a staggered UHC implementation

plan spread over a 15-year period, with three 5-year phases¹⁶. This phased approach can enable the government to create conditions for efficient and equitable provision of high-quality public services by addressing infrastructure deficiencies and ensuring routine availability of essential medicines. It can also provide a window for reforms such as creation of a purchaser/provider split, establishment of a tax funded National Health Insurance Fund, pool funds and schemes for purchasing services from both public and private providers¹⁷.

Define and implement a minimum package of health

Although Kenya has had a minimum package of health defined under the community health strategy, its implementation has been hampered by among other factors, shortage of human resources, underfunding, and a lack of community health policy to guide the implementation. Essential health packages (EHPs) concentrate scarce resources on interventions which provide the best 'value for money' and are suitable for achieving UHC goals¹⁸. Because EHPs guarantee a minimum package, they have been shown to enhance equity¹⁹. For instance, a study reported observed statistically significant increases in several service areas within communicable disease, prevention and population health promotion and environmental health based on a defined EHP²⁰.

However, for EHPs to support UHC processes (especially as a safety net for the poorest), additional deliberate efforts to improve access must be put in place and where possible private as well as public providers may need to be involved²¹. In the case of Ghana for instance, the government defined the NHIS benefit packages to cover 95 percent of disease conditions (primary, secondary, tertiary, and pharmaceutical goods and services)²². To ensure the poor are cushioned against OOPs, the Ghanaian scheme allows no co-payments or other fees at the point of service. EHPs also require strong private-public partnerships (PPPs) if they have to be used to achieve UHC and equity in the health sector^{23,24}. In the case of Ghana, NHIS enrollees may access benefits at any National Health Insurance Authority (NHIA) accredited public and private providers²⁵. Kenya recently developed a PPP policy for the health sector. There is need to implement the policy to harness the role of the private sector in UHC efforts.

Public participation and buy-in is critical

UHC is anchored on the principles of equity, public participation and individual and community empowerment to achieve goals of the health system. Several studies highlight the need for a carefully planned implementation approach with community/public engagement at the centre of these efforts. This is because, individuals and communities first need to understand health as a right then follow this by full ownership of the responsibility for their health. The evidence cited from Singapore above shows that the country, through foresighted and visionary planning, was able to achieve first-rate health care, with outstanding health outcomes, at a cost lower than in any other high-income country in the world because the implementation process was anchored in a value system that placed a premium on fairness and inclusiveness as a route to social cohesion, stability, and harmony²⁶. Kenya's Constitution provides a ready framework for in-depth public engagement that can support the implementation of UHC.

5. Conclusion

Achieving UHC in Kenya will require more than policy commitments. The government needs to do more to strengthen the health system to ensure that various components are ready for deployment of UHC. There will be need for enhanced public education to promote buy-in so that communities can own and support the roll-out. This review has highlighted the fact that Singapore was successful in rolling out UHC because, among other things, the government took into consideration the wishes of the public – thereby gaining public support and approval for changes in the health system. Equally important is the place of research and evidence in informing the UHC strategies, enhanced PPP and the willingness of government to invest more resources in the health system. Therefore, all the components of health systems must be strengthened to assure access to service delivery of acceptable quality for all Kenyans.

Image: Albert González Farran, UNAMID/Flickr.



Notes

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- ² Gilson, L., Doherty, J., Loewenson, R. & Francis, V. (2007). *Challenging Inequity Through Health Systems: Final Report of the Knowledge Network on Health Systems*. Geneva, WHO Commission on Social Determinants of Health
- ³ Chan, M.: Keynote address at the Ministerial Meeting on Universal Health Coverage: the Post-2015 challenge Singapore, 10 February 2015 available at: <http://www.who.int/dg/speeches/2015/singapore-uhc/en/> accessed on June 16, 2016.
- ⁴ WHO. (2014). What is universal health coverage? Accessed on June 16, 2016 from http://www.who.int/features/qa/universal_health_coverage/en/
- ⁵ de Savigny, D. & Adam, T. Eds. (2009). *Systems thinking for health systems strengthening*. Geneva, Alliance for Health Policy and Systems Research, WHO.
- ⁶ Chan, Keynote.
- ⁷ Spaan, E., Mathijssen, J., Tromp, N., McBain, F., Have, A. T. & Baltussen, R. (2012). "The impact of health insurance in Africa and Asia: a systematic review." *Bulletin of the World Health Organization* 90(9): 685-692
- ⁸ *ibid*
- ⁹ Blanchet, N. J. and Acheampong O B. (2013) *Building on Community-based Health Insurance to Expand National Coverage: The Case of Ghana*. Bethesda, MD: Abt Associates, Health Finance and Governance (HFG) Project.
- ¹⁰ *ibid*
- ¹¹ *ibid*
- ¹² Nyonator, F., Ofosu, A., Segbafah, M., d'Almeida, S. (2014). *Monitoring and Evaluating Progress towards Universal Health Coverage in Ghana*. *PLoS Med* 11(9): e1001691. doi: 10.1371/journal.pmed.1001691
- ¹³ Tinasti, K. (2015). "Morocco's policy choices to achieve Universal health coverage." *The Pan African medical journal* 21.
- ¹⁴ Chan, Keynote.
- ¹⁵ van den Heever, A. M. : The role of insurance in the achievement of universal coverage within a developing country context: South Africa as a case study. *BMC Public Health* 2012, 12(1):1-13.
- ¹⁶ Marten, et al. "An assessment"
- ¹⁷ WHO. (2008). *Essential health packages: what are they for and what do they change ? A technical brief*.
- ¹⁸ *ibid*
- ¹⁹ Lampe, S., Atherly, A., Van Raemdonck, L., Matthews, K., Marshall, J. : *Minimum Package of Public Health Services: The Adoption of Core Services in Local Public Health Agencies in Colorado*. *American Journal of Public Health* 2015, 105(Suppl 2):S252-S259.
- ²⁰ *ibid*
- ²¹ Blanchet & Acheampong. *Building on Community-based Health Insurance*
- ²² van den Heever : *The role of insurance*
- ²³ Marten, et al. "An assessment"
- ²⁴ *ibid*
- ²⁵ WHO. (2015). *Tracking universal health coverage: first global monitoring report*. Geneva available at: http://apps.who.int/iris/bitstream/10665/174536/1/9789241564977_eng.pdf

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