



Making adequate healthcare services universally available requires striking a delicate balance between a population’s health needs and available resources. It also requires the equitable and efficient allocation and use of those

resources. Without proper healthcare financing strategies, no government can hope to successfully meet the health needs of its citizens.

In 1989, the government of Kenya introduced cost sharing in an effort to bridge the growing gap between health sector expenses and available resources. Since that time, the government has strived to achieve a mix of healthcare financing strategies and systems that will enable the country to provide its citizens

with universal access to adequate basic health services. Currently, the health system relies on six main sources of financing:

- General government revenues (taxes paid by all Kenyans)
- User fees (paid by individual clients when accessing services)
- The National Hospital Insurance Fund (NHIF)—a government-sponsored health insurance scheme
- Employer-sponsored health plans
- Private health insurance plans
- Transfers from friends and relatives

Unfortunately, the lack of an overall healthcare financing strategy has hindered effective planning, budgeting, and provision of health services. The health system has also struggled with stagnant or declining budgets for health,

system inefficiencies, persistently poor service quality, and lack of equity.

Task Order 1 of the USAID | Health Policy Initiative and its predecessor, the POLICY Project, have been at the forefront of efforts to streamline Kenya’s healthcare finance system. The projects have strengthened the Division of Healthcare Finance (DHCF)—the government unit responsible for implementing the current healthcare finance system. Project support has enabled the DHCF to substantially increase cost sharing revenue and identify and correct leakages and mismanagement of funds. The project has also made vital contributions to the government’s efforts to design a comprehensive healthcare financing strategy and helped draft several key guidelines.¹ The Health Policy Initiative has also helped improve implementation of the system of fee exemptions and waivers for the poor and helped bring private healthcare providers into high-level policy dialogue for the first time.

Improving Cost Sharing

Cost sharing is one of Kenya’s central healthcare financing strategies, yet it has faced a number of challenges, including leakages and limited monitoring and supervision capacity. To help address these issues, the POLICY Project began supporting the DHCF in July 2001. The Health Policy Initiative has sustained this effort, continuing to provide financial and technical support to promote equity and efficiency in the collection, use, and management of public health sector funds.

One key element of this effort has been improving the software mechanism that tracks the mobilization and use of cost-sharing funds—

¹ “Guidelines for District Health Management Boards,” “Facilities Improvement Fund (FIF) Operations Manual,” and “FIF Supervision Manual for PMOs, DHMBs, DHMTs, HMBs, and HMTs for Health Centers.”

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the Financial Information System (FIS). The FIS provides data on the collection, banking, and use of cost-sharing funds at hospitals throughout the country, as well as tracking waivers and exemptions. Its accuracy, therefore, determines the extent to which policymakers are able to ensure that cost-sharing guidelines are being properly implemented—an important aspect of guaranteeing equitable access to health services.

Between 2006 and 2008, the Health Policy Initiative improved and updated the FIS and helped six hospitals implement the system. The project also strengthened the ability of DHCF staff and hospital administrators to use FIS to track revenues and expenditures. The project's contributions have improved the DHCF's capacity to track individual hospitals' cost-sharing performance.

Collaborating for Success

The Health Policy Initiative's close working relationship with the Ministry of Health contributed to its success. In a recent interview, Sam Munga, Head of the DHCF, praised the project's collaborative approach and emphasized the importance of involving stakeholders from the provincial and district levels in policy dialogue and strategic planning.

The ability of the FIS to provide accurate data is a key component of the policymaking and budgeting process. In November 2006, the Health Policy Initiative provided financial and technical support to provincial-level FIS staff to update cost-sharing data (FY2003–

2006). These data informed the cost-sharing report, which was used by the Ministry of Planning and National Development to draft the Health Sector Working Group's contribution to Kenya's Medium-term Expenditure Framework (MTEF). This document was then used to guide discussions during public budget hearings to justify the 2007 health sector budget allocation. Information generated from the FIS was also incorporated into the performance contracts of top Ministry of Health (MOH)² leadership, increasing their accountability for resource mobilization and expenditures.

² Under Kenya's new political power-sharing agreement, there are now two ministries of health—the Ministry of Public Health and Sanitation and the Ministry of Medical Services. For ease of reference, this brief uses "Ministry of Health" to refer to both ministries.

“Through monitoring and supervision, we were able to reduce the magnitude of audit queries from the Comptroller Auditor General. Things have improved.”

—Sam Munga
Head of DHCF

Strengthening the DHCF

In addition to strengthening the FIS, the Health Policy Initiative also built the capacity of the department responsible for implementing it—the DHCF. The project's support has enhanced the DHCF's ability to effectively supervise the cost-sharing system. Consequently, the DHCF was able to identify and expose the mismanagement of cost-sharing revenues and establish a system to recover misused or embezzled funds. The MOH also instituted a surcharge on facilities found to have mismanaged such funds. Between April 2004 and March 2007, these changes enabled the ministry to recover \$520,000 in cost-sharing revenue, which has been used to support public hospital services.

The project's support also helped the DHCF examine expenditure trends—revealing that hospitals were spending a large amount of money on areas not directly linked to patient care. As a result, according to the Head of DHCF, Sam Munga, “We've been able, in a good number of hospitals, to help them reprogram funds toward patient care.”

The project's support led to a 67.5 percent increase in health funds from the cost-sharing program between FY2004/2005 and FY2006/2007, including a Ksh. 44 billion (about US\$6 million) increase in cost-sharing revenues from facilities. The DHCF's improved ability to monitor the cost-sharing system, together with the introduction of consequences for the mismanagement of funds, can also be expected to increase cost-sharing revenues in the future.

Improving Management

One challenge faced by Kenya's health system is that managers are often health practitioners with little experience or training in financial or personnel management. In partnership with the DHCF and the Department of Policy Planning and Development (DPPD), POLICY also initiated and provided financial and technical assistance for the design of a curriculum and course materials for Senior Health Administrators in planning, budgeting, and priority setting at the United States International University (USIU) in 2005. Around 30 managers were trained, and the course has since been taken over by the Kenya Medical Training College, with support from USAID/Kenya.

Another management challenge faced by Kenya's health system is that, until recently, all personnel records were stored manually. This resulted in an enormous waste of time, as well as human and financial resources. It also led to irregular payments, poor personnel planning, and the proliferation of "ghost workers"—workers who are on the books as active staff and are collecting salaries but who do not actually show up for duty.

In 2005, POLICY provided technical and financial support for the purchase of computer equipment, the establishment of a Local Area Network, and the design of a computerized personnel management system. As a result of the new system, 4,000 ghost workers were discovered—resulting in the recovery of Ksh. 40 million.

Designing a Health Sector Financing Strategy

In addition to improving implementation of the current cost-sharing scheme, the Health Policy Initiative has also supported government efforts to design a comprehensive health sector financing strategy. The project helped facilitate stakeholder meetings to provide policy direction for the strategy, which led to the establishment of a Health Sector Financing Strategy Working Group in August 2006. The project has since been an active participant in the group—providing technical assistance and support alongside other healthcare financing experts. The working group

Involving the Private Sector

The voice of the private sector—particularly the for-profit sector—has long been absent from the policymaking process in Kenya. In September 2008, the Health Policy Initiative helped launch the Private Health Providers Consortium (PHEPCON) to bring providers together and enable them to speak with a unified voice on policy issues. By coming together, they have gained entry into the policy dialogue process for the first time. The top leadership of the MOH has already met with the group, and they are being included in key decisionmaking processes.

is examining a broad range of possible health financing mechanisms to draft a strategy that incorporates the best mix for the country. As part of this process, in December 2006, the Health Policy Initiative helped facilitate stakeholder consultations at the School of Law.

In June 2007, when the mandate of the working group was broadened to include poverty and access, the Health Policy Initiative helped convene and facilitate the first stakeholder discussions on existing models and best practices in enhancing access to services by the poor.

As of September 2009, the MOH was awaiting finalization of the healthcare financing strategy before deciding whether to establish a National Social Health Insurance Fund that would provide coverage to all Kenyans. Once the strategy is finalized and adopted, cost-sharing systems will need to be upgraded to effectively support the new financing mechanisms.

Enhancing Equity

Under Kenya's current healthcare financing system, 53 percent of healthcare costs are paid by clients when accessing services. This severely limits access to care by the very poor—who may not be able to afford service fees and who are also least likely to have access to alternative financing options. With almost half of Kenya's population living below the poverty line, this represents a significant restriction on access to healthcare.

The cost-sharing system does include a set of fee exemptions and waivers designed to enhance access to services for the poor. Unfortunately, the system's effectiveness has been hampered by an inability to accurately identify poor clients and by little incentive for facility managers to offer exemptions and waivers. Offering these options to poor clients results in

a revenue loss that is rarely compensated for through other resource allocation.

POLICY and later the Health Policy Initiative, helped improve the system by assisting the government in drafting cost-sharing guidelines, which clearly define eligibility criteria and procedures for accessing waivers and exemptions. The projects also enhanced the capacity of health facility managers to implement cost-sharing guidelines. As a result, the provision of waivers and exemptions rose significantly. In facilities that received support, the relative share of waivers and exemptions rose from only 3 percent of total collections in 2002 to 17 percent in 2004 and 18 percent in 2008. Related occupied bed days rose from 250,023 to 275,536 over the same period.

Creating Amenity Ward Guidelines

In Kenya, public hospitals operate three categories of wards—general, amenity, and private. In general wards, services are fully subsidized by the government. In private wards, patients pay the entire cost of services. In amenity wards, services are funded through a combination of user fees and reimbursements from NHIF. While all wards should provide comparable levels of clinical care, private and amenity wards are meant to offer patients improved amenities and services. Amenity wards have the potential to generate additional resources for public hospitals through user fees and higher NHIF rebate rates. Until recently, however, the lack of clarity surrounding their operation prevented hospitals from taking advantage of this potential.

Without uniform standards for the establishment, operation, and governance of amenity wards, quality of services has varied widely from facility to facility. The inconsistency has made it difficult to clearly distinguish between amenity and general

wards. While higher-quality, better-staffed, and more spacious facilities receive higher refunds from NHIF, the lack of clarity surrounding amenity ward services has caused the NHIF and other agencies to resist providing higher rebate rates for these wards. This reluctance has been exacerbated by hospitals' tendency to submit rebate requests for general ward services as amenity ward services to increase NHIF revenues.

In May 2006, the Health Policy Initiative helped establish a task force to draft guidelines governing the operation of amenity wards. The MOH approved and adopted the new "Guidelines for the Establishment and Operation of the Amenity Wards in Public Hospitals," in February 2008. Implementation of the guidelines has helped hospitals generate increased revenue—NHIF rebates increased from Ksh. 660 million in 2004/5 to 1.7 billion in 2008/9. In the future, revenues generated through amenity ward user fees can be used to upgrade hospital services and cover staff salaries—improving equity by subsidizing services for those who cannot afford them and helping ease staff shortages.

The Way Forward

Through its healthcare financing work, the Health Policy Initiative has supported a vital area of health system strengthening. With the project's support, the MOH has been able to draft key cost-sharing guidelines, including a comprehensive healthcare financing strategy, and has mobilized substantial new resources through improved efficiency in the cost-sharing program.

The work, however, is far from done. Striking the balance between the health needs of Kenya's population and its resources will continue to require a careful balance of healthcare financing strategies. As the country's needs change over time, the government will need to continue to strengthen and adapt its healthcare financing policies and implementation mechanisms.

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