

10 PIN-AAU-235
45664

ALTERNATIVES FOR FINANCING HEALTH SERVICES IN KENYA

PROFESSOR CARL M. STEVENS

AUGUST 30, 1984

ALTERNATIVES FOR FINANCING HEALTH SERVICES IN KENYA

Professor Carl M. Stevens

TABLE OF CONTENTS

| | <u>Page</u> |
|---|-------------|
| INTRODUCTION | iv |
| SUMMARY AND RECOMMENDATIONS | 1 |
| Health Strategy for Kenya and the Recurrent Cost Problem | 1 |
| Fees for Government Hospital Services | 3 |
| Fees and the Quality of Government Hospital Services: The "Fees-Efficiency Connection" | 4 |
| Complementary Relationships with the Private Health- Services Sector | 7 |
| Private Social Financing of the Demand for Health Services: Public and Private | 7 |
| Recommendations | 9 |
| ECONOMIC BACKGROUND | 13 |
| Population Growth Rates | 13 |
| Labor Force: Employment Status, Productivity, Earnings | 14 |
| Public Finance | 16 |
| Price Behavior | 19 |
| THE HEALTH-SERVICES SECTOR IN KENYA: SOME STRUCTURAL FEATURES AND THE RECURRENT-COST PROBLEM | 21 |
| The Level of Fiscal Effort on Health-Services Account | 21 |
| Allocation of MOH Funds Among MOH Programs and Activities | 24 |
| The Public-Private Mix in the Health Services Sector: Hospital Services | 35 |

ALTERNATIVES FOR FINANCING HEALTH SERVICES IN KENYA

TABLE OF CONTENTS (continued)

THE HEALTH-SERVICES SECTOR IN KENYA: SOME STRUCTURAL FEATURES
AND THE RECURRENT-COST PROBLEM (continued)

 The Public-Private Mix: The Drug Sector 40

 The Public-Private Mix: Other Sectors 46

FEEES FOR GOVERNMENT HEALTH SERVICES: GENERAL POLICY
CONSIDERATIONS 48

 Existing Fee Schemes 48

 Proposals to Increase Fees for Government Health
 Services and the Question of Equity 49

 Fees for Government Health Services as an
 Instrument of General Fiscal Policy 52

FEEES FOR GOVERNMENT HOSPITAL SERVICES: THE ORGANIZATION FORMAT 56

 Fees and the Quality of Government Health Services 56

 Steps in Implementing a Fee Scheme for Government Hospitals . . . 61

SOME UNIT COSTS FOR GOVERNMENT HOSPITAL SERVICES: KENYATTA
NATIONAL HOSPITAL (KNH) AND OTHERS 63

 Unit Costs for Kenyatta National Hospital (KNH) 65

 Unit Costs for Other Government Hospitals 72

 Charges for Government Inpatient Hospital Services and
 the Rate of Cost Recovery 73

 Comparison of Costs and Fees: Government Facilities
 with Others 77

 Social Financing of the Demand for Government Hospital
 Services 82

THE QUESTION OF AMENITY WARDS IN GOVERNMENT HOSPITALS 85

ALTERNATIVES FOR FINANCING HEALTH SERVICES IN KENYA

TABLE OF CONTENTS (continued)

| | |
|---|-----|
| RECRUITING RESOURCES FOR PREVENTIVE/PROMOTIVE SERVICES AND RURAL HEALTH SERVICES | 89 |
| "Public" vs. "Private" Goods and Services | 91 |
| Rural Health Services: The Curative Component | 92 |
| PRIVATE SOCIAL FINANCING OF THE DEMAND FOR HEALTH SERVICES: CURRENT STATUS AND PROSPECTS | 96 |
| The National Hospital Insurance Fund (NHIF)..... | 99 |
| Other Health-Insurance Schemes and Related Schemes | 105 |
| Self-employed Farmers: Arranging Their Participation in Social-Insurance Schemes | 108 |
| REFERENCES | 115 |

ALTERNATIVE FOR FINANCING HEALTH SERVICES IN KENYA

Professor Carl M. Stevens

INTRODUCTION

This Report has been produced pursuant to PIO/T No. 615-0510.15-40011 (USAID) which directed the investigator to perform an analysis of health-sector financing in Kenya and to make recommendations on one or two key approaches to alternative health care financing that appear to be most feasible in Kenya.

I have worked in Kenya during the period 18 July 1984 - 31 August 1984. I am under no illusion that in consequence of these few weeks here I have become an "expert" on the health services sector of Kenya. Indeed, I anticipate that some of what appears in this Report will reflect a less than adequate understanding of the institutional situation here. On the other hand, I have not permitted timidity on this score to deter me from calling the shots as I have seen them, for only in this way can I be of any real assistance to those in the health-services community here I have sought to assist.

I can best characterize the general thrust of this Report in a few words by saying that it may be regarded as addressed to the question of how to implement Kenya's health strategy over the coming decades. That strategy calls for placing a high priority on preventive and promotive health services and for greatly extending coverage under the rural health services. In my view, the problem of how to secure adequate funding for

operating (recurrent) cost of the government health services is the major bar to realization of these objectives. I suggest ways to cope. In the course of my inquiries here I have been privileged to discuss these matters with many people, officials in the Ministry of Health and other Ministries, members of the private health-services community, USAID staff and others. To attempt to enumerate all of these individuals here would be tedious. Selectivity to acknowledge some would be invidious. Suffice it to say that all of these individuals have received me with the utmost courtesy and have given generously of their time. For this I am grateful. And I entertain the hope that the contents of this Report will prove of some use to the health-services community in Kenya.

SUMMARY AND RECOMMENDATIONS

Health Strategy for Kenya and the Recurrent Cost Problem

Kenya's health strategy over the coming decades calls for:*/

Placing high priority on preventive and promotive health measures. Greatly increasing coverage and accessibility of health services in rural areas thereby correcting the present imbalance in favor of urban areas.

Implementation of these objectives will require major departures from past MOH budgetary allocations. Over the past five years, the government hospital sector has regularly claimed the lion's share of the MOH's recurrent budget, averaging about 68.5% over this period. Over this same period, Rural Health Services have claimed an average of only 9.4% and those programs budgeted under "Preventive Medicine and Promotive Health" have claimed only about 5.5%. To accomodate declared health strategy over the coming decades, the recurrent budget must feature significantly greater allocations for preventive/promotive services and rural health services relative to those for hospital services. For even relatively modest goals, the implied requirements for recurrent (operating) revenue are ominous. Suppose, for example, that the policy makers wanted to completely cover the rural population by the year 2000 with the same level of services now provided to the 30% or so of the rural population now covered by these services. A very rough calculation suggests that this would require an increase in the budget for rural health services on the order of 11.0% in real terms on average for each year over the period between now and the year 2000. Any such growth rate

*/ See Dr. W. Koinange, "Health Strategy for Kenya," 1982 (MOH, Republic of Kenya) pp. 3-4 and 12-13. Henceforth Koinange 1982.

would represent a torrid pace indeed as compared with the historical track record. And even then, no provision would have been made for improving the quantity or quality of services for each of the individuals (now extremely lean on both counts). And, at the same time, to implement the proposed health strategy, there would have to be significant increases in the recurrent budgetary provision for those programs comprising preventive medicine and promotive health.

In thinking about the prospects for these budget allocations, it is relevant to keep in mind that the MOH's recurrent-budget experience in recent years has been one of increasing stringency. Indeed, MOH recurrent expenditure per capita in real terms (constant prices) in 1983/84 stood at only about 73.0% of what it had been five years earlier. And, given likely constraints on overall GOK fiscal policy over the coming years, it would be unwise indeed for the MOH to anticipate salvation in the form of greatly increased allocations to the MOH.

Whatever the total resources available, increases in the efficiency with which they are deployed will help them go farther in achieving objectives. The recent and influential Mdegwa Committee report addressed the management of recurrent expenditure, expressing the views, viz:*/

"108 . . . There is, however, a great potential for realizing savings through improved efficiency in the use of recurrent expenditure. These savings should be divided between reducing the deficit and increasing the quantity and quality of government services.

"109. Much of the nation's development is dependent upon recurrent expenditure and the efficiency with which these funds are used. Recurrent expenditure on health, education . . . are truly investments in human resources."

*/ See REPORT AND RECOMMENDATIONS OF THE WORKING PARTY, Working Party on Government Expenditure, Chairman Philip Ndegwa, July 1982,

It is my impression based upon my experience here that these remarks characterize the government health-services sector as well as others-- that there is in the health services sector " . . . a great potential for realizing savings through improved efficiency . . . " as the Working Party puts it. Moreover, I think it fair to say that a major theme of Kenya's health strategy over the coming decades calls for increases in the efficiency with which sector resources are deployed. (See Koinange, 1982, pp. 18 et seq.).

Sometimes it happens that the solution to one problem helps also to provide a solution to other problems. In my view, and as will be explained, this fortunate circumstance obtains in the instant case. The solution to the MOH's recurrent cost problem provides, at the same time, an opportunity which would not otherwise be available to increase the efficiency of performance of government health facilities, notably government hospitals, which now consume the lion's share of the MOH budget.

Fees for Government Hospital Services

I have found it hard to escape the conclusion that, both for the near term and for the longer term, the prospects for recruiting adequate resources for government preventive/promotive and rural programs are remote indeed--so long as the system for financing government health services remains as it is, i.e., with virtually sole reliance upon general tax revenues. If, on the other hand, ways can be found to implement alternative financing schemes, the prospects will be much

brighter. In my view, the most promising strategy to recruit adequate resources for preventive/promotive services and rural programs will be to implement a fee scheme for certain government hospital services.*/

Fees and the Quality of Government Health Services: The "Fees-Efficiency Connection"

These phenomena are intimately related in two ways. If a fee scheme for government hospital services is to be workable, the government hospitals must deliver services of acceptable quality. In some countries where plans are underway to implement fees for government provided health services, this has been recognized as a problem, i.e., the necessity of increasing the quality of the services to support a workable fee scheme. A similar kind of problem may exist in Kenya.

The connection also runs the other way. That is, the implementation of fees for government hospitals is probably a necessary (if not also sufficient) condition for achieving efficient performance of these hospitals (one part of which would be the production by them of quality services). Thus the "fees-efficiency connection" is a package of generally interdependent elements.

A major reason for this interdependency inheres in the role played

*/ Even if it would otherwise make sense, is it politically feasible in Kenya to implement fees for government hospital services (in addition to the nominal fees which are now levied)? What would be the response of the budget authorities to significant private financing of government hospital services? I anticipate that these and other questions will occur to the reader reacting to these proposals. I must refer the reader to the Report for some comment on them. To attempt to engage them in this Summary would overly clutter the exposition.

by incentives in securing efficient performance. The efficiency with which any organization performs depends upon various factors, e.g., the skills of the organizations' planners, managers, administrators and other members of the work force. However, the most crucial factor is the incentive system. Whatever their skills, unless the members of the organization have adequate incentives to motivate efficient performance, efficient performance cannot be expected. That the MOH system in Kenya (as in many other countries) confronts problems on this score is a proposition with which most respondents here with whom I have discussed these matters agree.

From an incentive point of view, the government health services operate at a singular disadvantage. Financed by general tax revenues and providing a product (virtually) free of charge, there is no market link to consumers that makes it necessary for the survival of the organization to market an acceptable product. Absent this kind of discipline as an incentive to keep product quality up and costs down, effective substitute incentives must be devised. As commonly is recognized, this is not easy to do.

It is at this point that the implementation of fee schemes for government hospital services provides an opportunity which could not otherwise be provided. This is so because fees are a necessary, central element in the design of organization formats such that the management of government hospitals will be at risk for success and at risk for failure. Given that revenue from fees for government hospital services would be retained by the facilities marketing the services, organization formats

which will exhibit these properties can be designed around the procedure of "prospective budgeting."*/

Operating under prospective budgeting at risk for success and at risk for failure, hospital management should have the incentives necessary to motivate efficient performance. In addition, the managers of government hospitals will need enough directive management elbow room (especially with respect to personnel policy) to in fact be able to manage. It is my impression that in the government health services, the nature of public-service personnel policy militates against the capacity of even skilled, motivated managers to manage effectively. In Kenya, operating the hospital with a statutory board, as a so-called parastatal, is a strategy which might facilitate giving more directive management authority to hospital management.**/

*/ I recognize that as matters now stand revenue from such fees would revert to the exchequer. However, for the health-services sector, fees for services provided make little or no sense as an instrument of general fiscal policy. Consequently, it should not be hard to persuade the policy makers to abandon this policy in favor of permitting the facilities marketing the services to control this revenue (i.e., in the sense of A.I.E. authority, not necessarily cash on hand).

**/ I am aware (e.g., from the Ndegwa Committee Report and other sources) that in Kenya the performance of parastatals, generally speaking, has left something to be desired from an efficiency point of view. However, I am not invoking parastatal status "generally speaking," but rather "particularly speaking," i.e., in conjunction with prospective budgeting, etc. See comments on this in text of this report.

Complementary Relationships with the Private Health-Services Sector

In addition to recruiting significant private financing for costly secondary and tertiary curative services provided by government hospitals, national health policy should seek to rely more extensively upon the private health-services sector for the provision of curative services. A desirable general policy posture with respect to complementary relationships between the government and private sectors would be for the mission of the MOH to be defined such that it would, in effect, move, over the coming decades, in the direction of becoming more nearly a Ministry of Public Health, with its major emphasis and resource commitment in the domain of preventive/promotive services and rural health services. The major curative load would thus be assigned to the private sector.

Private Social Financing of the Demand for Health Services: Public and Private

There is a substantial private health-services sector in Kenya. From the point of view of national health policy, this can be regarded as a plus. There is no general reason to suppose that government agencies have an advantage in the provision of health care. Indeed, it may well be that private providers can use health care resources at least as efficiently. There is a problem in the private sector, however. Too much of the demand for these services is financed by out-of-pocket payments. It may be argued that government does have some responsibility on the demand side of the market for private services--namely, to help see to it that consumers of those services can have the benefits of

private social financing. Similarly, if government hospitals are to implement fee schemes and market services, consumers will benefit if they can finance their demand for these services by private social financing.

In addition to benefitting the consumer directly, private social financing schemes can encourage the growth of the private health-services sector, thereby facilitating a strategy of shifting more of the curative load off the back of the MOH and to the private sector.

Private social-financing schemes can also facilitate the design and operation of fee schemes for government hospital services--by helping to cope with collection problems and by making it easier to design income-related schemes.

There is another aspect of private social financing of the demand of health services to which special attention should be drawn. As with the National Hospital Insurance Fund (NHIF) in Kenya, in most countries, most of the beneficiaries of such social-security-type health insurance schemes are the wage earners employed in the urban areas. In Kenya, however, almost 80% of the labor force is employed in the rural, agriculture sector, most of these as self-employed farmers. How can self-employed farmers and other own-account workers participate in such social insurance schemes? An answer to this question is urgently needed. It may well be that a partial answer, at least, lies with using the cooperative movement as a vehicle to facilitate participation by the members (cooperators) in health-insurance and other social-financing approaches of one kind or another.

Recommendations

The foregoing summary comments and, more generally, the discussion in the body of the report, leads to these recommendations:*/

I: That the GOK give serious consideration to the implementation of a fee scheme for (at least some) government hospitals which would entail the organization format set out in this report, e.g., revenue from fees to revert to the account of the facilities marketing the services, prospective-budgeting relationship to the MOH, statutory-board or other semi-autonomous status, and other features.

IA: That, in this connection, the GOK give serious consideration to what would be its budget-making response should government hospitals recruit significant private financing for services marketed by them. More particularly, the GOK should seriously entertain the possibility of a response which would not entail pari passu reductions in the public financing available to the MOH.

II: That the MOH give serious consideration to possible implementation of the "diversion strategy"--i.e., in response to the recruitment of significant private financing for government hospital services, the diversion of significant public finance from the hospitals to the preventive/promotive services and rural health services.

If, at least in a provisional sense, the findings from the discussion and studies pursuant to I, IA and II were affirmative, i.e.,

*/ The statements of the recommendations have been kept very brief to facilitate the reader's obtaining an overview of the whole program suggested in the report. The report itself, of course, amplifies matters treated in this summary, including the recommendations.

if the preliminary judgment was that it would make sense to implement institutional developments on these lines--then:

III: That the GCK give serious consideration to the possibility of testing the fee scheme with a trial run with Kenyatta National Hospital (KNH). The in various ways unique status of KNH might well facilitate singling out this institution for such a trial run, as a way to test whether the benefits anticipated from the fee scheme are apt to be realized in practice. The results of this trial would help to inform longer-run decisions about the extent to which the fee scheme should be extended among government facilities, e.g., should it be restricted just to, say, KNH and the provincial hospitals, or extended to the districts, etc.?

If, at least in a provisional sense, the findings from the discussions and investigations pursuant to III were affirmative,--then:

IV: That the MOH undertake to design the trial run with KNH--this would entail designing the scheme in operational terms, e.g., answering questions such as what fees should be charged, how the demand for these services would be financed (NHIF and others), what rules should govern the use by KNH of the revenue from fees, what information would be required to engage in reasonable prospective budgeting, and other matters.

IVA: An important part of this design activity would be a proper determination of the unit costs of producing services by KNH and the setting up of accounting procedures which would, in the normal course of events, be appropriate for assembling this kind of information.

Assuming that the outcome under IV was a seemingly satisfactory design of the trial run--then:

V: That the GOK implement (embark upon) the trial run with KNH.

Additional recommendations which support the foregoing (and/or which may be regarded as standing on their own feet) are:

VI: That serious study immediately be undertaken of the ways in which the extensive cooperative movement in Kenya might be utilized to facilitate participation by self-employed farmers in the rural areas (and perhaps other categories of own-account workers) in social-insurance programs, especially health insurance and other social financing of the demand for health services.

VII: That serious study immediately be undertaken of certain aspects of the operation of the National Hospital Insurance Fund.(NHIF). One important question to be addressed is the relationship of the NHIF to the government hospitals (there appears now to be considerable ambiguity on this score). Another important question to be addressed is the extent of abuse of the NHIF by private facilities and providers (if any), and what is to be done about it (if it exists).

VIII: That the whole question of the supply of drugs and medications to the various facilities comprising the government health service be given prompt, further and serious study. There appears to be general awareness that the historical system for acquisition of distribution of these supplies by the Central Medical Stores (CMS) has not worked well. It further appears that plans are just now being implemented to remedy the situation. However, these plans themselves may leave a good bit to

be desired. And it appears in the field that there is a considerable amount of uncertainty with respect to the precise nature of the "new system" and considerable skepticism over whether it is apt to prove of much help.

IX: Give serious consideration to whether fees for services delivered by government health centres and dispensaries are a realistic prospect (e.g., politically) in the foreseeable future. If so, give some serious study to what kind of fee scheme might be designed in this domain. Give particular attention to whether what may look fine "on paper" can actually successfully be administered "on the ground"--this being a domain in which administration is notoriously difficult.

ECONOMIC BACKGROUND

This section selectively affords some economic background relevant for development of the health-services sector financing system in Kenya.

Population Growth Rates

Rapid population growth rates can be expected to stress the capacity of the basic-needs-services sectors including the health-services sector. Currently, Kenya features a population growth rate of on the order of 4.0% per year, one of the highest in the world. Projections of future population growth depend upon assumptions about future birth rates and death rates, there is room for difference of opinion about which such assumptions are to be regarded as the most plausible. A recent study of population events in Kenya has expressed the view: "If a single figure is to be given, the best bet is a total population of 31 million by the end of the century."*/ I shall adopt this projection with its associated growth as follows:

| | |
|------|--------------|
| 1985 | 19.5 million |
| 1990 | 22.8 million |
| 1995 | 26.6 million |
| 2000 | 30.8 million |

*/ See Kenya Population and Development, A World Bank Country Study, The International Bank for Reconstruction and Development/The World Bank 1980 (henceforth IBRD Population 1980), p. 40. In the case of Kenya, over the range of likely demographic scenarios, the range of total population in the year 2000 turns out to be relatively narrow with a high figure of 32.5 million and a low figure of 28.6 million.

Labor Force: Employment Status, Productivity, Earnings

According to a recent study, labor force distribution and productivity in Kenya in 1982 was as follows:*/

| | <u>Value Added</u> | | <u>Labor Force</u> | | <u>V.A. Per Worker</u> |
|-------------|--------------------|----------|--------------------|----------|------------------------|
| | <u>US\$ mln</u> | <u>%</u> | <u>mln</u> | <u>%</u> | <u>US\$</u> |
| Agriculture | 1,714 | 32.1 | 4.4 | 78 | 390 |
| Industry | 1,028 | 19.3 | 0.6 | 10 | 1,700 |
| Services | 2,593 | 48.6 | 0.7 | 12 | 3,700 |

Thus, of a total 1982 labor force of 5.7 million, 78% was employed in the agriculture sector. Only a minuscule proportion of the agriculture work force is in wage employment (reported as 167,500 workers in 1982).**/ Consequently, it would appear that on the order of 80% of the population derives its income as non-wage income from small-scale agriculture and pastoral pursuits. Total wage employment has been reported as 1,038,000 workers in 1982 (540,000 of these in the private sector and 497,600 of these in the public sector, including here parastatal bodies).**/ Thus wage employment would represent about 18.0% of the total labor force, which, taken together with the foregoing table, suggests that about 4.0 percent of the labor force is comprised of own-account workers in sectors other than agriculture.

*/ See Kenya Country Economic Memorandum, Document of the World Bank, Report No. 4689-KE, October 5, 1983. (Henceforth, IBRD 1983).

**/ See Statistical Abstract 1983, Central Bureau of Statistics, Ministry of Economic Planning and Development, Republic of Kenya, p. 228.

In thinking about the development of the health-services sector financing system in Kenya, the employment status of the labor force is an important consideration. In most countries, as with the National Hospital Insurance Fund in Kenya, health insurance (and other social-financing schemes) are in the main employee benefits in a wage-employment relationship. This is so because wage employment provides a feasible organization context for the implementation of such schemes, e.g., contributions to the health-insurance fund can take the form of deductions from wages paid into the fund by the employer. Self-employment, on the other hand, does not provide as feasible an organization context for the implementation of such schemes--indeed, in many countries, it seems simply to have been assumed that there is no feasible way in which self-employed farmers and other own-account workers can be included as beneficiaries in social-financing schemes for health services. Obviously, in Kenya, if employment-related social-financing schemes for health services were to cover the population generally, ways would have to be found to include self-employed farmers as beneficiaries. We turn to this matter subsequently.

GNP per capita in 1982 has been reported as the equivalent of US\$ 390 (see IBRD 1983). As previously noted, although agriculture employs some 78% of the labor force, it generates only about 32% of total value added in the economy, with a 1982 value added per worker in agriculture of the equivalent of only US\$ 390. Industry and services, on the other hand, generated a 1983 value added per worker of the equivalent of US\$ 1,700 and 3,700 respectively. Reflecting these relative productivities,

1981 average wage earnings per agricultural employee have been reported as only KL 237.9 as compared with, say, Transport and Communication, reporting average wage earnings per employee in that year of KL 1,781.7 (see IBRD 1983, p. 66). More generally, the distribution of wage employment by income groups for 1982 has been reported as follows:*/

| <u>Income Groups</u> Sh./mo. | <u>Number Employees</u> | <u>% Employees in each</u> <u>Group of Total</u> |
|---------------------------------|-------------------------|---|
| Under 215 | 21,605 | 2.5 |
| 215-399 | 139,153 | 16.0 |
| 400-699 | 171,749 | 19.7 |
| 700-999 | 172,470 | 19.8 |
| 1,000-1,499 | 147,235 | 16.9 |
| 1,500-1,999 | 84,904 | 9.8 |
| 2,000-2,999 | 60,048 | 6.9 |
| 3,000 & over | 73,934 | 8.5 |
| Total | 871,091 | 100.1 |

Public Finance

In Kenya, virtually all fiscal capacity lies with the Central Government, i.e., Central Government recruits virtually all such public resources. Local government has some fiscal capacity. The major sources of revenue for Municipal, Town, Urban and County Councils are rates, licenses, sale of goods and services and loans. In 1981, these sources yielded a total local government revenue of KL 61.95 millions, or about 5.5% of the KL 1,122.3 millions recruited by Central Government (1981/82 actuals) in the form of current revenue and external and internal

*/ See Statistical Abstract 1983, p. 257.

financing.^{*}/ In addition to its own resources, local government receives some funding via transfers by the Ministry of Local Government. In 1980/81 actuals, this amounted to KL 12.88 million, or about 20% of the amount yielded by own sources in 1981. In recent years, Ministry of Local Government recurrent expenditures have been running at about 2.0% of the total Central Government recurrent budget.^{**}/ The distribution of fiscal capacity between Central Government and local government has obvious implications for health-sector financing. More particularly, in Kenya, given sharply constrained fiscal capacity at the local level, and given the many competing demands upon that capacity (e.g., administration, roads, sanitary, education, health), unless new sources of local revenue are found it is not likely that local government can play any quantitatively significant role in health-sector financing.

Although government health services in Kenya are provided (virtually) free of user charges, these services are not of course "free" in an economic or aggregate-financing sense. These services are funded out of general tax revenues such that a relevant question becomes how this tax burden is distributed among the consumers and potential consumers of these services, e.g., the question whether the tax system

^{*}/ See Economic Survey 1984, Central Bureau of Statistics, Ministry of Finance and Planning, Republic of Kenya, pp. 72 et seq.

^{**}/ See "FY 1984 ESF Structural Adjustment Program Grant, 615-0213 Amendment," USAID Kenya, June 25, 1984, Table 6.

is progressive or regressive.*/ More analysis would be required to afford a definitive answer to this question (if, indeed, such an answer could be afforded) than would be warranted in this context. Generally speaking, however, one may infer from the sources of Central Government revenue, that the system is probably at least more neutral in its incidence than it is progressive. Thus, revenue from direct taxes (mainly income taxes), potentially the most progressive element in the tax structure, has, in recent years, comprised only about 25% of Central Government gross receipts on recurrent account. Indirect taxes, on the other hand (e.g., sales taxes, import duties, excise duties, etc.), potentially a regressive element, have in recent years yielded about twice the revenue yielded by the direct taxes.

Generally, government-budget austerity can be anticipated during the 1984-88 years of the current development plan. Budget crises of 1979 and the early 1980s necessitated painful budget cutbacks. Despite this, government plans to consolidate the gains of these years, limiting expenditure during 1984-88 to an average of 28.6 percent of GDP--below the 31.7 percent average of the previous five-year plan and well below

*/ This question may become relevant, for example, in a comparison of the relative merits of alternative health-sector financing schemes. In any event, i.e., however the health sector is financed, consumers in the aggregate will pick up the tab for the nation's health-care bill--by making some combination of tax payments, out-of-pocket payments, insurance premium payments and, perhaps, experiencing the consequences of deficit-financing induced inflation. Hence the relevant policy question in this domain is never whether consumers should pay for health services, but rather, what is the best way for consumers to pay for health services. One important criterion in making this evaluation will be the way in which the total burden for financing the health-services sector is distributed among consumers and potential consumers.

the level of 35 percent reached in 1980-81 (see USAID/Kenya 1984, p. 6). From the point of view of the prospects for health-sector financing, what this picture means is that it is very unlikely that the Ministry of Health (or any other Ministry for that matter) can expect over these years large increases in real terms in the resources available to it from government, indeed, a lower rate of increased funding in real terms than that experienced historically may be in the cards. In evaluating these prospects, it is important to keep in mind that in recent years in Kenya the cost of servicing the public debt has been putting an increasing load on the recurrent budget. Thus, in 1981/82 (Gross Approved Estimates) the ratio of debt service charges to the total recurrent budget was about 19%. By 1984/85 (Gross Estimates) this ratio was expected to climb to about 30%. Moreover, according to Economic Survey 1984 (p. 83), external debt servicing charges as a proportion of exports of goods and services increased from 5.2% in 1979 to 13.5% in 1983, a circumstance which increases the stress on foreign exchange availabilities.

Price Behavior

Kenya has experienced substantial price inflation in recent years as the following table indicates:

Consumer Price Index (CPI) all items Nairobi (unweighted) average of upper, middle and lower income indices--1975 eq. 100 */

| <u>Year/mo.</u> | <u>Index</u> | <u>% Increase</u> |
|-----------------|--------------|-------------------|
| 1978/12 | 149 | |
| 1979/12 | 166 | 11.0 |
| 1980/12 | 186 | 12.0 |
| 1981/12 | 225 | 21.0 |
| 1982/12 | 262 | 16.0 |
| 1983/12 | 289 | 10.0 |
| 1984/3 | 296 | 2.0 |

*/Source: Statistical Abstract 1983 Economic Survey 1984. Weighting the income-class components would have had very little effect on the composite index.

From 1978 to 1984/3, the average annual rate of inflation was about 12%.

The above data suggest that the inflation rate may be slowing down substantially--time will tell.

THE HEALTH-SERVICES SECTOR IN KENYA: SOME STRUCTURAL FEATURES AND THE
RECURRING COST PROBLEM

Introduction

I do not undertake in this section a detailed description of the health-services sector in Kenya. My intention is to draw attention to certain structural features of the sector which appear to me to be particularly relevant for consideration of cost and financing problems. The sector is comprised of both public (government) and private providers of services and of both public and private sources of financing the demand for services. I shall be in the main concerned with recurrent (operating and maintenance) budgets and expenditures rather than development (capital) budgets and expenditures.

The Level of Fiscal Effort on Health-Services Account

Table I exhibits Ministry of Health (MOH) gross recurrent expenditure for the years 1978/79 through 1983/84 in both current prices and constant (1978/79) prices.*/ Expenditures proposed by the current Development Plan are given for 1984/85-1987/88. As these data show, the MOH's recurrent-budget experience in recent years has been one of increasing stingency. Over the period 1978/79-1983-84, the average annual rate of increase in current prices expenditure was about 11.8%.

*/ Actual expenditures are given up to 1981/82, the last year for which they are available. The Approved Estimates for 1982/83 and 1983/84 are presumably closer to what will turn out to be the actuals than is the Estimate for 1984/85.

TABLE I

Kenya Ministry of Health Budget Data: Recurrent Expenditure

| | Actual 1978/79 | Actual 1979/80 | Actual 1980/81 | Actual 1981/82 | Approved Estimate 1982/83 | Approved Estimate 1983/84 | Estimate 1984/85 | Proposed 1985/86 | Proposed 1986/87 | Proposed 1987/88 |
|----------------------------------|-------------------|-------------------|-------------------|-------------------|---------------------------------|---------------------------------|---------------------|---------------------|---------------------|---------------------|
| Current Prices KL m | 35.38 | 42.94 | 52.87 | 59.08 | 58.32 | 61.19 | 68.56 | 70.04 | 73.45 | 76.92 |
| Constant 1978/79 Prices KL m | 35.38 | 38.68 | 42.30 | 39.39 | 33.14 | 31.54 | | | | |
| Per Capita, Constant Prices KSh | 46.2 | 48.7 | 51.3 | 45.8 | 36.9 | 33.9 | | | | |
| As % of Total GOK Recurrent Exp. | 7.4 | 7.8 | 7.6 | 7.2 | 6.1 | 5.9 | 6.2 | | | |

Sources: Ministry of Health Development Plan 1984-1988

Estimates of Recurrent Expenditure for years in question.

The Appropriation Accounts for the years in question.

This was, however, somewhat less than the inflation rate.^{*/} Consequently, in constant prices, the MOH total gross recurrent expenditure, after showing some modest improvement in the early years of the period, declined to KL 31.54 million in 1983/84. Thus in real terms, MOH expenditure in that year stood at only about 89% of what it had been five years earlier. Since the population continued to increase over these years, real MOH recurrent expenditure per capita for the population as a whole declined more rapidly than did aggregate expenditure. As Table I shows, MOH recurrent expenditure per capita in real terms (constant prices) stood at KSh 46.2 in 1978/79 but only KSh 33.9 in 1983/84 or about 73% of what it had been five years earlier. Table I also shows MOH gross total recurrent expenditure as a percent of total government recurrent expenditure. For the years 1978/79-1981/82, this averaged 7.5% and exhibited very little variance around that average. For the years 1982/83-1984/85 the average was about 6.0%, again with little variance around that average.

Thus, by any of various measures, the MOH has been confronted in recent years with increasingly severe constraints on its overall recurrent expenditure budget. For the period 1984/85-1987/88, the proposed recurrent expenditure rates imply an increase in real terms on the

^{*/} See section "Economic Background" for inflation data. The CPI is not, of course, the ideal deflator for these purposes although it should serve well enough.

average of about 4.0% in each of these years.^{*/} Time will tell whether these optimistic expectations are to be realized. However, constraints on overall GOK fiscal policy for the coming several years, at least, are apt to be such that one cannot be sanguine on this score. (See discussion in section "Economic Background".) Surely, the recent track record cannot be regarded as encouraging on this score. Indeed, it is plausible to suppose that if the MOH is in fact to enjoy increases in real rates of expenditure on recurrent account on the order of those depicted in the current Development Plan, there will have to be sources of funding in addition to the general tax revenue funds upon which the MOH has historically relied. (As I shall point out subsequently, Development Plan appears in some of its discussion to recognize this.)

Allocation of MOH Funds Among MOH Programs and Activities

Table II exhibits the allocation in percentage terms of the MOH recurrent budget among the various "votes" or accounts which comprise the total program--for the years 1978/79-1984/85. The allocations proposed for the following three years are also shown. An initial general consideration of these allocations will assist our understanding of the recurrent-cost problem. Subsequently, more detailed attention will be given some of the programs.

^{*/} MOH Development Plan 1984-1988 does not indicate whether the budget data presented therein are in constant prices (real terms) or current prices. It is my understanding, however, that these budgets have been depicted in real terms.

TABLE II (Continued)

Kenya MOH Recurrent Budget by Major Programs 1978/79 - 1987/88

Percent Each Program of Total Gross Recurrent Expenditure

| <u>Programs</u> | Approved Estimate 1983/84 | Estimate 1984/85 | Proposed 1985/86 | Proposed 1986/87 | Proposed 1987/88 |
|--|---------------------------------|---------------------|---------------------|---------------------|---------------------|
| 110 General Administration and Planning | 6.0 | 5.3 | 5.4 | 5.3 | 5.3 |
| 111 Curative Health | 66.9 | 67.3 | 64.0 | 63.4 | 62.3 |
| 112 Preventive Medicine and Promotive Health | 5.2 | 5.9 | 5.7 | 5.7 | 5.6 |
| 113 Rural Health Services | 10.7 | 9.8 | 9.2 | 10.3 | 11.7 |
| 114 Health Training | 7.2 | 7.1 | 9.0 | 8.8 | 8.7 |
| 115 National Health Insurance | 0.6 | 0.7 | 0.6 | 0.6 | 0.6 |
| 116 Medical Supplies Services | 1.0 | 0.9 | 1.1 | 1.1 | 1.2 |
| 117 Medical Research | 2.4 | 3.2 | 5.0 | 4.8 | 4.6 |
| Total | 100.0 | 100.2 | 100.0 | 100.0 | 100.5 |

Sources: Ministry of Health Development Plan, 1984-88

Estimate of Recurrent Expenditure for years in question.

The Appropriation Accounts for the years in question.

TABLE II

Kenya MOH Recurrent Budget by Major Programs 1978/79 - 1987/88

Percent Each Program of Total Gross Recurrent Expenditure

| <u>Programs</u> | Actual 1978/79 | Actual 1979/80 | Actual 1980/81 | Actual 1981/82 | Approved Estimate 1982/83 |
|--|-------------------|-------------------|-------------------|-------------------|---------------------------------|
| 110 General Administration and Planning | 5.2 | 5.6 | 5.5 | 6.0 | 6.6 |
| 111 Curative Health | 68.7 | 66.7 | 68.4 | 72.3 | 69.0 |
| 112 Preventive Medicine and Promotive Health | 4.8 | 6.0 | 6.6 | 4.6 | 5.2 |
| 113 Rural Health Services | 7.8 | 9.2 | 9.2 | 8.2 | 11.1 |
| 114 Health Training | 8.5 | 6.1 | 6.0 | 6.0 | 6.9 |
| 115 National Health Insurance | 0.4 | 0.5 | 0.3 | 0.2 | 0.5 |
| 116 Medical Supplies Services | 3.5 | 4.6 | 2.4 | 2.7 | 0.7 |
| 117 Medical Research | 1.2 | 1.4 | 1.8 | | |
| Total | 100.1 | 100.1 | 100.2 | 100.0 | 100.0 |
| 340 Grants to Church and Private Hospitals as % of Total MOH Recurrent Budget | 2.8 | 2.5 | 2.9 | 2.8 | 3.1 |

As can be seen from Table II, in percentage terms, the allocation of MOH funds among the various programs has been quite stable over these years. It is clear that Acct. 111 - "Curative Health" has regularly taken the lion's share of the budget averaging 68.5% over the period 1978/79- 1984/85 with relatively little variance around this average. The title "Curative Health" for Acct. 111 is a bit misleading in the sense that not all curative services are included in the account. This account includes:

Heads

- 315 Kenyatta National Hospital (which comprises somewhat less than 20% of the total Acct. 111 budget in recent years).
- 316 Provincial Hospitals
- 317 District Hospitals
- 318 Psychiatric Services /Hospital/
- 319 Private Hospitals (this is a subvention)
- 320 Spinal Injury Hospital

Thus, a more informative description of this account would be "Hospital Services," recognizing that additional "curative health" services are funded under other accounts, e.g., Acct. 113, Rural Health Services.

Rural Health Services have claimed an average of 9.4% of the total MOH recurrent budget over the period 1978/79-1984/85, again with relatively little variance around this average. This budget item includes Rural Health Centres (RHCs) and Dispensaries and the Rural

Health Training and Demonstration Centres.

The Rural Health Services network is, as I understand it, supposed to deliver some preventive and promotive services as well as curative services. However, various preventive and promotive programs and activities are budgeted under Acct. 112 - "Preventive Medicine and Promotive Health" including:

Heads

- 325 Communicable and Vector-Borne Diseases
- 326 Port Health Control
- 328 Family Planning, Maternal and Child Health
- 330 Health Education
- 331 National Health Laboratory Services
- 332 Drug Control Inspectorate
- 334 Radiation Control Inspectorate

Preventive Medicine and Promotive Health programs have claimed an average of only 5.5% of the total MOH recurrent budget over the period 1978/79-1984/85, again with relatively little variance around this average (in most years). For 1983/84 (Approved Estimates), of the total for Preventive Medicine and Promotive Health, only about 26% was allocated to "325 Communicable and Vector-Borne Diseases" (or about 1.4% of the total MOH recurrent budget in that year). It is worth reporting in this context that, on a recent visit to health facilities in Kisii and environs, all hospitals, public and private, reported that malaria was the number-one

diagnosis being admitted. At the same time, there appeared to be little or no malaria-control activity in the area, a circumstance possibly owing to the meagre budgetary provision for vector-borne diseases. In any event, in this area, it may well be that a stepped-up malaria-control program could make an important contribution to improving the health status of the population.

The budget data reviewed foregoing suggest that Kenya shares with many other LDCs a recurrent-cost problem which, indeed, appears to be almost ubiquitous--namely, the relatively generous funding afforded MOH hospital services which contrasts sharply with the relatively meagre funding afforded the rural health services and the preventive/promotive activities. We must recognize that, of course, the entire MOH program is severely resource constrained such that for every program, including hospital services, resources are scarce relative to "need" and relative to the many worthwhile claims that might be made upon them. We can never hope, e.g., as by shifting program shares in the budget, to eliminate scarcity in this sense--it is simply a fact of economic life, especially in LDCs. Moreover, it would require considerable analysis to determine in any very precise way what proportion of the MOH budget should go for hospital services and what for rural health and preventive/promotive services.*/ And, the policy decision with respect to these relative

*/ The analysis would seek to determine the health-status consequences of resource shifts on the margin between each of the hospital programs and each of the rural health and preventive/promotive programs. Needless to say, given data availabilities and the state of the analytic art in this domain, it is much easier to sketch this analytic format than it would be to carry out the analysis in any meaningful way.

shares would have to be informed not only by the findings from the analysis but also by social and political preferences over outcomes--the question how much for "rescue" (curative services) vs. how much for prevention/promotion is not just (or, perhaps, even in the main) a "technical" question.

The foregoing disclaimers notwithstanding, it is hard to escape the conclusion that the rural health services and preventive/promotive services are relatively underfunded. On a per capita basis, for the roughly 80% of the population living in the rural areas, the 1983/84 Approved Estimate for Rural Health Services would provide about KSh 8.6 per year (or, about 60¢ at current exchange rates).*/ Of course, the rural health services do not reach the entire rural population but rather something like, say, 30% of that population.**/ For those persons reached, the budget for Rural Health Services would provide about KSh 28.4 per person per year--of which the drug budget (Item 151) would provide about KSh. 6.0 per person covered per year (seemingly a lean provision in light of the cost of drugs and medications). On a per capita basis for the rural population as a whole, this drug budget works out to about KSh 1.8 per person per year.

*/ I recognize that some residents of rural areas will obtain some services from hospitals. More generally, the budget as exhibited in the Estimates is organized along administrative-program lines rather than functional-program lines--thus, not all curative output is in the program "Curative Health," not all prevention/promotion in the program "Preventive Medicine and Promotive Health", and so on. I doubt, however, that the findings from program budgeting along service-output or functional lines (an exercise I do not have time to undertake) would significantly alter the picture presented in my discussion.

**/ See Dr. W. Koinange, "Health Strategy for Kenya," 1982 (MOH, Republic of Kenya), p. 1. Henceforth, Koinange 1982.

In light of the foregoing discussion, it is, at least, not at all surprising to find that the informed opinion in Kenya is that the rate of resource allocation to rural health and preventive/promotive services is now too small relative to the rate of resource allocation for secondary and tertiary services. Thus, Dr. Koinange, Director of Medical Services, has recently expressed the views (1982, pp. 3-4 and 12-13):

Our Nation's health resources, both public and private, are disproportionately allocated to our urban as compared with our non-urban areas . . . now is the time to make a firm commitment to correct this imbalance in the distribution of health resources.

And, remarking that many of the common diseases and illnesses could be prevented, Dr. Koinange stresses that:

. . . high priority must be placed on preventive and promotive health measures in the implementation of future health programmes Preventive measures are particularly important in connection with many of our vector borne diseases Expanded efforts must be made in areas of basic sanitation improving the quality of water supplies and other public health prevention and promotion.

Thus, the "redirection" of the health-services system in Kenya called for by Dr. Koinange would feature relatively more resources for rural health and preventive/promotive health services and relatively less resources for urban-based secondary and tertiary care. This implies a higher proportion of the MOH recurrent budget for the former and a smaller proportion for the latter. Is such a change likely to be implemented? If so, when and on what scale? Only time can supply the answer to these question. The 1984-1988 Development Plan does appear to make some modest moves in this direction. The Proposed Budgets for 1985/86-1987/88 set the Acct.

111 "Curative Health" at an average of 63.2% of the total budget, about 5% less than the average share for Hospitals in the preceding seven years. The Proposed Budgets set the Acct. 112 "Preventive Medicine and Promotive Health" share at almost precisely its historical level of 5.5%--thus this part of the budget does not appear to be in line with the "redirection" called for by Dr. Koinange. On the other hand, the Proposed Budgets for Acct. 113 "Rural Health" are set at an average of 10.4% for the period 1985/86-1987/88--a somewhat higher percentage than the average of 9.4% over the preceding seven years. Of course, it remains to be seen whether the budgets proposed by the 1984/86-1987/88 Plan will in point of fact be implemented. The historical stability of the MOH budget in terms of the relative allocation of resources among the various programs has been remarked and is a factor which does not lead one to be sanguine about the prospects for implementation of the proposed budgets.

And even if these proposals were implemented, the movement in the direction of recruiting more adequate resources for prevention/promotion and rural health would be modest in the extreme--indeed, miniscule. As has been pointed out, the current Development Plan for health proposes an increase in the MOH budget in real terms of about 4.0% on average in each of the years 1984/85-1987/88. If realized, the budget would thus just about keep up with the anticipated population growth rate. Suppose that the policy makers wanted to "gain on" the population--say, to completely cover the

rural population by the year 2000 with the same level of service now provided to the 30% or so of those now covered. A very rough calculation suggests that this would require an increase in the budget for Rural Health Services on the order of 11.0% (in real terms) on average in each year over the period between now and the year 2000.*/ Put another way, the 1983/84 Rural Health Services budget of about KL 6.5 million would have to grow to KL 34.5 million (in 1983/84 prices) by the year 2000. Any such growth rate would of course represent a torrid pace indeed as compared with the historical track record. And even then, no provision would have been made for improving the quantity and quality of services for each of the individuals.

What I have termed "the recurrent-cost problem" could be characterized in many ways in addition to those presented foregoing. For example, without exception, those in government health facilities with whom I have discussed these matters contend that they experience severe inadequacies in the level of recurrent-cost funding, leading to shortages of essential supplies including medications, inadequate maintenance of plant and chronic non-functioning and malfunctioning of equipment. (Of course, some of these problems are exacerbated by problems in addition to inadequate funding per se, e.g., problems with supply logistics.)

*/ This rough calculation does not attempt to adjust for increasing urbanization over the interval, etc. My intention is just to convey general orders of magnitude to give a more realistic apprehension of recurrent funding requirements in the future than would otherwise obtain.

There is no need further to rehearse these problems to make the point. I find it hard to escape the conclusion that, both for the near term and for the longer term, the prospects for recruiting adequate resources for government preventive/promotive and rural programs are remote indeed--so long as the system for financing government health services remains as it is, i.e., with virtually sole reliance upon general tax revenues. If, on the other hand, ways can be found to implement alternative financing schemes, to tap sources of revenue for government health services in addition to general tax revenues, then the prospects for adequate rates of recurrent cost funding will be much brighter. In my view, and as will be explained in what follows, the most promising strategy to recruit adequate resources for preventive/promotive services and rural programs will be to implement a fee scheme for certain government hospital inpatient services, seeking in this way to recover a significant proportion of the cost of these services (which, as we have seen, now claim the lion's share of the MOH budget). Significant private financing of the demand for these services should facilitate diversion of scarce public funding from the hospital sector to preventive/promotive and rural health programs. An additional, major benefit of implementing a fee scheme for government hospitals is that it will facilitate developing institutional formats such that improvements in the efficiency of facility management can be expected. All of these matters will be discussed at some length in what follows.

The Public-Private Mix in the Health Services Sector: Hospital Services

Public policy with respect to developing health services in Kenya must take account of both the public and private components, seeking to develop complementary relationships between the two.

Table III on the following page exhibits the bed capacity of the various categories of hospitals which make up the hospital sector in Kenya. As the Table shows, of total beds (1982/83) of 23,554--56.2% are government, 43.8% non-government. If we assume a 1983 population of, say, 18 million, the bed/population ratio works out to about 1.3 beds/population. Various considerations suggest that this may be a fairly adequate bed/population ratio in Kenya, if the facilities are run efficiently and with sufficient funding for operating and maintenance expense to enable them to deliver inpatient services of reasonable quality.*/ By way of comparison, in terms of inpatient utilization rates, perhaps the leanest delivery setting in the U.S. is comprised of the Kaiser-Permanente Health Plans (K-P). The K-P Plans get by with on

*/ This evaluation neglects the problem of maldistribution of hospital capacity. See MOH Development Plan 1984-1988, page 7, Table 3, which points out that the bed ratio varies between a high of 4.5 for Nairobi to a low of 0.53 for N. Eastern province. The catchment area (market) for the hospitals in Nairobi is, of course, much larger than just the population of the province--thus the bed to population-served ratio is much less than that exhibited in Table 3. Nevertheless, there is a problem with geographic maldistribution of beds.

The contingent ". . . if . . ." is very important. A mere bed count does not really measure the capacity of the hospital sector to deliver services--since the bed is, of course, just one input among many in the production function for hospital services. As matters stand, shortfalls in funding for operating expense severely impair the capacity of many government hospitals to deliver services of desirable quality.

TABLE III

Public-Private Distribution of Hospital Beds 1982/83

| <u>Category</u> | <u>No. Beds*/</u> | <u>% of Total</u> | |
|--|-------------------|-------------------|--------|
| Government <u>1/</u> | 13,231 | 56.2 | |
| Church <u>2/</u> | 7,835 | 33.3 | } 43.8 |
| Private (Major nonprofit) <u>3/</u> | 717 | 3.0 | |
| Private (Nursing/Maternity Hospital) <u>4/</u> | <u>1,771</u> | <u>7.5</u> | |
| Total | 23,554 | 100.0 | |

*/ My understanding is that the government bed count includes "cots", hence these have been included where shown separately in some of the data for Church hospitals. These are, in any event, a very small part of the total beds.

1/ From Ministry of Health, Development Plan 1984-1988, p. 7, Table 3.

2/ From Protestant Churches Medical Association, Annual Statistical Return 1982/83 and Kenya Catholic Secretariat, Medical Department, Statistics of Facilities/Staff/Services, 1982.

3/ These are the Nairobi Hospitals, Aga Khan, M. P. Shah, Nairobi, Mater and Gertrude. Information from Aga Khan.

4/ Information from NHIF. This is the number of beds in this class of facilities "approved" for reimbursement by the NHIF--consequently it probably understates the total number of beds in this class of facility, i.e., approved and not approved.

the order of 2.0 beds/1,000 population served.*/ In the U.S., the older members of the population are the major utilizers of inpatient hospital services, and one might expect more generally to find this to be the case. Thus, by the comparison with K-P, considering the differences in the age distribution of the population between the U.S. and Kenya, the Kenya ratio of 1.3/1,000 appears pretty satisfactory. It is true that the government hospitals in Kenya tend to run at 100%-plus occupancy rates, with crowded facilities, long waiting times, and queues--that is, evidence of shortage of services. This is one kind of evidence of a shortfall in hospital capacity. However, investigations in the field suggest that in important part this may be owing to inefficiency in the way in which resources are being deployed in Kenya. Thus, a major part of the inpatient case load in a number of hospitals visited appears to be owing to health problems which could have been prevented with proper attention to preventive/promotive activities. Obviously, argument of the foregoing kind cannot be regarded as decisive for the question whether there is sufficient hospital inpatient capacity. Nevertheless, this kind of argument can, perhaps, make it reasonable to shift the burden of proof to those who would contend that priority in the allocation of scarce resources for health should be accorded to additional hospital capacity.

Unlike most government hospitals, the non-government hospitals, all

*/The K-P Health Plans feature pre-paid group practice (so-called, health maintenance organizations (HMOs) in current terminology). The fee-for-service sector of the U.S. health-services system exhibits much higher inpatient utilization rates than does K-P and much higher bed/population ratios. The old Hill-Burton standard regarded a bed/population ratio below about 4.5/1,000 as being under-bedded.

of which charge fees for services provided, do not run at full capacity. For example, the five Nairobi hospitals (see Table II, note 3) in the aggregate had a 1983 occupancy rate of only 57.0%, down from about 70.0% in 1980.*/ For 1983, the Catholic Church hospitals (those with resident doctors) in the aggregate had an occupancy rate of about 66.0%. The Protestant Church Hospitals (those with resident doctors) in the aggregate in 1983 had an occupancy rate of about 82.0%. Kisii Maternity and Nursing Hospital currently has an occupancy rate of about 60% (although it is expanding capacity in anticipation of future increases in demand) and my impression is that facilities of this type generally have similar occupancy rates. Thus it would appear that, generally speaking, the non-government hospital sector is running with what might be regarded as some excess capacity.

The capacity of the non-government hospital sector is potentially important from the point of view of national health-sector policy. Generally speaking, what the government needs to do or should do about the provision of health services depends upon the non-government alternatives available to consumers. More particularly, increases in private-sector hospital capacity will reduce the need for government hospital capacity which now takes the biggest share of the government health budget. Such a development enhances the prospect for more adequate

*/ These hospitals had 1983 patient days of 1150,170 compared with 1980 patient days of 182,885--a decline attributed to the impact of inflation and recession. (Data furnished by Aga Khan Hospital.) It appears that these hospitals are in a competitive relationship in the sense that increases in the market share of one or more means declines in the market share of others.

public financing of preventive/promotive services and basic rural health services.

Cooperative relationships between the private sector hospitals and the MOH include a program Acct. 340 "Grants to Church and Private Hospitals." These grants as a percent of the total MOH gross recurrent budget have varied little over recent years, viz: 1980/81 (actuals) 2.9%; 1981/82 (actuals) 2.8%; 1982/83 (Approved Estimates) 3.1%; 1983/84 (Approved Estimates) 3.4%; 1984/85 (Estimates) 3.0%. It appears that these government grants represent a very different percentage of the operating costs of the church hospitals who receive them. Information from the Protestant Churches Medical Association for four of their hospitals shows this percentage to range between 15% and 36%. What the logic of this distribution is I do not know. In any event, it might well pay the MOH to undertake some systematic study of this grant program with an eye to such questions as the relative efficiency of this kind of expenditure by the MOH in helping to make hospital services available to the public vs. direct expenditure by the MOH to field these services provided by the government hospitals. Additional kinds of cooperative relationships between the MOH and these hospitals might also be explored. Thus, for example, in rural areas where mission hospitals are located but government hospitals are not, it might make sense for the MOH to have a program to reimburse the mission hospitals for serving medically indigent patients on a fee for such service basis.

The Public-Private Mix: The Drug Sector

Drugs and medications and related items (Estimates Acct. 151, "Medical Stores, Sera and Vaccines") is a major item of expenditure for the MOH and in various ways a troublesome one. The 151 budget allocations are distributed to the various Heads in Estimates, i.e., not aggregated. Aggregating them reveals that, in terms of Actual Expenditures for the years 1977/78-1981/82, allocations to Acct. 151 have been in each of these years almost precisely the same 20% of the total gross recurrent budget for the MOH. A troublesome feature of the drug budget is revealed when we compare the Actual Expenditures in each of several years with the Approved Estimates for those same years, viz.:

TABLE IV

Acct. 151 - Medical Stores, Sera, Vaccines

| (1) <u>Year</u> | (2) <u>Approved Estimate</u> KL 000 | (3) <u>Actual Expenditure</u> KL 000 | (4) (3)/(2) |
|--------------------|---|--|----------------|
| 1981/82 | 9,581 | 11,272 | 1.18 |
| 1980/81 | 7,574 | 10,611 | 1.40 |
| 1979/80 | 6,194 | 8,975 | 1.45 |
| 1978//79 | 5,439 | 7,240 | 1.33 |
| 1977/78 | 3,728 | 5,723 | 1.54 |

Source: The Appropriation Accounts for these years.

On average over this period, Actual Expenditures on drugs and related items were 1.38 times the Approved Estimates. How is the

difference between the actual expenditures and the approved estimates financed? I am told that the government facilities go into debt to acquire drugs urgently needed for their patients but which have not been obtainable from the Central Medical Stores (CMS). And, I am told, ex post these transactions, the treasury and the legislature approve these expenditures. Currently, as in years past, there is much talk about budget discipline with respect to these expenditures, a firmly expressed intent to hold expenditures for drugs to the approved estimate. It would appear from the track record that, if this should actually happen, the "drug crunch" which characterizes the performance of the government health-services sector would become yet more severe.

The "drug crunch," ubiquitous acute relative scarcities, shortages and stock-outs of drugs and medications, is among the more serious malfunctions in the performance of the government health services system. Drug shortages in the government health centres and dispensaries drive patients to patronize the mission clinics and the OPDs of the district hospitals, in turn overloading these facilities.*/ The hospitals themselves experience severe drug shortages, frequently failing to have in stock for long periods of time common drugs essential for the treat-

*/ Patients must often travel long distances to reach district hospitals, paying a high cost in terms of time and effort. According to Mwabu (1984), based upon his survey research:

". . . patients perceive high quality facilities to be the mission clinics and government hospitals. The single most important aspect of quality in these facilities, however, is the availability of medicines and drugs The health care providers in the study area said that the greatest problems they had was . . . the lack of drugs to treat the illnesses that were brought to the clinic. (P. 177)

ment of their patients.*/

To what is this situation owing? In part, it may simply reflect the fact that, given many competing claims on scarce resources, not very much can be budgeted for drugs. As noted earlier in this section, the 1983/84 Approved Estimate for rural health services would provide a drug budget (Item 151) of only about KSh 6.0 per person per year for the 30% of the rural population estimated to be reached by these facilities. (On a per capita basis for the rural population as a whole, this drug budget works out to a lean KSh 1.8 per person per year.) In the case of government hospitals, the 151 provision for drugs and related supplies is likewise lean, but perhaps less so. For example, roughly estimated, for 1981/82 it would appear that for the district hospitals the 151 budget would work out to about KSh 24.0 per patient day. For KNH the analogous figure is about KSh 50.0.**/ By way of comparison, it is my understanding that Nairobi Hospital finds a flat charge to inpatients for drugs of KSh 50.0 per day (i.e., the same charge to all such patients, whatever the drug utilization of each) will about cover the cost of inpatient drugs.

*/ Even KNH has formidable problems on this score. In a recent Drug Information memo from the out-patient pharmacy to psychiatry and neurology clinic, of the 45 pharmaceuticals listed as ". . . usually stocked in this pharmacy . . .", only 17 were at that time actually in stock. My understanding is that this is not an atypical situation for KNH.

It appears that one consequence of severe drug shortages is to cause physicians to prescribe not what, in their judgment, the patients actually need, but rather, whatever happens to be available in the hospital pharmacy that day.

**/ These calculations assume a 100% occupancy rate for the district hospitals, the actual occupancy rate for KNH and that .75 of the 151 budget is for inpatients.

Considering that, presumably, the drugs purchased by Nairobi Hospital include trade markups not reflected in the prices of the drugs acquired by the CMS for the government facilities, this would suggest that KNH, at least, should have a fairly adequate drug budget.

The drug problems in the government health services may also reflect other kinds of malfunction. For example, the impression is widespread that there is considerable "leakage" (pilferage) of government drugs, some of these finding their way into the private market, some into the private stores of individuals. In addition, the sheer "logistics" of the government acquisition and distribution system in which the CMS has, historically, played the central role, has been a major source of difficulty.

The problems adduced foregoing are commonly recognized and efforts are underway to remedy the position. As I understand it, in the past, the 151 allocations were all aggregated in a central "control account" with the CMS, such that the CMS spent these allocations on behalf, so to speak, of the actual A.I.E. holders. The latter ordered from the CMS, frequently without knowing or being able to find out just what remained in their 151 budgets. The CMS was responsible for the physical distribution of the drugs. A new system is now said to be in place. Under this system, drugs are divided into two categories. One--drugs commonly used in volume. Two--more specialized drugs with lower-volume demand. For category one, the CMS will negotiate a price list with a local supplier, but it will be up to the facilities to place their order with that supplier (i.e., they will now manage their own A.I.E.'s) and it

will be up to the facilities and the supplier to agree upon the financing and mode of physical distribution of the commodities. For category two, the facilities will go to the open market, dealing with local manufacturers or the local agents of overseas firms. Again, arranging for distribution will be up to the parties. The CMS will go out of the business of stockpiling drugs and will go out of the business of the physical distribution of drugs.

In many ways this new system represents a considerable improvement over the old system. For the CMS to go out of the drug stockpiling and physical distribution business is surely a step in the right direction, as is permitting the actual A.I.E. holders to exercise this authority and to go to the open market. One large advantage for the facilities dealing with the market is that they ought to be able to negotiate for timely delivery of the commodities they actually order. (Under the old system, the facilities got from the CMS whatever happened to be in stock, rather than what they ordered--the delivery was far from timely--these, it may be noted, being characteristics of central government drug acquisition and distribution systems in many countries where they operate.)

The major problems with the new system appear to be with respect to the category one drugs. For one thing, it appears to be far from clear to those in the facilities in the field just what this part of the system is to be. The fear is that the supplier with whom the CMS negotiates the price list will turn out to be a sole source of supply exercising monopoly power such that many of the advantages of the facilities being able to negotiate directly with their supplier for timely delivery and

the like will be negated. It is important to stress that, if the new system is to be of substantial benefit to the facilities, there must be competition on the supply side of the market--it is this which gives the facilities the bargaining power they need in these markets.*/ It appears that several factors may militate against this approach for the category one drugs. One is an understandable desire to encourage local industry. The other is, I am told, that a plan is afoot to "emboss" government drugs (not just the containers they come in) with some kind of special symbol, this in an effort to cut down on pilferage and the flow of these drugs into the private market. It is thought that this makes it necessary to deal with only one supplier for each of these "embossed" drugs. Whether such an approach is apt to be effective I do not know. If, however, a necessary consequence of this approach is to eliminate the possibility of competition on the supply side of this market, the approach will be paying a very high price indeed.

In addition to government purchase of drugs, there is also a substantial private market for drugs in Kenya. According to the Statistical Abstract, 1983--for 1982, imports of medicinal and pharmaceutical products were valued (c.i.f.) at KL 18,361,000 while, on a similar value basis, the government 151 budget came to about KL 10,371,000--or approximately 56% of the imports, leaving 44% to be moved through private

*/ Representatives (detail men) of private drug companies operating in Kenya have told me that competition in this market place is in fact keen.

markets.*/

The foregoing has been a rather brief and not very comprehensive treatment of the drug sector--perhaps, enough, however to suggest that this is a sector that warrants prompt and serious study by the GOK. In particular, now that efforts are underway to improve the functioning of the system, every effort should be made to insure that the new arrangements which are adopted will in fact represent genuine solutions for the underlying problems.

The Public-Private Mix: Other Sectors

I cannot herein undertake a comprehensive account of the "mix" across all sectors. I have dealt in the main with the hospital sector and the drug sector from this point of view since these sectors are most immediately relevant to my immediate purposes in this report. It may be remarked in passing that, if in addition to the sizeable private components of the hospital and drug sectors, one takes into account that approximately 70% of the physicians in the country work exclusively in the private sector (while many government physicians, particularly the specialists, have substantial private practices also), it is apparent that the private

*/ I have been told that this kind of calculation understates the government's share of the domestic drug market because a good bit of the imported commodities are re-exported. The data don't confirm this however. Thus for 1981 (see Annual Trade Report for year ended Dec. 1981) re-exports of medicinal and pharmaceutical products is reported as only KL 168,078. The foregoing calculations neglect the domestic drug manufacturing industry (which, as I understand it, mainly packages imported pharmaceuticals and/or processes imported fine chemicals). In 1981, domestic exports were valued at KL 3.7 million, some part of which represents, presumably, the value of imported commodities.

health-services sector in Kenya represents a very substantial part of the total health-services sector, even if one does not count the traditional healers who are no doubt the most numerous primary providers in the country.

FEES FOR GOVERNMENT HEALTH SERVICES: GENERAL POLICY CONSIDERATIONS

Existing Fee Schemes

As matters now stand in Kenya, visits to government health centres and dispensaries and to the OPDs of government hospitals are free of any user charges (fees). Inpatient services at government hospitals are free of user charge to those patients 16 years of age and under. Adult inpatients in government hospitals are supposed to pay an admission charge of KSh 20/- and there are other assorted small charges (e.g., KSh 60/- for maternity patients, for some x-rays, for prosthetic devices, etc.). There are a few beds in government hospitals in so-called "amenity wards" for which a fee of KSh 30/- is supposed to be charged (KSh 40/- in Kenyatta National Hospital).*/

The existing fee scheme for government health services might be regarded as important "in principle"--i.e., it established the principle (legitimacy) of such fees. However, in terms of recovering the cost of these services, the existing fees have very little significance. For example, for 1981/82 (actual expenditure), the revenues collected under Appropriations in Aid amounted to only about 2.0% of the MOH budget in that year (other years show about the same). Also for example, for

*/ Developing policy for the amenity wards presents some special problems analysis of which will be found in a separate section of this report.

The fees for government-provided health services mentioned in the text are for what might be regarded as direct services. There are various other kinds of fees, e.g., for registration of drugs, rents for institutional houses, sale of health education materials, various lab and license fees, boarding fees for students, and a few others. Expectations for revenues from these various fees (and actual receipts when the information is in) are accounted for in the Estimates and The Appropriation Accounts . . . under account title "Appropriations in Aid."

1981/82 (actual expenditure), for Kenyetta National Hospital, revenue from fees amounted to only about 1.3% of the total expenditure, similar results obtain for other years.

Proposals to Increase Fees for Government Health Services and the Question of Equity

Proposals to increase fees charged for government health services have recently been put forward in several quarters. Ministry of Health, Development Plan 1984-1988 provides (pp. 19-20):

.

iii) Amenity Wards: During the plan period amenity wards will be established in all Provincial Hospitals and existing ones will be improved.

A fee will be charged to patients in amenity wards, commensurate with the services rendered.

iv) Selective charges for Hospital Out-Patient and In-Patient Medical Services: The Government has already established fixed nominal charges for inpatient services. Selective daily charges in line with the level of care provided will be introduced during the plan period. Measures will also be taken to introduce nominal selective charges for out-patient services in Government hospitals.

The overall Development Plan 1984-1988 reflects these provisions of the MOH development plan, itself providing (pp. 153-154): 6.119 Increase alternative financing mechanisms In view of the rising cost of providing good quality medical care, a variety of approaches have emerged as having the potential for directly or indirectly extending government's financial capacity to provide services. Notable among these are:

.

iii) Establishment and improvement of amenity wards.

- iv) Selective charges for hospital, out-patient and in-patient medical services.

In Ch. 2, Strategy for Future Development, Development Plan 1984-1988 lays down a more general framework of which the treatment of fees for government hospital services may be regarded as one case among others. Thus, on p. 38 we find:

"2.4 In addition to providing essential services and basic needs, it is the responsibility of Government:

.

- ii) to improve the quality and distribution of its services by sharing the cost of existing services with those who benefit,

. . . "

And, on p. 39 we find:

"2.8 . . . But the critical problem which must be addressed successfully during this Plan period is 'mobilizing domestic resources for equitable development.' That is the theme of this Plan "

Two years ago, an influential report, the Ndegwa Committee Report, called for increased consumer cost sharing for government services, viz., (pp. 20-21):*/

"Sharing the Costs of Services with those who Benefit

65. The Working Party is also concerned that many people throughout the nation are deprived of essential social and economic services and that improvements in the quality of many services are urgently needed Government should also expect as a matter of equity

*/ See REPORT AND RECOMMENDATIONS OF THE WORKING PARTY, Working Party on Government Expenditures, Chairman Philip Ndegwa, July 1982. Henceforth, Ndegwa Comm. Rep. 1982.

that those who are now benefiting from Government services should pay a higher share of the costs. This will increase Government funds which can be used to finance improvements in quality and the extension of services to new areas.

66. The arguments for cost sharing are two-fold. First, those who receive social and economic services are clearly better off than those who do not. If, through their payments of a share of the costs, services can then be extended to others, significant progress towards universal coverage can be attained. Second, per capita income has risen substantially since independence and most families are now better off. As incomes rise more people can, and, again as a matter of equity, should pay a larger portion of the costs of the services from which they benefit.

67. As examples of the application of this principle, the Working Party suggests that:

.

- v) the Working Party believes that the principles of equitable cost sharing should be applied more widely to such services as health care . . . "

As is clear from the foregoing, both the Ndegwa Committee Report and the Development Plan 1984-1988 urge greater consumer cost sharing for government-provided services. This is set out as a general principle or policy, an example of the application of which would be increased fees for government health services. In discussing these matters in the field with individuals in the health-services community, including those at various levels in the Ministry of Health and its facilities, I have found virtually unanimous agreement with the proposition that there should be increased reliance on private financing of the demand for government-provided health services, i.e., increased consumer cost sharing through the implementation of appropriate fee schedules. Many believe that it is only a matter of time until this policy is adopted. For reasons that have been set out in the quotations foregoing, and for reasons that will subsequently be spelled out in this report, I would join with those who urge adoption of the policy of cost sharing for government health

services by implementing appropriate fee schedules.

If the Government of Kenya is to embark upon significant consumer cost sharing (fees) for Government health services, it is, in my view, of central importance to be aware that, as these schemes are usually designed, the probability is very low that they will achieve the objectives which have motivated resort to them. If these schemes are to function, it will be necessary to go beyond the implementation of fees, per se. Institution building, which in some instances will entail departures from current fiscal and budgeting procedures, will be required to provide an appropriate organization context. It is also, in my view, of central importance to be aware that, with proper attention to organization format, the implementation of fees for government health services may provide an opportunity which would not otherwise be available to improve the efficiency of the public health service, to improve the quality of services provided by it, and to in other ways rationalize the health sector financing system.

In what follows in this report, the foregoing propositions will be elucidated.

Fees for Government Health Services as an Instrument of General Fiscal Policy

It will be well to attend initially to this policy question. As matters stand in Kenya, revenue from fees for government health services reverts to the exchequer as would the revenue from any additional, increased fees. Under this arrangement, these fees are to be evaluated as

an instrument of general fiscal policy. Looked at from this point of view, these fees are best regarded as an extremely low yield, inefficient tax--and as such, they make little or no sense.

As noted previously, for 1981/82 (actuals) revenues collected from various fees amounted to only about 2.0% of the MOH budget in that year. As Table I shows, the MOH budget was about 7.2% of total government recurrent expenditure in that year. Consequently, the revenue collected from the various fees represented only about 0.14% (i.e., 14//100 of one percent) of total government recurrent expenditure--a miniscule contribution to the exchequer.

Upgrading the fees might, of course, be expected to raise more revenue. Let us suppose that by implementing such a scheme we were able to recover, say, half the amount budgeted for hospitals, i.e., recover what would be about 34% of the total MOH budget in recent years. This would represent only about 2.0% of the total government recurrent budget in recent years, a modest contribution to the exchequer. However, the hypothesized revenue yield, modest as it is, probably greatly overstates what can be expected from fees for government health services--so long as these revenues revert to the exchequer. There are several reasons for this. For one, my findings in the field in various countries including Kenya have been that, without exception, those on the ground (hospital administrators, medical officers) who would be responsible for administering any such fee scheme exhibit very little enthusiasm for it unless the arrangement permits the facilities marketing the services to keep this revenue (to be used by the facility within suitable guide-

lines). If these individuals are not prepared to undertake this demanding (and frequently onerous) task in a whole-hearted, vigorous way, the fee scheme will not in any event fly, very little revenue can be anticipated from it. Also, usually, an improvement in the quality of services provided by the MOH delivery system will be necessary for successful administration of the fee scheme, e.g., to encourage enough consumer satisfaction to facilitate collections. And, in turn, usually, retention of fee revenue by the facilities marketing the services is probably a necessary condition for the necessary improvements in quality. (This matter is elucidated subsequently.) Thus, by this route too, retention of fee revenue by the facilities marketing the services is a condition necessary for a significant revenue yield from such schemes.*/

*/ It would be of some relevance in this context to have the findings from an investigation of the current experience with collections under the existing scheme for hospital fees, e.g., KSh 20/- per admit, etc. I have not had time to conduct such an investigation, however. Estimates and Appropriation Accounts report these revenues as "610 Hospital and X-ray Fees" (an Appropriations in Aid account). To disaggregate this account one might go to individual hospital records to determine, e.g., how much was for admits, how much for maternity, how much for X-rays, etc., in order to compare the findings with data on the service output of the facility. -I did look into this matter for Kenyatta National Hospital. There, the original record of these receipts are entries in what is known as the "Duplicate Cash Book." Going through these books might enable an investigator to assemble an account of these receipts by category of service output. It appears that each week a "Receipt Voucher" is sent to the MOH which, I understand, reports the Cash Book entries assembled by account number, i.e., by category of service output. Hence, consulting these vouchers might be another way to assemble this information. In any event, I did not have time to pursue these avenues.

I may report that my general impression, both from scanning the Kenyatta records and from conversations in the field, is that a rather small percentage of the KSh 20/- admission fees for adults is actually being collected.

And, in evaluating fees for government health services as an instrument of general fiscal policy, it should be kept in mind that such fee schemes are probably relatively inefficient taxes to raise the small amounts of revenue they can be expected to raise. The cost of administering the scheme (including resources committed to the collection machinery) can be expected to be relatively high per unit of revenue realized.

In my view, the government of Kenya would have little or nothing to lose by abandoning the policy of regarding fees for government-provided health services as an instrument of general fiscal policy. Rather, the facilities marketing the services should be allowed to retain the revenue from such fees--this to be utilized for the benefit of the facilities, within suitable guidelines. Such a change of policy could be expected to bring with it substantial benefits in the form of increased efficiency of government delivery systems. We may now turn to an elucidation of this matter, assuming from now on in this discussion that revenue from fees for government health services reverts to the facilities marketing the services.

FEES FOR GOVERNMENT HOSPITAL SERVICES: THE ORGANIZATION FORMAT

Introduction

In my view, if fees for government-provided health services are to be implemented, it is most appropriate that inpatient hospital services be marketed in this way rather than preventive/promotive services or even outpatient curative services whether delivered at a health centre or a hospital. The reasons for this position will be spelled out in the next section. Meanwhile, this section will deal with fees for government hospital services.

Fees and the Quality of Government Health Services

That these phenomena are intimately related has been recognized in some countries where plans are underway to implement fees for government health services. Thus, Pakistan's Sixth Plan, in stressing that the aim of the Sixth Plan is to improve the quality of government provided health-services, remarks:

This is also considered necessary so that beneficiaries, subsequently, are not reluctant to pay charges for services utilized. It will be difficult to introduce user charges in the beginning, as nobody will be prepared to pay for poor services. The system must function efficiently and provide quality services before charging people.

It is my impression from observations and discussions of these matters with respondents in the field that, generally speaking, a similar kind of problem may exist in the government hospital sector in Kenya. For example, the quality of services delivered in government hospitals appears to be adversely affected by shortages of important medications and supplies, the malfunction or non-function of important diagnostic and

therapeutic equipment, crowding owing to space shortage, and other factors.*/ If Kenya is to implement fees for government hospital services, it is crucial to recognize this relationship. It is equally important to recognize that the relationship also runs the other way. Not only are quality services necessary to support a workable fee scheme, but the institution of fees is (probably) a necessary (if not also sufficient) condition for achieving efficient performance of government hospitals and, as a part of this, the production by them of quality services. Thus, the "fees-efficiency connection" is a package of generally interdependent elements.

A major reason for this interdependency inheres in the role played by incentives in securing efficient performance. The efficiency with which any organization performs depends upon various factors, e.g., the skills of the organizations planners, managers, administrators and other members of the work force. However, the most crucial factor is the incentive system. Whatever their skills, unless the members of the organization have incentives to motivate efficient performance, efficient performance cannot be expected. That the MOH system in Kenya (as in many other countries) confronts problems on this score is a proposition with which most respondents here with whom I have discussed these matters

*/ Kenyatta National Hospital may in a sense have a lesser problem on this score than other government facilities. Thus, KNH appears to enjoy a general reputation for high quality services, it being noted, for example, that the specialists on the KNH staff are the same individuals who provide such services to hospitals such as the Aga Khan and Nairobi. At the same time there appears to be general agreement among informed individuals with whom I have discussed this matter that, from an efficiency point of view, KNH is not now working up to anything like its full potential.

agree.

From an incentive point of view, the government health services operate with a singular disadvantage. Financed by general tax revenues and providing a product (virtually) free of charge, there is no market link to consumers that makes it necessary for the survival of the organization to market an acceptable product. Absent this kind of discipline as an incentive to keep product quality up and costs down, effective substitute incentives must be devised. As commonly is recognized, this is not easy to do.

Moreover, even if managers have the requisite skills and motivation to attempt to achieve effective organization performance, it won't result unless they control incentives to motivate the performance of those they are attempting to direct. In the government health services, the nature of public-service personnel policy militates against the capacity of even skilled, motivated managers to manage effectively.

It is at this point that the implementation of fee schemes for government hospital services provides an opportunity which could not otherwise be provided. This is so because fees are a necessary, central element in the design of organization formats such that the management of government hospitals will be at risk for success and at risk for failure. These are formats under which good management, e.g., assiduous attention to cost containment and to marketing a high quality product, can result in a budget surplus which can be used (under suitable oversight and regulation) to improve the situation for the hospital and its staff, including, of course, the managers themselves. And under which sloppy

management can result in budget deficits for which hospital management can be held responsible in some meaningful way. Organization formats which will exhibit these properties can be designed around the institution of so-called "prospective budgeting."*/

Operating at risk for success and for failure, such that the hospital management and staff stand to gain from the former and lose from the latter, they are provided an incentive to seek efficiency in the conduct of the business of the hospital. In addition, the thus motivated managers will need enough directive management "elbow room" (especially with respect to personnel policy) to in fact be able to manage. In Kenya, operating the hospital with a statutory board (as a so-called parastatal) is an organization strategy which might facilitate this. As should be clear from the foregoing discussion, retention of fee revenue

*/ University Hospital in Jamaica is an example of this format. It is operated as a semi-autonomous unit (with a statutory board) within the MOH. The hospital is financed by revenues from fees charged to patients and by a grant (subvention) from the MOH. Fee revenue reverts to the hospital, the Board is free to use this revenue in ways it deems appropriate to fulfill the mission of the hospital (although it will be constrained by law with respect to some such matters). Once every three years, the hospital and the MOH negotiate a prospective budget for the coming budget period (based on an estimate of what it will cost to produce the anticipated service output). They also agree on an estimate of the prospective fee revenue. Subtracting the prospective fee revenue from the prospective budget yields the amount of the MOH grant to the hospital.

Under this arrangement, the hospital is at risk for success or failure. Prudent attention to costs may permit holding expenditures below those contemplated by the negotiated prospective budget. And, attention to marketing (collection procedures, customer satisfaction) may permit earning more from fees than the negotiated prospective revenue. Both of these results may give the hospital some net revenue to use pursuant to its mission. On the other hand, of course, inept management on either the cost or revenue side can result in budgetary shortfalls which will preclude the possibility of rewards for the hospital and its staff and may make it necessary to curtail operations in various ways.

by the hospital marketing the services is necessary for exploiting the improved-efficiency potential of implementing a fee scheme for these services. All of these advantages the government must give up if these fees are regarded as an instrument of general fiscal policy with fee revenue reverting to the exchequer (and, as has been pointed out, there would be very little gain to general revenues to offset this opportunity cost).*/

*/ In suggesting that government hospitals with a prospective-budgeting relationship to the MOH might be operated as parastatals, I am aware that there has been recently a good bit of concern over the question of the inefficiency of parastatals in Kenya generally. (See the discussion in the Ndegwa Comm. Rep. 1982, pp. 44 et seq.). It would not make much sense, however, to be "for" or "against" parastatals per se. Presumably, we are concerned with enterprise format because we wish to improve efficiency, i.e., enterprise format is a means to that end. In some instances, a means to that end might be to abandon parastatal organization in favor of regular private-enterprise organization. In other instances, however, a means to that end might be to abandon the regular government-enterprise format in favor of the parastatal format (e.g., as I have suggested in the text discussion for government hospitals).

In any event and in any context, the efficiency with which a parastatal can be expected to operate depends upon the operating rules and procedures including budgeting arrangements. Thus, even though historically, given the prevailing operating rules and procedures, parastatals in Kenya may not have operated efficiently--it might still well be the case that a parastatal format with prospective budgeting for government hospitals would yield far greater efficiency than the regular government-enterprise format. And, at the same time, it might well be that the parastatal format would be much better for achieving the social objectives of the health-services sector than would be a straightforward private-enterprise format. In short, the merits of any given organization format for the government hospitals must be examined in light of their peculiar context and mission. This issue cannot be settled by appeal to some kind of general, all-purpose position on the appropriateness of parastatals.

Steps in Implementing a Fee Scheme for Government Hospitals

Pursuant to actually implementing such a scheme, a number of issues or questions would have to be studied in order to inform the design of the scheme. The answers to some of these questions would turn in large part on general policy considerations. Among such issues and questions would be these: What is the appropriate unit of service to price, e.g., should there be one, inclusive per diem charge, or should there be a schedule of charges for room, diet, investigative services, drugs, etc.? What proportion of the cost of government hospital services should the fee scheme seek to recover? To what extent should the fee scheme be income related? The answers to the last two questions are interdependent with the answer to another, viz.: To what extent should the demand for government hospital services for which a fee is charged be financed by out-of-pocket payments by consumers vs. financed by consumer participation in private social-financing schemes of one kind or another (e.g., prepay schemes, insurance schemes)? Should all of the government hospitals feature the fees/prospective budgeting/parastatal format--or should this format be restricted to just the "major" hospitals, e.g., Kenyatta National Hospital (KNH) and, say, the provincial hospitals? Restricting the scheme might simplify the administration of it while at the same time permitting recovery of a significant proportion of the costs of government hospital services.

Although I will touch upon some of the foregoing questions in what follows, it is not my intention to attempt to engage them in detail. Indeed, until some decision has been made by the GOK with respect to the

acceptability of a fee scheme for government hospitals generally speaking, and until there is a definite intent to implement such a scheme if a suitable one can be devised, there would be little point in undertaking a detailed design.

SOME UNIT COSTS FOR GOVERNMENT HOSPITAL SERVICES: KENYATTA NATIONAL
HOSPITAL (KNH) AND OTHERS

Pursuant to informing initial general judgment about the appropriateness of a fee scheme for government hospitals, it will be helpful to get some idea of the unit costs of government hospital services. This will give us some idea of the fees that would be required to recover given percentages of these costs and hence some idea of the burden that different rates of cost recovery would put upon private payments by consumers. (These consumers are, of course, in the aggregate, already bearing the burden of financing these services through their public tax payments for them.)

I must stress at the outset of this section that the "unit costs" presented here are more "rough and ready" than they are precise, i.e., rough approximations of limited usefulness. For one thing, the units of output selected (on grounds of expediency)--the "patient day" and the "outpatient visit," while useful for some purposes, are not, more generally speaking, conceptually very satisfactory. For example, while gross differences in costs per patient day may imply something about the relative efficiency of the facilities thus compared, such data do not address the efficiency question in a satisfactory way. The observed differences may be owing to differences in the case load (diagnostic categories handled), or to differences in the quality of care, or to other factors rather than to differences in efficiency (measured as output per unit input). And, in any event, a much better unit of output for engaging the efficiency question would be the "episode" of illness--

the "management of a representative case" in each of various diagnostic categories (perhaps on a scheme analogous to the "diagnosis related groups" (DRGs) recently introduced to facilitate prospective budgeting under the Medicare public-insurance program in the U.S.).*/ For management purposes (e.g., the kind of question: "What is the least-cost combination of inputs to secure given health-status outputs?"), it is useful to have unit costs for the various "service centers" or service outputs of the hospital, e.g., investigative procedures, therapeutic procedures and material inputs, etc.

Even for one facility, to assign costs to any of these conceptually more satisfactory units of output would have entailed in investigation far beyond what it was possible to attempt in the time available for this exercise. Indeed, and as will appear from the discussion to follow, even for the output units selected, it was necessary to make do with a few rough estimation procedures.**/

*/ I here suggest DRGs as a useful output unit for unit costing where the interest is in efficiency. I do not mean by this to imply that DRGs should be used as a basis for prospective budgeting under health-insurance schemes in Kenya.

**/ A word of explanation may be in order. I have examined the accounting records of the government hospitals for Kenyatta Nation Hospital (KNH), it is my understanding that their format is representative. The accounting format apparently was designed mainly with an eye to accountability and stewardship for public funds, rather than for cost accounting. Indeed, my impression is that, up to now, there has been very little interest on the part of the management of government hospitals in cost accounting.

Given the accounting format, to assemble proper unit costs would entail a formidable exercise. Consider, for example, Estimates Acct: 151 - for drugs, sera, vaccines, supplies such as sutures, dressings, etc.--an account which, it may be noted, represents about 25% of the total budget for KNH. The basic accounting record for the 151 items is

Unit Costs for Kenyatta National Hospital (KNH)

With the foregoing "disclaimers" in mind, the reader is referred to Table V on the following page which will explain how an attempt has been made to arrive at some unit costs for KNH. The Table reports these as follows:

Cost per OPD Attendance: KSh 44/-

Cost per Inpatient Day: KSh 220/-

Tables Va, Vb, Vc exhibit some performance data for KNH.

The rough nature of these unit costs calculations will be evident

*/ (continued)

the "bin card"--there being over 2,000 of these for the various items. Each card shows by date the amount of each item issued to whom in physical terms and also shows the receipts in physical terms from the CMS--and the balance (inventory) on each date that there was a transaction. To allocate the 151 costs among various facility outputs (say, the outpatient visit and the patient day selected here) it would be necessary to go through the bin cards (or some suitably selected sample of them) and tabulate the physical flows to the various recipients (classified by service activity) and then obtain information on the costs of each item in order to convert the physical flows into money flows. Similarly onerous procedures would be necessary for the allocation of other operating costs, e.g., electricity, water and conservancy, etc. Perhaps needless to say, there was not time during my investigations here to attempt to engage in any such exercise.

In any event, a crash-type effort to come up with some unit costs would not really be very responsive to the cost-accounting problem--what is needed is a redesign of the accounting format such that the required information can readily be assembled in the ordinary course of business. There may well be now an emerging demand for this kind of information. For example, if there is a serious interest on the part of the GOK in fees for government hospital services which can recover a significant proportion of these costs, then, presumably, there will be an accompanying interest in cost accounting. Also for example, if the implementation of a fee scheme were to adopt a prospective-budgeting format for the facilities marketing services (see discussion in text), the management of these facilities would develop a keen interest in cost accounting. If there is an emerging demand for this kind of information, it would make sense now to think about ways in which the supply response might be facilitated. (On the other hand, here as elsewhere, attempting to "push" the information market from the supply may prove unavailing.)

TABLE V

Kenyatta National Hospital Estimates 1984/85 In KL-

Derivation of costs per inpatient day and per outpatient visit -

| <u>Inputs</u> | <u>COSTS</u> | |
|--|-----------------------------------|---------------------------|
| | <u>OPD</u> | <u>Inpatient Services</u> |
| <u>Personnel</u> */ | | |
| Patient Care except nurses | 594,240 | 1,782,720 |
| Nurses | 268,485 | 850,204 |
| "Overhead" Personnel | 59,217 | 177,650 |
| Drugs, Dressings, etc. (Acct. 151) **/ | 712,000 | 1,068,000 |
| Other Operating Expense ***/ | 635,750 | 2,357,000 |
| TOTAL | KL 2,270,000 | KL 6,236,000 |
| 1983 OPD Total Attendance 1,023,052 | Total Inpatient Days 556,587 #/ | |
| Cost per OPD visit—KSh 44/- | Cost per inpatient day--KSh 220/- | |

*/ Personnel, described by occupational category were partitioned into the three classes shown. The roster of KNH physicians was obtained to determine the number assigned to OPD and to inpatient activities, this turned out to be about 25% and 75% respectively. The total budget for personnel in the category "patient care except nurses" was calculated from Estimates 1984/85 and then partitioned 25% and 75% to OPD and Inpatient respectively. The roster of nurses for KNH was obtained and the advice of the nursing department sought on how to partition these between OPD and inpatient activities. Again, this split turned out to be about 25% and 75% respectively. The total budget for nursing services was calculated from Estimates 1984/85 and partitioned according to these percentages.

**/ Expenditure for Acct. 151 was obtained from Estimates 1984/85. This total was partitioned 40% OPD and 60% Inpatient on the basis of a "guestimate" by the pharmacy department at KNH.

***/ Other operating expenses were obtained from Estimates 1984/85 and partitioned in the same proportion as the expenses that had already been allocated, i.e., personnel and drugs, dressings, etc.

#/ Source: Medical Records Department, KNH.

TABLE Va

KENYATTA NATIONAL HOSPITALIN-PATIENT STATISTICS

| YEAR | ADMISSION | DISCHARGES | DEATHS | DISCHARGES AND DEATHS | IN-PATIENT DAYS | % OCCUPANCY | AVERAGE LENGTH OF STAY |
|------|-----------|------------|--------|--------------------------|--------------------|-------------|---------------------------|
| 1978 | 11183 | 30674 | 2293 | 32967 | 422588 | 91.1 | 14.0 |
| 1979 | 63167 | - | - | 53888 | 526436 | 101.4 | 9.7 |
| 1980 | 64303 | 60571 | 3519 | 64090 | 638106 | 118.7 | 9.7 |
| 1981 | 60921 | 59714 | 3106 | 62715 | 526527 | 96.0 | 8.8 |
| 1982 | 65463 | 61940 | 2678 | 64618 | 537002 | 86.7 | 8.3 |
| 1983 | 63981 | 59972 | 2908 | 62880 | 566587 | 86.1 | 8.8 |

Source: Medical Records Department, KNH

TABLE Vb
KENYATTA NATIONAL HOSPITAL
SURGICAL OPERATIONS

| <u>YEAR</u> | <u>MINOR</u> | <u>MAJOR</u> | <u>TOTAL</u> |
|-------------|--------------|--------------|--------------|
| 1978 | 7,939 | 4,038 | 11,977 |
| 1979 | 8,534 | 4,620 | 13,154 |
| 1980 | 8,327 | 4,517 | 12,844 |
| 1981 | 6,171 | 3,095 | 9,266 |
| 1982 | 6,465 | 3,902 | 10,367 |
| 1983 | 7,602 | 3,565 | 11,167 |
| TOTAL | 45,038 | 23,737 | 68,775 |

Source: Medical Records Department, KNH

TABLE Vc
KENYATTA NATIONAL HOSPITAL
OUT-PATIENT STATISTICS

| <u>YEAR</u> | <u>NEW CASES</u> | <u>RE-ATTENDANCES</u> | <u>TOTAL</u> |
|-------------|------------------|-----------------------|--------------|
| 1978 | 195940 | 223245 | 419185 |
| 1979 | 513130 | 415606 | 928736 |
| 1980 | 479443 | 393544 | 872987 |
| 1981 | 565106 | 397927 | 963033 |
| 1982 | 503544 | 560229 | 1063773 |
| 1983 | 573404 | 449648 | 1023052 |

Source: Medical Records Department, KNH

from the Table V notes. A few additional comments are in order. It is my understanding that the out-patient attendances exhibited in Table Vc represent both casualty and regular OPD, i.e., the total outpatient load, such that (insofar as the denominator is concerned) the unit cost of KSh 44/- is correct. This strikes one as a rather high figure which would warrant further investigation. (E.g., perhaps in partitioning the costs, too much has been assigned to OPD, or perhaps that assignment is o.k., such that the figure is correct insofar as the numerator is concerned too. If the latter obtains, a question might be raised whether the OPD is operating with acceptable efficiency.) Table Va reports 1983 inpatient days such that the occupancy rate works out to about 86%. This seems rather low in light of the many natural-history-type accounts of crowding in the government hospitals including KNH.*/ On the other hand the 1983 occupancy rate reported in Table V is not out of line with the data reported for other recent years, these showing a gradual decline in the occupancy rate from the high point of 118.7% in 1980. In any event, to the extent that units of output have inadvertently been omitted from the Table V calculations, the unit costs there reported will be too high.

On the other hand, the unit costs reported in Table V should be regarded as downward biased for the following reasons. (1) The budget data utilized for these calculations was Estimates 1984/85, the latest

*/ In addition to crowding in the sense of assigning more patients to a ward than the bed capacity of that ward was designed to accommodate, it appears the KNH features very long queues for, e.g., "elective" surgical procedures such as hernia repair. It may be that the natural-history-type accounts correctly depict the situation for some parts of KNH whereas the data reported by the Medical Records Department correctly depict the overall situation.

available. When the Actual Expenditures for 1984/85 become available two years from now, they will probably be in excess of the budget reported in Estimates. For example, for the period 1978/79-1981/82, on average, the Actual Expenditures were 113.0% of the Approved Estimates (which in turn tend to run ahead of the Estimates). (2) Most maintenance expenditure is not reflected in the budget data for the MOH as presented in Estimates. Rather, this expenditure comprises some portion of the budget of the Ministry of Works. The MOH's share of this is not broken out in Estimates, I have not run it down in order to include it in these calculations. (3) The specialists on the KNH staff are also Medical School Faculty Members on the payroll of the Medical School with this remuneration not reflected in the MOH budget. While a good bit of this cost presumably should be assigned to the "teaching" output of KNH, some of it probably also should be assigned to the "patient care" output of KNH. This has not been done.

I have been at some pains in the foregoing discussion to draw attention to the limitations of the KNH unit cost calculations, partly in order that the reader not be misled, partly to help inform the efforts of other investigators who will follow to work up better measures of these costs. All of this notwithstanding, I believe that, rough as they are, the unit cost data presented herein supply useful orders of magnitude for these costs, adequate to inform a number of conclusions and, of course, far better than no such estimates at all.

Unit Costs for Other Government Hospitals

As the national referral hospital, the peak organization, KNH can be expected to have higher costs than the representative provincial or district hospital.*/ But how much higher? Unfortunately, it has not been possible to undertake investigations of these other hospitals along the lines of the KNH investigation. We will have to settle for more general impressions from more general information. The following Table VI presents some budget and capacity information for the different classes of government hospitals.

TABLE VI

| (1) <u>Class of Hospital</u> | (2) <u>Gross Expenditure 1984/85*/ (KL)</u> | (3) <u>No.Beds Total #/</u> | (2)/(3) <u>Expenditure per Bed (KL)</u> |
|--|--|------------------------------------|--|
| K.N.H. | 8,532,660 | 1,804 | 4,729.9 |
| Provincial Hospitals | 10,702,330 | 3,093 | 3,460.2 |
| District and Sub-District Hospitals | 22,596,190 | 8,065 | 2,801.8 |

*/ Source: Estimates 1984/85.

#/ Source: TABLE VII following (MOH).

In the case of KNH, the OPD activities claimed about 25% of the budget and inpatient activities about 75%. For want of something better,

*/ In terms of goals, according to Estimates 1984/85, KNH is expected to claim about 12.7% of the total MOH recurrent budget in that year.

we can use these proportions to calculate an "adjusted" expenditure per bed for the provincial and district hospitals, i.e., adjusted to eliminate OPD expense. It was clear from visiting a number of provincial and district hospitals, as well as from many natural-history-type accounts in the field, that these hospitals, at least in the representative case, tend to run very full, with occupancy rates sometimes well over 100% being reported. Thus, an assumption that each of these beds generates about 365 inpatient days per year may not be too far wide of the mark. On the basis of these assumptions, we can infer a cost per inpatient day from the Table VI data:

Cost per inpatient day: Provincial Hospitals - KSh 142/-

District Hospital - KSh 115/-

These costs can be compared with the prior calculation of KSh 220/- per inpatient day for KNH. (If, as for the provincial and district hospitals, we assumed 100% occupancy for Kenyatta, the per inpatient day cost would reduce to KSh 195/- .)

Charges for Government Inpatient Hospital Services and the Rate of Cost Recovery

The foregoing results, rough as they are, enable us to draw at least some inferences about what rates of cost recovery would be implied by different levels of hospital fees. We may consider a couple of hypothetical "cases" as exemplary (the reader can work out additional "cases" to suit his or her tastes).

Case I: All government hospitals participate in the fee scheme with charges equivalent to KSh 50, 75 and 100 per patient day for the district hospitals, provincial hospitals and

TABLE VII

DISTRIBUTION OF GOVERNMENT HOSPITAL BEDS AND COTS BY PROVINCES, DISTRICTS AND TYPE, JUNE 1984

| PROVINCE | NATIONAL REFERRAL HOSPITAL | PROVINCIAL GENERAL HOSPITAL | DISTRICT HOSPITALS | | SUB-DISTRICT HOSPITALS | | PSYCHIATRIC & CHEST HOSPITALS | LEPROSY HOSPITALS | TOTAL OF BEDS |
|---------------|----------------------------|-------------------------------|--|---|------------------------|-----------|-------------------------------|-------------------|---------------|
| Nairobi | K.N.H. 1804 | - | - | - | - | - | Mathare 1138 | - | 2,942 |
| Central | - | Nyeri 407 | Kiambu 417 Kerugoya 197 Murang'a 317 Ol Kaloi 222 | Thika 317 Ganundu 124 Tigoni 35 Muriranjias 66 Nyahururu 105 Mt. Kenya 24 Karatina 88 | | | | | |
| | | 407 | 1153 | 759 | | | | | 2,319 |
| Coast | - | Mombasa 533 Lady Grigg 105 | Kilifi 192 Msambweni 106 Lamu 34 Wesu 150 Hola 157 | Malindi 145 Kinango 129 Kwale 16 Voi 88 Taveta 172 Ngao 77 | Port Reitz 181 | Tumbe 65 | | | |
| Total | | 638 | 639 | 656 | 181 | 65 | | | 2,179 |
| North Eastern | | Garissa 162 | Mandera 53 Wajir 67 | | | | | | |
| Total | | 162 | 120 | | | | | | 282 |
| Western | | Kakamega 322 | Bungo ma 184 | Port Victoria 68 | | Alupe 102 | | | |
| Total | | 322 | 348 | 68 | | 102 | | | 840 |

TABLE VII (continued)

| | | | | | | | | | |
|----|-------------|----------|-------|----------------|-------|-------------|-------|--------|--------|
| 72 | Eastern | Machakos | 507 | Embu | 199 | Chuka | 31 | | |
| | | | | Isiolo | 48 | Ishiara | 74 | | |
| | | | | Kitui | 175 | Moyale | 58 | | |
| | | | | Marsabit | 94 | Kangunda | 128 | | |
| | | | | Meru | 246 | Makueni | 158 | | |
| | | | | | | Makinda | 58 | | |
| | | | | | | Mwingi | 80 | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | Total | | 507 | | 762 | | 590 | | 1,859 |
| | Nyanza | Kisumu | 565 | Homa Bay | 294 | Nyamira | 145 | | |
| | | | | Kisii | 302 | Victoria | 22 | | |
| | | | | Siaya | 227 | | | | |
| | Total | | 565 | | 823 | | 167 | | 1,555 |
| | Rift | Nakuru | 492 | Kabarnet | 120 | Loitokitok | 150 | Gigili | 540 |
| | | | | Tambach | 72 | Londiani | 39 | | |
| | | | | Kajiado | 86 | Kapkatet | 46 | | |
| | | | | Kericho | 168 | Nandi Hills | 53 | | |
| | | | | Nanyki | 102 | Lokitaung | 16 | | |
| | | | | Kapsabet | 124 | Naivasha | 62 | | |
| | | | | Narok | 102 | Molo | 71 | | |
| | | | | Marala | 59 | | | | |
| | | | | Kitale | 217 | | | | |
| | | | | Lodwar | 38 | | | | |
| | | | | Eldoret | 185 | | | | |
| | | | | Kapenguria | 81 | | | | |
| | | | | Iten | 188 | | | | |
| | Total | | 492 | | 1543 | | 437 | 540 | 3,027 |
| | GRAND TOTAL | 1804 | 3,093 | | 5,388 | | 2,677 | 1,859 | 14,821 |
| | | | | Health Centres | 1982 | - | 242 | | |
| | | | | Dispensaries | 1982 | - | 872 | | |

TABLE VII (continued)

ADD - ARMED FORCES AND PRISON HOSPITAL BEDS

| ARMED FORCES | | PERSONS | |
|--|-----|---------------|--------|
| Nairobi | 90 | Nyeri | 12 |
| Lanet r | 18 | Shimo La Tewa | 25 |
| | | Mbololo | 17 |
| | | Kamiti | 195 |
| | | Kodiam | 44 |
| | | Kibos | 6 |
| | | Nakura | 3 |
| | | Naivasha | 26 |
| | | Athi liver | 7 |
| Totals | 108 | | 335 |
| Grand Total | 443 | | |
| Total Government Beds - Excluding Armed Forces and Prisons Hospitals | | | 14,988 |
| - Including Armed Forces and Prisons Hospitals | | | 15,431 |

Data compiled by S. J. M. Kalama--Hospital Secretary I, June 1984.

KNH respectively.*/ All clients are obligated to pay at these rates and the collections are in fact made (i.e., bad debt expense is negligible). With these assumptions, under Case I we would recover about half of the MOH's expenditures on inpatient hospital services, or about 25% of the total MOH recurrent budget in recent years.

Case II: Only KNH and the provincial hospitals participate in the fee scheme, with charges equivalent to KSh 200 and 150 per patient day respectively. The other assumptions are as in Case I. With these assumptions, under Case II we would recover about half of the MOH's expenditure on inpatient hospital services, or about 25% of the total MOH recurrent budget in recent years, i.e., as in Case I.

Various other hypothetical cases could be worked out, these being sufficient, however, to give an idea of the magnitudes involved. In the design of a fee scheme for implementation we would need to attend to such questions as whether the scheme was to be income related (higher fees for those with higher incomes). Also, the assumption of a virtually 100% collection rate would have to be modified, this being an unrealistic assumption. Pending decisions about these and other design features, there would be little point in here multiplying exemplary "cases."

Comparison of Costs and Fees: Government Facilities with Others

The foregoing rough calculations yielded an "adjusted" cost per inpatient day for government hospitals as follows, viz.:

*/ In practice, the choice of the unit of output to price might yield a flat per diem charge or charges for the service components, e.g., room, diet, drugs, surgery, etc. Whatever the arrangement on this score, in Case I the charges would be "equivalent" to the rates stated, likewise Case II, etc.

| | |
|----------------------|-----------|
| KNH | KSh 220/- |
| Provincial Hospitals | KSh 142/- |
| District Hospitals | KSh 115/- |

How do these costs compare with those exhibited by other hospitals. Although a thorough-going answer to this question cannot be supplied here, a few comparisons can be afforded, viz.:

TABLE VIII

Protestant Church Hospitals 1982/83:

| <u>Hospital</u> (No. Beds) | <u>Occupancy</u> <u>Rate</u> | <u>"Adjusted" Expense</u> <u>per Patient Day */</u> |
|----------------------------|---------------------------------|--|
| A.I.C. Kapsowar (114) | 120% | KSh 27/- |
| AGC Tenwek (140) | 115% | KSh 65/- |
| CPK St. Lukes (147) | 80% | KSh 45/- |
| EAYMF Kaimoso (150) | 65% | KSh 90/- |
| EAYMF Lugulu (118) | 62% | KSh 69/- |
| PCEA Chogoria (226) | 82% | KSh 96/- |
| | <u>Mean</u> | KSh 65/- |

Source: Calculated from data presented Protestant Churches Medical Association, Annual Statistical Return 1982/83.

*/ Adjusted to eliminate OPD costs. "Adjusted" expenditure eq. .75 x total exp.

For these Mission Hospitals (selected because data were available), the cost per inpatient day appears to be substantially less than for the government hospitals. One sometimes hears it said that the apparently low-cost operation of the mission hospitals is owing to the fact that they benefit from a large amount of donated, free or virtually free, labor. I have found no evidence to support this myth. In the case of Chogoria Hospital, for example, the Income and Expenditure Account for 1983 shows the value of donated services to be less than 6.0% of total expenses. Similarly for St. Joseph's Hospital (Kilgoris) the value of donated services is a very small percent of total expenditures. One should not jump to the conclusion that these differences in cost per inpatient day measure differences in efficiency (although, they may do so).*/ For any process or activity (including these hospitals) efficiency is measured as the ratio of wanted output to input. The costs presumably measure the inputs. The "patient day" is not, however, a very good measure of output for the purpose of measuring efficiency (see the discussion in this section, supra). What these comparisons do suggest on this front is that there may well be striking differences in the efficiency with which these hospitals are operated such that an investigation

*/ One problem is that, owing to the spreading of overhead costs, cost per patient day is very sensitive to changes in the occupancy rate. A more informative kind of comparison would be to compare unit costs for the various hospitals assuming each to be operated with an "optimum" occupancy rate. With reference to the instant comparisons, it will be recalled that, for the government provincial and district hospitals, the cost calculations were based on an assumed occupancy rate of 100%. For the Mission Hospitals, actual occupancy rates were used which, for four of the six, were less than 100%.

to check on this matter is very much indicated. Thus, for example, if it turns out upon systematic investigation that there are in fact significant differences in efficiency, an investigation to determine to what these are owing might serve to inform the development of policy with respect to government hospitals. In the case of both the government and mission hospitals, the costs are inclusive of all inputs (personnel, drugs, procedures, etc.).

I do not have cost per patient day for non-profit private hospitals such as Nairobi and Aga Khan. Since, however, these two hospitals in particular say that they are just about breaking even (Aga Khan has some deficit, Nairobi some "surplus" now going for long neglected maintenance), something about their costs can be inferred from their charges. Currently the charge (fee) at Nairobi Hospital for a ward bed (the least expensive) is KSh 385/- per day and the analogous charge at Aga Khan Hospital is KSh 345/- per day. These charges do not include drugs, physicians fees, investigative procedures and the like, i.e., additional charges are levied for all of these. From these data one may infer that for these hospitals the cost per patient day is several times that of the most costly government hospital (KNH). The reader is again cautioned about jumping to conclusions about efficiency. The small private proprietary hospitals, the so-called Nursing and Maternity Homes (Hospitals), have charges much below those of the big non-profit hospitals. Thus, the charge per day on the general ward for Kisii Maternity and Nursing Hospital is KSh 120/- per day and for Owino Nursing and Maternity Home KSh 100/- per day. Again these charges are

exclusive of drugs, physicians fees, investigative procedures, etc. Since these facilities appear to be profitable with these charges (and, frequently, rather low occupancy rates), we may conclude that their costs per patient day are considerably less than for the larger non-profit facilities.

One thing that stands out from these various comparisons is that in Kenya inpatient hospital services are being provided over a very large range of unit costs. What the medical-services significance of this phenomenon is will remain unclear until an investigation is undertaken to explore this matter. An illuminating kind of study would seek to determine the cost of managing each of several frequently encountered "episodes" of illness (i.e., the cost of managing "representative cases" in each of various diagnostic categories) in the various facilities. An effort would also be made to assess the quality of case management in each case. Only by such a study will we have any clear idea of the medical-services significance of the wide range of unit costs.

Another thing that stands out from these various comparisons is that if government hospitals were to implement fees for service provided, these fees apparently could be set at levels high enough to achieve significant cost recovery yet still leave the government hospitals in a good competitive position in the market, assuming that services of sufficient quality were delivered by them.

Social Financing of the Demand for Government Hospital Services

In thinking about implementing a fee scheme for government hospital services, it must be anticipated that collections may pose a problem. It is very difficult for government facilities to demand cash up front as a condition of admission. But, once the client has utilized the services, it may be difficult to collect the fees from him. For hospital services, the bad debts that might be in this way owing are apt to be large enough to justify investment in systematic collections procedures. One thing is clear on this front. A fee scheme for government provided services should not be implemented unless it is to be taken seriously with appropriate but strenuous efforts made to in fact collect the fees. To implement a fee system only to "wink" at it would be a demoralizing procedure with little to recommend it.

Another factor to take into account in the design of a fee system is that it is in various ways advantageous if the fees can be income related--such that the rich pay more than the not so rich and the "medically indigent" do not pay at all. If the scheme is not income related, i.e., if the same fee is charged to all, it has to be set low enough to be acceptable from the point of view of the low income patients. This will sharply constrain the amount of revenue which can be raised by the fees. More generally, the fee scheme will be and will appear to be more equitable if it is income related. There are problems in going this route, however, particularly if the demand for services is to be financed in the main by out-of-pocket payments by consumers. Under this arrangement, income relating the fees means charging at different

rates to different clients depending upon their income class. This in effect may imply administering a means test at the facility door, so to speak--an obviously formidable administrative problem, indeed, perhaps even an intractable one.*/

If, instead of out-of-pocket financing there can be social financing of the demand for these services a significant contribution is made to the solution of these problems. Insurance and other social financing schemes of course entail pre-payment, an obvious assist with collection problems (and the reason why such schemes tend to be very popular among providers). Income relating is also easier under social financing. The same fee can be charged to the insurance fund for all customers and all get the same service. However, the rate of contribution to the insurance fund can be income related, such that the poor bear a smaller burden than the rich. (See some additional discussion of this point in the section "Private Social Financing of the Demand for Health Services.") An obvious source of social financing of the demand for hospital services marketed by government hospitals is the NHIF. If a fee scheme is introduced, the government hospitals would, presumably, be entitled to fair reimbursement from this source. There are other possibilities. For example, government hospitals marketing services could offer to market

*/ There are some procedures which can give an assist on this front. In some countries where government hospitals charge for services, hospitals employ specialized workers (e.g., "social workers" or "welfare workers") to make determinations of the capacity of patients to pay, to followup patients who give problems on this score. Certification of the patient's status of being indigent (and hence not required to pay) can sometimes be delegated to authority outside the hospital, e.g., a magistrate.

these on a prepaid, capitation basis to groups of consumers, such as the members of cooperative societies, who might not be participating in the NHIF program.

THE QUESTION OF AMENITY WARDS IN GOVERNMENT HOSPITALS

Included among the alternative financing mechanisms proposed by the Ministry of Health Development Plan 1984-1988 we find (p. 19):

- iii) Amenity Wards: During the plan period amenity wards will be established in all Provincial Hospitals and existing ones will be improved.

A fee will be charged to patients in amenity wards, commensurate with the services rendered.

Appropriately for a statement on this subject at the remove of the five-year-plan level, this statement seeks to provide no more than general policy guidance, leaving open such questions as the number of amenity beds to be established, the extent and nature of improvements in existing beds contemplated, and what level of charge is to be regarded as "commensurate" with the services rendered. If the amenity-wards program is intended to be an important component of overall MOH strategy with systematic efforts made to develop it then the general prescription in the Development Plan will have to be operationalized (e.g., answers provided for the open questions enumerated foregoing, and others). Pursuant to this, it will be necessary for the policy makers to think about the objectives they intend to achieve with the amenity ward program.

Such a program could serve any of a number of objectives. For example, it makes a richer menu of services available to the consuming public, providing a quality and style of service intermediate between the regular public service and the much more costly deluxe service in the private hospitals. From this point of view the program would be regarded as in the main a service to the public, catering to certain legitimate preferences of some patients and their physicians--the revenue recruiting

function would be secondary. Alternatively, the policy makers might see as the main objective of the program that of recruiting revenue, with the public-service function secondary.

The way in which the amenity ward program should be designed depends of course upon which of the foregoing (or other) objectives it is intended to serve. That is, in the design and operation of any such program, decisions must be made about the level at which to set the fees, about the number of amenity beds to install, about the nature of the accommodations and service to be provided the amenity patients (call this product quality) and other matters. The higher the quality of the product, the more it will cost to produce. On the other hand, the higher the quality of the product, the more of it will be demanded at each price. And, for given product quality, the lower the price, the greater will be the demand for it. How the price and product-quality decisions are made will depend upon the objectives of the program. Pursuant to revenue raising as the main objective, the policy makers will seek that combination of price and quality which will maximize net revenue. Since the policy makers would have no feasible way, ex ante, to estimate the price/quality demand function, they would no doubt have to find the right (optimum) price-quality combination by trial and error. The decision about the number of beds to commit to amenity-bed status would likewise depend upon the net-revenue maximizing objective.

Suppose, on the other hand, the main objective of the program is seen as the service function, making a richer menu of services available to the consuming public. Here, the policy makers might well begin with a

decision about what service quality should be deemed to serve this objective and about what rate of output of services of that quality was deemed appropriate to this objective--in light, e.g., of perhaps unsatisfied demand for services of regular quality, etc. (That is, they would map planners preferences into the resource allocation decision, rather than, as with the revenue-raising objective, attempting to respond to consumers preferences in the design of the program.) In this case, some criteria would have to be established to rationalize the fee to be regarded as appropriate (or, "commensurate" with services rendered). Thus, one might set the fee at the difference between the cost of producing regular services and amenity services. The rationale here would be that the amenity patients were entitled to the same value of services free of user charge as anybody else--but, if they want higher quality services, they must pay the extra cost. Or, the fee might be set to cover the full cost of production of the amenity services, i.e., not just the cost in excess of regular costs of production. The rationale here would be that patients using amenity facilities have the ability to pay such a fee and it is equitable for them to do so since this will help conserve scarce general tax revenues for the provision of services to those who cannot pay for them. Perhaps other "principles" with their accompanying fees could be invoked. The general point is that unless the fee is to be determined by market criteria (as in the first amenity-ward model), then the concept of a "commensurate" fee must be operationalized by an appeal to some criteria.

A potentially very important consideration for design of the amenity

ward program is that of what is to be done about fees for regular government hospital services. If for example a fee scheme for general government hospital services were implemented, and if the fees (perhaps income related) were substantial, and if owing to the fee scheme the quality of general government hospital services were substantially improved, there might be little to be gained by also implementing an amenity-ward program.

As the foregoing discussion suggests, the problem of what operational design to adopt for an amenity-ward program is a complex one. In any case, it is not possible to make much progress on the design front until the policy makers have determined what the objectives of the program are to be.

RECRUITING RESOURCES FOR PREVENTIVE/PROMOTIVE SERVICES AND RURAL HEALTH SERVICES

The major theme of Kenya's health-sector development strategy over the coming decades is to shift the emphasis of the government health services away from the historically major commitment to secondary and tertiary curative services and much more toward the delivery of preventive/promotive services and rural health services generally. This implies a major increase in the rate of resource commitment to preventive/promotive services and to rural health services. The important and difficult question, of course, is just how this is to be accomplished. As explained foregoing, this will, in my opinion, require recruiting significant private financing for government provided hospital services which now claim the lion's share, on the order of 70%, of the MOH's total operating (recurrent expense) budget. If this can be accomplished, it will facilitate what we may refer to as the "diversion strategy" for recruiting resources for preventive/promotive services and for rural health services. Under the diversion strategy, public finance would be diverted from the hospitals (which would be supported in part by private finance) to preventive/promotive services and to rural health services. Given prevailing budget allocations, recovery of, say, half of the cost of government hospital services would permit a five-fold expansion in the commitment of public funding for preventive/promotive services or a three-fold expansion of the commitment of public funding

to the rural health services.*/ The diversion strategy is, in my view, by far the most promising approach to recruiting adequate resources for preventive/promotive and rural health activities. The frequently suggested alternative is directly to recruit private funding for preventive/promotive services and rural health services, by charging fees for these services, some versions of this approach belonging to the so-called "community financing" approach to health-sector financing. My preference for the diversion strategy is in part based upon a conceptual point, the distinction between "public" and "private" goods. It will be helpful briefly to elucidate this distinction.

*/ One sometimes encounters the view that, although the diversion strategy may look fine on paper, in practice it won't work because the government will respond to private financing of public hospital services by reduction in public funding. There are, however reasons to suppose that such a budget response is not inevitable.

If the hospitals were recruiting significant private financing (in consequence of user charges) of the demand for government delivered hospital services, the budget authorities might be justified in reducing somewhat the funding from general tax revenues available to them. Modest reductions of this kind would still permit the diversion strategy to work for the benefit of prevention/promotion and rural health. If, however, the budget authorities reduced the public funding available to the hospitals pari passu for each shilling of private funding recruited, the user-charge (fee) scheme would no longer facilitate the diversion strategy. Before adopting such a budget response, however, the authorities should be aware that the most likely result of it would be to kill a goose that otherwise could lay at least small golden eggs. For, if the budget response were pari passu reductions in public funding, those on the ground responsible for administering the fee scheme (at best onerous task) would no longer have any interest in it and consequently it could not be expected fly. Modest reductions in public funding, on the other hand, which would leave the fee scheme intact, could still yield at least something more for other activities making claims on the public budget. And, of course, to the extent that the government is genuinely interested in promoting preventive/promotive and rural health services, there will be reluctance to scuttle a scheme that holds some promise of progress on this front.

"Public" vs. "Private" Goods and Services

Preventive/promotive, public health services tend to be in the technical sense "public" goods such that public financing is peculiarly appropriate for resource allocation to their production. Attempting to rely upon private financing for public goods (in the health-services domain or any other) will likely result in inappropriately low rates of resource allocation to these activities. Private goods feature a property known as "excludability," which means that anyone who does not pay for the good can be excluded from enjoying its benefits. Private goods also feature a property known as "depletability," which means that more for any one consumer means that much less for any other. Technically, a "public" good is defined as any good or service which lacks both of these properties. Thus, private markets fail to allocate resources efficiently to the production of public goods both because of the free-rider problem entailed by non-excludability and because, where the marginal cost of serving an additional user is zero (the non-depletability property), charging a price is inefficient. Private markets may also fail for goods which, while not strictly public in the technical sense, do entail so-called "neighborhood" effects such that whether or not any individual consumer consumes the good in question is not neutral to the welfare of other consumers. I use the term "preventive/promotive, public-health services" to refer collectively to those services which belong to one or another of the foregoing categories.

Included here would be such services as health education, vector borne disease control, infectious disease control, immunizations, environmental sanitation including inspection activities, and the like. Hospital services are for the most part curative services and belong to the category of "private" goods for which private financing is conceptually appropriate. For preventive/promotive, public-health services, public financing clearly is indicated. And the diversion strategy, facilitated by significant private financing of government hospital services through fees charges for these services, is the most promising approach to increasing the availability of public financing for preventive/promotive and public-health services.

Rural Health Services: The Curative Component

The rural health services network is expected to carry a major part of the preventive/promotive, public-health services load. To this extent, the remarks foregoing apply the financing of this network. The rural health facilities also deliver curative services which are in the nature of private rather than public goods. Conceptually, private financing via fees would be appropriate for these curative services.*/

*/ Although curative services (primary, secondary and tertiary) are private goods for which private financing is conceptually appropriate, considerations of equity in access to these services may indicate some public financing of them, i.e., for those who have no other way to finance their demand for them. Here too, the diversion strategy facilitated by user charges for hospital services is important. For, only if those who can pay do pay for costly secondary and tertiary services will there be sufficient public finance to afford acceptable levels of service to those who cannot share costs in this way. Thus, there is a strong equity argument in favor of suitably income-related fees for government hospital services.

Should such a program be implemented?

Although there are arguments pro and con the implementation of charges for curative services delivered by the government rural health facilities, on balance I am skeptical about the probable success of any such program. In various countries, formidable problems have been encountered in attempts to implement fees for such services. Many patients presenting to these facilities may refuse to pay, on the ground that they do not have the ability to pay. It is difficult for the government to demand the money up front before individuals can have access to primary-care-type curative services. Once the consumers have utilized the services, however, it may be difficult to collect. Unlike the case of bad debts owing for hospital services, the amount owing in consequence of any one visit to a rural health facility would scarcely be enough to justify systematic attempts to recover what was owing--i.e., even if the attempt were successful, less would be recovered than the cost of the resources used by collection machinery. Moreover, grave difficulties have been encountered in attempting to administer these schemes (e.g., difficulties with accountability for the funds passed in the health centres) owing in part to the fact that, as in Kenya, the rural health network consists of hundreds of widely scattered facilities*/

*/ There is an additional problem with charges for curative services delivered by rural health facilities. Curative and preventive/promotive services produced by these facilities tend to be co-mingled such that price rationing of the former may reduce the exposure of consumers to the latter. This may particularly be a problem with respect to health education and family planning services.

On the other hand, the picture with respect to the feasibility of user charges for services provided by government rural health facilities may not be as bleak as that painted foregoing. For one thing, many consumers in fact do patronize mission and other private health centers and dispensaries where they must pay a fee for services. Many of these consumers have also a choice of free government services. Consequently, it would appear that they prefer to pay for what they regard as the higher quality services which in turn suggests a willingness on the part of many consumers to pay for government health centre and dispensary services if the quality were high enough. Indeed, a recent important study has reached the conclusion that if a fee of, say, KSh 5/- were charged by government health centres, and if the revenues were used to raise the quality of these facilities to that of the mission clinics, then the welfare of consumers would be improved.*/ It may be noted that a finding of this study was that consumers rated mission clinics and government hospital OPDs as higher quality sources of care than government health centers and dispensaries mainly because of the greater availability of drugs and medications in the former, i.e., the frequently non-availability of drugs and medications in the latter.

Also, in Kenya, difficulties with the administration of fee schemes for government rural health networks may not be as severe as one might suppose based upon experience in other countries. After all, some such

*/ See Germano M. Mwabu, A Model of Household Choice Among Medical Treatment Alternative in Rural Kenya, 1984--Ph.D. Dissertation, Boston University. This study will well repay the attention of all readers interested in development of the health services sector in Kenya.

schemes are in fact successfully administered in Kenya, notably, the mission clinics and health centres.*/ Moreover, there may be various ways around certain accountability problems, e.g., resort to cards and stamps to collect the fees and establish eligibility for services rather than simply passing cash in the facilities.

On balance, in my view, and although I think that there is reason for some skepticism, the feasibility of user charges for some curative services delivered by government rural health facilities should have serious study.

*/ According to MOH Development Plan 1984-1988 (p. 6) the government-private split on rural health facilities in 1982 was:

| <u>Facility</u> | <u>Government</u> | <u>Non-Government</u> | <u>Total</u> |
|-----------------|-------------------|-----------------------|--------------|
| Health Centres | 242 | 39 | 281 |
| Dispensaries | 872 | 362 | 1,234 |

PRIVATE SOCIAL FINANCING OF THE DEMAND FOR HEALTH SERVICES: CURRENT
STATUS AND PROSPECTS

Introduction

Pursuant to its long run strategy for development of the health-services sector in Kenya, the GOK should further promote and develop private social financing of the demand for health services marketed by both the private and the public sector. By social-financing schemes we have in mind any of various kinds of health insurance or prepayment schemes which feature risk spreading over the lifetime of each individual and as among individuals, or other kinds of what may be regarded as "collective purchase" of health services. A government health services system financed out of general tax revenues is an instance of social financing of the demand for health services. In this section, our main concern is with private social-financing schemes and the related question of the implications of these for the government health-services sector including the financing of that sector.

There are many reasons why the government should further promote and develop private social financing of the demand for health services. These include:

1) Social-financing schemes may contribute importantly to the welfare of consumers in health-care markets, providing the advantages of risk spreading as compared with the hazards of "going bare" in the out-of-pocket payment market. As has been pointed out

foregoing, there is a substantial private health-services sector in Kenya. There is nothing wrong with this, per se. There is no general reason to suppose that government agencies have a comparative advantage in the provision of health services. Indeed, it may well be the case that private providers use health-care resources more efficiently. There is a problem in the private sector, however--too much of the demand for these services is financed by out-of-pocket payment. Consumers are deprived of the advantages of social financing adduced above. It may be argued that the government does have some responsibility on the demand side of the market for private services--namely, to help see to it that the consumers of these services can have the benefits of social financing.

2) Social financing also has important inter-personal equity implications. To the extent that there is out-of-pocket financing, sick people bear the burden of supporting the health services system. Under social financing, well people make regular payment which support the health-services system--an arrangement which may be regarded as in accord with the ethical principle of attempting to move in the direction of equalizing net lifetime advantage as among individuals.

3) Generally, the way in which the demand for private-sector services is financed is not neutral to private sector growth rates. More particularly, widespread health insurance may do much to stimulate private sector growth. In Kenya, this phenomenon is already manifest--the NHIF appears to have stimulated considerable

growth in the private hospital sector (see discussion on this point following).*/

4) Kenya's longer-run health strategy entails a movement by the government health services towards more emphasis upon preventive/promotive services and rural health services and less emphasis upon secondary and tertiary curative services. I have argued that this almost certainly must entail a reduction in the fiscal commitment to hospital services. And this in turn implies greater reliance by government hospitals upon private financing and greater reliance upon private-sector hospitals. If the government seeks to reduce what would otherwise be its fiscal commitment to health services in favor of greater consumer dependence upon the private sector, and in favor of more private financing of the public sector--from a social-policy point of view, the approach is apt to be more comfortable to the extent that consumers can substitute private social financing (rather than out-of-pocket financing) for the public social financing that would in this way be withdrawn. This is for the reasons spelled out in 1) and 2) above. Moreover, the approach would further be facilitated by promoting private social financing for the reasons given in 3) above.

*/ This phenomenon is observed in other countries also. For example, a social-security-type health-insurance scheme (not unlike Kenya's NHIF) was recently introduced in the Philippines. The supply response to this demand event was quite dramatic, private hospital capacity developed rapidly. Among the many "laws of supply and demand" none is more immutable than the one that states: "Take care of the demand and the supply will take care of itself." Health planners, who have a strong propensity to work things mainly from the supply side of the market, would be well advised to ruminate upon the implications of this law.

The National Hospital Insurance Fund (NHIF)

This is the major "private" (i.e., at least in the sense of financed by other than general tax revenue) social-financing scheme presently operating in Kenya. Established by public law shortly after independence, this scheme is financed by beneficiary contributions or subscription fees of KSh 20/- per month. Membership is compulsory for all earners, i.e., wage earners or self-employed, earning more than KSh 1,000/- per month.*/ Others may enroll voluntarily. As a practical matter, virtually all of the contributing members are wage earners. The NHIF approves beds as eligible for reimbursement by the NHIF, the benefit being a per diem payment (called a "rebate") ranging between KSh 60/- and KSh 150/- per inpatient day, depending upon the nature of the facilities in which the beds are located. There are limits on total NHIF payments per beneficiary per benefit period.

For 1982/83, the NHIF current account position was:**/

| | |
|-----------------------------|---------------------|
| Revenue from Contributions: | KSh 92.8 million |
| Other Revenue: | <u>18.9 million</u> |
| Total: | KSh 111.7 million |
| Payout for Benefits: | KSh 92.2 million. |

*/ There is some ambiguity on this point. According to Koinange (1982, p. 8) membership is compulsory for "wage earners . . ." However, according to the Director of the NHIF, membership is legally compulsory for all earners in the stated income class. Here, as in other countries, it has not proven practicable to enforce this kind of regulation for the self-employed.

**/ Information from NHIF.

Thus it would appear that for FY 1982/83, the NHIF just about broke even on current account. The other revenue was owing mainly to investment of reserves put at KSh 175 million. The NHIF estimates that it has about 400,000 active (i.e., contributing, benefit-eligible) primary member beneficiaries. In addition, the scheme covers the dependents (spouse and children of the primary beneficiary). There are only 761 voluntary subscribers. Assuming this many active members, an average contribution of about KSh 232/- per year (very close to the KSh 20/- mo.) would have yielded the revenue from contributions shown above.

It appears that the NHIF is in fact enrolling the large majority of its feasible, mandatory beneficiaries. The distribution of employees by income group for 1982 presented earlier in this report (see section "Economic Background") showed 366,121 at 1,000/mo or over. The total number of employees in the sample which yielded the distribution by wage level data was shown as 871,091, whereas the total wage employment in 1982 was reported as 1,038,000 (see section "Economic Background"). Adjusting the 366,121 by $1,038,000/871,091$ (or, 1.19) yields an estimate of about 436,000 wage earners earning KSh 1,000/- or more per month, not far from NHIF's estimated enrollment. If each of the 436,000 eligibles contributed KSh 12.0 per year, the total 1982 contribution to NHIF would have been about KSh 5.2 million, not far from the actual revenue from contributions of KSh 4.7 reported above (i.e., KSh 92.8 million).

According to Koinange (1982, p. 8), the NHIF was established ". . . to provide a vehicle for giving Kenyans access to amenity hospital facilities previously utilized almost exclusively by non Africans." If for "amenity facilities" in this statement we read government hospital amenity beds (which, charge KSh 30/- per day, KSh 40/- in the case of KNH), the result of establishing the NHIF has been very different than that depicted by Koinange. There has been little or no payment from the NHIF to the government hospitals.*/ NHIF payments have gone to the private hospitals, that is, to the Church, non-profit and proprietary hospitals. Indeed, NHIF payments have been largely responsible, as I understand it, for the rapid recent growth in the number and capacity of the small or medium sized Nursing and Maternity Hospitals (or Homes) which are now fielding some 1,771 approved beds and in the last year, according to the NHIF, claiming about 53.0% of total benefit payments.

For reasons set out in the introduction to this section, the NHIF is an important and desirable component of the nation's health-sector financing system. The operation of this scheme,

*/ I have encountered in the field various versions of the relationship of the NHIF to the government hospitals. According to one (popular) version, none of the beds in government hospitals are approved for reimbursement under the NHIF, thus there are no payments to the government hospitals. According to another version, amenity beds in government hospitals are approved for reimbursement at the KSh 30/- (KNH 40/-) rate, but in fact such payments are seldom demanded or made. In any case, it is safe to say as in the text that there has been "little or no" payment from NHIF to government hospitals.

however, exhibits a number of problems which warrant prompt attention. The scheme has been in place for many years and it still operates with its initial design features. The time may have come to seriously consider some modification of these. Also, the time has come to rationalize the relationship between the NHIF and the government hospitals. We may briefly discuss some of these problems and policy questions, viz.:

A major problem may be suggested by the widespread impression one encounters in the field that the NHIF is subject to considerable abuse by facilities benefiting from payments made by it, e.g., billing NHIF for "phantom" patients, billing for "unnecessary" hospitalization, billing for lengths of stay longer than actually provided, and the like. Obviously, a scheme like the NHIF is susceptible to these kinds of abuse such that prudence in the management and administration of the scheme would, in any event, call for procedures to monitor its performance from this point of view as by, for example, random "audits" of facilities with approved beds. I understand that there may be legal barriers to some effective monitoring procedures. If this is so they should be cleared away. I also understand that the NHIF does not now have sufficient staff for effective monitoring. If so, this should be remedied. The NHIF is potentially too important a part of the nation's health-sector financing system to permit these kinds of bars to its effective functioning.

The original contribution rule, KSH 20/- per month for those

earning more than KSh 1,000/- per month, is still in place. The passage of time with its accompanying economic growth and inflation has considerably changed the significance of this formula. The KSh 20/- now buys much less medical services in real terms than it originally did. On the other hand, when the scheme was launched, those earning KSh 1,000/- per month were the relatively few at the top end of the income distribution. Now, on the order of half of all wage earners earn this much (see section "Economic Background") such that the beneficiary base of the NHIF has been greatly expanded over the years. Even though the KSh 1,000/-- mo. has crept down in the income distribution, the KSh 20/- contribution represents only 2.0% of that income, not, it might be argued, an unreasonable burden for health insurance even at fairly low levels of income. This would suggest that there may be no real need to raise the cutoff point on these grounds.

The scheme as it stands, however, is regressive in that the contribution represents a higher percentage of low incomes than of high incomes. Also, one hears expressions of opinion in the field that the benefit payments are too small in light of conditions in the medical services market and that at least those with higher incomes would be willing to pay more to enjoy higher benefits. A change in the contribution rule might address both of these problems--namely, a shift from defining the contribution in absolute terms to defining the contribution in percentage terms--say 2.0% of income (perhaps up to some upper cutoff point) which would not

increase the burden at the lowest wage level. Such a change would at least make the contribution rule neutral rather than regressive (i.e., those with higher incomes would now pay more into the fund in absolute terms, although their percentage burden would be no greater) and it would increase the aggregate rate of contribution to the fund. Consideration might be given to making the contribution rule progressive, such that those with higher incomes would pay higher percentage of income into the fund, a change which would of course yet further enhance the aggregate rate of contribution to the fund.*/ Another advantage of defining contributions in percentage rather than absolute terms is that the percentage formula "keeps up" with inflation, so to speak.

Turning to another NHIF policy matter, clearly the time has come to rationalize the relationship between the NHIF and the government hospitals. What form this rationalization would take would depend upon what policy is evolved with respect to amenity facilities in government hospitals and upon what policy is evolved with respect to general charges for inpatient services provided by government hospitals. Both of these matters are discussed in other sections of this report. The general objective of such rationalization would be to insure that, to the extent government hospitals

*/ I recognize that whether a shift to percentage contribution rates would be feasible would depend in part upon the extent to which, if at all, it increased the administrative burden on employers who, as I understand it, check off the employees contributions to the fund.

are marketing services, they have fair access to reimbursement by the NHIF.

Other Health-Insurance Schemes and Related Schemes

In addition to the government sponsored NHIF, various other private health insurance schemes operate in Kenya. Although I have not had time to determine the extent to which these schemes finance the demand for health services, it may nevertheless be helpful to at least draw attention to them. The Nairobi Hospital itself operates three different schemes under which, for an annual payment, beneficiaries are entitled to stated reductions in fees charged by the hospital. For members of NHIF, these might be regarded as in the nature of "NHIF-gap" policies (on an analogy to "Medi-gap" policies in the U.S. which cover Medicare co-pays and deductibles) which partly or completely cover the gap between what the hospital charges and what NHIF pays.*/ The Aga Khan Hospital participates in schemes which appear to be virtually identical to what are now called "Preferred Provider Organizations" (PPOs) in the U.S. Under these schemes, an insurance company, typically writing group policies for the employees of companies, gives the customer special premium rates if they agree to use the services of the "preferred provider"--in this case Aga Khan, this on the ground that the hospital has agreed to provide services at less cost than providers generally. Again, this is NHIF-gap type coverage, Aga Khan says that it has signed up quite a few major companies under this

arrangement. The Aga Khan and Nairobi programs are of considerable interest. They represent aggressive marketing tactics induced by competition in the Nairobi market. They also suggest that major providers and the private insurance industry are alert to possibilities for developing third-party financing of the demand for health services in Kenya, a good sign for the future development of these financing mechanisms.

In addition to schemes of the foregoing kind, large employers operate a variety of health schemes for their employees. For example, the Brooke Farm Tea Estate (town of Kericho) operates a 67 bed company hospital for its 14,000 employees and their dependents (a total of nearly 100,000 beneficiaries). The hospital runs with an occupancy rate of about 33.0%. This low rate is partly accounted for by the fact that the hospital has no maternity ward and by the fact that admission to the hospital is only by referral from one of the 18 dispensaries (and a mobile clinic) also operated by the company. Some companies, rather than operating facilities of their own, pay for health services obtained by their employees from the providers of their choice. An important example of this is the "coffee voucher" system under which providers submit vouchers to the coffee companies for reimbursement for services rendered to the

*/ Nairobi Hospital says that "quite a large number" of beneficiaries have signed up for these supplementary schemes, although no specific number was proffered. Even so, according to the hospital, less than 10% of its gross revenue is in the form of insurance payments.

eligible employees of the companies. Tea companies may have a similar arrangement. Sometimes these various programs can add up such that a provider may enjoy a large percentage of total revenue third-party paid. For example, for 1983, Chogoria Hospital (Presbyterian Church) had receipts for hospital services provided as follows:

| | |
|--------------------------------------|------------------|
| Invoiced to Coffee Societies | KSh 1,648,824 |
| Invoiced to NHIF | 1,116,350 |
| Invoiced to School Capitation Scheme | 141,430 |
| Out-of-Pocket Payments | <u>1,321,516</u> |
| Total | 4,228,120 |

Thus, out-of-pocket payments comprised only about 30% of total receipts. My impression is that this is an unusual reimbursement pattern for Church hospitals which tend to be located in the rural areas such that there is relatively little wage employment in the catchment area.

If government hospitals should implement fees for inpatient services, presumably they would be eligible for reimbursement not only by the NHIF but also by the third-party-pay schemes represented by other health-insurance schemes and related schemes herein briefly described. Thus, these schemes are potentially important from the point of view of developing alternative financing for the government health services. A more thorough-going investigation of this category of schemes than has been possible here would be in order.

Self-Employed Farmers: Arranging Their Participation in Social-Insurance Schemes

In Kenya, as in most countries, the beneficiaries of social-insurance schemes such as the NHIF and the various private health-insurance schemes discussed foregoing are in the main individuals employed in the modern, urban economy plus some employees in large scale, commercial agriculture. However, in Kenya, as in other countries, on the order of 80% of the work force is employed in the rural areas—a large percentage of these being self-employed in agriculture. Social-security-type insurance schemes traditionally have employees as beneficiaries and traditionally are financed by what amount to payroll taxes. Since, by definition, self-employed workers are not on payrolls, there has been an assumption in most countries that there is no feasible way to include them as beneficiaries in such schemes.*/ This assumption, however, represents too narrow a view of the matter. Fundamentally, social-security-type health-insurance schemes are simply employment-related schemes under which health benefits for the

*/ As in Kenya, the enrollment of the self employed at or above some income level may be mandated by law. Practically speaking, however, in Kenya as in most countries, it has not proven feasible actually to enforce this mandate. For familiar reasons which need not be rehearsed here, very few own-account workers will step forward to join a scheme such as the NHIF thereby declaring that their income is KSh 1000/=a month or more. In Kenya, individuals can enroll in the NHIF voluntarily by making the KSh 20/- mo. payment. Thus, in principle, self-employed farmers and other own-account workers could join the scheme in this way. Very few have, however.

beneficiary are financed by a levy on an economic transaction in which the beneficiary participates. In the usual case, this transaction has been a wage payment, but this circumstance is not central to the logic of such schemes. Self-employed farmers, say, also participate in economic transactions (e.g., the sale of their output) and there is no reason in principle why they cannot be the beneficiaries of employment-related health insurance schemes financed by a levy on those transactions.

To be practical (or, at least, to confer the full benefits of risk spreading), health insurance requires the group enrollment of beneficiaries such that the beneficiaries represent a fair cross section of the population in terms of health status.*/ Pursuant to this, health insurance is best marketed to pre-existing groups of individuals, i.e., groups formed for some purpose other than expressly for the purpose of consumption of health care. Group enrollment also greatly facilitates the administration of health-

*/ Individual voluntary enrollment in health-insurance schemes entails what is known as "adverse risk selection"--those who think that they will be sick (and hence those who turn out to be the high utilizers) enroll, those who think that they will be well (and hence would turn out to be the low utilizers) do not enroll--thereby greatly attenuating the risk-spreading function of this insurance. For this reason, individual health-insurance premiums are always much higher than group premiums for the same coverage.

From this point of view, the NHIF may reckon itself lucky that so few voluntary, individual subscribers have signed up. Indeed, it might pay the NHIF to give some thought to whether it should continue to hold open the option for such enrollments, thereby exposing the scheme to the possibility of adverse risk selection. (In any event, and as the NHIF has found out, the individual-voluntary enrollment feature can be an invitation to fraud.)

insurance schemes. For these reasons, the key to extension of health insurance and related social-financing schemes to those self-employed in agriculture is the extent and nature of "organized agriculture," i.e., organization among the farmers. The situation in Kenya looks promising from this point of view. This owing to the fact that the cooperative movement in Kenya is widespread in the rural areas and appears to be robust--in the sense that the primary societies and cooperative unions comprising the movement appear to be real, functioning organizations taken seriously by their members.*/ Farmers co-ops appear to be in the main producers co-ops, engaged in marketing, acquisition of inputs including credit, and the like.

The current membership of the KNFC is comprised of some six-country-wide cooperatives, forty-one Unions (of primary societies) and twenty-three large primary societies not part of unions. Total membership in the cooperative movement is estimated at over one million cooperators and, considering dependents, the movement says that it importantly "affects" the lives of some 10 million persons living in the rural areas. It appeared that, to date, little or no thought had been given to the possibility that

*/ Information on the cooperative movement in Kenya gained from discussion with spokesmen for the Kenya National Federation of Co-operatives, Ltd., the Deputy Commissioner for Co-operative Development GOK and the Ministry for Cooperative Development Nairobi Province. The KNFC publishes a periodical Mshiriki wa Kenya (most of the text is in English) four times a year which discusses cooperative movement activities and developments.

the cooperative movement might provide a vehicle for the participation of cooperative members in health-insurance and related schemes. Upon discussing this possibility, however, the prospect evoked genuine enthusiasm. It is clear that this prospect warrants further, serious study. I will attempt no more here than to suggest some of the ways in which the cooperative movement might seek to assist its members in engaging the health-services market.

Under one approach, large cooperative societies or cooperative unions might seek to contract with providers for the provision of services to their members on terms more favorable than the terms the members could obtain as individual marketeers in the open market. This approach is an effort to exploit the bargaining power inherent in collective action. Such contracts might be various kinds, e.g., to provide services on a pre-paid, capitation basis, to provide services on, say, a per session payment basis, to provide services at reduced fees for service. Contracts could be negotiated with both institutional providers (e.g., Church Hospitals) and individual practitioners. If government facilities implement schemes to market some services, they might be marketed to cooperatives on, say, a pre-paid, capitation basis. (There is discussion of the logic of this approach in the section "Fees for Government Hospital Services: The Organization Format"). Some technical assistance might be in order in negotiating such contracts. It is of interest to note in this context that the KNFC lists as among its "objectives" "--to act as an insurance agency for member co-operatives and to undertake all

work related to insurance " Although not "insurance" in the usual sense of this term perhaps, these contracts would represent a kind of "self insurance" by the cooperatives who were party to them under which the members paid contributions into an insurance fund used to pay benefits to those members.

The attractiveness and feasibility of the contracting approach would depend in part upon the availability of providers in the market area represented by the cooperative members. Mission hospitals tend to locate in rural areas and might be likely parties to such contracts as might health centers and dispensaries operated by the Church. There is also the important possibility that collective action by cooperative members could help to attract to rural areas providers who would not otherwise be there, i.e., the cooperatives might in effect contract to "make a market" for providers who might find such an opportunity attractive.*/

A question which warrants some examination is that of the most appropriate relationship of the self-employed farmers to the NHIF and, as part of this, that of the relationship of the cooperative movement to the NHIF. I have already expressed the view that individual voluntary enrollment is not an appropriate institutional vehicle for participation by these workers in the NHIF. An alternative would be voluntary group enrollment of cooperative

*/ Generally, self-help activities of co-ops (such as those alluded to) to arrange more acceptable means for their members to finance their demand for health care are very much in the spirit of the "district focus" for development.

members under the aegis of their cooperative societies and unions. Particularly if, as I previously have suggested, contributions to the NHIF by wage earners were put on a percentage (rather than absolute amount) basis, this would imply a different formula for the self-employed farmers and other own-account workers than for the wage earners. That is, cooperative societies would contract with the NHIF for their members to be enrolled as beneficiaries in exchange for a payment by the cooperative societies of so much per member per month. If a serious interest develops in income-related this insurance scheme, these payments, set as an absolute amount, could be varied depending upon the relative affluence of the group to be in this way enrolled. Another alternative would be to leave the self-employed farmers and other own-account workers entirely outside the NHIF, in favor of formalizing alternative, voluntary arrangements for this group, again, perhaps, on a contracting basis as foregoing. (It is unlikely that mandatory enrollment of self-employed members of the labor force in a scheme like NHIF can ever successfully be administered. Since laws and rules which can't be administered are at best demoralizing, there might be a good bit to be said for dropping this feature of the NHIF--if, indeed, this is a feature, see prior comment regarding ambiguity on this score.) The foregoing discussion of the role of the cooperative movement in providing a vehicle for participation by cooperative members in social-insurance schemes has been briefer than the importance of this topic warrants. Nevertheless, perhaps enough has been said to

suggest that some approach along the lines suggested is probably feasible and to urge that the matter be given further and prompt attention.

REFERENCES (In order of citation)

Dr. W. Koinange, "Health Strategy for Kenya," 1982--MOH, Republic of Kenya.

REPORT AND RECOMMENDATIONS OF THE WORKING PARTY, Working Party on Government Expenditure, Chairman Philip Ndegwa, July 1982.

Kenya Population and Development, A World Bank Country Study, IBRD 1980.

Kenya Country Economic Memorandum, Document of the World Bank, Report NO. 4689-KE, October 5, 1983.

Statistical Abstract 1983, Central Bureau of Statistics, Ministry of Economic Planning and Development, Republic of Kenya.

Economic Survey 1984, Central Bureau of Statistics, Ministry of Finance and Planning, Republic of Kenya.

"FY 1984 ESF Structural Adjustment Program Grant, 615-0213 Amendment," USAID Kenya, June 25, 1984.

ESTIMATES OF RECURRENT EXPENDITURE for various years.

THE APPROPRIATION ACCOUNTS for various years.

Ministry of Health, GOK, Development Plan 1984-1988.

Protestant Churches Medical Association, Annual Statistical Return 1982-83.

Catholic Secretariat, Medical Department, Statistics of
Facilities/Staff/Services, 1982.

Annual Trade Report, for year ended December 1981.

Development Plan 1984-1988, Republic of Kenya.

Germano M. Mwabu, A Model of Household Choice Among Medical
Treatment Alternatives in Rural Kenya, Ph.D. Dissertation,
Boston University 1984 (unpublished).

(Various unpublished annual reports for facilities and agencies and
the like, although referenced in the text, are not included in this
list.)

14 Sept 1984

Dear Terri -

Herewith the report, accompanying memo to those of Chuck is supposed to "sell" the project implications to the mission - I have sent the original to Bill for him to take ten and forward to USAID Kenya, original of report and memo both, that is.

Perhaps you can make a few copies of this for in-house distribution there.

I will be interested in your reactions to the report and memo -

We'll talk again before I take off for Swazi and environs.

Best regards.

30 August 1984

REF: ALTERNATIVES FOR FINANCING HEALTH SERVICES IN KENYA

Memo to: R. Britanak

C. Mantione

From: C. Stevens

Subject: Some implications of the above captioned report for USAID's health-sector assistance portfolio in Kenya.

Various of the institutional developments recommended by the report to the GOK provide attractive opportunities for USAID health-sector assistance. This is true both from the point of view of the objectives the recommendations are pursuant to and from the point of view of the content of the project-type activity they call for.

The major message of the Ndegwa Committee report was that economic and social development in Kenya will proceed best if there is a division of function such that government does what government does best and the private sector does what the private sector does best. My impression has been that USAID here finds itself in accord with this prescription.

In the health-services sector, this prescription means that government should seek to concentrate upon preventive/promotive, public-health services which tend, in the main, to be in the technical sense "public" goods while, to the extent possible consistent with equity of access, the curative load should be assigned to the private sector (curative

118

services tending to be, in the main, in the technical sense "private" goods).

The recommendations made in the instant report seek to promote this division of function. Thus, fees for government secondary and tertiary (hospital) services are recommended to recover a significant proportion of the cost of producing these services such that significant public financing can be shifted away from the government hospital sector (where most of it now is committed) to preventive/promotive services and to the rural health facilities network which is expected to carry a major part of the preventive/promotive load. Also, the recommendations urge efforts to promote the development of private social financing (health insurance, pre-paid capitation, etc.) of the demand for curative services provided by both the private and public sector. This too promotes the division of function between the private and public sectors because if there are to be fees for government hospital services, the design and administration of the scheme will be facilitated to the extent that the demand for these services can be socially financed. And, if the government is to reduce the commitment of public social (i.e., tax) financing to curative services, from the point of view of consumer welfare and compliance with commonly accepted principles of equity, the public-policy posture will be much more comfortable if private social financing rather than out-of-pocket financing can be substituted for the public social financing thus withdrawn.

In the health-services sector, the public-sector/private-sector division of function, to facilitate the diversion of scarce fiscal

capacity to preventive/promotive services, is most promising approach to recruiting adequate resources for these public-health activities. Thus, to the extent that USAID is interested in promoting preventive/promotive activities, the recommendations in the report on fees for government hospital services (and more generally, for greater reliance upon the private sector for these services) are directly in line with USAID's interests in this domain.

With respect to these institutional developments, a special problem is presented by that majority of the labor force in Kenya comprised of the self-employed farmers in the rural, agriculture sector. Is there any way in which these individuals and their families can be beneficiaries in health-insurance schemes and other social-financing-type schemes? The instant report recommends serious attention to this problem and to the possibility that the extensive cooperative movement in Kenya can provide the institutional vehicle to accomplish this.

To the extent that USAID assistance resulted in successful implementation of the foregoing institutional developments recommended by the instant report, USAID would have:

- (1) Made an important contribution to the well being of the people of Kenya (which is, after all, what social and economic development is supposed to be all about).
- (2) Helped to demonstrate in the health-services sector that division of functions between the private sector and the public sector which has become an important general policy objective here which USAID seeks to encourage.

- (3) Achieve a break through with respect to a problem which is of increasing concern in LDCs generally--namely, by what means can those self-employed in the rural, agriculture sector share with their counterparts in the modern wage sector the benefits of participation in social insurance schemes. This has become a lively issue because in many quarters there is no longer the conviction (as there was back in earlier times) that, in due time, general-tax financed government programs could deliver virtually everything "free" to the people that they might require for their social welfare. Alternatives are urgently needed to facilitate access to health care and in other domains.

Another major message of the Ndegwa Committee report was that there is a great potential for realizing savings through improved efficiency in the use of recurrent expenditure in the public sector. My impression has been that USAID here is in agreement with this judgment and regards the promotion of increased efficiency in the public sector as an important objective. In the government health-services sector (as in other government sectors) to achieve this objective requires the development of public and quasi-public organization formats which, unlike regular government-enterprise organization, afford incentives for efficiency.

The efficiency with which any organization performs depends upon various factors, e.g., the skills of the organization's planners, managers and other members of the work force. However, the most crucial factor is the incentive system. Whatever their skills, unless the

members of the organization have incentives to motivate efficient performance, efficient performance cannot be expected. The recommendations in the report seek to achieve this objective by urging an organization format for (some) government hospitals which would entail fees for services, retention of fee revenue by the facilities marketing the services, semi-autonomous status to permit management elbow room (especially with respect to personnel policy), and a "prospective-budgeting" relationship to the Ministry of Health. Under these arrangements, hospital management would experience the kinds of incentives that in large part account for the relatively greater efficiency of the private sector--namely, hospital management would be at risk for success (including tenure of position). The report recommends that a start be made in the near term on implementing this organization format by undertaking a trial run with Kenyatta National Hospital (KNH).

To the extent that USAID assistance resulted in successful implementation of the organization format entailing prospective budgeting and related features, USAID would have:

- (1) Helped to provide a solution to the KNH problem which rapidly is becoming a source of political embarrassment for the GOK.
- (2) Increased the efficiency of an institution, KNH, which makes a major claim upon scarce MOH resources, thereby making these resources go farther in the service of all MOH objectives, including preventive/promotive services.
- (3) More generally, and, in some ways as importantly, demonstrated

in the health-services sector an organization format of general interest and significance, for the problem of increased efficiency of public enterprise generally. That is, the health-services sector might in this sense be regarded as a kind of potentially leading sector for this kind of reform in the public sector more generally.

As the discussion foregoing has sought to make clear, at least from the point of view of the objectives which the recommendations in the report seek to achieve, the institutional developments recommended in the instant report do provide what must be regarded as attractive opportunities for USAID health-sector assistance. We may turn now, briefly, to the content of the project-type activity they call for.

A Health Sector Financing and Institutional Development Program

What I have in mind would be a program which, in spirit if not in institutional detail, would be very much along the lines of the 1972 HMO Act in the U.S. This legislation sought to promote the development of Health Maintenance Organizations (HMOs) regarded as economical and otherwise desirable delivery systems which ought to be encouraged by public policy. The HMO Act sought to be responsive to initiatives by parties who wanted to develop HMOs (e.g., hospitals, insurance companies, medical schools, and others). Various kinds of assistance were provided, front-end money for design activities, grants for operational planning, and some risk underwriting, i.e., grants and loans to help defray the operating deficits to be anticipated by newly organized HMOs in their

first several years of operation. A Health Sector Financing and Institutional Development Program (HSFIDP) along these same lines would be an appropriate kind of assistance program to help the GOK implement the institutional developments recommended in the instant report.

This is not the place to attempt to spell this program out in operational detail. The spirit which would inform the HSFIDP would be, as with the U.S. HMO Act, to be responsive to initiatives by parties who wanted to promote institutional developments of the kind recommended in the instant report, by parties who would step forward and apply for assistance. The HSFIDP might provide the kinds of assistance provided by the HMO Act including some funding for risk underwriting. The program should be willing to entertain (i.e., accept applications for assistance from) any of a variety of financing and institutional development proposals by any of various public or private parties in the health-services community, without preselecting the parties who, as the program is administered subsequent to its implementation, will turn out to be the particular parties assisted under the program.

The logic which informs the HSFIDP is that it be responsive to initiatives by the parties to institutional development schemes, thereby greatly increasing the probability that any scheme assisted by the Program will prove viable. However, it will be in various ways helpful for project implementation, and not inconsistent with this logic, to give some prior attention to the kinds of schemes, and, indeed, even particular parties, which or who might evolve as likely candidates for assistance under the Program. An example of this, discussed foregoing,

is the prospect of a trial run with KNH on the prospective-budgeting and related-features-organization format. This example can serve to illustrate one way in which the HSFIDP might play a vital role in implementing the kinds of institutional developments recommended in the instant report. In various countries, health officials and others have tried to persuade governments that much would be gained if revenue from fees for government provided health services could revert to the facilities marketing the services. These efforts have been unavailing. It appears that what may be required is an actual demonstration of the alleged benefits. At this point, however, with respect to a development such as that proposed for KNH, we confront a seemingly intractable problem. As will have been evident from the discussion in the instant report, in order to demonstrate the benefits in terms of improved efficiency and product quality and, indeed, in order to be able to operate the scheme at all, government facilities charging fees and marketing services must be allowed to retain the revenue from these fees. But, if ex ante such demonstration, governments cannot be convinced to let the facilities retain the revenue from fees, the demonstration cannot take place. We seem to be stuck on dead center in this domain.

It is at such a point that the HSFIDP could play a vital role. The central idea would be to have the Program provide the funding, in the instant case to KNH, necessary to run the trial as if KNH were entitled to retain the revenue from fees (and use this revenue under guidelines set out). KNH would be obligated de jure to turn all fee revenue over to the exchequer. However, the Program would pay KNH this same amount,

I.e., as if KNH had retained the revenue from fees. Thus, the demonstration could take place. And, if it were successful, the government would implement what had been its good faith commitment to adopt this as a regular part of government operating procedure if the trial proved successful. With respect to a trial such as that with KNH, the HSFIDP would also have played a vital role in funding TA to assist with operational design of the scheme, etc.

Another example of a kind of program which might apply for assistance under the HSFIDP would be, say, a large cooperative society or union of such societies which wanted to explore (study, design a program) the possibility of social financing schemes for their members. Or, a mission hospital seeking assistance to explore the feasibility of marketing services on a pre-paid, capitation basis. Other examples may come to mind.

Finally we may remark certain differences between HSFIDP-type assistance programs and the typical AID health project. The typical AID health project has a fairly narrow institutional focus in the sense that it engages some small subset of events or activities within the domain of the MOH. Assistance programs such as the HSFIDP however, which assist institutional developments which entail significant changes in the way in which the demand for health services is financed, must engage a wide range of economic, political and social issues and must involve the various parties at interest in the resolution of these issues, i.e., not only the MOH, but also other Ministries such as Finance and Planning, Cooperatives, and others--and not only the public sector but also

26

elements of the private health-services community. Although this feature of HSFIDP-type program assistance may put some additional burden on the implementation of this type of program, it also has a major benefit. Assistance programs of this type and the institutional developments they seek to promote help to cope with the traditional isolation of the health services sector, i.e., help to pull the health-services community and health-sector events more into the mainstream of social and economic development events.