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**FINANCING HEALTH CARE IN KENYA:
BACKGROUND AND FRAMEWORK
FOR STRATEGIC PLANNING**

by

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ABSTRACT

This paper adapts the strategic planning process to the public sector, specifically the health sector, to provide advisory policy support to the Government of Kenya on health care financing reform. It is not a strategic plan; it is a description of the process whose final product is to be a strategic ten year plan.

The authors describe a framework for the process based on four main points:

- Set goals in terms of the ultimate beneficiaries.
- Focus on economic issues.
- Separate financing and service delivery issues as much as possible.
- Remember people pay for the health system, directly or indirectly; "nothing is for free", therefore, the efficiency and equity of expenditures are important.

The paper concludes with a proposal for institutionalizing the process in the Ministry of Health and an action plan for carrying out the planning process.

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ACRONYMS

GDP	Gross Domestic Product
KHCFP	Kenya Health Care Financing Project
KNH	Kenyatta National Hospital
KSH	Kenyan Shilling
MOH	Ministry of Health
NGO	Nongovernmental Organization
NHIF	National Hospital Insurance Fund
PADS	Provincial and District Hospital Study
PHC	Primary Health Care
USAID	United States Agency for International Development

1.0 INTRODUCTION TO STRATEGIC PLANNING

Over the past decade, the Government of Kenya has made important strategic decisions in health care financing. These decisions include plans first enunciated in the early 1980s to emphasize the economic sectors and turn over to users a larger share of responsibility for funding the social sectors (and thus in health to implement a cost sharing program), to shift tax-supported health sector programs away from hospital-based curative services toward clinic-based primary and preventive services, to convert Kenyatta National Hospital (KNH) into a parastatal, to plan major investments to upgrade facilities, and to take steps to improve the coverage and benefits of the National Hospital Insurance Fund (NHIF). These actions, taken together, are elements of an implicit health financing strategy. The goal of this exercise is to assess where the country stands today in financing the health sector and, through an interactive process, to develop a plan for the next decade or more.

A strategic plan in a private business is an evaluation of the current situation facing the firm, the future environment it will face, and the risks and benefits of changing course, given the current situation and future opportunities. On the basis of this assessment and estimates of the costs and benefits of pursuing alternative paths, a strategic plan lays out general directions that the firm will take over the long term. Depending on the size and complexity of the business and its governance, strategic planning may be an interactive process or involve only a handful of people. It is typically based on quantitative assessments and budgets. The result is a general road map for managers, who develop implementation plans and regularly report on their progress relative to the strategic plan. Strategic planning in a firm is accompanied by long term capital expenditure plans, product development plans, marketing plans, and so on. Obviously strategic plans cannot be set in stone and must be adjusted to changing circumstances, especially new opportunities and problems that develop as the firm follows through with the plan.

Adapting strategic planning to the public sector requires some modifications. First, the scope and complexity of the task take on nation-size proportions. There are many stakeholders, including politicians, bureaucrats, service providers, private sector competitors, financial institutions, labor groups, taxpayers, and beneficiaries, all of whom must have a voice in the process and the decisions. Second, the strategic plan must concern itself almost completely with general direction rather than with the nuts and bolts of how to accomplish the goals. Third, as a result of the above two elements, the process must be open and consultative so that a broad consensus can be reached and stumbling blocks to implementation minimized. Fourth, capital budgets will not be a result of the strategic plan — at the national level they too will be implementation steps. Instead, the results must support general changes in direction for policy, with capital budgeting decisions following later. Thus the strategic plan developed as a result of this document will be oriented to policy — where is the policy direction already solid, and where does it require innovation and change? What areas of policy should be targets for action over the next decade? What kind of public and administrative processes must be developed to proceed along the lines emphasized in the strategic plan?

1.1 FRAMEWORK FOR STRATEGIC PLANNING

Exhibit 1 displays the elements of the health care system in Kenya that must be taken into account in developing a strategic plan for financing. It contains four components, which are labeled in the left column. First, the *beneficiaries* of the health care system are ultimately the individuals and households who use it. Of course there are many others involved in service delivery and administration, but we are concerned in this exercise principally

Exhibit 1 The Elements of Kenya's Health Care System

Beneficiary	Individuals and Households		
Health Care Activities	Public and Community Health	Preventive Services	Curative Services
Providers of Services	Ministry of Health	Charitable Organizations (NGOs)	Private for-Profit
Financing	Taxes	Out-of-Pocket Spending	Third Party (Employer, Insurer, NHIF)
	Foreign Assistance	Charitable Contributions	

with the welfare of the clients who are supposed to be served by the system. The goals of the strategic plan and of the health system must be stated in terms of these beneficiaries.

Continuing with the second row of Exhibit 1, the *health care activities* intended to reach the beneficiaries fall roughly into three categories, public or community health (e.g., vector control and health education), preventive services (e.g., immunizations), and curative services (acute care). These three categories have economic significance because their financing needs are substantially different. The most important economic issue is that adequate financing of *public health or community health services* will not arise in a free

market environment without government intervention because it is too easy for people to benefit from services like vector control without paying.¹ Curative services, at the other end of the spectrum, benefit the person who pays with few or no spill-over benefits to those who do not pay, so there is little trouble inducing individuals to finance them adequately without government intervention. A role for the government in financing curative care arises only due to concerns about access of the poor to curative services or potential catastrophic costs that can impoverish even an unlucky middle-class household. Preventive services fall in between these two extremes because they have characteristics of both public health and curative services — people are willing to pay for such services, but they will not purchase enough of them to protect the community without some form of government incentive or penalty structure that induces full coverage.

There are interactions among these services. Inadequate financing for public health and preventive services begets high expenditures for curative services. Three examples are malaria, measles, and injuries due to road accidents. Society can pay to prevent them or to treat them. Treating them tends to be more costly financially and is certainly more costly in terms of human suffering. Moreover, heavy public financing for curative care can crowd out financing for public health services and put society on a treadmill in which it spends more and more for curative care (easily justified because of high demand for the services) but cannot spare enough to invest in public health activities that might actually reduce the need for current levels of spending on curative care. How Kenya spends its public funds across these three types of health care activities is clearly a central strategic issue.

Continuing with the third row in Exhibit 1, in Kenya, as in other countries, the *providers of health services* are of three types: the Ministry of Health (MOH); non-governmental, charitable, or non-profit organizations (NGOs); and private-for-profit practitioners, clinics, and hospitals. The MOH currently provides, through its own service delivery system, all three types of health care activities discussed above. NGOs also provide curative and preventive services, and in some areas they finance and deliver public or community health services. Private for-profit providers specialize in curative services but also offer some preventive services to people who pay for them. Both charitable and for-profit providers are fully capable of delivering community health and preventive services. They tend not to provide high volumes of these services because of the financing problems cited above. The government's decisions about how to finance and deliver the three different types of health care activities affect the development and viability of non-government providers, because the government can choose to purchase these services from other providers or deliver them itself. These decisions ultimately affect the quality and quantity of health care services made available to the population.

¹ The result is that one household can "free ride" on another household's spending. This problem reduces the incentive of any household to spend on public health activities. For example, it does a single household no good to control mosquitoes on its property unless it is willing and able to do so for the whole community, because mosquitoes do not abide by human rules on property rights. Without some organized effort to control the vector community-wide, through government taxation and spending, vector control will not be effective.

Finally, the bottom row shows five sources of *financing* for service providers, including expenditures from tax collections; out-of-pocket spending by consumers; spending by third-party payers such as employers, insurers, and the National Hospital Insurance Fund (NHIF); charitable contributions (both domestic and foreign); and foreign assistance. Taxes and foreign assistance are two sources of funds that are available almost exclusively to the MOH, although it may use some of those funds to subsidize services delivered by NGOs and the private sector, or it may use those funds to contract for services from either of these other providers. Today, almost all of these funds are used to pay for the MOH's direct delivery system. Out-of-pocket spending is available to all three types of service providers, with the MOH currently taking only a tiny fraction of its revenues from this source. Third-party payments are dominated by the NHIF, and these flow almost exclusively to NGO and private hospitals. NGOs also benefit from charitable contributions.

Exhibit 2 Connections and Interactions among the Elements of Kenya's Health Care System

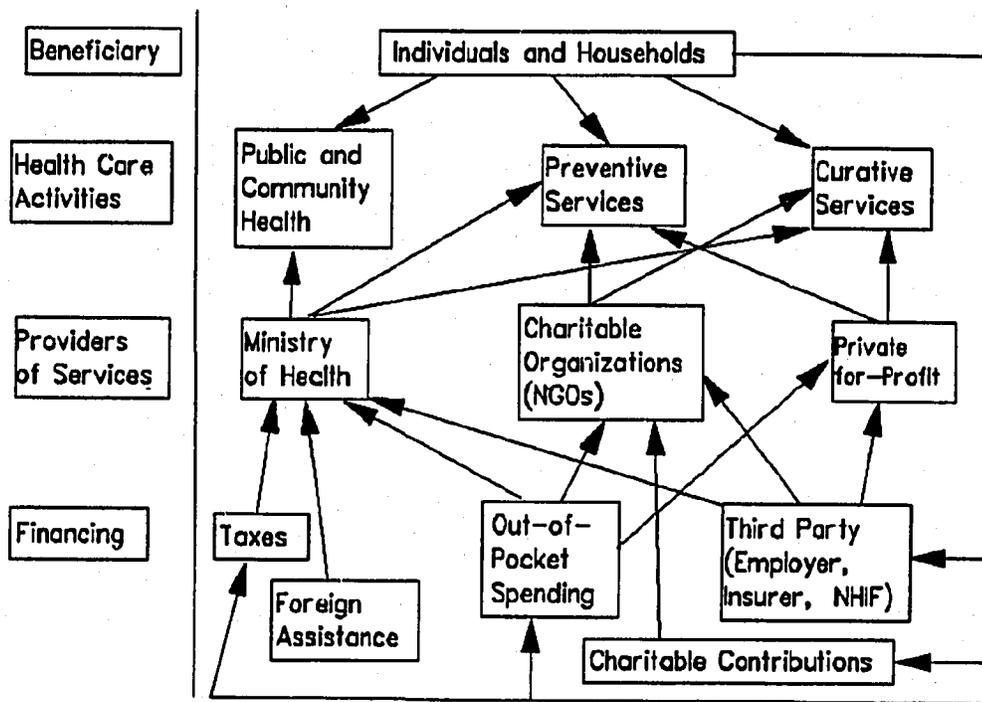


Exhibit 2 reproduces Exhibit 1, but includes arrows that illustrate the basic connections made among the different parts of the figure by the discussion above. While it is clear that the individuals and households at the top of the figure do indeed benefit from all three health care activities, they also are the ones who pay for them through taxes, out-of-pocket spending, third-party

contributions, and charitable contributions. From an overall social point of view, therefore, there are no gifts. Foreign assistance and some charity do come from outside the system, but both come either with strings attached or a requirement that they be repaid. The main problem for consumers in this framework is that only out-of-pocket spending is directly connected to the receipt of a service. All other forms of spending, especially taxes and third-party payments, involve fiduciary relationships in which an institution is spending money on behalf of households. In many ways, this strategic plan for health financing is an attempt to improve this fiduciary relationship.

In summary, this framework suggests the following main points for the strategic plan:

- a. **Goal setting in terms of the ultimate beneficiaries:** The need to set achievable goals for health financing that are oriented to the welfare of the final beneficiary (and financier) of the system, in the expectation that an efficient and equitable health care financing system that responds to the needs of individuals and households will result in better health for them.
- b. **Focus on economic issues:** It is important to distinguish between the economic and medical characteristics of the activities that are undertaken in the health system. The economic characteristics help considerably in defining the essential role of the government in financing some services — those that benefit groups rather than individuals — and the more optional role it takes in financing other services once this basic responsibility has been met. In short, an orientation to the economics of these activities helps develop a hierarchy for government financing decisions and areas for private sector involvement.
- c. **Service delivery versus financing:** The crucial problem of service delivery can be separated from the issue of financing to a large degree. The government may choose to expand or contract its role in service delivery. What it does in this area will discourage or encourage others who could do the same job, to expand their roles. The government must, however, take an active role in financing community-wide and preventive interventions.
- d. **There is no free lunch:** This point is so commonplace that it is almost trite. But its importance cannot be overemphasized. The beneficiaries of the health system are not receiving a free gift from the government or the insurers. They are paying for everything. Given the evidence of taxes and the NHIF contribution structure, poorer households pay a larger share of their incomes to support the health system than do the rich. Thus, improving the efficiency and equity of expenditures in the system is a serious responsibility of the institutions spending the money.

1.2 GOALS FOR THE HEALTH CARE FINANCING STRATEGY

The commonly stated goal is to improve health outcomes, but it is very difficult to measure progress against such a general goal.² However with this framework and the focus on outcomes for the final beneficiary of the health system, it is possible to state a narrower set of goals for the strategic planning process that provide a general orientation for the work, including the following:

1.2.1. Development of the Public Policy Role of the Ministry of Health

Continued development of the MOH orientation to public policy as opposed to the more narrow day-to-day problems of service delivery. The strategic planning process itself moves the MOH in this direction.

1.2.2. A Public Health Focus for Ministry of Health Spending

This goal requires an orientation to the following areas: improving the healthfulness of the environment within which people live and work, increasing the availability and effectiveness of preventive services, educating the public about how to achieve better health outcomes for themselves and their children, and facilitating improved financing of both public and private health services.

1.2.3. Targeting Public Subsidies for Curative Care to the Poor

With greater involvement of the private sector in service provision and an increasing role for beneficiaries in paying directly for the curative services they receive, the public sector will have the opportunity to better target its continuing subsidies for curative services to those who need them most, and to improve its provision of public and preventive health services that benefit poor and rich alike.

1.2.4. Encouraging a Larger Non-Government Role in Delivering and Paying for Curative Services

This goal includes further development of cost sharing in the public sector, a careful assessment of the MOH's role in direct delivery of services, and encouragement of private sector provision of services. The result should be a wider array of choices among service providers and financing options for consumers, better protection of consumers against catastrophic losses, more flexibility in the delivery system to respond to changes in income and tastes, and improved incentives for providers to provide high-quality care in an economically efficient manner. To the extent that the public system continues to be a major supplier of medical services — and it will, for a variety of reasons — it can contract with private suppliers for some inputs and can emulate to some degree the incentives that exist in the private sector by devolving

² Apart from the question of whether progress is to be measured against some absolute standard or relative to other countries.

authority, accountability, and responsibility for resource generation to the facility level.

1.2.5. Strengthening Alternatives to Tax and Out-of-Pocket Spending

A more pluralistic and flexible service delivery system requires a flexible and adequate social financing mechanism for curative services, whether they are purchased from the public sector, the charitable sector, or private providers. The government has a major role to play in ensuring that such mechanisms are available and adequate to the task.

A first task of the strategic planning process is to gain agreement on the general goals for the process. Do those listed above, or another set developed by those involved in the process, provide a broad statement of purpose agreeable to a majority of the interested parties? Focusing on goals that affect the welfare of the beneficiaries rather than the more general underlying goal of "better health" allows a few principles of public finance and economics to guide the process of setting priorities and developing an agenda for action.

1.3 STRATEGIC PLANNING WITHIN THIS FRAMEWORK

Exhibit 3 again reproduces the basic framework but this time includes the topic areas into which the strategic planning background work has been divided. These topics are in the boxes with thick borders and large type. They include resource allocation, efficiency in service delivery, cost sharing, the private sector (including the legal and regulatory framework), and social financing. Thick lines in the diagram indicate the strongest links, and thin lines represent weaker links in the current financing system. Each of these areas is briefly explained below.

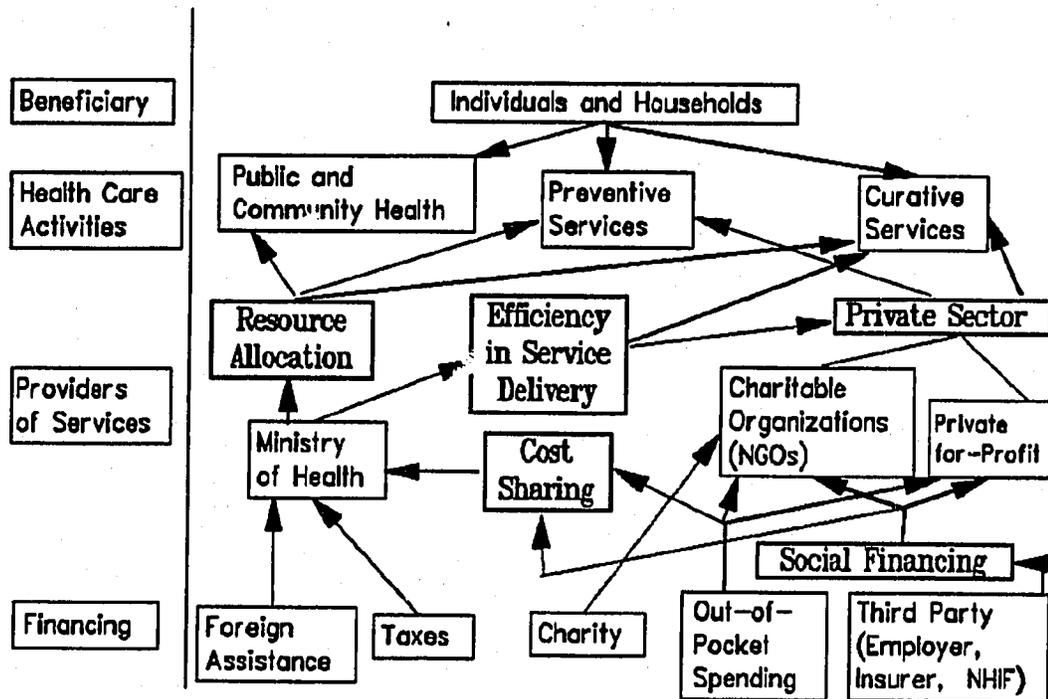
1.3.1. Resource Allocation

At the most basic level, resource allocation represents the decision by the MOH on how to allocate resources among the three possible types of health care activities: public health or community, preventive services, and curative services. Capital investment, labor, and recurrent budget allocations follow these choices. Exhibit 3 indicates with a thick line that resource allocation currently favors curative services. Within each of these three health care activities, additional resource allocation decisions are made, such as spending on vertical programs or clinic-based services, and spending on hospitals relative to health centers.

1.3.2. Efficiency in Service Delivery

Efficiency has come to refer principally to efficiency in the delivery of curative services in hospitals and clinics. It is also bound up closely in the quality of services, as managers attempt to squeeze the highest volume of high-quality services from the limited resources that are available. Although improving public sector efficiency in service delivery has been historically considered an internal managerial and budgeting problem, the private sector represents a tool that can be used, through contracting or other means, to raise

Exhibit 3 Choice of Topic Areas for the Financing Strategy and How They Fit Into the Overall Framework



efficiency and quality. Exhibit 3 indicates the strong link from the government's standpoint between efficiency considerations and management of curative services, as well as the weak link in the current environment between the efficiency/quality nexus and the private sector as another tool to achieve the same goal.

1.3.3. Cost Sharing

Cost sharing really means generating additional revenues for the MOH through user fees paid by clients. Because some clients are covered by the NHIF or other third-party payers, cost sharing has also come to mean collecting funds from these third parties. Although no arrows indicate it, the cost sharing program has been used also as a device to improve *resource allocation* by earmarking some of the funds to public and preventive health services. It has also been used as a device to improve *efficiency* and quality by allowing the remainder of collections to remain at the facility, under its authority, to purchase needed inputs to improve services. Thus the cost sharing program has multiple goals within this framework, based on tapping a source of revenue that has not been used much in the past by the MOH. However, it is important to note that cost sharing also plays a role in targeting public subsidies to individuals,

and it forces consumers to make a choice between paying at public service points, diverting their utilization to NGOs or private providers, or not using the curative system at all.

1.3.4. Private Sector

The role of the private sector in delivering modern medicine has increased tremendously over the years with the cumulative impact of large investments to train medical professionals, increasing incomes and higher levels of education among the population, development of the NHIF, and the growth of urban areas (to name but a few of the determinants of private sector growth). In addition, Kenya benefits from a large charitable sector whose growth has been fueled by the same factors, while support from charities and government budget transfers to them has fallen. In this environment of a maturing and growing private sector, along with ever-increasing demands on constrained public budgets, new opportunities arise for policy development and cooperation between public and private providers. The legal and regulatory framework is part of this area.

1.3.5. Social Financing

Social financing is a broad term that encompasses compulsory public insurance, voluntary private insurance, and less formal cooperative-based or village-based efforts to protect members from risk through prepayment mechanisms. It is a key element that can facilitate Kenya's unfolding policy initiatives in which beneficiaries are expected to shoulder a larger burden of the cost of curative care so that the government can channel its resources into community health and preventive services. In addition, this source of financing affects the development and diffusion of the private sector. Through the NHIF, the government has a key role to play in the further development of social financing mechanisms.

1.4 CONCLUSION TO INTRODUCTION SECTION

A possible set of goals for the strategic plan have now been outlined for discussion. The health system has been taken apart and reassembled to show the framework within which the strategic plan must seek these goals. The areas of the strategic plan have been embedded in this framework, with some discussion of the dimensions of each piece. The preliminary work that is left is to establish what has already been done in these areas, to review recommendations of needed actions in each area, to establish priorities, and to propose a plan for moving forward.

2.0 BACKGROUND TO STRATEGIC PLANNING IN HEALTH

2.1 THE 1990 CONCEPT PAPER

Mr. D.M. Mbiti, Mr. James Khachina, Mr. George Kioko Wa Luka, Mr. J.K. Mutai, Mr. Francis Mworia, Mr. Njorge, and Mr. G.H. Olum participated in a study tour in August and September of 1990 that culminated in the development of a concept paper laying out the main components of a health financing strategic plan. This concept paper had three main components: revenue generation or mobilization of financial resources; organization and structure of the health sector; and efficiency, effectiveness, and equity in the use of health sector resources. Key goals outlined in the concept paper for each area are summarized below.

2.1.1. Mobilization of Resources

The group focused on the need to increase the volume of resources available to the health sector. Methods of doing so were the following: (a) increase fees so that the contribution of *cost sharing* to the Ministry of Health's budget would increase from 5 percent to 20 percent of recurrent costs by the year 2000; (b) increase the contribution of *social insurance* through NHIF and the private insurance industry by widening membership and increasing their contribution to the total cost of medical care for members; (c) increase *government contributions from taxes* by earmarking taxes on cigarettes, alcohol, and car insurance to health.

2.1.2. Organization of the Health Sector

The government would encourage a variety of service delivery entities in the health sector: (a) *NGOs* would be encouraged to continue providing services, although without increased public assistance; (b) an effort would be made to better understand (and accommodate) the role of *private physicians and clinics* in providing services; (c) *decentralization* would be encouraged in the public sector service delivery network.

2.1.3. Efficiency, Effectiveness, and Equity

The MOH would take the following steps to improve its operation in these areas: (a) while the government service delivery system has a strong curative focus that the group thought was appropriate, they agreed to *emphasize preventive services* as a priority for new resources in the sector; (b) they agreed that improving the efficiency and effectiveness of MOH health services required *emphasizing nonpersonnel expenditures*; and (c) a strong information basis was called for to better *target resources across districts*. Considerable effort would be expended on developing effective information systems, drug procurement systems, and computer networks to increase the ministry's ability to manage its resources effectively.

The government has moved forward in all of these areas. Over the past two years, efforts have focused particularly on creating an effective and fair cost sharing program and assisting the NHIF to expand its capabilities as a financial entity in the health sector. Both as part of the cost sharing program and as

part of the MOH's efforts to reallocate its resources, the ministry has implemented policies to (a) ensure "additionality" of cost sharing resources at the facility level; (b) earmark 25 percent of those funds for primary/preventive services, and (c) devolve some decision making to the local level. Efforts to improve the allocation of resources between salaries and non-salary inputs have begun. A dialogue has been opened with the private sector.

The current strategic planning document builds on the work of this group in a number of ways. First, it has already developed a framework in which all pieces of the concept paper fit logically. Second, it proposes to make the strategic plan a living document by making it the outcome of a regular process of information gathering, debate, and decisions. Third, it proposes a more explicit approach to social insurance and to interactions with the private sector, including NGOs and private practitioners. Fourth, it suggests ways to take advantage of interactions between the public and private sectors to achieve national goals in health services.

2.2 HEALTH POLICY IN KENYA

The Ministry of Health has been working on a new health policy that sets goals in a number of areas:

- a. Reduce endemic diseases.
- b. Encourage healthful behavior and reduce "lifestyle" diseases among adults.
- c. Reduce infant and child mortality.
- d. Prepare for greater prevalence of AIDS.
- e. Increase access to health care for the poor.

The first two goals fall firmly within the public and community health category in Exhibit 1. Success in these two areas will have strong positive impacts on the third and fourth goals, which require additional activities that fall more within the preventive service category in Exhibit 1. Finally, the fifth goal suggests that public subsidies for preventive and curative services should target the poorest members of society. These goals for health policy are completely consistent with those outlined on page 5 for the health financing strategy. However, the health financing strategy, by addressing the whole health system, can provide a wide range of policy tools to reach these health sector goals.

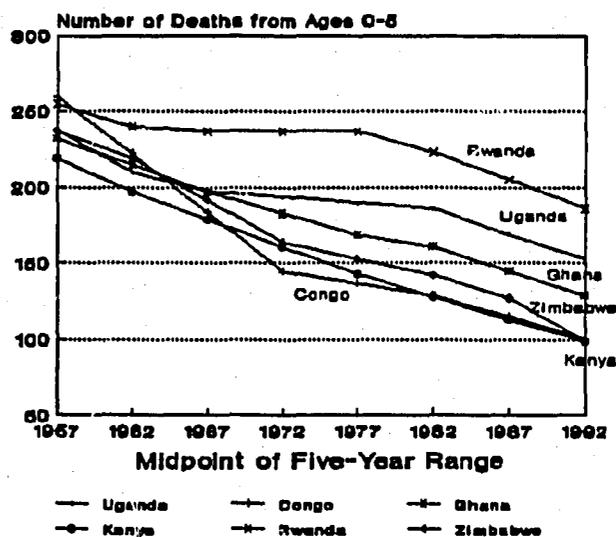
2.3 ISSUES IN THE FIVE TOPIC AREAS

As part of the preparation for the strategic plan, background papers were prepared in each of the five topic areas listed in Exhibit 3. In this section, the major findings are summarized.

2.3.1. Resource Allocation

Relative to other African countries, Kenya has performed well in improving overall health indicators. Infant mortality fell from 112 per thousand live births in 1965 to 67 in 1990. Over the same period, life expectancy at birth for men rose from 46 to 57 and for women, from 50 to 61. In all of these indicators it has raced ahead of its neighbors. For example, female life expectancy for Kenyans was about five years greater than for Tanzanians in 1965; by 1990, the spread had more than doubled to 12 years.³ Exhibit 4 compares estimates of child mortality for Kenya with those of five other African countries that started out at roughly the same point in the late 1950s.⁴

Exhibit 4 Comparison of Estimated Child (Under Five) Mortality Rates in Selected African Countries, Mid 1950s to Early 1990s



Kenya approaches the year 2000 with a strong record of accomplishment in the health sector. However, the challenges are also great. Regional variations in health indicators are wide. According to the Kenya Demographic and Health Survey, under-five mortality in Central Province in 1989 was less than 50, but it was well over 130 in Coast, Nyanza, and Western Provinces, where about 40 percent of the population lives.⁵ About 26 percent of new outpatient visits to MOH facilities in 1989 were due to malaria, and 22 percent were due to respiratory illnesses; these two general categories thus accounted for about half of all outpatient visits. Another 15 percent were caused by diarrheal diseases, intestinal worms, and diseases of the skin.⁶ The World Health Organization estimates that about 48 percent of all deaths in 1992 will be caused by infectious and parasitic diseases, 13 percent by respiratory diseases, and 13

³ All figures are from the World Bank (1992) World Development Report 1992. New York: Oxford University Press.

⁴ The graph is based on U.N. projections reported in Ross, John A., Marjorie Rich, Janet P. Molzan, and Michael Pensak (1988) Family Planning and Child Survival: 100 Developing Countries. New York: Columbia University Center for Population and Family Health.

⁵ National Council for Population and Development, Ministry of Home Affairs and National Heritage, and Institute for Resource Development/Macro Systems, Inc. (1989) Kenya Demographic and Health Survey. IRD/Macro Systems, 8850 Stanford Blvd., Suite 4000, Columbia MD 21045 USA.

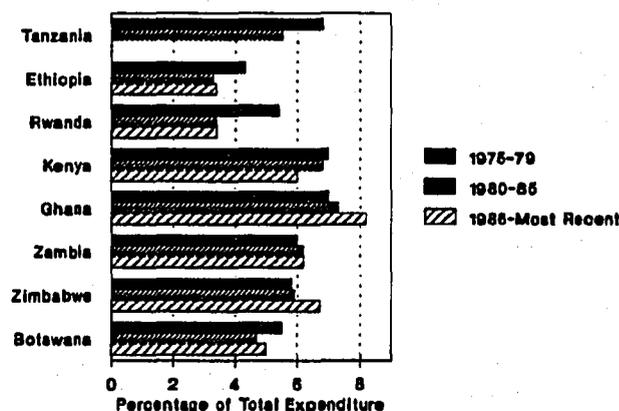
⁶ Republic of Kenya, Ministry of Health (1991) Health Information System 1989 Annual Report. Nairobi: Ministry of Health.

percent by diarrhea.⁷ Thus well over half of the health problems that are handled by curative services fall into the categories of public health problems (vector or water-borne) and preventable problems.

Data on hospital admissions for three hospitals in or near Nakuru District reveal a pattern of largely avoidable problems that is no less disconcerting than the outpatient data. In Nakuru Provincial Hospital in 1989, a sample of patient records revealed that burns, injuries and wounds, fractures, and malaria accounted for 26 percent of inpatient admissions. At Naivasha District Hospital, bronchial pneumonia, abortion, malaria, and burns accounted for 34 percent of inpatient admissions. In Mercy Mission Hospital, malaria, pneumonia, abortion, and measles accounted for 47 percent of admissions. In Naivasha and Mercy, malaria and abortion accounted for 37 and 42 percent of admissions to the female medical wards, respectively; malaria, wounds, injuries, fractures, and traffic accidents accounted for 52 and 27 percent of admissions to the male medical wards. In the pediatric wards, bronchial pneumonia and malaria accounted for 34 and 44 percent of admissions, respectively.⁸ These data suggest that a large fraction of inpatient cases — by far the most expensive level of treatment in the curative system — are preventable through other interventions.

Exhibit 5 Percent of Central Government Budgets Devoted to Health in Selected African Countries, Averages for Three Periods

Does Kenya spend enough on health care? Exhibit 5 shows a comparison of the percentage of government budgets devoted to health for a sample of African countries, including three of those shown in Exhibit 4. The countries are ordered by increasing per capita GDP. The range is from the poorest countries in the world, Tanzania and Ethiopia, with GDP of about \$115 per capita, to Zimbabwe and Botswana, with GDP of \$640 and \$2,040 per capita (respectively) in 1990. Kenya is around the middle of the list, with per capita income of \$370. On average, central



governments spent 6.0, 5.4, and 5.6 percent of their budgets on health during the three periods shown in the graph. Kenya's spending in each period is above the average, but it tends to be lower than in the countries with higher per capita incomes. It is the only country for which the percent of the budget devoted to health has fallen consistently over the period, from an average of seven percent

⁷ Davies, Dr. Marcella (1990) Kenya Annual Report for January - December 1989. Nairobi: World Health Organization Office.

⁸ REACH Project (1990) Provincial and District Health Services Study: Nakuru District Main Report. John Snow Incorporated, Arlington, Virginia, USA.

in the first period to six percent in the last period. As was stated earlier, this trend is the result of a strategic decision by the government to emphasize spending on the economic sectors.⁹

Exhibit 6 translates these figures into constant 1987 U.S. dollars. Kenya's spending is similar to countries that are about at its level of GDP per capita (Ghana and Zambia). This graph clearly shows, however, that the contraction in the percent of government spending going to health resulted in a real drop in resources for the health sector in the most recent period. With continuing slow growth in the economy, it is likely that there has been a further contraction in real spending since the late 1980s.

Finally, Exhibit 7 shows a very rough estimate of the percent of GDP spent on medical services and how it is split between government spending and private spending for the most recent year. According to this graph, Kenya is spending the smallest share of GDP on health of any country in the group, but a relatively high percentage of the total is from the central government.¹⁰

In summary, Kenya has achieved relatively good overall results in terms of health outcomes for its population. It has done this with an approximately average level of government fiscal effort in the health sector relative to a sample of other African countries. However, per capita spending by the government in real terms began dropping in the late 1980s, and

Exhibit 6 Per Capita Central Government Spending on Health in Selected African Countries, Averages for Three Periods in Constant 1987 U.S. Dollars

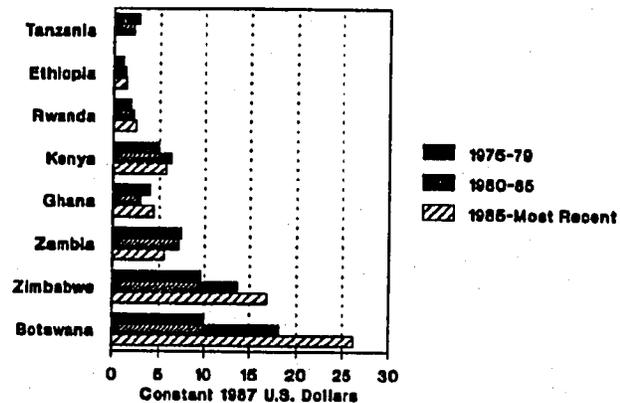
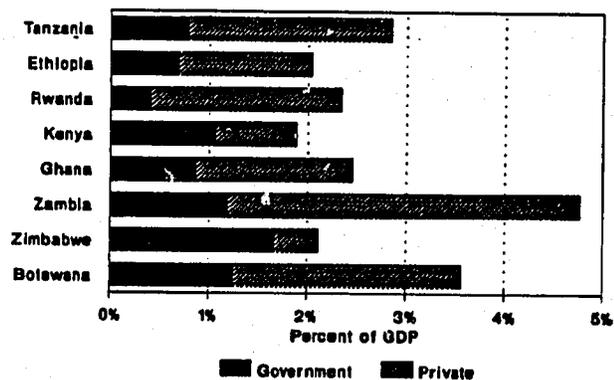


Exhibit 7 Estimates of the Share and Composition of Health Spending in GDP, Most Recent Year (1987-89)



⁹ Exhibit 5 through Exhibit 7 are based on data from the World Bank *World Development Report 1992*. New York: Oxford University Press (1992), and on data from the United Nations Development Programme and The World Bank (1992) *African Development Indicators*. The most recent year ranges from 1987 to 1989.

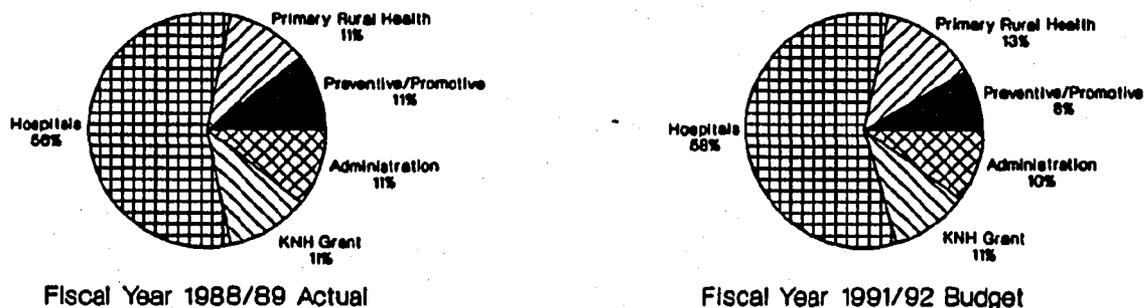
¹⁰ These estimates should only be treated as indicative. Central government spending as a percent of GDP was calculated, then it was subtracted from total public and private spending on medical care in GDP, as estimated by the International Comparison Project, to get an estimate of private spending. The data are not from the same year for each country, although it is probably safe to assume that these percentages do not change drastically from year to year.

this trend is expected to continue, given the continuing economic problems and past policy decisions outside the health sector. In the face of continuing rapid population growth, public resources in the health sector are likely to become more rather than less constrained. Health problems precipitating use of curative services continue to be dominated by morbidity and mortality from preventable infectious and parasitic diseases, accidents, injuries and abortions. Furthermore, some areas of the country have lagged far behind others in improving health indicators. Given this scenario, increasing or even maintaining the rate of improvement in health indicators will require great care in allocating public resources, both across types of services and geographically.

What actions have been taken in resource allocation? First, the Ministry of Finance has agreed as part of the Health Financing Project to maintain its funding for the MOH at least at the level that prevailed in FY1988/89 (apparently in nominal terms). Second, the MOH has committed itself to increase funding for the Primary/Rural Health and Preventive/Promotive categories until they total four to five percent more of the budget in FY1992/93 than in FY1988/89.

Exhibit 8 displays the distribution of the Ministry of Health's recurrent expenditures for FY1988/89 and its recurrent budget for FY1991/92.¹¹ Sixty-nine percent of the budget in both years was spent on hospitals. Rural primary health services are receiving an increased share of the budget in 1992, but this increase comes almost entirely from the share devoted to preventive and promotive activities in 1988. Putting these numbers in the language of Exhibit 1, the

Exhibit 8 Distribution of Recurrent MOH Spending, Kenya FY1988/89 and FY1991/92



allocation of resources to curative care in hospitals remains high and unchanged — consuming over two-thirds of the public budget. There has been some juggling of resources between public/community health and preventive services to increase the funding of rural primary care (which, of course, includes clinic-type curative services), and the result may well have been a fall in real resources devoted to pure public health activities.

While these actions respond to both problems — the persistent disease patterns that can be effectively battled through community health and preventive

¹¹ The source of the budget numbers is calculations by David Collins of the Kenya Health Care Financing Project.

programs, and the uneven distribution of health gains — they have not yet led to major changes in the budget, nor do we know if the intended actions go far enough relative to the needs. The real issue in resource allocation in Kenya is a need for allocations to reflect a strategy for solving disease problems rather than the needs of the public infrastructure and current employment patterns in the health sector. There are two major questions to answer. First, does Kenya spend enough on health to lead to substantial declines in morbidity and mortality from the disease problems it faces? Second, should large changes be made in the distribution of public expenditures among the health activities shown in Exhibit 1? The answer to the first question is relative: relative to other similar countries, Kenya's level of support for the health sector seems reasonable. The answer to the second question must be made in terms of Kenya's own disease patterns, and it is currently unknown.

Tools to allow reallocation of resources are available but most have not been used. Because much recurrent spending is predetermined by past capital budgeting decisions, a capital budget that is consistent with health goals and strategies for solving disease problems is an essential first step. Seeking non-tax sources of revenue, especially to support curative services, can allow the MOH to divert tax money toward public health services. Remaining tax-based subsidies for curative services can be carefully targeted to the needy. Greater coordination between the public and private sectors could allow the MOH to re-evaluate its role in service delivery in some parts of the country and in some parts of the health delivery system, again gaining more flexibility in making budgetary allocations. All of these actions require that the MOH take a greater role in policy formulation for the health sector as opposed to service delivery, which increases the need for information and policy analysis.

These points are summarized by the following general guidelines for development of a strategic plan in this area:

- a. Increase the policy and coordination role of the MOH in the health sector.
- b. Target public spending to the health needs of the population.
- c. Reallocate public spending toward activities with broad community benefits and away from those that primarily benefit specific individuals.
- d. Broaden the financial base of the MOH and the health sector as a whole through cost sharing, NHIF reimbursement, and planning for foreign assistance.
- e. Target curative care subsidies to the poor.

2.3.2. Efficiency in Service Delivery

The MOH and donors have been very interested over the years in measures to ensure that public resources devoted to service delivery are spent effectively

and produce services of reasonable quality. The Nairobi Area Study in 1988, for example, found that there is considerable unexploited potential for increasing the efficiency and effectiveness of curative health service delivery in hospitals and urban health centers. The studies identified problem areas such as inefficient use of existing physical capacity, ineffective deployment of staff, inappropriate flow of patients, inadequate administrative and management systems, and lack of accountability to organize and coordinate city-wide health services. Improving efficiency in these areas is expected to require reallocation of working hours, staffing, and functions of various service outlets.

The Provincial and District Hospital Study (PADS) focused on health services in Nakuru District. Out of 59 MOH facilities, it studied two hospitals (a provincial and a district hospital), three health centers, and four dispensaries. It also studied one mission hospital and 1 Nakuru City Commission-owned health center. This study identified four types of problems in the delivery of government health services: inadequate resources and planning, low productive efficiency, lack of expenditure containment measures, and low quality of care. The PADS conclusions are reviewed here as an example of the general prescriptions proffered for improving efficiency in the public system.

- a. ***Insufficient resources and planning:*** The inadequate allocation of financial resources to MOH facilities leads to problems that are well known: repeated shortages of drugs and other supplies as well as poorly maintained equipment, vehicles, and buildings. These problems have at their base the inability of the MOH to adequately fund the combination of buildings, equipment, and human resources it has accumulated over the past 30 years to provide health services. For example, Nakuru Provincial Hospital in FY1988/89 received 60 percent less than requested for non-personnel costs, and it proceeded to over-spend its allocation by about 33 percent.
- b. ***Low productive efficiency:*** Excessive lengths of stay for some patients and inappropriate treatment of others were observed in MOH hospitals. These are two areas in which inadequate resources for inputs are partially a cause of problems but also a result, creating a self-sustaining cycle of inefficient resource use. Long lengths of stay (and poorly executed outpatient treatment) are caused both by inadequate resources to complete tests and procedures in a timely manner and by patient behavior. The study suggests attacking the facility-based problems by providing additional funding for better screening, treatment, admission planning, standardized treatment protocols, and nonsalary inputs. Other related changes are to improve the quantity and mix of medical personnel and support staff through workload-based staffing norms and more autonomy over staff for facility managers. It suggests reducing patients' incentives to consume scarce resources by instituting a per-day hospital charge for inpatients and an outpatient fee.
- c. ***Lack of expenditure containment measures:*** This study suggests that many outpatients are seen in the wrong public facility because they tend to refer themselves to the most expensive level of care — the major hospitals. In addition, the study cites the inadequate

delivery of preventive care services in the health system as a reason for the heavy load of expensive curative care. It also concludes that ineffective delivery of outpatient services causes repeated use of the system and higher expenditures per illness episode. In either case, the net result is a failure to contain public expenditures on health services by spending the money in a less-than-optimal manner.

- d. **Low quality of care:** The study suggests that there are problems in the quality of care delivered to patients, including poor identification of symptoms, inadequate use of diagnostic tests, and poor prescribing practices. Curiously, the public hospitals in the sample performed worse on all of these criteria for quality of outpatient care than did health centers and dispensaries. Another indicator of low perceived quality of care cited by the study is the general decline from 1987 through 1988 in the number of new patients using MOH facilities, despite a growing population.

Recommendations for corrections include: increased allocations for nonpersonnel inputs, improved use of the existing referral network to put patients at the least-cost level of service appropriate to their needs, increased volume and quality of information available to managers, and increased authority of facility managers over their resources (including personnel).¹² Kenya has acted in all areas. It is using the cost sharing initiative to increase funding for equipment and supplies, it is expecting differential pricing across facilities to improve use of the referral network (more expensive hospitals charge higher prices than lower level facilities), it is studying health personnel needs and is developing utilization-based staffing norms, and it is increasing the autonomy and accountability of facility managers.

Beyond these actions, there are several issues to discuss in terms of the strategic planning exercise. First, all recommendations for improving quality of care and efficiency in the public sector require more money. Problems with quality are almost always related to shortages of necessary inputs, be they medical supplies, equipment, maintenance, standard treatment protocols, training, or additional personnel. These inputs cost money above and beyond the current costs of operating the system. Second, the public sector is strapped by incentive problems in trying to improve the efficiency and quality of service delivery. This is a general problem governments face, and the reasons for it are well known: low pay, permanent tenure for public employees, centralized decision making, and little power for the client over the system (among other reasons). Third, assuming these problems can be overcome, any improvement in quality and efficiency will result in increased use of the affected public facilities, causing the same cycle of problems to start again (unless the government can continue to raise budgets!). Thus the problem of inefficiency and low quality is likely to plague government services permanently, and policy changes can only be expected to result in marginal or temporary improvements.

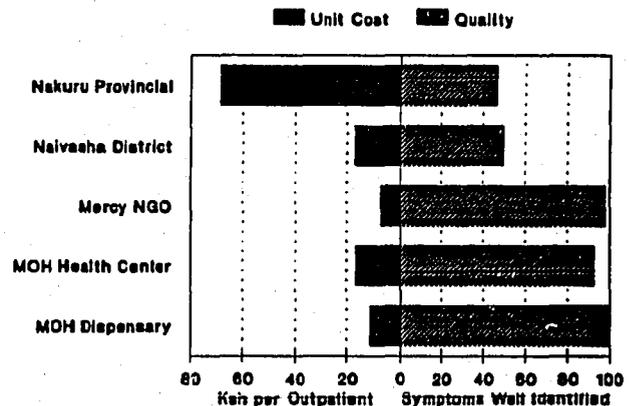
¹² It should be noted that these same problems are observed, and virtually the same corrections are prescribed, for public health care facilities no matter what the country or its ideology and no matter whether it is poor or rich. Kenya is not unique in facing either the problems or the proposed solutions.

Fourth, the problem of recurrent costs is also one of capital planning and spending—what size infrastructure can the system support with recurrent budgets that it can reasonably expect to receive in the future? It is evident to all observers that the current system cannot be supported by the MOH budget to a reasonable level of efficiency and quality. Attempting to solve this problem partially through the cost sharing program makes sense. However, it is only a partial solution. Some facilities will thrive under cost sharing; others will wither. Should the MOH subsidize the thriving ones, or should it start to redirect subsidies to the weaker institutions? However, on what grounds should it raise subsidies to institutions which are not supported by a client base willing to pay for services? Eventually the problem boils down to one of resource allocation—should the MOH operate a widely dispersed system that is poorly funded, or should it pull back and operate a smaller system that, through a combination of subsidies and fees, can efficiently produce services of reasonable quality?

Fifth, the MOH can solve some of the endemic problems of quality and efficiency in service delivery in the public sector by making greater use of the private sector. This can be accomplished in two ways, by (a) contracting for inputs from the private sector, and (b) paying for services to patients who receive care in the private sector. The first option ranges from small things, like contracting for maintenance and janitorial services on a competitive basis, to contracting for facility management. The orientation must be to identify the most severe bottlenecks to efficiency and quality and find alternative techniques, such as contracting out, to elicit the desired improvements. The ultimate form of contracting out is to sell public facilities to the private sector, convert them to independent status (such as has been done for KNH), or to dispose of facilities that cannot be justified based on economic criteria. The second option means focusing public subsidies on patients rather than institutions to serve them.

To illustrate one option, in Nakuru, the government spent Ksh. 68.9 per outpatient in FY1988/89 at Nakuru Provincial Hospital, but that patient probably received lower-quality service (at least in terms of accuracy of diagnosis) relative to that received in other hospitals and clinics. Exhibit 9 shows how. Unit cost per outpatient visit appears on the left for the three hospitals and the least expensive MOH health center and dispensary. On the right is the percent of a sample of outpatient diagnoses in which the symptoms were well identified, based on a review by a physician. By subsidizing specific patients rather than this institution, the government could have allowed them to choose any other provider in the group and receive a higher measured quality of care.

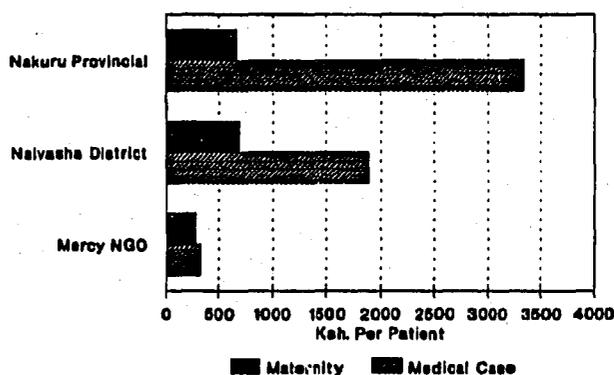
Exhibit 9 Comparison of Cost and Quality among MOH Hospitals and Health Centers and an NGO Hospital, 1988-89



The facilities would have to compete for the patient to receive the subsidy provided by the government. The NGO hospital, in particular, could have treated almost 10 outpatients for the cost of one in Nakuru Hospital and done a better job. Obviously such a comparison is not perfect and is affected by case mix and other factors. However, the general point that subsidies to the patient rather than to a facility can result in lower costs and competition on quality of care is consistent with the evidence.¹³ Exhibit 10 presents similar evidence on the inpatient side. It compares the unit cost of maternity cases and medical ward cases across the three hospitals in the sample. The same pattern emerges. The MOH could probably save money by paying for care provided in the NGO hospital, rather than providing the services directly through its own system.¹⁴

There is very little evidence about the quality and cost tradeoffs between public and private sector facilities in Kenya. A recent effort for NHIF to assess quality of care and costs in 14 hospitals found that MOH hospitals tended to rank in the lower half of the quality scale — government hospitals made up four of five achieving scores below 50 percent on the assessment. Only one government hospital exceeded the 50 percent mark, while eight private or NGO hospitals did.¹⁵ Daily inpatient cost estimates appear to be positively correlated with quality, but not perfectly. In addition, government hospitals tend to cost less per bed than comparable private hospitals and have lower quality. The results suggest that higher-quality services probably cost more than lower-quality services, whether in public or private hospitals, which is somewhat at odds with the Nakuru District data. However, this study looked only at overall inpatient costs; there is no analysis of outpatient costs. The evidence merely suggests that much more needs to be known, and very specific questions must be asked and analyzed before making policy changes.

Exhibit 10 Comparison of Cost and Quality among MOH Hospital and Health Center and an NGO Hospital, 1988-89



Thus the issues of efficiency and quality as well as the role of resource allocation, the role of management, and the role of the public and private sectors in solving them are very complicated. This area merits attention in the strategic plan, experimentation and evaluation of alternative approaches, and

¹³ Exhibit 9 is derived from the Provincial and District Study.

¹⁴ The costs for volunteer or below-market-priced labor in the NGO hospital are not included in the cost comparison, which may overstate the cost differential. However, one benefit of such a scheme is that the government is able to take advantage of these subsidies to cut the cost to the taxpayer.

¹⁵ The source of this data is a consultant's report for the Kenya Health Care Financing Project by Stephen Musau and Richard Siegrist.

efforts to widen the tools and approaches available to the MOH for solving the problems it faces. These points are summarized below:

- Improve criteria used when selecting among MOH curative services and facilities to receive funding when making resource allocations.
- Improve productivity of MOH inputs into medical services, including labor (allocating staff resources relative to utilization), capital (develop capital budgeting plan based on demand for services, competition, and other factors in the environment), and nonpersonnel recurrent costs. The result should be improved efficiency and quality.
- Lower the cost per unit of output and create incentives for improving the quality of MOH health services through contracting out for services and inputs, increased autonomy but greater responsibility for performance by local managers, improved support services to facilities and personnel, and improved financial control and inventory control.

2.3.3. Cost Sharing

It has already been mentioned that cost sharing was one of the important strategic decisions made in the health sector during the 1980s. Perhaps the most interesting aspect of the cost sharing initiative is the long period of time, essentially the whole decade of the 1980s, during which the policy was developed. Implementation is now proving to be an equally difficult and long-term process. Cost sharing was one aspect of a larger policy initiative, also discussed above, to increase the MOH's flexibility in reallocating resources and to improve its ability to meet patients' needs in the curative system.

The cost sharing initiative is still in its infancy, although it had a tumultuous birth. Small fees had always been charged by the MOH for specific services, such as an adult inpatient fee, some x-ray fees, and fees for prosthetic devices. These fees were rarely enforced, were extremely low, and produced very little income — less than three percent of the MOH budget in a typical year. The cost sharing initiative in December 1989 raised these fees and added a general outpatient fee throughout the MOH system, from hospitals down to the health center level. Collections from these fees were projected to increase from about five percent of the MOH budget in 1993 to 20 percent once the program was solidly institutionalized. A system of exemptions (classes of patients permanently and completely exempt from the fees, including children under 15, the mentally handicapped, prisoners, certain civil servants, and a number of other groups) and waivers (30-day exemptions based on income) was instituted to protect vulnerable groups. Responsibility for adjudicating exemptions and waivers rests with the facility.

The outpatient fee was suspended on August 30, 1990, after nine months. It was reinstated in provincial hospitals in January 1992, and in district hospitals in July 1992. There are two important questions for the strategic planning exercise. First, despite the short and incomplete history of the initiative, is there useful information about how it has performed relative to its goals? Second, what mid-term corrections are merited to resolve the important bottlenecks that have arisen? The following list takes each major category of desired outcomes for the initiative and discusses what we know about these two questions:

2.3.3.1. Increased Resources for Health Services

The cost sharing initiative was intended to increase resources available for health care. Before being suspended, collections were running at about 30 percent of projections, so they accounted for considerably less than the initial goal of five percent of the MOH recurrent budget. However, at the facility level, the increase in fees was connected with a large drop in utilization by outpatients (ranging from a 31 to a 45 percent drop in eight provincial hospitals from December 1989 through August 1990, see Exhibit 11).¹⁶ The simple mathematics of this situation implies a substantial increase at the facility level in the resources available to serve each remaining outpatient.¹⁷ The early experience of the provincial hospitals also suggests a slow recovery of utilization after the initial shock of the fees, although it never returned to pre-fee levels (see Exhibit 11). If utilization does rebound throughout the system, revenue projections may eventually be met, but resources per patient will fall back toward the original level. However, for the future, this experience makes plain that utilization and revenue are related: if the MOH wants to achieve a certain revenue goal, prices must be set in a manner that will achieve it by taking into account the behavioral reactions of the clients. Setting prices is thus the key variable, and this means setting relative prices across types of facilities, across services within facilities, and across clients who use the facilities, using considerable information and analysis.

Mombasa District
General Outpatient Attendances
July, 1988 to June, 1991

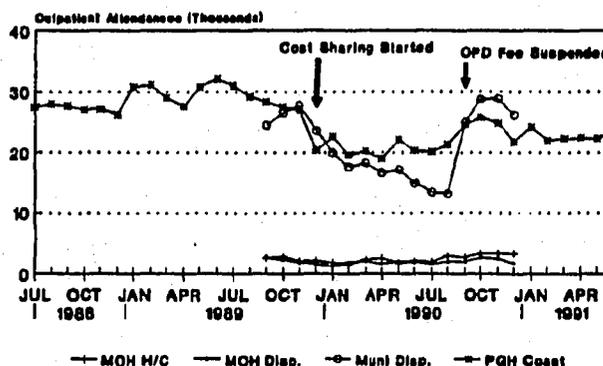


Exhibit 11 Example of Change in Outpatient Utilization Precipitated by Cost Sharing

¹⁶ Exhibit 11 is the result of analysis by Jono Quick of the Kenya Health Care Financing Project.

¹⁷ If facility revenues increased by 10 percent and patient volume fell by 30 percent, resources per patient would have risen to 1.57 times the previous level.

2.3.3.2. Reallocations of MOH Spending

By providing facilities with partial funding of their own, the cost sharing initiative was expected to allow the MOH to reallocate tax-supported expenditures toward services with greater community-wide benefits, especially those that could be targeted to the health problems of the rural population. Exhibit 8 indicates that there has been no change in plans for overall allocations to the combination of rural primary services and preventive/promotive services, although there have been reallocations between the two. However, success of the cost sharing initiative does guarantee some additional funding for rural services, because 25 percent of facility revenues are earmarked for this purpose. These funds are channeled through the District Health Management Boards.

2.3.3.3. Improved Equity

The cost sharing program was expected to better target public subsidies for curative care to the poor by waiving fees for them or charging them at a lower rate. This is an explicit element of the structure of the program. However, three types of problems have arisen. First, in reaction to the type of information shown in Exhibit 11, a question has arisen about the identity of the approximately 30 percent of patients who stopped using the public sector after implementation of the outpatient fee. Were they the poor? Did they use other providers or none at all? Did they need health care and not get it? While there is much speculation, there is little hard knowledge about this issue. Second, most facilities have not made use of the waiver system because of expected problems of enforcement. The result is that almost all patients are required to pay in facilities where fees are currently enforced. Third, the exemption system exempts a whole class of patients — civil servants — who account for a large share of formal sector employees in the country and are relatively well off. The overall result may be that the cost sharing system will have perverse impacts on the distribution of subsidies for curative care rather than improving this distribution. These questions need information and analysis, which should result in mid-term course corrections.

2.3.3.4. Improved Quality

Improving the quality of services at the facility level was to be accomplished through reduction in utilization, retention of fees, and decentralization of decision making to the district and facility levels. The MOH has pushed hard to realize these innovations by creating facility-level committees (Executive Expenditure Committees) and the District Health Management Boards to govern expenditures from the new funds. It allowed retention of 75 percent of fees, with the other 25 percent staying in the district.

Problems that have arisen and need attention through the strategic planning exercise are fairly obvious from this presentation. First, to achieve revenue and utilization targets, much more must be known about how to set prices for services and how to allow prices in the public sector to reflect local market conditions rather than being uniform throughout the system. Second, the cost sharing program includes many instruments that will affect resource allocation, but only at the margin. Institutionalizing cost sharing, however, will allow the MOH to move aggressively now in reallocating resources toward public health

services, because it provides curative institutions with a mechanism to make up reductions in their tax support in the future. The MOH has the option, if it chooses to exercise it, to begin to plan for major budget shifts that will give curative institutions a greater incentive to manage their own affairs efficiently and raise revenues to finance their operations. Third, equity is a major problem. The exemption and waiver system has some built-in, glaring inequities that merit correction. For example, the government may want to subsidize health care for civil servants, but is that a national health policy or a compensation issue? More than likely, it is the latter. In that case, the employing ministry should pay the bill; it should not come out of the national health budget. Finally, a problem that will arise from the fee retention policy is that well-used facilities in high-income areas of the country will become stronger while those in poorer areas will fall further behind. In the future, subsidies to fee-collecting curative institutions will have to take into account the unequal ability of these institutions to raise their own revenue.

As far as the impact on cost sharing of the strategic planning exercise is concerned, the following points merit consideration:

- a. Increase revenue from cost sharing through improved incentives for collecting revenue, an expanded fee structure, and increased prices where appropriate.
- b. Improve the targeting of waivers and exemptions by revising the exemption criteria.
- c. Improve the data and analytic bases for determining prices and subsidies in the MOH curative system.

2.3.4 Private Sector

The MOH's historical concern with service delivery and extension of the public system throughout the country has created a situation in which it has made decisions about its own service delivery network with little or no attention to alternative providers. However, a large charitable sector, which is widely dispersed into rural areas and among poorer populations, has existed in Kenya since colonial times. These NGOs have received subsidies from the MOH targeted to about 30 percent of their total operating costs. A vigorous private for-profit sector has developed over the past 20 years, and it was given a boost in the late 1980s, when governmental clinical officers and nurses were allowed to engage in private practice to augment their incomes.

Exhibit 12 shows ownership of each level of health facility in the country. Although MOH facilities play some role in providing public health and preventive services, virtually all have a primarily curative function. Exhibit 15 aggregates the categories in the table and shows how the system is distributed among hospitals, health centers, and dispensary-type facilities. Obviously the system is dominated by lower-level facilities, with hospitals accounting for less than eight percent of its facilities. Furthermore, hospitals make up an even smaller proportion of the government system, accounting for less than seven percent of the facilities (these few facilities absorb almost 70 percent of the

Exhibit 12 Public and Private Ownership of Health Facilities, 1989

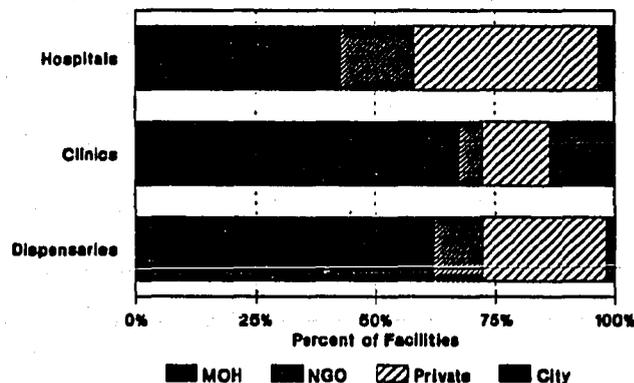
TYPE	AGENCY				TOTAL
	MOH	Mission	Private	Municipality	
Medical Centre	4	1	2	0	7
Hospital	98	34	50	1	183
Maternity Home	2	1	16	7	26
Nursing Home	0	1	26	0	27
Health Centre	311	23	60	25	419
Sub-Health Centre	12	1	1	6	20
R.H.T.C.	7	0	0	0	7
R.H.D.C.	31	0	0	0	31
Dispensary	975	160	411	27	1573
Health Clinic	5	2	16	43	66
Total	1445	233	582	109	2359
Percent of Total	61	9	25	5	100

Note: Draft data subject to revision based on 1992 resurvey of health facilities.
Source: HIS, MOH, 1990.

recurrent budget, however). Exhibit 13 shows more clearly the composition of each bar. The government owns less than half of the hospitals, about 70 percent of the health center-level facilities (clinics in the graph), and just over 60 percent of the dispensary-level facilities.

Exhibit 14 shows the distribution of facilities across provinces on the left, with the bars divided between MOH facilities and all others not owned by the MOH, including mission, private, and municipality-owned facilities. On the right side, the bars show the number of facilities per 100,000 people in each province, with the provinces arranged in increasing order of density of facility coverage. It is interesting to note that Coast Province, which has persistent and severe health problems, has the highest density of curative facilities to population. The other two severely lagging provinces, Western and Nyanza, rank low in terms of coverage by facilities (both public and private). Apart from this observation, MOH facilities largely complement the distribution, at least on a provincial basis, of

Exhibit 13 Distribution of Ownership of Hospitals, Health Centers, and Dispensaries, 1989



non-MOH facilities. Both are distributed throughout the country. Rift Valley, which has the highest concentration of non-MOH facilities, also has the highest concentration of MOH facilities.

Other data suggest that NGO and for-profit private facilities tend to be located in different areas, that about half of private physicians are located in the four major cities, but that only 12 percent of private nursing personnel are in these cities (suggesting that they are substitutes for private physicians in rural areas). There are two ways to look at the size and distribution of the private sector relative to the public sector. One way is to ask how to use the private sector to increase coverage in provinces where the facility-to-population ratio is low. A second way is to consider how to redeploy some public resources from areas well covered by the private sector to under-served areas, thus reducing competition for paying patients in the densely covered areas and allocating public resources where the need is greatest.

This type of thinking brings up the issue of constraints on the development of the private sector. These include, in addition to competition from the MOH, lack of capital markets for health care providers, heavy taxation on drugs and medical equipment, and requirements for many different licenses and permits to start business and to remain in business. These problems are partially offset, at least for hospitals and nursing homes, by the availability of NHIF reimbursement as a steady source of income. In addition, there is little or no contracting with private firms, medical facilities, or personnel for services by the MOH, which fragments and limits the size of the market they can serve.

As part of the strategic planning process, it is an appropriate time to consider public and private roles in the health sector. This area is a key element in the conceptual framework for the strategic plan and is the primary area of policy that can help the MOH reach several of its goals: an ability to redirect its spending to public health problems and to the poor, increasing the efficiency of curative care provision, and improving the quality of care

Exhibit 14 Distribution of Ownership of Hospitals, Health Centers, and Dispensaries, 1989

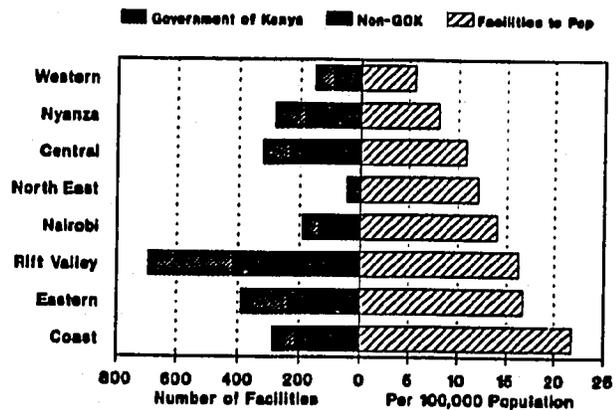
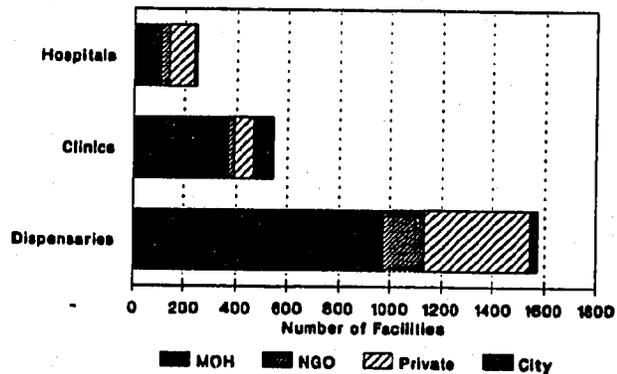


Exhibit 15 Number and Ownership of Hospitals, Health Centers, and Dispensaries, 1989



available to a population whose incomes and education levels improve at rates faster than the MOH can respond to with additional resources.

Achieving some of these goals will require action in several areas in which there has been little innovation to this date:

- a. Create enabling environment and reduce government-imposed cost of practicing medicine in the private sector.
- b. Increase demand for private sector services by reducing competition from the public sector, strengthening social financing, and through direct purchases of services from the MOH.
- c. Improve the quality of services from all providers while attempting to reduce costs to patients of medical care, irrespective of provider, through generic drug laws, standard medical procedure manuals, and close supervision of quality by the NHIF.
- d. Widen policy formulation process in the MOH to include all stakeholders: employers, consumers, private/NGO providers.

2.3.5. Social Financing

Another area in which there are opportunities for policy development is social financing, as defined earlier. Kenya, along with Zimbabwe and South Africa, leads Sub-Saharan Africa in development of social financing mechanisms, principally due to the creation of the National Health Insurance Fund in 1966. There are three other types of risk sharing mechanisms. One set is employment-related (as is the NHIF) and includes private insurance, worker's compensation, and direct coverage by employers through their own facilities. A second is community-based plans, which include the Harambee movement and activities under the Bamako Initiative. A third, of course, is the MOH, which acts as insurer of last resort for the population by offering free or very low-cost hospital services.

The government-administered NHIF is the key feature of this social financing system. It covers people who have regular, taxable wages, it is based on a payroll tax, and it reimburses hospitals for inpatient care only. NHIF has a number of problems. It is financed by a regressive tax structure, it provides low benefits for inpatient care, it has weak administrative mechanisms that result in long lags between hospital stays and reimbursement, it provides few or no incentives for providers to meet high standards of quality, it has accumulated large surpluses that bear no relation to the claims volume it faces each year, it provides no choice to beneficiaries about the level of benefits they desire and are willing to pay for, there is little knowledge of how NHIF funds are spent relative to the health needs of its beneficiaries, and management of the fund is not open and transparent to the public. In short, beneficiaries complain of receiving low benefits at high cost from this government monopoly.

On the positive side, the NHIF is an institution with a long experience in handling third-party payments for health care. Kenya is not in the position of having to invent such an institution; rather it has to reform an existing one.

In addition, NHIF has had a tremendous impact on development of the private sector by encouraging development of private hospitals, maternities, and nursing homes while also providing a source of income for mission hospitals as both donations from abroad and support from the MOH have declined. NHIF has helped to expand options in service delivery in Kenya by helping to finance a private hospital system that exists in few other African countries at Kenya's level of income.

For the MOH to realize its goal of moving more curative care financing to user fees, invigorating the social financing system is essential. If it is also interested in strengthening the private sector, the importance of social financing becomes even greater. What must be done? There are two basic areas of intervention: (a) widening the beneficiary base beyond the formal sector of employed people, and (b) improving the benefit package. Accomplishing these goals will require, but also result in, major changes in the social financing mechanism and in the health sector as a whole. For NHIF, success of the MOH in achieving its goals requires considerable strengthening of the institution, including solutions to the problems noted above. One possible tool to increase NHIF's incentive to reform itself is to put it in a more competitive environment.

Expanding the beneficiary base means finding mechanisms to bring more farmers, service sector employees, and others with irregular or noncash incomes into the system. Solving this problem means identifying well-established groups, such as cooperatives, that can be brought into the system. Doing so will require new contributory mechanisms.

Increasing benefits requires moving beyond a minimal set of inpatient benefits to include outpatient and preventive services. An increase in benefits will require new methods of paying for (options for capitation) and delivering care (networks, groups, managed care) under NHIF or other social financing mechanisms.

These innovations require a long-term perspective. Their impact will be felt first in urban areas, which will allow the MOH even more freedom to pursue a reallocation of its resources to those not yet participating in NHIF or other social financing mechanisms and to rural areas.

It should be noted that the NHIF is currently developing its own strategic plan. A workshop in May 1992 discussed approaches to: (a) changing the reimbursement system to a prepayment scheme to reduce the administrative bottlenecks, incentive problems (for hospitals and doctors), high transaction costs to the beneficiary, and quality of care/cost of providing care/reimbursement problems that characterize the current reimbursement system; and (b) expanding coverage to more of the population. A workshop in May 1992 on the overall MOH strategic planning exercise, which is the concern of this document, concluded that NHIF should also be concerned in its strategic planning with its low benefit-to-contribution ratio, lack of transparency in its management and dealings, low payout and consequent accumulation of reserves, and its role as a financing mechanism for the country as opposed to its members only. The social security system was also cited in this session as suffering from many of the same faults.

The following points summarize the main strategic issues in social financing:

- a. Increase available benefits of private and NHIF insurance plans and expand choices for consumers by increasing competition among insurers for clients.
- b. Increase population covered by health insurance by extending coverage to new groups and by developing low-cost plans for poorer clients.
- c. Take other steps in administrative reform, claims processing, licensing standards, collecting premiums from members, and alternatives to NHIF to achieve (a) and (b).

2.4 CONCLUSION TO BACKGROUND SECTION

This section has reviewed activities related to strategic planning that have already taken place, and it has assembled information in each of the technical areas into which the strategic planning exercise has been divided. Previous activities, including the MOH's concept paper for a health financing strategic plan and the formulation of its new health policy statement, are building blocks on which the current work is based.

The background information in the technical areas provides details of some problems in the sector, but also evidence of action by the MOH in almost all problem areas in which it has traditionally involved itself. A theme that arises again and again in this section, possibly due to the emphasis on it in the conceptual framework, is that resource allocation decisions by the MOH affect every technical area. Decisions by the MOH about how to allocate its resources among the three types of health activities can have a large impact on the health of the beneficiaries in the existing disease environment of the country. Decisions about how to allocate resources within the curative care system, especially regarding hospitals versus other types of facilities and widespread versus concentrated systems, affect every dimension of service delivery. Development of the private sector and the demand for social financing mechanisms are affected by the degree to which the MOH crowds out these competing providers and financial mechanisms. Resource allocation decisions also affect efficiency and quality in the public system, because one of the main determinants of both is the size of facility budgets. Cost sharing, development of the private sector, and development of social financing all provide additional instruments to the MOH. They allow the MOH more flexibility in making resource allocation decisions that respond more directly than they do today to the disease patterns of the population, and to the need for more public health and preventive spending from tax-generated funds. Each of these instruments also provides a means to improve the efficiency of service delivery and quality of curative care.

The area in which there has been the least development is in the information base on which resource allocation decisions are made. Budgeting has always been accomplished in an incremental accounting framework (with budgets generated by facilities and raised or lowered by small amounts annually), rather

than in a program budgeting framework, in which careful consideration of the appropriate role of government as well as health sector goals and needs determines why and at what level programs are funded. In addition, there has been relatively little explicit attention paid to the potential role of the private sector or to public-private interactions. Apart from the initial development of the NHIF, there has also been little attention paid to strengthening social financing mechanisms. In contrast, considerable resources have been devoted to the cost sharing initiative and to analyzing efficiency and management issues in KNH and at the provincial and district levels.

3.0 BUILDING THE STRATEGIC PLANNING FRAMEWORK

This section proposes a framework for strategic planning. This framework builds on the previous sections and depends heavily, in addition to previous work by the MOH, on a strategic planning workshop held during May 1992.

3.1 A PROPOSAL FOR INSTITUTIONALIZING STRATEGIC PLANNING IN THE MOH

If the strategic planning exercise follows the approach developed in this paper, the result will be (a few months hence) agreement on the main problems faced in the sector; priorities among technical areas for spending scarce resources on information collection, analysis, decision making, and forward planning; and development of action plans in each technical area. Following through with the strategic planning exercise therefore requires that it be institutionalized in the MOH at the level of the Permanent Secretary or his immediate assistants. Responsibility for development of work plans in each technical area must be delegated, along with budgetary authority and other resources to carry out the work. In some cases, the work may be further development of policy options through data collection and analysis (e.g., developing a five-year plan for program budgeting and reallocating MOH spending), running workshops (e.g., prioritizing needs of private sector providers for legal and regulatory reform), performing legal work (e.g., revising regulations, developing standard contracts for vector control, janitorial services, part-time physician consultants, or for management of public facilities). Work may also include assisting in personnel development (e.g., training managers in capital budgeting and developing program budgets); or performing policy analysis (e.g., developing criteria for choosing between performing tasks in-house or contracting for services, estimating the costs and benefits of contracting for services, developing strategies for vector control, or developing decision rules for choosing between vertical and facility-based public health programs). The MOH already has the capability to perform some of this work and is investing in a planning and evaluation office. Strategic planning will, however, create new demands for information, for measurement of progress, and for analytical work.

In addition, it is suggested that the MOH plan an annual strategic planning conference in which progress against goals is discussed, new analytical work is presented, follow-up plans are presented and debated, and implementation plans are discussed in each technical area. An annual report is an appropriate output of this work, and it should emerge following the annual meeting. Management meetings should convene, perhaps on a quarterly basis, to monitor progress on the year's implementation plan. All of these activities require that personnel and financial resources be set aside to institutionalize the MOH's strategic planning capability.

3.2 STRATEGIC PLANNING PRIORITIES

This document has suggested goals for the strategic planning process and considered the technical areas into which policy initiatives can be divided. Exhibit 16 displays goals down the left column and technical areas across the top. In the body of the table, there are marks in cells where there is a primary

Exhibit 16 Goals and Technical Areas in the Strategic Plan

GOALS	Technical Areas for Policy Initiatives				
	Resource Allocation	Efficiency	Cost Sharing	Private Sector Development	Social Financing
Public Policy Role for MOH	•			•	•
Reallocate MOH Spending to Public Health	•		•	•	•
Retarget MOH Curative Subsidies to Poor	•		•	•	•
Larger Non-Government Role in Curative Services	•	•		•	•
Strengthen Alternative Financing Systems				•	•

connection between achieving the goal and the policy tools available in each technical area. If there is agreement about the placement of the marks, there should also be agreement about developing priorities for action by the MOH across the technical areas.

One obvious result of this exercise is that improving efficiency and quality in government curative services is of relatively low priority in terms of achieving the goals. For it to matter more, additional goals would have to be defined. Even if that were done, though, would the additional goals be of higher priority than the ones already included? Probably not. The only area in which there is some cross-over between efficiency and the desired outcomes is with the goal of putting more delivery and financing of curative services into the private sector. The expected result would be more efficient production and higher-quality services. The policy tool involved is figuring out criteria on which to make decisions for moving services into the private sector. This is not to say that efficiency and quality are not important, only that they figure into the strategic goals in a specific and narrow way. Obviously, to the degree that the MOH continues to provide curative medical services, it will continue to devote much of its time internally to this issue. But from a more general policy perspective, efficiency is more of a narrow management issue that has a place in the strategic plan insofar as it creates a potential link to the private sector.

Most of the other marks in the table should be self explanatory, and the preponderance of black circles favors three areas: resource allocation, private sector development, and development of social financing. Strengthening the private sector and social financing have strong effects on each goal, principally

by giving the MOH flexibility to focus its efforts in areas other than direct service delivery. Resource allocation in the MOH also has impacts across most of the goals, as discussed in detail above, in the conclusion to the background papers. Cost sharing has important secondary impacts on the last two goals on the list, but its primary effect is on the MOH, in allowing it to improve the efficiency and equity of its spending.

The result of this analysis is largely consistent with discussions that occurred during the May workshop. As a final act in the workshop, three breakout groups were asked to identify priorities among the technical areas for action under the strategic plan. They did not have the benefit of having guidance from the framework presented in this document or a specific set of goals for the exercise. However, they had just finished one and a half days of discussion about the technical areas and health policy, and their conclusions mirror those in Exhibit 16. Group 1 identified as actions that would improve health care financing in Kenya: (a) an enabling private sector environment, increasing resources available for public and private sector health care through cost sharing and social financing, MOH divestiture of facilities, support for the NGO sector by the government, and privatization of the NHIF. Group 2 emphasized cost sharing in the public sector and enhancement of social financing mechanisms to support both the public and private sectors. Group 3 cited cost sharing, an enabling private sector environment, comprehensive health insurance coverage, and efficient resource allocation within the government as the major areas for action. Virtually all of these recommendations involve private sector action and social financing mechanisms but with an implicit outcome of improved resource allocation in the public sector.

For all practical purposes, Exhibit 16 is a compact statement of the strategic plan. It lays out a set of goals for sector finance and a broad set of policy tools in the various technical areas that have revolutionary implications for transforming the health sector. Just gaining agreement on this or another set of achievable goals and policy tools will be a major undertaking. Exhibit 16 has the advantage of portability as well. It could be issued on laminated cards to managers in the MOH. All management meetings could begin with a reminder that decisions made by managers must be consistent with these goals. Each meeting could end with an appraisal of how well the results of it conform to the strategic plan.

Thus a review of the goals is merited. The first strategic goal is to reform the Ministry of Health to give it a strong policymaking function and to reduce the relative importance to it of its service delivery function. This is a major change. The second goal, to reallocate public spending to public health and preventive services, would result in a major reorientation of public sector spending. The third goal, retargeting public subsidies for curative care to the disadvantaged, will require a new orientation in budgeting for curative services as well as information and analysis unlike anything currently available to decision makers in the MOH. The fourth goal, to strengthen the private and charitable sectors, is completely new territory for government policy in the health sector. The fifth goal, encouraging other mechanisms to finance curative health services, is also a new orientation for the MOH. In addition, the array of policy tools described in each technical area widens the scope and sophistication of health policy. Acting on these goals using the whole array of

policy tools will involve many outside groups interested in health policy, including employers, insurers, private providers, and consumers.

One could state quantitative measures of progress in achieving each goal, but at this level of generality, and given the shortage of information to support specific measures of success, such measures would be arbitrary and unnecessarily specific. Thus measures of success are relegated to the action plan, in which actions can be specified and success measured.

3.3 ACTION PLAN

A set of first-year actions is suggested in Exhibit 17 by technical area. This is the same type of table that would be the outcome of the yearly strategic planning workshop, at which the work of the previous year would be reviewed, goals for the next year would be discussed, and measures of success and actions to be taken for the following year would be agreed to. In addition, decisions made in each area during the previous year would be reviewed, and new decision points and recommendations for decisions based on the analytical work would be discussed. The result would be a rolling action plan based on the goals and technical areas of the strategic plan, to be reviewed on a yearly basis. The suggested action plan is self-explanatory and reflects what the author thinks are the priorities for action in each area. As with Exhibit 16, this table is deceptively simple. Each set of activities is easily a full year's work and would consume a substantial amount of resources. If completed successfully, these activities will allow policymakers to make informed decisions that are consistent with the strategic plan, then to move on to the next step.¹⁸

¹⁸ In addition, detailed lists of actions derived from the May workshop are included in Appendix 3.

Exhibit 17 Proposed Actions for Year 1

	Technical Areas for Policy Initiatives				
	Resource Allocation	Strengthening Private Sector	Social Financing	Cost Sharing	Efficiency
Goal for Year 1	Five-year plan for reallocating expenditures	Prepare plan to reduce redundancy of public sector facilities	Develop plans to expand benefits to include outpatient care, to expand beneficiary base, and to develop alternative benefit plan/premium combinations	Improve methods to target subsidies to the poor	Develop competitive contracting procedures, identify priority areas for contracting, and begin experimenting in high-priority areas
Development of Health Care Financing Policy Tools	Develop a program budget for the MOH, both capital and recurrent, including a cross-walk to the accounting budget	Develop a capital investment plan that reduces redundancy of public investment (to be coordinated with the program budget work)	Benefits assessment, planning, and cost estimation	Ability to assess cost sharing system's impact on the poor and to develop a plan to improve targeting of curative care subsidies	Strengthen capability to contract out for services
Information and Analysis Required	Put MOH recurrent and capital budgets into the program framework for the previous 10 years; project alternative budget paths for 1994-95 to 1999-2000 that reallocate resources to public health and preventive services; derive implications for future decisions	Analysis of needs for public facilities by level, district by district; development of criteria for rating public facilities for their value to beneficiaries; methods to take into account NGOs and private providers in public sector capital budgeting	Feasibility study for outpatient benefits, plan for extending coverage to new groups; implementable plan for both	Analysis of impact of cost sharing through household surveys, analysis of pricing and exemption/waiver system, proposal for new policies and expected impact	Investigation of successful examples of contracting procedures in government and adaptation to needs of the MOH, develop typologies for types of contracts, develop evaluation strategy, develop criteria and priority areas for contracting, develop evaluation plan
Measures of success	Five-year action plan for reallocations, with decision points outlined, and with agreement on targets and methods to achieve them	Plan for withdrawing and/or developing new public curative facilities and public health offices by district, with an action plan	Production of a plan for an outpatient benefits demonstration project, five-year plan for expanding beneficiary base	New pricing, waiver, and exemption policies proposed for testing, with an implementation plan, a monitoring and evaluation plan, and criteria for success	Procedures, tests, evaluation plan, and actual contracts negotiated
Follow-on Work for Year 2	Develop priorities for public health spending through cost-benefit analysis	Propose improvements to legal and regulatory environment	Options for privatizing claims processing, developing competition for NHIF	Decentralize price-setting to facilities, develop guidelines for setting prices in different markets	Apply same types of analysis to develop criteria and testing for appropriate amounts of decentralization for public sector management

APPENDIX 1: MAY 1992 HEALTH CARE FINANCING STRATEGIC PLAN WORKSHOP SCHEDULE
HEALTH CARE FINANCING STRATEGIC PLANNING WORKSHOP

Thursday, 21 May 1992

9:00	Welcome and Introduction of Participants	J. Njoroge
9:15	Overall Introduction to Health Sector	F. Mworia
9:45	Strategic Planning for Financing the Health Sector	C. Griffin
10:00	General Discussion	J. Njoroge
10:15	Background Papers	
	Resource Generation & Allocation	B. Obonyo
	Cost Sharing	B. Obonyo
	Private/NGO Sectors	T. Kibua
	Legal/Regulatory Framework	O. Mutungi
11:15	Tea Break	
11:30	Background Papers	
	Social Financing	J. Wang'ombe
	Efficiency	L. Forgy
12:00	General Discussion	T. Kibua & C. Griffin
12:45	Lunch	
1:45	Introduction: Working Group Session #1	C. Griffin
2:00	Working Group Session #1 (5 Groups, by Topic)	
	Task 1: Recommendations	
	Task 2: Implementable Actions	
	Task 3: Rankings or Priorities	
	Task 4: Prepare Report to Whole Group	
4:00	Tea and Departure	

HEALTH CARE FINANCING STRATEGIC PLANNING WORKSHOP

Friday, 22 May 1992

9:00	Welcome and Introduction	F. Mworia
9:10	Reports from Working Group Session #1	T. Kibua
	Group 1: Resource Generation & Allocation	
	Group 2: Cost Sharing	
	Group 3: Private/NGO & Legal/Regulatory Framework	
	Group 4: Social Financing	
	Group 5: Efficiency	
10:00	General Discussion	T. Kibua & C. Griffin
10:30	Tea	
10:45	Introduction to Working Group Session #2	C. Griffin
11:00	Working Group Session #2 (2 Groups)	
	Task 1: Interactions Across Topics	
	Task 2: Preconditions for Implementation	
	Task 3: Tentative Time Frame	
	Task 4: Prepare Report to Whole Group	
12:00	Reports from Working Group Session #2	J. Wang'ombe
	Group 1	
	Group 2	
12:30	General Discussion	J. Wang'ombe & C. Griffin
1:00	Lunch	
2:00	Introduction to Working Group Session #3	C. Griffin
2:15	Working Group Session #3 (2 Groups)	
	Task 1: Potential Implementation Steps: 1992-94	
	Task 2: Review and Critique of Workshop	
	Task 3: Recommendations for Next Steps in Process	
	Task 4: Prepare Report to Whole Group	
4:00	Reports from Working Group Session #3	B. Obonyo
	Group 1	
	Group 2	
4:30	General Discussion	B. Obonyo & C. Griffin
5:00	Next Steps for Planning	F. Kalikandar
5:10	Closing	J. Njoroge
5:20	Cash Bar, Snacks, Continuing Discussion	

APPENDIX 2: HEALTH CARE FINANCING STRATEGIC PLAN WORKSHOP PARTICIPANTS

	PARTICIPANTS	ORGANIZATION
1	Mr. Bango	KUSCO
2	L. Forgy	USAID
3	Dr. Fraley	CHAK Representative/AIC Medical Coordinator
4	C. Griffin	USAID Consultant/The Urban Institute
5	I. Hussein	MOH/KHCFP Secretariat
6	C. Johnson	USAID
7	K. Kabage	Kabage and Mwirigi Insurance Brokers
8	F. Kalikandar	Ministry of Health
9	B. Kangela	Ministry of Finance
10	T. Kibua	Kenya Health Care Financing Project
11	M. Kilonzo	MOH/KHCFP Secretariat
12	D. Kraushaar	Kenya Health Care Financing Project
13	J. Maitha	ADEC
14	J. Maneno	UNICEF
15	D. Mule	Ministry of Education
16	M. Mulusa	World Bank
17	T. Muriithi	Ministry of Health
18	O. Mutungi	KHCFP Consultant/University of Nairobi
19	J. Mwanzia	Ministry of Health
20	F. Mworia	Ministry of Health
21	J. Njoroge	Ministry of Health
22	W. Noreh	Kenyatta National Hospital
23	B. Obonyo	USAID
24	W. Oliech	MOH
25	S. Ongayo	AMREF
26	D. Oot	USAID
27	J. Quick	Kenya Health Care Financing Project
28	K. Wa Luka	Ministry of Finance
29	R. Wamakau	KNFC
30	J. Wang'ombe	KHCFP Consultant/University of Nairobi
31	R. Zimmerman	Africa Air Rescue

APPENDIX 3: DETAILED ACTION PLANS FROM THE STRATEGIC PLAN WORKSHOP

RESOURCE ALLOCATION AND GENERATION		
Goal	Issues	Strategic Options or Implementable Actions
Broaden the financial base of the MOH and the health sector as a whole	<ol style="list-style-type: none"> 1. Lack of adequate resources for financing health services 2. Over-reliance on traditional sources -- treasury, donor, community 3. Lack of awareness and readiness to accept health gains and partnership in health issues 	<p>Increase generation of funds through cost sharing, NHIF reimbursement, etc.</p> <p>Develop long-term plan to increase local, central, and foreign financing for health.</p>
Increase the policy and coordination role of the MOH in the health sector	<ol style="list-style-type: none"> 1. MOH has responsibility over health -- coordination 2. Duplication of activities by various agencies and geographical areas 3. Lack of support and enabling environment to health sector (NGO/Private) 4. Lack of clear-cut commitment to a particular vision of the health system for country to support 5. Lack of public investment program 6. Training and recruitment of personnel 	Sector-wide orientation of the MOH: government, private, NGO sectors. Commitment to solving sector-wide financing problems, health policy and policy analysis, appropriate research for the whole health system.
Reallocate public spending toward activities with broad community benefits and away from those that primarily benefit specific individuals	<ol style="list-style-type: none"> 1. Observed and continued bias in emphasis on curative services -- lack of attention to cost-effective allocation 	<p>Reallocate public spending toward public health, environmental health, preventive services, health education.</p> <p>Accelerate the reduction in public subsidies to high-level curative services</p>
Target public curative care subsidies to the poor	<ol style="list-style-type: none"> 1. Over-emphasis on curative services versus PHC. Only accessible to and benefit rich, given tendency to be located in urban areas. 2. Miss geographical location of poor. 	Monitor beneficiaries of public subsidies; act to improve distribution
Target public spending to the health needs of the population	<ol style="list-style-type: none"> 1. Concentration on curative services 2. Lack of information and guidance on budgeting and allocation in line with mortality and morbidity patterns to target resources; identifying problems, identifying interventions, and direct expenditure 	Use mortality-morbidity data to identify priority expenditure areas

COST SHARING		
Goal	Issues	Strategic Options or Implementable Actions
Improve quality of service	Staff rudeness/attitudes; cleanliness, equipment, bedding, drug availability inadequate	Assist facilities to use effectively the 75% withholding of revenues; also 25% to PHC
Increase revenue from cost sharing	<ol style="list-style-type: none"> 1. Inadequate resources, especially financial 2. Inefficiency in financial management 3. Lack of trained manpower and lack of incentives 	Improve incentives for collecting revenue (keep it within the department collecting it)
		Expand fee structure
		Increase fee levels
Improve planning and allocation of cost sharing revenues	Budget preparation; trained staff in planning; team work/coordination of disciplines lacking; structure needs to be there from dispensary to MOH Headquarters and be strengthened	Increase compliance, in particular claim forcefully from NHIF
		Improve administration and management of facility-level funds
Improve rational use of the health care system	Rules; patients bypass	Evaluate pricing strategy across facilities
		Encourage utilization shifts
Better targeting of waivers to low-income patients	Equity; difficult to identify cases deserving waivers	Revise exemption and waiver criteria, Designate free clinics for the poor, instead of waivers

PRIVATE SECTOR/NGO/LEGAL & REGULATORY ENVIRONMENT

Goal	Issues	Strategic Options or Implementable Actions
<p>Create enabling environment and reduce government-imposed cost of (practicing medicine), providing health service in the private sector.</p> <p>Equalize treatment of practitioners between public and private sectors</p> <p>Reduce costs imposed by government on private practice</p>	<ol style="list-style-type: none"> 1. Multiple licenses required to open private health facilities 2. High duties and taxes translate into high fee and hinder expansion of services in the private sector 3. Lack of resources available to the private sector 4. High cost of starting private services 5. Imbalance between rural and urban location of private services 	<p>One-stop licensing</p> <p>Reduction/consolidation of taxes on private for-profit providers</p> <p>Amend or make provision for waivers of requirements</p> <p>Introduction of assessment exams for volunteer doctors and short-term consultants</p> <p>Paperwork: Amalgamate and consolidate the fees, licenses, and taxes required by government</p> <p>Customs Duty: Encourage rural location through selected remission of duties</p> <p>Land Costs: Set aside public land in rural areas for health facilities.</p> <p>Targeted reduction of duties and taxes on imports for private for-profit facilities and waivers for mission/church facilities.</p> <p>Targeted subsidies for capital, personnel, and land costs for under-served areas</p>
<p>Enhance private sector role in curative care, freeing government resources to enhance promotive and preventive services</p>	<ol style="list-style-type: none"> 1. Government unable to provide sufficient services 2. Curative services consuming resources better used in preventive care 3. Insufficient resources targeted to the poor 4. Reduced charitable and donor resources available to missions 5. Disparate treatment of personnel and facilities relative to government facilities 	<p>Gradual privatization of MOH curative services/ departments/facilities</p>
<p>Revitalize mission facility support</p>		<p>Seconding staff; training of personnel; cross-subsidy through increased reimbursement rates from NHIF; favorable climate for use of voluntary personnel</p>
<p>Reduce costs to patients of medical care irrespective of provider</p>	<p>High cost of health care to general population</p>	<ol style="list-style-type: none"> 1. Consider generic drug laws, standard medical procedure manuals 2. Bulk purchasing by the private sector 3. Introduce legal provision to establish central purchasing for private sector to reduce cost to the patient
<p>Increase demand for private sector services by low-income families</p>	<p>Low-income people cannot afford formal private sector services</p>	<ol style="list-style-type: none"> 1. Increase purchasing power of households by widening coverage of social financing 2. Increase contracting out for private services by the MOH

SOCIAL FINANCING

Goal	Issues	Strategic Options or Implementable Actions
Privatize the management of the NHIF and NSSF	<ol style="list-style-type: none"> 1. Management problems 2. Accountability 	Amend the law
Restructure the NSSF. Introduce health as a scheme	<ol style="list-style-type: none"> 1. Social, legal protection of workers. Health problems which are traceable to working situations 2. Accounts are not known 	Amend SSF law and allow health to be treated as a benefit
Increase available benefits of private and NHIF insurance plans and expand choices for consumers	<ol style="list-style-type: none"> 1. Lack of information to the would-be insured 2. Income constraint 3. High premiums 4. Few companies offering health insurance 5. Cultural and religious factors (Islam) opposed to voluntary insurance 	Increase competition among insurance plans to increase benefits available to the insured and firms
		Increase variety of benefit plans and cost options for the insured and firms
Increase population covered by health insurance	<ol style="list-style-type: none"> 1. Population is uneducated about risk-sharing schemes such as NHIF 2. Low level of income 3. Lack of accountability and transparency 4. Subsistence life styles and extended family dependency 5. Population indifferent toward insurance (even the educated) 	Develop low-cost plans for poorer elements of the population (e.g. incomes < Ks. 1000/mo.)
		Tap potential of cooperatives and marketing boards for group coverage of agricultural sector through NHIF, private sector, or separate agency
		Assess potential of covering others through community-based schemes
Recognize the potential of NHIF and other social financing institutions for improving health services and quality	<ol style="list-style-type: none"> 1. NHIF has a narrow membership base 2. Benefit package not attractive or competitive 3. Legal limitations 4. Cost of insurance 5. Cooperative law should allow the movement to finance health delivery for certain negotiated benefits. 6. Excessive centralization of NHIF 	Supplement internal NHIF strategic planning with sector-wide goals for improving benefits and coverage of NHIF
		Consider options for increasing the responsiveness of NHIF to current and potential clients
		NHIF should act as a financier of the provision of health care
		Can the NHIF contribution be paid to other companies?
		Employer contribution to funding for workers after retirement

<p>Improve criteria for selecting among MOH services to fund. Use MOH resources for greatest health impact; example: PHC versus curative, non-facility-based (e.g., schools) versus facility</p>	<ol style="list-style-type: none"> 1. Historical precedent determines allocation of funds; no clear allocation process 2. Lack of information on: <ul style="list-style-type: none"> location of health resources utilization patterns health impacts 	<ol style="list-style-type: none"> 1. Cost-effectiveness analysis of approaches to health sector problems 2. Inventory of health resources -- public, private, individuals, and facilities 3. Synthesis of utilization and need, under-served populations 4. Develop process to allocate resources according to need
<p>Lower cost per unit of overall output of MOH health services</p>	<p>Low productivity of inputs</p>	<ol style="list-style-type: none"> 1. Labor: allocate staff resources relative to utilization; assess needs 2. Capital: develop capital budgeting plan based on demand for services. Re-assessment of economic configuration of MOH system: opportunities for consolidation, delivering services through least-cost outlets 3. Drugs and supplies: allocate by demand or workload; increase budgets; reform medical stores management and/or privatize the process 4. Maintenance and transport: develop budgeting criteria; under-funded 5. Potential of contracting out for services and inputs 6. Increased autonomy but greater responsibility for performance by local managers; plus 7. Added managerial training and professional management of facilities 8. Improved financial control and control over physical inputs within MOH 9. Make staff pay dependent on performance -- merit pay

APPENDIX 4: SCOPE OF WORK FOR THIS ACTIVITY

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COMPREHENSIVE KENYA HEALTH CARE FINANCING STRATEGY
Kenya Health Care Financing Programme

SCOPE OF WORK FOR THE PREPARATION OF "FRAMEWORK" FOR THE COMPREHENSIVE KENYA HEALTH CARE FINANCING STRATEGIC PLAN.

1. INTRODUCTION.

The Ministry of Health wishes to prepare a Comprehensive Health Care Financing Strategic Plan. In order to achieve this goal, the Ministry requires two consultants to synthesise existing literature in this area and to identify any gaps that may exist and to put together a framework for producing the strategic plan.

Some of the most current and relevant documents are the 1989-1993 Development Plan, the 1990 MOH Concept Paper and the Cost-Sharing Implementation Plan. The first document identifies the problem of health care financing as that the "government is faced with an inelastic revenue base and a growing demand for health services and hence finds itself in a situation in which devoting relatively more resources to health would compromise overall growth and employment" (p.238). The possible solutions to the problem are proposed to be: the government would attempt to maintain the level of public sector budgetary resources assigned to health in real terms; it would re-order priorities as between promotive, preventive, and curative health services to bring about cost-effectiveness; raise additional resources through cost-sharing; enhance contribution by communities, church organisations, NGOs, and private sector participation; enhanced utilisation of health insurance; and create an efficient and cost-effective administration of health services.

The concept paper addresses itself to the objectives of financing health services and identifies three areas which must be under-scored if the objective of HEALTH FOR ALL by the year 2000 will be met, namely: revenue generation/mobilisation of financial resources; organization and structure of health sector; and efficiency, effectiveness and equity in the use of health sector resources.

The Cost-sharing Implementation Plan details measures and procedures of collecting and utilising cost-sharing funds at government facilities. It is presented in six sections, namely: organisational support for health care financing; fee administration mechanism; measures to ensure access; utilization of fee revenues; monitoring and evaluation; and projected shifts in MOH expenditures from wage to non-wage categories and a breakdown of operating expenditures for the year 1988/89.

The framework should take into account the need for developing a consensus on the final strategy paper. It should include a review of the overall goals of the health sector in the country and a statement of the methodology for defining the roles in the use, provision and financing of health services as they relate to the health sector goals by such main providers as public sector, parastatals, private sector, communities and foreign donors. The methodology should take into account the relative abilities of the various providers to provide different types and levels of services, finance operating

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costs, provide services to those unable to pay, and make risk-sharing arrangements.

The framework must also underscore the need for political acceptability of the strategic plan if it is going to be implemented successfully. It should also take account of the fact that although political reaction/objection may not be completely avoided, there is need for policy-makers to be sensitised to and convinced of the economic realities that make it necessary for the government to look for alternative means of financing health services. It should indicate the manner in which political good-will could be cultivated. Other general areas of concern should include: the need for in-built flexibility in the strategic plan so that it can accommodate socio-political changes that may occur during plan implementation; and the need to develop adequate monitoring mechanism to provide information on how well the plans are working and to generate technical information which can be used whenever there is political outcry.

2. PURPOSE.

The purpose of the study is to define a strategic planning framework and produce a detailed outline of the country's health sector financing plan by synthesising existing documents and studies in the area of health care financing, and meeting with key individuals in government, non-governmental organizations, mission and private providers. The study should identify any gaps in materials or methods which exist and propose ways of closing them. The consultants will be expected to present their findings to senior MOH officials and thereafter incorporate any comments and suggestions arising therefrom.

3. SPECIFIC DUTIES.

The consultants will review available relevant literature on policies and strategies on health care financing and identify conceptual, analytical and practical issues that have been already addressed to and those that need to be looked into. The consultant will suggest a conceptual and practical/operational framework of preparing a plan that is integrated and implementable with specific policy options and recommendations for the mode of choosing the best policy. The consultant will also identify specific areas of further studies and prepare draft Terms of Reference for these areas of deficiencies giving specific tasks, duties, personnel requirements and their qualifications, time-line for each study and suggested methodology of approach.

Five specific tasks will be performed by the consultants. These are: (1) review MOH policy documents and important studies related to health care financing in Kenya; (2) review Kenya Health Care Financing program and project initiatives (e.g. scopes of work and survey instruments for various studies) relevant to preparing a comprehensive health care financing strategy; (3) identify and review other, non-Kenya Health Care Financing program/project, MOH initiatives relevant to financing the health sector; (4) make specific recommendations for additions, deletions, and changes in health care financing program/project activities in order to assure that project resources are used most efficiently to gather all essential background information for drafting the Comprehensive Health Care Financing Strategy; and (5) draft a detailed outline of the comprehensive health care financing strategy plan.

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Among other areas, the consultants will be required to look into the need to study the operations of private sector insurance as a possible source of health care financing in Kenya and the legal/regulatory aspects affecting the long-term strategy of the health sector.

The consultants should bear in mind a number of factors/considerations (e.g. how the plan will be practically used; how to finance the gap created by the drop in public financing and take care of the normal growth in the needs of the health sector; the definition of the roles and responsibilities of financing health services; ways and means of financing health services by developing systems/procedures of generating funds to provide and improve health services in the country; preparation of an implementable comprehensive financing plan that gives a practical and flexible health services provision road-map for the future; and enhancement of the participation of the public, the private sector, national health insurance schemes, etc.).

The consultants should also address, but not be limited to, the principal issues of: revenue generation and allocation, facility utilization, cost-containment, efficiency, acceptability, sustainability, equity/regional disparities, assurance to access, accountability, affordability, collaboration/coordination, and the role of the government as a provider, facilitator and regulator. The consultant should bear in mind the fact that underlying these issues are the questions: how well do we use available resources? who are we serving? who is going to pay? and what are they going to be paying for?

4. PERSONNEL.

The study will require an economic/planning consultant who should have wide international experience in the preparation of health care financing strategic plans with proven practical experience in developing countries (and especially in Africa). This consultant will provide cross-country comparative experience and perspective on planning processes and factors conducive to success. This international consultant will work jointly with a local Economist who is conversant with health sector financing planning and has sufficient experience in Macro-economic analysis. The local expert will provide knowledge of local factors, both enabling and constraints, that should be brought to bear if success is to be achieved. He/she will become the Economist/team leader to carry out the Private Sector Study immediately following the "framework" consultancy. The scope of work for the private sector study has already been prepared.

5. DURATION OF THE STUDY.

The study is expected to take a period of three calendar weeks with each consultant working for a total of three five-day work weeks starting about September 16, 1991. The consultants are expected to produce a draft paper within two weeks from the date of commissioning the study for presentation to a workshop of senior personalities in the health sector.

6. SUPERVISION.

The Kenya Health Care Financing Project Health Economist and the Head, Planning Division, Ministry of Health. The Health Care Financing Project

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Economist will work alongside the two chosen consultants during the three weeks of the consultancy. The consultant team with the Health Care Financing Project Economist and MOH head of planning will liaise with Health Care Financing Implementation Committee on a weekly basis.

7. EXPECTED OUTPUTS.

The consultants are required to complete the final report prior to completion of the assignment. The final report should include: a well-reasoned framework for preparing the health care financing strategic plan to include a concise literature review, a brief chronology of health care financing in Kenya, policy issues with decisions/actions already taken and decisions/actions still to be taken as well as questions to be answered, and a detailed outline for the strategic plan giving the content and format of the plan; identified gaps that need further studies with detailed terms of reference for each of the identified studies and descriptions of personnel requirements and time-line; and time-frame for the completion of the health sector financing plan.

8. FOLLOW-UP.

After all inputs into the strategic plan have been completed, as per the framework developed in this consultancy, one or both consultants may be asked to return and work alongside the Kenya Health Care Financing Project Economist to implement a workshop of senior policy makers to reach a consensus on the health sector financing strategy.

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CONCEPT PAPER

STRATEGIC PLAN FOR FINANCING HEALTH SERVICES
IN KENYA

- The overall objective in financing health services is to provide health for all.
- The strategy for financing health services consists of objectives and implementation activities in three fundamental areas:
 - 1) Revenue Generation/Mobilization of Financial Resources
 - 2) Organization and Structure of Health Sector
 - 3) Efficiency, Effectiveness, and Equity in Use of Health Sector Resources

I. REVENUE GENERATION/MOBILIZING FINANCIAL RESOURCES

The present level of government funding, even though keeping pace with inflation, is not adequate. The gap in funding of health services has recently been documented in a survey of expenditures on maintenance, transport, drugs, and personnel for preventive services. Although increases in the current national allocation to the health sector may be desirable and can be justified based on analyses from these studies, the share of national financial resources is unlikely to rise in the near future due to the economic circumstances which the country faces. Total expenditures on health as percentage of GNP are too low and should rise over this decade. Revenues for health will be provided through cost sharing, insurance, and government funding. The strategic orientation for each of these revenue sources is as follows.

A. Cost Sharing (Health Improvement Fees)

- Fees will remain a permanent feature of financing health services for the foreseeable future; consumers need to take responsibility for their health care as an individual service.
- Fees in place as of December, 1989, shall be increased over time.
- Over time the fee base will be broadened; an operational strategy needs to be identified to move towards charges for drugs at full recovery of drug cost.
- Fees presently are expected to account for around 5% of total recurrent costs of government service; this should increase to 20% by the end of the decade.

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Implementation of this strategy requires a strategy, promoting acceptability of fees. The concept of acceptability encompasses:

- an aggressive type of public education for consumers, communities, and politicians which focuses on the idea that health is a consumer responsibility (to include mass media, schools, church leaders public meetings -- at districts with DHNBs and in communities -- and traditional health education means)
- decentralization of responsibility for fee implementation to local level -- Health Centre Committees composed of local leaders, Executive Expenditure Committee
- visible changes in improvement of services at facilities
- strategy to ensure access of those who cannot pay for services

B. Insurance

1. National Health Insurance Fund (NHIF)

NHIF as a public insurance mechanism should move towards covering 90% of health care costs of its membership over this decade and should act as a source of funding for the health sector; it should remain a not-for-profit enterprise. Specific objectives are:

- broaden its membership -- one approach to be pursued aggressively is to investigate the mechanisms for including cooperatives whose members are not contributors to NHIF; NHIF should recruit agents for expanding membership
- increase its premiums in the long run and adjust benefits accordingly
- include employer as contributor to premiums with the employers eventually contributing on a 50/50 basis with employees
- allow for alternative benefit packages (a basic coverage plus additional coverage)
- allow a higher maximum claim for MOH facilities -- billing rate should be higher than the user fee charges so as to reduce the government subsidy to this higher income group
- MOH facilities need to efficiently manage billings and claims to NHIF; MOH hospitals should also make claims under car insurance for treatment of road accidents
- encourage shift to use of government facilities by NHIF membership -- move from 4% to a higher target rate by end of decade

- maximize returns to financial surpluses
- Use financial surpluses to improve quality of government services; study the feasibility and appropriateness of alternative mechanisms -- such as prospective payment -- to control the money in the fund to the benefit of improvements in government health services.
- Outpatient services will not be included in the benefit package in the near term. The addition of these services to the package will be studied for its fiscal impact on the financial viability of the NHIF.

2. Private Insurance

Private insurance is to be encouraged. Implementation of this strategy requires:

- legal changes for NHIF
- more information regarding employer coverage for health services and utilization patterns

Insurance schemes are complicated and need to include study of marketing and legislative requirements. Recommendations for policy and direction in the insurance area need to be based on further careful study.

C. Government Funding

- Budget allocation should increase at a positive real rate -- net of domestic inflation and local currency devaluation; the MOH recognizes that this would represent a new but desirable approach not presently used by Treasury.
- The priority status of the MOH for access to foreign exchange needs to be maintained.
- MOH recognizes that general taxes are already high and therefore difficult to increase; however, the taxable group is small and should be expanded.
- MOH should make a representation to government discussions on general taxation policies. Earnmarked taxes can provide source of funds for health sector. Taxes to consider include:
 - cigarettes
 - alcohol
 - car insurance
 - other commodities (based on income elasticity criterion)

The underfunding gap for health services is estimated very roughly at 1.4B Ksh. Insurance can be expected to contribute approximately 400M Ksh;

cost sharing can contribute 100M Ksh; an increase in the MOH budget allocation can provide 100M Ksh; new or increases in excise taxes have potential to contribute 200M to 400M Ksh; cost savings from efficiency improvements 400M Ksh.

II. ORGANIZATION AND STRUCTURE

Kenya's ability to achieve its objectives in improving the level of financial support for its health care system, and to improve its efficiency and effectiveness in managing these resources, is dependent on how the components of the system are organized and structured. The non-governmental health sector in Kenya is composed of KCS, CHAK, and other NGOs, private hospitals, private physicians, and pharmacies, private insurance plans, and industry sponsored health services. Of hospital beds in the country, approximately 69% are in MOH institutions (6% in Kenyatta National Hospital), 21% in "mission" hospitals and health centers, and 9% in private institutions. In comparison, about 71% of all health facilities are in the MOH, 17% in mission organizations, and 12% in private organizations. While these figures are approximate and need to be verified, it is apparent that non-governmental organizations make a significant contribution to health care in Kenya -- in the range of 30 to 40% of all health services in the country.

A. Non-Governmental Sector

The following principles should be considered in establishing a policy regarding the non-governmental health sector:

- As a continuation of its present policy, the government of Kenya does not wish to assume responsibility for operating non-governmental health facilities, nor increase financial assistance above the level now targeted.
- As a last resort, the MOH may step in to assist a NGO or mission facility that is mismanaged or is having financial difficulty, especially where that unit is considered important in maintaining the level of health services available in that area.
- The subsidy provided to non-governmental health facilities should continue to be targeted at about 30% of total operating costs, even though this level of funding has not been possible during these last few years.
- Non-governmental health facilities are located primarily in rural areas and are considered both supplemental and complementary to services provided by governmental units.
- Non-governmental facilities are supported financially from three primary sources: from external sources (ranging from a low of 20% up to 50%), up to 30% from governmental subsidies, and the balance from user fees.

- As external sources continue to diminish, non-governmental facilities should be encouraged to increase support from user fees rather than from increased governmental subsidies. Non-governmental facilities do not face the same restrictions on collecting user fees as do governmental facilities.
- Mission and other NGO facilities should be encouraged to expand their services in coordination with MOH priorities. NGO facilities should be included in the MOH annual planning process and coordinated at the central level, possibly through the re-activation of the Central Health Board.
- The role and utilization of private physicians and clinics should be quantified.

B. Governmental Sector -- Decentralization

Under the umbrella of Kenya's decentralization initiatives implemented in 1984, the MOH introduced a decentralization plan about one year ago. The plan aims to place more responsibility and authority for planning, budgeting, financial management, and program monitoring at the district and division levels. Responsibilities have been assigned to each level of the organization as described in the chart on the following page. This decentralized organization is intended to carry the MOH into the next decade.

- The decentralized system, as it applies to health financing, is new and should be monitored during the next few years so that refinements can be introduced.
- The District Health Management Board, under the broad direction of the District Development Committee, has responsibility for setting priorities, managing district funds (both those collected from fees and others), setting standards, and handling consumer complaints. It meets about every three months during the year.
- The District Health Management Team is responsible for professional and technical issues and meets every week.
- Each facility has an Executive Expenditure Committee to oversee the expenditure of funds collected from user fees -- within the limits approved at the district level.
- The needs and plans of NGOs and other non-governmental facilities will be coordinated primarily at the central MOH headquarters.

C. Guidelines and Standards

Certain incentives and controls need to be maintained in order to assure that the health services system moves in the desired direction of decentralization. Some of those incentives and controls include:

- The responsibilities and authorities assigned to each level of the organization, as described in item B, above, have been clearly delineated.
- The facility's ability to use 75% of collected revenues to address local priorities motivates the facility to improve collections and increases the acceptability of fees among users.
- Assigning increased responsibility and authority at the district and local levels is expected to increase commitment and improve performance.
- Outstanding performance at the local level should be recognized and the ideas generated should be shared with other local managers as a learning experience.

III. EFFICIENCY, EFFECTIVENESS, AND EQUITY

A. Management Systems

1. Budget Allocations

a. Allocations Between Preventive and Curative Services

Definitional problems regarding what expenditures are considered preventive and what are curative have hampered accurate assessment of the proportion of the budget spent on each. The definition needs to be broadened. Estimates have been difficult to make and imprecise. It is recognized that expenditure on preventive services can reduce or contain costs of curative services. It is also recognized that improvements on the prevention side must include coordination and cooperation with other ministries.

The policy of the last 10 years has put an emphasis on preventive and promotive services. However, budget allocations have not always been consistent with that policy, although the above mentioned definitional problem makes it difficult to determine the exact allocations to each area. Preventive services are to be a priority area for new financial resources that come into the system through government budget increases or cost sharing revenues. The following recommendations are geared toward achieving that objective.

- Curative services will continue to be an important focus of the health care system.

- Preventive services have a priority for new resources.
- Preventive services which reduce the need for curative services will be particularly emphasized.
- Specific areas of preventive services will be identified and targeted to maximize effectiveness (for example, the eradication of certain vectors).
- Creating public awareness for use of preventive services is an essential feature of the financing strategy.

b. Allocations Between Personnel and Nonpersonnel Expenditures

It is recognized that expenditures on personnel are a large proportion of overall MOH expenditures. These expenditures are difficult to adjust in the short term because salaries and staffing levels are fixed. The problem is compounded by overstaffing in some facilities or areas and serious personnel shortages in other places. In addition, salary levels are considerably higher in the private sector, which attracts health personnel away from the public sector, further aggravating personnel shortages. The imbalance between personnel and nonpersonnel expenditures contributes to low productivity because of inadequate supplies and equipment. The following represent the means to improve this situation.

- Human resource (manpower) planning is essential; accurate and reliable data based on information collected from both public and private sectors is necessary to make informed decisions on labor supply and demand.
- Staffing norms need to be reviewed, revised, and then used in the public sector.
- Human resource projections need to be developed with particular attention to replacement and growth needs.
- Less expensive cadres of staff should be substituted for more expensive cadres whenever appropriate.
- Nonpersonnel expenditures will be given priority for new resources as a means of reducing the imbalance between personnel and nonpersonnel expenditures, which will subsequently lead to an increase in productivity.
- Training and specialization of staff should be examined to avoid any duplication of operational functions.

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Allocations Across Districts

Up-to-date, reliable information is required to allocate the recurrent budget to district areas. This information should also be used more fully. A workable formula for MOH allocations should be developed, taking into account the following variables:

- population
- access indicators (# beds, hospitals, health centers; travel time to facilities)
- health status indicators (e.g., disease prevalence, infant mortality rates)
- income indicators

2. Information to Increase Efficiency, Effectiveness, and Access

High quality information is needed in order to make effective management decisions.

- Information must be brought up to date for planning and monitoring purposes.
- Timeliness and availability of information is to be improved at HQ, districts and facility levels.
- Trained analysts are required for data analysis. An epidemiologist should be hired to assist with the analysis of utilization information.
- Data collection efforts should be reviewed and revised to ensure that only data required for a useful purpose are collected.
- Efforts of committee in setting and achieving targets in reducing average length of stay need to include the clinic officer and an experienced medical officer from the field.
- Cost analysis capacity needs to be developed in-house at HQ and at district level; this requires technical assistance inputs.
- A study should be undertaken of the unit cost for each health service offered (e.g. inpatient day, outpatient visit), taking into account all inputs going into treatment.

3. Drug Management System

The components of a drug management system are:

- procurement
- distribution
- record keeping
- accountability

Different parts of the system have worked better than others in Kenya. A useful distinction may be to look at procurement issues separately from distribution, record keeping, and accountability. Regarding procurement, the following should be considered:

- Members of the procurement committee should not be permanent, should not know in advance the period of service, and should be well acquainted with on-the-job drug supply needs.
- A drug policy on what and how much to procure needs to be formulated.
- Outsiders should be involved in the procurement process.
- An external technical evaluation committee should be established.
- A study should be instituted immediately to develop a sustainable drug procurement system.

4. Computer Management

Management of computer resources is required for efficient information management.

- Purchase and servicing of computers should be standardized and centralized.
- The ability to service computers should be assured at the time they are acquired.
- Trained personnel are needed to use computers effectively.

B. Access

At the moment, clear and specific guidelines for ensuring access to services are contained in Chapter 4 of the Cost Sharing Instructions. These guidelines have been in place for less than a year. These guidelines must be monitored and a review, evaluation, and revision conducted by June/July next year.