AGENCY FOR INTERNATIONAL DEVELOPMENT

# PROJECT DATA SHEET

1. TRANSACTION CODE: A (A = Add, C = Change, D = Delete) — Amendment Number

DOCUMENT CODE: 3

2. COUNTRY/ENTITY: KENYA

3. PROJECT NUMBER: 615-0245 PDBBR 437

4. BUREAU/OFFICE: AFRICA 06

5. PROJECT TITLE (maximum 40 characters): KENYA HEALTH CARE FINANCING PROGRAM

6. PROJECT ASSISTANCE COMPLETION DATE (PACD): MM 08 DD 31 YY 93

7. ESTIMATED DATE OF OBLIGATION (Under 'B.' below, enter 1, 2, 3, or 4)
A. Initial FY 89 B. Quarter C. Final FY 89

8. COSTS ($000 OR EQUIVALENT $1 = )

| A. FUNDING SOURCE | FIRST FY B. FX | C. L/C | D. Total | LIFE OF PROJECT E. FX | F. L/C | G. Total |
|---|---|---|---|---|---|---|
| AID Appropriated Total | | | | | | |
| (Grant) | ( 5,300 ) | ( ) | ( 5,300 ) | ( 5,300 ) | ( ) | ( 5,300 ) |
| (Loan) | ( 5,300 ) | ( ) | ( 5,300 ) | ( 5,300 ) | ( ) | ( 5,300 ) |
| Other U.S. 1. | | | | | | |
| Other U.S. 2. | | | | | | |
| Host Country | | 1,800 | 1,800 | | 1,800 | 1,800 |
| Other Donor(s) | | | | | | |
| TOTALS | | 1,800 | 7,100 | 5,300 | 1,800 | 7,100 |

9. SCHEDULE OF AID FUNDING ($000)

| A. APPROPRIATION | B. PRIMARY PURPOSE CODE | C. PRIMARY TECH. CODE 1. Grant | 2. Loan | D. OBLIGATIONS TO DATE 1. Grant | 2. Loan | E. AMOUNT APPROVED THIS ACTION 1. Grant | 2. Loan | F. LIFE OF PROJECT 1. Grant | 2. Loan |
|---|---|---|---|---|---|---|---|---|---|
| (1) | 660 | 580 | | | | 5,300 | | 5,300 | |
| (2) | | | | | | | | | |
| (3) | | | | | | | | | |
| (4) | | | | | | | | | |
| TOTALS | | | | | | 5,300 | | 5,300 | |

10. SECONDARY TECHNICAL CODES (maximum 6 codes of 3 positions each)

11. SECONDARY PURPOSE CODE

12. SPECIAL CONCERNS CODES (maximum 7 codes of 4 positions each)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| A. Code | | | | | | | |
| B. Amount | | | | | | | |

13. PROJECT PURPOSE (maximum 480 characters)

To provide technical assistance, studies, workshops, training and limited commodities as an integral part of the Kenya Health Care Financing Program the purpose of which is to improve the delivery of efficient quality care in both curative and preventive/primary health care services.

14. SCHEDULED EVALUATIONS
Interim MM 08 YY 91 MM YY Final MM 03 YY 93

15. SOURCE/ORIGIN OF GOODS AND SERVICES
☐ 000 ☐ 941 ☐ Local ☒ Other (Specify) 935

16. AMENDMENTS/NATURE OF CHANGE PROPOSED (This is page 1 of a ____ page PP Amendment.)

USAID/Kenya Controller has reviewed and concurs in the methods of financing and implementation.

Thomas A. Totino

17. APPROVED BY
Signature: [signature]
Title:
Date Signed: MM 08 DD 23 YY 89

18. DATE DOCUMENT RECEIVED IN AID/W, OR FOR AID/W DOCUMENTS, DATE OF DISTRIBUTION
MM 09 DD 15 YY 89

AID 1330-4 (8-79)

# Kenya Health Care Financing PAAD
(615-0245)

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## I. EXECUTIVE SUMMARY OF HEALTH CARE FINANCING PROGRAM

The proposed Kenya Health Care Financing (KHCF) Program is a $15 million policy reform support program to be financed under the African Economic Policy Reform Program (AEPRP). The purpose of this Program is to provide sustained increased financial resources for the delivery of efficient quality care in both curative and preventive/primary health services. The Program will facilitate and support the Government of Kenya (GOK) in the implementation of health sector financing reforms.

These reforms are needed to address the large and growing financing gap in the health sector, particularly for preventive and primary services. Thus, the Program seeks to support the reallocation of financial resources; in favor of preventive/primary health services; and the introduction of cost sharing and other mechanisms that will increase the base of financial resources available to the overall GOK health sector, in order to make reallocation possible. To achieve this objective, the Program will support the implementation of various cost-sharing measures (e.g., introduction of user fees and efficiency improvements) and help further define a broader agenda for reform focusing both on cost-sharing and improved efficiency.

During the proposed four-year Program, it is expected that cost sharing will be firmly established within the public sector, and that the revenue generated and support provided under the AEPRP will result in improvements of hospital-based care and in the expanded availability and use of preventive and preventive/primary health services. In the longer run, the anticipated policy actions, implementation of these policy actions, and related efforts to further define and implement a broad program of reform, will result in improved health status, will contribute to the MOH's budget rationalization efforts, and will result in firm commitments of donor support for the longer-term GOK reform agenda in health financing.

The KHCF Program will support the policy reform strategy and process identified by the GOK's 1989-1993 Development Plan in the health financing sector. The policy agenda supports GOK efforts to mobilize additional resources for health financing, through the introduction of user-fees, reallocate resources from curative to primary/preventive services, reallocate the budget to non-wage expenditures and strengthen the overall capacity of the GOK health system to administer and manage its programs and resources. The increase in revenue collection will contribute to closing the recurrent cost financing gap. The proposed Program will also help the GOK in meeting selected recurrent cost requirements over the short-term while reforms are being introduced and implemented.

This Program builds on USAID's intensive dialogue with the GOK and other donors on the issue of cost sharing and related health sector reforms that has taken place over the past two years. In this regard the Program's design reflects the fact that this initiative is only the first step in a reform process that is seen as a 10-15 year effort. The strategy includes a complementary financing role for other major donors to play in the GOK's policy reform agenda for health financing over the short and long-terms.

Through the policy reform support component, the HCF Program will support implementation of reforms that are well-defined, and where the GOK is ready to proceed. The technical assistance and training components will assist the GOK to more clearly define additional reforms needed, steps required to implement these reforms, and areas where other donor investments are required. Finally, the Program will provide resources to strengthen GOK and implementing institution's capacity to conduct policy studies, assess their impact, and transfer skills required to implement the reforms.

Key policy reforms to be supported under this Program include:

- Establishment and implementation of a clear GOK policy with respect to cost sharing (user fees and insurance reforms) in public sector health facilities, including Kenyatta National Hospital (KNH).

- Establishment of policy permitting at least 50 percent of revenue generated through cost sharing to be retained by provider facilities, with the balance used to increase funds for primary and preventive services.

- Reforms in the National Hospital Insurance Fund (NHIF) to establish progressive fee structures, to introduce employer contributions, and to increase reimbursement levels to bring them in line with actual costs.

- Increased level of non-donor financing, both in absolute and percentage terms, for preventive/primary services within the MOH's recurrent budget.

The GOK lead implementing agency for this Program will be the Ministry of Health in conjunction with NHIF and KNH. The MOH will collaborate with the other related Ministries involved in the Program, i.e., Ministry of Finance and Ministry of Planning. Initially, the GOK's Health Care Financing (HCF) Steering Committee will provide oversight and guidance in implementation of the reform program. To support the MOH in

monitoring and evaluating the Program's progress, an HCF Implementation Committee and Secretariat within the MOH will be designated to assume oversight of the Program.

The Program will provide U.S. $9.7 million in direct program support to the Government of Kenya, conditioned on achievement of agreed-upon benchmarks for each component, relating both to the establishment and implementation of policies on health financing. The technical assistance and training components are budgeted at $5.3 million. Counterdeposit Kenya Shillings will be programmed, with the concurrence of USAID, as additive budgetary support in the health sector with specific emphasis on the MOH, KNH and NHIF.

The health sector reform program is clearly viewed as a multi-donor effort. While USAID will be the major donor during this initial stage, it is expected that the World Bank will assume this role as we move to the next phase. The other donors see the proposed AEPRP as a critical first step, both in testing and evaluating alternative cost-sharing strategies, and in helping to define a broader reform agenda which would receive multi-donor support for the additional structural and institutional changes which will assure the viability of the GOK's health care financing reform program.

## II. BACKGROUND

### A. MACROECONOMIC FRAMEWORK

#### 1. Highlights of Current Macroeconomic Situation

The overall performance of the economy has been relatively strong since the recovery in 1985. Gross Domestic Product (GDP), adjusted for inflation, is estimated to have grown by 5.0 percent in 1988, following 5.5 percent and 4.8 percent growth rates in 1986 and 1987. The agricultural sector is estimated to have grown by more than 4.0 percent in 1988. Investment recovered in 1987 and 1988, reversing the previous declining trend. The recovery of investment in the manufacturing sector together with strong domestic demand fueled the growth of the manufacturing sector in 1987-1988. The services sector also performed well, averaging more than 6 percent growth per year over the last three years. The tourism sector continues to experience remarkable growth: 8.0 percent in 1987. The construction sector leveled off in 1988.

The overall strong economic performance has been accompanied by rising aggregate demand and inflationary pressures. Inflation was estimated at about 10 percent in 1988. Following the sudden fall of coffee and tea prices and the resulting terms of trade deterioration in 1987, together with expansionary fiscal and monetary policies, macroeconomic imbalances (a large budget deficit and balance of payments difficulties) emerged. Economic stabilization was necessary as the effects of expansionary fiscal and monetary policies took hold in 1987. In early 1988, the Government of Kenya (GOK) received IMF assistance in the form of an 18-month stand-by arrangement and a three-year Structural Adjustment Facility (SAF) to support stabilization efforts.1]

#### 2. Macroeconomic Constraints and the Health Sector

Central to the GOK stabilization and adjustment program is public expenditure control and restructuring under its Budget Rationalization Program initiated in 1985. The stabilization effort began to take hold in fiscal 1988. The budget deficit was reduced from 7.6 percent of GDP in fiscal 1987 to 4.2 percent of GDP in 1988. The austere fiscal policy is likely to be pursued over the next few years given the difficult financial outlook. According to the real budget, government revenue is not expected to change significantly, and government expenditures are not likely to increase in real terms.

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1] For a more detailed summary of recent macroeconomic developments, see Kenya Structural Adjustment Assistance Program PAAD Amendments (615-0240) for fiscal 1987 and 1988. See also the World Bank report Kenya--Recent Economic Developments and Selected Policy Issues, September 1988.

In addition to controls on the overall level of spending, the thrust of budget rationalization calls for policies to change the composition of government spending. The GOK has been making efforts to address the imbalance between wage and non-wage operating and maintenance expenditures. Provision for increasing operating and maintenance outlays in selected ministries and ceilings on personnel expenditures were included in fiscal 1988/89 and in the forward budget. Increasing emphasis is also placed on making full use of installed capacity by providing adequate financing for recurrent expenditures. Social service outlays--notably health, education and water supply--are the main focus of the Budget Rationalization Program because of their recurrent cost implications and their prominence in the GOK budget due to their public good characteristics.

Progress in improving the composition of public expenditure has been very slow. Government employment continues to grow; an objective of restraining the increase in personnel expenditures to no more than 4 percent per annum has not been met. A substantial gap in recurrent cost financing for non-wage operating and maintenance requirements remains. Because the GOK does not have an explicit public investment program, it is difficult to assess its priorities and to ensure that capital spending is consistent with the Government's ability to operate and maintain the installed capacity.

The budgetary constraint has adversely affected and magnified the recurrent cost financing problem of the health sector by limiting resources available to the sector. Budgetary resources allocated per capita to the sector have declined in real terms. In the case of preventive and rural health, actual spending in recent years was only 70 to 90 percent of the budgeted levels. (See Table 1, Annex C.)

The health sector is further affected by the budgetary constraint in two ways. First, the sector has traditionally high recurrent cost financing requirements which tend to be associated with the provision of social services. According to a study on recurrent costs in sub-Saharan countries, Recurrent Costs of Development Programs in the Sahel, 1980, prepared by the Harvard Institute for International Development and funded by A.I.D., the sectoral recurrent cost ratio averages 0.1 to 0.5 (i.e., for one dollar of spending on putting into place a public service or facility, 10 to 50 cents is required to maintain and operate the installed service or facility each year). Second, the sector has limited absorptive capacity which, together with donors' propensity to provide project aid,

tends to aggravate recurrent cost financing requirements. Donors also tend to overlook the recurrent cost implications when they design projects.

Balance of payments difficulties place a constraint on the country's development efforts in the health sector. Combined with high deficits and pressures to reduce government expenditures in all areas, they have created both a local currency and a foreign exchange financing problem which call into question the long-term sustainability of many health sector activities under current policies and procedures. Foreign exchange shortages can curtail expenditures on critical drugs, equipment and spare parts. To a certain extent, these needs are met by donor contributions, which often provide start-up capital and equipment for projects. However, donor financing alone cannot solve the recurrent cost crisis. Although efforts to improve efficiency and to rationalize expenditures on health services are important, the foreign exchange constraint will have to be addressed beyond the scope of the health sector. The ongoing dialogue between the IMF/World Bank and the GOK is addressing the issue of import liberalization, which in the long run could ease some of the constraints currently faced.

## B. HEALTH SECTOR AND MAJOR CONSTRAINTS

### 1. Health Infrastructure

The Kenya health sector can be divided into three major sub-sectors: public, voluntary, and private. The public sub-sector comprises the government and municipal health services. The voluntary sub-sector consists of the church-related health services and the health activities of other non-government organizations. The private sub-sector includes the medical services provided directly by private companies to their employees, but consists mainly of medical care supplied through the "market" by private health institutions (hospitals and nursing or maternity homes), fee-for-service medical practitioners and pharmacies.

Table 2 in Annex C demonstrates that the Ministry of Health (MOH) is the dominant actor in Kenya's health care system, with 62 percent of the hospital beds. Other key providers include the church-related hospitals, 21 percent, private proprietary hospitals, 9 percent, and Kenyatta National Hospital (KNH), 8 percent. Similarly, 71 percent of the health centers and dispensaries are MOH-operated. Fourteen percent are operated by church-related NGOs, leaving the remainder split between various other government entities and private providers.

Kenya's health care network in the public sector is essentially a typical three-tiered system. At the apex are KNH and the provincial hospitals, which deliver tertiary care and serve as referral points for difficult or specialized cases. At the secondary level, district and sub-district hospitals provide both inpatient and outpatient services and are a referral point for the primary level rural health centers and dispensaries.In some areas, services have been extended to the community level through the training and deployment of village health workers. Family planning and other health services are integrated throughout the system.

The network of MOH and NGO rural health facilities and supporting community-based programs reaches about 50 percent of the rural population. The remainder of the rural population must often travel great distances at high cost to reach a care center. Currently, primary and out-patient services are free to clients in the MOH system, and utilization rates at all levels are high. In reality, clients often have to procure pharmaceuticals from the private sector as shortages and "stock-outs" (including contraceptives) in the public institutions are common. Although some hospitals apply a minimal in-patient registration charge and maternity fees, there are no consistent, enforced collection procedures. In recent years, these fees have been equivalent to only two percent of the total MOH budget. Fees are not retained by the MOH but are returned to the general treasury.

The private for profit sector is generally considered to be in reasonable economic health due to its small size in relation to the population able to pay high charges. The financial viability of the voluntary private sector (mainly church-related institutions), however, is in need of further assessment. In previous years, this group received large subsidies from abroad and the GOK. In recent years, these resources have dwindled. Many of these institutions charge costs net of subsidies but, as many are located in rural areas, they are often in the position of partially or totally waiving fees for those unable to pay.

In recent years, slowed growth in health financing has affected the ability of the public service to provide the quality of care delivered in earlier years. Rural health facilities often lack adequate trained staff, equipment, and supplies. Although a large infrastructure has been put in place, additional recurrent budget financing is needed for maintenance and repair of buildings, repair and replacement of equipment, and purchase of expendable supplies. These problems have been exacerbated by the rapid growth in demand for both curative and preventive care due both to population increases and an increased perception of the importance of these services.

Although recent years have seen changes, historically the bulk of the MOH budget has been directed at secondary and tertiary hospital services, leaving little funding for operation and development of rural health facilities. Public and private hospitals are greatly utilized, with occupancy rates often exceeding 100 percent. Due to perceived availability of resources, use of hospital outpatient services is also high; however, a substantial portion of those cases could be more cost-efficiently treated at a primary care facility. In addition, for those clients admitted to hospitals, the average length of stay and unit costs exceed generally-accepted norms for efficient service delivery.

As in most countries, health resources are highly concentrated in the urban areas. For example, although Kenya ranks very high among African countries on the ratio of population per hospital bed, large discrepancies in this ratio exist between rural and urban areas. While Nairobi has 4.65 beds per 1000 persons, North Eastern Province has a scant 0.78. Medical personnel, especially doctors, also tend to be concentrated in the urban areas.

Kenya has a well-trained cadre of health personnel. However, staff morale within the MOH system is often poor. Limited opportunities for advancement, lack of supportive supervision, and lack of logistical support dampen enthusiasm even of those who are deeply committed to their work.

### 2. Health and Demographic Status and Availability of Services

In the 25 years since Independence, dramatic improvements have occurred in the health status of Kenya's population. Deaths of children under age one have declined from 113 to 80 per thousand live births. During the same period, deaths of children aged 1 - 5 years have declined from 25 to 15 per thousand, and life expectancy has increased from 43 to 57 years. At the same time, fertility rates have risen and Kenya has the dubious honor of having one of the highest population growth rates (estimated at 3.8 percent) and an average family size of 8.2. The Kenya Contraceptive Prevalence Survey (KCPS) conducted in 1984 showed a contraceptive prevalence rate of 17 percent (10 percent modern methods). Service statistics and program and contraceptive logistics data suggest a marked increase in contraceptive use over the last several years. It is estimated that the rate is at least 22 percent. There is also increasing evidence that demand for family planning services is growing and that access is still a major constraint for further increases in use. Through its bilateral family

planning project, USAID is assisting the GOK to strengthen its family planning service delivery through public and private sector channels.

Despite important gains in infant and young child mortality rates at the national level, there remain regional variations with unacceptably high rates. For example, while infant mortality in Central Province is estimated to be between 40 and 50 per thousand, the rates in some districts of Nyanza and Coast Provinces are believed to be over 150 per thousand. These high regional rates of mortality are comparable to those found at the national level in countries that are much less developed than Kenya.

In both the high and moderate mortality areas, morbidity and mortality are largely preventable and are generally caused by illnesses whose early diagnosis and treatment could substantially reduce mortality. Most important among these are malaria, measles, diarrheal disease, acute respiratory infections and, though less well documented, neo-natal tetanus. Important underlying causes of much of this morbidity and mortality are malnutrition (under nutrition) and a large proportion of high risk births (i.e., births that occur to women under age 20, over age 35, less than two years apart, or to women with four or more living children).

Programs to address key preventable diseases have been expanding. However, they still reach only a small segment of the population, particularly in those geographic areas where the need is greatest. Considerable recent progress has been made in the availability of family planning services, yet they are still routinely available in less than 50 percent of MOH facilities. The National Control of Diarrheal Disease Program, which focuses largely on increasing the availability and use of oral rehydration therapy (ORT), is in the early stages of implementation and currently reaches almost 40 percent of the population. ORT use rates are 10 - 15 percent of the total population. The proportions of the population with access to safe drinking water and sanitary excreta disposal facilities are 17 percent and 25-30 percent, respectively.

It is estimated that 42 percent of the population lives within one hour's walk of a primary health care facility. In general, these facilities diagnose and treat common ailments and deliver a basic package of health services (i.e., immunizations, family planning, growth monitoring, and prenatal care).

### 3. Major Constraints to Increased Availability and Use of Primary and Preventive Health Care Services

It has been well established in various studies and assessments that much of the illness and death in Kenya can be averted through effective provision of primary and preventive health care.

Five major constraints to more effective use of the existing health resources have been identified. They are:

- excessive concentration of budgetary resources on hospital-based care as opposed to primary and preventive health services, wage versus non-wage expenses and capital versus maintenance outlays;
- lack of health care financing policies which address the budgetary constraints;
- inadequate public/private sector coordination;
- weak central administrative structures and institutions, particularly in hospital management, planning, policy analysis and coordination;
- weak delivery system for primary health care due to inadequate financial resources and program supervision, and overly centralized planning and management.

The levels and degrees of impact of these constraints on the Kenyan health sector are described below:

#### a. Misallocation of the Budgetary Resources in the Health Sector

There are three dimensions to the effect of the misallocation of health budgetary resources on the objective of promoting primary and preventive health care.

First, as shown in Section C.I, below, the allocation of budgetary resources to support the operation of the health system has been inadequate to accomplish the GOK's stated objective of improving preventive and primary health services. A disproportionate share of budgetary resources is allocated to curative health services. More than two-thirds of the health budget has gone to the national hospital and other hospital-based curative health services, leaving inadequate funding for cost effective primary care required to meet stated sector goals.

Second, there is an imbalance between current outlays for wage and non-wage operating expenditures, such as drugs, medical supplies, fuel and maintenance. According to World Bank estimates, non-wage spending decreased by an average of 4.4 percent, while expenditures on wages increased by an average of 6.4 percentage in real terms during the period 1985-88. The ratio of non-wage to wage spending fell from 0.70 in fiscal 1985 to 0.56 in 1988. This unbalanced spending pattern has resulted in drug shortages and lack of funds to pay for fuel and spare parts for vehicles, particularly at rural health facilities, thus devaluing investments in staff who have inadequate resources to provide effective services. Routine maintenance and repairs of buildings and equipment have also suffered, causing costly decapitalization of the existing system.

Third, growth of capital spending has contributed to diminished spending on maintenance and operation and increased the recurrent cost burden on the system. From 1985 to 1988, capital outlays increased significantly, going from 10 to 18 percent of total health spending. The capital spending was associated with the construction (and in a few cases major rehabilitation) of district hospitals, hospital wards, health centers, and purchase of curative equipment and new vehicles. This resource misallocation, according to the World Bank study on public expenditure issues, is probably the most important constraint to improved operational efficiency in the sector in the near term.

b. Lack of Health Financing Policies to Address Budgetary Constraints

Given limited prospects for increasing budgetary resources, consideration of other means of resource mobilization, such as user charges or efficiency improvements, is necessary. At present, the provision of health services by the public sector is, for the most part, free of charge. In addition, because all revenues must be returned to the general treasury, little incentive exists for collection of fees that could be charged at public facilities.

In recent years, the GOK has become increasingly aware of the need to develop a sector-wide program of health financing policy reform. An initial step toward reform was the transformation of KNH into a state corporation. The MOH has for some time accepted in principle the concept of cost recovery, with fees set at less than costs (known as "cost sharing"). However, no specific measures have been developed or implemented to date.

c. Inadequate Public/Private Sector Coordination

The Kenyan health sector comprises a variety of actors in the financing and delivery of health services. However, despite the severe financial constraints facing the sector, no overall plan exists for the integration of health resources in meeting sector goals. Lack of coordination leads to inefficiencies and ineffective utilization of scarce resources. Institution of cost sharing for public health services and other health financing reforms will add resources to the overall MOH health budget. However, at this point, the MOH's capacity to effectively utilize and invest existing or new resources is not optimal. An effective mechanism for coordinating the activities of private and public sector health providers does not exist. As a result, the MOH is unclear as to the health financing and service delivery requirements that are already being met by the private sector. Opportunities for avoiding duplication and over-concentration in particular areas are not being identified.

For example, decisions on where to locate new MOH and church-related health facilities are made independently without consideration of coverage requirements. MOH subsidies to most church-related health providers have been declining in recent years because of MOH budget constraints. As a result of inadequate coordination and exchange, the MOH is unaware of the financial status of the church-related facilities, including the extent of their dependence on NHIF reimbursements and impact of declining MOH subsidies. Preliminary donor assessments indicate that in the absence of the church-related health services and NHIF reimbursements to all private providers, the MOH's financial outlay would have to be 30 to 40 percent greater in order for it to maintain current levels of geographic and socio-economic coverage.

d. Weak Central Administrative Structure and Institutions

The sectoral policy shortcomings described above are exacerbated by weak or poorly utilized central administrative structures and institutions. A clear statement of policy and strategy objectives along with a ministry-wide action plan to implement this strategy is badly needed. There are a number of management requirements that are best placed at the central government level. They include responsibility for developing coordinated plans for financing and investment, assignment of personnel, logistical support, training policy, material resources, repairs and maintenance, or effective development of

information and education campaigns. The absence of this capacity within the MOH is further complicated by the lack of reliable information essential for policy analysis and formulation.

e. Inefficient Use of Existing Health Facilities

Closely related to the above institutional constraints are weaknesses in the use of existing resources. Patients often use hospitals for primary care, by-passing local health centers and dispensaries where such services are available. This occurs because hospitals are perceived to offer more sophisticated care and are thought to be more likely to have drugs and other supplies. Personnel deployment is frequently inconsistent with health priorities. Supportive supervision, training, drugs and medical supplies are often inadequate or not available in a timely fashion. This situation has resulted in considerable inefficiency and reduced effectiveness of the health delivery system.

C. HEALTH FINANCING

While the above constraints are highly inter-related and should be addressed, the analysis described below points out that the financing constraint is the critical handicap to the GOK's ability to effectively provide health services.

1. Government Revenue and Current Expenditures in Health

No significant increase in public spending on health is expected in the near to medium term. Allocations within the MOH budget have been inconsistent with stated health priorities. Actual expenditures on priority programs often fall short of amounts budgeted. Imbalances in spending between personnel and non-wage recurrent costs have been worsening. Forward budgets show some encouraging trends, but such projections have been difficult to realize in the past.

Limited possibilities for the GOK to improve its domestic revenue performance in the near to medium term mean that significant increases in public spending on health are unlikely. Kenya's overall domestic revenue effort in fiscal 1988 was 23 percent of GDP, which compares favorably with those being achieved in other sub-Saharan African countries (less than 20 percent). During fiscal years 1984-1988, government revenue averaged 22.6 percent of GDP. The GOK revenue rose from 24 billion shillings in 1986 to almost 33 billion shillings in 1988, a real increase of almost 20 percent. Real recurrent health expenditures have risen by about 8 percent since 1985. However, with a population growth rate of 3.8

percent (1989 estimate) per year, this represents a per capita decrease in real funds. With increased capital outlays, the health sector's share of total budget has remained relatively constant at about 7.6 percent. In light of this, and given that the GOK's ability to further increase domestic revenue is limited (the long term target is 24 percent of GDP), no significant real increase in public expenditure on health is anticipated in the foreseeable future.

Actual allocations within overall spending on health have been inconsistent with the GOK's stated policy of emphasizing preventive, primary and rural health services. This is true for both recurrent and development expenditures. The way in which MOH budgets are structured makes it difficult to discern with accuracy the amount spent on these emphasis areas. A crude breakdown of expenditures (shown in Table 3, Annex C) for the 1982-87 period shows that the shares for preventive and primary health and for rural health services have been stable at roughly 4 and 8 percent of total recurrent expenditure, respectively. Spending on curative health services consistently accounted for almost 72 percent of recurrent expenditures. The share of curative health in development expenditure dropped from 82 to 40 percent from 1983 to 1987, but still took the largest share of the total. Development expenditures on rural health rose from 15 to nearly 40 percent over the same period.

The bias of allocations toward curative health services also is illustrated by the significant shortfall in actual recurrent expenditures for preventive and primary health care by as much as 27 percent from budgeted levels over the period 1984-87. During the same time period, recurrent expenditures on curative health services frequently exceeded the allocated budget by as much as fifty percent, the excess representing an amount greater than the total primary care budget in absolute terms (Table 4, Annex C).

A growing imbalance between personnel outlays and non-wage operating and maintenance expenditures has characterized MOH spending. Salaries and related expenses absorb 62.6 percent of the fiscal 1988 recurrent budget (Table 5, Annex C). Non-salary expenditures for operations (drugs, fuel, equipment, vehicles, and buildings) and maintenance account for 22.1 percent of recurrent spending. The underfinancing of non-wage operating and maintenance outlays limits the effectiveness of health staff and reduces the quality of care. Health facilities, already absorbing capital and personnel budgetary resources, frequently report being inoperative for lack of drugs, fuel, or spare parts.

## 2. Projections of Health Budgetary Allocation

In the GOK forward budget issued in July 1988, the total expenditure on health as a proportion of all government expenditures is projected to remain at 7.6 percent annually during the 1990-92 period. The composition of the MOH forward budget reflects some attempt to address the need to increase spending on rural and preventive health, especially in the recurrent budget. The forward budgets also indicate the intention to increase overall spending for non-wage operating and maintenance costs.

Budget estimates for fiscal 1989-92 (Table 6, Annex C) show increases in the share of both the recurrent and development budgets going to rural and preventive/promotive health services. Curative health is expected to lose some of its share of the recurrent and development budgets.

The forward budgets for fiscal 1989-91 indicate some worsening of the ratio of personnel to non-wage recurrent costs imbalance to 20 percent in 1989, before a rise in the share of non-wage operating and maintenance funding to 24.7 percent in 1991 (Table 5, Annex C).

The trends shown in the forward budget allocations are favorable in that they show increasing the shares for currently underfunded primary care programs and functional expenditure categories. However, the magnitude of the shifts is modest. Moreover, the MOH has had difficulty in realizing its intentions in the past.

## 3. Recurrent Expenditure Gap

An analysis of recurrent cost estimates is necessary to assess the GOK's capacity to sustain a public service or facility once it has been put into place. Despite the importance of such estimates in analyzing the financial sustainability of ongoing service programs, they are difficult to make. Implicit in such estimates is some judgment about "acceptable" standards of operation of a public service, such as primary health care. Definition of the standards, to some extent, is subjective, may change over time, and is influenced by changes in certain policies.

To date, there has not been any comprehensive estimation of required recurrent cost financing for existing public health services or facilities. This is partly because a significant portion of what normally can be considered recurrent spending

is being financed by donors. Concerns about the growing recurrent cost financing gap and the eventual phasing out of donor support, have become more acute in recent years, resulting in increasing interest in health financing policies.

Table 7 in Annex C attempts to shed some light on the recurrent cost financing for four major public health programs--expanded program on immunization (EPI), control of diarrheal disease (CDD), family planning, and essential drugs. The estimates are intended simply to illustrate the order of magnitude of the health financing problem. They are far from comprehensive and probably understate the extent of the problem. (For example, the estimated financing requirements for promotion of these programs in the rural health services are not readily available.)

The financing gap for each program is derived by taking the difference between the required financing and the likely financing. The former is based on estimates contained in planning documents prepared by the donors. The latter is based on estimates as reflected in the government annual and forward budgets, and is intended to include likely donor assistance. All the estimates are shown in dollars using the current exchange rate. Implicit in the estimates of required financing is the assumption that such levels of assistance are necessary to maintain acceptable operating standards.

The total annual recurrent cost financing gap for the four programs is estimated at about $5.8 million in 1989 and is expected to rise to $10 million by 1992 (see Table 7, Annex C). These program budget estimates do not include the GOK recurrent budget on salaries, estimated at 60 percent of program cost.

An additional analysis developed for this PAAD reviewed MOH fiscal year 1988 budget requests against allocations for 11 district hospitals in Rift Valley Province. The 11 districts (of a total of 42 nationwide) represent various levels of wealth and population density. As can be seen from Annex C, Tables 8A and 8B, institutions received only 29 percent of their estimated budget (excluding drugs) for non-wage recurrent costs for adequately financing those institutions. Even with an assumption of some over-estimation on the part of the district officers in order to obtain larger budgets, a large recurrent cost gap is evident.

## D. THE FUTURE OF THE HEALTH SECTOR

### 1. Policy Implications

The financing problems described above have become major constraints to sustainable achievement of health improvement and fertility reduction goals in Kenya. It is clear that needed preventive and primary health care activities are under financed. Increased financial resources and greater efficiency are needed to allow budgetary reallocations to priority programs that will reduce morbidity, mortality and fertility. The analysis in the previous sections leads to three major policy implications for future development of the health sector.

#### a. Cost Sharing

Given the macroeconomic situation, especially the tight budgetary position, significant real increases in budgetary resources allocated to health are unlikely. Thus, as part of the future health strategy, mobilization of additional resources will have to include other health financing options. The most important potential means of raising revenues is implementation of cost sharing through user fees in the MOH system, complemented by collective risk-sharing financing like health insurance.

#### b. Budget Reallocation

Better utilization of existing health resources is needed, with particular emphasis on correcting misallocation of budgetary resources in the MOH. The disproportionately large share of government resources provided to hospital-based care and other secondary and tertiary services is not a cost-effective use of scarce public health sector funds. This high-cost approach, coupled with minimal cost recovery efforts to date, has significantly limited the scope for provision of health services in rural areas and for preventive and primary health care activities. National programs to address key preventable diseases that are the primary causes of high morbidity and mortality are still reaching only a small segment of the population. There is, therefore, an urgent need to redirect public resources from tertiary and secondary care to primary and preventive health care activities which can positively affect the MOH's ability to lower morbidity/mortality rates and result in fertility reduction.

Another key area where budgetary reallocation is required is from personnel to non-personnel costs, essential for operation and maintenance of the existing health facilities. Reallocation within the health budget would make it possible to

improve the efficiency and quality of health services, particularly by remedying shortages of drugs and medical supplies and by adequately funding maintenance of buildings, equipment and vehicles.

c. Institutional Strengthening

Institutional strengthening is needed to improve the coordination of health financing and services delivery policies in Kenya. Weak MOH administrative, management and planning structures have in part contributed to inconsistencies between announced health policy priorities and actual spending, as evidenced by inefficient utilization patterns, poor maintenance of health facilities, and an inefficient system of procurement and distribution of pharmaceuticals. Developing a more effective resource planning process in the MOH will require strengthening and improving coordination among staff responsible for planning health services, budgeting, accounting, and administration.

Further, the coordination of the sector as a whole is weak. There is currently no comprehensive strategy or understanding of the abilities and roles of the various actors in the sector in terms of delivery and financing of health services in order to meet overall sector goals.

2. GOK Health Financing Sector Strategy

The GOK has recently taken several concrete steps with respect to cost sharing in the health sector. As indicated in the 1989-1993 GOK Development Plan, the financing problem is seen as a major constraint in the health service delivery. The Plan describes in some detail the plans for implementing cost sharing. This includes proposals for introducing and/or expanding cost sharing within NHIF and KNH, as well as cost sharing within the MOH system more broadly.

Under consideration are modest user charges at all levels of services except at the dispensary level which will be phased in over the next four years. The fee schedules are being structured at levels suggested in recent studies on the public's ability to pay and in relation to encouraging more appropriate patterns of use.

In addition, the MOH is in the process of establishing a Health Care Financing Implementation Committee from within the Ministry to coordinate the implementation of the reform program. The Ministry actively participated in the recent World Bank-led Health Financing Mission (HFM) and sought advice and reactions to its cost-sharing plans. On the basis of the

HFM's recommendations, the MOH revised its implementation plans for cost sharing to reflect more realistic targets and timeframes for phasing in the introduction of user fees at facilities. It is also looking beyond cost-sharing implementation as a way of increasing its financing base and considering other methods such as investment planning, improved drug procurement and manpower deployment and restructuring as logical next steps to improving the quality and efficiency of health services in Kenya.

## III. PROGRAM STRATEGY AND RATIONALE

### A. HEALTH FINANCING STRATEGY

The Kenya Health Care Financing (KHCF) Program proposes to assist the Government with implementation of the cost-sharing and budget reallocation reforms which are fundamental to improving and ensuring the long-term sustainability of health services in Kenya. The Program will focus on three institutions, Kenyatta National Hospital (KNH), the Ministry of Health (MOH) and the National Health Insurance Fund (NHIF), which are key to implementation of these reforms. Cash transfer assistance will be provided to the Government on the basis of performance based conditionality. Local currency counterdeposits will be programmed to support the policy and institutional goals of the Program and broader health sector requirements of the MOH consistent with its overall agenda. Technical assistance and training will be provided to: (1) assist the three implementing institutions to establish the administrative systems necessary to implement cost sharing; (2) further define the long-term reform agenda; and (3) monitor and evaluate program impact.

The proposed KHCF policy reform program to be financed under A.I.D.'s African Economic Policy Reform Program (AEPRP) mechanism is designed as a first step in a longer-term, multi-donor effort in the health sector. Through the recent World Bank-led Health Financing Mission and other collaborative efforts, the Bank, USAID, and other interested donors have reached a consensus with the GOK on the policy reform agenda for health care financing.

The four-year KHCF Program will support implementation of key policy actions concerning cost sharing and help the GOK and other donors to define a much broader reform program expected to be implemented over a 10-15 year period. The proposed USAID and World Bank programs are complementary, with USAID taking the lead initially, both through program support and technical assistance. KHCF is expected to form the basis for much larger resource flows from the Bank and other donors.

An assumption of the KHCF Program is that support for analytical studies will help the GOK further define its reform agenda and also leverage other donor resources to finance key elements of the reform program. Coordination will take place in designing and implementing studies in order to avoid duplication and to ensure that issues of importance to both the GOK and other interested donors are addressed.

Future financial participation of USAID in the reform process beyond program assistance provided through this specially targeted effort is not contemplated. However, it is expected USAID will continue to provide limited technical support needed to sustain the reform process. In particular, review of and assistance toward expansion of the role of the private sector in assisting the GOK to meet health and fertility reduction targets would be an appropriate area for lower levels of future assistance.

## B. RATIONALE FOR PROGRAM ASSISTANCE

While not all weaknesses in the health sector can be addressed through increased and more efficient financing, the financing problem affects virtually all aspects of the health care system. If not addressed, the prospects for improving and expanding both curative and preventive services are bleak.

Effective adjustments made in health spending will contribute significantly to the achievement of not only the health sectoral objectives but also the budget rationalization goal. Sectoral program assistance can address the recurrent cost problem by supporting policy and institutional changes needed to ensure long-term sustainability. More appropriate financing of operating recurrent costs is needed to enable more efficient use of existing facilities and manpower and thereby contribute to GOK efforts to contain costs.

The GOK recognizes these points and is committed to embarking on a reform program. However, resources are needed to permit and encourage policy change. USAID program assistance for financial reforms is seen as a catalyst to development and implementation of a much larger reform process that will directly affect the sector's ability to affect health and demographic status and to better utilize GOK and donor resources. Funding and assistance at this stage in the reform process are particularly important to ensuring that appropriate reforms are undertaken and vulnerable groups are not negatively affected. The ability of the GOK to carry out any reform process will be substantially affected by the impact of these initial efforts.

Comprehensive program assistance for support of these policy and administrative reforms is not available in the short term from other donors currently participating in the sector. Because of the significant role USAID has already played in assisting the GOK to define its health financing reform agenda, USAID/Kenya has a comparative advantage for undertaking effective interim support to the reform process.

Although proposed USAID funding levels are low for policy reforms of the magnitude proposed, assessment of the recurrent cost constraints to implementation of the Program indicate that USAID's financing will be able to substantially help to address the short-term financing requirements of a larger reform agenda. The KHCF Program can influence the appropriateness and quality of inputs available for the reform process and contribute to the eventual success of the longer-term program.

In summary, the Program is needed to support a policy reform process critical to ensuring the long-term financial sustainability of publicly financed health services which are critical to improving health status and reducing fertility. USAID participation is appropriate on the basis of our commitment to helping ensure improved access to both primary and preventive health services for the poor in Kenya.

### C. OTHER DONOR ASSISTANCE

To date, the World Bank has been the other key donor in the health financing area. The Bank is planning a modest investment project with Kenyatta National Hospital. The project is to be appraised in FY 1990. A larger and broader Bank-led, policy-based health sector operation, with co-financing from other donors, is planned for FY 1991. Funds are to be disbursed beginning in FY 1992. The Bank's planning levels for these two operations are $15 million and $45 million, respectively. Co-financing from other donors is expected to increase the funding level for the policy-based operation. The Bank program is expected to have three main components: Policy Reform, Traditional Project Activities, and Technical Assistance.

The Policy Reform element will provide balance of payments support to the MOF in tranches tied to the formulation and implementation of an agreed list of policy reform and program measures. While the main thrust of A.I.D.'s assistance will be implementation of cost-sharing reforms, the World Bank Project is proposed to broaden these reforms and to concentrate on cost-containment.

The Traditional Project Activities segment will support to health service provider institutions of the MOH and the Nairobi City Commission. KNH will also receive financing for investment in material and human resource development and rehabilitation of physical assets to improve service delivery. The Technical Assistance element will provide support in the form of studies and institutional development assistance for policy preparation and implementation of policy reforms.

A UNICEF project currently under consideration proposes to set up a system of revolving funds managed by communities to ensure the sustainability of drug supplies and provide income for the overall health sector. The proposed project would build on the current Essential Drugs Program (EDP) in which drug kits are supplied to all rural health facilities. Because the EDP cannot meet demand for all needed drugs and depends to a large extent on external financing, the introduction of drug fees will contribute to the continued financing of this program and to greater prospects for sustainability. However, in addition to institution of user fees, donors are encouraging additional GOK financing of EDP to ensure the availability of adequate and effective drugs. The UNICEF project will cost $3.9 million and is estimated to benefit more than six million people. It envisions maintaining uniformity with charges for drugs in government health facilities once cost sharing at all health units is instituted. Moreover, it will include a specially developed training program to improve management and the correct use of drugs at all levels, thereby affecting both efficiency and quality of services. This project will thus complement GOK efforts in cost sharing and cost containment throughout the health sector.

The upcoming Provincial and District Study (PADS), jointly financed by USAID, DANIDA and ODA, will examine the issue of operational efficiency/effectiveness of MOH hospital-based services, as well as implementation issues relevant to cost sharing. DANIDA and SIDA are also jointly involved in an assessment of rural health facilities to determine needs for upgrading/expanding this level of service delivery. As part of this, and in conjunction with the USAID-financed Information and Planning Systems Project, DANIDA and SIDA are also analyzing methods for improving the planning and budgeting process for district-level services.

## D. RELATIONSHIP TO USAID COUNTRY DEVELOPMENT STRATEGY

The goals of the KHCF Program are to improve the health status of the population and to contribute to MOH budget rationalization efforts. These are consistent and directly

supportive of USAID's key objectives, as stated in the 1984 Country Development Strategy Statement (CDSS) and reiterated in the 1989-1991 Kenya Action Plan, calling for promotion of increased economic growth and reduction in population growth. In the health sector, USAID/Kenya's Child Survival Action Plan (May 1987) defines a strategy for reducing the major causes of childhood morbidity and mortality through support for child survival interventions such as control of diarrheal diseases and expanded immunization coverage and continued priority on family planning services, not only for fertility reduction, but also for birth spacing and mortality reduction.

USAID/Kenya's current program portfolio finances initiatives that relate in varying degrees to the goals of the HCF program. One example is the Structural Adjustment Assistance Program, which supports the GOK's overall economic stabilization efforts. In the population and health sector, major assistance is being provided to improve the GOK's service delivery capacity nationwide through the Family Planning Services and Support (FPSS) Project. Though that Project focuses on family planning, it includes related child survival initiatives designed to lower infant mortality and morbidity. The FPSS project is also strengthening the MOH capacity to establish improved information and planning systems related not only to family planning services but also to district-level planning and budgeting processes relevant to preventive/promotive services, i.e., control of diarrheal diseases and immunization services. The proposed KHCF Program is seen as strengthening the GOK's nationwide capacity to achieve larger gains in reducing fertility and population growth rates and expanding child survival activities. The Program supports financing reforms at all levels of the sector and is therefore expected to improve the efficiency and sustainability of these other USAID-funded activities.

## IV. PROGRAM DESCRIPTION

### A. GOALS AND OBJECTIVES

The ultimate goal of the Kenya Health Care Financing Program is to help the GOK to improve the health status of the population, particularly women and young children, and contribute to MOH budget rationalization. Increased financing for, and therefore expanded availability and use of, primary/preventive health services will be an important factor in reaching the goal. This will be achieved through the GOK's policy reform agenda introducing cost sharing and by shifting existing MOH budget resources from curative to primary/preventive services. Reallocation of budget resources within the health sector will also contribute to the Program goal of MOH budget

rationalization. In order to accomplish these objectives, USAID will provide conditional program financing and technical assistance to facilitate and support the implementation of needed policy and institutional reforms.

Through the reform process supported by this Program initiative and the financing provided, GOK expenditures for both preventive and primary health care are expected to increase in both absolute and percentage terms. While significant improvements in infant and young child mortality and fertility levels are unlikely to be seen in this period, as this Program supports the switch to preventive/primary care, it will strengthen the GOK and donor efforts in specific child survival activities. As a result, an increase in the availability and use of primary and preventive health services is expected, and perhaps a modest reduction in disease-specific mortality and morbidity. Over the short term, as cost sharing is phased in, investments in improving hospital-based care are expected to address the non-wage recurrent financing needs of these facilities, thereby contributing to the MOH budget rationalization process.

B. PROGRAM PURPOSE

In order to achieve the longer-term goals of improved health and MOH budget rationalization, the purpose of the Program is to provide sustained increased financial resources for the delivery of efficient quality care in both curative and preventive/primary health services. Specifically, the Program will result in:

- reallocation of financial resources in favor of preventive/primary health services; and
- increased financial resources available to the overall health sector, in order to make reallocation feasible.

By 1992, the end of the four-year program period, USAID/Kenya expects to see a reallocation of resources within the MOH budget such that the share of primary/preventive care will rise by 4-5 percent of the total allocated. It is also expected that by 1992, cost-sharing revenues will be equivalent to 10 percent of the total MOH budget.

Key assumptions linking the purpose and goal are that the GOK will remain committed to MOH budget rationalization and reallocation of resources toward preventive/primary care. It is also assumed that the public's willingness to pay for services will lead to increased investments in improving the quality and efficiency of care and that the increased

availability of resources in the sector will result in increased use of preventive and primary care which will lead to improvements in health.

C. OUTPUTS

In order to achieve the Program purpose of providing sustained increased financial resources for primary and preventive care and health care in general, the Program will support the MOH in a financial reform process. The Program will provide overall support and specific assistance for:

- implementation of currently defined policy reforms;
- further definition of the reform agenda; and
- enhancement of MOH and implementing institutions' capacities to design, implement and evaluate the reform programs.

1. Implementation of Currently Defined Policy Reforms

To increase financing resources available to the sector, policy and institutional changes in cost sharing and the allocation of resources within the sector will be implemented. These policy and institutional changes include the following reforms and expected results.

a. Establishment and implementation of a clear GOK policy on cost sharing in public sector health facilities. (Note: This policy will also affect the efficiency and quality of services.)

Ministry of Health Facilities

Initially, modest user charges will be established in all MOH hospitals and health centers. Fees will be structured with bypass charges to discourage inappropriate use of high-cost services. Administrative procedures for collecting, safeguarding, and accounting for cost-sharing revenues will be implemented or strengthened at all MOH facilities. Improvements in the quality of services will be required in order for cost sharing to be successfully implemented. Systems to waive fees for those unable to pay will be established or strengthened. The effects of cost sharing on efficiency and utilization, particularly by the poor, will be monitored. Data collected and analyzed through the monitoring system will be used to adjust the level and structure of fees over the life of the Program. Further, an appropriate referral system for all

levels of health care, eventually including the private sector, will be developed and implemented. This will ensure that the least-costly level of care will be utilized for each diagnosis.

Kenyatta National Hospital

A comprehensive cost-sharing program and a system for managing such a program will be established within KNH. Charges will be made for inpatient and outpatient services. The charges will be higher than at provincial and district hospitals, to discourage inappropriate use of KNH. In addition, fees will be charged for a set of 14 specialized services, including laboratory examinations. The system in place to waive fees for those unable to pay current token charges will be strengthened. Data will be collected to monitor the effects of the fees on financial access to services and on the appropriate use of KNH. Revenue generated through these cost-sharing measures is expected to finance at least 10 percent of the recurrent budget of KNH by year three of the Program. As a result, the portion of the KNH budget financed by GOK grants will decrease by an equal percentage.

KNH will also institute changes in order to improve efficiency. In particular, the program will support procedures and staffing reviews in six key departments providing specialized services, The reviews will provide a basis for instituting efficiency and qualtiy improvements at various levels of financing. Additionally, a cost finding (cost accounting) system will result in availability of information required for efficiency gains throughout KNH.

b. Establishment of a policy permitting at least 50 percent of the revenue generated through cost sharing to be retained by the GOK/MOH provider facility, with the remainder to be used to finance preventive and primary services.

To ensure that incentives exist for facilities to collect user fees and to provide financial resources to facilities that require revenues to help pay for both essential repairs and maintenance, at least 50 percent of the revenue generated will be retained at the facility level. Such decentralization will lead to more accurate targetting of priority needs and improved service quality. Guidelines will be developed by the MOH defining priority expenditure items for use of these revenues. The balance will be used within the MOH system to finance preventive/primary services.

c. Restructuring of the NHIF to introduce progressive premium rates, increase reimbursement levels to registered providers, and introduce modest (initially) employer contributions.

The NHIF will continue to serve its 900,000 contributors and their dependents. It will make some interim modifications to its premiums and benefit package, while strengthening itself administratively. NHIF will revise its premium schedule to make contributions progressive and to require a small contribution from employers. The NHIF also will double its reimbursement rates to bring them more into line with providers' costs. These measures will help ensure the success of the MOH's cost-sharing initiatives to the extent that NHIF contributors use MOH hospitals.

Early in the Program period, NHIF will reexamine its goals and objectives in light of the changing health financing situation in Kenya and its own improved administrative capabilities. At that time, it will consider whether to expand the groups it covers and whether to improve its package of benefits.

d. Agreement with the GOK on a mechanism and timetable for increasing the level of non-donor financing, both in absolute and percentage terms, for preventive and primary services within the recurrent budget of the MOH.

In addition to retention of cost-sharing revenue by the MOH and the provider facilities for the financing of preventive and primary services, the MOH will strengthen planning and budgeting systems which will make determinations and establish timeframes for reallocating the overall MOH budget in order to raise the proportion of resources going to primary/preventive care.

2. Further Defining of the Reform Agenda

Under this AEPRP, USAID will support the first stage of a reform program which introduces major cost sharing policy reforms in the health sector. Those reforms will form the basis for an IBRD-led multi-donor co-financing effort. The subsequent donor assistance is very much dependent upon the anticipated AEPRP support, which will both support reforms that are ready to be implemented and help shape a comprehensive reform program suitable for broad donor support through a 10-15 year effort.

The initial reform initiatives supported in this Program are largely policy-oriented reforms which require changes that affect how the MOH, KNH and the NHIF relate to the Ministry of Finance and other parts of the GOK. As the agenda is further defined, emphasis will be placed on institutional and structural reforms that relate more directly to the internal structure and organization of the MOH and the implementing institutions with a focus on improving efficiency or cost containment. Clearly it is more difficult to specify at this point the expected achievements resulting from reforms that have yet to be defined or fully analyzed. However, based on consultation with the GOK and other donors, further reforms in the following areas are anticipated. The MOH will devise and begin to implement a consistent agenda for reform. The MOH will clearly define additional institutional reforms emphasizing cost containment and cost efficiency including procurement and distribution of drugs, health manpower development and deployment policies, and investment planning requirements (short and long term). In order to fulfill its mandate as the GOK's coordinator for health sector activities, the MOH will re-examine and possibly redefine the roles played by the public sector, private sector, parastatals, communities and donors in the provision of health services. Support will be provided to the MOH in undertaking this strategic study effort. KNH will plan for and implement further efficiency reforms and quality improvements throughout the institution. KNH will also define a strategy that links its reform agenda with an overall investment program. NHIF will develop and initiate implementation of a business plan for reaching defined targets and goals. This will include appropriate use of planning tools, actuarial analysis, and use of automated data processing capabilities. Support will be provided to NHIF to assist it in developing in collaboration with the MOH a strategy that further defines its role in national insurance coverage.

3. Enhanced Institutional Capacity

Through the training and technical assistance provided by the Program, the capacity of the MOH, KNH, and the NHIF to support and achieve the Program's objectives will be enhanced. The institutions will demonstrate improved organizational ability to conduct policy analyses, monitor the implementation of activities and evaluate the impact of reforms. The MOH will establish the Health Care Financing (HCF) Implementation Committee from within its system to serve as the focal point on cost sharing implementation, to conduct health care financing analysis, develop strategies and coordinate all aspects of the reform. KNH will demonstrate improved management competence in

administering operations and finances. While NHIF's day-to-day operations will be more administratively efficient, organizationally it will also demonstrate increased strategic analysis and planning abilities required for responding to national health sector objectives.

The key assumptions linking the outputs and purpose are: (1) that the GOK will retain its commitment to the reform program as evidenced by timely submission of implementation plans satisfactory to USAID; (2) that inappropriate utilization of higher-level (particularly hospital) services can be significantly decreased with the bypass penalty structure of the fees and strengthening of referral procedures; (3) that the MOH will allocate staff needed to lead the reform effort and will endorse and act upon the agreed policy reform measures; (4) that introduction of cost sharing will not meet with strong adverse public reaction and that it will be sufficiently acceptable to enable significant resources to be generated; (5) that the further definition of the reform agenda will leverage additional donor resources to help implement a broad-based reform program in the sector; (6) that the GOK will retain its commitment to reduce the public subsidy to KNH; and 7) that legislation will be approved to make NHIF a State Corporation.

## D. PROGRAM INPUTS

The Program is organized into two components: 1) cash resource transfers - (Program), and 2) technical assistance - (Project).

### 1. Cash Resource Transfers - Program:

Dollar disbursement will be made directly to the Grantee, the Ministry of Finance, in tranches on satisfaction of conditions precedent. The conditions precedent to initial and subsequent disbursements of funds are expected to ensure attainment of the outputs of the AEPRP. These policy-based conditions are considered essential to achievement of the Program's purpose of providing increased sustained financial resources for the delivery of efficient quality health care in Kenya. The conditions precedent define a series of policy and institutional reform measures to be undertaken by the three implementing institutions. The rationale for conditions precedent, performance benchmarks and suggested criteria are defined in detail in Section IV.E and Annex G.

As called for in the conditions precedent, within a period of time from dollar disbursement to the Grantee, (e.g., 60 days) to be specified in the grant agreement, the GOK will establish a Kenya Shilling Counterdeposit Special Account. The account will serve as additional, but separate, budgetary resources and

shall be programmed jointly by the GOK and USAID as additive resources for the MOH, KNH and the NHIF. It is anticipated that use of the local currency will assist these institutions in meeting the costs associated with introduction and implementation of reforms.

The needs of the three institutions for local currency support to carry out the reforms vary greatly. The MOH has the greatest need for support since it will be undertaking cost sharing at close to 78 hospitals and more than 1500 health facilities. Cost sharing at dispensaries will be phased in later in the Program. The new policy will require systems development, training, possibly restructuring staff for more appropriate skill utilization or hiring some new staff, printing of forms and receipts, and additional supervision. In addition to the costs of implementation itself, the MOH will need to ensure that quality of services is improved to standards at which the public will be willing to pay user charges. This will be achieved, for example, by ensuring that drugs and supplies are present at facilities and by making essential repairs to buildings and equipment.

KNH has the second largest need for local currency support. KNH will need to hire new personnel, develop new systems, make drugs and supplies readily available, and make essential repairs to facilities and equipment.

The NHIF has relatively few needs for local currency support. It has run a surplus on operations for many years, so it has substantial reserves. The local currency costs of its interim reform program will be hiring of additional staff for its new actuarial and planning divisions, preparation of facilities for installation of automation equipment, and training.

The tranches are in relatively greater amounts at the initial disbursement to provide the institutions with the resources needed to start the reform process. The table below shows the disbursements planned, by tranche, for each:

($000)

| | Initial | Intermediate | Final | Total |
|---|---|---|---|---|
| MOH | 2,500.0 | 2,000.0 | 950.0 | 5,450.0 |
| KNH | 2,000.0 | 1,000.0 | 1,000.0 | 4,000.0 |
| NHIF | 100.0 | 100.0 | 50.0 | 250.0 |
| TOTAL | 4,600.0 | 3,100.0 | 2,000.0 | 9,700.0 |

2. Technical Assistance, Studies and Training (Project)

Short-term and long-term technical assistance (TA) will be provided under the projectized element of this AEPRP. This

technical assistance will (a) help develop detailed implementation plans for cost sharing; (b) assist with the implementation of the reform program; (c) assist in the analyses leading to the formulation of the comprehensive health financing strategy and subsequent reform agenda; (d) help monitor and evaluate the implementation of the reform program, particularly the fee-waiver system, the revenue projections, and the effects of the fee structure on referrals; (e) help the MOH devise a systematic method for allocation of funds to ensure balanced and adequate financing of all services and to diminish regional disparities; and (f) through participation in policy studies and evaluation, provide on-the-job training to Kenyan counterparts.

Modest levels of commodity assistance, e.g., micro-computers and software specifically related to the management of cost sharing would be provided. Support will also be given for policy studies, mid- and long-range planning, monitoring of cost sharing at MOH, and the establishment of an actuarial data base and analytical capability at NHIF. Long- and short-term training is also planned, both to establish the capacity to develop, plan and implement reforms, and to assess their effects, as well as to facilitate implementation of the proposed cost-sharing reforms.

The proposed technical assistance, commodity support, and training is the projectized element of the AEPRP. A total of $7.06 million (to include $5.3 million in USAID financing and $1.76 million in GOK contribution) is planned over the four-year program period, with the bulk of the funds to be used for technical assistance and related costs associated with policy studies, reform implementation, and institutional strengthening.

At this stage, it is planned that one TA contract would be financed to include resources for the financing, management and implementation of long-term and short-term technical assistance, long-term training in the USA, internships at other private health facilities for KNH, short-term training in-country, study tours and limited commodity procurement. The TA contract will be a joint U.S.-Kenya proposal and would utilize as much local Kenyan TA as possible. At least one long-term advisor and approximately 60 percent of local TA will be Kenyan. Kenyan experts from both the public and private sectors will be engaged, wherever possible, to provide technical support.

Tentative breakdowns of activities to be funded under the TA contract follow:

a. Long-term technical assistance: Seven person years of long-term technical assistance are budgeted under the grant: for the MOH HCF Implementing Committee, three long term advisors are planned - health economist (2 years), health planner/

evaluation expert (2 years), and management/ financial expert (2 years); for NHIF a health insurance specialist (1 year) who will then be available under short-term TA follow-up for 1 month per year in years 2 and 3 of the Program. The MOH advisors will assist the MOH in overall strategic planning, reporting, monitoring impact and referral systems. They will also join the key unit to manage the various in-puts to the total reform program. The NHIF advisor will focus on overall strategic planning and on development of the modified goals and objectives of the Reform Agenda.

b. Short-term technical assistance: Seventy-five person months of short-term technical assistance are programmed in illustrative areas shown below. The specific study agendas and corresponding short-term TA will be specified in each institution's annual plans and specifics may change over time to meet evolving needs.

(1) MOH:- General development and continued monitoring of cost-sharing plans and evaluation including private sector, referral systems, fee-waiver systems, financial management to develop computer models for fee generations and development of local training materials to initiate and monitor cost sharing.

(2) NHIF: Development of a planning division, assessment and development of needed actuarial resources, defining and reaching a consensus within NHIF regarding the appropriate role of NHIF in meeting health sector goals, assessment of automation needs, strategic planning, and development of a system for monitoring costs and quality of service providers.

(3) KNH: Development and implementation of cost-sharing and cost-containment reforms, including assistance for the following: development of implementation plan for introducing cost sharing with the proposed fee schedules and waiver systems for the general, private wing, and specialized services in KNH. The implementation plans would also define the administrative systems, training and capital improvement requirements, and systems for monitoring/evaluation. Development of a model fee waiver system with a monitoring /evaluation plan to assess impact of the system. Development of a model for projecting and developing benchmarks for estimated revenues to be generated from the user fee schedules for each area of services (general, private wing, and specialized). Identification and implementation of cost-containment strategies including development of a rationalized staffing plan for the private wing and specialized services, and development and implementation of a cost-accounting system for KNH.

c. Studies: Policy-related studies are planned in support of the Program. Illustrative topics for studies are identified above under short-term TA. All studies will be closely coordinated with other donor activities in the HCF arena, particularly the World Bank, SIDA, DANIDA and UNICEF. Specific study agendas will be finalized by the GOK implementing institutions and the TA contractor and shown in the yearly implementation plans.

d. Long-term training: Ten participants will receive Masters Level training in Health Economics (2), Health/Hospital Administration (2), Business Administration (2), Health Planning/Evaluation (2), and Information Systems (2) in the USA.

e. Intern training: The contractor will develop and implement a 7 month mid-level management training program utilizing internships and mentor relationships at facilities outside of Kenya for 12 persons for KNH personnel.

f. Short-term training: For MOH and KNH - five persons to be trained in the USA in health economics and finance; twenty-four mid-level managers outside of Africa and twenty-four mid-level managers in the Africa region in health/hospital administration, financial planning and budgeting, and other specialities as indicated in the yearly implementation plans; and for the MOH local training in health finance for the MOH HCF Implementation Committee. For NHIF- annual facilitated planning retreats. In addition, Training of Trainers (TOT) will be supported at the MOH in specific manangement techniques for introduction and implementation of cost sharing. These trainers (under the existing MOH continuing education program) will then provide in-country training to the District Health Management Team.

g. Observation Tours: One for selected members of the MOH Health Care Finance Steering Committee, to review three different private/public sector financing alternatives; one for NHIF's senior management including the new chief of the Planning Division to review insurance systems in the USA.

h. Commodities: For MOH - provision of computer hardware and software, training and limited commodities for the HCF Implementation Committee. For NHIF - provision and installation of computer hardware and software required to meet automation requirements.

i. Other: Related to TA and evaluation requirements, but funded outside of the TA contract are the following activities:

- Evaluation/Audit: Two evaluations are scheduled; one at mid-term and one at completion of the TA contract. One audit is scheduled approximately two-thirds into Program implementation.

- Program Support: Under this Program USAID will also hire one local health economist (PSC) to monitor the technical inputs to the TA contract and provide technical guidance to USAID/Kenya.

Budget

| | $000 |
|---|---|
| Technical Assistance | |
| Long-term | 1.390 |
| Short-term | 0.608 |
| Studies and Analysis | 0.314 |
| Training | 1.165 |
| Commodities | 0.728 |
| Contingencies | 0.430 |
| Evaluation/Audit | 0.080 |
| PSC | .150 |
| Other Costs | 0.435 |
| Total | 5.300 |

GOK: It is expected that the implementing agencies will provide the following in-kind contributions:

- Appropriate counterpart staff as required to maximize the transfer of skills;

- Salaries of counterpart staff and trainees;

- Appropriate office space, furnishings and electrical configuration for computer and machinery;

- Administrative and secretarial support for long-term consultants and for short-term consultants as appropriate;

- Recurrent costs associated with work for long-term consultants including paper and supplies, and

- Access to mid- and senior-levels of the GOK as required in conducting studies or developing recommendations for reform.

## E. PROGRAM CONDITIONALITY AND NEGOTIATING STATUS

The following are the policy-based conditions upon satisfaction of which disbursement will be made. The conditions fall into three categories: (1) conditions applicable only to initial disbursement; (2) conditions applicable to every disbursement, regardless of the institution involved; and (3) additional conditions pertaining only to the disbursements for particular institutions. Only the conditions in category one will apply to the technical assistance and training portion of this program. The major policy changes which are supported by this program are reflected in the conditions, particularly those in category two. Certain of the conditions in category three require that implementation plans be developed to initiate cost-sharing or revenue enhancing measures for the particular institutions, and that interim and final benchmarks (concerning, among other things, financial performance) be established in such implementation plans. Specific policy-based actions also are described as part of the conditions in category three. Until the implementation plans are developed, however, it is not realistic to specify precise financial targets for the cost sharing and revenue enhancing measures. These targets will be fully negotiated with the GOK within the concepts herein set forth. Given the dynamic environment in which this program is being developed and implemented, and the probable need for refinements as additional data is developed, project implementation letters ("PILS") will be issued by A.I.D. to further specify the requirements for compliance with each condition. Annex G discusses the criteria and procedures which will be used to specify appropriate parameters for the conditions in category three.

The principal policy issues and proposed measures outlined in this document have been discussed and carefully reviewed at the Permanent Secretary level in the Ministry of Finance, the Minister level at Health, and at the Chief Executive Officer (CEO) levels at KNH and NHIF. The principles of how the USAID/Kenya HCF Program would relate to the GOK's reform agenda and anticipated other donor support have been agreed upon with the GOK. The overall conditions relating to the MOF governing every disbursement have been negotiated and agreed upon in principle. Each implementing institution has carefully reviewed its respective conditions in draft form. Yearly implementation plans for each of the institutions will serve to fine-tune any of the benchmarks or conditions based on experience in implementation. At this stage in the USAID/GOK negotiations,it is not anticipated that major modifications will be made to the agreement text detailed below. Throughout the negotiation

process, discussions have been highly positive and have reflected the implementing institutions' view that the KHCF Program goals are consistent with their own reform agendas. A few details on implementation procedures remain to be negotiated. These matters should be resolved by mid/end July 1989.

USAID has received a formal request for assistance from the GOK (See Annex N).

1. Conditions Precedent to Initial Disbursement

Prior to any disbursement by A.I.D. of the dollars made available under this Grant, or to the issuance by A.I.D. of documentation pursuant to which such payment will be made, the GOK shall provide, in form and substance satisfactory to A.I.D.:

a. Documentation confirming the Grantee has established a separate, numbered Special Account entitled "1989 A.I.D. Health Care Financing Program" for deposit therein of Kenya Shillings in amounts equal to the dollar disbursements made by A.I.D. to the Government of Kenya under this Program.

b. Evidence that the GOK concurs with the Request for Proposal (RFP) for the USAID financed technical assistance and training to be funded under the complementary Health Care Financing Project Agreement.

Date for compliance with CP: November 1, 1989.

2. Conditions Precedent to Every Disbursement

Prior to the first dollar disbursement under this grant and prior to each subsequent dollar disbursement (except with respect to technical assistance and training) under this Grant, the GOK shall provide, in form and substance satisfactory to A.I.D., documentation confirming that:

a. The budget allocations for the MOH, KNH and NHIF have not been reduced below the budget allocation levels for such institutions established in the Government of Kenya's Forward Budget for 1988/1989. The Kenya Shilling allocations provided to such institutions from the Special Account established pursuant to Section III.E are to be considered additive resources and available for use as "no-year" funds to such institutions and not part of the budget allocation for purposes of this condition.

b. Each MOH facility which institutes cost sharing under this program shall retain not less than 50 percent of all revenues generated by the cost sharing measures adopted by that facility. Revenues which are not retained by the facilities shall be used for primary/preventive services.

The revenues from cost sharing are to be considered additive to the base levels established in the Government of Kenya's Forward Budget for 1988/1989 and available for use as "no year" funds, and not part of such facility's budget allocation for purposes of this condition precedent.

3. Conditions Precedent Related to Particular Institutions

a. Disbursements Related to Performance of KNH

(1) Conditions Precedent to First Disbursement (US$ 2,000,000).

Preparation of a cost-sharing plan by the KNH, in form and substance satisfactory to A.I.D. The requirements for the plan shall be further specified in PILS to be issued by A.I.D. but shall include (a) measures to ensure access of lower income groups; (b) proposed policies for use of cost sharing revenues; (c) methodology for assessing financial impact of plans on operations; (d) proposed administrative/managerial structures; and (e) time schedules with appropriate midterm and final implementation benchmarks for plan implementation of the cost-sharing plan.

Date for Compliance with C/P: November 1, 1989.

(2) Conditions Precedent to Second Disbursement (US$ 1,000,000)

Documentation, in form and substance satisfactory to A.I.D., that KNH has substantially progressed in implementing the cost-sharing plan prepared in compliance with Condition Precedent 3.A.(1). The requirements for satisfying the condition precedent shall be further specified in PILS to be issued by A.I.D. but shall include (a) an operational private wing; (b) adoption and use of a fee schedule system and (c) achievement of midterm benchmarks established in said cost-sharing plan.

Date for Compliance with C/P: May 1, 1991.

(3) Conditions Precedent to Third Disbursement (US$ 1,000,000).

Documentation, in form and substance satisfactory to A.I.D., that KNH has achieved the final implementation benchmarks set forth in cost-sharing plan.

Date of Compliance with C/P: November 1, 1992

b. Disbursements Related to Performance of MOH

(1) Conditions Precedent to First Disbursement (US$ 2,500,000).

(a) Preparation of a plan by the MOH, in form and substance satisfactory to A.I.D., for introduction of cost sharing at all MOH facilities. The requirements for the plan shall be further specified in PILS to be issued by A.I.D. but shall include (a) measures to ensure access of lower income groups to the MOH facilities, appropriate monitoring arrangements; (b) proposed policies for retention and use of cost sharing revenues by the facilities that earn the revenue including use as "no-year" funds; (c) increased allocation of MOH financial resources for preventive/primary health; (d) fee levels for services; and (e) time schedules with appropriate midterm and final implementation benchmarks for plan implementation.

(b) Evidence that the Health Care Financing Implementing Committee has been established reporting to the Permanent Secretary, MOH for purposes of monitoring and supporting the GOK in implementing the Reform Program.

Date of Compliance with C/P: November 1, 1989.

(2) Conditions Precedent to Second Disbursement (US$ 2,000,000)

(a) Documentation, in form and substance satisfactory to A.I.D., that the MOH has substantially progressed in implementing the plan prepared in compliance with Condition Precedent 3.B.(1)(a). The requirements for satisfying this condition precedent shall be further specified in PILS to be issued by A.I.D. but shall include (a) an operational Health Care Financing Implementation Committee at the MOH ; and (b) achievement of the midterm benchmarks established in the plan.

(b) Preparation of a financial strategy by the Ministry of Health, in form and substance satisfactory to A.I.D, which defines its respective roles for the public sector, parastatals, private sector, community governments and foreign donors in national health care strategy.

Date of Compliance with C/P: May 1, 1991.

(3) Conditions Precedent to Third Disbursement (US $950,000).

(a) Documentation in form and substance satisfactory to A.I.D., that the MOH has achieved the final implementation benchmarks set forth in the cost-sharing plan.

(b) Documentation that the MOH has completed an evaluation of the methods for allocating supplemental resources for preventive/primary services.

(c) Evidence that operational expenses devoted to primary/preventive services in FY 91 and 92 are at least equal FY 88 and 89 levels, and at least half of the cost-sharing revenues in FY 91 and 92 were allocated to primary/preventive services.

Date of Compliance with C/P: November 1, 1992.

c. Disbursements Related to Performance of National Hospital Insurance Fund.

(1) Condition Precedent to First Disbursement (US $100,000).

(a) Documentation, in form and substance satisfactory to A.I.D., that NHIF has adopted a progressive fee structure based on the interim reform program approved by parliament in 1989.

(b) Documentation, in form and substance satisfactory to A.I.D., that NHIF has enhanced its benefits package in accordance with the interim reform program.

(c) Documentation, in form and substance satisfactory to A.I.D., that NHIF has become a State Corporation.

Date of Compliance with C/P: November 1, 1989.

(2) Conditions Precedent to Second Disbursement (US $ 100,000):

Preparation of a medium and long term strategic plan by NHIF, in form and substance satisfactory to A.I.D., establishing the goals and objectives of NHIF and its role in the National Health Care System. The requirements for the strategic plan shall be further specified in PILS to be issued by A.I.D. but shall include (a) feasibility of mechanisms to achieve cross-subsidization of health resources; (b) feasibility of expanded NHIF role in preventive health care services; and (c)

time schedules with appropriate midterm and final implementation benchmarks for plan implementation.

Date of Compliance: May 1, 1991.

(3) Condition Precedent to Third Disbursement (US $50,000).

Documentation in form and substance satisfactory to A.I.D., that NHIF has achieved the interim implementation benchmarks set forth in the strategic plan developed in compliance with Condition Precedent III.B above.

Date of Compliance with C/P: November 1, 1992.

4. Covenants

The GOK covenants that all shilling deposits made by the GOK to the Special Account established hereunder shall be jointly programmed with A.I.D., on not less than a semi-annual basis, to provide additive budgetary resources to preventive/primary services within the Government of Kenya's health sector and shall be available for use as "no-year" funds, in support of the purposes and objectives of the Health Care Financing Program. The base-line for determining that such budgetary resources are additive shall be the budgetary allocation in the GOK's Forward Budget for 1989/1990, without adjustment for the revenues from cost-sharing revenues retained by MOH, KNH and NHIF and/or Kenyan Shillings jointly programmed by the Government of Kenya and A.I.D. pursuant to Section III.E of this Agreement.

a. Deposit

Except as A.I.D. may otherwise agree in writing, the GOK shall deposit in the Special Account entitled "1989 Health Care Financing Program" as established hereunder, Kenya Shillings in amounts no less than the dollar disbursements made by A.I.D. to the Government of Kenya under this Program. Each of said Kenya Shilling deposits shall be made no more than 60 days after the U.S. dollar disbursement to the GOK under this Program and shall be calculated at the highest rate per U.S. Dollar not unlawful to anyone in Kenya for any purpose at the time A.I.D. effects the U.S. Dollar disbursement.

b. Programming

Except as A.I.D. may otherwise agree in writing, all Kenya Shillings deposited in the Special Account shall be jointly programmed in writing by the GOK and A.I.D., as required but on a no less than annual basis (a) in support of the purposes of the Health Care Financing Program; and (b) in furtherance of the efforts of the three institutions (MOH, KNH, NHIF) identified as primary implementors of the purposes of the Program. Such funds will be available until expended without regard to fiscal year limitations applicable to budgeted funds.

c. Audits

GOK institutions which receive funds programmed from the Special Account as described above will be subject to the regular audit procedures of the Kenyan Auditor General. Audit reports generated by the Auditor General concerning the uses of these funds will be made available to USAID on request.

F. PROGRAM IMPACT

The expected impact of the policy reform effort supported under this Program can be viewed in the short, medium, and long term. Program impact in the near term focuses on the expected accomplishments during the proposed four-year AEPRP. Accomplishment of the medium-term objectives summarized below assumes the availability of broad-based donor support to help finance what is seen as a longer-term commitment and a GOK reform agenda more directly focussed on institutional and structural reforms which will further enhance the achievement of the policy reform agenda launched under this AEPRP. It also assumes the continuing political will of the GOK to implement reforms and allocate revenue generated for the health sector. The expected impact of the proposed AEPRP stated in terms of expected policy, program, and beneficiary effects, is presented below.

1. Near Term (within four years)

Policy

- Cost sharing (through user-fees and insurance reforms) initiated/expanded, with significant portion of revenue being retained by provider facility and the remainder being allocated to preventive/primary services.

- Broader policy/program reform agenda for cost sharing and cost containment more clearly defined, options chosen, and time-phased implementation plan developed.

- Financial commitment made by other donors to support implementation of these proposed reforms.

- NHIF program reforms, including progressive fee structure and more realistic reimbursement rates (linked to objective data on cost and quality), implemented and long-term strategy developed and approved.

- Policies and procedures established to ensure access for the indigent; system established for monitoring the impact of cost sharing.

Program

- Modest increase, in real terms, in level of funding (both in absolute and percentage terms) for preventive/primary health services, both through cost-sharing measures and additive budgetary allocations to the MOH estimated at 4-5 percent of the total.

- Modest expansion and improvement in both curative and preventive/primary services resulting from increased resource availability and improved efficiency.

- Portion of KNH's annual budget financed with government grants reduced by approximately 10 percent.

- Budgeting procedures established to ensure allocation of resources to districts based on need and revenue generating capacity.

- Long-range planning, enhanced by improved management information system within the MOH producing reliable, comprehensive data on services, resources, and health status.

- Not-for-profit providers receiving increased revenue resulting from revisions in NHIF reimbursement levels, bringing these levels more in line with costs.

Beneficiaries

- Users of the MOH system, primarily women and children, benefitting from improved quality of hospital-based care and increased access to primary and preventive services.

- Users of KNH receiving improved service (e.g., shorter waiting times, reduced lengths of stay, increased access to needed diagnostic services, etc.).

- Among providers, increased staff productivity resulting from improvements in the physical condition of service facilities and increased availability of medical equipment and supplies.

- GOK implementing institutions' capacity to conduct policy and financial analyses improved through training and technical assistance financed under the Program.

- Persons insured by NHIF and registered providers benefitting from increased reimbursement levels, while the progressive premium structure is passing benefits more equitably to the lower income members of NHIF.

2. Medium Term (4-8 years)

Policy

- Broad policy/institutional reform program in the health sector, addressing both cost-sharing and cost-containment issues, is in place.

Program

- Significant portion (between 20 and 30 percent) of MOH non-wage recurrent costs for secondary and tertiary health care financed through cost-sharing.

- Portion of MOH budget devoted to primary/preventive services increased to over 25 percent.

- Portion of MOH budget available to finance non-salary recurrent costs (e.g. drugs, repairs, maintenance) increased from 25 to 30 percent.

- Portion of KNH annual budget financed with government grants reduced by 20 percent.

- Condition of MOH provincial and district hospitals substantially improved, made possible by increased resources (linked to cost sharing) and availability of donor financing for the reform program.

- MOH hospitals providing services to NHIF insured, submitting and receiving reimbursement on a timely basis.

Beneficiaries

- Portion of population, particularly women and children, with access to primary health care and key preventive services increased substantially. Specific measures of increased coverage and use include data on ORT use and immunization coverage through sentinel surveillance, as well as increased access to, and use of, family planning services as measured both through the periodic surveys and MOH service statistics.

- Deaths related to measles, neo-natal tetanus, and diarrhea significantly reduced, accompanied by more modest reductions in malaria and acute respiratory infection (ARI) mortality by the end of this eight-year period.

- Number of persons insured by the NHIF increased and expanded to include rural population coverage.

- Appropriate diagnoses and treatment of illnesses in curative sub-sector following procedures outlined leading to shorter in-patient stays and fewer drugs utilized.

3. Long-Term (8-15 years)

Policy

- Policy and institutional reforms firmly in place. Core group of policy analysts monitoring impact of reform program, recommending revisions as necessary.

Program

- As a result of policy and institutional reforms, portion of GOK budget going to MOH decreased.

- Restructuring of MOH, including a much reduced role in the delivery of secondary and tertiary care, well underway.

- Efforts to expand NHIF coverage, focused particularly on the rural areas, continued with effective coverage of at least 33 percent of the population.

- Adequate budget for primary health care and selected preventive services in place, financed through a combination of government allocations and cost sharing.

- Per unit costs of delivery of curative care decreased to near optimal levels.

Beneficiaries

- Through effects of expanded primary and preventive health programs, infant and young child mortality rates reduced to 45 and 15 per thousand respectively by the end of this period.

## G. MONITORING AND EVALUATION

### 1. Monitoring

Since this AEPRP is focussed not only on facilitating implementation of well-defined policy reforms, but also toward further definition of structural and institutional reforms related to health sector financing, monitoring and evaluation feature prominently in the Program.

The MOH's HCF Implementing Committee will be responsible for monitoring and reporting on the progress (or problems) of implementation of the cost-sharing policy reforms, under this Program. Semi-annual reports, quarterly joint reviews with the implementing institutions and annual Policy Seminars will take place. In addition, the Implementation Committee will have the task of monitoring and evaluating the effects of policy change (both on beneficiaries and financial/budgeting levels) to be carried out under this Program. Key responsibilities will be to:

- Identify data to be used in the evaluation and determination of progress made in the implementation of the policy reform program;

- Collect the data identified above;

- Prepare necessary reports to be used as inputs in the review, assessment, and determination of whether the conditions precedent related to policy reforms have been satisfactorily met (with other implementing institutions);

- Finalize with the TA team the terms of reference for policy studies, policy seminars to ensure the inclusion of key issues relating to the overall policy reform framework;

- Provide continuing analysis and evaluation of the effects of policy changes on resource allocation, government finance, and health status;

- Provide annual budget estimates and expenditure reports on the reallocation of funds to primary/preventive activities and in favor of non-wage recurrent costs;

- Following the analysis and mid-term evaluation, make recommendations on any required modifications to the policy reform targets and serve to mitigate any unforeseen negative effects of the policy changes;

- Coordinate and assist other ministries or governmental agencies involved in the implementation of the policy reform program; and

- Prepare required reports for both the GOK and for USAID.

The TA team will assist the MOH in each of the above steps and will provide training aimed at transferring skills in economic policy analysis, formulation, and monitoring to the MOH Implementing Committee counterparts in order to enhance the policy analysis capabilities in the MOH. USAID will receive the various data and analyses and specifically monitor Program progress at the various levels.

Progress in attaining the purpose-level objectives will be monitored through achievement of conditions precedent as established in this PAAD for initial, mid-Program, and final disbursement of AEPRP funds. These conditions precedent require monitoring of both implementation and impact of reforms on financing and utilization of the health system.

Implementation of cost sharing and other reforms, reallocation of the MOH budget, and institutional strengthening (particularly development of planning capacities) will be assessed for the mid-Program and final disbursements. Benchmarks and targets will be established in initial plans developed by the implementing institutions and agreed upon by USAID prior to initial disbursement.

Capabilities needed to assess the impact of the Program on access to and utilization of MOH health services will be developed in each of the institutions. Methods of evaluating the fee waiver systems and of monitoring the income status and severity of illness of clients using all levels of the public health system will be developed and implemented by the participating institutions in order to meet conditions precedent.

In addition to tracking financial changes and internal efficiencies and effectiveness related to meeting conditionality, the GOK will provide monitoring data on the

impact of the reforms on utilization of health services and potential changes in access and disease specific mortality rates.

Through the Health Information Systems (HIS) unit, assisted by the USAID-financed Information Planning Systems Project (IPS), routine service delivery statistics are collected at the facility level, then sent to the District level where they are summarized and forwarded to headquarters. As part of the first condition, a monitoring system using facility-based data on utilization will be put into effect. The MOH HCF Committee (with HIS assistance) will monitor utilization as policy changes are put into effect. In addition, a modified population based monitoring system linked to the MOH Division of Family Health's sentinel disease surveillance reporting system for EPI diseases and diarrheal diseases is anticipated to become operational during the first year of the Program. Effects on the population of introduction of fees will be monitored through this system.

Normal reporting and intermediate indicators of health status are now in use in key MOH preventive and promotive programs. In addition, periodic surveys are undertaken under the KEPI and CDD Programs to assess EPI coverage and assess use of ORT. Similar information on malnutrition can be gathered through the UNICEF-supported CHANIS growth monitoring program.

A National Kenya Demographic and Health Survey (DHS) was recently carried out. Field work for the DHS was completed in May 1989, and the final report is expected by the end of 1989. A follow-on survey will ascertain the causes of infant and childhood deaths, the determinants of mortality (including the relationship to malaria) and the availability and utilization of health services. These will provide detailed information on a range of districts. The same population sample base can then be followed up to assess impact of the Program. Another DHS is planned under the FPSS Project for 1992 - the last year of disbursement under the KHCF Program.

Progress in meeting purpose-level objectives and in achievement of conditions precedent will be measured by USAID's review and assessment of consultant reports, new GOK policy documents, and participating agencies' records and reports in relation to the implementation plans in this PAAD at quarterly intervals.

Achievement of the output-level objective of increasing donor resources for the reform program will also be measured by the extent to which major donors such as the World Bank continue to participate in collaborative analyses and reviews of priority issues relating to the reform agenda, the extent to which firm

donor commitments to the planned initiatives over the four years are actually financed, and finally, the extent to which overall donor coordination of financing going to the GOK health financing sector is rationalized.

Achievement of other output-level objectives will be monitored through meeting of conditions precedent and review of required Program documentation.

Inputs will also be monitored on a quarterly basis through financial reporting, commodity and training documentation, and reports from the primary and other technical assistance contractors.

2. Evaluations

The evaluation component of the Program will be managed directly by USAID using standard A.I.D. procedures. All activities under this component will be carried out with the full collaboration of the GOK and its implementing institutions. Given that the policy reform agenda supported under this Program is geared toward financing issues, particular emphasis will be placed on evaluating the extent to which policy changes have improved the financial condition of the MOH, improved the sustainability of health services, and minimized negative impacts on vulnerable socio-economic groups.

Two external evaluations are proposed during the four-year life of Program. The mid-Program evaluation, scheduled for the 23rd month of Program implementation will:

- o review management of inputs, status of outputs, and progress in attaining purpose-level objectives, and define any management changes required for timely fulfillment of objectives;
- o provide an update on the PAAD impact analysis using empirical data gathered through Program-related studies, including analysis of the recurrent cost gap at district and sub-district levels, potential for revenue generation at all levels, and effects on service utilization of reforms;
- o review information available on proposed indicators against policy matrix to determine their adequacy for assessment of overall impact at final evaluation and make recommendations if lacking;
- o review donor plans for health policy reform and make recommendations regarding appropriateness of plans given Program progress; and

- based on other available studies/analyses, assess options for broader involvement of private sector in the GOK's reform agenda.

The final evaluation will take place after the 46th month of Program implementation. This evaluation will include:

- review of progress made in attaining purpose-level objectives and progress of Program in realizing input and output targets;

- analysis of macroeconomic impact of the reform program (e.g., review of reforms within overall budgetary constraints, issues regarding targeting of subsidies, allocative efficiencies, progressivity/regressivity);

- impact on health sector (e.g., interplay of public, parastatal, and private sectors within health sector; reduction in recurrent costs gap; demand for NHIF reimbursement; demand for health services);

- impact on access and quality of care;

- effectiveness of AEPRP mechanism to affect and support reforms as defined in this PAAD;

- projected mid-term and long-term impact (i.e., policy, program and beneficiary) of Program on the sector;

- assessment of attainment and potential for attainment of goal-level objectives.

## H. PROGRAM MANAGEMENT AND COORDINATION

Implementation responsibilities for this AEPRP will cut across a variety of levels, from overall national policy coordination and programming of local currency to management of technical assistance resources. Continued coordination and collaboration with other donors in the health care financing area is also essential. The MOF provides overall coordination for the GOK with donors . For the purposes of this AEPRP, the MOH has primary responsibility for the coordination, negotiation and monitoring of policy reforms relating to itself and the other two implementating agencies (KNH and NHIF).

1. Coordination

a. GOK

The MOF will play the main coordinating role for the GOK in the implementation of the KHCF Program. The MOF has convened a negotiating committee with representatives from the MOH, KNH and NHIF to finalize the terms and conditions for the KHCF Program. Once negotiations are completed, the MOF will establish a standing committee from the negotiating team membership which will meet semi-annually with the USAID Program Monitoring Committee in order to review Program status in achievement of the conditions precedent, discuss issues, and review implementation of the Program. In addition, when the conditions precedent relating to any of the implementing agencies are met, the GOK/KHCF standing committee will meet with USAID to program shilling counterdeposit funds according to agreed upon priorities.

b. A.I.D.

The Chief of the Mission's Population and Health (PH) Office will chair a USAID Program Monitoring Committee comprising the Mission's HPN health development officer, project development officer and program officer (economist). The USAID committee will have responsibility for monitoring the policy reform program and for jointly programming local currency counterdeposits with the GOK standing committee. It is expected that the USAID committee will benefit from the analysis and recommendations provided by the MOH's Implementation Committee in assessing progress being achieved in the Program.

The responsibilities of the USAID Program Monitoring Committee will include:

- monitoring the policy reform program and preparing reports for USAID as required under this Program;
- preparing and reviewing with the GOK any changes or revisions in the grant agreement;
- reviewing monitoring and evaluation reports to ensure that the policy reforms are properly implemented and targets are being met;
- coordinating with the Ministries of Finance and Health to ensure that conditions precedent in the grant agreement are met; and
- joint programming of local currency.

Based on recommendations of this USAID committee, the USAID Mission Director will have primary responsibility for making determinations as to whether conditions precedent have been met for the disbursement of funds or whether modifications of policy reform targets are needed. AID/W will be informed of decisions and provided with all relevant documents.

c. Donor Collaboration

This sector grant has been designed and will be implemented in close collaboration with other donors involved in the health sector. In a recent donor coordination meeting chaired by the World Bank, it was agreed that USAID would serve as the lead donor with respect to coordinating the health care financing program. In this capacity, USAID will convene regular meetings of the concerned donors and ensure, to the extent possible, that interested donors are kept informed of important developments. Several collaborative efforts by donors have taken place over the last several months. These include a study of willingness and ability to pay for health services financed jointly by SIDA and UNICEF, with subsequent technical assistance to review and evaluate findings from the World Bank and USAID, and the joint World Bank/USAID/UNICEF Health Financing Mission.

USAID and the other donors - specifically WHO, UNICEF, DANIDA and SIDA - meet regularly with the MOH to review the implementation of the Child Survival Program (i.e., CDD and EPI). UNFPA heads the donor coordinating committee on family planning which includes all major donors. These programs have direct donor input to preventive/primary care. The reforms which will allow GOK resources to be directed toward primary and preventive health will be of direct benefit to traditional donor programs in these areas. Thus, because these donor coordination mechanisms already exist and are effective, USAID is confident in its ability to adequately monitor donor co-financing initiatives in this sector and their impact on the GOK's reform agenda and MOH budget rationalization objectives.

2. Program Management

a. GOK

The MOH will be the lead official implementing agency and program coordinator for the GOK. The MOH will collaborate with the various other related ministries and institutions directly involved in the grant program.

The MOH is the logical implementing agency because: a) it is the technical ministry and the largest provider of health care in Kenya; b) it is the agency charged by the GOK with the legal obligation to supervise and provide policy guidance to all other providers of health care in the country; and c) it is the line ministry that directly relates to the proposed implementing entities.

In early 1988, the MOH formed a GOK Health Care Financing Steering Committee (which included representatives from the MOF, Ministry of Planning, MOH, KNH and NHIF). This HCF Steering Committee has guided the analytical work and development of the MOH's Reform Agenda. In order to provide more direct policy guidance for the implementation of reforms, the MOH will designate an Health Care Financing (HCF) Implementation Committee to provide oversight and and assist in the implementation of the reform process supported under this AEPRP. The HCF Implementation Committee will be the MOH counterpart to the long-term TA team to be financed under the Program. The MOH's Planning Divivision will serve as the key staff or secretariat to the HCF Implementing Committee to undertake specific work in this area.

Combined Duties and Responsibilities of the HCF Implementation Committee and the HCF Steering Committee include:

- Strategic planning for the entire health sector, including the public, parastatal, and private sectors;
- Strategic planning for the MOH, especially on financing to health services objectives;
- Formulate policy recommendations based on the strategies developed and coordination of policy within the MOH system and with other actors in the health sector;
- Conduct and direct special studies, such as those financed by the KHCF Program;
- Monitoring of cost sharing including accounting, audit of revenues earned; effects on utilization; and effects on resources available to facilities of various levels and in various geographic areas; and
- Financial planning for the MOH, including investment planning.

USAID would plan to meet quarterly with the HCF Implementation Committee to discuss progress and problems in the Program. The MOH Implementation Committee would be responsible for the preparation of semi-annual reports and will lead or participate in joint reviews and annual evaluations (leading to the annual Policy Seminars) of the Program, as required. Regarding day-to-day implementation and administration of the Program and its initiatives, it is anticipated that the GOK will nominate officers to serve as the authorized GOK representatives from each of the implementing institutions. These individuals will have direct responsibility for relating to the HCF Implementation Committee and for ensuring compilation and transmission to the Committee and USAID of evidence demonstrating satisfaction of conditions precedent. As necessary, these individuals will also receive training under the technical assistance component to strengthen their expertise.

The HCF Implementation Committee will be assisted by a long-term TA team during the first three years of the grant. The TA contractor will be selected and expected to be operational by March 1990. The contract will include funding to provide specialized short-term (local and ex-patriate) TA for a three-year period. In the interim, from the signing of the grant agreement (planned August 1989) until the arrival of the long term TA team, the MOH's HCF Implementation Committee will initiate long-term strategic planning based on the information provided by the MOH's HIS and Planning Units. In addition, short-term TA to undertake specific analysis and operations research for the three implementing agencies will be provided from the ST/HEA REACH Project financed through a buy-in to this Project.

The GOK/MOH now currently operates a substantial infrastructure of personnel and facilities comprising about 70 percent of all of Kenya's health care operations. In terms of implementing the proposed reform agenda to be supported under this AEPRP, the basic personnel and structures are in place. However, the MOH will need to strengthen certain aspects of their capacity in order to effectively implement and manage the Program. The details of the technical assistance and training requirements are outlined in Section IV.D.

b. USAID

The Program will be managed by the Office of Population and Health (PH) of USAID/Kenya which is currently staffed with four U.S. Direct Hires (two full-time and two part-time), one U.S. Personnel Services Contractor and three Kenyan professionals -

(two project specialists and one financial management specialist). In July 1989, the PH Office staff will be augmented by an International Development Intern (IDI) with business management expertise.

The KHCF Program will require the active involvement of USAID's technical personnel in policy dialogue and review of progress during the life of the Program. Therefore, USAID is in the process of hiring a Kenyan health economist Personal Services Contractor (PSC) to work full-time on assisting the PH Office in conducting and assessing the required economic and financial analysis.

The first year of the Program will be the most management intensive while the systems are being established for monitoring and reviewing the CPs for release of funds and the achievement of benchmarks. Because the TA team will not be in place at the time the first benchmarks are scheduled to be met, the following division of labor is anticipated. In the first year, the Chief of the PH Office will devote one third of her/his time to overall policy dialogue and specification of the policy reform agenda. The Health Population Officer will devote 60 percent of her/his time on the implementation of the reform agenda at the MOH and KNH. In addition, under the supervision of the HPN Officer, the IDI will spend 50 percent of her/his time on the implementation of reforms at NHIF and in developing the scope of work for the technical assistance component and overseeing TA team activities. Once in place, the PSC Health Economist will serve as backstop in all areas of technical review on the appropriateness of decisions taken and policy impact.

Midway in Year One, the TA team is expected to be in place and by the beginning of Year Two, it should be fully functional. The second disbursements are projected to take place midway through Year Two. The TA contractor is expected to play a major role in the day-to-day operations of Program implementation and monitoring of policy and infrastructure changes. Procedures for USAID monitoring will be in place based on Year One experience. Therefore USAID management time is expected to decrease to 15 percent of the time for the Chief of PH Office, 60 percent of the time the health popultion officer, and full time technical support of the PSC Health Economist.

### 3. Management and Use of Local Currency

U.S. $9.7 million will be transferred directly to the GOK/MOF in tranches on the satisfaction of conditions precedent. The equivalent of U.S $9.7 million in Kenya shillings will be

provided by the GOK and deposited in the Special Account as defined under conditions precedent to initial disbursement (see Section IV.E). The local currency will be jointly programmed by USAID and the MOF. As part of the conditionality, it has been agreed that the local currency will serve as additional budgetary resources for the implementing institutions. Use of the local currency counterdeposit monies will support the policy and institutional goals of the Program and broader health sector requirements of the MOH consistent with its overall agenda.

The KHCF standing committee, to be designated by the MOF, together with the USAID Program Committee will be responsible for review of programming proposals for use of local currency from the special account. Written recommendations from these two committees will be forwarded for the approval of the Permanent Secretary at the MOF and to USAID. No funds can be transferred from the special account without the written authorization of both the A.I.D. Mission Director and the Permanent Secretary for Finance. The Auditor General's (AG) Office of the GOK has responsibility for audits of GOK finance and will periodically audit the use of the funds to ensure compliance with the Program intent and GOK procedures. Any reports or audits performed by the AG on funds expended from the special account will be made available for USAID review.

4. DFA Procurement Plan - Goods and Services

Under the projectized element of the Progam, $5.3 Million in contractor service support is planned. Under DFA procurement policies, AID Geographic Code 935 is generally authorized. It remains A.I.D. policy, however, to maximize U.S. procurement whenever practicable. The following represents USAID/Kenya's analysis of the planned source and origin of goods and services to be financed under this element of the Program. Note that it is anticipated that the scope of work for the overall technical assistance contract, which is estimated at $5.0 million, will include financing for technical assistance, training, workshops, studies and commodity procurement. The contract will be subject to open competition. Eligible sources for bids to the RFP for this effort will be 000 and the Cooperating Country, Kenya. Priority consideration in selection criteria will be placed on joint ventures, i.e., U.S. and Kenyan. It is estimated that 60 percent (approximate value: $1.8M) of the technical assistance activities (long- and short-term experts) will be provided by U.S. consultants.

USAID/Kenya will require that any travel to and from the U.S. will be on U.S. carriers. Although not required to do so, USAID/Kenya will require conformance with the 50/50 requirements of the Cargo Preference Act for ocean shipments from the United States.

The anticipated source and origin of the commodities to be provided under the overall technical assistance contract element is as follows:

| Commodity | Source/Origin | Est. Value $ |
|---|---|---|
| - (2) Vehicles Right-hand drive | 935 (Mission Blanket Waiver | 40,000 |
| - (1) Computer Micro-computer | 935 | 625,000 |
| - Software Computer Packages | 935 | 58,000 |
| - (1) Photocopier | 935 (Cooperating Country) | 5,000 |

It is anticipated that virtually all long-term training (valued at $400,000) will go to U.S. universities and institutions [000]. Approximately half of the short-term training ($340,000) will be conducted at U.S. institutions. The PSC Health Economist position is designated to be filled by a Kenyan specialist (value over 3 years - $150,000).

Based on the above, USAID/Kenya believes that approximately 50 percent of the goods and services financed under the projectized element of the KHCF Program will have their source and origin in the United States. USAID/Kenya will report to AID/W annually on the status of procurement upon receipt of the reporting procedures under development in AID/W.

## I. IMPLEMENTATION PLAN

The implementation plan provided below is based on the assumption that the PAAD will be authorized by the end of July 1989. It includes time schedules for achievement of conditions precedent and for the programming of counterdeposit funds. Because technical assistance has been a critical element in the design process with the GOK and is linked to the implementing institutions' ability to meet program

conditionality for first disbursements, USAID has determined that certain technical assistance requirements must be met prior to the arrival of the long-term TA contract team (estimated by March 1990).

Therefore, in the interim, USAID plans to phase TA inputs to the institutions through buy-ins to the REACH Project. The scope of work of the Provincial and District Study has been expanded, and inputs from the analysis of the study will lead to the development of guidelines for expenditures with corresponding support for implementation plans on the cost-sharing system. An additional buy-in will become effective in August 1989 to support a series of analytical works, operations research and planning activities.

These represent the anticipated TA requirements in order to ensure that the GOK can meet the first set of conditions precedent (i.e., activities scheduled from Aug-Dec 1989). KHCF Project Agreement funds will be used for the final buy-in to REACH so that TA needs, observation/study tours schedule from January to March can take place.

Because a minimum six month delay is anticipated before the TA contractor team is on-site, the Mission proposes a four-year PACD from the date of Program and Project Agreements signature to accommodate the required three-year timeframe for the TA contract and to allow a longer timeframe to potentially meet the last disbursement. The final evaluation of the Program would then take place after the last disbursement has been made.

## Policy Reform Implementation Plan

| Action | Month/Year |
|---|---|
| Provincial & District Health Services Study (PADS) | Jun 1989 |
| Pre-PAAD REACH TA Buy-in (Studies) I | Jun 1989 |
| PAAD authorized | Jul 1989 |
| Grant Agreement Signed | Aug 1989 |
| 1st PIO/P Manpower Training-KNH | Aug 1989 |
| REACH interim buy-in completed | Sep 1989 |
| RFP issued for long term TA contract | Sep 1989 |

| Action | Month/Year |
|---|---|
| MOH-HCF Implementing Committee named | Sep 1989 |
| Interim Commodity Procurement Plan (computors and possibly vehicles) | Oct 1989 |
| Implementation Plans for Year 1 (for 1/2 year, Oct 89 - May 90) | Oct 1989 |
| PADs study completed | Oct 1989 |
| Observation Tour-MOH Steering Committee | Oct 1989 |
| 1st National HCF Policy Conference | Nov 1989 |
| Initial KNH CPs met* | Nov 1989 |
| Initial MOH CPs met* | Nov 1989 |
| Initial NHIF CPs met* | Nov 1989 |
| 1st Joint Programming meeting of local currency counterdeposits* | Nov 1989 |
| Pilot Monitoring System launched | Jan 1990 |
| TA contractor in place | Mar 1990 |
| MOH long-term trainees selected ('90-'91) | Mar 1990 |
| KNH long-term trainees selected ('90-'92) | Mar 1990 |
| 1st semi-annual GOK/USAID Program review | Mar 1990 |
| 2nd year Implementation Plan (draft) | May 1990 |
| U.S. Study Tour NHIF | Jun 1990 |
| 6 interns selected KNH (1990 Program) | Jul 1990 |
| Short-term training plan finalized | Aug 1990 |
| Pilot Monitoring System Evaluation (internal with World Bank inputs) | Sep 1990 |
| 2nd Semi-Annual Program Review | Sep 1990 |
| 2nd National Policy Conference | Nov 1990 |

| Action | Month/Year |
|---|---|
| National Policy Monitoring System begun (phased) | Jan 1991 |
| MOH long-term trainees selected ('91-'92) | Jan 1991 |
| KNH long-term trainees selected ('91-'92) | Jan 1991 |
| 3rd Semi-Annual Program Review | Mar 1991 |
| 3rd year Implementation Plan (draft) | May 1991 |
| 2nd year KNH CP's met* | May 1991 |
| 2nd year MOH CPs met* | May 1991 |
| 2nd year NHIF CP's met* | May 1991 |
| 2nd Joint Programming of Local Counterdeposits* | May 1991 |
| 6 interns selected KNH (1991 Program) | Jul 1990 |
| Mid-term Program Evaluation (external) | Aug 1991 |
| 4th Semi-Annual Program Review | Sep 1991 |
| MOH-1st long-term trainees return | Sep 1991 |
| KNH-1st long-term trainees return | Sep 1991 |
| 3rd Annual Policy Conference | Nov 1991 |
| 5th Semi-Annual Program Review | Mar 1992 |
| 4th year Implementation Plan | May 1992 |
| KNH 2nd long-term trainees return | Aug 1992 |
| MOH 2nd long-term trainees return | Aug 1992 |
| 6th Semi-Annual Program Review | Sep 1992 |
| Audit | Sep 1992 |
| 4th Annual Policy Conference | Nov 1992 |
| 3rd year KNH CP's Met* | Nov 1992 |
| 3rd year MOH CP's Met* | Nov 1992 |

| Action | Month/Year |
|---|---|
| 3rd year NHIF CP's Met* | Nov 1992 |
| 3rd Joint Programming of local counterdeposits* | Nov 1992 |
| 7th Semi-Annual Review | Mar 1993 |
| End of TA Contract | Mar 1993 |
| Final Evaluation | Mar 1993 |
| Final Policy Review/(Review of Final Evaluation) | May 1993 |
| PACD | Aug 1993 |
| TA Contract Close Out | Sep 1993 |

* Conditions Precedent for the three implementing institutions and the following programming of local currency may take place on different timeframes depending on when each institution meets its Conditions Precedent.

## J. FINANCIAL PLAN, BUDGET AND ANALYSIS

### 1. Financial Plan

The total funding level for the KHCF is $15 million over a four-year period. The source of funding for the Program is DFA, $10 million of which is part of the AEPRP. A total of $9.7 million is planned as dollar disbursements to be provided by cash transfers in support of proposed policy reform and costs associated with capitalizing the implementation of reforms. The U.S. $9.7 million will be disbursed directly to the MOF in nine tranches during fiscal years 1990-1992, subject to evidence of progress and/or accomplishment of the policy reform program and relatee conditionality.

Dollar disbursements will be made as follows:

(a) A.I.D. and the GOK will sign the Grant Agreement which will contain policy reform conditions precedent and indicators tied to the dollar disbursements.

(b) After the GOK has satisfied conditions precedent, the Regional Accounting Management Center (RAMC) Paris will be requested by the Controller, based on documentation provided by USAID/Kenya, to issue a U.S. dollar check to the Central Bank of Kenya.

(c) The USAID/Kenya Cashier will handcarry the check to the Treasury of Kenya, from where he/she will obtain a receipt which USAID/K will copy to the MOF

(d) The MOF will have established a Kenya Shilling Counterdeposit Program Account. Within 60 days of U.S. dollar disbursement, the MOF will deposit the U.S. dollar equivalent of local currency into the Kenya Shilling Counterdeposit Account.

In addition to the $9.7 million in dollar disbursements for local currency counterdeposit fund establishment, $5.3 million is proposed to be obligated through a complementary Project Grant Agreement. The $5.3 million budgeted for technical assistance, training, policy studies, seminars/workshops, evaluation and audit will be fully obligated in Fiscal Year 1989 and is not subject to the policy reform program. Direct A.I.D. contracting under a single contract to be managed by USAID/Kenya/PH is planned. The method of financing will be direct payment. Under the Technical Assistance Project, no local currency will be controlled by the Grantee. Direct procurement and payment will be used by USAID for this component of the Program. Funds have also been set aside in the foreign exchange component for technical assistance policy studies, seminars/workshops, long and short term training and support, as well as evaluation and audit of the Program which will be managed directly by USAID, using standard A.I.D. procedures. Normal USG audit provisions will apply under the Project grant to the technical assistance contractor(s) with whom USAID will have a direct contract relationship.

Procurement of office and household furniture and equipment for the technical assistance team will be carried out by the U.S. contractor institution involved in accordance with USG regulations. Some commodity procurement for the GOK implementing institutions, i.e., two computers at MOH and NHIF, will require foreign exchange and may need to be executed prior to the arrival of the technical assistance contractor. Standard A.I.D. procurement procedures would be followed. Any other commodity procurement which the GOK decides to carry out using its counterdeposit local currency fund under the Program will be handled directly by the GOK, subject to the GOK's procurement regulations.

As more fully described in Section IV.H., consistent with the accountability procedures for monitoring and accounting for host country owned local currency, USAID and the GOK will jointly program all local currency in the Special Account. Documentation will be available from the GOK that could be

reviewed by USAID at various points of time during the life of program to demonstrate that L/C was transfered from the Special Account to those areas or accounts within the MOH overall budget that are supportive of the health sector.

2. Budget Tables

The budget tables presented on the following pages are based on the assumption that the total planned life of program ($15M) funding will be obligated in FY 1989.

Table 1

Illustrative Disbursement of Funds
(Millions $)

| | FY 89 | FY 90 | FY 91 | FY 92 | FY 93 | Total |
|---|---|---|---|---|---|---|
| 1. Cash Transfer | | | | | | |
| (a) For KNH Reforms | | 2.50 | 2.00 | 0.00 | 0.95 | 5.45 |
| (b) For MOH Reforms | | 2.00 | 1.00 | 0.00 | 1.00 | 4.00 |
| (c) For NHIF Reforms | | 0.10 | 0.10 | 0.00 | 0.05 | 0.25 |
| Sub Total | 0.00 | 4.60 | 3.10 | 0.00 | 2.00 | 9.70 |
| 2. Technical Assistance | | | | | | |
| (a) Long Term | | 0.46 | 0.46 | 0.47 | | 1.39 |
| (b) Short Term | | 0.20 | 0.20 | 0.21 | | 0.61 |
| (c) Studies and Analysis | | 0.16 | 0.15 | | | 0.31 |
| (d) Commodities | | 0.73 | | | | 0.73 |
| (e) Other Costs | | 0.34 | | | | 0.34 |
| Sub Total | 0.00 | 1.89 | 0.81 | 0.68 | 0.00 | 3.38 |
| 3. Training | | | | | | |
| (a) Long Term | | 0.20 | 0.20 | | | 0.40 |
| (b) Short Term | | 0.38 | 0.38 | | | 0.76 |
| Sub Total | 0.00 | 0.58 | 0.58 | 0.00 | 0.00 | 1.16 |
| 4. Other Components | | | | | | |
| (a) Audit and Evaluation | | 0.04 | 0.04 | | | 0.08 |
| (b) Pre Contract TA | 0.10 | | | | | 0.10 |
| (c) Health Economist | | 0.05 | 0.05 | 0.05 | | 0.15 |
| Sub Total | 0.10 | 0.09 | 0.09 | 0.05 | 0.00 | 0.33 |
| 5. Inflation/Contingency | 0.08 | 0.19 | 0.12. | 0.04 | | 0.43 |
| GRAND TOTAL | 0.18 | 7.35 | 4.70 | 0.77 | 2.00 | 15.00 |

Table 2

Illustrative Methods of Implementation and Financing
(Millions $)

| Program Component | Method of Implementation | Method of Financing | Millions $ |
|---|---|---|---|
| 1. Cash Transfer | | | |
| (a) For KNH Reforms | | Cash Transfer to MOF | 5.45 |
| (b) For MOH Reforms | | Cash Transfer to MOF | 4.00 |
| (c) For NHIF Reforms | | Cash Transfer to MOF | 0.25 |
| Sub Total | | | 9.70 |
| 2. Technical Assistance | | Direct Payment | |
| (a) Long Term | | | 1.39 |
| (b) Short Term | | | 0.61 |
| (c) Studies and Analysis | | | 0.31 |
| (d) Commodities | PIO/C | | 0.73 |
| (e) Other Costs | | | 0.34 |
| Sub Total | | | 3.38 |
| 3. Training | | Direct Payment | |
| (a) Long Term | PIO/P's | | 0.40 |
| (b) Short Term | PIO/P's | | 0.76 |
| Sub Total | | | 1.16 |
| 4. Other Components | | Direct Payment | |
| (a) Audit and Evaluation | | | 0.08 |
| (b) Pre Contract TA | | | 0.10 |
| (c) Health Economist | PSC | | 0.15 |
| Sub Total | | | 0.33 |
| 5. Inflation/Contingency | | | 0.43 |
| Grand Total | | | 15.00 |

Table 3

FINANCIAL PLAN
All Institutions
(U.S. Dollars)

| | Year 1 | | Year 2 | | Year 3 | | Year 4 | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| | AID | GOK | AID | GOK | AID | GOK | AID | GOK | AID | GOK |
| Technical Assistance | 474,800 | | 887,125 | | 524,000 | | 111,675 | | 1,997,600 | 0 |
| Training | 119,850 | | 391,300 | | 486,700 | | 166,750 | | 1,164,600 | 0 |
| Studies and Analysis | 19,600 | | 129,225 | | 138,050 | | 27,325 | | 314,200 | 0 |
| Commodities | 128,000 | | 600,000 | | 0 | | 0 | | 728,000 | 0 |
| Administration Costs | 45,000 | | 90,000 | | 90,000 | | 45,000 | | 270,000 | 0 |
| Miscellaneous | 10,350 | | 23,900 | | 22,300 | | 8,750 | | 65,300 | 0 |
| Sub Total TA Contract | 797,600 | 0 | 2,121,550 | 0 | 1,261,050 | 0 | 359,500 | 0 | 4,539,700 | 0 |
| Audit and Evaluation | 0 | | 40,000 | | 0 | | 40,000 | | 80,000 | 0 |
| Pre Contract TA | 100,000 | | 0 | | 0 | | 0 | | 100,000 | 0 |
| AID Personnel Hire | 0 | | 50,000 | | 50,000 | | 50,000 | | 150,000 | 0 |
| Total TA Contract + Other Costs | 897,600 | 0 | 2,211,550 | 0 | 1,311,050 | 0 | 449,500 | | 4,869,700 | 0 |
| Inflation/Contingency (+/- 9%) | 79,300 | 0 | 195,450 | 0 | 115,850 | 0 | 39,700 | 0 | 430,300 | 0 |
| GRAND TOTAL | 976,900 | 332,000 | 2,407,000 | 818,000 | 1,426,900 | 485,000 | 488,200 | 165,000 | 5,300,000 | 1,800,000 |

3. Financial Analysis

The financial analysis shows the cost estimates developed for the training activities under the projectized costs of this program to be reasonable and in line with actual costs of similar training projects, such as the USAID-funded IPS Project and others elsewhere in Africa. Long-term (advanced degree) and short-term training costs are based upon AID Handbook 10 and upon a survey conducted by the technical analysis team of more specialized areas of training offered in the United States and Africa Region or Kenya. Long-term training costs per participant are estimated at about $40,000/per year. (A yearly inflation/contingency factor of 9 percent is included.) This closely parallels the costs estimated by the Office of International Training in AID/W. Short-term training in the Africa Region and Kenya averages $1,500 per month ($1,200 tuition/fees and $300 per diem and other costs). Short-term training courses will average two weeks in duration. Airfares and pre-departure costs are based on actual present costs. Salary contributions are based on published information concerning the salary and benefit levels of GOK civil servants and Kenyan academic community employees having the range of qualifications and required level of responsibility this training will target.

The technical services and management support costs of this program represent about 35 percent of the total life-of-program of this amount, 66 percent is directly related to technical assistance, policy studies, and training. The balance of 34 percent represent management and administrative overhead costs related to the overal contract. Costs for expatriate techical consultants in selected areas of expertise are budgetted at relatively higher rates (in excess of FS-1 salary ceiling) than is normally financed under traditional USAID project assistance in the health sector.

The cost estimate for the PSC health economist contractor to serve as Program Manager for four years is based on salary levels of Kenya health economists who provided similar professional services under local contract to A.I.D.

The GOK will contribute the equivalent of $1.7 million to the projectized side of the program valued at $5.3 million. Regarding short and long-term stateside training, the GOK will sponsor training participants by paying half of the round trip airfares to the U.S. and continuing salary/benefit payment of families while individuals are in training programs. For

in-country and third-country training, the GOK will continue salary/benefit payment while individuals are in training. For all training, the GOK will provide personnel to cover the work responsibilities for the person undergoing training.

The GOK's contributions to the technical assistance and institutional strengthening activities have been structured in such a way as to make greater use of existing GOK/MOH resources for implementation of cost sharing reforms. Thus, the contributions from the three implementing institutions, i.e., the MOH, KNH, and the NHIF consist primarily of existing staff facilities and operating costs that will be more directly dedicated to the administrative, management and analysis (financial and policy) requirements of the overall HCF Program. As a result of the training and technical assistance, staff will acquire new skills and be deployed to these activities. This approach of retraining existing resources will serve to minimize any probability of further increases in wage operating expenses and of introducing additional recurrent expenditures in the health sector that would be difficult to sustain.

ANNEX A.

# INSTITUTIONAL ANALYSES

## I. Ministry of Health (MOH)

### A. Institutional Description

Kenya has a plural health care system which includes the public sector (comprising mainly the Ministry of Health and Municipalities), proprietary private sector, voluntary private sector, and traditional medicine sector. The MOH is the largest provider of health care in the country. It is involved in the provision of all types of health services; viz curative, preventive, promotive health care and environmental protection and pollution surveillance. MOH has the legal obligation to supervise all the other providers of health care in the country and to provide policy guidance and inspection services.

The MOH is organized under the same setup that all the other Kenyan government ministries are organized. The political head of the MOH is the Minister, in this case the Minister of Health with three Assistant Ministers. The Permanent Secretary (PS) is the chief administrator and accounting officer of the ministry. The PS has several deputy officers working with him at the ministry headquarters. In every province and every district, the PS has officers in charge of particular ministry's activities. In the case of the MOH, these officers are Provincial Hospital Secretaries, District Hospital Secretaries and Hospital Secretaries.

Parallel to the PS is normally the technical head of the Ministry. In the case of the MOH the technical head of the Ministry is the Director of Medical Services (DMS). Like the PS, the DMS also works with several officers deputy to him at the Ministry's headquarters. In every province the DMS is deputized by the Provincial Medical Officer (PMO). Below the PMO is the Medical Officer of Health in charge of the district health care system. There are several Medical Officers of Health in a province depending on the number of districts in the province.

The MOH facility network follows a hierarchical organizational pattern. In certain areas of the country, community based health care workers now provide frontline health care and referral. Ideally, lower level primary health care facilities refer patients to the secondary, sub-district and district hospitals which in turn refer to provincial hospitals. KNH stands at the apex of tertiary care.

There are now over 2000 health facilities operated by the MOH - approximately 70 percent of all Kenya's health facilities. It is estimated that over 35,000 technical health care workers are

employed by the MOH including doctors, nurses, clinical officers, etc. In addition, the numbers of administrative, clerical and other support staff places the MOH as the largest employers in the country.

Until recently, the MOH directly controlled all of the major health training institutions. They have recently been moved to a semi-autonomous status.

B. Rationale for choice

As discussed above, the MOH is the legislated supervisor of all health care providers in Kenya and can, thereby, implement sector-wide policy initiatives. It provides policy guidance to the GOK in matters pertaining to health and manages GOK budgetary efforts in health care.

Given the scope of the MOH's mandate, it is uniquely placed to play the key role in implementation of cost sharing. Its ability to supervise providers empowers it to coordinate activities of the various actors. In its capacity as policy advisor to the GOK, it is the appropriate source of analysis on to the impact of cost sharing on the health system and on health status. Through its budgeting role it can ensure that the revenues generated by cost sharing will be used to rationalize health's part in the GOK budget. Further, it can oversee simultaneous efforts in fee collecting, cost-containment, quality improvements, and efficiency enhancement in the system. Thus, the performance of this institution is key to the Program achieving its purpose and goal.

C. Assessment of Institutional Capacity

1. Mandate

As described in the previous section, the MOH has the mandate for implementing cost-sharing, for ensuring coordination among providers, and for providing related policy guidance to the GOK.

2. Functional Organization

As described above, the MOH is divided into the technical side, headed by the Director of Medical Services (DMS), and the administrative side, headed by the Permanent Secretary (PS). The technical side is particularly skilled in medical matters, whereas the administrative side is more occupied with financial and administrative duties. The two halves often have difficulty understanding each others' problems and

arriving at concensus. As described below, the same division of skills and priorities is reflected at the district and provincial levels.

Consistent with general GOK policy, the MOH began a program of decentralization in 1983. Increasingly, responsibility for decisions on budgeting, training, manpower, and health coverage is devolving to the provincial and district levels. District Health Management Teams (DHMTs) and Provincial Health Management Teams (PHMTs) are the entities responsible for day-to-day district and provincial management. The DHMTs comprise representatives of the major health care functions, such as administration, nursing, pharmacy, education, clinical medicine, etc. It is meant to provide an opportunity for all key areas of the public health system to coordinate district-level health activities. The PHMT is comprised of a smaller group responsible for general supervision, monitoring and evaluation of district operations within the Province.

Externally, the MOH operates as part of a larger health care network including private providers. It also functions in the context of the larger GOK system, interacting most importantly with the Ministry of Finance (for budget allocations) and Ministry of Planning (for investment planning) and with the Office of the President (for overall administration of the health sector).

Some of the institutional infrastructure required to implement cost sharing is already in place at the MOH. Overall responsibility for implementing cost sharing activities will reside at MOH headquarters in Nairobi. Headquarters will provide the policy analysis and strategic and overall budgetary guidance for the process, working through the DHMTs and PHMTs. These health management teams will translate the strategy developed in Nairobi to local circumstances and supervise its implementation at the facility level. They will also supervise the collection of data required for monitoring cost sharing implementation and providing feedback necessary for policy analysis at headquarters.

It is expected that District Medical Officers of Health (DMOHs), Provincial Medical Officers (PMOs), District Hospital Secretaries (DHSs) and Provincial Hospital Secretaries (PHSs) will be the key personnel in cost sharing implementation. The PMOs and DMOHs are the heads of the health management teams. The PHSs and DHSs are the members of the DHMTs and PHMTs with the greatest training in the basic finance and administrative skills required for implementation and monitoring of cost sharing.

Staff at the hospitals, health centers and dispensaries will carry out the actual collection of fees and monitoring of data. It is expected that the health management teams will supervise training in these new responsibilities. The management teams will also assist the facilities to adjust to the new management burden and to develop priorities for the expenditure of cost-sharing revenue.

D. Human Resources Development Needs

At MOH headquarters development of human resources will be needed in the areas of finance, economics and planning as these skills are not now sufficiently present to undertake new analysis, planning, and coordination responsibilities with the introduction of cost sharing. At the provincial and district levels, budgeting, planning and auditing skills must be developed, while at the health center and dispensary level, administrative training and/or additional personnel will be required.

E. Operational Track Record

USAID enjoys good working relationship at senior MOH management levels concerned with design and development of projects. However, the MOH has had past difficulties in assigning qualified full-time operational counterparts. This has sometimes seriously hampered project implementation and progress. Designation of counterparts has either tended to be delayed for long periods or filled by highly qualified MOH officers who have many other demanding responsibilities. Assignment of appropriate counterparts to be affiliated with the Program will need to be specifically addressed.

F. Capability to Perform Policy Analysis

The MOH has concluded that cost sharing is necessary to sustain financing of the health sector. However, the ministry has not yet thought through wider issues related to health care financing, such as the role of the private sector and risk sharing. It must also consider the implications of cost sharing for current fee waiver systems, the MOH administrative burden, allocation of cost-sharing revenue and the effects of these changes on incentives in the system. The MOH will require some technical assistance and training to improve its policy analysis capability, as described below.

G. Capability to Track and Account for Program Funds

Based on the USAID/Kenya's experience to date with the MOH in projects funded by USAID, the ministry has been able to account for program funds with varying degrees of success. The Government's general accounting system is

adequate, tightly controlled and automated. Thus, there is no reason to be concerned about the essential integrity of expenditures. However, the system frequently does not provide the level of detail needed for separate program fund accountability. This level of responsibility rests with the internal MOH accounting system which still operates manually and does not currently have the capacity to consistently track field expenditures on externally-aided projects. Special attention will need to be given to this area, and specific procedures put in place to ensure accountability for program funds to the extent required. As noted in the below section, further capacity in this area will be provided to the MOH, through the HCF Implementing Committee by the technical assistance project activities funded by USAID. New systems and guidelines will be developed to enhance the MOH's capacity to account for program funds.

H. Training and Technical Assistance Needs

The implementation of cost sharing system-wide will present a host of new administrative challenges requiring technical assistance and training at each level of the system. MOH headquarters will require two significant structural changes.

As a part of the health financing program, the MOH will establish HCF Implementing Committee which will integrate health and financial policy and planning, including oversight and direction of all cost sharing activities. This Committee will report directly to the PS. This unit is expected to address a perceived weakness in policy development at the MOH and its establishment is one of this PAAD's conditions precedent. The terms of reference will include strategic planning, policy formulation and coordination, monitoring of cost sharing, and direction of special studies. It also will supervise the accounting and auditing of cost-sharing revenues. It is expected to be headed on a day to day basis by a Senior Deputy Minister and to have an appropriate staff of analysts with skills in the following: health economics, primary health care, planning/evaluation and financial, managerial and information systems. It is expected the Committee will require the following assistance:

- a local area network of about eight micro-computers
- word processing, data base, planning, spreadsheet and statistical software together with training in its use;
- office equipment, such as photocopiers, typewriters, etc.;

- long- and short-term technical assistance, particularly in guiding the development of policy analysis, accounting, auditing and financial monitoring capacities;
- access to a TA skills pool to be utilized as the need materializes;
- access to the local academic community for TA;
- Long-term training for the HCF Implementation Committee in the skills necessary for policy analysis, such as economics, planning, public health, statistics and information analysis; and
- a line-item in the MOH budget sufficient to operate effectively.

The second structural change at MOH headquarters will be to establish an organ to advise the MOH on health policy. It will carry on from the work of Health Care Financing Steering Committee. The Steering Committee was established early in 1988 as a temporary body to oversee and coordinate studies in the area of health financing. The advisory organ's representation should include all actors in the health care system, including, but not limited to, representatives from the Ministries of Health (HCF Implementation Committee), Finance and Plan, NHIF, municipalities, private proprietary and not-for-profit providers, consumers, health professionals and private insurers. private proprietary and not-for-profit providers of health care, consumers, health professionals and private insurers. A Central Health Services Committee (CHSC) already exists -- on paper -- at the MOH to provide a similar function. However, it has not yet become a reality. Thus, it may be possible to create the advisory organ by developing the CHSC with a mandate to advise the MOH on health policy, including financing. Coordination within the MOH, beneath the HCF Implementation Committee, will be done through its secretariate to the existing Senior Management Committee and Heads of Department meetings as forum for review of financing reform implementation issues, particularly those associated with cost sharing. Members of these committees may benefit from some short-term training in health financing policy and implementation.

The MOH will strengthen its procedures to ensure access to health services by the poor. It will also develop a system to monitor and evaluate the effectiveness of these procedures and the effects of cost-sharing in utilization of health care services in general. In this regard, to the maximum extent reliance will be placed on strengthening existing MOH information networks, such as the MOH's Health Information

System. This program provides funding to assist in the development, financing, monitoring and evaluation of the new system.

Some structural change at the DHMT/PHMT level may be required. More administrative and financial staff (possibly an additional hospital secretary) may be needed. The HMTs' role will expand in two ways:

- Greater responsibility for budgeting, planning, and expenditure of additional resources generated by cost sharing, and

- Responsibility for training, guidance, assistance, and oversight of health centers and dispensaries in the administration and expenditure of cost-sharing resources, including monitoring of compliance with MOH priorities for spending.

In addition, there are other areas at the HMT level that would benefit from additional training or analyses, that are not essential to achievement of this Program's success, but represent areas for further MOH strategy considerations. Examples include:

o Training for Medical Officers of Health in the elements of financial planning and budgeting to be better able to lead the health management teams in these areas. Hospital Secretaries also should receive additional training in financial planning and budgeting, and how to train, in the administration of cost-sharing, as well as in the basics of public health in order to assist and guide dispensary and health center staff. Further, these skills should be intergrated into the standard curriculum for basic training (community medicine for MOH's and health administrating for HSs) in these fields. This is necessary since the fields will overlap even more with the introduction of cost sharing. The rest of the team members should also receive similar training at a lesser depth.

o Re-establishment of a program in health administration. Because of lack of space, the Kenya Institute of Administration (KIA) stopped offering a diploma in hospital administration (the basic training of hospital secretaries) two years ago. This has meant that university graduates, without special training in health administration, have been recruited to fill the approximately ten openings per year. Given the key role these individuals are expected to play in cost sharing, consideration should be given to re-establishing the program in health administration.

- At Provincial and District hospitals, where fees are already collected, the fee structure proposed involves outpatient registration fees and additional charges for drugs prescribed. Thus, procedures may need to be developed for fee collectors to determine whether to charge patients for drugs. Further, the inpatient charges are to vary by length of stay (up to a ceiling) and MOH facilities will be permitted to retain NHIF reimbursements. These new elements will necessitate changes in procedures and, perhaps, staff. Effort also must be made to strengthen the current fee waiver system.

- The Provincial and District Study (PADS), starting in June, 1989, will make recommendations about staffing, procedures, and training needs associated with the institution of cost sharing at health centers and dispensaries. Since only minimal fees are collected at these facilities now, training will be required in procedures for collection and safeguarding and accounting for fees. Additionally, training will be required in budgeting and planning for expenditure of fee revenues at all levels of facilities.

## II. National Hospital Insurance Fund (NHIF)

### A. Institutional Description

The National Hospital Insurance Fund (NHIF) was established in 1966 as a parastatal intended to assist government employees to afford to stay at high quality private hospitals and to relieve congestion in free of charge public facilities. Over the last twenty years, employed, self-employed, and non-employed persons earning over 1,000 Ksh per month or 12,000 Ksh per year have made mandatory contributions of 20 Ksh per month to the Fund. In 1984-85, total contributions to the Fund were estimated at Ksh 129.2 million. NHIF currently serves a membership of over 900,000. Benefits include inpatient care up to a combined family maximum of 180 days per year in NHIF-approved hospitals, and apply to the contributor, his/her spouse and children. The Fund has been able to generate annual surpluses and receives no subsidy from the GOK.

The reimbursement rate paid to facilities varies according to the class of hospital in which the patient receives cares. There are currently six rates, ranging from 150 Ksh/day to 40 Ksh/stay (applicable only in government hospitals). In 1983-84 only four percent of Fund payments went to government hospitals. In part, this is because payments to these facilities are at a very low rate, but primarily because there is little incentive for government hospitals to claim reimbursement from the Fund, because any revenue from NHIF goes directly to the General Treasury rather than the provider

facility. As currently organized, the scheme encourages those covered to be admitted to a private hospital, where at this stage quality of services is higher.

The levels of contributions, benefits and reimbursement have changed little since the Fund's inception. Inflation and increases in per capita income have effectively extended coverage to a larger segment of the employed population, while reimbursement levels have remained constant. In the case of urban private hospitals, NHIF reimbursements cover only a small portion of the total hospital invoice -- in some instances only taxes. However, for many rural, church-related hospitals the NHIF reimbursement covers all charges.

B. Rationale for Choice

In order to address some of the inadequacies within the Fund's operating structure (e.g., a regressive contribution scheme, inappropriate utilization incentives) and to update some of its features, the NHIF recently submitted an ambitious proposal for expansion and restructuring to Parliament. This proposal was revised after review by a USAID/World Bank/UNICEF team in April 1989, as well as by the Ministries of Health and Finance. It was concluded that more time was needed to collect additional information and to study and prepare for proposed changes. Nevertheless, it was determined that the NHIF could and should undertake some reforms now, develop longer term plans for its goals and objectives, and play a major role in health care financing reforms in Kenya.

The three key elements of the reform to be undertaken by NHIF are the development of a consensus on the medium- and long-term goals and objectives of the Fund, implementation of interim reforms contained in the Bill currently before Parliament, and strengthening of its administrative and operational capacity.

Consensus needs to be reached about NHIF's goals and objectives, since there is debate over whether and how its influence should be used in the sector. The Fund currently provides its contributors with access to hospitalizations, particularly in private care facilities. In this way, it has contributed and will continue to contribute importantly to the financial sustainability of health sector programs by helping to finance the cost of hospital services delivered in both public and private sectors.

Interim reforms to be made will include introducing a progressive fee structure, initiating employer contributions, and increasing reimbursement rates to bring them more into

line with actual costs of delivering services. These changes will improve equity aspects of the Fund's operations and help to rationalize the utilization of services.

In order to undertake these reforms and to develop a longer-term strategic plan, the NHIF will need to strengthen its management and administrative capacity. In particular, it will have to develop a cost and actuarial database so as to adjust premium levels and determine benefit packages.

## C. Assessment of Institutional Capability

### 1. Mandate

The NHIF was established under Section 4 of the National Hospital Insurance Act with the objective of supplementing government provision of free medical services in two ways:

- Facilitating a cross-section of the people to have access to private hospital beds in order to reduce congestion in government hospitals.

- Integrating indigenous races into private hospitals, some of which had been reserved for the exclusive use of colonials.

In addition, the long term objective of establishing the NHIF was to create a national health insurance scheme, and thus pool together individual resources and risks of sickness in order to meet the costs of in-patient treatment.

Plans are for the National Hospital Insurance Act to be amended by the Parliament in August/September 1989. The amendments would change:

- NHIF to a State Corporation
- rates of contribution and benefits
- the type of investments NHIF will make, and
- the Board of Trustees' approval process for future changes in contributions/benefits, and coverage of beneficiaries.

### 2. Functional Organization

For management purposes, the NHIF is functionally organized into four divisions as follows:

- Administrative/Registration Divison. This division is responsible for processing registrations and issuing new cards, as well as for the personnel administration of the Fund.

- - Accounts Division. This division is responsible for sale of the National Hospital Insurance revenue stamps, handling of claims from hospitals and individuals, payments with respect to Fund activities, and preparation of annual accounts.

- - Inspectorate Division. This division is responsible for the inspection of employers to ensure accurate record keeping, and the inspection of facilities to ensure maintenance of quality.

- - Data Processing Division. This division stores and retrieves data related to the issuing of cards and processing of benefit claims.

3. Human Resources

Because the NHIF has no personnel authorizations of its own, it has had to rely on successive Permanent Secretaries to assign officers to manage the Fund. The number of officers seconded to the Fund depends on the availability of spare personnel at the Ministry of Health. This arrangement has contributed to a chronic shortage and lack of continuity of trained and experienced officers at the Fund. In particular, the NHIF has no personnel with actuarial training or with data processing skills. These skills will have to be developed in order to support future NHIF activities. Along those lines, the technical assistance/training component of the Health Care Financing Program will provide short-term training for NHIF staff as well as technical assistance.

4. Operational Track Record

USAID/Nairobi has only recently begun a working relationship with the NHIF and contact has been largely limited to the Director and Deputy Director of the Fund, who have been helpful and cooperative. The NHIF has expressed a strong interest in playing a role in USAID's Health Care Financing Program. With the assistance provided by this program, its services and capabilities should improve. To date, NHIF has not received external donor assistance financing.

D. Assessment of Capability to do Policy Analysis

Although the NHIF has concluded that a restructuring of its organization is needed, it currently lacks the requisite skills to both develop and carry out a comprehensive strategic plan for its goals and activities. The initial reform plan proposed was too ambitious and was based on insufficient information regarding utilization patterns, costs, and potential contributors. It was revised and simplified based on the

HCF team's recommendations. To develop a consistent strategy, the NHIF will have to analyze a variety of issues facing it including, among others: the potential of sharing automation services with the National Social Security Fund; the labor market effects of employer contributions; and the objectives and goals for NHIF and its role in the broader health sector.

In order to accomplish these tasks, the NHIF will require some technical assistance and training to improve its policy analysis capability in these areas.

### E. Capability to Track and Account for Program Funds

Although the NHIF has not had any experience to date in managing USAID or other donor financing, it would appear that its Accounts Division would be able to account for program funds to the extent required. In addition, an important component of this program will be to strengthen the NHIF's capacity to manage information, through the automation of services and data.

### F. Training and Technical Assistance Needs

The implementation of reforms within the NHIF will require technical assistance and training throughout the restructuring process. Long term technical assistance will be needed from a health insurance specialist who can help the NHIF to define and implement a strategic plan. Short-term technical assistance from actuaries, economists and health insurance specialists will be required for carrying out specific studies and assignments in order to meet conditions precedent. These will include planning for and implementing the automation of NHIF activities, development of a mechanism to assess providers' costs and quality of services, and a report on administrative problems with NHIF services encountered by employers and providers and steps to correct them. In conjunction with actually performing these tasks, these experts will work with NHIF counterparts and thus help to build the organization's own capacity to perform analytical work. Additionally, formal short-term training will be provided for management-level staff of NHIF, through an external study tour and annual retreats to develop the Fund's objectives and implementation plan.

## III. Kenyatta National Hospital (KNH)

### A. Description

Kenyatta National Hospital (KNH) is the tertiary referral hospital within the Kenyan health delivery system which also serves as a teaching hospital and research facility. In April 1987, it became a State Corporation by Presidential Order.

A Board of Directors of 11 members was established, with the Hospital Director as its secretary and the Chief Executive and is responsible for hospital administration and development. The objective in making KNH a state corporation is for the hospital to become more efficient in its operations and lessen its burden on the GOK budget.

In 1987, KNH provided 483,466 days of care, admitted 60,707 patients, and maintained 1,622 beds. It provides 16 clinical services, seven specialty programs, two diagnostic services, two ancillary services, and trains in 24 health specialties. Through the Ministry of Health, KNH employed 3,722 individuals in 1987, 55 percent of whom were technical. During the 1987/88 year, gross operating expenses for KNH were approximately $13 million.

B. Rationale for choice

KNH is chosen for support under this program to assist the GOK in realizing its objective of reducing the burden of the hospital on the budget. USAID has already assisted KNH's Board in identifying steps to take to become more effective and efficient. To implement those steps KNH management requires strengthening. In addition, KNH is ready to initiate cost sharing charges for in- and outpatient and specialized services to generate additional resources. The program will support KNH in these areas.

Immediately after the hospital's establishment as a state corporation, the Board set out to identify measures that would improve management and efficiency of services. A USAID study, carried out under the auspices of the centrally-funded REACH project in 1988, examined the hospital's operations with the objective of providing the Board with practical recommendations to improve the effectiveness and efficiency of delivered services. Based on the study's results and recommendations, the Board adopted a Plan of Policy and Institutional Reform, which includes a set of priority actions for implementation. While some progress has been made, many critical steps remain to be taken.

The two key elements of reform for KNH are the initiation of cost sharing and improvements in institutional capability. Cost sharing will raise additional revenues and provide consumers with indicators of the relative costs of services at KNH. Measures to ensure access to tertiary hospital services to all groups in the population will also be implemented. At the same time, cost-sharing reforms will be complemented by efforts to improve efficiency and effectiveness. These improvements will contain the costs of providing services, make more resources available, and reduce the financial burden to consumers, (e.g., by reducing average length of stay).

Quality improvements, (e.g., availability of drugs, working operating theatres) will ease the acceptance of consumer sharing of costs.

Institutional capability within the Hospital will have to be augmented in order to carry out the necessary reforms. At the same time, improvements of staff capacity will help to ensure the long-run sustainability of successful hospital operations.

## C. Assessment of Capability

### 1. Mandate

A Presidential Order of April 1987 made Kenyatta National Hospital a State Corporation. A Board of Directors with 11 members was established, with the Hospital Director as its secretary and Chief Executive. The Board is responsible for hospital administration and development. The hospital's functions are as follows:

- Receive patients on referral from other hospitals or institutions for specialized health care.

- Provide facilities for medical education for the University of Nairobi and for research either directly or through other cooperating health institutions.

- Provide facilities for education and training in nursing and other health and allied professions.

- Participate as a national referral hospital in national health planning and policy.

### 2. Functional Organization

The Board of Directors consists of three primary committees, as follows:

- Financial Committee - formulates the hospital's financial policies and serves as the hospital's Tender Board.

- Establishment Committee - formulates personnel policies and coordinates recruitment and staff development.

- Maintenance and Development Committee - formulates and implements policies with respect to maintenance and development.

3. Human Resources

With the establishment of Kenyatta National Hospital as a state corporation in 1987, a personnel unit for the hospital was established and its functions diversified. All personnel records were transferred from the Ministry of Health headquarters as were all personnel functions. The staff payroll was separated from the Ministry as well, and full control and administration of salary payrolls by the hospital is maintained by the hospital. As of late 1987, the total staff at KNH numbered approximately 3,800.

An important aspect of the proposed reforms for KNH is augmenting institutional capability. One of the first reforms called for is the filling of six senior management positions in Planning, Nursing, Clinical Services, Administrative Services, Finance and Personnel. Additionally, a staff position is needed to spearhead the reform process, reporting to both the KNH Director and Board.

While these are the most critical human resource needs at present, there are additional requirements for mid- and lower-level staff. These include management training needs for mid-level managers and training in the use of financial management, cost accounting and budgeting systems. Further, with the institution of cost-sharing, hospital personnel will need to be trained with respect to the collection and management of funds. Additionally, a targetted staffing assessment needs to be carried out, and a staffing plan developed for the future.

4. Operational Track Record

USAID/Kenya has enjoyed a satisfactory working relationship with KNH. The hospital's reforms reflected in its Plan of Policy and Institutional Reform are logical and well-defined, however, implementation has been slower than expected. In part, this has been the result of factors outside the control of KNH or MOH, including a lack of funding, MOH's somewhat slow handover of staff, and general uncertainty regarding the introduction of user charges. The reform plan has also been handicapped because KNH has devoted only limited personnel resources specifically to implementing the reform plan. The USAID/WB HCF Mission's recent review of the status of KNH reform implementation has contributed to renewed commitment in the MOH and KNH to quicken the pace of implementation. With the assistance to be provided by this program, the hospital's performance in carrying out the reforms, as well as its services and capabilities, should improve.

D. Assessment of Capability to do Policy Analysis

Because a large part of the reforms to be undertaken under KNH's new plan, it must analyze a variety of issues and establish policies in certain areas, including: operations and procedures reviews for specialized services (e.g. radiology, pharmacy); ensuring access to to all income groups; a feasibility study and business plan for doctors' practice; cost analysis of private wing services. In order to accomplish these tasks, KNH will require some technical assistance and training to improve its policy analysis capability. At the same time, KNH counterparts will be assigned to work with both external and local consultants on these issues in order to develop in-house capacity to carry out policy analysis.

E. Capability to Track and Account for Program Funds

Although KNH has not had any experience to date in managing USAID project funds, it would appear that its Finance Department would be able to account for program funds to the extent required. Additionally, an important component of this program will be to establish a financial management, cost accounting and budgeting system for the hospital, which should provide appropriate mechanisms to track program funds.

F. Training and Technical Assistance Needs

The implementation of reforms at KNH will require technical assistance and training throughout the reform process. Short-term technical assistance will be required from economists, management consultants, architects, financial specialists, and physicians to carry out specific studies and assignments in order to meet conditions precedent. These tasks will include defining a mid-level managers' development plan, conducting operations and procedures reviews for specialized services, designing and installing a cost accounting and financial management information system, and developing a business plan for doctors' practice. In conjunction with actually performing these tasks, these experts will work with KNH counterparts and thus help to build the organization's own capacity to perform analytical work.

Additionally, short-term training will be provided to hospital staff at a variety of levels. Mid-level managers will receive management training through internships at hospitals outside of Kenya. Personnel will also receive training in the operations of the centralized admissions and fee collection procedures, as well as the broader budgeting, cost accounting and financial management information system.

ANNEX B.

# IMPACT ANALYIS

## Introduction:

With the introduction of the policy and structural reforms currently proposed and anticipated, one must look at several types of impacts. In the following sections, the financial impact on the health care delivery system is examined both in terms of potential revenue generation and effects of financing on quality of care. Secondly, the potential impact of these reforms on the population at large is reviewed. The issues that still remain to be analyzed and how their potential impact will be taken into account during the implementation of the reform program are also described. Finally, an overall summary of anticipated impact based on the information available is presented.

## I. Economic Resources Invested and Benefits to be Realized

The ultimate goal of the KHCF Program is to improve health and to maximize the amount of health care services provided per shilling spent. As better health is attained, the benefits to be realized will include both productivity gains as well as pure utility gains from improved well-being. It is evident from the analysis which follows that the benefits of the program far outweigh the costs of implementing the reform agenda in the medium term.

The World Bank/USAID Health Financing Mission (HFM), conducted in May 1989, was a focused rapid assessment of the economic and financial impact of the GOK's proposed reforms. The HFM concluded that cost sharing through the introduction of user fees is a viable approach for the GOK to raise revenue and that the cost-sharing will have a positive economic impact on GOK health services. These conclusions are consistent with previous studies in Kenya and similar countries (see Annex I for details).

Additional studies could be conducted to refine the expected impact. However, based on existing data, it is clear that user-fees will be a significant source of revenue for the MOH, and will serve to sustain existing investments and provide a foundation for future growth. The GOK is committed to launching cost-sharing initiatives in the health sector this year, preferrably with the assistance of donors.

USAID will provide two sources of financing. First a total of $9.7 million will be provided in dollar disbursements (resource transers) in support of the outlined policy reform. The GOK will establish a Kenya shilling counterdeposit special account which will serve to meet the anticipated requirements associated with implementing the Program for the three institutions. In addition, USAID will provide $5.3 million in projectized support to technical assistance (short and long-term) training and limited commodity procurement.

There will be susbstantial initial costs to the MOH implementing institutions for personnel training and set up of fee collection and administration. However, the recurrent costs of administering the cost sharing system are expected to be low. The 1988 World Bank study conducted by Charles Griffin analyzed user charges in developing countries (1). It concluded that for rural primary health programs, it is exceptional to find situations in which the costs of collecting fees are excessive. Griffin reports that in Pikine, Senegal the cost of collection of less than 10 percent of revenues. In Ronald Vogel;s report on cost recovery in four West African countries (2) (Senegal, Mali, Cote d'Ivoire, and Ghana), collection costs were reported to be minimal, although the time spent by health workers in the collection of fees is often not accounted for. At the hospital level, Griffin states that revenues dwarf collection costs. He cites experience in Sudan where collection costs at hospitals were 5 percent or less of revenues.

Numerous studies have been conducted in recent years to identify potential mechanisms for additional revenue generation in the health sector. Of primary importance are the proposed introduction of cost sharing (paying less than cost); improved efficiency through better budget allocation and utilization of services and cost containment; and expansion of the role of the NHIF in meeting health sector goals. Potential for revenue generation has been assessed on the basis of the ability of the mechanism to increase the total amount of resources available to the sector as well as administrative and political feasibility.

Estimates of the revenue generation potential of cost-sharing measures have been prepared and analyzed (including R. Vogel (3), World Bank (4), Dr. Abel-Smith (5), R. Ellis (6) shown in Table 9 Annex C). These form the basis for the calculations and assumptions which follow. Though the GOK has not yet officially published the fee schedule and timing of implementation, key principles for the implementation of user fees have been agreed upon (See Annex I.2. World Bank/USAID Aide Memoire).

Estimated revenue generations developed for this PAAD, using projected MOH utilization data and high and low fee schedules, are equivalent to 19.8 percent and 12.2 percent, respectively, of the 1988 total MOH recurrent budget. Schedules based on the HFM's recommendations yield fee generations equivalent to 12 percent of the recurrent budget. Assumptions are made regarding the percent of persons unable to pay, the number of visits exempt from payment (e.g., children under 5, prenatal care), percentage of owed revenues likely to be collected by the MOH and willingness and ability to pay (e.g., price elasticity of demand for health services), especially with respect to the utilization of health services in the public sector.

Table A in Attachment I shows that substantial additional resources may be expected to be produced by the implementation of cost sharing for outpatient services at MOH facilities. The low fee estimate corresponds to the HFM proposal. The estimated revenue from the outpatient fees using the HFM schedule would amount to 11 percent of the 1988 MOH recurrent budget. The higher fee estimate is expected to generate nearly 19 percent of the recurrent budget.

The low-fee revenue performance would be achieved by asking households with the mean level of income in Kenya to spend less than 1 percent of their total income. At low outpatient fees a minimum wage household could expect to spend 3.5 percent of income on outpatient health services, if it were not exempted from payment. The high fee outpatient schedule would require average spending of less than 2 percent of mean income and less than 7 percent of minimum-wage income. It is expected that 40 percent of the population would be exempted from paying any fees because of limited ability to pay.

Table B. shows that revenue generated by the proposed fees for inpatient and delivery services is expected to be small relative to the MOH recurrent budget. In this case the higher fee estimate corresponds to the HFM proposal. The revenue estimates amount to the equivalent of only 0.7 percent (low estimate) and 1.2 percent (high estimate) of the recurrent budget.

Similarly, the burden that inpatient and delivery charges would put on household budgets is, on average, low (see Table C). For both mean-income and minimum-wage households, average annual expenditures would be less than one-half of one percent of income for either lower or higher fees.

Hospitalization and, to a certain extent, delivery do not occur "on average", however. Thus, it is useful to examine the burden imposed on a household by paying inpatient and delivery fees in a single year. The third through sixth columns of Table C do this. The average Kenyan family of six experiences less than one hospitalization per year. Those that do have a five days or more of hospitalization in a sub-center or dispensary) to Kshs. 500 (high estimate of five days or more at KNH). Delivery costs could range from Kshs. 20 to 60, except where the household elects to bypass the referral system to go directly to a Provincial Hospital or KNH.

For households with a mean income, the costs of hospitalizations and deliveries would not be a major burden. The share of household income needed to cover these costs never exceeds 1.5 percent. Such a household faced with a delivery and two hospitalizations, one at a Provincial Hospital and another at KNH, would pay a maximum of 2 percent of annual household income.

For households with a single minimum wage earner, the burden of paying for delivery and hospitalizations would be greater, but probably within reason. Only for hospitalizations at KNH would the burden on annual income exceed 1.6 percent. Even this burden is largely mitigated by the likelihood that such households would be exempt from payment at KNH (only 30 percent are expected to pay the higher fees and 40 percent of the lower fees). To compare this to other developing countries, P. Gertler and J. Van der Goog (7) have shown that is reasonable to expect approximately 5% of income to be spent on medical care.

One likely response to the introduction/expansion of cost sharing in the public sector will be increased demand for care delivered in the private sector. While this may mean less revenue generated for the public sector, this is likely to be offset by a reduction in the number of patients served. To a large extent, however, the demand response to various cost-sharing measures will not be known until tried. On the basis of analyses done to date, it is reasonable to assume that at least 10 percent of the recurrent budget of the MOH can be recovered through a combination of cost-sharing measures by completion of this Program when the system is fully implemented nationwide. A phased approach to the introduction of cost sharing will be implemented. Therefore, these higher levels of generated income would not be expected until the final year of the proposed Program when the system has been implemented nationwide to all MOH facility levels (See Annex I.3. World Bank/USAID HFM Aide Memoire).

A study financed by the Swedish International Development Agency (SIDA) suggested considerable potential for revenue generation through a restructured and expanded NHIF. However, the analysis performed by the HFM concluded that at this stage NHIF is not administratively ready to handle an expansion of contributors, and that further analysis is needed to determine its ability to provide additional revenue to the MOH for service provision. Information about the proportion of NHIF contributors who use MOH hospitals is not available, but is estimated to be low. Thus, reliance on NHIF as a significant source of revenues for the MOH on a reimbursement for services basis in the short-term would be risky.

However, as cost sharing especially for inpatient care, is initiated, both private and public risk-sharing mechanisms like NHIF will become more important. In addition, a modified role for NHIF in financing health care beyond hospitalization reimbursement and in financing the private sector will be addressed under this Program. Further analysis of the NHIF as a potential source of increased resource mobilization is planned.

Not only will the introduction of cost sharing in MOH facilities eventually generate significant new financial resources, but institutional resources will also be increased through training and organizational development. The Program will assist the three beneficiary institutions to enhance their organizational, operating and strategic capacities and their personnel's skills and experience. In addition, by involving local consultants, particularly from the academic community, in the provision of technical assistance during the Program, another reservoir of skills will be accumulated.

Improved efficiency in the health system will allow more health to be produced using given limited resources. Efficiency improvements are expected from improved coordination of all resources of health resources, reallocations within the MOH budget, more appropriate use of MOH facilities by consumers, and better use of resources through decentralized control. The Program will assist in strengthening the coordination of the use of health-sector resources from public, parastatal, private, community and external resources. Resource reallocations within the MOH budget from non-primary curative to primary and preventive services and from personnel to non-wage recurrent costs will bring these items into balance and allow more and better services to be provided. The cost-sharing fees will be structured and referral procedures strengthened to discourage use of high-cost hospitals when lower-level facilities are more appropriate. Cost-sharing

revenues are to be retained and used following guidelines by the earning facilities and their districts. This decentralization of allocation decisions is expected to result in efficient uses of the funds generated.

Substantial additional resources for the MOH system can be expected to be generated by the fees proposed by the HFM. This can be achieved by imposing a reasonable burden on mean income households and by exempting lower-income households, such as those with a single minimum-wage earner. The additional resources expected to be produced by outpatient and delivery fees are smaller. The burden of such fees on household income are small on average. Even when a mean-income household is faced with two relatively expensive hospitalization and a delivery in the same year, the burden would be reasonable. For the minimum-wage households, only the burden of hospitalization at KNH would be heavy. It is likely that such households would be exempt from payment.

All of these results of the KHCF Program will contribute to the overall improvement of health status. For example, additional financial resources can be used to build new facilities to reach underserved populations or to improve supplies and maintenance for existing facilities. Enhanced human resources will provide better care to patients and improve the overall operations of the sector. Reallocating resources toward more cost-effective services will utilize limited resources in the most efficient way, and will also promote primary and preventive services, of which important consumers are women and children. A shift in resources toward non-wage recurrent costs will provide needed supplies, especially drugs, a lack of which currently is a major constraint within the health sector.

It is also clear that the efficiency improvements expected from better coordination, decentralized control of resources, improved organizational capacity, and a more national budget allocation system will increase the cost-effectiveness of health sector resource utilization in Kenya. In conclusion, in terms of revenues generated and improved efficiency, the anticipated Program benefits are greater than the costs.

## II. Social Analysis: Kenya Health Care Financing Program

### A. Introduction

A principal objective of the Kenya Health Care Financing Program is to support the Government of Kenya in introducing user fees within the public health system as one means of placing the public health system on a sound financial footing. From a social perspective the following questions arise:

-- What are the main socio-economic factors influencing the utilization of health services?

-- Would people be willing to pay for government health services?

-- What proportion of people would be able to pay fees for treatment?

-- How is the introduction of user fees in public health facilities likely to influence patterns of use as regards government and non-government health services generally?

-- What can be done about those who are too poor to pay any additional user fees?

This report provides preliminary answers to these questions, drawing primarily upon the results of two studies: the Nairobi Area Survey (NAS), a facility-based study which assessed patterns of health-seeking behavior in the Nairobi urban area, and the Meru Area Survey (MAS), a community-based study which assessed patterns of health-seeking behavior in rural areas of Meru District. On the basis of the Meru Area Survey, Section II summarizes findings with respect to rural areas. On the basis of the Nairobi Area Survey, Section III summarizes findings with respect to urban areas. A final section presents conclusions and recommendations.

## B. Health-Seeking Behavior in Rural Areas

There are no national-level studies assessing patterns of health-seeking behavior in rural Kenya. To provide a minimal basis for judging the likely impact of user fees in rural areas, A.I.D. and UNICEF collaborated in sponsoring a rapid, small scale household survey in rural areas of Meru District (Kirigia et al. 1989), where people have a choice between government facilities (zero or minimal fees) and private or church sponsored facilities, where fees are charged. Four communities were studied, two of them in the relatively wealthy maize-coffee zone in upper Meru District, and two of them in the relatively poor sorghum zone in lower Meru District. Although the results cannot be generalized for rural areas in the nation as a whole, they shed useful light on a broad range of relevant issues. Key findings are summarized below.

## 1. Income Level and Health Care Choices in Meru

Most people, including many of the very poor, are already using fee-for-service facilities in rural areas. Table 1 shows how choice of facility varies with level of income. Most rural households derive their income from several sources, including formal employment, casual labor, remittances, sales of commercial crops, informal marketing of agricultural produce, handicrafts, livestock, and animal products. The income figures below represent a composite of all these.

Table 1. Income Distribution and Facility Choice in Meru Area

| | Income Quartile 1 | 2 | 3 | 4 | |
|---|---|---|---|---|---|
| Monthly Income (KSH) | | | | | |
| Range: | 0-150 | 160-455 | 480-1167 | 1170-12950 | |
| Average: | 86 | 289 | 771 | 3064 | |
| Facility Choices | | | | | Total |
| Govt Hospital | | | | | |
| Number: | 2 | 7 | 1 | 3 | 13 |
| Percent: | 15% | 54% | 8% | 23% | 100% |
| Govt Clinic | | | | | |
| Number: | 19 | 18 | 7 | 5 | 49 |
| Percent: | 39% | 37% | 14% | 10% | 100% |
| Private Clinic | | | | | |
| Number: | 8 | 5 | 16 | 5 | 34 |
| Percent: | 24% | 15% | 47% | 15% | 100% |
| Mission Hospital | | | | | |
| Number: | 7 | 6 | 9 | 5 | 27 |
| Percent: | 26% | 22% | 33% | 19% | 100% |
| Mission Clinic | | | | | |
| Number: | 14 | 11 | 20 | 21 | 66 |
| Percent: | 21% | 17% | 30% | 32% | 100% |
| Self Care | | | | | |
| Number: | 5 | 6 | 6 | 10 | 27 |
| Percent: | 19% | 22% | 22% | 37% | 100% |
| Total | | | | | |
| Number: | 55 | 53 | 59 | 49 | 216 |
| Percent: | 25% | 25% | 27% | 23% | 100% |

Fully 53% of the people in the lowest income quartile chose some type of fee-for-service facility in seeking treatment for their most recent illness episode, as against 63% of the people in the highest income quartile. On average, people spend about 19% of their income on health care (including transportation to the health facility, services, drugs, and other incidental costs). Paying for care is not new, and even low income earners pay for care. To understand why so many people, even very poor people, prefer paying facilities, we need to consider how people perceive the quality of alternative health care facilities.

2. Quality and Facility Choice in Meru

Most people have a very poor opinion of government facilities, and a very good opinion of church-sponsored facilities. This is illustrated in Table 2.

Table 2. Perceived Quality of Health Services in Meru

| Rating | Government Hospitals | Mission Hospitals |
|---|---|---|
| Poor | 53% | 4% |
| Fair | 19% | 8% |
| Good | 25% | 64% |
| Excellent | 4% | 25% |

Over one-half of all households rated government services as "poor"; by contrast, 89% of all households rated mission facilities as "good" or "excellent". Reasons for disliking free facilities include lax and discourteous staff, dirty surroundings, long waiting time, favoritism and corruption, sharing of inpatient beds, irregular and poorly prepared food, and thorough-going lack of drugs. Mission facilities on the other hand are considered to provide courteous, friendly, and fast service, clean and ample facilities, extremely reliable drug supplies, good meals for in-patients, many doctors with specialized skills, and thorough diagnosis. People clearly perceive that free facilities are no bargain when the care provided is poor, and are willing to pay to get reliable health care. Given this strong preference for high-quality, paying facilities, what factors cause people to choose low-quality, free facilities? This question is taken up below.

## 3. Who Chooses Poor-Quality but Low-Cost Facilities?

The decision to choose a non-paying facility can--in theory--be influenced by a broad range of socio-economic considerations. We used a multivariate discrete choice model to assess the joint influence on this decision of the following socio-economic factors: income, primary education, secondary education, marital status, household size, gender, age, facility fees, facility quality, travel cost, travel time, waiting time, and distance. Of these, only income and travel time had a significant influence on facility choice. Higher income makes people much more likely to choose fee-for-service facilities, but as the time required to get there increases, the likelihood grows that people will choose nearer facilities even if the quality is poor. Gender, age, marital status, and level of education seem to have little if any independent influence on health care facility choice in rural areas. Since income figures so importantly in health care decision-making, we need to take a closer look at the effect user fees (in effect, a reduction in income) might have on health care choices.

## 4. The Impact of User Fees on Rural Utilization Patterns

In the analysis above, we examined the factors influencing the choice of paying or non-paying facilities. In reality, people have at least one additional choice when they are ill, and that is to care for themselves. The self-care option clearly needs to be taken into account as the cost of health care rises. Accordingly, we considered the influence that user fees would have on each of three choices: the self-care choice, the non-paying choice, and the fee-for-service choice. To do this, we estimated multivariate discrete choice models incorporating (alternatively) no increase in user fees at government facilities, a 20 shilling increase in user fees at government facilities, and a 50 shilling increase in user fees at government facilities. The results are presented in Table 3.

A government facility user fee of 20 shillings would lead to a very small decline in use of government facilities, but would lead to a substantial shift of patients from self-care to paying facilities. This

Table 3. Simulation of Effects of User Fees on Health Care Utilization Patterns in Meru

When User Fees = 0 Shillings:

| | | |
|---|---|---|
| (a) | Probability of Choosing a Government Facility | = 0.252 |
| (b) | Probability of Choosing a Mission Facility | = 0.572 |
| (c) | Probability of Choosing Self-Care | = 0.176 |
| | | 1.000 |

When User Fees = 20 Shillings:

| | | |
|---|---|---|
| (a) | Probability of Choosing a Government Facility | = 0.251 |
| (b) | Probability of Choosing a Mission Facility | = 0.676 |
| (c) | Probability of Choosing Self-Care | = 0.073 |
| | | 1.000 |

When User Fees = 50 Shillings:

| | | |
|---|---|---|
| (a) | Probability of Choosing a Government Facility | = 0.188 |
| (b) | Probability of Choosing a Mission Facility | = 0.752 |
| (c) | Probability of Choosing Self-Care | = 0.060 |
| | | 1.000 |

reflects the fact that patients who would previously have gone to government facilities for a consultation and prescription and then to a pharmacy for medicines would--if the cost of the government prescription increased--go directly to a paying facility. (Note: Payment for drugs [treatment] at a pharmacy was counted as self-care, even if a diagnosis took place first at a government facility. The explanation given is that a consultation [low cash cost] plus purchase of a drug at a pharmacy is currently lower that the total charge including drugs at a paying facility. As a fee is introduced at the government facility the total price for consultation plus drug now changes). A government facility user fee of 50 shillings would reduce utilization of government facilities by six percentage points and increase utilization of NGO facilities by 18 percentage points. Obviously, when people must pay for health care they will choose better quality service. Hence it seems likely that user fees in government facilities will lead to an important redistribution of patients within the rural health care system as people avoid the low-quality (but suddenly more expensive) government facilities.

## C. Health-Seeking Behavior in Urban Areas

The Nairobi Area Survey is a major facility-based study sponsored by A.I.D. in cooperation with other donors. It was designed to assess health-seeking behavior in Nairobi and contiguous areas. The results cannot be generalized to other urban and quasi-urban places in the nation as a whole, but nevertheless provide valuable insights on health care decision making in Kenya's largest urban center. Key findings are presented below.

### 1. Income Level and Health Care Choices in Nairobi

Government facilities are far more popular in Nairobi than they are in rural areas. Table 4 shows how choice of facility varies with level of income in the Nairobi urban area. It is worth noting that average income in the lowest urban quartile is roughly equal to average income in the lowest rural quartile (the income-measuring methodologies used in the two studies are more-or-less comparable). The prevalence of substantial poverty in urban areas calls into question the notion that it might be appropriate to impose user fees in urban areas to the exclusion of rural areas, and suggests as well that higher fees in urban areas would result in substantial inequities.

About 19% of the people in the lowest income quartile chose some type of fee-for-service facility in seeking treatment for their current illness episode, as against 27% of the people in the highest income quartile. The magnitude of the spread in utilization patterns across income quartiles is similar to what was observed in rural areas of Meru District, although many more people choose government facilities in the Nairobi urban area. Since incomes are--on average--higher in Nairobi, and government facilities are used more often, people spend far less of their income on health care--an average of about 1%, against 19% in Meru. To understand this general preference for government facilities we need to consider how urban people perceive the relative quality of the health services available to them.

### 2. Quality and Facility Choice in Nairobi

People have a far higher opinion of government facilities in Nairobi than in rural places, as illustrated in Table 5.

Table 4. Income Distribution and Facility Choice in Nairobi

| | Income Quartile 1 | 2 | 3 | 4 | |
|---|---|---|---|---|---|
| Monthly Income (KSH) | | | | | |
| Range: | 0-450 | 480-1304 | 1310-2300 | 2305-23776 | |
| Average: | 83 | 904 | 1777 | 5386 | |
| Facility Choices | | | | | Total |
| Govt Facility | | | | | |
| Number: | 249 | 246 | 221 | 226 | 942 |
| Percent: | 26% | 26% | 23% | 24% | 100% |
| Priv Facility | | | | | |
| Number: | 12 | 31 | 35 | 19 | 97 |
| Percent: | 12% | 32% | 36% | 20% | 100% |
| NGO Facility | | | | | |
| Number: | 47 | 34 | 57 | 64 | 202 |
| Percent: | 23% | 17% | 28% | 32% | 100% |
| Total | | | | | |
| Number: | 308 | 311 | 313 | 309 | 1241 |
| Percent: | 25% | 25% | 25% | 25% | 100% |

Table 5. Perceived Quality of Health Services in Nairobi

| Rating | Govt Facilities | Private Facilities | NGO Facilities |
|---|---|---|---|
| Poor | 4% | 12% | 6% |
| Fair | 27% | 36% | 17% |
| Good | 69% | 52% | 77% |

Of the 1100 people who expressed a judgment about the quality of services in alternative facilities, fully 96% rated government facilities as "fair" or "good"; NGO facilities scored about the same (94%). Private medical facilities actually scored lower than government facilities, although not dramatically so (88% "fair" or "good"). Indeed, when people were asked to identify specific problems with various facilities, their responses

revealed no significant differences among these three facility types. This close alignment in perceptions of quality undoubtedly reflects the relatively high quality of urban government facilities, especially when compared to government facilities in rural places. Since low-cost government facilities in Nairobi seem generally acceptable to a broad range of people, including the wealthiest, it may be worthwhile to explore the factors which cause people to choose high-cost health care facilities.

## 3. Who Chooses High-Cost Health Care in Nairobi?

A multivariate discrete choice model was employed to assess the relative strength of various socio-economic factors influencing the decision to choose particular health care facilities in Nairobi. Factors considered include the following: gender, age, education, household size, marital status, men's wage income, women's wage income, income from other sources, cost of service, and travel time. The results suggest that the people who choose paying facilities instead of government facilities are young and well-educated, and that, whether men or women, they have relatively substantial wage-paying jobs. Those who choose government facilities, whether men or women, tend to be older and less educated, and derive more of their income from non-wage sources, including informal sector activities, transfers from rural areas, and the like. As in rural Meru, gender seems to have no independent effect on health care decision making. Since a very large proportion of people use government health services in Nairobi, and since their income is often uncertain and relatively low, we need to take a close look at how user fees in government facilities might influence health care choices.

## 4. Impact of User Fees on Utilization Patterns in Nairobi

Because the Nairobi Area Survey is a facility-based study, it does not provide information about the relative frequency with which urban dwellers choose self-care in preference to trained medical assistance. This undermines the logic of simulated increases in user fees, since the self-care alternative cannot be included as a choice. Nevertheless some attempt to assess changes in utilization patterns accompanying the imposition of user fees is desirable. Table 6 presents illustrative information on costs and income across facility types by gender and marital status.

Table 6. Socio-Economic Variation and Health Care Decision-Making in Nairobi

| | Men | | Women | | |
|---|---|---|---|---|---|
| | Married | Single | Married | Single | Total |
| Number Attending | | | | | |
| Govt Facility: | 298 | 177 | 297 | 147 | 919 |
| NGO Facility: | 90 | 26 | 58 | 20 | 194 |
| Percent Attending | | | | | |
| Govt Facility: | 77% | 87% | 84% | 88% | 83% |
| NGO Facility: | 23% | 13% | 16% | 12% | 17% |
| Cost/Visit (KSH)* | | | | | |
| Govt Facility: | 114 | 56 | 19 | 33 | 59 |
| NGO Facility: | 190 | 141 | 65 | 58 | 128 |
| Income/Month (KSH) | | | | | |
| Govt Facility: | 2006 | 2097 | 1867 | 1963 | 1949 |
| NGO Facility: | 2928 | 2104 | 2304 | 2881 | 2578 |

* Includes the direct cost of transportation as well as (for wage-earners) the income not earned while travelling.

The key figures here are those comparing average cost per visit in government facilities with average cost per visit in NGO facilities. The difference between these average fees is greatest among men, and far less among women. Among single women, a 20 shilling user fee at public facilities would make the cost of care at these facilities roughly equivalent to the cost at NGO facilities. Among married women, a 50 shilling user fee increase would generate a similar equivalency in cost between public and NGO facilities. Among men (either married or single), even a 50 shilling user fee would leave them paying less at public facilities than at NGO facilities. Given this structure of utilization and expenditure, we can speculate that moderate user fees would provide an incentive for many women to shift to NGO facilities, where the costs would be equivalent and the service somewhat better. Probably fewer men would make the same shift. Although the direction of this change in utilization patterns is relatively certain, it is impossible to estimate magnitudes. However, public facilities in Nairobi are perceived relatively favorably--compared to public facilities in rural places--so the fee-induced switch from public to NGO facilities in urban areas would likely be of less consequence than what can be expected in rural areas.

## D. Conclusions and Recommendations

The findings of this analysis are applicable to Nairobi and environs with respect to urban areas, and to Meru District with respect to rural areas. However, Nairobi is the most important urban area in Kenya, and the rural areas of Meru District are characteristic of high- and medium-potential zones in Kenya, where most rural people live and cultivate. Hence these findings are unlikely to be grossly misleading. At the same time, we have not analyzed health care decision-making in pastoral areas, nor in the relatively poor districts found in Coast Province and Eastern Province, nor in the relatively wealthy districts found in Rift Valley and parts of Western Province. The findings reported here should be interpreted with caution.

- The demand for medical care is not influenced very strongly by moderate increases in service fees. Moderate increases in user fees at government facilities are therefore feasible, especially in rural places where people have access to high quality fee-for-service health care alternatives. However, there is evidence that lower income groups in both rural and urban areas may be more responsive to fee changes than the population as a whole. Hence the very lowest income groups, especially in urban areas, could suffer a reduction in access to health care when fees are imposed.

- As the Program proposes, user fees will be implemented, but with provision for forgiveness based on a individual-specific means test. Since there are extreme variations in ability to pay even within small communities, it would not make much sense to categorically exclude some or all rural dwellers. Neither would it be sensible to categorically include all urban dwellers, since many of them are poorer and more dependent on government facilities than the rural population. Therefore, as a priority, a review of the current fee waiver system will take place and a modified system implemented as cost sharing is introduced. Access to health care will be monitored to assure service to the poor.

- In the rural areas, the means test might be administered by local sub-chiefs, who know the people living in their areas far better than government health personnel. To avoid subjective

interpretations, the means test should be based on easily verifiable empirical indicators closely related to income streams: does the person (or spouse) have a wage job? Does the person (or spouse) own dairy cattle? Does the person (or spouse) have more than one-half hectare planted to tea, coffee, cotton, pyrethrum, tobacco, vegetables? Under some circumstances, married women with responsibilities for child care may benefit little from money controlled by husbands; this will ordinarily be known by sub-chiefs, community development workers, and leaders of women's groups at the local level, and can be specifically incorporated into the means test.

- If fees are imposed at government facilities but quality stays the same, there will be a substantial shift of rural clientele away from low-quality public health services towards higher-quality church-sponsored facilities. The shift will be less significant in urban areas, where the difference in quality between government and non-government facilities is less profound.

- The GOK plans to upgrade quality in rural government facilities before or concurrently with the introduction of cost sharing to avoid placing an unbearable burden of service on the non-government health sector. As a start, a proportion of the increased revenue from user fees will be allocated to the facilities where they are collected, which would simultaneously improve quality and provide staff incentives for better performance.

- Travel time is a significant consideration in rural people's health care choices, sometimes outweighing the effects of either cost or quality. Rural people will choose nearby, costly facilities over distant free facilities, and they will choose nearby, low-quality facilities over those that are of higher quality but more distant.

- As one key analysis planned, the GOK will review the role of all health providers within the health care delivery system as well as its own investment strategy for further development of health facilities. One result may be that some proportion of the increased revenue from user fees could be used to expand coverage of the health care system, probably by providing incentives for an expansion of the private health sector into rural areas.

- Gender has no independent influence on health care decision-making in either urban or rural areas. Age and education make a difference in urban areas, where older and less educated people tend to choose government facilities independently of income level. Higher income, especially wage income, influences people to choose fee-for-service facilities in both rural and urban places.

- Health care financing reform can be undertaken without anticipating grossly inequitable impacts on women in rural or urban areas. The GOK must make a special effort to accommodate the needs of the elderly, especially in urban areas. Fee forgiveness for the elderly could be implemented with little difficulty and may become part of the waiver system. For the general population, some type of income-based means test should be devised to avoid imposing impossible burdens on poor people.

## III. Additional Studies/Research Required

As noted in the monitoring and evaluation plan (Section III.G) continued analysis and policy dialogue will be maintained as an integral part of this Program. Several key areas of continued impact analysis with assumptions and utility are noted below. All of this research will provide information on the economic impact of reforms carried out by or considered within this Program, and will provide the basis upon which to make improvements, and to evaluate the ability of the Program to meet its goals.

### A. Waiver Systems

There exists significant concern as to the effect of cost sharing on the low income segment of the population. The institution of fees at all levels of facilities will impose a cost on all, and it is possible that that cost will be insurmountable for some. However, steps will be taken to minimize the effects on them. The waiver system currently in place will be strengthened and monitored on an ongoing basis to protect those unable to pay. Moreover, a system of referrals from lower to higher level facilities will enable patients to receive the appropriate level of care without having to incur additional costs.

### B. Health Strategy/Monitoring

The major piece of analysis to be done during the Program is a study of the role of all of the actors within the

health sector as part of the design of a comprehensive health financing strategy. As initial reforms are begun within the sector, particularly the institution of cost-sharing measures, they will have an impact on the relationships among the various entities, including the public sector, parastatals, the private sector, the community, and foreign donors. These relationships will require re-examination in the context of the changing environment. The analysis will consider lack of the actors' abilities to provide different types of services and to finance their investment and operating costs, and establish criteria for subsidizing particular types of services (preventive, promotive, chronic illness) as well as certain groups and geographic areas. From this analysis, an agenda for additional health financing reforms will be developed.

In addition to this comprehensive study, several pieces of research will be carried out during the course of the KHCF Program. A series of studies will be undertaken to measure the sector's ability to ensure access to all segments of the population. This will consist of a baseline study at the outset of the Program, and annual follow-up studies to determine whether access to health services has changed. Where measures designed to ensure access are not working as intended, recommendations will be made for modification. In a similar vein, a cost-sharing monitoring system will be established to track changes in utilization of service and the types of consumers using health facilities. Both of these measures will seek to understand the impact of the reforms on the population.

C. Financial Impact

Three sets of studies will also be conducted to determine the fiscal impact of the financing reforms. One set of analyses will examine the allocation of resources by the GOK (e.g., among primary and preventive versus curative services, or amount personnel and non-wage operating costs). Another set will analyze the expenditure of cost-sharing revenues by earning facilities and District and Provincial Health Management Teams. A third set will evaluate the performance of the cost-sharing system, make new projections for the amount of revenues to be generated, and recommended adjustment fees as necessary. In addition to their use in determining the fiscal effects of the reforms during the life of the program, it is intended that these analyses become institutionalized as analytical tools for the MOH.

D. National Hospital Insurance Fund

Under this program, changes are proposed in the NHIF contributions and benefits scheme. Contributions, above the minimum of 30 shillings ($1.50) per month, will be two percent of income to a maximum of 380 shillings ($19). This represents an increase of between 50 and 1900% of the original contribution of a flat fee of Kshs. 20 per month. As the minimum salary for mandatory contribution to the scheme is Kshs. 1000/month, individuals earning between Kshs. 1000 and Kshs. 1499 per month will pay more than 2% to a maximum of 3% of income per month. However, as benefits are standardized and unrelated to contributions clients at these levels are more heavily subsidized by NHIF when they access care (benefits are more often greater than contributions, particularly given proposed new benefit levels). Therefore, the fee structure is not necessarily regressive.

An employer contribution is also approved of an amount equivalent to 10% of the amount contributed by the employee. This amount is set at a nominal level as the impact of this mandatory contribution on employment has not been determined. Under the Program, potential impact of higher levels of employer contributions will be assessed.

Currently, very little reimbursement is made to the public sector. Under the Program, MOH institutions will be provided incentive to seek reimbursement; however, within the income profile, the NHIF status of clients utilizing MOH facilities is not known. Therefore, the potential impact of this measure on the financial status of NHIF and/or the MOH cannot be assessed. The Program will include a means for monitoring the level of NHIF benefits provided to each type of provider and will be able to assess changes in groups provided benefits over the period of the Program.

Proposed increases in benefits paid by NHIF are substantial, in many cases representing doubling of the current schedule. As the proposed schedule is not directly linked to costs, increased benefits could be inflationary, particularly where NHIF represents a large portion of an institution's financing. As a part of the Program, a study will be conducted to develop a mechanism for assessing cost and quality of service provision in order that benefits can be more directly linked and, therefore, exert fewer inflationary pressures on the system.

In addition, in order to move to a more comprehensive NHIF strategy two further analyses will be undertaken. One will address the benefit options to be offered and the premiums associated with each, and assess the current potentially insurable populations. A second will analyze the effects of mandatory employer insurance contributions on labor markets.

E. Improved Efficiency in Utilization

The Program will impact efficiency in utilization in at least two ways. First, more appropriate use of the referral system is expected as proposed fees associated with initially accessing any given institution rise significantly with the level of the institution. Unfortunately, to date the referral system and its use have not been analyzed. Therefore, no quantitative estimates of revenue to be saved by appropriate use can be developed. Prior to implementation of the Program, however, review and improvement of the referral system will be undertaken. Baseline data will be collected and the effects of cost-sharing on appropriate utilization monitored. Potential savings will be calculated and attainment assessed at the mid program and final evaluations, respectively.

Second, more efficient resource utilization will result from implementation of a cost-accounting system at KNH which will assist managers in monitoring and standardizing resources provided for treatment of patients. Again, quantitative measures of the impact of this element are difficult in the absence of a cost-accounting system. However, in the final two years of the Program and beyond, information to evaluate changes in resource utilization will be available through the new system.

F. Kenyatta National Hospital

In addition to the impact of KNH reforms as it applies to the general reforms related to the MOH system, feasibility studies and cost analyses will be done for private wing services as well as for the doctors' practice plan. These studies will examine the ability of these services to generate income and to be self-sustainable. Further, methods will be developed for procedures reviews and applied in six key departments providing specialized services.

G. Private Sector

47% of health sector recurrent costs are incurred in the private sector. Roughly half of this expenditure represents payment of drugs to retain pharmacies and dispensing physicians. The remainder covers payments for service to individuals physicians and institutions in the private for profit and not-for-profit sectors.

33% of hospital bed and 18% of clinic facilities are managed by church-related or the for-profit private sector. These institutions charge fees for service which cover or exceed their net operating costs.

Evidence from a demand study recently conducted in Meru District suggests that a major impact from the proposed changes in the short-run will be that clients will move from the public sector for the private sector as the price of public sector care moves closer than that of the private care. In particular, an increased demand for services from clients in those income groups which are often waived from fees at mission institutions may be place and added burden on private sector care. As quality is increased in the public services, however, many of these clients with less ability to pay are expected to return to the lower private MOH facilities. A detailed review of the private health sector is proposed under the program in order to further assess the impacts of reforms.

IV. OVERALL IMPACT

The Program is designed to result in improved health status and reduced fertility for the Kenyan population in the medium and long term (4-15 years). Improved financial sustainability of the system and substantially increased funding for preventive and promotive programs will impact overall health status and access to family planning. The MOH absorptive capacity for utilizing donor financing will be increased through more efficient operations and increased management capability, making donor financing more effective in reaching demographic and health targets. Quantification of this impact will be measured through periodic demographic and health surveys over the long-term.

In addition, reallocation of the health budget will be a step in overall MOH budget rationalization. As this is a long-term goal, this will be measured through economic analyses as Kenya

continues in the GOK budget rationalization program.

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(1) C. Griffin, "1988 World Bank Study". (2) R. Vogel, "Cost Recovery in four West African Countries", (3) R. Vogel, "Estimates of Revenues Generated - Kenya", World Bank Paper, May 1989, (4) "Review of Expenditure Issues and Options in Health Financing", World Bank, 1988, (5) Dr. Abel-Smith, "Discussion Paper on Issues and Options in Health Financing", SIDA, January 1988, (6) R. Ellis, "Revenue Generating Potential of User Fees in Kenya Government Facilities", 1987, (7) P. Gertler and J. Van der Goog, "The Willingness to Pay for Medical Care. Evidence from Two Developing Countries", John Hopkins Press, Forthcoming.

Tables A-C and attached notes.

ATTACHMENT 1 to
IMPACT ANALYSIS

Table A: Outpatient Revenue Estimates

| Fee Level | Annual Revenue Generated | Percent of MOH Recurrent Budget | Proportion of Income: Mean Income HH | Proportion of Income: Minimum Wage HH |
|---|---|---|---|---|
| Sub-District Hospitals, Health Centres, Sub-Centres, and Dispensaries: | | | | |
| Low Est | 130.2 | 6.7% | 0.6% | 2.1% |
| High Est | 194.8 | 10.1% | 1.0% | 3.7% |
| District Hospitals: | | | | |
| Low Est | 70.2 | 3.6% | 0.3% | 1.1% |
| High Est | 140.0 | 7.2% | 0.7% | 2.6% |
| Provincial Hospitals: | | | | |
| Low Est | 13.6 | 0.7% | 0.1% | 0.2% |
| High Est | 25.4 | 1.3% | 0.1% | 0.5% |
| Total Outpatient: | | | | |
| Low Est | 214.0 | 11.0% | 0.9% | 3.5% |
| High Est | 360.2 | 18.6% | 1.8% | 6.8% |

Assumptions Used in PAAD Estimates:

| Low Fee Estimate | Higher Fee Estimate | |
|---|---|---|
| | | Sub-Dist Hosp, Hlth ctrs, Hlth sub-ctrs, & Disp: |
| 5 | 15 | KShs = registration fee |
| 10 | 15 | KShs = charge for drugs |
| 15 | 30 | KShs = total expected cost-sharing payment |
| | | District Hospitals: |
| 20 | 40 | KShs = registration fee |
| 10 | 40 | KShs = charge for drugs |
| 30 | 80 | KShs = total expected cost-sharing payment |
| | | Provincial Hospitals: |
| 30 | 50 | KShs = registration fee |
| 10 | 50 | KShs = charge for drugs |
| 40 | 100 | KShs = total expected cost-sharing payment |

| | | |
|---|---|---|
| | | Annual outpatient visits: |
| 37,575,000 | 37,575,000 | Sub-Dist Hosp, Hlth ctrs, Hlth Sub-ctrs, & Disp |
| 10,125,000 | 10,125,000 | District Hospitals |
| 1,470,000 | 1,470,000 | Provincial Hospitals |
| 20% | 20% | Proportion follow-up visits for same episode |
| | | Annual outpatient episodes: |
| 30,060,000 | 30,060,000 | Sub-Dist Hosp, Hlth ctrs, Hlth sub-ctrs, & Disp |
| 8,100,000 | 8,100,000 | District Hospital |
| 1,176,000 | 1,176,000 | Provicial Hospitals |
| 92.5% | 80.0% | proportional demand response for proposed fees |
| 25% | 25% | patients under 5 years and exempt from payment |
| 60% | 60% | adult patients able to pay |
| 75% | 75% | of eligible revenue will be captured by government |
| | | Annual Outpatient Episodes/Person with Access/Year: |
| 3.0 | 2.6 | Sub-Dist Hosp, Hlth ctrs, Hlth sub-ctrs, & Disp |
| 0.8 | 0.7 | District Hospitals |
| 0.1 | 0.1 | Provincial Hospitals |
| 42% | 42% | percent of population with access to a health centre or dispensary |
| 27.8 | 24.0 | million outpatient visits per year |
| | | Avg Annual HH Outlay (KShs): |
| 203 | 351 | Sub-Dist Hosp, Hlth ctrs, Hlth sub- 60 percent |
| 109 | 252 | District Hospitals |
| 21 | 46 | Provincial Hospitals |
| 334 | 650 | Total Avg Ann HH Outlay (KShs): |
| 6.0 | 6.0 | average household size |
| 22 | 22 | million = total population |
| 500 | 500 | KShs = monthly per capita income = $300 annual income |
| 800 | 800 | KShs = monthly minimum wage = $480 annual income |
| 1,938 | 1,938 | million KShs MOH 1988 Recurrent Budget |

Table B: Inpatient Revenue Estimates

| Fee Level | Annual Revenue Generated | Percent MOH Recurrent Budget | Proportion of Income: Mean Income HH | Minimum Wage HH |
|---|---|---|---|---|
| Lower Fee Est | | | | |
| Sub-ctrs & Disp | 1.4 | 0.1% | 0.01% | 0.02% |
| HC & sub D Hosp | 3.4 | 0.2% | 0.01% | 0.04% |
| Dist Hosp | 6.3 | 0.3% | 0.02% | 0.06% |
| Prov Hosp | 2.9 | 0.1% | 0.01% | 0.03% |
| KNH | 3.3 | 0.2% | 0.01% | 0.04% |
| Tot (less KNH) | 14.0 | 0.7% | | |
| Tot (incl KNH) | | | 0.05% | 0.20% |
| Higher Fee Est | | | | |
| Sub-ctrs & Disp | 2.2 | 0.1% | 0.01% | 0.04% |
| HC & sub D Hosp | 5.9 | 0.3% | 0.02% | 0.09% |
| Dist Hosp | 10.6 | 0.5% | 0.03% | 0.13% |
| Prov Hosp | 4.6 | 0.2% | 0.02% | 0.06% |
| KNH | 5.0 | 0.3% | 0.02% | 0.07% |
| Tot (less KNH) | 23.2 | 1.2% | | |
| Tot (incl KNH) | | | 0.10% | 0.39% |

Assumptions Used in PAAD Estimates:

| Low Fee Estimate | Higher Fee Estimate | |
|---|---|---|
| | | Bed days per year: |
| 1,095,000 | 1,095,000 | Health centres and sub-District Hospitals |
| 2,117,000 | 2,117,000 | District Hospitals |
| 1,131,500 | 1,131,500 | Provincial Hospitals |
| 658,460 | 658,460 | Kenyatta National Hospital |
| | | Daily fees (up to a maximum of five days) (KShs): |
| 5 | 10 | Health centres and sub-District Hospitals |
| 10 | 20 | District Hospitals |
| 15 | 30 | Provincial Hospitals |
| 50 | 100 | Kenyatta National Hospital |

| | | |
|---|---|---|
| | | Deliveries per year (ALOS): |
| 116,308 | 116,308 | Health sub-centres and dispensaries (1) |
| 144,948 | 144,948 | Health centres and sub-District Hospitals (2) |
| 80,682 | 80,682 | District Hospitals (3) |
| 6,601 | 6,601 | Provincial Hospitals (3) |
| 733 | 733 | Kenyatta National Hospital (5) |
| | | Delivery fees (KShs): |
| 20 | 40 | Health sub-centres and dispensaries |
| 25 | 50 | Health centres and sub-District Hospitals |
| 30 | 60 | District Hospitals |
| 50 | 100 | Provincial Hospitals |
| 100 | 200 | Kenyatta National Hospital |
| 42% | 42% | population with access to services |
| 54 | 54 | Crude Birth Rate |
| 22 | 22 | million = Total Population |
| 1.2 | 1.188 | million births per year |
| 30% | 30% | proportion of deliveries in private-sector facilities |
| 349,272 | 349,272 | births in health facilities per year |
| 6.0 | 6.0 | Family size |
| | | Facility of Initial Entry for Delivery (prop to outpatient visits): |
| 129,231 | 129,231 | Health sub-centres and dispensaries |
| 146,694 | 146,694 | Health centres and Sub-District Hospitals |
| 73,347 | 73,347 | District Hospitals |
| 0 | 0 | Provincial Hospitals |
| 0 | 0 | Kenyatta National Hospital |
| 10% | 10% | Deliveries referred to higher level |
| 95% | 80% | proportional demand response for proposed fees |
| 25% | 25% | patients under 5 years and exempt from payment |
| 75% | 75% | of eligible revenue will be captured by government |
| | | Adult patients able to pay: |
| 75% | 60% | Health sub-centres and dispensaries |
| 70% | 60% | Health centres and sub-District Hospitals |
| 60% | 50% | District Hospitals |
| 50% | 40% | Provincial Hospitals |
| 40% | 30% | Kenyatta National Hospital |
| | | Chargeable days: |
| 100% | 100% | Health centres and sub-District Hospitals |
| 100% | 100% | District Hospitals |
| 80% | 80% | Provincial Hospitals |
| 50% | 50% | Kenyatta National Hospital |
| 500 | 500 | KShs = monthly per capita income = $300 |
| 800 | 800 | KShs = monthly minimum wage = $480 |
| | | N.B. min wage as percent of mean HH income = 13% |

| | | |
|---|---|---|
| | | Average Length of Stay (days): |
| 5.00 | 5.00 | Health centres and sub-District Hospitals |
| 5.00 | 5.00 | District Hospitals |
| 6.25 | 6.25 | Provincial Hospitals |
| 10.00 | 10.00 | Kenyatta National Hospital |
| | | Expected Annual HH Spending at Each Level (KShs): |
| 2 | 4 | Health sub-centres and dispensaries |
| 4 | 8 | Health centres and sub-District Hospitals |
| 6 | 12 | District Hospitals |
| 3 | 6 | Provincial Hospitals |
| 3 | 7 | Kenyatta National Hospital |
| 19 | 38 | Total Expected Annual HH Inpatient Spending (KShs) |

Table C: Measures of Spending on Inpatient Health Services Required by the Proposed Fee Schedules (KShs)

| | Expected Annual HH Spending (a) | | Expected Maximum Expend Inpatient | | Expected Maximum Expend Delivery | |
|---|---|---|---|---|---|---|
| | Low Est | High Est | Low Est | High Est | Low Est | High Est |
| Sub-ctrs & Disp | 2 | 4 | - | - | 20 | 40 |
| HC & sub D Hosp | 4 | 8 | 25 | 50 | 25 | 50 |
| Dist Hosp | 6 | 12 | 50 | 100 | 30 | 60 |
| Prov Hosp | 3 | 6 | 75 | 150 | 30 | 60 |
| KNH | 3 | 7 | 250 | 500 | 30 | 60 |
| Total | 19 | 38 | | | | |

Measures of Ability to Pay for Health Services Under the Proposed Fee Schedules (expenditures as a percent of annual household income)

For households with mean annual per capita income (US$ 1,680 or KShs 33,600):

| | Expected Annual HH Spending (a) | | Expected Maximum Expend Inpatient | | Expected Maximum Expend Delivery | |
|---|---|---|---|---|---|---|
| | Low Est | High Est | Low Est | High Est | Low Est | High Est |
| Sub-ctrs & Disp | 0.01% | 0.01% | | - | 0.1% | 0.1% |
| HC & sub D Hosp | 0.01% | 0.02% | 0.1% | 0.1% | 0.1% | 0.1% |
| Dist Hosp | 0.02% | 0.03% | 0.1% | 0.3% | 0.1% | 0.2% |
| Prov Hosp | 0.01% | 0.02% | 0.2% | 0.4% | 0.1% | 0.2% |
| KNH | 0.01% | 0.02% | 0.7% | 1.4% | 0.1% | 0.2% |
| Total | 0.05% | 0.10% | | | | |

For households with one minimum wage earner (US$ 480 or KShs 9,600):

| | Expected Annual HH Spending (a) | | Expected Maximum Expend Inpatient | | Expected Maximum Expend Delivery | |
|---|---|---|---|---|---|---|
| | Low Est | High Est | Low Est | High Est | Low Est | High Est |
| Sub-ctrs & Disp | 0.02% | 0.04% | | | 0.2% | 0.4% |
| HC & sub D Hosp | 0.04% | 0.09% | 0.3% | 0.5% | 0.3% | 0.5% |
| Dist Hosp | 0.06% | 0.13% | 0.5% | 1.0% | 0.3% | 0.6% |
| Prov Hosp | 0.03% | 0.06% | 0.8% | 1.6% | 0.3% | 0.6% |
| KNH | 0.04% | 0.07% | 2.6% | 5.2% | 0.3% | 0.6% |
| Total | 0.20% | 0.39% | | | | |

(a) Defined as the amount the average household would be expected to pay annually for inpatient services, given the probabilities of being hospitalized at each level and of delivering. It is assumed for these calculations that all households would pay and that the maximum charge for hospitalizations would be incurred (i.e., that the length of stay would be five days or longer).

## Poverty Index

Brian Abel-Smith[1] rejects the feasibility of user payments for health services in Kenya because of the difficulty he sees in exempting the poor from payment. Abel-Smith suggests that assessment of which households are poor is extremely complex in Kenya, particularly in rural areas. Further, he cites the Central Bureau of Statistics (CBS) and UNICEF[2] as sources when describing the extent of poverty in Kenya.

The reasons given by Abel-Smith for the difficulty of assessing poverty assume that methods used in developed countries (e.g., calculations of the monetary value of output) would have to be applied in Kenya. This ignores the findings reported in the CBS/UNICEF document on the correlates of poverty.

Some combination of the correlates of poverty could be used to identify who is poor so that they may be exempted from payment for health services. Each of the following was associated with poverty to the extent indicated in parentheses:

- Head of household never attended school (27 percent poor)
- Household does not grow maize (54 percent)
- Land holding less than or equal to 0.5 hectare (32 percent)
- Miles to dry season water source greater than or equal to 2.0 miles (41 percent)
- No marketed agricultural production (36 percent)

As an example, questions about these items could be asked of those coming for health services who claim an inability to pay. Answers indicating poverty on, say, three or more of the questions might be used to grant an exemption.

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[1] B. Abel Smith, "Discussion Paper on Issues and Options in Health Financing", January 1988.

[2] Central Bureau of Statistics and UNICEF, Situation Analysis of Children and Women in Kenya, Section 1, 1984.

## Estimates of Revenue and Ability to Pay

### Revenue Estimates

The estimates of revenue generation potential prepared for the PAAD use the fee schedule proposed by the HFM and alternatives. The revenue estimates for outpatient services are shown in Table A and those for inpatient services, including deliveries, are shown in Table B. Estimated revenue is shown as a proportion of the MOH recurrent budget for 1988. This is done to indicate the relative order of magnitude of additional resources to be produced by cost sharing. Rough measures of ability to pay also are shown in Table A and B. Table C shows some additional information on ability to pay for inpatient services and deliveries.

### Assumptions Used in Making the Revenue Estimates

Key assumptions underlying the revenue estimates include utilization of services (inpatient bed days, deliveries, and outpatient visits), proportion of the population with physical access to services, the demand response to user charges, the proportion of services consumed by children under age five years and exempt from payment, the proportion of patients able to pay for services (or, conversely, the proportion of patients to be exempted from payment because of limited ability to pay), and the proportion of potential user payments actually collected by the health system.

The in- and outpatient utilization data used in the PAAD estimates come from the MOH, as reported in World Bank, "Review of Expenditure Issues and Options in Health Financing," July 1988. Outpatient revenues are estimated assuming that 20 percent of utilization is for follow up visits for a single Household Level: Results of a Rural Health Survey in Kenya, "Social Science and Medicine, 1986). The fee schedule proposed by the HFM calls for a single charge per episode of illness.

The number of deliveries performed in MOH facilities was estimated using the crude birth rate for Kenya published by UNICEF (UNICEF, State of the World's Children, 1989), the population with access to health facilities, and assumptions about the proportion of deliveries taking place at each level. In the absence of more-precise data it is assumed that deliveries are done at different levels proportionate to the number of outpatient visits at each, with 10 percent of cases referred upward from District to Provincial and Provincial to Kenyatta National Hospital. Note that the revenue estimates are calculated on the conservative assumption that fees are paid at the level of entry into the system and that all deliveries enter at the District Hospital level or lower. It is assumed that 30 percent of deliveries are done in the private sector, in line with the proportion of hospital beds under private sector control.

The proportion of the population with physical access to health services comes from the MOH finding that 42 percent of the population lives within one hour's walk of a primary care facility. The fee schedule proposed by the HFM provides that children under age five years be provided services at no charge. It is assumed that 25 percent of in- and out-patient services are provided to under fives.

The adjustments made for the proportional demand response roughly follow Ellis (R. Ellis, "The Revenue Generating Potential of User Fees in Kenyan Government Health Facilities", Boston University, 1987). These are the adjustments made for reduction in utilization resulting from the introduction of user charges. The effect on utilization is greater the higher are the user charges.

The estimates of the proportion of the population able to pay for services is based on Abel-Smith's (extremely conservative) assertions about ability to pay. Abel-Smith says that 50 percent of the population would be unable to pay charges at KNH higher than those proposed by the HFM. (B. Abel-Smith, "Discussion Paper on Issues and Options in Health Financing," January 1989.) The PAAD projections use ability to pay proportions of 75 percent for the lowest fees charged for inpatients (KShs 5 per day to a maximum of KShs 25 at Health sub-centres and dispensaries) to 30 percent for the highest fees charged at KNH (KShs 100 per day to a maximum of KShs 500 at KNH).

The government is expected to collect 75 percent of potential user payments, the figure used by Ellis, Abel-Smith, and the World Bank.

Assumptions Used in Assessing Ability to Pay

For each of the fee schedules used to make revenue estimates an estimate was made of the burden that they would impose on households' incomes. Two measures of household income were used for this purpose: mean household income and the income generated by one worker paid at the minimum wage. The mean household income is calculated as the annual per capita income for Kenya, $US 300 (UNICEF, State of the World's Children, 1989), multiplied by the average family size, 6.0 persons. This estimate of income represents a household that is better off than the medium income family, since the distribution of income in Kenya is skewed toward the upper end. The second measure, called here the minimum wage household, represents a household in the lower end of the income distribution. Such a household has only 27 percent of the income of the mean income household. It is expected that such households would be exempted from paying most, if not all, health fees.

Annex C
Table 1

Ministry of Health Recurrent Expenditures (Selected Functional Categories)
(Kf million)

| | | Curative Health | Preventive/Promotive Health | Rural Health | Training |
|---|---|---|---|---|---|
| FY 82 | Budgeted | 39.5 | 3.8 | 4.9 | 3.1 |
| | Actual | 42.7 | 2.7 | 4.9 | 3.5 |
| | Spending Ratio | 108.1 | 71.1 | 100.0 | 112.9 |
| FY 83 | Budgeted | 40.2 | 3.1 | 6.5 | 4.1 |
| | Actual | 44.4 | 2.8 | 5.7 | 3.6 |
| | Spending Ratio | 110.5 | 90.3 | 87.7 | 87.8 |
| FY 84 | Budgeted | 40.9 | 3.2 | 6.5 | 4.4 |
| | Actual | 44.7 | 2.7 | 4.5 | 3.6 |
| | Spending Ratio | 109.3 | 84.4 | 69.2 | 81.8 |
| FY 85 | Budgeted | 45.6 | 4.0 | 6.6 | 4.8 |
| | Actual | 48.6 | 2.9 | 4.2 | 3.8 |
| | Spending Ratio | 106.6 | 72.5 | 63.6 | 79.2 |
| FY 86 | Budgeted | 53.4 | 4.8 | 9.9 | 5.4 |
| | Actual | 57.2 | 3.5 | 6.7 | 4.3 |
| | Spending Ratio | 107.1 | 72.9 | 67.7 | 79.6 |
| FY 87 | Budgeted | 65.1 | 5.0 | 10.1 | 5.7 |
| | Actual | 69.6 | 4.0 | 6.5 | 5.0 |
| | Spending Ratio | 106.9 | 90.0 | 64.4 | 87.7 |

Source: GOK Appropriation Accounts for FY 82-FY 87

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Table 2

Health Care Facilities by Provider

| | Hospitals | | | Urban Health Centers/Clinics | Rural Health Centers | Rural Dispensaries/ Clinics |
|---|---|---|---|---|---|---|
| | | Beds | | | | |
| | Number | Number | % Total | | | |
| Government | | | | | | |
| MOH | 80 | 16,776 | 65 | 31 | 245 | 1,032 |
| Defense Department | 2 | 108 | 1 | 43 | | |
| Prisons Department | 9 | 356 | 1 | 28 | | |
| Municipalities | 1 | 350 | 1 | 107 | | |
| Missions | 42 | 5,480 | 21 | 11 | 72 | 165 |
| Private Companies | 4 | 257 | 1 | | | 59 |
| Private "Market" | 44 | 2,355 | 9 | 22 | | 17 |
| TOTAL | 182 | 25,682 | 100 | 242 | 317 | 1,273 |

SOURCE: MOH, Expenditure and Financing of the Health Sector in Kenya (draft), text Table 1, p. 7. 1986.

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Table 3

Ministry of Health Expenditures by Functional Classification
as percentage of total

| | Actual | | | | | | Budget Estimates | |
|---|---|---|---|---|---|---|---|---|
| | FY 82 | FY 83 | FY 84 | FY 85 | FY 86 | FY 87 | FY 88 | FY 89 |
| Recurrent Expenditure | | | | | | | | |
| Curative Health | 72 | 72 | 73 | 67 | 72 | 72 | 79 | 72 |
| Preventive and Promotive Health | 5 | 5 | 4 | 4 | 4 | 4 | 4 | 6 |
| Rural Health | 8 | 9 | 7 | 6 | 9 | 7 | 8 | 12 |
| Training | 6 | 6 | 6 | 5 | 5 | 5 | 5 | 6 |
| Others* | 9 | 8 | 10 | 18 | 10 | 12 | 4 | 4 |
| Total Recurrent Expenditure | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Development Expenditure | | | | | | | | |
| Curative Health | 78 | 82 | 50 | 42 | 40 | 40 | 55 | 35 |
| Preventive and Promotive Health | 1 | 2 | 2 | 1 | 3 | 2 | – | 7 |
| Rural Health | 19 | 15 | 30 | 39 | 40 | 37 | 39 | 47 |
| Training | 1 | 1 | 1 | 3 | – | 3 | 1 | 2 |
| Others* | – | – | 17 | 15 | 17 | 18 | 5 | 9 |
| Total Development Expenditure | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |
| Total Recurrent and Development Expenditure | | | | | | | | |
| Curative Health | 73 | 73 | 69 | 63 | 67 | 68 | 76 | 61 |
| Preventive and Promotive Health | 4 | 4 | 4 | 4 | 4 | 4 | 4 | 6 |
| Rural Health | 10 | 11 | 11 | 10 | 13 | 11 | 11 | 22 |
| Training | 5 | 5 | 5 | 5 | 5 | 5 | 5 | 5 |
| Others* | 8 | 7 | 11 | 18 | 11 | 12 | 4 | 6 |
| Total Expenditure | 100 | 100 | 100 | 100 | 100 | 100 | 100 | 100 |

*includes General Administration and Planning, National Health Insurance, and Medical Supplies
– denotes negligible

Sources: GOK Appropriation Accounts for FY 82-FY 87

## Planned and Actual Recurrent Expenditure of Ministry of Health
(Kf '000)

| | Preventive and Promotion Services a/ | Rural Health Services b/ | Curative Health Services c/ | Training d/ | Administration |
|---|---|---|---|---|---|
| **FY 84** | | | | | |
| Planned | 3,637.3 | 5,041.6 | 40,578.3 | 5,838.7 | 3,413.6 |
| Actual | 2,682.9 | 4,450.8 | 44,712.7 | 3,583.1 | 5,414.0 |
| Gap (- or +) | -954.8 | -590.8 | +4,134.4 | -2,255.6 | +2,000.4 |
| Gap as % of Planned | 26.2 | 11.7 | 10.2 | 38.6 | 58.6 |
| **FY 85** | | | | | |
| Planned | 3,830.5 | 5,759.0 | 42,953.3 | 6,056.2 | 3,577.6 |
| Actual | 2,898.0 | 4,190.0 | 48,565.9 | 3,849.1 | 4,091.7 |
| Gap (- or +) | -932.5 | -1,569.0 | +5,612.6 | -2,207.1 | +514.1 |
| Gap as % of Planned | 24.0 | 27.0 | 13.1 | 36.4 | 14.4 |
| **FY 86** | | | | | |
| Planned | 4,009.9 | 6,448.4 | 44,849.1 | 6,274.2 | 3,744.2 |
| Actual | 3,518.5 | 6,739.2 | 57,217.6 | 4,289.9 | 3,757.1 |
| Gap (- or +) | -491.4 | +290.8 | +12,368.5 | -1,984.3 | +12.9 |
| Gap as % of Planned | 12.3 | 4.5 | 27.6 | 31.6 | 0.3 |
| **FY 87** | | | | | |
| Planned | 4,183.8 | 7,252.9 | 46,553.1 | 6,487.8 | 3,906.1 |
| Actual | 3,971.0 | 6,473.2 | 69,648.2 | 5,024.6 | 6,696.7 |
| Gap (- or +) | -212.8 | -779.7 | +23,095.1 | -1,463.2 | +2,790.6 |
| Gap as % of Planned | 5.1 | 10.8 | 49.6 | 22.6 | 71.4 |

a. Preventive/promotive services include: communicable vector borne disease control, nutrition, environmental, health, maternal child health and family planning, health education, national health laboratories and radiation control.
b. Rural health services include rural health centers and dispensaries.
c. Curative health services include: Kenyatta National Hospital, provincial hospitals, district hospitals, psychiatric services and national spinal injury hospital.
d. Training includes: Medical Training Center (Nairobi), Field Medical Training Centers, Rural Health Training and Demonstration Centers.

Gap (- or +) implies underfunding or overfunding, respectively

Source: GOK Development Plan, 1984 - 1988
GOK Appropriation Accounts for FY 84-FY 87

Table 5

Ministry of Health Expenditure Projections by Economic Classification
(in FY 85 prices)

| | Budget Estimates | Forward Budget | | | Growth Rate | Budget Estimates | Forward Budget | | |
|---|---|---|---|---|---|---|---|---|---|
| | FY 88 | FY 89 | FY 90 | FY 91 | FY89-91 | FY 88 | FY 89 | FY 90 | FY 91 |
| | (Kf million) | | | | | (Percentage) | | | |
| Recurrent Expenditure | 79.2 | 77.0 | 79.9 | 83.4 | 4.1 | 100.0 | 100.0 | 100.0 | 100.0 |
| Personnel | 49.6 | 50.3 | 47.9 | 47.6 | -2.8 | 62.6 | 65.4 | 60.0 | 57.1 |
| Non-wage operating | 16.5 | 14.9 | 18.6 | 20.0 | 15.9 | 20.9 | 19.3 | 23.3 | 24.0 |
| Capital Formation a/ | 0.4 | 0.4 | 0.4 | 0.5 | 14.1 | 0.5 | 0.5 | 0.5 | 0.6 |
| Maintenance | 0.6 | 0.5 | 0.6 | 0.6 | 6.6 | 0.7 | 0.7 | 0.7 | 0.7 |
| Grants and Transfers | 12.1 | 10.9 | 12.4 | 14.7 | 16.4 | 15.3 | 14.1 | 15.5 | 17.6 |
| Development Expenditure | 31.4 | 26.3 | 15.2 | 13.4 | -28.5 | 100.0 | 100.0 | 100.0 | 100.0 |
| Personnel | 0.6 | 0.1 | 0.1 | 0 | -100.2 | 1.9 | 0.5 | 0.7 | 0 |
| Non-wage operating | 9.4 | 8.0 | 4.4 | 2.2 | -47.4 | 30.0 | 30.5 | 29.2 | 16.5 |
| Capital: equipment | 3.2 | 2.6 | 1.3 | 1.6 | -21.9 | 10.0 | 9.7 | 8.6 | 11.6 |
| construction | 16.3 | 13.8 | 8.1 | 9.4 | -17.2 | 52.0 | 52.4 | 53.5 | 70.3 |
| Maintenance | 1.4 | 1.6 | 1.0 | 0.2 | -63.1 | 4.6 | 6.1 | 6.6 | 1.6 |
| Grants and Transfers | 0.4 | 0.2 | 0.2 | 0 | -100.0 | 1.3 | 0.8 | 1.4 | 0 |
| Total Expenditure | 110.6 | 103.3 | 95.0 | 96.8 | -3.2 | 100.0 | 100.0 | 100.0 | 100.0 |
| Personnel | 50.2 | 50.5 | 48.0 | 47.6 | -2.9 | 45.4 | 48.9 | 50.0 | 49.2 |
| Non-wage operating | 26.0 | 22.9 | 23.0 | 22.2 | -1.5 | 20.9 | 19.3 | 23.3 | 24.0 |
| Capital: equipment | 3.6 | 2.9 | 1.7 | 2.1 | -16.3 | 3.2 | 2.8 | 1.8 | 2.1 |
| construction | 16.3 | 13.8 | 8.1 | 9.4 | -17.2 | 14.8 | 13.3 | 8.5 | 9.8 |
| Maintenance | 2.0 | 2.1 | 1.6 | 0.8 | -37.8 | 1.8 | 2.1 | 1.6 | 0.9 |
| Grants and Transfers | 12.5 | 11.1 | 12.6 | 14.7 | 15.3 | 11.3 | 10.7 | 13.3 | 15.2 |

a/ Includes capital formation on equipment only.
Source: World Bank, Kenya - Public Expenditure Issues, January 1989

Table 6

Ministry of Health Expenditure Projections (Latest Forward Budget, January 1989)

| | Revised Budget FY 89 | Forward Budget FY 90 | FY 91 | FY 92 | Revised Budget FY89 | Forward Budget FY 90 | FY 91 | FY 92 |
|---|---|---|---|---|---|---|---|---|
| | | (Kf million) | | | | (Percentage) | | |
| Recurrent Expenditure | 105.5 | 122.3 | 128.3 | 135.2 | 100.0 | 100.0 | 100.0 | 100.0 |
| Curative health services | 74.6 | 80.5 | 84.5 | 89.0 | 70.7 | 65.8 | 65.9 | 65.8 |
| Preventive/promotive health | 6.3 | 13.2 | 13.9 | 14.6 | 6.0 | 10.8 | 10.8 | 10.8 |
| Rural health | 11.8 | 15.6 | 16.7 | 18.0 | 11.2 | 12.8 | 13.0 | 13.3 |
| Others a/ | 12.8 | 13.0 | 13.2 | 13.6 | 12.1 | 10.6 | 10.3 | 10.1 |
| Development Expenditure | 45.0 | 38.4 | 33.5 | 30.3 | 100.0 | 100.0 | 100.0 | 100.0 |
| Curative health services | 15.8 | 9.2 | 13.0 | 9.3 | 35.1 | 24.0 | 38.8 | 30.7 |
| Preventive/promotive health | 3.3 | 4.0 | 2.5 | 5.7 | 7.3 | 10.4 | 7.5 | 18.8 |
| Rural health | 21.4 | 17.8 | 13.8 | 8.6 | 47.6 | 46.4 | 41.2 | 28.4 |
| Others a/ | 4.5 | 7.4 | 4.2 | 6.7 | 10.0 | 16.3 | 12.5 | 22.1 |
| Total Expenditure | 150.5 | 160.7 | 161.8 | 165.5 | 100.0 | 100.0 | 100.0 | 100.0 |
| Curative health services | 90.4 | 89.7 | 97.5 | 98.3 | 60.1 | 55.8 | 60.2 | 59.4 |
| Preventive/promotive health services | 9.6 | 17.2 | 16.4 | 20.3 | 6.4 | 10.7 | 10.1 | 12.2 |
| Rural health | 33.2 | 33.4 | 30.5 | 26.3 | 22.0 | 20.8 | 18.9 | 16.1 |
| Others a/ | 17.3 | 20.4 | 17.4 | 20.3 | 11.5 | 12.7 | 10.8 | 12.3 |

a/ Includes administration, training, supplies coordination, and the National Hospital Insurance Fund

Source: GOK Forward Budget for FY 90-92, latest estimates as of January 1989

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## Projections of Financing Gap for Key Preventive and Primary Health Programs
(in U.S. $'000)

| | 1989 | 1990 | 1991 b/ | 1992 b/ |
|---|---|---|---|---|
| I. Expanded Immunization Program | | | | |
| Estimated required financing | 3,550.7 | 3,513.3 | 3,554.4 | 3,219.9 |
| Likely actual financing a/ | 1,373.7 | 1,870.0 | 1,468.4 | 1,136.9 |
| Gap | 2,177.0 | 1,643.3 | 2,086.0 | 2,083.0 |
| II. Control of Diarrheal Disease | | | | |
| Estimated required financing | 1,320.0 | 1,491.0 | 1,817.6 | 2,190.6 |
| Likely actual financing a/ | 410.5 | 819.4 | 273.7 | 273.7 |
| Gap | 909.5 | 671.7 | 1,543.9 | 1,916.9 |
| III. Family Planning | | | | |
| Estimated required financing | 5,182.8 | 6,361.6 | 6,734.9 | 7,033.6 |
| Likely actual financing a/ | 4,305.3 | 5,246.9 | 3,034.9 | 6,055.8 |
| Gap | 877.5 | 1,114.7 | 558.0 | 997.8 |
| IV. Essential Drugs Program c/ | | | | |
| Estimated required financing | 6,935.7 | 7,706.3 | 8,478.0 | 9,325.8 |
| Likely actual financing a/ | 5,092.6 | 5,587.2 | 4,584.2 | 4,210.5 |
| Gap | 1,843.1 | 2,119.1 | 3,893.8 | 5,115.3 |
| Total for I - IV | | | | |
| Estimated required financing | 16,989.2 | 19,072.3 | 20,584.9 | 21,769.9 |
| Likely actual financing | 11,182.1 | 13,523.5 | 9,361.2 | 11,676.9 |
| Gap | 5,807.1 | 5,548.8 | 11,223.7 | 10,093.0 |

Sources:
1. MOH Forward Budget, 1989/90-1991/92
2. CDD, Five Year Plan
3. EPI, Six Year Plan (USAID/Kenya, DANIDA)
4. Family Planning Project Paper (GOK and Donors)
5. MOH officials provided information on ED program

a/ Taken from MOH "development" budget. GOK recurrent budget on salaries is not included. This is estimated to be 60% of program cost.

b/ Donor funds not shown in estimates of likely actual financing unless agreement has been signed. Figures in later years are an underestimate because of this.

c/ Estimates of required financing for essential drugs are probably underestimated as mouh as 20% due to further increases in population and cost of drugs which had not been previously taken into account.

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Table 8A
Rift Valley Province
Requests by District Hospital GOK FY 88/89
(Kenya Pounds)

| Hospital Codes | 711 | 720 | 730 | 742 | 760 | 770 | 821 | 830 | 831 | 860 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Transport Operating Expenses | 10,776 | 13,853 | 12,527 | 18,974 | 12,768 | 16,162 | 10,500 | 14,500 | 10,774 | 13,728 | 134,562 |
| Postal and Telegram | 306 | 393 | 400 | 515 | 362 | 449 | 164 | 6,000 | 306 | 393 | 9,288 |
| Telephone | 1,224 | 1,572 | 6,750 | 3,234 | 1,451 | 1,835 | 1,200 | 0 | 1,223 | 1,578 | 20,067 |
| Electr, Water & Conservancy | 11,591 | 12,355 | 10,285 | 19,334 | 10,416 | 14,414 | 840 | 8,500 | 9,490 | 12,355 | 109,580 |
| X-Ray Supplies | 0 | 1,591 | 1,000 | 28,775 | 1,467 | 1,623 | 750 | 0 | 1,238 | 1,591 | 38,035 |
| Patients Food | 20,592 | 37,440 | 41,596 | 40,656 | 34,560 | 47,840 | 27,000 | 50,000 | 20,592 | 37,440 | 357,716 |
| Uniforms and Clothing | 5,666 | 1,248 | 3,600 | 74,974 | 1,152 | 2,404 | 937 | 8,500 | 1,134 | 1,248 | 100,863 |
| Stationery | 1,130 | 1,872 | 1,400 | 17,683 | 1,728 | 0 | 695 | 3,000 | 0 | 1,872 | 29,380 |
| Misc Other Charges | 3,056 | 3,931 | 7,400 | 12,340 | 3,528 | 4,586 | 1,650 | 13,000 | 687 | 21,586 | 71,764 |
| Purchase of Plant & Equip. | 901 | 0 | 2,390 | 0 | 1,464 | 2,046 | 0 | 17,500 | 3,058 | 1,587 | 28,946 |
| Purchase of Plan Mach & Equip. | 35,000 | 14,560 | 0 | 117,370 | 0 | 0 | 0 | 85,000 | 1,158 | 0 | 253,088 |
| Maint. of Plant & Equip. | 3,130 | 4,024 | 1,350 | 14,064 | 3,715 | 4,696 | 525 | 6,000 | 3,130 | 4,025 | 44,659 |
| Total | 93,372 | 92,839 | 88,698 | 347,919 | 72,611 | 96,055 | 44,261 | 212,000 | 52,790 | 97,403 | 1,197,948 |

Hospital Codes:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 711 | Loitokitok | 730 | Nanyuki | 760 | Kitale | 830 | Kapsabet |
| 720 | Kericho | 742 | Molo | 770 | Eldoret | 831 | Nandi Hills |
| 821 | Iten | 960 | Kapenguria | | | | |

% of budget that was allocated: 29%

PH:06/14/89

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Table 8B
Rift Valley Province
Allocations by District Hospital GOK FY 88/89
(Kenya Pounds)

| Hospital Codes | 711 | 720 | 730 | 742 | 760 | 770 | 821 | 830 | 831 | 860 | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Transport Operating Expenses | 5,250 | 7,250 | 5,250 | 3,733 | 5,500 | 6,000 | 5,250 | 7,000 | 5,250 | 4,800 | 55,283 |
| Postal and Telegram | 232 | 266 | 232 | 106 | 259 | 116 | 232 | 208 | 232 | 232 | 2,115 |
| Telephone | 600 | 850 | 600 | 426 | 800 | 8,500 | 600 | 800 | 600 | 600 | 14,376 |
| Electr, Water & Conservancy | 7,377 | 6,097 | 4,797 | 3,564 | 7,197 | 9,597 | 7,797 | 6,197 | 7,797 | 7,797 | 68,217 |
| X-Ray Supplies | 375 | 528 | 375 | 266 | 500 | 528 | 375 | 500 | 375 | 375 | 4,197 |
| Patients Food | 13,500 | 17,500 | 13,500 | 9,600 | 13,000 | 11,889 | 13,500 | 18,000 | 13,500 | 12,300 | 136,289 |
| Uniforms and Clothing | 490 | 878 | 490 | 666 | 803 | 878 | 490 | 803 | 490 | 490 | 6,478 |
| Stationery | 675 | 950 | 675 | 480 | 3,351 | 950 | 675 | 0 | 675 | 675 | 9,106 |
| Misc Other Charges | 2,501 | 1,427 | 1,650 | 870 | 2,200 | 2,195 | 2,501 | 2,601 | 2,501 | 2,501 | 20,947 |
| Purchase of Plant & Equip. | 525 | 486 | 525 | 373 | 700 | 750 | 525 | 525 | 525 | 525 | 5,459 |
| Purchase of Plan Mach & Equip. | 2,501 | 2,866 | 1,725 | 1,004 | 1,977 | 4,215 | 1,501 | 4,177 | 1,501 | 1,501 | 22,968 |
| Maint. of Plant & Equip. | 356 | 831 | 654 | 167 | 674 | 443 | 356 | 779 | 356 | 356 | 4,972 |
| Total | 34,382 | 39,929 | 30,473 | 21,255 | 36,961 | 46,061 | 33,802 | 41,590 | 33,802 | 32,152 | 350,407 |

Hospital Codes:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 711 | Loitokitok | 730 | Nanyuki | 760 | Kitale | 830 | Kapsabet |
| 720 | Kericho | 742 | Molo | 770 | Eldoret | 831 | Nandi Hills |
| 821 | Iten | 960 | Kapenguria | | | | |

% of budget that was allocated: 29%

PH:06/14/89

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Annex C
Table 9-1

Table 9: Various Estimates of Revenue Generation Potential from Cost-Sharing Fees for Health Services in Kenya

Estimates from R. Ellis, "The Revenue Generating Potential of User Fees in Kenyan Government Facilities," 1987

| Fee Level | Ann Revenue Generated | Percent of MOH Recurrent Budget |
|---|---|---|
| Low (a) | 96.9 | 5% |
| Medium (b) | 153.0 | 8% |
| High (c) | 227.8 | 12% |

Assumptions:

17 KShs = US$ 1.00
1,938 KShs (million) = MOH 1988 Recurrent Budget
60% of services are eligible for fees
90% of patients are able to pay low fees
75% of patients are able to pay medium
50% of patients are able to pay high fees
95% proportional demand response for low fees
90% proportional demand response for medium
80% proportional demand response for high fees
75% of eligible revenue will be captured by government
10 KShs = average low (a) fee level or KShs 5/visit, plus KShs 5 for drugs
20 KShs = average medium (b) fee level or KShs 10/visit, plus KShs 10 for drugs
50 KShs = average high (c) fee level or KShs 25/visit, KShs 25 for drugs
11.3 million outpatient visits per year
1.23 outpatient visits per person with access to HC or dispensary per year.

Annex C
Table 9-2

Estimates of Revenues Generated by In- and Out-Patient Fees
Prepared by R. Vogel for the HFM

| Fee Level | Ann Revenue Generated | Percent of MOH Recurrent Budget |
|---|---|---|
| See below | 58.1 | 3% |
| | 77.5 | 4% |

Assumptions:

Dispensaries and Health Centres:

5 KShs = registration fee for persons 5 yrs and older
10 KShs = charge for drugs for adults (once/yr for chronic)
5 KShs = charge for drugs for children under 5
10 KShs = daily inpatient charge (health centres only), up to a maximum of KShs 50
40 KShs = inpatient maternity at dispensary
50 KShs = inpatient maternity at health centre, KShs 0 if referred

District Hospitals:

20 KShs = registration fee for persons 5 yrs and older, KShs 0 if referred
10 KShs = charge for drugs all ages (once/yr for chronic)
20 KShs = daily inpatient charge, up to a maximum of KShs 100
0 KShs = inpatient drugs
60 KShs = inpatient maternity, KShs 0 if referred
60 KShs = outpatient casualty

Provincial Hospitals:

30 KShs = registration fee for persons 5 yrs and older, KShs 0 if referred
10 KShs = charge for drugs all ages (once/yr for chronic)
30 KShs = daily inpatient charge, up to a maximum of KShs 150
0 KShs = inpatient drugs
100 KShs = inpatient maternity, KShs 0 if referred
100 KShs = outpatient casualty
200 KShs = daily amenity ward charge

Kenyatta National Hospital:

50 KShs = outpatient curative episode
10 KShs = charge for drugs all ages (once/yr for chronic)
100 KShs = daily inpatient charge, no maximum
0 KShs = inpatient drugs
200 KShs = inpatient maternity plus the daily rate of KShs 100, KShs 0 if referred
200 KShs = outpatient casualty
400-600-800 KShs = private wing charges (ward-single-VIP suite)
schedule = charge for specialized services

Estimates of Revenues Generated by In- and Out Patient Fees from World Bank, "Review of Expenditure Issues and Options in Health Financing," 1988

| Fee Level | Ann Revenue Generated | Percent of MOH Recurrent Budget |
|---|---|---|
| Option A | 360.5 | 19% |
| Option B | 558.1 | 29% |

Assumptions:

Outpatient Visit and Prescription:

| Option A | Option B | |
|---|---|---|
| 13 | 27 | KShs at Health Sub-Centres and Dispensaries |
| 15 | 32 | KShs at Health Centres and Sub-District Hospitals |
| 22 | 47 | KShs at District Hospitals |
| 26 | 58 | KShs at Provincial Hospitals |

Hospital Stay of 10 Days, 2 Prescriptions, and 1 X-Ray:

| Option A | Option B | |
|---|---|---|
| 130 | 210 | KShs at Health Centres and Sub-District Hospitals |
| 230 | 360 | KShs at District Hospitals |
| 230 | 410 | KShs at Provincial Hospitals |
| 430 | 760 | KShs at KNH |
| 90% | 75% | patients able to pay |
| 75% | 75% | revenue captured by government |

Estimates of Revenues Generated by In- and Out Patient Fees by B. Able-Smith, "Discussion Paper on Issues and Options in Health Financing," SIDA, 1989

| Fee Level | Ann Revenue Generated | Percent of MOH Recurrent Budget |
|---|---|---|
| Option A | 135.7 | 7% |
| Option B | 193.8 | 10% |

Assumptions:

Outpatient Visit and Prescription:

| Option A | Option B | |
|---|---|---|
| 13 | 27 | KShs at Health Sub-Centres and Dispensaries |
| 15 | 32 | KShs at Health Centres and Sub-District Hospitals |
| 22 | 47 | KShs at District Hospitals |
| 26 | 58 | KShs at Provincial Hospitals |

Hospital Stay of 10 Days, 2 Prescriptions, and 1 X-Ray:

| Option A | Option B | |
|---|---|---|
| 130 | 210 | KShs at Health Centres and Sub-District Hospitals |
| 230 | 360 | KShs at District Hospitals |
| 230 | 410 | KShs at Provincial Hospitals |
| 430 | 760 | KShs at KNH |
| 60% | 45% | patients able to pay |
| 75% | 75% | revenue captured by government |

5C(2) - PROJECT CHECKLIST

Listed below are statutory criteria applicable to projects. This sections divided into two parts. Part A includes criteria applicable to all projects. Part B applies to projects funded from specific sources only:
B(1) applies to all projects funded with Development Assistance;
B(2) applies to projects funded with Development Assistance loans; and
B(3) applies to projects funded from ESF.

| | | |
|---|---|---|
| CROSS REFERENCES: | IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED FOR THIS PROJECT? | (a) Yes.<br>(b) Yes. |

A. GENERAL CRITERIA FOR PROJECT

| | |
|---|---|
| 1. FY 1989 Appropriations Act Sec. 523; FAA Sec. 634A. If money is sought to obligated for an activity not previously justified to Congress, or for an amount in excess of amount previously justified to Congress, has Congress been properly notified? | A Congressional Notification for $15.0 million has been submitted to the Congress and expired without objection on _____ |
| 2. FAA Sec. 611(a)(1). Prior to an obligation in excess of $500,000, will there be (a) engineering, financial or other plans necessary to carry out the assistance, and (b) a reasonably firm estimate of the cost to the U.S of the assistance? | (a) Yes<br>(b) Yes |
| 3. FAA Sec. 611(a)(2). If legislative action is required within recipient country, what is basis for a reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance? | A draft Amendment to the National Hospital Insurance Act Chapter 255 is scheduled to be acted on by the Parliament and approved by July 31, 1989 and published Aug/Sept 1989. At the latest, this amendment is expected to be affected by Nov/Dec 1989. Major delays are not anticipated because the amendment already has the approval of a sub-committee of Parliament. |

| | |
|---|---|
| 4. FAA Sec. 611(b); FY 1989 Appropriations Act Sec. 501. If project is for water or water-related land resource construction, have benefits and costs been computed to the extent practicable in accordance with the principles, standards, and procedures established pursuant to the Water Resources Planning Act (42 U.S.C. 1962, et seq.)? (See A.I.D. Handbook 3 for guidelines.) | N/A |
| 5. FAA Sec. 611(e). If project is capital assistance (e.g., construction), and total U.S. assistance for it will exceed $1 million, has Mission Director certified and Regional Assistant Administrator taken into consideration the country's capability to maintain and utilize the project effectively? | N/A |
| 6. FAA Sec. 209. Is project susceptible to execution as part of regional or multilateral project? If so, why is project not so executed? Information and conclusion whether assistance will encourage regional development programs. | The Project is country specific but is designed to coordinate with the activities of other donors, particularly the World Bank, in the area of health care financing. |
| 7. FAA Sec. 601(a). Information and conclusions on whether projects will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unions, and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture and commerce; and (f) strengthen free labor unions. | N/A |
| 8. FAA Sec. 601(b). Information and conclusions on how project will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise). | It is anticipated that the Project will rely primarily on contract services of U.S. private firm(s) to provide the technical assistance to the GOK/MOH, and other implementing institutions. |

| | |
|---|---|
| 9. FAA Sec. 612(b), 636(h). Describe steps taken to assure that, to the maximum extent possible, the country is contributing local currencies to meet the cost of contractual and other services, and foreign currencies owned by the U.S. are utilized in lieu of dollars. | The GOK will provide local currency equivalent to the U.S. dollars disbursed for policy reform. |
| 10. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? | The U.S. does not own excess Kenyan currency. |
| 11. FY 1989 Appropriations Act Sec. 521. If assistance is for the production of any commodity for export, is the commodity likely to be in surplus on world markets at the time the resulting productive capacity becomes operative, and is such assistance likely to cause substantial injury to U.S. procures of the same, similar or competing commodity? | N/A |
| 12. FY 1989 Appropriations Act Sec. 549. Will the assistance (except for programs in Caribbean Basis Initiative countries under U.S. Tariff Schedule "Section 807," which allows reduced tariffs on articles assembled abroad from U.S.-made components) be used directly to procure feasibility studies, prefeasibility studies, or project profiles of potential investment in, or to assist the establishment of facilities specifically designed for, the manufacture for export to the United States or to third country markets in direct competition with U.S. exports, of textiles, apparel, footwear, handbags, flat goods (such as wallets or coin purses worn on the person), work floves or leather wearing apparel? | N/A |
| 13. FAA Sec. 119(g) (4)-(6) & (10). Will the assistance (a) support training and education efforts which improve the capacity of recipient countries to prevent loss of biological diversity; (b) be provided under a | (a. thru d.) N/A |

long-term agreement in which the recipient country agrees to protect ecosystems or other wildlife habitats; (c) support efforts to identify and survey ecosystems in recipient countries worthy of protection; or (d) by any direct or indirect means significantly degrade national parks or similar protected areas or introduce exotic plants or animals into such areas?

14. FAA Sec. 121(d). If a Sahel project, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of project funds (either dollars or local currency generated therefrom)? N/A

15. FY 1989 Appropriations Act. If assistance is to be made to a United States PVO (other than a cooperative development organization), does it obtain at least 20 percent of its total annual funding for international activities from sources other than the United States Government? N/A

16. FY 1989 Appropriations Act Sec. 538. If assistance is being made available to a PVO, has that organization provided upon timely request any document, file, or record necessary to the auditing requirements of A.I.D., and is the PVO registered with A.I.D.? N/A

17. FY 1989 Appropriations Act Sec. 514. If funds are being obligated under an appropriation account to which they were not appropriated, has prior approval of the Appropriations Committees of Congress been obtained? N/A

B. FUNDING CRITERIA FOR PROJECT

1. Development Assistance Project Criteria

| | |
|---|---|
| (a) FY 1989 Appropriations Act Sec. 548. (as interpreted by conference report for original enactment). If assistance is for agricultural development activities (specifically, any testing or breeding feasibility study, variety improvement or introduction, consultancy, publication, conference, or training), are such activities (a) specifically and principally designed to increase agricultural exports by the host country to a country other than the United States, where the export would lead to direct competition in the third country with exports of a similar commodity grown or produced in the United States, and can the activities reasonably be expected to cause substantial injury to U.S. exporters of a similar agricultural commodity; or (b) in support of research that is intended primarily to benefit U.S. producers? | N/A |
| (b) FAA Secs. 102(b), 111, 113, 281(a). Describe extent to which activity will (a) effectively involve the poor in development by extending access to economy at local level, increasing labor-intensive production and the use of appropriate technology, dispersing investment from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward a better life, and otherwise encourage democratic private and local governmental | (a) The Program is designed to have an overall macro-economic impact but will involve the poor in development by increasing their access to health services, in particular rural inhabitants. U.S. techical expertise will be provided to the GOK counterpart institutions to enhance their ability to reach targets of the GOK Reform Agenda.<br>(b) The Program will help the GOK to increase financial resources for health activities which will improve the quality and efficiency of health service delivery in the rural and urban areas of Kenya.<br>(c) The Program will support Kenya's self-help efforts by assisting the |

| | |
|---|---|
| institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries. | GOK in achieving greater-financial self-sufficiency through public cost sharing for health services. (d) The Program will improve women's assess to health services which will impact on their ability to participate in the economy. (e) The Program is not designed to encourage regional cooperation by developing countries. |
| c. FAA Secs. 103, 103A, 104, 105, 106, 120-21; FY 1989 Appropriations Act (Development Fund for Africa). Does the project fit the criteria for the source of funds (functional account) being used? | N/A |
| d. FAA Sec. 107. Is emphasis placed on use of appropriate technology (relatively smaller, cost-saving, labor-using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)? | N/A |
| e. FAA Secs. 110, 124(d). Will the recipient country provide at least 25 percent of the costs of the program, project, or activity with respect to which the assistance is to be furnished (or is the latter cost-sharing requirement being waived for a "relatively least developed" country)? | Yes |
| f. FAA Sec. 128(b). If the activity attempts to increase the institutional capabilities of private organizations or the government of the country, or if it attempts to stimulate scientific and technological research, has it been designed and will it be monitored to ensure that the ultimate beneficiaries are the poor majority? | The Program has been designed to increase the GOK/MOH capability to effectively monitor use of existing and planned financial resources in the health sector with the goals of ensuring retargeting of resources on primary/preventive services that reach the rural areas and of ensuring access to the medically indigent. |
| g. FAA Sec. 281(b). Describe extent to which program recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intelectual resources to encourage institutional development; and supports civil education and | The Program's technical assistance activities for the institutional strengthening of the MOH and other key areas that are based on the GOK's priority interests and needs. |

training in skills required for effective participation in governmental processes essential to self-government.

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| h. <u>FY 1989 Appropriations Act Sec. 536.</u> Are any of the funds to be used for the performance of abortions as a method of family planning or to motivate or coerce any person to practice abortions? | No |
| Are any of the funds to be used to pay for the performance of involuntary sterilization as a method of family planning or to coerce or provide any financial incentive to any person to undergo sterilization? | No |
| Are any of the funds to be used to pay for any biomedical research which rates, in whole or in part, to methods of, or the performance of, abortions or involuntary sterilization as a means of family planning? | No |
| i. <u>FY 1989 Appropriations Act.</u> Is the assistance being made available to any organization or program which has been determined to support or participate in the management of a program of coercive abortion or involuntary sterilization? | No |
| If assistance is from the population functional account, are any of the funds to be made available to voluntary family planning projects which do not offer, either directly or through referral to or information about access to, a broad range of family planning methods and services? | No |

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| j. FAA Sec. 601(e). Will the project utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? | Yes. Full and open competitive procedures will be used to obtain the contractual services required under this Program. |
| k. FY 1989 Appropriations Act. What portion of the funds will be available only for activities of economically and socially disadvantaged enterprises, historically black colleges and universities, colleges and universities having a student body in which more than 40 percent of the students are Hispanic Americans, and private and voluntary organizations which are controlled by individuals who are black Americans, Hispanic Americans, or Native Americans, or who are economically or socially disadvantaged (including women)? | None |
| l. FAA Sec. 118(c). Does the assistance comply with the environmental procedures set forth in A.I.D. Regulation 16? Does the assistance place a high priority on conservation and sustainable management of tropical forests? Specifically, does the assistance, to the fullest extent feasible: (a) stress the importance of conserving and sustainably managing forest resources; (b) support activities which offer employment and income alternatives to those who otherwise would cause destruction and loss of forests, and help countries identify and implement alternatives to colonizing forested areas; (c) support training programs, educational efforts, and the establishment or strengthening of institutions to improve forest management; | Yes. A categorical exclusion was approved by AID/W on April 3 1989. |

(d) help end destructive slash-and-burn agriculture by supporting stable and productive farming practices; (e) help conserve forests which have not yet been degraded by helping to increase production on lands already cleared or degraded; (f) conserve forested watersheds and rehabilitate those which have been deforested; (g) support training, research, and other actions which lead to sustainable and more environmentally sound practices for timber harvesting, removal, and processing; (h) support research to expand knowledge of tropical forests and identify alternatives which will prevent forest destruction, loss, or degradation; (i) conserve biological diversity in forest areas by supporting efforts to identify, establish, and maintain a representative network or protected tropical forest ecosystems on a worldwide basis, by making the establishment of protected areas a condition of support for activities involving forest clearance or degradation, and by helping to identify tropical forest ecosystems and species in need of protection and establish and maintain appropriate projected areas; (j) seek to increase the awareness of U.S. government agencies and other donors of the immediate and long-term value of tropical forests; and (k)/utilize the resources and abilities of all relevant U.S. government agencies?

m. FAA Sec. 118(c)(13). If the assistance will support a program or project significantly affecting tropical forests (including projects involving the planting of exotic plant — N/A

species), will the program or project (a) be based upon careful analysis of the alternatives available to achieve the best sustainable use of the land, and (b)/take full account of the environmental impacts of the proposed activities on biological diversity?

n. FAA Sec. 118(c)(14). Will assistance be used for (a) the procurement or use of logging equipment, unless an environmental assessment indicates that all timber harvesting operations involved will be conducted in an environmentally sound manner and that the proposed activity will produce positive economic benefits and sustainable forest management systems; or (b) actions which significantly degrade national parks or similar protected areas which contain tropical forests, or introduce exotice plants or animals into such areas? N/A

o. FAA Sec. 118(c)(15). Will assistance be used for (a) activities which would result in the conversion of forest lands to the rearing of livestock; (b) the construction, upgrading, or maintenance of roads (including temporary haul roads for logging or other extractive industries) which pass through relatively undegraded forest lands; (c) the colonization of forest lands; or (d) the construction of dams or other water control structures which flood relatively undegraded forest lands, unless with respect to each such activity an environmental assessment indicates that the activity will contribute significantly and directly to improving the livelihood of the rural poor and will be conducted in an environmentally sound manner which supports sustainable development? N/A

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| p. FY 1989 Appropriations Act. If assistance will come from the Sub-Saharan Africa DA account, is it (a) to be used to help the poor majority in Sub-Saharan Africa through a process of long-term development and economic growth that is equitable, participatory, environmentally sustainable, and self-reliant; | (a) Yes. The Program's targeted beneficiaries include women and children who would benefit from improved MOH health service delivery capacity. |
| (b) being provided in accordance with the policies contained in section 102 of the FAA; | (b) Yes |
| (c) being provided, when consistent with the objectives of such assistance, through African, United States and other PVOs that have demonstrated effectiveness in the promotion of local grassroots activities on behalf of long-term development in sub-Saharan Africa; | (c) N/A |
| (d) being used to help overcome shorter-term constraints to long-term development, to promote reform of sectoral economic policies, to support the critical sector priorities of agricultural production and natural resources, health, voluntary family planning services, education, and income generating opportunities, to being about appropriate sectoral restructuring of the Sub-Saharan African economies, to support reform in public administration and finances and to establish a favorable environment for individual enterprise and self-sustaining development, and to take into account, in assisted policy reforms, the need to protect vulnerable groups; | (d) Yes. The Program is helping the GOK to promote reforms in health sector economic/financing policies, to enable the MOH to rationalize its budget in favor of increased spending for primary/ preventive activities. |
| (e) being used to increase agricultural production in ways that protect and restore the natural resource base, especially food production, to maintain and improve basic transportation and communication networks, to maintain and restore the nature resource base in ways that increase agricultural production, to improve health conditions with special emphasis | (e) Yes. The Program's support for GOK reforms in health care financing will strengthen the GOK's institutional capacity and financial base necessary for it to meet the health needs of the population, particularly women and children. The reforms will enable the GOK to retarget its own resources increasingly to primary/ preventive activities and provide a means for assuming more of the |

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| on meeting the health needs of mothers and children, including the establishment of self-sustaining primary health care systems that give priority to preventive care, to provide increased access to voluntary family planning services, to improve basic literacy and mathematics especially to those outside the formal educational system and to improve primary education, and to develop income-generating opportunities for the unemployed and underemployed in urban and rural areas? | costs associated with these activities. |
| q. FY 1989 Appropriations Act Sec. 515. If deob/reob authority is sought to be exercised in the provision of DA assistance, are the funds being obligated for the same general purpose, and for countries within the same general region as originally obligated, and have the Appropriations Committees of both Houses of Congress been properly notified? | N/A |
| 2. Development Assistance Project Criteria (Loans Only) | N/A |
| a. FAA Sec. 122(b). Information and conclusion on capacity of the country to repay the loan at a reasonable rate of interest. | |
| b. FAA Sec. 620(d). If assistance is for any productive enterprise which will compete with U.S. enterprises, is there an agreement by the recipient country to prevent export to the U.S. of more than 20 percent of the enterprise annual production during the life of the loan, or has the requirement to enter into such an agreement been waived by the President because of a national security interest? | N/A |

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| c. FAA Sec. 122(b). Does the activity give reasonable promise of assisting long-range plans and programs designed to develop economic resources and increase productive capacities? | N/A |
| 3. Economic Support Fund Project Criteria | |
| a. FAA Sec. 531(a). Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA? | N/A |
| b. FAA Sec. 531(e). Will this assistance be used for military or paramilitary purposes? | N/A |
| c. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made? | N/A |

3(A)2 - NONPROJECT ASSISTANCE CHECKLIST

The criteria listed in Part A are applicable generally to FAA funds, and should be used irrespective of the program's funding source. In Part B a distinction is made between the criteria applicable to Economic Support Fund assistance and the criteria applicable to Development Assistance. Selection of the criteria will depend on the funding source for the program.

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| CROSS REFERENCES: | IS COUNTRY CHECKLIST UP TO DATE? HAS STANDARD ITEM CHECKLIST BEEN REVIEWED? | Yes/Yes |

A. GENERAL CRITERIA FOR NONPROJECT ASSISTANCE

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| 1. FY 1989 Appropriations Act Sec. 523; FAA Sec. 634A. Describe how authorization and appropriations committees of Senate and House have been or will be notified concerning the project. | Congressional Notification for $15.0 million has been submitted to the Congress and expired without obligation on _____. |
| 2. FAA Sec. 611(a)(2). If further legislative action is required within recipient country, what is basis for reasonable expectation that such action will be completed in time to permit orderly accomplishment of purpose of the assistance? | See project checklist (attached) |
| 3. FAA Sec. 209. Is assistance more efficiently and effectively provided through regional or multilateral organizations? If so, why is assistance not so provided? Information and conclusions on whether assistance will encourage developing countries to cooperate in regional development programs. | No |

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| 4. FAA Sec. 601(a). Information and conclusions on whether assistance will encourage efforts of the country to: (a) increase the flow of international trade; (b) foster private initiative and competition; (c) encourage development and use of cooperatives, credit unison and savings and loan associations; (d) discourage monopolistic practices; (e) improve technical efficiency of industry, agriculture, and commerce; and (f) strengthen free labor unions. | This is a Program targeted on encouraging and supporting reforms in public health financing.<br>(a) N/A<br>(b) N/A<br>(c) N/A<br>(d) N/A<br>(e) N/A<br>(f) N/A |
| 5. FAA Sec. 601(b). Information and conclusions on how assistance will encourage U.S. private trade and investment abroad and encourage private U.S. participation in foreign assistance programs (including use of private trade channels and the services of U.S. private enterprise). | Private U.S. firms will participate in the Program by providing techicians under the technical assistance and training component. |
| 6. FAA Secs. 612(b), 636(h); FY 1989 Appropriations Act Secs. 507, 509. Describe steps taken to assure that, to the maximum extent possible, foreign currencies owned by the U.S. are utilized in lieu of dollars to meet the cost of contractual and other services. | Not applicable. The GOK will contribute local currency equivalent to the non-project dollar disbursement. The local currencies, however, will not be owned by the U.S. Government. |
| 7. FAA Sec. 612(d). Does the U.S. own excess foreign currency of the country and, if so, what arrangements have been made for its release? | No |
| 8. FAA Sec. 601(e). Will the assistance utilize competitive selection procedures for the awarding of contracts, except where applicable procurement rules allow otherwise? | Yes |
| 9. FAA Sec. 121(d). If assistance is being furnished under the Sahel Development Program, has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of A.I.D. funds? | N/A |

10. FY 1989 Appropriations Act
Will assistance be designed so that the percentage of women participants will be demonstrably increased?

The Program has been designed to emphasize enhancement of skills of existing GOK personnel. To the extent that new positions are established for administration of cost-sharing selection of women will be privitized.

B. FUNDING CRITERIA FOR NONPROJECT ASSISTANCE

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| 1. Nonproject Criteria for Economic Support Fund | N/A<br>AEPRP-DFA funding |
| a. FAA Sec. 531(a). Will this assistance promote economic and political stability? To the maximum extent feasible, is this assistance consistent with the policy directions, purposes, and programs of Part I of the FAA? | N/A |
| b. FAA Sec. 531(e). Will assistance under this chapter be used for military or paramilitary activities? | No |
| c. FAA Sec. 531(d). Will ESF funds made available for commodity import programs or other program assistance be used to generate local currencies? If so, will at least 50 percent of such local currencies be available to support activities consistent with the objectives of FAA sections 103 through 106? | N/A |
| d. FAA Sec. 609. If commodities are to be granted so that sale proceeds will accrue to the recipient country, have Special Account (counterpart) arrangements been made? | N/A |
| e. FY 1989 Appropriations Act. If assistance is in the form of a cash transfer (a) are all such cash payments to be maintained by the country in a separate account and not to be commingled with any other funds? (b) will all local currencies that may be generated with funds provided as a cash transfer to such a country also be deposited in a special account to be used in accordance with FAA Section 609 (which requires such local currencies to be made available to the U.S. | (a) N/A<br>(b) N/A |

government, as the U.S. determines necessary for the requirements of the U.S. Government, and which requires the remainder to be used for programs agreed to by the U.S. Government to carry out the purposes for which new funds authorized by the FAA would themselves be available)? (c) Has Congress received prior notification providing in detail how the funds will be used, including the U.S. interests that will be served by the assistance, and, as appropriate, the economic policy reforms that will be promoted by the cash transfer assistance?

(c) Yes

2. Nonproject Criteria for Development Assistance

a. FAA Secs. 102(a), 111, 113, 281(a). Extent to which activity will (a) effectively involve the poor in development, by expanding access to economy at local level, increasing labor-intensive production and the use of appropriate technology, spreading investment out from cities to small towns and rural areas, and insuring wide participation of the poor in the benefits of development on a sustained basis, using the appropriate U.S. institutions; (b) help develop cooperatives, especially by technical assistance, to assist rural and urban poor to help themselves toward better life, and otherwise encourage democratic private and local governmental institutions; (c) support the self-help efforts of developing countries; (d) promote the participation of women in the national economies of developing countries and the improvement of women's status; and (e) utilize and encourage regional cooperation by developing countries?

The program will induce policy changes in health care financing which are expected to benefit all Kenyans, including the poor. A covenant requiring cost sharing revenues to be retained by local facilities which earn such revenues will assist local government institutions. Beneficiaries will include women. The program has no significant regional impact.

b. <u>FAA Secs. 103, 103A, 104, 105, 106, 120-21</u>. Is assistance being made available (include only applicable paragraph which corresponds to source of funds used; if more than one fund source is used for assistance, include relevant paragraph for each fund source):

(1) [103] for agriculture, rural development or nutrition; if so (a) extent to which activity is specifically designed to increase productivity and income of rural poor; [103A] if for agricultural research, account shall be taken of the needs of small farmers, and extensive use of field testing to adapt basic research to local conditions shall be made; (b) extent to which assistance is used in coordination with efforts carried out under Sec. 104 to help improve nutrition of the people of developing countries through encouragement of increased production of crops with greater nutritional value: Improvement of planning, research, and education with respect to nutrition, particularly with reference to improvement and expanded use of indigenously produced foodstuffs; and the undertaking of pilot or demonstration programs explicitly addressing the problem of malnutrition of poor and vulnerable people; and (c) extent to which activity increases national food security by improving food policies and management and' by strengthening national food reserves, with particular concern for the needs of the poor, through measures encouraging domestic production, building national food reserves, expanding available storage facilities, reducing post harvest food losses, and improving food distribution.

(1) No
(a) N/A
(b) N/A
(c) N/A

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| (2) [104] for population planning under Sec. 104(b) or health under Sec. 104(c); if so, extent to which activity emphasizes low-cost, integrated delivery systems for health, nutrition and family planning for the poorest people, with particular attention to the needs of mothers and young children, using paramedical and auxiliary medical personnel, clinics and health posts, commercial distribution systems, and other modes of community outreach. | (2) The Program emphasize support for GOK reforms in health care financing intended to provide additional revenue to the MOH to enable it to reallocate existing and new resources to lower-cost nationwide primary/ preventive care delivery systems. |
| (3) [105] for education, public administration, or human resources development; if so, (a) extent to which activity strengthens nonformal education, makes formal education more relevant, especially for rural families and urban poor, and strengthens management capability of institutions enabling the poor to participate in development; and (b) extent to which assistance provides advanced education and training of people of developing countries in such disciplines as are required for planning and implementation of public and private development activities. | (3) No<br>(a) N/A<br>(b) N/A |
| (4) [106] for technical assistance, energy research, reconstruction, and selected development problems; if so, extent activity is: | (4) No |
| (i)(a) concerned with data collection and analysis, the training of skilled personnel, research on and development of suitable energy sources, and pilot projects to test new methods of energy production; and (b) facilitative of research | (i)(a) N/A<br>(b) N/A |

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| on and development and use of small-scale, decentralized, renewable energy sources for rural areas, emphasizing development of energy resources which are environmentally acceptable and require minimum capital investment; | |
| (ii) concerned with technical cooperation and development, especially with U.S. private and voluntary, or regional and international development, organizations; | (ii) N/A |
| (iii) research into, and evaluation of, economic development processes and techniques; | (iii) N/A |
| (iv) reconstruction after natural or manmade disaster and programs of disaster preparedness; | (iv) N/A |
| (v) for special development problems, and to enable proper utilization of infrastructure and related projects funded with earlier U.S. assistance; | (v) N/A |
| (vi) for urban development, especially small, labor-intensive enterprises, marketing systems for small producers, and financial or other institutions to help urban poor participate in economic and social development. | (vi) N/A |
| (5) [120-21] for the Sahelian region; if so, (a) extent to which there is international coordination in planning and implementation; participation and support by African countries and organizations in determining development priorities; and a long-term, multi-donor development | (5) No<br>(a) N/A<br>(b) N/A |

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| plan which calls for equitable burden-sharing with other donors; (b) has a determination been made that the host government has an adequate system for accounting for and controlling receipt and expenditure of projects funds (dollars or local currency generated therefrom)? | |
| c. FY 1989 Appropriations Act. Have local currencies generated by the sale of imports or foreign exchange by the government of a country in Sub-Saharan Africa from funds appropriated under Sub-Saharan Africa, DA been deposited in a special account established by that government, and are these local currencies available only for use, in accordance with an agreement with the United States, for development activities which are consistent with the policy directions of Section 102 of the FAA and for necessary administrative requirements of the U.S. Government? | No, but they will be. |
| d. FAA Sec. 107. Is special emphasis placed on use of appropriate technology (defined as relatively smaller, cost-saving, labor using technologies that are generally most appropriate for the small farms, small businesses, and small incomes of the poor)? | N/A |
| e. FAA Sec. 281(b). Describe extent to which the activity recognizes the particular needs, desires, and capacities of the people of the country; utilizes the country's intellectual resources to encourage institutional development; and supports civic education and training in skills required for effective participation in governmental and political processes essential to self-government. | The GOK has requested this assistance. A major portion of the TA will be from Kenyans. |

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| f. FAA Sec. 101(a). Does the activity give reasonable promise of contributing to the development of economic resources, or to the increase of productive capacities and self-sustaining economic growth? | Yes. The Program focuses on support of GOK reforms the health care financing will result in a strengthened financial and institutional base within the MOH, thereby enabling it expand primary/ preventive health care activities and reallocate its budget resources to ensure greater efficiency and quality of services. |

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Annex E

## PROGRAM DESIGN SUMMARY
## LOGICAL FRAMEWORK

Program Title and Number: Kenya Health Care Financing Program (615-0245)

Life of Program: $16,700,000 (U.S.)
Total US Funding: $15,000,000 (U.S.)
Date prepared: May 23, 1989

| NARRATIVE SUMMARY | OBJECTIVELY VERIFIABLE INDICATORS | MEANS OF VERIFICATION | IMPORTANT ASSUMPTIONS |
|---|---|---|---|
| Goal:<br>(a) Improve the health status of the population, particularly women and young children; and<br>(b) Contribute to MOH budget rationalization. | Measures of Goal Achievement:<br>(a) Infant, young child and maternal morbidity/mortality decreased.<br>(b) MOH budget shows consistent shift to preventive/primary care and non-wage recurrent costs.<br>(c) Guidelines for MOH budget allocation institutionalized. | (a) Census, Demographic and Health Survey, and Health Information System of Ministry of Health.<br>(b) MOH and MOF budget documents. | Goal Assumptions:<br>(a) Improvements in quality/ quantity of health services (particularly preventive/ primary care) will lead to significant reduction morbidity/ mortality and fertility reduction levels.<br>(b) GOK commitment to budget rationalization program is sustained. |
| Program Purpose:<br>To provide sustained increased financial resources for the the delivery of efficient quality care in both curative and preventive health services. | End of Project Status<br>(a) Reallocation of resources within the MOH budget such that the share of primary and preventive care will rise by 4-5 percent of the total allocated by 1992.<br>(b) Cost-sharing gains equivalent to 10 percent of the total allocated MOH budget by 1992. | a) MOH budget review study<br>b) Financial records maintained by MOH headquarters and relevant service facilities.<br>c) MOH annual budget and expenditure data. | Assumptions:<br>(a) Increased availability of resources in the sector, and the resulting increased use of preventive/primary care will lead to improvements in health status.<br>b) GOK will remain committed to budget rationalization.<br>(c) GOK will remain committed t reallocation of resource toward primary and preventive care.<br>(d) Cost sharing revenues retained by provider facilities used to make improvement will result in public willingness to pay fees for health care. |

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PROGRAM DESIGN SUMMARY
LOGICAL FRAMEWORK

| NARRATIVE SUMMARY | OBJECTIVELY VERIFIABLE INDICATORS | MEANS OF VERIFICATION | IMPORTANT ASSUMPTIONS |
|---|---|---|---|
| Outputs:<br>1. Implementation of Cost-Sharing Reforms<br>(a) Cost-recovery and related cost-control measures contained in KNH reform plan implemented.<br>(b) Cost-sharing measures introduced in GOK health facilities.<br>(c) Revised premium structure for National Hospital Insurance Fund (NHIF) designed and implemented.<br>(d) Mechanism and timetable for increasing the level of non-donor financing for preventive and primary services established within the MOH recurrent budget. | Reforms Implemented:<br>. MOH system for allocating increased proportion of financial resources to augment budget for preventive/primary services fully operational.<br>. Administrative procedures ensuring access for those unable to pay for services operational in KNH and all MOH service facilities engaged in cost-sharing.<br>. System for monitoring the impact of cost-sharing reforms on utilization of health services in place.<br>. More progressive premium structure in place at NHIF including employer contributions<br>1. Implementation of Cost Sharing<br>(a) Kenyatta National Hospital<br>- Comprehensive cost-sharing program, and system for managing such measures established with KNH.<br>- At least 10 percent of KNH recurrent budget financed through cost-recovery by 1992 | (a) GOK policy documents<br>(b) MOH central and facility level financial documents<br>(c) HIS data and operations research.<br>(d) Records of MOH and technical assistance contractor.<br>(e) NHIF records.<br>(f) MOH budgets. | Assumptions:<br>(a) GOK political climate favoring cost sharing does not change.<br>(b) MOH will allocate staff needed to lead this design effort and will endorse and act upon the agreed on policy reform measures.<br>(c) Introduction for cost-sharing at MOH facilities will not be met with strong adverse public reaction.<br>(d) Introduction of revised fee structure at NHIF is accepted.<br>(e) MOH will undertake redistribution of public resources to needy areas which do not generate sufficient revenues from cost sharing. |

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PROGRAM DESIGN SUMMARY
LOGICAL FRAMEWORK

| NARRATIVE SUMMARY | OBJECTIVELY VERIFIABLE INDICATORS | MEANS OF VERIFICATION | IMPORTANT ASSUMPTIONS |
|---|---|---|---|
| | - Portion of KNH budget financed by GOK grants reduced by 5 and 10 percent by end of year two and three respectively.<br><br>(b) MOH Service Facilities<br>- Modest user charges established in all MOH facilities on a phased time schedule with 100% of revenue retained within district, during the LOP with a portion (at least 50 percent at facility) with the balance of these resources used to increase budget for primary/preventive Programs.<br>- System for monitoring the impact of cost-sharing measures established, with findings being used to modify fee schedules, as appropriate.<br>(c) Health Insurance<br>- Public sector providers seeking and receiving reimbursement from NHIF according to revised benefit structure.<br>- NHIF reform program approved and implemented, including establishment of progressive premium structure and employer contributions. | | (e) GOK retains commitment to reduce proportion of public subsidy to KNH.<br>(f) GOK introduction to cost sharing at MOH facilities and KNH is approved on schedule.<br>(g) Willingness and ability to pay for health services adequate to recover significant portion of costs of service delivery.<br>(h) Inappropriate use of hospital-based services can be significantly decreased by introduction of by-pass fees and measures.<br>(i) By helping to further define the refomr agenda, additional donor resources will be leveraged to help implement in broad-based reform program in the sector.<br>(j) Other donor assistance for complemtary inputs (e.g., renovation of facilities, equipment, etc.) will be made available in a timely manner. |

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PROGRAM DESIGN SUMMARY
LOGICAL FRAMEWORK

| NARRATIVE SUMMARY | OBJECTIVELY VERIFIABLE INDICATORS | MEANS OF VERIFICATION | IMPORTANT ASSUMPTIONS |
|---|---|---|---|
| 2. Further Definition and Implementation of the Reform Agenda:<br>(a) Sector-wide coordination in health.<br>(b) Overall efficiency improvements at KNH.<br>(c) Expanded role for NHIF in health sector.<br>(d) Donor support for on-going reform process. | 2. Further Defining the Reform Agenda<br>(a) MOH designated Health Care Financing Implementation Committee fulfilling its mandate.<br>(b) Agenda for further policy and institutional reforms designed to control costs/improve efficiency approved by GOK by end of CY 1991 in both MOH and KNH.<br>(c) Strategic plan encompassing the definition of the future role of insurance coverage approved by GOK in 1991.<br>(d) Utilizing findings/recommendations of AID-financed analytical studies, firm commitments for donor support for reform program received by end of year two. | (a) MOH reports.<br>(b) Service providers collecting and utilizing fees accourding to provided guidelines.<br>(c) Improved referral system.<br>(d) Information regarding costs and use of six specialized departments at KNH available. | |
| 3. Enhanced Institutional Capacity:<br>Support for Implementation of Reforms. Necessary administrative systems for collection and expenditure implemented; baseline monitoring developed; systems established for increased efficiency. | 3. Enhanced Institutional Capacity<br>(a) Plan for introducing cost sharing at KNH through establishment of private wards, selected fees-for-service, and rental of clinic/office space for consulting physicians prepared, approved, and implemented. Systems for managing revenue generated, and exempting the medically indigent, established and functioning. | (a) KNH records and reports.<br>(b) Study reports, MOH official documents, and program monitoring reports.<br>(c) Study documents and records of NHIF. | (a) Administrators review plans, recommendations and make decisions to implement in a timely manner. |

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PROGRAM DESIGN SUMMARY
LOGICAL FRAMEWORK

| NARRATIVE SUMMARY | OBJECTIVELY VERIFIABLE INDICATORS | MEANS OF VERIFICATION | IMPORTANT ASSUMPTIONS |
|---|---|---|---|
| | (b) Plan for introducing user fees in provincial/district MOH hospitals, health centers, and dispensaries designed, implemented and evaluated by end of CY 1991. Management/accounting and waiver systems designed/implemented in all participating facilities.<br>(c) NHIF: Organizational goals/objectives established, revised premium and benefit structure in place, provide quality and cost assessment system to establish reimbursement levels in place, automation plan implemented, and actuarial data base established. | | |
| Inputs:<br>1. Policy Reform Support - Dollar Disbursements<br>Upon achievement of conditions precedent and subsequent establishment of local currency special account funds for disbursement to implementing institutions. | (1) USAID/GOK joint programming plans for Kenya Shillings equal to U.S. $9.7 million over life of program. | (a) GOK/USAID Programming Documents.<br>(b) GOK Auditor General audits of local currency programming. | |
| 2. Technical Assistance Component:<br>(a) Studies and Analyses<br>Studies and analyses, including pilot tests, required to define additional policy and institutional reforms needed, and steps required to implement these reforms. Studies and analyses needed will be identified by participating donors. | (a) Studies completed, options identified and implementation plans approved by relevant authorities. | (a) Study reports, MOH records and statistics. Special studies.<br>(b) Study reports, MOH records, and records of facilities affected.<br>(c) Reports and MOH records.<br>(d) Consultant report(s) action plan documents, contractor and MOH records. | (b) GOK utilizes results of studies to make decisions regarding policy and institutional reforms.<br>(c) Appropriate GOK counterpart staff are available to ensure technical transfer. |



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PROGRAM DESIGN SUMMARY
LOGICAL FRAMEWORK

| NARRATIVE SUMMARY | OBJECTIVELY VERIFIABLE INDICATORS | MEANS OF VERIFICATION | IMPORTANT ASSUMPTIONS |
|---|---|---|---|
| Illustrative list of priority issues includes:<br>(1) Study to re-examine and, possibly, redefine the roles played in provision and payment of health services by the public sector, private sector, parastatals, community, and foreign assistance.<br><br>(2) Review of methods being used to waive fees for those unable to pay (e.g., administrative feasibility and cost, accuracy in identification of those unable to pay).<br><br>(3) Study to define and establish systematic mechansims for rational allocation of MOH resources consistent with stated priorities (e.g., primary curative services, administration, non-wage operating costs).<br><br>(4) Study of the effectiveness of pricing structures (e.g., by pass premiums) and medical referral rules in containing costs by guiding patients to be treated at the appropriate level of facility.<br><br>(5) Review of role and potential contribution of private sector in meeting health targets. | | | |

PROGRAM DESIGN SUMMARY
LOGICAL FRAMEWORK

| NARRATIVE SUMMARY | OBJECTIVELY VERIFIABLE INDICATORS | MEANS OF VERIFICATION | IMPORTANT ASSUMPTIONS |
|---|---|---|---|
| b. Institutional Strengthening: Establish the capability to: (1) conduct policy and systems analyses in the health sector and monitor/evaluate impact of policy/institutional reforms; and (2) strengthen capacity of KNH and MOH to operate and manage a cost-sharing system. | b. Institutional Strengthening<br>(1) Persons trained in health policy and systems analysis.<br>(2) System established in the MOH for monitoring/evaluating reform programs.<br>(3) Persons from KNH and selected provincial/district hospitals trained in financial planning and management relevant to cost-sharing.<br>(4) Through long-term technical assistance contractors, capacity enhanced within the MOH to monitor and evaluate the GOK's health reform agenda and its impact.<br>(5) NHIF planning unit operational. | USAID and contractor training records.<br><br>Contractor reports.<br>USAID mid-term and final evaluations | (a) GOK implementing institutions are able to recruit/retain qualified staff to manage cost-sharing program.<br>(b) Appropriate counterpart staff are available to ensure technical transfer.<br>(c) Institutions will meet conditions precedent. |
| C. Evaluation/Monitoring | C. Mid-term and final evaluations. | | |
| Resources: | | | |
| Policy Reform Support | 9.7 million | | |
| Technical Assistance | 2.0 million | | |
| Cost of Studies/Pilot Tests | 0.3 million | | |
| Training | 1.2 million | | |
| Commodities | 0.7 million | | |
| Other Costs/Contingency | 1.0 million | | |
| Evaluation and Monitoring Costs | 0.1 million | | |
| | 15.0 Million | | |

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Policy Reform Matrix
Health Sector Reform Program

| | Background | Indicators | Timing |
|---|---|---|---|
| Program Goal:<br>(a) Improve the health status of the population, particularly women and young children;<br><br>(b) Contribute to MOH budget rationalization.<br><br>Sub-Goal:<br>Expand the availability and use of primary and preventive health services. | Despite major improvements in infant and young-child mortality (80 and 25 per thousand respectively) these levels remain unacceptably high. Much of this mortality is preventable through early diagnosis/treatment and preventive measures. Major causes of this mortality are measles, malaria, diarrhea, and acute respiratory infections). Under the Sixth Plan (1988-1993), the GOK plans to increase financial allocations for primary and preventive health services, and to focus these resources on those geographic areas of greatest need.<br><br>Implementing a budget rationalization program in order to improve the efficiency of the delivery of government services within an environment of public expenditure restraint, is a major thrust of GOK's 1986 Sessional Paper No. 1. This Sessional Paper entitled Economic Management for Renewed Growth outlines Kenya's development strategy for the remainder of this century. Within the health sector, a reallocation of resources in favor of primary and preventive health services, as well as increasing resources for non-wage | Infant and young child mortality decreased from 80 and 25 per thousand to 45 and 15 respectively.<br><br>Portion of MOH budget allocated to primary and preventive care and for non-wage recurrent costs show a consistent shift to a more cost-effective level of health service delivery. | |

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| | Background | Indicators | Timing |
|---|---|---|---|
| | operating and maintenance expenses to bring about improved capacity utilization, are expected to contribute to MOH's budget rationalization program. The 1986 Sessional Paper No. 1 envisages a gradual reduction in the GOK's overall fiscal deficit from a budgeted 4 percent of GDP in FY 86 to 2.5 percent by the turn of this century, as necessary for stabilization of the economy.<br><br>The government's ability to control the budget deficit will depend on reduced public spending and increased domestic resource mobilization. The implementation of cost sharing within the health sector, in which recipients of selected health services pay for part of the cost of these services, will eventually relieve the public sector burden of financing the full cost of such services. | | |

Policy Reform Matrix
Health Sector Reform Program

| | Background | Indicators | Timing |
|---|---|---|---|
| Program Purpose:<br>To provide sustained increased financial resources for the delivery of efficient quality care in both curative and preventive health services. | Program Purpose:<br>In order to bring about increased allocations for primary/preventive care, and sustain existing health care services (including curative), steps must be taken to address address the financial crisis currently facing the public sector health system. Due to the rapid expansion of the largely hospital-based curative care system, increasing demand to related to population growth, and commitment to "free" health care, the GOK's ability to adequately finance services in the public sector has become severely constrained. These fiscal constraints have also resulted in a reduction in government grants to church-related hospital/ health facilities, severly limiting their ability to sustain, let alone expand, preventive and community based programs.<br><br>Increased GOK allocations to finance this budgetary shortfall in the health sector appear very unlikely. Options available are to find ways of generating revenue through cost-sharing and/or contain costs through improved efficiency. A variety of policy and institutional changes will need to occur to achieve this purpose. These include | Overall<br>(a) Reallocation of resources within the MOH budget such that the share of primary and preventive care will rise by 4-5 percent of the allocated by 1992.<br>(b) Cost sharing gains equivalent to 10 percent of the total allocated MOH budget by 1992. | |



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| | Background | Indicators | Timing |
|---|---|---|---|
| | further refinement and implementation of reforms related to cost-sharing, restructuring of health system in the public sector to improve efficiency, and reforms designed to encourage more effective use of private sector in meeting national health objectives. | | |
| Policy Actions<br>A. Cost-Sharing<br>1. Revise GOK policy to introduce cost sharing and allow collection and retention of fees for services delivered in MOH facilities. | Since independence, GOK has been largely committed to "free" health care in government facilities. To the extent that modest fees have been collected, they have reverted to the Treasury, providing little incentive at the provider level to collect and manage this system. To address the health financing crisis, widespread cost sharing (especially for hospital-based curative care) must be introduced, and a significant portion of the revenue retained by the facility. | GOK policy revised to permit cost sharing in MOH facilities with at least 50% of the revenue retained by the facility, with. balance to finance primary/preventive programs. | Nov 1989 |
| 2. Agreement with GOK on a mechanism and timetable for increasing the level of non-donor financing both in absolute and percentage terms, for preventive and primary services within the MOH recurrent budget. | | Cost-sharing introduced in MOH facilities in a phased manner. | Jan 1990 (beginning) |
| 3. Implement comprehensive cost-sharing program in Kenyatta National Hospital (KNH) with revenue retained by KNH. | Though established as a state enterprise in 1987, to date comprehensive cost-sharing measures have yet to be introduced at KNH. These measures, in conjunction with steps to contain costs, must be undertaken if KNH is to improve quality of care, and over time decrease the public subsidy required. | KNH cost-sharing plan prepared and approved by GOK. | Nov 1989 |
| | | Implementation of first phase of cost-sharing plan begins. | Dec 1989 |

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| | Background | Indicators | Timing |
|---|---|---|---|
| 4. Review and revise the financial contributions to National Hospital Insurance Fund (NHIF) to make them more relevant to level of health risk and cost of treatment. Complete feasibility study to determine the potential for expanding health insurance coverage in the private sector. | Currently insurance finances only 5% of national health care costs. The largest insurer, the National Hospital Insurance Fund, covers about 900,000 contributors, their spouses, and children. The monthly fee of KShs. 20/= (approx. US $1.0) per month has not increased in over 20 years. The fee is regressive, with all income groups paying the same amount. Currently, government facilities generally do not seek reimbursement under the NHIF. | (a) Revised NHIF premium and payment schedule approved. | July 1989 |
| | | (b) Implementation of revised premium/payment schedule initiated. | Sept 1989 |
| | Contributions are very low, do not match the level of health risk and cost of treatment. Plans are under active consideration to revise the benefit and the payment schedule. | (c) Feasibility plan for further revisions to NHIF completed with timephased implementation plan. | May 1991 |
| B. Efficiency and Cost Containment: The proposed program will provide financing to assess a variety of options for improving efficiency. Following list is for illustrative purposes only. Research agenda will be developed with GOK, in consultation with interested donors. | | | |

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| | Background | Indicators | Timing |
|---|---|---|---|
| 1. Redefine the role of the private sector in the provision of health services. | Currently, the MOH operates 62 percent of hospital beds and 71 percent of health centers and dispensaries. The remainder of hospital beds, health centers, and dispensaries are operated mainly by the proprietary and not-for-profit private sector. The private sector participation relieves the GOK from a large share of the burden of providing and paying for health services. Further, the private sector is widely regarded as being more efficient in the provision of higher-quality services than the public sector. MOH/GOK policies on cost-sharing in public facilities, NHIF reimbursement rates and coverage of new groups, and referral practices all affect the financial viability of the private providers. Moreover, it is likely that movement of selected facilities and/or services (e.g., laundry, food service, selected diagnostic tests) currently in the public sector to the private sector might substantially improve quality and reduce costs. The GOK is interested in assessing the feasibility of such changes and has already taken some steps in this direction (e.g., establishment of KNH as a parastatal). | Study re-examining the role of the private sector completed. | May 1991 |



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Policy Reform Matrix
Health Sector Reform Program

| | Background | Indicators | Timing |
|---|---|---|---|
| 2. Systematically apply pricing mechanisms (e.g. by-pass fees) and medical referral rules to discourage inappropriate utilization of secondary and tertiary care facilities. | Substantial evidence exists that lower level health facilities are by-passed by clients seeking essentially primary care. This practice results both in the inefficient use of secondary and tertiary care facilities, and frequently in higher out-of-pocket costs to clients. | Study of use of by-pass fees completed; recommendations reviewed and accepted. | Jan 1991 |
| 3. Develop pilot programs to improve cost-recovery and improve efficiency in selected private non-profit facilities. | Though many church-related and other non-profit health providers are charging fees for selected services, these fees often do not match the costs of providing treatment. The ability of these non-profit providers to subsidize the costs of preventive and community-based programs is increasingly constrained by declining government grants. These groups are seeking assistance in analyzing options for enhancing cost sharing. | | Sept 1991 |
| 4. Develop a systematic mechanism for allocating MOH resources consistent with stated priorities. | Despite policy statements indicating a desire to give priority to primary and preventive services and non-wage recurrent costs, actual spending has continued to favor secondary and tertiary hospital-based services an personnel costs. The stated priority categories remain underfunded. The introduction of cost-sharing is expected to bring substantial new resources to the sector. There is a need to develop procedures and a mechanism to ensure that the new resources are channeled to the underfunded priority areas. | Study of alternative allocation mechanisms completed, preferred option chosen, and preparations made for implementation. | May 1991 |



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Policy Reform Matrix
Health Sector Reform Program

| | Background | Indicators | Timing |
|---|---|---|---|
| 5. Refine methods used to waive fees for those unable to pay. | The planned increase in user charges at KNH and MOH hospitals and introduction of charges at MOH health centers and dispensaries will necessitate strengthening of refinement of procedures to ensure access to services by people of all socio-economic strata. | Study of recommended options for strengthening of current fee-waiver systems completed, preferred option chosen, and phase-one implementation plan prepared. | Oct 1989 |
| | | Studies assessing performance and making recommendations for adjustments to the fee-waiver system completed. | April 1991 and Oct 1992 |

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ANNEX G

# CRITERIA FOR CONDITIONS PRECEDENT

The following is an overview of the rationale for the conditions precedent and the criteria for the PILs to be issued by A.I.D. setting forth specific requirements for compliance with each condition precedent. The contents are necessarily "illustrative" in order to allow USAID to react to the evolving environment and data base.

## I. Disbursements related to performance of Kenyatta National Hospital (KNH)

### A. Rationale for Policy Conditions:

The two key elements of the reform of KNH are the initiation of cost sharing and improvements in efficiency and quality of service. Cost sharing is expected to raise additional revenues and provide consumers with an understanding of the relative costs of services at KNH, while assuring access to tertiary hospital services for all groups in the population. At the same time, the cost-sharing policy will be complemented by efforts to improve efficiency and effectiveness. It is an assumption of this Program that cost-sharing measures cannot succeed without concurrent improvements in efficiency and quality. The cost-sharing plan, therefore, will contain elements to address both efficiency and quality. Efficiency improvements will contain the costs of providing services, make more resources available and reduce the financial burden to consumers (e.g., by reducing average length of stay). Quality improvements (e.g., appropriate drugs available, operating theatres working) will make the acceptance of consumer sharing of costs more palatable.

The overall goal of both of these elements of reform is to decrease KNH's financial burden on the MOH/GOK budget. In the medium-term, this will be accomplished through cost sharing, as the portion of the KNH budget funded by consumers increases, cost containment improves, and efficiency measures take hold. In the longer-term, these measures will allow the real subsidy provided to KNH by the MOH/GOK budget to decline, as both cost sharing and cost savings (from improved efficiency) take place.

KNH has an agenda of reforms (arising mainly from the Reach/KNH Study completed in 1988) that includes both cost sharing and efficiency/effectiveness measures. Further, KNH has set priorities for the order in which it will undertake the reforms.

The cost-sharing priorities are grouped under three headings: cost sharing for general services, for private wing services, and for specialized services. The goals for cost sharing for general services at KNH are to:

- Raise additional revenues for the hospital by increasing consumer contributions well above the current token levels (Ksh 20 per person per year); and

- Through the pricing structure, provide consumers with an understanding of the higher costs of providing services at KNH relative to secondary and primary health facilities to discourage inappropriate use.

The goals for cost sharing for private wing services are to:

- Raise revenues in excess of costs for these services to allow subsidization of general services; and

- Provide KNH's physicians with a place to admit private patients so that there are adequate incentives for them to affiliate with KNH (as opposed to private hospitals).

The goals for cost sharing for specialized services are to:

- Raise revenues for the hospital by increasing consumer contributions; and

- Improve the quality and cost-effectiveness of services in order to attract both private wing and general ward patients.

B. Illustrative PIL Content:

1. First Disbursement.

KNH will provide USAID with an implementation plan and time schedule for introducing GOK approved cost-sharing measures within KNH. This plan should describe the specific cost sharing measures to be undertaken, including proposed fee schedules, policies on retention, arrangements for use and administering income generated, centralization of admissions and fee collection. The implementation plan also will identify those persons at KNH selected to receive training in financial management/accounting, some of whom will be financed under the technical assistance and training

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component of the Program. KNH will also conduct an annual review of fees based on updated cost estimates and quality of those services.

The implementation plan should describe procedures for ensuring access for those patients unable to pay. The plan should describe the design and establishment of an on-going monitoring system to be used by KNH to assess changes in the number and socio-economic characteristics of KNH patients. The plan should provide a schedule for the immediate collection of baseline data to provide a basis against which to compare future measurements and describe the methodology to be used for determining the proportion of operating costs being recovered through cost sharing. The submission should include an analysis of baseline data and proposed targets for subsequent benchmarks.

Related to cost sharing, the plan will include a report showing the methodologies; (1) to determine the proportion of operating costs being recovered through cost sharing and (2) to be used by KNH to decide pricing, expansion, and capital improvements in the private wing. The methodology should be based on a long-term goal of at least breaking-even on long-run marginal costs (the additional cost of providing the service including depreciation of capital) in the provision of private wing services and in the interim period not increasing the total or per-patient subsidy element in the pricing of private wing services. The methodology should include collection and analysis of data on:

- Estimates of the costs of the investments and other activities associated with services in the private wing;

- Proposed prices for services in the private wing;

- Projected occupancy rates of beds in the private wing;

- Projected time path to a break-even or profitability point; and

- Process by which prices or the level of services provided will be adjusted.

The plan should show the development of an operations and procedures review for specialized services. The focus of this review will be on improving the quality of services and identifying opportunities for cost containment. The methodology developed will be pilot-tested in one of the following departments or services: pharmacy, radiology, laboratory, sterile preparation department (SPD), theatre, and casualty. A report on the results of this pilot test will show how actual practices were evaluated against suggested procedures and recommend reforms to be made, if any. If necessary, the methodology will be adjusted based on findings from the pilot test.

The documentation should confirm that the six senior management positions (Planning, Nursing, Clinical Services, Administrative Services, Finance and Personnel) have been filled, and that a staff position to lead the reform process, reporting to both the KNH Director and Board has been established (this may be the head of Planning) and filled (either by elevation or appointment). This position should have the authority and responsibility to execute reforms. Further, positions will be established by KNH to support the reform leader at a level of qualification to permit the holders to be delegated the coordination of reform projects.

2. Second Disbursement.

KNH will provide USAID with evidence that the proposed fee schedules, the arrangements for administering income generated and centralizing admissions and fee collection as defined in the implementation plan required for the first disbursement, including any modification of fees, are in place. This will include the personnel hired and the implementation of procedures as specified in the plan.

The documentation should include an assessment of procedures used to ensure access for those patients unable to pay. This assessment will be based on the results of the ongoing facility-based monitoring system and a special study carried out jointly by KNH and the Ministry of Health comparing the socio-economic status of Provincial and District Hospital referred and non-referred patients to KNH patients. Further, data produced by studies evaluating the adequacy of access-ensuring measures at the Provincial and District Hospitals will be examined. If

results of the study indicate that access-ensuring procedures are not performing adequately (i.e., evidence is found of socio-economic hindrances to use of KNH services), modifications to the procedures used to identify patients to be exonerated from fees will be proposed.

The documentation should include a report to USAID showing that a time-phased implementation plan has been developed for procedures reviews for the remaining departments or services not assessed for the first disbursement: i.e., pharmacy, radiology, laboratory, SPD, theatre, and casualty. The KNH report will assess progress in achieving benchmarks established under the implementation plan. Finally, the report will show how actual practices were evaluated against procedures and identify time-phased steps to be taken to improve these services.

The documentation should show that the private wing is breaking even on its short-run marginal costs (i.e., that fees adjusted for bad debt cover the additional costs of serving patients, not accounting for depreciation of capital).

The documentation should include a feasibility analysis to USAID and subsequently a business plan for investments proposed for the establishment of a doctors' practice plan. The feasibility analysis should recognize that the doctors' practice plan will bring both direct-financial and non-financial benefits to KNH. For example, the methodology for the study should consider that non-financial benefits will come from attracting the association with KNH of the best consultants (medical specialists), thereby enhancing the hospital's reputation. Normally, the results of a feasibility analysis should show potential profitability to go on to the stage of business-plan preparation. However, given the non-financial benefits of the plan, feasibility-analysis results projecting small losses may be sufficient to go on to the business plan stage if non-financial benefits are significant. The business plan will include:

- Estimated costs of the investments and other activities associated with establishing the plan;

- Proposed prices (e.g., office rents) for services provided to doctors;

- Projected occupancy rates of offices and private and general beds;

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- Expected time path to profitability; and
- Time schedule for implementation.

The documentation also will include evidence that the targets established in the implementation plan for the proportion of operating costs recovered through cost sharing have been met. If the targets have not been met, documentation of constraints preventing their realization, and proposed revisions should be included.

3. Final Disbursement.

KNH will provide USAID with evidence that benchmarks related to fee schedules, arrangements for administration of income and centralization of admissions and fee collection have been achieved as specified in the implementation plan.

KNH will provide documentation to USAID that modifications, as necessary, that have been made to the procedures used by KNH to ensure access for those patients unable to pay. This documentation will be based on either the results of a repetition of the study described in response to the condition precedent for the second disbursement or data from the population-based monitoring system recommended in the World Bank Health Financing Mission Aide Memoire of 16 May 1989.

The documentation should confirm that the targets established in the implementation plan for proportion of operating costs being recovered through cost-sharing have been met. If the targets have not been met, KNH's written report will document the constraints preventing their realization. The documentation should show, however, that the private wing is breaking even on its long-run marginal costs (i.e., that fees (adjusted for bad debt) cover the additional costs of serving patients, including depreciation of capital). The documentation also should show achievement of the time schedule for implementation of the business plan (see condition #2) for the doctors' practice plan. Finally, the documentation should contain evidence that the implementation plan (see condition precedent #2) for procedures reviews has been completed and that reforms have been instituted in the specialized service departments, as recommended in the reviews.

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## II. Disbursements Related to Performance of Ministry of Health (MOH)

### A. Rationale for Conditions:

The Ministry of Health has embarked on a process of reform of the financing of the health sector. This reform is based on the institution of consumer sharing of the costs of providing health services through user charges. In addition to generating resources directly, user charges also can affect the efficiency with which consumers use services. In this way user charges can help contain costs. The additional resources generated for the sector through cost sharing are intended to be used to increase support for currently underfunded health services. The subsector most underfunded is primary and preventive services.

To achieve the objective of improving support for underfunded services through cost sharing and cost containment, the user-charge system itself must work properly to generate revenues and contain costs. Further, there must be a mechanism to direct additional resources generated toward the underfunded services. To make the user-charge system work, several steps must be taken:

- Administrative arrangements for the collection, safeguarding, and allocation of funds must be in place;

- Quality of services for which charges are made must be high enough for consumers to be willing to pay for them;

- Measures must be in place to ensure access to services to all, regardless of ability to pay; and

- A system must be in place to monitor the impact of the program measures on utilization so that adjustments to the fee structure can be made, as needed.

To provide incentives for consumers to use the appropriate (and efficient) level of services in the MOH system, the structure of user charges can be set so that more-costly higher-level services require the payment of higher fees. The use of such a fee structure, along with administrative measures to strengthen referral practices, would direct patients to the level of service at which they could be most efficiently treated.

The mechanism to channel additional resources generated by cost sharing and cost containment to underfunded services must differ from the usual allocation mechanisms, since those mechanisms led to the underfunding in the first place.

Lastly, but most importantly, the MOH plays a key role in the success of the sector's reform. The MOH must design and implement its financing reforms, monitor and evaluate them, and then modify them as necessary. Moreover, the reforms made within the MOH system affect and are affected by the reforms being made at Kenyatta National Hospital and the National Hospital Insurance Fund. In addition, consumers, employers, health professionals, private proprietary and not-for-profit providers, and municipalities are affected by the changes being made. It is the MOH's role to provide leadership for the sector as a whole by setting up a consistent strategy that takes into account the needs, wants, and abilities of all concerned parties. Thus, the MOH's capacity to play this role is critical to the success of the process.

The MOH is committed to initiating cost sharing in its facilities in GOK FY 89-90. In the first year fees will be set at modest levels and the actual introduction of fees will be phased in gradually, as administrative arrangements are put into place. Further, the mechanisms for channeling additional resources to underfunded services will take time to set up. Thus, the expected revenue and cost savings and new resources flowing to primary and preventive services in the first year of the program are modest. However, the first year of the cost-sharing program should set the stage for the expected growth in revenues (as the system becomes fully implemented and, later, through increases in fees), containment of costs, and improvement of funding of primary and preventive services in GOK FY 90-91 and beyond.

The conditions set for the MOH reflect the time-phasing and the needs of the financing reform program. In all instances, fine tuning of the conditions can be expected during implementation. Recognizing that the policy environment is dynamic and requires continued adjustment as the data base is improved, the substantive condition precedent will be set forth in the ProAg, with the detailed requirements to be contained in PILs. PIL Number 1 shall be agreed upon and delivered at time of ProAg execution. Subsequent PILs will be used to reflect necessary modifications in the detail of compliance with conditionality. Provided below is illustrative PIL content for MOH conditions precedent.

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B. Illustrative PIL Content

1. First Disbursement

The MOH will provide USAID with an implementation plan which should include:

- Schedule of fees to be used and its rationale;
- Steps to be taken to strengthen mechanisms for fee collection, including audit;
- Plan and rationale for phased introduction of fees (e.g., geographically or by level of facility);
- Percentage of fees to be retained by the collecting facility (at least 50 percent);
- Steps to be taken to introduce and/or strengthen procedures to waive fees for those unable to pay (strengthening to take place before the introduction of fees);
- Monitoring and evaluation plans including collection of information on financial and economic costs of implementing the fee system;
- Projections of the annualized rate of fee revenue generation to operating expenses; and
- Implementation schedule.

The plan also should describe the system to waive fees for those unable to pay at all levels of MOH facilities, which system would be based on:

- Review and evaluation of fee waiver systems currently used in provincial and district hospitals, NGO hospitals and health centers and in other sectors, (e.g., education);
- Review and evaluation of studies of ability and willingness to pay for health services in Kenya; and
- Analysis of the recommended options for accuracy in identifying those unable to pay and administrative feasibility.

The plan should describe options considered and chosen for strengthening the system, and should include the criteria to be used for waiving fees at each level of the system.

The plan should describe the monitoring and evaluation methods for assessing administration of the waiver system, including collection of information on the financial and economic costs to facilities implementing and clients complying with the system.

The plan should describe methods for monitoring the impact of user-fees on access, referrals, and utilization of MOH facilities. The plan should describe the specific indicators (i.e., client characteristics), methodology to be employed, and persons responsible both at the central and facility level for collecting and analyzing these data. The plan should confirm that initial baseline date will be collected prior to initiating new user fees and will have appended the data collection instruments to be utilized. Mid-term and final benchmarks for positive changes in access, utilization, and referral patterns will be provided.

The plan should include a report showing the breakdown of actual operating expenditures by the GOK on health (i.e., by the MOH, Municipalities, and KNH) for FY 88-89 and budgeted operating allocations for FY 89-90. The plan also should include documentation will include these guidelines governing the use of the cost-sharing revenues by the retaining facilities or teams.

The documentation confirming that a Health Care Financing Implementation Committee has been established at the Permanent Secretary level in the MOH should include terms of reference for the Committee, job descriptions and authorization of key professional positions. The documentation will confirm that the position of Committee head has been filled and that the Committee is located so that it will have direct access to senior policy makers in the MOH. The documentation should also confirm that the Health Care Financing Impementation Committee secretariat will serve as counterparts to the long-term technical assistance team.

2. Second Disbursement

MOH will provide USAID with evidence that the benchmarks set under the plan have been achieved. The documentation concerning the second disbursement should include:

- An actual annualized rate of revenue collection through cost sharing to operating expenditures on 1 January 1991 projected to be at least 4 percent or such other annualized rate accepted by USAID;

- Required revisions to the fee schedule to correct for weaknesses observed, with particular attention to access for those unable to pay;

- Required revisions in administrative arrangements (such as fee collection, recording, and safeguarding procedures); audit; planning and budgeting for expenditures of fee revenues at all levels to correct for weaknesses observed in GOK FY 90-91; and

- Projected rate of fee-collection revenues to operating expenditures for GOK FY 91-92 (showing a projected rate of at least 7 percent or such lesser figure as A.I.D. may determine to be adequately justified).

Documentation describing the performance of the fee-waiver system will be based on the information produced by the monitoring system, and should describe:

- Administrative costs of the system;

- Accuracy of the system in identifying those who are unable to pay;

- Procedures to ensure access for those unable to pay;

- Revenue opportunity costs of the system (i.e., the fees that would have been collected if everyone had been able to pay);

- Costs to consumers (e.g., time spent justifying eligibility for a fee waiver);

- Recommendations for modifications of the fee-waiver system to take effect 1 July 1991; and

- Recommendations for changes in the monitoring system.

The documentation should show the breakdown of actual operating expenditures by the GOK on health for FY 89-90 and budgeted operating allocations for FY 90-91. The documentation will describe the changes in non-primary curative, primary and preventive program expenditures and budgets for all levels of facilities and programs. The documentation will provide this information for both GOK spending alone and combined GOK and donor spending.

The documentation should confirm that cost-sharing revenues retained locally were expended in accordance with guidelines issued by the MOH. Documentation will also be submitted by the MOH describing proposed modifications to guidelines for the spending of cost-sharing revenues for GOK FY 90-91, continuing emphasis on primary and preventive services and critically-needed and quality-of-care repairs to facilities and equipment.

The documentation should confirm that a systematic mechanism for allocating resources has been adopted for phased application beginning in GOK FY 91-92. This mechanism will apply to MOH resources in general, and to the supplemental resources generated by cost-sharing in particular. In the latter case, resources will be allocated increasingly in favor of primary and preventive care. This mechanism will be designed to:

- Ensure that primary and preventive services receive a growing share of total operating expenditures; and

- Allocate resources among facilities and districts to compensate for inequalities in their health care needs and in their health care needs and in their ability to earn user-fee revenues.

The comprehensive financing strategy developed by the MOH Health Care Financing Implementation Committee for the Kenyan health sector should include:

- Definition of the overall goals of the health sector in Kenya;

- Definition of the roles for each of the following in the use, provision, and financing of health services as they relate to health sector goals in Kenya;

- Public sector (e.g., Ministry of Health, City Commissions/Municipalities);

- Parastatals (e.g., Kenyatta National Hospital, National Hospital Insurance Fund);

- Private sector (e.g., proprietary and not-for-profit providers, employers, cooperatives, and private insurers);

- Communities; and

- Foreign assistance.

The documentation should include an analysis and definition of the roles of the various actors, considering the relative abilities of each to:

- Provide different types and levels (i.e., primary, secondary, and tertiary, and curative, preventive, and promotive) of services;

- Finance investment and operating costs, services provided to those unable to pay, and risk-sharing arrangements; and

- Development of criteria concerning:

- - Subsidization of services (e.g., preventive and promotive, chronic, etc.); groups (e.g., mothers, children, those unable to pay, refugees); and geographical areas (e.g., arid and nomadic); and

- - Facility location (e.g., objectives for physical access, taking into account current location of public and private facilities).

The documentation should describe the status of progress in the implementation of the time phased plan for cost sharing. The documentation should include copies of the population and facility-based monitoring reports from 1 April 1991. The monitoring reports should include:

- Data and analysis of patterns of utilization of all levels of MOH facilities, including both intensity (numbers of users) and access (geographical and socio-economic);

- Revenues earned at each level of facility, broken out geographically and showing revenues not collected because of fee waivers and showing shortfalls in expected revenues from collections model from non-waivered clients; and

- Data and analysis of trends, and corrective measures proposed for undesirable trends.

3. Final Disbursement

The documentation submitted to meet the third condition should describe the performance of the cost-sharing system, updating projections, and adjusting fees for GOK FY 92-93, as appropriate, and showing:

- An actual annualized rate of revenue collection through cost sharing to operating expenditures for GOK FY 91-92 of a projected 7 percent;

- Any revisions to the fee schedule and rationale showing how the new schedule will correct for past weaknesses;

- Revisions to administrative arrangements (such as fee collection, recording, and safeguarding procedures; audit; planning and budgeting for expenditures of fee revenues; and fee-waiver procedures) at all levels to correct for weaknesses encountered in GOK FY 91-92; and

- Projected rate of fee-collection revenues to operating expenditures for GOK FY 92-93 of a projected 10 percent or such lesser amount as A.I.D. may determine to be adequately justified.

The documentation also should describe the performance of the fee-waiver system. In this respect, the documentation should:

- assess the accuracy of the system in identifying those who are unable to pay;

- access revenue opportunity costs of the system (i.e., the fees that would have been collected if everyone had been able to pay);

- access costs to consumers (e.g., time spent justifying eligibility for a fee waiver);

- Present recommendations for modifications of the systems used at each level of facility to take effect 1 July 1993; and

- Present recommendations for changes in the monitoring system.

The documentation also should show that the final benchmarks contained in the monitoring plan accepted by AID to meet condition 1 have been achieved and provide an analysis of changes in utilization, referral and access patterns that have occurred since introduction of fees.

The documentation should show the breakdown of actual operating expenditures by the GOK on health for FY 90-91 and budgeted operating allocations for FY 91-92. The documentation should contain an analysis of the changes in non-primary curative and primary and preventive expenditures and budgets for all levels of facilities and programs. It should show that the share of operating expenditures allocated to primary and preventive services in GOK FY 91-92 have been maintained at no less than the FY 88-89 levels (in both GOK spending alone and for combined GOK and donor spending) and that the equivalent of fifty percent of actual cost-sharing revenues generated in FY91-92 were allocated to and spent on primary and preventive services.

The documentation should evaluate the systematic method for allocating the supplemental resources generated by cost-sharing increasingly in favor of primary and preventive services. The documentation should describe the performance of the system in raising the share of operating expenditures allocated to primary and preventive services, versus non-primary curative services. Further, the documentation should make recommendations for revisions to the system.

The documentation also should describe progress in implementing the comprehensive financing strategy for the Kenyan health sector developed by the MOH Health Care Financing Implementation Committee. In this respect, the documentation should include:

- The agenda for reform developed by the MOH based on the sector strategy;

- A time-phased plan for implementing the reform agenda; and

- Progress made in meeting benchmarks as described in the plan benchmarks and recommended modifications to the plan.

The documentation on progress in implementing the monitoring plan accepted by AID to meet conditions 1 and 2 should describe progress in achieving the plan's objectives and recommend additional modifications to the monitoring system. Further, the documentation should include copies of the monitoring reports for GOK FY 91-92. The monitoring reports should include:

- Data and analysis of patterns of utilization of all levels of MOH facilities, including both intensity (numbers of users) and access (geographical and socio-economic);

- Revenues earned at each level of facility, broken out geographically and showing revenues not collected because of fee waivers and under collection of expected revenues from non-waivered clients; and

- Data and analysis of trends, and corrective measures proposed for undesirable trends.

## III. Disbursements Related to Performance of National Hospital Insurance Fund (NHIF) Reforms

### A. Rationale for Conditions.

The three key elements of the reform of the National Hospital Insurance Fund (NHIF) are the development of a consensus on the medium and long term goals and objectives of the Fund within the larger health system in Kenya, the implementation of the interim reforms contained in the Bill currently before Parliament, and strengthening of its administrative and operational capacity.

Consensus needs to be reached about NHIF's goals and objectives, since there is debate over whether and how its influence should be used in the sector. It currently fulfills the role assigned to it by its charter, providing its contributors with access to hospitalizations, particularly in private care facilities. In this role, the NHIF has contributed and will continue to contribute importantly to the financial sustainability of health sector programs. Through this mechanism, NHIF has helped to finance the cost of hospital services delivered in both the public and private sector.

Through the recently-approved reform program, NHIF will introduce a progressive fee structure, and employer contributions and reimbursement rates will be increased to bring them more in line with actual costs of delivering services. In the longer term, however, the Fund needs to consider the role it can, and should, play in providing coverage to non-salaried workers. In this regard NHIF should determine:

- The extent to which the NHIF should attempt to bring new groups (e.g., non-salaried workers) under its coverage;

- The changes that should be made in benefits offered; and

- The extent to which new providers should be registered, and the criteria to be applied, etc.

In order to implement the recently-approved reform program, the NHIF will need to strengthen its management and administrative capacity, particularly the cost and actuarial data base needed to adjust premium levels and determine appropriate benefit packages.

B. Illustrative PIL Content.

1. First Disbursement.

Documentation submitted in respect to the first disbursement should describe the revised (progressive) premium structure, employer contributions, the new reimbursement schedule, staff development requirements anticipated, and organizational changes. It should indicate that NHIF has taken steps to ensure that all public-sector health facilities eligible to claim reimbursement for NHIF-insured parties are aware of the revised payment schedule, and the procedures for claiming reimbursement.

The documentation should confirm that an actuarial division has been established in the NHIF organization and that the position of division head has been authorized and filled. The documentation should include the job description of the position. It also should define the requirements for automation of NHIF, with respect to actuarial, audit, claims processing, accounting, and management information. It also should specify the appropriate hardware and software required for these systems.

2. Second Disbursement.

The medium and long term strategic plan should be presented including, among other things:

- Definition and assessment of current and potentially insurable populations and strategy for reaching these groups;

- Description of the benefit options to be offered and the premiums associated with each;

- Identification of resources required (including personnel, financing, infrastructure);

- Description of the options considered and those recommended for implementation; and

- Delineation of steps to be taken, including identification of persons responsible, and a time schedule for implementing the plan.

The plan should include a report showing that a mechanism for assessing registered providers' costs and quality of

services has been implemented. The documentation should describe the methodology and procedures followed (including criteria for assessing quality), as well as samples of output reports from the system.

3. Final Disbursement.

Documentation concerning the final disbursement should include, among other things, a plan for the next stage of restructuring of NHIF. The plan should include an assessment of NHIF's current structure versus its mandate with respect to contributors, benefits, and reimbursements, supported by actuarial data. Further, the plan should propose changes in the structure of NHIF and a timetable for revising the National Hospital Insurance Act to accomodate those changes.

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ANNEX H

LEGISLATIVE REQUIREMENTS: FAA Section 611(1)(2)

A. Required Actions: The only legislative action necessitated by the Kenya HCF Program relates to the National Hospital Insurance Fund. It is anticipated that the National Hospital Insurance Act Chapter 255 will be amended as follows: (See original act attached).

1. Change of the NHIF to a State Corporation;

2. Change in the rate of contributions and benefits;

3. Change in the types of investment NHIF will be able to make; and

4. Change in the approval process for Board of Trustees approval of future changes in contribution/benefits, and coverage of beneficiaries.

B. Timing: The necessary legislative enactments have proceeded as follows:

June 6, 1989: Draft Amendment Act 255 was sent to the Minister of Health.

June 12, 1989: Forwarded to the Attorney General's (AG) Office for review.

The next steps are for the AG to concur and publish the amended Act and for the Minister for Health to present the Act to Cabinet for their review and comment.

The Act is on the docket to be acted upon during this session of Parliament, i.e., June 13 to July 31, 1989. The draft amendment has already been reviewed by a sub-committee of Parliament and their comments incorporated. Delays in Parliament approval are not anticipated.

At the latest, by July 31, 1989, Parliament is expected to approve the Act and forward it to the President for signature, whose signature is usually obtained within two weeks. The Act is then sent to the AG's Office to sign the Act into Law. The signed Act is then sent to the Minister for Health for gazetting by August/September 1989.

(NOTE: If the Bill does not pass through legislative action during this session of Parliament, it will appear on the docket for the next session in September. The sequence would be the same but the law would not come into effect until November/December 1989.

C. Program Impact: There is high political pressure to move the Health Care Financing Reform Agenda; therefore, we do not anticipate any major GOK delays in amending the Act.

However, in the event of such, it would not adversely affect the overall HCF Program because the three implementing organizations have separate conditionality. Therefore, a delay in NHIF reform agenda will not affect the pace of reform at the MOH or KNH. Furthermore, NHIF's interim reform agenda is a first step in the direction of additional major changes in the Fund planned over the coming 18 months. The bulk of NHIF's activity during this timeframe center on strategic planning and internal efficiency changes that can take place without an amendment to the Act. Thus, planned HCF support to NHIF under the technical assistance component can continue and certain administrative/management changes can be made.

Ideally, the law needs to be in effect at the latest in May 1991 to avoid any significant negative impact on this aspect of the financing program. Therefore, it is our opinion that AID should make the judgement that it is reasonable to expect that the legislative actions necessitated by the Reform Program will be accomplished in a timely fashion.

WP#5134M

# Kenya Health Finance Mission

## Final Aide-Memoire

16 May 1989

A World Bank/USAID/UNICEF mission led by Mr. N. Burnett (World Bank) and including Ms. L. Alexandre and Messrs. Bennett, Forgy, Franey, Gertler, Hopkinson, and Vogel (consultants) visited Kenya from April 24 to May 15. The mission's objectives were to review the cost-sharing measures that the Government of Kenya is introducing in the health sector, to identify measures to accompany cost-sharing (especially at Kenyatta National Hospital), and to help develop a program of studies for further sectoral reform.

The Government's tight budgetary situation will permit it only to maintain the real level of public spending on health financed from general revenues. While this has led to the emphasis on cost-sharing as a source of additional resources, the mission agreed with the Government that this situation also warrants an increased emphasis on preventive and family planning measures and on improving efficiency, both allocative and managerial. Donor support for the Government's program is proposed from USAID, with a Health Care Financing Program to be agreed by September 1989, and from the World Bank, with an IDA investment project at Kenyatta National Hospital (KNH) to be appraised during 1989/90 and an IDA health policy operation to follow.

This aide-memoire summarizes the recommendations made by mission and the agreements and understandings it reached with the Government. In doing so, the mission has been concerned to consider the impact of proposed changes in the public sector on the health care system as a whole, including private and voluntary providers.

### A. Policy Context and Supervision

A Letter of Health Policy from the Government will be part of the documentation for the Bank project at KNH and will serve to link it to the subsequent policy operation. To prepare for the letter, a high level Policy Review Meeting will be held in the first week of August at the start of the next Bank mission. A draft letter will be prepared by the Government during the mission's stay. The present mission left with the Ministry of Health (MOH) examples of policy letters and some ideas about the possible content of the Government's letter (Annex 1).

The extent of the various reforms under way and planned, notably but by no means exclusively the introduction of user charges, is such that the mission has agreed with MOH that a special policy supervisory unit should be established, headed by a full-time senior official reporting to top departmental management, charged with overseeing the ongoing and planned reforms.

It was further agreed that there would be no Government regulation of the fees charged by private health providers.

B. User Charges.

Principles. Principles were agreed for user charges at public sector health facilities (Annex 2). User charges will be phased in, with a first phase in 1989/90.

Implementation during 1989/90. The mission agreed with the Government on the goals, timing, general levels, protection of the poor, administration, monitoring and expenditure priorities of user fees during the first phase:

1. Goals. The goals for 1989/90 are to gain public acceptance, to establish a proper structure of incentives, to put in place administrative procedures to collect and spend fees and to permit free followup visits and referrals, and to ensure that all members of society, including the poor, continue to have access to care.

2. Timing. Fees will be announced before the end of 1988/89 but implementation will not take place until (a) an administrative structure is in place to collect fees and allow free follow-up visits and referrals; (b) a facility-based monitoring system is established; (c) a system for auditing facilities' fee collection is set up; (d) procedures are implemented to waive the fees for the poor; and (e) agreement is reached between the Government and municipalities that the latter will introduce the same schedule of fees. These administrative arrangements are essential to the smooth functioning of the user charge program and hence to its acceptance by the public. While they will take several months to establish and will first be implemented at hospitals, which already have fee collection procedures in place, the entire fee collection system should be operating fully by the end of 1989/90. The period between announcement and implementation will also be used for an intensive program of public education about the objective of charging fees to improve quality.

2. Fee Levels. Table 1 illustrates a fee structure that is consistent with the agreed principles and goals for 1989/90. Fees increase with the level of care, but outpatients referred to higher levels are not charged. Nominal registration fees at the lowest level of care deter unnecessary utilization but are low enough for the vast majority of people to afford. In order to promote the best health outcomes, the fee structure allows free followup visits, preventive and family planning visits, and visits by children under 5 who have an immunization card and whose immunizations are on record at dispensaries and health centres. A policy regarding notifiable diseases should be developed. Fees will be collected in advance; for inpatients, this will just be a deposit.

Table 1
Kenya: Initial Structure of Health Care Fees
(KSh)

| Level of Service / Type of Service | Dispen-sary | Health Center | Dist. Hospital | Prov. Hospital | Kenyatta National Hospital |
|---|---|---|---|---|---|
| 1.Registration, per illness | | | | | |
| Children under 5 | (a) | (a) | 20, but 0 | 30, but 0 | 0, as only |
| Adults and over 5 | 5 | 5 | if refer. | if refer. | by referral |
| 2.Outpatient, curative (b) | 0 | 0 | diagnosed & treated | diagnosed & treated | 50 |
| 3.Outpat, preventive (c) | 0 | 0 | 0 | 0 | 50 |
| 4.Outpatient, casualty (d) | NA | 0 | 60 | 100 | 200 |
| 5.Outpatient, drugs (e) | | | | | |
| Children under 5 | 5 | 10 | 10 | 10 | 10 |
| Adults and over 5 | 10 | 10 | 10 | 10 | 10+ |
| 6.Inpatient, general per day | NA | 10 max 50 emer: 0 | 20 max 100 | 30 max 150 | 100 (f) |
| 7.Inpatient, amenity per day | NA | NA | NA | 200 | (g) |
| 8.Inpatient, maternity | 40 | 50 refer: 0 | 60 refer: 0 | 100 refer: 0 | 200 + daily rate refer: 0 |
| 9.Inpatient special service | NA | NA | (h) | (h) | per sched. established |
| 10.Inpatient, drugs (i) | NA | 0 | 0 | 0 | 0 |

FOOTNOTES:

(a) Children under 5 not charged if immunization card presented. Otherwise adult registration fee applies.

(b) Registration fee already paid.

(c) Registration fee waived for immunizations, ante-natal care, family planning. Consideration needed for notifiable diseases.

(d) True emergency cases to be free; fee is for those who use casualty as after-hours treatment facility.

(e) If physician certifies chronic illness, free refills for 1 year.

(f) Consideration may be given to a maximum number of days.

(g) KSh 800 per day for VIP suite; KSh 600 for single room; KSh 400 for general amenity ward. Non-Kenyans would pay KSh 1,300, 900, and 600 for the same accommodations.

(h) Initially, no fee for services at Dist. and Prov. Hospitals because of lack of data. Fees charged in subsequent phases after data for fee schedules for these services is developed.

(i) Drug costs included in the daily rate.

In order to tie the fees to valued services, there will be nominal charges for drugs. Thought needs to be given to whether to charge for preventive drugs such as chloroquine. Amenity ward charges may not cover costs in this first year, as information on such costs is not yet available. Fees are expected to initially generate the equivalent of 3-4 percent of the Ministry of Health's recurrent budget on an annualized basis.

3. Protecting the Poor. Explicit procedures will be introduced to ensure that the poor are able to obtain care. Registration fees are set at very low levels at the dispensaries and health centres. Free followups and referrals to higher levels of care ensure access to outpatient care. Moreover, there will be no charges for children under five who present an immunization card or for family planning services. The existing formal procedure to waive fees for the poor will be continued at each facility but will be regularly audited to minimise cheating. Because of the referral system, there will be no waiving of outpatient fees at the higher levels of care. At the lowest level facilities, with the lowest fees, few waivers will be required; a higher proportion of inpatient fees will be waived.

4. Administration. At each facility, a centralized admissions location will allow the fee and monitoring information to be collected and a receipt issued. At this point, waivers for the poor will be determined and issued. The patient will then see a medical care provider; if a followup visit or referral is necessary, the provider will indicate this on the receipt.

5. Monitoring. A population-based monitoring system will be put in place as quickly as possible to complement the facility-based monitoring to be introduced ahead of charges. This monitoring will be used to assess the effect of fees on the poor and to gather the information needed for future adjustments to fees. The Ministry of Health has requested the World Bank to present detailed options for implementation of the monitoring system and to coordinate donor financing (see outline terms of reference in Annex 3). The Ministry of Finance endorsed this request and asked the World Bank to plan the population-based monitoring system in the larger context of the effects on social welfare of user charges in all sectors and suggested a followup mission within the next two months.

6. Expenditure Priorities. A significant portion (50-75%) of the fees collected at each facility will be made available to improve the quality of care at the facility, without any commensurate reduction in the funds it receives from MOH. Equally, MOH's funding from the Ministry of Finance should not be reduced as revenues begin to accrue. The remainder of the fee revenues will be divided among district, provincial and national health authorities to be used to increase spending on preventive services and to improve quality at facilities that may not initially raise much from fees as they are located in poor areas. To guide the expenditure of revenues generated from user fees, a system of guidelines will be introduced to enable local officials to determine quality enhancing priorities at the facility level. The mission found that the quality of care at

provincial and district hospitals was low, largely because of a lack of recurrent funds for supplies and maintenance. A similar system will also be needed to determine prevention expenditures and subsidies to poorer districts.

It was agreed among the Government, the World Bank and USAID to refocus slightly the terms of reference of the Provincial and District Health Services Study, scheduled to start in June, so that its outputs would include recommendations on alternative procedures for admissions and fee collection, referrals and follow-up visits, and determining spending priorities at the facility level. This study will also generate cost data essential for future adjustments to charges, especially for amenity wards. A second phase of the study - as yet unfunded - should focus on spending priorities and the budgetary and management system at the district, provincial and national levels; outline terms of reference will be provided in the mission's final report.

Subsequent Implementation. Based on initial experience as indicated by the monitoring system, the fee structure and administrative system will be adjusted in future. Expected changes include raising most fees; possibly lowering fees at some levels of care and in some geographic areas to protect the poor; adjusting the relative fee levels across levels of care to improve incentives for appropriate use of facilities; and introducing differential drug pricing according to the number of drugs included in the prescription and whether these include antibiotics. Revenues from fees will rise signficantly over time and may ultimately be expected to reach 15-20% of the Ministry of Health's recurrent budget. A community-based waiver system for the poor will be introduced, perhaps administered under one program that will apply also to other Government services such as education and water supply. Specific service fees (e.g. for surgery, lab work or X-rays) may be introduced at the secondary level. Charges for drugs may be further refined and related more to costs. Amenity ward charges will be raised to more than cover costs; the Government agreed that it would not be advisable to build new amenity wards until charges cover costs at existing provincial hospital wards.

## C. National Hospital Insurance Fund

The mission has reviewed NHIF's proposed restructuring and the comments made by the Ministries of Health and Finance and concluded that the proposed changes are neither financially viable nor administratively feasible. Sufficient information is not available on patterns of health care utilization of the proposed new membership categories to actuarially assess potential liability. Even excluding them, proposed benefits - especially those associated with outpatient care - will create liabilities greater than the funds available from contributions. While the current manual process for registering contributors and processing claims is adequate, the additional workload implied by the proposed benefit changes could not be accommodated manually and the introduction of automation is at least a year away.

Accordingly the Government and NHIF will adopt a phased implementation plan that will protect the financial viability of the Fund

while allowing time to collect the necessary socioeconomic, demographic and utilization data on existing and proposed contributors and to define automation requirements, procure equipment and train staff.

Changes for 1989/90. In the first phase of this plan, to be incorporated in a bill to be approved by Parliament by 1 July 1989:

- Contributions will be based on 15 income groups until administrative procedures have been changed to facilitate application of a straight percentage of actual income; the mission finds no reason to raise contributions above a level equivalent to about 2% of income.

- Membership will be compulsory only for current contribution categories;

- Employers will be required to contribute 10% of the total amount of contributions deducted from employees;

- Benefits will continue to be limited to inpatient care;

- A copayment equal to the charge of the first full day of inpatient care will continue to be assessed;

- Reimbursement to all providers will be doubled, based on current levels of payment until better cost and quality data are available for specifically adjusting rates;

- Generated reserves will be restricted to the alternative uses specified in the Trustee Act;

- The terms of service of the Trustees on the NHIF Board will be staggered to ensure continuity;

- Additional studies will be carried out and assistance sought to build a national consensus on NHIF's objectives and its role in health policy; assess the potential of sharing services (e.g. collection of contributions) with the National Social Security Fund; develop an actuarial database; analyse the labor market effects of employer contributions; implement automation; develop a provider quality and cost reporting system for establishing reimbursement levels; and develop a phased implementation plan for future reforms. These activities should be used to rationalize various policy objectives (e.g. the use of insurance payments and the cross-subsidization of public facilities) so that they can be incorporated in the plan for future reforms.

Subsequent Implementation. Using the actuarial, provider quality, cost and health policy information available from the recommended studies performed during the first phase of implementation, it is envisioned that subsequent reform of NHIF will follow quickly and include expanding the membership to other categories of contributors, an increase in the scope and magnitude of benefits, and an adjustment in reimbursement levels to reflect differences among providers in quality and cost. These

modifications will include changes that incorporate explicit policy objectives, following a decision on the broad purpose of NHIF.

D. Kenyatta National Hospital

In late 1988 the KNH Board adopted a Plan of Policy and Institutional Reform, following a USAID-financed study. The Plan's priorities (Annex 4) are logically and practically consistent and should improve the efficiency and effectiveness of delivered services. The Board may wish to consider modifying the Staff Welfare priority to include employees more broadly and to focus on the improvement of overall morale.

General Progress of the Reform. Some progress has been made in rehabilitating and replacing installations and in introducing very limited user fees. Otherwise, implementation has progressed slowly. In part, this has been the result of factors outside the control of KNH, including a lack of funding, MOH's slow handover of staff, and general uncertainty regarding the introduction of user charges. However, KNH has been handicapped by devoting only limited personnel resources specifically to implementing the reform and this has further slowed implementation. Thus organizational restructuring has yet to take place, senior managers are not appointed, and authority has not yet been delegated. Even though financial resources are still to be committed by donors, it is imperative that KNH move more quickly to strengthen administrative procedures and overall management. No further studies are necessary for implementation to proceed.

It was agreed that reform activities should continue to focus on strengthening functional and administrative procedures to improve the management and delivery of health care in anticipation of improvements to equipment and the physical plant. As soon as new management is in place, the Board will establish timetables for continued implementation of the Plan of Reform and these timetables will be strictly followed. Additional staff resources will be devoted to the reform.

In addition to the existing priorities, KNH will develop a cost accounting system, determine manpower requirements and develop a staffing plan, and prepare a doctors' practice plan. These will be initiated by KNH management with some intermittent technical assistance. As in the past, a committee team will be established with direct responsibility for development and implementation.

User Fees. The general principles to guide the implementation of user fees in MOH facilities will apply also at KNH (Annex 2). As it is a tertiary care centre, its costs are higher per episode of illness and so its use must be restricted to those who cannot be treated at lower levels of the health care system. Its fees should therefore be some graduated multiple of those elsewhere in the system, as well as reflect internal costs of production. Private Wing fees should eventually more than cover costs, with the resulting surplus available to improve the Wing and to subsidize other parts of the Hospital.

The mission has reviewed the fee schedule proposed by KNH management to the Ministry of Health in 1987 and has agreed with KNH and MOH on the introduction, levels and administration of new fees:

1. Timing. The new fee structure will be implemented immediately after the Government's announcement of a countrywide system for health user fees. Implementation should not be postponed, as an approved fee schedule will already exist and the administrative structure is in place.

2. Level and Structure. The distinction between Kenyans and non-Kenyans will be maintained. The fee levels proposed in 1987 will be adjusted for inflation, resulting in a general ward inpatient fee of KSh 100 per day. Fees in the Private Wing for Kenyans will be raised much nearer to costs, currently estimated at KSh 1,500 per day. Suggested fees by category of rooms are as follows: KSh 400 per day for 6-bed private wards, KSh 600 for private rooms, and KSh 800 for the VIP suite. (Once quality has been enhanced, and the Private Wing provides competitive services, the fees will be adjusted to reflect costs until such time as capacity has been reached and they are raised to a level that generates profits). This should occur relatively rapidly. The proposed 26-category pricing structure for specialized services will be simplified to 13 categories (Annex 5). Charges will be introduced for drugs.

3. Administration. Revenue officers issuing numbered receipts will continue to collect fees at the ward and department levels. There will also be a central administrative unit to coordinate elective and casualty admissions and the overall fee collection effort so as to affirm the financial integrity of each ward and clinic. Outpatients referred to KNH from lower levels of the health system will not be required to pay for care. A community-based system will be introduced to identify the poor in order to waive fees.

Facilities Assessment. The present physical environment and facilities, while well planned and adequately dimensioned, reflect the multiple consequences of inappropriate architectural design, insufficient investment in maintenance and repair, and neglectful use. Serious structural defects and installation problems include:

- In several blocks, flat roof construction has leaked for years, seriously damaging facilities, installations and equipment in important nursing and clinical areas such as wards, X-ray and operating theatres.

- The Tower Block's toilets are inappropriately arranged which, together with insufficient cleaning, has led them to malfunction and block, seriously affecting hygiene.

- Extensive leakages in the steam and medical gas reticulations seriously waste resources.

- Diagnostic equipment is unreliable and materials required for its use are in short supply, afffecting the efficiency with which patients can be diagnosed, treated and discharged.

Some departments are grossly under-dimensioned, notably the pediatric casualty observation ward which at times exceeds its original patient design capacity by up to 400%. Other seriously overcrowded departments are medical and surgical casualty, maternity delivery and maternity wards, the dispensary and the records. The question can be raised whether this overcrowding indicates that KNH is still used for primary health care functions by the local population and whether this results in the unacceptable admission to a tertiary provider of patients requiring lower level care.

The mission has agreed with KNH management on priorities for investments which are actions:

1 - where present unsafe conditions threaten the well-being of the occupants;

2 - to improve unacceptable hygienic and functional conditions;

3 - to repair, and where necessary replace, existing buildings, installations and equipment; and

4 - to improve the diagnostic and treatment capabilities.

Annex 6 is a prioritized list of the resulting projects. Its principal components are repairing and replacing as necessary roofs, ceilings, doors and windows, floor finishes and equipment; extensive refurbishing of services and medical gas reticulations; the extension and upgrading of the Private Wing and doctors' offices; the provision of adequate space for workshops; and pediatric casualty. A four year investment program of 8.6 million Kenyan pounds is called for, with 2.3 million in the first year, 2.9 in year 2, 2.1 in year 3, and 1.4 in year 4.
KNH will also have further investment needs outside the physical plant and equipment, e.g. for a management information system, but the mission has not examined these in detail.

World Bank Project. To further prepare a World Bank financed project for KNH, it was agreed that the Bank would send a preparation mission in early August and that by that date the Hospital would have appointed senior managers, implemented the user charge schedule, and designated a senior offical as Project Coordinator, reporting to a small committee including both administrative and engineering management and with representation from MOH.

E. Program of Further Analysis.

Detailed suggestions for studies needed to prepare for further reform will be contained in the final mission report. As noted, no further studies are needed at KNH. In addition to the Provincial and District Health Services Study, the Cost-Sharing Monitoring System and the insurance studies discussed above, the mission agreed with MOH that future work should cover the health sector investment program; financial management; the procurement and distribution of drugs; health manpower, education and training; and improved health and management information systems.

In addition, once a procedure for setting spending priorities at MOH facilities has been developed under the Provincial and District Health Services Study, it should be applied to other facilities and a detailed plan developed to improve quality at MOH facilities.

F. Next Steps.

The World Bank will send a detailed report of its findings to the Government as soon as possible, will further explore the organization and funding of the monitoring system, and will send a mission in early August to prepare a project at KNH and to hold further discussions on health policy and the monitoring system. This will be after the Government has announced the introduction of user charges and amendments to the National Hospital Insurance Fund.

The Government and the Bank will hold a one day Health Policy Review Meeting at the start of the August mission to prepare for the writing of a letter of health policy.

The Government will establish a health policy supervisory unit in the Ministry of Health, headed by a full-time senior official reporting to top departmental management.

KNH will put senior managers in place and appoint a Project Coordinator ahead of the August mission.

# Letter of Health Policy

## Note for the Ministry of Health

May 10, 1989

It is now a routine procedure for the World Bank's borrowers to provide letters of sectoral policy to accompany Bank and IDA lending. In Kenya, for instance, this has already been done for agriculture and industry and is currently in process for the financial sector. Several examples from various countries, including Kenya, are attached. Such letters are normally addressed to the President of the Bank from the relevant Minister. As they constitute commitments, they are normally approved by countries' senior political levels, typically the Cabinet.

The World Bank is considering financing an investment project at Kenyatta National Hospital as a first step in a program of support for reform in Kenya's health sector. This is on the assumption that cost-sharing measures are introduced in the health sector during 1989/90, along the lines now being discussed with the multi-donor health financing mission. The Bank anticipates further support for policy reform in the future through a sectoral operation. The KNH and sectoral operations should thus be seen as two elements in a continuum of support for reform in Kenya's health sector. In order to assist fitting the proposed KNH operation into a broader program of reform, it is proposed to hold a one-day Health Policy Review Meeting at the beginning of the preparation mission for the KNH operation, tentatively scheduled for August. The Review Meeting could discuss the documentation that will come out of the present health financing mission, the broad direction of reform in the health sector, and how the KNH reform and investment program fit into this. It is proposed that immediately following the Review Meeting, the Government could draft a letter of health policy for discussion with the Bank before the preparation mission departed some two weeks later. It is recommended that attendance at the Review Meeting should be limited to a small number of those directly concerned with health policy, including the Minister, PS, DMS and senior officials of the Ministry of Health, the Chairman of the Board, Director and senior officials of KNH, and representatives of the Nairobi City Commission, the National Hospital Insurance Fund, and the ministries of Finance and Planning.

The topics that a letter of health policy might contain could include:

1. The broad policy and macroeconomic context, referring to Sessional Paper No. 1, the 1989-93 Development Plan and the Policy Framework Paper, the constraints on public expenditure, and preceding sectoral operations in agriculture, industry and finance.

2. The broad health status and problems of Kenya, including progress over time. The Government's health objectives and targets.

3. The major policies to achieve health objectives, described where possible with specific actions proposed and dates:

- mobilizing additional resources through cost-sharing (user charges, insurance and community contributions).
- using charges to allocate resources efficiently
- improving the efficiency of public expenditure on health (through improved management, reallocations from personnel to non-personnel recurrent spending, improving the drug procurement and distribution system, improving the referral system, developing a public sector investment program, etc).
- putting priority on preventive, promotive and primary health services and reallocating expenditure toward them.
- developing policies to encourage the efficient provision of services by providers outside the Government: traditional health providers, the private sector, the voluntary sector, municipalities, and parastatals like KNH.

4. The specific role of KNH in the health system and the rationale for directing initial World Bank financing toward it.

# AGREED PRINCIPLES FOR THE IMPLEMENTATION OF USER FEES

1. The ultimate objective of the program is to improve health status. To do so, more resources per ill person are required. At present, and for the foreseeable future, additional general tax revenues are unavailable. There are several other avenues, however, which the Government will pursue vigorously. The greatest increase in resources per ill person can be achieved by reducing the number of ill people; for this the primary policy instruments are prevention and family planning. A second source is the reduction of costs through improved management and by providing incentives for patients to seek the most cost-efficient level of care. In the same vein, more resources are available to treat the ill if there is no unnecessary utilization; incentives to seek the appropriate level of care and to minimize unnecessary utilization can be achieved through the proper structuring of user fees. These types of savings, and therefore incentives, should apply to those covered by insurance and other prepayment schemes as well as to the general public. Thus, user charges are a necessary part of any insurance and prepayment plan. Indeed, insurance is not a substitute for user charges but rather a complement. An additional means of raising resources is through user charges, insurance plans and community contributions, consistent with the Harambee tradition. Finally, returning to the primary goal, the amount of health ultimately improved will depend on how effectively the new revenues are used to raise the quality of care and to expand preventive services.

2. A significant portion (50-75%) of user fee-generated revenues will be retained by the facility collecting them to improve its quality of care. Before the revenues are spent, each facility, together with MOH, will establish a list of priorities for improving quality, visibly linked to services being purchased by patients (e.g. drug availability, waiting time). The retaining of revenues will not result in any decline in MOH support to the facility and hence will increase the total funding of the facility. The 25-50% of revenues that is not retained by the facility will be used to increase the funding of preventive programs and to improve the quality of care at facilities located in poorer districts. Over time, the proportion of revenues retained for the facility's use may be adjusted in the light of progress in improving quality.

3. The fee structure and levels will (a) generate revenue sufficient to improve quality; (b) provide incentives for individuals to seek the appropriate level of care, involving higher fees at higher levels of the health care system, waived if an outpatient is referred to a higher level; (c) cover an episode of illness; (d) be set at zero for preventive services and for children; (e) permit subsidization of the care of the poor by the rich; (f) permit the poor to obtain access to care without further impoverishment; and (f) be the same at MOH facilities and those operated by municipalities like Nairobi City Commission.

4. Implementation will be phased over several years, requiring several adjustments. The goals for 1989/90 are to gain public acceptance, to establish a proper structure of incentives, to put in place administrative procedures to collect and spend fees and to permit followup

visits and referrals without cheating, and to ensure that all members of society, including the poor, continue to have access to care. Initial fee levels will thus be modest so that the public will accept them and the poor will be able to afford them. The experience gained initially will be used in subsequent years to raise fee levels and increase cost sharing while protecting the poor.

5. A formal monitoring system will be established to determine how the introduction of user fees affects the poor and so help determine the appropriate future level of fees. The system will obtain and analyze facility utilization information as well as monitor a population-based sample of households on a regular basis.

# PRELIMINARY DESIGN OF A SYSTEM FOR MONITORING COST SHARING

The mission agreed with the Government that a formal monitoring system should be implemented as part of the cost sharing program. The purpose of the system is to assist the proper and successful phasing in of the program, to monitor the effect of cost sharing on the poor, and to establish an actuarial data base for insurance reform. The Government is deliberately setting fees at modest levels so as to minimize their effect on the poor in the first year of the program. The monitoring system will provide the necessary information to determine how high fees can be raised in subsequent phases in pursuit of additional revenues, how the relative levels of fees will need to be adjusted to encourage individuals to obtain care at the most appropriate level, and whether to lower some fees and/or adjust the process for waiving fees for the poor in order to ensure that the poor are obtaining necessary care.

The monitoring system will include two components: a facility-based rapid assessment system and an in-depth population-based system. The rapid assessment system will compile facility data to monitor changes in aggregate utilization patterns by geographic region, age, sex and possibly illness type. This system will provide early warnings of emerging problems and provide a useful data base for facility level planning. In order to provide as complete a picture as possible, the rapid assessment system should include non-government facilities as well as government facilities. It will likely be financed by USAID.

The rapid assessment system, however, has limited ability to provide the information required for future fee adjustment. Because of the method of collection, it can only obtain rudimentary information such as name, age, sex, address and possibly illness. No information on important factors that influence health decisions will be collected, such as income, education, family structure, and other competing needs for scarce family resources. In particular, it provides no information on non-users, on why and what happened to individuals who stopped obtaining care, and on the overall health status of the population. The rapid assessment system has limited ability to assess whether individuals who reduce their utilization of public facilities are switching to private or voluntary facilities or going without care. Because it does not collect severity of illness and health status information, it is not able to analyze whether individuals are seeking the appropriate level of care. With respect to protecting the poor, the facility-based system cannot determine whether any drop in utilization is concentrated among the poor and whether any reduced utilization is for minor problems or life-threatening ones. It cannot determine the extent to which families are impoverishing themselves by selling assets and borrowing to obtain care. Also, the aggregate facility-level system cannot determine what other factors may influence utilization and health patterns. For example, utilization may fall because increased prevention causes a reduction in medical need--a positive outcome--or utilization may be reduced because other financial burdens are placed on the family such as increases in other fees like education.

Therefore, it has been determined that data on a population-based household sample of individuals will also be collected on a regular ongoing basis as part of the monitoring system. This data will provide the

information necessary to answer the above issues and, consequently, to properly adjust the fee schedule in subsequent phases of the program. It will provide an actuarial data base that can be used for the proper implementation of NHIF insurance reform, and it could be used to monitor other programs such as family planning and cost-sharing in other sectors such as education.

A new household survey explicitly designed for monitoring cost sharing needs to be created. Existing population data-bases are not sufficiently detailed to serve as the population-based monitoring system. These are single purpose surveys and are missing key data elements necessary for the monitoring effort. The income-expenditure surveys have limited health and almost no health care utilization data. Moreover, they are over five years old and not longitudinal in nature. Similar problems apply to the nutritional survey. The Demographic Health Survey has no income and very limited asset information. However, it could be used to serve as epidemiological data for certain types of problems. The use of this should be explored further.

Therefore, during the first phase of the cost sharing program, both the facility-based rapid assessment and in-depth population-based monitoring systems will be put in place. The facility-based system can be put in place immediately as it requires only minor adjustments in current data collection effects. Specifically, registration forms at facilities need to be altered, the data collected and automated, and trend analyses completed. Modest technical assistance may be required; however, the bulk of the system costs will be incurred in Kenya.

To implement the population-based monitoring system, a new household survey that is conducted on an ongoing basis will be created. The survey will be used to monitor the effect of cost sharing on the poor and to provide the necessary information to adjust fees in subsequent phases of the cost sharing program. In addition, it could at minimum additional cost also be used to minotor other programs, such as cost sharing in education and the effects of family planning. The survey could be conducted by the Central Bureau of Statistics in the Ministry of Planning, which has the necessary survey research experience, with the analysis performed in the Ministry of Health. Analysis produced through the Ministry of Health is more likely to affect policy and this process would substantially strengthen its analytic capability. Technical assistance will be required to design and field the survey so that information collected is appropriate and the speed of collection and analysis is timely.

In addition, a monitoring unit should be identified within the Ministry of Health. This unit will be responsible for the monitoring effort, and the analysis and reporting of results to the Director of Medical Services and Permanent Secretary. Efforts will be made to use members of the Kenyan academic community in the analysis. It is anticipated that some technical assistance will be required to get this unit going.

The monitoring effort is estimated to require approximately one million dollars in funding for the first year and one-half million for subsequent years; including allowance for price and other contingencies,

$5 million would be required over 5 years. It is anticipated the monitoring program can be conducted mostly by Kenyans with minimal technical assistance. In the first year, about 75% of the funds will be spent in country. Based on experience in other countries, it is expected that the program can be completely operated by the Government after a few years.

The Ministry of Health has requested the World Bank to present detailed options for implementation of the monitoring system and to coordinate donor financing. The Ministry of Finance has endorsed the request and asked the Bank to plan the population-based monitoring system in the larger context of efforts to monitor the effects of user charges in all sectors on the level and distribution of social welfare. The Ministry of Finance has requested a follow-up mission to examine this.

# A SUMMARY OF K.N.H. POLICY AND INSTITUTIONAL REFORMS

The following is a summary of reforms the Board plans to undertake, in order of priority:

1. Organisation Structure

   This is a key policy change deemed necessary in order to reflect the new status of K.N.H.

2. Maintenance/Rehabilitation and replacement of equipment, plant and buildings

   This exercise will eventually increase productivity of service delivery.

3. Supplies Management

   Strengthening of supplies management and inventory control for general supplies and drugs.

4. Expansion of private medical wing

   (a) Operationalise 100 bed Amenity Unit.

   (b) Office space for patients follow up.

   These two programmes will require strong support facility back-up such as radiology, laboratory, theatre.

5. Communication

   Establish a mechanism to ensure adequate communication. The input requirements include establishment of a public relations office and publication of bulletins and magazines etc.

6. Accounting Systems

   Strengthening of financial management (e.g. budgeting, accounting etc). This requires development of personnel and office accomodation.

Best Available Document

Annex 5

KENYATTA NATIONAL HOSPITAL

Suggested Consolidation of Fees for Specialised Services (a)

INDIVIDUAL FEES TO BE CHARGED FOR EACH OF THE FOLLOWING (b)

- Bed Charges
- Radiotherapy Charges
- Nuclei Investigations
- X-Ray Charges
- Cardiac Treatments
- Physiotherapy Charges
- Renal Treatments
- Dental Treatments
- S.P.U. Charges
- Vaccines and Sera
- Animals
- Mortuary

SUGGESTED SUBCATEGORIES TO BE GROUPED TOGETHER UNDER ONE LABORATORY FEE STRUCTURE (c)

- Biochemistry
- Haematology and Blood Transfusion
- Bacteriology and Parasitology
- Sputum
- Faeces (Stool)
- Swabs
- Mycology
- Cerebrospinal Fluids (SCF)
- Blood
- Bacteriological Quality Control
- Mycotoxins Laboratory Tests
- Histology and Cytology
- Immunology
- Tests

(a) The grouping of laboratory services under one fee structure is suggested to facilitate administration and fee collection.

(b) The World Bank Mission concurs with KNH's proposal to charge individual fees for each of these twelve services.

(c) The World Bank Mission suggests that these services be grouped under a single fee structure. KNH has proposed an individual fee system for each of the fourteen services.

Best Available Document

KENYATTA NATIONAL HOSPITAL NAIROBI.

LIST OF PROPOSED CAPITAL PROJECTS.

The following lists are based on an inspection of the hospital undertaken in May 1989.

The projects aim at solving present physical and functional problems, in terms of the following agreed priorities.

PRIORITY ONE

CARRYING OUT URGENTLY REQUIRED REPAIRS AND MAINTENANCE WORK WHERE PRESENT CONDITIONS ARE DANGEROUS.

PRIORITY TWO

IMPROVING PRESENT UNACCEPTABLE HYGIENIC AND FUNCTIONAL CONDITIONS

PRIORITY THREE

IMPROVING THE RELIABILITY OF EXISTING SERVICES, FUNCTIONS AND INSTALLATIONS

PRIORITY FOUR

PROVIDING FACILITIES WHICH ARE MISSING AND WHICH ARE REQUIRED FOR THE INSTITUTION TO FUNCTION PROPERLY

PRIORITY FIVE

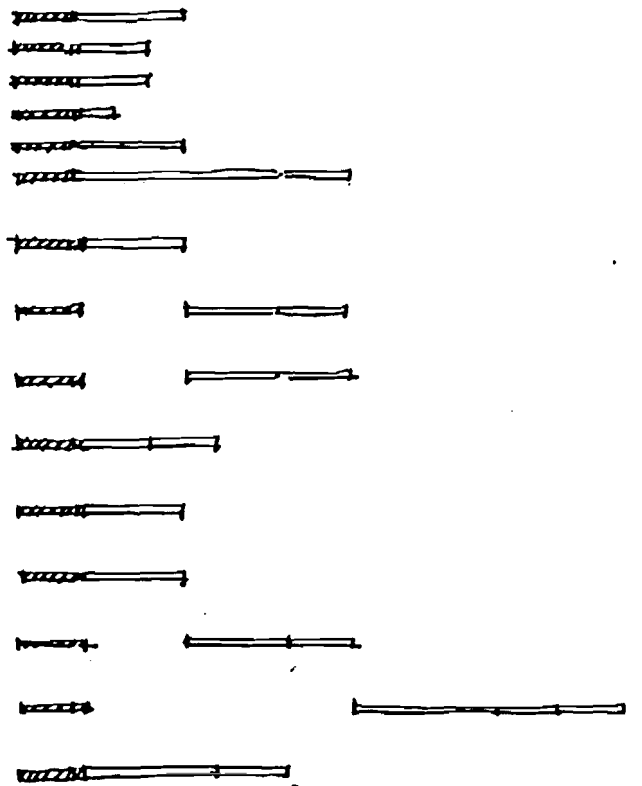
IMPROVING DIAGNOSIS

The priority given the different projects is shown in the following sheets However the projects are listed according to type of building work required, and are not shown therefore, in order of priority.

KENYATTA NATIONAL HOSPITAL NAIROBI. LIST OF PROPOSED CAPITAL PROJECTS.

| | PROJECT | ESTIMATED COST KE | PRIORITY | EFFECT ON RC | INCL. IN PROPOSALS |
|---|---|---|---|---|---|
| 1.1 | REPLACE ROOFS TO : WARDS | 135 000 | 1 | NEGAT. | YES |
| | CASUALTY | 53 000 | 1 | NEGAT | YES |
| | X-RAY | 64 000 | 1 | NEGAT | YES |
| | MATERNITY DELIV. | 23 000 | 1 | NEGAT | YES |
| | CANTEEN. | 106 000 | 1 | NEGAT. | YES |
| 1.2 | REPAIR ROOFS TO OTHER BUILDINGS | 30 000 | 1 | NEGAT. | YES |
| 1.3 | REPLACE OR REPAIR CEILINGS IN PUBLIC Z | | | | |
| 1.4 | REPAIR CEILINGS IN CONSULTATION ZONE | | | | |
| 1.5 | REPAIR CEILINGS IN OTHER ZONES. | | | | |
| 1.6 | REPAIR MAIN DOORS TO DEPARTMENTS | | | | |
| 1.7 | REPAIR DOORS AND WINDOWS | 600 000 | 2 | NEGAT | YES |
| 1.8 | REPAIR FLOORS IN PUBLIC ZONES | | | | |
| 1.9 | REPAIR FLOORS IN CONSULTATION Z. | | | | |
| 1.10 | REPAIR FLOORS IN OTHER ZONES | | | | |
| 1.11 | REPAIR SANITARY IN PUBLIC ZONES | 300 000 | 2 | NEGAT. | YES. |
| 1.12 | REPAIR SANITARY IN OTHER ZONES | included in 1.11 | 2 | NEGAT | YES |
| 1.13 | REPAIR WATER & DRAINAGE. | included in 1.11 & 1.12. | 2 | NEG. | YES |
| 1.14 | REFURBISH ELECTRICAL INSTALLAT. AND FITTINGS. | | | POSITIV | NO |

TIME SCHEDULE — MONTHS

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KENYATTA NATIONAL HOSPITAL NAIROBI. LIST OF PROPOSED CAPITAL PROJECTS.

| | PROJECT | ESTIMATED COST | PRIORITY | EFFECT ON RUNNING COSTS | INCL IN KNH PL. | TIME SCHEDULE. 2 months / 2 4 6 8 10 12 14 16 18 20 22 24 26 28 30 32 34 36 38 40 42 |
|---|---|---|---|---|---|---|
| 1.15 | REFURBISH AND REDECORATE PUBLIC ZONES | Included in above | 2 | | | |
| 1.16 | REFURBISH/REDECORATE IN CONSULTATION Z | | 2 | | | |
| 1.17 | REFURBISH/REDECORATE - MEDICAL SERVICE Z | | 2 | | | |
| 1.18 | REFURBISH/REDECORATE - OTHER ZONES | | 3 | | | |
| 1.19 | REFURBISH EXTERNAL FACADES - WALKWAYS. | | 4 | | | |
| 2 | AMENITY WARD. UPGRADING, REFITTING, EXT. | 130 000 | 2 | - | | |
| 3 | ADMISSIONS, REINTRODUCE ON GROUND FLOOR | 30 000 | 2 | - | | |
| 4 | DOCTOR'S OFFICES: ESTABLISHED IN UN-USED AREA | 25 000 | 2 | - | | |
| 5 | PEDIATRIC CASUALTY OBS. ESTABLISH IN OLD HOSP. | 25 000 | 2 | SAVINGS | | |
| 6 | CONSULTATION SUITES IN OLD PED. CAS. OBSERV. | 25 000 | 3 | - | | |
| 7 | RENOVATION OF MAIN KITCHEN | 25 000 | 2 | - | | |
| 8 | RENOVATION OF LAUNDRY. | 25 000 | 2 | INCREASE? | YES | |
| 9 | RENOVATION OF CSSD AND FSSU. | 50 000 | 2 | SAVINGS | | |
| | [illegible] | 10 000 | 2 | ... | | |
| 11 | ESTABLISH BIOMEDICAL W/SHOP IN CANTEEN | 35 000 | 2 | SAVINGS | | |

Annex 6
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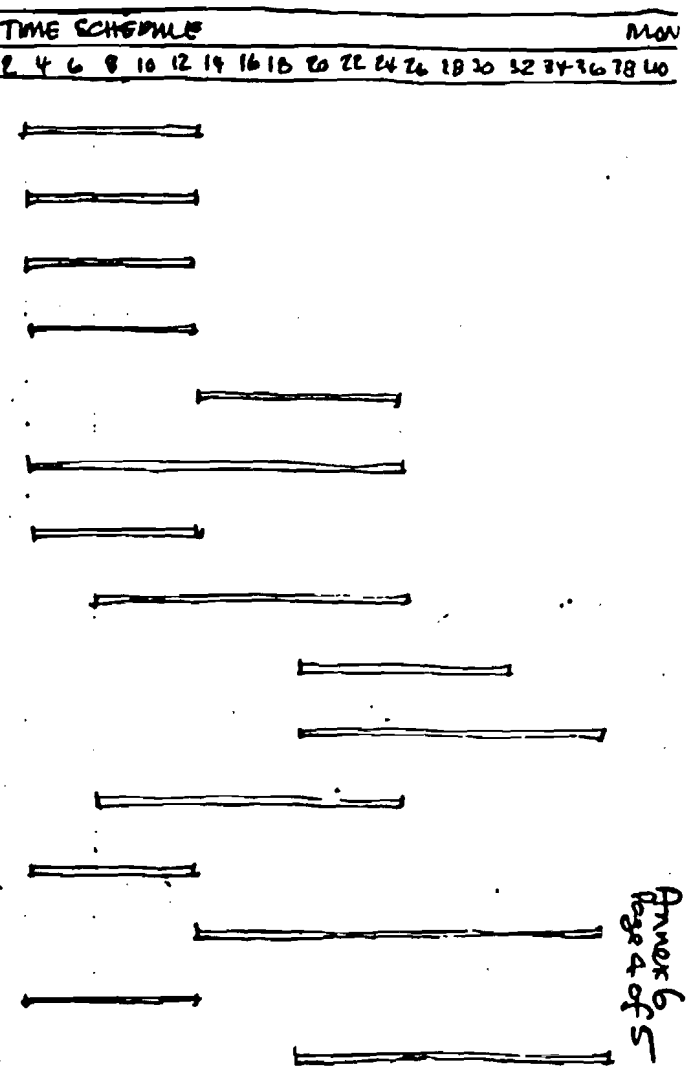
KENYATTA NATIONAL HOSPITAL NAIROBI. LIST OF PROPOSED CAPITAL PROJECTS.

| | PROJECT | ESTIMATED COST | PRIORITY | EFFECT ON RUNNING COST | INCL IN KNH LIST |
|---|---|---|---|---|---|
| 12 | DISMOUNT OBSOLETE EQUIPMENT & SPARE PARTS | 25 000 | 2 | CONSIDERABLE SAVINGS | |
| 13 | BURGLAR PROOFING IN DISPENSARIES | 20 000 | 3 | SAVINGS | YES |
| 14 | SIGNPOSTING IN PUBLIC AREAS | 32 000 | 3 | – | |
| 15 | CONTROL SCREENING IN X-RAY | 40 000 | 2 | – | |
| 16 | REFURBISH A/C IN MATERNITY | 40 000 | 3 | – | YES |
| 17 | RENOVATE/IMPROVE STEAM RETICULATION | 120 000 | 3 | CONSIDERABLE SAVINGS | YES |
| 18 | ESTABLISHMENT OF OVERVOLTAGE PROTECTION | 20 000 | 2 | SAVINGS | YES |
| 19 | REFURBISH ELECTRICAL MAINS. | 120 000 | 3 | SAVINGS | |
| 20 | PROVISION OF LOCAL HOT WATER HEATERS | 24 000 | 4 | SAVINGS? | |
| 21 | IMPROVE AUTOMATIC TELEPHONE SYSTEM | 85 000 | 4 | – | |
| 22 | IMPROVE MEDICAL GAS STORAGE & RETICUL. | 90 000 | 2 | CONSIDERABLE SAVINGS. | |
| 23 | COLD WATER STORAGE TANKS. | 20 000 | 2 | SAVINGS | YES. |
| 24 | REPAIRS & IMPROVEMENTS TO HOUSING | 20 000 | 4 | – | |
| 25 | IMPROVE DRAINAGE SYSTEM TO HOUSING EST | 25 000 | 2 | – | YES |
| 26 | EMERGENCY LIGHTING SYSTEM - THEATRES | 90 000 | 4 | – | YES |
| 27 | PROVIDE & INSTALL EQUIPMENT IN FOLLOWING LISTS. | | | | YES |

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KENYATTA NATIONAL HOSPITAL NAIROBI : SURVEY MAY 1989.
EQUIPMENT REQUIREMENTS

| DEPARTMENT | REPAIRS ESTIMATED COSTS | ACQUISITIONS ESTIMATED COSTS | PRIORITIES | TOTAL PRIORITY 2 | TOTAL PRIORITY 3 | TOTAL PRIORITY 4 | TOTAL PRIORITY 5 |
|---|---|---|---|---|---|---|---|
| A. PROPOSED BY HOSPITAL. | | | | | | | |
| 1A MAINTENANCE UNIT | | 33 000 | | 175 700 | 175 700 | – | – |
| INSTRUMENTS & TOOLS. | | 318 400 | | | | | |
| LIBRARY | | 30 000 | | – | 30 000 | – | – |
| SPARE PARTS see C | | | | | | | |
| 1H RADIOTHERAPY | 15 000 | 24 000 | | 19 000 | 60 000 | 60 000 | – |
| 1V CARDIOLOGY | | 107 000 | | | 68 000 | 31 000 | 8 000 |
| EEG | | 158 000 | | | 90 000 | | 68 000 |
| 2A RENAL DIALYSIS | 63 000 | 281 000 | | 63 000 | 8 500 | 75 000 | 210 000 |
| 2D ICU. | | 247 000 | | | – | 147 000 | 100 000 |
| 2J THEATRES | 17 000 | 156 000 | | 17 000 | – | 100 000 | 56 000 |
| 2L PHYSIOTHERAPY | 7 900 | 66 200 | | | 7 900 | 33 100 | |
| 3 WARDS & CLINICS | 41 000 | 484 500 | | 41 000 | 170 500 | 314 500 | |
| 4M X-RAY | 96 000 | 1 200 000 | | 96 000 | 300 000 | 450 000 | 450 000 |
| 4O LABORATORIES | 1680 | 290 000 | | 1680 | 96 000 | 96 000 | 96 000 |
| KITCHEN | 15 000 | 40 000 | | 15 000 | 40 000 | – | – |
| LAUNDRY | 10 000 | 400 000 | | 10 000 | 400 000 | – | – |
| AUTOCLAVES | 60 000 | 85 000 | | 60 000 | 85 000 | – | – |
| CSSD EQUIPMENT | | 36 500 | | | 36 500 | – | – |
| DENTIST | 50 000 | 105 000 | | | 50 000 | 50 000 | 55 000 |
| AMENITY WARD. | | | | | | | |
| BEDS/FURNITURE | | | | 90 000 | | | |
| LABORATORY | | | | 55 000 | | | |
| X-RAY | | | | 60 000 | | | |
| | | | | | 1618 100 | 1356600 | 1043000 |
| SPARE PARTS 10% | | | | 70 000 | 161 810 | 135660 | 104 300 |
| GRAND TOTAL | | | | 773 380 | 1 779910 | 1492200 | 1147300 |
| ADD 18% INFLATION | | | | 139 208 | 320383 | 268600 | 206 514 |
| | | | | 912 588 | 2100293 | 1760800 | 1353814 |

Annex J

MOH Forward Budget: 1988/89-1991/92, for Selected Areas
(figures expressed in '000 Kenya Pounds)

| | | 1988/89 | | 1989/90 | | 1990/91 | | 1991/92 | |
|---|---|---|---|---|---|---|---|---|---|
| | | Development | Recurrent | Development | Recurrent | Development | Recurrent | Development | Recurrent |
| Development Recurrent | | | | | | | | | |
| Kenyatta National Hospital | Gross | 912 | 13,527 | 337 | 14,026 | 741 | 15,284 | - | 15,982 |
| | AIA | 614 | 592 | 36 | 771 | - | 827 | - | 859 |
| | Net | 298 | 12,935 | 301 | 13,255 | 741 | 14,457 | - | 15,123 |
| Provincial Hospitals | Gross | - | 17,369 | - | 18,988 | - | 20,351 | - | 21,233 |
| | AIA | - | 337 | - | 3,721 | - | 4,491 | - | 5,011 |
| | Net | 280 | 17,032 | 320 | 15,267 | 1,210 | 15,860 | 1,490 | 16,222 |
| District Hospitals | Gross | - | 35,409 | - | 39,918 | - | 41,938 | - | 44,466 |
| | AIA | - | 412 | - | 4,015 | - | 5,017 | - | 7,019 |
| | Net | 5,789 | 34,997 | 3,280 | 35,903 | 9,176 | 36,921 | 6,617 | 37,447 |
| Preventive Medicine and Promotive Health Total | Gross | - | 12,215 | - | 13,239 | - | 13,869 | - | 14,590 |
| | AIA | - | 66 | - | 1,326 | - | 1,430 | - | 1,566 |
| | Net | 1,010 | 12,150 | 2,190 | 11,913 | 1,545 | 12,440 | 1,250 | 13,024 |
| Rural Health Services Total | Gross | - | 11,989 | - | 15,625 | - | 16,729 | - | 18,002 |
| | AIA | - | 51 | - | 180 | - | 210 | - | 230 |
| | Net | 6,669 | 11,939 | 7,329 | 15,445 | 9,988 | 16,519 | 7,515 | 17,772 |
| National Hospital Fund | Gross | - | 1,008 | - | 1,710 | - | 1,709 | - | 1,701 |
| | AIA | - | 977 | - | 1,710 | - | 1,709 | - | 1,701 |
| | Net | - | 31 | - | - | - | - | - | - |

Source GOK Forward Budget: 1989/90
(figures may not add due to rounding)

# INITIAL ENVIRONMENTAL EXAMINATION

COUNTRY: Kenya

PROJECT TITLE: Health Care Financing Program (615-0245)

FUNDING: Proposed Life of Project Funding - $15,000,000 (DFA)

PERIOD OF PROJECT: Three years (8/89-7/92)

## Activity Description:

The program is intended to assist the Government of Kenya (GOK) to improve the health status of the population and contribute to GOK budget rationalization efforts. The program consists of (1) U.S. dollar disbursements for implementation of policy reform and (2) technical assistance and training to strengthen the GOK's capacity to research and analyze further reform initiatives and to monitor and evaluate the impact of the reform program.

## Environmental Action Recommended:

Categorical exclusion in accordance with 216.2(c)(2)(i) relating to technical assistance and training, 216.2(c)(2)(viii) relating to health programs, and 216.2(c)(2)(xiv) relating to development of host government capacity for future planning.

## IEE Prepared By:

Carla Barbiero, Project Development Officer,
USAID/Kenya

Clearance: RLA:SSpielman
PRJ:SBaker:

## Reviewed By:

Edward McGowan, Mission Environmental Officer
REDSO/Kenya

## Determination:

Steven W. Sinding, Mission Director
USAID/Kenya

Approved: SW Sinding

Date: 3/16/89

## Bureau Environmental Officer's Recommendation:

Approved: Bessie L. Boyd

Bessie L. Boyd, AFR/TR/ANR

Disapproved:

Date: APR 3 - 1989

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ANNEX L

## BIBLIOGRAPHY


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ANNEX M

## ACRONYMS
KHCF PAAD (615-0245)

| | |
|---|---|
| AEPRP- | African Economic Policy Reform Program |
| AID- | Agency for International Development |
| CDD- | Control of Diarrheal Diseases |
| CDSS- | Country Development Strategy Statement |
| CHANIS- | Child Health and Nutrition Infomation System |
| DANIDA- | Danish International Development Agency |
| DFA- | Development Fund for Africa |
| DFH- | Division of Family Health |
| DHS- | Demographic and Health Surveys |
| EPI- | Expanded Program on Immunization |
| FPPS- | Family Planning Private Sector |
| FY- | Fiscal Year |
| GOK- | Government of Kenya |
| HCF- | Health Care Financing |
| HIS- | Health Information Systems (Unit) |
| IEE- | International Environmental Examination |
| IDI- | International Development Intern |
| IPS- | Information Planning Systems |
| KEPI- | Kenya Expanded Program on Immunization |
| KHCF- | Kenya Health Care Financing |
| KNH- | Kenyatta National Hospital |
| MOF- | Ministry of Finance |
| MOH- | Ministry of Health |
| MOP- | Ministry of Planning |
| NGO- | Non-governmental Organization |
| NHIF- | National Hospital Insurance Fund |
| ODA- | Overseas Development Agency |
| PAAD- | Program Assistance Approval Document |
| PHC- | Primary Health Care |
| PH- | Population and Health |
| SIDA- | Swedish International Development Agency |
| UNFPA- | United Nations Fund for Population Activities |
| UNICEF- | United Nations International Children Educational Fund |
| USAID- | United States Agency for International Development |
| WHO- | World Health Organization |

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# MINISTRY OF HEALTH

Not USG Classified

ANNEX N.

Telegrams: "MINHEALTH", Nairobi
Telephone: Nairobi 728370
When replying please quote

OFFICE OF THE PARMANENT SECRETARY
AFYA HOUSE
CATHEDRAL ROAD
P.O. BOX 30016
NAIROBI

Ref No. FIN/30/A and Date 22nd June 19.89

The Director
USAID
P.O. Box 30261
NAIROBI.

RE: RESTRUCTURING OF HEALTH CARE

This is to inform you that shortly the Ministry will be embarking on a far reaching cost sharing effort in order to improve delivery of Health Care to our people.

In order to assist the Ministry in giving better Curative and Preventive health services, the Government will need your assistance not only by the Ministry but also at Kenyatta National Hospital and National Hospital Insurance Fund so that all of us may play our roles in meeting health challenges for the future.

DANIEL M. MBITI
PERMANENT SECRETARY

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~~CONFIDENTIAL~~

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ANNEX O

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PROJECT - 615-0245

ACTION: AID-3 INFO: ECON POL/RLO

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TO AMEMBASSY NAIROBI IMMEDIATE 4448
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UNCLAS STATE 123437

AIDAC NAIROBI FOR USAID/KENYA

E.O. 12356: N/A

SUBJECT: KENYA HEALTH CARE FINANCING PROGRAM (615-0245)

THE KENYA HEALTH CARE FINANCING PROGRAM PAIP WAS REVIEWED AND APPROVED ON APRIL 17, 1989 AT AN AFRICA BUREAU ECPR MEETING CHAIRED BY DAA/AFR, E.L.SAIERS. MISSION IS AUTHORIZED TO COMPLETE DEVELOPMENT OF PAAD FOR SUBMISSION TO A.I.D./W IN FY 1989. PLEASE PROVIDE PAAD SUBMISSION AND OBLIGATION SCHEDULE. ECPR GUIDANCE FOR PAAD DEVELOPMENT SUBJECT SEPTEL. BAKER
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ANNEX O

PROJECT - 615-0245

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BT
UNCLAS SECTION 01 OF 03 STATE 158128

AIDAC, NAIROBI FOR ~~REDSO/ESA~~ RLA AND EEO

E.O. 12356: N/A

SUBJECT: KENYA HEALTH CARE FINANCING PROGRAM (615-0245), PAIP ECPR GUIDANCE

THE AFR BUREAU ECPR CHAIRED BY DAA/AFR, E. L. SAIERS, MET ON APRIL 17, 1989 AND APPROVED THE PAIP FOR THE KENYA HEALTH CARE FINANCING (KHCF) PROGRAM AT A LOP OBLIGATION LEVEL OF DOLS FIFTEEN (15) MILLION

ATTENDEES INCLUDED AFR/PD/EAP, AFR/EA, AFR/DP, AFR/TR, GC/AFR AND KENYA MISSION REPRESENTATIVE, DAVID OOT. THE ECPR APPROVED THE SUBJECT PAIP WITH THE UNDERSTANDING THAT THE KHCF PROGRAM WILL NOT EXCEED THREE YEARS

ALSO, THE ECPR DECIDED THE KHCF PAAD SHOULD BE REVIEWED AND APPROVED IN A.I.D./W

1. THE ECPR COMMENDED THE MISSION ON SUBMISSION OF A WELL WRITTEN DOCUMENT DESCRIBING AN INNOVATIVE HEALTH SECTOR REFORM INITIATIVE. A.I.D./W APPRECIATED THE ASSISTANCE PROVIDED BY MISSION REP., DAVID OOT, IN DISCUSSION OF THE KENYA HEALTH SECTOR AND CLARIFICATION OF POINTS RAISED DURING THE DISCUSSION OF THE PAIP. HE WAS WELL PREPARED, KNOWLEDGEABLE, AND MADE PERSUASIVE ARGUMENTS.

2. PROGRAM STRATEGY

A. THE ECPR NOTED THAT THE PAIP STATES THAT THE KHCF PROGRAM IS THE FIRST PHASE OF A LONG-TERM REFORM PROCESS IN THE HEALTH SECTOR IN KENYA. HOWEVER, THE PAIP IS SILENT ON THE PARTICIPATION OF A.I.D. BEYOND THE THREE-YEAR KHCF PROGRAM TIMEFRAME. THE ECPR DID NOT TAKE A POSITION REGARDING AN A.I.D.-FINANCED HEALTH CARE FINANCING FOLLOW-ON ACTIVITY. HOWEVER, IT RAISED SOME QUESTIONS REGARDING THE RELATIONSHIP OF THIS PROGRAM TO THE MISSION'S AND OTHER DONORS' STRATEGIES IN THE HEALTH SECTOR WHICH SHOULD BE ADDRESSED IN THE PAAD. THE ECPR FELT THESE QUESTIONS WERE PERTINENT WHETHER OR NOT THE OTHER DONORS' PROGRAMS START-UP

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BECAUSE A.I.D. MAY OR MAY NOT AGREE WITH WHAT IS PROPOSED BY THE OTHER DONORS.

(1) TO WHAT EXTENT DOES THE MISSION CONSIDER THE KHCF PROGRAM THE FIRST STAGE OF A LONG-TERM INTERVENTION WHICH COULD BE THE CENTERPIECE OF THE MISSION'S LONG-TERM HEALTH SECTOR PROGRAM?

(2) DOES THE MISSION CONSIDER A.I.D. PARTICIPATION IN THE HEALTH CARE FINANCING FOLLOW-ON ACTIVITIES SUFFICIENTLY IMPORTANT OR SUCH A CENTRAL ISSUE THAT IT IS ENCOURAGED TO PURSUE AN A.I.D.-FINANCED KHCF PROGRAM SECOND PHASE ACTIVITY? WHAT CONDITIONS MUST EXIST FOR THE MISSION TO ENCOURAGE A.I.D. PARTICIPATION IN A SECOND PHASE/FOLLOW-ON ACTIVITY?

(3) WHAT DOES THE MISSION EXPECT WILL BE ACCOMPLISHED BY THE KHCF PROGRAM, IF OTHER DONORS' ASSISTANCE PROGRAMS IN THE HEALTH CARE SECTOR DO NOT MATERIALIZE AS ANTICIPATED IN THE PAIP, AND THERE IS NOT AN A.I.D.-FINANCED FOLLOW-ON ACTIVITY?

B. THE PAIP STATES THAT THE PRIMARY PURPOSE OF THE KHCF PROGRAM IS TO INITIATE POLICY AND STRUCTURAL CHANGES IN THE HEALTH SECTOR WHICH WILL LEAD TO INCREASED RESOURCES FOR PRIMARY AND PREVENTATIVE CARE. THE CAUSAL LINKAGE(S) BETWEEN THE KHCF PROGRAM POLICY REFORMS AND IMPROVEMENTS IN PRIMARY AND PREVENTATIVE CARE IS/ARE NOT OBVIOUS AND SHOULD BE CLEARLY ARTICULATED IN THE PAAD. ANY OTHER REFORMS, MECHANISMS

OR SYSTEMS WHICH WILL BE INITIATED OR EXPANDED TO FACILITATE THIS SHIFT SHOULD BE IDENTIFIED. THE IMPORTANCE OF THE POLICY REFORMS AND OTHER MEASURES IN ENSURING THE LONG-TERM SUSTAINABILITY OF PRIMARY AND PREVENTATIVE CARE SHOULD BE FULLY ADDRESSED DURING PAAD DESIGN. THE PAAD ALSO SHOULD ADDRESS THE AVAILABILITY OFCOMPETITION WITHIN THE ALLOCATION SYSTEM FOR FINANCIAL RESOURCE IN THE MOH BUDGET.

C. THE ECPR NOTED THAT THERE MAY BE A STRONG NEED TO IMPROVE HEALTH CARE FACILITIES AND SERVICES IN CONCERT WITH THE IMPLEMENTATION OF COST-SHARING MEASURES ENVISIONED BY THE KHCF PROGRAM. SUBSTANTIAL INVESTMENTS MAY BE REQUIRED IN THE NEAR-TERM TO UPGRADE PUBLIC SECTOR FACILITIES TO THE POINT WHERE THE COST-SHARING MEASURES ARE GENERALLY ACCEPTABLE TO THE CONSUMERS AND CAN BE IMPLEMENTED IN A TIMELY MANNER. THE ECPR UNDERSTANDS THAT A NUMBER OF THESE IMPROVEMENTS HAVE BEEN MADE AND THAT THE INITIAL COST-SHARING MEASURES WILL BE MODEST AND IMPLEMENTED IN STAGES. NONETHELESS, THE PAAD DESIGN SHOULD ADDRESS

THE FEASIBILITY OF IMPLEMENTING ALL OF THE KHCF PROGRAM COST-SHARING AND COST CONTAINMENT MEASURES IN THE PROPOSED THREE-YEAR TIMEFRAME. IT SHOULD DISCUSS THE DEMAND SIDE IMPLICATIONS FOR THE TYPES OF UPGRADED SERVICES, AND THE ORDER AND EXTENT OF COST-SHARING. THE ANALYSIS SHOULD ALSO CONSIDER HOW THE DEMAND SIDE MAY HELP TO ENSURE THE REALLOCATION OF BUDGET.

3. PROGRAM BENEFICIARIES

ALTHOUGH THE PAIP STATES THAT THE KHCF PROGRAM PURPOSE IS TO FACILITATE AND SUPPORT THE IMPLEMENTATION OF POLICY AND INSTITUTIONAL REFORMS NEEDED TO ENSURE SUSTAINABILITY OF PRIMARY AND PREVENTIVE HEALTH CARE, IT DOES NOT ADDRESS THE ISSUE OF HOW THESE RESOURCES WILL BE DISTRIBUTED. GIVEN THE REGIONAL DISPARITY IN MORBIDITY AND MORTALITY IN KENYA, THE PAAD SHOULD IDENTIFY AND ADDRESS THE TYPES OF POLICY ISSUES WHICH WILL ENSURE THAT THE PROGRAM'S BENEFICIARIES INCLUDE THE MORE DISADVANTAGED AREAS. THE ANALYTICAL WORK ON CRITERIA FOR ALLOCATING RESOURCES BASED ON NEED BEING DONE BY SIDA AND THE USAID INFORMATION AND PLANNING SYSTEMS COMPONENT OF THE FAMILY PLANNING SERVICES AND SUPPORT PROJECT (615-0223) SHOULD PROVIDE A GOOD BASIS.

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A. PROGRAM MANAGEMENT. THE ECPR NOTED THAT THE POTENTIAL COMPLEXITY OF THE KHCF PROGRAM POLICY REFORM FRAMEWORK AND THE MANAGEMENT INTENSITY IT IMPLIES ARE OF CONCERN BECAUSE OF THE DEMANDS WHICH WILL BE PLACED ON THE MISSION AND THE GOK IN IMPLEMENTING THE OTHER TWO POLICY REFORM PROGRAMS RECENTLY APPROVED FOR KENYA. IN ADDITION, THE PAIP DESCRIBES A DISBURSEMENT SCHEDULE FOR THE DOLLAR CONDITIONALITY WHICH HAS THREE COMPONENTS, AND EACH COMPONENT HAS THREE LEVELS OF DISBURSEMENTS WHICH ARE TRIGGERED BY THE ACHIEVEMENT OF AN ARRAY OF BENCHMARKS. THE ECPR UNDERSTANDS THAT THE MISSION AND THE GOVERNMENT OF KENYA (GOK) HAVE BEEN ENGAGED IN EXTENSIVE DISCUSSIONS OF HEALTH CARE FINANCING REFORM ISSUES FOR A LONG TIME AND SOME OF THE PROPOSED HEALTH CARE SECTOR POLICY REFORM AGENDA MAY BE REALIZED RELATIVELY QUICKLY. HOWEVER, THE PAAD SHOULD ADDRESS THE FEASIBILITY OF IMPLEMENTING THE PROGRAM CONDITIONALITY IN THE MANNER DESCRIBED IN THE PAIP AND DISCUSS THE MANAGEMENT/STAFFING IMPLICATIONS OF THE MISSION'S PREFERRED APPROACH.

B. TECHNICAL ASSISTANCE. IT APPEARS THAT THE TECHNICAL ASSISTANCE (TA) COMPONENT OF THE KHCF PROGRAM IS A CRITICAL ELEMENT OF THE PROGRAM AND MAY HAVE A CONSIDERABLE IMPACT ON THE ABILITY OF THE GOK TO CARRY OUT AND MEET THE PROGRAM CONDITIONALITY. THE PAIP STATES THAT THE MISSION WOULD PREFER THAT THE TA BE PROVIDED BY A SINGLE CONTRACTOR. CONSIDERING THE LENGTH OF TIME IT NORMALLY TAKES TO PROCURE AND MOBILIZE A TA CONTRACTOR, THE ECPR NOTED THE

POSSIBILITY THAT THE KHCF PROGRAM WOULD BE WELL INTO THE THREE-YEAR IMPLEMENTATION PERIOD BY THE TIME THE TA CONTRACTOR IS MOBILIZED. THIS SITUATION WOULD LEAVE THE TA CONTRACTOR WITH A PERIOD TIMEFRAME IN WHICH TO GET THE JOB COMPLETED. WE UNDERSTAND THAT SHORT-TERM TECHNICAL ASSISTANCE (E.G. IQCS, BUY-INS, HCN/PSCS) WILL BE OBTAINED AS APPROPRIATE FOR SPECIFIC SHORT-TERM TASKS UNTIL A LONG-TERM TA CONTRACTOR IS PROCURED. BECAUSE OF THE PERCEIVED CRITICAL NATURE OF THE TA COMPONENT, THE PAAD SHOULD DESCRIBE IN DETAIL THE NATURE, SOURCE, AND TIMING OF ALL SHORT-TERM AND LONG-TERM TA ARRANGEMENTS INCLUDING A DISCUSSION OF THE FEASIBILITY OF THE SELECTED APPROACH, OR WHETHER THE PACD SHOULD BE ADJUSTED AT THE OUTSET TO ALLOW SUFFICIENT TIME FOR TA-DEPENDENT OUTPUTS TO BE ACHIEVED.

C. MONITORING AND EVALUATION. THE PAIP INCLUDES A DESCRIPTION OF THE EXPECTED OUTCOMES/IMPACT OF THE KHCF PROGRAM. HOWEVER, IT DID NOT OUTLINE A MONITORING AND EVALUATION PLAN FOR THE PROGRAM. THE PAAD DESIGN SHOULD INCLUDE A MONITORING AND EVALUATION PLAN. AT A MINIMUM, THE PLAN SHOULD INCLUDE BASELINE DATA COLLECTION AND ANALYSIS; PERFORMANCE BENCHMARKS; A SCHEDULE FOR ALL MONITORING EVENTS AND EVALUATIONS AND A DESCRIPTION OF THE EVALUATION METHODOLOGY. THE PAAD DESIGN SHOULD INCLUDE THE ANALYTICAL FRAMEWORK WHICH WILL ALLOW A.I.D. TO CLEARLY DEMONSTRATE THE DEVELOPMENTAL IMPACT OF ITS ASSISTANCE TO THE KENYA HEALTH SECTOR AT THE CONCLUSION OF THE KHCF PROGRAM. IT IS IMPORTANT THAT A.I.D. CAN DEMONSTRATE THAT THE POLICY REFORM WHICH WILL BE ACCOMPLISHED AT THE END OF THE KHCF PROGRAM HAS MADE A DIFFERENCE AND FOR WHOM IT HAS MADE A DIFFERENCE.

5. FAA SECTION 611(A)(2) CONSIDERATIONS

THE ECPR NOTED THAT FAA SECTION 611(A)(2) REQUIRES A JUDGEMENT BY A.I.D. WHETHER THERE IS REASONABLE EXPECTATION THAT ANY REQUIRED COOPERATING COUNTRY
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LEGISLATIVE ACTION WILL BE COMPLETED IN TIME TO PERMIT ORDERLY ACCOMPLISHMENT OF THE PURPOSE OF THE PROGRAM ASSISTANCE. THE ECPR UNDERSTANDS THAT SOME OF THE POLICY REFORMS DESIGNED TO MAKE A MORE EFFECTIVE NATIONAL HOSPITAL INSURANCE FUND MAY REQUIRE CHANGES TO THE FUND'S CHARTER WHICH REQUIRES KENYA LEGISLATIVE ACTION(S). THE PAAD SHOULD SPECIFICALLY STATE WHETHER ANY TYPE OF GOK LEGISLATIVE ACTION IS REQUIRED TO IMPLEMENT ANY ELEMENT OF THE KHCF PROGRAM. IF THE KENYA MISSION DETERMINES THAT GOK LEGISLATIVE ACTION (REGARDLESS OF THE MAGNITUDE) IS REQUIRED, THE PAAD SHOULD DISCUSS ANTICIPATED TIMING OF SUCH ACTION AND ITS IMPACT ON THE KHCF PROGRAM.

6. IEE. AFRICA BUREAU ENVIRONMENTAL OFFICER HAS CONCURRED WITH THE IEE INCLUDED IN THE KHCF PAIP. A COPY WILL BE FORWARDED TO MISSION FOR INCLUSION IN PAAD.

7. PAAD AUTHORIZATION VENUE

THE ECPR DECIDED THAT THE KHCF PAAD SHOULD BE REVIEWED AND APPROVED IN A.I.D./W. THE ECPR NOTED THAT THE KHCF PROGRAM IS A MAJOR POLICY REFORM INITIATIVE IN THE HEALTH SECTOR FOR THE AFRICA BUREAU. THEREFORE,

A.I.D./W AND THE KENYA MISSION SHOULD BENEFIT FROM FURTHER DIALOGUE REGARDING THE PROGRAM'S POLICY REFORM FRAMEWORK AND STRATEGY.

8. AVAILABILITY OF PROGRAM FUNDING

THE ECPR APPROVED THE KHCF PAIP AT A LOP OBLIGATION LEVEL OF DOLS FIFTEEN (15) MILLION-

HOWEVER,
A.I.D./W WILL NOT/NOT BE ABLE TO PROVIDE MORE THAN DOLS TEN (10) MILLION FOR THE KHCF PROGRAM FROM THE THE FY 1989 AND/OR FY 1990 AEPRP FUNDS. WHILE IT IS POSSIBLE THAT THERE MAY BE SOME FY 1989 FALLOUT, MISSION SHOULD PLAN TO MAKE UP THE DIFFERENCE OF DOLS FIVE (5) MILLION FROM ITS FY 1989 OR FY 1990. BAKER
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ANNEX P

# RESPONSE TO PAIP APPROVAL CABLE

The following USAID/Kenya response to the Health Care Financing PAIP Approval Cable is keyed to paragraph numbers of the cable (State 158128, Annex O).

## 2A. Program Strategy/Other Donors

As stated in the PAIP, the Mission considers the proposed AEPRP to be the first phase of a longer term reform process. It is not expected, however, that A.I.D. will make a major financial commitment of this effort beyond the 15 Million proposed in this PAAD. In the first phase of this reform program, the focus will be on introducing and/or strengthening cost-sharing. This will include the establishment of appropriate fee schedules, administrative/accounting mechanisms, procedures for ensuring access for those unable to pay, and policies and procedures for improving the allocation of resources in the sector. We feel confident that this can be accomplished during the four-year AEPRP.

The Mission does consider health sector reforms, and especially those related to financing, to be of key importance to improving the quality, accessibility, and sustainability of services. We believe our role, however, to be catalytic. The initiatives established during the AEPRP will be continued and expanded through a consortium of donor assistance. For example, the World Bank is proposing to finance two linked operations in the health sector. The first, to be appraised in FY 89/90, would finance capital improvements at KNH to help introduce cost sharing with quality improvements. It would also finance some additional studies to prepare for future sector reforms. Further reforms would then be supported with a second, much larger policy-based operation. In essence, other donor commitments are already projected to span a 10 year timeframe. The highly collaborative program development process with the World Bank that has characterized PAIP and PAAD preparation can be expected to continue, as evidenced by the World Bank request for A.I.D. representation on the World Bank appraisal team in August to assess the first phase of their operation. Lack of agreement between USAID and the World Bank (the other major donor) is largely a non-issue. Assuming satisfactory progress is made in the initial phase of the USAID/GOK program, we do expect that we would continue to provide some amount of technical support needed to sustain the reform process. For example, review of and assistance toward expansion of the role of the private sector in assisting the GOK meet health targets might be an appropriate area for limited follow-on assistance.

The larger amounts of funding necessary to support a broad-based sector-wide reform program, however, will require resources far in excess of those potentially available from A.I.D.

2B. As described in the PAIP and PAAD, the lack of financial resources for primary and preventive services is the key constraint to improved access and use of these services. Under the HCF Program, increased resources for these services will become available in three ways:

(1) Through the fees generated and retained by all levels of the MOH system. This will be particularly true for health centers and dispensaries, which are the major sources of primary and preventive services in the system;

(2) Through the additional resources made available through reallocations at the central level; and

(3) Through the use of local currency made available under the program support component of the Program.

These resources will, in particular, help to meet critical shortages in non-wage recurrent budgets for these facilities and programs. This includes the maintenance and repairs of buildings and equipment, replenishment of expendable supplies (especially essential drugs), and operating expenses (e.g., transport for field staff and logistics).

Clearly, the hospital-based element of the health care system will continue to make demands on the resources of the MOH, both those allocated by the Ministry of Finance and those generated through cost sharing. We believe, however, that improvements in funding for primary and preventive services will materialize due to:

(a) conditionality associated with the HCF Program which will require that resources equal to a specified portion of revenue expected to be generated through cost sharing will be used to augment the central MOH budget for primary and preventive services;

(b) conditionality associated with a World Bank Project planned for FY 90, and subsequently associated with a larger, longer term multi-donor effort to be led by the Bank;

(c) the establishment of a clear policy which allows primary-level facilities (i.e., health centers and dispensaries) to retain most of the revenue they generate; and

(d) the commitment of the MOH to reallocating resources in favor of primary and preventive care as stated in the Development Plan and Forward Budgets.

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The long-term sustainability and/or maintenance of this shift within the MOH programming framework is a key requirement for the success of the program. In this regard, it is essential that the HCF program establish the capacity within the MOH to adequately relate and translate the population's critical health needs into programming and budgeting approaches that expand preventive services. The longer term financed commitments other donors (particularly the World Bank) plan to make in the sector will admittedly be critical to ensuring not only that the MOH maintains the redirection of resources, but that it also has the financial capacity to translate rhetoric into reality.

2C. Improvement of Health Facilities:

The qualitative deficiencies existing in the public sector are most apparent in the provincial and district hospitals. It is planned, therefore, that additional resources will be made available to them through cost sharing, supplemented by a portion of the local currency support that will be available in the GOK's special account for this program. On the basis of the recent Bank-led health care financing review, it seems clear that marked improvements in quality could be made quickly and easily through this provision of modest amounts of financial resources. These improvements will substantially enhance the acceptability of cost sharing.

Second, from studies conducted both in Kenya and elsewhere, it is expected that the modest fees likely to be introduced in the first phase of the Program will not result in significant reduction in legitimate demand for services. These studies suggest the price elasticity of demand for such services is such that, to the extent that a reduction in utilization occurs, it will tend to be for so-called "frivolous" demand (i.e., a person will not go to a hospital for minor ailments or will seek care at a more appropriate level). The reduction in "frivolous" demand expected to result from user fees is expected to reduce waiting times and to enable more time to be spent with each patient - two important measures of quality.

Finally, the MOH recently has begun to take steps to increase financing of non-wage recurrent expenditures of these facilities. This will intensify prior to initiating cost-sharing. Though substantial improvements in quality will take time, we see little likelihood that the resources will be available to finance these without cost sharing.

The proposed Program is really focused on establishing cost sharing at Kenyatta National Hospital (KNH) and Ministry of Health (MOH). To the extent improvements in efficiency (cost containment) occur, they will be due in part to the effects of cost sharing. For example, increased financial resources will increase the likelihood that equipment and supplies will be available and functioning, one of the major causes of the

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unacceptably long lengths of stay in public hospitals. Improved referral and utilization patterns should reduce overcrowding and allow hospital staff to devote this attention to those in real need of care. We do not propose, however, to try to take on broad-based management improvements in the system during this four-year timeframe.

In the case of KNH, the World Bank has already made a preliminary assessment of physical facility improvements necessary on a prioritized basis over a four-year time frame to improve capacity. Together with the Bank, KNH is developing a four-year investment program that would be financed by the Bank and through KNH's eventual revenue generation. This same concept approach to "investment planning" will be introduced more broadly into the MOH's planning and budgeting processes through USAID's and other donors' support of analytical/assessment studies, such as the Provincial and District Health Services Study.

3. Program Beneficiaries:

The program will target beneficiaries by two approaches. One output of the PD&S-funded Provincial and District Health Services Study that is now underway will be the development of guidelines for the Provincial and District Health Management Teams for the utilization of resources generated through cost sharing. A draft methodology of prioritizing spending has already been developed by IPS and will serve as the basis for the guidelines. These guidelines will outline the methods to identify areas needing primary attention and those activities which would have the most impact on the health status of the population served. A certain percentage of funds would be designated for primary and preventive programs and for those locations and sub-locations having greatest need. This within-District allocation method will continue during the LOP, being modified as the monitoring and evaluation system notes possible improvements in the system.

By the end of the fourth year of the Program, we envision the reallocation from better to worse off Districts will be fully functioning. The MOH currently has developed an index of need for each district. The following indices are included: population, population density, morbidity rate, percentage of population living more than four Km from a health facility, number of GOK health centers, number of GOK dispensaries, qualified staff, GOK Health Center beds. These are weighted and a "need co-efficient" calculated. Currently the MOH then compares this "coefficient of need" to estimated budget allocations in the planning process.

Given regional differences, we anticipate that many districts have the ability to raise significant revenues. In other geographical areas with minimal economic resources, the

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revenues generated will be quite low. The central headquarters will take the lead by year three of the program in reallocating resources from the richer to poorer areas. Based on the revenues generated the year before, an average per capita allocation of revenues generated through cost sharing will be estimated. Though the exact methodology of resource allocation will need to be refined over the program, the MOH will shift central allocations to those districts generating lower levels. Once these additional funds are released to the districts, they will be allocated according to the District Guidelines described above.

4A. Program Management

USAID notes the concern of the ECPR in the Program Management aspect of the proposed program. We anticipate that the first year of the Program will be the most management intensive. A system for monitoring the conditionality and the achievement of benchmarks must be put into place. In addition the Technical Assistance team will not yet be in place at the time we anticipate the first benchmarks to be met. Thus, the following division of labor is anticipated.

In the first year, the Chief of the HPH Office will devote 30 percent of his/her time to overall policy dialogue and specification of the Policy Reform Agenda. The Health Population Officer will devote 60 percent of his/her time to the implementation of the Reform Agenda at the MOH and KNH. In addition the IDI under the supervision of the HPN Officer will spend 50 percent of his/her time on the implementation of reform at NHIF and in finalizing the RFP for Technical Assistance. The PSC Health Economist will serve as backstop in all areas of technical review of appropriateness of decisions taken and policy impact and will spend 100 percent of his/her time on the Program.

Midway in year one , we expect the T.A. team to be in place and fully functional by the beginning of year two. The second disbursements are are projected to take place midway through year two. We expect the TA contractor to play a major role in the day to day operations of the program implementation and monitoring the policy and infrastructure change. Procedures for AID monitoring will be in place based on year one experience.

The Chief of the Division will continue his/her involvement at the Policy level for 15 percent time monitoring conditionality with 50 percent time of the HPN officer monitoring the achievements of conditionality and the TA contract with the technical assistance of the full time PSC health economist. This division of time will be maintained until the end of the Program.

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4B. Technical Assistance

The implementation and further definition of the reform agenda is well underway. These activities cannot wait for long-term TA to arrive. In fact, additional analytical must be undertaken in order to meet the conditions for the first disbursement. The Mission, with the implementing agencies, has outlined a fairly tight schedule of actions required over the next year. We anticipate that if the PROAG is signed in August, the RFP will be out in September and a contractor chosen before Christmas, the TA team will be in place in March.

In the interim, we plan to phase TA inputs to the system via buy-ins to the REACH Project. When the REACH ceiling was raised, Kenya was given a level of $400,000 for buy-ins. We expanded the Scope of the Provincial and District Health Services Study. The analysis of the study will lead to the development of guidelines for expenditures and implementation plans for the new system ($80,000). An additional buy-in will become effective as of August to support 15 analytical works, operations research and planning activities ($220,000). These are the anticipated TA requirements to assist the GOK to meet the first set of conditionality (activities scheduled from August to December 1989). We will use our KHCF program funds for the final buy-in to REACH ($100,000) so that TA needs and observation/study tours anticipated from January to March can take place. Finally, we will hold some program funding free in case there is a delay in putting the TA contractor in place. The Mission would then do direct contracting for small activities as needed. (See PIO/Ts 615-0510-3-90062 and 615-0510-3-90033 for details of pre-implementation activities.)

For the majority if not all of this work, we plan to use the centrally-funded Reach Project for two reasons. One is that REACH has worked in Kenya on two activities, KNH and NAS studies. They know the context and are familiar with the Kenyan financing situation. They are also known and respected by the Kenyans. Secondly, as all three implementing agencies, reform actions are influenced by the others, and recommended reforms in one will affect reforms suggested for others, overall technical supervision is required to assure the development of a rational sector-wide reform agenda.

The timing delay of the TA inputs to the program noted in PAAD cable is important. Therefore, though the disbursements are anticipated to take place over three years (3 1/4 years from signing of the PROAG), given the timing lag of TA inputs to assist the reform agenda, the mission proposes a four-year PACD. From signing the PROAG this allows an appropriate length of the TA contract and allows a longer time-frame to meet the last disbursement if delays take place. The final evaluation of the Program would then take place after the last disbursement has been made.

5. FAA Section 611(A) (2) considerations shown as Annex H.

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ANNEX P

# RESPONSE TO PAIP APPROVAL CABLE

The following USAID/Kenya response to the Health Care Financing PAIP Approval Cable is keyed to paragraph numbers of the cable (State 158128, Annex O).

## 2A. Program Strategy/Other Donors

As stated in the PAIP, the Mission considers the proposed AEPRP to be the first phase of a longer term reform process. It is not expected, however, that A.I.D. will make a major financial commitment of this effort beyond the 15 Million proposed in this PAAD. In the first phase of this reform program, the focus will be on introducing and/or strengthening cost-sharing. This will include the establishment of appropriate fee schedules, administrative/accounting mechanisms, procedures for ensuring access for those unable to pay, and policies and procedures for improving the allocation of resources in the sector. We feel confident that this can be accomplished during the four-year AEPRP.

The Mission does consider health sector reforms, and especially those related to financing, to be of key importance to improving the quality, accessibility, and sustainability of services. We believe our role, however, to be catalytic. The initiatives established during the AEPRP will be continued and expanded through a consortium of donor assistance. For example, the World Bank is proposing to finance two linked operations in the health sector. The first, to be appraised in FY 89/90, would finance capital improvements at KNH to help introduce cost sharing with quality improvements. It would also finance some additional studies to prepare for future sector reforms. Further reforms would then be supported with a second, much larger policy-based operation. In essence, other donor commitments are already projected to span a 10 year timeframe. The highly collaborative program development process with the World Bank that has characterized PAIP and PAAD preparation can be expected to continue, as evidenced by the World Bank request for A.I.D. representation on the World Bank appraisal team in August to assess the first phase of their operation. Lack of agreement between USAID and the World Bank (the other major donor) is largely a non-issue. Assuming satisfactory progress is made in the initial phase of the USAID/GOK program, we do expect that we would continue to provide some amount of technical support needed to sustain the reform process. For example, review of and assistance toward expansion of the role of the private sector in assisting the GOK meet health targets might be an appropriate area for limited follow-on assistance.

The larger amounts of funding necessary to support a broad-based sector-wide reform program, however, will require resources far in excess of those potentially available from A.I.D.

2B. As described in the PAIP and PAAD, the lack of financial resources for primary and preventive services is the key constraint to improved access and use of these services. Under the HCF Program, increased resources for these services will become available in three ways:

(1) Through the fees generated and retained by all levels of the MOH system. This will be particularly true for health centers and dispensaries, which are the major sources of primary and preventive services in the system;

(2) Through the additional resources made available through reallocations at the central level; and

(3) Through the use of local currency made available under the program support component of the Program.

These resources will, in particular, help to meet critical shortages in non-wage recurrent budgets for these facilities and programs. This includes the maintenance and repairs of buildings and equipment, replenishment of expendable supplies (especially essential drugs), and operating expenses (e.g., transport for field staff and logistics).

Clearly, the hospital-based element of the health care system will continue to make demands on the resources of the MOH, both those allocated by the Ministry of Finance and those generated through cost sharing. We believe, however, that improvements in funding for primary and preventive services will materialize due to:

(a) conditionality associated with the HCF Program which will require that resources equal to a specified portion of revenue expected to be generated through cost sharing will be used to augment the central MOH budget for primary and preventive services;

(b) conditionality associated with a World Bank Project planned for FY 90, and subsequently associated with a larger, longer term multi-donor effort to be led by the Bank;

(c) the establishment of a clear policy which allows primary-level facilities (i.e., health centers and dispensaries) to retain most of the revenue they generate; and

(d) the commitment of the MOH to reallocating resources in favor of primary and preventive care as stated in the Development Plan and Forward Budgets.

The long-term sustainability and/or maintenance of this shift within the MOH programming framework is a key requirement for the success of the program. In this regard, it is essential that the HCF program establish the capacity within the MOH to adequately relate and translate the population's critical health needs into programming and budgeting approaches that expand preventive services. The longer term financed commitments other donors (particularly the World Bank) plan to make in the sector will admittedly be critical to ensuring not only that the MOH maintains the redirection of resources, but that it also has the financial capacity to translate rhetoric into reality.

2C. Improvement of Health Facilities:

The qualitative deficiencies existing in the public sector are most apparent in the provincial and district hospitals. It is planned, therefore, that additional resources will be made available to them through cost sharing, supplemented by a portion of the local currency support that will be available in the GOK's special account for this program. On the basis of the recent Bank-led health care financing review, it seems clear that marked improvements in quality could be made quickly and easily through this provision of modest amounts of financial resources. These improvements will substantially enhance the acceptability of cost sharing.

Second, from studies conducted both in Kenya and elsewhere, it is expected that the modest fees likely to be introduced in the first phase of the Program will not result in significant reduction in legitimate demand for services. These studies suggest the price elasticity of demand for such services is such that, to the extent that a reduction in utilization occurs, it will tend to be for so-called "frivolous" demand (i.e., a person will not go to a hospital for minor ailments or will seek care at a more appropriate level). The reduction in "frivolous" demand expected to result from user fees is expected to reduce waiting times and to enable more time to be spent with each patient - two important measures of quality.

Finally, the MOH recently has begun to take steps to increase financing of non-wage recurrent expenditures of these facilities. This will intensify prior to initiating cost-sharing. Though substantial improvements in quality will take time, we see little likelihood that the resources will be available to finance these without cost sharing.

The proposed Program is really focused on establishing cost sharing at Kenyatta National Hospital (KNH) and Ministry of Health (MOH). To the extent improvements in efficiency (cost containment) occur, they will be due in part to the effects of cost sharing. For example, increased financial resources will increase the likelihood that equipment and supplies will be available and functioning, one of the major causes of the

unacceptably long lengths of stay in public hospitals. Improved referral and utilization patterns should reduce overcrowding and allow hospital staff to devote this attention to those in real need of care. We do not propose, however, to try to take on broad-based management improvements in the system during this four-year timeframe.

In the case of KNH, the World Bank has already made a preliminary assessment of physical facility improvements necessary on a prioritized basis over a four-year time frame to improve capacity. Together with the Bank, KNH is developing a four-year investment program that would be financed by the Bank and through KNH's eventual revenue generation. This same concept approach to "investment planning" will be introduced more broadly into the MOH's planning and budgeting processes through USAID's and other donors' support of analytical/assessment studies, such as the Provincial and District Health Services Study.

3. Program Beneficiaries:

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5. FAA Section 611(A) (2) considerations shown as Annex H.

4C. Monitoring and Evaluation

In addition to tracking financial changes and internal efficiencies and effectiveness via meeting conditionality, the GOK and USAID will receive monitoring data on the impact of the reforms on utilization of health services and potential changes in access and disease specific mortality rates.

Through the MOH Health Information Systems (Unit), assisted by the USAID-financed Information Planning Systems Project (IPS), routine service delivery statistics are collected at facility, level, sent to District level where there are summarized and forwarded to headquarters. As part of the first condition, a monitoring system using facility-based data on utilization will be put into effect. The Kenya Heath Care Financing Implementation Committee (with HIS assistance) will monitor utilization as policy changes are put into effect.

Normal reporting and intermediate indicators of health status are in use now in key MOH preventive and promotive programs. The Expanded Program on Immunization (KEPI) and the Control of Diarrheal Disease (CDD) Programs have developed a disease surveillance sentinel reporting system that should be operational in 1990. In addition periodic surveys are undertaken to assess EPI coverage; assess and use of ORT. Similar information on malnutrition can be gathered via the UNICEF supported CHANIS growth monitoring program. In addition, a modified population-based monitoring sytem linked to the Division of Family Health's sentinel disease surveillance reporting system for EIP diseases and diarrheal diseases is anticipated to become operational during the first year of the Policy Reform Program. Effects of the introduction of fees will be monitored.

Currently, a National Kenya Demographic and Health Survey (KDHS) is being carried out. Field work for the KDHS was completed in May 1989. A follow-on survey will ascertain the causes of infant and childhood deaths, the determinants of mortality (including the relationship to malaria) and the availability and utilization of health services. These surveys will provide detailed information on a range of districts. The same population sample base can then be used to analyze impact of the KHCF Program. Another DHS is planned under our FPSS Project for 1992 - the year of the last disbursement by the HCF Program.

5. FAA Section 611(A) (2) considerations shown as Annex H.

FINANCIAL PLAN for Ministry of Health (U.S. Dollars)

| | Year 1 | | Year 2 | | Year 3 | | Year 4 | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| | AID | GOK | AID | GOK | AID | GOK | AID | GOK | AID | GOK |
| Technical Assistance | | | | | | | | | | |
| External:Long Term-Economist | 115,000 | | 230,000 | | 115,000 | | | | 460,000 | 0 |
| -Planner | 115,000 | | 230,000 | | 115,000 | | | | 460,000 | 0 |
| Short Term-Economist/ Mgt Consultant | 8,725 | | 15,600 | | 11,150 | | 4,275 | | 39,750 | 0 |
| Local:Long Term-Mgt Consultant | 0 | | 60,000 | | 120,000 | | 60,000 | | 240,000 | 0 |
| Short Term-Economist/ Mgt Consultant | 9,375 | | 15,625 | | 8,750 | | 2,500 | | 36,250 | 0 |
| Total Technical Assistance | 248,100 | 0 | 551,225 | 0 | 369,900 | 0 | 66,775 | 0 | 1,236,000 | 0 |
| Training | | | | | | | | | | |
| External:Long Term (6) | 60,000 | | 120,000 | | 60,000 | | | | 240,000 | 0 |
| Short Term (5) | 28,750 | | 28,750 | | | | | | 57,500 | 0 |
| Local:Health Sector Coord Body | | | 21,900 | | 21,900 | | | | 43,800 | 0 |
| MOH Facility personnel | | | 27,900 | | 27,900 | | | | 55,800 | 0 |
| Total Training | 88,750 | 0 | 198,550 | 0 | 109,800 | 0 | 0 | 0 | 397,100 | 0 |
| Studies and Analysis | | | | | | | | | | |
| -Baseline Follow-Up | 19,600 | | 34,225 | | 22,900 | | 8,275 | | 85,000 | 0 |
| -Private Sector Study | | | 29,450 | | 29,450 | | | | 58,900 | 0 |
| -Referral Study Follow-Up | | | 6,600 | | 12,600 | | 6,000 | | 25,200 | 0 |
| Total Studies and Analysis | 19,600 | 0 | 70,275 | 0 | 64,950 | 0 | 14,275 | 0 | 169,100 | 0 |
| Commodities: | | | | | | | | | | |
| -Computers (9), Software | 58,000 | | | | | | | | 58,000 | 0 |
| -Photocopiers | 5,000 | | | | | | | | 5,000 | 0 |
| -Vehicles (2) | 40,000 | | | | | | | | 40,000 | 0 |
| Total Commodities | 103,000 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 103,000 | 0 |
| Miscellaneous | 6,500 | | 8,000 | | 3,000 | | 1,500 | | 19,000 | 0 |
| GRAND TOTAL | 465,950 | 0 | 828,050 | 0 | 547,650 | 0 | 82,550 | 0 | 1,924,200 | 0 |

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FINANCIAL PLAN for Kenyatta National Hospital (U.S. Dollars)

| | Year 1 | | Year 2 | | Year 3 | | Year 4 | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| | AID | GOK | AID | GOK | AID | GOK | AID | GOK | AID | GOK |
| Technical Assistance | | | | | | | | | | |
| External:Short Term | | | | | | | | | | |
| -Mgt Consultant | 20,450 | | 43,100 | | 31,550 | | 8,900 | | 104,000 | 0 |
| -Architect | 5,850 | | 11,700 | | 5,850 | | 0 | | 23,400 | 0 |
| -Finance Specialist | 4,850 | | 9,700 | | 13,400 | | 8,550 | | 36,500 | 0 |
| Local:-Short Term | | | | | | | | | | |
| -Mgt Consultant | 60,000 | | 95,000 | | 47,500 | | 12,500 | | 215,000 | 0 |
| Total Technical Assistance | 91,150 | 0 | 159,500 | 0 | 98,300 | 0 | 29,950 | 0 | 378,900 | 0 |
| Training | | | | | | | | | | |
| External:Short Term | | | | | | | | | | |
| -6 Mid Level 6 Month Interns | | | 60,750 | | 121,500 | | 60,750 | | 243,000 | 0 |
| -12 Mid Level | | | 48,000 | | 96,000 | | 48,000 | | 192,000 | 0 |
| Long Term-2MHA/MBA | | | 40,000 | | 80,000 | | 40,000 | | 160,000 | 0 |
| Local:Short Term-12 Mid Level | | | 18,000 | | 36,000 | | 18,000 | | 72,000 | 0 |
| Total Training | 0 | 0 | 166,750 | 0 | 333,500 | 0 | 166,750 | 0 | 667,000 | 0 |
| Studies and Training | | | | | | | | | | |
| -Private Wing Services | | | 29,150 | | 42,200 | | 13,050 | | 84,400 | 0 |
| Total Studies and Training | 0 | 0 | 29,150 | 0 | 42,200 | 0 | 13,050 | 0 | 84,400 | 0 |
| Other Costs | | | | | | | | | | |
| Non TA Study Costs | | | 5,000 | | 10,000 | 0 | 5,000 | 0 | 20,000 | 0 |
| Miscellaneous | 3,350 | | 9,300 | | 7,600 | | 1,650 | | 21,900 | 0 |
| GRAND TOTAL | 94,500 | 0 | 369,700 | 0 | 491,600 | 0 | 216,400 | 0 | 1,172,200 | 0 |

FINANCIAL PLAN for National Hospital Insurance Fund (U.S. Dollars)

| | Year 1 | | Year 2 | | Year 3 | | Year 4 | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| | AID | GOK | AID | GOK | AID | GOK | AID | GOK | AID | GOK |
| Technical Assistance | | | | | | | | | | |
| External:Long Term | | | | | | | | | | |
| -Health Ins Specialist | 115,000 | | 115,000 | | | | | | 230,000 | 0 |
| -Short Term | | | | | | | | | | |
| -Health Ins Specialist | | | 20,650 | | 32,600 | | 11,950 | | 65,200 | 0 |
| -Actuary | 16,050 | | 27,250 | | 11,200 | | | | 54,500 | 0 |
| Local: Short Term | | | | | | | | | | |
| -Actuary | 4,500 | | 7,500 | | 3,000 | | | | 15,000 | 0 |
| -Computer Specialist | | | 6,000 | | 9,000 | | 3,000 | | 18,000 | 0 |
| Total Technical Assistance | 135,550 | 0 | 176,400 | 0 | 55,800 | 0 | 14,950 | 0 | 382,700 | 0 |
| Training | | | | | | | | | | |
| External:Study Tour | 31,100 | | | | | | | | 31,100 | 0 |
| Local:Retreats | | | 26,000 | | 43,400 | | | | 69,400 | 0 |
| -Computer training | | | | | | | | | | |
| Total Training | 31,100 | 0 | 26,000 | 0 | 43,400 | 0 | | 0 | 100,500 | 0 |
| Studies and Analysis | | | | | | | | | | |
| -Labor Market Analysis | | | 29,800 | | | | | | 29,800 | |
| -Provider Study | | | | | 30,900 | | | | 30,900 | |
| Total Studies and Analysis | 0 | 0 | 29,800 | 0 | 30,900 | 0 | 0 | 0 | 60,700 | 0 |
| Commodities:TA Microcomputers, Accessories Supplies | 25,000 | | | | | | | | 25,000 | 0 |
| NHIF Hardware/Software | | | 600,000 | | | | | | 600,000 | 0 |
| Total Commodities | 25,000 | 0 | 600,000 | 0 | 0 | 0 | 0 | 0 | 625,000 | 0 |
| Miscellaneous | 500 | | 1,600 | | 1,700 | | 600 | | 4,400 | 0 |
| GRAND TOTAL | 192,150 | 0 | 833,800 | 0 | 131,800 | 0 | 15,550 | 0 | 1,173,300 | 0 |

FINANCIAL PLAN
Other Costs not directly related to Institutions
(U.S. Dollars)

| | Year 1 | | Year 2 | | Year 3 | | Year 4 | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|
| | AID | GOK | AID | GOK | AID | GOK | AID | GOK | AID | GOK |
| Administrative Costs | 45,000 | | 90,000 | | 90,000 | | 45,000 | | 270,000 | 0 |
| Audit and Evaluation | 0 | | 40,000 | | 0 | | 40,000 | | 80,000 | 0 |
| Pre Contract TA | 100,000 | | 0 | | 0 | | 0 | | 100,000 | 0 |
| AID Personnel Hire | 0 | | 50,000 | | 50,000 | | 50,000 | | 150,000 | 0 |
| Inflation/Contingency | 79,300 | | 195,450 | | 115,850 | | 39,700 | | 430,300 | 0 |
| Total | 224,300 | 0 | 375,450 | 0 | 255,850 | 0 | 174,700 | 0 | 1,030,300 | 0 |