

Kenya: Non-Governmental Health Care Provision

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Harvard University

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**Data for Decision Making Project
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in collaboration with

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Data for Decision Making

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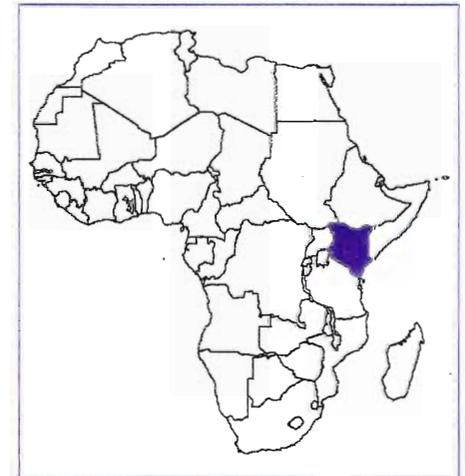
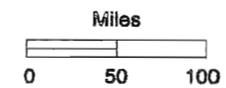
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List of Abbreviations

AIDS	Acquired Immuno-deficiency Syndrome
AMREF	African Medical Research Foundation
ARI	Acute Respiratory Infection
CBD	Community-based distributor
CBHC	Community-based health care
CDD	Control of diarrhoeal diseases
CHAK	Christian Health Association of Kenya
CHW	Community Health Worker
CMA	Crescent Medical Aid
DDM	Data for Decision Making Project
DFH	Department of Family Health
DGH	District General Hospital
DHMT	District Health Management Team
DHS	Demographic and Health Survey
DMOH	District Medical Officer of Health
EPI	Expanded Program on Immunization
FPAK	Family Planning Association of Kenya
FPFS	Family Planning Private Sector
HIV	Human Immunodeficiency Virus
GDP	Gross Domestic Product
GOK	Government of Kenya
HHRAA	Health and Human Resources Analysis for Africa
HIS	Health Information System
IUD	Intra-uterine contraceptive device
JICA	Japan International Cooperation Agency
KCS	Kenya Catholic Secretariat
KDHS	Kenya Demographic and Health Survey
KEPI	Kenya Expanded Programme on Immunization
KHCFP	Kenya Health Care Financing Project
KMA	Kenya Medical Association

MCH	Maternal and Child Health
MLG	Ministry of Local Government
MOH	Ministry of Health
MSH	Management Sciences for Health
MTC	Medical Training College
NGO	Non-governmental organization
NHIF	National Hospital Insurance Fund
NLTP	National Leprosy and Tuberculosis Programme
OPD	Outpatient Department
ORS	Oral Rehydration Solution
PCEA	Presbyterian Church of East Africa
PGH	Provincial General Hospital
PMO	Provincial Medical Officer
PPO	Preferred-Provider Organization
SES	Socioeconomic status
STD	Sexually Transmitted Disease
TB	Tuberculosis
TBA	Traditional Birth Attendant
TR	Total revenue
USAID/K	United States Agency for International Development, Kenya Mission
USAID/W	United States Agency for International Development, Washington
VAT	Value-added tax
WMES	Welfare Monitoring and Evaluation Survey
ZCCM	Zambia Consolidated Copper Mines
ZDHS	Zambia Demographic and Health Survey

KENYA



Legend

- INTERNATIONAL BOUNDARY
- PROVINCIAL BOUNDARY
- ★ NATIONAL CAPITAL
- PROVINCIAL CAPITALS

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Executive Summary

Kenya has long followed a strategy of pluralism in the health sector, allowing a large and diverse non-government health sector to develop. This report documents the contributions of this non-government sector to some of Kenya's health goals. The potential exists for much higher levels of contribution from the non-governmental sector. This requires collaboration between the public and private sectors in identifying national public health priorities and in putting in place a framework for achieving those goals.

Findings

The major findings of the assessment are as follows:

There is some confusion over the classification of private providers. Documenting the composition of the private sector by type of health care organization has proved to be very difficult.

Non-government providers are a significant part of Kenya's overall health care provision capacity. They account for 50% of all hospitals and 36 % of Kenya's hospital beds. They also account for approximately 21% of health centers and 51% of all other outpatient treatment facilities, although these include a wide variety of different levels of quality and capacity, as noted above.

Studies undertaken in the mid-1980's suggest that non-government sources of finance account for slightly less than half of total health expenditures in Kenya.

The private sector has grown from a few providers when Kenya became independent of British rule in 1963, to nearly 1500 in 1993. In the provider survey, we noted a rise in the numbers of providers beginning work since 1990, implying recent rapid growth.

The geographic distribution of private health facilities in the country shows strong patterns of rural-urban differentiation and concentration of certain types of providers in certain areas.

The non-governmental health sector makes a substantial contribution to Kenya's health services provision. Non-government services are used by all socio-economic classes, although the type of facility used may differ across these groups.

A review of a variety of disease and problem-specific studies shows that non-government providers contribute in varying degrees to addressing public health problems.

Evidence on the quality and efficiency of services provided by the private sector is very limited and inadequate for any substantial conclusions.

Kenya has both public (NHIF) and private health insurance. Private third-party insurance is a growing industry, but is still quite small and limited to urban areas and covers primarily those employed in the formal sector. At present, the NHIF suffers from a variety of problems, which impair its role as a successful risk-sharing scheme and make it difficult to assess its overall impact on the private sector.

Kenyan laws concerning the private health sector appear to regulate the quality of inputs. They establish minimum standards for entry into the sector and the framework of exchange in the private health sector market. There are significant gaps in the laws affecting non-government health care providers, particularly those addressing the development of private practice by non-physicians. The laws are reportedly very poorly enforced and so often do not have the desired effect.

The provider survey showed that private health facilities in Kenya face a number of constraints which differ by facility type. They include high taxes, high transport costs, lack of access to credit, very low rural incomes, poor rural infrastructure, and lack of information from the Ministry of Health concerning public health activities and pharmaceuticals.

Recommendations

The recommendations are grouped under three headings:

1. System/General Policies

The MOH should improve institutional linkages between itself and the organized non-governmental provision sector including CHAK, KCS and CMA. The recently established Office for NGO health providers should be strengthened and invested with real powers and responsibility including development of programs to support health NGOs. An effective mechanism should be established for eliciting private sector input to health policy formulation.

The MOH should look for appropriate incentives to enhance coverage of services in relatively under-served areas of the country. Policies could include subsidies to reduce start-up costs, adaptations of licensing rules and regulations, and where appropriate, provision of inputs such as seconded government personnel.

Government capacity to monitor quality in both the public and private sectors, improve it overall, and take action to remedy problems is weak. Efforts should include review and development of input standards, monitoring the output of facilities, and continuing education/training opportunities for private providers. These could be focussed initially on services of public health importance. Efforts should also be made to use educational and promotional activities to influence the behavior of private providers.

Current laws regulating non-government providers seem to be a burden to providers, provide little effective regulation or information for the state, and offer limited protection for consumers. The objectives and processes of regulation, including existing laws, should be reviewed. Enhancement of the MOH's regulatory role must be accompanied by a careful analysis of the resources and capabilities required for it to successfully and effectively carry out these activities.

The MOH should consider:

Developing a comprehensive database of private providers, which could be used to monitor changes, identify targets for policy strategies, and develop operations research on quality and efficiency.

Strengthening the newly-established division of health systems research, including the development of a research agenda and provision of adequate resources to undertake operations research.

The role/potential for current cost-sharing policies in public facilities to improve the quality of public sector health services, increasing price competition with non-government providers.

2. Provider-Specific Recommendations

Mission facilities

The MOH could accelerate and simplify procedures for seconding health staff to mission facilities in the context of newly decentralized authority; it should also consider greater use of incentives to encourage staffing of remote facilities.

The MOH should encourage the dedication of a number of places in training institutions, for example in the Medical Training College (MTC) for mission health facilities.

The GOK and donors could assist mission facilities to improve their medical records, book-keeping and other records.

Donors and the GOK could assist more mission hospitals to replicate PCEA

Chogoria's insurance experience.

The GOK should review the size of grants and the process of grant-making to the mission health facilities.

For-profit providers

The cost of malpractice insurance for sole providers is currently high. The GOK may wish to consider reforming insurance for practitioners in private practice.

The GOK should enact enabling laws to formalize private practice by nurses and pharmaceutical technologists in order to allow for them to be better monitored and regulated; it should also amend the Medical Practitioners and Dentists Act to reflect the new role of clinical officers as operating in both the public and private sectors.

Operations research should be conducted in order to better understand the role being played by small for-profit providers, including the quantity and type of services being provided, and the quality of these services. There is also a need to assess the continuing education requirements of this type of provider.

NHIF

The ongoing efforts to reform the NHIF have potentially important implications for the non-government hospital sector.

Pharmacies

Pharmacies are increasingly becoming a source of primary care in Kenya. The MOH should recognize this and take appropriate actions, for example, to assure that pharmacies providing such care employ appropriately-trained personnel.

Traditional health practitioners

The MOH should explore the use of traditional health practitioners in the distribution of health information and family planning commodities.

Pilot programs should be developed to expose medical school undergraduates to traditional healing practices.

Community health workers and pharmacies

The MOH and the donor community should continue to encourage them by providing seed capital or subsidized drugs.

3. Service-Specific Recommendations

The role of TBAs as care-givers during pregnancy and delivery is fairly well demonstrated. Efforts at evaluating, identifying training needs, and providing training for this group of providers should continue.

The MOH and the donor community should maintain and expand existing efforts at integrating private providers. Integration of privately-practicing nurses and clinical officers into family planning programs should continue; the MOH and donors should consider undertaking studies to evaluate the cost-effectiveness of this model of service provision, and the feasibility of extending it to other services of public health interest.

Relatively few private providers are providing immunization services as part of their regular activities, and their contribution to overall immunization activity appears to be relatively small. The cost-effectiveness of integrating the small for-profit private provider sector into immunization activities (along the lines of the KMA family planning project, adapted to include providing free or subsidized vaccines) should be explored.

Efforts at educating and updating the knowledge of private providers regarding correct treatment regimens and the problems caused by defaulting patients should continue.

Ways to increase the role of the private sector in prevention activities, such as provision of impregnated bednets, should be explored.

The role of commercial sources (pharmacies and shops) in treatment needs to be recognized. Efforts at quality assurance (particularly in respect of appropriate chemotherapy) need to be targeted at these providers. Public information about the causes and dangers of drug-resistant forms of malaria is another strategy to increase appropriate treatment.

Ways to make the promotion of ORS more attractive to commercial sources should be identified. Private providers (including commercial sources) should be included in training activities, focusing on those providers with the least access to continuing education activities.

Social marketing should be explored as a way to increase demand for ORS.

The role of commercial providers in the treatment of childhood illness needs to be recognized, with these providers included in education efforts.

Social marketing of condoms should be continued and intensified. The Ministry should continue to strengthen links with NGOs through the AIDS NGO Consortium, including making available training opportunities provided through external agencies.

Introduction

In 1989 the Government of Kenya (GOK) introduced cost-sharing in its health facilities. The main reason for this change in policy was the need to mobilize additional resources for the continued maintenance and improvement of the health of Kenyans. Impressive gains in health have been made since independence. Mortality rates have fallen and average life expectancy has risen. These were achievements made possible in part by substantial investments by the government in health with active participation from the private sector. In recent times some of these gains are reported to have stagnated (1993 KDHS) while others are on the verge of being reversed.

This threat of an erosion in health gains has been attributed in part to the generally poor performance of the economy. Falling revenues have severely constrained the government's ability to continue to make substantial budgetary allocations to health. The new fiscal reality, the emergence of new diseases and resurgence of old and almost-contained diseases have created an environment in the Ministry of Health in which new ideas and approaches to mobilizing resources to improve the health of Kenyans are being explored.

GOK Sessional Paper No. 1 of 1986, provides the basis for the ongoing reforms in the Kenyan health sector. Enunciating the view that the government will not be able to continue to provide "social (and economic) services at current levels unless *participants contribute more*" (italics in original p.106), it laid the groundwork for the introduction of cost-sharing in education and health. Scarce resources were to be redirected "toward growth-producing sectors", and domestic resources mobilized towards achieving national goals.

The Sessional Paper also announced the government's intention to a) review fees charged by the GOK for certain services where "participant support has fallen behind the level of costs and the ability to pay", b) introduce new charges and c) to reduce spending on health from 9 to 8% (p.30) of recurrent expenditures. Some of the fiscal burden of health was to be transferred to private health providers and individuals. Pursuant to this, the GOK undertook to create and promote an environment conducive to greater private sector involvement in health.

Having decided to accept a pluralistic health sector, Kenya faces a challenge. How can non-governmental health care make a greater contribution to national health goals? This question has formed part of the policy agenda of the Minis-

try of Health for some time. Private sector development issues are an important component of the Ministry's Five-Year Strategic Plan for the Financing of Health Services in Kenya. A number of studies, workshops and consultations have already been undertaken as part of this process. However in Kenya as in many other countries, there continues to be little information about the composition of the private provision sector and the nature of services that it provides. Furthermore, the information available is not usually in a form easily accessible to the policy maker or researcher. This study thus aims to contribute to this broader process of reform by addressing that informational problem. It was funded by the Health and Human Resources Analysis for Africa (HHRAA) project of the Africa Bureau of USAID/W. The study was undertaken by the Data for Decision Making Project at Harvard University in collaboration with the African Medical Research Foundation (AMREF) and with the active assistance of the MOH, USAID/K and the Kenya Health Care Financing Project.

Methodology

The Private Sector Assessment follows the methodology in DDM's Working Draft "Assessing the Private Sector: Methodological Guidelines" (Berman and Hanson, 1994). Data from different sources and of different kinds were used. The principal sources of information and data were GOK publications such as the Statistical Abstract and the Economic Survey, the many background papers prepared for the Kenya Health Care Financing Project and consultants' reports, including evaluations of the cost-sharing scheme. Two sources of new information which merit particular attention are the Provider Survey undertaken by DDM/AMREF as part of this study and the 1993 Kenya Demographic and Health Survey which DDM further analyzed to obtain evidence on the contribution of the private provision sector to certain services. The Health Provider Survey provided information on certain variables on which the construction of the profile of the private provision sector could be premised. Further detail about the provider survey appears in Appendix 1.

An important shortcoming of our reliance on secondary data is the difficulty it poses for comparing evidence across sources and across time periods. The most important source of facility-based health information in Kenya, the Health Information System (HIS) database, is incomplete. For example, during the provider survey field work in Kisumu we found that more than half of the private providers were not in the HIS database. Response rates vary across years and across institutions and there is some confusion over the classification of facilities by type and ownership. Delays in collecting and processing information mean lags of up to two years in the availability of information regarding facility-reported mortality and morbidity.

Structure of the Report

This report consists of 10 Chapters. Chapters 2 and 3 provide background information on Kenya, its economy, health indicators and the health system. The purpose of these two chapters is to lay the groundwork for the assessment of the private sector's contribution to health and to understand the economic environment in which private providers operate. In Chapter 4 we develop a typology of the private provision sector. Chapter 5 looks at the characteristics of private providers, including the growth of the sector, and their distribution. The utilization of private providers for curative services and factors affecting it are discussed in Chapter 6. Chapter 7 looks more specifically at the private sector contribution to major public health activities. Government policies have direct and indirect impacts on the private provision sector. These are analyzed in Chapter 8. Regulatory issues are outlined in Chapter 9. The report concludes in Chapter 10 with a discussion of some of the key findings and a preliminary list of strategies that may be considered to make better use of the non-governmental sector in achieving Kenya's health goals.

1 General Background Information

The Economy

Kenya's post-independence economic history can be divided into three distinct periods: 1) a period of rapid growth which spanned the 60s and 70s; 2) a period of measurable growth which lasted for most of the 1980's; and 3) a period of stagnation which began in the 90s. The first period was characterized by decent growth rates of 6.6% per annum and a very low inflation rate of 3% per annum. Savings and investment were relatively high and comprised about 20% of GDP. The growth rate in the second period averaged about 4% per annum while in the third period growth declined to an average rate of 0.2% per annum. Table 1 summarizes Kenya's key macroeconomic indicators for the period 1965 to 1992.

Fiscal Position

Since the 1980s the Kenyan economy has been characterized by large fiscal imbalances, although much of the financing gap has been offset by credit from donors and heavy GOK borrowing from the domestic capital market. As of June 30 1993 total GOK debt outstanding to foreigners was KSh. 271,568.2 million up from KSh. 53,525.20 million in 1989. In the same period domestic debt rose from KSh.13,369 million to KSh. 38,751.2 million, a five-fold increase. The increase in the shillings amount of the external debt is largely due to the series of currency devaluations undertaken by the government beginning in 1993. Judging from the debt service ratio, external debt at its current level does not appear to be a constraint on the longer term prospects of the Kenyan economy. Provisional figures for 1993 show that only 7% of Kenya's export earnings in that year was devoted to servicing the external debt, down from 17% a year earlier.

Faced with declining donor support and increased budgetary constraints, the GOK has sought to diversify sources of revenues. There is an increasing reliance on indirect taxes. As Table 2 below shows, indirect taxes make up close to two-thirds of total GOK revenues. This is likely to increase in 1994 onwards as the net of goods and services subject to VAT (value-added tax) is widened. This increased reliance on indirect taxes, insofar as those taxes are regressive, has important implications for income distribution and equity in the country.

Table 1**Kenya: Economic Growth Indicators and International Trade**

	<i>1964-1971</i>	<i>1975-1980</i>	<i>1980-1984</i>	<i>1985-1991</i>	<i>1992-1993</i>	<i>1982-1993**</i>
GDP GROWTH p.a %	6.50	5.60	2.10	5.00	0.30	3.90
Agriculture	4.20	2.60	2.80	3.50	3.50	2.20
Industry	...	...	2.10	5.00	4.00	3.90
Manufacturing	8.20	7.60	3.70	5.30	0.80	4.70
Services	...	...	4.10	5.10	1.80	4.60
EXTERNAL TRADE					1991-92	1982-92
Export Growth (real, annual %)		0.50	-2.80	3.20	7.20	3.00
Growth of Manufacturing Exports (real,p.a) %)		-4.10	-5.80	12.90	10.50	
Non-Oil Imports/GDP (%)		22.50	18.00	19.10	18.30	18.20
Domestic Exports/GDP (%)		20.60	16.60	13.40	13.20	
Gross Investment/GDP		28.80	23.80	20.00		
Savings and Investment (%of GDP)						
Fixed Investment		23.20	21.60	19.40	...	...
Public		10.40	8.80	8.10	...	...

* Provisional

** Trend

Source: Statistical Abstract, several issues and Economic Survey, several issues. The series for 1975-80 is adapted from Swamy, G (1994).

Employment

It is in the area of employment creation that Kenya is having her greatest difficulty. As a result of the high population growth rates of the 1960s and 1970s, Kenya's labor supply situation has changed. The ability of the economy to gainfully employ new entrants into the labor market has decreased as the number of new entrants has grown. Reported unemployment in 1993 was 22% (Economic Survey, 1994.) The situation has been exacerbated by the restrictive employment policy in public institutions. Indeed, public sector employment fell by 1.9% in 1993. The slack in public sector employment appears to have been picked up by the informal sector where over 48% of currently employed Kenyans work. Indeed, this sector has accounted for much of the reported

Table 2

Analysis of GOK Revenues 1989/90-1993/94, K£million*

Year	Total Revenue	Indirect Taxes		Direct Taxes	
		Total	as % of Total Revenue	Total	as % of Total Revenue
1989/90	2,056.11	1,231.48	59.89	599.15	29.14
1990/91	2,436.82	1,389.80	57.03	713.08	29.26
1991/92	2,788.06	1,625.06	58.29	851.39	30.54
1992/93	3,479.55	2,072.01	59.55	997.94	28.68
1993/94	4,551.14	2,800.73	61.50	1,243.76	27.33

Source: Derived from Economic Survey, 1994.

*K£1 = KSh. 20

employment growth in the country.

Unemployment in Kenya varies by gender. Women are much more likely to be unemployed. Of those in wage employment only 23.1% are women. Because health insurance and access to health services in Kenya is largely employment based, the under-representation of women in the workforce has implications for their health status.

The high rate of unemployment and the reliance on indirect taxes as a source of revenues likely contribute to overall levels of poverty, and may reduce the impact of poverty alleviation/mitigation measures. According to evidence from the Kenya Welfare Monitoring Survey, the prevalence of rural poverty in Kenya in 1993 was 47.9% , up from 33% reported in 1974 while 29.3% of the urban population was found by the same survey to be poor (Economic Survey, 1994 p.44). Inequality between groups has thus widened. The health implications of this have not been quantified. As most research has shown, the poor are more prone to disease, consume less health care and seek curative health care quite late.

Causes of the Poor Economic Performance

There are remote and proximate, exogenous and endogenous factors responsible for Kenya's poor economic performance. The remote factors include: the oil price shocks of 1973 and 1979, which caused a deterioration of the external terms of trade; the collapse of the East African Community, which decreased the size of the market for Kenya's manufactured exports; and the 1982 drought. Instability in the Horn Region in the 1970s and 1980s also necessitated substan-

tial expenditures on defense. The proximate factors include the drought of 1992-94 and the general political instability in the region (recent events in Ethiopia, Somalia and Rwanda have benefitted Kenya enormously through the huge injections of foreign exchange for UN peace keeping and relief operations), and increased uncertainty in the level of donor support. The endogenous factors relate to deficiencies in economic management as exemplified by the erosion of fiscal discipline in the wake of the coffee boom of the 1977-78, and the failure to carry policy reforms through. It should nevertheless be recognized that by the end of the 1970s, Kenya had exhausted the easy parts of import-substitution industrialization. Further developments were going to be difficult largely because the constraints to growth -- human capital, infrastructure and lack of domestic absorptive capacity -- had become more binding.

Reform Measures

The government made several attempts in the past to adjust the economy to changes in the external economic environment. Previous attempts focussed mainly on stabilization measures: devaluation of the currency and exerting greater control over public expenditures. Little was done to liberalize trade and stimulate domestic production. Some of the adjustment policies succeeded, particularly policies aimed at diversifying the agricultural base of the economy. Horticultural exports doubled in the 1980s to become one of the country's export revenue earners alongside tea, coffee and tourism. New reform measures were announced in the 1994 budget. Under these new reforms, the economy will be further opened to international competition. Many more prices, including the price of grains and some petroleum products, will be liberalized and the scope of VAT as a source of revenue widened.

The Role of the Private Sector

The reforms call for greater private sector involvement in the economy and mechanisms have been put in place to facilitate this. Accordingly, a substantial part of Kenya's large parastatal sector is scheduled for privatization. A Privatization Committee has been set up and the government has decided to borrow less from the domestic capital market in order to make more credit available to the private sector.

Implications for the Health Sector

The fiscal constraints have led the GOK to reduce her overall expenditures. For health this has meant reductions in budgetary allocations. This is not likely to change any time soon, nor is it possible to expect the share of health in GOK expenditures to rise should the economy resume growth. In several policy

documents the GOK has made clear her intentions to reduce allocations to the "nonproductive" sectors of the economy, including health and education. Kenyans will increasingly be required to contribute more to the maintenance of their health.

The implications of the reduction in expenditures for health are substantial both for the future sustainability of GOK facilities and for the growth of the private health care sector. Fee paying consumers will be more selective in their choice of care provider. And to the extent that GOK facilities are perceived to provide services of lower quality than private facilities, those Kenyans with the highest ability and willingness to pay will select out of the public system. This could create a two-tier health system in which the poor would be predominantly served by government facilities. Given the limited ability of the poor to pay for health services, the revenue earning capability of GOK facilities, based on cost-sharing, may be greatly reduced. This could necessitate increased GOK expenditures on these facilities. A second implication of the reduction in expenditures is that the cap it places on incomes could cause an increase in turnover of health professionals in the public sector if wage differentials between the public and private health sectors are widened. This may pressure the GOK to improve the terms and conditions of service in the public sector, requiring an increase in total expenditures.

Demographic and Health Situation

Kenya, like most countries in sub-Saharan Africa, inherited a fairly small health sector upon independence. In the thirty-one years of independence it has made substantial progress in improving the delivery of health care and in raising the health status of the population.

Demographic Indicators¹

Kenya's population in 1993 was estimated at 24.5 million, and to be growing at an annual rate of 3.4%. Approximately 21% of the population lives in urban areas, with the urban population having increased from 2.3 million in 1979 to 5.2 million in 1992. The rate of rural-urban migration is estimated at 6.5% per annum. While only 34 centers were classified as urban in 1962, by 1989 this had increased to 146 (Republic of Kenya Development Plan 1994-6).

Significant progress has been made in reducing mortality rates, including infant and under-five mortality rates. For instance, the crude death rate has fallen from 20 per 1000 in 1963 to 12 in 1990. Under-five mortality has also declined from 211 per 1000 live births in 1962 to 93.2 in 1993 while infant mortality rate fell from 120 in 1963 to 62.5 in 1993. Improvement in the health status of Kenyans is also reflected in gains in life expectancy at birth, which has risen

1/ Unless otherwise indicated, the analysis in this section is based on the report of the 1993 Kenya Demographic and Health Survey.

from 38 in 1948 to 59 in 1989 (KDHS 1993). However, the child mortality rate is reported to have increased from 28.1 in 1983-87 to 36.7 in 1988-93.

Important regional and geographical variations in health indicators are masked by global aggregates. Figures 1 and 2 depict provincial differences in infant and child mortality rates in 1993. For example, while the under-five mortality rate has fallen on average, the rate reported for Nyanza province remains very high. The reported rate for Nyanza province in 1993 was 186.8, not better than the rate (187) reported for Western province in 1979, and more than twice worse than the rate of 85 reported for Central province in the same year. The greatest gains in the reduction of under-five mortality were made in Rift Valley and Central Provinces while Nyanza had the worst indicators. Excluding Rift Valley province, the gap in under-five mortality rates between the province with the best indicator, Central province, and the others widened over the period 1979-1993. Table 3 summarizes these variations in regional indicators.

Table 3

Kenya: Under-Five Mortality Rates* by Province, 1979, 1989, 1993

<i>Province</i>	<i>1979</i>	<i>1993</i>	<i>% change</i>	<i>Relative to Central 1979</i>	<i>Relative to Central 1993</i>
URBAN		75.4			
RURAL		95.6			
Nairobi	104	82.1	-21	1.22	1.98
Central	85	41.3	-51	1.0	1.00
Coast	206	108.7	-47	2.42	2.63
Eastern	128	65.9	-49	1.51	1.60
Nyanza	220	186.8	-15	2.56	4.52
North Eastern	160	not covered			
Rift Valley	132	60.7	-54	1.55	1.45
Western	187	109.7	-41	2.2	2.66

Source: Compiled and Derived from CBS 1984, KDHS 1993

* Expressed per 1000 live births

There are also substantial differences among provinces in the infant mortality rate, summarized in Table 4. As the table shows, four out of the seven provinces covered during the survey experienced reductions in the infant mortality rate with Coast province recording the largest improvement. However, an increase was reported for the other three provinces. Rift Valley province moved from being the province with the best indicator in 1989 to the second worst in 1993.

Table 4
Kenya: Infant Mortality Rates*, by Province 1989, 1993

<i>Province</i>	<i>1989</i>	<i>1993</i>	<i>% change</i>
URBAN		45.4	
RURAL		64.9	
Nairobi	46	44.4	-3.48
Central	37	30.9	-16.50
Coast	107	68.3	-36.16
Eastern	43	47.4	10.23
Nyanza	94	127.9	36.06
North Eastern	n.c	n.c	n.c
Rift Valley	35	44.8	28.00
Western	75	63.5	-15.33
Western	75	63.5	-15.33

* Expressed per 1000 live births

n.c: Not covered.

Source: Compiled and Derived from KDHS 1989, KDHS 1993

The infant mortality rate in Nyanza province has historically been high. Between 1989 and 1993 it rose by 36%. One child in almost eight does not live to see his/her first birthday, which is more than four times the rate for Central province and almost twice the rate for Coast province. This high rate of infant mortality in Nyanza is perhaps due to the reportedly high prevalence of both malaria and HIV/AIDS. Another factor could be poverty. Nyanza has the highest incidence of poverty in Kenya. About 40% of households in the province are female-headed, a category among which reported poverty is highest. Poverty has important implications for health status. The health problems of Nyanza province merit special attention from the GOK, NGOs, USAID and other donors.

Contraceptive Prevalence

In the 1970s and early 1980s Kenya was reported to have one of the fastest rates of population growth in the world. However, current evidence shows a substantial decrease in the fertility rate which fell from 7.7 in 1984 to 5.4 in 1993 (KDHS, 1993)². Current users of family planning have increased significantly over the past decade, from 17% of currently married women in 1984 to 33% in 1993. This increase has been accompanied by a switch to modern methods of contraception, with use of pills and injectables registering the largest

Figure 1 Infant mortality rates by province, Kenya 1993

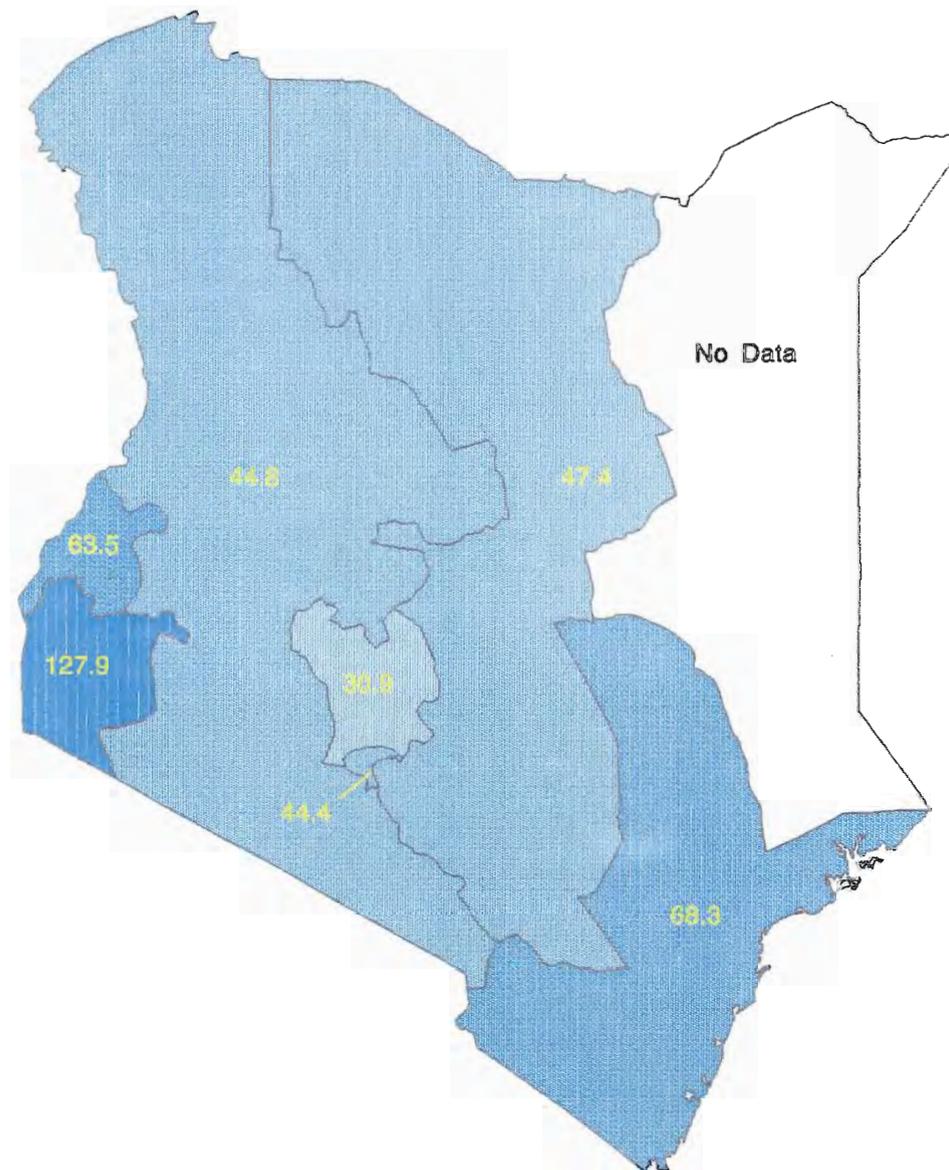
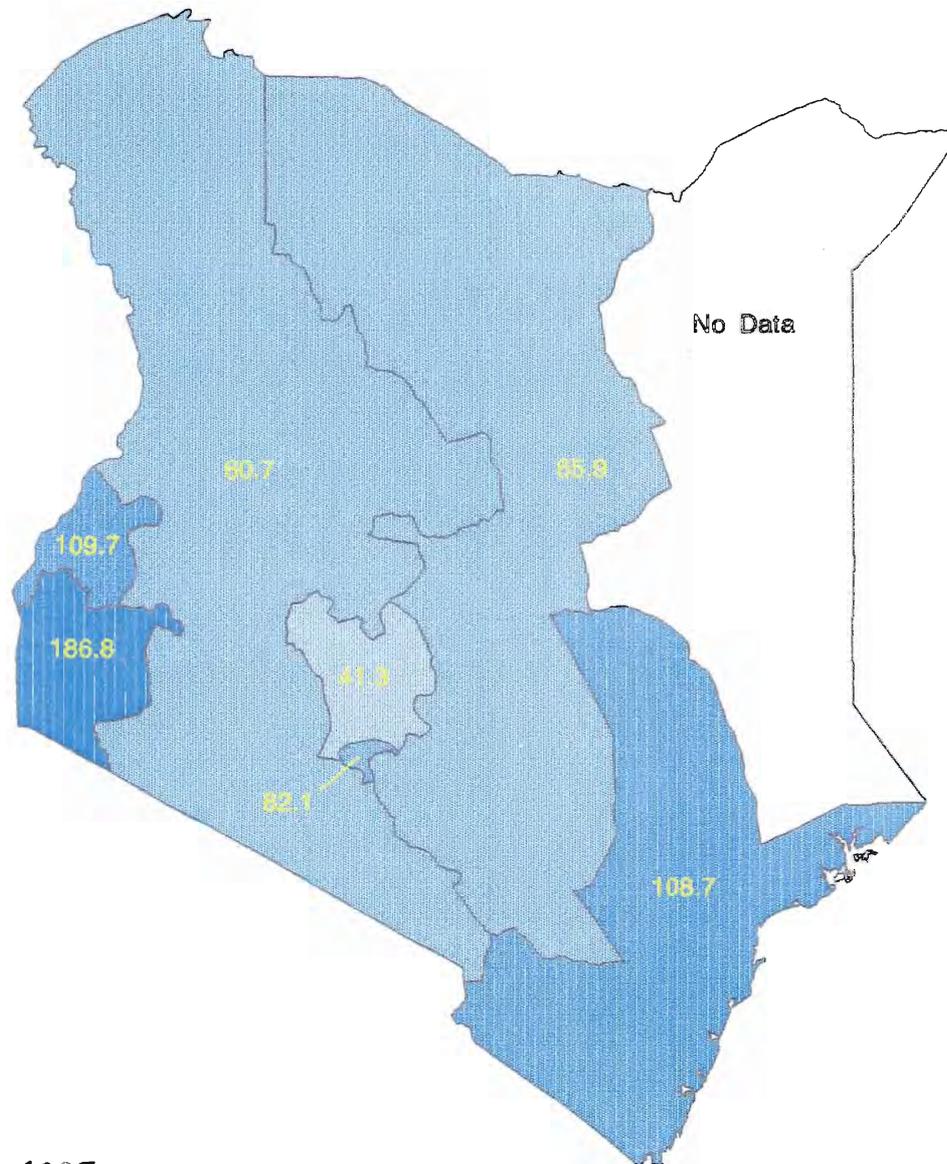


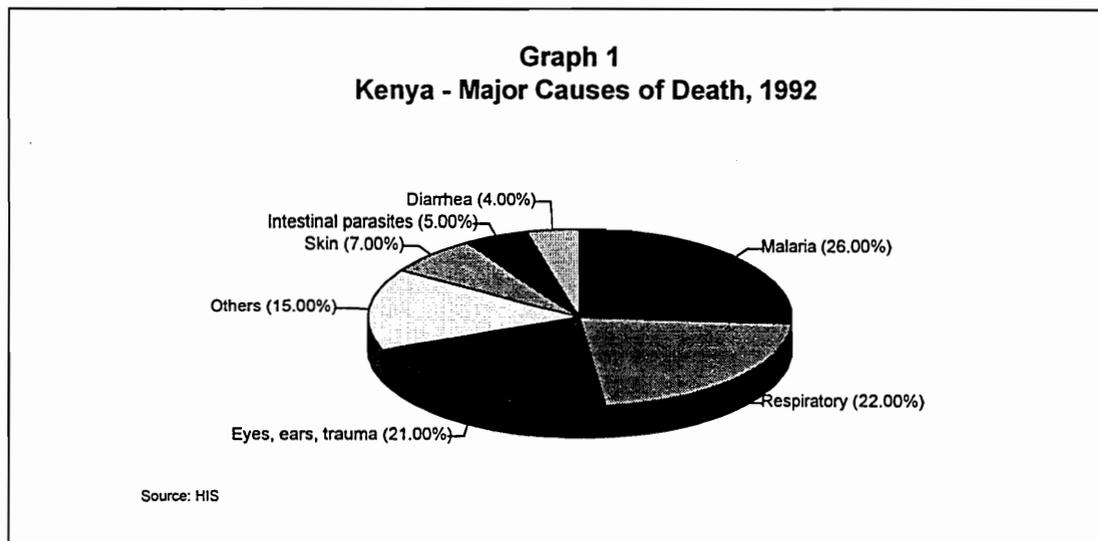
Figure 2 Under-five mortality rates by province, Kenya 1993



absolute increases. Knowledge about methods of contraception is high. Ninety-six percent of women report knowing at least one method of family planning. Of currently married women, 97% know a modern method of contraception, and 94% know a source where family planning services are provided.

Health Problems

Kenya's mortality and morbidity data highlight the following major health problems: acute respiratory infections (ARI); parasitic infections, including malaria; gastrointestinal diseases; vaccine-preventable diseases; STDs, including AIDS; and nutrition. Graph 1 shows the distribution of the major causes of death in 1992. Although the Kenyan government has made substantial progress in containing these diseases, poor health is still prevalent in the country. Case fatality rates have been rising for various other diseases including malaria and tuberculosis.



Very little is known about maternal mortality. Although the prevalence of HIV/AIDS has been reported to be high in Kenya, it is yet to be reflected in higher overall mortality and morbidity rates from infectious and opportunistic diseases. However, hospital admissions for TB, in many cases associated with HIV/AIDS, have risen and case fatality rates have risen although this may be due to better reporting.

Nutrition

Although not a direct problem, malnutrition is a significant contributor to poor

2/ Fertility decline in Kenya preceded family planning interventions (Swamy, 1994). Factors responsible for this demographic transition include increases in female education, the rising private cost of education, and the modernization of the Kenyan society.

health. In Kenya malnutrition is pervasive and its causes are quite complex. Although the direct effects of nutritional deficiencies on health status are difficult to quantify, malnutrition is a source of substantial demand for curative services and a major contributory cause of mortality and morbidity. The 1993 KDHS classified 33% of children under five years in Kenya as stunted and 12% as severely stunted³. Stunting is most prevalent among rural children and children aged between 12 and 23 months. There are also wide disparities across provinces in the prevalence of stunting. Coast province has the highest proportion of stunted children followed by Eastern and Nyanza. Nairobi has the lowest percentage.

Overall, 5.9% of children in Kenya are wasted⁴. The distribution of wasting by province mirrors that of stunting. Wasting is more widespread in Coast, Rift Valley and Eastern provinces. Malnutrition and undernutrition are both direct and indirect causes of death, especially during infancy and early childhood. Table 5 and Figures 3 and 4 summarize evidence on the extent of stunting and wasting in the country.

Table 5

Kenya: Nutritional Status of Children Under Five Years, by Province, 1993

<i>Province</i>	<i>Percent Wasted</i>	<i>Percent Stunted</i>
Nairobi	0.80	24.20
Central	4.00	30.70
Coast	10.60	41.30
Eastern	6.80	39.40
Nyanza	4.70	32.10
Rift Valley	7.90	28.50
Western	3.90	30.00
Total	5.90	32.70

Source: Adapted from KDHS 1993.

3/ Stunting is defined as falling more than 2 standard deviations below the median of the WHO/NCHS/CDC reference population for height for age. Children below 3 standard deviations of the median are classified as severely stunted.

4/ Wasting is defined as falling more than 2 standard deviations below the median of the WHO/NCHS/CDC

2 The Health Sector: Development, Composition and Distribution

Kenya's health system comprises both an official and an unofficial sector. By the official system we mean that part of the health sector which falls within the regulatory purview of the Ministry of Health, and which is statutorily required to submit returns to the Health Information Systems Department at the Ministry of Health. The unofficial system comprises those health institutions and providers over which the Ministry of Health has no control, i.e. traditional healers. We defer further discussion on this to the next chapter, where we discuss the typology of private providers.

In the rest of this section, we focus on the official system. We first describe the growth of the health sector, both in terms of the number of health facilities and in terms of personnel. We next examine GOK health expenditures in light of the GOK Sessional Paper No. 1 of 1986 which envisaged a sustained reduction to 8% of health's share in total GOK expenditures. The allocation of GOK health expenditures between recurrent and development budgets is examined. We also examine the expenditures of local governments and households on health.

Growth of the Sector

The Kenyan health system has expanded quite rapidly in the past 25 years. This expansion was driven by a commitment on the part of the immediate post-independence government to make modern health care services accessible and affordable to the majority of the Kenyan people. This expansion was achieved in two ways: a) increased GOK allocations to the health sector, fueled in large measure by revenues from taxation, tourism, exports, and extensive donor support and b) a non-restrictive policy environment toward private provision of health services.

Table 6 provides evidence on the physical growth of the health services infrastructure in Kenya. Both nominal access, measured in terms of distance to a health facility, and effective/real access measured by the availability of doctors per 100,000 population have improved. The number of hospitals has grown from 148 in 1963 to 308 in 1993, a more than two-fold increase. In the same period the number of health centers increased from 160 to 569. As a result, in

reference population for weight-for height. Children who fall below the cut-off of 3 standard deviations below the median are classified as severely stunted.

Table 6
Kenya: Number of Health Facilities, Selected Years

<i>Year</i>	<i>Hospitals</i>	<i>Health Centers</i>	<i>Health Sub-Centers and Dispensaries</i>	<i>Total</i>
1964	148	160	n.a	?
1982	220	276	1,135	1,631
1991	277	357	1,712	2,346
1993	308	569	2,267	3,144

Source: Statistical Abstract and Economic Survey, several issues.

1993 over 65% of the population lived within 15 km of a health facility.

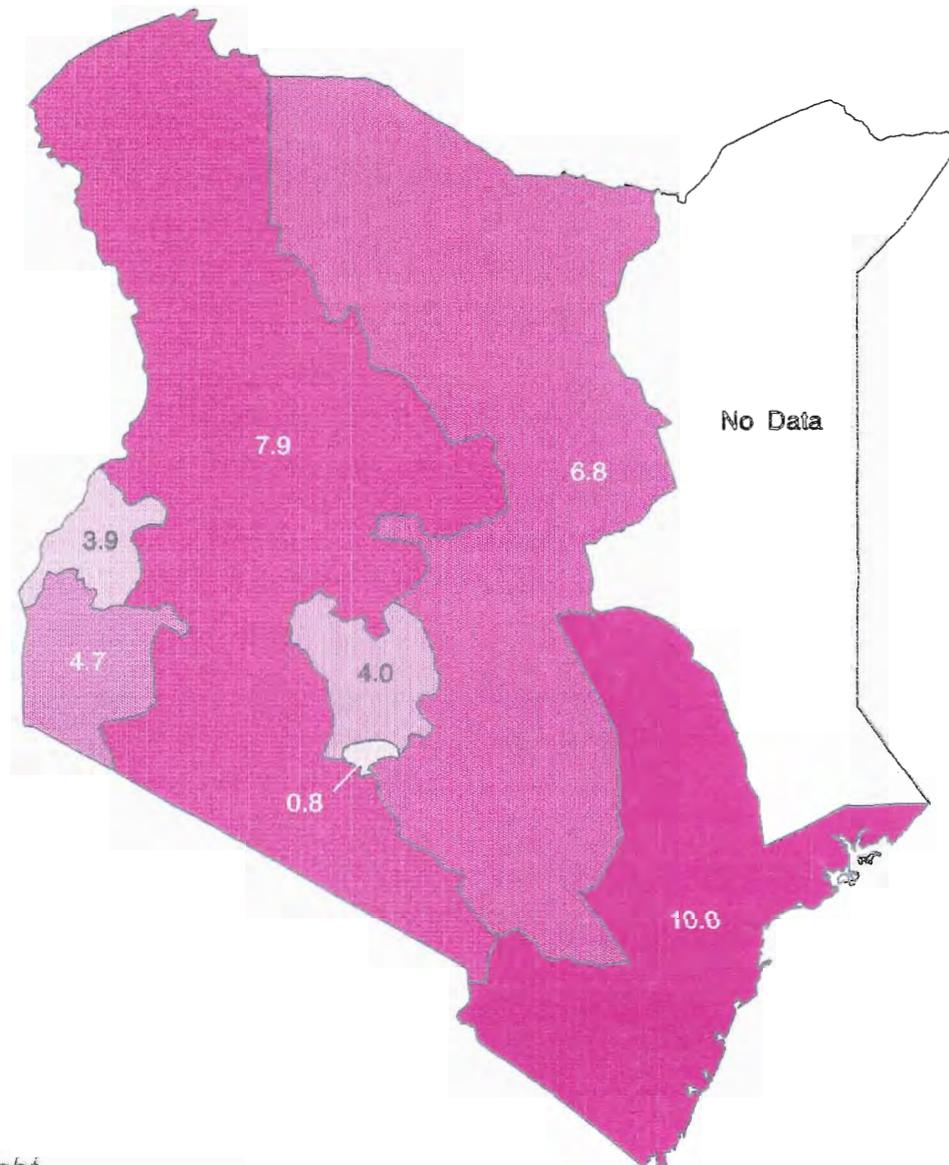
In tandem with the expansion of health facilities, the government also pursued a policy of increasing the number and quality of health personnel in the country. As Table 7 shows, the ratios of health personnel to every 100,000 people has improved quite markedly since independence. In 1963 there were 7.8 doctors, 0.3 dentists 1.6 pharmacists and 22.9 registered nurses for every 100,000 Kenyans. By 1993, these numbers had risen to 15.5, 2.7, 2.5 and 25.3 respec-

Table 7
Kenya: Registered Medical Personnel per 100,000 Population, Selected Years

<i>Cadre of Personnel</i>	<i>1964</i>	<i>1982</i>	<i>1991</i>	<i>1993</i>	<i>In Training</i>	
					<i>1992/93</i>	<i>1993/94</i>
Doctors	7.8	12.67	15	15.5	1,254	1,318
Dentists	0.3	1.40	2.8	2.7	150	162
Pharmacists	1.6	0.51	2.3	2.5	245	252
Pharmaceutical Technologists	none	2.12	2.9	2.9	132	148
Registered Nurses	22.8	45.24	24.9	25.3	1,165	1,165
Enrolled Nurses	29.9	56.10	82.9	85.4	4,292	4,292
Clinical Officers	none	10.73	11.8	11.9	694	745
Public Health Officers	none	none	2.9	3.0	105	88
Public Health Technicians	none	none	14.6	17.1	560	1,033
TOTAL ALL HEALTH CADRES		21,849	35,455	40,774	8,597	9,203

Source: Statistical Survey & Economic Survey several issues

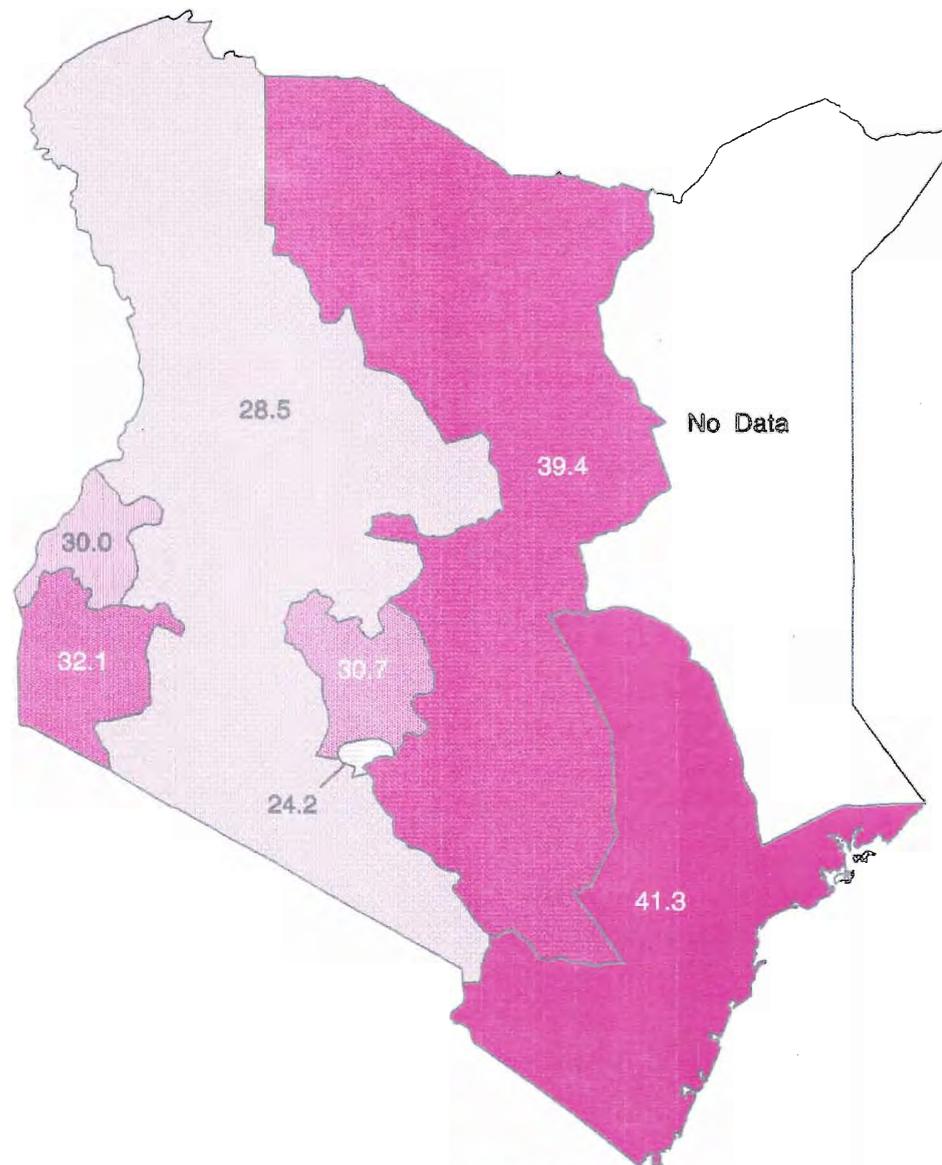
Figure 3 Percent of under-5's wasted* by province, Kenya 1993



* Measured by weight-for-height
< 2 standard deviations from median of NCHS/CDC/WHO international reference population

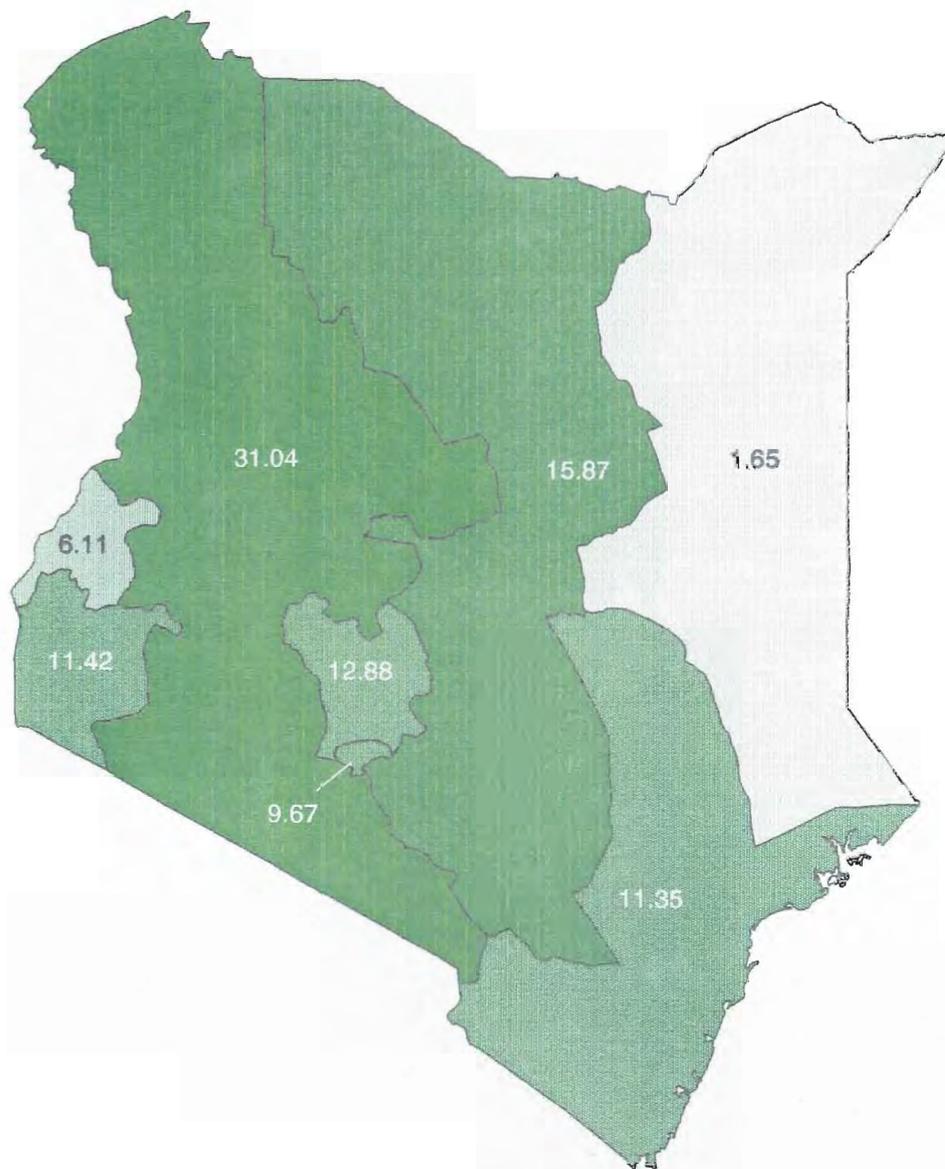
Source: KDHS, 1993
GIS: Harvard/DDM

Figure 4 Percent of under-5's stunted* by province, Kenya 1993



* Stunting measured by height-for-age. Children less than 2 std. deviations from median of NCHS/CDC/WHO reference population classified as stunted

Figure 5 Percent distribution of health facilities by province, Kenya 1993



tively. New categories of health personnel such as clinical officers have been created. In 1993 there were 11.9 clinical officers per 100,000 population.

The GOK continues to aggressively pursue the policy of training more health personnel. In the 1993/94 academic year, the number of health personnel in training in Kenya was 9203 out of which 1318 (14%) were training to become doctors, 88 (less than 1%) were training to become public health officers, and 4203 (about 47%) were training to become enrolled nurses.

Distribution of Facilities

Health facilities are unevenly distributed across the country. In 1993, a third of all GOK facilities were located in Rift Valley province, while North-Eastern province accounted for less than 2%. There appears to be a higher concentration of personnel and facilities in the more urbanized provinces. Table 8 and Figure 5 summarize evidence on the distribution of health facilities by province for selected years.

Table 8
Distribution of Health Facilities by Province, Selected Years

Province	1981				1985				1990				1993			
	Hosp.	H/Ctr.	H-sub/Ctr.	Total	Hosp.	H/Ctr.	H-sub/Ctr.	Total	Hosp.	H/Ctr.	H-sub/Ctr.	Total	Hosp.	H/Ctr.	H-sub/Ctr.	Total
Nairobi	17	8	62	87	27	17	116	158	31	18	139	188	39	92	173	304
Coast	24	22	133	179	24	26	139	189	26	32	162	220	34	56	267	357
Eastern	27	27	193	247	36	35	201	272	42	43	223	308	43	56	400	499
N/Eastern	3	3	18	24	3	6	12	21	3	6	31	40	6	10	36	52
Central	45	38	180	263	44	40	187	271	44	46	234	324	45	69	291	405
Rift Valley	52	86	363	502	51	61	335	447	61	65	457	583	64	155	757	976
Nyanza	38	39	142	219	38	47	139	224	42	49	254	345	47	76	236	359
Western	15	39	39	93	20	37	44	101	19	40	64	123	30	55	107	192
TOTAL	221	262	1130	1614	243	269	1173	1683	288	299	1564	2131	308	569	2267	3144

Source: Derived from Economic Survey, several issues

There are substantial regional variations in the distribution of beds even controlling for differences in population among provinces. These differences call for targeted policies by the GOK (for example, the use of direct fiscal incentives, discriminatory bonding of GOK trained physicians, etc.) to encourage private providers to locate in underserved areas.

Health Expenditures⁵

A critical issue facing health policy makers in Kenya, as in other countries, is how to improve the health status of the citizenry in the wake of decreasing resources and ever-increasing demands for health services. In this section we review trends in health expenditures in Kenya particularly against the backdrop of the policy enunciated in 1986 in Sessional Paper No. 1 to reduce the propor-

5/ All money values are in nominal terms

tion of health expenditures in total recurrent GOK expenditures from 9 to 8%. The government at that time, recognizing the need to redirect "resources toward growth -producing sectors", declared its intention to review the fees it charged for certain services where "participant support has fallen behind the level of costs and the ability to pay". It also declared its intention to introduce charges for certain services that had been free. This document thus laid the groundwork for the introduction of user charges (cost sharing) in public health institutions in 1989.

We preface our discussion of health expenditures by noting that all monetary values are in nominal terms. One way to measure amount of resources that a country devotes to health is by considering the share of health expenditures in GDP. The trend in health expenditures as a share of Kenya's GDP for the period 1983-1992 is summarized in Table 9. As is evident from the table there has been very little variation in health's share of GDP. This share has averaged 1.3% p.a. during the period under consideration. Health expenditures have grown at an annual rate of 5.2%.

Table 9

Share of General Government and Health Expenditures in GDP 1982-1992 (current KSh. million and %)

	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992*
Total General Government Expenditure	9,505	10,444	12,327	15,129	17,169	19,960	22,863	25,970	29,175	34,642
Government Health Expenditure	1,046	1,131	1,317	1,550	1,744	1,939	2,287	2,696	3,089	3,432
GDP at Market Prices	76,404	88,867	100,74	117,48	131,16	151,19	171,58	195,53	220,87	258,08
Health as % of GDP	1.4	1.3	1.3	1.3	1.3	1.3	1.3	1.4	1.4	1.3
Gov't as % of GDP	12.4	11.8	12.2	12.9	13.1	13.2	13.3	13.3	13.2	13.4

* Provisional figure

Source: Compiled from Central Bank of Kenya Quarterly Review, October-December 1993

In Kenya there are three principal spenders on health: the GOK, local governments and the private sector, including households. NGOs and donors are also significant spenders on health in Kenya. Preparing national health accounts was outside the purview of this study. For estimates of the principal spenders' share and the sources of the funds they spend on health in Kenya's total health expenditures, we have relied on the 1984 estimates of Bloom and Segall (1993). While their estimates may be a bit dated, they remain the only ones for Kenya. Given the changes in the financing of health care in Kenya, in particular the introduction of user charges in government health facilities, their numbers may now underestimate the contribution of out-of-pocket payments to the financing of health care in Kenya.

GOK Health Expenditures

Development and trend

The GOK is the largest spender on health. In 1985, the latest year for which national health accounts for Kenya were prepared, the GOK was reported to account for 42% of total recurrent health expenditure (Bloom & Segall, 1993). Table 10 summarizes the trend in GOK expenditures on health for the period 1972-1992.

As can be seen from the table, the share of health in total government expenditures has declined over time, from a high of 7.2% in FY1976/77 to 5.1% in FY1992/93. During the same period total GOK expenditures grew at an average of 7% p.a with health expenditures tracking it very closely at 6.5% p.a. The impact of the policy change announced in 1986 appears to have been minimal. For the period 1986-1992, total health expenditures in nominal terms fell by only 0.2%. On the recurrent expenditure side, the share of health began to decline in FY1975/76 after peaking at 8.1% in FY1974/75. But for a slight increase in 1984/85, it has been declining since then. In 1992/93 the share of health in total GOK recurrent expenditure was 4%. While total recurrent expenditure on health has been falling, the proportion of total GOK development expenditures devoted to health remained fairly stable between FY1986/87 and FY1989/90. This proportion began however to rise in FY1990/91 and in 1993 amounted to 8.5% of total GOK development expenditures.

Is there an imbalance in GOK health expenditures?

There appear to be two imbalances in GOK health expenditures: the first is between recurrent and development expenditures, and the second is between wage and non-wage components of recurrent expenditures.

Imbalance between recurrent and development expenditures

There appears to be a growing imbalance in GOK health expenditures between recurrent and development expenditures. This is evident from the behavior of the ratio of development to recurrent expenditures which in FY1992/93 was 0.625 having risen from 0.15 in FY1986/87. Another way to look at the imbalance is to consider the share of development health expenditures in total health expenditures. This too has risen from 11.8% in FY1986/87 to 38.4% in FY1992/93.

There are two potential sources of funds for the increase in development expenditures which are included in the development budget. It could be wholly financed by the GOK out of its tax revenues or financed from donor funds. Our

Table 10

**GOK Expenditures and the Share of Health Expenditures (K£million* and %)
1972/72-92/93**

Year	Recurrent Expenditure			Development Expenditure			Total GOK Expenditure		
	Total K£ million	Health		Total K£ million	Health		Total K£ million	Health	
		K£ million	% Total		K£ million	% Total		K£ million	% Total
1972/7	139.58	10.59	7.6	61.83	2.18	3.5	201.41	12.77	6.3
1973/7	163.74	12.11	7.4	66.44	2.32	3.5	230.18	14.43	6.3
1974/7	208.89	16.85	8.1	92.54	3.83	4.1	301.43	20.68	6.9
1975/7	248.59	19.52	7.9	124.52	4.77	3.8	373.11	24.29	6.5
1976/7	287.03	21.26	7.4	122.75	8.30	6.8	409.78	29.56	7.2
1977/7	402.30	29.20	7.3	238.66	10.78	4.5	640.96	39.98	6.2
1978/7	477.52	35.38	7.4	220.10	7.75	3.5	697.62	43.13	6.2
1979/8	549.25	42.78	7.8	232.05	10.75	4.6	781.30	53.53	6.9
1980/8	689.32	52.60	7.6	282.73	12.68	4.5	972.05	65.28	6.7
1981/8	830.25	59.83	7.2	294.36	11.30	3.8	1124.61	71.13	6.3
1982/8	967.66	61.99	6.4	223.03	7.71	3.5	1190.69	69.70	5.9
1983/8	1011.47	64.44	6.4	211.43	11.08	5.2	1222.90	75.52	6.2
1984/8	1026.72	72.42	7.1	507.95	10.31	2.0	1534.67	82.73	5.4
1985/8	1346.61	78.76	5.8	309.12	13.95	4.5	1655.73	92.73	5.6
1986/8	1626.31	95.54	5.9	462.18	14.73	3.2	2088.49	110.27	5.3
1987/8	1818.95	103.97	5.7	408.6	13.96	3.4	2227.55	117.93	5.3
1988/8	2336.28	117.47	5.0	630.42	21.52	3.4	2966.70	138.99	4.7
1989/9	2500.47	119.37	4.8	762.68	24.96	3.3	3263.15	144.33	4.4
1990/9	3278.24	133.39	4.1	828.13	39.52	4.8	4106.37	172.91	4.2
1991/9	3772.91	152.44	4.0	651.69	37.58	5.8	4424.60	190.02	4.3
1992/9	4503.78	181.55	4.0	1333.06	113.37	8.5	5836.84	294.92	5.1

* £1 = KSh. 20

Source: Ministry of Planning and National Development (1994): Historical Economic Data for Kenya 1972-92.

data do not permit such disaggregation. Nevertheless, the growing imbalance between recurrent and development expenditures is ironic, in light of the difficulties the MOH has in maintaining existing health facilities and in paying staff salaries.

Imbalance between wage and non-wage components of recurrent expenditures

The cumulative consequence of the growth in the workforce and the reductions in recurrent GOK expenditure has been a deterioration in the efficiency of the health personnel and in the quality of service provided. There are pervasive shortages of drugs; hospital buildings are seldom maintained; and vehicles required for emergencies, outreach programs and general logistic support are frequently out of order. The impact of these expenditure policies on the private health provision sector are considered in greater detail in Chapter 6 of this report.

Local Government Expenditures

Development and trend

In addition to central government, local governments also devote some proportion of their annual budgets to health. The extent to which changes in financing health expenditures at central level have shifted the burden of providing health care to the councils is unclear. Available evidence (Table 11) shows steadily increasing local government expenditure on health. Between 1986 when the policy change was announced and 1994, local government expenditure grew by an annual rate of 4.9%. However, the ratio of local government to central government health expenditure has changed little over time, rising from 8.9% in 1986 to 10.3 in 1993.

Table 11

Local Government Expenditures on Social Services Including Health, 1986-1993.
(K£millions*)

	1986	1987	1988/89	1989/90	1990/91	1991/92	1992/93	1993/94
Total	16.28	15.24	23.00	30.00	29.52	29.83	32.35	32.30
out of which Health	7.04	7.20	12.49	17.40	15.08	15.23	15.71	17.38
as % of Total	43.24	47.24	54.30	58.00	51.08	51.06	48.56	53.81

* £1 = KSh. 20.

Source: Economic Survey, 1988, 1991, 1993, 1994

The Private Sector

Outside of the GOK, households, missions and other non-governmental health care providers also spend substantially on health. According to evidence reported in the 1992 Welfare Monitoring Survey, Kenyans devote about 2.2% of their non-food expenditures to health. Expenditure on health does, however, vary with wealth status. The non-poor spend more per capita on health in absolute terms than the poor, although health expenditures command a much larger share of the per capita non-food expenditures of the poor (Table 12). Admittedly, differences in health expenditures reflect differences in ability to pay. They also reflect differences in private valuations of the costs and benefits of good health.

Table 12

Private Spending on Health, 1992 (Ksh. per year and percent)

	<i>Health Expenditure per capita (KSh.)</i>	<i>Share in Non-Food Expenditure per capita (percent)</i>
Poor	32.0	3.3
Non-poor	152.4	2.1
All	103.9	2.2

Source: WMES '92.

According to estimates in Bloom and Segall (1993), the private sector including households and missions accounted for a cumulative 43% of all health expenditures in 1984. Of this, 24% was on household drug purchases, 6% on mission services, 8% on private hospitals and private practitioners, and 3% on other household out-of-pocket expenditures.

Sources of Finance for Health Expenditures

The major sources of finance for health expenditures in Kenya are a) for the GOK: tax revenues, NHIF premia, cost-sharing/cost-recovery, and foreign assistance; b) for missions: direct user fees, subsidies from overseas churches, grants from the GOK, NHIF reimbursements, volunteer labor of religious personnel, and private insurance; c) for the for-profit sector: NHIF, private insurance and direct user fees. Each of these financing mechanisms and their impact on the utilization and supply of private health services are discussed in Chapters 5 and 6.

The GOK finances most of its expenditures from tax revenues. Of this, income taxes account for about 40% with indirect taxes accounting for the rest. The

regressive effect of indirect taxes has been discussed in Chapter 1. In 1984, the NHIF accounted for about 4% of the financing of recurrent health expenditures. The missions are a very insignificant source of finance. Household out-of-pocket expenditures on health accounted for 41% of non-governmental finance in 1984. The contribution of private insurance to the financing of health care in Kenya remains minimal, although it is reported to be growing quite rapidly as a financing source for many Kenyans.

The Administrative Organization of the Health System

As in many countries, the government oversees the health of the population through the Ministry of Health. Our discussion of the Kenyan health system therefore begins with a brief description of the Ministry of Health.

The Ministry of Health

The MOH is responsible for national health policy. It is also the main actor, the largest provider of health services in the Kenyan health care system. Some local government units have limited authority delegated to them (in the Local Government Act and the Public Health Act) for specific services. The MOH consists of two wings: the administrative wing headed by the Permanent Secretary (PS) and the professional wing headed by the Director of Medical Services (DMS). The former is responsible for planning, budgeting and development while the latter is responsible for hospitals and other health facilities, training and medical research. The Medical Practitioners and Dentists Board, chaired by the DMS⁶, is responsible for approving private hospitals and clinics and for the overall supervision of the practice of medicine by qualified physicians and dentists in the country. A Senior Deputy Director of Medical Services is responsible for coordinating NGO and private health providers' activities.

Kenya is divided into 8 administrative provinces. A Provincial Medical Officer (PMO) oversees the health system of each province. The PMO is also responsible for coordinating government and nongovernment health services and for the overall administration of GOK health facilities in the province. Below the provinces are administrative districts. The health system in the districts is administered by a District Medical Officer of Health (DMOH) who is assisted by a District Health Management Team (DHMT). The DMOH answers to the PMO.

The organization of the health system mirrors the administrative division of the country. Each province has a provincial general hospital (PGH), and each district a district general hospital (DGH). Rural areas have health centers and dispensaries. The health system is thus organized around the concept of a pyramid of health facilities. At the rural level, health care is provided by health centers, dispensaries and mobile clinics which form the base of this pyramid.

We caution here that this delineation in Kenya is rather problematic because many of the district headquarters are in rural areas. The putative primary responsibility of these health centers and dispensaries is preventive and primary care. Some also provide limited curative care. The DGH and PGH form the intermediate section of the pyramid while the national referral center, Kenyatta National Hospital is at the apex.

Local Governments

Before 1970, various local governments were responsible for the operation of health centers and dispensaries and for the provision of public health services. These services and facilities were taken over by the central government in 1970. Nevertheless, six municipalities, including Nairobi, Kisumu, and Mombasa, still provide services for their residents. The most important of these is the Nairobi City Council, whose health services and facilities have recently been the subject of intense reform debate.

3 Overview of Private Health Provision in Kenya: Developing a Typology

Kenya has a pluralistic health system. Health services are produced by the government and a host of nongovernmental providers which includes religious organizations, the for-profit private sector, pharmacies/chemists, traditional healers and community health workers. While the public provision sector has been well studied and is fairly well understood, very little is known of the nongovernmental health sector. Assessments of the nongovernmental sector are hampered by its diversity in terms of providers and facilities. Hence a necessary first step in assessing the private provision sector is to devise a detailed typology.

Developing such a typology is not without difficulties. A wide but confusing array of terminologies to classify private health care providers and facilities is in use. The diversity of the sector was fueled in part by the government's decision in the late 1980s to allow clinical officers, nurse-practitioners and pharmaceutical technologists to engage in private provision of health services. Although all health facilities in Kenya are required to submit annual returns to the HIS, the response rate is low and there is some confusion over the coding and classification of health facilities and by ownership⁷.

These caveats in place, this chapter seeks to characterize private health facilities with a view to devising a framework for analyzing the structure and composition of the private health provision sector in Kenya. The characterization is based on data made available by the HIS, evidence available from secondary sources and from a provider survey undertaken as part of this study. Appendix 1 of this report presents the evidence from the provider survey which forms the basis of this section.

The private sector can be classified according to a number of criteria. They can be classified according to economic orientation as either for profit or not-for-profit, by ownership, by type of facility, by therapeutic system and by whether or not they are formal or informal. Each criterion is designed to emphasize a specific aspect of the sector. For the purposes of this study, we shall suggest a classification of the private provision sector in Kenya by economic orientation, ownership, and healing system.

The main components of a classification by economic orientation are for-profit

⁷ Even the MOH is bewildered by the wide array of terminologies used to classify health facilities in Kenya and in order to streamline it recently set up a committee to review the classification of health institutions.

or not-for-profit. Church- and mosque-run health facilities constitute the major part of the not-for-profit sector. Other non-governmental organizations in this sector include single purpose organizations such as the Family Planning Association of Kenya (FPAK) and community based providers. In the for-profit sector are health facilities owned by sole proprietors and partnerships, companies and parastatals (to the extent that the objective of the parent firm is assumed to be profit maximization), pharmacists and traditional health practitioners.

Classification of Private Health Providers by Type of Facility

Official Kenyan statistics⁸ provide three broad categories of health facilities by type. These are: hospitals, health centers and sub-health centers. The HIS database lists the following types of private health facilities: hospital, health center, sub-health center, dispensary, health clinic, maternity home, nursing home, medical center, mobile clinic, special health institutions, health programs and community pharmacies. What distinguishes one type of health facility from the other is not clear⁹. The provider survey identified the following, albeit incomplete, listing of types of health facility: hospital, health center, dispensary, health clinic, maternity home, nursing home and medical center. Admittedly, this nomenclature is an artifact of our sampling frame. Much of the detail which appears in the description below is from the provider survey.

Hospitals

As of July 1994, there were 92 private hospitals in Kenya. Health facilities can be identified as hospitals according to the complexity of their operations; by whether or not they are NHIF-approved for inpatient reimbursement, and also by the presence of visiting (attending) specialist physicians, etc. Hospitals are expected to provide both curative inpatient and outpatient care.

Facilities identified as hospitals in Kenya vary enormously in size from the 297-bed Protestant Church of East Africa (PCEA) Chogoria hospital to small 12-bed facilities. They also vary in the range and quality¹⁰ of services that they provide. A few, like the 197-bed Nairobi Hospital and Aga Khan Hospital are equipped with the state-of-the-art technology.

There were 17 private health facilities that identified themselves as hospitals in the provider survey. In order to create a profile of a typical private hospital in Kenya, we attempted to map onto those facilities a few of the distinguishing variables discussed above. All of the facilities identified as hospitals had at least pediatric, maternity and general wards. A number had "amenity" (private) wards. All listed the NHIF as a principal mode of payment by its clients and many use a variety of mechanisms to compensate doctors on their payroll. Most (12) pay a basic salary, 3 compensate doctors based on a basic salary plus a percentage

8/ See for example Statistical Abstract and Economic Survey

9/ A good guide would have been the conditions which health facilities must meet in order to be licensed by the Medical Practitioners and Dentist Board. At the time of writing this report, the guidelines and conditions were been revised by the Ministry of Health.

based on the number of patients, while another 3 hospitals pay doctors a percentage based on the number of patients seen.

Based on these characteristics we conclude that a typical private hospital in Kenya is a health facility with a complement of beds in several specialties that provides inpatient care, that provides a wide array of services and that depends largely on the NHIF for the payment of inpatient services.

Health Centers

By definition health centers are expected to provide mainly primary care with some limited inpatient capabilities. Those health centers which provide inpatient services can be NHIF-approved and make claims from the NHIF. Only two health facilities identified themselves as a health center during the survey. They provide mainly outpatient services and do have a limited number of beds. Because of the smallness of the size of the sample no generalizable profile of a health center can be adduced from the provider survey.

Dispensaries

These facilities provide largely outpatient services. Together with health clinics they make up about 79% of the modern for-profit private provision sector in Kenya. There were 20 dispensaries in the provider survey. Dispensaries provide limited outpatient curative services in addition to dispensing drugs. They do not provide inpatient services and therefore do not receive reimbursements from the NHIF. They do not appear to provide many health services for employers, depending on sales to the general public for most of their revenues. Less than half of the dispensaries in the survey identified an employer as the financier of the services provided.

Health Clinics

There has recently been an increase in the number of these facilities identifying themselves as health clinics (surgeries). This is largely attributable to a government decision in 1989 to allow nurses and clinical officers to enter private practice. All of the clinics provide outpatient care although a few have minimal inpatient facilities. During the provider survey 41 health facilities identified themselves as a health clinic.

Health clinics are mostly run by doctors, nurse-practitioners or clinical officers. We do not know how many of these clinics are operated by these different types of practitioners. The HIS reports facilities registered in the name of the proprietor, but that is not a sufficient basis for deciding whether the facility is owned by a doctor, a nurse or a clinical officer. This is further complicated by

the proliferation of the use of the title "Doctor", in Kenya. For example, traditional health practitioners and pharmacists, and possibly clinical officers, have adopted this title particularly in rural areas.

Maternity Homes

These are specialized health facilities where expectant mothers go to have their babies delivered. They provide antenatal and postnatal services and also serve as service delivery points for immunizations and other mother and child services. Since they provide inpatient services to expectant and new mothers, maternity homes can also make claims to the NHIF. During the provider survey, 15 health facilities were identified as maternity homes.

Nursing Homes

Nursing homes are the fourth type of health facilities in Kenya that provide inpatient services. Their main purpose is to provide inpatient nursing care to the ill although they also provide a limited range of outpatient services. Mostly run by clinical officers and nurses, nursing homes are required to have a visiting physician. NHIF-approved nursing homes can submit claims for reimbursement to the NHIF for inpatient care. There were 5 facilities identified as nursing homes identified during the survey, four of which mentioned the NHIF as the second most common mode of payment by its clients.

Medical Centers

These medical facilities appear to provide only outpatient services. It is difficult to characterize these facilities because the terminology is used by various providers to describe health facilities of varying capabilities and sizes. Two out of the 5 facilities identified as medical centers during the survey are owned by sole proprietors, 1 by a mission and another one by a company. Based on the fact that none of the medical centers identified the NHIF as a source of revenue, it is safe to assume that they provide largely outpatient services. A minority (2 of 5) reported having laboratory personnel.

Clinical Laboratory and Radiological Services

This is an important sub-sector of the private provision sector. These were not sampled for the survey, hence we are unable to characterize them. However, during the provider survey they were mentioned as a rapidly growing area. The reasons for this rapid growth are unclear. One possibility is the GOK's 1989 decision to allow nurses and clinical officers to engage in private practice. It is believed that this policy switch has caused a substantial increase in the demand

for diagnostic services.

Another commonly-mentioned reason for growth in this sub-sector is the erosion of the capacity of public sector institutions to provide these services. However, given the large presence of mission and private hospitals and other health institutions each equipped with their own radiological and clinical laboratories, this explanation is not very plausible unless there is evidence that a) mission and private labs charged substantially higher prices than laboratories owned by individual proprietors; or that b) that mission and private hospitals were, like GOK facilities, unable to provide those services either for lack of supplies or for inadequate capacity. It has also been submitted that this growth is largely due to doctors combining clinical and other services. It is difficult to determine the direction and nature of causality in this case. Is the growth in the number of private providers causing the growth in the number of clinical and radiological laboratories? Or is the growth in the number of clinical and radiological laboratories resulting from the inadequacy of the public sector to provide those services inducing the growth in the number of clinics and dispensaries?

Retail Chemists/Pharmacies

Alongside hospitals and dispensaries, pharmacies and chemists also provide health services. Pharmacies are registered and licensed sellers of prescription and over-the-counter drugs. By law these must be run by a qualified pharmacist. Fifty-two pharmacies were surveyed as part of this study.

Forty-eight pharmacies (about 92% of those surveyed) indicated that patients came directly to them for consultation. Two of the pharmacies employ doctors, while others listed clinical officers and nurses. We can thus infer from this evidence that pharmacies may often serve as one-stop providers, transforming themselves from mere places where prescription drugs are dispensed to places where drugs are actually prescribed. Evidence from the provider survey shows that a number of pharmacies diagnose and prescribe medicines.

Shops, Drug Stores and Vendors

Medicines are also sold in shops, drug stores and by street peddlers. This group of providers are not licensed to sell prescription drugs yet it is not uncommon to freely purchase antibiotics at street corners and from various kiosks. There are claims that drugs sold through these outlets are cheaper than those sold in pharmacies. We are unable to characterize this group of providers because it was not included in our sampling frame. They are, however, commonly found in Kenya at bus stations and street corners and may be a major source of care for the poor.

Classification of Private Health Facilities by Ownership

As has been emphasized elsewhere in this report, Kenya is a free enterprise economy. In the health sector as in other sectors of the economy, the private sector is active. All of the private health facilities discussed in the preceding section are owned by different economic agents. These owners can be broadly classified by economic orientation into for-profit and not-for-profit. Based on secondary data and evidence from the provider survey, we can distinguish the following owners of health facilities in the private sector: religious organizations, companies, parastatals, individuals such as traditional healers and pharmacists, companies and private enterprise (sole proprietors and partnerships). This last group reflects more an artifact of the law than an ownership category per se. We interpret companies to mean employers. Table 13 summarizes information on the distribution of health facilities in our sample by ownership. Other tables which inform the discussion in this section are in Appendix 1 of this report.

Table 13
Classification by Ownership and Facility Type

	<i>Hospital</i>	<i>Health Center</i>	<i>Dispensaries</i>	<i>Health Clinic</i>	<i>M/ Home</i>	<i>N/ Home</i>	<i>Medical Center</i>	<i>Other</i>	<i>Total</i>	<i>%</i>
KCS	3	-	10	-	1	-	-	-	14	13.2
CHAK	2	-	5	2	-	-	1	-	10	9.4
Sole	5	-	1	23	8	2	2	2	43	40.6
Partnershi	1	-	1	8	3	2	-	-	15	14.2
Company	2	1	-	-	2	1	1	-	7	6.6
Parastatal	-	-	1	1	-	-	-	-	2	1.9
Other	4	1	1	7	1	-	-	-	15	14.2
Total	17	2	19	41	15	5	5	2	106	100.0

Source: AMREF/DDM-Harvard Provider Survey, 1994

Religious Organizations

There are two main religious organizations active in the provision of health services in Kenya. These are a) the various denominations of the Protestant church and b) the various orders of the Catholic church. Although there are mosque-affiliated health facilities and reported cases of health facilities associated with the Hindu and Buddhist religions, none was sampled. The reason for this was that these facilities are not yet in the HIS database which formed our sampling frame. We provide below a brief characterization of the owners of the private health facilities in Kenya beginning with the oldest provider, Christian

missions.

Christian missions

The involvement of Christian missions in the delivery of health services in East Africa dates back to the latter part of the eighteenth century. The purpose of the early medical institutions was to proselytize among the African population. With the passage of time, this has become less important. The activities of these health institutions are coordinated by two different groups, Kenya Catholic Secretariat (KCS) and Christian Health Association of Kenya (CHAK) which reflect the two broad divisions of the Christian church.

Christian Health Association of Kenya (CHAK)

CHAK coordinates the activities of about 230 health facilities in Kenya operated by various protestant denominations such as the Seventh Day Adventist Church (SDA), Presbyterian Church of East Africa (PCEA), Church of the Province of Kenya (CPK), the African Inland Church (AIC). Each hospital member of CHAK is autonomous and makes its day-to-day operational decisions independent of CHAK and other member-facilities. CHAK exists to represent its member-institutions on common issues before the GOK, disburse grants from the GOK to member facilities, to coordinate the activities of the facilities on issues of mutual concern and to be the repository of aggregate information on the health activities of member-facilities.

There were 10 CHAK-affiliated health institutions identified during the provider survey. This represents 9.4% of our sample. CHAK facilities depend mainly on direct cash payments, and a little on employer purchase of services, but are less likely to depend on the NHIF as a source of revenues and grant very few exemptions to the indigent. CHAK facilities appear to be in need of assistance. About 80% of the CHAK facilities surveyed said they would need incentives in order to provide public health services while another 70% would like to be given incentives in order to provide additional curative services. A larger proportion of them reported not receiving any health information from the Ministry of Health.

Kenya Catholic Secretariat (KCS)

There are about 354 Catholic-affiliated health facilities. Catholic health facilities are, like their CHAK counterparts, autonomous in their day-to-day operations. They are largely supported by volunteers and donations from abroad. The KCS performs the same duties for its members as does CHAK. There were 14 (13.2%) KCS health facilities identified during the survey.

From the evidence, KCS facilities appear to be very dynamic. Judging from the

plurality of payment instruments these facilities report to accept, they appear to attract patients from different segments of society. Cash payment was the most commonly reported payment instrument, followed by employer reimbursement and, for inpatient services, the NHIF. KCS facilities report granting more fee exemptions to the indigent.

KCS facilities appear to rely more than CHAK institutions on the NHIF for inpatient reimbursements although this may be an artifact of the data (given the larger number of KCS facilities in the sample). However, KCS facilities are generally regarded to be of very high quality and, all things being equal, should be expected to attract more NHIF patients than CHAK facilities.

In addition, these facilities appear to want their independence. A majority of those responding said they did not want any incentives from the GOK in order to provide curative services although 71% would like incentives in order to provide public health services. All but two reported receiving some kind of health information from the GOK.

Crescent Medical Aid

Mosque-affiliated health facilities are run and operated by the Crescent Medical Aid (CMA). There are about 12 mosque health facilities in Kenya. The CMA, unlike CHAK and KCS, directly runs the facilities for the individual mosque owners. No mosque facilities showed up in the provider survey perhaps because of coding errors in the HIS database which informed the sampling frame or because these facilities are recently established and do not yet send monthly returns to the HIS.

Employers

Employer-provided health services are an important source of care for many. Some employers own and directly operate their own health facilities; those who do not, purchase health services for their employees from private health care providers. The main argument in favor of employer-provided services is that they reduce productivity losses associated with illness, truancy and absenteeism. They also reduce the cost of absenteeism and truancy, since many employers are not able to monitor workers who take off from work to go to seek treatment from an outside provider. Indeed a selling point for one insurance company in Kenya is its ability to act as a monitor for firms that purchase health insurance for its workers from them. It does this by clocking-in and clocking-out workers when they come for treatment at its clinics.

As best as our research could ascertain, there are no estimates of the number of employer-provided health facilities in Kenya or of the number of Kenyans who benefit from such services. We did not attempt to estimate it, since it would

require an employer survey. The best basis for such an undertaking, the HIS database, is incomplete and lumps employer-owned health facilities together with private-for-profit providers making it difficult to attempt to estimate their number.

There were 7 (6.6% of the sample) company-owned health facilities in our sample. There appears to be some co-payment for health services rendered since both company reimbursement and direct cash payments are important payment instruments in these facilities.

Sole Proprietors

Sole proprietors operate 43 (40.6%) of all the health facilities in our sample. Most (98%) depend on direct cash payments for outpatient services and report fewer payment exemptions to the indigent relative to their representation in the sample. They also appear to depend substantially on employers who purchase services from them for revenues and may receive payment in-kind. Indeed, this group of owners reported accepting more in-kind payment more CHAK- and KCS-affiliated facilities combined. The acceptance of this mode of payment by sole proprietors might be indicative of a fairly competitive market for patients.

Sole proprietors also report very little dependence on the NHIF and other insurance. This suggests that this group of providers is largely engaged in the provision of outpatient services. Many reported that they do not receive health information from the MOH. This suggests that most of the health clinics and dispensaries in our sample are owned by sole proprietors.

Partnerships/Groups

Fifteen health facilities in our sample identified themselves as owned by partners. This is about 14% of the sample. Like sole proprietors, this group of owners receive mostly payment in cash, although one reported being NHIF-approved. Employers also appear to purchase health services from this group of providers. Our evidence suggests that partnerships are less likely to grant fee waivers to the indigent. Only one reported doing so in our sample. This may reflect the difficulties of making a determination on such issues when there is more than one owner or when the hierarchy of command and responsibility are not clear.

Partnerships appear to be very well-supplied with information from the MOH. In response to a question on the provider survey regarding incentives for expanded provision of key services, more than 70% of them responded that they would like to be given incentives in order to provide promotive public health services. An even larger number would require incentives in order to expand the provision of curative services.

It is difficult to draw a profile of a partner-owned health facility. They span the range of health facilities identified during the survey. A distinguishing feature, at least from evidence reported in the survey, is the absence of arrangements to exempt or waive payment for services received in facilities which would reflect a slow or difficult decision making process.

Parastatals

There were 2 health facilities identified as owned by parastatals in our sample. These facilities do not report receiving any payments of any kind. We can thus conclude that a health facility that provides services for free is much more likely to be owned by a GOK parastatal.

Community-Based Health Workers

This group of providers includes community health workers (CHWs), community-based distributors (CBDs) of contraceptives and community pharmacies (see Box 1). These providers were not sampled in all of the four survey sites. During the fieldwork however, it was discovered that these providers appear to be much more widely distributed and not mainly concentrated in the Western parts of Kenya as had been thought. For example, in Embu district they are becoming very active providers of services in the rural areas. We include this group of providers as a separate ownership category because we have insufficient information about their operations to be in a position to categorize them as either for-profit or not-for-profit. It is possible that their "hybrid" character implies motivations that do not fit easily into such a two-dimension classification.

Classification by Healing System: Traditional Health

Practitioners

Although classification of private health care providers by type of facility and ownership, as described above, appears to clarify most of the differences between modern private providers, traditional health care providers do not seem to fit easily into any of the resulting categories. We therefore propose a third dimension of a typology, which is therapeutic or healing system.

Before the advent of modern medicine, traditional health practitioners were the main providers of health services. Although largely overshadowed by modern practices, they continue to be an important source of care for many, especially in rural areas. There is evidence that they are also very active in urban areas. Some of the traditional health practitioners in urban areas have acquired the trappings of the western-trained medical practitioner.

Box 1**Community Pharmacies**

Kenya, like a number of other countries in Africa, has begun to establish community-operated pharmacies as one strategy to increase the overall availability of health services in rural areas. The provider survey conducted as part of this study included a questionnaire for community pharmacies. Seven such facilities were visited by the survey teams. The results of the survey are summarized here.

All of the community pharmacies are managed by a Village Health Committee, and staffed by a combination of community health workers and TBAs. All of them dispense drugs, sell mosquito nets, conduct health education activities, assist in water and sanitation projects, and participate in immunization activities in collaboration with nurses from the local health facility. In addition, most conduct growth monitoring of under-fives and provide condoms. Potential family planning clients are referred to the nearest health facility. Respondents from all 7 of the pharmacies stated that these facilities serve mostly low income groups, treating common illnesses in their communities such as malaria, diarrhoea, worms and eye and skin infections.

Being community-based, these pharmacies are able to allow patients to delay payment or be exempted altogether from payment if they meet certain criteria determined by the Village Health Committee. "We come from the same community so we know them and their financial status," reported one facility.

Drug prices are set by the Village Health Committee. Prices in local private pharmacies, and the cost of the drugs are the factors they use to determine what to charge for different drugs and bednets. In five of the facilities, workers are paid a small stipend, while in the other two, CHWs work on a volunteer basis. Some communities are still accumulating their surplus funds to use for future development projects, while others use their profits to pay CHWs, pay rent for the building, and purchase inputs such as stationary and basins for re-impregnation of bednets.

A number of advantages to having a community pharmacy nearby were cited: these include low prices, accessibility to the community, opportunities to provide health education, and positive spin-offs in terms of other local development projects. Shortages of drugs, the inability of some people to afford drugs even at low prices, lack of stipends for CHWs, water and sanitation problems, and transport constraints were mentioned as the main problems they face.

Although still in the early stages, community pharmacies represent an innovative form of private provider with strong linkages to local health facilities and to the community.

Source: DDM/AMREF Provider Survey, 1994

Although there have been several studies of traditional healers in Kenya there are no firm estimates of their number. There were 35 traditional health practitioners (32 males and 3 females) in our sample all of who provide services on a fee-for-service basis. About one third (31%) of the sampled healers were located in rural areas and the rest in urban areas. The majority (66%) were herbalists, 20% were herbalists/diviners and 9% herbalists/bonesetters. Only one out of the 35 traditional healers was a *bonesetter*. About half of the traditional healers (49%) inherited or learned the trade from their parents or grandparents while 26% learned the trade from other practitioners. The remaining 26% claimed to have learned the trade through personal experience after being instructed through a dream/vision to practice traditional healing.

In terms of the healing experience, approximately one-third (31%) of the traditional healers had less than 10 years, 17% between 11 and 20 years, while the remainder (51%) had more than 20 years. These results suggest that traditional medicine is mainly practiced by the older generation. The assumption underlying this conclusion is that in the absence of the practitioner's age (which was not sought) years of experience can be a reasonably good proxy for age of the practitioner.

Herbalists

Herbalists are the most common of the traditional health practitioners. They are distinguished from other traditional health practitioners by the fact that they use only herbs to treat their patients. These healers appear to be itinerant, with some conducting home visits. Evidence reported in the survey revealed that 52% of the traditional healers conducted all their business from one location, while the remainder (49%) operated from more than one location. Furthermore, 43% of traditional health practitioners in the survey reported that they treated patients in the patient's own home. The sector appears to be relatively dynamic: one of the healers stated that he conducts some business in a modern health facility.

Traditional healers charge treatment fees per episode of illness or per visit. Furthermore, while 39% of the 33 traditional healers who responded to these questions charged the same fee to all patients suffering from the same illness, 61% charged differential fees. The patient's economic status was the main criterion for price discrimination, with the poorer patients being charged less and the richer more. In addition, patients who were likely to make a return visit were also charged less than those who were not. Some traditional healers charged children less than adults. Other criteria included duration of illness and instructions from ancestors for the traditional healer to provide free treatment to a patient. The traditional healers charged higher fees to those in high income groups and those requiring more expensive herbs. Traditional healers enter into negotiations with the patients to determine their ability to pay.

The most popular method of payment was cash, followed by livestock and crop produce. Only two traditional healers accepted labor as a form of payment. When specifically asked to state the most common mode of payment, 94.1% of the 34 traditional healers who responded to this question named cash while the remaining 5.9% named livestock.

Traditional Birth Attendants (TBA)

The role of traditional birth attendants as health care providers has been emphasized in the literature and is increasingly being recognized by health policy mak-

ers. The number of TBAs in Kenya in 1994 is reported to be 7953. TBAs were not sampled during the survey but evidence of their activities has been documented in various studies by AMREF. About 21% of total births are assisted by TBAs, the majority of whom are untrained (KDHS, 1993).

Towards a Typology of the Private Provision Sector in Kenya

It is evident from the discussion in the preceding sections that there is considerable confusion in the terminologies used to classify private health facilities in Kenya. While classification by ownership-types appears to be less confusing because of the differences in the behavior of the owners, it still does not present a sufficiently complete framework for the analysis of the private health care provision sector.

The last section of this chapter attempts to suggest a typology of private health providers in Kenya, based on the synthesis of the preceding discussions. The major dimensions of this typology are ownership and economic orientation. By economic orientation, we group the private sector as for-profit and not-for-profit. The not-for-profit sector is further subdivided into facilities affiliated with religious organizations and other nongovernmental organizations such as community health workers, FPAK, not-for-profit hospitals etc. The for-profit sector is additionally classified by type of ownership and also includes hospitals. This classification is summarized in the following schema, which is informed by Table 13.

While this typology may not completely capture the multiplicity of private providers in Kenya, it nevertheless presents a useful basis on which analysis can be premised and policy interventions considered.

Typology of Private Health Care Providers in Kenya

<i>Not-For-Profit</i>		<i>For-Profit Sub-Sector</i>
<i>Religious Organizations</i>	<i>Other NGOS (Non-Profit)</i>	
<i>Church Health Association of Kenya (CHAK)</i> Hospitals Health Centers Clinics/Dispensaries	<i>NGOs involved in family planning</i> Family Planning Association of Kenya clinics	<i>Sole/Group Practices (Clinics) and Hospitals</i> Doctors Clinical Officers Nurses Private Hospitals
<i>Kenya Catholic Secretariat (KCS)</i> Hospitals, Cottage Hospitals Health Centers, Sub-Centers, etc.	<i>Community-Based Providers</i> Community Health Workers Community Pharmacies	<i>Employers (including parastatals)</i> Industrial Clinics Parastatals Pharmacies/Chemists
<i>Crescent Medical Association (CMA)</i> Clinics Dispensaries Pharmacies	<i>Other Non-Profit Organizations</i> Hospitals	<i>Individual Pharmacies</i> Registered Pharmacists/Chemists Pharmaceutical Technologists <i>Individual Laboratories</i> Radiological Laboratories Clinical Laboratories <i>Stores and Shops</i> <i>Traditional Health Practitioners</i> Traditional Birth Attendants Herbalists Bonesetters Diviners

4 Characterizing the Private Sector

In this section we review some of the other characteristics of the private health care provision sector in Kenya. These include the growth of the private sector and the distribution of health care providers.

Growth of the Private Provision Sector

As of October 1994, there were approximately 1500 private health facilities. There are two periods in Kenya's recent past when private provision of health services was reported to have grown rapidly. The first was in the 1970s when the government permitted civil servants to engage in private remunerative activities in their free time, conditional on those activities not been prejudicial to their public service (Bloom & Segal 1993). The second was in the early 1980s when the government sought to withdraw this privilege because of abuses. Many doctors were reported to have resigned from government services in 1984 after part-time licenses were withheld. The policy has since been modified to allow specialist doctors to engage in part-time private practice while denying junior doctors this opportunity. It is not unlikely that the recent doctors' strike will add impetus to the growth of the private provision sector.

The research team was not able to obtain historical data from the Medical Practitioners and Dentists Board on registration and licensing of private health facilities and doctors in private practice. In the absence of official statistics, evidence collected from the provider survey was used to explore the trend in the growth of the private provision sector in Kenya¹¹. The oldest facility in our sample was established in 1900.

The majority (63%) of the facilities in our sample was established between 1986 and 1994. Slightly more than a third of the facilities were established between 1991-1994, that is in the last three years. The reasons behind this rapid growth in the number of private health facilities are complex and cannot be ascribed to a single factor. Three commonly mentioned factors are a) the decision by government in 1989 to allow nurses and clinical officers to set up private practice; b) the revision upwards of NHIF reimbursement rates; and c) deteriorating terms and conditions of service and diminishing job satisfaction in the public sector.

The impact of the NHIF on both consumption and provision of health services in Kenya is discussed in Chapter 6. Evidence from the provider survey and inter-

11/ One of the questions on the questionnaire was date of establishment of the facility.

views with physicians and nurses suggest that the lack of promotion opportunities, poor remuneration and lack of equipment were some of the reasons why health personnel were leaving the public sector. The impact of this is reflected in the age and experience distribution of physicians in the public sector. According to the results of a recent survey by Development Solutions for Africa (1994), slightly more than half (51%) of the medical officers in GOK employment have six or fewer years of experience (i.e. they were employed between 1988 and 1994). If the 30% employed between 1984 and 1999 is added, then the percentage of GOK doctors with less than 10 years experience rises to 81%. Only 6% of all medical officers employed by the GOK have more than 16 years experience.

The small number of experienced doctors on the MOH payroll may result in junior doctors engaging in costly "learning by doing", thereby reinforcing the perception in the general public that GOK health services are of poor quality. This is especially potent in a culture in which age is respected and is often associated with wisdom, experience and competence.

Distribution of Private Health Facilities by Ownership

For purposes of policy coordination, it is important to have an understanding of the distribution of private health facilities by type of owner. As we have seen from the preceding discussions, private health facilities are owned by a variety of agencies and individuals. Each of these owners pursues a different set of objectives. For some, the objective is to maximize profits, for others it is to reduce production losses from ill workers, and for religious groups the driving force may be philanthropic or to gain new converts. Thus, in order to put the discussion that follows about locational decisions in context, it is appropriate to briefly discuss the distribution of private health facilities in Kenya by ownership.

As of October 1994, there were 1446 private health facilities in Kenya. Of these, 47.3% are in the mission sector, 51% in the private/company sector and the remaining 1.7% are owned and operated by the Family Planning Association of Kenya (FPAK). Table 14 summarizes this evidence. Figure 6 displays information about the relative distribution of mission and private (for-profit and employer) facilities. Numbers greater than one indicate a relative concentration of mission facilities, while numbers less than one reflect a relatively greater number of private facilities. Western, Nyanza and Eastern Provinces have relatively more mission than other private facilities. Nairobi, in contrast, has a markedly higher relative number of private facilities.

In terms of the distribution of types of health facilities by ownership, the mission sector owns more than two-thirds of the hospitals, 86.6% of the health centers and 42% of "other" health facilities. The private/company sector owns

Table 14
Distribution of Private Health Facilities by Ownership, 1994

<i>Facility</i>	<i>Mission</i>		<i>Private/Company</i>		<i>FPAK</i>		<i>Total</i>
	<i>Total</i>	<i>%</i>	<i>Total</i>	<i>%</i>	<i>Total</i>	<i>%</i>	
Hospital	62	68.10	29	31.90	0	0.00	91
Health Center	84	86.60	13	13.40	0	0.00	97
Other Facilities	538	42.80	695	55.30	25	2.00	1258
Total	684	47.30	737	51.00	25	1.70	1446

slightly more than 30% of the hospitals, less than 15% of the health centers and more than half (55%) of all the "other" health facilities. From this evidence, we can conclude that the mission sector is the largest non-governmental provider of curative care.

Geographical Distribution of Private Health Facilities

A number of factors affect the geographical distribution of health facilities. These include provision of infrastructure, size of the market and the availability of inputs and factors of production.

Geographical Distribution of Facilities Run by Religious Organizations

Table 15 and Figure 7 summarize evidence on the distribution of mission health facilities in 1994. The evidence suggests that missions concentrate their health facilities in areas with large concentrations of Christians. This pattern of location results in non-Christian areas being underserved (in terms of relatively good quality mission provided health services). This pattern is very visible in Kenya where Coast and Northeastern provinces have the least number of mission health institutions (7% for Coast province and about 1% for Northeastern), despite the fact that they had the first historical contacts with Christian missionaries.

We do not have evidence to characterize mission facilities in terms of their urban/rural distribution. It is however a generally held view that they are mostly active in the rural areas of Kenya. By making health services more available to rural Kenyans, mission-run health facilities promote equity of access.

Table 15
Distribution of Mission Facilities by Province, 1994

Province	Hospitals		Health Centers		Other Facilities*	
	N	%	N	%	N	%
Nairobi	2	3.2	-	0	26	4.8
Central	12	19.5	11	13.1	52	9.7
Coast	3	4.8	1	1.2	40	7.5
Eastern	14	22.2	7	8.3	144	26.8
N/Eastern	3	4.8	-	0	2	0.4
Nyanza	7	11.1	33	39.3	46	8.6
Rift Valley	13	20.6	25	29.8	177	33.0
Western	9	14.3	7	8.3	49	9.1
Total	63	100	84	100	537	100

Source: MOH/HIS 1994

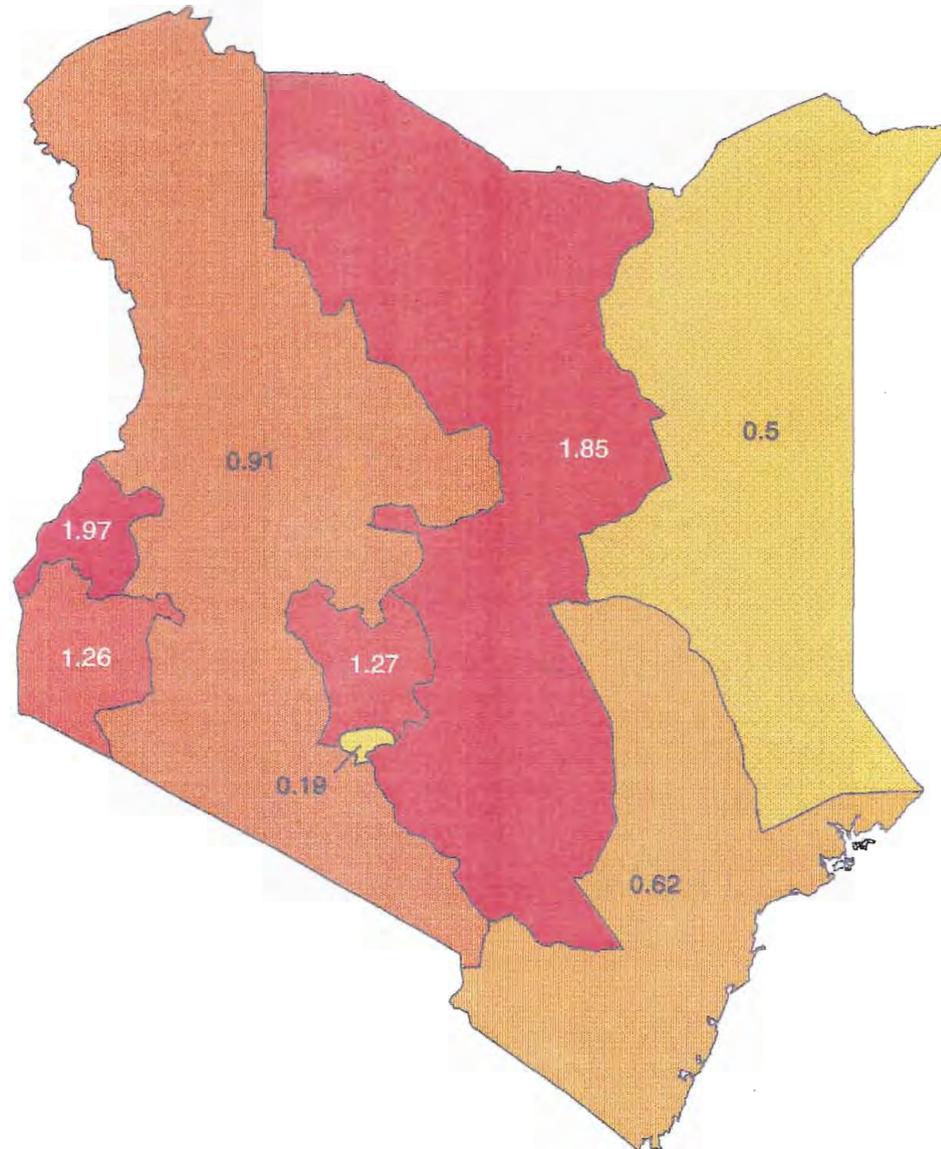
* Includes sub-health centers, dispensaries, maternity homes, mobile clinics, medical centers, nursing homes, etc.

Although mosque-affiliated health institutions are found in predominantly Moslem areas, it is perhaps too soon to talk about a locational pattern. They are a recent addition to the health sector in Kenya and there does not appear to be a visibly conscious choice of location. Since the CMA does not own the health facilities that it manages (they are owned by individual mosques), the choice of location is largely *ex ante* determined. Mosque-affiliated health institutions are found in four urban areas: 8 of the clinics are in Nairobi, 2 in Mombasa and one each in Malindi and Nakuru.

Geographic Distribution of Company and Private For-Profit Health Facilities

Most company and for-profit health facilities are concentrated in the urban areas, although a few may be found on plantations and at parastatal sites in rural areas (such as the hydroelectric dam clinic in Gitau). The for-profit providers in this group are driven by factors such as the willingness and ability of prospective patients to pay and the size of the market. In short, they are influenced by profitability conditions. Employers, on the other hand, are driven by the need to provide employees with health services in order to reduce production losses. Rift Valley province has the highest concentration of private/company health facilities followed by Nairobi province. Nairobi and Rift Valley

**Figure 6 Ratio of mission to non-mission private facilities
by province, Kenya 1994***

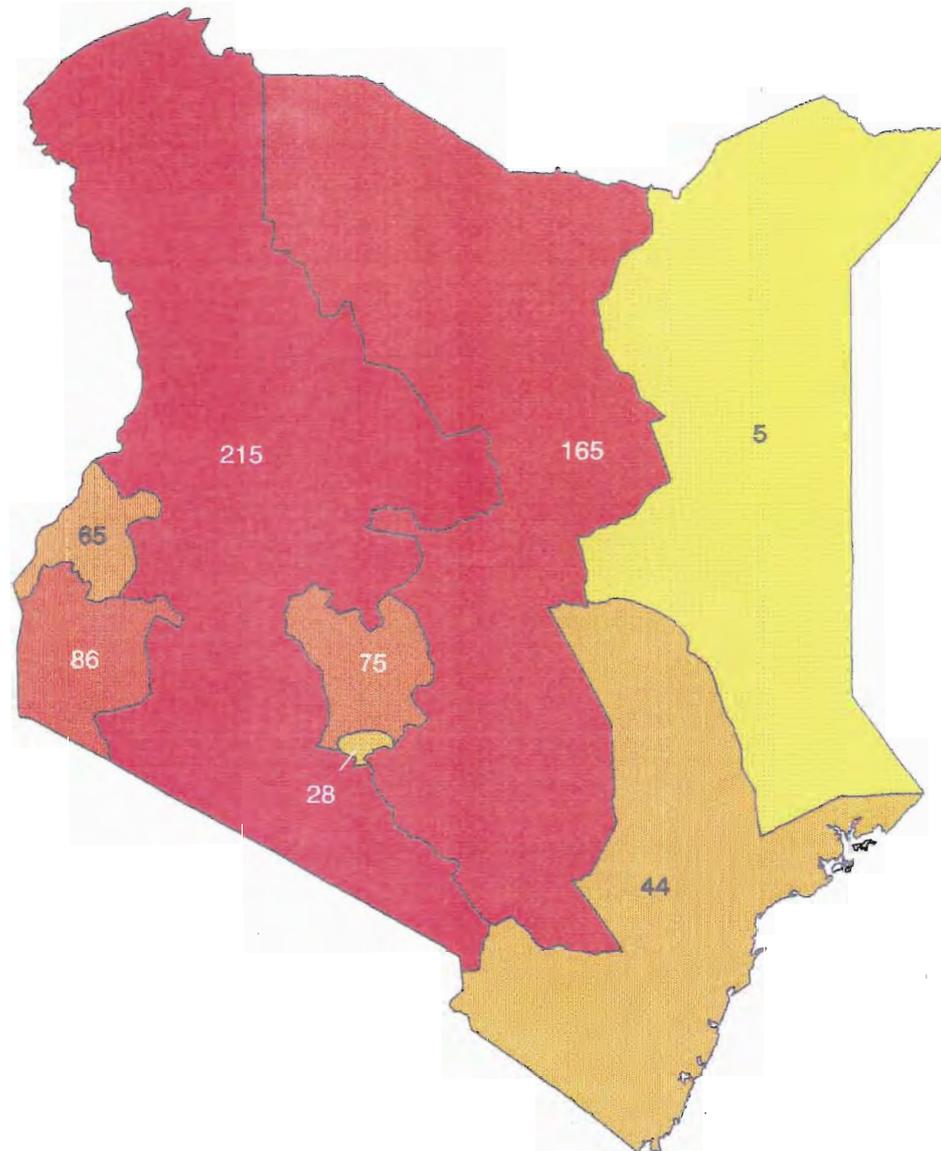


Source: MOH/HIS, 1994

*Ratios greater than one imply more mission than non-mission private facilities

GIS: Harvard/DDM

Figure 7 Number of mission facilities by province, Kenya 1994



Provinces together account for more than 50% of all private hospitals. North-eastern province has the lowest number. This evidence is summarized in Table 16 and Figure 8.

Table 16
Distribution of Private/Company Health Facilities, 1994

<i>Province</i>	<i>Hospital</i>		<i>Health Centers</i>		<i>Others*</i>		<i>% Total All Facilities</i>
	<i>Total</i>	<i>%</i>	<i>Total</i>	<i>%</i>	<i>Total</i>	<i>%</i>	
Nairobi	6	20.70	1	7.80	142	21.10	21.00
Central	-	-	1	7.80	58	8.60	8.30
Coast	4	13.80	3	23.10	64	9.50	10.00
Eastern	1	3.50	1	7.80	87	13.00	12.50
N/Eastern	-	-	-	-	10	1.50	1.40
Nyanza	2	6.90	4	30.80	62	9.20	9.50
R/Valley	15	51.70	3	23.10	217	32.30	33.00
Western	1	3.50	-	-	32	4.80	4.60
Total	29	100.00	13	100.00	672	100.00	100.00

Source: MOH/HIS 1994

A good illustration of the influence of competing factors on locational choices can be seen in the distribution of sole practitioners in 1992. Clearly doctor, nurses and clinical officers face different constraints and different markets. These are factored into their decision matrix when they choose where to locate their practices. In 1992, the latest year for which numbers are available, half of all doctors who went into private practice set up practice in Nairobi. This is in contrast to the much lower proportion of clinical officers and nurses entering private practice in Nairobi (9% and 12.3% respectively). This evidence is summarized in Table 17.

It would be illuminating to look in closer detail at the spatial distribution of each type of health facility in the private sector. Time and space constrain us from doing so. However one can safely conclude that there is an urban bias in the distribution of for-profit health facilities in Kenya; that mission health facilities are predominantly located in rural areas, and especially in regions with a predominantly Christian population. We can also conclude that different private providers are influenced by quite different factors when they make decisions about where to site their health facilities.

Table 17
Distribution of Registered Private Medical Practitioners, 1991

<i>District</i>	<i>Clinical Officers</i>		<i>Doctors</i>		<i>Nurses</i>	
	<i>Total</i>	<i>% of Total</i>	<i>Total</i>	<i>% of Total</i>	<i>Total</i>	<i>% of Total</i>
Nairobi	54	9.50	515	50.80	66	12.30
Mombasa	18	3.20	182	18.00	0	0.00
Nakuru	26	4.60	49	4.80	11	2.10
Meru	32	5.60	9	0.90	102	19.00
Others	438	77.10	258	25.50	359	66.70
Total	568	100.00	1013	100.00	538	100.00

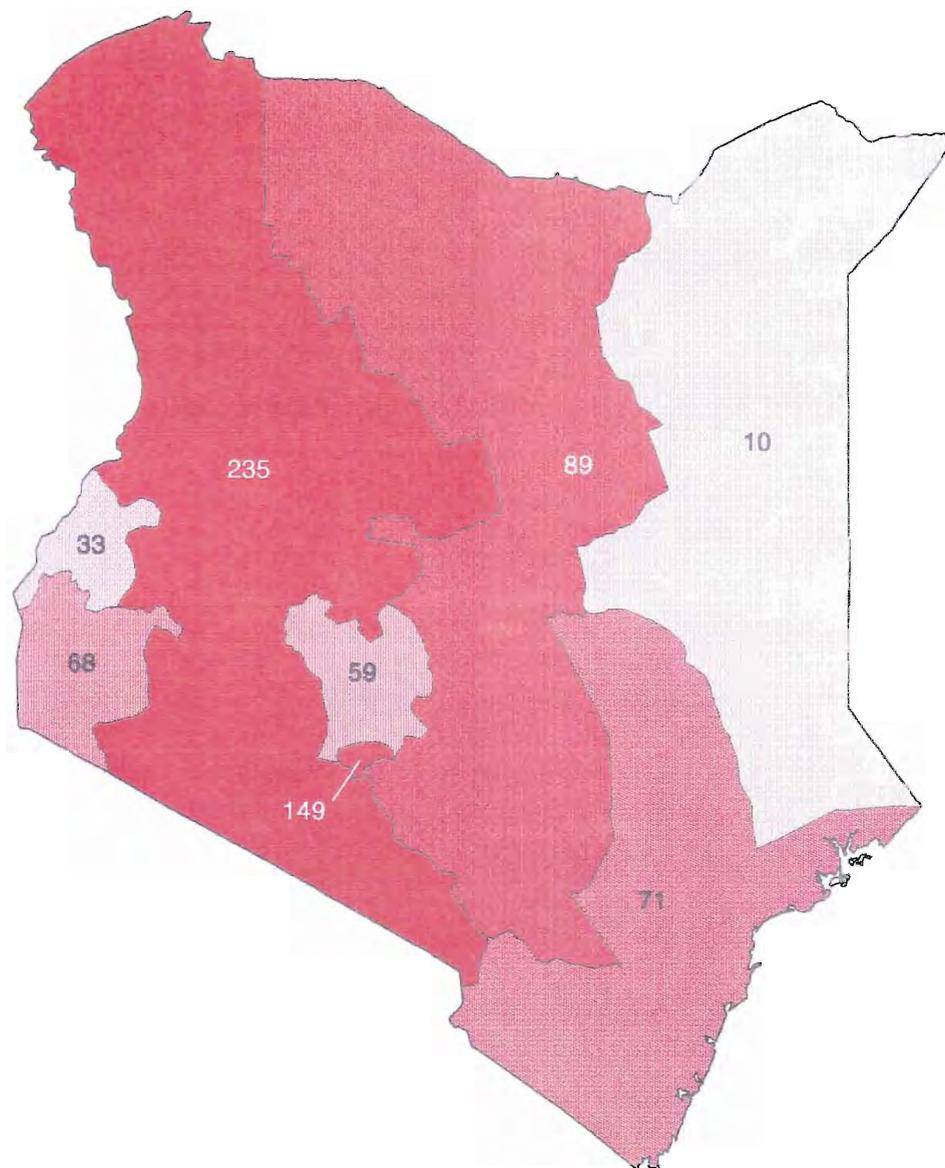
Source: Kibua (1992)

Geographic Distribution of Other Health Care Providers

Tables showing the distribution of pharmacies, traditional birth attendants, community pharmacies and community health workers are given in the appendix. Of the 290 pharmacies and chemists in Kenya as of July 1994, Nairobi has the largest concentration (47%), followed by Rift Valley (13.8%) and Coast (10.3%). These three provinces together account for about 71% of all pharmacies in the country. TBAs and community health workers are more commonly found in Nyanza, Eastern and Western provinces. About 44% and 32% of all community pharmacies and community health workers respectively are in Nyanza province. There is not much that can be said about the distribution of shops, drug stores and vendors except that they are widely dispersed across the country.

We conclude this section by noting two implications of the wide variations in the distribution of private health facilities which may suggest a role for government. First, private facilities charge fees that are considerably higher than those charged in GOK facilities. This means that those Kenyans living in areas predominantly served by the private sector may be paying more for their health care than others, all other things being equal. Assuming that there are significant differentials in quality and that mission and other private health facilities provide better services, it is not clear that people in areas which are predominantly served by non-government providers will not be willing to trade off some high quality care for lower out-of-pocket expenditures on health. Secondly, there is room to use deliberate government policy to encourage the private sector to locate in underserved areas of the country. Alternatively, the GOK may concentrate all its own new developments in the health sector in underserved areas, leaving the "mature markets" such as Nairobi and Mombasa for

Figure 8 Number of private non-mission facilities by province, Kenya 1994



the private sector.

The Contribution of the Private Health Sector

There are a number of different ways in which the contribution of the private sector can be measured. The importance of private health expenditures has been considered in section 3.2. Total numbers of visits would be another way to measure the contribution of private providers, although the absence of private sector utilization data precludes this type of analysis. Population-based utilization of private providers is considered in Chapters 6 and 7. Here we look at the contribution of the private sector to the total availability of health facilities and beds, to drug supply, and consider the contribution of traditional healers. Different measures of private sector contribution are shown in Box 2.

Box 2 Contribution of the Private Sector	
<i>Measure</i>	<i>Percent of Total</i>
Hospitals	49.50
Health Centers	21.00
Other Health Facilities	51.40
Pharmacies and Pharmaceutical Supply	>80.00
Hospital Beds	36.00
Health Personnel (volunteer doctors and nurses)	n/a
Outpatient Attendances	n/a
Inpatient Admissions	n/a
Training	very small (mainly nurses)

Health Facilities and Beds

The nongovernmental health sector contributes substantially to the overall availability of health services in Kenya. Table 18 and Figures 9 and 10 summarize the evidence. The private sector owns and operates about 42% of all health facilities in the country. Broken down by facility-type, this comes down to about 50% of all hospitals, 21% of all health centers and about 50% of all other health facilities. Figure 9 shows the ratio of government to non-government (private and mission) beds by province. As is readily seen, there is considerable variation: while Western Province is the only one which has fewer government than non-government beds, the ratio for those provinces with more government beds ranges from 1.36 to 13.31.

Table 18
Distribution of Health Facilities by Provinces, 1994

Province	Hospitals			Health Centers			Other Facilities		
	GOK	Non-GOK	% Non-GOK	GOK	Non-GOK	% Non-GOK	GOK	Non-GOK	% Non-GOK
Nairobi	8	7	46.70	27	2	6.90	122	190	60.90
Central	14	12	46.20	48	12	20.00	213	117	35.50
Eastern	15	15	50.00	43	8	15.70	251	242	49.10
Rift Valley	24	29	54.70	100	28	21.90	431	424	49.60
N/Eastern	3	3	50.00	9	-	-	35	17	32.70
Nyanza	7	9	56.30	50	38	43.20	158	137	46.40
Coast	16	7	30.40	35	4	20.30	194	117	37.60
Western	7	10	58.80	61	7	10.30	51	86	62.80
Total	94	92	49.50	373	99	21.00	1,457	1,330	51.40

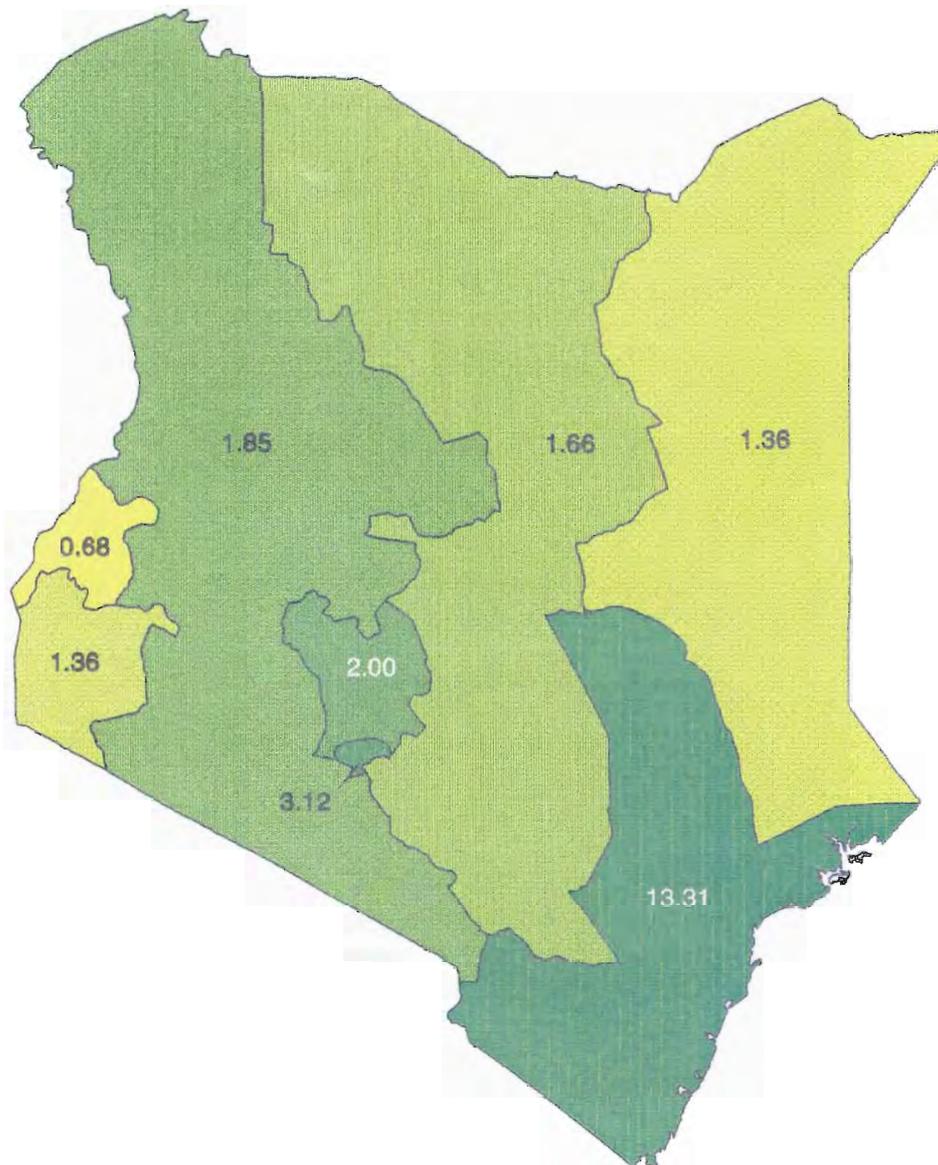
Source: MOH/HIS 1994

The missions own about 20% of all the health facilities in Kenya. A majority of mission facilities are dispensaries (481), followed by health centers (84) and hospitals (62). It is difficult to estimate the volume of health services directly provided by employers in Kenya. The lack of data about utilization of employer-provided services owes largely to the fact that there is no single dominant economic sector. This is in contrast to the situation in Zambia where the Zambia Consolidated Copper Mines (ZCCM) is a dominant provider.

A different measure of private sector contribution is the number of beds in the private system relative to the overall availability of beds in the country. As of October 1994, more than a third of all hospital beds in Kenya are in the private sector (see Table 19). This is a substantial increase from 1955 when they provided 1812 or 23% (missions 14.9 and the for-profit sector 8.14%) of all hospital beds. The proportion of private sector beds rose to roughly 45.9% (8357) in 1973 (missions: 31.7% and the rest of the private sector 14.2%) the last year for which such disaggregation is available. In terms of the types of beds, the private sector accounts for 39% of general beds. It also accounts for 29% of maternity beds and 26% of cots.

Variation by province in the contribution of the private sector in terms of beds in 1994 is summarized in Table 20. The private sector is the dominant provider in Western province, accounting for nearly 60% of all beds, but less so in Coast province where their bed share is less than 10%. This data is also displayed in Figure 9.

Figure 9 Ratio of GOK to non-GOK beds by province, Kenya 1994 *



Source: MOH/HIS, 1994

*Ratios greater than one imply more non-government than government beds.

GIS: Harvard/DDM

Table 19
Number and Proportion of Non-GOK Beds by Province

	<i>Population</i>	<i>Non-GOK</i>	<i>GOK</i>	<i>Total</i>	<i>% Non-GOK</i>	<i>% GOK</i>
Nairobi	1,596,106	1,335	4,165	5,500	0	0.76
Central	3,755,625	1,756	3,512	5,268	0.33	0.67
Coast	2,204,174	186	2,476	2,662	7.00	0.93
Eastern	4,541,253	1,821	3,024	4,845	0.38	0.62
N/Eastern	447,526	519	704	1,223	0.42	0.58
Nyanza	4,226,127	1,773	2,405	4,178	0.42	0.58
R/Valley	6,002,840	2,591	4,796	7,387	0.35	0.65
Western	3,065,914	2,822	1,917	4,739	0.60	0.41
Total	25,839,565	12,803	22,999	35,802	0.36	0.64

Source: HIS, 1994

Drug supply

We were unable to estimate the contribution of the private sector to total drug distribution (end-users) in the country. Anecdotal evidence suggests that this is about 80%, given the dominance of the private pharmacies and the chronic and persistent lack of drugs in GOK facilities. Furthermore, the mission sector receives drug donations from overseas which to some limited extent add to the overall drug supply in the country.

The role of pharmacies appears to be rising quite rapidly in the area of diagnosing and prescribing treatment. Interviews with private pharmacists and evidence from the provider survey indicate that clinical practice by pharmacists is growing. In the survey, 92% of all pharmacies interviewed stated that they provided health consultations and advice to patients. Whether this is an overstatement reflecting the ongoing struggle between physicians and pharmacists in Kenya is difficult to ascertain¹². What appears to be obvious is that increasing numbers of Kenyans go to pharmacists for medical treatment and advice. This is probably a substitution effect. As the price of medical care has risen with the introduction of cost sharing in GOK facilities, and with rising prices in private facilities, many Kenyans are perhaps substituting out of visits to a formal health facilities in favor of less expensive pharmacies where they at least will not pay a consultation fee.

Traditional Practitioners

It is difficult to quantify the contribution of traditional health practitioners in

12/ The struggle revolves around whether pharmacists can engage in clinical practices and whether they can go by the title "Doctor". Pharmacists appear to be winning. All go by the title of doctor and many appear to engage in clinical practices. As a matter of fact, one of the most important subcommittees of the Pharmaceutical Society of Kenya is the Clinical Pharmacists Sub-committee.

13/ See for example Katz & Katz (1987) for a study of the treatment of infertility and Lowenthal and Peer

Table 20

Utilization of Private Providers for Curative Care: Summary of Available Evidence

Source	Gov't	Private	Mission	Drugs	Trad'l	Herbs	None/Self
WMS 1992	[-----47.00-----]			35.00	0.00	6.00	6.00
HCFP 1993 (6 indicator districts)							
-all	40.00	17.00	3.00	22.00	[-----5.0-----]		13.00
-hospital	57.00	28.00	10.00				
GOK/UNICEF 1990-2							
-Embu	[-----57.80-----]			30.60	0.90	2.20	8.60
-Kisumu*	[-----63.60-----]			34.80	0.60	9.01	13.05
-Kisumu**	[-----60.00-----]			29.20	2.30	8.50	0.00
-Kitui+	[-----43.50-----]			42.80	0.40	5.21	8.15
-Kwale	[-----53.90-----]			31.80	1.80	12.50	6.40
-Mombasa	[-----68.30-----]			26.00	0.70	6.40	4.30
Mwabu et.al. 1980/1	35.50	19.50	5.60	[-----39.40-----]			

Notes: * Unweighted mean of 6 divisions

** Illness in children under 5 years

+ Units in original report are unclear; percentages have been imputed assuming that the row total adds to 100%; unweighted mean calculated across divisions

terms of the number of facilities, beds provided or patients seen. Evidence on this issue is difficult to get and very unreliable. Nevertheless, traditional health practitioners claim to cure a variety of illnesses¹³, some of which form part of the public health agenda¹⁴. The findings of the 1993 Welfare Monitoring Survey suggests that traditional health practitioners are used in less than 1% of illness episodes. This is likely to be an underestimate. It is believed that many Kenyans are reluctant to reveal their having used a traditional health practitioner because of the stigma of witchcraft and sorcery often associated with it .

Other areas in which the private sector contributes to Kenya's health system include: the training of nurses in mission-affiliated nursing schools; the presence of foreign doctors and other health personnel in mission hospitals which adds to the overall supply of qualified health professionals in the country; drugs received from other church organizations overseas, and; the use of church hospitals for undergraduate medical education. The private sector also makes a substantial contribution in terms of inpatient admissions and outpatient attendances which helps reduce congestion in GOK health facilities.

(1991) for ophthalmic diseases.

14/ The provider survey asked traditional healers to indicate the ten most common illnesses they treat. Among the most common responses were illnesses of the stomach/ulcers/diarrhea; STD/AIDS; malaria/headache; joint pains and arthritis; infertility/impotence/PID.

Quality and Efficiency: Performance of the Private Sector

Evidence on the relative quality and efficiency of private health care provision in Kenya is scarce. A number of studies have documented the inefficiencies of publicly-provided services, attributing the shortcomings to deficiencies in public sector management practices¹⁵. However, comparable evidence from the private provision sector is rare.

A recent study of 18 hospitals (the Curative Gap Study, Musau and Sliney, 1994) attempted to fill this gap. It assessed both quality and costs. "Structure" indicators were used, based on the assumption that their presence is a necessary, though not sufficient, prerequisite for good quality of care. Key areas investigated included the availability of qualified staff and of specialized diagnostic and clinical services, facility status, the existence of management processes and information, and patient satisfaction. Neither measures of process nor of health outcomes were investigated.

A mixed picture of relative quality differences between mission and government hospitals emerges. Of the top five overall quality scores, 2 are government and 3 mission facilities. Of the lowest five, 4 are government and 1 mission. Mission hospitals appear to perform somewhat better than government on service availability indicators, patient satisfaction, and facility status. Government hospitals performed better on staffing indicators. No clear pattern of public or mission sector dominance was seen for management process indicators.

A similarly equivocal picture of efficiency differences is seen when cost data are examined. The mean cost per inpatient day is slightly higher in government than in mission facilities, and the variation is considerably greater for government. However, the mean cost per outpatient visit is lower in government facilities, and variability less than in the case of mission facilities.

Caution must be used in interpreting unit cost differences as reflective of differences in efficiency. Low unit costs could reflect high utilization, efficient combination of inputs, or overall lack of resources. The results summarized here demonstrate that little generalization can be made about the relative efficiency of government and mission hospitals. The authors of the gap study conclude that management practices are the most important determinants of efficient production of health services, and it is not clear that ownership per se is very important.

Problems Confronting the Private Provision Sector

Much more is known about the constraints and problems faced by the mission sector than by other types of private provider. For this reason, only mission facilities are treated in this section.

15/ See for example the Provincial and District Study, Nairobi Area Study, and Kenyatta National Hospital Study

There are three major problems facing most mission facilities. The first is financial, the second is the lack of management and administrative skills and the third is the lack of places in local medical institutions for them to train their paramedics such as radiographers, laboratory technicians and technologists etc. These problems appear to be especially serious for CHAK-affiliated hospitals, three of which were recently taken over by the GOK in keeping with a pledge to assume full responsibility for any failing church health institutions. A management study¹⁶ identified the following as the major constraints facing CHAK facilities: a) lack of a system for controlling and managing drug supplies and b) lack of a system for monitoring the purchase and use of food in the hospital kitchens. Fourteen percent of the facilities studied had no inventory system while 40% of the small units had no drug inventory system.

Availability of funds is also a problem. In recent years GOK subsidies to mission health institutions have declined dramatically (see Table 31 for details about the size of government transfers to the mission sector over time). Non-profit health institutions can also petition for a 50% reduction of foreign trade taxes on imported items. In order to make up for their financial shortfalls, some church-affiliated facilities have decided to make a deliberate effort to attract more NHIF patients.

Finally, the lack of places in local institutions for the training of paramedical staff is a serious problem confronting the mission health sector. KCS for example, reported difficulty in enrolling qualified candidates in programs at the Medical Training College. Since there does not appear to be a deliberate policy to deny places to candidates from other non-government health providers, the need to meet the training needs of government health institutions may explain this problem.

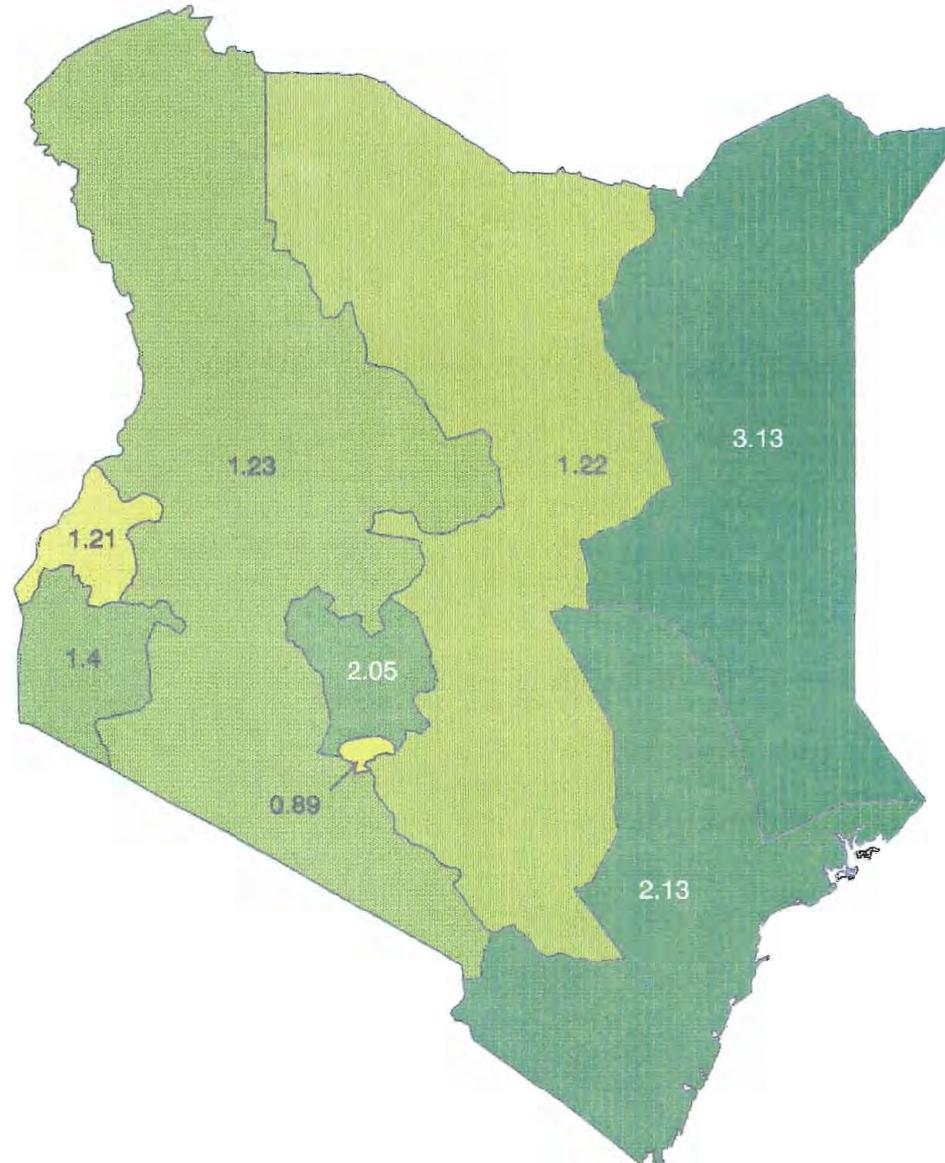
On the Relationship between the Private Health Sector and the GOK

Interviews suggest that there is very little consultation between the Ministry of Health and the private health sector either in terms of policy formulation or in terms of coordinating responses to specific health problems. For example, there has been little or no coordinated response between the MOH and the mission sector to the recent outbreaks of malaria and meningitis in several parts of the country.

In recognition of the importance of private health providers in Kenya's health system and the need to use available resources more efficiently, a new office responsible for coordinating the health activities of the private sector and the government was recently created in the Ministry of Health. While the mandate of this new office is still being developed, it is expected to work very closely

16/ These problems have been documented in the report of a management study of CHAK facilities undertaken by MSH in 1990

Figure 10 Ratio of GOK to non-GOK facilities by province, Kenya 1994*



Source: MOH/HIS, 1994

*Ratios greater than one imply more GOK than private facilities.

GIS: Harvard/DDM

with the private sector and serve as a clearing house for all their requests, policy recommendations, etc., to the GOK. This is along the lines observed for similar bodies in other countries.

Traditional health practitioners appear to have been left out in the new arrangements. There is very little communication between them and the Ministry of Health and none between them and the "modern" health sector; although according to the provider survey, most traditional healers are eager for such a relationship (perhaps to confer official legitimacy to their activities). The Ministry of Health recognizes that traditional healers provide services to a varied group of Kenyans but appears to be indifferent in her attitude to them¹⁷.

The problem of employer-provided services has not been central to health policy debates in Kenya. It has thus not featured prominently in Kenya's ongoing health sector reform debate. The explanation for this could lie in the absence of a dominant private sector employer such as the ZCCM in Zambia, with its extensive network of health facilities whose distribution and capacity have important implications for the availability of health services in the country. However, if the quality of care in GOK facilities continues to deteriorate, and if costs are not contained in the private sector, many employers may be forced to expand the scope of their on-site health services in order to contain health care costs.

17/ A registry of traditional healers was opened in September 1994 in the Ministry of Culture and Social Development. To be registered, a traditional healer must pass two examinations administered by the Ministry.

5 Utilization of Private Providers in Kenya

The preceding sections reveal a highly pluralistic health system. Kenyans seeking care have a nominally wide range of providers from which to choose. In this section we assess how Kenyans seeking care make their choices and what factors influence those choices, using evidence from various household surveys. We first review evidence about utilization of private providers for curative health services. We then examine the relationships between private health care utilization and certain socioeconomic characteristics, such as age, gender and education.

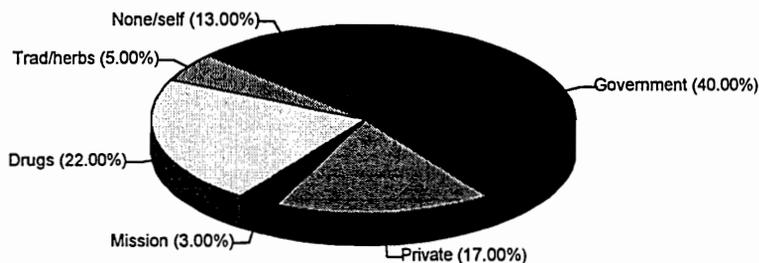
Utilization of Private Providers for Curative Care

The only recent national surveys that could provide insight into the characteristics of private health care users and the pattern of use of health services in the country are the 1992 and 1994 National Welfare Monitoring and Evaluation Surveys (WMS). In the case of the 1992 survey round, information is not sufficiently disaggregated to provide evidence on the pattern of utilization of different providers of health services. Data collection for the 1994 round, which contains more detailed questions about provider use, has recently been completed, and should contribute to our understanding of this issue. The 1993 Kenya DHS is also a rich source of information, although questions about curative care were asked only about children under 5 years, and for specific illnesses (fever/cough and diarrhea).

In the absence of appropriate national survey data, this assessment has relied on information from a variety of smaller-scale surveys. There are two major shortcomings of this approach: these surveys are limited in their geographical coverage and were undertaken at different times. Furthermore, provider categories are not always consistent across surveys and the precise questions asked may have differed, particularly with respect to the reporting of multiple provider use for a single illness episode. These limitations notwithstanding, Table 20 summarizes the results of these various studies of health seeking behavior in Kenya. Graph 2 displays the results of the KHCFP household survey for outpatient care in six districts.

Detailed breakdowns of source of patient care are provided in surveys undertaken by the Health Care Financing Project in 1993 in 6 districts, and by AMREF in

Graph 2
Utilization of Private Providers 6 Districts, 1993



Source: KHCFP

1994 in 3 districts (see Table 21). Estimates from the KHCFP data suggest that utilization of private and mission facilities for outpatient care together amounts to 20% of total utilization. When the purchase of over-the-counter drugs is added, the private sector contribution rises to 42%, with traditional medicine and herbs contributing a further 5% of total utilization. Government facilities, on the other hand, were used in 40% of visits. The survey targeted areas close to MOH facilities in order to capture the substitution effect of the user fees and may be an underestimate for other areas.

Table 21

Utilization of Private Providers for Curative Care: Evidence from Three Districts

<i>District</i>	<i>Public Hospital</i>	<i>Private Hospital</i>	<i>Private Medical Practitioner</i>	<i>Traditional Healer</i>	<i>Self-Medication</i>	<i>No Care</i>	<i>Total Private</i>
Siaya (n = 1174)	46.90	14.60	3.60	5.40	19.60	10.00	43.20
Kisumu (n = 1616)	56.40	8.80	4.00	3.10	15.80	11.80	31.70
Nandi (n unknown)	57.50	7.20	3.20	3.20	13.30	11.10	26.90

Source: AMREF, unpublished data

The results of the AMREF survey suggest a slightly lower total private sector contribution, amounting to 43% in Siaya, 32% in Kisumu and 27% in Nandi district (AMREF, unpublished report). Self-medication constitutes the largest

share of the total private sector contribution in all three districts, amounting to 20% in Siaya, 16% in Kisumu, and 11% in Nandi (see Table 21).

Two other sets of surveys combined public and private facilities into a "modern health facility" category, but distinguished over-the-counter purchase of drugs. According to these estimates, use of privately-purchased drugs ranges from 22% to 42% (CBS, 1992; GOK/UNICEF 1990-2).

In contrast to informal and anecdotal evidence, all of these surveys show very low levels of use of traditional healers and low-to-moderate use of herbal treatment. To the extent that this is due to under-reporting of use of this sector, it may reflect the questionnaire design. In any case, it is clear from the evidence pieced together in Table 20 that private sources of curative care are very important in Kenya.

Factors Affecting the Utilization of Private Providers

Households differ in their use of different health care providers. Age and gender, socioeconomic status, education, and place of residence are some of the individual and household characteristics likely to affect the utilization of privately-provided health services. Using evidence obtained from further analysis of the DHS data set and from other surveys, this section considers the impact of these characteristics on the utilization of private health care services.

Age and Gender

In a recent survey conducted by the Kenya Health Care Financing Project, women were found to have a slightly higher rate of utilization of private for-profit providers than men. The reasons for this are not known but a plausible explanation could be the occupational status of their husbands. Employers in Kenya purchase care for their workers from private providers. Since women are more likely to visit a health institution in a year due to their childcare responsibilities, it is plausible that they take advantage of their having to take their children to the doctor to also seek treatment.

Available data do not reveal any impact of age on the utilization of traditional healers. In some other countries, for example, Zambia, the rate of increase in the use of traditional healers appears to increase with age.

Income

Income is a determinant of overall health expenditures in most countries. The share of total household income that a household spends on privately-provided health services depends in part on the amount of subsidies made available by

the government and the terms of any health insurance contracts into which the household may have entered.

There are no comprehensive data about the utilization of health services by income group. Many of the household studies of health seeking behavior use education as a proxy for socioeconomic status (SES). The first round of the Welfare Monitoring Survey uses occupational category as the main indicator of SES. The survey results presented in Mbugua et al (no date) from Kibwezi district, however, indicate relatively higher use by the poor of private and mission services than of government health services. Although limited in coverage, this result suggests that even for the poor, the private sector may be an important source of care.

Insurance

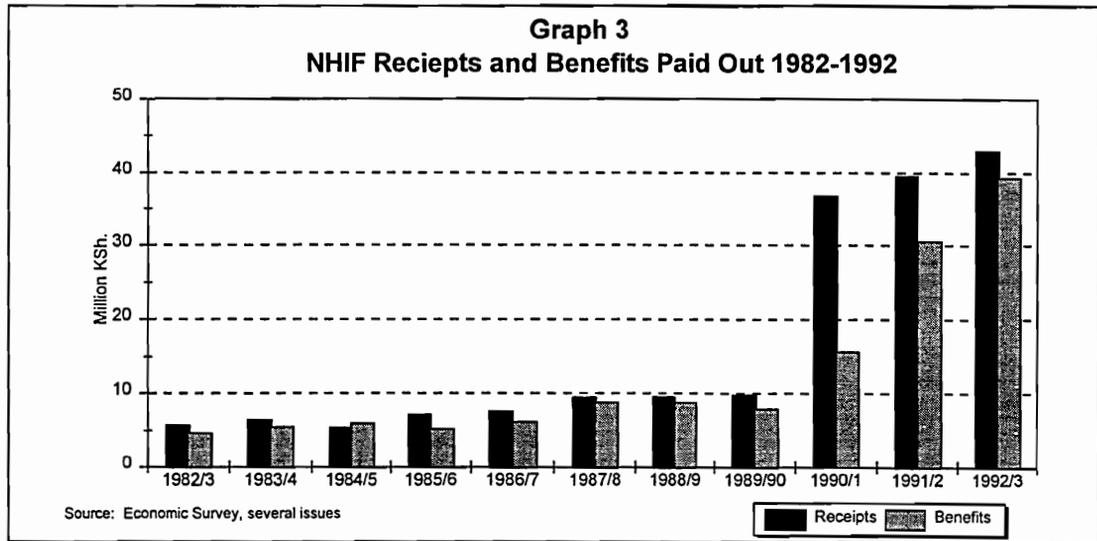
Insurance affects the demand for private health services by lowering the cash cost of care at the time of illness. In so doing, it makes a greater variety of providers financially accessible to the patient, increasing their choice set. In Kenya there are two broad types of formal insurance: the National Health Insurance Fund (NHIF), and private health insurance. In addition there is an informal risk-sharing arrangement known as *Harambee*. We discuss below information about how the utilization of private providers is affected by insurance coverage.

NHIF

The NHIF is a mandated hospital insurance program which has been in existence since 1966. It is financed through a payroll tax on all those earning regular, taxable wages of KSh.1000 or more per month (generally those in formal employment). The NHIF covers inpatient care only and is estimated to effectively cover 6 million people. The main advantage of the NHIF as a mandatory program is that it limits adverse selection.

NHIF and consumer incentives

Models of insurance predict that insured patients will (*ex post*) consume more health services than they otherwise would have because insurance largely frees them and the physician from the discipline of cost. The extent to which the NHIF has encouraged over-consumption of health services in Kenya has not, as far as our research could ascertain, been studied. Graph 3 provides evidence on NHIF receipts and benefits paid from 1982/83 to 1992/93 (the data for this graph appear in Appendix 2). Receipts and benefits paid out have been rising, particularly since 1989/90 when NHIF contribution rates were revised. In that year the flat contribution rate which had been in place since the NHIF was founded was replaced with a graduated contribution schedule. Workers contrib-



ute 2% of their monthly income to a maximum of KSh 320 per month. Since 1990 benefits paid have risen while revenues have changed little. This would be consistent with increased consumer use of health care under insurance.

There are competing explanations for these trends. The revision of reimbursement rates in 1989 could have resulted in an increase in total benefits paid out even after controlling for the increase in the number of institutions making claims. There has also been an increase in the number of facilities claiming from the NHIF. This could include newly-registered providers (evidence from the provider survey suggests that over 30% of the health providers in our sample were established between 1989 and 1994). Another factor that could explain the decline in net revenues is the fact that GOK facilities are now making increased efforts to claim from the NHIF. Previously they had no incentives to pursue NHIF claims because all such revenues collected were returned to the treasury. With the introduction of cost sharing in government facilities, the GOK has permitted these facilities to retain collected revenues for their own use in a facility improvement fund and this has found reflection in vigorous efforts by these facilities to mobilize revenues including those from the NHIF. Finally, a number of mission facilities have intensified their efforts to increase the importance of the NHIF as a source of revenues to attract NHIF patients. They are doing this by actively identifying NHIF patients. In sum, then, there are various explanations for rising NHIF claims, and one cannot conclude that this reflects moral hazard alone.

NHIF and type of facilities used

NHIF reimburses all inpatient facilities for bed costs. A 1993 survey of NHIF

members and beneficiaries collected information about the individual's most recent hospitalization. Overall, the most common source of care was private hospitals (36%), followed by government hospitals (27%) and mission hospitals (22%). The pattern differed slightly between urban and rural areas, with use of mission hospitals marginally higher in rural areas, and private hospitals dominating in urban areas (McCann Research 1993, see Table 22). Despite this relatively evenly distribution of utilization, more than 90% of total reimbursements are paid to private for-profit hospitals (Dan Kraushaar, personal communication). This is due to higher average length of stay in the for-profit sector, as well as higher average reimbursement rates.

Table 22

Choice of Hospital by NHIF Members and Beneficiaries, 1993

<i>Type of Facility</i>	<i>Urban</i>	<i>Rural</i>	<i>Total</i>
Government Hospital	27%	27%	27%
Private Hospital	44%	29%	36%
Mission Hospital	12%	30%	22%
Private Nursing Home	16%	13%	14%

Source: McCann Research 1993

Using evidence on the distribution of income among those in formal employment and the pattern of reimbursements to public and private sector health facilities Akumu (1992) found that a majority of low-income, public sector employees were much more likely to seek hospitalization in GOK facilities than in the private health sector, even though they constitute a significant proportion of NHIF contributors. He attributed this to the large gap between hospital charges in the private sector and NHIF reimbursement rates, and concludes that NHIF benefits de facto discriminates against low-income contributors.

Although the existence of the NHIF appears to have contributed towards increasing the health care choices open to members and beneficiaries, the extent to which it contributes to inequity as concluded by Akumu is difficult to assess. A more revealing comparison would consider differences in the distribution of sources of hospital care among the general population and the NHIF population; or the ratio of NHIF contributions to benefits for different levels of income.

Private health insurance

The second type of formal insurance is private insurance, taken out by individuals or by employers on behalf of their employees. There are no reliable esti-

mates of the number of Kenyans covered by private insurance schemes. Evidence from a recent study of the insurance market suggests that as in the case of the NHIF, private insurance coverage is largely limited to those in formal sector employment (Mwabu et al 1993). Insurance companies report that the majority of clients are located in urban areas, and 80% of all insurance agents operate in urban areas (ibid.).

There is at least one exception to the urban bias in insurance coverage. Chogoria Hospital in Meru district facilitates a pre-payment program for coffee plantation workers and their family members. There are now 1400 policies with about 8000 people insured. The pre-payment program covers both outpatient and inpatient care. Subscribers can also pay their premium with coffee vouchers, payable against future crops. Members of the scheme now account for 6% of the workload at Chogoria.

As noted earlier, insurance coverage may be associated with over-consumption of health services, resulting in rapid increases in the cost of insurance. There is evidence that this may be occurring at least for outpatient care in Kenya: there are reports of increasing numbers of large employers choosing to self-insure for outpatient service expenses. In addition to potential over-consumption, the possibility of fraudulent collusion between patients and providers is also an underlying concern. Insurance firms are responding to this change in the market by offering "administrative only" schemes: in these schemes, insurance companies manage a health care fund for employers, including the claiming process, in return for a management fee. Other innovations include the development of preferred-provider organization (PPO) arrangements, where the insurance company negotiates preferential rates with specific providers, including pharmacies. Some providers also assure priority to PPO clients, reducing the time costs of employee health-care seeking.

Although formal private insurance is emerging as an important source of financing for upper income Kenyans and those employed in the formal sector, it is unlikely to become a very important source of health financing for the majority of the Kenyan population in the medium term. Two factors constrain the scope of private insurance. First, it has a predominantly urban bias, and second, it is generally employment-related, thus its availability is likely to remain limited to those in formal employment. Incomes in most other sectors remain too low to support the cost of insurance.

The Harambee movement

A third, informal type of insurance is provided by the "Harambee" movement. This is the practice of communities voluntarily pooling together their funds for private or public projects (Mwabu et. al 1993). As well as contributing towards infrastructure investment, raising Harambee funds is a relatively common way to

assist families facing catastrophic illness. Although not strictly insurance because it is an *ex post* financing mechanism, Harambee funds do represent risk-pooling in that the incentive for individuals to contribute to Harambee fundraising lies in their expectation that they, too, would receive the same assistance were it to be needed. By increasing the access of households to cash for paying medical bills, the Harambee movement probably increases utilization of private health care providers.

Quality

In discussing the quality of health services, it is standard practice to distinguish between technical and perceived quality. Although the two are clearly related, it is the quality of services as perceived by the consumer that affects the demand for health services. Where consumers are choosing between public and private health care options, quality differentials favoring the private sector will, all else being equal, increase the demand for private services.

Quality of care in government facilities is widely reported to have deteriorated over the 1980s, accompanying falling real government health expenditures. Drug shortages are relatively common in government facilities and essential medical items are reported to be chronically undersupplied. With an increased cost to the patient of seeking care in government facilities and limited improvements in perceived quality, we would expect the demand for comparably-priced private services to increase.

Private facilities appear to enjoy considerably higher perceived quality. The NHIF member study (McCann Research, 1993) looked at the reasons why people chose a particular facility for their last hospitalization. While cost and proximity were most commonly stated as reasons for choosing public sector hospitals, users of private facilities (private hospitals, mission hospitals and private nursing homes) were more likely to mention clean environment, good food and good overall services, in addition to recommendations from employer and proximity to home or place of work. The Nairobi Area Study (USAID/REACH, 1988) found a similar pattern of differences among users of free and paying services, with quality cited more frequently by paying clients as the main reason for choice of facility.

Although now dated, results from a MOH exit poll conducted at both government and NGO facilities in 1990 corroborates this picture of a gap in perceived quality between government and NGO services. Patient ratings of drug availability, quality of bedding and linen, cleanliness of waiting areas, and length of waiting time were considerably higher in NGO than in government facilities (Ministry of Health, 1990b).

Education

Higher levels of education are associated with an increased likelihood of seeking medical care, and with increased demand for higher quality services. If privately-provided health services are perceived to be of higher quality than public services, then higher levels of education should be associated with higher levels of demand for privately-provided health services, other things being equal. There is however a confounding factor: higher levels of education are generally associated with higher income. It may thus be difficult to disentangle the independent effects of each of these two factors.

Many of the health utilization studies undertaken in Kenya (for example, the DHS and the KHCFP surveys) use education as a proxy for income, and do not attempt to collect information about household income. Thus, some of the results of the simple cross-tabulations presented below may represent the combined effects of income and education.

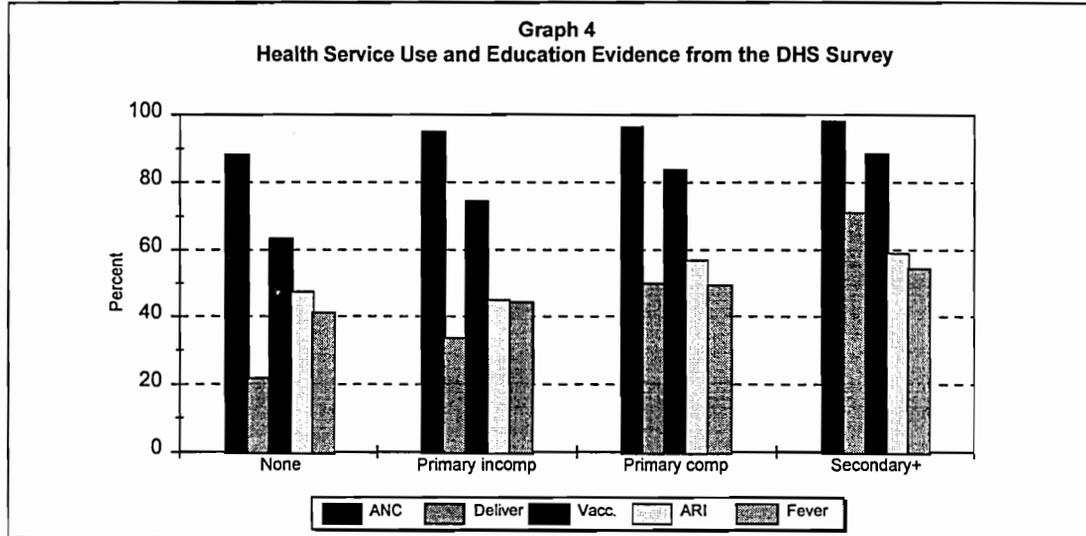
Higher levels of education are associated with higher overall use of health services in Kenya. The KHCFP household survey shows that the proportion of illness episodes for which no care is sought decreases with education. Higher mothers' education is associated with an increase in health facility use by children with respiratory infections, fever and diarrhoea (KDHS 1993). For preventive services the same pattern holds. Pregnant women with higher levels of education are more likely to seek antenatal care, and less likely to deliver at home. The proportion of children who receive all 9 childhood vaccinations also increases with mothers' education (Table 23).

Table 23
Use of Health Services and Level of Education

<i>Mothers' Education</i>	<i>ANC from Trained Health Worker</i>	<i>Delivering in Health Facility</i>	<i>Children Receiving All Vacc.</i>	<i>Children Taken to Health Facility for: ARI</i>	<i>Fever</i>	<i>Diarrhea</i>
None	88.30	21.90	63.30	47.30	41.20	37.90
Primary Incomplete	95.10	33.70	74.50	45.00	44.30	35.90
Primary Complete	96.50	50.00	83.60	56.80	49.40	43.80
Secondary +	98.20	71.20	88.50	59.00	54.60	49.10

Source: KDHS 1993

Graph 4 displays this data for antenatal care, deliveries, vaccination and children taken to a health facility for treatment of acute respiratory infection and fever.



There is only scattered evidence about the relationship between education and the use of private health care services in Kenya. Results of the household survey conducted by the KHCFP do not reveal any significant difference in the pattern of health care providers used between those with no education and those with primary education. For those with secondary education there appears to be a relatively higher use of private facilities and lower use of government health centers. With post-secondary education there is a dramatic increase in the use of private facilities and government hospitals, with much lower use of government health centers, suggesting that education is associated with higher use of facilities with higher perceived quality. The number of people with post-secondary education in this group is small, however ($n=57$), and conclusions should be treated as tentative. In addition, it is likely that the majority of those with higher education reside in urban areas, and that it is this effect that is being captured in addition to that of education. Another potential confounding factor is that those with more education are more likely to be employed in the formal sector, to be covered by the NHIF and private insurance, and thus more likely to use private health care services (see Table 24).

Table 24

Choice of Provider and Level of Education (column percentages add to 100)

<i>Source of Care</i>	<i>None</i>	<i>Primary</i>	<i>Secondary</i>	<i>Post Secondary</i>
NO OR SELF CARE	40	41	38	34
No Care	14	14	11	9
Herbal Traditional	5	5	6	7
Drugs	21	22	21	18
PRIVATE	18	18	28	32
Private Provider	16	15	23	32
Mission Facility	2	3	5	0
PUBLIC SECTOR	42	41	34	36
MOH Hospital	15	15	18	25
MOH HC	23	23	13	7
MOH Dispens.	4	3	3	4

(percentages may not sum exactly to 100 because of rounding)

Source: Kenya Health Care Financing Project Survey Data, 1993

6 Private Provision and the Public Health Agenda

The contribution of private providers to public health services is of particular interest when considering the potential for increasing the role of the private sector. In this section we consider program areas of public health significance in Kenya, presenting evidence from a variety of sources about the magnitude of the role played by different types of private provider.

Reproductive Health Services

Family Planning¹⁸

Evidence from the 1993 DHS survey shows that fertility levels in Kenya have fallen dramatically during the past decade. The total fertility rate has fallen from 8.1 in 1975-7 to 5.4 in 1993. The decline in fertility accelerated during the 1980s, falling 20% between 1984-8 and 1990-2 (1993 DHS:24). Almost all (96%) Kenyan women know at least one method of family planning. Knowledge of modern methods is high among married women (97%). Current use of family planning has increased from 17% of married women in 1984 to 33% in 1993. Comparing the results of the 1989 and 1993 DHS surveys we see that use of any method increased from 27% to 33% over the period, with use of modern methods increasing from 18% to 27%. Reported use of traditional methods actually declined between 1989 and 1993.

A large variety of private providers (both medical and non-medical) are involved in the provision of family planning services. These include mission hospitals and health centers, the Family Planning Association of Kenya (FPAK), private for-profit providers (including doctors, nurses and clinical officers), employer-provided health services (through the Family Planning Private Sector project), and pharmacies. In addition, condoms are widely available in shops and kiosks.

Household-level data from the DHS indicate the magnitude of the contribution of the private sector to family planning service provision. Of current users of all modern methods of contraception, 24.7% were supplied through private medical sources and 68.2% supplied through public sources. As can be seen in Table 25, the relative contributions of public and private sources differ by method.

18/ It should be noted that donor and other external agency interest in and support of family planning activities in Kenya have, as elsewhere, been considerable. As a result, the private sector contribution to family planning activities may appear relatively larger than in other areas because of the increased attention paid to monitoring and evaluating these donor-funded activities.

Table 25

Distribution of Current Users of Modern Contraceptive Methods by Most Recent Source of Supply, According to Specific Methods, 1993

<i>Source</i>	<i>Pill</i>	<i>IUD</i>	<i>Injection</i>	<i>Condom</i>	<i>Female Sterilization</i>	<i>All Modern</i>
PUBLIC	72.50	68.90	70.50	36.60	63.90	68.20
Gov't Hosp	24.20	29.60	18.20	13.20	60.60	29.60
Gov't HC	29.10	27.50	34.20	12.80	2.90	24.60
Gov't Disp	19.10	11.80	18.20	10.60	0.40	13.90
MEDICAL PRIVATE	16.20	31.10	26.50	25.60	33.20	24.70
Mission/Church Hospital	4.50	5.60	8.80	2.40	15.10	7.70
FPAK	3.30	7.30	5.10	3.30	5.10	4.80
Other NGO	0.40	0.60	1.60	0.00	0.90	0.80
Priv. Hospital/Clinic	4.50	11.60	8.80	3.30	11.20	7.80
Pharmacy	0.90	0.00	0.00	14.60	0.00	1.00
Priv. Doctor	2.60	6.00	2.20	2.00	0.90	2.60
OTHER PRIVATE	2.50	0.00	0.00	21.90	0.00	1.90
Shop	0.00	0.00	0.00	9.20	0.00	0.40
Friends/Relatives	2.50	0.00	0.00	12.70	0.00	1.50
Mobile Clinic	1.00	0.00	1.80	1.90	0.40	1.00
CBD	6.30	0.00	0.40	3.20	0.00	2.50
Other	0.60	0.00	0.30	0.00	0.00	0.30
Don't Know	0.20	0.00	0.00	10.10	0.30	0.60
Missing	0.60	0.00	0.50	0.70	2.20	0.80
TOTAL	100.00	100.00	100.00	100.00	100.00	100.00

Source: 1993 DHS survey, p. 49

Private providers are relatively more important suppliers of IUDs and female sterilization (31.1% and 33.2% respectively) than of other methods. Both IUDs and female sterilization are mostly provided in private hospitals and clinics, and FPAK clinics. Public sector sources, on the other hand, are used by more than 70% of users of pills and injections. Private sources (medical and other) are more important as suppliers of condoms. This may be related to the widespread availability of condom dispensers in private clinics. Analysis by the Department of Family Health Logistics Unit suggests that condom distribution by an "aver-

age" private outlet is up to 6 times greater than by an equivalent public unit (DFH Logistics Unit analysis).

Two donor-funded projects have directed their efforts in family planning promotion towards private providers. The KMA Family Planning Project Through Private Practitioners, funded by Pathfinder, has trained 800 physicians in family planning and supplies them with free contraceptives which are to be supplied at minimal charge. The most recent phase of this activity has integrated nurses and clinical officers in recognition of their role as health service providers in rural and small market areas. To date 223 nurses and clinical officers have been trained, with plans to train a further 200 during the current phase¹⁹.

The Family Planning Private Sector project, funded by USAID targets NGO and community-based clinics, private hospitals and nursing homes, and health facilities operated by parastatals and commercial companies. The project supported training, equipment, commodities, and IEC for family planning, MCH and AIDS education activities in 1993 (FPPS 1994).

Community-Based Distributors of contraceptives (CBDs) are yet another private source of family planning services. A recent review of CBD activities in Kenya enumerated at least 14 major implementing agencies (NGOs) with over 4000 distributors based in 1200 sub-locations (Lewis, Keyonzo and Mott, 1992). While following a variety of program designs, all use community-based structures to provide clients with family planning information and services. CBD workers can directly supply pills, condoms and foaming tablets. Clients who wish to use injectables, sterilization and IUDs are referred to the nearest clinic. The 1993 DHS estimated that 2.5% of all current users of modern contraceptives were supplied by CBDs, with their contribution relatively larger for pills (6.3% of current users) and condoms (3.2% of current users).

The DDM/AMREF provider survey indicated that of the 94 facilities who responded to the question, over half (53%) had provided family planning services during the preceding year. There does not appear to be any clear pattern of difference by ownership, although hospitals and medical centers were both less likely to have provided these services than other types of facility.

Maternal and Perinatal Services

Unfortunately only information about the provider of antenatal care was captured in the DHS survey, and not the type of facility. More detailed information is available for delivery care.

Table 26 presents information about place of delivery. Overall, 55% of women deliver at home, 34% at public facilities, 7.4% at mission facilities, and 2.4% at private hospitals or clinics (KDHS, 1993). The proportion who deliver at home

19/ Personal communication, Mrs. Hellen Mbaabu, Deputy Programme Manager.

Table 26
Place of Delivery

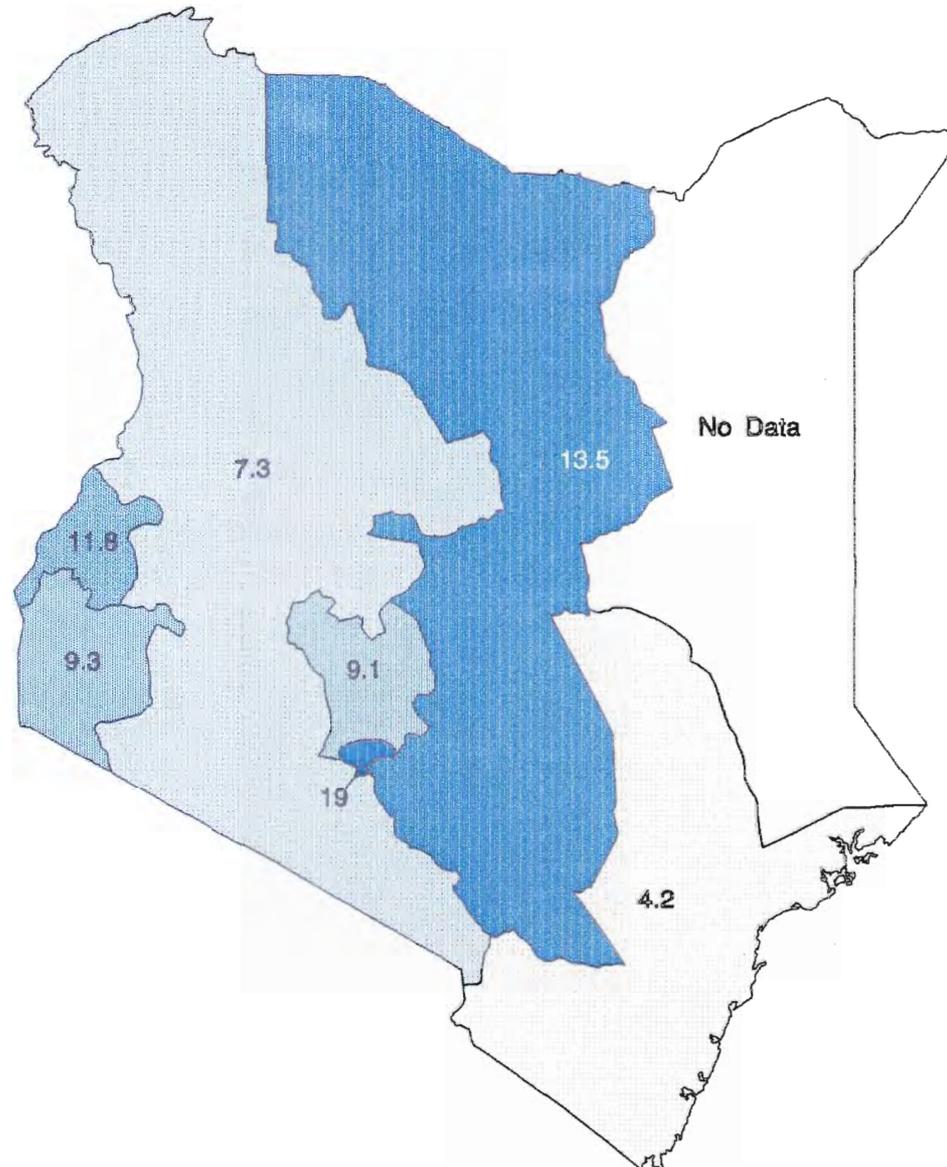
	<i>Home</i>	<i>Public</i>	<i>Mission</i>	<i>Private</i>	<i>Other</i>	<i>Missing</i>
RESIDENCE						
Urban	21.20	58.00	12.00	7.60	0.60	0.60
Rural	59.50	30.50	7.40	1.30	0.80	0.60
PROVINCE						
Nairobi	19.50	60.00	11.50	7.50	0.50	1.00
Central	26.60	63.40	7.40	1.70	0.90	0.00
Coast	67.90	26.70	1.50	2.70	0.20	1.00
Eastern	52.60	32.40	12.80	0.70	0.70	0.80
Nyanza	61.00	28.40	6.40	2.90	0.90	0.50
Rift Valley	59.80	31.60	5.80	1.50	0.70	0.60
Western	66.00	20.80	9.60	2.20	1.10	0.30
MOTHERS' EDUCATION						
None	76.70	16.90	3.80	1.20	0.40	1.10
Primary Incomp.	65.10	27.40	5.60	0.70	0.90	0.20
Primary Comp.	48.60	40.40	7.90	1.70	0.50	0.90
Secondary +	27.50	50.40	15.40	5.40	1.20	0.10
ALL BIRTHS	54.60	34.00	8.00	2.10	0.80	0.60

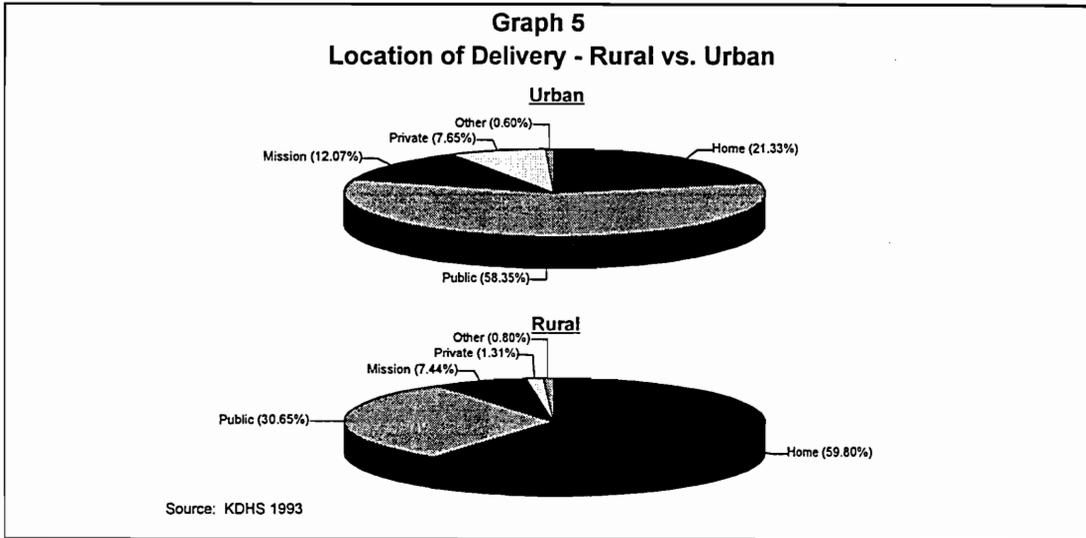
Source: KDHS 1993, p. 98

declines dramatically with education; of women with at least some secondary education, only 27.5% deliver at home; 50% deliver in public facilities, 15.4% in mission and 5.4% in private facilities. Once more, education may be capturing the effect of a number of other socioeconomic variables, such as place of work (implying access to insurance) and income. Mothers who reside in urban areas are more likely to deliver in a health facility than women in rural areas. Information about location of delivery for women in rural and urban areas is displayed in Graph 5. Delivery in private facilities is considerably higher in Nairobi than in other provinces, while delivery in mission facilities is most common in Eastern and Nairobi provinces (see Figure 11). Nairobi also has the smallest number of GOK facilities and the largest number of private maternity homes in the country. Many of the maternity homes have substantial capacity.

Trained and untrained traditional birth attendants together assist in over 20% of births (trained 8.7%; untrained 12.4%) (KDHS 1993). A recent survey conduct-

Figure 11 Births in mission/private facilities by province, Kenya 1993
Percentage of all births





ed by AMREF indicated high levels of TBA assistance for home births, ranging from 25% in Siaya district to 66% in Kisumu district (AMREF, unpublished report). Assistance by trained medical personnel decreases with parity, however, lower

order births are associated with higher risk. As expected, assistance by TBAs is much more common in rural than in urban areas. This is likely due to issues of accessibility of modern health facilities, and the difficulty of travelling once a woman is in labor (Hodgkin, 1994).

Communicable Diseases

Immunization

The recent immunization coverage survey (July 1994) provides evidence about the contribution of the private sector to EPI activities. Out of 359 children sampled, 81% were immunized in public facilities (outreach, dispensary, health center and hospital) and 18% in private facilities (Table 27). The contribution of the private sector was marginally higher in rural areas (18% vs. 16%), but this is not likely to be statistically significant. No distinction was made between private for-profit and mission/NGO services in the survey questionnaire.

Of the 94 facilities surveyed in the provider survey, only 37 (39%) had given any childhood immunizations during the year. Immunizations were more common at mission than for-profit facilities (36% of Catholic facilities and 63% of Protestant facilities had given immunizations, in contrast to 31% of sole practitioners and 14% of partnerships). Hospitals, health centers and maternity

Table 27
Immunization by Source

<i>Source</i>	<i>Rural</i>		<i>Urban</i>		<i>Total</i>	
	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>	<i>N</i>	<i>%</i>
Not Immunized	3	1	0	0	3	1
Gov't Outreach	18	7	0	0	18	5
Gov't Health Center	105	40	25	27	130	36
Gov't Dispensary	36	14	21	22	57	16
Gov't Hospital	54	20	33	35	87	24
Private Outreach	22	8	0	0	22	6
Private Health Center	6	2	1	1	7	2
Private Dispensary	15	6	3	3	18	5
Private Hospital	6	2	11	12	17	5
Total	265	100	94	100	359	100
Total Private		18		16		18
Total Public		80		84		81

Source: KEPI Coverage Survey July 1994, Central Bureau of Statistics.

tioners and 14% of partnerships). Hospitals, health centers and maternity homes were the types of health facility most likely to have administered childhood vaccinations.

Tuberculosis

Excluding cases occurring in refugee populations, 20,451 cases of tuberculosis were identified in 1993. This represents an increase of 40% over 1992 figures. The National Leprosy and Tuberculosis Programme (NLTP) estimates that 75% of the increase over the previous year is attributable to HIV infection, inferred from the age groups in which new cases are concentrated (15-35 years). The remainder of the increase is attributed to a combination of increased program activities resulting in improved reporting, and a dramatic rise in drug costs causing a switch from the private to the public sectors (NLTP, 1993). The impact of HIV infection is also being felt through increased tuberculosis case fatality rates. For HIV-infected patients, the TB case fatality rate is approximately 30%, considerably higher than the 5-8% rate amongst individuals not infected with HIV.

TB detection and treatment services in the country. Mission and NGO facilities which report TB cases to the NLTP receive drugs at no charge. Drugs are jointly funded by the Ministry of Health and a bilateral program of cooperation with the Netherlands. Cases occurring amongst refugee populations (5000 cases in 1993) are treated in health facilities run by UNHCR.

Of the approximately 20,000 cases of TB diagnosed in the general population in 1993, it is estimated that 20-30% were treated in mission facilities. Up to an additional 10-20% of cases may have been diagnosed in mission facilities and then referred to public sector facilities for treatment; therefore, the figure for cases actually treated may understate the overall contribution of the mission sector to TB-related activities (personal communication, Dr. Kibuga). This pattern of referral exists because individuals with TB are exempt from payment of user fees in public facilities. Although TB drugs are free in mission facilities, patients are usually required to pay the usual fee for hospitalization during the first 30-60 days of chemotherapy.

A rise in the cost of TB drugs in the private market is believed to have caused a reduction in the number of cases treated in the private sector. As in the case of the mission sector, the role played by private providers may be greater in diagnosis than in treatment. Although TB is a notifiable disease according to the Public Health Act, it has not been possible to enforce this requirement, largely because of both the time involved in filling out the notification forms, and issues of confidentiality.

According to the NLTP manager, the main issue in private sector treatment of TB concerns compliance with case management and chemotherapy guidelines. Anecdotal evidence suggests that because of use of short-course chemotherapy without adequate follow-up, the default rates in the private sector are considerably higher than in either the mission or public sectors. There is also evidence of inappropriate treatment regimes being used, contributing to drug resistance. Such quality of care problems are being addressed by the program management through seminars and other fora for training of private health professionals in case management. These events are reported to have been very popular with private physicians.

HIV/AIDS

The first cases of AIDS were diagnosed in Kenya in 1984. By July 1994 almost 50,000 cases were reported by the National AIDS Control Programme (NACP) (Daily Nation, 18 July 1994). It is estimated that the true number of cases is up to three times more than the number of reported cases. The number of people infected with HIV is estimated to be 841,700, of which 30,000 are children.

Trends in seropositivity are monitored by sentinel surveillance activities in 13

Trends in seropositivity are monitored by sentinel surveillance activities in 13 antenatal clinics in the country. Among pregnant women attending these clinics, HIV positivity rates more than doubled between 1990 and 1993, rising from 6% to 13% over the period. Overall, HIV positivity rates among women of reproductive age is estimated to be 7%. Upward trends in infection levels continue to be observed at all sites except for Kisumu where there are indications that the prevalence of infection is levelling at 20% (NACP, report presented to Donor Meeting, 25 August 1994). The potential economic impact of the AIDS epidemic has been examined in the National Development Plan, 1994-6 and in a study by AIDSTECH (Forsythe et al, 1993).

The contribution of the private sector to AIDS treatment and prevention activities is difficult to assess, however more than 60 NGOs are involved in HIV/AIDS activities in Kenya. A broad range of activities is undertaken by NGOs, including HIV/AIDS education and the production of education materials, counselling, provision of AIDS/STD education and alternative income generating opportunities for sex workers, home-based care, and AIDS orphan support. It appears that the contribution of the NGO sector to HIV/AIDS prevention and education activities is significant.

The Kenya AIDS NGOs Consortium, established in 1989, is a coordinating body which convenes more than 40 of these organizations regularly to share experiences and coordinate activities. They are currently developing a project tracking system which will enable them to better coordinate the type and geographical targeting of NGO activities.

Malaria

Malaria is the single largest cause of morbidity in the country, accounting for nearly 30% of all illness countrywide, and is the most common presenting complaint at health facilities. Although data are not available, the private sector contribution to malaria treatment is likely to be substantial. Disease-specific outpatient morbidity information is not available from the mission facilities, but the pattern of mission facility use for malaria is likely to parallel that of the public sector. Private chemists and pharmacies provide a wide range of anti-malarial drugs, including those designated as second-line drugs to be made available upon prescription only.

A series of district-level household surveys undertaken by the Ministry of Planning presents data for a specific category of health service utilization representing the purchase of over-the-counter drugs for self-medication for a number of common illnesses, including malaria. These data are summarized in Table 28 which shows that a significant proportion of episodes of malaria are self-treated using drugs purchased over-the-counter. In Kisumu and Kitui districts, self-medication is chosen for over half the episodes of malaria/fever. The modern

Table 28
Choice of Treatment for Malaria/Fever, by District

<i>District</i>	<i>Consulted Modern Health Facility</i>	<i>Drugs Purchased Over-the- Counter</i>	<i>Used Herbs</i>	<i>Traditional Healer</i>	<i>Did Nothing</i>
Embu	57.80	30.60	2.20	0.90	8.60
Kisumu*	42.00	50.00	4.00	2.00	2.00
Kitui	36.40	51.10	-	0.50	5.00
Kwale	50.30	39.20	4.60	2.60	5.00

* Question was asked about treatment choice for childhood illness

Source: GOK/UNICEF Household Welfare Monitoring and Evaluation Surveys, 1990, 1991, 1992

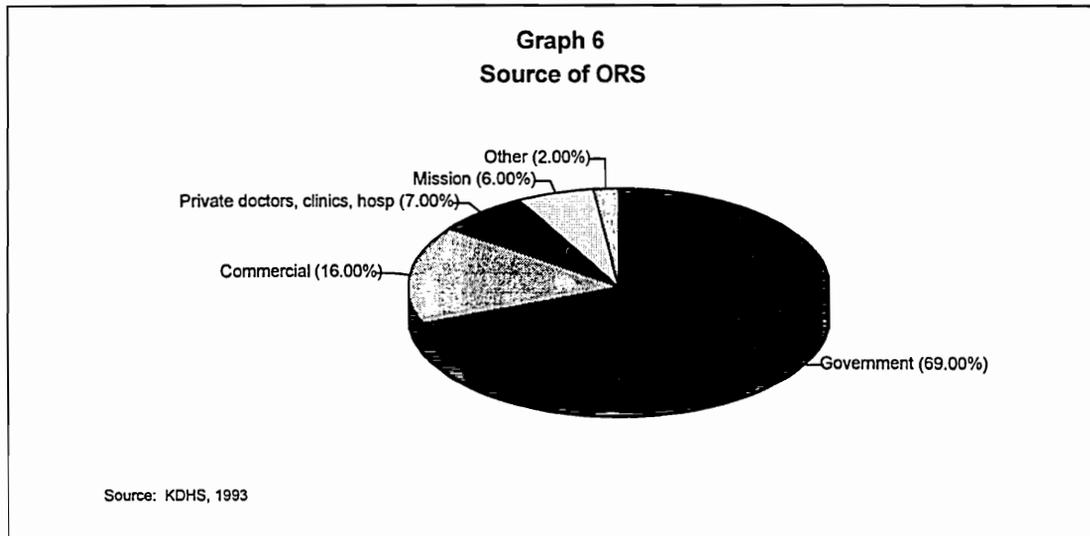
that at least some of the use of modern services takes place in the private sector (either mission or private for-profit), it is clear that the overall contribution of the private sector to malaria treatment is considerable. The private sector contribution to prevention activities, through the provision of bednets for example, is not as well documented. According to the provider survey, very few pharmacies/chemists sell bednets.

There are also a number of NGOs engaged in malaria-related activities in Kenya. AMREF is involved in a number of projects including research into the effectiveness and socioeconomic impact of impregnated bednets, community financing of malaria prevention activities, identification of alternative anti-malarial, and application of remote sensing and Geographical Information Systems (GIS) technology to malaria tracking. Many other NGOs include malaria treatment and prevention activities as part of their Community-Based Health Care programs.

Childhood Illness

Overall child mortality levels and trends were reviewed in Chapter 2. As estimated in the 1993 DHS survey, the two-week prevalence of illness among children under five was 18% for cough with rapid breathing, 42% for fever, and 14% for diarrhea and diarrhea with blood. Over 5% of children had diarrhea within the 24 hours preceding the survey.

The public sector remains the dominant source of oral rehydration solution (ORS) (69%) (see Graph 6). However the private sector contribution is significant, with shops providing ORS in 8.8% of cases, pharmacies in 6.7% and mission facilities in 5.6%. The private sector contribution is higher in urban than rural areas (35% v. 29%), and differs somewhat by province (Figure 12). The bulk of ORS consumed in the country is produced by local private pharma-



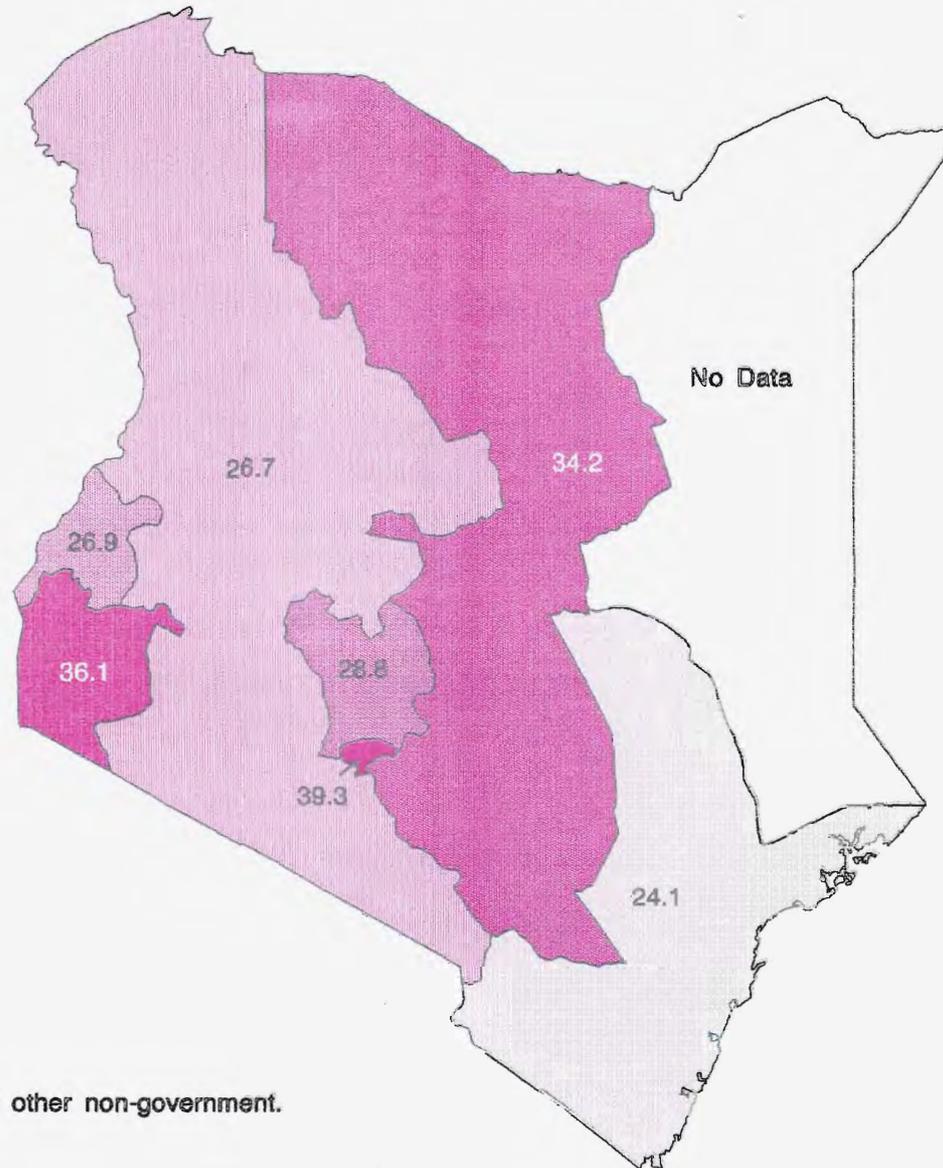
ceutical companies. Because of import taxes on raw materials and packaging, locally-produced ORS is about twice as expensive as its imported equivalent. Multiple brand-names are in use, and may be a source of confusion to both pharmacists and consumers.

A 1992 review of the Control of Diarrheal Disease program noted high levels of use of anti-diarrheals and widescale advertisement by drug companies promoting their use (KCDDP 1992). There is some evidence that children taken to public sector facilities for diarrheal illness are more likely to receive ORS. While 55-70% of children taken to government hospitals, health centers and health posts receive ORS, the proportions receiving ORS are much lower for private hospitals and clinics, (24%), private pharmacies (22%), private doctors (35%) and mission facilities (34%). Similarly, the likelihood of being treated with antibiotics appears to be higher in private hospitals/clinics and pharmacies, although this is not the case for private doctors or mission facilities (DDM analysis of KDHS 1993). Lack of information on the part of private providers about appropriate treatment of diarrhea, or lower profit margins on ORS are possible explanations for this treatment pattern. The absolute numbers taken to private facilities are smaller, though, so some caution is required in interpreting these findings.

The picture of drug use for diarrhea is confirmed by household-level data from the GOK/UNICEF Welfare Monitoring Surveys, which indicate that a large proportion of cases of diarrhea/vomiting are treated with drugs purchased over the counter, ranging from over 60% in Embu to 25% in Kitui. This suggests that pharmacies may be an important source of inappropriate drugs for treatment of diarrhea. Greater scope exists for education of both pharmacists and consumers in appropriate treatment of diarrhea. Social marketing of ORS through pharmacies and other retail outlets should be explored, using the successful experiences

Figure 12 Source of ORS by province, Kenya 1993

Percent from private sources*



*Private = Private, mission, shop and other non-government.

Source: KDHS, 1993
Analysis: Harvard/DDM

GIS: Harvard/DDM

of other countries.

The use of private providers for treatment of fever and cough in under-fives lies in approximately the same range as that for diarrhea. Overall, 26% of cases are treated in the private sector, of which 12% is shops and approximately 3% each by mission facilities, private hospitals/clinics, and private doctors. The rural-urban difference is even less marked than it is for diarrhea.

The Private Sector and the Public Health Agenda: Summary

Service Area	Private Contribution	Geographic Differences	Issues	Source
Family Planning	<ul style="list-style-type: none"> Medical private: 25% (of which mission, 8%; FPAK, 5%; private hospital/clinic, 8%; private doctor, 3%; pharmacy, 1%) Other private: 2% 		Magnitude of contribution of the private sector differs by method	KDHS 1993
Antenatal Care	Not available			
Delivery	<ul style="list-style-type: none"> Private 10% (Mission, 7%, private hospital/clinic, 2%) 	<ul style="list-style-type: none"> Urban: private contribution is 20% v. 8% in rural areas; Private contribution is highest in Nairobi (21%) and Eastern (15%); lowest in Coast and Rift Valley (each 7%). 		KDHS 1993
Treatment of Diarrhoea (<5)	Private 22%	<ul style="list-style-type: none"> Urban: private contribution is 14% v. 24% in rural areas Private contribution is highest in Eastern (29%) and Nyanza (27%); lowest in Nairobi (11%) and Central (13%). 	<ul style="list-style-type: none"> Most important private source: Rural - Shop, Urban - private hospital/clinic, private doctor Private providers less likely to treat with ORS and more likely to use antibiotics than public sector 	KDHS 1993
Source of ORS	<ul style="list-style-type: none"> Private 30%, of which: shop, 9%; pharmacy, 7%; mission, 6%; private hospital/clinic, 4%; private doctor, 3%. 	<ul style="list-style-type: none"> Urban: private contribution is 35% v. 29% in rural areas; Private contribution highest in Nairobi (39%) and Nyanza (34%); lowest in Coast (23%) and Western (26%) 	<ul style="list-style-type: none"> Most important private source: Rural - Shop, Urban - Pharmacy 	KDHS 1993
Immunization	Private = 18%		Information not available to disaggregate mission and for-profit	CBS EPI coverage survey 1994
Treatment of Fever/Cough (<5)	<ul style="list-style-type: none"> Private 27%; of which: shop, 12%; mission, 4%; private hosp/clinic 4%; private doctor 3%; other NGO, 2%; and pharmacy, 1%. 	<ul style="list-style-type: none"> Urban 30% v. 26% in rural areas; Private contribution highest in Nairobi (34%) and Eastern (29%); lowest in Western (22%) and Rift Valley (25%). 	<ul style="list-style-type: none"> Most important private provider: Urban and rural: shop No striking differences in treatment type of source of care 	KDHS 1993
Treatment of Malaria (all ages)	Private 30-50%		For drugs purchased over-the-counter only	GOK/UNICEF household surveys 1990/2
Tuberculosis	Private: minimum 20- 30% (missions)		For treatment. Role of missions and private sector may be higher for diagnosis than treatment	Estimate, National Leprosy and TB program

7 Factors and Public Policies which Affect the Private Sector

There are a number of ways in which public policy affects the operations of the private health care sector. Some of these affect the overall environment within which the private sector operates. This group of factors includes the political system and political ideology, the overall availability of infrastructure, the availability of technology, and the macroeconomic management issues influencing the availability of credit. A further environmental issue concerns the nature of disease patterns and distribution, and the extent to which the health transition affects differential utilization of health care providers. A second group of factors are public policies which act directly on health care providers (either government or private), and which affect the operations of private health care providers. These can be grouped into public provision, taxes and subsidies, regulation and licensing, insurance, and factor market interventions. In this section we begin by reviewing the policies which affect the overall environment, and then consider the specific mechanisms through which private provision is affected by government policy. Regulation and licensing issues are reviewed in the next chapter.

Factors Affecting the Environment within which the Private Sector Operates

Political System and Property Rights

The political system of a country is an important expression of that country's views on the issue of property rights. This determines how private enterprise operates, exerting a powerful influence on individual initiative. Kenya's political philosophy has espoused a free mixed-economy system with both government and private provision of goods and services. In the area of health, the GOK, religious organizations (Christian and Moslem), the for-profit private sector and a host of NGOs are all engaged in the provision of services.

This has created a nominally competitive system, offering consumers a fairly large set of providers from which to choose. Kenyan laws guarantee private ownership and protect individuals from expropriation. This has had the effect of

removing uncertainty in the areas of property rights, and may act as an impetus to growth in all sectors of the economy including the health sector.

Provision of Infrastructure

While the provision of infrastructure may not be a sufficient condition for the growth of the private provision sector, it is a necessary one. The availability of infrastructure is a major determinant of how economic agents respond to new opportunities and to changes in transactions costs. Water, electricity, telephones, etc., are all necessary inputs to the production of health services. Their development affects the size of the market and increases effective demand, thus enabling health care providers to exploit economies of scale.

In Kenya, weak infrastructural development is a constraint on the development of the private health sector, particularly in rural areas. In the provider survey, many pharmacists identified transport costs as the second most binding constraint on their activities. Although reasonable progress has been made in the provision of infrastructure since independence, much remains to be done. The road network is in bad shape and only 10% of rural areas have electricity.

Technology

The impact of technology on the development of the private sector lies more in the area of diffusion of technology than in the generation of new ideas. In Kenya, radiology technology has been so well diffused that there are now a substantial number of private X-ray laboratories in the major cities. The availability of private diagnostic labs has made it possible for physicians who otherwise might not have done so, to venture into private practice: rather than undertaking expensive capital investment in laboratory facilities, they are able to refer patients to a private facility. Similarly, because several ways of treating illnesses and diseases have been reasonably diffused, clinical officers and nurses can now set up private practice and operate without a doctor's supervision. Although the direction of causation is not clear, it is plausible that the diffusion of medical technology in Kenya has added impetus to the growth of the private provision sector.

To the extent that government exerts control over technology acquisition and location (because of efficiency considerations), this can also act as an impediment to the development of the private sector²⁰. We did not identify, however, any evidence of regulation of this particular area in Kenya.

Credit

The health sector is capital intensive, requiring large initial capital outlays and

20/ An indirect way of controlling technology acquisition is through control over access to foreign exchange. With liberalization of foreign exchange markets in Kenya (initially in 1991, with full liberalization in 1993) this is no longer an important factor.

working capital for the day-to-day running of the health facility. Landlords commonly require several years' rent in advance. In addition, doctors in private practice are required to purchase malpractice insurance at a cost of approximately KSh. 3000 per month (public sector doctors' salaries are currently KSh. 5000 per month) and are required by the provisions of the Medical Practitioners and Dentists Act to hold an adequate stock of drugs. These are visible constraints on doctors and other health professionals who are considering establishing a private practice.

Although Kenya has a fairly developed capital market, credit constraint is a fact of business life. Asymmetric information and moral hazard are serious. There is not enough collateral to secure loans and because of the specificity of medical facilities, their liquidation value may be low, making lending to the health sector even less attractive. Indeed the problem of low liquidation value may be exacerbated by the low level of wealth in the country in general and the illiquidity of the financial market. These factors thus lead banks and other financial institutions to ration credit.

The credit situation is not helped by prevailing economic conditions in the country. During the past year the GOK has been pursuing a tight monetary policy to rein in inflation and stabilize the economy. Money creation fell from 35% in 1992 to 28% in 1993 whilst the reserve requirement has been raised from 30% to 50%. This has resulted in the contraction of bank credit to the economy and a steep rise in the cost of funds. Credit to the private sector grew by only 6%²¹.

Because of the high cost of funds, health providers seek to finance their activities using other mechanisms. Most businesses are self-financed. According to Kibua (1992) most private providers in Kenya used own-savings to finance the startup of their practices. The provider survey identified a number of other mechanisms, the most important of which is trade credit (see Table A.1.7 in Appendix 1).

Unlike the agricultural and industrial sectors, there are no specialized financial institutions lending to health providers. Certain types of provider may have more limited access to credit than others. According to the evidence from the provider survey, hospitals are much more likely to obtain credit from banks than private clinics. In addition to regular commercial credit, some private laboratories report receiving substantial loans from medical equipment suppliers (in one case, a loan of KSh. 1 million, repayable over three years). There may be other ways to get around the credit constraint; according to the 1994 Auditor-General's report, the extent of pilfering of drugs and medical equipment from the public sector is enormous. A 1993 survey by McCann & Ericsson reported that some drugs dispensed in private clinics bore the GOK stamp on them.

In the case of religious organizations, capital for expansion comes from donations (local and foreign) and government capital grants/matching grants. As far

21/ We note here that this contraction is largely due to reductions in GOK borrowing from the financial market.

as this research could establish, only one mission facility, Chogoria PCEA Hospital has borrowed from the capital market in the recent past. Chogoria is also a large recipient of donor funds (from USAID and the Japanese government especially).

Government Policies that Influence the Development of the Private Sector

Public Provision

Direct public provision of services

An important interaction between the public and private sectors is competition: by directly providing health services, the government competes with the private sector. When government services were essentially free of charge, and before the current financing crisis began to cause serious deterioration in the quality of public sector services, the considerable network of public facilities provided an attractive alternative to fee-paying private services, and may have acted as a deterrent to the development of the private sector. In some instances this continues to be the case. For example, capacity in GOK facilities as measured by the number of beds may deter private providers from entry in certain locations. In Nakuru, Pine Breeze hospital has delayed expansion because "the provincial hospital has an amenity ward and is too large". Similarly, the Nakuru War Memorial hospital, which shares the same grounds with the amenity ward section of the provincial hospital, has no radiology department because this service is provided by the PGH. In other cases there is duplication of health facilities in geographical areas while others remain relatively underserved. The Ministry's Five-Year Financing Plan advocates better coordination between sectors of the location of health facilities. The plan envisions assigning the role of district hospitals to mission/NGO facilities in those districts where government district hospitals do not exist, in order to avoid duplication of infrastructure.

Cost-sharing in the public sector

At Independence in 1963, the new government committed itself to providing universal access to medical services. Soon after, the pre-independence attendance fee of KSh. 5 per visit was discontinued, although nominal fees remained in place for inpatient care and selected outpatient services.

In December 1989, the Government introduced an expanded fee schedule as part of its "cost-sharing" program. Cost sharing was also introduced in other sectors such as education and agriculture. These new health service fees result-

ed in significant decreases in the utilization of government facilities. Under considerable political pressure, the outpatient registration fee was suspended in September 1990. Although widely perceived to be an abandoning of the policy of cost-sharing (Mbiti et. al. 1993), all other fees which were introduced in December 1989 remained in place. With the start of the USAID-funded Kenya Health Care Financing Project in 1991, a program of strengthening of the fee collection and management system began, first with the PGHs and Kenyatta National Hospital in April/June 1991, and gradually extending to district hospitals in May 1992. Outpatient treatment fees were introduced in health centers in July 1993. Since then there have been periodic fee increases, and the gradual introduction of new fees, such as maternity and theater fees. Fees were increased again in October 1994.

Impact of cost-sharing on utilization of public services

The following section draws heavily on the results of a recent evaluation of the cost-sharing program (Quick and Musau, 1994).

Two basic features need to be distinguished when considering the impact of user fees on utilization. First is the trend decrease in utilization of government facilities. The other is the more immediate change in utilization following the introduction of user charges in government facilities. Analysis of utilization data for government health facilities in a number of districts has been undertaken by the Kenya Health Care Financing Project. Their analysis shows that there was a decrease in general outpatient attendance of 27 to 45% in government hospitals and health centers associated with the introduction of the outpatient registration fee in December 1989²². When the OPD registration fee was suspended in September 1990 utilization returned to its previous (downward) trend path. Modest (6%) and statistically insignificant declines in OPD attendance were associated with the introduction of the treatment fee in provincial hospitals in April - June 1991 and district hospitals in May 1992.

The same KHCFP data suggest that the introduction of cost-sharing does not appear to have adversely affected the number of inpatient admissions. Nor does it seem to have had an effect on inpatient mortality rates or average length of stay at hospitals. This suggests that people were not measurably sicker by the time they reached inpatient facilities. Child welfare, post-natal and family planning service utilization, all of which remained free-of-charge, do not appear to have been adversely affected by fees for outpatient care. There is evidence, however, of an early decrease in utilization of antenatal care after the introduction of the outpatient registration fee in December 1989.

22/ Large declines in utilization following the introduction of user fees in public facilities were also recorded in a longitudinal study of household health seeking in Kibwezi (Mbugua et al., no date)

Impact of cost-sharing on quality of care in public facilities

The only empirical information regarding quality change in government health care facilities is from the evaluation of cost sharing conducted by the KHCFP. These data, however, relate to the status of government health facilities as of May 1993. At that time, the most marked improvements in patient satisfaction as measured by surveys conducted before and after the introduction of OPD treatment fees, had been in Provincial General Hospitals. Perceived quality in district and sub-district hospitals had not improved. Drug shortages remained common in public facilities, with improvements in drug availability most commonly mentioned by patients as the most important area for strengthening. However, it is likely to have been too early to observe any widespread changes resulting from the introduction of cost sharing. More recent anecdotal evidence suggests a somewhat mixed picture of quality changes, with improvements in some facilities, and continued deteriorations in others. In face of declining real levels of government expenditure, it may be that the existence of cost-sharing revenue is simply allowing facilities to maintain existing levels of care, or at worst, to slow down the rate of deterioration. It appears that despite the fact that Ministry of Health guidelines on expenditure of Facility Improvement Fund revenues explicitly discourage their use for ordinary operating expenses, a significant proportion of cost-sharing revenues have continued to be used to pay for water, electricity, and essential patient care items which are supposed to be purchased from central government funds. According to Quick and Musau (1994) "most districts report that FIF [Facility Improvement Fund] revenue is being used primarily to maintain patient care services rather than to make substantive facility improvements."

Possible impact of cost-sharing on private providers

Without widespread and sustained improvements in the quality of services available in the public sector, we would expect an increase in the cost to the patient of seeking care in government facilities to result in switching of utilization from public to private sources of care. It is thus interesting to note that aside from the longer-term trend decrease in utilization of government facilities, and the short-term fall in utilization associated with the introduction of the registration fee, the KHCFP data do not show any evidence of widespread switching away from the government sector. From the side of the private provision sector, available data do not permit a comprehensive evaluation of this hypothesis. We have, however, examined utilization data from facilities operating under the umbrella of the Kenya Catholic Secretariat and Chogoria (see Tables 29 and 30). Although there was a small increase in inpatient admissions to Catholic mission hospitals, the overall trend for both outpatient and inpatient utilization at KCS facilities is also downwards.

Table 29
Inpatient Utilization Trends - Selected Mission Facilities

	1989	1990	1991	1992	1993
CHOGORIA HOSPITAL					
Admissions	10,256	9,295	7,347	11,009	12,669
ALOS	9.30	8.80	10.10	9.40	10.70
Occupancy Rate	0.85	0.73	0.66	0.95	1.18
KENYA CATHOLIC SECRETARIAT					
Admissions	170,436	183,606	183,081	183,081	158,558
ALOS	8.42	8.35	8.45	8.45	6.90
Occupancy	0.71	0.73	0.75	0.75	0.65

Source: Kenya Catholic Secretariat Annual Statistical Reports, various years; Chogoria Hospital Annual report, 1990, 1993.

Without evidence of widespread switching out of the public sector, the main utilization "puzzle" to be solved relates to the trend decrease in utilization which is observed for government facilities and certain mission facilities. This trend reduction in utilization of public sector services reflects either switching to other sources of care (for example, the private for-profit sector, to traditional healers, to self-care and pharmacies) or to no care. Unfortunately, data are not available to examine attendance trends for other private providers (for example, traditional healers or clinics operated by clinical officers and nurses). Population-based utilization rates need to be carefully examined to determine whether there is a secular declining trend in health service utilization and the extent to which the utilization of other providers is increasing.

Other public sector financing issues

Although it does not fit easily into the category of "policy", the long-term secular decrease in real Ministry of Health expenditures appears to have had an effect on the private sector. It is a commonly-held feeling that at least part of the recent growth in the private sector is related to the widespread deterioration of the availability and quality of services in the public sector. One Ministry of Health official reported that "the only business which is booming in Kenya is the private medical business".

The effect of this under-funding is not restricted to clinical services. Although only anecdotal evidence is available, discussions with a number of private laboratories suggest that an important impetus for the recent boom in private labora-

Table 30
Outpatient Utilization Trends - Selected Mission Facilities

<i>Facility (ies)</i>	<i>1989</i>	<i>1990</i>	<i>1991</i>	<i>1992</i>	<i>1993</i>
CHOGORIA HOSPITAL					
Hospital OPD	50,509	41,726	45,834	51,504	62,913
Clinics	117,058	132,622	135,542	155,557	184,501
KENYA CATHOLIC SECRETARIAT					
Hospitals	1,556,05	1,194,79	1,537,10	1,106,76	1,177,61
Cottage/Grade III Hospitals	1,563,90	1,832,38	1,697,08	1,274,08	1,143,84
Sub- Center/Dispensaries	1,703,03	1,487,63	1,493,01	1,333,88	2,159,86

Source: Kenya Catholic Secretariat Statistical Reports, 1989-93
 Chogoria Hospital Annual Reports, 1990, 1993

tory services has been the absence of re-agents and equipment in public hospitals. Referrals from government hospitals to private laboratories were said to be relatively common. Similarly, private x-ray services in major towns are flourishing because of equipment malfunctions and lack of supplies in radiography facilities in government hospitals.

The decline in public sector resource availability appears to be having a negative impact on mission health services. In the past these organizations received substantial financial support from the MOH in the form of grants and subventions. This support has declined significantly in the last five years.

Taxes and Subsidies

Taxes and subsidies to consumers

Health services can be subject to both direct taxation and indirect taxation. In turn, taxes may be levied on the consumer or the producer, with differing implications for quantity demanded or supplied depending on the relative elasticities. In Kenya, health services and direct inputs into health services such as drugs and equipment are not subject to value-added tax, although some inputs are subject to import duty. The direct tax treatment of health expenditures differs somewhat between employers and individuals, and the nature of the payment.

Tax treatment of individually purchased health services/insurance

Individual out-of-pocket expenses on health services are not deductible against taxable income. This is also true of individually-purchased health insurance, although a small allowance can be claimed (reported to be maximum of KSh. 720 per year). Furthermore, *ad hoc* payment of health expenses by an individual's employer is treated as ordinary income to that person, and subject to income tax.

Direct taxation of corporate health expenses

As long as a company health scheme (either insurance, directly provided health services, or reimbursement of out-of-pocket employee health expenses) applies to *all* employees, these expenditures can be treated as part of ordinary business expenses and deducted from taxable income. Given a corporate tax rate of 37.5%, this considerably reduces the effective cost to the employer of providing health care.

Import and other taxes

The taxes which affect private providers of health services include import duties and corporate taxes. Non-governmental organizations are permitted to request a 50% reduction in the import duty payable on imports of medical supplies and equipment. Each request must be submitted through the Ministry of Health separately, as blanket authorizations for duty exemption are not made. There are reports of considerable delays in processing of these waiver applications. In some cases the costs of these delays may outweigh any savings from the duty exemption.

An issue which arose in the literature review concerned import duties applicable to the local production of ORS. Although ORS itself can be imported duty-free, the raw materials and packaging required for local production are subject to both import and value-added taxes. The resulting price differential between imported and locally-produced ORS is significant: one liter of imported ORS costs approximately KSh 3.5, while the locally-produced equivalent costs approximately KSh 7 (1992 prices). Tax exemptions have since been permitted for dextrose and printed aluminum laminate (for packaging), provided the material is used for ORS production (CDD Focused Programme Review, 1992).

Other taxes pertaining to health services include taxes levied on the insurance companies. These are the insurance premium tax (2.5% of total premia paid), and the insurance training tax, revenues from which are used to finance the office of the Commissioner of Insurance; and the insurance training tax (0.35% of total premia), used to support the running costs of the Insurance Training

College.

Direct public subsidies to private providers

In Kenya, public resource transfers to the private sector take place by several methods:

- Direct cash transfers to NGOs;
- Provision of medical equipment and supplies, vehicles, drugs, vaccines, contraceptives and other commodities. In some cases these are provided by donor agencies and channeled to NGOs through the public sector supply system;
- Support to NGO activities such as consultancies, construction and upgrading of facilities. Payments for such services are made by the Ministry of Health without necessarily transferring the cash to the NGOs;
- Support through the National Council for Population and Development to organizations dealing with population and family planning;
- Secondment of health personnel to NGO institutions. These include doctors, clinical officers, nurses and hospital administrators;
- Duty exemptions for health-related non-profit organizations.

Table 31 provides information on the estimated value of these transfers over time. Information about the magnitude of duty exemptions is difficult to obtain because of the way records of such exemptions are kept. Secondment of government officers takes place at Provincial level and thus it was not possible to collect information about all government personnel seconded to NGO facilities.

Medical education

One of the most important subsidies to the private sector occurs through the public financing of medical education. There is an expressed intention to introduce cost-sharing in universities for medical education. This will obviously affect the pool of applicants wanting to become doctors and affect the supply of labor to this sector in the future.

Assessing the public sector subsidy to the private sector

Ideally, it would be desirable to assess the "appropriateness" of the public sector subsidy to private health care providers. This could be in terms of the type of services provided (whether they are targeted at priority services, at cost-effec-

Table 31**GOK Subsidies to NGO Health Providers through the Ministry of Health, Current Kenyan Shillings**

<i>Year</i>	<i>Direct Cash</i>	<i>Capital Grants</i>	<i>Other Grants</i>	<i>Total Grants</i>	<i>Grants as a % of GOK Health Expenditures</i>
1982/83	39,212,600	5,000,000	1,461,060	6,461,060	0.40
1983/84	38,500,620	5,000,000	6,809,980	11,809,980	0.80
1984/85	40,080,700	5,000,000	33,150,640	38,150,640	2.30
1985/86	40,991,280	5,000,000	15,908,360	20,908,360	1.20
1986/87	34,449,000	6,009,860	6,129,400	12,169,260	0.40
1987/88	29,899,660	5,604,700	71,680,160	77,284,860	3.30
1988/89	14,952,540	6,000,000	6,800,980	10,800,980	0.80
1989/90	19,535,500	2,846,920	604,100	3,451,020	0.01
1990/91	22,111,260	89,020	172,220	261,240	0.06
1991/92	7,254,500	2,973,600	-	2,973,600	4.80

Source: Controller and Auditor General's Reports on Appropriation Accounts for the Ministry of Health, various years.

tive interventions, whether they are public goods or goods with positive externalities which would tend to be under-provided by the private market and the populations served. With the information presently available it is difficult to make such an assessment. There is no evidence to suggest that any of the direct grants (cash or commodities) by the Ministry of Health to non-government organizations are inappropriate as defined by the above criteria. More detailed information would be needed to consider the beneficiaries of any "implicit" subsidies: for example, the extent to which government may be subsidizing care in its amenity wards by charging less than full cost.

Insurance: The National Hospital Insurance Fund

All NHIF-approved health facilities (hospitals, maternity homes and nursing homes in the public, NGO and private for-profit sectors) make claims for reimbursement for care provided to NHIF members and beneficiaries. In order to qualify to make claims from the NHIF, inpatient facilities must be first approved by the Ministry of Health acting through the agency of the Medical Practitioners and Dentists Board. Facilities are thereafter inspected by the NHIF and approved if the minimal conditions are met.

Facilities are reimbursed a flat rate per day irrespective of the type of ailment, up

to a maximum of 180 days per family per year. There is also a length-of-stay limit. Reimbursement rates are based on the type and level of facility and range from KSh. 80 to KSh. 450 per inpatient day. Kenyatta National Hospital is considered a special hospital and is granted a reimbursement rate of KSh 650.

NHIF and provider incentives

The criteria according to which NHIF establishes reimbursement rates for health facilities has two perverse incentive effects on providers. First, because the reimbursement rate is dependent on, among other things, the bed capacity of the facility, private providers have an incentive to either expand capacity or to misrepresent their capacity so as to be assessed a higher reimbursement rate. Although there is considerable under-utilization of capacity in the sector, the number of private inpatient facilities continues to grow and some existing facilities are expanding their capacity. Others have simply changed their name from hospital to nursing home, thereby qualifying for a higher reimbursement level.

Secondly, the NHIF may create incentives for frivolous inpatient admissions, and for longer length-of-stay than is necessary. Evidence provided by the Kenya Health Care Financing Project shows that the average length of stay in private health facilities has risen since 1989.

NHIF and the structure of the private hospital sector

The NHIF may reduce the incentive for hospitals and nursing homes to seek economies of scale, leading to a fairly fragmented sector. Of the 295 health facilities approved by the NHIF, about 78 (26%) have 50 beds or less (a number have less than 20). Yet empirical evidence shows that hospitals begin to achieve economies of scale from 200 beds and above.

NHIF and transactions costs

The manner in which the NHIF is organized raises transactions costs. It is highly centralized in Nairobi, where all claims are processed. Health facilities in the rest of the country are required to make monthly trips to Nairobi to pursue claims. The processing of claims is slow because a large part of the process is yet to be computerized. There are allegations of fraud whereby claimants are required to pay NHIF officers in order to have their claims expedited. According to one mission hospital administrator, it takes the clerk at least 3 days to get claims processed at the NHIF, while the for-profit providers spend at most a day. These transactions costs may be a source of pressure on the fees charged by private health care providers.

In addition, delays in the issue of NHIF membership cards have acted to restrict

NHIF reimbursement. It is reported that members may be without cards (and thus, without access to benefits) for up to one-third of the year. This may help to explain how the NHIF accumulates its operating surplus.

NHIF and crowding out of other forms of risk sharing

The NHIF is the primary mechanism for risk-sharing in the country. Private insurance supplements its benefits. As has been discussed elsewhere in this report, the administration cost of private insurers in Kenya is high because of high taxes and other levies imposed on it by the government. Hence private insurers focus their canvassing on wealthy individuals, the expatriate sector and those Kenyans in wage employment in the formal sector in order to reduce actuarial risk. Combined with the widespread practice of employers directly providing health services to their employees or purchasing these from private providers, the NHIF has helped to slow the growth in demand for other insurance.

How appropriate is the NHIF?

The NHIF is a hospital insurance scheme, not a health insurance scheme, because it pays only for inpatient services. It pays for less than half of a typical inpatient bill in the private for-profit sector in urban areas. Although benefits rates have been increased twice since the outset of the cost-sharing program, NHIF reimbursement levels remain a small proportion of the total costs of care in many for-profit facilities. In addition, the fee structure provides few incentives for improved quality.

Interventions in Factor Markets

Labor market issues

Government policies which have directly affected the availability of personnel to the private sector include the practice of permitting government-employed consultant physicians to work in private practice, and the Acts which have permitted nurses and clinical officers to operate private practice conditional upon leaving public service. Public sector wage policy has had an indirect effect on the private sector by ensuring a constant flow of trained medical professionals out of public service to the private sector.

Wage policy in the public sector

The low level of salaries paid to those working in the public sector has had the effect of ensuring a steady flow of trained health personnel into the private for-

profit sector. Doctors working in private practice are reported to earn two to three times more than their public sector counterparts (Bloom and Segall 1993).

After the 1994 doctors' strike, physicians in the public service were paid KSh. 11,000 per month. This is in comparison with, for example, pharmacists working in the private sector who typically receive a starting salary in the region of KSh. 20,000 (Dr. Ombega, personal communication).

Different parts of the private sector differ in their ability to benefit from this outflow from the public sector. For example, mission facilities report some difficulty attracting skilled personnel. Discussions with mission organizations revealed that the lack of pension arrangements and loss of a guaranteed "job for life" because of the practice of short-term contracts in the mission sector are important reasons why the mission sector is not as attractive to Kenyan health professionals.

Education and training

Well-qualified medical professionals are a prerequisite for a well-functioning health system. The GOK has expanded local capacity to train qualified and skilled medical personnel in line with the high rate of expansion of health infrastructure in the immediate post-independence years. Kenya now trains most of the doctors and other medical personnel such as nurses, clinical officers, pharmacists and pharmaceutical technologists locally. A few still study overseas, particularly for specialist training. As of July 1994 there were about 38,000 health personnel in Kenya, about 9% (3,554) of whom are doctors²³. Of these doctors, only 770 (excluding specialists) worked in the public sector. The residual 80% worked in the non-governmental sector and the Ministry of Defense²⁴.

There are two medical schools in Kenya: the University of Nairobi and Moi University. The University of Nairobi also has a post-graduate program in internal medicine and in obstetrics/gynecology. Tuition for medical training programs is KSh. 50-60,000 per year. Approximately 90% of this is subsidized by the GOK, and loans are available to finance the balance. In addition, students receive a quarterly stipend and book allowance. The GOK has expressed its intention to introduce a greater degree of cost-sharing in its educational institutions. This may have a long term impact on the availability of medical personnel, given the low levels of ability to pay. Mission health facilities run a few nursing schools where enrolled and registered nurses are trained.

The potential for the mission sector to enhance its contribution to the supply of health professionals in the country is constrained by two factors. First, although mission nursing schools are accredited by the MOH and the Nursing Council of Kenya, graduates from mission nursing schools face labor market discrimination in access to GOK posts. It was reported to the research team that nurses

23/ This includes dentists. The actual number of physicians may be lower.

24/ This number is likely to be smaller. In September 1994, the GOK dismissed over 300 striking government doctors and dentists. The doctors had been pressing for better terms and conditions of service and for the registration of their union, the Medical Practitioners and Dentists Union.

trained in mission nursing institutions are more likely to be unemployed upon graduation and that their duration of unemployment is usually longer than for equally-qualified graduates from GOK institutions. Second, mission hospitals are not accredited for training of medical undergraduates.

Local training of health professionals is supplemented by constant inflows of volunteer doctors and other health professionals into the mission sector. By providing services in the mission facilities, they free up Kenyans who would otherwise have accepted positions in the mission hospitals to work in the private sector. A major problem with the training of medical professionals in Kenya is the inability of mission facilities to secure places in GOK-run training schools (MTCs). KCS, for example, has been unable to secure places for its equally-qualified candidates to train as radiologists in the MTC.

The availability of capital and credit

The macroeconomic background to the problem of credit constraint was outlined above. The important public policy issue relates to the absence of intervention in the form of financial institutions specializing in health sector finance.

One way in which government acts indirectly as a provider of credit is by acting as guarantor of last resort to mission facilities. In recent years a number of mission hospitals have encountered severe management and financing difficulties. Because the Ministry of Health is ultimately responsible for all health facilities in the country, it has the right to take over the management of such facilities through the appointment of an outside caretaker Management Board which remains in place until such a time as the Minister (through the Provincial Medical Officer) is satisfied that the problems have been rectified. The potential effect of such a policy is clear: like any business which is provided with a guarantee of continued funding should it run into difficulties, there is less incentive for efficient operations and investment strategies. Missions do not like to be taken over by government, and may resist such takeovers. The relevant empirical question here is whether it would be more cost-effective for the government to provide more regular subsidies/grants to support mission facilities than to take them over when they have reached a state of financial crisis.

Public information

Public policy in the area of the dissemination of public health information has a direct impact on private providers. Evidence from the provider survey indicates that as many as 70% of the providers in the sample did not receive relevant public health information from the Ministry of Health. These include information on treatment guidelines for certain diseases, public health materials and national drug formulary (see Table 32).

Table 32
Health Information from MOH received by Private Health Providers

Type of Information	<i>Hospitals, Clinics and Dispensaries</i>		<i>Pharmacies</i>	
	N (105)	% Receiving	N (52)	% Receiving
Treatment Guidelines	33	31.40	7	13.50
National Drug Formulary	28	28.00	9	17.30
Public Health Information	44	42.00	11	21.20
List of Approved/Banned Drugs	38	38.00	11	21.20
Other Types of Information	-	-	2	0.04
No Information at All	25	25.00	-	-

Source: DDM/AMREF Provider Survey, 1994

The matrix below summarizes these public policies which have an impact on private health care providers.

Public Policies which Affect the Private Sector: Summary

<i>Policy Instrument</i>	<i>Policy Intervention</i>	<i>Private Providers Affected</i>
Public Provision	Government production Cost sharing Resource shortages	All All All
Taxes and Subsidies	Tax treatment of personal and corporate health expenditures Corporate tax treatment of private providers Insurance premium tax; Training Tax Subsidies to mission sector; provision of commodities	For-profit For-profit providers Insurance Firms Mission sector NGO'S
Insurance and Cost-Sharing	NHIF/Harambee	Inpatient facilities
Factor Market Interventions	Labor market: Public Sector Wage Policy; Education and Training Capital market: Lack of Special Credit Facilities Government Guarantee of Missions Technology: Lack of government regulation of technology acquisition	All. Missions are most affected. Most cannot get places in government institutions for their candidates and their candidates are assessed higher fees than their GOK counterparts. All Mission sector Mostly for-profit
Public Provision	Provision of information to providers; Policies on provision of information to consumers	All

25/ This privilege is not extended to junior doctors in public service. This asymmetry in practice (and income-earning) opportunities is an important reason behind the recent breakaway of the junior doctors to form the Medical and Dental Practitioners Union.

26/ It is interesting to speculate that the direction of causation is indeed the reverse: that the possibility of practicing privately is the factor which ensures a ready supply of consultants to the public sector.

8 Laws and Regulations

Laws and regulations are yet another mechanism which affects the operation of the private sector. In a private enterprise economy laws serve three principal functions: they define property rights, regulate the terms and conditions of exchange between free individuals and provide a framework for the resolution of conflicts between parties in free exchange. Consequently they affect the structure of incentives facing economic actors and the behavior of those actors. The purpose of this section is to review and discuss the impact of Kenyan laws affecting private health providers.

Regulation of Private Practice

The Ministry of Health has overall responsibility for regulating the private provision sector. However, day-to-day oversight is exercised by four statutory bodies in the Ministry: the Medical Practitioners and Dentists Board (MPDB), the Clinical Officers Council, the Nursing Council, and the Pharmacy and Poisons Board. In addition to registering all newly qualified medical doctors and dentists in the country, the Medical Practitioners and Dentists Board is also responsible for licensing private clinics and hospitals.

Private Practice by Government Consultants

Government-employed consultant physicians are permitted to practice privately alongside their government duties²⁵. This policy has been an important factor contributing to the supply of medical personnel available to set up private consulting offices and skilled professionals for the private for-profit hospital sector²⁶. Consultants working privately are supposed to declare the hours they intend to work in their public sector post in order to ensure that they maintain the terms of their contract; however, in the absence of adequate monitoring of contractual obligations it is likely that the public sector is not getting its full output from these consultants. There are also reported cases of consultants admitting their own private patients to GOK facilities and not paying the facility for the services rendered.

Indeed, when in the early 1980s government attempted to curb widespread abuses of private practice by government doctors by withdrawing this privilege, there was a significant exodus of physicians from the public sector. Unfortunately, it is not possible to determine the specific direction of this relationship between public and private sector employment.

Sole and/or Group Practice by Doctors

The GOK has never attempted to prohibit or restrict private medical practice in Kenya. Any doctor who satisfies the minimal requirements as set out in the Medical Practitioners and Dentists Act can enter private practice. These requirements are that the doctor a) be registered with the Medical Practitioners and Dentists Board (the prerequisite for which is the possession of a medical degree from an accredited institution and the completion of a one-year internship program); b) have worked in a salaried position under supervision for at least three years; and c) must obtain a private practice license from the MPDB. The same minimum private practice eligibility requirements must be satisfied by locum doctors.

Private practice licenses are issued only in respect of premises and are not transferable among individuals or facilities. Issued in the first instance for one year, private practice licenses must be renewed annually. A "one doctor-one clinic" rule is in place, although in rural areas a doctor can operate two clinics. Separate licenses must be obtained for each clinic.

Doctors in private practice are required to notify the Medical Officer of Health of cases of notifiable diseases, to keep an adequate stock of essential drugs and to keep good records of all drugs. Their clinics may include clinical and radiological laboratories if certain eligibility conditions are met: a qualified person must be employed to run the lab or the doctor himself must be qualified in the secondary discipline.

Private Practice in Nursing Homes and Hospitals

Kenyan law distinguishes between private health provision by sole or group practices and private provision by institutions such as hospitals and nursing homes. There do not appear to be any minimal conditions that must be met before a hospital can be established, neither are there any restrictions on the number of facilities that can be operated by any formally incorporated hospital.

Private hospitals are responsible for enforcing the provisions of the law as they apply to individual doctors and must submit the list of all general practitioners and dentists in their employment every six months. They are also required to submit another list of all general practitioners to whom they have granted admitting privileges and the location of the primary places of practice of these individuals. Private nursing homes and hospitals must also ensure that doctors in their employ do not practice in areas outside their competency (except in cases of emergency).

Private Practice by Clinical Officers

An important feature of the Kenyan health system is the existence of a cadre of health care practitioners known as clinical officers, the origins of which date back to the first World War when Africans were trained to provide assistance to British doctors. In 1989, the GOK began to grant clinical officers leave to run and operate their own private clinics. The enabling law for this is the Clinical Officers Act of 1989. In order to enter into private practice, clinical officers must have worked for at least 10 years. Over 700 clinical officers are currently in private practice.

Private practice licenses are issued in respect of premises by the Clinical Officers Council for one year in the first instance, and are subject to annual renewals. The law also provides for the regulation of opening and closing hours of the practice. Although there are no legal restrictions on the number of clinics a clinical officer can have, the requirement that clinics can only be open while the clinical officer is physically present is an indirect restriction on the number of clinics a clinical officer can operate.

Private Practice by Nurses

The standing order permitting nurses in Kenya to run and operate their own private clinics was not reviewed. The Nurses Act which regulates the practice of nursing in Kenya does not have any provisions for private practice by nurses. Discussions with MOH personnel suggest that the minimal requirement for private practice by nurses is that the nurse must have worked for at least 10 years.

Private Radiological Laboratory Practice

This group of providers appears to be largely unregulated, although anecdotal evidence suggests that they are licensed by a board. We did not identify any documentation for the conditions needed for licenses to be issued.

Private Practice by Pharmacists

Practice in pharmacy in Kenya appears to be treated as a non-medical service. Unlike in the cases of doctors and clinical officers, there are no laws regulating the conditions under which a pharmacist can set up private practice. This is perhaps because chemists and pharmacies have always been treated as private sector activities and existing laws regulate the activities of the health service sector. The basic requirement for the practice of pharmacy in Kenya is registration by the Pharmacy and Poisons Board, subject to the possession of a degree from a recognized institution. Pharmacies in Kenya are prohibited from falsely

representing the efficacy of drugs and from advertising abortion drugs or of any drugs that can induce miscarriage in women.

A recent phenomenon in Kenya is the entry into private practice of a group of health professionals known in Kenya as pharmaceutical technologists. This is the pharmacy equivalent of the clinical officers. There are at present about 120 of them registered with the Ministry of Health. There are as yet no laws regulating this practice and nothing can be said about the conditions which must be met for licensing.

Laws on Contracting

As best as our research could establish there does not appear to be any contracting-out or contracting-in of services between the GOK and private health care providers, although the Public Health Act does make provisions for such an arrangement particularly in respect of local governments. The Act empowers municipal and local governments to: a) own, operate or build hospitals; b) contract for the use of any such hospitals; c) enter into any agreement with the management of any hospital for the reception of the sick of the area; d) contract with any person to provide temporary drugs, supply of medicine and medical assistance for the poor.

Laws Pertaining to Health Insurance

There are two types of health insurance mechanisms in Kenya (excluding Harambee). Aspects of these have been discussed in other parts of this report. Here we simply note the key features of the laws regulating the provision of insurance in Kenya.

The largest health-related insurer in Kenya is the NHIF, a statutory body set up in 1966. The law establishing the NHIF provides for the enrollment in the NHIF of all Kenyans between the ages of 18 and 65 and mandates employers to deduct premia from wages and salaries. The level of contribution is graduated according to income, ranging from KSh. 30 per month to KSh. 320. The Act also provides for the fund to make loans from its reserves to hospitals for service improvements.

The private insurance industry is regulated by the Insurance Act of 1986. The law requires insurance companies to pay a number of levies which appear to increase their costs. These levies include a training levy and a levy for the upkeep of the Insurance Commission etc. The Insurance Act is currently being re-written to promote more competition among insurers.

Other Laws which Affect Private Health Care Providers

There are a number of other laws which affect private providers as businesses. These laws include a) The Food, Drugs and Chemical Substances Act (Cap. 254) which prohibits the sale of adulterated and substandard drugs, and deceptive labeling; and provides for the establishment of the Public Health Standards Board which is empowered to implement the provisions of the law; b) The Foreign Investments Protection Act (Cap. 518) 1964 which protects foreign investments in Kenya; c) The Local Government Act (Cap. 265) which empowers local governments to impose service charges on businesses operating within their jurisdiction; d) The Corporate Income Tax Law which allows firms to consider employer-provided health services as part of overhead expenses and therefore tax deductible. These laws have an indirect effect on private provision of care. Some of the laws raise the direct cost of provision; others change the relative price of health services. These laws have not been reviewed here for lack of time and space.

Effects of the Laws on the Private Health Care Market

A useful framework for analyzing the effects of the laws on the private health care market is to consider how they affect the structure, conduct and performance of private providers. Little is known, however, about these aspects of the health care market in Kenya. Because entry barriers in the sole or group practice sub-sector are not very high and the law restricts the number of health facilities that an individual may own, it is safe to assume that each provider is monopolistically competitive, acting as a monopoly in its catchment area yet aware of what its competitors may be doing.

Licensing requirements can be considered a barrier to entry in Kenya in terms of the way they apply to foreign and foreign-trained doctors. This is particularly relevant to physicians on short-term assignments at mission facilities. The second group of actors affected by the registration and licensing requirement are Kenyan doctors trained overseas, even if they have practiced for long periods of time overseas. It has been pointed out that the requirements are tedious and time-consuming and should be waived, particularly for doctors on short assignments at mission facilities and for overseas-trained Kenyan doctors with many years experience. Against this argument, however, public interest must be considered. Control of inputs appears to be the only means through which the quality of care is regulated in Kenya. Easing registration and licensing controls may open the process up to abuse and subvert its purpose.

There are no price controls in Kenya other than controls on the prices of drugs (which are observed in the breach). Each provider is free to establish her own price.

27/ Being bench-trained does not mean that they are any less competent than those more formally trained. Rather, the issue is that there may not be a universal curriculum or standards, and the quality of informally-trained personnel may be more variable.

It appears that a central focus of the laws regulating health service provision in Kenya is to assure the quality of care by ensuring the quality of the inputs. There are no requirements for in-service training, refresher training, etc., to update the skills of physicians. There are no malpractice laws designed to protect the patient from negligent doctors or those whose skills have atrophied. On the other hand, all duly registered and licensed health providers must be paid for services rendered. The rapid growth of the private provision sector requires that such an asymmetry in protection should be bridged as a matter of urgency.

Despite the focus of regulation on the quality of inputs, there are a number of gaps in regulation and enforcement which may compromise the quality of services provided in some private facilities. For example, discussions with Ministry of Health officials in Kisumu district revealed that recent years have seen a rapid increase in the number of private laboratory facilities operated out of doctors' offices. Although doctors are legally required to register their laboratory facilities separately, and there are minimum qualifications stipulated for those who work in private laboratories, to date there has been little enforcement of this requirement. This absence of effective regulation has doubtless been an important contributing factor to the growth in this particular sector. There has been an intention expressed by the Ministry of Health to enforce registration and regular inspections of these facilities.

Concerns were expressed by both MOH officials and operators of registered laboratories about the ethical and quality implications of this increase in the number of labs operated by private doctors. Self-referral has been identified as an important issue in the US, where strict restrictions exist on levels of investment and the types of diagnostic service companies in which private doctors can hold personal interests. This emerges from a concern about the ethics of self-referral and the potential for supplier-induced demand. In the Kenyan context, concerns were raised about the qualifications of personnel hired to work in these laboratories, many of whom are "bench-trained" (i.e. trained on-the-job)²⁷. Where these facilities are not separately registered, regular inspection by qualified laboratory personnel and monitoring of the quality of tests performed is difficult. Further attention is warranted on this issue.

9 Strategies to Promote Public/Private Linkages to Achieve National Health Goals

In recent years, Kenya has recognized the major challenges it faces in reforming its health sector. Health needs remain high, even augmented by new problems such as the HIV/AIDS epidemic, while the potential for growth in public resources for health is limited. As a result of years of tight budgets, the quality and functioning of the public sector health facilities has been difficult to maintain.

Kenya has long followed a strategy of pluralism in the health sector, allowing a large and diverse non-government health sector to develop. This report documents the contributions of this non-government sector to some of Kenya's health goals. The potential exists for much higher levels of contribution from the non-governmental sector. This requires collaboration between the public and private sectors in identifying national public health priorities and putting in place a framework for achieving those goals. This chapter suggests some broad lines of to develop such cooperation between the state and the private sector.

The chapter begins with a review of the major findings of the study. It then provides three sets of recommendations regarding public/private linkages in support of priority national health goals. These recommendations address system-wide actions; those relating to specific types of providers; and service-specific recommendations.

Findings

Size and Composition of the Private Provision Sector

The most recent studies from the mid-1980s suggest that non-government sources of finance account for slightly less than half of total health expenditures in Kenya. The largest share of this non-government expenditure is household out-of-pocket spending -- mainly fee-for-service for self-treatment (drug purchases) and non-government providers. These funds support a large and diverse group of non-government providers.

We use three characteristics of providers to develop a typology of the private provision sector: economic orientation (for-profit or not-for-profit); type of health care organization; and clinical system (traditional or cosmopolitan medicine). The

not-for-profit sector comprises organizations with religious affiliation (church missions and Islamic groups), non-government social service organizations (such as the Family Planning Association), and large non-profit providers such as Aga Khan and Nairobi Hospitals. The for-profit sector includes a large number of facilities and practices ranging from small shops to large industry-owned hospitals.

Documenting the composition of the private sector by type of health care organization has proved to be very difficult. We used the official MOH health information system and conducted a survey of over one hundred facilities. Hospitals have been reasonably well identified, usually including at least several medical specialties. Other facilities, such as maternity and nursing homes, provide inpatient care and many hospital-like services and are mainly found in the for-profit sector. Many of these also provide outpatient services. Facilities providing only outpatient treatment use a variety of titles which appear to have little relation to the actual services being provided. "Health centers" and "dispensaries" are mainly found in the government and mission sectors. "Health clinics", "medical clinics", "medical centers", and "dispensaries" are some of the main titles used in the for-profit sector. These range from individual practices of nurses and clinical officers to larger multi-practice facilities run by companies. In addition, pharmacies and other drug sellers provide a significant amount of outpatient diagnosis and treatment. At present, national information on this variety of non-government providers is insufficient to develop well-designed policies targeting specific parts of the for-profit provision sector.

Non-government providers are a significant part of Kenya's overall health care provision capacity. They account for 50% of all hospitals and 36 % of Kenya's hospital beds. They also account for approximately 21% of health centers and 51% of all other outpatient treatment facilities, although these include a wide variety of different levels of quality and capacity, as noted above.

Growth

Kenya has an open economic environment which has encouraged private sector involvement in the provision of health services. The private sector has grown from a few providers when Kenya became independent of British rule in 1963 to nearly 1500 in 1993. There is little reliable national quantitative evidence on the growth of different types of providers. In the provider survey, we noted a rise in the number of providers beginning work since 1990, implying recent rapid growth. This is supported by observations of recent departures of public sector health personnel from government jobs, and anecdotal reports of increasing numbers of nursing homes and other facilities being established, even outside the larger urban areas.

Geographical Diversity

The geographic distribution of private health facilities in the country shows strong patterns of rural-urban differentiation and concentration of certain types of providers in certain areas. This is very important for policy strategies. Mission health facilities are concentrated in provinces with large Christian populations. Similarly, mosque-clinics are all located in the Moslem quarters of the major cities in which they are found. The major private hospitals, clinics and dispensaries owned by doctors and other for-profit health facilities are predominantly located in urban areas as are the vast majority of pharmacies (however, this doesn't mean they only serve the affluent, as shown below). Smaller for-profit providers such as nurses and clinical officers practices are probably distributed more evenly between cities and towns, with greater access to the rural population. Drug sellers and traditional practitioners are ubiquitous.

Contribution of Non-Government Provision to Kenya's Health Services

The non-governmental health sector makes a substantial contribution to Kenya's health services provision. Survey data suggest that 45-60% of illness episodes are treated by non-government providers. Non-government services are used by all socioeconomic classes, although it is likely that there are significant differentials in the types of providers used by different economic groups. Drug sellers, small individual providers, and mission and mosque facilities are likely more used by the poorer classes, while the large urban facilities such as Aga Khan and Nairobi Hospitals serve more of the affluent population.

The review of a variety of disease and problem-specific studies shows that non-government providers contribute in varying degrees to addressing problems of public health importance. Common infectious diseases of childhood, such as diarrhea and ARI, are often taken to private facilities or sources of pharmaceuticals for self-treatment. Non-government providers give immunizations, assist in deliveries, treat malaria, STDs, and TB, among others. Who they reach and the types of services they provide vary between types of providers (e.g., mission facilities versus outpatient practice of a nurse, or paramedic versus drug seller) and between rural areas, small towns, and large cities. There is probably considerable scope for increasing their contribution to these services, but this must be done carefully with attention to quality and coverage issues.

Quality and Efficiency

Evidence on the quality and efficiency of services provided by the private sector is very limited and inadequate to permit us to come to any substantial conclu-

sions. There are almost no systematic studies of private sector quality or public-private quality comparisons. There are, of course, anecdotal reports of abuses by private providers, such as dilution of drugs in private facilities in order to offset the lower prices charged. In contrast, some non-government providers, such as mission hospitals, are generally thought of as high quality. Only one comparison of government and non-profit hospitals was found, the Curative Services Gap study. This did not find much systematic difference between the different types of facilities, although there was a wide range of quality and efficiency across facilities in general.

Insurance

Kenya has both public (NHIF) and private health insurance. Private third-party insurance is a growing industry, but is still quite small and limited to urban areas and coverage of those employed in the formal sector. We did not find it to be a very important influence on private health care provision at this time. Self-insurance by private companies is also common, including both ownership of dedicated facilities (hospitals, clinics) as well as direct payment for employees expenses. This contributes to the development of for-profit health care, mainly in urban areas.

The NHIF is a mandatory contributory scheme for government and formal sector employees. It finances inpatient treatment costs in both public and private facilities and has become an important source of financing for the non-government hospital sector, including both the for-profit and non-profit. At present, the NHIF suffers from a variety of problems, which impair its role as a successful risk-sharing scheme and make it difficult to assess its overall impact on the private sector. Among these problems are: payment mechanisms which create incentives for expansion of private bed capacity but not for quality improvement or cost control; high transactions costs in claims processing, limited ability to control fraud and abuse; and differences in benefit use for high and low income contributors. While it was beyond the scope of this study to assess the NHIF in detail, such work has been done under the KHCFP. As an important source of financing for non-government hospitals, the NHIF must be considered in any policy strategies addressing that sector.

Regulation

Kenyan laws concerning the private health sector appear to regulate the quality of inputs. They establish minimum standards of entry into the sector and the framework of exchange in the private health sector market. There are significant gaps in the laws affecting non-government health care providers, particularly those addressing the development of private practice by non-physicians. The laws are reported to be poorly enforced, and thus often do not have the desired

effect.

Constraints Faced by Private Health Facilities and Providers

The provider survey showed that private health facilities in Kenya face a number of constraints that differ by facility type. They include high taxes, high transport costs, lack of access to credit, very low rural incomes, poor rural infrastructure and lack of information from the Ministry of Health concerning public health activities and pharmaceuticals. A few cited harassment from Ministry employees as another constraint. Mission health facilities identified lack of places in local training institutions and their relative unattractiveness to Kenyan doctors and other health professionals because of the lack of pension schemes.

Recommendations

Policies towards the non-governmental sector must recognize the heterogeneity of the sector and the diverse interests of the providers. In addition to general policies that focus on the health system as a whole, policies to enhance support for national health goals must be tailored to the specific needs of each type of provider in response to the identified constraints facing the provider-type. In designing policies for the private provision sector, the costs and benefits of increased private sector involvement in the provision of health care in Kenya should be clearly factored in. Some of the advantages and disadvantages of private provision of health services have been highlighted in the accompanying boxes.

The recommendations in this report are informed by the mass of evidence collected from various sources including the literature review, the provider survey, interviews with officials of the Ministry of Health, CHAK, KCS, KMA, PSK, RCAF and other health professionals. Some of the recommendations may sound familiar to those who have looked at the private health sector in Kenya in recent times²⁸. In that sense they reveal the persistence of some of the problems facing private health care providers in Kenya.

System/General Policies

Health is an integral part of the economy. It is therefore affected by global economic and social policies. In addition to those policies that affect the whole economy, there are also a group of policies that affect the health sector as a whole but which may have different impacts on each provider or facility-type. The global policies that affect the health sector are as follows:

Economic Reforms

The ongoing reforms of the Kenyan economy have been enunciated in Sessional Paper No. 1 of 1994 (Recovery and Sustainable Development to the Year 2010). The GOK is committed to having an open and receptive attitude to the private sector including private health providers, continuing to deregulate financial and credit markets with a view to lowering interest rates and continuing to encourage competition in the health sector through cost sharing in public health facilities. Thus, the challenge facing the MOH within these general reform strategies is twofold: to strengthen the appropriate contribution of the non-government health sector to national health goals; and to reduce the burden on the government of inappropriate resource use.

Advantages of Private Provision of Health Services in Kenya:

- It reduces the administrative burden on the MOH;
- It reduces the fiscal burden on the MOH;
- It reduces the workload in MOH facilities;
- In the case of for-profit providers, taxes paid form an additional source of revenues for the government;
- It has enabled the government to retain the services of specialist doctors who are permitted in their free time to sell their services to the private sector. This also has enabled the Kenyan society to make a more effective use of its limited specialists pool;.
- The existence of the private sector has also enabled Kenya to retain a substantial number of its medical professionals, most whom were trained at public expense and many of whom may have emigrated in search of better opportunities;
- Mission facilities make an additional contribution by making available to Kenya volunteer doctors and other health personnel from overseas who would otherwise not have been available to the Kenyan people. Most of these health personnel serve in rural areas;
- The private sector has broadened the choices of health care providers available to the Kenyan people;
- Allocative efficiency in the Kenyan health system may have improved as a result of private sector involvement. This may be particularly true in the area of curative care;
- By introducing competition in the health sector, it is gradually encouraging improvements and policy innovations in the public sector. The public sector has for example introduced a number of fee paying (Amenity) wards in order to attract private patients.

Institutional Linkages

The MOH should improve institutional linkages between it and the organized non-governmental provision sector such as CHAK, KCS and CMA. The recently

established Office for NGO Health Providers should be strengthened and vested with real powers and responsibility including the potential to develop real programs to support health NGOs. An effective mechanism should be established for eliciting private sector input to health policy formulation.

Disadvantages of Private Provision of Health Services in Kenya:

- Private for-profit health facilities do not provide equal access to most Kenyans because they are mostly located in urban areas and their use depends on ability to pay;
- Duplication of existing publicly-provided services could cause allocational inefficiency;
- Mission and mosque facilities are predominantly located in areas of large concentration of their religious followers;
- Because they are predominantly fee-for-service institutions, access to them by the poor may be limited;
- They do not appear to be any more efficient than the public sector implying that there may be some resource misallocation;
- For-profit providers draw qualified and experienced health personnel away from the public hospitals, leaving the majority of Kenyans who use public facilities with a large pool of fairly inexperienced health professionals;
- Private providers bid up the cost of health professionals in the country;
- They create conflict of interest problems for specialist doctors working in the public sector who have to serve both the public and the private interest at the same time;
- Private practice by public sector physicians erodes the public's confidence in public health facilities and the public's support for requests from doctors in the public service for better terms and conditions of service;
- The private sector makes it easier for the government to break industrial actions and strikes by public sector health workers.

Geographic Distribution

The geographic composition of non-government provision (rural-urban, different regions of the country) shows that some providers are concentrated in certain areas, while others are quite widespread. The MOH should look for appropriate incentives to enhance coverage with services in relatively under-served areas of the country. These could involve non-government providers, especially the non-profits in rural areas. Policies could include subsidies to reduce start-up costs, adaptations of licensing rules and regulations, and where appropriate, provision of inputs such as seconded government personnel.

Quality Assurance

Government capacity to monitor and improve quality in the public and private

sectors, and to take action to remedy problems, is extremely weak. Efforts should include review and development of input standards, monitoring the output of facilities, and continuing education/training opportunities for private providers. These could be focussed initially on services of public health importance. Efforts should also be made to use educational and promotional activities to influence the behavior of private providers.

Regulatory Environment

The government's current regulation of non-government providers seems to be both a burden to providers and provide little effective regulation or information for the state. Its objectives and processes should be reviewed. For example, this could include a one-stop approach to licensing and renewal of licenses. It could also involve increasing the availability of information to the public regarding, for example, providers' qualifications, restrictions on their clinical practice, and location of admitting privileges. Regular certification of health facilities could also be reinforced. Existing laws should be reviewed and new laws enacted concerning private practice by nurse-practitioners and pharmaceutical technologists. The organization of the Medical Practitioners and Dentists Board is being reviewed. Consideration is being given to separating dentists and medical practitioners and making the Board an autonomous statutory body charged with responsibility for overseeing and regulating medical education and practice in the country. Enhancement of the MOH's regulatory role must be accompanied by a careful analysis of the resources and capabilities required for it to successfully and effectively carry out these activities.

Other Reforms

The MOH should consider:

- Developing a comprehensive database of private providers, which could be used to monitor changes, identify targets for policy strategies, and develop operations research on quality and efficiency;
- Strengthening the newly-established division of health systems research, including the development of a research agenda and provision of adequate resources to undertake operations research. Further research into some of the private sector issues identified in this report would be a useful contribution to the development of policy in this area;
- Reinforcing the role/potential for current cost-sharing policies in public facilities to improve public service quality and hence increase price competition with non-government providers.

Provider Specific Recommendations

Mission facilities

The MOH could accelerate and simplify procedures for seconding health staff to mission facilities in the context of newly decentralized authority and consider greater use of incentives to encourage staffing of remote facilities.

The MOH should encourage the dedication of a number of places in training institutions, for example in the Medical Training College (MTC) for mission health facilities. This will encourage young, capable Kenyans to consider working in mission health facilities as a viable employment option.

The GOK and donors could assist mission facilities to improve their medical records, book-keeping and other records. Some hospitals do not have qualified book-keepers and many do not have relevant expertise in administration and management.

Donors and the GOK may assist more mission hospitals to replicate PCEA Chogoria's insurance experience.

The GOK should review the size of grants and process of grant-making to the mission health facilities. These providers are an important source of services in some rural areas. Could their contribution in reaching underserved and priority areas be enhanced? Could their contribution to specific public health programs also be enhanced?

For-profit providers (all)

There are discrepancies in the minimum level of amenities a clinic must possess. Clinics run by physicians are required to have a higher level of facilities than those run by nurses and clinical officers. These requirements were cited as onerous by some physicians. What are the justifications for such regulatory requirements? Can they be enforced? Is there any evidence of benefit? Should they be revised?

The cost of malpractice insurance for sole providers is currently high. The GOK may wish to consider reforming insurance for practitioners in private practice;

The GOK should formalize private practice by nurses and pharmaceutical technologists to that it can be better monitored and regulated; it should also amend the Medical Practitioners and Dentists Act to remove special privileges for clinical officers;

For-profit providers (small)

Particular attention should be paid to the needs of the small for-profit sector, particularly facilities run by nurses and clinical officers. Operations research should be conducted in order to better understand the role being played by these providers, including the quantity and type of services being provided, the quality of these services, and the continuing education requirements of this type of provider.

NHIF

The ongoing efforts to reform the NHIF have potentially important implications for the non-government hospital sector. Appropriate reforms could both increase benefits to members and enhance quality and control costs in the hospital sector. We strongly support this reform process.

Pharmacies

Pharmacies are increasingly becoming a primary source of care in Kenya. The MOH should recognize this and assure that pharmacies providing such care employ either a pharmacist with clinical training or a medically qualified individual (doctor, nurse, or clinical officer).

A better system is required for providing pharmacies with current information on drugs.

Traditional health practitioners

Pilot programs should be developed to expose medical school undergraduates to traditional healing practices. For example the University of Sokoto Medical School, Nigeria, has incorporated instruction in traditional healing practices in its curriculum. This not only exposes the young medical student to this ancient practice but also enhances their ability to recognize patients who have been to traditional health practitioners prior to coming to the hospital and thus improves the effectiveness of their treatment.

Community health workers and pharmacies

The MOH and the donor community should continue to encourage them by providing seed capital or subsidized drugs.

Service-Specific Recommendations

The following recommendations are structured around the set of health services that are of particular public health interest. A useful approach would be to develop specific *models of collaboration* based on the types of services to be provided (disease treatment, referral, preventive care, health promotion and information), the target population (rural, town, urban, specific age-sex groups), etc. The KMA-Pathfinder family planning project, and the USAID-funded Family Planning Private Sector project activities provide useful examples of such models which integrate private health care providers into the delivery of these public health services. Different health problems and population groups targetted will, however, require different models.

Maternal and perinatal care

The role of TBAs as care-givers during pregnancy and delivery is fairly well demonstrated. Efforts at evaluating, identifying training needs, and providing training for this group of providers should continue.

Family planning

The MOH and the donor community should maintain and expand existing efforts at integrating private providers. Integration of privately-practicing nurses and clinical officers into family planning programs should continue.

The MOH and donors should consider undertaking studies to evaluate the cost-effectiveness of this model of service provision, and the feasibility of extending it to other services of public health interest.

Immunization

Relatively few private providers are providing immunization services as part of their regular activities, and their contribution to overall immunization activity appears to be relatively small. The cost-effectiveness of integrating the small for-profit private provider sector into immunization activities (along the lines of the KMA family planning project, with the provision of free/subsidized vaccines) should be explored. This might be especially promising for urban areas.

Tuberculosis treatment

The main concerns relating to private sector TB treatment relate to quality. Efforts at educating and updating the knowledge of private providers regarding correct treatment regimens and the problems caused by defaulting patients should continue.

The right incentives need to be identified which will encourage private sector reporting and referral of TB cases.

Malaria

Ways to increase the role of the private sector in prevention activities, such as provision of impregnated bednets, should be explored.

The role of commercial sources (pharmacies and shops) in treatment needs to be recognized. Efforts at quality assurance (particularly in respect of appropriate chemotherapy) need to be targeted at these providers. Public information about the causes and dangers of drug-resistant forms of malaria is another strategy to increase appropriate treatment.

Diarrhoeal disease

ORS remains predominantly supplied by the public sector. This may be due to both ignorance and inadequate profit margins. Ways to make the promotion of ORS more attractive to commercial sources should be identified. Private providers (including commercial sources) should be included in training activities, focusing on those providers with the least access to continuing education.

On the demand side, experience in many countries show that demand creation through social marketing of ORS is a viable way to increase ORS use and to decrease the demand for antibiotics and anti-diarrheals. These opportunities should be further explored in Kenya.

Other childhood illness

The DHS revealed that commercial sources are the most important private sector sources of care for childhood illness in both urban and rural areas. The role of these providers needs to be recognized and efforts at provider education should include these "providers".

HIV/AIDS

Social marketing of condoms should be continued and intensified.

The Ministry should continue to strengthen links with NGOs through the AIDS NGO Consortium, including making available training opportunities which are provided through external agencies.

References

- Akumu, O.** (1992) *Some issues of class equity at the National Hospital Insurance Fund* (Nairobi: Kenya Health Care Financing Project).
- Bennett, S. and Ngalande-Banda, E.** (1994) *Public and Private Roles in Health: A review and analysis of experience in sub-Saharan Africa* (Geneva: World Health Organization).
- Berman, P. and Hanson, K.** (1994) *Assessing the Private Sector: Methodological Guidelines* (Boston MA: Data for Decision Making Working Draft).
- Bloom, G. and Segall, M.** (1993) *Expenditure and Financing of the Health Sector in Kenya* (Institute for Development Studies, Sussex, Commissioned Research).
- Central Bureau of Statistics** (1989) *Kenya Population Census 1989 vol 1.*
- Central Bank of Kenya** (1993) *Quarterly Economic Review* Oct-Dec.
- Chogoria Hospital** (1990, 1993) *Annual Report 1990; Annual Report 1993.*
- Data for Decision Making Kenya Trip Reports,** March 19 - 31, June 1-18, July 30 - September 10, 1994.
- Development Solutions for Africa** (1994) *A Survey of Ministry of Health Personnel in Kenya* (report submitted to the Ministry of Health; mimeo).
- Forsythe, S., Sokal, D., Lux, L., King, T. and Jonston, A.** (1993) *An Assessment of the Economic Impact of AIDS in Kenya* (AIDSTECH/AIDSCAP/Family Health International, August 1993).
- FPPS** (1994) *Family Planning Private Sector 1993 Second Semi-Annual Report* (Nairobi).
- Government of Kenya** (1981) *The Public Health Act* (Nairobi: Government Press).
- Government of Kenya** (1983) *The Medical Practitioners and Dentists Act* (Nairobi: Government Press).
- Government of Kenya** (1985) *The Nurses Act* (Nairobi: Government Press).
- Government of Kenya** (1989) *The Pharmacy and Poisons Act* (Nairobi: Govern-

ment Press).

Government of Kenya (1990) *The Food Drugs and Chemical Substances Act* (Nairobi: Government Press).

Government of Kenya (1990) *The Local Government Act* (Nairobi: Government Press).

Government of Kenya (1990) *The Clinical Officers (Training, Registration and Licensing) Act* (Nairobi: Government Press).

Government of Kenya (1990) *Foreign Investments Protection Act* (Nairobi: Government Press).

Government of Kenya (1990) *The Imports, Exports and Essential Supplies Act* (Nairobi: Government Press).

Government of Kenya (1990) *The Restrictive Trade Practices, Monopolies and Price Control Act* (Nairobi: Government Press).

Government of Kenya (1990) *The Local Authority Services Charge Act* (Nairobi: Government Press).

Government of Kenya (1991) *The Witchcraft Act* (Nairobi: Government Press).

Government of Kenya (1991) *The Trade Licensing Act* (Nairobi: Government Press).

Government of Kenya (1991) *The Mental Health Act* (Nairobi: Government Press).

Government of Kenya (1994) *The Provisional Collection of Taxes and Duties Act* (Nairobi: Government Press).

Government of Kenya (1994) *Recovery and Sustainable Development to the Year 2010* (Sessional Paper No. 1 of 1994).

Government of Kenya (1994) *National Development Plan 1994-6*.

Government of Kenya/Central Bureau of Statistics *Statistical Abstract* (various years).

Government of Kenya/Ministry of Finance (1994) *Auditor General's Report 1994*.

Government of Kenya/Ministry of Finance (various years) *Controller and Auditor General's Reports*.

Government of Kenya/Ministry of Health. 1994. *Investing in Health (mimeo)*.

Government of Kenya/Ministry of Planning and National Development *Economic Survey* (various years).

Government of Kenya/Ministry of Planning and National Development (1994) *Kenya Historical Economic Data 1972-1993*.

Government of Kenya/UNICEF (1990) *A Household Welfare Monitoring and Evaluation Survey of Kisumu District* (Nairobi: Ministry of Planning).

Government of Kenya/UNICEF (1992a) *Household Welfare Monitoring and Evaluation Survey, Embu District* (Nairobi: Ministry of Planning).

Government of Kenya/UNICEF (1992b) *A Household Welfare Monitoring and Evaluation Survey of Kitui District* (Nairobi: Ministry of Planning).

Government of Kenya/UNICEF (1992c) *A Household Welfare Monitoring and Evaluation Survey of Mombasa District* (Nairobi: Ministry of Planning).

Government of Kenya/UNICEF (1992d) *A Household Welfare Monitoring and Evaluation Survey of Kwale District* (Nairobi: Ministry of Planning).

Hodgkin, D. (1994) *Household Characteristics Affecting Where Mothers Deliver in Rural Kenya*. (Boston: Economics Department, Boston University, mimeo).

Katz, S.S., Katz, S.H. and Kimani, V. (1982) "The making of an urban mganga: New trends in traditional medicine in urban Kenya" *Medical Anthropology* Spring 1982.

Katz S.S. and Katz, S.H. (1987) "An evaluation of traditional therapy for barrenness" *Medical Anthropology Quarterly* 1(14):394-405.

Kenya Catholic Secretariat. *Statistics of Facilities, Training, Staff, Services*, various years (Nairobi: KCS).

Kibua, T.N. (1992) *Financing Health Services: Coordination and Opportunities in the Private Sector in Kenya*. (mimeo).

Kirigia, J.M. (n.d) *Cost sharing in Health. Ministry of Health Status Report*.

Lewis, G.L., Keyonzo, N.A. and Mott, P. (1992) *Community-based family planning services: Insights from the Kenyan Experience* (paper presented at Population Association of America annual meeting, 1992).

Mbiti, D.M, Mworio, F.A. and Hussein, I.M. (1993) *Cost-recovery in Kenya* (letter to the editor) *The Lancet*, vol 341, 6 Feb 1993.

Mbugua J.K., Bloom, G.H. and Segall, M.M.(no date) *The Impact of User Charges on Vulnerable Groups: The Case of Kibwezi in Rural Kenya* (mimeo).

Mbugua, J.K. (1993) *Impact of User Charges on Health Care Utilisation Patterns*

in Rural Kenya: The Case of Kibwezi Division. Unpublished PhD Thesis, University of Sussex, UK.

McCann Research (1993) *NHIF Survey Part I: Members'/Beneficiaries Survey* (Nairobi: study prepared for the Kenya Health Care Financing Project).

Ministry of Health (1990a) *Diarrhoeal Diseases Household Case Management Survey* (Nairobi: Control of Diarrhoeal Diseases Programme).

Ministry of Health (1990b) *MOH Exit Survey Report* (draft, July 1990).

Ministry of Health (1991a) *CBD Policy Guidelines Workshop Report* (Nairobi: MOH).

Ministry of Health (1992) *Kenya Control of Diarrhoeal Diseases Programme Focused Programme Review*. Draft April 1992 (Nairobi: MOH).

Ministry of Health (1993) *National Leprosy and Tuberculosis Programme Annual Report 1993*.

Ministry of Health (1993b) *Five-year implementation plan for financing health care in Kenya* (workplan for implementing the Strategic Action Plan for Financing Health Care in Kenya, Ministry of Health, Nairobi).

Musau, S.N. and Sliney, I.J. (1994) *Curative Services Financing Gap Study* (Nairobi: MOH).

Mutungi, O.K (1992) *Health Care Financing in Kenya: The Legal and Regulatory Environment of the Private Sector*. MOH/Kenya Health Care Financing Project/ Management Sciences for Health.

Mwabu, G., Ainsworth, M. and Nyamete, A. (1994) "Quality of Medical Care and Choice of Medical Treatment in Kenya: An Empirical Analysis" *Journal of Human Resources* 28(4).

Mwabu, G., Wang'omb, J., Ikiara, G., Muthami, L., Manundu, M. and Kiugu, S. (1993) *Financing health services through insurance: A case study from Kenya* (Abt Associates: Health Financing and Sustainability Project).

National Council for Population and Development (NCPD) and Institute for Resource Development/Macro Systems, Inc (1989) *Kenya. Demographic and Health Survey 1989* (Columbia, MD: NCPD and IRD).

National Council for Population and Development (NCPD) and Macro International (1994) *Kenya Demographic and Health Survey 1993* (Calverton, Maryland: NCPD and Macro).

Quick, J.D. and Musau, S.N. (1994) *Impact of Cost Sharing in Kenya: 1989-1993* (Nairobi: Management Sciences for Health).

REACH (1988) *Nairobi Area Study* (Arlington VA: John Snow Inc.).

REACH (1989) *Kenyatta National Hospital Study* (Arlington VA: John Snow Inc.).

REACH (1990) *Provincial and District Study: Nakuru District* (Arlington VA: John Snow Inc.).

Swamy, G. (1994) *Kenya: Structural Adjustment in the 1980s*. World Bank Policy Research Working Paper No. 1238.

University of Zambia, Central Statistical Office and Macro International, Inc (1993) *Zambia Demographic and Health Survey 1992* (Columbia, Maryland: University of Zambia and Macro).

Wang'ombe, J.K. (1992) *Health Care Financing in Kenya: The Role of Social Financing*. Paper prepared for the Strategic Plan for Financing Health Care in Kenya (Nairobi: Kenya Health Care Financing Project).

World Bank (1994) *Public Expenditure Review*, forthcoming.

World Health Organization (1991) *The public/private mix in health systems and the role of ministries of health*. Report of an interregional meeting held in Morelos, Mexico (Geneva: World Health Organization, unpublished document WHO/SHS/NHP/91.2).

Appendix 1: Private Provider Survey

Based on the key gaps identified during the course of the literature review, a survey was undertaken of private health care providers. The objective was to learn more about the services provided by the private sector in Kenya, including public health activities. Questions were asked about activities, staffing patterns, attendance, expenditures and other features of private practices. Constraints faced by private providers were also examined through survey questions.

Field work for the survey was conducted by a team assembled by AMREF. Because of time and resource constraints, the study was limited to four sites. These sites (Embu, Kisumu, Mombasa, and Nairobi) were chosen on the basis of the concentration of private health care providers and because they would provide a relatively good balance of provider types.

Separate survey instruments were developed to capture information about four different broad types of health care provider: modern health care providers, pharmacies/chemists, traditional healers and community pharmacies. The questionnaires were pre-tested in Nairobi province and adapted based on experiences of this pre-test. Where possible, questionnaires were interviewer-administered. Occasionally where time constraints did not permit this format, questionnaires were left with facility proprietors/managers to fill out.

Survey teams were provided with a print-out of all private health care facilities in the district. These lists were updated with the assistance of the District Medical Officer of Health and the District Public Health Nurse. Purposive sampling, based on a target for each type of facility, was then undertaken based on this updated list. Rather than representing a truly random sample, the survey can be thought of as an attempt to capture as much variation among provider types in order to enrich our understanding of the sector. In the case of community pharmacies, the objective was to identify and survey a total of 5 pharmacies in Kisumu and Mombasa districts, where the largest concentration of these facilities is located. A further community pharmacy was identified by the survey team in Embu and a questionnaire administered.

Table A1.1 shows the number of each type of facility visited, categorized by study site.

Data were entered using DBase III and analyzed using SPSS-PC. Tables based on preliminary analysis of this data set follow. Further analysis will be undertaken.

en and reported separately. Interested readers may contact the Data for Decision Making Project for further information about the survey instruments and study design.

Table A1.1
Breakdown of Sample by District

<i>District</i>	<i>Modern Providers</i>	<i>Pharmacies/ Chemists</i>	<i>Traditional Healers</i>
Embu	31	5	8
Kisumu	25	13	11
Mombasa	30	14	10
Nairobi	21	20	6

Note: All numbers are counts (i.e. n) except where otherwise specified.

Table A.1.2
Classification by Ownership and Facility Type

	<i>Hospital</i>	<i>Health Centres</i>	<i>Dispensaries</i>	<i>Health Clinic</i>	<i>M/ Home</i>	<i>N/ Home</i>	<i>Medical Centre</i>	<i>Other</i>	<i>Total</i>	<i>%</i>
KCS	3	-	10	-	1	-	-	-	14	13.2
CHAK	2	-	5	2	-	-	1	-	10	9.4
Sole	5	-	1	23	8	2	2	2	43	40.6
Partnershi	1	-	1	8	3	2	-	-	15	14.2
Company	2	1	-	-	2	1	1	-	7	6.6
Parastatal	-	-	1	1	-	-	-	-	2	1.9
Other	4	1	1	7	1	-	-	-	15	14.2
Total	17	2	19	41	15	5	5	2	106	100.0

Source: DDM/AMREF Provider Survey, 1994

Table A.1.3
Facilities by Method of Compensation to Doctors on Payroll

	<i>Salary</i>	<i>Basic Salary + % Based on No. of Patients Seen</i>	<i>% Based on Number of Patients Seen</i>	<i>Other</i>
Hospitals	12	3	3	3
Health Centres	2	-	-	-
Dispensaries	6	-	-	-
Health Clinics	14	-	7	3
Maternity Homes	13	1	-	1
Nursing Homes	3	2	1	-
Medical Centres	2	-	1	-
Other	1	-	1	-
Total	53	6	13	7

Table A.1.4
Facility Type by Mode of Payment Including Exemptions

	<i>Cash</i>		<i>In - Kind</i>		<i>NHIF</i>		<i>Other Insurance</i>		<i>Employer Pays Directly</i>		<i>Exempted from Paying</i>	
	OP	IP	OP	IP	OP	IP	OP	IP	OP	IP	OP	IP
Hospitals	17	16	1	2	-	16	9	12	15	14	8	9
Health Centres	2	1	-	-	-	-	1	-	1	-	2	1
Dispensaries	19	1	2	-	-	1	3	-	8	1	14	1
Health Clinics	39	-	4	-	-	-	7	2	16	2	23	1
Maternity Homes	15	14	-	-	-	13	5	6	9	9	9	7
Nursing Homes	2	2	-	1	1	4	3	3	3	3	1	1
Medical Centres	4	2	-	-	-	-	-	-	1	1	1	1
Other	2	-	-	-	-	-	2	-	2	-	-	-
Total	100	36	7	3	1	34	30	23	55	30	7	21

OP: Outpatient
IP: Inpatient

Table A.1.5
Facility Type by Information Received

	<i>Treatment Guidelines</i>	<i>National Drug Formulary</i>	<i>Public Health Materials</i>	<i>Approved/Banned Drugs</i>	<i>No Information at All</i>	<i>Other</i>
Hospitals	7	4	10	9	2	14
Health Centres	-	1	-	-	-	-
Dispensaries	4	3	7	5	5	15
Health Clinics	14	11	16	14	11	29
Maternity Homes	7	8	9	8	3	12
Nursing Homes	1	1	1	1	-	4
Medical Centres	-	-	1	-	3	3
Other	-	-	-	1	1	2
Total	33	28	44	38	25	79

Source: DDM/AMREF Provider Survey, 1994

Table A.1.6
Whether Facility Needs Incentives

	<i>Need Incentives from GOK</i>	<i>Do Not Need Incentives</i>
Hospitals	12	5
Health Centres	1	1
Dispensaries	11	5
Health Clinics	28	11
Maternity Homes	11	4
Nursing Homes	3	1
Medical Centres	2	2
Other	1	1
Total	69	30

Source: DDM/AMREF Provider Survey, 1994

Table A.1.7

Sources of Credit by Type of Facility

	<i>Commercial Banks Loans</i>	<i>Development Bank Loans</i>	<i>Concessionary Loans from Parent Group</i>	<i>Trade Credit from Suppliers</i>	<i>Credit from Family and Friends</i>	<i>Other</i>
Hospitals	4	-	1	11	1	
Health Centres	-	-	-	2	-	
Dispensaries	-	-	1	7	2	
Health Clinics	5	1	2	15	3	
Maternity Homes	4	-	-	8	2	
Nursing Homes	-	-	-	2	1	
Medical Centres	1	-	-	3	-	
Other	-	-	-	2	2	
Total	14	1	4	50	11	

Source: DDM/AMREF Provider Survey, 1994

Table A.1.8

Ownership by Sources of Credit

	<i>Commercial Banks Loans</i>	<i>Development Bank Loans</i>	<i>Concessionary Loans from Parent Group</i>	<i>Trade Credit from Suppliers</i>	<i>Credit from Family and Friends</i>	<i>Other</i>
Mission (Catholics)	-	-	1	5	2	
Mission (Prot)	1	1	2	3	-	
Sole Proprietor	8	-	-	22	6	
Partnership	1	-	-	6	2	
Company	3	-	-	4	-	
Parastatal	-	-	-	-	-	
Other	1	-	1	9	-	
Total	14	1	4	49	10	

Source: DDM/AMREF Provider Survey 1994

Table A.1.9
Method of Payment for Outpatient Services

	<i>Cash (n)</i>	<i>In-kind (n)</i>	<i>Private Insurance (n)</i>	<i>Employer Pays (n)</i>	<i>Exemption (n)</i>
Mission - Catholic	14	2	4	7	10
Mission - Protestant	10	1	1	4	4
Sole Proprietor	42	4	13	23	24
Partnership	14	0	4	10	7
Company	5	0	5	3	3
Parastatal	0	0	0	0	0
Other	7	0	7	7	10

Source: DDM/AMREF Provider Survey, 1994

Table A.1.10
Method of Payment for Inpatient Services

	<i>Cash (n)</i>	<i>In-kind (n)</i>	<i>NHIF (n)</i>	<i>Private Insurance (n)</i>	<i>Employer Pays (n)</i>	<i>Exemption (n)</i>
Mission - Catholic	4	1	5	2	3	3
Mission - Protestant	3	0	2	1	1	1
Sole proprietor	15	1	12	7	13	10
Partnership	4	1	6	4	4	1
Company	5	NR	4	4	4	3
Other	5	0	5	5	5	3

Source: DDM/AMREF Provider Survey, 1994

Table A.1.11

Type of Information Required from Ministry of Health

	<i>Treatment Guidelines (n)</i>	<i>National Drug Formulary (n)</i>	<i>Public Health Materials (n)</i>	<i>Approved/ Banned Drugs (n)</i>	<i>None (n)</i>
Mission- Catholic	3	1	6	6	2
Mission - Protestant	4	2	3	2	4
Sole Proprietorship	13	11	17	15	13
Partnership	6	8	7	7	1
Company	1	1	2	2	1
Parastatal	1	1	2	1	0
Other	5	4	6	5	3

Source:DDM/AMREF Provider Survey 1994

Table A.1.12

Whether Provider Requires Incentives to Provide Public Health Services

	<i>Yes (n)</i>	<i>No (n)</i>	<i>% Yes</i>
Mission-Catholic	10	4	71.40
Mission-Protestant	8	1	88.90
Sole Proprietorship	37	5	88.10
Partnership	11	4	73.30
Company	3	3	50.00
Parastatals	2	0	100.00
Other	8	7	53.30

Source: DDM/AMREF Provider Survey, 1994

Table A.1.13

Whether Provider Requires Incentives to Provide Curative Health Services

	<i>Yes (n)</i>	<i>No (n)</i>	<i>% Yes</i>
Mission-Catholic	5	7	41.70
Mission-Protestant	7	1	87.50
Sole Proprietorship	30	13	69.80
Partnership	13	2	86.70
Company	4	1	80.00
Parastatals	2	0	100.00
Other	7	6	53.40

Source: DDM/AMREF Provider Survey, 1994

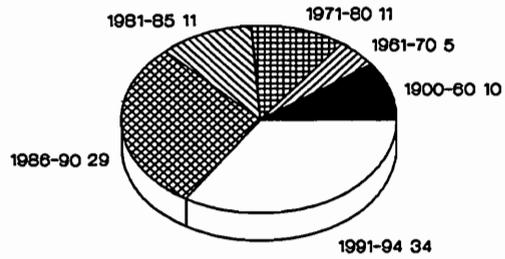
Table A.1.14

NHIF Receipts and Benefits Paid Out, KSh. millions, 1982/3 - 1992/3

<i>District</i>	<i>Public Hospital</i>	<i>Private Hospital</i>	<i>Private Medical Practitioner</i>	<i>Traditional Healer</i>	<i>Self-Medication</i>	<i>No Care</i>	<i>Total Private</i>
Siaya (n = 1174)	46.90	14.60	3.60	5.40	19.60	10.00	43.20
Kisumu (n = 1616)	56.40	8.80	4.00	3.10	15.80	11.80	31.70
Nandi (n unknown)	57.50	7.20	3.20	3.20	13.30	11.10	26.90

Source: AMREF, unpublished data

Graph A.1.1
Year of Establishment
Sampled Private Facilities



Source: Survey Data

Appendix 2: Data from NHIF Table

Table A.2.1

NHIF Receipts and Benefits Paid Out, KSh. millions, 1982/3 - 1992/3

<i>Year</i>	<i>Receipts</i>	<i>Benefits</i>	<i>Receipts Less Benefits</i>
1982/3	5.64	4.61	1.03
1983/4	6.46	5.46	1.00
1984/5	5.36	5.95	-0.59
1985/6	7.14	5.24	1.90
1986/7	7.62	6.16	1.46
1987/8	9.47	8.86	0.61
1988/9	9.52	8.80	0.72
1989/90	9.72	7.94	1.78
1990/1	36.8	15.60	21.20
1991/2	39.61	30.60	9.01
1992/3	42.97	39.38	4.59

Source: Economic Survey, several years.

Appendix 3: Partial List of Persons Met

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Mr. Kahutu - Planning
Dr. Gesami - NGO Coordination
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Mr. Orenje, Clinical Officer (private clinic)

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Many people helped us in this research. This list is not exhaustive. We apologize to those whose names have been omitted.

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