

Private Health Sector Assessment in Kenya



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Acronyms and Abbreviations

ACT	Artemisinin-Based Combination Therapy
AIDS	Acquired Immune Deficiency Syndrome
AKI	Association of Kenya Insurers
AMREF	African Medical and Research Foundation
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
CBS	Central Bureau of Statistics
CDC	Centers for Disease Control and Prevention
CFW	Child and Family Wellness
CHAK	Christian Health Association of Kenya
CHW	Community Health Worker
CIC	Cooperative Insurance Company of Kenya
CPE	Continuing Professional Education
CPR	Contraceptive Prevalence Rate
CRB	Credit Reference Bureau
DCA	Development Credit Authority
DFID	Department for International Development (United Kingdom)
DHS	Demographic Health Survey
DOTS	Directly Observed Therapy, Short-Course
DPHK	Development Partners in Health in Kenya
ECLOF	Ecumenical Church Loan Fund
FBO	Faith-Based Organization
FBHS	Faith-Based Health Services
FHI	Family Health International
FP	Family Planning
GDP	Gross Domestic Product
GOK	Government of Kenya
GSN	Gold Star Network
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HENNET	Health NGOs Network
HERA	Health Research for Action
HIV	Human Immuno-Deficiency Virus
HMIS	Health Management Information Systems
HMO	Health Maintenance Organization
ICT	Information and Communications Technology
IFA	Italian Foreign Assistance
IFC	International Finance Corporation
IPT	Intermittent Preventive Treatment
IRA	Insurance Regulatory Authority

ITN	Insecticide-Treated Net
IUD	Intrauterine Device
KAH	Kenya Associations of Hospitals
KAIS	Kenya AIDS Indicator Survey
KAM	Kenya Association of Manufacturers
KANCO	Kenya AIDS NGOs Consortium
KAPH	Kenya Association of Private Hospitals
KDHS	Kenya Demographic Health Survey
KEC-CS	Kenya Episcopal Conference-Catholic Secretariat
KEMRI	Kenya Medical Research Institute
KEMSA	Kenya Medical Supply Agency
KEPSA	Kenya Private Sector Alliance
KHF	Kenya Health Federation
KMA	Kenya Medical Association
K-MET	Kisumu Medical & Education Trust
KSh	Kenya Shillings
KWFT	Kenya Women Financial Trust
MCO	Managed Care Organization
MEDS	Mission for Essential Drugs and Supplies
MFI	Micro-Finance Institution
MIP	Medical Insurance Provider
MOH	Ministry of Health
MOMS	Ministry of Medical Services
MOP	Ministry of Planning
MOPHS	Ministry of Public Health and Sanitation
MOU	Memorandum of Understanding
NASCOP	National AIDS and STI Control Program
NESC	National Economic & Social Council
NFP	Not-for-Profit
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHIF	National Hospital Insurance Fund
NMS	National Malaria Strategy
NQCL	National Quality Control Lab
OBA	Output-Based Aid
OOP	Out-of-Pocket
ORS	Oral Rehydration Salts
PEPFAR	President's Emergency Plan for AIDS Relief
PHECON	Kenya Health Care Professional Association
PMTCT	Prevention of Mother-to-Child Transmission
PPB	Pharmacy and Poisons Control Board
PPP	Public-Private Partnership
PS	Permanent Secretary
PSI	Population Services International
PSK	Pharmaceutical Society of Kenya
PSP- <i>One</i>	Private Sector Partnerships-One

RH	Reproductive Health
RPM Plus	Rational Pharmaceutical Management Plus Project
SACCO	Savings and Credit Co-Operative Organizations
SHEF	Sustainable Health Enterprise Foundation
SHF	Sustainable Healthcare Foundation
SME	Small and Medium Enterprise
SPA	Service Provision Assessment
STI	Sexually Transmitted Infection
SUPKEM	Supreme Council of Kenyan Muslims
SWAp	Sector-Wide Approach
TB	Tuberculosis
TFR	Total Fertility Rate
THE	Total Health Expenditure
TPA	Third-Party Administrator
TWG	Technical Working Group
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Executive Summary

Kenya's private sector is one of the most developed and dynamic in Sub-Saharan Africa. In the health sector—where the leading causes of death are HIV/AIDS, acute respiratory infection (ARI), diarrheal diseases, and malaria (World Health Organization [WHO] 2004)—the private commercial (for-profit) sector and the not-for-profit sector play critical roles in preventing and treating disease. Even among the poor, the private sector is an important source of care. For example, 47 percent of the poorest quintile of Kenyans use a private facility when a child is sick (Marek et al. 2005). In recognition of this important role, the Government of Kenya has developed strategies to develop the private health sector in its Vision 2030 plan as well as in the strategic plans for 2008–2012 of the Ministry of Medical Services (MOMS) and Ministry of Public Health and Sanitation (MOPHS). (These two ministries are the component branches of the recently divided Ministry of Health.) Some of the key features of those plans include social health insurance to increase access to health care, a reduced role for the Ministry of Health in service delivery, more delegation of authority to provincial and district level, and promoting more public-private partnerships (PPPs).

In this context, USAID/Kenya requested that the Private Sector Partnerships-*One* project (PSP-*One*) conduct an assessment of the private health sector in Kenya. The scope of work involved assessing the role of the private sector in the overall health system, considering the potential of the private sector to play a greater role and identifying ways to improve the public-private interface to increase equity, access and efficiency in the health system. The development of the scope of work also coincided with the start-up of the World Bank/International Finance Corporation (IFC) program for Better Health in Africa, which envisions improvement of the government-private sector interface to create new opportunities for investment and lending for growth of the private health sector in Africa. As a result, the PSP-*One* team was able to benefit from World Bank/IFC support for both this report and a summary report that served as a catalyst for a policy dialogue. The recommendations in this report have been revised in consideration of stakeholder feedback received during the policy process.

Key Findings

In general, the PSP-*One* team found that the private commercial health sector plays a very significant role—and has the potential to play a greater role in providing quality care to Kenyans. This is true for nearly all disease areas. For example:

- Children with symptoms of ARI are taken to private sector providers more often than to public sector providers.
- One-third of couples obtain their family planning methods from the private commercial sector and another 10 percent go to facilities run by nongovernmental organizations (NGOs) and faith-based organizations (FBOs).
- One-third of men and one-quarter of women go to for-profit and not-for-profit providers to receive an HIV test.

In terms of number of facilities and personnel, the private sector is larger than the other sectors and growing. 2006 data from the MOH shows that of 5,129 health facilities in the country, 2,217 are in the private commercial sector, 792 are non-profits, and 2,120 are in the public sector.

The degree to which the private sector is leveraged to improve access to quality care for more Kenyans will depend on how well the Government of Kenya and other stakeholders address key issues in the following five areas:

- Stewardship of the private sector
- Health financing and insurance
- Delivering quality services in the private health sector
- Delivery of health products through the private supply chain
- Collecting data and information on the private health sector

Stewardship of the private sector

There is an important opportunity in Kenya for providing needed stewardship of the private health sector. In and outside of government, there is a general consensus that the private health sector has an important role to play in the country; but it is less clear how to define appropriate roles and responsibilities for the public and private sectors in health. While stakeholders can see the advantages of PPPs, the processes and institutions to create those partnerships must be defined. Several factors contribute to the window of opportunity. The Kenyan government is actively engaging with the private sector; the MOMS and MOPHS have demonstrated interest in collaborating with the private health sector; private sector actors are well organized; and there is strong donor support for the private sector partnerships in health.

Health financing and insurance

The MOMS and MOPHS are actively developing a new health financing strategy that will use a mix of taxes, social health insurance, and private insurance systems to increase access to health care and promote equity. Increasing the purchasing power of Kenyans through demand-side health financing is probably the greatest single factor that could drive the growth of the private health sector. There are, however, several challenges in building a market for health insurance.

- The few private insurers in existence are serving only the high end of the market. The private health insurance sector in Kenya is still relatively small, covering about 2 percent of the population, mostly high-income groups working in the formal sector.
- Both consumers and health care providers have poor knowledge and perceptions of health insurance. Consumers generally have a poor understanding of the concept of risk pooling, and the insurance industry has a poor image due to the collapse of several managed-care schemes.
- Most insurers are reluctant to create true risk-pooling products and treat health care like other lines of indemnity insurance due to weak underwriting capacity and overly restrictive regulations that prevent innovation.
- Low-cost, innovative insurance products are uncommon in Kenya. The absence of data on the lower end of the market, lack of underwriting skills

needed to develop low-cost products, and need for economies of scale have dampened innovation in this area.

- There is strong interest in developing low-cost health insurance/micro-insurance plans. A number of insurance companies and medical insurance plans are working with microfinance institutions to introduce low-cost health insurance products.
- Fee-for-service is the predominant mode of provider payments in both private and public health insurance. The low use of capitation has been attributed to lack of skills, lack of reliable statistics, negative attitudes by providers, and the low bargaining power of payers.
- Most private health insurance providers do not see significant competition from social health insurance except in the lower market segment. Everyone anticipates that some form of universal or social health insurance scheme will be established in Kenya. Such a scheme will not pose a threat to the middle-to upper-income segment of the market, but could compete with private insurers' efforts to develop low-cost insurance products.
- Regulatory reform is critical to consolidate and grow the health insurance market. Most private health insurers believe that the most important and complex aspects of health insurance are not covered by the current law, hindering the development of innovative risk-pooling mechanisms. The central issue for reform is whether or not the health insurance laws, and the regulatory agency, should be separate from the structure for regulating other types of insurance.

Delivering quality services through the private sector

Kenya has many legal and regulatory components in place to facilitate growth of the private health sector. There are effective regulatory schemes for health professionals, and the concept of continuing professional education is well established. Moreover, all of the Boards of Registration have procedures in place to withdraw the practice licenses of the health professionals they supervise. But there are still areas that need to be strengthened to improve the quality of services.

- Lack of enforcement by the professional boards result in a highly unregulated private health sector.
- Unqualified health professionals continue to practice privately in the country, despite some well-publicized crackdowns.
- Responsibility for licensing of private health facilities is spread across too many regulatory bodies, leading to inefficiencies and gaps in monitoring quality of care.
- There is no non-governmental accreditation or certification for facilities and laboratories.

Delivering quality health products through private channels

The private sector supply chain is highly fragmented and inefficient.

- There are *too many suppliers* in the marketplace, driving down price and quality. Virtually all levels, from importers to retailers, are characterized by a high degree of competition and fragmentation.
- Large quantities of substandard and counterfeit drugs circulate in Kenya, and government has *limited capacity to monitor and enforce quality standards*.
- Public resources are used inefficiently due to *duplication of efforts across the public, private, and not-for-profit supply chains*. Several parallel systems have emerged to circumvent the public supply chain.
- *The Pharmacy and Poisons Control Board (PPB) has a large mandate but insufficient capacity*. The PPB has a much greater burden for inspecting facilities than other boards, with 6,000 facilities in need of inspection—including nearly two-thirds that need to be shut down for operating without a license.

Information and data on the private health sector

Lack of information is one of the greatest barriers to public sector understanding of the private health sector and a serious constraint on the ability of private sector entities to analyze risks of entering the health market. Basic data are lacking on the private health sector, the business environment, and consumer preferences.

Recommendations

The following recommendations address the key issues highlighted in the report and are intended to serve as a starting point for dialogue between the public and private sectors.

Stewardship and governance

- Strengthen the MOMS' and MOPHS' stewardship of the private sector by establishing the institutional framework for a new PPP in health. Once established, resources and assistance should be mobilized to build the unit's capacity to create and implement PPPs, to identify key PPP champions, and to strengthen their management skills.
- Establish a formal mechanism or forum for dialogue that engages all stakeholder groups. One possibility is to use an existing framework, such as the Ministerial Stakeholder Forum, to continue the dialogue.
- Lead a participatory process to prioritize and segment the different health markets. As stewards of the health sector, the MOMS and MOPHS can bring together key stakeholders to discuss which segments of the health market each group should serve based on comparative advantage. The team recommends analyzing disease-specific products or services, where there is often overlap and duplication of effort between the public, not-for-profit, and commercial sectors.

Health financing and insurance

Support efforts to create a mixed health insurance system in Kenya by:

- supporting a dialogue among key stakeholders;
- clearly defining the future role of the National Hospital Insurance Fund;

- encouraging the private insurance sector to create more health insurance products for lower-income Kenyans;
- developing a regulatory regime specific to health insurance; and
- amending the current insurance law to foster consolidation of the health insurance market.

Delivering quality services

To improve the *quality* of private sector services, the team proposes the following actions:

- *Strengthen regulations to enforce policies on quality* by streamlining professional boards' internal disciplinary procedures and creating a shared system of hearings officers and enforcement attorneys.
- *Create a unified licensing agency for all health facilities*, overseen by the lead health agency (presumably the MOMS). Among other tasks, this licensing authority would enforce requirements for staffing by licensed professionals and would validate licenses through the relevant professional board, as well as assume responsibility for defining, categorizing, and coding all health facilities.
- *Establish a public-private sector task force to develop the license standards and operating guidelines for a unified facility licensing agency*. The task force would draft the licensing regulations for each class of facility. At the same time, the governing statutes should be revised to consolidate the powers of the new agency and clarify its relationship with the professional licensing boards.
- *Test the concept of voluntary accreditation and certification*. The Gold Star Network represents one immediate opportunity for voluntary accreditation or certification, as a mechanism to ensure quality in certain private sector services.
- *Develop a system of quality assurance for private laboratories using an accreditation mechanism*. Provide technical assistance and funding to set up such a program, perhaps through the Kenya Association of Laboratory Scientific Officers.

To improve *access* to key health services, the team proposes maximizing the private sector role in health by:

- *Formalizing PPPs in key health markets* such as: antiretroviral treatment and voluntary counseling and testing for HIV/AIDS; bed nets and artemisinin-based combination therapy (ACT) markets for malaria; family planning products and reproductive health services; and management of chronic noncommunicable diseases.
- *Creating a chain of retail drug outlets that offer essential medicine and some of the commonly prescribed branded medicines*. Donors could support a pilot area (currently underserved by retail pharmacies or chemist shops) and invest in the creation of the franchisor function of the retail network.

Improving human resource capacity

A few interventions could easily build private sector human resource capacity and strengthen the quality of services:

- Opening donor-funded training for public health officials to include private sector providers, as successfully demonstrated in other African countries.
- Support the health insurance course offered by the College of Kenya Insurers with curriculum development and training.
- Promote business skills development for public and private practitioners, managers, and administrators. Health care management can be integrated into existing training programs in both the public and private sectors, such as health management training at the Kenya Institute of Management and Strathmore Business School. Business management courses for health providers can also be offered through professional associations and accredited for Continuing Professional Education credit.

Distributing quality health products through the private supply chain

- Reform the PPB into an independent agency with resources commensurate with its mandate. The PPB should continue to fulfill its existing role in the regulation of the profession—defining the scope of practice, and regulating the course requirements for diplomas and continuing medical education requirements.
- Assign responsibility for registering drugs and ensuring drug quality to an entity other than the PPB. This new, independent entity would assume the functions of the National Quality Control Labs and be overseen by the MOMS.
- Review and update the Pharmacy and Poisons Act (Cap 244). Such a review is underway and will require contributions from multiple stakeholders from the public, private, and not-for-profit sectors.
- Consider regulation and other incentives to consolidate the pharmaceutical market. The government could auction a limited number of licenses for pharmaceutical wholesalers and distributors.

Information to support private sector engagement

- Create a health market and consumer research clearinghouse, which could be run as a partnership involving: the national statistical service; HENNET, the Health NGOs Network; and the Kenya Private Sector Alliance from the commercial sector.
- Create a clearinghouse of information on the private health sector. The PPP in Health Unit should produce data and analysis from various sources to inform policy and program design. For example, the clearinghouse could generate analysis to match sources of health care with appropriate population segments in different disease or service provision areas.

Areas for Future Study

A number of areas merit further exploration: other health financing approaches (e.g., contracting out, vouchers, and donation of subsidized products and other inputs); building capacity in the health workforce (e.g., project workforce needs); exploring private sector provision of medical health education; and prioritization of health care markets followed by more in-depth analysis. Nevertheless, the government and its partners should seize the opportunity to continue a dialogue on improving the

performance of the private health sector to help achieve public health goals. A forum is needed to bring together all stakeholders to build consensus on the respective roles and responsibilities of the public and private sectors, and on the areas of health that are ripe for PPPs.

Introduction and Background

Introduction

Over the last 20 years, the private health sector in Kenya has grown significantly. Any meaningful strategy to improve health outcomes in Kenya must look beyond the public sector and consider the potential of the not-for-profit and the for-profit (commercial) health sector. The current Government of Kenya (GOK) understands this, and the private sector is very much a part of their Vision 2030 plan for growth in all areas, including health. The government's development partners—both bilateral and multilateral—are also becoming aware of how large a role commercial health providers play in the health system. As a result, there is an important need to understand the characteristics of the private health sector as well as to identify appropriate and effective ways to engage the private commercial health sector.

In order to address this need, USAID/Kenya, in partnership with the GOK and the World Bank and International Finance Corporation (IFC) requested the Private Sector Partnerships-*One* (PSP-*One*) project to conduct a broad health sector assessment. The assessment involved a synthesis of health systems analysis and market analysis. The health systems analysis considered the legal and regulatory framework, the policy environment, the human resource capacity, and the financing of health systems. The market analysis focused on selected diseases, health products, and service areas that constitute existing or potential markets for the private commercial sector. The overall objective of the assessment was to inform the GOK and its partners about different ways to build public-private partnerships (PPPs). PSP-*One* identified three general areas for PPPs:

- Improved policy for a more effective interface between the public and private sector
- Operational partnerships that improve access to quality products and services by bridging market gaps
- Creation of sustainable institutional frameworks for future public-private consultation and partnership development

Background

Economy

The Kenyan government has recently invested significantly in developing and promoting an ambitious economic growth strategy, Vision 2030. This plan sets a target of 10 percent gross domestic product (GDP) growth per annum, a target that now appears unrealistic, in light of the global financial collapse and considering Kenya's

record of erratic economic growth. During the years following independence (approximately 1964-74), the economy grew around 7 percent per year (CBS 2003). Since then, the economy has been in decline, reaching its lowest growth level (2 percent) between 1996 and 2002. Contributing factors in this decline were low commodity prices, world recession, bad weather, poor infrastructure, and drought in the 1980s. (United Nations Development Programme [UNDP] 2006). Since 2002, however, Kenya experienced a substantial economic recovery. Currently, Kenya's GDP is approximately \$22.78 billion, with an annual GDP growth of 6.1 percent (World Bank 2008). It remains to be seen how severely the Kenyan economy will be affected by the current global recession. Because the economy depends on many discretionary consumer items (cut flowers, coffee, tourism), it seems clear that Kenyans will feel the impact of reduced spending in the Europe and the United States.

Population dynamics

Kenya has an estimated population of 37.5 million people (World Bank 2007). The population has grown steadily, although the growth rate decreased from 3.4 percent in the period 1969-1989 to 2.9 percent in 1989-1999. The population density has increased from 19 per km² in 1969 to 49 per km² in 1999 (CBS et al. 2003), with the proportion of Kenyans living in urban settings steadily increasing, from 9.9 percent in 1969 to 19.4 percent in 1999 (CBS et al. 2003). The increased population density in urban areas both reflects economic growth and contributes to it, by helping to create viable markets.

Socio-economic factors

There are other characteristics of the national population that are not favorable to the growth of the economy and the strengthening of the health market. 56 percent of Kenya's population lives in poverty, over half of them below the absolute poverty level (CBS 2003). This impoverished population lives primarily in rural areas (75 percent), but there are also large numbers of urban poor living in informal peri-urban settlements. There are large differentials in this respect, both across provinces and at the sub-district level within provinces (International Monetary Fund 2005). Poverty levels are exacerbated by high unemployment, affecting 37.9 percent of Kenyan women and 23 percent of men (CBS 2003). Wealth in Kenya is also distributed inequitably, with the richest quintile earning 51.2 percent of national income while the poorest quintile earns only 5.6 percent of national income (Earthtrends 2003 data¹).

Another negative factor for the development of the health market is the low level of education of a large segment of the population. Illiteracy complicates health education programs, making it less likely that consumers will be able to use health insurance or access written information needed for patient compliance—follow prescriptions, for example, or read and understand preventive health messages. Approximately 23 percent of females and 16 percent of males have no education at all (CBS 2003). Urban populations have more years of education than rural populations, with the median number of years of education at 7.1 and 7.5 for urban females and males, respectively; compare with 3.5 and 4.2 for rural females and males, respectively. Overall, illiteracy is 21.5 percent among females and 12 percent for males. (This substantial difference mainly reflects a large gender gap at older ages.)

The Kenyan population is also relatively young, although the trend is upward. The median age of the population was 17.5 years according to the 2003 Kenya Demographic Health Survey (KDHS), up from 16.9 in 1998 and 15.3 in 1993 (CBS 2003). Forty-five percent of the total population is under age 15, 52 percent is age 15-64, and only 3 percent is 65 and older (CBS 2003). The median age at first marriage is 19.7 for women and 25.1 for men. Both women and men in lower wealth quintiles or with little to no education tend to marry at an earlier age (CBS 2003). The youth of the population is a positive factor for certain health markets (pediatrics and obstetrics), but less so for chronic diseases or geriatrics.

Notes

¹ <http://earthtrends.wri.org>.

Methodology

P*S*P-*O*ne has conducted a number of private sector health assessments in different parts of the world since its inception in 2004. Each one varies with the particular interest of the USAID mission requesting the assessment. In the case of the Kenya assessment, USAID indicated from the outset that they would like *P*S*P*-*O*ne to look beyond a single health sector (e.g., reproductive health or RH), to more broadly assess the role of the private sector in the overall health system. The development of the scope of work coincided with the start-up of the World Bank/ IFC program for Better Health in Africa, which envisions improving the public-private sector interface to create new opportunities for investment and lending, to promote growth of the private health sector in Africa. USAID encouraged *P*S*P*-*O*ne to coordinate with the World Bank, resulting in the scope of work shown in Appendix 1.

Considering the range and breadth of private sector activities in Kenya as well as the number of past and ongoing initiatives in PPPs, health financing, and health policy and regulation, *P*S*P*-*O*ne planned an extensive review of available research, data, and project information, conducting a comprehensive literature review of surveys, studies, laws and policy documents. *P*S*P*-*O*ne also analyzed several data sources, including the 2005/06 National Health Accounts (NHA), the 2004 Service Provision Assessment (SPA), and the 2003 KDHS. Although a wealth of data exists on health care and disease burden in Kenya, it is often difficult or impossible to disaggregate data relating to the private commercial sector. Consequently, data analysis of the private sector's role was limited to selected disease or product/ service provision areas.

In-country assessment work was done in three phases. The first phase, in December 2008, was an initial "landscaping" of the private sector health environment to identify key players, major initiatives, and key issues. This assessment also helped to focus the literature review and to recruit key stakeholders for the second phase of the in-country assessment, which took place February 10-23, 2009. A list of informants interviewed as a part of the in-country work is shown in Appendix 2.

During the second phase, a team of four met with providers and stakeholders in four cities: Nairobi, Embu, Naivasha, and Machakos. Because time did not permit travel to other large cities where the private sector is active, such as Mombasa, Kisumu, or Nakuru, or to get the perspective of private clinical officers and nurses, *P*S*P*-*O*ne organized ten focus-group discussions with nurses and clinical officers from Kisumu and Nairobi. The findings of this research are presented in Appendix 3.

The third phase involved the presentation of the main findings of this report to a group of private health sector stakeholders in Naivasha on April 19-23, where the findings were discussed and validated. The study recommendations were also refined,

and the revised recommendations are included in this report. The policy dialogue involving key stakeholders continues as this report is published. While some specific recommendations can be acted on in the short term, other general recommendations will require more careful study and debate before they can be finalized and implemented as policy.

In anticipation of the policy dialogue that this report is intended to inform, PSP-*One* spent substantial time developing and refining the recommendations that make up a large part of this report. All of the recommendations were made with a view to achieving the following broad objectives:

- Increasing the availability of health care by expanding the private sector
- Increasing equity in the health system by making private care more affordable
- Improving the quality of private sector health care to improve health outcomes
- Improving efficiency in the health system by targeting public subsidies where they are most needed and by promoting the comparative advantage of each player in the health system

In addition to the policy reform recommendations, PSP-*One* also made a number of “Donor Opportunity” recommendations presented in Appendix 4. These are recommendations for specific activities that can be easily supported through typical donor funding mechanisms, and that will either strengthen the environment for developing PPPs or further develop experiences or models that PSP-*One* considers instructive and promising.

Through the evidence and arguments provided in this report, PSP-*One* hopes to act as a catalyst for a policy reform and investment that will lead to better health for all Kenyans.

Assessment Findings and Issues

Private Sector Size and Structure

Much is known about the public and not-for-profit health sectors in Kenya. This section attempts to describe and quantify the size, scope, and use of the private health sector, drawing on a variety of data sources including the NHA, KDHS, SPA, the Kenya AIDS Indicator Survey (KAIS), and MOH statistics.

Definition of the private sector

Private sector health care is often defined to include all the providers outside the public sector. The private sector includes both for-profit and not-for-profit entities, such as faith-based organizations (FBOs) and nongovernmental organizations (NGOs). The private sector covers a wide range of health care providers, such as doctors, nurses, midwives, clinical officers, and pharmacists.

These providers practice in a variety of settings, including commercial clinics and hospitals, nursing and maternity homes, university hospital and academic centers, pharmacies and drug shops, and private laboratories and other diagnostic services.

Figure 3.1 illustrates the makeup of the private health care sector, reflecting the fact that segments of the private health care sector can sometimes overlap and the lines are often blurred. A 2004 study revealed a confusing array of terms used to classify health care providers and facilities in the private sector. Doctors, nurses, or clinic officers operate most private health care facilities. However, the title “doctor” has proliferated in Kenya; traditional health practitioners, pharmacists, and even clinical officers are commonly referred to with the title of “doctor,” particularly in rural areas. In addition, some health facilities identify themselves as hospitals whereas others with similar features identify themselves as clinics or nursing homes. Terms used for providers and facilities are also inconsistent when referring to the public and private sectors.

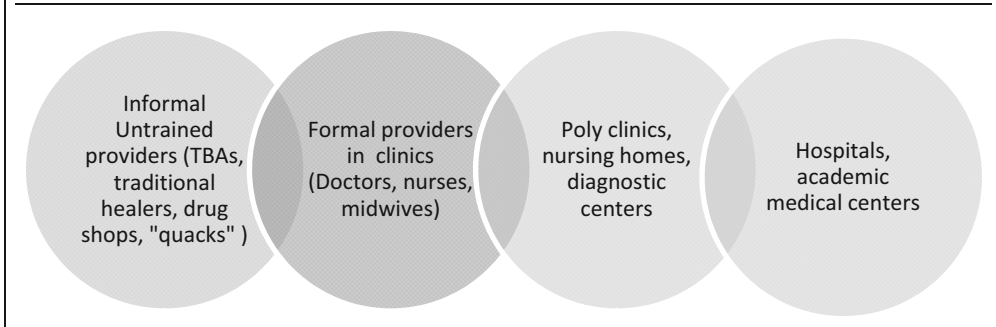
Box 3.1. Did You Know?

The size of the private health care market is Ksh 20.7 billion.

Two-thirds of money spent in the private sector is on health services rendered in hospitals.

The private health sector owns and manages almost two-thirds of all Kenya's health facilities.

The private sector is the largest employer of health care professionals in Kenya.

Figure 3.1. Private Health Care Providers

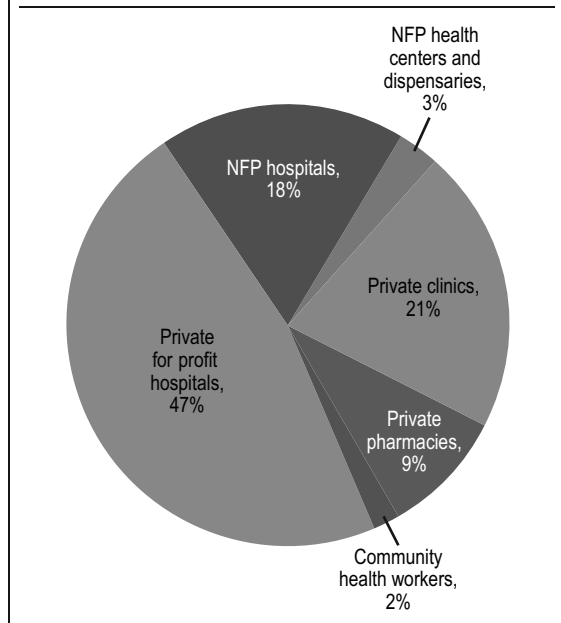
Source: Authors.

This private health sector assessment focused exclusively on the for-profit (commercial) sector, in view of the extensive existing research and documentation on the FBO/NGO sector. Moreover, while the assessment only examined the formal health sector, the importance of informal sector providers should not be underestimated.

Size of the private health sector market

The 2005/06 NHA analysis estimates the private sector market at Ksh 20.7 billion, as one indicator of the size of that market. The estimate is conservative, because it excludes expenses for health policy and health education—especially significant because of the recent emergence of private medical schools (e.g., Nairobi West Hospital). There are indications that these private medical schools can be part of a vertical integration strategy, in a commercial network of hospitals and clinics. The NHA analysis may have also excluded expenses made by foreign nationals for health care in Kenya.

Figure 3.2 illustrates how the Ksh 20.7 billion was spent in the private health sector. Two-thirds were spent at hospitals: 47 percent at private for-profit hospitals, and 18 percent at not-for-profit (faith-based and NGO) hospitals. Approximately one-quarter of these funds were spent at clinics, health centers, and dispensaries. Unlike in other developing countries, a small percentage (9 percent) of health spending is at private pharmacies.

Figure 3.2. Distribution of Total Health Expenditures in the Kenyan Private Sector, 2005/06 (100% = 20.7 billion ksh)

Source: NHA 2005/06.

Growth of the private health sector

The private health sector has grown dramatically over the last two decades. Possible factors contributing to its growth include: lack of adequate and quality public health care services; the introduction of user fees in public facilities; and health sector reforms in the 1980s and 1990s that relaxed licensing and regulation of private health care providers and allowed public sector personnel to work in private practice (Muthaka 2004). One indicator of growth is the increase in health facilities owned by the private sector. In 1992, the private sector owned and managed less than half (47 percent) of all health facilities in Kenya. By 2006, private sector ownership grew to 59 percent (see Tables 3.1 and 3.2).

Table 3.1. Number of Health Facilities by Type and Ownership, Kenya, 1999

Facility Type	MOH	FBO	Private	Total
Hospital	110		111	221
Nursing homes*			189	189
Health centers	465		115	580
Dispensaries	1,583		992	2,575
Clinics	94		635	729
Total	2,252	0	2,042	4,294

Source: Muthaka 2004: 21, Table 2b (table adapted from Government of Kenya statistics, 2001a).

Note: The MOH data did not distinguish between not for profit and for profit facilities in 2004.

*Nursing homes are mainly small to medium size private hospitals (Level 3 facility).

Table 3.2. Distribution of Health Facilities in Kenya by Type and Ownership, 2006

Facility Type	MOH	FBO	Private	Total
Hospital	158	74	68	300
Nursing homes*			191	191
Health centers	459	172	21	652
Dispensaries	1,503	546	203	2,252
Clinics			1,734	1,734
Total	2,120	792	2,217	5,129

Source: Adopted and modified from Ministry of Medical Services (MOMS) (2006): 42

*Nursing homes are mainly small to medium size private hospitals (Level 3 facility).

MOH data show the distribution of ownership of health facilities. In 2006, the public and private sectors manage and operate comparable levels of Kenya's health infrastructure, at 41 percent and 43 percent respectively. The majority of public facilities consist of hospitals and dispensaries, while private sector facilities are primarily clinics and nursing homes. Not-for-profit entities own 16 percent of all health facilities, comprising mostly dispensaries and health centers. The public sector has the largest number of hospitals (53 percent), followed by the not-for-profit sector (24 percent) and the private sector (23 percent). The private sector dominates the nursing home segment (mainly small-to-medium-size private hospitals) and health clinics. The public sector and not-for-profit sectors own most of the health centers and dispensaries.

While the data on the number of facilities is thought to be very accurate, the number of facilities alone does not say anything about which services are being provided by each sector or about the workload of providers in the different sectors. There is inadequate reporting to the MOH Health Management Information Systems (HMIS) Unit on patient visits or client registries. In 2006, the overall response rate to the HMIS unit was 67 percent, with considerable variance between provinces. A better indicator is available from the household expenditure survey, which asked informants about which types of medical care and health providers they had accessed in the last four weeks (MOH 2003). The usage over the last four weeks is annualized to show the relative usage of different providers, as shown in Table 3.3.

Table 3.3. Out Visits to Providers by Provinces and Sector, 2007 (in %)

Province	Public	Private	FBO	Chemist	Others	Total
Nairobi	34.6	34.6	8.3	18.6	3.9	100.0
Central	69.1	18.0	10.5	2.3	0.0	100.0
Coast	56.3	27.0	2.6	12.5	1.6	100.0
Eastern	66.4	18.4	10.2	4.6	0.4	100.0
North Eastern	79.8	17.1	0.0	2.5	0.6	100.0
Nyanza	60.1	12.4	2.9	20.9	3.7	100.0
Rift Valley	55.4	20.4	8.7	12.3	3.2	100.0
Western	47.8	15.5	3.4	30.5	2.9	100.0
Cluster Type						
Urban	45.5	29.0	4.8	18.7	2.0	100.0
Rural	59.5	16.8	6.8	14.3	2.7	100.0

Source: MOH 2003.

These data show that use of private commercial providers is high throughout the country, although, as expected, the share of outpatient visits is greatest in Nairobi (34.6 percent). Interestingly, the share of outpatient visits to the private commercial sector exceeds that of the FBO sector in both urban and rural settings. This is largely explained by the fact that there are roughly 1,400 more (280 percent more) private facilities (especially clinics) than FBO facilities. However, the private share of outpatient visits is more than five times the share of FBO facilities in urban settings and more the twice the share in rural settings. This suggests that on average the client flow in commercial facilities is equal or greater to that in the faith-based facilities.

Private health sector workforce

The team estimated numbers of private medical professionals based on MOH statistics combined with information collected from key informants. Table 3.4 shows that the majority of Kenyan health care professionals work in the private sector, at either a for-profit or a not-for-profit entity. Almost three-quarters of doctors and almost two-thirds of nurses and clinical officers work in the private sector. This large number of health care professionals in the private sector underscores the need to better integrate them into the overall health system, not only to ensure quality of care, but also to realign some of their activities to help address the country's health priorities.

Table 3.4. Estimates of Health Personnel in the Public and Private Sectors, 2007, 2008

Cadre	Total Registered (2007)	Public Sector (2008)	Public Sector (% of total)	Private Sector*	Private Sector (% of total)
Doctors	6,271	1,605	26%	4,666	74
Dentists	631	205	32%	426	68
Pharmacists	2,775	382	14%	2,393	86
Pharmaceutical technologist	1,680	227	14%	1,453	86
Nursing officers	12,198	3,013	25%	9,185	75
Enrolled nurses	31,917	11,679	37%	20,238	63
Clinical officers	5,797	2,202	38%	3,595	62

Source: Adopted from MOMS (2008): 44-45.

*Estimate ignores changes in registered numbers in 2008.

It should be noted that there may be some overestimating of providers in the private sector because the councils that record provider registrations do not systematically analyze the sector in which a provider is working. Not all councils update provider registrations to reflect providers who have emigrated, retired, or died. The Nursing Council is one exception; it tracks emigrating nurses by destination country. Otherwise, the number of providers in the private sector is inferred by the MOH HMIS division by simply subtracting the number of public sector workers from the total providers registered. Another caveat to these data is that not all registered providers working in the private sector are providing health care. Many providers maintain their registration, but may be working in insurance, project administration, consulting, or a completely unrelated field. Informants estimate that as many as 10 percent of registered providers may not be providing health care.

Structure of the private health sector

The structure of the private health sector is lopsided, with a small number of large, successful private providers who own hospitals and clinics that offer high-quality services, concentrated mainly in Nairobi, Kisumu, and Mombasa. Below this level is a large number of small-scale providers at small primary care facilities that struggle to remain financially viable and whose quality varies. These small-scale providers are located throughout the country and serve lower-to middle-income clientele. This gap in the middle range of private facilities has implications for the effectiveness of referral systems and continuity of care in the private sector. The absence of private secondary care facilities means that private primary care providers have few options for referrals other than to send patients to public sector providers. Several private primary care providers reported problems for their patients when they are referred to public sector secondary care facilities. The public facilities do not accept the diagnoses made by the private providers and often require the patient to begin the consultation process over again. It would appear that some policy work needs to be done to clarify the protocols for referrals of patients between the public and private sectors.

Kenyan Burden of Disease and the Private Health Markets

As in most countries in Sub-Saharan Africa, the burden of disease in Kenya is driven primarily by infectious and parasitic diseases including HIV/AIDS, tuberculosis (TB), malaria, diarrheal diseases, and childhood vaccine-preventable diseases. Maternal morbidity and mortality, injuries, and cardiovascular disease are also major contributors to the burden of disease. The assessment team assessed selected six treatment areas (malaria, HIV/AIDS, RH, maternal care, deliveries, and child health) to understand the role of the private commercial sector and to discuss potential opportunities for the private sector to play a larger role in the different health markets. The current role of the private sector in providing health care and the opportunities for an increased role vary considerably from one disease or service area to another. The team did find two general issues that seem to stem from a common practice of “stove-piping” within each health sector. Health planners, program managers, and policymakers generally do not look across all sectors to identify strategies for serving all population segments or for identifying resources that can be shared.

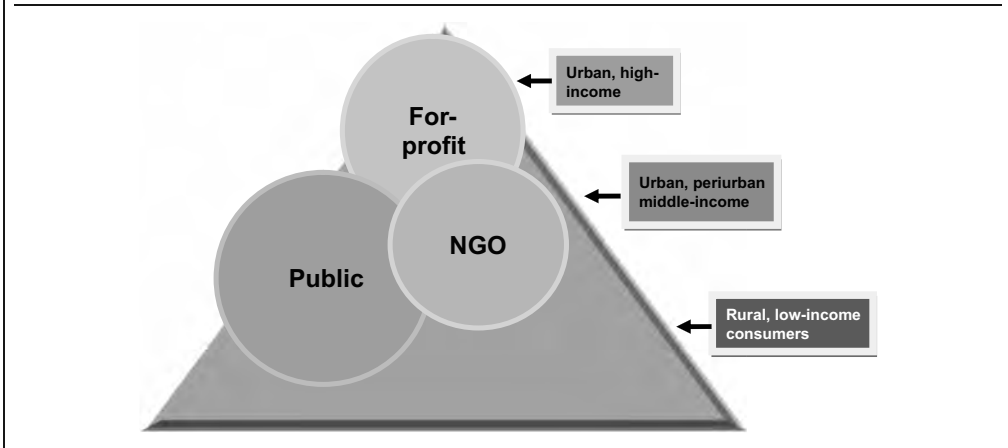
Segmenting the Kenyan health market

In general, the public sector, the not-for-profit sector, and the private commercial sector each play an important role in the overall health market, although the importance of each varies significantly by region and by the type of services or products being offered. Although nearly all informants recognized the relative importance of other sectors, the team found few examples where any strategic analysis had been done with a view to determining what each sector could best contribute to meeting Kenya’s health needs. Most government officials acknowledge that the public sector cannot provide for all of Kenya’s health needs and recognize the importance of the private for-profit, private not-for-profit, and faith-based sectors. This is articulated clearly in the Vision 2030 and in the Ministry of Health strategy documents. What is lacking is any consensus or clarity about what role each sector should play and the conditions under which each sector should play its role. In different ways, the private providers (both not-for-profit and for-profit) see themselves as addressing gaps left by the public sector. However, the process for filling these gaps is essentially ad hoc and opportunistic. In a more coordinated market segmentation approach, different types of health providers could be matched to different population segments based on geographic location, ability to pay, and consumer preferences. The guiding principles would be to improve access, use public resources efficiently, and increase equity. This matching would not be done by regulation or by forcing consumers to use certain providers. Rather it would be done by analyzing the facilities and skills in the different sectors and the needs of the different population groups, and by directing public sector investments and incentivizing private providers where the gaps are greatest. Consumers would continue to use the providers that are the most convenient, affordable, and responsive to their needs.

Of course, not all informants agree that such an approach is appropriate. For some in the not-for-profit sector, the mere fact that private health providers earn any sort of profit is reason enough to exclude them from obtaining any public support, be it financial or in kind (e.g., access to subsidized commodities and training). Some private providers fail to see why faith-based or not-for-profit providers should be given direct

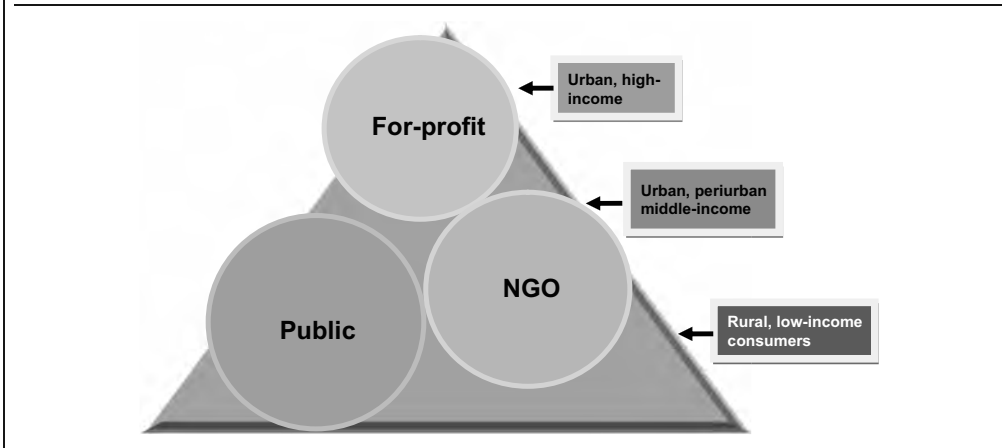
public support and be excluded from paying taxes when they are engaging in the same activities, charging fees, and perhaps competing unfairly with the private commercial providers. Regardless of whether the playing field is “level,” it is reasonable to ask whether it is efficient to use donor and government funds to perform services that the private commercial sector could perform more sustainably. The resources that are freed by leveraging the private sector are better invested in performing those functions that only government can do—regulation, health education, monitoring, and policy development and implementation. The current lack of a policy relating to health market segmentation is resulting in a health system in which the urban, higher-income consumers have much greater access to quality care than rural lower-income ones. Through investment and incentive policies, Kenya can move from the scenario in Figure 3.3 toward that in Figure 3.4.

Figure 3.3. Current Health Care Coverage



Source: Authors.

Figure 3.4. Health Care Coverage with Market Segmentation



Source: Authors.

In Figure 3.3, the different sectors supplying health care are competing (overlapping) for consumers in middle-and upper-income groups, while leaving large numbers of consumers in the rural, lower-income groups underserved.

In Figure 3.4, there is better coverage of all population segments, less competition between public/not-for-profit and for-profit sectors, and larger markets for providers in all sectors. Of course this is a very simplified approach to matching market shares to population segments. In some cases, the private sector could be better placed to serve the rural poor. In other cases, allowing NGOs to serve upper-income groups allows them to cross-subsidize services to the poor. Different population segments could be defined according to lifestyles or behaviors rather than income level and location. For example, in some countries, commercial sex workers and other high-risk groups prefer the commercial sector for services because of greater perceived confidentiality. In general, however, by consciously analyzing each sector's supply of health services and comparing it with the needs of underserved population segments, more effective strategies can be developed that integrate all health providers. By consciously avoiding unproductive competition between the public sector and other sectors and steering investments to serve the underserved, all market shares can grow and more Kenyans will have better access to quality care.

Sharing resources across health sectors

When health policymakers plan across all sectors of health providers, clearer policies surrounding shared resources can also be developed. With few exceptions (e.g., TB), there is little formal policy that guides whether and how public sector and private sector providers can share access to diagnostic equipment, training resources, subsidized donor commodities, and health data. The PSP-*One* assessment team heard numerous anecdotes about sharing of resources by public and private sector providers. However, these on-the-ground PPP's occur at the initiative of providers, who want to be efficient and practical and thus work out informal arrangements for sharing of staff, equipment, commodities, and knowledge. These partnerships are entirely dependent on the initiative and personal relationships of the individuals involved and often disappear when those individuals move on. Because these are driven by individuals, such partnerships are often not documented, replicated or systematized, resulting in missed opportunities for improving quality and increasing efficiency.

The example most often cited by private for-profit providers involves access to health commodities (contraceptives, antiretroviral (ARV) drugs, HIV testing kits, Artemisinin-based combination therapy (ACT) for malaria) that are offered for free to public and NGO facilities, but not always to commercial providers. In fact, many private providers also obtain these commodities for free, but there seems to be a policy gap regarding whether for-profit facilities can receive publicly financed commodities, and if so, under what conditions.

Malaria

Malaria is a major public health concern for Kenya, with 70 percent of the population (20 million) living in malaria-endemic areas and therefore at risk of infection (MOH 2001). The Kenya Division of Malaria Control estimates that approximately 26,000 Kenyan children die each year as a direct consequence of malaria infection (MOH

2001). Furthermore, World Health Organization (WHO) estimates that approximately 5 percent of deaths are due to malaria (WHO 2002¹).

Malaria cases are a significant burden on Kenya's health care system. It is estimated that approximately 30 percent of all outpatient attendance and 19 percent of inpatient admissions are due to malaria (MOH 2001). The government adopted ACT in April 2005 as the preferred course of treatment, although monotherapies are still sold and used. The National Malaria Strategy (NMS) places considerable importance on the availability of sulfadoxine-pyrimethamine, ACT, and other drugs for clinical management, but focuses almost exclusively on the availability of drugs in the *public sector* system. The only mention of the private sector in the NMS is:

The National Malaria Control Program will promote public/private partnerships at all levels as part of the NMS, particularly on service delivery, regulatory issues, quality and supply of commodities, sponsorship of IEC [information, education and communication] activities and testing new products.

A role for community-based health workers and not-for-profit facilities is described in the strategy, but no role is mentioned for commercial providers. In practice, however, the government has shown an openness to considering commercial perspectives: The MOH Division of Malaria Control, in its technical working group meetings, involves representatives from Vestergaard and Olyset, the two largest international manufacturers of the long-lasting insecticide-treated bed nets approved by the WHO Pesticide Evaluation Scheme (WHOPES). However, because these manufacturers are also the main suppliers for free-net programs, they may not adequately represent the interests of local bed net manufacturers or distributors. The import tariff regime currently favors the imports of sewn nets (treated or untreated), which are duty free, over the importation of netting material, which is not duty free. Retreatment kits are duty free.

In general, the strategies adopted by the GOK and its partners have approached malaria control as an emergency relief operation, using massive subsidies and entitlements to promote and distribute long-lasting insecticide-treated nets, ACTs, and indoor residual spraying with only limited consideration for efficiency or sustainability. The U.K. Department for International Development (DFID) currently funds a program that distributes over 2.4 million free nets per year throughout the country through public sector clinics, and supports social marketing of approximately 800,000 subsidized long-lasting nets in the rural trade. Similarly, the Global Fund to Fight AIDS, TB and Malaria has a multi-year target of over 4 million treated nets for free distribution, mostly through PSI.

Although there has been massive free distribution of nets, there has also been some attempt to preserve commercial involvement in the net market. The socially marketed nets are sold through commercial channels, maintaining the perception of nets as a consumer product. Population Services International (PSI) has also licensed its brand of nets, SUPANET, to a commercial entity, Country Mattresses, which sells about 20,000 units per year in urban areas at fully commercial prices. DFID is also implementing a strategy to support the commercial sector. Most commercial nets manufactured in Kenya are made of imported, untreated netting material that requires

consumers to use a retreatment tablet that DFID also distributes to commercial providers for free. PSI estimates that in 2008 local manufacturers sold 460,000 nets treated with DFID-supplied retreatment tablets. However, it is unclear how this arrangement is formalized and what, if any, strategy DFID has for downscaling or ending the provision of free treatment tablets. Vestergaard sells its own long-lasting net at fully commercial prices, but in very small quantities. Olyset is in discussions with commercial distributors about selling its own commercially priced net.

The NMS makes no mention of market segmentation and targeting of subsidies to the needy. This is in contrast to the late 1990s, when the GOK had a more mixed approach to net distribution involving the private commercial sector. At that time, the distribution of free insecticide-treated net focused on pregnant women and children under five. More recently, free nets are becoming an entitlement for all Kenyans in endemic areas. Although it may not be the most efficient use of donor resources, this approach is beginning to yield results. PSI's household surveys show that households owning at least one net have increased from 30.4 percent in 2003 to 65.1 percent in 2007. Use of nets has also increased, with the percentage of children under five who have slept under a net (any type) the last night increasing from 23.8 percent in 2003 to 55.8 percent in 2007. Use of nets by pregnant women has grown at a much lower rate (24.9 percent in 2003 to 48.3 percent in 2007), in spite of the fact that distribution at antenatal clinics has been one of the main free distribution strategies. This gap between ownership and use is a reminder that there is a much greater need for public funds to promote behavior change—which the commercial sector will not do—than for product distribution, which the commercial sector performs well.

Indoor residual spraying is done only under epidemic conditions. It would therefore seem to be a service that the government could contract with the private sector to perform when needed, but the current strategy involves management of spraying activities by District Outbreak Management Teams. It is not clear how much (if any) of the spraying is being done outside of the public sector.

There appears to have been more active engagement with the private commercial sector in the area of drugs, ensuring that private chemists and pharmacies are correctly dispensing malaria treatment drugs of sufficient quality. The Rational Pharmaceutical Management Plus (RPM Plus) Project has received support from USAID and the Presidential Malaria Initiative to train providers on the new treatment protocols. In an assessment of prescribing habits of providers conducted by RPM Plus in December 2006, private pharmaceutical outlets were prescribing consistently with the treatment guidelines as often as public sector facilities. Mission hospitals and private clinics, however, did not perform as well on this task. In terms of correctly *describing* the administration of antimalarials, however, private clinics and mission hospitals performed better than public sector clinics. This assessment showed considerable need for provider training in all sectors, but it is interesting that the private commercial sector showed as much familiarity with the new government protocols as the government providers.

PSI is currently conducting a pilot program for the social marketing of pediatric ACT under the "Tibamal" brand, which will be owned by the GOK. This will be marketed at highly subsidized prices through rural retail shops whose owners are

trained in appropriate prescribing practices. This pilot is being monitored by the Kenya Medical Research Institute (KEMRI) Welcome Trust; results are expected in late 2009.

HIV/AIDS

With an HIV prevalence rate of 7.4 percent, and approximately 1.4 million Kenyan adults living with HIV/AIDS (National AIDS and STI Control Program [NASCOP] 2007), the disease is a significant burden to the health system and society in general. HIV prevalence in urban areas, at 9 percent, is higher than rural prevalence, at 7 percent; however, the majority of HIV cases are in rural areas.

The NHA HIV subaccounts analysis in Table 3.5 below shows that the financing burden of HIV/AIDS is shared by the GOK, the private sector (insurers and workplaces), donors, and consumers (households). In some countries, the scale-up of donor investments in HIV/AIDS care and treatment has crowded out the private sector.

Table 3.5. NHA HIV Subaccount Analysis

Indicators	2001/02	2005/06
Prevalence rate (adults)	6.7%	5.1%
Number of PLHIV	982,685	1,091,000
Total HIV/AIDS expenditure (THE _{HIV}) Ksh	9,927,769,404	17,883,561,276
Total HIV/AIDS expenditure (THE _{HIV}) US\$	126,307,499	243,562,292
HIV/AIDS health spending per PLHIV Ksh	10,103	18,082
HIV/AIDS health spending per PLHIV US\$	129	246
HIV/AIDS spending as a % of general THE	17.4%	25.8%
HIV/AIDS spending as a % of GDP	0.9%	1.2%
THE _{HIV} as a % of total HIV/AIDS spending (health and non health)		91.1%
THE _{HIV} % targeted for HIV/AIDS		89.5%
Financing sources as a % of THE_{HIV}		
Public	21.3%	7.8%
Private	27.8%	24.7%
Donor	50.8%	67.5%
Other	0.1%	0.1%
Household (HH) spending		
Total HIV HH spending as % of general THE	4.6%	6.2%
OOP spending as % of THE _{HIV}	21.3%	23.2%
Financing agent distribution as a % of THE_{HIV}		
Public	60.0%	23.2%
Private	24.8%	32.4%
Donor and NGO	15.2%	44.3%
Provider distribution as a % of THE_{HIV}		
Public facilities	41.4%	32.8%
Private facilities	14.4%	21.1%
Other	44.2%	46.1%
Function distribution as a % of THE_{HIV}		
Curative Care	44.2%	54.0%
Prevention and public health programs	47.1%	28.3%
Pharmaceuticals	4.9%	1.3%
Other	3.7%	16.4%

Source: NHA 2001/02, NHA 2005/06.

In contrast, in Kenya, private facilities have expanded in this area along with donor funding. As donor contributions increased from 50.8 percent of total health expenditure in 2001/02 to 67.5 percent in 2005/06, the private facilities' share of total health expenditure going to HIV/AIDS also increased, from 14.4 percent to 21.1 percent. The increase in donor funding has primarily relieved some of the expenditure burden on the public sector, but not on households: household out-of-pocket spending also increased in the same period, albeit slightly, from 21.3 percent to 23.2 percent. Most of the increase in out-of-pocket spending went for inpatient costs, primarily in private hospitals: private hospital consumption rose from 14.8 percent of household out-of-pocket spending in 2001/02 to 50 percent in 2005/06. The care and treatment burden also is shared between the GOK, the not-for-profit sector, and the private for-profit sector.

One intervention that may have contributed to the private sector maintaining its share of antiretroviral therapy (ART) provision was the Gold Star Network, which provided training as well as access to ARVs and lab services to private providers treating patients on ART. (See Case Study #1 in Appendix 5.)

Another service where the private commercial sector could play a larger role is the provision of voluntary counseling and testing (VCT). The KAIS found that demand for this service has increased rapidly, with HIV testing uptake tripling among women and doubling among men ages 15-49 since 2003 (NASCO 2007). However, there is enormous unmet need for this service. Two-thirds of Kenyans ages 15-64 report never having been tested, and they are unaware of their status. There is a large disparity among testing between urban and rural residents: half of all urban Kenyans have been tested at least once, compared to 30 percent of rural residents.

The KAIS also found that almost 80 percent of individuals who were HIV-positive were not aware of their HIV-positive status. Among individuals who tested positive for HIV in the KAIS, 57 percent reported they had never tested for HIV. Another 26 percent reported themselves as negative based on their last HIV test, but tested positive during the survey. Of greatest concern is the 63 percent of HIV-positive people who would be eligible for ART but were not aware of their status.

If behavior change communications can succeed in motivating more Kenyans to know their status, the demand for both VCT services and ART will increase. In 2007, approximately 140,000 persons were receiving ART, which was only 35 percent of those eligible for treatment (NASCO 2007). Of those eligible but not taking ART, 97 percent reported either that they had never been tested for HIV, or that they believed that they were HIV negative.

Currently, quality VCT services are provided primarily by the government and the not-for-profit sector. To support this effort, the GOK has received funding from the Global Fund to expand the number of facilities providing VCT, the number of counselors trained, and the number of people counseled and tested; however, it is underperforming in all three categories.²

Most private facilities offer some form of HIV testing, but it is not always promoted and testing is not always done with the full range of quality supports. The 2004 SPA showed that private facilities offering testing have lower rates of offering pre-and post-test counseling by a trained counselor (Muga et al. 2005). Typically, one of the barriers to provision of quality VCT in the commercial sector is the time it takes

the provider to conduct pre-and post-test counseling. This suggests that strategies to promote VCT through the private commercial sector should link financial incentives to improved counseling; alternatively, task shifting (to trained but less expensive staff) should be considered. The commercial sector could also be stimulated to provide a larger share of VCT and ART by increasing the access of private providers to state-of-the-art training in ART and to subsidized test kits or ARV drugs—subject to quality and reporting controls.

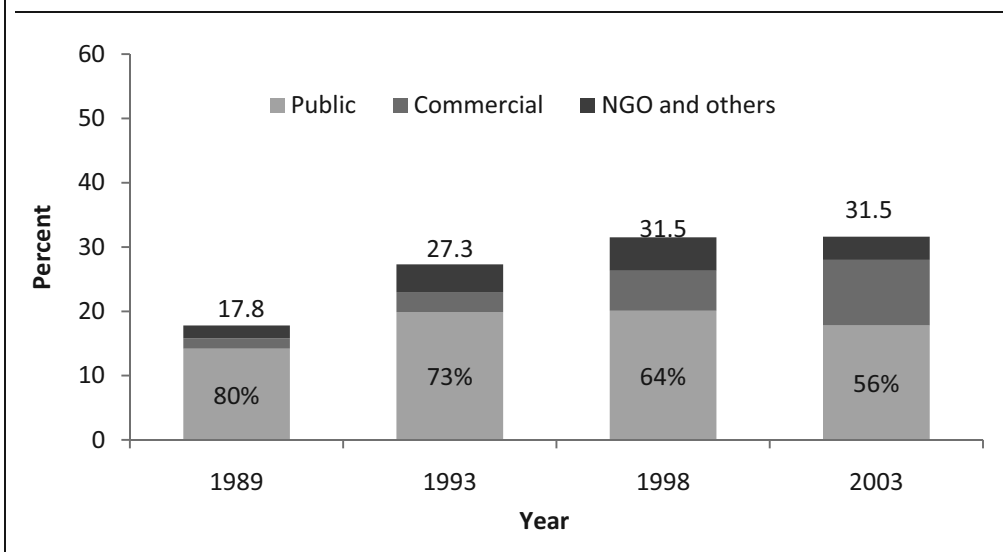
Family planning and reproductive health

Kenya's contraceptive prevalence rate (CPR) showed steady progress from the late 1970s, when contraceptive prevalence was just 7 percent, to 1998, when it had risen to 39 percent for all methods. Since then, there has been little progress in increasing the CPR or decreasing the total fertility rate (TFR), which stands at 4.9 (CBS 2003). Currently, the TFR is higher among rural women (5.4) than urban (3.3) (CBS 2003). The level of unmet need for family planning (FP) has also remained flat, barely moving from 24 percent in 1998 to 25 percent in 2003.

In 2002, 39 percent of all currently married women ages 15-49 used some FP method (CBS 2003): 32 percent use a modern method while 6 percent use a traditional method. Since 1998, there has been a slight increase in contraceptive use (from 39 percent to 41 percent of married women). Use of any modern method has increased among all women (20.7 percent in 1993 to 23.6 percent in 2003); it has increased among currently married women from 27.3 percent in 1993 to 32.9 percent in 2003, and among sexually active unmarried women from 36.2 percent in 1998 to 44.3 percent in 2003 (CBS 2003).

The most commonly used modern methods among married women are injectables (15 percent) and pills (8 percent). Injectables (19 percent) are also the most commonly used method among sexually active unmarried women, and this method has increased while pill use has declined. Besides consumer preferences, one factor that may have driven this switch (while contributing to the lack of progress in the CPR) is that the supply of FP products has been inconsistent in both the public and private sector. A number of studies have documented the problem of stockouts of FP products in the public sector as well as the work done with the Kenya Medical Supply Agency (KEMSA) to improve resupply. Unfortunately, the commercial supply chain also suffers from weak resupply systems (see Section 4.5 below); it is not surprising that low-margin products like FP pills would suffer from frequent stock-outs in private chemist shops and pharmacies. This does not seem to have affected access to condoms, which are sold in a much broader range of outlets. The male condom (16 percent) is significant only among sexually active unmarried women and is the second most commonly used method among this group (CBS 2003).

Whether increased private sector involvement can help the government get beyond the current plateau in CPR and unmet need is unclear. Already the private sector plays a considerable role in provision of FP/RH product and service delivery, but it may be able to play a larger role. As with other forms of health care, many Kenyans seem to prefer to obtain their health care from the private sector. Figure 3.5 shows the increased share of commercial provision for contraceptive methods.

Figure 3.5. Contraceptive Prevalence by Source of Supply (CPR for Modern methods)

Source: CBS 2003.

This increased commercial provision is also associated with a positive perception of the private sector and its quality of care. An analysis of the 2004 SPA data showed that consumers from all wealth quintiles perceived the waiting times to be shorter, the patient-provider interaction to be longer, and the private facility to be more convenient in terms of distance and opening hours.

Although supply problems persist in both the public and private sector, it is the team's opinion that women's unjustified fear of side effects, lack of couple communication, and provider biases are more significant barriers to increased contraceptive use than supply interruptions. For example, among non-contraceptive users, fear of side effects was the second-most cited deterrent (at 13.4 percent), after the desire for more children. Nor does lack of affordability seem to be a factor. The experience of the KfW-supported FP voucher scheme showed that providing a demand-side subsidy made little difference to use of long-acting methods. The transaction costs involved with the procedure were probably more significant than the price of the method. Myths about side effects of long-term methods also negatively affected demand for the vouchers.

Unsurprisingly, one of the strongest drivers of contraceptive use is the woman's educational level. Educational level may also drive exposure to FP messages, which is another strong determinant of contraceptive use. It would seem that the best way to increase CPR and move beyond the current plateau would be to increase female educational attainment.

Educated women live primarily in urban settings and seem to offer a good opportunity to private providers, since they are consistent users of FP services and are willing to pay for private sector services. The wealthiest quintile of consumers obtains their FP method at least as often in the private sector as in the public sector. In terms of "underused" methods, the greatest opportunities are for longer-term methods,

especially implants and IUDs—but these would have to be promoted with communications that address the fear of side effects, and with efforts to ensure that providers have the skills to offer such services. PSI is in the process of creating a net provider network with such a strategy: promoting long-term FP methods through private providers with supporting communications. Since they will also be in a position to ensure uninterrupted supply, it will be interesting to see if they can increase use and stimulate more private sector provision of FP services for long-term methods.

Tuberculosis

Kenya ranks 13th among 22 countries with a high TB burden (WHO 2008). In 2006, the estimated TB prevalence in Kenya was 334 cases per 100,000 population, and the incidence rate was 384 new cases per 100,000 population per year (WHO 2008).

Over the last 18 years, Kenya has experienced a growing TB epidemic, increasing from 11,625 cases in 1990 to 116,723 in 2006 (Ministry of Public Health and Sanitation [MOPHS] 2007). The major reason for this is the high co-infection rate with HIV (USAID 2006); approximately 47 percent of new TB cases are HIV positive (MOPHS 2007). However, there have been some recent signs of progress: the annual increase in the number of TB cases has slowed in the past five years to an average of approximately 4 percent per year, and the rate declined by 9.2 percent from 2005 to 2006.

TB case notifications in Kenya increased steadily over many years despite full coverage through Directly Observed Therapy, Short-Course (DOTS); however, the level has stabilized in the past three years, while the number of reported re-treatment cases increased (WHO 2008). Case notification rates are highest among 25-34 year olds and are higher among males than females for most age groups, except 0-14 and 15-24, where they are slightly higher for females (WHO 2008). Since 1996, DOTS coverage in Kenya has been estimated at 100 percent (WHO 2008). The DOTS treatment success rate (among new sputum smear-positive cases) is estimated at 82 percent and has been fairly constant since 1998 (77 percent to 82 percent) (WHO 2008).

The MOH established a PPP for TB control, with clear guidelines entitling private sector providers to access free TB control drugs and requiring them to adhere to quality monitoring by the government's TB control program. This partnership was also championed by the Kenya Association of Chest Physicians (KAPTLD). The 2007 Annual TB report estimates that approximately 10 percent of TB patients in urban areas are managed by the private for-profit sector.

Maternal health

Maternal health conditions also contribute significantly to the disease burden in Kenya that is shared across the public and private sectors. Women in urban or rural settings seek antenatal care (ANC) services from both public and private facilities, with around 70 percent of women using the public facilities (see Table 3.6). Of those using the private sector, 67 percent of urban women and 36 percent of rural women seek services from a private hospital or clinic; 62 percent of rural women seek ANC from mission hospitals or clinics, compared with 28 percent of urban women (CBS 2003). Maternity homes and other private centers are not highly utilized among either population.

Table 3.6. Source of ANC in Kenya, Most Recent Birth

Sector	Urban (%)	Rural (%)
Public sector	73.55	69.56
Private sector	24.57	26.67
Other	1.88	3.77

Source: CBS 2003.

Wealth tends to influence whether a pregnant woman sees a doctor or nurse/midwife for ANC. ANC by a doctor increased in general by wealth quintile, going from 16 percent in the lowest wealth quintile to 25 percent in the highest wealth quintile. For ANC by a nurse/midwife, the data fluctuate more, going from 60 percent in lowest quintile up to 78 percent in second highest quintile, then down to 69 percent in highest quintile.

For all wealth quintiles, the public sector was used more than private sector for ANC, as shown in Table 3.7. The general trend shows use of the public sector for deliveries increasing as wealth quintile increases, except among the richest (CBS 2003). The preferred private sector locations for ANC are private hospitals or clinics rather than maternity homes or mission hospitals or clinics.

Table 3.7. Source of ANC by Wealth Quintile, Most Recent Birth

Sector	Wealth Quintile				
	Poorest	Poorer	Middle	Richer	Richest
Public sector	64.6	71.36	71.31	77.54	68.17
Private sector	27.78	24.76	25.96	21.04	30.66
Other	7.62	3.87	2.72	1.41	1.17

Source: CBS 2003

Location of delivery also varies by wealth quintile. Public sector deliveries increase with wealth, while they decrease in other settings. The richest also have the most private facility deliveries (29 percent); however, there is no general trend. As with women seeking ANC care, the majority of the richest (72 percent) go to private hospitals/clinics and the majority of the poorest (60 percent) go to mission hospitals/clinics (CBS 2003).

The majority of Kenyan women deliver at home (59 percent), which has not changed since 1998 (CBS 2003). Home deliveries are much more common among rural women than among urban women (66 percent versus 29 percent, respectively). One would expect home deliveries to be a driver of maternal mortality. Maternal mortality in 2003 was estimated at 414 per 100,000 live births (CBS 2003), which was lower than the estimate of 590 per 100,000 from 1998 and well below the Sub-Saharan average of 920 (WHO 2002). However, due to differences in survey and estimation methods, it is unclear whether there was a true decline. This would also seem to represent a significant unmet need for general health care. It is unclear whether the private commercial sector has a comparative advantage in addressing this need, however.

Child health

The infant mortality rate per 1,000 births declined from 119 in 1969 to 77.3 in 1999 (CBS 2003). Meanwhile, the percentage of neonatal deaths occurring in first week of life increased from 74 percent in 1998 (and 75 percent in 1993) to 82 percent in 2003 (CBS 2003). Along with malaria, acute respiratory infections (ARIs) are a leading cause of neonatal deaths. Overall reported prevalence of ARIs (i.e., children with cough and rapid breathing) was 18 percent in 2003. There is a slightly higher ARI prevalence in rural areas (19 percent) than in urban areas (16 percent), with very large differences among the provinces (CBS 2003). The 2003 KDHS shows that when children show symptoms of ARI, they are taken to private sector providers more often than to public sector ones, as shown in Tables 3.8 and 3.9.

Table 3.8. Treatment Source for Child's Cough or Fever, Limited to Most Recent Birth, by Geographic Region

Sector	Urban	Rural
Public sector	41.37	43.45
Private sector	57.75	52.88
Other	0.89	3.67

Source: CBS 2003.

Table 3.9. Private Sector Source of Care for Child's Cough or Fever, Limited to Most Recent Birth, by Geographic Region

Private Sector Location	Urban	Rural
Private hospital/clinic	43.65	34.49
Private pharmacy	39.60	33.23
Private mobile clinic		0.51
Community health worker		2.08
Mission hospital/clinic	8.74	8.64
Shop	8.00	19.97
Other private source		1.08

Source: CBS 2003.

Chronic illnesses

Analyzing the use of the private sector in area of chronic illnesses was not part of this private health sector assessment's original scope of work, but such an analysis would be an important contribution because of the potential for commercial health providers. There are some signs that Kenya is experiencing the beginning of an epidemiologic transition in which chronic "lifestyle" diseases make up a larger share of the disease burden relative to communicable diseases. According to a Business Monitor International projection, disability adjusted life years (DALYs) lost to noncommunicable diseases will rise from 19.7 to 24.0 percent of the overall disease and injury burden, from 2007 to 2030 (BMI 2009). This trend is likely to increase as the younger population ages and more people move into the middle class. There is little data on which population segments are most affected by chronic diseases, but it is clear that private providers will have to play a role in addressing this disease burden in the

years to come. Over 2 million Kenyans were diagnosed with diabetes in 2007, and the antidiabetes drug market is estimated at \$1.8 million in that year (Musinguzi 2009). One might expect this burden to be greater in urban areas, where food is more plentiful and lifestyles require less exercise. On the other hand, the poor, especially the rural poor, have less access to preventive health education information and supportive services. The private sector share of this care is likely to depend on consumer preferences and whether treatment for such care is included in public and private health insurance coverage.

Ensuring Delivery of Quality Services in the Private Health Sector

The primary means by which the government interfaces with the private sector is through regulation. Through the laws of the government and the institutions enforcing them, the government determines who can operate in the private sector, what quality standards they must meet, what services they can provide, and where they can practice. Effective and appropriate regulation is a major driver of the quality and quantity of private health services. Professional and facility regulation establishes minimum standards for quality, and, if effective, puts providers who do not meet those standards out of business. Improving the quality of private providers requires supporting systems through access to medical education, improved technologies, and creation of incentives including through accreditation or certification. The *PSP-One* assessment team considered the conditions and opportunities for both quality assurance and quality improvement.

Health professions

The legal scheme for regulation of health professionals is well developed and includes five Boards of Registration, for Medical Practitioners and Dentists, Nurses (the Nursing Council), Pharmacists and Pharmacy Technologists (Pharmacy and Poisons Board, or PPB), Clinical Officers, and Laboratory Technologists. The level of funding and activity varies greatly between boards. As in much of Africa, the Nursing Council is the most mature and best organized, with a staff of 35. The Council provides oversight of training programs at different levels, qualification examinations, and registration and re-registration of nurses, with a requirement for continuous professional education (CPE). The Medical Practitioners Board is also active, and (as discussed below) is effectively the lead agency licensing health facilities in Kenya.

All of the boards have procedures in place to withdraw the practice license of the health professionals they supervise. However, the level of legal and staff support for this disciplinary function varies widely. The Medical Practitioners Board has a budget that permits hiring an outside lawyer for disciplinary hearings. Even so, the process is convoluted and moves too slowly; as a result, 77 percent of the 333 complaints filed with the board in the last ten years remain unresolved. At the Laboratory Board, technically qualified inspectors must be drawn from the members of the Board itself, as there are no inspectors—let alone enforcement staff.

The principle of CPE is now well established with the professional boards. The CPE requirement for nurses is in force, and requirements for doctors and dentists come into force this year. Focus groups suggest that private practitioners feel at a

disadvantage in meeting the CPE requirement, since such training is more accessible to government health care professionals.

The right to practice privately is well established for all medical professionals. The amount of time before an individual can establish his/her own private practice—after working in an employed capacity—varies by profession. Fortunately, the scope of practice for nurses and clinical officers is well developed and the parameters of a legal private practice are clear; doctors do not challenge the right of nurses or clinical officers to treat patients within their respective scope of practice. There is dispute about the role of nurse’s aides or patient care assistants—individuals providing patient services in hospitals that arguably do not require the training and experience of a fully qualified nurse. With this exception, however, there do not appear to be sharp wars across “professional boundaries” among the health professions. This could change, of course, if pressure increases to shift tasks to lower levels of practice, in light of severe human resource gaps in some areas of the country and in some specialties.

Despite the existence of these boards, however, there is a feeling among most regulated professionals that quacks and unqualified health professionals continue to practice privately in the country, despite some well publicized crackdowns. In some cases, training schools unapproved by the responsible board started courses that did not qualify a graduate for registration. In other cases, individuals assume the title of nurse or doctor without registration, and escape punishment. Our focus groups suggest that many licensed practitioners blame corruption in the regulatory apparatus for the continuation of unregistered competition.

The most significant issue the professional boards face is their limited ability to enforce their rulings. The boards need to improve their ability to investigate and resolve complaints against licensed professionals, and to effectively enforce actions against unlicensed (or de-licensed) professionals. Without changing the jurisdiction of the boards over their licensed professionals (or training institutions), it might be possible to create a unified enforcement division to serve all five Boards and to work closely with the Attorney General to follow through on enforcement actions. At the same time, internal disciplinary procedures at each board can be reviewed to see how complaints can be adjudicated more quickly without abrogating the rights of professionals or patients.

Health facilities: licensing

For health facilities, the outside observer senses something of a “free for all” in the regulatory arena. The 2008 split in the MOH likely makes it more difficult to unify the approach to facility regulation. The MOMS appears to have general regulatory responsibility for both health professionals and facilities, but the MOPHS deals with important aspects of facility sanitation and hygiene. At the moment, the Medical Practitioners and Dentists Board is effectively the responsible agency for facility licensure and leads a “posse” of the different boards in onsite inspections of hospitals and clinics. In addition to the boards, health facilities are subject to public health regulation through their district public health office, and medical waste disposal is regulated through the environmental protection agency.

Most regulated facilities do not view the existing rules of the various regulatory agencies as burdensome or unreasonable, but the process of multiple inspections and

licenses can be costly and time consuming. Many licensed private hospitals still operate out of facilities cobbled together from several residential structures. In general, the professional boards' interest is to see that properly qualified professionals are serving in these institutions—a function that need not require onsite inspection by members of the Boards. Instead, facilities could be required to keep records of currently valid licenses for key personnel, and facility inspectors could easily check through the central office of the respective board in order to detect forgeries. The Nursing Council has already computerized its professional registration system, and the same U.S. group is now working with the Medical Practitioners and Dentists Board. With good cell phone communication, verification of a suspect license should be relatively easy. A corps of trained facility inspectors could then focus on some of the operational issues that directly influence patient care: infection control, equipment maintenance, medical record keeping, etc.

The diffusion of regulatory authority raises the cost of inspection for well-run facilities, and at the same time it also decreases the likelihood that many illegal or questionable establishments will be inspected, or that an illegal facility will be shuttered and remain closed. The Medical Practitioner and Dentists Board must organize inspections nationwide from its headquarters in Nairobi. There is no regional network of inspectors to provide frequent follow-up. A national system of health facility inspection would require periodic rotation of inspectors as well as quality control measures to prevent abuse, but a fully accountable system would also require a regional presence in order to follow through with noncompliant facilities. We often heard complaints, from a variety of medical professionals, that quacks and illegal drug shops would reopen quickly after being closed for noncompliance. Some even claimed that suspect facilities had advance notice of upcoming inspections.

Encouragingly, the MOH began to develop an integrated facility licensing and certification system several years ago, in an effort supported by DFID. A computerized facility inspection checklist was created. The inspection system was to be integrated with the National Health Insurance Fund (NHIF), presumably envisioning reduced NHIF payments or loss of NHIF provider status for noncompliant hospitals. The effort seems to have collapsed when the principal architects moved on to other jobs, but the existing body of work could form the basis for creating an integrated facility inspection system.

The current system of hospital regulation through the professional boards has been challenged by one private hospital in Nairobi (Avenue Hospital), arguing that the GOK is obligated to establish a system for licensing hospitals through a central Board of Health. Instead, the government elected to continue giving the Medical Practitioners and Dentists Board the lead in licensing clinics and hospitals. In most developed countries, hospital licensing or accreditation is an activity quite separate from the registration of individual medical professionals. A single health facility licensing agency, with proper quality and corruption controls, operating under a clear set of comprehensive regulatory standards and with a well-trained inspectorate, would likely lead to more consistent quality and more predictable regulatory costs.

A key issue in establishing a unified health facility inspectorate and its regulations will be whether such regulations apply equally to all facilities, regardless of ownership. At the moment, regulatory violations that might result in the closure of a private

hospital will not result in the closure of a public hospital with similar violations. The Medical Practitioners Board has investigated allegations of poor medical practice in some public facilities, but such facilities are not yet treated equally in the regulatory regime. If Kenya is to move toward a broader-based system of health financing, facility regulations should be developed—and applied—equally to all facilities, regardless of ownership. If public facilities cannot generally comply with a proposed regulation, then it must be asked whether the regulation is really necessary to protect patients. If a universally agreed regulation is violated by a few public facilities, then they should be allowed a limited time to improve or close.

Accommodations can be made for facilities operating in isolated locations, public or private. But if a regulation is worth enforcing, it should be enforced regardless of ownership. This will be even more critical if Kenya moves forward with any form of social health insurance; all facilities participating in such a program should meet the same standards. But government may be reluctant to commit to having its own institutions meet the accepted standards, or to see public institutions that fail license inspections lose funding from third parties, such as the NHIF or private insurers. The government's maternity voucher scheme provides a model for applying objective accreditation standards to all participating facilities and will likely continue to do so as the scheme is expanded. In designing a facility license system, the same principle of universal applicability should be paramount in developing the regulatory framework.

Consolidation and effective management of facility licensing is clearly a prerequisite to improved quality of private health care in Kenya. There are inherent conflicts in leaving facility licensing to boards that license medical professionals. None of these boards have the requisite staff, enforcement "clout," or management capacity. At the moment, someone contemplating opening a hospital would have great difficulty determining which regulatory standards the new facility must meet. A consolidated agency should develop and promulgate regulations for different categories of hospital, clinic and laboratory.

Professional boards—particularly the Medical Practitioners and Dentists Board—may resist the creation of a consolidated facility licensing agency. But this development need not threaten the integrity of the process of regulating health professionals. In fact, it may free up resources for boards to improve CPE and resolve complaints against individual practitioners, as well as to follow through on legal actions to permanently bar unlicensed practitioners from providing medical services.

In developing and enforcing facility standards, we need to consider pharmacies as well as hospitals and clinics. At the moment, the PPB has several functions: it approves the marketing of drugs and is supposed to ensure the quality of drugs sold; it qualifies individual pharmacists and pharmacy technicians; and it sets and enforces the rules governing sites that sell drugs. This last function requires well-distributed inspection and enforcement capacity, and the PPB has some of this. In the pharmacies the PSP-*One* assessment team visited in Nairobi, inspectors came at least once a year (usually more often) to check for outdated or counterfeit drugs, proper storage and recordkeeping, qualified staffing, and for the presence of certain restricted drugs. Nevertheless, the perception on the part of the licensed facilities is that unqualified (and unlicensed) competitors continue to sell (and recommend) drugs they are not authorized to stock. The team was not in a position to measure the extent of this

problem or to determine if it reflects inadequate budget and staffing, erratic enforcement mechanisms, or irregularities in the inspection process. If Kenya moves toward a consolidated system for licensing health facilities, with adequate staffing, strong enforcement powers, and internal quality controls, then the country may consider including inspection of pharmacies within the remit of a new integrated facility licensing agency. The standards to be enforced for retail drug sales are not as complex as those governing hospitals (which will also be operating pharmacies). Just as inspectors could readily check the validity of physician and nurse licenses with the responsible board, they could do the same for pharmacists and pharmacy technicians through an electronic link to the PPB.

Accreditation and certification

There is no nongovernmental hospital accreditation agency. The most respected hospitals in Nairobi (Aga Khan, Gertrude Children's) have applied for and obtained International Organization for Standardization (ISO) certification, but these standards are likely beyond the budget and management capacity of most hospitals in Kenya. Compared to a good facility licensing system, the development of separate accreditation systems may seem a luxury. But such systems can raise standards by setting a level of performance above what can be enforced universally through licensing. Accreditation or certification can also be used to set standards for a service of particular interest that cannot effectively be addressed through licensure. Good accreditation systems work to improve quality by showing providers the infrastructure, processes, or outcomes that need to be improved to obtain accreditation. An even better accreditation system can link providers who aspire to improve their quality with the technical resources to help them achieve higher standards. A license, in contrast, can only be either given or withheld: the provider is either operating or not. The biggest challenges for accreditation systems are (1) covering the costs of their implementation, and (2) linking them to incentives to encourage private providers to invest resources to achieve the quality standards defined in the system.

The best opportunity for providing this accreditation incentive is probably the NHIF, which has already implemented a form of accreditation. Hospitals that wish to be eligible for NHIF payments must submit regular data on various aspects of activity and quality. Some of these data are verified by NHIF staff, who also visit the hospitals regularly to review the necessity of admissions and extended stays. The results of these reports factor into the determination of the NHIF "rebate" (the amount paid per day for hospitalization of an NHIF beneficiary). The NHIF system could be expanded to offer similar incentives for improvement of outcome indicators that are not easily reduced to the "yes/no" decisions that determine whether a facility receives a license.

Another suggestion for ensuring the quality of providers that emerged from the Naivasha workshop was to institute a licensing requirement that providers carry professional indemnity insurance. Insurers would provide an additional level of verification of professional qualification, CPE requirements, and whether there were any outstanding investigations against the providers before issuing professional insurance.

A significant weakness in the private health care system is the lack of any accreditation or quality monitoring system for private laboratories. The only legal

apparatus for controlling such facilities is the Laboratory Technicians Board. There is no government agency that provides reference samples or that spot-checks lab results. The “high end” private hospitals in Nairobi (Aga Khan, Nairobi Hospital) have made arrangements for such quality assurance, but the assessment team found no evidence of similar arrangements further down the system. Although external investments have improved national laboratories for TB and capabilities for AIDS-related testing, there appears to be no general laboratory quality control system for government or mission hospitals, let alone private laboratories. The uncertainty of laboratory quality results in physician skepticism about test results, and likely in inappropriate treatment based on apparent symptoms. This has been shown to result in extensive treatment of bacterial and viral infections with antimalarials, with concomitant risks to patients and the possibility of speeding the development of drug resistance (Petti et al. 2006).

Although nominally billed as a “franchise” network, Kenya does have one home-grown system for certifying providers of a particular service. This is Gold Star, a network that certifies private providers complying with national guidelines for provision of ART, developed by Family Health International using U.S. Government funds. The system was designed to steer private AIDS patients to providers with the proper training in national ART protocols. Gold Star is now being used, on a limited basis, to distribute donor-funded ARVs to some private patients. See Appendix 5 for a fuller description of the Gold Star Network, and the potential to use it as a disease management organization to increase the availability of AIDS care through private insurance. In the long run, the experience with Gold Star may provide lessons that could be applied to certification of laboratories, or to certifying specialist providers or private providers offering critical public health services. The opportunity exists to make Gold Star a model for such elective certification, with an incentive for compliance provided in the form of donor-funded ARVs. While there may be controversy in extending donor-funded drugs to private patients, the fact is that very few Kenyans can afford lifetime treatment with ARVs and will perforce revert to public sector treatment. Moreover, a precedent exists in the treatment of TB: a program started by the Kenya Association of Chest Physicians provides discounted TB drugs for selected physicians to treat private TB patients. Gold Star provides the opportunity to create a PPP based on insurance risk pooling to carry consultation and laboratory costs, while donors provide ARVs that would be provided to these patients in any case when they seek public sector treatment.

Health education

In Kenya, training of health workers is provided by a range of institutions—public, faith-based, not-for-profit, and private sector. Comprehensive information on all these training institutions is not readily available, as each professional council seems to keep information only for the training institutions offering courses relevant for the cadres they license/register. There is no single regulatory authority that registers and regulates health training institutions. The MOH, multiple professional councils, local authorities, and the Commission for Higher Education are all involved in some way. In the case of a university, the Commission accredits the university while the relevant regulatory board approves the training program. From interviews it was not clear what role the Ministry of Education plays in registering health training institutions.

There has been a gradual increase in the number of private medical schools over the last decade. This is a positive development, in terms of increasing the supply of health workers to fill shortages, particularly in the public sector. However, proliferation of medical schools has raised issues of quality control and whether all diplomas and degrees can be considered equal. Some pharmaceutical technologists report problems in having their degrees recognized, demonstrating the importance of defining standards transparently and ensuring that they are applied by accredited training institutions. Lack of credible accreditation may present a bottleneck in expanding a private market for medical education, along with other factors such as the shortage of qualified teaching staff, equipment, cadavers, etc.

Nairobi West Hospital indicated that it plans to start its own medical schools for nurses and clinical officers, since the shortage of qualified providers proved to be the primary constraint in expanding its network of primary care clinics. This suggests that there are opportunities in the private medical education market for private hospitals or clinic networks, in providing a well-equipped training ground and also absorbing graduates into immediate employment. A more detailed analysis of the need for health workers and the supply from all training institutions is needed to assess the size of this market. The public sector certainly has an interest in maintaining private medical schools and ensuring that graduates can be absorbed into private facilities. When the public sector does recruit staff, especially nurses and clinical officers, most of their recruits come from private sector jobs.

The quality of health care training is, in theory, ensured to be of a high standard and consistent among schools, both through the accreditation system and through consistent application of professional exams, designed and administered by the professional councils. Nevertheless, a number of participants at the Naivasha workshop raised concerns about pressure being applied to staff at training institutions to admit and graduate students who did not meet defined standards. Some also felt that the number of regulatory bodies involved in licensing training institutions was itself a barrier to entry for private medical and nursing schools. A single licensing body for training institutions that worked closely with the professional bodies would help to improve or maintain standards of quality while facilitating entry for more medical schools.

The PSP-*One* assessment team was not able to conduct a comprehensive analysis of the “supply chain” of health workers being trained relative to projected needs. The most recent effort was conducted by a Human Resource Working Group in 2006 that provided some preliminary information about the number of health graduates being produced by medical schools for all professions (Table 3.10). This effort should be updated as a part of a more systematic market analysis.

Health Financing and Insurance

Although the private commercial insurance sector is currently small, the level of interest and investment in risk-pooling mechanisms is appreciable and growing. Whether through NHIF, employer-managed plans, or new forms of social health insurance, risk pooling probably offers the greatest opportunity for growth of the private health sector because it increases consumers’ ability to pay for services. This view was expressed by the vast majority of private providers at all levels.

Table 3.10. Output of Kenyan Training Institutions, Selected Health Worker Cadres, 2002 and 2005

Institution	Cadre	Capacity	Output: 2002	Output: 2005
University of Nairobi	Doctors	100	98	199
	Pharmacists	40	42	64
	Dentists	33	32	36
	Nurses	40	40	52
Moi Training and Referral Hospital	Doctors	50	41	36
	Nurses	20	19	34
Aga Khan University	Nurses	40		63
Christian Health Assn of Kenya (CHAK) training institutions (9 institutions)	Nurses	240	380	460
Catholic Secretariat (12 institutions)	Nurses	454	399	429
Nairobi Hospital	Nurses	180	150	
African Medical and Research Foundation (AMREF)				
Kenya Medical Training College (KMTC) (25 colleges)	Clinical Officers		346	535
	Nurses (EN)		688	1,077
Moi University (School of Medicine)	Doctors			

Source: Human Resources Working Group members 2006.

Private health insurance

The private health insurance sector in Kenya is still relatively small, with about 600,000 insured, as compared with the public health insurance (NHIF) with over 2 million principal members. The penetration of private health insurance is about 2 percent of the total population.

There are two distinct players in the private health insurance sector: insurance companies (underwriters), and medical insurance providers (MIPs—the local equivalent of managed care organizations). The distinction between the two is not always clear to consumers. According to Association of Kenya Insurers (AKI) statistics, in 2007 there were 14 insurance companies offering health insurance products; total gross premiums for health insurance were over Ksh 4.25 billion, with an average loss ratio of 65 percent. The gross premium revenue for MIPs was estimated at Ksh 1.5 billion, making the total for the sector close to Ksh 6 billion. The sector grew by over 20 percent from 2006; it made a modest underwriting profit of Ksh 7.4 million, compared with a much larger loss of Ksh 144 million the previous year. The poor underwriting performance is attributed to high commission rates paid to brokers (officially 10-20 percent) and relatively high management expenses (average 18 percent).

The 20 percent growth rate of private health insurance schemes is probably due to conversion of existing self-funded and third-party administration schemes into insured plans, along with shifting insurance business from MIPs to underwriters, the effects of medical inflation (hence increase in premium contributions), and a small expansion of the corporate and individual market.

The overall average premium *per person* is approximately Ksh 7,000 per annum, payable upfront annually (assuming 600,000 insured). Assuming an average family size of four, the average annual premium *per family* is therefore Ksh 28,000. One rule of thumb for affordability is that the annual premium should not exceed 50 percent of the monthly wage or salary (QED Actuaries/AON Consulting). At current levels, private health insurance premiums are therefore unaffordable for any household with a monthly income of less than Ksh 56,000. Only about 11 percent of the population is in formal employment, with another 39 percent in the informal sector and an equal proportion in agriculture (mostly peasant/subsistence farming). Casual laborers earn Ksh 3,000-6,000 per month, while an average teacher's salary is about Ksh 30,000 per month and a policeman earns about Ksh 20,000. Clearly, the majority of those in formal employment would find private health insurance unaffordable, if not for the fact that their employers pay the full premium.

The private health insurance sector is also characterized by low product differentiation and stiff competition for a small and largely corporate clientele. This has led to premium undercutting and thus, with relatively high administrative expenses, underwriting losses. The last decade has witnessed the collapse of a number of high-profile managed care/health maintenance organizations (MCOs/HMOs); this has eroded market confidence in health insurance, reduced the bargaining power of insurers (*vis-à-vis* providers), and led to ad hoc changes in the regulatory framework. A large pool of consumers (approximately 1.5 million) are covered under various types of self-funded schemes. Many such plans have outsourced administration to third-party administrators (TPA). The current law requires that TPAs be licensed as MIPs—a peculiar requirement, since TPAs do not carry any risks. Probably it is one reflection of the ad hoc nature of the regulatory changes. A number of employer groups still administer insurance schemes in-house, with mixed results. Most of the institutions running self-funded/TPA schemes are large businesses, mainly in the parastatal and banking sector. Converting TPAs into risk-pooling mechanisms presents an opportunity to grow health insurance coverage.

Health insurance regulation

Private health insurance is currently regulated under the Insurance Act Cap 487. There is a brief mention of health insurance introduced as an amendment in 2004, following collapse of several MCOs (now referred to as MIPs in the Act). That section was introduced as a stop-gap measure awaiting further and more comprehensive review. Most players in the private health insurance sector are of the opinion that current law fails to cover most of the important aspects of health insurance and therefore to create a level playing field, and that this hinders the development of innovative risk-pooling mechanisms. The current law makes little mention of health insurance, other than the need for a license and the restriction of MIPs from carrying risks. For example, the law is silent on outpatient services provided by MIPs.

Although the formal structure for regulation of *health* insurance is minimal, health insurers are subject to all of the rules that apply to life and casualty insurers. After the collapse of several managed care organizations in Kenya and East Africa, a very brief amendment to the general insurance law required all MIPs to be licensed as regular insurance companies, or to reinsure all risk with licensed insurers.

The fact that no separate law (or section of the law) has been developed for health insurance creates a number of problems.

- It is difficult for provider-based insurance organizations to develop. Developing a plan based on mission hospitals, such as those that predated the national health insurance plan in Ghana, would be very difficult with this structure. There is a provision for exemption from the “fully licensed insurer” requirement if an organization solely provides “services in kind.” African Air Rescue, which owns a number of outpatient clinics, is able to work within this exception for its outpatient benefits, but this was the only such example that the assessment team observed. Avenue Healthcare attempted to develop a “self-insured” plan using its hospital and clinics, but encountered problems. If mission health facilities developed a plan that permitted insured referrals between facilities, even if they were few in number, the participating facilities would need to either obtain an insurance license or transfer all such risk to an existing insurance company.
- Premiums must be paid annually, in advance. Monthly payments can be structured only if some organization is willing to lend the policyholder the entire amount and collect the loan in monthly installments. This requires any micro-insurance plan to be linked to a loan program. This structure does reduce the problem of monthly fluctuations in enrollment and premium payment, and it puts the collection burden on the organization granting credit. But it will be hard to build broader-based health plans for the middle class if there is no explicit acceptance of monthly premium payments.
- Brokerage commissions typically raise the cost of health insurance by 10-15 percent. This reflects both the legal requirement of licensed brokerage and the fact that most health insurance is issued by multiline insurers that depend on brokers for other business. This helps to explain why medical payouts (as a percentage of the premium) are low by the standards of health insurance programs in other countries.

The locus for all insurance regulation recently moved from the Ministry of Finance to an independent Insurance Regulatory Authority (IRA). However, this body has no particular expertise in matters of health insurance (premium determination, benefits design, control of adverse selection, alternative methods of provider payment). Matters governing health insurance are dealt with by the same examiners that deal with other casualty insurance. There is no mechanism for resolving appeals if an insured party alleges that a medical benefit was unfairly denied.

The GOK has accordingly decided to review and revise the entire insurance law, and the AKI is currently preparing its proposals for legal reform. At this point, however, the issues of health insurance are not a high priority for the IRA or the AKI. Staff within the IRA are not aware of the different approaches to health insurance regulation in other countries, such as the Medical Schemes Regulatory Authority in South Africa, the extensive national regulation of sickness funds in Germany and of health insurance in the Netherlands, or the U.S. approach that creates a separate unit within State Insurance Commissions to deal with health insurers. However, the IRA staff appear open to learning about these options.

In short, the current insurance law and regulatory apparatus clearly inhibit some interesting possible health insurance innovations. But the mechanisms to prevent abuses of more sophisticated health insurance products also do not exist. With the insurance law scheduled for revision, there is a unique opportunity to create a legal structure in which health insurance innovation could flourish in a controlled manner. The first issue for this reform is whether or not the law, and the regulatory agency, should be entirely separate from the structure for regulating other types of insurance. In South Africa, as in parts of Europe, health insurance regulation is the province of a separate agency and a separate law. In the United States, there are specific laws on health insurance, but some general provisions of insurance law apply, and regulations are administered by a separate division of the general insurance regulator. Kenya needs to decide which reform route it wishes to follow; either is plausible. The only mistake would be to leave the current law untouched, treating health insurance in all matters as simply another form of casualty insurance.

Once the structure is chosen, then it will be necessary to determine just how much detail to put in the new legal structure, and in what ways elements of general insurance law should continue to apply. This is an ideal opportunity for the public and private sectors to work together to identify the current barriers to more innovative health insurance, as well as the dangers to be prevented (such as bankruptcies of managed care organizations). The assessment team suggests strongly that the industry and the regulators look to the experience of other jurisdictions as they develop this law. Health insurance innovation in Kenya is still relatively limited, and the potential for abuse is probably not yet well understood.

Low management and ICT capacity

There is a notable lack of skills and expertise in health management and information and communication technology (ICT) across both the private and public sector for health insurance, including regulatory bodies such as the IRA. Health insurance training is very briefly and superficially covered in the curriculum of professional insurance courses offered at the College of Insurance and other institutions. The courses available are the Diploma in Insurance and Advanced Diploma in Insurance (ACII). In these courses, health insurance is covered in only one paper (Private Medical Insurance).

Most users find the content inadequate because it is based on a traditional indemnity cover approach and is not customized to the local setting. Not covered are such areas as locally appropriate health financing options, some managed care principles, benefit utilization management, management of provider networks, claims adjudication, and health data management. The AKI is of the opinion that there is great need for curriculum development and training in health insurance management.

There is also inadequate deployment of appropriate ICT in the administration of health insurance schemes, largely due to the scarcity of appropriate local solutions or customizable overseas health care ICT solutions. Most health insurance operations are paper intensive, resulting in relatively high administrative costs, operational inefficiency (and the attendant disputes with providers and clients and poor customer service), and poor data management. Further hindering the introduction of ICT applications is an insurance regulation that prohibits health insurers from requiring the

use of procedure codes as a condition for claim reimbursement. NHIS and some MIPs are starting to do this, but the regulations need to be redrafted to facilitate the development of industry-wide codes.

Low public understanding of and trust in risk-pooling mechanisms

There is a general lack of awareness and significant misunderstanding of how risk pooling works (for all classes of insurance, not just health), as confirmed by the AKI Customer Survey in 2008. Most consumers would prefer to exchange each contribution for a specific benefit, and are uninterested in paying for potential future benefits, or maintaining solidarity with other consumers in their risk pool. A survey conducted by Steadman Group of consumers and their use of financial services found widespread lack of insurance of any type. Reasons for not having insurance included affordability (69.3 percent), lack of information on how insurance works (31.3 percent), the perception that insurance companies are dishonest (17.4 percent), and fatalism (8.3 percent).

The lack of awareness is combined with misunderstanding and mistrust of insurance plans. This situation was worsened by the spectacular failure and collapse of a number of high-profile managed care plans (HMOs, now MIPs) in Kenya (and Uganda) that reflected lack of adequate regulation, lapses in corporate governance, poor financial management, and medical claims fraud.

This unfortunate development led to ad hoc changes in the Insurance Act as well as erosion of public confidence in risk-pooling mechanisms, with increased mistrust between clients and insurers and between providers and insurers. The bargaining power of insurers was seriously diminished, and providers gained the upper hand. Because most consumers did not readily distinguish between HMOs and insurance companies, the negative image created by these corporate failures affected the whole private insurance sector.

This lack of understanding hinders the expansion of existing health insurance plans and stifles innovation that could be critical to expanding the market. For example, it was observed in certain micro-insurance plans that members who completed a year without lodging a claim (and thus without benefitting from the scheme) tended to pull out the next year. This misunderstanding of risk pooling was mentioned in the AKI Journal of 2005.

Poor understanding of insurance concepts also extends to private health care providers, whose concern for revenue maximization outweighs considerations of efficiency, equity, and sustainability in health care financing. Few providers are willing to accept any risk in the management of health costs of their patients. This may be due partially to general distrust of insurance, but it may also be related to generally poor business practices among health providers, who have no confidence in their ability to understand, much less manage their own cost structures.

Private health insurance plans are focused on middle-to upper-income groups in formal employment

Most of the private health insurance plans provided by insurance companies and MIPs are targeted at, and generally designed for, up-market formal employer groups; they therefore mainly cover the middle and upper socio-economic groups. Until recently, NHIF also catered mainly to those in formal employment.

Most of the plans cover hospitalization costs, and a modest number also cover ambulatory (outpatient) care. Most private health insurance is employment-group based, and only a few companies sell coverage for individuals. For instance, of the 14 insurance companies that were selling health insurance in 2008, only three offered individual coverage. Among insurance companies, approximately 80 percent of the membership is group schemes. MIPs provide more individual coverage than insurance companies, but even here the proportion of individual membership is only about 35 percent.

The schemes tend to be fee-for-service indemnity plans, with little application of managed care tools to control utilization and costs. Claims costs, and consequently premium contributions, are therefore relatively high.

These high-end indemnity plans are plagued by the usual problems, including adverse selection, moral hazard, medical benefit fraud, over-servicing by providers, supplier-induced demand, and escalating health care costs (medical inflation was estimated to be over 20 percent). Other provider issues include lack of standardization or coding of health care services, lack of a structured service quality framework, and concentration of providers within cities and urban areas.

Low-cost innovative products are uncommon

Low-cost and innovative health insurance plans are uncommon. The obvious reasons include high poverty levels and low literacy levels that make it hard to market low-cost products. Historically, the industry has an up-market orientation of insurance services; there is a lack of data on the lower end of the market and a lack of underwriting skills needed to develop low-cost products. Profitable low-cost plans would require larger volumes and economies of scale, but most insurance companies lack the necessary management, administrative, and ICT capacity to manage higher volumes of claims. Compounding this management burden is the fact that product marketing and distribution, premium collection, and fraud control are all more difficult for those consumers who tend to operate more in the informal sector.

Another set of challenges is the lack of awareness and understanding about risk pooling, as mentioned above, which affects both members of the public (the potential market) and service providers. Kenyans are suspicious of insurance schemes and the insurance industry in general, which has a poor image.

Finally, the regulatory regime does not encourage innovation. The current law is silent on the development and management of micro-insurance products, and some provisions (such the mandatory requirement for annual premiums and the prescribed high intermediary commissions) may actually hinder the development of low-cost products.

Initiatives to develop low-cost health insurance/micro-insurance plans

A number of insurance companies and MIPs, working with microfinance institutions (MFIs) and with the support of development partners, have introduced low-cost health insurance products in the past five years or so. On the face of it, a partnership between the MFIs and the insurance companies should be mutually beneficial. The MFIs give the insurance companies access to the most creditworthy lower-end consumers, allowing them to save on marketing costs. The MFI is also able to pay the annual premium payment on behalf of their subscribers, which is currently a regulatory

constraint for health insurers. On the MFI side, they are able to offer an additional benefit to their members and earn additional income. Selling health insurance also reduces risk of default on their business loans (through significant illness).

One of the MFIs that has a health insurance product is the Ecumenical Church Loan Fund (ECLOF). ECLOF's original health insurance product was a Ksh 2,000 annual product, that could be enhanced with coverage of personal accident and funeral expenses with an annual cost of Ksh 3,650, paid in 3-6 months as a separate loan. Enrollees can seek care at public facilities or mission hospitals, or at private facilities if they are willing to pay an additional cover charge. ECLOF gets 12.5 percent of the premium as an insurance fee. ECLOF sold 6,000 policies at the Ksh 2,000 level.

Equity Bank's micro-health insurance product, called Equihealth, is still in the pilot stage and has only been offered in Nairobi since mid 2008. The product is underwritten by UAP Provincial Health Insurance Company and is designed as a four-tier system in which clients choose various annual premium levels with specific benefits at each level, with Equity Bank financing the premium payment. It is not required to be a current client of Equity Bank to purchase coverage under Equihealth, which claims to be the most comprehensive and accessible medical cover offered by a financial institution. The coverage includes dentist, optician, chronic disease, maternity, HIV, and other special medical coverage, as well as inpatient and outpatient visits to the hospital. Including outpatient care distinguishes Equity Bank's product from the micro-health products of other financial institutions, which exclude outpatient care to avoid problems with fraud and losses for the underwriter.

The Cooperative Insurance Company of Kenya (CIC) is working with the NHIF to sell complementary insurance products as riders to the NHIF voluntary plan. The same challenges affect these initiatives, resulting in slower than expected uptake of the low-cost health insurance products and the termination of some plans. Newer challenges include the difficulty in distributing health insurance products using MFI staff, differences in business models and culture between the insurer and the MFI, and the need for outpatient insurance.

Experience has shown that it is difficult for a typical bank or MFI employee to sell insurance products successfully while attending to their other work. The staff members tend to view the insurance product as an additional work burden and difficult to understand and hence pay less attention to it than to more familiar banking duties. It may therefore be necessary to train a special sales team within the bank to handle sales; routine bank staff and tellers would only identify and direct leads. Clashes have occurred between the risk carrier and the MFI/bank, reflecting different organizational cultures (e.g., in workplace and performance management).

Outpatient coverage has generally been neglected, as prone to abuse and difficult and expensive to administer. However, innovative risk pooling for outpatient care (such as provider-based plans) and a shift from fee-for-service to capitation could overcome the challenges of providing outpatient coverage.

AKI recognizes the urgent need for low-cost health insurance. In their view, the current initiatives are laudable but disjointed. They would like to play a leading and supportive role in developing successful and sustainable low-cost products. Health insurance, as the fastest growing insurance product, presents a good investment opportunity.

Predominance of fee-for-service model of provider payments in both private and public health insurance

Both private insurers and NHIF reimburse providers using a fee-for-service system. Capitation is very rare, although there are a few attempts at fixed reimbursements packages. In the fixed reimbursement system, the insurer negotiates with selected providers fixed prices for various types of treatments and services. Under such schemes, the provider assumes some of the risk and is less likely to over-service clients. Critics say it creates an incentive to under-service clients, leading to poorer health outcomes. This development has been catalyzed in part by the experience of dealing with providers in Asia, through overseas patient referrals, and by the recent NHIF initiative to introduce comprehensive care plans in public and faith-based hospitals. In the NHIF plan, hospitals are paid a fixed amount per day for in-hospital care. The reimbursement amount varies slightly with the type and level of provider.

Private insurers and private providers have negotiated fixed reimbursements mainly for inpatient care, based on the diagnosis type and the type of care/procedures required (popularly referred to as packages). Such “packages” are becoming popular in maternity and surgical services. A few insurance companies such as UAP and CFC Life have experimented with outpatient fixed reimbursement. AAR (an MIP) has applied capitation in dental and optical services as well as in their own outpatient clinics.

The fee-for-service system has been identified as one of the key drivers of escalating health care costs, as it creates incentives to encourage over-servicing and supplier-induced demand.

The low application of capitation was attributed to lack of skills, lack of reliable statistics, negative attitude by providers toward capitation (as leading to reduced income and lower-quality care), and the comparatively low bargaining power of payers.

High administration costs of NHIF and private insurers

The administrative cost of both private and public health insurance schemes was found to be relatively high, ranging from 20 to 40 percent. In the case of private insurers, a huge portion of administrative expense is commission paid to insurance intermediaries (brokers and agents). This commission is prescribed in law (up to 20 percent of premium contributions). Administrative expenses for NHIF have dropped in the last several years from a high of over 60 percent to about 40 percent. This is still high compared to other countries’ social health insurance schemes, whose administrative expenses range from 3 percent to 6 percent.

Most private health insurance providers do not see any significant challenge (competition, disruption) from social health insurance except in the lower market segment

Most private health insurers and service providers anticipate that some form of universal or social health insurance scheme will be eventually established in Kenya. Depending on how it is designed, they do not see the development of such a scheme as a threat to their current business, which is mainly targeted at the middle-to upper-income segments. This view is premised on the assumption that any proposed financing mechanism (such as payroll taxes) will not significantly increase employment costs. Private health insurers and large private hospitals would like to be involved in

the design of any new proposed social health insurance scheme to avoid a repeat of what happened in with the previous attempt (2003-2005).

Smaller health care providers actually see a universal health insurance scheme as a good business opportunity and as a means of dealing with bad debts that plague their current operations. However, for private insurers who are pioneering low-cost insurance products, any proposed social health insurance scheme is a cause of some concern as it will inevitably, to a significant extent, compete for the same clients. A few of the private insurers thinking about venturing into the lower end of the market have adopted a cautious wait-and-see attitude. If the government does not plan to pursue a universal social health insurance scheme, it needs to send a clear signal to the private sector to encourage more innovation in insurance products for the lower end of the market.

Social health protection strategy supports a mixed system

In January and February 2009, the two MOHs conducted a study tour to Europe to review different social health insurance schemes to inform the development of a national strategy for social health insurance in Kenya. The key conclusion from this tour was that there was no single system that could easily be transferred to the Kenyan context; the systems that work well took a long time to develop, and they reflect the national economic and cultural conditions where they have evolved.

Box 3.2. Shalom Community Hospital Was Only Able To Access Financing After It Became More Established

Shalom Community Hospital in Machakos is a 170 bed facility located within 50 meters of a large government hospital and within 100 meters of a large Catholic hospital. This hospital started as a nursing home in 1992 and in 1995 became a hospital. Ownership is a limited liability company, with a doctor and his wife as the main shareholders. The hospital began with personal savings. It was able to obtain financing only after it had been in operation for three years. At that time, it obtained a loan and converted from a nursing home to a hospital. Generally, the hospital cannot save much out of operations and relies on sponsors, donors, or community (government community grants) for project specific capital funding.

Following this tour, the participants developed a framework for a long-term process to achieve universal coverage and social health protection. The key strategic goals of this framework include:

- Expand NHIF coverage
- Improve private health and other social health insurance systems
- Protect the poor
- Improve PPPs
- Improve health regulation and standards
- Improve capacity and quality in the public health system

Many of PSP-*One's* findings regarding the needs of the health financing sector are reflected in this strategic framework.

The Business Environment for the Private Health Sector

The right to practice privately is well established for all medical professionals in Kenya. The professional boards determine the amount of time an individual must work before establishing his/her own private practice, and the licensing requirements are clear. The existing rules of the various regulatory agencies are not unreasonable, but for facilities the process of multiple inspections and licenses from different regulatory bodies can be confusing, costly, and time consuming. Private practices must also obtain business licenses from the local authorities, and in some areas, the fees for business licenses can be significant. Creation of a single licensing agency could help reduce barriers to starting new practices in the private sector.

The private health sector's ability to access financing

In general, larger private hospitals and pharmaceutical manufacturers have accessed formal credit more often than smaller facilities or sole practitioners. For instance, Nairobi Hospital, one of the largest private hospitals in Kenya, is owned by a not-for-profit limited company, but it operates like a for-profit. The hospital started business in the 1950s and has expanded with commercial loans. In contrast, the faith-based sector, which provides care to a substantial number of Kenyans, does not have a source of capital for expansion or replacement of facilities or equipment. Smaller hospitals or clinics often cannot obtain financing as start-ups until they are well established.

For sole proprietorships, access to finance is generally even more difficult, given that financial institutions view the credit risk as higher than that of a limited liability company or partnership. Most of them are considered small or medium enterprises (SMEs). While there is no standard definition of SME in Kenya, lenders typically have defined SMEs as businesses with six to 50 employees or having annual revenues of less than Ksh 50 million (equivalent to \$625,000). A recent 2007 study by Strategic Business Advisors of 147 Nairobi SMEs indicated that 50 percent have annual revenue of Ksh 5-20 million (\$62,500 to \$250,000); 60 percent are less than 10 years old, 38.4 percent are in services-related businesses, and 59 percent have fewer than 20 employees. Although market research would need to verify this conclusion, most of the private health providers in Kenya appear to fall into this category, with the exception of the largest hospitals and pharmaceutical manufacturers.

Access to financing for SMEs

Despite the recent increase in interest by financial institutions in SMEs, lending to the sector is still limited. Overall, the assessment found that very few banks have incorporated a SME strategy into their methodology for credit assessment or management of loans. As mentioned earlier, most private health facilities in Kenya are SMEs. The World Bank's Doing Business 2008 ranked Kenya 82nd out of 181 economies in terms of ease of doing business—including starting a business, getting credit, protecting investors, and employing workers. According to a recent assessment (Microfinance Risk Management, LLC 2008), fewer than 20 percent of SMEs in Kenya had ever accessed finance from formal financial institutions (that is, all formally regulated financial institutions, including the Kenya Post Office Savings Bank). Interviews with health providers during the assessment echoed these findings. The IFC has a facility to support SME lending, with long-term advisors working in commercial

banks including FINA Bank, Diamond Trust, and Bank of Africa. Hopefully this will be an important step towards expanded SME lending. USAID also has several Development Credit Authority (DCA) loan guarantee facilities for Kenyan banks that encourage lending to the SME sector.

Interviews with sole proprietorship pharmacists indicated that most of them used personal savings for start-up financing and very few have accessed formal financing. Some health associations have established SACCOs (savings and credit co-operative organizations) to obtain financing for members interested in establishing their own private practices. The nurses association of Kenya indicated that start-up capital often comes from termination payments at the time of retirement, plus personal savings. A typical nurse in public service would have Ksh 500,000 in a pension plan at retirement, of which she might be able to withdraw two-thirds. Some nurse practitioners have established SACCOs, obtaining loans through group guarantees. The Pharmaceutical Society of Kenya (PSK) is in the process of establishing a SACCO, but the difficult business environment means that many pharmacists are not willing to take on loans.

Business characteristics of the health sector also constrain growth

Access to finance for private health providers is even more constrained than for other types of SMEs; the unique characteristics of health care businesses increase the risk of lending, from the perspective of a financial institution.

Dominance of sole proprietorships reduces profitability and increases risk profile to banks. Group practice is rare in Kenya. There is no tradition of formal contracts/profit-sharing agreements between medical providers as there are with lawyers in legal practice. Some established private practitioners do hire a junior doctor or take one as a junior partner. Where “groups” form, it is usually more an expense-sharing arrangement than a formal group practice (entailing sharing calls, common medical records, etc.). Individual physician practices have high overhead expenses because they must pay for their own offices, medical equipment, security, generators, and other support services, which decrease profitability. Group practices could therefore create the economies of scale that would allow providers to expand into underserved areas, employing a high volume–low margin strategy that would make care more affordable.

Because of the competition of other small practices, many providers feel compelled to invest in medical equipment to attract clients even when they know the equipment will be underused. This may also tempt providers into inducing demand for the use of the equipment for unnecessary tests or other procedures. The fragmented, small-scale nature of the private health sector increases the risk profile from the perspective of financial institutions, reducing access to finance for health providers. Some alternative business models are being developed but have not been proven (see Case Studies in Appendix 5). One possible reason for providers’ reluctance to pursue group practices may be the lack of good legal models that providers can easily understand. Providers must have confidence that in a group practice, the terms of the contract can be enforced and will not lead to conflicts with partners.

Private providers often lack financial statements, business plans, and business skills. Even health care providers that have active, sustainable practices often lack audited financial statements, business plans, or systems for analyzing costs or profit. Sole proprietors are often unable to say how profitable their practice is or what activities generate the most

profit in their medical facility. While providers may understand why banks need to have financial statements and a business plan to evaluate a loan application, they often lack the capacity to develop them. More generally, inability to analyze which of their activities is profitable can lead to misallocation of resources and missed opportunities for expansion. With little rationalization of investments, justification and approval of loan proposals becomes difficult, hindering expansion of equipment or facilities. Although a provider may not be able to evaluate the profitability of an investment, many providers perceive a competitive pressure from clients to procure the latest diagnostic or treatment equipment. The pressure on private providers to over-invest in such services leads to underutilization of equipment and more inefficiency in the health system.

Resistance to applying business principles to health care. As large as the private commercial sector has become, many Kenyans believe that health care should be a public good, not a profit-making business. This perception may influence consumers' unwillingness to pay for consultations that they do not consider treatment. As a result, write-offs of bad debts on cash-paying patients are substantial. The notion that providing health care and managing a business effectively is incompatible also underlies the resistance of some providers to seek out business training in management, information technology, and insurance. It may also be a factor in the reluctance of medical schools to include management, ICT, and insurance courses in their curricula.

Cash flow can be an issue. In addition to bad debts from fee-for-service clients, revenue recovery for insured patients can be problematic, even though they typically make up a small portion of total clients. Cash flow from the NHIF is relatively good, with payment within two to four weeks, which is better than private health insurers. Corporate sponsors generally pay in 30 days, but some providers mentioned six-month delays in payment, resulting in providers having to spend time and resources on collections.

Competition from unlicensed providers or the informal sector can hurt formally registered providers. Competition from informal providers with no medical training and fake drugs is a major challenge in operating a private practice in Kenya, making it even more difficult to attain and maintain profitability. Several pharmacists mentioned this as a factor limiting their profitability as well as tempting them to cut corners on quality in order to stay competitive.

Limited understanding of regulatory issues can dissuade financial institutions. Regulation of health facilities and health professionals is much more complex than for other small businesses. The risk that a profitable practice could be shut down for noncompliance with regulation is another consideration for banks underwriting loans. Financial institutions are leery of approving credit for a medical facility if they cannot easily verify the legality of the facility and the medical staff. In theory, it should be relatively easy to confirm whether a provider is properly licensed. However, the Kenyan Women Financial Trust (KWFT) specifically mentioned this factor in explaining why they have a limited health sector portfolio. KWFT has chosen to market its financial services to the Kenyan nursing association, presumably on the assumption that its members are all licensed providers. A single facility-licensing entity could also

make it easier for banks and suppliers to verify whether a provider is duly licensed before making a loan.

Kenyan financial sector

The financial sector in Kenya is composed of a variety of actors, including private commercial banks, state-owned banks (43 as of 2008) and MFIs (42 registered as of 2008). Although five years ago the banking system faced substantial nonperforming loans, the last three years have seen major developments in providing services to lower-income Kenyans, especially in the retail sector. The Central Bank of Kenya (CBK) has strengthened the regulatory and supervisory framework especially in regard to provisioning for non-performing loans. Until the current credit crisis of 2008/09, interest rates had declined significantly, deposits had grown, and banks were increasing their lending instead of investing in government securities. Loan balances increased by 76 percent between 2003 and 2006 (FSD 2008). SME lending is now viewed by many banks as a growth area necessitating a more efficient way of assessing credit risk. This will be especially true for the health sector, given that its business characteristics are not known to most lenders.

Overall, there is increasing competition in the financial sector. This growth has been led by Equity Bank, which has increased its asset base tenfold and the number of its clients by a factor of nine in the last five years, finishing 2007 among the top ten banks by asset size. More importantly, by June 2005, Equity was the largest institution in terms of outreach (with the exception of the Kenya Post Office Savings Bank), with over half a million accounts representing 21 percent of the total number of bank accounts in Kenya. By the end of 2007, Equity had a market share of 39 percent, representing over 1.8 million accounts, with a focus on lower-income and unbanked clients. Family Bank and K-Rep Bank also showed strong growth, as did Co-operative Bank, Barclays Bank, and National Bank, adding more than 100,000 accounts over the past three years.

Branch networks are also expanding rapidly, with a total number of bank outlets increasing by more than 20 percent during 2007, reaching 688 by December 2007. Alternative channels have also opened up, with ATMs increasing to 1,103—two and a half times more than three years ago—and Safaricom and Celtel launched mobile phone payment systems in 2007.

Micro-finance Institutions

MFIs are also contributing to the growth of the financial sector with the transformation of KWFT and Faulu Kenya into deposit-taking institutions, enabling them to offer more services to clients and to increase viability, given the increasing competition from banks moving down-market. MFIs might be a lending option for small loans for health care providers such as nurses/midwives, and possibly for some pharmacists who may require small loans but lack collateral. In addition, some Kenyan MFIs such as KWFT have considerable outreach. KWFT is the largest MFI in Kenya, with 142 offices, over 200,000 clients, and Ksh 5.9 billion disbursed in 2007. The clients are all women, and KWFT has made an effort to market its loan products to nurses.

MFIs, however, do not offer loans with long durations or large principal amounts; and although individual loans are now offered, the focus is still on group lending. KWFT, for example, offers range of loan products such as business, emergency, start-

up, and individual loans, with durations of usually less than one year although some tenors extend to three years.

Kisumu Medical & Education Trust (K-MET) is an NGO that provides medical services for lower-income Kenyans in the Kisumu area but also extends loans to health care personnel. K-MET is unique in that it utilizes Kiva, an online lending platform to obtain loans for providers in its network. One-third of the loans are health care related, supporting RH providers. Kiva supports providers who otherwise would not get loans; however, the maximum loan amount is around \$2,000 equivalent, which is not sufficient for the significant investments in equipment.

Faulu, the second largest MFI in Kenya with over 161,000 clients, focuses on lending to the poorest in Kenya; no loans above Ksh 1 million (equivalent to \$12,500) are issued. 98 percent of the portfolio is group loans, of which 90 percent are below Ksh 100,000 (equivalent to \$1,250). In the first quarter of 2009, Faulu will launch an individual business loan product for members who have been repaying loans and have graduated to larger loans. These loans will amount to no more than 10 percent of the loan portfolio and will be limited to Ksh 5 million. The tenor will be 60 months, possibly 72. These loans will be collateralized, with 70 percent using land titles.

Another drawback of MFIs is that their interest rates are even higher than those of commercial banks, reflecting the higher cost of underwriting many small loans. For instance, the lending rate for Faulu is an 18 percent flat rate, declining to 15 percent for repeat loans; consumer loans are 20 percent, as are micro-health insurance loans. In addition, for each loan, a 2 percent loan insurance is required as well as an application fee of 1.5 percent of the loan amount.

Challenges facing financing institutions in Kenya

Despite the recent growth, financial institutions in Kenya are facing a number of challenges. The central bank has increased the capital requirement to over Ksh 1 billion; due to the current financial crisis, it is urging financial institutions to reach this new level sooner than anticipated. Kenyan banks have been somewhat isolated from the financial crisis because they did not participate in as heavily leveraged transactions as did U.S. and European banks. Some banks, however, will lose lines of credit from parent companies, and larger transactions will not be done because third-party guarantees are less available. Liquidity in the local currency has not yet been seriously affected for most institutions, but this may change as the economy slows down. The top four producers of liquidity are floriculture, tea, remittances, and tourism. The Kenyan shilling has weakened, which will help exports, and oil prices have gone down. The next six months will indicate the course of the economy. For now, the central bank has reduced reserve requirements to add liquidity to the banking system. Banks are also facing other challenges, including increased pressure to invest in technology, declining interest margins, increasing competition, and the need to diversify.

Health sector lending in Kenya

While there are creditworthy borrowers in the private health sector, Kenyan banks do not have much exposure to the health sector; most of that lending focuses on large pharmaceutical companies and private hospitals. Large private hospitals can charge high prices, so margins are larger and they can absorb the costs of financing. Many of

the banks that were interviewed do not have statistics on health sector loans because health sector lending is not specifically tracked in bank loan portfolios. All of the financial institutions interviewed indicated that the health sector was not a significant sector in terms of lending. Despite the limited levels of lending and lack of information on health sector lending, all of the financial institutions interviewed indicated interest in lending to the sector and were interested in a market research survey that would demonstrate growth and potential to lend to the sector.

Constraints to health sector lending

Despite the interest in health sector lending, interviews with financial institutions identified a number of key constraints.

Perceived risk and lack of quantifiable risk assessment of SME/health sector loans. Many of the financial institutions that were interviewed identified risk as a significant constraint to lending to the health sector, reflecting a number of factors discussed earlier: the predominance of sole proprietorships, competition with the informal sector, the fact that health care is viewed as a social good, and the unique regulatory considerations. These risks can be mitigated by market information on health care businesses and credit scoring, as well as loan guarantees and facilities designed by donors to encourage lending.

Some of the risks identified by financial institutions in lending to health care businesses are risks that are generic to the SME sector. For example, a recent assessment of the potential for credit scoring for SME lending in Kenya found that one major impediment to SME lending (including to health providers) is that banks lack cost-effective ways to quantify risk. Until very recently, there were no licensed credit bureaus; the Banking (Credit Reference Bureau, or CRB) regulation 2008 was published in September 2008, and credit bureaus became operational in February 2009 with just two suppliers (CRB, and Africa LTD and Quest Holdings). CRB Kenya is already collecting performance data from 21 banks, but the quality and usefulness of the data will remain limited until the new credit bureau system is fully operational.

Given that financial statements from SMEs are often not audited or not available, banks often will not lend to SMEs or will charge high interest rates and require collateral equal to 100 percent or more. Many of the private health providers interviewed indicated that they do not apply for bank credit of high interest rates and collateral requirements. Credit scoring would help develop risk-based pricing, not only giving lower-risk clients lower costs of borrowing but possibly also increasing credit availability for high-risk clients who otherwise would receive no credit. Another positive aspect would be a reduction of collateral requirements. Turn-around time from application to approval and funding would also decrease.

Some banks interviewed, such as FINA Bank (ranked 27th in total assets among commercial banks), are significantly increasing SME lending by utilizing custom-designed data systems for loan applications. The majority of FINA's credit clients are SMEs, and FINA plans to grow its SME portfolio by 100 percent annually, from a current account base of around 700 clients. A relationship manager completes credit applications on a Excel spreadsheet, collecting all the application and financial data and calculating financial ratios. The underwriting is done centrally, and the customer receives notification within two days of formal application.

All of the banks interviewed indicated that they require audited financial statements from certified accountants. In financial statements, however, cash flow may be understated (typically for tax reasons), which lessens the usefulness of the statements in assessing loan quality. Most of the banks surveyed typically validate the cash flow or financial statements by analyzing inflows and outflows from checking and savings accounts. Almost all of the banks require loan applicants to have had a checking or savings account with them for at least six months.

Lack of collateral. The majority of SME loans are secured by some form of collateral, usually landed title. Lenders are concerned about securing collateral in the event of default; but in the case of health providers, lenders are reluctant to take the land or collateral of a clinic or hospital given the public relations problem of closing such a facility. Additional concerns are the accuracy and reliability of appraisals and confirmation of the lien position. The Central Bank of Kenya suggests at least a 100 percent collateralization of all loans, although there is flexibility in defining collateral. For the banks interviewed, collateral requirements range from 100 percent to 200 percent of the loan amount, depending on whether it is immovable (personal house, building) or moveable property (vehicle, machinery).

FINA is an exception in that collateral requirements vary substantially depending on both the loan size and the risk classification of the applicant. Equity Bank also offers a range of loan products, some requiring collateral and others not. All of Equity's loan products emphasize cash flow, given that average Kenyans do not have land to offer as collateral. Even MFIs in Kenya often require substantial collateral for loans. For example, ECLOF, a second-tier MFI, requires that loans be 100 percent collateralized, although the collateral is mostly movable assets such as household appliances.

Box 3.3. Interest Rates Discourage Provider from Seeking Financing

Polyclinic Hospital in Naivasha, owned by a doctor who now leases it to a nurse administrator, has been upgraded incrementally over the last ten years. However, cash flow constrains the medical services that can be offered. The hospital has never applied for a bank loan; it is considered too expensive. The X-ray machine currently is not working and the hospital cannot afford to purchase a new one—though it did manage to lease a new ultrasound from a medical equipment supplier.

The collateral requirements of Kenyan financial institutions can be a real constraint for private providers in accessing financing. Many small and medium private health care providers operate out of rented facilities, or they are reluctant to pledge family homes as collateral for a loan. In addition, medical equipment and other operating assets of health care providers are not viewed as acceptable collateral by most commercial banks.

Loan products and terms offered by commercial banks. Many of the loan products and terms offered by financial institutions in Kenya do not meet the financing needs of private providers. Among the largest banks in Kenya, the average **loan amount** to a registered SME is about Ksh 5 million (around \$62,500 equivalent). This level of loan would meet the lending needs of many sole proprietor medical providers, but not of larger medical facilities. Bank loans generally are only available to those who also have a salaried job (as salary is the security).

Providers' greatest need for credit arises when starting a new practice. However, banks usually do not offer **start-up loans**, and doctors are reluctant to borrow because of uncertain ability to repay and extensive competition. Most providers interviewed indicated that they were only able to start their businesses with personal savings and financial assistance from friends and family. Start-up costs for the health care practitioners are substantial—the equivalent of tens of thousands of dollars for a pharmacy, nursing home, or clinic—and are especially high in Nairobi. Most physicians manage their own clinics and hospitals; nurses who own their businesses usually manage maternity homes. Most of the providers had expanded their practices over time, and almost all of them did so without bank financing.

Although **interest rates** had decreased, they are now increasing again due to the financial crisis. The lowest commercial bank base lending rate was 15.5 percent, plus a risk premium of between 3 percent and 10 percent, depending on the bank. A representative organization of the private health sector, the Kenya Healthcare Consortium, indicated that there is no demand for credit at current interest rates because profit margins won't allow providers to repay loans at these rates. Most providers only want subsidized rates.

In many countries, **lease financing** can be an important source of financing for private providers. Health care businesses worldwide use leases to acquire equipment. Leases can be a good option for providers who do not have access to lump-sum funding. In many cases, a lease is structured so that the equipment being financed is the security, which can be beneficial for providers that do not have adequate collateral for other types of financing. Banks in Kenya however do not generally offer lease funding for medical equipment; industry suppliers offer lease financing only for certain lab equipment where cost is recovered through reagent purchases, as well as for some oxygen generators.

When medical suppliers do give credit, it is often only for a short duration (30 days) or for an amount too small to meet the financing need.

Many health care providers interviewed indicated that they could not repay **loan tenors** of less than one year, as the cash flow generated would not be sufficient for loan repayment. Examples of insufficient loan duration were for medical equipment purchases and construction costs related to a maternity hospital. While longer financing of up to five years is available from most commercial banks, it appears that many private providers are not able to access long-term loans and are forced to rely on (expensive) overdraft facilities, which do not meet their broader financing needs. Of the providers interviewed, pharmacists were most able to receive financing to restock drug supplies—often from wholesale drug distributors—but most often only for 30 days. Some pharmacists are able to secure up to 90-day financing for drugs. This lack of financing is somewhat mitigated in Nairobi by the fact that re-supply of drugs is fast due to the competition among drug wholesalers. Nurses and physicians do not have as much access to credit for medical supplies as pharmacists do, which can result in difficulty in finding everyday working capital.

Private Sector Supply Chain

A considerable amount of work has gone into documenting and analyzing the problems associated with the supply chain of pharmaceutical products in Kenya, both

in the public sector (especially around KEMSA) and in the private sector. The most recent and most comprehensive effort was conducted in 2005 by Health Research for Action (HERA) for the MOH. This assessment drew on that and other studies, with a view toward identifying ways to improve the quality of drugs in the private sector supply chain as well as the efficiency of the private sector supply chain in making drugs accessible to Kenyans.

Too many suppliers, too many bad suppliers

Field visits by the assessment team to drug retailers and chemists confirmed many of the problems highlighted in multiple reports on the pharmaceutical sector. Virtually all levels in the supply chain, from importer/ distributors to wholesale to retail, are characterized by a high degree of competition and fragmentation. Indeed, the definition of these different levels is blurred, as some operators fill multiple functions; manufacturers may import, distribute, and retail products (e.g., Njimia), and other operators who call themselves wholesalers fill only the most basic function of reselling to retailers in restricted areas. These regional resellers typically employ no pharmacist, perform no quality control, and are unable to track lots sold or manage a recall. The result of this fragmentation is a super-competitive environment in which minimum standards are not enforced or respected and competition is driving a race to the bottom. To survive, most of the players in the commercial market look for ways to earn some additional margin by procuring from dubious sources, cutting corners on quality, and failing to provide basic services that are available in most supply chain systems in Africa—including countries with a weaker commercial sector than Kenya.

For example, many chemists engage in a practice known as the “merry-go-round.” This involves establishing a credit line with a supplier for 30-60 days’ credit, then reaching the credit ceiling and then failing to pay. When the wholesaler cuts off the retailer from further supply, the retailer simply begins procuring the same products from a different wholesaler who is unaware of the retailer’s poor credit practices. The new supplier is only too happy to gain a new client, because there are too many wholesalers competing for too few retailers, especially retailers in high-volume areas.

The excessive competition between wholesalers means that few of them can achieve the economies of scale necessary to warrant investment in a national distribution system. In Nairobi, virtually all pharmacists interviewed confirmed that wholesalers can resupply on orders within 24 hours, and usually less. In Machakos and Naivasha, however, both a short distance from Nairobi, the resupply times reported averaged 3-5 days. When asked about preferred sources of supply, most chemists cited several different wholesalers; it was clear that no single wholesaler had enough clients in those towns to justify resupply trips once a day or even every two days. In countries where the number of distributors and wholesalers is restricted and minimal margins are assured, suppliers compete on the quality of their products, the speed and convenience of resupply, and their credit terms. Even in a country like Senegal, which has a weaker economy, wholesalers are able to ensure resupply anywhere in the country in less than 24 hours.

Some of the private wholesalers do not meet even the most basic standards for pharmaceutical wholesalers. They are best described as resellers. Many are very small regional operations that simply buy from other distributors and resell to

chemists/pharmacies in a very limited zone. As noted above, they have minimal storage capacity that does not meet the standards for pharmaceutical premises, and they have no capacity for record keeping, tracking lots, or managing a recall. It is unclear whether such operations are even formally licensed as wholesalers, but they are recognized as wholesalers by pharmacists, PSI, and other key informants.

Too many retailers, too many bad retailers

This situation does not mean that retailers are immune from cutthroat competition. Neither wholesale nor retail prices are controlled, and they vary tremendously. Most chemists interviewed reported using the “Pharmafinder” reference document as a guide to pricing; most reported normal margins above wholesale price at 30 to 33 percent. However, this guideline seems to be used only as a ceiling on pricing, and there does not seem to be any standard “floor.” As a result, there is considerable downward pressure on prices. Because prices vary so much and so unpredictably, consumers will shop around for the cheapest price, and most of the retailers interviewed complained about losing customers to competition selling cheaper drugs of dubious quality.

The actual number of drug retailers is not known with any level of confidence. A number of documents and informants cited between 1,250 and 1,500 registered and practicing pharmacies, but the number of unlicensed retailers can only be guessed at. Informants estimated between 3,000 and 4,000 unlicensed retailers nationally. Using its sales force, Surgipharm estimated the number of unlicensed pharmacies in Nairobi alone at 500. The distribution of retail outlets is highly skewed toward urban areas. According to the HERA study, 71 percent of the private retail outlets are located in the five main urban areas, serving only 18 percent of the population. Even within Nairobi, the huge variance in access to chemist shops was apparent to the team—15 chemists could be found in three blocks of Westlands. Some of the informants cited a guideline of 1 kilometer minimum distance between drug retail outlets, but this guideline has no basis in law and even less effect in practice. Restrictions on siting and demonstration of need are not part of the licensing process for pharmacies.

Chemists and pharmacists were also asked about the problems of counterfeit or poor-quality drugs. Most reported having strategies for distinguishing between good and the bad drugs, including procuring from only trusted sources, reading the announcements from the PPB, and inspecting packages. Some of the methods described seemed dubious, illustrating how the prevalence of poor quality drugs in the system drive up operational costs. Additional time is spent inspecting products received, and probably rejecting some good-quality drugs while accepting some poor-quality ones.

Too many drugs, too many bad drugs

By all accounts, there is a large quantity of substandard and counterfeit drugs in circulation in Kenya. One of the major deterrents for the multinational pharmaceutical companies considering investing in the Kenyan market is the risk of having their branded drugs copied. Lilly, the manufacturers of Cialis, has had to invest in educational materials and package changes for Kenya to discourage copies. They report finding 27 different version of their original. In a sample of 126 drugs purchased

at retail outlets in 2002, Mission for Essential Drugs and Supplies (MEDS) found that 37 percent of the sample failed to meet the standards for active ingredients.

Unfortunately, it is all too rare that drug quality is monitored at the point of importation much less at the retail level. The main problem is the lack of monitoring and enforcement. Sharing a border with a low-regulation country like Somalia certainly complicates the situation; many informants suggested that the worst-quality drugs are brought across that border by so-called suitcase vendors. There is, however, a policy side of the problem that contributes to the burden of pharmaco-vigilance and explains the high levels of low-quality and counterfeit drugs. The current Pharmacy and Poisons Act (Cap 244), as interpreted by PPB, does not allow the PPB to refuse registration of a drug on the basis of public health benefit. The result is that too many versions of the same molecule are registered for importation and sale, which increases the pharmaco-vigilance burden, drives down price, and increases the risk that some of the versions will be of poor quality. Informants reported that there are over 20 versions of Fansidar, 70 versions of amoxicillin, and 100 versions of ibuprofen on the market.

Kenyan pharmaceutical manufacturers

Unlike most countries in Sub-Saharan Africa, Kenya—along with Nigeria and South Africa—has significant local manufacturing capacity in the pharmaceutical sector. There are approximately 30 locally licensed manufacturing facilities that are either locally owned or subsidiaries and joint ventures. Virtually all of the Kenya-based manufacturers are located in the Nairobi area.

Although the local Kenyan pharmaceutical industry has considerable production capacity and a large potential market in the East African trade zone, the trade deficit in the pharmaceutical sector is large and growing (Table 3.11). In addition to large imports from the U.K., France, and Germany, the large number of parallel imports, generic imports, and illegal imports have driven a trend toward an increasing trade deficit.

Table 3.11. Kenya's Pharmaceutical Trade Balance, 2003-2008 (US\$ million)

	2003	2004	2005	2006	2007	2008
Pharm exports	29.8	28.0	25.6	23.2	22.7	20.4
Pharm imports	109.8	127.6	165.0	225.2	243.2	262.7
Trade balance	79.9	99.7	139.4	202.0	220.5	242.2

Source: BMI 2008.

Much of the local production is focused on over-the-counter products, which typically represent around a third of the total market value for pharmaceutical products. In 2008, the value of the over-the-counter market was \$81 million, or 35.4 percent of the total market. The largest category is analgesics (which totaled Ksh 288 million in 2008), followed by cold remedies (Ksh 155 million) and vitamins and tonics (Ksh 120 million).³

While the local manufacturing sector may continue to be profitable for the internal market, unless trade policy or quality controls restrict imports, the sector is not likely to grow significantly for the export markets. Restricting new product registration on

the basis of health need and requiring plant inspections before issuing import authorizations may slow the growth in imports and create a space for local manufacturers. These statistics do not account for local production and consumption of traditional medicines which, according to anecdotal evidence, is also a sizeable market and in need of regulation. The Kenya Medical Research Institute (KEMRI) was reportedly tasked with testing traditional medicines for toxicity, but there is a policy gap regarding what quality standards should be applied to traditional medicine and who should apply them.

Large mandate, insufficient capacity

The PPB has received considerable attention in the various studies of the pharmaceutical sector. The PPB has the same basic mandate as the other professional boards: to determine the standards of the profession, the educational requirements that are necessary to stay in the profession, and procedures for enforcing professional standards. However, the PPB has a much greater burden for inspecting facilities than the other professional bodies, which as noted above are also too poorly organized to conduct facilities inspections. With 6,000 facilities in need of inspection, including nearly two-thirds that need to be shut down for operating without a license, the PPB's lack of enforcement capacity is especially acute.

In addition to this mandate, the PPB oversees the National Quality Control Lab (NQCL) and is responsible for registering drugs, inspecting manufacturing facilities both in Kenya and abroad, and conducting pharmaco-vigilance in a country with porous borders and active trade. The NQCL, established in 1992, was supposed to be an autonomous agency, but through board control, the PPB remains effectively in charge of NQCL operations. To its credit, the PPB has made investments to improve its performance in this area. The NQCL has been prequalified by WHO, and the number of site inspections of manufacturers has increased. The NQCL has also recently established 11 inspection sites at all the official ports of entry, to conduct random sampling and testing of drugs being brought into the country. Even with this increased investment, the NQCL has nowhere near the capacity it needs to conduct batch testing on all drugs being imported and registered, but any increase in the percentage of testing will serve as a deterrent for unscrupulous importers.

One problem that the PPB will have in trying to reduce the burden of product registration is financial. The 2005 HERA report documented that 94 percent of the PPB's operating revenues come from drug registration fees. This creates a strong incentive not to refuse registration of drugs. However, if the PPB is serious about conducting pharmaco-vigilance, it should consider that registering more drugs may increase income in the short term but will drive up operational costs on the quality assurance side. Clearly, PPB will have to find other sources of budgetary support if it implements a more restrictive approach to drug registration.

Practice of pharmaceutical technologists

The pharmacy law (Cap 244) was modified to create a scope of work for pharmaceutical technologists (pharm tech), with the idea that a different course of study was needed than for someone who would spend their career in retail pharmacy. Pharmacists can practice clinical pharmacy as well as retail, but a pharmaceutical technologist cannot. The intention behind the creation of this second tier may have

been sound, but in practice the course of study and the scope of practice were not well defined. The PPB is only now setting and standardizing degree requirements and CPE requirements. One of the reasons that the PPB has had to become more proactive is that a number of private medical schools created pharm tech certificate programs without proper certification, and their graduates have had difficulties getting licensed, leading to understandable frustration and controversy.

The PSK still sees the pharm tech degree as a “shortcut to pharmacy practice.” However, the vast majority of pharm techs seem to serve as cheaper labor in retail shops than a pharmacist. Approximately 80 percent of pharmacy staff interviewed by the assessment team were pharm techs, not pharmacists. Many of those expressed an aspiration to own and operate their own chemist shops. Given the persistent low access to quality drugs and the availability of “suitcase drug sellers,” it seems unwise to restrict retail pharmacy practice to too high a standard. That said, some clearer delineation of the difference between pharmacists and pharm techs is needed.

Duplication of efforts

As mentioned earlier, there is inefficient use of public resources in the health system due to duplication of capacity across the public, private, and not-for-profit sectors. Nowhere is this more apparent than in the pharmaceutical supply chain function. KEMSA is the dominant player in supply chain in Kenya, but it is as much a problem as a solution. These problems have been documented extensively elsewhere, but what is relevant for this report is that frustration over KEMSA’s inability to ensure consistent supply of drugs and other health products has led to numerous reinventions of the supply chain wheel. The so-called “spaghetti diagram” in the 2006 evaluation of KEMSA (Huff Rousselle et al.) illustrates quite clearly how different vertical programs have set up their own parallel distribution networks. On a small scale, the Child and Family Wellness (CFW) Shops network also attempted to create its own stand-alone supply chain. PSI maintains a significant investment in national distribution for its range of products and makes minimal use of the commercial distribution infrastructure.

After KEMSA, MEDS may be the second single largest distributor of drugs and medical products. MEDS supplies hundreds of health facilities in the FBO and NGO sector. Informants at MEDS said openly that it was established primarily because its FBO and NGO member facilities could not count on KEMSA for obtaining supplies of drugs. MEDS gets high marks on the quality of its operation from all observers, but there is less consensus on the cost-effectiveness of its operation. It is understandable that programs with specific mandates and limited time and funding choose to set up something that is manageable and controllable to fill a specific need. However understandable, setting up project-specific supply chain systems is increasing the level of inefficiency and dysfunction in the system. Donor-funded parallel supply chains may also be crowding out the private commercial sector, which in most countries fulfills a much larger share of the storage, distribution, and delivery function. As noted above, one of the reasons the national distributors do not invest in more efficient systems with broader coverage is lack of economies of scale. Shifting some of the project-based distribution to the private sector could help the commercial sector achieve economies of scale and bring down costs for all stakeholders.

One specific case of duplication that seems especially unfortunate given the high costs involved is the lack of coordination between MEDS and the NQCL on the manufacturer facility inspections and lot testing associated with approving facilities. This is a critical function that has been missing, and it would serve everyone's interests for these two organizations to coordinate their activities in this respect. Whether it involves inspecting manufacturing facilities in Kenya, China, or India, this is highly technical and expensive work and essential to ensuring that drugs registered in Kenya are produced in facilities respecting Good Manufacturing Practice (GMP). Both MEDS and the NQCL have the capacity to perform this function, but they should be consulting each other in prioritizing which plants to inspect, coordinating efforts, and sharing results.

Some informants blamed the deregulation efforts of the 1990s for having gone too far and creating the conditions that are seen in the market today: poor quality, cutthroat competition on prices, and a loss of professionalism in the sector. As one informant put it, people in the sector are selling discounts, not drugs. The inability to control quality seems to have had the effect of discouraging the more responsible players from participating in the market. The number of multinationals in the market has declined considerably. Even the larger market players have no incentive to invest in quality. For example, Laborex is a multinational that specializes in importing and wholesaling in other parts of Africa, typically operating national distribution systems to reach all licensed outlets. They have not invested in distribution or logistics to the same degree in the Kenyan market, presumably because the uncontrolled competition does not make this profitable.

Policy Reform Environment

The health sector in Kenya is an intricate web of complex relationships and alliances between different organizations—including professional associations, private sector entities, and NGOs/FBOs—representing different areas of the private health sector. This section describes the different actors in the health sector. At the end of the section is a diagram that provides an overview of all the health stakeholders and their relationships with each other. Understanding the policy reform landscape is critical to designing effective PPPs and to successfully implementing the recommendations made in Section 5.

Key players in the policy environment

Public sector

One of the agreements emanating from the Peace Accord was the division of the MOH into two: the Ministry of Medical Services (MOMS) and the Ministry of Public Health and Sanitation (MOPHS). Each is led by a Permanent Secretary—currently, Professor James Kiyapi and Mr. Mark Bor, respectively. The MOMS is charged with overall health sector governance and stewardship and managing the hospital sector, while the MOPHS manages all operations at the secondary level and below.

The division of roles and responsibilities and the separation of functions between the two MOHs has created challenges for organizations working in health outside of the public sector. Many assessment informants commented on the difficulty of

knowing which function resides within which ministry. Moreover, the individuals interviewed were concerned about the additional time and effort required to re-establish working relations with not just one but now two organizations. Given the importance of each ministry, commercial health entities will now have to invest additional time building relationships with staff in both ministries and fostering consensus for initiatives that may fall across both ministries.

Currently, Prime Minister Raila Odinga is spearheading a national dialogue on how to stimulate greater private sector participation in all aspects of Kenyan life. This policy debate is conducted through a series of Round Table discussions. The Honorable Odinga has assembled a large team of high-level government officials comprising ten Ministers, including MOMS Permanent Secretary Professor Kiyapi, in addition to a number of Assistant Ministers and other senior government officials. This public sector team represents all aspects of the Kenyan government in the Round Table discussions. The private sector is represented by a federation of multiple trade associations representing all the sectors in the economy, including health. They have formed an umbrella organization named the Kenya Private Sector Alliance (KEPSA).

The Prime Minister and KEPSA held the first Round Table meeting on August 15, 2008. In the area of health, the MOMS and MOPHS agreed to enforce all laws that regulate the practice of medicine, with the aim of eliminating quacks from practice, and to liaise with Treasury in settling all legitimate debts that KEMSA owed suppliers.

KEPSA organized and hosted the second Prime Minister's Round Table meeting, where the Prime Minister established a Monitoring Unit to oversee implementation of all decisions made at the Round Table meetings. This unit, which will reside in the Prime Minister's office, will report progress throughout the dialogue process rather than *ad hoc*. In the Prime Minister's closing remarks, he requested that government work with the private sector to ensure that the Kenya business enabling environment is improved, thus attracting and retaining investment and ultimately making Kenya a globally competitive nation. The Prime Minister reiterated his support for working with the private sector; his press conference with KEPSA highlighted the advancements and agreements made by the GOK with the private sector.

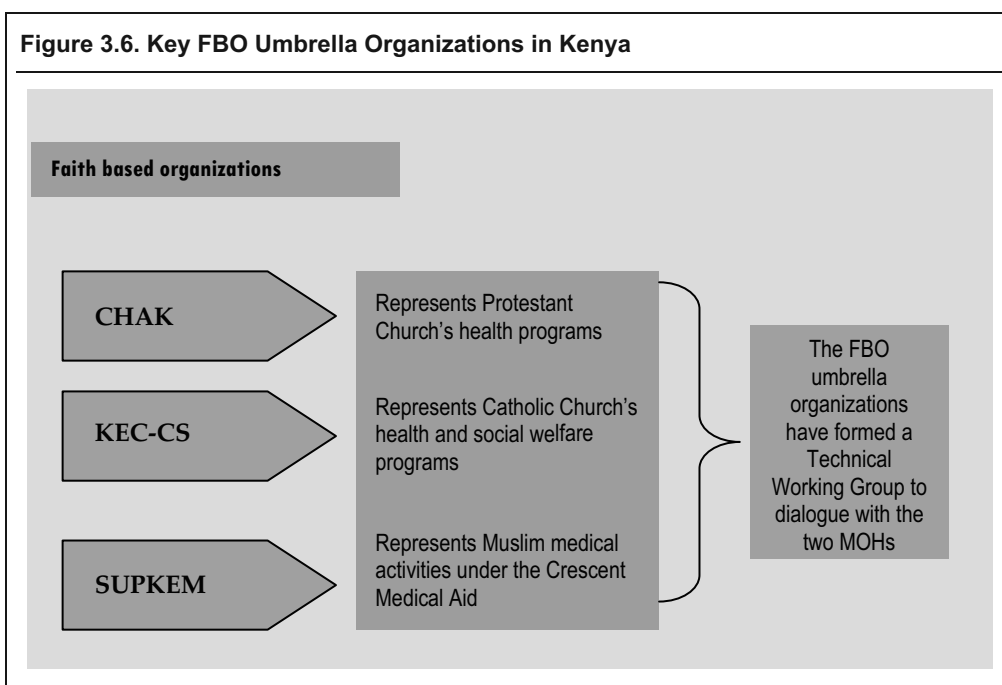
Faith-based organizations

Traditionally, FBOs have played a critical and significant role in Kenya by providing health care services in remote, rural, and underserved areas. In particular, the Kenyan FBOs have a long history in health (over 100 years in some cases) and long-standing relationships with each other and the MOH. The FBOs are organized into three associations along religious lines: (i) *Christian Health Association of Kenya* (CHAK) representing Protestant Church's health facilities and community-based health programs; (ii) the *Supreme Council of Kenyan Muslims* (SUPKEM), which has a medical branch called the Crescent Medical Aid; and (iii) *Kenya Episcopal Conference-Catholic Secretariat* (KEC-CS) which implements a wide array of social and health programs on behalf of the Catholic Church.

These umbrella organizations are large. For example, CHAK has a membership of 456 health care providers comprising 25 hospitals, 50 health centers, 58 church health programs, and 322 dispensaries, as well as nine nurses training colleges with wide geographical representation. The associations perform many functions for their

members, including advocacy and representation with the MOHs to gain recognition for their contribution. They also promote capacity building, procurement and medical equipment in mission hospitals, health care financing, networking, and communications and information sharing.

The FBOs have joined forces to create a forum for regular engagement with the GOK and MOHs through a technical working group called *MOH-FB Health Services Technical Working Group* (MOH-FBHS-TWG). The Technical Working Group (TWG) is chaired by the two MOHs, with CHAK serving as its Secretariat. The objective of the TWG is to formalize the long-standing relationship with the MOH (see Figure 3.6.)



To date, the FBOs have had many interactions with MOH, as a source of (i) in-kind support through drug donations (vaccines, TB drugs, malaria therapy, RH commodities, and essential drug kits for community dispensaries); (ii) seconded MOH staff; and (iii) financial grants. The FBOs would like a more predictable arrangement for staff-sharing that makes sense for both MOH and FBOs,

In 1996, the MOH withdrew its direct financial support to the FBOs for services delivered in clinic, and the FBOs no longer receive grants from the government. CHAK and the other TWG members believe they would still be receiving grants if they had a more formal agreement in place. The TWG drafted a memorandum of understanding (MOU) but, with the division of the MOH, this initiative stalled as the TWG awaits clarification on which ministry should be the signatory of the MOU. To date, there has been minimal interaction between the FBOs and the for-profit health sectors.

Nongovernment organizations

Kenya has a thriving and active NGO sector in health that performs a wide array of activities, ranging from advocacy to community mobilization to health service delivery and policy planning. The assessment team visited two umbrella associations for NGOs: the Health NGOs Network (HENNET) and Kenya AIDS NGO Consortium (KANCO), described in detail below. Unlike the FBO sector, the health NGOs in general—and HENNET and KANCO in particular—are establishing ties with the for-profit health sector and exploring new ways to work together. These new relations with the private health sector complement the NGO sector's existing strong relations with the public health sector.

In response to the growing number of health NGOs, several NGO umbrella organizations were established, prominently including HENNET. HENNET was founded in April 2005 with financial support and technical assistance from GTZ, to create a forum for health NGOs to facilitate collaboration, sharing of experiences, and advocating on behalf of its members regarding challenges and constraints affecting health NGOs.

HENNET brings together health-oriented civil society organizations with diverse interests who share a common vision of a "Healthy Kenyan Society." It currently has approximately 70 member organizations. HENNET has purposefully limited its membership, recruiting those NGOs (including FBOs) who have a long track record in health. HENNET activities include: (i) building members' capacity in common interest areas; (ii) developing and advancing health NGOs in the Sector-wide Approach (SWAp) process; (iii) representing HENNET members in key MOH governance and operational structures; (iv) summarizing key national health operational documents; and (v) facilitating exchange of information.

One important initiative spearheaded by HENNET is a PPP framework. In 2007, the MOH delegated to HENNET responsibility for initiating a process to design a public-private policy along with implementation framework. To date, HENNET has only developed a concept note on how to draft a PPP framework. It is interesting to note that, although HENNET's organizational mandate is to represent NGOs, it appears to be increasingly involved in the for-profit sector, as evidenced by the strong for-profit focus of its concept note.

The largest network of HIV/AIDS NGOs is KANCO. Formed in 1990, KANCO represents community-based organizations as well as FBOs, parastatals, and research and learning institutions involved in some way with HIV/AIDS activities in Kenya. To date, its membership has grown to over 960, only 15 percent of whom are service delivery NGOs. KANCO's activities are organized around four areas: (i) exchange and sharing of information; (ii) policy development and advocacy; (iii) grant making and management assistance for HIV/AIDS NGOs; and (iv) capacity building. KANCO charges an annual membership fee of Ksh 1,000. KANCO is a well-funded NGO, receiving most of its funding from the President's Emergency Plan for AIDS Relief (PEPFAR), through the Centers for Disease Control and Prevention (CDC), and through the Global Fund.

KANCO has a long history of working and partnering with the public health sector and works closely with the MOHs. Given its HIV/AIDS focus, KANCO has tended to consolidate its public sector relationships with NASCOP. KEMSA is another

important public sector partner for KANCO, for the supply and distribution of drugs, testing kits, lab machinery, etc.

More recently, KANCO has reached out to for-profit providers as well. KANCO's work with the for-profit sector has focused on: (i) partnering with the Kenya Medical Association (KMA), under a CDC project to ensure clinical guidelines are followed by private health care providers; (ii) training for-profit health care providers and lab technicians in VCT; and (iii) helping define an appropriate role for the for-profit sector in HIV/AIDS. Based on the responses of for-profit providers, KANCO identified several potential channels for engaging them in HIV/AIDS programs: (i) accessing the MOH program that supports private providers offering treatment for HIV/AIDS patients with government-donated ART; (ii) participating in MOH training on diagnosis and treatment of HIV/AIDS; and (iii) investing in home-based care for people living with AIDS. KANCO has targeted the private providers associated with the NHIF; it is also exploring ways to use micro-finance to cover the cost of private health services for the poor, for example through KWFT, one of the biggest funds (sponsored by Grameen Bank).

For-profit health sector

Unlike other developing countries, Kenya's private sector is well organized around professional associations and newly formed trade groups. In turn, these professional associations have formed smaller coalitions and groupings: pharmaceutical, hospital, health insurance, health care providers, and others.

Kenya Private Sector Alliance (KEPSA) and the Kenya Healthcare Federation (KHF): In March 2003, a group of high-level business leaders formed KEPSA to provide a unified voice for the private sector in the policy process. Four years ago, the Prime Minister challenged the private sector to organize itself so the GOK would have a partner to dialogue and work with. This alliance includes *all* major private sector industries, not just health. KEPSA is considered by many to be the private sector equivalent of the Prime Minister and his/her Ministers. Through KEPSA, the government and private sector have created a framework for public-private dialogue at the macro level on a wide array of sector issues, including health.

As the umbrella body for the private sector, KEPSA creates a unified voice for the private sector to influence public policy formulation, as it brings together all the key member-based private sector organizations. KEPSA has a simple governance structure that comprises a Board of Directors, Governing Council, and Secretariat. The Governing Council is KEPSA's policy organ and comprises representatives from the sector federations and multi-sector thematic organizations. The sectors represented on the Governing Council are diverse, including infrastructure, microfinance, technology, agri-producers, and transport. Health and education are more recent additions to KEPSA's federations. Health is represented by the KHF, with Mr. Walter Oookok currently serving as its chairman. KEPSA and its affiliates, including KHF, are very active in the Prime Minister's Round Table discussions.

Pharmaceutical sector: The two big actors in the pharmaceutical sector are the Pharmaceutical Society of Kenya (PSK) and the Kenya Association of Manufacturers (KAM). Almost all interviewees mentioned that the organizations representing this sector are some of the most mature private sector entities, well funded by their

membership. PSK is a not-for-profit organization, representing pharmacists and their concerns vis-à-vis the government. PSK serves a range of professional goals, seeking to (i) advance the study and practice of the profession of pharmacy among its members; (ii) promote pharmaceutical education and the application of pharmaceutical knowledge for the good and health of mankind; (iii) uphold ethics; (iv) safeguard and promote the interests of the members in the practice of pharmacy; and (v) represent, protect, and assist pharmacists in general and its members in particular regarding conditions of practice.

KAM is a trade association representing manufacturers in general; it has been very active in discussing the current counterfeit law in Parliament. KAM's mission is to advance the industrialization of Kenya through promoting competitive manufacturing and markets.

Insurance sector: This sector is well organized through the Association of Kenya Insurers (AKI). The AKI was established in 1987 as a consultative and advisory body for the insurance industry and is open to any insurance company registered under the Insurance Act. Currently, AKI has approximately 41 member insurance companies, mostly in general and life insurance. AKI is one of the most influential private sector associations in the health arena.

Hospital sector: Compared to the pharmaceutical and insurance sector, the hospital sector is the least organized. Initially, NGO and for-private hospital owners did not see the need for a common association that would present their interests. By 2000, the sector began to organize itself, forming the Kenya Associations of Hospitals (KAH) and the Kenya Association of Private Hospitals (KAPH). The sector is nevertheless led informally by the directors of the most important hospitals: Kenyatta National Hospital, Aga Khan Hospital, Gertrude Garden Children's Hospital and Nairobi Hospital. Any private sector opportunity involving hospitals and/or private sector providers will need to consult some of these hospital directors because of their standing within the private sector.

Private health care providers: There are two main provider groups. The Kenya Healthcare Consortium (the Consortium) represents private sector providers at "grade level"—physicians, dentists, and pharmacists. An umbrella organization, the Kenya Healthcare Professional Association (PHEPCON), represents all other health care provider categories.

In the past year, the Kenya Medical Association (KMA) came together with KAH and KAPH to form the Consortium, a not-for-profit national umbrella organization of private health care provider institutions and organizations. The objective (as stated in its brochure) is to become "a pro-active player in advocating for health reforms, health policy formulation and in harmonizing the health sector operations between the public and private health care."

The KMA itself is a voluntary membership organization open to all medical practitioners (doctors and dentists) registered in the Republic of Kenya. Founded in 1968, KMA activities include: (i) promoting the practice of medicine in Kenya; (ii) upholding high standards of medical ethics; (iii) advising the government and the general public on matters related to health; (iv) advocating for the welfare of doctors; and (v) supporting CPE through periodic publications, seminars, and scientific conferences. KMA has over 2,000 registered members.

The Consortium has established a separate policy process from that of KEPSA and its member organization representing health, KHF. The Consortium has become a policy leader; it held a large stakeholder meeting in November 2007, co-sponsored by the MOH, to develop a policy framework for PPPs in health. The Consortium is also an officially recognized participant in the Global Fund Kenya Country Coordinating Mechanism (CCM). USAID is supporting this nascent organization through technical assistance and financial support from the HPI project and USAID representatives speak of the Consortium as the “private sector representative.”

PHEPCON is an umbrella organization that brings together all health care providers not represented by the Consortium. Included in this group are private sector cadres important to the assessment team, such as nurses, midwives, clinical officers, lab technicians, and pharmacist assistants.

International donor community

The international donor community is another important stakeholder in the health sector. It is very large and active in Kenya, and the donors work very closely together. They have formed a working committee called Development Partners in Health in Kenya (DPHK). The Chair of this standing committee rotates annually. Last year, USAID was the Chair; currently, Dr. Klaus Hornetz of GTZ serves as Chair with USAID as co-Chair. The group is committed to coordination and has developed a Code of Conduct, including as signatories high-level officials from the GOK, donors, and implementing partners. To date, the following countries and multilateral organizations have signed the Code of Conduct: Denmark, European Union, Germany, Japan, United Kingdom, UNAIDS, UNFPA, UNICEF, United States, World Bank Group, and WHO. HENNET and CHAK are the Kenyan implementing partners that have signed the Code of Conduct.

Almost all of the large donors present in Kenya are working to support the development of the for-private sector in health. In the area of policy and dialogue, the Italian Foreign Assistance (IFA) has taken the lead in supporting the ability of the two MOHs to engage the private sector, by providing funds and technical assistance to establish a new PPP Unit within the MOMS. GTZ and USAID are supporting organizations that help organize and represent the not-for-profit and for-profit sectors respectively. Finally, many donors actively participated in developing the Kenyan Healthcare Financing Strategy and Health Sector Reform initiatives, both of which have relevance for the private health sector. GTZ and DFID are working closely with the MOMS and MOPHS to design and promote a new national health insurance scheme.

In the area of service delivery and product supply, there is an extensive history of donor collaboration with the NGO/FBO sector, and more recently with the for-profit sector. Many of the donors have provided technical assistance, financial support, and/or commodities for NGO/FBO health care providers.

Relationships between the actors

One of the policy challenges will be navigating the different relationships between and within the different segments of the health sector (see Figure 3.7).

- All the stakeholders are moving to establish new relationships following on the division of the MOH into two entities.

- The health FBOs have formed a coalition to help them better navigate relations with the two MOHs and to negotiate with the public sector from a position of strength in numbers. The FBO coalition will also formalize the relationships between the ministries and the health FBOs through a MOU or other formal legal arrangement.
- The health NGOs are coming together under the umbrella of HENNET. There is a long history of NGO/FBO collaboration; this tradition has been further strengthened as FBOs become members of HENNET and actively participate in HENNET's policy and advocacy activities.
- There are multiple organizations in the for-profit health sector with a history of collaboration around key policy and program issues that directly affect the private sector. For example, the pharmacy sector groups, health insurance groups, and KMA, KAH, and KAPH interact and engage with each other on a broad spectrum of issues. KMA, KAH, and KAPH recently formed the Consortium, which now represents their interests. Similarly, the health care providers—the Nursing Council being one of the strongest—have formed a larger group under PHEPCON.
- Interactions between the private health sector and the public sector tend to be ad hoc, related to specific projects or initiatives. For example, MOPHS works with private providers on a variety of HIV/AIDS issues. There is more institutionalized collaboration between the MOMS and MOPHS and NGOs/FBOs, and there are few examples in which all the key stakeholders engage in sector-wide and/or systemic topics.

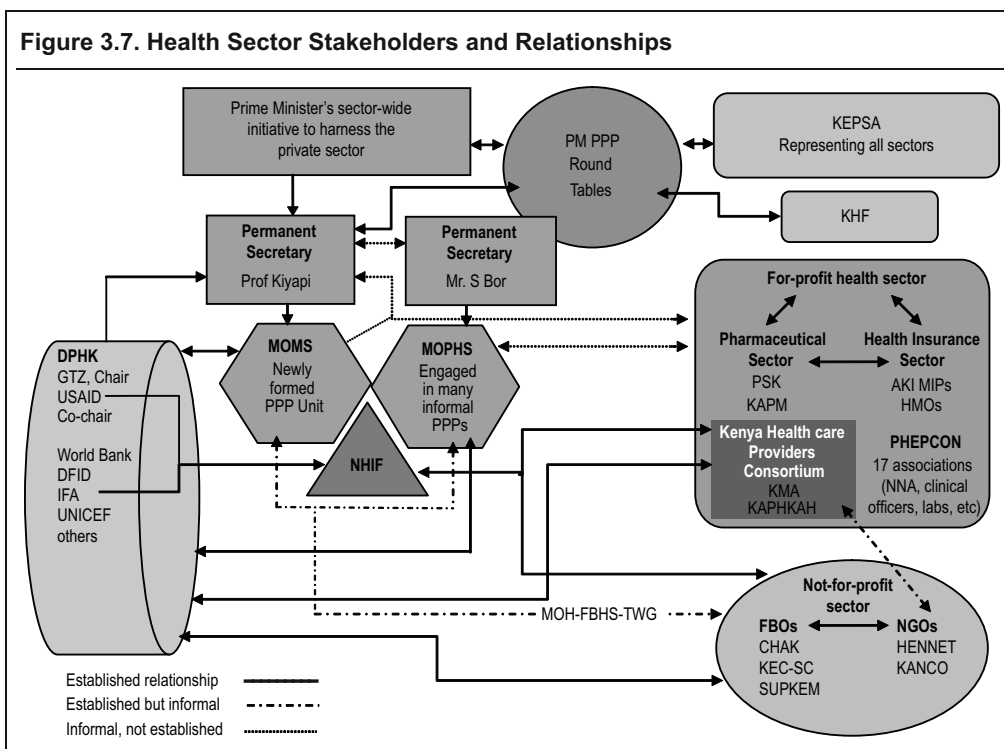
Factors favoring improved policy for PPPs

Government is willing to engage the private sector on critical and politically sensitive health issues

Kenya is actively engaging the private sector in a variety of sectors including health. A formal Round Table process has successfully brought the Prime Minister and his key high-level government officials to meet with different private sector groups. This process has become very visible in the public eye through media coverage. Moreover, the Prime Minister is raising public expectations by putting into place a mechanism to hold the process accountable for results. The Prime Minister's dialogue with the private sector provides an excellent backdrop for all discussions on PPPs in health.

In addition to the Prime Minister's Round Table initiative, the Kenyan government and MOH have demonstrated interest in addressing some of the most critical health problems, with major impact on private provision of health care and products. In informal discussions and official government strategies, the GOK has shown a profound commitment to engaging the private sector and appears to understand better how to do this. For example, although the draft law on counterfeit drugs before Parliament is a sensitive topic for the pharmaceutical sector, the GOK is working with all the key stakeholders to resolve the critical problem of fake drugs and medicine in the Kenyan marketplace. There are also some ongoing reviews of private sector regulation underway that underscore the need for a broader vision of the public-private interface.

Figure 3.7. Health Sector Stakeholders and Relationships



AKI	Association of Kenya Insurers	KHF	Kenya Health Federation
CHAK	Christian Health Association of Kenya	KPA	Kenya Pharmaceutical Association
DFID	Department for International Development (U.K.)	KMA	Kenya Medical Association
DPHK	Development Partners in Health for Kenya	MOH-FBHS TWG	MOH–Faith Based Health Services Technical Working Group
GOK	Government of Kenya	MIPs	Medical Insurance Providers
GTZ	German Development Assistance	MOMS	Ministry of Medical Services
HENNET	Umbrella NGO	MOPHS	Ministry of Public Health and Sanitation
IFA	Italian Foreign Assistance	MSF	Ministerial Stakeholder Forum
KANCO	Kenya AIDS NGO Consortium	NNAK	National Nursing Association of Kenya
KAH	Kenya Association of Hospitals	PHEPCON	Kenya Healthcare Professionals Association
KAPH	Kenya Association of Private Hospitals	PSK	Pharmaceutical Society of Kenya
KAPM	Kenya Association of Pharmaceutical Mfg.	SCM	Supreme Council of Muslims
KEC CS	Kenya Episcopal Conference Catholic Secretariat	SIDA	Swedish International Development Cooperation Agency
KEMSA	Kenya Medical Supply Agency	SUPKEM	Supreme Council of Kenyan Muslims
KEPSA	Kenya Private Sector Alliance	Consortium	Kenya Private Health Providers' Consortium

Government and stakeholders are less polarized

The GOK is now interested in pursuing more flexible approaches to the sensitive topic of social health insurance. Two years ago the government attempted to introduce a social health insurance scheme, focusing on public financing and provision of health

care and services. The dialogue was not inclusive, however, and the proposal was rushed; this allowed the private sector to mobilize for the express purpose of defeating the initiative. Donors supporting different proposals were also pulled into the conflict. The health initiative was handily defeated, leaving scars on both the public and private sector groups. With two years of hindsight, the two sides now recognize that something needs to be done to increase access to health services for the poor, and that there is no single solution. Both sides have learned from the prior policy debate and are now more open to discussing the type of national health insurance scheme needed. This has also been borne out in the general consensus around the implementation framework for a Social Health Protection Strategy, developed following the February 2009 study tour by the government and key stakeholders to view European social health insurance programs.

Timing

In addition to the political consensus, timing needs to be opportune to push through new ideas and policies. The current political administration in Kenya has two years left in its term. This should be sufficient time to launch a couple of major policy initiatives and to put into place PPPs. It is critically important to act now, before this window closes—and avoid two and a half years' delay, waiting for the political transition to occur.

Private sector actors are well organized

As Figure 3.7 illustrates, many organizations represent the range of private sector actors in health. In some cases, such as AKI, PSK and KMA, the organizations are mature and well-funded and have years of experience in engaging the public sector on behalf of their members. Other organizations, such as the Consortium, are newer. The perception expressed by some in government is that they would like to work with the private sector, but they don't know which organization represents it. Their expectation is that there should be a single consortium that can speak for the private commercial sector, the way HENNET speaks for (and to) the NGO/FBO sector. The PSP-*One* assessment team believes this expectation is not realistic, and that the existing private sector organizations are established, competent, and representative. Their number is also small enough to facilitate a participatory dialogue and policy process that integrates a private sector perspective. Naturally, there are some tensions between some of the private sector bodies. This is true in all sectors, but in the team's opinion such tensions are manageable, given the widespread desire to forge a consensus and move to policy reform.

Differing levels of support between the two health ministries

Even though MOPHS staff have ongoing activities with private providers in a range of health services, they seem less supportive of expanding and/or formalizing partnerships with the private commercial sector. The MOMS, in contrast, has demonstrated interest in supporting greater dialogue and engagement with the for-profit private sector. The MOMS Permanent Secretary seems to have both the commitment and the knowledge of working with the private sector that is necessary to achieve successful partnerships.

One lingering issue is a stated requirement by the government that private sector organizations must sign the same Code of Conduct that FBOs/NGOs have signed as a condition for membership in HENNET. In the assessment team's opinion, this Code of Conduct is not an appropriate vehicle for private commercial providers, although most of the commitments are unobjectionable. The Consortium representative agrees that the Code of Conduct was not written for the private sector, but his members nevertheless do not object to signing it. It is not clear whether all private sector organizations share this willingness. *PSP-One* recommends that the government consider a slightly different version of the Code of Conduct that recognizes the more independent status of commercial entities.

International donor support

Kenya is unique in having strong donor support not only for public sector and not-for-profit policy and program initiatives, but also for programs that will increase private sector involvement in addressing key health issues. The donor interest in the private sector can be translated into funding and technical assistance to support many of the recommendations in this report.

It is always challenging to integrate transversal approaches like PPPs with donor portfolios, which are often vertical. However, Kenya seems to have a favorable environment for overcoming this challenge, with a strong donor coordination mechanism and a flexible approach being taken to the government SWAp.

Notes

¹ http://www.who.int/whosis/mort/profiles/mort_afro_ken_kenya.pdf.

² http://www.theglobalfund.org/grantdocuments/2KENH_243_184_gpr.pdf

³ Business Monitor International Kenya Pharmaceutical Sector 2008.

Recommendations

The recommendations in this section were formulated with a view toward creating more PPPs for health in Kenya. The majority of these recommendations involve policy reform, but some involve new activities that would improve the public-private interface. There are significant budgetary implications for some of these implications; the team does not address these, but rather invites further discussion among the donor partners.

These recommendations are primarily “headlines” of possible interventions and activities to increase the private sector role in health. All of the recommendations require more detailed conceptual development, costing, assigning of responsibilities, etc. The assessment team encourages stakeholders to play an important and essential role in further developing the recommendations, once the recommendations have been prioritized and received sufficient “buy-in” from stakeholders. The Naivasha workshop was an important first step at prioritizing and refining the recommendations, but much more detailed work is needed to reach implementation.

A special category of recommendations, “Donor Opportunities,” was developed by the team; it is included in Appendix 4. These are somewhat more developed ideas for activities that could be easily implemented in a well-defined framework with donor support. Those activities complement or support the basic recommendations in this section.

The recommendations focus around five core themes:

- Stewardship and governance of the private health sector
- Health financing and social health insurance
- Delivering quality services in the private sector
- Distributing quality health products in the private sector
- Providing information to support private sector engagement

Stewardship and Governance of the Private Health Sector

The current political climate and timing is favorable for introducing policies and strategies to promote PPPs. Therefore, it is imperative to establish a mechanism for dialogue among the different stakeholders and to reinforce the skills and abilities of individuals to become “champions” for PPPs. The PSP-*One* assessment team thus recommends the following three strategies, which are also linked to Donor Opportunity Eight in Appendix 4.

Establish a mechanism or forum for dialogue process

Following the circulation of the draft summary report, a steering committee was mandated by KEPISA and MOMS to organize the two-day meeting in Naivasha in April 2009. This meeting helped to refine and revise the initial recommendations of the assessment team and created considerable momentum for sustaining the dialogue to reach significant policy reform and develop PPPs. However, no institutional forum was established, and the recommendations were not prioritized or organized to facilitate implementation.

A second workshop was conducted in June 2009 in Nairobi to map out the roles and responsibilities, activities, resources, and technical expertise needed to implement the plan. The resulting action plan can serve as the basis for dialogue with donors on the needed resources to nurture and institutionalize the policy forum on PPPs. A transition from the steering committee to the PPP in Health entity is needed to ensure continued momentum on the public-private dialogue. A summary of the results of this meeting is included in Appendix 7.

Identify key PPP champions and strengthen their leadership skills

Through the policy dialogue process, a select number of individuals will emerge as leaders and champions for the nascent PPP roadmap. To increase the likelihood of successful partnerships, it is important to create a critical mass of leaders who will champion and promote the PPP roadmap within their respective organizations in the health sector. To be successful champions, however, requires leadership and management skills that many of them may or may not have. PPP champions will need to develop several core skills and functions, such as facilitation, negotiation, coaching, and providing effective feedback. Training in these skills may be needed to increase the chances of successful PPPs.

Build the institutional framework and the PPP in Health

The MOMS and MOPHS have endorsed the idea of creating an independent “PPP in Health.” This entity would have a status similar to a council, with a mandate and the participation of government, but separate from government and independent of ministerial authority. Once formally established, the PPP in Health would benefit from strategic technical assistance during its start-up phase. Currently, many African and Asian countries have established PPP Units to help guide the MOH on PPPs; some of these experiences may provide useful lessons for the Kenyan model. A clear mandate for the PPP in Health will need to be defined, making sure that the broad PPP entity facilitates and supports PPPs in specific areas, but does not become a bottleneck when TWGs need to move quickly to establish PPPs for specific issues. Donor resources may be needed to ensure a functional operation for the PPP in Health; recruitment of staff should follow quickly thereafter.

Health Financing and Social Health Insurance

Since the ability to pay for services is the biggest constraint to accessing health care for the majority of Kenyans, health financing strategies that increase ability to pay should be considered top priority. Given the importance of private providers and the evidence that many Kenyans prefer to obtain their care in the private sector, PSP-One

recommends health financing strategies that emphasize the demand side, so consumers may be empowered to purchase services from providers most suited to their needs. That said, there are many approaches to health financing on the supply and demand side that should be considered, and there will not be a single solution to the problem. As noted earlier, the failed attempt to introduce a sweeping universal social health insurance is fresh in the minds of all stakeholders in the public-private health forum. The team agrees with many of the informants that the problem is too large and complex for a “one-size fits all” solution. Of the many approaches that have been started, each has the potential to be part of the solution.

National dialogue on health insurance approach

The team therefore recommends a dialogue process of all key stakeholders to explore how to create a mixed health insurance system in Kenya. The government and its donors should play a role of encouraging innovation in this area and ensuring that evidence of success or failure is collected and shared to accelerate progress. As with the market for different health services, the government can lead an effort to segment the health insurance market based on comparative advantage. The implementation framework for Social Health Protection that was developed following the government’s study tour in February 2009 is a good road map that incorporates the principles of participation of both private providers and private insurers. An additional recommendation, discussed at Naivasha and endorsed by the PSP-*One* team, is the principle that insurers and providers should each focus on their core businesses. Accountability and conflicts of interest become more difficult to manage when providers sell health insurance for their services and insurance companies invest in health provision.

Support ongoing risk-pooling initiatives

As the assessment highlights, there are a variety of different risk-pooling schemes underway in Kenya that should be nurtured to determine their potential in addressing the financial barriers to health care services.

- The NHIF, despite any shortcomings, is making progress in lowering administrative costs and has had a positive impact on cash flow for private facilities. More can be done to improve the NHIF’s performance and to expand the number of clients. The team encourages additional experimentation by the NHIF in the area of outpatient coverage, as well as expanding coverage packages to include Kenyans working in the informal sector.
- The government should also encourage the private insurance sector to create more health insurance products for lower-income Kenyans by (1) creating a specific health insurance regulatory law and (2) making it clear that a sweeping social health insurance scheme will not make their efforts irrelevant.
- Donor-supported financing schemes that involve targeted subsidies—such as the output-based aid program funded by the government and KfW—should be expanded and documented. Such programs provide important operational lessons learned as well as essential data on costing that can be critical for scaling up national health financing programs.

- Government or donor funding could also support the design and implementation of innovative health financing approaches by creating a clearinghouse for data on health costs, consumers' ability to pay, utilization rates, and other data necessary for improved underwriting and better health insurance products. This initiative could be led by the AKI, with limited donor funding for technical support and a website. Private insurers could contribute their data and might support operating costs through subscriptions.

Develop a regulatory regime specific to health insurance

Donors should support the development of a new Kenyan law (or portion of the revised insurance law) that specifically addresses the regulation of health insurance. (See Appendix 4, Opportunity One, for an in-depth discussion of regulatory strategies on health insurance.)

Donors should also provide support for capacity-building for staff members working on revision of the national Insurance Law:

- As a critical first step, staff members need detailed education on the options for health insurance regulation.
- A second useful step may be providing these staff members with documentation on health insurance regulation in other jurisdictions, and sponsoring a public/private study tour to show how these regulatory systems actually work.

Also, the law needs to be amended to facilitate consolidation of the many existing insurance providers into fewer larger operators with better economies of scale (lower administrative costs, and hence better benefits) as well as more market power. While it is often difficult for government to reengineer markets through regulation, some options exist.

Delivering Quality Services in the Private Health Sector

The quality of services in the private health sector can be significantly improved through a combination of improved regulation, improved incentives, and increasing access to supportive services such as management training and credit. The GOK has many of the instruments and tools in place to regulate the private health sector. The team recommends several strategies to help strengthen the regulatory framework, as summarized below. A more in-depth discussion of some of these recommendations can be found in Appendix 4.

Strengthen enforcement by supporting the professional boards

Although some policy weaknesses are noted by the team, the main problems reflect lack of enforcement of existing regulations. In most cases, the weak enforcement results from under-resourced or poorly organized professional boards. Two specific measures recommended by the team are:

- *Streamline internal disciplinary procedures.* The Medical Practitioners and Dentists Board has already recognized this need, and has begun to look at precedents in other countries. Once this task is completed for the Medical

Practitioners and Dentists Board, a similar effort can be undertaken for the other boards.

- *Create a shared system of hearings officers and enforcement attorneys.* While the decision as to what constitutes professional misconduct may reasonably be left to each profession, the skills to determine if a complaint is justified rely on objective fact-finding that is as much legal as professional. To avoid the risk of regulatory capture, the follow-up on “negative” decisions (that a violation has occurred) can be done by a small group of lawyers who serve *all* the professional boards. At the same time, this group could keep up legal pressure on unlicensed individuals who continue to practice, ultimately working with the Attorney General’s Office to obtain criminal convictions if necessary

Creation of a unified licensing agency for health facilities

The biggest constraint to effective facility enforcement seems to be lack of logistical capacity and legal support, not professional expertise. To address this gap, the team recommends creating a consolidated licensing agency for all health facilities. This agency would issue licenses to all health facilities, including hospitals and clinics at all levels, as well as pharmacies, chemist shops, and pharmaceutical wholesaler and distributor premises—whether the ownership is public, not-for-profit, or for-profit. The facility licensing agency should be overseen by the lead health agency (presumably the MOMS) and should assume the powers currently exercised over health facilities by the MOPHS.¹ Professional boards would continue to control training and registration of health professionals, but would not be responsible for inspection of health facilities (hospitals, clinics, laboratories, nursing homes).² Requirements for staffing by licensed professionals would be enforced by this facility licensing authority, which could validate relevant licenses through the responsible professional board.

Development of the license standards and operating guidelines for this agency is an opportunity for public-private collaboration. A task force could be convened to draft the licensing regulations for each class of facility—at the same time framing the necessary changes in the governing statutes to consolidate the powers of the new agency and clarify the relationship with the professional licensing boards.

Create a unified licensing agency for health training institutions

One of the recommendations emerging from the Naivasha discussions and endorsed by the PSP-*One* team is the creation (or designation) of a single licensing entity for all training institutions. The diffusion of regulatory authority over medical schools creates problems similar to those that exist with medical facilities. The role of councils to define curricula, prepare professional examinations, and set standards would still be maintained. However, a single licensing agency for training is needed to ensure consistent application across all types of training institutions, to conduct inspections, and to establish guidelines for good governance of training institutions in the health sector.

Promote voluntary accreditation and certification

In addition to licensing, there are at least two immediate opportunities to test the concept of voluntary accreditation or certification. One would be to expand the Gold Star concept, making Gold Star qualification a requirement to offer insured HIV/AIDS

care (which should become a standard health insurance benefit). The new program to distribute donor-funded ARVs through the Gold Star network would be expanded to beneficiaries in *all* insurance plans, provided that the insurer pays for other treatment costs, and with ARVs distributed only at Gold Star providers. (See Opportunity Three, Appendix 4.)

Establish an accreditation system for laboratories

An accreditation need exists with laboratory services. Unlike Gold Star, the necessary organization has not yet been developed. However, given the state of private laboratories in the country, and the importance of reliable laboratory tests in improving health services and health outcomes, such an intervention merits donor or government support. There may also be significant opportunities for investment in private laboratories that could be created through the establishment of a reliable accreditation system accepted by the entire health community. The Kenya Association of Laboratory Scientific Officers could lead the activity, which would require government endorsement and technical assistance. A competent national laboratory would have to be selected as a reference lab. The accreditation system, once established, could be further strengthened if the NHIF and private insurers refused to reimburse tests that were not performed by accredited labs. (See Opportunity Four, Appendix 4.)

Provider sectors to consumer segments

There appears to be widespread consensus that the public sector cannot provide for all of Kenya's health needs. What is lacking, however, is any consensus or clarity on what role each sector should play, and the conditions under which each sector should play its role. If government can guide provider segments to appropriate consumer segments, access to care can be increased, public resources can be used more efficiently, and private investment can be mobilized with greater confidence that private providers can operate in a stable market.

Therefore the team recommends a participatory process in which all the key stakeholders come together to discuss which segments of the health market should be served by which group, based on comparative advantage. Ideally, this process would not be done as something completely new, but rather integrated as a new step into existing processes for formulating national strategy for HIV, FP, TB, malaria, heart disease, etc. The process should be driven by evidence from the KDHS, household surveys, and other sources that show which provider segments are already serving which consumer segments for a specific disease area or package of services. For HIV, the team might prioritize ART and VCT. For malaria, the bed net market and the ACT market might be priority areas. FP products and RH services would be another area. This first step would also require some data analysis for evidence-based strategies for market segmentation. Some of the needed data would emerge from the research forum recommended in Section 4.5.2 below.

Some of the priority areas for market segmentation include:

Malaria

The government, through the MOH Division of Malaria Control, and its stakeholders should carefully monitor the progress of the current strategy for malaria control. If the

resulting increases in bed net use, preventive measures, and proper treatment significantly relieve the burden of malaria on the health system, a case can be made for continuing the approach, assuming that the large subsidies needed can continue to be mobilized. If the gains are more modest, then it seems reasonable to ask whether more progress could have been made with a mixed approach, using targeted subsidies on nets and ACT for a more restricted segment of the population and allowing a space for commercial providers to service those consumers with the ability and willingness to pay. It will be particularly important to track consumer behavior around net and drug use, as well as consumer perceptions of access to malaria drugs and treated nets. Once consumers consistently show that they can obtain their malaria prevention and treatment products, reflecting stable social norms around malaria product use, then government can begin to shift more of the supply burden to the commercial sector. Indeed, as social health insurance and other demand-side financing is expanded, government and donors can cease all supply-side subsidies for nets and drugs and allow consumers to use their own health financing to procure their malaria products. Irrespective of the results of the current approach, as the global financial crisis begins to impact the availability of donor funding, a more balanced approach may become a necessity and not just a strategic choice. As a result, consumers may have to pay what they can afford to prevent or treat their own malaria, and the government may want to define an enlarged role for the commercial sector in both the treatment and prevention of malaria.

Voluntary counseling and testing

Private providers in Kenya are offering some form of HIV testing, but it is not always promoted and done in compliance with the norms and the full range of quality supports. Other country examples—Ethiopia and Guatemala—demonstrate that the private sector can become more active in VCT under certain conditions, such as widespread distribution of norms, available training, referrals to qualified laboratories, and financial incentives. The team recommends exploring how to mobilize private sector participation in VCT. Fully commercial VCT is offered by the private commercial sector, but typically the service is not actively promoted or pursued by private clinics because of the relatively high cost of providing counseling to clients who receive tests. Ethiopia has developed a model for contracting out VCT to private providers during targeted communications campaigns through the use of mobile vans. This provides a closer link between demand creation and service provision and allows for greater flexibility in investment of public funds. By hiring qualified clinics to conduct periodic, targeted testing services, the government gets greater efficiency, targets testing where it is most needed, and stimulates the private sector to provide quality VCT on a more sustainable basis.

Antiretroviral therapy

The Gold Star Network could be expanded, particularly if linked to health insurance or voucher reimbursements. The output-based aid scheme developed by the government (with funding from KfW and now in an expansion phase) could also be adapted to ART and other services, since it links targeted subsidies with quality assurance and allows consumers the freedom to choose between public, private, or not-for-profit

providers that meet the quality standards. (See Donor Opportunity Three, Appendix 4.)

Family planning

The recent KDHS indicates that many Kenyan women are already going to the private sector for their FP method, particularly resupply methods such as condoms, pills, etc. The public sector is the primary supplier of the under-used methods such as implants, IUDs, and female/male sterilization. PSI has received funding from the Buffett Foundation to expand access to long-acting and permanent methods through private providers, mostly female nurses located in rural areas. The assessment team recommends tracking and monitoring the progress of this project to determine whether there will be opportunities for partnering with the district-level MOPHS to ensure success of these growing networks of private nurses.

Deliveries and maternal care

One of the most alarming findings from the data is how poorly the health sector as a whole is meeting the maternal care needs of rural, lower-income Kenyan women. Nearly 60 percent of Kenyan women deliver at home, and most of them are in the poorer income quintiles. Women in the upper income quintiles benefit disproportionately from the public sector—although it would appear that most could afford to access services from the commercial sector, as 29 percent of them deliver in the private sector. (See Graph T in Appendix 6.) The PSP-*One* team urges the MOH to conduct a market segmentation analysis just for maternal care for lower-income women, to determine how each provider sector can play an increased role in addressing this service gap, which is clearly a factor in Kenya's high maternal mortality rates.

Formalize PPPs in support of market segmentation strategies

As a part of each national strategy, the government would provisionally assign different provider segments to different consumer segments, as an illustrative guide to each sector to direct their investments and efforts. Ultimately, however, consumer choice will determine the market share of each provider group. One important step to support market segmentation is to formalize arrangements to share training, commodities, and information, to encompass the commercial as well as the not-for-profit and faith-based sectors. Typically, commodity subsidization, technical training, and access to new research is organized around the same disease or service delivery areas that constitute the health markets. As a part of the national strategies, government should formalize the mechanisms and conditions for non-public providers to benefit from subsidized commodities, training, and research.

Promote commercial and social provider networks

Provider networks are another strategy for increasing the quality and quantity of private sector provision of care, giving members access to knowledge dissemination and sharing of best practices. Kenya has its share of experiences in this area. The Gold Star network shows some promise, the CFW Clinic experience has been instructive, and there are also commercial network models such as the Clinix network run by Nairobi West Hospital. Vertical integration increases economies of scale, while

common quality standards and branding attract more clients. In the commercial sector, provider networks can be promoted by facilitating access to credit for expansion. Professional associations should also promote group practice concepts and legal models to their members, so providers can move from individual practices to group and network models.

In the not-for-profit sector, even if networks are focused on low-value services, donor-supported models can leverage commercial infrastructure with supply systems, insurance linkages, access to credit, and professional management services.

One variant of provider networks could be focused on retail drug outlets. This would involve creating a chain of retail drug outlets that offer essential medicine as well as some of the more commonly prescribed branded medicines, and that are staffed by qualified pharmaceutical technicians. This could help increase commercial sector investment in areas currently underserved by any sector. (See Donor Opportunity Five, Appendix 4.)

Increase health financing

If the private sector develops confidence that their market opportunities will not be undercut by the public or not-for-profit sector, they can invest to expand more aggressively. Expansion, however, requires access to finance. Technical assistance is required on both the supply and demand side of the commercial credit market to stimulate increased financing to the health sector. USAID has one DCA guarantee for Faulu that covers the micro-health insurance product. Structuring additional DCA portfolio guarantees for private health care investment would have the following benefits:

- *Additionality.* A portfolio guarantee for the private health care sector would stimulate new lending to the private health care sector and not subsidize existing lending. Lending will provide capital for expansion of existing facilities of private health care providers as well as start-up financing for new providers.
- *Improve the quality of the health care* provided to Kenyans by providing financing to licensed private sector health care providers to improve their practices.
- *Take pressure off the public health care sector* by expanding private services. Kenyans who can afford to pay will have more options in utilizing the private health care sector.

Obviously, any other mechanism for investing in health care through the Kenyan banking system would have similar benefits. Increasing capital available for health lending on its own may not be enough to achieve these objectives. It will also be important to incorporate technical assistance for the participating banks, with an emphasis on cash flow lending and specific aspects of health care lending. The banks should be encouraged to develop new loan products that are better suited to those health providers that have the greatest unmet need for capital. (See Donor Opportunity Six, Appendix 4.)

Upgrade health providers' business management skills and knowledge

Much focus is given to health care providers' clinical skills and competencies. But in the private sector, many physicians, nurses, and pharmacists are also business owners who may lack the necessary skills to run a small company. The team recommends the following strategies to strengthen their businesses management skills.

Both to take advantage of increased health lending and to improve private practices, private health providers need access to more and better business and financial training. Some health care providers realize the importance of basic financial management encompassing financial statements and business plans and are interested in training that would provide them with basic skills. Other health providers would prefer to use to business development providers who can assist them in developing financial statements and establishing a basic financial management system for their business. Others resist the notion that they are managers in business and do not realize that better management of their practices can lead to increased capacity and better health outcomes. The assessment team recommends that a variety of business and training options be available to private providers. (See Opportunity Seven, Appendix 4.)

In addition, the success of the DCA guarantee will depend on providing this training to private health care providers and on developing sustainable training delivery. Through development of sustainable financial management training for private health care providers, the cost of loan appraisal for lenders should decrease, encouraging more health care lending.

An argument can be made that training in basic management principles, ICT, and principles of health insurance should be introduced as core elements of basic medical training. Throughout the Kenyan health system, in both the public and non-public sectors, doctors are brought into positions in which management skills are as important or more important than their diagnostic and treatment skills. Including some courses on these topics in medical school would at least ensure some basic skills that all providers would have when management responsibilities are given to them later in their careers.

Delivering Quality Drugs through the Private Supply Chain*Update the Pharmacy and Poisons Act*

A review and update of the Pharmacy and Poisons Act (Cap 244) is apparently underway and long awaited. Undoubtedly this is a complex effort that will require contributions from multiple stakeholders from the public, private, and not-for-profit sectors. The PSP-*One* assessment team recommends that the following issues be addressed in the final version of the law:

- Introduction of siting requirements for retail pharmacies/chemists
- More restrictive registration of drugs based on public health benefits
- Strengthened enforcement by increasing licensing fees (that finance enforcement activities) and increasing fines for operating without a license
- Increased licensing requirements for wholesalers and distributors to catalyze an industry consolidation

Catalyze industry consolidation through licensing requirements

As was recommended for the insurance sector, the government might consider regulation to catalyze market consolidation. The government could auction a limited number of licenses for pharmaceutical wholesalers and distributors. Applicants would have to demonstrate sufficient capacity to distribute drugs nationally as well as minimum storage capacity and IT capacity for recording importation, lot tracking, and recall management. To allow licensees to make these investments, *minimum margins* would have to be legislated in addition to ceiling margins. With minimum margins ensured and the number of players reduced, a more restricted competition for market share would follow that would be based as much on quality as price. Wholesalers would have an incentive to invest in distribution capacity and increase their ability to cover the entire country. Project-based distribution systems could begin to shift responsibilities for distribution and storage to the commercial sector, by contracting out the resupply function to one of the larger distributors. The resulting savings for donors could be redirected to other needs in health education and promotion of health products. Distribution of health commodities would become significantly more sustainable.

Mobilize new resources for strengthened enforcement

These recommendations would require significant new resources for the PPB to implement them. Except for selling wholesale/distributor licenses, the PSP-*One* assessment team has not identified any new sources of revenue. Unless new sources of revenue are found, it will be impossible for the PPB to apply the recommendations for more restrictions on imports, because fees from these import licenses make up the main source of their operating income. This constitutes a significant conflict between the PPB's organizational interests and its interest in maintaining drug quality. Alternative sources of revenue are indispensable to reform. Another possibility is simply to greatly increase the costs of import licenses to the manufacturers, but this could drive up prices or restrict supplies to the consumer. Whatever combination of new resources is identified, PSP-*One* feels it is important that the funds be dedicated in a way to minimize the conflict between organizational needs and professional mandates, and that appropriate firewalls be maintained between the PPB's drug quality assurance function and its profession and facility regulation function.

Pursue the reform of KEMSA

Although it was beyond the scope of this assessment to analyze the performance of KEMSA, it was apparent that what KEMSA does affects the entire health system as well as the public and private sector supply chain. Many other studies have considered the weaknesses in KEMSA's internal operations, and reforms of KEMSA to address those weaknesses are underway. Clearly the public sector needs a reliable supply chain system, so those improvements should be pursued. The PSP-*One* team further encourages KEMSA and its stakeholders to consider more PPPs in improving ways to procure, store, deliver, and test drugs and medical supplies.

Bridging the Knowledge Gaps to Stimulate Investment and Inform Public-Private Policy Dialogue

Asymmetry of information and knowledge in the health sector is one of the greatest barriers to public sector understanding of the private sector—and to private providers' ability to analyze risk in entering the health market. The PSP-*One* team recommends creating mechanisms to generate, disseminate, and apply information on the private health sector as a way of informing public policy, supporting business decisions, and driving both social and commercial investments in the health sector.

Build an evidence base for public-private policy

This private sector assessment is one of the first attempts to better understand and document the private health sector in Kenya. But basic information is needed if the GOK, in partnership with other health stakeholders, is going to identify, design, and implement policies and PPPs. Key information gaps include: (i) number, type, location, and services offered by private providers; (ii) number, type, capacity, and location of private facilities; and (iii) consumer preferences of providers, and their ability to pay for services or for health insurance. One of the functions that the newly established PPP in Health could serve would be to work with the different sources of data on the private health sector to produce data to inform policy issues.

The PPP in Health should also be responsible for helping to establish the private sector research agenda: addressing the most critical information gaps, helping to mobilize resources needed to collect data, or ensuring that questions of interest to the private health sector are included in existing data collection instruments. The PPP in Health will not have the technical or management capacity to manage, design, or contract research studies itself. Another important function of the PPP in Health should be ensuring that information gets to the appropriate end-user—whether it is a public sector policymaker or a private provider—to help in policy/project design and implementation. This dissemination function can be done through provider association meetings, conferences, websites, or social networks.

Create a health market research forum

PPPs are often designed to address market failures. One of the most common market failures is the information gap. The Kenyan health sector suffers from a number of information gaps: insurers don't have enough data about the probability of diseases to underwrite risks; medical providers don't know their patients' willingness to pay in order to appropriately price their services; banks don't understand the size or the potential for profit in the health sector and therefore overestimate the risks of lending to the health sector.

Although these information gaps persist, there is considerable investment of government and donor money in consumer research. Even in assembling the literature for this assessment, it was apparent the Kenya benefits from many more studies than most African markets: not only SPA, KDHS, KAIS, and NHA, but also even more targeted studies, such as the consumer research conducted by PSI, including three rounds of household surveys with large samples. Many of these studies are widely disseminated and promoted, but much of the information is not readily available, and the data is not analyzed in a way that would serve the private commercial sector.

The PSP-*One* assessment team therefore recommends the creation of a health market research clearinghouse. This forum could be run as a partnership between government (represented by the national statistical service), the NGO sector (represented by HENNET), and the commercial sector (represented by KEPSA). The forum, which could be run as a website, would have several functions: to announce planned research topics, solicit sponsorship of research studies, share findings and data sets to make better use of data already being collected, and create the opportunity for more efficient funding of future studies. The Financial Access in Kenya study (conducted in 2006 by the Steadman Group) is a model for such an opportunity. The study was conducted with support from the Financial Access Partnership, a consortium of private commercial banks, micro-credit institutions, and insurers.

Notes

¹ MOPHS could retain the ability to intervene in a public health emergency (e.g., an Ebola outbreak at a licensed hospital).

² Such an organization could also inspect pharmacies and drugs shops, although many countries continue to leave this responsibility to the same agency that licenses pharmacists.

Conclusions

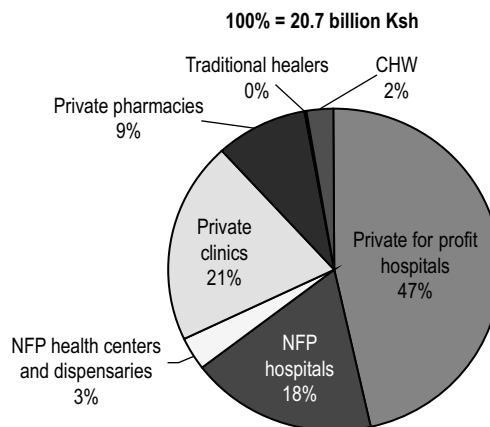
Estimating the Impacts

One of the challenges in analyzing the private health sector is helping high-level policymakers to prioritize private sector health strategies, among all the many other development challenges facing Kenya. One way of prioritizing recommendations is from a financial perspective, considering the potential impact in growing the private health market. Another way is to consider their potential health impact in terms of increased access, improved quality of care, or lives saved.

Quantifying the precise impact of the recommendations made by the team is inherently difficult, since data are often unavailable or incomplete and the results of the recommendations may be difficult to foresee. Nonetheless, Table 5.1 is an attempt to illustrate the likely impact of implementing selected recommendations. While implementation of some recommendations may cause short-term disruptions of private care service delivery, over the longer term they should increase both the quality and quantity of private care.

As of 2005/06, the NHA analysis estimated the private sector market at Ksh 20.7 billion. For purposes of financing, the total health expenditure “consumed” most closely represents the size of the private sector market. The breakdown of that consumption by provider type is shown in Figure 5.1.

Figure 5.1. Breakdown of Total Health Expenditure by Provider, 2005/06



Source: NHA 2005/06.

It should be noted that the figure Ksh 20.7 billion is a very conservative estimate of the market, because it includes only expenses consumed in the period studied and excludes investments made in stocks and supplies consumed beyond the year under study. Moreover, the definition of health expenses used by the NHA methodology excludes investments and expenses for supportive work, in the area of health policy or health education. This is significant especially because of the recent emergence of private medical schools, and some indications (e.g., Nairobi West Hospital) that creating private medical schools can be part of a vertical integration strategy in a commercial network of hospitals and clinics. The NHA also excluded health expenses made by foreign nationals in Kenya. Given the strategy of the government to develop selected facilities for health tourist destinations (e.g., Nairobi Hospital, Agha Khan) this market opportunity needs to be assessed and costed separately.

Table 5.1 illustrates some of the potential impacts of other key recommendations.

Table 5.1. Potential Impacts of Assessment Recommendations

Selected Recommendation	Market Growth Potential	Short-term Effects	Long-term Effects	Health Impact
Support of risk pooling Initiatives	Increase of private insurance schemes to 3 million lives	Growth of insurance market by Ksh 21 billion. (See note 1)	Increase in overall health insurance and potential reduction in burden on NHIF. Expansion of private health insurance markets attracted new investments in IT, increased economies of scale and lowered administrative costs. Increased levels of demand for services in private sector allow for greater expansion.	Specific health impacts depend on how government reinvests resources "freed up" by the reduced burden on NHIF and how private sector reinvests revenues from the increased demand for its services.
'Blended' approach to malaria control adopted	Increase in bednet coverage from 65.1% to 70%	Immediate decrease in malaria incidence of 4.9% at a cost of Ksh 8,000 per case; decrease in immediate health expenditure of Ksh 2.6 billion.	Decreased malaria burden on Kenyan population, with consequent decrease in health expenditure of Ksh 2.6 billion. (See note 2.)	Decreased health burden on population of at least 1,600 deaths and 32,000 cases.
Expansion of VCT via private providers	Potential expansion of 14% of the market	Growth of VCT market by Ksh 800 million. Short term increases in numbers of patients on ART and in HIV spending. (See note 3.)	Decrease in HIV incidence among Kenyans, with consequent decline in health expenditures.	Decrease in HIV prevalence among the Kenyan population, increase in patients on ART with reduced HIV mortality.
Increased health financing through DCA and other guarantee mechanisms.	Increase in health lending by Ksh 2.1 billion. (See note 4.)		Overall increase in private sector turnover to Ksh 9.5 billion, with a profit of around Ksh 13 million, improving significantly if efficiency ratios continue to improve.	Improved health care among Kenyans, though actual estimates of impact cannot be made.

Notes:

1. The private sector currently insures around 600,000 Kenyans. We assume that 1 million lives (currently insured through private companies that self insure) and another 1.4 million Kenyans (in formal employment and insured through NHIF or uninsured) move to the private commercial sector. Applying the fivefold growth in lives to the value of the premium market, we get a KSH 21 billion market for private health insurance.
2. This calculation presumes that in East Africa there exists a population of some 100 million people. As a consequence, in Kenya, there are proportionately about 6.7 million cases of malaria occurring every year. A 4.9% increase in bednet coverage will therefore reduce cases by about 330,000 annually, preventing 32,000 deaths. Assuming an annual expenditure per case for treatment of Ksh 8,000, savings would be approximately Ksh 2.6 billion.
3. This calculation assumes that there will be an increase in number of Kenyans tested from 36% of the population to 50%. Of these, the percentage testing positive will be proportionate to the infection level of the overall population (though the percentage will in fact very likely be higher). Those testing positive will seek at least outpatient care from the private sector, and will spend 20% of their out of pocket expenses on such care over a year. Those testing positive demand much higher levels of care (an average of 11.97 visits per year against 1.92 for the general population).
4. Experience of USAID DCA office shows a 30 fold increase in sector lending, relative to the cost of guarantees. This estimate for market growth assumes US\$1 million is invested in purchasing guarantees and that other interventions to support the lending environment (favorable regulation, increased levels of health insurance, provider training) are also implemented, to realize the 30 to 1 ratio.

Other Market Opportunities

Some market opportunities cannot be measured or modeled with data currently available, but still merit exploration. As noted above, one of the best uses of donor or public resources to leverage the private health sector is to conduct the research or collect the data that can be turned into a business case that will attract health investments. Table 5.2 provides a selection of other opportunities which PSP-*One* believes merit further exploration.

Table 5.2. Health Market Opportunities in Kenya

The Market	The Market Opportunity	Market Gaps	Areas for Exploration
Health insurance for lower income groups	Mobilizing incomes among informal sector Kenyans to pay for primary care coverage	Lack of trust in insurance. Underwriting skills needed to write a basic benefit package at affordable prices.	Public education in favor of risk pooling and health insurance. Costing and underwriting research and development.
Chronic care services	Need for treatment of increased incidence of "lifestyle" diseases: diabetes, heart disease, lung cancer. Need for wellness education	Lack of data on chronic care diseases, lack of awareness that such diseases can be improved through diet and exercise.	Targeting middle and upper income Kenyans through workplace programs.
Health education	Persistent shortages of nurses, doctors, clinical officers in the public sector	Lack of comprehensive analysis of human resource supply and demand that considers public, private, and not for profit sectors. Difficulties in licensing new medical education institutions makes costing of new medical school difficult.	Government or donor support for systematic analysis across all sectors. Policy reform around licensing of training institutions.
HIV diagnostics	Increased population on ART and in need of reliable CD4 and viral load testing	Lack of lab accreditation system and access to technical assistance for private labs.	Establish reliable lab accreditation agency: prioritize CD4 and viral load tests for verification.

Appendixes

Appendix 1. Scope of Work

Scope of Work: Kenya Private Sector Health Assessment Private Sector Partnerships-*One*

Background

Kenya's dynamic private sector is one of the most developed and fastest growing in sub-Saharan Africa. The private commercial and nonprofit sectors play a central role in the provision of health care in Kenya, where the leading causes of death are HIV/AIDS, acute respiratory infections (ARIs), diarrheal diseases, and malaria (WHO 2004). Private expenditures (third-party, household out-of-pocket etc.) are an important source of financing for health care, comprising 57.3% of total expenditures. Even among the poor, the private sector is an important source of care. For example, 47% of the poorest quintile of Kenyans use a private facility when a child is sick (Marek et al. 2005). According to the 2001-2002 Kenya National Health Accounts study, the Government of Kenya (GOK), through the Ministry of Health (MOH), manages only about 52 percent of a total of approximately 4,500 health facilities in the country. Religious missions and non-governmental organizations (NGOs), which often are located in rural and underserved areas, are important sources for smaller health facilities, providing 94 percent of health clinics, maternity and nursing homes and 86% of medical centers.

The public sector plays an important role in overall provision of contraceptives, serving 53.4% of all women (CBS 2003). According to the 2003 KDHS, 23.6% of women are currently using a modern contraceptive method, with the leading methods being injectables (10.8%), pills (5.1%), and female sterilization (3.0%). For the leading method, injectables, public sector provision is (61.2%) with private hospitals and clinics as the leading private source (29.3%). Furthermore, 45.5% of oral contraceptives are provided by the private sector through both private hospitals and clinics and pharmacies/chemists. Private hospitals and clinics likewise play a significant role (25.3%) in the provision of sterilization services. Other private sources such as shops and friends supply the majority of male condom users (56 percent).

There are many private sector initiatives being supported by USAID and other donors in Kenya. For example, the KfW-supported Output-Based Approach (OBA)

voucher scheme provides subsidized safe motherhood, FP, and gender-based violence recovery service vouchers to the poor. AIDS, Population, and Health Integrated Assistance Program II (APHIA) partners include and support many NGO and faith-based organizations. Gold Star (implemented by FHI/CRTU and APHIA II Coast and Rift) enlists private providers into a network designed to assure and support the quality provision of HIV/AIDS, family planning (FP) and other services. The Population Services International led Health Communications and Marketing (HCM) project and JHPIEGO support a network of private providers to increase use of FP and long-acting and permanent methods (LAPMs), the HCM social marketing program markets a variety of FP/RH, HIV/AIDS, malaria and MCH services and products, and the HealthStore Foundation operates Child and Family Wellness (CFW) Shops, a franchise of pharmacies and clinics that provide a range of health services and products.

Objectives

While there are many constraints to private sector provision of services, there are also numerous opportunities to expand its role. PSP-*One* will conduct an assessment of the private health sector in Kenya to assist USAID and other stakeholders to develop a strategy for further engaging the private sector in Kenya to complement and augment public sector health with a focus on family planning, reproductive health and HIV/AIDS services

The assessment will focus on the following five main components:

1. The diversity and distribution of private for-profit providers and health sector entities;
2. The demand for private sector products and services for family planning and HIV/AIDS;
3. The policy and regulatory environment for private provision of health products and services;
4. The leading initiatives in health financing and opportunities for the expansion of private sector provision as part of those initiatives; and
5. The financing needs of the private health sector and the extent to which access to credit could improve quality of care or expand service provision.

In addition, the assessment team will examine the HealthStore Foundation's CFW Shops in greater detail. The assessment will provide a range of options and recommendations for better utilization of services and future investment, including identifying potential formal public-private partnerships.

Statement of Work

1. Assess the diversity and distribution of private sector for-profit providers and other health sector entities

- Document the range, distribution and contribution of commercial private sector health care providers and other commercial and health sector players in Kenya, including their activities, products and/or services, their consumer targets, and their influence on one another.

- Assess private provider networks (including professional associations, training and insurance schemes, social franchises, etc.) for their feasibility in creating entry points to working with private health providers and consider their potential for traditional “franchisor functions”, quality assurance, access to training and provider inputs, data collection, management and marketing support, etc.
- Assess opportunities for public sector contracting of private sector providers.
- Assess provision by the private sector of the continuum of care for HIV/AIDS (prevention, treatment, care and support) and existing public-private partnerships with government entities. Assess scale-up of potential existing models for private sector provision of HIV/AIDS services, including counseling and testing, treatment, palliative care, hospices, PMTCT and make recommendations for increasing scale-up of potential existing or emerging commercial sector models.
- Evaluate the private sector supply chain for health products—both pharmaceutical and over the counter, such as drug manufacturing and distribution firms, local chemists, other drug shops and retail outlets involved in selling and distributing health products. Consider which sources of supply and distribution have adequate quality controls on products and whether uncontrolled products negatively impact the market for health products. Assess whether parallel distribution systems (e.g., MEDS) could be expanded to better serve the commercial sector.
- Conduct focus groups among individual private providers (such as doctors and midwives) to determine their client profile, services offered, technical assistance and financing needs.

2. Analyze demand for private sector provision of health products and services.

- Utilize available consumer surveys to analyze the existing and potential demand for private sector provision of health products and services and understand the main factors that affect demand.
- Identify potential opportunities to create or increase demand for private sector provision of health products and services.
- Assess recent efforts to create demand for health products and their prospects for growing the market for reproductive health and HIV/AIDS products and services.
- Estimate the commercial sector’s likely market share for increased demand relative to the public sector and the NGO/not-for-profit sector. Make recommendations about how the demand creation activities can improve market segmentation between these three sectors.

3. Assess the policy and regulatory environment for private provision of health products and services.

- Assess the level of cooperation and exchange between public and private sector providers.
- Examine existing policy and regulatory frameworks and other environmental factors impacting the private sector provision of health products and services.

Determine the mechanisms for accrediting, regulating and monitoring private commercial providers of health products and services and their relative effectiveness.

- Assess the extent to which regulations hinder or favor private sector product and service provision, consolidation of separate private product or service practices, and ownership of accredited health facilities. .
- Explore opportunities to strengthen links between the private commercial and public sectors (e.g., private providers as source of surveillance and other health data, collaboration with MOH officials, public investments which may leverage and help the commercial sector expand, public sector contracting of private provision).
- Analyze health care reform or other government-led initiatives that may impact private providers.

4. Assess health financing initiatives and opportunities for expanding private sector provision.

- Analyze financing options, such as the Kenya Health Insurance Scheme and third-party payment mechanisms, and the opportunities they present for expanding access to private sector coverage of health services.
- Examine the USAID investments in health financing schemes (including the Kenya Health Insurance Scheme) to determine their effectiveness, which public and private sector stakeholders are involved, and whether and how they could be expanded.
- Assess private provider incentives, especially as they relate to HIV/AIDS prevention, treatment, care and support. Determine the existing or potential health financing mechanisms that can be used to bridge any gaps between willingness to pay and cost of providing care in the private sector.
- Determine if the National Health Insurance Scheme can be a possible source of funds to the private sector.

5. Assess financing needs of the private health sector and the extent to which access to credit could improve or expand private sector service provision

- Examine access to financing to determine if it is a constraint to the delivery of family planning and/or HIV/AIDS services and/or products in the private sector.
- Identify how start up capital is typically obtained.
- Assess financial institutions lending to the health sector, to what areas of the health sector, and what type of loan products/terms are available.
- Identify the financial management and business support service needs by private health care businesses.

6. Examine in greater depth the HealthStore Foundation's CFW Shops

- Examine key operational issues around the CFW shops, including the sustainability of their franchise business model, potential for introducing and enhancing specific health services (e.g., FP/RH and HIV/AIDS services), effectiveness of marketing the franchise and building brand identity, the business skills of franchisees and other issues potentially impacting

sustainability, expansion and scale-up of the model. This preliminary assessment will inform a more in-depth evaluation of the model that could be conducted at a later stage.

Based on the assessment findings, the assessment team will provide a range of options and recommendations for consideration by the GOK, USAID and other stakeholders (including identifying potential formal public-private partnerships) to further engage the private sector in Kenya. Furthermore, the recommendations will help strengthen private sector integration into the broader health system.

Suggested Methodology

Step 1—Finalize SOW: Work with USAID/Kenya Office of Population and Health (OPH) to finalize the scope of the assessment.

Step 2—General background research and document review: Conduct background research using secondary research sources, secondary data analysis of DHS, National Health Accounts, and/or other sources, and interviews conducted prior to the first in-country visit.

Step 3—Conduct Country Assessment: The following components will be included in the team’s assessment methodology.

Stakeholder Meetings: Conduct stakeholder meetings with key decision makers such as MOH, USAID, and representatives of private sector entities to build support for and buy-in to the assessment, vet research questions, determine if stakeholders have additional issues they’d like addressed and, if necessary, expand the research questions. Additionally, there will be discussions on the goal and objectives, design, and participants in the consultative process. This is designed to increase the likelihood that its findings and recommendations will be used by stakeholders and to ensure greater relevance of the assessment results.

Key Informant Interviews: Conduct qualitative, in-depth interviews with key stakeholders and partners. Key informants should include, but not be limited to:

- USAID/Kenya OPH staff
- US Government (USG) counterparts including CDC
- Implementing partners (contractors and cooperating agencies) working on private sector initiatives including Population Services International, JHPIEGO, Family Health International, and the HealthStore Foundation.
- USAID/Washington staff backstopping the Kenya Program
- A cross-section of private providers including general practitioners, ob/gyns, pharmacists, midwives, in rural and urban areas
- Private and commercial enterprises, professional associations, pharmaceutical manufacturers, health insurance companies, micro-finance institutions, etc.
- Key Government of Kenya and parastatal staff, including the MOH’s Division of Reproductive Health, Ministry of Medical Services, Ministry of Public Health and Sanitation, the National AIDS Control Council, and the Kenya Medical Supplies Agency

- Other donors supporting the health sector (including UNFPA, KfW, DFID)
- Professional medical, nurses-midwives, pharmacists, bio-laboratory associations, e.g., the Kenya Medical Association

Field Visits: The assessment team will visit field sites where private sector initiatives are underway, including private hospitals, clinics, midwife practices, and the HealthStore Foundation's CFW Shops.

Focus Group Discussions: The assessment team will conduct focus groups with private providers (such as doctors and midwives).

Data Analysis: Conduct data analysis of data collected during key informant interviews and field visits.

Step 4—Identification and Presentation of Findings: At the conclusion of the assessment, preliminary findings will be presented to key stakeholders and USAID/Kenya OPH staff for accuracy and recommendations.

Step 5—Report Writing & Dissemination: The assessment team will write a draft report for USAID/Kenya OPH staff review. Upon receipt of comments from USAID/Kenya, the team will revise and finalize the report accordingly. The report will then be disseminated through multiple channels, but primarily through the stakeholder dialogue process.

Step 6—Conduct Stakeholder Dialogue: (Conditional on World Bank/IFC funding.) Using the draft assessment report, a stakeholder dialogue meeting comprised of both public and private sector will be held following the assessment to: a) Reach a common understanding of the opportunities for the private sector to complement the public sector, and b) Clarify roles and responsibilities between both sectors.

Step 7—Stakeholder Planning: (Conditional on World Bank/IFC funding.) After conducting the stakeholder dialogue, a planning process will be held to a) Gain agreement on two to three areas for public-private collaborations, and b) Outline possible implementation approaches for public-private partnership activities.

Deliverables

Final SOW: Developed in consultation with OPH in advance of the assessment visit, including:

- Team composition, roles and responsibilities
- Assessment budget, including dollar amount of POP core funding
- Relationships and responsibilities (regarding key points of contact, logistical arrangements, scheduling of meetings and appointments, etc.) of assessment team and OPH
- Timeline and level of effort

Debriefing Meeting: The assessment team will hold a debriefing meeting with OPH and USAID/Washington Kenya backstopping staff to present the major findings and recommendations of the assessment.

Assessment Report: The assessment team will provide OPH with a final assessment report should include: an executive summary; scope and methodology used; important findings and conclusions; recommendations and opportunities for future investment/support.

Duration, Timing and Schedule

It is anticipated that the period of performance of this assessment will be approximately 10 months, including preparation time in Washington, two in-country visits, and report writing, production and dissemination.

Appendix 2. Stakeholders Interviewed

Date	Interviewee	Organization
Thu 22-Jan	Bedan Gichanga, Karen E. Klimowski	USAID
	Pamela Mutua	PSI
	Mary Ann Seday	PSI
	Ruth Okowa	HENNET
	Daun Fest	PSI
Fri 23-Jan	Sammy Muthui	AON
	Dr. Wary	MOPHS
	Esther Njuguna	CFW
	Dr. Saini	Nairobi West Hospital
	Geoffrey Kimani (sitting in for Onguti)	MOMS
	Peter Mwarogo	FHI
	Sat 24-Jan	Dr. Samuel Mwenda Rukunga
Mon 26-Jan	Allan Ragi	KANCO
	Mark K. Bor (Permanent Secretary)	MOPHS
	Peter Nduati	Resolution Health
	Diana Patel	Avenue Hospital
	Dr. Cleopa Mailu	Nairobi Hospital
	Mr. Wandera	British American Insurance
	Dr. Saini, Amit Singh	Nairobi West Hospital
	Mike Mills	World Bank
	Dr. Rukwaro, Stephen Maina	African Air Rescue
	D.K. Ronoh	CIC Insurance
Tue 27-Jan	Dr. Ambrose Nyangao	UAP Insurance
	Josephine Mburu	CFW shops in Embu
	Cavin Otieno	GTZ
	Mrs. Macharia	Nairobi Equator Hospital
	Manya Andrews	PSI
	Veronica Musembi	PSI
	Dr. Rukwaro	African Air Rescue
Wed 28-Jan	Rose Wanjohi	ECLOF
	Danson M. Muema	Machakos Health care Centre
	Peter Mwarogo, Susan Kimani, Dr. Frank Mwangemi, Dr. J.A. Aulloch (Gold Star Physician)	FHI Gold Star Clinics
	Dr. F.J.A. Onyango	Shalom Community Hospital, Machakos
	David Mugun	Fina Bank
Thur 29-Jan	Moses Lorre	Association Of Lab Techs
	Dr. Gunther L. Faber	The Healthstore Foundation
	Josephine Mburu, SHF Office Staff	CFW Offices
	Dr. Dominic M. Mutie, Dr. Wilfred O. Oguta	Pharmacy Poisons Board

Date	Interviewee	Organization
	Dr. D.N. Wachira	Njimia Pharmaceuticals
	Michael Thuo, Joseph Shitandi Mukoko	MSH
	Aggrey Ashinhundu (Hospital Administrator), Miyoko Otumba (Medical Officer), Albert Khainga (Comptroller)	Mount Longonot Hospital, Naivasha
	Polyclinic Hospital Staff	Polyclinic Hospital, Naivasha
Fri 30-Jan	Henry Karugu	Equity Bank
	Mr. Kiptum	IRA
	Vipin Shah	Surgipham
	Pharesh Retego	USAID
	Dr. Wasunna Owino, Dr. Dan Wendo	Policy Project
	Peter Mahanu	PACIS Insurance
	Helen Kithinji	Faulu Kenya
	Maureen Nafula (Director, Certificate in Advanced Health Care)	Strathmore Business School
	Moses Lorre	Association of Kenya Lab Scientists Officers
	Mr. Luke	Nurses Association at Kenyatta National Hospital
	Agnes Ndirangau	Insurance Regulatory Authority
Mon 2-Feb	John Ledidi	Kenya Pharmaceutical Association, Kenyatta Hospital, Comprehensive Care Centre & Pharmacy
	Mr. Manyuru, Jane E. N. Masiga, Ruth Njoroge, Joachim Githinji, Jonathan Kiliko	MEDS
	Aida Kimemia	IFC
	Dr. H. Michael Thuo, Josephine Maundu, Dr. Mary Wangai, Joseph Shitandi Mukoko	MSH
	Mr. Odundo	Getrudes Children's Hospital
	Evans Kebaso	K Rep Bank
Tues 3-Feb	Dr. Midiwo	NHIF
	Elizabeth Dwyer	Nursing Council of Kenya
	Dr. Maliti	The Consortium
	Dr. Daniel Yumbya	Medical Practitioners and Dentists Board
	Henry Karugu	Equity Bank
	Dr. Klaus Hornetz	GTZ
	Jennifer Riria	KWFT
	Dr. Monica Oguttu	K MET
Wed 4-Feb	George Maina (Chief Executive), Moses Murungi (Technical Insurance Manager)	Faulu Advisory
	Dr. Sule	KMA
	Mark Rostal	USAID, DAI
	Burkard Komm	GTZ
	Nina Stochniol	IFC
	Moses Murungi	Faulu Advisory Services

Date	Interviewee	Organization
Thursday 5 Feb	Debrief Mike Mills, Nina Stochniol, Wacuka Ikua, Bedan Gichanga	World Bank, USAID
	Dr. Amit Thakker, Kevit Desai, Dr. Anastasia Nyalita	Kenya Private Sector Alliance
Fri 6-Feb	USAID debrief Bedan Gichanga	USAID
	Tom Gichuhi, Nelson C. Kuria	Association Kenya Insurers
Mon 9-Feb	Dr. S K. Ngugi	Pharmaceutical Society of Kenya
	Professor Kiyapi (Permanent Secretary)	MOMS
Tue 10-Feb	Khama Rogo	IFC/World Bank
Wed 11-Feb	Mark Rotich	DFID
Tues 17-Feb	Dr. K'Ochola	MOMS
Wed 4-Mar	Professor Kiyapi (Permanent Secretary)	MOMS
Thur 5-Mar	Dr. Francis Kimani (DMS)	MOH
Tues 10-Mar	Dr. Saini	Nairobi West Hospital
Thur 12-Mar	Nairobi West Hospital Satellite Clinic Staff	Embakasi Clinic
Fri 13-Mar	Nairobi West Hospital Satellite Clinic Staff	Haile Selassie Ave Clinic

Appendix 3. Focus Group Discussion Analysis

Understanding the Private Health Sector in Kenya: An Analysis of Focus Group Discussions with Private Health Providers

Scope and Objectives of the Study

The USAID-funded PSP-One project seeks to develop a strategy to expand the role of the private health sector in Kenya. In an effort to identify ways to better engage the private health sector, focus group discussions with private providers were conducted throughout the country. This study aimed to better understand the private health sectors' contributions, constraints, and opportunities for playing a larger role in providing health care in Kenya.

Study Methodology

Focus group discussions were conducted to collect data on the contributions of private providers to public health, the constraints preventing private providers from playing a larger role in the provision of services, and potential strategies for improving the quality and quantity of health care provided by the private sector. Qualitative data gathered from 10 focus group discussions with nurses/midwives, clinical officers, pharmaceutical chemists, and pharmacists were analyzed using an inductive approach to qualitative data analysis.

Results of the Study

Research findings for private providers in Kenya are organized into three categories: (1) Contributions of Private Providers to Public Health; (2) Constraints Preventing Private Providers from Providing More Services; and (3) Potential Strategies for Improving the Health care Provided by the Private Sector.

Contributions of Private Providers to Public Health

Nurses/Midwives and Clinical Officers report three main contributions of private providers to public health. These contributions are:

- **Meeting demand for quality care:** Some private providers said that the private sector plays an important role in meeting consumer demand for quality care in Kenya. For example, one nurse/midwife said, *"Most people prefer to go to private hospitals where you can get good services. Getting clients is not a problem, they are so many of them at the moment that prefer private hospitals."*
- **Providing specialty services:** Private providers report that the private sector fills a gap in health care by providing specialty services, like caring for children and providing HIV care and treatment. One nurse/midwife describes, *"They [clients] go to the government hospitals and get treated. If the CD4 count is below 100, you go and find a private facility that deals with HIV and know can provide ARVs."*
- **Mobilizing human resources:** There is consensus among private providers (so far) that the private sector helps absorb the increasing amount of out-of-work providers in Kenya. Some private providers said that there are many

providers (nurses/midwives in particular) who are out of work because the government is not hiring. One nurse/midwives who hopes to start her own private practice explains, *“I want to absorb people because are there so many nurses out here who are not working.”*

Constraints Preventing Private Providers from Providing More Services

Even though the private providers believe that they are an important source of care in Kenya, they face many barriers to providing services. These barriers are:

- **Financing barriers:** There is consensus among private providers that they face many financial disincentives to opening and sustaining a private practice. The primary financial disincentives are securing a loan and purchasing and maintaining medical equipment. The private providers who tried to secure a loan said that they were rejected because they did not meet certain financial requirements or because their business proposition seemed too risky. Others said that if they were accepted for a loan, they did not get the full amount they requested, making it difficult to open a practice. One clinical officer explains, *“They [the bank] agreed to give me a loan, but they didn’t agree to the amount I wanted. The amount they were offering could not let me start anything so I declined.”*
- **Strict regulatory requirements:** Private providers face many regulatory barriers preventing them from opening a practice. These regulatory barriers are stringent work experience requirements (10 years of work experience) and various forms of licensing that are difficult to acquire. One provider describes the licensure requirements, *“When you want to start a business, you need a license. You need a license from the City Council, from the Medical and Dentist’s Board. If you are a nurse, you need one from the Nursing Council. If you are from a laboratory, you need one from the Laboratory Board. It is very difficult to find somebody having all of these documents in place...”*
- **Physical barriers:** The private providers said that they face many physical barriers to opening a practice. They have to find a location that is appealing for clients, safe and secure, and has a functional waste management system. For example, one clinical officer describes, *“an incinerator cannot just be built anywhere...it to be over thirty meters high so that the smoke should go up. It is very difficult to build such a thing in a shopping center.”*
- **Better working conditions in the public sector:** Most private providers said that they sometimes prefer to work in the public sector because of the benefits of being a government employee. In public facilities, employees have job security, less strenuous work schedules, are paid on time, and receive allowances for trainings, transportation costs, and uniforms. One provider describes, *“My boss feels like he is the owner and he can give you the payment whichever day he feels like and whatever package. But with the government there are rules. You are sure by every 24th the salaries are processed.”*
- **Differentiating themselves from unqualified practitioners:** Most private providers find it difficult to differentiate themselves from unqualified practitioners in Kenya. This is a challenge given that unqualified practitioners have unrecognized certifications, do not have training in basic medical

techniques (e.g., stitches and circumcision), are devoid of formal licensing, and are providing services outside of the scope of their professional training (e.g., pharmacist technologists providing general care). One provider describes, *"There are so many people who dropped out of college but they are providing services out there."*

- **Lack of business skills:** Some of the private providers said that they do not want to open a private practice because they do not think they have what it takes to compete with other private providers who have a lot of work experience, even if they have fewer qualifications, or are specialists. One nurse describes, *"You feel so bad because you have gone to a medical training school for 3.5 years or 2.5 years and passed exams. The clinical tests you have gone through, that grilling process and then you go home you wait for your results, you get a job, when you land there, you find that your matron is a nurse aid...she has never gone to nursing school and is earning three times more than what I earn."*

It is important to note that some of the private providers said that wished that there were not so many barriers to working in the private sector since they *"dream of opening their own hospital."*

Potential Strategies for Improving the Health Care Provided by the Private Sector

Private practitioners provide a number of strategies for improving the quality and quantity of care provided by the private sector in Kenya. These strategies are:

- **Standardizing public and private sector protocols:** There is consensus among the private providers (so far) that protocols need to be standardized across the private and public health sectors. They believe that all providers should be trained using the same curriculum and have the same laws governing their workplaces. For example, one nurse/midwife explains, *"It is better we have standardized procedures on how we are trained, you get a standard training on ARV, a standard training on disaster, a standard training on malaria management so that we don't have fabrication on the same program."*
- **Incentivizing practitioners to provide quality care:** Some of the private providers said that they should be given incentives to provide quality services. Some of the incentives mentioned included a "best provider" contest and better salaries. One nurse/midwife says that the Nurses Council could incentivize practitioners to provide quality care by launching a "Nurse of the Year" [contest]. *It is like some examination where you are told to write down an essay and they pick the highest according to provinces."*
- **Providing practitioners with training:** All of the providers said that private providers and hospital staff should be provided with free training opportunities. Unlike public health providers, private providers are expected to pay for their own continuing education. One provider explains, *"Nurses continuous education is required and continuous medical exams [CME] every three years because this when licenses are renewed, but have to do at own cost. For government it is for free, but for the private sector, you have to pay."* Private

providers said that sometimes they are not even invited to participate in trainings. One nurse/midwife explains, *“You would find that out of 40 people invited, I was the only one from the private sector. This tells you that the people in the private facility are not considered.”* Some of the training opportunities that the private providers said they would like to participate in are: safety measures in hospital settings, accounting, HIV education, new drug therapies, the latest medicine, customer care, and basic emergency medical training for onsite customer relations officers and inventory staff.

- **Sharing resources with NGOs and the public health sector:** There is consensus among private providers (so far) that sharing resources across the public and private sectors could be an effective way to improve the quality and quantity of services provided in Kenya. Some resources include ambulances, medical equipment and expensive drug treatments. They also mentioned that the public and private sectors could share information about best practices in the workplace. For example, some private providers mentioned that they could learn how to do better reporting from NGOs and the provider community, as opposed to primary-level care from the government. One nurse/midwife explains, *“The government should reach out to private clinics... The government can actually help by sealing the gaps [in quality care] which are there.”*
- **Developing stricter regulations against unqualified providers:** All of the private providers said that they needed better monitoring and oversight of private clinics in Kenya. They said that regulatory bodies should do a more timely and comprehensive evaluation of private employees to make sure that they are qualified to provide care. Regulations need to be put in place to prevent unqualified matrons from managing hospitals, practitioners from providing services outside of their professional parameters, and companies selling medical equipment to unlicensed providers. One nurse/midwife explains, *“Before licensing, [regulatory bodies] should do a total evaluation. Sometimes, you find someone opening a clinic and it operates for more than two weeks without being inspected.”*

Appendix 4. Donor Investment Opportunities

Opportunity One: Creating a Legal Structure for Innovation and Security in Health Insurance

Objective

Enable Government of Kenya officials to understand the structural and legal options for regulating health insurance, and to include the chosen controls in the revised Insurance Law

Background

Existing insurance laws that treat health insurance like life or accident insurance stifle innovation, limit risk pooling and restrict the number of lives insured in the private commercial market.

What Donors Can Do

1. Donor support and technical assistance is needed to organize a study tour to inform the revisions to the law.
 - a. Select three to four key Government of Kenya personnel working on the redraft of the insurance law.
 - b. Organize a study tour for these officials and representatives of insurance companies AND innovative health providers. Prior to the study tour, the participants would be provided with background memos and copies of current law regulating health insurance in:
 - i. Republic of South Africa
 - ii. Germany
 - iii. Netherlands
 - iv. Two American states
 - c. Organize the study tour so that the group can meet with regulators and regulated insurers in each venue visited.
2. Select a “study tour guide” who will not only provide logistic support, but will help the group to digest the information received at each site.
3. Assist the study tour participants in preparing a summary of the favored options observed.
4. Support a consultant and Kenyan lawyer to draft a separate health insurance law (or health insurance segment of a revised general insurance law) for inclusion in the proposed reform package for the insurance law.

Time is of the essence in seizing this opportunity since both the government and the insurance industry are already preparing to propose revisions to the existing insurance law.

Opportunity Two: An Integrated Licensing and Enforcement Structure for Health Facilities

Objective

Assist the Government of Kenya to develop an integrated health facility licensing process that:

- Provides for integrated and publicly disseminated facility regulations;
- Reduces the number of different inspections to which facilities are subject;
- Provides for a well-trained national health facility inspectorate;
- Integrates licensing with NHIF accreditation;
- Develops internal quality controls on the inspection process;
- Strengthens enforcement mechanisms; and
- Reduces the number of unlicensed health facilities in operation.

What Donors Could Do

The work previously supported by DFID in the Ministry of Health provides a starting point. Hopefully, a donor would step forward to support the following:

- Funding for a public-private working group to develop integrated regulations for each class of facility (hospital, clinic, laboratory, etc.). Draft regulations would be subject to a period of public comment. Differences in standards might be permitted for facilities at different levels, but would be expected to apply equally to public, mission and private hospitals. Each integrated regulation would include staffing standards,¹ physical facility standards, equipment standards, waste disposal standards and record-keeping requirements.
- Development of a budget and staffing standards for a national health facility inspection agency.
- Development of standardized inspection reports and checklists.
- Development of a computerized list of licensed facilities (and facilities due for license renewal). The data base would also include the inspection and enforcement history of each facility.
- Development of a procedure for receiving, investigating, and resolving complaints against licensed facilities, or complaints alleging the operation of unlicensed facilities.
- Development of more effective enforcement procedures, including fines, administrative proceedings for the withdrawal of licenses, clarification of public health emergency procedures to close particularly dangerous facilities, and a mechanism to follow up and ensure that noncompliant facilities remain closed.
- Drafting and gazetting of the necessary laws and regulations to implement the program.
- Education of the public and licensed facilities about the new standards, and complaint and enforcement processes.

Opportunity Three: Linking Gold Star, Insurance, and Affordable ART Supply

Objective

Increase the availability of good quality ART through health insurance programs in Kenya. Create a public-private partnership in which Kenyan insurers provide risk pooling of clinical expenses, while coverage of AIDS treatment is rendered more affordable through the availability of donor-funded drugs. The Gold Star network would be the mechanism for achieving this, and in the process could obtain partial funding for its operations by acting as the disease manager for participating insurance firms thereby reducing its dependence on donor funds.

Background

Gold Star started granting the Gold Star seal of approval to providers of HIV/AIDS care who meet minimum training requirements and follow national treatment protocols. This role has been further expanded to provide “hot line” consultation for concerned patients (including referral to Gold Star providers) and a service that enables Gold Star providers facing a new ART treatment problem to consult with a Kenyan AIDS expert. To date (2/09), Gold Star has qualified 190 providers in four provinces, and hopes to expand to 250 with those currently in training.

Starting in November 2008, the lead organization (Family Health International) that implemented Gold Star began using the network to make donor-funded ARVs available to a limited number of patients (300 at 2/09) seen privately in Gold Star clinics. Gold Star providers identify patients who cannot afford ARVs. After Gold Star review of the prescription for conformance with national treatment guidelines, the ARVs are made available to these patients at no cost. The Gold Star provider continues to charge for his/her consultation services and tests.

In effect, the Gold Star network is now functioning very much like a South African disease management organization (Right to Care, Aid for AIDS) in regulating the quality of ART within its network. Unlike South African disease managers, the Gold Star network is not linked into the health insurance system. Currently, participation in the scheme is purely voluntary and participating providers are not asked to pay for the training or benefits they receive. However, Gold Star could be used by Kenyan health insurers to improve the quality and efficiency of care for which they pay. In return, these insurers could pay a fee to Gold Star, as South African medical schemes now pay the disease management organizations.

What Donors Can Do

The necessary negotiations with providers, donors, and insurers will not be trivial, but Gold Star could be supported to expand its “free ART” program and to upgrade the quality of AIDS care for privately insured Kenyans. The innovation would work as shown below. These steps would need to be codified in a Memorandum of Understanding (with the donors) and contracts (between insurers, Gold Star, and Gold Star providers).

1. Health insurers provide full coverage of AIDS treatment, including first and second line ARVs, but ONLY if prescribed and managed by Gold Star providers.

2. Gold Star continues the existing elements of its program, and expands the program to the remaining Kenyan provinces. (This expansion will require donor support and collaboration with PEPFAR contractors in these provinces.)
3. The Gold Star network will:
 - a. Provide access to ART training for selected private providers.
 - b. Review the treatment arrangements of all candidate providers, including access to necessary laboratory tests.
 - c. Certify providers as complying with national ART treatment guidelines.
 - d. Conduct periodic reviews/reaccreditation to confirm compliance with national treatment guidelines. Since treatment guidelines may change, Gold Star will need to offer continuing medical education on these changes.
 - e. Provide a “hot line” service for potential Gold Star patients.
 - f. Provide telephone consultation on problem cases for Gold Star network providers.
4. Donors agree to provide ARVs at no cost to certain insured patients of Gold Star providers. These providers could not charge for the drugs, but would continue to charge normally for consultation and tests. Eligibility for these “free” drugs might initially be limited to “low-cost” insurance plans; e.g., those that provide reasonable benefits, including AIDS care, for a premium at or below a certain monthly level. This level would be set to clearly include the “micro-insurance” type products currently developing. Gold Star would confirm that the prescriptions conform to national treatment guidelines.
5. Participating insurers (those that cover AIDS treatment through Gold Star providers) would pay a fee (perhaps a fixed amount plus a variable amount per insured, or per AIDS patient) to Gold Star. These fees would partially cover the cost of maintaining the Gold Star organization.

Family Health International must agree to move in this direction. If they do, USAID should arrange the initial negotiations with health insurers. The “ART subsidy” program will need to be codified so that insurers will know which insureds are covered. Gold Star will need to keep its franchisees informed of these developments.

If there is preliminary acceptance of this concept, USAID could hasten the development by providing a consultant and Kenyan lawyer to conduct the negotiations with the insurers and reduce the agreement to writing.

Opportunity Four: Accreditation and Quality Assurance for Laboratories

Objective

To develop a system of quality assurance for private laboratories using an accreditation type mechanism, perhaps through the Kenya Association of Laboratory Scientific Officers.

Background

Private laboratories are probably the most weakly regulated part of the private health care system in Kenya. Except for the wealthiest private institutions (Aga Khan Hospital, Nairobi Hospital) there is no program for external quality assurance, include reference testing.

What Donors Can Do

Provide technical assistance and funding to set up a laboratory quality assurance and accreditation program. This would NOT replace minimum facility licensing standards, which would govern staffing, equipment, sanitation, and record keeping.

Under the quality assurance program, a competent national laboratory would be identified as a reference lab. This laboratory would periodically provide reference samples (samples with a known but undisclosed value) to participating laboratories; these laboratories would test the samples and send the results back to the reference lab, which would compare the results to the “correct” values. The reference lab could also collect duplicate patient samples from participating laboratories and compare the value found by the reference lab with the value found by the originating lab.

The result of these comparisons would be aggregated in a “scorecard” for each participating lab. A laboratory receiving a score over a certain level would receive accreditation for a fixed period of time – although periodic quality assurance testing would continue during this period. Laboratories with a slightly lower score might receive a “provisional” certification for a more limited period of time, during which they would be required to improve test scores to standard values. Technical assistance might be available through the accreditation agency to assist the provisionally accredited labs to improve operations and reach full accreditation.

Insurers (including the NHIF) would be encouraged to limit payment for tests to accredited laboratories. Accredited labs would also receive public recognition that they can use in advertising and signage.

The program might begin with a relatively small number of tests, perhaps those particularly prone to error, or where error tends to result in particularly inefficient or dangerous treatment. The number of tests in the accreditation program could be expanded over time. Laboratories would be required to pay a fee to receive the quality assurance samples or to send duplicate samples to the reference laboratory for verification. These fees would also cover the operating costs of the accreditation organization. If insurers made accreditation a condition of payment, this system could become self-supporting while improving the quality of private sector care.

Opportunity Five: Rural Retail Drug Network*Objective*

Develop an appropriate scope of practice for retail drug outlets staffed by qualified pharmaceutical technologists to increase access to quality drugs in underserved areas.

Background

The problems encountered by the Child and Family Wellness (CFW) drug shop network demonstrate that there is a market gap between the need for access to drugs in rural areas and the ability of consumers to pay for those drugs such that pharmacist

can profitably operate retail outlets. Restricting the range of drugs and health products and using health workers was not an effective strategy because that model addresses a small part of the needs and generates enough business to be sustainable. A retail outlet that can sell all essential medicines as well as some of the more commonly prescribed branded medicines would stand a better chance of addressing the needs in the smaller towns and being commercially viable. Profitability is still somewhat questionable, however, and it seems that most pharmacists would rather take their chances in the highly competitive markets of the largest cities than to risk operating where there is less competition but also less ability to pay. It is also understandable that providers who invest in a long course of health studies expect to practice where they can recover their investment. Some donor investment could be effective in bridging the gap between the providers and the paying consumers. A pilot network could be useful in testing the viability of a network model that could potentially be replicated and expanded with decreasing levels of subsidy.

What Donors Could Do

Donor funding and support would be required to identify a pilot area that is currently underserved by retail pharmacies or chemist shops. Initial donor support would go toward the creation of the franchisor function of the retail network in which the franchisor provides start-up capital (in partnership with a private credit institution), helps with licensing of franchisees, procures and distributes supplies (in partnership with a commercial distributor), and ensures quality control.

One key feature of the network would be to recruit pharmaceutical technologists as franchisee owners of each retail shop. They would be required to put up a significant share of the upfront investment and would be able to keep all profits, but they would have to accept the conditions of network membership, which would include sourcing of drugs from network-approved sources, adherence to quality standards and supervision from network pharmacists. In addition to quality assurance, the key strategy of the network would be to achieve economies of scale in procuring and distributing drugs.

In addition to testing the viability of the network model, the experience could be instructive to help redefine an independent scope of practice for pharmaceutical technologists to restricted areas. This could help redeploy pharmaceutical professionals to areas where they are most needed and help mitigate the problem of pharm techs performing more and more functions of a pharmacist.

This network model should be piloted in one province and closely monitored for its impact in improving access to essential drugs for target groups, the quality of drugs dispensed, the adherence to quality standards and the levels of profitability of different franchisees in the network. The model should be planned for gradual phase-out of donor support, with a commercial distributor eventually assuming ownership of the network and the regulatory authorities establishing the legitimacy of the pharm tech scope for well defined areas.

Opportunity Six: Expand Access to Finance

Objective

Expand the number of private health care businesses that are able to access timely and appropriate financing to expand and improve their businesses.

Background

The assessment revealed that there are a number of constraints to access to financing in Kenya. Financial institutions cited lack of market information, perceptions of risk, collateral concerns, and a lack of understanding of the private health sector business model as factors that limit lending to the sector. Without access to financing, providers are not able to grow and improve their practices, resulting in a health sector that is fragmented and isolated.

What Donors Could Do

Donors can consider a number of interventions that will stimulate health sector lending. These include:

- Support market research that will allow financial institutions to make informed decisions about entering the health care market.
- Provide training and technical assistance to financial institutions in health care lending, marketing to the sector, and loan product development.
- Support a credit guarantee to reduce risk in lending to the sector.
- Consider other mechanisms, such as credit line, that may be necessary depending on the impact of the credit crisis.
- Sponsor private health sector trade fairs to improve market linkages and create a forum for providers to meet financial institutions, equipment, and pharmaceutical suppliers, associations, and other groups that can support the development of the health sector.

Opportunity Seven: Develop Local Training Capacity in Health Management and Finance

Objective

Expand the number of Kenyans with training in health and management. In the long run, this should include providing those with management training with sufficient public health training to enable them to function more effectively as managers in health facilities and health insurers. In the short term, the need is to provide additional management training for trained health professionals at a variety of levels.

Background

There is some management training for health professionals in Kenya. Management is included as a subject in advanced nursing courses; however, it is not included in any other professional training that we could identify. In general, those we interviewed who had moved into private practice had not received training in business and financial management. The exception was in nursing, and, of course, pharmacists have had some training in inventory management.

Equally disconcerting was the lack of specialized training for those in the highly competitive health insurance industry. The most skilled are generally health professionals who have learned the insurance industry “the hard way” – by working in it. These individuals are much in demand as the volume of health insurance expands. But there is currently no course in Kenya that teaches health insurance principles. We found that concepts such as contract administration of social insurance (a model used by Medicare in the United States and by the Nigerian national health insurance program), or capitation-based payments to providers, are unfamiliar to most now working in the industry.

Work has been done to expand the availability of health management education. At the “high end” of the spectrum, Strathmore University now offers a Certificate in Advanced Health Care Management. Strathmore has recently conducted a study of the demand for health management education and the current sources of supply. There are some courses available for health managers in the public service. There is a little training available to the limited number of private sector providers who take out loans. But the need is much greater than the current supply.

What Donors Could Do

There is need, and demand, both for curriculum development, and for direct support of tuition costs for health management training. Donor investments might include:

- Curriculum development, and initial offering, for a health insurance course. This could be offered by the College of Kenya Insurers. Insurance companies and medical insurance providers would pay for employees to take such a course. However, selective scholarships should be available to individuals working in the Insurance Regulatory Agency and the National Hospital Insurance Fund, and perhaps in some of the mission hospitals or smaller private health facilities. This will raise the sophistication, and potentially the creativity, of all parties involved in health financing in Kenya. Materials included in the course would cover:
 - Claims processing systems and claims edits;
 - Insurance and risk-pooling concepts and managed care;
 - Provider selection and contracting;
 - Benefit package decision;
 - Actuarial techniques and premium estimation;
 - Provider payment methodologies (pros and cons of various methods); and
 - Client relations and marketing.
- Development of business skills for private practitioners. The curriculum could be offered through several venues, including existing educational institutions, lending agencies, or professional associations. Subsidized provider networks should also consider offering standardized management training for member providers. It would provide the basic skills to: estimate revenue and expense for a practice,

- Establishing activity-based accounting systems;
- Manage costs and cash flow;
- Handle insurance claims;
- Improve the quality of operations, as well as patient satisfaction;
- Understand management information, using ICT and reporting systems; and
- Manage inventory and reduce purchase costs.

The courses could also include a module on regulatory requirements and approvals necessary to open a private practice. Professional boards should incentivize such courses by giving Continuing Professional Development credit for business and management courses. Diplomas from such courses should also be given consideration by banks when considering provider loan applications.

- Development of online training program and other forms of distance learning. Distance learning for nurses is currently being done by the African Medical and Research Foundation (AMREF), which provides access to education to students in rural areas and avoids the cost of relocations and increases the availability of specialized skills in rural areas. 4,500 nurses have participated through a network of 127 schools and E-centers. Enrolled students work toward certifications as registered nurses using a mixture of computer and in-clinic learning. Partnership with the Nursing Council of Kenya provides certification for the program. Private partner Accenture provides financial support and skills transfer to develop and manage the E-curriculum. AMREF covers the program's costs internally; student tuition goes 80 percent to partner schools and 20 percent to the Nursing Council of Kenya.

Opportunity Eight: Support for the Policy Reform Process

Objective

PSP-One has conducted policy dialogue work in many developing countries and has learned from experience that the partnership and dialogue skills are as important as technical capacity to implement PPPs. PSP-One recommends donor investment in *partnership and dialogue skill building* for the Kenyan stakeholders who emerge as leaders from the Naivasha Workshop in May. In addition, the PPP in Health members will also benefit from an overview and *introduction to the range of promising PPPs* that can help inform the implementation of the PPP Roadmap. To sustain the good will and collaboration achieved at the same workshop, donors should also invest in *formalizing the policy dialogue process* by supporting the newly formed PPP in Health committee and to fund its first year's activities including a local consultant to serve as an honest broker.

Partnership and dialogue skill building

A select number of individuals will emerge as leaders and champions for the nascent PPP dialogue process. To increase the likelihood of successful partnerships, it is

important to create a critical mass of leaders—public, private, NGO/FBO—who will champion and promote the PPP roadmap within their respective organizations in the health sector. To be successful champions, however, requires leadership and management skills that many of them may or may not have. Table 4.1 presents a list of the core skills PPP champions will need to steward successful PPPs. These skills can be transferred through a series of “mini-workshops” (approximately 90 minutes in length) that are coordinated with the PPP in Health’s tasks and activities (see Table 4.2).

Table A4.1. Leadership and Management Skills

Skills	Functions
Facilitation	Manage early encounters between key players Facilitate meetings, small group activities, larger task oriented workshops
Negotiation	Help partners negotiations based on meeting each other’s underlying interests Create “safe” environment for different partners to explore differences and commonalities
Coaching	Transfer responsibilities to partners Work behind the scenes and mentor partners
Reviewing	Mirror back what partners have said and agreed upon Provide partners opportunities to reflect on how partnership is going Help keep momentum and energy

Introduction to PPPs

In addition to helping the PPP in Health develop leadership skills, the team recommends providing targeted technical assistance in how to apply the policy tools available to work with the private sector. PSP-*One* has developed a one-week workshop that provides an overview to the most common policy options and interventions and can adapt this workshop to the Kenyan context. This workshop is based on the USAID-and WHO-supported workshop held in Addis Ababa, Ethiopia, and repeated in Abuja, Nigeria. The workshop covers the following topics: an overview of the stewardship role of the Ministry of Health in governing the private sector; an introduction to the management and leadership skills needed to engage the private sector; presentation on how to do contracting out; overview of strategies to improve the quality of the private sector; presentation of health financing and risk-pooling mechanisms; and discussion of a supportive legal and regulatory framework. During the workshop, the participants can identify the technical assistance needs in one or more of these policy areas.

Policy dialogue process

At the Naivasha Workshop, the participants agreed to establish a representative body that will sustain the dialogue process started in Naivasha Workshop. This entity, provisionally called the PPP in Health, will be housed in a neutral entity such as the National Health Insurance Fund. PSP-*One* experience demonstrates that investing in the defining the “rules of the road” for the dialogue process will minimize conflict and disagreement in the future. Therefore, the PPP in Health would benefit from technical assistance during its start-up phase to help lay the foundation for its activities.

TableA 4.2. Technical Assistance to Establish PPP in Health

“Building Blocks” to establish the new PPP in Health	Overview of Content
PPP in Health Statement of Purpose (Public document describing PPP in Health)	<ul style="list-style-type: none"> • Problem statement • Why is the PPP in Health is needed (benefits from Naivasha) • Statement of purpose of the PPP in Health • Guiding principles (sustainability, access, efficiency, equity, quality) of the PPP in Health • How the PPP in Health fits into Multi Stakeholder Forum process
PPP in Health Terms of Reference (Outlines how PPP in Health members will work together)	<ul style="list-style-type: none"> • Mission and purpose of the PPP in Health • Tasks of the PPP in Health • Location of the PPP in Health • Where should be the PPP in Health to be located (e.g., NHIF)? • Lines of communication (internally and externally) • Agreement on decision making processes • Composition of the PPP in Health • PPP in Health members’ roles and responsibilities
PPP Roadmap (prioritize Naivasha recommendations)	<ul style="list-style-type: none"> • In June, several members from the Naivasha Workshop will meet to prioritize the recommendations from the May Workshop and draft a workplan to implement them.
PPP in Health workplan of activities	<ul style="list-style-type: none"> • At the same time, during the June workshop, the same group will identify the activities the PPP in Health will assume in relation to the PPP Roadmap. This will result in a one year workplan requiring funding to support its activities which includes meetings, advocacy events, dissemination events, etc.
Seed funds to support “honest broker”	<ul style="list-style-type: none"> • Local consultant to serve as technical resource in PPP dialogue process, provide training in leadership skills, facilitate meetings as needed, help implement PPP in Health’s workplan.

Table 4.2 outlines necessary activities to lay the foundation for a sustainable policy dialogue process. The June workshop will assist the PPP in Health to develop a consensus roadmap of that prioritizes the recommendations from the Naivasha Workshop (Activity #3). However, donor funds will be needed to support the other activities, such as drafting a public statement that outlines the purpose of the PPP in Health that can be used in all its advocacy activities and a half-day workshop to reach agreement on how the PPP in Health will operate. In addition, it is critical for donors to support a third party who is not perceived as a stakeholder with a vested interest in the PPP’s outcomes. This outside consultant can serve as an “honest broker” and will facilitate the dialogue process, train the stakeholders, and coach and model the leadership skills. This outside facilitator will also help the PPP in Health implement its first-year activities, including managing a budget that provides seed funds for the PPP in Health’s meetings and advocacy activities.

Note

¹ Any questionable qualification of designated personnel would be confirmed through the board or council without the need for the board to physically inspect the facility.

Appendix 5. Case Studies

Case Study #1: The Gold Star Network

The Gold Star Network (GSN) is a collaborative effort between Family Health International (FHI) and the Kenya Medical Association (KMA) to engage private practitioners in Kenya in the delivery of HIV/AIDS treatment services. Members of the **Gold Star Network** are private physicians who have been trained and agree to abide by quality standards set by FHI and KMA for the delivery of ARV treatment services, with the approval of the Government of Kenya. Gold Star was launched in 2006 by FHI primarily as a program to help employers support ART services for their HIV-positive employees. A further impetus to expand the program to independent private providers was the observation that many patients living with HIV/AIDS were receiving inappropriate prescriptions from providers in the private sector. Membership in the GSN also provides access to lower cost and subsidized sources of drugs and test kits as well as negotiated group rates at a nationally recognized reference laboratory for CD4, CD8, and viral load testing.

Currently, GSN receives PEPFAR funding through USAID/Kenya's APHIA II program and operates in four provinces: Coast, Rift Valley, Nairobi and Central (the later two in collaboration with Pathfinder). Its membership includes about 190 providers with a planned expansion to 250 providers in the near term. GSN providers in Nairobi maintain about 1,900 patients on ART, as well as over 4,000 HIV-positive clients who are being monitored and treated for opportunistic infections as needed. GSN customized training for private providers and developed modules in conjunction with the KMA based on a curriculum developed by the National STD and AIDS Control Programme (NASCOP) for health care providers in the public sector.

GSN providers also assess patients' ability to pay for ARVs and match them with one of two sources of lower-cost drugs available through the program. GSN purchases low-cost ARV drugs, as well as drugs for treatment of opportunistic infections, through Pharm Access Africa Limited, a logistics management organization. Patients who cannot afford even these lower-cost drugs can access the free drug supply from the public sector. The GSN closely monitors this system by reviewing all prescriptions to both prevent abuse and ensure consistency with treatment protocols. GSN staff collects drugs at the public sector and delivers them to network providers in sealed, numerically labeled packages to ensure confidentiality. Currently, fewer than 10 percent of Gold Star patients are receiving free PEPFAR-provided ARVs through the GOK.

In addition to training and the linkages with low-cost drug supply, Gold Star offers other services to support private physicians' treatment of HIV patients. These include:

- A hotline for ART patients to call in with questions. GSN staffs the hotline with a trained counselor who refers callers to GSN providers and is able to answer questions about drug side effects and other concerns. GSN also uses the hotline to provide referrals and links to social support services for clients on ART.

- A system to identify patients who are delinquent on their prescriptions refills and to follow up with phone reminders, in an effort to promote adherence.
- A mentoring program in which experienced HIV/AIDS treatment physicians are available to answer questions from those who are newer to this type of practice.

The GSN model presents a positive example of how the private sector can be engaged to provide high-quality HIV treatment services. Whether clients are purchasing reduced-price drugs sourced through Pharm Access, or free drugs from the donor-funded public sector supply, they continue to pay for consultation and lab services out of pocket, thereby contributing to the total cost of their treatment. For patients who can no longer afford the full commercial cost of their treatment, the GSN provides an alternative that keeps them out of the over-burdened public sector, and maintains their treatment with a private provider who can also meet their other routine health needs. Gold Star is an example of a provider network initiative that can be replicated as one of many strategies that will be needed to shift donor-funded HIV/AIDS treatment to more sustainable sources of local financing.

Some issues to consider for the expansion or future replications of the GSN:

- The model, as it exists today, grew in an evolutionary steps, beginning with a provider training program and gradually adding components of access to ART, improved lab services and supportive services like the hotline and mentoring. It is unclear whether it would be more successful by offering all of these services at once to new members or whether there are advantages in adding elements of support gradually as providers demonstrate competency and show commitment.
- Providers contribute very little to the overall objectives of the program – either in helping to cover the costs of the supportive services or by contributing to them in kind. Particularly, if the Gold Star certification is linked to financing mechanisms, FHI might want to consider requiring membership fees for providers to be a part of the network.
- Promotion of the Gold Star brand and what it means needs some clarification. FHI has developed a consumer-targeted brochure for Gold Star, but it is unclear how consumers perceive this brand and whether the Gold Star stamp of approval will appeal to consumers. Some consumers may avoid providers that are actively promoted as places where one can receive quality ART. If the primary target of the Gold Star brand is providers, health professionals, and insurers, a very different promotional strategy for the brand should be adopted. Another factor influencing the strategy could be whether rural or urban providers are targeted.

Case Study #2: Sustainable Healthcare Foundation/CFW Shops

Franchising is a commercial business model that has recently become a popular strategy in public health for increasing access to health care as well as improving provider quality. In some cases, the term “social franchise” is used loosely to refer to any provider network that receives training and product support for a specific package of services. This is not the case with the CFW Shop/Clinic franchise model that has been in operation in Kenya which was initiated, funded, and managed by a Kenyan NGO (Sustainable Healthcare Foundation, or SHF) and its parent U.S.-based not-for-profit, Healthstore Foundation. The network faithfully uses a true franchise model in which there are legal obligations between the franchisor and franchisees. This relationship is summarized in the table below.

Franchisor (SHF)	Franchisees (Clinics, Shop owners)
<p>Rights: Right to terminate franchise agreement if franchisee does not meet obligations or under other specified conditions.</p> <p>Right to collect service provision data, inspect financial statements and health records.</p>	<p>Rights: Non-exclusive right to use CFW brand.</p> <p>Right to render approved services and sell approved products in a defined territory.</p>
<p>Obligations:</p> <p>Assist franchisee in selection of site.</p> <p>Provide franchise operations manual.</p> <p>Provide initial mandatory training to franchisees and onsite training for 10 days.</p> <p>Provide list of required drugs, equipment, and commodities.</p> <p>Provide technical updates, clinical and business advice.</p> <p>Conduct annual audit.</p>	<p>Obligations: Active involvement in health promotion activities in the community;</p> <p>Maintaining high professional and ethical standards.</p> <p>Abide by policies and rules set forth by SHF.</p> <p>Payment of initial franchise fee (Ksh 10,000), monthly service fee of 5% of gross sales (waived from 9/08), monthly lease fee for standard CFW furniture, fixtures, and equipment.</p> <p>Repayment of loan to SHF for initial inventory, Payment of a transfer fee (Ksh 5,000) if the franchise is sold or otherwise transferred. Payment of a renewal fee (Ksh 5,000 for renewal of the franchise after 5 years.</p> <p>Pay for travel, meals, lodging to attend trainings (waived).</p> <p>Agree to inspection and audit by franchisor.</p> <p>Maintain CFW systems and standards.</p> <p><i>Only sell drugs supplied by SHF or another approved source.</i></p> <p>Monthly reporting of sales, expenditures, and inventory.</p>

Another benefit from the franchising model is its potential to put more health workers into practice than might otherwise be the case. Since the CFW network is focused on underserved areas, creating practices in those areas that would not otherwise exist has the potential for significant health impact. The key is offering a potential franchisee a sufficiently attractive package. The benefits and challenges from the franchisees perspective are summarized below.

Summary of benefits and challenges of belonging to the franchise

Benefits	Challenges
<ul style="list-style-type: none"> -Drug supply is reasonably priced. -Drug quality is ensured through SHF. -As new entrepreneurs and private practitioners, there is security in being part of an organization. -The franchisor provides some start-up capital and a ready-made business plan with management tools (e.g., standardized income statement) that can help launch would-be entrepreneurs. -Potential to receive training updates. -Ability to earn a good monthly income. 	<ul style="list-style-type: none"> -Lack of laboratory capacity as part of the model constrains the range of services that can be offered, such as antenatal care. -Demand for services outside the approved list of services cannot be met, for example, IUDs and Norplant. -Restrictions on procuring products only from franchisor may result in missed sales opportunities for products desired by the communities, but not available through the franchisor. -Increasing competition from other private practices: nurses, pharmacies, pharmacies employing nurses. -SHF requirement to be open everyday makes it difficult to do outreach without closing the clinic. -Clients sometimes resist paying consultation fees, and prefer to pay only for the drug(s).

In general, the business model gets good marks for improving provider knowledge and developing a standardized business plan that seems well suited to the providers and the Kenyan context. Another strength has been the way the franchisor has liaised with government health authorities in each district to introduce the franchisees and assist them in obtaining necessary licenses.

The target for the franchise is Kenyans in the lowest income groups in underserved communities, which is the segment of the population least served by the commercial sector. While this is a worthy objective for applying a commercial model, it is not clear that the franchise is as scalable or sustainable as the Healthstore Foundation has hoped it would be. In spite of projecting geometric growth for the franchise over the last few years, the network has only increased from about 60 outlets in 2004 to a little over 80 in 2009. The network has also been highly subsidized. The PSP-*One* assessment team calculated only 3 percent recovery of franchisor support costs through franchisee fees and contributions.

In spite of the failure of the franchise to achieve the ambitious targets of its owners, the PSP-*One* team feels that the model holds some promise and the experience of the CFW network offers some useful lessons learned for other service delivery approaches for the low-income, underserved Kenyans. These lessons are summarized below.

Limitations of the Shop Model

Initially the network consisted primarily of shops staffed by community health workers (CHW) selling health and hygiene products. The approved list of products available to shops include analgesics, first aid supplies, diapers, and hygiene items as well as cotrimoxazole, antimalarials, mosquito nets, condoms, oral contraceptive pills, and oral rehydration salts (ORS). SHF has essentially decided to phase out this model and that all new outlets would be based on the clinic model. PSP-*One's* assessment is that this is a good decision since shops are able to provide a much narrower range of products that don't really satisfy the needs of the communities. Since nurses can stock pharmaceutical products and CHWs can only stock the approved list of health and

hygiene products, the clinics seems to be more commercially viable. The combination of a CHW selling some products and conducting community outreach and a nurse staffing the clinic seems to be a better model, but it has created a management problem since only one can be a franchisee.

Recruitment and Retention Issues

Where the owner/franchisee CHWs have employed nurses to expand the range of goods and services they can provide, they have found it difficult to identify and retain nurses with the requisite credentials (five years of post-graduate experience) who are willing to work in rural areas. All of the CHWs-owned franchises (4 in Nairobi, 12 in the Central Region and 6 in the Western Region) were recruited through HSF's relationship with Christian Community Services, a faith-based organization that initially trained the workers. It was apparent from the comments of some franchisees that their motivation stemmed as much from a desire to serve the health needs of the poor as it is to run their own profitable business. Nurses who are interested only in maximizing their incomes are unlikely to become franchisees or employees of other CFW franchisees.

Supply Chain and Logistics

One of the contractual conditions of the franchisor is that franchisees may only procure health products from the franchisor. This is both a quality control measure and, in theory, a means for the franchisor to earn margin on the sale of products. In reality, what was earned on margin seems to have been far less than it cost to operate the procurement/distribution system. Until this past year, all procurement was done through MEDS, but since MEDS does not have its own distribution infrastructure throughout the country, the Sustainable Health Enterprise Foundation (SHEF) was assembling orders in Nairobi and dispatching them to franchisees throughout the country. Recently, SHEF has moved to a partnership with Surgipharm Pharmaceuticals, which has regional warehouses and can offer greater economies of scale in delivery of products. This experience serves as an example that it is better to partner with the private sector than to have another not-for-profit reinvent the supply chain wheel.

Contract Enforcement

As with most social franchises, the CFW franchise has struggled to achieve the proper balance between businesslike approaches to running a profitable franchise and the objective of increasing access to quality health services. Some of the fees stipulated in the agreement are not being collected simply because SHF realizes that in collecting more fees, they risk losing members, decreasing their health impact and getting further behind their growth targets that are necessary to achieve economies of scale. Although SHF has excluded some non-compliant franchisees, staff at SHF acknowledge that it is challenging to obtain the required reports from franchisees in a complete and timely manner, and no sanctions appear to be used for "minor" infractions such as failing to report consistently.

Business Financing

Within the present model, SHF acts not only as a franchisor, but also as a financier of loans to its franchisees. SHF loans franchisees the funds to purchase the standard package of required furniture and equipment as well as the initial inventory of drugs and health and hygiene products. The role of lender has added an administrative and financial burden on SHF, and has created role conflict among field managers who both support the franchisees as well as collect loan payments. To address these issues, SHF plans to shift away from providing direct loans and will instead link franchisees with micro-finance institutions to obtain financing for the start-up costs related to establishing their businesses.

Insurance

In recognition that one of the biggest challenges of franchisees is the ability of clients to pay for services, SHF now has plans to develop a “proprietary” insurance product (likely a pre-paid scheme or membership plan), that would provide members with discounted services linked to CFW clinics. This strategy is still in development and SHF would do well to learn from other attempts to create health insurance for the poor that are mentioned in this report.

Conclusion

The lessons learned from the CFW network would be useful to anyone interested in establishing a provider network to serve consumers at “the bottom of the pyramid” in Kenya. It may be that a network that is wholly owned, with more vertical integration around supply, testing, and referral services would require less subsidy and attract more consumer uptake. That has been the approach of the fully commercial Clinix network, which admittedly is serving a better-off segment of the population.

Case Study #3: Low-end Insurance Product

One of the companies that has tried to develop new insurance products for lower-income Kenyans is Cooperative Insurance Company of Kenya (CIC). CIC is the only cooperative insurance company in Kenya.

CIC currently insures 13,000 lives with an inpatient-only policy. They have a provider network and negotiate an annual service agreement with each provider. They try to be selective, but in some places there is only one competent inpatient provider. Each year, the participating hospitals announce their fee schedule, and CIC decides if it will accept, or try to negotiate a discount. They employ utilization review nurses to authorize continued stay and attempt to reduce inflated claims. They tried to introduce a “smart card” system to their hospitals to collect patient data and improve the speed and security of payments. Unfortunately, the hospitals in their network resisted this as a requirement and CIC had to drop the innovation.

CIC will pay outpatient claims for clients as a third-party administrator, but will not underwrite the risk. Many of the private insurance companies offer claims administration to large private companies that self-insure. Many in the insurance industry see these companies as a potential source of growth for the industry. However, many of the companies (which include some large parastatals) are reluctant to outsource their insurance because of a perception that private companies will make

“excessive” profits. Others believe that the lack of outsourcing is because preserving jobs within the company is more important than cost savings. CIC is reluctant to provide outpatient insurance and will not do so on an individual basis. This is due to high levels of fraud and abuse with outpatient claims which CIC estimates at 30-40 percent of all claims.

In looking to grow their business and sensing too much competition to profitably expand the high-end market, they decided to explore insurance products for the lower end of the market. To explore the low-end market, they commissioned their own “clinical” study to get an estimate of the burden of disease and likely cost of treatment in target populations. They funded this market research themselves.

They did not obtain any data on consumers’ willingness to pay for health insurance. Generally, pricing of health insurance in Kenya is done by referring to competitors’ premium, not through any analysis of actual or potential claims. They market directly, not through brokers (who take a 15 percent commission), and target a somewhat lower level in the market. They will try to enroll cooperatives by working with the Board or General Manager to give them pricing options and encourage them to buy the program.

CIC developed a product targeted at clients of micro-finance institutions. Premiums started at Ksh 6,000 per year per family. The product was marketed through the micro-finance institutions (MFIs) (Faulu, etc.), which would finance the annual premium as a loan with monthly payments. However, this has not sold well. The original concept was that the policy would be mandatory for borrowers (so loans would not default due to untreated illness or medical bills), but it was never mandatory. Marketing through the MFIs was poor because the product was not part of the MFI core business, and the MFI staff had no incentive to sell it to borrowers.

CIC has now shifted their downmarket insurance strategy to a new “3 in 1” product that involves adding two covers to the basic NHIF benefit. CIC sells the 3 in 1 product that includes inpatient health cover (the NHIF benefit), and funeral and accident insurance. CIC takes the risk and pays claims only on the funeral and accident cover, and cedes all risk and claims management on the inpatient benefit to NHIF. Of the Ksh 3,650 per family per year premium, Ksh 1,920 goes to the NHIF, and Ksh 1,730 goes to CIC for funeral and accident. This product has not been on the market for very long, so it is difficult to tell how successful this approach will be. 3 in 1 was started as a pilot in September 2007, and launched nationwide in September 2008. To control adverse selection, 3 in 1 is sold only to groups of 10 or more. Currently, there are 12,700 policies in force. The premium is collected annually in advance which may discourage some consumers.

CIC hopes that promoting this product will help to educate the population on the concept of insurance and health insurance, and demonstrating that insurance can work and will pay when necessary. Ultimately this may expand the market for other products that CIC sells. They see a potential of 5 to 10 million potential consumers in the informal sector. CIC sees the following challenges to expanding the health insurance market for lower-income consumers:

- **Market access:** Reaching potential lower-income consumers in risk pools can be expensive and time consuming. Using brokers is prohibitively expensive.

MFI would seem to be one logical entry point, but new arrangements have to be worked out so the product does not become too expensive and both the MFI and the insurance company can benefit.

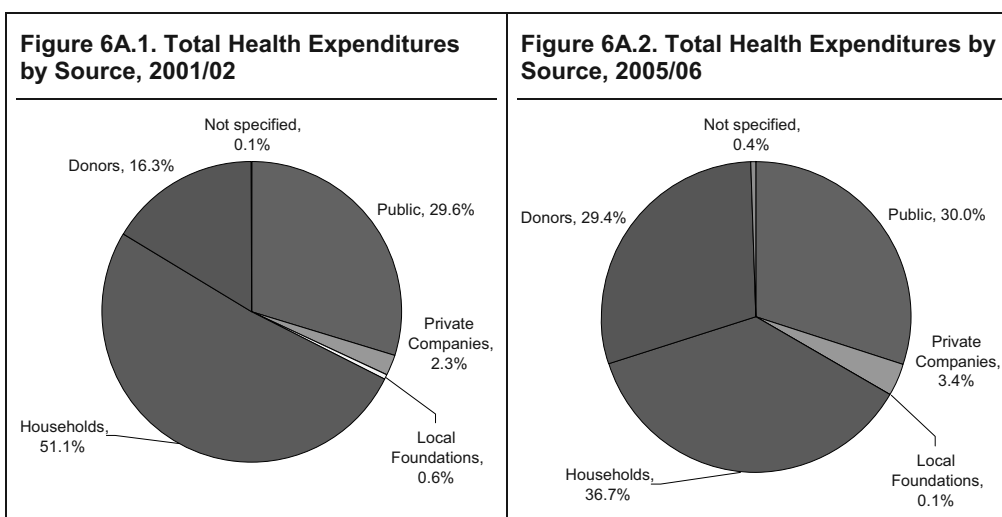
- **Social health insurance:** Government is sending mixed signals. CIC and others are reluctant to pursue innovation in this market because they think the government will offer "free" coverage that will make their products uncompetitive. They see their partnership with NHIF as increasing the insurance sophistication of that organization.
- **Lack of qualified insurance professionals:** Lack of professionals trained in health insurance is a constraint on their growth, and by implication, on implementation of any form of social health insurance. To implement the MFI and NHIF products, the General Managers have been doing most of the work, because they do not have trained staff with the necessary knowledge to serve as project managers. They have had some collaboration with International Labor Organization for training and product development, but they would like to see better opportunities for health insurance/health management training in Kenya.
- **Consumer attitudes:** The Kenyan public is still highly suspicious of insurance due to unfamiliarity with insurance and probably related to the well-publicized failures of managed care programs. Low literary levels have also contributed as people are slow to understand the evolving insurance environment and concepts. Consumers typically expect insurers to pay for all conditions or treatment without exceptions or exclusions. The sense that some consumers must get more out of it than they put in may also drive the high levels of fraud and abuse.

Appendix 6. Selected Data on Key Health Markets

1. National Health Accounts

Kenya National Health Accounts (NHA) data provides important information on the country's financing sources of health care. Figures 6A.1 and 6A.2 show a breakdown of the financing sources in two fiscal years, 2001/02 and 2005/06. In 2001/02, private sources provided most funding for health (54.0 percent); public sources provided 29.6 percent. The public health funds were supplemented by donor spending (16.3 percent). It is important note that the principal source of private funds was individual households (51.1 percent of all health funding).

The proportion of financing sources for health changed in the four-year interim between NHA estimations: By 2005/06, the percentage of private funds paying for health services had declined to 40.2 percent of total health expenditure (THE). This is evident primarily in the level of household spending, which fell from 51.1 percent to 36.7 percent. The proportion of public financing of health increased, driven by the dramatic influx of donor funds for health—whose percent increase was almost twofold.



Source: NHA 2001/02.

Household expenditures are an indicator of consumer preferences. Using NHA data, Figures 6A.3 and 6A.4 illustrate where individuals and households spent their own resources in health. Figure 6A.3 shows that, in 2001/02, health consumers spent more of their out-of-pocket (OOP) funds in the public than private sectors (54 percent and 42 percent respectively). Three-quarters of the OOP funds were spent on services rendered in hospitals. In 2005/06, Kenyans spent even more out of pocket on overall hospital services, 79 percent, and there was a notable shift in consumer spending from public sector hospitals to private sector ones: the percentage of OOP payments going to private hospitals increased two and one-half times.

Figure 6A.3. OOP Spending by Provider, 2005/06

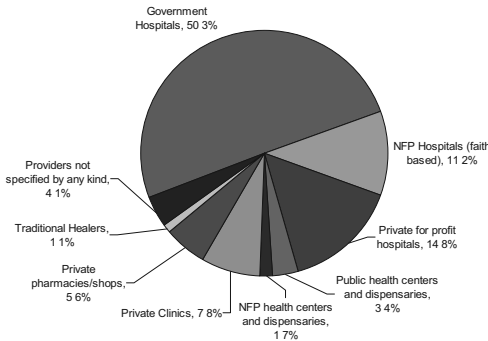
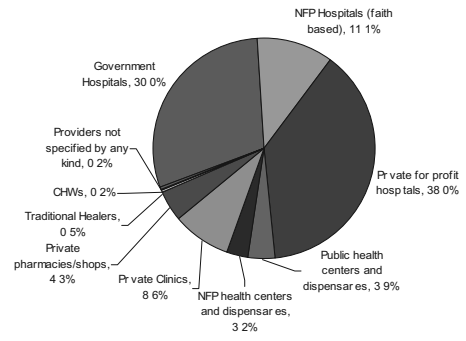


Figure 6A.4. OOP Spending by Provider, 2001/02

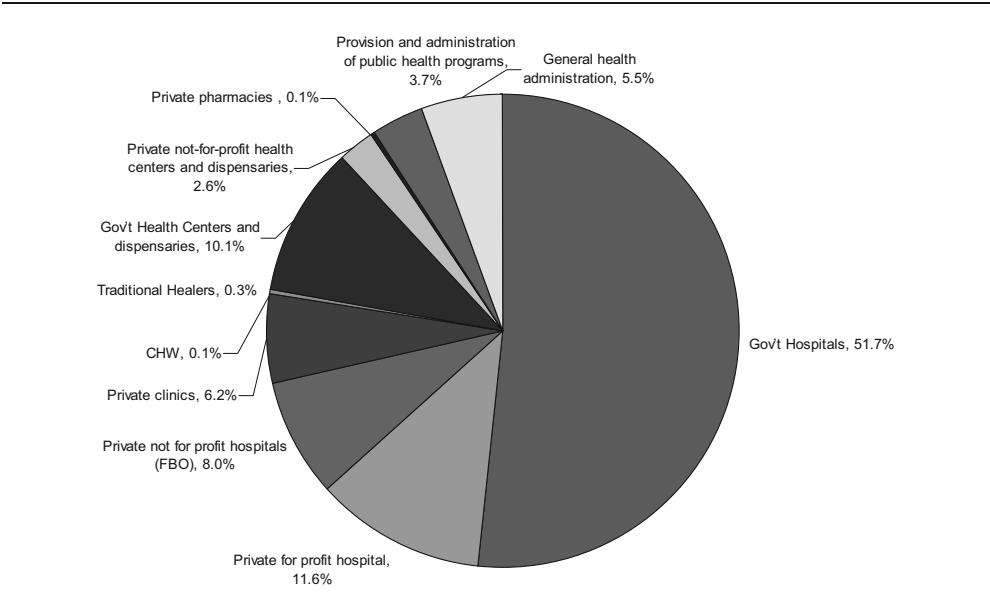


Source: NHA 2001/02.

2. Women’s Health (Delivery, Antenatal, and Family Planning Services)

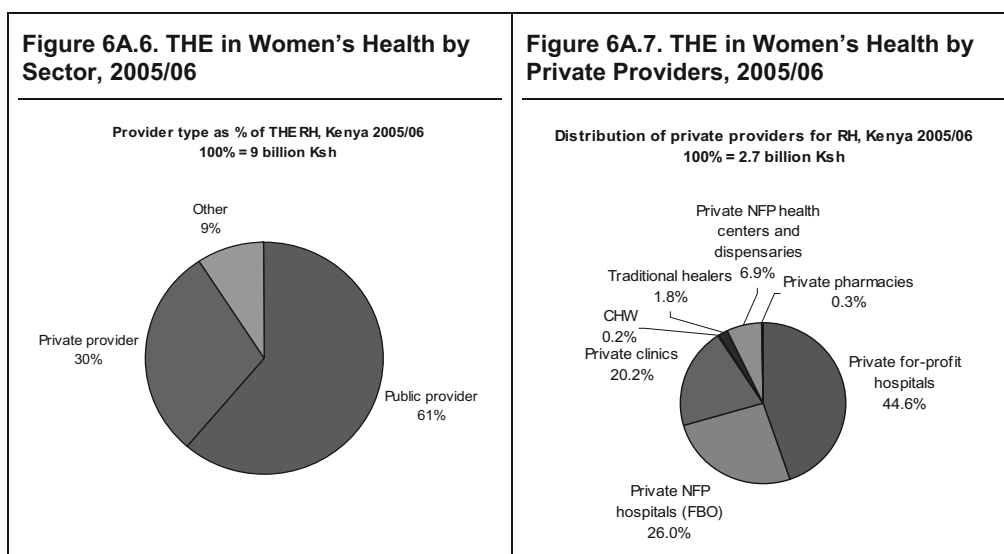
The NHA data can also be used to track health expenditures by different health interventions (figure 6A.5). In 2005/06, THE for women’s health services was KSh 8,757,266,691. Government hospitals accounted for 52 percent of market share; while private for-profit hospitals had the second largest market share (12 percent), followed by government clinics (10 percent) and private not-for-profit hospitals (8 percent).

Figure 6A.5. Total Health Expenditures for Women’s Health Services (2005/06)



Source: NHA 2005/06.

Figures 6A.6 and 6A.7 show where the health expenditures were spent in 2005/06. As seen in Figure 6A.6, 61 percent of THE for women's health was spent in the public sector while 30 percent was spent in the private sector (including for-profit and not-for-profit mission and NGO providers). Figure 6A.7 illustrates how the THE funds in the private sector were distributed among the different types of private sector providers, out of a total of KSh 2.7 billion spent in the private sector for women's health. The majority of THE in the private sector went to hospital care (71 percent), primarily in private for-profit hospitals (44.6 percent). A quarter of THE was spent in clinics; once again most funds were expended in private clinics.



Source: NHA 2005/06.

The following three sections review Kenyan Demographic and Health Survey (KDHS) data to determine use of private sector services for key women's health services such as antenatal care, delivery, and family planning. (Unless noted, the 2003 KDHS (CBS 2003) is the source for all the data on health markets.)

2.1. Antenatal services

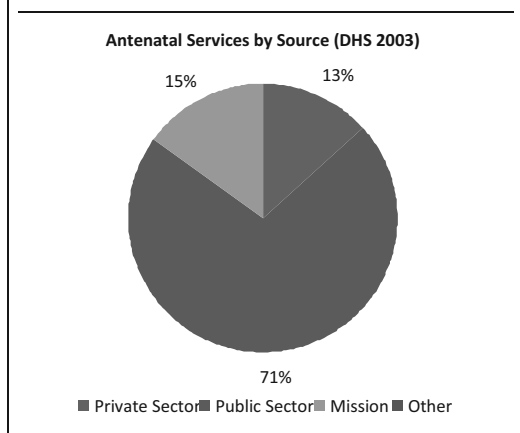
Almost 90 percent of Kenyan women receive antenatal care from a professional. Proper antenatal care (which includes a recommended two doses of tetanus toxoid injections, iron tablets for the duration of the pregnancy, and antimalarials), if obtained within the first three months of pregnancy, can reduce neonatal mortality (CBS 2003).

Figure 6A.8 illustrates the source of antenatal services in Kenya. The public sector is the most commonly used source for antenatal services (71 percent), followed by mission hospitals/clinics (15 percent) and the private sector (13 percent).

Urban areas

Figures 6A.9 and 6A.10 show antenatal services by source in urban areas. In urban areas, the public sector continues to play a predominant role in providing antenatal services (74 percent), while the private sector provides 25 percent of the services. Private hospitals/clinics make up 67 percent of the private sector market share in urban areas. Mission hospitals/clinics contribute 28 percent of the share, while private maternity homes provide only 4 percent of the antenatal services.

Figure 6A.8. Antenatal Services by Source



Source: CBS 2003.

Figure 6A.9. Source of Antenatal Services by Sector in Urban Areas

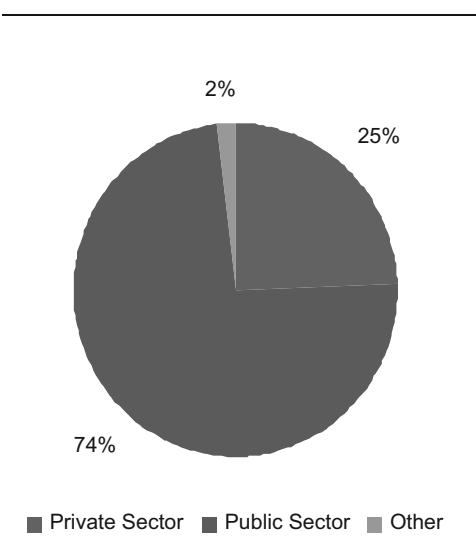
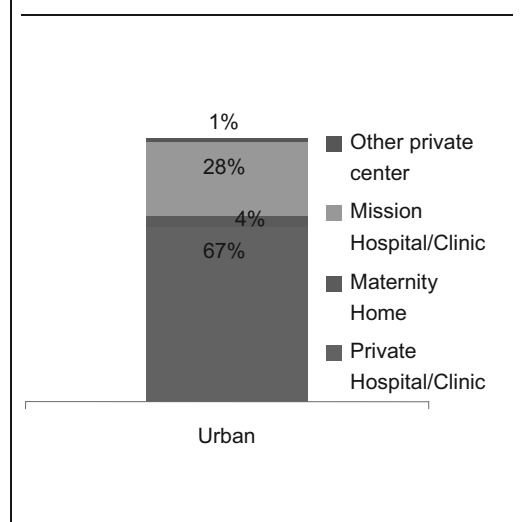


Figure 6A.10. Range of Private Sector Providers Offering Antenatal Services in Urban Areas



Source: CBS 2003.

Rural areas

The majority of antenatal services in rural areas are provided by the public sector (70 percent) (see Figure 6A.11). The private sector provides 27 percent of overall antenatal services in the rural areas (see Figure 6A.12). Unlike in the urban areas, private hospitals play a secondary role (36 percent) to mission hospitals/clinics, which provide 62 percent of the antenatal services.

Figure 6A.11. Source of Antenatal Services by Sector in Rural Areas

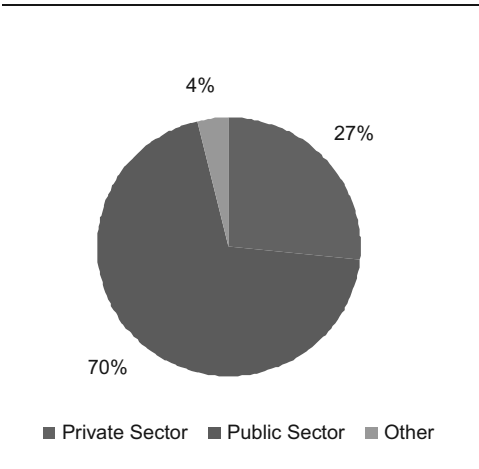
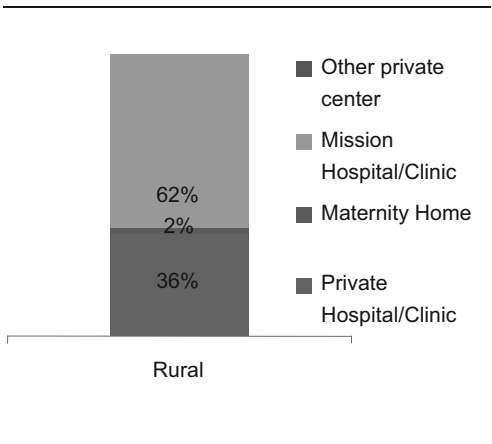


Figure 6A.12. Range of Private Sector Providers Offering Antenatal Services in Rural Areas

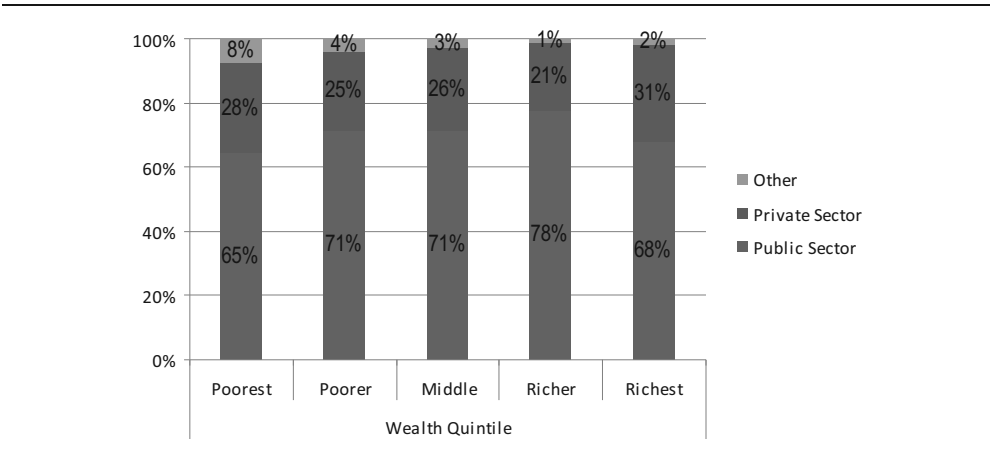


Source: CBS 2003.

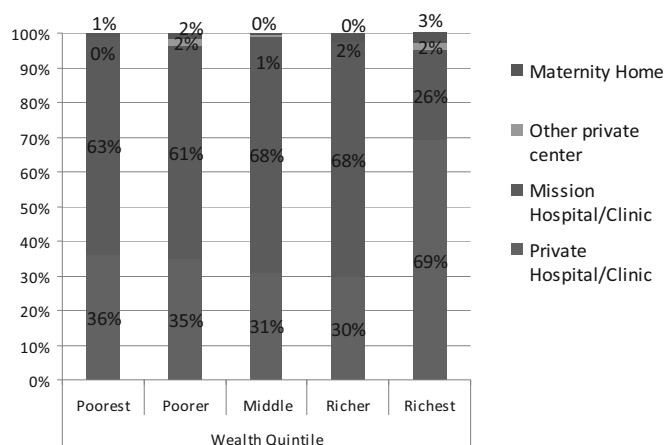
Use of antenatal services by wealth quintile and source

Regardless of wealth quintile, the majority of the population (65 to 78 percent) seeks antenatal services in the public sector (see Figure 6A.13). Indeed, the public sector is providing subsidized antenatal services to those income groups (richer and richest) who can afford to pay for them. It is important to note that fewer individuals in the poorest quintile use public services than in the higher-income groups. Women in the poorest and richest quintiles use the private sector at comparable levels, 28 percent and 31 percent respectively.

Figure 6A.13. Source of Antenatal Services by Income Group



Source: CBS 2003.

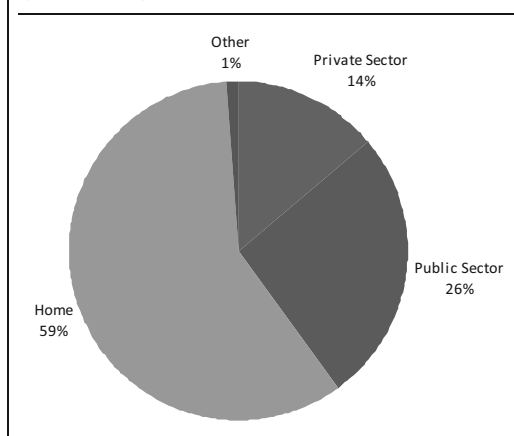
Figure 6A.14. Antenatal Services by Wealth Quintiles and Private Service Sector

Source: CBS 2003.

When analyzing the type of private sector provider used by income groups, the poor mostly seek antenatal services at mission hospitals and clinics (63 percent) (see Figure 6A.14). Still a significant percentage of poor women use private hospitals and clinics (36 percent). As can be expected, women in the richest quintile use private hospitals and clinics (69 percent). Although mission hospitals/clinics' mission is to serve the poor, more than two-thirds of women in middle and richer quintiles use mission hospitals/clinics for antenatal services.

2.2. Delivery services

The majority (59 percent) of Kenyan women still deliver their children at home; only 40 percent deliver in institutions (Figure 6A.15). Home deliveries can be a possible explanation for the high levels of maternal mortality, estimated at 414 per 100,000 live births (CBS 2003). (Note: WHO 2002 estimates maternal mortality at 590 per 100,000.)

Figure 6A.15. Delivery Services by Source (DHS 2003)

Source: CBS 2003.

Urban areas

In urban areas, 48 percent of women deliver their children in public sector facilities, compared with 23 percent who deliver in the private sector (Figure 6A.16). Within the private sector, private hospitals or clinics are the most common type of provider (76 percent), followed by mission hospitals or clinics (19 percent) and maternity homes (5 percent) (Figure 6A.17).

Figure 6A.16. Source of Delivery Services by Sector in Urban Areas

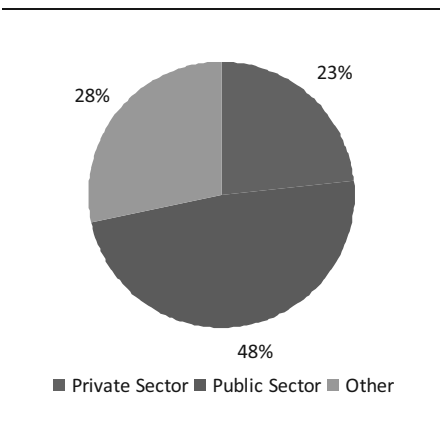
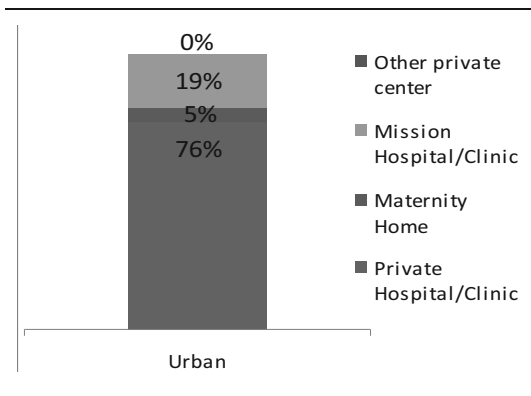


Figure 6A.17. Range of Private Sector Providers Offering Delivery Services in Urban Areas



Source: CBS 2003.

Rural areas

The majority of women in rural areas deliver at home (66 percent); only 35 percent deliver in public or private institutions (Figure 6A.18). Of the 13 percent that deliver in private institutions, the vast majority deliver at either mission hospitals/clinics (48 percent) or private hospitals/clinics (47 percent) (Figure 6A.19).

Figure 6A.18. Source of Delivery Services by Sector in Rural Areas

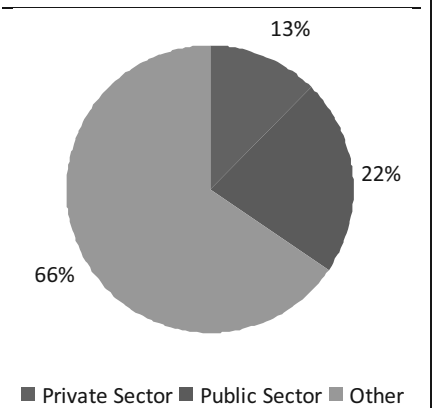
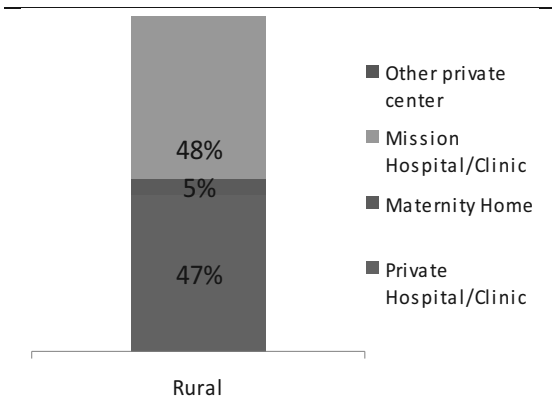


Figure 6A.19. Range of Sector Providers Offering Delivery Services in Rural Areas



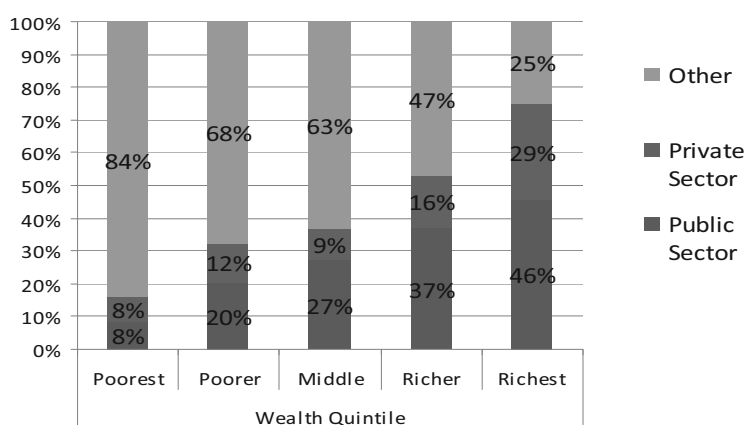
Source: CBS 2003.

Delivery services by wealth quintile and source

There is a strong correlation between wealth quintile and frequency of home deliveries (see Figure 6A.20). The poorer a woman, the more likely she is to deliver at home. Kenyan women in the poorest quintile are three times more likely to deliver at home than those in the wealthiest quintile. Consequently, only a small percentage of the poorest women use public and private institutions. A significant percentage of higher-

income women still deliver at home: 47 percent of richer women and 25 percent of richest women. The public sector is utilized more frequently than the private sector across all income groups. The largest percentage of women who use public sector facilities for delivery are those from the wealthiest quintile (37 percent richer and 46 percent richest), thereby benefitting from government subsidies.

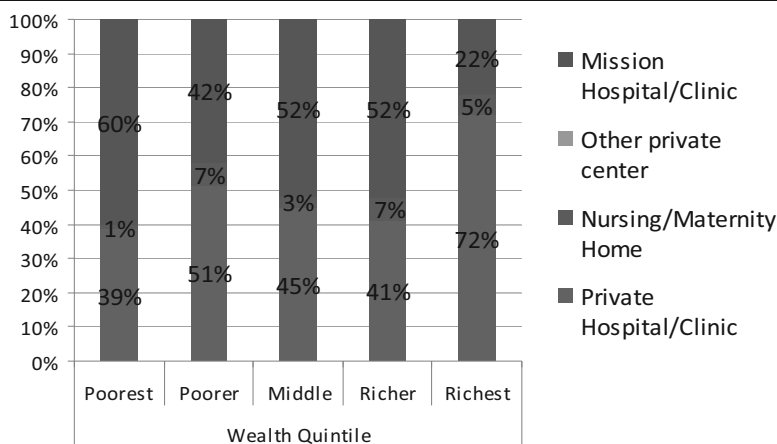
Figure 6A.20. Delivery Services by Wealth Quintiles and Service



Source: CBS 2003.

Women in the richest quintile who deliver in private facilities are most likely to deliver in a private hospital or clinic (72 percent), while women in the poorest quintile who deliver in private institutions are most likely to deliver in a mission hospital or clinic (60 percent) (Figure 6A.21). Seven percent or less across all income groups go to nursing/maternity homes for deliveries.

Figure 6A.21. Delivery Services by Wealth Quintiles and Private Service Sector



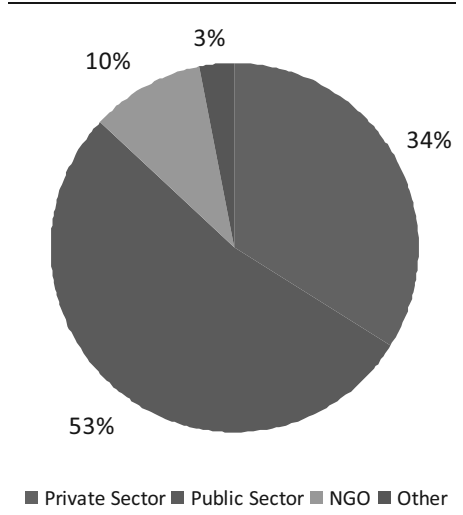
Source: CBS 2003.

2.3. Family planning methods

In 2002, 39 percent of married women ages 15-49 used any method of family planning (CBS 2003). Also among this group, 32 percent used a modern method while 6 percent used a traditional method. The most commonly used modern methods among married women in Kenya are injectables (15 percent) and pills (8 percent). Injectables are also the most commonly used method among sexually active unmarried women (19 percent), and this method has increased while pill use has declined.

As Figure 6A.22 shows, the majority of family planning services are carried out by the public sector (53 percent). The private sector accounts for about a third (34 percent) of family planning service provision, followed by NGOs (10 percent) and other service providers (3 percent).

Figure 6A.22. Family Planning Services by Source (DHS 2003)

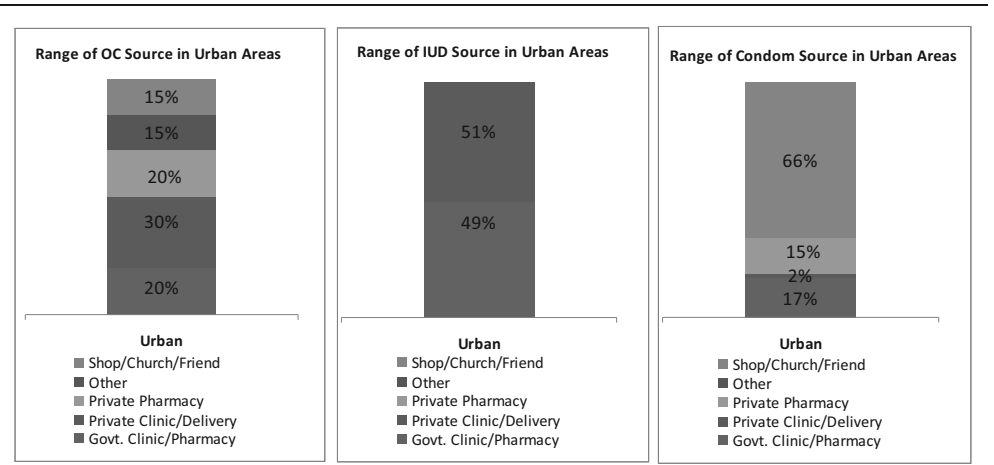


Source: CBS 2003.

Urban areas

The private sector plays an important role in delivering family planning methods in urban areas (Figure 6A.23). The most common source of oral contraceptives (OCs) is private clinics. About half (49 percent) of women using intrauterine devices (IUDs) obtain them from government clinics/pharmacies, and the other half (51 percent) obtain them from private clinics. Condoms are available in a variety of locations; the most common source (66 percent) of condoms is shops/churches/friends.

Figure 6A.23. Use of Private Providers in Urban Areas by Method

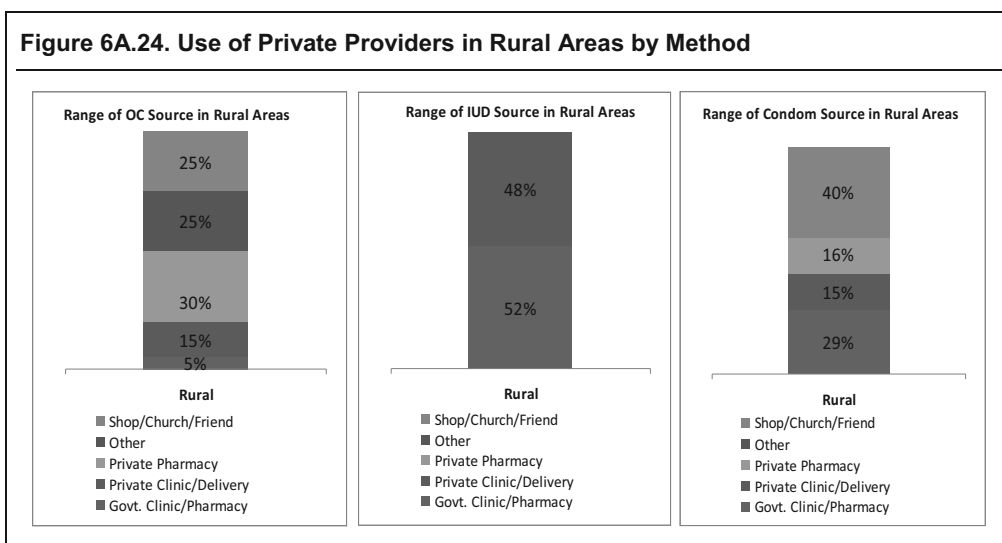


Source: CBS 2003.

Rural areas

The private sector also has a strong presence delivering family planning methods in rural areas (Figure 6A.24). The most common sources of oral contraceptives are private pharmacies (30 percent), followed by government clinics (25 percent), shops/churches/friends (also 25 percent), and private clinics (15 percent). Private sector use for IUDs is similar to that in urban areas: about half (48 percent) of all women who use IUDs get them from private clinics, while 52 percent obtain them from government clinics. Condoms are readily available in a variety of sources, including shops/churches/friends (40 percent), government clinics (29 percent), private pharmacies (16 percent), and private clinics (15 percent).

Figure 6A.24. Use of Private Providers in Rural Areas by Method



Source: CBS 2003.

3. Treatment of Childhood Diarrhea

Diarrhea can cause dehydration, a leading cause of illness and death among children in Kenya. Diarrhea is most common among children 6 to 11 months old. The treatment of childhood diarrhea includes increased fluid intake, preferably through the use of ORS. Approximately 30 percent of children suffering from diarrheal disease are taken to a health care provider (CBS 2003).

Urban areas

As Figures 6A.25 and 6A.26 demonstrate, private providers treat almost half (47 percent) of children with diarrhea and public sector providers treat nearly as much (42 percent). Within the private sector, private hospitals/clinics treat the majority of diarrhea cases (70 percent), followed by private pharmacies (23 percent), and mission hospitals/clinics (7 percent).

Figure 6A.25. Treatment Source for Child's Diarrhea by Sector in Urban Areas

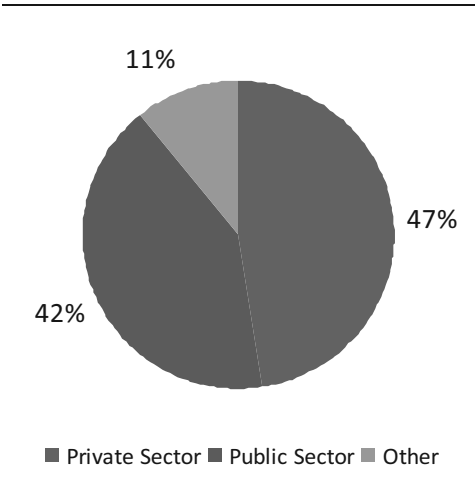
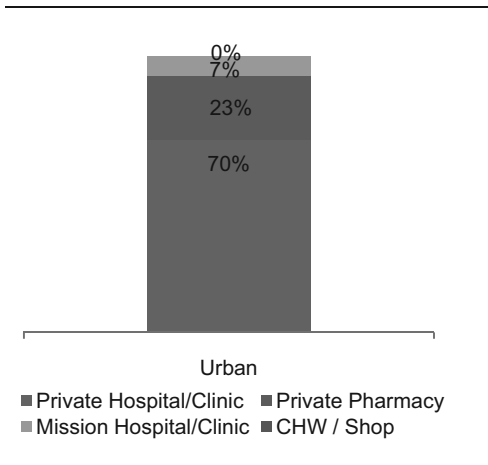


Figure 6A.26. Range of Private Sector Providers Offering Child Diarrheal Treatment Services in Urban Areas



Source: CBS 2003.

Rural areas

In rural areas, public sector providers treat the majority of children’s diarrhea cases (52 percent), followed by private sector providers (35 percent) and other providers (13 percent) (Figure 6A.27). When examining which private sector providers treat diarrhea cases (Figure 6A.28, once again the majority of cases (34 percent) are treated in private hospitals/clinics, followed by mission hospitals/clinics (31 percent). Only 19 percent are treated in private pharmacies, and 15 percent are treated by community health worker/shops.

Figure 6A.27. Treatment Source for Child's Diarrhea by Sector in Rural Areas

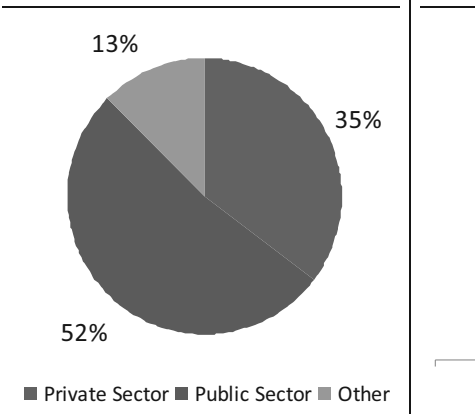
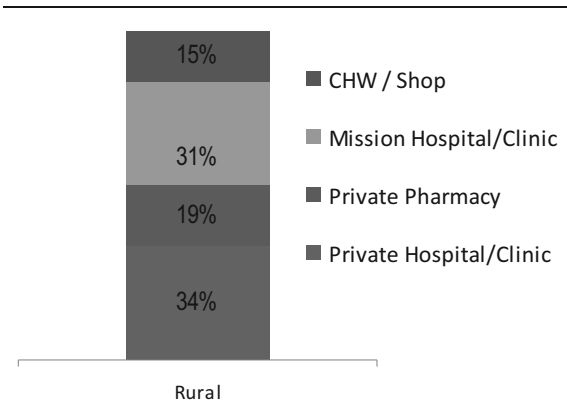


Figure 6A.28. Range of Private Sector Providers Offering Child Diarrheal Treatment Services in Rural Areas



Source: CBS 2003.

Treatment of childhood diarrhea by wealth quintile and service sector

Treatment sources for childhood diarrhea vary slightly across wealth quintiles (see Figure 6A.29). The majority of the richest population quintile uses the private sector (54 percent), while 38 percent in the same income group use the public sector. The middle and richer wealth quintiles, however, rely on the public sector—close to 60 percent compared with approximately a third that utilizes the private sector. The poorer and poorest wealth quintiles rely predominately on the public sector (58 percent and 46 percent respectively) but an important percentage—approximately 33 percent of the poorest and 30 percent among the poorer income groups use the private sector. One-fifth of the poorest seek care among other sources, such as drug sellers and traditional healers.

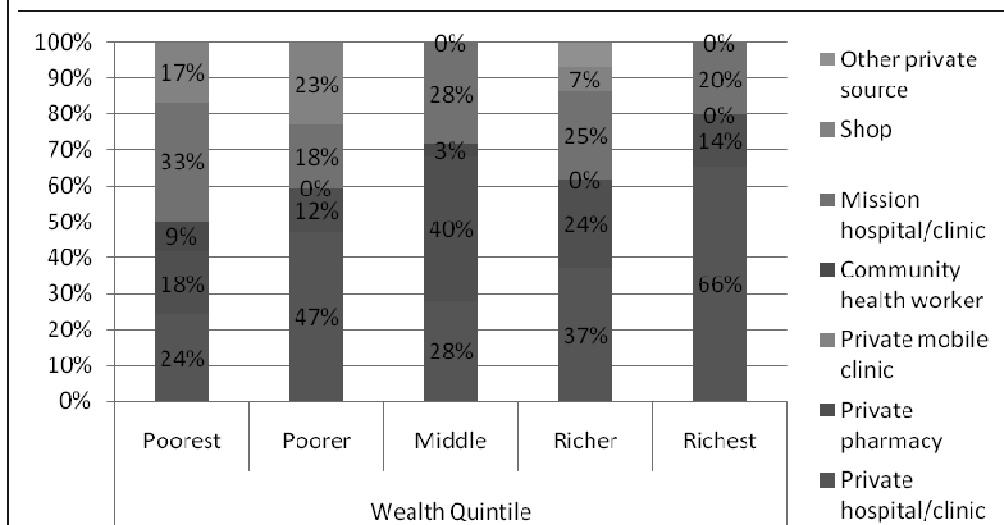
Figure 6A.29. Treatment Source for Child's Diarrhea by Wealth Quintiles and Service Sector



Source: CBS 2003.

There is no common pattern of private sector use in seeking care for children with diarrhea (Figure 6A.30). Among the richest income group, two-thirds seek care at a private hospital or clinic. The other third use a mission hospital or clinic and/or private pharmacy. The same pattern holds true for the richer income groups. It is interesting to note that although mission hospitals and clinics' mandate is to serve the poor, they are also subsidizing families who can afford to pay for the services.

The principal source of care for the middle wealth quintile is a private pharmacy (40 percent) yet 28 percent uses a private and/or mission hospital and another 28 percent use a private clinic.

Figure 6A.30. Treatment Source for Child's Diarrhea by Wealth Quintiles and Private Service Sector Source

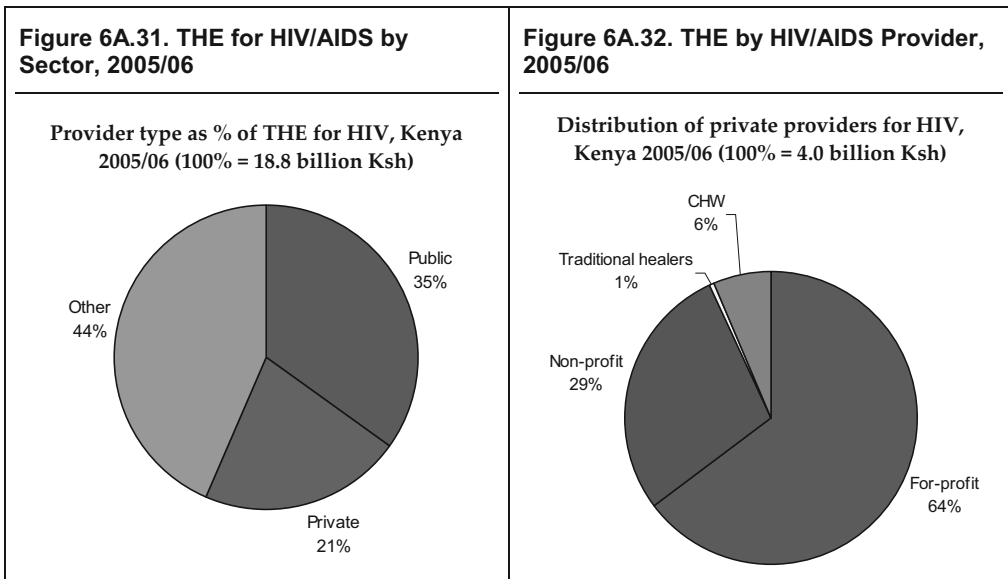
Source: CBS 2003.

Almost half of the poorer income group (47 percent) goes to a private hospital/clinic. The poorest use a wide range of private providers: a third (33 percent) use a mission hospital/clinic, 24 percent go to a private hospital/clinic, 18 percent to a private pharmacy, and 17 percent to a shop.

4. HIV/AIDS

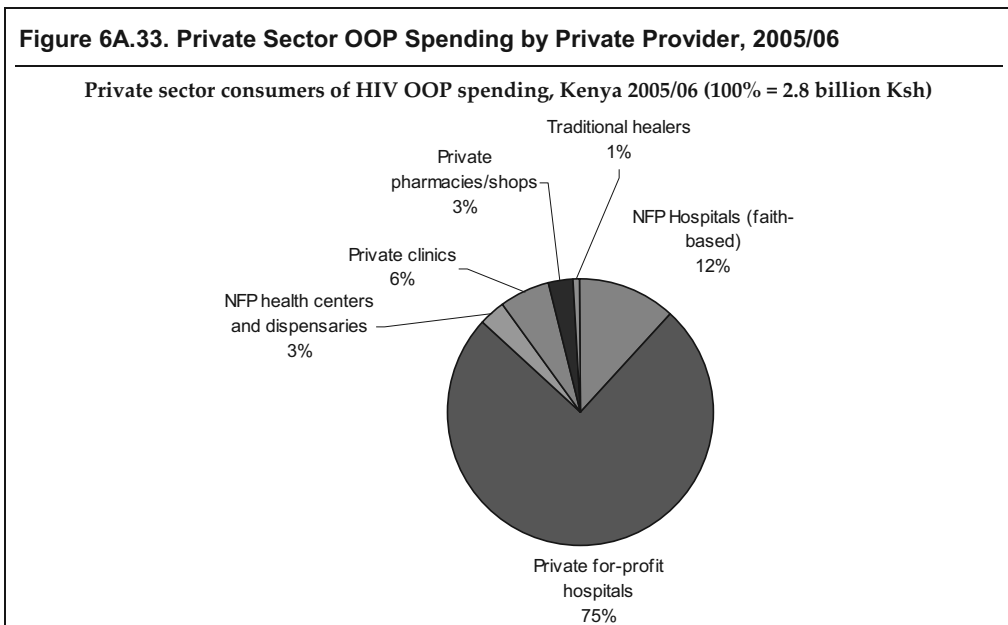
4.1. Total health expenditure on HIV/AIDS

The Kenyan government also collected health expenditure data for the full range of HIV/AIDS services, ranging from public education, HIV/AIDS testing, treatment for opportunistic infections, ART, PMTCT, to palliative care. This section provides an overview of trends in THE and OOP payments on HIV/AIDS in Kenya. In 2005/06, approximately Ksh 18.8 billion was spent on HIV/AIDS; 35 percent of this was expended in the public sector and 21 percent (Ksh 3.9 billion) in the private sector (Figure 6A.31). Almost two-thirds of this amount was spent for services rendered by for-profit providers, while 29 percent went to not-for-profit ones (Figure 6A.32).



Source: NHA 2005/06.

Figure 6A.33 shows the breakdown of consumer (household) spending on HIV/AIDS by different types of private sector providers. Three-quarters paid for private hospital services. Much smaller percentages were expended in other private facilities: 12 percent in not-for-profit hospitals and 6 percent in private clinics, and 3 percent each on private pharmacies/shops and not-for-profit health centers and dispensaries.



Source: NHA 2005/06.

Appendix 7. Naivasha Workshop Report

Public-Private Partnerships in Health Workshop Report Great Rift Valley Lodge, Naivasha April 19th to 22nd 2009

Antecedents

The Kenyan government has launched several initiatives to improve the health and well being of its population. Key among them is the adoption of Vision 2030, covering the time period 2008 to 2030. Vision 2030 is based on three pillars—economic, social and political—in which health plays a central role in the social strategy. To improve Kenyan livelihoods, “the government aims to provide an efficient and high quality health care system with the best standards.” Key features of Vision 2030 include a national health insurance scheme to increase access to health care, a reduced role for the Ministry of Health in service delivery with a greater focus on preventive care, more delegation of authority to provincial and district levels, and promoting more public-private partnerships.

Vision 2030’s core principals are reflected in both the MOMS and MOPHS key planning documents and strategies, such as the ministries’ strategic plans for 2008-2012, and more recently the 2009 Health Financing Strategy. Under the leadership of MOMS and MOPHS, initial discussions have taken place on key components of Vision 2030 in the areas of health insurance and the role of the private health sector. There is a strong interest on the part of all public and private stakeholders in health, including the MOMs and MOPHS, FBOs, NGOs, and commercial, for-profit entities, to play their part in addressing the country’s health priorities. There is also growing recognition that if all sectors work together, they can define how, as an integrated sector, to realize the Vision 2030 goals.

To support the Kenyan government’s initiative to partner with the private health sector to address the most pressing economic and social issues confronting Kenya today, the United States Agency for International Development (USAID) and the World Bank are collaborating in a partnership to produce an assessment of the Kenyan private health sector that will foster dialogue among the key stakeholders through a consultative process.

Workshop Overview

Role of the Steering Committee

The Ministerial Stakeholder Forum (MSF) has been driving Public Private Partnership at the Health Sector level based on the wider Prime Minister’s Round Table meetings with the private sector. The private health sector assessment sponsored by USAID/WB was presented to the MSF, and a decision was made to create an intersectoral Steering Committee to coordinate and plan for a Public Private Partnership Workshop to discuss the findings of the assessment and chart the way forward. The Steering Committee had a time-bound purpose and scope: organize the Naivasha Workshop and ensure proper dissemination of the outcome. All sectors were present in the

Steering Committee and consisted of representatives from the Ministry of Medical Services, Ministry of Sanitation and Public Health, the Private Health Sector in KEPISA and a representative of the Abt team. This makeup ensured balanced representation from both Health Ministries as well as from key stakeholders from the private sector. Tasks included: 1) location and organization of workshop venue and logistics, 2) development of agenda, 3) delineation of workshop participants, and 4) mobilization of participants to attend the workshop.

This Committee played a critical role in the Workshop's success and can serve as model on how to ensure consultation and dialogue between the sectors. The Steering Committee consistently consulted their constituencies in both the public and private sectors to make certain that the participant list was representative, balanced and included key decision-makers from critical organizations in the Kenyan health sector. Moreover, they reviewed draft agendas with their respective communities so that it reflected their expectations and issues. Finally, Steering Committee members used their professional networks and relations to follow up with each participant, motivating each participant to attend the workshop.

Workshop objectives and methodology

The Navaisha Workshop is one of the many activities contemplated to help foster greater dialogue between the public and private sector. The objectives of the Workshop were:

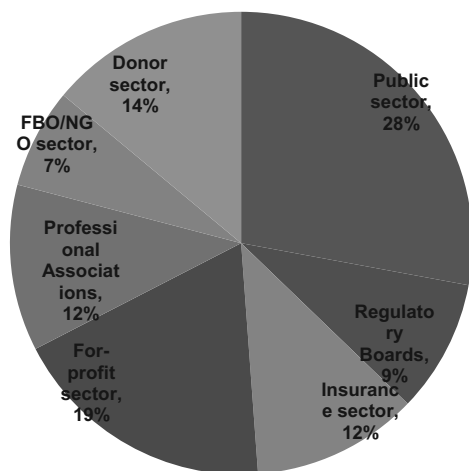
- Provide critical feedback on the private health sector assessment
- Formulate priority recommendations for addressing key health systems issues
- Identify concrete next steps through which the public and private sector can work together to implement the priority recommendations

The Steering Committee, with technical support from the Abt team, designed a workshop agenda and approach that ensured maximum participation and was action-oriented. The technical presentations (four in total) helped frame the discussion around core topic areas related to the private health sector and served as starting points for the working group discussions. To foster discussion and exchange of perspective, the composition of the working groups was carefully balanced to ensure adequate representation of each of the sectors—public, private and FBO/NGO. In addition to the breakout group session, participants had ample opportunity to make comments after each of the technical presentation and at the end of each day during the “wrap-up” session. The working group spent considerable time focusing on recommendations to improve public-private interface in health and on the commitment and actions needed to implement the recommendations.

Participants

High-level government officials as well as prominent business leaders from the private commercial and not-for-profit health sectors participated in the Navaisha Workshop. Moreover, there was a wide and diverse representation of the key actors in Kenyan health sector (see Figure 7A.1), including government, private healthcare providers, regulatory boards and professional associations, pharmaceutical sector, and government and private health insurance. (See Annex A for list of participants.) The

Figure 7A.1. Distribution of Workshop Participants by Sector



Source: Naivasha Workshop Report

high level of donor participation indicated their level of interest and commitment to supporting public-private interactions in the Kenyan health sector. Since no single sector dominated the workshop proceedings, the resultant commitment, recommendations and proposed next steps represent collective views and opinion of most participants.

Expectations

Workshop participants had varied expectations vis-à-vis the objective of the workshop. The public sector hoped to: 1) define a mechanism to better partner with the private sector, 2) exchange of ideas and points of views between the public and the private sectors, and 3) identify quick

wins that the private and public sectors implement together. The private sector, on the other hand, expected: 1) opportunities for both sectors to share and better understand the challenges and constraints facing each sector, 2) areas of consensus and agreement on next steps after the Naivasha Workshop, and 3) integration of the private sectors into policy-making and decision making processes.

Addressing Misperceptions, Building Trust

The first workshop exercise was a mapping of the different sectors' strengths and weakness and exploration of the benefits of partnering. The participants were organized into groups according to sector and were asked to analyze the strengths and weaknesses of the other two sectors. Through this exercise, the workshop participants were able to challenge many of their misperceptions and to have a candid conversation on the beliefs and fears of working with the opposite sector.

As Table 7A.1 illustrates, the public and FBO/NGO sectors listed observations and beliefs commonly held about the private sector: that they only serve the wealthy, that they make excessive profit, that they are unwilling to report to the public sector, etc. Similarly, the private sector reflected widespread views held in other countries about the public sector, alleging inefficient use of resources, lack of leadership, and mistrust of the private sector.

Table 7A.1. Strengths and Weaknesses by Sector

Sector	Strengths	Weaknesses
Public	<ul style="list-style-type: none"> More affordable services Large staff and well trained Ability to bring on board other sectors Governance role for the entire health sector Large infrastructure 	<ul style="list-style-type: none"> Insufficient resources Inefficient use of money and other resources Poor enforcement of policies Donor driven Suspicion of the private sector
Private	<ul style="list-style-type: none"> Profit driven Client/customer oriented Innovation Good management, efficient use of resources and highly productive Highly motivated staff Less bureaucracy Mobilizes own resources 	<ul style="list-style-type: none"> Profit driven Narrow focus: located in urban areas Only serve certain segments of the health market, e.g. wealthy Competitive instead of complementary Do not trust public sector Inconsistent reporting (i.e. do not trust service/consumer statistics),
FBO/NGO	<ul style="list-style-type: none"> Good coverage Strong network Well organized Long standing relationships with the MOH Sustainable programs Good public image 	<ul style="list-style-type: none"> Unpredictable source of funding, less sustainable Pre set objectives Suspicion of private sector and profit motive

Source: Navaisha Summary Report.

The frank discussions during this exercise provided the participants with new insights and a better understanding of the other sectors' perceptive and realities. Ultimately, the participants realized they have more in common than they originally suspected and fewer major disagreements.

In addition, the participants shared their views on the benefits of partnering and were able to reach common ground. They recognized that both the public and private sectors share similar opinions on why it is important to partner. *All agreed that the primary purpose of public private partnerships is to improve the health of poor Kenyans who are not receiving adequate health services.* The participants identified other benefits:

1. Better use of existing resources as well as leveraging additional resources (e.g., staff, facilities, infrastructure, etc.)
2. Greater innovation (in policies, services, technologies) by including private sector expertise and know-how
3. Improved relationships between all the actors in the health sector
4. Better health policies and planning that integrate and reflect the perspectives of the different sectors in health

Box 7A.1 presents additional benefits of tapping into the private health sector as a partner (Navaisha Summary Report).

Box 7A1. Other Benefits of Partnerships

- The private sector plays a large role in financing health.
- When offered a choice, consumers often prefer the private sector.
- The private sector also delivers services for the poor.
- The private sector can increase the scope and scale of services.
- Partnering can help the public sector focus its resources on the neediest.

Source: Navaisha Summary Report.

Challenges to Partnership in the Kenyan Health Sector

The private health sector assessment underscores the many challenges in creating an enabling environment so that the non-government organizations (NGOs), faith-based organizations (FBOs), and commercial entities can fully partner together. Some of the challenges are highlighted below in Table 7A.2 (Refer to Annex B—Technical Presentations).

Table 7A.2. Challenges in partnering with the private sector

Health system area	Challenge
Health financing and insurance	<p>Few private insurers serving only the highest end of the market</p> <p>Poor knowledge and perception of health insurance</p> <p>Weak capacity of the insurance industry to develop and administer appropriate health insurance products</p> <p>Predominately a fee for service mode of provider payments in public and private sector</p> <p>Regulatory reform strong needed to consolidate and grow health insurance market</p>
Quality of private health sector services	<p>Boards lack enforcement capacity to ensure qualified providers and quality services</p> <p>Private health facilities licensing in disarray</p> <p>No accreditation and certification for private facilities and laboratories</p>
Supply chain of private health products	<p>The private sector supply chain is highly fragmented and inefficient resulting in: i) too many suppliers driving price and quality to the bottom; ii) too many drugs and too many poor quality drugs in the marketplace; iii) too many drug retailers creating cut through competition and iv) duplication of efforts in the supply chain.</p> <p>The PPB has a large mandate, insufficient capacity and resources to fulfill it.</p>
Stewardship and governance	<p>Information gap on basic data on the private health sector, business environment and consumer preferences</p> <p>Little or no dialogue between sectors</p> <p>No mechanism for all sectors to participate in health policy and planning</p>

Source: Navaisha Summary Report.

Description of the private health sector

The discussion after the presentation on the public-private mix of health services revealed critical gaps in the data describing the private health sector. All the working groups accepted that the findings were generally accurate, although most felt that the data “underestimated” the private sector contribution for several reasons: 1) statistics on MOH, FBOs and Private Sector facilities appeared understated; 2) the National

Health Accounts may not capture all the private sector finances; and 3) data were lacking on private pharmacies, laboratories, and diagnostic centers such as radiology. The debate about the reliability of the data on the private sector underscored the need for better and additional data collection, including proposals to: 1) develop standard definitions of facility and provider types that would be used in the public, private and NGO sectors, 2) better define data needed for policy and planning, and 3) create simpler mechanisms for the private and FBO/NGO sectors to report to the public sector.

Many workshop participants felt that further study was needed to:

1. Map the health infrastructure for all sectors (number of FBO, private and MOH facilities) in each province to include data on bed capacity, client flow, staffing patterns, and range of services offered for each facility mapped.
2. Analyze human resource supply and demand from a system-wide perspective that establishes the current stock of health personnel by cadre and by sector. In addition, this analysis would examine the production of health personnel through the medical education system, both public and private, in relation to future needs.

Supply of health products through private channels

The four working groups agreed that the Private Health Sector Assessment accurately captured the core problems in the Kenyan supply chain for health products. The key points raised by the workshop participants included:

- The need to put more teeth in regulations governing supply. This includes exploring mechanisms to reduce the number of counterfeit drugs in the health supply, enforcing prescription guidelines, etc.
- The need to consolidate and rationalize the pharmaceutical market and supply chain.
- Re-valuing the role of pharmacists and other players in the pharmaceutical sector. A few of the participants passionately described private pharmacists' involvement in improving Kenyan health and the need to better recognize their contribution. Local manufacturing is another group whose potential is not fully understood nor analyzed.
- The need to better clarify the respective scopes, functions, and roles of pharmacist and pharmacist technician.
- The need to continue with reforms of KEMSA that would allow a greater public-private mix to improve performance.

While participants agreed that the PPB should be independent of government, there was less consensus that the National Quality Control Lab and the drug quality function should be separated institutionally from the PPB.

Strategies to improve quality of public and private providers

Workshop participants agreed that there is a need to put more "teeth" into the regulations governing quality. There was general consensus for the proposed regulatory reforms: 1) streamline the Boards' internal disciplinary procedures and create a shared system of hearings, offices, and enforcement attorneys; 2) create a

unified licensing agency for all health service facilities; and 3) test the concept of voluntary accreditation. In fact, many of the recommendations are in line with current regulatory initiatives, such as the review of 1994 health policy framework and Public Health Act and policies governing professional associations.

In addition, the participants developed a list of “quick wins” for the Ministry of Health (or another entity) to take a leadership role in implementing, in consultation with other key stakeholders. The following quick wins can be carried out while major regulatory reforms are underway:

- NHIF and AKI can start linking payment for contracting health services with a set of basic requirements and/or criteria (e.g., ICT & other quality standards).
- MOMS can make mandatory professional indemnity insurance for all health care providers, including those in the public sector.
- MOMS can make mandatory membership of a recognized professional bodies/associations for all healthcare professionals.
- MOPHS can define training and scope of responsibility for auxiliary health workers, as well as the scope of practice for all professional cadres.
- MOMS and MOPHS can develop common ICT standards/protocols for the health sector.

Health financing strategies to increase access to health care

Ministry of Medical Services staff presented the landmark agreements achieved, and an implementation framework for social health and protection strategy (see Annex C). Workshop participants enthusiastically endorsed the principles outlined in the framework; their discussions focused on defining the possible roles for the public and private sector. Discussion centered on 5 core areas: 1) how to improve efficiencies of NHIF; 2) how can private health insurance, including low cost insurance products, complement government’s effort to cover the poor; 3) how can private providers contribute to increasing underserved groups access to services; 4) how can technology lower costs to deliver services; and 5) the need to create laws supporting health insurance.

Emerging consensus on key areas for action and improvement

In addition to dispelling myths, building trust, and reaching common ground on key health areas, the Workshop culminated in three other positive outcomes.

Demonstration of political commitment

Professor Anyang’ Nyong’o sent a clear message to the participants that the Ministry of Medical Services recognizes the importance of dialogue between the government, NGOs/FBOs, and private sector to improve access to and quality of health services. His Honorable Minister also stated that he regarded the Navaisha Workshop as a turning point for the country and challenged the participants to make important decisions that are clear, focused, and time-bound that will ultimately help improve health services in Kenya.

Emerging consensus on what needs to be done

Energized by the Honorable Minister’s call to action, the workshop participants worked across the different sectors to arrive on a preliminary set of recommendations

to present to both Ministries of Health (see Annex D). The recommendations will be further developed in a subsequent workshop in June. The workshop participants also signed a public statement, entitled the Navaisha Declaration (see Annex E), demonstrating their commitment to work together to implement the proposed recommendations and to monitor the progress of the deliverables agreed upon at the workshop.

Advice on how to continue the dialogue process

The workshop participants, pledging to continue the dialogue, mapped out the next steps to create a formal mechanism to bring all the key stakeholders together. The workshop organizers and the Steering Committee are asked to: 1) produce a summary report in 2 weeks, 2) produce a full report in 4 weeks, 3) propose a structure and process to continue the dialogue, and 4) organize the planning workshop for mid-June.

The proposal for a dialogue structure and process focuses on creating an independent, neutral public-private-partnership “unit” or secretariat, comprised of public, private, and FBO/NGO staff, that could possibly be housed at the National Health Insurance Fund. This entity would assist the Ministerial-Stakeholder Forum to convene and inform the different public, private, and FBO stakeholders on the progress on various policy reforms. Additionally, this entity will also oversee the different task force activities working on the various recommendations and action plan, ensure regular communication between the sectors, and monitor progress on implementation of the recommendations. The details for the dialogue process will also be finalized at the June workshop.

Closing Remarks

In addition to the commitment to continue the policy dialogue, workshop participants acknowledged that by working together, there is a greater likelihood of success in improving health for all Kenyans. Participants noted that, as individuals, one may be tempted to focus on one’s own interests or that of one’s organization. However, as health professionals with positions of great responsibility, it is important to keep in mind that many Kenyans suffer from poor health and are unable to access quality, affordable care. Addressing this problem must be the predominant priority and guide all deliberations—current and future—between the public and private sectors. All present also agreed to put aside past misunderstandings and disagreements between various sectors and forge ahead in an atmosphere of mutual respect and acceptance, with their focus firmly set on the greater and higher good of collectively contributing to the betterment of the livelihood of Kenyans.

Annex A: List of Naivasha Workshop participants

#	NAME	POSITION	ORGANIZATION	E-MAIL
1	Hon (Prof) Anyang' Nyong'o	Minister	MOMs	
2	Victor Nyagaya	PA to the Minister	MOMs	
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24	Antony Wanjohi	Prog. Officer	KEPSA	aweru@kpesa.or.ke
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Annex B: Implementation Framework for Social Health Protection Strategy

Goal	Immediate (0-6m)	Short term (1-2 yr)	Medium Term (3-5yr)	Long Term (>5 yr)	Responsible
Achieve universal coverage and social health protection (SHP) a. Expand NHIF coverage and shift to SHP b. Improve private health and other social health insurance systems c. Protect the poor	Revise NHIF Business Plan to increase coverage and shift to SHP Develop systems for OPD benefits Amend NHIF Act (essential provisions)	Phase in OPD benefits and increase benefits package Increase informal sector coverage to at least 20% Improve NHIF governance and maximize on efficiency Change to progressive contributions Develop systems for covering the poor Review NHIF Act (entrench Social Health Protection) Set up Health Insurance Regulatory Board	Increase coverage to informal sector to at least 50% Expand OPD coverage to all contributors Provide benefits package to the poor	Increase coverage to informal sector to at least 80% Introduce structural changes to improve SHP (collection /pooling /purchasing) Channel Tax Funds for health through SHP	MOPHS MOMS /NHIF Board MOF
	Refine tool for indentifying the poor	Abolish and replace user fees in public health centers and dispensaries, and for MDG 4,5 &6 (use HSSF to channel funds) Expand demand side financing (OBA and CBHIS) Create systems for targeting the poor	Introduce equity /and solidarity funds for the poor Contribute premiums for the poor	Expand SHP coverage to the poor	MOMS /NHF Board /MOPHS
Improve Public private partnership	Commission capacity assessment study on public and private health service providers	Develop Public Private Partnerships Strategy for health Strengthen institutional capacity of state and non state health service providers Replace user fees in FBO service providers (include MDG4,5,&6)	Expand benefits package to all providers (who satisfy set standards)	At least 80% services purchased through SHP Deploy full or part time doctors at health centres /dispensaries	MOMS /MOPHS KEPSA /CPHP /HENNET
Improve health regulation and standards	Develop Health Financing policy and strategy Define the benefits package	Cost the Benefits Package Review and harmonise all health legislations Set up quality assessment and accreditation system	Set up Tariffs and Benefits Board Set up Health Services Commission	Regular reviews of benefits package and tariffs Establish Strategic Purchasing Trusts	MOMS /MOPHS
Improve the capacity and quality in the public health system	Map out all providers in the country Gazette rules on construction of new facilities	Grant autonomy to Provincial hospitals Facilitate introduction of new courses on health service management Retrain health services managers Increase tax funding to health Increase human resource capacity	Grant autonomy to selected district hospitals Introduce career structure for health service administrators Devolve health service provision	Appoint trained managers in all hospitals Continue training of health service managers Purchase public services on the basis of Output	MOMS /MOPS /MOE

Annex C: Naivasha Declaration

The Naivasha Declaration on Public Private Partnership in Health

Key stakeholders in the health sector from the public sector including the Ministry of Health and Medical Services, Ministry of Public Health and Sanitation, Ministry of Finance, Ministry of Planning, representatives from the private sector such as Professional and Regulatory bodies, health training institutions, faith-based organizations, and for-profit health providers, and development partners all met in Naivasha from April 19th to 22nd 2009, with the following objectives:

- Provide critical feedback on the private health sector assessment jointly sponsored by the World Bank and USAID
- Formulate priority recommendations for addressing key health systems issues
- Identify concrete next steps through which the public and private sector can work together to implement the priority recommendations

The priority recommendations and next steps are summarized in the attachment to this Declaration. In addition, the participants proclaim publicly:

- The positive spirit, candor and mutual respect shown by all participants during the Naivasha Workshop demonstrate that public private partnerships can develop effective solutions that lead to improvements in the entire health system.
- We strongly urge the government to continue to endorse and support the collaboration of all sectors and stakeholders in the health system to develop health policies that improve the health of all Kenyans.
- We, the partners, including the government of Kenya, private sector entities and faith-based organizations with the support of development partners, are committed to achieving the agreed recommendations outlined in the Naivasha Declaration.
- All the stakeholders will continue to monitor the progress and deliverables that were drawn out of this workshop.

**Agreed on 22nd of April, 2009
at the Great Rift Valley Lodge in Naivasha
by all participants whose names are attached to this Declaration**

Signatures of the Naivasha Declaration

Y.Y. Abdulla Revital Healthcare	Dr. Hellen Mbugua Ministry of Medical Services	Walter O. Oookok KHF/KEPSA
Mahin Abdillahi Kenya Clinical Officer's Association	Prof. Haroun N.K. Mengech Ministry of Medical Services	Titus Osero IRA
Ochieno Fredrick Nursing Council	Dr. Jotham Micheni KNH	Fredrick Osundwa NNAK
Dr. K.K. Gakombe PHP Consortium	Dr. Edwin Muinga PHP Consortium	Daisy Ouya IAVI
Dr. U.N. Ghandhi Kenya Medical Association	A.N Mwando Ministry of Public Health and Sanitation	Francis Otwane Ministry of Medical Services
Dr. S.M. Irungu Ministry of Medical Services	Prof. Richard Muga GLUK	D.K. Ronoh Association of Kenya Insurers
Richard Kerich National Health Insurance Fund	Moses Mwangi Kenya Association of Pharmaceutical Industry	Edward Rukwara AAR Health
Dr. Larry M. Kimani Cosmos Limited	Dr. D.S.K Ngugi PSK	Moses S. Smith Ecumenical Centre for Justice and Peace
Nelson C. Kuria Association of Kenya Insurers	Joseph K. Njagi Ministry of Planning	Mike Terik Xllent/Karishma
Moses C.O. Lorre AKMLSO	Dr. Frank Njenga AAR Health Service	Moses Teti Kenya Pharmacist Association
Joyce Njuguna Ministry of Finance	Dr. J. R. Nyaummah PHP Consortium	Dr. Amit Thakker KHF
John A.M. Maliti PHP Consortium	Dr. Esther Ogara Ministry of Medical Services	Dr. Sam Thenya PHP Consortium
Dr. Lawrence Mbae Catholic Secretariat	Elkana Ongu'ti Ministry of Medical Services	Anthony Weru KEPSA

Development Partners invited:

United Kingdom Department of International Development (Dfid)
Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)
Italian Foreign Assistance (IFA)
United States Agency for International Development(USAID)
The World Bank

Annex D: The Naivasha Workshop Recommendations—April 2009

RECOMMENDATIONS	QUICK WINS (within 6 months)	MEDIUM-TERM (6 to 12 months)	LONG-TERM (over 12 months)	RESPONSIBLE PARTY
Create enabling environment: Establish and sustain public-private dialogue on key issues in the health sector				
Conduct additional research to better understand the size, distribution, human resources and services provided by the private sector	✓			MOMS; MOPHS; KEPSA; Development Partners;
<p>Create a formal PPP structure with a secretariat to continue the dialogue among the key stakeholder groups and to coordinate the implementation of recommendations outlined at Naivasha Workshop</p> <ul style="list-style-type: none"> • Build on existing process and structures to establish a responsive PPP structure that will ensure full representation of all stakeholders. • New structure to coordinate and feed into MSF process and to appoint task forces to address specific issues • The Naivasha Workshop Steering Committee to report to MSF at next meeting in two months on the progress on the PPP dialogue process. 	✓			MOMS, Steering Committee, Development Partners
Develop a private sector policy within the context of the review of the existing national health policy		✓		MOMS; MOPHS; KEPSA; Development Partners;
Improve the supply chain: Strengthen the supply of essential drugs and products through private channels				
Publish the agreed-upon guidelines for parallel importation of drugs in the Kenya Gazette	✓			MOMS
Within context of ongoing review of KEMSA's systems, KEMSA should outsource more of its distribution function to the private sector	✓			MOMS; Steering Committee;
<p>Review and update the Pharmacy and Poisons Act</p> <ul style="list-style-type: none"> • Raise standards for pharmaceutical distributors and wholesalers licenses • Assure minimum margins to catalyze consolidation. • Establish regulations for alternative and informal health care products. 	✓			MOMS, PPB, Professional Associations
<p>Reform the Pharmacy and Poisons Board (PPB) into an independent agency</p> <ul style="list-style-type: none"> • Separate functions so that the Chief Pharmacist of the Government is not the registrar of the PPB. • Make registration of new drugs in Kenya conditional on respective international reference prices & demonstration of public health needs of the country 		✓		MOMS, PPB

RECOMMENDATIONS	QUICK WINS (within 6 months)	MEDIUM-TERM (6 to 12 months)	LONG-TERM (over 12 months)	RESPONSIBLE PARTY
Expand access to health care: Strengthen the quality of care in both the public, private and NGO sectors				
Define training and scope of responsibility for auxiliary health workers as well as the scope of practice for all professional cadres	✓			MOMS; Professional Boards
Make professional indemnity cover mandatory for health care providers, including those in public service.	✓			MOMS; Prof Associations and Regulatory Boards
Develop common ICT standards/protocols for health sector and use data to monitor quality & performance (involve e-health team at MOMs)	✓			MOMS; KEPSA; NHIF
Make membership of recognized professional bodies mandatory for all healthcare professionals.	✓			Prof Associations; Regulatory Boards
Create a unified licensing agency for all health service facilities. (Clarify mandates of existing boards).		✓		MOMS; MOPHS; Regulatory Boards
Create a unified licensing agency for all health training institutions to implement and enforce standards.		✓		MOMS; MOPHS; Min of Education; Regulatory Boards
Strengthen corporate governance of all training institutions to maintain high standards.		✓		Professional Boards, Min of Education; MOMs and MOPHS
Use accreditation process linked to incentives to drive quality and expand services to underserved populations (including accreditation of laboratories and pharmacies)		✓		MOMS; MOPHS; Regulatory Boards; NHIF; Prof Associations
Scale up Health Management training for providers and health managers and establish criteria and qualifications needed for hospital administrators in both public and private sectors	✓			MOMS; MOPHS; Regulatory Boards; Training institutions; KEPSA

RECOMMENDATIONS	QUICK WINS (within 6 months)	MEDIUM-TERM (6 to 12 months)	LONG-TERM (over 12 months)	RESPONSIBLE PARTY
Mobilize additional resources and Create more equitable financing of health services and products				
Group endorsed all the recommendations in the ongoing healthcare financing matrix. Review the NHIF business plan to ensure that it is responsive to the needs of contributors and has adequate resources for planned expansion of benefits to contributors.	✓			MOMS; Min of Finance
Ensure that both Insurers and providers focus on their core mandates to avoid conflict of interest and enhance accountability. Resolve the issue of provider based plans within the broader context of risk pooling.	✓			MOMS; NHIF; IRA
Set up a specialized health insurance unit to regulate the sector within IRA supported by PPP forum with the mandate to regulate both public and private insurance.		✓		PPP Steering Committee; IRA;
NHIF to explore sub-contracting out to the private sector non-core functions such as accreditation and claims administration.		✓		MOMS; NHIF
Encourage Private insurance to develop micro-insurance to increase coverage of the lower income segments.		✓		IRA; Private insurers
Explore innovative ways of increasing health financing for the poor such as “the health shilling” and establish more opportunities for lending for private investment in health on more affordable terms.		✓		Min of Finance; MOMS; Private insurers; Bankers; Development partners
Promote development of complementary private health insurance policies in the country and use the private sector to market NHIF policies to risk pools.		✓		IRA; Private insurers; NHIF; KEPSA

Appendix 8. Second PPP Workshop: Building a Roadmap for Health PPPs in Kenya (follow-up to Naivasha workshop)

Holiday Inn
Nairobi, Kenya
June 25 and 26, 2009

1.0. Introduction Workshop Overview

At the Navaisha Workshop, Prof. Anyang' Nyong'o earnestly urged the workshop participants to identify policy priorities and actions that will foster greater public-private engagement. He also encouraged the participants to continue the momentum created at the Naivaisha Workshop by focusing on recommendations and actions that will yield visible results public-private partnerships (PPPs) in a short time period.

A smaller, yet representative, group of the participants from the Naivasha Workshop reconvened a two-day workshop to build a "roadmap" for PPPs in health. The meeting—entitled *Building a Roadmap for Health PPPs in Kenya*—was held on June 25 and 26, 2009 at the Holiday Inn in Nairobi, Kenya. (Please refer Annex A for a copy of the Workshop Agenda.) The purpose of the workshop was three-fold:

- Prioritize the Navaisha Workshop recommendations and reach agreement on policy priorities
- Develop action plans to implement the policy priorities (PPP Roadmap)
- Define the PPP structure and dialogue process to sustain the momentum created at Naivasha

There was balanced representation and participation from the *all* key sectors in health: i) public sector including representatives from MOMS/MOPHS, ii) private, for-profit sector and iii) FBO/NGO sector. The Nairobi Workshop had stronger and consistent representation from the FBO/NGOs compared to the Naivasha Workshop. And the regulatory bodies were present in the PPP process for the first time. As a result, both of these key stakeholder groups were successfully integrated into the PPP dialogue. Also of note was the high-level representation from MOPHS; the Minister from MOPHS opened this workshop.

In the two days, the main achievements included participants:

1. reaching consensus on priority policies and PPPs and action plan ("roadmap") to implement them;
2. defining the PPP Council and actions to institutionalize it; and
3. recommending a program of activities to sustain a dialogue process between the key stakeholders

2.0. Background

The Navaisha Workshop (held April 19 through 22, 2009, at the Great Rift Valley Lodge) launched a ground-breaking collaboration between the Kenyan public and private sectors in health. High-level government officials as well as prominent business leaders from the private and not-for profit health sectors participated in the Navaisha Workshop. Moreover, there was wide and diverse representation of the key actors in Kenyan health sector: government and private sector leaders, public and private healthcare providers, regulatory boards and professional associations, pharmaceutical sector, and government and private health insurance.

Through the course of two and a half days, the workshop participants achieved many significant results that laid the groundwork for a productive dialogue and inclusive participation in future collaborations between the public and private sectors in the policy and planning process. The achievements included:

- **Dispelled myths and built trust:** Participants frankly discussed the different sectors' strengths and weakness and explored the benefits of partnering, realizing they have more in common than they originally suspected and fewer major disagreements.
- **Reached common ground:** Both participants from the public and private sectors shared similar opinions on the importance of partnering and agreed the primary purpose of public private partnerships is to improve the health of poor Kenyans who are not receiving adequate health services.
- **Demonstrated political commitment:** MOMs acknowledged the importance of and need for dialogue between all sectors and regarded the Navaisha Workshop as a turning point for the country.
- **Emerging consensus on what needs to be done:** Workshop participants agreed on a preliminary set of recommendations to present to both Ministries of Health and signed a public statement—entitled the Navaisha Declaration—demonstrating their commitment to work together.
- **Concrete next steps:** Pledging to continue the dialogue, the participants agreed to meet in June to prioritize the Navaisha recommendations and to propose a structure and process to continue the PPP dialogue.

The United States Agency for International Development (USAID) and the World Bank are collaborating to facilitate this growing dialogue. The partnership produced an assessment of the Kenyan private health sector that has been used to initiate a dialogue among the key stakeholders, including the Navaisha and Nairobi Workshops.

The Navaisha Workshop prompted a flurry of activities leading up to and in preparation for the June Workshop at the Nairobi Workshop at the Holiday Inn. The Steering Committee sponsored a debriefing with the MOMS Minister and Permanent Secretary on June 12th. MOMS expressed full support for the new PPP initiatives and urged all players to maintain the momentum created at Navaisha. They also underscored the importance and urgency of institutionalizing the PPP process and structure, offering to “gazette” the PPP process. They further admonished that the participants at the June workshop to reach agreement on the details of the PPP

structure, its participation and where it will be housed. Both high-level officials from MOMS agreed to continue supporting of this initiative.

Box A8.1. KEPSA Response

- Free markets are very important for the private sector, including the concept of choice.
- Mandatory membership to professional associations as proposed in Naivasha might be counterproductive.
- The private sector is concerned about ideas or attempts to control prices. Price controls will lead to shortage of goods and services.
- The market should be allowed to decide the number of registered drugs subject to all the players meeting revamped and strict entry criteria.
- Innovative health insurance models are required to reduce cost of entry.
- The private sector supports mixed financing and complementary roles with NHIF but would not like to play second fiddle.
- Most regulations in the health sector needs streamlining and KEPSA has prepared a three page document with its recommendations.

In addition, KEPSA sponsored a series of email chain discussions and meetings with its membership to arrive at a list of recommendations and inputs on the Naivasha Recommendations as reflected in Text Box One. The inputs were offered in the context and new spirit of Private Public Partnerships in health. But KEPSA also stressed that fair-play and the wider public good should be the basis of the partnerships. Also, KEPSA cautioned that all players—public, for-private and not-for-profit—should strive to work towards the common good and set aside sector and/or individual interests.

3.0. Highlights from Opening Speech by Permanent Secretary, Mr. Mark Bor

To demonstrate unity in their support of the PPP process, the Permanent Secretary Mark Bor inaugurated the Nairobi workshop. During his welcome address, he not only declared his support of the partnering with the private sector but he also offered concrete areas in which MOPHS is seeking private sector participation. Key highlights from his speech include:

- The government recognizes the complementary role played by the private sector.
- There is need to discuss on how the two sectors can work together in a better way.
- Vision 2030 sees health as a major part in it social pillar and delineates several strategies such as introduction of social health insurance, increasing access to care, delinking MOH from provision of services, devolving authority to local health authorities and *fostering partnerships with the private sector in both financing and provision of healthcare*. The various health sector strategic plans also promote partnerships between the private and public sectors.
- The biggest challenge is implementation of these noble ideas. There is significant variation between policy, strategy and action).

- MOPHS has experience in PPPs. An example of a PPP that has worked is the MOU with FBO facilities to provide staff and essential supplies.
- The output of the second workshop should include: (i) a time bound PPP road-map with priorities, (ii) a dialogue process, and (iii) a list of resources and TA needed to carry forward the PPP.

Box A8.2. MOPHS proposals for PPPs

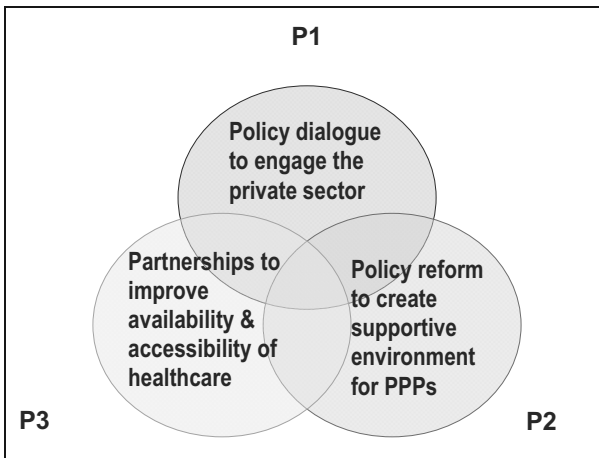
- CDF funds have been used to construct over 800 primary health facilities countrywide and there is a need for partnership with the private sector to help manage and operate these clinics
- Health Sector Services Fund (MOPHS) at community level

4.0. Prioritization of Naivasha Workshop Recommendations

One of the challenges in PPP dialogue is the confusion surrounding what is a PPP. ILO defines a PPP as “an institutional relationship between the state and the private profit and/or the private non-profit sectors where the different public and private actors jointly participate in defining objectives, methods and implementation of an agreement of cooperation.” Although this definition captures how the different actors will work

together in a PPP, it is not helpful in defining the range and levels of PPPs.

The workshop participants developed their own working definition of PPPs called P “3” (or P “cubed”). The graph to the left illustrates, there are three levels of PPPs. The first level—**P1**—focuses on the types of activities that bring together all the key stakeholders in a dialogue process to discuss and identify areas of common interest. The second level—**P2**—



centers on the policy reforms needed to create an enabling environment for PPPs to thrive. Finally, **P3** refers to concrete partnerships between multiple actors that will help address the key health issues in Kenya by improving access and removing economic barriers to health services and products.

A review of the 22 Naivasha Workshop recommendations revealed that the majority fell into P2 (68% or 15 recommendations), compared to 10% (2 recommendations) in P1 and 23% (5 recommendations) in P3. The participants first agreed that 22 was an unrealistic number of policies and agreed to reduce the number: 4 to 5. Moreover, the group recognized that most of the recommendations were policy-oriented and run the risk of taking too many years to produce results.

Although all participants agreed that addressing the policy constraints to PPPs is important, they stated that only focusing on P1-and P2-type of PPPs is not necessarily the type of partnerships of most interest to the private sector—particularly the private-for-profit sector. Therefore, the participants agreed to strike a balance between the three levels and add more “P3” type partnerships to the mix. Also, the workshop participants recognized that including P3-type partnerships will also create a greater likelihood of some “quick wins” when compared to the policy types of PPPs.

In addition, the workshop participants agreed that priorities should be more specific and focus on the PPPs that have the necessary resources (technical expertise, staff, financial, and political) for implementation and can be achieved in a realistic (one year) timeframe. Table A8.1 identifies the 6 PPP priorities for the next year.

4.1.P1—Policy dialogue to engage and interact with private health sector

Table A8.1. PPP Priorities

PPP Framework	Proposed Prioritizations
P1 Policy dialogue to engage the private sector	<ul style="list-style-type: none"> ▪ Institutionalize the PPP Health Council into a formal entity that represents key groups in the health sector in all policy health forums ▪ Strengthen government’s stewardship capacity to engage and interact with the private sector
P2 Policy reforms to create an enabling environment for PPPs	<ul style="list-style-type: none"> ▪ Accelerate the review of the National Health Policy framework to integrate a PPP perspective ▪ Review, harmonize and consolidate key Health Acts , with a focus on reforming healthcare professionals, facility and medical training licensing
P3 Partnerships to improve availability and accessibility of healthcare	<ul style="list-style-type: none"> ▪ Establish a PPP Framework to guide P3 initiatives ▪ Analyze the healthcare gaps to identify opportunities to implement 2 to 3 PPPs ▪ Integrate private sector into NHIF 3 pilots in financing of out patient services and introduce low cost insurance products through a PPP with private health insurance

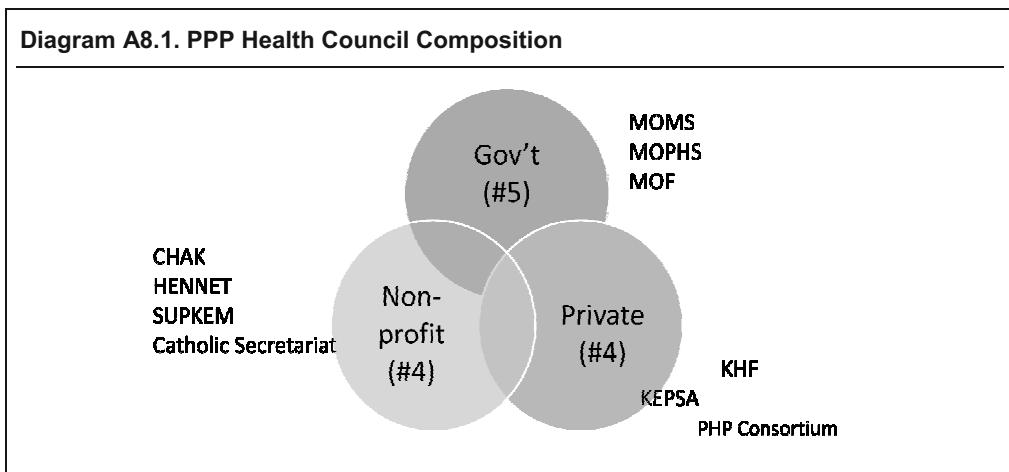
Recommendation #1—Establish PPP Health Council and formalize a PPP dialogue process

The Workshop Participants strongly agreed on the need to institutionalize and legalize an entity that would equally represent all the key health stakeholders in a formal dialogue process on PPPs. As per the recommendations made by the MOMS Minister and PS in the last debriefing, the participants propose “gazetting” the PPP Health Council so that it will remain intact under different political administrations. Ideally, the gazette will be introduced and signed by the two Ministers. But if this is not possible, then the participants suggest a single signature will suffice. To maintain momentum, the participants strongly recommend the current Steering Committee proceed with all necessary steps to establish the PPP Health Council while at the same time securing the gazette. The Steering Committee will remain in place until the 1st meeting to officially create and launch the PPP Health Council meeting. (The Steering Committee currently consists of three representatives from MOMS, two from MOMPMS, two from KEPHSA, and one from FBO sector.)

Name: The participants agreed on its name—*the PPP Health Council*—and that the Steering Committee will disband once the PPP Health Council is constituted.

Composition: Diagram A8.1 illustrates the consensus on the number of participants by sector for the PPP Health Council. The group strived to keep the numbers manageable (13 members to start with) and identified government, for-profit, and the FBOs-NGOs as the three core groups representing the health sector. The participants also identified the different organizations and institutions to represent each of the core sectors, as indicated in Graph One. It is important to note that a representative from a key government agency—the Ministry of Planning—is represented in MOMS and MOPHS as the MOP staff are seconded within these two ministries.

Diagram A8.1. PPP Health Council Composition



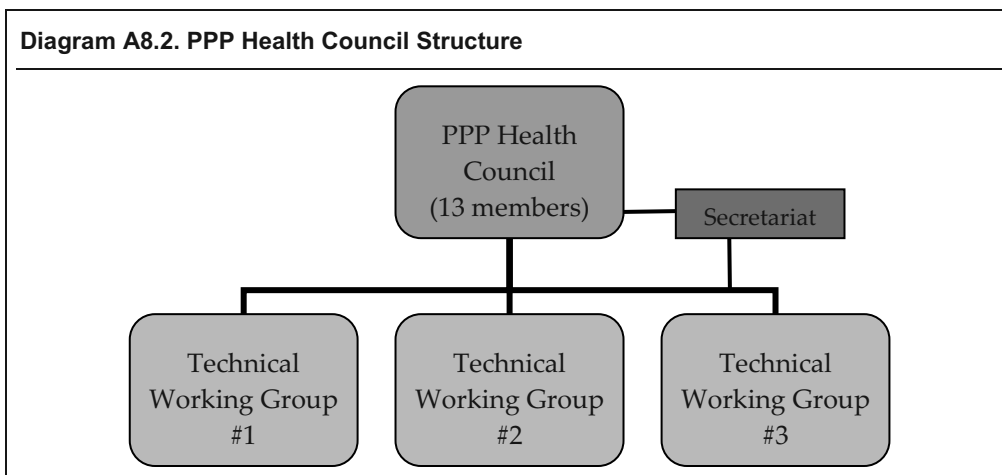
Each subsector will be responsible for nominating their representatives. For the government it is important to ensure that planning section in MOH is included. A write up on the profile of the required representatives (caliber and qualities) will be prepared by the interim team to guide each sector in selecting their respective representatives. The profile should form part of the sector briefing to be done by each sector representative in the workshop/steering team (KEPSA, FBO, NGO). A special briefing breakfast for the Ministers will be done preferably next week.

In addition, the participants proposed including the “consumer voice” in the Council. Discussions revealed, however, that it would difficult to achieve because there are no organizations representing the consumer perspective in health care. Although it is important to include the client perspective, members agreed that may not be possible to do now. In the meanwhile, the participants acknowledged that there is a wealth of information collected by the private and donor sectors on consumers (e.g., market research, consumer research, etc.) that can be used to help integrate consumer’s voice in the Council.

Structure: Diagram A8.2 provides a structure to help the PPP Health Council work to realize its roles and responsibilities and to carry out its activities. The thirteen members sit on the Council in a voluntary capacity and represent their organization and sector’s

interests. The PPP Health Council will create a secretariat to support both the Council members and Technical Working Groups to carry out their workplan. At this point, the group contemplate hiring an administrative staff person who will be the only full time person working in the Secretariat. The Secretariat can reside in any of the participating Council member's offices. The Italian Cooperation representative reiterated their support and indicated they have resources to support an administrative staff person and have also created and equipped office space at the NHIF that can be used by the Secretariat.

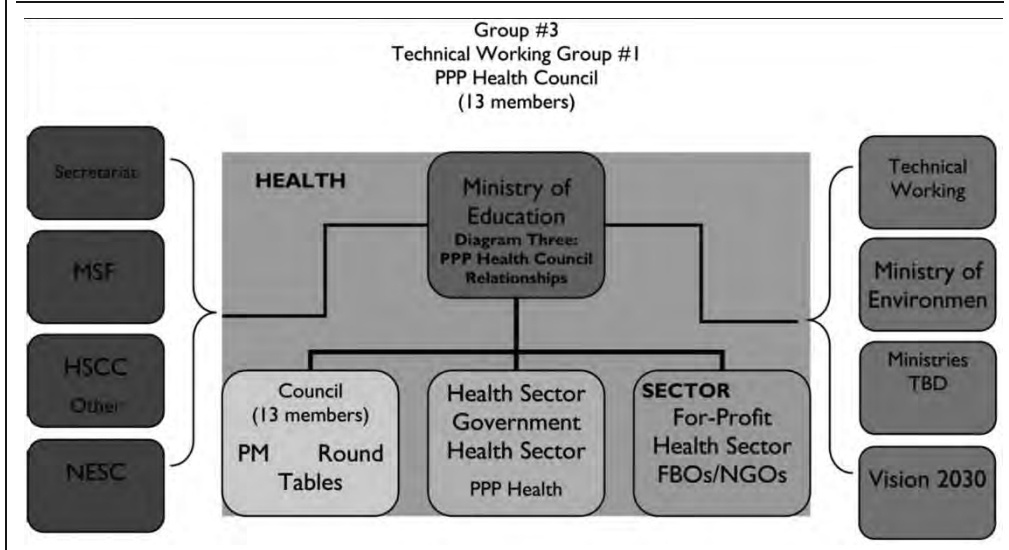
Diagram A8.2. PPP Health Council Structure



The Council will have the authority to form technical working groups based on its workplan of activities. The technical working groups will afford the Council many opportunities to not only tap into their own organization's staff and expertise but also other technical experts within their sector.

Relations in health sector: Clearly the PPP Health Council does not operate in a vacuum. The Workshop participants also discussed how the Council will interact with and represent their interests and priorities in a variety of policy forms (see Diagram A8.3). On one hand, the PPP Health Council squarely sits within the health sector and is accountable to and represents the different stakeholders and organizations in health. Moreover, the Council will need to link to important policy initiatives within the health sector, such as health financing strategy.

On the other hand, the Council will need to build on and link to other existing policy forums related to health such as the Prime Ministers Round Table discussions, the Ministerial Stakeholder Forum, Health Sector Coordinating Committee, and National Economic & Social Council (NESC). One of the important policy outcomes in linking to these efforts will be the insertion of the private health sector perspective into these dialogue processes; in particular, it will be critical in HSCC forum to integrate the commercial health sector as a member in the SWAP.

Diagram A8.3. PPP Health Council Relationships

Also, the PPP Health Council will be able to link an integrated health sector approach to other government sectors related to health, such as education, environment, agriculture, veterinary, housing and others. The participants agreed that one of the first tasks of the newly formed PPP Health Council will be to identify the key policy initiatives and governmental agencies and to define the nature the Councils interactions with them.

Functions: The participants identified some preliminary functions of the PPP Health Council but once again, agreed that defining the Councils' functions will be one its first tasks. Below is a preliminary proposal of roles and responsibilities for the Council.

- Define guiding principles for PPPs and set priorities for PPPs (P3-type)
- Coordinate PPPs (P3 level) and other policy related initiatives (P2) between the sectors
- Represent constituency in dialogue process (P1)
- Share information among the sectors
- Monitor progress of the policy reforms (P2) and health partnerships (P3) underway

Activities: Many of the activities discussed during the workshop will become part of the Council's first year workplan, such as defining a dialogue process that will systematically involve for-profit and not-for-profit sectors, spearheading the policy review process, or drafting PPP Guiding Principles. Please refer to the PPP Roadmap for some of the preliminary suggestions discussed at the workshop.

Recommendation #2—Strengthen government capacity to engage and interact with the private sector

There was a lively discussion on the differences and/or similarities between the proposed PPP Health Council and the emerging trend in PPP Units housed in Ministries of Health or Ministry of Finance in African countries. Table A8.2 provides a comparison between these two types of initiatives. Although these two entities are quite different, they serve different and complementary functions that together can help PPPs be a success.

Table A8.2. Comparison between PPP Council and PPP Units within MOH/MOF

PPP, multi-sectoral initiatives	PPP Units (within MOHs/MOF)
<ul style="list-style-type: none"> ▪ Define guiding principles for PPPs and set priorities for PPPs (P3 type) ▪ Coordinate PPPs (P3 level) and other policy related initiatives (P2) between the sectors ▪ Represent constituency in dialogue process (P1) ▪ Share information among the sectors ▪ Monitor progress of the policy reforms (P2) and health partnerships (P3) underway 	<ul style="list-style-type: none"> ▪ Knowledge/Information role (i) repository of information on PPPs in health and (ii) PPP tools for MOH staff ▪ Strategic advice for MOH (i) conduct sector analysis, (ii) scope out PPP opportunities and (iii) strengthen PP interface ▪ TA and implementation support for MOH to implement PPPs (i) design, (ii) oversight, (iii) M&E

The private sector and FBO/NGO participants stressed the importance of having a centralized group within MOMS/MOPHS who could be their point of contact, their source of information on PPPs and eventually, engage and/or transact with. The MOMS/MOHPS staff indicated the need to build the internal capacity and systems to work with the private sector. As a result, the workshop participants agreed on the need to have both a PPP Health Council and a PPP unit within MOMS/MOPHS and recommended to build the government capacity to work with the private sector.

Due to time constraints, the participants did not have time to fully discuss this policy recommendation. Two key points emerged, however: 1) IFA has funds to support the creation of a PPP Unit, and 2) there is a lack of political support to proceed with this effort by MOMS/MOPHS.

4.2. P2—Policy reforms to create an enabling environment for PPPs

Recommendation #1: Accelerate the review of the National Health Policy framework

The national health policy of 1994 needs review and update to make it relevant to current challenges and realities. Key objective in the Public Health Act and Health Policy Framework is to recognize the existence of the private health sector.

Mr. Onguti, MOMS's Planning, provided an update on the Health Policy and Health Policy Frameworks review. He indicated that some preparatory and planning work for the review of the Health Policy Frameworks has already been done. MOMS has created working forums and task groups but they have not commenced work. Mr. Onguti agrees that a consultative process is needed and agrees to the parallel review process and initiation meeting proposed. He expects the timeline for this process is between one to one and half years (need to harmonize this with the 8 months envisaged in the workshop).

Recommendation #2: Review and harmonize the Health and other related Acts to integrate a PPP perspective

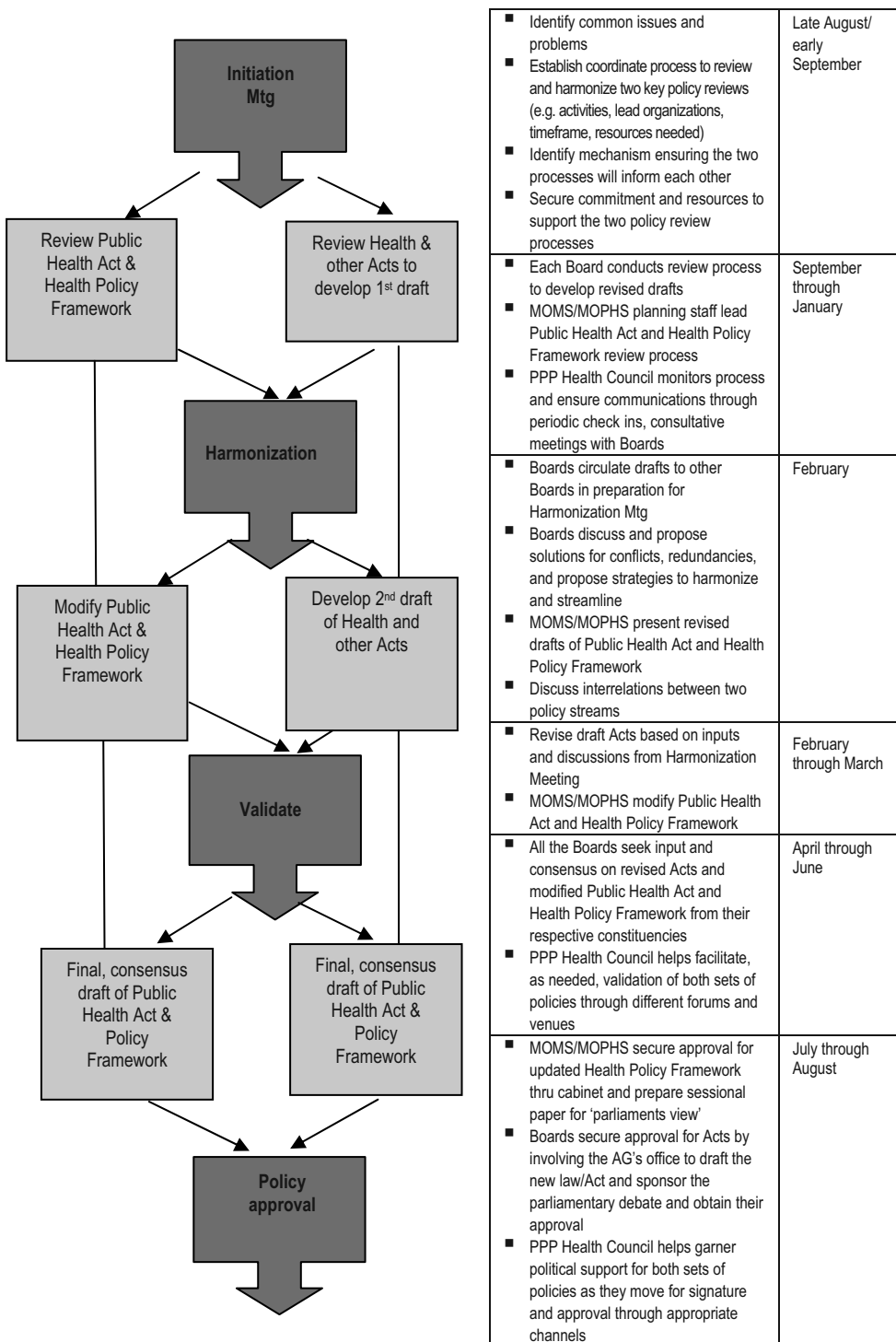
There was a strong representation from many Boards and Council (See Annex B-Participants) and they shared the multiple, on-going efforts to address the contradictions and redundancies in the current Acts (see Annex C for a summary of their presentations). Their presentations quickly revealed that: i) there is no coordination between the different review processes, ii) there are many inconsistencies and conflicts between the different Acts that create barriers to private sector participation, and iii) there is no common discussion on mechanisms and processes to harmonize the review of different Acts.

All the Boards agreed on the need to review the relevant Health Acts to make them more relevant to current needs, to harmonize them to avoid conflict and increase efficiency of regulation. They also agreed on the need to synchronize these disparate efforts through a broad based reform of all the regulatory boards in health. Each Board would be empowered to lead and facilitate a review of their Act while simultaneously coordinating with the other Boards identify areas and mechanisms to harmonize the Acts. This reform process would be all inclusive, including 1) MOMS/MOPHS, 2) Boards and Councils, 3) Professional Associations, 4) Medical education community, 5) FBO/NGOs, 6) private sector. In addition, the development partners should be brought on board to provide the necessary budgetary and technical assistance needed to carry out this reform process.

Participants stressed that key words for the health Acts is *review, harmonize and consolidate*. Moreover, the review process should not be limited to 17 Acts but instead, be based on identifying all the health and health related Acts (which maybe close to 25), and prioritizing them to remain focused. Many stressed the need to include the review of the NHIF Act as a priority. Others proposed considering the KEMSA legal notice and possible convert it into an Act.

Parallel Review Processes: The workshop participants suggested creating a parallel review in which both levels of policies are undertaken at the same time and brought together at key juncture to ensure that they are coordinated and relate to each other (See Diagram A8.4). All agreed the PPP Health Council is the correct vehicle to take responsibility and monitor the implementation of the two policy review processes. The participants suggested several mechanisms and/or approaches to help harmonize the Acts, including an umbrella regulatory body (and others emerged as recommendations at Naivasha such as unified licensing Board), will be considered as part of the discussion between the regulatory bodies on how to best harmonize their functions and operations.

Diagram A8.4. Parallel Policy Review Process



The general view is that technical work and stakeholder consultations can be completed within 8 months but the final stages that involve cabinet and parliament are unpredictable and may therefore take longer. Also, many expressed concern that even though all acknowledge the urgency to conduct both of these policy reviews, there has been little or no leadership to undertake and follow-through on these efforts to update and harmonize the laws. Without leadership and political commitment, the consultation process may languish. Others acknowledge there will be need for lobbying to ensure the policy approval process is completed in reasonable time.

4.3. P3—Partnerships to increase access to and affordability of healthcare

Recommendation #1—Establish PPP Framework to guide PPPs

The first priority is the PPP guidelines/principles to guide P3 level partnerships. The PPP Framework will provide the philosophy and vision of partnerships in health along with guiding principles governing the identification and selections of PPPs. There will also be a Code of Conduct assisting the partnerships in the design of the PPPs. Given there exists several versions of country PPP Frameworks and Guiding Principles, the participants believe this is an area that they can produce a “quick win.” They outlined the following steps:

1. Abt team will send copies of different country PPP Policies, Frameworks, etc with some analysis and guidance on how to adapt them to the Kenyan context
2. Steering Committee will develop a draft that will be widely circulated for review
3. Steering Committee will meet on July 14th to review the draft and comments received
4. Steering Committee will distribute updated versions for comments
5. Steering Committee will finalize on/around August 1

Recommendation #2—Analyze healthcare gaps to identify opportunities to implement 2 to 3 PPPs

The second priority is to identify opportunities for P3 level partnerships. One of the first steps in this process will be to make an inventory of existing opportunities and show possible linkages. The inventory will be based on the secondary analysis on key health markets and opportunities identified in the PHSA report. Some of the opportunities mentioned include Community Strategy for health, KEMSA, NHIF, PEPFAR, Global Fund, OBA, Private Insurance Initiatives on low income insurance etc.

The Steering Committee will convene a meeting in September, 2009, of interested stakeholders to review the data and inventory of opportunities to identify two to three concrete P3 level partnerships. At this time, they may also identify some additional work to expand and complete the picture for PPPs.

Recommendation #3—Integrate PPPs into NHIF pilot financing of out-patient services and introduce low-cost insurance products by private insurance

Representatives from the private health insurance and donor community shared what is going on in the area of **innovative financing including health insurance** in Kenya. There are three to four low-cost insurance examples, primarily supported by the ILO. They include:

- CIC/NHIF/MFI
- BRITA/KTDA
- UAP/Equity Bank
- JAMII BORA (MFI model)

The participants agreed it would be beneficial to hold an information meeting with interested stakeholders. There was a suggestion to contact a regional organization on micro finance/insurance in Africa so they can also share information on other country examples in this area.

Also, the participants identified the **NHIF initiative to pilot financing out-patient care** as an opportunity for PPPs. Professor Nyarango from GTZ provided an update on the NHIF's progress to launch the pilots. According to Professor Nyarango, NHIF is in the process of designing the pilots and expects to launch them in October, 2009. He will circulate a document on healthcare financing delineating the upcoming outpatient services cover pilot and issues of organizational development at NHIF. The outpatient pilot will involve providers from all sectors. Through the course of the discussion, it was clear that to-date, there was no mechanism established yet to involve the private sector in the design and implementation of the NHIF pilots. A team made up of E. Onguti, Kerich and Prof Nyarango was given the task of ensuring all stakeholders were involved in the outpatient plan (a quick win in level P3 PPP).

Professor Nyarango also provided an update on the GTZ sponsored **OBA pilot program in Kenya**. The pilot project provides health services vouchers to poor women (identified with set criteria) in three districts. The vouchers are purchased for Kshs 200 each and covered safe motherhood, family planning and gender violence. Services are provided by accredited public or private provider. NHIF does the accreditation while PWC manages the voucher payments. UNICEF is involved in NE Province with a similar program. GTZ indicated that the Kenyan MOPHS will scale up of the OBA for safe motherhood as voucher program this summer/fall 2009. The participants revealed that a significant portion of the private sector is not aware of the OBA project. It was agreed to: 1) involve private sector representation in the design of the scale-up and 2) thorough a communication strategy, inform private sector provider the opportunity of participating in the OBA project as it scales-up nationwide.

5.0. Aureus Capital

The HIA has launched a new equity vehicle to be implemented through Aureus Capital. In addition to the workshop participants, KHF invited several of its members from the health sector to also attend the evening presentation by Aureus Capital on HIA's equity program. Representatives from Aureus-both headquarters and Nairobi office—attended to present and answer questions. The objective of the presentation was to describe the new HIA equity program and to inform Kenyan private sector representatives that Aureus is taking investment requests now (see Annex E for a copy of the presentation).

6.0. Next Steps and Road Map

The participants identified some immediate next steps to maintain momentum and to initiate some of the activities outlined in the PPP Road Map (see Table A8.3). Activities include:

1. Debrief with Ministers and Permanent Secretaries of both Ministries by the Steering Committee (early July)
2. Arrange for the Steering Committee to present the progress to-date and future direction at the next DPKH meeting (month of July)
3. Donor partners (World Bank, USAID and IFA) to determine how to support the Steering Committee in the next three months to put into place the many policy and PPP activities identified in the Road Map
4. Set up the next Ministerial debriefing to present the workshop findings and to request “gazettement” of PPP Health Council (week of July 14th)
5. Steering Committee, through KEPISA, to set up a meeting with NACPD to present OBA voucher experience in Kenya (month of July)
6. Steering Committee, through Mr. Onguti, to follow up with Mr. Kerich (NHIF) and Prof Nyarango (GTZ) to set up a meeting with private sector stakeholders to involve them in the design of the outpatient plan (month of July)
7. Steering Committee, with assistance from Abt team, will develop first draft of PPP Guiding Principles
8. Steering Committee, with assistance from Abt team, will pull together the inventory of PPP opportunities
9. Steering Committee to secure commitment from donors and own organizations to assume leadership for the policy initiation meeting in September. Based on resource commitments, the Committee should begin planning and preparation for this first meeting.

Table A8.3. DRAFT Private Health Sector Road Map

Goal	Immediate (0-3months)	Short term (3-9 months)	Medium Term (9-18 months)	Resources Available/ Resources Needed	Lead
<p>P1 Establish PPP Health Council and formalize PPP dialogue process</p> <p>Strengthen government capacity to engage and interact with the private sector through a PPP Unit</p>	<ul style="list-style-type: none"> Debrief the 2 Ministers and PS Two Ministers sign gazette creating PPP Health Council Invite organization to become Council members Donors commit to supporting Council Secretariat 	<ul style="list-style-type: none"> Steering Committee transitions to PPP Health Council PPP Health Council convenes 1st meeting to define TORs, governance and Action Plan Council organization commit to participating in Council 	<ul style="list-style-type: none"> Monitor progress of P2 policy review initiative (see below) Monitor new and on-going P3 partnerships, OBA and NHIF Identify P3 partnership opportunities Maintain regular and frequent communications with constituents on progress PPP activities and policy reforms 		Steering Committee >>> PPP Health Council
	<ul style="list-style-type: none"> Debrief 2 Ministers on importance of PPP Unit Secure Ministerial commitment 	<ul style="list-style-type: none"> Identify staff, budget and training needs Define SOW and TORs Donors commit to supporting newly formed PPP Unit 	<ul style="list-style-type: none"> TA to support PPP Unit negotiating two to three P3 partnerships (see below) 	<p>Available resources (i) IFA funds to support PPP Unit</p> <p>Needed resources (i) MOMS/MOPHS approval; (ii) TA and training to constitute and build capacity</p>	MOMS/ MOPHS IFA
<p>P2 Accelerate the review of the National Health Policy Framework to integrate PPP focus</p> <p>Review and harmonize the health Acts</p>	<ul style="list-style-type: none"> Work with Donors to secure needed resources for policy review process Commission staff needed to prepare for Initiation meeting 	<ul style="list-style-type: none"> Council sponsors Initiation Meeting 	<ul style="list-style-type: none"> Convenes Harmonization Meeting Facilitates validation of Acts Creates support needed for approval of all revised Acts and National Health Policy Framework, and other mechanisms to foster harmonization 	<p>Available resources (i) GOK—MOMS/MOPHS political commitment, staff time including AG and MOMS legal staff; (ii) the Public Law institute; (iii) Board commitment and staff</p> <p>Needed resources (i) to hire lawyers to assist Boards to complete the review and validation process; (ii) to hire policy expert(s); and (iii) to finance consultative process</p>	MOMS/ MOPHS PPP Council
<p>P3 Establish a PPP Framework to guide PPPs</p> <p>Analyze healthcare gaps to identify 2-3 pilot PPPs</p> <p>Integrate private sector into NHIF outpatient pilots Introduce 1-2 low-cost insurance products thru a PPP with the private insurance sector</p>	<ul style="list-style-type: none"> Develop draft PPP Guidelines Circulate widely for input Approve PPP Guidelines 	<ul style="list-style-type: none"> Disseminate PPP Guidelines widely to increase awareness and to inform PPP selection and design 	<ul style="list-style-type: none"> PPP Guidelines inform PPP selection and design 	<p>Available resources (i) drafts of PPP Policies and Guidelines from other countries</p> <p>Needed resources (i) TA to develop draft; and (ii) to disseminate</p>	PPP Council
	<ul style="list-style-type: none"> Create inventory of PPPs opportunities Convene meeting to id two to three P3 partnerships Convene meeting to integrate private sector representatives in NHIF pilot design Integrate private sector participation in design and scale up of OBA voucher program 	<ul style="list-style-type: none"> Conduct additional analysis Initiate negotiation to define terms of partnerships Private sector participates in design and as provider NHIF pilot Ensure private sector participation in OBA nationwide scale-up 	<ul style="list-style-type: none"> Initiate P3 partnerships 	<p>Available resources for P3 partnerships (i) USAID funds for P3 partnerships; (ii) private sector own funds; and (iii) IFC Equity Fund</p> <p>Needed resources (i) to conduct additional analysis; (ii) TA to develop draft; (iii) to disseminate</p>	

Annex A: Agenda for June 25 and 26 Workshop at Holiday Inn, Nairobi

Workshop objectives

- Prioritize recommendations and reach agreement on policy priorities
- Develop action plans for the agreed upon policy priorities
- Define the PPP structure and dialogue process

Workshop Agenda—Thursday

Time	Session	Facilitator
08:30 09:30	Welcome (in plenary) Introductions Review of workshop agenda and objectives Stage setting (in plenary) Review of activities to date (sharing from different groups) Summary of Navaisha outcomes	Steering Committee Mark Bor, PS MOPHS Barbara O'Hanlon Steering Committee Nelson Gitonga
09:30 11:00	Priority setting (in plenary) Introduction to P3 Framework Presentation and discussion of proposed priorities	Barbara O'Hanlon Steering Committee
11:00 11:30	Coffee break	
11:30 13:00	P2 Priority setting of Navaisha recommendation Group work to review, prioritize policy recommendations Develop detailed workplan of P2 type recommendations	3 working groups
13:00 14:00	Lunch	
14:00 15:30	P3 Priority setting of Navaisha recommendation Group work to review, prioritize policy recommendations Develop detailed workplan of P3 type recommendations	3 working groups
15:30 16:00	Coffee break	
16:00 17:00	P1 Defining PPP entity and policy dialogue process Discussion on composition, institutional home, scope of PPP Committee Recommendations and plan to create public private entity	Barbara O'Hanlon
17:00 17:15	Wrap up and preview of next day	Barbara O'Hanlon

6:00PM Reception with presentation by Aureos Capital on the Private Equity Fund for Health in Africa

Workshop Agenda—Friday

Time	Session	Facilitator
08:30 9:00	Concluding P1 Defining PPP entity and policy dialogue process	Barbara O'Hanlon
9:00 10:30	Report out on group work for P2 priority recommendations Groups report out Discussion in plenary to reconcile and agree on priorities	Barbara O'Hanlon
10:30 11:00	Coffee break	
11:00 12:30	Report out on group work for P3 priority recommendations Groups report out Discussion in plenary to reconcile and agree on priorities and action plans	Barbara O'Hanlon
12:30 13:00	Next steps and closure Discussion on next steps to seek approval and promote in PPP Roadmap and to implement priority recommendations Wrap up and closure	Barbara O'Hanlon Steering Committee

Annex B: Participant List

HOLIDAY INN PPP WORKSHOP: PARTICIPANTS LIST 25TH & 26TH JUNE 2009		
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Annex C: Summary of Board/Council Activities to Update Their Respective Health Act

Board or Council	Key Issues and Status
Kenya Medical Lab Technicians and Technologists Board Prof Magambo	<ul style="list-style-type: none"> • The board was recently inaugurated in 2001 with the publication of its relevant Act. The Board's secretariat is weak and has only 5 staff. • The Board is in the process of reviewing several scattered policies on laboratory medicine and will soon publish a harmonized policy. This will lead to the review of the Act. • The key issues include recognition of various levels of training (Certificate, Diploma, Degree) and the technical definition of the lab medicine disciplines required for registration. • The other major key issue is registration of training institutions which is currently done by Ministry of Technical Training. KNEC is also involved in setting curricular and exams without the board's oversight. Universities also have their own Act (and so does KMTC). • Technical assistance and financial resources will be required to review the Act.
Medical Practitioners and Dentists Board Mr. Daniel Yumbya	<ul style="list-style-type: none"> • The relevant act for this board is Cap 253 of 1978. • The Act regulates doctors and dentists only but in 2000 some rules were created to allow the board to also regulate health facilities. Public health institutions were excluded from the Boards oversight in these rules. • Board members are doctors only and there is no representation of facility owners. • Mr. Yumbya proposes forming a central board with representation of all the other regulatory boards to harmonize oversight of the health sector. • The Act requires amendment and a draft of the revised Act is ready but requires input from all stake holders in consultative process.
Nursing Council Ms. Sarah Burje	<ul style="list-style-type: none"> • Set up under Cap 257 which had some amendments in 1983. The council regulates nursing practice and education. • The board has 22 members (including representatives of MOH, educational institutions and FBO's) and a secretariat with over 40 staff. • The board has recognised the need to review the Act for the last 5 years but has been hampered by lack of resources. The board needs TA and financial support to be able to start the review. • The current Act does not recognise private practice by a nurse. Nurses in private practice depend on a letter from the council (initially issued by MOH DMS).
Pharmacy and Poisons Board Personal Comments by PSK Chair, Dr. DSK Karanja	<ul style="list-style-type: none"> • The Board was formed under CAP 244 and has oversight on pharmacy training, practice, trade and registration of drugs. • There have been several piecemeal amendments to the Act that have made the Board function like a department in the MOH. • The government's Chief Pharmacist is also the Registrar of the board. • In 2002 the Act introduced another lower cadre (diploma level) of pharmacy practitioners (pharmaceutical technologists) without clearly defining their role or scope of practice. • The national pharmaceutical policy is under review and a draft is about to be approved.
Clinical Officer's Council W. Tomno	<ul style="list-style-type: none"> • The Clinical Officer's Board was established under CAP 260 of 1986 to regulate clinical officers' training, registration and licensing. • The Board has several committees (inspection, education, financial etc). • The Board has had some disagreement with KMTC on the number of students being admitted to the course and is concerned that there is a mismatch between the large numbers being admitted and the available training capacity and this may compromise quality. • MOH and other GOK facilities are very difficult to regulate. • The greatest challenge is regulation of training (NB: MOM's clarified that a training policy for all health professionals has been under review since 2006 and a draft is already been discussed with stake holders). The Board feels that a proper training regulatory body is needed.

Annex D: Private Health Sector Work Plan DRAFT

Policy Priority	Actions	Qtr1 Jun- Jul- Aug	Qtr2 Sep- Oct- Nov	Qtr 3 Dec- Jan- Feb	Qtr 4 Mar- Apr- May	Lead Agency
(P1) #1 Establish PPP Health Council and formalize a PPP dialogue process	Steering Committee debrief the 2 Ministers and PS	July				Steering Committee
	Two Ministers introduce and sign a Gazette creating the PPP Health Council					PPP Council
	Steering Committee invite proposed organizations to participate in the Council	July				
Steering Committee convene 1st meeting to establish PPP Health Council			Sept			
(P1) #2 Strengthen government capacity to engage the private sector thru a PPP Unit	Steering Committee debrief the 2 Ministers and PS on purpose and need for PPP Unit and secure commitment to proceed with IFA proposal to create a PPP Unit	July				MOMS/MOPHS Donors, IFA
	Define SOW and TORS; Identify budget, staff and TA needed to establish a PPP Unit					
	Create and provide needed inputs to build PPP Unit capacity					
(P2) Review of the National Health Policy Framework to integrate PPP focus Review and harmonize the health Acts	Define a consultative process including identifying key stakeholder participations	July				MOMS/MOPHS PPP Council
	Meet with leadership to propose a stakeholder process and timeframe	July				
	Secure resources to conduct legal review (e.g. legal expertise) and to sponsor consultative meetings (3 joint mtgs and several Council/Board individual meetings)	July				
	Prepare for convene Initiation meeting		Sept			
	Prepare and convene Harmonization meeting			Feb		
	Monitor progress of consultations					
	Facilitate validations of acts and harmonization of Act with Health Policy and Framework					
Help lobby for approval of Health Actions and Health Policy and Framework						
(P3) Establish a PPP Framework to guide P3 initiatives	BOH to send copies of different PPP Frameworks with recommendations on how to draft one	July 4				Steering Committee, PPP Health Council
	Steering Committee develops draft and meets on July 14th for comments and consensus on draft	July 14				
	Steering Committee circulates draft widely for comments	August				
	Steering Committee finalizes PPP Guiding Principles	August 30				

(Table continued on next page)

Annex D (continued)

Policy Priority	Actions	Qtr1 Jun- Jul- Aug	Qtr2 Sep- Oct- Nov	Qtr 3 Dec- Jan- Feb	Qtr 4 Mar- Apr- May	Lead Agency
(P3) Analyze the healthcare gaps to id opportunities to implement 2 to 3 pilot PPPs	Pull together inventory of opportunities and data on health markets (trip by Abt)	July thru Aug				PPP Health Council
	Convene meeting of stakeholders to discuss opportunities and Id 2 3 concrete PPPs		Sept			
	Conduct additional analysis, as needed for PPPs					
	Negotiate and define terms of PPPs					
Launch PPPs						
(P3) Integrate private sector into NHIF pilot Introduce low cost insurance products thru PPP with private insurance	Share information on NHIF pilot proposal to finance out patient services	July				Steering Committee, PPP Health Council NHIF, NCAPD
	Integrate private sector participation in design of three pilots	Aug Sept				
	Ensure private sector participation in implementation of pilots					
	Share information on OBA programs (GTZ and UNICEF)	July				
	Integrate private sector participation in design of scale up of OBA voucher program	Aug Sept				
	Ensure private sector participation in implementation of nationwide voucher program					

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"I wish to reiterate the government's commitment to engaging the private sector in improving the health of all Kenyans. The high-level participation and diversity of the stakeholders that took part in the Great Rift Valley Lodge, Naivasha, workshop indicate the broad support we have for a strong public-private partnerships in health."

Professor Anyang' Nyong'o
Honorable Minister of Health
Ministry of Medical Services
Kenya



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