Expanding access to healthcare for the poorest and marginalised in Kenya

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Introduction

Equitable access to quality healthcare remains a challenge in Kenya. Although key health indicators have been improving in recent years, access by various socio-economic groups remains highly disproportionate. For instance, major improvements have been made in the area of child and maternal health related indicators. Infant mortality rate improved from 74 to 39 deaths per 1000 live births between 1998 and 2014 (KDHS 2014). Similarly, under-five mortality rate improved from 111 to 52 deaths per 1000 live births over the same period. On the other hand, deliveries assisted by a skilled provider increased from 42 percent to 62 percent between 2003 and 2014, while deliveries in a health facility increased from 40 to 61 percent over the same period (KDHS 2014).

However, these increases mask major access differences between regions and socio-economic groups. For instance, recent evidence indicates that the poor consume less than a third of the health services than the rich[1]. The same is the case with health insurance, where just about 2.9 percent of the poor are insured compared to 41.5 percent of the very rich on cover. Even within the national insurance scheme (NHIF Act 1998), the poor and the marginalised are among the groups that are supposed to enroll on voluntary basis, yet they cannot afford the contributions. In this regard, they rely on public sector services – which are heavily under-resourced and quality is at times a challenge (MoH NHA Reports – various years). Further, evidence shows that households' health expenditure at 32 percent constitutes the highest source of health financing in Kenya[2].

With the global push towards universal healthcare and the provisions in the Constitution of Kenya 2010 for the "right to health" for everyone, the need to ensure equitable access, especially by the poor and marginalised cannot be over-emphasised. The Government of Kenya has made several efforts to improve access to healthcare by the poor and the marginalised, including changes in policy, legal, health financing and programming, but serious challenges remain.

This Policy Brief therefore reviews the policies and strategies to expand access to healthcare by the poor and marginalised as well as approaches used by Kenya and other countries and recommends options that are likely to work to achieve universal health coverage.

Methodology

A desk study review of published literature and policy documents was used to gather the experiences of countries in Africa and Asia that are implementing similar reforms to achieve universal health coverage and experiences gathered from the Kenyan situation.

Key Messages

- Access to quality health care by the poor and marginalized remains a major challenge in Kenya.
- While user fees is a common policy option for many governments for the provision of health care, it often hinders many poor and marginalized groups from accessing quality care.
- In order for Kenya to ensure that user charges levied in primary health facilities for services do not hinder access for disadvantaged groups, there is need to involve user communities when setting such tariffs. In the case of secondary and tertiary level institutions, prepayment mechanisms should be considered or a defined range of services be completely exempted from payments.
- Government should consider implementation of health equity funds and vouchers where services are clearly defined and beneficiaries easily identifiable and be accompanied with other interventions that ensure the supply of sufficient quality services and address other non-financial barriers to demand.
- For a health insurance subsidy to work, it needs to be properly designed with a clear targeting mechanism and a benefit package that encourages utilisation of primary healthcare services to mitigate possible negative effects on the scheme. Secondary and tertiary services would then be offered with a functional referral system.

Discussion of Policy Options

User fees and exemptions

Although this mode of financing the health sector rapidly became widespread[3], many have voiced their concern about its inefficiency and its potentially negative impact on equity. It is considered inefficient because it does not generate sufficient resources to overcome the sector's structural lack of financing, except possibly for an elitist, restricted urban private sector. It is also considered inequitable, since user fees are shown to be regressive and affect the poorest more than all other segments of the population [4,5,6]. User fees have also deterred poor and vulnerable patients from seeking care (particularly at referral hospitals)[7]. However, the user fees mode of health fiancing has been observed to be successful

at primary health level when supported by strong policy and administraive mechanisms as well as beneficiary participation as is the case of Cambodia[8].

Following the implementation of the National Charter on Health Financing that also included staff incentives in 1996 in Cambodia, it was observed that activity levels substantially increased, unofficial payments were eliminated and there were increased access for the poor. The charges were set by communities and exemptions schemes implemented. This was, however, not the case for secondary and tertiary level institutions where community participation in facility management is not effective and costs are high. It is for these reasons that Cambodia introduced Health Equity Funds to reimburse facilities for services provided to poor patients to ensure sustainability of the system. The use of or removal of user fees and targeted subsidies for various groups of beneficiaries in Cambodia show that a pro-poor health financing policy is much more than a technical issue such as financing and should be put in the perspective of overall political and economic context of the country.

In Kenya, it has been observed that as many as 12.7 percent of the people that fell sick in 2013 could not seek healthcare due to financial barriers (mainly user fees).[9] This lack of social health protection compounded by financial barriers often leads to exclusion from healthcare and impoverishment, trapping families in a cycle of poverty and ill health. The impact of user fees on healthcare utilisation especially by the poor can further be demonstrated with the elimination of user fees charged for maternity at public dispensaries and health centres that resulted in a massive influx of patients seeking healthcare.[10] Similar results have also been noted with the abolition of user fees for all classes of patients at public dispensaries and health centres on 1st June 2013.

The main reason for application of user fees in Kenya has been the low level of government expenditure on health as a proportion of total government expenditure which had fallen from eight percent in 2001–02 to 4.6 percent in 2009–10 before rising again to 6.1 percent in 2012/13[11]. This is in spite of the government's commitment to increase the proportion of funding for health to 15 percent of the national budget as part of the commitment to the Abuja Declaration[12]. Various studies have shown that reforms related to the introduction of user fees in 1980s and subsequent changes in this policy reform may have contributed to high out-of-pocket expenditure and accompanying fall in service use[13]. User fee exemptions to cushion the poor from their adverse effects have not worked well either as they were characterised by the inconsistent application to groups such as children under the age of five years[14].

Health equity funds

Health equity funds (HEFs) are health financing initiatives that are aimed at protecting the poor from cost recovery by injecting external funds into health facilities (health centres or hospitals) and by managing those funds to exempt the poor from fees while compensating the provider for the associated user-fee revenue forgone[15]. HEFs are in effect funded fee-exemption schemes designed to help the poor overcome these financial barriers[16]. The HEFs reimburse health facilities for the cost of user-fee exemptions at public health facilities provided to the identified poor and which also subsidise the poor for the costs of transport and food required during health-seeking episodes[17]. This is because health equity funds achieve good targeting outcomes and are a cost-effective way of protecting the poor from user fees.

In Cambodia, Vouchers in health and HEFs were introduced to increase access to skilled birth attendants and reduce maternal deaths among poor women from 2005. Results showed that facility deliveries increased sharply from 16.3 percent of the expected number of births in 2006 to 44.9 percent in 2008 after the introduction of voucher and HEF schemes, not only for voucher and HEF beneficiaries, but also for self-paid deliveries[18]. The increase was much more substantial than in comparable districts lacking voucher and HEF schemes. In 2008, voucher and HEF beneficiaries accounted for 40.6 percent of the expected number of births among the poor. It was concluded that Vouchers plus HEFs, if carefully designed and implemented, have a strong potential for reducing financial barriers and hence improving access to skilled birth attendants for poor women. To achieve their full potential, vouchers and HEFs require other interventions to ensure the supply of sufficient quality maternity services and to address other non-financial barriers to demand including informational barriers and lack of respect. This conclusion has been supported by other studies that noted that the last decade's investment into Cambodia's public health service benefited the non-poor more than the poor as evidenced by child mortality figures[19]. Therefore, if these other barriers are addressed, voucher and HEF schemes can be further scaled up under close monitoring and evaluation.

Vouchers

Voucher programmes have been used by various countries to access reproductive health services, especially among poor populations with the overall objectives of meeting the Millennium Development Goals (MDGs). Voucher programmes are consumer-led or demand-side financing, where donor or government funds are used to stimulate demand for services by directly connecting the benefit to the intended beneficiary[20]. Voucher programmes have several advantages that include better targeting of the poor; allowing for participation of private providers, hence promoting competition; allowing use of minimum quality standards to accredit facilities and encouraging providers who do not qualify to make improvements to become eligible[21]. Voucher programmes are increasingly being used to address disparities in reproductive health as donors and national governments are keen to target demand subsidies to the most in need within transparent healthcare delivery systems[22].

In a study of nine countries with voucher programmes, it was noted that vouchers increased the utilisation of facility-based deliveries (Bangladesh and Cambodia); have significant increases in antenatal and post-natal care visits (Bangladesh) and lead to significantly higher utilisation rates of reproductive healthcare and condoms compared to non-voucher receivers (Nicaragua). And in Uganda, although there was a non-significant increase in utilisation of STI services in the general population, there was a significant increase among the poor located within 10 km of contracted health facilities[23].

These results have been corroborated in a study that evaluated the effects of a universal demand side financing (DSF) on maternal healthcare service utilisation in Bangladesh based on the voucher scheme, one year after the initiation of the project[24]. The utilisation rates of maternal health services were found to be higher for all socio-economic groups in the project area than in the comparison areas. Voucher recipients in the project area were 3.6 times more likely to be assisted by skilled health personnel during delivery, 2.5 times more likely to deliver the baby in a

health facility, 2.8 times more likely to receive post-natal care (PNC), 2.0 times more likely to get antenatal care (ANC) services and 1.5 times more likely to seek treatment for obstetric complications than pregnant women not in the programme. The degree of socio-economic inequality in maternal health service utilisation was also lower in the project area than in the comparison area. The use of vouchers evidenced much stronger demand-increasing effects on the poor. Poor voucher recipients were 4.3 times more likely to deliver in a health facility and 2.0 times more likely to use skilled health personnel at delivery than the non-poor recipients. The voucher scheme was found to reduce inequality even in the short run. Despite these improvements, socio-economic disparity in the use of maternal health services has remained pro-rich, implying that demand-side financing alone will be insufficient to improve access to the poor and marginalised. A comprehensive system-wide approach, including supply-side strengthening, will be needed to adequately address maternal health concerns in poor developing countries[25].

In Cambodia, where both vouchers and health equity funds were applied for public health facilities, there was a significant increase in facility deliveries among poor women because vouchers covered the full cost of deliveries and transport[26]. However, those who did not use the vouchers cited staff attitude, no one to leave to take care of the home and likely higher transport costs than the voucher is likely to cover (especially at night) as some of the reasons for the non-use. Some of the solutions suggested include contracting private providers to enhance facility convenience, better voucher distribution and more promotion of the programme. A combination of both vouchers and health equity funds was also observed to produce better results. Other studies have also concluded that the potential for RH voucher programmes appears positive; however, more research is needed to examine programme effectiveness using strong study designs and address issues of cost-effectiveness and population health impacts[27].

Vouchers have also been used for reproductive health in Kenya and Uganda. The Kenya Reproductive Health Output Based Approach (RH-OBA) voucher pilot was established in 2005 and covers three rural districts and two Nairobi slums. Individuals who fall below a poverty threshold are eligible to buy a family planning (FP) voucher for long acting and permanent methods for the equivalent of about US$1.25 and a Safe Motherhood (SM) voucher for antenatal care (ANC), institutional delivery and postnatal care (PNC) services for about $2.50. RH-OBA vouchers are redeemed at 54 public, private for-profit and private non-profit providers[28].

Results from the study showed that in Kenya, uptake of RH-OBA safe motherhood vouchers was high with 78,651 vouchers being sold between June 2006 and October 2008, and 60,581 of these were used to deliver in a participating facility. In contrast, use of FP vouchers was considerably lower than expected. In the same period, only 25,620 FP vouchers were sold, and 11,296 (41 percent) of these were used. It was noted that results from Uganda showed that uptake was slow because voucher systems take long to set up. However, it was noted that the gap between the number of vouchers sold and used was fast closing – with 61percent used. Other positive results including quality improvements and enhanced accountability were noted.

Kenya's experience with SM vouchers and Uganda's with STI vouchers shows that vouchers can help increase uptake of SM and STI services among poor populations. The evidence, however, is less clear in the case of FP vouchers in Kenya. The evidence suggests that a complex mix of factors is responsible for low uptake of FP vouchers, reiterating the earlier findings pointing to the fact that financial barriers are not the only obstacle to FP use. The evidence therefore implies that an independent FP voucher programme may not be the most appropriate strategy for increasing FP uptake among poor communities.

Social health insurance

Social health insurance (SHI) is one of the key mechanisms for increasing healthcare coverage to a large proportion of the population. The WHO also considers health insurance a promising means for achieving universal health-care coverage[29]. A study of 59 countries found lack of health insurance as one of the main factors engendering health expenditure at a level that can be thought of as catastrophic, up to nearly 40 percent of all household expenditure, and recommended the provision of some form of financial risk protection[30]. Such expenditure is likely to cause further impoverishments among households; for example, three-five percent of the Indian annual poverty rate can be attributed to high level of health expenditure relative to total household expenditure[31]. SHI models vary but they share a number of defining characteristics, including mandatory membership and contributions for a defined package of health benefits, mostly for formal sector workers and their dependents. In some cases, employers also contribute. When schemes are open to everyone, people outside of formal employment are required to enroll and pay an annual premium to join, mostly a flat rate. Even when SHI is mandatory for everyone, not everyone can afford to join. Some countries therefore give partial or full subsidies for the informal and poor populations to enroll into the insurance schemes.

However, even with subsidies, access and utilisation has not substantially improved. The PhilHealth in the Philippines is one of the oldest SHI to have used subsidies to cover the poor and indigents. However, coverage among the indigents and informal sector members is still just about five percent of those covered[32,33]. The central government and local government share the subsidies for indigents through the ''Plan 5 million'', a political move to enroll an additional five million indigents into PhilHealth by 2004. This approach is similar to the one in Thailand where targeted policies of the Thai Universal Coverage Scheme have increased the number of insured indigents and the poor population[34].

In evaluating the impact of Colombia's subsidised health insurance program on preventive healthcare utilisation and hospitalisation services of Medellin's citizens[35], it was observed that subsidised health insurance programmes resulted in a net increase in utilisation for the poor beneficiaries. However, subsidised people had a higher probability of hospitalisation than individuals who were not in the subsidy programme. It was concluded that perhaps people involved in the programme were less concerned about preventive services because they knew that hospitalisation services were not too expensive due to their situation.

Recommendations

i). In order to ensure that user charges levied in primary health facilities for services do not hinder access for disadvantaged groups, there is need to involve user communities when setting such tariffs. In the case of secondary and tertiary level institutions, prepayment mechanisms should be considered or a defined range of services be completely exempted from payments.

ii). The implementation of health equity funds and vouchers should be considered where services are clearly defined and beneficiaries easily identifiable and be accompanied with other interventions that ensure the supply of sufficient quality services and address other non-financial barriers to demand.

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