Healthcare Policy Administration and Reforms in Post-Colonial Kenya and Challenges for the Future

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Abstract

The underlying vision for health developments and reforms in Kenya as detailed in the on-going 1994 *Kenya Health Policy Framework Paper* is to provide "quality health care that is acceptable, affordable and accessible to all". This paper discusses the reforms in the healthcare policy in Kenya by evaluating the health sector developments in the post-colonial era. Key issues, trends, challenges and future innovations are analysed within the framework of continuous reforms aimed at improving coverage and efficiency. It is argued that providing a quality healthcare package to all will require a holistic systems development approach that gives priority to improving access and coverage by improving facilities, providing affordable and accessible healthcare services, increasing healthcare professionals and further decentralization in financial management and decision-making.

Introduction

The vision for a healthy nation in Kenya was contained in the 1965 landmark nation-building and socio-economic development blueprint – the *Sessional Paper No. 10 on African Socialism and its Application to Kenya* – that emphasized the elimination of disease, poverty and illiteracy. The universalist 'free health for all' policy saw a rapid expansion of the healthcare infrastructure, particularly in the 1970s and 1980s, and advances in health and social indicators. For example, while the number of health facilities increased from 808 in 1964 to 4,214 in 1998, that of personnel grew from 16,387 in 1977 to 55,732 in 2000 and life expectancy increased from 40 years in 1963 to 60 in 1993 (Kimalu 2001:29; Owino 1999:273-5; Wamai 2004:125). With the growing population and worsening socio-economic and political factors, a severe crisis of health and social development unravelled in the 1990s (Kimalu 2001:21; UNDP 2002:43, 46). As a result of the crisis, the government's objectives and commitments to free healthcare provision for all eroded dramatically forcing it to implement a cost-sharing scheme in 1989.

As in many other developed and developing countries, the Kenya's post-colonial health system development has been influenced by three major international health policy developments over the last three decades. First was the World Health Organization (WHO) 1978 Alma Ata "Health for All by the Year 2000" (HFA) programme which called for a shift in healthcare delivery from the hospital system to a primary health care system emphasizing the role of communities (Owino 1999:269; Dror, Preker and Jakab 2002:42). Secondly, the World Bank's neo-liberalist model detailed in *Financing Health Services in Developing Countries: An Agenda for Reform* (1987) and other structural adjustment policies gave a particular impetus to the introduction of user charges, the development of the insurance system, increased use and development of the non-governmental (NGO) sector, and decentralization of health services (Koivusalo and Ollila 1996:149; Wamai 2004:136-7). Third is the Bamako Initiative (BI) promulgated in Bamako, Mali, in 1987 by the United Nations Children's Fund (UNICEF) as a developing-countries' approach towards the HFA targets for financing primary health care through selling essential drugs at the village level.

Throughout the past three decades, health developments and reforms have been implemented under conditions of economic, political, structural, cultural, as well as donor-dependency constraints (Oyaya and Rifkin 2003). This paper will discuss health sector developments in Kenya's post-colonial era. Key issues, trends, challenges and future innovations are analysed within the framework of continuous reforms aimed at improving coverage and efficiency. I will first provide a review of the health policy development followed by a section on situation analysis of the health system with regard to organization, distribution, financing and actors. A later section will consider the question of how the on-going reforms can achieve the intended objectives.

Development of Healthcare Policy Administration in Post-colonial Kenya

The main objective of health policy developments and reforms undertaken by the post-colonial government since independence in 1963 has been to create a healthy working nation. This objective is motivated by the evidence that investing in health produces positive outcomes in human capital that have long term impacts in the overall socio-economic

development of a country (World Bank 1993; Mwabu 1998). From the outset, the government's health policy stated four key components for the country's healthcare development: expanding the system coverage, developing an insurance scheme, preventive health, and family planning. Until the 1980s, health policies were detailed in the National Development Plan, 5-year blueprints outlining government intentions and strategies for socio-economic development produced since 1966-1970. As the first step undertaken with the first Development Plan, the free access policy abolished the Ksh 5 (equal to about sixty cents of one US$ at the time) co-payment operative until 1965. The policy proposed expanding coverage through centralizing the delivery responsibilities from the counties and municipalities to the Ministry of Health. This saw the creation of 250 "rural health units" by 1979 all over the country; a unit served 50,000-100,000 people and was focused around a health centre (Mwabu 1995:249).

While achieving harmonization of the system, however, the centralization did not eliminate regional disparities (Mwabu 1995:249). To improve administration of the programme, a decentralization policy involving deconcentration – transferring decision-making to lower administrative bodies (Saltman and Figueras 1997:44) – was pursued. The announcement of the *District Focus for Rural Development* (DFRD), a sweeping cross-government decentralization programme, in 1983 strengthened the push towards district-based health management. Following the WHO policy direction for primary health care (PHC), the government published the *National Guidelines for the Implementation of Primary Health Care in Kenya* in 1986. With these guidelines for continuing PHC development, the system structures were readjusted to emphasize "decentralization, community participation, and inter-sectoral collaboration" (Oyaya and Rifkin 2003:115). The key change this new policy heralded was the introduction of user fees in accessing healthcare in order to supplement the MOH budget for maintaining health facilities. Although this was already announced in the fourth Development Plan of 1979-1983, and reiterated in the subsequent ones, the policy was not introduced until 1989 amid "considerable pressure from donors" to do so (Mwabu 1995:248). However, after 9 months of implementation, the cost-sharing scheme was scrapped due to mounting opposition from the population only to be re-introduced in 1992 (Mwabu 1995:248; Collins et al. 1996:15-23).

Early in the country's health system infrastructure development was the establishment of a national health insurance scheme. Established in 1966, the National Hospital Insurance Fund

(NHIF) is a compulsory scheme for all salaried formal sector employees whose income exceeds a certain set minimum. From the beginning, the insurance has covered the contributor's spouse and children under 18 without discrimination on the type of ailment suffered or number of children. By year 2003, the scheme was covering over 9 million people (30% of the country's 30 million) with about 1.3 million individual contributors (Wamai 2004:124). As of 2003, the NHIF system coverage comprised 414 health institutions, 120 of which were run by government, 210 run by the private sector, 63 by NGO/Church-missions, and 21 by communities/foundations all with a bed capacity of 36,463 (Wamai 2004:202). In 1998 NHIF was corporatized through an amendment to the 1966 Act and is currently fully autonomized and is run by a broad board of directors drawn from all the healthcare providing sectors; it receives no budget funds from the state. The latest health insurance policy drawn in 2003 has, however, sought to make a radical transformation of the NHIF (see below).

The early post-colonial health policy recognized the need for addressing preventive health. The policy stated that: "to reduce the incidence of disease and to start eliminating many of the preventable diseases, a vital part of the public policy on health will be directed towards preventive measures" (Republic of Kenya 1966). However, not much was done in this regard either in committing resources or in institutional development. For example, although the Division of Health Education (DHE) was created in 1953 (a decade before independence in 1963) at the Ministry of Health (MOH), the formal training of health education officers did not begin until 1976 (Republic of Kenya 1998:2). The policy did, however, focus attention on the high population growth rates by starting a family planning campaign to reduce fertility rates that stood at 7% in the mid 1960s. Started in 1967, the National Family Planning Program – the first for a sub-Saharan African country – was managed by an NGO (the Family Planning Association of Kenya, established earlier in 1962) with the MOH taking coordination and supervisory roles (Mwabu 1995:250). The program was spread throughout the country with over 160 family planning clinics being established in government hospitals and health centres by 1969 (Mwabu 1995:250). After the 1969 population census revealed that the fertility rate continued to grow, reaching 7.6%, the government reformed the program to integrate maternal and child health services leading to the establishment of the National Council for Population and Development (NCPD) in 1982 (Republic of Kenya 1996:5). The greater coordination and expansion of family planning activities explains, at least in part, the decline in fertility rate to 5% (Republic of Kenya 2003a:9).

Another major development in the country's healthcare system in the early 1980s was the policy to integrate traditional medicine into modern medicine in an effort to accelerate the healthcare coverage (Mwabu 1995:249). The process to professionalize their knowledge and practices was achieved with the establishment of a research unit on traditional medicine at the Ministry of Health in 1980. At the same time, licences were issued to traditional health practitioners to operate outside the public system while many traditional midwives were recruited to work in government facilities especially in the rural areas where there was more acute need (Mwabu 1995:249). The development was, however, not isolated to the country but had followed international debates and directions from a series of WHO meetings in 1976 and 1977 leading to the Alma Ata declaration on Health for All by Year 2000 (Johnson 2001:168). The 1995 WHO publication, *Traditional Practitioners as Primary Health Care Workers*, acknowledged that: "The Western system of healing has not replaced but has augmented indigenous health systems. This is because traditional healing is deeply embedded in wider belief systems and remains an integral part of the lives of most people" (p, 3, in Johnson 2001:170-1). In spite of the international and national recognition of traditional medicine as part of the health system, challenges to integration, such as distrust from conventional medicine and lack of information for the health system, have remained. The use of traditional medicine while linked with cultural-specific practices has been augmented by poverty, which makes healthcare unaffordable for the over 50% of Kenyans living under a dollar a day (Wamai 2004:118). Although there are no records available in the Health Management Information System (HMIS), studies have found that the use of traditional medicine had been on the rise in the 1990s (Berman et al 1995:46) and is as high as 23% of those seeking healthcare (Republic of Kenya 2003c:21). A legislative framework, the Traditional Health Practitioners Bill, was developed in 2003 to regulate the sector.

In the long-running health reform processes, the 1990s brought major changes in the health system structures administration, financing and insurance. By means of the DFRD framework, health management was somewhat decentralized to the country's 71 districts with the creation of District Health Management Boards (DHMBs) in 1992. The DHMBs are meant to "represent community interests in health planning and to co-ordinate and monitor the implementation of projects at the district level" (Republic of Kenya 1999a:12) and thus have broad-based membership. They are supported by a team of health experts from the district and oversee the running of other lower levels of health administrations from the district hospitals to health centres and dispensaries. The creation of the DHMBs, following

the re-introduction of cost sharing, strengthened the management capacity of the revenue generated. A Health Care Services Fund was established in which 75% of the income generated by health facilities would be used by the collecting facility with the remaining 25% going towards the promotion of PHC activities in the source districts (Republic of Kenya 1999a:12-13). Although the DHMBs are responsible for developing the healthcare infrastructure in the districts through managing these so-called Facility Improvement Funds (FIFs), they require an authorization to incur expenditure from the Provincial administrations.

Under recent and on-going transformations, the health policy, set out in the 1994 *Kenya Health Policy Framework Paper* (KHPFP) with a lifespan to 2010, has aimed at decentralizing all aspects of health management and decision-making to the districts (Oyaya and Rifkin 2003:116). The long-term policy outlined reforms aimed at four key areas: sustainable, accessible, and affordable quality healthcare; resource mobilization; participation and collaboration with other actors; and the regulatory role of the government. Under the policy, the MOH would play mainly a regulatory and steering role with delegated authority to the provinces and the districts. The 1996 *Implementation and Action Plans* (IAP) laid out the framework for KHPF implementation. However, IAP was abandoned as it "did not reflect the shared views and priorities by all concerned and, therefore, lacked the commitment required for effective implementation" (Republic of Kenya 1999:1). In its place was developed the *National Health Sector Strategic Plan (NHSSP) 1999-2004*, and later NHSSP-II (2005-2010), which entrenched the intentions for the reforms even more strongly.

The significant change of government in January 2003 ushered in a new era of policy making in Kenya. In July 2004, then Minister for Health Charity Ngilu declared a new policy for user fees at primary healthcare facilities. The policy declaration stated that all services needed/rendered (including diagnosis, lab and pharmaceuticals) would cost only Ksh. 10 and Ksh. 20, respectively, at the dispensary level (the lowest level of healthcare in Kenya) and at the health centre level (the second level of healthcare facility). The public declaration did not have any detail or guidelines, neither was the fee system above the health centre level addressed. Recentralizing user-fee setting for the lowest government healthcare providers, the policy meant a significant shift in revenue generation and the running of the health facilities as well as access to healthcare, especially at the dispensary level.

The latest and most controversial reform to be introduced in the 2000s was the plan for a radical transformation of the NHIF into a mandatory National Social Health Insurance Fund (NSHIF). Contained in a task force report – the *National Social Health Insurance Strategy* (NSHIS) (February, 2003) – a *Sessional Paper* (August, 2003) and a bill of law for Parliamentary debate (May, 2004), the policy proposes the replacement of the current cost-sharing scheme with a prepaid/insurance one. While the cost-sharing scheme entail that patients pay at the point and time of treatment, the new system would provide that contributions are prepaid into the NSHIF allowing patients to procure health care free of charge at the point and time of treatment. Under the new policy, fees for basic hospital care – including doctor's fees, bed admission and drugs – regardless of the disease or socio-economic status would be fully covered through the NSHIF. In order to finance the scheme to cost an estimated Ksh40 billion (US$536,927,000) annually, the Strategy requires that every Kenyan and permanent resident contribute, at the minimum, between Ksh400 and Ksh600 ($US5-8) per year. Those unable to contribute due to poverty would be covered by the government through earmarked tax collections. The insurance reform has however not be implemented due to political handicaps.

Kenya's Health System: Situational Analysis

Health system macro-organization and distribution

The healthcare infrastructure is captured in the country's Health Management Information System (HMIS) maintained by the Division of Health Management Information System at the Ministry of Health. Although it lacks up to date, detailed and integrated information, the first and mostly cited HMIS provided a good view of the country's health system including the NGO and private sector providers. As shown in table 1 below, the healthcare system is largely mixed with the government operating about half of the facilities (51%), NGOs 20% and private sector 29%. However, there are wide variations in sector penetration in the different facility types. The private sector has a commanding domination in nursing and maternity homes and health clinics and medical centres with 94.2% and 83.7%, respectively. On the other hand, the government operates most health centres and dispensaries as well as hospitals with 80%, 60.9% and 50%, respectively. NGOs second government in these types of facilities with 17.4%, 23.6% and 30.7%, respectively. In another light, the primary healthcare system

(health centres and dispensaries) takes the largest overall share of total health facilities (74%) indicating the pyramidal nature of the system which is bottom heavy, typical in developing countries (Akin et al. 1985:8).

Table 1. Distribution of health facilities by type and provider sector, 1998

Type of Facility	Government		NGOs		Private		Total No.
	No.	%	No.	%	No.	%	
Hospital	109	50	67	30.7	42	19.3	218
Health Centre	460	80	100	17.4	15	2.6	575
Dispensary	1,537	60.9	595	23.6	391	15.5	2,523
Nursing & Maternity Home	0	0	11	5.8	180	94.2	191
Health Clinics/Medical Centres	43	0.1	72	10.2	592	83.7	707
Total	**2,149**	**51**	**845**	**20**	**1,220**	**29**	**4,214**

Source: ROK (1999a:5)

In terms of health personnel, the number is relatively large at about 60,000 in 2003 comprising nearly 40,000 nurses (Republic of Kenya 2005:4). Although the majority (69%) of personnel are supplied by the MOH (Wang'ombe et al. 1998:3), the larger number work in private practice (Republic of Kenya 1999b:8). In fact, of the about the 5,000 doctors in the country, only about 1,000 work in the public sector according to data released by the health Minister in 2003 (Kimani 2003). It should be noted, however, that the distribution of the health facilities and personnel differ across the different parts of the country. As measured by number of the population per health facility by province, the figure ranges from 5,325 to 11,869 in the worst off in 2000 (Wamai 2004:125). In terms of personnel, the majority are concentrated in urban areas, with over 50% working in a few major towns (Nairobi, Mombassa, Nyeri, Nakuru, Kisumu, Eldoret) representing only 16% of the country's population (Wang'ombe et al 1998:4). For instance, while Nairobi alone accounts for only 12.3% of nurses, it accounts for 50.8% of all the doctors (Berman et al 1995:49).

Healthcare financing

In general, spending on healthcare as a percentage of Growth Domestic Product (GDP) has declined in the 1990s to average 8% compared to an average of 9% in the 1980s. The decline is attributed to government policy in 1986 in line with the donor-imposed structural adjustment policies that called for a reduction of government spending (Mwangi 1996). The overall result of the cost-cutting has seen the per capita health expenditure from both recurrent

and cost sharing fall by 64.2% from a high of US$9.5 in 1980/81 to US$3.4 in 1997 (Oyaya and Rifkin 2003:114). From the beginning, the Ministry of Health (MOH) has operated two sets of accounts to finance healthcare: a *recurrent* and a *development* budget. Recurrent budgets are used for a variety of purposes such as staff salaries, purchasing drugs, maintenance and transportation whereas the development budget is for constructing facilities, buying new equipments, etcetera. Throughout the 1980s and 1990s, the recurrent spending has averaged 70-80% of the combined recurrent and development budgets. Notably, 67% of the recurrent budget goes towards staff payments while 15% is a grant to the national hospital (Kenyatta) and the rest is spent on medical supplies, repairs and maintenance (Republic of Kenya 1999a:59). Of the total Ministry of Health expenditures, 67% have gone to specialized curative care, 13% to rural primary health care, 6% to preventive and promotive health, and the rest to central administration and planning (UNDP-Kenya 2002:51).

The first National Health Accounts report showed that in 1994 the government's share of national health expenditure was 29%, donors 8%, households 53% and private firms 10% (Republic of Kenya 1999b:12). According to the latest data, private financing amounts to 75% while the government contributes only 25% (Republic of Kenya 2003b:5). When these figures are broken down (table 2), it is obvious that out-of-pocket payments, which comprise cost sharing, by households is the main form of financing healthcare at 53.1% (Republic of Kenya 2003b:5).

Table 2. Health care expenditures by source of finance, 2001

Source	% share
Government (tax-financed)	21.4
Households (out-of-pocket)	53.1
NHIF (statutory insurance)	3.9
Firms (private employer-paid)	16.4
Pre-paid private plans (social insurance)	3.6
NGOs	1.6
Total	**100**

Source: Republic of Kenya (2003b:5).

In spite of institutional weaknesses in its implementation (Owino 1999:267) revenue generation from the cost-sharing programme initiated in 1992 increased exponentially from only Ksh60 million (US$805,300) in 1992/1993 to over Ksh700 million (US$9,396,000) in 2000/2001 financial year, an increase of 1,000% (Republic of Kenya 2002a:19,27). Although

about 20% of total inpatients are NHIF beneficiaries, the NHIF contribution to overall expenditure in health and as a measure of overall cost-sharing revenues is small: only about Ksh41 million for financial year 2000/01 (Republic of Kenya 2002a:vi,vii). In fact, the NHIF share of revenues from total collections has decreased throughout the 1990s from a high of 35% in 1992-93 to 7% in 2000-01 (Republic of Kenya 2002a:27). This indicates that there has been a decreasing trend in (pre-paid) health insurance and an escalation of pay-as-you-consume healthcare demand. The reform of the cost-sharing policy in 2004 was an attempt to reduce the cost burden to users in primary healthcare facilities. According to the only study available on the impact of the policy carried out by the MOH in 2005, there was a dramatic initial increase in demand/utilization while revenue collection dropped by half in most facilities (Ministry of Health 2005). However, as the policy was not followed by increased government input to ensure the facilities coped with the increased demand, a decline in utilization ensued soon after defeating the purposes of the policy.

Throughout the1990s, the MOH recurrent budget grew tremendously from about Ksh2 billion in 1990 to Ksh15 billion in 2000 reflecting the rising GDP (Wamai 2004:132). On the other hand, the development budget remained relatively low during the same period and never rose beyond Ksh4 billion (Wamai 2004:132). Trends at the start of the 2000s reflected a decline in the recurrent spending and an upward movement for the development budget. It is noteworthy that the larger part of the external funding goes for the development budget, which comprised 95% in 1999/2000 with the rest coming from the government (Republic of Kenya 1999a:58). Another characteristic of the donor funding is that it is significantly larger in funding preventive and community (rural) health than the government or private sector's share (Watanabe and Takahashi 1997). Such targeting of donor financing has contributed to the expansion of the rural primary health and preventive/promotive healthcare (R/PHC).

The 1989 introduction of cost sharing coincided with a government policy to increase spending on R/PHC within the auspices of the WHO HFA. As a result, R/PHC expenditures increased rapidly almost equalling the combined recurrent and development expenditures on curative services during 1994/95-1995/96 financial year. Although by the end of the 1990s, this had fallen to around 17%, spending on R/PHC from the development budget has been high at almost 68% in 1998/99 while the comparable level for curative services was about 13% during the same period (Mwangi 1996:11). The increased spending on R/PHC was most notably reflected in the sharp increase in primary healthcare facilities (dispensaries and health

centres). Between 1990 and 1994, these facilities increased by 82% from 1,527 to 3,390 as compared to hospital increases of 20% from 268 to 324 (Wamai 2004:140).

Managing Health Sector Reforms: Key Issues and Challenges for the Future

Given the prevailing socio-economic, political and cultural characteristics, healthcare management in Kenya poses one of the greatest challenges for policy makers. The country's Poverty Reduction Paper (2001-2004) identified the high cost of healthcare as "one of the leading causes of poverty" (Republic of Kenya 2003c:4), suggesting that poverty and the demand for healthcare reinforce each other. Because of the high levels of poverty, a sustained approach is needed, which on the one hand tackles poverty and on the other reduces healthcare costs to increase utilization. On the whole, government efforts towards poverty reduction and healthcare provision along the 1965 nation-building framework have been influenced by changes in the economy and politics.

While economic growth rate stood at 6.6% during the period of rapid growth (1964-1973), it constantly fell to reach a bottom of negative 0.3% in 2000 (Republic of Kenya 2002b:v,1). This decline was reflected in worsening health indicators, especially during the 1990s, as poverty levels reached 56% in 2000. For example, exacerbated by the increase in HIV prevalence from 5.3% in 1990 to 13.1% in 1999 (Office of the President 2000a:2), life expectancy that peaked at 60 in 1993 dropped to 54 in 1999 (UNDP 2002:14). There was also an upward trend in infant mortality rate from 64 in 1993 to 72 in 1998 (Republic of Kenya 2002a:64). A more distressing characteristic of the 1990s was that as the number of poor increased, the society became more stratified with 20% of the population earning 70% of the national income (UNDP 2002:31), making Kenya the fourth highest unequal country in the world (Throup 2001:2). Although the economic indicators show a recovery in the 2000s (at 1.8% in 2003) and falling HIV prevalence – at 9.4% in 2003 (Republic of Kenya 2003a:37) – major challenges remain with the on-going health system reform processes. Coming to power in 2003, the Narc government pledged its commitment to the reforms and health system renewal as highlighted in its *Economic Recovery Strategy for Wealth and Employment Creation* 2003-2007 (Republic of Kenya 2003d:40-41). The government has already brought

some changes in the system, notably the radical 10-20 policy (Agutu 2004; Ministry of Health 2005). In the following sub-sections, we will consider three outstanding areas of challenges in the reform processes, namely decentralization, systems organization and financing.

Decentralizing the public health sector system

In spite of the much-hailed and long-running decentralization of healthcare management to the districts, the process has been extremely slow and a clear plan and guidelines were only developed for the first time in a collaborative stakeholder workshop on decentralization held in 2000 that agreed on the organizational structure of the system (Ministry of Health 2000). In fact, only 14 districts have been under trail in a program funded by the World Bank and the Swedish development agency SIDA (Wamai 2004:142). These pilots were expected to create models and best practices that would then be replicated all over the country. As pointed out earlier, the decentralization being pursued entails deconcentration where all aspects of health management including coordination, systems development and setting user charges would be made at the district level. The decentralization introduces new management styles, which may differ from district to district. Thus, providing sustained "quality health care that is acceptable, affordable and accessible to all" (Republic of Kenya 1999a), as stated in the KHPF vision, pose serious regulatory challenges for the Ministry of Health in a country with vast disparities in health and poverty levels along provincial, district and rural-urban divides (Society for International Development 2004; Wamai 2007). For example, while Central province has a doctor-patient ratio of 1:20,000, the worst off North Eastern has one for every 120,000; life expectancy is twice as high in the leading district, Meru, with 68.6, with the lowest, Mombassa, at just 33.1; and while Nyanza province leads with an HIV prevalence rate of 15.1%, North Eastern has virtually none (Society for International Development 2004:21, 22, 35).

In fact, because the health system indicators vary widely, the challenge of reaching the stated health policy objective is further complicated by the fact that such figures can be deceptive, and, as such, there seems to be no single 'good' indicator which would characterize a region as therefore healthy. To illustrate, while North Eastern province has the worst doctor-patient ratio and the worst distribution in population per health facility, it has the lowest HIV prevalence rate and a higher life expectancy (51.8) than the worst province, Nyanza (47.7) (Society for International Development 2004:21, 24). Again, while the capital city province

Nairobi has the best ratio of population per health facility (5,331), it has a lower life expectancy (61.6) than Central with 7,742 persons per health facility and the highest life expectancy of 63.7 (Society for International Development2004: 24). Given the awareness of these disparities and discrepancies, it is surprising that the decentralization framework has largely ignored them. In this light, it is questionable how the pilot districts could produce models applicable to all 71 or how such an exercise can achieve uniform health goals. Obviously, part of the problem lies with the poor Health Management Information System, whose development is essential if the MOH will be able to steer health management in line with the stated policy vision (Republic of Kenya 2001:84).

Another challenge to decentralization is creating effective collaboration with and participation of other stakeholders. As pointed out earlier, the District Health Management Boards (DHMBs) comprise members of the community and health stakeholders. We also saw that the NGO/private sector plays a significantly large role in healthcare provision. However, the sector participation varies widely across the regions (Wamai 2004:126). In addition, although centralization in the 1960s brought health administration directly under the Ministry of Health (under which the DHMS fall), the legislation in place allows local authorities to provide a level of healthcare to their inhabitants. Of the 44 municipal councils, seven (in large urban areas such as Nairobi and Mombassa) operate health centres and clinics. This means that there is a dual public structure to some extent, especially in Nairobi, which not only poses challenges for the district-based health administration but also for the private/NGO operators (Wamai 2004:199-200). And while the local authorities are elected through political competition, the district administration structures are established by the central government. As such, it is obvious that a change in legislation is needed to harmonize health administration and encourage meaningful and enhanced collaboration and participation.

In order to create a broader participation in health planning and decision-making at the district, the decentralization framework suggested the formation of District Health Stakeholder Forums (DHSFs), again to be started out in 14 pilot districts. At the national (MOH) level, steps to set up a Donor and NGO Coordination Division (DNCD) for the same purpose were initiated earlier in 1997 within the flagship agency mandated to steer the reforms, the Health Sector Reform Secretariat (HSRS). To date, except for a few operational DHSFs, these structures have failed to take off in spite of the implementation plans detailed in the *National Health Sector Strategic Plan 1999-2004* (NHSSP-I) (Wamai 2007; Wamai

2004:145, 266-7). Reasons for this failure, as for the sluggish decentralization plan, lie largely in the institutional inertia and lack of resources given the heavy dependency on (unreliable and conditional) donor funding for these processes (Oyaya and Rifkin 2003). Another major challenge identified by Oyaya and Rifkin (2003) and Wamai (2007) in their evaluation of the extent of decentralization on district level planning is the lack of health management skills among members of the district health administrations most of who are medical professionals.

System organization: shifting healthcare provision from the public to the private sector

The *Kenya Health Policy Framework Paper* (KHPF) emphasized a clear departure from the public healthcare system organization model by seeking to transfer the provision of curative services to the NGO/private sector (Oyaya and Rifkin 2003:115). As clarified in NHSSP-I (1999-2004), the participatory health planning committed the government to "engage dialogue with the private/NGO health providers for them to take up more discretionary health packages (mainly curative)" (Republic of Kenya 1999a:63). This shift in policy is expected to "free more government resources to be allocated to preventive and promotive health services in order to reduce burden of diseases" (Republic of Kenya 2003c:4). In the proposed framework, the government was "promising/offering material (e.g., land) and financial (e.g., tax exemptions) incentives" (Republic of Kenya 2003c:11) and to decentralize "the licensure and certification process as well as enforcement of rules and regulations by the provinces" (Republic of Kenya 1996:viii). Since 2000, NGO/private healthcare providers have been required to obtain a certificate of registration and licence from the Medical Practitioners and Dentists Board (MPDB), a partially autonomous agency of the MOH and watchdog over all NGO/private operators. The licensure is not uniform in that different rules and fees discriminate between NGOs and private operators and across types of health facilities.

Furthermore, the issuing and vetting of licences and registration certificates is duplicated by the local authority in the domain of NGO/private operations. This is a cumbersome process that raises serious conflicts. An NGO/private operator working in various locations has to secure a local license from each local authority under the criteria prevailing in the area. In addition, they are not exempt from certain municipal taxes such as property tax, land rates and other charges such as the use of its drains or sewers as a sanitary service charge (Wamai 2004:199-200). As such, changes through legislative and policy mechanisms are certainly needed if the government is to achieve its objective in this area to "encourage the provision of essential and discretionary health services by the private sector and NGOs in underserved

areas" (Republic of Kenya 1999a:11). The pro-NGO/private sector policy could, however, not be achieved in the existing administrative structure of the MOH. Attempts to have a functioning Donor and NGO Coordination Division appear to have been abandoned altogether.

The policy aimed at focusing government resources for preventive health is a positive shift given the fact that the disease burden in the country lies in "preventable vector-borne diseases" (Watanabe and Takahashi 1997:116) particularly malaria, which is the single largest killer disease accounting for over 30% of reported illnesses in the country (Republic of Kenya 1998:1). Other leading killers include HIV/AIDS, tuberculosis and, among children, measles and diarrhoea. These diseases pose enormous economic burden to households and communities (Russell 2004). While health-promoting behaviour and other public health measures can be used to address the impact of these diseases, two major obstacles stand in the way of implementing an effective health communication strategy. The first has to do with the implementation infrastructure and the second with the high levels of poverty creating barriers to health affordability.

The preventive health framework, *National Health Communication Strategy – 1999-2010* (NHCS), is touted as the "road map and compass to help guide the planning, implementation, monitoring and evaluation of health communication programmes and their effective integration into the healthcare delivery system" (Republic of Kenya 1998:ix). With its dual objectives to promote public health education around 14 health issues – such as nutrition, immunization, reproductive health, sexually transmitted infections and mental health – and to strengthen the Division of Health Education (DHE), the strategy faces numerous challenges from the high levels of poverty and related effects to resources, and organizational and partnership issues. One valid criticism is that there does not seem to be a sense of urgency given the fact that, as the ambitious strategy is based on the KHPF, a five-year time period had elapsed before the NHCS could be developed. Moreover, although the strategic plan is in its fifth year, little has been achieved (Wamai 2004:216). The slow implementation is also due to the fact that the plan was heavily dependent on inter-sectoral collaboration across all levels of the health system, various ministries and NGO/private and community stakeholders. Successful collaboration would, therefore, require a strengthened coordination capacity within the DHE, which means putting more funding and enhanced governance.

Managing healthcare financing: from NHIF to NSHIF

With the high levels of poverty and poor economic performance, Kenya faces tremendous financial constraints in improving the healthcare sector. In light of such constraints, the 2004 10-20 policy to reduce user fees for primary healthcare and to introduce a universal healthcare insurance system in 2003 had great potential to reach the health vision set in the KHPF. However, while the government had targeted to make the National Social Health Insurance Fund (NSHIF) operational in July 2004, it was never implemented due to challenges by sections of professional bodies and the private healthcare industry. In spite of its obvious appeal for the majority of poor Kenyans, in its sensitization campaign the government was not able to convince private healthcare providers and employees in the public and private sectors of the workability of the system. The fears linger over possible loss of income and increased taxation. On the other hand, there is a degree of misunderstanding and more clarity is needed.

Among the leading opponents are the two health bodies – the Kenya Association of Private Hospitals (KAPH) and the Kenya Medical Association (KMA) – and the largest employer and trade associations: the Federation of Kenya Employers (FKE), the Organization of Trade Unions (COTU) and the Kenya National Union of Teachers (KNUT) (Mulee 2004). It is surprising that these organizations would oppose a scheme in which some of them were involved in its design. Regardless, with little support from private health providers, who make up the largest current NHIF system, the new system could not succeed. The key bottleneck lies in the prevailing reimbursement and organizational system of the NHIF. Since the accredited providers have to submit payment claims – to the NHIF branch offices in the area of their operations – lack of efficiency means that they often have to wait for months before the claims are processed. Such experience, although not generalized, has prompted opposition since the new system would introduce a third party (the statutory insurer) in all health transactions in which every client would be covered. A first step in the transformation would then be to put in place an efficient patient-provider information as well as operation management system. Opposition from the providers, including government and traditional health practitioners, also stems from the fact that only those meeting quality standards established by the MOH would be contracted. Crucial also is the concern over what bargaining system and standards will be used to set the terms for provider payments; presently this is done by the NHIF based on its own quality criteria (Wamai 2004:201).

Concerns over the sources of financing the NSHIF also arose across different sectors of the society. Among employees in the public sector, teachers were most adamant to accept the new system due to the fact that they would lose their medical allowances currently paid directly to them along with their monthly salaries. The suggested harmonization of civil servants' contributions would mean that such payments are re-directed to the NSHIF. As such, teachers and other civil servants would naturally suffer a loss of direct cash income. It is, therefore, unlikely that such employees accept to participate in the scheme. The successful registration of all salaried (public and private) and self-employed persons and deduction of their premiums, and the identification of those unable to pay who would be covered by the government is also difficult to achieve. The *Sessional Paper* on the NSHIF suggests that registration of employees can be achieved in a year while that of the self-employed could take 9 years (Republic of Kenya 2003b:20). Registration of the estimated 3 million self-employed persons (Republic of Kenya 2003a:17), the unemployed, the poor as well as children would be done by using identification cards. However, this method assumes every individual possess an identification such as the national card, passport, birth certificate or an address (World Health Organization, German Technical Service (GTZ), Department for International Development, International Labour Organization 2004:11). Although a cap on high-income earners (salaried and self-employed) of over Ksh150,000 was been suggested at Ksh5,000 (US$65) deduction a month (WHO and GTZ 2004:6), a major problem is the method for ascertaining those who would be unable to pay the yearly contribution.

Furthermore, since employers are required to contribute double the part paid by the employee, they will have little incentive to do so and may evade registration. It is also important to acknowledge that the method for ascertaining the poor would have to be flexible because people may fall in and out of the poverty cap due to seasonal changes in cycles of livelihoods especially for rural peasants. Another crucial area that needs clarity and development is the governance system of the NSHIF. One of the key issues the wide-ranging field consultations for the task-force report identified was the general view that: "the management of the proposed NSHIF must have less government and be stakeholder-controlled. Without a sense of ownership of the scheme by the stakeholders, the Kenyans would not have confidence in it" (Republic of Kenya 2003c:19). The draft legal framework for establishment of the scheme tabled in Parliament in June 2004 proposed the system would operate as an independent entity run through a board of trustees consisting of representatives from the larger stakeholder organizations. This governance structure is, however, far from the one identified in the field

consultations that suggested grass-root representation from the village level. By not taking into account the people's wishes as regards governance, the scheme may, therefore, disenfranchise the voices of those it claims to serve.

Conclusion

Kenya's health development has followed a pattern similar to other developing countries. The post-colonial government was quick to develop a health system controlled by the central government aimed at providing healthcare universally free of charge. With the population expanding faster than the hospital system, as health improved and mortality rates decreased, a need for an easily accessible system providing basic healthcare emerged. With the worsening internal economic, political governance and management challenges and external influences from the 1980s, free healthcare provision became unsustainable. The World Bank and International Monetary Fund's imposed neo-liberalist structural adjustment programs that called for the minimization of state's responsibilities (Mohan et al 2000) forced the government to cut expenditures on health. The ensuing social-development crisis and the HIV/AIDS pandemic in the 1990s easily characterize the decade as the darkest in the country's history socially, economically and politically. In the 2000s, the health system is undergoing radical renewal, as are other spheres of society, economy and politics. Nevertheless, administration of the new healthcare policy faces major challenges. As Oyaya and Rifkin (2003) argue, the aims of the health reforms were largely based on assumptions about resources, institutional capacities, the willingness of the NGO/private sector to support government objectives, and reliable donor support.

The policy shift to give greater responsibility for the provision of curative services to the NGO/private sector while strengthening government's role in steering and regulation, and preventive health in Kenya reflects a global trend (Harding and Preker 2003; Wamai 2004) reinforced by two sets of neo-liberal discourses. One is the decentralization and marketization discourse that calls for greater individual responsibility and citizen participation in health policy making, and outcome-centred management that saves or cuts costs and generates revenue for improvement (Pineault et al 1993; Ollila, Koivusalo and Baru 2002). The other is the public-private partnership discourse in which the different sectors are no longer seen as

alternatives (as was the case in the 1980s), but are partners who function in a synergistic relationship (Mwabu 1998:18; Bennett, McPake and Mills 1997; Harding and Preker 2003). A key challenge in Kenya is to develop the appropriate legal and policy framework that creates an enabling environment for the NGO/private-public sector and partnerships to flourish. On the other hand, it is unrealistic to expect them to offer an adequate health package for all. As the data presented in table 1 show, much of the private sector health system is below the health-centre level. On the other hand, the NGO system is much larger above the dispensary level. Since the majority of the population utilize the health system from the health-centre level and below, the policy must encourage NGO and private operators to expand on this area. In the partnership and participation discourse, there will remain challenges in coordination and orchestration. As Watanabe and Takahashi (1997:122-123) assert, coordination among the many players in the country's health strategies pose a major bottleneck in their successful implementation.

The proposed statutory and universal healthcare financing policy is timely and reflects a growing trend in developing countries. Such pro-poor schemes draw particular support from the vast majority of poor underprivileged members of society. Given that similar schemes have in recent times been introduced in other developing countries, such as Senegal, Ghana, Mexico, Indonesia and Vietnam, Kenya has ample opportunity to learn. It is clear that the pro-poor health insurer would benefit the whole society in terms of long-term health benefits as well as reduced healthcare costs. For example, as the projected health financing data show that if the scheme is successfully implemented, the total private contributions – those out-of-pocket, contributions to NHIF/NSHIF, contributions of the self-employed and pre-paid plans – and employer paid medical costs would decrease by about half (Republic of Kenya, 2003b:19). The pooling of resources into a common insurance fund with efficient management can help reduce cost escalation. The financing policy plan also represented a break with the status quo where healthcare financing depended on foreign funding as, which has largely been unreliable (Watanabe and Takahashi 1997:119-120).

In Kenya, as in many countries, politics remain the biggest driver of health reforms (Reich 2002). Hence, and unfortunately, since the formulation of the insurance policy, little has happened. Although the legislation to establish the scheme was passed in Parliament in 2007, the President did not ascent it into law citing high cost and sent it back it to Parliament for amendment. However, with the change of government and health Minister in 2008 the

legislation has not been further pursued. Furthermore, with the formation of a coalition government, the Ministry of Health has been split into two: a Ministry of Medical Services and a Ministry of Public Health. Most commentators and academics, as well as senior policy officials at the Ministry, believe this to be a negative development. Duplication of efforts, shared resources, and uncertainties in responsibilities are some of the handicaps that can further prevent the country from achieving the stated health goals and the Millennium Development Goals for health. Clearly, major new reforms are needed in order to achieve the country's policy of providing quality, affordable, equitable and accessible healthcare to all Kenyans.

Notes

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