Empirical Assessment of the Various Sustainable Financing Mechanisms for Health Care Services in Kenya

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Abstract

Many world economies including Kenya have over the issues endeavored to provide quality health care to its populace. However, the various macroeconomic performance experienced in the late 1980s, negatively affected the government’s ability to sustain the government funded health programs. This is demonstrated by high out-of-pocket spending, and the dwindling of donor support as well as stagnating budgetary allocation estimated to be way below the Abuja declaration of 2001. The high out-of-pocket spending has various economic effects especially among the poor including high financial catastrophe and the impoverishment of the poor. Since them various financing mechanisms have been suggested for consideration. The objective of the study was therefore to examine the viability of these financing mechanisms from the government’s health planners. The study established that the planners prefer financing health care through risk-pooling, dedicated taxes and issuance of health infrastructure bonds guaranteed by the central government. These financing mechanisms are in addition to the normal government budgetary allocation. The success of these financing mechanisms according to the planners will however, depend on the ability of the government to identify the poor, who might not be able to afford the premiums in the case of risk-pooling and consequently undertake sustained subsidization their contributions. Others include the ability to identify the products upon which the dedicated taxes will be levied in addition to lobbying the key stakeholders to support the scheme. Finally, establishment of the necessary legal framework to support the initiatives is also recommended.

Keywords: Dedicated taxes, Risk polling, Infrastructure bonds, User-fees

1. Introduction

1.1 Background of the Problem

The pursuit of access to quality health care has been a critical focus for many stakeholders including governments, multilateral institutions, NGOs as well as CBOs. As a result, the Kenya government with support from various stakeholders worldwide has continued to develop and implement national health policies and strategies necessary for enhancing financing of a well-functioning health system. Due to the economic performance experienced in the 1980s, the government was forced to initiate economic reforms, which partly contributed towards the
abolition of free and subsidized public goods including healthcare. Similarly, the health sector became too large for the line ministry to manage accordingly. It soon however, became evident that the available government resources were insufficient to fully finance a basic package of cost-effective services. With increasing budgetary pressure, it also became a reality that the health sector was financially unstable, as the government could not fully support the health sector single-handedly. This led to the development of alternative financing mechanisms, including user charges/fees, whose main objective was cost recovery, from users of public health facilities to generate additional revenue and augment the financing of the under-funded non-wage recurrent expenditure items, reduce excessive use of services.

The policy change was considered pro-poor if used to improve access to quality health care, and help reorient public financing towards serving poor and other vulnerable. They were however concerns that the fees could limit access to services particularly by the poor thus argued that the charges should be accompanied by appropriate systems of waivers for the poor, exemptions for preventive and some primary health care (PHC) services as well as other mechanisms of financial protection including cash transfers to the poor. In terms of financing, studies show that user charges through out-of-pocket (OOP) expenditure represent a major source of health care financing (GoK, 2010; GoK, 2011). For instance, it is estimated that OOP expenditure remains, in general, the principal method of financing healthcare services and contributes towards at least 36% of total health expenditures (THE). This kind of expenditure leads to the impoverishment of an estimated 1 million households, while a further 39% of sick people fail to seek treatment (Gitahi, 2011). In 2007/08 financial year, 36% of THE, was financed by households, mainly through OOP spending estimated to be way above the WHO recommended level of 15-20% (GoK, 2009; Chris and William, 2010; WHR, 2010). This kind health financing makes it impossible to spread costs over an individual’s life cycle. Consequently, the risk of financial catastrophe and impoverishment is expected to worsen especially among the poor making the realization of universal coverage a dream.

There is also evidence that public financing benefit the rich more therefore replacing charges by public financing may not improve equity as would be expected. In a report by Gitahi (2011), out of Kshs 236.6 billion allocated to social services in 2009/2010 the Ministry of Education received 73.8% while the Health Sector received only 16.0% of the allocation (GoK, 2010). Reports show that between 2008 to 2012, the health sector requirement was estimated at Kshs 386.4 billion against an allocation of 191.2 billion (Gitahi, 2011) representing an estimated funding gap in equipment, drugs, non-pharmaceuticals, human resource and infrastructure of Kshs 195.2 billions. This allocation is considered insignificant compared to economy’s growth rate reported over the same period (GoK, 2010). Additionally, despite an increased growth in Kenya’s economy from stagnation of 0.5% in 2002 to a high rate of 7.0% in 2007, THE as a percentage of gross domestic product (GDP) increased by a small proportion from 4.5 in 2000 to 4.7 in 2007 (GoK, 2008; WHS, 2010). Although in nominal terms, the overall government expenditure on health increased in the last seven years, from 16.4 billion in 2003/04 to 39.9 billion in 2009/10 (USD 13.6 per capita), health financing in Kenya continues to pose a major challenge in health care delivery. This level of funding is well below the Abuja declaration target
of 15%, the Economic Recovery Strategy of 12% and the WHO recommended level of US$ 44 per capita on average (unweighted) in 2009, rising to a little more than US$ 60 per capita by 2015 for low income countries (GoK, 2009, WHR, 2010). This trend in funding continues to be realized despite the government’s commitment in Kenya Vision 2030. In the document, the government of Kenya has reiterated its commitment in revitalizing the health infrastructure, strengthening health care service delivery and developing equitable health care financing mechanisms (GoK, 2008; GoK, 2010). Based on the foregoing discussion, the study first reviewed literature on alternatives sustainable financing of health care and sought the views of key health personnel in the Ministry of Health on their practicability and implementation in the Kenya’s context.

1.2 Situational Analysis

The trends in health indicators in Kenya since the 1960s show a strong downward trend until the 1990s, thereafter, a deceleration, and finally, a momentary reversal in some of the indicators, particularly infant and child mortality rates. During the period, life expectancy rose from about 43.4 years (1960) to 62 years (1990), before declining and stabilizing at about 52 years (2006). Similarly, infant mortality dropped from 122 per 1,000 live births (1960) to 63 in 1990, before rising to 83 in the year 2000, followed by a drop to the current level of 52 (GoK, 2010). The estimates for the under-five-year mortality rate at similar periods were 204 per 1,000 live births, 93, 134 and 77 respectively. Finally, maternal mortality rates still remain high at 414 per 100,000 live births, 650 in 1990 and 1,000 in the year 2000. Evidently, these rates are far above the targets set for the MDGs for the country. Life expectancy (LE) at birth in Kenya had reduced to a low of 45.2 years during the previous policy period, but was estimated to have risen, up to 60 years by 20091. This trend was reflected across all age groups, with stagnation / worsening of the health situation seen across all age – specific impact indicator trends. By the beginning of this policy, however, some evidence of improvements for specific age cohorts was emerging, particularly for Adult, Infant and Child mortality.

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1 WHO 2010 World Health Statistics
In terms of causes of morbidity, table 1.1 provides a summary of the leading causes of deaths and disabilities in the country in order of magnitude.

Table 1.1: Leading causes of deaths, and disabilities in Kenya

<table>
<thead>
<tr>
<th>Causes of death</th>
<th>% total death</th>
<th>Causes of DALY's</th>
<th>% total DALY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ran k Disease or injury</td>
<td>% total death</td>
<td>Ran k Disease or injury</td>
<td>% total DALY</td>
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<tr>
<td>1  HIV/AIDS</td>
<td>29.3</td>
<td>1  HIV/AIDS</td>
<td>24.2</td>
</tr>
<tr>
<td>2  Conditions arising during perinatal period</td>
<td>9.0</td>
<td>2  perinatal period</td>
<td>10.7</td>
</tr>
<tr>
<td>3  Lower respiratory infections</td>
<td>8.1</td>
<td>3  Malaria</td>
<td>7.2</td>
</tr>
<tr>
<td>4  Tuberculosis</td>
<td>6.3</td>
<td>4  Lower respiratory infections</td>
<td>7.1</td>
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<tr>
<td>5  Diarrheal diseases</td>
<td>6.0</td>
<td>5  Diarrhoeal diseases</td>
<td>6.0</td>
</tr>
<tr>
<td>6  Malaria</td>
<td>5.8</td>
<td>6  Tuberculosis</td>
<td>4.8</td>
</tr>
<tr>
<td>7  Cerebrovascular disease</td>
<td>3.3</td>
<td>7  Road traffic accidents</td>
<td>2.0</td>
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<tr>
<td>8  Ischemic heart disease</td>
<td>2.8</td>
<td>8  Congenital anomalies</td>
<td>1.7</td>
</tr>
<tr>
<td>9  Road traffic accidents</td>
<td>1.9</td>
<td>9  Violence</td>
<td>1.6</td>
</tr>
<tr>
<td>10 Violence</td>
<td>1.6</td>
<td>10 Unipolar depressive disorders</td>
<td>1.5</td>
</tr>
</tbody>
</table>

Source: GoK, 2010

As indicated in the table, HIV/AIDS constitutes the highest cause of deaths in the country followed by conditions arising during perinatal period, tuberculosis, diarrheal diseases and malaria in that order. In terms of disabilities, again HIV/AIDS is rated the leading cause followed by conditions arising during perinatal period, malaria and lower respiratory infections. Other
causes of disabilities include diarrheal diseases, tuberculosis, road traffic accidents among others.

1.3 Health Sector Reforms

In order to respond to the demands of the health sector, particularly the need to reform its systems and operations, various policies and strategies have been initiated over time by the government with support of various key stakeholders. Among these include Health Policy Framework Paper, National Health Sector Strategic Plan I & II, Vision 2030. In this sub-section, a brief overview of the reforms is discussed.

1.3.1 The Health Policy Framework

The Health Policy Framework 1994 and successive 5-year National Health Sector Strategic Plans (1999-2004 and 2009-10) set the targets and processes driving the health sector development, as well as healthcare service delivery. The aim of the policy was to introduce reforms, specifically in the way the healthcare services are not only organized but also financed, delivered and evaluated. Key to the realization of these was equitable allocation of government resources to reduce disparities in health status; increased cost-effectiveness and efficiency of resource allocation and use; and manage population growth. Others were enhanced regulatory role of the government in health care provision; creation of an enabling environment for increased private sector and community involvement in service provision and financing; and increase and diversify per capita financial flows to the health sector.

Important approaches and innovations of the health policy especially in NHSSP II were the concept of Kenya Essential Package of Health (KEPH), the Community Strategy, the Joint Framework of Work and Financing (JPWF) an essential element for entrenching the Kenya Health Sector-Wide Approaches (KHSWAp), and finally, the Annual Operational Planning process. These approaches are increasingly becoming a feature of the health sector necessary to enhance financing of health care in the country. In 1994, the Government of Kenya (GOK) initiated and implemented the Kenya Health Policy Framework (KHPF) as a blueprint for developing and managing health services. It spelt out the long-term strategic vitals and the agenda for Kenya’s health sector. To operationalize the policy document, the Ministry of Health (MOH) developed the Kenya Health Policy Framework Implementation Action Plan and established the Health Sector Reform Secretariat (HSRS) in 1996 under a Ministerial Reform Committee (MRC) in 1997 to spearhead and oversee the implementation process. A rationalization programme within the MOH was also initiated. These policy initiatives aimed at responding to i) the decline in health sector expenditure, inefficient utilization of resources; ii) centralized decision making; iii) inequitable management information systems and outdated health laws; iv) inadequate management skills at the district level, worsening poverty levels; and v) increasing burden of disease, and rapid population growth.
The Healthcare Policy Framework of 1993 aimed at reversing the downward trends in health indicators through fundamental changes in healthcare financing systems, increasing the number and diversity of healthcare providers, particularly through the use of the public private partnerships strategies. As a means of increasing financial access, the National Hospital Insurance Fund Act was repealed and new legislation enacted in 1998. The new Act provided for the expansion of the benefit package to, among others, cover out-patient healthcare services, expand coverage to include the informal sector, and provisions for improving governance. However, NHIF service coverage was not expanded at that time, and the population continued to experience even greater constraints in affording the user-fees applicable in the public sector, while the prospects of meeting any of the health goals, including MDGs, remained remote. The situation became critical in 2002, forcing the Ministry of Health to drastically rethink about the user-fees policy. In the process, user fees were abolished in the health centres and dispensaries, leaving only the registration fees of KSh 20 and KSh 10, respectively otherwise known as 10/20 Policy.

1.3.2 The Kenya Vision 2030

Further commitments by the Kenyan government in pursuing reforms are also reiterated in the Kenya Vision 2030. In the blueprint, the central role of health as a key pillar in driving Kenya to be a globally competitive and prosperous nation with a high quality of life equal to that of a middle-income country, by 2030 is emphasized. In the strategic document, the government affirmed its commitment of providing “equitable and affordable healthcare at the highest affordable standard” to its citizens. In the document, these are to be realized through i) access including actual availability of services and financial access - targeting affordability; ii) equity and quality; and iii) institutional capacity. The goals reiterated in the KV by the government include revitalizing the health infrastructure; strengthening health service delivery (especially through human resource strategies); development of equitable financing mechanisms with an emphasis on preventive healthcare; and finally creation of fiscal space through efficient use resources and expansion of health insurance schemes.

2. Health Financing in Kenya

2.1 General Financing Mechanisms

The healthcare financing system is complex and fragmented with respect to how revenues are raised, managed including payment mechanisms and availability of healthcare services. This process is summarized in figure 2.1
The GOK funds the health sector through budgetary allocations to the MOH and related government departments. However, tax revenues are unreliable sources of health finance, because of macroeconomic conditions such as poor growth, national debt, and inflation, which often affect health allocations. A manifestation of the health budget shortfalls is the widespread lack of adequate drugs and pharmaceuticals, staff shortages, and poor maintenance of equipment, transport, and facilities. Over the past two decades, the GOK has pursued a policy of cost sharing to bridge the gap between actual budgets and the level of resources needed to fund public health sector activities. The revenue from the cost-sharing programme has continued to grow in absolute terms and as a percentage of the recurrent government budget. In 2002-03, cost sharing contributed over 8 percent of the recurrent expenditure and about 21 percent of the non-wage recurrent budget of the MOH (GoK, 2010).
Reviews of public expenditures and budgets in the country show that total health spending constitutes about 8 percent of the total government expenditure while recurrent expenditures have been consistently higher than the development expenditures, both in absolute terms, and as a percentage of the GDP. Studies reveal that recurrent expenditure is mostly on program management including wages, with very little spend on drugs and others medical supplies. Also, the per capita expenditure falls short of the Government of Kenya’s commitment to spend 15 percent of its total budget on health based on the Abuja Declaration of 2001. The under-financing of the health sector has impacts negatively on the poor and other vulnerable on their ability to access quality health care.

Overall health system expenditure has significantly increased in nominal terms, from 17 US$ per capita, to an estimated 40US$ by 2010 (GoK, 2010). This expenditure increase is primarily driven by Government and donor resource increases, with proportion of household expenditures reducing as a proportion of the total expenditures. There is, however, no real increase in health system resources, with health expenditures as a proportion of GDP, and public expenditures as a proportion of general government expenditures remaining stagnant during the policy period (GoK, 2010).

2.2 Ministry of Health Total Health Expenditures

Reports show that budgetary allocations to the Ministry of Health between 2000 and 2005 have increased steadily (Ksh. 12 billion in 2000-01 to Ksh. 23 billion in 2004-05) in absolute terms. Table 1.2 shows MOH expenditures for both the Recurrent Account (RA) and the Development Account (DA). Recurrent expenditures have increased both in absolute terms and as a proportion of total GOK spending and GDP, while development expenditures are somewhat variable, reflecting fluctuations in donor spending (GoK, 2005b). Although the government health budget has increased in absolute terms - from KSh 15.3 billion in 2003/4 to KSh 34.4 billion in 2007/082 (MPER, 2009) - it has declined significantly as a share of government spending from 7.66% in 2004/05 to 7.3% in 2007/08 (including on budget donor funding), and from 8.0% in 2002 to 5.2% in 2006 (focusing solely on government financing). This suggests that, as on budget donor funding has increased, domestic funding has been withdrawn casting doubts on sustainable financing of health care in the country. As noted elsewhere, these levels

2 Of this recurrent expenditures accounted for some KSh 23.5 billion
remain well below the Abuja Declaration commitment figure of 15% and the Economic Recovery Strategy target of spending 12% of the budget on health. Similarly, per capita government spending has remained at less than US$ 8, which is below the average for sub-Saharan Africa, with total health expenditure, as a percentage of GDP, at just 4.8%.

Notwithstanding the allocation to the ministry by the central government, the actual spending is skewed in favor of tertiary and secondary care facilities, which absorb 70 percent of health expenditures. Yet primary care units, being the first line of contact with the population, provide the bulk of health services and are cost effective in dealing with the disease conditions prevalent in communities. Health personnel expenditures on the other hand are high, compared to expenditures on drugs, pharmaceuticals, and other medical inputs such as medical equipment and supplies an indication that budgetary allocation is skewed towards program management and as opposed to preventive and curative. Recent estimates reveal that personnel spending accounts for about 50 percent of the budget, leaving 30 percent for drugs and medical supplies, 11 percent for operations and maintenance (O&M) at the facility level and 10 percent for other recurrent expenses. Expenditures for curative care constitute more than 48 percent of the total MOH budget. Donor contributions to the health sector have been on the increase, rising from 8 percent of the health budget in 1994-95 to 16 percent in the fiscal 2001-2002. In some years, donor contributions accounted for over 90 percent of the development budget of the MOH. In summary, the Ministry of Health Public Expenditure Review (GoK, 2004b) reported that the flow of funding to health facilities, especially at the primary care level as being poor with high incidences of leakage estimated at 22 of the user fee revenue collected.

Further, prospects for increasing public funding appear weak, although successive Budget Outlook Papers (BOPA) focused on increasing the share of resources earmarked for the core poverty areas including health. For instance, the 2007 BOPA projected a small increase in the allocation to the health sector from 7.66% of total government expenditures in 2006/07 to 7.59% in 2008/09, and 8.53% in 2009/10. However, these figures are actually much lower than those set out in BOPA 2006 (from 9.0% in 2006/07 to 9.4% in 2008/09). Perceptions about the relative efficiency and effectiveness of existing spending, the budget execution issues mentioned above and the feeling that the sector is already well catered for by donors, is likely to have had an impact on the reluctance of the government to substantially increase health funding. Additionally, scope for increases from other sources is limited, with little room for government to incur additional debt to finance public borrowing. Given the current global financial crisis, it appears unlikely that significant additional external resources will be available, and there may even be some reductions in allocations by some donors.

On the other hand, NHIF resources accounts for about 10% of public health spending. Services are purchased from a total of 501 accredited hospitals totaling over 44,000 beds, of which 65% are derived from government hospitals and 35% from faith-based, private and community-based hospitals. NHIF has accumulated large surpluses due under-utilization of the contributions. This trend is attributed to i) the narrow benefit package (which has not been
expanded despite the legal changes of 1998), and ii) lack of incentives for public sector providers to seek reimbursements; and iii) bureaucracy and sloppy management. Although the share of contributions devoted to providing benefits has increased in recent years in 2007/08, it was only 45%, and in view of NHIF’s wide network, administration costs account for a large share of revenue. Efforts to replace the NHIF with the National Social Health Insurance Fund (NSHIF) in 2006/07 were unsuccessful when the Act failed to receive presidential assent. The fund is in the process of piloting out-patient cover with the intention of rolling over to the entire membership.

2.3 Current Sources of Health Care Financing in Kenya

2.3.1 Out-of-Pocket Spending

In the country, out-of-pocket (OOP) spending generates the largest proportion of the revenue used to access healthcare services. This source contributed 52% and 36% of all the health expenditures in the country in 2002 and 2005, respectively. These funds are used directly at the point of accessing healthcare and are therefore subject to their actual availability at the time of illness, and the cost of the services. At least 65% of these funds are destined for use in the private sector. The Ministry of Health is the second most important source of funding, contributing to about 30% of all health expenditures in the country (almost exclusively for use in the public sector). Resources from development partners are principally channeled to support direct expenditures in programmes and projects, particularly those of a non-curative nature. A small proportion of Kenyans have their health resources channeled into the system though the National Health Insurance Fund and private health insurance. The principal feature of the collection process is that it is fragmentary, unpredictable and except for NHIF, there is no legal or formal provision for how much may be contributed from any of these sources. Consequently the poor are not assured of accessing healthcare services when they are sick, government has not been consistent in meeting its commitments to increase allocations to the health sector, nor are most development partner funds on budget, or on-account. Heavy Reliance on Out-of-Pocket Spending as a Source of Healthcare Financing – Cost Remains a Major Barrier to Access, Often Purchasing Poor Quality Services

The majority of Kenyans do not have access to affordable healthcare due to poverty, which is currently estimated at 42 percent. According to the Household Health Expenditure Report of 2008, by KNBS, 44% of Kenyans who fall sick do not seek healthcare services, due to lack of finances. The report also indicates that over 40% of the poor undertake self-diagnosis when sick. Levels of self-diagnosis and/or self-treatment among the poor in Nyanza of 44%, 51% in Western and 42% in Eastern Provinces, respectively, are mainly due to lack of money. Private spending accounts for a large share of total health expenditure. Most of this takes the form of un-pooled, out-of-pocket spending, which is well recognized as an inequitable and inefficient means of funding healthcare (WHO, 2000) although the poor spend less in absolute terms than the better-off, a larger share of their household expenditure is devoted to meeting their healthcare needs. Figure 2.3 provides a summary of out-of-pocket spending by wealth quintile.
It is far from clear that such spending offers value for money since 69% of private spending on out-patient care is for drugs, with little or no evidence on whether this follows the practices of rational use of drugs. The share of private financing, especially out-of-pocket spending, has declined rapidly in both relative and absolute terms. According to the latest National Health Accounts, the share of private financing fell from 54% in 2002 to 39.3% in 2006, with much of this due to the increase in the share accounted for by donor support. Private spending declined in real terms by 9.8% from KSh 30.8 to KSh 27.8 billion over said period. Household spending dropped from 51% to 36% of total health expenditures, and spending per capita (inflation adjusted) declined from KSh 770 to KSh 713. Perhaps more importantly, direct out-of-pocket spending decreased by 29% from KSh 819 to KSh 578. This huge drop in household spending mirrored a significant increase in flow of development partner funds, especially from PEPFAR, to the sector, which is however expected to suffer given the current funding schedule to developing countries including Kenya.

2.3.2 Overreliance on User-Fees Public Facilities to Fund Services

In 2007/08, reported cost sharing revenues amounted to some KSh 1.57 billion (MoH). Revenues have increased dramatically from around KSh 28m in 1990/91 and KSh 720m in 2000/01. District hospitals accounted for just below 60 percent of total revenues and provincial hospitals almost 30%. Collections in Central Province were more than 10 times greater than those in North Eastern Province. Although small, in absolute terms, they are significant at the

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3 This expenditure is in the form of direct payments, payment into an insurance scheme, or by purchase of a “health card” that gives access to services for a defined period of time.
operational level, accounting for 61%, 50% and 19% of the provincial, district and rural health facility operational budgets (excluding salaries), respectively. There has been a system of waivers and exemptions to cover children under five, TB treatment, malaria drugs, HIV/AIDS treatment and the poor, but this system is not well defined and is complex to administer, since there are no clear criteria to determine the patients who qualify. The important role for user-fees, as a mechanism for healthcare financing, is curtailed largely due to lack of third party payment for the cost of waivers and exemptions instituted to protect and guarantee access by the needy. As a result, the fee levels have been kept low, thereby undermining its revenue generating potential, and consequently its ability to support increased provision and availability of quality services.

2.3.3 Risk-Pooling

In the country, less than 4% of all the health funds are subjected to risk-pooling under both NHIF and private health insurance otherwise known as health management organizations (HMOs). This is an indication of insufficient cross-subsidy from among the different socio-economic groups in the country. Similarly, the purchasing of healthcare services is predominantly personalized (fee-for-service), or input-based (as line item budgets) in the public sector. Only NHIF, private health insurance and a few demand-side financing agencies benefit from output-based purchasing. As noted before, the public sector is not, therefore, able to channel a significant proportion of health funding to the point of neither use, nor can the low-income groups afford healthcare when they are sick.

3. Alternatives Financing Mechanisms for Health Care

In this sub-section, various financing mechanisms are reviewed. These include risk-pooling (including micro-insurance, community based health insurance, social insurance, among others), dedicated tax funds, infrastructure bonds as some of health financing mechanisms are briefly discussed.

3.1 Risk-Pooling and Prepayment Approaches

Risk pooling and prepayment approach is of fundamental importance of improving domestic health financing policy to meet the health MDGs in an equitable way. People contribute to a pool that they, or others, can draw on in the event of illness. In some years, they may receive services that cost more than their contributions, and in some years, less. According to World Health Report (WHR) of 2010, the funds are effective especially since they can cover prescription medicines, ambulatory care, hospitalization, disease prevention and health promotion. With these arrangements, the incidence of financial catastrophe and impoverishment falls to negligible levels especially among the vulnerable including the poor (Chris and William, 2010).
According to WHR (2010), the past three decades have provided lessons on the failure of direct payments such as user fees in financing health systems. As a result, many countries have embraced a system of prepayment and pooling, sharing the financial risks of ill health and to ensure that efforts to contain the growth of expenditures do not, in fact, extend the reliance on direct payments and to become more efficient and equitable in the use of resources. These have been pilot-tested in Rwanda and they seem to be successful. On average studies show that people appear willing to cover closer to one-half of the costs of healthcare for the poor. Although this seem to work in various world economies, there will be need to caution the poor who may not be able to pay the necessary premiums. The success of these mechanisms will however depend on how the public conceives the idea and the ability to minimize the embedded transaction costs.

3.2 Dedicated Tax Funds

Dedicated tax fund is another promising alternative of innovative financing in the health sector. This is because the mechanism has the capacity to generate adequate financial resources and has relatively low. In the US for instance, an additional US$ 10 billion annually for global health is raised through this method (TIIFHS, 2009) through introduction of a tax on air tickets, foreign exchange transactions, as well as tobacco and alcohol consumption. Other sources of solidarity levies include a range of products and services, such as mobile phone calls (Musango and Aboubacar, 2010; Stenberg et al., 2010) as well as sugary drinks and foods high in salt or transfats (Leonhardt, 2010; Holt, 2010).

Some of the earliest developments in this area occurred Australia and California. An increase in tobacco taxes in states in Australia in 1983, resulted in a considerable injection of funds for health promotion which resulted in generation of US$ 1.2 million which was directed to the ‘Tobacco Tax Trust Fund’ (Holman et al., 1984) while in 1988, Californian voters approved 25 cents per package increase on cigarette tax, a quarter of which was earmarked for anti-smoking education and tobacco-related research (Bal et al., 1990). The last two decade has seen a number of other states and countries establish dedicated funds for health. Although there have been some increases since 2000, there is great scope for revenue raising in this area, as advocated by the WHO Framework Convention on Tobacco Control (Prakongsai et al., 2008). Analysis on the consumption, taxation and pricing of alcoholic beverages shows that, if excise taxes were raised to at least 40% of the retail price, substantial additional revenue could be generated and the harmful effects of drinking alcohol reduced. In Stenberg et al. (2010), it was estimated that levying such taxes would lead to a reduction in consumption of alcohol by more than 10%, while tax revenues would more than triple to a level amounting to 38% of total health spending especially in low income countries (LICs).

In practice, however, LICs have a large informal sector and quite often tend to focus on taxes that are relatively easy to collect, such as those on formal-sector employees and corporations, import or export duties of various types and value added tax (VAT). Ghana, for example, covers 70–75% of funding needs for its National Health Insurance Scheme with general tax funding,
notably through a 2.5% national health insurance levy on VAT estimated at 12.5% (Witter and Garshong, 2009). Chile on the other hand, introduced a 1% increase in VAT in 2003 to finance public health. The VAT-based National Health Insurance Scheme has been able to support an increase in total health expenditure through domestically generated pooled funds. At the same time it has lessened the system’s dependence on direct payments such as user fees as a source of finance (Tsounta, 2009).

According to WHR (2010), the potential to increase solidarity taxes on specific goods and services exists in many countries. Analysis by WHO on the potential gains from increasing taxes on tobacco in 22 of the 49 LICs shows that an excise taxes in these countries range from 11% to 52% of the retail price of the most popular brand of cigarettes, representing a nominal range of US$ 0.03–0.51 per pack of 20. If these are considered, a 50% increase in tobacco excise taxes would generate US$ 1.42 billion in additional funds in these countries. These taxes are however not universal and therefore governments will need to implement those that best suit their economies. Additional, there is need for political commitment for the success of these taxes (WHR, 2010). For instance, India has a significant foreign exchange market, with daily turnover of US$ 34 billion (Bank for International Settlements, 2007) while Gabon imposed a 1.5% levy on the post-tax profits of companies that handle remittances and a 10% tax on mobile phone operators raising an equivalent of US$ 30 million for health in 2009 (Musango and Aboubacar, 2010; Stenberg et al., 2010). Similarly, the Pakistan government has been taxing the profits of pharmaceutical companies to finance part of its health spending for many years (Nishtar, 2010).

It is noteworthy that governments and ministries of finance in particular, are generally not enthusiastic about earmarking taxes for specific purposes as pointed out by Busse (2007). As a result, this should be carefully done because earmarking some products can be politically sensitive and will invariably be resisted by particular interest groups. A tax on foreign exchange transactions, for example, may be perceived as a brake on the banking sector or as a disincentive to exporters/importers. For instance when Gabon introduced a tax on money transfers in 2009 to raise funds to subsidize health care for low-income groups, some people protested that it constituted an exchange restriction. However, a 1.5% levy on the post-tax profits of companies that handle remittances and a 10% tax on mobile phone operators in Gabon the same year were successful (Musango and Aboubacar, 2010; Stenberg et al., 2010).

### 3.3 Issuance of Infrastructure Bonds

With loans difficult access credit, bonds provide debt financing over long periods, which may cater for the long time investment expenditures such as expansion or construction of health facilities. There are two types of bonds that are commonly used namely general bond and municipal bonds. General bonds are issued and guaranteed by the central government. Traditionally, governments issue Treasury Bonds to finance public expenditure. For instance in 2009, the Kenyan government launched the first infrastructure bond (a 12-year bond) worth Kshs. 18.5 billion to finance water, sewerage and irrigation, roads and energy projects (Central Bank of Kenya, 2009). To attract investors, the government included incentives withholding tax
exemption on interest income and listing at the Nairobi Stock Exchange – this would increase the bond’s liquidity.

Municipal bonds on the other hand, offers a way of helping local governments, particularly urban governments to finance critically infrastructure with domestic private capital, rather than sovereign borrowing by national governments (The Bond Market Association, 2008). These bonds are usually exempted from taxes. There are two types of municipal bonds depending on the source of debt service namely revenue bond and general obligation bonds. Revenue bonds are a type of municipal bonds, whose debt service is normally payable from identified sources of revenue generated from the financed project. On the other hand, general obligation bonds are a type of municipal bonds, whose debt service is payable from general revenues of the issuer of such municipal bonds. Although health care projects in developing countries have not tapped into the bond market, the sale of bonds in international bonds market has mostly been available to large projects by donor countries where issuance of these bonds has raised more than US$ 2 billion since 2006 [International Financing Facility for Immunization (IFFIm), 2010]. These funds are channeled to the International Financing Facility for Vaccines, linked to the GAVI Alliance.

It is clear from the foregoing discussion that households spending through out-of-pocket spending, and donors remain the largest contributors of health funds. The private sector, which comprises of households, private companies, and local foundations, contributed 39% of total health expenditure, with 36% coming from households, mainly through out of pocket spending in year 2007/08 (NHA, 2009). Such systems of health financing make it impossible to spread costs over the life-cycle: paying contributions when one is young and healthy and drawing on them in the event of illness later in life. Consequently, the risk of financial catastrophe and impoverishment is expected to be high, and achieving universal coverage becoming unattainable. Based on this, the study sought to examine the public perception of the financing mechanisms for health care services in Kenya.

4. Methodology and Findings

4.1 Methodology

A descriptive research design was employed in this study with an aim of securing a representative sample of the relevant population to ensure the assessments of the target population that would represent the general population. The research design was appropriate for this study as it allowed for the analysis of the views of health care personnel involved in financing of health care. The sampling frame consisted of planning personnel drawn from the Ministry of Medical Services and the Ministry of Public Health and Sanitation. Multi-stage sampling technique was adopted in the study to identify the sample elements.

A self administered structured questionnaire that contained both open-ended and closed ended questions was used in collecting primary data. Additional data was collected from the ministry's
strategic plans, draft financing strategy as well as Kenya Vision 2030. Others were relevant journals, published authoritative sources from WHO and World Bank. Data collected was cleaned and validated before being coded in a mode that could be picked by the necessary statistical package. Finally, the analysis was conducted using Statistical Package for Social Scientists (SPSS) and MS Excel in terms of frequency tables, charts and graphs.

4.2 Findings and Discussion

The reported in this sub-section are in terms of various financing mechanisms discussed above. The first sub-section provides the views of respondents in terms risk-pooling followed by dedicated taxes and finally issuance of infrastructure bonds earmarked for health financing.

4.2.1 Risk-Pooling

The study reveals that all the respondents expressed their support for risk pooling and prepayments schemes. Their support was founded on the basis of the financing mechanism in supporting the solidarity needed to build a wider movement towards universal coverage, by removing financial barriers to access of health care, especially for the poor and reduces financial risks of illness. Pooling the resulting funds builds the solidarity needed to build a wider movement towards universal coverage. This makes the system progressive to the extent that the wealthier will be paying for services used by the poor. However, the 97% of the respondents felt the sick should not pay a significant share of the costs of health services that they use. This demonstrates that as the government struggles to realize universal coverage, Kenya would need to extend coverage to more people and/or pay a greater part of the cost. This finding is in agreement with the World Human Report (WHR) of 2010, which noted that the payments made in advance of an illness, and pooled in some way are used to fund health services for everyone who is covered – treatment and rehabilitation for the sick and disabled, and prevention and promotion for everyone.

Regarding contributions, all the respondents reiterated that the contributions should be compulsory with subsidies for the poor. Respondents observed that if the contributions are voluntary the rich are likely to chicken out and seek individualist health insurance from cooperates. This in the process is likely to contribute to insufficient resources to cover the health needs of the vulnerable especially the poor. This finding is in agreement with that of WHR (2010), which acknowledges that participation will need to be compulsory if 100% of the population is to be covered. Longer-term plans for expanding prepayment and incorporating community and micro-insurance into the broader pool are important in order to cover more services. Further, all respondents indicated that it is important to consolidate all the schemes into one national scheme. This is in agreement with the WHR (2010) assertion where that the most effective way to deal with the financial risk of paying for health services is to share it, which ensures better protection of the venerable.
4.2.2 Dedicated Taxes

With regard to dedicated tax fund, variant views were expressed. Whereas majority of the respondents were of the opinion that dedicated tax fund protect and improve people’s health, a few noted that it provides a stable revenue stream, whose cost of collection is relatively low for the government given the various tax reforms including incentives that the government has introduced in the recent past. These findings support the assertions by Prakongsai and Patcharanarumol (2008) where this option was considered promising since it offers a sustainable capacity to generate income and that it attracts relatively low administration costs. Prakongsai et al (2008) noted that key attribute of an ideal dedicated tax fund is raising more funds and improving health at the same time by reducing consumption of harmful products such as tobacco or alcohol. The findings are also consistent with those of Stenberg et al (2010) whose analysis on the consumption, taxation and pricing of alcoholic beverages showed that substantial additional revenue could be generated and the harmful effects of drinking alcohol reduced.

The finding supports the analysis by Stenberg et al (2010) on the potential gains from increasing taxes on tobacco in 22 of the 49 LICs, which showed that an increase in excise taxes of cigarettes would generate additional funds to cover for health expenses. The results are consistent with UNITAID (2010), Fryatt (2010) and Nishtar (2010) who separately noted that a levy on air ticket and on mobile phone operators is an effective way of raising additional funds for drug purchase facility for various diseases. While agreeing with the respondents that collecting taxes is more efficiently would effectively raise additional funds, Gordon (2009) noted that improving revenue collection is something that all countries might need to consider, especially the LICs where this is a dominant problem. These findings are also inconsistent with the WHR (2010) which points that progressive tax system is a more sustainable alternative of financing health care.

The finding that the fund is easy to administer however contradicts, Lucas (1998) who argued that the new funding mechanisms attract a high level of interest and scrutiny by government, the media and the community, which may hamper its administration. Lucas further observed that policy-makers and others tend to have high expectations of what may be achieved by the new funding in the short or even medium term. For instance, they may expect that the fund will demonstrate a contribution to economic development, as well as measurable health improvements, in a relatively short time. Such expectations are unlikely to be realized and may be damaging if not corrected. According to the respondents, implementing the dedicated taxes should be done systematically by first identifying the products that should be targeted for tax increase, followed by the necessary consultation with key stakeholders (such as politicians, the media, health professionals, key opinion leaders and the general community) to get their buy-in otherwise it is likely to be contested in the court of law.
This according to the respondents, some products could be politically sensitive and will invariably be resisted by particular interest groups. Additionally, taxes have distortionary effect to various economic agents including households, firms and the society at large and therefore will be opposed by those with vested interests. The respondents further observed that once these have been accomplished, then the case for dedicating part of funds for specific health programmes can be initiated with the necessary policy action and legal framework. Legislation will ensure that all or a reasonable proportion of the tax is dedicated to health care financing. Finally, specific organization to administer the resources generated need to be estimated with the necessary management structures for prudent financial management. The study further revealed that lack of judicious implementation of a dedicated tax fund would suffer from various challenges. Among them opposition by the companies affected, as well as the Ministry of Finance and by the agencies such as sports which are funded by the companies affected.

Regarding the products and services that should be earmarked for dedicated tax funds, 90% of the respondents were of the opinion that tobacco, airtime, air ticket and alcoholic drinks should be subject to these taxes. According to the respondents, these products exhibit inelastic demand and are habitual in nature as a result; their respective demand will not be affected adversely. Other products suggested by respondents were sugary drinks and foods high in salt due to their health hazards. The findings are consistent with WHR TIIFFFS (2009), which listed that air ticket tax as one of the sources for dedicated tax. All the respondents were however, of the opinion that these will require putting in place necessary legislation since according to the respondents; it might be challenged by interest groups.

4.2.3 Issuance of Health Infrastructure Bonds

Regarding the issuance of bonds earmarked specifically for health care infrastructure, all the respondents supported this is a noble idea which need to be pursued. In particular 100% of the respondents felt that it was a worthy course with the general bonds, issued and guaranteed by the government preferred to municipal bond. The preference according to respondents was associated with the history of the Kenyan government’s use of government guaranteed debt. This was reinforced by the oversubscription of the first ever infrastructure bond that was issued on January 28th 2009. Notwithstanding this, only 3% of the respondents expressed their preference for municipal bonds. Although revenue from municipal bonds may still be acceptable, general obligation municipal bonds were found to be unattractive by all the respondents. This may be attributed to the inability of local government bodies to settle their debts in time and, notwithstanding investors’ nature of being risk averse. Local government authorities in Kenya receive about 40% of their budget financing from the central government (LATF, 2007). This would mean that their ability to repay debt obligations from their general revenues is limited.

Respondents however, noted that the success of the facility will depend on how first the government in consultation with key stakeholders moves to establish the necessary legal framework to stir the process. Other key issues raised for the success of the facility were level
of development of the bond, government guarantee, and the ability to sell the bond before maturity, availability of information regarding bond risks, tax treatment of investor returns and credit rating of the issuer. This finding supports Hyun et al. (2008) and Lei gland (1997). Hyun et al. for instance, emphasized the importance of the legal framework by stating that legal measures are very important in encouraging the issuance of infrastructure bonds. The study also reveals that bonds offer several benefits to the issuer including reduced borrowing costs, increased investor base for infrastructure, provision of a means of raising large sums of money, assisting to diversify sources of funding, and establishing a favorable credit history in the capital markets. In terms of the need to issue part of the initial infrastructure bond to a reputable investor, such as the World Bank, to boost investor confidence, the response was that having such an anchor investor in the Kenyan market was of little importance. This is at variance with the assertion by Hyun, et al. (2008) that the presence of an anchor investor would build confidence in the market and, therefore, contribute to the success of an infrastructure bond issue. However, the fact that Kenyan investors have demonstrated their willingness to purchase infrastructure bonds may imply that there is sufficient investor confidence and hence no need for an anchor investor in the Kenyan infrastructure bond market.

5. Conclusion and Way Forward

5.1 Conclusion

From the preceding discussion, it is apparent that risk pooling and prepayments, dedicated tax funds, infrastructure bonds are favored by health planners especially at the two ministries of health in the country as sustainable mechanisms for financing health care in the country. Based on the research findings prepayments would facilitate in spreading the cost of health care and reduce incidences of catastrophe and impoverishment, among the poor in the society. Dedicated tax funds on the other hand, would provide a stable revenue stream for financing health care, promote and protect peoples’ health. This according to the respondents will ride on the back of the various tax reforms that the government has continued to initiate and implement since the late 1990s which has seen incidences of tax evasion dwindle as well as a reduction in cost of collection. However, according to the respondents, the success of this will depend on the ability to identify the products on which the tax will be levied followed by an all inclusive consultation with key stakeholders for consensus building and avoidance of cases where the scheme might be challenged in the court of law. Similarly, according to the respondents, establishment of the necessary legal framework upon which the scheme will be anchored including establishment of the organization to spearhead the process was raised. Lastly, the study established that respondents favored issuance of general infrastructure bond, issued and guaranteed by the government as opposed to the municipal bonds. According to the respondents, investors have minimal confidence in the ability of local government to settle their debts in time. Like in the case of dedicated tax funds, respondents noted that a legal framework will be critical in issuance of the bonds.
5.2 Way Forward

The success of risk pooling and prepayments schemes involves making the contributions compulsory. However, there is a segment of the population that may not afford the charges therefore, it will be necessary that that subsidies are designed to caution these group. As a first step towards this, it will be necessary to design a tool that will facilitate in the identification of the poor. In terms of dedicated tax fund, it is necessary that an inclusive process of consultation is adopted to minimize incidences where these funds are challenged. This will also require formation of a lobby group to facilitate the buy-in of the various interest groups. Lastly, necessary legal frameworks need to be established so that the scheme is anchored onto the laws of the country. This should be considered alongside the establishment of a legal entity that will prudently manage the funds collected. This indicates that efforts to establish a dedicated tax fund should include strategic approach to lobbying and advocacy targeting especially the affected companies.

Besides presenting a clear and firm vision, not only of the uses to which the funds are to be directed, but also of the mechanisms by which the funds will be allocated, the advocates for dedicated taxes will need to learn the language of economists and the type of arguments that convince the ministry of finance of the need for additional funding for health care. They will also be able to convince the treasury that dedicated taxes do not discourage investment, but rather it is an important investment in one of the important pillars of economic development, the social pillar. Establishing a facilitative legal framework would enable potential investors embarrass the concept so as to finance public infrastructure. The success of this will however depend on the credit ratings of the issuer. Unlike some countries such as South Africa that are considered success story, in Kenya, there is no credit rating agency despite corporate bonds having successfully traded in the local market for many years. This is an important factor in issuing bonds as improved credit ratings help in reducing debt-servicing costs as a percentage of overall expenditure.

Références


WHR. (2010). Thresholds of health expenditure for protection against financial risk
