



Are We Reaching the Poor and Vulnerable?



**Interpretation of Data for Policy Implementation –
A Review of Findings from Kenyan Health System Related Studies**



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Interpretation of Data for Policy Implementation – A Review of Findings from Kenyan Health System Related Studies

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KEY MESSAGES

- Women and the poor rely heavily on primary care and benefit relatively little from secondary or tertiary care.
- Regional disparities in terms of access and quality of services coincide with higher morbidity.
- Poverty is still a significant barrier to accessing health care.
- The poor often rely on family and social networks for support due to unavailability of cash. This is a high risk factor for falling deeper into the poverty trap.

1. Introduction

This paper summarises the key findings of six different health systems related assessments conducted in Kenya that include: National Health Accounts (NHA) 2005/06, Household Health Expenditure & Utilization Survey (HHEUS) 2007, Public Expenditure Tracking Survey (PETS) 2008, Client Satisfaction Survey (CSS) 2009, Social Spending, Poverty & Gender Inequality: A Benefit Incidence Analysis 2009, and Kenya's Integrated Household Budget Survey (KHIBS) 2005/06. This is complemented by a brief analysis and suggested measures to address some of the shortcomings and inequities that were frequently identified in the surveys. An overview of the surveys can be found in Annex 1.

2. The Kenyan Context

Over the past decade, healthcare reforms to address inequities in the funding and access of healthcare services have been promoted by both the Kenyan government and development partners. The National Health Sector Strategic Plan (NHSSP) II prioritises interventions to improve access and quality of health services, in particular for the poor. However, a growing body of evidence - like the studies examined in this paper - illustrates that Kenya is still far from reaching equitable access to quality care. Some possible explanations include: continued financial barriers to access care, uncoordinated investments in the health sector, improvements in health from which the poor benefit less than richer segments of society, and insufficient coverage of health services. Interacting with these barriers is the fact that national health spending as a percentage of the total resource envelope for public services has dropped.

3. Methodology

Data from six different assessment studies were reviewed to obtain a comprehensive picture of the performance of the health sector in Kenya in terms of access, quality and financial performance. Given the different study designs and heterogeneous dimensions of health system assessments, the comparison of data posed some challenges to meaningful interpretation and drawing of conclusions. The wealth of information generated by the different studies made this already challenging task even more complex. Comparability was further impaired by the timing of the studies, which cover a time span of almost six years. In order to harmonise the findings, this

paper categorises the detailed findings into a number of different domains before clustering and analysing them under the following sub-headings (a) Access (b) Equity (c) Quality (d) Health Sector Financing.

4. Limitations

The limitations for the PETS, as well as for the Client Satisfaction Survey, are that they target the public sector only. It was also noted that certain questions, which help the reader to qualify the sampling method, were not answered in the final reports. For example, the Client Satisfaction Survey failed to report on how clients were selected (the sampling of facilities is clear but not that of clients), and how the researchers dealt with issues such as illiteracy and language barriers within the sampled community. The PETS states that District Health Management Teams (DMHT) were part of the selection process of facilities, which could skew the selection. There are also some contradictory findings on for example out-of-pocket expenditure between the PETS and the NHA. The differences and shortcomings are taken into account within the analysis.

5. Summary of Key Findings

Despite the methodological limitations of the surveys and studies examined for this paper, coherent patterns emerged after the comparative analysis:

- Women and the poor rely heavily on primary care and benefit relatively little from secondary or tertiary care.
- Regional disparities in terms of access and quality of services coincide with higher morbidity.
- Poverty is still a significant barrier to accessing health care, and the poor often rely on family and social networks for support due to unavailability of cash. It is widely acknowledged that this is a risk factor for falling deeper into the poverty trap.
- Women and the poor are most likely to be burdened by out-of-pocket (OOP) expenditures and the costs represent a much larger share of their income.
- There are still serious quality concerns in the sector, in particular at lower levels of care.



In the table below, we have summarised what we believe to be key findings from the various reports and examined their relevance for the Health Sector in Kenya from a pro-poor and equity perspective:

Table 2: Summary of Findings

FINDINGS	RELEVANCE FOR HEALTH SECTOR
1. Access and Equity in Kenya's Healthcare System	
There is a 20 percent increase of patients who regard user-fees as being high ^{4&6}	Households need to be protected from high health expenditures through universal coverage. This has to be the backbone of the new health financing strategy.
Amongst the sick who did <u>not</u> seek treatment during their last illness, 38 percent identified lack of money as the reason ²	The health financing strategy must take the situation of the poor and women into account when designing systems for social health protection.
Women and poor are most likely to be burdened by high OOPs ²	
Fees for services are collected from fewer patients but higher rates are levied ⁵	There is a need to design as system with more rigorous checks and balances to ensure that free services are actually free and accessible.
People are still paying for "free" services ⁴ .	
The percentage of household OOP spending at public health centres increased from 3 to 15 percent ⁴	
Service users travelled on average 11.7km to nearest health facility – previously 8.8km ⁴	Need to work with the Community Development Fund (CDF) and other funding mechanisms for infrastructure.
37 percent of people bypass other health facility on way to final health facility; suggesting that perception of quality is a key determinant in choosing one health facility over another ⁴ .	There is a need to fast track the community health strategy in order to reach out with health services. There is a need to develop and implement a referral strategy including its link to the financing strategy (by-pass fees etc).

¹National Health Accounts (NHA) 2005/05,

²Household Health Expenditure & Utilization Survey (HHEUS) 2007,

³Public Expenditure Tracking Survey (PETS) 2008,

⁴Client Satisfaction Survey (CSS) 2009, Social Spending,

⁵Poverty & Gender Analysis (Demery et al) 2009

⁶Kenya's Integrated Household Budget Survey (KHIBS) 2005/06.

Investment into facilities above health centre level benefit wealthier people more than poorer segments of society.	Still an inequitable system where the rich access health services more than the poor. This needs to be addressed in priority discussions on government and DP budgets, monitor where investments go and ensure links to health financing strategy.
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Morbidity in Western and Nyanza Province are significantly above the national average ⁶	Regional disparities persist and need to be taken into consideration when determining priority areas.
Except for droughts and floods, chronic or severe illnesses are the most common form of economic shocks, regardless of poverty status ² .	Protection from catastrophic expenditures relevant to all segments of society.
Households spend 57 percent of their OOP on reproductive health (RH) at private providers and contribute 37 percent to the total spent on RH services ¹ .	Financing of maternity and reproductive health services needs to be given further impetus. Continued and strengthened cooperation with the private is sector necessary.

2. Utilisation/ Availability of Services and Quality

54 percent of patients choosing a particular healthcare facility did so because it is close to home ⁴ .	Provider choice is not a real choice everywhere.
District health facilities are attractive to patients because of comparatively higher availability of medicines ⁴ .	Patients are treated at expensive, high level facilities even if their disease status does not warrant it. There is a need to implement a referral strategy and to ensure availability of drugs at lower levels of care.
Women make more out-patient visits than men and poor people use out-patient services more ² There is a strong positive correlation between the wealth index and use of in-patient services and a negative correlation with out-patient services ²	Ensure free out-patient services and/or coverage in a social health protection scheme protecting the poor from paying for out-patient visits. Should be addressed in health financing strategy.

¹National Health Accounts (NHA) 2005/05,

²Household Health Expenditure & Tracking Survey (NNEUS) 2007,

³Public Expenditure and Tracking Survey (PETS) 2008,

⁴Client Satisfaction Survey (CSS) 2009, Social Spending,

⁵Poverty & Gender Analysis (Demery et al) 2009

⁶Kenya's Integrated Household Budget Survey (KHIBS) 2005/06

<p>The rich still use health services more than the poor, especially higher level facilities, whilst poor people utilize more frequently less resourced low level facilities (dispensaries, health centres)⁵</p>	<p>Pro-poor strategies should focus on improving low level facilities.</p>
<p>Rich attract more in-kind support from the government compared to the poor⁵</p>	<p>Need to identify innovative ways of reaching the poor, e.g., mobile healthcare units and system strengthening at lower level facilities.</p>
<p>Over half of all diseases are diagnosed by individuals with no formal training⁶.</p>	<p>Pattern of utilisation of health services needs to be given priority when deciding on investments into the health sector.</p>
<p>Immunisation rates vary from 7.6 percent in Northern to over 90 percent in Central Province with marginally better coverage amongst the non-poor⁶</p>	<p>Barriers to accessing formal healthcare lead to wrong diagnosis and/or treatment.</p>
<p>3. Financing of the Health System and Public Financial Management</p>	
<p>While government spending on health increased by 23 percent, government expenditure for all sectors doubled during this same period¹</p>	<p>Health is doing a lot worse than other sectors in terms of accessing government funds.</p>
<p>Health as percentage of total government expenditure was 5 percent in 2005/06, down from 8 percent reported in 2001/02¹</p>	<p>Sustainability and the commitment of government to health are in question.</p>
<p>Donors continue to be a major source of HIV/AIDS funding¹</p>	
<p>Donor funding and out-of-pocket expenditure account for 60 percent of the total health expenditure¹</p>	
<p>Between 2001/02 and 2005/06, donor funding increased by 135 percent, with NGOs managing the majority of these funds¹</p>	<p>NGOs, as signatories to the health sector Code of Conduct, should be made to account for funds they manage – and if not signatories, they need to be brought on board. Initiate discussions with the Health NGO Network HENNET is suggested.</p>
<p>The share of Kenyans who have health insurance is about the same as in 2003, around 10 percent¹</p>	<p>There is probable scope for more insurance and competition to NHIF.</p>
<p>National Hospital Insurance Fund's (NHIF) spending increased by 14 percent from 2.3bn in 2001/02 to 2.6bn in 2005/06. However, NHIF share of the total health insurance spending decreased from 51 percent in 2001/02 to 41 percent in 2005/06¹.</p>	<p>Healthcare financing strategy needs to address the roles and responsibilities of alternative health insurance schemes.</p>

There are 23 micro insurance schemes available in Kenya ¹	There is a limited understanding of role, depth and breadth of micro-insurances in Kenya.
Poor record keeping of reimbursements from NHIF ³	NHIF funds are not captured at facility level - needs to be addressed.
Poor record keeping on funds from DPs ³	Need to support facilities to capture also development partner funds.
4. Disease Patterns	
Childhood communicable disease is the single largest consumer of resources ^{6&7}	Communicable diseases and respiratory tract infections are responsive to preventive measures.
Respiratory diseases consume a disproportionate amount of health resources ^{6&7}	There is a need to re-visit the KEPH and make a cost-benefit analysis of introducing more interventions in favour of preventing over treating these conditions.
41.4 percent of the sick population has suffered from malaria over the past month ⁶	Regional disparities in morbidity are largely attributable to malaria. This needs to be addressed in the design of malaria programmes and interventions. Equity issues still persist in the access to malaria prevention services.
Less than one-fifth of the poor, compared to a third of the non-poor, slept under mosquito nets ⁶ .	
5. Resource Constraints	
Distribution of staff across provinces is uneven. The staff incentives structure is skewed towards urban areas ⁵	Consider implementation of a human resource strategy that addresses inequalities before or concurrent with other national reforms.
Distribution of staff across levels of healthcare provision is uneven ⁵	Incentivise staff to move to understaffed and underserved areas. Substantiate findings that provincial and district levels are overstaffed. Community strategy could improve the quality of lower level facilities, thus attract more staff.

6. Results and Discussions

The table above gives a snapshot of the situation in the health sector in Kenya with a focus on the poor. It also highlights some of the potential interventions for the Government of Kenya and its partners in the health sector, based on the review of survey data and reports.

At a glance it is evident that Kenya has to address a number of structural, financial and behavioural health determinants if it is to achieve the objectives of the Vision 2030 and the National Health Sector Strategic Plan II.



Commonalities across the different data sources are many but for the purposes of presentation and analysis they have been

clustered into four domains: Access, Equity, Quality and Financing of the Health Sector.

6.1 Access

With 37.1 percent of the total health expenditure, households are still the largest financial contributor to healthcare services in Kenya (NHA 2009). The majority of household spend is through out-of-pocket spending. Despite the fact that the household share has decreased from 51 percent of the total health expenditure in 2001/02, the household financial burden of out-of-pocket expenditure appears to have increased, according to the results of the HHEUS (2009). This suggests a 20 percent increase of patients who regard user-fees as too high. This finding is consistent with extrapolations from the NHA (2009) that OOP has increased at primary health facilities, where the poor mainly seek their care. At first glance we seem to witness a positive development with OOPs decreasing at the public hospital level, but this does not benefit the poorest people who have limited access to public hospitals, nor does it encourage access to health services at lower, less costly primary healthcare facilities. Indeed, at public health centres and private facilities OOP spending has increased by 12 percent and 35 percent, respectively.

6.2 Equity

In spite of the 24 percent increase in government funding, considerable equity issues persist. In fact, the increased spending has been widening the gap that exists between the poorer and wealthier in terms of access to health benefits. The Benefit Incidence Analysis calculated that the government's health subsidies going to the poorest are only about half of those going to the richest. This is mainly due to the fact that richer groups in society tend to access higher level facilities, which benefit disproportionately from government funding. It is also apparent, that as a proportion of income, the poor continue to spend more than the rich.

NHIF, as the largest social health insurance scheme in Kenya, retains the bulk share of the insurance. It is worth mentioning that only about 10 percent of Kenyans can

enjoy health protection through pre-paid insurance schemes³. This has remained unchanged between 2003 and 2008. The previously mentioned reduction in OOP spending, therefore, has to be attributed to improved financial support from donors and government.

Households in the poorest quintiles spend on average 8 percent of their income on health, in contrast to the richest quintiles, which spend approximately 6 percent on health. Poorer women are particularly disadvantaged in terms of benefiting from health subsidies. This is largely due to difficulties in accessing referral hospital care. Waiver systems and exemptions which were introduced with the intention to minimise inequities in accessing care appear to have failed. To this end the PETS (2007) reads *'the application of waiver and exemption guidelines at facility level is not standard and is subject to abuse by the facility staff. In particular, and against laid down procedures, the well-to-do groups of society are being exempted from payments an issue which works against the principles of equity and access to health services by the poor and vulnerable groups'*.

There is also a need to point at geographic disparities. Morbidity in Western and Nyanza Provinces are significantly above the national average. Immunization rates - a commonly chosen indicator of equity and health system performance - ranges from 7.6 percent in Northern to over 90 percent in Central Province. Regional disparities are further compounded by uneven distribution of staff across provinces. The distribution of staff and healthcare facilities, highlight profound inequalities in the provision of services.

6.3 Quality

Quality aspects of healthcare seem to directly affect the utilisation of services. For example, patients seek care at district healthcare facilities because the availability of medicines is superior to that at other facility levels. A striking finding is that over half of all diseases are diagnosed by individuals with no formal training.

The out-of-pocket expenditures on drugs at private pharmacies have reduced from 5.6 to 4.3 percent. This finding is somewhat off-set by stock-outs, which affected 32.5 percent of dispensaries and 22.7 percent of health centres for periods of up to 4 months (PETS 2008).

The annual rate of admission has increased to 27 admissions per 1,000 of the population, from an admission rate of 15 per 1,000 recorded in 2003. This might indicate an improvement in the sense that inpatient services are increasingly able to meet previously unmet demand. However, it can also mask other causes, such as failure of the primary facilities to offer early successful intervention, or failure on patients' part to report early signs of disease. The latter might be due to perceived lack of quality in lower level facilities or restrictions of access imposed by high user-fees. In any case, the increase in hospital admissions warrants more detailed analysis.

The reviewed studies consistently found that quality aspects are a major determinant in patients choosing one healthcare provider over another, with availability of medicines and qualification of staff topping the list.

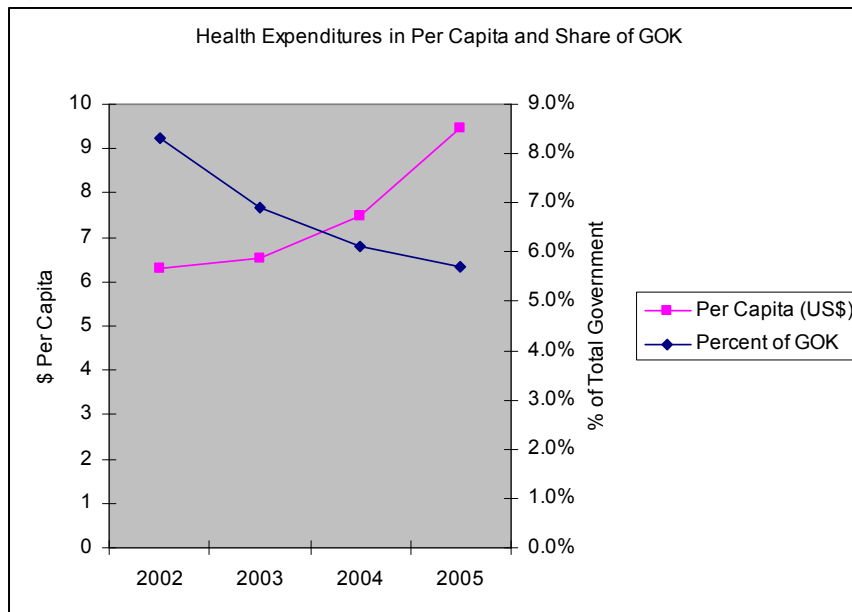
³ National Health Account (2005/06)

On a positive note, the incidence of malaria, the most common illness amongst hospitalised patients (23 percent), fell significantly. The HHEUS attributes the reduction to earlier and more frequent visits to providers, but preventive and promotive health measures supported by Kenya and its development partners cannot be ignored.

6.4 Financing

Kenya had spent approximately Kshs 71 billion (US\$ 964.4 million) in 2005/06 on the health sector. Although this presents an increase of 23 percent from the figures released in the NHA 2001/02 estimate, spending on all sectors doubled over this period. The total spending on healthcare translates into a US\$ 27 per capita spending. While these figures compare favourably with recommended per capita spending by WHO (US\$ 12 for basic health services), UNDP (US\$ 22 to reach MDG), it falls short of recommended levels for financing an essential package of health (WHO US\$ 34 per capita, NHSSP I US\$ 44, Kenya Dynamic Costing Study US\$ 47).

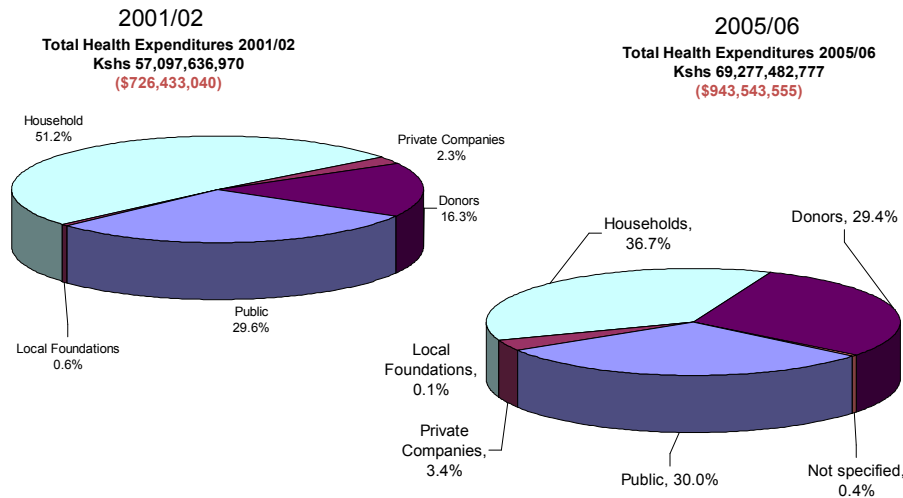
Figure 1 – Trend of per-capita Health Expenditure and GoK Share



By sub-Saharan African standards, financing of the Kenyan health sector is relatively high. Unfortunately, this is not reflected in health outcomes and system performance when compared to other health systems in low-income countries. This finding suggests that inefficiencies and issues of cost-effectiveness are preventing the Kenyan health sector from achieving its full potential.

According to the NHA (2009), OOP spending has reduced from 51 percent in 2001/02 to 36 percent in 2005/06 as mentioned above, please see figure 2 for details. This reduction is largely fuelled by increased donor spending, particularly in the area of HIV. In total, donor funding and OOP expenditures make up 60 percent of the total health expenditures. Despite the differences in distribution, this share remains largely unchanged from the previous NHA. Hence, concerns remain over the equity and sustainability of the health sector finance.

Figure 2 Total Health Expenditure by Financial Source



PETS (2008) also found issues concerning the flow of finances in the health system. It observed significant delays in processing Authority to Incur Expenditure (AIEs) which results in District Medical Officers of Health (DMOH) and health facilities not receiving funds on time. Concerns remain whether DMOH as the fund holder of AIE is delaying the access of funds at health facility level. There is also a discrepancy between budget allocations and actual funds being disbursed. This situation is made worse by the leakage rates that have been reported in the health sector. In summary, the financial recording and reporting systems do not provide sufficient knowledge and awareness of the flow of finances at and below the district level. Some of the inefficiencies and issues around cost-effectiveness stem undoubtedly from those inadequate public financial management systems. Recent developments, such as the Health Sector Services Fund (HSSF), may have the potential to offer more transparency of financial flows and improve utilisation of financial resources at lower levels in the health sector.

Lastly we would like to draw the readers' attention to some of the inconsistencies encountered during the course of evaluating and analysing the different data sources. For example, in the HHEUS, it is noted that in 2007 the poor were slightly more likely to obtain care than the rich. However, in the same report it is noted that the relatively wealthy use healthcare more. A possible explanation could be the free HIV/AIDS services to the poor by big donor programmes. However, there is a need to "dig deeper" to find explanations in order to draw the correct policy conclusions.

7. Conclusion

Kenya has not yet reached the NHSSP II goal of equal access to quality health services. Studies point at inefficiencies at various levels, which lead to inefficient disbursement of resources, inefficient financial management and inefficient resource allocation. These inefficiencies are matched with insufficiencies in terms of resource availability. For several reasons, the health sector has failed to secure similar increases of government funding that has seen the education sector prosper. The limitations and recognised weaknesses are further compounded by the inequitable healthcare system. In Kenya inequities are multifaceted and include economic, gender related and geographical inequities, all of which are negatively correlated to access and utilisation of health services. Current resource allocation systems do little to counteract the situation, in fact in some cases the situation is made worse through for example the disproportionate investments in higher level, urban facilities. This provokes the debate for more investments in lower level services and in areas where need is comparatively greater.

Kenya's health financing system is weak and provides only a minority of the population with social health protection. Segments of society considered as poor and vulnerable continue to rely on out-of-pocket financing of their health care. The poor have the highest out-of-pocket expenditure as a proportion of their income. This mode of financing subjects a high number of people to the risk of increased destitution. Due to the inefficiencies and inequities in resource allocation, increased funding might perpetuate the problem unless the root-causes are addressed. Therefore, increased funding must be accompanied by comprehensive reforms.

Over the past two decades Kenya has implemented several reforms but the desired effects of improved access and quality have failed to materialise. Against this background the Government of Kenya has recently initiated a number of new and broad reform processes to improve access, efficiency, quality, aid effectiveness and transparency in the sector with a focus on the poor. Most notable in this reform package are the recently developed Healthcare Financing Policy and Strategy and the establishment of a Health Sector Services Fund (HSSF).

Externalities such as the economic downturn, competition for public resources, and political instability act as additional triggers for making the health system more efficient and responsive. Whether ongoing reform initiatives deliver the intended results depend on the continued commitment of the Kenyan Government and its partners.

Annex 1:

Table 1: Overview of the Surveys and Studies Included in this Review

Type of survey	Key features	Purpose	Data collection	Problems
National Health Accounts (NHA) 2005/06	<ul style="list-style-type: none"> ■ Tracks health expenditure trends. ■ Offer possibility to compare health expenditure of one country with that of another. ■ WHO standardised processes. 	<ul style="list-style-type: none"> ■ Obtain reliable national information on the expenditure and use of funds in the health sector. ■ Answer the question how much money is spent, where it is spent, what it is spent on and for whom. ■ Help to determine the success of the health system. 	<ul style="list-style-type: none"> ■ Data is collected from a number of sources, including tax reports, budget reports, and provider surveys. ■ Economic surveys. ■ Data is evaluated in accordance to quality standards. 	<ul style="list-style-type: none"> ■ Complex data collection methods. ■ Full potential only achieved if regularly conducted.
Household Health Expenditure & Tracking Survey (HHEUS) 2007	<ul style="list-style-type: none"> ■ Analysis of households as entities in the holding and expending of funds. ■ Households as final actors in the overall health accounts. 	<ul style="list-style-type: none"> ■ To understand healthcare seeking behaviours amongst the Kenyan population. ■ To collect detailed information on healthcare service utilisation. ■ To investigate patterns of outpatient and inpatient healthcare use and by type of provider. 	<ul style="list-style-type: none"> ■ Systematic randomised collection of survey data. ■ Face-to-face interviews of over 8,000 households across all provinces. 	<ul style="list-style-type: none"> ■ Labour intensive. ■ Face-to-face interviews often result in an upwardly-biased response.
Public Expenditure & Tracking Survey (PETS) 2008	<ul style="list-style-type: none"> ■ Comparison of budget allocations with actual spending at district or provider level. ■ Tracks the flow of funds 	<ul style="list-style-type: none"> ■ To estimate the existence and severity of leakage (providers do not obtain what they are entitled to). ■ To restore the link 	<ul style="list-style-type: none"> ■ Collected from administrative level at local and central government level charged with financing 	<ul style="list-style-type: none"> ■ Good record keeping, which is often a problem in developing countries, is a prerequisite.

	<p>from central government through different tiers of administration to the front-line service providers.</p>	<p>between public spending and outcome.</p> <ul style="list-style-type: none"> To highlight inefficient use of funds. 	<p>and governing of health facilities.</p> <ul style="list-style-type: none"> Survey questionnaires administered using random selection. 	<ul style="list-style-type: none"> Complex triangulation of data collected from a variety of sources.
<p>Client Satisfaction Survey (CSS) 2009</p>	<ul style="list-style-type: none"> Emphasises the responsiveness and accountability of public services to public needs. Captures the perceptions of patients. Captures the demands and constraints on using services. 	<ul style="list-style-type: none"> To measure and improve the quality of health services, regardless of the type of provider. To understand the variables used by patients in defining quality. 	<ul style="list-style-type: none"> Exit questionnaires administered in person were used in Kenya. 	<ul style="list-style-type: none"> Opinion surveys capture expectations and knowledge of patients, which can vary enormously across patients.
<p>Social Spending, Poverty and Gender Equality Analysis (Demery et al) 2009</p>	<ul style="list-style-type: none"> It examines the unit costs of providing services with information on who is using these services. Illustrates how public spending on health is distributed in society. 	<ul style="list-style-type: none"> To answer the question, 'who is benefiting from public services' and 'what is the welfare impact on different groups of people of government spending?' 	<ul style="list-style-type: none"> It compares data from public expenditure accounts with survey data on the use of publicly subsidised services. KIBHS and economic surveys were used. 	<ul style="list-style-type: none"> Use of secondary data. High degree of technical expertise.
<p>Kenya's Integrated Household Budget Survey (KIHBS) 2005/06</p>	<ul style="list-style-type: none"> Includes detailed socio-economic data on aspects such as health, energy, education, housing, water and sanitation. 	<ul style="list-style-type: none"> Capturing poverty and welfare statistics to analyse the progress made on improving living standards. To identify areas into which private and public funds need to be invested. Data derived informs decision making on development policies. 	<ul style="list-style-type: none"> Representative sample through randomized selection of clusters. Households within the clusters were also randomly selected with equal probability. 	<ul style="list-style-type: none"> It is a highly complex and costly exercise.