THE 'IRON' TRIANGLE, HEALTH ACT, 2017, AND THE COST OF UNIVERSAL HEALTH COVERAGE AGENDA IN KENYA

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Abstract

The 'iron' triangle concept emphasizes on three ingredients for proper policymaking in healthcare; namely access, quality and cost. Achieving the three however, is no mean fete. As such the Kenyan Health Act, 2017 while it remains the main framework to achieve universal health coverage (UHC) in Kenya, may fail to meet its targets. The key weakness in the Act on moving towards UHC is on cost. It is not clear under the Act who will pay for the cost and where the sources of revenue are going to come from. The commitment to the 2001 Abuja Declaration that required African States to commit 15% of the total national budget to finance health has not been achieved, further exacerbating the already dire financial situation. While the Act is strong on access and quality, the two may not be adequately achieved until the issue of healthcare cost is also properly articulated and reflected in the national health legislation. This article, therefore, seeks to analyse the issue of health care cost in the context of a developing country and how the same can be expressly addressed in the national health legislation starting with the 15% Abuja Commitment being entrenched into the law. Health financing as a topic is especially important in developing countries as financing of education because many users of health care in developing countries are poor and cannot afford to pay for the services from their own income leading to poor health outcomes and stunted development.

Key words: *Universal health coverage, Kenya Health Act, 2017, health finance, Abuja Declaration, 2001.*

1. INTRODUCTION

Health or eradicating disease in Kenya is complex and has presented numerous challenges for the Kenyan State since attaining independence in 1965. Health, as a priority following Independence was prioritized in the *Sessional Paper No 10 of 1965 on African Socialism and its Application to Planning in Kenya*. In this article the government stated that dealing with *'disease'* was part of its objectives that needed to be addressed (Sessional Paper No 10 of 1965, para. 4). In the current context, this challenge has yet to be dealt with conclusively and just like the former President Jomo Kenyatta, his son, President Uhuru Kenyatta, has once again prioritized this issue but from a Universal Health Coverage (UHC) perspective. It is clear that Kenya is committed to this agenda and has

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prioritized it as part of its development agenda in line with United Nations (UN) sustainable development goals (SDGs), which are to be achieved before 2022.

Achieving UHC however is a daunting task and it is important that all resources be put in place including an enabling national health legislation. The Health Act, 2017 is the main health legislation in Kenya because it was enacted to implement Article 43(1) of the Constitution, 2010 on the right to health in Kenya. Using the 'iron' triangle of healthcare framework, it is possible to evaluate whether the Kenyan legislation is prepared for this function. The 'iron' triangle framework emphasizes that health policies need to address elements of access, quality and cost (Carroll, 2012). In other words, for the Health Act, 2017 to be fit for purpose it should be able to satisfy the three elements of health mentioned above. Unfortunately, a cursory review of the Health Act, 2017 reveals serious gaps in the legislation especially from the element of cost perspective. This gap makes it doubtful that the UHC agenda will be achieved in Kenya by 2022. At the very basic level, even the 2001 Abuja Declaration's 15% of total budget commitment to finance health has not found itself in the present law, and remains currently a non-binding commitment (Africa Union, 2001). What is available in Part XII of the Health Act, 2017 is inadequate and should be grafted with concrete and clear provisions on finance.

Financing health especially in developing countries is crucial because of poverty. Out-of-pocket expenditure for health in Kenya is particularly high while the government expenditure still remains low thereby disenfranchising the poor in the Kenyan health sector with devastating consequences. (Njuguna & Pepela, 2019, 5). It is crucial to note that the current UHC focus on reforming the National Hospital Insurance Fund (NHIF) Act, 1998 may be premature since a holistic approach to healthcare reforms in Kenya requires that the Health Act, 2017 be amended further in order to address the issue of cost comprehensively as opposed to piecemeal (Ouma, 2017, p.3). This article analyses the cost element of the 'iron' triangle framework in relation to the Health Act, 2017. The structure of this article is as follows: introduction to 'iron' triangle framework, UHC in Kenya; legal framework for UHC in Kenya; and strategies for health financing in Kenya.

2. OVERVIEW OF THE 'IRON' TRIANGLE FRAMEWORK

The 'iron' triangle of healthcare means that 'healthcare is a tightly interlocked, self-reinforcing system of three vertices - *access, quality, and cost* - and improvement in two vertices necessarily results in a worsening of the third.' (Kissick, 2015, p.73) In the United States, the 'iron' triangle of healthcare has been employed by health economists to criticize the Patient Protection and

Affordable Care Act (PPACA). Critics of this legislation argue that delivering healthcare in the 21st century while simultaneously delivering on all three fronts of access, quality and cost still 'remains a fantasy.' (Lehman, 2015, p.365) These critics further contend that no law, system, or intervention has been able to break the healthcare 'iron' triangle in the past. In this regard, the PPACA is thought to have only bent and not or 'will never break-the healthcare iron triangle.' (Lehman, 2015, p.73) It seems therefore that the 'iron' triangle *'remains as iron clad as ever.'* (Lehman, 2015, p.79) Accordingly, the World Health Report 2010 observed that *'[n]o country, no matter how rich, is able to provide its entire population with every technology or intervention that may improve health or prolong life.*' (WHO report, 2010, p.21). Despite all this, no one health legislation is usually capable of achieving all the three components of access, quality and cost (Riggs, 2015, p.334).

From the foregoing, it appears that health policymaking is a life-long commitment. The target is to break the 'iron' triangle but this is still a faraway dream for many countries including the most developed economy (US). In Kenya, the Health Act, 2017 can be said to be a feeble attempt to break the 'iron' triangle. The reforms targeted at the NHIF Act, 1998 in relation to UHC is therefore bound to fail in the absence of a better foundation in terms of a stronger Health Act, 2017, which should deal with health financing in a much more robust manner.

3. UNIVERSAL HEALTH COVERAGE IN KENYA

3.1 The World Health Organization

The idea of UHC arguably appears to have been championed by the World Health Organization (WHO). In its resolution of 2005, the World Health Assembly (WHA) called for the health system to move towards UHC whereby everyone has access to key promotive, preventive, curative, and rehabilitative health interventions at affordable cost, thereby achieving equity in access (World Health Assembly, 2005). In this regard, UHC therefore embodies three related objectives of equity, quality and financial risk protection. That is equity in access to health services – everyone who needs health services should get them, not only those who can pay for them; the quality of health services should be good enough to improve the health or those receiving services; and people should be protected against financial risk, ensuring that the cost of using services does not put people at risk of financial harm. The element of financial risk protection presents it with a need to rethink about how health is financed in Kenya so as to be able to protect the patient from being overburdened.

In 2010, in order to aide in the implementation, four elements were flagged out

to be critical in achieving the UHC including: *'(i) a strong, efficient, well-run health system; (ii) access to essential medicines and technologies; and (iv) a sufficient capacity of well-trained, motivated health workers.'* (World Health Organization, 2010) From the above elements, it appears that the issue of cost is also missing when in fact it is the most critical part of a health system especially in resource-constrained countries like Kenya. It is therefore important that these elements be reconsidered to introduce a strong focus on health financing.

3.2 UN SDGs

In 2015, the UHC was incorporated as part of the United Nations (UN) Sustainable Development Goals (SDGs) under target 3.8, which committed to *'[a]chieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe effective, quality and affordable essential medicines and vaccines for all.'* The language of UN SDGs appears to be very similar to the WHO language especially in regards to the element of financial risk protection. As noted previously, this also means that the government has to play a bigger role in covering the healthcare cost than before especially in poor countries if equitable access is to be achieved. Consequently, health finance appears to be the main driver of health care delivery in developing countries and therefore human development.

3.3 'Need of care' as opposed to 'ability to pay'

Inevitably, therefore, the implementation of UHC in line with the WHO resolution and the UN SDGs must focus on addressing the issue of out-of-pocket healthcare expenditure in order to optimize utilization of healthcare services in Kenya (Wamai, 2009, p.138). Put differently, equity in access means that Kenya should move from the ability to pay to need of care in relation to the distribution of health benefits in the country. It should however, be appreciated that the need of care model does not entitle everyone to coverage for all their needs since UHC is not a one-size-fits-all concept (Chuma, Maina & Ataquba, 2012, p.22). What this means is that while everyone should be targeted for access including the poor, the government should define a package for UHC as a priority to its commitment to development of the health sector pursuant to the founding Sessional Paper No. 10 of 1965.

3.4 Kenya Vision 2030 and the UHC package

In Kenya, UHC is contained as part of the Kenya Vision 2030 and specifically being implemented through its Third Medium Term Plan alongside affordable housing, manufacturing, and food security. Various stakeholders are involved in

the implementation of the UHC and one of them is canvassed below.

The Parliamentary Budgetary Office (PBO) has identified the following key initiatives in relation to UHC (Parliamentary Service Commission, 2018, p.25):

Driving NHIF uptake through enlisting 37,000 banking sector agent network, leveraging on self-help groups and religious groups for advocacy; Enlisting 100,000 Community Health Volunteers to each recruit 20 households; Expansion of the 'Linda Mama' programme to mission hospitals; Legal reforms to align NHIF with the UHC; Adopt new health care financing models that include gradual increment of budgetary allocation to health from 7percent in 2017 to 10 percent in 2022, introduction of Robin-Hood taxes on Real Time Gross Settlements (RTGS), mobile money transfers, and airfares; and Adoption of new low cost service delivery model that leverage on technology such as eHealth for telemedicine, mHealth, and eHubs collection and dissemination of information.

From the above, the commitment to adopt a new healthcare financing model that allows for gradual increments in the budget is welcomed alongside other initiatives. In order to achieve the above, the following targets have been prioritized: first, legislations on health insurance reforms particularly the review of the NHIF Act 9 of 1998 to align it with the UHC agenda, review of the Insurance Act and Retirement Benefits Act to set private health insurances as primary insurers and NHIF as secondary insurer for the formal sector, and amendment of the Public Finance Management (PFM) Act and County Allocation of Revenue Act to provide for ring-fencing of health services funds at the County level. Second, the implementation of the managed medical equipment services (MMES) which is expected to ensure provisions of specialized medical services in at least 2 public hospitals per county and the roll out of Computed Tomography (CT) scan screening services. Third, the implementation of the Linda Mama programme which aims at providing free maternity services including postnatal care to expectant women through NHIF in all public hospitals and selected faith-based health facilities across the country; and lastly, the enrolment of residents into the NHIF through County Governments community-based model initiatives.

The above prioritization shows that the focus of UHC for PBO is financing health through private and public means including government programmes like the Linda Mama programme, insurance coverage, and provision of medical equipment (Parliamentary Service Commission, 2018, p.25). However, amongst the legislation targeted for reforms, the Health Act, 2017 is still missing and this is concerning since it is the national health legislation that should provide a comprehensive framework for dealing with the issue of cost of health in Kenya.

Lastly, it is curious that the implementation of the UHC in Kenya has failed to prioritize reforms in the national health legislation despite the fact that one of the key problems facing the sector currently is health financing. The focus on national health insurance is clearly, as will be explained later, a feeble attempt aimed at addressing the issue. Much more needs to be done especially through the budget and public investment in the healthcare system if progress is to be made on the cost element. The next section will highlight the various laws underpinning UHC and health financing in Kenya.

4. LEGAL FRAMEWORK FOR UHC AND HEALTH FINANCING IN KENYA

The legal framework for UHC in Kenya is robust. To begin with, the entire system is based on the constitutional right to health, which means that more focus is made on vulnerable and marginalized groups including the poor during the implementation of government development programs. The lack of focus on poor and vulnerable populations in relevant health legislation may therefore violate the constitution and specifically undermine government development programmes such as UHC.

4.1 The Constitution, 2010

The constitutional framework for the right to health in Kenya is found under Article 43(1)(a), which provides as follows: *'[e]very person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care.'* There are also other provisions recognizing the right to health for special demographic groups including children (Article 53) in the Constitution, 2010. Prior to 2010, the only legislation on the right to health was that for persons living with HIV and AIDS, namely: the HIV and AIDS Prevention and Control Act, 2007.

4.2 International law

The previous (now repealed) Constitution had no economic, social and cultural rights in its Bill of Rights (Constitution of Kenya, 1969). Notwithstanding this, Kenya's obligations in relation to the right to health could be found in various international and regional instruments guaranteeing the right to health. For example, Kenya has currently ratified the International Covenant for Economic, Social and Cultural Rights (Article 12) and the African Charter on Human and People' Rights (Article 16), which both provides for the right to health in their provisions. Currently, Articles 2(5) and 2(6) of the Constitution incorporates international treaties as well as principles of international law as valid sources of

law in the country in effect meaning that the country has changed from a dualist to a monist system. On health finance, the 2001 Abuja Declaration is a good starting point since it calls on the government to commit at least 15% of its budget to health. This should indeed be reflected at the national level through the national health legislation.

4.3 Health Act, 2017

In addition to the Constitution and the international treaties, the Kenyan Parliament for the very first time since Independence enacted the Health Act, 2017 to implement Article 43(1)(a) of the Kenyan Constitution, 2010 on the right to health. The Health Act, 2017 describes itself as *'[a]n Act of Parliament to establish a unified health system, to coordinate the inter-relationship between the national government and county government health systems, to provide for regulation of health care service and health care service providers, health products and health technologies and for connected purposes.'*

Section 3(b) of Health Act, 2017 identifies as one of its *objectives 'protect, respect, promote and fulfill the health rights of all persons in Kenya to the progressive realization of their right to the highest attainable standard of health, including reproductive health care and the right to emergency medical treatment[.]'* Section 4(a) of the Health Act, 2017 outlines the government responsibility in relation to the right to health by observing as follows:

It is a fundamental duty of the State to observe, respect, protect, promote and fulfill the right to the highest attainable standard of health including reproductive health care and emergency medical treatment by inter alia developing policies, laws and other measures necessary to protect, promote, improve and maintain the health and well-being of every person[.]

Part XII of the Health Act, 2017 provides for health financing. The section is a good step towards addressing this issue, but it remains grossly inadequate as will be canvassed later.

4.4 NHIF Act, 1998

As noted above, section 86(1)(a) focuses on the development of an integrated national health insurance system which includes social health protection. In the context of UHC, the NHIF Act, 1998 is therefore important. The NHIF Act, 1998 describes itself at *'[a]n Act of Parliament to establish a National Hospital Insurance Fund; to provide for contributions to and the payment of benefits out of the Fund; to establish the National Hospital Insurance Fund Management Board and for connected purposes.'*

The legislation is particularly important because the UHC advocacy at the international level has gone hand in hand with the need to promote a variety of health financing policies including health insurance (Gautler & Ridde, 2017). The NHIF Act is also relevant in relation to the Kenya Health Policy 2014-2030, which pays special attention to developing and implementing a policy on health care financing (Kenya Health Policy 2014-2030, 50). At the moment, and as part of the reform agenda, section 15(2) of the NHIF Act, 1998 is perhaps restrictive because it allows for both standard and special contributions by salaried and self-employment employees respectively. Reforms in this area should be undertaken in order to allow for community enrolment alongside other reforms aimed at expanding the benefits available under NHIF to include maternity services for the poor once universal coverage is achieved. The Linda Mama Programme is a reflection that the NHIF has not yet achieved universal coverage.

5. ANALYSIS OF HEALTH ACT VIA 'IRON' TRIANGLE FRAMEWORK

What follows next is an analysis of the Health Act, 2017 from the 'iron' triangle perspective. Specific reference has been made to South African health legislations (and US PPACA) on the right to health in a comparative manner, where necessary. Apart from Kenya, South Africa is the other country with progressive right to health laws and the right to health is entrenched in the Constitution, 1996 under section 27(1)(b). Consequently, the obligations under the right to health in both Kenya and South Africa may be the same and this provides a useful source of comparison. In addition, case laws from various jurisdictions have been utilized to emphasize the point being made. The main argument that emerges is that whilst the access and quality elements have been adequately elucidated in the Health Act, 2017 the issue of cost appears to be insufficiently developed and the department for health will be expected to deal with this issue later. There no solid commitments in this section.

5.1 Access

UHC requires that access to healthcare services be guaranteed. In this regard, access to healthcare is the *'grundnorm'* of any health care system (Ouma, 2017, 4). The healthcare system of a country should therefore be accessible to both the rich and the poor without discrimination. However, increased access to healthcare demands that more resources be availed to fund different programmes that have been introduced. The need to raise more funds for health becomes crucial under the Health Act, 2017 because it has many provisions aimed at removing access barriers. Below are five such interventions that will necessitate more funding in the health sector if they are to be achieved without

compromising on quality.

5.1.1 The rights to reproductive health care and emergency treatment

In Kenya, there are many barriers on access to reproductive health and emergency treatment. Consequently, and in line with the Constitution Articles 43(1)(a) and (2) on reproductive health and emergency treatment respectively, the Health Act, 2017 addresses these barriers. Sections 6 and 7 of the Health Act, 2017 is the legislative framework for dealing with reproductive health care and emergency treatment respectively. Section 6 on reproductive health on one hand covers mainly the issues of: family planning services; maternal, neo-natal and child health (MNCH); and access to abortion services (even though it is crafted in technical language under section 6(1)(c)). The right to reproductive health should for instance include abortion not just on medical grounds but also on other socio-cultural grounds such as incest and rape in order to save the many lives of mothers dying while procuring illegal abortion in backstreet health facilities.

In South Africa, another country with a constitutional right to health like Kenya, The Choice on Termination of Pregnancy Act, 1996 allows for abortion on request during the first 12weeks of pregnancy. In South Africa, emphasis is on choice and safety of the mother as opposed to religious or cultural views. Indeed, it is because of the strong religious and cultural factors against the abortion in Kenya that the African Commission on Human and Peoples' Rights (African Commission) in its concluding observations recently advised Kenya to *'fast track the law on Safe Abortion and resolve some of the obstacles impeding the passing of the law by sensitizing religious leaders on the consequences of unsafe abortion[.]'* (Concluding Observations and Recommendations on the 8th to 11th Periodic Report of the Republic of Kenya, para 55(v)) In fact, despite its liberal approach, the South African abortion laws has been found to be inclusive as opposed to exclusive to religious ethics in so far as it restricts abortion as it progresses in term (Jogee, 2018, 49). It should be noted however that in South Africa, fetal personhood is not recognized under the Constitution, 1996 as confirmed by the case of *Christian Lawyers Association of SA and Others v Minister of Health and Others* 1998 (4) SA 1113 (T).

5.1.2 Emergency treatment

Apart from declaring the right emergency treatment, section 7 on the other hand focuses on two things. One, section 7(2) provides for a broad range of services that is included under this right including pre-hospital care at a scene of an accident or emergency for instance and referral services. Two, section 7(3) focuses on enforcement of this provision by making it an offence for a medical institution to deny emergency treatment. Criminalizing non-compliance is first

and foremost problematic because it may achieve negative results such as hospitals not responding to emergency situations. This section would have been strengthened by for instance focusing on funding the right by for instance indicating that the national government will underwrite all cost incurred by a hospital in providing emergency treatment. The failure to address the issue of payment for the service has technically led to a chilling effect on the realisation of this right. The right to emergency treatment in Kenya is today hard to implement even though the government has committed to *'[p]utting in place comprehensive mechanism for financing of emergency health services.'*(Kenya Health Policy 2014-2030, 50) Until this commitment is realized, many problems are bound to occur still.

In South Africa, the right to emergency treatment is provided under section 27(3) as follows: *'[n]o one may be refused emergency medical treatment'*. Moreover, section 5 of the National Health Act, 2003 elaborates on this by providing that *'[a] health care provider, health worker or health establishment may not refuse a person emergency medical treatment.'*
However, the actual enforcement has however been left to the courts as opposed to legislation as was in the case in *Soobramoney v Minister of Health (Kwazulu-Natal)* ZACC 17, 1998 (1) SA 765 (CC), 1997 (12) BCLR 1696 (CC). In this regard, in the absence of a clear rule on funding for emergency treatment, Kenyan courts should begin playing a more proactive role to make this right a reality locally.

5.1.3 Marginalized communities and access

Another key area addressed in the Health Act, 2017 relates to the issue of marginalized communities. In Kenya, the healthcare system has been developed in urban areas with very minimal penetration in rural and marginalized communities. Consequently, the Health Act, 2017 expressly requires the government to establish functioning health facilities in marginalized communities pursuant to its section 4(c). This section requires the State to ensure *'the realization of the health-related rights and interests of vulnerable groups within society, including…members of minority or marginalized communities and members of particular ethnic, religious or cultural communities[.]'* This provision therefore requires that all areas in Kenya must have functioning health facilities. Indeed, section 15(f) of the Health Act, 2017 requires the national government to:

develop policy measures to promote equitable access to health services to the entire population, with special emphasis on eliminating the disparity in realization of the objects of this Act for marginalized areas and disadvantaged

populations[.]

Section 5 of the Health Act, 2017 is particularly important because it guarantees free services with funding from national government in order to reach out to the marginalized communities including women and children in terms of health service delivery. Section 5 of the Health Act, 2017 provides as follows: the national and county governments shall ensure the provision of free and compulsory - vaccination for children under five years of age; and maternity care. For the purposes of implementing the section, the national government shall in consultation with the respective county governments provide funds to county governments. The current 'Linda mama' programme that is being implemented by the government has an appropriate legal framework to support its implementation however the issue of cost still remains an issue.

5.1.4 County referral hospitals

Prior to the enactment of the Health Act, 2017, Kenya had only two referral hospitals in Nairobi and Eldoret. Since the establishment of the devolved governments, health is amongst such devolved functions. One of the greatest innovations in the Health Act, 2017 is the creation of County Referral Hospitals. In this regard, section 20(e) of the Health Act, 2017 requires that county governments in accordance with their functions under the Fourth Schedule of the Constitution to designate *'county referral hospitals according to criteria agreed upon by the intergovernmental health coordinating mechanism.'* It is expected that county referral hospitals should have well equipped maternity wings to be able to handle complicated complex cases referred to it from lower level health care facilities within the county. The national government is expected to set guidelines for the designation of referral health facilities pursuant to section 15(k) of the Health Act, 2017. These guidelines have not yet been put in place thereby affecting the implementation of this provision Notwithstanding, many counties have now designated health facilities for this purpose but the standards including quality of health care in these facilities are yet to be improved due to lack of the said guidelines. The availability of county referral hospitals will avoid delays associated with having to travel long distances in Nairobi and Eldoret and save lives and cost to patients. However, the hospitals cannot survive on exchequer alone and funding strategies should be clearly stipulated

5.1.5 Free vaccination

Vaccination services have been made free in Kenya as a matter of policy except those required for foreign travel (National Policy Guidelines on Immunization, 2013, 13). This is expected to make the services affordable to both the poor and the rich without the issue of financial barrier. However, the Health Act, 2017

should have gone ahead to make access to treatment for poor people also free as is the case with the South African National Health Act No 61 of 2003. Section 4(1) provides that *'[t]he Minister, after consultation with the Minister of Finance, may prescribe conditions subject to which categories of persons are eligible for such free health services at public health establishments as may be prescribed.'* At the moment, the funding for vaccinations is being provided by development partners. This is not sustainable, and the government should prepare to take over and this may require raising more revenue.

5.2 Quality

The second pillar of the iron triangle for health is quality. Since the iron triangle doesn't define this aspect, reliance is made on the General Comment 14 on the Right to the Highest Attainable Standard of Health. According to paragraph 12 of general comment 14, quality connotes *'health facilities must also be scientifically and medically appropriate and of good quality.'* Therefore, this requires the training of health professionals and the proper regulation of the health sector among other things. The Health Act, 2017 has provisions to deal with the issue of quality in the health care sector in Kenya as discussed below. Even these interventions aimed at improving quality will put more pressure on resources thereby bringing into focus the issue of health financing in Kenya.

5.2.1 Training of health care professionals including midwives

In ensuring sustainable development of the healthcare sector, trained healthcare professionals are important intermediaries in delivering healthcare. It is this realization that has led to the Health Act, 2017 emphasizing on training not just doctors and nurses but also healthcare providers in the informal sector. This holistic approach to training will improve the quality of care for many patients in Kenya especially the rural poor. Under section 6(2) of the Health Act, 2017 on the right to reproductive health, training of all health professionals is required meaning that quacks are not allowed to provide health care services. In the interpretation section, healthcare professionals include midwives who are crucial in managing pregnancies especially in rural areas where health care providers are scarce.

However, there is need to develop and approve a curriculum for midwives and start their training. Section 107(1) of the Health Act, 2017 contemplates *'[t]he establishment, management and maintenance of institutions for the training of all categories of health professionals…'* Under section 107(2), the Cabinet Secretary is expected to issue administrative guidelines and regulations on *'professional post basic training of all health workers for implementation in line*

with the national training policy for health professionals.'

Lastly, the Kenyan government has imported health professionals to cover the skills gap and ensure skills transfer. This move is welcomed particularly in order to deal with complicated cases and yet the current work force is overstretched. This programme however is currently under threat in the counties next to Somalia as a result of the recent abduction of two Cuban doctors in Garissa County (Otsialo & Misiko, 2019, April 12, *Daily Nation*).

5.2.2 Complaint procedures

Apart from training, quality can also be maintained if patients are allowed an opportunity to complain about lower standards in health service delivery. The right to complain is therefore important in order to ensure that patients can report relevant cases and appropriate remedial action may be taken in order to remedy the situation. Without the right to complain, health workers may get away with poor service delivery. Consequently, the complaint procedure is a necessary check in order to ensure the maintenance of high-quality services in the health sector. In this regard, section 14 (1) of the Health Act, 2017 is an important part of the Health Act, 2017 because it provides that *'[a]ny person has a right to file a complaint about the manner in which he or she was treated at a health facility and have the complaint investigated appropriately.'*

5.2.3 Health research and ethical clearance

Health research is important in order to ensure that the quality standards in the country are maintained and improved. The health system needs constant monitoring in order to discover new ways of delivering preventive and treatment services. Without constant research in the health sector, many illnesses may not be addressed. Research is as such a lifeline for the survival and development of the health sector. The development of new medicines also requires investment in research and development. Section 93(1) contemplates the establishment of a National Health Research Committee which shall be a technical committee to coordinate research in the health sector. Section 99(2) also requires the ethical clearance of health research in the country. In this regard, research and studies conducted in the country is subjected to ethical regulations thereby ensuring the protection of patients as well as the observance of quality standards.

5.2.4 Blood transfusion or tissue transplant

In order to deal with certain ailments, there is need to ensure that blood transfusion or tissue transplant is safe. The proper regulation of blood transfusion or tissue transplant is therefore important to avoid mistakes in the sector and treat

very complicated diseases including HIV. The Health Act, 2017 therefore provides under section 80 deals extensively with the regulation of human organs transplantation.

5.3 Cost

The last element of the iron triangle is cost or health finance. A cursory overview of the Health Act, 2017 reveals that the issue of cost has not been satisfactorily addressed in the legislation. Indeed, some studies seem to suggest that the Kenyan healthcare financing system is regressive and not progressive (Muunge & Briggs, 2014, 912-920). The issue of cost has been dealt with at length under Part XII. Section 86 (1) of the Health Act, 2017 bestows the responsibility to finance UHC progressively upon the department of health. In this regard, it is expected to:

[*develop] mechanisms for an integrated national health insurance system including making provisions for social health protection and health technology assessment; the department of health should also '[establish] in collaboration with the department responsible for finance oversight mechanism to regulate all health insurance providers; the department of health is expected to '[develop] policies and strategies that ensure realization of universal health coverage; the department of health is expected to '[determine], during each financial period and in consultation with individual county authorities, cost sharing mechanisms for services provided by the public health system without significantly impending the access of a particular population groups to the system in the areas concerned; the department of health is expected to '[define] in collaboration with the department responsible for finance, public financing of heath care framework, including annual allocations towards reimbursing all health care providers responding to disasters and emergencies as contemplated under this Act; the department of health is expected to '[ensure], that all pharmaceutical and nonpharmaceutical products correspond to Kenya Medical Supplies Authority market prices; and the department of health is expected to '[define] in collaboration with the department responsible for finance, a standard health package financed through prepayment mechanisms including last expense.*

Other provisions include section 86(2), which mandates the Ministry of Health in consultations with the Inter-governmental Authority to: *provide a framework for collaboration with the ministries responsible for finance, planning and any other relevant department to secure health care for vulnerable groups and indigents; provide a framework for examining means of optimizing usage of private health services as a result of relieving the burden carried by the publicly financed system; and provide a framework for establishing a harmonized*

common mechanism for coordinating planning and financing and monitoring and evaluation within the health sector.

In South Africa, unlike in Kenya, a separate advisory body, the National Health Council (NHC), has been established and tasked with the responsibility of advising the *'Minister on equitable financial mechanisms for funding of health services'* pursuant to section 23(1)(a)(vi) of the South African National Health Act No 6 of 2003. Perhaps, Kenya should consider such an advisory body in the future to take care of equitable issues regarding the financial mechanisms put in place even as the Ministry of Health implements.

The problem with the Health Act, 2017, however, is that it does not specify the strategies that it intends to employ to finance healthcare in Kenya apart from giving broad commitments. Health is a critical pillar of the Kenya Vision 2030, which aims at transforming the country into 'a globally competitive and prosperous industrialized, middle-income country.' (Kenya Vision 2030) This is indeed a big omission considering that relevant norms in relation to healthcare financing currently exists particularly at the regional front as will be discussed below. In this regard, the Health Act, 2017 is very weak in relation to addressing the issue of cost, which is an important component of the 'iron' triangle of health care framework. By leaving the issue of cost unaddressed, the revolutionary impact of the Health Act, 2017 is diminished. The effect of this is that the implementation of the right to health in real terms is political and will depend on the budgetary priorities of the government of the day as opposed to concrete legislative commitments by the government. This situation therefore has the unintended effect of transforming the right to health or UHC agenda from being a human rights issue into a political commitment strictly speaking. There is no guarantee that the next administration may prioritise UHC in the future.

Comparatively, the US PPACA has clear revenue provisions under its Title IX, which clearly identifies sources of health funding for the various programmes initiated by the government including Medicaid. In Kenya, the government is already considering applying 40% of betting taxes towards financing UHC (Muchangi, J, 2019, May 10, *The Star*). These sources should be clearly spelt out in the health legislation so that the sources of fund are clear. In the next section, the strategies for healthcare financing having been outlined including demand side financing, health budgeting, national health insurance fund, and Official Development Assistance (ODA). Human development is only possible if the needs of the people are sufficiently met and acknowledged (Ventura et. al., 2016, 27). In relation to right to health, the UHC should be able to reach even the poorest of the poor in Kenya by eliminating all access barriers including healthcare cost.

6. STRATEGIES FOR HEALTHCARE FINANCING IN KENYA

This section analyses the three main sources of healthcare financing in Kenya outside out-of-pocket expenditure, namely: budget; insurance; and ODA. In Kenya, the majority population are poor and it is therefore desirable to focus on the above three alternative strategies as opposed to optimizing out-of-pocket expenditure, which is currently too high and is often a barrier to the full utilization of health care services. Currently, it is estimated that 32% of the total health expenditure in Kenya comes from out-of-pocket expenditure, which has further entrenched health inequity in Kenya in favour of the rich and at the expense of the poor (Njuguna & Pepela, 2019).

6.1 Free primary health care and output-based approaches/demand side financing

Due to the adverse impact of user fees on the poor and the desire to enhance health equity, the President abolished user fees at primary health care facilities as well as introduced free maternal health care programme in public health facilities in 2013 during the Madaraka day celebrations (Okech & Ltumbesi). To begin with, the decision to abolish user-fees is welcomed because the majority poor cannot afford to pay for the services. However, the challenge remains that most primary health facilities are poorly equipped, and patients are usually expected to buy supplies as well as medicines from private sources. In this regard, the reality is that the poor Kenyan is still disenfranchised.

The *Linda Mama* programme is particularly important since it aims at ensuring that pregnant women can access quality maternity services. The financing of the 'Linda Mama' programme by the national government to county health facilities for example has revealed challenges in terms of the way the reimbursements are made. There are often delays experienced by health facilities when money is routed through the county government. Direct reimbursements to the health care facilities will therefore work better to boost service delivery instead of the current route of using the county government to reimburse health care facilities for every delivery. This approach however does not solve the issue of cost since no resources are generated to plug the demand.

Perhaps the greatest challenge with the 'Linda Mama' programme is its financing. In the past, it appears that the programme was funded by the German Development Bank (KfW) under its output-based approach which is about utilizing 'explicit performance-based subsidies to motivate providers to deliver selected reproductive health services at specified level of qualityat an affordable cost so that the economically disadvantaged are not excluded.' (Warren et al.,

2011, 2) The programme was later transferred to the government. In this regard, the government is currently encouraging that all mothers and children be covered under the National Hospital Insurance Fund (NHIF) as part of the UHC agenda. The NHIF therefore has a benefit package for both the principal member and declared dependants that includes 'maternity services, with the treatment protocols pegged on Kenya national treatment guidelines and the Kenya Essential Package for Health (KEPH)' (Okech & Ltumbesi, 2016, 225).

However, the reality on the ground is that the free maternity services in many public hospitals is still a mirage. In *Milicent Awuor Omuya & Another v. The Attorney General & 4Others* (Petition No 562 of 2012, para 162) the High Court dealt with the issue of detention of patients at Pumwani Maternity Hospital due to bills and found that it was a violation of the right to health since maternity bills was a barrier on access to health services, which violates the constitutional right to health.

6.2 Health budget and the 15% Abuja Declaration Commitment

There are many documented strategies for healthcare financing that the Health Act, 2017 should have considered and implemented. To begin with, like other developing countries, Kenya's healthcare system is still heavily dependent on tax-financing as allocated directly to the Ministry of Health despite the gradual changes introduced in health financing policy that has undergone three phases of: free access to healthcare; user fees; and global development goals (Muiya & Kamau, 2013, 2). Since the budget is crucial, the Health Act, 2017 could for instance start by incorporating the 15% Abuja Declaration on HIV/AIDS, tuberculosis and other related infections, 2001 commitment (Abuja Declaration, 2001). This would ensure that the health sector is adequately financed eventually from the consolidated fund.

The state should also put in place appropriate policies to deal with many ailments including diabetes. In *Mathew Okwanda v. The Minister of Health and Medical Services & 3Others* (Petition No 94 of 2012, paras 2 and 24), the High Court declined to issue appropriate orders because the state had failed to put in place appropriate policy framework for the containment and treatment of various health afflictions including diabetes mellitus that requires proper care, diet and medication.

6.3 National Health Insurance Fund

In Kenya, it is estimated that about 20% of Kenyans or nine million Kenyans have insurance cover with 88% of these covered under the National Hospital Insurance Fund (NHIF). The NHIF:

envisages universal coverage in which both in patient and out-patient services for members are catered for. As such, three categories of membership have been identified as Formal, Informal and Indigents/Sponsored with monthly contributions rates (family cover) have also been varied with the formal sector being on a graduated scale ranging from Ksh.150 to Ksh. 1700. Informal sector contributions have been pegged at Ksh. 500, while the voluntary/sponsored category has been set at Ksh. 300 per month. In terms of membership, members are required to register with the scheme and declare their preferred facility of choice including their declared dependents for capitation purposes. As a starting point, access to out-patient services forms the entry point, while in patent services can only be provided on referral from an outpatient case, although some can occur on demand based on level of care requirements (Okech & Ltumbesi, 2006, 224).

The Millennium Development Goals (MDGs) (currently replaced by the SDGs) appear to put more emphasis on insurance schemes. (Muiya & Kamau, 2013, 2) The incorporation of the informal sector will undoubtedly increase coverage and critical lessons could be learnt from the experiences of Germany, Ghana, Tanzania, and Singapore (Muiya & Kamau, 2013, 4-6). Munyao, for instance, contends that the following three options can be considered in order to achieve UHC: i) a compulsory national health insurance should be established and having this made compulsory to everyone by legislation; ii) a social health insurance can be established and workers and self-employed be allowed to pool funds in a single or multiple funds subsidized by the government where necessary; and iii) a community health insurance to reach out the margnalised and the poor populations in order to cushion them from out-of-pocket expenditures (Muiya & Kamau, 2013, p.6). The Kenyan model appears to incorporate all the above however there is need to make coverage for the poor free as is the case in South Africa. In South Africa, the National Health Insurance (NHI) Fund raises some of its funds through '[l]arge amount from general taxes'; and consequently *'[p]eople with low income will not make any direct payment to the NHI Fund.*' (Department of Health Republic of South Africa, 3) In the US PPACA section 2001, the low income earners are taken care of under the public Medicaid coverage program. The NHIF Act, therefore, needs to adopt the South African and US approach if it is to achieve UHC.

While the NHIF Act is an important piece of legislation, it appears from the above discussion that perhaps the government should subsidize contributions made by employees, employers, informal sector, and families in order to exempt the poor from making contributions. If this is achieved, the money could then be channeled towards payment for services. It is therefore incumbent that the 15%

Abuja commitment be achieved to make this possible as discussed in the previous section. Also, the reforms under NHIF should not just focus on increasing the number of people covered but also expanding the list of health care benefits available under the cover. Under the US PPACA section 1101, for instance, it is illegal to deny coverage for people with pre-existing conditions. The NHIF should adopt the same approach and ensure that everyone is registered without considering preexisting conditions.

Lastly, the NHIF cover should also be able to cover for chronic diseases including in private hospitals. In 2015, in the case of *Luco Njagi & 21 Others v. Ministry of Health & 2 Others* ([2015]eKLR paragraphs 79 and 85), the High Court declined to declare a violation of the constitutional right to health for a denial of regular dialysis for chronic renal failures in private hospital for the benefit of the petitioners due to lack of resources. The above case reveals the challenges that exists in relation to accessing insurance coverage benefits and this should be addressed in the legislation.

6.4 ODA and extra-budgetary funding

The government can also pursue specific strategies under the Health Act, 2017 to optimize on the Official Development Assistance (ODA), which is currently pegged at 0.7% pursuant to the resolution of the UN General Assembly of 24 October 1970. The Ministry of Foreign Affairs can play a critical role in this regard. This source of funding will become important especially in the context of the receding support from the extra-budgetary funding such as Global Fund to fight AIDS, Tuberculosis and Malaria (founded in 2002) as well as President's Emergency Plan for AIDS Relief (launched in 2003). Withdrawal of the above sources of funds without simultaneously increasing the level of ODA will only spell doom to poor countries such as Kenya.

7. CONCLUSION

The Health Act, 2017 is the main framework for the implementation of the constitutional right to health as enshrined under Article 43(1)(a). This Act is supposed to consider holistically health care reforms in the country. The 'iron' triangle model requires health policy to address access, quality and cost. As analyzed above, the Act appears to be strong in relation to access but needs more improvements in terms of the cost if the quality of healthcare in the country can be maintained. More access to health means that more financing is also needed in the health sector otherwise the system will not be able to deliver on its promise. Consequently, as a reform agenda, the Act should among other things expressly incorporate the progressive achievement of the 15% Abuja Commitment in order to boost health financing in the country. Currently, there

is no firm commitment on this issue except at the political level, which should not be the case where a comprehensive national health legislation exists such as in Kenya. The law should therefore replace politics. Secondly, the reforms currently being undertaken in relation to the NHIF Act, 1998 should focus on increasing coverage for poor Kenyans. As a matter of fact, those with low incomes should not be required to pay premiums before coverage. Those that are rich on the other hand can be made to bear the burden of supporting the system with help from the government. Ideally, healthcare should be like any other service, whereby everyone is able to pay for it in line with market forces of demand and supply. Unfortunately, in developing countries, this is not the case and more government intervention is needed owing to the fact that the sector is very critical for development akin to education. The above reforms and many others discussed in this article will go a long way to ensure that the UHC is achieved in the country by 2022 in line with the constitutional right to health, the 'big four' agenda as well as the UNSDGs.

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