

Can you reap what you don't sow?

HEALTH FINANCE IN KENYA'S PROGRESS TOWARDS UNIVERSAL HEALTH COVERAGE

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Abstract

“Rights are not moral fruits that spring up from bare earth, fully ripened, without cultivation.”¹ They must be adequately financed.

Key words: *right to health, finance, universal health coverage, SDG3*

1. INTRODUCTION

Rights are concerned with action. Consequently, rights can be possessed, enjoyed, exercised, claimed, demanded and asserted. They can also be limited and violated. As such, rights result in correlative duties. In other words, every right has a duty and every duty a right, as with Hohfeld's claim right. But, do rights always entail a corresponding duty? The answer will depend on the types of duty we believe are necessary to uphold a right. Can we then say that there is a duty to finance the right to health? Should this duty to finance be precisely set out in law?

The right to health is of central importance in the development of the modern world. It is also very much theory-laden, implying a general view on the role of government in its maintenance. The right to health is a claim upon the state, a demand that it provide and guarantee the means for achieving access to adequate, affordable and quality health care. In Kenya, the right to health is a constitutional right. Its normative content is addressed under article 12 of the International Covenant on Economic, Social and Cultural Rights and General Comment No. 14 on the Highest Attainable Standard of Health. These international law documents have been ratified by Kenya and are a source of domestic law. The right to health is subject to progressive realisation based on a state's available resources. The current discourse on Sustainable Development Goal 3 on Health and Well Being seeks to extend the normative content on the right to health under the expression Universal Health Coverage. As an SDG3 goal, the validity of UHC rests upon each state's commitment to its implementation.

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¹ Daniels, 1985.

UHC does not automatically acquire legal enforceability unless given legal recognition and sustainable financial backing both by the domestic state and through international assistance and cooperation. UHC, as a political goal embedded within right to health discourse, joins together the exercise of legal and political power to secure deliberate action by government, either acting alone or in partnership with other state and non-state actors, to guarantee the achievement of the right to health. Such deliberate action may involve inserting SDG3 targets and indicators as part of the binding responsibilities towards the progressive realisation of the right to health, to be secured based on the availability of resources accessible both domestically and beyond. The right to health is, therefore, subject to the implementation of both hard (for example the Kenyan Health Act) and soft law (various health policies, UHC) with finance playing a pivotal role. However, the claim against the right to health as theory-laden has indirectly removed the role of finance from forming part of its correlative duty. But contextualising the right to health within the UHC framework; a political goal, invites finance back into the discourse. Yet, health continues to be underprioritised and underfunded. This article discusses the complex correlation between the right to health and finance.

2. RIGHT TO HEALTH IN KENYA

Article 43(1) (a) of the 2010 Kenyan Constitution provides for the right of every Kenyan to the highest attainable standard of health. This right includes the right to healthcare services as well as a right to reproductive healthcare. Article 43(1) (a) is subject to progressive realisation and the availability of resources.² It does not set out a minimum health budget. Promulgated in 2010, the article makes no reference to the content of the MDGs nor the SDGs. Instead, it delegates the unpacking of the constitutional R2H to legislation. In 2017, seven years later, after the coming into effect of the Constitution, the Health Act was enacted as the first legislation to establish a comprehensive health governance structure in line with R2H norms. This Act establishes a unified health system, coordinates the inter-relationship between the national and county government health systems, provides for regulation of healthcare services, healthcare providers, health products and health technologies. Only section 86 of the Health Act makes specific reference to health finance and UHC. Section 86 permits the department of health at county level to take several steps to ensure progressive financial access to UHC. The steps specified focus around:

² Articles 20(5) and 21(2) of the Constitution of Kenya, 2010.

□ **Collaboration**

- *Between the department of health and the department responsible for finance oversight mechanism to regulate all health insurance providers*
- *Defining together with the department responsible for finance, public financing of a healthcare framework, including annual allocations towards reimbursing all healthcare providers responding to disasters and emergencies*
- *Defining in collaboration with the department responsible for finance, a standard health package financed through prepayment mechanisms*

□ **Regulation**

- *By developing policies and strategies that ensure realisation of UHC*
- *By ensuring all pharmaceutical and non-pharmaceutical products correspond to Kenya Medical Supplies Authority market prices*

□ **Financial risk protection**

- *By developing mechanisms for an integrated national health insurance system, including making provisions for social health protection*
- *Determining, during each financial period and in consultation with individual county authorities, cost sharing mechanisms for services provided by the public health system without significantly impeding the access of particular groups to the system in the area concerned*

At the national government level, section 86 empowers the Ministry of Health to establish an inter-governmental platform through which it is tasked to provide the following three separate frameworks:

- *Framework for collaboration with the ministries responsible for finance, planning and any other relevant department to secure healthcare for vulnerable groups and indigents*
- *Framework for examining means of optimizing usage of private health services as a result of relieving the burden carried by the publicly financed system*
- *Framework for establishing a harmonised common mechanism for coordinating, planning and financing and monitoring and evaluation within the health sector.*

Prior to the enactment of the Health Act, implementation of the R2H was subject to soft law. It was described in the Kenya Health Policy 2012-2030 and the Kenya Health Sector Strategic and Investment Plan 2014-2018 (Ministry of Health, 2014). This policy identified 12 health programs that summed up the entire health needs of the country.³ They have served as domestic metrics to

³ These programs are; (i) child health and immunisation, (ii) environmental health, (iii) emergency care and blood safety, (iv) health promotion, (v) HIV and sexually transmitted infections, (vi) malaria, (vii) maternal, new-born and reproductive health, (viii) non-communicable diseases, (ix) neglected tropical diseases, (x) nutrition, (xi) other specialisations and (xii) tuberculosis.

assess the country's progress towards implementing UHC. A recent study conducted by Perales, Dutta and Maina estimated that the implementation of these programs will cost Kenya US\$ 4,715,832,997.76 (Kshs 473 billion) over a five-year period. The study has also estimated that the Kenyan Government will experience a shortfall of US\$ 2,412,751,859.23 (Kshs 242 billion) in ensuring their implementation over the 2013-18 fiscal period (Perales et al, 2015). The shortfall indicates that the financial resources for implementing the programs are limited. Therefore, the Health Act responded with section 86 stipulations.

When compared with previous health policies and strategies developed since 1965 (*discussed later in Section 3 of this article*), section 86 takes a different approach in looking at health finance. It puts it at the centre of implementing UHC, which is seen as instrumental in achieving R2H under article 43(1) (a) of the Constitution. The previous policies put more emphasis on identifying health priorities than on their financing. Arguably, the principle of collaboration and financial risk protection under section 86 rectifies the historic disconnect from associating the implementation of local health policies to a predetermined costed health financing scheme. But section 86 does not state this explicitly. It does not create a legal obligation for providing a predetermined costed health financing scheme for the implementation of health policies. The section is also silent on leveraging international assistance and cooperation on progress towards UHC. International assistance and collaboration have not been expressly identified as the financial measures contemplated under section 86. This may be following the Africa Union Agenda 2063 that impressed upon member states to instead focus on domestic sources of revenue to strengthen their service delivery.

As a result, no legal duty arises under the Health Act to source for finances outside the country. African scholars insist on finance as a significant requirement towards achieving UHC and have emphasised the need for a legally enforceable financial framework that identifies revenue streams targeted towards UHC (Amporfu, 2013; Sanogo et al, 2019; Waris and Latif, 2015b). The Health Act having avoided prescriptions on finance in my view has disengaged and isolated it from being a necessary condition to the normative content of UHC. Binding commitments on finance are essential. First, it is constitutive to the social contract theory: the state has promised to be bound by article 43(1) (a) of the Constitution. Second, such promise requires other forms of commitments, for example, through taxation securing certain minimum core obligations under R2H. Third, this has an enormous influence on healthcare organisation and delivery. Fourth, a health financing policy secures the link between health expenditure and revenue streams thereby avoiding a situation where revenues tend to fall short of expenditure and cause health crises (Bell, 1976; Goldschied, 1925; Schumpeter, (1918) 1958).

In the absence of a health financing strategy in Kenya, the assumption is that the public and private international sources of finance are left subject to political negotiations. Domestic health financing remains dependent on budget allocations which are skewed towards funding recurrent expenditure largely focused around remuneration of healthcare workers and personnel costs (The National Treasury, 2017). This approach has weakened the implementation of the R2H nationwide. The continued exclusion of finance locally available in setting out and selecting manageable health goals can no longer be ignored. The next section looks at the poor application of the rights require budgeted costs discourse on R2H in Kenya (Waris and Latif, 2015a, b).

3. THE HISTORICAL DISCONNECT BETWEEN R2H AND ITS FINANCING FRAMEWORK

3.1. Fiscal policy – undermining social rights in favour of economic growth

The question of rights in Kenya has centered around political and legal debates on whether they are undermined or supported by the state's fiscal policy (Saul, 2016; Lumumba et al, 2013; Mbariza, 2004; Hansard, 1995, 2019). These debates have contributed to a better understanding of the rights discourse in Kenya. It has allowed for a deeper inquiry into the claims made by society against the state in pursuing a fiscal policy that undermines adequate allocation of financial resources to implement social rights, leading to a view that social rights are deemed subordinate to policies directed towards funding economic growth. Such is the division between society and the state in their understanding of the greatest good of the greatest number, economy over social rights for the latter and the converse for the former. Such divide follows the fiscal philosophy underpinning Sessional Paper No. 10 of 1965 in which was entrenched the first development blueprint to guide the transition of the post-colonial Kenyan state towards modernization. The Paper reduced spending on social rights in favour of economic growth. While it recognized and sought to promote social rights, it did so with reference to a proviso, which pegged the implementation of social rights on first achieving economic prosperity.

It thus became a settled political principle of successive governments to promote the economy ahead of social rights (Kimenyi et al, 2016; Speich, 2009). Consequently, the realisation of R2H in Kenya has been locked within this paradigm and weakened by the absence of a sustainable financing policy. The conceptualization of R2H in the Sessional Paper was based on its colonial model. During its colonial rule in Kenya, the British focused more on economic expansion than on the provision of healthcare services, which were mostly offered by Christian missionaries (Beck, 1970). This is not to say that no

healthcare services were provided by the colonial government, albeit that, the services were limited in availability, accessibility and were based initially only on curative coverage. It was only after World War 1 and following demand from locally organized associations led by natives that the colonial government reviewed its health budget upwards and contrived to widen access to healthcare by subsidizing mission health centres (Ndege, 2001). The only problem was that the negligible increase in health spending was not matched to the achievement of a particular health goal. A problem that has continued to thrive and undermine the health sector.

The absence of a health financing policy during colonial rule may have produced a discriminatory effect in accessing healthcare. Centred along the city, access to hospitals was available to white settlers, while natives had the option to access the sparse dispensaries and mobile health centres staffed by missionaries and subsidized by the colonial government. Despite the subsequent provision of a health budget for the colony, it was directed towards meeting the costs and coverage of hospitals within the city (*Nairobi*) and major towns (*Mombasa and Kisumu*) to address the healthcare needs of the white settlers (Ibid). The financing of new clinics and provisions of healthcare in rural areas was subjected to the creation of subordinate Local Native Councils (LNC) that were sanctioned with fiscal powers to raise revenue towards funding health and building schools. This provided the disconnect necessary to absolve the colonial government from spending on health and instead placed the burden on the LNCs. The colonial policy on health while guided by the need to cater for the welfare of the colonized population was thus undermined by its capitalistic ideology.

In order to support its capitalist tendencies while meeting societal demand for healthcare, a decentralized colonial healthcare model was designed. Under this model, local communities were themselves responsible to plan and fund their healthcare needs. The area chief, who was part of the LNC was empowered by law to raise revenue by imposing local rates (Ibid). Accordingly, he imposed rates, in addition to taxes that were already being collected by the colonial government, towards funding the establishment of health centres and clinics. This model ensured a separation of duties between the colonial government and the colonized. While the former continued its policy on economic growth, the latter were granted fiscal autonomy conditional on raising revenue to spend on social services.

The framework within which LNC operated permitted local residents to collectively participate in identifying their health needs and contribute towards building of dispensaries. Stocking of essential medicines and posting healthcare workers (HCW), however, remained the prerogative of the colonial government

(Beck, 1970; Ndege, 2001). This resulted in instances where dispensaries were constructed but remained inoperative due to scarce HCW and delay with medical supplies. Limited availability of sources of revenue became a prominent feature within healthcare discourse. Finance was sourced internally (LNC, local taxes imposed) from the colony. The Colonial Development Fund (CDF) set up in Britain after World War 1 to provide development assistance to British colonies included funding for public health from which recurrent expenditure for hospitals in the city and major towns were paid out of however, the CDF was not accessible to LNCs (Ndege, 2001; Constantine, 1984). This meant that health financing for the natives was restricted to domestic revenue mobilisation.

3.2. Health policy – the absence of commensurate finance to implement health goals

The history of health in colonial Kenya did not change with independence in terms of its underlying philosophy. The Development Plans prepared between 1966 and 1978 committed government to focus and promote economic growth (Green, 1965). The provision of social services, in essence R2H for all was declared with an understanding that the government would have greater expenditures on their provision and reduce the amounts available for economic growth that would subsequently retard growth. Nevertheless, the government provided healthcare, free during economic boom and charging user fees during economic regression (Development Plans 1966-1978). By 1982, the colonial decentralized health model was introduced by the government under its District Focus Rural Development Plan. The Plan required local communities to raise local revenue and finance their community health needs, effectively shifting the burden of healthcare away from the state (District Focus Rural Development, 19883). Thereafter free healthcare was removed, and user fees implemented. However, by 1989, user fees were abolished following a reduction in the number of patients accessing healthcare in government health facilities but were re-introduced again in 1992 (Chuma et al, 2009; Mwabu, 1995).

Immunization, nutrition, sanitation and health education featured as the prioritized health needs of the country without a sustainable framework to secure consistency in their financing. With the detection of the HIV virus in the 1980s, government spending alongside international assistance was directed towards combatting the disease, resulting in neglect of the other health priority areas. In the long run, this undermined healthcare service delivery. It jeopardized matching the provision of health needs to a guaranteed budget. 20 years of independence revealed a vulnerable health sector developed to respond to curative and rehabilitative care. A strategic health financing framework could have potentially prevented such a weakened health sector. In 1994, to salvage the further decline of the health sector, the government prepared its first health

policy clearly setting out what the health needs of the country were and how they were to be financed (Government of Kenya, 1994). This policy addressed two main issues that were to solve the financially challenged health sector; cost sharing, and the transfer of public health to local provincial budgets.

The 1994 policy was to be implemented through two-time bound strategic plans. The first National Health Sector Strategic Plan I (NHSSP I) to be implemented from 1994 to 2004 and NHSSP II from 2005 to 2010. The latter drew from the targets set out under MDG4 (*reduce child mortality*), MDG5 (*improve maternal health*) and MDG6 (*combat HIV/AIDS, malaria and other diseases*) collectively referred to as health related MDGs. The efforts made under the NHSSP I did not contribute towards the improvement of the health sector. Instead, infant and child mortality rates increased, and the use of public healthcare facilities declined. The doctor to population ratio also reduced. The policy of delegating the provision of healthcare to provincial level and allocating a budget for each province to provide those services proved catastrophic. Each province utilised the budget for spending on other public services and allocating a paltry sum towards financing health (Kimalu et al, 2004; Muga et al). ***“This could have been omitted had the national government released funds against a well-articulated, prioritised and costed health financing strategy.”***⁴

Over 60% of Kenya's domestic health spending centered on HIV/AIDS (Amico et al, 2010). This raised not only major issues of distorted priorities and very serious issues of sustainability in health service delivery, but also on the allocation of very little funding for the other health programs. NHSSP II, therefore, sought to reverse these trends. Under this plan, health service delivery would be provided through the Kenya Essential Health Package that would be delivered through the envisaged six levels of healthcare delivery and supported by international assistance (see figure below). Level 1 healthcare would be provided at community level. The community would collectively define their own health priorities, and services shall be provided to meet those priorities. Village Health Communities would be organised in each community through which households and individuals would participate and contribute for their own health needs and that of their village. Levels 2 and 3 healthcare would be provided through dispensaries, health centers and maternity/nursing homes providing promotive and curative healthcare. Levels 4, 5 and 6 healthcare would be provided by constituency, provincial and national hospitals focusing mainly on curative and rehabilitative care.

⁴ Interview 1 (on file with author) – Executive Director, Civil Society Organisation focused around health, Nairobi.

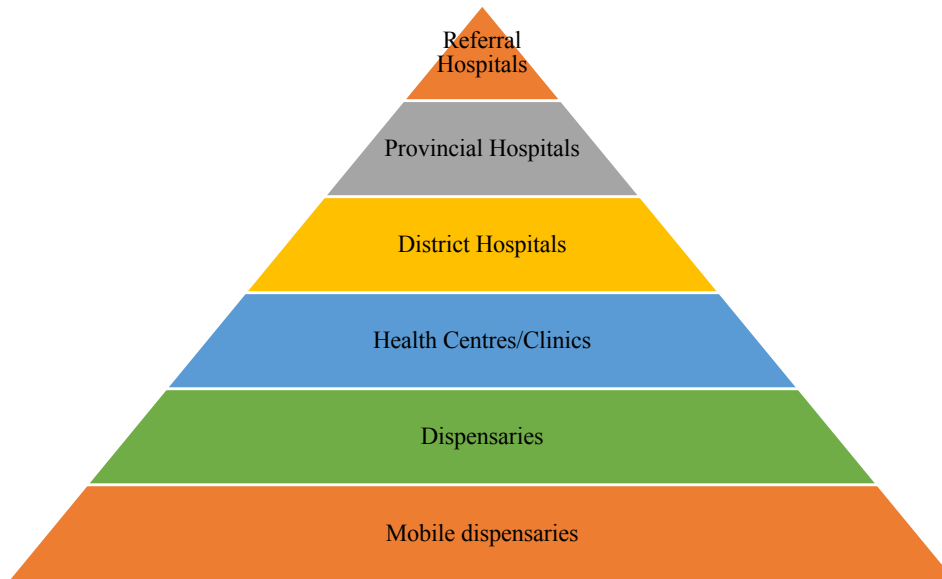


Figure 1: Health Governance Structure
Source: Author

The NHSSP II suffered a similar fate as that of its predecessor. The public health sector continued to deteriorate. The damage resulting from the failure of releasing health funds to provinces without a well-articulated, prioritised and costed health financing strategy was beginning to show. The concentration of international assistance around HIV/AIDS also meant that international finance and partnership were skewed towards health goals that were not representative of the nation as a whole. Leprosy, water borne diseases, mental health illnesses and non-communicable diseases received far less financial attention. Global partnership was built on addressing health related MDGs, preventing and combatting epidemics and pandemics, while endemic diseases received scant attention. Regional imbalances in accessing healthcare, lack of adequate HCW, limited supply of essential medicines, and unavailable public health facilities at community level continued without recourse to mitigating strategies pegged on a health financing model.

The Kenya Vision 2030 launched in 2008 sought to counter these negative trends that had significantly weakened the public health sector. The Vision's goal in its First Medium Term Plan (MTP) (2008-2012) for health was to provide equitable and affordable quality health services to all Kenyans. It sought to build on the achievements of the NHSSP II by focusing on 6 essential features.

- **Health infrastructure**
- *Providing functional, efficient and sustainable health infrastructure network in the country by focusing on rural and disadvantaged areas and communities.*

- **Strengthening government's procurement agency**
- *Bolster the management of procurement and supply of drugs and medical supplies that are paramount in the delivery of quality healthcare.*

- **Community based information systems**
- *Promote the participation of individuals and communities to take charge of their health by developing a community strategy to enhance their awareness of the health preventive and promotive aspects of health, in order for them to adopt positive health seeking behaviour.*

- **Delinking the Ministry of Health from service delivery**
- *Removing service delivery from the duties of the Ministry of Health by establishing a Health Service Commission.*

- **Developing a Human Resource Strategy**
- *Balancing the supply and demand for human resources in the entire public health sector to reduce constraints on healthcare delivery due to the lack of adequate staff.*

- **Develop equitable health financing mechanism**
- *Introducing a system with which to channel funds directly to healthcare facilities to ensure that funds allocated are utilised for their intended purpose.*

The Vision's approach towards developing a health financing strategy was limited to establishing the Health Sector Services Fund (HSSF) as the medium through which the government would transfer funds directly to health facilities. This strategy did not contemplate:

- *Mobilising local revenue intended specifically to finance health.*
- *Guaranteeing a fixed budget for health at village level.*
- *Identifying and fixing sources of revenue to specifically finance particular health goals.*

Recognition of a health financing strategy based on a progressive resource mobilisation scheme that targets all sources of funds for health was made in the Second MTP (2013-2017) of the Vision. This followed the identification, among other challenges, of the problem of the high costs of financing health. Accordingly, the Second MTP proposed the following specific measures intended to mitigate against these costs (*discussed in Section V*):

1. *A social health subsidy mechanism for the poor*
2. *Free maternity services in public health facilities*
3. *Expanding coverage of health benefits to all the indigents*
4. *Establishing a national social health insurance mechanism that caters for employees, employers and the informal sector*
5. *Reforming the National Hospital Insurance Fund to act as a medium for implementing the National Health Insurance Scheme*
6. *Designing a harmonised and progressive resource mobilisation strategies targeting all sources of funds, both domestic and international*
7. *Strengthening programming of external funding of health through improved harmonisation and alignment o sector priorities and improved reporting*
8. *Ensuring efficient allocation and utilization of resources*
9. *Progressively eliminating payment at the point of use of health services, especially by the marginalised.*

The Kenya Health Policy 2012-2030 was thereafter prepared to give effect to these measures. Items 1-5, 8-9 are being implemented. Items 6 and 7 are yet to be addressed by the government. While the Policy offered twelve healthcare programmes seen as representative of the entire country's health needs, it did not elaborate on the content of the health financing strategy and how it was to be designed (Ministry of Health, 2014). The assumption, in my view being that it would be taken up through legislation – the Health Act, 2017 whose shortcomings on such strategy I have already discussed. It is important to point out here that the Kenya Health Policy 2012-2030 was developed after Kenya transitioned from an authoritarian and centralised state to a democratic and devolved state. The impact this had on health was that the constitution secured health as a legally enforceable right, providing it with its normative content and enforcement capability.

Through article 43(1) (a) read together with article 2(6), the Constitution recognised the International Covenant on Economic, Social and Cultural Rights and relatedly General Comment No. 14 on the Highest Attainable Standard of Health in providing the constitutional R2H with its normative content. Articles 1(4) and 6(2) read together with article 209(3) and the Fourth Schedule authorises the exercise of conditional fiscal powers towards implementing R2H at county level. Following the failure in previous policies to set out a health financing strategy, there was expectation that the Health Act 2017 would rectify this neglect. Regrettably, Kenya to date has not prepared its comprehensive health financing strategy. How then has health been financed in the country?

4. FINANCING HEALTH IN KENYA

Kenya has various sources of health finance to complement tax funding.

Contributions to the National Hospital Insurance Fund (NHIF) is mandatory for those working in the formal sector and voluntary for others. Contributions range from Kenya Shillings 360 to Kenya Shillings 3,840 (US\$3.6-38.40) monthly based on income level but as the rates have remained static over 40 years while incomes have increased, their progressivity has been eroded. Those working outside the formal sector contribute a flat rate of Kshs 1,920 per annum (US\$ 19) (MoMS and MoPHS, 2009). NHIF contributes less than 1% to the health budget (Lakin and Magero, 2018).

The Kenyan government has introduced various other tax-based funding schemes for health. For example, in 1999, the Local Authorities Transfer Fund provided for services in large urban local authorities and supplemented funds for less financially viable authorities. The Constituency Development Fund, introduced in 2004, allocates 2.5 per cent of government's annual budget to promote constituency development, with allocations to constituencies based on their population and poverty levels (Ibid). Most of the revenue from these funds are directed to infrastructure development in the transport sector.

Health in Kenya is largely financed through the national budget (see figure below). In the fiscal years 2014/15 and 2015/16, 4% of the budget was allocated to health. This was reduced to 3.5% in 2016/17. But increments followed with an increase to 3.9% in 2017/18 and 5.1% in the current 2018/2019 fiscal budget.⁵ Such budget approach to financing health has resulted in apportioning an average of 4.1% for health, well below both the Abuja and WHO targets. This echoes the government's position under Sessional Paper No. 10 of 1965 that skewed spending towards economic growth than on health.

⁵ The budget statements for the fiscal years 2010 to 2017 are available at the Republic of Kenya, National Treasury's website.

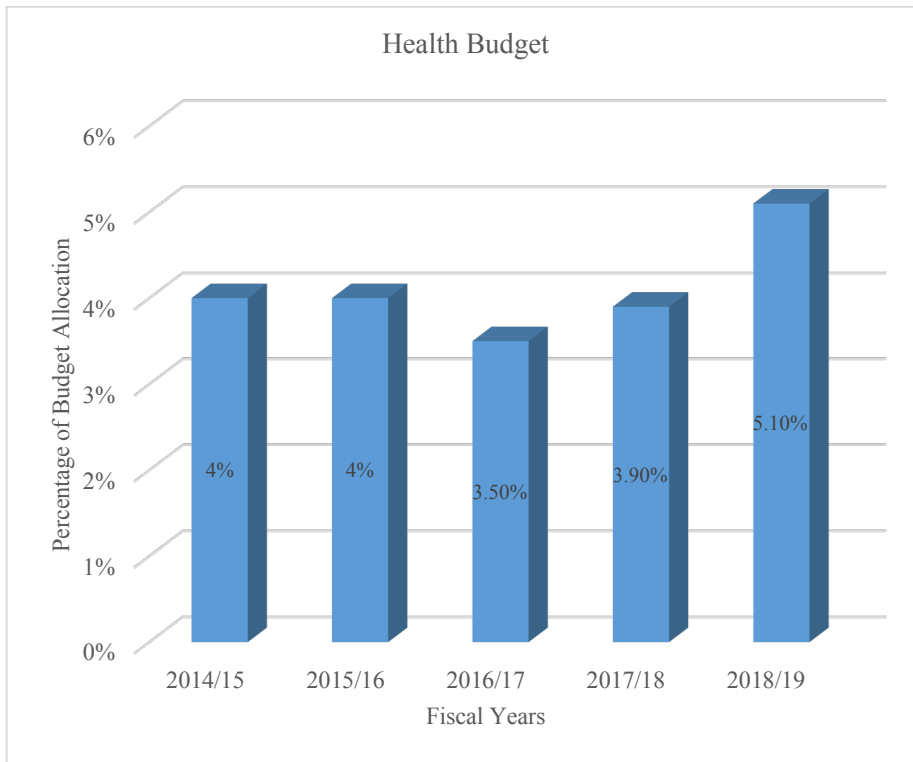


Figure 2: Health Budget
Source: Author

Donor led financing of specific health programs related to HIV/AIDS as at 2013 stood at 40% with most of the funding coming from PEPFAR and the Global Fund for AIDS Tuberculosis and Malaria (the Global Fund) while the government contributed 20.7% (GoK, 2013; Amico et al, 2010). In the fiscal year 2014-15, international assistance contributed 51% of the Kenyan health budget (USAID, 2016). Other than donor aid and external grants, out of pockets expenses by individuals also finance the health sector in Kenya (Wamai, 2009). Out of pocket payments in the 2006-07 and 2013-14 fiscal years contributed to a third of the total health expenditure (Ibid; USAID, 2016). Munge and Briggs explain that a healthcare system that relies on out of pocket payments is regressive and creates a barrier for the poor to access the healthcare system (Munge and Briggs, 2014).

There is no government led innovative intervention that publicly mobilises additional domestic revenue for health in Kenya. For example, a specific tax earmarked for health. In finance, legal rights exist in reality when and if they have budgetary line (Waris and Latif, 2015b). If the state claims to grant the right to free health, this will only take place on the ground if there are adequate resources to build clinics near communities. This conceptual lacuna in the human rights principles that stopped short of stating resources were required has impeded national realization of the right to health as it relies solely on political

will and the budget allocated to the health sector. The government, however, supports innovative financing models.

Innovative health financing strategies in Kenya fall into three groups; public – private partnerships, out of pocket payments and donor led financing of specific health programs. In 2015, the government entered into a public – private partnership scheme with GE Healthcare Africa to provide medical equipment at county level under a seven-year Managed Equipment Services Partnership. Under this partnership the government can budget healthcare expenditure over several years by deferring upfront capital outlay.⁶ This means that the government is a debtor to GE Healthcare Africa. This form of a public – private partnership does not address the issue of raising additional domestic revenue. Rather, it increases the government's debt. User fees are also imposed for the private sector to recover their capital spent under this scheme.

Out of pocket payments have supported Kenya's healthcare sector. User fees paid at the point of accessing healthcare have partially met the financing needs of dispensaries and health centres in rural areas where government financing has been constrained. Recognising the importance of out of pocket payments, the private sector created the M-Tiba health financing scheme (Wagenaar, 2017). This scheme is managed by Safaricom Limited; a telecommunication service provider together with UAP Insurance in Kenya. Under this scheme, an insurance policyholder would set aside a sum of money in contemplation of future healthcare financing. The amount set aside is stored on their mobile application and is the premium paid to UAP. Depending on the premium paid, UAP then provides healthcare coverage to the policyholder by directly remitting the cost to the service provider that has subscribed to the M-Tiba scheme. While this is an innovative scheme intended to increase access to healthcare, it is dependent on monies an individual is to set aside on a monthly basis. Statistics, however, are grim as most of the Kenyan population lives below the poverty line and 6 out of 10 Kenyans were unable to access essential healthcare services in 2014 (KEMRI, 2019). This innovative scheme therefore serves to benefit those with the ability to pay leaving out those who are unable and most vulnerable.

Donor led financing of specific health programs have also developed innovative health financing methods using the voucher program. This voucher program funds maternal healthcare, family planning, and gender violence services in selected rural areas in Kenya. Under the **Safe Motherhood Voucher**, women are entitled to a variety of services from professional antenatal care, delivery services, and referral to hospitals when needed. However, members of the target

⁶ <http://blogs.worldbank.org/ppps/transforming-kenya-s-healthcare-system-ppp-success-story>

group must pay Kenya Shillings 200 (US\$ 2) for a safe motherhood voucher. **The Family Planning Voucher** entitles clients to long term contraception methods including monitoring, referral and consultation. This voucher offers a range of family planning procedures such as intrauterine contraceptive devices (IUCD) and both male (vasectomy) and female (bilateral tubal ligation) voluntary contraceptive surgery. The voucher costs Kenya Shillings 100 (US\$ 1) and buys up to Kshs 3,000 (US\$ 30) worth of services. **The Gender Violence Services Voucher** entitles victims to medical and surgical treatment as well as counselling. It is provided to clients free of charge. Those with the ability to pay are able to access the healthcare services provided under the two former vouchers.⁷

Discussions on innovations at the international level include suggestions of new taxes and funds to mitigate against financial risk. However, they do not canvass the loss of uncollected revenues through tax evasion and aggressive tax avoidance; the use of current funds like carbon tax which is collected on global emissions but deposited in one state to be used at will or tobacco tax collected domestically but not earmarked to health-related spending. The emphasis is on new ideas such as the Health Impact Fund,⁸ instead of fixing the existing ones. The new ideas are not widespread probably due to the novel nature of the idea and possibly due to challenges involved in adding a new mechanism to the already burdened international system. Existing ideas such as earmarking transaction taxes, the tobacco tax and part of the climate fund to cater for health needs are interesting. But they are not fleshed out in terms of guiding principles and an overall structure within which these taxes are to operate to finance health domestically.

The existing ideas are also dependent on the socio-economic development of a country. Half of the Kenyan population lives under the poverty line, therefore, tax mobilisation is not the best option to finance health. To increase health financing, reliance should be placed on collecting more taxes by tighter controls on evasion schemes, or earmarking, for example, part of the climate fund. However, Kenya also has a growing debt that needs repayment and tapping into the uncollected taxes through efficient collection mechanisms should be aimed to reduce the debt. Kenya's climate fund also requires an additional US\$1 billion to operationalize (IIED, 2014) hence fully focusing on mobilising revenue for financing health does not seem very plausible.

Considering these circumstances, the underlying position under the Sessional Paper No. 10 of 1965 to promote economic growth over financing health seems

⁷ GIZ, Vouchers: making motherhood safer for Kenya's poorest women (accessed 13 May 2018, available: https://health.bmz.de/ghpc/case-studies/Vouchers-MDG5/Vouchers_short_EN.pdf)

⁸ <http://healthimpactfund.org/>

to be ubiquitous and unavoidable. Despite the proposals for innovative health financing strategies, studies have shown that there has been a lack of proper monitoring of health finance at the institutional level. This has resulted in low health spending as a result of corruption, and bureaucracy in the timely release of funds (Kimathi, 2017; Transparency International, 2011; Kenya Anti-Corruption Commission, 2010). While new financing methods may be useful it may likely add on more complication to an already complex system.

While financing health may not entirely be a problem resting on shortage of funds, but on mismanagement and lack of priority setting, the absence of a legal obligation to set a health finance strategy seems to be the overt challenge. In discussing sections 2, 3 and 4, my aim has been to show the disconnect between R2H and health financing that has resulted in separating the connected concepts of legal right (R2H) and legal obligation (finance). This has placed finance within soft law. No legal duty arises under the Health Act to earmark domestic mobilisation of resources towards a health fund or to source for finances outside the country.

While article 43(1) (a) of the Constitution provides the sound basis for making claims and demands, and for criticising the acts of public officials it falls short of placing the achievement of rights against a financing framework. Underfunding health and shortages of available monies to finance health cannot be solved by ignoring the need to prepare a financing model. Finance is too deeply cemented into the structure of health governance in Kenya. Though the Health Act gives a skeleton of what the financing model should focus on, its flesh is to be arranged through a separate law that interlocks the different sources of finance available through domestic resource mobilisation and the SDG17 partnerships. Current health financing initiatives are vague and have fuzzy edges since they indicate the means through which access to healthcare services will be provided, but do not explain from where the finances will be mobilised to sustain these initiatives. Whether UHC provides Kenya with solutions to design its health financing framework based on revenue mobilisation through domestic measures is currently under study. What is amiss is discussing UHC without an interdependent strategy on SDG17 interventions. This is discussed next. The next section shows the criteria that can be applied to identify the features for a sustainable health financing strategy for Kenya.

5. CAN UHC FINANCING GUIDELINES AND AN INTERDEPENDENT STRATEGY ON SDG17 HELP DEVELOP KENYA'S HEALTH FINANCING STRATEGY?

Finance is, as it were, the stomach of the country, from which all other organs take their tone.

W.E. Gladstone, 1981

Kenya's thinking about finance has gone through different stages over the last few decades. Having begun as a state centred approach, to involving the private sector and donors to support health coverage, Kenya is moving away from its policy that supported the dichotomy between social rights and economic growth. The reciprocal nature of socio-economic realities is beginning to guide policy and law making. Development signifies not only economic growth but improvements in standards of living, including healthcare. However, in so far as finance is concerned in the progressive achievement of R2H its focus continues to remain centred around the national budget. This is despite the constitutional diversification of fiscal authority that authorises counties to develop local strategies in mobilising more funds for health (Constitution of Kenya, Articles 209, 210).

Separate directives and policies on free maternal healthcare, reform of the National Hospital Insurance Fund and on introducing the Health Insurance Subsidy for the Poor (HISP) have intermittently improved access to healthcare for the vulnerable and marginalised population, women, children and the poor in specific areas but these programs have been undermined by ambiguities. These programmes have not been matched to a financing framework making their implementation challenging. The process of deciding how to commit the country's resources across these programmes has not been agreed upon by the national government.

Take the NHIF for instance, it is based on member contributions. The more one pays, the more the coverage. Noting that the majority of the contributors are from the formal sector with the ability to pay more, the NHIF coverage takes a regressive form (taking from the poor to pay for the rich) – as members from the informal sector are also joining the NHIF scheme and subscribing for the minimum package. The pooled funds result in shifting resources between the two groups (formal and informal) where the formal sector benefits more. There is no financing policy on how government chooses to direct these flows of NHIF resources. The HISP policy also does not set out government's financing policy to sustain the program years after donor support wanes. The program is hugely supported by the World Bank Group and other development partners. In Siaya

County where HISP operates, severe limitations have been noted. The poor still have to pay user fees for laboratory services, injections, and basic hospital commodities. Since NHIF payments for HISP are constantly delayed, public health facilities-imposed user fees undermining the very aim of HISP –financial risk protection for the poor (Kabia et al, 2019).

Separately, counties such as Machakos, Isiolo, Kisumu and Nyeri are beneficiaries of the country's free medical scheme pilot project for immunisation, maternal and child health services (Nzwili, 2018). This pilot project focuses around:

- *Expansion of the population under universal health insurance coverage,*
- *Increasing the availability and coverage of quality essential interventions,*
- *Ensuring financial risk protection for Kenyans with a special focus for the poor, and*
- *Ensuring adequacy of health resources for delivery of health services.*

The provision of these services is through a number of schemes. The introduction of (a) Civil Servants Scheme (CSS), (b) stepwise quality improvement system, (c) HISP, (d) revision of monthly contribution rates and expansion of the benefits package and (e) the upward revision of provider reimbursement rates. Without incorporating these schemes into a harmonised financial framework, their sustainability is undermined. These schemes respond to the benchmarks prescribed in section 86 of the Health Act.

The information next presented in this section studies the recent legislative approach to financing health in Kenya. It compares the benchmarks prescribed by the government of Kenya to fund health with financing measures set out under SDG3 and 17 to understand whether taken together they are sufficient in developing a health financing framework. Since the current prescriptions are skeletal, this section contributes to understanding whether SDG3 and 17 can add flesh to the Kenyan approach to designing its own health finance model.

Presented in a table format, the aim is to show the various steps taken by the government in moving towards UHC alongside the challenges encountered. The SDG3 and 17 proposed financing measures are highlighted and then used to draw out principles that could potentially help in developing a health financing strategy for Kenya and also address the identified challenges.

Kenya's recent legislative approach (measures) to health finance (section 86, Health Act)	Steps taken and challenges encountered in implementing the section 86 (Health Act) measures	What is needed? How can the SDG3/17 framework for finance assist?
<p>Develop mechanisms for an integrated national health insurance system and its regulation</p>	<p>This has been done through:</p> <p><i>Reforming the National Hospital Insurance Fund</i></p> <p>The fund provides health coverage to formal sector employees with an option for informal sector workers to also subscribe to the benefits of the fund. In providing healthcare coverage, the fund is dependent on the financial contributions made by both employers, employees and the government. The fund managers have no powers to mobilise additional revenue sources save from the returns on their investment of contributions not immediately required. The primary source of revenue for the fund are the contributions made hence constraining NHIF funding. Though the <i>de jure</i> NHIF benefit package was comprehensive, the range of benefits that its members <i>de facto</i> received was limited because certain services were often unavailable from healthcare providers that the NHIF had contracted to provide services to its members. Increase in benefit package will only benefit the formal sector workers. Main challenges are:</p> <ul style="list-style-type: none"> □ Health insurance is inequitable and skewed against poor. □ Mobilisation of resources is secured only through contributions paid. □ Lack of a health insurance law and regulatory framework. Current Insurance Act does not cover health insurance and Insurance Regulatory Authority lacks adequate capacity to handle aspects related to health insurance. 	<p>SDGs 3.8 and 17.1-5 focus on finance. Their implementation is subject to ongoing discussions, but financing strategies have already been suggested and accepted as models.</p> <p>Section 86 can benefit with the insertion of the following SDG financing measures to complement its envisaged health insurance system:</p> <p><i>In developing mechanisms for an integrated national health insurance system, the government will:</i></p> <ul style="list-style-type: none"> ▪ <i>Seek to match funds by tapping into the SDG Fund (introduced the use of matching funds that are provided by national and local governments, international donors and the private sector).</i> ▪ <i>Supplement Health Insurance Subsidy for the Poor (HISP) with a Public Private Partnership (PPP) model under the Private Sector Advisory Group that has been established under the SDG Fund to contribute to developing strong PPPs for health (formed by business leaders of major companies from various industries globally the aim is to collaborate and discuss practical solutions for healthcare delivery).</i>

	<p><i>Micro Insurance Policy Paper</i></p> <p>Micro Insurance Policy Paper proposes that waiting periods for maternity, surgical and other benefits be 9 months, 6 months and 2 months respectively. These proposals are not reflected in existing insurance law or draft regulations and there are no guidelines supporting their implementation. Neither are they linked to any particular health policy or regulation.</p> <p><i>Introduction of the Health Insurance Subsidy for the Poor (HISP)</i></p> <p>Strategy to expand population coverage and improve equity in coverage. It is a comprehensive, fully subsidised, health insurance program for selected poor orphans and vulnerable children. Currently a pilot program targeting 170,000 households. HISP faces implementation challenges: (1) capacity to carry out poverty targeting to identify beneficiaries, (2) weak communication and hence low awareness among beneficiaries of their entitlement and how to access services, (3) slow contracting of healthcare facilities by the NHIF.</p>	
<p>A cost sharing mechanism between the national and individual county governments to be agreed upon</p>	<p>This has been done through:</p> <p>Preparation of the Kenya Essential Package for Health which outlines the services to be purchased. County departments of health purchase health services from tier 1 (community health units), tier 2 (health centres and dispensaries) and tier 3 (county hospitals) public healthcare providers within their jurisdictions.</p> <p>Payment for these services informed by the Public Finance Management Act (PFMA) and related regulations.</p>	<p>A financing framework under section 86 can benefit with the insertion of the following SDG financing measures to complement the government's cost sharing mechanism:</p> <ul style="list-style-type: none"> ▪ <i>Include a provision under section 86 and the PFMA that permits seeking to match funds by tapping into the SDG Fund.</i> ▪ <i>Split the cost sharing mechanism with the Private Sector Advisory Group that has been established under the SDG Fund to contribute</i>

	<p>National government to fill service delivery infrastructure gaps.</p> <p>Main challenges on cost sharing are:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Poor coordination between the two levels of government. <input type="checkbox"/> No adequate and strategic purchasing practice. <input type="checkbox"/> Budget constraints. <input type="checkbox"/> Poor prioritization during the budget making process. <input type="checkbox"/> Not clear what the cost sharing is on. Is it focused on sector specific inputs (personnel, medicines), programs/activities (immunization) or diseases (HIV/AIDS)? <input type="checkbox"/> Leveraging private sector resources underexplored. 	<p><i>to developing strong PPPs for health.</i></p>
<p>Defining a framework for public financing of healthcare</p>	<p>This has been done through:</p> <p><i>Revision of Monthly Contribution Rates and Expansion of the Benefit Package</i></p> <p>NHIF increased contribution rates for its national scheme members to account for increased cost of service provision and to expand the benefit package.</p> <p><i>Upward Revision of Provider Reimbursement Rates</i></p> <p>NHIF increased the inpatient reimbursement rates as a means to reduce the proportion of direct costs payable by its members for inpatient care. Upward revision of NHIF premium contribution rates is unaffordable to informal sector individuals. A GIZ (2016) study on willingness and ability to pay the NHIF premium by the informal sector showed that the new rate was unaffordable for 75% of this group.</p> <p><i>Contracting healthcare facilities to provide services</i></p> <p>Biased in favor of urban facilities (mostly hospitals) rather than small outpatient facilities that provide</p>	<p>To move this measure from an open-ended abstract guideline to a clear and well-defined financing framework under section 86 the insertion of the following SDG financing measures is useful:</p> <ul style="list-style-type: none"> ▪ <i>Earmark the framework for public financing of healthcare to fiscal interventions – change in tax rates and bases, exemption and subsidy policies, compliance policies, StAR funds and include these as part of defining this framework.</i> ▪ <i>SDG 17 allows developing countries to seek international support by tapping into the available ODA – subject deficit in health finance to ODA</i> ▪ <i>SDG 17 targets mobilisation of additional financial resources – use this to tap into and earmark portions of finance from African, Caribbean and Pacific (ACP) cooperation, private sector development and macro-financial assistance (MFA) from the north.</i> ▪ <i>Include a VAT action plan.</i>

primary healthcare. The poor typically reside in rural regions and tend to use smaller outpatient facilities rather than hospitals in urban areas. This bias promotes inequities.

Main challenges on this are:

- It is not clear what is meant by the term to define a framework for public financing of healthcare. Rather than attempting to unpack the meaning contemplated by the legislature in the use of the term defining, I would argue that the measure does not expressly state the need for an operational health financing framework. I will explain this. An operational health financing framework identifies the health programs that require financing and costs them. It then refers to the fiscal health framework to identify what revenue streams have been earmarked for healthcare before drawing on them to finance the selected health program. In defining a framework for public healthcare financing, the government is seeking to conceptualise the meaning of a financing framework. Perhaps this is an important first step towards formulating a fiscal health framework.
- Limited financial autonomy. Public Finance Management Act requires all revenue raised by or received on behalf of the county government be transferred into one county revenue fund for public service provision. Public health providers in the past were allowed to keep user fee revenues in their own bank accounts and draw on them through the authorisation to incur expenditure. Transferring user fees revenues into the county revenue fund undermined their authority over finances, which limited their purchasing decisions and power and demotivated both management and staff.

	<ul style="list-style-type: none"> □ Expanding coverage based on voluntary contributory mechanism. Out of the 49 million Kenyans, as at 2017 those enrolled in the NHIF were 6.6 million out of which 2.2 million were from the formal sector. International experience has shown that few countries have made substantial progress towards UHC on a voluntary basis. □ By increasing benefits, the NHIF is implicitly trading off population coverage for greater benefits. This is because there is an expansion of services without an expansion of population coverage and the current covered population is predominantly composed of the well off. 	
<p>. Identifying a standard health package to be financed through prepayment mechanisms</p>	<p>This has been done through:</p> <p>The Kenya Health Policy 2014 – 2030 having identified the health package for the country. The shortcomings of the policy have already been explained in sections 2, 3 and 4. Part of this policy is to be financed by the Health Sector Services Fund (HSSF) – revolving fund that provides direct cash transfers to primary healthcare facilities (dispensaries and health centres). The local communities represented by the Health Facility Management Committee manage the funds received and prioritise their use according to health needs. HSSF is heavily budget based without additional revenues earmarked from other different streams of resource mobilisation.</p>	<p>To develop this measure into a clear and well-defined financing framework under section 86 the insertion of the following SDG UHC financing measures is useful:</p> <p>In addition to those identified under item 1 (above) integrating the existing voucher systems as part of the prepayment mechanisms.</p>

Source: Author

These measures miss out on expressly committing government to increase its public spending capacity for healthcare. They leave health financing at a nascent stage, presenting only an outline of what needs to be done without specifying how it is to be done leaving counties to prepare strategies for tailor-made delivery of healthcare. The problem is that this is then done without putting

earmarked domestic resource mobilisation strategies toward UHC. Section 86 misses out on providing certainty on financing health. The measures do not attach responsibility to reprioritise health within government budget, earmark income and consumption taxes directed toward the health sector and external aid. Scholars such as Heller, Tandon and Cashin have argued that these three features are necessary to inform the development and implementation of health financing in developing countries (Tandon and Cashin, 2010; Heller, 2006). The SDG3 and 17 provide helpful criteria to strengthen health financing in Kenya by anchoring resources within the reality of the country's fiscal context (shown in the last column of the table).

6. CONCLUSION

The relationship between R2H (rights) and finance (duty) guided the arguments made in this paper. Kenya's healthcare history has shown that its relationship with finance is not clearly delineated, the correlation is not clearly outlined and reciprocal expectations from a budgetary point of view is weak. Thus, this paper sought to push for a tight, but not strict correlativity between R2H and finance. R2H is not entirely dependent on finance to enable its exercise. As a constant right, its correlative obligations are defined by socio-economic realities, which in turn are partly based on the determinants of public finance. Having a health financing policy is, therefore, necessary to avert healthcare crises. In this paper, I have shown the disconnect between R2H and health financing that has resulted in separating the connected concepts of legal right (R2H) and legal obligation (finance).

While article 43(1) (a) of the Constitution provides the sound basis for making claims and demands, it falls short of placing the achievement of rights against a financing framework. Finance is not too deeply cemented into the structure of providing healthcare in Kenya. The need for a separate health financing policy is thus necessary. The paper has shown the criteria that can be applied to identify the features for a sustainable health financing strategy for Kenya. The state has limits to its fiscal potential. There is the burden of funding a constantly expanding public debt. Social expenditure is growing following increase in population to 53,000,000 Kenyans. The state's commitment to full employment and to a rising standard of living requires an economic reorganisation. What implications this may have on healthcare can be understood by looking into Kenya's history of the health sector. A health financing framework strengthens R2H in Kenya so as not to be left behind in light of domestic difficulties.

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