Kenya
Achieving Universal Health Coverage and Reaching the Poor

Kenya has made some impressive gains in improving health outcomes

Health outcome/output	KDHS 2003	KDHS 2008	Change
Under 5 Mortality Rate	115	74	Decreased by 41%
Infant Mortality Rate	77	52	Decreased by 25%
Children fully immunized	57	68	Increased by 14%
Contraceptive Prevalence Rate	39	46	Increased by 7%
Prevalence of HIV (population 15-49 years)	7.6	6.3	Decreased by 1.3%
Women receiving antenatal care	88	92	Increased by 4%
Ownership of Bednets	22	61	Increased by 39%
TB Treatment Success Rates (World Bank indicators)	80	87	Increased by 7%

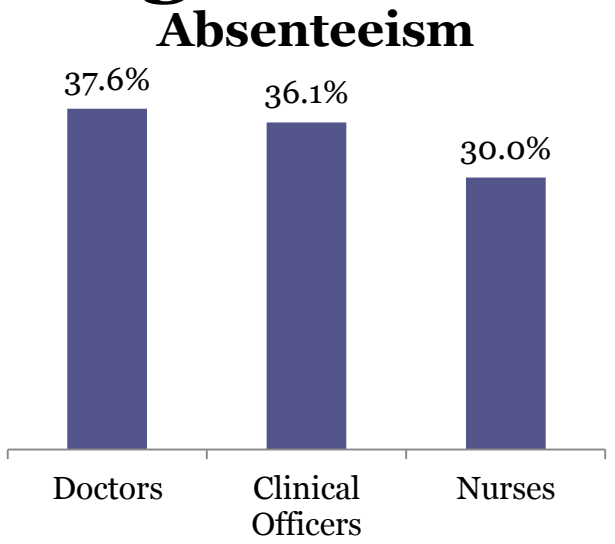
Health Sector still faces serious challenges

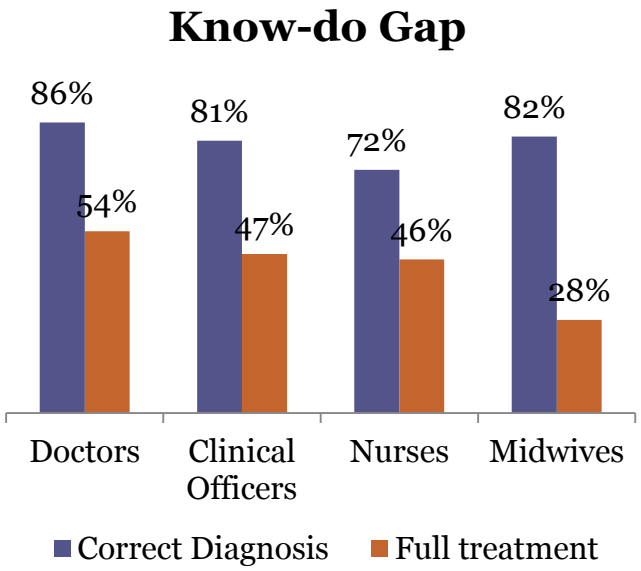
Kenya will increasingly face dual burden of disease:

- **Maternal mortality in Kenya remains stubbornly high. Nearly 40 mothers die every day**
- **Over a third of Kenyan children continue to be shorter for their age**
- **HIV/AIDS still remains a challenge - 6.3% prevalence**
- **Non-communicable diseases are increasing**
  - **Higher mortality compared to the global average (624 vs. 573 deaths per 100,000).**
- **More deaths due to injuries compared to the global average (116 vs. 78 deaths per 100,000).**

Health Systems Challenges

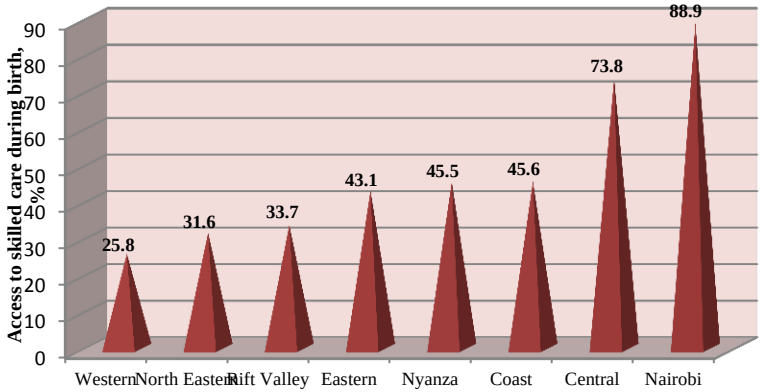
- Devolution enhances accountability but may cause initial disruption of services
- Efficiency of health systems remains low:
- Technical Inefficiencies:
  - Absenteeism – One third of staff absent
  - Large know-do gap – High level of knowledge not translating to better treatment
- Allocative Inefficiencies:
  - Hospitals take major chunk of the budget
  - Absorption of allocated funds remains low

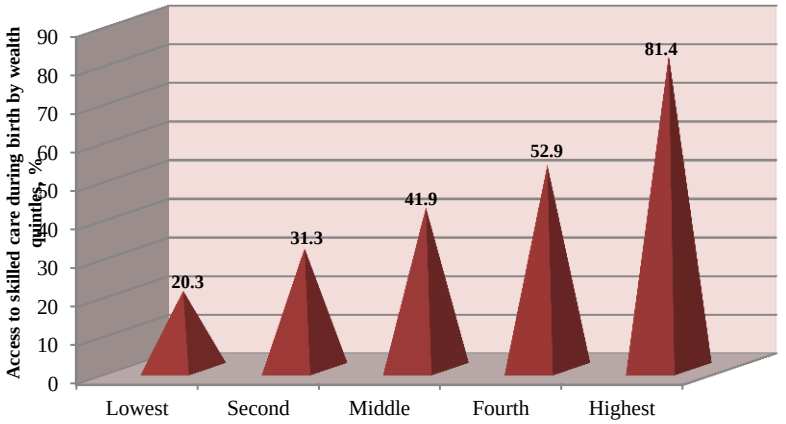




Healthcare Delivery Challenges

Geographic and economic inequities continue:

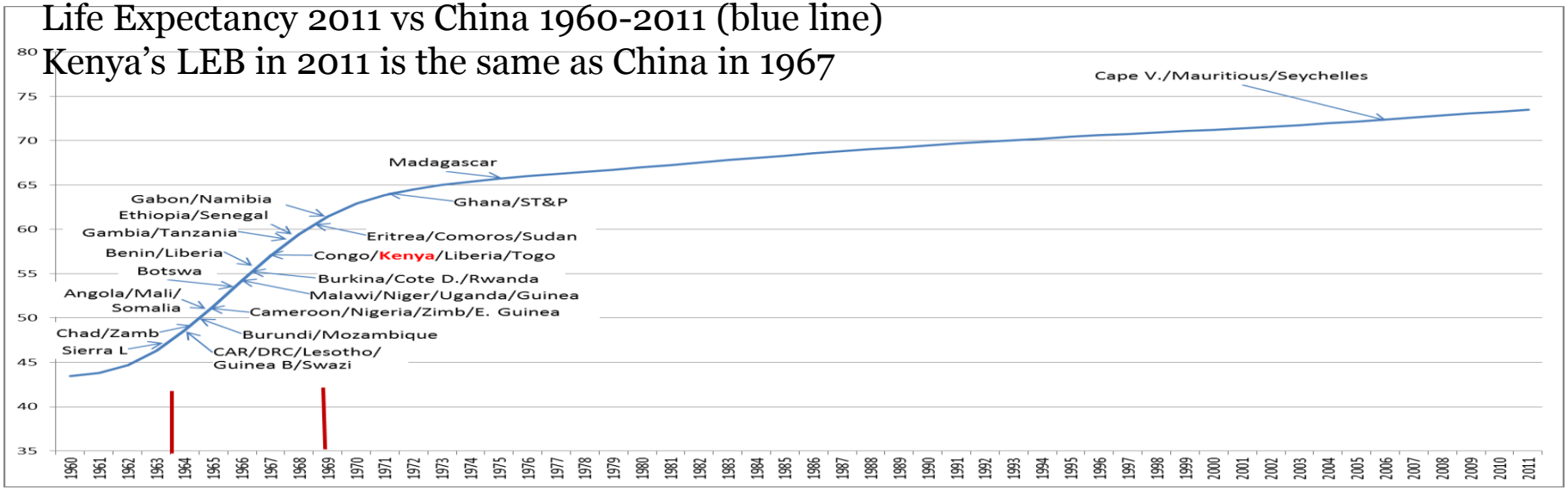


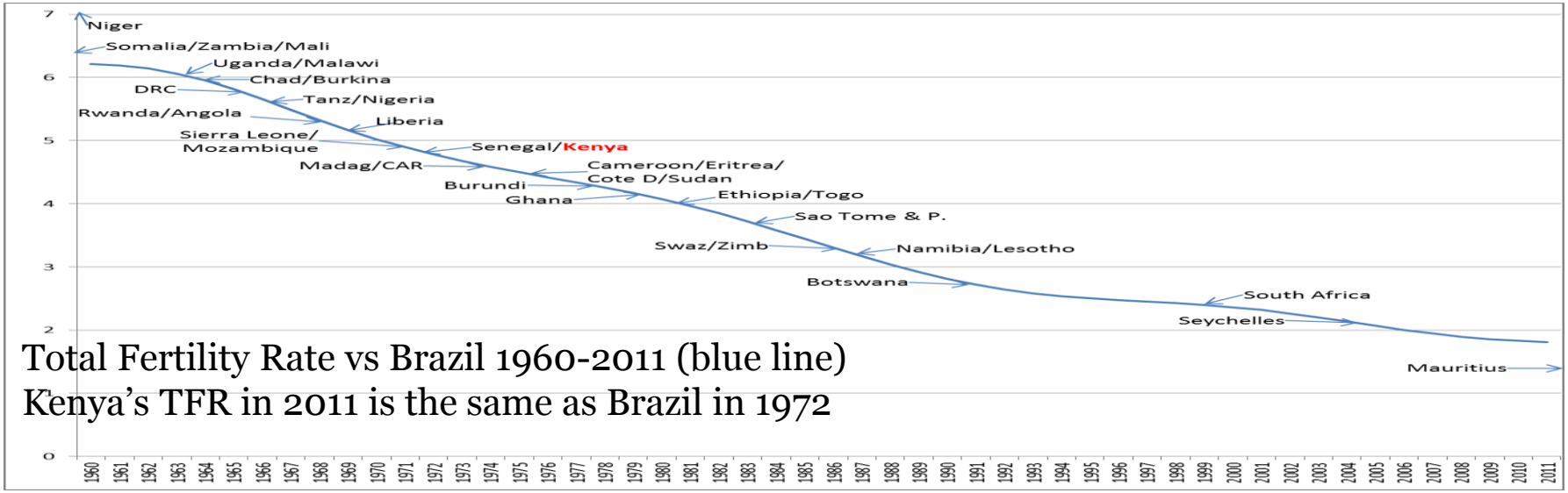


- Poor still face challenges in accessing essential health services and out of pocket expenditure is high

Health Outcome Challenges

Life Expectancy 2011 vs China 1960-2011 (blue line)
Kenya's LEB in 2011 is the same as China in 1967



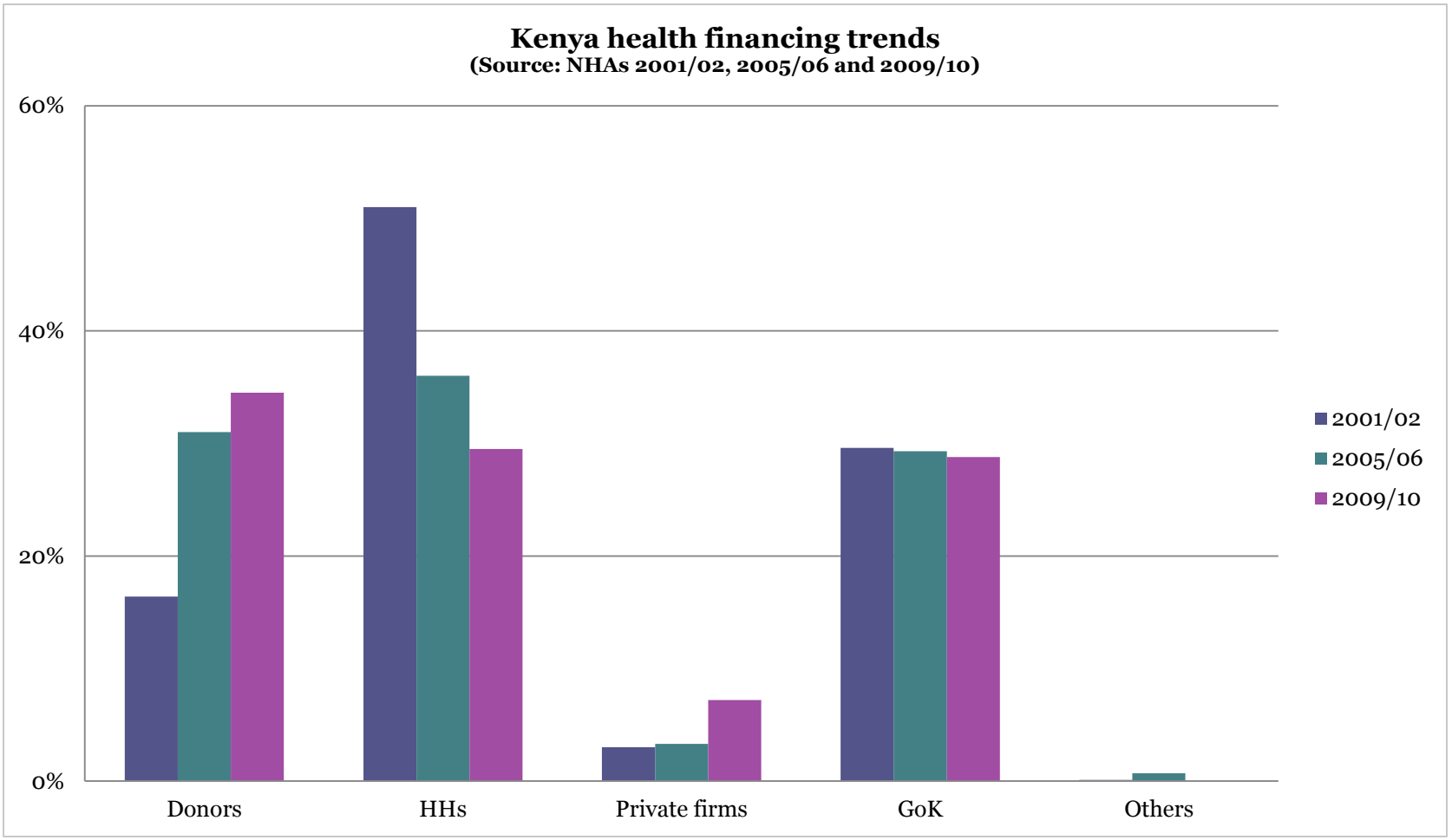


Total Fertility Rate vs Brazil 1960-2011 (blue line)
Kenya's TFR in 2011 is the same as Brazil in 1972

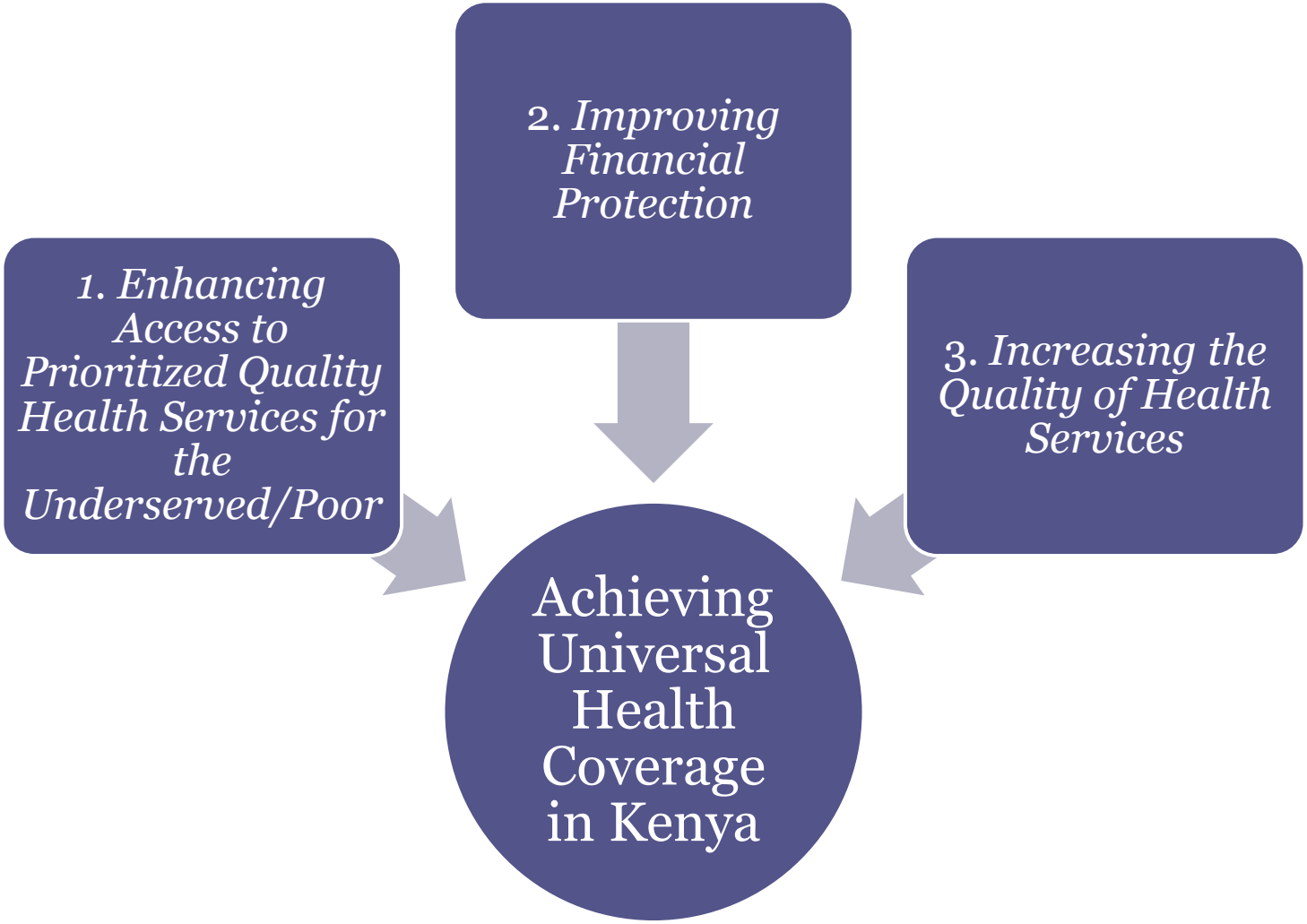
Health Financing Challenges

- **Declining Government Commitment to Health** (from 8% of Total Government Expenditure in 2001, to 4.6% in 2009)
- **Large Out of Pocket Expenditure** limiting access to the poor and highly inefficient
- **Fragmented and mostly off-budget Donor Funding** subsisting govt. resources and expected to decline
- **Limited insurance/pre-payment** – Less than a quarter

Limited Public Commitment



Health Financing Framework



1. Enhancing Access to Prioritized Quality Health Services for the Underserved/Poor

Removing User-Fees for priority services (including maternal health)

Defining a benefits package for all which is sustainable

Improving efficiency through RBF (absenteeism, know-to gaps)

Improving allocation and absorptive capacity through devolution

2. Improving Financial Protection

Implementation of National Hospital Insurance Fund Reforms (governance, information systems)

Health Insurance Subsidies for the Poor (HISP)

Expansion to other "informal sector"

3. Increasing the Quality of Health Services

Strengthening QA mechanisms using a step-wise approach

Enhancing Regulatory Capacity for Health Financing

Promoting quality in private sector through franchised networks

Introducing private supplementary health insurance (beyond the basic package)

Kenya Results Based Financing Early Lessons

Key Assumptions:

- Facility autonomy to hire staff, procure supplies, improve infrastructure using RBF incentives and direct cash transfers
- Accurate, complete and timely data reporting
- Active community involvement that empowers clients and builds trust

Monitoring and Verification

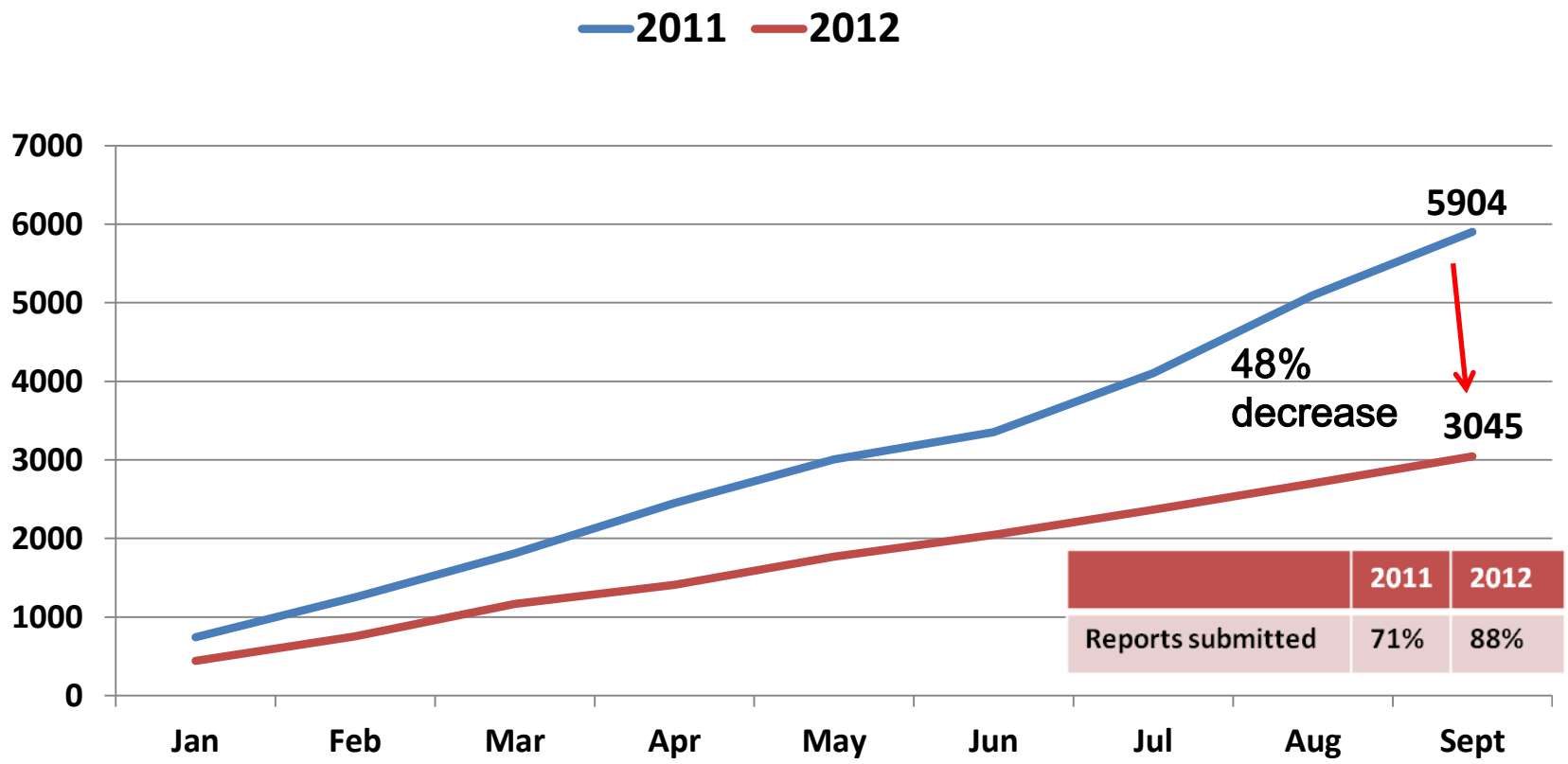
1. Review of DHIS outputs
   - Month-on-month contrasts
2. Joint verification teams visit PBF and control facilities quarterly
   - Measure “cross cutting” quality
   - Measure clinical quality linked to PBF indicators
   - Record PBF outputs in facility registers
3. Verification by External Agency

RBF indicators

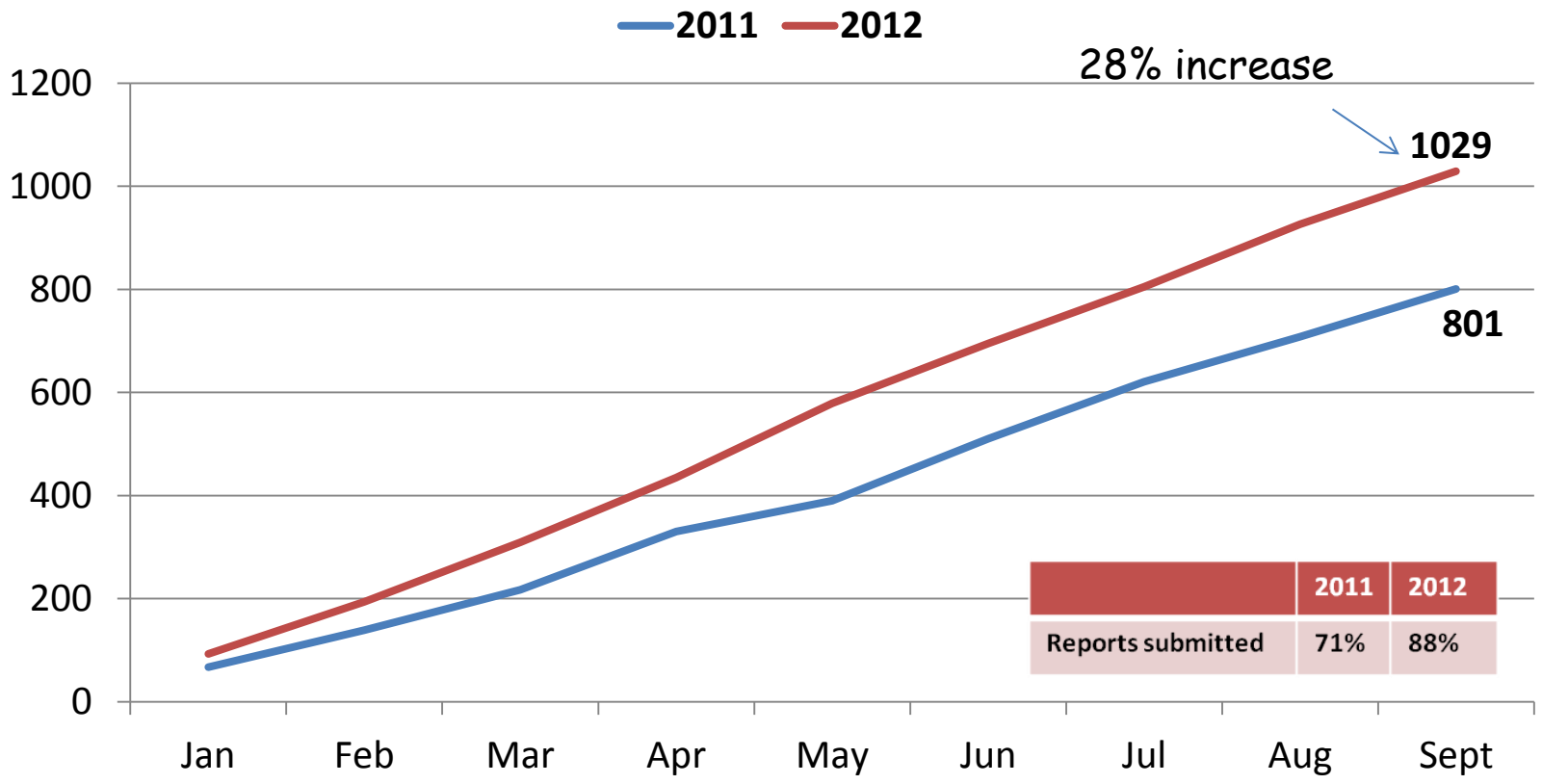
1. No. attending 4+ ANC
2. No. of facility based deliveries
3. No. of women receiving FP commodities
4. No. of fully immunized children (FIC)
5. No. of children at CWC
6. No. counselled and tested for HIV

- 10 clinical quality scores
- 22 cross-cutting quality scores

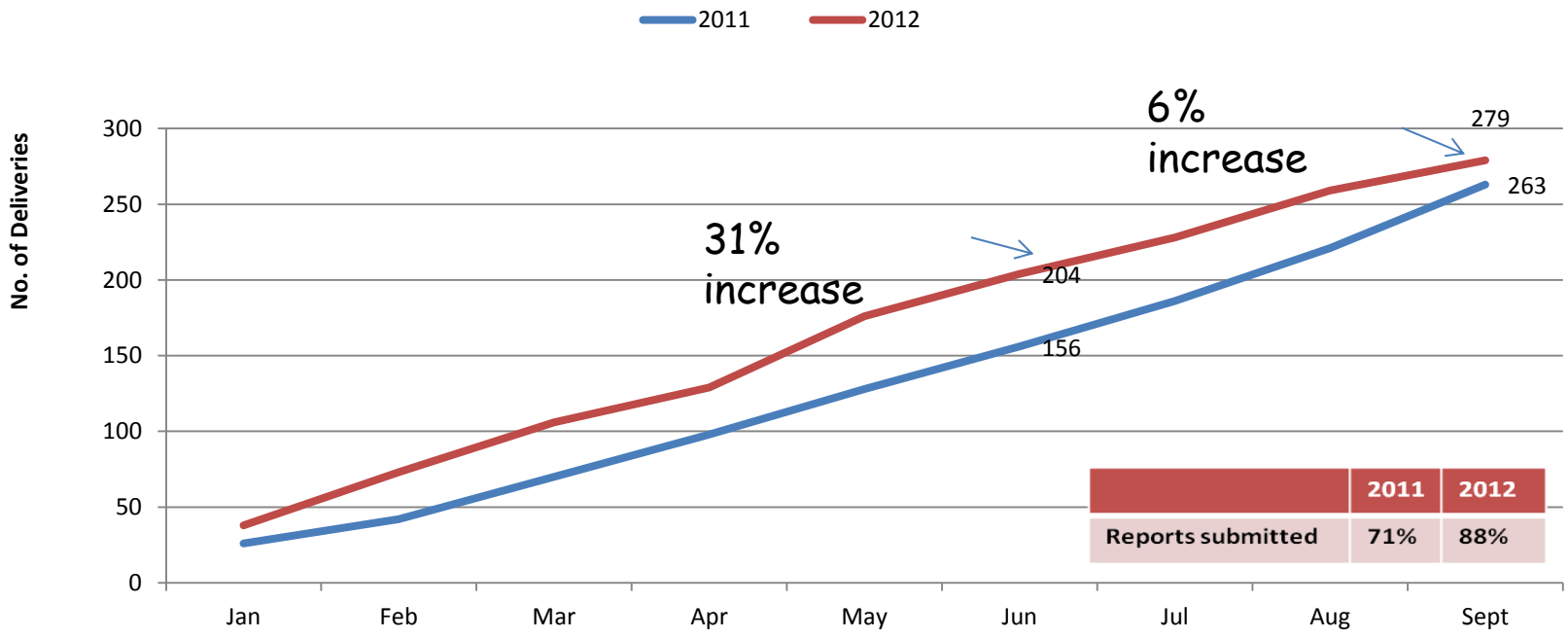
Indicator #1 – Cumulative no. of Women in Reproductive Age with contraceptives in RBF pilot facilities Jan-Sep 2011 & Jan-Sep 2012



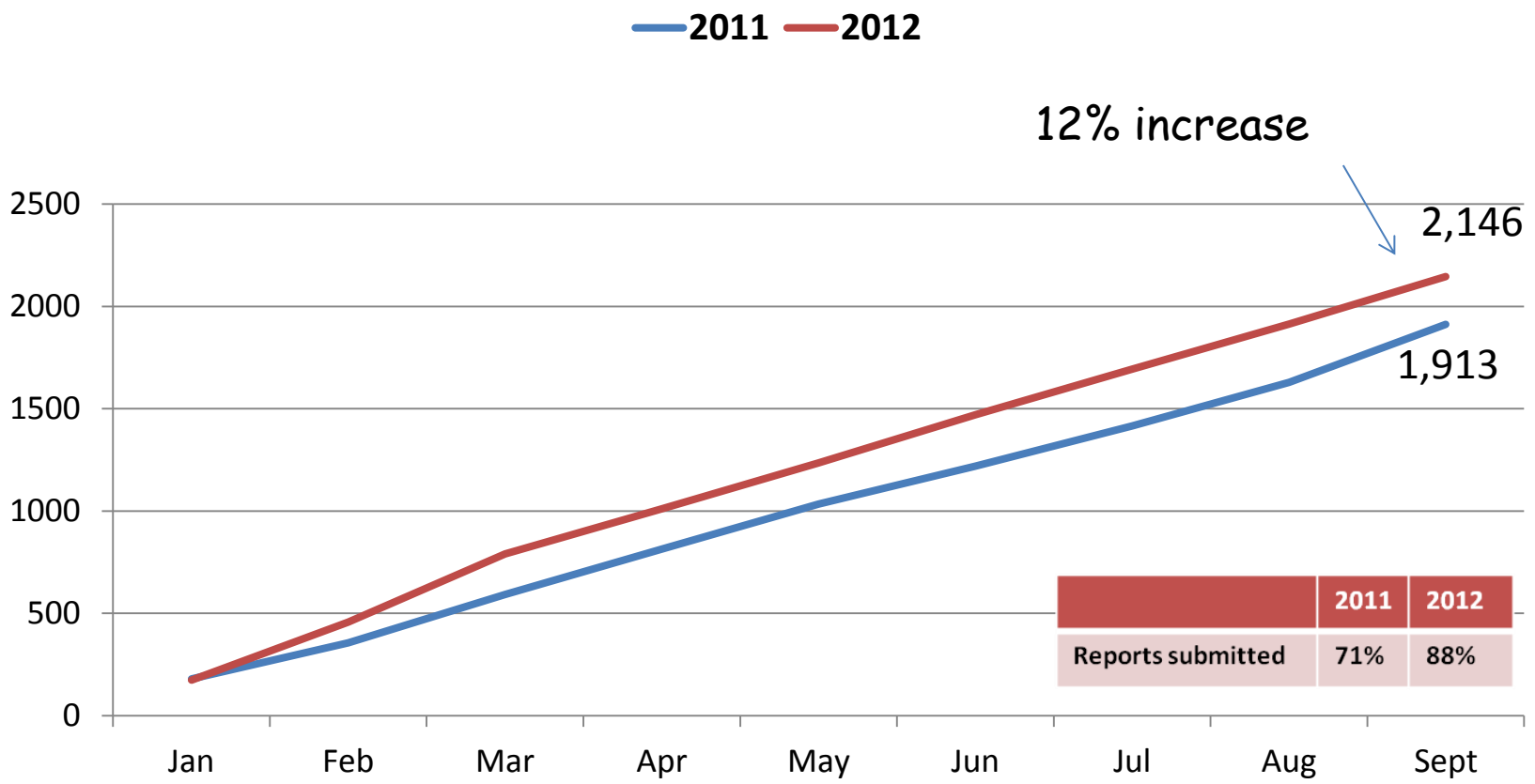
Indicator #2 – Cumulative no. of 4 ANC visits in RBF pilot facilities
Jan-Sep 2011 & Jan-Sep 2012



Indicator #3 – Cumulative no. of deliveries in RBF pilot facilities
Jan-Sep 2011 & Jan-Sep 2012

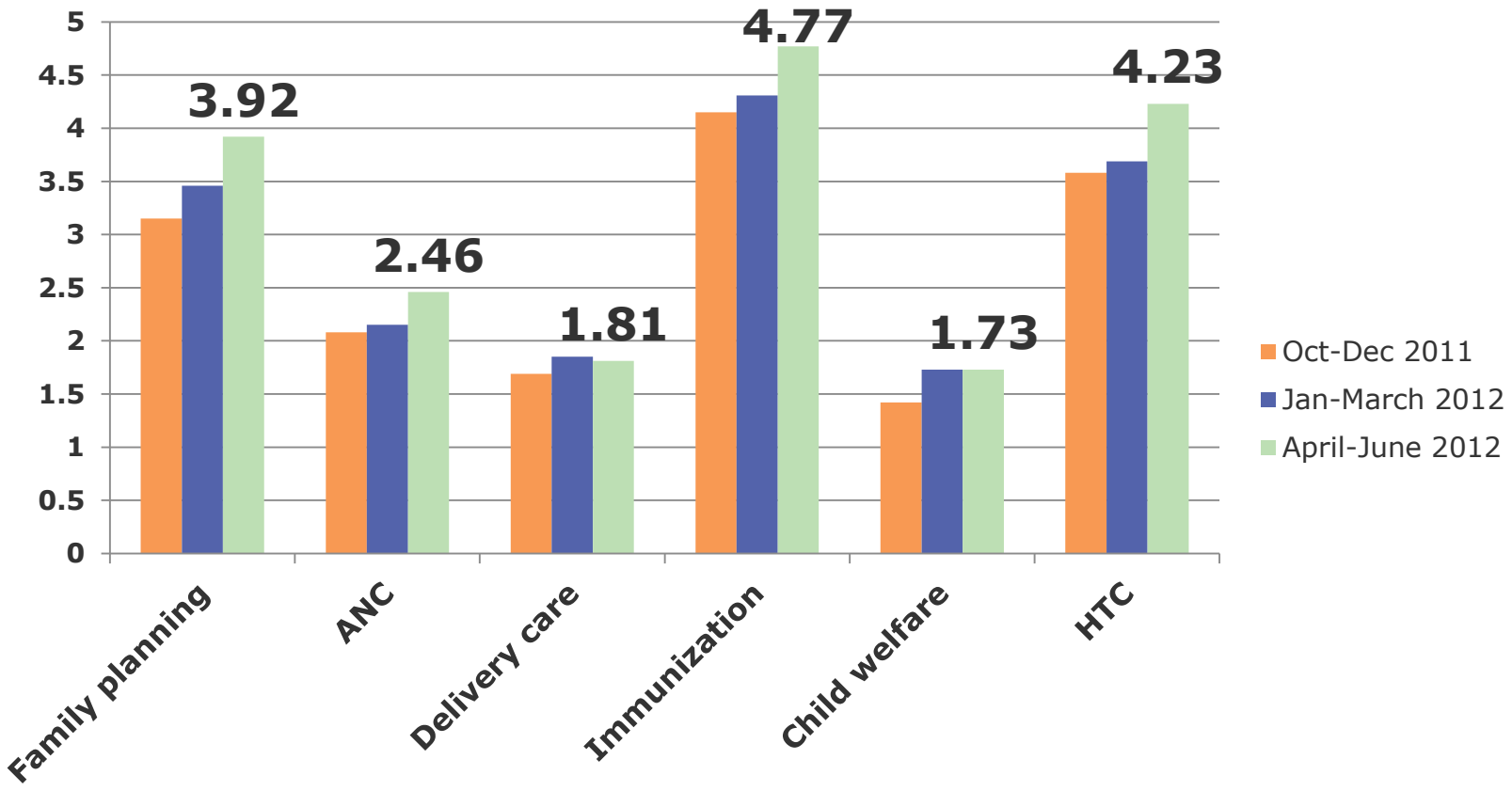


Indicator #4 – Cumulative no. of Fully Immunized Children in RBF pilot facilities Jan-Sep 2011 & Jan-Sep 2012



Clinical Quality Scores

Average clinical quality scores by PBF output indicator across 3 quarters (n=26 PBF facilities)



Key Findings of External Review

- HMIS Reporting frequency for facilities improved
- Utilization trends improving for some services
- Quality of care improving
- Verification costs, above operating costs, estimated at 20% of total PBF budget for Samburu Central

Early Lessons

1. The Direct Cash Transfer Program has provided good foundation for RBF for funds flow and management
2. Under the devolved health system, a strong ownership and county level oversight required.
3. A strong interdepartmental team supported by a technical working group would help to institutionalize RBF.
4. MOH should harmonize institutional arrangements for it results based initiatives (Voucher, RBF and Free Maternity care) in the new organizational structures
5. Community verification needs to be introduced and external counter-verification requires institutionalization

Health Insurance Subsides for the Poor

- 300 households to be selected from each of the 47 counties based on a triangulation of poverty levels, the number of Orphans and Vulnerable Children (OVCs) and availability of healthcare facilities
- Total Targeted households – 15,000 (90,000 Individuals)
- Period - 18 to 24 months
- Benefit package – Inpatient and outpatient cover in public and low cost non public facilities
- Providers: Public and Private (Including Faith Based)
- Provider payment mechanism: Fee for Service and Capitation for outpatient and Fee for Service for inpatient.
- Impact Evaluation being designed.

Supporting Kenya to achieve Universal Health Coverage

- Technical Assistance: through Providing for Health Partnership (P4H)
- Analytical Support: Public expenditure tracking (2013); Fiscal space for health study (2013); Efficiency of public facilities study (2013);Household Survey (2013)
- Program support: for scale-up of RBF and Phase I of Health Insurance Subsidies for the Poor (HISP)
- Impact Evaluation of RBF; output based aid, Health for all Kenyans through innovations (on-going)