A call to more sustainable Domestic Financing for Health in Kenya

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Key Messages

- Kenya’s Total Health Expenditure (THE) has increased to USD 4.9 billion in 2018/19 from USD 4.3 billion in 2016/17, due to increased government contribution and private sources of revenue.

- There is potentially a substitution effect with reduced donor funding being taken on more by public sources of financing.

- Kenya needs to develop and implement strategies that will ensure that the reduction in donor funding is progressively replaced by sustainable domestic funding such as mandatory prepayment mechanisms (tax and health insurance).

Introduction

Achieving Universal Health Coverage (UHC) will require that people are protected from the consequences of paying for health services through direct out-of-pocket payments at the point of service. Financial risk protection reduces the possibility of households compromising the consumption of their basic needs, selling assets, borrowing or even using their lifetime savings and eventually being driven into poverty.

Increasing domestic health financing is thus not only critical for achieving Sustainable Development Goal 3 on UHC on which Kenya reaffirmed commitment at the United Nations General Assembly High-Level Meeting on UHC in 2019, but also Goal 1 of ending poverty in all forms everywhere and contribute to other health related targets.

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Kenya remains one of the fastest growing economies in Sub-Saharan Africa. The economic growth has averaged about 5% over the past decade with the country transitioning into a lower-middle income in 2014. The economic contraction as a result of COVID19 has been of less magnitude than many of the other countries. Despite the high rate of economic growth in Kenya, households remain vulnerable to financial risk and there is a possibility of negating the gains in health outcomes if the country does not finance the sector in a more sustainable manner. Sustainable financing entails mobilizing and utilizing domestic sources of financing preferably from public sources.

The Ministry of Health carried out National Health Accounts estimations to inform the health financing policy dialogue in the context of Kenya’s commitment to scaling up UHC in a more sustainable manner. The purpose of this brief is to provide trends in the financing landscape that supports the call for more sustainable domestic sources of financing healthcare.

**Methodology**

This policy brief was informed by findings from the National Health Accounts (NHA) 2021 for FY 2016/17 to FY 2018/19, as well as evidence from other health sector documents that assessed health sector performance. Publications on access to health services were also used to corroborate the findings. The Kenya National Health Accounts (NHA) estimation was undertaken in order to track the flow of funds and their source to the health sector.

**Findings**

**How much money is spent on health in Kenya?**

Total Health Expenditure (THE) in Kenya was KSh 497.7 billion (USD 4,920 million) in 2018/19, from KSh 442 billion (USD 4,315 million) in 2016/17, representing a 13 percent increase. Total health spending as a percent of GDP increased slightly to 5.6% in 2018/19 from 5.5% in 2016/17.

The government expenditure on health as a percentage of total government expenditure increased from 10.8 % in 2016/17 to 11.7 % in 2018/19. The per capita spending on health increased by 9 percent from USD 97.4 in 2016/17 to USD 105.8 in 2018/19.

**Figure 1: Selected Health Expenditure Statistics, 2001/02 to 2018/19**

**Where does the financing come from?**

Resources to finance healthcare came from three major sources namely ‘the government’, ‘households and private firms’, and ‘donors (rest of the world)’.

The government was the major financier of healthcare contributing 52.3 percent of THE in 2018/19 up from 37 percent in 2015/16, as shown in Figure 2 below. The contribution from private sources (households and private firms) to THE was 30 percent in 2018/19;
a decrease from the 2015/16 estimates of 39.6 percent, while the donor contribution was 17.8 percent of THE in 2018/19 down from 23.4 percent in 2015/16. The greater increase in public domestic financing for healthcare is a demonstration that Kenya is moving towards sustainable financing.

**Financial burden by households**

The financial burden of healthcare is usually heavier on the poor. Direct OOP places the burden of bearing the costs of illness to the sick person and their families and is, therefore, a major contributor to inequities.

The KHHEUS 2018 presents data at a household level indicating their contribution to total spending, health-seeking behavior, out of pocket spending and health insurance coverage. In 2018, an analysis of catastrophic health expenditure in Kenya (using 40% threshold) established that 4.9% of households that sought health care experienced “catastrophic health expenditures”. This is an improvement from the 2013 figure of 6.2%. From the year 2013 to 2018, the total out-of-pocket expenditure has grown from KSh 85.6 billion to KSh 118.2 billion, representing a 36% increase. Despite the absolute increase in OOPs, more households are gaining financial risk protection.

The 2018 KHHEUS recorded 19.9% of the population has a health insurance cover, which was a 2.8% growth from 17.1 per cent recorded in the same survey of 2013. This represents the coverage of 9.5 million Kenyans out of the estimated 47.8 million total national population for the year 2018.

**Recommendations**

**Towards Sustainable Domestic Financing for Health**

Sustainable financing is a key component of the SDG agenda. Within the context of the health sector, the implication is that countries must increase domestic revenue to finance the health sector and less on the foreign sources of revenue. This has become even more important in the context of COVID-19 pandemic which caused an economic crisis even in the donor countries.
As fiscal space in Kenya is increasing, there is need to increase budget allocation to health to match the potential for resource growth.

**Explore methods to reduce the burden to household due to high out-of-pocket expenditures especially the poor**

As noted, out-of-pocket expenditures comprise 24 percent of total health expenditures. With 28% of Kenyans did not seek health care despite reporting illness, there is need to relook at the country’s health financing landscape to ensure that more people enroll to mandatory prepayment mechanisms so as to lower the direct out-of-pocket spending at the point of care.

Mandatory prepayment recognized as a key mechanism to reduce direct payments at the point of care, enable pooling of risks among the population of different socio-economic status in avoiding catastrophic health-care expenditure and impoverishment.

**The coordination of policy and implementation are essential**

Reforms in Healthcare financing mechanisms to raise more resources, reduce the existing fragmentation between public and private health financing systems are some of the important policy steps toward creating a more cost-effective thus sustainable health service delivery model. Yet it alone cannot drive the nation to achieve UHC.

An inputs-outcome assessment on the on-going healthcare financing reforms needs to be undertaken so as to evaluate whether the intended changes such as increased financing for health, as well as increased population’s health outcomes are being achieved. There is need to ensure efficiency in resource allocation and use along the policy reform.

**REFERENCES**