

The Experiences on Attempts and Challenges of Providing Free or Affordable Universal Health Care in Developing Countries: Review of Kenyan Situation

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ABSTRACT

Ensuring the availability of quality and affordable health care for all citizens is a primary goal of every government. However, how they do it differs from country to country, but the bottom line is that many countries especially developing ones have challenges in providing accessible quality health care to all their citizens. Among the numerous approaches to providing health care to all, universal health care is the newest 'kid in the block' approach. Kenya has made numerous attempts to provide free or affordable health care to citizens but has encountered numerous challenges in the process. The approach has been mainly through health care reforms such as universal or categorical free health care or the introduction of health insurance and the expansion of its coverage. In Kenya, health care had been free since independence. Achieving quality health care requires concerted efforts aimed at diversifying and strengthening financing mechanisms and schemes as well as eliminating inefficiencies in health care. Moreover, there is a need to boost economic growth so as to raise GDP and income per capita which will go a long in improving the affordability of health care. This review article has looked at various mechanisms and challenges of financing health care in developing countries, with a particular focus on Kenya, in order to achieve universal health care. Nonetheless, there is a need for further research and comparative analysis on the cost-effectiveness of various financing mechanisms for health care in different countries. This is vital considering that health care is a right to all people.

Keywords: Developing Countries, Financing, Health, Kenya, Universal Health Care.

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I. INTRODUCTION

It is the concern and responsibility of every government to ensure availability of health care services for all its citizens. However, how they do it differs from country to country, but almost all countries have challenges in providing accessible and quality health care to everyone who needs it (Ensor, 1998). In 2001 African countries made a commitment in Abuja, Nigeria of allocating 15% of their annual budgets to health sector which came to be known as Abuja declaration (Ojalere & Munyua, 2020). Although there are a number of ways or approaches of providing health care to all, universal health care is the recent approach (WHO, 2019). In addition governments have developed elaborate health policies incorporating universal health care. Thus many countries including Kenya have embarked on ambitious programmes of health care aimed at achieving universal health coverage (UHC) to all Kenyans irrespective of their socio-economic status. In essence UHC aims at making everyone access effective quality health services everywhere and anytime when needed at affordable cost without suffering financial hardships (Malusha, 2021). In this connection, governments across the world have made varied efforts to provide free health care or affordable health care through health insurances or other means in order to facilitate access to health services for its population (Meessen *et al.*, 2011).

Kenya has made numerous attempts to provide free or affordable health care to citizens but has encountered numerous challenges in the process. The country's approach has been mainly through health care reforms such as universal or categorical free health care or the introduction of health insurance and the expansion of its coverage. In Kenya, health care had been free since attainment of independence. However in 1989 following a funding crisis and pressure from World Bank, International Monetary Fund (IMF) and other donors, the government of Kenya introduced user charges commonly known as cost sharing. And in

1992 the user charges were converted from consultation fee to treatment fee. Despite this valiant effort, sustaining or enhancing utilization of health services provided has been a challenge.

This review paper looks at various efforts by Kenyan government in providing free or affordable health care to the needy citizens. It is guided by the following research questions: i) What are the various attempts/efforts of financing health care, and ii) what constraints and challenges have been experienced in the process of providing free or affordable health care in Kenya? This is based on reviewing existing literature from various sources including several peer reviewed published articles.

II. FINANCING FREE OR AFFORDABLE HEALTH CARE

Many countries have or have started universal health care to make health care accessible to individuals through government financing or pooling of financial risks so as to uplift the burden of expenses from users of services. However, a number of developing countries particularly in Africa face challenges at varying levels in providing health care to their people. This is despite making a commitment in Abuja, Nigeria of allocating 15% of their annual budgets to health sector which came to be known as Abuja declaration (Olalere & Munyua, 2020). In fact it is estimated that developing countries spend about \$8 to \$129 per capita on health care (owing to low GDP and low tax collection due to inefficiency) compared to high income countries which spend about \$4,000 (Olalere & Munyua, 2020).

Thus there is no doubt majority of developing countries are struggling to provide free or affordable health services dubbed as universal health care (UHC). Understandably, universal health care implies that all individuals and communities receive essential quality health services they need from health promotion to prevention, treatment, rehabilitation and palliative care in any hospital or health facility without any hindrances or financial hardship. In this context free health care means at the point of service, since in reality there is nothing free in entirety. And if services owing financing constraints cannot be free then effort should be made to make them affordable.

Despite valiant efforts to improve health services, Kenya with a population of 52.6 million, population growth of 2.3 % and total fertility rate of 3.5, its health care indicators are fairly low compared to other countries (ThinkWell, 2020; UNDP, 2019). For instance, infant mortality rate (2020) stands at 31.2 deaths per 1000 live births, under five (child) mortality rate is 41.9 deaths per 1000 live births, neonatal mortality rate is 20.5 per 1000 live births while life expectancy is 67 years (World Data Atlas, 2020).

Thus the Kenyan health policy (2014-2030 aims to ensure right to access to health care to every citizen (Republic of Kenya, 2014). More importantly the goal of the policy is attainment of the highest standard of health in a manner responsive to need population. Health problems coupled with unaffordable expenses are some of the key issues associated with the descent into poverty (Krishna *et al.*, 2006). Besides, health problems lead to short-term loss of earnings or a permanently decreased ability to make a living. Moreover health expenses can push people to sell property such as animals or other assets so as to cater for the treatment costs in case of illness. Furthermore, this might also happen either directly or indirectly through incurring debt. In essence selling assets can diminish capacity for people's sustenance (Krishna *et al.*, 2006; Otieno & Nicholas, 2013).

Despite many years of government efforts to avail free health care to citizenry, myriad challenges including attempts to lower user costs on health care have been encountered in the process (Republic of Kenya, 2014; Republic of Kenya, 2012). The escalating cost of health care as well as rising need or demand are some of the challenges to providing health care. The emergence of new diseases such as HIV/AIDS, Ebola, and recent COVID 19 pandemic coupled with non-communicable diseases such cancer, cardiovascular etc. has worsened the situation.

III. PER CAPITA EXPENDITURE ON HEALTH AND PROPORTION OF GDP

Appropriate quality health care is important and mostly accounts for significant portion of spending in governments and individuals as well. Country spending on health care is usually adopted as indicator of government commitment to the health of its citizens (Republic of Kenya, 2012). Thus per capita and proportion of GDP are some of the key indicators to gauge the level of health care financing and expenditure. For instance, in Kenyan, analysis on expenditure per capita and proportion of GDP show significant expenditure on health care marked by yearly fluctuations and sometimes increasing slowly owing to economic growth turbulence (Lu *et al.*, 2010). On the other hand in the past 20 years (i.e. from 2000 to 2019) the average per capita was \$51.4 whereas proportion of GDP was \$5.3. This low compared to high income countries (World Bank, 2021). Thus owing fragility of economic systems, there is need for enhancing economic growth so as to uplift income per capita in order to make health care affordable, if not free. This will be a driving force towards achieving UHC. Here it's assumed that, holding all factors constant, increasing income per capita will increase spending on health care. Table 1 shows expenditure

per capita on health and proportion of GDP.

Furthermore a number of countries are facing challenges in financing health care owing to weak economies. Thus they have challenges in providing free or affordable health care. For instance in comparison with other similar countries in economic status, Kenya with \$83 income per capita lies at position 24 out of 36 countries indicating that its income per capita is still low. This is in stark contrast with Kenyan's 1960 per capita income of \$260 (World Bank, 2021). This perhaps explains why the country has experienced challenges in providing free or affordable health care. Also in this conundrum there are numerous countries especially developing ones which have low per capita income and GDP and thus experiencing challenges in providing free or affordable health care (Lu *et al.*,2010). Table II shows ranking with similar countries for comparison purposes.

TABLE I: SPENDING ON HEALTH CARE IN KENYA

Year	Per Capita (US \$)	%of GDP (US \$)	Year	Per Capita (US \$)	%of GDP (US \$)
2019	83	4.59	2009	55	6.03
2018	74	4.31	2008	55	6.05
2017	65	4.14	2007	50	6.00
2016	73	5.14	2006	40	5.87
2015	70	5.22	2005	30	5.31
2014	72	5.46	2004	27	5.34
2013	67	5.52	2003	25	5.17
2012	64	5.61	2002	22	4.96
2011	56	5.81	2001	21	4.80
2010	58	6.12	2000	21	4.64

Source: World Bank

TABLE II: RANKING WITH SIMILAR COUNTRIES

Country	Per Capita (US \$)	Country	Per capita (US \$)	Country	Per capita (US \$)
Micronesia	\$415	Egypt	\$150	Lao PDR	\$68
El Salvador	\$300	Philippines	\$142	Papua New Guinea	\$65
Georgia	\$291	Lesotho	\$124	India	\$64
Moldova	\$284	Indonesia	\$120	Kyrgyz Republic	\$62
Eswatini	\$2264	Bhutan	\$116	Djibout	\$62
Ukraine	\$248	Cambodia	\$173	Myanmar	\$60
Bolivia	\$246	Solomon Islands	\$172	Mauritania	\$58
Tunisia	\$233	Sao Tome and Principe	\$108	Cameroon	\$54
Honduras	\$188	Vanuatu	\$104	Republic of Congo	\$49
Vietnam	\$181	Uzbekistan	\$99	Sudan	\$47
Cabo Verde	\$178	Timor Leste	\$93	Bangladesh	\$46
Morocco	\$174	Kenya	\$83	Pakistan	\$39
Kiribati	\$172	Ghana	\$75	-	-
Mongolia	\$163	Nigeria	\$71	-	-
Nicaragua	\$161	Angola	\$71	-	-
Sri Lanka	\$161	Zambia	\$69	-	-

Source: World Bank

In regard to economic growth vis-à-vis health care, observations have shown that although some countries have high GDP and income per capita, their health indicators are still not impressive. According to Garrin *et al.*,(1996) economic growth alone does not lead to health improvements. That means the way the gains of economic growth as well as resources are distributed are equally important. In other words there is need for equity in sharing of health care resources. But allocation of resources in health care is delicate balancing act involving tradeoffs, as allocating more resources in health care deprives other crucial sectors such as education, water, environment, rural development etc. Thus there is need for proper prioritization in allocating resources.

IV. CHALLENGES TO FINANCING OF HEALTH CARE FREE OR AFFORDABLE HEALTH CARE

There are several mechanisms of financing health care to make it free or affordable. These mechanisms or ways include revenue from general taxation, earmarked taxes, social insurance contributions, private insurance premiums, community financing schemes and employer-based schemes as well as direct out of pocket payments (World Bank, 2021).

General taxation refers to both direct and indirect tax receipts collected by government to fund among other things healthcare. Earmarked tax or hypothecated tax is a component of general taxation, usually based on income. It is normally levied to be used for a particular purpose. The current national insurance scheme in Kenya started as a form of hypothecated taxation. In this case the best example of a hypothecated tax is the use of tobacco tax for anti-tobacco. The user may pay out-of pocket which is characterized by

two forms of user charges- those that top up funding from other sources (general taxation or various insurance schemes) e.g. charges for dental treatment, and those that cover the entire cost of treatment.

Private medical insurance is run by companies, usually for profit, and contributions are paid by individuals. Whereas social insurance is a system where employers and employees make contributions which are compulsory, and premiums are underwritten by the state for high risk and non-employed groups. People generally have to pay for services then make a claim afterwards, and re-imburement may not be complete. On the other hand community financing entails schemes based on principles of community co-operation, local self-reliance and pre-payment. Employer based schemes of financing is offered both by public and private sector companies through their own employer managed facilities. Workers buy health insurance through their employers taking insurance partly in lieu of wages (Ensor, 1998; World Bank, 2021; Witter *et al.*,2000).

V. FREE HEALTH CARE IN KENYA

For many years the Kenya government endeavored to provide free health care services to its citizens, albeit with numerous challenges. This started way back in 1963 when the Kenya government, as was the case in several African countries, introduced free health care for all following attainment of independence that year. This was viewed as a window of opportunity to appease citizens after struggling for independence. Notably this was the first attempt to introduce free universal health care for all in Kenya. However although free health care can either be universal or partial, this one was universal for all.

Providing free or affordable health care was part of national development long term plan popularly known as vision 2030, whose aim is to assist people to access health care who cannot afford owing to financial constraints (Republic of Kenya, 2007). This ambitious plan was reinforced by the new Kenyan constitution which guaranteed every Kenyan the highest standard of health including right to access health care services (Kunzler, 2016; Republic of Kenya, 2010).

As continuation of Kenyan effort in providing free or affordable health care, free maternity health care was introduced in 2013 by Jubilee government immediately after elections (Kunzler, 2016). The declaration of free maternity was part of reforming health policy to make health services accessible to less fortunate and vulnerable population. As aforementioned this was alignment to vision 2030 as well as the constitution of Kenya.

VI. NATIONAL HEALTH INSURANCE SCHEMES IN KENYA

One year after free medical services were introduced, around 1966, the Kenya government established the national hospital insurance fund (NHIF) which was compulsory for formal sector employees (Koltermann & Ulrike, 2004). This NHIF medical scheme covers public servants and their core families which include the principle member, a spouse and three children only.

The scope of the scheme entails coverage of inpatient and outpatient medical services in accredited hospitals. This scheme is funded through monthly contributions on graduated mode of payment. In addition to this some employers contract private insurance companies to provide health care schemes for their employees. Although it's difficult to determine how many people are covered by such schemes, several private schemes collapsed in 1990s (World Bank, 2010). Nonetheless whereas some private health insurance schemes are in competition with NHIF, it's crucially important that others are in collaboration with it to expand provision of health services (Kunzler, 2016). However, one notable drawback for an employer based health insurance is that when employer retires the scheme is terminated, thus necessitating the need for medical saving plans to cater for post-retirement life.

VII. ATTEMPTS TOWARDS REFORMING KENYAN NATIONAL SOCIAL INSURANCE

Efforts have been made since 2002 to broaden NHIF coverage by making it compulsory. Thus a National Social Health Insurance Fund (NSHIF) was proposed to replace NHIF (Kunzler, 2016). It was intended to have three-tiered member contribution: Five percent (5%) of value-added tax money was to finance 30% of poorest Kenyans, half of population was to have flat contribution rate and contributing employees accounting for about 20% was to have their contributions paid by employers. A 2004 NSHIF bill was not assented by the president owing to technical, affordability implementation and sustainability issues (Abuya *et al.*, 2015). Its adoption and implementation was met with a lot of resistance from various stakeholders owing to mistrust regarding its transparency, accountability, fairness, effectiveness and efficiency.

Similar reform was initiated in 2007 during grand coalition government following elections that year. However the bill was not taken to parliament for approval owing to mistrust. Subsequently, in June 2008,

vision 2030 was launched and had in it the creation of NSHIF which was to be started in 2012 (Garin & Politi, 1996). Thus a new sessional paper No.7 regarding Universal Health Coverage (UHC) proposed transforming National Hospital Insurance Fund (NHIF) to National Health Insurance Fund (NSHIF) which would have government contributions for vulnerable poor people. However, this paper was not approved by parliament in 2012. The failure of introduction of NSHIF despite numerous attempts can be attributed to lack of political good will (Koltermann & Ulrike, 2004). In spite of these setbacks, a number of counties in Kenya have made NHIF registration compulsory as well as paying contributions for elderly citizens so as to support UHC.

As stated in 2013 the government unveiled free maternity health care. This was in line with the international community goal of introducing free maternity services to all who are in need, and this was thus in accordance with United Nations sustainable development goals (SDG) (Abuya et al., 2015).

In December 2017 the national government unveiled and piloted UHC programme in four counties, namely Kisumu, Nyeri, Isiolo and Machakos as one of the country big four development agenda. These counties were selected because they had high incidence of communicable and non-communicable diseases as well as road traffic accidents. In 2021 the government launched country wide implementation of UHC which is ongoing.

VIII. COMMUNITY INSURANCE SCHEMES

A number of developing countries started community financing schemes following initiation by UNICEF and WHO in 1988 (Witter *et al.*, 2000). In that context community insurance schemes referred to schemes based on principles of community co-operation, local self-reliance and pre-payment. Thus community financing in form of community based health insurance (CBHI) introduced in 1999, is another alternative way of financing health services at community level. In some circles this is also known as micro-insurance. Owing to emerging challenges on financing health care, a number of community schemes have been started to complement NHIF and private insurance. However since CBHI premiums are lower compared to NHIF and private insurance companies, they have been viewed as appropriate for informal and self-employed workers as well as non-employed workers. The main drawback is on tracking progress as there is no update data on beneficiaries of community based insurance schemes.

Moreover due to inherent limitations on CBHI such as lack of subsidization for the poor vulnerable groups, CBHI unless its re-distributive capacity is expanded, cannot be a major source of funding for UHC. This notwithstanding, CBHI plays a complementary role in national health financing, thus crucial in achieving UHC. Hence there is need for mandatory coverage for the entire population, with government revenues subsidizing coverage for the poor vulnerable people (WHO, 2019). More importantly governments should consider strengthening primary health care and community based health services as a key pillar of universal health coverage (WHO, 2016).

IX. CONCLUSION

Many Kenyans are not covered by any form of health or medical insurance just as in other developing countries, thus experiencing difficulties in accessing health care. Although several attempts have been made to introduce NSHIF, they have not been successful. Hence further efforts are being made to widen NHIF coverage and UHC in general to make quality accessible health care free or affordable to everyone. There is no doubt free or affordable quality health care is key to development and economic growth (WHO, 2019). This, as in many African countries, has been part of a development strategy of Kenyan government since attaining their independence (Kunzler & Daniel, 2014). The overriding goal, therefore, is to make health care services available to all. This can be achieved through exploring, diversifying and strengthening financing mechanisms and schemes as well as eliminating inefficiencies in health care delivery.

More importantly there is need to further stimulate economy growth so as to increase income per capita which will go along in making health care affordable. This will be a driving force towards providing universal health care.

This is crucial considering that quality health care is a right to all people. Of great significance also there should be avoidance of 'moral hazard' among users of free health care services. Nonetheless further research and comparative analysis on cost effectiveness of various financing mechanisms for health care in different countries is absolutely important in providing health care to all.

Hopefully this review article, though largely focused on Kenya situation, has highlighted some experiences of varied attempts of providing health care for all as well as their shortcomings and challenges, thus providing useful information for policy makers and implementers in shaping or reforming of health policies to provide health care to everyone either through UHC or other approaches.

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CONFLICT OF INTEREST

I declare that I have no conflict of interest.

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