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Health Sector Reforms in Kenya: User Fees

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Introduction

Health sector reforms were introduced under the umbrella of Structural Adjustment Programmes (SAPs) implemented in the 1980s, necessitated by the debt crisis. The economic crisis was evident in the diminishing financial abilities of government to provide social services such as health and education. With or without Structural Adjustment Programmes, African governments were faced with the challenge of sourcing funds in order to continue financing social service provisioning. One of the ways of sourcing funds was located in the potential to pay by users, hence the introduction of cost sharing.

Cost sharing is variously called by such terms as user fees, co-financing, and cost-recovery. In Kenya, the introduction of user fees was the first reform in the health sector. As part of health sector reforms, cost sharing in public health facilities was meant to improve the provision of quality health care services. Funds generated from user fees would supplement government's diminishing expenditure allocated to health care services and, therefore, would ensure continued provision of health care services through supply of drugs and medical equipment, as well as in maintaining and expanding health facilities.

Health sector reforms in Kenya were tailored to meet Kenya's health sector policy goal of providing accessible, affordable and efficient health care services to all Kenyans. Before their implementation, it was feared that health reforms would marginalise the poor and vulnerable in accessing health care. However, the government of Kenya took care of this concern by introducing the system of waivers and exemptions. Under exemptions, certain categories of patients were automatically exempted from user fees. These included those seeking family planning, children under five years, sexually transmitted disease patients, and those

suffering from HIV/AIDS. Exempting children under five years was in realisation of the fact that such children have a low immunity development, which predisposes them to sickness. Indeed, statistics on malaria morbidity attests to this fact, as children under five years are the most affected both in terms of morbidity and mortality.

On the other hand, waivers were supposed to take care of those who could not afford to pay for health services because of their inabilities. Waivers and exemptions were put under the care of medical staff and social workers at the hospitals who were charged with the responsibilities of assessing the financial position of patients and waiving part or all of their bills. This paper discusses the impact of health sector reforms, especially users fees, on Kenya's health policy objective of "Health for All".

Meeting Kenya's Health Policy Objectives

Over the years, Kenya's health policy was designed to achieve the following objectives:

- Increase coverage and accessibility of preventive and promotive curative health services especially in rural areas.
- Consolidate urban and rural curative and preventive/promotive health services, i.e. rural-urban referral system.
- Increase emphasis on Maternal-Child Health (MCH) and Family Planning (FP) in order to reduce morbidity, mortality and fertility through related public health education programmes.
- Strengthen the Ministry of Health's Health management capabilities, with emphasis being placed at the district level in order to take care of management problems such as facility management, drug supply, and transport and equipment maintenance.
- Increase inter-sectoral coordination between the Ministry of Health and other ministries such as agriculture, water, education, social services, information and NGOs.
- Increase alternative mechanisms for financing health care programmes.
- Improve and expand the National Health Insurance.

In pursuing the above health care objectives, the Government of Kenya targeted achievement of its long-term goal of Health for All by the year 2000 (Owino 1997). The government realised that this objective would be achieved if citizens lived within a radius of ten kilometres of the nearest health facility, and if primary and preventive health care services were extended countrywide. As a result the Government of Kenya pursued various initiatives: It constructed new health facilities in 'under-served' areas and upgraded existing ones. Grants were provided to church or mission hospitals to complement the government in providing health

care services. The government made efforts aimed at ensuring that essential medical supplies and equipment were made available through the construction of depots in strategic locations. It encouraged and promoted community and NGO participation through grants for capital development. Training opportunities and career development for health personnel were expanded through the government's continuing education and on-the-job refresher and residential training programmes.

Kenya's health policy, at independence, was shaped by both historical and global factors, and was designed to achieve both political and health objectives. Many independent African countries began their lives as populist regimes (Walt 1994), and came up with populist policies. In the case of Kenya, health services were made 'free' in order to meet health needs of all Kenyans while at the same time making the government popular among the masses. In fact the introduction of 'free' medical care in government facilities was done in line with the guidelines of the Kenya African National Union's (KANU) manifesto (Odada and Ayako 1989). By then KANU was the political party, which had won elections at independence and formed government. Providing 'free' public health care services served two very important functions. One function of 'free' health care was to discontinue African experiences of the colonial past. Africans were not accorded the best health care services, as was the case with members of the European descent in the period of African colonisation. The second function was to make the government popular among the people. 'Free' health care delivery was part of the government's scheme of centralising its functions and having control and discipline over its population. The Government of Kenya designed a health care delivery system that would serve its entire population both in the rural and urban areas. The Cold War that underlined global politics at the time contributed to this situation because supplementary financing for health care could be easily obtained from foreign debts and aid depending on a country's political leaning.

Kenya's health care delivery system, which is charged with meeting health policy objectives, is organised around the Ministry of Health (MoH). The Ministry of Health headed by the Minister is charged with the responsibility of setting policies, coordinating the activities of Non-Governmental Organisations (NGOs), and managing, monitoring and evaluating policy implementation (Owino 1997). Kenya's Ministry of Health is the largest provider of health care (curative, preventive and promotive) and undertakes environmental protection and pollution surveillance (Odada and Odhiambo 1989). In general, the Ministry of Health is involved in six-health related programmes, namely promotional and preventive health care, family planning and population control, environmental protection and programme supervision, special programmes (such as disease control projects), and research. The Government of Kenya has also encouraged the plural system of health service delivery. Other providers of health care services include local authorities which, by law, are required to undertake public health activities, supported by

public finance. They provide curative in-patient and out-patient care. In addition, there is a for-profit private sector, which comprises private hospitals and nursing homes and concentrates on curative services. Missions and religious groups charge fees for their curative services but much below the prices charged by the for-profit private sector. Parastatals and private companies provide curative services for their staff within their own facilities. Finally, the traditional medicine sector is often a resort of those in ill-health.

Kenya, in pursuit of its health policy, was able to achieve much in the field of health care provisioning especially in the 1960s through to the late 1980s. This was demonstrated over the years through increasing the number of, and expanding, health facilities and training medical personnel. The government dominated the provision of health care services and by 1996 'it provided 43 percent of the total sector funding and 70 percent of hospital beds of which the Ministry of Health (MOH) provided 62 percent. As a result, the government realized a decline in crude death rate from 20 per 1000 persons in 1963 to 13 in 1987, and 12 in 1991; life expectancy increased from 40 years in 1960 to 58 years in 1994; infant mortality declined from 126 per 1000 in 1962 to 60 per 1000 in 1994; and the immunization coverage rose to 70 percent in 1994 from less than 40 percent at independence in 1963' (Kenya Development Plan, 1997/2001). According to Rae et al. (1989), measles immunisation coverage increased from about 55 percent in 1982 to about 60 percent in 1987 as a result of the Kenya Expanded Programme on Immunisation (KEPI).

Declining mortality rates are some of the indicators of improvement in the health status of society (Rae et al. 1989). As the table below shows, Kenya made remarkable reductions in infant mortality rates since 1948.

Table 1: Mortality and Life Expectancy, Kenya, 1948-1987

Year	Crude death rate per 1000 population	Infant mortality rates per 1000 live births	Life expectancy at birth
1948	25	184	35
1962	20	120	44
1969	17	119	49
1979	14	104	54
1987	13	84	58

Source: Kenya Contraceptive Prevalence Survey 1984 – First Report.

In 1979 'Kenya had one doctor per 10,107 population, and this had risen to about one doctor per 7,542 in 1987 despite population growth' (Rae et al. 1989:54).

Table 2: Estimated Personnel/Population Ratio 1979-1987

Type of personnel	1979 (ratio)	1980 (ratio)	1981 (ratio)	1982 (ratio)	1983 (ratio)	1984 (ratio)	1985 (ratio)	1986 (ratio)	1987 (ratio)
Doctors	10,107	10,408	8,898	8,850	8,368	7,482	7,535	7,473	7,542
Nurses	1,144	1,142	1,138	1,107	1,058	1,039	1,038	1,009	1,004
Clinical officers	11082	10,889	10,623	10,506	10,306	10,290	10,163	10,013	9,834

Source: Rae *et al.* (1989:55).

However, constraints resulting from the debt crisis, which was evident in many developing countries in the late 1980s, curtailed government's ability to continue with its expansion of the health sector. Challenges occasioned by new diseases such as AIDS notwithstanding, the success story of the pre- SAPs began to diminish resulting from government's diminishing per capita expenditure on health. According to Owino (1997:4) the increases in nominal funding notwithstanding, Kenya's Ministry of Health's 'total and recurrent spending as a percentage of the GDP and treasury budget allocations were on the decline, which coincided with the implementation of adjustment in the early 1980s'. The story in other countries is the same. For example, in Zimbabwe it has been noted that 'child mortality figures have began to rise reversing the gains made in the previous decade as a result of declining per capita expenditure on health and the declining quality of health services' (Bijlmakers et al. 1996:14).

Faced with financial constraints, inefficiency and inequities, poor management and inappropriate pricing of services, there was a need to rethink a proper method of improving quality health care delivery. These formed the background of health sector reforms, especially cost sharing.

Rationale of Health Sector Reforms

Cassels (1995) asserts that reforms are triggered by crisis, which may be economic or political. The economic crisis of the late 1980s formed the background for Structural Adjustment Programmes (SAPs). Health sector reforms were an outcome of SAPs. Health reforms try to correct system-wide problems that hinder the delivery of priority health services (Dmytraczenko et al. 2003). Kenya introduced health sector reforms in line with its health sector policy objectives of providing affordable, accessible and efficient health services for all (Kenya Development Plan 1997/2001). The rationale of introducing health reforms was predicated on the realities of the 1980s - the debt crisis - in which the government found itself unable to continue financing health services yet at the same time was committed to achieving health for all. As a result, the government introduced cost-sharing or user fees. The user fees were intended to enable individual health facilities to meet their financial demands that would in turn make possible the

provision of drugs and medical equipment. The same funds generated would also cater for those who could not afford health care. Aware that there was a poor section of the population that could not afford to meet the user fees, the government introduced a system of waivers and exemptions in order to ensure that health care was accessible to all. In general, therefore, reform policy in the health sector was in line with the general health policy as it was geared towards improving accessibility, affordability and efficiency of health services for all.

The World Bank (1992) admits that 'implementation of macro-economic adjustment policies causes various groups to become vulnerable and these include the poorest in society, the relatively scattered rural communities who have not benefited greatly from public expenditure and are facing discontinued subsidies during SAPs, and the urban dwellers who, prior to reforms, have disproportionately benefited from quality public services and subsidies like the civil servants and other middle income groups and the poorest groups'. Several scholars debated the side effects of SAPs on vulnerable and poor groups in society as early as 1989. According to Rae et al. (1989) the various components of SAPs, which fall under six broad categories, were considered to have a direct and indirect impact (positively or otherwise) on the health sector. The six SAP components were the devaluation of the Kenyan currency; cuts in government spending on social services, especially in health and education; additional taxation on mass consumption goods; the removal of price controls; the removal of subsidies on food, etc.; and improvements in public sector planning and execution.

Scholars projected possible impacts of various SAP measures outlined above on the delivery of health care services and health status of vulnerable groups. Rae et al. (1989:60-61) outlined some of them as in Table 3.

Even though SAPs entailed negative impacts on the health sector, the need to institute health reforms rested on the positive side of SAPs because waivers and exemptions, which the government would provide to the poor and vulnerable, would contain the negative effects of SAPs. As a result health sector reforms were instituted.

Health Sector Reforms in Kenya

The cost sharing programme was mooted in the 1984/88 Development Plan (MoH 1984, Owino 1997). The most forceful policy statements on user fees are contained in the Ministry of Health 1984-88 Development Plan, Seasonal Paper No. 1 of 1986, and the Ministry of Health Concept Paper of 1989 on cost-sharing. Details about overall health sector reforms are contained in the Health Policy Framework Paper (MoH 1994). These health reforms, which were to be implemented over fifteen years, included mobilising additional resources; enhancing the role and participation of the private/NGO sector in health care delivery; redefining the role of MoH in health care delivery; organisational and management adjustments; and resource reallocation.

Table 3: Possible Impacts of Various SAP Measures on the Delivery of Health Care Services and Health Status of the Vulnerable

SAP measure	Negative effect	Positive effect
Devaluation	<ul style="list-style-type: none"> *Rise in domestic prices of imported goods such as drugs, vehicles and medical equipment *Increase in cost of health inputs *Rise in the cost of availing safe and clean water *Fuel inflation further causing rises in prices of commodities *Placing of more burden on vulnerable groups 	<ul style="list-style-type: none"> *Stimulation of exports hence raising incomes and employment. When poverty declines, health improves *Protective effect on domestic industries as import prices rise
Cuts in public spending	<ul style="list-style-type: none"> *Reduction of funds for buying drugs, vaccines and other medical supplies *Reduction in available training funds, reduced number of trained manpower and reduced access to trained health personnel *Limitation of the ability of MoH to employ more health manpower, thereby inhibiting further improvements of ratios of health manpower to population *Reduction of funds for preventive and promotional health interventions 	<ul style="list-style-type: none"> *Reduction of government deficits and debt *Fall of rate of inflation and rise of purchasing power *Improvement of health status *Release of resources for development expenditure and capital formation for further economic growth *Benefit to vulnerable groups
Additional taxation on mass consumption goods	<ul style="list-style-type: none"> *Further training of the already trained will be slowed down *Welfare of poor households will be reduced 	<ul style="list-style-type: none"> *Fall of Central government *Improvement of health status
Removal of subsidies on basic foodstuffs and other basic needs	<ul style="list-style-type: none"> *Reduction of access to food and increase of malnutrition *Poor Housing 	<ul style="list-style-type: none"> *Reduction in government deficits and debt. Fall of inflation and benefit to vulnerable groups as purchasing power rises
Removal of price controls	<ul style="list-style-type: none"> *Cause of additional burden on vulnerable groups because of the tendency of prices to go up 	<ul style="list-style-type: none"> *Creation of incentives for more production and employment in the medium and long term vulnerable groups benefit
Improvements in public sector planning and execution		<ul style="list-style-type: none"> *Increase of efficiency of health care delivery resulting in savings on resource inputs and enhancing the quality of health care services

Source: Rae *et al.* (1989:60-61).

Of all of these, health financing was identified as the key constraint to increasing the efficiency and quality of health services in the public health sector. For the same reason, reforms in the health sector were mainly focussed on developing alternative financing mechanisms to those provided by government. On the list are strategies such as increased cost recovery, social insurance, maintaining health facilities through communal fundraising efforts (the 'harambee' spirit) and community-based health care. A priority area became the introduction of user charges. The main objectives of cost-sharing were to encourage increased cost-recovery from users of public health facilities as one of the ways of mobilising additional revenue to augment the financing of the under-funded non-wage recurrent expenditure items, minimise on excessive use of services, promote functioning of the referral system, and improve access by the poor to health services by charging those who make most use of the curative care and who are most able to pay, and channelling the subsidies to those least able to pay (Owino 1997).

In August 1989, the results of the discussion on cost-sharing, which took place between the Government of Kenya and its development partners (mainly donors), were put before the Kenyan cabinet, which basically endorsed the proposed system of health financing for the public sector. The Ministry of Health expressed its fears about the introduction of user fees and complained to the World Bank that the proposed fees to be charged were high. The introduction of user fees also coincided with the introduction of multi-party politics in Kenya and this threatened the popularity of the ruling party KANU among the masses. The opposition political parties took advantage of the introduction of user fees to challenge the government's inability to provide 'free' health care services to its citizens. Generally, the government was not willing to introduce user fees and even after their introduction, revisions were continuously announced, mostly at public rallies, in order to rally the support of the masses. User fees charged on patients was deemed as low in the first instance, but the statistics regarding hospital attendance began to take a downward trend, prompting the president to intervene. The president called for a reduction from 100 to 20 Kenyan shillings per day at Kenyatta National Hospital for in-patients (Dahlgren 1990). This was done after it was realised that the utilisation of the hospital service had fallen drastically due to reasons related to affordability, and subsequently bringing to the fore the issue of accessibility. But despite all this, Ake (1996) asserts that 'Africa still lost out as it continued complaining while implementing SAPs, imposed on these societies by the World Bank and the IMF as a condition for additional extension of credit'.

A system of waivers and exemptions was provided in the new policy to address the concern that the policy could not be affordable to the vulnerable who would in turn be denied access to modern health services. Initial beneficiaries of this system included children under five years, prisoners, the destitute and the

mentally handicapped, patients attending family planning, antenatal and post natal care, child welfare, sexually transmitted diseases, psychiatric illnesses, tuberculosis, leprosy, AIDS, and patients referred 'downward' or 'upward' within the Ministry of Health system.

Exemptions were also extended to civil servants including spouses and children under 22 years old. The responsibility of adjudicating the system rested with the individual facilities. Those entrusted to grant waivers included clinical officers and community nurses at the health centres, and clinical or medical officers in the case of hospitals. After the first consultation, patients were referred to the area chief or sub-chief with an exemption form for endorsement to certify the person's hardship. After this, the authorised officer issued an exemption certificate valid for a period of one year. The whole system of cost sharing with its attendant waivers and exemptions was not able to work efficiently enough to guarantee every Kenyan adequate health care. This is based on a number of reasons as stated below.

Firstly, several changes have been made to the system of exemptions such as a rise in the exemption ages to 10 and later to 15, excluding civil servants and omitting certain diseases and categories of patients originally included. Secondly, there was limited consultation between government and stakeholders in the design of the programme, and the modalities of its implementation. Thirdly, the six-week period given for the implementation was too short to build acceptance of the policy (Mbugua 1993). Fourthly, the management and administrative structures for implementation were either not in place or inappropriate. Fifthly, funds raised during the initial period of the programme were tied up in bureaucratic obstacles or lay idle in bank deposits, instead of being used to improve the quality of health services (Owino 1993).

As a result of the above reasons the cost-sharing programme was suspended in 1990 in order to put in place institutions that would solve the administrative and management problems. The first institution was the Health Care Financing Division (HCFD), which was set up in 1991 to improve revenue generation and the utilisation of such funds. The second institution to be set up was the District Health Management Board (DHMB), in May 1992, to oversee the operations of the cost-sharing programme at the district level. Thereafter, there were fee adjustments and then the re-introduction of the cost-sharing programme in early 1992.

The management of financial resources deriving from user fees was entrusted to the Health Care Financing Division (HCFD), centrally placed under Ministry of Health headquarters. This division was in charge of controlling revenue generated from the cost-sharing programme and authorising expenditure by public health facilities (MoH 1994). HCFD was inadequately prepared to handle this immense task. In 1993, HCFD was overburdened by the additional responsibilities of strengthening the National Hospital Insurance Fund (NHIF) and rehabilitating major equipment in the health facilities, comprising eight provincial hospitals, ninety-four district hospitals, and four hundred health centres (Owino 1997a).

HCFD could not afford to carry out these responsibilities given its lean technical staff of six at the secretariat. Its performance was inadequate and this translated into deteriorating health standards in health facilities, bringing into debate the issue of quality and efficiency of health services. This time again, the 'free' media highlighted the problem. Deterioration in health services was evident in the lack of curative patient care items like drugs and laboratory reagents, poorly maintained medical equipment and buildings, and congestion (Owino 1997). It was against this background that a proposal was mooted to transfer financial management to lower levels in the health care hierarchy to strengthen and empower districts and individual health facilities in order for them to develop and build capacities in modern management and planning. The rationale was to improve organisation and decision making abilities at the local level, greater community involvement in health programmes, closer integration of the activities of the government, the NGO sector and the private sector, and reductions in red tape.

This did not, however, mean that the DHMBs were fully authorised to determine their user fees and implement them. They were required only to propose budgets and forward them to the HCFD for approval. The result was that it took too long for the HCFD to respond to individual proposals and this resulted in individual facilities implementing their proposed, but yet to be approved, changes. This translated into increases in fees beyond the reach of the poor. Corruption led to further deteriorating conditions of the health facilities because the money raised from user fees for improving the quality of health services ended up in the pockets of individuals, thereby impacting on efficiency. This further put Kenya's health policy objective into question as well as the rationale of health sector reforms. Studies on user fees have provided empirical evidence for the negative impact of user fees on the poor and vulnerable.

Impact of Health Reforms on the Poor and Vulnerable

Bijlmakers (2003:104) asserts that 'the effects of user fees on clinic attendance in low-income countries have been documented extensively in the international literature'. Studies undertaken during the early years of the introduction of user fees give different results of the impact of user fees on hospital attendance. There are studies which have documented major and long-lasting declines in the use of health services as a result of users fees (Waddington and Enyimayew 1989, Moses et al. 1992). Others have claimed that after an initial period of decline, utilisation gradually reverted to 'normal levels' after some time (Nyonator and Kutzin 1999), or even that there was no significant decline at all (Chawla and Ellis 2000).

It has been noted that there is no universally accepted definition of the quality of health (Campbell et al. 2000). Definition is subject to perceptions of the different stakeholders – users, health care providers, health care managers – who have different perspectives of quality of care based on different dimensions in

their definitions, such as availability of physical structures, adequacy of staff, technical quality of clinical care, the nature of interpersonal interaction between the provider and the user, the efficacy outcome of treatment and user satisfaction. These varying perceptions also impact on the conceptualisation of the impact of users fees on access to quality health care.

Health sector reforms are aimed at correcting system-wide problems (Dmytrascenko 2003). In the case of Kenya, 'Cost-sharing aimed at making people more responsible for their own health care by sharing in the cost of the services they received' (Quick and Musau 1994). Ngugi (1995), Mwabu (1992) highlight the rationale for the introduction of cost sharing which was to relieve the government of the financial burden of providing public health services. Cost sharing mobilises resources to supplement government contributions so as to improve the quality of services provided.

Decentralisation regarding the determination of the level of user fees has led to health institutions putting their fees so high as to be beyond the ability of poor people to pay (Owino 1998, Sauer et al. 1994). The latest case of arbitrary increases in user charges took place at Kenyatta National Hospital in January 2004, in which the daily bed charges for in-patients rose from 300 to 450 Kenya Shillings, while clinic consultation charges shot up from 200 to 350 Kenya Shillings. The registration fee also went up from 150 to 200 Kenya Shillings. The question of raising fees notwithstanding, there is evidence that funds generated through user fees were diverted through corruption. According to recent internal audit reports (Nos. KNH/1A/57/51 and KNH/FIN/35) at Kenyatta National Hospital, senior management officers have defrauded the hospital of 51 million Kenya Shillings.

This sum of money was enough to buy anti-retroviral drugs for 17,000 people living with AIDS, or for building two well-equipped operation theatres to boost the already strained hospital theatres. The systems of waivers and exemptions put in place to cushion the poor are continually collapsing (Owino 1998). Since its inception, several changes have been made to the system, which have included raising the exemption ages to 10 and later to 15, excluding civil servants, and omitting certain diseases and categories of patients originally included. The collapse in the system of exemptions and waivers has had the greatest impact on the vulnerable population, especially children under five years whose immunity to common diseases like malaria is very low. For example, Kenyatta National Hospital introduced user fees for children under five in January, 2004. Children who had previously been exempted from user fees now have to pay the mandatory 200 Kenya shillings as a registration fee besides their parents meeting the costs of any further medical investigations or treatment (*Daily Nation* 2004). According to Doctor Fred Were, chairman of Kenya Paediatricians' Association, the new policy will worsen the already poor child survival rate.

The consequences of de-exempting children are already emerging at the Kenyatta National Hospital where the number of children under five years attending the hospital has gone down. Statistics indicate that there has been a drop in seeing between 300 and 500 children a day to less than 200 (*Daily Nation* 2004:25). Several studies have revealed a declining demand for public health services with the introduction of fees (Ngugi 1995, Mwabu et al. 1995, Quick et al. 1994, Kirinjia et al. 1989). Findings from these studies reveal that the introduction of user fees where none existed before may create the perception of a high percentage increase and also that the demand for health services is highly sensitive to price levels. According to Rae et al. (1988:61), 'cost-sharing through charging fees for health services at public institutions worsened the plight of the vulnerable groups'.

Experience in Zimbabwe is also telling. Bijlmakers et al. (1996:13-14) have observed that during the 1980s, infant mortality especially among children under one year of age in Zimbabwe declined from pre-independence levels of 120 to 150 per 1000 live-births, to 61 by 1990. In addition, they observed that child mortality among children one to four years also declined from 40 per 1000 in 1980, to 22 in 1990. However, there is accumulating sad evidence that mortality figures have started to rise in the 1990s, and that 'the gains made in the previous decade are being reversed'. They have attributed this to several reinforcing factors, namely: the declining per capita expenditure on health and the declining quality of health services, the drought, the HIV/AIDS epidemic and the general deterioration in the living conditions of large segments of the population. Turshen (1999) is among the outspoken opponents of user fees in Zimbabwe and has observed that Structural Adjustment Policies were, in general, designed to reduce the demand for public health services, and user fees, in particular, were a mechanism of rationing care. This assertion has been reinforced by studies conducted in Chitungwiza and Murewa Districts in Zimbabwe, which have added evidence to the existing literature on user fees and service utilisation, and bring in the dimension of quality of care to help explain the relationship between user fees, quality of care, and clinic attendance. Creese (1997) makes a very important observation, arguing that user fees have detrimental effects on health seeking by the poor and the vulnerable. He adds that user fees are a political strategy for shifting health care costs from the better off to the poor and sick and that this method of raising revenue and maintaining access to care is based on need rather than ability to pay.

The concept of stewardship as it relates to the issue of good governance demands that government should try to overcome its inadequacies in terms of enhancing responsiveness, improving and maintaining health, and assuring fairness of financial contribution (Sama 2004). According to Sama (2004), the poor emerge as receiving the worst level of responsiveness as they are treated with less respect, given less choice of service provision, and offered lower quality amenities.

Governments have failed to address the question of corruption (black market) in the health sector and this has further worsened the situation because the few funds generated from user fees end up in private pockets. Through involvement,

governments can achieve good stewardship through receiving information that would help improve and correct system-wide problems in the health sector. Stewardship ‘encompasses the tasks of defining the vision and direction of health policy and collecting and using information’ (Sama 2004).

Conclusion and Recommendations

Studies on user fees in Kenya have shown that cost-sharing is having a negative impact on attendance at health facilities. User fees have denied access and created inequity in health care seeking. This study proposes two ways that will promote access to health by the poor and the vulnerable, namely advocacy and the expansion of the Kenya National Insurance Fund (NHIF).

The first recommendation is advocacy. Health is a human right (Committee on Economic, Social and Cultural Rights 2000) and the ‘core element of the right is prevention of ill-health’ (Packer 2002). The state is duty-bound to respect and protect the human rights of its people, otherwise, under the International Law, the state is held responsible for its omissions (Packer 2002). It is therefore, the recommendation of this paper that advocacy groups engage the health agenda in their activities. Advocacy in the area of health has worked under certain circumstances such as in women’s reproductive health. Advocacy groups have questioned the usefulness of certain cultural practices, which have posed risks to women’s health and thereby contributed to the violations of the right to health, such as female circumcision, early pregnancy, and incisions in pregnancy, some traditional birth practices and delivery taboos. Advocacy groups have opposed these practices and made some progress. Advocacy in conjunction with the media can bring desired ends in the field of health care access. An example is the Kenyan government’s legislation against female circumcision, and this has gone a long way in improving women’s reproductive health. In order for advocacy to be effective, those advocating must come up with a scheme that can work to ensure that all Kenyans have access to health as a basic right. One such scheme is social health insurance.

The second recommendation, therefore, is the expansion of the Kenya Health Insurance Fund (NHIF). This Fund was established in Kenya in 1968 as a social insurance fund. In its initial years it was meant to assist Government employees to gain access to higher quality private hospitals, thereby relieving congestion in the ‘free’ public hospitals. NHIF provided a cover for the contributors, including their families, for in-patient care in NHIF-approved hospitals. Contributions, benefits and reimbursement rates remained static until mid-1990, after which they were reviewed upwards. The importance of such a scheme has been indicated by Owino (1997) and Kraushaar and Akumu (1993), who have observed that the NHIF’s potential reimbursements to public health facilities alone could increase the state’s vote for preventive and primary health care funds by about 25 percent. Together with the mandatory enrolment requirement and long experience in handling third party payments for health care, the future impact of the

NHIF on financing, coverage and access to health services could be very significant. Other than the government, and despite its low population coverage, the NHIF remains the largest financier of health services, apart from direct government funding, providing approximately 50 percent of actual revenue generated from the cost-sharing programme.

All that the NHIF requires, therefore, are necessary reforms, which include broadening its functions and coverage, promoting competition, and providing an enabling environment for its operation and expansion (GoK 1995). Reforms should be targeted to solve current problems and inadequacies of the NHIF, which include provision of low benefits for in-patient care, weak administrative mechanisms, lower than expected returns on investments, poor incentive for health care providers to meet high standards of quality health, low claims at public health facilities, accumulated huge surpluses that bear no relation to the claims volume, lack of transparency in the management and accountability of funds, among others. Only a small population of Kenyans has coverage from commercial health insurance and, in its present form and structure, the NHIF covers between about 20-35 percent of the total population (that is the contributors and their dependents). The rest of the population cannot qualify for the more traditional insurance, and need to be enrolled in some flexible risk-pooling schemes. A state health insurance scheme is the only feasible insurance cover for the poor and vulnerable who cannot meet the insurance costs of private insurance companies from their pockets.

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