



Case Study

KENYA: POLICY DEVELOPMENT AND IMPLEMENTATION OF USER FEES

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GROUP WORK

Read the accompanying dialogue between the Permanent Secretary in the Kenyan Ministry of Health and the Chief of the National Health Policy Coordinating Unit.

Having read it closely, break into groups of five or six people each. Then discuss the following questions and decide what you would tell the Secretary. Be prepared to present your ideas in a plenary session!

1. How well was the user fee scheme designed and implemented? Consider both the technical design features and the process of implementation.
2. To secure a better outcome, what approaches to design and implementation should the Kenyan government have adopted?
3. Given your answers to question 2, what should the Kenyan government do now?

1. BACKGROUND

Kenya, a country in East Africa, lies along the equator and has a varied landscape, climate and vegetation. The people, 24.5 million in 1993, come from more than 40 ethnic groups, with about 80% still making their living from agriculture. Per capita income is about \$340, but income distribution is extremely inequitable. The top 20% of the population receive 60 % of the national income, while the bottom 20% receive less than 3 %. A population growth rate of about 3 % will double the population in under 25 years, placing further pressure on the labour market weakened by inflation and international competition, and on the amount of arable land per person.

Starting in the late 1970s and continuing through the 1980s, the global recession caused economic output in Kenya to shrink on a per capita basis. The economy recovered by the mid-1980s, with an overall real growth rate of about 5%. Real per capita growth has been only about 1 to 1.5%. Inflation has generally been between 10 and 20 %, with a record high of 27% in 1992. Government expenditure, while rising in nominal terms, declined in real terms by 13% between 1979/80 and 1991/92, and by even more in per capita terms.

The Ministry of Health (MOH) plays a central role in the financing and delivery of health services. The MOH runs 56% of the country's facilities, employs 69% of its health personnel, and is responsible for 43% of Kenya's total health expenditure. However, the MOH facilities are estimated to serve less than 20% of the population. Those with formal employment, and their dependants – about 5.6 million people - are insured by the National Hospital Insurance Fund (NHIF), a semi-autonomous unit under the MOH.

The MOH services are structured like a pyramid. At the base are 1,100 dispensaries, then 329 health centres, 69 district and sub-district hospitals, 7 provincial hospitals and at the apex is the Kenyatta National Hospital (KNH), a tertiary care facility. In the 1992/93 financial year (FY), hospitals accounted for 63% of recurrent MOH expenditure, and primary health care about 26%. Staff salaries and allowances account for over 70% of recurrent expenditure, and are growing at the expense of expenditures for drugs, consumables, equipment and maintenance. In FY 1992/93 the MOH's recurrent budget was KSh 4,184 million, representing 7.7 % of total government expenditure.

Private, for profit health services have grown over the years but have been focussed on the wealthier urban population. There are about 43 private hospitals and about 800 dispensaries and clinics. Private non-profit services include 63 hospitals, and 540 dispensaries and clinics, and are estimated to serve 40 % of the population. Many of the non-profit organisations have struggled to survive budget cuts from government and donors.

2. AN UNFOLDING DRAMA!

In July 1989, Dr Adenubo Chief of the National Health Policy Coordinating Unit, sat before the Permanent Secretary of the Ministry of Health with her head in her hands.

Dr Adenubo:

The pressure from these donors to implement higher user fees is so intense – I only wish they would stop providing conflicting advice on things like:

i) the levels of user charges to implement, ii) the level of services to be charged for, iii) the criteria for exempting certain groups iv) the level of NHIF contributions and v) the uses for the additional revenue.

Secretary:

But you know, these issues have to be resolved, and soon. First because our National Health Plan for 1989-1994 calls for increased reliance on user fees. Second, because the World Bank is threatening to withdraw their support for additional projects if we don't institute fees.

Dr Adenubo:

It all started with the many studies of health care costs and possible financing mechanisms in the past five years. Then a World Bank mission in early 1988 adopted the recommendation of raising fees. In a study done at that time they estimated 90 % of the population could afford to pay the fees they proposed. They estimated that 20 to 30 % of the recurrent budget could be covered through the introduction of user fees.

Secretary:

There are other benefits to user fees, such as discouraging the over use of services, and encouraging referral patterns from dispensaries to provincial hospitals. However, I worry that the bank is over-optimistic about the ability of the population to pay the fees proposed, and whether proper account has been taken of the administrative costs.

Dr Adenubo:

More recently we had a consultant from the World Bank propose that the increase in user fees should be more modest than proposed in the 1988 study, but that the NHIF should be restructured with employers and employees each paying 2 % of wages as compulsory insurance premiums. This consultant estimated that 30 to 50 % of the Ministry's recurrent budget could be paid through these collections. The NHIF funds could pay either public or private providers and would thus release more of the MOH's funds for preventive and promotive care.

Secretary:

Yes, we'd been thinking along these same lines. However, the World bank didn't accept the consultant's recommendations. Instead, they are proposing somewhat lower fees than before (but higher than proposed by the consultant) and a 2% contribution from employee wages over KSh 1,000 but only a token 0.2 % contribution by employers, so as not to discourage employers from hiring labour.

Dr Adenubo:

USAID seems to now be moving to concur with the Bank's proposal. In addition, they have agreed to finance a Kenya Health Care Financing (KHCF) project to help implement the financing reforms and to aid in further defining the reform agenda.

Secretary:

I have heard of the project, but doesn't it include some "conditions precedent"?

Dr Adenubo:

Yes, but fortunately these are in line with what the MOH would like to have happen. Some of the "conditions precedent" include:

- i) retention of cost-sharing revenues by the MOH
- ii) cost-sharing revenues would be additional to budgetary support from the GOK and not appear as "Appropriations-in-Aid" in the budget estimates
- iii) development of a waiver system for those unable to pay
- iv) assurances that cost-sharing revenues would be "no year" funds (i.e. if not spent in any given year could be rolled over to following years)
- v) separation of the cost-sharing revenues into 75% for the institution and 25% for preventive and primary care activities (P/PHC) under District health management Boards (DHMBs) and teams (District health Management Teams)

Secretary:

I think we should signal the Bank and USAID that we are seriously going to undertake reform of our user fee systems, and as a first step set up a Health Care Financing Advisory Committee from members of government ministries, donors and private organisations to reach consensus on proposed policies and develop implementation systems.

Dr Adenubo:

I'll get on to that directly.

In August 1989 the Cabinet wrote a paper establishing the tenets of cost-sharing and the MOH created a Health Financing Secretariat. The Secretariat consisted of four part-time members: two hospital administrators and two accountants. Two months later, on October 18th 1989, after a donor-sponsored health financing study tour to Africa, Europe, Latin America and North America, Dr Adenubo was called to meet the Secretary.

Secretary:

How are the plans for implementation of the user fee policy going?

Dr Adenubo:

Well, the group has had a slow start, but we think we can start to implement it in some government facilities by early summer of next year (1990).

Secretary:

Unfortunately, we don't have the luxury of that time. The government has just announced that fees will be introduced 6 weeks from now on December 1, 1989. The policy that is to be implemented is outlined on this sheet of paper (see Annex). I'm calling on the Health Financing Secretariat to develop rapidly materials for administration of a user fee system and to train the relevant hospital and health centre personnel. I hope we can draw on the members of the Health Care Financing Advisory Committee for some help. The technical assistance team for the KHCF project has not yet arrived in country, but we will get some technical assistance from another project.

Dr Adenubo:

This is ridiculous! It isn't possible to institute a new policy like user fees in 6 weeks. Can't we slow down the implementation?

Secretary:

I'm afraid not, please keep me posted on developments.

Two months later, Dr Adenubo and the Secretary again met to discuss user fee policy

Dr Adenubo:

...Just as I said the rapid implementation of the user fee policy has been disastrous. Out-patient attendances at provincial hospitals are down 27 %, at district hospitals by 46 % and at health centres by 33 %. To top it off, President Moi rescinded the maternity bed fee, and there's talk that he will exempt civil servants from paying fees. I wouldn't be surprised if by the end of the year he didn't rescind the out-patient fees altogether.

Secretary:

Yes, it seems that a good idea has faltered on the back of weak implementation. I understand that the DHMBs did not function well enough to permit decisions on how the funds collected were to be used at the local level. The Ministry of Finance is not yet convinced that the MOH can properly account for funds "off budget". They say we need to further refine our accounting procedures so that they can "stand-up to" internal and external audits. Nevertheless, we have met the "conditions precedent" for the first tranche (\$2.5 million) of the USAID grant program, funds which we will use to purchase supplies and equipment. We still also expect that we will get technical assistance from USAID for user fee policy and implementation. When is it expected they will arrive?

Dr Adenubo:

In early 1991, maybe the right time to start all over again.

Almost a year passed. The USAID technical assistance team had arrived in Nairobi. Their first task had been an assessment of the problems with the first time user fees for health had been implemented.

Team Leader:

Well, we are all excited to be here. Let me introduce the expatriate team. We consist of myself – a public health physician, David – a financial management advisor, and Jonathan – a health care planner/evaluator. We are joined by several Kenyans with overlapping and complimentary skills. We understand that you recently strengthened the Health Financing Secretariat from four-part-time to 10 full-time staff, and this encourages us that you are serious about a second attempt at instituting user fees, and that we will have counterparts to work with as well.

Secretary:

You are welcome in Kenya. Can you share with us what you found from your evaluation of last year's failed attempt at instituting user fees?

Team Leader:

Well, in spite of the fact that out-patient and maternity fees were suspended, in-patient, lab and x-ray fees continue to be collected, although they are not referred to as "cost-sharing" but rather as "Facility Improvement Funds". The bad news is that the revenue generated from all fees is less than expected, especially at health centres. The KHCF project's goal is to generate 10 % of total recurrent expenditure through user fees. We are not sure precisely why revenues are low, but we think it has to do with that fact that patients expect to receive medications when they have to pay for services, and that drugs were not available, especially at health centres. Redoing the study of patients' satisfaction, and comparing the results of your earlier study during the 1989 cost sharing experiment, would help us clarify a few things about this issue.

We also found that few hospitals tried to collect from the NHIF as collection procedures are cumbersome. Nevertheless, this is a good course to follow as the NHIF can pay higher rates than those paying out-of-pocket. It is estimated that 80 % of provincial government hospital revenue will come from the NHIF.

Another factor is that staff are reluctant to provide waivers to the truly indigent, as they are afraid once the availability of waivers became well known that all patients would try to obtain one. Little of the revenue collected has been targeted to improving P/PHC services. Procedures for banking are not followed and accounting, monitoring, and evaluation systems are inadequate. Finally, the DHMBs are not operational, thus limiting the amount of community representation, increasing the poor public image, limiting supervision and monitoring, and limiting feedback into policy and planning decisions about the use of funds for P/PHC services.

Secretary:

That's quite an agenda for improvement. Where do you think we went wrong and what should we do about it now?

Team Leader:

Well...

**ANNEX: FEE SCHEDULE APPROVED BY THE GOVERNMENT OF KENYA,
DECEMBER 1989**

- Fees
 - Outpatient fees in Government Hospitals 20 KSh (\$1.00)
 - Outpatient fees in Health Centres 10 KSh (\$0.50)
 - Dispensaries Free
- Revenue stamp attached to patient's health care allowing the person free care to the same or lower level facilities for the following month.
- If person is referred to a higher level of care within that month an additional fee of 10 KSh will be charged.
- Free services: care for children under 5 years of age; family planning, prenatal care; visits for treatment of psychiatric illnesses, tuberculosis, leprosy and sexually transmitted diseases. No additional charges for drugs.
- Additional fees for x-rays, lab tests, special services.
- 75% of user fees should remain at the institution where collected; 25% should be used for preventive services within the district.
- Outpatient charges at public facilities should be used for local primary health care initiatives that will preferentially benefit the poor.
- Mechanisms to reduce the impact on the poor:
 - No fees on basic health services.
 - 25% of user fees should be used for local primary health care initiatives that will preferentially benefit the poor.
 - Fee exemptions (outpatients fee exemptions range between 11 and 34 %)