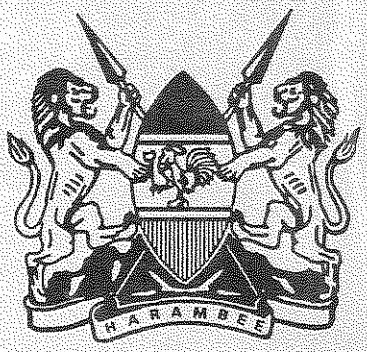
GOVERNMENT OF KENYA

MINISTRY OF HEALTH



KENYA'S HEALTH POLICY FRAMEWORK

NOVEMBER 1994

Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity

World Health Organisation

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FOREWORD

This policy framework paper is devoted to the health sector, and takes as its particular theme that of ***Investing in Health.*** It begins with a series of situational analyses which highlight the problems faced by the health sector in Kenya. Next it elaborates general strategies to address the particular problems identified, and finally defines the horizon of the Government's health policies into the next century.

The health sector in Kenya is at a crossroads, at a point where a bold and major change in the direction of health policy is to be mapped out. Future investments in the health sector have the potential to promote good health rather than simply treat disease and disability, but they will require a sea-change in the manner in which the Government supports the sector.

Despite a massive expansion of the health infrastructure since independence, it is widely recognised that increasing population and demand for health care outstrip the ability of Government to provide effective services. To markedly change the burden of sickness and disease in Kenya, the Government will embark upon a bold programme of health sector reforms. These will transform the patterns of Government investment in health away from capital intensive projects for the construction of new curative care facilities towards investment in Kenya's most precious capital, her people.

As health sector reforms proceed however, the Government will ensure that they do so in a manner which offsets the undesirable effects of the general structural adjustment programme.

Good health begins with the individual, and sustainable improvements to the health status of Kenya's rapidly growing population will only occur when the state plays a more prominent role in promoting individual good health. The focus of the Government's future health policies will thus be to provide an enabling environment for good health.

This enabling environment will first and foremost ensure that sufficient finances are mobilised to support the entire health sector, and that effective and efficient use is made of those resources to provide the best quality care and services at the lowest possible cost. The chronic underfunding of primary health care will end, and future investments will be used to encourage individuals and communities to play a more active role in preventing disease and ill health. At the same time, curative care will be made more cost efficient by encouraging and rewarding professionalism and by stimulating competition amongst the wide panoply of providers of care in both the Government and private and mission sectors.

Throughout, the locus for the executive control of resources will undergo further, functional decentralisation. This will ensure that local health authorities become both more autonomous and more responsive to local needs. The role of the central Ministry of Health will be transformed from that of provider of services to that of policy maker and regulator of service provision. This will make it more effective both as guarantor of equity in the distribution of resources, and protector of the poor and needy.

HON. JOSHUA M. ANGATIA, EGH, MP.
MINISTER FOR HEALTH

LIST OF ABBREVIATIONS

ADB	African Development Bank
AIA	Appropriations in Aid
AIDS	Acquired Immunodeficiency Syndrome
CDD	Childhood Diarrhoeal Disease
CHS	College of Health Sciences
CO	Clinical Officer
DALY	Disability Adjusted Life Year
DDC	District Development Committee
DH	District Hospital
DHMB	District Health Management Board
DHMT	District Health Management Team
DPM	Directorate of Personnel Management
EDF	European Development Fund
EDL	Essential Drugs List
FY	Financial Year
GDP	Gross Domestic Product
GOK	Government of Kenya
HCF	Health Care Financing
HIS	Health Information Systems
HIV	Human Immunodeficiency Virus
IDA	International Development Association
IFAD	International Fund for Agricultural Development
IPPF	International Planned Parenthood Federation
KEPI	Kenya Expanded Programme of Immunisation
KHRP	Kenya Health Rehabilitation Project
KNH	Kenyatta National Hospital
MLG	Ministry of Local Government
MoF	Ministry of Finance
MoH	Ministry of Health
NACP	National AIDS Control Programme
NDP	National Drug Policy
NGO	Non Government Organisation
NHIF	National Hospital Insurance Fund
PGH	Provincial General Hospital
PHO	Public Health Officer
PHT	Public Health Technician
PTPP	Part time private practice
SDH	Sub District Hospital
STD	Sexually Transmitted Disease
UNICEF	United Nations Childrens Fund
USA	United States of America
WHO	World Health Organisation

INTRODUCTION

CRITICAL PROBLEMS FOR THE KENYAN HEALTH SECTOR

There are a number of critical problems which constrain the ability of the Ministry of Health to legislate for and ensure the delivery of adequate levels of quality health care in Kenya. These are described in detail in this document, but those of particular importance are summarised here.

FINANCES The Ministry of Health is seriously underfunded. *Per capita* expenditures on health were US$9.50 in 1980/81, but since then have dropped to about US$4.50 in 1991/92, and due to the devaluation of the Kenya shilling in early 1993, are unlikely to rise above US$3.50 per capita by 1996/97. This is despite a rise in local currency expenditures from K£50 million in 1979/80 to over K£175 million in 1991/92, and an anticipated rise to over K£350 million by 1996/97. Furthermore the share of general Government recurrent expenditures allocated to the Ministry of Health has declined from 9.26% of the Government total for 1979/80 to 8.51% in 1991/92, and is expected to fall further to 7.61% by 1996/97. In addition, health centres and dispensaries belonging to the Ministry of Local Government were taken over by the Ministry of Health in 1970 without any increase in its recurrent budget. Finally, the costs of caring for AIDS patients could be equivalent to the entire 1993/94 recurrent budget of the Ministry of Health by the year 2000.

CAPACITY OF THE PUBLIC HEALTH CARE SYSTEM Kenya's health infrastructure has grown rapidly since independence, and currently there are well over 3,200 health care institutions nationwide. With approximately 1,100 MoH dispensaries, 400 health centres and 100 hospitals, the Ministry of Health has built an impressive, pyramidal health referral system, often with considerable support from harambee efforts. Despite these major gains population growth outstrips the capacity of the Ministry of Health to cater for the demand for services, and currently over 70% of the recurrent budget is devoted to the payment of staff salaries and benefits to the detriment of expenditures on other essential items, particularly medicines. This lack of resources has meant that a number of facilities have been constructed but have never been opened, and has caused the referral system to fail, resulting in unnecessary congestion of hospitals by patients who should be treated at lower cost in health centres and dispensaries. Plans for the expansion of coverage of public health services must take into account the availability and utilization of Private, NGO and Mission Sector facilities and must also guarantee improvements to the efficiency of public resource allocation and utilization.

STAFFING The Ministry of Health has a surplus of staff in lower cadres and deficits in the numbers professional staff. The distribution of professional staff does not reflect real needs, and there is a concentration of key personnel in urban areas and in in-patient services This is compounded by increases in the numbers of staff leaving public service to engage in private practice, Furthermore, although not legally entitled to do so, many are engaging in part-time private practice while in the employment of the Government, often to the detriment of the patients who come for medical attention in Government health institutions. Furthermore the mushrooming of unregistered clinics run by staff not licensed under the existing laws has threatened the well-being of the general public.

LAWS The Laws governing the health sector require to be enforced, and in some cases amended to respond better to present circumstances. Ethical and clinical standards need to be set and maintained, private practice needs to be regulated for the public good, and the land belonging to the Ministry of Health must be protected and must not be encroached upon.

In the light of these and other issues, this policy framework paper presents a first, comprehensive vision of current Ministry of Health policies. It is designed to be used by health policymakers to regularly review and revise policies within a set framework, which will evolve with time as information relevant to the health sector develops and improves.

Part 1 consists of a set of situational analyses, and within the confines of available information, examines the health sector in the context of general Government policies since Independence, identifies strengths and weaknesses, and presents the constraints which impinge upon future growth and development.

Part 2 presents a series of strategic imperatives developed by Senior Ministry Officials which mirror the situational analyses, and which identify the major strategies to be employed in improving the overall function of the sector.

Part 3 contains a description of those policies adopted by the Ministry of Health as a means of applying the strategies identified in Part II to address the constraints described in Part I. It also identifies where in the absence of clear policies, these will be formulated after careful study as part of an overall policy reform program.

The document is presented in such a manner that it may either be read in its entirety, or section by section for those with particular interests in its content.

Part 1
SITUATIONAL ANALYSES

1. MACROECONOMIC PROFILE

The Kenyan economy has generally undergone mixed experiences since independence The growth in Gross Domestic Product (GDP) averaged 6.5 per cent over the period 1964 to 1970, however, the first oil crisis of 1972 brought an abrupt halt to this level of achievement. Consequently the growth rate decelerated to below 4 per cent for much of the early 1970s until the unexpected "coffee boom" of 1976 and 1977 when growth rate in GDP averaged 8.2 per cent. The situation worsened when the price of crude petroleum doubled from US$ 13 per barrel in 1978 to US$ 27 in 1979, generally pushing up the inflation rate, and the cost of imported input and raw materials resulting in the slowdown of economic growth.

For much of the early 1980s the rate of growth in GDP remained below 5 per cent and for the first time in Kenya's history, the growth rate fell below 1 per cent in 1984. This was largely attributed to the severe drought of that year. Favourable weather conditions coupled with Government budgetary discipline and improved management enabled Kenya to achieve significant 4.8 per cent and 5.5. per cent growth rates in 1985 and 1986 respectively.

Since 1990, however, the rate of growth in GDP has continued to slide below 4 per cent and fell dramatically to a mere 0.4 per cent in 1992, the lowest since independence. This slowdown in GDP growth since 1991 could be explained in terms of the actual decline in real output and value added in agriculture, due to below average amount of rainfall, sluggish growth in aggregate private domestic demand and foreign exchange shortages leading to reduced imports of intermediate goods, and perhaps due to the immediate impacts of the suspension of donor aid. The Government has taken remedial measures to reverse this trend.

One other general observation is that, as would be expected of a modernizing economy, the contribution of the traditional non monetary sectors of the economy have steadily declined from 24.7 per cent in 1964 compared to 5.4 per cent in 1992. Similarly, the contribution of the agricultural sector has steadily declined from over 45 per cent of GDP in 1963 to about 28 per cent in 1992. What this implies is that the contribution to GDP from manufacturing and government services have steadily expanded.

Inflation trends The rate of inflation in Kenya is currently measured by the Nairobi Consumer Price Index which is a weighed average index for each of the three income groups in a calendar year. During the first

decade or so of independence, Kenya enjoyed a single digit inflation rate, mainly due to the effects of the prices control system and good economic performance. However, after the first oil shock of 1973, the inflation rate rose to 17.0 per cent in 1974 and subsequently to 19.1 per cent in 1975. Apart from the years 1973, 1979, 1984, 1986 and 1987 the rate of inflation has ranged between 10 to 20 per cent per year with the exception of 1982 and 1992 when the inflation rates were 21.54 and 27.50 respectively, the latter being the highest inflation rate ever recorded since Independence.

While it is true that the inflation rate has been determined by domestic policies and price control regimes, it has also been determined by the state of the international economic recession in the early eighties and the second oil crisis in 1980, compounded by a rapid increase in money supply, the introduction of price decontrol of some consumer items and the devaluation of the Kenyan Shilling under the continued implementation of the Structural Adjustment Programme and the 1991 freeze of donor aid to Kenya. .

The overall performance of the economy has had both a direct and an indirect adverse effect upon the health sector and the health status of the Kenyan population. The macroeconomic policy for growth and sustainability described in the seventh development plan will help to alleviate the undesirable effects of poverty, which constrain the ability of the Ministry of Health to ameliorate the burden of disease. Therefore, within this general macroeconomic framework, the Ministry of Health will present policies designed to improve the health status of the Kenyan people.

2. PAST HEALTH POLICIES

Since the attainment of Independence in 1963, the Government has given high priority to the improvement of the health status of Kenyans. It recognizes that good health is a prerequisite to socioeconomic development, and its commitment to the provision of health services is evident from the phenomenal growth of the local currency health budget and the expansion of the network of government health facilities across the country.

In a number of Government policy documents and in successive National Development Plans, it is set forth that the provision of health services should meet the basic needs of the population, be geared to providing health services within easy reach of Kenyans and place emphasis upon preventive, promotive and rehabilitative services without ignoring curative services.

Achievements, successes and failures The policies that the Government has pursued over the years have had a direct impact in improving the health status of Kenyans. Despite a decline in economic performance, cumulative gains have been made in the health sector as evidenced by the improvement in basic health indicators.

The crude death rate dropped from 20 per 1000 at independence to 12 per 1000 in 1993 and the crude birth rate from 50 per 1000 to 46 per 1000 over the same period. Likewise, both infant mortality and life expectancy, basic indicators of health status, improved dramatically. It is however important to note that although the above national health indicators look impressive, there are significant geographic disparities which need to be addressed in order to achieve some equity.

Three recent policy initiatives have met with considerable success. These are:

Cost Sharing Amended in 1989 to introduce consultation fees in Government health facilities, and modified in 1992 to convert user charges from a consultation fee to a treatment fee, this program has increased the level of resources available at the local level for improving the functions of the health system. Three quarters of the revenues are used at the collecting facility, and one quarter are set aside for district level expenditure on primary health care.

District Health Management Boards Created by legal notice in 1992, these Boards provide local oversight of the cost sharing program.

Civil Service Health Manpower Reform. Civil service reform in general seeks to trim the size of the civil service, and as part of this reform program, in 1993 the Ministry of Health began implementation of a voluntary early retirement scheme for those in lower job groups.

However, not all policies formulated over the period were translated into actions or realised their desired outcomes. The decline in resource availability and to some extent the mismanagement of resources limited the implementation of policy and expected benefits were not fully realized. The Government is no longer able to provide unlimited free care, as budgetary allocations are insufficient to meet rising costs. Furthermore, in 1965 the late President Kenyatta abolished fee collection in health facilities, and in 1970, the Ministry of Health took over the health centres and dispensaries run by local authorities without a corresponding transfer of budget from local authorities to the Ministry of Health.

Likewise, the growth in fixed capital and facilities was not matched by the growth of recurrent budget allocations. This has resulted in both chronic and sometime acute shortages of essential and critical inputs for health care delivery. Investments made through donor and community financing have greatly expanded the network of health facilities, however there has not been proper coordination to ensure that future requirements for the correct balance of recurrent inputs are catered for and are sustained after the commissioning of new facilities.

There are also indications that urban slums are without organized health care delivery systems and thus the health status of their residents is far below national indicators.

3. MINISTRY OF HEALTH MANAGEMENT INFORMATION SYSTEMS

The Ministry of Health operates a variety of management information systems at both headquarters and elsewhere. These systems are characterised by a lack of integration, and are disjointed and widely dispersed, with no effective central coordination to ensure that the information which they contain is readily available to all who need it. Many systems collect and process data into management information accurately and in a timely manner, whereas others are barely functional. Those systems which do operate effectively tend to be highly localised and are often relatively inaccessible. This needs to change.

Health manpower information To be able to manage effectively, health managers at headquarters, province or district level need accurate, reliable, and up-to-date information for planning and budgeting, and for the day to day management of their specialised and highly professional human resources. Presently, the Ministry of Health has no

reliable, accurate, standardised information system for personnel management, planning and budgeting, and for evaluating and tracking the performance of employees. Most health facility managers can only provide a rough estimate of how many people are employed on-site, and at headquarters, the consensus is that the basic need from a health manpower information system *is simply to know who is where and how much they are being paid.* This problem is complicated by the Ministry's practice of frequently shifting employees from one physical location to another.

As a minimum, the Ministry of Health requires a modern information system capable of providing the data necessary to manage and monitor staffing levels and productivity and to prepare staffing budgets and payroll listings. Additional requirements include the establishment of practical staffing norms on which to base day-to-day deployment decisions as well as for career development and recruiting efforts.

The Ministry of Health is now assembling a comprehensive database concerning its available manpower complement of approximately 45,000 persons, and this system will identify each individual at their place of work. After careful verification, this system will become the basis for the preparation of all future health manpower budgets and for long term projections of manpower supply and demand and training needs.

Physical facilities and resources There are nine principal types of health facilities in the Kenyan public health system, ranging from rural dispensaries to Kenyatta National Hospital, which is the national referral, teaching and research hospital. There are additional specialized facilities for certain types of ailments, maternity, etc., and private mission and NGO facilities which, though licensed by the MoH and subject to inspection, are managed privately.

The MoH has begun to establish criteria for defining facility types, and these include services offered, physical structures, staffing norms, catchment population, and number of beds. This data is critical for deriving workload statistics as it provides the baseline against which expenses, human resources, and patient loads can be measured. *To date, this information has not been systematically updated and verified, and because of the importance of knowing what each facility offers to the public, and the unavailability of this basic information to decision makers and planners at all levels, the planning of the distribution of facilities and services in Kenya is far from ideal.*

Financial management and accounting The MoH has in place a functioning financial management system based on the accounting principles mandated by the Ministry of Finance. As such, the system serves the defined set of needs for reporting and compliance with the Treasury. *It does not interact readily with operational, clinical, inventory, or planning data from computerized systems to facilitate planning and decision making.* At the hospital and smaller health facility level, finance/budget departments account for the revenues received and or incurred for the facility. They maintain accounting records to provide data about the expenditures by expense classification and by the major departments within the hospital. Similarly, provincial and district medical officers account for non-hospital health facilities within their areas. The accounts do not provide accounting for the cost of operating specific service/cost centers within departments. However, accounts, or subheads, have been established both by hospitals and in districts, to account

for funds provided by donors. These accounts are used for recording transactions for each donor fund since donor funds are often earmarked for a particular purpose. Since the introduction of user fees, more and more cash handling occurs at hospitals and other health facilities. This has brought about the need for good cash control systems and procedures, and accounting for the management and banking of funds collected. Very few of these systems are computerised.

Workload and operational information Routine, regular workload and operational statistics, the numbers and types of patients, procedures, diagnoses, etc form the essential core data against which other data and information for any health care facility are crossed and compared for planning or management purposes. Unit costs can be derived by comparing clinical data against expenses, catchment population served, and staff. Deficits or surpluses in any type of resource can be readily identified using a mix of operational and workload statistics.

At present, these statistics are compiled at most quarterly and often only annually. Reporting rates from facilities are low and the headquarters does not have complete data for all facilities for any one year. Furthermore, those workload data that are compiled are often derived from morbidity and mortality statistics with no valid cross reference with medical records, residence of the patient, public health survey data, etc. There exist considerable opportunities for the introduction of transcription and arithmetic errors in data due to the high volume of information and lack of computer facilities.

All these management information systems must be operationalised at all levels of the health system in order to provide managers and planners with the information they require.

4. SECTORAL ECONOMIC PROFILE

Expenditure on health care Considering the sector in its entirety, Table 1 shows that in FY 1983/84, of a total of almost KSh2.9 billion spent on health care nationwide, 42.09% was spent on health care provided at Ministry of Health institutions, with a combined Government total of 50.13%. Over the counter expenditures on drugs and pharmaceuticals accounted for a further 23.6%, and private health institutions accounted for almost KSh265 million or 9.21% of the total. Expenditures on the services of private medical practitioners totalled KSh216 million (7.51%), and Ministry of Local Government and Mission Facilities each accounted for slightly less than 6% of the total. It is therefore clear that the private sector, particularly privately owned pharmacies, are making a considerable contribution to the provision of health care in Kenya, and are benefitting from their activities.

Sources of finance When one examines the sources of financial flows to the health sector shown in Table 1, one immediately recognises the important role that Government plays in promoting good health. Of all health care expenditures in FY 1983/84, 41.97% were financed by the Ministry of Health, with an additional 5.31% coming from the Ministry of Local Government. However, the contribution of individuals to their own good health is not to be underestimated, since a further 40.88% of the total was derived from their out of pocket expenditures. Mandatory health insurance mediated through the National Hospital Insurance Fund provided less than 4% of the total in 1983/84 and combined donor inputs provided less than 3%.

Table 1. Total Gross Recurrent Expenditure by Provider and Source of Financing 1983/84[1]

SERVICE PROVIDER	KSh	%	SOURCE OF FINANCES	KSh	%
MoH	1,210,400,000	42.09%	MoH	1,206,800,000	41.97%
NHIF	8,400,000	0.29%	NHIF	109,000,000	3.79%
CHS	25,400,000	0.88%	CHS	25,400,000	0.88%
MLG	160,600,000	5.58%	MLG	152,600,000	5.31%
OTHER GOK	36,800,000	1.28%	AIA	3,700,000	0.13%
Government Total	**1,441,600,000**	**50.13%**	**Government Total**	**1,497,500,000**	**52.07%**
MISSIONS	168,900,000	5.87%	MISSIONS	29,300,000	1.02%
COMPANIES	11,400,000	0.40%	COMPANIES	53,600,000	1.86%
Private Market			DONORS	71,000,000	2.47%
INSTITUTIONS	264,800,000	9.21%	NGOS	13,400,000	0.47%
PRACTITIONERS	216,000,000	7.51%	**Private Market**		
DRUGS	680,000,000	23.64%	INSURANCE	35,300,000	1.23%
OUT OF POCKET	93,300,000	3.24%	OUT OF POCKET	1,175,600,000	40.88%
Private Total	**1,254,100,000**	**43.61%**	**Private Total**	**1,210,900,000**	**42.11%**
GRAND TOTAL	**2,876,000,000**	**100.00%**	**GRAND TOTAL**	**2,875,700,000**	**100.00%**

Ministry of Health recurrent expenditure trends As one would expect, Table 2 and Figures 1 & 2 show that Ministry of Health expenditure on the health sector is also showing signs of decline, despite the efforts of the Government to protect it. Although Ministry of Health local currency expenditures have risen steadily, from K£50 million in 1979/80 to over K£175 million in 1991/92, and are expected to rise to over K£350 million by 1996/97, in real terms the trend is one of decline. Per capita expenditures on health were US$9.50 in 1980/81, but since then have dropped to about US$4.50 in 1991/92, and due to the devaluation of the Kenya shilling in early 1993, are unlikely to rise above US$3.50 per capita by 1996/97 unless the economy makes a dramatic recovery.

When one examines the share of general Government recurrent expenditures allocated to the Ministry of Health, it is evident from Table 2 that this too has been reducing steadily.

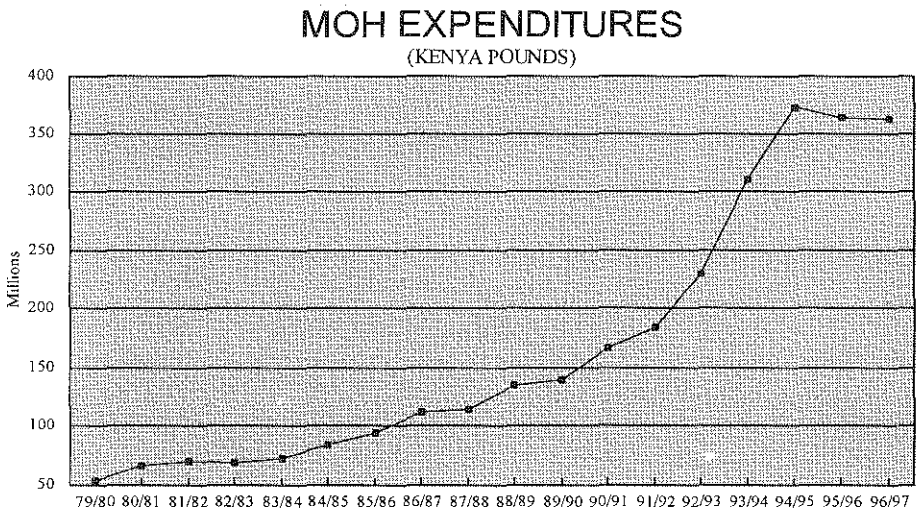
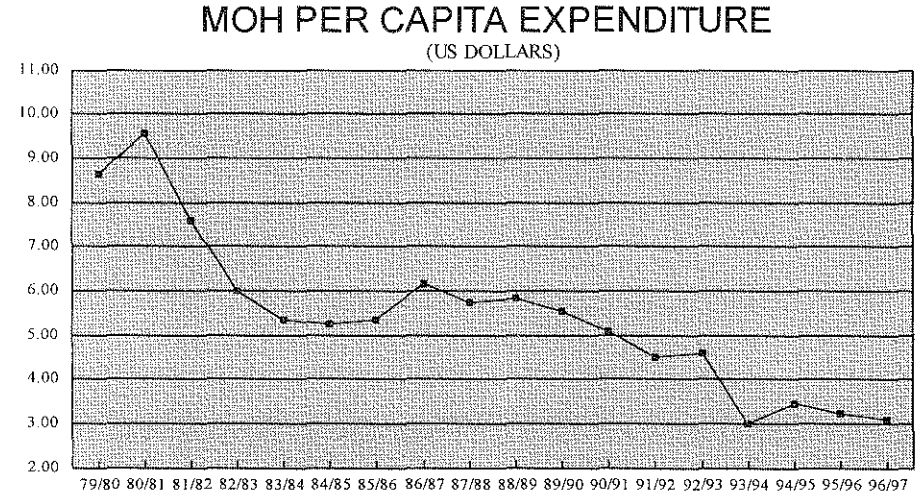


Figure 1 (Above) MoH Recurrent Expenditures 1979-1997.

Figure 2 (Below) MoH Per Capita Expenditures 1979-1997.



In 1979/80 Ministry of Health recurrent expenditures accounted for 9.26 of the Government total for that year. From 1986/87 onwards, this percentage has dropped and by 1991/92 was only 8.51% of total Government expenditure. This is expected to fall by almost one percentage point to 7.61% by 1996/97.

Internal allocations of Ministry of Health recurrent budgets The internal allocations of Ministry of Health recurrent budgets shown in Table 2 continue to favour curative care in hospitals. Since 1979/80, the percentage of MoH recurrent expenditure attributable to the provision of curative services has remained at approximately 70% of the total, although within hospitals a greater share of their expenditure has been on preventive services carried out in outpatient clinics. Increases to the direct funding of primary and preventive health care from 15% in 1979/80 to 21% in 1991/92 have occurred at the expense of expenditure on administration and training.

Table 2. Ministry of Health Recurrent Budget Expenditures. (Internal Allocations, As percentage of Government Total and in US Dollars per capita) [2]

YEAR	Total K£	CURATIVE	RURAL & P/PHC	ADMIN & TRAINING	NON DRUG SUPPLIES & RESEARCH	R11 as % GOK	US$ Per Capita
79/80	42,943,415	66.69%	15.13%	11.70%	6.48%	9.26%	8.65
80/81	52,868,619	68.36%	15.74%	11.43%	4.47%	9.45%	9.55
81/82	59,075,879	72.33%	12.75%	11.98%	2.94%	9.32%	7.60
82/83	61,306,323	72.41%	13.84%	12.44%	1.31%	9.32%	6.00
83/84	61,765,853	72.39%	11.55%	14.57%	1.49%	8.83%	5.36
84/85	73,007,033	66.52%	9.71%	10.88%	12.89%	9.19%	5.24
85/86	79,653,593	71.83%	12.88%	10.10%	5.19%	9.25%	5.35
86/87	96,546,022	72.14%	10.82%	12.14%	4.90%	8.95%	6.16
87/88	101,014,500	78.18%	10.50%	9.56%	1.77%	8.38%	5.76
88/89	113,686,327	72.24%	16.48%	9.63%	1.65%	7.38%	5.85
89/90	115,032,567	69.39%	18.92%	10.58%	1.11%	7.87%	5.54
90/91	128,807,254	69.76%	19.87%	9.17%	1.19%	7.82%	5.08
91/92	147,833,073	67.77%	21.62%	9.28%	1.32%	8.51%	4.50
92/93	169,489,868	68.72%	22.02%	8.65%	0.61%	8.46%	4.60
93/94	209,125,600	62.74%	25.49%	9.17%	2.60%	7.65%	2.99
94/95	299,529,639	67.23%	20.95%	9.65%	2.16%	7.59%	3.44
95/96	315,133,200	67.11%	21.38%	9.28%	2.22%	7.60%	3.22
96/97	350,586,292	66.86%	21.39%	9.58%	2.17%	7.61%	3.09

Table 3. Combined Recurrent and Development Budgets by Source of Finance.

YEAR	TOTAL (K£)	GOK	DONORS	GOK %
92/93	286,494,589	200,299,263	86,195,326	69.91%
93/94	310,947,827	223,946,610	87,001,217	72.02%
94/95	343,916,500	255,364,811	88,551,689	74.25%
95/96	375,833,659	269,227,550	106,606,109	71.63%

Table 4. Development Budget by Source.

SOURCE	1992-93	1993-94	1994-95	1995-96
Kenya	22.02%	14.49%	24.08%	16.91%
Austria	1.76%	1.13%	1.66%	2.33%
Belgium	0.32%	0.06%	0.00%	0.00%
Britain	0.00%	6.40%	0.00%	0.00%
Canada	2.44%	0.66%	1.81%	2.54%
China	2.26%	0.00%	2.04%	1.43%
Denmark	6.50%	4.58%	2.16%	2.80%
EDF	0.92%	0.00%	0.91%	0.64%
Finland	7.49%	6.26%	3.64%	4.93%
Germany	2.68%	1.48%	0.25%	0.17%
IDA	11.94%	11.16%	31.85%	32.04%
IDRC	0.08%	0.00%	0.00%	0.00%
IFAD	1.53%	1.21%	1.95%	1.46%
IPPF	0.30%	0.00%	0.00%	0.00%
Italy	0.50%	0.00%	0.00%	0.00%
Japan	0.00%	22.64%	0.00%	0.00%
Netherlands	4.12%	4.30%	0.70%	0.49%
Sweden	17.42%	9.99%	9.86%	10.83%
UNICEF	0.36%	0.00%	0.00%	0.00%
USA	17.36%	15.62%	19.10%	23.43%
TOTAL (K£)	59,780,328	88,341,068	60,224,760	85,779,260

Development Expenditures When one considers Development Expenditures as shown in Table 3, it is evident that they represent approximately 25% of total Ministry of Health expenditure. Despite considerable increases in total donor inputs to the health sector since the 1980's, these inputs still represent less than 30% of total Ministry of Health expenditures, *making the Ministry of Health the single most important source of health care financing today, and therefore making reform of that institution an absolute necessity.*

Nevertheless, donor contributions represent approximately 80% of the Development Budget alone, as shown in Table 4, and there exists a tendency for approximately 40% of development expenditures provided by donor agencies to be a form of recurrent budget support. This is in particular for the supply of commodities to the Essential Drugs Programme, the Kenya Expanded Programme on Immunisation and the Family Planning Programme, as shown in Table 5.

Table 5. Development Budget by Type of Expenditure

EXPENDITURE	1992-93		1993-94	
TYPE	K£	%	K£	%
AIDS	1,835,175	3.07%	1,612,000	1.82%
CONSTRUCTION	14,740,638	24.66%	15,622,684	17.68%
CONSULTANTS	1,414,000	2.37%	2,486,000	2.81%
C.D.D.	28,000	0.05%	50,000	0.06%
DRUGS	5,884,500	9.84%	4,896,000	5.54%
EQUIPMENT/PLANT	2,407,680	4.03%	22,655,500	25.65%
FAMILY PLANNING	7,620,700	12.75%	13,148,504	14.88%
HCF	3,150,000	5.27%	4,300,000	4.87%
HIS	10,000	0.02%	0	0.00%
KEPI	1,210,000	2.02%	400,000	0.45%
KHRP	1,020,000	1.71%	1,870,000	2.12%
KNH	3,012,500	5.04%	0	0.00%
MAINTENANCE	1,817,000	3.04%	1,930,000	2.18%
MISCELLANEOUS	1,586,955	2.65%	3,726,230	4.22%
NGO	1,769,000	2.96%	1,942,700	2.20%
PLANNING/STUDIES	780,600	1.31%	385,000	0.44%
PRIMARY HEALTH CARE	5,644,080	9.44%	8,070,050	9.14%
REHABILITATION	1,295,000	2.17%	1,550,000	1.75%
TRAINING	4,404,500	7.37%	3,521,400	3.99%
VEHICLES	150,000	0.25%	175,000	0.20%
TOTAL	59,780,328	100.00%	88,341,068	100.00%

The contribution of cost sharing to health care financing The innovative cost sharing programme in Government health facilities was introduced in phases beginning in 1989 and its impact has recently been evaluated. It has been widely accepted as a means of generating additional revenues to be used for the improvement of Government facilities and services and revenues are maintained in a separate account at the district level. These revenues, which have steadily increased over the past two years, are derived from two sources - user fees, primarily for curative services, and from NHIF reimbursements. For Ministry hospitals and health centres, current cost sharing revenues represent approximately 7% of the non-staff recurrent budget (3% of total budget), and this is expected to rise over the next five years to 30% of non-staff expenditures (12% of total).

Hospital revenues by source The three largest sources of cost sharing revenue are NHIF reimbursements, inpatient cash collections, and the outpatient treatment fee which together account for 75% to 80% of revenue at hospitals. NHIF reimbursements are the largest single source of revenue, accounting for 35% of all revenues which totalled KSh70 million in FY 1992/93.

In contrast to NHIF reimbursements, which are the greatest share of revenue for the PGHs, treatment fee revenue represents only 20% of the total, and laboratory, x-ray, and mortuary fees together account for 10% to 13% . Other revenue sources include Mental Health Services fees (1.3%), medical examination fees (3.3.%), circumcision fees (0.3%), physiotherapy fees (0.5%), and miscellaneous fees (3.3%).

NHIF Revenues NHIF reimbursement now represent the largest single source of cost sharing revenue, and during FY 1992/93, average quarterly NHIF reimbursements to district hospitals doubled and reimbursements to sub-district hospitals tripled as a result of improved claiming procedures. Nevertheless, in most hospitals, NHIF reimbursements are less than one-quarter of their potential and on current NHIF collections of about Kshs. 2 million per month, the annual NHIF revenue potential for facilities is KSh. 150 million. This suggests a revenue loss of at least KSh125 million per year due to under collection of NHIF revenue.

Revenue losses due to exemptions and waivers Potential revenue is also lost through waivers and exemptions, the biggest impact of which is upon outpatient collections. In FY 93/94, with implementation of the treatment fee at health centres, implementation of the treatment fee at district and sub-district hospitals and fee increases at hospital, estimated revenue losses from exemptions will be nearly Kshs. 60 million.

Estimated inpatient cash collection for FY 92/93 were roughly Kshs. 20 million. If this amount represented 60% of expected revenue, then the expected revenue would have been Kshs. 33 million, suggesting an inpatient collection gap of about Kshs. 13 million. Comparison of FY 91/92 and FY 92/93 expenditures also suggests the beginning of a shift of basic operating expenses from the recurrent health budget to cost sharing revenue.

Control of resource allocation and expenditure The decline in overall economic performance in Kenya has had an adverse effect on the social sectors of the economy including the health sector. *As a result of the economic decline the Ministry of Health's real allocations per capita have declined significantly, resulting in inadequate funding and shortages of key inputs required to*

maintain adequate standards of care. This is particularly true for certain categories of manpower, drugs, dressings, sera and vaccines, equipment and other essential non-pharmaceutical supplies. *The Ministry of Health is today faced with a crisis where available resources cannot match the demand for services.* This has caused shortages and under utilization of existing health manpower and medical equipment. This situation has been aggravated still further because over 70% of the funds actually allocated to the Ministry's Recurrent Budget are used first and foremost to pay staff salaries and allowances. *This leaves absolutely insufficient resources for operational expenses and in particular the purchase of drugs and dressings.* These fiscal constraints have been further aggravated by the 1993 devaluation of the Kenya shilling. For example, this devaluation reduced the value of the budget line items for drugs and dressings by 53% from US.$13.6 million in July 1992 to US.$5.81 million in July 1993, at a time when the Ministry of Health estimated its annual drugs and dressing requirements to be at least US.$25 million per year[3].

The programme review and forward budget are routine and rigid and imposed ceilings have not allowed growth over and above the traditional 4% annual increment, which does not compensate for inflation, nor for the local costs of foreign exchange. Furthermore, the recent tendency to freeze Ministry of Health expenditures before the closure of the financial year has made control of appropriate expenditure on health care extremely difficult. This has exacerbated the overall shortfall of resources by creating additional artificial imbalances between expenditures on manpower and operations and maintenance. This has again further compromised the quality and quantity of care offered by Ministry of Health facilities and deepened the Ministry's debt arrears. Breaking this rut will require more than this traditional resource allocation approach. Other constraints to the effective and efficient use of health sector resources are related to the limited decentralisation of the executive control of these resources to the district level. These issues are discussed later.

5. DEMOGRAPHIC PROFILE

On the basis of census statistics shown in Table 6, Kenya's population increased from 5.4 million in 1948 to 15.3 million in 1979 and estimated to 24.5 million people by 1993. Estimates from the 1979 census indicated that the population growth rate was 3.8 per cent per annum. This has now declined to 3.4 per cent in 1993. Preliminary results of 1993 Demographic and Health Survey[4] have revealed that the total fertility rate declined from 6.7 children per woman for the period 1984 - 1989 to 5.4 children per woman in 1993. So this means that Kenya has experienced a 20 percent decline in fertility in just over four years, one of the most precipitous ever recorded.

The crude birth rate decreased from 52/1000 in 1979 to 46/1000 in 1993 whereas the crude death rate declined from 14/1000 to 12/1000 over the same period. The infant mortality rate also declined from 104/1000 to 67/1000 in 1993. As a result almost 50 per cent of Kenya's population is under 15 years of age and 10 per cent above 50 years. There appears to be tremendous demographic momentum in Kenya, despite the impressive decline in fertility, with a large pool of sexually active individuals in the 15 to 49 year age cohort. Furthermore, population growth rate in urban areas is over 7 per cent largely attributable to migration from the rural areas.

Predictions of population growth in Kenya must take into account these trends in fertility and mortality, as well as the potential effect of the AIDS epidemic and migration into urban areas. As a result the population of Kenya is expected to grow to between 34-38 million over the next decade, and this will put increasing pressure upon the Government to provide adequate levels of Health Care coverage to a young population.

Table 6. Demographic Indicators 1963 to 1993[5]

INDICATOR	1963	1979	1984	1989/90	1993
Estimated Population	8.90	15.30	18.40	21.40	24.50
Population Growth rate	3.00	3.80	3.70	3.00	3.40
Fertility Rate	6.80	7.90	7.70	6.70	5.40
Population under 15 years	48.00	48.00	48.00	47.00	47.00
Females 15-49 years	27.00	21.00	22.00	22.00	22.00
Population 15-49 years	42.00	43.00	43.00	43.00	43.00
Population 50 years and above	10.00	9.00	9.00	10.00	10.00
Crude Death Rate	20/1000	14/1000	13/1000	12/1000	12/1000
Crude Birth Rate	50/1000	52/1000	50/1000	49/1000	46/1000
Life Expectancy at Birth	44	54	56	58	60
Infant Mortality Rate	120/1000	104/1000	87/1000	74/1000	67/1000
Child Mortality Rate	156/1000	n/a	n/a	n/a	n/a

6. EPIDEMIOLOGIC PROFILE

The burden of disease in Kenya is not well quantified, and much needs to be done to improve the availability and reliability of available information, most of which is derived from reported disease statistics. It is known that there exist marked regional variations in epidemiologic patterns but in general, preventable, vector-borne diseases are the most important causes of morbidity and mortality nationwide. Accurate statistics are not available, however malaria and respiratory diseases account for almost 50% of all reported diagnoses in Government health facilities, and intestinal parasitic infections and diarrhoea increase this to almost 60% of all reported cases.

Reported Disease	Morbidity Rate
Malaria	26%
Respiratory Diseases	22%
Eyes, Ears, Anaemia,Trauma, etc	21%
Others	15%
Skin	7%
Intestinal Parasites	5%
Diarrhoeal Disease	4%
Total	**100%**

Malaria causes more that 25% of all reported illnesses countrywide. In terms of mortality, malaria accounts for 6% mortality of all cases admitted to health institutions, but accounts for 30 - 50% of child death in highly endemic areas.

Diarrhoeal diseases are the fourth leading cause of death in children under five years of age in Kenya and accounts for 4% of all out-patient cases.

The HIV and AIDS epidemic now poses a serious health problem. The National Aids Control Programme (NACP) had reported 39,000 cases of AIDS by August 1993, when it was believed there were about 110,000 people who had contracted the AIDS in the country. It is estimated that some 841,700 people were Human Immuno-deficiency Virus (HIV) positive in 1993, out of which 30,000 were children.

Assuming current trends continue, the HIV positive population is expected to rise from a total of 448,000 in 1990 to about 1,270,000 by 1996, and AIDS related deaths will rise from 20,000 in 1990 to 86,000 in 1996. These projections are presented in Table 7.

From available evidence it as been established that the prevalence of HIV/AIDS in the regions that border Uganda and Lake Victoria and along major trans-African transportation routes of Kitale, Busia and Kisumu is 20 - 30 per cent of relevant populations. The next highest prevalence rates are 10 -20 per cent occurring in Nairobi and along the same route to Mombasa on the Indian Ocean. Lower infections rate have been reported in Kisii, Nyeri, Kitui and Garissa at between 2 - 10 per cent.

Table 7. HIV positive population and aids related deaths by age, sex, and rural urban location.[6]

	1990	1993	1994	1995	1996
HIV Positive Population '000s					
Rural	151	284	334	383	428
Urban	298	558	665	752	842
Male	244	457	537	617	689
Female	205	384	452	518	581
Total	**449**	**841**	**989**	**1135**	**1270**
HIV Related Deaths '000s					
Rural	7	15	19	25	30
Urban	13	29	37	46	56
Male	11	24	30	38	56
Female	9	20	26	33	40
Total	**20**	**44**	**56**	**71**	**96**

Transmission In Kenya, there are three significant modes of transmission: These are heterosexual transmission, which accounts for about 75%, perinatal transmission which accounts for about 23%; and blood transmission which historically accounted for between 3 - 5 %, but which is expected to decline with improved blood screening.

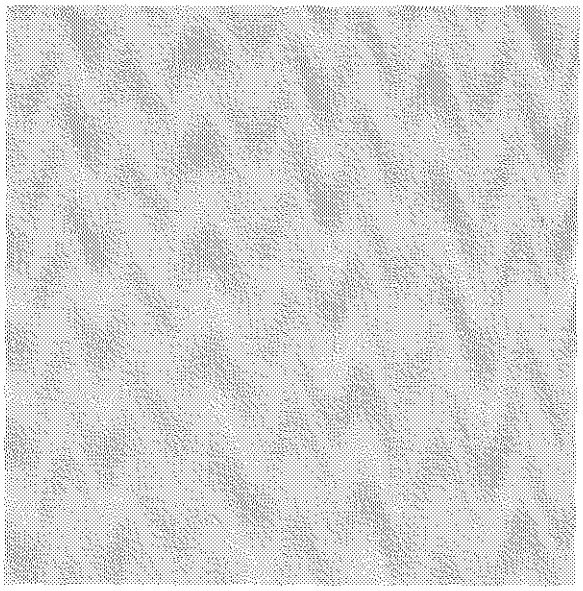
Development issues relating to AIDS The spread of AIDS will have significant effects not only on the demographic compositions of the Kenyan population but also on the social and economic structure of the country.

First, HIV/AIDS is likely to make an important difference to demographic variables for Kenya, including mortality, life expectancy and infant survival. There will be a reduction in some of the gains made in increased child survival and life expectancy. Overall life expectancy could be reduced by up to 17 years by the year 2000. The impact on child survival will be severe because it will be affected both directly through perinatal infection, and indirectly through increased numbers of orphans, who will put severe stresses on communities' ability to maintain them. At present there are estimated to be 150,000 such orphans, increasing to 600,000 by the year 2000.

Secondly, the costs of caring for AIDS patients could be equivalent to the entire 1993/94 recurrent budget of the Ministry of Health by the year 2000. It is predicted that the total direct and indirect costs of AIDS to Kenya could reach 15 per cent of GDP by the year 2000, compared to current cost estimates for 1991 of between 2 - 4 per cent of GDP.

Thirdly, since the prevalence of HIV among Kenyans working in the "modern" sector is approximately twice as high as those working in the small farm sector, the obvious implication of this is that those with a higher socio-economic status are more likely to be infected than those in subsistence farming. Moreover, the epidemic imposes a double burden on women. Already more vulnerable to HIV infection, women are likewise affected by the AIDS epidemic in their role as providers of care in the family and community.

Psychiatric morbidity Empirical research studies in Kenya have consistently shown that approximately 20% of patients seeking outpatient care in both public and private institutions do suffer from some form of mental illness. The majority of these patients present with physical complaints which lead to misdiagnosis and numerous and often repeated wasteful and expensive investigations and prescriptions. Despite acceptance that mental well-being is essential to good health, this apparent widespread psychiatric morbidity has not significantly influenced the planning of health services in Kenya to date.



7. INFRASTRUCTURE PROFILE

Kenya's health infrastructure has grown rapidly since independence, and Table 8 shows that currently there are well over 3,200 health care institutions nationwide. The Ministry of Health administers over 50% of these institutions, and the Ministry of Local Government just over 3%. The remainder are operated by the Private, Mission and NGO sector. With approximately 1,100 MoH dispensaries, 400 health centres and 100 hospitals, the Ministry of Health has built an impressive, pyramidal health referral system extending from Kenyatta National Hospital in the capital city through provincial and district hospitals to rural health centres in major towns and dispensaries in most rural locations.

Construction Despite these major gains perhaps the most crucial factor influencing both the quantity and quality of health care services to be delivered is the planning of where health facilities will or will not be constructed and the types of services they will or will not offer. Capital investments in new public facilities, or in the rehabilitation of old ones, will have substantial long term repercussions upon the recurrent budget of the MoH. Currently, over 70% of that recurrent budget is devoted to the payment

Table 8. Distribution of Health Facilities by Provider and Type[7]

Type	MoH	Private/ Company	Mission	MLG	FPAK	GOK	TOTAL	%
Dispensary	1,158	409	285	28	0	2	1,882	57.36%
R.H.D.C.	32	0	0	0	0	0	32	0.98%
R.H.T.C.	7	0	0	0	0	0	7	0.21%
Mobile Clinics	4	0	12	0	0	0	16	0.49%
Health Centre	350	87	68	31	0	0	536	16.34%
Sub Health Centre	13	1	2	6	0	0	22	0.67%
Health Clinic	51	230	19	39	21	3	363	11.06%
Medical Centre	8	10	3	0	1	0	22	0.67%
Health Programme	0	0	6	1	1	0	8	0.24%
Hospitals	101	43	62	1	0	1	208	6.34%
Maternity Home	2	19	4	6	0	0	31	0.94%
Nursing Home	4	34	2	0	0	0	40	1.22%
Office	103	6	1	0	0	0	110	3.35%
Special Institution	1	0	3	0	0	0	4	0.12%
Total	1,834	839	467	112	23	6	3,281	100.00%
%	55.90%	25.57%	14.23%	3.41%	0.70%	0.18%	100.00%	

of staff salaries and benefits to the detriment of expenditures on other essential items, particularly medicines. The future viability of the public health care system is therefore dependent upon decisions affecting the location of health facilities both by the GOK and other providers, and the type of services, both preventive and curative that they will provide. Plans for the expansion of coverage of public health services have seldom if ever, taken into account the availability to and utilization of Private, NGO and Mission Sector facilities and improvements to the efficiency of public resource allocation and utilization can only be accomplished by considering the respective roles of GOK and non governmental health care providers.

Rehabilitation *The physical infrastructure for health in Kenya has expanded rapidly since independence, but maintenance and upkeep of public sector health facilities has become an insuperable burden for the MoH recurrent budget.* The MoH recognizes that many facilities are in need of repair, rehabilitation, and replacement of basic capital equipment essential to the effective and efficient provision of quality health care, but the expansion of the infrastructure has been paralleled by an increasing shortfall in the level of resources available for maintenance of the growing numbers of fixed facilities. This has resulted in physical deterioration of facilities and their basic equipment, and the MoH is currently engaged in a budget rationalization programme designed to limit new construction and to ensure that existing facilities are brought back to their desired operational status.

Standardisation of equipment, fixtures and vehicles The Ministry of Health has been unable to enforce standards for the types, quality and quantity and compatibility of the vast array of equipment, fixtures and vehicles which it acquires. This has been due in part to pressure and bias imposed by international donors who supply many of these items, and has made cost-efficient maintenance, repair and replacement extremely difficult.

8. PROVIDERS OF HEALTH SERVICES

In the absence of workload data, Table 9 presents a simplified comparison of the percentages of total health sector expenditure, numbers of fixed facilities and manpower attributable to the Ministry of Health and all other providers. It can be seen that the Ministry of Health has the lowest percentage of total expenditure but that this is not reflected in its infrastructure or manpower.

This is despite the tendency for private and mission sector institutions to pay staff significantly higher salaries than the Ministry of Health. What this means is that Ministry of Health institutions are overstaffed in comparison with non-government institutions and staff members are poorly paid.

Furthermore, in Ministry Facilities, as described elsewhere in this document, there is a general lack of the essential inputs required for effective patient care. None of this augers well for providing quality care in MoH facilities, and with the existence of these structural imbalances, it is not surprising that the Ministry is increasingly unable to provide adequate levels of quality care in its institutions.

Compounded with this imbalance within the Ministry of Health, there also exist trends indicating a decline in the quantity and quality of care offered by some Mission facilities. This is matched by increases in the numbers of

private health facilities, with a pronounced urban bias, and a flow of qualified health professionals away from the Ministry of Health towards the private sector.

The assumption that in Kenya the private sector is in general more cost-efficient than the public sector may not be true. A recent study carried out in Kenya on costs and quality of care provided in mission, for-profit

Table 9.Providers of Health Services

Provider	Expenditure	Facilities	Manpower
Ministry of Health Total	43.26%	55.34	69.48%
All Others Total	56.74%	44.66	30.52%

and Government hospitals[8] suggests that for-profit-hospitals (purely private) provide comparable quality care to mission hospitals but at a very high cost. Also, many Government facilities may be providing care at higher than optimum cost and lower than optimum quality, and considerable cost savings may be possible through improvements to management practices without compromising the quality of care delivered.

Other structural problems related to the different providers of health care are all related to the regulatory and facilitative role that the central Ministry of Health should support and nurture.

Private Practice In Kenya today, health care professionals, the great majority of whom are trained at public expense, are tending to leave Government service as soon as they possibly can in search of greener pastures in the private sector where they are establishing private clinics, maternity homes and surgeries. Although not legally entitled to do so, many are engaging in part-time private practice (PTPP) while in the employment of the Government. In a considerable number of cases these professionals have given more time to their part time private practice than to their employer, often to the detriment of the patients who come for medical attention in Government health institutions. Furthermore the mushrooming of unregistered clinics run by staff not licensed under the existing laws has threatened the well-being of the general public.

The legal position Existing health legislation stipulates that no one should engage in private medical practice if not licensed. In the case of doctors and dentists the Medical Practitioners and Dentists Board (MP&DB) is required to regulate medical and dental practice. It is also responsible for ensuring good standards in the practice of medicine through maintenance of professional ethics, and also to protect the public from those who may abuse their privileged position by engaging in professional misconduct.

There is evidence to suggest that present licensing arrangements have loopholes and that inspections of those involved in both part time and full time private practice are both inadequate and too infrequent. These need to be streamlined in the interest of the general public.

Public interest In the better interest of the public, those health boards charged with the responsibility of registering and licensing

practitioners and clinics and maintaining professional ethics and discipline should include representatives of the general public to protect the public interest by ensuring that where `individual' interests conflict with the public interest the latter prevails over the former. This will ensure that the interest of the public is not compromised.

Therefore, while the reasons for the exodus of doctors from the Public Service to the private sector are understood, as are the reasons for PTPP by consultants employed by the Government, both types of services should be regulated to ensure that they comply with the law and with standards of acceptable professional conduct. There exists a need to amend and strengthen the existing Law relating to private practice to ensure that performance in both the public and the private sector is properly regulated.

The prevailing macro-economic climate means that health professionals will continue leaving the public sector to join the private sector where remuneration is more attractive. The Government however has a responsibility to ensure that those leaving have adequate training and experience before leaving so that the well being of the general public is safeguarded.

Provision of support services The control and containment of costs in medical care institutions and the regulation of the quality of care they offer are currently issues of great concern. Many health care institutions in the public and private sectors tend to offer services which are not the most cost effective and efficient, and as a result the quality of care they are able to offer falls short of that required.

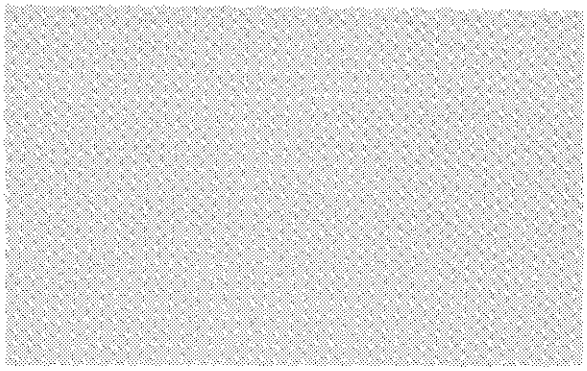
Mechanisms need to be developed which can promote more efficient management and use of the scarce resources available to them. In many countries, support functions such as medical laboratory, pharmacy, cleaning and housekeeping, laundry and restaurant services are contracted out to private sector operators because they are able to provide those services at a lower cost than the parent institution. This practice already exists in some private sector health care facilities in Kenya.

Quality Assurance It has not been possible to uphold and maintain high standards of care, and there is need for strengthening quality control and assurance procedures.

Cross Referral There are no proper procedures on cross-referral between the different providers due to lack of clear policy guidelines, and fee policies between providers are inconsistent

Urban Bias The coverage and distribution of Health Services shows an urban bias, with certain rural communities being under-served especially those in geographically difficult areas.

Community Initiatives There continues to be a gap between the formal health system and the health initiatives that have been developed at the Community Level, such as the Bamako Initiative.



9. HEALTH CARE SERVICES

The Health care system in Kenya has been perceived as being divided in two major divisions, i.e. Curative services and Preventive Health Services, and this has been reflected in patterns of finance. In fact, both should be regarded as elements of the essential integrated health care services that all Kenyans should have access to.

Curative Services in Kenya are provided by the Government and private/NGO sectors. The Government services are organized in a hierarchial system from the smallest and simplest facility (dispensary) to the most complicated and sophisticated (national and teaching hospital.) In between are the health centres, the district hospitals, and the provincial hospitals. The private sector runs hospitals surgeries and clinics.

There has been a bias in the distribution of these services, which has tended to favour the urban areas, and this inequality needs to be addressed.

Mental health services tended to remain static, mainly institutionalised and centralised until the early 1960's, when psychiatric services were decentralised by the establishment of 22 bed psychiatric units in the Provincial General Hospitals. Since then, only seven more psychiatric units have been established in District Hospitals, and some of the remaining districts have established psychiatric outpatient services.

Although the Government clinical services are meant to have a self-regulatory referral system from a lower level to the next higher level, this system does not necessarily work that way. Ideally only those patients needing very highly specialized clinical care need to be referred to national teaching hospital as most of the provincial and some district hospitals are sufficiently equipped.

Private hospitals are well equipped with sophisticated diagnostic facilities, but because of their high cost, these facilities can only be afforded by a few people. Mobile outreach services by both Government and NGOs for communities that have no static health facilities have been established.

Preventive and promotive services A large proportion of patients seen in health institutions in Kenya suffer from communicable diseases, which can be prevented through simple public health interventions. As a result, preventive and promotive health services have formed the major emphasis of Kenya's health policy as a means to reduce the burden of disease. However, this policy is yet to be translated into concrete actions. As shown earlier, in terms of resource allocation, preventive and promotive services only receive approximately 20 per cent of the recurrent health budget.

Preventive/Primary Health Care services, which have been going on through government, NGO, Mission and, to a lesser extent, private initiatives, will need to be integrated, intensified and expanded. These services have been and still are largely dependant upon financial and material support from international donors and do not yet cover the whole country.

The public health interventions that are currently taking place require to be intensified and expanded. These include immunisation against vaccine preventable diseases, use of safe water and sanitation, adequate and proper nutrition, and public health education on health promotion and disease prevention. Special attention will be paid to the major causes of morbidity, mortality and disability, such as malaria, respiratory infections,

diarrhoeal diseases, AIDS and STDs and road traffic accidents.

10. HEALTH PERSONNEL

Preliminary results of a Ministry of Health Manpower and Training study reveal that the number of trained professional health cadres (Doctors, nurses, C.O.'s, PHO/Ts etc) have increased at twice the rate of the population.

The distribution of health personnel The current distribution of health personnel is not equitable. When one considers all persons employed in the health sector, it is apparent from Table 10 that Ministry of Health staff are found predominantly in rural areas 63.67% compared with only 52.07% of those staff employed by other providers, who therefore exhibit a bias towards the provision of services in urban areas.

More detailed analysis reveals the following:

Inequitable distribution among provinces Some provinces have less than 90 key health personnel (MD's, Clinical Officers, Nurses and Public Health Staff) per 100,000 population while other provinces have more than 130 per 100,000.

Concentration of key personnel in urban areas. The major urban areas of Kenya which include about 12% of the population have 375 key Health Personnel per 100,000 while the ratio in the rural areas (88% of the population) have less than 90, a difference of about 400%.

Concentration of personnel in in-patient services. Between 70% and 80% of the key health staff are involved primarily in in-patient curative care. Out-patients services have a manpower deficit of about 50%. Furthermore, over 60% of the in-patients are in the hospitals and health centers with illnesses that are basically preventable.

Table 10. Distribution of Total Health Manpower by Provider

	MOH	OTHER	TOTAL
URBAN	36.33%	47.33%	39.87%
RURAL	63.67%	52.07%	60.13%
TOTAL	**69.48%**	**30.52%**	**100.00%**

11.DRUGS AND PHARMACEUTICAL SUPPLIES

This is perhaps the most critical area where policy reforms are required. Today, the effects of the currency devaluation and subsequent cost inflation have constrained the ability of the Ministry of Health to provide its health facilities with adequate drug supplies. This has become an issue of national importance.

Estimates reflect a need for the local currency equivalent of US$25milllion per year to provide adequate stocks of drugs and dressings in Government facilities, but the FY 1993/94 Ministry of Health recurrent budget only made provision for the local currency equivalent of US$5.8million. Furthermore, since a large share of total Ministry of Health drugs and dressings supplies are provided for in the development budget by contributions from international donors, this calls for the

Government to address the question of the future sustainability of even these supplies.

Despite rising prices, there are no shortages of drugs and dressings in private sector pharmacies. However, the prices of medicines in these retail outlets are beyond the reach of most Kenyans. This places a heavy burden upon vulnerable groups and the solution of these problems presents a serious challenge to the Ministry of Health.

Currently, approximately 50% of the value of all pharmaceuticals consumed in Kenya are those provided in Ministry of Health facilities. Almost 45% are consumed by NGOs and the remaining 5% is consumed by those who pay "out of pocket" in retail outlets[9] Furthermore, over 73% of supplies are imported, a situation which imposes a heavy financial burden upon foreign exchange reserves.

Management of Procurement and Distribution by the Ministry of Health Procurement of drugs and dressings is accomplished by the Ministry of Health through a Departmental Tender Board. Within the Ministry of Health, there exists a drug storage and distribution system with a central warehouse in Nairobi and a well developed network of regional depots in the provinces. Despite major improvements made through a decentralisation of the distribution system, it remains inefficient, and often drugs and dressings do not reach their intended destination.

It is clear that in the opinion of those that make use of Government health services, the availability of drugs is the most important local factor determining that use. As a result, management systems are required that can guarantee the delivery of adequate levels of drugs and dressings to health facilities

National Drug Policy A Kenya National Drugs Policy has been developed which will guide the development of pharmaceutical services and the management and control of human and veterinary medicine well into the next century. The National Drug Policy document was developed through a consultative process involving a series of six major national meetings, with participation by over eighty health professionals and administrators from the Ministry of Health, other Government of Kenya Ministries, the Universities, the private sector, the mission sector, other NGOs, and international organizations.

The goal of the National Drug Policy is to use available resources to develop pharmaceutical services to meet the requirements of all Kenyans in the prevention, diagnosis and treatment of diseases using efficacious, high quality, safe and cost-effective pharmaceutical products. The NDP should serve as the guiding document for legislative reforms, staff development, and management improvements.

12. DECENTRALISATION

A recent study of decentralisation in the health sector in Kenya[10] has shown that the focus of decentralization in Kenya has been on *planning.* Since the inception of the District Focus for Rural Development in the early 80'S, the district has been the administrative focus of Government and therefore of its health care delivery systems. The coordination of cross-sectoral district planning is the responsibility of the District Development Committee(DDC), with health sector plans produced and submitted to them by District Health Management Boards.

In addition, local health planning currently has no reference to a realistic resource framework, plans are rarely taken into consideration in national planning and budgeting, and the center does not usually provide any feedback to districts on their submissions. There is, therefore, little relationship between plans, available funds and actual implementation. Local planning and self-help efforts seldom take into account national policy goals, and are usually concerned with capital development and with time limited 'projects'. Insufficient attention is paid to recurrent cost implications and the long-term sustainability of benefits.

With the introduction of the cost sharing scheme in Government health facilities in 1989, it became clear that more local control of the funds generated by this scheme was required. As a result, in May 1992 a major and significant reform of the public health act created the District Health Management Boards. These Boards, appointed by the Minister of Health are in general empowered to superintend the management of hospital, health centre and dispensary services and support public health care programmes, and specifically to oversee the cost sharing programme. Members of the Board represent the Ministry of Health, the District Administration, Local NGOs and Religious Organisations and the local community.

As a result a quite different model of resources planning has emerged under Cost Sharing. In this case, District Health Management Teams (DHMTs), District Health Management Boards (DHMBs) and facility management teams work closely together in prioritizing needs to be met with funds available from fee income. At this time, District Health Management Boards are only concerned with the use of funds from Cost Sharing and are not directly involved in decisions regarding funds available from the district health vote. However, the Ministry intends that eventually, these Boards assume more responsibility.

The role of the province The provincial medical offices have been superseded by the district under the present decentralization policy. This has been recognised as a problem for the effective operation of health services in Kenya, and the Ministry of Health is committed to reforming and strengthening the Provinces.

Central functions and structures Vertical programme management and cadre-specific personnel management and technical support remain powerful factors in maintaining a centrally controlled system. Information and reporting systems as well as personnel management continue along vertical lines, fostering cadre-specific loyalties rather than horizontal integration at district level.

Apart from decentralized planning systems, most other management systems have remained centralized. Districts and provinces have little opportunity for making contributions to policy development. Although policy development must be centrally coordinated, a more structured participatory process for reviewing policy options can be established. One of the objectives of the district focus policy is improved equity. however, the role and responsibility of central government in safeguarding equity by subsidizing poorer districts with a weak income base, poor infrastructure and a smaller share of trained manpower, is not clearly spelled out.

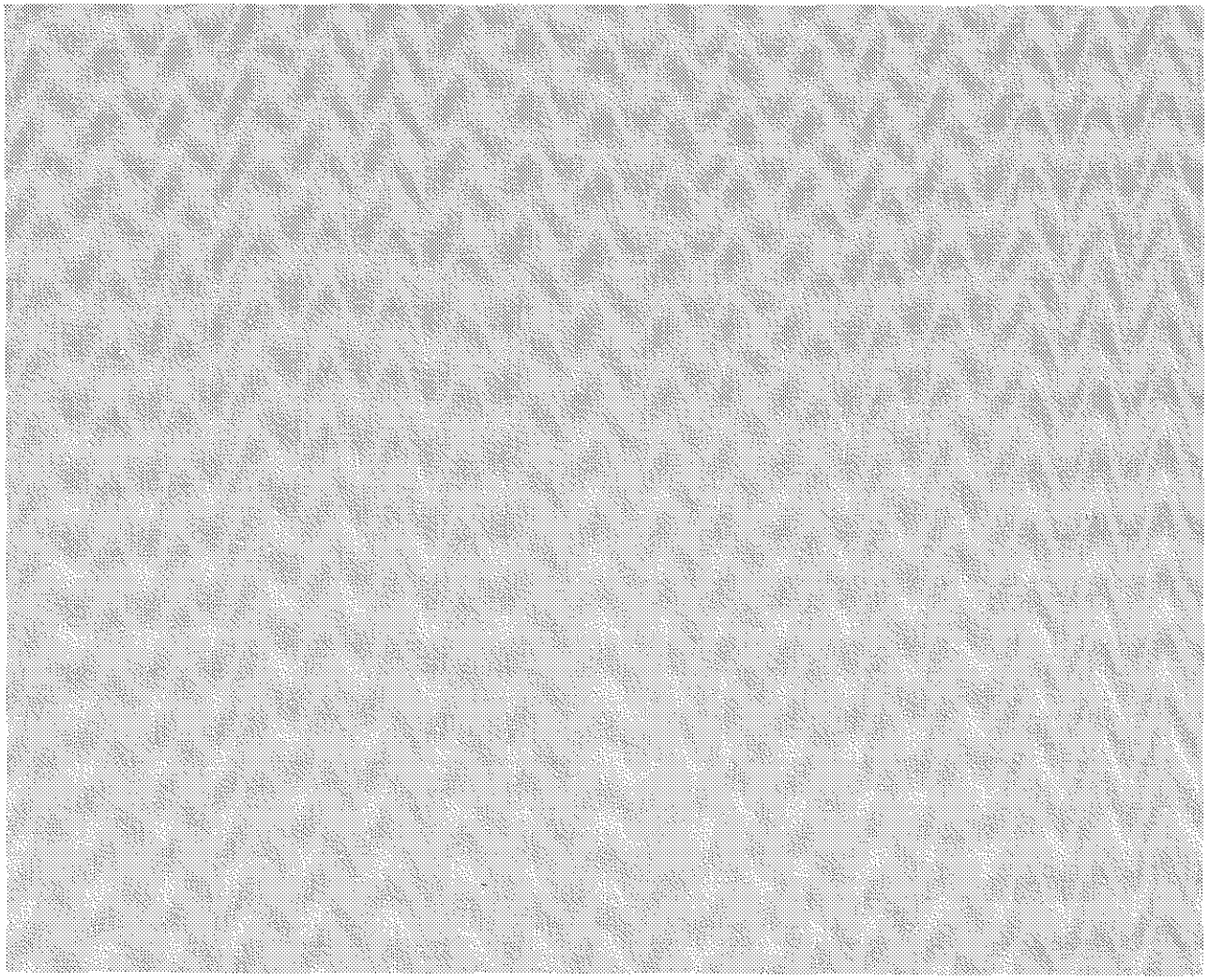
Setting priorities and monitoring health systems performance Standards for health systems performance, criteria for priority setting, including epidemiological and demographic factors, cost and efficacy of

proposed interventions, and capacity for implementation, are not well defined.

Private and NGO sector Information on the scope and scale of activities by private health care providers, including private pharmacies, is difficult to obtain, and relations with NGOs and missions range from close collaboration to relatively separate and uncoordinated project activities.

Health services operated by local councils are poorly managed, underfinanced, and technically not well supported. In most instances, fee income appears to go to the general pool rather than to health activities.

It is therefore clear that although the decentralisation process in Kenya, and in the health sector in particular is underway, a lot remains to done in delegating *real* authority to the districts. At the same time, it will be essential to ensure that the centre is appropriately oriented to fulfilling its role in spelling out national policy, and in coordinating, monitoring and supporting policy implementation in districts. The revitalization of the intermediate level, the province, will be important for facilitating this process.



Part 2
STRATEGIC IMPERATIVES

This section of the policy framework paper presents a series of strategies developed by Senior Ministry Officials which mirror the situational analyses presented in Part I, and which identify the major strategies to be employed in improving the overall function of the sector.

The strategic theme embodied in the policy reforms elaborated in Part III of this document is that of ***Investing in Health***. A number of strategic imperatives exist which describe the general direction in which health policy should be leading the health sector in Kenya, and these imperatives are set out here to meet a very clear and specific goal which unifies all health policies under one banner.

The overall goal of health sector policy until the year 2010 will be

> ***To promote and improve the health status of all Kenyans through the deliberate restructuring of the health sector to make all health services more effective, accessible and affordable.***

The *strategic imperatives* which have been identified are listed on the left and the particular *strategies* which will be adopted to address them are listed on the right as follows:

1. ENSURE THE EQUITABLE ALLOCATION OF GOVERNMENT RESOURCES TO REDUCE DISPARITIES IN HEALTH STATUS

- Development of a combined epidemiological and micro-economic framework for health planning. Planning for all health resources to be linked to analyses of health status and a clear definition of the types and scale of cost-effective interventions that will ensure nationwide, equitable access to essential curative as well as preventive services.
- Development, adoption and use of standard criteria for the geographic allocation of resources
- Development, adoption and use of standard criteria for the allocation of resources to individual health facilities

2. INCREASE THE COST EFFECTIVENESS AND THE COST EFFICIENCY OF RESOURCE ALLOCATION AND USE

- Estimation of the burden of physical and mental disease and ill health in Kenya and of the local cost effectiveness of a variety of interventions aimed at reducing the burden of disease and ill health.
- Definition and prioritisation of the essential and most cost effective curative and preventive health services which must be provided in all regions of Kenya
- Definition of the types and levels of essential curative and preventive health services to be provided by each type of health care institution in each region
- Adjustment of institutional health budgets to local conditions on the basis of historical workload data, local disease incidence and prevalence rates and Government budgetary ceilings.
- Establishment of norms defining an appropriate mix of personnel and operations and maintenance inputs at all levels in order to obtain optimal performance and efficiency.
- Control and containment of the unit costs of service delivery through sound management practice, including the contracting of some services to the private or mission sector where those providers are shown to be the most cost effective.

2. INCREASE THE COST EFFECTIVENESS AND THE COST EFFICIENCY OF RESOURCE ALLOCATION AND USE (continued)

- Expansion of the capacity of health planners and managers at all levels to collect, analyses, interpret and make use of health planning and financial data at source to monitor and evaluate the impact of efforts to reduce the burden of disease and disability.
- Institutionalise information systems and operational research methods to establish health service utilisation patterns and their determinants as a means of improving service coverage, accessibility and availability

3. CONTINUE TO MANAGE POPULATION GROWTH

- Increase the numbers of service delivery points for family planning services.
- Increase and diversify the range of available family planning services
- Intensify efforts in fertility control by increasing community participation
- Identify and focus upon areas of unmet needs, such as services to the youth through family life education and promotion of safe motherhood.
- Promote and increase in maternal literacy rates and educational attainment through collaboration with the Ministries of Education and Culture and Social Services.
- Promotion of fora to examine the sensitive issue of youth contraceptives by involving all the concerned parties

4. ENHANCE THE REGULATORY ROLE OF THE GOVERNMENT IN ALL ASPECTS OF HEALTH CARE PROVISION

- Strengthening of the central public policy-making role of the Ministry of Health headquarters by further devolving executive operations to the provinces and districts.
- Strengthening the enforcement of the MOH's regulatory powers over other health providers as stipulated in the Public Health Act Cap 242 and related health legislation.
- Remodelling and reinforcing the provincial tier of the health system and devolving to it responsibility for oversight of the implementation of health policy, the maintenance of standards of quality and performance, and the coordination, regulation and control of all health services in both the public and private sectors
- Extension of the roles and responsibilities of the DHMBs to permit them to control and oversee all health services in their districts in both the public and private sectors.
- Creation of local hospital management boards to superintend the management of Ministry of Health hospitals.
- Continuing the process of gradual decentralization of the management and control of resources to lower level institutions. This would result in empowerment of local institutions to be both responsible and accountable for the resources provided from the central level as well as from the district and lower levels.
- Building the capacity of the district and lower levels through training in modern management and planning methods to permit them to better fulfill their operational responsibilities and functions.

5. CREATE AN ENABLING ENVIRONMENT FOR INCREASED PRIVATE SECTOR AND COMMUNITY INVOLVEMENT IN HEALTH SERVICE PROVISION AND FINANCE

- Creating a formal set of fora and avenues for dialogue and collaboration between the Ministry of Health and other health providers.
- Promising/Offering Government material (e.g. land) and financial (e.g. tax exemptions) incentives to encourage the provision of essential and discretionary health services by the private sector and NGOs in underserved areas
- Effecting amendments to relevant legislation to facilitate and streamline the registration and licensing of private and NGO health providers and institutions.

6. INCREASE AND DIVERSIFY PER CAPITA FINANCIAL FLOWS TO THE HEALTH SECTOR

- Maintaining or expanding in real terms the present budgetary allocations to the public health sector while striving to close the gap of underfinancing.
- Developing closer functional linkages between mandatory health insurance and coverage of essential clinical care services.
- Reviewing NHIF to extend and diversify the range of benefits and to overhaul fund management with a view to converting NHIF from a Hospital to a Health Insurance Fund.
- Expanding the role of other social financing mechanisms by increasing coverage beyond the formal sector, by encouraging private incentives through legislative measures
- Expansion of beneficiary contributions through cost sharing by review of fee levels, structure and collection efficiency, and changes to exemption and waiver policies.
- Continuing to use 75% of cost sharing revenues to protect, strengthen and further improve the clinical performance of hospitals. The list of contributors should be expanded and amount of contributions increased.
- Exploration of the feasibility and sustainability of *Bamako Initiative* type mechanisms to mobilise resources from communities.

Part 3
THE AGENDA FOR REFORM

This final section contains a description of those policies adopted by the Ministry of Health as a means of applying the strategies identified in Part II to address the constraints described in Part I. It also identifies where in the absence of clear policies, these will be formulated after careful study as part of an overall policy reform program.

Therefore, to meet the goal of strategic health policy as set out in section II of this Policy Framework Paper, and to respond to the future health needs of the Kenyan people, the Ministry of Health is committed to act and to implementing the following reforms of the health sector:

1. STRENGTHENING THE CENTRAL PUBLIC POLICY ROLE OF THE MINISTRY IN ALL MATTERS PERTAINING TO HEALTH.

- **Creation of a forum for the periodic review and revision of comprehensive health sector policy.** This will be achieved by amending the Public Health Act to give the Central Board of Health greater responsibility for guiding National Health Policy, and the Ministry of Health greater responsibility for its implementation. This will lead to the operationalisation of a high level Health Sector Policy Review and Implementation Committee at Ministry of Health Headquarters.

- **Elaboration and Implementation of Specific Policies** The Ministry of Health will take the lead in ensuring that health sector policies are elaborated and implemented, and where necessary, suitable legislation is either enacted or amended. The areas of policy to be considered in the immediate future and described in detail later include:

    - adoption of an explicit strategy to reduce the burden of disease among the Kenyan population and definition of those cost effective and essential curative and preventive services which will be provided for by the Ministry of Health

    - reinforcement of the Provincial level to permit effective superintendence of the districts and further decentralization of planning, management and resource creation, control and use to the districts.

- strengthening of NGO, Local Authority, private and mission sector health service providers

- generation of increased levels of financial resources for the provision of cost-effective services through widely accepted cost sharing and alternative health financing initiatives.

- shifting part of the financial burden of essential care from the Ministry of Health budget to insurance schemes.

- further reduction in the rate of construction of new government facilities and a focus on consolidation, rehabilitation and maintenance of existing ones based on need and their cost effectiveness in delivering health care.

- increasing the level of adequate human, financial and organizational resources to properly maintain and repair facilities and equipment

- reorientation, retraining and redeployment of health manpower to meet manpower demand projections and resource availability.

- prevention and control of AIDS, HIV infection and sexually transmitted diseases.

- adoption and implementation of a national drug policy

- consolidation and strengthening of key health management information systems to support the policy-making role of the Ministry of Health in budgeting, planning and management functions in the districts.

- institutionalization of management tools for cost containment and cost control particularly for the hospital and curative sector.

- strengthening of health research

- reorientation of the organization, structure and function of the Ministry of Health to meet the proposed reforms.

- **Regulation and Enforcement.** The Government will continue to regulate the health sector and the provision of services through enforcement of regulatory legislation as stipulated in the following Laws of Kenya: Cap. 242 Public Health Act, Cap. 243 Radiation Protection Act, Cap. 244 Pharmacy and Poisons Act, Cap. 245 Dangerous Drugs Act,Cap. 246 Malaria Prevention Act, Cap. 248 Mental Health Act (1989), Cap. 253 Medical Practitioners and Dentists Act, Cap. 257 Nurses Act,Cap. 260 Clinical Officers (Training, Registration and Licensing) Act, Cap. 255 National Hospital Insurance Act, Cap. 254 Food, Drugs and Chemical Substances Act, Cap. 364 Animal Diseases Act.

This strengthening of the public policy making role of the central Ministry of Health will

therefore focus upon the following key issues:

- **Expansion of Health Service Coverage.** The Government will continue to promote the expansion of health care services in underserved areas and will provide care to the majority poor staying in the rural and urban areas. This will be achieved through regulatory measures which will encourage the proliferation of the private, Mission and NGO sectors by providing material and financial incentives to providers operating or establishing clinics in underserved areas.

- **Equity.** One of the objectives of the district focus policy is improved equity. The Ministry of Health will develop standard criteria for the equitable allocation of its human and financial resources to regions and to individual facilities. The subsequent utilisation of these criteria for planning and budgeting and controlling disbursements will safeguard equity by subsidizing poorer districts with a weak income base, poor infrastructure and a smaller share of trained manpower.

- **Quality Assurance.** The Government will enhance the regular quality control and quality assurance of care through statutory and management inspections with the aim of maximizing efficiency in man and machines commensurate with the investments made.

2. ADOPTION OF AN EXPLICIT STRATEGY TO REDUCE THE BURDEN OF DISEASE AMONG THE KENYAN POPULATION AND DEFINITION OF THOSE COST EFFECTIVE AND ESSENTIAL CURATIVE AND PREVENTIVE SERVICES WHICH WILL BE PROVIDED FOR BY THE MINISTRY OF HEALTH.

To be able to improve the effectiveness and efficiency of the allocation and use of health sector resources, it is necessary to first define those curative and preventive health care interventions considered to be absolutely essential to reducing the burden of disease amongst the people of Kenya, and which are affordable, to both the Government and to their beneficiaries

Two vital steps need to be taken to define those essential interventions. First, the burden of disease experienced by the people of Kenya must be measured and quantified, so that the major causes of morbidity and mortality can be identified and ranked according to their importance. Their importance will be measured in terms of their contribution to a reduction in disability-adjusted life years (DALYs) lost by the population.

Second, the various interventions which can be employed to either prevent or treat these priority diseases and or conditions must be costed at local prices, to that the local costs of averting them may be compared.

Calculation of the local costs of specific health care interventions and their individual contribution to the reduction of DALYs lost will permit comparisons to be made of the costs and effectiveness of each intervention as they relate to a reduction in the burden of disease in Kenya.

Finally, comparison of the total costs of each intervention must be related to the estimated levels of resources which will be available to the health sector, both from the Government

and other sources. Then, given the future resource constraints which will be imposed by the Treasury, the MoH will be able to define those services which it will be able to guarantee, and finance, and those additional services which can be provided should incremental resources be available over and above those provided by the Treasury.

Once those essential services have been defined, all Government facilities would be expected and required to provide them. The quantity of those services to be provided and their costs would then be determined by local variations in disease incidence and prevalence and the local costs of providing the services. Hence the allocation of public health sector resources would become more equitable, as allocations would be controlled by factors which seek to maximise the effectiveness of those resources in reducing of the local burden of disease. The basic package of care would remain consistent across all regions, but local costs would be determined by local disease rates.

Such reform measures are intended to reduce demand for curative services and to free more financial and other resources for public health interventions and primary health care. This in turn will still further reduce the demand for curative care and lead to improvements of the quality of both preventive/promotive and curative services provided by the public health sector This realization will make possible further reforms in cost-sharing initiatives as public confidence is enhanced. These reforms will be accomplished in the following manner:

Curative Care. The Ministry of Health will *contain* and *target* government expenditures on curative care, particularly in hospitals. This will be achieved by developing an essential curative care package. Projected increases in demand for non-essential curative care will be met not through increases in Ministry services, but through increases in private, mission and other non-government care. Over the next decade this should reduce the Ministry share of inpatient services roughly from 50% to 40% and its share of outpatient care from 40% to 30%. Such a shift will require strict control of health facility plans and staffing, efficiency improvements, and use cost sharing revenues to discourage unnecessary care. Government curative care will be focussed on target groups such as mothers and children, those unable to pay for basic services and patients with communicable diseases and mental illnesses.

Preventive and Promotive Health Care. The Ministry of Health will *intensify* and *expand* the coverage of its preventive and promotive health care interventions through the development of an Essential Preventive/Primary Health Care Package for Kenya, with a concomitant preferential allocation of incremental resources towards these services. This will include promotion of ante- and post-natal care, well baby care, breast-feeding, improved diet and nutrition, health education and family planning in a comprehensive safe motherhood programme, as well as a strengthening of Community Based Health Care activities aimed at enabling individuals to assume responsibility for their own health. There will be an expansion and further integration of already existing preventive/promotive programmes such as the Kenya Expanded Programme on Immunization, Family Planning, AIDS and STD prevention and control, the National Mental Health Programme, Environmental Health including food safety measures, the provision of safe water, proper sanitation and housing and vector control, This will be achieved by expansion of the *Bamako Initiative* which is aimed at strengthening Primary Health Care through ensuring essential or basic preventive, promotive, curative and rehabilitative care at

the household level. Likewise, there will be further development and consolidation of programmes for the prevention of substance abuse and for injury and accident control and prevention.

3. REINFORCEMENT OF THE PROVINCIAL LEVEL TO PERMIT EFFECTIVE SUPERINTENDENCE OF THE DISTRICTS AND FURTHER DECENTRALIZATION OF PLANNING, MANAGEMENT AND RESOURCE CREATION, CONTROL AND USE TO THE DISTRICTS.

Decentralisation Policy. After thorough examination of the issues, a National Policy concerning decentralisation in the Health Sector will be prepared, adopted and implemented.Consideration will be given to fully decentralizing decisions regarding at least the non-salary operating budget for health.

Policy Dialogue. Districts and provinces have little opportunity for making contributions to policy development. Although policy development must be centrally coordinated, a more structured participatory process for reviewing policy options will be established. Regular meetings involving senior officers from central, provincial and district levels to discuss specific policy issues could be followed up by working groups involving different levels of the system who would analyze policy options for consideration by the MOH senior management.

Management Systems. Apart from decentralized planning systems, most other management systems have remained centralized. A careful review of roles and responsibilities at different levels of the system with regard to all major management functions will be carried out to determine which functions are essentially central (such as drug procurement and basic training) and which could be potentially decentralized. *However, it is certain that manpower management information systems currently under development will be fully decentralised to the districts to give them far greater responsibility for the day to day management of personnel and for planning and budgeting.*

The Provinces. The Provincial Medical Offices have were been superseded by those of the district level under the present decentralization policy. This has been recognised as a problem for the effective operation of health services in Kenya, and the Ministry of Health is committed to reforming and strengthening the Provinces. It is proposing to the Government supplementary legislation which will convert the Provincial Medical Offices to an inspectorate arm of the Ministry, empowering the Provinces to assume a greater level of responsibility than they enjoy at present. This legislation will create a Provincial Health Inspectorate, and a number of functions which are currently centralized will be devolved to them. These include monitoring health systems performance, management and financial audit, continuing education and on-the-job training, and support for problem-based operational research. Their responsibility will be to oversee the implementation of health policy, the maintenance of standards of quality and performance, and the coordination, regulation and control of all health services in both the public and private sectors in their areas of jurisdiction. This new institution will be a vehicle for the implementation of national health policy and provide a strong intermediary between the central Ministry and Districts.

District Level Planning, Budgeting and Control of Resource Use. The current *needs-based* approach to district planning and budgeting, drawing on "wish lists" elicited from communities and locational authorities, will shift to a *resource-based* model. A key aspect of resource-based planning will be the production of budgets which are not simply inflated 'bidding documents' but convey a sense of realism and provide sensible and convincing justifications and explanations about trade-offs between competing priorities. These budgets will reflect strategies set out in a national framework for health development, which will define those essential curative and preventive services to be provided, but which will be adjusted to local conditions and requirements. Information about flow of funds at district level is poor. In order to facilitate financial management, the link between planning, preparation and approval of estimates, cash-flow, release of funds and actual expenditure needs to be improved. Improved financial information systems need to be put in place to ensure transparency in all financial transactions.

Management Boards. To-date the role of the *District Health Management Boards (DHMBs)* has been limited to oversee the management of cost sharing monies. This will be extended to permit them to oversee all health sector activities within their districts. This will be coupled with the formation of *Hospital Management Boards* to manage Ministry of Health hospitals. To reinforce this important innovation, DHMBs, DHMTs and HMBs will receive training and material support to promote more effective operations. These changes will call for amendment of the appropriate legislation in order to enable the Boards to assume much broader roles. At the lower level, health centre and dispensary committees will be established to enhance the functioning of these facilities and promote community ownership.

Management Teams. To effectively implement present and future health policies the DHMBs will need greater support from the *District Health Management Teams (DHMTs)* which will be expanded and trained in modern management and planning methods to permit them to better fulfill their operational responsibilities and functions. The proposed strengthening of district level planning and management combined with effective leadership from the DHMBs will make health management more effective and responsive to local needs, thereby improving accountability and reducing inefficiencies.

Diagnostic Facilities. Medical diagnostic facilities (laboratory and radiological) at the Health Centre level will be strengthened so as to elevate the standard of clinical care at that level. This will promote more cost-effective clinical services.

Manpower. The critical clinical staff (doctors, nurses and clinical officers) at the Health Centre level will be strengthened so as to improve the clinical performance of the health centres. This will improve the referral system of patients.

Outreach and Mobile Clinical Services. These will be intensified in the remote areas with nomadic and semi nomadic populations, as well as in other under-served areas, particularly in urban slums.

4. STRENGTHENING OF NGO, LOCAL AUTHORITY, PRIVATE AND MISSION SECTOR HEALTH SERVICE PROVIDERS

This will be achieved by providing an *Enabling Environment* for their expansion to take on incremental health services over and above those which the Government undertakes to provide. This may include subsidizing or contracting these services in areas where the

Ministry of Health is not able to cater for the population specifically.

Regulating the standards of ethics and quality of care. It will be necessary to ensure that the quality of care and standards of medical practice and professional ethics meet what is stipulated in the regulatory health legislation in the Laws of Kenya. To better respond to the needs of patients and health care professionals alike, the main legislation must be amended to provide for an inspectorate and for the institution of proper regulatory mechanisms. This will entail regulating private practice to ensure compliance with the relevant laws and regulations concerning to standards of care and maintenance of good medical practice, as well as the regulation of part time private practice (PTPP) by Consultants employed by the Government to ensure that they provide the services for which they are paid.

Licensing of practitioners. It is apparent that the legal framework for the practice of the medical professions needs to be revised so that private practice becomes easier to initiate, but is regulated in such a manner that the quality and costs of care delivered are maintained at levels acceptable to both providers and beneficiaries. At the same time, those who choose to remain in practice in Government health care institutions must be offered the necessary financial and professional incentives to do so. The legislation governing private practice of the medical professions and the rules governing *part-time* private practice (PTPP) by consultants employed by the Government requires revision. Currently part-time private practice is not addressed by the Medical Practitioners and Dentists Act, but is covered by an administrative arrangement allowing doctors in Government service to engage in PTPP due to demand for specialized services outside Ministry of Health Institutions. In the interest of the public PTPP should be well regulated by the Ministry of Health and by the respective Professional Boards. Consultants should be well informed that abuses of this practice could lead to withdrawal of privileges and discipline for professional misconduct.

Also, in the interest of the general public the respective Boards will be required to define what constitutes professional misconduct and such definition should be made available to all the professionals concerned. The training curricula should give more emphasis to professional ethics than is the case at present.

Increasing the share of curative care provided by non-government sources. Shifting a proportionally greater burden of curative care to private, mission and other non-governmental sources will require reducing government imposed costs and constraints, strengthening the financial viability of mission health services, and expanding insurance coverage and benefits. The government will provide incentives to those practitioners who wish to establish private practice in under served areas.

Following completion of a study currently underway, a National Policy defining the relative roles and responsibilities of Government and Non Government Providers and Health Care will be prepared, adopted and implemented.

Increased Coverage of Family Planning Services by Non Government Providers. The Government and Private, Mission and NGO providers all need to increase the numbers of service delivery points for Family Planning. Research will be carried out to establish cultural factors that inhibit acceptance of family planning acceptance. The sensitive issue of youth and their use of contraceptives will also be examined and solutions developed.

5. GENERATION OF INCREASED LEVELS OF FINANCIAL RESOURCES FOR THE PROVISION OF COST-EFFECTIVE SERVICES THROUGH WIDELY ACCEPTED COST SHARING AND ALTERNATIVE HEALTH FINANCING INITIATIVES.

Communities and other institutions' efforts and resources must be harnessed and directed towards improving the health of the individual, family, community and the Nation. Gaps between resources and need can only be filled when bold decisions are taken to reverse the resources allocation. Otherwise resources will continue to be directed to curative services which are not cost-effective. The Government cannot afford to sustain huge expenditure on curative care in hospitals and health centres. In the process towards this objective three important principles have to be recognized and taken into account.

- Achievement of cost-effectiveness
- Responsibility of individual, family, community, self-help group, NGOs and private sector in health delivery
- That within Government, the Ministry of Health is not solely responsible for health delivery but shares this responsibility with others such as Ministries of Local Government, Water Development, Agriculture and Livestock, Education.

It is important to note that Government revenue base is in-elastic while the demand for health services grows with the increasing population. The additional resources required to maintain the level of services, therefore, will have to be obtained through a re-ordering of priorities between curative and preventive and promotive health services and raising of additional resources through widely accepted cost-sharing initiatives.

Five Year Plan for Financing Health Care in Kenya This well formulated plan will be fully implemented, and in particular there will be:

- **Increased public funding for primary and preventive (P/PHC) services.** Over the next five years Ministry financing of P/PHC should rise from the current 20% to 30% of recurrent expenditures. This will be achieved through preferential allocation of central budget increases and district level user fee revenue to P/PHC.

- **Increased Ministry of Health Revenue Generation** Cost Sharing revenues should increase from the current 7% to 30% of non-staff expenditures. This will be accomplished through increases in NHIF claiming, improved collection efficiency, periodic fee increases and control of exemptions.

Long Term Options. Longer term options which are under consideration include the provision of block grants from the Government to districts. Under these arrangements district level planners and managers will have the option of restructuring health services in a manner that best suits both local circumstances and the levels of resources they are allocated and those local funds they can raise from cost sharing and other local initiatives.

6. SHIFTING PART OF THE FINANCIAL BURDEN OF CURATIVE CARE FROM THE MINISTRY OF HEALTH BUDGET TO INSURANCE SCHEMES.

This will require a review of NHIF with a view to reforming it and seek possibility of other types of health insurance.

Expansion of the role of NHIF and other social financing mechanisms Through policy leadership, legislation, regulation and education the Ministry will work to strengthen the role of NHIF, increase the population covered by health insurance (both NHIF and private), broaden insurance benefits, and increase community financing efforts. The expansion of existing private and community insurance schemes will be promoted through the forging of links with these financing institutions.

Expansion of Mandatory Insurance Coverage. The NHIF will be encouraged to develop and expand its benefits package to cover more than reimbursement for board and lodging in hospitals and nursing homes. In this manner, it will become a National Health Insurance Fund. Likewise, the creation of an enabling environment for the expansion of private practices into underserved areas will be examined, with a view towards NHIF offering loans for the establishment of these practices at preferential rates.

7. FURTHER REDUCTION IN THE RATE OF CONSTRUCTION OF NEW GOVERNMENT FACILITIES AND A FOCUS ON CONSOLIDATION, REHABILITATION AND MAINTENANCE OF EXISTING ONES BASED ON NEED AND THEIR COST EFFECTIVENESS IN DELIVERING HEALTH CARE.

National Policy on Development of Physical Facilities and Major Equipment. To guide and improve public investments in health facilities and equipment, a national policy on the development of physical facilities and equipment will be prepared and implemented. This national policy will govern the future choice of type and location of physical facilities and equipment by all providers, and will seek to limit new construction only to those facilities considered necessary to provide equitable access to essential curative and preventive services. Guidelines will be developed for the provinces and districts which will permit them to decide where additional facilities or services should be located in their areas of jurisdiction. At the same time, the policy will define the requirements for the rehabilitation of existing facilities and equipment and for their continued maintenance and repair.

Two ongoing studies are designed to assist the Ministry of Health to prepare these policy guidelines. The first will examine the current distribution of facilities and services nationwide, including those belonging to both the Government and the Private and Mission Sectors, and will make recommendations for improving equity in their spatial distribution, and will provide cost estimates for their future operation.

The second study will survey the rehabilitation needs of existing buildings, plant and medical equipment in Ministry of Health Hospitals, Medical Training Centres and Rural Health Training Centres, and will provide budgetary estimates of the investment costs required to bring them to a satisfactory level of performance. This will be combined with existing data concerning rural Health Centres and Dispensaries to ensure completeness.

The combination of the outputs from these two studies and the development of appropriate policy guidelines will contribute to the preparation of a long term Public Investment Plan for the health sector by the Ministry of Health which will channel future investments towards a more equitable and sustainable provision of health care services in Kenya.

8. INCREASING THE LEVEL OF ADEQUATE HUMAN, FINANCIAL AND ORGANIZATIONAL RESOURCES TO PROPERLY MAINTAIN AND REPAIR FACILITIES AND EQUIPMENT

Standardisation. For the MOH to manage a viable preventive maintenance operation for buildings, biomedical equipment and its fleet of vehicles it will have to standardize the equipment, vehicles and fixtures used by the Ministry, and which are often imported. This will enable the MOH to build the required stocks of spare parts which is currently not possible due to lack of standardization.

Rehabilitation The Ministry of Health, with investment aid from the World Bank, ADB and other donors will bring these infrastructure up the standards expected for the effective and efficient provision of quality health care. This will involve the rehabilitation and re-equipping of certain facilities, and will require considerable investments over at least the next five years. The planning of these investments will form an essential component of a Public Investment Plan for the health sector in Kenya, which will seek to demonstrate the priority areas of investment which are required to ensure that the MoH can advance its policy of ensuring that quality health care is delivered to the nation. Initially, to ensure smooth and effective and above all sustainable implementation, the Ministry of Health will therefore focus upon the rehabilitation and re-equipping of priority facilities in those districts with an ongoing maintenance programme, and will thereafter continue to expand the existing maintenance programme to other priority districts.

Maintenance The Ministry will take steps to increase the budgetary allocations and actual expenditures on preventive maintenance as a means of protecting its fixed assets from deterioration. This will be done through requesting the Treasury to provide more funds for maintenance. At the same time, resources will be mobilised from Cost Sharing revenues to supplement those available from the Ministry

9. REORIENTATION, RETRAINING AND REDEPLOYMENT OF HEALTH MANPOWER TO MEET MANPOWER DEMAND PROJECTIONS AND RESOURCE AVAILABILITY.

Health Manpower and Training Policy The Ministry is finalising a major study designed to reformulate its National Manpower and Training Policies. It is expected that the revised policies will focus upon the following issues.

Priority in resource deployment. Personnel and supplies must be directed to the peripheral

dispensaries and health centers. If effectively managed, this should reduce the workload at hospitals. Clear staffing norms will be developed to form the basis for future personnel policy geared towards making smaller facilities functional and adequately staffed so as to enhance their outpatient services. Similar norms for manpower allocations and postings to the districts will be set.

District Health Management Teams will be given greater authority with regard to personnel management, including posting, transfers and staff discipline.

Types of Health Professional. Using staffing norms, policies will be directed towards ensuring that there exists a proper ratio amongst the various cadres. These ratios will be used to control either increases or reductions in the numbers of certain cadres trained at public expense. At the same time, training of essential clinical specialists will be closely controlled and monitored to ensure the availability of the most critical cadres.

Redeployment It will be necessary to redeploy some staff from in-patient services in favour of out-patient and community based services. Priority will be given to the deployment of newly trained staff to under served provinces and rural health facilities. Ceilings will be imposed upon the numbers of Ministry of Health personnel deployed to hospitals and large urban facilities, and this may mean the establishment of targets for the number of Ministry of Health hospital beds which will receive support.

Basic Education of Health Professionals This will be reformed to ensure they have a high level of skill to deal with the problems of curative care and in preventive strategies. It will be necessary to meet projections of future demand given current attrition rates from the existing supply of health personnel. This will include curricula reform, substantial training of trainers and administrative staff and the establishment of a full time professional trainers scheme of service and benefits.

The Organization of a Decentralized Continuing Education Strategy This will strengthen the basic skills of personnel already in service. Elements of the strategy will include:

- Continuing Education Units with full time staff in each District.
- A core programme based upon epidemiological data and other assessments of training needs.
- Adaptations of the core programme to local conditions.
- Ongoing monitoring and performance based assessments.

Management and Regulatory Reform. There will be a number of changes for strengthening personnel management, increasing their effectiveness and efficiency personnel retaining and attracting qualified staff, zero growth budgeting for staff and the creation of a balance between urban and rural staff deployment through the following measures:

- **Harmonization of policies** among cadres who wish to leave the public sector and enter into private practice
- **Pay scales and terms of service.** Health professionals' terms and conditions of service will be improved to assure basic individual needs.
- **Hardship pay and other incentives.** It is critical to deploy and retain staff at facilities in the rural areas where more than 85% of the population lives. A

system to encourage rural staff retention will be established. The classification of hardship areas needs to be reviewed to improve the incentive and benefits structure.

- **Subordinate Staff.** The Ministry of Health will have to drastically reduce the number of subordinate staff on its payroll. District will be empowered to recruit subordinate staff in accordance with the needs of their facilities and they will be expected to meet their costs from new and innovative sources.

- **Targets** Similarly, the Ministry of Health will have to set targets for other health personnel to be paid in each District using a *weighted capitation* formula. Additional staff could be hired and paid directly at the District level.

10. PREVENTION AND CONTROL OF AIDS, HIV INFECTION AND SEXUALLY TRANSMITTED DISEASES.

Given the potential of the AIDS/HIV epidemic to negate health gains since Independence, the Government recognises the special status it must accord to this problem. The main goal of the Government will be to slow down and eventually halt the progression of the AIDS epidemic in Kenya through:

Prevention of HIV Infection through information, communication and education on measures of control and prevention of HIV and AIDS.

Prevention of Bloodborne Transmission of HIV: Transmission through blood for transfusion has already been minimized through effective screening. However, efforts will be made to sustain this practice and also ensure that 100 per cent screening takes place. In addition, sterile surgical procedures will be practiced by all health workers .

Prevention of Perinatal Transmission of HIV: Prevention of transmission of HIV to women is by far the best strategy for preventing transmission from mothers to child. Because most women are unaware of their infection status, efforts will be made to provide facilities for voluntary testing of pregnant women. Secondary prevention of perinatal transmission currently depends on the avoidance of childbearing by HIV positive women. Voluntary counselling, contraception and other fertility regulation services will be made available to women everywhere as part of health services and supportive environment needed for prevention of perinatal transmission. Research is needed to evaluate the impact of current counselling methods for couples and women of childbearing age, and to determine how to improve this impact through alternative methods, for example using religious leaders and traditional health practitioners. Over the longer term, biomedical research needs to pursue the development of `perinatal vaccines' and other such drugs for preventing HIV infection in the unborn and newborn babies of HIV positive women.

Care, Including Counselling and Clinical Management. Proper care and support of HIV positive persons will be stressed to that they be useful and productive for the rest of their lives and their dignity safeguarded. The Government will strive to ensure that humane care of a quality at least equal to that provided for other disease is everywhere available for HIV positive infected adults and children. Services will be appropriate, accessible and continuous. At the minimum, clinical care will include pain relief and treatment for common opportunistic infections.

Social and Economic Support for AIDS Patients and their Families. With regard to social security and health insurance schemes, the coverage afforded to people with HIV/AIDS should be equal to that provided for people with other diseases. Community Based Home Care for AIDS sufferers will be emphasized and developed. Traditional approaches to care of orphans will need to be supplemented by community-based foster care homes, day-care centres, and a bigger parenting role for schools. Other options include village associations or cooperative which parents join in preparation for the orphanhood or their children, the use of religious and other charitable institutions to protect orphans' property, and the creation of a protective climate for widows and orphans.

National Coordination of Research aimed at sharing information and experiences, as well as accelerating scientific progress using appropriate technologies,will be a main areas of focus. Training and transfer of technology will ensure that the results of biomedical and other research are made easily available.

Meeting National Financial Needs: The financial burden brought about by the impact of the epidemic on the entire health care system is enormous. There will be need to mobilize more financial resources to meet this burden. Financial resources from various sources (e.g. International Agencies and Donors, NGOs, Government Sectors and Communities) will be coordinated.

Organisation and Management Structures: The Government will set the National AIDs Council with broad representation of different sectors and NGOs to address the problem of HIV/AIDS. The Council will also be mandated to foster collaboration with international and Donor Agencies in support of the AIDS Control Programme.

11. ADOPTION AND IMPLEMENTATION OF A NATIONAL DRUG POLICY

This is called for so that available resources may be used to develop pharmaceutical services to meet the requirements of all Kenyans in the prevention, diagnosis and treatment of diseases using efficacious, high quality, safe and cost-effective pharmaceutical products. The National Drugs Policy will serve as the guiding document for legislative reforms, staff development, and management improvements.

Drug Availability -- Drug availability will be increased at government health facilities through improvements in the selection, financing, procurement, distribution, and use of pharmaceuticals. The first critical step in making drug selections more cost-effective was already taken in September, 1993 with the launching of the revised National Essential Drugs List (EDL). With assistance from the World Health Organisation, the list has been made available to all health institutions in the country, both governmental and non-governmental. Availability of drugs at Ministry health institutions will also be improved through financing arrangements based on actual per capita drug requirements and on re-establishment of a well-managed revolving drug fund. Good Pharmaceutical Procurement Practices will be implemented: procurement by generic name, concentration on the EDL, rational needs assessment, pre-qualification of suppliers, competitive tendering among pre-qualified suppliers, improved quality assurance, and systematic monitoring of supplier performance. Efforts to improve distribution will also continue. The Ministry has already obtained a commitment from WHO to provide financial and technical support for a senior-level committee to re-structure the supply process. Drug availability in the private, mission, and NGO sectors will be improved

through a strengthened registration system, a more systematic approach to determining where particular types of drugs may be sold ("scheduling"), and streamlining of the importation process.

Affordability -- The high cost of drugs in the public sector will be addressed primarily through the improved financing and procurement procedures described in the preceding section. Affordability of drugs in pharmacies and at private health institutions will be addressed by several measures in the National Drug Policy. First, a major emphasis will be placed on promoting generic labelling, prescription, and substitution. Educational programmes for medical practitioners, pharmacists, other health professionals, and the general public will emphasize the cost-effectiveness of generic products. Proper registration and quality assurance procedures should ensure that generic products are safe and effective. Second, registration of drugs in Kenya will be limited to products which have proven quality, safety, and efficacy and which meet a specific medical need. Products whose proposed wholesale and retail prices are excessive compared to those already on the market will not be accepted. Third, efforts will be made to extend NHIF and other insurance coverage to include pharmaceuticals, thus easing the burden on individuals. Fourth, alternatives to the current system of compensating pharmacists/pharmaceutical technologists will be explored. Fifth, traditional medicines will be encouraged, but supervised through the new policy. Finally, though there will be no formal price control mechanism, the Ministry will ensure that established wholesale prices are regularly published and that a mechanism is established to exchange price information with other countries.

Rational Use -- Rational drug use improves health and reduces costs. Better prescribing, dispensing, and patient use of drugs will be addressed by regularly updating and widely disseminating standard treatment guidelines for hospitals and rural health facilities, standardizing levels of authorized prescribing, integrating the Essential Drugs Concept into all health-related training, introducing Pharmacy and Therapeutics Committees into all major health institutions, establishing a national drug information system, and controlling drug advertising and promotion.

Quality of Drugs -- The quality of drugs imported into Kenya and manufactured in Kenya will be controlled by making the National Quality Control Laboratory fully operational, by enforcing international-standard Good Manufacturing Practices among all manufacturers, and by actively participating in the WHO Certification Scheme on the Quality of Pharmaceutical Products.

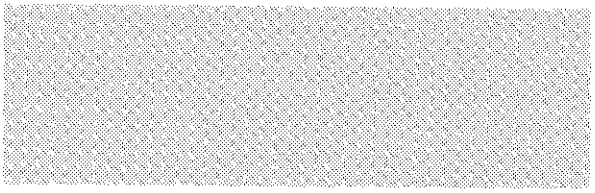
Local Production -- Kenya has an active pharmaceutical industry which contributes to the economy, security and health of the country. Continued growth of this industry will be encouraged through promotion of generic products, local production incentives, a local-preference margin in Ministry pharmaceutical tenders, review of applicable patent laws, and harnessing of potential research and development funds to expand local technical know-how.

Drugs for veterinary services -- The availability, affordability, rational use, and quality of drugs for veterinary services will be improved by applying the same Essential Drugs Concepts to the selection, procurement, distribution, and use of veterinary drugs as are applied to drugs for human consumption. This includes preparation of a Veterinary Essential Drugs List, promotion of general prescribing, and related activities.

Implementation of the National Drug Policy Implementation of the National Drug Policy will not occur over-night. Some policy elements require legislative changes, others require regulatory adjustments, while still other require changes in day-to-day Ministry operations. Implementation of certain aspects of the NDP rests solely with the Ministry of Health, while the implementation of other aspects requires collaboration among several Ministries. Enabling legislation already exists in the following Acts of Parliament, in some of which specific sections will require subsidiary legislation in support of the National Drug Policy:

> he Public Health Act Cap 242, the Pharmacy and Poisons Act Cap. 244, the Dangerous Drugs Act Cap 245, the Medical Practitioners and Dentists Act Cap 253, the Clinical Officers (Training, Registration and Licensing) Act, Cap. 260, the Nurses Act Cap. 257, the Malaria Prevention Act Cap. 246, the National Hospital Insurance Act Cap. 255, the Food, Drugs and Chemical Substances Act Cap 254, the Animal Diseases Act Cap. 364 and the Price Control Act Cap. 504.

A five-year implementation plan for the National Drug Policy when operationalised will include specific actions required, areas in which legislative changes will be initiated, proposed timing, responsibilities, resource requirements, capacity building and institutional arrangements.



12. CONSOLIDATION AND STRENGTHENING OF KEY HEALTH MANAGEMENT INFORMATION SYSTEMS (HMIS) TO SUPPORT THE POLICY-MAKING ROLE OF THE MINISTRY OF HEALTH IN BUDGETING, PLANNING AND MANAGEMENT FUNCTIONS IN THE DISTRICTS.

Facilities and fixed assets. The Ministry of Health requires an information system which can identify all its fixed assets and provide accurate and timely information to planners. This will necessitate the creation and routine and continuous updating of a facility information system which would capture details of each and every health facility in Kenya, both those belonging to the Government and those belonging to private and mission sector organisations. There should also be provision for an inventory system for all items of medical and non-medical equipment and vehicles belonging the Ministry of Health. Such information is of critical importance to any form of planning.

Financial resources data. To improve financial planning and budgeting in the Ministry of Health, it will be necessary to implement financial and accounting systems which provide the data needed to generate meaningful financial management and cost control information. Also, systems are required to provide the data needed to support the development of financial planning models of the Kenyan health care system. This involves having a set of systems and output reports which will provide for tracking and control of cash, inventory, and fixed assets, and reports to present organization unit, service, and program costs. The availability of budgets and standard costs would support the

establishment of an effective control system and financial models.

The initial requirement is to introduce a set of accounts and the appropriate ledgers to gather actual financial and cost data in sufficient detail that the desired control systems, modeling requirements and output reports can be developed. The current budgetary control system must be strengthened and broadened to include the preparation of budgets at the service/cost center level for all health facilities. Standardised *unit costs* are useful for performance measurement, for pricing services, and for use in planning models to help evaluate the costs of adding, expanding, or changing services and programs within the health care system.

Workload and operational data. Accurate, timely and pertinent operational and workload data is needed to develop health care plans and budgets, and for support to management decision-making, for example to provide the means to measure the efficiency and the productivity of performance, and to show the utilization level of a health facility, a cost center or a department. Such information, when compared to planned levels of performance or to the performance of a similar facility or unit, also provide insight into such factors as its budgetary allocations, the suitability of the staffing levels compared to activity, the suitability of its equipment, its supply allocations, and inventories, and the types of patients served etc.

Manpower data. The effective management of manpower requires tracking the assignment and job placement of employees, managing payroll and benefits, processing new recruits and terminations of various types, and handling employees of different status. In addition, human resources functions encompass employee performance and career tracking in order to support decision making about appointments, promotions, and other matters. It is this detailed data, coupled with baseline information concerning staffing norms and authorized staffing levels that should provide the basis for determining the numbers and types of staff employed, their qualifications and experience and suitability for promotion or training, where they are working, the type of work they are doing, and the efficiency and acceptability of their performance. Such information is the basis for the preparation of staffing budgets and operational performance standards for different types of jobs and pay grades. Without it there can be no effective manpower management.

Given that over 70 per cent of recurrent health expenditures are devoted to those of personnel, it is again critically important for the Ministry of Health to develop and maintain accurate information systems for its health manpower. As the situational analyses indicated, such a system is under development. This will continue and will eventually permit information-based health manpower planning

Information for Planning. Facility and workload data, when aggregated and compared with those data concerning both personnel and the Ministry of Health recurrent and development budgets have the potential, if they are accurate, timely and complete, to provide the substrate for real and effective information-based planning systems within the MoH. The development of planning models also requires providing information about the geographic areas where specific programs and services are either available or are lacking. Also, the actual and planned levels of service delivery can be determined from this data. Staffing levels needed for actual and planned service levels and drug and medical supply needs based on epidemiologic data should be routinely available to support planning needs.

A comprehensive set of networked Health Management Information Systems will be designed and rapidly implemented to provide the information required to support activities at all levels of the health infrastructure. This will include elements concerned with Human Resources Management, including and interface with the Treasury payroll system, financial accounting, budgeting, control of fixed assets, financial resources, tracking of operational, workload and epidemiologic data to permit performance of the health system to be related to costs.

13. INSTITUTIONALIZATION OF MANAGEMENT TOOLS FOR COST CONTAINMENT AND COST CONTROL PARTICULARLY FOR THE HOSPITAL AND CURATIVE SECTOR.

The efficiency of the use of resources in the health sector will determine how well inputs are translated into outputs, both in terms of the cost efficiency of specific types of interventions as they relate to a reduction in the overall burden of disease, and in terms of the cost efficiency of individual institutions which provide those interventions.

To improve the local management of resources, particularly in resource constrained public sector health care facilities, limits will have to be set on local expenditures. These limits should be imposed to encourage more effective management, which should seek to maintain defined standards of quality of care within strict cost limits.

The cost of an inpatient bed day or of an outpatient visit in a health care facility should be consistent between all facilities of that particular type and capacity. Although variations in local costs will have an influence upon these costs, since certain zones are more costly than others, due for example to geographic variations in the cost of providing inputs, these variations must not be excessive. For example, under ideal circumstances, during the course of one financial year the average cost of an inpatient bed day or of an outpatient visit in a PGH should not vary widely between two such institutions. By allocating resources to institutions on the basis of reasonable unit costs and historical workload data, greater managerial efficiency can be promoted and inequalities in resource allocation between facilities of the same type and capacity can be minimised.

Improvements to Local Management and Planning . Strengthening the planning and management skills of health personnel is required at all levels. Simple and effective management tools capable of providing information concerning the costs and quality of care provided in Government and Non-Government health institutions are currently under development. When finalised, they will be implemented nationwide to provide managers with the tools they need to improve the quality, efficiency and cost effectiveness of the services their institutions provide.

Improvements to National Management and Planning The Government needs to promote cost-effectiveness in the provision of health care. It will develop its capacity to measure the cost effectiveness of different interventions in curative care and in public health, and after careful prioritisation direct more public sector resources to the essential curative care and public health packages that will benefit the majority of Kenyans and limit public support to those that are not cost-effective e.g. highly specialized tertiary health care services that benefit only a small fraction of the population.

Support Services The Government needs to study the potential costs and benefits as well as the rules and regulations governing the

contracting out of support services as they may apply to Government operated heath care institutions. In doing so, it may be possible to develop and implement feasible options for the contracting of these services in Government facilities to private sector contractors.

14. STRENGTHENING OF HEALTH RESEARCH

The Government recognises that health research should support the activities of all agencies operating within the health sector, and that research into priority diseases and conditions and the means to combat them must be better coordinated.

Division of Research, Health Standards and Inspectorate. The Government, through the Ministry of Health has recently established the Division of Research, Health Standards and Inspectorate. This Division, together with the National Health Research Development Centre (NHRDC), will coordinate all health research services in the country including the creation and implementation of health standards to ensure compliance with the health laws. This will involve:-

- Coordination of health systems as well as clinical and biomedical research
- Setting health standards as a priority for patient care and management of disease.
- Reinforcing the set health standards
- Collaborating with all health research institutions (eg. NHRDC, KEMRI, ICIPE)
- Collaborating with the relevant Boards/Councils on matters of health standards (eg. Medical Practitioners and Dentists Board, Nursing Council, Clinical Officers Council).

15. REORIENTATION OF THE ORGANIZATION STRUCTURE AND FUNCTION OF THE MOH TO MEET THE PROPOSED REFORMS.

This agenda for reform of the Health Sector is ambitious, and in order for it to act as a tool for both shaping and regulating the sector, the Ministry of Health must itself revisit its roles and responsibilities so that it may, as the preamble to this document suggests, continue to play the role of protector of the poor and needy.

Health Sector Reform Secretariat and Reform of the Structure, Organisation and Management of the Ministry of Health. The Government has set up a Secretariat to oversee the sectoral reform process, and the action plan for the implementation of the DPM Study Team Report of 1993 has been accepted by the Government as the vehicle for the reorientation and reorganization of the structure, management and operations of the Ministry of Health, and also as the basis for Civil Service Reform in the Health Sector as required by the Structural Adjustment Program.

However, in view of the need to develop a small and decentralized structure for the Ministry of Health, the DPM Study Team Report which formed the basis for this action plan will be revisited in order to accommodate this reform agenda. This will then establish a smaller span of structural control than recommended by the DPM report, as well as the new Provincial Inspectorate. This reform will demand that some of the functions of the central Ministry be devolved from headquarters in favour of a more decentralized management. This will contribute to a real strengthening of rural health management and health service delivery.

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