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# Achieving Universal Healthcare Coverage: Lessons to Consider

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Health is fundamental to happiness and overall well-being of households. A healthy population translates to greater strides in economic development since such population is more productive, and saves and invests more. The important role of better health as a catalyst for development thus provides justification for governments to prioritize and invest more in health. Countries across the globe including Kenya have identified access to health services as a basic human right. This has resulted in heightened efforts towards universal healthcare coverage (UHC) to ensure citizens satisfy their right to health and right to life.

Universal health coverage means that all individuals receive the health services they need, not necessarily free, but without suffering financial hardship. Besides health financing, UHC implies putting in place efficient health service delivery systems; adequate health facilities and human resources; information systems, good governance and enabling legislation. Thus, UHC is an efficient way of ensuring equity, promoting quality, and enhancing financial risk protection. Kenya adopted the objective of achieving UHC by 2030 as part of the Sustainable Development Goals (SDGs). The SDG target 3.8 aims to "achieve UHC, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality, and affordable essential medicines and vaccines for all.

In Kenya, National and County governments have initiated and are implementing programmes towards UHC. Some of the recent interventions by the government include free maternity services in all public health facilities since 2013, the programme to equip major public hospitals across the country with modern diagnostic equipment, and free primary healthcare in all public primary healthcare facilities. A key agency, the National Health Insurance Fund (NHIF) also provides health insurance subsidies by targeting disadvantaged groups. County governments have expanded recruitment of health workers and provision of more infrastructure and equipment for health facilities, including new wards and ambulances. However, allocation of adequate resources and improved efficiency in the health system remains a priority in order to secure the gains made.

Besides, social health insurance has been recognized as one of the pillars for Kenya to achieve UHC. In this regard, the government has instituted reforms in the National Hospital Insurance Fund (NHIF). These reforms include changing the management structure at NHIF to make the institution more effective and responsive to customer needs; reviewing the contributions of all members; expanding the benefit package to include out-patient cover for all members; and new packages related to addressing non-communicable conditions; and instituting strategies to enrol more members. The target during the third Medium Term Plan (2018-

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2022) is to achieve over 70% health insurance coverage up from 36%. In addition, private health insurance companies are envisaged to continue playing an important but modified role in financing the health system by providing top-up supplementary health insurance.

Notwithstanding the initiatives in place, the path to UHC is still beset with various challenges that the country needs to overcome. One of the challenges is the relatively large and growing informal economy. The experience of most countries indicates that a crucial ingredient in the achievement of sustainable healthcare financing strategies is achieving economic development in general. Economic development and formalization of the labour market may offer an easier path to the achievement of a more equitable universal system of health coverage in Kenya. In many countries in Asia, the extension of coverage of social health insurance occurred concurrently with the formalization of the entire labourforce. For Kenya, sustained economic growth and development is a necessary complement in the achievement of equitable and sustainable social health insurance coverage.

Another related challenge is the relatively large poor population in Kenya. Overall poverty was estimated at 36.1% or about 16 million individuals in 2015/16 having declined from 46.6% in 2005/6. The relatively high poverty level makes achievement of UHC more challenging. Countries usually use safety nets to cover their poor populations. One of the strategies is to subsidize the social health insurance systems to help the poor pay low premiums. Some reforms could aim at assisting the self-employed and informal sector workers to join the existing social health insurance schemes by helping them overcome financial obstacles. A key obstacle though is that these forms of assistance stretch the resource envelope – sometimes to unsustainable levels – further buttressing the need to support UHC by strong economic growth and development.

Although countries across the globe have innovative health financing (insurance) schemes involving public-private competition that Kenya could adopt, the country faces the limitation of low levels of penetration of private insurance (about 7%). The key factors contributing to the low penetration include costs and perceptions. The predominant schemes across the globe include introduction of private-public competition for mandated health insurance such as in Chile, Colombia and Estonia; and private-public competition for the provision of publicly financed health services as in Chile and Argentina. The challenge can be mitigated by expanding private health insurance schemes that encourage members through groups such as investment groups, community groupings and families. Group coverage reduces administrative costs, mitigates adverse selection, and provides uniform premiums to the members of the group.

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Lastly, is the envisaged speed of transition towards UHC. Although Kenya has set out to achieve UHC by 2022, the speed of transition towards universal coverage usually takes a longer time based on experiences across the globe. In addition, reforms towards UHC are likely to be successful if they are gradual, sustained, continuous and carefully planned. Most successful countries achieved a predominantly tax-based financing system or a social insurance system through a long gradual process. For example, it took Canada and the Republic of Korea 30 and 12 years, respectively, to achieve UHC. For the Republic of Korea, national health insurance (NHI) coverage was gradually extended to firms with over 500 workers, before covering those with more than 300 workers. The last group to be incorporated

in the NHI scheme were the urban self-employed and firms with more than five workers – and this was after 21 years following the rollout of the programme. In addition to gradual inclusion of constituents or beneficiaries, services that are covered by the universal coverage are usually introduced gradually. As an example, Canada initially extended universal access to hospital services before extending it to doctor services.

Amidst these and other challenges, there are also opportunities that can ease the effects of the identified challenges. Although the large and growing informal economy presents a challenge, especially in mobilizing regular payments, technological advancements in cellular mobile technology offer opportunities for effective application that can mitigate this challenge. Technologically inclined innovations can significantly cut the time towards achieving UHC, and the country may not need to tread a path like that of other countries.

To overcome the challenges associated with poverty, Kenya can enhance investments in social safety nets. Some common innovations to expand social protection (safety nets) in health include: opening voluntary affiliation to self-employed and informal workers; providing public subsidies to social health insurance systems to enroll the poor; compulsory universal participation; and expanding the pool through the integration of private health insurance. These innovations may have their unique shortcomings and may require careful design before their adoption.

Another key opportunity is through supportive and synergistic investments in related sectors such as water and sanitation. As an example, Chile which has a GNI per capita of PPP $13,440 scores well in terms of health indicators. Its infant and maternal mortality are among the lowest in Latin America. Average life expectancy in 2009 was 79 years, up from just over 60 years in the early 1970s. These achievements are attributed to investments in public goods such as education, child health control, sanitation, water and sewerage management, among others.

In a related vein, supportive and flexible statutory and regulatory laws are crucial for the success of health financing reforms and outcomes. In the case of Canada, the clear statutory demarcation of healthcare sectors that are financed by the public sector and those that are not is given as a factor that has supported economies of scale and administrative efficiency within the public and private sectors. In some documented reform experiences, e.g. Chile's case in the 1980s, introducing private health insurance competition within social health insurance systems without the necessary regulations, harmony, and risk adjustment mechanisms (to avoid adverse selection and moral hazard) can have negative consequences on efficiency and equity. Chile had to introduce new regulations and a new law in 2005 that established a list of 56 priority health problems that both the public and private insurance sectors were obliged to cover. This was to prevent the public sector from being overburdened.

A key lesson for Kenya is that different countries achieve satisfactory health indicators using varying financing strategies and mechanisms. Countries with better indicators tend to have larger "general government expenditure on health as a percentage of total expenditure." Efficiency in the use of resources varies across countries and some countries are considered less efficient than others. As an example, the USA has higher expenditure per capita for comparable health indicators with most developed countries. Some countries such as Malaysia and Korea have a relatively high out of pocket expenditure as a percentage of private expenditure on health but still achieve good health indicators through innovative compulsory products. Singapore's case is particularly worth noting – as a country that implemented innovative compulsory saving schemes that rely/relied on a policy of "personal responsibility" that has been successful in achieving impressive health outcomes.

There are also successful examples to draw from in Kenya.

Makueni County residents, since 2014, enjoy all year medical cover for a subsidized cost of Ksh 500 per household through MakueniCare. The programme piggybacks on the national government's free primary healthcare policy and the national coverage provided by NHIF. The initiative began with a pilot programme offering free care to individuals aged over 65 years. The County government invested in expanding facilities, including an additional 113 dispensaries and health centres, and has more than doubled the number of health facilities

within five years. These developments have reduced the average distance to a health facility from 9km to 5km. Compared to 38 doctors in 2013, the county now has 160 doctors. However, with individuals seeking medical care for minor complaints, this could divert resources from primary and preventive care. In addition, the influx of people from neighbouring counties could pressure the county resources.

Kakamega County also provides useful lessons in addressing high maternal and child mortality rates and moving towards UHC. The county rolled out its *Imarisha Afya ya Mama na Mtoto* in the face of one of the highest maternal mortality rates in Kenya. This was done collaboratively with UNICEF, AMREF and the Swedish government. Enrolled women deliver free in health facilities (rather than at home) and receive a full vaccination cycle. Mothers also receive a grant to take care of themselves and their babies. Initial results indicate improvement in skilled deliveries from 33% to 56% and a reduction in maternal mortality from 800 to 460 per 100,000 mothers in the programme's 3-year cycle.

## About KIPPRA Policy Briefs

KIPPRA Policy Briefs are aimed at a wide dissemination of the Institute's policy research findings. The findings are expected to stimulate discussion and also build capacity in the public policy making process in Kenya.

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