(D)Evolved Healthcare: Makueni's Trailblazing Experiment in Providing Universal Health Coverage

By Patrick Gathara

Universal health coverage is by many measures considered to be the Holy Grail of delivering quality healthcare. In fact, achieving universal health coverage by 2030 – ensuring that all people have access to the health services they need without the risk of financial hardship – was included as part of the Sustainable Development Goals (SDGs) adopted by the United Nations in 2015. Writing a year later, Marie-Paule Kieny, Assistant Director-General at the World Health Organization (WHO), described it as "the linchpin of the health-related SDGs; the one target that, if achieved, will help deliver all the others by providing both population- and person-centred high-quality services that are free at the point of delivery and designed to meet the realities of different people's lives." WHO estimates that about 150 million people around the world suffer financial catastrophe annually from out-of-pocket expenditure on health services, while 100 million people are pushed below the poverty line.

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In Kenya, though access to quality healthcare is a constitutional right, the scarcity of quality public and private health facilities, as well as the high cost of care even when it is available, means that universal health coverage remains little more than words on paper for much of the population. President Uhuru Kenyatta has made achieving universal health coverage by 2022 a major part of his second term agenda and indicated in his inauguration speech that this would be achieved by expanding coverage under the National Health Insurance Fund (NHIF). The president said that half a century after it was established in 1966, the Fund has only attracted 6.8 million beneficiaries. The World Bank estimates that only a fifth of Kenyans have any sort of medical cover, which means that as many as 35 million Kenyans are vulnerable to the financial devastation occasioned by a medical emergency.

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When illness eventually strikes, it takes a huge financial toll. According to the 2013 Kenya Household Health Expenditure and Utilisation Survey, medical expenses account for more than 40 per cent of non-food bills in over half the counties in the country. In fact, direct payments by citizens accounted for a third of the country's total health expenditure in the same year, according to Dr. Izaaq Odongo, the head of the Department of Curative and Rehabilitative Health Services at the Ministry of Health, with the balance being made up by government (36 per cent), donors (20 perc ent) and employers (10 per cent). As a result, many Kenyans are forced to resort to selling off property, relying on networks of relatives and friends, or even making desperate appeals on social media to raise the necessary funds. Hence the large, and seemingly never-ending appeals all Kenyans make when clearing medical bills. Despite this, according World Bank Country Director, Diarietou Gaye, the number of those thrust into poverty by medical expenses is close to one million.

Kenya's network of public healthcare facilities has traditionally been hierarchically organised into 6 levels, with the lowest unit being community health workers embedded within communities. At level 2, dispensaries and clinics provide the link between community-based healthcare and the formal health system. Together with level 3 facilities – health centres, maternity clinics and nursing homes – these make up the primary healthcare units. Levels 4-6 are sub-county, county and national referral hospitals. It is at the lower levels that the majority of people interact with the healthcare system and it especially at the primary healthcare facilities that national government interventions with regard to cost have been most consequential.

Since independence, Kenya has blown hot and cold on the abolition of user fees and decentralisation, both of which, given the economic circumstances of most Kenyans as well as the devolution introduced by the 2010 constitution, are prerequisites for universal health coverage. In 1965, according to the paper "*Reforming health systems: The role of NGOs in decentralization – lessons from Kenya and Ethiopia* by Richard G. Wamai of the Harvard School of Public Health, "a free access policy abolished the KSh5 co-payment operative in the colonial healthcare system… [and] proposed expanding coverage through centralizing the delivery responsibilities from the counties and municipalities to the Ministry of Health". Eighteen years later, the provision of health services was again decentralised as part of the District Focus for Rural Development programme and in December 1989, user fees were reintroduced in an effort to inject money into crumbling health facilities. The "cost-sharing" programme was part of a comprehensive health financing strategy that also included social insurance, efficiency measures and private sector development. The fees would, the argument went, generate additional revenue, incentivise use of low-cost primary healthcare services rather than the more expensive referral facilities and improve targeting of resources by reducing unnecessary demand.

Still, implementation problems led to the suspension of the policy less than a year later though it was gradually reintroduced in 1991. A 1996 study found that despite revenue increases and facilities

being allowed to budget for three-quarters of the money they remitted to the districts, this did not necessarily result in improved quality of care because the funds were used to offset a fall in government funding for basic care. As evidence mounted that despite a waiver policy to protect the poor and children under five, user fees were proving to be a significant barrier to access, the government – in what came to be known as the 10/20 policy – again reversed course and in 2004 eliminated all fees in dispensaries and health centres, save for a minimum registration fee of KSh10 and KSh20, respectively. By 2007, it had instituted a maternity waiver allowing for free deliveries in public health facilities and introduced the Health Sector Service Fund (HSSF) to compensate these facilities for lost revenue.

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However, as a study published in 2015 showed, this was largely ignored by health facilities for whom user fees represented almost all the cash income they used to cover basic operating costs. As a result, most patients ended up being charged for more than the specified amount while very few received waivers. In 2013, the government abolished all user fees in public dispensaries and health centres and allocated KSh 700 million to the HSSF.

The picture was further complicated by the fact that health is one of the services devolved by the 2010 constitution. This means that while the national government is still responsible for policy and managing two Level 5 referral facilities, namely, the Kenyatta National Hospital and the Moi Teaching and Referral Hospital, the bulk of public healthcare in Kenya is delivered in facilities run by county governments. A history of skewed investment that marginalised some counties, as well as the lack of policy coordination between the various counties and between the counties and the national government, have left a rather confused picture of access to healthcare across the country.

There have, however, been some wins. For the first time since independence, residents of historically marginalised counties, such as Lamu and Mandera, now have access to Caesarean section procedures within their county. There have been problems too: from the controversy arising from the national government forcing counties to lease equipment they neither wanted nor had the resources to use, to ambulance purchases that seemed more about burnishing a governors' image than delivering care to constituents, to the First Lady's much trumpeted Beyond Zero initiative that today is in shambles, with many of the facilities either abandoned or turning patients away.

The Makueni model

Nonetheless, an ambitious experiment in the provision of universal health coverage is underway in Makueni, a county that borders Kajiado, Machakos, Kitui and Taita-Taveta counties. Since October 2014, Makueni has been offering its one million residents free healthcare across all its public facilities, including county and sub-county hospitals. It is a model well worth examining if President Kenyatta is serious about expanding access to medical care across the country.

"When we took over in 2013, we realised that 40 per cent of the people of Makueni would sell land and exhaust family income to pay medical bills for relatives," says Makueni's Governor, Prof. Kivutha Kibwana. Given that medical services in dispensaries and health centres were already free and paid for by the national government, the county government figured that if it doubled the 100 million that its Level 4 sub-county hospitals were collecting in user fees, it could offer free, across the board healthcare to its residents.

Thus MakueniCare, as the county government has labelled it, was conceived. It piggybacks on the

national government's free primary healthcare policy and the national coverage provided by NHIF to plug the gap in between with the aim of providing seamless cover across all public health services.

Thus, for an annual subscription of KSh500 per household, which covers parents and all their children under the age of 18 years (or up to 24 years in case of students), Makueni residents can access free primary healthcare at dispensaries and health centres courtesy of the national government, free treatment, including inpatient care and ambulatory services, at the 13 level 4 hospitals within the county paid for by the county government, and, if they're subscribed to NHIF, free care at referral facilities outside the county. The Level 4 hospitals provide free care and bill the county government, which also supplies them as well as the primary healthcare facilities with drugs, equipment and medical staff.

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However, universal health coverage is more than eliminating out-of-pocket expenditure; it is also about ensuring access to healthcare. According to Dr. Cyrus Matheka, the head of the county's Health Promotion Services, MakueniCare took two years to plan and was preceded and piloted by a programme offering free care to those over the age of 65 without a requirement for registration. Within that time, the county government invested in expanding facilities, from dispensaries and health centres to sub-county hospitals, and has continued to do so. In under five years, it has more than doubled the number of health facilities built by the colonial and national governments over the last 50 years. Apart from an additional 113 dispensaries and health centers, the county now boasts 13 Level 4 hospitals and has employed 160 doctors, compared to just 38 doctors and 3 hospitals in 2013. At KSh2.3 billion, health is the county's single largest budget item.

All this means that the county can offer a wide array of free services to residents, from hospital admission, surgical procedures, X-ray imaging, laboratory testing, to dental and counselling services. Even in death, patients benefit from 10 days of free mortuary services. However, the cover does not apply to specialised care and equipment that are not available at the hospitals, including dialysis for patients suffering from kidney failure, intensive care units, implants, as well as auxiliary devices, such as wheelchairs.

> Insurance schemes are essentially funds where people pay into a pool when they are healthy – in this case through both taxes and direct contributions – which they can draw on when sick. The Makueni recruitment model reversed this, thus courting adverse selection, or the tendency of people to get insurance only when they are seriously sick, which can consume huge resources.

Dr. Andrew Mutava Mulwa, the County Minister of Health, estimates that MakueniCare covers at least 93 per cent of the county's healthcare needs. He says it is built on a platform of ensuring adequate provision of primary care by increasing facilities, improving services and ensuring that medicines are available. "Someone who is sorted at the dispensary will not find their way to the hospital," he says, adding that only 35 per cent of patients in Makueni need to seek care in the secondary institutions covered by MakueniCare or in tertiary referral facilities outside the county.

Challenges

However, the programme has had its share of challenges. The first, rather surprisingly, was low uptake. In March last year, when *The Elephant* visited Makueni, less than 10,000 households had signed up for the programme out of a potential 200,000. The scheme had a mere 30,000 beneficiaries. Part of the reason for this was the decisions taken to make the coverage voluntary, to

register subscribers at county hospitals when they sought care and to make the cover active immediately upon registration and payment. Initially there did not seem to be much of a public campaign to get residents to register: there were no posters announcing the programme in all the hospitals *The Elephant* visited and, despite officials claiming to advertise on vernacular radio, most residents we spoke to had not heard about MakueniCare.

Julia Musau of Kaselia village, who we met at the Tawa Sub-County Hospital, is a typical case. She had been unaware of the scheme until a month prior to our visit. She found out about it after she took a patient to the Makueni General Hospital in Wote, and had difficulty settling the bill. It was another woman whose child had been admitted there who told her about MakueniCare. That was when she enrolled her family immediately.

However, even those who know about it opt to wait till they or their dependents get ill to register since there is no penalty as the cover is activated immediately and registration is done at the hospitals, anyway. This made registration vulnerable to industrial action by medical personnel. For example, during the nationwide strikes, first by doctors and then nurses, fewer people went to the hospitals as there was little expectation of receiving care. In any case, According to Dr. Matheka, less than 5 per cent of the county's population seeks medical care at any one time, and many of these are over the age of 65, a group that already enjoys free care. This means registration will inevitably be slow unless there is a serious epidemic.

The Makueni model also faces other challenges. Insurance schemes are essentially funds where people pay into a pool when they are healthy – in this case through both taxes and direct contributions – which they can draw on when sick. The Makueni recruitment model reversed this, thus courting adverse selection, or the tendency of people to get insurance only when they are seriously sick, which can consume huge resources. This brings into question the sustainability of the programme. However, in more recent times, according to Wambua Kawive, a former Makueni County Minister, the county government has ramped up its recruitment efforts and has now launched a mass registration exercise targeting 100,000 registrations by the end of the year.

Another challenge the system needed to cope with was an initial influx of patients into hospitals once the policy was implemented. Tawa Sub-County Hospital Administrator, Justus Kilonzo, told *The Elephant* that the workload at the hospital had increased, which necessitated the recruitment of more staff. Further, there has been an influx of people from neighbouring counties who sought to take advantage of the system. Geoffrey Kirui, the Health Administrative Officer at Makindu Hospital next to the busy Nairobi-Mombasa highway, spoke about having to filter out patients from other counties, especially Taita Taveta, Kajiado and Kitui. Still, trying to determine someone's place of residence using identification cards, birth certificates and a ward administrator's or chief's letter is an inexact science and one gets the sense that this too was not well thought through.

MakueniCare also faces a hazard where, having paid the subscription, patients will head to the hospital for even minor complaints that can be addressed at lower levels, adding stresses to the system. They may also engage in risky behaviour knowing that there is the safety net of free care. Such behaviour may be inadvertently complemented by a shift in focus from preventative to curative care by hospitals seeking to generate more revenue and county officials seeking to make political hay from the scheme.

The latter is particularly important. It is crucial to note that MakueniCare is undergirded by an administrative structure that was created to deliver a different type of healthcare where users contributed directly. Suddenly eliminating such fees can have unintended deleterious effects on both the facilities and their ability to deliver quality services. One study on the effect of the removal of user fees found that although the revenue generated was generally low, it served to ensure that

facilities met the costs of services and salaries for support staff not directly funded through the government's budget.

> There is also a legitimate fear that the political priority placed on MakueniCare may be diverting resources from primary and preventative care at the health centre and dispensary levels.

In Makueni, a doctor-turned-administrator who did not want to be named told *The Elephant* that MakueniCare had created a mismatch of skills, with doctors having to do administrative tasks rather than attend to patients. When MakueniCare was first proposed, the doctor told us, there was much resistance from hospitals, which were concerned about the lack of a clear system as well as lack of necessary training and preparation. "Why the rush to launch in October 2016?" asked the doctor, concluding that the timing had largely been influenced by the interests of county politicians vying in the August general election.

MakueniCare essentially transfers control over funds and decision-making away from hospitals to bureaucrats at county headquarters in Wote town. Hospitals not only have to worry about delays in receiving reimbursements for resources spent in providing care – which can happen if, for example, the national government delays disbursements to the county governments – but also about losing their largely autonomous decision-making power on the equipment they need to procure and the staff they need to recruit. Similarly, where and when new facilities are built may reflect more the political priorities of those running the county government rather than the genuine health needs of the populace. Lastly, as with all government-driven procurement decisions, the spectre of corruption is never far away.

There is also a legitimate fear that the political priority placed on MakueniCare may be diverting resources from primary and preventative care at the health centre and dispensary levels. Ilatu dispensary, which was built by the Kenya Pipeline Company and opened in March 2014, may be a case in point. In September 2015, the facility was handed over to the county government that provided staff and equipment. Adjacent to a settlement scheme, it is the busiest facility in Kibwezi West and offers outpatient, maternal and child health, family planning as well as HIV testing and counselling services. The staff of two nurses and one laboratory technologist attend to between 70 and 100 patients every day. The county government is upgrading it to a health centre and building a 40-bed inpatient facility.

Jacinta Mbula is the nurse in-charge. She says staffing and resources are big challenges. When *The Elephant* visited the facility, her fellow nurse was on maternity leave and she was running the facility on her own. She said that there is only enough accommodation for one nurse to stay at the facility and take care of overnight maternity cases, and that nurse still has to report to work the next day. Although they receive adequate supplies of essential medicines from the county government, they do sometimes run out of non-essential drugs.

Further, she only gets KSh60,000 – "peanuts" – every quarter from the county government to pay casual labourers and purchase essential supplies. She currently employs one casual worker and one watchman but says she actually needs – but cannot afford – two casuals and a groundsman to manage the 10-acre facility. And because it was not built by the national government, the dispensary is not entitled to access the HSSF, despite its workload, though other less busy facilities do. Ilatu does, however receive, as all facilities do, reimbursement from the national government for maternal deliveries –KSh2,500 each.

> Dr. Matheka says the average distance to a health facility has been nearly halved, from 9km to 5km in the last 4 years. However, having more facilities will not necessarily improve health outcomes for the people of Makueni if the quality of care they provide begins to decline as a result of underinvestment.

So as the county keeps building more dispensaries and health centres, questions must be asked about whether underfunded facilities can truly serve as the bedrock for universal health coverage even though access has been improved. Dr. Matheka says the average distance to a health facility has been nearly halved, from 9km to 5km in the last 4 years. However, having more facilities will not necessarily improve health outcomes for the people of Makueni if the quality of care they provide begins to decline as a result of underinvestment. Further, especially as the county expands the number of Level 4 hospitals, one must wonder whether this is being done at the expense of funding primary healthcare.

Makueni officials say some of the potential pitfalls are ameliorated by enhancing public participation. Governor Kibwana says local committees of citizens participate in co-supervision of projects and must, along with technical people and administrators, give approval. This, Kawive asserts, removes politics from the equation and makes bureaucrats and hospital administrators directly accountable to citizens. While it is definitely a good idea to involve local communities, true accountability must be accompanied by real access to information as well as consequences for those who are implicated in wrongdoing.

Though MakueniCare faces its share of challenges, everyone *The Elephant* spoke with in Makueni who was aware of the programme was full of praise for its ambition, including those who were critical of its implementation. The fact is, as Kenya ponders the way to achieve universal health coverage, the country would do well to pay attention to the lessons from Makueni. The expansion of NHIF cover by itself will not suffice; the national government must work with county governments to outline a plan that creates a seamless spectrum of cover at every level of care and provides the necessary resources at the appropriate time.

Further, there should be horizontal cooperation among counties in providing healthcare and any plan must strive for equity but without punishing the counties that have taken serious strides. Criteria for eligibility for county programmes should be clearly spelt out and counties should be encouraged to collaborate in designing their schemes within the framework of the national plan.

Thirdly, the system should primarily invest in and direct resources towards building the capacities of the public health sector, not in creating opportunities to generate private profits. It should embrace a rights-based approach that seeks to deal with health as a human right rather than an industry. That shifts the focus away from the needs of "investors" to those of citizens. As Ann Wanyoike notes, "an expanded role for the private sector became a health sector reform theme of the 1990s" but this resulted in "a dichotomous health structure that was characterised by the rich opting for high-cost private healthcare providers, with a majority of the populace who had no such means relying on the publicly run health institutions". This means that those who can contribute the most to a national universal health coverage scheme have little incentive to do so, especially if such contributions are voluntary. More on that later.

In addition, it does no good to simply superimpose universal health coverage on a system designed for hospitals to generate revenue. The latter must be fundamentally retooled to suit the former and this will take both time and resources.

Fourth, the plan must prioritise prevention and care at the lower levels. In 2013, according to the

Kenya Service Availability and Readiness Assessment Mapping report, less than 6 out of 10 health facilities in the country have the capacity to provide the Kenya Essential Package for Health (KEPH) – a standardised comprehensive package of health services – and less than half have the basic amenities to provide healthcare services. And while two-thirds have half the basic equipment required, 59 per cent do not have essential medicines. Only 2 per cent of facilities are providing all KEPH services required to eliminate communicable diseases. Providing universal healthcare on such a foundation would be building on sand.

Universal healthcare requires a substantial increase in the resources both levels of government commit to health. The point is not that both levels of government should spend more on health at the expense of other social services; rather they should increase spending on the full range of human rights and social determinants of health. For example, Kenya's Health Policy identifies reducing the burden of violence and injuries as one of the top objectives and notes that this will require addressing causes. Given that road crashes account for between 45 and 60 per cent of all admissions to surgical wards, comprehensively addressing the problems on our roads would free up considerable resources in the health sector.

> According to Djesika Amendah, an associate research scientist at the African Population and Health Research Centre, Kenya spends most of its health budget on salaries, allowances, drug supplies and other recurrent costs; only 7 per cent of the budget goes towards capital expenditure to improve the quality of healthcare by building new facilities or purchasing equipment to care for more people in the future.

How the money that is allocated to the health sector and how it is spent should also change. According to Djesika Amendah, an associate research scientist at the African Population and Health Research Centre, Kenya spends most of its health budget on salaries, allowances, drug supplies and other recurrent costs; only 7 per cent of the budget goes towards capital expenditure to improve the quality of healthcare by building new facilities or purchasing equipment to care for more people in the future.

In addition, the country spends nearly four times as much on curative care as it does on disease prevention and "we devote a higher share of our health shillings (20 per cent) on governance, health system and financing administration; in other words, paying people in the ministries of health who actually do not see any patients rather than spending money on preventing diseases or promoting health." Further, although most Kenyans live in rural areas, government health expenditure has in the past tended to favour urban areas. Given the country's limited resources, more prudence will need to be exercised if universal access to care is to be guaranteed to all.

Along the same lines, there should be an emphasis on getting Kenyans to pay into the system when they are healthy and not to wait till they get sick to get the cover. This also means making it easier for people to register and pay. For example, one can currently download a registration from the NHIF website but one then has to deliver it physically to their offices. There appears to be no way to pay via mobile money or credit/debit card. With nearly all Kenyans able to access the internet though their mobile phones, allowing online registrations and payments would be an easy way to bring in more registrations.

Further, whether the scheme should be voluntary or compulsory is a matter for serious debate. While Makueni's system is completely voluntary, the NHIF is compulsory only for those in formal employment. Yet the WHO's 2010 World Health Report titled "The Path to Universal Coverage" says that "there is strong evidence that raising funds through compulsory prepayment provides the most

efficient and equitable path towards universal coverage. In the countries that have come closest to achieving universal health coverage, prepayment is the norm, organised though general taxation and/or compulsory contributions to health insurance."

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There is also the question of whether, like in Makueni, everyone pays the same amount regardless of income, and whether wealthier people are asked to pay a little bit more in order to lighten the load on the poor. As the WHO notes, "financial risk protection is determined by how funds are raised and whether and how they are pooled to spread risks across population groups" and "rais[ing] funds equitably … usually implies a degree of progressivity (where the rich contribute a higher proportion of their income than the poor)". The NHIF, rather strangely, only has a graduated scale for contributions from those in formal employment; others who join pay a flat monthly fee regardless of income. This is curious for a country where, according to the United Nations' Economic Commission for Africa, only a quarter of workers are in the formal sector.

Fifth, accountability must permeate the entire system. Implementation of the scheme should not become, as we have seen with the free primary education reintroduced in 2003 and the Standard Gauge Railway, hostage to political priorities. Kenyans must accept that if it is to be done well, it will not be done overnight. Public participation at every stage should be encouraged and resources, especially human resources, should be utilised in the most appropriate and effective manner. Effective public participation as well as transparency will be indispensable if the country is to avoid universal health coverage becoming another avenue for looting by the state.

While universal health coverage focuses on reducing the financial burdens of patients, more will be required if access to the healthcare system is to be expanded. As the World Health Report notes, "eliminating direct payments will not necessarily guarantee financial access to health services, while eliminating direct payments only in government facilities may do little to improve access or reduce financial catastrophe in some countries. Transport and accommodation costs also prevent poor people using services, as do non-financial barriers, such as restrictions on women travelling alone, the stigma attached to some medical conditions and language barriers."

Finally, Makueni teaches us that universal health coverage is doable and that we do not need to have the resources of an industrialised country to achieve it. All that is needed is a belief that Kenya should be run for the benefit of all Kenyans and that Kenyans are just as capable as any other people of imagining and creating better worlds and better futures. This may be the greatest lesson we can learn from Makueni County.

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