

Public Health Financing Policy: The Case of Baringo County-Kenya

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Abstract: Health financing refers to how financial resources are used to ensure that the health system can adequately cover the collective health needs of every person in a state. The paper was guided by the following two objectives; to examine the public health financing policy in Baringo County, and to find out the quality of services rendered in the public health facilities in the county. The researcher adopted a qualitative study technique and an interview schedule to collect the data, frequencies and percentages were used to analyse and interpret the data to arrive at logical conclusions. The geographical scope of the study covers Baringo County in Kenya, while the time scope 2003-2005. The authors found that the cost-sharing policy has not been effective since majority of the population are unable to pay due to poverty. In addition, there is inadequacy in finances both from the Central and the County government which affects the quality of health care delivery to the population. Finally, the Central government should restructure the public health care insurance popularly called NHIF, to accommodate outpatient services and to cater for the less privileged members of the society.

Key words: Public health, Health care, Finance, Policy, County government, Central government

I. BACKGROUND OF THE STUDY

Health policies have been of crucial concern to various institutions, scholars, policy makers and communities' worldwide. Critical to health systems in the world is arriving at a common understanding on what should constitute a health system of a given population. Unfortunately, there is no agreement on 'what' should be distributed equally (Culyer, 2001). There is a fair consensus that a fair distribution of healthcare is a more realistic objective of health system than a fair distribution of health. This is based on the argument that equity in health suggests equality in health outcome, and there are numerous factors that affect health status that are outside the locus of health system (Whitehead, 1992).

In the continental Africa, health issues have negatively impacted on socio-economic development. As Cooke (2009) notes, nowhere are global public health's more acute than in Africa. The continents immense disease burden and frail health system are embedded in broader context of poverty, underdevelopment, conflicts and weak or ill-managed government institutions. One of the major constrain in health sector is inadequacy and gaps finances.

According to World Bank (2011), Africa is estimated to host 11% of the world's population but accounts for 24% of the global disease burden. More worrisome still, the region

commands less than 1% of global health expenditure. More than half of healthcare costs on the continent are currently met by out-of-pocket spending, a ratio that rises to as much as 90% in some countries. Because of the inadequacy of government programs to address Africa's health emergencies, the continent has long been a big recipient of external aid in the healthcare sector. In addition, African countries have traditionally had fewer healthcare workers per head, Low pay and poor living conditions among its population contribute to a continuous brain-drain of health professionals to the developed world and this makes it difficult to recruit and retain skilled staff, particularly in more remote regions where the need is often greatest (W.H.O, 2011).

Increased urbanization along with growing incomes and changing lifestyles, have led to a rise in the rate of chronic conditions such as diabetes, hypertension, obesity, cancer and respiratory diseases in many African countries. These pose a considerable further strain on already overstretched healthcare systems. The WHO estimates that chronic diseases will overtake communicable diseases as the most common cause of death in Africa by 2030 (W.H.O, 2011).

To improve healthcare in Africa, primary healthcare should be strengthened. Evidence suggests that health systems that are oriented towards the PHC approach are likely to deliver better outcome (Macinko et al, 2003). The organization of PHC is less hierarchical and primary healthcare physicians are closer to the patient's milieu (Maeseneer et al, 2007). The system is therefore inherently more adaptable to the changing needs of the community and the physicians are in a better position to appreciate social and environmental impacts on illness (Maeseneer et al, 2007). World Bank (2011) notes that, by the end of the decade, many African countries will have overhauled their health facilities and treatment pathways to emphasize primary care services that educate people about healthy lifestyles keep them in good health and help them to manage chronic conditions which offer a glimpse of hope.

However, primary health care provision can only thrive in an environment where there is a greater representation through devolution. In recent years, decentralization has been promoted by advocates of health sector as a means of improving efficiency, quality of service; promoting democracy and accountability to the local population (Green, 1999). The argument is that decentralization facilitates the design of the most effective mechanism for coping with three

crucial challenges to the health system. The first challenge is that it is common to find diversity in the epidemiological pattern of disease across regions and populations within a country. This is accounted for by characteristics of the health sector, geographical, ecological, environmental, economic, social, behavioral, demographic and cultural factors that may differ from population to population in regions within a country. The second challenge is the increased complexity of health care. The greater awareness of the important influences of non-medical factors on health status requires the mobilization of complementary inter-sectoral action from agriculture, education, sanitation, labor and industry. Third, the delivery of health care has to respond constantly to changes occurring in the health situation in local areas, especially as these changes do not occur uniformly nor at the same pace in all regions of the country (Adetokunbo, 1999). It brings decision making closer to the field-level providers of health care and it is also suggested that breaking down the large monolithic decision-making structures that are typical of centralized health system increase efficiency of service provision (Green, 1999). Fiscal decentralization brings expenditure and budgeting decision-making closer to the communities, and therefore has potential to increase the responsiveness of the public sector to differential needs of local jurisdiction (De Mello, 2000) and reduces information and transaction costs associated with provision of public goods and services (World Bank, 1997).

South Africa has set the processes of laying emphasis on primary health care through her 1996 constitution which led to fiscal federal system and implementation of health policies spread across three levels of government: national, provinces and local municipality levels. In practice, national governments role in the area of joint responsibility with the provinces is primarily to determine policy, while provincial government shape some policy and have considerable role in implementation (National treasury, government of South Africa, 1999).

Like South Africa, Kenya for decades has formulated and strived to implement primary health care policies and with the devolution of healthcare in the newly promulgated constitution, PHC is expected to yield better results in reducing disease burden. The Kenyan devolution is a revenue sharing model where the national government collects revenue and share it to the counties for various development agendas by which health is one of them. It is on that basis that Kenya through its constitution has embraced the role of primary health care. As noted by KPMG (2013) through Kenya Health Policy (2012-2030), devolution of healthcare to the counties provides an enabling environment for this approach as the county governments are responsible for the provision of primary care. Bringing primary care services closer to the people allows for ownership and participation (KPMG, 2013).

Baringo County is one of the rural counties in Kenya that has some of these characteristics that reveal low levels of health care. A review by ministry of health conducted in 2014 ranked

Baringo County number 38 out of 47 counties in County sanitation benchmarking. The same study notes that through these indicators, Baringo loses Ksh. 538m each year due to poor sanitation. This includes losses due to access time, premature deaths, health care costs and productivity. Funding for Health in Baringo County is still marginal. According to MoH 2014/2015 National and County Health Budget Analysis Report published in 2015, Baringo allocates 22% of the total budget to health that gives majority for funding on recurrent expenditure at the expense of development expenditure which further compromises the provision of primary health care.

II. STATEMENT OF THE PROBLEM

Health policies formulation and implementation are of immense importance globally, regionally and at state level for any form of development to be realized. According to WHO (2010), avers that the overall progress towards meeting these Millennium Development Goals (MDGs) in Africa had been less than impressive. A 2010 review of the health situation in Kenya performed by the Ministry of Medical Services and the Ministry of Public Health and Sanitation reveals that improvements in health status have been marginal in the past few decades and certain indicators have worsened (G.o.K, 2010). The persistence of these health care problems prompted the researcher to interrogate the financial policy aspect which is considered a major contributor to this persistence. The success for public health policies also depends on the amount of funds available to operationalize policies. Therefore, to what extent is funding for health care policies responsible for success or failure in the implementation in Baringo County? In a bid to unravel the mystery of never ending challenges of public health through policy implementation, this study sought to identify the nature of funding for public health policies and other challenges that hinder implementation

III. JUSTIFICATION OF THE STUDY

The study intended to provide new literature on the implementation of public health policies especially finance policy across the globe, Africa and Kenya in particular especially at this current dispensation where health policies have been devolved to Kenya's forty seven county governments.

This study data is going to provide information on appropriate techniques of public health implementation to policymakers and planners for health since health is critical for development as notes by Schultz, (1993) human health has a major role to play in social-economic and political development. There is a direct link between the health of a population and its productivity, and this relationship has been demonstrated in industrial countries, which are now benefiting from years of investment in health services (ibid). In addition, the findings and recommendations emanating from this research shall provide great insights for stakeholders in bid to curb public health challenges. Finally, the findings from the study are useful to scholars of policy and other academicians on issues

of policy formulation and implementation on devolution and healthcare financing.

IV. SCOPE OF THE STUDY

The study was conducted in Baringo County in Kenya reviewing the implementation of public health finance policy formulated and implemented between the periods 2003 to 2015. This was the period when governments had come up with a lot of public health policies and other policies related to health care. Baringo County was chosen as an area of study because of its diversity of the population living in the area owing to their socio-economic, historical cultural and political diversity necessary for such a kind of study. According to Mwasii (2010) area specific analysis of needs and barriers can produce useful data for informing policy on improving accessibility to health service.

V. FINANCING OF PUBLIC HEALTH POLICIES IN BARINGO COUNTY

Funding for public health policies is important for those policies to realize their intended objectives. Finance is a constraint that determines the success or failure of policies as meager budgets hinders implementation. Consumers of public health policies can also be constrained by the health care finances that often limited their choices of maximizing health care services provided within their locality. In an attempt to find out the level of funding for public health policies, this research operationalized the following variables: the health facility attended by respondents, charges in those visits, the mode used by the respondents and their perception about the cost vis a vis the quality of services offered.

Health Facilities Attended in the Last One Year

The choice of a health facility is motivated by individual needs, proximity, costs and quality of services offered. Some of the operationalized variables are; Government, Private, N.G.O Funded facility and Traditional Doctor. Data on facility attended is presented in table 1

Table 1. Health Facilities Attended

| Health facilities | Frequency | Percentage |
|-----------------------|-----------|------------|
| Government | 190 | 62.5 |
| Private | 101 | 33.2 |
| N.G.O Funded facility | 7 | 2.3 |
| Traditional Doctor | 6 | 2.0 |
| Total | 304 | 100.0 |

Source: Field data, 2015

From the findings it was evident that; (62.5%) visited Government facility, (33.2%) visited Private facility, (2.3%) visited N.G.O Funded facility and (2.0%) visited Traditional Doctor. From the findings it was deduced that government facility has the most visits and thus plays a key role in health management. It also indicates that residents have faith in the

government managed health facilities although others prefer private health facilities because of the convenience and quality of services they offer. The data obtained seems to validate the KPMG report (2012) on the future of health care financing that at the moment the governments which are successfully addressing their populations' medical needs are combining direct expenditure with other financing models. In some, government chooses to finance the administrative side of healthcare, leaving specific projects relating to the control of epidemic diseases to external donors, and more and more medical services to the private sector (KPMG, 2012: 9). The data calls for planners to put more resources and attention to governments health facilities as they remain preferred health care facility by the residents.

Charges per Visit in Health Facility

The researcher found it important to establish on the charges per visit. Charges are usually calculated based on amount spent or rather the total cost incurred. This data is presented in table 2

Table 2 Charges per visit in health facility

| Charges | Frequency | Percentage |
|----------------|-----------|------------|
| Expensive | 93 | 30.6 |
| Moderate | 180 | 59.2 |
| Cheap | 26 | 8.6 |
| Very Expensive | 5 | 1.6 |
| Total | 304 | 100.0 |

Source: Field data, 2015

From the data gathered it was evident that (30.6%) of the respondents cited charges being expensive, while (59.2%) cited charges being moderately, (8.6%) cited charges being cheap and (1.6%) cited charges being very expensive. From the findings it can be deduced that most respondents go for affordable health services. It is evident that majority of the residents prefer government managed health facilities due to their moderate costs. In the provision of health care, costs are critical because it can discourage users from utilizing the facility especially when other providers are available for choice.

Government officials interviewed cited the costs that are passed to the residents as a cost sharing costs. This is what one of them had to say:

"These costs are meant to boost the management of the health facility thus there is no free health care in public health facilities for older citizen unless for children under the age of five and maternity services for women. This money recovered is used to finance operations within the health facility for better service delivery."

According to the literature reviewed, the rationale for cost sharing was to charge those who make most use of the

curative care and those who are most able to pay and channel the subsidies to those least able to pay (Owino *et al*, 1997). However, previous studies reveal that in many public health systems the scheme turned out to be an avenue to siphon public funds from the users and was marred with a lot of challenges in the process of implementation. According to Mwabu *et tal* (2004) more than a decade after its implementation, the cost sharing program has not fully addressed the problems of the vulnerable and has not promoted access to modern healthcare. Implementation problems and institutional weaknesses mar the program and there has not been corresponding improvement in the quality of healthcare (ibid). Nevertheless, literature reviewed has lauded this policy in other parts of Africa. For instance, World Bank (1994) lauded experiences from the initiative where community were involved in cost sharing mechanisms in support of primary healthcare suggested that cost sharing in local health centers paid significant dividends. In countries like Benin, Guinea and Nigeria where experiences have been closely monitored, local operating costs (including salaries) are being covered by user fees in facilities participating in the Bamako Initiative (ibid). It is therefore important for government to relook in to the implementation of this noble policy and make a comparison with those countries that were able to achieve their objective for a better and affordable health care provision.

Mode of Payment in Every Healthcare Visit

The researcher found it important to establish on the mode adopted by the respondents in settling their hospital bill. The modes adopted are based on convenience and affordability. This information is presented in table 3

Table 3 Mode of Payment in Every Health Care Visits

| Mode of payment | Frequency | Percentage |
|-----------------|-----------|------------|
| Out of pocket | 260 | 85.5 |
| NHIF | 44 | 14.5 |
| Total | 304 | 100.0 |

Source: Field data, 2015

From the data collected it was evident that (85.5%) do use out of pocket and the remaining (14.5%) do use NHIF. From the findings it can be deduced that out of pocket and NHIF are the common modes used in Baringo County. The use of out of pocket in settling medical bills in health is not cost effective. Moreover, many of those who were beneficiaries of NHIF insurance scheme still opted for out of pocket spending because the scheme was only valid for hospital bed occupancy and not for outpatient service. In addition, many health facilities in Baringo were not NHIF approved facilities thus constrained the residents from benefiting from the insurance scheme. According to Economic Intelligence Unit report 2011, direct payment at point of use is the least-optimal way of financing healthcare, as in poor countries in particular, dramatic and expensive ailments can push the poor into

bankruptcy, or else high costs can dissuade people from seeking desperately needed medical care. From the data collected, proper education and awareness should be enhanced in the communities for residents to register and pay for health care insurance to reduce the burden of health care financing. The same observation was supported by literature reviewed that for an unchanged level of government and external funding, improving Africa’s healthcare expenditure profile will thus mean shifting private expenditure from direct payment to prepaid or pooled expenditure (KPMG, 2012).

VI. QUALITY OF SERVICES RENDERED IN THE PUBLIC HEALTH FACILITY

The researcher was keen to establish the quality of service on resident’s well-being. This was to verify whether the respondents are comfortable with the health policies in the local health facilities. This data is presented in table 4.

Table 4 Quality of Services Rendered in the Public Health Facility

| Quality of services | Frequency | Percentage |
|---------------------|-----------|------------|
| Good | 68 | 22.4 |
| Poor | 51 | 16.8 |
| Fair | 185 | 60.9 |
| Total | 304 | 100.0 |

Source: Field data, 2015

From the data collected it was evident that (22.4%) of the respondents termed services offered within health facilities to be good, while (16.8%) termed services to be poor, and (60.9%) rated services to be fair. This implied that the services are averagely good and thus meet residents need. However, the county government officials interviewed during the study pointed several challenges that have hindered the provision of quality services to the residents of Baringo:

“The finances that are allocated to the health sector are not enough to effectively implement the public health programs within Baringo County. For instance in the last financial year, KSH.1.3 Billion was allocated to health ministry and 1Billion were used on salary for medics and support and administrative staff leaving 300million to implement other health programs within the entire Baringo.”

According to the County government officials, national government revenue allocation to Baringo is meager because the County has never been considered a marginalized region to attract the equalization fund which in his view would help to fund health programs. The finding concurs with Mwabu *et tal*, (2004) that Kenya has invested heavily in healthcare in terms of infrastructure and health personnel training but the quality is still low due to various reasons including inadequate financing, inadequate medical supplies, lack of transport, and imbalances in staffing.

It was also established from the study that services were still centrally allocated across different regions of the County

despite the decentralization of health care provision as the best way of providing public health care. This is contrary to World Bank report (1993) that decentralization is a key component of health sector reform of decentralizing fiscal, administrative, ownership and political authority in the health sector from the ministry of health (MoH) to lower levels which has been advocated as one of the ways through which efficiency in delivery of healthcare services could be improved. According to a senior technical County Public Health official interviewed, there is uneven resource allocation on health within the County budgets and priority spending within the department of health. This is what he pointed out:

“Resource allocations for various community projects are neither informed by community concerns and priorities nor indicators from the grassroots but from competing political interests. Such a kind of allocation is likely to compromise sustainability and equity within and across different regions of the county.”

This data is consistent with the literature reviewed that not only is Kenya spending a relatively low amount as a percentage of GDP on healthcare, but the allocation of funds to public facilities has been uneven (KPMG, 2013). According to the public health official interviewed centralized resource allocation for health compromises technical efficiency (cost-consciousness at the periphery) and allocative efficiency (allowing the mix of services and expenditures to be decided and shaped by the local users' choice) necessary for effective and efficient service delivery. Proponents of devolution have always feared the role power elite can do to undermine devolved initiatives. For instance, Sott-Herridge (2002) while assessing devolution in Uganda observed that mechanism of participation should be in place in determining service priorities yet this is not fully effective as local elites still seek to determine priorities and local people are not always consulted.

VII. CONCLUSION AND RECOMMENDATION

The study recommends increased budgetary allocation to the health sector. The biggest challenge to the provision of health care is lack of enough resource which has hindered the provision of essentials services offered at secondary and primary level of health care. The current equitable share allocated to Baringo county government is meager for implementation of critical services such as health care. Furthermore, the county government should apportion more funds to health department in the budgetary allocation and ensure that the allocation is informed by priority health needs from the community other than political patronage.

Cost sharing strategy should be re-evaluated to establish its viability as a cost recovery strategy in the new dispensation. Sensitization of residents to enroll for prepaid or pooled payment for health care other than relying on out of pocket spending which is expensive in the long run need to be emphasized especially in the rural areas. The government should restructure the public health care insurance popularly called NHIF, to accommodate outpatient services and to cater for the less privileged members of the society. The scheme should be made available in all public health facilities located in the rural areas. The government can borrow a leaf from African governments that have excelled in improving health insurance cover for majority of their citizen such as South Africa, Tunisia and Ghana.

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