ACCOUNTABILITY AND HEALTH CARE MARKETIZATION IN KENYA: WHY REFORM PUBLIC LAW?

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I. INTRODUCTION

A recent attempt by the Ministry of Health to establish a mandatory social health insurance scheme was vehemently opposed by various interest groups, culminating in the withdrawal of the National Social Health Insurance Fund (NSHIF) Bill.[1] Their concerns varied. For instance, the Minister of Finance thought that the scheme was unaffordable.[2] Others doubted whether the government could be entrusted with the management of the proposed fund in light of recent corruption scandals and poor management of the existing National Health Insurance Fund (NHIF).[3] It was thus reported that the NHIF lost some K.Shs. 300 million due to fraudulent claims in 2003 alone.[4] There were also concerns that because all Kenyans and permanent residents would be compelled by law to contribute to the fund, it not only constituted an abrogation of the freedom of choice[5] but would also lead to extra taxation of "already overburdened taxpayers."[6] Health management organizations were also gravely concerned that they would lose a large portion of their clients if the NSHIF Bill became law.[7]

The proposed National Social Health Insurance Scheme (NSHIS) should be seen in the context of efforts by successive administrations in Kenya to reform the health care sector. Like other developing countries, Kenya's public health care

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[1] The National Social Health Insurance Fund Bill, 2004, Kenya Gazette Supplement No. 29 (Bills No. 10) [*Hereinafter* NSHIF Bill].

[2] 'Health Minister Opens New Wounds in the Cabinet,' *East African Standard*, November 23, 2004 (Kenya).

[3] *See, e.g.*, 'Lecturers Reject New Health Scheme,' *East African Standard*, July 10, 2004 (Kenya)

[4] 'National Health Insurance Fund (NHIF) Swindled of Sh300m,' *Daily Nation*, October 30, 2003 (Kenya).

[5] 'Lobby Group Challenges Health Bill,' *Daily Nation*, December 31, 200 (Kenya)(Reporting that the National Private Sector Foundation moved to the High Court asking for a declaration that the NSHIF Bill is unconstitutional).

[6] 'Group Opposed to Government's Health Insurance Scheme,' *East African Standard*, November 14, 2004 (Kenya).

[7] 'Fund Losers and Winners,' *East African Standard*, June 20, 2004 (Kenya).

sector has been characterized by various problems, including scarcity and inefficient use of financial resources, low accessibility of health care, poor quality of service, and demoralized work forces.[1] Further, Kenya's public health care system has been characterized by poor management, widespread corruption and inefficiency. The evidence for such malaise includes the pilferage and theft of equipment and supplies, unaccountable procurement systems and overstaffing of facilities especially with non-technical workers.[2] There has also been an emphasis on curative care instead of prevention and the delivery of basic services, with the result that lower level facilities where basic services should be provided are by-passed in favour of secondary and tertiary care facilities.[3]

In efforts to address these problems, the World Bank and other international financial institutions have since the 1980s called upon African countries to reduce the level of government involvement and promote private sector participation in health care by implementing various marketization measures.[4] Accordingly, Kenya has experimented with a number of health care marketization measures as part of structural adjustment over the last two or so decades.

This article reviews Kenya's experience with health care marketization from the viewpoint of accountability. Given the persistence of corruption in the public sector, the article argues that health care marketization measures are unlikely to succeed in Kenya in the absence of accountability-enhancing public law reforms. The idea of a national social health insurance scheme is therefore premature, quite apart from the fact that it is arguably unconstitutional. Further, the article argues that the proposed NSHIF is neither efficient nor legitimate since it unduly restricts private choice over health insurance. Instead of compelling citizens to subscribe to the NSHIF, the government should enhance competition in the market for health insurance while it simultaneously strengthens its capacity to regulate this market.

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[1] *See* M Madeo and S Spinaci, 'Health Sector Reforms in Developing Countries,' 5 *Giornale Italiano Di Medicina Tropicale* (2000) p.2; PA Berman and TJ Bossert, 'A Decade of Health Sector Reform in Developing Countries: What Have We Learned?,' Paper prepared for the Data for Decision Making Symposium: Appraising a Decade of Health Sector Reform in Developing Countries, Washington, D.C., March 15, 2000, p. 1. It is estimated that about four out of 10 Kenyans do not seek treatment because they cannot afford it. *See* Ministry of Health, *Household Health Expenditure and Utilisation Survey Report* (2003).

[2] D Sahn and R Bernier, 'Have Structural Adjustments Led to Health Sector Reform in Africa?,' 32 *Health Policy* 193 (1995) p. 193 at 198.

[3] Ibid.

[4] S Bennett, B McPake and A Mills, 'The Public/Private Mix Debate in Health Care,' in S Bennett , et al, eds., *Private Health Providers In Developing Countries: Serving The Public Interest?* (1997), p. 1 at 2. [Hereinafter *Private Health Providers in Developing Countries*]. I use the term "marketization" to refer to all mechanisms which seek to increase the role of the private sector in activities which formerly were the preserve of the public sector. Such mechanisms range from organizational reforms within the public sector to outright privatization.

Part II provides the article's conceptual framework. It examines the theoretical bases for government intervention in health care and the need for accountability in health care administration. Part III reviews Kenya's experience with health care reforms. Part IV reviews the legislative and institutional framework for health care regulation and makes a case for accountability-enhancing public law reforms. Part V is a brief conclusion.

II. ACCOUNTABILITY AND HEALTH CARE

Accountability denotes "the obligation of individuals or agencies to provide information about, and/or justification for, their actions to other actors, along with the imposition of sanctions for failure to comply and/or to engage in appropriate action."[5] Thus answerability, and the availability and application of sanctions constitute the defining elements of accountability.[6] That is, being accountable means having the obligation to answer questions regarding decisions and/or actions.[7] Further, the overseeing actor(s) must be able to impose punishment on the accountable actor(s) for failures and transgressions.[8]

Accountability serves three – often overlapping,[9] sometimes conflicting[10] – primary purposes.[11] First, actors may be required to account for the financial resources entrusted to them according to prescribed standards and procedures. Such "financial accountability" entails "tracking and reporting on allocation, disbursement and utilization of financial resources, using the tools of auditing, budgeting and accounting." Accounting actors are thus required to comply with laws, rules and regulations regarding financial control and management. Second, actors may be required to demonstrate and account for performance in light of agreed-upon performance targets. Such "performance accountability" differs from financial accountability to the extent that it concentrates on results. Finally, governments in democratic societies are generally required to meet certain societal needs and concerns. In particular, citizens expect governments to deliver on electoral promises. Governments that do so are said to be accountable. This kind of accountability has been termed "political/ democratic" and is mainly effected through elections and the political process.

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[5] DW Brinkerhoff, 'Accountability and Health Systems: Toward Conceptual Clarity and Policy Relevance,' 19 *Health Policy and Planning* (2004) p. 371 at 372.

[6] Ibid.

[7] Ibid.

[8] Ibid.

[9] Thus "Performance accountability is connected to political/democratic accountability in that among the criteria for performance are responsiveness to citizens and achievement of service delivery targets that meet their needs and demands." Ibid at 374

[10] For example, "there can be conflicting pressures between the pursuit of efficient health system performance and democratic principles of equitable service provision." Ibid.

[11] Ibid at 373-374.

As a commodity, health care possesses certain unique characteristics[12] which necessitate suitable accountability frameworks if it is to be provided efficiently and equitably. First, in most societies health care is a "merit good" which everyone ought to have in the interests of equity or social justice.[13] That is, it is a good that most societies want their citizens to have out of concern for their welfare, irrespective of their ability to pay. This is one of the principal reasons why governments frequently play a central role in the financing of health care. Second, certain forms of health care are "public goods," that is, one person's consumption does not reduce the amount available for others to consume. The prevention and treatment of communicable diseases are good examples. Consumers cannot be excluded from these goods: if they are made available to anyone, they are available to all.[14] Since people can consume such goods without having to pay for them, their production will always be less than socially optimal. To ensure socially optimal production of such goods, they must be financed by government or some other non-market alternative.[15]

Third, health care is characterized by the problem of asymmetric information between patient and provider. Patients often do not know what is wrong with them and visit doctors not only for curative services but also for extra information.[16] Furthermore, visits to health-care providers often occur when patients are feeling sick and vulnerable and thus unwilling to take responsibility for making their own decisions.[17] The health care provider must therefore make decisions for the patient. Unfortunately, because health care providers have their own needs and preferences, such decisions may not be in the interests of the patient. For example, the health provider may prescribe unnecessary or expensive procedures or medications.

Information asymmetries also exist between health service providers and oversight bodies. Because service providers typically control the necessary information, oversight bodies invariably experience difficulties in monitoring provider performance.[18]

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[12] While other markets also have some of the unique characteristics described in the text, what makes health care stand out is that it possesses *all* of those characteristics. *See* S Bennett, 'Health-care Markets: Defining Characteristics,' in *Private Health Providers in Developing Countries*, supra note 11, p. 85 at 88.

[13] Ibid at 87.

[14] Philip Musgrove, 'Public and Private Roles in Health: Theory and Financing Patterns,' World Bank, Health, Nutrition and Population (HNP) Discussion Paper, (1996), p.11.

[15] Bennett, supra note 11 at 87. (Noting, however, that while externalities and public goods explain the role of government in health care markets, "they do not necessarily suggest extensive government provision of services (or indeed very extensive financing); pure public goods are few and far between and externalities may require only a limited degree of subsidization.")

[16] Ibid at 87-88.

[17] Ibid.

[18] Brinkerhoff, supra note 12 at 374.

Fourth, while insurance is necessary if there is to be sufficient provision of health care, the market for health insurance often fails thereby necessitating governmental regulation. The need for insurance arises because the demand for health care is derived. People demand health care because it is a means to achieving improved health status, which explains why much demand for health care cannot be planned in advance but is contingent upon deterioration in health status.[19] Moreover, while health care costs may be high, most people are risk averse and do not want to incur large costs at unforeseeable points in the future. For these reasons, insurance or risk sharing for health care becomes important.[20] "Under insurance or risk-sharing schemes, individuals or households pay a premium in advance (which may or may not be related to their actuarial risk of illness) in return for free or subsidized health-care coverage if they fall ill."[21]

But insurance does create a 'moral hazard' problem. Since insurance is a contract by which someone other than the patient agrees to pay for his or her health care, the insured has an incentive to indulge in health risks which otherwise would have been avoided or consuming more health care than otherwise. When that happens, the cost of insurance is likely to rise in order to accommodate the increased demand. Further, insurers will be reluctant to insure high-risk individuals unless they can charge them premiums which reflect their high chance of becoming ill. Alternatively, insurers may seek to deter high-risk individuals from registering with them. Among other things, governmental regulation seeks to ensure the provision of insurance to such individuals.

Given the nature of health care, accountability mechanisms are necessary for two primary reasons. First, accountability mechanisms serve to control the misuse and abuse of public resources and authority by ensuring that "resources are used and authority exercised according to appropriate and legal procedures, professional standards and societal values."[22] As we have seen, health care is predominantly financed using public funds since it is deemed a merit and public good. Public funds devoted to health care must thus be utilized accountably. Indeed, the typical problem in many developing countries is that resources allocated to the health sector are often diverted to parochial causes, given the prevalence of neo-patrimonialism. That is, in the absence of accountability mechanisms, governments in developing countries invariably

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[19] Bennett, supra note 11 at 86.

[20] Musgrove, supra note 21 at 18. (Noting that "When risks cannot be fully controlled, and the associated costs may be catastrophic, the only solution is to share the risk.")

[21] Bennett, supra note 11 at 86.

[22] Brinkerhoff, supra note 12 at 374.

use public resources as instruments for realizing patronage and other parochial political goals.[23]

Secondly, accountability mechanisms are required if the government is to effectively regulate the private provision of health care. As we have seen, health care is characterized by various information asymmetries and market failures, which make governmental regulation inevitable. Accordingly, many things could go wrong in the provision of health care. For instance, a hospital could provide inadequate care, deny patients necessary treatment, or even perform unnecessary or wrong procedures. In such situations, patients typically have no recourse since they do not have the information to make informed choices. Government should therefore step in to ensure the provision of adequate care. Since such governmental regulation entails the grant of wide discretionary powers to regulatory agencies, it also becomes necessary to keep such powers within the bounds of law to ensure that they are not abused. In addition, it may be necessary to compel regulatory agencies to perform their duties since they may fail to act, especially where they have been captured by the industries they are meant to regulate.

Further, governmental efforts to ensure the optimal production of health care increasingly involve the use of contractual relationships with private providers to deliver health services. Indeed, governments worldwide are outsourcing many of their "traditional functions" thanks to privatization and globalization.[24] Given the likely impact of such outsourcing on the provision of health care, it again becomes important that it is formulated and implemented through accountable processes. Here, accountability mechanisms become important in so far as they are not only likely to facilitate the provision of information that will enable citizens to assess the effectiveness of such public/private contractual relationships, but also ensure that outsourcing arrangements are conceptualized in a way that guarantees fairness for those affected.[25]

The task of establishing suitable accountability mechanisms falls to public law, especially administrative law, which establishes procedures for public notice and comment, and facilitates access to information and judicial review of the exercise of administrative action such as the regulation of health care providers. In addition, given that sound health is considered a prerequisite for the economic productivity of the citizenry, it may be necessary to establish a sound constitutional framework for the accountability of public health care institutions. Enhancing the effectiveness of health care interventions in developing countries may therefore require the reform of public law.

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[23] *See, e.g.*, J Herbst, 'The Politics of Privatization in Africa,' in EN Suleman & J Waterbury, eds., *The Political Economy of Public Sector Reform and Privatization* (Boulder: Westview Press, 1990), p.234.

[24] *See* J Freeman, 'The Contracting State,' 28 *Florida State University Law Review* (2000), p. 155.

[25] AC Aman, Jr., 'Privatization and the Democracy Problem in Globalization: Making Markets More Accountable through Administrative Law,' 28 *Fordham Urban Law Journal* (2001), p. 1477 at 1498.

The following part reviews Kenya's experience with healthcare marketization in the context of neo-liberal reforms and argues that the process has largely been unaccountable and is therefore ineffective in many respects.

III. HEALTH CARE REFORMS IN KENYA

A. Health Care Marketization in Developing Countries

In general, health care "privatization"[26] has been rare in developing countries and the most common marketization measures have been organizational reforms, contracting out, the introduction of user fees, and health insurance reforms.[27] Organizational reforms and contracting out seek to reform public provision arrangements, while user fees and health insurance reforms seek to reform public finance arrangements. Further, organizational reforms and contracting out should be seen in the context of changes in management practice and theory, which are termed the "new public management" and which seek to improve the efficiency of public service provision through the introduction of market mechanisms into the public sector.[28] The following paragraphs examine the nature of these four reform measures.

i. Organizational Reforms

Organizational reforms seek to "move public hospitals out of the core public bureaucracy and transform them into more independent entities responsible for performance."[29] Organizational reforms may either be 'marketizing' or 'non-marketizing.' Marketizing organizational reforms seek to incorporate a greater use of market mechanisms, and include reforms which expose public hospitals to market pressures, and efficiency-enhancing reforms which require public hospitals to balance their budgets, earn profits and keep their savings.[30] Conversely, non-marketizing organizational reforms such as decentralization seek to change the institutional structures of public hospitals.[31]

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[26] Privatization entails transferring a public hospital to private ownership, either as a for-profit or non-profit enterprise. Privatization is excluded from the discussion here for the simple reason that there is very little health care privatization experience in developing countries.

[27] Bennett et al, supra note 11 at 6-7.

[28] A Mills, 'Contractual Relationships Between Government and the Commercial Private Sector in Developing Countries,' in *Private Health Providers In Developing Countries*, supra note 11 at 189. (Noting that market mechanisms "involve financial devolution, explicit standards of measuring performance, clear specification of relationships between inputs and outputs, and belief in the superiority of private-sector management practice and in the virtues of competition, competitive tendering and internal markets.")

[29] M Jakab et al, 'The Introduction of Market Forces in the Public Hospital Sector: From New Public Sector Management to Organizational Reform,' World Bank HNP Discussion Paper (2002), p. 6.

[30] Ibid.

[31] Ibid at 7.

Measures to enhance the autonomy of public hospitals constitute perhaps the main example of non-marketizing organizational reforms.[32] In public hospitals many decisions typically require authorization from the ministry of health that may take a long time, require a discouragingly complex process of filling out forms, or both.[33] Autonomy reforms aim to remove such regulatory and bureaucratic constraints to efficient decision making. But while increasing the decision-making autonomy of public hospitals is desirable, it is not easy to achieve. It has, for instance, been difficult to grant decision rights to hospitals, particularly over labour, capital assets and setting of user fees.[34]

ii. Contracting Out

Contracting out involves "the use of contractual relationships with private providers to deliver health services."[35] The government's role shifts from providing to financing health care and stimulating competition between providers.[36] Health care services that can be contracted out include clinical services (such as primary care, speciality care services, surgical procedures and laboratory tests), non-clinical services (such as pharmacy, catering, laundry, cleaning, building and equipment maintenance and security) and functions (such as personnel recruitment and employment, management, computing and purchasing).

There are various forms of contracting out, including: (1) competitive tendering, where public servants can bid in competition with private contractors; (2) cases where only private bids are allowed, and contracts may be agreed with or without competitive tendering; and, (3) internal contracting, where only internal bids are allowed.[37] Competitive contracting out is the form most commonly discussed in relation to developing countries, where contracts are agreed with for-profit enterprises or church providers.[38]

Various economic justifications are offered for contracting out. The economic justifications rely on public choice theory and property rights theory. Basically, public choice theory argues that government officials, like all other private individuals, pursue their own interests.[39] For instance, politicians seek to maximize their chances of being re-elected, while bureaucrats seek to enhance their status and salary. And because politicians and bureaucrats therefore have

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[32] Ibid.

[33] Ibid.

[34] Ibid at 8.

[35] Madeo and Spinaci, supra note 8 at 8.

[36] Ibid.

[37] Mills, supra note 11 at 190.

[38] Ibid.

[39] For a review of public choice theory, *see, e.g.*, K Walsh, *Public Services and Market Mechanisms: Competition, Contracting and the New Public Management* (1995).

no incentive to promote efficiency, the public sector becomes wasteful. For their part, property rights theorists contend that the source of inefficiency in the public sector is the weakening of property rights.[40] Because public servants do not own public enterprises, they have no incentives to perform efficiently. By contrast, the entrepreneurs and shareholders of private enterprises are said to have a strong interest in the efficient use of resources.

Contracting out offers four distinct advantages, according to economists.[41] First, it can enhance the efficiency of public health care service provision. Second, it can confer the benefits of "functional specialization." In this regard, Anne Mills notes that "A hospital, for example, is unlikely to have a competitive advantage in all areas required for [it] to function. A cleaning company may have advantages of size (economies of scale, large pool of skilled managers) and specialization (responsiveness to changing technologies, low overheads). The private sector tends to be better than the state at adjusting to changing factor prices and technology."[42] Third, contracting out offers greater flexibility to coping with changing demand since contract workers can be readily hired and fired."[43] Finally, contracting out may offer a much-needed means of distancing the provision of services from the political process.[44]

Nevertheless, contracting out can be quite demanding institutionally. The contracting process involves defining the services to be provided, negotiating contractual terms and conditions, and implementing and monitoring the contract. For example, the terms and conditions of the particular contract will determine whether private providers will bid or perform efficiently.[45] The more that contracts constrain providers and shift risk towards them, the less willing they are likely to bid. Conversely, less stringent contracts are likely to reduce incentives to efficient performance.

iii. User Fees

User fees refer to the payment of out-of-pocket charges at the time of use of health care.[46] Three economic justifications have been offered for the imposition of user fees.[47] First, payments for services discourage frivolous use of health

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[40] *See, e.g,* A Harding and AS Preker, 'Understanding Organizational Reforms: The Corporatization of Public Hospitals,' World Bank HNP Discussion Paper (2000), p.6.

[41] *See* Mills, supra note 35.

[42] Ibid at 191.

[43] Ibid.

[44] Ibid at 192.

[45] Ibid at 193.

[46] D Arhin-Tenkorang, 'Mobilizing Resources for Health: The Case for User Fees Revisited,' WHO Commission on Macroeconomics and Health Working Paper No. WG3:6 at 5 (2000).

[47] GC Griffin, 'User Charges for Health Care in Principle and Practice, in Health Care Financing,' Proceedings of Regional Seminar on Health Care Financing, July27 - August 3, Asian Development Bank, Philippines (1987); Arhin-Tenkorang, supra note 53 at 5-10.

facilities. Second, where consumers pay for health services they become conscious of quality and will demand it. And third, the greater availability of funds through user fees at the point of service increases both the availability and quality of services.

In practice, however, the imposition of user fees has not led to these outcomes and has instead had a socially regressive impact. User fee systems have been difficult to administer and the revenue gains have been modest, at best.[48] Even where user fees have been accompanied by some quality improvements, they have had "severe effects on the demand for health care by the poor who get 'priced out' of the market."[49] Furthermore, in many cases no mechanisms have been established to protect vulnerable groups.[50]

Accordingly, the general assessment from the empirical studies is that the experience of user fees has been unsatisfactory with respect to quality and accessibility of services.[51] In particular, user fees are unlikely to ensure equity in the access and consumption of health care. For this reason, many commentators have suggested insurance as the solution to financing and guaranteeing equitable access to public health care services in developing countries.

iv. Health Insurance Reforms

Health insurance denotes "a system in which [a] potential consumer of health care makes an advance payment to an insurance scheme. In the event of future health service utilisation the insurer will pay the provider of care some or all the direct expenses incurred."[52] Typically, premiums are based on the incidence of diseases and use of services, and are thus related to the clients' risk, irrespective of their income.

Health insurance provides a means by which the society may share the costs of public health care: those who do not fall sick but participate in insurance schemes contribute towards the expenses of those do fall sick, while they are guaranteed that in times of illness their care will be paid for by a third party.

In practice, however, the potential of health insurance is constrained by the prevalence of market failure. As we have noted, the moral hazard problem

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[48] Arhin-Tenkorang, supra note 53 at 11. (Arguing that "Given [the] low revenue performance of user fees, development assistance remains the most viable instrument for addressing the resource constraint faced by the health sectors of developing countries.")

[49] Ibid at 12.

[50] BC Purohit, 'Structural Adjustment and the Health Sector in India: Some Policy Issues in Financing,' Queen Elizabeth House Working Paper No. 2, University of Oxford (1997), p.5.

[51] *See* Arhin-Tenkorang, supra note 53.

[52] Madeo and Spinaci, supra note 8 at 8.

tends to be common in health insurance, as consumers use too much care thereby escalating its costs. Second, insurers are often reluctant to cover high-risk individuals, such as chronic patients, with the result that a significant segment of the population may not be covered. Third, unregulated health insurance may lead to excessive 'medicalization' as health care providers seek to maximize their profits. And in developing countries, the population coverage can be limited because of their large informal sectors and urban bias. In these countries, it can be expected that health insurance coverage in the rural areas will be inadequate.

The resolution of these efficiency and equity problems requires governmental regulation. Unfortunately, however, the administrative capacity required for effective regulation is often not readily available in many developing countries.[53] Furthermore, few developing countries have the institutional infrastructure needed to implement a formal national health insurance scheme that provides national coverage.[54]

B. Health Care Marketization in Kenya

Since the late 1980s, the government has introduced a number of reform measures in the health care sector, including organizational reforms in public hospitals, user fees and social health insurance. Despite these efforts, however, the quality of care in government health facilities is yet to improve and inequality in access to health care continues to be a major and growing problem.[55] And as government-sponsored health care has declined, private health care providers have emerged to take the place of government. Unfortunately, the quality of care in private health facilities has also tended to be poor since they are largely unregulated.[56] Poor management and corruption also continue to undermine the health care system.[57]

The organizational reforms initiated so far include the establishment of an autonomous agency, the Kenya Medical Supplies Agency (KEMSA),[58] to procure and distribute drugs and other medical supplies and the grant of operational autonomy to the Kenyatta National Hospital (KNH) to facilitate improvements in management.

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[53] Musgrove, supra note 21 at 26 (Noting that health insurance fraud has been a major problem in Brazil.)

[54] Arhin-Tenkorang, supra note 53 at 15.

[55] PN Mbatia and YW Bradshaw, 'Responding to Crisis: Patterns of Health Care Utilization in Central Kenya Amid Economic Decline,' 46 *African Studies Review* (2003), p. 69 at 87.

[56] Ibid.

[57] Ibid at 76.

[58] Legal Notice No.28 of 1994 establishing KEMSA.

KEMSA replaced the scandal-ridden Medical Supplies Coordination Unit established in 1994.[59] But the Ministry of Health has not given KEMSA the autonomy to perform its functions. Indeed, the Ministry has established its own tendering committee to handle procurement.[60] Annual budgetary allocations for the purchase of drugs and medical equipment amount to some Kshs.2 billion and it appears that vested interests are keen to ensure that KEMSA does not assume control of procurement.[61] Indeed, corruption in the procurement of drugs and other medical supplies and equipment has been widespread. For instance, there have been irregularities in the tendering process in numerous cases.[62]

On the other hand, KNH has over the years experienced problems such as overcrowding, poor quality of care, shortages of drugs, equipment and other supplies, and low staff morale.[63] These problems have also been attributed to centralization of decision-making in the Ministry of Health and the absence of administrative oversight mechanisms. The government's first attempt to address these problems was to convert KNH into a state corporation in 1987 through a presidential order. The order established a Kenyatta National Hospital Board (KNHB) and made it "responsible for the administration, management and development" of KNH.[64] Thus the Board was now to be in charge of matters such as staff establishment levels, hiring and firing of staff, procurement of supplies and use of resources. But the Board was to perform these functions under the control of the minister for health. The government therefore retained ownership of KNH, and continued to fund the hospital.

The Board's chairman is appointed by the president. Other members of the Board are the Director of KNH who is appointed by the minister of health and serves as the chief executive and secretary to the Board, permanent secretaries in the ministries of health and finance, the principal of the College of Health Sciences of the University of Nairobi, the principal of the College of Health Professions, and five other members appointed by the minister of health.

The organizational reforms initiated by this grant of autonomy did not, however, serve the intended goals for various reasons. Although the Board legally assumed control of the hospital in April 1987, it was not operational for some months due to lack of preparation. There were lengthy delays in

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[59] Gakuu Mathenge, 'The Dilemma of State Medical Supplies Agency,' *Sunday Nation*, June 19, 2005 (Kenya).

[60] Gakuu Mathenge, 'Tug-of-war Over Drug Tender Billions,' *Sunday Nation*, June 19, 2005 (Kenya).

[61] Ibid.

[62] *See, e.g., Flambert Holdings Limited v. Ministry of Health*, Public Procurement Complaints Review and Appeals Board (PPCRAB) Application No. 25/2003 (Kenya).

[63] The following account of the grant of operational autonomy to KNH is drawn from D Collins, G Njeru and J Meme, 'Hospital Autonomy in Kenya: The Experience of Kenyatta National Hospital' (1996).

[64] Legal Notice No. 109 of 1987, section. 4(1).

strengthening the hospital's management as some managers were reluctant to accept change. Salary caps also made it difficult for the Board to attract experienced managers from outside the ministry of health. Furthermore, members of staff were not adequately informed about the changes.

The slow progress in achieving the desired improvements prompted the government to hire a private hospital management firm to speed up the process. But this management contract did not succeed either, due to the exclusion of the Board and KNH management from its development and the inexperience of the hospital management firm. The contract was therefore rescinded in 1992. The situation improved somewhat thereafter, as the Board became more involved in decision-making. Nevertheless, the government needs to transfer a sufficient degree of financial risk to the Board if the grant of autonomy is to significantly improve its efficiency.[65] For instance, it should allow KNH to pursue external funding and hire better-qualified staff. Further, members of the Board should be appointed in a transparent and accountable manner to ensure that the best-qualified persons are chosen.

User fees were reintroduced in 1989, having been in force prior to 1967 when the government decided to abolish fees for outpatient services at public health facilities to make medical care accessible to all citizens.[66] A nominal fee was nevertheless payable in respect of inpatient treatment in government hospitals.[67]

Under pressure from the World Bank and the International Monetary Fund, the Moi administration reinstated user fees in public health facilities in 1989.[68] Citizens were thus required to pay for part of their health care and medications. This policy change saw an immediate decline in attendance at government health facilities by some 40 to 50 percent.[69] In particular, it led to reduced use of medical care by the poor. The government responded to the decline in usage by exempting the poor from paying fees, although this directive did not work well due to the difficulties involved in identifying the poor.[70]

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[65] *See* F Eid, 'Hospital Governance and Incentive Design: The Case of Corporatized Public Hospitals in Lebanon,' Paper prepared for the World Bank Research Project, Analyzing Problems in Public Hospital Corporatization Using Information Economics, 2001.

[66] G Mwabu, et al, 'The Demand for Medical Care in Kenya: An Application of Quantile Regression,' in G Mwabu, et al, eds., *Improving Health Policy in Africa* (Nairobi: University of Nairobi Press, 2004), p. 121.

[67] Ibid.

[68] Mbatia and Bradshaw, supra note 62 at 76.

[69] G Mwabu, et al, 'Financing Medical Care through Insurance: Issues From an Analysis of Facility and Household Surveys in Kenya,' in *Improving Health Policy in Africa*, supra note 73 at 180.

[70] Ibid.

The user fees policy was suspended for several months by President Moi in 1990 in response to public pressure.[71] In addition, the Ministry of Health was ill-prepared to implement the policy. Thus essential accounting and management systems were not established and the government had not developed the means to monitor and evaluate its implementation.[72] But the policy was later reinstated and implemented in phases after the government developed better management systems.[73] This led to better acceptance by providers and patients. The improved management system included the preparation of cost sharing operation manuals, and staff training for procedures pertaining to patients' claims, cash collections, waivers, exemptions, accounting and reporting. These changes helped to reduce the decline in demand and revenue collections improved somewhat.

But user fees continue to adversely impact on access to health care by the poor, who should be the primary beneficiaries of public health care. Further, the revenues generated from cost-sharing have not been adequate to ensure better services in public hospitals and clinics. The imposition of user fees has also assumed that the country is well-endowed with public infrastructure such as roads and telecommunications.[74] But most rural areas in Kenya do not have such infrastructure and many people have difficulties accessing health facilities even if they are able to pay the user fees. It therefore becomes important to pay attention to the broader environment in which user fees are being imposed.

Because the imposition of user fees has significantly reduced access to health care by the poor, there is now a belief that medical insurance might offer a suitable alternative in efforts to ensure universal access to health care. Kenya has had a national insurance scheme established by the National Hospital Insurance Fund (NHIF) Act of 1966, [75] which covers about 25 percent of the population for part of their health expenses.[76] The NHIF is mandatory for all formally-employed Kenyans earning over Kshs. 1000, who are required to pay monthly premiums based on their salary levels. These premiums are collected through the imposition of a payroll tax. Self-employed Kenyans and those working in the informal sector may also choose to join the scheme. All beneficiaries are given membership cards, which they are required to produce

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[71] G Mwabu and J Wang'ombe, 'Health Service Pricing Reforms in Kenya: 1989-93,' International Health Policy Program Working Paper, (February, 1995); Mbatia and Bradshaw, supra note 62 at 76.

[72] JC Setzer and M Lindner, 'The Use of USAID's Non-Project Assistance to Achieve Health Sector Policy Reform in Africa,' USAID Policy Paper No.12 (1994), p.19.

[73] D Collins, et al, 'The Fall and Rise of Cost Sharing in Kenya: The Impact of Phased Implementation,' 11 *Health Policy & Planning* (1996), p.52.

[74] R Gesami, et al, 'The Effect of Cost-Sharing on Health Service Utilization in Kenya: Evidence from Panel Data,' in *Improving Health Policy in Africa*, supra note 73, 133 at 142.

[75] National Hospital Insurance Fund Act, Chapter 255, Laws of Kenya (Repealed).

[76] Republic of Kenya, Ministry of Health, *Sessional Paper No.2 of 2004 on National Social Health Insurance in Kenya* (2004) [Hereinafter *Sessional Paper No.2 of 2004*]. It should be noted, however, that the NHIF only accounts for about 3.9% of the total cost of health care in the country. Ibid at 4.

in order to benefit from the scheme. Whenever a beneficiary of the scheme is hospitalized in an accredited facility, the NHIF compensates such facility at a fixed daily rate depending on whether it is a small or large facility. The beneficiary is then expected to pay for any expenses in excess of the daily rate allowed for the particular facility.

The NHIF is run by a board, whose chairman is appointed by the president. Other members of the board are the permanent secretaries of the ministries of health and finance, representatives of employers, representatives of trade unions, and a representative of the insurance industry. The board performs its functions under the direction of the minister of health, who also has powers to dismiss members of the board. The board's main responsibilities are to receive all contributions and payments to the scheme and make payments to health providers. The board also establishes criteria for the accreditation of hospitals, but in consultation with the minister.

In order to help it perform these functions, the board has established branches throughout the country. The branches verify claims before forwarding them to the headquarters for payment. They are also responsible for the surveillance of accredited facilities. In addition, the NHIF employs enforcement inspectors to identify employers and ensure they are registered with the scheme and remit their employees' contributions.

While the NHIF has made some useful contribution in the quest for accessible health care, it has a number of shortcomings.[77] It does not cover out-patient costs. In addition, the coverage provided for in-patient costs is inadequate since it usually covers only part of the cost of the services provided to beneficiaries. The procedures for processing claims are also cumbersome with the result that the claimants are rarely compensated on time. Because of inefficient compliance and monitoring systems, fraud has also been a major problem. It has thus been estimated that the NHIF receives less than 70 percent of its expected revenue,[78] due to fraud and administrative inefficiencies. It is also claimed that private facilities have mastered the claims process more effectively than facilities serving poorer population groups, thereby skewing the scheme's resources in favour of the better off.[79]

The latest reform initiative consists in an attempt to transform the NHIF into a mandatory national social health insurance scheme, with a particular emphasis on "facilitating the provision of healthcare to all Kenyans irrespective of their

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[77] United Kingdom, Department for International Development, 'Proceedings of the DFID Health Insurance Workshop' (2002), p. 13. Available at <www.healthsystemsrc.org>.

[78] Ibid.

[79] Ibid. (Citing a study finding that "private hospitals, nursing homes and maternity homes accounted for 26 per cent of approved facilities but received 58 per cent of total NHIF reimbursements.")

age, social, or economic status."[80] Under the proposed scheme, every employed Kenyan will be required to pay regular contributions to the National Social Health Insurance Fund (NSHIF) before an illness occurs. But the government will pay for the poor from its tax revenues. It is expected that the introduction of the scheme will also free up resources, which the government can use to "intensify disease prevention activities, improve quality of health services in public health facilities, build new health facilities and strengthen compliance to health standards by all health providers."[81] Another significant feature of the proposed scheme is that, unlike the NHIF, it seeks to cover both outpatient and inpatient services. In addition, insurance coverage will embrace all accredited health facilities, including traditional health providers.

The NSHIF is to be managed by a Board of Trustees whose chairman is to be appointed by the president.[82] Other members of the Board are the permanent secretaries in the ministries of finance and health, the attorney general, the director of personnel management, the Director of Medical Services, nominees of the Federation of Kenya Employers, the Central Organization of Trade Unions, the Kenya National Union of Teachers, the Association of Kenya Insurers, non-profit making health care providers, the Kenya Medical Association, non-governmental organizations, and a representative from each of Kenya's eight provinces. The functions of the Board include determining the benefits package in consultation with the minister, prescribing the formulary of registered cost-effective drugs to be used in the benefits package, determining the contribution levels of fund members, receiving contributions, contracting health service providers, ensuring compliance by contracted providers with prescribed quality standards, and advising the minister on social health insurance policy.[83]

The health care marketization reforms described above raise a number of accountability issues. The following section discusses those issues in the context of the legal framework for health care regulation with a view to proposing accountability-enhancing administrative law reforms. In doing so, I adopt a broad approach to health care regulation, which I define as governmental oversight of the health care system.

IV. HEALTH CARE REGULATION IN KENYA

Kenya's experience with health care marketization raises the following accountability issues. First, in view of the prevalence of corruption in the public health sector, how adequate is the legislative framework in ensuring accountability and controlling the abuse of public resources and authority?

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[80] *Sessional Paper No. 2 of 2004*, supra note 83.

[81] Ibid.

[82] NSHIF Bill, supra note 1 at s 8.

[83] Ibid, s 9.

Second, in the context of user fees and the proposed NSHIF, should there be due process in the determination of who qualifies to be exempted from paying fees or contributions? In addition, does the existing administrative framework ensure fairness, accountability and public participation in this determination? Third, is it just or efficient to restrict private choice in order to ensure universal access to health care? Fourth, given the presence of information asymmetries in health care, how should the private health sector be regulated to offset failures in the market for health? Finally, given the potential for contracting out to promote public ends, how can public law facilitate the realization of this potential?

Despite attempts to implement organizational reforms such as granting the Kenyatta National Hospital some autonomy, health care decision-making in Kenya continues to be highly centralized. Further, the public health system's management cadre is dominated by medically trained staff, who typically have little management training. These attributes of the system are reinforced by a legislative framework that places virtually all public health institutions under the control of the minister for health. The minister not only appoints the managers and boards of these institutions, but also controls the performance of their functions.[84] As a result, principal administrative institutions such as the office of Director of Medical Services (DMS) do not have the autonomy to perform their functions.[85] Indeed, directors of medical services hardly last a year in office and have reportedly been fired for making decisions that are not favourable to the minister.[86]

Further, it is not clear from the legislation who, between the DMS and the permanent secretary, is ultimately responsible for the administration of the public health system. Their functions overlap in a manner that can only attenuate the lines of accountability. In addition, there are many institutions charged with the task of regulating various aspects of health care. Thus there is a Central Board of Health established by the Public Health Act,[87] a Medical Practitioners and Dentists Board established by the Medical Practitioners and Dentists Act,[88] a Clinical Officers Council established by the Clinical Officers

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[84] *See, e.g.,* The Public Health Act, Chapter 242, Laws of Kenya; The Pharmacy and Poisons Act, Chapter 244, Laws of Kenya.; The Medical Practitioners and Dentists Act, Chapter 253, Laws of Kenya; The Nurses Act, Chapter 257, Laws of Kenya; The Clinical Officers (Training, Registration and Licensing) Act, Chapter 260, Laws of Kenya; and, The National Hospital Insurance Fund Act, No. 8 of 1998.

[85] The Office of the DMS is established by the Public Health Act, s 9. Its main functions are to promote public health and advise and direct local authorities on public health. Ibid at section 10.

[86] *See, e.g.,* 'Why DMS Was Replaced,' *Daily Nation,* November 19, 2003 (Reporting that "The removal of Dr Richard Muga as Director of Medical Services came in the wake of differences among top ministry officials over a multi-million-shilling tender for supply of Aids testing equipment.")

[87] Public Health Act, supra note 91, at s 3.

[88] Medical Practitioners and Dentists Act, supra note 91, at s 4.

(Training, Registration and Licensing) Act,[89] a Nursing Council of Kenya established by the Nurses Act,[90] and a Pharmacy and Poisons Board established by the Pharmacy and Poisons Act.[91] In addition, health management boards are now being established under the Local Government Act.[92] This proliferation of institutions, many of whose functions and membership overlap, does not also auger well for accountability.

The existing legislative framework is therefore not adequate in ensuring accountability and controlling the abuse of public resources and authority. Perhaps out of the recognition of the need for clear lines of accountability and efficient administration, the draft constitution of the Constitution of Kenya Review Commission (CKRC Draft) sought to consolidate the institutional framework for heath care administration by establishing a Health Services Commission (HSC) as the sole health care authority.[93] Its functions would have been to register all health sector professionals, recruit and employ registered health workers, ensure planned health and professional standards and ethics, ensure viable technical management including procurement of services and supplies, and oversee health care financing.[94] The CKRC Draft also sought to ensure autonomy for and accountability in the appointment of members of the HSC by granting them security of tenure and subjecting their appointment by the president to parliamentary approval.[95]

There is also a need to ensure that public health institutions are managed by persons who possess the requisite management and financial skills. Part of the explanation for the failure of health care managers to account for the utilization of public resources is the fact they tend to be medical practitioners who possess little or no management or financial skills.[96] In addition to health professionals, it would therefore be useful if some members of the proposed HSC were to be skilled in resource management.

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[89] Clinical Officers Act, supra note 91, at s 3.

[90] Nurses Act, supra note 91, at s 3.

[91] Pharmacy and Poisons Act, supra note 91, at s 3.

[92] The Local Government Act, Chapter 265 of the Laws of Kenya, at s 271 empowers the minister for local government to make rules for the "better carrying out of the purposes and provisions of the Act." The first hospital management board created pursuant to this power is the Pumwani Maternity Hospital Management Board. This board was created in 2000 and consists of a chairman appointed by the minister, the DMS and the Director of KNH.

[93] The Constitution Of Kenya Review Commission Draft Constitution, s 269(1) (2004) [Hereinafter CKRC Draft Constitution]. It should be noted that The Proposed New Constitution of Kenya, Kenya Gazette Supplement No. 63 (2005) sought to establish a similar health care regulatory authority. *See* ibid, s 251.

[94] CKRC Draft Constitution, s 269(2).

[95] Ibid, ss 290, 294.

[96] *See, e.g.*, 'KNH Medics Seek a Director Well Versed in Management,' *Sunday Nation*, May 22, 2005 (Kenya).

The second accountability question concerns due process in exemption schemes, that is, the determination of who is poor and therefore entitled to free health care services. It will in all likelihood be quite difficult to come up with objective measures of poverty, and it can therefore be expected that exemption decisions will be based on subjective factors in the absence of administrative law controls.[97] In order to ensure that such discretionary decisions are accountable, it will thus be necessary to establish administrative procedures for public notice and comment and also facilitate access to the decisions of the institutions established to administer exemption schemes. Further, it may be necessary to enable applicants dissatisfied with the decisions of such institutions to appeal to the courts for judicial review. So that securing the entitlement of the poor to free health care services will require the establishment of an elaborate administrative machinery and oversight mechanisms to ensure its accountability.[98] The administration of exemption schemes is thus likely to be a costly affair. In Kenya, such administrative costs are likely to be even higher given that about 56% of Kenyans "would be exempted according to any reasonable definition of poverty."[99]

The idea that the rich should pay for the health care services of the poor is also problematic. Under the proposed NSHIF, it would be compulsory for all Kenyans and permanent residents to join the scheme, since "only social health insurance... provides for sufficient solidarity across all population categories (the rich subsidizing the poor, the young supporting the elderly and the healthy supporting the sick), thus promoting equity and access for everyone."[100] Further, the role of private health insurance will be confined to insuring "especially against the costs of higher standards of amenities in clinics and hospitals."[101]

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[97] A Mills, 'Improving the Efficiency of Public Sector Health Services in Developing Countries: Bureaucratic versus Market Approaches,' in C Colclough, ed., *Marketizing Education And Health In Developing Countries: Miracle Or Mirage?* (Oxford: Clarendon Press, 1997), p. 241 at 261-262 [Hereinafter 'Improving the Efficiency of Public Health Services'].

[98] *See* RB Stewart, 'U.S. Administrative Law: A Resource for Global Administrative Law?,' NYU Institute for International Law and Justice Working Paper No.7 (2004), p. 12 (Observing that apart from "protecting individuals against coercive impositions by government that lack constitutional and statutory authority," administrative law also serves the "broader functions of securing persons' entitlements to government assistance and other benefits including regulatory protection, assuring the legality of general administrative rules and regulations, and controlling the exercise of administrative discretion.")

[99] *See* 'Improving the Efficiency of Public Health Services,' supra note 104 at 263 (Observing that "in most poor countries the great majority of public facility users would be exempted according to any reasonable definition of poverty.") It is estimated that about 56% of Kenyans live below the poverty line. *See* Society For International Development, *Pulling Apart: Facts And Figures On Inequality In Kenya* (Nairobi: SID, 2004).

[100] *Sessional Paper No. 2 of 2004*, supra note 83 at 3.

[101] Ibid.

While the idea of solidarity is laudable and indeed noble, it may be quite troublesome from a libertarian viewpoint. Being a transcendental value, the solidarity objective should ideally be pursued in a manner that is compatible with market values. This is especially the case since there is no guarantee that the proposed NSHIF, which is likely to be a public monopoly, will be efficient. There is a danger that the object of establishing a national social health insurance scheme will quell the private health insurance market. This would be quite ironic, considering that the government has been pursuing a policy of market liberalization.

Most people will no doubt agree that society has an obligation to contribute to the development and well being of all its members, especially since market exchanges are so often inequitable. In fact, society may thus be justified in taking away from the better-off to ensure the development of the worse-off. But the question is, how far should society go in pursuing this objective?

"Classical liberals"[102] would say that society (acting through government) should not go far at all. They argue that it is "the equal right of each individual to pursue her own conception of the good."[103] The basis for this argument is their belief that "the ultimate good for men and women is plural and can be realized only by voluntary efforts."[104] For the most part, therefore, they believe that individuals should be left to their own devices; the commitment to individual liberty dictates that "government must strive to remain neutral among competing conceptions of the good."[105] Their commitment to individual liberty also "implies endorsement of the institutions of private property and the free market."[106] Private property ensures personal independence while the free market represents "the only non-coercive means of coordinating economic activity."[107]

On the other hand, socialists would argue that society should go far in its endeavours to provide for the worse-off. They criticize the liberal conception of individual liberty for being bare and maintain that liberty involves having an opportunity for self-realization, and even presupposes its achievement.[108] Further, they argue that the institution of private property only enhances the liberty of those who have resources but does nothing for those who are not

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[102] I use the term "classical liberals" to refer to the original proponents of liberal theory, who sought "to uphold the values of freedom of choice, reason and toleration in the face of tyranny, the absolutist system and religious intolerance." They include philosophers like John Locke, Jeremy Bentham and James Mill. *See* D Held, *Models Of Democracy* (1996), p. 74.

[103] RB Stewart, 'Regulation in a Liberal State: The Role of Non-Commodity Values,' 92 *Yale Law Journal* 1537 at 1539 (1983), p. 1537 at 1539.

[104] Ibid.

[105] Ibid.

[106] J Gray, *Liberalism* (Minneapolis: University of Minnesota Press, 1995), p. 61.

[107] Ibid at 61, 66.

[108] Ibid at 56.

propertied.[109] They also question the liberal faith in the market, and point out that markets often break down.[110]

These social critiques occasioned the revision of liberal theory. Thus "modern liberals"[111] agree that the market often allocates resources inequitably and that societal income disparities are often substantial. Some measure of governmental regulation of the private sphere is therefore perhaps inevitable. But such regulation ought to be efficient and legitimate.

It is doubtful, however, whether the proposed NSHIF attains this balance. In order for the scheme to do so, it must be objectively determined that its act of compelling everyone to contribute thereto is the least restrictive means of regulating private choice regarding where to obtain health insurance.[112] In order to appreciate the approach taken by the NSHIF on the private health insurance, it is necessary to examine recent efforts to regulate this market in light of the collapse of a number of health maintenance organizations (HMOs).

The idea behind the HMO concept is to control health care costs.[113] They do so by managing the care provided to plan members with the principal objective of avoiding the unnecessary utilization of services.[114] The HMO concept is a response to the traditional fee-for-service system in which the patient selects a health provider who then provides or orders the care that, according to the best medical judgment, the health provider believes to be appropriate, and the insurer pays the resulting bills for the care.[115] This traditional system is said to be inefficient since health providers have inappropriate incentives to provide arguably unnecessary services and to overcharge for their services.[116]

But while the HMO concept promises to control health care costs, it fuses the functions of providing and paying for health care services.[117] This fusion is particularly problematic as far as the physician-patient relationship is

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[109] Ibid at 64.

[110] KF Koerner, *Liberalism And Its Critics* (1985), pp. 68-69.

[111] I use the term "modern liberals" to refer to pragmatic liberals who question dogmatic adherence to the tenets of classic liberalism in view of existing societal inequalities. Modern liberals are also often referred to as "maximalists." They include modern philosophers like T.H. Green and Leonard Hobhouse. *See, e.g.*, TH Green, *Lectures On The Principles Of Political Obligation* (1931); L Hobhouse, *The Elements Of Social Justice* (1922).

[112] The "least restrictive means" standard is used, for example, in the context of international trade to ensure that governmental regulation does not unduly impede trade. As used in this article, it constitutes a useful test for balancing "competing conceptions of the good" in the context of regulating private choice over health insurance.

[113] ED Kinney, 'Resolving Consumer Grievances in a Managed Care Environment,' 6 *Health Matrix* (1996), p. 147 at 150 [Hereinafter 'Resolving Consumer Grievances'].

[114] Ibid at 149.

[115] Ibid.

[116] Ibid.

[117] Ibid at 151.

concerned. Ideally, the physician is the patient's advocate, and should seek the highest quality care for the patient irrespective of cost and other considerations.[118] Although physicians are able to perform this patient advocacy function in the traditional fee-for-service environment, it is doubtful whether they can do so where they are either employed or contracted by HMOs. In this latter scenario, physicians have a financial interest in limiting care to their patients since they stand to benefit from constraining resources.[119] Efforts to regulate HMOs in Kenya should therefore be alive to this potential conflict of interest.

While private health insurance in Kenya has typically been provided by a few insurance companies,[120] a significant segment of this market is now occupied by HMOs. There are about twenty-five HMOs doing business in the country presently.[121] But over the last decade, a number of them have collapsed due to various reasons, including the failure or delay of payments by insurance companies that underwrite their health risks, fraudulent claims, poor management and misuse of customer deposits.[122] It should also be noted that for a long time HMOs were not properly regulated. They only had to satisfy the regulations on incorporation established by the Companies Act.[123] Unlike insurance companies, for instance, they were not compelled to adhere to minimum capitalization requirements.[124] Further, while some HMOs operated as health care providers, others operated as insurers, or as both health care providers and insurers.

Nevertheless, the government moved in to regulate the sector by amending the Insurance Act[125] so as to ensure the financial accountability of HMOs.[126] This amendment seeks to separate the businesses of health insurance and health service provision, so that firms may only engage in one and not both activities. That is, it deems HMOs to be insurance brokers and requires "persons engaged in the business of undertaking liability by way of insurance in respect of funding private medical care" to apply for registration as medical insurance providers.[127]

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118 Ibid.

119 Ibid at 152.

120 G Mwabu, et al, 'Financing Health Services through Insurance,' supra note 73 at xi (Noting that only five out of some 23 insurance companies sell medical insurance schemes as "pure insurance packages.")

121 *See, e.g.*, 'Smart Card to Curb Fraud in EA Health Sector,' *East African*, December 22, 2003 (Kenya).

122 *See, e.g.*, 'Kenya's Health Industry is Set to Expand,' *Daily Nation*, April 11, 2004 (Kenya).

123 The Companies Act, Chapter 486, Laws of Kenya.

124 'Time to Regulate Health Insurance,' *Daily Nation*, August 28, 2003 (Kenya).

125 Chapter 487, Laws of Kenya.

126 The Insurance (Amendment) Act, No. 9 of 2003.

127 Insurance Act, ss 2, 150A.

On the one hand, this separation of the businesses of health insurance and health service provision may have ignored market realities. In particular, some market players think that allowing them to offer both services is instrumental in curbing fraud thereby enhancing their efficiency.[128] Thus African Air Rescue (AAR), which is the market leader, argues that owning its own medical services has helped it to detect collusion between some of its insurance clients and doctors in other establishments.[129] Indeed, AAR refused to comply with the new law, arguing that it does not appreciate market dynamics and threatens the existence of HMOs.[130]

But on the other hand, consumers of the services of HMOs and some physicians have a markedly different viewpoint.[131] In particular, they are concerned that HMOs compromise the health care of plan members. The practices of HMOs that compromise health care include the following. First, HMOs typically do not refer members to the most qualified doctors as such doctors tend to be the more expensive. Second, HMOs invariably prescribe generic drugs (which are cheaper than patented drugs) even where their effectiveness is not completely proven. HMOs also compromise on investigations. Thus physicians employed or contracted by the HMOs must make their prescriptions within a list of approved drugs and investigations. In addition, many HMOs are quick to deny coverage for expensive medical procedures on the basis of, for example, prior existing medical conditions. Such decisions are typically made unilaterally. In any case, many patients neither have the resources nor the information to challenge such decisions. And it seems that the smaller the HMO, the more prevalent these practices are. Thus in the perception of some physicians, health care standards are significantly lowered for those who belong to HMOs.

These different viewpoints call for further market analysis to facilitate a thorough appreciation of the market for health care insurance. But assuming that HMOs do compromise the health care of their members, the quality of their services ought to be regulated.[132] In particular, the law should require HMOs to maintain internal grievance procedures for the consumers of their services for purposes of resolving coverage disputes, for instance.[133] Further, a consumer

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[128] *See, e.g.*, 'Strategis Owed Insurer Sh10m,' *Daily Nation*, June 28 2005 (Observing that "The HMOs fraud prevalence is 40-60 per cent but this is reduced where a company has its own clinics.")

[129] 'AAR in Government's Bad Books,' *Indian Ocean Newsletter*, June 19, 2004 (Nexis Library).

[130] Ibid.

[131] This paragraph is based on unstructured interviews with a few consumers and physicians who are familiar with the services of HMOs.

[132] While contract remedies are in theory available to dissatisfied members of HMOs, they may not be suitable especially considering the costs of litigation and the ignorance of the consumers of health care services. Regulation may therefore be the best available means for ensuring quality services in the health insurance market.

[133] *See, e.g.*, SJ Stayn, 'Securing Access to Care in Health Maintenance Organizations: Toward a Uniform Model of Grievance and Appeal Procedures,' 94 *Columbia Law Review* (1994), p.1674. It should be noted that some HMOs, such as AAR, in their contracts with consumers provide for arbitration of disputes on "medical matters." But given the frequency with which consumers are

dissatisfied with the outcome of such an internal process ought to be able to challenge it before an impartial tribunal. The proposed Health Services Commission could perform this function. In order for such an administrative review process to work, two preconditions should be met. First, there ought to be objectively-determined standards and criteria for measuring and monitoring the quality of care provided by HMOs.[134] Again, this should be a task for the HSC. Secondly, the law should require HMOs to furnish the consumers of their services with comprehensible information to enable them to challenge coverage and other decisions.[135]

An argument might plausibly be advanced that such regulation would be excessive. Nevertheless, the information asymmetries that characterize the health insurance market dictate that consumers should be empowered if they are to get value for their money. In any case, the provision of health care is arguably a governmental function and any private firm given the privilege of providing it ought to be responsive to the public. Because they would be exercising a public function, such firms should thus be held to a higher standard of accountability than ordinary firms.[136]

Accordingly, instead of compelling Kenyans to contribute to the proposed NSHIF thereby possibly hastening the demise of HMOs, the government should regulate them while fostering competition in the market for health insurance. So far, the health insurance market is organized such that different firms serve different populations. Thus the expensive insurance firms provide unlimited access to health care for those who can afford their services. On the other hand, while they have a number of problems the HMOs nevertheless have the potential to meet the health care needs of a significant segment of the population at reasonable cost especially if they are properly regulated.

But the fact is that not many Kenyans will be able to pay the compulsory NSHIF contributions and still afford to purchase additional health insurance from HMOs.[137] Accordingly, the proposed scheme would unduly restrict private choice and artificially limit competition in the market for health insurance. Rather than compelling Kenyans to contribute to a scheme whose benefits may be doubtful in view of the many (and yet to be addressed) problems confronting the existing NHIF, the government should promote competition in the market for health insurance by allowing HMOs and insurance firms to freely compete

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denied coverage for expensive medical care, it is doubtful if these arbitration clauses work in practice.

[134] *See* ED Kinney, 'Protecting Consumers and Providers under Health Reform: An Overview of the Major Administrative Law Issues,' 5 *Health Matrix* (1995), p. 83 at 121.

[135] *See* Resolving Consumer Grievances, supra note 120 at 162.

[136] *See* J Freeman, 'Extending Public Norms through Privatization,' 116 *Harvard Law Review* (2003), p. 1285.

[137] *See* NSHIF Bill, supra note 1 at section. 14(5), which provides that members of the Fund are not precluded from taking additional health insurance cover.

with the NSHIF. Kenyans should join the scheme because they think it is better than the HMOs and insurance firms, and not because they are compelled to do so. But in the absence of governmental efforts to facilitate such competition, it is doubtful whether the proposed NSHIF constitutes the least restrictive means of regulating private choice over health insurance. On the contrary, the citizenry is unlikely to perceive it as legitimate.

That is not to say, however, that the idea of expanding the government's role as purchaser of health care through a health insurance scheme should be abandoned altogether. Indeed, a reorganized NSHIF may potentially assist the government in controlling some of the information asymmetries that characterize the provision of health care.[138] If it were able to attract private health service providers to serve its members it would be able to ensure the regulation of the quality of care through its accreditation program. In this regard, it should be noted that the NSHIF Bill requires contracted health service providers to fulfill the criteria, including quality standards, established by the ministry of health.[139] Because such an accreditation program would require health care providers to furnish the NSHIF administration with such information, it would in particular lower the scheme's costs of information collection.[140]

A final accountability concern relates to the implementation of contracting out. While there is little evidence of contracting out in Kenya's health care so far, it is likely to be used more frequently in the near future. For example, the NSHIF proposes to contract qualified health providers to serve its members.[141] Arguably, the provision of health care is a governmental function. Further, problems are likely to arise in the course of the provision of this service. Where government is the provider and problems occur, citizens have some recourse: they may sue the government or vote for a new government. But matters are somewhat more complicated where the government contracts out the provision of health care. For instance, what happens where a member, who is denied treatment by a contracted provider on the erroneous belief that she is not a paid-up member or does not qualify for free care, subsequently dies? What if a member is dissatisfied with the quality of care provided by a contracted provider? Should such problems be regulated exclusively by the contract between the NHSIF and the contracted provider? In other words, what rights would members have in such arrangements?

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[138] Sara Bennett, 'Private Health Care and Public Policy Objectives,' in *Marketizing Education And Health In Developing Countries*, supra note 104, 93 at 119.

[139] NSHIF Bill, supra note 1 at s 31(3).

[140] Bennett, supra note 145.

[141] NSHIF Bill, supra note 1 at s 31(1).

The contracting out of health care provision thus raises a significant question as to what should constitute an appropriate accountability regime.[142] In particular, because such contractual arrangements will affect a fundamental interest of the citizenry - namely, their health - they should be designed and implemented in a democratic (that is participatory and accountable) manner.[143] Further, those affected by such contractual arrangements are entitled to a guarantee that they will be implemented fairly. It may therefore become necessary for such contracts to provide for third party rights so that beneficiaries of the NSHIF, for instance, may sue to enforce them.[144]

The design and implementation of contracting out of health care services should therefore be accompanied by a re-conceptualization of public law to ensure that the process accords with principles of good administration such as accountability, participation, fairness and rationality.[145]

V. CONCLUSION

Accountability is important in health care both because it will enhance efficiency and ensure fair and legitimate administration. Unfortunately, Kenya's public law has thus far facilitated centralized and unaccountable decision-making in health care. Further, it has led to a proliferation of health care administrative institutions, which have overlapping mandates and memberships. It is not always clear what their responsibilities are, with the result that lines of accountability have become attenuated.[146] No wonder corruption has been a major problem in the health system. In order to ensure that the system serves the public better, it will be necessary to reform public law so as to curb the abuse of public resources and control the wide discretionary powers typically wielded by the public health administrative institutions. In this regard, the idea of establishing a Health Services Commission should be embraced. In addition, administrative law should provide control mechanisms to ensure that such a commission does not also abuse its regulatory powers.

Such accountability-enhancing public law reforms would perhaps make the idea of a mandatory social health scheme more workable and legitimate. While there is no doubt that a social health scheme would be useful in enhancing access to health care especially by the poor, two key concerns need to be

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[142] *See* AC Aman, Jr., 'The Limits of Globalization and the Future of Administrative Law: From Government to Governance,' 8 *Indiana Journal of Global Legal Studies* (2001), p. 379.

[143] *See* JM Migai Akech, 'Public Law Values and the Politics of Criminal (In) justice: Creating a Democratic Framework for Policing in Kenya,' 5 *Oxford University Commonwealth Law Journal* (2005), p. 225.

[144] *See* Freeman, supra note 143.

[145] *See* M Taggart, 'The Province of Administrative Law Determined?,' in M. Taggart, ed., *The Province Of Administrative Law* (Oxford: Hart, 1997), p. 1.

[146] I am principally referring here to political/democratic accountability, but which as we have seen does implicate financial and performance accountability. *See* Part II, supra.

addressed. First, the government must strive to adopt measures that least restrict the choice of citizens regarding where they purchase health insurance. Compelling them to contribute to the proposed NSHIF does not meet this test, especially given that the government could adopt a policy that strives to accommodate rather than destroy competition. And second, the government must establish an elaborate administrative machinery and oversight mechanisms to ensure due process in securing the entitlement of the poor to free health services. In addition, there is a need to reform public law to facilitate the accountability of contracting-out arrangements.