

**AN EXAMINATION OF THE LEGAL, POLICY AND INSTITUTIONAL
FRAMEWORK FOR UNIVERSAL HEALTH COVERAGE IN KENYA**

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School of Law**

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Declaration

I, **Timothy Wafula Makokha**, do declare that this is my original work, and it has not been submitted and is not currently being submitted for a degree in any other University.

Signature

Date

Timothy Wafula Makokha

This thesis has been submitted with my approval as the University of Nairobi Supervisor.

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Date

Dr. Jackson Bett

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Dedication

This academic piece is dedicated to sons Eli and Avel; wife Brenda and my mother, Dina. I

cherish you for the love, prayers, encouragement, and inspiration.

Abbreviations and Acronyms

ACHPR	African Charter on Human and Peoples' Rights
AIDS	Acquired Immunodeficiency Syndrome
ASAL	Arid and Semi-Arid Land
CBA	Collective Bargaining Agreement
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CESCR	Committee on Economic, Social and Cultural Rights
CoG	Council of Governor
CoK	Constitution of Kenya
COTU	Central Organization of Trade Unions
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
CS	Cabinet Secretary
FKE	Federation of Kenya Employers
FNS	Food and Nutrition Security
GDP	Gross Domestic Products
GoK	Government of Kenya
HFA	Health for All
HFG	Health Finance & Governance
HISP	Health Insurance Subsidy Programme
HIV	Human Immunodeficiency Virus
ICERD	International Convention on the Elimination of All Forms of Racial Discrimination
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICT	Information and Communications Technology

IFC	International Finance Corporation
IMF	International Monetary Fund
K-CHIC	Kitui County Health Insurance Cover
KEMSA	Kenya Medical Supplies Agency
KEPH	Kenya Essential Package for Health
KES	Kenya Shillings
KHHEUS	Kenya Household Health Expenditure and Utilization Survey
KLRC	Kenya Law Reform Commission
KMA	Kenya Medical Association
KNCHR	Kenya National Commission on Human Rights
KNUT	Kenya National Union of Teachers
KUPPET	Kenya Union of Post Primary Education Teachers
MES	Managed Equipment Services
MOH	Ministry of Health
MTEF	Medium Term Expenditure Framework
MTP	Medium Term Plans
NHIF	National Hospital Insurance Fund
NPHI	National Public Health Institute
NSHIF	National Social Health Insurance Fund
OOP	Out Of Pocket
OVC	Orphans and Vulnerable Children
PPP	Public-Private Partnerships
PWSD	Persons with Severe Disabilities
SDG	Sustainable Development Goals
TB	Tuberculosis

UDHR	Universal Declaration of Human Rights
UHC	Universal Health Coverage
UN	United Nations
UNGA	United Nations General Assembly
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
WHA	World Health Assembly
WHO	World Health Organization

Table of Statutes

Alcoholic Drinks Control Act (Act No. 4 of 2012)

Constitution of the Republic of Kenya, 2010

Health Act, 2017 (Act No. 21 of 2017)

Health Records and Information Managers Act (Act No. of 15 of 2016)

HIV/AIDS Prevention and Control Act (Act No 14 of 2006)

Kenya Medical Supplies Authority Act (Act No. 20 of 2013)

Narcotic Drugs and Psychotropic Substances Act (Act No. 4 of 1994)

National Hospital Insurance Fund Act, 1998

Pharmacy and Poisons Act

Public Health Act

Public Health Officers (Training, Registration, and Licensing) Act (Act no. 12 of 2013)

International Instruments

African Charter on Human and Peoples Rights, 1981

Convention on the Rights of Persons with Disabilities, 2006

Convention on the Rights of the Child, 1989

International Convention on Elimination of All Forms of Racial Discrimination, 1979

International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, 1990

International Covenant on Civil and Political Rights, 1966

International Covenant on Economic, Social and Cultural Rights, 1966

Sustainable Development Goals, 2015

The United Nations, United Nations Charter, 1945

Universal Declaration of Human Rights, 1948

World Health Organization Constitution, 1945

Abstract

Kenya has recently adopted universal health coverage (UHC) as one of the ‘big four’ priority agenda. The goal is that by 2022, all persons in Kenya will be able to use the essential services they need for their health and wellbeing through a single unified benefit package, without the risk of financial catastrophe.

However, there are glaring inconsistencies and incoherence in the legal, policy, and institutional design to realize the dream of universal health coverage. For instance, whereas the ‘big four’ agenda designates the National Hospital Insurance Fund (NHIF) as the institution to deliver universal health coverage by 2022, this new mandate is not enshrined in the National Hospital Insurance Fund Act (1998). Further, while the Constitution devolves the health function with county governments mandated to deliver the bulk of health services, the ‘big four’ agenda does not clearly articulate the place of universal health coverage in this devolved setting.

This study argues that the absence of a clearly defined legislative, policy, and institutional framework has contributed to the failure to realize the dream of universal health coverage in Kenya. The study interrogates the following three interrelated issues: Is the ‘big four’ agenda anchored on a policy framework that will realize the dream of universal health coverage? Is the legal and policy framework aligned to define an appropriate architecture of universal health coverage? Are institutions like NHIF and County governments properly positioned to steer Kenya towards UHC?

The study applies the doctrinal research methodology to identify and examine whether the laws, policies, and institutions critical to universal health coverage can support its realization in Kenya. The research establishes the need for reforms to the existing policy, legal, and institutional arena, given that: first, policies have not comprehensively defined the design of universal health coverage. Second, laws, for instance, the National Hospital Insurance Fund Act, are yet to be aligned to the Constitution and to design a suitable legal architecture of UHC. Moreover, the identified institutions such as NHIF are wallowing in challenges that hinder their effective delivery.

TABLE OF CONTENTS

Declaration.....	ii
Acknowledgements	iii
Dedication.....	iv
Abbreviations and Acronyms.....	v
Table of Statutes.....	viii
International Instruments	ix
Abstract.....	x
CHAPTER ONE: BACKGROUND	1
1.1. Background to the Study.....	1
1.2. Statement of the Problem.....	5
1.3. Justification of the Study.....	5
1.4. Objectives of the study.....	7
1.4.1. Main objective	7
1.4.2. Specific Objectives	7
1.5. Research questions	7
1.6. Theoretical framework.....	7
1.7. Research Methodology	11
1.8. Literature Review	11
1.9. Scope of study	17
1.10. Hypothesis.....	17
1.11. Chapter Breakdown	17
CHAPTER TWO: CONCEPTUAL FRAMEWORK: RIGHT TO HEALTH AND UNIVERSAL HEALTH COVERAGE.....	19
2.0. Introduction	19
2.1. Right to health	19
2.2. Universal health coverage (UHC)	23
2.3. Universal health coverage as a practical expression of the right to health.....	28
2.4. Essential components of universal health coverage:	30
CHAPTER THREE: EXAMINATION OF THE POLICY FRAMEWORK ON UNIVERSAL HEALTH COVERAGE IN KENYA	36
3.0. Introduction	36

3.1. Background	36
3.2. Previous policies on ‘universal’ health in Kenya	39
3.3. Current policies on universal health coverage in Kenya:.....	42
3.3.1. Kenya Vision 2030:	42
3.3.2. Third Medium Term Plan (2018 – 2022): The “Big Four” Agenda	45
3.3.3. Kenya Health Policy 2014 – 2030:	49
3.3.4. Kenya National Social Protection Policy	50
3.4. Projects introduced and implemented towards UHC	51
3.5. Conclusion	55
CHAPTER FOUR: LEGAL AND INSTITUTIONAL FRAMEWORK FOR UNIVERSAL HEALTH COVERAGE IN KENYA	56
4.0. Introduction and background.....	56
4.1. Legal framework for UHC in Kenya	57
4.1.1. Constitution of Kenya	57
4.1.2. The Health Act, 2017	59
4.1.3. National Hospital Insurance Fund Act, 1998	61
4.2. Existing legal framework vis-à-vis universal health coverage	63
4.3. Institutional framework for universal health coverage	65
4.3.1. National Hospital Insurance Fund (NHIF)	65
4.3.2. Can NHIF ensure realization of UHC in Kenya?	69
4.3.3. County Governments	72
CHAPTER FIVE: FINDINGS, CONCLUSION AND RECOMMENDATIONS	78
5.1. FINDINGS	78
5.1.1. Conceptual framework: right to health and universal health coverage.	78
5.1.2. Findings on policy framework.....	79
5.1.3. Findings Legal Framework	81
5.1.4. Findings on institutional framework	83
5.2. CONCLUSION	85
5.3. RECOMMENDATIONS	86
BIBLIOGRAPHY	89

CHAPTER ONE: BACKGROUND

1.1. Background of the Study

Since the 2010 World Health Report¹, the concept of universal health coverage (UHC) has gained prominence and momentum, with numerous countries making commitments to achieve it. In 2012, the United Nations General Assembly (UNGA) adopted a resolution endorsing UHC.² This concept was subject to the 2005 World Health Assembly's (WHA) discussion where a resolution on "sustainable health financing, universal coverage, and social health insurance" was made.³

In 2015, the Sustainable Development Goals (SDGs) engrained UHC as one of the critical components. The SDGs include a specific health goal (SDG 3): "ensure healthy lives and promote wellbeing for all at all ages." Within this health goal, there is a specific target for UHC: "achieve UHC, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all."⁴

Kenya has recently adopted universal health coverage as one of the 'big four' priority agenda, with an aspiration that by 2022, all persons in Kenya will be able to use the essential services

¹ World Health Organization, *The World Health Report: Health Systems Financing: The Path to Universal Coverage* (World Health Organization, 2010).

² Resolution of the World Health Assembly (WHA) No. 67/81, *Global health and foreign policy*, Resolution adopted by the General Assembly on 12 December 2012.

³ Resolution of the World Health Assembly (WHA) No. 58.33, *Sustainable health financing, universal coverage and social health insurance*, In the Fifty-eighth World Health Assembly, Geneva, 16–25 May 2005.

⁴ Sustainable Development Goals (SDGs): Goal 3; Target 3.8.

they need for their health and wellbeing through a single unified benefit package, without the risk of financial catastrophe.⁵

Universal health coverage has thus increasingly become an essential concept in both the international, regional, and national health agenda.

The World Health Organization (WHO) defines universal health coverage as “access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access.”⁶

The definition means that people have access to needed health services of sufficient quality to be useful, and the use of services does not expose the user to financial hardship.”⁷ It entails the equitable delivery of health services with health care benefits distributed based on the need for care and not on the ability to pay.⁸

In universal coverage, there is a legal obligation of the government to provide health care to all its citizens, with particular attention to ensuring the inclusion of all disadvantaged and excluded groups.⁹ Therefore, universal health coverage enables everyone to access the services that

⁵ Edwine Barasa, Peter Nguhiu, and Di McIntyre, ‘Measuring progress towards sustainable development goal 3.8 on universal health coverage in Kenya,’ [2018] Vol. 3(3) BMJ Global Health < <https://gh.bmj.com/content/bmjgh/3/3/e000904.full.pdf>> accessed 2 January 2019.

⁶ Resolution of the World Health Assembly (WHA) No. 58.33 (n 3).

⁷ World Health Organization ‘Health systems: Universal health coverage,’ (World Health Organization) <https://www.who.int/healthsystems/universal_health_coverage/en/> accessed 2 January, 2019. See also World Health Organization, *The World Health Report – Health Systems Financing: The Path to Universal Coverage* [2010].

⁸ Jane Chuma, Thomas Maina, and John Ataguba, ‘Does the distribution of health care benefits in Kenya meet the principles of universal coverage?’ [2012] Vol. 12(20) BMC Public Health < <https://bmcpublihealth.biomedcentral.com/track/pdf/10.1186/1471-2458-12-20>> accessed 3 January, 2019.

⁹ See Michael Kirby, ‘The right to health fifty years on: Still skeptical?’ [1999] Vol. 4(1) Health and Human Rights < <https://www.jstor.org/stable/pdf/4065166.pdf?refreqid=excelsior%3Adc7f649726df67ba4c2a2aa0ad099c57>> accessed 4 January, 2019.

address the most significant causes of disease and death. It ensures that the quality of those services is good enough to improve the health of the people who receive them.¹⁰

Promoting and protecting health is essential to human welfare and sustained economic and social development.¹¹ Health is critical to individual wellbeing and brings economic benefits to individuals, households, and countries because people are more economically productive.¹² Health, as defined by WHO as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, is recognized by international, regional, and national legislative instruments as a fundamental human right.¹³

The 1948 WHO Constitution recognizes that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.¹⁴ It was reaffirmed by the 1978 Alma-Ata Declaration that noted that ‘Health for All’ would contribute both to a better quality of life and also to global peace and security.¹⁵ The International Covenant on Economic, Social and Cultural Rights (ICESCR), recognizes “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”¹⁶ Regionally, Article 16 of the African Charter on

¹⁰ World Health Organization, ‘WHO Facts Sheet Universal health coverage (UHC)’ [2018] <[https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-\(uhc\)](https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc))> accessed 2 January, 2019.

¹¹ World Health Report, *ibid*.

¹² World Health Report, *ibid*.

¹³ CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) [2000] <<https://www.refworld.org/pdfid/4538838d0.pdf>> accessed 2 June 2019.

¹⁴ Constitution of the World Health Organization (1948)

¹⁵ Declaration of Alma-Ata - *International Conference on Primary Health Care*, Alma-Ata, USSR, 6-12 September 1978.

¹⁶ See Article 12 International Covenant on Economic, Social and Cultural Rights. Other international human rights treaties recognizing the right to health include: The 1965 International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) (Art. 5 (e) (iv)); The 1979 Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (Arts. 11 (1) (f), 12 and 14 (2) (b)); The 1989 Convention on the Rights of the Child (CRC) (art. 24); The 1990 International Convention on the Protection of the Rights of All Migrant Workers

Human and Peoples' Rights (ACHPR) (1981) recognizes that “every individual shall have the right to enjoy the best attainable state of physical and mental health.”

Recently, there has been a growing push for countries to achieve universal health coverage (UHC) in order to strengthen health systems and improve health equity and access to health services.¹⁷ WHO terms UHC as “a practical expression of the right to health.”¹⁸

The commitment to universality in access to health services is explicit in crucial international and regional human rights instruments, including the International Covenant on Economic, Social and Cultural Rights (ICESCR). The same is also evident in relevant global declarations. For example, the United Nations (UN) Sustainable Development Goals (SDGs) recognize that “ensuring healthy lives and promoting the well-being for all at all ages is essential to sustainable development.” The target set is to “achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.”¹⁹

On the same breadth, Article 43 of the Constitution of Kenya (CoK) now guarantees every Kenyan the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care.

and Members of Their Families (Arts. 28, 43 (e) and 45 (c)); The 2006 Convention on the Rights of Persons with Disabilities (CRPD) (Art. 25), among others.

¹⁷ Audrey R. Chapman, 'The Contributions of Human Rights to Universal Health Coverage' [2016] Vol. 18(2) Health and Human Rights Journal, 1.

¹⁸ World Health Organization, 'Positioning health in the post-2015 development agenda' [2012] <https://www.who.int/topics/millennium_development_goals/post2015/WHODiscussionpaper_October2012.pdf> accessed 7 January 2019.

¹⁹ Sustainable Development Goals (SDGs): Goal 3. Target 3.8

1.2. Statement of the Problem

Kenya has recently adopted universal health coverage as one of the big four priority agenda, with an aspiration that by 2022, all persons in Kenya will be able to use the essential services they need for their health and wellbeing through a single unified benefit package, without the risk of financial catastrophe.²⁰

However, there are glaring inconsistencies and incoherence in the legal, policy, and institutional design to realize the dream of universal health coverage. For instance, whereas the ‘big four’ agenda designates the National Hospital Insurance Fund (NHIF) as the institution to deliver universal health coverage by 2022, this new mandate is not enshrined in the National Hospital Insurance Fund Act, 1998. Further, while the Constitution devolves the health function with county governments mandated to deliver the bulk of health services, the ‘big four’ agenda does not clearly articulate the place of universal health coverage in this devolved setting. Similarly, equitable access to affordable and quality health care to the majority of Kenyans is still a mirage despite the ‘big four’ policy commitment.

1.3. Justification of the Study

At least four reasons justify this study:

First, Article 43 of the Constitution guarantees every citizen the right to the highest attainable standard of health. Kenya is also a signatory to international conventions and commitments that enshrine the right to health. The government is thus under an obligation to realize this right. Article 21(2) of the Constitution requires the State to take legislative, policy and other measures, including the setting of standards, to achieve the progressive realization of the rights guaranteed

²⁰ Edwine Barasa, Peter Nguhiu, and Di McIntyre [2018] *ibid*.

under Article 43, the right to health included. The examination of the ‘big four’ agenda on universal health coverage is thus critical to determine whether it contributes to realizing the right to health.

Second, universal health coverage is not a new concept in Kenya. For example, following independence in 1963, the post-colonial government made universal health care a significant policy goal and abolished user fees that were implemented by the colonialist. Further, there was the establishment of a national health insurance scheme in 1966, with the establishment of the National Hospital Insurance Fund (NHIF).²¹ In 2004/2005, the government attempted to introduce the National Social Health Insurance Fund (NSHIF) and the 10/20 policy to cushion the poor and realize the vision outlined in the Kenya Health Policy Framework of 1994. NSHIF aimed to expand the coverage and benefits package of the National Hospital Insurance Fund (NHIF). However, it was not implemented. This study is thus important as it examines a current initiative, and its policy, legal and institutional strengths.

Third, there is no existing literature that has examined the legal, policy, and institutional framework on universal health coverage in Kenya. Further, no literature has interrogated the soundness of universal health coverage as a ‘big four’ agenda item

Lastly, the study makes essential recommendations and suggestions for legal, policy, and institutional reforms to realize the dream of universal health coverage in Kenya.

²¹ Richard G. Wamai, ‘Healthcare policy administration and reforms in post-colonial Kenya and challenges for the future’ [2009] in Tuija Veintie and Pirjo Kristiina Virtanen, eds. *Local and Global Encounters: Norms, Identities and Representations in Formation* [2009] Renvall Institute for Area and Cultural Studies, University of Helsinki, pp. 136-158.

1.4. Objectives of the study

1.4.1. Main objective

The main objective of this study is to examine whether the legal, policy, and institutional framework in Kenya supports the realization of universal health coverage.

1.4.2. Specific Objectives

- (i) To examine the impact of the policy framework on the realization of universal health coverage in Kenya.
- (ii) To examine whether the existing legal framework in Kenya supports the realization of universal health coverage.
- (iii) To examine whether the existing institutional framework is sufficient to realize universal health coverage in Kenya.
- (iv) To examine what reforms are needed to the existing legal, policy, and institutional framework to support the realization of universal health coverage in Kenya.

1.5. Research questions

- (i) What is the existing policy framework on universal health coverage in Kenya?
- (ii) What is the existing legal framework for universal health coverage in Kenya?
- (iii) What is the institutional framework for universal health coverage in Kenya?
- (iv) What reforms are needed to the existing legal, policy, and institutional framework to support the realization of universal health coverage in Kenya?

1.6. Theoretical framework

An egalitarian rights-based theory is the basis of this study. Egalitarianism is the position that equality is central to justice: that people should be treated as equals, should treat one another as equals, should relate as equals, or enjoy an equality of social status of some sort. Egalitarian

doctrines tend to rest on a background idea that all human persons are equal in fundamental worth or moral status.²²

Egalitarians argue for the equalization of unfair life prospects. Secondly, that equality is the most or one of the most essential irreducible intrinsic or constitutive worth(s) of justice. Thirdly, increase in welfare. Fourthly, that justice is comparative. Fifthly, that inequalities are just when otherwise advantages are destroyed in the name of justice. Lastly, there are certain absolute humanitarian principles like autonomy, freedom, or human dignity.²³

A general theory of equality predicates the comprehensive strategy for justifying universal access to health care on egalitarian grounds. What is the best account of what constitutes an individual's equal share of the advantages of social life? Egalitarian theories, like the general theory of distributional equality, maintain that universal access to health care can be justified in a more controlled fashion because it is necessary for fair equality of opportunity.²⁴

This study adopts the egalitarian rights-based theory put forward by Norman Daniels that argues for a right to health care on the basis of "equality of opportunity." In this theory, there is the proposition for arrangement of social institutions affecting health care distribution, as far as possible, to allow each person to achieve a fair share of the normal range of opportunities present

²²Richard Arneson, 'Egalitarianism' [2013] The Stanford Encyclopedia of Philosophy (Summer 2013 Edition), Edward N. Zalta (ed.), <<https://plato.stanford.edu/archives/sum2013/entries/egalitarianism/>> accessed 15 April, 2019.

²³ Richard Arneson, *ibid.* See also John-Stewart Gordon 'Moral Egalitarianism' Internet Encyclopedia of Philosophy <https://www.iep.utm.edu/moral-eg/> accessed 15 April, 2019.

²⁴ Lesley Jacobs, 'Can An Egalitarian Justify Universal Access to Health Care?' [1996] vol. 22(3) Social Theory and Practice, 315 <<https://www.jstor.org/stable/23559054>> accessed 12 April, 2019).

in that society. There is determination of the usual range of opportunity by the range of life plans that a person could reasonably hope to pursue, given his or her talents or skills.²⁵

Norman Daniels concludes that a health care system should be designed to even out differences among individuals in terms of personal health in the same way that it should be designed to even out differences between similarly talented individuals from different socio-economic classes.

For Daniels, then, “the moral function of the health care system must be ... to help guarantee fair equality of opportunity.” He argues that “health is an inappropriate object, but health care, action which promotes health, is appropriate.” Moreover, that “a right claim to equal health is best construed as a demand for equality of access or entitlement to health services...”²⁶

With this view, Daniels says that we should handle health together with all social determinants to reach the health status required for the normal functioning of human species. Hence ethical value of health services and social determinants of health emerges from their crucial role to provide the individual the ability of normal functioning specific to human species.

Other egalitarian theorists like Dworkin have stated that “government must act to make the lives of those it governs better, and it must show equal concern for the life of each.” Specifically, Dworkin maintains that in order for a government to show equal concern for the life of each of those it governs, it must design a mechanism that distributes privately owned resources in a

²⁵ Jennifer Prah Ruger, ‘Toward a Theory of a Right to Health: Capability and Incompletely Theorized Agreements’ [2006] vol. 18(2) Yale Journal of Law & the Humanities <<http://digitalcommons.law.yale.edu/yjil/vol18/iss2/3>> accessed 13 April, 2019.

²⁶ Jennifer Prah Ruger, *Ibid.*

manner that treats each individual as an equal, and to do so it must be sensitive to the different ambitions, goals, and choices of each.²⁷

John Rawls's theory of justice, on the other hand, is considered as a contemporary reflection of egalitarian ethical theories. It addresses the issue of fair distribution of social goods. Although Rawls did not discuss the right to health in his theory, the attempts to enlarge the theory to cover the concept of health advanced vastly.²⁸ The first aim of Rawls's theory is to achieve a well ordered and well-administered community by the establishment of a fair distributive system of social goods. Rawls states that rational individuals agree on two fundamental principles of justice: equal liberty that each individual should have equal fundamental rights; and social inequalities where "the inequalities of income and welfare are considered to be fair if and only if these inequalities are for the benefit of the worst off."

This study thus benefits from and expands the egalitarianism theory by adopting the approach for universality, fairness, equality, and equity in the distribution of health care to individuals. The study examines policies, laws, and institutions that ought to ensure the equitable distribution of social goods, and takes the egalitarian approach that the government should ensure equal and equitable access to quality and affordable health care to all.

²⁷ Jennifer Prah Ruger, *ibid.*

²⁸ Perihan Elif Ekmekci and Berna Arda, 'Enhancing John Rawls's theory of justice to cover health and social determinants of health' [2015] vol. 21(2) *Acta Bioethica*, 227 <
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4915381/pdf/nihms739788.pdf>> accessed 13 April 2019.

1.7. Research Methodology

The basis of this study is the doctrinal research methodology. The study undertakes an in-depth analysis of legal doctrines and legal reasoning. The study focuses on laws and policies likely to have an impact on the realization of universal health coverage in Kenya. In this study, the process involved formulation of research questions through background literature review, identification of relevant laws and policies, examination and analysis of those laws, policies and related legal doctrines, and formulation of recommendations based on identified gaps in the laws and policies.

The study adopts a qualitative approach in the analysis and interpretation of the relevant legal texts and policies. Both international, regional and national legal texts were identified and examined including the International Covenant on Economic, Social and Cultural Rights (1966), African Charter on Human and Peoples' Rights (1981), United Nations (UN) Sustainable Development Goals (SGDs), Constitution of Kenya, Health Act 2017, National Hospital Insurance Act, 1998 as well as Vision 2030, Health Policy 2014 – 2030, and Third Medium Term Plan 2018 – 2022. Further, the research examined secondary data sources to aid in the interpretation of the identified legal sources, including electronic journals, books, monographs, reports, policy documents, newspapers, magazines, online publications, and occasional papers, among others. These secondary data sources were selected based on their relevance to the research question.

1.8. Literature Review

The literature selected for this research focused on three primary areas: first, literature that conceptualized the right to health vis-à-vis universal health coverage. Second, the study reviewed

literature that discussed universal health coverage in Kenya and thirdly literature that analyzed reforms to realize universal health coverage.

(a) Right to health vis-à-vis universal health coverage

Alicia Ely Yamin²⁹ discusses the normative definitions of the right to health in international law. Alicia Yamin argues that there has been considerable development in international law concerning the normative definition of the right to health. These norms offer a framework that shifts the analysis of issues, such as disparities in treatment from questions of quality of care to matters of social justice. Alicia Yamin further makes the argument that international law offers standards for evaluating governmental conduct as well as mechanisms for establishing some degree of accountability.

On the other hand, Gorik Ooms et al.³⁰ make a comparison between the concept of universal health coverage and the right to health. They conduct a comparative normative analysis to verify WHO's contention on UHC being the practical expression of the right to health.

Devi Sridhar et al.³¹, in their article, propose measurable and achievable indicators for universal health coverage based on the right to health. Their article identifies three significant challenges that face any exercise in setting indicators: data availability as an essential criterion, the universality of targets, and the adaptation of global goals to local populations. They argue that

²⁹ Alicia Ely Yamin, 'The right to health under international law and its relevance to the United States,' [2005] vol. 95(7) *American Journal of Public Health*: 1156.

³⁰ Gorik Ooms, et al. 'Is universal health coverage the practical expression of the right to health care?' [2014] vol. 14(1) *BMC International Health and Human Rights*: 3 <
<https://bmcinthealthhumrights.biomedcentral.com/articles/10.1186/1472-698X-14-3>> accessed 7 July 2019.

³¹ Devi Sridhar, et al. 'Universal health coverage and the right to health: from legal principle to post-2015 indicators,' [2015] vol. 45(3) *International journal of health services*: 495 <
https://www.researchgate.net/profile/Devi_Sridhar/publication/278409898_Universal_Health_Coverage_and_the_Right_to_Health_From_Legal_Principle_to_Post-2015_Indicators/links/55806d7e08aea3d7096e49aa.pdf>
accessed 7 July 2019.

the idea of UHC is rooted in the right to health, set out in the International Covenant on Economic, Social, and Cultural Rights (ICESCR). Devi Sridhar et al. identify six legal principles that, in their opinion, should underpin UHC based on the right to health: minimum core obligation, progressive realization, cost-effectiveness, shared responsibility, participatory decision making, and prioritizing vulnerable or marginalized groups.

(b) Universal health coverage in Kenya: policy, legal and institutional framework

Richard G. Wamai³² discusses the reforms in the healthcare policy in Kenya by evaluating the health sector developments in the post-colonial era. Richard's study is relevant to this research as it provides a historical analysis of the issues, trends, challenges, and future innovations within the framework of continuous reforms aimed at improving health coverage and efficiency. Richard Wamai argues that providing a quality healthcare package to all requires a holistic systems development approach that gives priority to improving access and coverage by improving facilities, providing affordable and accessible healthcare services, increasing healthcare professionals, and further decentralization in financial management and decision-making. This argument is compared to the current initiative to realize universal health coverage.

Jane Chuma and Vincent Okungu³³ assess the extent to which the Kenyan health financing system meets the critical requirements for universal coverage, including income and risk cross-subsidization. Their paper reviews how the Kenyan health system performs the essential financing functions and the implications of these arrangements for equity and universal

³² Richard G. Wamai, 'Healthcare policy administration and reforms in post-colonial Kenya and challenges for the future' [2009] in Tuija Veintie and Pirjo Kristiina Virtanen, eds. *Local and Global Encounters: Norms, Identities and Representations in Formation* [2009] Renvall Institute for Area and Cultural Studies, University of Helsinki, pp. 136-158.

³³ Jane Chuma and Vincent Okungu, 'Viewing the Kenyan health system through an equity lens: implications for universal coverage' [2011] vol. 10(1) *International journal for equity in health*: 22.

coverage. Their paper also looks at the progress Kenya has made towards achieving internationally accepted benchmarks in health care financing. It makes recommendations on how the country can progress towards universal coverage. Jane Chuma's and Vincent Okungu's study is relevant to this research as it provides a comprehensive description of Kenya's health care financing system, the changes over time, and the critical equity concerns - arising from current, past, and upcoming health financing policies.

Edwine Barasa, Peter Nguhiu, and Di McIntyre³⁴ examine the measure of universal health coverage for Kenya and track the country's progress over time. Their study identifies the gaps that exist in Kenya's quest to achieve universal health coverage. Edwine, Peter, and Di McIntyre argue for targeted health financing and other health sector reforms to achieve universal health coverage. They note that those reforms should be focused on both, rather than on only either of the dimensions of universal health coverage.

Timothy Chrispinus Okech and Steve Ltumbesi Lelegw³⁵ review the various initiatives that the government of Kenya has over the years initiated towards the realization of Universal Health Care (UHC) and how this has impacted on health equity. Their paper makes some critical findings including that there has been minimal solidarity in health care financing; cases of dysfunctionality of health care system; minimal opportunities for continuous medical training; quality concerns in terms of stock-outs of drugs and other medical supplies, dilapidated health infrastructure and inadequate number of health workers. Other findings from their paper include governance concerns at the National Hospital Insurance Fund (NHIF) coupled with high

³⁴ Edwine Barasa, Peter Nguhiu, and Di McIntyre, 'Measuring progress towards sustainable development goal 3.8 on universal health coverage in Kenya,' [2018] vol. 3(3) *BMJ Global Health* <<https://gh.bmj.com/content/bmjgh/3/3/e000904.full.pdf>> accessed 3 July 2019.

³⁵ Timothy C. Okech and Steve L. Lelegw, 'Analysis of Universal Health Coverage and Equity on Health Care in Kenya' [2016] vol. 8(7) *Global Journal of Health Science*.

operational costs, low capitation, fraud at facility levels, low payout ratio, accreditation of facilities, and narrowness of the benefit package, among others. Okech's and Lelegw's study is relevant to this research as it provides a proper analysis of the challenges that have previously faced universal health coverage initiatives in Kenya. Their paper provides a good point for comparison with the current initiative – and a comparison of the changes (or lack thereof) of the policy and legal framework.

Edwine Barasa, Khama Rogo, Njeri Mwaura, and Jane Chuma's (2018)³⁶ study focused on reforming the National Hospital Insurance Fund (NHIF) to achieve universal health coverage. Their study identifies and describes the reforms undertaken by the National Hospital Insurance Fund (NHIF) and examines their implications for Kenya's quest to achieve universal health coverage (UHC). Edwine Barasa et al.'s study is relevant to this research as it examines the institutional strength of NHIF to spearhead UHC. Their study examined the various reforms NHIF had initiated to provide universal health insurance, including the introduction of the Civil Servants Scheme (CSS), the health insurance subsidy for the poor (HISP), revision of monthly contribution rates and expansion of the benefit package, among others.

Adam Dale Koon (2017)³⁷ examines how actors understood and engaged with three highly contested health financing policies introduced as part of the movement towards universal health coverage in Kenya: user fee removal, raising contributions to the mandatory health insurer, and

³⁶ Edwine Barasa, et al. 'Kenya National Hospital Insurance Fund Reforms: Implications and Lessons for Universal Health Coverage,' [2018] vol. 4(4) Health Systems & Reform: 346
<<https://www.tandfonline.com/doi/full/10.1080/23288604.2018.1513267>> accessed 20 July 2019.

³⁷ Adam Dale Koon, *Framing Universal Health Coverage in Kenya: An Interpretive Analysis of Health Financing Politics* [2017] PhD thesis, London School of Hygiene & Tropical Medicine <https://researchonline.lshtm.ac.uk/4398421/1/2017_PHP_PhD_Koon_AD.pdf> accessed 2 January 2019.

the failed 2004 Bill on Social Health Insurance. This study benefits immensely from the historical analysis by Adam Koon.

Lastly, concerning proposals for reforms, David Nicholson, Robert Yates, Will Warburton and Gianluca Fontana³⁸ in their report makes suggestions of key policy recommendations for countries aiming at achieving universal health coverage. They argue that, first, countries should give a high priority to achieving full population coverage of an affordable package of services, rather than covering selected population groups with more generous packages of services and leaving some people uncovered. Second, that universal health coverage can only be achieved through publicly governed, mandatory financing mechanisms (general taxation and social health insurance contributions) that compel wealthier and healthier members of society to subsidize the poor and the vulnerable. Financing systems dominated by private voluntary financing (user fees and private voluntary insurance) will never achieve universal health coverage. Third, the transition towards universal health coverage, in redistributing health benefits and financial burdens, is a highly political process that is likely to face opposition from powerful interest groups. Sustained political commitment from the highest level of government, including the head of state, is, therefore, essential in implementing successful universal health coverage reforms.

An analysis of the existing literature demonstrates there is a gap in the literature that examines legal, policy, and institutional framework for UHC in Kenya.

³⁸ David Nicholson, et al. 'Delivering universal health coverage: a guide for policymakers' [2015] Report of the WISH Universal Health Coverage Forum < <https://www.imperial.ac.uk/media/imperial-college/institute-of-global-health-innovation/public/Universal-health-coverage.pdf>> accessed 2 January 2019.

1.9. Scope of study

The study is limited to examining the concept of universal health coverage from a legal point of view. The analysis looks at health from a right to health angle rather than the medical or public health perspective.

1.10. Hypothesis

The absence of clearly defined legislative, policy, and institutional framework has contributed to the failure to realize the dream of universal health coverage in Kenya.

1.11. Chapter Breakdown

Chapter one is the introductory chapter of the study. It provides a background and outlines the statement of the problem. Further, this chapter defines the study objectives, hypothesis as well as the research questions examined by the study.

Chapter two of the study analyzes the concept of universal health coverage, the right to health, and the interrelationship between the two. This chapter also examines the agreed parameters on what constitutes universal health coverage.

Chapter three examines the policies on universal health coverage in Kenya. This chapter provides a historical context as well as an analysis of the current policies and related projects aimed at achieving universal health coverage in Kenya.

Chapter four examines the legal and institutional framework of universal health coverage in Kenya. This chapter examines the primary laws as well as institutions that are currently implementing UHC in Kenya.

Chapter five provides a summary of the findings, conclusion, and recommendations of the study.

CHAPTER TWO: CONCEPTUAL FRAMEWORK: RIGHT TO HEALTH AND UNIVERSAL HEALTH COVERAGE

2.0. Introduction

This chapter examines the concept of universal health coverage and the right to health. The chapter examines how these concepts have been defined in international and regional legal texts and documents. The objective of this conceptual examination is twofold: (i) lay a common understanding of core terms whose theme runs across the study; (ii) examine the international legal and normative framework of universal health coverage as a baseline to guide examination of the national frameworks.

2.1. Right to health

The Committee on Economic, Social and Cultural Rights (CESCR) has interpreted the right to health as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.³⁹

Further, the committee has noted that the right to health should not be understood as a right to be healthy but instead that it contains both freedoms and entitlements. That is, the right to control one's health and body, including sexual and reproductive freedom; the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and

³⁹ CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) [2000] < <https://www.refworld.org/pdfid/4538838d0.pdf>> accessed 2 June 2019. See also Gunilla Backman, et al. 'Health systems and the right to health: an assessment of 194 countries.' [2008] *The Lancet*: 2047.

experimentation; and the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.⁴⁰

The right to health contains the following interrelated and essential elements: first, availability of functioning public health and health-care facilities, goods, and services. Second, accessibility of health facilities, goods, and services to everyone without discrimination. Health facilities, goods, and services must be within safe physical reach, affordable, and information concerning them easily accessible. Third, acceptability of health facilities, goods, and services, that is, respectful of the culture of individuals, minorities, peoples, and communities. Fourth, health facilities, goods, and services must be scientifically and medically appropriate and of good quality.⁴¹

From the foregoing, it is clear that health is a fundamental human right indispensable for the exercise of other human rights. As such, under international law, there is a right not merely to health care but the much broader concept of health. Because rights must be realized inherently within the social sphere, this formulation immediately suggests that determinants of health and ill-health are not purely biological or “natural” but are also factors of societal relations.⁴²

The first notion of a right to health under international law is found in the 1948 Universal Declaration of Human Rights (UDHR), which was unanimously proclaimed by the UN General Assembly as a common standard for all humanity.⁴³ Article 25.1 of the Universal Declaration of Human Rights (UDHR) affirms that: “everyone has the right to a standard of living adequate for

⁴⁰ CESCR General Comment No. 14 (2000), *ibid*

⁴¹ CESCR General Comment No. 14 (2000), *ibid*.

⁴² Alicia Ely Yamin, ‘The right to health under international law and its relevance to the United States,’ [2005] vol. 95(7) *American Journal of Public Health*: 1156.

⁴³ Alicia E. Yamin [2005] , *ibid*.

the health of himself and of his family, including food, clothing, housing, and medical care and necessary social services.”

The International Covenant on Economic, Social, and Cultural Rights (ICESCR) provides the most comprehensive provisions on the right to health in international human rights law. In accordance with Article 12.1 of the Covenant, State parties recognize “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”, while Article 12.2 enumerates, by way of illustration, a number of “steps to be taken by the States parties ... to achieve the full realization of this right”.⁴⁴

The preamble of the 1946 Constitution of the World Health Organization (WHO) defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” The preamble further states that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”⁴⁵

Other international human rights treaties recognize or refer to the right to health or elements of it. For example, Article 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965; Articles 11.1(f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979 and Article 24 of the Convention on the Rights of the Child of 1989, among others.

Regionally, Article 16 of the African Charter on Human and Peoples’ Rights (ACHPR) (Banjul Charter) (1981) underscores Article 12 of the ICESCR by providing that “every individual has the right to the best attainable state of physical and mental health.” The State parties are further

⁴⁴ CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12) [2000]

⁴⁵ See Constitution of the World Health Organization [1946].

expected to take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.”⁴⁶

In Kenya, the right to health is a fundamental human right guaranteed in the Constitution. Article 43 (1) (a) of the Constitution provides that every person has the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care. Article 43 (2) also provides that a person shall not be denied emergency medical treatment.⁴⁷

Under international law, states that are party to a variety of different treaties assume tripartite obligations in relation to implementation of the right to health: (i) to *respect* the right to health by refraining from direct violations, such as systemic discrimination within the health system; (ii) to *protect* the right from interference by third parties, through such measures as environmental regulation of third parties; and (iii) to *fulfill* the right by adopting deliberate measures aimed at achieving universal access to care, as well as to preconditions for health.⁴⁸

Article 2 of the ICESCR defines the obligations of States in the implementation of economic and social rights. States parties are thus obligated to “to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.” Furthermore, that States “undertake to guarantee that the rights

⁴⁶ Kenya National Commission on Human Rights (KNCHR) ‘The Right to Health: A Case Study of Kisumu County,’ [2017]

<<http://www.knchr.org/Portals/0/OccasionalReports/The%20Right%20to%20Health%20in%20Kisumu%20County.pdf?ver=2018-01-18-142546-863>> accessed 9 July 2019.

⁴⁷ KNCHR [2017] *ibid*.

⁴⁸ See CESCR General Comment No. 14 [2000]. See also Alicia E. Yamin [2005] *ibid*.

enunciated in the present Covenant will be exercised without discrimination of any kind as to race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”

Along with the obligation of progressive realization is a presumption that States should not take any retrogressive measures. Once a State has taken a measure to realize the right to health, it should only expand on that measure and not take away or reduce the availability of that measure.⁴⁹

Article 21 of the Constitution of Kenya makes it a fundamental duty of the “State and every State organ to observe, respect, protect, promote and fulfill the rights and fundamental freedoms in the Bill of Rights.” Moreover, that concerning the realization of economic and social rights, the “State shall take legislative, policy and other measures, including the setting of standards, to achieve the progressive realization of the rights guaranteed under Article 43.”

Further, in the implementation of these rights, the government has to address the needs of the vulnerable and marginalized in society – and ensure the fulfillment of its international obligations in respect of human rights and fundamental freedoms. As such, the right to health is a recognized right with the State bestowed with clear responsibilities to ensure it is implemented.

2.2. Universal health coverage (UHC)

Universal Health Coverage (UHC) is widely considered one of the key components for the post-2015 global health goal.⁵⁰ UHC is the goal that all people receive the essential health services

⁴⁹ Arlan Fuller, Oscar Cabrera, Angela Duger *Health and Human Rights - Resource Guide* [2015] FXB Center for Health and Human Rights <<https://www.hhrguide.org/introduction/>> accessed 9 July 2019.

⁵⁰ Devi Sridhar, et al. ‘Universal health coverage and the right to health: from legal principle to post-2015 indicators,’ [2015] vol. 45(3) *International journal of health services*: 495 <https://www.researchgate.net/profile/Devi_Sridhar/publication/278409898_Universal_Health_Coverage_and_the

that they need, without being exposed to financial hardship, and is central to the health-related targets of the Sustainable Development Goals (SDGs).⁵¹

The idea of UHC is deeply rooted in the right to health.⁵² It is described as a practical expression of the right to health.⁵³ Thus it is argued that UHC is indeed both an end in itself, as expressed in SDG target 3.8, as well as the most logical way to ensure progress towards meeting other health-related SDG targets and realizing the right to health.⁵⁴

Since the 2010 World Health Report, the concept of universal health coverage (UHC) has gained prominence and momentum, with numerous countries making commitments to achieve it, and the 2012 UNGA Resolution endorsing it.⁵⁵

The authoritative source of the norms that underpin UHC is the 2005 World Health Assembly (WHA) resolution on “Sustainable health financing, universal coverage, and social health insurance.” The resolution urged member states “to plan the transition to universal coverage of their citizens so as to contribute to meeting the needs of the population for health care and improving its quality, to reducing poverty, to attaining internationally agreed development goals, including those contained in the United Nations Millennium Declaration, and to achieving health

[Right to Health From Legal Principle to Post-2015 Indicators/links/55806d7e08aea3d7096e49aa.pdf](https://www.who.int/publications/i/item/9789241501031-chapter-2)> accessed 7 July 2019.

⁵¹ Daniel R. Hogan, et al. ‘Monitoring universal health coverage within the Sustainable Development Goals: development and baseline data for an index of essential health services,’ [2018] vol. 6(2) *The Lancet Global Health*: e152 < <https://www.sciencedirect.com/science/article/pii/S2214109X17304722>> accessed 9 July 2019.

⁵² Devi Sridhar, et al. [2015] *ibid*.

⁵³ Gorik Ooms, et al. ‘Is universal health coverage the practical expression of the right to health care?’ [2014] vol. 14(1) *BMC International Health and Human Rights*: 3 < <https://bmcinthealthumrights.biomedcentral.com/articles/10.1186/1472-698X-14-3>> accessed 7 July 2019.

⁵⁴ Daniel R. Hogan, et al. [2018] *ibid*.

⁵⁵ Gorik Ooms, et al. [2014] *ibid*.

for all.”⁵⁶ The Assembly urged member states to ensure that health financing systems incorporate an element of pre-payment and risk pooling.⁵⁷

The Secretariat’s Report to the 2005 WHA would eventually describe universal health coverage as follows:

“Universal coverage is defined as access to key promotive, preventive, curative, and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access. The principle of financial-risk protection ensures that the cost of care does not put people at risk of financial catastrophe. A related objective of health-financing policy is equity in financing: households contribute to the health system on the basis of ability to pay. Universal coverage is consistent with WHO’s concepts of health for all and primary health care.”⁵⁸

The principle of universal coverage was then reaffirmed in the World Health Report 2008⁵⁹ on primary health care and the subsequent World Health Assembly resolution. Further, the World Health Report 2010 on health systems financing built on this heritage by proposing that health financing systems – which countries of all income levels constantly seek to modify and adapt – should be developed with the specific goal of universal health coverage in mind.⁶⁰

⁵⁶ World Health Assembly Resolution 58.33 ‘Sustainable health financing, universal coverage and social health insurance’ [2005] in World Health Organization *Fifty-eighth World Health Assembly* [2005] < https://apps.who.int/iris/bitstream/handle/10665/20398/A58_2005_REC1-en.pdf?sequence=1&isAllowed=y> accessed 10 July 2019.

⁵⁷ Jane Chuma and Vincent Okungu, ‘Viewing the Kenyan health system through an equity lens: implications for universal coverage,’ [2011] vol. 10(1) *International journal for equity in health*: 22 < <https://equityhealth.biomedcentral.com/articles/10.1186/1475-9276-10-22>> accessed 10 July 2019.

⁵⁸ World Health Assembly Resolution 58.33 (2005) *ibid*.

⁵⁹ World Health Organization (WHO) *The World Health Report 2008 – Primary Health Care (Now More than Ever)* [2008] < <https://www.who.int/whr/2008/en/>> accessed 10 July 2019.

⁶⁰ World Health Organization *The World Health Report 2010. Health Systems Financing: The Path to Universal Coverage* [2010] < <https://www.who.int/whr/2010/en/>> accessed 10 July 2019.

The twin goals of ensuring access to health services, plus financial risk protection, were reaffirmed in 2012 by a resolution of the United Nations General Assembly, which promoted universal health coverage, including social protection and sustainable financing.⁶¹

In 2015, UHC was engrained as a critical component of the Sustainable Development Goals (SDGs). The SDGs include a specific health goal (SDG 3): “Ensure healthy lives and promote wellbeing for all at all ages.” Within this health goal, there is a specific target for UHC: “Achieve UHC, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.”⁶²

Responding to the WHO call, the 56th session of the regional committee for health in Africa urged member states to strengthen their national prepaid health financing systems, to develop comprehensive health financing policies and strategic plans and to build capacity for generating, disseminating and using evidence from health financing in decision making. They also called on the World Health Organization (WHO) to provide support to fair and sustainable financing and to identify financing approaches most suitable for the African region.⁶³

From the foregoing, universal health coverage is now generally described as “ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation, and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user the financial hardship.”⁶⁴ Universal health coverage is

⁶¹ See United Nations General Assembly Resolution A/RES/67/81, ‘Global health and foreign policy’ Sixty-seventh session, Agenda item 123, 2012.

⁶² Sustainable Development Goals (SDGs): Goal 3. Target 3.8

⁶³ Jane Chuma and Vincent Okungu [2011], *ibid.*

⁶⁴ World Health Organization (WHO) “Health systems: Universal Health Coverage,”

“about ensuring that people have access to the health care they need without suffering financial hardship. UHC also allows countries to make the most of their strongest asset: human capital.”⁶⁵

Three core justifications are advanced in support of universal health coverage: First, to ensure that everyone can use the health services they need without risk of financial ruin or impoverishment. UHC enables all individuals and communities to receive the health services they need without suffering financial hardship. Protecting people from the financial consequences of paying for health services out of their own pockets reduces the risk that people will be pushed into poverty because unexpected illness requires them to use up their life savings, sell assets, or borrow – destroying their futures and often those of their children.⁶⁶

Second, to support the goal of universal health coverage is also to express concern for equity and for honoring everyone’s right to health.⁶⁷

Third, progress towards universal health coverage is a guiding principle for the development of health systems and human development generally. Healthier environments mean healthier people. UHC enables everyone to access the services that address the most significant causes of disease and death and ensures that the quality of those services is good enough to improve the health of the people who receive them.⁶⁸ UHC includes the full spectrum of essential, quality

<https://www.who.int/healthsystems/universal_health_coverage/en/> accessed 13 May 2019.

⁶⁵ The World Bank “Universal Health Coverage,” <<https://www.worldbank.org/en/topic/universalhealthcoverage>> accessed 13 May 2019.

⁶⁶ WHO ‘Universal health coverage (UHC): WHO Fact Sheet,’ [2019] <[https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-\(uhc\)](https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc))> accessed 13 May 2019.

⁶⁷ WHO Fact Sheet [2019], *ibid.*

⁶⁸ WHO Fact Sheet [2019], *ibid.*

health services, from health promotion to prevention, treatment, rehabilitation, and palliative care.⁶⁹

Therefore, universal health coverage is a broad term that encompasses any action that a government takes to provide health care to as many people as possible. Some governments do this by setting minimum standards and regulations and some by implementing programs that cover the entire population. However, the ultimate goal is health coverage for all citizens.

2.3. Universal health coverage as a practical expression of the right to health

Universal health coverage is an aspiration that underpins “the enjoyment of the highest attainable standard of health.” The commitment to universality in access to key health services is implicit in international and regional human rights instruments, including the International Covenant on Economic, Social and Cultural Rights (ICESCR), the African Charter on Human and People’s Rights (ACHPR), among others. The WHO Constitution describes the fundamental right of every human being to enjoy “the highest attainable standard of health.” Universal coverage is the best way to attain that right. It is fundamental to the principle of ‘Health for All’ set out in the Declaration of Alma-Ata. The declaration recognized that promoting and protecting health were also essential to sustain economic and social development, contributing to a better quality of life, social security, and peace.⁷⁰

A further expression of the importance of universal health coverage in realization of the right to health came in September 2015 when UHC was selected as one of the key targets to implement the health goal in the United Nations Sustainable Development Goals (SDGs). SDG 3 calls on countries to “ensure healthy lives and promote well-being for all at all ages.” Under this goal,

⁶⁹ WHO Fact Sheet [2019], *ibid.*

⁷⁰ World Health Report 2010, *ibid.*

countries target to “achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.”⁷¹ Thus supporting the right to health and ending extreme poverty can both be pursued through universal health coverage.⁷²

Importantly, UHC is termed as “a practical expression of the right to health,” “the single most powerful concept that public health has to offer” and a representation of the “ultimate expression of fairness.”⁷³

Dainius Puras, the current Special Rapporteur on the right to health, has identified additional requirements for UHC to be consistent with the right to health. In his recent report on the *2030 Agenda for Sustainable Development and the Sustainable Development Goals*, he notes that:

“the right to health requires that health care goods, services, and facilities be available in adequate numbers; financially and geographically accessible, as well as accessible on the basis of non-discrimination; acceptable, that is, respectful of the culture of individuals, minorities, peoples and communities and sensitive to gender and life-cycle requirements; and of good quality.”⁷⁴

He cites the need for an effective and integrated health system to incorporate the human rights principles of equality and non-discrimination, transparency, accountability, and participation. He

⁷¹ See SDG 3 Target 3.8.

⁷² WHO ‘Anchoring universal health coverage in the right to health: What difference would it make? Policy brief,’ [2015] <https://apps.who.int/iris/bitstream/handle/10665/199548/9789241509770_eng.pdf;jsessionid=7D721F6777FD438C0B651521BEA2CB6D?sequence=1> accessed 1 July 2019.

⁷³ Gorik Ooms, et al. [2014] *ibid*.

⁷⁴ Audrey R. Chapman, ‘The contributions of human rights to universal health coverage,’ [2016] vol. 18(2) *Health and Human Rights Journal*: 1 <<https://www.hhrjournal.org/2016/12/editorial-the-contributions-of-human-rights-to-universal-health-coverage/>> accessed 1 July 2019.

makes the further point that states should ensure that rights-holders, including those from marginalized groups, are provided with the conditions to participate in the design, implementation, and monitoring of laws, policies, and strategies.⁷⁵

He underscores the need for UHC policies to make an explicit commitment to prioritize the poor and marginalized in the process of expanding coverage and in determining which services to provide in order to avoid entrenching inequality.⁷⁶

For WHO, “UHC is, by definition, a practical expression of the concern for health equity and the right to health”; thus promoting UHC advances the overall objective of WHO, namely the attainment by all peoples of the highest possible standard of health as a fundamental right, and signal a return to the ideals of the Declaration of Alma Ata and the WHO Global Strategy for Health for All by the Year 2000.⁷⁷

Relatedly, significant progress towards UHC, consistent with the requirements of the right to health, has the potential to provide the approximately one billion people currently estimated to lack access to necessary health services the opportunity to obtain them.

2.4. Essential components of universal health coverage:

According to the World Bank, at least half of the world’s population still cannot obtain essential health services, with close to 100 million people being pushed into extreme poverty each year because of health expenses. And that a further 800 million people spend more than ten percent of

⁷⁵ Audrey R. Chapman [2016] *ibid.*

⁷⁶ Audrey R. Chapman [2016] *ibid.*

⁷⁷ WHO, ‘Anchoring universal health coverage in the right to health: What difference would it make? Policy brief,’ [2015] *ibid.*

their household budgets on health care.⁷⁸ This is the scenario that UHC aims to rectify by ensuring access by all and that the access does not occasion financial hardship.

The 2005 World Health Assembly laid down three core principles of universal health coverage as follows: First, equity in access to critical promotive, preventive, curative and rehabilitative health interventions; Second, the principle of financial-risk protection that ensures that the cost of care does not put people at risk of financial catastrophe; and Third, equity in financing where households contribute to the health system on the basis of ability to pay.⁷⁹

Specifically, the 2005 WHA Resolution urged member states to:

- (a) ensure that health-financing systems include a method for prepayment of financial contributions for health care, with a view to sharing risk among the population and avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking care;
- (b) ensure adequate and equitable distribution of good-quality health care infrastructures and human resources for health so that the insurees will receive equitable and good-quality health services according to the benefits package;
- (c) ensure that external funds for specific health programs or activities are managed and organized in a way that contributes to the development of sustainable financing mechanisms for the health system as a whole;

⁷⁸ World Health Organization and the International Bank for Reconstruction and Development / The World Bank *Tracking Universal Health Coverage: 2017 Global Monitoring Report* [2017] < <http://pubdocs.worldbank.org/en/193371513169798347/2017-global-monitoring-report.pdf>> accessed 6 July 2019.

⁷⁹ World Health Assembly Resolution 58.33 (2005) *ibid.*

- (d) plan the transition to universal coverage of their citizens to contribute to meeting the needs of the population for health care and improving its quality, to reducing poverty, to attaining internationally agreed development goals, including those contained in the United Nations Millennium Declaration, and to achieving health for all;
- (e) recognize that, when managing the transition to universal coverage, each option will need to be developed within the particular macroeconomic, socio-cultural and political context of each country;
- (f) to take advantage, where appropriate, of opportunities that exist for collaboration between public and private providers and health-financing organizations, under strong overall government stewardship;
- (g) to share experiences on different methods of health financing, including the development of social health-insurance schemes, and private, public, and mixed schemes, with particular reference to the institutional mechanisms that are established to address the principal functions of the health-financing system.”⁸⁰

Relatedly, the 2010 World Health Report and the 2012 WHO Discussion Paper⁸¹ explain UHC in three ‘dimensions’:

First, the extent of population covered under UHC. Second, the financial contribution covered by the government or government-supported schemes. In this dimension of UHC, the ideal is that

⁸⁰ World Health Assembly Resolution 58.33 (2005) *ibid*.

⁸¹ WHO discussion paper ‘Positioning Health in the Post-2015 Development Agenda,’ [2012]

<https://www.who.int/topics/millennium_development_goals/post2015/WHODiscussionpaper_October2012.pdf> accessed 8 July 2019.

direct payments disappear, or if they have to be maintained, then it is at a level that does not exclude people from healthcare and does not create a financial hardship.

Third, the benefits of the health package. According to the 2012 WHO Discussion Paper, UHC implies that people “have access to *all* the services they need.” The 2012 UNGA Resolution states that UHC “implies that all people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative and rehabilitative basic health services”, and acknowledges that “when managing the transition of the health system to universal coverage, each option will need to be developed within the particular epidemiological, economic, socio-cultural, political and structural context of each country in accordance with the principle of national ownership.”⁸²

2.5. Conclusion

From the foregoing: UHC does not mean free coverage for all possible health interventions, regardless of the cost, as no country can provide all services free of charge on a sustainable basis. UHC is not just about health financing. It encompasses all components of the health system: health service delivery systems, the health workforce, health facilities and communications networks, health technologies, information systems, quality assurance mechanisms, and governance and legislation. UHC is not only about ensuring a minimum package of health services, but also about ensuring a progressive expansion of coverage of health services and financial protection as more resources become available. UHC is not only about individual treatment services, but also includes population-based services such as public health campaigns, adding fluoride to water, controlling mosquito breeding grounds, among others. UHC is

⁸² Gorik Ooms, et al. [2014] *ibid*.

comprised of much more than just health; taking steps towards UHC means steps towards equity, development priorities, and social inclusion and cohesion.⁸³

From the previous, the following are, therefore, the core components of universal health coverage:

First, financial protection: financial protection is achieved when direct payments made to obtain health services do not expose individuals to financial hardship and do not threaten living standards. The removal of user fees or the implementation of health insurance (with subsidized contributions for those unable to afford premiums) are key policies to promote financial protection as health systems need to have a predominant reliance on public revenue sources: mandatory, pre-paid, and pooled to achieve financial protection.⁸⁴

Second, equity: equity in health involves more than just equality concerning health determinants, access to the resources needed to improve and maintain health, or health outcomes. It also entails a failure to avoid or overcome inequalities that infringe on fairness and human rights norms. Groups that commonly experience inequalities can be defined socially, economically, demographically, or geographically and commonly include poor or marginalized persons, racial and ethnic minorities, and women.⁸⁵

Third, access: access has three dimensions: physical accessibility, in terms of the availability of quality health services within reasonable reach; financial affordability, in terms of people's ability to obtain services without financial hardship; and acceptability, where patients perceive

⁸³ WHO Fact Sheet 2019, *ibid*.

⁸⁴ Shreeshant Prabhakaran, et al. 'Do Better Laws and Regulations Promote Universal Health Coverage? A Review of the Evidence,' [2017] <<https://www.hfgproject.org/better-laws-regulations-promote-universal-health-coverage-review-evidence/>> accessed 9 July 2019.

⁸⁵ Shreeshant Prabhakaran, et al. [2017], *ibid*.

services to be effective, and they are not discouraged from using them by social or cultural factors.⁸⁶

Fourth, quality: six aspects pertain to the quality of healthcare services: safe, effective, patient-centered, timely, efficient, and equitable.⁸⁷

This understanding guides the examination, contained in the next chapters, of the policy, legal and institutional framework of universal health coverage in Kenya.

⁸⁶ Shreeshant Prabhakaran, et al. [2017], *ibid.*

⁸⁷ Shreeshant Prabhakaran, et al. [2017], *ibid.*

CHAPTER THREE: EXAMINATION OF THE POLICY FRAMEWORK ON UNIVERSAL HEALTH COVERAGE IN KENYA

3.0. Introduction

This chapter examines the policy framework on universal health coverage in Kenya. The objective of the chapter is to examine whether the existing policy framework supports the realization of universal health coverage in Kenya.

The chapter reviews previous initiatives in Kenya to achieve the ‘universality’ of health care. Current health policies are then identified and analyzed to assess whether they set any policy goals for universal health coverage. This chapter reviews the following policies: Vision 2030; Third Medium Term Plan 2018 – 2022; Health Policy 2014 – 2030; and the National Social Protection Policy.

3.1. Background

As earlier discussed, universal health coverage has become a policy priority at both the national and global level.⁸⁸ Kenya has recently adopted universal health coverage as one of the big four priority agenda, with an aspiration that by 2022, all persons in Kenya will be able to use the essential services they need for their health and wellbeing through a single unified benefit package, without the risk of financial catastrophe.⁸⁹

Kenya’s renewed political and policy commitment towards universal health coverage should be viewed in light of at least three recent developments:

⁸⁸ Edwine Barasa, Peter Nguhiu, and Di McIntyre, ‘Measuring progress towards sustainable development goal 3.8 on universal health coverage in Kenya,’ [2018] vol. 3(3) BMJ Global Health <<https://gh.bmj.com/content/bmjgh/3/3/e000904.full.pdf>> accessed 3 July 2019.

⁸⁹ Edwine Barasa, Peter Nguhiu, and Di McIntyre [2018] *ibid*.

First, there exists a constitutional framework that guarantees Kenyans the right to the highest attainable standard of health. The Constitution also devolves the provision of health services, with county governments bestowed with the responsibility of providing the bulk of health services. The national government has retained the function of formulating policy and managing national referral hospitals.

Second, Kenya has a mixed health financing system that is financed by revenues collected by (i) the government (national and county) through taxes and donor funding; (ii) the National Hospital Insurance Fund (NHIF) through member contributions; (iii) private health insurance companies through member contributions; and (iv) Out of Pocket (OOP) spending by citizens at points of care.⁹⁰

Third, household Out of Pocket (OOPs) expenditure continues to be a major source of financing for health services in Kenya.⁹¹ WHO defines Out-of-pocket payments (OOPs) “as direct payments made by individuals to health care providers at the time of service use excluding any prepayment for health services, for example in the form of taxes or specific insurance premiums or contributions and, where possible, net of any reimbursements to the individual who made the payments.”⁹²

These user fees and out-of-pocket payments (OOPs) have impacted negatively on the utilization of health care services in Kenya. The majority of the population cannot afford to pay for health

⁹⁰ Edwine Barasa, et al. ‘Kenya National Hospital Insurance Fund Reforms: Implications and Lessons for Universal Health Coverage,’ [2018] *ibid*.

⁹¹ Government of Kenya (GoK) *Third Medium Term Plan 2018 – 2022: Transforming Lives: Advancing socio-economic development through the “Big Four”* [2018] <<http://planning.go.ke/wp-content/uploads/2018/12/THIRD-MEDIUM-TERM-PLAN-2018-2022.pdf>> accessed 3 July 2019.

⁹² WHO ‘Health Financing: Out-of-pocket payments, user fees and catastrophic expenditure,’ <https://www.who.int/health_financing/topics/financial-protection/out-of-pocket-payments/en/> accessed 3 July 2019.

care, the poor are less likely to utilize health services when they are ill, and wide disparities in utilization exist between geographical regions and between urban and rural areas.⁹³ Those who pay for care incur high costs that are sometimes catastrophic and adopt coping strategies with negative implications for their socio-economic status, while others fail to seek care. The ‘Health Sector Working Group Report, 2018-19 to 2020-21’ acknowledges that high OOP Expenditure on health continues to be a major issue in Kenya, constituting about 32 percent of total health expenditure (when all sources are considered: government, private and development partners). Furthermore, that as a result, close to 6.2 percent of Kenyans spend over 40 percent of their non-food expenditure on health (catastrophic health expenditure) – hence pushing close to 2.6 million poor people below the poverty line every year.⁹⁴

The World Health Organization (WHO) has opined that OOPs are inefficient, inequitable, and contribute to households’ poverty and impoverishment. Increasing the share of tax funds allocated to the health sector and promoting health insurance can offer financial risk protection for the population.⁹⁵

In Kenya, insurance continues to be a relatively niche sub-sector, with the level of usage remaining low. By 2016, only about 19 percent of the population had some form of health insurance cover. In 2017, there were only 6.8 million people registered as members under the National Hospital Insurance Fund (NHIF) scheme. Further, there were approximately 1,200

⁹³ Jane Chuma and Vincent Okungu [2011], *ibid.*

⁹⁴ Ministry of Health (MoH) *Health Sector Working Group Report: Medium Term Expenditure Framework (MTEF) For the Period 2018/19 To 2020/21* [2017] <<http://www.treasury.go.ke/component/jdownloads/send/194-2018/731-health-sector.html>> accessed 3 July 2019.

⁹⁵ World Bank *Kenya public expenditure review (Vol. 2): Laying the foundation for a robust health care system in Kenya* [2014] <<http://documents.worldbank.org/curated/en/278451468038960033/pdf/940210WP0v20Bo0-Vol01120140FINALpdf.pdf>> accessed 3 July 2019.

registered retirement benefits/pensions schemes offering health insurance to only 2.2 million members in 2017. The usage of formal pensions is also relatively low at 12 percent of adults.⁹⁶

Therefore, this chapter reviews policies in place on universal health coverage in Kenya and whether they are sufficient to ensure UHC is indeed achieved by 2022.

3.2. Previous policies on ‘universal’ health in Kenya

Kenya has, over the years, had mixed policy measures to guide the provision of effective and accessible healthcare based on the foundations of solidarity, responsibility, equity, and transparency. Three major international health policy developments influenced the post-colonial health system:

First, the World Health Organization (WHO) 1978 Alma Ata “Health for All by the Year 2000” program which called for a shift in healthcare delivery from the hospital system to a primary health care system emphasizing the role of communities. Second, the World Bank’s neo-liberalist model detailed in ‘Financing Health Services in Developing Countries: An Agenda for Reform (1987)’ and other structural adjustment policies gave a particular impetus to the introduction of user charges, the development of the insurance system, increased use and development of the non-governmental (NGO) sector, and decentralization of health services. Thirdly, the Bamako Initiative promulgated in Bamako, Mali, in 1987 by the United Nations Children’s Fund (UNICEF) as a developing-countries’ approach towards the Health for All (HFA) targets for financing primary health care through selling essential drugs at the village level.⁹⁷

⁹⁶ Third Medium Term Plan 2018 – 2022, *ibid*.

⁹⁷ Richard G. Wamai, ‘Healthcare policy administration and reforms in post-colonial Kenya and challenges for the future’ [2009] in Tuija Veintie and Pirjo Kristiina Virtanen, eds. *Local and Global Encounters: Norms, Identities and*

Following independence in 1963, the post-colonial government made universal health care a major policy goal. The vision for a healthy nation in Kenya was contained in the 1965 ‘nation-building and socio-economic development blueprint’ – the Sessional Paper No. 10 on African Socialism and its Application to Kenya – that emphasized the elimination of disease, poverty, and illiteracy.⁹⁸

Thus, the post-colonial government abolished user fees that were implemented by the colonialist. Health services would then be funded primarily through general tax up to 1988 when the Kenyan government yielded to pressure from the World Bank and International Monetary Fund (IMF) to introduce user fees and other major reforms in the health sector. Poor economic performance, inadequate financial resources, and declining budgets were cited as some of the reasons to justify the introduction of user fees.⁹⁹

The introduction of user fees was suspended in 1990 and reintroduced in phases in 1991. Following the reintroduction in 1991, user fees were charged for individual services like drugs, injections, and laboratory services instead of consultation, as was previously the case. Revenue collected was returned to the district level to cater to public health needs within the district, and facilities developed detailed plans for spending 75% of the revenue. A waiving policy to protect the poor was put in place, and children below five years were exempted from all charges, but in

Representations in Formation [2009] Renvall Institute for Area and Cultural Studies, University of Helsinki, pp. 136-158.

⁹⁸ Richard G. Wamai [2009] *ibid.*

⁹⁹ Jane Chuma, and Thomas Maina ‘Free Maternal Care and Removal of User Fees at Primary-Level Facilities in Kenya: Monitoring the Implementation and Impact—Baseline Report,’ [2013] Washington, DC: Health Policy Project, Futures Group.

reality, waiving mechanisms hardly existed. The waivers and exemptions also covered maternal health services and tuberculosis.¹⁰⁰

Earlier in the country's health system, infrastructure development was the establishment of a national health insurance scheme. The National Hospital Insurance Fund (NHIF) was established in 1966 as a compulsory scheme for all salaried formal sector employees whose income exceeded a certain set minimum.¹⁰¹

In 2004/2005, the government attempted to introduce the National Social Health Insurance Fund (NSHIF) and the 10/20 policy to cushion the poor and realize the vision outlined in the 'Kenya Health Policy Framework of 1994'. NSHIF, which was never implemented, aimed to expand the coverage and benefits package of the National Hospital Insurance Fund (NHIF). The 10/20 policy capped the fees charged by government dispensaries at Ksh. 10 and by health centers at Ksh 20. All children younger than age five and specific health conditions such as malaria and tuberculosis were exempt from payment.¹⁰²

However, these policies did not achieve the intended objectives. For example, it has been reported that among households that used healthcare services in 2003, 10.3 percent experienced catastrophic health expenditures, and 3.5 percent were impoverished by having to pay for healthcare services at the point of consumption. In 2007, 11.1 percent of households experienced catastrophic health spending, with 4 percent impoverished. The poorest households experienced

¹⁰⁰ Jane Chuma and Vincent Okungu, 'Viewing the Kenyan health system through an equity lens: implications for universal coverage' [2011] vol. 10(1) International journal for equity in health: 22.

¹⁰¹ Richard G. Wamai [2009] *ibid.*

¹⁰² Richard G. Wamai [2009] *ibid.*

the highest incidence of catastrophic health expenditures in 2003 and 2007 (20%).¹⁰³ As such, despite these initiatives, the realization of universality in health care has remained a dream.¹⁰⁴

In addition to user fees, the government encouraged the development of the private health sector, a move that saw an upsurge in private health care providers in the country. Many private providers came up to respond to the demand for health care. Since public hospitals charged fees and were perceived to offer low-quality care, people opted to pay for private services that were perceived to be of better quality. The private sector has since grown in Kenya, owning 49% of health services, and regulating it remains a major challenge.¹⁰⁵

Therefore, despite the preceding development, OOP expenditure in health facilities has continued to rise. Currently, Kenya's health policy frameworks have been designed to realize Kenya Vision 2030, the Kenya Health Policy 2014 to 2030, and achieve the Constitutional right to the highest attainable standard of health, as discussed in the next section.

3.3. Current policies on universal health coverage in Kenya:

3.3.1. Kenya Vision 2030:

Kenya Vision 2030 is the long term development program for the country.¹⁰⁶ It was launched in 2008 and aimed to transform Kenya into a “newly industrializing, middle-income country providing a high quality of life to all its citizens in a clean and secure environment.”

¹⁰³ Diana Kimani and Thomas Maina 'Catastrophic Health Expenditures and Impoverishment in Kenya,' [2015] Washington, DC: Futures Group, Health Policy Project <
https://www.healthpolicyproject.com/pubs/522_CatastrophicExpendituresReportFINAL.pdf> accessed 10 July 2019.

¹⁰⁴ Diana Kimani and Thomas Maina [2015], *ibid*.

¹⁰⁵ Jane Chuma and Thomas Maina [2013], *ibid*.

¹⁰⁶ Government of Kenya (GoK) *Kenya Vision 2030: A Globally Competitive and Prosperous Kenya* [2007].

Kenya Vision 2030 is anchored on three key pillars, that is, economic, social, and political Governance. The economic pillar aims to achieve an economic growth rate of 10 percent per annum and sustain the same till 2030; the social pillar seeks to create just, cohesive and equitable social development in a clean and secure environment; and the political pillar aims to realize an issue-based, people-centered, result-oriented and accountable democratic system.¹⁰⁷

For the health sector, Vision 2030 notes that Kenya’s vision for health is to provide equitable and affordable health care at the highest affordable standard to her citizens. The Vision projects to “restructure the health delivery system and also shift the emphasis to ‘promotive’ care in order to lower the nations’ disease burden thus improving access and equity in the availability of essential health care and result in a healthy population that will effectively participate in the development of the nation.”¹⁰⁸

Vision 2030 outlines the following as the core strategies to improve health care in Kenya:

First, through the revitalization of health infrastructure where the Vision acknowledges that in order to provide efficient, equitable, affordable, and high-quality health care, a functional health delivery infrastructure must be put in place. The Vision projects that this will be achieved through increasing access to health facilities, strengthening the Kenya Medical Supplies Agency (KEMSA) to be the strategic procurement unit for the sector, establishing and strengthening health facility-community linkages, building the capacity of community extension workers and community-owned resource persons.¹⁰⁹

¹⁰⁷ *Kenya Vision 2030* ibid.

¹⁰⁸ *Kenya Vision 2030* ibid.

¹⁰⁹ *Kenya Vision 2030* ibid.

The second strategy to improve health care under Vision 2030 is the strengthening of health service delivery to be achieved through decentralization and operationalization of health care management to the facility level; introduction of qualified health facility managers; separation of the regulatory function from health service delivery; and development of a policy on Public-Private Partnerships (PPPs).¹¹⁰

Third, vision 2030 seeks to develop equitable financing mechanisms to be attained through an emphasis on preventive health financing, creation of fiscal space through efficient use of resources, and expansion of health insurance schemes.

Furthermore, a mix of health care financing mechanisms will be developed to make health care accessible to all. It is under this strategy that Vision 2030 seeks to promote affordable and equitable health care financing, which will reduce Kenyans' out-of-pocket expenditure on medical care to 25%.¹¹¹ Further, under this strategy, a social health insurance scheme (purchaser-provider system) would be put in place in addition to developing a social health insurance scheme.

Therefore, universal health coverage is firmly anchored in Kenya's long term development blueprint.

Kenya's Vision 2030 is implemented through five-year Medium Term Plans (MTP) that also serve as the primary basis for the alignment and coordination for development partners.

¹¹⁰ *Kenya Vision 2030* ibid, at 110.

¹¹¹ *Kenya Vision 2030* ibid, at 110.

3.3.2. Third Medium Term Plan (2018 – 2022): The “Big Four” Agenda

The Third Medium Term Plan (MTP III) of the Kenya Vision 2030 outlines the central policies, legal and institutional reforms, as well as programs and projects that the Government plans to implement during the period 2018-2022. It builds on the achievements of the first and second MTP’s.

MTP III prioritizes policies, programs, and projects which will support the implementation of the “Big Four” initiatives namely: (i) increasing the manufacturing share of GDP from 9.2 percent to 15 percent and agro-processing to at least 50 percent of total agricultural output; (ii) providing affordable housing by building 500,000 affordable houses across the country; (iii) enhancing Food and Nutrition Security (FNS) through construction of large-scale multi-purpose and smaller dams for irrigation projects, construction of food storage facilities and implementation of high impact nutritional interventions and other FNS initiatives; and, (iv) achieving 100 per cent Universal Health Coverage.

Therefore, MTP III outlines measures that the government intends to undertake in order to achieve 100 percent universal health coverage. It proposes to expand social health protection schemes to cover harmonized benefit package to targeted populations and ensure that Kenyans have access to health insurance mainly through NHIF by 2022. Further, MTP III proposes to establish ten new referral hospitals and increase the number of health facilities at the community level, including mobile health services.

Under this plan, the government proposes to implement the following programs and projects between 2018 – 2022:¹¹²

¹¹² Third Medium Term Plan 2018 – 2022, *ibid.*

First, expand social health protection by implementing schemes to cover harmonized benefit package to targeted populations through the following key projects: Health Insurance project for Elderly People and Persons with Severe Disabilities (PWSDs) to cover about 1.7 million persons by 2022; Health Insurance Subsidy Programme (HISP) for the orphans and the poor to cover about 1.5 million persons by 2022; *Linda Mama* Project to cover 1.36 million mothers and babies by 2022; Elimination of user fees in public primary health care facilities; Informal Sector Health Insurance Coverage to cover 12 million informal sector workers by 2022; and Formal Sector Medical Insurance (Medical Insurance Cover for Civil Servants Retirees) to cover 4.2 million workers by 2022.

Second, Medical Tourism Programme that will market Kenya as a hub for specialized healthcare, support training and retain specialized health expertise, create employment in specialized health care and make healthcare a vibrant socio-economic sub-sector in Kenya;

Third, Health Infrastructure Programme, where the Government will develop key health infrastructure components, for example, expansion and completion of Managed Equipment Services (MES) project in 120 hospitals by 2022, among others.

Fourth, Community Health High Impact Interventions Programme, where the government will implement components that include using community health workers to scale up health insurance coverage.

Fifth, Digital Health Programme, where the government will digitize services and adopt technologies such as e-health, m-health, telemedicine, and space technologies by leveraging on the improved ICT infrastructure and mobile penetration rates, which stands at over 80 percent.

Sixth, Human Resource for Health Programme aimed at addressing capacity gaps within specialized and sub-specialized areas in the health sector and also reduce shortages in the health workforce, especially in the ASAL areas.

Seventh, Quality Care/Patient and Health Worker Safety Programme to ensure provision of quality services and safety of the environment in which services are provided.

In order to achieve 100% universal health coverage, MTP III proposes that the following policy, legal and institutional reforms be undertaken:¹¹³

First, at the policy level, MTP III proposes to: Implement Sessional Paper No. 2 of 2017 on the Kenya Health Policy 2014-2030; Finalize and implement Health Financing Strategy and Health Internship Policy; Develop a Medical Tourism Strategy; Develop the Emergency Medical Care Policy; Implement the Kenya Environmental Sanitation and Hygiene Policy 2016-2030; Implement the National Food and Nutrition Security Policy 2012 and the Nutrition Plan of Action; and Implement the Community Health Policy.

Second, MTP III proposes the following legal reforms: review the NHIF Act, 1998; implement the Health Act, 2017; finalize the Food and Nutrition Security Bill; develop Food and Drug Authority Bill; develop the National Public Health Institute (NPHI) Bill; finalize the Environmental Health and Sanitation Bill 2017; and develop the National Research for Health Bill.

Third, the strategy proposes to make the following institutional reforms: develop and implement an effective partnership framework for health service delivery. This will promote the delivery of

¹¹³ Third Medium Term Plan 2018 – 2022, *ibid*, pp. 76.

efficient, cost-effective, and equitable health services; establish institutions as provided in the Health Act, 2017; and establish the Kenya Institute of Health Systems Management.

Therefore, MTP III is the policy document that provides in detail the measures that the government intends to take in order to achieve 100% universal health coverage in Kenya. This policy seeks to ensure the following components of UHC are realized:(i) access – through increasing the number of health facilities; (ii) quality – through quality through addressing the human resource concerns; (iii) equity – through targeting certain specific populations to ensure access to care; (iv) and financial through expansion of NHIF.

However, a few challenges may be experienced in realizing the objectives of this strategy. Currently, health is a devolved function. However, MTP III has not laid down strategies that explicitly recognize and appreciate the role of county governments in realizing universal health coverage. The Strategy plans to use conditional grants to Counties to implement the “Big Four” initiatives and other targeted programs. However, if this not correctly managed through clear intergovernmental agreements, challenges are bound to arise, as has been witnessed with the Managed Equipment Service (MES) program. For instance, four years after the launch of the Programme, MES equipment services remain unused in some facilities across the counties. Notably, renal equipment is in use in only 44 out of the 49 earmarked facilities in which it has been installed. Counties in which this equipment remains unused include Lamu, Mandera, TanaRiver Wajir, and West Pokot. This has been attributed to the lack of requisite staff and inadequate water and electricity.¹¹⁴

¹¹⁴ Parliament of Kenya ‘The Managed Equipment Service (MES) Project: Brief and Suggested Questions,’ [2018] <http://www.parliament.go.ke/sites/default/files/2018-11/MES%20Brief_Nov%202018%20%285%29_%20With%20Suggested%20Questions%20.pdf> accessed 8 July

3.3.3. Kenya Health Policy, 2014 – 2030:

The Kenya Health Policy 2014–2030 has as one of its objectives “to attain universal coverage of critical services that positively contribute to the realization of policy goals.” The goal of the Policy is “to attain the highest possible standard of health in a responsive manner” and that this would be achieved by supporting equitable, affordable, and high-quality health and related services at the highest attainable standards for all Kenyans.

The policy commits to ensure the progressive realization of the right to health with the national and county governments putting in place measures to progressively realize the right to health as outlined in Article 21 of the Constitution. The policy also commits to put in place a basic and expandable package—the Kenya Essential Package for Health (KEPH)—that will be defined and shall consist of the most cost-effective priority healthcare interventions and services, addressing the high disease burden, that are acceptable and affordable within the total resource envelop of the sector. Further, the policy commits to contribute to the attainment of the country’s long-term development agenda outlined in Kenya’s Vision 2030 through the provision of high-quality health services to maintain a healthy and productive population able to deliver the agenda.

In terms of health financing, the policy commits to “progressively facilitate access to services by all by ensuring social and financial risk protection through adequate mobilization, allocation, and efficient utilization of financial resources for health service delivery.” Moreover, financial barriers hindering access to services will be minimized or removed for all persons requiring health and related services, guided by the concepts of Universal Health Coverage and Social

2019. See also newspaper reports: Ibrahim Oruko ‘Governors want health equipment scheme probed,’ *Daily Nation* April 24, 2019 <<https://www.nation.co.ke/news/Governors-want-health-equipment-scheme-probed/1056-5084754-chx54m/index.html>> accessed 8 July 2019.

Health Protection. Further, the policy commits to identify and directly address sociocultural barriers hindering access to services to ensure all persons requiring health and related services can access them.

The policy notes that the primary responsibility of providing the financing required to meet the right to health lies with the national and county governments.

3.3.4. Kenya National Social Protection Policy¹¹⁵

The National Social Protection Policy seeks to “ensure that all Kenyans live in dignity and exploit their human capabilities for their own social and economic development.

The policy outlines measures in three areas: social assistance, social security, and health insurance. The policy makes the following proposals with regards to health insurance:

First, re-establish the NHIF as a fully-fledged comprehensive national health insurance scheme, which covers all Kenyans, and to which those who can afford it must contribute.

Second, establish a framework for enabling those who are not able to contribute to access a core package of essential health services, including maternity care and treatment for HIV/AIDS and related diseases.

Third, extend the range of benefits provided by the NHIF, including outpatient care, specialized treatment, and quality of care assurance, sickness benefits, and mandated post-retirement health coverage.

¹¹⁵GoK Kenya National Social Protection Policy June 2011 [2011]

<<https://www.socialprotection.or.ke/images/downloads/kenya-national-social-protection-policy.pdf>> accessed 5 July 2019.

Fourth, ensure that benefits made available by the NHIF and other medical schemes are adequate and are geographically and demographically accessible.

Fifth, streamline institutions by removing all duplication and inconsistencies between healthcare providers.

Sixth, establish a health insurance regulator to improve standard setting, regulation, and supervision in the health sector.

Eighth, provide a supportive framework for private sector participation in the health sector and determine the exact role, place, and function of medical benefit (insurance) schemes about the NHIF and Government interventions in healthcare.

3.4. Projects introduced and implemented towards UHC

3.4.1. Free maternal health (“Linda Mama”)

In 2013, the national government introduced the free maternity program that removed user fees for deliveries in all public facilities. Abolition of user fees for primary care and maternal health services as part of the government’s efforts to put Kenya on track to achieving universal health coverage (UHC) by 2030.¹¹⁶

¹¹⁶ Lisa M. Calhoun, et al. ‘The effect of the removal of user fees for delivery at public health facilities on institutional delivery in urban Kenya,’ [2018] vol. 22(3) Maternal and Child Health Journal: 409 <<https://link.springer.com/article/10.1007/s10995-017-2408-7>> accessed 14 July 2019.

From the final quarter of the 2016/17 financial year, the project was implemented through the NHIF and was supposed to cover antenatal care, deliveries, postnatal care, and other illnesses for the new-born.¹¹⁷

Currently, the free maternal health program is referred to as the “Linda Mama Project.” It is entrenched in MTP III (2018-2022) to cover 1.36 million mothers and babies by 2022.¹¹⁸ The goal of the project is to achieve universal care to maternal and child health service and contribute to the country’s progress towards UHC by ensuring that pregnant women and infants have access to quality and affordable health services on the basis of need and not ability to pay, positioning Kenya on the pathway to Universal Health Coverage (UHC).¹¹⁹

The Ministry of Health reports that the project has seen the number of deliveries being conducted at public health facilities in the country increased from 925,716 (2014/15) to 995,905 (2015/16) and 972,526 (2016/17) deliveries in health facilities, and a total of KSh.12.2 Billion transferred to public health facilities offering the service.¹²⁰

However, the project has been marred with challenges.

First, access to health by the poor depended on whether health centers and dispensaries could deliver the bulk of the primary interventions related to the program, given that these facilities act as the entry point for care. Secondly, the overall compliance with the policy across facilities has been a concern, with many expectant mothers being turned away due to delays in the

¹¹⁷ *Health Sector Working Group Report: Medium Term Expenditure Framework (MTEF) For the Period 2018/19 To 2020/21*, *ibid*, pp. xxii.

¹¹⁸ Third Medium Term Plan 2018 – 2022, *ibid*, pp. 75.

¹¹⁹ See NHIF “Linda Mama Services” <<http://www.nhif.or.ke/healthinsurance/lindamamaServices>> accessed 2 July 2019.

¹²⁰ *Health Sector Working Group Report: 2018/19 - 2020/21*, *ibid*, pp. xxii.

reimbursement by NHIF. Further, there were reports of transfer of patients from private facilities (not covered by part of the policy, or less likely to implement) to public or non-profit facilities (covered by the policy, more likely to implement).¹²¹

Despite increased demand for services, no steps were taken to support health facilities, and more clients led to increased staff workloads, reduced motivation, and staff burnouts. It also strained facilities' physical capacity; for instance, some hospitals were forced to fit many beds into small ward spaces, and in some cases, mothers were made to share beds. There have also been problems with reimbursements to facilities – which have been both inconsistent and unpredictable. This has made it difficult for facilities to plan how to spend funds and was a substantial challenge for hospitals that were dependent on it to run the facility.¹²²

Other concerns include stock-outs of drugs and other medical supplies, poor maintenance of equipment, lack of transport, and medical facilities. Similarly, there were cases where expectant mothers were asked to bring their gloves, cotton wool, and other medical items before delivery.¹²³

¹²¹ Timothy C. Okech 'Devolution of Public Health care Services in Kenya and its Implication on Universal Health Coverage,' [2017] vol. 7(5) IOSR Journal of Pharmacy: 9
<https://pdfs.semanticscholar.org/670d/cc8cf7a278d2c4ea7b3ce72bc6a3d5059bc4.pdf> accessed 19 July 2019.

¹²² Eric Tama, et al. 'Examining the implementation of the free maternity services policy in Kenya: a mixed methods process evaluation,' [2018] vol. 7(7) International journal of health policy and management: 603 <
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6037504/>> accessed 19 July 2019.

¹²³ Timothy C. Okech [2017] *ibid*.

3.4.2. The Health Insurance Subsidy Program (HISP)

In April 2014, the Kenyan government launched the HISP pilot program—a comprehensive, fully subsidized health insurance program for selected poor orphans and vulnerable children—benefiting from the government’s cash transfer program.¹²⁴

The main objective of the project (implemented through NHIF) is to increase prepaid health insurance coverage, especially for the poor populations of the country.

The project aims to ensure that the state covers the full insurance premiums for beneficiaries, and the beneficiaries would then be entitled to the full benefits of the health insurance cover. The projects cover households that were already taking care of orphans and vulnerable children in the society and were already identified as very poor through community-based poverty identification mechanisms.¹²⁵

3.4.3. Health Insurance for the Elderly and People with Severe Disabilities Program

The Ministry of Health undertook to cover all the elderly and persons with severe disabilities who were receiving cash transfer from the Ministry of East Africa, Labour and Social Security, Department of Social Services as per the Presidency’s directive of February 2014.¹²⁶

The cover was offered to the beneficiaries by the NHIF through its premier Super-Cover initiative, and the State offered the beneficiaries a full subsidy for their premiums. Between 2014 and 2016, the total coverage under the project was 231,000 beneficiary households for the

¹²⁴ Edwine Barasa, et al. ‘Kenya National Hospital Insurance Fund Reforms: Implications and Lessons for Universal Health Coverage,’ [2018] vol. 4(4) Health Systems & Reform: 346

<<https://www.tandfonline.com/doi/full/10.1080/23288604.2018.1513267>> accessed 20 July 2019.

¹²⁵ Health Sector Working Group Report 2017, *ibid.*

¹²⁶ Health Sector Working Group Report 2017, *ibid.*

insurance cover. This number was, however, reduced to a total of 42,000 households in all counties due to the reduced funding and increasing NHIF premiums required for the cover.

3.5. Conclusion

There exists a policy framework to guide the realization of universal health coverage. However, the policies exhibit deficiency when it comes to implementation under the devolved government framework.

Further, the projects implemented under the policies, for example, *Linda Mama*, Health Insurance for the Elderly and People with Severe Disabilities Program, and the Health Insurance Subsidy Program (HISP), are laudable for targeting specific marginalized and vulnerable groups. However, the success of these projects depends on fixing the core parameters of health, that is to say, health services must be available, easily accessible, and acceptable and of high quality.

Lastly, the policy framework places the National Hospital Insurance Fund (NHIF) at the driving seat in achieving universal health coverage. The next chapter interrogates whether NHIF as an institution is appropriately situated to drive and ensure the UHC agenda is achieved in Kenya.

CHAPTER FOUR: LEGAL AND INSTITUTIONAL FRAMEWORK FOR UNIVERSAL HEALTH COVERAGE IN KENYA

4.0. Introduction and background

This chapter discusses the legal and institutional framework that exists to support universal health coverage in Kenya. The objective of the chapter is to examine whether the existing legal and institutional framework in Kenya is sufficient to support the realization of universal health coverage.

The first part of the chapter discusses the various laws likely to impact on universal health coverage. These include the Constitution, Health Act (2017), and the National Hospital Insurance Fund Act (1998). The second part examines institutions at the center of universal health coverage, that is, the National Hospital Insurance Fund and County Governments.

Laws can either promote or inhibit efforts towards universal health coverage, and as such, creating an enabling legal environment means taking steps to remove legal barriers as well as developing and maintaining laws that support the different dimensions of universal health coverage.¹²⁷

Further, laws can help assure health system goals of universal health coverage; create a legal mandate for universal health service access; set and enforce fair rules and incentives to ensure that a health system and its actors act consistently with the goals of universal health coverage;

¹²⁷ WHO 'Health laws and universal health coverage,' <<https://www.who.int/health-laws/universal-health-coverage/en/>> accessed 10 July 2019.

and provide a critical means for implementing UHC policies and programmes and supporting health system strengthening efforts.¹²⁸

4.1. Legal framework for UHC in Kenya:

4.1.1. Constitution of Kenya

The Constitution of Kenya 2010 provides the overarching legal framework for universal health coverage.

First, Articles 2(5) and 2(6) of the Constitution provides the legal basis for the application in Kenya of the general rules of international law and treaties or conventions that Kenya has ratified. The State also should enact and implement legislation to fulfill its international obligations in respect of human rights and fundamental freedoms.¹²⁹

Second, the Constitution guarantees the right to health. Article 43 (1) (a) provides that “every person has the right to the highest attainable standard of health which includes the right to health care services, including reproductive health care.” Article 43(2) provides further that a person shall not be denied emergency medical treatment. With respect to the realization of the right to health for children, Article 53(1)(c) and (d) provides that, “every child has the right to basic nutrition, shelter and health care; [and] to be protected from abuse, neglect, harmful cultural practices, all forms of violence, inhuman treatment and punishment, and hazardous or exploitative labor. Some of the other rights guaranteed by the Constitution that are interrelated with the right to health include right to life; equality and freedom from discrimination; human dignity; right to privacy; right of access to information, among others.

¹²⁸WHO ‘Health laws and universal health coverage,’ *ibid*.

¹²⁹ Article 21(4) Constitution of Kenya.

Third, the Constitution introduces a devolved system of government with Kenya divided into 47 counties and one national government. The governments at the national and county levels are distinct and inter-dependent and are to conduct their mutual relations based on consultation and cooperation.¹³⁰ In the devolved system of governance, health is a devolved function. Under the fourth schedule, the national government is responsible for national referral health facilities and health policy; whereas the county governments are responsible for providing the bulk of health services including county health facilities and pharmacies; ambulance services; promotion of primary health care, among others.

Fourth, the constitution obligates the government to take “legislative, policy and other measures, including the setting of standards, to achieve the progressive realization of the rights guaranteed under Article 43.” The right to health is thus to be achieved progressively with the following as the guiding principles:¹³¹ it is the responsibility of the State to show that the resources are not available; in allocating resources, the State shall give priority to ensuring the widest possible enjoyment of the right or fundamental freedom having regard to prevailing circumstances, including the vulnerability of particular groups or individuals; and the court, tribunal or other authority may not interfere with a decision by a State organ concerning the allocation of available resources, solely on the basis that it would have reached a different conclusion.

Relatedly, Article 10 outlines the national values and principles of governance that State organs, State officers, public officers, and all persons must adhere to whenever they enact, apply or interpret any law; or make or implement public policy decisions. These national values and principles of governance include sharing and devolution of power, the rule of law, democracy

¹³⁰ Article 6(2) Constitution of Kenya.

¹³¹ Article 20(5) Constitution of Kenya.

and participation of the people; human dignity, equity, social justice, inclusiveness, equality, human rights, non-discrimination and protection of the marginalized; good governance, integrity, transparency and accountability; among others.

The constitutional guarantee of the right to health thus provides a sound legal basis for the realization of universal health coverage.

4.1.2. The Health Act, 2017

The enactment of the Health Act 2017 was set to achieve the following purposes:¹³²First, establish a national health system that encompasses public and private institutions and providers of health services at the national and county levels and facilitate progressively and equitably, the highest attainable standard of health services.

Second, protect, respect, promote and fulfill the health rights of all persons in Kenya to the progressive realization of their right to the highest attainable standard of health, including reproductive health care and the right to emergency medical treatment;

Third, protect, respect, promote and fulfill the rights of children to basic nutrition and health care services contemplated in Articles 43(1) (c) and 53(1) (c) of the Constitution. Fourth, protect, respect, promote, and fulfill the rights of vulnerable groups as defined in Article 21 of the Constitution in all matters regarding health.

The Health Act makes provision on universal health coverage in the following ways:

First, the guiding principle of universal health coverage is aptly captured in section 4(d) where the Act notes that it is the fundamental duty of the State to ensure: “provision of a health service

¹³² Section 3 Health Act 2017.

package at all levels of the health care system, which shall include services addressing promotion, prevention, curative, palliative, and rehabilitation, as well as physical and financial access to health care.”

Second, the UHC principle is partly captured as a standard of health where section 5(1) states that: “Every person has the right to the highest attainable standard of health which shall include progressive access for provision of promotive, preventive, curative, palliative and rehabilitative services.”

Third, the Act removes user fees for certain health services. For example, under section 5(3) of the Act, the national and county governments are obligated to ensure the provision of free and compulsory vaccination for children under five years of age; and maternity care.

Fourth, the Act makes it a responsibility of the national government to “develop policy measures to promote equitable access to health services to the entire population, with special emphasis on eliminating the disparity in realization of the objects of the Act for marginalized areas and disadvantaged populations;”¹³³ and “ensure through intergovernmental mechanisms that financial resources are mobilized to ensure uninterrupted access to quality health services countrywide;”¹³⁴

Fifth, with regards to health financing, Section 86 of the Act provides that “the department of health shall ensure progressive financial access to universal health coverage by taking measures that include: (i) developing mechanisms for an integrated national health insurance system including making provisions for social health protection and health technology assessment; (ii) establishing in collaboration with the department responsible for finance oversight mechanism to

¹³³ Section 15 (1)(f) Health Act 2017.

¹³⁴ Section 15 (1)(p) Health Act 2017.

regulate all health insurance providers; (iii) developing policies and strategies that ensure realization of universal health coverage; (iv) determining, during each financial period and in consultation with individual county authorities, cost-sharing mechanisms for services provided by the public health system without significantly impeding the access of a particular population groups to the system in the areas concerned; and (v) defining in collaboration with the department responsible for finance, a standard health package financed through prepayment mechanisms including last expense.

The Cabinet Secretary is mandated to make regulations for the fees to be paid to access services in a public health facility.¹³⁵

Therefore, the Health Act lays the basis for ensuring access to health services, equity, quality, and financial access.

4.1.3. National Hospital Insurance Fund Act, 1998

The NHIF Act 1998 is an Act of Parliament that establishes the National Hospital Insurance Fund (NHIF) and makes provisions with regards to contributions to and the payment of benefits out of the Fund, and management of the Fund.

Under section 15 of the Act, persons who are ordinarily resident in Kenya; have attained the age of 18 years; and whose total income, whether derived from a salary or self-employment are liable as contributors to the Fund.

Contributors are categorized as salaried and self-employed. Under section 16, salaried contributors must pay the standard contribution through monthly deductions from their salary or

¹³⁵ Section 112.

other remuneration, and the employer of such person shall be liable to deduct and to pay the contribution to the Board on behalf of and to the exclusion of that person.

The Act makes it an offense to fail without a lawful excuse to pay the standard contribution.

Self-employed persons are under section 19 required to make special contributions to NHIF every month at a rate to be prescribed. If the contributions are not remitted on time, there is a penalty (equaling to five times the amount of contribution). The Act also makes it an offense to fail to submit special contributions. Under section 20, voluntary contributions are also allowed under the Act.

Section 4 of the Act establishes a National Hospital Insurance Fund Board of Management comprising of Chairman appointed by the President; Principal Secretaries of Health and Treasury; Director of Medical services; representatives of Federation of Kenya Employers (FKE), Central Organisation of Trade Unions (COTU); Kenya National Union of Teachers (KNUT) and Kenya Union of Post Primary Education Teachers (KUPPET), Kenya Medical Association (KMA) and faith-based organization. One glaring omission from the membership of this board is a representation of county governments who have a greater role to play in the delivery of health services.

Section 6 of the Act gives the Board all the powers necessary for the performance of its functions – and including the powers to manage, control and administer the assets of NHIF: receive any gifts, grants, donations or endowments made to NHIF; determine the provisions to be made for capital and recurrent expenditure and for reserves of the Board; open a banking account or banking accounts for NHIF; invest any monies of NHIF not immediately required for the purposes.

Section 22 makes provision on how benefits are paid and limits the benefits payable from the Fund to expenses incurred in respect of drugs, laboratory tests and diagnostic services, surgical, dental or medical procedures or equipment, physiotherapy care and doctors' fees, food and boarding costs.

The Board has powers under section 30 in consultation with the Minister and the chairman of the Medical Practitioners and Dentists Board to declare any hospital, nursing home, or maternity home to be a hospital for the Act.

Section 34 authorizes the Board to invest NHIF monies. The Act also allows the Board to advance money to any declared hospital for improvement of medical and health care services, subject to the Board satisfied that such a hospital is financially viable and in any underserved area. The Auditor-General does auditing of the NHIF with the Cabinet Secretary (CS) laying the audit report before the National Assembly within nine months after the report has been submitted to CS.

4.2. Existing legal framework vis-à-vis universal health coverage

The Constitution lays the basis for a sound legal framework for the realization of the right to health. These constitutional principles are, to some extent, properly captured under the Health Act 2017. In this regard, these two pieces of legislation properly implemented can ensure the realization of the right to health and in extension, universal health coverage. Both laws provide the legal basis for non-discrimination, access to health services, ensuring equity, provision of quality services and protection against financial risk.

The NHIF Act, on the other hand, has a few aspects that need to be addressed. First, an analysis of the Act shows that it is yet to be aligned with the Constitution of Kenya. For example, the

realization of the constitutional right to health is conspicuously missing as an objective of the Act. Second, the achievement of universal health coverage is not one of the objectives of the Act; neither is it an objective of the institution created by the Act. UHC's core principles of equity, access to health services, quality services, and financial risk protection do not form the core approach of the Act. Third, the Act does not acknowledge the fact that health is a devolved function. Counties are not part of the decision-making process of the board of NHIF; neither do they participate in any way in its affairs. Fourth, the Board of Management under the Act has wide powers to make decisions with venues for consultation or cooperation not provided by the Act.

Apart from the Constitution, the Health Act, and the NHIF Act, multiple laws exist that regulate the health sector. Some of these laws include: (i) Kenya Medical Supplies Authority Act (Act No. 20 of 2013) that makes provisions for the establishment of the Kenya Medical Supplies Authority which procures, warehouses and distributes drugs and medical supplies; (ii) HIV/AIDS Prevention and Control Act (Act No 14 of 2006) that makes provisions on measures for the prevention, management and control of HIV and AIDS; (iii) Public Health Act that makes provision for securing and maintaining health; (iii) Pharmacy and Poisons Act that makes provision for the control of the profession of pharmacy and the trade in drugs and poisons;(iv) Narcotic Drugs and Psychotropic Substances Act (Act No. 4 of 1994) that makes provisions with respect to the control of the possession of, and trafficking in, narcotic drugs and psychotropic substances and cultivation of certain plants; (v) Public Health Officers (Training, Registration and Licensing) Act (Act no. 12 of 2013) that makes provision for the training, registration and licensing of public health officers and public health technicians; (vi) Health Records and

Information Managers Act (Act No. of 15 of 2016) that makes provision for the training, registration and licensing of the health records and information managers; among others.

There is thus the need to harmonize these laws to ensure that they are aligned to the constitution and promote the realization of the right to health and universal health coverage.

4.3. Institutional framework for universal health coverage

4.3.1. National Hospital Insurance Fund (NHIF)

Under the Third Medium Term Plan 2018 – 2022, NHIF is the vehicle through which the government intends to use to attain universal health coverage. In this regard, the government intends to expand social health protection schemes to cover harmonized benefit package to targeted populations and ensure that Kenyans will have access to health insurance mainly through NHIF by 2022.¹³⁶

Kenya is one of the few African countries that has had a national hospital insurance scheme in existence since the 1960s. NHIF was established in 1966 as a department of the Ministry of Health (MOH) to provide health insurance cover to the formal sector. Salaried individuals contributed a flat premium rate and were entitled to an inpatient benefit package. In 1972, the law that governed the NHIF was amended to extend insurance coverage to individuals in the informal sector. In 1990, the law was further amended to introduce a graduated premium payment structure.¹³⁷

¹³⁶ Third Medium Term Plan 2018 – 2022, *ibid.*

¹³⁷ Edwine Barasa, et al. [2018] *ibid.*

In 1998, the original law was repealed and replaced with the NHIF Act of 1998 that transformed the institution from a department of the Ministry of Health to an autonomous state corporation.¹³⁸

In 2004, the then Minister of Health attempted to introduce a social health insurance scheme. A law was passed by parliament, but the president refused to sign it, citing concerns related to the scheme's technical design.¹³⁹

In 2015, the NHIF Act was amended to revise premiums upwards. The NHIF expanded its benefit package from inpatient only, to include outpatient services as well as a raft of what has been termed special packages.¹⁴⁰

Membership into the NHIF is mandatory for formal sector workers, who pay an income rated monthly contribution through statutory deductions, whereas it is voluntary for informal sector workers, who pay a flat rate contribution directly to the NHIF.

NHIF reports that its membership grew to 6.8 million by 2016/17, which translates to 17 million Kenyans (principal contributors and their dependents), providing overall coverage of 36 percent.¹⁴¹

NHIF works with accredited health providers to provide services to its members.

¹³⁸ Jane Chuma and Vincent Okungu [2011], *ibid*.

¹³⁹ Edwine Barasa, et al. [2018] *ibid*.

¹⁴⁰ The special packages include radiology, cancer care, ambulance services, surgical care, chronic care, maternity care, overseas travel, renal dialysis and kidney transplant. For the national cover which every NHIF member is part of, outpatient benefits include consultation, lab investigations, day care procedures, drugs and dispensation, health education, wellness and counseling, physiotherapy, immunization and vaccines as per the KEPI schedule. The Fund further covers specialized treatment such as renal dialysis, radiology and cancer treatment, surgical procedures, maternal care and reproductive health services, emergency road evacuation, overseas treatment and rehabilitation for drug and substance abuse.

¹⁴¹ Third Medium Term Plan 2018 – 2022, *ibid*.

NHIF has designed and implemented special packages with a view of achieving universal health coverage. However, as earlier noted, these services are only accessible to the members registered under NHIF, leaving out a majority of Kenyans. Some of the special programs introduced under NHIF include:

First, there is the *Linda Mama* program, which is a free benefits package that ensures expectant mothers get ante-natal, delivery care, postnatal care, referral, and infant care. This program was launched in October 2016, followed by the signing of a memorandum of understanding between the Government and NHIF in February 2017. However, services are only provided to registered mothers. NHIF reports that so far, there have been 395,918 mothers registered with 223,459 deliveries done across the country.¹⁴²

Second, there is a *Secondary School Cover* whereby the government launched and rolled out a free cover for all students in public secondary schools. However, these students must be registered under NHIF to access free health services in the accredited health care facilities.

Third, there is a *Health Insurance Subsidy Program (HISP)*, which targets the very poor, orphans, and vulnerable children. This program was launched in April 2014 to offer comprehensive, fully subsidized health insurance programs for selected poor orphans and vulnerable children—benefiting from the government’s cash transfer program.

Fourth, NHIF has implemented a *Health Insurance Subsidy Program (OPPD)*, which targets the very old and persons with severe disabilities.

¹⁴² NHIF ‘NHIF Performance Report 2018,’ [2018]
<http://www.nhif.or.ke/healthinsurance/uploads/notices/NHIF_Performance_Report_2018_08.08.2018.pdf>
accessed 25 June 2019.

Fifth, NHIF has further implemented a *Civil Servants Scheme*. This scheme was introduced in 2012 for formal sector government workers and their dependents (civil servants). Through this scheme, the funds for the CSS are managed separately from other NHIF funds, and beneficiaries enjoy a wider benefits package, including comprehensive outpatient and inpatient services accessed through contracted health care providers. This scheme has, however, been criticized for being discriminatory and promoting inequality in access to health care.

Sixth, NHIF implemented the *Stepwise Quality Improvement System program* in 2013 with financial support from the IFC and technical support from the PharmAccess Foundation. The aim was to support basic health care providers in resource-restricted settings to go through stepwise structured improvement programs to deliver safe and quality-secured care to their patients according to internationally recognized standards.¹⁴³

Seventh, NHIF has also in 2015 revised the *Monthly Contribution Rates* and expanded the *Benefit Package*: NHIF increased contribution rates for its national scheme members, to account for increased cost of service provision and to expand the benefit package. Prior to this revision, the NHIF premiums were last revised in 1988. The monthly contributions for the lowest-paid formal employee increased by 400%, and rates for the highest earners increased by 431%. Contribution rates for the informal sector increased by 213%. This increase was accompanied by expansion of the benefit package to include outpatient services and a range of what the NHIF labels special packages that include chronic diseases, surgical care, chemotherapy, renal dialysis, kidney transplant, and magnetic resonance imaging and computed tomography scans.¹⁴⁴

¹⁴³ Edwine Barasa, et al. [2018] *ibid.*

¹⁴⁴ Edwine Barasa, et al. [2018] *ibid.*

However, this increase has been criticized for making the scheme unaffordable and inaccessible to low-income Kenyans.

Eighth, in 2016, NHIF revised Provider Reimbursement Rates upwards. There was thus an increase in the inpatient reimbursement rates following negotiations with health providers, as a means to reduce the proportion of direct costs payable by its members for inpatient care. For example, reimbursement for a normal delivery increased from 6,000 KES to 10,000 KES, and the daily rebate for inpatient care in a public facility doubled, from 600 KES to 1,200 KES.¹⁴⁵ However, NHIF has been criticized for delays in reimbursing providers of health services, which has led some providers to turn away patients hence affecting their timely access to the needed health care.

4.3.2. Can NHIF ensure the realization of UHC in Kenya?

Health insurance coverage in Kenya is generally low (19%). The NHIF is the main health insurer in Kenya, covering 16% of Kenyans, whereas the 32 private health insurers collectively cover a mere 1% of the Kenyan population.¹⁴⁶

According to MTP III, health insurance continues to be a relatively niche sub-sector, with the level of usage remaining at 6 percent of the population and contributing 1.5 percent to GDP in 2016. Further, that by 2016, 19 percent of the population had some form of health insurance coverage with the statutory National Hospital Insurance Fund (NHIF) at 21 percent. MTP III also notes that in 2017, membership to NHIF grew to 6.8 million persons up from 6.1 million in

¹⁴⁵ Edwine Barasa, et al. [2018] *ibid.*

¹⁴⁶ Edwine Barasa, et al. [2018] *ibid.*

2016, accounting for 11.1 percent increase. Moreover, there were approximately 1,200 registered retirement benefits/pensions schemes, with over 2.2 million members in 2017.¹⁴⁷

Despite the existence of NHIF, a significant majority of the population still do not have access to needed health services. The Kenyan health sector is significantly dependent on out of pocket payments for health services, and health care costs are increasingly impoverishing Kenyan households and pushing some households into poverty.

NHIF, as currently constituted, is unlikely to ensure the realization of universal health coverage to Kenyans for several reasons:

Devolution of health

Health is a devolved function with the bulk of services being provided by county governments. However, NHIF, as a national government institution, is yet to be structured in a way to facilitate the participation of county governments in its decision-making processes. There is a need to ensure NHIF is an inter-governmental institution with counties, which are the largest beneficiaries of NHIF services, being members of the board to ensure they are part/influence the decision-making process that impacts health services delivery at county level.¹⁴⁸

Coverage of the informal sector

Enrollment and retention among the informal sector using a voluntary contributory mechanism have been criticized since significant proportions of informal workers are less well-off compared to formal sector workers and, therefore, could have a lower ability to pay for health insurance.

¹⁴⁷ Third Medium Term Plan 2018 – 2022, *ibid*.

¹⁴⁸ Council of Governors (CoG) and Kenya Law Reform Commission (KLRC) *Report on the Audit of National and County Policy and Legislation* [2018] <<http://www.klrc.go.ke/index.php/reports-and-publications/644-report-on-the-audit-of-national-and-county-legislation-and-policy>> accessed 2 July 2019.

Further, given that the informal sector is not organized in sizeable groups, it is administratively difficult to recruit, register, and collect regular contributions cost-effectively.¹⁴⁹

'Limited' access to services

It has been reported that though the *de jure* NHIF benefit package was comprehensive, the range of benefits that NHIF members *de facto* received was limited because certain services were often not available from the health care providers that NHIF had contracted to provide services to its members. For example, medicines, laboratory, and radiological tests.¹⁵⁰

Equity concerns

Some projects implemented by NHIF are inequitable. For instance, the decision to first expand coverage to civil servants, who represent a sizeable number of the well-off population, has been criticized for being unfair and inequitable because a sizeable proportion of Kenya's population is in the informal sector, and 36% of the population lives below the national poverty line.¹⁵¹

Unaffordable rates

The upward revision of the NHIF premium contribution rates has been criticized as being unaffordable to informal sector individuals. Informal sector individuals have expressed concern about the affordability of the revised premium contribution rate.¹⁵²

Coverage in urban v. rural areas

Contracting of health care facilities to provide services to NHIF members is biased in favor of urban facilities, predominantly hospitals, rather than small outpatient facilities that provide primary health care. This bias, therefore, promotes inequities in access to services.¹⁵³

¹⁴⁹ Edwine Barasa, et al. [2018] *ibid.*

¹⁵⁰ Edwine Barasa, et al. [2018] *ibid.*

¹⁵¹ Edwine Barasa, et al. [2018] *ibid.*

¹⁵² Edwine Barasa, et al. [2018] *ibid.*

Weak accountability mechanisms

Weak accountability mechanisms have led to an increase in cases of fraud by the NHIF and health care providers. Fraud leads to leakage of resources, which results in inefficiencies. Further, the Ministry of Health lacks clear structures to provide oversight of the NHIF.

Delayed disbursements to providers

Delayed disbursements of payments to facilities with public and private hospitals experiencing delayed disbursements of NHIF payments by up to three months. This has led to some facilities introducing OOP payments to cover the costs, while others either denied or rationed services.¹⁵⁴

4.3.3. County Governments

The most significant feature of the Constitution of Kenya 2010 is the introduction of a devolved system of government, which is unique for Kenya and provides for one (1) national government and forty-seven (47) county governments.

The governments at the national and county levels are “distinct and interdependent” and are expected to undertake their relations through “consultation and cooperation.” The distinctiveness of the governments under the devolved system is determined by the Fourth Schedule of the Constitution, which has assigned different functions to the two levels of government.

In line with devolution, the Constitution distributes the provision of health services between the National Government and the County Government and in order to ensure the realization of the right to health. Devolution of the health system in Kenya was informed by the desire to promote access to health services throughout Kenya; address discrimination of the “low potential areas” where urban areas had better health services than rural areas; address problems of bureaucracy in

¹⁵³ Edwine Barasa, et al. [2018] *ibid.*

¹⁵⁴ Edwine Barasa, et al. [2018] *ibid.*

matters of health service provision especially procurement-related problems; promote efficiency in the delivery of health services; and address problems of low quality of health services, among others. The highly centralized government system had led to the weak, unresponsive, inefficient, and inequitable distribution of health services in the country.

The 47 county governments with independently elected governors and county assemblies constitutionally have the right to receive a minimum of 15% of national revenue through a combination of block and conditional grants. Besides, counties can raise funds through local taxes to support the implementation of devolved functions across all productive sectors, works, transport, environment, and social sectors, including health.

The health function is distributed between the national and county governments as follows: the National government is responsible for national referral health facilities and health policy; whereas county governments are responsible for the provision of the bulk of health services including: county health facilities¹⁵⁵ and pharmacies¹⁵⁶; ambulance services; promotion of primary health care;¹⁵⁷ licensing and control of undertakings that sell food to the public;

¹⁵⁵ These include County hospitals, Sub-county hospitals, Rural health centres, dispensaries, Rural health training and demonstration centres, rehabilitation and maintenance of county health facilities. See Council of Governors (CoG) and Kenya Law Reform Commission (KLRC) [2018], *ibid* at pp. 10.

¹⁵⁶ These include specifications, quantification, storage, distribution, dispensing and rational use of medical commodities. See Council of Governors (CoG) and Kenya Law Reform Commission (KLRC) (2018), *ibid* at pp. 10

¹⁵⁷ These include health education, health promotion, community health services, reproductive health, child health, tuberculosis, HIV, malaria, school health program, environmental health, maternal health care, immunization, disease surveillance, outreach services, referral, nutrition, occupation safety, food and water quality and safety, disease screening, hygiene and sanitation, disease prevention and control, ophthalmic services, clinical services, rehabilitation, mental health, laboratory services, oral health, disaster preparedness and disease outbreak services. planning and monitoring, health information system (data collection, collation, analysis and reporting), supportive supervision, patient and health facility records and inventories. See Council of Governors (CoG) and Kenya Law Reform Commission (KLRC) [2018], *ibid* at pp. 10

veterinary services (excluding regulation of the profession);¹⁵⁸ cemeteries, funeral parlours and crematoria; and refuse removal, refuse dumps and solid waste disposal.¹⁵⁹

The fourth schedule provides an important guide on the mandates of each level of government concerning the provision of health services. The provision of the bulk of health services is devolved to counties, with the national government retaining the function of setting the required standards through policy and managing national referral facilities.

The functions of the national government are unbundled under section 15 of the Health Act. The Act elaborates on what policies the national government should develop, guidelines and standards to set, management of national referral facilities, and interrelationship with devolved units.

In undertaking these functions, the national government is expected to adhere to the spirit of devolution by ensuring there is consultation and cooperation with county governments. Therefore, in developing health policies, laws, and administrative procedures and programs, the national government is obligated to consult with county governments and health sector stakeholders.

The functions of the county government are unbundled under section 20 of the Act. Since health is a devolved function, the bulk of delivery of health services is the function of county governments. In this sense, counties thus have the responsibility to implement national health

¹⁵⁸ Coordinate and oversee veterinary services including clinical services, artificial insemination, reproductive health management.

¹⁵⁹ Refuse removal (garbage): provision of waste collection bins, segregation of waste at source, licensing of waste transportation; refuse dumps including: zoning waste operation areas, conducting environmental impact assessment for the siting of dumps, fencing of dumps, controlling fires, monitoring waste.

policies and standards, deliver health services, ensure staffing of health facilities, procure and manage health supplies, among other functions.

From the preceding, it is apparent that counties are critical to the achievement of universal health coverage.

4.3.4. County government in the UHC agenda

County governments are central to the realization of universal health coverage since they implement the bulk of the health function.

The national government has set a political and policy agenda to achieve 100% universal health coverage by 2022. In order to achieve this, the national government has piloted UHC in four counties, that is, Kisumu, Isiolo, Machakos, and Nyeri. These four counties were chosen because, collectively, they have a high prevalence of communicable and non-communicable diseases, high population density, high maternal mortality, and high incidence of road traffic injuries.¹⁶⁰

Some of the other counties have also, in the recent past, launched projects aimed at realizing universal health coverage. For example, Kajiado County launched a mass registration exercise for the National Hospital Insurance Fund (NHIF) health scheme.¹⁶¹

Makueni County, on the other hand, has been offering its people free healthcare across all its public facilities and sub-county hospitals. For an annual subscription of Kshs. 500 per household covering parents and all their children under the age of 18 years or up to 24 years in case they are

¹⁶⁰ See WHO 'Building Health: Kenya's Move to Universal Health Coverage,' <<https://www.afro.who.int/news/building-health-kenyas-move-universal-health-coverage>> accessed 1 July 2019.

¹⁶¹ See County Government of Kajiado 'Universal Health Coverage,' <<https://www.kajiado.go.ke/news/universal-health-coverage/>> accessed 3 July 2019.

students, Makueni Care has managed to offer free healthcare across the board to its residents eliminating user fees that sub-county hospitals would collect.¹⁶²

Kitui County is also on track to providing its residents with access to subsidized healthcare. Known as the Kitui County Health Insurance Cover (K-CHIC), the recently launched program targets more than 270,000 households in Kitui to access high-quality medical services including curative, promotive, preventive, rehabilitative and specialized services within all county public health facilities.¹⁶³

However, counties have faced challenges in providing health services. For example, there have been more than two dozen strikes since the devolution of health services in 2013. One of the most severe was a 100-day strike by Doctors that began at the end of 2016 and ended in March 2017. Nurses, too, had a 5-month strike between June and November 2017 over non-implementation of their collective bargaining agreement (CBA).¹⁶⁴ Further, there have been reports of delay in funds disbursement to counties from the National Government.

Some counties also do not have clear procurement plans in place for the purchase of medical supplies. The county governments are under no obligation to procure from the Kenyan agency for drug supply (KEMSA), which has been procuring in bulk and thus enhancing economies of scale while also monitoring the efficacy of the drugs for purposes of continuous improvement. Thus has now introduced an opportunity for corruption in supplies procurement where suppliers

¹⁶² See Government of Kenya 'County Governments at the Centre of Achieving Universal Health Care,' <<https://vision2030.go.ke/county-governments-at-the-centre-of-achieving-universal-health-care/>> accessed 3 July 2019.

¹⁶³ Ibid.

¹⁶⁴ Phares Mugo, et al. *An Assessment of Healthcare Delivery in Kenya under the Devolved System* [2018] Kenya Institute for Public Policy Research and Analysis.

are acting in cahoots with corrupt county officials to supply medical supplies of questionable quality at inflated prices.

4.4. Conclusion

In conclusion, it is not in doubt that the Constitution of Kenya lays a strong basis for the realization of universal health coverage. The Constitution guarantees the right to the highest attainable standard of health. It also guarantees a raft of other fundamental rights whose implementation is central to achieving universality in health coverage. It is, however, apparent that other pieces of legislation, for instance, the NHIF Act 1998, do not embrace the rights-based approach enshrined in the Constitution. The NHIF Act 1998 focuses on only financial insurance ignoring a comprehensive rights-based approach and other core components of universal health coverage. Relatedly, despite the focal position of institutions in the implementation of formulated policies and laws, it has emerged that the NHIF as an institution is deficient and not positioned to support universal health coverage. Its deficiency stems from its weak legal design and a mandate that focuses on financial insurance (to a large extent of salaried Kenyans), ineffective programming, operational inefficacies, lack of transparency, and accountability. On the other hand, county governments face myriad challenges that hinder effective delivery on the health mandate.

The next section provides a summary of the findings as well as the proposed policy, legal and institutional reform to realize universal health coverage.

CHAPTER FIVE: FINDINGS, CONCLUSION, AND RECOMMENDATIONS

5.1. FINDINGS

5.1.1. Conceptual framework: the right to health and universal health coverage.

The study adopted a definition of universal health coverage from the Secretariat's Report to the 2005 WHA, which defined universal coverage as access to key promotive, preventive, curative, and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access.¹⁶⁵

The study thus established the following as the four main components of universal health coverage: financial protection where direct payments made to obtain health services do not expose individuals to financial hardship and do not threaten living standards;¹⁶⁶ equity in health;¹⁶⁷ physical and financial accessibility as well as acceptability;¹⁶⁸ and quality of healthcare services.¹⁶⁹

The study established that UHC is engrained as a critical component of international legal instruments including the Sustainable Development Goals (SDGs) which has a specific target for UHC: "Achieve UHC, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all."¹⁷⁰ Further, since UHC is a practical expression of the right to health,¹⁷¹ the following international and regional legal instruments are also relevant: 1948 Universal Declaration of

¹⁶⁵ World Health Assembly Resolution 58.33 (2005) *ibid.*

¹⁶⁶ Shreeshant Prabhakaran, et al. 'Do Better Laws and Regulations Promote Universal Health Coverage? A Review of the Evidence,' [2017] <<https://www.hfgproject.org/better-laws-regulations-promote-universal-health-coverage-review-evidence/>> accessed 9 July 2019.

¹⁶⁷ Shreeshant Prabhakaran, et al. [2017], *ibid.*

¹⁶⁸ Shreeshant Prabhakaran, et al. [2017], *ibid.*

¹⁶⁹ Shreeshant Prabhakaran, et al. [2017], *ibid.*

¹⁷⁰ Sustainable Development Goals (SDGs): Goal 3. Target 3.8

¹⁷¹ Gorik Ooms, et al [2014] *ibid.*

Human Rights; International Covenant on Economic, Social and Cultural Rights, 1966; and the African Charter on Human and Peoples' Rights, 1981.

5.1.2. Findings on policy framework

The existing policy framework that guides universal health coverage in Kenya is as follows:

First, the Kenya Health Policy 2014–2030 which outlines measures to (i) attain universal coverage of critical services;¹⁷² (ii) ensure progressive realization of the right to health;¹⁷³ (iii) put in place a basic and expandable package - the Kenya Essential Package for Health (KEPH);¹⁷⁴ (iv) contribute to the attainment of the country's long-term development agenda outlined in Kenya's Vision 2030 through the provision of high-quality health services to maintain a healthy and productive population able to deliver the agenda;¹⁷⁵ and (v) minimize or remove financial barriers hindering access to services for all persons requiring health and related services guided by the concepts of Universal Health Coverage and Social Health Protection.¹⁷⁶

Second, Kenya Vision 2030 outlines Kenya's vision for health to provide equitable and affordable health care at the highest affordable standard to her citizens. It commits to “restructure the health delivery system and also shifts the emphasis to ‘promotive’ care in order to lower the nations’ disease burden, thus improving access and equity in the availability of essential health care. Under Vision 2030, the government commits to promote affordable and equitable health care financing and reduce Kenyans’ out-of-pocket expenditure on medical care to 25%.¹⁷⁷

¹⁷² Kenya Health Policy 2014–2030 *ibid*, at 31.

¹⁷³ Kenya Health Policy 2014–2030 *ibid*, at 30.

¹⁷⁴ Kenya Health Policy 2014–2030 *ibid*, at 30.

¹⁷⁵ Kenya Health Policy 2014–2030 *ibid*, at 30.

¹⁷⁶ Kenya Health Policy 2014 – 2030 *ibid*, at 37.

¹⁷⁷ *Kenya Vision 2030* *ibid*, at 110.

Further, the government commits to establish a social health insurance scheme (purchaser-provider system) in addition to developing a social health insurance scheme.

Third, the immediate policy framework on universal health coverage is outlined in the Third Medium Plan (MTP III), where measures that the government intends to undertake in order to achieve 100 percent universal health coverage are outlined. MTP III proposes to expand social health protection schemes to cover harmonized benefit package to targeted populations and ensure that Kenyans have access to health insurance mainly through NHIF by 2022. Further, MTP III proposes to establish ten new referral hospitals and increase the number of health facilities at the community level, including mobile health services. Under MTP III, the government proposes to implement the following programs and projects between 2018 – 2022 in order to achieve universal health coverage: (i) expand social health protection by implementing schemes to cover harmonized benefit package to targeted populations (elderly, orphans and the poor, mothers and babies, civil servants, and informal sector); (ii) Medical Tourism Programme; (iii) Health Infrastructure Programme; (iv) Community Health High Impact Interventions Programme; (v) Digital Health Programme; (vi) Human Resource for Health Programme; (vii) Quality Care/Patient and Health Worker Safety Programme.¹⁷⁸

However, the existing policies need to comprehensively define how the main components of universal health coverage would be realized. These should be anchored in the constitutional guarantees of the right to health – with clear measures outlined on ensuring financial protection of the entire population, equitable health services, access (physical access, financial access, acceptability, and availability of services) and the quality of services. The focus of MTP III is on

¹⁷⁸ Third Medium Term Plan 2018 – 2022, *ibid* at 74 – 76.

implementing projects (for instance, *Linda Mama*) with no clear long term and sustainable blueprint to realize UHC.

5.1.3. Findings Legal Framework

First, the study established that the Constitution of Kenya provides a sound legal framework for the realization of the right to health, and in extension, universal health coverage. The constitutional guarantee of the right to health under Article 43, in addition to elaborate rights defined under the bill of rights section (including the right to non-discrimination, information, privacy, human dignity, life, among others) is critical in safeguarding and ensuring the realization of health for all.¹⁷⁹

Second, the study also found that the Health Act 2017, to an extent, incorporates constitutional principles that lay the legal basis for non-discrimination, access to health services, ensuring equity, provision of quality services, and protection against financial risk.¹⁸⁰ Therefore, the proper implementation of this law has the potential to lead towards universal health coverage.

Third, the study established that Kenya's model of universal health coverage is centered on the National Hospital Insurance Fund (NHIF). However, the legislation that establishes NHIF (that is, the National Hospital Insurance Fund (NHIF) Act, 1998) is problematic for various reasons:

- (i) This Act is yet to be aligned to the Constitution of Kenya. For instance, the Act has not been reviewed to incorporate constitutional values and principles concerning health, including the aspect of health as a right.
- (ii) The achievement of universal health coverage is not one of the objectives of the Act; neither is it an objective of NHIF as an institution created under the Act.

¹⁷⁹ See Chapter IV, Constitution of Kenya.

¹⁸⁰ See, for example, sections 3, 4, 5, and 86 Health Act 2017.

- (iii) UHC's core principles of equity, access to health services, quality health services, and financial risk protection do not form the core approach of the Act. The Act focuses on financial risk using an approach that has proven effective for a small percentage of Kenyans who are salaried.
- (iv) The Act has not been reviewed to incorporate the devolved system of governance entrenched in the Constitution; neither does the Act acknowledge the fact that health is a devolved function. Consequently, county governments are not part of the decision-making process of the NHIF board and have no legal opportunity under the Act to participate in the affairs of NHIF, even though the operations of NHIF affect the provision of health services by county governments.
- (v) The Board of Management of NHIF under the Act has wide powers to make decisions. The Act does not clearly define avenues for consultation, public participation, transparency, and accountability in the operations of this Board.

Fourth, apart from the Constitution, the Health Act, and the NHIF Act, this study also established that there exist multiple laws that regulate the health sector.¹⁸¹ These multiple laws create multiple regulatory and implementing authorities, hence pose the danger of duplication of roles and poor coordination in achieving policy objectives. There is thus a need to harmonize these laws to ensure that they are aligned to the Constitution and promote the realization of the right to health and universal health coverage.

¹⁸¹Some of the laws include: Kenya Medical Supplies Authority Act (Act No. 20 of 2013); HIV/AIDS Prevention and Control Act (Act No 14 of 2006); Pharmacy and Poisons Act; Public Health Act; Narcotic Drugs and Psychotropic Substances Act (Act No. 4 of 1994); Public Health Officers (Training, Registration and Licensing) Act (Act no. 12 of 2013); Health Records and Information Managers Act (Act No. of 15 of 2016); among others.

5.1.4. Findings on institutional framework

This study evaluated two institutions mentioned in policy documents as critical to universal health coverage, that is, the National Hospital Insurance Fund and the County Governments.

First, concerning the National Hospital Insurance Fund (NHIF), the study established that NHIF as an institution is inadequately positioned to ensure realization of universal health coverage in Kenya for several reasons:

- (i) The legislation that establishes NHIF has not been reviewed to incorporate principles contained in the Constitution of Kenya 2010. In extension, NHIF is not tailored to ensure the realization of the highest attainable standard of health but rather as an institution focusing narrowly on health insurance.
- (ii) NHIF, as a national government institution, is yet to be structured in a way to facilitate the participation of county governments in its decision-making processes, even though it performs roles that are in the domain of county functions.¹⁸²
- (iii) NHIF has weak accountability mechanisms that have led to an increase in cases of fraud by the NHIF and health care providers. The Board of Management has been bestowed with too much power with weak oversight mechanisms in place.¹⁸³
- (iv) NHIF has implemented a poor strategy towards enrolment and retention among the informal sector, for example, introducing unaffordable rates to the majority of people in the informal sector. This has led to a low percentage of people from the informal sector being registered under the scheme, leaving the bulk of people uninsured.¹⁸⁴

¹⁸² Council of Governors and Kenya Law Reform Commission [2018], *ibid*.

¹⁸³ Edwine Barasa, et al. [2018] *ibid*.

¹⁸⁴ Edwine Barasa, et al. [2018] *ibid*.

- (v) NHIF has implemented programs that promote inequity and favor those in formal employment, especially civil servants (for example, the Civil Servants Scheme).¹⁸⁵
- (vi) The system of registration of providers where one accesses services has made it difficult for equal access to services between people in rural areas and urban areas. Most facilities are concentrated in urban areas, and some of the health facilities contracted by NHIF do not have all the services required hence posing a challenge of access to services.
- (vii) NHIF has also been accused of delayed disbursements of payments to facilities by up to three months leading to some facilities introducing OOP payments to cover the costs, while others either deny or ration the services.¹⁸⁶

Second, concerning county governments, the study established the following:

- (i) The national government continues to undermine counties by undertaking and performing functions that are meant for counties. The fact that health is a devolved function means that the national government should only set policies and manage national referral hospitals leaving counties to undertake the remaining health functions. Concerning UHC, the national government has set the national policy agenda and has defined projects whose implementations are under its control.¹⁸⁷
- (ii) Counties are constitutionally mandated and best placed to ensure the realization of UHC in Kenya. This has been manifested from the example of Makueni County, which has been offering its people free healthcare across all its public facilities and

¹⁸⁵ Edwine Barasa, et al. [2018] *ibid.*

¹⁸⁶ Edwine Barasa, et al. [2018] *ibid.*

¹⁸⁷ See Third Medium Term Plan 2018 – 2022, *ibid.*

sub-county hospitals.¹⁸⁸ However, the lack of a clear policy direction formulated through a consultative process places this ability under threat.

- (iii) Counties are also facing challenges which if not addressed, threaten the realization of universal health coverage. For example, there have been more than two dozen strikes since the devolution of health services in 2013; delay in funds disbursement to counties from the National Government; lack of clear procurement plans; rampant corruption, among others.¹⁸⁹

5.2. CONCLUSION

In conclusion, the study has established that the existing policy, legal, and institutional framework is inadequate to support the realization of universal health coverage. Policies have not comprehensively defined the design of universal health coverage, with the focus being on defining piecemeal projects. The policies also designate NHIF as the vehicle to realize universal health coverage. However, the legislation establishing NHIF has not been reviewed to reflect this aspect; neither has it been reviewed to incorporate constitutional principles. This study, therefore, concludes that reforms are needed in the policy, legal, and institutional arena in order to realize universal health coverage in Kenya.

¹⁸⁸ See Government of Kenya 'County Governments at the Centre of Achieving Universal Health Care,' <<https://vision2030.go.ke/county-governments-at-the-centre-of-achieving-universal-health-care/>> accessed 3 July 2019.

¹⁸⁹ Phares Mugo, et al. [2018], *ibid.*

5.3. RECOMMENDATIONS

This study proposes the following policy, legal and institutional reforms for realization of universal health coverage in Kenya:

Policy reforms

First, develop a comprehensive policy on universal health coverage that concisely defines measures to achieve financial protection, equity, access and quality in provision of health services;

Second, define a policy measure that adopts a human rights approach to universal health coverage, specifically:¹⁹⁰

- (a) Ensure that the policy measure designed to achieve universal health coverage are placed within the context of a national effort to provide equitable access to the social determinants of health.
- (b) Ensure that the policy measures design a universal health coverage model that is based on true universality providing benefits to all Kenyans without any distinction.
- (c) Ensure that the policy measures accord priority to health system strengthening in order to make good-quality health services widely available, especially in currently underserved communities, and with a greater balance between rural and urban areas.
- (d) Ensure that the policy measures pay explicit attention to equity considerations in the design of the universal health system and throughout the process of expanding coverage, especially to the implementation of measures to reduce barriers for low-

¹⁹⁰ Audrey R. Chapman, 'The contributions of human rights to universal health coverage,' [2016] vol. 18(2) Health and Human Rights Journal: 1 < <https://www.hhrjournal.org/2016/12/editorial-the-contributions-of-human-rights-to-universal-health-coverage/> > accessed 1 July 2019.

income groups, rural populations, women, and other vulnerable groups that are often disadvantaged in terms of service coverage and health.

- (e) Ensure that the policy measures define an equitable and progressive system of health funding for financial risk protection to eliminate or at least significantly reduce financial barriers, especially for poor and disadvantaged groups.
- (f) Ensure policy measures respect Article 10 provisions on the Constitution on national values and principles of governance by providing opportunities for consultation with and the participation of the population in the design and the determination of benefits packages.

Legal reforms

First, review the Health Act 2017 to incorporate legal obligations on universal health coverage anchored on the right to health.

Second, review the National Hospital Insurance Fund Act 1998 to integrate as its core objective realization of the right to health and universal coverage.

Third, review the National Hospital Insurance Fund Act 1998 to provide legal obligations concerning the components of universal health coverage of financial access, equity, access, and quality.

Fourth, review the National Hospital Insurance Fund Act, 1998 to incorporate the constitutional spirit of devolution with institutions created under the Act being intergovernmental.

Fifth, harmonize the multiple health laws to ensure that they promote the realization of the right to health and that none of these laws act as a barrier to the realization of universal health.

Institutional reforms

First, restructure the National Hospital Insurance Fund to ensure its main goal is to facilitate the realization of the right to health generally, and specifically universal health coverage characterized by financial protection, equity, access, and quality health services.

Second, review the National Hospital Insurance Fund to increase transparency and accountability, public participation, good governance, and other measures to ensure the institution effectively realizes its mandate.

Third, strengthen support to county governments to ensure accessibility, availability, acceptability, and quality health services.

Fourth, the national government should respect the devolution of health services and ensure that counties are financially equipped to provide health services.

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