UNIVERSITY OF NAIROBI

SCHOOL OF LAW

COSTS AS A BARRIER TO ACCESSING HEALTH CARE IN KENYA: A CASE FOR REGULATION.

BY

DEYNES MURIITHI

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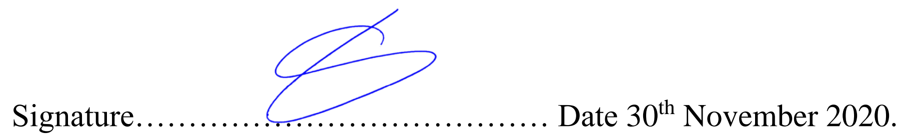
A Thesis Submitted to the University of Nairobi in Partial Fulfilment of the Requirements for the Award of the Degree of Master of Laws (LL.M)

DECLARATION

I declare that this thesis is my original work and has not been presented before for a degree in this or any other university.

Deynes Muriithi.



Signature………………………………… Date 30th November 2020.

This thesis has been submitted for examination with my approval as the University Supervisor.

Supervisor/Naomi Nyawira Njuguna.

Faculty of law, University of Nairobi.

naomi njuguna

Signature…………………………………..Date 30th November 2020.

DEDICATION

This thesis is dedicated to all Kenyan women and men whose right to accessing health care has been limited due to costs and inability to pay.

ACKNOWLEDGEMENTS

A great number of people have made this study possible through encouragement. I thank each of you. To my friends in and out of school, the journey would not have been complete without you.

To my supervisor, Naomi Nyawira Njuguna, your guidance and patience over time is and was invaluable.

I finally acknowledge that I would not have done this without God.

ABSTRACT

This study focuses on the right to accessing health care in Kenya against the background of a free market where market forces determine the success of accessing health care. It seeks to establish among others, whether Kenya's legal, policy and financial structure is sufficient to protect the right to access to health care within a market influenced by neo-liberal practices where health care has been commodified. It is motivated by the continued challenge to accessing health due to high costs despite the right having been recognized in international and national law in Kenya. It adopts a socio-legal methodology and analyses various subjects including law, human rights, neoliberalism, the purpose of regulation and their interconnection with access to health care.

The study is organised in five chapters. Chapter 1 provides a general outline of the study including the objectives of the study and the problem statement. It sets out the questions and assumptions of the study which are linked to the sufficiency of the regulatory, policy and financial structure of Kenya health system for purposes of enhancing financial access to health care. Chapter 2 considers commodification of health care on accessing health care. It established that commodification of health care results in restricting access to health care.

Chapter 3 assesses the sufficiency of Kenya's regulatory and policy structure in protecting Kenyans from the negative effects of high costs of health care. It proceeds from the presumption that Kenyans have continued being denied access to health care despite the recognition of the right in various laws. The study finds that Kenya's structure is deficient in overcoming the restrictions on financial access to health care. Chapter 4 focuses on the financial structure of Kenya's health system. . It discusses the various ways that Kenya raises revenue for health care and further, how it allocates and manages the revenue raised. It notes that Kenya has failed to raise sufficient funds and that it has mismanaged the funds raised. This has affected the ability of the system to enhance the right to health. Chapter 5 concludes the study by summarising the key findings and recommendations. It recommends that Kenya should consider undertaking reforms aimed at enhancing access to health care, among them being the regulation of the costs of accessing health care.

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LIST OF ABBREVIATIONS

ICESCR	International Covenant on Economic and Social Cultural Rights
UNDP	United Nations Development Fund
WHO	World Health Organisation

LIST OF STATUTES

1. Constitution of Kenya.
2. Constitution of Kenya (Repealed).
3. Health Act.
4. Public Health Act.
5. National Health Insurance Fund Act.
6. Persons with Disabilities Act.
7. Children Act.
8. Persons Deprived of Liberty Act.
9. Medical Practitioners and Dentists Act.
10. Price Control (Essential Goods) Act.
11. Energy Act.

LIST OF CITED CASES

1. Meme v The Permanent Secretary, Ministry of Health [2013] eKLR
2. In the Matter of the Principle of Gender Representation in the National Assembly and the Senate [2012] eKLR.
3. Luco Njagi& 21 others v Ministry of Health & 2 others [2015] eKLR
4. Soobramoney –vs- Minister of Health Kwa Zulu Natal 1997 (12) BCLR 1696.
5. Isaac Ngugi v Nairobi Hospital & 3 others (2013) eKLR.
6. Mathew Okwanda v Minister of Health and Medical Services & 3 others [2013] eKLR
7. HIV & AIDS (KELIN) & 3 others v Cabinet Secretary Ministry of Health & 4 others (2016) eKLR.

CHAPTER ONE
BACKGROUND TO THE STUDY

1.0 Introduction

This study explores the need for regulation of costs of accessing health care. This is because health is vital for the well-being of humans and their existence.[1] Good health ensures that human beings live healthy and dignified lives. Owing to its significate, Kenya has recognized access to health as a human right..[2] The right to the highest attainable standard of health is categorized as an economic and social cultural right which focuses on the quality and dignity of life.[3]

The Committee on Economic and Social Cultural Rights[4] notes in General Comment 14 that the right to health contains both a freedom and an entitlement.[5] As a freedom, it signifies a person's right to control his or her health and to be free from external interferences with their body and health. This can be linked to the absence of disease identified in the constitution of the World Health Organisation.[6] As an entitlement, it signifies that every person has a right to access health care services which are available, acceptable and of good quality.[7]

General Comment Number 14 provides that the right to health entails the right to timely and appropriate access to health care services as well as access to the underlying determinants of health which include among others safe and potable water, adequate sanitation and supply of safe food, nutrition, housing, healthy environment. The former relates to the ability to make entry into the health system and make use of the available resources while the later relates to the availability and accessibility of other factors which may affect the health of a person.

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[1] Rout Himanshu et all, 'Health and Health Economics: A Conceptual Framework', University Library of Munich, Germany, MPRA Paper, 2007. Available at <https://www.researchgate.net/publication/24115043_Health_And_Health_Economics_A_Conceptual_Framework/citation/download> (Accessed on 4th September 2019).

[2] Constitution of Kenya, Article 43 (1) (a).

[3] Mohammad Reza Saran, 'The Concept of "Right" and its Three Generations', (2017) International Journal of Scientific Study, Volume 5 page 36.

[4] Established through Resolution 1985/17 of 28th May 1985.

[5] Committee on Economic, Social and Cultural Rights (CESR), General Comment 14, The Right to the Highest Attainable Standards of Health. U.N. Doc E/C.12/2000/4. 51(AUG,2000)

[6] The World Health Organisation in its Constitution defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.

[7] Ibid

Access to healthcare, as an obligation, makes it obligatory for health care facilities and services to be made accessible to everyone without discrimination.[8] It entails the concepts of non-discrimination, affordability of health care, physical accessibility to services and the access to information relating to health care.[9] Access to health care depends on various factors such as levels of income in a country. Access to health care is important because it enables people have access to services that would otherwise be out of reach. [10] With limited or no access to health care, people may become more exposed to the risk of disease and other health complications which can be treated or avoided in the first place. With the current Covid-19 pandemic, it has been observed that the loss of income and health insurance as a result of job losses owing to the laying off of employees will further increase the burden on patients seeking treatment for the disease.[11] The United Nations Development Fund has already noted that the pandemic will have adverse socio-economic effects on Kenya and that as such, the government ought to take steps and measures to ensure that pandemic does not exacerbate the already low access to health care in Kenya owing to poverty and low income.[12]

Various international instruments have made it an obligation for states to take purposive measures, which include the raising of sufficient funds to promote, protect, fulfil and respect the right to health. In Kenya, the right to health in Kenya has been promoted through various means including protection in law, development of policies and financing of health care by various stakeholders including the government. The Constitution, which recognizes the right to health under Article 43, also recognizes application of international laws such as the International Covenant on Economic and Social Cultural Rights which requires member states to take immediate and progressive measures in protecting the right to the highest attainable standard of health pursuant to Article 12.

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[8] General Comment No. 14, Supra.
[9] Ibid
[10] Chuma Himonga, 'The Right to Health in an African Cultural Context: The role of Ubuntu in the Realization of the Right to Health with Special Reference to South Africa,' (2013) 57 Journal of African Law at page 165.
[11] Jaime King, 'Covid-19 and the Need for Health Care Reform', (2020) 382 The New England Journal of Medicine at page 104.
[12] United Nations Development Fund, 'Articulating the Pathways of the Socio-Economic Impact of the Coronavirus (COVID-19) Pandemic on the Kenyan Economy' Available at <http://www.undp.org> (Accessed on 8th July 2020).

Article 2 (5) and (6) of the Constitution recognizes the application of international law and the ratified treaties and conventions as forming part of the law of Kenya.

Pursuant to Article 21 (2) of the Constitution, Kenya has adopted a progressive approach towards the realization of the right to the highest attainable standard of health. This approach requires Kenya to undertake legislative, policy and other measures towards attainment of the right to health, a position which has been supported by various judicial decisions.[13] Some of the measures taken include the development of policies such as the Kenya Health Policy 2014-2030, [14] the Ministerial Strategic and Investment Plan July 2014-June 2018[15] and programmes such as the Health Insurance Subsidy Programme which targets the vulnerable population[16] and the free maternity program labelled 'Linda Mama – Boresha Jamii'[17] which are being implemented through the National Health Insurance Fund.[18] Kenya has also enacted various laws such as the Health Act,[19] Public Health Act[20] and the National Health Insurance Fund Act[21] which deal with various issues surrounding access to health care including financing and costs. In addition, the national and the county governments have over the years allocated additional funds for financing health care through their annual budgets while devolution has increased the access to health care in the country [22]through increased allocation in the county budgets[23]. In an analysis conducted in relation to funding in the years 2018/2019, it was established that there was an increase in funding due to an increased allocation by county governments in their budgets.[24] It has been argued that that the

[13]MMM v Permanent Secretary, Ministry of Education & 2 others [2013] eKLR.
[14] It focuses on a human right—based approach in the provision of health care including the concepts of equity and fairness.
[15] Government of Kenya, Ministerial Strategic and Investment Plan July 2014-June 2014, Government of Kenya, 2014. It seeks to ensure the allocation of funds to hospitals providing equitable, accessible and quality health care.
[16] National Health Insurance Fund Performance Report 2018 available at <http://www.nhif.or.ke/> (Accessed on 11th April 2019).
[17] Ibid.
[18] This is pursuant to the National Health Insurance Fund Act, Act No. 9 of 1998.
[19] Act No. 21 of 2017.
[20] Chapter 242.
[21] Act No. 9 of 1998.
[22]Kipruto Arap Kirwa et all, 'Factors Influencing Provision of Health Care in a Devolved System of Government, Bungoma County, Kenya', (2017) Global Journal of Health Science Volume 2 Issue 1 Number 3 at page 13 – 38.

financing and management of the revenue is hindered by various other factors including poor governance which contributes to the decreased access to health care.[25]

The incidences of patients being denied medical treatment due to the lack of funds have continued being experienced in Kenya. [26] In other instances, they have been denied access to services and facilities due to high costs. [27] It was reported in the year 2010 that several patients were denied medical attention at a hospital because they were not able to raise the deposit for admission. [28] In Kenyatta National Hospital, a special audit report for the year 2012 showed that the hospital continued to detain patients because it did not have a way for recovery upon discharge.[29] It has been established that 6.3% of Kenyan households had experienced catastrophic health expenditures while 4.6% of households had been impoverished as a result of costs of health care.[30] In a study conducted in 2018, it was realized that close to 1.1 million people in Kenya had been pushed into poverty due to direct payments paid in accessing health care. [31] This increased the percentage of poor people in Kenya by 2.2%.[32] Due to inability to afford, a patient may opt not to seek treatment which may be catastrophic in the event of death.[33] In other instances, they might

[25] Phidiliah Rose Mwaambi, 'Universal health care coverage: healthcare financing and access to health care services in Kenya', (2017) Clinical Case Reports and Reviews, Volume 3 Issue 10 at page 2-3.

[26] Jill Cottrell Ghai, 'The Right to the highest standard of health', Available at <http://www.katibainstitute.org/the-right-to-health/ > (Accessed on 11th April 2019).

[27] Jullie Zollman et all, ' Struggling to thrive: How Kenya's low-income families (try to) pay for healthcare', Available at <https://fsdkenya.org/publication/struggling-to-thrive-how-kenyas-low-income-families-try-to-pay-for-healthcare/> (Accessed on 10th November 2019).

[28] NTV, 'Accident victims turned away from private hospital in Kajiado' (NTV 15th February 2017) <http://ntv.nation.co.ke/news/national/2725528-3815508-ftygs8z/index.html> (Accessed on 19th February 2017).

[29] Government of Kenya, 'Performance Audit Report of the Auditor-General Specialized Healthcare Delivery at Kenyatta National Hospital Waiting-time for Cancer, Renal and Heart Patients, Government of Kenya, 2012.

[30] Jullie Zollman et all, ' Struggling to thrive: How Kenya's low-income families (try to) pay for healthcare', Available at <https://fsdkenya.org/publication/struggling-to-thrive-how-kenyas-low-income-families-try-to-pay-for-healthcare/> (Accessed on 10th November 2019).

[31] Paola Salari et al, 'The catastrophic and impoverishing effects of out-of-pocket healthcare payments in Kenya, 2018' 2019, BMJ Global Health 2019, Pp1.

[32] Ibid.

[33] Timothy C. Okech, 'Empirical Analysis of Possible Alternative Sustainable Financing Options for Primary Health Care Services in Kenya', (2012) IOSR Journal of Pharmacy Vol. 2, Issue 4 at page 84-96.

seek low quality health services. [34] These effects continue being experienced despite Kenya having adopted a rights-based approach in realization of the right to health care with its recognition under Article 43 of the Constitution. [35] The foregoing confirms that costs can have devastating effects. [36]

The government has mainly been responsible for financing of healthcare through the introduction of various measures over time. [37] These have included the introduction and abolition of user fees, and cost-sharing among others.[38] The intention has been to ensure that the health sector is sufficiently financed in order to improve service delivery.[39] The role of the government in financing healthcare has however changed over time.[40] These changes have been necessitated by the need to raise sufficient revenue to bridge the deficit left by the government. Currently, financing in Kenya is by the government, donors and the private sector.[41] It has been argued that the introduction of the private sector through privatization was introduced when the World Bank and the International Monetary Fund proposed a minimized role of the government in the provision of public goods such as health care and an increased reliance on privatization where the market is deemed to be the best method of allocating resources.[42] Through privatization, there has been an increase in private health facilities and uptake of private health insurance.[43].[44] Services in the

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[34] Frank Kagema et all, 'Quality of Care for Prevention and Management of Common Maternal and Newborn Complications: Findings from a National Health Facility Survey in Kenya', (2016), Government of Kenya.
[35] Valerie Obare et all, 'Indicators for Universal Health Coverage: can Kenya comply with the proposed post-2015 monitoring recommendations?', (2014) International Journal of Equity and Health, Volume 13 pp 123.
[36] Matt Kukla et all, 'The effect of costs on Kenyan households' demand for medical care: why time and distance matter' (2017) Health Policy Plan, Vol 32 Issue 10 pages 1397-1406.
[37] David Collins et all, 'The fall and rise of cost sharing in Kenya: The impact of phased implementation', (1996) Health policy and Planning, Volume 11 Issue 1 pages 52-63.
[38] Ibid.
[39] Reena Anthonyraj'A health financing reform solution for Kenya: Expansion of National Health Insurance Fund (NHIF)', (2016) Global Journal of Medicine and Public Health Volume 5 Issue 4 Pp 1-5.
[40]Ezekiel Mbitha Mwenzwa et all, 'The Oscillating State's Role in the Provision of Social Welfare Services in Kenya' (2016) International Journal of Humanities and Social Science, Volume 6 Issue 5 at page 119.
[41] Ibid.
[42] Ibid.
[43] Jane Chuman and Vincent Okungu. "Viewing the Kenyan health system through an equity lens: implications for universal coverage." (2011) International journal for equity in health, Volume 10 No 22 pp 1-14.
[44] Ibid.

private healthcare facilities have been argued to be expensive and costly to Kenyans who have low incomes and limited finances to afford healthcare as well as other necessities of life.[45] When commodified, healthcare becomes a commodity capable of being exchanged in the market with the costs and the price being dependent on the market forces of demand and supply.[46] This has been urged to be a barrier to accessibility of healthcare among the poor in Kenya because of the high costs associated with private healthcare facilities.[47]

The foregoing presents several issues related to the right to accessing healthcare in Kenya including the effects of commodification of health care on the right to accessing healthcare, financing of health, the role of the government in the realization of the right to the highest attainable standard of healthcare within the context of commercialization of healthcare among others. This study seeks to analyze the economic accessibility of health in Kenya in the context of the right to accessing healthcare. This is with the aim of establishing whether there is a need to regulate economic accessibility of healthcare to ensure that there is better realization of the right to health.

1.2 Problem statement

Despite Kenya having recognized access to health care as a right, the costs of accessing health care are not regulated and have become a barrier to access health care thereby affecting the better realization of the highest attainable standard of health. They have in addition led to poverty and impoverishment.

1.3 Justification of the Study

The fact that Kenya has continued facing challenges to accessing health care due to costs raises the question of the adequacy of Kenya's structure on accessing health care. As such, there is a pressing need to study the effects of costs of accessing health care with a major focus being on the

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[45] Jullie Zollman et all, ' Struggling to thrive: How Kenya's low-income families (try to) pay for healthcare', Available at <https://fsdkenya.org/publication/struggling-to-thrive-how-kenyas-low-income-families-try-to-pay-for-healthcare/> (Accessed on 10th November 2019).

[46] Sheri D. Bell, 'Commodifying Health: An Analysis of the Effects of Western Medical Consumerism on Malaria Treatments in Africa', Available at <https://openjournal.cc.umanitoba.ca/index.php/mb-anthro/article/view/68> (Accessed on 18th January 2019).

[47] Ibid.

need to regulate the costs.. It is hoped that it will provide a basis of assessing whether Kenya is making progress in achieving the progressive realization of the right to the highest attainable standard of health.

The study will be beneficial to legislators policy makers and health care providers since it will provide a context for development of laws, policies, programmes, measures and strategies that will promote not only the right to the highest standard of health but also providers of health care with a profit-motive.

1.4 Statement of Objectives

The main aim of the study is to examine the existing legal and policy framework relating to the right to health in Kenya. This is with a view of ascertaining whether it is necessary to undertake reforms necessary for the better realization of access to health care such as through the regulation of costs. adequate The other objectives of the research are;

1. To investigate whether health care in Kenya is a right or a commodity.
2. To investigate whether commodification of health care has resulted in increased costs of health care thereby affecting the human rights approach in accessing health care in Kenya.
3. To identify inadequacies in the legal, policy and financial framework that may have failed to guarantee economic accessibility to health care.
4. To propose reforms on the legal, policy and financial framework to address the challenges faced by economic accessibility of health care in Kenya.

1.5 Hypothesis

This study makes the following assumptions

a. Health care is capable of being commodified.
b. The commodification of health care results in restricting access to health care due to the costs involved.

c. If Kenya's legal, policy and financial framework is reformed to take into account the need to balance between health care as a commodity and as a human right, there is a possibility of regulation of costs of health care leading to enhanced access.

1.6 Research Questions

The research will seek to answer the following questions.

1. Is health care in Kenya a right or a commodity?
2. What effects does commodification of health care have on a right's-based approach on accessing health care in Kenya?
3. Is Kenya's legal, policy and financial framework sufficient for purposes of protecting the right to economic accessibility of health care in Kenya?
4. Is there a need to regulate the costs of health care in Kenya?
5. What reforms should Kenya adopt to enhance the right to economic accessibility of health care within the context of commodification of health care?

The answers to these questions will assist in proposing various recommendations for the better realization of the right to accessing health.

1.7 Theoretical Framework

The adopts two theories, being the human rights theory and the public interest theory. The former advocates for the need to provide access to health care as a human right while the latter focuses on the need for regulation of costs of health.

1.7.1. Human rights theory

The human rights theory is based on the significance of human rights which have over time found increased recognition in the world. The theory has been supported by various proponents including Aquinas, Socrates, Aristotle Locke and John Stuart Mill among others.[48] The theory is found in various texts including the American Declaration of the Rights and Duties of Man, Declaration of

[48] Walters, Gregory J. 'Human Rights in Theory and Practice: A Selected and Annotated Bibliography, with an Historical Introduction', Metuchen, New Jersey & London: Scarecrow Press, and Pasadena, CA & Englewood Cliffs, N.J.: Salem Press 1995

the Rights of Man and of the Citizen, the Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights.

The theory argues that all human beings are born equal in dignity and in rights and that human rights are universal and are to be enjoyed by each and every human being by virtue of being human beings irrespective of any consideration.[49] It is based on the principles that human rights are universal, interrelated, interdependent and are inherent and are intended to promote human dignity.[50] Human rights have been deemed as conditions precedent for a dignified human existence based on the importance of human dignity.[51] They create obligations which require the human rights to be protected, promoted, fulfilled and observed.[52] Since one is born equal in rights and dignity, the theory argues that human rights need not be reduced into writing as a condition precedent before they can be recognized or before one can enjoy them.[53] However, the reduction of human rights into law is necessary for purposes of ensuring a better realization of the human rights.[54]

The theory has however been criticized on the basis that human rights have become irrelevant and ineffective having failed to achieve their desired objectives. [55] The argument is that whereas they were supposed to improve the welfare of human beings, the existence and the language of human rights has however not achieved this[56] due to various factors such as lack of support by the

[49] Nickel, James, 'Human Rights', The Stanford Encyclopedia of Philosophy (Winter 2014 Edition), Edward N. Zalta (ed.), <https://plato.stanford.edu/archives/win2014/entries/rights-human/> (Accessed on 25th January 2017).
[50] Gregory J. Walters, 'Human Rights in Theory and Practice: A Selected and Annotated Bibliography, with a Historical Introduction', Metuchen, New Jersey & London: Scarecrow Press, and Pasadena, CA & Englewood Cliffs, N.J.: Salem Press 1995.
[51]Demelesh Shiferaw and Yonas Tesfa, 'Theories of Human Rights and Justification' Available at <https://www.abyssinialaw.com/about-us/item/943-theories-of-human-rights-and-justification> (Accessed on 1st May 2018).
[52] Rex Martin, 'Are Human Rights Universal?' in Cindy Holder and David Reidy, 'Human Rights: The Hard Questions' Cambridge University Press, 2013 pp 59.
[53] Amartya Sen, 'Elements of a Theory of Human Rights' (2004) Philosophy and Public Affairs, Volume 32 Issue Number 4 at pages 315-316.
[54] Ibid
[55] Malcolm Langford, 'Critiques of Human Rights', (2018) Annual Review of Law and Social Science, Volume 14 at pages 69-89.
[56] Ibid

governments.[57] A further argument is that they are not universally applicable as the theory suggests.[58] As a result, different parts of the world continue to suffer from injustices despite the existence of human rights.[59] The economic and social cultural rights, in which category the right to health is located,[60] continue to be more prejudiced as opposed to political and civil rights because they get little political support for enforcement.[61] They are also deemed not to be proper legal rights properly so called.[62]

The recognition of human rights in law does not necessarily result in their application as argued by Peter Onyango.[63] He notes that despite Kenya's introduction of the right to health, the country has faced a surmountable challenge in the enforcement of equality rights which has not eliminated the social inequalities in the country.[64] This study proposes that despite the criticism of the human rights theory, human rights remain a fundamental tool in ensuring the realization of the right to accessing healthcare since the markets cannot be used to eliminate economic inequalities and financial discrimination in accessing healthcare.

1.7.2. Public Interest Theory

The study seeks to establish whether the regulation of costs of accessing health care can be beneficial in enhancing access to health care in Kenya. This is based on the public interest theory

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[57] Samuel Moyn, 'The Last Utopia: Human Rights in History' Belknap Press of Harvard University Press – 2012.

[58] Michael J Perry, ''Human Rights?''Against the Orthodox View' , (2015) Emory Legal Studies Research Paper Number 15-239, Available at <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2597403#> (Accessed on 9th July 2020).

[59] Stephen Hopgood, 'The Endtimes of Human Rights' Cornell University Press (2014) at pp 255.

[60] Mohammad Reza Saran, 'The Concept of "Right" and its Three Generations', (2017) International Journal of Scientific Study, Volume 5 at page 4.

[61] Amartya Sen, Supra.

[62] Perry, Supra.

[63] Peter Onyango Oloo, 'Understanding Enforceability Challenges Facing Equality Rights Under Art. 27 of the Constitution of the Republic of Kenya, '(2014) Sociology and Anthropology, Volume 2 Issue 5 at pp 179-189.

[64] Ibid.

of regulation which argues that regulation is necessary for purposes of advancing social welfare in the society. [65] It is traceable to writers such as A C Pigou[66] and Richard Posner.[67]

The theory is based on several assumptions including that the government should assume the role of the regulator since markets are bound to experience market failure.[68] It assumes that the government should seek to promote social welfare for purposes of promoting public interest. Johan argues that as a result, government is viewed as having the knowledge of the market and the ability to correct the failures through enforcement of the regulation.[69]

In the context of accessing health care through the markets, Murray has argued that governments have an obligation to correct market failures through regulation.[70] The regulation plays a crucial role since commodification of health care has led to negative effects such as discrimination in access to health care.[71] The limitation to access to health care has been argued to be against human dignity.[72] Under the International Covenant on Economic and Social Cultural Rights,[73] state parties are required to take measures which are not limited to regulatory measures for purposes of ensuring the better realization of the various human rights in the covenant.

The theory has however been criticized on various grounds. Andrei has argued that markets have the ability to correct their own imperfections, that in the event that the market is not able to, the

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[65] Andrei Shleifer, 'Understanding Regulation', (2005) European Financial Management, Volume 11, Issue Number 4 at pages 439-451.

[66] A G Pigou, 'The Economics of Welfare' quoted in Henry N. Butler et all, 'Health Care Reform: Perspectives from Economic Theory of Regulation and the Economic Theory of Statutory Interpretation', (1993-1994) Cornell Law Review, Volume 79 at pages 1435.

[67] Michael Hantke-Domas, 'The Public Interest Theory of Regulation: Non-Existence or Misinterpretation?." (2004) *European Journal of Law and Economics, Volume 15 Issue Number 2 at pages 165-194*.

[68] Andrei, Supra.

[69] Johan den Hertog, 'Review of Economic Theories of Regulation', Available at <https://www.semanticscholar.org/paper/Economic-Theories-of-Regulation-Hertog> (Accessed on 17th November 2020).

[70] Robert Murray, 'Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience', (2009) Health Affairs Journal, Volume 28 Issue 5 at page 1397.

[71] Clarke Havingghurst,'Health Care Cost Containment Regulation: Prospects and an Alternative,'(1977) American Journal of Law and Medicine Volume 3 at page 309 to 322.

[72] Elizabeth Anderson, 'Why some things should not be for sale: The moral limits of markets Debra Satz', (2012) New Political Economy Volume 17 Issue 2 at page 239-242.

[73] Article 2

judicial system ought to intervene and that in any event, governments are known not to be effective in market regulation.[74] Langwell, in opposing regulation of the market, argues that regulation may lead to closure of hospitals which are unable to reduce their costs or lead to poor quality of services.[75] Posner argues that the theory however flawed since the market is comprised of individuals who have private interests. [76] He nevertheless agrees that regulation plays an important role in the market.[77]

This notwithstanding, the theory is justified because it supports the argument for regulation of costs of health care which has been posited by Clarke to have increased access to health care [78] with the issue being the form and nature of the regulation to be introduced such as non-uniformity in the prices to be paid by different people within the society. [79] It is notable that Kenya does not established regulations that regulate costs of health care in private and public hospitals.

1.8 Research methodology and Methods.

This study adopts a socio-legal methodology. It analyses the phenomenon of human rights, the law and their intersection with economic access to healthcare in Kenya. This methodology is justified since the law relating to the right to accessing health care does not exist in a vacuum. Rather, it intersects with the realities of life such markets, commodification and the roles of government among others.

The method to be used for purposes of collecting data will be qualitative. It will involve interpretation of various sources of published information. The primary sources of information

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[74] Andrei Shleifer, 'Understanding Regulation', (2005) European Financial Management, Volume 11, Issue Number 4 at pages 439-451.

75 Kathryn Langwell 'Price controls: on the one hand ... and on the other', (1993) Health Care Financing Review Volume 14 Issue Number 3 at page 5-10.

[76] Richard A. Posner, 'Theories of Economic Regulation' (1974) NBER Working Paper No. w0041, Available at <https://ssrn.com/abstract=259352> (Accessed on 17th November 2020).

[77] Posner, Supra.

78 Clarke Havighurst, 'Health Care Cost Containment Regulation: Prospects and an Alternative' (1977) American Journal of Law and Medicine Volume 3 Issue Number 3 at page 310

79 Sarah Barber et all, 'Price setting and price regulation in health care: lessons for advancing Universal Health Coverage', Available at <https://www.oecd.org/health/price-setting-and-price-regulation-in-health-care-ed3c16ff-en.htm> (Accessed on 26th July 2020).

will include international and regional treaties as well as Kenya's domestic regulation and policies. This will be necessary for purposes of analyzing Kenya's legal, policy and financial framework in promoting the right to access health care. The secondary sources of information will include journals, books, website articles and scholarly articles The secondary sources will be important for purposes of analyzing the relationship between the right to accessing health care, the costs of health care and the resultant effect of this relationship.

1.9 Literature Review

Accessing health care in the context of commodification is central to this study. Roger Ritvo et all discuss health care as a human right. [80] They question whether health care is a human right and how it can be best realized. This is considering the various contentions surrounding the claim to a right and the allocation of lesser resources to health than in other sectors by governments. They contend that a decision must be made on whether the government or the private sector is the best placed to ensure that healthcare as a right is realized. They note that competition in the market has led to the poor being economically discriminated unlike the rich. This brings out into focus the issue of markets, prices and costs and their effect on the right to accessing healthcare, the raising and allocation of revenue and who between the government and the markets is best placed to provide healthcare.

Pavlos Eleftheriadis discusses the legal and moral claim to health care.[81] He contends that the protection in various international legal instruments has not enabled the full realization of the right to health care since people still lack access to primary health care acre with many other affected by disease and other threats to their health. In his view, if a human right is considered as a right then the lack or limitation of access is a violation of this right. He develops the theory that if human beings are to live a life of equality, then it is the responsibility of governments to take steps to ensure that human beings are protected from any adverse situations which limit equality. In the context of this study, this is important since it makes an argument for the need to regulate costs of health care. It has been argued by Posner that regulation plays an important role in aiding

[80] Roger Ritvo, Edward Mckinley & Prenab Chatterjee, 'Healthcare as a Human Right,' (1978) Case Western Reserve Journal of International Law, Volume 10 at page 323.
[81]Pavlos Eleftheriadis, 'A right to Healthcare', (2012) Journal of Law, Medicines and Ethics, Volume 40 Issue 2 at page 268.

commodification of health care and the functioning of markets.[82] In addition, Clarke has argued that regulating costs of health care leads to increased access to health care through elimination of inequalities.[83] In Japan, it has been argued that the introduction of a uniform fee payment has helped the country minimize exploitation by providers since the cost is readily known and because all providers are required to charge the same fee.[84]

Tom Allen notes that civil and political rights do not have value without the support of economic and social rights.[85] He states that even though progressive realization of the economic and social rights requires governments to commit maximum available resources to fulfill them, it does not reduce their status as human rights. He argues that economic and social rights are essential for civil and political rights since human rights are dependent on each other. Susan Randolph and Patrick Guyer make an analysis of the progressive and immediate obligation of states.[86] In their article, they posit that the aspect of progressiveness and resources does not mean that economic and social rights are not human rights. Approaching healthcare as a human right calls for health as a right and not just an interest or claim therefore placing it properly on a high place in human affairs and affairs of the state.

Kenya has adopted a progressive realization towards the right to health including the introduction of devolution. Kipruto Arap Kirwa[87] and Leah Kimathi[88] argue that Kenya has made progress in increasing access of health care through devolution which was introduced in 2010. They however

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[82] Richard A. Posner, 'Theories of Economic Regulation' (1974) NBER Working Paper No. w0041, Available at <https://ssrn.com/abstract=259352> (Accessed on 17th November 2020).
[83] Clarke Havingghurst,'Health Care Cost Containment Regulation: Prospects and an Alternative,'(1977) American Journal of Law and Medicine Volume 3 at page 309 to 322.
[84] Naoki Ikegami, 'Japanese Health Care: Low Cost Through Regulated Fees', (1991) Health Affairs, Volume 10 Issue Number 3 at page 87.

[85] Tom Allen, 'Commonwealth Constitutions and Implied Social and Economic Rights', (1994) 6 African Journal of International and Comparative Law, page 571.
[86] Susan Randolph & Patrick Guyer,'Tracking the Historical Evolution of States Compliance with their Economic and Social Rights Obligations of Result', (2012) Nordic Journal of Human Rights.
[87]KiprutoArap Kirwa et all, 'Factors Influencing Provision of Health Care in a Devolved System of Government, Bungoma County, Kenya', (2017) Global Journal of Health Science Vol.2, Issue 1, No.3, pp 13 – 38.
[88] Leah Kimathi, 'Challenges of the Devolved Health Sector in Kenya: Teething Problems or Systemic Contradictions?' Africa Development, Volume XLII, No. 1, 2017 at pages 55-77.

note in their separate works that access to health care has been marred by various factors including wastage of funds and wrangles between the national and the country governments.

Zanellize Strauss et all argue that the right to accessing medicine is an essential element in the right to accessing the right to health. [89] In their analysis, they state that poverty is a barrier to accessing health care and that poor health and illness contributes to poverty. This is partly because financial resources are depleted as families dispose their property to raise funds for accessing health care. They argue that the governments need to take necessary measures to ensure that the right to access health care, with focus on the right to access medicine, is realized. Whereas the authors focus on the human rights angle in accessing health care, they do not try to balance this with the reality where markets continue being in competition with human rights and how to strike a balance.

Seymour Rubin points out access to health care as a cause of inequality.[90] He argues that as the world economy develops, there is need to ensure that the world economy is organized in a manner that eliminates inequality. He points out that the cost of healthcare is a cause of inequality and argues that states need take measures to eliminate such inequalities. This necessitates the need to regulate introduce regulation to limit market failures, a position which has been urged by Richard Posner[91], Clarke [92] and Sarah et all who advocate for the adoption of different mechanisms of ensuring enhanced access to health care.[93] Some of the measures which their study establish include the use of regulation to remove financial discrimination, price controls and changes in payment systems.[94]

[89] Z Stauss& D Horsten, 'A Human Right-Based Approach to Poverty Reduction; The Role of Right of Access to Medicine as an Element of the Right of Access to Healthcare,' (2013) Potchefstroom Electronic Law Journal, Volume 16 Issue 3 at page 336

[90] Seymour Rubin, 'Economic and Social Human Rights and the New International Economic Order,'(1986) 1 American University Journal of International Law and Policy at page 86.

[91] Posner, Supra.

[92] Clarke, Supra

[93] Sarah Barber et all, 'Price setting and price regulation in health care: lessons for advancing Universal Health Coverage', Available at <https://www.oecd.org/health/price-setting-and-price-regulation-in-health-care-ed3c16ff-en.htm> (Accessed on 26th July 2020).

[94] Ibid.

Bernard Lown argues against the commodification of health care on the basis that it is a right.[95] He posits that it is not possible to treat health care as a commodity since it does not have similar characteristics as other commodities in the market. For instance, he argues that patients are not rational decision makers like other rational buyers in the market since they may not know what is wrong or what is required for purposes of diagnosis or the dangers involved. This is unlike in the normal market where the buyer is rational and where he knows what he wants. This argument has also been supported by Pellegrino who argues that whereas health might have certain characteristics with other commodities, it does not make it a right.[96]

Claire Andre and Manuel Velasquez[97]analyse the contrasting arguments in commercialization of health care. They provide the various arguments in support of commercialization which are based on the need to make a profit and the freedom to use private property as they desire and that for-profit health care providers do not have an obligation to provide health care. On the other hand, they present the various arguments against commercialization arguing that commercialization defeats virtues such as human dignity and social justice.

Maureen Mackintosh defines commercialization of health care as the provision of health care based on market relationships and a focus on investing in health care for purposes of an income or profit. [98] She notes posits that commercialization has been made possible by neoliberal practices, an argument which is supported by Sheri D Bell.[99] Bell argues that commercialization of health care leads to an increase in inequalities within the society and it is thus destructive. This argument

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[95]Bernard Lown, 'The Commodification of Health Care, Available at <http://www.pnhp.org/PDF_files/spring2007newsletter_lown.pdf> (Accessed on 29th June 2017).

[96] Edmund Pellegrino, The Commodification of Medical and Health Care: The Moral Consequences of a Paradigm Shift from a Professional to a Market Ethic' Journal of Medicine and Philosophy, 1999, Vol. 24, No. 3, pp. 243–266.

[97] Claire Andre and Manuel Velasquez, 'A Healthy Bottom Line: Profits or People?',(Issues in Ethics, Vol 1, N.4 Summer 1988) available at <https://www.scu.edu/ethics/focus-areas/bioethics/resources/a-healthy-bottom-line-profits-or-people/> (Accessed on 18th February 2017).

[98] Maureen Mackintosh, 'Health care commercialization and the embedding of inequality' (2003) RUIG/UNRISD Paper on Globalization, Inequality and Health, <http://www.unrisd.org/80256B3C005BCCF9/(httpAuxPages)/4023556AA730F778C1256DE500649E48/$file/mackinto.pdf> (Accessed on 18th February 2017).

[99] Sheri D. Bell, 'Commodifying Health: An Analysis of the Effects of Western Medical Consumerism on Malaria Treatments in Africa', Available at <https://openjournal.cc.umanitoba.ca/index.php/mb-anthro/article/view/68> (Accessed on 18th January 2019).

is also supported by Christiansen Isaac who posits that the commodification of health care leads to inequalities and a barrier to accessing health care.[100] He notes that neoliberalism is characterized by deregulation, privatization, capital investments and the use of markets in provision of public goods such as health care. [101] Roberto forms the opinion that commodification can lead to exploitation and the lowering of human dignity.[102] Although Mackintosh's and Roberto's studies are worthwhile in showing the demerits of commercializing health care, it is blind to the fact that there are costs associated with health care and which are incurred by health providers who require a system that sustains and promoted the health care facilities.

Culyer notes that anything, including health care, is capable of commodification.[103] This argument is also supported by Richard Posner who notes that there is nothing that sets health care apart from other commodities in the market.[104] He notes that it is only through commodification that certain things that were otherwise not capable of being sold are made available for sale. In his view, commodification should be encouraged, and the law should play a role of supporting commodification rather than limiting it. Basing her argument on the right to equal protection, Anita argues that commodification supports the privacy of the person and promotes equal protection of people since it allows them to enter into commercial arrangements which are otherwise not capable of being entered into previously.[105]

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[100]Christiansen Isaac, 'Commodification of Healthcare and its Consequences', World Review of Political Economy, Available at <https://www.researchgate.net/publication/317295191_Commodification_of_Healthcare_and_its_Consequences> (Accessed on 20th August 2019).

[100] Ibid.

[101] Cornel Ban, 'Neoliberalism in Translation: Economic Ideas and Reforms in Spain and Romania', 2001, Available at <https://www.researchgate.net/publication/277119462_Neoliberalism_in_Translation_Economic_Ideas_and_Reforms_in_Spain_and_Romania>, (Accessed on 11th September 2019).

[102]Andorno, Roberto. (2017). 'Buying and Selling Organs: Issues of Commodification, Exploitation and Human Dignity', Journal of trafficking and Human Exploitation. Vol 1. 119-127. (2017).

[103] A J Culyer, 'The nature of the commodity health and its efficient allocation', (1971) Oxford Economic Papers, Volume 23, Issue 2, Pages 189–211.

[104]Richard A. Posner, "The Regulation of the Market in Adoptions," (1987) Boston University Law Review at Page 59.

[105] Allen L Anita, Supra.

The literature review identifies various topical issues which are analysed in the study. These include commodification of health care, the dilemma as to whether to prioritize profits realized through markets or focus on the right to health, how to effectively access and provide access to health care and whether regulation can be an effective tool in striking a balance between the competing claims so that health care is affordable. This is with an aim of ensuring that whether as a human right or a commodity, access to health care is protected.

1.10 Limitations

This study does not involve field work as a source of information from various stakeholders in the health sector such as entrepreneurs, human rights activists, government entities, members of the public and health professionals. It is therefore be possible that this research did not capture all the issues that it ought to have covered.

1.11 Chapter Breakdown

Chapter One

This Chapter discusses the structure of the study. It provides the background to the study and identifies the problem. This provides the basis of why the study is necessary and provides the objectives which it needs to achieve based on the research questions. Further, it identifies the theoretical framework of the study and briefly analyses previous literature and writings on the various key issues within the study. In addition, it also provides the assumptions relied upon, the research methodology and sources of data as well as a breakdown of what the different Chapters of the study will consider.

Chapter Two

The Chapter discusses the concept of health as a commodity based on the assumption that health care is capable of being commodified. It will analyse how health has been commodified and the factors that have enabled its commodification. It will explore the various arguments in favour of and against commodification and discuss the various effects of commodification and the right to accessing health care. This way, it will evaluate the tension between health as a commodity and health as a human right considering the co-existence of both in Kenya.

Chapter Three

The Chapter focuses on the regulatory and policy framework on the right to health in Kenya with a key focus on accessibility as a core element of the right to health. It proceeds on the assumotion that Kenya's framework is not sufficient for purposes of enhancing access to health care. It will identify the measures undertaken by Kenya in seeking to attain the right to the highest attainable standard of health. It will test the efficiency of the framework in protecting the right to access health care as against the effects of commodification which will have been identified in Chapter Two.

Chapter Four

The Chapter will analyse Kenya's financing model of the health sector. It will explore how Kenya raises, manages and allocates funds for the health sector and how this has affected access to health care. It will try and identify the various challenges in the model. It will in addition seek to establish whether Kenya has made progress in promoting access to health care through a reduction of the negative effects of costs.

Chapter Five

This is the final Chapter of the study. It will recap the objectives of the study and the various assumptions made in Chapter One. It will then proceed to present to key findings and propose reforms which if adopted, may enable Kenya to enhance the economic accessibility to health care and the realisation of the right to the highest standard of health in general.

CHAPTER TWO

COMMODIFICATION AND FINANCIAL ACCESS TO HEALTH CARE

‘Health care is a commodity, not a right – and markets, not government are the solution in medical care’[106]

2.1. Introduction

This Chapter analyses the concept of health care as a commodity and its application in Kenya. It looks at the contemporary view of healthcare as a commodity with those accessing health care being the buyers and the ones providing it as the sellers. It analyzes the language of commercialization of healthcare and the effect it has on the right to the highest standard of health care and the notion that the markets, rather than the government, are the best placed to provide healthcare. In so doing, the contest is between a rights-based approach and a market-based approach to accessing and distributing health care. To analyze the concept of commodification of healthcare, the primary concepts such as the meaning of commodity and commodification ought to be defined. This is in general and in the context of healthcare. A discourse on various neoliberal practices will be necessary for purposes of discussing the efficacy of commodification in the provision and access to healthcare.

2.2. Definition of ‘Commodity’ and ‘Commodification’.

The term ‘commodity’ does not have a universal definition and can refer to many things such goods or raw materials.[107] It is also defined as a good or a service which is produced in capitalism and which is a means of exchange. [108] It has further been deemed as that which must have a value for it to be capable of exchange.[109]

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[106] Mark J Perry, ‘Health care is a commodity, not a right – and markets, not government are the solution in medical care’ Available at <https://www.aei.org/carpe-diem/health-care-is-a-commodity-not-a-right-and-markets-not-government-are-the-solution-in-medical-care/> (Accessed on 20th June 2020).

[107] Oliver, J.R. and Robison, L.J. (2017) ‘Rationalizing Inconsistent Definitions of Commodification: A Social Exchange Perspective’ Modern Economy, 8, 1314-1327 Available at <https://doi.org/10.4236/me.2017.811088> (Accessed on 10th September 2019).

[108] Natascha Pröschel, ‘ Commodification and Culture How can culture be economically used without selling it out?’, Available at <https://www.modul.ac.at/uploads/files/Theses/Bachelor/Thesis-2012-Proeschel-Natascha.pdf> (Accessed on 10th September 2019).

[109] Lesley A. Sharp, ‘The commodification of the body and its parts’, (2000) Annual Review of Anthropology, Volume 29 at page 287–328.

Commodification has been defined as the 'the conversion of a service or an object into a product that can be bought and sold for profit, in a market place thereby making it an object for profit generation.'[110] It has further been defined as the making of something which is otherwise not for sale into something for sale. [111] Additionally, it has been described as the making of things capable of being exchanged with each other and which process assists in the introduction of capital in the market.[112] It is also defined as the treating of things as properties which are capable of being sold and purchased.[113] In the context of health care, commodification, as will be seen below, will focus on the treatment of health care as a commodity capable of being exchanged in the market. In doing so, patients are the purchasers while providers are the sellers.

This study adopts the definition of transformation of something that ought not to be sold into something which can be sold. Through this definition, healthcare becomes a commodity capable of being sold and purchased. This is considering the tension between health care as a right (hence ought not to be sold) and as a commodity (capable of being sold). This definition is based on the neoliberalism theory which advocates for privatization and the use of the markets for purposes of allocation of resources.[114] The theory promotes deregulation, privatization, capital investments and the use of markets in the distribution, provision and access of public goods such as healthcare.[115] It has been argued that in Kenya, neoliberalism was introduced in the 1990's following interventions by the World Bank and the International Monetary Fund which campaigned for a reduced government participation in provision of public goods such as health and education.[116]

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[110] Margaret Lysaght, 'Your Wealth is your Health': A Study of the Commodification of Health Services in Ireland', Critical Social Thinking: Policy and Practice, Vol. 1, 2009.

[111] S Timmermans and R Almeling, 'Objectification, standardization, and commodification in health care: a conceptual readjustment', Social Science &Medicine, 69(1), (2009) pp.21-27.

[112] John Harrington, 'Law and the Commodification of Health Care in Tanzania', 2003 (2)Law, Social Justice & Global Development Journal (LGD). <http://elj.warwick.ac.uk/global/issue/2003-2/harrington.html> (Accessed on 28th August 2019).

[113] David B Resnik, 'The commodification of human reproductive materials', Journal of Medical Ethics (1998) 24 Pp 388-393.

[114] Mary Kiveu, 'Enhancing market access in Kenyan SMEs using ICT', (2013) Global Business and Economics Research Journal, Volume 2 Issue 9 at page 29.

[115] Cornel Ban, 'Neoliberalism in Translation: Economic Ideas and Reforms in Spain and Romania', 2001, Available at <https://www.researchgate.net/publication/277119462_Neoliberalism_in_Translation_Economic_Ideas_and_Reforms_in_Spain_and_Romania>, (Accessed on 11th September 2019).

[116] Ezekiel Mbitha Mwenzwa et all, 'The Oscillating State's Role in the Provision of Social Welfare Services in Kenya' (2016) International Journal of Humanities and Social Science, Volume 6 Issue 5 at page 119.

Commodification of health care has been made possible by various factors including free markets and competition which are neoliberal practises.[117] The increase in competition has partly been blamed by an increased population and a competition by doctors for patients.[118] It has been proposed that globalization and the introduction of the internet have also led to commodification.[119] This has also contributed to changes in consumer culture where people become more aware of the health needs and have made health their own responsibility.[120] As a result, patients aim to maximise value as they access healthcare while for-profit facilities seek to maximise their profits.[121]

2.3. Healthcare as a commodity

Is healthcare a commodity? Different arguments have arisen surrounding this issue. Authors such as Pellegrino[122] and Lown[123] have argued that healthcare is not a commodity because of its unique characteristics. These include the special relationship between a doctor and a patient which is not a simple commercial relationship but one based on trust.[124] They further argue in concurrence that patients, unlike other normal purchasers in the market, are not rational purchasers since they do not possess the ability or information for knowing what is wrong with them, the diagnosis required or the kind of care to be provided.[125] Elizabeth Anderson suggests

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[117] Sheri D. Bell, 'Commodifying Health: An Analysis of the Effects of Western Medical Consumerism on Malaria Treatments in Africa', Available at <https://openjournal.cc.umanitoba.ca/index.php/mb-anthro/article/view/68> (Accessed on 18th January 2019).

[118] Bernard Lown, 'The Commodification of Health Care', Available at <http://pnhp.org/PDF_files/spring2007newsletter_lown.pdf> (Accessed on 5th September 2019).

[119] John D. Stoeckle, 'From Service to Commodity: Corporization, Competition, Commodification, and Customer Culture Transforms Health Care', (2000) Croatian Medical Journal Volume 41 Issue 2 at pages 141-143.

[120] Margaret Lysaght, 'Your Wealth is your Health': A Study of the Commodification of Health Services in Ireland', Critical Social Thinking: Policy and Practice, Vol. 1, 2009.

[121] Ibid.

[122] Edmund Pellegrino, The Commodification of Medical and Health Care: The Moral Consequences of a Paradigm Shift from a Professional to a Market Ethic' Journal of Medicine and Philosophy, 1999, Volume 24, No. 3 at page243–266.

[123] Bernard Lown, 'The Commodification of Health Care, Available at <http://www.pnhp.org/PDF_files/spring2007newsletter_lown.pdf> (Accessed on 29th June 2017).

[124] Ibid

[125] Pellegrino, supra.

that goods and services which are connected to the human dignity, such as healthcare and human body parts, ought not to be commodified. [126]

Anita argues that health care is not a commodity within the context of reproductive health since it can lead to slavery in surrogacy the treatment of babies as items. [127] Courts of law have in some jurisdictions declared surrogacy contracts as being void due to public policy.[128] Further, by being treated as a commodity, the accessibility and provision of healthcare can lead financial exploitation and discrimination of patients seeking access healthcare, [129] the trafficking of human beings and the sale of human body parts.[130] It is argued that all these are practices that lower the human dignity since patients are treated as commodities in the market.[131] In Kenya, the sale and purchase of human organs has been restricted[132] presumably because of this argument. The central theme that runs in this argument is that health care plays a very important role in the society and as a result, it should be distributed according to the need of those who require it but not commodified.[133] This means that someone's ability or inability to afford treatment should not be a determinant in accessing health care. This argument supports accessibility of healthcare from a rights-based approach as opposed from a market approach.

Joseph Heath argues that healthcare is capable of being treated as a commodity.[134] In his argument, he notes that there is nothing wrong with treating healthcare as a commodity. He is of the further view that access to healthcare involve an expense to be incurred by the patient

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[126] Elizabeth Anderson, 'Why some things should not be for sale: The moral limits of markets Debra Satz', (2012) New Political Economy Volume 17 Issue 2 at pp 239-242.
[127] Allen L. Anita, "Surrogacy, Slavery, and the Ownership of Life" (1990). Faculty Scholarship. Paper 805, (1990)., Available at <http://scholarship.law.upenn.edu/faculty_scholarship/805>, (Accessed on 11th September 2019).
[128] In re Baby M, 537 A.2d 1227 (N.J. 1988). Cf. Johnson v. Calvert, 19 Cal. Rptr. 2d 494 (1993).
[129] Elizabeth Anderson, 'Why some things should not be for sale: The moral limits of markets Debra Satz', (2012) New Political Economy Volume 17 Issue 2 at pp 239-242.
[130]Andorno, Roberto. (2017). 'Buying and Selling Organs: Issues of Commodification, Exploitation and Human Dignity', Journal of trafficking and Human Exploitation. Vol 1 at pp 119-127.
[131]Ibid
[132] Section 80 (4) of the Health Act
[133] A J Culyer, 'The nature of the commodity health and its efficient allocation', (1971) Oxford Economic Papers, Volume 23, Issue 2, Pages 189–211.
[134] Joseph Heath, 'Health care as a commodity' available at <https://philpapers.org/rec/HEAHCA>, (Accessed on 18th January 2019).

and that the monetary compensation serves as a motivation to doctors. He however opines that the focus should be on the failure to have accessibility to health but not on whether it is a commodity or not. From his argument, it is discernible that whereas there exists a right to health, there also exists the commodity health. Posner argues that anything, including healthcare, can be deemed to be a commodity.[135] There is nothing that is unique about healthcare which makes it special since other public goods such as education and water are capable of being exchanged within the market. [136]

In analyzing commodification, Margaret Radin et all[137] draws conclusions from various writers about commodification. They argue that commodification can play an important role of granting more liberty, equality and freedom for some people within the society while on the other hand, it might result in more harm to the society such as class stratification, subjugation, exploitation and erosion of human dignity. To avoid these negative effects, there is need to identify those aspects which can be commodified and those which ought not to be commodified.

They further argue that there are different schools of thought in respect to commodification since the classification of what can be termed as a commodity will change from one location to another depending on various factors including the decision of the person controlling the commodity. [138]As a result, whereas it may be possible to have commodification in one aspect, it may not be possible to do so in another. In essence, two opposing sides of complete commodification and incomplete commodification. Complete commodification proposes free markets which are not regulated and where there is no government intervention while incomplete commodification supports free markets but advocates for certain form of regulation.[139] Incomplete commodification appreciates the benefits of the market and the need to protect the ideals of humanity.[140] This notwithstanding,

[135] Richard A. Posner, "The Regulation of the Market in Adoptions' (1987)Boston University Law Review 59 at page 67
[136]Culyer, Supra
[137] Margaret Radin and Mandhavi Sunder, 'The subject and object of commodification', UC Davis Law, Legal Studies Research Paper No. 16; Stanford Public Law Working Paper No. 97 Available at <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=582641> (Accessed on 16th July 2020).
[138] Ibid.
[139] Ibid.
[140] Kimberly D. Krawiec, 'Lessons From Law About Incomplete Commodification in the Egg Market', Journal of Applied Philosophy, 2015, DOI: 10.1111/japp.12144.

she postulates that some items may possess various characteristics which make them not fall within the two opposite sides but rather have the different characteristics overlap each other.[141] Borrowing from Miranda Joseph,[142] she notes that there are certain aspects of life which affect human dignity and which ought not to be commodified owing to various factors such as social inequalities. As will be discussed below, healthcare is a multivalent item which bears various characteristics.

2.4 Commodification and Healthcare

The commodification of health care involves 'transforming the status of health as an inherent right for all people, to a market-based commodity that is subject to cost and profiteering.'[143] It has further been described as commercialization and has broken down to mean the use of markets to provide health care, generation of profits from health investments and access of health care through private insurance and private payment of costs.[144] Roberto Andonno views commodification as the treatment of people and human body organs as things which can be exchanged in the market.[145]These definitions imply that it is possible to treat healthcare and human beings as commodities or items capable of being traded.

Commodification of healthcare focuses on healthcare in the context of a free market which has been advanced by neoliberalism.[146]Neoliberalism is characterized by deregulation, privatization, capital investments and the use of markets in provision of public goods. [147]It aims at promoting

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[141] Margaret Jane Radin, 'Contested Items' Harvard University Press, 1996 at 102-114.
[142] Miranda Joseph, The Multivalent Commodity: On the Supplementarity of Values and Values', In Rethinking Commodification: Cases and Readings in Law and Culture, edited by Martha Ertman and Joan Williams, New York: New York University Press, 2005 at pp 383-401
[143] Margaret Lysaght, 'Your Wealth is your Health': A Study of the Commodification of Health Services in Ireland', Critical Social Thinking: Policy and Practice, Vol. 1, 2009.
[144] Maureen Mackintosh, 'Healthcare commercialisation and the Embedding of Inequality', Available at <http://www.unrisd.org/80256B3C005BCCF9/(httpAuxPages)/4023556AA730F778C1256DE500649E48/$file/mackinto.pdf> (Accessed on 10th September 2019).
[145]Andorno, Roberto. (2017). 'Buying and Selling Organs: Issues of Commodification, Exploitation and Human Dignity', Journal of trafficking and Human Exploitation. Vol 1. 119-127. (2017).
[146] Mary Kiveu, 'Enhancing market access in Kenyan SMEs using ICT', Global Business and Economics Research Journal ISSN: 2302-4593 Vol. 2 (9): 29 – 46.
[147] Cornel Ban, 'Neoliberalism in Translation: Economic Ideas and Reforms in Spain and Romania', 2001, Available at <https://www.researchgate.net/publication/277119462_Neoliberalism_in_Translation_Economic_Ideas_and_Reforms_in_Spain_and_Romania>, (Accessed on 11th September 2019).

efficiency, reducing costs and increasing available options. [148] In a free market, private actors are allowed to own, control and use their property based on self-interest with the forces of demand and supply playing a central role in allocating resources in the most efficient way.[149] It opposes the distribution of public goods such as healthcare through the public sector owing to its inefficiency and proposes that the markets are best where buyers and sellers maximize value and profits respectively.[150] In Kenya, it has been established that the revenue raised for the health system has been mismanaged through theft of funds[151] with the Ministry of Health having been ranked the second most corrupt department in Kenya in the year 2016.[152] The mismanagement has been deemed to push costs of health care further up through intentional inflation.[153] Andrew Feris and Griffin Seiller argue that in order to reduce the high costs of healthcare, there should be minimal government intervention.[154]

When health care is commodified, the accessibility and distribution of health care will depend on the various market factors such as price, costs, availability, distribution, demand and care.[155]As a commodity in the free market, the access to health care will depend on the ability of a person to

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[148] Ibid.

[149] Bruce Scot, 'The Political Economy of Capitalism,' Harvard Business School Working Paper, No. 07-037, December 2006. Available at <https://www.hbs.edu/faculty/Pages/item.aspx?num=23129> (Accessed on 14th September 2020).

[150] Christiansen Isaac, 'Commodification of Healthcare and its Consequences', World Review of Political Economy, Available at <https://www.researchgate.net/publication/317295191_Commodification_of_Healthcare_and_its_Consequences> (Accessed on 20th August 2019).

[151] In a report prepared by the Kenya Anti-Corruption Commission in 2010, titled 'Sectoral Perspectives on Corruption in Kenya: The Case of the Public Health Care Delivery', the commission noted that the ministry of health had been affected by various forms of malfeasance including corruption and disregard of procurement laws. This it noted had a negative effect on delivery of services due to a compromise on the available resources.

[152] Kenya Ethics and Anti-corruption Commission, 'National Ethics and Corruption Survey, 2016', EACC Research Report No. 3 of January 2017.

[153] Kenya Anti-Corruption Commission, 'Sectoral Perspectives on Corruption in Kenya: The Case of the Public Health Care Delivery', Available at <https://www.eacc.go.ke/wp-content/uploads/2018/09/health-report.pdf> (Accessed on 10th November 2019).

[154] Andrew Ferris & Griffin Seiler 'Health Care Reform - A Free-Market Proposal', (1995) Loyola Consumer Law Review, Volume 7 Issue Number 2 at page 45.
Available <http://lawecommons.luc.edu/lclr/vol7/iss2/3> (Accessed on 20th August 2019).

[155] Sheri Bell, 'Commodifying Health: An Analysis of the Effects of Western Medical Consumerism on Malaria Treatments in Africa', Available at <https://openjournal.cc.umanitoba.ca/index.php/mb-anthro/article/view/68> (Accessed on 18th January 2019).

afford the price offered, the availability and the quality among other characteristics of neoliberalism which supports commodification of health care.[156]

Commodification of healthcare is further characterized by removal of barriers to exit and entry from and into the healthcare market, increase in private hospitals and financing of private hospitals, profit making motive. [157]There is also the private financing of health care by private individuals and distribution and access to health care based on the forces of demand and supply.[158]This is opposed to access and distribution as an entitlement as a human right.

Following from the above, it has been argued that healthcare is multivalent in nature since it bears characteristics of a human right on the one hand and a commodity in the market on the other.[159] The law recognizes the right to accessing healthcare and the right to health in general as human rights. However, with liberalization and commodification, healthcare is capable of being treated as a commodity like other commodities in the market. This is taking into account that there are other public goods, such as water and education, which although are human rights, have also been treated as commodities in the market. Heath postulates that there is nothing wrong with commodification of healthcare which prejudices human dignity.[160] As such, whereas they remain public goods and considered as human rights, they are also readily sold and purchased within the market and are affected by the usual features of markets including demand, supply, price and costs which are features of the free market under neoliberalism. [161]

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[156] Maureen Mackintosh, 'Health care commercialization and the embedding of inequality' (2003) RUIG/UNRISD Paper on Globalization, Inequality and Health', Available at <http://www.unrisd.org/80256B3C005BCCF9/(httpAuxPages)/4023556AA730F778C1256DE500649E48/$file/mackinto.pdf> (Accessed on 18th February 2017).

[157] John Harrington and Maria Stuttaford, 'Global Health and Human Rights :Legal and Philosophy Perspectives' 2nd Edition , Routledge at Page 300

[158] Mackintosh M, Kovalev S. 'Commercialisation, inequality and transition in health care: the policy challenges in developing and transitional countries.' (2006) Journal of International Development, Volume 18 Issue Number 3 at page 387-391.

[159] Edmund, Supra.

[160] Joseph Heath, 'Health care as a commodity.' Available at <https://philpapers.org/rec/HEAHCA>, (Accessed on 18th January 2019).

[161] Edmund, Supra.

2.5. Commodification of health care: A critique

Gadamer argues that health is a freedom and an integral part of human life and that as such, health ought not to be treated as a commodity but rather as a social good.[162] This argument has also been supported by Pelegrino who suggests that due to the negative effects of disease, there is need to ensure that health care is not commodified. [163] According to Feldstein, the resources available in a country ought to be allocated in order maximize the health of a nation by enhancing access to healthcare as opposed to individual interests in the free market. [164] To do this, health care therefore ought not to be commodified.

Feldstein further argues that the commodification of health care is not practical since free markets only exist in economic theories but not in reality. [165] This is because in the real word, the market is characterized by exploitation, monopolization, unequal bargaining power and lack of information among others.[166] According to the United Nations, the commodification of healthcare may lead to dangers such as class stratification and discrimination within the society which affects the accessibility to healthcare.[167] Those who are better placed financially might have the benefit of accessing better health care than others thereby prejudicing those who cannot afford.[168] Those with low incomes may either fail to access health care, delay in accessing treatment or seek low quality care. A perfect market can thus be a danger to the society.[169]As was seen in the case of Alex Madaga, the lack of funds and the high costs of health care can be catastrophic where one is

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[162] Gadamer Hans-Geog, The Enigma of Health: The art of healing in a scientific age', quoted in Iva ŠOLCOVÁ, 'Health- As seen by Philosophy of H-G Gadamer', School and Health 21, 3/2008, Contemporary Discourse on School and Health Investigation, Available at <http://www.ped.muni.cz/z21/2007/konference_2007/sbornik_2007/sb07_soucasny_diskurs/eng/solcova_eng.pdf> (Accessed on 4th September 2019).

[163] Pellegrino, Supra.

[164] Feldstein M.S., 'Economic analysis, operational research and the National Health Service', (1963) Oxford Economic Papers, Volume 15, at pages 19-31.

[165] Ibid

[166] Elizabeth Anderson, 'Why some things should not be for sale: The moral limits of markets Debra Satz', (2012) New Political Economy Volume 17 Issue 2 at pp 239-242.

[167] UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), 11 August 2000, E/C.12/2000/4, available at: https://www.refworld.org/docid/4538838d0.html [accessed 20 April 2019].

[168] Sheri D Bell, Supra.

[169] Ari Mwachofi et All. "Health care market deviations from the ideal market." (2011) Sultan Qaboos University medical Journal Volume 11 Issue 3 pp 328-337.

denied access to medical treatment. The Kenyan government has confirmed that the treatment of Covid-19 are very high and might be a challenge for Kenyans to afford treatment in hospitals.[170] The cost for one average symptom was averaged at between Kshs. 21, 000 and Kshs. 21, 400/-.[171]

It has also been argued that the use of the free market for purposes of determining access to healthcare is inapplicable owing to the unique characteristics identified above[172] which include the inability of patients to make rational decisions and the trust relationship that exists between patients and doctors.[173] This trust is necessary because the patients may not have the expertise of trained health professionals and rely mostly on the doctor's knowledge and expertise.[174] In addition, the trust is necessary because it promotes decision making between the patient and the doctor.[175] Commodification may however erode this trust due to the conflict of interest which might arise in the desire to maximize profits in the free market.[176] In the United States of America, it was observed that there was an increase in overmedication for people who had insurance owing to the need to increase sales and profits.[177] In Kenya, maternal deaths and abortions have become common in private facilities which has been argued to be as a result of the desire to make money through any means including illegal means.[178] The desire may also lead to infiltration of the health

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[170] Angela Oketch, 'Amoth: Treating coronavirus costs Sh300,000', Daily Nation 11th July 2020, Available at <https://nation.africa/kenya/news/treating-coronavirus-costs-sh300-000-1475490 > (Accessed on 14th September 2020).
[171] Ibid.
[172] A J Culyer, 'The nature of the commodity health and its efficient allocation', (1971) Oxford Economic Papers, Volume 23, Issue 2, Pages 189–211.
[173] Prudence Ramokgopa, 'Commodification of Health Care in a Private Health Care Facility: Ethical implications for Nurse-Patient relationship', Available at <http://wiredspace.wits.ac.za/jspui/bitstream/10539/25522/1/NPR09112017%20%284%29.pdf> (Accessed on 10th September 2019).
[174]Lown, Supra.
[175] Ellery Chih-Han Huang Et All, 'Public Trust in Physicians—Health Care Commodification as a Possible Deteriorating Factor: Cross-sectional Analysis of 23 Countries', (2018) Journal of Health Care Organization, Provision, and Financing Volume 55 at pages 1 –11.
[176] P.M.A. Hendrikx, 'Priced, Not Praised: The Effects of Economization on the Professional Identity of Dutch General Practitioners', Available at <http://thegoodproject.org/wp-content/uploads/2012/09/Priced-Not-Praised-The-Effects-of-Economization-on-the-Professional-Identity-of-Dutch-General-Practitioners-Wiljan-Hendrikx.pdf> (Accessed on 5th September 2019).
[177] Isaac Christiansen, 'Commodification of Healthcare and Its Consequences', (2017) World Review of Political Economy Volume 8 Issue 1 at pages 82-103.
[178] Donatus Githui, 'Ethical issues in health care in Kenya: A critical analysis of health care stakeholders', (2011) Research Journal of Finance and Accounting, Volume 2 Issue No3 at page 121.

sector by quacks which has been prevalent in Kenya.[179] These unlawful activities may threaten the quality of services provided.

2.6 Commodification and regulation

Kenya has prices of some commodities being controlled by the government through regulations. This has however not been the case with health care where the price and costs of accessing health care has been blamed for the increase in maternal mortality due to economic inaccessibility.[180] The negative effects of commodification and the markets has been argued to have created the need to regulate commodification.[181] Regulation becomes important for purposes of correcting market imperfections[182] because completely free markets may not exist in reality but rather as an abstract in the economic theory.[183] The intervention by the law and the government would therefore be to facilitate the functioning of the market.[184]

Regulation of various issues in health care, such as the costs and accessibility, should therefore not be restricted if they are geared towards enhancing accessibility to healthcare since there are regulations that control certain sectors of health care such as licensing of doctors.[185] The regulation would find an anchor in consumer protection rights which are protected under Article 46 of the Constitution which recognizes, among others, protection of health, safety and economic interests for consumers.[186] The expansion of the definition of unfair practices under the Consumer Protection Act[187] to restrict the charges fixed by the law might make this a possibility and probably,

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[179]Kifaya Abdulkarim Ibrahim, 'Resolving Medical Malpractise Claims: A critical study of disciplinary proceedings in Kenya', Strathmore University, 2017.

[180] Agnes W. Kibui, 'Health Policies in Kenya and the New Constitution for Vision 2030', (2015) International Journal of Scientific Research and Innovative Technology, Volume 2 Issue 1 at page 127

[181] Margaret Radin and Mandhavi Sunder, 'The subject and object of commodification', UC Davis Law, Legal Studies Research Paper No. 16; Stanford Public Law Working Paper No. 97 Available at <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=582641> (Accessed on 16th July 2020).

[182]Thiankolu Muthomi, 'Reconciling incongruous policy objectives and benchmarking Kenya's public procurement law: A review of the Selex case 1, (2011)Journal of Public Procurement Volume 11 at pages 451-481

[183] Feldstein M.S., 'Economic analysis, operational research and the National Health Service', (1963) Oxford Economic Papers, Volume 15 at pages 19-31.

[184] Radin & Sunder, Supra.

[185] Part XIII of the Health Act.

[186] Article 46 (1) (d).

[187] Act No. 46 of 2012. The definition of unfair practices under Part III of the Consumer Protection Act and illegal does not at the moment include a restriction on the price of healthcare goods and services.

provide an avenue for increasing economic accessibility to healthcare. This study argues that the regulation of the costs of health care would not be a new phenomena having been utilized in other sectors and as such, can be utilized as one of the mechanisms of promoting access to health care.

2.7 Commodification of health care in Kenya

Kenya has not been left behind in the commodification of healthcare. Since independence, the provision of health care has largely remained the government's role.[188] With time, this has changed with a remarkable change being the introduction of neoliberal practices and the use of the market for purposes of provision of healthcare. [189] This has been traced to the 1990's when the World Bank and the International Monetary Fund recommended privatization and reduced role of the government in the provision of public goods. .[190] The introduction of neoliberalism resulted in the introduction of user charges in hospitals, privatization and the introduction of policies aimed at sharing of costs in Kenyan hospitals.[191] This in turn resulted in increased revenues for hospitals which assist in sustaining hospitals and bridging the gap left behind by low government funding.[192]

Health care in Kenya has adopted a multivalent nature where it is a right and a commodity. The Constitution recognizes the right to accessing healthcare under Article 43 as well as guaranteeing equality and non-discrimination in the enforcement and application of human rights. The state is required to take progressive measures in ensuring the realization of the right to health.[193] The Constitution has, without providing any limitation on financial ability of a person, recognized that emergency medical treatment should not be denied to anyone.[194] Whereas Kenya has recognized the right to health, the access to health services in Kenya is not free. Costs are charged in

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[188] David Collins et all, 'The fall and rise of cost sharing in Kenya: The impact of phased implementation', (1996) Health policy and Planning, Volume 11 Issue 1 at pages 52-63.

[189] Ezekiel Mbitha Mwenzwa et all, 'The Oscillating State's Role in the Provision of Social Welfare Services in Kenya' (2016) International Journal of Humanities and Social Science, Volume 6 Issue 5 at page 119.

[190] Ibid.

[191] Ibid.

[192] Alfred Anangwe, 'Health sector reforms in Kenya: User fees. Governing Health Systems in Africa' quoted in Reena Anthonyraj, 'A health financing reform solution for Kenya: Expansion of National Health Insurance Fund (NHIF)', (2016) Global Journal of Medicine and Public Health Volume 5 Issue 4 at pages 1-5.

[193] Article 21.

[194] Article 43 (2).

government and private healthcare facilities.[195] The costs involved include consultancy costs, travelling costs and costs for medication among others.[196] In the government facilities, the country has over the years adopted policies in relation to the application of costs and access to healthcare including the introduction of user charges and cost-sharing.[197] Regrettably, the various costs have also been blamed for limiting accessibility to those who cannot afford[198] and for increasing rate of poverty and impoverishment.[199]

The government has undertaken various policies and measures which seek to promote a human-rights approach towards access to healthcare. These include the introduction of universal health care[200] which seeks which aims at increasing access to affordable health care to citizens while at the same time shielding them from the negative effects of costs.[201] Jane Chuma has argued that a rights-based approach that focuses on equity in accessing healthcare is integral role in attaining the right to health.[202] Kenyan law facilitates the ownership of private property which is central to private healthcare facilities. The Health Act recognizes the participation of the private sector in the provision of health care.[203] This is also supported by the Constitution which allows the ownership of private property.[204] Doctors and other players in the market are thus at liberty to establish private facilities. As at the year 2015, 54% of health facilities in Kenya were privately

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[195] Kenneth Munge et all, 'A Critical Analysis of Purchasing Arrangements in Kenya: The Case of the National Health Insurance Fund', (2018) Internal Journal of Health and Policy Management, Volume 7 Issue 3 at page 244-254.
[196] Ibid
[197] Ibid.
[198] Japheth Ososti Awiti, 'Poverty and health care demand in Kenya', (2014) BMC Health Services Research Volume 14 at page 560.
[199] Vincent Okungu et all, 'The cost of free health care for all Kenyans: assessing the financial sustainability of contributory and non-contributory financing mechanisms', (2017) International Journal for Equity in Health, Volume 16 at page 39.
[200] Government of Kenya, Ministry of Medical Services, 'MMS Sessional Paper No 7 of 2012 on the Policy on Universal Health Coverage in Kenya', Available at <https://academia-ke.org/library/download/mms-sessional-paper-no-7-of-2012-on-the-policy-on-universal-health-coverage-in-kenya/ > (Accessed on 26th July 2020).
[201] Timothy Chrispinus Okech et all, 'Analysis of Universal Health Coverage and Equity on Health Care in Kenya' (2016) Global Journal of Health Science Volume 8 Issue 7 at pages 218-227.
[202] Jane Chune and Vincent Okungu, 'Viewing Kenyan health system' International Journal for Equity in Health, Volume 10, Article number: 22 (2011).
[203] Part XIII of the Health Act.
[204] Article 40.

owned[205]with various forms of business organizations in the health sector.[206] The government and the private sector have cooperated in public-private partnerships in the development of hospitals and provision of healthcare services. [207] It has been argued that joint cooperation has played an important role in treatment of disease in Kenya.[208] Kenya's health system appreciates the multivalent nature of health care which calls for the incomplete commodification of healthcare for purposes of enhancing access.

The analysis above has presented several issues regarding access to health care in the context of commodification. Central to commodification is the desire to make profits by healthcare providers. Whereas this may have a positive impact such as the injection and generation of revenue required for sustenance of business and further supply of health care, it might have negative results where there is exploitation and subjugation of patients. In addition, it might lead to class stratifications within the society which might increase inequalities and disparities life. In addition, it might become a barrier to accessing health care and in other instances lead to poverty and impoverishment.

This is however not to suggest that commodification is always negative. Commodification results in ensuring that various things which were otherwise not available for sale such as human body parts, become available for sale and can thus be purchased legally. The increased competition in the market can also result in reduced costs where competitors try to outdo each other in increasing the demand for their products for example by improving the quality of services and products. Through advertising, there is an increased flow of information to the consumers which enables them to make better decisions.

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[205] Government of Kenya, Kenya National Health Accounts 2015/2016, Government of Kenya, 2017.

[206] There have been mergers, acquisitions and takeovers of private hospitals and the injection of new capital. In 2017, two hospitals, Avenue Healthcare and Metropolitan Hospital were acquired by other companies. In the year 2016, the Dutch Life Sciences and Health Sector identified various business opportunities where they could invest. The areas included e-health, medical devices, health financing, training and building of hospitals. This was through a study commissioned by the Dutch Embassy in Nairobi. The United Nations has identified Kenya as a lead destination in medical tourism with the increase being supported by the search for low-cost services.

[207] Matt Kukla et all, 'The effect of costs on Kenyan households' demand for medical care: why time and distance matter' (2017) Health Policy Plan, Volume 32 Issue 10 at page 1397-1406.

[208] Barnes, Jeff et all'Private health sector assessment in Kenya' World Bank working paper; no. 193. Washington, DC: World Bank, 2010.

Whereas there are divergent views on how to distribute healthcare in order to ease and enhance economic access, it may not be possible to single out any of the arguments as being the best placed to provide health care. In Kenya for example, whereas the private sector has increased the supply side of healthcare, direct and indirect costs have continued being a hindrance to accessing health care. The market has therefore not been able to fully allocate resources in a way that promotes the full realization of the right to health.

Without regulation in place, costs have continued to hamper access. This presents various tensions including, the protection of human rights in the context of commodification, the place of commodification in the human rights sphere and the efficiency or markets in accessing healthcare in Kenya. With this in mind, whereas it is important that health care be recognized as a right, it is equally important that this recognition should consider the reality of Kenya's economy. The various tensions identified above justify the need undertake reforms for purposes of better realization of the right to health. One such approach identified by the study is the regulation of costs of health care.

2.8. Conclusion

The discussion of whether health care can be commodified results in divergent views on how to distribute and access healthcare. Different arguments have been made to justify commodification of health care including that markets are best placed to allocate resources. On the other hand, it has been argued that it negative results that may result from the market factors and which might stifle access to health care through increasing disparities and costs.

Commodification in Kenya has resulted in various outcomes. Whereas there have been positive developments attributed to commodification, there have been negative outcomes which have become barriers to the right to accessing healthcare. This has affected the realization of the right to the highest attainable standard of health. Commodification of healthcare in Kenya has existed alongside the constitutional protection of the right to accessing health care. As seen above, commodification has shown that it can prejudice the right to accessing healthcare by reason of costs, financial discrimination and exploitation through the market. The foregoing calls into

question the effectiveness of Kenya’s regulatory, structural and policy framework in enhancing economic accessibility of healthcare in Kenya.

CHAPTER 3

ACCESS TO HEALTHCARE IN KENYA: REGULATORY, LEGISLATIVE AND POLICY FRAMEWORK.

‘Every person has the right to the highest attainable standard of health.[209]

3.1. Introduction

In appreciating the importance of access to health, General Comment Number 14[210] has identified economic accessibility to healthcare as one of the components of access to the right to health. The previous chapter has examined how commodification has negatively affected the access to health. It is thus necessary to identify how Kenya’s regulatory and policy framework has protected the right to accessing healthcare. The aim of this Chapter is to explore the two concepts of health and the right to access to healthcare in the framework of economic accessibility. This will form the basis of analysing government’s obligations in realizing the right to accessing healthcare under international, regional and domestic laws. This will be necessary for purposes of investigating whether to regulate the costs and prices of healthcare. The Chapter also considers the impact of the various policies developed by Kenya such as the Vision 2030 and the judicial approach towards economic access to healthcare. With devolution having been introduced as a form of increasing the reach of citizens to government services, it will be important to consider whether it has enhanced access to health care. The overall aim will be to evaluate how Kenya’s regulatory and policy framework affects economic accessibility to healthcare.

3.2. Health as a concept

Historically, health was based on various concepts such as absence of disease, the relationship between human beings and the proper functioning of human organs.[211] This changed over time with the introduction of international bodies such as the World Health Organization which expanded the definition of health. The Constitution of the World Health Organisation defined health as ‘a state of complete physical, mental and social well-being and not merely the absence

[209] Article 43, Constitution of Kenya

[210] Committee on Economic, Social and Cultural Rights (CESR), General Comment 14, The Right to the Highest Attainable Standards of Health. U.N. Doc E/C.12/2000/4. 51(AUG,2000)

[211] Anna Lydia et all, ‘Concepts and definitions of health and health-related values in the knowledge landscapes of the digital society’ (2017) Croat Medical Journal Volume 58 Issue 6 at page 431.

of disease or infirmity.'[212] This definition has been criticized on various fronts including the fact that it has been overtaken by time, that it is not possible to have a complete well-being of an individual and finally that it is not possible to measure the suggested state of well-being of a person.[213] Huber argues that this definition be changed to focus on other changing aspects of health and in his view, the definition should be one that focuses on a person's ability to adapt and self-manage their well-being in the context of mental, physical and social spheres. [214] Health has further been defined as 'relative state in which one is able to function well physically, mentally, socially, and spiritually to express the full range of one's unique potentialities within the environment in which one lives.'[215] This definition incorporates other socio-economic factors which might have an impact on health such as social justice, food and water identified in the Ottawa Charter for Health Promotion.[216]

3.3 Health as a human right

The right to health is traceable to the Universal Declaration of Human Rights in 1948 which is recognized as the foundation of human rights.[217] The introduction of the Universal Declaration of Human Rights in general was based on the negative experiences that the world had suffered in the course of the World War I and World War II.[218] Mann argues that it was thus deemed necessary that every person should be guaranteed the basic human rights on the basis of being a human being.[219] With the coming into force of the International Covenant on Economic, Social and Cultural Rights, the right to health was reaffirmed as a human right under Article 12. Under Article 12, every person has the right to the highest attainable standard of physical and mental health.[220] In recognizing that the right to health does not exist in isolation and is dependent on other factors

[212] The Constitution of the World Health Organization.
[213]Machteld Huber et All. 'How should we define health?', (2011) The BMJ Volume 11 at page 343.
[214] Ibid.
[215] Anna Lydia et all, 'Concepts and definitions of health and health-related values in the knowledge landscapes of the digital society' (2017) Croat Medical Journal Volume 58 Issue 6 at page 431.
[216] Ottawa Charter for Health Promotion 1986.
[217] Richard Pierre Claude & Burns Weston, 'Human Rights in the World Community: Issues and Action', (2006) University of Pennsylvania Press, 1st edition, at page 168.
[218] Stephen P. Marks, 'Emergence and Scope of the Right to Health' in José M. Zuniga, Stephen P. Marks, and Lawrence O. Gostin 'Advancing the Human Right to Health', (2013) Oxford University Press.
[219] Jonathan Mann et all, 'Health and human rights: if not now, when?', (1997) Health Human Rights Volume 2 Issue Number 3 at page 113-120.
[220] Article 12 of International Covenant on Economic, Social and Cultural Rights.

such as development and the economy, the World Health Organisation adopted the 'Health for All by the Year 2000' in 1977 which a multisectoral approach towards the right to health to ensure that it was accessible to every person was adopted.[221] Hall and Taylor argue that the Alma-Ata Declaration of 1978[222] recognized that the fulfilment of the right to health required cooperation between the health sector and other socio-economic sectors such as an inequality in income levels.[223] As will be discussed later, the right to accessing healthcare in Kenya is partly dependent on economic factors including costs of healthcare services and commercialization of healthcare.

It forms part of the second-generation rights otherwise known as the economic and social cultural rights which focus on the quality and dignity of life such as water, sanitation and food.[224] As a human right, the right to health entitles a person have access to certain health related benefits.[225] Article 12 of the International Covenant on Economic, Social and Cultural Rights recognizes that everyone has the right to the highest standard of healthcare. Kenya's Article 43 of the Constitution replicates this benefit and further adds that the right includes the access to reproductive healthcare services as well as providing for access to emergency medical treatment to everyone.[226]

The main duty bearer to ensure the realization of the right is the government.[227] Article 12 of the International Covenant on Economic, Social and Cultural Rights requires State parties to take measures to ensure the realization of the right to health. In Kenya, the Constitution has mandated the government to take steps and measures to ensure the progressive realization of the right to

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[221]Halfdan Mahler, 'The Meaning of "Health for All by the Year 2000', (2016) AMJ Public Health Volume 106 Issue 1 at page 36.

[222] Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.

[223] John J Hall and Richard Taylor, 'Health for all beyond 2000: The demise of the Alma-Ata Declaration and primary health care in developing countries', (2003) Medical Journal of Australia Vol 178 (1) pp 17-20.

[224] Mohammad Reza Saran, 'The Concept of Right" and its Three Generations', (2017) International Journal of Scientific Study, Volume 5 Issue 4.

[225] Leslie London et all, 'Social solidarity and the right to health: Essential elements for people-centred health systems' 'Health Policy and Planning (2015); Vol 30:938–945

[226] Article 43.

[227] Alison Barnes and Michael McChrystal, 'The Various Human Rights in Healthcare', (1988) Human Rights, Faculty Publications Paper 316 at page 12, Available at <https://scholarship.law.marquette.edu/facpub/316/>, (Accessed on 18th July 2020).

health.[228] Kenya has taken various steps including enactment of legislation such as the Health Act[229] and policies such the Kenya Health Policy 2014-2030 which seek to promote universal healthcare which is equitable, affordable and of good quality for all citizens.[230] Various judicial decisions cases such as Luco Njagi& 21 others v Ministry of Health & 2 others[231] have recognized Kenya's obligations such as providing sufficient resources for purposes of health care. In the case, the petitioners had sought to have an order directed at the Ministry of Health to meet their costs for dialysis at a private hospital after they were unable to access the services at Kenyatta National Hospital.

The right to health is an inclusive right encompassing other human rights[232] Including freedom from discrimination, freedom from torture and oppression to women among others.[233] This is based on the principle that human rights are interdependent and interrelated.[234] The violation of one right, such as limitation to clean water and adequate food can have a negative effect on the right to health since food and water have a relation to health.[235] This interdependence has also been

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[228] Article 21 (3) of the Constitution.
[229] Act No. 21 of 2017.
[230] Government of Kenya, Ministry of Medical Services, 'MMS Sessional Paper No 7 of 2012 on the Policy on Universal Health Coverage in Kenya', Available at <https://academia-ke.org/library/download/mms-sessional-paper-no-7-of-2012-on-the-policy-on-universal-health-coverage-in-kenya/ > (Accessed on 26th July 2020).
[231] (2015) eKLR.
[232] General Comment No. 14, Supra.
[233] In a statement styled as 'Forging the Link Between Health and Human Rights, Statement of the Consortium for Health and Human Rights (Francois-Xavier Bagnoud Center for Health and Human Rights; Global Lawyers and Physicians; International Physicians for the Prevention of Nuclear War; and Physicians for Human Rights)' to mark the 50th anniversary of the Universal Declaration of Human Rights, it was noted that health is linked to various other social issues which have a direct effect on human rights including access to health care, oppression of women, torture, discrimination, unfair labour practices, violent conflict, education and dignity among others.
[234] United Nations Human Rights Office of the High Commissioner, 'Vienna Declaration and Programme of Action', Available at <https://www.ohchr.org/en/professionalinterest/pages/vienna.aspx> (Accessed on 18th July 2020). It recognized that 'All human rights are universal, indivisible and interdependent and interrelated. The international community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis. While the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of the States, regardless of political, economic and cultural system, to promote and protect all human rights and fundamental freedoms.'
[235] Priscila Neves-Silva, 'Human rights' interdependence and indivisibility: a glance over the human rights to water and sanitation', (2019) BMC International Health and Human Rights' Volume 19 Article 14.

recognized by Kenyan courts where the right to privacy and dignity by having medical records being kept private have been linked to the right to health. [236]

The right to health is founded on the human rights theory which argues that human rights belong to every person[237] and they serve the purpose of ensuringa decent and flourishing human life. . [238] Through the human rights theory, it follows that everyone is entitled to the right to health without any form of discrimination.[239] Going by this understanding, costs should therefore not be a barrier to accessing health care.

3.4. Access to healthcare as a human right

Clark described access to health care as the 'entry or use of the healthcare system' by people. [240] He further notes that it can also have a political dimension in which governments seek to provide healthcare to their populations.[241] It has further been defined as 'the availability of good health services within reasonable reach of those who need them and of opening hours, appointment systems and other aspects of service organization and delivery that allow people to obtain the services when they need them.'[242] Levesque defines it as 'the opportunity to reach and obtain appropriate health care services in situations of perceived need for care.' [243] Lodenyo described access to healthcare based on the time expended to access services and how this affects health.[244] In his view, the ease of which a person can obtain health services is critical for purposes of

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[236] HIV & AIDS (KELIN) & 3 others v Cabinet Secretary Ministry of Health & 4 others (2016) eKLR.

[237] Amartya Sen, 'Elements of a Theory of Human Rights', (2004) Philosophy and Public Affairs, Volume 32 Issue 4 at page 315.

[238] Stephen P. Marks, 'Human Rights – A Brief Introduction' (2019) Boston, Harvard School of Public Health at page 24.

[239] Article 5 of the International Convention on the Elimination of All Forms of Racial Discrimination of 1965 provides that 'The right to public health, medical care, social security and social services."

[240] Duncan Clark, 'Dimensions of the concept of access to health care', (1983) Bulletin of the New York Academy of Medicine, Volume 59 Issue No. 1 at page 5-8.

[241] Ibid

[242]David B Evans et all, 'Universal health coverage and universal access', (2013) Bulletin of the World Health Organization.

[243] Jean-Fredrick Levesque et all, 'Patient-centred access to health care: conceptualising access at the interface of health systems and populations', (2013) International Journal for Equity in Health, Volume 12, Article 13.

[244] Martin Lodenyo et all, 'Factors affecting time of access of in-patient care at Webuye District hospital, Kenya' (2016) African Journal of Primary Health Care & Family Medicine, Volume 8, Issue Number 1 at page 898.

determining access to healthcare. This approach has further been identified by Martin Gulliford et all in their research on what constitutes access to health care in which they note that 'facilitating access is concerned with helping people to command appropriate health care resources in order to preserve or improve their health.'[245] These definitions suggest a patient's ability to procure and utilize available health care services. This study argues that access to healthcare is the means towards achieving the end-result of a better realization of the right to health.

Dikaios et all have argued that access to health care is a human right.[246] Ithas been identified in law in various international and regional instruments. [247] The Constitution of the World Health Organization recognizes that the enjoyment of the highest standard of health care for every person is a human right.[248] The right has also been recognized under the International Covenant on Economic and Social Cultural Rights[249] at Article 12, the African Charter on Peoples and Human Rights[250] and the Universal Declaration of Human Rights.[251] Kenya has recognized access to healthcare as a right under Article 43 of the Constitution of Kenya and in other domestic legislations such as the Health Act, Persons with Disabilities Act and the Children Act. As a socio-economic right, the recognition in law is important since it assists in making it a legal right and not merely a moral right capable of enforcement. [252] This makes it justiciable in various courts and tribunals.[253]

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[245] Martin Gulliford et all, 'What does 'access to health care' mean?' (2002) Journal of health services research & policy, Volume 7 at page 186.
[246]Sakellariou Dikaios et all' The effects of neoliberal policies on access to healthcare for people with disabilities', (2017) International Journal for Equity and Health, Volume 16 at page 199
[247]Camilo Hernán Manchola Castillo, 'Access to health care as a human right in international policy: critical reflections and contemporary challenges', (2017) Ciência & Saúde Coletiva Volume 22 Issue No. 7 at page 2151-2160.
[248] Preamble to the World Health Organisation
[249] Article 12
[250] Article 16
[251] Article 25.
[252] Amartya Sen, 'Elements of a Theory of Human Rights', (2004) Philosophy and Public Affairs, Volume 32 Issue 4 at page 315.
[253]Ted Schrecker et all, 'Advancing health equity in the global marketplace: How human rights can help' (2010) Social Sciences and Medicine, Volume 71 Issue 8 at pages 1520-1526.

Giorgi argues that the main duty bearer to ensure realization of access to health care is the government.[254] The International Covenant on Economic and Social Cultural Rights has obligated State parties to take steps and measures towards realization of the highest attainable standard of health. The strategy 'Health for All by the Year 2000' by the World Health Organisation also recognized the various sectors and the government in ensuring access to healthcare.[255] The Kenyan Constitution has made it an obligation on the government to ensure that it provides sufficient resources for purposes of the progressive realization of the various economic and social rights.[256]

The right to access to healthcare requires that there be equal access to healthcare and that there is no discrimination of any nature. [257] Neoliberal practices have however limited access to health care due to costs of purchasing health services..[258] Pellegrino has argued that neoliberal practices such as commodification, costs and prices have been barriers to accessing healthcare.[259] Poverty has also been identified as a major barrier to access healthcare[260] where limited finances have led to patients opting for cheap and low quality services. [261] Some of the mechanisms proposed for ensuring equity is regulation of costs.[262]

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[254] Maite San Giorgi, The Human Right to Equal Access to Healthcare', (2012) School of Human Rights Research Series, Volume 53 at page 1.
[255] Halfdan Mahler, 'The Meaning of "Health for All by the Year 2000', (2016) AMJ Public Health Volume 106 Issue 1 at page 36.
[256] Article 21.
[257] Maite San Giorgi, The Human Right to Equal Access to Healthcare', (2012) School of Human Rights Research Series, Volume 53 at page 1.
[258] Camilo Hernán Manchola Castillo
[259] Edmund Pellegrino, The Commodification of Medical and Health Care: The Moral Consequences of a Paradigm Shift from a Professional to a Market Ethic' Journal of Medicine and Philosophy, 1999, Vol. 24, No. 3 at pages 243–266.
[260] Z Stauss& D Horsten, 'A Human Right-Based Approach to Poverty Reduction; The Role of Right of Access to Medicine as an Element of the Right of Access to Healthcare,' (2013) Potchefstroom Electronic Law Journal, Volume 16 Issue 3 at page 336
[261] Frank Kagema et all, 'Quality of Care for Prevention and Management of Common Maternal and Newborn Complications: Findings from a National Health Facility Survey in Kenya', (2016), Government of Kenya.
[262] Naoki Ikegami, 'Japanese Health Care: Low Cost Through Regulated Fees', (1991) Health Affairs, Volume 10 Issue Number 3 at page 87.

Chuma has argued that access to health care plays a key role in the society[263] because it enables people gain access to health facilities which would otherwise not be available.[264] Without access to health care, the society may suffer disease and other harmful factors of health which limit the realization of the right to health. This is because patients may not be able to access the needed treatment and which can be catastrophic in the event of death. It is through access to health care that people will then be able to obtain health care services and thereby improve their health.[265] The World Health Organization identified the importance of the access to healthcare by noting that the way to attaining the highest standard of health was by ensuring that everyone had access to primary health.[266]

The General Comment Number 14[267] observes that access to healthcare has four different aspects which are intertwined.[268] These are non-discrimination, physical accessibility, affordability (economic accessibility) and information accessibility.[269] All state parties to the International Covenant on Economic and Social Cultural Rights are under an obligation to ensure their application in their respective systems without any form of discrimination or limitation. [270]

This study focuses on the economic accessibility to healthcare and how it has been affected by the commodification of health care. Economic accessibility has been outlined as the aspect of having healthcare being affordable to everyone and measures being taken to ensure that the costs of

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[263]Chuma Himonga, 'The Right to Health in an African Cultural Context: The role of Ubuntu in the Realization of the Right to Health with Special Reference to South Africa,' (2013) Journal of African Law Volume 57 at page 165.

[264] Martin Gulliford at all, 'What does 'access to health care' mean?' (2002) Journal of Health Services Research & Policy, Volume 7 at page 186.

[265] Ibid.

[266] Physical accessibility has been described to mean that health services ought to be within a physical distance within which they can be easily reached by everyone who is need of the services. On the other hand, accessibility to information means that people should be in a position to access any and all information in relation to health services. It also includes the right to seek and receive information on issues relating to health care.

[267] Commentary 12.

[268] A. B. Morrison, 'The World Health Organization And "Health For All', (1985) Health Affairs Volume 4 Issue 1 at page 102.

[269] Ibid

[270]Gruskin S et all, 'Rights-based approaches to health policies and programs: Articulations, ambiguities, and assessment', (2010) Journal of Public Health Policy Volume 31 Issue 2 at page 138.

accessing healthcare do not lead to negative effects such as impoverishment and poverty. [271] Economic accessibility is important in this study because financial ability has been identified as one of the determinants of the right to accessing healthcare.[272]

Economic insufficiencies have been identified as having affected Kenya's efforts towards realizing the right to accessing health care.[273] This is intertwined with Kenya's failure to raise sufficient revenue for the healthcare system despite being a signatory to the Abuja Declaration and Plan of Action which required countries to allocate at least 15% of its annual budget on healthcare.[274] Kenneth Munge et all have argued that it is important that governments, Kenya included, to raise sufficient revenue so as to overcome the challenges of economic accessibility. [275]

3.3. Governments' obligations in relation to access to healthcare.

When countries become state parties to various international treaties dealing with human rights, they are obligated to protect, promote, respect and fulfil the various human rights provided in the respective treaties.[276] General Comment Number 3[277] requires state parties to take all necessary measures to ensure that there is realization of the various rights provided in the various treaties and covenants. The steps to be taken are however not qualified and are not limited taking into account that different state parties have different characteristics and abilities.[278] The various steps and measures have been identified to include legislation, judicial remedies, policies, administrative, financial and education and social measures among others.[279] The measures to be

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[271] Commentary 12 of General Comment Number 14.

[272] Jean-Fredrick Levesque et all, 'Patient-centred access to health care: conceptualising access at the interface of health systems and populations', (2013) International Journal for Equity in Health, Volume 12, Article 13.

[273]Zollmann, J. & Ravishankar, N. (2016). Struggling to thrive: How Kenya's low-income families (try to) pay for healthcare. Nairobi, Kenya: FSD Kenya

[274] Njuguna David and Pepela Wanjala, Policy Brief on 'A Case for Increasing Public Investments in Health Raising Public Commitments to Kenya's Health Sector' Ministry of Health, 2017.

[275] Kenneth Munge et all, 'The progressivity of health-care financing in Kenya' (2014) Health Policy and Planning, Volume 29, Issue 7 at page 912.

[276] Stephen P. Marks, 'Emergence and Scope of the Right to Health' in José M. Zuniga,Stephen P. Marks, and Lawrence O. Gostin 'Advancing the Human Right to Health', (2013) Oxford University Press.

[277] CESCR General Comment No. 3: The Nature of States Parties' Obligations (Art. 2, Para. 1, of the Covenant)

[278] Stephen Marks, Supra.

[279] Stephen Marks, Supra.

undertaken ought to be cross-cutting for purposes of ensuring that there is equity and non-discrimination in accessing healthcare in the context of income inequalities.[280]

The measures to be adopted are geared towards ensuring the progressive realization of the various rights, including the right to the highest standard of health.[281] Progressive realization of human rights is a concept that allows for gradual realization of human rights due to various factors such as economic resources and time. [282] The Supreme Court of Kenya has held that the term progressive realization refers to the 'gradual or phased-out attainment of a goal.'[283] It is a recognition that some human rights may not be achievable immediately but rather over time in the context of the real situations in the world such as vulnerability and marginalization of certain societies.[284] The convention does not however limit the measures to be taken by the state parties. This does not however take away state parties' obligations at ensuring the implementation of the core minimum elements of the right to health.[285]

General Comment 14 makes various recommendations for purposes of promoting access to health care.[286] It urges State parties to ensure that the core elements of the right to health, which include accessibility in all its forms, are fully implemented notwithstanding any other measures undertaken by a country.[287] In particular, it requires State parties to take measures to ensure that the services are affordable and accessible without any form of discrimination and that the marginalized of the society are not further burdened by the costs.[288] Where services become affordable, it alleviates

[280]StefanicaIlinca et all, 'Socio-economic inequality and inequity in use of health care services in Kenya: evidence from the fourth Kenya household health expenditure and utilization survey', (2019) International Journal for Health and Equity, Volume 18 at page 196.
[281] Article 2 of ICESCR.
[282] Katharine G. Young. "Waiting for Rights: Progressive Realization and Lost Time."The Future of Economic and Social Rights, KatharineG. Young, ed., Cambridge University Press(2019) at page 1
[283] In the Matter of the Principle of Gender Representation in the National Assembly and the Senate [2012] eKLR.
[284] Commentary 9 of General Comment Number 3
[285] Colleen M. Flood and Aeyal Gross, 'Introduction: Marrying Human Rights and Health Care Systems Contexts for a Power to Improve Access and Equity' in 'The Right to Health at the Public/Private Divide: A Global Comparative Study', (2014) Cambridge University Press at page 1-16.
[286] Alicia Yamin, 'The Right to Health Under International Law and its Relevance to the United States,'(2005) 95 American Journal of Public Health, at page 1157
[287] Colleen M. Flood and Aeyal Gross, Supra.
[288] Alicia Yamin, Supra.

the burden of costs on the poor thereby promoting access to health care. .[289] The focus on the vulnerable in the society and the provision of the basic and essential services has been argued to be a positive step towards enhancing economic accessibility. [290] Other measures include granting of subsidies, reduction of user fees, increase the transparency in the costing and pricing of services[291] and the introduction of equity in access through universal health coverage.[292] Universal health care demands that access to healthcare should not be limited by financial burdens.[293] Kenya has prioritized universal health coverage through the National Health Insurance Fund.[294]

In a system where prices of health care services are dependent on the market, States are required to correct market failures by taking measures such as regulating the prices. .[295] It has been argued that regulation is necessary because markets have not managed to control the costs of healthcare thereby limiting access.[296] Without regulation, the market can lead to not only an increase in prices but also other vices such as discrimination and stratification of the society which Elizabeth Anderson has argued that they lower human dignity.[297] This study has argued that the regulation may facilitate the right to accessing healthcare thereby enabling the country better realize the right

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289 Vincent Okungu, 'The cost of free health care for all Kenyans: assessing the financial sustainability of contributory and non-contributory financing mechanisms', (2017) International Journal for Equity in Health, Volume 16 at page 39.

290 Lisa Forman et all. 'What Do Core Obligations under the Right to Health Bring to Universal Health Coverage?', (2016) Health and Human Rights, Volume 18 (2) at page 22-34.

291 Matt Kukla et all, 'The effect of costs on Kenyan households' demand for medical care: why time and distance matter' (2017) Health Policy Plan, Volume 32 Issue 10 at page 1397-1406.

292 Universal Health Coverage was adopted through a resolution of the United Nations General Assembly which recognized the importance of access in promoting the right to health. The resolution provides that 'All people have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative and rehabilitative basic health services and essential, safe, affordable, effective and quality medicines, while ensuring that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor, vulnerable and marginalized segments of the population.'

293 Valerie Obare et all, 'Indicators for Universal Health Coverage: can Kenya comply with the proposed post-2015 monitoring recommendations?', (2014) International Journal of Equity and Health, Volume 13 Issue 123 at page 1-15.

294Rahab Mbau et all, 'Examining purchasing reforms towards universal health coverage by the National Health Insurance Fund in Kenya', (2020) International Journal for Equity in Health, Volume 19 Issue 19 at page 1-18.

295 Robert Murray, 'Setting Hospital Rates to Control Costs and Boost Quality: The Maryland Experience', (2009) Health Affairs Journal, Volume 28 Issue 5 at page 1397.

296 Clarke Havingghurst,'Health Care Cost Containment Regulation: Prospects and an Alternative,'(1977) American Journal of Law and Medicine Volume 3 at page 309 to 322.

297 Elizabeth Anderson, 'Why some things should not be for sale: The moral limits of markets Debra Satz', (2012) New Political Economy Volume 17 Issue 2 at page 239-242.

to health as mandated under the International Covenant on Economic and Social Cultural Rights. It is thus necessary to examine Kenya's regulatory and policy framework regarding access to health care.

3.4. Kenya's regulatory and policy framework for the right to access.

As the main duty bearer, the government is under an obligation to undertake cross-cutting measures for purposes of ensuring that there is no discrimination in accessing health care.[298] The various measures which have recommended include enactment of legislation and policies . This section sets to detail the various legislative and policy measures that Kenya has undertaken in fulfilling its obligations.

3.4.1 Legislation

General Comment Number 14[299] and the International Covenant on Economic and Social Cultural Rights[300] have recommended the use of regulation for purposes of protecting the right to health. In undertaking this recommendation, Kenya has adopted a regulatory framework which consists of international and domestic law which is discussed below.

3.4.2 International law.

The application of international law in Kenya is pursuant to the Constitution which provides that the general rules of international law and international conventions that have been ratified by Kenya form part of Kenyan law.[301] The application of international law does not require the enactment of domestic legislation to make it operational.[302]

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[298]Stefania Ilinca et all, 'Socio-economic inequality and inequity in use of health care services in Kenya: evidence from the fourth Kenya household health expenditure and utilization survey', (2019) International Journal for Health and Equity, Volume 18 at page 196.

[299] Comment Number 35.

[300] Article 2.

[301] Article 2(5) and 2(6) of the Constitution.

[302] Tom Kabau and OsogoAmabni, 'The 2010 Constitution and the Application of International Law in Kenya: A Case of Migration to Monism or Regression to Dualism?' (2013) African Nazarene University Law Journal, at page 36.

Kenya has promoted access to health care by ratifying various international and regional legal instruments. Under the African Charter on Human and Peoples Rights, Kenya undertook to take legislative and non-legislative measures[303] in promoting the right to healthcare which is provided in Article 16 (1) of the Charter. Kenya also undertook to take measures to promote the health of the people and to ensure that medical attention was given to the sick.[304]

Kenya is a state party to the International Covenant on Economic, Social and Cultural Rights which requires it to take all necessary measure to ensure the progressive realization of the right to health. Kenya ratified the treaty on 1st May 1972. In the context of this study, the treaty requires Kenya to among others, eliminate discrimination in the access to health care. As a result, Kenya required to ensure that access to healthcare is provided to all person without discrimination due to financial inequalities, lack of resources or other socio-economic factors.[305] A mechanism adopted is the introduction of universal health care[306] which recognizes that poverty has been a hindrance to accessing healthcare and which has sought to promote more affordable healthcare.[307]

There are other treaties which Kenya has ratified which relate to the right to health. These include the Convention on the Elimination of all Forms of Discrimination Against Women, the Convention on the Rights of the Child, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Convention on the Rights of Persons with Disabilities, the International Covenant on Civil and Political Rights and the International Convention on the Elimination of all forms of Racial Discrimination. As a member of the United Nations, Kenya is also bound by the provisions of the Universal Declaration of Human Rights and the various decisions made by

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[303] Article 1

[304] Article 16 (2), Article 18.

[305] Other obligations specific to health care include to take steps to ensure the reduction of infant mortality, right of children to a healthy development, improvement of environmental and industrial hygiene and the provision of duction of the stillbirth-rate and of infant mortality, healthy development of the child, the improvement of all aspects of environmental and industrial hygiene, the prevention, treatment and control of epidemic, endemic, occupational and other diseases and the creation of conditions which would assure to all medical service and medical attention in the event of sickness.

[306] Government of Kenya, Ministry of Medical Services, 'MMS Sessional Paper No 7 of 2012 on the Policy on Universal Health Coverage in Kenya', Available at <https://academia-ke.org/library/download/mms-sessional-paper-no-7-of-2012-on-the-policy-on-universal-health-coverage-in-kenya/ > (Accessed on 26th July 2020).

[307] Timothy Chrispinus Okech et all, 'Analysis of Universal Health Coverage and Equity on Health Care in Kenya' (2016) Global Journal of Health Science Volume 8 Issue 7 at pages 218-227.

international bodies dealing with health such as the World Health Organisation. The Universal Declaration of Human Rights introduced the right to health under Article 25 which recognizes that every human being is entitled to a standard of living adequate for himself and his family, medical care included.

3.4.3. The Constitution

The Constitution was promulgated on 27th August 2010. The Constitution of Kenya Review Commission noted that Kenya had faced various human rights violations and that the country ranked poorly in access to health care due to various factors such as poverty.[308] This was despite the country having signed various treaties dealing with the right to health. As such, there was a need to provide the protection of healthcare during the review of the Constitution.[309] The Constitution now provides for the right to health among other socio-economic and cultural rights at Article 43. It is possible that the failure to recognize health as a right in the Constitution led to the challenges.

Access to health care has been constitutionalized under Article 43 which recognizes 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. The right also includes an entitlement to not to be denied emergency medical treatment. Article 43 does not however provide a mechanism for the implementation of the right which may pose a challenge on its enforcement.[310] Oduor and Simiyu have argued that whereas the Constitution has recognized the right to healthcare, Kenyans have continued being denied emergency medical due to inability to afford the high costs of admission.[311] This calls into question the efficacy of the Constitution in protecting the right to health.

To secure sufficient resources for healthcare and other socio-economic rights, the government is required to observe equity and give priority to the vulnerable groups in the society.[312] The country

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[308] Constitution Review of Kenya Commission Ibid, at page 56.
[309] Ibid.
[310] Faith Simiyu et all, 'Constitutional approach to Devolved Governance as Building Block of the Right to Health in Kenya', (2019) The Law Society of Kenya Journal, Volume 15 Issue 1 at page 135-166.
[311] Maurice Oduor and Ben Simiyu, 'The Right to Emergency Medical Treatment in Kenya', Available at <https://ssrn.com/abstract=2695134> (Accessed on 25th July 2020).
[312] Article 20 (5).

has also taken a progressive approach towards the realization of the right to health in the context of its fundamental duty to ensure the realization of the human rights.[313] This is in line with General Comment Number 3 and 14 which recognize that resources may not be sufficient due to the realities of different countries. Where there is an allegation of inadequate resources, the government has the obligation to show that resources are not available and that in the allocation of resources that are available, it has given priority to ensure the widest enjoyment of the right while having regard to all prevailing circumstances. [314] This provision is however open to abuse since it leaves the onus of proof on the government while at the same time seeking the implementation on the government. The government can use this provision to allocate resources to other undeserving purposes or even divert funds meant for health care which is a prevalent problem identified by the Auditor General.[315]

3.4.1.3. Statutes

Other than the Constitution, Kenya has enacted various statutes which facilitate access to healthcare. Kenya did not have a substantive statute dealing with the right to health prior to the enactment of the Health Act[316] which came into effect in 2017. This was 7 years after the promulgation of the Constitution which had already provided for the right to health as a substantive right. During the Health Bill debate in Parliament, it was noted that Kenyans continued to suffer prejudice in accessing health care and as a result, it was necessary that the Bill be passed into law.[317]

The preamble of the Health Act identifies the regulation of health care services and the coordination between the national and the county governments in providing health care as some of the purposes of the Act. As argued by Posner,[318] regulation plays a key role of facilitating the

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[313] Article 21 (2).
[314]LucoNjagi& 21 others v Ministry of Health & 2 Others [2015] eKLR.
[315] Government of Kenya, The Report of the Auditor General in the Financial Statements of National Government for the year 2015/2016, Government of Kenya.
[316] Act No. 21 of 2017
[317] The Kenya Parliament Hansard of 10th November 2015 which is available at <http://info.mzalendo.com/hansard/sitting/national_assembly/2015-11-10-14-30-00> (Accessed on 21st April 2019).
[318] Richard A. Posner, "The Regulation of the Market in Adoptions," (1987) Boston University Law Review at Page 59.

running of the market considering that health care in Kenya has also been treated as a commodity. [319]

Section 3 of the Health Act recognized the principles of equity and the progressive realization of the right to health. This is important since social inequalities have been described as having contributed to limitations on access. [320] The Health Act makes it an obligation of the national government to ensure equitable access to healthcare for all Kenyans.[321] The government is further required to ensure the health and well-being of all persons, ensure adequate investment, ensuring equity in provision and access to health care services to the vulnerable and special groups in the society and ensuring that services are provided at all levels of the health system. This is important since access to healthcare in Kenya has been facilitated mostly by the government since independence.[322]

In the context of privatization, the Health Act recognises that the private sector and the government sector play a key role of complementing each other. [323] It does not however provide for the regulation of costs which this study has argued creates an avenue for limiting access. The only focus is about the costs of accessing services at a public facility which costs are to be determined by the Cabinet Secretary in charge of health.[324]

Towards reducing the financial burden of costs of accessing healthcare, Kenya enacted the National Health Insurance Fund Act[325] which provides for the establishment of the National Health Insurance Fund which is a contributory insurance scheme. The raising of revenue for the fund is though pooling of resources contributed by employers, employees, self-employed people and the

[319] Ezekiel MbithaMwenzwa et all, 'The Oscillating State's Role in the Provision of Social Welfare Services in Kenya' (2016) International Journal of Humanities and Social Science, Volume 6 Issue 5 at page 119.
[320] Ezekiel Mbitha Mwenzwa et all, 'The Oscillating State's Role in the Provision of Social Welfare Services in Kenya' (2016) International Journal of Humanities and Social Science, Volume 6 Issue 5 at page 119.
[321] Section 15.
[322] David Collins et all, 'The fall and rise of cost sharing in Kenya: The impact of phased implementation', (1996) Health policy and Planning, Volume 11 Issue 1 at pages 52-63.
[323] Section 88 of the Health Act.
[324] Section 112.
[325] Act No. 9 of 1998.

government.[326] The core mandate of the fund is to provide accessible, affordable, sustainable and quality health insurance to all adult Kenyans. The fund performs a critical function of easing the burden of costs and promoting universal health coverage thereby promoting access to health care.[327] The various reforms which have been introduced in the National Health Insurance Fund such as the civil servants scheme, subsidies for the poor and the increased reimbursement rates resulted in greater access to groups such as pregnant women and the vulnerable in the society.[328] The Health Act has also noted that the financing of healthcare is important and as a result, it has provided for various mechanisms aimed at ensuring that there is progressive financing. These include having coordination between the central government and the county governments, development of a national health insurance system and cost sharing mechanisms.[329]

Whereas this section has focused on the statutes mentioned above, there are other domestic laws in operation in Kenya and which seek to promote access to healthcare with target to specific groups. These include the Persons with Disabilities Act,[330] Children's Act,[331] and the Persons deprived of Liberty Act[332] among others. These, together with other legal provisions enhance the protection of the right to health and signify the intention of the government to ensure the realization of the right to health.

3.4.4. Policies

Section 86 of the Health Act mandates the Department of Health to develop policies and strategies that seek to promote universal health coverage in Kenya. Kenya has established various policies relating to the right to health and promoting access to healthcare. These policies are designed to

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[326] Kenneth Munge et all, 'A Critical Analysis of Purchasing Arrangements in Kenya: The Case of the National Health Insurance Fund', (2018) Internal Journal of Health and Policy Management, Volume 7 (3) pp 244-254.
[327]EdwineBarasa et all 'Kenya National Health Insurance Fund Reforms: Implications and Lessons for Universal Health Coverage', (2018) Health Systems & Reform Volume 4 Issue 4 at page 346.
[328] National Health Insurance Fund Performance Report 2018 available at <http://www.nhif.or.ke/> (Accessed on 11th April 2019).
[329] Section 86.
[330] Section 10 recognizes that persons with disabilities are entitled to access to healthcare at a reasonable cost.
[331] Under Section 9, the government and parents are responsible for the right to health of a child.
[332] Under Section 15, persons who have been detained are entitled to have access to medical examination and treatment notwithstanding their detention.

focus on specific areas such as financing, affordability, human rights and standards among others. This section will consider a few of the policies and how they are geared towards access to healthcare.

Through Sessional Paper Number 10 of 1965, the government had noted that there was need to increase the number of hospitals and health centres.[333] It advocates for the government as the main provider of social goods including health services but noted that this could not be provided freely.[334] This was a change from the idea at independence of providing free health care for everyone. [335] Other than this Kenya also sought to change its approach with the introduction of the various plans over time which have focused on reforming the health sector for purposes of enhancing the right to health.[336] The National Health Sector Strategic Plan 1999-2004 intended to reform health acre through provision of increased reproductive health care services[337] while the National Health Sector Strategic Plan 2005-2010 aimed to guide donors in their participating in the health sector.[338] Sessional Paper Number 7 of 2012[339] focuses on affordable health care to everyone. It recognises that the lack of finances and poverty in Kenya are barriers to accessing healthcare and that there is need to provide health care that is equitable, affordable and of good quality.[340] The Kenya Health Policy 2014-2030 was further developed to focus universal health care. [341] The policy is being implemented through the National Health Insurance Fund which has

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[333] Government of Kenya, 'African Socialism and its Application to Planning in Kenya', Sessional Paper Number 10 of 1965.
[334] Ibid.
[335] Kenneth Munge et all, 'A Critical Analysis of Purchasing Arrangements in Kenya: The Case of the National Health Insurance Fund', (2018) Internal Journal of Health and Policy Management, Volume 7 Issue 3 at page 244-254.
[336] Steffen Flessa et all, 'Basing care reforms on evidence: The Kenya health sector costing model' (2011) BMC Health Services Research, Volume 11 at page 128.
[337] Ibid
[338] Anna H Glenngård, 'Policies in the Kenyan Health care sector– Why are they so difficult to implement?', (2005) SIDA, Available at <https://www.sida.se/English/publications/publicationsearch/> > (Accessed on 17th November 2020).
[339] Government of Kenya, Ministry of Medical Services, 'MMS Sessional Paper No 7 of 2012 on the Policy on Universal Health Coverage in Kenya', Available at <https://academia-ke.org/library/download/mms-sessional-paper-no-7-of-2012-on-the-policy-on-universal-health-coverage-in-kenya/ > (Accessed on 26th July 2020).
[340] Valerie Obare et all, 'Indicators for Universal Health Coverage: can Kenya comply with the proposed post-2015 monitoring recommendations?', (2014) International Journal of Equity and Health, Volume 13 Issue 123 at page 1-15.
[341] Ibid

several programmes running currently such as the Health Insurance Subsidy Programme which targets the vulnerable population [342] and the free maternity program labelled ‘Linda Mama – BoreshaJamii’.[343] These programmes, among others, seek to increase the accessibility of health care to Kenyans through reducing the financial burden.

In addition, the policy has been designed in a way which seeks to introduce a human-rights approach by seeking to promote non-discrimination and fairness in provision of health care. This has also been replicated in the Kenya Health Sector Strategic and Investment Plan 2014-2108 which seeks to introduce a human rights-based approach to provision of healthcare while taking into account the important role of financing.[344] This study has argued that a human-rights based approach might be more suitable for purposes of promoting access to healthcare as opposed to a market based approach.

The Vision 2030 was launched as a mechanism for transforming Kenya into a middle-income country by the year 2030.[345] It identified the health sector as one of the crucial sectors towards this aspiration. It recognized that quality and affordable health care in Kenya is necessary for purposes of realizing the right to health.[346] Universal healthcare has also has been identified as one of the four pillars of the Big 4 Agenda in President Kenyatta’s administration.[347] With the focus on the vulnerable in the society and the provision of the basic and essential services, it has been posited

[342] National Health Insurance Fund Performance Report 2018 available at <http://www.nhif.or.ke/> (Accessed on 11th April 2019).
[343] Ibid.
[344]Laila Abdul Latif et all, ‘A Case Study on the Application of Human Rights Principles in Health Policy Making and Programming in Cherangany Sub County in Kenya’, (2017) Integrated Journal of Global Health, Volume 1 Issue 1 at page 1.
[345] This information is available at the Kenya Vision 2030 website at <http://vision2030.go.ke/> (Accessed on 9th July 2018).
[346] Agnes W. Kibui, ‘Health Policies in Kenya and the New Constitution for Vision 2030’, (2015) International Journal of Scientific Research and Innovative Technology, Volume 2 Issue 1 at page 127.
[347] Rosalind McCollum et all, ‘Healthcare equity analysis: applying the Tanahashi model of health service coverage to community health systems following devolution in Kenya’, (2019) International Journal for Equity and Health, Volume 18 at page 65.

that it will lead to enhanced access to healthcare. [348] Further, by making services more affordable and easily accessible, it might reduce the burden of costs.[349]

The study has focused on the current policies in Kenya. The above policies do not reflect the entirety of all the policies that Kenya has established in its efforts to ensure that the right to accessing healthcare is better realized. The policies reflect the efforts by the government in an attempt at meeting its obligations. Kibui has argued that the various policies have not managed to fully resolve the limitation to access due to costs and that as a result, there is need for reforms including through regulation.[350] This notwithstanding, there have been some progress as a result of the implementation of the policies which include an increase in the number of the people insured,[351] reduced maternal deaths[352]and increase in access to healthcare in general.[353]

3.4.5. Devolution and access to health care

Kenya has a devolved form of governance comprised of the national and county governments. The two levels of government are required to work through coordination and consultation.[354] The national government is responsible for the national referral health facilities and the health policy of Kenya. On the other hand, the county governments are responsible for County health services, including, county health facilities and pharmacies and promotion of primary health care including others. They are also under an obligation to implement the national health policies developed by the national government.[355] This obligation means that they must enforce the various policies such

[348] Lisa Forman et all. 'What Do Core Obligations under the Right to Health Bring to Universal Health Coverage?', (2016) Health and Human Rights, Volume 18 Issue 2 at page 22-34.
[349] Vincent Okungu, 'The cost of free health care for all Kenyans: assessing the financial sustainability of contributory and non-contributory financing mechanisms', (2017) International Journal for Equity in Health, Volume 16 at page 39.
[350] Agnes W. Kibui, 'Health Policies in Kenya and the New Constitution for Vision 2030', (2015) International Journal of Scientific Research and Innovative Technology, Volume 2 Issue 1 at page 127
[351] Matt Kukla et all, 'The effect of costs on Kenyan households' demand for medical care: why time and distance matter' (2017) Health Policy Plan, Volume 32 Issue 10 at page 1397.
[352] P.B Gichangi and W.O Mwanda, 'Satisfaction with Delivery Services Offered under the Free Maternal Healthcare Policy in Kenyan Public Health Facilities', (2018) Journal of Environmental and Public Health.
[353] Matt Kukla, Supra.
[354] Article 6 of the Constitution.
[355] Joy Mauti et all, 'Kenya's Health in All Policies strategy: a policy analysis using Kingdon's multiple streams', (2019) Health Research Policy and Systems, Volume 17 Issue Number 15 at page 1-12.

as the Vision 2030, Universal Health Coverage and Kenya National Health Policy 2014-2030 identified above.

The Constitution recognized that the objectives of devolution include enhancing of access to services in counties.[356] The intention in decentralizing healthcare services to the county governments was to improve efficiency, promote equity and improve access.[357] This is in line with the recommendation by General Comment Number 14 on the taking of steps such as administrative steps. As a devolved function, it was thus expected that healthcare ought to be readily accessible due to devolution.[358] As a result of devolution, counties have reformed their health systems based on their peculiar circumstances.[359]

Rosalind has argued that devolution has been beneficial since it has resulted in an increase in the number of hospitals in the counties due to various reasons such as politicians urge to appease the voters who are promised access to health care among other social services.[360] The increase in the number of hospitals has reduced the transportation costs which would otherwise have been incurred in accessing further away facilities such as in the case of Bungoma County.[361] It has also seen a reduction of inequalities in the access to healthcare which had been experienced in the past.[362]Other benefits of devolution have included the provision of drugs within county hospitals

[356] Article 174.
[357] Benjamin Tsofa, Catherine Goodman, Lucy Gilson & Sassy Molyneux, 'Devolution and its Effects on Healthcare Workforce and Commodities Management- Early Implementation Experiences in Kilifi County, Kenya,' (2017) 16 International Journal of Equity Health at page 169
[358] Ibid.
[359] Leah Kimathi, 'Challenges of the Devolved Health Sector in Kenya: Teething Problems or Systemic Contradictions?' Africa Development, Volume XLII, No. 1, 2017 at pages 55-77.
[360] Rosalind McCollum et all, 'Priority setting for health in the context of devolution in Kenya: implications for health equity and community-based primary care', (2018) Health Policy and Planning, Volume 33, Issue 6, July 2018, Pages 729–742.
[361]Kipruto Arap Kirwa and Nicholas Letting, 'Factors influencing provision of health care in a devolved systment of government, Bungoma County, Kenya' (2017) Global Journal of Health Science Volume 2 Issue 3 at page 13-38.
[362] Rosalind, Supra.

which reduces the instances of patients having to purchase the drugs in private facilities which may be more costly.[363] In addition, it has led to lower costs of access of services.[364]

3.4.5. Judicial decisions and access to health care

The right to health has been litigated in several court cases with the courts upholding the right to health as provided in the constitution and international treaties.[365] In the case of Meme v The Permanent Secretary, Ministry of Health,[366] the High Court held that socio-economic rights are justiciable in Kenya and that Kenya has obligations to ensure the progressive realization of the socio-economic rights under international and domestic law. The court also observed that with the passage of time, it might no longer be justifiable to rely on the defence of progressive realization of the right to health since this might continue being a barrier to accessing health care. The Supreme Court of Kenya has recognized the applicability of the progressive realization of economic and social rights.[367]

In the case of LucoNjagi& 21 others v Ministry of Health & 2 others,[368] the petitioners prayed to have the costs incurred at a private facility settled by the government and in the alternative to have the costs subsidized to an equivalent amount which they would have paid at the Kenyatta National Hospital. Although the court did not find a violation of the Petitioner's rights, it acknowledged that the government had shown that it had limited resources and further that an ideal situation would be to have health care being provided at an affordable cost. It recognized the aspect of the government providing insurance cover as a solution to the high cost of health care. The detention of patients for failure to pay hospital bills has been held to be a violation to the right to human

[363] Rosalind McCollum et all, 'Healthcare equity analysis: applying the Tanahashi model of health service coverage to community health systems following devolution in Kenya', (2019) International Journal for Equity and Health, Volume 18 at page 65.
[364] Ibid
[365] Oloka Onyango, 'Beyond the rhetoric: Reinvigorating the struggle for economic and social rights in Africa', (1995) California Western International Law Journal, Volume 26 Issue Number 1 Article 3 at page 1-74.
[366] MMM v Permanent Secretary, Ministry of Education & 2 others [2013] eKLR.
[367] In the Matter of the Principle of Gender Representation in the National Assembly and the Senate [2012] eKLR.
[368] (2015) eKLR.

dignity and the freedom of the person and further that private entities are also bound to respect the right to health.[369]

One of the cases that was relied on by the court in the case of Luco Njagi and 21 others v Ministry of Healthand 2 others[370] is the South African case of Soobramoney –vs- Minister of Health Kwa Zulu Natal.**[371]** The case brought into issue various aspects relating to the right to health including the issue of costs, sustainability of health facilities on the one hand and the entitlement to the right to health on the other and which showcase the practicality of implementing the right to health in the real world where there are other socio-economic factors intertwined with the right to health. The court noted that the question of how to allocate funds was not be decided by the court but rather are issues to be determined by policy makers.**[372]** This is because a decision on such issues could have other far reaching implications on the economic and social aspects of the society which are outside the court's scope.

The difficulty of making such decisions also arose in the case of Mathew Okwanda v Minister of Health and Medical Services & 3 others[373] where the court held that such matters were issues to be dealt with by the policy makers. That notwithstanding, the High Court has in the case of JOO (also known as JM) v Attorney General & 6 others[374] ruled that the failure to implement policies relating to access to healthcare can lead to violation of the right to health. In the same case, the court held that the right to health includes the proper treatment in hospitals, availability of

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[369]Isaac Ngugi v Nairobi Hospital & 3 others (2013) eKLR.
[370] (2015) eKLR.
[371]1997 (12) BCLR 1696.
[372] The court borrowed a quote from R v Cambridge Health Authority in which the court held that 'I have no doubt that in a perfect world any treatment which a patient, or a patient's family, sought would be provided if doctors were willing to give it, no matter how much it cost, particularly when a life was potentially at stake. It would however, in my view, be shutting one's eyes to the real world if the court were to proceed on the basis that we do live in such a world. It is common knowledge that health authorities of all kinds are constantly pressed to make ends meet. They cannot pay their nurses as much as they would like; they cannot provide all the treatments they would like; they cannot purchase all the extremely expensive medical equipment they would like; they cannot carry out all the research they would like; they cannot build all the hospitals and specialist units they would like. Difficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients. That is not a judgment which the court can make.'
[373] (2013) eKLR.
[374] (2018) eKLR.

medicines, availability of medical facilities and quality healthcare which are central to access to healthcare.

3.5. Pricing and regulation of health care in Kenya

In the government facilities, the Cabinet Secretary in charge of health is required to formulate regulations fixing the prices and costs.[375] Kenya does not however have a law that regulates the costs of accessing health care. The Medical Practitioners and Dentists Act[376] provided guidelines and rules for the charging of fees by doctors and dentists in Kenya. The rules and guidelines provide the maximum fees to be charged on certain services and procedures. Notably though, they do not regulate the cost of drugs which are necessary in treatment. In addition, they do not refer to any other costs such as transport costs which are incurred by patients.

However, certain sectors have the process of goods regulated by the government through regulation. In energy, the Energy and Petroleum Regulatory Authority has the mandate of regulating the costs of fuel through the Energy (Petroleum Pricing) Regulations of 2010 while under the Price Control (Essential Goods) Act No.26 of 2011, the Cabinet Secretary of Agriculture, from time to time, has the power to declare goods to be essential commodities and set the maximum prices for such goods after consultation with the particular industry.

Clarke has argued that regulation of costs and price is necessary for purposes of controlling the cost of healthcare.[377] This argument has also been supported by Sarah Barber et all who have argued that the regulation of costs would involve providing different costs for various services areas so that the costs are not uniform for everyone.[378] This might however distort the functioning of the markets as argued by Langwell who is of the view that regulation may lead to closure of hospitals which are unable to reduce their costs or lead to poor quality of services.[379]

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[375] Section 112.

[376] Chapter 253 of the Laws of Kenya

[377] Clarke Havighurst, 'Health Care Cost Containment Regulation: Prospects and an Alternative' (1977) American Journal of Law and Medicine Volume 3 Issue Number 3 at page 310

[378] Sarah Barber et all, 'Price setting and price regulation in health care: lessons for advancing Universal Health Coverage', Available at <https://www.oecd.org/health/price-setting-and-price-regulation-in-health-care-ed3c16ff-en.htm> (Accessed on 26th July 2020).

[379] Kathryn Langwell 'Price controls: on the one hand ... and on the other', (1993) Health care financing review Volume 14 Issue Number 3 at page 5-10.

It has however been argued that the governments should focus on various ways of making health care affordable including regulation.[380] Naoki has argued that the action of the government setting a uniform payment for services has led to decreased costs thereby increasing access to services in Japan.[381] She however argues that this was not the sole action since the country adopted other policies which assisted the country including reimbursement of costs incurred by providers.[382]

In some countries such as Cuba, the country adopted a free for health policy and which was recognized in law with access to health care being incorporated in other social and economic policies.[383] The government of Seychelles has provided for free health care to its citizens and recognized free health care in its public institutions under its Constitution.[384] Seychelles has also adopted multisectoral approaches towards reforming access to health care including political commitment, investment in primary health care and effective public health institutions have greatly enabled the country improve its access to health care. [385] In Rwanda, the country introduced community based health insurance which aimed at increasing the number of people covered by universal access to health care.[386] However, it has been noted that it has been challenged by lack of political commitment and insufficient funding.[387] Due to insufficient funding, it is not possible to provide free health care.

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[380] Sarah Barber et all, 'Price setting and price regulation in health care: lessons for advancing Universal Health Coverage', Available at <https://www.oecd.org/health/price-setting-and-price-regulation-in-health-care-ed3c16ff-en.htm> (Accessed on 26th July 2020).
[381] Naoki Ikegami, 'Japanese Health Care: Low Cost Through Regulated Fees', (1991) Health Affairs, Volume 10 Issue Number 3 at page 87.
[382] Ibid.
[383] Wiliam Keck et all, 'The Curious Case of Cuba', (2004) American Journal of Public Health, Volume 102 Issue Number 8 at page e12.
[384] Article 29
[385] Netsanet Walelign et all, 'Who Needs Big Health Sector Reforms Anyway? Seychelles' Road to UHC Provides Lessons for Sub-Saharan Africa and Island Nations', (2018) Health Systems & Reform, Volume 4 Issue $ at pages 362-371.
[386] Médard Nyandekwe et all, 'Universal health insurance in Rwanda: major challenges and solutions for financial sustainability case study of Rwanda community-based health insurance part I, (2019) Pan-African Medical Journal, Volume 37 Issue Number 55 at page 1.
[387] Ibid.

The three countries being developing countries have adopted various ways of promoting access to health care. It is thus arguable that regulation of costs is not the only means towards attaining enhanced access to health care. This does not however mean that Kenya should not consider regulation of costs as one of the means of promoting access to health care. As such, Kenya should adopt an multisectoral approach that considers all aspects of access to health care with the aim of making health care more affordable, if not free like in the case of Cuba. This is considering that as a developing country, it already faces the problem of raising sufficient funds for universal access to health care.[388]

3.6. Conclusion

Prices, costs, and affordability are determinant factors in accessing health care and the general realization of the right to health. There is therefore a need to ensure that that these are well managed for purposes of promoting the right to accessing healthcare. Whereas Kenya has taken various steps to ensure is affordability, the country has continued to suffer prejudice in its attempt to realize the right to health. Whereas there is need to keep focusing on the progressive realization of the right to health, Kenya's efforts may be hampered if it does not take immediate steps to control the effects of costs. The Chapter has identified various ways such as the raising of sufficient funds, increased political will and provision of free health care. Whereas it is desirable that everyone has access to health care, this may not be possible to inequalities and in particular, the lack of sufficient funding of the health system which have hampered the implementation of court decisions dealing with access to health care and costs. [389]

With the role of the government being to protect, promote and fulfil the right to health, the foregoing brings into issue the efforts by Kenya in financing its health system as one of the steps to ensure the highest standard of health. It is in this context that the next chapter will discuss the financing of health in Kenya and its effects towards promoting access to health care.

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[388] Edwine W. Barasa et all, 'Assessing the impoverishing effects, and factors associated with the incidence of catastrophic health care payments in Kenya (2017) International Journal for Equity in Health, Volume 16 Issue 31 at pages 1-14.

[389] Peter Onyango Onyoyo, 'Understanding Enforceability Challenges Facing Equality Rights Under Art. 27 of the Constitution of the Republic of Kenya', (2014) Sociology and Anthropology Volume 2 Issue Number 5 at page 179-189.

CHAPTER 4

PROMOTING ACCESS TO HEALTH CARE THROUGH FINANCING

'Money is the mother's milk of health care'[390]

4.1 Introduction

Unaffordability of health care and the high costs of access may affect accessibility to health care.[391] In appreciating the importance of financing of health care, state parties to the International Covenant on Economic and Social Cultural Rights have been mandated to take economic and technical steps.[392] This chapter examines the importance of financing in accessing health care by patients. This is against the background of the negative effects of high costs of health care. It will also analyse how Kenya has over time raised revenue for the health sector and identify gaps how the revenue has been managed with the significant questions being whether the revenue raised has been sufficient and whether the revenue has been managed efficiently. The aim of the chapter is to answer the question on whether Kenya has taken sufficient economic steps towards promoting access to health care.

4.1.1 Financing of health care defined

Mills has defined the financing of health care as the raising of money for purposes of running a health system.[393] Schieber defines it as the way in which money for financing of health is raised and allocated within a health system. [394] According to the World Health Organisation, the financing of health means the 'function of a health system concerned with the mobilization,

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[390] William C. Hsiao, 'Why Is A Systemic View Of Health Financing Necessary?' (2007) Health Affairs Journal, Volume 26 Issue 5 pages 950-961.

[391] Clarke Havighurst, 'Health Care Cost Containment Regulation: Prospects and an Alternative' (1977) American Journal of Law and Medicine Volume 3 Issue Number 3 at page 310.

[392] Article 2 of the ICESCR.

[393] Mills A.J. and Ranson M.K. 'The design of health systems'. In: Merson M.H., Black R.E., Mills A.J.(editors). International public health - Diseases, Programmes, Systems, and Policies. Gaithersburg: Aspen Publishers. 2001 at page 515-557

[394] George Schieber et all, 'Health Systems in the 21st Century' In: Jamison DT, Breman JG, Measham AR, et al 'Disease Control Priorities in Developing Countries' (2006) 2nd Edition, The International Bank for Reconstruction and Development, Oxford University Press.

accumulation and allocation of money to cover the health needs of the people, individually and collectively.'[395]

Against this background therefore, a health system will be dependent on funds for its effective running and functioning. It will involve not only the raising of money but also the allocation of the funds within the health system. According to the World Health Organisation, the system should ensure that there are sufficient funds so that the people are protected from the negative effects of costs of health. [396] It can be deduced that the financing of health care involves the combined issues of raising revenue, the pooling of the revenue from the different sources, expenditure and allocation of the revenue collected within the health system.[397] The mismanagement and misallocation of revenue may hinder access through diversion of funds which may leads to delay in delivery of services, unavailability of services and an increase in costs.[398]

4.1.2. The role of finance in access to health care

Financing of health care ensures that there are sufficient funds to ensure that every one is able to access services.[399] This is in line with the obligation to ensure that those who do not have sufficient resources, such as the poor and the vulnerable, are able to access services without financial discrimination.[400] This is important taking into account that poor Kenyans have been subjected to

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[395] World Health Organization. 'The World health report, 2000. Health systems: Improving performance' Available at <http://www.who.int/whr/2000/en/whr00_en.pdf?ua=1> (Accessed on 12th September 2020).
[396] World Health Organization (WHO). Everybody's business-strengthening health systems to improve health outcomes: WHO's framework for action. Geneva: WHO; 2007. Available at <http://www.who.int/healthsystems/strategy/everybodys_business.pdf.> (Accessed on 13th September 2020).
[397] George Schieber et all, 'Health Systems in the 21st Century' In: Jamison DT, Breman JG, Measham AR, et al 'Disease Control Priorities in Developing Countries' (2006) 2nd Edition, The International Bank for Reconstruction and Development, Oxford University Press.
[398]Taryn Vian, 'Review of corruption in the health sector: theory, methods and interventions', (2008) Health Policy and Planning, Volume 23, Issue 2, pages 83–94.
[399] J. M. Kirigia et all, 'An overview of health financing patters and patterns and the way forward in the WHO African region', (2006) East African Medical Journal Volume 83 Issue No. 9 (Supplement) at page S1.
[400] Recommendation 19 of the General Comment Number 14.

further impoverishment and poverty as a result of high costs. .[401] Kenya has not been able to reduce the negative effect of costs as barriers to accessing health care costs. [402]

Financing has been considered a valuable tool in promoting the sustainability of a health system.[403] The provision of services comes with various costs such as purchase of equipment, drugs and payment of salaries for health workers among others. It is thus important to raise sufficient revenue not only for the access to health care but also for the sustainability of the health care system and the services provided.[404] In the wake of the Covid-19 pandemic, the Kenya Medical Research Institute has noted that it is important that a good financing system be established for purposes of ensuring that the pandemic does not result in a catastrophe in Kenya.[405] It is thus important that Kenya seriously considers the issue of financing of health care to achieve its ambition towards achieving the right to the highest attainable standard or health.

4.1.3 Characteristics of a good financing model.

Kirigia has argued that the system should raise sufficient revenue without causing unnecessary hardship while ensuring that costs do not become a barrier to accessing health care.[406] Carrin argues that the system should ensure that there is universal access to health care for everyone through promoting economic accessibility.[407] Moreover, it should be able to protect itself from the

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[401] Guy Carrin et all, 'Health financing reform in Kenya - Assessing the social health insurance proposal' (2007) South African Medical Journal Volume 97 Issue 2 at pages 130-135.
[402]Edwine Barasa et all, 'Assessing the impoverishing effects, and factors associated with the incidence of catastrophic health care payments in Kenya' (2017) International Journal for Equity in Health, Volume 16 Issue 31 at page 1-14.
[403]Liaropoulos Lycourgos et all, 'Health care financing and the sustainability of health systems', (2015) International Journal for Health and Equity at page 14-80.
[404] Ibid.
[405] Edwine Barasa et all, 'What Does it Cost to Treat a COVID-19 Patient in Kenya?', available at <https://kemri-wellcome.org/news/what-does-it-cost-to-treat-a-covid-19-patient-in-kenya/ > (Accessed on 14th September 2020).
[406] J. M. Kirigia et all, 'An overview of health financing patters and patterns and the way forward in the WHO African region', (2006) East African Medical Journal Volume 83 Issue No. 9 (Supplement) at page S1.
[407] Guy Carrin et all, 'Health financing reform in Kenya - Assessing the social health insurance proposal' (2007) South African Medical Journal Volume 97 Issue 2 at pages 130-135.

negative effects of neoliberalism [408] and should sustain itself.[409] Phua has opined that the financing of health care should incorporate the principles of good governance which include transparency, efficiency in the utilization of resources and accountability.[410]

4.2. Financing of health care in Kenya

The financing of health in Kenya is a combined effort by several stakeholders who include the government and other non-state actors. This section considers the various sources of financing of health care in Kenya where the government has remained the major financier of health care. [411]

4.2.1. Government

The government plays an important role in enhancing financial access to health care.[412] With the recognition of the right to health under the Constitution,[413] the government is mandated to provide sufficient resources for the progressive realization of the right to the highest attainable standard of health.[414] The expectation is that the government discharges its obligation to provide sufficient resources. Where resources are insufficient, the government is under an obligation to prove that

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[408]LycourgousLiaropoulos et all, 'Health care financing and the sustainability of health systems', (2015) International Journal for Equity in Health Volume 14 Issue No. 80 at page 1.

[409] Sarah Thomson et all, 'Addressing financial sustainability in health systems', World Health Organisation, Available at <http://www.euro.who.int/__data/assets/pdf_file/0005/64949/E93058.pdf> (Accessed on 18th March 2020).

[410]Phua Kai Hong, 'Governance Issues in Health Financing, (2017) Governance Issues in Health Financing', In: Quah, S.R. and Cockerham, W.C. The International Encyclopedia of Public Health, 2nd edition, Volume 3 Pp 330–341.

[411] David Collins et all, 'The fall and rise of cost sharing in Kenya: The impact of phased implementation', (1996) Health policy and Planning, Volume 11 Issue 1 at page 52-63.

[412] Japheth OsostiAwiti, 'Poverty and health care demand in Kenya', (2014) BMC Health Services Research Volume 14 at page 560.

[413] Article 43 (1) (a).

[414] Article 20 (5) (a).

resources are insufficient. [415] This is because the distribution of resources will also be dependent on the executive arm of the government.[416]

The government is also under an obligation to ensure the allocation of resources in a way that promotes the widest enjoyment of the right to health taking into account the vulnerable in the society such as the poor and marginalized.[417] Kenya is therefore under an obligation to ensure that the raising and allocation of funds promotes financial accessibility to health care.[418] In an attempt to do this, the Health Act has sought to protect the funds allocated to health care through restricting the appropriation of funds allocated for health care to any other purpose.[419] It has also recognized the necessity of cost sharing and cooperation between the county government and the national government. [420]

Financing of health in Kenya has over the years remained a responsibility of the government. [421] This is despite it being blamed for not having raised sufficient funds.[422] The revenue has been raised through taxation with the allocation being through the budget.[423] Kenya has over time adopted different approaches based on different factors over time. [424] The factors which have led to changes include budgetary constraints, [425]the changing government administrations and

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[415] The issue has arisen in several cases determined by the High Court including in the case of LucoNjagi& 21 others v Ministry of Health & 2 others [2015] eKLR, one of the issues for determination was whether the government had taken reasonable steps to ensure that it had provided adequate resources in the treatment of renal failure. The court in dismissing the suit noted that whereas the Petitioners had raised valid concerns with regard to affordability of renal failure treatment, the government had shown reasonable steps taken in provision of services.

[416] Peter Onyango Onyoyo, 'Understanding Enforceability Challenges Facing Equality Rights Under Art. 27 of the Constitution of the Republic of Kenya', (2014) Sociology and Anthropology Volume 2 Issue 5 at page 179-189.

[417] Article 20 (5).

[418] Recommendation 12 of General Comment Number 14.

[419] Part XII of the Health Act.

[420] Part XII of the Health Act.

[421] David Collins et all, 'The fall and rise of cost sharing in Kenya: The impact of phased implementation', (1996) Health policy and Planning, Volume 11 Issue 1 pages 52-63.

[422] Eric Tama et all, 'Examining the Implementation of the Free Maternity Services Policy in Kenya: A Mixed Methods Process Evaluation', (2018) International Journal of Health Policy and Management, Volume 7 Issue 7 pages 603-613.

[423] Ibid.

[424]Ibid.

[425] Ibid

changing poverty levels.[426] The different measures have been designed that services are available to the people under the varying circumstances.[427]

One of the main avenues through which Kenya has financed the provision of health is through the National Health Insurance Fund which was introduced in 1966.[428] The fund is funded by contributions from the government, employers and employees. The introduction of the fund also saw the withdrawal of fees which were being charged for accessing health services then. The introduction of the fund has assisted in reducing the impact of costs and increasing access to health care.[429] This has been through various policies including the Health Insurance Subsidy Programme which is a programme that targets the vulnerable population, the 'Linda Mama – Boresha Jamii' programme introduced in 2016 and Older Persons and Persons living with Severe Disabilities programme.[430]

The government has made efforts towards realization of universal health coverage which aims at increasing access to affordable health care while at the same time shielding them from the negative effects of costs.[431] It underscores the role of financing of the health system in ensuring that the poor in the Kenya are also able to afford and access health care services.[432] Rosalind has argued that the introduction of universal health coverage is aimed the promoting equity in accessing health care and the financial accessibility to health care. [433]Universal health coverage has been replicated

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[426] Richard Wamai 'The Kenya health System—Analysis of the situation and enduring challenges' (2009) Japan Medical Association Journal Volume 52 Issue 2 at page 134

[427] Reena Anthonyraj,'A health financing reform solution for Kenya: Expansion of National Health Insurance Fund (NHIF)', (2016) Global Journal of Medicine and Public Health Volume 5 Issue 4 at page 1-5.

[428] Timothy Abuya, 'Historical account of the national health insurance formulation in Kenya: experiences from the past decade', (2015) BMC Health Services Research, Volume 15 Issue 56 pages 1-11.

[429] Ibid.

[430] Republic of Kenya, 'Policy Brief: A Case for Increasing Public Investments in Health Raising Public Commitments to Kenya's Health Sector', available at <http://www.health.go.ke/wp-content/uploads/2019/01/Healthcare-financing-Policy-Brief.pdf > (Accessed on 10th November 2019).

[431] Government of Kenya, Ministry of Medical Services, 'MMS Sessional Paper No 7 of 2012 on the Policy on Universal Health Coverage in Kenya', Available at <https://academia-ke.org/library/download/mms-sessional-paper-no-7-of-2012-on-the-policy-on-universal-health-coverage-in-kenya/ > (Accessed on 26th July 2020).

[432] Ibid

[433]Rosalind McCollum et all, 'Healthcare equity analysis: applying the Tanahashi model of health service coverage to community health systems following devolution in Kenya', (2019) International Journal for Equity and Health, Volume 18 at page 65.

in various other policies as discussed in Chapter 3. At present, the provision of universal health care is one of the goals of the 'Big Four' agenda by Uhuru Kenyatta's administration.[434] These policies are aimed at increasing good governance in the allocation and management of revenue raised.[435] It is hoped that it will increase access to health care by provision of affordable health care to those who are disadvantaged or who cannot afford access medical care.[436]

Enhancing economic accessibility to health care has been devolved to the county governments.[437] County governments now have an obligation under Section 4 and 5 of the Health Act to ensure adequate financing. Jane Chuman et all have argued that county governments have made a positive contribution towards promoting financial access through allocations of funds in their budgets.[438] The allocation of revenue by counties differs from county to county with some allocating as little as 6.5% and others as high as 44.3%.[439] Phares Mugo et all have argued that whereas there are different allocations, there has generally been an increase in expenditure in health care with counties expending about 20% of their finances on health care.[440] In the financial year 2018/2019, county governments increased their provisions to health care by 27.2%.[441] This can be attributed to counties giving prominence to financing of their health systems.[442]

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434 Hellen Oka et all, 'Realizing the "Big Four"Agenda through Energy as an Enabler' (2018) Kenya Institute for Public Policy Research and Analysis Issue 9 Number 3.

435 Haradhan Kumar Mohajan, 'Improvement of the Health Sector in Kenya', American Journal of Public Health Research, 2014, Volume 2, Issue 4 Pp 159-169.

436 Jane Chuman and Vincent Okungu. "Viewing the Kenyan health system through an equity lens: implications for universal coverage." (2011) International journal for equity in health, Volume 10 Number 22 at pages 1-14.

437 Leah Kimathi, 'Challenges of the Devolved Health Sector in Kenya: Teething Problems or Systemic Contradictions?' Africa Development, Volume XLII, No. 1, 2017 at pages 55-77.

438 Jane Chuman, Supra.

439 Phares Mugo et all, 'An Assessment of Healthcare Delivery in Kenya under the Devolved System', (2018) Kenya Institute for Public Policy Research and Analysis, Sessional Paper No. 19, available at <https://kippra.or.ke/index.php/publications/category/3-publications-downloads>) (Accessed on 16th November 2020).

440 Ibid.

441 Government of Kenya, National and County Health Budget Analysis FY 2018/2019.

442 Phares Mugo et all, Supra.

The increased funding by county governments has resulted in the increase in the number of government hospitals,[443] a reduction on the costs of transport costs to hospitals due to reduced distances to the health facilities such as in the case of Bungoma,[444] reduction of inequalities in accessing health care in the rural areas,[445] introduction of affordable health care schemes such as in Makueni County which focused on old members of the society[446] and an increased demand for services due to lower costs of drugs and services in the county health facilities.[447] This signifies that devolution and finance have played a key role in enhancing access to affordable health care in Kenya.

The various approaches have had different effects in promoting the right to accessing health care. Cost sharing has been posited as a having assisted in sustainability of the health facilities considering the meagre resources available.[448] It has also been argued that the introduction of user fees bridged the gap exposed by insufficient funding from the government.[449] However, it has also been counter-argued that user fees reduces the number of people able to access the facilities especially the poor.[450] On the other hand, the withdrawal of charges such fees for maternity services has been argued to have led to an increase in access to health care in poor rural areas of Kenya. [451]

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[443] Rosalind McCollum et all, 'Priority setting for health in the context of devolution in Kenya: implications for health equity and community-based primary care', (2018) Health Policy and Planning, Volume 33, Issue 6, at, pages 729–742.

[444]Kipruto Arap Kirwa et all, 'Factors influencing provision of health care in a devolved systment of government, Bungoma County, Kenya' (2017) Global Journal of Health Science Volume 2, Issue 1, Number 3 at pages 13 – 38.

[445] Rosalind, Supra.

[446] Presentation by Kivutha Kibwana, County Universal Social Protection Coverage for All: A Case Study of Makueni County, Kenya, available at <https://spc.socialprotection.or.ke/.../Kivutha-Kibwana-County-Universal-Social-Protect..> (Accessed on 10th April 2019).

[447] Ibid

[448] Alfred Anangwe, 'Health sector reforms in kenya: User fees. Governing Health Systems in Africa' quoted in Reena Anthonyraj, 'A health financing reform solution for Kenya: Expansion of National Health Insurance Fund (NHIF)', (2016) Global Journal of Medicine and Public Health Volume 5 Issue 4 at pages 1-5.

[449] Eric Tama et all, 'Examining the Implementation of the Free Maternity Services Policy in Kenya: A Mixed Methods Process Evaluation', (2018) International Journal of Health Policy and Management, Volume 7 Issue 7 at pages 603-613.

[450] David Collins et all, 'The fall and rise of cost sharing in Kenya: The impact of phased implementation', (1996) Health policy and Planning, Volume 11 Issue 1 pages 52-63.

[451] Eric Tama et all, Supra.

4.2.2. Non-state actors

Other than the government, there are other non-state actors that play a crucial role of financing access to health care in Kenya. These include donors, private investors and patients who make payment to hospitals at the time of accessing services. These non-state actors have contributed to the growth of private health facilities spread in various parts of the country.[452]As at 2015, 46% of the health facilities in Kenya were government owned while the rest were either privately owned or owned by faith-based organisations.[453] Weldemariam et all have argued that commercial private hospitals, made possible through commodification and privatization, have been commended for playing an important role in enhancing the access to health care.[454] This has been through providing services which might otherwise not be available in the government facilities.[455] By doing so, they bridge the gap left by the government.

4.3. Sources of revenue for the health system in Kenya

The raising of revenue for purposes of health care in Kenya is through various means. These include the government, donors and other private sources such as patients making direct payments to hospitals at the time of accessing services.[456] Each of these has made a contribution towards have Kenya's efforts in enhancing access to health care and the better realization of the right to the highest attainable standard of health.

4.3.1. Government

The raising of revenue by the government is through taxation and levying of other payments.[457] The various types of taxes include the Income Tax, Capital Gains Tax, Stamp Duty Tax, Customs

[452]Haradhan Kumar Mohajan, 'Improvement of Health Sector in Kenya', (2014) American Journal of Public Health Research, Volume 2, Issue Number 4 at pages 159-169.
[453] Government of Kenya, Kenya National Health Accounts 2015/2016, Government of Kenya, 2017.
[454]Teklay Weldemariam et all, Health Service in Developing Countries: Does the Private Health Sector Contribute to Achieve Health-Related MDGs? A Systematic Review', (2015) A Journal of Immunology, Volume 5 Issue 3 at pages 7-13.
[455] Steffen Flessa et all, 'Basing care reforms on evidence: The Kenya health sector costing model' (2011) BMC Health Services Research, Volume 11 at page 128.
[456] Jane Chuman and Vincent Okungu. "Viewing the Kenyan health system through an equity lens: implications for universal coverage." (2011) International journal for equity in health, Volume 10 No 22 pp 1-14.
[457] Article 209 of the Constitution provides for the power to raise revenue by the national government and the county governments.

Tax and Value Added Tax among others. The allocation of revenue is through the annual budget. According to the Kenya National Health Accounts 2015/2016,[458] the total health expenditure in Kenya was Kshs. 346 Billion which was 5.2% of the country's Gross Domestic Product. In the financial year 2018/2019, the government accounted for at least 44% of the total health expenditure. [459] The government allocated the sum of Kshs. 207 Billion for health which was about 5.1% of its budget.[460] The county governments on the other hand increased their combined provisions by 27.2%. The increased allocation by the county governments has led to increased access to health care services and lower costs for accessing health care especially in rural areas in Kenya.[461] As part of its response to the Covid-19 pandemic management, the government put in place several economic measures such as tax reliefs, reduction of the rate of Value Added Tax, reduction of Pay as You Earn and allocated an additional Kshs. 10 Billion for purposes of supporting the vulnerable in the society.[462] The government also established a fund whose aim was to mobilise resources for dealing with the effects of the pandemic.[463]

4.3.2. Out-of-Pocket (Direct payments)

Out-of-Pocket represent the direct payments which patients pay at the time of accessing services.[464] They constitute savings, payment by employers on behalf of employees for insurance, personal payments for insurance and donations among others.[465] Some payments are made on the spot at the time of accessing services, while in other instances they are prepaid through insurance

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[458] Government of Kenya, Kenya National Health Accounts 2015/2016, Government of Kenya, 2017.

[459] Boniface Owino, 'Kenya's Covid-19 budget: Funding for health and welfare', Available at <https://devinit.org/resources/kenyas-covid-19-budget-funding-for-health-and-welfare/ > (Accessed on 13th September 2020).

[460] Government of Kenya, National and County Health Budget Analysis FY 2018/2019.

[461] Phares Mugo et all, Supra.

[462] KPMG, 'Kenya: Tax developments in response to COVID-19', Available at <https://home.kpmg/xx/en/home/insights/2020/04/kenya-tax-developments-in-response-to-covid-19.html> (Accessed on 13th September 2020).

[463] This information is available on the Kenya Covid-19 Fund website accessible at <https://www.kenyacovidfund.co.ke/ > (Accessed on 14th September 2020).

[464] Edwine W Barasa et all, 'Assessing the impoverishing effects, and factors associated with the incidence of catastrophic health care payments in Kenya', (2017) International Journal for Equity in Health, Volume 16 Issue No. 13 at Page 1.

[465] J. M. Kirigia et all, 'An overview of health financing patters and patterns and the way forward in the WHO African region', (2006) East African Medical Journal Volume 83 Issue No. 9 (Supplement) at page S1.

and sometimes even after patients have already accessed services.[466] The allow a patient to access services especially where health facilities demand payment before services can be provided. Out-of-Pocket has been deemed to be the main source of funds for health in low and middle-income countries such as Kenya owing to the increased use of user charges and fees in health facilities. [467] In Kenya, this mode has contributed immensely in financing of health with the government estimating the contribution to have been about 32.8% in the year 2015/2016.[468] This notwithstanding, the mode has been argued to be the biggest contributor towards impoverishment and limiting access to health care.[469] This is due to inability to afford the costs involved.[470]

4.3.3. Donors

Donor funding in Kenya has been extended to the health sector. It plays an important role of supplementing the government efforts and the direct payments. [471] In terms of expenditure on health, it is estimated that in the financial year 2015/2016, donors contributed 22% of the expenditure on health which was a drop from 32% in the financial year 2009/2010.[472] Donor participation takes various forms such direct funding of project budget support to governments, purchasing of drugs, equipment and provision of health care services to specific sectors such as improving the access to reproductive health for women.[473] Donor funds have also been utilized in payment of salaries and supporting community based health insurance schemes.[474] In Kenya, donors have supported various projects such as promoting access to reproductive health care for

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[466] Kenneth Munge et all, ‘A Critical Analysis of Purchasing Arrangements in Kenya: The Case of the National Health Insurance Fund’, (2018) Internal Journal of Health and Policy Management, Volume 7 (3) at page 244-254.
[467] Timothy Abuya, ‘Historical account of the national health insurance formulation in Kenya: experiences from the past decade’, (2015) BMC Health Services Research, Volume 15 Issue 56 at pages 1-11.
[468] Government of Kenya, Kenya National Health Accounts 2015/2016, Government of Kenya, 2017.
[469] Paola Salari et all, ‘The catastrophic and impoverishing effects of out-of-pocket healthcare payments in Kenya, 2018’, (2019) BMJ Global Health, Volume 4 Issue No. 6 at page 1.
[470] Ibid.
[471]Estele M. Sidze et all, ‘Reproductive health financing in Kenya: an analysis of national commitments, donor assistance, and the resources tracking process’ (2013) Journal of Reproductive Health Matters, Volume 21 Issue 42 at pages 139-150.
[472] Government of Kenya, Kenya National Health Accounts 2015/2016, Government of Kenya, 2017.
[473]Nabyonga Orem Juliet et all, ‘Can donor aid for health be effective in a poor country? Assessment of prerequisites for aid effectiveness in Uganda’, (2003) The Pan African Medical Journal, Volume 3 Issue 9.
[474] Jane Chuman et all. ‘Viewing the Kenyan health system through an equity lens: implications for universal coverage’ (2011) International journal for equity in health, Volume 10 Number 22 at page 1-14.

women.[475] In 2020, donors such as the World Food Programme have provided cash support for families in response to the Covid-19 pandemic.[476] Munge argues that donor funding is important because it reduces the reliance on direct payments which have become regresseive in nature leading to reduced access to health care.[477]

The various ways above have contributed to the increase in use of health services and increased access to health care in Kenya.[478] However, despite the positive progress, Kenya has continued facing challenges in the raising, management and allocation of the revenue.

4.4. Challenges facing Kenya's health finance model

Carrin has argued that Kenya has made progress in the financing of the health sector. [479] He however opines that there have been challenges which include mismanagement, theft of funds, appropriation, deviation and corruption among others.[480] The predecessor to the Ethics and Anti-Corruption Commission established that corruption and other forms of malfeasance have greatly contributed to the costs of health care as a result of intentional inflation by procurement entities and suppliers.[481] In the wake of the Covid-19 pandemic, there have been allegations that funds set aside and donations by donors have been stolen and cannot be accounted for.[482] Whereas there are

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475 Estele M. Sidze et all, 'Reproductive health financing in Kenya: an analysis of national commitments, donor assistance, and the resources tracking process', (2013) Journal of Reproductive Health Matters, Volume 21 Issue 42 at pages 139-150.

[476]World Food Programme, 'WFP supplements Government support to poor families in Kenya hit by COVID-19', available at <https://www.wfp.org/news/wfp-supplements-government-support-poor-families-kenya-hit-covid-19> (Accessed on 14th September 2020).

[477] Kenneth Munge et all, 'The progressivity of health-care financing in Kenya' (2014) Health Policy and Planning, Volume 29, Issue 7, at page 912-920.

[478]Haradhan Kumar Mohajan, 'Improvement of the Health Sector in Kenya', American Journal of Public Health Research, 2014, Volume 2, Issue 4 at pages 159-169.

[479] Guy Carrin et all, 'Health financing reform in Kenya - Assessing the social health insurance proposal' (2007) South African Medical Journal Volume 97 Issue 2 at pages 130-135.

[480] Ibid.

[481] Kenya Anti-Corruption Commission, 'Sectoral Perspectives on Corruption in Kenya: The Case of the Public Health Care Delivery', (2010) Available at <https://www.eacc.go.ke/wp-content/uploads/2018/09/health-report.pdf> (Accessed on 10th November 2019).

[482]Rose Achiego, 'Kenya's religious leaders call for accountability in the use of COVID-19 funds', available at <https://www.vaticannews.va/en/africa/news/2020-08/kenya-s-religious-leaders-call-for-accountability-in-the-use-of.html > (Accessed on 14th September 2020).

various challenges affecting Kenya's health system, this section will only analyse the ones that are directly related to financing, and access to health care in the context

4.4.1. Failure to raise sufficient revenue

Whereas the government of Kenya has over the years allocated money for the health system, the government has not managed to sufficiently raise sufficient revenue. [483] Moritz has argued that this inability has affected Kenya's obligations under the Abuja Declaration and Plan of Action in which it is supposed to allocate at least 15% allocation of its budget to health care. [484] This has mainly been due to inadequacy of resources.[485] On the other hand, donor funding has not been steady and has fluctuated over time.[486] Oketch has argued that decreased donor funding was as result of various factors including demands by donors such as privatization of government entities[487] while Wamai opines that donors haave in the past reduced their funding owing to political challenges in Kenya such as the push for democracy.[488] This has affected various projects which the government has taken together with the donors.[489] On the other hand, Out-of-Pocket has remained regressive and ineffective in raising revenue due to inability to raise sufficient funds on account of low incomes and poverty in Kenya.[490]

4.4.2 Failure to cushion Kenyans against the negative effects of costs

It has been argued that Kenya has not managed to cushion Kenyans against the negative effects of costs since it has not been able to raise sufficient revenue. [491] The failure to raise sufficient funds

[483] Kenneth Munge et all, 'The progressivity of health-care financing in Kenya' (2014) Health Policy and Planning, Volume 29, Issue 7, Pp 912-920.
[484] Moritz Piatti-Fünfkirchen et all, 'What Are Governments Spending on Health in Eastand Southern Africa?' (2018) Health Systems & Reform, Volume 4 Issue Number 4 at pages 284-299.
[485] Ibid.
[486] Jones Mobegi et all, 'Economic Environment and Performance of Donor Funded Health Projects in Kenya' (2019) Journal of Economics and Business, Volume 2, Issue Number 4 at pages 1118-1128.
[487] Timothy C. Okech, 'Empirical Analysis of Possible Alternative Sustainable Financing Options for Primary Health Care Services in Kenya', (2012) IOSR Journal of Pharmacy Volume 2, Issue 4 at pages 84-96.
[488] Richard Wamai, 'The Kenya health System—Analysis of the situation and enduring challenges' (2009) Japan Medical Association Journal Volume 52 Issue Number 2 at page 134.
[489] Jones Mobegi, Supra.
[490] Timothc C. Okech, Supra.
[491] Edwine W. Barasa et all, 'Assessing the impoverishing effects, and factors associated with the incidence of catastrophic health care payments in Kenya (2017) International Journal for Equity in Health, Volume 16 Issue 31 at pages 1-14.

has contributed to poverty and impoverishment due to the high costs of accessing health care.[492] It is estimated that in 2013, 6.2% of Kenyans who expended finances on health care were pushed into poverty.[493] In the 2013 Kenya Household Health Expenditure and Utilisation Survey, it was established that poor Kenyans were not able to access health insurance and inpatient services compared to the wealthy.[494] Kenyans have also been forced to seek lower quality services and self-diagnosis as a result of lack of funds.[495] This can have dangerous results such as wrong diagnosis, low and poor quality of services which can result to death.[496] In the case of Kenyatta National Hospital, a special audit report for the year 2012 (which was after coming into force of the constitution) showed that the hospital continued to detain patients because there was no way of ensuring that the bills were paid upon discharge.[497] The provision of essential services is also hampered with the insufficient funds. [498]

4.4.3 Failure to incorporate principles of good governance

The lack of good governance in the health system has been argued to be a contributor to disruption in delivery of health care services.[499] In China, Bebibei Yuan et all have argued that, good governance has contributed to increased access to health care in the rural areas in the country.[500] They further argue that through good governance, low and middle income countries can manage

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[492] Guy Carrin et all, 'Health financing reform in Kenya - Assessing the social health insurance proposal' (2007) South African Medical Journal Volume 97 Issue 2 at pages 130-135.
[493] Government of Kenya 'Kenya Household Health Expenditure and Utilisation Survey 2013', December 2014
[494] Government of Kenya, Ibid.
[495] Timothy C. Okech, 'Empirical Analysis of Possible Alternative Sustainable Financing Options for Primary Health Care Services in Kenya', (2012) IOSR Journal of Pharmacy Vol. 2, Issue 4 PP 84-96.
[496] Frank Kagema et all, 'Quality of Care for Prevention and Management of Common Maternal and Newborn Complications: Findings from a National Health Facility Survey in Kenya', (2016), Government of Kenya.
[497]Government of Kenya, 'Performance Audit Report of the Auditor-General Specialized Healthcare Delivery at Kenyatta National Hospital Waiting-time for Cancer, Renal and Heart Patients, Government of Kenya, 2012.
[498] Edwine W. Barasa, Supra.
[499] Reinhard Huss et all, Good governance and corruption in the health sector: lessons from the Karnataka experience', (2011) Health Policy and Planning, Volume 26, Issue 6 at pages 471–484
[500] Beibei Yuan et all, 'The role of health system governance in strengthening the rural health insurance system in China', (2017) International Journal for Equity in Health, Volume 16 Issue Number 44 at page 1.

to better develop their health systems. [501] Some of the principles which have been identified include accountability and inclusivity in decision making.[502]

Kenya has experienced corruption, diversion of funds, theft and flouting of procurement of laws.[503] In the Auditor General's audit report of the year 2015/2016, it was established that in one project, funds had been diverted to another ministry while several millions of shillings could not be accounted for.[504] The report also identified mismanagement of budgetary allocations by the government where there have been expenditures which are not supported by any documents.[505] There have also been cases of public officers who have been prosecuted of graft.[506]

The mismanagement of revenue and the lack of observance of good public finance principles has serious implications such as wastage of funds, delayed project and inadequate medical equipment.[507] These have a ripple effect of affecting Kenya negatively since they affect the provision and access to health care.[508]

4.4.4 Lack of coordination between the national and county governments

Kenya's Auditor General has noted that there has been lack of coordination between the national government and the county governments in matters related to financing. [509] This has also been observed by Kirwa who further argues that the lack of coordination leads to delay and

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[501] Ibid

[502] Rosalind McColum et all, Health system governance following devolution: comparing experiences of decentralisation in Kenya and Indonesia', (2018) BMJ Global Health, Volume 3, Issue Number 5.

[503] Taryn Vian, 'Review of corruption in the health sector: theory, methods and interventions', (2008) Health Policy and Planning, Volume 23, Issue 2, pages 83–94.

[504] Government of Kenya, The Report of the Auditor General in the Financial Statements of National Government for the year 2015/2016, Government of Kenya.

[505] Ibid

[506] Cases have been instituted against high ranking officials in the Ministry of health including Dr. Julius Meme and Davy Koech who held high offices in the Ministry of Health. See Kenya Anti-Corruption Commission v Davy Kiprotich Koech & another [2018] eKLR and Julius Meme v Republic & another [2004] eKLR.

[507] Taryn Vian, 'Review of corruption in the health sector: theory, methods and interventions', (2008) Health Policy and Planning, Volume 23, Issue 2, at pages 83–94.

[508] Ibid.

[509] Government of Kenya, The Report of the Auditor General in the Financial Statements of National Government for the year 2015/2016, Government of Kenya.

unavailability of services in the counties. [510] In other instances, it has led to lack of funds for paying workers in the county hospitals leading to strikes.[511] This lack of coordination, cooperation and wrangles has gone on despite the constitutional requirement for the two levels of government levels to cooperate.[512]

4.5 Conclusion

The debate about Kenya's right to accessing health care has elicited various tensions. During the review of the constitution, Kenyans had an aspiration for a decent life which included the fundamentals of a health care system.[513] Kenyans had had suffered economically and socially which had in turn affected their accessibility to certain basics such as health, food and shelter.[514] Some Kenyans advocated for free or subsidized health care services.[515] Pursuant to the recommendations made, Kenya introduced an elaborate Article 43 of the constitution which seeks to guarantee the a right to the highest attainable standard of health care.

For purposes of realizing the right to accessing health care, Kenya has adopted various commendable measures towards raising revenue and managing the revenue raised for the health system. The revenue raised has assisted the country in its efforts of achieving the progressive realization of the right to health care. This notwithstanding, Kenya has continued facing many challenges including the lack of sufficient resources and the mismanagement of revenue. even after the declaration of the Covid-19 pandemic.[516] These challenges have affected service delivery and economic access to health care.

Despite the various efforts that Kenya has undertaken in discharging its obligations towards the progressive realization of the right to health, there is more that the country needs to do. This is because the realization of the right to health is not only a matter of regulation. It puts into issue the

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[510]Kipruto Arap Kirwa et all, Supra.

[511]Irimu Ogero et all 'Tackling health professionals' strikes: an essential part of health system strengthening in Kenya', (2018) 3 (6) The BMJ Global Health .

[512] Article 189.

[513] Constitution of Kenya Review Commission Report at page 68.

[514] Ibid.

[515] Ibid.

[516] Edwine Barasa, 'Assessing the hospital surge capacity of the Kenyan health system in the face of the COVID-19 pandemic' (2020) Public Library of San Francisco Volume 5 Issue 17 at page 1.

question of whether there might be a need to undertake reforms which recognize the competing arguments regarding commodification and the role of markets in distribution of health care. This is important for purposes of determining how Kenya can best promote access to health care whether it is from a rights-based perspective, a free market perspective or a combined perspective.

CHAPTER 5

FINDINGS, RECOMMENDATIONS AND CONCLUSIONS

5.1 Introduction

This study set out to analyse Kenya's regulatory, policy and financial structure in the context of financial access to health care and costs of health care. It was necessitated by among others, the continued limitation to the right of access to health care owing to high costs notwithstanding the constitutional protection of the right to health. It was assumed that health can be accessed either as a commodity or as a human right. A further assumption was made that the high costs of health care due to market forces have a negative effect on access to health care. It was also assumed that the regulatory and policy framework is insufficient for purposes of enhancing access.

This chapter provides a summary of the key findings of the study together with various recommendations based on the findings.

5.2 Key findings

Arising from the analysis in the previous chapters, this study makes various findings relating to the access to health care and the realization of the right to the highest attainable standard of health in Kenya from a perspective of costs and financing.

5.2.1 The multifaceted nature of 'health'.

In Chapter 2, the study sought to answer the question whether health care is a human right or a commodity. It assumed that health care in Kenya has been treated as a commodity and as a human right. This question has been answered through the finding that health care is multifaceted owing to the congruence between the law and commodification. As a commodity, access to health care and its cost will be based on market factors while as a human right, the qualifying factor for access will be the fact that one is a human being. Since access to health care is affected by various socio-economic factors, the challenge should be how to promote the right to access to health care regardless of whether how it is treated.

5.2.2. Effect of costs on access to health care

The study formed the hypothesis that commodification leads to high costs of health care thereby becoming a barrier. The hypotheses will discussed in Chapters 2, 3 and 4. It established that markets have resulted in high costs of health care. These high costs have over time continued being barriers to the right to accessing health care to many Kenyans. The high costs of treatment have contributed to poverty, impoverishment and social inequalities. Kenya does not have a law that regulates regulate the costs of accessing health care like in some other sectors such as energy. Without regulation, access to health care, whether as a right or a commodity, continues being affected. This is notwithstanding the constitutional protection of the right to health in Kenya.

5.2.3 Flaws in Kenya's health financing model

Chapter 4 of the study sought to answer the question whether Kenya's structure has managed to cushion Kenyans against the negative effects of costs. Whereas Kenya has made efforts to raise, allocate and manage funds, the funds raised are insufficient for purposes of enabling universal access to health care. The revenue has further been mismanaged through diversion of funds, theft and lack of accountability among other forms of malfeasance. Political challenges between the central government and the county governments have further made it difficult for the model to be efficient. Whereas the Health Act has recognized crucial objectives for ensuring the right to health in relation to financing, the objectives have not been attained. For example, the emergency medical treatment fund has not been set up. The model has proven to be inadequate in promoting financial access to health care. This has contributed to the country's problem of realizing its right to health.

5.2.4 Inadequate regulatory and policy framework.

Chapter 3 analysed Kenya's regulatory and policy structure on access to health care for purposes of answering the question whether the structure is sufficient. It established that the country has put in in place laws and policies that promote constitutes of international and domestic legislation and policies. Whereas this has had positive effects, the right to access to health care has continued being limited by various factors such as poor implementation of the policies, lack of sufficient funds for the various policies, mismanagement and other neoliberal attributes including costs and desire to make profits by entrepreneurs.

5.3. Importance of the findings

The findings are useful in that they can form a basis for reform of Kenya's approach towards the right to access to health care. They can be utilized to develop policies geared towards a rights-based approach in access to health care regardless of commodification.

5.4. Recommendations.

Kenya requires to improve its regulatory, policy and finance structure regarding health care of it is to achieve the right to health. Whereas there are many recommendations that can be made, this study focuses on the following multisectoral approaches. Multisectoral approaches have been identified to have worked in Rwanda and Seychelles.

5.4.1 Regulation of costs

The reliance on markets as a basis for determining access to health care may lead to exploitation and discrimination in accessing health care. The negative effects may continue being aggravated by the lack of a price control mechanism. This study suggests that the various stakeholders should consider controlling the costs of health care through legislation or policy. The introduction of regulation would assist in removing inequalities and discrimination in access to health care as has already been noted by World Health Organisation. As was noted in the case of Japan where there is regulation on costs or in the case of Cuba where the law provides for free access to health care, this can lead to an improvement in access to health care. A further way which has been proposed is to have a maximum price of prices set and with the patient then being required to pay any amount that is above the maximum price. Additionally, it can be done through providing a fixed fee payable for services as was done in Japan. It should also consider the types of services which can be offered for free and where possible, the maximum costs for services.

5.4.2 Raising of sufficient revenue for the health system.

Kenya has not raised sufficient revenue for purposes of the health sector. Kenya's policy makers should review and redesign the financing model to ensure that it raises sufficient revenue. Efforts should be placed to achieve not only the minimum threshold of 15% under the Abuja Declaration and Plan of Action but should aim at providing revenue that protects everyone from the negative effects of costs. Towards this, effective tax collection methods and other methods of avoiding

wastage should be applied for purposes of increasing the overall available revenue for allocation. The government should take a purposive approach in providing an efficient health insurance system which is widely and readily available and affordable to all people. It should aim at increasing the number of people who contribute to the current National Health Insurance Fund. Diversification of the source of revenue should also be considered and reliance on out-of-pocket expenses should be discouraged. Where possible, those who can afford ought to be encouraged through civic education to take out private insurance to reduce the overreliance on the National Health Insurance Fund.

To decrease cases of people being denied emergency medical treatment, the implementation and financing of the emergency medical fund under Section 15 of the Health Act should be undertaken. With sufficient funding, the fund will ensure that private health facilities are compensated for provision of services provided as intended in the Health Act. This is taking into account that under the Health Act, the duty to provide emergency medical treatment also extends to private health facilities. This might motivate private health facilities since they will be able to meet their profit ambition while at the same time providing services. It should however be important that the fund is designed in a way that private health facilities do not take advantage of the reimbursement mechanisms through fictitious claims. If possible, the fund should also be diversified to provide for additional services and not just emergency medical treatment.

5.4.3 Improvement on good governance in the management of the health system.

Other than raising sufficient revenue, Kenya should introduce reforms which fully incorporate and implement the principles of good governance. This ensures that the revenue raised is efficiently allocated and managed. Those responsible for management of funds should be well trained not only on the management of revenue but also on the various principles of good governance. In addition, measures and policies aimed to preventing theft and siphoning of funds should be strengthened. The introduction of greater accountability and transparency may have a positive impact in increased donor funding which would lead to increased revenue.

5.4.4 Stricter penalties for malfeasance

Whereas the Health Act provides at Section 87 that funds allocated health care are not to be appropriated for any other purpose, it does not provide an offense for misappropriation. Rather, it provides a general penalty for an offense under the Health Act by imposing a fine of Kshs. 2 Million or a jail term not exceeding three months. With lengthy court processes and the minimal penalty, it is arguable that the system does not create a strong deterrence against malfeasance. Parliament should consider the introduction of stiffer penalties for all forms of malfeasance in the management of funds set aside for health care.

Further, Kenya can introduce more efficient recovery processes for funds stolen or misappropriated. Examples can be borrowed from the long jail terms and high fines which various Kenyan statutes have provided for offenses such as poaching, corruption and drug trafficking.

5.5 Suggestions for further research

This study did not involve going into the field to source data from various stakeholders in the health sector. It is thus possible it did not capture all the issues that it ought to have covered. Further research should be undertaken using a different approach in the collection of data. It is possible that the analysis of the data collected will support the key findings and conclusions or disprove the hypothesis of the study.

5.6 Conclusion

This study has established that neoliberal practices and high costs of accessing health care combined with insufficient funds have a negative effect to the right to economic accessibility to health care in Kenya. Whereas Kenya has put in place a robust system of laws and policies, they have not managed to alleviate the inability to access health owing to costs. Laws alone are thus not sufficient to guarantee economic accessibility to health care to everyone. This is because access to health care in Kenya is also affected by other extraneous factors such as costs, availability of funds and socio-economic inequalities in the population. There is therefore a need to strike a balance in order that neoliberal practices do not become hindrances to accessing health care. Whereas markets are important, they ought not be the primary determinants of accessing health care at the expense of human rights. The focus by the government should not solely be on

protecting the right to accessing health care but it should also protect commercial private health facilities which aim to make profits. Unless a balance is struck between the two opposing claims, Kenya's aspiration towards the better realization of the right to the highest attainable standard of health may be derailed. There is thus need to consider the regulation of costs of accessing health care.

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