Policy Brief

Financing Government's *'Cinderella'*

Establishing the needto mobilise additional sources of revenue to fund the Kenyan healthcare sector

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Abstract

Is health in Kenya adequately financed? Relatedly, is there a need for additional sources of revenue to fund health? The limited resources that are available to the Kenyan government are prioritised in the budget that earmarks how much is to be allocated to each public sector. Regrettably, health financing has been on a reducing scale and the government is considering ways to broaden its revenuebase for financing health. This policy brief picks up on the argument of limited resources and posits Islamic taxation as an alternative source of revenue potentially available to the Kenyan government for financinghealth. Scholars have considered the argument of limited resources from the lens of prioritisation – that is the need to make the best possible use of these limited resources to continually improve the well-being of society and increase the revenue in the long term. Other scholars have posited that the argument on limited resources is to be examined by inquiring into different ways by which the resource base can be increased. Among the latter scholars, many suggest an examination of the tax policy of a state to increase taxation. Tax increments place a higher burden on the poor and middle-income earners, and is thereforenot a persuasive approach to broadening the tax base.If the discourse on limited resources is to be analysed further from the scholarship on broadening the tax base then it is important to also address it from a different discipline, Islamic taxation.

1.0.Introduction

Article 43(1)(a) of the 2010 Kenyan Constitution provides for the right of every Kenyan to the highest attainable standard of health.[1] This right includes the right to healthcare services as well as a right to reproductive healthcare. Article 43(1)(a) is subject to progressive realisation and the availability of resources.[2] The minimum core content of the right to health has been described in the Kenya Health Policy 2014-2030 and the Kenya Health Sector Strategic and Investment Plan 2014-2018.[3] This policy has identified 12 health programs that sum up the entire health needs of the country.[4] They

[1] Republic of Kenya. The Constitution of Kenya, 2010. Nairobi: National Council for Law Reporting.

[2] Articles 20(5) and 21(2) of the Constitution of Kenya, 2010.

[3] Ministry of Health. 2014. Kenya Health Policy 2014-2030: Towards Attaining the Highest Standards of Health. Nairobi: Ministry of Health.

[4]These programs are; (i) child health and immunisation, (ii) environmental health, (iii) emergency care and blood safety, (iv) health promotion, (v) HIV and sexually transmitted infections, (vi) malaria, (vii) maternal, new-born and reproductive health, (viii) non-communicable diseases, (ix) neglected tropical diseases, (x) nutrition, (xi) other specialisations and (xii) tuberculosis.

[4] Perales, N., A. Dutta, and T. Maina. 2015. 'Resource Needs for the Kenya Health Sector Strategic and Investment Plan: Analysis Using the OneHealth Tool. Washington, DC: Futures Group, Health Policy Project.

are to be implemented in time bound stages. A recent study conducted by Perales, Dutta and Maina has estimated that the implementation of these programs will cost Kenya US$ 4,715,832,997.76 (Kshs 473 billion) over a five-year period. The study has also estimated that the Kenyan government will experience a shortfall of US$ 2,412,751,859.23 (Kshs 242 billion) in ensuring their implementation over the 2013-18 fiscal period.[5]The shortfall indicates that the financial resources for implementing the programs are limited. There may be a necessity to seek for new/alternative revenue sources for health financing.

The problem of limited health financing in Kenya is historical. During the early stages of Kenya's colonial rule between 1895 and 1924, spending on the health sector was limited and secondary to trade, extraction of raw materials, economic development, production of exportable goods, and defence spending.[6] Later, in 1924 the colonial administration set up the Local Native Councils[7] to levy local rates for financing welfare projects such as building hospitals, whereas the colonial administration continued to focus on political governance and trade while also training the natives as medical workers and on procuring essential medicines.[8]Public health financing remained limited to the major towns and cities whereas rural healthcare was restricted to local community financing.This led to regional imbalances in the delivery of healthcare services. These neglected rural areas lacked access to healthcare, medicines and healthcare workers. Finances were targeted towards growth rather than on social spending. This trend continued following independence, and the Kenyan government adopted a regressive model for health financing.[9]

The political justification in reducing health financing over the years is based on a notion of African Socialism[10] advanced through Sessional Paper No. 10 of 1965, which

[5] Perales, N., Dutta, A., and Maina, T. (2015). Resource Needs for the Kenya Health Sector Strategic and Investment Plan: Analysis Using the OneHealth Tool. Washington, DC: Futures Group, Health Policy Project.

[6] Latif, L.A. 2018. Framing the Argument to Broaden Kenya's Limited Fiscal Space for Health Financing by Introducing Zakat. Biomed J Sci & Tech Res 5(5). 2018 BJSTR.

[7] The Local Native Councils were comprised of the area chief and tribal rulers in each rural region within Kenya's 8 demarcated provinces. These Councils were established in 1924 and existed until independence in 1963. In 1954 the Councils were renamed as African District Councils. The Council pronounced decisions on disputes between natives, administered the district areas on behalf of the colonial administration and collected the hut and poll taxes from the natives. In addition it imposed levies for financing welfare or development projects. For more information see Ndege, G. 2001. Health, State and Society in Kenya: Faces of Contact and Change. USA: University of Rochester Press.

[8] Beck, A. 1970. A History of the British Medical Administration in East Africa, 1900-1950 (Cambridge: Harvard University Press); Ndege, G. 2001. Health, State and Society in Kenya: Faces of Contact and Change. USA: University of Rochester Press.

[9] After 1963, the Kenyan government embarked on an ambitious plan to provide free healthcare subject to availability of resources and economic growth. The provision of free healthcare was embarked upon without a fiscal framework to ensure its long-term sustainability. The health sector was subsequently swamped by demands for healthcare by the population and the government failed to match the finances required to the ever growing need for healthcare. This resulted in the government introducing user fees for public health facilities, which in the long run saw a reduction in the population that accessed public health facilities. This was due to the fact that the sick population were unable to pay for health services as a result of poverty. The removal of user fees coincided with the economic depression that resulted in the International Monetary Fund (IMF) requiring the Kenyan government to reduce spending on social services and focus on economic growth. This marked the beginning of the government reducing its spending on health.

[10] In 1965, the Kenya African National Union (KANU) government prepared Sessional Paper No. 10 on African Socialism and its Application to Planning in Kenya. This Paper summarised KANU's political

justifies reduction in spending on social services in favour of economic growth and development.[11]Kenya's colonial history alongside the political philosophy espoused as African Socialism adopted after independence in 1963 in so far as health financing is concerned has defined the fiscal health relationship between the state and the Kenyan society. This fiscal health relationship relegates spending on the health sector in favour of directing finances towards economic growth. Growth is seen as a driver of economic development and social progress. It is to take priority over the provision of social services such as health and education.[12] This means that thefiscal relationship between the Kenyan state and its citizens is defined by the available financial resources that make up the budget. This relationship in turn influences the availability and accessibility of social services whose provision is affected by either an increase or decrease in the budget. Such state-society relationship contingent on the budget describes the fiscal sociology within which the Kenyan state operates and attempts to meet its duties and legal obligations.

1.1.The Kenyan state-society relationship defining health finance

The Kenyan state's fiscal sociology is a mix of Smithian and Schumpeterian approach towards defining how the state financially relates with the society. Smith provides the maxims necessary to ensure a sound taxation/fiscal policy and imposes limits on the power of the state to tax, while Schumpeter linked the change in the revenue structure and tax types closely to the inherent changes in the state, its form and its needs.[13]The Kenyan budget and the revenue that constitutes it, is subject to Smiths' proportionality maxim. The budget will reflect what the revenue authority is able to collect from the tax payers in proportion to their sources of income. The budget is also subject to Smiths' maxims on predictability, efficiency and convenience in the payment and collection ofother taxes (such as VAT, transactions tax), excise, duties, rates and levies. These collate to generate the redistribution capacity of the government towards social services and on their spending.

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ideology and guided government policy on development, including health. The paper outlined the framework for economic development and social progress for the newly independent nation. It described African socialism as a political and economic system that is based upon the African tradition of mutual social responsibility. This means that the State accepts to take upon itself the responsibilities for social services and recognises the reciprocal response of society's contribution as a group and as individual members. This reciprocal response automatically results through the payment of taxes, which are then redistributed by the State towards the provision of social services. Okoth Ogendo categorised African Socialism as a mere political tool coined by the first President Jomo Kenyatta in order to advance his policy on the centralisation of the State and to promote a cohesive spirit of nationalism in light of the calls for secession that followed independence. Barrack Obama Snr and Dharam Ghai critiqued the Sessional Paper for being neither African nor socialist enough. Atieno Odhiambo argued that African socialism was an endorsement of the capitalist approach that was favoured by the British and President Kenyatta when negotiating independence. This is because the concept of the State taking upon itself responsibilities for social services was secondary to economic growth.

[11] Sessional Paper No. 10 of 1965: African Socialism and Its Application to Planning in Kenya. Nairobi: Government Printed, 1965

[12] Sessional Paper No. 10 of 1965: African Socialism and Its Application to Planning in Kenya. Nairobi: Government Printed, 1965.

[13] Schumpeter, J. 1950. Capitalism, Socialism and Democracy, 3rd ed., New York. This argument was earlier made by Ibn Khaldun, The Muqaddimah: An Introduction to History. Trans. by Franz Rosenthal. Princeton University Press, 1967.

Schumpeter postulated the nexus between the state and the revenue structures. According to him, the two are closely related. The form of a state will dictate its revenue structure.[14]This consequently, will define the fiscal relationship that then emerges between the state, its revenue structure and redistribution to the society. Waris has grounded Schumpeter's fiscal relationshipbetween the state, its revenue structure and redistribution to the society to human rights.[15]This anchors this policy brief's approach to using Schumpeter's fiscal sociology in addressing the right to health. Applied to the Kenyan context, Schumpeter's postulation explains two phenomena. First, the post-colonial Kenyan state adopted a centralised and authoritative form of governance. Its revenue structure while imposed taxation nationally confined its redistribution towards the central sphere of governance; being the main cities and major town areas, ignoring the rural areas.[16] Local authorities were denied fiscal autonomy.

Second, following the post 2010 devolved form of political and governance framework adopted after the promulgation of the 2010 Constitution in August, the revenue structure is now partially devolved.Each of the 47 counties within the Republic of Kenya under article 209(3) of the constitution are granted the fiscal autonomy to mobilise local revenue for local redistribution. The Kenyan state is no longer centralised and authoritative. However, income tax remains the preserve of the national government.[17] This paradigm shift in Kenyan politics provides the academic space to inquire into broadening the country's fiscal space towards introducing new/alternative revenue bases to meet the shortfall of US$ 2,412,751,859.23 (Kshs 242 billion) in ensuring the implementation of Kenya's 12 health programs.

1.2.Recognising the need to broaden the revenue base for health finance

The need to raise new/alternative revenue sources is important for the realisation of the right to health in Kenya. The health budget has been on a regressive scale since 2010 following devolution.[18] As at 2018, the government has allocated 3.9% of the budget to the health sector as compared to 7.1% in 2010.[19]Financial constraints have impeded the delivery of healthcare in Kenya since colonialism.[20]The continued reduction of finances has further restricted the growth of the health sector evenly throughout the country following independence. Public health in rural Kenya is fragile. The lack of healthcare workers, functioning equipment, essential medicines and proximate health facilities within the poor rural areas raises the following question – whether there is a need to increase domestic spending on public health.

The introduction of new/alternative revenue bases or broadening the fiscal space in a state is first subject to interpretation of the legal sources that impose the authority to

[14] Schumpeter, J. 1950. Capitalism, Socialism and Democracy, 3rd ed., New York.
[15] Waris, A. 2013. Tax and Development. LawAfrica
[16] Latif, L.A. 2016. Centralised Revenue Redistribution as a Potential Cause of Internal Conflict in Kenya. Modern Africa: Politics, History and Society, [S.l.], v. 4, n. 1, p. 91-105.
[17] Article 209(1) of the Constitution of Kenya, 2010.
[18] Waris, A and Latif, L.A. 2015. Financing the Progressive Realisation of Socio Economic Rights in Kenya. University of Nairobi Law Journal 8(1).
[19] The budget statements for the fiscal years 2010 to 2017 are available at the Republic of Kenya, National Treasury's website.
[20] Ndege, G. 2001. Health, State and Society in Kenya: Faces of Contact and Change. USA: University of Rochester Press.

tax. In the context of Kenya, articles 2(6) and 209(3) of the constitution contain the language and legal mandate that may or may not permit an interpretation that favours introduction of new/alternative revenue bases or an interpretation that favours broadening the scope of the state's mandate to mobilise revenue. In the context of the right to health, article 2(6) authorises the application of the International Covenant on Economic, Social and Cultural Rights (ICESCR)[21] and its General Comment 14 on the Right to the Highest Attainable Standard of Health.[22]

The ICESCR and General Comment 14 contain language that has the potential to elicit an interpretation that may broaden the scope of a state's mandate to mobilise revenue. This language is contained in the phrase – *maximum available resources,* which appears in article 2(1) of the ICESCR and articles 32 and 47 of General Comment 14. While article 209(3) of the constitution grants counties with conditional fiscal autonomy. The attempt to raise new/alternative revenue sources is subject to Parliament's assent. The constitution does not provide direction on the methodological approach to use in making an informed interpretation. Similarly, the international human rights legal framework is also silent on a methodology to help interpret the content of the ICESCR and General Comment 14.[23] Reliance on the Vienna Convention on the Law of Treaties is not sufficient.[24]

The task of this brief, therefore, is to inquire into broadening the fiscal space for health financing. The briefasserts that public health financing in Kenya is limited and thus arises the need to identify new/alternative revenue sources to supplement the limited health budget. It points towards Islamic taxes to provide these alternative revenue sources.[25]Itassumes that an interpretation of *maximum available resources* under article 2.1 of the ICESCR[26] may provide the legal framework that may potentially support the inclusion of Islamic tax that is available to the Kenyan state, for health financing. However, before this argument can be explored further, the main issue to first be addressed is whether there is a problemof financing health in Kenya.

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[21] UN General Assembly, International Covenant on Economic, Social and Cultural Rights, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3, available at: http://www.refworld.org/docid/3ae6b36c0.html

[22] 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: http://www.refworld.org/docid/4538838d0.html

[23] I find that there is a widespread, albeit contested view that human rights treaties are a form of a special regime that therefore, warrant a special interpretative methodology. See: Toufayan; Merrills, J.G. 1993. The Development of International Law by the European Court of Human Rights. (2nd ed, Manchester United Press). Chs 4-5; Bernhardt, R. 1988. Thoughts on the Interpretation of Human Rights Treaties. In: Matscher, F and Petzold, H (eds) Protecting Human Rights: The European Dimension: Studies in Honour of Gerard J Wiarda (1 edn, Heymanns, 1988), at p. 65.

[24] The general rule of treaty interpretation is contained under article 31(1) of the Vienna Convention on the Law of Treaties (VCLT): a treaty shall be interpreted in good faith in accordance with the ordinary meaning to be given to the terms of the treaty in their context and in light of its object and purpose. Vienna Convention on the Law of Treaties (VCLT) (Vienna, 23 May 1969, entered into force 27 January 1980, 1155 UNTS 331).

[25] Latif. L.A. 2017. An Explication on Broadening the Definition and Scope of Maximum Available Resources under General Comment 14 of the ICESCR to include Islamic Taxation in Financing the Right to Health.
Biomed J Sci & Tech Res 1(3)- 2017. BJSTR.

[26] UN General Assembly, International Covenant on Economic, Social and Cultural Rights, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3, available at: http://www.refworld.org/docid/3ae6b36c0.html

2.0.The problem of limited health financing in Kenya

The Kenyan government has made specific commitments towards health financing at the regional and international levels. At the national level, the government committed under article 43(1)(a) of the 2010 Constitution to provide every Kenyan citizen with the right to the highest attainable standard of health.[27] There is no commitment to setting a percentage of the budget for health financingat the domestic level. At the regional level, Kenya in 2001 under the Abuja Declaration agreed to allocate 15% of its total budget to health.[28] The need to increase health financing was further reiterated in the Addis Ababa Declaration of 2006 on community health in the African region[29], the 2008 Ouagadougou Declaration on Primary Health Care and Health Systems in Africa[30] and in the 2012 Tunis Declaration on Value for Money, Sustainability and Accountability in the Health Sector.[31] At the international level, the World Health Organisation recommends governments to commit 5% of their total budget to health if governments are to achieve a target of 90% coverage for maternal and child health services.[32] Kenya is yet to implement the WHO recommendation and meet the 15% Abuja health target.

According to Njora who reports that in March 2010 at the Third Joint Annual Meeting of the African Union and Economic Commission for Africa Conference of Ministers of Finance in Malawi, the Ministers of Finance called for the Abuja target to be scrapped.[33] Di McIntyre explains that finance ministers have been very dismissive of the target and have simply chosen to ignore it in their decision-making.[34] In Kenya, health financing depends on a percentage of the national budget that is allocated to the health sector and additional financial support is provided through donor aid. Budget financing is dependent on domestic and international mobilization of revenue sources, both of which are limited.[35] Domestic revenue sources are raised through taxes, licensing fees, rates, levies, duties and service charges. Grants and borrowings by the government from foreign states and international bodies such as the World Bank feature as international revenue sources. These also include donor aid. There are no

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[27] Republic of Kenya, Constitution of Kenya, 2010. Nairobi: National Law Reporting.

[28]UN (2001). African summit on HIV/AIDS, tuberculosis and other related infectious diseases: Abuja declaration on HIV/AIDS, tuberculosis, and other infectious diseases. New York: United Nations, 2001. http://www.un.org/ga/aids/pdf/abuja_declaration.pdf

[29] The Addis Ababa Declaration on Community Health in the African Region, 20-22 November 2006. http://www.afro.who.int/publications/addis-abeba-declaration-community-health-african-region-20-22-november-2006

[30]Regional Committee for Africa, 58. (2008). Adoption of the Ouagadougou Declaration on primary health care and health systems in Africa: achieving better health for Africa in the new millennium. World Health Organization. Regional Office for Africa. http://www.who.int/iris/handle/10665/19989

[31] Ministerial Conference on Value for Money, Sustainability and Accountability in the Health Sector. Tunis 4-5 July 2012. http://www.who.int/workforcealliance/media/news/2012/hhaconf2012story/en/

[32] McIntyre, D., Meheus, F., and Rottingen, J.A. (2017). What level of domestic government health expenditure should we aspire to for universal health coverage? Health Economics, Policy and Law, 12, 125-137.

[33]Njora, G. (2010). African finance ministers dismiss development declarations. FAHAMU, http://pambazuka.org/en/category/comment/63894

[34] McIntyre. D and Meheus, F. (2014). Fiscal Space for Domestic Funding of Health and Other Social Services. Working Group on Financing, Paper 5. The Royal Institute of International Affairs

[35] McIntyre. D and Meheus, F. (2014). Fiscal Space for Domestic Funding of Health and Other Social Services. Working Group on Financing, Paper 5. The Royal Institute of International Affairs

formal rules that govern the percentage of the budget to be apportioned for health at the national and county level. The health budget is entirely dependent on the availability of funds, which are tied to prioritised health needs as set out under the prevailing policy.

2.1. Sources of health finance

Kenya has various sources of funding to complement tax funding. The National Hospital Insurance Fund (NHIF) is mandatory for those working in the formal sector and voluntary for others. Contributions range from Kenya Shillings 360 to Kenya Shillings 3,840 (US$3.6-38.40) per annum based on income level but as the rates have remained static over 40 years while incomes have increased, their progressivity has been eroded. Those working outside the formal sector contribute a flat rate of Kshs 1,920 per annum.[36] NHIF contributes less than 1% to the health budget.[37]

The Kenyan government has introduced various other tax-based funding schemes for health. For example, in 1999, the Local Authorities Transfer Fund provided for services in large urban local authorities and supplemented funds for less financially viable authorities. The Constituency Development Fund, introduced in 2004, allocates 2.5 per cent of government's annual budget to promote constituency development, with allocations to constituencies based on their population and poverty levels.[38] Most of the revenue from these funds are directed to infrastructure development in the transport sector.[39]

The majority of the health budget is financed through the budget. As such, health financing through the budget remains minimal and constrained. In 2011 general government expenditure on health as a percentage of GDP was at 1.8% whereas 38.8% of the health expenditure was financed externally.[40] Between the fiscal years 2013-14 and 2014-15 after devolution, 3.8% of the total budget was allocated to the national health sector. This budget was increased to 4.1% in the fiscal years 2015-16 and 2016-17, but in 2017-18, it was reduced to 3.9%. This echoes the government's position under Sessional Paper No. 10 of 1965 that favoured growth over increase in health spending.[41]

I must point out at this stage that following devolution in Kenya, each county is responsible to set aside its health budget from the total revenue allocated to it by the national government. Under the Fourth Schedule to the 2010 Constitution counties are responsible for the promotion of primary health, ambulance services and county health facilities. Whereas the national government remains responsible for the development of the health policy and maintaining the national referral health facilities to which the allocated budget referred above is applied. Country governments are responsible to prepare their own health financing strategies.

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[36]MoMS and MoPHS (2009) Health care financing policy and strategy: systems change for universal coverage, GoK, Nairobi; Public expenditure tracking survey, MoH, Nairobi. (2008).

[37] Lakin, J and Magero, V. (2018). Budget Brief No. 14 – Healthy Ambitions? Kenya's NHIF must become more transparent if it is to anchor UHC. International Budget Partnerships

[38] Ibid.

[39] Akech, M. (2016). Administrative Law. Nairobi: Strathmore University Press.

[40] World Bank, WHI NHA dataset.

[41] Sessional Paper No. 10 of 1965: African Socialism and Its Application to Planning in Kenya. Nairobi: Government Printed, 1965, p. 30-31.

2.2. *Fiscal autonomy to increase health finance*

Article 209(3)(c) of the 2010 Constitution provides counties with the fiscal autonomy to impose taxation under the current devolved structure- *"A county may impose – any other tax that it is authorised to impose by an Act of Parliament".* This article creates the fiscal space to either increase available domestic revenue sources or impose new domestic taxes. The article does not specify for what purposes a tax can be imposed, it merely provides counties with the discretion to impose a tax. However, specific legislation is required to justify linking article 209(3) (c) to the making of a health financing framework. Despite this provision, no county has utilised this article in imposing taxes earmarked for health. Further, the most recent Kenya Health Policy 2014-2030 is also silent on a health financing strategy. There is no legal framework that provides for revenue mobilisation specific for health. Health financing therefore, remains dependent on the budget with no reference to an independent health financing framework.

The 2016/17 fiscal year statistics show that the government had budgeted 4.1% for health but its spending on health had pushed the budget to 19.16%. This additional financing was met through external borrowings, donor aid, and out of pocket payments by individuals at the point of accessing health. These statistics reveal that a larger percentage of health financing in 2016/17 was through public debt, donor aid and the imposition of user fees. Further, health spending for the 2015/16 fiscal year cost the government 18.97% of its total budget compared to the 4.1% allocated for health. These recent statistics demonstrate that health financing in the long run is not sustainable. The current revenue streams are not sufficient to support Kenya's overall budget. Increased borrowings to finance the budget creates a growing debt that impacts negatively on development. The health budget for financing its recurrent and development expenditure for the 2017/18 fiscal year is set by the government at 3.9%. Data on the percentage of health spending is currently unavailable.

The potential of government to source for additional domestic revenue sources depends on the economic conditions of its population. 49% of the urban population and 53% of the rural population in Kenya live below the poverty line.[42] Since they do not earn an adequate income, they are not taxed. This limits the tax revenue that the government is able to then collect from its population. Instead, formal sector employees earning taxable salaries shoulder the burden of taxation. The taxable profits declared by private corporations also provide government with a revenue source. Not all private corporations are transparent with their profit declarations and operate various tax avoidance schemes that result in loss of revenue for the government. In sourcing for additional funds, an increase in taxation would only increase the burden on the working class and dissuade the private sector from investing domestically. Generating additional domestic revenue targeted for health would then have to be from elsewhere.

There must be specific health objectives for which additional domestic revenue can be used to finance. In the previous paragraphs, I showed that the Kenyan budget in the

[42] Ministry of Public Health and Sanitation & Ministry of Medical Services (2009); World Bank Group, 2014. Kenya State of the Cities: Baseline Survey: Overview Report.

2016/17 fiscal year was financed through public debt. Sourcing for additional revenue domestically for health would therefore play an important role in leading the health sector towards self-sustainability. In 2007, 38% of sick Kenyans did not access health because they lacked money.[43] Data from the World Bank showed that in 2010 there were 1.4 hospital beds per 1000 people,[44]0.868 nurses and midwives per 1,000 people,[45] and 0.199 physicians per 1,000 persons in 2013.[46] Maternal deaths as at 2015 stood at 8,000 per year.[47] On regional distribution of health facilities, the rift valley region maintained the highest number, followed by the eastern region. The north eastern region continued to have the lowest concentration of health facilities out of the 10,506 public health facilities operated by the government countrywide.[48] As at October 2015, these facilities lacked drugs, health workers, and medical equipment.[49] Additional domestic revenue sources for health would aim to reduce these disparities.

2.3. Reducing health finance

If the Kenyan government is to meet its commitments to health financing by either allocating the 15% Abuja target or to maintain the WHO recommended 5% health budget for maternal and child health care, additional domestic revenue must be mobilised. The current health expenditure set at 3.9% of the total budget is insufficient when compared to the government's commitment under the Abuja Declaration and the WHO recommendation. While the government has adopted the Kenya Health Policy 2012-2030 identifying 12 health programs to be implemented in time bound stages,[50] it has been estimated that there is a shortfall of Kenya Shillings 242 billion in ensuring their implementation over the 2014-18 fiscal period.[51]

Donor led financing of specific health programs related to HIV/AIDS as at 2013 stood at 40% with most of the funding coming from PEPFAR and the Global Fund for AIDS Tuberculosis and Malaria (the Global Fund),[52] while the government contributed 20.7%.[53] In the fiscal year 2014-15, international assistance contributed 51% of the Kenyan health budget.[54]Other than donor aid and external grants, out of pockets

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[43] Ministry of Public Health and Sanitation & Ministry of Medical Services (2009).

[44]https://data.worldbank.org/indicator/SH.MED.BEDS.ZS?locations=KE

[45]https://data.worldbank.org/indicator/SH.MED.NUMW.P3?locations=KE

[46]https://data.worldbank.org/indicator/SH.MED.PHYS.ZS?locations=KE

[47]https://data.worldbank.org/indicator/SH.MMR.DTHS?locations=KE

[48] Kenya Master Health Facility List, http://kmhfl.health.go.ke/#/home

[49] Open Africa, https://africaopendata.org/dataset/health-facilities-in-kenya/resource/0257f153-7228-49ef-b330-8e8ed3c7c7e8

[50]These programs are; (i) child health and immunisation, (ii) environmental health, (iii) emergency care and blood safety, (iv) health promotion, (v) HIV and sexually transmitted infections, (vi) malaria, (vii) maternal, new-born and reproductive health, (viii) non-communicable diseases, (ix) neglected tropical diseases, (x) nutrition, (xi) other specialisations and (xii) tuberculosis.

[50] Perales, N., A. Dutta, and T. Maina. 2015. 'Resource Needs for the Kenya Health Sector Strategic and Investment Plan: Analysis Using the OneHealth Tool. Washington, DC: Futures Group, Health Policy Project.

[51] Perales, N., Dutta, A., and Maina, T. (2015). Resource Needs for the Kenya Health Sector Strategic and Investment Plan: Analysis Using the OneHealth Tool. Washington, DC: Futures Group, Health Policy Project.

[52]GoK and Health Systems 2020 Project (2013) Kenya national health accounts, Health Systems 20/20, Abt Associates Inc, Bethesda, MD

[53] Amico. P., Aran C., and Avila C. (2010). HIV Spending as a Share of Total Health Expenditure: An Analysis of Regional Variation in a Multi Country Study. PLoSONE 5(9).

[54] USAID. (2016). Health Financing Profile, Kenya.

expenses by individuals also finance the health sector in Kenya.[55] Out of pocket payments in the 2006-07[56] and 2013-14[57] fiscal years contributed to a third of the total health expenditure. Munge and Briggs explain that a healthcare system that relies on out of pocket payments is regressive and creates a barrier for the poor to access the healthcare system.[58]

Despite these statistics, the Kenyan government has been progressively reducing its health budget. This I have observed from the states' budget allocation to the healthcare sector, which has been on a reducing scale for the past 7 years. In 2010, 7.2 per cent of the total budget was allocated to the health sector. In 2011, only 6.1 per cent was allocated while in the 2013/14 budget, the health sector allocation had been reduced to 5.9 per cent of the total budget. Further reduction followed in the 2014/15 budget, which was set at 4% while the 2015/16 budget allocated 3.9% to the health sector. The 2016/17 budget allocates 4% to the health sector while the current 2017-18 reduced this to 3.9%.[59] The Kenyan government operates a deficit budget, which means that it relies on borrowings and donor aid in order to manage the economy. A deficit budget does is not sustainable in the long term. This gives credence to Schumpeter's view that as a state develops it revenue generating ability reduces and this adversely affects the provision of services for citizens.[60]In this respect, it is important to explore whether there exist new/alternative forms of legally financing health so that the government does not have to continuously rely on donor aid, out of pocket payments and official development assistance, but that it can look into other revenue resources domestically available to it such as Islamic revenue sources.

3.0. Can Islamic tax in the form of zakat be the missing 'Glass Slipper' to salvage health financing in Kenya?

Schumpeter did not restrict the understanding of the state-society relationship to a specific category. He focused on the economic relationship between the two. The provision of social services such as healthcare I would argue reflects this relationship. The state's obligation in providing healthcare and the extent of its availability for society's use falls within Schumpeter's theoretical framework. The more the budget allocated for healthcare the better its access and availability. In the previous section, I pointed out the percentage of the budget that had been allocated for healthcare between 2010 and 2018 and argued that the limited budget resulted in health inequities regionally. This follows that the limited health budget has shaped the state and society's relationship in terms of access to available healthcare. The state can only provide healthcare based on the revenue sources that are available. Society can only access the extent to which the revenue sources make it possible for healthcare to be delivered.

[55] Wamai, R.G. (2009). The Kenya Health System – Analysis of the situation and enduring challenges, JMAJ 52(2):134-140
[56] Ibid.
[57] USAID. (2016). Kenya County Health Accounts
[58] Munge, K. and Briggs, A.H. (2014). The Progressivity of Health-Care Financing in Kenya. Health Policy and Planning:29:912-920.
[59] The budget statements for the fiscal years 2010 to 2017 are available at the Republic of Kenya, National Treasury's website.
[60]Schumpeter, J. 1950. Capitalism, Socialism and Democracy, 3rd ed., New York.. Similarly argued by Ibn Khaldun: The Muqaddimah. Translated From the Arabic (and with an Introduction) by Franz Rosenthal. (Routledge & Kegan Paul. 1958. 3 Vols, 481, Plus 463, Plus 603 Pp. 6 Guineas the Set.).

Schumpeter took a conventional approach to taxation that is tax imposed on income, profits, goods and services. I seek to broaden the fiscal understanding of what constitutes taxation. In doing so, I ask whether religious taxes or revenue sources can fit within a broader understanding of taxation. The impact of introducing a different understanding of taxation could redefine the state and society relationship on healthcare. The recent theoretical connection of tax for the realisation of human rights by Waris[61] has led taxpayers to exercise their right to participate in budget making in order to demand that their taxes are matched to financing the fulfilment of human rights. This means that the governance principles of accountability and transparency can now be applied to assessing how much of tax revenue is applied towards the fulfilment of human rights.

This paradigm shift from traditional Smithian understanding of tax as compulsory levy for the defence of the nation and for the maintenance of the institutions of good government through the application of positive law, to the convergence of tax and the realisation of rights by Waris and Latif[62] has forced governments to address the *'respect, protect* and *fulfil'* principles under human rights law within their positive law framework in challenging and addressing inequalities in the fulfilment of human rights through taxation.

Now that the tax and human rights connection has been made,[63] I argue that this connection is conventional and western in its underlying philosophy. It assumes that the taxes referred to are those that a state domestically imposes on its citizens on their income, on the profits made by corporations, on certain goods purchased and for services provided. This is a limited understanding of what constitutes the tax base. Therefore, I seek to extend this tax and human rights link through the rights require budgeted resources nexus suggested by Elson, Balakrishnan, Heintz, Waris and Latif[64] to also include Islamic sources of revenue generation. I shall rely on the human rights framework to justify this position. The ICESCR under article 12 states that governments must use to the maximum of their domestically available resources to progressively achieve human rights.[65] General Comment 14 on the *Right to the Highest Attainable Standard of Health*instructs governments to meet this responsibility of using domestically available resources towards financing the right to health. This concept of maximum available resources has no settled definition and its scope, I argue, can be

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[61] Waris, A. 2013. Tax and Development. LawAfrica.
[62] Waris, Attiya and Latif, Laila Abdul. 2015. Towards Establishing Fiscal Legitimacy Through Settled Fiscal Principles in Global Health Financing. Springer: Health Care Analysis 23(4):376-90
[63] Waris, A. 2013. Tax and Development. LawAfrica; Jones, M.D., and Kinley, D. 2011. Minding the Gap: Global Finance and Human Rights. Ethics & International Affairs, 25, no. 2, pp. 183-210; Hunt, P. UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. UN Doc. A/HRC/7/11. 2008, and Eide, A. 1995. Economic, social and cultural rights as human rights. In Eide, A., Krause, C., Rosas, A., editors. Economic, Social and Cultural Rights: A Textbook. Dordrecht: Martinus Nijhoff Publishers; 1995.
[64] Elson, D., Balakrishnan, R., and Heintz J. Public Finance, Maximum Available Resources and Human Rights. In: Nolan, A., O'Connell, R., and Harvey C. Human Rights and Public Finance. Budgets and the Promotion of Economic and Social Rights. Oxford: Hart Publishing Ltd; and Waris, Attiya and Latif, Laila Abdul. 2015. Towards Establishing Fiscal Legitimacy Through Settled Fiscal Principles in Global Health Financing. Springer: Health Care Analysis 23(4):376-90
[65] United Nations. 1976. International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No.16) at 49, U.N. Doc A/6316 (1966), 993 U.N.T.S. 3, entered into force 3 January 1976.

extended to include Islamic sources of revenue. One such Islamic source of revenue is *zakat*; simply translated to mean wealth tax.[66]

3.1. Is it possible to broaden Kenya's revenue base for financing health with zakat?

The question whether Islamic law can support health financing in Kenya therefore becomes pertinent in addressing the problem of limited funds for health care. Under Islamic law, there is consensus among the four main schools of Sunni legal on revenue mobilisation. Common among these revenue sources is the *zakat*, that I translate to mean a wealth tax annually imposed on savings and assets. *Zakat* is domestically available in every country having aMuslim population that meets the eligibility criteria for paying the tax. *Zakat* revenue is religiously prescribed to be targeted towards specific beneficiaries in financing their wellbeing. I question its potential as a health financing strategy by attempting to place *zakat* within the parameters of human rights law. My argument is that in applying human rights law to introduce Islamic law for financing healthcare shall redefine the current state – society's fiscal relationship. This in turn, I argue, shall lead to a new fiscal sociology for the Kenyan health sector.

Under human rights law, the concepts of progressive realisation and maximum available resources are core towards achieving the rights set out under the ICESCR. The concept of progressive realisation recognises the difficulty of resource constraints and that there are legitimate reasons why a state may not be able to fully realise the right to health. Progressive realisation therefore, means that a country must take planned and targeted steps towards full realisation, but is not to be criticised for not immediately achieving the highest standard of health for its people if that is not attainable. The concept of maximum available resources on the other hand, requires states to individually mobilise to the maximum the revenue that is domestically available to finance economic, social and cultural rights.

Related to this, there is then a need to isolate for critical examination the concept of maximum available resources to assess the potential of broadening the concept to include Islamic sources of revenue. I contend that linking *zakat* to maximum available resources shall give legitimacy to a state that seeks to widen its revenue base to tap into religious funds. Such legitimacy would redefine the state – society fiscal relationship. Thus, the argument on whether *zakat* can provide the additional sources of revenue to finance health, while persuasive on initial thoughts must first be subjected to theoretical and theological justification both under human rights and Islamic law. The latter part is beyond the scope of this brief and therefore subject to further research.

4.0. Conclusion and future research

> *Finance is, as it were, the stomach of the country, from which all other organs take their tone.*
>
> *W.E. Gladstone*[67]

[66] Zakat is obligatory on specific items such as land, cattle, gold and silver as well as on savings. The rate of Zakat on savings, gold and silver is set at 2.5% on the value. The value is determined differently on these items. For example; Kshs 80,000 and above attracts 2.5% Zakat, 80g and above of gold attracts 2.5% Zakat. As for land and cattle, different rules applies. Zakat on cattle is normally given in kind, some scholars permit its conversion to cash.

A majority of African countries underfund their public health sector citing insufficient finances. Many of these countries rely on borrowing loans to fund their annual budgets. The loans provided by the World Bank and International Monetary Fund require that the monies be used for structural development, that is building roads, railways, improving the ports, and financing economic growth. The conditions do not permit the borrower to utilise the funds for financing social rights. Policymakers argue that once economic growth is achieved, it will lead to improvement and investment in social rights. This underlying political and economic policy has resulted in Kenya reducing its spending on social rights.

An increase in health spending would therefore be ideal. In order to increase the health budget, a government can take a number of measures. One, by increasing the allocation of the total budget for health. Two, by imposing out of pocket payments or user fees at the point of accessing health care services. Three, by making national health insurance available. Four, by introducing cost sharing arrangements and pre-payment schemes. Five, by increasing taxes or broadening the revenue base to introduce additional sources of funds targeted for health finance. Each measure has its own implications.

4.1. Key highlights

Firstly, increasing the health budget is a political and economic decision that cannot be made in isolation of the other sectors, such as education, roads, environment and defence, that also require increased financing. Currently, the Kenyan government is operating on a financial deficit. The government owes Kshs 4.8 trillion (US$ 49 billion) in debt and is experiencing a shortfall of Kshs 242 billion in funding its health care programs under the Kenya Health Policy 2014-2030. It is also short of Kshs 282 trillion in funding its Climate Change Action Plan. The option to increase the health budget in such circumstances is therefore not reasonable.

Secondly, studies have shown that imposing out of pocket payments at the point of accessing health care services reduces the number of sick people seeking medical assistance. These studies have explained that 49% of the rural population are within the poverty threshold estimated by the World Bank to be at $1.25 a day. Paying user fees to access medical care therefore deters the poor, rural population from seeking health care services.

Thirdly, national health insurance require a working population employed in the formal sector to contribute monthly payments which are matched by the employer. The National Hospital Insurance Fund (NHIF) established under the NHIF Act in 1966 is the only state run insurance scheme which has attempted to either provide free health care for its pre-paid contributors or sharing the cost with its contributor under a cost sharing agreement. This scheme however, has not fully achieved the objectives for which it was set out. Its poor management and lack of transparency in its administration has led to financial losses through corruption and embezzlement. The scheme also does not cover those working in the informal sector, which represents 83.1% of the country's total labour force. The poor also do not benefit from the NHIF.

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[67] W.E. Gladstone, The Past and Present Administrations', quoted from Richard Kesner, *Economic Control and Colonial Development: Crown Colony Financial Management in the age of Joseph Chamberlain* (Oxford, 1981), p. vii.

Lastly, private health insurance is available to those who are able to afford it and access private hospitals. Finally, increase in taxation depends on the type of tax. Indirect taxes, such as the value added tax, excise duties and custom duties levied on imports, are as a group, regressive. An increase in indirect taxes means taking a proportionally greater amount from those on lower incomes. Human rights scholars have argued against increases in indirect taxation in developing countries. Instead, their focus has been two fold. First, on imposing progressive taxation on income, that is the more income a taxpayer earns, the higher taxes he pays and second, on curbing tax evasion practices that limits the revenue earned by the state.

Despite the existing revenue mobilisation measures discussed, human rights scholars have identified additional sources of revenue for funding health, such as the tobacco tax. In 2007, Kenya enacted the Tobacco Control Act following ratification of the WHO's Framework Convention on Tobacco Control in June 2004. This Act imposes three forms of taxation on all tobacco products; excise duty, VAT and import duty.[68] The tobacco tax earned by the government is not kept separate from the rest of the revenue collected. This means that the tobacco tax is not entirely utilised towards exclusively financing health. Governments have various obligations and socio-economic rights to fund that it is impossible to direct specific sources of tax revenue wholly for health, or to allocate a higher percentage of its available resources towards health.

4.2. Further considerations

In Kenya, health financing between 2013 and 2018 remained below 4.5% of the total budget. This contradicts the Kenyan government's agreement made under the Abuja Declaration signed in 2001 to increase health funding to 15% of its total budget. Similarly, the WHO recommendation of allocating 5% of the total budget to the health sector, has not been met by the Kenyan government. The Kenya Health Policy 2014-2030 recognises the problem of limited sources of finance for health. In response, the government enacted the Health Act 2017 and under section 86 has established legal and targeted measures for health finance. Section 86 contains the first legal commitment to financing health set out in statute. This legal commitment requires the department of health to ensure progressive financial access to universal health coverage by; one, developing a national health insurance system. Two, determining cost sharing mechanisms between the national government and individual county authorities for services provided by the public health system. Three, defining with the department responsible for finance, a standard health package financed through prepayment schemes.

Section 86 has merely reinforced the measures and recommendations identified in the previous Kenya Health Policies of 1994-2010, 2014-2030 and the National Health Sector and Strategic Plans of 1994-2004, 2005-2010 and the Kenya Health Sector Strategic and Investment Plan 2014-2018. Health finance is mentioned in these policy documents and strategic plans on an ad hoc basis and this has limited government's full realisation of the right to health. I explain this next. The government's approach to health financing is that estimates should be made after health programs are identified in the health policy. After this, government would then identify the sources of funding these health programs. This

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[68] http://ilakenya.org/wp-content/uploads/2015/01/Economics-of-Tobacco-Taxation-in-Kenya-ILA-2011.pdf

means that health finance is not a separate and independent category for the government to consider alongside its planning for health programs. This explains why Kenya has not developed an independent health financing framework that identifies sources of revenue for specifically financing health. An independent health financing strategy would provide a sound basis for planning health programs within the available budget and existing revenue base. The strategy would also suggest alternative and additional methods of mobilising revenue sources.

The lack of a legal provision on developing a health financing strategy under section 86 of the Health Act, 2017 limits the full realisation of the right to health as described under the tripartite legal framework for health in Kenya; the ICESCR, General Comment No. 14 on the Highest Attainable Standard of Health and article 43 of the Constitution of Kenya, 2010. As a result of this limitation, the Health Act does not subject progressive realisation of the right to health to maximum available resources.

Under human rights law, two obligations are the focal points towards the full realisation of the right to health. The first is progressive realisation, the second; maximum available resources. Both these obligations are subject to resource limitations. Progressive realisation recognises that the state does not have the capacity and resources to immediately achieve the full implementation of rights. However, the obligation also recognises that despite these limitations, there are certain minimum core obligations that must be achieved immediately. These are; one, ensuring non-discriminatory access to health facilities, goods and services, especially for vulnerable or marginalised people. Two, ensuring access to food, basic shelter, housing, sanitation and water. Three, providing essential drugs as defined by the WHO. Four, ensuring equitable distribution of all health facilities, goods and services, and five, adopting a national public health strategy and plan of action addressing the concerns of all.[69]

The obligation of maximum available resources requires that a state takes steps whether individually or through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the ICESCR by all appropriate means, including particularly the adoption of legislative measures. The definition and meaning provided in the ICESCR and GC 14 on maximum available resources is limited and vague. There are two fundamental concepts underpinning the ambiguous obligationthat I wish to first set out; resource availability and resource constraints. The MAR obligation is guided by these two concepts that are important towards the Kenyan government meeting its right to health obligations. Resource availability assumes that each state has the following resources; financial, natural, technological, human and information. Resource constraints recognises that these resources may be limited or unavailable. It is unrealistic to think that a state would devote all of these potential resources to fulfilling the right to health.

Section 86 opens upthe Kenyan jurisprudence on further analysing the obligations of progressive realisation and maximum available resources within the context of *zakat*. Relatedly, this brief has extensively engaged in driving home this point.

[69] UN Committee on Economic, Social and Cultural Rights, 'General Comment 14, The Right tothe Highest Attainable Standard of Health (Twenty-Second Session, 2000)', UN Doc. E/C.12/2000/4 (2000), para. 43.

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