The fall and rise of cost sharing in Kenya: the impact of phased implementation

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The combined effects of increasing demand for health services and declining real public resources have recently led many governments in the developing world to explore various health financing alternatives. Faced with a significant decline during the 1980s in its real per capita expenditures, the Kenya Ministry of Health (MOH) introduced a new cost sharing programme in December 1989. The programme was part of a comprehensive health financing strategy which also included social insurance, efficiency measures, and private sector development.

Early implementation problems led to the suspension in September 1990 of the outpatient registration fee, the major revenue source at the time. In 1991, the Ministry initiated a programme of management improvement and gradual re-introduction of an outpatient fee, but this time as a treatment fee. The new programme was carried out in phases, beginning at the national and provincial levels and proceeding to the local level. The impact of these changes was assessed with national revenue collection reports, quality of care surveys in 6 purposively selected indicator districts, and time series analysis of monthly utilization in these same districts.

In contrast to the significant fall in revenue experienced over the period of the initial programme, the later management improvements and fee adjustments resulted in steady increases in revenue. As a percentage of total non-staff expenditures, fiscal year 1993–1994 revenue is estimated to have been 37% at provincial general hospitals, 20% at smaller hospitals, and 21% at health centres. Roughly one-third of total revenue is derived from national insurance claims. Quality of care measures, though in some respects improved with cost sharing, were in general somewhat mixed and inconsistent.

The 1989 outpatient registration fee led to an average reduction in utilization of 27% at provincial hospitals, 45% at district hospitals, and 33% at health centres. In contrast, phased introduction of the outpatient treatment fee beginning in 1992, combined with somewhat broader exemptions, was associated with much smaller decreases in outpatient utilization.

It is suggested that implementing user fees in phases by level of health facility is important to gain patient acceptance, to develop the requisite management systems, and to orient ministry staff to the new systems.

Introduction

In the June 1995 issue of Health Policy and Planning,1 Mwabu et al. describe some of the problems resulting from the initial user fee programme introduced in Government of Kenya health services in December 1989. These early implementation problems led in September 1990 to the suspension of the outpatient registration fee, the major revenue source at the time. In 1991, the user fee programme was re-introduced in a way which avoided most of the early problems, and is now widely accepted. This paper examines some of the reasons behind the failure of the initial programme and the success of the re-introduction, and suggests some lessons which can be drawn from the experience.

In recent years, many developing countries have been unable to meet the financial burden of increasing de-
mand for modern health care stemming from rapidly growing populations and epidemiological changes. In response, some governments have begun to develop health financing reform programmes aimed at improving efficiency and quality of services, generating additional funding, and making people more responsible for their own health care. In Africa, governments have increasingly turned to user fees to generate revenue for operating their health services. In its 1987 *Agenda for Reform* of health services in developing countries, the World Bank recommended that the principle of cost recovery be incorporated into national health financing strategies. The World Health Organization has also recognized user fees as a potentially significant source of financing.6,12,13

Debate continues regarding the impact of user fees on health service utilization, health status, quality of care, equity, and household welfare. Proponents argue that user fees not only provide additional revenue, but also improve the quality and scope of services, and promote efficient resource utilization by discouraging unnecessary care.5,7,14,15,16 On the other hand, it is cautioned that user fees may raise relatively little revenue, may discourage necessary utilization of health services, or may not necessarily improve the quality of care.17-21

In Kenya, active consideration of health financing alternatives dates back to the mid-1980s.22 During the 25 years since independence, dramatic improvements had occurred in the health status of Kenya’s population, mainly due to the rapid expansion of government-financed programmes in the first two decades. Since the mid-1980s, however, Kenya’s economic performance has deteriorated and financial resources have been insufficient to keep pace with population growth, the impact of AIDS, and the resurgence of other diseases.23

In its 1989–1993 National Development Plan,24 the Government of Kenya recognized the critical state of health financing in the country and committed itself to a series of health financing reforms. From the late 1980s, the US Agency for International Development (USAID), the World Bank, and other agencies cooperated in funding a number of studies to help the government establish which direction financing reforms should take.25-29 Based on the results of these studies, the Ministry of Health (MOH), with support from USAID, developed the first health financing policy reform programme, which began in 1989. The components of the reform programme included expanding cost sharing in government facilities, increasing the role of social insurance in funding public and private health care, and improving the efficiency of resource use. This analysis focuses on the evolution of the cost sharing programme over the period 1989 to 1994 and the impact of the programme on revenue, quality of care, and outpatient utilization.

Many assessments of user fee programmes have been based on short-term experience and/or experience with only local or regional implementation.5,7,12,21 Similarly, earlier reports on experiences with user fees in Kenya have focused on the adverse effects of the outpatient registration fee, covering only the early implementation period in which significant start-up problems were experienced, and have been limited to a few areas of the country.1,19,30 In contrast, this report covers national and indicator district data over a five-year period.

Development of the cost sharing programme

Cost sharing policy

The main objectives of the MOH cost sharing programme were (1) to generate additional revenue to improve the quality of curative and preventive services; (2) to encourage use of more cost-effective preventive and primary health services; and (3) to encourage people to be more responsible for their own health care. Revenue would be generated by increasing the existing nominal fees, introducing new fees, and recovering the full cost of inpatient services for beneficiaries of the National Hospital Insurance Fund (NHIF), the compulsory government social insurance scheme which covers inpatient services for about one-fifth of the Kenyan population.31

The programme had several key policy elements. To provide collection incentives and to ensure the availability of the extra funds, cost sharing revenues would be additive to government allocations and would be retained at the local level, 75% for the collecting facility and 25% for district-level primary and preventive health care (P/PHC). To encourage the efficient use of resources, funds would not be used for capital works or staff, but would be used for areas of critical need, such as supplies and maintenance. To increase first use of primary services, fees would be graduated between facility levels with dispensary
services remaining free. Services with public health benefits, such as vaccinations, would be automatically exempt from fees to encourage people to use them.

In addition, procedures would be in place for granting fee waivers to the poor.

Initial implementation experiences

During the months after cost sharing was implemented in December 1989, there were many complaints in the press that the introduction of fees had not resulted in any improvement in quality and that the poor were being refused access to services. During the continuing bad publicity, the maternity bed fee was greatly reduced (January 1990), civil servants were exempted (April 1990), and finally – in September 1990 – the outpatient fee was suspended. General belief was that cost sharing had been cancelled, even though inpatient and other fees remained in place.

In early 1991, following the arrival of a resident technical assistance team, a number of field trips were made to assess the situation. Several problems were discovered concerning the fee structure, waiver system, quality of care, and revenue collection.

First, the monthly outpatient registration fee (KSh 20 at hospitals and KSh 10 at health centres), which covered consultation and treatment, was felt by patients and providers to be unfair because quality had not improved. In particular, the supply of drugs had not become more reliable. When drugs were not available, patients had already paid the registration fee and thus had less money available to buy the drugs elsewhere.

Second, procedures for granting waivers to the poor had been reasonably well-designed, but were not well-understood or properly used by either patients or providers. At the same time, staff said that free care was being provided to some patients who could afford to pay, and that they were reluctant to publicize the availability of waivers because they felt there would be increased abuse. In addition, proper records were not kept, making it impossible to monitor the level or appropriateness of waivers granted.

Third, there was indeed a disappointing lack of visible quality improvements. This was due to slow preparation and approval of expenditure plans; lack of collaboration from District Treasuries in releasing funds; use of funds in areas not visible to patients (e.g. painting offices); and sometimes to fraudulent misuse of funds. Unhappy with the perceived lack of improvement, many medical staff did not support the programme and in some cases advised patients not to pay.

Finally, revenue collection was poor. Very few NHIF claims were being submitted because of lack of staff training and cumbersome procedures, and many of the claims submitted were not reimbursed due to minor errors. The lack of claims meant that the large increase in July 1990 of the daily reimbursement rate paid by NHIF had resulted in no significant increase in revenue. Cash collection was also poor, especially of the inpatient fees, and the wide range of exemptions (e.g. children and civil servants) was believed to be resulting in significant losses. Managers did not know how much was being exempted, waived, or collected, and it was clear that the government accounting system was inadequate for control or management purposes. The health information system was also not working well and managers did not know how many services were being provided.

There are several reasons why these problems occurred. There had been no information campaign to advise the public about the programme and to win their support. Providers were not adequately oriented or trained and many were not in favour of cost sharing. Insufficient staff were assigned by the MOH at the central level to implement and manage the programme. Systems were not in place to control revenues and expenditures and to enable management to monitor performance. Finally, and perhaps most importantly, the cost sharing programme was introduced at all 80 MOH hospitals and all 320 health centres on the same day with no pilot testing or phasing, which meant that there was no opportunity to identify and resolve any of the above problems at an early stage.

Phased expansion of cost sharing

It was clear that a major effort would be needed to successfully re-implement cost sharing and that the re-implementation process would have to be carried out in phases over a two-year-period. Given concerns about the acceptance of new outpatient fees, new management systems would be implemented first in order to demonstrate success and win support. The MOH recognized that additional staff would be necessary and expanded the Health Financing Secretariat (the programme management unit) from two administrative staff to a multi-disciplinary group of 10 persons.
The new management systems were developed together with staff from hospitals, district health management teams, and District Treasuries; a cost sharing operations manual was produced; and an extensive training programme was undertaken. Key elements included strengthened procedures for NHIF claiming, cash collection, waivers, exemptions, expenditures, accounting, and reporting. Emphasis was put on, designating a senior administrator in each hospital to manage cost sharing; setting collection targets; opening inpatient billing offices; involving medical staff more in the programme; and focusing efforts on services with the greatest revenue potential.

A two-step process was introduced for granting waivers to the poor, involving an initial interview with medical staff using agreed criteria and authorization by a designated officer. The number and value of waivers for each department are reported monthly so that the effectiveness of the system can be easily monitored.

New accounting and reporting systems were introduced to provide the additional control and information lacking in the government system. The main feature of the new systems was that accountability would not be limited to the revenue shown on the receipts issued (the government system), but would extend to total revenue earned, based on services provided. Each department has to account for all revenue earned, showing how much is received in cash and how much is represented by waivers and exemptions.

The new systems and fees were introduced in phases so that they could be tested and refined at each level. A top-down process was used, starting with the national referral hospital, because it was felt that:

1) The higher-level hospitals had the best potential for quick success in increasing revenue, which could help to win support for the programme;
2) Senior medical and administrative staff who accepted new systems and fees at the higher level facilities would help to convince staff at the lower level facilities;
3) Each facility could be used as a training centre for staff of facilities at the next lower level;
4) Introducing new fees at the higher level would start encouraging patients to use lower level facilities for first contact.

The new management systems were introduced first at Kenyatta National Hospital and the 7 provincial hospitals between June and December 1991. Implementation started with a training workshop for senior hospital managers using the operations manual as a basis. Monthly supervisory visits were made to each hospital after the workshop to review how systems were operating and to discuss any possible system improvements. Following the successful use of the systems in the provincial hospitals, they were extended to district and subdistrict hospitals in May 1992, and to health centres in March 1993. In May 1992, the MOH established District Health Management Boards to provide independent oversight of cost sharing in their districts, and they also received training in the new management systems.

To allow time for greater public acceptance during the early part of the implementation period, fee changes were kept to a minimum. The first major change was the re-introduction of the outpatient fee. Taking into account the complaints about the unfairness of the original registration fee, it was re-introduced as a per item treatment fee, to be paid only if treatment is available. In the case of drugs it is a flat fee per prescription item. The treatment fee was introduced at Kenyatta National Hospital in April 1992, and when it was clear that the fee had been accepted by patients and providers, it was introduced at the provincial hospitals, and then at the other facilities (see Table 1). During that period, other new fees were introduced, and some existing fee levels and exemptions were adjusted. The daily inpatient reimbursement rates paid by NHIF were significantly increased in April 1992. For example, the rate for a bed day at a provincial hospital increased from KSh 200 to KSh 350.

After fees had been introduced and generally accepted at each level, they were periodically adjusted upward, while maintaining the principle of graduation among levels of health facilities (Table 1).

Methods
The impact of the cost sharing programme has been monitored through a routine reporting system, indicator district information, and special studies. Routine reporting consisted of a series of financial and health information reports prepared by districts and hospitals on a monthly or quarterly basis (depending on the type of report). Data presented on revenue generation derives from these routine reports. Reporting completeness for revenue reports ranged from
Table 1. Phased introduction of outpatient treatment fees (all fees in Kenya shillings)

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100% for most provincial hospitals to less than 50% for some district and subdistrict hospitals. The total revenue figures for each month used to determine the trends were based on the average revenue for each type of facility (provincial hospital, district and subdistrict hospital, and health centre) according to the figures provided by those facilities which reported for the month. In this analysis, figures for district and subdistrict hospitals are combined under ‘district hospitals’. Data reported by fiscal year (FY) are based on the Government of Kenya fiscal year (1 July to 30 June).

Data on quality of care and utilization impact are from studies conducted in 6 indicator districts. Indicator districts were selected purposively to ensure variability within the constraints of feasibility. Factors considered were cultural and geographic diversity, distribution of ministry and non-government facilities, and accessibility. Districts were excluded if past utilization data were sufficiently incomplete as to make longitudinal comparison impossible. Three of the 6 districts contain a provincial hospital; the remaining contain district and in some cases subdistrict hospitals.

Evaluation of utilization changes was conducted as an interrupted time series analysis. Three potential effects of the fee changes were modelled: the initial impact of a fee change, the recovery from a fee change over time, and the rebound effect from reversing the change. The time series analysis took into account long-term utilization trends and seasonal effects (to compensate for cycles of disease, family economics and ministry supplies) using empirically-derived quarters.

Data on quality of care were obtained from hospital outpatient exit surveys conducted before and 6 to 10 months after the introduction of the outpatient treatment fee. Respondents were randomly sampled from general outpatient clinics and were interviewed after they had been evaluated and treated. For provincial and district hospitals, respectively, the pre-treatment fee survey included 643 and 304 patients and the post-treatment fee survey included 330 and 325 patients. Additional data on exemptions and other implementation effects were gathered through special studies carried out in the indicator districts. Further details on evaluation and sampling methods can be found in Quick and Musau.

Results: impact on finances and services

Revenue generation

Revenues fell significantly and consistently during the 10 months between the initial implementation of fees in December 1989 and the suspension of the outpatient fee in September 1990 (Figure 1). The decline seems to relate almost entirely to the absence of management systems and controls and to the lack of support from providers and patients, since it does not relate to the fall in utilization (which occurred in the first month), or to fee structure changes, such as the exemption of civil servants. Moreover, this decline occurred despite a large increase in July 1990 of the daily inpatient reimbursement rate paid by NHIF.

Following the introduction of the new management systems at provincial hospitals between June and December 1991, and at district hospitals in May/June 1992, revenue began to climb steadily. From April–June 1991 to the same quarter in 1992, provincial hospital revenue increased three-fold, and from October–December 1991 to the same quarter in 1992, district and subdistrict hospital revenue doubled.
Cost sharing in Kenya

KSh Millions

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--- Provincial Hospitals --- District Hospitals --- Health Centres

--- Provincial Hospitals --- District Hospitals --- Health Centres

HC revenue estimated.

Figure 1. Monthly cost sharing revenue by level of facility, December 1989 to June 1993

(Revenue fluctuations after December 1991 relate mostly to irregular NHIF reimbursements.)

The increases were primarily due to the new systems, since there was no major fee or exemption change during the period, and increased NHIF revenue was due more to greater volumes of claims rather than to the April 1992 increase in the daily reimbursement rate. As a result of systems, fee and NHIF rate changes, total revenue from all facilities increased from KSh 35 million in FY 1990/91 and KSh 33 million in FY 1991/92 to KSh 70 million in FY 1992/93, and to KSh 130 million (US$ 2.6 million) in FY 1993/94.

Much of the increase in revenue resulted from improvements in NHIF claiming, in particular at provincial and district hospitals. In the period January–June 1993, inpatient revenue from NHIF claims and cash fees totalled 62% of total revenue at provincial hospitals and 48% at district hospitals. Outpatient treatment fees, by contrast, only represented 21% of total revenue at provincial hospitals and 28% at district hospitals. At subdistrict hospitals, NHIF revenue was a less significant part of total revenue because member occupancy levels were less and claiming efficiency was worse. Figure 2 shows revenues by source for the three types of hospital.

An analysis carried out in early 1993 indicated that automatic exemptions were resulting in significant foregone revenue. The data showed that 54.3% of outpatient pharmacy items and 42.2% of outpatient laboratory tests were for exempt patients and that about 20% of inpatients were exempt. The cost of outpatient exemptions alone was estimated at KSh 56 million in FY 1993/94, nearly half of which was for children age 6 to 15 and civil servants— the two groups for which no clear public health argument existed for exemption. The reduction of the exemption age for children to five years and the removal of the exemption for civil servants, both in October 1994, eliminated these subsidies. Civil servants received a new medical allowance in place of free services.

On the other hand, less than 1% of all patients received an official waiver due to poverty, although this probably understates services to the poor, since some are covered by automatic exemptions and others are included in the significant number of inpatients not accounted for.

The amount of cost sharing revenue being generated provided significant additional funding at the facility and district level. By FY 1993/94 cost sharing revenue was estimated to be equivalent to about 37% of total Treasury-funded non-staff recurrent expenditures at provincial hospitals, 20% at district and
Successful hospitals have been able to collect more from cost sharing than the cash funding they receive from the government (i.e. the non-staff, non-drug recurrent allocation).

Quality of care
Following the introduction of the new management systems, improvements in the planning and processing of expenditures and the use of increased supervision have generally resulted in more timely and appropriate use of funds. P/PHC funds have been used to support such activities as combating local disease outbreaks, district P/PHC training programmes, maintaining the vaccine cold chain, and essential drugs and supplies for health centres and dispensaries. Facility funds have been used for putting operating theatres back into service, procuring emergency drug supplies, renovating inpatient wards, painting wards and outpatient areas, and keeping laboratory and x-ray equipment functioning.

Patient perceptions of quality highlight inconsistencies among facilities. Outpatient surveys carried out to measure perceived changes in quality at provincial hospitals before and after the outpatient treatment fees were introduced found significant increases in overall quality, staff qualifications, staff attitude, cleanliness, building appearance and confidentiality ($P < 0.05$; Figure 3). Availability of drugs was also judged to have improved, but this may reflect the timing of the survey, since supplies are generally lowest in June, at the end of the fiscal year. At district hospitals, however, the same surveys indicated no significant perceived change in overall quality, but significant decreases in patient perception of some aspects, including staff qualifications, staff attitude, and confidentiality ($P < 0.05$; Figure 3). Waiting time was perceived to have worsened at both provincial and district hospitals.

The difference in the perceived quality changes between the provincial and the district hospitals appears to reflect the more highly developed cost sharing management systems, greater revenue generation and greater survey interval (10 months as compared with 6) at the provincial hospitals. Interestingly, many areas of quality improvement desired by outpatients (waiting time, cleanliness, and staff efficiency and attitude) require little in the way of financial resources, and are more dependent on good management.
Improvements in quality have not been consistent and it appears that the use of funds has varied with the effectiveness of management and the overall financial situation of the facility. For example, despite the availability of cost sharing revenue, an assessment of essential care items at four hospitals in early 1993 found serious shortages of such items as intravenous fluids, dressing materials, antiseptics, surgical supplies, and cleaning materials. This may reflect poor expenditure planning at those facilities, but may also relate to two other factors. First, although Treasury allocations have been increasing, they have not kept pace with rising costs, and cost sharing revenue has been increasingly used to cover the shortfall in areas such as water, electricity, and patient food. Second, the effective use of funds has been limited by the lack of mechanisms for purchasing drugs and medical supplies at wholesale prices, since, according to MOH policy, such items should be supplied by the Central Medical Stores.

Utilization impact
The introduction of the outpatient registration fee in December 1989 resulted in a substantial decrease in general outpatient attendances of 27% at provincial hospitals (Figure 4), 46% at district hospitals (Figure 5) and 33% at health centres (data not shown). However, there is no evidence of a compensatory shift to MOH dispensaries or non-government facilities. After the initial decrease in utilization, during the 9 months before the registration fee was suspended, there was no clear recovery pattern or increase in utilization toward pre-fee levels. Suspension of the outpatient fee in September 1990 led to a prompt return to pre-registration fee utilization levels.

In sharp contrast to the experience with the outpatient registration fee, the introduction of the outpatient treatment fee in hospitals was associated with very modest decreases in outpatient utilization (6%, NS). The much smaller reaction to the treatment fee is attributed primarily to patients’ preference for a fee charged only for tangible treatment, but broader exemptions, comparatively higher prices of all commodities (including retail drugs), and wider acceptance of user fees may also be factors.

The changes in utilization described above are after adjusting for long-term trends and for significant seasonal effects at both provincial and district hospitals (for example, the decreases experienced around the end of the calendar year) which are believed to relate to the holidays and the need to pay school fees. For provincial hospitals, there was a significant long-term downward trend, while for the district hospitals there was no such trend. The absence of a long-term decline in utilization at district hospitals suggests that the decrease at provincial hospitals was related to other factors such as increasing availability of alternative sources of health care, rather than cost sharing as such.

Discussion
From 1989 to 1991, the initial outpatient fee structure, weak implementation efforts and lack of systems resulted in adverse utilization effects, low revenue generation, few visible improvements in quality and the eventual suspension of the outpatient fee. In con-
contrast, new management systems, more acceptable fee policies and strengthened implementation efforts from 1991 through 1993 have resulted in large, steady increases in cost sharing revenue, much smaller and statistically non-significant decreases in utilization, and some perceived improvements in quality. A comparison of the initial implementation experience and the subsequent re-implementation experience provides many valuable lessons.

**Phased implementation**

The initial implementation of cost sharing simultaneously at all facilities did not permit testing of fees and systems, proper training of staff, or adequate supervision. As a result, implementation was weak and when problems emerged they were so widespread that the MOH was unable to take corrective action. In contrast, re-implementation in phases over two years allowed time for testing fees and
systems and for proper training and supervision. Phasing downward from the referral hospitals was a good strategy in that quick success was demonstrated in generating revenue, senior medical and administrative staff at those hospitals became useful advocates of the programme, and staff at each level helped in the training and supervision of the next level.

**Revenue retention, management, and accounting systems**

The policy of allowing facilities to keep 75% of the revenue generated provided sufficient incentive to collect fees and NHIF claims. However, without proper training and appropriate management systems the retention incentive was not enough to ensure good levels of collection. Treasury allocations to health have increased in local currency terms over the period and cost sharing revenue has been additive to those allocations. However, the allocations have not kept pace with inflation, so cost sharing revenue has been partially used to maintain services.\(^{33}\)

Traditional government systems did not permit proper control and management of cost sharing, and revenue generation was very weak as a result. With the introduction of complementary systems, the collection of revenue greatly improved. The lack of adequate human and financial resources in the national management unit responsible for implementing, managing, and supervising the cost sharing programmes was a major reason for the poor results of the initial implementation. In contrast, a larger, better trained, multi-disciplinary team with more financial support for training and supervision was a key factor in the successful re-implementation of cost sharing.

**Fees, exemptions and waivers, and utilization shifts**

Due to the frequent shortages of supplies in MOH facilities, the treatment fee was much more acceptable than the registration fee. The slow and systematic introduction and adjustment of fees during the re-implementation stage and the priority given to acceptability rather than revenue generation were important and successful strategies.

The broad range of automatic exemptions for services with public health benefits was probably helpful in gaining political and public acceptability when the outpatient fee was re-introduced, though the revenue foregone was high. Once acceptance was achieved, the exemptions for civil servants and children between 6 and 15 years old, for which there was no clear public health benefit, were removed. The current system of authorizing all waivers for poverty at the facility level has been more acceptable to providers, although the number of waivers granted appears to be small. Improvements in the recording and reporting of waivers have been useful for monitoring effectiveness.

Graduation of fees among levels of facility has not been sufficient to bring about any significant shift in utilization to lower level facilities with the fee levels used.

**Quality of care**

When management systems were well implemented and supervised, cost sharing funds were used to improve quality of care. However, the inability of the government allocations to keep up with inflation has meant that the cost sharing revenue has often been used to prevent deterioration in services rather than to improve quality. The use of funds to improve quality has also been restricted by the absence of procurement mechanisms which would allow good prices to be obtained. At some hospitals, improvements were noted in areas such as cleanliness and staff attitude, which were rated as very important by patients, and which did not require much in the way of financial resources. In districts where facilities collect significant revenue, the 25% portion which goes to P/PHC has provided very useful amounts of extra funding.

**Remaining issues**

Aside from the topics presented in this study, there are several other questions of concern in the evaluation of user fee programmes. One question is the impact of user fees on household expenditures. How are households, especially poorer households, paying the new government user fees? The effect may be favourable or unfavourable, depending on other choices faced by the family. Paying user fees at government facilities may substitute for more costly purchase of drugs or other services in the private sector. At the same time, payment of user fees may have substituted for purchases of food or other household necessities.

Other questions concern the impact of user fees on community-wide utilization patterns, the cost of administering cost sharing, and the extent to which user fee revenue supplements or substitutes for central Treasury allocations to health. Available data from Kenya on some of these and other issues will be reported separately in a detailed description of the
cost sharing programme. Broader issues are also laid out in a set of guidelines for introducing and managing cost sharing programmes, which will shortly be available.

Conclusion
The Kenya experience shows that a well-managed programme of cost sharing can contribute significantly to the funding of government health services. However, the experience has also shown that a successful cost sharing programme requires gaining public and provider acceptance, collecting and retaining significant levels of additional revenue, protecting vulnerable groups, and achieving visible quality improvements, especially with regard to drugs and medical supplies. Such a programme also requires careful design and testing of fee structures and management systems, implementation in phases, and considerable training and supervision. The resources needed to carry out such a major, sustained, long-term effort are significant, but without such commitment, even a well-designed cost sharing policy may fail during implementation.

References


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