

# Research Implementation Plan Kenya

*What mechanisms have been found to be effective in persuading governments to invest in primary health care that might be implemented in Kenya?*

## Background and significance

Many governments in both high and low income countries remain heavily burdened with “fighting illness” at the expense of optimising health for the people they govern. This results in inadequate funding for health promotion and disease prevention resulting in increasing burden of illness in vulnerable groups.<sup>1</sup> In the low and middle income countries (LMICs) inadequate funding of health care and more so PHC has led to “out-of-pocket financing of healthcare” as the main funder for healthcare by families as they struggle with the double burden of both communicable and the rising non-communicable diseases.

A few examples of governments that have strong policy documents that guide investment include:

- Constitutional statements and direction that declare that provision of health was a human right and explicitly state and guide that governments are expected to provide universal primary health care funding. In Canada the CANADA HEALTH ACT obligates the government of the day to use funds collected through taxation of her citizens to fund primary health care. Guided by judicial interpretations of certain provisions of the Canadian constitution, there is clarity on the ambit of power between the federal and provincial governments over these essential health care matters.<sup>2</sup>
- In the United Kingdom (UK), the National Health Service (NHS) was established in 1948 in accordance with the National Health Service Act of 1946. It was founded on “the principle of collective responsibility by the state for a comprehensive health service, which was to be available to the entire population free at the point of use.” This principle of the NHS has been preserved over the years despite multiple reforms by incoming governments and devolution to the constituent countries of the UK.<sup>3</sup>
- In the Nordic countries primary health care is financed and provided by the central governments through legislation.<sup>4</sup>

The Kenyan health funding is mainly out-of-pocket payment where the poor members of the population contribute a larger proportion of their income than the rich for what is a not necessarily optimal health service.<sup>5</sup> Available documents on health expenditure in Kenya are summarised in Table 1. It is unlikely that much has changed in the last five years.

**Table 1: Shares of Total Health Expenditure (THE) in Kenya as at May 2016<sup>6</sup>**

Key Indicators	
Population (2014)	44.9 million
Gross Domestic Product (GDP) per capita (2014, USD)	\$1,420
Health Financing (2013)	
Total Health Expenditure (THE) per capita	\$66.6
THE as % of GDP	6.8%
Government Health Expenditure (GHE) as % of THE	33.5%
GHE as % of General Government Expenditure (GGE)	6.1%
Out-off pocket (OOP) as % of THE	29%
Development Assistance for Health (DAH) as % of THE	26%
Pooled Private as % of THE	2%

### **What has worked in other countries?**

Zhang et al, in their analysis of the Chinese government investment in primary healthcare institutions to promote equity reported deliberate government proactive increment in funding of these facilities from 2008 to 2011.<sup>7</sup> They documented this as resulting in promotion of equity to primary healthcare and universal coverage. Their article does not, however, analyse healthcare indicators of improvement.

Schneider et al documented five change factors that are requisite for facilitating implementation of primary health care reform in a South African province.<sup>8</sup> These factors do not consider financing challenges but can be used to promote and/or market effective primary health care reforms in Kenya where the government has relegated this function to poorly resourced and poorly supported community health facilities.

Primary health care services are mainly outpatient care for the unwell with huge components of enhanced community health promotion, disease prevention and early diagnosis of disease. Yuan et al carried out systematic reviews to assess the impact of different payments methods on the performance of the facilities that offered outpatient services. They compared intervention that augmented ongoing payments by “pay for performance” and “fee-for-service”. Payment for the performance was directly linked to the performance of health care providers while payment for the service resulted in enhanced use of specific service items provided at the facility. Each of these approaches resulted in positive and not so positive health care outcomes.<sup>9</sup>

### **What has not worked in other countries**

Wiysonge et al carried out systematic reviews on the effects financial arrangements for health systems in low and middle income countries (LMICs) and the effects these had on healthcare outcomes in these countries between 2010 and 2016.<sup>10</sup> Remarkable in their documented findings was the fact that most of the ongoing interventions that included enhancing salaries of health workers, cost sharing by patients and recipient incentives did not improve outcomes.

Panellists of stakeholders in health that included ministers for health and finance during a series of discussions that evaluated and upraised financing health systems towards universal health coverage in Africa highlighted both the bottle necks and ways of making meaningful changes to overcome the bottle necks.<sup>11</sup>

### **Specific Aims**

1. To review grey literature in PHC investments to determine which countries have invested highly and those that have not, and to conduct key informant interviews with conveniently selected representatives from countries that have invested highly in PHC and those that have not.
2. Using these data to develop a tool to use in interviewing key stakeholders in health services management in Kenya.

### **Study Design**

We will use a mixed methods using both qualitative and quantitative data.

**Methods** We will review the grey literature on PHC investment globally and categorise them into two groups (those that have invested highly and those that have not). We will also review

and compare health care cost per capita and health indicators in the two categories. We will identify countries from which key informants will be conveniently selected for in-depth interviews on government investment in PHC. Questions mailed using the “Google forms” application and where possible video conferences will be set up. The WONCA secretariat and the research group leadership will be approached to assist us access these busy officials.

Findings of the literature search will be tabulated following the systematic review format. Qualitative and quantitative data collected from the key informants will be stored in appropriate databases and at the end of data collection be analysed using scientific software packages mutually agreed among team members.

The findings will guide the development of an interview guide to be used on conveniently selected key informant representatives of Kenyan health sector stakeholders among policy makers, economic experts, fiscal planning experts, health managers, health professional teachers and health workers in Kenyan national and regional governments. The interviews will include focus group discussion and in-depth interviews aimed at working towards implementing enhanced PHC funding in Kenya.

### ***Inclusion and exclusion criteria for countries with high and low investment in PHC***

1. Inclusion for countries with high investment in PHC
  - a. Governments whose PHC funding component forms at least 15% of national health budget.
2. Inclusion criteria for countries with low investment in PHC.
  - a. Governments whose PHC funding component forms less than 5% of national health budget.
3. Inclusion criteria for key stakeholders in health in Kenya.
  - a. Consenting policy makers in health in national government.
    - i. Cabinet secretary for health or an appointed representative,
    - ii. Cabinet secretary for finance and fiscal planning or an appointed representative.
    - iii. Head of the national PHC department.
  - b. Consenting policy makers in health in randomly selected five county governments (10% of 47 regional governments).
  - c. Consenting county health facility managers from five randomly selected county hospitals.
  - d. Deans from the five Kenyan medical schools.
  - e. Heads of departments of the five family medicine programs in Kenya.

### **Potential research team and partners**

The team will include:

- a. *Dr Patrick Chege*. Principal investigator. Department of Family Medicine Moi University Will play the overall role of coordinator of proposal writing, data collection, report writing and dissemination of results, and communication with WONCA. [chege200851@yahoo.com](mailto:chege200851@yahoo.com)
- b. *Dr Joseph Thigiti*. Department of Family Medicine Kenyatta University. Will coordinate the selection of key informants in health care in Kenya and facilitate collection of data [jthigiti@yahoo.co.uk](mailto:jthigiti@yahoo.co.uk)
- c. *Dr Ann Mwangi*. Research expert (PhD Biostatistics and an expert in research methodology) in the department of medical psychology. [annwsum@gmail.com](mailto:annwsum@gmail.com)

- d. *Dr Joy Mugambi*. Represents the Kenya Association of Family Physicians (KAFP) and the regional governments' family doctors. [dr.mugambijoy@gmail.com](mailto:dr.mugambijoy@gmail.com)
- e. *Dr Bruce Dahlman*. One of the fathers of Family Medicine in Kenya and a close associate of the KAFP. [bruce.dahlman@aimint.org](mailto:bruce.dahlman@aimint.org)
- f. *Dr. Izaaq Odongo*. Senior deputy director of medical services in the national Ministry of Health and has been involved in national matters on family medicine in the past ten years [izaqo@yahoo.com](mailto:izaqo@yahoo.com)
- g. *Dr. Jeremiah Laktabai* .Department of Family Medicine Moi University. To play the role of research methods coordination. [idrlaktabai@yahoo.com](mailto:idrlaktabai@yahoo.com)
- h. *Edith Kabure*. Administrator with the Institute of Family Medicine and can run the research secretariat as its administrator. [edith@chak.or.ke](mailto:edith@chak.or.ke)

### **Overview work plan**

1. Getting the research team together with membership determined by individual support and commitment to this task.
2. Set up a secretariat for the study and provide the necessary resources for effective operation
3. Agreeing and establishing the terms of reference and operation procedures with a log frame
4. Assigning tasks to sub groups and individuals within the team
5. Monitoring and evaluating progress through regular feedback by team members as data are collected and managed
6. Data collection and data management
7. Data analysis and report writing
8. Publication and dissemination of study findings through peer reviewed journals, workshops with different stakeholders, mass media and other locally convenient and acceptable methods of informing the communities
9. Lobby for the team to be part of the process of change in health system management.

### **Implementation of the study**

- First quarter: work plan items 1 to 4
- Second quarter: work plan 5, 6 and 7
- Third quarter: work plan 7 and 8
- Quarter four: monitor and evaluate progress

Note that regular reports will be filed with the funders and the WONCA research working group

### **Barriers to implementation**

Anticipated barriers to implementation include:

1. The Kenyan government focus on delivery universal health coverage (UHC) in the current five year plan is acknowledged and appreciated. This offers ground for lobbying for primary health care to play a central role in UHC. The policy makers seem to favour enhanced specialised health care services as drivers of health service enhancement at the expense of primary health care
2. Kenyan health budget on health remains below 10%. This presents severe completion for the limited funds in managing the health workers wage bill and the growing double burden of managing both communicable and non-communicable diseases at the expense of health promotion and disease prevention.
3. We anticipate slow response by the Kenyan political class and policy makers who already have plans that may not rank PHC very high among their priorities.

## Dissemination of results

Publication and dissemination of study findings through peer reviewed journals, workshops with different stakeholders, mass media and other locally convenient and acceptable methods of informing communities.

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