Channeling Funds to Private Providers for HIV Services in Kenya

Kenya, a low-income country in East Africa, is facing a serious, generalized HIV epidemic. In the mid-1990s, prevalence peaked at 9.8 percent among the adult population. Increased commitments by the government of Kenya and international donors have helped expand and strengthen the national HIV response. By 2012, prevalence among the adult population had declined to 6.2 percent. Enrollment in antiretroviral therapy (ART) increased from 57 to 81 percent of eligible people living with HIV between 2009 and 2012 (UNAIDS, 2013). Although Kenya has the second highest prevalence rate among its five immediate neighboring countries, it has succeeded in getting a larger proportion of eligible patients on ART than these same neighbors (UNAIDS, 2013).

Despite these successes, the HIV response remains the target of reforms that aim to address challenges in Kenya's health system. These challenges include unequal access to services and excessive reliance on household out-of-pocket spending. The private sector will likely play an important role in these reforms. For example, governments across sub-Saharan Africa are developing new strategies to engage the private sector. Accounting for just under half of all health facilities in Kenya, the private health sector is a key potential partner to help the government of Kenya sustain the country's HIV response.

Financing and ART Coverage in Kenya

Data on past HIV spending in Kenya's health sector, tracked using the national health accounts (NHA) and HIV subaccounts methodologies, help explain private sector engagement in the HIV response and can support the government of Kenya's efforts to improve the sustainability of its HIV programs. The SHOPS project used data from the 2006 and 2010 Kenya NHA (Government of Kenya and Health Systems 20/20, 2009 and 2011) to track how HIV funds flow through Kenya's health system and to identify ways for donors and the government to better work with the private health sector. NHA tracks the flow of health spending in a country.

This flow begins with an entity (source), which may be the Ministry of Finance, an external partner, or household, before moving to an agent (manager), such as the Ministry of Health or an NGO. Managers spend

Jessica Scranton

A private pharmacy in Kenya

HIV Spending in Kenya, 2006–2010

All figures in billions.

- Total health spending increased from Ksh 94.3 to Ksh 122.8
- Total HIV spending increased from Ksh 25.0 to Ksh 30.1
- HIV spending at private for-profit hospitals, medical centers, and pharmacies increased from Ksh 3.5 to Ksh 4.7
- HIV spending at public hospitals and clinics increased from Ksh 9.1 to Ksh 11.3

SHOPS
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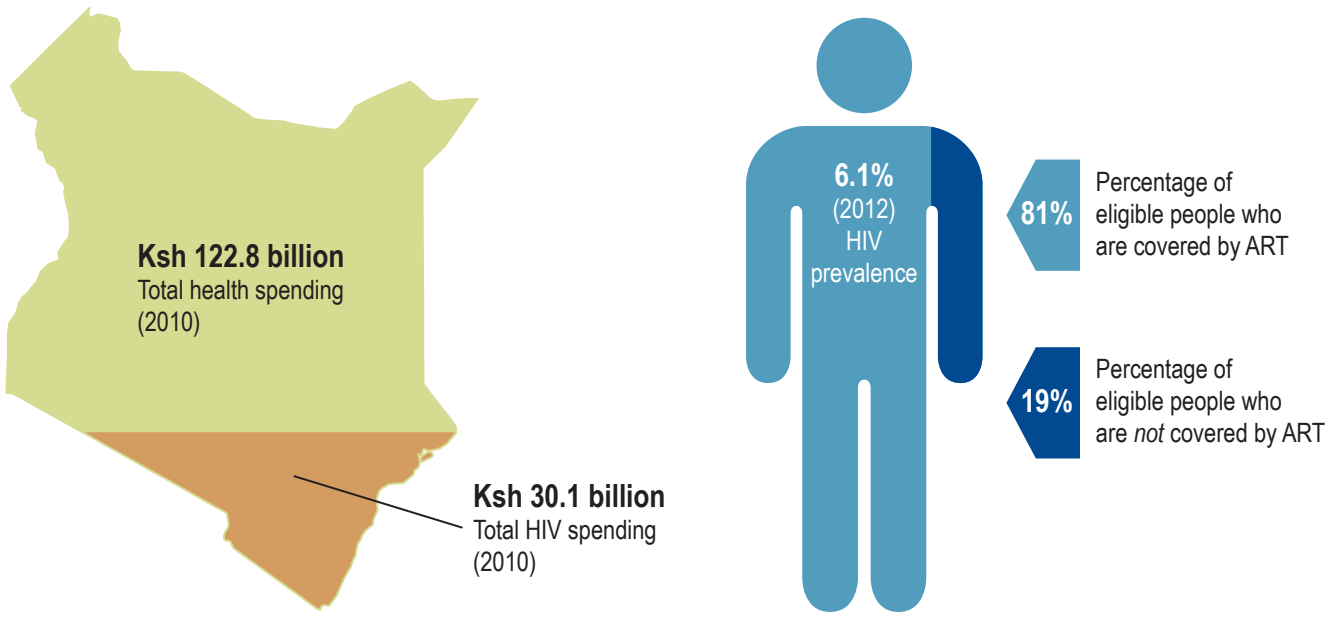


the funds at health care providers. NHA identifies the amount of funds spent at each type of provider (public or private, health clinic or hospital), as well as the types of health care goods and services consumed there. While the general NHA tracks total health spending, the HIV subaccounts detail health spending on HIV.* Estimates of total health spending used in this analysis only include spending on HIV activities that aim to improve, maintain, or prevent deterioration of health. They do not include non-health programs such as those focused on orphans and vulnerable children. NHA and HIV subaccounts data can inform decisions about resource allocation and strategic planning, increase transparency, track progress toward spending goals, and inform civil society's advocacy efforts.

Private Health Sector Composition

The nonprofit sector consists of:

- Faith-based organizations
- Charities
- NGOs
- Nonprofit hospitals
- Community-based organizations

The for-profit sector consists of a wide range of commercial entities, including:

- Private health insurance companies
- Privately owned clinics, hospitals, and medical centers
- Companies with employee health programs
- Private pharmacies
- Provider associations and coalitions

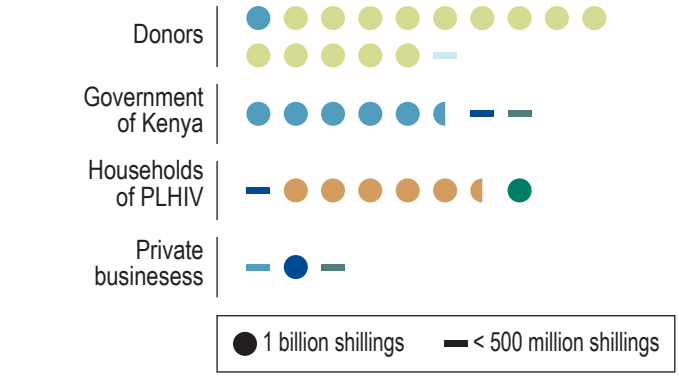
* This methodology was updated in 2011. The Kenya data used in this fact sheet were generated before the update.

The Flow of HIV Funds to For-Profit Facilities

The diagram below illustrates the flow of HIV funds from various sources to public and private managers, and depicts the following findings:

- Donors accounted for 51 percent of HIV funding in 2010, proportionately greater than their share of general health funding (35 percent). This indicator decreased by 19 percent between 2006 and 2010.
- The government accounted for 21 percent of HIV funding in 2010, an increase from 7 percent in 2006 but still less than its share of general health funding (29 percent).
- Private insurance accounted for 6 percent of HIV spending, and the government-managed National Hospital Insurance Fund (NHIF) for 4 percent. This 10 percent share represents a tenfold increase from 2006 and matches the level of general health expenditures managed by insurance (11 percent).
- The NHIF was financed exclusively by mandatory formal sector contributions and informal sector premiums from households, while private insurance was financed by employers (parastatal and private companies) and household premiums.
- Out-of-pocket spending by people living with HIV (PLHIV) accounted for 19 percent of HIV spending in 2010.

Where Do the Funds Originate?



Who Decides How to Spend HIV Funds?

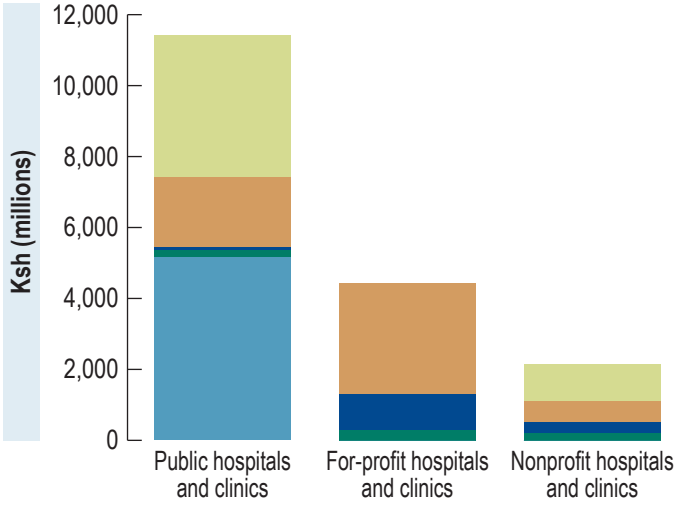
- Public agencies
- Private insurance
- Households (out-of-pocket spending by people living with HIV)
- Companies (parastatal and private)
- International and national NGOs
- Donors
- Public insurance

HIV Spending at Facilities

The graph below shows HIV spending at public and private facilities. NHA data indicate that HIV spending at public health facilities is much larger than spending at for-profit health facilities.

- The NHIF spent Ksh 283 million at for-profit facilities and Ksh 199 million at nonprofit facilities. These amounts represent 37 percent of all NHIF spending on HIV in 2010. Additionally, private insurance companies spent Ksh 1 billion on HIV at for-profit facilities and Ksh 304 million at nonprofit facilities in 2010, comprising 72 percent of private insurance HIV spending. Insurance accounts for just under one-third of spending at for-profit facilities and approximately one-quarter of spending at nonprofit facilities.
- Of the Ksh 14.5 billion spent by NGOs on HIV services in 2010, less than Ksh 500,000 was spent at for-profit providers. However, NGOs spent over Ksh 1 billion at nonprofit facilities.
- PLHIV spent Ksh 3 billion out-of-pocket at for-profit facilities in 2010. This amount was 71 percent of all for-profit facility resources—a main source of funding for these providers. It accounts for 54 percent of all out-of-pocket spending by PLHIV. Another 10 percent was spent at nonprofit facilities and 33 percent was spent at public facilities for HIV goods and services.

Facilities that Receive HIV Funds



17.9 billion Kenyan shillings were spent on HIV services at all health facilities in 2010. Sixty-three percent of that spending went to public facilities, while 25 percent went to for-profit facilities—an increase from 23 percent in 2006.

Figures based on 2010 data.

Policy and Program Implications

As Kenya's HIV spending has increased, its HIV response has become more self-financed, but remains donor-dependent.

Public and private entities in Kenya have increased their spending on HIV, reducing reliance on external sources and improving the sustainability of the national HIV response. However, donors still account for more than half of HIV funding, leaving Kenya vulnerable to changes in donor priorities. NHA data show that external funds for health in 2010 increased by Ksh 20.5 billion since 2006, but 89 percent of that additional funding was allocated to non-HIV health priorities. These findings highlight the importance for the government of Kenya to continue supporting efforts to increase country ownership and ensure sustainability of the country's HIV program.

Universal health coverage reforms have the potential to reduce out-of-pocket spending.

Out-of-pocket payments by PLHIV as a percentage of total HIV spending on health are decreasing and are lower than the relative contribution of households in the overall health sector. These findings indicate that increased investment in HIV programs has reduced the burden on PLHIV to finance their health needs. However, out-of-pocket spending still averages Ksh 146,323 per PLHIV, which may result in financial hardship and even catastrophic spending on health for poor PLHIV.

NHA data also show gross inequity in the use of insurance funding. Though private insurance accounted for more HIV funding than NHIF in 2010, it covers only 800,000 people (Barnes et al., 2009), compared to NHIF's 2.7 million members (JLN, 2014). Those covered are primarily formal sector workers, indicating that insurance-managed funding benefits a small, wealthy subset of the Kenyan population (Barnes et al., 2009; JLN, 2014).

In addition to pursuing government-led reforms to expand NHIF and incorporate outpatient services like ART, public and private stakeholders can also pursue other strategies to increase effective insurance coverage. For example, health insurance companies can develop new low-cost products that are affordable for a greater percentage of the population, and track how these new financing mechanisms decrease the financial burden on PLHIV.

Reforms should continue to incorporate for-profit facilities within new payment mechanisms.

NHA data show that the dependence of for-profit facilities on out-of-pocket spending decreased with increased spending by the NHIF and private insurance companies at for-profit facilities. However, out-of-pocket spending by PLHIV still accounts for most HIV spending at for-profit facilities, indicating that more involvement of for-profit providers in insurance schemes may facilitate effective and sustainable financial protection of PLHIV. Beyond ensuring that for-profit providers are part of Kenya's health finance reforms, stakeholders should ensure that new payment mechanisms are reliable and efficient to reduce administrative burdens on both payers and providers. For example, the SHOPS project is piloting an electronic database to foster information exchange between providers and insurers to reduce inefficiencies in claims reporting and reduce the cost of health insurance products. These and other reforms will go a long way in supporting the HIV response in Kenya.

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For more information about the SHOPS project, visit: www.shopsproject.org

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