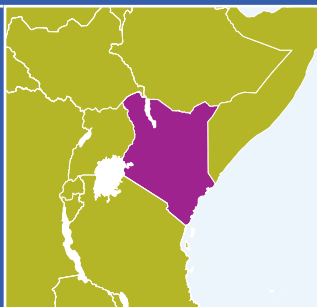




MINISTRY OF HEALTH

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policy



EXPLORING 10 YEARS OF HEALTH SERVICE COST AND USE IN KENYA

Brief

Background

In 2013, the Kenya Ministry of Health, with support from the USAID- and PEPFAR-funded Health Policy Project (HPP) and in conjunction with the Kenya National Bureau of Statistics (KNBS), conducted the 2013 Kenya Household Health Expenditure and Utilisation Survey (2013 KHHEUS). The results of this survey will significantly contribute to policy decisions, planning, and monitoring and evaluation related to Kenya’s health sector, at both the national and county levels. The survey explored how health services are used and paid for in Kenya, as well as the various demographic and socioeconomic factors that affect health-seeking behavior. Significantly, the 2013 KHHEUS compared results to those of previous surveys (2003 and 2007), providing important insights into how healthcare utilisation, spending, and insurance coverage have changed in Kenya over the past decade. The survey included 33,675 households drawn from 1,347 select clusters—814 (60%) rural and 533 (40%) urban—and covered 44 of Kenya’s 47 counties.¹

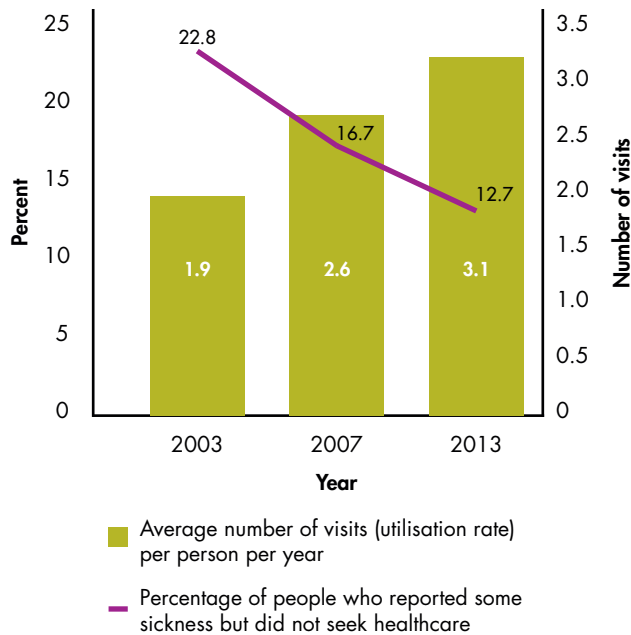
Key Findings

Outpatient Utilisation and Expenditure

Utilisation of outpatient services

The past decade saw a steady rise in the use of outpatient care. The average number of visits to an outpatient health provider (utilisation rate) per capita, per year increased by 35 percent from 2007 to 2013 (Figure 1). In fact, the overwhelming majority (87.3%) of survey respondents reported that they consulted a healthcare provider when ill. Of those that did not seek care when ill, most reported that they did not consider the illness serious enough, that they self-medicated, or that the cost of care was too high. Those that lived within 3 km of a health facility were much more likely to seek care than those who lived over 10 km, 6–9 km, and even 4–5 km away.

Figure 1. Trends in Outpatient Service Utilisation



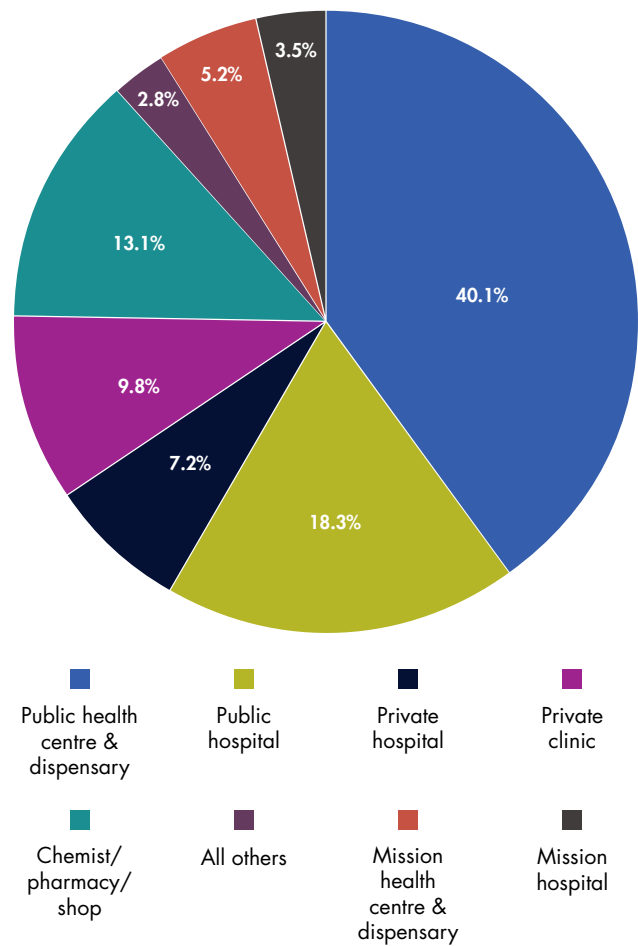
In general, the youngest and oldest segments of the population (ages 0–4 years and 65 years and older) were the largest consumers of outpatient care. Wealthy individuals were more likely than the poor to consult a healthcare provider when ill, but the difference was minimal. Individuals with higher levels of education and those who resided in urban areas were more likely to seek care and utilise private providers than those with lower levels of education and rural dwellers. Females were more likely than males to seek outpatient care, and much more likely to get care at a public health facility. While private health facilities are becoming a major provider of outpatient services in urban areas, Kenya is highly dependent overall on public facilities. In 2013, public health facilities accounted for over 58 percent of all outpatient visits (Figure 2).

Outpatient expenditures

The past decade has seen a decline in catastrophic health spending² (11.4% in 2007 to 6.2% in 2013). Out-of-pocket (OOP) spending, however, has been inconsistent. After a steady drop between 2003 and 2007, OOP spending rose from 2007 to 2013 to KSh 61.5 billion; outpatient care accounted for approximately 78 percent of this figure (KSh 48.4 billion). Average annual per capita spending on outpatient care fell between 2003 and 2007, but rose again from 2007 to 2013, to KSh 1,254. In general, females, urban households, older segments of the population, and

those with college and university educations spent the most on outpatient services. There was also considerable variation in outpatient utilisation and per capita spending between counties (see Figure 3 on p. 4). Health insurance coverage did not seem to significantly affect whether someone sought outpatient care, with the insured and uninsured reporting almost the same number of outpatient visits per capita (3.2 and 3.0 visits, respectively).

Figure 2. Main Providers of Outpatient Health Services, 2013



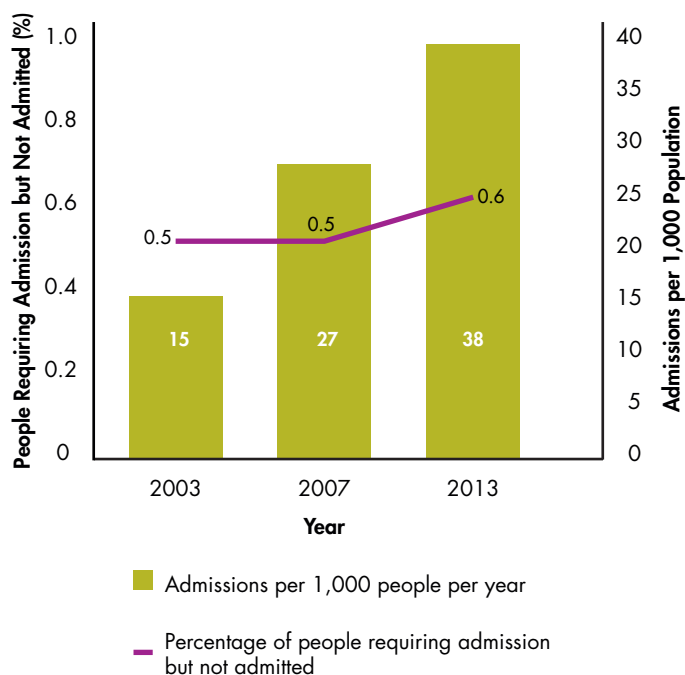
Inpatient Utilisation and Expenditure

Utilisation of inpatient services

Inpatient service utilisation rates also increased. Hospital admissions rose from 2003 to 2013, but the average length of stay decreased (from 8.5 days in 2003 to 6.7 in 2013). Older Kenyans (those 65 years and above), the wealthy, and females were most likely to use inpatient services. Similar to trends in outpatient health services,

survey results revealed that the public sector is the main provider of inpatient care across all demographics (56% of inpatient admissions), and that people residing in rural areas and the poor were more likely to use public sector providers than those in urban areas and the rich. Individuals' choice of provider was also greatly influenced by proximity and the perceived quality of care, with "close to home" and "staff are qualified" as the top two reasons respondents reported choosing a particular provider.

Figure 4. Trends in Utilisation of Inpatient Services, 2013



Inpatient expenditures

Inpatient care accounted for just over one-fifth (21.6%) of the total OOP spending for 2013. Average annual per capita spending for inpatient services increased from 2003 to 2007, but then declined from 2007 to 2013 (from KSh 505 to KSh 355). As with outpatient trends, inpatient annual per capita spending varied greatly by demographic characteristics, and there was considerable variation among counties for inpatient per capita spending (see Figure 5 on p. 4). Individuals with insurance had higher rates of hospital admission (76 per 1,000 population) than the uninsured (30 admissions per 1,000 population).

Health Insurance Coverage

In 2013, about one in five Kenyans (17.1%) had some form of health insurance coverage, an increase from previous years. The National Hospital Insurance Fund (NHIF) was the most prolific provider, covering over 88 percent of the insured. Private insurance was the second-largest insurer (covering 9.4% of those insured), followed by community-based insurance (1.3%). The wealthy and those residing in urban centers were more likely to have insurance than the poor and those in rural areas. Those with health insurance coverage consistently spent more on healthcare (inpatient and outpatient) than those without insurance.

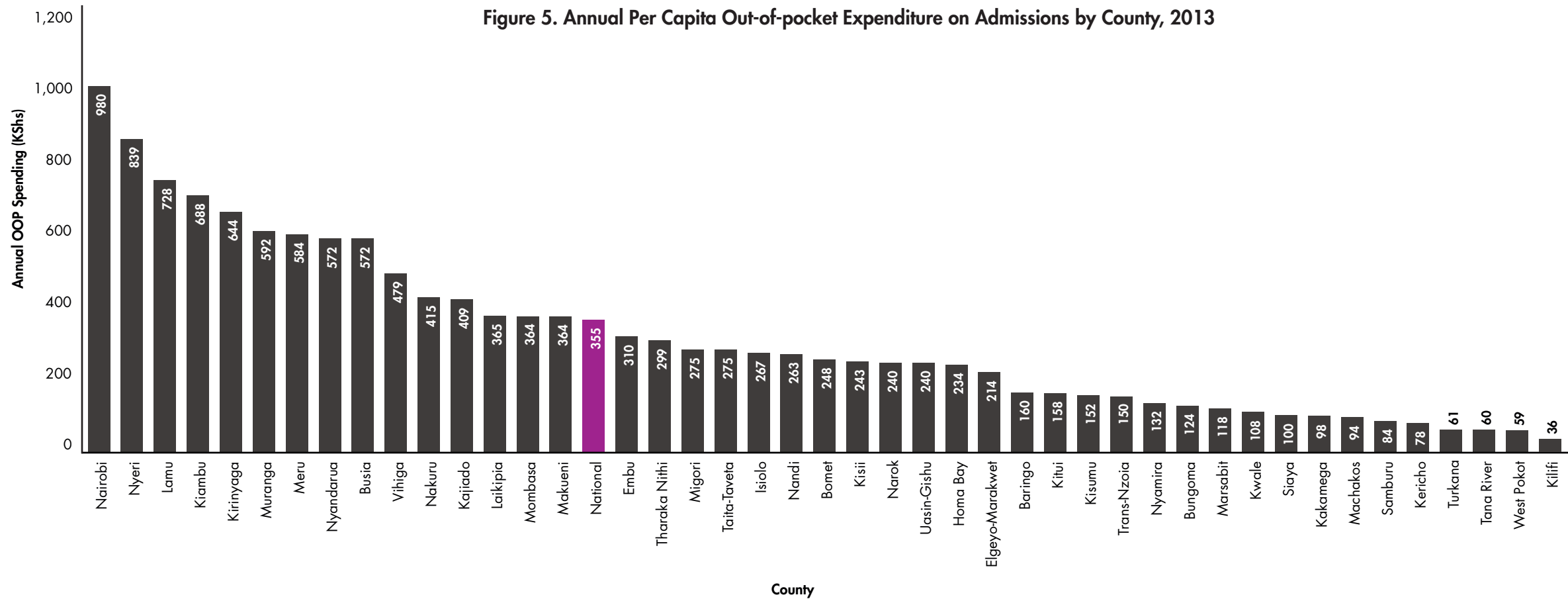
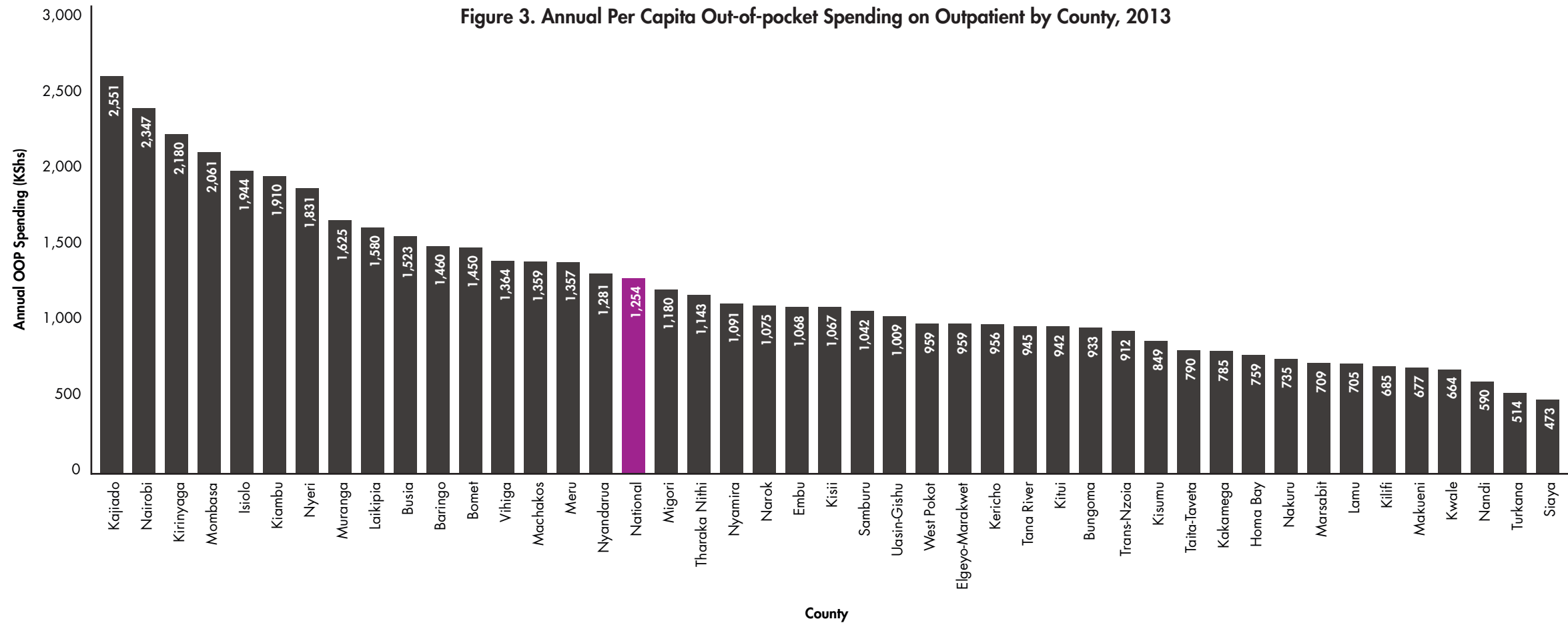
Catastrophic Health Spending

When OOP healthcare payments are large, relative to a household's budget, the disruption to living standards can be catastrophic. While overall catastrophic health spending is down, from 11.4 percent in 2007 to 6.2 percent in 2013, thousands of Kenyan households continue to be pushed into poverty as a result of health-related expenses. The poor, already at an economic disadvantage, bore a disproportionate burden of catastrophic expenditures in 2013. Rates of catastrophic spending also varied considerably between counties, with 22 reporting a rate of catastrophic health spending higher than the national average.

Implications

The results of the 2013 *KHHEUS* have important implications for the future of health and health policy in Kenya.

- Access to health services has improved over the past decade; however, inequalities between the rich and the poor still exist, and access is largely dependent on demographic factors such as residence, education, and wealth.
- More people than in years past are seeking healthcare when ill, and healthcare utilisation trends indicate that economics greatly influence the decision of whether or not to seek care, as does physical proximity to a healthcare facility.
- Urban populations spend more on healthcare than rural populations, indicating a higher purchasing power among those residing in urban settings.



- Despite declines in catastrophic health spending, thousands of Kenyan households are still pushed into poverty as a result of health-related expenses.
- Almost one-fifth of Kenyans have some sort of health coverage; NHIF is the largest provider in all markets.
- Insurance coverage was not a significant factor in explaining demand for outpatient care but, in some instances, it enhanced access to inpatient healthcare.

These and other results from the 2013 *KHHEUS* will provide critical evidence for the planning and development of Kenya's health sector at both the national and county levels. Specifically, results will inform the development of Kenya's new health financing strategy, policy decisions related to the future of universal health coverage, the NHIF, and the National Health Accounts estimation process.

Notes

1. At the time of the survey, the KNBS had not updated Kenya's National Sample Survey and Evaluation Programme (NASSEP) master sample (the sample used to select representative clusters and households) to include Mandera, Wajir, and Garissa counties, so these counties were not included.
2. Catastrophic spending refers to healthcare payments that are so large (relative to a household's budget) that they disrupt living standards.

References

Ministry of Health, Government of Kenya. 2014. *2013 Kenya Household Health Expenditure and Utilisation Survey*. Nairobi: Government of Kenya.

The full report, *2013 Kenya Household Health Expenditure and Utilisation Survey*, is available for download from the Health Policy Project, www.healthpolicyproject.com, and Kenya's Ministry of Health, <http://www.health.go.ke/>.

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