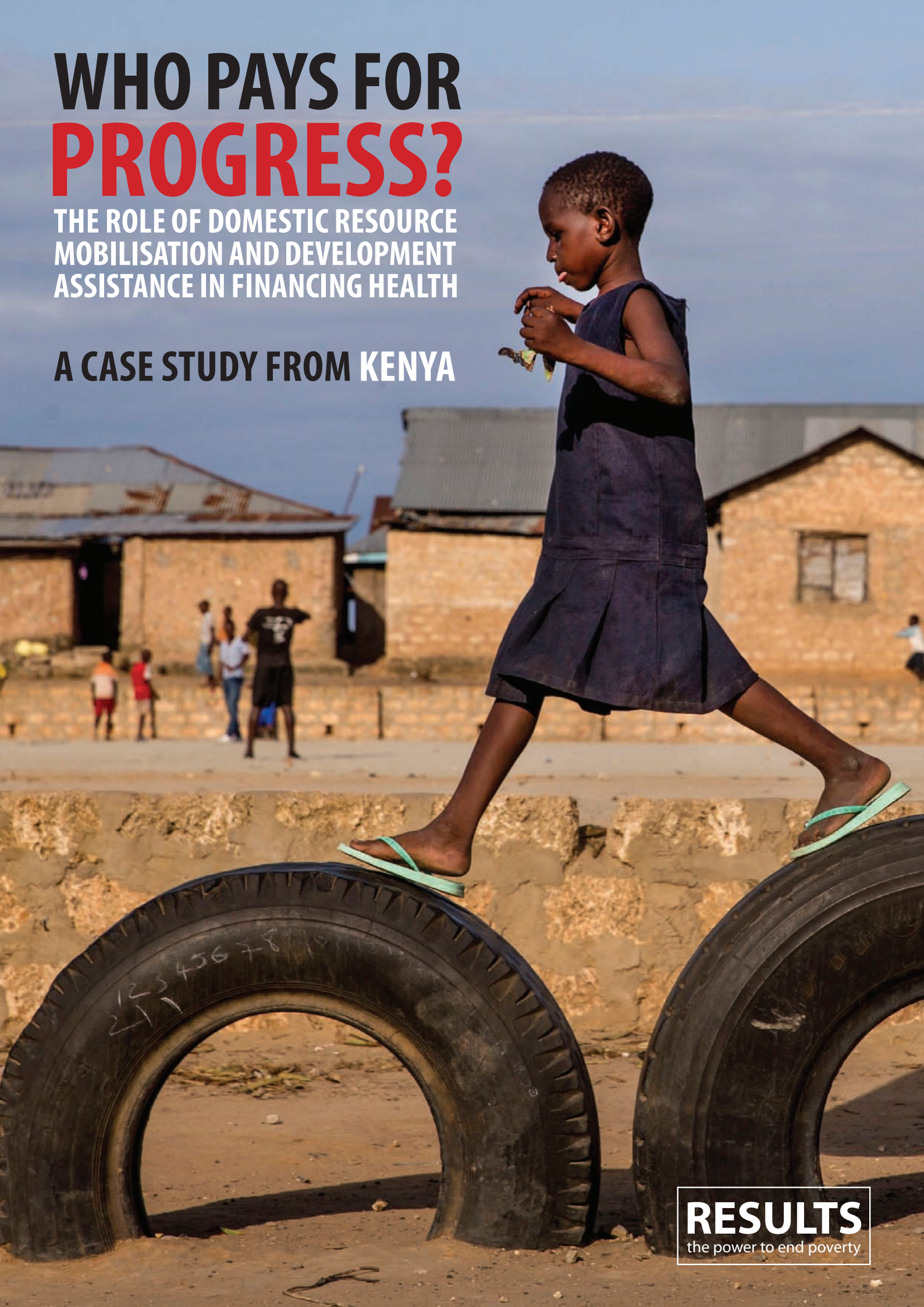
WHO PAYS FOR PROGRESS?

THE ROLE OF DOMESTIC RESOURCE MOBILISATION AND DEVELOPMENT ASSISTANCE IN FINANCING HEALTH

A CASE STUDY FROM KENYA



RESULTS
the power to end poverty

> We know that our social and economic transformation shall come first from within our nations, our region and our continent, and only secondly from the compliment of external ideas and resources
>
> **PRESIDENT KENYATTA,**
> **UNITED NATIONS GENERAL ASSEMBLY 2014**

ACKNOWLEDGEMENTS

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METHODOLOGY

The research for this report was based on semi-structured interviews with economists, academics, civil society, the Government of Kenya, UN organisations, and health professionals in Kenya during March 2015, followed by desk research and internal discussions within the ACTION Global Health Partnership member organisations. Some quotes from interviewees are found in the text. Any errors are those of the author.

When discussing Official Donor Assistance (ODA) we focus on OECD-DAC countries and do not explore assistance from non-OECD countries.[2] We acknowledge that finance for development comes from many sources, such as private investment and remittances. This reports focuses on ODA and Domestic Resource Mobilisation (DRM), as these are the funding sources most likely to be used to reach the poorest sectors of the population through public health services.

Kenya was chosen as our country case study as an example of one of many developing countries recently 'graduating' to middle-income status. With this in mind, the report does not go into detail on the issue of devolution in Kenya. The implications of devolution are still continuing to emerge and it is too early to assess the impact of devolution on health provision. This would require a separate report.

All figures are given in US dollars unless stated.

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EXECUTIVE SUMMARY

Kenya has one of the most vibrant economies in Sub-Saharan Africa. Economic growth is strong, and in 2014 it was announced that Kenya had crossed the threshold from a 'Low-Income Country' (LIC) to a 'Lower-Middle-Income Country' (LMIC). Yet, 43% of the people live on less than $1.25 a day and in some parts of Kenya only 28% of infants are fully immunised. Lack of finance is the main, though not only, cause of these poor health indices. This report examines what can be done in Kenya to bring additional finance into the health sector.

The Government of Kenya aims to achieve Universal Health Coverage (UHC). UHC is defined as ensuring that all people receive the health services they need, without suffering financial hardship. UHC would bring a number of benefits for the nation: First it would save lives and reduce disease and disability. For example, the Ministry of Health has estimated that 3 million lives can be saved in Kenya by 2025 by moving to a UHC approach for maternal and neonatal care.

Second, increased funding for health is an economic investment for the country. It is estimated that a quarter of all growth in full income in low- and middle-income countries between 2000 and 2011 resulted from health improvements.

A third benefit is more subtle but no less important. As economies grow and local investments increase, gaps in health coverage will begin to shrink. This helps dispel a number of damaging myths in donor nations, for example that "nothing ever changes, and aid will be always be needed." Destroying these myths is necessary if we are to protect spending on Official Development Assistance (ODA).

HEALTH AND EQUITY IN A NEW MIDDLE-INCOME COUNTRY

In Chapter 2, the report outlines the concern in Kenya that the country will lose access to ODA given its new LMIC status. Since almost half of Kenya's funding for health programmes comes from donors, it is feared that the change from LIC to LMIC status could result in a serious drop in funding for health programmes. This does not need to be a problem since other options are open. In fact World Bank President Jim Kim has said that "If we rely only upon foreign aid, then our aspirations are far too low."[i] Health care in Kenya is a mixed story of progress and inequality. While in some areas there has been good progress, in others there still remains much to be done. For example, the 2014 national health survey showed that 32% of children aged 12-23 months are not fully vaccinated and that 39% of births are still delivered at home. Overall it is estimated that for at least 25% of the population there is an unmet need for most forms of health care.

Kenya needs to bring in additional finance in order to fund such gaps in provision. To reduce the unmet need in health, in an era of shared responsibility, the government needs to increase Domestic Resource Mobilisation (DRM) and donors need to increase. Economic growth at present is strong, but the pattern of economic growth is very unequal. Recent evidence from the International Monetary Fund (IMF) calls for increased investment in health and education to reduce poverty, and states that "Raising the income share of the poor is actually good for growth."[ii]

FINANCING HEALTHCARE IN KENYA

In Chapter 3 the report considers how healthcare is financed in Kenya. Around 48% of all expenditure on health is Out of Pocket expenditure (OOP). Evidence shows that the more a country relies on OOP financing, the more its poorest households face the risk of financial catastrophe. The long-term strategy for Kenya should be to reduce the percentage of healthcare paid for by OOP expenditure and increase the percentage covered by government sources.

Kenya has made good progress on removing health user fees; however overall, the finance available for publicly provided healthcare in Kenya is insufficient. As a percentage of GDP, only 4.7% is spent on health. This is low in comparison to neighbouring countries such as Tanzania (7%) or Uganda (10%).

Within public funding, a key balance lies between funds provided by donors (ODA), and funds raised inside the country (DRM). Figures from WHO show that 45% of the health budget in Kenya is financed by ODA. Some programmes are even more dependent on donors, for example around 70% of the HIV/AIDS budget is provided by ODA. These figures show the percentage of funds being provided for existing programmes; however, there still exists a gap of unmet need. For example, in Kenya, the Tuberculosis response is 23% funded domestically, 17% funded internationally, but the remaining 60% of need goes unfunded and unmet.

ODA in Africa has helped increase the provision of health services but cannot deliver sustainable development on its own. For that, local generation of resources is essential. Increasing the percentage of healthcare covered by DRM is advantageous, because domestic resource flows are predictable and make fiscal planning easier for a country compared to ODA, which is not under a country's direct control. President Kenyatta himself in June 2015 called on African leaders to move away from dependence on ODA and therefore raise the percentage covered by domestic resources.

However, it takes time to scale up domestic resource mobilisation and it does not always cover the need. A study in The Lancet shows that even using the most optimistic DRM scenario, with a tripling of funding allocated to HIV/AIDS, Kenya would still only be able to fund 66% of its HIV/AIDS budget, leaving an unmet need of 34%. Therefore this report offers the premise that it is only possible to achieve equitable access to health with both an increase in domestic resources and an increase in development assistance. ODA is certain to be a vital part of the development landscape, at least for the short and medium term.

FUTURE ODA FUNDING

In chapter 4 the report looks at the major health donors and asks what their likely response will be to the change in Kenya's income status in order to assess if they are likely to decrease their support to Kenya in the near future.

It appears that although ODA will not decrease immediately, in the next 3 to 5 years the process will begin. Kenya will have to contribute more to donor counterpart funding, will begin to find it more difficult to access ODA and will begin to find development finance borrowing to be slightly more costly. As the Kenyan economy grows the percentage of finance received as ODA will decrease and the percentage of loans will increase. Therefore some analysts consider that the most important change in the next decade will be the rates of interest on which Kenya receives loans from the World Bank, African Development Bank and IMF.

INCREASING DOMESTIC FUNDING FOR HEALTH

In Chapter 5, the report looks at ways to make more funding available for public health in Kenya. The most sustainable way to move towards UHC is to strengthen the tax base and raise more funds for the national budget. Analysis by the Kenya Institute for Public Policy Research estimates Kenya's overall untapped tax capacity to be KSH 244bn ($2.86bn) per year, which is more than double the current government spending on health. This report looks at four possible ways of increasing tax income that could be used for healthcare:

1 **Increase the prioritisation given to health in the national budget. At present Kenya only spends around 5.6% of it's budget on health, much lower than its commitment made in Abuja to allocate at least 15%.**

2 **Increase the overall efficiency of the tax system. For example, it is believed that more tax could be collected both from high net worth individuals and from multinational companies. Donor nations can support improvements in efficiency of the revenue service, which gives excellent return-on-investment.**

3 **Reduce Illicit Financial Flows (IFFs) out of the country According to research, Kenya lost $4.9 billion in capital flight in 2010 alone: this is approximately $120 per person.** [iii]

4 **Strengthen pooled Social Health Insurance but cover, through tax revenue, the contributions of the poorest members of society.**

Chapter 6 makes recommendations both for the government of Kenya and for donors. The recommendations for Kenya range from preparing in advance for a gradual decline in support from donors, through to strengthening tax mechanisms. The major recommendation for donors countries is to make progress towards meeting 0.7% of GNI to ODA, with a timetable for reaching that point preferably by 2020, and for donor institutions to avoid withdrawing from LMICs 'too fast, too soon.' All LICs and most LMICs will continue to need donor support for many years to come if the country is to make progress on reducing the unmet need, and move towards UHC.

i *Jim Yong Kim, President of the World Bank Group, Oxfam Blog, Private Sector Investment is Critical to End Extreme Poverty, October 2013, available at https://blogs.oxfam.org/en/blogs/13-10-28-private-sectorinvestment-critical-end-extreme-poverty (accessed 17.06.15)*
ii *IMF, Causes and Consequences of Income Inequality, A Global Perspective, June 2015*
iii *Political Economy Research Institute, Research Report 2012, Capital Flight from Sub-Saharan African Countries: Updated Estimated, (1970 – 2010), page 11*

1 | INTRODUCTION

> The statistics have changed but you don't see any difference for most of the people
>
> **KENYA HEALTH MINISTRY OFFICIAL[1]**

Kenya is a country of 44 million people and has one of the most vibrant economies in Sub-Saharan Africa. Economic growth in recent years averages 6% per annum, and in 2014 it was announced that Kenya had crossed the threshold from a 'Low-income Country' to a 'Middle-Income Country' (MIC).[2] Yet 43% of the people live on less than $1.25 a day and Kenya languishes in 147th place in the World's Human Development Index.[3] In some parts of Kenya, only 28% of babies are fully immunised and over a quarter of children are stunted.[4] Lack of funds is the main, although not the only, cause of these poor health indices. This report examines what more can be done in Kenya to bring additional funding into the health sector, and the lessons learnt and shared with other developing countries.

This report focuses on who pays for health progress in Kenya – between households, the government and donors. It looks at how the relative contribution of each might change in the wake of the change to Middle-Income status, if current progress is to be sustained. We especially look at how healthcare is financed in Kenya, and the balance between Domestic Resource Mobilisation (DRM) and funding from donors, ODA.[5]

Most African leaders and development economists think the way forward for African developing countries is to plan a course for achieving Universal Health Coverage (UHC), which aims to provide healthcare to all, including the poorest.[6] Secondly, they believe it can be achieved if Domestic Resource Mobilisation (DRM) is substantially increased while donor assistance continues and increases.[7]

Speaking at the United Nations General Assembly in 2014, His Excellency, President Kenyatta of Kenya underlined this by saying:

> We know that our social and economic transformation shall come first from within our nations, our region and our continent and only secondly from the compliment of external ideas and resources[8]


Tembelea
kliniki
unapokua
mjamzito
AFYA YA

Both DRM and ODA are crucial to achieving better health outcomes in Kenya because tax and donor finance provide the funds for the public health sector, which runs the majority of health services in Kenya. This short report focusses on public sector health provision, which provides healthcare to the majority of Kenyans. Private healthcare, paid at the time of provision, is not an option for the vast majority of the country, and private health insurance schemes tend to reach a small clientele consisting of the relatively healthy and wealthy. Expanding public provision of health services is key to achieving UHC.

This case study aims to look at the situation in one country and one sector, and bring out some achievable recommendations that can be acted on in both donor countries and implementing countries. Many of these points could also be applied to other countries in Africa. Kenya is not unique, it is just one country of many that is looking for a better way to finance healthcare and a feasible plan for achieving UHC.

CASE STUDY

KENYA

KENYA WAS CHOSEN AS A CASE STUDY FOR THE FOLLOWING REASONS:

- **Kenya is a major recipient of ODA and its health sector is heavily dependent on donor support.[9]**
- **Kenya has just become a MIC and there is concern that donor support will decrease in the coming years.**
- **Kenya is a developing African country with good economic potential. To some extent Kenya is a development success story. For example, the infant mortality rate has fallen from 74 per 1,000 in 2008 to 52 per 1,000 today.[10]**
- **President Kenyatta has been visible and vocal on the topic of Domestic Funding for Development and there is a high level of political support for DRM.[11]**

THE VIEW FROM DONOR NATIONS

The overall recommendations of this report are that donors should sustain and increase ODA, and that African countries can and should increase their domestic mobilisation of resources for development. Increasing DRM and targeting funding to those most in need will have some clear benefits. It will improve the health of the poorest elements of society and will also reduce dependence on donor nations. However, there is another benefit that is less obvious: increasing African mobilisation of funds for development in a visible way sends a message that foreign aid will not be needed for ever and thus supports the efforts of those politicians in donor countries who argue for the provision of aid.

In donor countries, some politicians are in favour of increasing ODA, while others aim to cut the aid budget. In various countries in recent years, assistance to Africa has been reduced. Some politicians and media in donor countries are "tired" of the narrative of supporting aid. Even in the UK, a country with commendable support for aid, there is now a political party that wants to cut aid by 90%.[12]

It is essential that developing countries are seen to be assisting their own populations more so as to dispel the persistent – and inaccurate – myths that many developing countries do not pull their weight when it comes to looking after their own people.

THREE COMMON MYTHS ABOUT DEVELOPMENT:

01

MOST DEVELOPMENT WORK IN AFRICA IS PAID FOR BY DONORS

Many politicians in donor countries believe that overseas aid is the main source of finance for development programmes in developing countries. In fact most development work is paid for from domestic sources. Globally, ODA only accounts for around 10% of development finance.[13] In India ODA contributes just 0.2% of their GNI[14]. Although in many countries, including Kenya, the health sector is too dependent on ODA (see chapter 3), this is beginning to change. It will be beneficial to demonstrate that development in Africa has been, and is increasingly being, paid for by Africans themselves.

02

NOTHING IS CHANGING

A common refrain from some commentators in donor countries is that "We are spending all this aid each year and nothing is changing." That is why it is essential that development agencies and developing countries themselves publicise the progress being made. For example, globally in 1999, 13 million children died before their fifth birthday. That figure has now been halved.[15] Global progress is made up of many country-level success stories: In Kenya, annual AIDS-related deaths declined from about 85,000 in 2009 to 58,000 in 2013.[16] This tremendous and tangible progress should be better publicised.

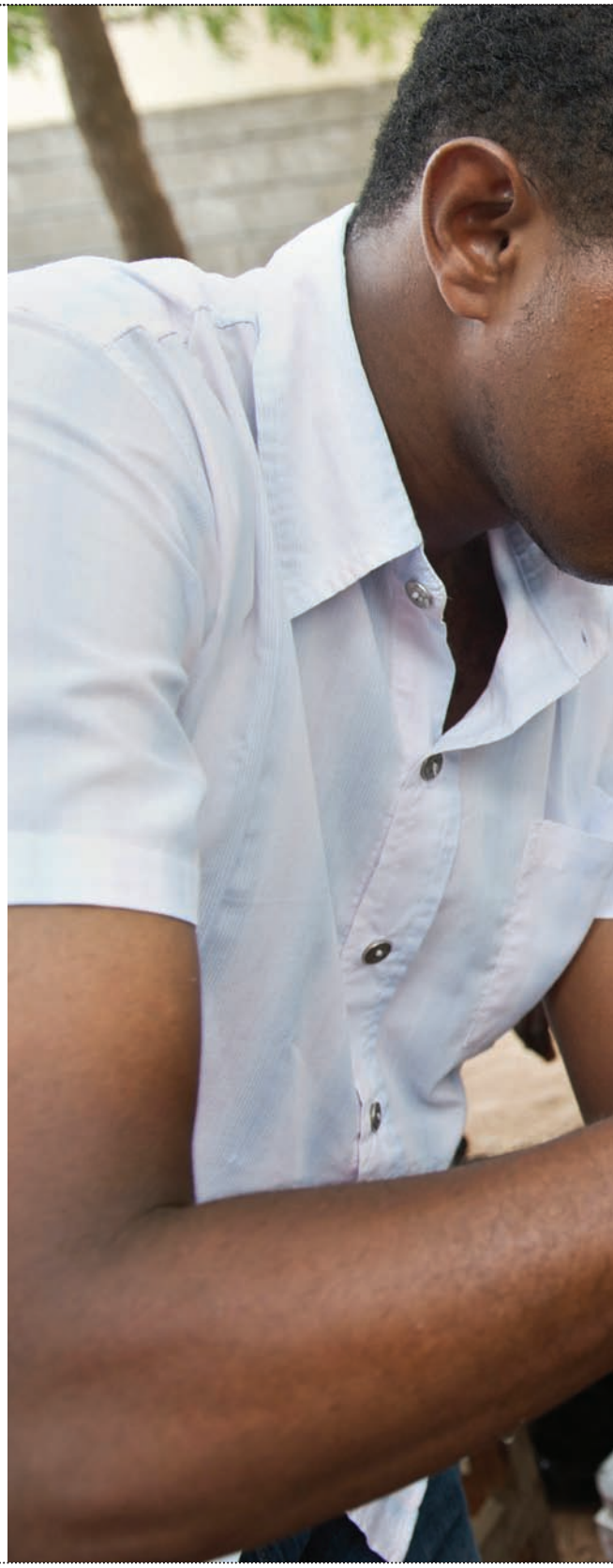
03

'MOST AID IS LOST TO CORRUPTION'

Corruption exists in all countries in the world and at all levels, from junior public servants, to global institutions. Corruption at any level should be stamped out. The narrative that leaders in countries receiving development assistance have free rein to misuse funds does not match today's reality. The development world has never had better monitoring, auditing, and transparency of development funds, including freer press, more active civil society, and well-functioning political systems in recipient countries. Organisations like the Global Fund, for example, transparently pursue funds lost to corruption, and have a strong track record of reclaiming these funds.[17] As African countries raise a larger percentage of their own funds, and spend them wisely, the myth of pervasive corruption consuming 'most aid' will be shown to be false.

2 | HEALTH & EQUITY IN A NEW MIDDLE-INCOME COUNTRY

> Despite economic growth over the last decade, healthcare outcomes in Kenya remain weak. Rates of maternal mortality and stunting among children have barely changed…
>
> **WORLD BANK, FINANCIAL REPORT (KENYA), JUNE 2014[18]**



According to the World Bank categorisation, Kenya was a Low-income Country (LIC) until 2012, and thus for many years has been a substantial recipient of ODA from donor nations. In September 2014, it was announced that after a 'rebasing' exercise undertaken by the Ministry of Finance, the national income was sufficiently high, at $1,160 GNI per capita, for Kenya to become a MIC.[19] Since there are a large number of MICs, the World Bank categorisation makes a distinction between a Lower-Middle-Income Country (LMIC) and an Upper-Middle-Income Country (UMIC).

With new LMIC status, there is a major concern in Kenya that the country will lose access to donor grants and concessional finance. The World Bank and other financing institutions apply different policies for LICs and for MICs. Since most funding for health programmes comes from donors, some officials are worried that ODA will begin to dry up, or made available only on more onerous terms and conditions. It is thus essential, if Kenya is aiming to achieve UHC, to start planning now.

KENYA'S HEALTH TODAY

CHILD **UNDER-FIVE MORTALITY RATE** IS **52 DEATHS** PER **1,000 LIVE BIRTHS**[26]

26% **OF CHILDREN UNDER FIVE** ARE STUNTED (TOO SHORT FOR AGE)

8% ARE **SEVERELY STUNTED**[27]

60% **OF HOUSEHOLDS OWN AN INSECTICIDE-TREATED NET** TO PREVENT THE TRANSMISSION OF **MALARIA**

40% **DO NOT**[28]

HIV/AIDS **PREVALENCE IS** **5.6%**

THIS HAS **DECLINED SUBSTANTIALLY SINCE 2010**[29]

KENYA IS ONE OF THE **22 HIGH TUBERCULOSIS BURDEN COUNTRIES** THAT CONTRIBUTE 80% OF **GLOBAL TB**

But progress is being made: the country has moved from 10th highest (worst) to 15th highest, from 2006 to 2013.[30]

THE HEALTH GAP

Globally, there is a shortfall in funding for health. The most recent study showed that to achieve UHC in MICs alone, $270 billion would be required.[20] The Global Fund has an 'unfunded' register of proposals which need almost $2 billion in funding.[21] In Kenya, figures from the most recent Demographic and Health Survey (DHS) suggest that at least 25% of the population regularly lack access to healthcare. This is especially the case for those in the lowest quintile.[22] Health services and health workers are concentrated in urban areas, whereas 75% of the population live in rural areas.[23] The DHS showed that 32% of children aged 12-23 months are not fully vaccinated and that 39% of births, mainly in rural areas, are still delivered at home with the ensuing risk.[24] The basic vaccination rate declined from 77% to 71% from 2008 to 2014, and in some Northern counties vaccination rates are only 42%.[25] The unmet need in provision is the reason Kenya should bring in additional finance. To do this the government should increase DRM and donors need to increase aid.

INEQUALITY IN KENYA

Kenya is among the top 10 most unequal societies in the world, with the richest 10% owning more than 40% of the land and resources, and the poorest 10% a mere 1%.[31] The richest quintile of the population takes home 53% of national income, whereas the bottom quintile takes only 5%.[32] Kenya had 8,400 dollar millionaires in 2012 and in Nairobi alone there are at least 65 high net-worth individuals with wealth exceeding $30 million.[33] Yet 43% of Kenyans live on less than $1.25 a day.[34] The IMF and the Word Bank are both agreed that inclusive growth is a preferred route to boost economic growth in a country. A recent IMF report stated that "If the income share of the top 20% increases, then GDP growth actually declines over the medium term, suggesting that the benefits do not trickle down. In contrast, an increase in the income share of the bottom 20% is associated with higher GDP growth."[35]

The health statistics cited in Kenya's Health Today (see box above) give a misleading impression because they are national averages. Inequalities in income translate into inequalities in health provision across the country. For example, within the most wealthy 20% of the population, 70% of women who gave birth had a postnatal examination within 48 hrs, but in the poorest 20% of the population the figure was only 30%.[36]"

Even in our best performing counties in terms of immunisation rates, outbreaks of vaccine-preventable diseases are being reported. This is because the poorest are not reached with the vaccines. Vaccination is our most cost-effective intervention, but in the Horn of Africa the rates are stagnant. An estimated one million children are missing, usually the poorest

PETER OKOTH, HEALTH SPECIALIST, CHILD HEALTH, UNICEF KENYA

Inequalities are especially severe in the national nurse-to-population ratio: in Kenya there are 51 nurses per 100,000 population. However this figure varies from 122 nurses per 100,000 in Isiolo County to just 20 in Wajir, and as low as 9 per 100,000 in Mandera.[37] Further, nurses and healthcare professionals are disproportionately based in the country's main hospitals, which are inaccessible for the much of the population. Unequal access to healthcare holds back progress for the entire sector. Making progress on the issue of inequality in Kenya would make it easier to deliver UHC across the country.

MOVING TO UNIVERSAL HEALTH COVERAGE IN KENYA

Kenya's quest for universal access for health is achievable but expensive. Investing in comprehensive primary healthcare is a cost effective way to achieve universal health coverage[38]

THE WORLD BANK, FINANCIAL REPORT (KENYA), JUNE 2014

Universal Health Coverage is defined as ensuring all people receive the health services they need, without suffering financial hardship. In the language of the Sustainable Development Goals the desire is "to leave no-one behind". Because it is difficult for this to happen overnight, countries move in incremental steps towards UHC. In order to achieve UHC a country needs:

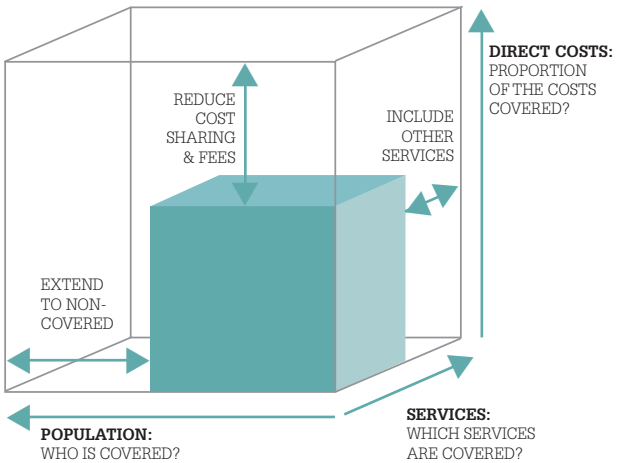
- **Sufficient Human Resources for Health (HRH)**
- **Sufficient facilities, such as buildings and vehicles, adequately equipped**
- **Sufficient finances so that all people can obtain needed services without experiencing financial hardship**

Universal Health Coverage brings with it many benefits. Firstly, UHC is a critical pillar of the strategy in the Sustainable Development Goals, to address poverty and social exclusion, and will bring strong benefits in terms of lives saved and disease averted.[39] As part of the planning process for the Global Financing Facility (GFF), the Ministry of Health has estimated that 3 million lives can be saved in Kenya by 2025 by moving to a UHC approach for maternal and neonatal care including pre-conception nutrition, improved care around labour, during birth, and in the first week of life.[40]

Secondly, UHC is cost-effective and has a long-term beneficial effect on a country. A quarter of the growth in full income in low- and middle-income countries between 2000 and 2011 resulted from health improvements.[41] Global figures show that every dollar invested in nutrition to reduce stunting yields a benefit of more than $16.[42] If people are healthy, they are able to be economically productive members of society. Further, The Lancet estimates decreasing mortality accounts for 11% of recent economic growth in LICs and MICs.[43] Therefore planning a course to achieve UHC is an economic investment for the country, even though it requires an initial upfront cost.

THE UHC CUBE

The UHC cube, from the 2010 World Health Report, shows the different policy choices available for moving towards universal coverage. The three axes show the three dimensions that can be expanded to ensure universal coverage: the population, the service and the cost. For example, if you wish to expand the service, you could include nutritional health services for young women during pregnancy to increase the quality of the service, which would also reduce infant mortality.



3 | FINANCING HEALTHCARE IN KENYA

> Even tiny Out-of-Pocket charges can drastically reduce the use of needed services. This is both unjust and unnecessary
>
> **THE WORLD BANK GROUP PRESIDENT, JIM YONG KIM[44]**

HEALTHCARE IS UNDERFINANCED

A nation's healthcare is financed by private sources or public (government) sources. Private sources include Out-of-Pocket (OOP) spending and private insurance schemes. OOP expenditure is the most regressive form of health financing and hurts the poorest the most. In some cases, OOP costs can become catastrophic - pushing families into selling livestock and businesses and further into acute poverty. In Kenya, it is estimated that 48% of all expenditure on health is OOP.[45] The long-term strategy for Kenya and other developing countries must be to reduce the percentage of healthcare paid for by OOP expenditure and increase the percentage covered by government sources. Evidence shows that the more a country relies on OOP financing, the more its poorest households face financial catastrophe.[46]

Any fees for healthcare at the point of delivery (user fees) are an impediment for low-income Kenyans who need to access healthcare. The Government has reduced user fees in the last decade and has introduced a number of free gov-


12

CASE STUDY

MARY'S BATTLE WITH TB: THE IMPACT OF USER FEES FOR ONE KENYAN FAMILY

Mary Ruto lives in Kangemi , a slum area of Nairobi, with her parents. At the age of three, she had symptoms which were diagnosed as a common eye infection, and she was given eye drops. The problem kept recurring yet she was always offered the same treatment. At the age of four her symptoms progressed to swollen lymph glands, a much more serious condition, which gravely worried Mary's parents.

Her parents visited a number of local hospitals but no-one was able to diagnose the cause of Mary's symptoms. As her condition worsened and with no satisfactory treatment suggested by local doctors, Mary's parents turned to a 'specialist' doctor in a private health facility in the hope of getting treatment for Mary.

The 'specialist' doctor charged Ksh 4,500 ($45) for a consultation every two weeks, and when Mary's condition got worse, the doctor became 'unavailable' and they could not contact him. The doctor's fees and the cost of fuel to travel to appointments cost Mary's family their savings and they lost the small business they ran.

Mary's family brought her to a public health facility, Mgabathi hospital, a District Hospital in Nairobi County, in the hope that it would be cheaper. A biopsy for Tuberculosis (TB) was recommended. They were required to pay for some items including Ksh 600 ($6) for a syringe and Ksh 1,300 ($13) for drugs. The family could not afford to pay this straight away and it took them a month to raise the funds. Meanwhile Mary's health worsened as she could not be put on treatment. Mary continued vomiting, had a low appetite and was socially cut off as she was too weak to play or go to school.

Eventually her parents raised and paid the funds and the tests were carried out. Results showed Mary had extra-pulmonary TB. She was referred to a facility in Kangemi (near her home), where she was found also to have malnutrition. Mary finally received the TB medication and nutritional support she needed. In February 2015, after nine months of treatment, she successfully completed her treatment for TB.

"Mary's sickness was the most trying period of my life" said Mary's mother. "The disease finished our business and ate up our every resource. We are now on a journey to rebuild our business, but I don't know if we will ever fully recover." Mary's diagnosis took over 10 months, and the family had to pay, including the cost of travel, over Ksh 50,000 ($500) before Mary even received any treatment.

Evelyn Kibuchi, from KANCO, adds, "An exorbitant charge for TB diagnosis in children discourages seeking treatment. Some parents just give up, they stay home with the child. If you can't get a clear diagnosis, it's an avenue for troubled parents to be ripped off."

ernment services, including introducing free maternal healthcare. However, in practice, many health posts continue to charge for services, often because otherwise they would not have funds to operate.[47] The low health service budget, especially in rural areas, weakens equitable access to healthcare and widens the gap between the rich and the poor. In the absence of a health service free at the point of delivery, patients often delay seeking treatment, pushing them into further ill-health, which in turn deepens poverty. Globally health user fees have been estimated to push 150 million people into poverty each year.[48]

In order to reduce health disparities and reach more people with services, Kenya should reduce the percentage of health spending that comes from OOP and increase public financing. This is the most equitable way to finance a health system, as it pools resources from the whole population, allowing redistribution from the wealthier or healthier groups in the population to those who are poor and sick.

PUBLIC FINANCING

> Health is a low priority. …The Kenya development model relies heavily on economic growth and trickle down to fund social programmes. We can only sustain development progress if the government allocates sufficient resources

JOHN KITUI, COUNTRY MANAGER, CHRISTIAN AID KENYA[49]

In Kenya there is insufficient finance available for primary healthcare to cover the entire population with no user fees. That is why in some areas health posts are understaffed, mothers die in childbirth and children go without essential vaccinations. It can be seen through two measures: health spending as a percentage of GDP, and health spending as a percentage of national budget. In Kenya, 4.7% of GDP is spent on health. This is low in comparison to other countries such as Tanzania and Sudan (7%), Uganda (10%), and Rwanda (11%).[50] As a percentage of the overall national budget, only around 5.6% is spent on health.[51] This is considerably less than many African Governments, including Kenya, signed up to in 2001 with the Abuja Declaration which committed them to spend 15% of their budget on health.[52] Few countries have met the commitment signed up to at Abuja.

BALANCE OF ODA AND DOMESTIC FUNDING

> The leadership of the health sector needs to be the country- if we don't own our health service we can't make demands on others.[53]

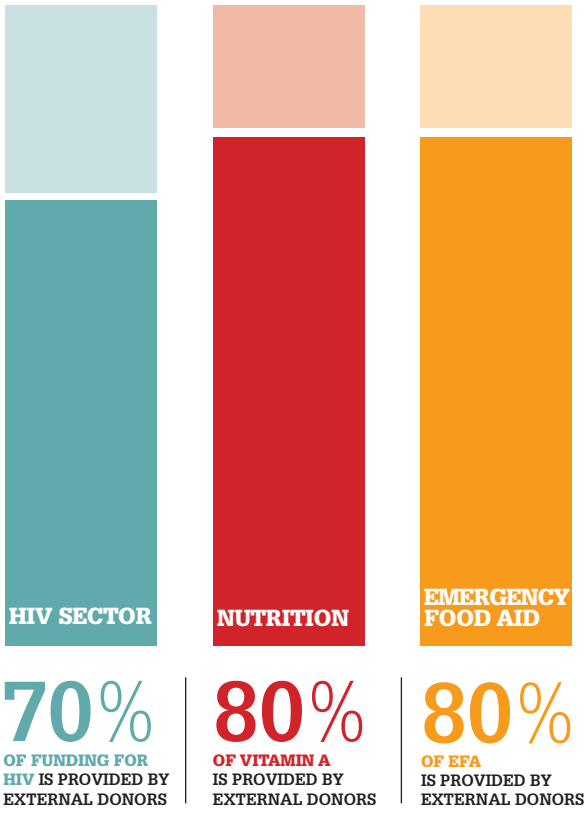
REGINA OMBAM, HEAD OF STRATEGY DEVELOPMENT, NATIONAL AIDS CONTROL COUNCIL (NACC), KENYA

Public financing of the health system is the most important funding source for a country's population, especially for the poorest, such as women and girls in rural areas. The key balance is that between funds provided by donors (ODA), and funds raised inside the country (DRM). ODA to health in Africa has helped increase the provision of health services but cannot deliver sustainable development on its own. For that local generation of resources is essential.

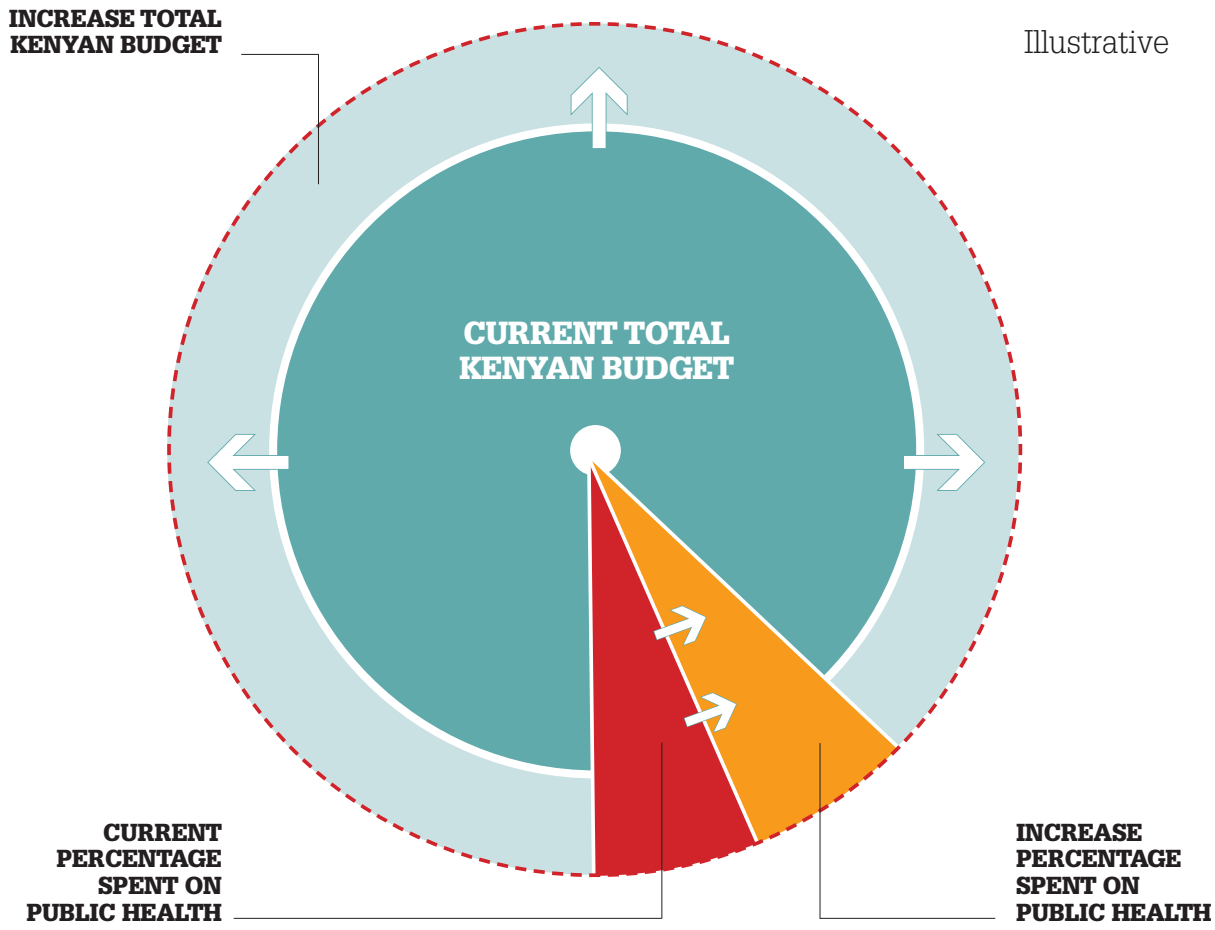
In a series of interviews with health stakeholders in March 2015, the very high level of dependence on donor funding for many essential health programmes was apparent. It is estimated that around half of the health budget in Kenya is financed by ODA when one includes the staffing and health delivery system.[54] However, our research has shown that many individual programmes have a much higher dependency on donor aid, including:

- **In the HIV sector, around 70% of funding in Kenya is from donors.[55]**
- **In the nutrition sector, 80% of Vitamin A is provided by Micronutrient Initiative (MI) and UNICEF, while 80% of emergency food aid is provided by World Food Programme (WFP).[56]**

OVERDEPENDENCE ON ODA



WHAT CAN BE DONE TO MAKE MORE FUNDS AVAILABLE FOR PUBLIC HEALTH?



In addition, the above statistics only show the percentage of funds being provided for existing programmes. There still exists a gap of unmet need. For example, in Kenya, the TB response is 23% funded domestically, 17% funded internationally but is currently 60% unfunded.[57] It is for this reason that Kenya should increase DRM as a way to fill the financing gap for health.

DOMESTIC RESOURCE MOBILISATION

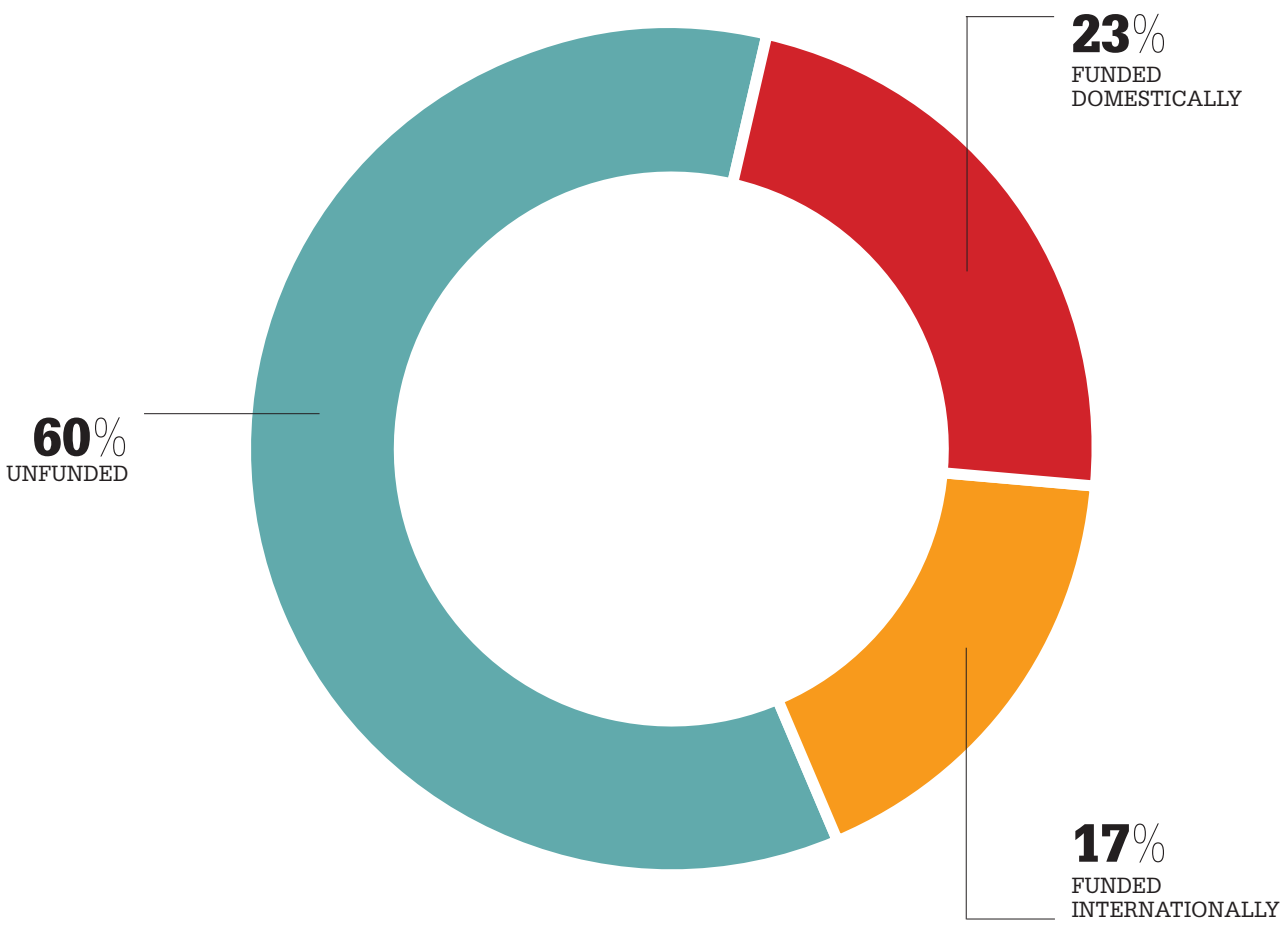
African countries are showing that it is possible to fund more of their health and development programmes from domestic resources. Africa already generates more than US$520 billion annually from domestic resources and the title of a recent report, "From Billions to Trillions: Transforming development financing" is indicative of the progress the World Bank feels is achievable in terms of increasing DRM.[58]

DRM can include philanthropic initiatives such as the 'Beyond Zero' Campaign in Kenya. This campaign raises funds from the public to help reduce maternal and child mortality, and is spearheaded by The First Lady of Kenya, Margaret Kenyatta.

More usually however, the term DRM is used to describe government efforts in a country to raise additional funds for public spending. In May 2015, the African Union produced a progress report on the 'Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria Response.' Among many signs of progress, figures show that domestic funding of the AIDS response has increased in Rwanda (up to 24% of total), Liberia (19%), Zambia (16%), and Togo (15%).[59]

Domestic Resource Mobilisation is the most desirable source of funding, for Kenya and other developing countries, for the following reasons:

HOW IS FUNDING FOR TB ALLOCATED IN KENYA?



- **Domestic resource flows are predictable and make medium-term fiscal planning easier for a country compared to ODA which is often unpredictable. For example, in May 2015 Australia cut ODA to Africa by 70%.[60]**

- **Domestic resources create fiscal space for the country to prioritise its spending in line with its own policy priorities and political commitments. In comparison, ODA is frequently delivered with conditions attached, especially in controversial areas such as family planning or abortion policies.**

- **DRM through taxation is crucial for creating the sense of participation among people in the development process of the country. This can act as a mechanism to create pressure on the public representatives to be accountable and transparent on the use of resources.[61]**

- **Increased DRM improves a country's credit-worthiness in international finance markets.[62]**

It is important to note that DRM is not a magic bullet, and increasing domestic finance does not eliminate many of the challenges which exist with finance for health. For example, in the HIV sector, spending needs to increase significantly in the short term to reverse the epidemic and to save lives and funds, in the long term. The Lancet recently identified that even using the most aggressive DRM scenario, (with a tripling of funding to HIV/AIDS), Kenya would still only be able to fund 66% of its HIV/AIDS budget, leaving an unmet need of 34%.[63] Therefore we will only see a major advance in filling the financial gap with both an increase in domestic resources and an increase in aid. ODA remains a vital and essential part of the development landscape.

4 | CHANGE IS COMING…

> We have been talking about sustainability since 2009 - that was the year we had stock-outs of essential medicines - but so far little has changed.
>
> **NELSON OTWOMA, EXECUTIVE DIRECTOR, NEPHAK[64]**

STATIC GLOBAL ODA

As discussed before, although there is considerable unmet need for health provision in Kenya, it is unlikely that ODA will increase in the future, mainly owing to Kenya's graduation to a LMIC. Donor countries should meet their promise to spend 0.7% of their GNI on ODA – preferably by 2020. However, the OECD DAC has forecast a likely levelling off, if not decrease, of aid spending in the immediate future unless there is a change in the commitment from donor nations.[65] In real terms there was a 0.5% fall in total ODA in 2014.[66] Whilst ODA to health rose significantly from 2000 it has flattened since 2010.

Currently, only 5 countries, including the UK, have met their commitment to 0.7%, and some are moving in the opposite direction. For example, in May 2015, Australia announced it was cutting aid to Africa by 70%.[67] Even if ODA rises, Kenya is unlikely to receive any increased funding as Kenya is already the largest ODA recipient from Japan, and the 6th largest from the US and the UK. If the trend for static or decreased ODA funding continues it is important to consider two things: alternative sources of finance for essential development programmes, and how efficiency can be improved.

INSTITUTIONAL POLICY CHANGES FOR NEW MICs [68]

> We would be happy to see all donors ask for local contribution - that is a healthy relationship.
>
> **NELSON OTWOMA, EXECUTIVE DIRECTOR, NEPHAK[69]**

Most global agencies have criteria of Eligibility to determine how countries can receive ODA funding, and Graduation, which determines when a country loses access to funding. Some agencies also require certain conditions to be met to receive support. It might be assumed that all the agencies would use the same set of criteria, for example the same LIC to MIC cut off point. In fact, each institution has a different set of policies.

Some donors, both bilateral and multilateral, are not happy with the current dependence on definitions of LIC and MIC status based mainly on country income figures (GNI). There is a discussion going on at present, named the Equitable Access Initiative (EAI),[70] around whether improvements could be made to the classifications for the purposes of health financing. From this it may be possible to include a wider set of criteria, including burden of disease and human development indicators.

Below is a rapid overview of the four major agencies involved in ODA for health in Kenya and how their policies will affect financing in the short term. Overall, it appears that within about 3 years it is likely Kenya will start to lose some access to ODA, concessional finance and concessional trade.

THE GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA

The Global Fund has been one of Kenya's most important health partners in the last decade. Kenya has received around $385 million for HIV, $254 million for malaria and $53 million for Tuberculosis (TB), making a total of almost $700m so far.[71] Global Fund financing policies will entail some changes for Kenya now that it is a LMIC.

In terms of funding, LICs are asked to contribute 5% of programme costs while MICs should contribute 20%. According to Regina Ombam from the National AIDS Control Council, this will not present immediate difficulties because Kenya in recent years has already been making a counterpart contribution of around 20% of Global Fund grant budgets, taking into consideration health facilities and costs of health workers. However that still leaves Kenya overly dependent on the Global Fund contributing 80% of the total programme.

In terms of programming, more policy conditions are imposed on grants from the Global Fund for LMICs. While an LIC can submit any programme it thinks appropriate, a LMIC must devote at least 50% of their grant to focus on pre-specified populations.[72] Therefore, from 2016 onwards, Global Fund grants will only be available to fund more specific interventions than previously.

It is unknown whether Global Fund finance will decrease after 2017. The Global Fund places countries in four 'Bands' and uses a complex allocation formula to determine how much funding to allocate to each country. A new country allocation will be calculated for 2017 onwards – with more funds raised meaning more funds available to countries. With current rules, Kenya will remain in 'Band 1', described as 'Low Income, High Burden', meaning there are no dramatic changes to how its allocation is calculated.

Without knowing the amount the Global Fund will raise at its 2016 replenishment, it is impossible to predict precisely whether funding to Kenya will go up or down.

Its LMIC status change is a factor in the calculation, and given Kenya is reducing its disease burden and increasing its GDP it is likely to see a decrease – despite there being substantial unmet need.

GAVI, THE VACCINE ALLIANCE

The Gavi approach is a good one – it's not correct that donors pour in money without local counterpart financing – it creates dependency

ALLAN RAGI, KANCO DIRECTOR[73]

Gavi is a public-private partnership that funds vaccines for LICs and LMICs. Since Gavi's inception in 2000 to 2014, Kenya has received disbursements from Gavi totalling $325 million to support the roll-out of five vaccines in Kenya. [74]

Gavi has a different set of policies than the Global Fund and uses different cut-off points for eligibility and their phased graduation process. At present Gavi still considers Kenya to be a LIC, because it is using GNI figures from before the rebasing. LICs only have to contribute $0.20 per dose of vaccine used, but LMICs have to increase their contribution each year.

It is believed that within a year Gavi will begin to consider Kenya to be a LMIC.[75] It follows that by 2017, Kenya will have to start contributing more to vaccine costs. Under Gavi regulations for the 'Intermediate/Phase One countries', Kenya will have to increase their contributions by 15% per year.[76] Since Kenya may remain for some years in the Intermediate stage, the Ministry of Finance needs to be able to provide an increased 15% per annum for some years to come.

Gavi has a stricter 'graduation policy' than the Global Fund.[77] The current cut-off point to enter 'Graduation Phase/Phase Two' is GNI of $1,580 per capita.[78] It is estimated by the International Monetary Fund (IMF) that Kenya will reach this level of income in about nine years – i.e. by 2024.[79] From that point in time, Gavi policies have a linear increment of 20% increase in country contribution each year for five years.[80] As such Kenya will have five years until it is 'graduated' off Gavi support. If the 2024 year estimation is correct, then by 2029 Kenya will cease to receive Gavi funds and will have to pay for all vaccinations itself.

THE WORLD BANK AND BEYOND

The biggest change from graduation will be the change of terms on which Kenya receives loans from the World Bank, African Development Bank and IMF

TIM JONES, JUBILEE DEBT CAMPAIGN[81]

The World Bank is a major provider of finance for Kenya. In general terms, the World Bank's International Development Association (IDA) is responsible for finance to LICs, and the World Bank's International Bank for Reconstruction and Development (IBRD) works more with MICs. The current Kenya IDA portfolio amounts to $4.7 billion in 24 national and seven regional projects. New commitments of almost $500 million were delivered in Fiscal Year (FY) 2014 and an estimated $565 million will be available in FY 2015.[82]

There will certainly be a significant financing change for Kenya now that it is a LMIC, although this may not be felt during the course of the next two years, and the likely impact is a matter of debate. By losing LIC status, Kenya will slowly lose access to grants from the World Bank and will gain access to concessional loans, from WB-IBRD. WB-IDA largely provides grants whereas the WB-IBRD mainly provides loans. A key aspect of these loans is the interest rate available to Kenya from financial institutions. As Kenya's economy continues to grow, they will move from an IDA-only support to a blend of grants and loans from the IBRD. Practically, this means, IDA loans of 0.5% interest will slowly become IBRD loans with 3% to 6% interest. In the long run, Kenya will lose all IDA support and will only access finance from the IBRD. Similar changes will ultimately affect the finance available from a number of other financial institutions.

World Bank staff are keen to stress that "there is no cliff edge between WB-IDA and WB-IBRD." Discussions with the World Bank Health, Population and Nutrition team suggested that there are benefits in moving from IDA to IBRD. "It is correct that Kenya may lose access to some quantity of grants….but they gain access to much larger overall quantities of finance overall. A significant portion of IBRD loans are on concessionary terms….overall we have 27 different mechanisms to ensure the transition from IDA to IBRD is a beneficial process."[83]

FUTURE DEBT?

> The Kenyan government currently receives $1.3 billion a year in loans from multilateral institutions. So changes in the terms of borrowing may be of greater importance overall than any change in the terms of ODA grants
>
> **TIM JONES, JUBILEE DEBT CAMPAIGN[84]**

Kenya receives significant and increasing soft loans from a variety of lenders, and foreign debt payments are scheduled to increase from 4% of government revenue in 2013 to 10% by 2024: this is an increase from $400 million in 2013, to $4 billion by 2024.[85] The impact of the repayments can be managed if the economy of Kenya grows according to plan (7% growth per annum). However, if Kenya's economy does not grow according to projections, the burden of debt will grow substantially. In this case, within a short number of years, Kenya could find itself paying substantially more than today to borrow funds, and also be paying very large debt payments each year.

GLOBAL FINANCING FACILITY

The World Bank is seeking to address part of the financial gap for health through a new financing mechanism, the Global Financing Facility (GFF). The facility was unveiled by World Bank Group President, Jim Yong Kim during the UN General Assembly in 2014 and will be formally launched at the UN Financing for Development conference in July 2015. At the time of writing, details of the facility were still to be confirmed and the following is based on the final Business Plan and conversations with the World Bank.

"The Global Financing Facility in Support of Every Woman Every Child" will contribute to global efforts to end preventable maternal, newborn, child and adolescent deaths by 2030 by providing smart, sustainable and scalable financing for reproductive, maternal, newborn, child and adolescent health (RMNCAH). With full financing, an accelerated investment scenario would help prevent four million maternal deaths, 107 million child deaths and 21 million stillbirths between 2015 and 2030 in 63 high-burden countries.[86]

The GFF is not a new vertical fund for maternal and child health but an ambitious attempt to coordinate all health financing for RMNCAH under one country plan, and to provide a 'top-up' when funding from other sources is missing. It aims to ensure a larger proportion of World Bank-IDA funding is used for global health purposes, and particularly RMNCAH (only approximately 4.4% of World Bank-IDA funds are currently put towards health).[87]

Kenya is a 'front-runner country' and will pilot the GFF country-planning approach and receive early financial support from the new facility. The first technical consultations to plan Kenya's Investment Case for Women's, Children's and Adolescent's Health were held in January 2015 and in April the Ministry of Health produced a Zero-draft Plan Investment Case . In current versions, Kenya is described in the category of "high-burden LICs transitioning into MIC status."

The GFF will again have different eligibility and functioning criteria than other global finance mechanisms. For example, the GFF has always included a consideration of DRM. The GFF Concept Note states that, "GFF grants will aim to increase coverage of key RMNCAH interventions, but would adopt a design that facilitates DRM to sustain the growth in RMNCAH financing when overall external assistance declines."[88]

Most health policy makers see the GFF as an exciting new venture for maternal and child health, after the relative failure of progress on MDGs 4 and 5 between 1990 and 2015.[89] With initial pledges of support from Canada and Norway, it is hoped that the UK will also contribute, especially given the support DFID provided to the Health Results Innovation Trust Fund, on which the GFF was built on. An important aspect of the facility is its focus on nutrition, a grossly underfunded sector which is often neglected even though undernutrition is responsible for 45% of all child deaths.[90]

BILATERAL DONORS

Kenya receives significant funding from bilateral donors countries. A disadvantage of bilateral donor ODA in general is that it can be quite volatile, often as a result of political changes in the donor country. For instance, in May 2015 Australia cut ODA to Indonesia for political reasons.[91] Kenya at present gets very good donor support – for example it is the number one recipient of ODA country for Japan[92] and Japanese funding to the health sector in Kenya has more than doubled since 2006.[93]

Bilateral donors generally don't have fixed guidelines on eligibility and graduation comparable to Gavi. From the UK, DFID have 28 active projects in Kenya and spend almost 20% of the portfolio on health projects.[94] In conversations with DFID officials in March there does not seem to be an expectation of a major change in funding in the next few years. "In general we would say that whereas countries may change to LMIC status, their challenges such as urbanisation, climate change, increased urban unemployment and conflict are likely to be of continued DFID priority."[95]

The USA has been for years the largest donor to Kenya.[96] One of the most important programmes is the U.S President's Emergency Fund for AIDS Relief (PEPFAR) which finances the largest share of Kenya's response to HIV/AIDS. Stakeholders in Kenya are concerned that PEPFAR is planning to diminish their funding.[97] This is not connected to rebasing as PEPFAR has no stated conditionality that links assistance to country-income status, but PEPFAR has put a ceiling on the number of people on treatment it will fund.[98]It is not clear if PEPFAR funding for Kenya will decline or hold stable but from available information,[99] it seems unlikely that it will increase to fill the current funding gap.

From the review above it appears that although ODA will not decrease automatically or immediately, in the next 3 to 5 years the process will begin. Kenya will begin to find it more difficult to access development funding and will begin to find development finance to be slightly more costly.

SUMMARY

It is not possible to make definite conclusions from this section, partly because the economic rebasing happened only in 2014 and has not yet been taken into account by all donors. Within multilateral agencies the criteria on Eligibility and Graduation are reviewed and updated on a regular basis. Within bilateral agencies, criteria for funding one particular country or set of countries can change at relatively short notice depending o n political changes in the donor country.

However, from the review above it appears that although ODA will not decrease automatically or immediately, in the next 3 to 5 years the process will begin. Globally donor nations are being encouraged to dedicate a greater proportion of their assistance to Least Developed Countries. In Kenya it is very likely that the proportion of finance received in loans will increase. Kenya will begin to find it slightly more difficult to access development funding as grants, and will begin to find development finance slightly more costly. Funding from Gavi in the long-term will progress through a series of steps that require greater recipient country contributions. The overall lesson is that Kenya will have to increase domestic resource mobilization of revenue if there is to be any chance of reaching the poorest and those unserved at present by health services.

5 | WHAT CAN BE DONE?

> People would be happy to pay more tax if they got access to decent services, but not here where the schools and hospitals are inadequate.
>
> **ROSEMARY MBURU, DIRECTOR, WORLD AIDS CAMPAIGN INTERNATIONAL**[100]

Many African leaders have emphasised that they do not want to be reliant on aid. For example, AU Chairperson, Nkosazana Dlamini-Zuma, has said that Africa wants to move away from its reliance on aid, preferring to call on countries to raise domestic resources through taxes and other financing mechanisms.[101] **However global evidence warns that very often for a new MIC, the total public resources fall continuously until a country is well into middle-income status. This is because international assistance falls faster than tax revenues rise. This is the 'missing middle' dilemma that Kenya will need to avoid.** [102]

Three things can happen that will allow Kenya to move towards Universal Health Coverage: reduce the percentage of healthcare covered by Out of Pocket; reduce User fees; and increase the public funding available for health. To increase the funds available for health it can:

- **Increase the domestic 'fiscal space' i.e. raise more funds for the national budget, so more can be spent on any issue.**
- **Increase the prioritisation given to health i.e. raise the percentage of the national budget allocated.**
- **Increase efficiency, so that more can be achieved with the existing finance.**


ngaza Uliona Tumaini Clinics
AINI MEDICAL CENTRE
linics
Maternity

INCREASE DOMESTIC FISCAL SPACE

> In absolute terms, tax revenues dwarf ODA: the total collected in 2012 in Africa was ten times the volume of development assistance provided to the continent
>
> **THE OECD DEVELOPMENT CO-OPERATION REPORT 2014**[103]

The most sustainable way for Kenya to own and develop all its development programmes (health, education, agriculture etc.) is to strengthen the tax base. Improving tax collection not only raises income but has the advantage of building ownership and accountability in the country. Analysis by the Kenya Institute for Public Policy Research and Tax Justice Network estimates Kenya's overall untapped tax capacity to be KSH 244bn ($2.86bn), which is more than double the current government spending on health.[104]

It is especially important to strengthen tax collection systems now because of predicted growth in the extractives sector in Kenya. As in neighbouring Tanzania with natural gas, there is a strong likelihood in Kenya of new mineral deposits coming on stream in the next decade.[105] If taxed appropriately these new developments could bring in important new funding streams to expand development programmes and reach the poorest.

Other ways Kenya could increase its fiscal space include setting up new taxes, strengthening overall tax collection, reducing Illicit Finance Flows and strengthening National Health Insurance.

1 | SET UP NEW TAXES OR A 'LEVY'

Some countries in Africa have set specific taxes where the income is earmarked to cover expenditure on HIV/AIDS, or wider health sectors. According to the Africa Union Roadmap on Shared Responsibility for AIDS, TB and Malaria, Cameroon, Congo, Madagascar, and other countries all apply an airline levy to raise funds which are set aside for HIV programmes. Cape Verde and other countries charge alcohol excise taxes with funds earmarked for HIV programmes.[106]

Kenya does not have an AIDS levy although this has been recommended for some years by the National AIDS Control Council (NACC). A trust fund for AIDS and non-communicable diseases which would draw 1% of government revenue each year has been considered by parliament for some years, but is still awaiting approval. "NACC projections indicate the trust fund would cover 74% of the HIV/AIDS financing gap up to 2019."[107] In Kenya, the Bill and Melinda Gates Foundation have recently commissioned the Excelsior group to look at the viability of sin taxes or other new taxes.[108]

However, there are various disadvantages to an HIV levy or earmarked taxes. Firstly, is the problem of deciding what benefits and what is excluded. In Africa the HIV sector has a louder political voice than other sectors in health (for example the nutrition sector). Therefore, it has been HIV activists who have called for an HIV levy, and in various countries the levy only covers HIV.[109] Given that all health issues are inter-connected, and all underfunded, there is little logic in arguing for a levy that only funds one part of the health service. Further, why should one tax be ringfenced for health and not another ringfenced for a sector such as education? The new taxes are likely to be viewed by Finance Officials as being outside the mainstream of tax (i.e. as temporary or unimportant niche taxes) and will have extra costs and procedures to administer.

Another problem is that these taxes are regressive. For example, a tax on Sim cards for mobile phones was introduced in Tanzania but dropped a year later, because it was expensive to collect and had a disproportionate negative effect on low-income consumers.[110] More fundamental is the issue of displacement. According to interviews with World Bank economists, funds raised for health through visible and 'one-off' means tend to only increase the funding available in the short term.[111] In the medium term, the country's Ministry of Finance reduces funding from general taxation. The health levy funds 'displace' general budget funds and don't increase the total finance available.[112] A better long term approach is to support the entire, integrated tax system and to improve the tax collection system.

2 | STRENGTHEN THE TAX COLLECTION SYSTEM OVERALL

> We are not saying don't make profits, but pay fair taxes
>
> **JOHN KITUI, COUNTRY MANAGER, CHRISTIAN AID KENYA**[113]

It has been estimated that to meet the proposed SDGs, a further $1.5 trillion extra in public financing annually from 2016 to 2030

would be required.[114] The 'Government Spending Watch' report recommends that the $1.5 trillion can be financed through a three-pronged approach:

1. Doubling tax revenue, by radically overhauling global tax rules
2. Doubling concessional development cooperation, and improving its effectiveness
3. Raising US$500 billion in public innovative financing.

In addition, "all spending must be dramatically reoriented to fight inequality, and be much more transparent and accountable to the world's citizens."[115]

How could Kenya meet the 'doubling of tax income' itemised in the Government Spending Watch report? The most progressive way would be through closing loopholes for wealthy individuals, increasing tax collection from Multinational Companies (MNCs), and reducing tax evasion and avoidance. According to one estimate there are 40,000 wealthy people in Kenya who are not paying the correct tax.[116] The current official tax threshold for high net worth individuals is Ksh 44 million but only 100 people in Kenya have registered an income exceeding that level. The Kenya Revenue Authority has set up a special unit to investigate low rates of tax return from wealthy individuals.[117]

3 | REDUCE ILLICIT FINANCIAL FLOWS

An important area where revenue is lost is through Illicit Funding Flows (IFFs) from commercial activity. IFFs cost Africa more money than is received in ODA and occurs when MNCs take advantage of financial systems within their global operations to avoid paying taxes.[118]According to research by the Political Economy Research Institute, Kenya lost $4.9 billion in capital flight in 2010 alone: this is approximately $120 per person.[119] Save The Children estimate that the average annual tax loss per person over the past ten years was the same as the amount the government spent on health[120]. If these finance flows out of the country could be addressed, it would reduce the need for Kenya to introduce new regressive taxes.

Addressing IFFs is a priority for the AU who recently commissioned a High Level Panel on Illicit Financial Flows from Africa chaired by the ex-President of South Africa Thabo Mbeki.[121] The report found that $50 billion is lost every year but that 65% are legal under current tax rules. The report has a full set of recommendations which should be followed.

One recommendation is that African countries must avoid a 'race to the bottom' on tax incentives.[122] This can happen as a result of government agencies, such as the Kenyan Investment Promotion Agency, which offers tax holidays and other incentives to attract foreign companies.[123] Evidence suggests, however, that most of these tax holidays could be ended without losing foreign direct investment, which would increase tax revenues.

Transparency in all sectors strengthens income collection. In Kenya, President Kenyatta is well placed to lead the fight against IFFs and tax avoidance due to his previous experience as Minister of Finance. He has implemented new procedures to make public tenders and procurements more accountable, requiring all information to be publically available online.[124] This makes the system much more transparent and is a move that should be replicated in other sectors

4 | STRENGTHEN NATIONAL INSURANCE

A further avenue to bring in more income for health would be for Kenya to improve the National Hospital Insurance Fund (NHIF). According to interviews in March 2015 many Kenyans don't use this system. "They don't trust it, they think their contributions might get stolen… people prefer to pay out of pocket."[125] This scheme was established nearly 50 years ago but still insures only 18 per cent of Kenyans.[126] This is unfortunate because good Social Health Insurance has in some countries been a mechanism for moving towards UHC.[127] The best systems have pre-payments into a pooled fund, used for equitable distribution according to need. In this way the healthy and wealthy cross subsidise the sick and the poor. However, in a system where most middle-class Kenyans contribute to private health insurance then the healthy/wealthy are only supporting other healthy/wealthy with no cross-benefit to the poor majority.

Although Social Health Insurance has been successful in some OECD countries, it has rarely proved to be a success in developing countries because adjustments to the model have not been made to reflect the more limited ability of low-income citizens to contribute. Oxfam, for example, argues for "governments and donors to prioritise general government spending for health – on its own or pooled with formal sector payroll taxes – to successfully scale up UHC."[128]

DONOR SUPPORT FOR IMPROVED TAX COLLECTION SYSTEMS

There is an important role for donors to play in helping ODA-recipient countries to increase their fiscal space, by improving the efficiency of tax collection systems. UNDP has estimated that if developing countries can reach a ratio of domestic taxation to GDP of at least 20%, they will be able to finance their development needs.[131] On average, developed countries collect 34% of their GDP from tax, whereas half of Sub-Saharan Africa collects less than 17% of GDP from tax.[132]

Therefore, there are benefits to be gained by supporting ODA-recipient countries to make these improvements. Presently, only around 0.07% of global donor assistance is devoted to this form of capacity building, but the payoff can be very good.[133] DFID currently has a very good example of this in Kenya. DFID is supporting the Kenya Revenue Authority to replace the current revenue systems with a modern integrated customs management system.[134] This will provide the following benefits:

- **Reduce the number of hours the customs system is 'down' from 128 hours per annum to no more than 10 hours per annum;**
- **Improve tax payment compliance through faster access to electronic information and automated processes;**
- **Achieve a 30% increase in customs revenue, Ksh 70 billion in new revenue.**

DFID is investing £8.4 million in this project and the expected new income, if achieved, will total around £540 million.[135] This return on investment would be remarkable but not unheard of. An OECD pilot project in Kenya found that for every $1 invested in tax administration, $1,650 was returned. The project was considered 'highly responsive' to Kenya's need and increased tax revenues in just one year by $33 million.[136]

The OECD and DFID examples show what just one donor can achieve on their own but there are also other possible avenues of global support to improve tax collections systems, which the international community agree would have a positive impact:

- **Modernise global tax rules by creating an empowered intergovernmental body on tax which is mandated to set tax rules and empowered to enforce these rules. The current UN Tax Committee does not have the status to act with sufficient authority and should be upgraded to a full intergovernmental body under the UN, with strong representation, and technical expertise, of developing countries. The institution should provide an "inclusive political framework where all countries can participate in tax negotiations on an equal footing (one country, one vote)."[137]**
- **Provide capacity building and technical assistance so that countries can develop their own progressive tax systems, based on equity, and transparent bidding and contracting systems.**
- **Move towards increasing international tax transparency, ending the abusive practices of trade mis-invoicing, and tax-haven countries with secretive norms and arrangements. Countries should set clear timetables and targets to achieve this.**

Instead of relying on contribution-based schemes, which often gain the support of relatively small percentage of the population, Kenya may find it more effective to adopt tax-based systems as used in countries like Sri Lanka and Brazil. These countries prioritised the principles of equity and universality, and rejected systems that tried to collect insurance premiums from those who are too poor to pay. Instead they fund UHC from tax revenues and progress has been good. In Brazil in the 1980s, half the population had no health coverage. Two decades later, after a tax-financed unified health system, nearly 70% of Brazilians rely on it for healthcare.[129]

INCREASE THE PRIORITISATION OF HEALTH SPENDING IN THE GOVERNMENT BUDGET

> We can't assume increases in health spending will flow naturally from economic growth, or from governments' increased budget
>
> **AFRICA HEALTH BUDGET NETWORK[138]**

A key way to promote the health of the nation would be to increase the priority given to health in the national budget. At present Kenya only spends around 5.6% of the budget on health. In 2001, Heads of State of the African Union signed the Abuja Declaration, which contained a commitment to allocate at least 15% of their annual budget to the health sector, while urging donor countries to fulfil their promise of 0.7% ODA.[139] Neither of these two commitments has been met.

One issue is a common misconception that a rise in GDP will lead automatically to an increased health budget. This is not always so. Kenya was included in a three country case study by RESYST which looked at the fiscal space for health and found that greater government budget didn't always translate into more health spending per person. The reasons for this are:

- **The health sector had to compete with prioritisation of debt repayments and curbing overall government spending due to macro-economic policy – not just in competition with other sectors.**
- **The Ministry of Health often lack political influence and technical know-how to negotiate greater health spending from the Ministry of Finance.**
- **Ministry of Finance was often reluctant to increase health budget as it didn't trust the health sector to deliver results[140].**

If we are to see an increase in public health spending, and if the Abuja target is to be met, the decision must come from within government to increase the health budget.

REDUCE INEFFICIENCIES IN THE HEALTH SECTOR

> The government needs to spend more or spend smart
>
> **WORLD BANK COUNTRY DIRECTOR DIARIETOU GAYE.[141]**

The sections above showed how to get more money for health. It is also important is to get more health for your money. By this we urge an improved efficiency of the health system so that available funds stretch further. Estimates suggest that as much as 20% of health spending is wasted due to inefficiency.[142]

Below are three suggestions to help Kenya get 'more health for its money':

- **Ensure health budgets at a national and a county level are in synergy.** Devolution of health to county governments is an important way to prioritise the problem areas of health at a local level, but it is crucial that this does not result in gaps in basic healthcare. National and county budget holders must be clear who is responsible for what health services and ensure all areas are covered.
- **Change the balance between prevention and cure.** National hospitals receive a disproportionately high amount of the health sector budget. A World Bank lead economist has said, "although spending on primary health is highly beneficial for the poor it only receives 29% of the budget compared to about 40% if given to curative Health."[143] Primary healthcare which prevents illness is a more cost-effective strategy, especially for reaching the poorest sectors of society.
- **Integrate health services to ensure improved access to basic health services.** Improving health system strengthening will give both better health outcomes and financial efficiencies. Stakeholders in Kenya are optimistic about the potential impact of the GFF to enhance integrated health services across maternal and child health.[144]

5 | RECOMMENDATIONS

> If you are not planning five years in advance you are already behind…
>
> **JOSEPH KEFAS, HEAD OF NACC, BOTSWANA**[145]

OVERALL RECOMMENDATIONS

PUT EQUITY AT THE HEART OF ALL HEALTH POLICIES AND TAX POLICIES

Achieving the highest attainable standard of health for the whole of the population is the goal of the Kenyan health service and this should be the bedrock for all health policies and programmes. Reaching 'the final fifth' is the most difficult challenge for health programmes in developing countries. This report has argued that the public health system is the primary route through which health services can reach the poorest.

Donors and the government should collaborate on a joint effort to reduce Out of Pocket expenditure and increase the resources available to strengthened public health systems. All policies should be reviewed to assess if they enhance coverage of health services to those who at present do not receive them. Examples of changes include the reduction and eventual elimination of user fees at the point of delivery, and the outlawing of informal user fees.

PREPARE IN ADVANCE

The government, including both the Ministry of Finance and the Ministry of Health should enter into dialogue with donors about changes to eligibility polices, to ensure uninterrupted services. Donors with eligibility and graduation criteria (which may be complex and changing) should ensure that these are shared and understood by all health stakeholders in each relevant country.


STOP
GO
SEX
FOR
ABSTINENCE

RECOMMENDATIONS FOR KENYA

INCREASE PRIORITY OF HEALTH IN NATIONAL BUDGET ALLOCATION

Kenya should increase the budget allocation for Health, taking into account that the current allocation is less than 6% and the government committed in Abuja to spend 15%. The government should set realistic targets to raise the allocation in incremental steps. Continued collaboration with donor partners should ensure that domestic revenue does not replace donor funds but is a compliment to them, to ensure that health spending can reach those who currently lack access to health. Within the increase in the health budget the government should increase its allocation for nutrition programmes so as to drive down the current high rate of stunting.

INCREASE DRM THROUGH TAXATION

The government should strengthen tax collection to increase domestic resources for health. Special emphasis should be made to tax all industries in an equitable manner, including multinational corporations. A dialogue should be held with neighbouring countries to reduce unnecessary tax incentives to multinationals and avoid a 'race to the bottom' on issues such as tax holidays. Kenya should aim to meet the UN suggested ratio of tax to GDP of at least 20%.

REDUCE ILLICIT FINANCE FLOWS

Kenya should strongly increase efforts to track and halt IFFs, given that Kenya lost $4.9 billion in capital flight in 2010 alone. Following the strong set of recommendations in the Mbecki Report, which showed that 65% of outflows are legal, the government should crack down both on tax evasion and avoidance (legal and illegal IFFs).

STRENGTHEN BOTH NATIONAL AND DEVOLVED COVERAGE TO REACH THE POOREST

To be effective for the poor, Kenya needs more inclusive growth. Balanced growth that reduces inequality has been shown by the World Bank and IMF to promote the overall rate of economic growth. To ensure that 'no-one is left behind', social health insurance contributions should be mandatory and benefits must be for all, but the government will need to cover the contributions of the poorest through tax income.

Since the health sector is now decentralized there is potential for an unforeseen increase in inequalities in regard to access. There thus should be very strong dialogue between national and county-level budget holders and officials to ensure the correct allocation of resources within the country.

GRADUAL TRANSITION FROM GRANTS TO LOAN

Global trends in ODA show an increased proportion of donor assistance is going to soft loans instead of grants. Recent research by Development Initiatives shows that ODA loans to Kenya increased by 520% since 2005. The country should discuss options carefully with international finance institutions to ensure loans can be absorbed without incurring onerous levels of debt. Kenya should work closely with the World Bank to make a gradual transition from WB-IDA to WB-blend and eventually WB-IBRD.

IMPROVE EFFICIENCY IN HEALTH SERVICE DELIVERY

The government should step up efforts to reduce corruption both in the health sector and in all areas of public spending. The recent move to improve transparency of bidding and contracts is a good step.

The efficiency of the health system can be improved by moving the focus from curative healthcare to primary healthcare, since this is the sector that most reaches the poorest. An emphasis on prevention will allow the Ministry of Health to take advantage of 'cheap wins', such as investment in micronutrients. Ensuring the roll out of Vitamin A to the whole population is just one example of a highly cost-efficient intervention which can give a cost benefit return of $1/ $30.[146]

IMPROVE INTEGRATION OF HEALTH PROGRAMMES

Health delivery should be as integrated as possible, with most services delivered from integrated public health facilities. Kenya should gain valuable support in this respect from the new GFF, and Kenya as a pilot country should share its learning from this process with other countries.

RECOMMENDATIONS FOR DONORS

AVOID TOO FAST TOO SOON

All LICs and most LMICs will continue to need donor support in the years to come. Bilateral donors and institutions such as World Bank IDA, Gavi and the Global Fund should not withdraw from countries too fast or too soon. Transition policies should be phased and transparent so countries have time to increase public funding for health.

MEET THE PROMISES MADE ON 0.7% AID

Even if African countries are able to scale up their DRM in the years to come, ODA remains essential to reach the goal of UHC. Donor nations committed in 1970 to devote 0.7% of GNI to ODA, yet few countries have achieved it. All rich nations who have not met the target should recommit to reach 0.7% by 2020 and set a specific timetable.

PROVIDE QUALITY AID

Donors and governments should work together to use ODA as a contribution to improving equity within health delivery. ODA should not just fund a certain percentage of health services but should be used to ensure that the health service can reach the poorest. Donors should support the principles of Development Effectiveness and also support civil society to hold their governments accountable and track progress towards health goals.

SUPPORT IMPROVED TAX COLLECTION

Donors should support African countries to improve their tax collection systems and thus enlarge the fiscal space for development. Evidence shows that relatively small grants (or technical assistance) can have very large cost/benefit ratio. Donor programmes such as the DFID technical support to Kenya Revenue Authority are examples of good practice that could be replicated elsewhere.

REDUCE ILLICIT FINANCE FLOWS

Working collectively at the global level all nations can support a more efficient and egalitarian, global tax system. For example by supporting institutions such as the Africa Tax Administrative Forum, which determines Africa-wide policy against duplicative tax avoidance by supporting an intergovernmental body on tax which is mandated to set tax rules and empowered to enforce these rules – as a key step to ending the abuse of tax havens. The current UN Tax Committee should be upgraded to a full intergovernmental body, and must have strong representation, and technical expertise, from developing countries.

DO NOT SUPPORT PROGRAMMES THAT PRIVATISE HEALTH SYSTEMS

Since ODA is precious it should be used to support equity and to reach the poorest in society. Donors should not use ODA to support the privatisation of health services. In Kenya for example there is a burgeoning private sector which provides health services, and this does not need the support of ODA. Donor assistance should be to support programmes that will take UHC to the most difficult areas.

USE FINANCIAL INFLUENCE FOR MARKET SHAPING

Bilateral and multilateral agencies should work together to use market-shaping interventions to drive down costs of medicines and medical products.

SUPPORT THE NEW GLOBAL FINANCE FACILITY (GFF)

The GFF is a new initiative that aims to leverage additional resources for women and children's health and nutrition needs. Donors should support the GFF at its launch and by joining the original donor nations in its initial funding call.

SUPPORT THE EQUITABLE ACCESS INITIATIVE (EAI)

Many analysts believe that the current classifications used to determine 'cut-off points' such as LIC, LMIC and UMIC are unsatisfactory because they are predominantly based on country income status, which hides the visibility of poor people in MICs. Donors should support discussions on alternatives by collaborating in discussions such as the Equitable Access Initiative[147] which are presently at an early stage. so as to ensure that donor ODA is still available for health programmes targeted to benefit poor people, wherever they may live.

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ACRONYMS

AU	African Union
CSR	Corporate Social Responsibility
DAC	The Development Assistance Committee of the OECD
DFID	The UK Department for International Development
DRM	Domestic Resource Mobilisation or Domestic Revenue Mobilisation
EAI	Equitable Access Initiative
FfD	Financing for Development
FY	Fiscal Year
Gavi	Gavi, the Vaccine Alliance
GDP	Gross National Product
GFAN	Global Fund Advocacy Network
GFF	Global Financing Facility
Global Fund	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GNI	Gross National Income
HPN	Health, Population and Nutrition
HRH	Human Resource for Health
IBRD	World Bank International Bank for Reconstruction and Development
IDA	World Bank International Development Association
IFFs	Illicit Financial Flows
IMF	International Monetary Fund
KANCO	Kenya Aids NGO Consortium
KETAM	Kenya Treatment Access Movement
Ksh	Kenyan Shillings
LIC	Lower-Income Country
LMIC	Lower-Middle-Income Country
MDG	Millennium Development Goals
MI	Micronutrient Initiative
MIC	Middle-Income Country
MNCs	Multi-National Corporations
MNI	Micronutrient Interventions
MoF	Ministry of Finance
MoH	Ministry of Health
NACC	National AIDS Control Council (of Kenya)
NEPAD	New Partnership for Africa's Development
NEPHAK	Network of People Living with HIV AIDS Kenya
NGO	Non-Governmental Organisation
NHIF	National Hospital Insurance Fund
ODA	Official Development Assistance
OECD	Organisation for Economic Co-operation and Development
OOP/OOPE	Out-of-Pocket (expenditure)
PEPFAR	The United States President's Emergency Fund for AIDS Relief
PPP	Public Private Partnership
SDG	Sustainable Development Goals
TB	Tuberculosis
UHC	Universal Health Coverage
UMIC	Upper Middle-Income Country
UN	The United Nations
UNDP	the United National Development Programme
UNICEF	United Nations International Children's Fund
UNITAID	a global health initiative that supports Research & Development on global health issues
USAID	The United States of America's lead development agency
VAT	Value Added Tax
WACI	World Aids Campaign International
WB	The World Bank
WFP	World Food Programme
WHO	World Health Organisation

RESULTS UK

RESULTS UK is a non-profit advocacy organisation that aims to generate the public and political will to end hunger and poverty. RESULTS' focus is on educating and empowering people – whether they are ordinary citizens or key decision-makers – to bring about policy changes that will improve the lives of the world's poorest people. Our advocacy focuses on areas that have the most potential to make a difference. RESULTS UK has a track record of expertise in education, microfinance and global health and nutrition issues.

www.results.org.uk | @resultsuk
For more information on this topic, please contact: steve.lewis@results.org.uk

KANCO

The Kenya AIDS NGOs Consortium (KANCO) is a national membership network of NGOs, CBOs, and FBOs, Private Sector actors and Research and Learning Institutions involved in or that have an interest in HIV, AIDS, TB and other public health concerns. KANCO's vision is a healthy people with secure and sustainable access to HIV/TB and other public healthcare services.

www.kanco.org | @KancoKE | ekibuchi@kanco.org

WORLD AIDS CAMPAIGN INTERNATIONAL

World AIDS Campaign International (WACI) is an African regional organization that works to galvanize a strong pan-African civil society voice and action to influence policy decisions and implementation towards improved HIV and broader health outcomes. WACI hosts the Africa Civil Society Platform on Health and GFAN Africa hub.

www.worldaidscampaign.org | @WAC_Tweets | mburur@worldaidscampaign.org

ACTION GLOBAL HEALTH ADVOCACY PARTNERSHIP

RESULTS UK and KANCO are partners in ACTION and WAC collaborates with ACTION. ACTION is a global health advocacy partnership with 11 partners working in 10 countries and in the European Union. ACTION works to influence policy and mobilise resources to fight diseases of poverty and achieve equitable access to health. ACTION was founded in 2004 with the shared mission of mobilising new resources to respond to TB globally. Since then, ACTION has expanded its advocacy efforts to include the promotion of child survival, with a particular focus on expanding access to childhood vaccines and fighting childhood undernutrition.

www.action.org | @ACTION_tweets | info@action.org

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