Health Care Utilization in the Kenyan Health System: Challenges and Opportunities

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A country of approximately 37 million people, Kenya has struggled to build a health system that can effectively deliver quality health services to its population. Access to health care varies widely throughout the country and is determined on numerous factors, though in particular, major divides exist between rural and urban communities, and between the moneyed elite and the poorer masses. In Kenya, the poorer masses—those living below the national poverty line—constitute approximately 52% of the population.i

According to the World Health Organization (WHO), in 2007 the average life expectancy for both sexes in Kenya was 54 years, compared to a global average of 68 years.ii Healthy life-years are anticipated at 48, with 82% of lost healthy life-years attributed to communicable disease.iii The overall under-five child mortality rate is approximately 121 per 1000 live births, or roughly double the global average.iv However, this number drops significantly, to 91 per 1000, for the wealthiest 20% of the population, while it jumps to nearly 150 for the poorest 20%.v

The prevalence of communicable disease in Kenya is a major factor in determining health outcomes. HIV prevalence among urban adults is estimated at 10%, versus an estimated 5.6% for rural adults.vi HIV prevalence is not evenly distributed throughout the country, with prevalence rates in Nyanza province nearly double the national average.vii Compounding the challenge presented by high HIV positive rates, there were in excess of 100,000 cases of Tuberculosis (TB) in 2008, with co-infection rates for TB and HIV of 45%.viii Malaria represents another significant burden, with 13.6% of deaths in children under five caused by the disease.ix The WHO refers to Malaria as a “a major public health problem in Kenya.”x The disease is ubiquitous among adults living in malarial areas.

This paper is based on observations from visits by the author to dozens of Kenyan health facilities between May and June 2010. Photo © Dustin Turin.

Considering this challenging health landscape, utilization of health services is a key factor in improving health outcomes for Kenyans, in both the short- and long-term. Currently, the level of and access to care varies by region, with the most facilities per person located in Central Province, and the least located in...
the border provinces of Western Valley and Nyanza.xi According to recent data, the health care utilization rate in Kenya is approximately 77% for those who are sick, meaning that a large percentage of the population does not seek care despite being ill.xii In order to bring about broad improvements in health in Kenya, it is essential to understand who is currently using the facilities that are available, and what factors are preventing those who do not seek care from doing so.

This paper explores the Kenyan health system and the two major factors that prevent individuals from seeking care—cost and access—and also addresses the existence of other social and cultural factors that might affect health seeking behavior and utilization of health services.

II. Overview of the Kenyan Health System

A hierarchical structure, the Kenyan health system is administered from the top down by the Ministry of Health (MOH), an institution which remains broken into two sister Ministries since the post-election turmoil of 2007: the Ministry of Medical Services, and the Ministry of Public Health and Sanitation. The split of MOH has led to additional strain on the health system by causing overlap and inefficiency in both planning and implementation processes, in addition to the obvious inefficiency that has accompanied the maintenance and daily operations of two separate institutions in the place of one.xiii

Health facilities are distributed regionally, with the most sophisticated services available in the major cities or only at the national level. At the top of the service spectrum are the National, Referral, and Teaching Hospitals (NRTTH) such as Kenyatta National Hospital in Nairobi. The next best level of care is found in the provincial hospitals, followed by sub-district hospitals. Beneath the sub-district level, there are health centers, dispensaries, and at the bottom of the heap, community health organizations.

Visiting these different facilities, stark disparities are apparent both vertically, between the different levels of care, and also horizontally, from facility to facility in different regions.

One example of these contrasting levels of care is available within a single facility, the Kenyatta National Hospital (KNH). KNH offers both public and private wards in the same facility, attended by the same doctors. A patient in the public ward, as we witnessed, can expect to spend long hours waiting to be seen, and will likely be expected to share one bed with another patient. These patients are grouped in large, open, chaotic rooms and afforded no privacy. The cost, however, is minimal when compared to the private ward of the hospital, where a room costs between Ksh. 2,350 – 4,000 per night.xiv The doctors attending both the public and private ward are the same, though they are paid at a higher rate for working in the private wing.

While both public and private patients can expect to receive a high level of care at KNH, the disparity between services offered there and at a provincial hospital can be substantial. Visiting the Provincial General Hospital in Nyeri, there was a major drop in the quality of care. On the day of our visit, the hospital was under strain from a shortage of morphine, the gold standard in pain management for major trauma, and patients were visibly suffering from this shortfall.

At the health center level and below, a minimal level of care can be expected, with serious conditions being referred to the nearest hospitals or private facilities. Health centers tend to focus on basic services such as diagnosis, counseling and testing, maternal and child health, and the prescription of medication. At some centers, simple surgical procedures such as male circumcision may also be available.

The Kenyan health system is also strongly impacted by the work of non-governmental organizations (NGOs), including faith-based organizations (FBOs) and private health facilities. In 2008, the Government of Kenya (GOK) operated 48% of the country’s health facilities, with NGOs/FBOs operating a combined 15% (13% FBO, 2% NGO), and the private for-profit sector operating 34% of all facilities.xv Not surprisingly, private facilities offer a superior level of care when compared to public facilities of comparable scope, though they remain out of reach for most of the population due to their high cost.

Facilities operated by NGOs are often the best balance of care and cost where they are available. At the Lwala Community Health Center, a facility operated by the NGO group Lwala Community Alliance, the minimal fee of Ksh. 50 (about $0.65 USD) is waived for up to 85% of patients, according to Executive Director James Nardella. As a result of the high quality of care and low cost, patients come from a wide area of up to 30 to 40 kilometers to access the facility. Unfortunately, this phenomenon also challenges the sustainability of the facility, which is almost completely reliant on donor funding. In the NGO sector as a whole, reliance on donor funding is often the limiting factor that prevents facilities from offering a broader service spectrum, or offering services to more people.

Overall, and as outlined in the National Health Sector Strategic Plan II (NHSSP II), the health system is relying on a Sector Wide Approach (SWAp) that aims to integrate the efforts of public, private not for-profit (NGO/FBO), and private for-profit health facilities into a unified drive towards “health for all.” This approach has so far had mixed results, with some facilities collecting and sharing data with the broader health system (such as the Bomu Medical Center in Mombasa, a privately run NGO facility), while others have failed to integrate successfully.

III. Health Care Utilization: Who is Missing Out?

A. Major Barriers to Entry: Cost and Access

The two most significant barriers to entry in the Kenyan health system are the cost of care, and the availability of suitable care within a reasonable distance (i.e., geographic barriers). According to NHSSP II, “the physical [health] infrastructure in some regions of the country has a coverage of one facility per 50-200 km,” making the availability of health resources to those who are sick virtually non-existent in certain cases.xvi

On the contrary, Dr. Peter Njorge pointed out that one of the ongoing goals of the health system in Kenya is to ensure that every Kenyan lives within 4 kilometers of a health facility.xvii a feat that would significantly improve access to care for many Kenyans. It is important to note, however, that distance from a health center can also be a subjective measurement. While some citizens might be 15 km from a well-equipped hospital on a tarmac road, many others might indeed be only 4 km from a health facility, but it may be a limited facility (e.g., a dispensary) with few resources, no doctors, and accessibility only by foot or bicycle. In this scenario, it is easy to see why someone might make the journey once, and never again thereafter. This reality may also help explain the fact that 22.8% of those who were sick did not seek care, according to the 2003 Kenya Household Expenditure and Utilization Survey (KHHUS).xviii

Access to a well-equipped health facility may be more important than the cost of services in determining whether an individual seeks care, in certain cases. Wamai writes, “despite the fact that average cost for outpatient utilization in urban areas was twice that of rural areas,” urban residents sought health services 81.5% of the time when they were ill, versus only 75.9% for residents of rural areas.xix
In 2008, there were 6,190 health facilities in Kenya, the equivalent of 16 facilities per 100,000 people, or 11 facilities per 1,000 km².xx In 2006, Rift Valley and Western Province have the least number of hospital beds per 100,000 population, with only 13.6 and 15.4 beds per 100,000 population, respectively. The highest number of beds is found in Nyanza province, with 30.3 beds per 100,000.xxiv In Northeastern Province, there are only 16.1 beds per 100,000 population, while this region also has the lowest healthcare utilization rate, at only 63.4%.

Another major issue affecting access to care is the uneven distribution of health workers between urban and rural areas.xxvii In order for an individual to access health services, they must have both physical access to a health facility, and the health facility must also be able to provide service. The 2005/2006 Kenya National Health Accounts (KNHA) note the top two “key challenges to achieving better health status in Kenya” as “inequitable access to health services,” and “shortages of qualified health workers with appropriate skills.”xxviii According to 2008 figures, there were only 728 medical doctors (MD) working in the Kenyan health system, with only 477 employed in the public sector.xxviii With little incentive provided, well-qualified health workers rarely choose to work in rural health facilities when they can enjoy a higher standard of living and additional employment opportunities by remaining in the urban hubs, particularly Nairobi and Mombasa. The result is that rural health facilities suffer from chronic human resource shortages, in terms of both the numbers and qualifications of health workers.

The cost of care nevertheless remains a paramount issue in Kenya. For those who were ill but did not seek treatment, the high cost of care was noted as the primary reason by 44% of those surveyed in KHHEUS 2003.xxiv Funding by the national government to the health sector has been inadequate for minimizing out of pocket expenses on care. Funding to the health sector has ranged from between 6-8% of total government spending in recent years, “well below the [2000] Abuja declaration target of 15%.”xxvii In the 2008/09 fiscal year, Total Health Expenditures (THE) were estimated at KSh. 34.8 billion, or approximately USD $1.180 per capita.xxviii This figure represents a 65% shortfall from the WHO recommended spending level of USD $34 per capita.xxix

As a result, funding for the health sector is financed primarily by the private sector, with 36% of THE originating from households, “mainly through out of pocket spending.”XXX The MOH, National Health Insurance Fund (NHIF), National AIDS Control Council, local authorities, and other parastatals contributed only 29% towards THE, while the bulk of remaining funds came from donors (31%).x xxxi

Indeed, the high burden of health care costs was immediately apparent during a joint field visit, with University of Nairobi medical students, to the Githunguri community outside Nairobi. The medical students were operating a free health clinic for one day after several weeks of conducting local surveys and data collection. The makeshift facility, which was set up in a local primary school, had long lines of patients interested in the free consultations. In talks with one medical student, Frank Gakuru, he commented on the high turnout, saying, “women here come out because they can get a free medical consultation and free medicine,” when normally both of these services must be paid for out of pocket. Many people were lined up to receive free medicine, and nearly all who were asked cited the cost (free) as their primary reason for coming out. On the contrary, the high cost of medicine and health services under normal conditions is a major impediment to health seeking behavior.

B. Other Social and Cultural Factors Influencing Health Seeking Behavior

There are a number of other, harder to quantify factors that also shape the utilization of health services in Kenya. For example, the impressions that individuals and communities form from past interactions with the health services sector may influence their decision to seek healthcare in the future. If the population has a favorable view of health services, it follows that the utilization of health services will improve as more people seek care.

While no comprehensive studies have been completed to analyze the relationship between impressions of healthcare and healthcare utilization in Kenya, it was easy to gather the general sense, from talking to both health workers and patients, that dissatisfaction with the health system affects health seeking behavior. One particular concern that came up on multiple occasions was the shortage of medicine in some facilities. If an individual makes what is likely to be an arduous trip to a health facility only to discover that they are out of medicine, the likelihood that the same individual will make the trip again in the future is lessened. When this scenario becomes commonplace, an entire community might become less likely to seek health services, even when they are needed.

Individuals in many communities also continue to seek traditional health services over or in addition to conventional medicine. In fact, studies in the 1990s found that up to 90% of the population in sub-Saharan Africa used traditional medicine as their source of primary healthcare.xxxii In our discussions with herbalist Gabriel Onzongo in Kisii, Nyanza Province, Mr. Onzongo emphasized that approximately 80% of Kenyans utilize traditional medicine as a primary form of healthcare. Traditional and herbal medicine is viewed as a suitable replacement for conventional medicine, and it may even be thought of as more effective.

We met with the former patient of a traditional doctor, also in Kisii, who had undergone as many as nine surgical procedures outside the conventional health system. Her original symptoms included headaches and dizziness, and she had consulted with a conventional health worker prior to seeking alternative treatment. After conventional medication did not relieve her symptoms, she sought the help of a traditional doctor with whom she ultimately underwent surgery in an unregulated environment. She conveyed that she was happy with the service she received and that her symptoms had been relieved, though she underwent multiple procedures presumably because her symptoms returned.

The use of traditional medicine and traditional doctors is not included in healthcare utilization data, which only measures the conventional health system. The strong cultural association with traditional forms of healthcare is certainly a factor that decreases utilization in the conventional system, though the tradeoff is that many people continue to be satisfied with traditional services. Nevertheless, there are clear risks associated with relying on traditional medicine for serious medical conditions, and little documented research has been done to measure the efficacy of traditional treatment strategies.xxxiii There is a need for traditional medicine to be brought into the fold of the Kenyan health system, in a way that would foster improved regulation and safety standards while also enabling this widespread practice to have a legitimate role in Kenya’s overall health strategy going forward.

Other factors exist which affect health seeking behavior, and many of these factors are interrelated and compound one another. Low education levels, particularly in rural areas, may influence the ability of individuals to judge when care should be sought, while knowledge of what care is available and its potential benefits may be incomplete or totally unknown. The sheer isolation of some communities—such as the Maasai tribe we visited, located at least three hours walking distance from the nearest road—suggest that the community is not likely to utilize health services except in the direst circumstances. Negative stigma towards certain conditions, such as HIV, and towards westernized medicine as a whole, also has effects on if and when individuals seek health services.

IV. Discussion and Conclusion

Kenya’s health system currently suffers from a lack of political will and a wavering commitment to its improvement. To broadly advance health outcomes in Kenya, it is necessary for the central government to take the lead and redouble its efforts to create a more effective system. In particular, if the GOK truly
wishes to achieve “a high quality of life [for] all its citizens by the year 2030,”xxxiv as it proposes in Kenya Vision 2030, serious efforts need to be made to reduce barriers to entry across the formal health sector.

The two biggest factors currently preventing healthcare from reaching a larger proportion of the population are the high cost of services, and poor access to health facilities. Individuals currently carry the highest burden of healthcare costs, above both the central government and donor organizations. In a country where one out of two citizens lives below the poverty line, there is a vital need for a revamped health financing structure that can reduce the burden of out of pocket spending on health. With most people employed in the informal economy, access to health insurance through the NHIF is out of reach, while “plans to expand and transform the NHIF into a social health insurance system in 2004” collapsed in the midst of political headwinds.xxxv Meanwhile, infrastructure challenges continue to make accessing health services unpractical or impossible for much of the rural population.

The high prevalence of traditional medicine, which is sometimes viewed as at odds with the adoption of a more modern health system, should instead be viewed as an opportunity to reach a wider portion of the population, if only this practice can be brought into the overall health strategy and even integrated with the current SWAp. Other cultural influences could similarly be turned around to spread information about services and public health interventions, serving to benefit the long-term health strategy.

The way forward for health in Kenya, in the end, requires a stronger commitment from the country’s top leadership. Under the SWAp, greater integration is needed to facilitate the delivery of services, reduce out of pocket spending on health, and improve monitoring and data collection; all of this in order to push forward with evidence-based strategies that are effective in providing better health outcomes to a broader base of the Kenyan populace.

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**Endnotes**


iii.) Ibid.

iv.) Ibid.

v.) Ibid.


vii.) Ibid.


xii.) Ibid.


xxviii.) Ibid.


xxxi.) Ibid.


xxxiii.) Ibid, 76.
