

Wrong Prescription

The Impact of Privatizing Healthcare in Kenya

Wrong Prescription

The Impact of Privatizing Healthcare in Kenya

*The Economic and Social Rights Centre-Hakijamii
and the Center for Human Rights and Global Justice
at New York University School of Law*

2021

Publication date: November 17, 2021

Cover photograph by © Zulekha Amin/Hakijamii 2021

Copyright © 2021 by the Economic and Social Rights Centre-Hakijamii. All rights reserved.

Economic and Social Rights Centre-Hakijamii
P.O. Box 11356-00100
Nairobi, Kenya

www.hakijamii.com

Copyright © 2021 by the Center for Human Rights and Global Justice. All rights reserved.

Center for Human Rights and Global Justice
New York University School of Law
Wilf Hall, 139 MacDougal Street
New York, New York 10012

www.chrgj.org

This report does not necessarily reflect the views of NYU School of Law.

CONTENTS

<i>EXECUTIVE SUMMARY</i>	7
<i>METHODOLOGY</i>	10
<i>1. INTRODUCTION AND BACKGROUND</i>	11
1.1 Privatization of Healthcare	11
1.2 Need for Research	13
1.3 Promotion by International Actors	14
<i>2. BAD VALUE</i>	18
2.1 High Costs for Individuals	18
2.2 Draining Public Coffers	19
<i>3. A FAILING APPROACH</i>	23
3.1 Unsafe and Underregulated	23
3.2 Misaligned Incentives	25
3.3 Entrenched Inequality in Access	27
3.4 Lack of Accountability	28
3.5 Poor Employer	32
<i>4. SEVERE HUMAN RIGHTS IMPACTS</i>	33
4.1 Exclusion and Denial of Service	33
4.2 Inadequate Care	34
4.3 Poverty and Debt	34
4.4 Low-Income People	35
4.5 Rural Residents	36
4.6 People with Disabilities	36
4.7 Women	37
<i>5. THE PATH TO UNIVERSAL HEALTH COVERAGE</i>	39
5.1 Shortcomings of the NHIF	39
5.2 The Value of Public Healthcare	41
<i>6. THE RIGHT TO HEALTH</i>	44
<i>7. CONCLUSION</i>	47
<i>8. RECOMMENDATIONS</i>	48
<i>ACKNOWLEDGMENTS</i>	49

EXECUTIVE SUMMARY

In recent years, policymakers in Kenya have sought to expand access to healthcare by embracing the private sector, undertaking a wide range of reforms and initiatives to encourage private actors to get into the business of healthcare.¹ The role of for-profit actors in health has grown rapidly over the past decade, and the private sector now constitutes a major part of Kenya's healthcare system.² This embrace, coupled with chronic underinvestment in the public healthcare system that reduces the quality of service and pushes many to seek private care, amounts to de facto privatization. This report explores how privatizing healthcare—defined as increasing the role of the for-profit, private sector—has failed many Kenyans, undermined the right to health and set back the goal of universal health coverage.

The private healthcare sector in Kenya has generally failed to deliver on many of its proponents' promises about value for money and access to quality, affordable care. The results have been disastrous for many, especially for poor, vulnerable, and historically marginalized communities. Privatizing healthcare has proven costly, led to the neglect of public health priorities, contributed to the rise of low-quality, low-cost providers that offer inadequate and unsafe care, and resulted in severe human rights problems including exclusion and denial of service.

Privatization makes healthcare more expensive for individuals and the government, and it is bad value for money. Private providers need to extract profits, face higher borrowing costs than the public sector, and often charge patients overwhelmingly more than public providers. Community members interviewed for this report—residents of informal settlements in Mombasa and Nairobi, as well as rural areas in Isiolo—described facing excessively high fees at private health facilities, where treatment can cost in excess of twelve times more than the public sector.³ Out-of-pocket healthcare spending in Kenya has risen 53 percent per capita between 2013 and 2018 as the role of private facilities has increased.⁴

The burden on public coffers has been significant. The private sector is often promoted as a solution when public resources are scarce, but its growth has been highly dependent on the commitment of major resources from the Kenyan government. The government now transfers tens of billions of shillings to the private sector annually to contract with private facilities, subsidize access to private care, and pay for secretive

¹ These include public-private partnerships, the expansion of national health programs to include private providers, and tax incentives. See Monish Patolawala, "Transforming Kenya's Healthcare System: A PPP Success Story," *World Bank Blogs*, May 24, 2017, <https://blogs.worldbank.org/ppps/transforming-kenya-s-healthcare-system-ppp-success-story>; Stacey Orangi et al., "Examining the Implementation of the Linda Mama Free Maternity Program in Kenya," *International Journal of Health Planning and Management* (2021): 5, <https://doi.org/10.1002/hpm.3298>; Task Force Health Care and Kenya Healthcare Federation, *Kenyan Healthcare Sector: Opportunities for the Dutch Life Sciences and Health Sector*, 2016, 56, <https://www.tfhc.nl/publication/kenyan-healthcare-sector-report-2016>.

² Health Policy Plus, *Kenya Health Financing System Assessment: Time to Pick the Best Path*, 2018, 83-84, <http://www.healthpolicy-plus.com/pubs.cfm?get=11323>.

³ Sujha Subramanian et al., "Cost and Affordability of Non-Communicable Disease Screening, Diagnosis and Treatment in Kenya: Patient Payments in the Private and Public Sectors," *PLOS ONE* 13, no. 1 (January 2018): 7-8, <https://doi.org/10.1371/journal.pone.0190113>.

⁴ Ministry of Health, *2018 Household Health Expenditure and Utilization Survey*, 2018, 47-48, 21.

public-private partnerships with global corporations.⁵ Far from simply filling a gap left by an insufficient public health system, the private sector has been intentionally invited in, and rewarded handsomely by the government and development actors for showing up.⁶

The private sector offers wildly different care to the “haves” and the “have nots,” entrenching inequality in access to care. While those who can afford it may enjoy excellent private care, lower income areas are dominated by low-cost, low-quality private providers pedaling services that are often unsafe, inadequate, or even illegal.⁷ For many, this means an undesirable choice between shady or subpar private providers and public facilities that may be underfunded, far away, or lacking critical medicines.

Private providers’ focus is on making a profit, not providing a strong healthcare system that meets national objectives. Because of these misaligned incentives, the private sector neglects important public health priorities. Instead, it is heavily concentrated in the most profitable forms of care, and has spurned less commercially viable areas, patients, and services—including important preventative and family planning services.⁸ Healthcare workers described having to meet patient “targets” as well as enduring workplace conditions inferior to those in the public sector. Additionally, private providers, who are insulated from democratic processes, operate with significantly less transparency and accountability.

Privatization is impacting human rights severely. The private sector routinely excludes and denies access to those who cannot afford their services, while driving others into poverty and debt due to the high cost of care. Many people interviewed for this report described facing immense hardships to pay for private care, including selling important assets, like land, and forgoing educational and livelihood opportunities. Others described severe problems resulting from poor quality care at private providers, including unnecessary deaths and disabilities. The impact of privatization has been especially severe for women and people who are poor and low income, live in rural areas, and have disabilities.

Ultimately, the privatization of healthcare in Kenya is undermining efforts to achieve universal health coverage. The choice to prioritize a private-sector friendly social insurance program, the National Hospital Insurance Fund (NHIF), will not resolve,

⁵ The government does not publish figures on the total amount of public health expenditure directed towards the private sector and did not respond to queries seeking such figures. However, public information regarding specific initiatives indicates that tens of billions of shillings in public funds are directed to the for-profit private sector each year. For example, in the 2021/22 budget, the national government allocated 6 percent of its health spending (Kshs. 7.21 billion) to the Managed Equipment Services arrangement, a public-private partnership for medical equipment, and in 2021, it was reported that Kshs. 11 billion of the Kshs. 14 billion that the NHIF pays out for medical care in Nairobi annually goes to private facilities. Parliamentary Budget Office, Unpacking the Estimates of Revenue and Expenditure for 2021/2022 and the Medium Term, May 2021, 11-12, [http://www.parliament.go.ke/sites/default/files/2021-05/Unpacking of the FY 2021-22 budget.pdf](http://www.parliament.go.ke/sites/default/files/2021-05/Unpacking%20of%20the%20FY%2021-22%20budget.pdf); Maureen Kinyanjui, “NMS Pushes for Policy to Make NHIF Only Useable in Public Hospitals,” *The Star*, September 5, 2021, <https://www.the-star.co.ke/counties/nairobi/2021-09-05-nms-pushes-for-policy-to-make-nhif-only-useable-in-public-hospitals/>.

⁶ See Ministry of Health, *Kenya Health Policy 2014-2030*, 2014, 35, 49-50, 52-53, http://publications.universalhealth2030.org/uploads/kenya_health_policy_2014_to_2030.pdf; “Kenya Encourages Private Sector Investment in the Health Sector,” Ministry of Health, October 31, 2019, <https://www.health.go.ke/kenya-encourages-private-sector-investment-in-the-health-sector/>; State Department for Planning, *A Summary of Key Investment Opportunities in Kenya*, undated, 24-25, newdemo.planning.go.ke/wp-content/uploads/2021/02/A-SUMMARY-OF-KEY-INVESTMENT-OPPORTUNITIES-PRESENTATION-revised-2-22-01-2021.pdf.

⁷ See Kennedy Abuga et al., “Sub-Standard Pharmaceutical Services in Private Healthcare Facilities Serving Low-Income Settlements in Nairobi County, Kenya,” *Pharmacy* 7, no. 167 (December 2019): 7-8, <https://doi.org/10.3390/pharmacy7040167>; World Bank and Government of Kenya, *Kenya Health Service Delivery Indicator Survey 2018 Report*, May 2019, xiii, <https://ncpd.digis-pureenterprises.com/wp-content/uploads/2021/02/Final-KESDI-Health-Technical-Report-1.pdf>; Ministry of Health, *Kenya Harmonized Health Facility Assessment 2018/2019 Main Report*, 2020, 268, <https://khro.health.go.ke/files/Kenya-Harmonized-Health-Facility-Assessment-2018-2019.pdf>.

⁸ See Ministry of Health, *Harmonized Health Facility Assessment 2018/2019 Main Report*, 58, 95, 199; World Bank and Government of Kenya, *Health Service Delivery Indicator Survey 2018 Report*, 51, 83-84; Stefania Ilinca et al., “Socio-Economic Inequality and Inequity in Use of Health Care Services in Kenya: Evidence from the Fourth Kenya Household Health Expenditure and Utilization Survey,” *International Journal for Equity in Health* 18, no. 196 (2019): 9, <https://doi.org/10.1186/s12939-019-1106-z>.

and may actually exacerbate, these problems. Although the NHIF is a public insurer, it contracts extensively with the private sector, offers private facilities higher reimbursement rates, and sends most of its claims money to private actors.⁹ As a result, its expansion will divert more public money to private actors without eliminating high costs, aligning private interests with public health goals, or addressing exclusion in the private sector. Expanding coverage through the NHIF instead of investing in a strong public health system is a major step backwards. The public system, which still delivers the majority of inpatient and outpatient care in Kenya despite severe underinvestment,¹⁰ is best suited to deliver universal health coverage. In fact, recent investments in the public system led to surges in use, demonstrating an enduring appetite for quality and affordable public healthcare.¹¹

Kenya's embrace of privatized healthcare has taken place at the urging and encouragement of key actors in the development sector, including international financial institutions, private foundations, and wealthy countries looking for new markets. Many of these actors have provided financial and technical support for, and even conditioned aid on, pro-private sector reforms, without acknowledging or paying adequate heed to the harms being caused.¹² An uncritical ideological commitment to privatization and a determined push to engage the private sector have trumped the health needs and rights of the Kenyan people.

Despite these failures, the government and international actors continue to promote the privatization of care at the expense of improving the public health care system. Policymakers have misdiagnosed the situation, and should undertake a thorough impact evaluation with a view to reconsidering the overall approach. The regulatory framework that applies to private providers should be significantly strengthened and far better enforced. To the extent the NHIF continues to contract with private providers, it should radically reshape its relationship with them. The public health system is far better positioned to deliver on public goals than the private sector. Health policy and expenditure should prioritize the public system. National and county governments should work together to ensure the public healthcare system provides accessible, affordable, quality care for all Kenyans, and that healthcare workers enjoy dignified working conditions. Greater transparency and access to information relating to the private sector's role in healthcare is also sorely needed.

⁹ Gabriella Appleford and Edward Owino, *National Hospital Insurance Fund Tariffs: What are the Effects on Amua Franchisee Businesses?* (London: Marie Stopes International, 2018), 5, <https://hanshep.org/our-programmes/AHMEresources/case-study-national-hospital-insurance-fund-tariffs>; Kinyanjui, "NMS Pushes for Policy."

¹⁰ Ministry of Health, *2018 Household Health Expenditure and Utilization Survey*, 20, 41-42.

¹¹ See Thomas Maina and Doris Kirigia, *Annual Evaluation of the Abolition of User Fees at Primary Healthcare Facilities in Kenya* (Washington, D.C.: Health Policy Project, 2015), v, https://www.healthpolicyproject.com/pubs/524_FINALAbolitionofUserFeesPolicy.pdf; Maureen Kinyanjui, "Newly Launched Hospitals Record High Patient Turnout," *The Star*, August 26, 2021, <https://www.the-star.co.ke/counties/nairobi/2021-08-26-newly-launched-hospitals-record-high-patient-turnout/>.

¹² See World Bank, *Private Health Sector Assessment in Kenya*, April 2010, xiv, xvii, xix, 64, <https://openknowledge.worldbank.org/handle/10986/5932>; World Bank, *Financing Agreement Between Republic of Kenya and the International Development Association*, August 2017, 14-15, documents1.worldbank.org/curated/en/153191504040149253/pdf/Financing-Agreement-for-Credit-6121-KE-Closing-Package.pdf; McKinsey & Company and USAID, *Private-Sector Investment Opportunities in Primary Healthcare in Kenya: Implementation Roadmap*, 2018, https://pdf.usaid.gov/pdf_docs/PA00TGSC.pdf; USAID, *RFI Attachment 1: Private Sector Opportunities to a Fully Private Care and Treatment*, 2020, 1, <https://www.grants.gov/view-opportunity.html?oppId=328744>.

METHODOLOGY

This report is based on interviews with 55 community members; more than 130 private and public healthcare workers, community health volunteers, government officials, and experts and activists engaged on issues of health and human rights; and a review of public documents, surveys, and laws related to health in Kenya.

Interviews were conducted by trained human rights researchers between March and May 2021 in Isiolo, Mombasa, and Nairobi. In each county, researchers conducted individual, semi-structured interviews of community members (30 in total: 18 women and 12 men, which included nine people with disabilities); focus groups with community members (three groups for a total of 25 participants consisting of 12 women and 13 men); individual semi-structured interviews with healthcare workers from the public and private sector (12 total); focus groups with community health volunteers (three groups for a total of 29 participants); and county-level officials (11 total). Interviews were conducted in English and Swahili. Interviewees were informed of the nature and purpose of the research and the researchers' intention to publish a public report. Interviewees were not compensated for their participation. Research validation meetings were carried out with community members and county-level officials in Isiolo, Mombasa, and Nairobi.

A summary of findings and detailed questions were sent to the Ministry of Health, the National Treasury, the Public Private Partnership Directorate, the National Hospital Insurance Fund, the President's Delivery Unit, the Vision 2030 Delivery Secretariat, the Office of the Auditor General, the Ethics and Anti-Corruption Commission, county officials in Isiolo, Mombasa, and Nairobi, the World Bank, the International Finance Corporation (IFC), the United States Agency for International Development, the Netherlands Embassy in Nairobi, the Bill and Melinda Gates Foundation, General Electric, Koninklijke Philips N.V., and TPG. Responses were provided by the Public Private Partnership Directorate, the Vision 2030 Delivery Secretariat, the IFC, the Netherlands Embassy, General Electric Healthcare, and the Rise Fund and Evercare (writing jointly in response to our questions to TPG).¹³ The report was externally reviewed by two independent Kenyan healthcare experts prior to publication.

The names of some interviewees have been withheld at their request. These instances are referenced in the footnotes. All community member, healthcare volunteer, and healthcare worker names have been replaced with pseudonyms to preserve privacy and anonymity.

¹³ The letters and responses are available in full at <https://chrgj.org/kenya-health-correspondence/>.

1. INTRODUCTION AND BACKGROUND

1.1 Privatization of Healthcare

In December 2017, President Uhuru Kenyatta announced that his administration would be dedicated to the realization of universal health coverage (UHC), one of the major priorities of his “Big Four” agenda.¹⁴ This ambitious goal is consistent with a broader push over the past decade to improve equitable access to quality healthcare in Kenya.

The need for improvement is undisputed. The Ministry of Health considers healthcare quality “inadequate countrywide,” with wide variation including between levels of care in urban and rural areas.¹⁵ A 2018 survey of thousands of public and private healthcare facilities found that, on the day they were surveyed, only a tiny fraction (6 percent) had all basic amenities and none had all essential medicines.¹⁶ Many facilities are understaffed and access to healthcare is highly unequal along economic lines.¹⁷ In 2018, an estimated 1-1.1 million people were pushed into poverty due to the cost of healthcare.¹⁸ Kenya is falling woefully short in realizing the right to health, guaranteed under both its Constitution and international law, which requires that health facilities, goods, and services be available, of good quality, culturally acceptable, and accessible to everyone without discrimination.¹⁹

In seeking to improve access to healthcare, Kenyan policymakers have pushed to increase the role played by for-profit private actors. Policymakers have explicitly embraced the private sector, providing it with public resources and undertaking favorable policy reforms.²⁰ Far from simply filling a gap left by the public health system, the private sector has been intentionally invited in. At the same time, chronic underinvestment in the public system and a lack of sufficient infrastructure, staff, and medicine have pushed many to seek care from private providers. While the government has not formally privatized its existing public healthcare system by selling it off, its policies in many instances amount to a determined push towards privatization.

¹⁴ “Speech by His Excellency Hon. Uhuru Kenyatta, C.G.H.,” Statements and Speeches, president.go.ke, December 12, 2017, <https://www.president.go.ke/2017/12/12/speech-by-his-excellency-hon-uhuru-kenyatta-c-g-h-president-and-commander-in-chief-of-the-defence-forces-of-the-republic-of-kenya-during-the-2017-jamhuri-day-celebrations-at-the-moi-international/>.

¹⁵ Ministry of Health, *Harmonized Health Facility Assessment 2018/2019 Main Report*, xxxv.

¹⁶ *Ibid.*, xxvi.

¹⁷ Ministry of Health, *Harmonized Health Facility Assessment 2018/2019 Main Report*, xxvi; Ministry of Health, *2018 Household Health Expenditure and Utilization Survey*, 18, 26, 40-41.

¹⁸ Paola Salari et al., “The Catastrophic and Impoverishing Effects of Out-of-Pocket Healthcare Payments in Kenya, 2018,” *BMJ Global Health* 4 (2019): 6, <http://dx.doi.org/10.1136/bmjgh-2019-001809>.

¹⁹ See Kenya National Commission on Human Rights, *The Right to Health: A Case Study of Kisumu County*, 2017, <http://www.knchr.org/Portals/0/OccasionalReports/The%20Right%20to%20Health%20in%20Kisumu%20County.pdf>; Hakijamii, *Debunking the Public Health Puzzle*, February 2020, <https://www.hakijamii.com/?p=6214>; Constitution of Kenya, arts. 26, 43(a); International Covenant on Economic, Social and Cultural Rights, opened for signature December 16, 1966, (entered into force January 3, 1976), 993 U.N.T.S. 3, art. 12; UN Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, E/C.12/2000/4, para. 12 (August 11, 2000), <https://undocs.org/E/C.12/2000/4>.

²⁰ As discussed further below, while the government does not publish figures on the amount of public health expenditure directed towards the private sector and did not respond to queries seeking such figures, public information and media reports regarding specific initiatives indicate that tens of billions of shillings in public funds are directed to the private sector each year. For example, in the 2021/22 budget, the national government allocated 6 percent of its health spending (Kshs. 7.21 billion) to the Managed Equipment Services arrangement, a public-private partnership for medical equipment, and in 2021, it was also reported that the Kshs. 11 billion of the Kshs. 14 billion that the NHIF pays out for medical care in Nairobi annually goes to private facilities. Parliamentary Budget Office, *Unpacking the Estimates of Revenue and Expenditure for 2021/2022*, 11-12; Kinyanjui, “NMS Pushes for Policy to Make NHIF Only Useable in Public Hospitals.”

Privatization has been embedded in key national policies. The overarching Kenya Health Policy 2014-2030 seeks to strengthen the role of the private sector as both a financier and a provider of healthcare services, including through legal reforms, fiscal incentives, and public-private partnerships.²¹ The Kenya Health Sector Strategic Plan 2018-2023 calls for expanding the role of private healthcare and financing through private insurance products, specialized private hospitals, and other public-private partnerships.²² President Kenyatta affirmed the integral role of the private sector when he announced his pledge to achieve universal coverage.²³ The President, cabinet members, and other high-level officials often reference the necessity of private finance for universal health coverage and actively present the health sector as an opportunity for private firms, with Kenyatta declaring the country “open to private sector investment in healthcare.”²⁴

This is not just talk. The government has embarked on large-scale contracts with the private health sector including public-private partnerships, offered favorable tax incentive, and expanded national health programs, like Linda Mama, to include private health providers—effectively subsidizing private care.²⁵ The administration’s signature policy for achieving universal health coverage—the planned nationwide expansion of social insurance through the National Hospital Insurance Fund (NHIF)—could actually accelerate privatization, with a transformational shift in the government’s role from a provider of health services to purchaser. Some county governments, which have significant responsibility for delivering healthcare services under the 2010 Constitution, have also embarked on efforts to promote or embed the private sector in healthcare delivery.²⁶

As a result, the role of private healthcare providers is rapidly growing. Kenya has long had a mixed healthcare system, but historically relied on its nationwide network of public hospitals, clinics, and community health services. However, the number of private facilities and the proportion of total health expenditure they receive have rapidly increased in recent years. Between 2013 and 2020, the proportion of private for-profit facilities grew from 33 to 42 percent of the total,²⁷ while private clinics experienced a more than sixfold increase in the share of health spending countrywide between 2009/10 and 2015/16.²⁸ The

²¹ Ministry of Health, *Kenya Health Policy 2014-2030*, 2014, 35, 49-50, 52-53, http://publications.universalhealth2030.org/uploads/kenya_health_policy_2014_to_2030.pdf.

²² Ministry of Health, *Kenya Health Sector Strategic Plan*, 2018, 53, 70, 71, 77, <https://www.health.go.ke/wp-content/uploads/2020/11/Kenya-Health-Sector-Strategic-Plan-2018-231.pdf>.

²³ “Speech by His Excellency Hon. Uhuru Kenyatta,” 2017.

²⁴ John Muchangi, “Private Hospitals to Get UHC Cash,” *The Star*, September 6, 2019, <https://www.the-star.co.ke/news/2019-09-06-private-hospitals-to-get-uhc-cash/>; “Kenya Encourages Private Sector Investment in the Health Sector,” Ministry of Health, October 31, 2019, <https://www.health.go.ke/kenya-encourages-private-sector-investment-in-the-health-sector/>; State Department for Planning, *A Summary of Key Investment Opportunities in Kenya*, undated, 24-25, newdemo.planning.go.ke/wp-content/uploads/2021/02/A-SUMMARY-OF-KEY-INVESTMENT-OPPORTUNITIES-PRESENTATION-revised-2-22-01-2021.pdf.

²⁵ GlobeNewswire, “Gruppo San Donato, Italy’s Leading Private Hospital Group, and Kenya Sign an Agreement to Strengthen the East African’s Local Health Care,” news release, July 19, 2021, <https://www.globenewswire.com/en/news-release/2021/07/19/2264986/0/en/Gruppo-San-Donato-Italy-s-leading-private-hospital-group-and-Kenya-sign-an-agreement-to-strengthen-the-East-African-s-local-health-care.html>; Monish Patolawala, “Transforming Kenya’s Healthcare System: A PPP Success Story,” *World Bank Blogs*, May 24, 2017, <https://blogs.worldbank.org/ppps/transforming-kenya-s-healthcare-system-ppp-success-story>; Task Force Health Care and Kenya Healthcare Federation, *Kenyan Healthcare Sector*, 56; Orangi, et al., “Examining the Implementation of the Linda Mama Free Maternity Program in Kenya,” 5.

²⁶ See “Partnership for Primary Care: A Sustainable Model to Revolutionize Primary Care,” Amref, accessed August 17, 2021, <https://amref.org/partnershipforprimarycare/>.

²⁷ According to the Kenya Master Health Facility List, as of September 2020, there were 5,932 public facilities, 5,282 private facilities (42 percent of the total), and 1,342 faith/non-profit facilities. According to a 2013 Ministry of Health document, 49 percent of facilities in the country were government-owned, 33 percent were private for-profit, and 16 percent private non-profit. “Kenya Master Health Facility List,” Ministry of Health, accessed August 17, 2021, http://kmhfl.health.go.ke/#/facility_filter/results; Ministry of Health, *Kenya Service Availability and Readiness Assessment Mapping (SARAM)*, 2013, 12, http://guidelines.health.go.ke:8000/media/Kenya_Saram_Report.pdf.

²⁸ Health Policy Plus, *Kenya Health Financing System Assessment*, 84.

proportion of outpatient visits conducted at private hospitals and clinics increased from 17 to 25 percent between 2013 and 2018,²⁹ while visits at public primary health care facilities (dispensaries and clinics) fell from 40.1 percent to 27.5 percent.³⁰ The private sector now constitutes a major and growing part of the healthcare system in Kenya.

1.2 Need for Research

The effects of the intentional, institutionally supported growth of the private sector are underappreciated and underexplored. This report seeks to understand how privatization of healthcare—defined as increasing the role of the for-profit, private sector—has served Kenyans, and particularly how it has affected the right to health.

At a macro level, this period of growing privatization coincides with troubling trends that merit further examination. In recent years, out-of-pocket healthcare spending has increased significantly, even though people are making fewer visits, and a growing proportion of people report falling ill but not seeking care.³¹ Between 2013 and 2018 the number of people estimated to have been pushed into poverty because of out-of-pocket spending on healthcare more than doubled.³²

Globally, proponents of privatization often argue that the private sector is better than the public sector at delivering healthcare. They contend it is more innovative and efficient, offers superior customer service, and provides higher quality care.³³ Others promote privatization as inevitable due to limited public resources and insist that only private capital can cover the so-called “financing gap.”³⁴ They present private actors and financing as “indispensable,” and they repackage public aims, such as the Sustainable Development Goals, as opportunities for profitable investments.³⁵ Many actors in the development space have embraced this mindset, crystalized in, for example, the World Bank’s Maximizing Finance for Development approach and international financial institutions’ Billions to Trillions agenda.³⁶

However, the evidence in support of these claims is highly contested. Critics contend that private actors’ focus on profit can run counter to public health goals, for example by causing providers to focus primarily on high-return curative services and neglect important preventative care.³⁷ Research shows that private healthcare is often significantly

²⁹ Ministry of Health, *2018 Household Health Expenditure and Utilization Survey*, 21. The category of private facilities does not include chemists/pharmacies or faith-based facilities.

³⁰ Ibid.

³¹ Ibid., 47-48, 20, 17.

³² Salari et al., “The Catastrophic and Impoverishing Effects of Out-of-Pocket Healthcare Payments,” 6, 8.

³³ See “Expanding Quality Health Care in Sub-Saharan Africa,” International Financial Corporation, accessed October 6, 2021, https://www.ifc.org/wps/wcm/connect/news_ext_content/ifc_external_corporate_site/news+and+events/news/expanding-quality-health-care-in-sub-saharan-africa.

³⁴ See United Nations Economic Commission for Africa, *Healthcare and Economic Growth in Africa*, February 2019, xvi, <https://hdl.handle.net/10855/43118>; OECD, *Making Blended Finance Work for the Sustainable Development Goals*, 2018, 38, <https://doi.org/10.1787/9789264288768-en>.

³⁵ UN Conference on Trade and Development, *World Investment Report 2014*, xi, https://unctad.org/system/files/official-document/wir2014_en.pdf; “Doing Good While Doing Well – Private Sector and SDGs,” United Nations Department of Economic and Social Affairs, accessed October 6, 2021, <https://www.un.org/en/desa/doing-good-while-doing-well-private-sector-and-sdgs>.

³⁶ World Bank, *Maximizing Finance for Development: Leveraging the Private Sector for Growth and Sustainable Development*, September 2017, 1-2, https://www.devcommittee.org/sites/dc/files/download/Documentation/DC2017-0009_Maximizing_8-19.pdf; African Development Bank et al., *From Billions to Trillions: Transforming Development Finance*, 2015, <https://pubdocs.worldbank.org/en/622841485963735448/DC2015-0002-E-FinancingforDevelopment.pdf>.

³⁷ See Audrey Chapman, *Global Health, Human Rights and the Challenge of Neoliberal Policies* (Cambridge: Cambridge University Press, 2016), 94.

more expensive, predominately serves affluent populations, and excludes poor patients, and that privatizing healthcare can increase inequalities in access to care.³⁸ While private providers are often associated with high-end care, private care is in fact highly varied, with lower income patients often left with informal, unlicensed, and unqualified small-scale private providers.³⁹ A review of 102 studies of the private and public sector found that private providers had significantly worse knowledge of diagnostic and treatment procedures and were more likely to carry out unnecessary procedures and dispense unnecessary medications.⁴⁰ Private equity involvement in care has been linked to declining availability of health workers, increased patient mortality, and higher costs.⁴¹

Critics also contest the notion that the private sector alleviates public resource constraints.⁴² Even proponents of engaging the private sector in healthcare acknowledge that it requires channeling public funds to the private sector.⁴³ This can take many forms, such as contracts to build infrastructure or the inclusion of private facilities in voucher schemes. But this reliance on public coffers means privatizing care can actually become more expensive than public provision, drastically undermining the case for private care as a way to conserve public resources.

This longstanding debate over the role of private actors in a public health system is playing out around the world as many countries seek to achieve universal health coverage, an aim enshrined in the Sustainable Development Goals.⁴⁴ As countries make decisions about whether to invest in existing public health systems or to rely on and subsidize private healthcare—for example through public-private partnerships and social insurance programs—a diverse set of actors is seeking to influence those choices. These include private sector actors who stand to make significant gains depending on how universal health coverage is interpreted and implemented.⁴⁵ Kenya's experience holds lessons for other countries as they seek to deliver universal health coverage.

1.3 Promotion by International Actors

The government has not acted alone in embracing the privatization of healthcare in Kenya. A range of influential international actors have directed a staggering amount of energy and resources towards private sector-friendly policy reforms and to private actors directly. As set out below, international financial institutions, development agencies, philanthropic organizations, and healthcare companies have engaged in sustained and

³⁸ Sanjay Basu et al., "Comparative Performance of Private and Public Healthcare Systems in Low- and Middle-Income Countries: A Systematic Review," *PLoS Med* 9, no. 6 (2012): 4, 8-9, <https://doi.org/10.1371/journal.pmed.1001244>.

³⁹ *Ibid.*, 11.

⁴⁰ *Ibid.*, 5-7.

⁴¹ Atul Gupta et al., "Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes," (working paper 28474, NBER Working Paper Series, National Bureau of Economic Research, Cambridge, MA, February 2021), 35, <http://www.nber.org/papers/w28474>.

⁴² See Kate Bayliss, Maria Jose Romero, and Elisa Van Waeyenberge, "Uneven Outcomes from Private Infrastructure Finance: Evidence from Two Case Studies," *Development in Practice* 31, no. 7 (2021), <https://doi.org/10.1080/09614524.2021.1938513>.

⁴³ See World Health Organization, *Engaging the Private Health Service Delivery Sector Through Governance in Mixed Health Systems: Strategy Report of the WHO Advisory Group on the Governance of the Private Sector for Universal Health Coverage*, 2020, 17, <https://www.who.int/publications/i/item/strategy-report-engaging-the-private-health-service-delivery-sector-through-governance-in-mixed-health-systems>.

⁴⁴ "Goal 3: Ensure Healthy Lives and Promote Well-Being for All at All Ages," United Nations, accessed September 22, 2021, <https://www.un.org/sustainabledevelopment/health/>.

⁴⁵ Helena Nygren-Krug, "The Right(s) Road to Universal Health Coverage," *Health and Human Rights Journal* 21, no. 2 (2019), <https://www.hhrjournal.org/2019/12/the-rights-road-to-universal-health-coverage/>; Melissa Mialon, "An Overview of the Commercial Determinants of Health," *Globalization and Health* 16, no. 74 (2020): 4-5, <https://doi.org/10.1186/s12992-020-00607-x>.

often coordinated efforts to increase the role of the private sector—ranging from helping small private clinics gain accreditation with the NHIF to providing tens of millions of dollars to finance reforms, including through loans contingent upon meeting pro-private sector benchmarks. Private actors—large multinational health companies, as well as consultants and private equity firms—have also sought to expand their share of the healthcare sector in Kenya.

The World Bank has long been involved in healthcare policy, including through its support for user fees and reduced healthcare expenditure in the 1980s and 1990s. Over the past decade it has actively promoted the role of the private sector in health through loans and expertise. As early as 2010, the Bank called for several pro-private sector measures⁴⁶ and it has provided \$90 million in loans to—in its own words—“kick-start Kenya’s public-private partnership (PPP) programs.”⁴⁷ This includes a loan whose disbursement is tied to progress moving the public-private partnership agenda forward, such as the gazettement of new regulations and closing of agreements.⁴⁸

The Bank’s work in Kenya is consistent with its broader global commitment to Maximizing Finance for Development (MFD), adopted in 2017. This approach explicitly prioritizes private sector solutions in achieving development goals. Under it, the World Bank supports public funding only when it concludes there are no private sector solutions and that no amount of reforms or incentives can produce one.⁴⁹ This approach has drawn scrutiny for directing limited aid to the private sector and because of the risks associated with private provision of essential goods and services. One major Bank-endorsed public-private partnership in Kenya, the Managed Equipment Services project, has resulted in poor value for money and is embroiled in controversy (see page 30).⁵⁰ The Bank did not respond to written questions about its basis for supporting the private sector in Kenya and the steps taken to ensure that public-private partnerships comply with best practices.

The International Finance Corporation (IFC), the World Bank Group’s private sector-focused arm, has committed over USD \$50 million to private healthcare companies in Kenya since 2010.⁵¹ It has also encouraged private sector-friendly reforms and amalgamated financing from development actors.⁵² For example, in 2019 the IFC launched a holding company to acquire healthcare businesses in East and Southern Africa, with backing from other European development finance institutions like Swedfund and Finnfund.⁵³ Through

⁴⁶ World Bank, *Private Health Sector Assessment in Kenya*, April 2010, xiv, xvii, xix, 64, <https://openknowledge.worldbank.org/handle/10986/5932>.

⁴⁷ For more on the Infrastructure Finance and PPP Project, see World Bank, *Kenya: Enabling Private-Sector Participation in Infrastructure and Social Services*, April 2018, <https://www.worldbank.org/en/about/partners/brief/kenya-enabling-private-sector-participation-in-infrastructure-and-social-services>. See also “Kenya Infrastructure Finance/PPP project,” World Bank, accessed February 24, 2020, <https://projects.worldbank.org/en/projects-operations/project-detail/P121019>.

⁴⁸ World Bank, *Financing Agreement Between Republic of Kenya*, 14-15.

⁴⁹ World Bank, *Maximizing Finance for Development*, 1-2.

⁵⁰ The Managed Equipment Services project is a public-private partnership under prevailing definitions, though it was not organized under Kenya’s Public Private Partnerships Act, 2013. World Bank, *Public-Private Partnerships: Reference Guide Version 3*, 2017, 5-10, <https://openknowledge.worldbank.org/handle/10986/29052>.

⁵¹ International Finance Corporation, email message to author, October 5, 2021, <https://chrgj.org/kenya-health-correspondence/>.

⁵² See International Finance Corporation, *Creating Markets in Kenya: Unleashing Private Sector Dynamism to Achieve Full Potential*, 2019, 8, 54-55, <https://www.ifc.org/wps/wcm/connect/9cdd17da-fccb-4ca8-a71c-ea631593463a/201907-CPSP-Kenya.pdf?MOD=AJPERES&CVID=mMGBDRv>.

⁵³ International Finance Corporation, “IFC and Development Partners Make Landmark Health Care Investment in East and Southern Africa,” news release, November 23, 2019, <https://pressroom.ifc.org/all/pages/PressDetail.aspx?ID=24868>. See also, “Project Hippo,” IFC Project Information & Data Portal, International Financial Corporation, accessed February 25, 2021, <https://disclosures.ifc.org/project-detail/ESRS/38280/project-hippo>.

its subsidiary, the company has already broken ground on a new hospital in Nairobi.⁵⁴ The United Nations also promoted the private sector through the 2017 establishment of a largely healthcare company-funded “SDG Partnership Platform” which focuses on identifying and brokering large scale public-private partnerships.⁵⁵

National development agencies have sought to promote the private sector in Kenyan healthcare, at times with an explicit aim of creating opportunities for their own domestic companies. The United States has long advocated for the role of private actors in healthcare around the world and in Kenya specifically, where it has carried out a number of pro-private sector healthcare projects since at least 2004.⁵⁶ Its Private Sector Engagement Policy echoes the World Bank’s MFD approach in its embrace of the private sector, but also explicitly aims to benefit US companies and promote US economic growth.⁵⁷ In August 2020 it posted a request for bids on a multimillion dollar contract “to reshape the healthcare supply in Kenya using market-based approaches.”⁵⁸ Similarly, the Netherlands has used aid to support Dutch health companies in Kenya and to promote the Dutch health sector as a whole.⁵⁹ For example, the Netherlands commissioned a study that identified “opportunities” for Dutch companies in the Kenyan healthcare sector.⁶⁰ Between 2017 and 2018, 61 percent of the total value of contracts awarded by OECD members to least developed countries and highly indebted poor countries went to companies from the donor’s home country; 87.7 percent of US contracts awarded went to US companies.⁶¹

Private philanthropic institutions have also supported the private sector’s expansion of healthcare in Kenya. For example, the Bill and Melinda Gates Foundation has long supported the growth of the private sector in Africa including through the development of technical expertise⁶² and investments.⁶³ Along with others, it funded a six year project focused on delivering private sector primary health care, particularly to poor people in Kenya and Ghana.⁶⁴ The collaboration, which provided extensive support directly to private providers in Kenya, aimed to “test and demonstrate how quality essential health services and commodities provided by non-state providers can be accessible to poor people,” and

⁵⁴ Christine Muchira, “Kiambu Road Investment Limited Invests Ksh3bn in Hospital,” *Kenya Broadcasting Corporation*, March 26, 2018, <https://www.kbc.co.ke/kiambu-road-investment-limited-invests-ksh3bn-hospital/>.

⁵⁵ The platform’s five contributors are Philips, the Government of the Netherlands, AstraZeneca, Merck, and the Rockefeller Foundation. “Kenya SDG Partnership Platform MPTF,” UN Development Programme, accessed June 9, 2021, mptf.undp.org/factsheet/fund/KEN00?fund_status_month_to=&fund_status_year_to=2020.

⁵⁶ See USAID, *PSP-One and Health Financing*, May 2008, https://www.shopsplusproject.org/sites/default/files/resources/5111_file_Health_Financing_Final_1_pager.pdf; USAID, *Sustainable Strategies for Accessible, Quality Health Care: Public-Private Sector Engagement in Kenya*, undated, 1-2, https://www.shopsplusproject.org/sites/default/files/resources/Kenya_Program_Brochures_0.pdf.

⁵⁷ USAID, *Private-Sector Engagement Policy*, 2018, 4, 9, https://www.usaid.gov/sites/default/files/documents/1865/usaid_psepoli-cy_final.pdf.

⁵⁸ USAID, *RFI Attachment 1: Private Sector Opportunities to a Fully Private Care and Treatment*, 2020, 1, <https://www.grants.gov/view-opportunity.html?oppld=328744>.

⁵⁹ Wemos, *In the Interest of Health for All? The Dutch ‘Aid and Trade’ Agenda as Pursued in the African Healthcare Context*, 2020, 34, https://www.wemos.nl/wp-content/uploads/2020/10/Dutch-AT-in-Health-Kenya_Wemos-discussion-paper_Oct-2020.pdf.

⁶⁰ Task Force Health Care and Kenya Healthcare Federation, *Kenyan Healthcare Sector*.

⁶¹ OECD, *2020 Report on the DAC Recommendation on Untying ODA*, March 2021, 14, [https://one.oecd.org/document/DCD/DAC\(2020\)54/FINAL/en/pdf](https://one.oecd.org/document/DCD/DAC(2020)54/FINAL/en/pdf).

⁶² See International Finance Corporation, *The Business of Health in Africa: Partnering with the Private Sector to Improve People’s Lives*, January 2008, v, <https://documents.worldbank.org/pt/publication/documents-reports/documentdetail/878891468002994639/the-business-of-health-in-africa-partnering-with-the-private-sector-to-improve-peoples-lives>.

⁶³ See “Africa Health Fund,” Bill and Melinda Gates Foundation, accessed February 25, 2021, <https://sif.gatesfoundation.org/investments/africa-health-fund/>; “Growth Markets Health Fund,” Bill and Melinda Gates Foundation, accessed February 25, 2021, <https://sif.gatesfoundation.org/investments/aghf/>.

⁶⁴ Gabrielle Appleford, Isaac Theuri, and Edward Owino, *Brokering Accreditation in Kenya’s National Hospital Insurance Fund: Lessons Learned from Marie Stopes Kenya’s AMUA Social Franchise Network* (London: Marie Stopes International, 2018), <http://www.hanshep.org/our-programmes/AHMEresources/brokering-accreditation-in-kenya2019s-national-hospital-insurance-fund-lessons-learned-from-marie-stopes-kenya2019s-amua-social-franchise-networks>.

to “build and communicate the evidence base, raising the profile of the need for mixed health systems in policy dialogue with country partners and international fora.”⁶⁵

Healthcare is a big business and private actors have been eager to expand their role in Kenyan healthcare. For example, Philips—which funds the UN platform focused on private actors in healthcare—is engaged in public-private partnerships at the county and national level.⁶⁶ It is one of several companies involved with the controversial Managed Equipment Services project (see page 30). Private equity firms and consultants are also increasingly involved in running healthcare for profit. For example, global private equity firm TPG manages, through its impact investing arm, a healthcare fund that owns several Kenyan private healthcare providers such as Nairobi Women’s Hospital, Avenue Healthcare, Metropolitan Hospital, and Ladnan Hospital.⁶⁷ A recent book, co-authored by senior leaders at the global consulting firm McKinsey & Company, touts growing demand in health services in Africa as a “megatrend” creating “big opportunities for business,” and estimates Africa’s pharmaceutical market to be worth between USD \$40 and \$65 billion.⁶⁸ Consulting companies like McKinsey—which recently completed a report for USAID that identified “ten ‘big ideas’ for unlocking greater private sector investment” in Kenyan primary healthcare—are also profiting from the push to expand the role of the private sector.⁶⁹

⁶⁵ Department for International Development of the United Kingdom, *Annual Report: Harnessing Non-State Actors for Better Health for the Poor (HANSHEP)*, August 2019, 2, http://iati.fcdo.gov.uk/iati_documents/50313127.odt.

⁶⁶ Philips, *Annual Report 2019, 2020, 203*, <https://www.results.philips.com/publications/ar19/downloads/pdf/en/PhilipsFullAnnualReport2019-English.pdf>.

⁶⁷ Evercare, *The Evercare Group Annual Impact Report 2020-2021*, 2021, 8, <https://evercaregroup.com/wp-content/uploads/2021/06/evercare-group-annual-impact-report-20202-20201.pdf>; “Kenya,” Evercare, accessed October 4, 2021, <https://evercaregroup.com/kenya/>.

⁶⁸ Acha Leke, Musta Chironga, and George Desvaux, *Africa’s Business Revolution: How to Succeed in the World’s Next Big Growth Market* (Boston: Harvard Business Review Press, 2018), 39, xv, 17-18.

⁶⁹ McKinsey and USAID, *Private-Sector Investment Opportunities in Primary Healthcare in Kenya*.

2. BAD VALUE

In Kenya, privatization has imposed high costs on individuals and the state. For a start, private actors extract profits that public providers don't seek. Private actors also face higher borrowing costs than the public sector, which can further drive up costs. The significant expense of private sector care and financing undermines one of the key arguments of its proponents: that the private sector is useful—or even indispensable—because it helps conserve scarce resources.⁷⁰ There is little evidence that relying on the private sector to provide care saves Kenyans money or reduces public spending. In fact, there is significant evidence that it is more expensive than public healthcare. Between 2013 and 2018, as the role of private providers increased, the total out-of-pocket expenditure on healthcare increased by 90 percent overall, and by 53 percent per capita, even though the average number of outpatient visits fell from 3.1 per year to 2.5.⁷¹

2.1 High Costs for Individuals

For individuals, seeking healthcare from private providers is significantly more expensive than from public ones. Community members overwhelmingly considered the cost of care in the private sector to be expensive and public sector care to be more affordable. As Eunice explained, at private facilities, “money is a must.”⁷² Individuals reported paying thousands of shillings simply for consultations and described excessively high fees at private facilities for services that were offered for free or considerably less at public facilities.

The gap between the cost of private and public care is huge. Perhaps unsurprisingly given that certain healthcare fees were abolished at many public facilities in 2013, private facilities in Kenya are far more likely to charge for both inpatient and outpatient care.⁷³ One comprehensive study, which compared costs of screening, diagnosing, and treating four common non-communicable diseases, found that private facilities charged more than public facilities, often substantially.⁷⁴ For example, private sector breast cancer screening was more than four times as expensive as public sector screening (USD \$18 private vs. \$3.90 public), diagnostic procedures were more than three times as expensive (USD \$1,205 vs. \$401), and treatment was eight to 12 times as expensive depending on the stage of the cancer.⁷⁵ Another study, which examined the treatment of four common conditions, found that patients paid on average about four times more in the private sector but did not receive better care.⁷⁶ Other studies and surveys have found that private providers

⁷⁰ For example, asked about its rationale for supporting for-profit private healthcare actors in Kenya, the IFC replied that, “With public resources strained in many countries in Africa, the private sector has an important role to play in meeting the needs of more people.” International Finance Corporation, email message to author, October 5, 2021, <https://chrgj.org/kenya-health-correspondence/>.

⁷¹ Ministry of Health, *2018 Household Health Expenditure and Utilization Survey*, 47-48, 20.

⁷² Interview with Eunice, Kangemi, Nairobi, March 2021.

⁷³ Ministry of Health, *Kenya Harmonized Health Facility Assessment 2018/2019 Annex Tables, Questionnaires, and Footnotes*, 2020, 289, <https://www.health.go.ke/wp-content/uploads/2020/01/KHFA-2018-19-ANNEX-TABLES-FINAL.pdf>.

⁷⁴ Subramanian et al., “Cost and Affordability.”

⁷⁵ *Ibid.*, 7-8.

⁷⁶ Benjamin Daniels et al., “Use of Standardised Patients to Assess Quality of Healthcare in Nairobi, Kenya: A Pilot, Cross-Sectional Study with International Comparisons,” *BMJ Global Health* 2, no. 2 (2017): 8, <http://dx.doi.org/10.1136/bmjgh-2017-000333>.

charged higher prices for family planning services,⁷⁷ imposed high and burdensome fees for hypertension treatment,⁷⁸ and were far less likely to have information on user fees posted in patients' view.⁷⁹

The higher costs of private facilities carry over to medicines as well. A 2018 government survey looked at the pricing of eight essential generic medicines and found that patients at private primary hospitals paid approximately twice as much as patients at public primary hospitals and that private primary hospitals charged a significantly larger markup over what they paid to procure the medicines.⁸⁰ Private providers in informal settlements have been found to overprice numerous medicines⁸¹ and sell drugs at profit margins of up to 100 percent.⁸²

2.2 Draining Public Coffers

Despite being presented as a solution for scarce public resources, the growing role of the private sector places a significant burden on the state. The government transfers large sums of public money to the private sector to subsidize access to care, contracts with private facilities at considerable public expense, and commits substantial resources to a secretive, expensive public-private partnership. There is a risk that the private sector, rather than supplementing the public sector, will supplant it—with a more expensive, ineffective, and inadequate system.

Even for proponents, the expansion of private care is premised on significant state support, which is considered necessary to subsidize access for those who cannot afford healthcare out of pocket and to incentivize private actors' participation in, and financing of, the sector. Many people, including most in low-income countries, cannot afford even basic care at market prices.⁸³ Private actors instead rely on the state for a “base level of stable income,”⁸⁴ what one economist refers to as a “safety net” for investors.⁸⁵

Unfortunately, the Kenyan government does not make public the total amount of government expenditure on private sector health care and financing and did not respond to queries on the issue. The lack of transparency, discussed further below, presents a barrier to informed debate about the full extent of public support for the private sector. However, it is clear from publicly available evidence that public-private partnerships in health, the NHIF, and other forms of collaboration have required the Kenyan government to take on significant obligations and resulted in the transfer of large amounts of money from the public to the private sector.

The government is increasingly contracting with private facilities to provide healthcare services at significant public expense. The NHIF, which paid out more than

⁷⁷ World Bank and Government of Kenya, *Health Service Delivery Indicator Survey 2018 Report*, 72.

⁷⁸ Aisha Walcott-Bryant et al., “Addressing Care Continuity and Quality Challenges in the Management of Hypertension: Case Study of the Private Health Care Sector in Kenya,” *Journal of Medical Internet Research* 23, no. 2 (2021): 4, <https://doi.org/10.2196/18899>.

⁷⁹ Ministry of Health, *Harmonized Health Facility Assessment 2018/2019 Annex Tables, Questionnaires, and Footnotes*, 289.

⁸⁰ Ministry of Health, *Harmonized Health Facility Assessment 2018/2019 Main Report*, 247.

⁸¹ Dennis Ongarora, et al., “Medicine Prices, Availability, and Affordability in Private Health Facilities in Low-Income Settlements in Nairobi County, Kenya,” *Pharmacy* 7, no. 40 (2019): 10, <https://doi.org/10.3390/pharmacy7020040>.

⁸² Abuga et al., “Sub-Standard Pharmaceutical Services,” 6.

⁸³ Barbara McPake and Kara Hanson, “Managing the Public-Private Mix to Achieve Universal Health Coverage,” *Lancet* 388, no. 10044 (2016): 627, [https://doi.org/10.1016/s0140-6736\(16\)00344-5](https://doi.org/10.1016/s0140-6736(16)00344-5).

⁸⁴ International Finance Corporation, *Business of Health in Africa*, 2008, 26.

⁸⁵ Daniela Gabor, “The Wall Street Consensus,” *Development and Change* 52, no. 3 (May 2021): 431, <https://doi.org/10.1111/dech.12645>.

Kshs. 37 billion in claims in fiscal year (FY) 2017/2018,⁸⁶ did not reply when asked to provide a breakdown of the money it sends to private and public sector facilities or for information on its reimbursement rates. However, based on publicly available information, it's clear that at least for certain services, the NHIF reimburses private facilities at a higher rate than public facilities⁸⁷ and sends far more money to the private sector than the public sector. Between FY 2016/17 and FY 2019/20, private facilities received 82 percent of NHIF outpatient benefits and 64 percent of inpatient benefits.⁸⁸ According to a recent media report, the NHIF spends Kshs. 14 billion annually on claims in Nairobi, 11 billion of which goes to private hospitals.⁸⁹ Kenya's Directorate of Criminal Investigations reportedly estimates that the NHIF loses more than Kshs. 10 billion (or roughly USD \$90 million) in false medical claims every year.⁹⁰

In addition to contracting with private facilities, the Kenyan government has embraced private finance in health. To this end, President Kenyatta and other high-level officials have touted private capital as necessary to achieve development goals. They have pledged to use public policy and resources to “de-risk” investments and marketed the health sector as an investment opportunity for private firms.⁹¹

Worryingly, evidence from elsewhere shows that collaborating with the private sector can ultimately reduce, rather than enlarge, the fiscal space for improving access to healthcare—and weaken the public sector by diverting funds and human resources.⁹² Relying on private financing to achieve development goals is costly and can create fiscal burdens.⁹³ “De-risking” is not designed to eliminate risks, but to transfer them to the public sector through a broad range of tools, such as demand guarantees and termination payments.⁹⁴ Other policies to encourage private investment in health can be structured in ways that undermine the fiscal resources available to provide healthcare, such as tax breaks that reduce revenue.⁹⁵ Questions about whether the private-led development model is more aligned with the interests of global investors than it is with the achievement of development objectives abound.⁹⁶

As Kenya has pursued a private-led approach to development, including the embrace of private healthcare providers and financiers, its public debt has rapidly increased and the amount spent repaying debts has skyrocketed. Between June 2012 and June 2019,

⁸⁶ National Hospital Insurance Fund, *Strides Towards Universal Health Coverage for All Kenyans*, 2018, 2.

⁸⁷ Appleford and Owino, *National Hospital Insurance Fund Tariffs*, 5.

⁸⁸ Private facilities constituted 26 percent of NHIF-contracted facilities.

⁸⁹ Kinyanjui, “NMS Pushes for Policy.”

⁹⁰ John Muchangi, “NHIF Drops 1,700 Facilities over Fraud, Poor Services,” *The Star*, February 18, 2020, <https://www.the-star.co.ke/news/2020-02-18-nhif-accredited-1700-bogus-facilities-to-steal-public-funds/>.

⁹¹ See “Speech by His Excellency Hon. Uhuru Kenyatta,” 2019; John Muchangi, “Private Hospitals to Get UHC Cash,” *The Star*, September 6, 2019, <https://www.the-star.co.ke/news/2019-09-06-private-hospitals-to-get-uhc-cash/>; Chris Mahandara and Aphleen Dorothy, “Government to Review PPP Act to Woo Investors,” *Kenya News Agency*, February 2, 2021, <https://www.kenyanews.go.ke/government-to-review-ppp-act-to-woo-investors/>.

⁹² Ramya Kumar, “Public-Private Partnerships for Universal Health Coverage: The Future of ‘Free Health’ in Sri Lanka,” *Globalization and Health* 15, no. 75 (2019): 6, <https://doi.org/10.1186/s12992-019-0522-6>.

⁹³ Bayliss, Romero, and Van Waeyenberge, “Uneven Outcomes from Private Infrastructure Finance.”

⁹⁴ Gabor, “Wall Street Consensus,” 441.

⁹⁵ Alicia Yamin, “Struggles for Human Rights in Health in an Age of Neoliberalism: From Civil Disobedience to Epistemic Disobedience,” *Journal of Human Rights Practice* 11, no. 2 (July 2019): 368, <https://doi.org/10.1093/jhuman/huz026>.

⁹⁶ Kate Bayliss and Elisa Van Waeyenberge, “Unpacking the Public Private Partnership Revival,” *Journal of Development Studies* 54, no. 4 (2018): <https://doi.org/10.1080/00220388.2017.1303671>; Fathimath Musthaq, “Development Finance or Financial Accumulation for Asset Managers?: The Perils of the Global Shadow Banking System in Developing Countries,” *New Political Economy* 26, no. 4 (2021): 554-573, <https://doi.org/10.1080/13563467.2020.1782367>.

total external debt service rose more than elevenfold, from Kshs. 31 billion to 368 billion.⁹⁷ The proportion of Kenya's national budget spent on servicing external debt rose drastically over the past decade, from less than 3 percent of its national budget in 2012 to roughly 15 percent in 2019—more than the total combined allocation for health, agriculture, and justice that year.⁹⁸

One of the principal mechanisms for private actors in health are public-private partnerships (PPPs), long-term contractual arrangements in which the private sector takes on a significant role in providing health infrastructure or services in return for revenue—in the form of user fees, government funding, or some combination.⁹⁹ Proponents argue the approach provides cash-strapped governments with an efficient, affordable alternative to general tax funded projects and services. Illustrating this viewpoint, the Kenyan PPP Directorate wrote that public-private partnerships in health, “have a number of benefits compared to ... traditional tax-funded arrangements,” including “efficiency” and “better value for money.”¹⁰⁰ Unfortunately, the evidence shows that public-private partnerships often fail to deliver.

While private partners can provide short-term infusions of capital, public-private partnerships are often more expensive over time,¹⁰¹ leading to their characterization as “budgetary timebombs.”¹⁰² They frequently entail significant, binding, and unpredictable costs, including fees for preparation, frequent renegotiations, subsidies, and guarantees to the private sector.¹⁰³ A wide range of studies show that rather than creating fiscal space, public-private partnerships often exceed the cost of financing public infrastructure,¹⁰⁴ are inefficient,¹⁰⁵ are subject to major cost increases,¹⁰⁶ and pose high administrative burdens.¹⁰⁷ The full long-term costs of public-private partnerships are often disguised because common accounting practices can circumvent reporting requirements, making public-private partnerships appear less expensive than public investment, especially in

⁹⁷ National Treasury, *Kenya Annual Public Debt Management Report 2014-2015*, January 2016, 4, <http://ntnt.treasury.go.ke/wp-content/uploads/2021/02/Annual-Public-Debt-Report-2014-2015.pdf>; National Treasury, *Kenya Annual Public Debt Management Report 2018-2019*, September 2019, 15, <http://ntnt.treasury.go.ke/wp-content/uploads/2021/02/Annual-Public-Debt-Report-2018-2019.pdf>.

⁹⁸ Cynthia Nona Tamale and James Thuo Gathii, “Snapshot of Kenya's External Debt Over the Last Decade,” *AfronomicsLaw*, February 15, 2021, <https://www.afronomicslaw.org/category/african-sovereign-debt-justice-network-afsdjn/snapshot-kenyas-external-debt-over-last>.

⁹⁹ There is no single universally accepted definition of a PPP. For additional background on varying definitions and analysis of the different forms of private sector participation, see World Bank, *Public-Private Partnerships: Reference Guide Version 3*, 2017, 6-12, <http://hdl.handle.net/10986/29052>.

¹⁰⁰ PPP Directorate, email message to author, October 6, 2021, 2-3, <https://chrgj.org/kenya-health-correspondence/>.

¹⁰¹ Timothy Irwin, Samah Mazraani, and Sandeep Saxena, *How to Control the Fiscal Costs of Public-Private Partnerships* (Washington, D.C.: International Monetary Fund, 2018), 1, <https://www.imf.org/en/Publications/Fiscal-Affairs-Department-How-To-Notes/Issues/2018/10/17/How-to-Control-the-Fiscal-Costs-of-Public-Private-Partnerships-46294>; James Leigland, “Public-Private Partnerships in Developing Countries: The Emerging Evidence-Based Critique,” *The World Bank Research Observer* 33, no. 1 (2018): 108, 123, <https://doi.org/10.1093/wbro/lkx008>.

¹⁰² Daniela Gabor and Ndongo Samba Sylla, “Planting Budgetary Time Bombs in Africa: The Macron Doctrine En Marche,” *Commission for the Abolition of Debt* (blog), January 14, 2021, <https://www.cadtm.org/Planting-budgetary-time-bombs-in-Africa-the-Macron-Doctrine-En-Marche>.

¹⁰³ Leigland, “Public-Private Partnerships,” 110, 112; Bayliss and Van Waeyenberge, “Unpacking the Public Private Partnership Revival,” 586; World Bank, “Public-Private Partnerships: Reference Guide,” 23-24.

¹⁰⁴ Bayliss and Van Waeyenberge, “Unpacking the Public Private Partnership Revival,” 586; Alessandra Cepparulo, Giuseppe Eusepi, and Luisa Giuriato, “Public Private Partnership and Fiscal Illusion: A Systematic Review,” *Journal of Infrastructure Policy and Development* 3, no. 2 (2019): 299, <http://dx.doi.org/10.24294/jipd.v3i2.1157>.

¹⁰⁵ National Audit Office, *PF1 and PF2*, January 2018, 10, <https://www.nao.org.uk/wp-content/uploads/2018/01/PF1-and-PF2.pdf>.

¹⁰⁶ European Court of Auditors, *Public Private Partnerships in the EU: Widespread Shortcomings and Limited Benefits*, 2018, 10, https://www.eca.europa.eu/Lists/ECADocuments/SR18_09/SR_PPP_EN.pdf.

¹⁰⁷ Sonia Languille, “Public Private Partnerships in Education and Health in the Global South: A Literature Review,” *Journal of International and Comparative Social Policy* 33, no. 10 (2017): 156, <https://doi.org/10.1080/21699763.2017.1307779>.

the short term.¹⁰⁸ This frustrates informed public debate about debt, deficits, and fiscal decision-making.¹⁰⁹

The limited public information available about the fiscal implications of public-private partnerships in Kenya is concerning and the national government appears to be underreporting risks. In 2020, the Parliamentary Budget Office raised concerns about the government's failure to factor public-private partnerships into the national public debt.¹¹⁰ The IMF also recently concluded that there is "no transparent disclosure of the full assets and liabilities relating to ongoing and planned public-private partnerships, despite this financing modality being increasingly preferred by the government," and estimated the total value of public-private partnerships in the pipeline to be 13 percent of GDP.¹¹¹ The IMF noted incomplete reporting on potential risk exposure from existing public-private partnerships and zero risk analysis of the growing list of pipeline projects¹¹²—although, according to the PPP Directorate, accountability and transparency mechanisms are currently being strengthened.¹¹³

What figures have been revealed are alarming. Despite the shortcomings and secrecy associated with the Managed Equipment Services project, the government allocated 6 percent of its health spending to the project in the 2021/22 national budget (Kshs. 7.21 billion), about half of what it allocated to the entire rollout of universal health coverage.¹¹⁴ And as county level governments enter health public-private partnerships, concerns about the drain on limited resources multiply.

¹⁰⁸ Cepparulo, Eusepi, and Giuriato, "Public Private Partnership and Fiscal Illusion," 292-94.

¹⁰⁹ Irwin, Mazraani, and Saxena, *How to Control the Fiscal Costs of Public-Private Partnerships*, 3-4, 7-9.

¹¹⁰ Parliamentary Budget Office, *Unpacking of the Budget Policy Statement and Medium-Term Debt Management Strategy 2020*, February 2020, 3, [www.parliament.go.ke/sites/default/files/2020-03/Unpacking of BPS 2020 final.pdf](http://www.parliament.go.ke/sites/default/files/2020-03/Unpacking%20of%20BPS%202020%20final.pdf).

¹¹¹ International Monetary Fund, *Kenya: Fiscal Transparency Evaluation Update*, 2019, 61, <https://www.imf.org/en/Publications/CR/Issues/2020/01/13/Kenya-Fiscal-Transparency-Evaluation-Update-48941>.

¹¹² *Ibid.*, 63.

¹¹³ PPP Directorate, email message to author, October 6, 2021, 4, <https://chrgj.org/kenya-health-correspondence/>.

¹¹⁴ Parliamentary Budget Office, *Unpacking the Estimates of Revenue and Expenditure for 2021/2022*, 11-12.

3. A FAILING APPROACH

Private care is frequently depicted as a high-quality, efficient alternative to an under-resourced public sector characterized by long lines and drug shortages. When asked about the rationale for promoting the private sector in health, the Vision 2030 Secretariat wrote that private facilities “hold a prominent position in terms of cost-effectiveness, diverse range of health and related products and services, and good quality services.”¹¹⁵ But that image is at odds with the reality of a private sector that offers wildly different care to the “haves” and the “have nots,” with low-end, low-quality providers pedaling services that are unsafe and inadequate. The private sector also neglects unprofitable but essential services and does a much poorer job delivering on a wide range of public priorities, such as compliance with various best practices, opportunities for accountability, and providing good quality jobs.

3.1 Unsafe and Underregulated

There are significant issues with the quality and safety of many private providers, especially those in lower-income areas such as informal settlements. Many interviewees, including those who worked in the private sector, expressed concerns about the quality of care, staff qualifications, lack of oversight, and impact of providers’ profit motive on the care offered. Several people reported experiencing significant health issues because of misdiagnoses and inadequate or unnecessary treatments by private healthcare providers.

A significant body of evidence suggests clear and troubling patterns of problems with the safety and adequacy of treatment by private providers. One 2018 World Bank survey of over 3,000 health facilities in Kenya found that private facilities had worse diagnostic accuracy, adherence to clinical guidelines, and management of maternal and neonatal complications than public facilities.¹¹⁶ Another 2018 survey of thousands of Kenyan facilities found that private ones were less likely to have a system for monitoring adverse events, undertaking mortality and morbidity reviews, and providing supportive supervision.¹¹⁷ Private facilities were also less likely to provide adequate pharmaceutical storage.¹¹⁸ In one instance, a private healthcare provider, Ruai Family Hospital, provided COVID-19 vaccinations at a political rally without following health directives related to refrigeration and safe handling, forcing the Kenya Medical Practitioners and Dentists Council to suspend the license of the provider and temporarily close the facility.¹¹⁹ Despite development actors’ enthusiastic and active support for the private sector, these alarming findings cast doubt on many of the claims about its superiority and suggest that research into the safety and adequacy of private providers is sorely needed.

Indeed, extensive evidence shows that these quality issues are particularly acute

¹¹⁵ Vision 2030 Delivery Secretariat, email message to author, October 7, 2021, 1, <https://chrgj.org/kenya-health-correspondence/>.

¹¹⁶ World Bank and Government of Kenya, *Health Service Delivery Indicator Survey 2018 Report*, xiii.

¹¹⁷ Ministry of Health, *Harmonized Health Facility Assessment 2018/2019 Main Report*, 259, 268, 264.

¹¹⁸ *Ibid.*, 273.

¹¹⁹ Dorcas Wangira, “Ruai Family Hospital License Reinstated, Remains Suspended as a Vaccination Centre,” *Citizen Digital*, September 1, 2021, <https://citizentv.co.ke/news/ruai-family-hospital-license-reinstated-remains-suspended-as-vaccination-centre-13098488/>.

at lower-cost private providers in informal settlements, where poor and low-income people are more likely to live. One survey of private facilities in informal settlements in Nairobi found that nearly half of them (44 percent) had names that did not correspond with the level of operations they were licensed for, including clinics and medical centers depicting a higher level of care.¹²⁰ The study also found that many facilities did not dispose of expired drugs properly, demonstrated poor observance of ethical guidelines, and delegated pharmaceutical services to non-pharmaceutical employees.¹²¹ It concluded that the “private sector is laden with problems of manpower shortages, blurred boundaries on scope of practice and poor inter-professional coordination.”¹²² According to one study, only 47 percent of private facilities in low-income areas in Nairobi had licenses.¹²³ Interviewees who were residents of areas where low-cost and unlicensed private facilities dominate, said private providers offered inferior quality care and were more likely to compromise patient safety, citing poorly qualified staff, poor or absent screening or counseling, expired or fraudulent medications, and a profit motive. Compared to the private options available to them, they felt public facilities offered higher quality and more comprehensive medical care.¹²⁴

Community members described a dismal and unsafe low-end private healthcare sector worlds apart from the quality of care associated with high-end facilities. Many interviewees reported problems with low-quality providers and felt the public sector offered better quality care, although, as discussed below, they also described challenges in the public sector—including having to travel great distances, long waits, and lack of medications—that led them to visit private providers despite the drawbacks. Some said private providers cut corners with diagnostic procedures. One patient, Grace, described being treated for years by a private facility that misdiagnosed her with high blood pressure. When she finally visited a public facility, she was offered different diagnostic tests and received a correct heart condition diagnosis. She explained, “In public facilities...they do all tests properly, unlike private where they diagnose you by just observing you or asking you what symptoms you have.”¹²⁵ A community health volunteer, Kennedy, raised similar concerns: “When you go to private facilities, they never do proper tests, they diagnose you off the top of their head.”¹²⁶

One Mombasa woman’s inadequate treatment and subsequent death provides a tragic example. According to her daughter, the woman visited a private facility for diagnostic tests related to a cough and was given the wrong test results. Because of this, her throat cancer was not diagnosed and treated in a timely fashion. By the time the mistake was discovered seven months later, the cancer had progressed and could not be treated. The woman died shortly thereafter, leaving her family destitute and bewildered. Her case is indicative of the harm that private facilities have caused too many in Kenya, especially those from low-income segments of society.¹²⁷

¹²⁰ Abuga et al., “Sub-Standard Pharmaceutical Services,” 4.

¹²¹ Ibid., 1.

¹²² Ibid., 9.

¹²³ Sirina R. Keesara, Pamela A. Juma, and Cynthia C. Harper, “Why Do Women Choose Private Over Public Facilities for Family Planning Services? A Qualitative Study of Post-Partum Women in an Informal Urban Settlement in Kenya,” *BMC Health Services Research* 15, no. 335 (2015): 1, <https://doi.org/10.1186/s12913-015-0997-7>.

¹²⁴ Ibid., 3-6.

¹²⁵ Interview with Grace, Kisauni, Mombasa, May 4, 2021.

¹²⁶ Interview with Kennedy, Kisauni, Mombasa, May 4, 2021.

¹²⁷ Interview with Halima, Mombasa, September 7, 2021.

Community members, health volunteers, and healthcare workers frequently raised concerns over the quality of staff at private providers, especially lower quality private providers in informal settlements. They also noted consequences of workplace conditions like high turnover, low pay, and lack of coordination. Healthcare workers interviewed—both those in private and in public facilities—overwhelmingly felt that public facilities had more qualified staff. This is consistent with surveys and studies on staffing in private facilities in Kenya, which have found that private healthcare professionals often have inadequate training¹²⁸ and are less likely to have a system in place for regular, continuous medical education than public facilities,¹²⁹ and that people are more likely to bypass private facilities due to unqualified staff.¹³⁰ One private healthcare worker, Robert, described private employees as “quacks,” adding that public providers had more rigorous recruitment procedures.¹³¹

A number of interviewees, including healthcare professionals and experts, felt that oversight and regulation of private clinics were woefully insufficient, and that the public system was significantly better regulated. One healthcare expert explained that although the national government has sufficient constitutional authority to monitor and enforce regulations, the existing regulatory framework is weak and lacks meaningful standards. To complicate matters further, monitoring and enforcement activities remain underfunded and are not transparent.¹³² Community health volunteers explained that private clinics would often close on the day regulators visited, suggesting advance knowledge of the inspection. Fredrick, a clinical officer at a private healthcare facility, said that the facility sometimes knew in advance of authorities’ visits and that he would take certain measures like ensuring the room was ventilated.¹³³ Halima, a health volunteer, explained that clinics closed by authorities would sometimes operate illegally at night.¹³⁴

3.2 Misaligned Incentives

Private providers’ focus is on making a profit, not providing a strong healthcare system that meets national objectives. Because of these misaligned incentives, important public health priorities are being neglected by the private sector. The private sector is heavily concentrated in the most profitable forms of care, and has spurned less commercially viable areas, patients, and services—including important forms of preventative care and family planning services.

Public health experts and Kenyan authorities agree that the country needs to increase access to a range of essential healthcare services.¹³⁵ Yet in many instances private providers in Kenya are less willing to offer critical forms of care with low returns, preferring high-cost curative services.

According to a 2018 survey of thousands of facilities nationwide, private providers are less likely to offer family planning services, antenatal and postnatal care, post-abortion

¹²⁸ Walcott-Bryant et al., “Addressing Care Continuity,” 5.

¹²⁹ Ministry of Health, *Harmonized Health Facility Assessment 2018/2019 Main Report*, 258.

¹³⁰ Ministry of Health, *Household Health Expenditure and Utilization Survey*, 2019, 33.

¹³¹ Interview with Robert, Kibera Makina, Nairobi, March 2021.

¹³² Interview with Allan Maleche, February 5, 2021.

¹³³ Interview with Fredrick, Kipngetchi Kirui, Isiolo, May 25, 2021.

¹³⁴ Interview with Halima, Kongowea, Mombasa, May 4, 2021.

¹³⁵ See Ministry of Health, *Kenya Health Policy 2014-2030*, 33-34.

care, routine child immunizations, care for child malnutrition, adolescent health services, tuberculosis diagnosis and treatment, care and support for HIV/AIDS, and services for survivors of violence and sexual abuse.¹³⁶ Private facilities are also less likely to offer key vaccination services. Public facilities offer on average 81.4 percent of key vaccinations and private facilities on average offer far fewer, just 40.7 percent.¹³⁷ Private facilities are, however, considerably more likely to offer comprehensive surgical services, which have higher returns.¹³⁸

Many people interviewed felt that private providers' desire to make money affected the quality of care, caused patients to spend more than necessary, and, at its worst, led to unnecessary or harmful care. Miriam, a community health volunteer explained that some private providers, "keep injecting patients, doing tests, always say you have something and only refer you to public [facilities] after things get worse."¹³⁹ According to Fatuma, a nurse who worked in the private healthcare sector, "Some [private providers] are just in business giving patients follow up appointments so as to make money from them or even giving water through the drips instead of medicine."¹⁴⁰ In a recent study, private sector providers acknowledged that they lacked a financial incentive to refer patients back to the community or lower-level facilities or to task-shift within their hospitals to use lower level professionals.¹⁴¹ Nairobi Women's Hospital, which is owned by a health fund managed by TPG Capital, was embroiled in scandal in 2020 when a media exposé revealed allegations of unnecessary admissions and delaying the discharge of patients.¹⁴²

Finally, relying on the private sector to expand and improve health infrastructure, such as through public-private partnerships, can warp the healthcare system around private profits and jeopardize the development of a strong, comprehensive, and equitable healthcare system. Private actors, focused on profitable projects, have little incentive to invest in areas and infrastructure with lower returns. A state focused on "de-risking" the health sector for private actors can quickly assume a policy of "little more than planning and overseeing public-private partnership projects," rather than ensuring access.¹⁴³ Policy experts in Kenya raised concerns about the lack of clarity around who was initiating public-private partnerships in health and questioned whether the private sector was driving the agenda rather than public priorities.¹⁴⁴ Civil society recently challenged a planned public-private partnership involving construction of a private hospital on the campus of the country's premier public hospital, arguing it would pose a burden to public resources and do little to address pressing health needs (see page 27).

¹³⁶ Ministry of Health, *Harmonized Health Facility Assessment 2018/2019 Main Report*, 58, 61, 82, 78, 90; Ministry of Health, *Harmonized Health Facility Assessment 2018/2019 Annex Tables, Questionnaires, and Footnotes*, 71, 78, 97, 101, 103, 161.

¹³⁷ World Bank and Government of Kenya, *Health Service Delivery Indicator Survey 2018 Report*, 50-51.

¹³⁸ Ministry of Health, *Harmonized Health Facility Assessment 2018/2019 Main Report*, 199.

¹³⁹ Interview with Miriam, Kisauni, Mombasa, May 4, 2021.

¹⁴⁰ Interview with Fatuma, Tudor, Mombasa, May 6, 2021.

¹⁴¹ Walcott-Bryant et al., "Addressing Care Continuity," 5.

¹⁴² Owaahh, "Customers, Not Patients: The Nairobi Women's Hospital Saga," *The Elephant*, February 6, 2020, <https://www.theelephant.info/features/2020/02/06/customers-not-patients-the-nairobi-womens-hospital-saga/>; Grace Ng'ang'a, "KMPDC finds Nairobi Women's Hospital Guilty of Misconduct," *The Standard*, February 26, 2020, <https://www.standardmedia.co.ke/nairobi/article/2001361960/kmpdc-finds-nairobi-womens-hospital-guilty-of-misconduct>. According to The Rise Fund and Evercare, following the allegations, two independent investigations were carried out and a number of reforms were implemented. See The Rise Fund and Evercare, email message to author, October 5, 2021, <https://chrgj.org/kenya-health-correspondence/>.

¹⁴³ Gabor, "Wall Street Consensus," 432.

¹⁴⁴ Interview with public policy experts, August 10, 2020.

3.3 Entrenched Inequality in Access

The ways in which health systems are structured can exacerbate or ameliorate exclusion and inequality in access to care.¹⁴⁵ Rather than delivering a universal high standard of care, the private sector in Kenya risks further entrenching inequalities, including along lines of income, gender, region, and ethnicity.¹⁴⁶

Private healthcare in Kenya consists of a highly heterogeneous, uncoordinated collection of providers, offering widely varying levels of care. While expensive and higher quality private facilities cater to the wealthy in urban areas, residents in lower income areas are more likely to encounter a private sector that is characterized by low quality—at times illegal—clinics and pharmacies with less qualified staff and little specialized equipment.¹⁴⁷ Overall, poor people are more dependent on the public sector and less likely to access care at private providers.¹⁴⁸ In rural areas, private providers are less likely to operate at all due to the lack of opportunities for revenue.¹⁴⁹ Encouraging the growth of expensive, fee-charging private facilities all but guarantees exclusion, leaving the majority who cannot afford such care to unsafe and underregulated low-cost private providers and an under-resourced public sector (see box 1).

Box 1: Kenyatta National Hospital Public-Private Partnership

In October 2019, the Board of Kenya's premier public referral hospital, Kenyatta National Hospital (KNH), published an advertisement seeking bids for the construction and management of a new private hospital on the KNH campus that would focus on high quality specialist healthcare services.¹⁵⁰ The hospital, a public-private partnership, would be funded primarily by healthcare users, and the winning bidder would have nearly complete discretion over what services to offer and what fees to charge, meaning lower income people could be effectively locked out.¹⁵¹

The benefit to the public is unclear. As proposed, the private company would enjoy a range of benefits including a 30-year lease for 3.6 hectares in a rapidly growing business district, the possibility of a patient referral arrangement with KNH, and the full range of tax incentives available to private actors in healthcare.¹⁵² Yet there is scant publicly available information about what the government or the public would gain in return. While the KNH Board has said that the private company would pay a percentage of its revenue to the hospital, there is no

¹⁴⁵ Yamin, "Struggles for Human Rights in Health in an Age of Neoliberalism," 365-66.

¹⁴⁶ Kenya National Bureau of Statistics, *Inequality Trends and Diagnostics in Kenya 2020*, November 2020, 77-80, <https://www.knbs.or.ke/wp-content/uploads/2021/07/Inequality-Trends-and-Diagnostics-in-Kenya-Report.pdf>.

¹⁴⁷ See Abuga et al., "Sub-Standard Pharmaceutical Services," 4.

¹⁴⁸ Ilinca et al., "Socio-Economic Inequality and Inequity in Use of Health Care Services," 9.

¹⁴⁹ World Bank and Government of Kenya, *Health Service Delivery Indicator Survey 2018 Report*, 83-84.

¹⁵⁰ Kenyatta National Hospital, *The Proposed KNH Private Hospital PPP: Project Information Memorandum*, 2019, 27, 30. The request for qualification and accompanying documents, including the Memorandum, can be found at "PPP Hospital," Kenyatta National Hospital, accessed August 4, 2021, <https://knh.or.ke/index.php/ppp-hospital>.

¹⁵¹ Kenyatta National Hospital Board, *Clarification No 1*, November 2019, 2, https://knh.or.ke/wp-content/uploads/2019/12/Clarification-No.-1-KNH-PPP_RFQ_01_2019-2020-29Nov2019.pdf; Kenyatta National Hospital, *The Proposed KNH Private Hospital PPP*, 31.

¹⁵² Kenyatta National Hospital Board, *Clarification No 1*, 3; Kenyatta National Hospital, *The Proposed KNH Private Hospital PPP*.

indication of what that would be.¹⁵³ KNH did not respond to a written request seeking clarity about the revenue arrangement or about measures taken to ensure that the services would be affordable and equally accessible to all. There is a real risk that the government is using its limited resources to support an exclusionary and expensive set of services for the wealthy while receiving little in return.

Civil society actors and medical professionals have criticized the plan, concerned that it would entrench rather than address inequality in healthcare access and ignore public health necessities.¹⁵⁴ In November of 2019, the Kenya Medical Practitioners Pharmacists and Dentists Union (KMPDU), with the support of Hakijamii, sued the hospital board and the Ministry of Health over the project. They alleged that the new private hospital would lead to discrimination in healthcare provision because it would be better equipped and staffed than the main hospital which serves the poor and marginalized.¹⁵⁵ They also claimed that public participation was inadequate, given that they, as major stakeholders in the medical field, were not consulted.¹⁵⁶ The suit sought an injunction restraining the hospital board from continuing the project.¹⁵⁷

3.4 Lack of Accountability

Achieving universal health coverage involves significant public resources and requires tough policy decisions about what to prioritize and when, making robust public accountability especially important.¹⁵⁸ However, private actors remain largely unaccountable, insulated from the obligations and democratic processes associated with the public sector.¹⁵⁹ One survey found that nearly three quarters of public facilities had a routine system for community representation, compared to 16 percent of private facilities.¹⁶⁰ Patients described struggles with lack of accountability in the private sector. For example, George described how a private hospital administrator refused to settle a bill after a family member died and rejected the Kshs. 450,000 that the family painstakingly fundraised. The administrator insisted on holding the body until the family paid the entire Kshs. 2.3 million bill. It was only when the family turned to the County Commissioner, who referred them to a lawyer, that the family was able to secure the body's release.¹⁶¹

One significant barrier to accountability is the lack of information, which is endemic to the private sector even when it carries out public functions. Unlike the public sector, where data on outcomes is often widely available, there is typically little comparable data from the private sector and even public-private partnerships rarely report information sufficient to assess performance.¹⁶² Contracts with private actors are often kept confidential, despite

¹⁵³ Kenyatta National Hospital, *The Proposed KNH Private Hospital PPP*, 31.

¹⁵⁴ See Lukoye Atwoli, "KNH Deal is a Scam; Thought You Should Know," *The Nation*, October 19, 2019, <https://nation.africa/kenya/blogs-opinion/opinion/knh-deal-is-a-scam-thought-you-should-know-214688>.

¹⁵⁵ Kenya Medical Practitioners Pharmacists and Dentists Union v. Kenyatta National Hospital Board & Others, petition 452 (High Court of Kenya, Constitution and Human Rights Division 2019), para. 24.

¹⁵⁶ *Ibid.*, para. 25.

¹⁵⁷ *Ibid.*, para. 27.

¹⁵⁸ World Health Organization, *Making Fair Choices on the Path to Universal Health Coverage: Final Report of the WHO Consultative Group on Equity and Universal Health Coverage*, 2014, xi-xii, 42, <https://www.who.int/publications/i/item/9789241507158>.

¹⁵⁹ John Forrer, et al., "Public-Private Partnerships and the Public Accountability Question," *Public Administration Review* 70, no. 3 (May/June 2010): 477, <https://doi.org/10.1111/j.1540-6210.2010.02161.x>.

¹⁶⁰ Ministry of Health, *Harmonized Health Facility Assessment 2018/2019 Main Report*, 266.

¹⁶¹ Interview with George, Jomvu, Mombasa, May 4, 2021.

¹⁶² Basu, et al., "Comparative Performance of Private and Public Healthcare Systems," 10, 8.

the public interest involved. In Kenya, both Parliament and civil society groups have raised repeated concerns about a profound lack of access to information about fiscal obligations and contracting.¹⁶³ Even members of Parliament and the Attorney General have not been allowed to view contracts with the private sector for health services, seriously compromising the ability of these institutions to provide meaningful oversight and accountability (see page 30). Caroline, a community member, described the situation as such: “We don’t get even the basic information...we have no idea how these funds are used or to what project they go to here.”¹⁶⁴ Corruption is also a constant challenge in Kenya and transferring major healthcare functions to the private sector presents a very lucrative opportunity.¹⁶⁵ Meaningful and independent transparency and accountability mechanisms are urgently required to ensure that public money is not wasted or used on private enterprise to the detriment of healthcare needs.

The international actors who promote private healthcare, shaping policy from behind closed doors thousands of miles away, are arguably even less accountable than private providers in Kenya. Many have played a direct role in privatizing the health sector in Kenya, seemingly without analyzing (at least publicly) the impact on the enjoyment of the right to health, especially for the most vulnerable and marginalized. We asked a number of development actors—including the World Bank, the IFC, the Netherlands and the United States—whether they had assessed the impact of their support for private sector healthcare on human rights, social risks, or access to healthcare. Only the Netherlands responded to the question, asserting that it “always assessed” the human rights impact of embassy-funded private healthcare initiatives.¹⁶⁶

While some, such as international organizations like the World Bank, must at least make routine disclosures, others, like the Gates Foundation, offer exceedingly little information about their activities and certainly no meaningful opportunities for Kenyans—whose rights are at stake—to raise their concerns or seek to influence policy. The Gates Foundation did not reply to written questions about whether it has any mechanisms for facilitating Kenyans’ participation in its decision-making process, or how it ensures accountability to Kenyans who are affected by its actions.

¹⁶³ Parliamentary Budget Office, *Unpacking of the Budget Policy Statement and Medium-Term Debt Management Strategy 2020*, 3; Tamale and Gathii, “Snapshot of Kenya’s External Debt Over the Last Decade.”

¹⁶⁴ Interview with Caroline, Bullapesa, Isiolo, May 27, 2021.

¹⁶⁵ See Dominic Omondi, “Reveal the Names of Covid-19 Millionaires Now, IMF Tells Kenya,” *The Standard*, June 29, 2021, <https://www.standardmedia.co.ke/business/news/article/2001416921/reveal-the-names-of-covid-19-millionaires-now-imf-tells-kenya>.

¹⁶⁶ Netherlands Embassy in Nairobi, email message to author, October 18, 2021, <https://chrgj.org/kenya-health-correspondence/>.

Box 2: Managed Equipment Services

Managed Equipment Services (MES) is a high-profile, seven-year arrangement with five global companies to equip 119 public Kenyan hospitals with leased medical equipment at an estimated cost of more than Kshs. 60 billion (over USD \$500 million).¹⁶⁷ Launched in 2015, it epitomizes a number of problems with the private sector approach, including poor value for money, misalignment with public health needs, and a lack of accountability. Heralded as a success by some—including in industry-authored blogs published by the World Bank¹⁶⁸—it has drawn significant scrutiny from civil society organizations, Kenyan officials, and others.¹⁶⁹

Poor value for money

The project has drawn criticism for its extremely high cost and alleged waste of resources. The MES has placed a significant burden on public coffers, draining as much as 14 percent of some counties' health budgets.¹⁷⁰ During the first four years of the contract, Kenya paid Kshs. 25.9 billion towards the project (or roughly USD \$250 million).¹⁷¹

The leased equipment appears to have been significantly overpriced. Ministry of Health records suggest that some of the equipment was leased at many times the normal market price, such as an ultrasound with a market price of Kshs. 3 million leased for 23.6 million and a stethoscope with a market price of Kshs. 12,000 leased for more than 1.2 million.¹⁷² An ad hoc Senate committee established to investigate the project concluded that equipment cost was "grossly exaggerated,"¹⁷³ and counties have reported procuring similar equipment at a fraction of the cost of the lease.¹⁷⁴

Meanwhile, private actors have derived significant returns from the project—even when the equipment was undelivered or inoperative. The CEO of General Electric boasted of closing a "big healthcare deal in Kenya worth more than \$200 million," representing a 42 percent increase on orders in Africa.¹⁷⁵ Philips' CEO also touted the value of the agreement on an earnings call and the company considers MES a "proven approach" that should be expanded to other African countries.¹⁷⁶ Legal and financial firms have also profited handsomely,¹⁷⁷ with one law firm receiving a half million dollar no-bid contract to advise the government on the project and

¹⁶⁷ John Mutua and Noah Wamalwa, *Leasing of Medical Equipment Project in Kenya: Value for Money Assessment*, (Nairobi: Institute of Economic Affairs, 2020), 6, 13-15, <https://ieakenya.or.ke/download/leasing-of-medical-equipment-project-in-kenya-value-for-money-assessment/>.

¹⁶⁸ Monish Patolawala, "Transforming Kenya's Healthcare System: A PPP Success Story," *World Bank Blogs*, May 24, 2017, <https://blogs.worldbank.org/ppps/transforming-kenya-s-healthcare-system-ppp-success-story>; Cynthia Olotch, "How Managed Equipment Services in Kenya Help the Private Sector Contribute to Healthcare," *World Bank Blogs*, January 4, 2018, <https://blogs.worldbank.org/ppps/how-managed-equipment-services-kenya-help-private-sector-contribute-healthcare>.

¹⁶⁹ See Crystal Simeoni and Wangari Kinoti, *Medical Equipment Leasing in Kenya: Neocolonial Global Finance and Misplaced Health Priorities* (Suva: DAWN, 2020), https://dawnnet.org/wp-content/uploads/2021/01/Medical-Equipment-Leasing-in-Kenya_Neocolonial-Global-Finance-and-Misplaced-Health-Priorities_DAWN-discussion-paper-25.pdf.

¹⁷⁰ Mutua and Wamalwa, *Leasing of Medical Equipment Project in Kenya*, 18.

¹⁷¹ Senate Ad-Hoc Committee to Investigate the Managed Equipment Services, *Report of the Investigation of the Managed Equipment Services*, September 2020, 49-50, https://www.kelinkkenya.org/wp-content/uploads/2020/09/Final-Version-of-MES-Committee-Report-for-Tabling_08092020.pdf.

¹⁷² Ibid., 101-02.

¹⁷³ Ibid.

¹⁷⁴ Ibid., 101-02, 242-43.

¹⁷⁵ General Electric Co., *Edited Transcript: GE - Q2 2015 General Electric Co Earnings Call*, 2015, 3, 6, https://www.ge.com/sites/default/files/ge_webcast_transcript_07172015_1.pdf.

¹⁷⁶ Philips, *Edited Transcript: Q1 2015, Koninklijke Philips NV Earnings*, April 28, 2015, 2015, <https://www.results.philips.com/publications/q115/downloads/files/en/philips-first-quarter-results-2015-transcript.pdf?v=20210726183841>; "2017 Annual Results," Philips, February 20, 2018, <https://www.results.philips.com/publications/ar17>.

¹⁷⁷ Senate Ad-Hoc Committee to Investigate the Managed Equipment Services, *Report of the Investigation*, 33.

nearly one million dollars in “donations” from the five MES companies.¹⁷⁸

Misalignment with public health needs

The project has also been criticized for poor alignment with the priorities of some of the counties and facilities involved. County governments, despite their responsibility for delivering healthcare services, were not even consulted during a 2014 Ministry of Health needs assessment for the project. Although the assessment found that many counties either lacked the infrastructure and specialists necessary to use the equipment or already had sufficient equipment, the project went ahead.¹⁷⁹ Given other urgent needs, like developing a more specialized health workforce, it is not clear why upgrading equipment was an appropriate priority.¹⁸⁰

The Senate committee’s findings appeared consistent with widespread reports that equipment was never delivered, delivered only after substantial delay, or was unusable due to lack of infrastructure and staff.¹⁸¹ The report concluded that five years into the project, despite making annual payments, some counties still lacked functioning equipment with key items like x-ray machines, CT scanners, and surgical theatres unavailable or nonfunctional in many places.¹⁸² In November 2019, the Committee visited a hospital in Isiolo where much of the equipment was not in use, including a seemingly unused surgical theatre with unopened, rusty equipment, an ultrasound machine still in its original packaging, and an x-ray machine only partially installed. Hospital management reported that the project had limited impact because the facility lacked specialized personnel and adequate electricity and water.¹⁸³ One county official interviewed for this report said much of the equipment did not work, and that the “ghost project” had diverted funds that would have otherwise gone to support poor and marginalized people.¹⁸⁴

Lack of accountability

Concerns about the waste of public resources and poor outcomes have translated into extraordinarily little accountability for the private companies or officials involved. The Senate committee report called for a forensic audit by the office of the Auditor General and an investigation by the Ethics and Anti-Corruption Commission, yet neither appears to have been initiated.¹⁸⁵ Although the Senate committee invited General Electric to appear three times, it

¹⁷⁸ Ibid., 76-77.

¹⁷⁹ Ibid., 34, 43.

¹⁸⁰ Mumbo Hazel Miseda et al., “The Implication of the Shortage of Health Workforce Specialist on Universal Health Coverage in Kenya,” *Human Resources for Health* 15, no. 80 (2017), <https://doi.org/10.1186/s12960-017-0253-9>.

¹⁸¹ See John Mutua, “Taxpayers Paid 6 Times More for GE Hospital Machine,” *Business Daily*, November 25, 2019, <https://www.businessdailyafrica.com/economy/Taxpayers-paid-6-times-more-for-GE-hospital-machine/3946234-5362374-4j8ch0z/index.html>; Ibrahim Oruko, “Medical Kits ‘Lying Idle’ in 27 Counties,” *The Nation*, October 22, 2019, <https://allafrica.com/stories/201910230354.html>; “Tana River’s Sh800m Idle Medical Machines,” *The Standard*, November 11, 2019, <https://www.standardmedia.co.ke/coast/article/2001348873/tana-river-s-sh800m-idle-medical-machines>; Roselyn Obala and Jacob Ng’etich, “How Sh63 Billion Health Project Bleeds Taxpayers,” *The Standard*, December 1, 2018, standardmedia.co.ke/health-science/article/2001304678/how-sh63-billion-health-project-bleeds-taxpayers; Angela Oketch and Samwel Owino, “How Uhuru’s MES health care scheme went to the dogs,” *The Nation*, October 4, 2020, <https://nation.africa/kenya/news/how-uhuru-s-mes-health-care-scheme-went-to-the-dogs-2456164>.

¹⁸² Senate Ad-Hoc Committee to Investigate the Managed Equipment Services, *Report of the Investigation*, 240-241. The report was ultimately not adopted by the Senate.

¹⁸³ Ibid., 203-05. Asked to comment, General Electric maintains it delivered and installed fully functional diagnostic and ultrasound systems in 98 hospitals across Kenya’s 47 counties and that its equipment has been in full working order more than 99 percent of the time.

¹⁸⁴ Interview with Peter Warutere, Member of Nairobi City County Assembly, Chairperson of Health Committee, March 2021.

¹⁸⁵ Senate Ad-Hoc Committee to Investigate the Managed Equipment Services, *Report of the Investigation*, 228.

*failed to send an adequate representative.*¹⁸⁶

*An extreme lack of information has fundamentally challenged efforts at scrutiny and oversight by civil society, oversight bodies, county authorities, and even members of Cabinet.*¹⁸⁷ *Counties report being forced to sign off on the project without reviewing the terms of the MES contracts and not being informed about what equipment they would receive.*¹⁸⁸ *Even the former Attorney General said his office was denied access to the contracts, despite his responsibility for scrutinizing and approving them to ensure their compliance with the Constitution and other relevant laws.*¹⁸⁹

3.5 Poor Employer

Private sector healthcare workplace conditions appear in many ways inferior to those in the public sector, especially at low-cost service providers. Healthcare workers noted that private sector healthcare providers' wages varied considerably depending on the facility and they considered public sector wages relatively superior depending on the level of healthcare service provision. One private sector nurse, Fatuma, explained that the number of inpatients determined how much people made, and that her salary depended on having a "good number of patients."¹⁹⁰ Many felt the public sector offered better benefits, including retirement. Several private sector healthcare workers felt they had less job security and said that private employers discouraged or prohibited employees from organizing at work. Some of the private healthcare workers did not even receive health insurance. Healthcare workers in the public sector also felt they had more flexibility to address personal issues like attending a funeral while private healthcare workers said they had less control over their schedule. Workers described long shifts in the private sector of up to 24 hours.

Multiple private healthcare workers described the pressure to meet patient "targets" or risk termination. Robert, a private sector clinical officer, explained:

When you work in the private sector it is quite hectic because you have a lot of pressure. You have to work and you have to achieve the set targets.... For example, within a day we serve 10 patients, it is my responsibility to retain this number and even get more.¹⁹¹

Workplace conditions in private healthcare facilities reflect a lack of accountability as well as regulatory and monitoring failures which affect both patient welfare and the welfare of the general public.

¹⁸⁶ Ibid., 166-67.

¹⁸⁷ Mutua and Wamalwa, *Leasing of Medical Equipment Project in Kenya*, 11.

¹⁸⁸ Joy Kirigia, "Public Disservice, Kenya: Shiny New Useless Machines," *Africa Uncensored*, July 3, 2019, <https://africauncensored.online/public-disservice-kenya/>.

¹⁸⁹ Rawlings Otieno, "Former AG Faults CS Macharia on Multi-Billion Medical Leasing Deal," *The Standard*, July 23, 2020, <https://www.standardmedia.co.ke/business/article/2001379751/former-ag-faults-cs-macharia-on-multi-billion-medical-leasing-deal>.

¹⁹⁰ Interview with Fatuma, Ganjoni, Mombasa, May 6, 2021.

¹⁹¹ Interview with Robert, Kibera Makina, Nairobi, March 2021.

4. SEVERE HUMAN RIGHTS IMPACTS

4.1 Exclusion and Denial of Service

Researchers found that private providers routinely exclude and deny service to Kenyans who cannot afford higher private sector prices, compromising their access to essential healthcare, and that high costs frequently deter people from seeking healthcare altogether. Because private facilities typically impose far higher fees than public ones—which generally charge lower or no fees depending on the facility—privatization risks exacerbating exclusion rather than increasing access to care.

Despite a constitutional prohibition on refusing emergency medical care, a number of people said that private healthcare providers refused to offer emergency medical treatment.¹⁹² Purity explained that when she took her son to a private hospital for emergency care for a severe burn, a doctor said she needed to pay up-front. Because she didn't have the amount required, the hospital refused to treat him.¹⁹³

Many interviewees described being refused care by private providers unless they paid a significant deposit. As Sharon explained, “The problem with private facilities is they are money minded. No matter how sick you are, even if it's an emergency you must pay a deposit before being attended to...you must pay first even if the patient is dying.”¹⁹⁴ She described a time when she and her family rushed her brother to a private hospital following a violent robbery only to have the hospital refuse to treat him without a deposit of Kshs. 30,000. Similarly, Joshua said he took his unconscious nephew to a private hospital after a serious accident but it declined to treat him without a Kshs. 10,000 deposit—despite the constitutional prohibition on denial of emergency care.¹⁹⁵ Given that over a third of the country lives under the national poverty line—Kshs. 3,252 per household per month in rural areas and Kshs. 5,995 per household per month in urban areas—such deposits are simply unworkable for many.¹⁹⁶

Many people reported having to stop treatment due to high costs in the private sector and multiple private sector healthcare workers said patients declined treatment because it was too expensive. One worker, Robert, who often saw this happen, said that once he laid out the options for treatment cost, patients would “walk away.”¹⁹⁷ As Purity explained, paying for only partial treatment meant that sometimes health issues would reoccur: “You just be honest with [private providers] that you can't afford the full dosage and that you can only afford half at that moment.... but a week later, the problems develop again.”¹⁹⁸ Another man said his wife's health deteriorated after they stopped treatment because they were unable to afford the Kshs. 50,000 fees a private hospital wanted to charge for her care.¹⁹⁹

¹⁹² Constitution of Kenya, art. 43.

¹⁹³ Interview with Purity, Mkuru Kwa Reuben, Nairobi, March 2021.

¹⁹⁴ Interview with Sharon, Likoni, Mombasa, May 4, 2021.

¹⁹⁵ Interview with Joshua, Waber, Isiolo, May 27, 2021.

¹⁹⁶ Kenya National Bureau of Statistics, *Basic Report on Well-Being in Kenya*, March 2018, 9, <https://www.knbs.or.ke/?wpdmp=ba-sic-report-well-kenya-based-201516-kenya-integrated-household-budget-survey-kihbs>.

¹⁹⁷ Interview with Robert, Kibera Makina, Nairobi, March 2021.

¹⁹⁸ Interview with Purity, Mkuru Kwa Reuben, Nairobi, March 2021.

¹⁹⁹ Interview with Dennis, Bula Pesa, Isiolo, May 25, 2021.

Private actors' high costs deter people from seeking care altogether. Cost, which is significantly higher in the private sector, is a major barrier to accessing care and discourages people from even seeking care.²⁰⁰ Between 2013 and 2018, as the role of private providers increased and health expenditure rose, Kenyans sought less and less care.²⁰¹ National data show that a major reason people choose not to seek treatment is the cost of care.²⁰² Many community members told researchers they avoided care due to the anticipated cost.

4.2 Inadequate Care

Despite the increased cost of privatized healthcare, in many cases it is still delivering subpar care, especially in low-cost private healthcare facilities. Many people reported receiving misdiagnoses at private healthcare providers. They described treatments for conditions they did not have, for example being treated for ulcers when they actually had an amoeba or being given the wrong medicine.²⁰³ One woman said that a private hospital failed to diagnose her baby with sickle cell anemia, but that she subsequently received the correct diagnosis at a public hospital.²⁰⁴

Some described severe problems and tragedy as a result of poor private care. Halima said her mother died after visiting a private hospital that failed to correctly diagnosis her because her endoscopy results were swapped with those of another patient.²⁰⁵ Brenda said that a botched leg surgery at a private hospital left her with a disability. She experienced significant pain, was unable to walk well, and could no longer work.²⁰⁶

4.3 Poverty and Debt

Many individuals described facing hardships in trying to pay for private healthcare. Medical costs in 2018 were estimated to push 1-1.1 million Kenyans into poverty each year²⁰⁷—a significant increase from an estimated 0.5 million in 2013.²⁰⁸ According to one estimate, a whopping 7.1 percent of households in 2018 incurred healthcare payments that were “catastrophic”—defined as costs exceeding 40 percent of non-food expenditure.²⁰⁹ The cost of healthcare can trigger a “poverty trap mechanism,” anchoring people to poverty rather than helping them escape it.²¹⁰

People often have to borrow money to pay for healthcare and the resulting debt can cause major deprivations. Community members said they had difficulty paying for care for themselves or a family member while many described facing significant challenges to pay for private healthcare. Several said they took out loans to pay for private care

²⁰⁰ Sujha Subramanian, et al., “Financial Barriers Related to Breast Cancer Screening and Treatment: A Cross-Sectional Survey of Women in Kenya,” *Journal of Cancer Policy* 22 (December 2019): 5, <https://doi.org/10.1016/j.jcpc.2019.100206>.

²⁰¹ Ibid., 17. The proportion of households who did not seek healthcare despite reporting illness in the four weeks preceding the survey rose from 18 to 28 percent between 2013 and 2018.

²⁰² Ministry of Health, *2018 Household Health Expenditure and Utilization Survey*, 19.

²⁰³ Interview with Ann, Kibra, Nairobi, March 2021; interview with Stephen, 51, Merti, Isiolo, May 25, 2021.

²⁰⁴ Interview with Belinda, Nairobi, March 2021.

²⁰⁵ Interview with Halima, Kongowea, Mombasa, May 4, 2021.

²⁰⁶ Interview with Brenda, Shimanzi, Mombasa, May 4, 2021.

²⁰⁷ Salari et al., “The Catastrophic and Impoverishing Effects of Out-of-Pocket Healthcare Payments,” 6.

²⁰⁸ Ibid., 8.

²⁰⁹ Ibid. Using a threshold of OOP exceeding 10 percent of total, 10.7 percent of households incurred catastrophic payments.

²¹⁰ Ibid., 10.

and experienced long-term negative consequences. Others reported selling important personal assets, including cars and land, and forgoing educational opportunities to pay for private healthcare. Many turned to their communities to help pay for unaffordable private healthcare bills, in many cases communities that already had high rates of poverty.

Despite multiple court rulings finding the detention of patients unlawful, private healthcare providers continue the practice.²¹¹ Interviewees described their own detention and that of family members by private facilities. Several private healthcare workers confirmed that detentions continue at their facilities. Many also described private hospitals refusing to release the bodies of family members and loved ones who had passed away unless their bills were paid.

4.4 Low-Income People

Privatizing care poses a major threat to healthcare access for poor and low-income Kenyans. They start off at a huge disadvantage in accessing care,²¹² face significant socio-economic inequalities and obstacles to healthcare,²¹³ and are far more likely to forgo it.²¹⁴ National survey results show that the richest households used preventative and inpatient care nearly twice as often as their poorer counterparts.²¹⁵ Those in the poorest quintile live in areas with lower quality of service²¹⁶ and are disproportionately burdened by healthcare spending. The poorest quintile of the population spend on average between 10-15 percent of their budget on healthcare, while all other quintiles spend less than 5 percent.²¹⁷ In 2018, 13.1 percent of poor households experienced catastrophic healthcare expenditure, compared to 1.9 percent of the wealthiest.²¹⁸ In addition, the poorest quintile have worse access to insurance and other forms of cost protection: 4.5 percent of people in the lowest quintile had insurance in 2018 compared to 42.3 percent of the wealthiest.²¹⁹ They are also more likely than the wealthy to have to borrow money to pay for healthcare.²²⁰

Given such vulnerability, privatization is bound to disproportionately affect poor and low-income Kenyans. First and foremost, they are the least able to afford expensive private care. Many community members from informal settlements said private providers were unaffordable and people described fees for routine care that are clearly a burden for those under the national poverty line, such as Kshs. 1,500-3,000 for a consultation or Kshs. 2,000 for malaria treatment.

A number of people also said private facilities discriminated against them because of their economic status. Interviewees told researchers that private healthcare workers,

²¹¹ See *MAO v. Attorney General*, Petition 562 of 2012, eKLR (High Court of Kenya at Nairobi, 2015), <http://kenyalaw.org/caselaw/cases/view/131104/>; *Veronica Nyangai v. Nairobi West Hospital Ltd*, Petition 63 of 2017, eKLR (High Court of Kenya at Nairobi, 2017), <http://kenyalaw.org/caselaw/cases/view/133560/>; *Mary Nyang'anyi Nyaigero v. Karen Hospital Limited*, Civil Suit 448 of 2015, eKLR (High Court of Kenya at Nairobi, 2016), <http://kenyalaw.org/caselaw/cases/view/118675/>; *Gideon Kilundo v. Nairobi Women's Hospital*, Petition 242 of 2018, eKLR (High Court of Kenya at Nairobi, 2018), <http://kenyalaw.org/caselaw/cases/view/158915/>.

²¹² Ministry of Health, *2018 Household Health Expenditure and Utilization Survey*, 26, 41.

²¹³ Ilinca et al., "Socio-Economic Inequality and Inequity in Use of Health Care Services," 2.

²¹⁴ Ministry of Health, *2018 Household Health Expenditure and Utilization Survey*, 18.

²¹⁵ Ilinca et al., "Socio-Economic Inequality and Inequity in Use of Health Care Services," 4-6.

²¹⁶ *Ibid.*, 2-4.

²¹⁷ Salari et al., "The Catastrophic and Impoverishing Effects of Out-of-Pocket Healthcare Payments," 4.

²¹⁸ *Ibid.*, 4-5. Using the 10 percent threshold, CHE is 16.2 for the poorest quintile and 5.4 percent for the wealthiest.

²¹⁹ Ministry of Health, *2018 Household Health Expenditure and Utilization Survey*, 58.

²²⁰ *Ibid.*, 53.

“judge and treat you based on your appearance or social status,” “only faithfully attend to patients viewed as able to afford their kind of treatment,” and “serve you differently compared to those perceived to be of higher social class.”²²¹

We asked a number of development actors—including the World Bank, the IFC, the Gates Foundation, and the United States—what steps they took to ensure their support of the private sector in health benefits poor and lower income Kenyans, given that accessing private healthcare is often substantially more expensive than public healthcare in Kenya. Only the IFC replied to the question, asserting without elaboration its commitment to healthcare providers that serve the “bottom of the pyramid,” and offered an example related to an investment in Ghana—not Kenya.²²²

4.5 Rural Residents

Rural residents, who are in many respects effectively ignored by the private sector, are particularly vulnerable to privatization. Rural households have much higher rates of poverty²²³ and lower rates of insurance coverage.²²⁴ They are thus less able to pay the higher fees of the private sector and are far more reliant on public health facilities for care.²²⁵ Many rural community members said they rely entirely on the public sector and consider private care unaffordable and inaccessible. Private care facilities are heavily concentrated in urban areas, where returns are higher. For example, in Nairobi, which has a poverty rate of 16.7 percent, private practices account for 68 percent of total facilities.²²⁶ In Isiolo, which has a 51.9 percent poverty rate, just 21 percent of facilities are private practice.²²⁷ Relying on the private sector to deliver healthcare risks rural residents’ financial and physical access to it, which is detrimental to the governmental objective of universal access to healthcare.

4.6 People with Disabilities

People with disabilities, who in many cases have been woefully failed by the existing health system, routinely raised concerns about the lack of accessible and appropriate services at private facilities. For example, Ibrahim explained, “Most private hospitals lack structures and equipment to accommodate my disability.”²²⁸ A participant in a validation exercise described the difficulties he faced as a result of inaccessible private facilities—such as being treated outside designated rooms in the open—and said such challenges discouraged him and others with disabilities from seeking health services.²²⁹ Several community members said that public facilities were generally more accessible than private facilities. Multiple private sector healthcare workers said that their facilities lacked ramps

²²¹ Interview with Brian, Shimanzi, Mombasa, May 5, 2020; interview with Purity, Mkuu Kwa Reuben, Nairobi, March 2021.

²²² International Finance Corporation, email message to author, October 5, 2021, <https://chrgj.org/kenya-health-correspondence/>.

²²³ Kenya National Bureau of Statistics, *Basic Report on Well-Being in Kenya*, 44.

²²⁴ Ministry of Health, *2018 Household Health Expenditure and Utilization Survey*, 55.

²²⁵ *Ibid.*, 28, 41.

²²⁶ Kenya National Bureau of Statistics, *Basic Report on Well-Being in Kenya*, 50; Kenya National Bureau of Statistics, *Inequality Trends and Diagnostics in Kenya 2020*; authors’ calculation from the Kenya Master Health Facilities List, accessed July 23, 2021.

²²⁷ *Ibid.*

²²⁸ Interview with Ibrahim, Central, Isiolo, May 25, 2021.

²²⁹ Interview with John, Isiolo, September 2, 2021.

and other features to ensure accessibility. One explained that parts of the facility were not accessible “because the structure is not ours...It will require the owner of the house to repair and he is not forthcoming.”²³⁰

4.7 Women

Women are also disproportionately affected by the privatization of healthcare. Women earn less,²³¹ are more likely to be in poverty,²³² and head households associated with less access to primary care.²³³ Furthermore, women are more likely to suffer chronic conditions, have a higher hospital admission rate,²³⁴ and spend 37 percent more on healthcare than men.²³⁵

Women are highly affected by the misalignment of private profit-seeking and public health priorities since private facilities in Kenya are less likely to offer many of the services that women most need to protect their health, but which do not offer high returns. Private facilities are less likely to offer family planning services, post-abortion care, antenatal care, and maternal postnatal care.²³⁶ Interviewees also raised concerns that private providers pressured women to undergo cesarian sections because they generate greater revenue.²³⁷ This is consistent with research showing that those who delivered in private facilities in Kenya had a higher chance of cesarean delivery,²³⁸ a phenomenon that has been linked to financial incentives.²³⁹ Women also shared stories of receiving very poor reproductive and maternal care at private providers.

The public sector appears to do a far better job meeting the health needs of women, with public facilities more likely to offer all those services. Public sector community health volunteers reported assisting women with preventative care, pre-natal care, and family planning—services that generate no direct revenue despite their immense value. Public facilities are also approximately twice as likely to offer services for survivors of violence and sexual abuse compared to private facilities.²⁴⁰

Given their economic disadvantages, women are also disproportionately affected by the high cost of private providers. They described facing exorbitant fees at private facilities for labor and delivery, as well as pre-natal care. Diana described being told by a private hospital that she would not be admitted unless she paid a Kshs. 40,000 fee despite severe labor complications which necessitated a blood transfusion. She had only Kshs. 2,000 and would have been turned away, if not for a hospital worker who agreed to guarantee the fee.²⁴¹ While many women took advantage of Kenya’s program for free

²³⁰ Interview with Julius, Bamburi, Mombasa, May 5, 2021.

²³¹ Kenya National Bureau of Statistics, *Inequality Trends and Diagnostics in Kenya 2020*, 67, 103-105.

²³² Kenya National Bureau of Statistics, *Basic Report on Well-Being in Kenya*, 62.

²³³ Peter O. Otieno et al., “Access to Primary Healthcare Services and Associated Factors in Urban Slums in Nairobi-Kenya,” *BMC Public Health* 20, no. 981 (2020): 7, <https://doi.org/10.1186/s12889-020-09106-5>.

²³⁴ Ministry of Health, *2018 Household Health Expenditure and Utilization Survey*, 14, 39.

²³⁵ *Ibid.*, 49.

²³⁶ Ministry of Health, *Harmonized Health Facility Assessment 2018/2019 Main Report*, 56-58, 76-78, 60-61, 80-82.

²³⁷ Interview with Belinda, Nairobi, March 2021.

²³⁸ Malachi Ochieng Arunda, Anette Agardh, and Benedict Oppong Asamoah, “Cesarean Delivery and Associated Socioeconomic Factors and Neonatal Survival Outcome in Kenya and Tanzania: Analysis of National Survey Data,” *Global Health Action* 13, no. 1 (2020), <https://doi.org/10.1080/16549716.2020.1748403>.

²³⁹ Ana Pilar Betrán, et al., “Interventions to Reduce Unnecessary Caesarean Sections in Healthy Women and Babies,” *The Lancet* 392, no. 10155 (October 2018), [https://doi.org/10.1016/S0140-6736\(18\)31927-5](https://doi.org/10.1016/S0140-6736(18)31927-5).

²⁴⁰ Ministry of Health, *Harmonized Health Facility Assessment 2018/2019 Annex Tables, Questionnaires, and Footnotes*, 161.

²⁴¹ Interview with Diana, Bengala, Mombasa, May 3, 2021.

delivery at public facilities, Linda Mama, others said they were asked to pay significant fees when attempting to use the program at private hospitals. A 2018 World Bank survey found that 70 percent of patients paid for family planning services at private facilities compared to 11 percent at public facilities and that private hospitals charged three times as much as public facilities.²⁴²

Women are ultimately more dependent than men on public healthcare²⁴³ and are thus more negatively affected by reduced investment in the public sector and greater systemic reliance on private providers.

²⁴² World Bank and Government of Kenya, *Health Service Delivery Indicator Survey 2018 Report*, 72.

²⁴³ Ministry of Health, *2018 Household Health Expenditure and Utilization Survey*, 16.

5. THE PATH TO UNIVERSAL HEALTH COVERAGE

Private sector involvement in healthcare is often depicted as essential to achieving universal health coverage, defined in the Sustainable Development Goals as: “financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.” Yet, in many respects, privatization is undermining that goal by diverting resources away from the public sector, which—if properly resourced—is more capable of providing a high-quality, affordable, physically accessible, and comprehensive healthcare system. Indeed, not all paths taken in the name of achieving universal health coverage are consistent with the goal.²⁴⁴ Increasing the role of the private sector while shrinking that of the state—even if pursued under the auspices of improving access—can widen inequalities and worsen access to care.²⁴⁵ Privatization may be inimical to, rather than supportive of, the realization of equitable and universal health coverage. This is exemplified by the shortcomings of the NHIF, the government’s primary avenue for the realization of universal health coverage.

5.1 Shortcomings of the NHIF

In seeking to achieve universal health coverage, the government is leaning heavily on the NHIF. As discussed above, although the NHIF is a public insurer, it favors the private sector, and while it may not have been established to benefit private actors, it now pays out far more to private providers than to the public system. The National Hospital Insurance Fund (amendment) Bill, 2021 makes NHIF membership mandatory with a monthly fee of Kshs. 500. Choosing to pursue universal health coverage through the NHIF—rather than through the public health system—will have far reaching consequences. It will entrench private actors and almost certainly result in more public money going to private profit. Unfortunately, relying on a combination of social insurance and private providers to deliver healthcare also guarantees that Kenyans will continue to experience problems associated with privatized care: high and impoverishing costs, inequality in access, and unmet health needs. Expanding coverage through the NHIF instead of investing in a strong public health system is not a small step in the right direction—it’s a step backwards.

Relying on the NHIF does not align private actors with public health needs, but instead leaves members dependent on an uneven patchwork of private providers driven by profit and puts taxpayers on the hook for subsidizing corporate revenue. Private actors are in the driver’s seat deciding where to open, what to charge, what services to offer, what equipment to invest in, and how much to train and pay staff. Mandating insurance instead of investing in public healthcare offers, at best, some degree of financial protection for certain services—but does not address the need for expanding the healthcare workforce or infrastructure, particularly in rural or low-income areas.

Although NHIF coverage is often presented as a way of making healthcare affordable, members still face high costs at private providers—especially members with

²⁴⁴ World Health Organization, *Making Fair Choices*, 2014, 37.

²⁴⁵ Sonja Kristine Kittelsen, Sakiko Fukuda-Parr, and Katerini Tagmatarchi Storeng, “The Political Determinants of Health Inequities and Universal Health Coverage,” *Globalization and Health* 15, no. 73 (2019): 1, <https://doi.org/10.1186/s12992-019-0514-6>.

the low-cost plan set to be rolled out nationwide. Because private facilities often charge people in excess of NHIF reimbursement, coverage does not prevent high out-of-pocket charges, catastrophic spending on healthcare, or exclusion. In addition, the NHIF's low-cost plan offers no cost protection for many vital expenses that are not covered, such as palliative care, certain medication, many diagnostic tests, and the cost of managing complications.²⁴⁶ Many people interviewed said they faced high costs at private providers despite NHIF coverage such as significant co-pays for routine treatment and staggering medical bills for lifesaving care. For example, Joshua said that after his nephew was treated in a private facility's intensive care unit, the NHIF paid only Kshs. 600,000 of the 1.7 million bill.²⁴⁷ The failure of insurance to offer meaningful financial protection was underscored by a 2018 national survey that found households with at least one person covered by health insurance were more likely to experience catastrophic healthcare payments.²⁴⁸

Because many cannot afford to pay a monthly fee, a mandatory contributory scheme effectively guarantees exclusion. Many interviewees who signed up for NHIF coverage said the monthly fee of Kshs. 500 was unaffordable and that they had been forced to default on payments and lose coverage. Many individuals the NHIF counts as members are lapsed.²⁴⁹ According to the NHIF Chief Executive Officer in April 2021, of the 10 million members it has registered over the years, active membership was only about half that, with a whopping 75 percent of voluntary members in default.²⁵⁰ Those who default have to pay an entire year (currently Kshs. 6,000) in advance to rejoin—an impossible sum for many.²⁵¹ While the government pledged to subsidize contributions for a million poor households, that is woefully insufficient given that 36.1 percent of the population is estimated to live under the national poverty line.²⁵² Along with the abysmal ineffectiveness of Kenya's existing insurance program for poor households, such targeted approaches may do little to close gaps in access.²⁵³

Finally, funding social insurance through mandatory contributions is often depicted as a fiscally prudent approach, but it may make less fiscal sense and be less effective than a general tax-funded model that would offer care free at the point of use. In fact, there is strikingly little evidence that mandatory social insurance programs raise more money or are easier to collect than taxes,²⁵⁴ and they frequently lead to the exclusion of poor people and low enrollment.²⁵⁵ A comparison of tax funded and social insurance systems found the latter increases per capita health spending by 3 to 4 percent but does not lead to better health outcomes.²⁵⁶ A 2017 study comparing the two approaches in Kenya found that

²⁴⁶ Subramanian et al., "Cost and Affordability," 12.

²⁴⁷ Interview with Joshua, Bullapesa, Isiolo, May 27, 2021.

²⁴⁸ Salari et al., "The Catastrophic and Impoverishing Effects of Out-of-Pocket Healthcare Payments," 11.

²⁴⁹ Rahab Mbau et al., "Examining Purchasing Reforms Towards Universal Health Coverage by the National Hospital Insurance Fund in Kenya," *International Journal for Equity in Health* 19, no. 19 (2020): 10, <https://doi.org/10.1186/s12939-019-1116-x>.

²⁵⁰ John Muchangi, "All I Want is to Put a Smile on a Patient's Face – NHIF Boss," *The Star*, April 15, 2021, <https://www.the-star.co.ke/news/big-read/2021-04-15-all-i-want-is-to-put-a-smile-on-a-patients-face-nhif-boss/>.

²⁵¹ Ibid.

²⁵² Kenya National Bureau of Statistics, *Basic Report on Well-Being in Kenya*, 9.

²⁵³ Ministry of Health, *2018 Household Health Expenditure and Utilization Survey*, 61; Edwine Barasa et al., "Kenya National Hospital Insurance Fund Reforms: Implications and Lessons for Universal Health Coverage," *Health Systems & Reform* 4, no. 4 (2018): 354, 358, <https://doi.org/10.1080/23288604.2018.1513267>.

²⁵⁴ Adam Wagstaff, "Social Health Insurance Reexamined" (World Bank Policy Research Working Paper 4111, January 2007), <https://openknowledge.worldbank.org/handle/10986/6886>.

²⁵⁵ Ibid., 11-15.

²⁵⁶ Adam Wagstaff, "Social Health Insurance vs. Tax-Financed Health Systems - Evidence from the OECD" (World Bank Policy Research Working Paper No. 4821, January 1, 2009), 2, <https://doi.org/10.1596/1813-9450-4821>.

both would require considerable government funding, but that the contributory approach would become less sustainable over time, with expenditure outstripping revenue—while financing healthcare through general revenue would be less costly and more sustainable both in the short and long-term.²⁵⁷

Supporters of social insurance often refer to other countries where private providers deliver care under tightly regulated national social insurance programs. However, these programs are often highly context specific, have evolved over decades, and are not easy to duplicate.²⁵⁸ For example, Japan's social insurance program is strictly regulated, reimburses private and public providers equally, determines reimbursement rates through a rigorous and transparent process that firmly limits total expenditure, and generally prohibits private providers from balance billing patients.²⁵⁹ It is far from clear whether or not these are appropriate comparisons. Much of the Kenyan population—including a number of county officials and health experts with whom we spoke—are in the dark about key details of the planned nationwide rollout of mandatory coverage. The NHIF and Ministry of Health did not respond to our questions regarding projected costs and revenue; what services would be covered (and whether that information was publicly available); if any impact assessment of mandatory contributions for poor households had been carried out; and what would happen to those who cannot afford a monthly contribution.

5.2 The Value of Public Healthcare

Despite being starved of resources, Kenya's public health system is vibrant and impressive. In 2018, it accounted for 58 percent of outpatient visits and more than half of inpatient admissions,²⁶⁰ more than for-profit, non-profit, and faith-based providers combined. It caters to the needs of the majority of Kenyans, provides more affordable quality healthcare, offers a comprehensive range of services including preventative and promotive care, and employs thousands of highly qualified workers in secure jobs with benefits. While it has many severe challenges, with adequate resources and oversight, it offers far more potential for expanding access to quality healthcare than privatization has shown.

Several developments in healthcare policy illustrate the value of an affordable public system. In 2004 when user fees at lower-level public facilities were replaced with more modest registration fees and services for children under five and treatment for key conditions were exempted from payment, healthcare use rapidly increased. It initially spiked 70 percent before settling at 30 percent higher than before.²⁶¹ Following the complete abolition of user fees in public dispensaries and health centers in 2013, healthcare use

²⁵⁷ Vincent Okungu, Jane Chuma, and Di McIntyre, "The Cost of Free Health Care for All Kenyans: Assessing the Financial Sustainability of Contributory and Non-Contributory Financing Mechanisms," *International Journal for Equity in Health* 16, no. 39 (2017), <https://doi.org/10.1186/s12939-017-0535-9>.

²⁵⁸ Mary Suma Cardosa et al., "How to Sustainably Finance Universal Health Care," *Inter Press Service*, August 10, 2021, www.ips-news.net/2021/08/sustainably-finance-universal-health-care/.

²⁵⁹ See Naoki Ikegami, "Japan: Achieving UHC by Regulating Payment," *Globalization and Health* 15, no. 72 (2019), <https://doi.org/10.1186/s12992-019-0524-4>.

²⁶⁰ Ministry of Health, *2018 Household Health Expenditure and Utilization Survey*, 27, 42.

²⁶¹ Jane Chuma and Thomas Maina, *Free Maternal Care and Removal of User Fees at Primary-Level Facilities in Kenya: Monitoring the Implementation and Impact: Baseline Report* (Washington, D.C.: Health Policy Project, 2013), 3, https://www.healthpolicyproject.com/pubs/400_KenyaUserFeesBaselineReportFINAL.pdf.

again increased, rising 37 percent for all patients over the age of five.²⁶²

Indeed, despite an explicit policy focus, particularly at the national level, on increasing the role of the private sector, recent investments in the public healthcare system demonstrate the enduring appetite for quality, affordable public healthcare. The pilot phase of universal health coverage, which entailed removing user fees at public facilities in four Kenyan counties in 2018 and 2019, led to increased use of healthcare.²⁶³ Interviewees in Isiolo, one of the pilot counties, offered exceptionally strong praise for the program, underscoring the value of the public system. Community members, healthcare volunteers, and healthcare workers reported it ensured access to previously unaffordable specialist care and drugs regardless of wealth. Similarly, some county authorities are undertaking ambitious programs to improve access to public healthcare. For example, Nairobi Metropolitan Services recently constructed six new health facilities that saw more than 70,000 patients between March and June of 2021.²⁶⁴

Certainly, the public system has significant shortcomings, many of which are tied to underinvestment in health infrastructure, staff, and services. Public health spending has increased in recent years but the allocation of 7 percent of the most recent budget is still well under the Abuja Declaration goal of 15 percent.²⁶⁵ In addition, significant public health spending is directed to the private sector, starving public facilities of much needed resources.

The public system needs significant investment and improvements. Interviewees frequently reported long wait times to access care at public facilities, severe medicine shortages, and concerns about the cost of transportation to distant public facilities. Surveys and studies show that public facilities have higher caseloads, shorter hours, and are less likely to stock certain medicines.²⁶⁶ Programs to reduce fees have been implemented unevenly and patients can still face considerable out-of-pocket costs. Healthcare workers have also been neglected, with long delays in compensation and a lack of much-needed psychosocial support and personal protective equipment during the COVID-19 pandemic.²⁶⁷ When asked what recommendations they would make, many community members said they wanted medicines to be more regularly stocked in public facilities, more health personnel, and new public facilities in informal settlements where facilities are often few and far between. Others stressed the need for more comprehensive care for people with disabilities and more meaningful opportunities for participation in public health decision-making.

Despite these shortcomings, many of the interviewees stressed their faith in the public system, their belief in its quality, and its superior affordability. Vivian, a healthcare worker, said, “I always tell everyone in my life if I ever collapse where I am and they are with me, take me to a public hospital. Let me wake up in a public facility. I have interacted

²⁶² Maina and Kirigia, *Annual Evaluation of the Abolition of User Fees*, v.

²⁶³ Derrick Okubasu, “830K People Stranded as Governor Scraps Uhuru’s Free Healthcare Project,” *Kenyans.co.ke*, August 26, 2020, <https://www.kenyans.co.ke/news/56765-830k-people-stranded-governor-scraps-uhurus-free-healthcare-project>.

²⁶⁴ Maureen Kinyanjui, “Newly Launched Hospitals Record High Patient Turnout.”

²⁶⁵ Darmi Jattani and Oscar Ochieng, “Can People Afford to Pay Out of Pocket for Health Care in Kenya,” *Institute for Economic Affairs* (blog), July 15, 2021, <https://ieakenya.or.ke/blog/can-people-afford-to-pay-out-of-pocket-for-health-care-in-kenya/>.

²⁶⁶ World Bank and Government of Kenya, *Health Service Delivery Indicator Survey 2018 Report*, 31, 25; Ministry of Health, *Harmonized Health Facility Assessment 2018/2019 Annex Tables, Questionnaires, and Footnotes*, 242.

²⁶⁷ Human Rights Watch, *Kenya: Pandemic Health Workers Lack Protection*, October 2021, <https://www.hrw.org/news/2021/10/21/kenya-pandemic-health-workers-lack-protection>.

with both public and private, and I tell you public [facilities] give treatment to save life, not to benefit from money.”²⁶⁸

²⁶⁸ Interview with Vivian, Tudor, Mombasa, May 7, 2021.

6. THE RIGHT TO HEALTH

Health is a fundamental human right.²⁶⁹ It is guaranteed under the Kenyan Constitution and the International Covenant on Economic, Social and Cultural Rights (ICESCR), which Kenya ratified in 1972, and is recognized in a range of other international and regional human rights instruments.²⁷⁰

The right entails significant obligations for the Kenyan government. The right to health is understood to impose three types of obligations on ICESCR State parties: to respect, or to refrain from interfering with the enjoyment of the right to health; to protect, or to take measures that prevent third parties from interfering with the right to health; and to fulfil, or to adopt appropriate legislative, administrative, budgetary, and other measures to fully realize the right to health.²⁷¹ These obligations are also reflected directly in the Kenyan Constitution, which requires the State respect, protect, promote and fulfil rights, including the right to health; imposes a duty on State organs and officers to address the needs of most vulnerable groups in society; and requires the State to prioritize the widest possible enjoyment of rights in its allocation of resources, including the right to health.²⁷²

The right to health includes the right to the facilities, goods, and services necessary for the realization of the highest attainable standard of health.²⁷³ In its General Comment Number 14 on the right to health, the UN Committee on Economic, Social and Cultural Rights (CESCR), which authoritatively interprets the ICESCR, explained that goods and facilities must be available in sufficient quantity, accessible to everyone without discrimination, culturally acceptable, and of good quality.²⁷⁴ Accessibility entails both physical accessibility, including for people with disabilities and those in rural areas, as well as economic accessibility, which requires that facilities, goods, and services be affordable for all.²⁷⁵ Discrimination is prohibited and States must use their maximum available resources for the realization of the right to health.²⁷⁶

Privatized care in Kenya is not satisfying these criteria. Private providers' preference for higher-profit curative services is adversely affecting the availability of many essential ones, such as preventive and promotive care. The concentration of high-end private services in the regions and neighborhoods that offer the highest returns and on patients with the most resources has made quality healthcare less physically and financially accessible for many others—who often depend on a subsector of private actors that offer lower quality and often unsafe and illegal services. The diversion of public resources to ineffective private actors also casts doubt on whether maximum available resources are being dedicated to the realization of the right to health, as required by international law. Additionally, the right

²⁶⁹ While this analysis focuses on the right to health, the right to health is indivisible from, dependent on, and related to other human rights, including the rights to life, effective remedy, freedom of association, and to take part in the conduct of public affairs. See UN Committee on Economic, Social and Cultural Rights, General Comment No. 14, para. 3; Vienna Declaration and Programme of Action, adopted by the World Conference on Human Rights in Vienna, June 25, 1993, <https://www.ohchr.org/en/professionalinterest/pages/vienna.aspx>.

²⁷⁰ International Covenant on Economic, Social and Cultural Rights, art. 12; Constitution of Kenya, art. 43.

²⁷¹ UN Committee on Economic, Social and Cultural Rights, General Comment No. 14, paras. 33, 35.

²⁷² Constitution of Kenya, arts. 21(1), 21(3), 20(5)(a).

²⁷³ UN Committee on Economic, Social and Cultural Rights, General Comment No. 14, paras. 9, 17.

²⁷⁴ These interrelated elements of the right to health are often referred to collectively as AAAQ. Ibid., para. 12.

²⁷⁵ Ibid.

²⁷⁶ International Covenant on Economic, Social and Cultural Rights, art. 2; UN Committee on Economic, Social and Cultural Rights, General Comment No. 3, The Nature of States Parties' Obligations, E/1991/23, para. 9 (1990).

to health includes the right to information and guarantees the population's participation in health-related political decisions at the national and community level,²⁷⁷ two areas where the private sector has fallen woefully short.

Although human rights law does not prohibit private healthcare or specify who must pay for and provide services,²⁷⁸ the human rights risks posed by health privatization have been well documented. CESCR has expressed concerns about the negative consequences of privatized healthcare, including inequalities in access, unaffordability,²⁷⁹ suboptimal use of public resources,²⁸⁰ proliferation of unauthorized private practitioners,²⁸¹ siphoning healthcare workers from the public sector,²⁸² and insufficient compliance with regulations.²⁸³ The UN Committee on the Elimination of Discrimination against Women and the UN Committee on the Rights of the Child have noted particular risks privatization poses to women and children, especially those in rural areas.²⁸⁴ Recognizing the challenges that States face in complying with their obligations due to the increased role of private actors in traditionally public sectors like health, CESCR clarified that States “retain at all times the obligation to regulate private actors to ensure that the services they provide are accessible to all, are adequate ... [and] meet the changing needs of the public.”²⁸⁵ According to the Committee, private healthcare providers should be, “subject to strict regulations that impose on them so-called ‘public service obligations’” and should be prohibited from denying access to affordable and adequate services.²⁸⁶

In this regard, the Kenyan State appears to be falling woefully short, given the many problems associated with the private sector, including inequitable access, denial of service, and quality and safety issues. Kenya's experience also highlights a deeper contradiction between conceiving of health as a right and treating it as a business, between universal access and access that is conditioned upon the characteristics of the person seeking care. This contradiction may not be impossible to resolve through robust regulation, ample use of public resources to ensure access, and avoidance of State capture, but it also points to the natural advantages of a strong, efficient, public healthcare system—tax-funded and free at point of use—that is structured around meeting healthcare needs, rather than making a profit.

²⁷⁷ UN Committee on Economic, Social and Cultural Rights, General Comment No. 14, paras. 12, 17.

²⁷⁸ UN Committee on Economic, Social and Cultural Rights, General Comment No. 3, para. 9; UN Committee on Economic, Social and Cultural Rights, General Comment No. 12, The Right to Adequate Food, E/C.12/1999/5, para. 36 (May 12, 1999), <https://undocs.org/E/C.12/1999/5>; UN Committee on Economic, Social and Cultural Rights, General Comment No. 24, State Obligations Under the International Covenant on Economic, Social and Cultural Rights in the Context of Business Activities, E/C.12/GC/24, para. 21 (August 10, 2017), <https://undocs.org/E/C.12/GC/24>.

²⁷⁹ UN Committee on Economic, Social and Cultural Rights, Concluding Observations on the Second to Fourth Periodic Reports of Viet Nam, E/C.12/VNM/CO/2-4, para. 22 (December 15, 2014), <https://undocs.org/E/C.12/VNM/CO/2-4>.

²⁸⁰ UN Committee on Economic, Social and Cultural Rights, Concluding Observations on the Second Periodic Report of Lebanon, E/C.12/LBN/CO/2, paras. 10, 11 (October 24, 2016), <https://undocs.org/E/C.12/LBN/CO/2>.

²⁸¹ UN Committee on Economic, Social and Cultural Rights, Concluding Observations on the Initial Report of Togo, E/C.12/TGO/CO/1, para. 30 (June 3, 2013), <https://undocs.org/E/C.12/TGO/CO/1>.

²⁸² UN Committee on Economic, Social and Cultural Rights, Concluding Observations on the Second Periodic Report of China, including Hong Kong, China, and Macao, China, E/C.12/CHN/CO/2, para. 50 (June 13, 2014), <https://undocs.org/E/C.12/CHN/CO/2>.

²⁸³ UN Committee on Economic, Social and Cultural Rights, Concluding Observations on the Combined Second to Fourth Periodic Reports of the Former Yugoslav Republic of Macedonia, E/C.12/MKD/CO/2-4, paras. 47-48 (July 15, 2016), <https://undocs.org/E/C.12/MKD/CO/2-4>; UN Committee on Economic, Social and Cultural Rights, Concluding Observations on the Initial Report of Mauritania, E/C.12/MRT/CO/1, para. 26 (December 10, 2012), <https://undocs.org/E/C.12/MRT/CO/1>.

²⁸⁴ UN Committee on the Elimination of Discrimination against Women, Concluding Comments of the Committee on the Elimination of Discrimination against Women, CEDAW/C/LBN/CO/3, para. 34 (April 8, 2008), <https://undocs.org/CEDAW/C/LBN/CO/3>; UN Committee on the Rights of the Child, Concluding Observations on the Combined Third and Fourth Periodic Reports of India, CRC/C/IND/CO/3-4, para. 63 (July 7, 2014), <https://undocs.org/CRC/C/IND/CO/3-4>.

²⁸⁵ UN Committee on Economic, Social and Cultural Rights, General Comment No. 24, para. 22.

²⁸⁶ *Ibid.*, para. 21.

External actors, including international financial institutions and companies, also have obligations and responsibilities that are implicated by their support for healthcare privatization.²⁸⁷ Under ICESCR, States have an obligation to take steps through international assistance and cooperation towards the realization of the right to health.²⁸⁸ In several contexts, CESCR has made clear that a State's support for privatization through development assistance could run afoul of its obligations, clarifying that international assistance related to sexual and reproductive care should not push recipient countries to adopt models of privatization, and expressing concerns about the United Kingdom's support for privatized education in developing countries.²⁸⁹

²⁸⁷ Juan Pablo Bohoslavsky (Independent Expert on the effects of foreign debt and other related international financial obligations of States on the full enjoyment of all human rights, particularly economic, social and cultural rights), Effects of Foreign Debt and Other Related International Financial Obligations of States on the Full Enjoyment of all Human Rights, Particularly Economic, Social and Cultural Rights, A/74/178, paras. 61-64 (July 16, 2019), <https://undocs.org/en/A/74/178>; United Nations, *Guiding Principles on Business and Human Rights*, 2011, https://www.ohchr.org/documents/publications/guidingprinciplesbusinesshr_en.pdf.

²⁸⁸ International Covenant on Economic, Social and Cultural Rights, art. 2.

²⁸⁹ UN Committee on Economic, Social and Cultural Rights, General Comment No. 22, The Right to Sexual and Reproductive Health, E/C.12/GC/22, para. 52 (May 2, 2016), <https://undocs.org/E/C.12/GC/22>; UN Committee on Economic, Social and Cultural Rights, Concluding Observations on the Sixth Periodic Report of the United Kingdom of Great Britain and Northern Ireland, E/C.12/GBR/CO/6, paras. 14-15 (July 14, 2016), <https://undocs.org/E/C.12/GBR/CO/6>.

7. CONCLUSION

The privatization of healthcare in Kenya has led to high costs for care, failed to deliver on public health priorities, reduced access to care, and pushed people into poverty. As the role of private actors has grown, individuals have been forced to spend more money for less care and public resources have been squandered, diverted to private profits and suspect initiatives.

From a public health perspective, the results have been disastrous in many respects. Private actors have largely concentrated on providing the most profitable forms of care and have neglected less commercially viable services, areas, and patients. To the extent that lower income communities have access to private care, service is too often low-quality, unsafe, and illegal. The high cost of private care has discouraged many from seeking care and pushed others into debt and poverty. Privatization has disproportionately burdened those who most need and deserve better access to quality care—including poor people, people with disabilities, those in rural areas, and women—and it has led to poor employment conditions for many workers. While mandatory NHIF coverage has been depicted as a way to achieve universal health coverage, in reality it represents a new and startling commitment of vast public resources to private actors while entrenching the problems they contribute to, including high costs, misalignment of interests, and exclusion.

Despite the dismal track record of privatization, government and international actors continue to support privatization of care. At the end of September 2021, Parliament passed a bill that has the potential to cement the pro-private sector NHIF as the path of choice for delivering universal health coverage.²⁹⁰ Development actors seem to have little appetite for reckoning with the obvious failures of privatization and no need to justify their continued support. Their enthusiasm for the private sector appears as strong as ever, with plans to pour millions of dollars more into the private healthcare sector in 2021. Such ideological commitment, despite the private sector's inability to deliver on public goals from universal health coverage to fulfillment of the right to health, is deeply troubling. The public health sector, while in need of significantly more resources and oversight, is best positioned to deliver on these goals.

²⁹⁰ Edwin Mutai, "MPs Pass Bill Making NHIF Mandatory for all Kenyans," *Business Daily*, September 29, 2021, <https://www.businessdailyafrica.com/bd/economy/mps-pass-bill-making-nhif-mandatory-for-all-kenyans-3566398>.

8. RECOMMENDATIONS

Prioritize the public health sector as a path to universal health coverage:

The public health system is best positioned to deliver on public goals, including universal health coverage. However, the sector is in need of significant improvement, which will require a coordinated effort by both national and county governments. Health policy and expenditure should prioritize the existing public system and ensure it is capable of providing accessible, affordable, quality care for all Kenyans. Public health spending should be increased, but also invested first and foremost in the public health system. This includes expanding and improving public health facilities and infrastructure, ensuring workers have dignified working conditions, and making drugs much more widely available at public facilities.

Rethink support for the private sector: The government and development actors should reassess their support for the privatization of healthcare in Kenya in light of its significant shortcomings. To the extent the private sector continues to play a role in public health programs and receive state funds, it should only be engaged when public provision is not feasible, after a careful cost/benefit analysis that takes public goals into account, and subject to obligations to serve the public interest including with regard to where they operate, what services are offered, conditions of work, access to information, and what they charge.

Exert meaningful control over private healthcare providers: The regulatory framework that applies to private providers should be significantly strengthened and far better enforced to address problems such as high costs, denial of service, and unsafe care. Regulators should ensure that private providers offer essential services, are physically and economically accessible, are culturally acceptable, and offer uniformly high-quality services. To the extent the NHIF continues to contract with private providers, it should radically reshape its relationship with them and adopt a transparent approach that puts the private sector on equal footing with the public one.

Greater transparency and access to information: Information relating to the private sector's role in healthcare in Kenya—including contracts for public-private partnerships and information about public health expenditure on the private sector—must be public and made available online. Existing secrecy is an invitation to corruption and self-dealing.

ACKNOWLEDGMENTS

The Economic & Social Rights Centre-Hakijamii and the Center for Human Rights and Global Justice at New York University School of Law (CHRGJ) would like to thank the community members, healthcare workers, and community health volunteers who generously took the time to speak with researchers amidst a pandemic and to share their experiences.

Hakijamii and CHRGJ would also like to thank the many experts and organizations that contributed to the research, including Anthony Adoyo, Audrey Chapman, EACHRights, the Global Initiative for Economic, Social and Cultural Rights (GI-ESCR), the Kenya Legal and Ethical Issues Network on HIV and AIDS (KELIN), Open Society Foundation, People's Health Movement-Kenya, Paola Salari, Transparency International Kenya, Wemos, and Alicia Yamin. We would also like to thank Allan Maleche and Dr. Amos Otara for reviewing the report.

This report was researched and written by the following individuals (in alphabetical order): Philip Alston (Faculty Director of CHRGJ), Zulekha Amin (former Program Manager at Hakijamii), Bassam Khawaja (Co-director of the Human Rights and Privatization Project at CHRGJ), Annet Nerima Majoni (former Program Manager at Hakijamii), Nicholas Orago (Executive Director at Hakijamii) and Rebecca Riddell (lead author and Co-director of the Human Rights and Privatization Project at CHRGJ).

The report was designed and prepared for publication by Nou Moua (Director of Strategic Initiatives and Outreach at CHRGJ). Lucy Baraza (Finance Administration and Human Resources Managers at Hakijamii), Clinton Gekara (Program Officer at Hakijamii), Evelyn Kaumba (Monitoring and Evaluation Manager at Hakijamii), Lauren Stackpoole (Director of Operations and Academic Programs at CHRGJ), and Pauline Vata (former Executive Director at Hakijamii) provided additional support. Kiana Boroumand, David Hamer, Rachael O'Byrne, and Marissa O'Toole (Human Rights Scholars and Research Assistants at CHRGJ) also contributed to the report.



Wrong Prescription

The Impact of Privatizing Healthcare in Kenya

Growing reliance on the private healthcare sector in Kenya is undermining the right to health, excluding many from care, and setting back the country's goal of achieving universal health coverage. National policies designed to increase private sector participation in health, in combination with chronic underinvestment in the public system, have rapidly increased the role of for-profit actors and amount to privatization. Unfortunately, while the wealthy may be able to access high-quality private care, for many, particularly in lower-income areas, the private sector offers low-quality services that may be inadequate or unsafe. It also provides poor value for money, neglects key public health priorities, and pushes individuals into poverty and debt.

Wrong Prescription: The Impact of Privatizing Healthcare in Kenya, a collaboration by the Economic and Social Rights Centre-Hakijamii and the Center for Human Rights and Global Justice at New York University School of Law, shows how healthcare privatization has proven costly, failed to ensure access to quality, affordable care, and resulted in severe human rights problems including exclusion, hardship, and inadequate and harmful service. Based on interviews with 55 community members from informal settlements and rural areas, as well as more than 130 public and private healthcare workers, community health volunteers, officials, investors, experts, and others, the report finds that the Kenyan government is providing the private sector with significant public resources, while private actors, including global health companies and private equity firms, are extracting large profits.

To fulfill the right to health and achieve universal health coverage, policymakers and development actors should rethink their support for the private sector and prioritize the public healthcare system which, despite chronic underinvestment, is best-suited to provide accessible, affordable, quality care for all Kenyans.

A private clinic in Kibera, Nairobi. © Zulekha Amin/Hakijamii 2021

Center for Human Rights and Global Justice
New York University School of Law
Wilf Hall, 139 MacDougal Street
New York, New York 10012

www.chrgj.org

Economic and Social Rights Centre-Hakijamii
P.O. Box 11356-00100
Nairobi, Kenya

www.hakijamii.com

November 2021