The Global Initiative
for Economic, Social and Cultural Rights

Policy Brief

Patients or customers?

The impact of commercialised healthcare on the right to health in Kenya during the COVID-19 pandemic

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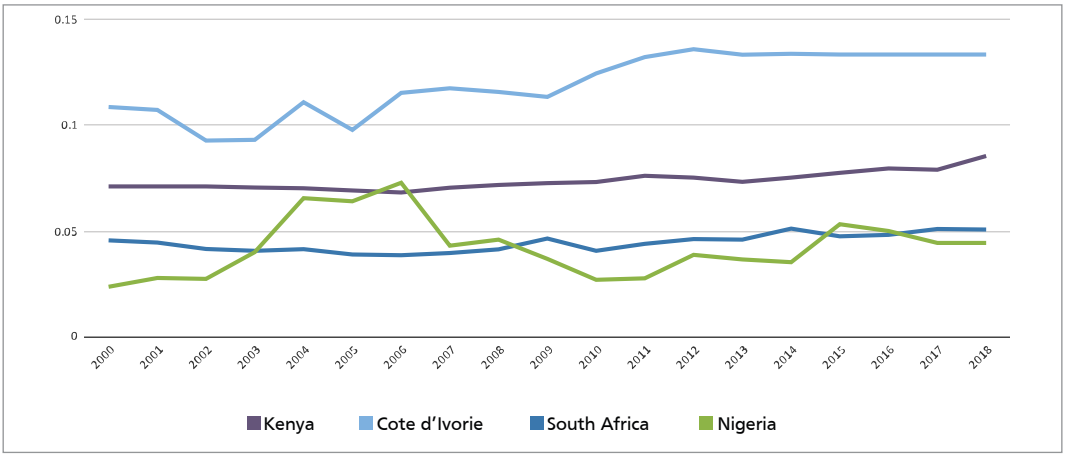
In Kenya, the right to health is legally well-protected.[1] According to the law, the East African State, which as of 2020 has a population of 53.77 million, must provide quality and timely healthcare services to everyone, without discrimination.[2] However, there is a wide gap between norms and reality. Health services are limited: while the World Health Organisation (WHO) recommends a minimum of 21.7 doctors and 228 nurses per 100,000 people,[3] Kenya has only 16 doctors per 100,000 and 167 nurses per 100,000 as of 2018.[4] In 2018, an official survey found that none of the country's health facilities had all essential medicines, and that only a small fraction (12%) had all items needed for infection prevention.[5]

This is perhaps not surprising, as healthcare services are starved of resources: domestic spending on health was as low as 9% of the national budget in 2020,[6] far below the target of 15% to which the African Union States committed to in the Abuja Declaration.[7] Looking at health spending as a share of national income, Kenya's general government spending on health in 2018 accounted for only 2.17% of its gross domestic product (GDP).[8]

Healthcare spending as a share of total government spending (%) over 2000-2018, selected comparable African countries

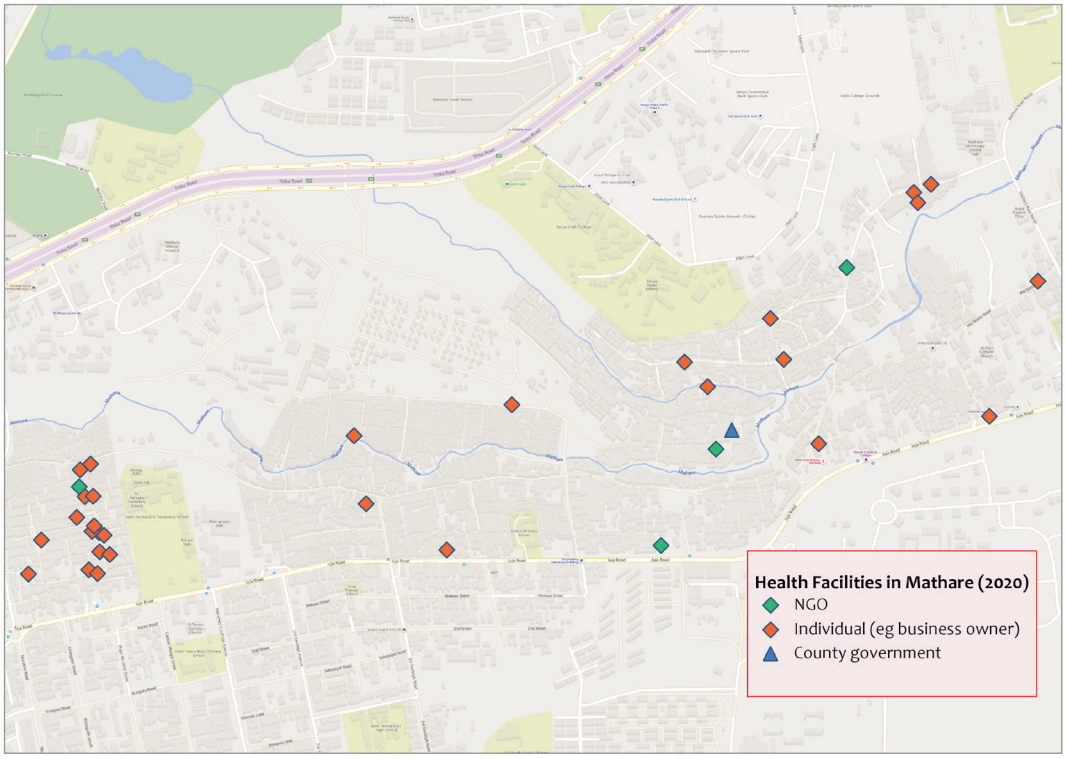


Source: Source: WHO Global Health Observatory data, available for download here (accessed 18 January 2022).

1. Constitution of Kenya (2010); African Charter on Human and Peoples' Rights (adopted 27 June 1981, entered into force 21 October 1986) (1982) 21 ILM 58 (African Charter).
2. International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 999 UNTS 3 (ICESCR) Art. 12.
3. WHO, *Health Workforce Requirements for Universal Health Coverage and the Sustainable Development Goals* (2016) < https://apps.who.int/iris/bitstream/handle/10665/250330/9789241511407-eng.pdf> accessed 14 March 2022.
4. World Bank, *World Bank Databank* (2022) https://data.worldbank.org/indicator/SH.MED.NUMW.P3?locations=KE accessed 10 January 2022.
5. Ministry of Health, *The Kenya Harmonized Health Facility Assessment (KHFA) 2018-2019* (2020) https://www.health.go.ke/wp-content/uploads/2020/01/KHFA-2018-19-Popular-version-report-Final-.pdf accessed 03 January 2022.
6. Republic of Kenya. 2013/14—2019/20. County Budget Estimates. Nairobi, Kenya: Republic of Kenya; see also: Health Policy Plus, 'Is Kenya allocating enough funds for healthcare' (February 2021) <http://www.healthpolicyplus.com/ns/pubs/18441-18879_KenyaNCBABrief.pdf> accessed 10 January 2022.
7. WHO, *The Abuja Declaration: Ten Years On* (2011) <https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1> accessed 14 March 2022.
8. WHO, *Global Health Expenditure Database* (2022) https://data.worldbank.org/indicator/SH.XPD.GHED.GD.ZS?locations=NG-KE-ZA-CI-ZG accessed 21 January 2022.

The scarce medical resources are also unevenly distributed. Across the 47 counties of Kenya, acute socio-economic health inequalities exist in accessing medical services,[9] including reproductive and maternal healthcare,[10] prevention and immunisation,[11] and urgent care.[12] Beyond economic inequality, spatial factors are also an obstacle to accessing quality healthcare: high-end medical services are concentrated in the wealthy areas of cities, at the expense of those living in rural and marginalised urban areas.[13]

Health Facilities in the urban Informal Settlement of Mathare (2020)



Source: UN-Habitat Data (2020), available here. Map made by the authors of this report (GI-ESCR) using the software QGIS.

The array of challenges have many causes. Increasingly, civil society and academic research are demonstrating that commercialisation of healthcare - that is the proliferation of market logic and mechanisms, including competition and performance incentives to gain private benefits - within the healthcare system is among the most prominent impediments to the progressive realisation of the right to health in Kenya.[14] Private

9.Julius Korir, Jacob Omolo and Charles C Nzai, 'An Empirical Analysis of the Effect of Poverty on Health Care Utilization in Kenya' (2018) 14 European Scientific Journal.

10.Emily Catherine Keats and others, 'Assessment of Inequalities in Coverage of Essential Reproductive, Maternal, Newborn, Child, and Adolescent Health Interventions in Kenya' (2018) 1 JAMA Network Open e185152; Jennifer Yourkavitch and others, 'Using Geographical Analysis to Identify Child Health Inequality in Sub-Saharan Africa' (2018) 13 PLOS ONE e0201870.

11.Carine Van Malderen and others, 'Decomposing Kenyan Socio-Economic Inequalities in Skilled Birth Attendance and Measles Immunization' (2013) 12 International Journal for Equity in Health 3.

12.WP O'Meara and others, 'Heterogeneity in Health Seeking Behaviour for Treatment, Prevention and Urgent Care in Four Districts in Western Kenya' (2014) 128 Public Health 993.

13. Nirali M Chakraborty and others, *'Assessing Provision and Equity in Low- and Middle-Income Country Health Markets: A Study from Kenya'* (2017) Oakland CA: Metrics for Management http://m4mgmt.org/wp-content/uploads/2018/07/PEM-Report.pdf accessed 30 November 2021.

14.Economic and Social Rights Centre – Hakijami and the Centre for Human Rights and Global Justice, 'Wrong Prescriptions: the Impact of Privatising Healthcare in Kenya' (17 November 2021) https://chrgj.org/wp-content/uploads/2021/11/Report_Wrong-Prescription_Eng_.pdf accessed 13 January 2022; People's Health Movement (PHM) and Regional Network for Equity in Health in East and Southern Africa (EQUINET), 'Report of the East and Southern Africa Regional People's Health University' (2021) <https://www.equinetafrica.org/sites/default/files/uploads/documents/ESA%20RPHU%20Report%202021.pdf> accessed 14 January 2022; UNISON

health actors have been present in the country since its independence, and it is important to acknowledge that private actors are diverse, including a significant share of non-profit actors that play a positive role in filling some of the gaps left by insufficient public healthcare provision. However, for-profit providers have considerably increased their activities in relatively recent times. Between 2013-2021, the share of health establishments that are for-profit in Kenya grew from 33% to 43% in less than 10 years.[15]

This has not happened by chance. It is the result of political choices. The Kenya Health Policy 2014-2030 frames strengthening the role of the private sector as both a financier and a provider as one of its core objectives, including through tax exemptions and the development of an enabling legal framework for private-public partnerships.[16] International development actors have also contributed to higher private health sector involvement, investing in private-sector-led healthcare projects across a wide range of medical services.[17]

This report assesses whether the commercialisation of healthcare in Kenya has undermined the realisation of the right to health, particularly in the context of the COVID-19 pandemic. The focus is on individuals living in poverty in urban informal settlements. This is a population that has a high risk of suffering the worst effects of the current pandemic. Living where social distancing and adherence to hygiene routines are nearly impossible, financially deprived individuals have higher odds of contracting infective diseases, including the COVID-19 virus. Likewise, due to pre-existing comorbidities that are frequent in their communities, such as respiratory problems, those living in informal settlements are also more prone to suffer the worst health consequences from the virus.

What is privatisation and commercialisation in healthcare?

For the purposes of this report, we define privatisation in healthcare as the growth of the share of private sector involvement in healthcare, or the adoption of private-sector practices in the health sector. This might take several forms. Increased private sector involvement in the ownership, financing, management, governance or provision of healthcare services can all be deemed as privatisation in healthcare. Examples of privatisation are selling public assets to private actors or the governance and administration of healthcare services being shifted from the public into the private sphere, including through public-private partnerships. Privatisation is thus an umbrella term that might cause or encompass one or more of the following:

<https://gala.gre.ac.uk/id/eprint/16416/7/16416%20LETHBRIDGE_Unhealthy_Development_2016.pdf> accessed 14 January 2022.

15. Data from 2013 are from the following official report: Ministry of Health, Kenya Service Availability Readiness Assessment Mapping (SARAM) Report, <http://guidelines.health.go.ke:8000/media/Kenya_Saram_Report.pdf> page 12.

16. Ministry of Health, 'Kenya Health Policy 2014-2030' (2014) <http://publications.universalhealth2030.org/uploads/kenya_health_policy_2014_to_2030.pdf> accessed 09 November 2021.

17. BEAMExchange, 'PSP4H: Private Sector Innovation Programme for Health' (June 2016) https://beamexchange.org/practice/programme-index/112/ accessed 14 January 2022.

- Commercialisation: the progressive spread of market mechanisms in health, such as competition and performance incentives, to gain private benefits
- Marketisation: enabling state enterprises to operate as market-oriented firms
- Financialisation: the increasing influence of financial motives and financial markets in health, such as private investment in health-related bonds.

The last few decades have seen increasing privatisation in healthcare across the world. This raises several challenges in terms of the realisation of the right to health, as United Nations Human Rights monitoring bodies, as well as human rights organisations and scholars, are increasingly recognising.

Source:

- GI-ESCR, 'Compendium on United Nations Human Rights Treaty Bodies' Statements on Private Actors in Healthcare' (June 2021) <https://www.gi-escr.org/publications/compendium-of-united-nations-human-rights-treaty-bodies-statements-on-private-actors-in-healthcare> accessed 14 March 2022.
- GI-ESCR, 'Italy's experience during COVID-19 and the limits of privatisation in healthcare' (2 June 2021) <https://www.gi-escr.org/publications/policy-brief-italys-experience-during-covid-19-and-the-limits-of-privatisation-in-healthcare> accessed 16 March 2022.
- Audrey Chapman, 'The Impact of Reliance on Private Sector Health Services on the Right to Health' (2014) 16 Health Hum Rights 122.
- Antenor Hallo de Wolf and Brigit Toebes, 'Assessing Private Sector Involvement in Health Care and Universal Health Coverage in Light of the Right to Health' (2016) 18 Health and Human Rights 79.

To undertake this research, we conducted 47 individual interviews and three focus group discussions in three of Nairobi's largest informal settlements: Dandora, Mathare and Mukuru Kwa Njenga. We conducted such data collection over a three-month period, from September to November 2021.

Description: A focus group conducted for this study, Mathare, Nairobi.

Using a human rights framework to assess private sector involvement in healthcare, the report identifies four ways through which the commercialisation of healthcare impacts on the right to the highest standard of health of Kenyans, especially those from a disadvantaged socio-economic background, amidst the COVID-19 crisis.

First, decades of commercialisation have resulted in a lack of public healthcare services. Currently, Kenya lacks the necessary medical resources to respond effectively to both the current pandemic and to future ones. Kenya is remarkably short on medical resources that are vital to identify COVID-19 cases, such as reagents for testing, and to treat COVID-19, such as ventilators and acute care hospital beds.

Second, commercialisation is exacerbating inequalities in access to healthcare services. First-class looking private health facilities are largely inaccessible to low-income individuals, who instead rely on the limited availability of public medical facilities or low-cost private health services offering substandard medical services.[18] The COVID-19 pandemic has cast into stark relief these inequalities, with the worst-off facing the highest difficulties in accessing COVID-19 testing and treatments, as well as other medical services, during the public health crisis.

Third, the public policies that have encouraged higher private sector engagement in healthcare over the last few decades have not been accompanied by sufficient regulation and monitoring of private healthcare actors, which has contributed to a proliferation of ramshackle private clinics, nursing homes and laboratories. While a legal framework for the regulation and monitoring of private healthcare providers exists, it has not been sufficiently implemented in practice. As a result, the private health sector is fragmented and plagued by episodes of negligence, malpractice and other forms of lack of adherence to scientific protocols and medical ethics.

Fourth, partly because of insufficient regulation and monitoring several private health facilities in marginalised areas are unsafe and offer substandard medical services. These facilities, often unlicensed, often employ unqualified doctors and chemists or sell expired drugs.[19] Registered private facilities also have challenges, including episodes of misdiagnosis, unnecessary treatments or misrepresentation of medical qualifications.[20] The chaos created by the COVID-19 pandemic seems to be a breeding ground for these practices in the for-profit health sector as demonstrated in this report. Health workers and community leaders we interviewed reiterated that they prefer to refer patients to the nearest public facility available as the quality is perceived as better; however, as it has been already noted, public health services are limited.

These four findings demonstrate that, in a system that has experienced a rapid increase of commercial private sector participation in healthcare, access to quality healthcare depends on one's position in society, including relative access to wealth, employment, education, transportation and information. Those occupying the higher echelons of society can enjoy quality healthcare as a luxury by paying for it or travelling abroad.

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18. Stefania Ilinca and others, 'Socio-Economic Inequality and Inequity in Use of Health Care Services in Kenya: Evidence from the Fourth Kenya Household Health Expenditure and Utilization Survey' (2019) 18 International Journal for Equity in Health 196.
19. David I Muthaka and others, A Review of the Regulatory Framework for Private Healthcare Services in Kenya (2004) https://pdf.usaid.gov/pdf_docs/pnads076.pdf accessed 14 March 2022.
20.Ibid.

However, entrusting healthcare to commercial actors, private interests and the market logic is a loss for everyone. Private health providers are less likely to operate where there is less opportunity for revenue, such as in rural areas.[21] By the same token, for-profit health providers will be less likely to deliver services that do not generate high returns but are essential for protecting populations' health, like prevention, family medicine and emergency care. Healthcare systems based on commercial drivers are in this way less resilient to shocks such as epidemics and prioritise short-term profits over public health goals, undermining the realisation of the right to health.

Policy recommendations

We urge the government of Kenya to:

Increase government funding to health to at least 15% of the national budget to expand the availability of quality, well-coordinated public healthcare services

Kenya is among the African Union States that pledged in the 2001 Abuja Declaration to raise the proportion of government funding for health to at least 15% of the overall national budget.[22] However, Kenya is far below that target. Domestic public spending on health was at 9% of general government expenditure in 2018 (figure 2).[23] Increasing the public spending on health would also be in line with Kenya's obligation to allocate its maximum available resources to ensure that everyone has access to universal, public healthcare services, in accordance with the African Charter on Human and Peoples' Rights and the other international human rights treaties that Kenya has ratified.

Ensure that all healthcare providers are strictly monitored and regulated at the national, county and local levels

The legal framework on private actors' regulation is well-developed, yet it is not accompanied by sufficient implementation in practice. However, the study confirms that, in practice,

21. World Bank and Government of Kenya, Health Service Delivery Indicator Survey 2018 Report 83-84.
22. WHO, The Abuja Declaration: Ten Years On (2011) <https://www.who.int/healthsystems/publications/abuja_report_aug_2011.pdf?ua=1> accessed 25 October 2021.
23. Republic of Kenya. 2013/14—2019/20. County Budget Estimates. Nairobi, Kenya: Republic of Kenya; see also: Health Policy Plus, 'Is Kenya allocating enough funds for healthcare' (February 2021) <http://www.healthpolicyplus.com/ns/pubs/18441-18879_KenyaNCBABrief.pdf> accessed 10 January 2022.

the quality of private healthcare provision is sometimes very low and not in line with medical or human rights standards. The national and county governments should coordinate efforts to ensure that all health care providers in the country comply with regulatory requirements as established in the national and international legal framework.

Take concrete steps to ensure universal access to health insurance

As this report highlights, participation in the National Health Insurance Fund is extremely low. Marginalised populations face financial and information barriers that often prevent them from accessing the scheme. It is thus particularly important to take proactive steps, through adequate public health policies, to address cost or information as a barrier to access healthcare insurance or any other form of pre-pooled scheme.

Promote the development of a stronger public healthcare system accessible to all

As this report demonstrates, market mechanisms in healthcare fail to adequately fill the gaps left by a weak public sector. Rather than promoting market-based solutions that have dangerous impacts on the realisation of the right to health, Kenya should invest in a strong public universal healthcare system that is democratically managed, funded and delivered by non-commercial actors, and reinforce the public healthcare sector's capacity. This would be in accordance with Kenya's obligation to prevent, respond to and detect pandemics and to provide universal healthcare services, including during public health crises.

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Read the full report on the Global Initiative for Economic, Social and Cultural Rights website at the following link: https://www.gi-escr.org/publications/report-kenya-health-commercialisation

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