Poor people bear burden of inequitable health systems

As we observe World Health Day, experts call for the streamlining of healthcare services as per this year's theme of 'Together for a fairer, healthier world'

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Experts are calling for the assessment of inequality in healthcare, in a country where the gap between the rich and the poor impact greatly on their access to quality healthcare.

Nearly half of Kenya's populace live in poverty and struggle to get access to basic health care services and medical treatment particularly those living in the rural communities and densely populated areas such as slums.

Research by Kenya Medical Research Institute-Wellcome Trust Research Programme in 2019 revealed wealthier Kenyans are better protected than their poorer compatriots.

"Only three per cent of the Kenyan poor have access to any health insurance coverage, compared to 38 per cent among the rich. Although there have been slight increases in the overall number of Kenyans with access to health insurance coverage between 2009 and 2014, most of this increase has been in the formal sector or the well-off people, but not in the informal sector, which means that the poor are still cut off from insurance," the report indicates.

Relook devolution

While the National Hospital Insurance Fund tries to fill in, the gap between the rich and poor is still present since membership is based on contribution of monthly premiums, cash which people in the informal sector can't pay consistently due to irregular flow of income.

"Most poor people don't know the packages available for a comprehensive health insurance. For instance, a parent is able to cover their own children and sometimes their family and sometimes most of the problem can be covered with a comprehensive cover which is as affordable as paying Sh500 per month," explains Dr Eileen Adhiambo of Siaya District Hospital.

In 2001, Kenya signed the Abuja declaration and was committed to allocate 15 per cent of the national GDP on health, but despite of this, the government still continues to spend five per cent on health. As a result, people are forced to resort to out of pocket payments. This means the poorest and most vulnerable end up bearing the greatest burden, and as a result, most Kenyans have been pushed to poverty as they pay heavily for their health care.

Wealth disparity also means poor people are more likely to be sick as a result of living in places with poor sanitation which might bring typhoid and cholera, leaking roofs, which might cause pneumonia, crowded places which might bring TB and Covid-19. Lack of or inadequate and unhealthy food also conributes to diseases.

The causes of inequality are considered unavoidable. Some of underlying causes, especially relevant to Kenya include political priorities, unequal distribution of wealth, poverty and marginalisation.

Devolution of health care in Kenya is a simple example of how political priorities can play a big role in addressing health inequities. While devolution presented numerous opportunities, a number of challenges arose.

"The challenge that comes about is these decisions made heavily depend on the county leaders' ability to make appropriate decisions with regards to the health sector. The result is large differences in health services across counties with regards to accessibility, affordability and quality," says Dr Lillian Mbau, CEO Kenya Cardiac Society.

Dr Mbau adds the management of human resources of health seems to have suffered the biggest blow with some counties giving low priority to this leading to staff shortages and lack of motivation leading to perpetual strikes. In hind sight devolution of the health sectors needs to be relooked with the view of having some functions centralised to enhance equity.

5%
What the government spends on health.

3%
of the Kenyan poor have access to any health insurance coverage, compared to 38 per cent among the rich.

There are also marked differences between the 47 counties in availability of essential health package, health facilities and health workers, resulting in inequities in service use. For example, there is less than one health facility per 10,000 people in Bungoma county, compared with over 3.5 health facilities per 10,000 people in Mombasa county. This trend continues within counties, with those living in the most remote areas often having lower access and use of health services compared with those living closer to a facility. Even within a single community there are some who are underserved by health services compared with their neighbours.

Money talks

Three years ago, the Kenyan government piloted a universal health coverage programme in four counties namely Isiolo, Machakos, Kisumu and Nyeri, which has eased access to health care services and since then, more than 200 community health units, 7,700 community health volunteers, as well as 700 health workers have been employed. It also meant abolition of fees at both local and county referral hospitals. However, there is still a gap when it comes to access to health care.

"Still, patients can't access lifesaving drugs such as antibiotics when they get to public hospitals. This means sometimes the family is told to buy for these drugs outside the hospital as they are not available. Sometimes during resuscitation, it is difficult to do so due to lack of equipment such as monitoring devices, bagging equipment, and in some facilities, oxygen might be an issue too. Access to blood and blood products too is an issue especially in rural public hospitals, and sometimes one is told to be told to have tests in private hospitals which might be more expensive," says Dr Adhiambo.

With some diseases, inequalities are more pronounced; for instance, screening colon cancer might not be accessible to all types of people and economic background.

"You'll find those who are wealthy, great insurance covers and are more knowledgeable and have access to information are likely to have more screening rate. When you look at pap smears, it will be more than those who are better educated and informed. The rural person living in the slums or remote areas probably has never heard of cervical cancer or colon cancer and is never ever going for screening and might be presented with late disease," says Dr Andrew Odhiambo, an oncologist.

Dr Odhiambo adds that those who live in urban areas have better access to the screening modalities will have better recovery rate.

"If you have to travel 300km every time to be screened or tested, probably you'll never bother with it," he says.

In terms of diagnosis, the wealthier, those who have resources, connections as well as great medical covers probably will have a timely one. Money gives them the ability to go through the diagnostic process much faster and probably be in the top tier hospitals or they will have the ability to fly out to India or South Africa for an advanced diagnosis than the person in the slums in Kibera.

"Health inequalities go against the principle of social justice and in the end disadvantage people and limit their chance to live longer and healthier lives. The government should ensure they improve the capacity and numbers of health care providers in underserved communities and expand the knowledge base on causes and interventions that can reduce disparities," he notes.

DR MBAU

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