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The National Hospital Insurance Fund under Resource Allocation Discrepancies and Economic Restructuring, 1973–1986

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***Abstract*— The social health insurance established in Kenya in 1966 as the National Hospital Insurance Fund (NHIF), underwent various reforms to enhance its service delivery in theperiod 1973 to 1986. This paper traces the impacts of resource allocation inequalitiesdue to the declining global economic performance experienced in the 1970s. The resource scarcities attributed to the subsequent economic restructuring hindered access to equitable and quality healthcare through the NHIF in accredited facilities. The government as a result, formulated policies to guide financing modelsfor healthcare for the employed and unemployed. These developments were realised in the midst of adoption of adjustments and economic restructuring for social policy on healthcare financing aimed at enhancing efficiency. Thus by 1986 service delivery by NHIF was guided by policy decisions implemented by the government in adherence to the global expectations.**

***Index Terms*— adjustments, economic performance, financing models, health, inequalities, insurance, NHIF, reforms, resources, restructuring, SAPs.**

I. INTRODUCTION

This article evaluates the NHIF under Resource Allocation Discrepancies and Economic Restructuring, 1973–1986.The global economic upheavals witnessed in the 1970s impacted on numerous socio-economic institutions, which included the NHIF in Kenya and re-organised healthcare provision. There were factors which influenced the performance of NHIF in the period 1973 to 1986. Firstly, the impacts of resource allocation inequalities necessitated the formulation of policies governing its distribution to the various socio-economic sub-sectors. Inflation and high cost of living attributed to decline in the global economy from 1973 resulted in commodisation of basic health-related goods and services. Restructuring led to job cuts and therefore, disincentives to health-seeking behaviour, evident from decline in the quality of health services, thusunder utilisation of NHIF for care. Secondly, there were impediments which were slowing attainment of NHIF objectivesleading toinefficientservice deliveryto the populace. The implementation in Kenya of the Structural Adjustment Polices (SAPs), for instance, resulted in financial and managerial crises attributed to budgetary cuts. Subsequently, user fees were introduced in public health facilities to mobilise resources to the sector. Additionally, limited NHIF cover to those who could afford the premiums hampered on the financing model. The government as a result, formulated policies to enable the expansion of health insurance cover to include the unemployed who financed care through private means.Thirdly, government policy on financing models for the employed and unemployed in the period under examination was significant in enhancing the performance of NHIF. The policy formulated was to expand compulsory membership for the employed and incorporate other individuals in informal sector with a monthly income of KShs.1 000 to the insurance scheme.Fourthly, the adoption of adjustments and economic restructuring for social policy on healthcare

financing was essential in this period. This was through government emphasis on decentralisation of essential health services forstrengthening the primary healthcare (PHC), aimed at enhancing access to care by the rural populations.

II. METHODS

a. Study Approach

This study adopted the historical method, to discover from records and other accounts what happened in the past period. The *ex-post facto* design was used in this study to examine the record of past events and explain why they so happened. The design entails gathering of information from archival documents and oral interviews, which are then subjected to external and internal criticism. Other sources of information for the study included peer-reviewed publications and grey literature on the NHIF since 1973.

Archival information was obtained from documents in the Kenya National Archives (KNA) from files in the Ministry of Health, annual reports, memoranda, articles, journals, development plans, such as the Development Plans; 1970–1974, 1974–1978, 1979–1973, Government of Kenya Sessional Papers, such as *Sessional Paper 4 of 1986*, *Weekly Review* magazines series from 1975–1987. The World Bank reports, such as 1978–1979, 1981–1982,were also reviewed to examine the influence of international policy makers in the performance of NHIF in this period.

Oral interviews were also conducted on government agencies, such as the Ministry of National Treasury and Planning, Ministry of Health, NHIF and accredited healthcare facilities. Others included employers, such as Federation of Kenya Employers (FKE), labour unions, such as Central Organisation of Trade Unions (COTU)and Kenya National Union of Teachers (KNUT) as well as the faith-based organisations, such as Christian Health Association of Kenya

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(CHAK). Similarly, the beneficiaries of NHIF from 1973 to 1986 were also interviewed.

b. Analytical Framework

This article adopted the Political Economy perspective to examine The NHIF under Resource Allocation Discrepancies and Economic Restructuring, 1973–1986. The significance of this perspective was on its analysis of how power and resources are distributed and contested in different contexts as well as its implications for development outcomes.[8][2] The political economy perspective demonstrates that economic interests are significant in defining political agenda which results in the rise of interests within the production system.[5][42]

In this study, the desire by the independent government to achieve socio-economic progress was evident in the formulation of policies to steer the development agenda. For instance, Kenya's economic development plan for 1970–1974 envisaged the introduction of health planning to cope with the emerging constraints, such as population growth, inequitable distribution of health services, among and within administrative units, such as provinces and districts. Further, policy formulation in this period also aimed at devising modes of healthcare financing to reduce barriers which impeded access to equitable services. Therefore, the amendment of the NHIF Act of 1972 enabled the incorporation of citizens not in formal employment to contribute a monthly premium of KShs.20 to NHIF to access healthcare needs.[33][19] The policy formulation, therefore, was constituted as part of the political agenda, which championed the rise of class interests, within the various forms of production in the formal and informal settings,

such as administration, agriculture, health, education, commerce and industry.[17][11]

Therefore, improving the health systems was a form of legislation that was utilised to facilitate legitimisation of the social order to counter dissatisfaction with the political order. Politics therefore, offered an alternative to what the market could not provide.[7][8]

The political economy perspective was relevant to this study as it identified the formal structures that the independent government derived from policy decisions of the development partners, such as the World Bank [WB] and International Monetary Fund [IMF] and influenced performance of the NHIF,in the period 1973 to 1986.[3][43]The influence of these development partners in restructuring of the financing models was aimed at adoption of the economic model to benefit every citizen to progress and subsequently, improvement of standards of living. However, the significance of community wants rather than individual needs resulted in inequalities that impeded on access to health care by the majority of the citizens.[32]

III. RESULTS

This study examined the NHIF under Resource Allocation Discrepancies and Economic Restructuring in the period 1973–1986 and established that there were numerous factors that influenced its performance in this period. These were discussed as follows;

a) Resource Allocation Discrepancies

The Kenya government experienced numerous challenges in the provision of accessible and affordable healthcare to its citizens. The development crisis of the 1970s, for instance, had been experienced due to both external and internal factors and were characterised by low economic growth, declining personal incomes, savings and investment ratio, fiscal and balance of payment deficits as well as the increasing external debt.[16][11]Further, there were numerous external factors that resulted in poor performance of the economic sectors. They included declining terms of trade for the country's primary exports, interest hitches for foreign loans, appreciation of hard currencies and the world economic recession.[4][30]On the contrary, the internal factors that inhibited progress included inappropriate macro-economic policies, over-extended public sector, weak institutions, imperfect private markets, weak managerial skills in the public sector and vulnerability to erratic weather. These factors impacted on the social sector and resulted in underfunding and poor health status of the populace.[32][33]

The Kenya national economic development plan for the period 1970–1974 envisaged the introduction of health planning to cope with the emerging constraints such as population growth, inequitable distribution of health services among and within units of administration, such as provinces and districts.[19]Further,these shortcomings were compounded by severe shortage of medical, administrative and financial resources as well as lack of statistical information on the healthcare needs of the populations. The health policy formulation for this period therefore, aimed at devising modes of financing to reduce barriers which impeded access to equitable services.[32]

Despite the formulation of policies to steer the development agenda, the economy stagnated from 1973, as a result of inflation, high costs of living and deteriorating quality of health services in the public facilities. It therefore, became financially untenable to continue administering healthcare facilities and services from government resources, necessitating assistance from other sources to fill in the demand gap.There was also increased commoditisation of basic health-related goods and services which made them unaffordable to the majority of the citizens.[30][31]

Hence, the spiralling costs for essential commodities, such as food resulted in priority choices for consumers, who opted to purchase medical necessities when funds became available. Therefore, access to healthcare by the communities who utilised these facilities in their localities were hindered as the majority were in the informal sector and therefore could not afford to finance for services through alternative modes of financing, though private means.[17]

During this period, the healthcare programmes, formulation and implementation of policies were, influenced by the programmes whose effects were realised in the disincentives to the health-seeking behaviour, low utilisation rates for healthcare as well as decline in the cost and quality of services. Household expenditures on healthcare and the ability to cater for costs for services declined.[19] Additionally, inflation on health services and additional costs for utilisation impacted on disposable incomes of households for other

needs, such as food consumption. Job cuts and redundancy resulted in prioritising of needs by individual households as purchasing power was determined by availability of finances.[22]

The policies formulated would subsequently be driven by ideas which advocated for the need to adopt economic indicators to gauge progress. For instance, there was the adoption of a comprehensive health policy and related strategic management of financial optionsthat defined the roles of the private sector aimed at improving efficiency of service delivery.[4][15] Further, the adoption of cost recovery in health institutions was intended to increase revenue collection for the government to enhance service delivery. The result, however, was counterproductive as access to affordable, equitable and quality healthcare was impeded by underfunding to the sector. The inefficiency was caused by the declining fiscal support, shortage of foreign exchange and an increase in debt level.[27]The World Bank and International Monetary Fund agenda determined resource allocation to receiving countries rather than the direct health needs of the populations. According to an informant, the challenges experienced in the 1970s on financing policies by the international community continued to hinder progress on socio-economic institutions in the 1980s. This was due to the fact that as policy makers, these institutions effectively advocated for the implementation of the reforms by developing economies.[16] These policies, however, failed to achieve the expected outcomes attributed to economic restraints and poor governance. Similarly, the policies for reforms were hindered by inadequate financing from the government as it relied on external sources as either loans or grants. Hence, the donors allocated funds for the health sector reforms that would enforce market agenda through the creation of policy mechanisms that support and maintain a demand-driven health system.[4][10]

The policies by IMF and World Bank determined fiscal terms at higher levels of decision making, while the social service Ministry of Health became involved at the implementation level, operating on restricted budgets.[30]An informant indicated that the government adhered to the vertical procedures necessary for accessing financial assistance in loans or grants.

Subsequently, the privatisation of these institutions was to open markets for health service preference.[16]

Commoditisation of health-related goods and services led to a further deterioration of the standards of living, occasioned by reduction and elimination of subsidies on transport of medical necessities. Therefore, the recurrent and unchanged allocations for health expenditures led governments through respective ministries, to re-allocate the existing budgets to reflect the health sector priorities. In Uganda, for instance, funding the health sector through government budget allocation, donor funding, through budget or out of budget and private financing from user fees were insufficient due to the macro-economic policy constraints by the international financial institutions.[9]In Kenya,the government adopted and implemented policies as part of policy agenda to enhance attainment of objectives which includes a decline in infant and child mortality index and crude death rate among citizens in this period.[9][34]

Table 4.1: Resource Allocation for the Health Sector and Impacts, 1973-1986

Year	Economic Growth [%)	Donor Financing [%)	Gov't Funds [%)	Private Finances [%)	Infant Mortality [000]	Crude Death Rate [000]
1973	6.6	93	6	1	219	91
1983	0.6	78	14	8	68	33
1986	0.3	32	33	13	60	20

Source: Government of Kenya, "Strategic Action Plan for Financing Healthcare in Kenya," Nairobi: Government Printers, 1993, p.29.

Table 4.1 shows how financial resources were distributed in the health sector and the impact it had on the population and government in the period between 1973 and 1986. Notable from this table was how the Kenya economy started to decline from an annual growth of 6.6% in 1973 to 0.3% in 1986. This decline can be linked to the policy reforms advocated by the international fiscal and policy makers. The table also demonstrates how the dwindling financial support from donor community was impacting on the performance of the various socio-economic projects of developing economies. Of importance also is how resource allocation by government impacted on other socio-economic activities, such as agriculture, education and infrastructural developments.

b) Impediments to Effective Performance of NHIF

Healthcare is inextricably linked to a nation's political and economic system. Hence, medical underdevelopment is a necessary feature of economic regression. Aspects that slow or halt the progression of attainment of set out objectives are collectively referred to as impediments.[13]There were various factors that impeded the NHIF efficient service delivery in this period.

Resource scarcity became manifest as the Kenya government continued to experience financial and managerial crises in the second decade of independence, more so with the feasibility of a "sustained free" healthcare provision to its citizens. This was attributed to the global activities such as increased cost of oil prices witnessed from the period 1973,resulting in inflation and high cost of living. Similarly, the government's inability to provide accessible healthcare to the populace in relation to affordability of the services resulted in their underutilisation.[1]

To promote access to healthcare by the poor and vulnerable, therefore advocacy and expansion of the social health insurance through the NHIF was implemented by the government. This was reinforced in the statement that health is a human right and the core element of this right is the prevention of ill health.[19][35]

The performance of NHIF was limited by coverage of the

population as it targeted only those who can afford the premiums. This impeded on the sound financing model for the government that endeavoured to expand coverage to the majority of the citizenry. Similarly, the health insurer since the incorporation of voluntary contributors to the scheme in 1973 had been unaccountable to its members on how revenue collected was utilised to make healthcare accessible and affordable.[21]An informant acknowledged that this was a common phenomenon with the user fees paid in for healthcare. The management of the NHIF was also less responsive to the needs of the members as revenue collection was prioritised over the disbursement of funds to enhance the delivery of services in accredited healthcare facilities.[12][32] Additionally, the claiming process is a highly bureaucratic and tedious exercise, characterised by high transaction costs and is vulnerable to fraud and abuse. Moreover, weak administrative systems, poor investment portfolio and slow claims settlement for reimbursement to the NHIF accredited healthcare facilities creates inefficiency in service delivery.[43]

The collection of user fees in the period between 1973 and 1986 was poorly enforced, majorly because it contradicted the government's policy of the provision of "free" medical services to the populace. As the constraints of social spending became more evident, the government keenly, but gradually implemented cost sharing policies as a means of opening up markets for private healthcare providers.[22] Hence, the reforms in the health sector were aimed at realigning the NHIF performance, but resulted in shortcomings which were mainly institutional. There were, for instance, incompetency from the human resource as well as the lack of political will to implement the recommended changes. The inefficiencies in the administrative system and the socio-political tendencies therefore, hindered the attainment of goals of providing accessible, affordable and equitable healthcare to the populace.[32]

The declining economic growth hampered on individual households' abilities to finance healthcare. According to an informant, the poor economic indices implied low income earned by majority of the citizens was inadequate to finance basic needs, including health. The result therefore was household poverty. This was aggravated further by the AIDS pandemic experienced in Kenya from 1984, which hindered government's ability to finance healthcare needs for the endemic diseases, such as malaria and tuberculosis.[16] The funds meant for the health sector were redirected to deal with the new scourge. The impact on the reduced funding to NHIF was animpediment to the utilisation of insurance cover for opportunistic diseases, such as tuberculosis, associated with AIDS, rather than on the commonly occurring diseases, such as malaria, pneumonia and other respiratory diseases.[12][41]

This was also the scenario in other parts of the continent where pressure on the available healthcare resources was exerted by the prevalence of HIV/AIDS pandemic. In many southern African states, for instance, the cost for treating HIV/AIDS patients rose to 0.2% of the GDP in Botswana and 2.4% in Malawi.[1] Similarly, the utilisation of the social health insurance for AIDS related illnesses such as TB and meningitis rose in the region during this period. Donor funding for the health sector was also intensified towards the scourge, resulting in neglect in other health sub sectors such as personnel training and infrastructural development.[43]

The AIDS pandemic also impacted on resource allocation as it put a strain on resource allocation, evident on bed occupancy and other amenities. The result was a stretch on healthcare personnel available to render services, whilst increasing morbidity rates attributed to tuberculosis, pneumonia, malaria and meningitis.[16] Similarly, financial priorities were directed towards the increasing cases of the AIDS pandemic, which resulted in numerous mortalities. Further, more financial and human resources were needed to tackle the changing patterns of endemic diseases and the increasing incidences of malaria, respiratory illnesses and digestive system disorders.[32][10]

c) Government Policy on Models for Financing Healthcare for the Employed andUnemployed

There were numerous amendments to the government policy on financing of healthcare that have been put to place since independence. These amendments were formulated to improve efficiency in healthcare service delivery. There were amendments to the National Health Insurance Fund on its formulation in 1965, establishment in 1966, on management and administration in 1967 as well on incorporation of voluntary contributors in 1972.

The amendments done to the NHIF in the period 1973 to 1986 were aimed at extending coverage to as many Kenyans as possible. There was, for instance, an amendment to the legislation which governed the performance of the health insurer in 1973. The amendment was for expanding compulsory membership in the bid to make all persons in employment earning KShs.1 000 or above per month to contribute premiums through their employers to the scheme.[20]This was a government policy to be effected through the Treasury, Ministry of Health as well as other planning and development agencies. The funds derived from the contributions were utilised by the government to finance the health sector through expansion of hospital infrastructure such as amenity wards. The accruing funds also catered for the recurrent expenditure such as salaries for the hospital staff.[24]

An oral informant attested that the amendment done to the NHIF Act in 1973 was aimed at increasing in-patient benefits to the contributors. These benefits were implemented on the basis of the available reserves from the Fund. This was as a result that the Fund had accumulated substantial amounts of resources since its inception in 1966. However, there had been delays in the disbursement of pooled funds to the healthcare facilities which were causing inefficiencies in service delivery.[10]The amendment of the NHIF Act in 1972 therefore, recommended that the contributions collected from members be disbursed immediately to the Fund so that the benefits can be utilised for hospitalisation services.[25] The bureaucracies in resource distribution had hindered access to healthcare services as members financed their needs through out-of-pocket spending. Similarly, the costs of healthcare services had spiralled not only as a result of amenity charges, but also x-ray and laboratory costs as well as medication. The upward trend in healthcare costs were attributed to inflation

rates caused by the global economic depression of 1973.[27]

Other amendments to the Fund regarded the introduction of a system by the government that enabled the NHIF contributors to enjoy similar benefits as those of the NSSF, which were at the rates of a minimum of KShs.5 per day and maximum of KShs.20 for in-patient hospitalisation.[25]This amendment further proposed refunds to the private healthcare providers for out-patient services rendered to the NHIF contributors. The government also provided interest-free loans to private hospitals through the Treasury, for capital expenditure for purchase of modern equipment for theatre, x-ray facilities and laboratories as well as construction of reservoir tanks to deal with water shortage. This incentive by the government aimed at enabling private facilities to ease congestion at public healthcare facilities by attending to patients with another cover other than the compulsory NHIF.[26]

The 1973 amendmentof NHIF anticipated the introduction of a voluntary scheme to employees as some employers provided out-patient cover which catered for them and their dependants. The aim of proposing membership to the NHIF on a voluntary basis for the employed citizens was to avoid double deductions for compulsory contributions based on income and the private insurance from their employers.[22] Further, the amendment put a cap on the age limit to fifty years for both compulsory and voluntary contributors. This capping aimed at guarding the profit motive of the Fund as incidences of ill health increase with age.[24] According to an informant, expanding compulsory membership, while raising the premium contributions of those earning KShs.2000 and over per month was significant. Doubling of premium of these contributors to KShs.40 per monthand raising of their in-patient benefits to KShs.120 per day from KShs.60 were aimed at encouraging membership and utilisation of NHIF for healthcare.[10] However, for the contributors earning more than KShs.1000, but less than KShs.2000 their monthly contribution rates remained the samefollowing review by the Advisory Council.Guarding against arbitrary charges by the hospitals was significant. This was becauseraising medical charges on prevailing wage earnings, complicated control of disbursement of claims as hospitals that were privately managed were driven by profit motive.[24]

Another key amendment to the NHIF Act was the restriction on its core mandate to healthcare provision to its members and as such, was not to participate in the management of private hospitals as it does to public facilities. This was a precautionary measure that the government adopted so as not to hinder delivery of services in the facilities, as they were essential in the provision of healthcare services to the middle and upper income groups.[20] The Advisory Council therefore, required these hospitals to furnish the Fund with their accounts annually. The facilities also consulted the Advisory Council whenever they adjusted charges upwardly. The NHIF, however, considered what it could offer, but not what the various hospitals demanded. This is because, the contributor always had a choice of facility for healthservices and thus the premiums for hospitals were pegged on what these facilities offered.[26]

According to an informant, the Amendment of the NHIF Act of 1979 was done after concerns were raised by the Fund to the Attorney General on sale of stamps to affix to the cards. There were sale of counterfeit stamps by the staff of the Fund. The implication was sabotage of government policy aimed at reaching the targeted population for health insurance cover. The Treasury had therefore, through the Advisory Council recommended for the amendment of this section to control fraud and safeguard the resources of the Fund.[15] Following the Amendment, the government increased financial resources for the health sector through sale of stamps affixed to the NHIF cards indicating premiums contributed for particular periods. As means of improving revenue collection to the Fund, implementation of the proposed amendments of the Stamps Act of 1979 was necessary. Failure of enforcing the policy had resulted in loss of revenue to the government through incidences of counterfeit stamps sold to contributors by the postal corporation staff.[27]An informant notes that the government therefore, formulated measures for ensuring that the resources for healthcare were collected and accounted for. This was achieved through the use of law enforcers, such as the police who arrested individuals selling counterfeit stamps and arraigned them for prosecution aimed at discouraging similar incidences from occurring.[15][27]

d) Significance of Adjustments and Economic Restructuring for Social Policy onHealthcare Financing

Economic restructuring involved the arrangements for improving performance of key socio-economic institutions by governments geared towards achievement of development objectives. The World Health Organisation considers health reforms as "part of a sustained process of fundamental change in policy and institutional arrangements guided by the government, designed to improve the functioning and performance of the health sector and ultimately, the health status of the populations."[44]Health sector reforms were, therefore, concerned with defining priorities, refining policies and reforming institutions through whichthe policies were implemented to improve the health standards of the populace. This became the basis of the adoption of healthcare reforms by the government to address the discrepancies in the sector.[32]

During the period 1973–1986, the Ministry of Health policy formulation emphasised on rural health, through provision of Primary Health Care (PHC) to the populace. This was only possible through infrastructural development, such as engaging the local communities in the financing of the healthcare projects, which included health centres and dispensaries to make services more accessible. Similarly, the government contributed to the development of healthcare in the rural settings through external financing sourced from the World Bank and other multilateral donors.[43][16] These funds were utilised in the establishment of healthcare facilities as well as equipping them with requisite amenities, such as wards, beds, laboratories and x-ray machines. The funds were also utilised in the establishment of training institutions for additional manpower to the health sector.[24][32]

The Ministry of Health since the 1970s took over the management of rural health projects, which were formerly under the administration of local governments, resulting in

enhanced progress in service delivery to the populations in these set ups. This was evident in the extent of financing for the health projects through collaborations with donors. For instance, the WB funded healthcare projects mainly on infrastructural developments, such as the construction of hospitals and medical colleges to train nurses, clinical officers and other cadres of work force to render services in health centres and dispensaries.[43][36] The establishment of health centres and dispensaries was the responsibility of the local communities through the spirit of "*Harambee*." This entailed the involvement of locals in the activities surrounding their welfare who became partners with the government in primary health care provision.[22][14] Similarly, the collaborative programmes between the Kenya government and the donors were evident from the manner in which the projects had to be implemented within particular time frames. Therefore, adherence to budgetary allocations was significant to ensure set objectives were attained. In 1978, for instance, there were several projects within Nairobi area that had not been completed within the stipulated time frame. The government therefore, had to request for extension of time to enable the completion of the projects.[26][25]

By 1978, the government had expanded the in-patient health facilities to the rural set-ups by increasing the amenities, such as wards and bed capacity. There was also, during this period the introduction of enhanced family planning programmes concurrent with the care provided to mothers and their children.[14] The financial implication for this programme was through external funds from the World Bank, while the policy formulation was from the World Health Organisation to check on population growth to ensure the resource distribution was equitable for the populace. This was also adopted to enable the communities to meet their priority needs and consequently contribute to the NHIF.[43][37]

The significance of the external financing was evident in the Ministry of Health budget for the 1980/1981 financial year. The funds were from such agencies as the Swedish International Corporation Development Agency (SIDA) and the Danish International Development Agency (DANIDA), which financed up to 68% of the health projects, whereas the European Economic Community (EEC) contributed 26% and the government of Kenya financed the remaining 6%.[43] These funds were disbursed according to the most deserving regions, projects and socio-economic bases of the communities. These multi-laterally financed projects were aimed at making healthcare accessible for the proximity of facilities and also reducing costs that inhibited utilisation from the non-waged citizenry.[28][10]

The government adopted and implemented the World Health Assembly's "Health for All by the year 2000" during the 1978 Alma Ata Declaration on Primary Health Care. This was a policy decision aimed at popularising the provision of affordable, accessible and equitable healthcare for all citizens. The policy statement became essential in championing for the utilisation of government managed facilities that provided care at subsidised cost and enabled the utilisation of the NHIF to cover the financial outcome of services.[27] Similarly, "The Global Strategy for All by the year 2000" was another significant health policy formulation by the World Health Assembly in 1981 aimed at achieving universal health cover by reducing the financial burden borne by individuals while seeking services in publicly managed institutions.[27][39]

Further, the health sector reforms of the 1980s were part of the national strategies for improving service delivery. According to an informant, these reforms resulted in the decentralisation of health services and structural change to public health management and delivery system. The decentralisation policies were evident in the government's publication of the District Focus for Rural Development (DFRD) in 1983. The DFRD was one of the complementary sectoral reforms for the harmonisation and decentralisation of the healthcare service delivery system essential for the involvement of the citizens in the development of infrastructure.[7][15]Within the DFRD policy framework, the emerging organisations of the health system are hierarchical, with strategic and operational points at national, provincial and district level. In this hierarchy, the district was established as a basic level for operational tasks with limited strategic functions. Decentralisation therefore, ensured the gradual transfer of decision making process and management of resources from central administration at national to the local level.[7][40]

The National Guidelines for Implementation of Primary Health Care in Kenya was published in 1986 by the government through the Health Ministry. According to an informant the policy guideline was significant as a feasibility means for adopting alternative financing strategy for the healthcare.[15][7]The health policy therefore resulted in the re-organisation and re-orientation of the existing health systems and structures based on the principles of decentralisation, community participation and inter-sectoral collaboration. This policy also enabled the government to provide health services to the populace through cost-sharing. This was made possible as the Policy Guidelines had pledged to "increase alternative financing mechanisms for healthcare."[17][7]

Prior to the formulation of the policy guidelines, budgetary allocations from the Treasury and the Exchequer were directed towards the financing of public health institutions. However, theadjustment policies had necessitated the review of expenditure for healthcare.[43] Alternative models for healthcare financing to restructure the health sector were necessary. According to an informant;

Policy formulation for the introduction of healthcare financing reforms were developed and implemented to achieve these objectives. There was, for instance, the introduction ofa policy for socio-economic development aimed at reduction of household poverty. This was achieved through theestablishment of a model for financing that shielded the populations with lowincome and the unemployed from financial constraints accruing from private financing for healthcare.[12]

The budgetary austerity measures were evident in Kenya from 1986 during the implementation of the Structural Adjustment Programmes (SAPs) and the stabilisation policies. Although initially the budgetary austerity measures

were for the economic sectors, they were later extended to cover the social sector of health.[7] The government therefore, adopted a major policy of improving services, through opening up these institutions to external markets and thus liberalise management to enhance efficiency. However, prior to the adoption of the SAPs by the government, budgetary allocations from the Treasury and Exchequer were the main sources of financing for public health institutions. However, adjustment policies necessitated review of expenditure for health services that resulted in spiralling costs inhibiting access.[30][31]

Hence, the effect of budget cuts in the health sector led to a shift from general tax revenue by the government for recurrent expenditure and donor-based financing for development of healthcare infrastructure to one based on greater sectoral recovery of costs through user fees.[29][12] Similarly, the Kenya government in this restructuring period attempted other means of maintaining the quality standards in the healthcare facilities. There was, for instance, the redirection of resources from other sectors, such as infrastructure to health in the bid to maintain the goal of reducing financial strain to the populace attributed to inflation and other inhibitions by the government.[43]

IV. DISCUSSION

This paper examined the various factors which influenced the performance of the NHIF in Kenya in the period 1973 to 1986.The global upheavals of the 1970s influenced resource allocation to the various socio-economic sectors such as health. This paper established that the resource allocation inequalities led to commodisation of basic health-related goods and services, such as medicine and the general cost of care, through elimination of subsidies on transport of medical necessities. The service delivery of the NHIF was impeded by numerous factors in this period.The declining economic growth experienced globally resulted in managerial and financial inefficiencies in the socio-economic sectorsin Kenya during this period. The government's social spending was restricted due to the inadequate resources and individual households were unable to finance their basic needs. Government policy on models for financing for healthcare for the employed and unemployed was formulated and implemented in this period. This was through amendments to the NHIF at various times. For instance, the 1973 amendment was aimed at incorporating voluntary contributors to the Fund who were not in formal employment with a monthly income of KShs.1 000 or over. The paper found out that this policy was formulated and implemented with the aim of extending health insurance cover and fiscal resources to the NHIF. Finally, this paper assessed the significance of adjustments and economic restructuring for social policy on healthcare financing. Policy formulation in this period emphasised on rural health through provision of primary health care for infrastructural developments. The paper found out that through the *Harambee* spirit, communities contributed to financing of healthcare projects such as health centres and dispensaries to enhance access to services.Decentralisation policies were also evident in the publication in 1983 of the DFRD as complementary sectoral reforms to harmonise health service delivery. Subsequently, the National Guidelines for the Implementation of PHC published in 1986 was important for adopting alternative financing strategy for the healthcare.

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