PRACTICALITY OF UNIVERSAL HEALTH COVERAGE IN ENFORCING THE RIGHT TO EMERGENCY MEDICAL TREATMENT: ANALYSING THE LEGAL BOTTLENECKS.

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Declaration

I, MARGRET AWUOR AWINO, do hereby declare that this research is my original work and that to the best of my knowledge and belief, it has not been previously, in its entirety or in part, been submitted to any other university for a degree or diploma. Other works cited or referred to are accordingly acknowledged.

Signed: .....

Date: .....

This dissertation has been submitted for examination with my approval as University Supervisor.

Signed:.....

PURITY WANGIGI

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Acknowledgement

I would like to express my sincere gratitude to my supervisor, Purity Wangigi, for the continued support, patience, motivation, enthusiasm and immense knowledge in the research and writing of this dissertation.

Dedication

To God Almighty for his grace and mercies; to my parents for their continued support and tireless effort in educating me; to my dear brothers for the encouragement; and to all my friends who contributed to the success of this work.

List of Abbreviations

CoK Constitution of Kenya

CESCR Committee on Economic, Social, and Cultural Rights

ICCPR International Covenant on Civil and Political Rights

ICESCR International Covenant on Economic, Social and Cultural Rights

NHIF National Hospital Insurance Fund

SDGs Sustainable Development Goals

UHC Universal Health Coverage

UN United Nations

UNICEF United Nations Children's Fund

WHO World Health Organization

List of Cases

Alex Madaga Matini v Kenyatta National Hospital & Coptic Hospital

Allinson v General Council of Medical Education and Registration (1894)

Isaac Ngugi v National Hospital and 3 others

Luco Njagi& 21 others v Ministry of Health & 2 others (2015)

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International Code of Medical Ethics

Medical Practitioners and Dentists Board Act (No. 12 of 2012)

Medical Practitioners and Dentists (Professional Fees) Rules (2016)

Universal Declaration of Human Rights

World Medical Association Declaration of Geneva

Abstract

Achieving universal health coverage is no mean feat. This study delves into the importance of delivering universal health coverage when it relates to access to emergency medical treatment. It aims to investigate the role of universal health coverage in developing emergency care systems in Kenya and proposes a human rights based approach. The first chapter introduces us to the necessity of the study which proposes the introduction of a complete legislative framework on emergency medical treatment regardless of ability to pay, by utilizing the universal health coverage system to combat the inhibitions of finances. Additionally, a critical analysis of the nature and scope of emergency medical treatment in Kenya is done which aims to make a case for universal health insurance in the sphere of access to emergency medical treatment. The study is of the opinion that where one has the ability to administer emergency clinical treatment in an effort to save a life, there is no reason to withhold the said service just because of an individual's ability to pay for that service. The Ubuntu concept that promotes the dignity of the human person is discussed as it impacts on the need for health care personnel to offer emergency treatment. The third chapter seeks to determine the viability of a separate health fund for poor vulnerable groups in society by proposing a home grown pro-poor health financing policy. In conclusion, an analysis of the challenges encountered and expected while using the separate health fund are examined and solutions to the same are provided.

Chapter One: Introduction

1.1 Background of the problem

Widespread Health Coverage has become a strategy need at both the public and worldwide levels. The objective of widespread wellbeing inclusion is to guarantee that each resident approaches quality medical care benefits that they need without getting into monetary challenges or, more awful, drove into destitution. To advance towards general wellbeing inclusion (UHC), nations should progress along at any rate three lines of activity. They should extend need administrations, incorporate more individuals, and decrease cash-based installments[1]. Be that as it may, populace inclusion is still low and portrayed by imbalances where the rich have preferred inclusion over poor people and about a portion of Kenyans (24 million) don't approach basic medical care administrations, and 33% of Kenyans (14 million) are not shielded from the destructive impacts of cash-based medical services installments in 2013.[2]

Apparently, the privilege to crisis medical care is accidentally withdrawn from the privilege to wellbeing and hence our nation has perceived the need of explicitly including it in the Kenyan Constitution that guarantees each individual of their entitlement to emergency clinical therapy which will not be denied[3]. The administration ought to be of sensible quality as the patient has the privilege to the most noteworthy feasible norm of wellbeing which incorporates the privilege to medical care administrations[4]. The arrangement that an individual will not be denied crisis clinical is set out in negative terms, lifts up this privilege to the domain of promptly feasible sacred cases, much the same as common and political rights[5]. In any case, also likewise with the case with various monetary rights, unequivocal evaluations that should be taken by the State and the inhabitants identifying with their obligations in gathering their commitment concerning rules concerning installments of expenses towards sponsoring the human administrations' structure are oftentimes destroyed[6].

[1] Towards Universal Health Coverage in Kenya: Are We on the Right Path? HERU Policy Brief January 2019, 1.
[2] Towards Universal Health Coverage in Kenya: Are We on the Right Path? HERU Policy Brief January 2019, 3.
[3] Article 43(2), Constitution of Kenya (2010).
[4] Article 43(1), Constitution of Kenya (2010).
[5] Oduor M, The Right to Emergency Medical Treatment in Kenya.
[6] Measuring Progress Towards Universal Healthcare Coverage, KEMRI, Well come Trust 2019.

One such effect of the harmful nature of out of pocket payments was witnessed in the case of one Alex Madaga, a patient who died after spending 18 hours in an ambulance awaiting emergency medical treatment.[7] In October 2015, an occurrence happened that was generally revealed by the media. Alex Madaga was engaged with a quick in and out mishap on the fifth of October 2015 at 9 pm. He was taken to Kikuyu Mission Hospital by rescue vehicle where he was referred to Kenyatta National Hospital. At Kenyatta National Hospital the staff guaranteed not to have any Intensive Care Unit (ICU) beds. They looked for help from Coptic and Ladnan medical clinic where his better half was approached to store Kenyan shillings (Kshs) 200,000/= for Mr. Madaga to be conceded. Tragically, she was unable to collect the cash. They got back to Kikuyu Mission clinic to top off the oxygen tank since it was running out. The paramedics in the rescue vehicle said that he had an internal head injury. They returned to Kenyatta National Hospital where he was admitted upon his cousin's grievance. He lost his life soon afterwards[8]. Mrs Madaga had to suffer the pain and anguish of watching helplessly as her husband's life ebbed away right before her very eyes, and, in the full knowledge that, at least two hospitals, were in a position to help, but refused on account of non-payment of a deposit.[9]

Another occurrence shed light into the plight of emergency medical treatment in Kenya. This was the incident of Okach Chege (alias name). At around midnight on a Saturday, Chege rushed his brother to the Aga Khan hospital and he was examined by the doctor. The doctor's diagnosis was that the patient has suffered a mild heart attack. As per the doctor's diagnosis, it was very likely that Chege's brother would suffer another heart attack. Chege and his sister agreed that their brother was to be admitted for proper medical care. However, the hospital's receptionist insisted that a deposit of seven hundred thousand shillings be made for the admission to be processed. The deposit fee was too high in comparison to Nairobi Hospital's six hundred thousand shillings fee and MP Shah's four hundred and fifty thousand shillings fee. Chege's

[7] Eunice Kilonzo, 'Car accident survivor spends over 18 hours waiting in ambulance', *Daily Nation,* 7 October 2015 -< http://www.nation.co.ke/news/Pain-of-patients-18-hours-in-ambulance/1056-2903538-vvf181/index.html>- on 23 December 2020.
[8] 'Eunice Kilonzo: 'Car accident survivor spends over 18 hours waiting in ambulance', *Daily Nation,* 7 October 2015-< http://www.nation.co.ke/news/Pain-of-patients-18-hours-in-ambulance/1056-2903538-vvf181/index.html>- on 23 December 2020.
[9] 'Eunice Kilonzo: 'Car accident survivor spends over 18 hours waiting in ambulance', *Daily Nation,* 7 October 2015 -< http://www.nation.co.ke/news/Pain-of-patients-18-hours-in-ambulance/1056-2903538-vvf181/index.html>- on 23 December 2020.

family was able to raise the fee for a night but his brother could still not be admitted due to failure to prove the ability to pay the rest of the medical fees[10].

Despite efforts to seek justice for such families, majority of offenders often walk free. However, Alex Madaga's family managed to get compensation when Chief Magistrate Peter Gesora ruled in their favour. He ruled that the family was to get one hundred and fifty thousand shillings as compensation for Mr Madaga's suffering. Also, they were awarded Kshs 2,068,248 as minimum wage compensation of 20 years and Kshs 189,659 as special damages[11]. These unfortunate incident shed light into the nature and scope of emergency medical treatment in Kenya.

1.2 Statement of the problem

Ideally, the right to access emergency medical treatment should be upheld by any healthcare facility regardless of the patients' ability to pay for the services offered as it is meant to stabilize the situation of the patient in order to preserve life and save the patient. Furthermore, the universal healthcare coverage systems of the State should prioritize the funding and implementation of emergency care systems. The current situation falls short of the ideal situation where access to emergency medical care in public hospitals where majority of the poor vulnerable groups access medical care is flooded with financial barriers in comparison with private hospitals where there is timely emergency health care regardless of mandatory payment required which is out of reach to the very poor. This is coupled by the funding challenge whereby citizens have a corresponding obligation to pay for minimum premiums to fund the national healthcare system, NHIF, a cover acceptable in most healthcare institutions.

1.3 Statement of objectives

The aim of the study is to investigate the role of universal health coverage in developing emergency care systems in Kenya through a human rights-based approach.

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[10] 'Gatonye G. and Mohamed H, 'How huge medical bills are crippling millions of families' *Standard Media Group*, 11 April 2017 https://www.standardmedia.co.ke/business/article/2001235904/how-huge-medicalbills-are-crippling-millions-of-families on 9 September 2020.

[11] 'Eunice Kilonzo, 'Death After Arrival: Terrible emergency services are killing by the thousand' *Daily Nation*, 7 November 2017 http://www.nation.co.ke/health/Dead-after-arrival/3476990-4176182-n522p3z/index.html on 13 September 2020.

1. To evaluate the viability of a separate health fund for poor vulnerable groups within the society.
2. To evaluate the viability of civic tools to enhance NHIF fund and hence the ability to subsidise for the poor vulnerable groups.
3. To identify potential challenges of reducing fraud while using the separate fund.

1.4 Research questions

1. Whether a separate health fund for poor vulnerable groups is viable.
2. Whether incentivizing the separate health fund through civic tools is viable.
3. Whether alleviating potential challenges while using the health fund will enhance its viability.

1.5 Justification of the study

This study has both academic and policy relevance. From a policy perspective, it will contribute to an elaborate policy meant to address the challenges that have continued to bedevil the laws on emergency healthcare in Kenya. Additionally, this study will be an addition to the emerging body of literature that seeks to make recommendations on the universal health care systems in Kenya can be made more inclusive and effective especially with regard to access to emergency medical treatment in Kenya. From an academic perspective, this study will contribute to further understanding and debate on the universal health coverage systems and whether it should be fully implemented and become operational specifically with regard to access to emergency medical treatment. Thus, the study proposes the introduction of a complete legislative framework on emergency medical treatment regardless of ability to pay, by utilizing the universal health coverage system to combat the inhibitions of finances.

Given that the Constitution states clearly in Article 43 (2) that a person shall not be denied emergency medical treatment and medical practitioners have a legal duty to provide emergency medical treatment, this dissertation will delve into why this is not enough to effectively realize the right to emergency medical treatment in Kenya. Furthermore, medical practitioners have a moral obligation having sworn the Hippocratic Oath which reads in part: “I swear to fulfil, to the best of my ability and judgment, this Covenant:

… Most especially must I tread with care in matters of life and death? If it is given me to save a life, all thanks…. I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person’s family and economic stability. My

responsibility includes these related problems, if I am to care adequately for the sick. I will prevent disease whenever I can, for prevention is preferable to cure. I will remember that I remain a member of society, with special obligations to all my fellow human beings that sound of mind and body as well as the infirm…. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help."[12] This calls for health care professionals to attend to patients requiring emergency medical treatment.

Odour and Simiyu did a study of the right to emergency medical treatment in Kenya in 2015. This paper was limited to what the Constitution says in terms of the right to health including emergency medical treatment. When discussing and describing the nature and scope of emergency medical treatment and the legal issues arising from the right to emergency medical treatment, the authors were very limited to the Constitution. This is because the Health Act 2017 was then the Health Bill 2014. They refer to other Statutes such as the Medical Practitioners and Dentists Act.

Further, the extent of their investigation was more extensive as they likewise centred on the detainment of patients subsequent to delivering emergency clinical treatment for the absence of paying cash owed to the specialists. They think about the Medical Practitioners and Dentists Act and the International Covenant on Civil and Political Rights (ICCPR) which deny the detainment of an individual, in this setting a patient, just on the ground of powerlessness to satisfy an authoritative commitment.

Yadav also writes on the right emergency medical care in 2011. Yadav's paper critically reviews recent judgment of State Consumer Court of Delhi with regards to the right to emergency care. The author was limited to a geographical scope of India. Odhiambo did a study on the right to emergency medical treatment in Kenya in 2015. His paper focuses on the opportunities, strategies and challenges that arise from the right to emergency medical treatment in Kenya. He greatly relies on the Constitution and the Medical Practitioners and Dentist Act. The Health Act 2017 was then the Health Bill 2015. Therefore, limited in the statutory law in Kenya.

[12] Collins O, *No one shall be 'Denied Emergency Medical Treatment' in Kenya: Opportunities, challenges and strategies*, July 20, 2015 https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2662417 on 26 September 2020.

Darlene, Nyabera, Yusi and Rusyniak did a study in the Western Kenya concerning the emergency centres. The goal of their study was to determine the characteristics of emergency centre patients in Eldoret based in Uasin Gishu County, Kenya. It will be difficult to generalize results derived from one part of the country to other emergency centres. Moreover, the study focused on both private and public medical facilities.

In 'Medical ethics and payment of fees before treatment', David wrote a paper and discussed whether it is ethically acceptable for doctors to require payment of fees before treatment and whether refusal to treat before payment represents abandonment of a patient. He limits himself to the ethical responsibility of all doctors whether in private or public facilities. He does not discuss legal issues that emerge from the right to emergency medical treatment.

1.6 Limitation of the study

Research into the current state of legal doctrine can hardly be pursued through the methods of sociologic studies, whilst the strictly doctrinal approach of the black-letter methodology is incapable of analysing policy and moral questions effectively.

1.7 Assumptions of the Study

For this study, the assumption that the lack of proper universal health coverage inhibits access to emergency medical treatment will be held to be true.

1.8 Research Methodology

For this examination, the majority of the data will originate from essential and auxiliary sources. The essential sources incorporate Constitutions, Statutes, legal disputes, worldwide instruments, and authoritative guidelines.

Secondary sources incorporate distributed diaries and articles, law-word references, editorials, and philosophical works.

1.9 Definition of terms

Chargeable fees refers to the fees enumerated under the Schedule to be charged by practitioners offering medical or dental services, or both[13].

Emergency refers to health threats that are life threatening and beyond the capacity of the individual or community to manage, and lead to an irreversible damage if not addressed[14].

Emergency medical treatment

The Kenya Health Policy 2012-2030 characterizes 'crisis clinical treatment' as medical care administrations important to forestall and deal with the harmful impacts from an emergency circumstance. Also, crisis care includes courses of action for the exchange of customers once the crisis idea of the assistance is settled. Execution of these exchange courses of action closes the crisis period of medical services[15]. Crisis clinical therapy administrations are given after the unexpected beginning of an ailment showing itself by intense side effects of adequate seriousness that the nonattendance of prompt clinical consideration could sensibly be required to bring about setting the patient's well-being in genuine peril[16].

Health refers to a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity[17].

A Health Care Professional is a person who has health professional qualifications and is licensed by the relevant regulatory body[18].

Health care services refer to the prevention, promotion, management or alleviation of a disease or illness, whether mental or physical and is delivered by healthcare professionals[19].

Universal health coverage is defined by the World Health Organization as ensuring that all people have access to needed health services which includes prevention, promotion, treatment,

[13] Section 3(1), *Medical Practitioners and Dentists (Professional Fees) Rules* (2016)
[14] Ministry of Health, *Kenya Health Policy*, 2014-2030, 66.
[15] Ministry of Health, *Kenya Health Policy*, 2012-2030, 34.
[16] -< https://publichealth.gwu.edu/departments/healthpolicy/CHPR/nnhs4/PCCM/subheads/pccm116.html> accessed on 10 October 2020.
[17] Section 2, *Health Act* (No. 21 of 2017
[18] Section 2, *Health Act* (No. 21 of 2017
[19] Section 2, *Health Act* (No. 21 of 2017

rehabilitation and palliation of sufficient quality to be effective while also ensuring that the use of these services does not expose the user the financial hardship[20].

Medical emergency conditions: The Kenya Health Policy 2012-2030 defines

'emergency conditions', as the following[21]:

a) Those health conditions that are of sudden onset in nature;

b) Those that are beyond the capacity of the individual/ community to manage;

c) Those that are life threatening, or will lead to irreversible damage to the health of the individual/ community if not addressed.

The concept of sustainable development implies that humanity has the ability to make development sustainable to ensure that it meets the needs of the present without compromising the ability of future generations to meet their own needs[22]. The third sustainable development goal is ensuring healthy lives and promotion of well-being for all at all ages[23].

1.10 Theoretical Framework

Ubuntu Philosophy

The Ubuntu philosophy of Africa correctly understands that we are truly human only in community with other persons[24]. The Ubuntu philosophy essentially stands for the fact that people are not individuals, living in a state of independence, but part of a community, living in relationships and interdependence[25]. Broodryk states that any management theory based on Ubuntu philosophy must include the role of the Ubuntu virtues. These virtues are humanness, caring, sharing, respect, and compassion virtues[26]. Consequently. One can say that they cannot separate their humanity from that of others[27]. Therefore in applying the Ubuntu philosophy, we understand that every person should have the access to emergency medical treatment regardless of their ability to pay. This is because we are all human and since we cannot separate our humanity from that of others, we should uphold the virtues that Ubuntu prescribes when it

[20] -< https://www.who.int/healthsystems/universal_health_coverage/en/> accessed on 10th October 2020.
[21] Ministry of Health, *Kenya Health Policy*, 2012-2030, 21.
[22] Brundtland Report of the World Commission on Environment and Development: Our Common Future, 1987.
[23] -< dp.org/content/undp/en/home/sustainable-development-goals.html> accessed on 10th October 2020.
[24] Lutz D, African Ubuntu Philosophy and Global Management, Journal of Business Ethics, Springer 2009.
[25] Turaki Y, Foundations of African Traditional Religion and Worldview, *WordAlive Publishers, Nairobi*, 2006.
[26] Broodryk J, Ubuntu Management Philosophy, *Knowres, Randburg, South Africa*, 2005.
[27] MacIntyre A, After Virtue: A Study in Moral Theory, 3 *University of Notre Dame Press, Notre Dame, IN*, 2007.

comes to saving the lives of our fellow countrymen. Everyone should be able to access medical treatment that is life-saving when an emergency arises and their life is threatened.

Rawls's theory of justice

Drawing form Rawls's book, A Theory of Justice, Rawl views justice from the lens of fairness[28]. Apart from defining justice via his concept of the veil of ignorance, he also gives an example of what would be the best way to determine what justice is. He states that in a given group of people who neither know their origin, profession, sex nor race, such people should draw the principles of justice. Since the people in this group would not be biased, it would only be as a result of fairness[29]. Rawl argues that everyone should have equal rights and no one should be above another when it comes to rights. Additionally, socio-economic inequalities are intended to satisfy two conditions. The first is that they are to be attached to positions and offices open to all under conditions of fair equality of opportunity. Secondly, they are to be the greatest expected benefit of the least advantaged members of society[30].

Although Rawl's work impacted significantly on trying to simplify the concept of justice, his work faced certain criticisms. The most relevant one was that he focuses on primary goods but seems to take little note of the diverse nature of human beings. Furthermore, it is impossible for a reasonable man to be in this original position given that human beings are biased and limited[31]. Just because his theory faces criticisms does not mean that we should dismiss it. In fact, in applying Rawl's theory of justice, it is evident that we should eliminate discrimination when admitting patients that require access to emergency medical treatment because of their inability to pay. According to this theory, it will be fair and just to do so seeing as the right to emergency medical treatment is a right enumerated by the Constitution in Article 43(2) where it states that a person shall not be denied emergency medical treatment.

1.11 Chapter summary

This chapter introduces the relationship between proper universal health coverage and its effect on access to the right to emergency medical treatment as envisioned by Article 43 of the Constitution of Kenya. The background of the problem shows us why the current state of affairs regarding access to this right is limited due to various factors, the prominent one being the lack

[28] Rawls J, 'A Theory of Justice', *Cambridge* (2005).
[29] Rawls J, 'A Theory of Justice', *Cambridge* (2005).
[30] Rawls J, 'A Theory of Justice', *Cambridge* (2005).
[31] Kerketta L, 'Theory of Justice by Rawls: its criticisms by Martha C. Nussbaum and Amartya Sen', 9 September 2015 http://www.legalservicesindia.com/article/article/theory-of-justice-by-john-rawls-itscriticism-by-martha-c-nussbaum-and-amartya-sen-1897-1.html on 9 August 2020.

of proper funding of the universal health coverage system in Kenya. This begs the question of whether our system is viable for everyone in society as there are questions on equality and fairness that arise. Additionally, the theoretical framework that support this research is analysed in brief. Finally, the the introduction of a complete legislative framework on emergency medical treatment regardless of ability to pay, by utilizing the universal health coverage system to combat the inhibitions of finances is proposed at the end of this chapter. The subsequent chapter will focus on the right to access emergency medical treatment, the nature and scope of this right and the duties that various stakeholders have in realizing this right.

Chapter Two: Nature and Scope of Emergency Medical Treatment in Kenya

2.1 What constitutes Emergency Medical Treatment?

UN Committee on Economic, Social and Cultural Rights recognises the right to health care as being fundamental to the mental and physical well-being of individuals, seeing as it is a necessary condition for the exercise of other human rights[32]. Similarly, the highest attainable standard of health is recognised as a fundamental right of every person by the World Health Organisation[33]. The right to emergency medical treatment lacks recognition as a human right on its own. Other than listing the right as a socio-economic right, the Constitution of Kenya has not defined what the right to emergency medical treatment entails[34]. Thus, Kenya lacks a statutory definition of what amounts to emergency medical treatment. The Kenya Health Policy however defines emergency medical treatment as the health care services necessary to prevent and manage the damaging health effects from an emergency situation. It involves services across all aspects of health care services and includes first aid treatment of ambulatory patients and those with minor services; public health information on emergency treatment, prevention, and control; and administrative support including maintenance of vital records and providing for a conduit of emergency health funds across Government. Emergency care involves arrangements for transfer of clients once the emergency nature of the service is stabilized. Execution of these transfer arrangements ends the emergency phase of health care[35].

The Health Bill 2015 defines emergency medical treatment as necessary immediate health care that must be administered to prevent death or worsening of a medical situation[36]. Section 7 of the aforementioned bill states that emergency medical treatment shall include pre-hospital care, stabilizing the health status of the individual or arranging for referral in cases where the health provider of first call does not have facilities or capability to stabilize the health status of the victim[37]. From the definitions above, it is important to note that illnesses that are of a chronic nature are not included. Therefore, such illnesses are not considered as being entitled to emergency medical treatment. This was the position of the court in the case of *Luco Njagi &*

[32] UN Committee on Economic, Social and Cultural Rights, General Comment No. 14, 2000
[33] WHO Constitution, 1946
[34] Article 43, *Constitution of Kenya* 2010.
[35] Ministry of Health, Kenya Health Policy, 2012-2030, 21.
[36] Section 2, The Health Bill, 2015.
[37] Section 7, The Health Bill, 2015.

21 others v Ministry of Health & 2 others where it was held that the petitioners were not entitled to emergency medical treatment by virtue of being patients suffering from renal cancer[38].

2.2 A case for universal health insurance

In delivering universal health coverage, there are four core requirements. These include financing, human resources, equipment and infrastructure, capitalising on synergies between sectors and good governance[39]. These requirements are critical in developing health insurance that includes special measures for the poor. In Kenya, huge medical bills cripple millions of families especially when they require access to emergency medical treatment since huge deposits are required before patients can be attended to. In the case where different stakeholders in the healthcare sector collaborate to ensure the success of universal health coverage in Kenya, the challenge of accessing emergency medical treatment may be alleviated. This is because for universal health coverage to be achieved, parties have to capitalise on the synergies between health and governance sectors within the country. Only then will citizens have the ability to access emergency medical treatment without financial hurdles.

2.3The duty of the State

The right to emergency health care should therefore be realised through the lens of what constitutes the core elements of a right to health. These include but are not limited to, progressive realisation using maximum available resources and non-retrogression[40]. With this in mind, the State should take immediate steps in the fulfilment of these rights. Of keen interest is that the State should not allow the deterioration of socio-economic and cultural rights without providing strong justifications for such retrogressive measures[41]. Additionally, the State should ensure the availability, accessibility, acceptability and quality[42] of health care systems in implementing the right to access emergency medical treatment. These four qualities are core in supplementing the core elements of the right to health.

Of particular interest is Article 43 (3) of the Constitution of Kenya which places an obligation on the State to provide appropriate social security to persons who are unable to support

[38] Luco Njagi & 21 others v Ministry of Health & 2 others [2015] eKLR

[39] Health in the Framework of Sustainable Development, Delivering Universal Health Coverage

[40] CESCR (Committee on Economic, Social, and Cultural Rights) 2000 11 August

[41] "Guiding Principles on Business and Human Rights: Implementing the United Nations 'Protect, Respect and Remedy' Framework, Office of the high Commissioner for Human Rights, Geneva, 2011

[42] Transforming our World: The 2030 Agenda for Sustainable Development, UN General Assembly, 2015, 21 October.

themselves and their dependants[43]. Does the nature of this obligation extend to promoting access to quality emergency medical treatment? In determining this matter, the distinction between positive and negative forms of rights may be essential in establishing the nature of government obligations regarding this right. We then ask ourselves whether the right to access emergency medical treatment is a right meant to be realised progressively similarly as other economic and social rights. This is evident in Article 43 of the Constitution of Kenya which provides for the realisation of such rights. Additionally, it is important to note that every person shall enjoy the rights and fundamental freedoms, including the right to access emergency medical treatment, to the greatest extent consistent with the nature of the right or fundamental freedom[44]. Therefore in interpreting any legislation, every court or forum must promote the purport, spirit and objects of the Bill of Rights[45].

On the implementation of rights and fundamental freedoms, the Constitution expressly provides that the State shall take legislative, policy and other measures, including the setting of standards, to achieve the progressive realisation of the rights guaranteed under Article 43[46]. Justice Mumbi Ngugi posited that the state has a duty to make the necessary budgetary allocation as well as to take the necessary legislative and policy measures to ensure that the right to health is realised[47]. With this regard, it is evident that the State has the responsibility to ensure that in allocating resources, it shall give priority to ensuring the widest possible enjoyment of the right or fundamental freedom having regard to prevailing circumstances, including the vulnerability of particular groups or individuals[48]. The obligation of providing resources to ensure implementation of the right to access medical treatment is on the State as it extends from the right to health. In the event that a State claims to lack resources for the implementation of this right, the burden of proof lies with it[49]. The State has a duty to promote the development of an organised national emergency care system and facilitate the special training on emergency medical treatment. The importance of health financing arises from this duty since without health financing, the efforts of the State will be futile.

[43] Article 43(3), *Constitution of Kenya*, 2010.
[44] Article 20 (2), *Constitution of Kenya*, 2010.
[45] Section 39(2), Constitution of South Africa
[46] Article 21 (2), *Constitution of Kenya*, 2010.
[47] *Luco Njagi & 21 others v Ministry of Health & 2 others* [2015] eKLR
[48] Article 20 (5), *Constitution of Kenya*, 2010.
[49] Article 20 (5) (a), *Constitution of Kenya*, 2010.

2.4 State Approaches to Financing Healthcare for the poor.

In an effort to achieve universal health coverage in Kenya, the National Hospital Insurance Fund was established[50]. The National Hospital Insurance Fund operates using premiums paid by citizens. Ideally, it should cover every citizen during illnesses but due to various challenges, the major one being health financing, it has failed to assist patients seeking emergency medical treatment on numerous occasions. In as much as the Medical Practitioners and Dentists Board Act provides that if a person is able to administer medical treatment in order to remove a patient from an emergency condition and that there is no reason to withhold this service or duty[51], this is not the situation on the ground. When a patient is seeking emergency medical treatment, there are certain procedures that they are required to follow even before they are attended to at the hospital. For instance, if a situation requires surgery so as to remove the patient from a critical condition in order to avoid death, the patient has to be admitted in hospital and pay some amount for this process to be seamless. This is a major hurdle given that during emergency situations, coming up with huge funds to cater for this procedures within such a short time may be impossible especially to vulnerable groups. Given that the National Hospital Insurance Fund does not cover everything when a patient is sick, what about when the said patient is in dire need of access to emergency medical treatment? There lacks a mechanism of determining the services to be covered by the insurance fund and what not to be covered especially in emergency medical situations.

2.5 To what degree can the right to emergency clinical treatment be guaranteed against non-state parties?

It is pretentious to say that only the State and its representatives may abuse common freedoms. Parties other than the state may as well abuse this fundamental right. Article 20(1) of the Constitution of Kenya provides that the Bill of Rights applies to all law and binds all State organs and persons[52]. Evidently so, this provision is not strictly limited to the state only. For instance, in the case of *Isaac Ngugi v National Hospital*, it was established by the court that the inquiry regarding whether such a right is to be applied on a level plane or only vertically against the State relies upon the idea of the privilege and basic opportunity and the condition

[50] _< http://www.nhif.or.ke/healthinsurance/>-
[51] *Medical Practitioners and Dentists Board Act*, No 12 of 2012.
[52] Article 20 (1), *Constitution of Kenya,* 2010.

of the case[53]. Crucial rights like the right to access emergency medical treatment are appropriate in their application both vertically and on a level plane save that even application would not make a difference when in doubt. However, it would just be an exemption which would clearly request that the court do treat it dependent upon the situation by looking at the conditions of each case before it is legitimized[54]. Justice Lenaola established that the enforcement of the provisions of the Bill of Rights can be done against a private individual and that this is not limited to the state only. This was the outcome of the case of *Satrose Ayuma v Registered Trustees of the Kenya Railways Staff Retirement Benefits Scheme*[55]. In this case, the first and second respondents were of the opinion that the provisions in the Bill of Rights were binding solely on the organs of the state. However, as Article 2 (1) of the Constitution of Kenya, 2010 posits, the Constitution being the supreme law in Kenya, is binding on all individuals and organs of the state at both government levels[56]. Given that the right to access emergency medical treatment is a provision under the Bill of Rights, it follows that the commitment to notice, regard, secure, advance, and satisfy the residents' entitlement to emergency clinical treatment ties all State organs and all people both common and juristic[57]. Therefore, if an individual experiences an injustice having been denied the right to access emergency medical treatment, the person has the right to institute proceedings of a private nature in an effort to seek justice. Consequently, in the event that they succeed, the court will award them the damages that they may have incurred. This is supported by Article 22 (1) of the Constitution of Kenya, 2010. This article provides that every individual has the right to institute proceedings against another person claiming that their rights or fundamental freedoms have been infringed upon[58]. We see therefore that the private health care providers are not exempt from the binding nature of this provision. Where private health care providers deny emergency services to individuals that are seeking them, such persons may institute legal proceedings against the private parties with a claim that the private health care providers or persons denied them access to this essential service therefore causing them harm in one way or another. Given the express and direct nature of the provision as written in the Constitution, if an applicant can prove in any way that the respondent denied them access to the essential emergency medical treatment, their chances of success in the suit will always be high although it varies on a case by case

[53] Petition Number 407 of 2012 [2013] eKLR.
[54] *Mwangi Stephen Mureithi v Daniel Toroitich arap Moi*
[55] 2013, eKLR
[56] Article 2(1), *Constitution of Kenya*, 2010.
[57] Oduor M, The Right to Emergency Medical Treatment in Kenya, 2015
[58] Article 22 (1), *Constitution of Kenya*, 2010

basis. The commitment to 'secure' the rights in the Bill of Rights is normally perceived to imply that the state should shield singular citizenry from encroachments of their privileges by outsiders and should guarantee the sufficiency of lawful cures that forestall or make up for such encroachments[59]. In the case of *Velazquez Rodriguez v Honduras*, it was determined by the Inter-American Court that when a State permits a private people or gatherings to act unreservedly and without any potential repercussions to the hindrance of the rights recognized, it would be in away from of its commitments to ensure the basic freedoms of its residents[60]. Drawing from this, it is evident that the government has been vested with the responsibility of ensuring that other individuals do not infringe on the rights of others. The government should therefore institute measures to protect the rights of individuals and provide plausible remedies for those whose rights have been infringed.

2.6 Establishing the link between the dignity of a person and the right to access emergency medical treatment

Dignity is defined as the state or quality of being worthy of honour or respect[61]. What then is the purpose of recognizing the rights and fundamental freedoms of individuals? The purpose of recognizing and protecting such rights and freedoms is to ensure that the dignity of individuals, their society and community is upheld. This is supported by Article 19 of the Constitution. Article 28 of the Constitution provides that every individual has inherent dignity and the right to have that dignity be protected[62]. The dignity of the human person is alluded to them simply by the virtue of being human[63]. Neglecting to act in a way reliable with keeping up life is annihilating human dignity. The pride of an individual cannot exist without the individual, accordingly, its safeguarding is principal to the protection of the individual's life[64]. The Constitution also states in the preamble that Kenya as a country is committed to the nurturing and protection of an individual coupled with the protection of the human rights of the person[65]. The preservation of dignity is key seeing as it is the core element that governs the protection of human rights in the Kenyan Constitution.

[59] Chirwa M, 'The Horizontal Application of Constitutional Rights in a Comparative Perspective,' (2006) 10(2) Law, Democracy and Development 559-560.
[60] *Velazquez Rodriguez v Honduras*, 1988
[61] Oxford Learner's Dictionary
[62] Article 28, *Constitution of Kenya*, 2010.
[63] Hughes A, Human dignity and fundamental rights in South Africa and Ireland 2014, 36.
[64] Kankindi A, False Freedom, The Hollow Pillars of Liberal Democracy
[65] Preamble, *Constitution of Kenya*, 2010.

International human rights instruments also show that dignity is central to their frameworks. For instance, in the Universal Declaration of Human Rights states in Article 1 that all human beings are born free and equal in dignity and rights. They are enriched with reason and soul and should act towards each other in a feeling of brotherhood[66]. The preambles of The International Covenant on Civil and Political Rights (ICCPR) and The International Covenant on Economic, Social and Cultural Rights (ICESCR) also embody the principle respecting and protection [67]of human dignity of the human person[68]. In the United Nations Charter, the preamble reaffirms confidence in the dignity and worth of the human person[69]. The African Charter on Human and People's Rights in Article 5 states that very individual shall have the right to the respect of the dignity inherent in a human being and to the recognition of his legal status[70]. In the case of *S v Makwanyane*, the court established that human dignity is important even in the African context. The place of Ubuntu is established where the court recognised that the theory of Ubuntu recognizes that given a person's status as a human being, this person is consequently entitled to the protection of his dignity as a human being[71]. The philosophy of Ubuntu is that it asserts that the society or community gives human beings their humanity[72]. In the same spirit, health care providers and health care workers need to assist individuals requiring access to emergency medical treatment. Health care professionals should be up to the task when it comes to providing emergency services that may help to save a life even without the fear of not making any money from doing so.

Let us then analyse an instance where a health care professional refused to provide emergency medical treatment to a patient and the consequences thereof. In the case of *Medical Board of Australia v Dekker,* Leila Dekker, a health care professional got involved in a motor vehicle accident in the evening of twenty seventh April 2002. Leila's car had minimal injuries while the other car involved in the accident was shoved into a ditch. Leila drove to a nearby police station without checking on the medical condition of the people in the other car yet the occupants had sustained some injuries. When Leila was brought to court, she was charged with improper professional conduct seeing as she left the scene of the motor vehicle accident without

[66] Article 1, Universal Declaration of Human Rights
[67] Preamble *The International Covenant on Economic, Social and Cultural Rights* (ICESCR)
[68] Preamble, *International Covenant on Civil and Political Rights* (ICCPR)
[69] Preamble, *United Nations Charter*
[70] Article 5, The African Charter on Human and People's Rights , adopted 27 June 1981, entered into force 21 October 1986)
[71] Eze M, What is African Communitarianism? Against consensus as a regulative Ideal" 27 S*outh African Journal of Philosophy* 4, 2008, 386-399
[72] Christian B, What is Ubuntu? Different Interpretations among South Africans of African Descent, *South African Journal of Philosophy*, 2012, 484-503

ascertaining at all whether the occupants of the vehicle shoved into the ditch were okay or whether they had sustained any injuries[73]. This incident shows us that a health care professional or health care providers are mandated to provide emergency medical services to patients requiring it in an effort to stabilise the individuals' condition and save their life. All this should be done without expecting any form of payment or monetary compensation and also regardless of the patient's ability to pay the health care worker or service providers. Given that health care professionals through their oath to serve humanity are bound by the World Medical Association Declaration of Geneva to practice their profession with conscience and dignity, they should give emergency medical care as their humanitarian duty. In so doing, they will have respected the dignity of human life by helping to save it without any motives for monetary compensation[74].

2.7 Chapter Summary

The contention of this study therefore is that there is a need to develop an organised national emergency care system with a separate health fund for poor vulnerable groups in society since they are most affected when it comes to raising funds to pay for medical bills during emergencies. In conclusion, for the right to emergency medical treatment to be realised, there is a need for the State to ensure the availability, accessibility and quality health care systems are developed as this is the only way to alleviate the poor vulnerable groups from hefty payments when they seek emergency medical treatment. As a result, the next chapter will focus on the viability of a separate health fund in seeking to alleviate poor vulnerable groups from huge medical bills incurred when seeking emergency medical treatment in Kenya.

[73] Section 13(1)(a) of the Medical Act 1894 (WA) (Act)
[74] The International Code of Medical Ethics, 1949

Chapter Three: Establishing the Viability of a Separate Health Fund for Poor Vulnerable Groups in Society

Introduction

According to the World Bank, a person living in poverty is one who lives on $1.90 or less a day[75]. However, poverty is more than what level of income one belongs to. This is evidenced by the efforts of sustainable development goals in reducing and ending poverty in all its forms everywhere[76]. Since a more multidimensional approach on poverty[77] is accurate, it enriches the understanding of socioeconomic matters like access to health care which would have ordinarily been excluded in identification of the poor. Amartya Sen posits that one cannot draw a poverty line and then apply it across the board to everyone the same way, without taking into account personal characteristics and circumstances[78]. Being poor means having an income level that does not allow an individual to cover certain basic necessities, taking into account the circumstances and social requirements of the environment[79]. This also means that if a person has a level of income that does not allow them to access health care, they can be identified as poor.

3.1 Determining poor and vulnerable groups

In order to provide minimum protection to the poor through social assistance schemes, their proper identification is necessary. Therefore, establishing a criteria adopted for the poor vulnerable groups in Kenya is necessary. In a study conducted for the purposes of understanding poverty in Kenya, it was established that being poor in terms of resources means not having access to or power over resources that can be used to sustain a decent living standard and improve one's life[80]. Additionally, both material and immaterial resources affect the capability of a poor vulnerable person[81] to access social services and infrastructure that greatly influence their right to access quality healthcare[82].

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[75] -https://www.worldbank.org/en/topic/poverty/overview on 23 September 2020.
[76] -https://www.un.org/development/desa/disabilities/envision2030-goal1.html on 23 September 2020.
[77] Wagle U, Multidimensional poverty measurement: Concepts and Applications, New York, 57.
[78] Sen A, Development as Freedom, New York: Oxford University Press, 1999.
[79] Sen A, Development as Freedom, New York: Oxford University Press, 1999.
[80] Vidya Diwakar and Andrew Shepherd, Understanding Poverty in Kenya, A multidimensional analysis, Report December 2018, 11.
[81] Sida, Perspectives on Poverty, 2002, 23.
[82] Dimensions of Poverty, Sida's Conceptual Framework, 2017.

A home-grown pro-poor health financing policy is appropriate for identified poor vulnerable groups since poor access to health services inhibit their ability to exercise their right of access to emergency health care as envisioned by Article 43 of the Constitution of Kenya, 2010.

3.2 What is the best way to operationalise identification of the poor?

In delivering universal health coverage for poor vulnerable groups, proper targeting of these groups is essential since proper identification of groups in need will consequently translate to efficient delivery of health coverage to the targeted population. In this regard, the necessity of analysing the processes of identifying poor vulnerable groups arises. Drawing insights from the Cambodian national poverty identification system[83], a standardised procedure for identification of poor households[84] is essential in assessing the targeted vulnerable groups in order to provide services effectively. Identification plays a major role in providing access to health care in that it provides a criteria for eligibility for the health initiative and without it, anyone who claims to be poor can access the benefits of this initiative and potentially lock out people who need it more[85]. Additionally, when targeting poor and vulnerable groups, the poorest individuals were identified through household assessments. These relied on a community-based targeting approach where a combination of targeting techniques were used to reduce significantly the possibility of leakage to the non-poor at the expense of the real poor[86]. Drawing from the Cambodian national poverty identification system, it is clear that when operationalising identification of the poor, individual assessments are key since they are best to appropriately qualify target groups based on household poverty status[87]. In as much as different sets of criteria for identification of the poor exists, the most appropriate criteria should have a strong correlation with poverty, be easily observable, verifiable by a third-party and immune to manipulation by applicants[88].

Since the main aim of the separate health fund for poor and vulnerable is to remove as much as possible the multiple barriers that are faced by the poor when it comes to accessing emergency medical treatment, this study proposes a pro-poor health financing policy that is

[83] Leave no one behind: Insights from Cambodia's national poverty identification system, Federal Ministry for Economic Cooperation and Development, German Health Practice Collection, December 2017
[84] _< https://www.giz.de/en/worldwide/17300.html> on 23 September 2020.
[85] -https://www.giz.de/en/worldwide/17300.html on 23 September 2020.
[86] Leave no one behind: Insights from Cambodia's national poverty identification system, Federal Ministry for Economic Cooperation and Development, German Health Practice Collection, December 2017
[87] Leave no one behind: Insights from Cambodia's national poverty identification system, Federal Ministry for Economic Cooperation and Development, German Health Practice Collection, December 2017

[88] Devereux 2002

compatible with user fees. This financing policy has to be home grown to ensure that the assistance offered really fits the specific needs of the poor and vulnerable leading to a significant outcome. Identification of the poor and vulnerable groups[89] is therefore very central in making sure that the resources go to as many of the poor as possible. It further enhances the delivery of universal health coverage to citizens as it is intended to increase coverage for poor and vulnerable people. Therefore, establishing the poor and vulnerable through a home grown standardised system is the key to inclusion of those of who really need these services more than others. Furthermore in order to fully understand the necessity for the introduction of this health fund to promote access to the right to healthcare, we must first establish the link between poverty and vulnerability and how it affects access to emergency medical treatment in Kenya.

3.3 A case for poor vulnerable groups.

Establishing the link between poverty and vulnerability is essential in this case as it provides for an understanding of the effect of poverty on access to healthcare. Being poor and vulnerable inhibits the ability of a person to access emergency health care especially when the subject lacks insurance. The introduction of a health fund for such groups of people is essential in removing the myriad of barriers faced by the poor. Making the effort to create a waiver system for such groups is not only a matter of strategic self-interest but also moral obligation since poverty affects the ability and capacity of the vulnerable to cope with risks that arise when they require access to emergency medical care. In developing a home grown health equity fund that includes special measures for the poor and vulnerable in our society, it is essential to identify those who are eligible for this initiative. Two key elements stand out in identifying vulnerable individuals. The first element is an expected well-being below the poverty line and the second element is a relevant risk of falling into poverty[90]. The classic definition of a poor person being one who lives using a dollar or less[91] does not cover other aspects of poverty. This is because poverty is more than just the lack of income. A multidimensional approach towards poverty is essential in the identification process of those who are vulnerable in society. Apart from the classic definition of a poor person, we must establish other factors that may inhibit their access to medical treatment. These include poor infrastructure like roads and well equipped hospitals that are essential in providing this service.

[89] Vidya Diwakar and Andrew Shepherd, Understanding Poverty in Kenya, A multidimensional analysis, Report December 2018, 11

[90] Gallardo M, Identifying Vulnerability To Poverty: A Critical Survey, Journal of Economic Surveys (2018) Vol. 32, No. 4, pp. 1074–110

[91] Sen A, Development as Freedom, New York: Oxford University Press, 1999.

3.3 A home-grown pro-poor health financing policy

Health determines an individual's capacity to operate which eventually rubs off on the nation[92]. As per the World Health Assembly resolution of 2005 on UHC, the recommendation that states design health financing systems that do not cause financial hardship on citizens while providing quality and effective access to health care was established[93]. Poverty affects the capacity of individuals to cope with risks that may arise from lacking access to resources that can be used to sustain their needs. Poor access to health care services usually inhibit an individual's ability to exercise their right of access to emergency medical treatment and hence arises the need for a health equity fund for the poor and vulnerable[94]. This study proposes a health equity fund policy that targets the poor and vulnerable. The fund abolishes user fees for those properly identified using the home grown identification criteria and provides for special health insurance provisions which in effect increases the coverage of effective emergency health services for poor and vulnerable groups[95]. The establishment of a separate health equity financing policy for the poor and vulnerable is viable provided that the identification criteria is appropriate and home grown as this is the only way it will be tailored to the needs of Kenyans.

3.4 Examining the methods of encouraging contributions

In a bid to encourage contributions to the health fund, we carefully examine methods that may yield fruit and these include incentivising employers in the informal economies and creating awareness in the community to encourage payment among others.

3.4.1 Incentivising employers in informal economies.

Ever escalating health care costs have proven to cause difficulty in solving the health care challenges arising in the country. This is either due to financial or political challenges that the state has. Given that the uninsured have reduced access to health care services, solving this problem creates a moral crisis with political consequences[96]. The government can provide incentives to the employers of the poor and vulnerable in society to minimise the financial burden that is incurred by these individuals. Studies exist which show that there are major challenges in encouraging informal sector workers to enrol in health insurance programs[97]. Universal health coverage is a complex

[92] Yunusa U, Irinoye O, *et al*. Trends and challenges of public healthcare financing system in Nigeria: The way forward. 4 Journal of Economic Finance 2014, 28-34.
[93] _< https://www.who.int/health_financing/HF%20Resolution%20en.pdf.> on 28 November 2020.
[94] Swedish International Development Cooperation Agency
[95] Brazil, Delivering Universal Health Coverage, 1988
[96] Dallek G, States Face Pressing Health Care Problems
[97] Reich M, Harris J, Ikegami N, Maeda A, Moving towards universal health coverage: lessons from 11 country studies

process that is fraught with challenges and various pitfalls but it is also feasible and achievable[98]. Therefore, the government should subsidise the contributions of such individuals through transfers to the health equity fund[99]. Given that the movement towards universal health insurance is a long term policy engagement that requires both technical expertise and political will, providing incentives to workers in the informal sector to enrol in this health equity fund is best as such a technical solution will have to accompanied by a pragmatic [100]strategy for inclusion of poor and vulnerable groups in the society.

3.4.2 Community's role in encouraging payment.

A study conducted in Indonesia on enrolment of informal sector workers in the national health insurance system determined that there are three main factors that influence the decisions of informal sector workers to join the national UHC system[101]. These include, their health conditions, their family, peers and existing knowledge and experience[102]. From this, it is evident that there is a feasible route for expanding universal health coverage among workers in the informal sector by maximising the influence that their leaders have. If the local leaders encourage informal sector workers to enrol for universal health coverage programs, it will be easier for the poor and vulnerable individuals to apply for the health equity fund where they will be able to receive emergency medical treatment.

3.4.3 Societal values and effecting access to emergency treatment via UHC

The societal values in a community may also influence the willingness of its individuals to enrol to the health equity fund for the poor and vulnerable. For instance, in the study conducted in Indonesia, one of the main factors that influenced the decisions of workers in the informal sector to join the national health insurance system was family values

[98] Dartanto T, Enrolment of informal sector workers in the National Health Insurance System in Indonesia: A qualitative study

[99] I. Vilcu, L. Probst, B. Dorjsuren, I. Mathauer, Subsidized health insurance coverage of people in the informal sector and vulnerable population groups: trends in institutional design in Asia, International Journal for Equity in Health

[100] The Lancet, Moving towards universal health coverage: lessons from 11 country studies

[101] Dartanto T, Enrolment of informal sector workers in the National Health Insurance System in Indonesia: A qualitative study

[102] Agustina, T. Dartanto, R. Sitompul, K.A. Susiloretni, Suparmi, E.L. Achadi, Universal health coverage in Indonesia: concept, progress, and challenges, _< http://www.ncbi.nlm.nih.gov/pubmed/30579611> on 28 November 2020.

and peers[103]. The effect of running promotional campaigns will in turn change the perception of the communities towards universal health coverage as it will promote societal values of family and togetherness. Therefore, the distorted view on the benefits and costs of the health equity fund will be reverted as individuals will see that it helps them in the long run[104] as such strategies to extend coverage in predominantly vulnerable groups will help to address the challenges of inequity that are prevalent.

3.5 Chapter summary

In conclusion, the viability of a separate health fund for poor vulnerable groups in society is dependent on certain factors. These include a proper rationale for determining poor and vulnerable groups, identifying the best way to operationalise identification of the poor, examining the methods of encouraging contributions and tailoring the needs of individuals using the fund through a home grown pro-poor health financing policy as it is the only way Kenyans will get home grown solutions. In a bid to ensure maximum access to emergency medical treatment, all these factors need to be taken into consideration while developing the home-grown pro-poor health financing policy as they ensure equity while using the fund. Thus, this will be a major step towards achieving universal health coverage especially when it comes to accessing emergency medical treatment in Kenya. Consequently, the fourth chapter will analyse the challenges that may bedevil the separate health fund and how to solve or prevent them in order to ensure access by all while seeking emergency medical treatment.

[103] Agustina, T. Dartanto, R. Sitompul, K.A. Susiloretni, Suparmi, E.L. Achadi, Universal health coverage in Indonesia: concept, progress, and challenges, _< http://www.ncbi.nlm.nih.gov/pubmed/30579611> on 28 November 2020.

[104] I. Vilcu, L. Probst, B. Dorjsuren, I. Mathauer, Subsidized health insurance coverage of people in the informal sector and vulnerable population groups: trends in institutional design in Asia, International Journal for Equity in Health

Chapter Four: Analysing the challenges of reducing fraud while using the separate fund

Introduction

Like any other health fund, the separate home grown health financing policy has challenges that need to be addressed. Failure to do so would result in leakages in the fund that would cause those who really need the fund to lack means of obtaining access to emergency medical treatment. This chapter thus describes what constitutes health care fraud, the challenges that arise because of it, schemes used to defraud the health care system and how best to promote responsibility while using the fund.

4.1 What constitutes health care fraud?

Health care fraud occurs when a dishonest provider or consumer intentionally submits, or causes someone else to submit, false or misleading information for use in determining the amount of health care benefits payable[105]. It involves filing dishonest health care claims so as to make profits[106]. This criminal act may be perpetrated by either an individual or a company which defrauds an insurer or a government healthcare program. Such problems may arise when using the home grown equity fund that is intended to provide for access to emergency medical treatment to poor vulnerable groups. Thus, it is essential to determine what challenges may arise and how to solve them.

4.2 Schemes used to defraud the health care system

There are numerous schemes that are used to defraud the health equity fund that provides for access to emergency medical treatment. These include billing patients for services that have not been rendered, up coding of services, up coding of items, duplicate claims, offering unnecessary services, kickbacks and unbundling[107]. Up coding of services is the practice of billing for services that are more costly in comparison to the actual service rendered or procedure that was done[108]. For instance, a health care provider may charge a thousand shillings more for providing a service which ordinarily costs five hundred shillings. Up coding of items is the practice of billing a higher price for health care equipment. For instance, while using the fund, a health care provider may bill the equity fund for a power-assisted wheelchair for patient who required it after breaking her legs during an accident, while only providing the patient

[105] _< https://www.law.cornell.edu/wex/healthcare_fraud>_ on November 28 2020
[106] _< https://www.law.cornell.edu/wex/healthcare_fraud>_ on November 28 2020
[107] Racjzi A, The Ethics of Universal Health Insurance, 82. See also -< https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-016-0436-3> on December 4 2020
[108]

with a manual wheelchair. Duplicating claims is the practice where the health care provider charges the health fund twice for the same service or procedure rendered to a patient. Thus, the same procedure is billed twice in an effort to be paid twice. Regarding unnecessary services, a health care provider may render a service to a patient that the patient does not require in order to obtain profits from it. Also, when individuals provide false information when applying for the pro poor financing policy or using another person's insurance card they commit health care fraud.

4.3 How does fraud and abuse affect health care?

The major challenge that arises when health care fraud occurs is that the cost of such activities is passed on to the consumer who is the patient. This may hinder those who really need to access emergency medical treatment through this fund from enjoying its benefits. This happens because funds that would ordinarily be used to subsidise the poor vulnerable groups are channelled towards payment of fraudulent health care claims[109].

4.4 Best practices for health care providers to avoid fraud

One then asks, how do we promote responsibility while using the fund? First, the government should incorporate the enterprise risk manager (ERM) to the health fund that will be conducting a holistic audit to pre-empt risks that may arise. Enterprise risk management is defined as the process through which the management personnel and directors of an establishment strategically identify potential risks that may affect the establishment's objectives and how to mitigate such risks[110]. Establishing such measures can help in providing target risk areas that can be curbed before causing too much damage to the fund. Additionally, taking action on employees that are found to be engaging in fraudulent activities is another step that will deter fraud while using the health equity fund. Heavy punishment should be given to such individuals as a determent measure to set an example to others so that they are responsible while using the fund. Furthermore, if any health facilities providing access to the financing policy are found to be fraudulent, they should be suspended as they will be abusing the trust placed by poor vulnerable groups in safeguarding their interests, something that is against the values provided for in the Constitution of Kenya[111].

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[109] _< https://www.law.cornell.edu/wex/healthcare_fraud>_ on November 28 2020

[110] _< https://kfknowledgebank.kaplan.co.uk/risk-ethics-and-governance/risk/controlling-risk>_ on December 4 2020

[111] Article 10, *Constitution of Kenya*, 2010

The health care providers should maintain proper documentation of users of the fund, which should be regularly updated. Also, accurate billing of patients is paramount as it will be the only way of determining whether there are inflated medical charges. Health care providers should embrace the digitisation of their operations concerning the fund in an effort to curb fraud perpetuated by rogue hospitals.

4.5 Chapter summary

In conclusion, it is evident that like any other health fund, the home grown financing policy for poor vulnerable groups may have challenges. These challenges mainly arise from individuals or health care service providers who attempt to defraud the system in order to obtain profits. Thus, it is essential to mitigate any risks that may be pre-empted through the enterprise risk management system. Furthermore, the state should take measures in ensuring that billing records by health care service providers are audited regularly to promote transparency while using the emergency fund. Also, creating awareness of the consequences of fraudulent activities among individuals using the fund is essential as it may deter them from engaging in health care fraud. This is so since if they truly appreciate the value of the emergency fund and the benefits that arise from it, they would not want to compromise on a health coverage system that helps them in times of need.

Chapter Five: Findings, Conclusions and Recommendations

5.1 Introduction

The problem identified by this dissertation is that the right to access emergency medical treatment is violated in that health care providers discriminate on the patients' ability to pay. Therefore, citizens with funding challenges mostly lack the capacity to seek urgent treatment yet the state has a responsibility to ensure universal health coverage is accessible to all its citizens.

In this respect, the hypothesis of the dissertation was that the right to emergency medical treatment shall not be denied as guaranteed by the Constitution in Article 43 (2). The assumption of this study was that the lack of proper universal health coverage inhibits access to emergency medical treatment. In order to arrive at an answer the following questions were posed including: What constitutes emergency medical treatment? What is the role of universal health insurance in realising this right? What is the duty of various stakeholders in realising this right? What is the viability of a separate health fund for poor vulnerable groups? What is the viability of civic tools in enhancing the fund and thus enhancing the capacity to subsidise for poor vulnerable groups? What are the potential challenges of reducing fraud while using the separate health fund?

5.2 Findings

The right to emergency medical treatment unwittingly, is detached from the right to health care in the Constitution of Kenya[112]. Proper access to universal health coverage has a direct effect on the capacity to access emergency medical treatment in Kenya. In order to understand the link between universal health care and emergency medical treatment, one must first assess what constitutes emergency medical treatment and why universal health coverage is essential towards realising it. Furthermore, while making the case for universal health insurance, it was evident that different stakeholders in the healthcare sector have to work hand in hand in order to ensure the success of universal health care in promoting access to emergency medical treatment in Kenya.

[112] Article 43(2), *Constitution of Kenya* (2010).

The viability of a separate health fund for poor vulnerable groups in society is dependent on accurately identifying citizens who require these services through a home grown identification criteria for determining poor vulnerable groups and tailoring a home grown pro-poor health financing policy for the identified poor vulnerable Kenyans. The challenges of managing the health equity fund are mainly fraudulent ones and the government has to take measures to ensure that such fraudulent activities are avoided while using the fund. Education of citizens and health care service providers on the necessity for transparency and honouring the values espoused in Chapter six of the Constitution of Kenya should be paramount.

In conclusion, this study has proven the assumption that the lack of proper UHC inhibits access to emergency medical treatment to be true. Where UHC works properly, it significantly reduces the chances of citizens dying due to lack of access to treatment. After all my research I have deduced that my hypothesis was correct and the best way to deal with lack of access is to ensure proper working structures for UHC in Kenya.

5.3 Recommendations.

It is the obligation of the national government to provide policy and training, maintenance of standards and co-ordination mechanisms for the provision of emergency healthcare[113]. Kobusingye states that the goal of an emergency medical system should be to provide universal emergency care that is, emergency care should be available to all who need it. He equates ambulances to be the pre-clinical care. However, this is insufficient as the first aid in the ambulance will not stabilise the individual in a critical condition. In addition, there are mandatory components of an emergency medical system. This includes the prehospital care, personnel, equipment and communication, transport and health facilities. The medical practitioners should be highly trained in order to stabilise an emergency situation in the shortest time possible[114]. It is a matter of legal duty, as well as a moral obligation, to provide emergency medical treatment even in the absence of a deposit or fees[115]. This does not mean that the right to remuneration should not be observed[116]. It is prudent that both these rights are balanced to ensure that the separate health fund works for its citizens.

[113] Section 15(1)(z), *Health Act* (No.21 of 2017)
[114] Bulletin of World Health Organisation, Emergency medical systems in low- and middle-income countries: Recommendations for action, August 2005, 2.
[115] Anne H., Human dignity and fundamental rights in South Africa and Ireland, 2014, 36.
[116] Odour M. And Simiyu D, 'The Right to Emergency Medical Treatment in Kenya' *SSRN Journal* (2015), 10 https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2695134 on 14 December 2020.

In conclusion, the Government of Kenya has a duty to develop an organised national emergency care system tailored to the needs of Kenyans. In so doing, the legislative and policy formulation surrounding the realisation of the right to emergency medical treatment should be implemented. The government should also facilitate special training on emergency medical treatment for seamless provision of this service. Additionally, incentivizing the separate health fund through civic tools is a viable solution to enhance access to emergency medical treatment. The public authority needs to concoct dire proportions of padding private medical services suppliers through repayment for the expenses caused during and after the controlling of emergency clinical therapy to people who can't pay. The state should take measures in ensuring that billing records by health care service providers are audited regularly to promote transparency while using the emergency fund. Also, creating awareness of the consequences of fraudulent activities among individuals using the fund is essential as it may deter them from engaging in health care fraud.

5.4 Conclusion

The study is supported by the philosophy of Ubuntu and Rawls's theory of justice. Through the philosophy of Ubuntu, one cannot separate their humanity from another person. Therefore, even when it comes to saving lives, medical personnel have a moral obligation to offer emergency medical treatment in order to remove patients from life threatening situations. In implementing the theory of justice, one may be able to determine the criteria of admitting patients requiring emergency medical treatment with no bias on the patient's ability to pay. Even so, it will be able to admit patients seeking emergency treatment regardless of their ability to pay. The government should consider incentivizing the separate health fund for poor vulnerable groups in society seeing as the viability of the health equity fund requires political will from the government. Consequently, when it comes to seeking emergency medical treatment, it is the state's obligation to ensure that there is an efficiently working emergency medical system seeing as there is a need to facilitate and encourage emergency care of high quality[117].

The introduction of a complete legislative framework on emergency medical treatment regardless of an individual's ability to pay, by utilizing the universal health coverage system to

[117] Hirshon J, Risko N, Calvello E, "Health Systems and Services: The Role of Acute Care" *Bulletin of the World Health Organization* (2013) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3646345/ on January 2020.

combat the inhibitions of finances is proposed. The viability of a separate health fund for poor vulnerable groups in society is dependent on certain factors. These include a proper rationale for determining poor and vulnerable groups, identifying the best way to operationalise identification of the poor, examining the methods of encouraging contributions and tailoring the needs of individuals using the fund through a home grown pro-poor health financing policy as it is the only way Kenyans will get home grown solutions.

Bibliography

A. Books

Anne H., Human dignity and fundamental rights in South Africa and Ireland, 2014.

D M Chirwa, 'The Horizontal Application of Constitutional Rights in a Comparative Perspective,' (2006) *Law, Democracy and Development*.

Rawls J, 'A Theory of Justice', *Cambridge* (2005).

Summers J, Principles of Health care Ethics.

B. Chapters in Books

Summers J, Principles of Health care Ethics, Chapter 2.

C. Journal Articles

Chang Y, Abujaber S, Reynolds A, Camargo A, Obermeyer Z, 'Burden of Emergency Conditions and Emergency Care Utilization: New Estimates from 40 Countries' *Emergency Medicine Journal* (2015) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5179323/ on 15 January 2021.

Darlene R, Nyabera L, Yusi K and Rusyniak D, 'Descriptive study of an emergency centre in Western Kenya', *African Journal Emergency Medicine,* volume 4, March 2014.

David M, 'Medical ethics and payment of fees before treatment', *South African medical journal, Volume 101* (2011).

Eze M, What is African Communitarianism? Against consensus as a regulative Ideal", S*outh African Journal of Philosophy Volume 4* (2008).

Michelle Maiese, *Procedural Justice*, January 2004 http://www.beyondintractability.org/essay/proceduraljustice on 9 August 2017.

Odour M. And Simiyu D, 'The Right to Emergency Medical Treatment in Kenya' *SSRN Journal* (2015), 10 https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2695134 on 14 January 2021.

Tara Schofield, *Procedural Justice in the Workplace: Definition, Theory and Examples* http://study.com/academy/lesson/procedural-justice-in-the-workplace-definition-theoryexamples.html on 9 August 2020.

Yadav M, Right to Emergency Care: Consumer Court, 2011, http://medind.nic.in/jal/t11/i3/jalt11i3p248.pdf on 8 September 2020.

Yunusa U, Irinoye O, *et al*. Trends and challenges of public healthcare financing system in Nigeria: The way forward. *Volume 4 Journal of Economic Finance* (2014).

D. Conference Reports

Kenyan Healthcare Sector, Market Study Report: Opportunities for the Dutch Life Sciences & Health Sector, 2016.

E. Dissertation

Collins O, *No one shall be 'Denied Emergency Medical Treatment' in Kenya: Opportunities, Challenges and Strategies,* July 20, 2015, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2662417 on 26 September 2020.

F. Institutional Reports

Bulletin of World Health Organisation, Emergency medical systems in low- and middle income countries: Recommendations for action, August 2005.

Hirshon J, Risko N, Calvello E, "Health Systems and Services: The Role of Acute Care" *Bulletin of the World Health Organization* (2013) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3646345/ on January 2021.

Medical Practitioners and Dentists Board, *The Code of Professional Conduct and Discipline,* 2012.

Ministry of Health, *Kenya Health Policy*, 2012-2030.

Ministry of Health, *Kenya Health Policy,* 2014-2030.

G. Online Resources

'Eunice Kilonzo, 'Death After Arrival: Terrible emergency services are killing by the thousand' *Daily Nation*, 7 November 2017 http://www.nation.co.ke/health/Dead-afterarrival/3476990-4176182n522p3z/index.html on 13 December 2020.

'Gatonye G. and Mohamed H, 'How huge medical bills are crippling millions of families' *Standard Media Group*, 11 April 2017 https://www.standardmedia.co.ke/business/article/2001235904/how-huge-medical-billsare-crippling-millions-of-families on 9 August 2020.

Ethical Realism, 'Three Theories of Justice', 26 April 2011 https://ethicalrealism.wordpress.com/2011/04/26/three-theories-of-justice/ on 9 August 2020.

Kerketta L, 'Theory of Justice by Rawls: its criticisms by Martha C. Nussbaum and Amartya Sen', 9 September 2015 http://www.legalservicesindia.com/article/article/theory-of-justice-by-john-rawls-its-criticism-by-martha-cnussbaum-and-amartya-sen-1897-1.html on 9 August 2020.

H. Website

http://medical-dictionary.thefreedictionary.com/justice on August 2020.

I. Other Materials

Code of Federal Regulations 42 U.S.C

General Comment No. 14, the Committee on Economic and Social Rights

Kenya National Assembly Official Record (Hansard) 15 April 1998.