Reviewer's report

Title: Does the distribution of health care benefits in Kenya meet the principles of universal coverage?

Version: 1 Date: 11 September 2011

Reviewer: Viroj Tangcharoensathien

Reviewer's report:

Does the distribution of health care benefits in Kenya meet the principles of universal coverage?

Reviewer: Viroj Tangcharoensathien

General comments

This is an interesting piece of evidence from Sub-Saharan African setting (Kenya) on how government health budget benefit different group of population measured by expenditure quintiles and health needs (measured by self assessment health status) using two national representative household surveys in 2003 and 2007 and provides information on trend, as well as the application of concentration index and the standard methodology of Benefit Incidence Analysis (BIA). Effort to take into account health needs is appreciated in view of data limitation.

Major compulsory revision

There is a major methodological problem. The BIA is an assessment how government budget was consumed by different groups of population, in this case measured by rich and poor per capita household expenditure quintiles.

The basic formulae for BIA is the utilization rate per capita per annum for outpatient and inpatient at different level of care multiplied by appropriate unit cost per outpatient visit and per admission and then minus by the total out of pocket payment for health by households. This is the net benefit flows to different group of population, classified by rich poor quintiles.

Therefore BIA confines its assessment only to healthcare providers that received government budget allocation. If in the Kenyan health systems, the government neither allocates budget to private for profit sector nor to private not for profit providers; the authors cannot assess BIA in these two private sectors. If the government only allocate budget to public sector, then BIA only assess in this sector. There is therefore a need in the section of Kenyan health financing systems to spell out this very clearly.

It is very unlikely that governments in developing countries, including Kenya allocate budget to private clinics and hospitals; therefore services provided by private sectors are totally financed by household out of pocket payment, and a
small extent private voluntary insurance, which favour the rich who can afford to pay.

Therefore table 3 must be totally revised if this is the BIA results. However, Table 3 is useful. I understand that table 3 is the results of [utilization rate X unit cost] minus out of pocket payment at three types of providers, public, private not for profit, and private for profit. If this is true, the table should be called, distribution of total healthcare consumption by SE groups. And produce another table on BIA specific for public providers.

Prior to producing Table 3, there is a need, also very useful, to produce a new table on equity in utilization at three types of providers for OP and IP by consumption quintiles, including concentration index.

On data source; it was said expenditure data for the private sector were estimated from the household surveys. It is not clear how the author estimate unit cost for private for profit and private for profit using data from household surveys. There is a need to clarify this.

On data analysis, I agree to use the formulae for hospitals providing outpatient and inpatient care; that outpatient visits were converted into inpatient days by dividing by three, though the reference very old, and that relative cost of outpatient and inpatients may change significantly. This can be a weakness that should be highlighted in the discussion section. However, it is not clear on the methods used to estimate unit cost in private sectors, as well as problems in access to private sector financial data. However, this comment is not valid if the government did not allocate budget to private sector, then it is not appropriate to estimate BIA in private sectors.

The authors should be transparent by providing unit cost figures for outpatient and inpatients by different levels of public sector, as well as the household direct payment for OP and IP. As these intermediate figures are essential for the estimate of BIA

Minor Essential Revisions
On measurement of health need; it was said that good health (indicating no need for care) if they reported their health status to be very good or good; and poor health (indicating need for care) if they reported their health status to be satisfactory or fair. This means there are only four scale of self assessment of health status. Please clarify this

Level of interest: An article of importance in its field

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.
Declaration of competing interests:

Declared none