

Expanding Investments in Preventive Care: Policy and Legislative Facilitators to this Paradigm Shift

INTRODUCTION

Variations in health care services have been widely documented across the world. There is consensus that although per-capita expenditure on health remains a critical indicator in measuring various nations pursuit of good health, increased health care spending is not uniformly associated with improved health¹. For Countries and Counties to optimize health investment, there is need to pay attention to its investment details, including resource split to prevention, curative and rehabilitative services. This policy paper critically reviews key barriers to preventive health, and suggests policy solutions

Why preventive health now?

In recent decades, Kenya's population has rapidly grown, life expectancy improved and an ageing population started to emerge despite the fact that the majority of Kenyans are aged below 35. The disease profile has changed from a context where communicable diseases comprised a majority of priority diseases, to a new norm where communicable diseases, non-communicable diseases and injury all pose a big strain to the health system. The prevalence of chronic lifelong conditions continues to increase. All these are critical pointers that Kenya needs to prioritize investments in preventive health and classical Public Health interventions if it's to achieve universal health coverage². Studies have shown that in contexts like these, a failure to invest adequately in preventive health is likely to cause unsustainable increases in health costs. With most counties already investing about 30% of their budgets in health – despite having 14 devolved functions – and with continuous emerging needs for further investment in healthcare, and reducing donor funding, it is time to make a paradigm shift in health investments and ensure more elaborate investments in preventive health. Early investment in effective prevention would enhance good population health, reduce morbidity and mortality including from lifelong chronic illnesses and save resources in both healthcare and social services. A dollar invested in preventive health has been found to save 5 dollars in direct medical costs and up to 11 dollars on the overall costs, factoring in other potential losses like individual's productivity and caretaker costs. Despite this knowledge, investing in preventive care remains a big challenge to governments, both at national and sub national levels. Overall, countries that do not invest in preventive health spend much more per capita cost, in both direct and indirect costs, than those who invest in preventive health.

KEY ISSUES, CHALLENGES AND POLICY OPTIONS

Most Kenyan leaders, Policy makers, health managers, healthcare workers and communities agree to the slogan *Prevention is better than cure* - but that is as far as it goes. Investments in primary disease prevention remains low at individual, community, county, and national levels. This paper critiques key barriers to this investment and provides policy and practice options.

Expanding operational definition of preventive health in Kenya's health sector?

In recent decades, scientific and technological advances have rapidly expanded and accelerated understanding of disease causes, progression and transmission. This has resulted in innovative preventive, curative and rehabilitative approaches³. Once a preserve of classical public health

¹ Carolyn M. Clancy and Kelly Cronin, Evidence-Based Decision Making: Global Evidence, Local Decisions, Health Affairs Vol. 24, No. 1

² <https://healtheconomicsreview.biomedcentral.com/track/pdf/10.1186/s13561-021-00321-3.pdf>

³ Institute of Medicine. 2010. *Redesigning the Clinical Effectiveness Research Paradigm: Innovation and Practice-Based Approaches: Workshop Summary*. Washington, DC: The National Academies Press. <https://doi.org/10.17226/12197>.

interventions, disease prevention currently encompasses a wide range of activities – both clinical and non-clinical – that are aimed in some way to reduce the acquisition or transmission risk of any disease. With this expansion, most health managers perceive community level and primary health facility level interventions as preventive health, thus showing budgets as such. It is important to note that Community Health Volunteers in Kenya perform preventive, curative and rehabilitative work, and this is true for most levels of health care. As such, in identifying Kenya's investment in preventive health, there is a need for functional analysis. Evidence also shows minimum investment in classical Public Health interventions.

Perceptions and misconceptions on preventive health

Studies show that negative perceptions and misconceptions among policy makers, health decision makers and healthcare workers on disease prevention could result in lowered investments in the area. In this paper, we have given an indicative three perceptions and misconceptions that negatively affect preventive health and suggest policy options.

First and foremost, we note the misconception that increasing investment in disease prevention means there will be fewer resources available for treatment, leading to increased complications and death among patients. Also associated is a misconception that effective prevention could reduce patient flow numbers leading to job losses among treatment-based staff. These misconceptions fail to acknowledge the fact that better health potentially frees up resources for health care services by reducing avoidable health problems, thus allowing more investment in prevention, care, treatment and rehabilitation. Rather than reduce investments, preventive health has been found to allow the health sector to optimize the prevention and treatment investments since it's a cost-effective solution. For instance, effectively preventing diseases like malaria and diarrhoea at community level will cut off a large number of patients seeking healthcare at health facilities, thus freeing up time for the already overwhelmed clinicians and saving on other resources. This will allow better patient – clinicians interactions, this improves not just the quality of diagnosis for complex conditions, but also foster the patient clinician relationship, making health facilities more socially accountable.

Secondly, there is a general misconception that disease prevention interventions can only make sense if they save money within the health sector sphere. While some disease prevention interventions are cost saving in the immediate term and within the sector, it should be noted that there are wider and longer-term cross-sectoral benefits of disease prevention beyond health. A disease successfully prevented means more hours of productivity for would-be patients and their caretakers, alternative utilization of medical costs by families (especially off-pocket health spending) and a reduction of days learners are absent from school among other benefits. Improving school attendance has been found to have lifelong benefits to learners, their families and the broader national development agenda.

Last, despite population level evidence from studies and evaluations showing disease prevention as an effective tool, there remain perceptions among some health workers and decision makers that the evidence base on the effectiveness of health promotion and disease prevention interventions is weaker than that for treatment-based care⁴. We note that the Kenya Health Information System (KHIS) and other available health information tools do not capture preventive data in a way that allows attribution of various positive outcomes and specific prevention efforts. As such, most disease prevention practitioners rely on scientific studies to make arguments for investments rather than local data. There is however a wide base of data that proves the effectiveness and cost efficiency of disease prevention. There is therefore a need for continued

⁴ Policy Paper - Using economic evidence to help make the case for investing in health promotion and disease prevention

efforts to change negative misconceptions, perceptions and beliefs about preventive health interventions.

Measuring and presenting health outcomes

In recent years, evidence-based decision making has become a benchmark of best practice. With this, investments in healthcare have increasingly followed demonstratable outcomes. Apart from evidence from wider studies, various challenges face preventive health practitioners in presenting solid local evidence bases to convince policy makers on investment. The longer timeframes needed for most preventive health interventions to impact overall health outcomes, capacity gaps in preventive health care to accurately harvest outcomes and the population nature of preventive health outcomes – which are sometimes difficult to measure – remain key challenges in effective measurement of health benefits attributable to prevention. Much as most policy makers agree that for instance, hand washing has been an important component in COVID-19 prevention, it is difficult to quantify its contribution at local levels. What would have been the cost if this intervention was not taken up? What did this intervention really save? In addition to this, there are economic models that disadvantage preventive health. For example, the conventional use of discounting in economic analysis means that benefits appear less appealing the further into the future they occur, thus most preventive health interventions are disadvantaged, in contrast, many health care treatments have more immediate benefits that are not affected as much by discounting. We also note that Population interventions are impersonal and less attractive since they lack ‘identifiable victims’ while clinical many other interventions have this. Public health practitioners need to integrate social marketing approaches to give a human face to the potential beneficiaries of public health interventions, creating an image of a single individual who could benefit, and with whom decision-makers can identify – rather than a whole community or county. As such, there is a need to invest in improving measurements of outcomes for preventive health – both in human capacity as well as systems like the KHIS. Preventive health specialists need to integrate interventions with both short, medium term and longer-term results, and educate stakeholders on benefits of prevention – immediate, mid-term and long term.

Intersectoral Collaboration

Preventive health goes beyond activities done within the health sector. There is a wide range of activities and actions that promote and protect health that are delivered in other sectors outside the mainstream health system. Whilst in a few cases the mother sectors either underestimate or under-prioritize the importance of such interventions, the most common scenario is insufficient capacity in understanding and maximizing cross sectoral health benefits. Agriculture, education, physical planning, infrastructural development, water and sanitation as well as many other sectors directly drive health outcomes. In certain contexts, there are also fragmented funding structures for intersectoral activities. For instance, much as there are the current Kenya national sanitation function is delivered under the Ministry of Water, Sanitation and Hygiene, there still is a sizable sanitation workforce under the Ministry of Health. As such, there is a need to strengthen intersectoral collaboration in maximizing intersectoral benefits in preventive health. This collaboration should seek sectors to prioritize activities and interventions that pose benefits to health. There is a need to: a. Showcase non-health sector specific benefits associated with health promotion and disease prevention when making a case for investment; b. Identify potential shared objectives and goals and highlight ‘win-win’ situations for both sectors by investing in disease prevention; and c. Seek opportunities to co-locate relevant health and other sectors to help establish working relationships and trust.

CONCLUSION

Kenya's policy and legislative structures need to support optimal investment in disease prevention. In doing this, there is need to itemize and determine the level of funding spent on disease prevention, especially classical public health interventions; invest in changing negative misconceptions, perceptions and beliefs about preventive health interventions; invest in improving measurements of outcomes for preventive health – both in human capacity as well as systems like the KHIS; and strengthen inter-sectoral collaboration.