



## Health financing reform in Kenya – assessing the social health insurance proposal

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Kenya has had a history of health financing policy changes since its independence in 1963. Recently, significant preparatory work was done on a new Social Health Insurance Law that, if accepted, would lead to universal health coverage in Kenya after a transition period.

Questions of economic feasibility and political acceptability continue to be discussed, with stakeholders voicing concerns on design features of the new proposal submitted to the

Kenyan parliament in 2004. For economic, social, political and organisational reasons a transition period will be necessary, which is likely to last more than a decade. However, important objectives such as access to health care and avoiding impoverishment due to direct health care payments should be recognised from the start so that steady progress towards effective universal coverage can be planned and achieved.

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Since independence in 1963, Kenya has had a predominantly tax-funded health system, but gradually introduced a series of health financing policy changes. In 1989, user fees, or 'cost-sharing' were introduced.<sup>1</sup> User fees were abolished for outpatient care in 1990, inspired by concerns about social justice, but re-introduced in 1992 because of budgetary constraints. Until recently, these fees have remained, with their impact on access to health care the subject of several empirical studies.<sup>2-7</sup> The user fee system was significantly altered in June 2004, when the Ministry of Health stipulated that health care at dispensary and health centre level be free for all citizens, except for a minimal registration fee in government health facilities.

The most significant event since 1989 has been the government's interest in social health insurance (SHI). The purpose of the latter is to ensure access to outpatient and inpatient health care for all Kenyans and to significantly reduce the out-of-pocket health care expenditure of households,

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especially the poorest.<sup>8</sup> An intersectoral taskforce was established to prepare a national strategy and legislation as a first step in the preparation of Kenya's National Social Health Insurance Fund (NSHIF) (Ministry of Health, Nairobi, Kenya – National Social Health Insurance Strategy Report, prepared by the Task Force on the Establishment of Mandatory National Social Health Insurance, 2003 (unpublished), and Mboya T, Stierle F, Sax S, Muga R, Korte R, Adelhardt M – Towards establishing national social health insurance in Kenya. Ministry of Health, Nairobi, Kenya, and Department of Standards and Regulatory Services (GTZ), Eschborn, Germany, 2004 (unpublished)). Parliament passed the NSHIF Bill in December 2004, but the president decided it still needed amendments and returned it to parliament for debate.

The implementation of a well-run and effective NSHIF will be a formidable challenge. The main objective is nothing less than granting all population groups, including the poor, access to a comprehensive benefit package of health services.

### Key design features of the proposed NSHIF

When evaluating the proposed NSHIF, we have assessed the Kenyan government policy discussion papers, notably the *Sessional Paper on National Social Health Insurance in Kenya* (Sessional Paper) and the *National Social Health Insurance Fund Bill* (Bill).<sup>9,10</sup> Unless otherwise stated, figures used are from these documents.

To assess the expected performance of the NSHIF in Kenya, we applied a conceptual framework developed to monitor and evaluate progress in social health insurance implementation.<sup>11</sup>

The World Health Organization (WHO) stated that 'the purpose of health financing is to make funding available, as well as to set the right financial incentives for providers, to



ensure that all individuals have access to effective public health and personal health care'.<sup>12</sup> Hence we evaluate how well the NSHIF is expected to perform in relation to the following health financing targets: (i) resource generation (sufficient and sustainable); (ii) optimal resource use; and (iii) financial accessibility of health services for all.

Performance in relation to these targets is assessed against the three broad functions of health financing, viz. revenue collection, pooling and purchasing.<sup>13</sup> Revenue collection is the process by which the health system receives contributions from households, enterprises, government and other organisations including donors. Pooling is the accumulation and management of these revenues in order to spread the risk of payment for health care among all members of the pool. Purchasing is the process by which these pooled contributions are used to pay providers to deliver a set of specified or unspecified health interventions.

For each of these functions, key performance issues are identified and related to the realisation of health financing targets (Table I). Using this framework, performance of the NSHIF in these health-financing functions is evaluated through easily measurable indicators.

### Application to the proposed health financing reform in Kenya

The following assessment of expected performance of the new NSHIF rather than performance of the current NHIF is largely based on a series of six technical mission reports (TMRs) that resulted from advisory missions<sup>14</sup> between 2003 and 2004.

#### Revenue collection

**Population coverage** (rationale: to maximise the number of people with improved financial protection).

*Performance indicator:* Percentage of population covered by SHI. The NSHIF intends to systematically enrol the entire

population over a transition period, taking 9 years following implementation. Kenyan policymakers recognise that revenue collection from the self-employed is less straightforward than from the employed, although international experience suggests that 9 years remains a too-optimistic timeframe.<sup>15,16</sup>

Subsequent reports envisaged more gradual transitions to universal coverage, with coverage levels at 60 - 80% 9 years after implementation (TMR No. 6). Rapid inclusion of the poor, however, is seen as a priority in the Sessional Paper, despite debate on the best way to finance this.

**Method of finance** (rationale: to ensure adequate financial protection for SHI members).

*Performance indicator:* Ratio of prepaid contributions to total costs of the SHI benefit package. This ratio should be close to 100%, with the NSHIF financed through members' contributions (income-rated for employees and employers, flat-rated for the self-employed), and government contributing on behalf of the poor. Contributions will be set so the NSHIF can cater for the complete cost of a comprehensive benefit package in all public, all mission and most private facilities. This is a response to the current NHIF's limited financial protection. A radical change is expected, with 75% of total health expenditure to be financed through the NSHIF and the Ministry of Health, compared with 44% in 2002.<sup>17</sup>

Contribution setting has been sensitive to concerns of adverse effects on employment and compliance, with caps on contributions and lower flat-rate fees for dependents from larger households (TMR No. 6). Penalties for self-referral and minimal registration fees of 10 - 20 KSh at the outpatient level to help counteract potential moral hazard behaviour have also been suggested (TMR No. 3).

*Performance indicator:* Percentage of households with catastrophic spending. By including all of the poor within the scheme and offering a more comprehensive benefit package, the NSHIF is expected to improve access and be more effective in reducing

**Table I. Health financing functions and targets**

Health financing functions and key performance issues	Health financing targets		
	Resource generation (sufficient and sustainable)	Optimal resource use	Financial accessibility of health services for all
Revenue collection	X		X
Population coverage	X		X
Method of finance	X		X
Pooling	X	X	X
Composition of risk pool/s	X		X
Fragmentation of risk pooling			X
Management of risk pool/s		X	
Purchasing		X	X
Benefit package		X	X
Provider payment mechanisms		X	
Administrative efficiency		X	



catastrophic spending. This contrasts with the NHIF, where a recent study demonstrated that 10% of households using health services faced catastrophic expenditures in 2003, with the NHIF not reducing catastrophic expenditures.<sup>7</sup>

## Pooling

**Composition of risk pool** (rationale: to limit problems of adverse selection).

*Performance indicator: Is membership compulsory in all/some contributing population groups?* NHIF membership is compulsory for all employees and their dependents but voluntary for the self-employed. With the new NSHIF, membership will ultimately be compulsory for all, but voluntary for the self-employed during a transition period. Policies are being considered to ensure that not only high-risk individuals enrol into the scheme.

*Performance indicator: What percentage of each contributing group is covered by SHI?* For private employees, and to a lesser extent public employees, the main reason for coverage not being 100% immediately will be compliance. Measures to improve compliance are based on improving information exchange with business-registering authorities for registration, and with tax revenue authorities for contribution collection (TMR No. 2). For the self-employed and their dependents, coverage targets were initially 60% after 5 years, although more gradual implementation has been analysed (TMR No. 6).

*Performance indicator: Are dependents of contributing groups compulsorily insured?* Dependents will be compulsorily insured, as is the policy with the current NHIF. To help tackle fraud each individual above a minimum age will have his/her own membership card (TMR No. 2).

**Fragmentation of risk pooling** (rationale: to minimise horizontal inequities).

*Performance indicator: Multiple risk pools? If yes, are there risk-equalisation measures in place?* The NSHIF will operate as a single risk pool, with all members entitled to the same benefit package thus avoiding fragmented risk pools. Health maintenance organisations (HMOs) will continue to play a role in financing the health system, by providing top-up supplementary health insurance. Despite the single risk pool, fragmentation may still be implicit because of variation in provider quality. Indeed, in the case of the current NHIF, membership and access to health services is lower in poorer, more remote geographical provinces. To limit disparities between the services offered in public and private facilities, public facilities will continue to receive partial subsidisation from the Ministry of Health for a number of years, for personnel costs and large infrastructure investments (TMR No. 3).

**Management of risk pools** (rationale: to enhance technical efficiency).

*Performance indicator: Are there efficiency incentives for the management of risk pools?* Local branch offices are expected to

have increased autonomy for claims processing and dealing with informal sector workers and their families. But there has been little discussion on policies to ensure that local branch offices actively engage in advocacy to speed up coverage, and to monitor and contract with providers (TMR No. 2).

## Purchasing

**Benefit package** (rationale: to ensure that adequate health care services are received)

*Performance indicator: Is the benefit package based on explicit efficiency and equity criteria?* A comprehensive standard benefit package (SBP) is being developed for health services at each of the 5 levels in Kenya (these are: level I – dispensary, level II – health centre, level III – district/sub-district hospital, level IV – provincial hospital, and level V – national referral and teaching hospital). For certain services, notably long-term care, patients may have to co-pay, although less than is currently paid out-of-pocket. Excluding certain services, such as orthopaedic appliances, and limited mortuary storage time, has also been discussed. Services for HIV/AIDS and tuberculosis will be included but accounted for separately and potentially co-financed initially through external mechanisms and non-governmental organisations (NGOs). Health facility-based preventive care will be included, although other preventive and health-promotion services will be under the remit of the Ministry of Health (TMR No. 3). Exclusions and/or greater levels of co-payment seem to be based purely on cost-containment reasoning rather than explicit efficiency or equity criteria.

*Performance indicator: Are monitoring mechanisms – patient appeal mechanisms, full information on claimant rights, peer review committee and claims review – in place?* General sensitisation of the population on the benefits offered by membership is underway (TMR No. 5). Active involvement of the population in the running of the NSHIF, along with an Appeals Tribunal, was originally planned, but is no longer viewed as necessary. Appointment of an independent ombudsman has also been offered as a monitoring mechanism (TMR No. 3).

**Provider payment mechanisms** (rationale: to ensure good-quality care is provided at the lowest possible cost).

*Performance indicator: Do provider incentives encourage the appropriate level of care?* A flat rate remuneration per inpatient day (daily payment) has been proposed. For outpatient care, a flat fee per visit (case payment) will be paid to providers. These mechanisms were chosen for their ease of administration and resemblance to current practice. Suggested remuneration levels are 1 500 - 2 500 KSh per inpatient day and 100 - 400 KSh per outpatient visit (TMR No. 2), estimated to cover the complete cost of the benefit package plus an extra allowance for improved quality and infrastructure development. Reductions in fee levels may also be considered in the short term if facilities cannot provide the full benefit package.



Both methods create an incentive to treat patients at the lowest possible cost; this is beneficial for cost containment, but may lead to lower-quality treatment. This perverse incentive will be addressed by basing provider reimbursement levels on adherence to a set of health standards defined in the Kenya Quality Model (Mboya T, Stierle F, Sax S, Muga R, Korte R, Adelhardt M – Towards establishing national social health insurance in Kenya. Ministry of Health, Nairobi, Kenya, and GTZ, Eschborn, Germany, 2004 (unpublished)) (TMR No. 2). Daily payment for inpatient care may lead to supplier-induced lengths of stay that could be addressed through reduced rates after the first few days to discourage excessive stays, and monitoring by local branches.

**Administrative efficiency** (rationale: to enhance technical efficiency).

*Performance indicator: Percentage of expenditure on administrative costs.* Administrative costs and reserves will not be permitted to exceed 8% of total NSHIF expenditures. Investments in new health facilities and expensive equipment will be excluded from the NSHIF's remit. These are a response to major criticism of the NHIF, which in the past spent more than 25% of its budget on administration and 53% on investments.

**Financing of the NSHIF**

**Financial projections – feasibility of alternative contribution scenarios**

Different financing options have been explored through the use of SimIns (using version 2 which is available via both the WHO and GTZ websites), a health insurance simulation model. Table II illustrates required government contributions, given

different contributions from the salaried sector and assuming a more realistic implementation scenario (for a broader range of different expansion scenarios, the reader is referred to TMR No. 6 and TMR No. 3).

These results demonstrate that government contributions can be lower than the Sessional Paper recommendations in the early years of NSHIF implementation. This is due to only partial autonomy of government health facilities and with lower population coverage of the self-employed (whose contributions are partially cross-subsidised by the salaried sector). But in later years required government contributions will have to be at levels consistent with the Sessional Paper, with the government needing to make more difficult trade-offs between health and non-health sector allocations.

**Areas of recent debate**

**Contributions from government tax revenues**

The Sessional Paper stressed that earmarked taxes should contribute 11 billion KSh (2001 figures). Maintaining some government contributions was seen as imperative, given that contributions from the salaried sector would not be fully able to cross-subsidise the poor. Timing of government contributions has been an important concern, however, including whether the government should wait for an improved macro-economic situation and whether the quality of health facilities should first be improved.<sup>16,18</sup>

**Contributions from employees and their employers**

Initial projections of the sources of finances for the NSHIF assumed that it would be possible to use medical allowances paid to civil servants and teachers, known as payroll

**Table II. Required government support for different contributions from the salaried sector (moderate population expansion scenario)**

	Years following implementation:				
	+1 year	+2 years	+3 years	+6 years	+10 years
<b>Population expansion scenario</b>					
Coverage					
Total population coverage (%)	26	34	45	53	62
Exempted population coverage (%)	12	20	30	30	30
<b>Required government contributions</b> (KSh billion, 2004 prices, with % of general government expenditure in brackets)					
Employee/employer contributions (% of salary)					
2.9 + 2.9	2.1 (0.69)	5.6 (1.77)	11.3 (3.41)	16.1 (4.24)	30.3 (6.70)
3.5 + 3.5	0.5 (0.17)	3.9 (1.23)	9.4 (2.84)	13.7 (3.61)	27.3 (6.03)
4.5 + 4.5	0.0 (0.00)	1.0 (0.32)	6.3 (1.90)	9.8 (2.58)	22.4 (4.95)
Less ART provision*	-1.0	-1.6	-2.4	-3.9	-6.6

\*In this case, the non-poor pay a 50% co-payment for antiretroviral treatment (ART). The poor remain fully covered.





harmonisation. Following opposition by concerned groups that view these allowances as part of their income, alternative policies based on paying a slightly higher rate contribution were analysed. Capping of contributions was also suggested to avoid some high-income earners contributing greater amounts than needed to secure private health insurance.

## Reimbursement of patients visiting high-cost private hospitals

To maximise choice of provision for the insured, it has been proposed that patients may visit one of 11 'high-cost' private hospitals, but with the NSHIF reimbursing only up to the amounts paid for public, mission and other private facilities. Such patients would meet the balance of expenses through out-of-pocket spending or private top-up insurance (TMR No. 6).

## Organisation of the NSHIF

The NSHIF Bill requires an adjustment in the structure of the insurance organisation. A key component of this structure is a reformed Board of Trustees, including representatives from civil society, which appoints a Chief Executive Officer (CEO) who is responsible for defining the detailed vision and strategy of the NSHIF.

New departments have also been proposed, namely:

1. Fraud and Investigation, to check the NSHIF's financial activities, and to report directly to the Board of Trustees and ensure transparency and accountability of the NSHIF.

2. Controlling, to focus on implementing procedures to check budget allocations within the NSHIF departments.

3. Information Technology, to computerise and improve operations, contracting and quality assessment.

4. Marketing, to develop and implement the communications strategy of the NSHIF.

5. Benefits and Quality, to define: (i) standards of health services for NSHIF members at each level of care; and (ii) the criteria for assessing the quality of health service delivery at individual health facilities.

6. Contracting, to facilitate negotiations on provider payment methods and levels.

## Initial response to the social health insurance proposal

Stakeholders outside government have expressed their concerns with the NSHIF proposal (Table III), and potential solutions to some of these concerns have since been addressed in the various TMRs. Although concerns from the other stakeholders remain, the media consulted suggests that most stakeholders other than the health maintenance organisations (HMOs) have been supportive of the Bill.

## Challenges in implementation

Implementation is facilitated through experience with the current NHIF. But it is imperative that the NSHIF be seen as a

**Table III. Summary of stakeholders' responses to the NSHIF**

Stakeholders	Initial responses
Health maintenance organisations	Private medical schemes and the quality of private care would suffer Equal NSHIF benefits will be to the detriment of the middle class Concern about government inefficiency and corruption Higher contributions based on the payroll will lead to job losses Insufficient information on the NSHIF and its cost The poor should rather be protected via a direct budgetary allocation from the Ministry of Health
Federation of Kenyan Employers	Concern about paying higher contributions for their employees' health insurance Fear of strife in the labour market due to a reduction of employee benefits
National Nurses Association of Kenya Kenya National Union of Teachers Kenya Medical Association	Opposition to medical allowances being abolished
Central Organisation of Trade Unions Kenya Manufacturing Association Kenya Medical Association	Concerns about governance for the NSHIF
Health and HIV/AIDS Development Partner Working Group*	Concerns about transition to full coverage, particularly enrolment and provision of preventive services for the poor, slow process of consultation with key partners and insufficient attention to preventive health services and primary health care
Christian Health Association of Kenya Kenya Catholic Commission for Health and Family Life	Agreement with the vision of NSHIF

\*See Donor Coordination Group (DCG) Demarche Points, Health and HIV/AIDS Development Partner Working Group, 30 June 2004, Nairobi, Kenya (unpublished).



new policy direction, given the criticism of the NHIF by several stakeholders. Testing new procedures on representative pilot region/s before they are introduced on a larger scale has been suggested. Working groups for core tasks of the NSHIF (TMR No. 2) have been set up. Progress has been made on training NHIF staff and the registration process, but much less has been done on tasks such as identifying the poor and revenue collection in local branch offices. A fuller evaluation of progress can be found in TMR No. 5.

### Which way next?

This article has assessed the NSHIF proposal in terms of key performance issues. Questions of economic feasibility and political acceptability continue to be discussed, with different stakeholders voicing concerns on a number of design features. For economic, social, political and organisational reasons, a well-prepared transition period that may last more than a decade will be necessary. However, objectives related to accessing health care and avoiding impoverishment due to direct health care payments should be recognised from the start so that steady progress towards effective universal coverage across the population can be planned and achieved.

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