REPUBLIC OF KENYA

MINISTRY OF HEALTH

SESSIONAL PAPER No. 2
on
National Social Health Insurance in Kenya

April, 2004

Theme: Providing Quality healthcare to all Kenyans

DSRS

Executive Summary

The Sessional Paper on National Social Health Insurance in Kenya contains the proposed social health insurance reforms which the government will put in place as from 1st July, 2004 to ensure access to quality healthcare to all Kenyans.

The existing healthcare financing arrangements is based on the design that majority of people can afford to pay medical care at the point and time of treatment. This is not feasible in a country where 56% of the population lives below the poverty line. The high level of out-of-pocket financing, which includes cost-sharing sustains and exacerbates poverty among Kenyan households. In view of this widespread poverty in the country, there is need to reduce healthcare burden on households, ensure equity and access, and improve quality of health services.

The proposed social health insurance reforms will ensure that every Kenyan pays small regular contributions to the National Social Health Insurance Fund before an illness occurs. When illness occurs, Kenyans will not pay medical care at the time and point of treatment. The National Social Health Insurance Fund will pay all the bills to Health Providers. The benefits package will include out-patient and in-patient care. The Ministry of Health will re-direct the use of resources allocated to it through the regular budget to intensify disease prevention activities, improve quality of health services in public health facilities, build new health facilities and strengthen compliance to health standards by all health providers.

Based on more than two years [2001-3] of sustained research and development by the Ministry's Department of Standards and Regulatory Services (DSRS) with in-put from an Inter-sectoral Task Force established by the Minister for Health, technical assistance by the World Health Organization together with the German Development Agency (GTZ), this Sessional Paper contains the following proposed institutional and legislative reforms:

(i) That the National Hospital Insurance Fund Act should be repealed and replaced with new legislation capable of facilitating the provision of healthcare to all Kenyans irrespective of their age, social, or economic status.

(ii) That there should be a new law to facilitate the establishment of a National Social Health Insurance Fund and to ensure that it is run competently and efficiently.

(iii) That detailed research is required to be undertaken to accurately segregate the various categories of healthcare providers from whom Kenyans seek medical treatment, especially since all of them, including traditional medicine practitioners, will seek reimbursement from the Fund once established.

(iv) That it is necessary to put in place a Health Insurance Act to regulate and supervise all health insurance schemes, including those offered by Health Management Organizations, particularly to ensure that Health Management Organizations operate as either as health insurers or health service providers but not both.

(v) That there is need for a detailed and continuous research to ensure realistic and feasible benefits package which is responsive to changing health needs of the population.

(vi) That for the long-term effectiveness of the proposed scheme, there need for the following to be in place:

a. Traditional Health Practitioners Act

b. Constitutional provision guaranteeing a Right to Health, whic should be implemented through a mandatory National Soci Health Insurance Scheme, and the Office of the Director Gener of Health.

c. The Office of the Director General of Health to be established a a Constitutional Office to ensure full implementation an enjoyment of the Constitutional right to health.

(i) That no service provider should be contracted under the propose scheme unless:-

i. such provider is regulated under the relevant laws governing the practice.

ii. Their services meet the quality and safety standard as prescribe by the Ministry of Health or such other body as may be mandate by the Ministry for the purpose.

iii. Are recommended to the Council by their professional bodies.

The Guiding Principles of National Social Health Insurance in Kenya are:

i. NSHI shall contribute to the vision of the Kenyan MOH to create an enablin environment for the provision of sustainable quality healthcare that is acceptable affordable and accessible to all Kenyans.

ii. It will be compulsory for every Kenyan and every permanent resident to become member through enrolment and payment of a subscription.

iii. Since not everybody is deemed to be able to pay contributions to the NHSIF, it is the policy of the Government to subsidize the poor by earmarking at least 11% of total expected revenue from consumption taxes to be paid into the NSHIF.

iv. The NSHIF will be guided by a community spirit of solidarity. It must enhance risk sharing among income groups, age groups, and persons of different health status, and residing in different geographical areas.

v. The NSHIF shall promote maximum community participation through a process of representation from the village upwards to the National Council. The NSHIF will be owned by the stakeholders.

vi. The NSHIF shall build on existing community initiatives for registration procedures, contribution collection and human resource requirements.

vii. The NSHIF shall balance economical use of resources with quality of care. It shall provide effective stewardship, fund management, and maintenance of reserves.

viii. All the money received through contributions and other means minus minimum administrative costs and reserves shall be returned to the insured in the form of improved health service provision.

ix. The NSHIF shall assure that all participating healthcare providers are responsible and accountable in all their dealings with the Fund and its members.

x. The Government, for the time being, will continue to pay for the wages and salaries in the public health sector. The medium-term goal (5 to 10 years) for the NSHIF shall be to cover all recurrent expenditure related to health service provision including personnel costs. In addition, the goal is for infrastructure investments to become co-financed by both the Government and the NSHIF.

Finally, a communications strategy for all concerned stakeholders and for all population groups is key to the efficiency and effectiveness of the scheme.

CHAPTER 1
BACKGROUND

1.1 Introduction

One of the major development objectives of the government is to provide effective and accessible healthcare to the whole population. Since Independence in 1963, the Government has developed comprehensive health policies to guide its activities in meeting the health needs of the population. Consistent with these policies, networks of health facilities have been established in all parts of the country, and a sizeable private health sector has taken root. However, access to quality healthcare remains a dream for most Kenyans.

The health of the population has improved considerably over the four decades since independence. The infant mortality declined from 119 per 1000 live births in 1969 to 74 per 1000 in 1998. Total fertility rate declined from 7.6 in 1969 to 4.7 in 1998. Life expectancy at birth increased from 40 years in 1963 to 60 years in the early 1990s. However, since the mid-1990s, life expectancy began to fall due to effects of the HIV/AIDS pandemic and as a result of increasing poverty. The infant mortality rate is also increasing.

Throughout the four decades (1963-2002), the government has used several methods of financing health services. Until 1965, co-payments of Kshs. 5.00 per user were in force in all public health facilities. Between 1965 and 1989, the government used revenue from general taxation to finance health services in line with its policy of free medical care, as stated in Sessional Paper No. 10 of 1965 (*African Socialism and its Application to Planning in Kenya*). The Government reversed this policy in 1989 and introduced modest user charges for health services in public health facilities because of severe budgetary constraints and declining support from donors. The fees, which were temporarily suspended in 1990, but reintroduced in 1992, are still in force. The user charges (also called cost-sharing) were meant to supplement the Ministry of Health (MOH) budget in the overall running and maintenance of health facilities. In 2001, net out-of-pocket

spending on health, including user fees and direct payments, amounted to 53.1% of total health expenditure.

1.2 Social Health Insurance

The current system of cost – sharing in the health sector is based on the assumption that the majority of people can *afford* to pay medical care at the *point* and *time* of treatment. There are two major problems with this assumption. First, it is not realistic in a situation where 56% of the population lives below the poverty line. Second, it discourages people (the poor included), who can pay for treatment before the illness occurs from making such payment. These disadvantages can be avoided through systems that pool risks and financial resources, and that aim to give people equal access to healthcare. Health insurance is one such system.

In a health insurance system, people pay for the cost of illness before the time of treatment, that is, before an illness occurs. This is done through small, regular contributions, also known as premiums, to a health insurance organization that pays for medical care when an illness occurs and treatment is sought. Thus, in contrast to a cost-sharing situation, where only two parties are involved (the patient and the healthcare provider), in a health insurance context three parties are involved namely: the patient (household), the provider of healthcare (health facility) and the payer of medical bills (the health insurer). The health insurer can also be active in choosing the best care for its members. It can in fact assume the role of 'purchaser' of health services.

It is important to point out that a 'social' health insurance system rather than a private system is preferred. Social health insurance is based on *risk pooling of its members*, in principle all of the population, and on *pooling the contributions* of these members and other stakeholders. The major contributors are the households, enterprises and Government. These contributions serve to pay for health services, thereby giving access to its members, irrespective of income or social status. Household contributions are set such that they are based on ability to pay. Enterprise contributions are usually fixed as a

percentage of wages and salaries. The level of government contributions is generally determined in such a way that it at least covers those households that are unable to pay contributions and therefore allows for their inclusion into the social health insurance system.

Social health insurance seeks to enrol the whole of the population and is therefore run on a *compulsory basis*. Social health insurance can be managed by *a single fund or via multiple funds*. Multiple funds are usually associated with different population groups. In the latter case, equalization mechanisms are developed such that the funds receive sufficient resources in order to ensure that all population groups have equal access to the defined health insurance benefits.

In *private health insurance*, contributions or premiums are risk-related: Individuals or groups of individuals pay premiums that are related to *their* risks only. Private health insurance can be run by for profit companies or non-profit organizations. In the context of the Kenyan social health insurance reform, the role of private health insurance would be to insure especially against the costs of higher standards of amenities in clinics and hospitals.

Finally, it should be emphasized that only social health insurance, also referred to as *national* social health insurance in Kenya, provides for sufficient solidarity across all population categories (the rich subsidizing the poor, the young supporting the elderly and the healthy supporting the sick), thus promoting equity and access for everyone.

1.3 Situation Analysis

1.3.1 Poverty reduction and the National Health Sector Strategy Plan

Kenya's Poverty Reduction Strategy Paper (PRSP), 2001-4 states that the high cost of healthcare in the country is one of the leading causes of poverty. The paper recognizes good health as a pre-requisite for the socio-economic development of the country. The performance of the health sector is affected by high cost of healthcare contributing to

poor access, declining standards, increased re-emergence of diseases like tiberculosis, high cost of drugs and inadequate funding.

To address the above-mentioned health situation, the Ministry of Health is currently implementing a five-year National Health Sector Strategic Plan (1999/2004) whose objectives are to : (1) ensure equitable allocation of Government resources to reduce disparities in health resources ; (2) increase the efficicacy and cost effectiveness of resource allocations and use ; (3) manage population growth; (4) enhance the regulatory role of the Government in all aspects of healthcare provision ; (5) create an enabling environment for private sector and community involvement in health service provision and financing, and to play a greater role in curative services, thus allowing the Government concentrate on preventive services ; and (6) increase and diversify per capita financial flows to the health sector.

Healthcare services are delivered to the 31 million people in Kenya through a network of 15,400 healthcare facilites. These facilities include an estimated 400 hospitals, 5,000 primary healthcare facilities and over 10,000 private clinics. 60% of the hospitals, healthcentres and dispensaries in the country are provided by the Government while the remaining 40% are provided by NGOs, Missions and the private sector.

1.3.2 The need to reduce out-of-pocket health expenditure

In 2001, households' out-of-pocket expenditure (OOP) accounted for 53.1 % of the total cost of healthcare in the country, with the remainder being tax-financed government expenditure on health (21.4%), expenditure by the National Hospital Insurance Fund (3.9%), prepaid private plans (3.6%), firms and employer-paid medical services (16.4%) and NGOs and non-profit institutions (1.6%). Thus, in the current healthcare financing system private financing dominates with 74.7% of total health expenditure. We refer to figures 1 and 2 for a graphical representation of the structure of public vs. private expenditure and of a more detailed structure by sources of health financing, respectively. What re-emerges clearly is the high level of out-of-pocket financing of healthcare, which

includes cost-sharing. This is an important concern as it is likely to sustain and/c exacerbate poverty among Kenyan households.

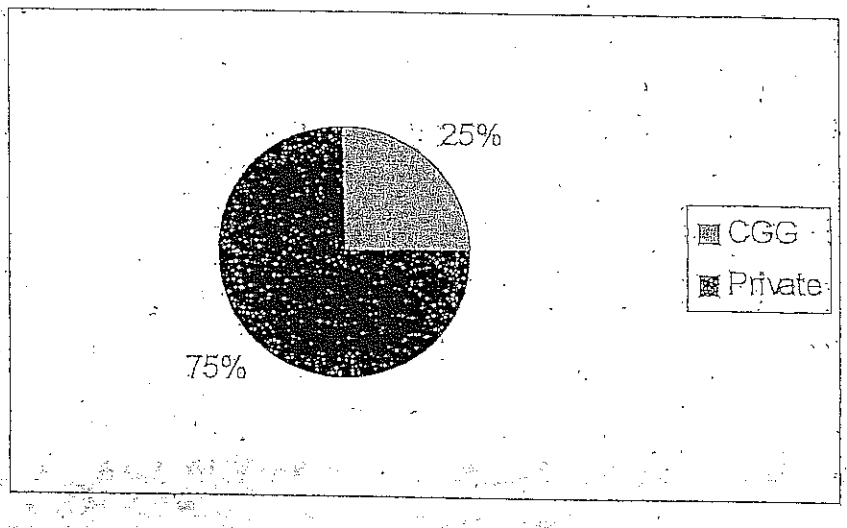
In view of widespread poverty in the country, there is need to reduce the healthcar expenditure of households. The conversion would increase health service utilizatior which has suffered under cost-sharing. In addition to reducing healthcare burden c households, thereby ensuring equity and access to all Kenyans and increasing servic utilization, such conversion would move patterns of government health expenditure in th direction of patterns in many developed countries. The ideal situation should be th position where the Government, through National Social Health Insurance (NSHI) an tax-financed MOH expenditure, is carrying 75% of the national health expenditur burden while private health expenditure would be reduced to 25%. This can be done to large extent by *converting* the cost-sharing scheme in public health facilities into a socia health insurance scheme.

Basically, the current cost-sharing fees paid by the population will be replaced by prepai contributions into the NSHIF. It is expected that in the first stage of the development o the NSHIF, the provider payment schedule is set in such a way that payments cover th essential drugs and medical supplies, out-patient and in-patient care, small repair an maintenance costs, water & electricity, and administration (forms, books etc.). If such recurrent expenditure was previously financed via the government budget, henceforth there would be extra room within the government budget, as these particular costs would now be covered via the NSHIF. These freed resources can be allocated to investment o renovation of the health infrastructure. They can also be allocated to preventive an promotive health services. With respect to the latter, contracts could also be established with private sector institutions such that these are incorporated in preventive care delivery and health promotion activities.

1.3.3 The role of the private sector

The private sector will have a proper role in this new health financing structure. The Health Policy Framework Paper 1994 advocates that the Government creates the environment for increased private sector participation in the provision of healthcare services. The National Social Health Insurance Fund (NSHIF) will detain the financial resources (contributions from households, enterprises and Government), and with these it will purchase the necessary health services. Via *contracts* with the NSHIF, private providers will be able to provide health services according to a remuneration or payment schedule which is agreed upon by these providers and the NSHIF. These payments are disbursed by the NSHIF.

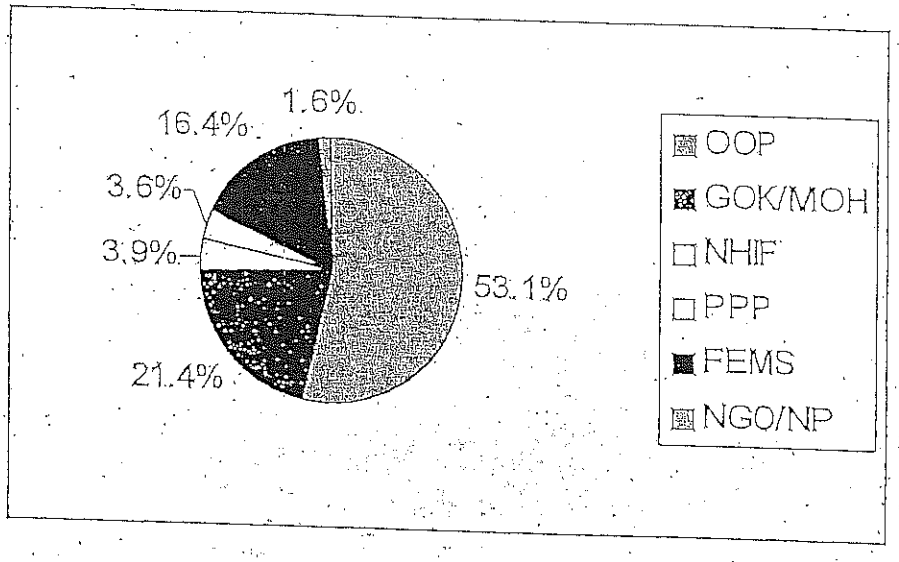
Figure 1: National Health Expenditure: Consolidated General Government versus Private expenditure (2001)



Source: MOH, 2003 and National Health Accounts (WHO/NHA unit, 28-5-03)

NB: CGG= consolidated general government which includes government health expenditure at all government levels as well as expenditure by the National Hospital Insurance Fund. 'Private' includes out-of-pocket health expenditure, and health expenditure via Private Prepaid Health Plans, firms and employer-based schemes, NGOs and non-profit institutions.

Figure 2: Sources of Health Financing by percentage contribution to the total national healthcare expenditure per annum in Kenya (2001)



Source: MOH, 2003 and National Health Accounts (WHO/NHA unit, 28-5-03)

NB: OOP= out of pocket expenditure; GOK/MOH refers to tax-funded health expenditure by the Government of Kenya/Ministry of Health; NHIF = National Hospital Insurance Fund; PPP=Private Prepaid Health Plans, FEMS= firms and employer-based medical services; NGO/NP= non-government organizations and non-profit institutions.

1.4 Milestones to introducing national social health insurance in Kenya

i. 1965

a) Parliament passed the Sessional Paper No.10 on "African Socialism and its application in Kenya" in which it outlines its plans to "provide welfare on a large scale" through a National Provident Fund and National Health Insurance among other mechanisms.

b) The Government waived the Kshs. 5.00 charged to every person who attends a health facility in line with the pronouncement of Sessional Paper No. 10 of the same year.

ii. 1970

Failure by Local Authorities to offer satisfactory health services in conformity with Sessional Paper No. 10 lead to the transfer of Health Centers and Dispensaries from the Local Authorities to Central Government, but did not give extra funds in the budget to meet these extra costs.

iii. 1989

Government introduces cost sharing to meet costs of maintaining facilities which it had failed to renovate over the years.

iv. 1994

Government through the Cabinet approved "Kenya Health Policy Framework" in which it clearly outlines where its priorities in health were.

v. Task Force set up to look into how to make healthcare affordable.

vi. November 2001

a) Official opening of the First National Congress on Quality Improvement in Health, Medical Research and Traditional Medicine

b) The President of the Republic of Kenya directed the Ministers responsible for Health to take necessary actions that would lead to the establishment of a mandatory National Social Health Insurance, for all Kenyans.

c) The President urged the delegates to discuss the feasibility of establishing mandatory National Social Health Insurance, which can facilitate all Kenyans to have access to quality healthcare;

d) The delegates adopted a resolution calling on the Government to include in the Constitution of Kenya, the following statement: "The right to health shall be a fundamental right in the Constitution of Kenya and that the Constitution protects the right of every Kenyan to have access to quality healthcare". They resolved that implementation of the Constitutional provision be through the establishment of mandatory National Social Health Insurance, and a Constitutional office for the Director General of Health be created. The Cabinet in January 2002 approved these recommendations. The draft Constitution provides for the right to health.

e) The Delegates also adopted a report prepared by a Government Task Force on Affordable Healthcare, which recommended the establishment of National Social Health Insurance.

vi January 2002

The Cabinet adopted a resolution calling for the establishment of National Social Health Insurance. The Minister responsible for Public Health then took the necessary steps leading to the establishment of the Task Force for that purpose.

vii May 2002

The Minister for Public Health established and launched an inter-sectoral Task Force to prepare a National Strategy and a Draft Bill, which is expected to lead to the establishment of a National Social Health Insurance Fund. The Task Force which is chaired by the Permanent Secretary, Ministry of Health, includes: the Director of Medical Services, Head of the Department of Standards and Regulatory Services [Secretary], Ministry of Finance & Planning, Directorate of Personnel Management, Office of the President, The Attorney-General Chambers, National Social Security Fund, National Hospital Insurance Fund, Kenya Revenue Authority, Kenya Medical Association, Christian Health Association of Kenya, Kenya Law Reform Commission, Association of Kenya Insurers, Federation of Kenya Employers, Central Organization of Trade Unions, the Standing Committee on Human Rights (Kenya), Pharmaceutical Society of Kenya, Commissioner of Insurance and a health consultant. With the prior approval of the Minister, the Task Force may co-opt additional members to deal with particular aspects of the terms of reference.

1.5 Terms of Reference for the Task Force

Reporting to the Minister for Public Health, the Task Force was instructed to consult with all key stakeholders within the country and come up with a feasible and realistic programme for implementation of a mandatory National Social Health Insurance in Kenya. Specifically:

i. Recommend the requisite legislative reforms of the National Social Security Fund (NSSF) that would enable it to purchase a comprehensive health insurance for all its contributors;

ii. Recommend the necessary reforms within the NHIF to enable it provide a comprehensive health insurance to poor people in Kenya;

iii. Recommend the policy and legal framework provisions necessary to ensure that Traditional Medicine is made an integral part of the National Healthcare System;

iv. Identify strategies for capitalization and utilization of the Kenya Medical Supplies Agency to ensure cost-effective procurement and distribution of drugs and medical supplies to the country's health services;

v. Consult with development partners for bridge-financing of the proposed National Social Health Insurance Fund, preferably through debt cancellation and/or grants;

vi. Consider special levy on tobacco, alcohol and related products and services to contribute to financing of a National Social Health Insurance Fund and to

vii. Perform any other activities incidental to the effective discharge of the foregoing terms of reference.

This Task Force completed its work and has presented a National Social Health Insurar Strategy Report and a National Social Health Insurance Fund Bill to the Honoural Minister of Health on June 4th, 2003. Subsequent to the latter Report and Bill, a numl of tasks need to be undertaken in order to be well prepared for the implementation national social health insurance when the Law is passed by Parliament. These tasks are the areas of management, of legislation and regulation, of the benefit package, of mod and levels of provider payment, of financing and implementation before launching t NSHIF.

NSHIF Implementation Task Force

Because of the importance of adequate preparation for the implementation, *a NSH Implementation Task Force* is established in the Department of Standards and Regulat Services, composed of at least 5 full-time staff with expertise in the areas mention above. This Task Force will be supported in the next half year by at least two techni assistance missions covering the areas mentioned above. It is expected that the mention tasks will be undertaken jointly by the Task Force and the members of the techni assistance missions.

1.6 *Mobilisation Process*

1.6.1 *Provincial Consultations (8 provinces)*

The Task Force held consultations on the proposals with a wide cross-section of Kenyans in all the eight provincial headquarters and in fifteen districts. These discussions provided useful information on informal sector participation in the proposed scheme. Involvement of this sector is viewed as critical for sustainability.

1.6.2 *National Assembly Report*

The Task Force also received and reviewed the report of an international study tour on Social Health Insurance by Members of the National Assembly. The objective of the study tour was to assist the National Assembly Committee on Health, Housing, Labour and Social Welfare understand the requisite reforms that need to be undertaken in the health sector in general, and in health insurance, in particular. The report recommends that National Social Health Insurance should be based on the principle of social solidarity where the young subsidise the old, the rich subsidise the poor, the healthy subsidise the sick, and the small families subsidise the large ones. The Committee visited Germany, Chile, United Kingdom, South Africa, Malaysia, Philippines and Thailand from April to June 2002. In its report tabled in Parliament, the Committee states that "it is our hope that the experiences of the Committee will not come to naught but will be useful in the healthcare reform process ... it serves as a catalyst in raising the profile of health insurance so that the health of the people can be taken much more seriously by all the parties concerned, starting with the Government. The National Hospital Insurance Fund is a national asset within the framework of universal health coverage – its operational functions and network needs to be reviewed so as to be relevant to the country's needs of enhancing accessibility, affordability and quality of healthcare services – this also requires a multisectoral approach in reducing poverty levels, promoting health seeking behaviour, reducing incidence of disease, enhancing good governance, decentralization of power and responsibility, accountability and transparency in healthcare delivery".

The National Assembly Report recommended: (a) increasing budgetary allocation o Government expenditure to the Ministry of Health from 3.8% to 15%; (b) reduc dependence on Donors to finance development expenditures, (c) greater autonomy fo hospitals, (d) increase quality of healthcare services, (e) review the Local Governmer Act to provide for mandatory investment in health by a percentage of total revenue, (f create competition in the social health insurance market by removing the monopol enjoyed by NHIF, (g) repeal the National Hospital Insurance Fund Act, 1998 and replac it with a National Social Health Insurance Act to regulate the health insurance sectc which should also include insurance brokers such as Health Management Organization (HMOs), and (h) restructure the NHIF to improve efficiency in resource mobilization.

On NHIF expenditure the Report states: "Utilization ratio of 22% is grossly inadequat and the 25% expenditure on administrative costs unacceptable and so is the high annu investment portfolio, which places funds in projects which have nothing to do wit health. Any surplus funds should be utilized in enhancing health benefits and /c increasing the scope of coverage. Health Insurance Organizations in some of the Asia countries visited attained a utilization ratio of 70%. The NHIF must develop and mark different health insurance packages to attract more members and enhance its benefits' (a) NHIF, Ministry of Health and Local Authorities must develop a clear policy c providing subsidy to the poor, (b) the Government must encourage employer/employe schemes in the private health insurance sector, (c) ways and means of involving th communities through co-operatives, SACCOs, etc in the provision of healthcare service should be explored in order to widen the scope of social health insurance coverage, (c the system of collecting and administering contributions and benefits should be integrate with the social security/identification mechanisms to reduce administration costs so th one card could be used for identification as well as for seeking medical services, (e contributions to social health insurance should be made by both employers an employees at the ratio of 1:1 to boost the resource base, (f) additional funds should b mobilized through contributions based on a percentage of salary and not on a fixed rat (g) the Government should also provide counterpart funds for people who volunteer t

join health insurance schemes as an incentive to the self-employed, (h) the Government should also provide tax incentives to employers who contribute to the Fund and (i) the provision of accessible and affordable healthcare services should be a basic human right which should be entrenched in the Constitution.

This Report therefore agrees that there ought to be a commitment from Government to provide for co-financing of the NSHIF, especially to pay for the contributions of those who are not able to pay the scheduled social health insurance contributions. The Ministry of Finance may directly allocate these funds to the NSHIF. Thus, *consolidated* general government expenditure on health is expected to increase. The latter expenditure consists mainly of health expenditure of MOH and of expenditure by parastatals such as the NSHIF.

1.7 Challenges

The challenges posed by improved healthcare services, facilitating quality, affordable healthcare for all in Kenya, include:

- Insurance Fraud
- Weak Judicial System
- Unregulated Traditional Medicine practice
- The high cost of treatment especially for HIV/AIDS
- Ensuring public ownership of the proposed scheme, to avoid control by Government/private sector/NGOs-Missions
- Sustainable financing
- Lack of regulation of fees charged by healthcare providers
- Regulation of Health Management Organizations (HMO) as either health insurers or healthcare providers but not both
- Lack of enforcement of the existing laws and ethics regulating healthcare provisions
- Poor /inadequate services in public health facilities

- Expected resistance to change from beneficiaries of the poor state of public healt services

1.8 Opportunities

- The concept of social health insurance is not new in Kenya. All employed peopl in Kenya make statutory health contributions to the National Hospital Insuranc Fund every month. NHIF is over 30 years old and has built a decentralize infrastructure to serve its members (mostly employed and those able to pay Therefore there is opportunity to leverage on the existing NHIF infrastructure ar experience.

- The private sector, i.e. prepaid private plans, firms and employer-paid medic services, NGOs and non-profit institutions, accounts for 21.6% of total healthca expenditure.

- As reflected in extracts of the PRSP, Parliament and the people of Kenya wa cost-sharing stopped in public health institutions. So, there exists public dema for the establishment of an alternative health financing mechanism as opposed cost-sharing. It should be understood, however, that the NSHIF will be run w *contributions* of households, enterprises and Government. In addition, so schedule of registration fees to help avoid excessive healthcare demand may ne to be studied and considered.

- There is opportunity to leverage on the existing political climate in favour of establishment of a NSHIF scheme.

- Possible ease of selling the benefits of a quality health insurance scheme wh guarantees access to quality healthcare for their members, to the pension scher through capitation e.g. through the National Social Security Fund.

CHAPTER 2
METHODOLOGY AND FINDINGS

In search of strategies for the provision of quality, affordable, healthcare services for all the Kenyans – rich or poor, employed or unemployed, young or old – a lot of information/data became, as expected, indispensable. Such data informs on both the theoretical policy and implementation framework in the past and the present status, by highlighting what the vision and objectives were/are; and the shortcomings in the achievement of the anticipated benchmarks, that have led to the current position; and what needs to be done to correct the situation – the way forward.

2.1 Literature Review/Expert Papers

To understand what has led to the current problems in the delivery of healthcare services in Kenya, documents and papers on key policy issues had to be studied, and analyzed. Such documents and papers include:

i. Poverty Reduction Strategy Paper, 2001 – 2004.
ii. National Health Sector Strategic Plan, 1999 – 2004.
iii. Papers by leading experts on insurance and social health insurance, at brainstorming workshops, late 2001 and early 2002.

The summary from the documents and papers is that whereas healthcare in the country is one of the leading causes of poverty, the objectives set out in the second document have not been achieved, as anticipated. For example, equitable allocation of Government resources to reduce disparities in healthcare provision has not been effected, population growth rate has come down, but not because of following the envisaged methods; Government regulatory role, in healthcare provision, has performed below par.

A close examination and analysis of the legal and regulatory frame work of such key institutions as the National Social Security Fund (NSSF); the National Hospital Insurance Fund (NHIF) and the Kenya Medical Supplies Agency (KEMSA) reveals certain

weaknesses therein, and the urgency for reform in such institutions. For instance, there is as yet no legal provision within the NSSF statute that any of the contributor's funds shall be committed or applied to healthcare. On the NHIF, the National Assembly Report (April – June 2002) clearly indicated how far short of expectations the Fund has performed:

- Imprudent and inefficient application of the resources entrusted to it;
- Limited coverage and benefits packages;
- Lack of quality and standards enforcement mechanisms.

The report also provides useful comparables of the management, financing and regulatory frameworks of similar institutions in the countries visited and studied by the team, during the study tours, with what exists in Kenya. The need for reforms in the Kenyan healthcare services and facilities as well as increased levels of financing are heavily underlined.

From the expert papers and the brainstorming workshops, the main outputs were:

- an understanding of the concepts and definitions of the various forms of social health insurance in Central and Eastern Europe, Latin America and South East Asia and
- a perception that a mandatory social health insurance, or national social health insurance, in Kenya is feasible.

2.2 *Primary Information/Data*

Primary information/data was collected through consultations with a wide cross-selection of Kenyans in all the eight provinces and fifteen (15) selected districts, throughout the entire country. The consultations were carried out through focus group discussions guided by a structured questionnaire. The groups consisted of 20 – 30 participants representing stakeholders at each level.

The participants, at both the provincial and district levels, represented: the centra government; local authorities; farmers; co-operative societies; teachers; fishermen employer and employee organizations; civil society; community based organizations matatu welfare associations; youth and women groups; religious groups; professiona bodies, and the informal sector.

At each level and selected venue, the process of consultations started with comprehensive lecture, by a group of members of the Task Force. The lecture covered:

(i) The rationale/justification of the proposed National Social Health Insurance Fun (NSHIF) and how it differed from the existing schemes such as the Nation Hospital Insurance Fund (NHIF);
(ii) The structure of the proposed NSHIF;
(iii) The financing of the proposed scheme and,
(iv) The legal framework of the proposed new body – NSHIF.

At each stage of the lecture, questions and discussions have taken up more than 50% the time allocated to the topic or theme. The discussions and questions focused on:

- Acceptance of the proposed scheme and the underpinnings of such acceptance,
- The role and place of the grassroots-stakeholders in the control, ownership, a management of the proposed NSHIF, all of which hinged on:
  - the structure of the scheme;
  - how the proposed scheme would/should raise its finances (throu individual or group contributions to the scheme);
  - the most efficient and cost effective methods of collecting su contributions;

- where people seek or get their treatment (from Government, mission, non-governmental organizations, private healthcare facilities, traditional medicine practitioners or other outlets such as spiritual healers) and why.
- The rating of satisfaction of the services provided by the healthcare facilities available at the given area or level.
- How to curb/eliminate/reduce fraud or theft for sustainability of the proposed scheme.

➢ How to improve the efficiency of the proposed NSHIF, in light of the experiences from existing schemes.

2.3 *Collation, Analysis and Interpretation of the Information/Data.*

The information/data collected from the provinces and districts was collated in thematic chapters which included (as per the Questionnaire): acceptance, financing, structure, where people seek medical treatment, the legal framework, and implementation. This sub-chapter deals with the information/data collected and the interpretation of some of that information. This is necessary because the face value of such data can have different interpretations or convey varying signals, or be misleading altogether.

On acceptance of the proposed National Social Health Insurance Fund, all the participants in all the districts/provinces expressed their unanimous support. The scheme was seen as an excellent idea. However, such acceptance was subject to the following caveats:

i) The NSHIF should be guarded against the factors that have led to the collapse and subsequent disillusionment of previous schemes when they turn out to be white elephants. Such factors include: fraud and theft of the resources by those entrusted with their management, incompetence, political interference, and corruption.

ii) The management of the proposed NSHIF must have less government and b stakeholder-controlled. Without a sense of ownership of the new scheme by th stakeholders, the Kenyans would not have confidence in it.

iii) Social mobilization and sensitization of the members as to their rights an obligations within the scheme was stressed as the critical turning point of th success or otherwise of the proposed NSHIF. This point is linked with (ii) above All Kenyans, down to the village level and up to the apex organ of the NSHIF must be represented and given a say and control of the scheme, through democratically elected, structure. Such structure would include: village, sub locational, district and national council representation, by elected, qualified, an competent persons of integrity and commitment.

iv) On the all-important issue of financing the NSHIF, varying methods and figure were suggested, ranging from Kshs. 12/= per person per year to 1,000/= pe person per year. Whether the contribution to the scheme should be per family o individual members of the family was a point of heated debate. Ultimately, an given the varying family sizes within Kenya, one has to see the success of th contributions in terms of the individual members, rather than through the social o economic groupings to which they belong. After all, it will be the individual wh will seek medical treatment, and not the organization he/she belongs to.

Taking an average of the proposed rates of contributions, the national averag worked out to Kshs. 400/= per person per year, in the country. This average figur can only make sense in terms of those persons who cannot contribute (for or reason or another) in which case the Government, through taxation, would pa their contributions. The employed persons' contributions to such bodies as th NHIF and NSSF, which have to be matched by their employers, would have t remain at the current levels at least at the initial stages of the scheme.

When the above figures and proposals are simulated, it is possible for the scheme to start with Kshs. 40 billion per year, provided that: the compliance rate is not less than 85%; the administrative costs of the scheme are efficiently managed, and the benefits package worked on the basis of the available resources, rather than on the ideal. The situation must be subjected to regular reviews to capture emerging trends and factor in requisite reforms and changes.

v) On the methods of collecting the proposed contributions; it should be noted that whereas there is no envisaged problem with the employed persons, the most efficient methods must be adopted when it comes to those in the informal sector and the self-employed. It would not be in the interest of the proposed NSHIF to have contributions collected by bodies or persons who will not remit the same immediately, or at all. Nor will it make sense to adopt uneconomic methods of collection. This topic needs further refinement and should be subjected to frequent scrutiny when the scheme is launched.

v) On the Legal Framework, whereas it was agreed that the proposed NSHIF must be independent and autonomous, it must be added that the success of the scheme will depend on how rigorously the law and the regulations therein are enforced.

vi) On where people seek treatment, the information/data collected from the field shows that approximately 60%, 37% and 23%, go to Government, private/mission/NGO and traditional medicine practitioners, respectively. In inspecting these figures, the following points need to be considered:

- The figures are not sector-absolute. Indeed, it was observed during the discussions that a large number from each of the sectors visit the other or others either prior to or after failing to receive their "expected" results from the other or others. In other words, the success or failure of one sector's "performance" determines the weakness or otherwise of the other or others.

- The information/data in this section re-enforces the old adage that medical treatment is not only the chemicals but also the psychology of the patient concerned. The data is of great importance to the proposed NSHIF if all healthcare providers, including at some stage the traditional medicine practitioners, will be brought on board and claim from the Fund for the services they provide to any of the insured.

- Of even greater concern is the fact that to date, what constitutes traditional medicine is still a subject of hot-debate. Until such an issue is finalized the area will remain gray, with all the implications for the claims from the proposed NSHIF by such health providers.

- It should, however, be pointed out that the Task Force did not have either the time or the resources to carry out the necessary detailed research that would accurately segregate the attendance to the various health facilities. To that extent, the percentages cited above are mere approximations.

2.4 *Summary of the Information/Data*

Acceptance of the NSHIF scheme has been amply indicated in this chapter. It was seen as crucial as to whether or not the proposed NSHIF scheme will:

- be implemented,
- perform to the expectations.

The provincial and district representatives were of the opinion that the success of the proposed scheme will depend on the following:

- Political Goodwill

  There can be no success of the NSHIF without the political goodwill which has been expressed by the then President of the Republic of Kenya, H.E. Daniel arap Moi in his opening address at Mbagathi, the Cabinet approval and the political goodwill by politicians of all political parties in Kenya.

- **Ownership**

  People expressed their wish to own and control the proposed scheme.

- **Cost**

  Access to healthcare services, by all, is a must if the scheme would be:

  - Affordable
  - Equitable
  - Properly accounted for
  - Collect contributions in user-friendly ways
  - Free of fraud

- **Quality of Health Services**

  Government facilities must improve their physical structures and service delivery standards. The expectation of Kenyans is that the quality of healthcare provision in Government hospitals should be comparable to that in the private hospitals.

- **Attitude of health personnel**

  It is necessary to engender a positive attitude among health workers by putting in place: training, discipline and competitive terms and conditions of service.

- **Mobilization**

  Public education and sensitization of NSHIF by the public before implementation will be a key factor leading to the success of NSHIF. It is clear from the provinces and district visits that people would like to be certain of the following before they fully embrace the proposed NSHIF.

  - Clear management roles outlined and understood by the professionals who will be in the Board of Trustees and the management.
  - NSHIF should have a cost-effective benefits package.

- Effective systems that capture all the activities of the Fund including accounts and database.
- The Fund should ensure equitable access of healthcare services as close to the people as is practicable including mobile clinics where necessary.

➢ The Government should continue with its role in enhancing and promoting public and primary healthcare services.

2.5 *Further Practical Study for Priority Attention in the first 2 years of Implementation*

Future information and data gathering will be necessary so as to be able to address a series of important issues for the implementation of national social health insurance. The issues to be covered include:

- The transformation from NHIF to NSHIF;
- The ability of the people to pay into the NSHIF;
- Definition of exemption criteria (categories of the population exempted from contributions);
- The average costs of inpatient and outpatient care at different levels of the healthcare system (levels 1 to 5);
- Options for provider payment (at levels 1 to 5 of the healthcare system);
- The NSHIF and additional private health insurance;
- Financial analysis: Sources of financing and allocation of expenditure;
- Capacity building and public relations strategy;
- Administrative control and quality assurance;
- Efficient options to control entitlements (membership cards, identification procedure) and to collect contributions;
- Mechanisms to prevent or reduce excess utilisation, moral hazard and adverse selection;
- Information systems and data processing at all levels of the healthcare system;
- Development of monitoring systems and procedures;
- Implementation strategy and timetable.

CHAPTER 3
BASIC HEALTH INSURANCE DESIGN FEATURES

3.1 *The Benefits Package*

The benefits package is the specific healthcare services that would be covered by, and delivered under the proposed National Social Health Insurance. The main characteristics of the benefits package are that it:

- maintains and promotes good health;
- is cost-effective and meets expectations for basic health needs of all Kenyans;
- will provide both outpatient and inpatient services through contracted health facilities in accordance with a prescribed drug formulary and other pre-costed health services.

It is expected that the Government (Ministry of Health) will continue to discharge its obligation of providing public health and preventive and promotive services over and above the benefits package provided by the proposed NSHIF. The benefits package will be determined by the NSHIF and will be reviewed from time to time.

The design of the benefit package will have to be built on existing practices that are both acceptable to the patients and the healthcare providers at all 5 levels of the Kenyan healthcare system.

The introduction of cost-sharing mechanisms at all levels of the healthcare system has resulted in a growing burden on patients. There is evidence that an increasing number of poor are excluded. On the other hand cost-sharing has become an important source of financing for healthcare providers in the public and private sectors. The role of Government has largely been limited to financing the salaries of staff and basic infrastructure.

Healthcare providers find it increasingly difficult to provide adequate services that include treatment, diagnostics and drugs with the available financial resources. The reason is that children under 5 are exempted and that approximately 20% of cost-sharing contributions have to be waived for poor patients who can not afford them.

The NHIF reaches a sizable proportion of the population of employees in the formal sector, approximately 1.2 million members and their families composing a group of some 7 million beneficiaries. While the National Hospital Insurance Fund (NHIF) pays fixed rates for in-patient days, these payments only cover the "hotel" costs. All other user fees for treatment, diagnosis and pharmaceuticals have to be paid out-of-pocket by the NHIF-insured patient. The "benefit" is therefore not perceived as substantial by the NHIF-insured patient as a considerable amount of extra costs may be due.

Against this background a new social health insurance benefit package and provider payment strategy needs to be designed so that the beneficiary is relieved of high cost-sharing charges. At the same time sufficient income has to be generated to healthcare providers in the public sector to finance pharmaceuticals, diagnostics and other essential services.

Different design approaches can be used to arrive at a reasonable balance of socially acceptable health insurance contributions by the members of the NSHIF and appropriate level of remuneration for healthcare providers who will be responsible for the provision of a comprehensive diagnostic, treatment, medication and care package:

1. A *cost-accounting approach* through costing all the desirable service elements to be provided multiplied by the expected frequency of the diagnoses and duration of treatment.
2. *Extrapolation* from existing provider payment schemes (e.g. NHIF and cost-sharing charges).

3. Special payment mechanisms for *long term care and HIV/AIDS* will have to be developed with supplementation from special external resources and in cooperation with NGOs.

4. Decisions on financing of expensive healthcare services will evaluated on a case by case basis through special review committees established by the Fund Management.

The *cost-accounting approach* was used by the Benefit Package Drafting Committee (Benefit Package for National Social Health Insurance Draft 4 of 9-6-2003). The resulting estimates include staff time. An average inpatient day in hospital was estimated to cost approx. Kshs. 6,000, a dispensary consultation Kshs. 410. When staff cost are deducted the amounts will probably be closer to Kshs. 4,000 and Kshs. 310 respectively. These estimates are apparently based on current charges in the private sector.

Using the *extrapolation approach* e.g. an estimated remuneration for each in-patient day of Kshs. 2,300 at a district hospital was considered reasonable. This figure assumes that all personnel cost and infrastructure maintenance cost are covered by the MOH. This would constitute a considerable increase from the current NHIF reimbursements. In addition payments for fees of the indigent that so far had to be waived will be covered. Furthermore income that is currently forfeited due to the free-care-for-under-fives policy, will be generated. The NHIF presently only reimburses flat rates for in-patient days by category of hospital.

For level 1 out-patient visits the cost accounting approach leads to a remuneration of Kshs. 410. On the other hand an extrapolation of current dispensary out-patient fees amounts to some Kshs. 100 including diagnostics and drugs under the current cost sharing mechanism. A remuneration of Kshs. 150 –200 per out-patient visit will probably cover all desirable and feasible items including drugs at that level of care.

These provider payment levels will have to be reviewed and discussed with healthcare providers and broad consensus with the stakeholders should be aimed at. The benefit package has to be clearly communicated to the insured, the patients and healthcare

providers. It is important to anticipate that some private health providers may claim vis-à-vis their patients that certain items are not covered by the NSHIF and that supplementary payments may be called for. It is encouraged these five star hotel services be covered through top-up health insurance by the private sector.

Evidence-based medicine and stringent use of essential drugs as generics will be the guiding principles of healthcare provision.

For long term care, including mental patients, special low daily in-patient rates e.g. Kshs. 1,000 may have to be negotiated with providers. Special Review Committees set-up by the Fund Management will evaluate expensive treatments including referrals to treatments out of Kenya on a case by case basis.

Preventive measures should be included as long as they relate to clinical services e.g. ANC, Under Fives' Clinics, contraception etc. Prevention and health promotion will remain under the responsibility of the MOH including the provision of vaccines for the national vaccination programmes.

In the implementation of the benefit package some of the following elements may be considered to contain costs:

1. A flat rate *remuneration for in-patients* per day with or without weighting by diagnostic groups. To discourage excessive stays, rates may have to be reduced after e.g. 7 days. Initially simple remuneration criteria close to current practice may be more practicable, and only as cost accounting procedures improve, more sophisticated approaches may evolve. Minimal cost sharing for food in hospitals especially for guardians may be considered (e.g. Kshs. 3000 per day). Cost may be contained also by consistent *quality management* procedures which should be a prerequisite to registration as a service provider with the NSHIF. Gradually professionally acceptable clinical pathways should be developed by professional groups. Flat rate remuneration should be accompanied by adherence to minimum quality standards. *Provider payment levels* may also consider the level of healthcare provided by different institutions using a grading

system similar to that currently in use by the NHIF. For rehabilitative or long term care the use of lower cost nursing homes may be encouraged. The *list of essential drugs* to be included in the benefit package should be regularly reviewed against the background of WHO essential drug recommendations. Special review procedures for expensive drugs may have to introduced. *Mortuary storage time* should be strictly limited (e.g. maximum 3 days). All extra services like embalming have to be charged at cost or provided for under top-up private health insurance. *Accidents* which are covered by third party insurance should be charged directly to the insurer. NHIF should develop mechanisms to ensure it is re-imbursed for these expenses by private insurance. Similar arrangements will be for expenses provided for under the Workman's Compensation Act.

3.2 *Costing of the benefit package*

The costing assumptions in this paper for the benefit package are currently of a very preliminary nature. Forthcoming technical work will include a systematic and more accurate analysis of healthcare in the benefit package together with its costs based as much as possible on rational diagnosis, treatment and prescription.

3.3 *Administration*

The administrative costs of the scheme ought to be efficiently managed. This means, that the responsible body of the NSHIF draws up a yearly plan of the administrative overheads, such as costs of staff (central, regional), buildings and electricity, computer infrastructure, etc. The budget for administrative overheads and the building of reserves will not exceed 8 % of the total expenditures of the NSHIF.

3.4 *Financing*

3.4.1 *An overview of sources and levels of financing*

The estimated total financing of the NSHIF is Kshs. 40 billion annually. Sources of funding are as follows:

- Payroll Harmonization (Teachers and Civil Servants) Kshs. 7 billion
- Earmarked Taxes(11% of VAT and Excise to finance the contributions for those who are unable to pay) Kshs.11 billion
- Self-employed (Kshs 400.00 – Ksh 600 per head,) Kshs.10 billion
- NHIF (employee: employer contribution ratio of 1:2 at current rates, 90% compliance) Kshs.12 billion
- Others – Donations, Grants, Airport Tax US$ 5 per ticket Kshs. 1 billion

The NSHIF is a social health insurance fund to whom everyone should contribute without exemption. For administrative purposes, the contributions should be per head and not per family although current entitlements in the NHIF also include family members of insured. For those too poor to pay the Government will pay for them.

The contribution for the self-employed of the informal sector considered the suggested amount for annual contributions made during the provincial and district consultation meetings. The average in each province was determined and the national average was calculated as follows:

Province	Average suggested contribution (Kshs.)
Nyanza	200
Central	300
Nairobi	404
Rift Valley	300
Western	270
Coast	1,175
North Eastern	210
Eastern	543
National Average	425

The Task force discussed and proposed to round the figure of Kshs. 425/= to Kshs. 400/= per person per year. It was suggested that the Kshs. 400/= person /year contribution be only for those who are not in formal employment.

An appropriate contribution schedule for the self-employed professionals will need urgent consideration. One possibility is to define contributions based on the level of income assessed by both the professionals and the tax authorities.

3.4.2 Sources of Financing: a further discussion

- **Tax Revenue**

  Indirect taxation through consumables is the only viable way through which everyone will contribute. Earmarking 11% of the total expected collection consumption taxes namely VAT and Excise Duties for the financial year 2003/2004 estimated at Kshs. 100 billion would raise Kshs. 11 billion. Consumption taxes would be an indirect strategy of getting everybody to contribute to the fund. The more one consumes the more contribution is made to the fund.

- **Payroll Contributions (Public and Private Sector)**

  Harmonization of medical payroll contributions of Public Sector employees: Approximately **Kshs. 6.7 billion** from the Civil Servants, Teachers and Discipline Forces. If other public sector employees are included such as those in Parastatals, the figure is likely to go higher.

  The private sector can contribute towards the fund through deduction in the payroll for employees and the matched by the employers at the rate of 1:2. The payroll deductions could be made to KRA and directly remitted to the NSHIF. This is estimated to raise Kshs. 7.5 billion

- **The National Hospital Insurance Fund (NHIF)**

  Those in formal employment will continue to pay the NHIF contributions at the current rate. The employer will match at 1:2 the contribution at the current rate or at such a rate as is revised. With improved efficiency in collection this is expected to raise a total of **Kshs. 12 billion**.

- **Prudent Investment by the National Social Health Insurance Fund**

  The National Council will come up with an Investment Policy for the Board of Trustees to invest funds not immediately required for the functions of the Fund. Such investments could be in Treasury Bills, short-term non-fixed assets, Bonds, on-call-Bank Deposits in reputable institutions, etc. Together with administrative expenditure, investment should not exceed 8% of the total income of the National Social Health Insurance Fund.

- **External / Donor Funding**

  Given the importance of the scheme, recurrent expenditure should not be pegged on funds from external sources. External funding will be best suited for initial stages of the Fund in the form of projects, mobilization and training.

  - **Debt cancellation or conversion** through negotiating with development partners could be mobilized and have funds released to the proposed NSHIF.

  - **Concessionary Loans.** These loans with low interest rate, grace periods and long repayment periods may be sought from institutions such as from European Investment Bank (EIB), International Development Agency (IDA) and African Development Fund (ADF).

- Grants. A proposal for soliciting grants may be sent to potential donors. Grants are the most ideal mode of external financing especially for social sector programmes. Grants can be through technical assistance provided to cater for specified scope of work, product or service within a specified period and does not have to be repaid.

3.4.3 Contribution collection and registration

3.4.3.1. General principles

A major challenge for the NSHIF will be the registration of members and the contribution collection.

The registration and the issuing of millions of health insurance cards must be done accurately. Already, the NHIF has procedures and systems in place to manage this process. Nevertheless the capacity of the NHIF system will not be capable of registering and issuing cards for so many people in a very short time.

The design of the social health insurance card merits special attention. For example, one is to examine how the identification of the member of the NSHIF is best ensured and how fraud can be minimized. A photograph and smart card will be considered but the financial constraints and the need to ensure that the contribution due is effectively paid (e.g. stamps with the NHIF) will be taken into account. An additional question is whether there should necessarily be one expiry date for all health cards. At first sight, this looks attractive for planning needs of the NSHIF, but from the viewpoint of the workload and the logistics it is much more efficient to have an individual issue and expiry date printed on each card. In other words, the issuing or renewal cards can best be spread over the year.

The NSHIF will have to establish strong and competent branch offices, so that they can play an effective role in the interaction with those organizations that are involved in the

contribution collection for the self-employed. Accurate procedures and controllin mechanisms will be established.

The social health insurance card will give the members of the NSHIF access to healt services. Before inpatient care is used, a mandatory approval (checking the membership by the branch office of the NSHIF can be considered.

3.4.3.2 Contribution collection in the different economic sectors

The collection of contributions in the formal sector must be enforced in all companies This should be basically feasible, but the experience from the NHIF shows, that only low number of employers outside Nairobi comply with the current obligation to pa contributions. It will be an important task for the NSHIF to include these companies an to ensure compliance.

Contributions from the informal sector are estimated to raise Kshs. 10 billion. It is als considered how the contributions for the informal sector population can be collected b various organizations that are close to the population. One can select from the followin organizations:

- Cooperatives / SACCO. The SACCO would collect on behalf of its members an pay directly to the NSHIF.
- Delivery points of their respective cash crops or commodities
- Jua Kali Artisans Associations
- Women and Youth Groups
- Matatu Welfare Organization
- Fishermen
- Group Ranches
- City / Municipality/County Councils.
- Village Post Office
- Local Bank
- Utility Companies such as Electricity, Telephone.

- Tour Operators
- Kenya Revenue Authority (Customs & Excise Department) at entry points.
- Churches
- Community Based Organizations (CBOs) and Non-Government Organizations (NGOs).

These organizations will be contracted for the purpose of contribution collection and remunerated for the service that they deliver. They may well collect contributions more effectively than a NSHIF branch office. Some of these organizations may be licensed to issue or stamp the social health insurance card. However, adequate control will be necessary so as to ensure that the contributions collected by these organizations are transferred regularly to the NSHIF.

A number of recommendations are in order;

- Contributions need to be realistic and affordable to increase compliance.
- Sustainable level of funding for the defined benefit package.
- A contributor shall become a member of the scheme upon payment of the required contributions for a given year.
- A number of people in the informal sector will be recognized as those that are unable to pay. The NSHIF will not be able to assess who can afford to contribute and who can't, especially for the self-employed in the informal sector. Such an assessment can be done at village level, however. Furthermore, for those who are not able to pay contributions, the Government will fund their contribution and transfer this into the NSHIF.
- Contract with organizations that register, collect and remit quickly to the bank; commissions for these organizations need to be devised as incentives.

3.4.4 *Other possible sources of revenue to be considered*

- Businesses that increase disease burden such as through air and water pollution, tobacco products, flower farms, alcohol, chemicals etc. should be considered for a special levy.
- A percentage of Mobile Phone Service Provider Companies levy could be earmarked for NSHIF.
- A percentage of Traffic Revenue could be set-aside for the NSHIF.
- Government should rationalize and harmonize all health-related funds such as those earmarked for HIV /AIDS drugs, TB, malaria and bring them under NSHIF.
- A percentage of revenues from utilities such as electricity, telephone and water could be paid into to the NSHIF. This can be done through a card system where the cards are updated annually by paying a fee.
- A health levy contribution of, for example, US $ 5 per foreigner collected at entry points or/and through air tickets.
- Fees from sand harvesters and other exploiters of natural resources.
- Livestock fees such as Auction Fees and Loading Fees.
- Cess funds from cash crops.
- Donations.

3.4.5 *Implications of the National Social Health Insurance Strategy on the share in total health expenditure of the economic sectors*

Table 1 Total Health Care Expenditures, 2001

Source	Bn Kshs	Share (in %)
Out-of pocket spending	37.3	53
Government from tax revenues	14.9	21
NHIF	2.8	4
Private prepaid health plans	2.5	4
Non-profit institutions	1.1	2
Employer paid medical services	11.5	16
Total Health Expenditures	70.1	100

It is observed from the table above, using the most up-to-date national health accounts for Kenya, that Government and NHIF together have a share of 25 % of total health expenditures. Private sources add up to 75 %. The health expenditures by the new NSHIF are estimated at 40 bn Kshs annually (see Table 2). The latter can be financed by transferring 37.3 bn Kshs of out-of-pocket expenditure into prepaid contributions to the NSHIF. Another source is the amount which is now spent via the NHIF, i.e. 2.8 bn Kshs. The earmarked taxes of Kshs 11 bn would raise the total budgetary allocation of the Government to Kshs 25.9 bn.

Table 2 Possible sources of Financing of the NSHIF according to the National Social Health Insurance Strategy Report

Source	Bn Kshs	Share in %
Payroll Harmonization (civil serv.)	7	17
Earmarked taxes (VAT)	11	27
Contributions of the self-employed	10	24
Contributions of employees and employers	12	29
Others (Donations, etc.)	1	3
Total	40	100

Previously, the Government contributed 14.9 bn Kshs to health services. This sum will now be (partially) used for the payment of the salaries of the health workers as well as of investment in public health facilities. In the medium to long run, it will need to be addressed whether and how the payment for health personnel salaries can be secured by the NSHIF. In the latter case, it stands to reason that the provider payment schedule will need to be readjusted.

Private Insurers and other private sources contributed 2.5 bn Kshs. Non-profit institutions paid 1.1 bn Kshs. It is to be expected that these sources will remain.

The employers (public and private employers) paid 11.5 bn Kshs for health care of their employees. This could change after the introduction of the NSHIF. The assumption is made here, that in the public sector payroll harmonization will lead to contributions to the NSHIF and private employers would approximately halve their expenditure on health care.

In Table 3, it is estimated total healthcare expenditure after introducing the NSHIF, assuming that Government and NSHIF will spend, respectively, 14.9 and 40.1 bn Kshs. We first present the healthcare expenditure in prices of the year 2001; the Kshs 40 bn by the NSHIF is thereby assumed to be expressed in prices of 2001 as well. We then present healthcare expenditure in prices of the year 2003; these estimates are based on the 2001 figures, but all adjusted for an average inflation of 7%.

Table 3 Total Healthcare Expenditure after introducing NSHIF

Source	Bn Kshs (prices 2001)	Bn Kshs (prices 2003)	Share in %
Out-of Pocket	9.3	10.6	13
NSHIF	40.0	45.8	57
Government from tax revenue	14.9	17.1	21
Private prepaid health plans	2.5	2.9	3
Non-profit institutions	1.1	1.3	2
Employer paid (private sector)	2.3	2.6	4
Total Health Care Expenditures	**70.1**	**80.3**	**100**

The out-of-pocket expenses that would remain are payments for health services, including fees for amenities, that are not part of the benefit package.

In Table 4, the impact on the economic sectors (households, employers, government, non-profit institutions) is presented.

Table 4 Impact on the economic sectors (in bn Kshs)

	2001	with NSHIF (prices 2001)	Absolute Change	With NSHIF (prices 2003)
Private households				
- out-of-pocket	37.3	9.3	- 28	10.6
- Contributions NHIF / NSHIF	2.8	4 *	1.2	4.6
- Contributions of self-employed	0	10	10	11.4
- Private prepaid health plans	2.5	2.5	0	2.9
Total private households	*42.6*	*25.8*	*- 16.8*	*29.5*
Employer				
- Contributions NHIF / NSHIF	0	8 *	8	9.2
- Payroll harmonization (teachers and civil servants)	7	7	0	8
- Employer paid medical services	*4.5*	*2.3*	*- 2.2*	*2.6*
Total Employer(public and private)	*11.5*	*17.3*	*5.8*	*19.8*
Government				
- general taxes	14.9	14.9	0	17.1
- earmarked VAT	0	11	11	12.6
Total Government	*14.9*	*25.9*	*11*	*29.7*
Non-profit Institutions	*1.1*	*1.1*	*0*	*1.3*
Total	*70.1*	*70.1*	*0*	*80.3*

* Contribution rate employee-employer in a ratio of 1:2

3.4.6 Preliminary financial projections of the NSHIF

3.4.6.1 Basic scenarios

A number of preliminary projections were made, using a simulation model. The basic hypotheses (demographics, contributions, costs of health services, membership) are presented in Table 1 of Annex I. In addition, the four scenarios explained below assume a membership of 90% for all population groups from the year 2004 on. These projections need to be further refined, better distinguishing the different types of health services in the country as well as revising the costs of services based on cost-accounting. A scenario where the implementation is rather assumed to be staggered is developed below.

However, it is understood that the health service costs introduced in the present simulations include the essential drugs and medical supplies, out-patient and in-patient care, maintenance, electricity & water as well as administration. They exclude salaries as well as investment costs and depreciation.

Four scenarios are developed: 1. Low cost and low utilisation ; 2. Low cost and high utilization ; 3. High cost and low utilization ; 4.High cost and high utilization. The figures for 'low cost 'attempts to represent the result of rational diagnoses and prescriptions. 'Low utilisation' attempts to capture current use of health services in public health institutions. 'High utilisation' intends to capture a possible increased demand for health services at all levels, following the introduction of the NSHIF. 'High cost' reflects the preliminary cost estimates of the GOK Task Force on the Benefit Package.

The projection estimates are presented in Table 2 of Annex I. The projected expenditure vary between a minimum of Kshs. 33.617 bn (low cost/low utilisation) to Kshs. 70.525 bn (high cost/high utilisation). For policy purposes, it would be prudent to accept the low cost/high utilisation scenario as the most plausible among the four presented.

3.4.6.2 Ensuring financial equilibrium while decreasing the contribution for children of the self-employed

During implementation, the NSHIF Board may consider to lower the contributions for children of the self-employed, as large low-income (but non-poor) families might be burdened by a flat contribution of Kshs. 400 – 600 per child. In Table 3, is presented alternative scenarios whereby this flat contribution is lowered to Kshs. 200 and Kshs. 100. Efforts required from either government or employees and employers in order to ensure a financial equilibrium also indicated.

It is observed from Table 3 that additional government contributions vary from Kshs. 6.794 bn to Kshs. 9.686 bn. Alternatively, the percentage contribution of employees and employers would have to be raised from 2.65% to 3.60%.

3.4.6.3 Gradual implementation of the NSHIF

It stands to reason that the enrolment of the population will be gradual. Especially among the self-employed, enrolment may require a significant amount of time. Hence, a 'gradual implementation' scenario is developed. In this scenario we hypothesize that full coverage among the self-employed would be reached in 9 years time, whereas 5 years would be needed for the employees. The technical work ahead in the coming six months before commencement of the scheme will have to assess which implementation schedule would be most realistic. In Table 4 in Annex I are the results. One important observation is that, given the contributions for the employees/employers, significant surpluses would be realized in the first 4 years of the implementation of the NSHIF. This is a consequence of the gradual enrolment of the self-employed. It would therefore be possible for government to initially lower its contributions and/or for employees/employers to contribute a lower percentage of wage income.

3.4.7 Allocation to providers

3.4.7.1 The health provider network

The 15,400 healthcare facilities in which healthcare services are delivered are not allocated in such a way that all Kenyans have the same access to healthcare. The MOH will therefore establish regulation criteria for a medium term plan that will define the health infrastructure needs for each province and district of Kenya. Important criteria will be the population number and the prevalence of diseases. On this basis the MOH will establish a middle range plan for healthcare facilities all over Kenya.

During a transitional period mobile healthcare could be provided in remote regions. Moreover it will be regulated by the MOH which services from the benefit package must be provided at each institutional level, with a special focus on the appropriate mix of preventive and curative healthcare. It will also be considered if healthcare could be made more efficient by introducing Centers for Long Term Health Care.

The investment in new health facilities and expensive equipment is not the responsibility of the NSHIF. However, the MOH will stimulate investments in regions, which have a deficit on this area. The NSHIF will also contract with newly established health institutions that respond to the defined criteria.

The MOH will establish a regulation on the accreditation of healthcare facilities. This regulation will ensure the provision of quality healthcare in all institutions and will regulate, among others, the education of the health workers at each level, as well as the standard for the facilities and the equipment needed. It will also regulate the Board of Control that will authorize and register the health institutions and will monitor the standards.

To obtain the most cost-effective health care, the MoH will adopt regulatory measures for a referral system, that ensures, that the health care will be provided at an appropriate level. For the sake of exposition, health care provision could be divided, for instance, into

primary health care (dispensaries, health center, pharmacies, private practitioners), secondary health care (district and provincial hospitals) and tertiary health care (national hospitals). Health services on secondary level may only be called upon with a referral from the primary health care level, and tertiary healthcare only with a referral from the secondary level. Emergencies are exempted from the referral regulation. As long as there are no adequate health facilities at the required level in the district or province, the regulation of the competent authority may accredit an institution belonging to the secondary or tertiary level for health care at a lower level. Finally, it is obvious that the this division of healthcare can easily be related to the above-mentioned 5 levels in the Kenyan healthcare system.

3.4.7.2 *Provider payment methods*

There are six major ways of paying for providers in Kenya:

- Cost-sharing (out-of-pocket payments at health facilities): the health facility collects the payments directly from the patients; this is done through a fee-for-service system,
- Salaries of health workers in public health institutes are financed by Government
- Immunization and other preventive programs are financed by Government (MOH)
- Inpatient bed costs of NHIF-insured members by the NHIF
- Fee-for-service payments and prepayment for private healthcare.

For the future NSHIF, the following payment methods will be assessed regularly. A combination of payment methods will be considered, e.g. a flat or lump sum for basic healthcare at outpatient and inpatient level, but a fee-for- service for highly specialized healthcare services.

1. Fee for service. This payment method is most similar to the cost-sharing and private claim procedures used today. This payment mechanism may lead to excess use, as single detail of diagnostics and treatment will be paid for and providers stand to gain from induced healthcare. Another disadvantage is that the administrative costs for checking the claims are high. From the point of view of the NSHIF, forecasting (reimbursed) healthcare expenditure is quite difficult.
2. Payment per case. The contract will provide for a flat or lump sum for each patient. This can be a payment per visit, per hospital admittance, per bed day, per diagnosis related group (DRG), etc. The administrative procedures are rather simple, but this method may not totally avoid excess use. Forecasting of healthcare expenditure remains difficult.

3. Budget. It can be assessed how much each health institution needs for the provision of the benefit package. Assuming a certain quantity of healthcare services for the coming year, a prospective budget can be calculated and offered to the health facility. This payment system is associated with easy administrative procedures, but may tend to under-provision. The NSHIF will have to monitor, if the necessary healthcare services are really provided. From the point of view of the NSHIF, forecasting of expenditure is easy.
4. Capitation. This payment method would require that all NSHIF-insured register at one particular health facility. A flat or weighted capitation rate is paid per registered insured member. Each facility will have the responsibility to delivery healthcare to the registered members when they seek care. From the viewpoint of administrative simplicity and planning, this payment method is among the simplest. It also transfers the responsibility for delivering efficient and effective healthcare to the provider. The registration at one health facility, certainly when a population is mobile, is a main obstacle, however. In addition, there is the risk that this payment method leads to under-provision. It is expected that the NSHIF would have an interest, among others for reasons of administrative simplicity, in more comprehensive payment methods including payment per case, per bed-day or admission, or per diagnosis related group.

Whatever the payment method, the payments of the NSHIF will only be made on the basis of contracts with health facilities. These health facilities must be registered in the Health Institution Network. Through the contracts, the NSHIF will commit itself to pay for the healthcare that is provided within the context of the benefit package. In return, the contracted health facility respects the provider payment schedule and refrains from charging additional fees or co-payments for health services in the benefit package. Still, health services that would not be in the benefit package could be covered via private health insurance or direct payments for care.

CHAPTER 4
ORGANIZING HEALTH INSURANCE VIA THE NATIONAL SOCIAL HEALTH INSURANCE

4.1 Structure of the proposed NSHIF

The proposed NSHIF is to be an independent, autonomous, statutory body with corporate personality. The Fund will be established under the National Social Health Insurance Fund Act, to be enacted by parliament.

It will be compulsory for every Kenyan and every permanent resident to become a member through enrolment and payment of a subscription either monthly or annually, or as may be deemed convenient to different socio-economic groups. Subscriptions for the indigent will be paid for with funds from the Government and other sources. People who have no health insurance, e.g Kenyans who have failed to enroll with social health insurance, refugees and visitors to Kenya will be required to meet the full cost of treatment at the point of service.

The NSHIF is expected to benefit from the network already established through the National Hospital Insurance Fund. Those in the formal sector will continue to pay subscriptions at the current rates, through the payroll with the employers matching the contributions of employees (in a 2:1 ratio) while collection points will be identified for those in the informal sector with heavy reliance on organized groups such as co-operative societies, matatu owners' associations and "jua kali" Artisans organizations.

4.1.1 *Objects of The NSHIF*

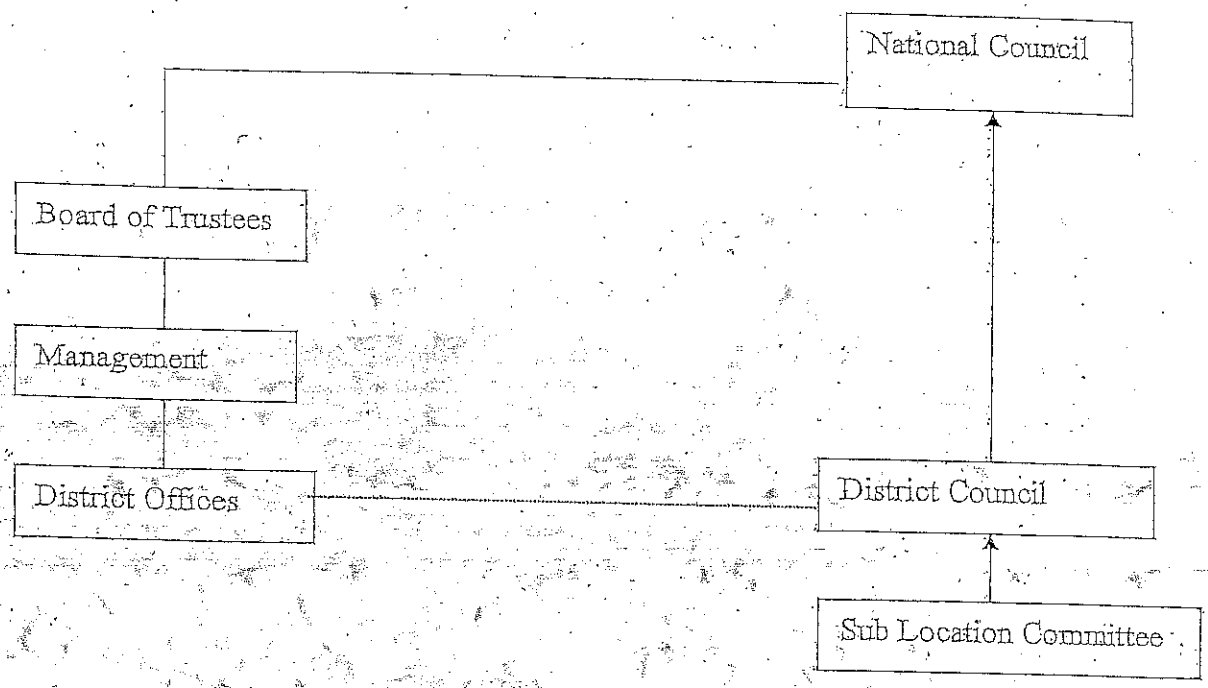
The main object of the Fund is to facilitate access to quality affordable, accessible and acceptable healthcare to all Kenyans. Its specific objects will be to:

i. Collect premiums and source for additional resources;
ii. Use the pooled contributions to pay for the utilization of health services by covered beneficiaries;
iii. Contract health service providers;
iv. Prescribe the minimum quality standards for the efficient provision of health services;
v. Prescribe the formulary of cost-effective drugs to be used in the benefits package;
vi. Prescribe the benefits package;
vii. Ensure the equitable access to quality healthcare services for all geographical areas of Kenya (including the provision of mobile clinics where necessary);
viii. Protect the interest of the members;
ix. Advise the Minister on the national policy to be followed with regard to the NSHIF and implement all government policies relating there to;
x. Perform such other functions that are incidental to the efficient discharge of the Fund's functions.

4.1.2 An overview of organs of the National Social Health Insurance Fund

It is proposed that the Fund will have the following structure:

Organization Chart



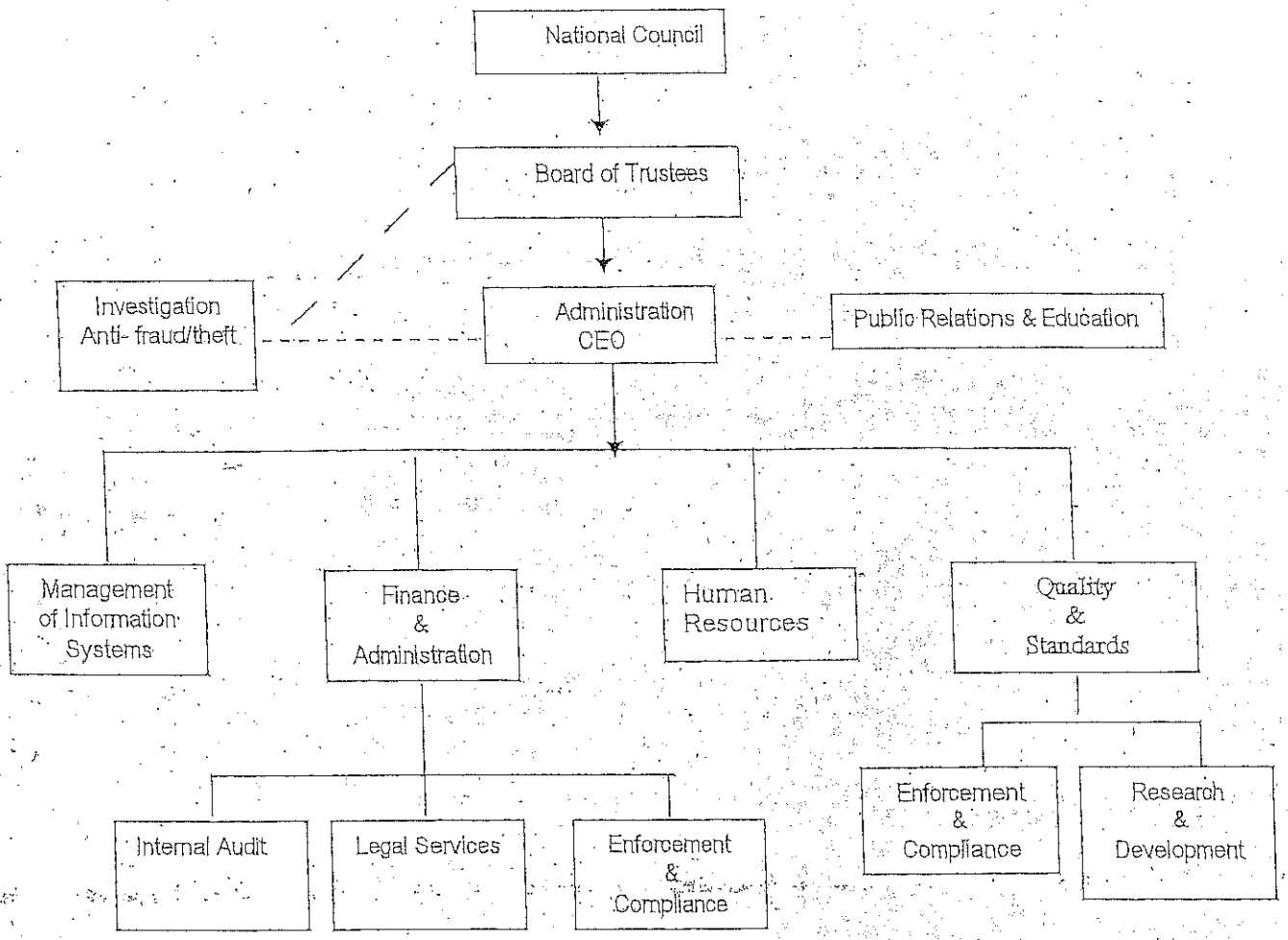
The relationships between each of the organs of the National Council will be as follows: There will be grassroots representation from the village level. The lowest level will be the sub-locational committee, which will be composed of one person from each village. The adult Fund members of each sub-location will democratically elect one person to the District Council. The District Council will democratically elect two (2) representatives to the National Council.

4.2 *Management of the NSHIF*

4.2.1 Organizational Chart

The NSHIF should have the following organizational chart:

National Social Health Insurance Fund Structure



i. **Finance and Administration**

This department has special responsibility concerning membership and contributions. In addition, it is to undertake *claim reviews*. Thus, one may consider establishing a special sub-unit for this particular function.

ii. Quality and standards

It is also considered that this department should be responsible for the definition and revision of the benefit package and for the accreditation of healthcare providers.

iii. Investigation/Anti-fraud/Theft Unit

This unit will investigate grievance matters and appeals brought to its attention by any other unit, person, and body or on its own volition and report to the CEO for action. However for matters relating to the CEO's office it will report directly to the Board of Trustees for necessary action. It doesn't need to have its own expertise but may draw from other departments or contract independent expertise as and when necessary.

Administratively this department answers to the CEO.

iv. Compliance and Enforcement

The other units i.e. Finance & Administration and Quality & Standards will still have enforcement and compliance units.

v. Public Relations & Education

The office shall be responsible for public information and education on matters relating to the Fund. This will be a unit in the CEO's office and shall be the response organ for the Fund.

vi. Internal Audit

Administratively, this unit will be under the Finance & Administration but it will report directly to the CEO if and when necessary.

Each of these departments shall be decentralized to the districts and any such lower levels as may be deemed necessary.

vii. The functions of the Administrative District Offices shall be:

- Assessing and evaluating the viability of the health service providers at their level.
- Processing and reimbursement of the contracted health service providers.

4.2.2 The Board of Trustees

4.2.2.1 Functions and Powers of the Board of Trustees

The Board shall administer the Fund and have such other powers as are necessary for the discharge of the functions of the Fund. In particular the Board shall have power to:

(i) Define the benefits package to be provided to members;
(ii) Determine and prescribe the contribution levels of the members and submit it to the National Council for approval;
(iii) Collect the prescribed contributions from the members of the Fund;
(iv) Manage, control and administer the assets of the Fund in such manner as best promotes the objects for which the Fund is established. However, the Board shall not have power to charge or dispose of any immovable property without the prior approval of the National Council;
(v) Receive any gifts, grants, donations or endowments made to the Fund or any other monies in respect of the Fund and make disbursement there from subject to prior authorization of the National Council;

(vi) To prepare and present for approval to the National Council: the annual budget, audited accounts and investment policy for the following financial year;

(vii) Open a bank account or accounts for the Fund in reputable banks and financial institutions and to invest prudently any monies of the Fund not immediately required for its purposes;

(viii) In consultation with the Ministry of Health, prescribe the minimum quality standards to be met by health service providers contracted by the Fund;

(ix) Contract health service providers that meet the quality standards prescribed by the Ministry of Health;

(x) Ensure the utilization of formulary of essential drugs prescribed by the Ministry of Health to be used in the benefits package;

(xii) Recruit the Chief Executive Officer and all staff of the Fund on such terms and conditions that the Board may from time to time determine;

(xiii) Establish such departments or units as may be deemed necessary for the efficient discharge of the functions of the Fund;

(xiv) Facilitate the carrying out of research to update itself on changing healthcare needs;

(xv) Advise the Minister on the national policy to be followed with regard to social health insurance and implement all Government policies relating thereto.

4.2.2.2 *Composition of the Board of Trustees*

The Board of Trustees should be sufficiently small for efficiency but be reflective of the sense of ownership from the grassroots level. It is therefore suggested that the Board be composed of the following:

- One members from each province [8 people] where possible drawn from the following areas of specialization:
  - Medicine [Medical Doctor, Nurse, Pharmacist, Dentist, Paramedic, and Traditional Medicine Practitioner]
  - Finance
  - Institutional Management
  - Law
  - Investment
- Interest Groups [at least 4 people]
  - Health Service Providers - KMA
  - Employers – FKE
  - Workers – COTU
  - Insurance - AKI
- Government [3 people]
  - Permanent Secretary, Finance
  - Permanent Secretary, Health
  - Director of Medical Services

The Chief Executive officer of the Fund shall be the Secretary to the Board and shall have no voting powers.

The Board may co-opt key stakeholders among its members as may be deemed necessary for specific tasks from time to time.

4.2.2.3 The process of selecting the Board of Trustees

The procedure to be followed in the selection of the Board of Trustees is as here below:

(i) The posts will be advertised by the National Council in the print media.

(ii) All interested persons from any of the above mentioned fields of expertise will apply to their respective District Council.

(iii) Each District Council will consider the applications and based on the rule of pluralism, nominate three candidates to the National Council.

(iv) The National Council will receive the nominations and from these select members to the Board of Trustees after considering regional representation, special interest groups and the requisite expertise.

(v) Before the Minister responsible for Health formally appointing the nominees to the Board of Trustees, their names shall be published in the media for public scrutiny and comments.

4.2.3 Decentralized management

For managerial efficiency purposes, a proper degree of decentralisation of the management of the NSHIF to the provincial and district offices will be scrutinized. District management units could be given the following tasks:

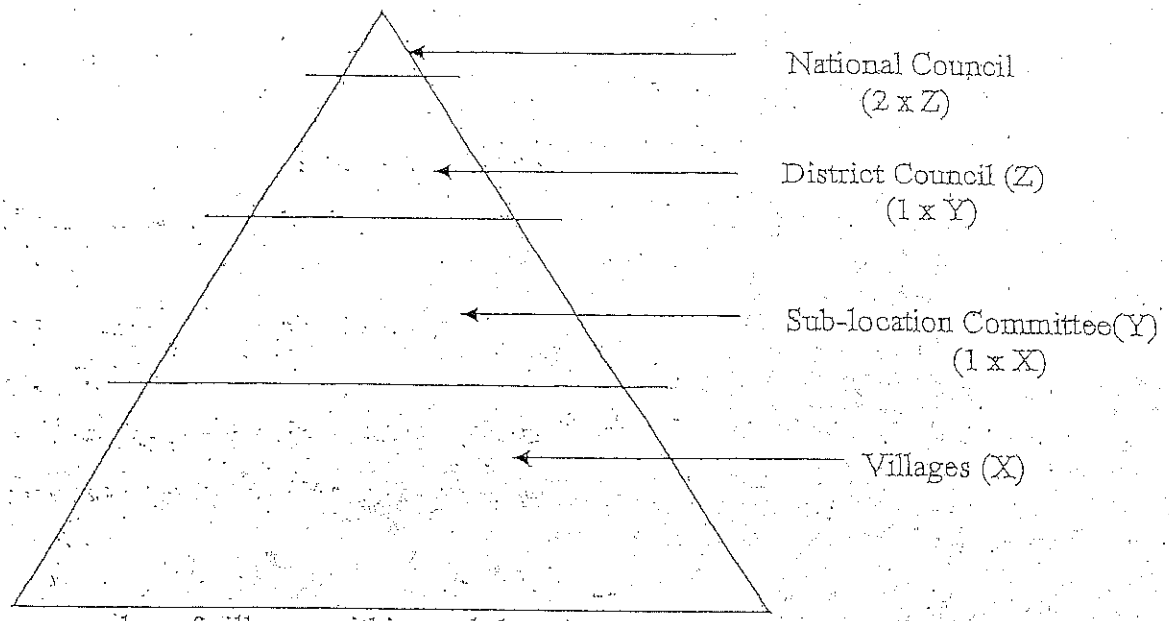
- Assessing and evaluating the viability of the health service providers at their level;
- Processing the claims;
- Reimbursing the contracted health service providers.

Contracting of providers of ambulatory and hospital care, however, is to be managed at the provincial and central level. There should also be a reporting mechanism to ensure improvement in the health sector infrastructure, registration and compliance in contribution collection, quality of healthcare provision, utilization levels, satisfaction of the insured population and of providers, and operation of the NSHIF at all levels.

4.3 Relationship between the NSHIF management and Grassroots

4.3.1 Pyramid of representation from Grassroots

The following is the pyramid of representation from the grassroots to the National Council.



X = number of villages within a sub-location

Y = number of sub-locations (number of sub-location within a district)

Z = number of districts (currently estimated at 80)

The National Council will elect its office bearers, and the regulations will give the procedures for election. The Grassroots representation will also be reviewed in the light of the Constitutional Reform in Kenya.

4.3.2 *The National Council*

The National Council shall be the policy-formulating organ of the Fund and it will have the powers to do the following:

(i) To appoint and remove the members of the Board of Trustees on specified grounds.

(ii) To propose the contribution level and benefit structure of the Fund.

(iii) To receive, consider and approve the annual budget and investment policy of the Fund from the management.

(iv) To provide an effective feedback mechanism between the Fund and its members.

(v) Be actively involved in the social mobilization and sensitization of the members on the objectives and activities of the Fund.

(vi) To act as a general oversight body for the effective discharge of the duties of the Board of Trustees and the protection of the interests of the members of the Fund.

(vii) In collaboration with the Ministry of Health, address matters relating to the efficient delivery of healthcare services including primary health (this collaboration shall be clearly defined in the regulations to ensure that the Fund does not take over any functions of the Ministry of Health).

(viii) Perform any other functions incidental to the achievements of the objectives of the Fund.

Provision will also be made in the regulations for the removal of the members of the National Council who are not serving the interests of the Fund.

Members of the Secretariat of the National Council shall include:

- Chairman of the National Council
- Vice-Chairman of the National Council

- Sixteen (16) Provincial Representatives, two from each province elected from among the members of the National Council
- Permanent Secretary, Finance.
- Permanent Secretary, Health / Director of Medical Services
- Chairman of the Board of Trustees who shall be the Secretary
- Chief Executive of the National Social Health Insurance Fund

The Chairman and vice-Chairman of the National Council could also be given the role of ombudsman and receive complaints about the working of the NSHIF. The latter should be complementary then to the tasks assumed by the Department of Anti-Fraud/Theft Investigation.

The Secretariat will be responsible for the facilitating National Council activities to enable the Council fulfill its mandate.

4.3.3 Functions of the District Council

The District Council will perform the following functions:

(i) Liaise with the sub-locations on problems and issues arising at the sub-locations on matters relating to the Fund.

(ii) Receive and consider complaints relating to the Fund.

(iii) To be a communication link between the National Council, Board of Trustees and the sub-location committees.

(iv) Vet applicants from the districts and shortlist three for consideration by the National Council for appointment to the Board of Trustees.

(v) Perform any other functions that are incidental to the foregoing.

The members of the District Council perform their task as a service to the nation. However certain allowances might be given for transport, food and other expenses related to the performance of the duties of the District Council members.

The District Council shall have a Secretariat composed of:

- A Committee Chairman
- Vice Chairman
- Not more than seven other members from sub-locations not represented by the Chairman and the Vice-Chairman.
- District Social Health Insurance Manager – who shall be the Secretary.

The Secretariat will receive complaints from members for onward submission to the District Council for necessary action. If the complaint is against the NSHIF District Secretariat then such members of the secretariat shall not sit in the meetings that consider such complaints.

4.3.4. Functions of the Sub-locational Committee

The Sub-locational Committee will be responsible for:

- Social mobilization and education at the village level on the objectives and activities of the Fund.
- Identifying those who are unable to contribute and submit the names and contact addresses to the District Council for review and approval.
- Drawing the attention of the District Councils to issues of public concern with regard to health services.
- Monitoring the impact of the activities of the Fund at the sub-locational level.
- Identifying problems that are unique to their sub-location and reporting to the District Council for necessary action.
- Performing any other functions incidental to the above.

The members at this level will be democratically elected, but will serve on voluntary basis.

4.4 Relationship between the Ministry of Health and the NSHIF

The NSHIF and the Government through the Ministry of Health will be partners in the promotion of health in Kenya. However each partner shall have clearly defined roles as follows:

- The NSHIF will deal mainly with facilitating curative aspects while;
- The Government will concentrate on
  - preventive programmes,
  - development of health facilities (as part of its social obligations to the citizens),
  - enforcement of compliance by all health providers to the Kenya Health Standards and
  - the overall regulation of all health insurance schemes (the NSHIF being one of them) through the Health Insurance Act.

4.5 Relationship between the NSHIF and other stakeholders

The NSHIF will consult with relevant key stakeholders within the country in order to regularly inform the public and to catch their views on the strategy and operation of the NSHIF. Basically, these stakeholders include representatives from all groups which are members of the Board of Trustees. For special purposes, other stakeholders could be involved.

CHAPTER 5
LEGAL FRAMEWORK

5.1 *Current Legal Framework*

The present legal regime relating to insurance, health insurance and employees' welfare are found in the following statutes:

- The Insurance Act (Cap 487)
- The National Hospital Insurance Fund Act (No. 9 of 1998).
- The National Social Security Fund Act (Cap 258)
- Employment Act (Cap 226)
- Workmen's Compensation Act (Cap 236)

In order to come up with an appropriate legal framework for the proposed NSHIF, it was found prudent to review the relevant provisions of the legislations herein above mentioned.

5.1.1 *The Insurance Act (Cap. 487)*

This Act regulates the companies that offer insurance on a commercial basis. However this Act has no specific provisions relating to health insurance.

At the same time, there is a large number of health insurance providers operating in the private sector, whose operations are not regulated by the law. This poses a great risk to the consumers of their services. It was in the light of this that the Commissioner of Insurance recently attempted to regulate the business of Health Management Organizations through the Insurance (Amendment) Bill 2002.

This Bill required that:

- All health management organizations register with the Commissioner as medical insurance providers.
- The provisions of the Insurance Act relating to insurance brokers, apply to such medical insurance providers.

The relevant provisions of the Insurance Act include the qualifications of the principal officers of an insurance broker and the requirement that such a broker should not act as an insurer by purporting to provide insurance cover, but should work with a registered insurer.

At the time of writing this sessional paper, the Insurance (Amendment) Bill 2002 had not been introduced.

From the foregoing it is imperative that Health Management Organizations and other medical insurance providers be regulated in order to provide legal protection to members of the public who pay the premiums. Health Management Organizations should operate either as insurers or health service providers but not both.

5.1.2 The National Hospital Insurance Fund Act (No. 9 of 1998)

The NHIF Act establishes the Fund and makes detailed provisions regarding the contributions, which are mandatory for all persons who-

- are ordinarily resident in Kenya;
- are of the age of 18 and over; and
- have a prescribed total income whether from salaried or self-employment.

The Act also provides for the declaration of participating hospitals by the Board of Management in consultation with the Minister for Health and the payment of benefits to

such hospitals for the expenses of a contributor, his named spouse, child or other named dependant.

The Board of Management of the NHIF is appointed by election but is by and large institutional representation and has inadequate grassroots representation.

5.1.3 The National Social Security Fund Act (Cap 258)

This legislation does currently not have any provision requiring that a members' contribution or part of it be committed to healthcare. However, it could be further scrutinized which role the NSSF could play in facilitating the collection of contributions of the retired.

5.1.4 The Workmen's Compensation Act (Cap 236)

This legislation deals with payment of compensation by employers to workers for injuries suffered in the workplace. It currently does not address medical treatment of the worker, only medical examination for the assessment of the extent of injury for purposes of determining the amount of compensation. Like the NSSF, this Act does currently not directly deal with the financing of healthcare provision to the workers. It should be reassessed, however, whether the medical costs as a result of injury in the workplace should not be covered by this Act.

5.1.5 Employment Act (Cap 226)

This legislation has a provision that requires employers to cater for the medical care of their employees.

5.2 *The Proposed Legal Framework*

After examining the existing legislation and the institutions established under them, relating to health, health insurance and other workers' welfare concerns and after interpreting and analyzing the information/data collected from a wide cross-section of the Kenyan society, the Committee finds that the existing legal regime is inadequate for the provision of equitable, quality and affordable healthcare for all Kenyans. To ensure the provision of quality healthcare for all Kenyans, there is need to introduce two pieces of legislation; one to provide for general Health Insurance (The Health Insurance Act); and another to establish the National Social Health Insurance Scheme (The National Social Health Insurance Fund Act).

5.2.1 *The Proposed Health Insurance Act*

If enacted into law, the Draft Health Insurance Bill will empower the Ministry of Health to carry out regulatory, supervisory and co-ordinating functions with regard to all healthcare insurance schemes. These schemes will be the Private Health Insurance (including the Health Management Organizations) and the proposed National Social Health Insurance Scheme. The legislation on health insurance will harmonise all the existing Acts relating to health and insurance such as the National Hospital Insurance Fund Act (NHIF); the Employment Act and the Insurance Act.

The proposed Health Insurance Act will provide for the establishment of the various health insurance schemes and define their respective functions. For example the HMOs will not be allowed to operate as both insurance carriers and healthcare service providers. The Act will also define, set up and regulate adherence to the quality standards applicable to all healthcare service providers.

To summarize, this Act should contain the following essentials:

- The role and responsibilities of the MOH (regulatory, supervisory and co-ordinating function, preventive and promotive healthcare, rehabilitation, quality

assurance, HIV/AIDS programme, staff payment, human resource development, healthcare infrastructure etc.)

- Harmonization of laws related to health and insurance
- Regulation of private health insurance (incl. HMOs)
- Regulation of community-based health insurance organizations
- The transformation of NHIF to NSHIF
- Any additional regulation related to health insurance.

5.2.2 *The Proposed National Social Health Insurance Fund Act*

This proposed Act will establish the National Social Health Insurance Fund (NSHIF). The NSHIF will be a legal entity and it is proposed to be independent and autonomous. This Fund will be mandatory and as such all Kenyans will be required by law to be its members. It will be national because it will apply to the whole population of Kenya and in all parts of the Country. It will be social because in the spirit of solidarity (Harambee) the rich will subsidize the poor, the young will subsidize the old the employed will subsidize the unemployed and the healthy will subsidize the sick.

The Fund will be owned by the stakeholders, and the Act will create the various organs of the Fund, namely, the National Council, the Board of Trustees, the District and Sub-locational Committees. The proposed Act will define the functions and powers of each of the above organs. It will specifically deal with the manner in which the cases of fraud/theft will be dealt with. Stiff penalties will be put in place to deter those involved in fraud. The accounts of the Fund will be audited regularly and an anti-fraud/theft unit will be established within the Fund.

The Guiding Principles of the National Social Health Insurance Act

i. NSHI shall contribute to the vision of the Kenyan MOH to create an enabling environment for the provision of sustainable quality healthcare that is acceptable, affordable and accessible to all Kenyans.

ii. It will be compulsory for every Kenyan and every permanent resident to become a member through enrolment and payment of a subscription.

iii. Since not everybody is deemed to be able to pay contributions to the NHSIF, it is the policy of the Government to subsidize the poor by earmarking at least 11% of total expected revenue from consumption taxes to be paid into the NSHIF.

iv. The NSHIF will be guided by a community spirit of solidarity. It must enhance risk sharing among income groups, age groups, and persons of different health status, and residing in different geographical areas.

v. The NSHIF shall promote maximum community participation through a process of representation from the village upwards to the National Council. The NSHIF will be owned by the stakeholders.

vi. The NSHIF shall build on existing community initiatives for registration procedures, contribution collection and human resource requirements.

vii. The NSHIF shall balance economical use of resources with quality of care. It shall provide effective stewardship, fund management, and maintenance of reserves.

viii. All the money received through contributions and other means minus minimum administrative costs and reserves shall be returned to the insured in the form of improved health service provision.

ix. The NSHIF shall assure that all participating healthcare providers are responsible and accountable in all their dealings with the Fund and its members.

x. The Government, for the time being, will continue to pay for the wages and salaries in the public health sector. The medium-term goal (5 to 10 years) for the NSHIF shall be to cover all recurrent expenditure related to health service provision including personnel costs. In addition, the goal is for infrastructure investments to become co-financed by both the Government and the NSHIF.

5.3 *Conclusions*

i. The introduction of the Health Insurance Act and the National Social He Insurance Fund Act will improve access to quality healthcare services to Kenyans.

ii. The Kenyan public will accept the NSHIF only if it is properly planned and v managed by men of honesty and integrity.

iii. The NSHIF Act provides directly for the payment of providers for the use medical services by members of the Fund.

iv. There is currently no law regulating the business of a large number of priv health insurance providers. It is necessary to have such a law in order to give le protection to members of the public who choose to insure themselves privately addition to their NSHIF membership.

v. The place of the NSSF Act and the Workmen's Compensation Act vis-à-vis National Social Health Insurance law will need to be considered.

CHAPTER 6
KEY CONCERNS AND SUCCESS FACTORS

6.1 *Acceptance*

The fundamental concept of the establishment of a National Social Health Insurance Fund, was universally accepted in all the districts and provinces visited. The successful implementation of the Fund was seen to hinge on the following essential pillars:

- Independence and autonomy;
- Ownership by stakeholders;
- Access to quality health services through the Fund;
- Accountability of the Board of Trustees, the management, and contracted service providers;
- An appropriate legal framework to empower the Fund and with appropriate inbuilt checks and balances;
- Political goodwill.

6.2 *Issues of stewardship/governance*

6.2.1 The National Council

During the Focus group discussions in the districts and provinces, deep concerns were expressed concerning ownership, control, transparency and accountability of the Fund.

The credibility and integrity of the people to serve at all levels right from the National Council, Board of Trustees, to the management of the Fund, were felt to be of critical importance. The selection of the Council members was seen to be a bottom up approach from the grassroots sub-location level to the national level. This was to be by an election process of highly credible, honest and transparent individuals, who could be trusted to safeguard the stakeholders' interests in the Fund. The council was also seen to be multi-sectorial with representation from farmers, fishermen, matatu operators, religious groups

and market traders. The National Council was to be the general governing body with stewardship functions related to the Fund, and to have the mandate of appointing the Board members from a list of grassroots nominees.

6.2.2 *Board of Trustees and the general fund management*

The key concerns with the management revolved around the election of the Board of Trustees. The Board has to oversee the day-to-day running of the fund. It was crucial that stakeholders elect the Board from the representative grassroots level. Their tenure on the Board should be limited to two terms of four years each based on performance.

The competence of the Board members to execute their responsibilities was also of critical importance and it was felt that a professional mix was essential. The ability to discipline errant board members was of fundamental importance, and it was felt that the creation of a National Council, composed of stakeholders from the various grassroots was essential to "oversee" their operation.

6.2.3 *Elimination/Curbing/Reduction of Fraud/Theft*

Fraud within the Fund was seen as one of the biggest concerns that would greatly undermine the sustainability of the Fund. It was observed that fraud could be perpetrated at the following levels:

- internally, within the management of the Fund
- at contracted service providers.
- at beneficiaries of the scheme.

The need to vet the quality of the contracted providers and institutions was felt to be very important. An inspectorate to ensure compliance was found necessary. Stiff penalties for fraudsters were recommended with suggestions that they should, in addition to criminal penalties be made to pay back any assets fraudulently acquired and their names published in the local print media. The establishment of a unit to deal with fraud and theft was also recommended.

6.2.4 *Implementation and monitoring of progress*

At the policy level, it is important to monitor progress of health insurance development. The indicators proposed below relate to the three important functions of financing via social health insurance: the revenue collection, the risk pooling and the purchasing. Below we present a set of relatively easily measurable performance indicators and design features. The sources of information for these indicators and design features should normally include Reports of the NSHIF, results from Demographic and Health Surveys, and the Economic Survey.

A. Revenue collection

A1. Performance indicators

1. Population coverage

- *Percentage of population covered ?*

A social health insurance scheme with a higher percentage of population covered by the scheme is associated with a better performance.

- *Coverage by socioeconomic group ?*

The socioeconomic groups would need to be defined within the context of Kenya. For instance, there could be the groups of civil servants and teachers, enterprise workers and employees, self-employed professionals and other self-employed including rural workers. It would be important to monitor the coverage of each of those groups, so as to see which specific groups merit additional efforts in order to speed up enrolment.

2. Financing of health expenditure

a) Extent of prepayment

- Ratio of prepaid contributions to total health care costs ?

The greater this ratio, the better the protection against the financial consequences
healthcare.

- Prepayment ratio by socioeconomic group ?

Analysing the extent of prepayment by socioeconomic group is important becaus
indicates how equitable a social health insurance scheme is. The challenge is to ens
that prepayment ratios are also sufficiently high for the poorer population groups.

b) Protection against catastrophic expenditure

- Percentage of households with catastrophic spending ?

It is expected that social health insurance would lower this percentage of househol
Catastrophic spending arises when households are spending more than a cert
percentage of their net income (income minus food) on healthcare; that percentage co
be defined for instance as 40% or 50%. Through this indicator, it can be checked what t
impact would be of the social health insurance scheme on poverty reduction.

- Catastrophic spending by socioeconomic group ?

Analysis by socioeconomic group is useful in showing how equitable the social heal
insurance scheme is. Catastrophic spending is likely to be a greater problem amongst t
poorer socioeconomic groups, but a well performing scheme would limit such spendi
even amongst such population groups.

A2. Design features related to the ability to pay contributions

- Are contributions flat-rated or income-rated ?

From an equity viewpoint, income-rated contributions are preferable to flat-rate contributions as the former are better related to capacity to pay. However, it is admitted that in the first stages of health insurance development, and in countries with an important informal sector, it is difficult to assess incomes and as a consequence to define income related contributions.

- If flat rates are practised, is there a schedule of flat rates ?

A schedule of flat rates, with rates increasing with socio-professional status and adapted to capacity to pay, is better than a uniform rate for all. It is more feasible for example to assess incomes of the self-employed professionals and to establish a flat rate schedule according to capacity to pay.

For equity reasons, it may also be envisaged to differentiate flat rates between adults and children, with the flat rate for the latter lower than for the former. A lower flat rate for children will reduce the burden on large poor families.

B. The degree of risk pooling

Performance indicator

- In case of the existence of multiple pools, what is the level of risk equalization ?

For social health insurance schemes with only a single risk pool, pooling is maximized, as all members' risks are combined into one pool and as they are entitled to the same health insurance benefits. However, in the case of a multiple risk pooling systems, members' risks are not necessarily fully combined across pools. The degree of risk pooling in a multiple pooling system depends on the risk equalisation measures that are in

place. For instance, a very adequate risk equalisation mechanism could make a mul pool system almost as effective in terms of risk sharing as a single pool.

C. Purchasing

C1. Performance indicators

1. Ensuring benefit package is fully received

- *Full information on claimant rights? / Existence of claims review?*

The pooled contributions of a SHI system are used to purchase a set of he interventions, with all members of the pool entitled to a specified benefit package fundamental performance indicator is ensuring that this benefit package is fully recei by all those who are entitled to it. Without full information readily available on clain rights, members may unknowingly not be accessing the full range of services they entitled to.

2. Administrative efficiency

- *Is there a maximum ceiling on the percentage of administrative expenditur total NSHIF expenditure ?*

C2. Design features

1. Efficiency and equity of benefit package

- *Design of benefit package incorporates explicit efficiency and equity criteri*

A benefit package should seek to make the best use of the limited resources availa through social health insurance. A number of efficiency and equity criteria can h improve the use of these resources, and should be considered when choosing wh interventions to include in a benefit package. The criteria that could be conside include cost-effectiveness, the need for poverty reduction, severe health conditions, equal treatment for equal need.

2. Provider payment mechanisms

- *Cost containment: Are cost-containment mechanisms and incentives in place ?*
- *Quality of service provision:*
  - Does the provider payment mechanism incite providers to provide an acceptable standard of care ?
  - Are methods in place to discourage underproduction.?
  - Is there a claims review ?

6.3 Access to Quality And Equitable Health Services

Minimum standards of quality healthcare were deemed necessary at all levels of health service provision. The quality and types of medicines to be used and the cost needs to be agreed through a comprehensive drug formulary. The formulary is to be made up of a list of essential, comprehensive and quality drugs with recommended pricing. Contracted Health Providers were to use this formulary in their treatment. A separate body like KEMSA, could be used as a central procurement agency, to further ensure reduced cost of drugs. The need to contract services as close to the people as possible was also critical, and Mobile clinics where necessary in remote areas. Traditional medicine providers also needed to be vetted, as their services were highly rated, yet no control mechanisms on safety and standards exist for this sector of health providers.

In all, the administration of health services through the scheme should be done fairly without favours or discrimination of social status.

6.4 *Goodwill of Contributors/Members*

The success of the Fund depends heavily on contributions of members, and t willingness to continue supporting the scheme. This goodwill needs to be nurtu through efficient service delivery and the education of members on their rights obligations, within the scheme. Social mobilization of members at the Grassroot le and the inculcation of a strong sense of ownership were felt to be of paramc importance. The process of election of representatives at all levels is essential in instill a sense of ownership.

CHAPTER 7
CONCLUSIONS AND RECOMMENDATIONS

7.1 *General Conclusions*

Based on the findings from the literature review, primary and secondary data and analysis of the same, the following conclusions are made:-

(i) Good health is a pre-requisite for the social and economic development of the country. It is necessary to provide alternative strategies for the provision of equitable, quality and affordable healthcare for all Kenyans.

(ii) The existing legal regimes relating to health and insurance and the institutions established thereunder are inadequate and in dire need of reform.

(iii) Some of the institutions currently charged with the duty of healthcare provision have a limited mandate and inadequate benefit packages. They need to be overhauled and not merely reformed.

(iv) There are various categories of healthcare providers in the country, all of whom offer their services to Kenyans. There is urgent need for enforcement of quality healthcare regulations in order to ensure that all Kenyans receive healthcare of uniform quality at respective levels.

(v) Given the levels of poverty among the Kenyans, it is necessary to provide healthcare for all through a Social Health Insurance Scheme.

7.2 *General Recommendations*

Arising from the foregoing conclusions, the following social health insurance reforms recommended:-

(i) That the National Hospital Insurance Fund Act should be repealed a replaced with new legislation capable of facilitating the provision healthcare to all Kenyans irrespective of their age, social, or econor status.

(ii) That there should be a new law to facilitate the establishment o National Social Health Insurance Fund and to ensure that it is r competently and efficiently.

(iii) That detailed research is required to be undertaken to accurat segregate the various categories of healthcare providers from wh Kenyans seek medical treatment, especially since all of the including traditional medicine practitioners, will seek reimburseme from the Fund once established.

(iv) That it is necessary to put in place a Health Insurance Act to regul and supervise all health insurance schemes, including those offered Health Management Organizations, particularly to ensure that Hea Management Organizations operate as either as health insurers health service providers but not both.

(v) That there is need for a detailed and continuous research to establish:-

a. The benefits package, which a Kenyan should be entitled to obtain from a healthcare provider, under the proposed scheme.

b. The amount of contribution that such a person should make to the Fund.

(vi) That, there is need for the following to be in place for the long-term effectiveness of NSHIF:

a. Traditional Health Practitioners Act

b. Constitutional provision guaranteeing a Right to Health, which should be implemented through a mandatory National Social Health Insurance Scheme, and the Office of the Director General of Health.

c. The Office of the Director General of Health to be established as a Constitutional Office to ensure full implementation and enjoyment of the Constitutional right to health.

(vi) That no service provider should be contracted under the proposed scheme unless:-

i. such provider is regulated under the relevant laws governing their practice.

ii. Their services meet the quality and safety standard as prescribed by the Ministry of Health or such other body as may be mandated by the Ministry for the purpose.

iii. Are recommended to the Council by their professional bodies.

7.3 Recommendations concerning implementation

The strategies and the implementation methods contained in this Sessional Paper shc be reviewed regularly in keeping with changing health needs. In particular, in the com period, the implementation needs to be prepared by a whole series of further practi studies concerning the contents of the benefit package, the provider payment method be adopted, as well as pressing health financing and implementation issues bef launching the NSHIF in July, 2004.

Finally, a communications strategy for all concerned stakeholders and for all populat groups must be developed and implemented.

ANNEX I: Financial Projections

Table 1 Basic Hypotheses

Population growth rate	2.4%
Percentage of dependants	65%
Percentage of children <18 years among dependants	80%
Percentage of self-employed in the active and retired population	80%
Percentage of civil servants in the active and retired population	7%
Percentage of employees in the active and retired population	10%
Percentage of retired in the active and retired population	3%
Average annual salary of civil servants in 2004 (afterwards adjusted by 6% yearly)	60,000 Kshs
Average annual salary of employees in 2004 (afterwards adjusted by 6% yearly)	140,000 Kshs
Average annual pension in 2004 (afterwards adjusted by 2% yearly)	15,000 Kshs
Inflation rate	7%
Insurance contribution for civil servants and employees (employer part included)	7%
Insurance contribution for the retired	3%
Contribution per adult self-employed	450 Kshs
Contribution per child in self-employed families	450 Kshs
Self-employed adults and children for which insurance contributions are waived	25%
Government contribution in 2004 (afterwards inflation adjusted)	11 bn Kshs
Other insurance revenues in 2004 (afterwards inflation adjusted)	1 bn Kshs
Co-payments for all health care services	0%
Cost of outpatient visit in 2004 (afterwards inflation adjusted)	Low scenario: 180 Kshs High scenario: 310 Kshs
Cost of inpatient day at district level in 2004 (afterwards inflation adjusted)	Low scenario: 2,300 Kshs High scenario:3,550 Kshs
Cost of inpatient day at national hospital level in 2004 (afterwards inflation adjusted)	Low scenario:2,800 Kshs High scenario:4,910 Kshs
Outpatient visits per capita	Low scenario:2 High scenario:3
Inpatient days per capita at district level	Low scenario:0.175 High scenario:0.2
Inpatient days per capita at national level	Low scenario:0.0495 High scenario:0.0510
Administrative costs as a percentage of health care expenditure	5%
Reserves as a percentage of health care expenditure	3%

Table 2. Preliminary estimates of income and expenditure of the NSHIF (90% membership)

Alternative scenarios
(2005)

Cost of healthcare	Utilization of healthcare	
	LOW	HIGH
LOW	R 35.840 bn Kshs E 33.617 bn Kshs % diff +6.2% Hexp pc 964 Kshs	R 35.840 bn Kshs E 42.634 bn Kshs % diff -19.0% Hexp pc 1.223 Kshs
HIGH	R 35.840 bn Kshs E 55.375 bn Kshs % diff -54.5% Hexp pc 1,588 Kshs	R 35.840 bn Kshs E 70.525 bn Kshs %diff -96.8% Hexp pc 2,023 Kshs

Notes: R= revenue; E=expenditure; % diff is the gap between revenues and costs percentage terms; Hexp pc is total health expenditure per capita

Table 3 Child contributions in the Low Cost-High utilization scenario (90% membership)

Additional resources needed in 2005 in order to financial equilibrium

Level of child contribution (in Kshs/ 2005)	Required change in Government contribution	Required change in the % of employee/employer contributions
450	+ 6.794 bn Kshs	+ 2.65%
200	+ 8.702 bn Kshs	+ 3.25%
107	+ 9.465 bn Kshs	+ 3.60%