Towards UHC in Kenya: issues, options and guiding principles for the way forward

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WHO Health Level Expert Mission

Summary briefing for all UHC stakeholders

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Main findings

Progress towards UHC will require coordinated action across the health system; it is not just about financing or “insurance”

National and county health budgets will be key drivers of change

Recommendations (starting at the end)

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1. The main revenue source for rapid scale up towards UHC is general tax revenues for a universal essential service package with non-contributory entitlement
2. Main opportunities to raise more revenues in context of the Big 4 agenda, including UHC, are corporate taxes and VAT
3. Introduce or increase taxes that improve health (tobacco, added sugar, petroleum) and reduce future cost growth
4. Create strong incentives for counties to invest in preventive and promotive services and health enablers (PHC, community health, water, sanitation, nutrition) through single conditional matching grant for this purpose

Recommendations (2)

5. For initial implementation, start with modest county essential service package focused on health priorities, with clear pathways for expansion
6. Support counties to develop tailored service delivery strategies in line with their particular health situation and context
7. Consolidate funding streams for some programs (e.g. free maternity, elderly, children), while ensuring accountability/reporting for these specific prioritized groups and services
8. Enable more effective system governance for evidence-informed decision-making through linked data platforms throughout the health sector (including MOH, NHIF, private sector)

Recommendations (3)

9. Accelerate restructuring of NHIF to reflect its role as purchaser in a unified, universal, and mostly tax-funded and devolved health system
10. Address current constraints that prevent public facilities in counties from receiving payment directly
11. Create evaluation (not just monitoring!) framework and implement concurrently with reform rollout

Overview

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0. Background
1. Financing
2. Design
3. Implementation
4. Governance
5. WHO support

0. BACKGROUND

Operationalizing UHC

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WHO definition: all people get the services they need, of good quality, without fear of financial hardship

Therefore, these objectives should drive country reforms:

- Reduce the gap between need and utilization
- Improve quality
- Improve financial protection

Practical questions to develop Kenya's reform model

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What are the specific ways that the system is "under-performing" relative to these 3 UHC goals?

What are the causes of those problems?

In the next 5 years, what should Kenya do to address those causes, while also building the foundation for future progress?

1. FINANCING

Health financing reform for UHC: guiding principles adapted to Kenya

1. Predominant reliance on public funding, sourced mainly from budgets, given difficulty of enforcing mandate on informal sector

2. Reduce fragmentation in pooling to allow flexibility in resource use and provide complementarity between of different funding streams in contributing to coverage and affordability

3. From passive to "strategic" purchasing of health services to drive performance and manage cost growth

4. Improve efficiency to enable more results from available spending, and to build credibility

5. Define a "fiscally sustainable" essential service package

6. Implementation will be necessarily phased, as will incremental resource needs over the coming years

How to find more public funding for UHC in Kenya

Context of high informality limits potential to mobilize significant funding through mandatory contributions for health insurance

Global experience (and economic theory) show that unsubsidized voluntary prepayment is not viable

- Mobilizes little (e.g. 3% of NHIS revenue in Ghana) and plagued by adverse selection

Mission conclusion: the main source of funding for rapid scale-up of UHC in Kenya must be national and county government budgets (i.e. taxes)

Raising more revenues, including for health

There is large potential to raise more revenues. Some options:

- Raising VAT by from current 16 to 17% would yield 0.3% of GDP annually
- Eliminate VAT exemption for petroleum (would increase revenue by 1% of GDP annually and reduce pollution and congestion!)
- Curtail exemptions for corporate tax and VAT (would increase revenue by up to 4% of GDP)

Using taxes to improve health (and increase revenues, at least in early years) and save money in longer run by reducing NCD burden

- Increase tobacco tax (taking into account EAC taxes)
- Introduce tax on sugar-sweetened beverages (sodas)

Efficiency improvement will generate resources for UHC

More than 70% of gov't health spending is on wages, but system still needs to address key problems like absenteeism and low productivity

Increase relative priority in health spending for preventive, promotive and health enabling interventions (water, sanitation, nutrition, etc.)

Establish function of health technology assessment (HTA) to ensure that proposed new investments or services are cost-effective and that the likely budgetary impact is transparent, as in Thailand and South Africa

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2. SOME DESIGN ISSUES

Key design issues

Essential service package: content and policy framing

County-tailored service delivery strategies

Policy towards the private sector in health

Roles and responsibilities

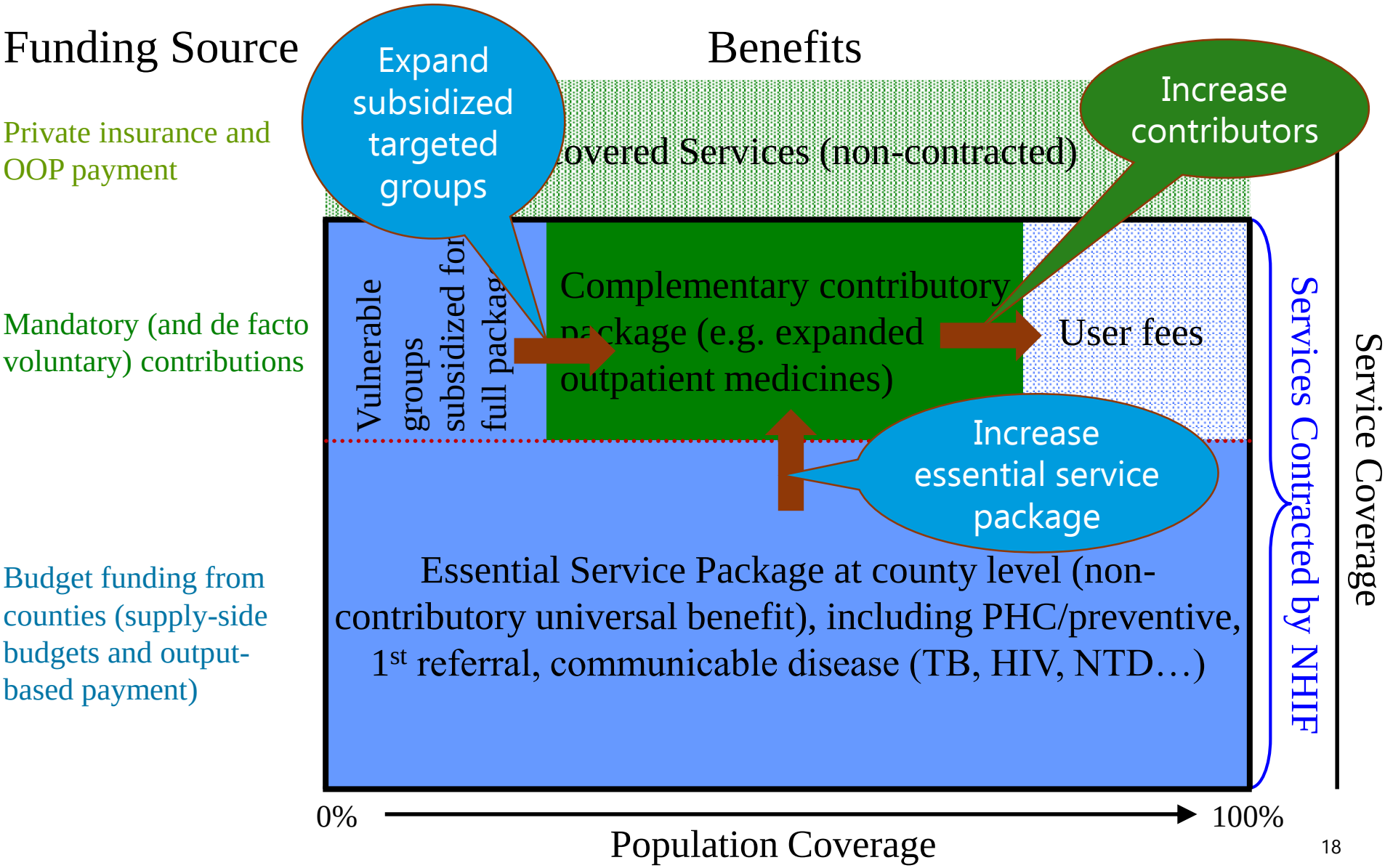
Essential service package – content issues

Link content to the achievement of both health (disease burden) and financial protection objectives

- County-level health services, priority for primary and community care, preventive services, and 1st referral services.
- Manage high-cost, low-frequency services, subject to explicit rationing (Mexican example can be explored for application to Kenya)

Establish transparent process for analyzing proposed changes to package over time (e.g. HTA and budget impact) – can bring countries that have done this

Vision: benefit design for unified system with complementary funding sources



County-tailored service delivery

Diversity across Kenya in terms of disease burden, population density, access, etc., requires a tailored service delivery (NOT financing) response

Devolved county structure ideally suited for this role/responsibility, with budget (and TA from centre as needed) to support county-specific development and monitoring

Policy towards private sector, aligned with UHC goals

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Service delivery

- Qualified private (for-profit, NGO) providers can be contracted to provide all/part of the essential service package, subject to standards and mechanisms and data reporting to be applied to all providers for purpose of quality improvement
- Regulate dual practice and conflict of interest (e.g. physician-owned diagnostic centres)

Financing/insurance

- Space for private insurance to cover services outside the publicly regulated package (i.e. providers not contracted for that package)
- No tax subsidies for this, as it would largely benefit the rich

Roles and responsibilities (some initial ideas)

MOH is responsible for policy, including e.g. final decision on package definition

Purchaser (NHIF) is an executing agency, without a policy function

Accreditation to be separated from NHIF

Public providers to become "entities" in the Public Financial Management system so that they can receive payment directly from purchaser

3. SOME IMPLEMENTATION CONSIDERATIONS

Build foundation for strategic purchasing and effective system governance

2017 Health Act aims "to establish a unified health system" (think "universal=unified")

Critical early step is to put in place **unified national database on patient activity**

- One form, regardless of insurance status or ownership of provider
- Co-management of database by NHIF and MOH

Without this, there is no strategic purchasing, and MOH will never have the information needed to monitor and adapt to changing circumstances

Shift payment mechanisms gradually, enable providers to respond

Likely too disruptive to put all money (e.g. including salaries)for county health services into output-based payment in year 1

Review rules that don't allow public providers to receive payment directly from purchaser

- Combine limited autonomy with clear accountability, financial and output reporting
- Support the providers (purchaser-provider collaboration, not "split")

Initial package design

County-level services currently provided free (but funded at a higher level)

- Don't hold implementation hostage to detailed and lengthy costing exercise; use Health Accounts data and simple assumptions for rough estimates
- Cost structure may change due to new incentives
- Generate better cost data through the implementation process to enable refinement over time

Take care not to be overly generous in initial rollout phase

- Next year, it will be easier to scale up rather than reduce benefits

Develop and apply evaluation framework

Accompany implementation with analysis to provide "early warning system" and derive lessons over the next year

- Higher-level objectives of overall reform and first phase of implementation are the same
- Take disaggregated view (not about the entire reform, but specific elements such as access, purchaser and provider performance, citizen satisfaction, etc.)
- Generate better service use and cost data through the implementation process
- Not just about indicators (you want to explain change and not merely describe it)

Create incentives for PHC and especially preventive services

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For example, “matching grant” approach

- Reward county investments that strengthen preventive/promotive services (including also actions to address health determinants such as water, sanitation and nutrition) with central grant (probably requires new conditional grant)

External aid

Can support implementation and funding within the frame of the government's reform plan and public financial management system

- As part of funding for the package, including e.g. specific elements such as incentive grant mechanisms for preventive and promotive services and health enablers, or for specific diseases or populations
- Technical assistance
- Contribute to building unified underlying support systems rather than parallel systems, to enhance efficiency and sustainability, and enable more effective transition from aid

4. GOVERNANCE

Transparency and accountability essential for reform

Accountable to county stakeholders, and not only national

Annual reporting to be made publicly available, showing revenues and expenditures, as well as results achieved against defined targets

Implement citizen involvement mechanisms and institutional mechanisms (and time) for consensus building and communication

Aligning partners (more effective cooperation)

Ensure connection of DPs to UHC governance structures to ease alignment to government vision and implementation, and to strengthen accountability of DPs for this

Request partners to organize and engage with a consolidated position in these governance structures

Connect and continuously update all UHC DP stakeholders in joint platform

DPs to share all information related to external assistance to the UHC process, to build their technical capacity and promote collaborative support (using e.g. the P4H network platform

Data and knowledge management

Operationalize "National Health Observatory"

- Support analysis of unified health sector databases as well as other data sources
- Establish platform for policy expertise and dialog on UHC in Kenya among MOH, other national institutions, and experts
- Support applied research on the reforms as well as definition and monitoring of KPIs (e.g. scorecard, UHC index)
- Knowledge development and dissemination