NATIONAL SOCIAL HEALTH INSURANCE STRATEGY

Comments and Suggestions of the Joint WHO/GTZ mission[1] on Social Health Insurance in Kenya June 3-13, 2003

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1 Background

1.1 Introduction

The current user charges in MoH facilities are estimated at Kshs 2.2 bn per annum, or about 3.1% of total health expenditure. It is advised to review this figure. According to recent National Health Accounts estimates[2], net out-of-pocket spending in 2001 amounted to 53.1% of total health expenditure. Thus the level of user charges is expected to be much higher than the figure stated above.

1.2 Social Health Insurance

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 they allow for the inclusion into the social health insurance system of those households that are unable to pay contributions.

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 all population groups 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 organisations. 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.

1.3 Situation analysis

The private sector participation within the context of National Social Health Insurance Fund (NSHIF) will consist mostly of *provision of health care services*. The NSHIF will detain the financial resources, and with these it will purchase the necessary health services. Via *contracts* with the NSHIF, private providers will be

[2] Kenya National Health Accounts Estimates, 28th May 2003 (NHA unit, WHO)

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 financed by the NSHIF.

Basically, the current cost-sharing fees paid by the population will be replaced by prepaid contributions into the NSHIF. It is expected that in a first stage of the development of the NSHIF, the provider payment schedule is set in such a way that payments cover the necessary pharmaceuticals, small repair and maintenance costs, water & electricity, and administration (forms, books etc.). In so doing, government budgetary resources will be freed up, as these particular costs would now be covered via the NSHIF. These freed resources can be allocated to investment or renovation of the health infrastructure. They can also be allocated to preventive and promotive health services. Also here, contracts could be established with private sector institutions incorporating them in the provision of preventive and promotive health care.

1.4 Milestones to social health insurance

1.5 Terms of reference for the Task Force

Subsequent to the National Social Health Insurance Strategy Report and the approval of the National Social Health Insurance Fund Bill, a number of tasks will need to be undertaken in order to be well prepared for the implementation of social health insurance. These tasks are in the areas of management, of legislation and regulation, of the benefit package, of modes and levels of provider payment, of financing and implementation before launching the NSHIF.

Because of the importance of adequate preparation for the implementation, it is strongly suggested that a NSHIF Implementation Task Force be established, composed of at least 5 full-time staff with expertise in the areas mentioned above. This Task Force will be supported in the next half year by two technical assistance missions covering the areas mentioned above. In Annex I proposals are given for the terms of reference of these missions. It is expected that the mentioned tasks will be undertaken jointly by the Task Force and the members of the technical assistance missions.

1.6 Mobilisation process

1.6.2 National Assembly Report

It is suggested to refer here to the Government's commitment to provide for co-financing of the NSHIF, especially to pay for the contributions of those who are not able to pay the scheduled 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.

It is also suggested to refer to the NSHIF as the ultimate holder of funds. Immediate elements of competition would be present only among health care providers, as they can compete for patients. Those providers that offer quality services are likely to attract the patients. Patients will thus be able to choose their provider, who in turn will be reimbursed according to the NSHIF provider payment schedule.

1.7 Challenges

1.8 Opportunities

One of the major objectives of converting cost-sharing into social health insurance is risk sharing among all insured members as well as pooling of contributions. In this way, even relatively costly care can be made accessible to those who need it. Of course, as health care is not 'free', contributions will still need to be paid on beforehand into the NSHIF, and minor additional contributions at the point of health service may still be considered (e.g. registration fees, self-referral fees etc.).

2 Methodology and findings

2.1 Literature review

2.2 Primary Information/Data

2.3 Collation, analysis and interpretation of the information

We would suggest adding the following topics for further study:

- 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 health care system (levels 1 to 5)
- Options for provider payment (at levels 1 to 5 of the health care 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 the various levels of the health care system (levels 1 to 5)
- Development of monitoring systems and procedures
- Implementation strategy and timetable.

3 Basic health insurance design features

3.1 The benefit package

The design of the benefit package will have to built on existing practices that are both acceptable to the user and the service provider at all 5 levels of the health care system.

The introduction of cost-sharing mechanisms at all levels of the health care system have 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 health care providers in the public and private sectors. The role of Government has largely been limited to financing the salaries of staff and basic infrastructure.

Health care 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 health care 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 insurance contributions by the members of the NSHIF and appropriate level of remuneration for health care providers who will be responsible for the provision of a comprehensive diagnostic, treatment, medication and health 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 remuneration** schemes (e.g. NHIF and cost sharing charges).

3. Special payment mechanisms for **long term care and HIV/AIDS** which will have to be supported financially by external resources.
4. Exclusion of health care services.

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. 6000 Kshs, a dispensary consultation 410 Kshs. When staff cost are deducted the amounts come closer to 4000 Kshs and 310 Kshs respectively.

These estimates are apparently based on current fees in the private sector. The NHIF currently only pays flat rates for in-patient days by category of hospital. Many claims are, however, submitted with a complete bill including all charges to the patient, in some instances even including a diagnosis. Therefore a simple sample survey should generate reasonable estimates of current fees at different levels of hospitals in the country.

Using the **extrapolation approach,** an estimated remuneration for each in-patient day of 2300 Kshs 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 payments to providers. In addition, such payments would be made for indigent patients, and thus hospitals stand to gain from the new NSHIF. So far, fees for indigent patients are waived. Furthermore new income will be generated, that is currently forfeited due to the policy of free care for under fives.

For level 1 out-patient visits the factorial approach, taking account of salaries of health personnel, leads to a remuneration of 410 Kshs. On the other hand, an extrapolation of current dispensary out-patient fees amounts to some 100 Kshs incl. diagnostics and drugs under the current cost sharing mechanism. A remuneration of 150 –200 Kshs per out-patient visit will probably cover all desirable and feasible items incl. pharmaceuticals.

These remuneration levels, should the NSHIF want to apply them, will have to be discussed with health care providers and broad consensus with the stakeholders has to be reached. It needs to be clearly communicated to patients and members as well as providers which health care services are covered. It is important to anticipate that providers may claim vis-à-vis their patients that certain items are not covered by NSHIF and that supplementary payments may be asked for.

Criteria for the **exclusion of health services and long term care** will have to be developed. The benefit package presented in Draft 4 is very comprehensive. Only major heart surgery, depending on outcome assessment, orthopaedic appliances, cancer and terminal care are excluded or subject to individual case assessment. For long term care, including mental patients, special low daily in-patient rates e.g. 1000 Kshs may have to be negotiated with NGOs and welfare organisations. Tuberculosis

treatment is excluded, which is no problem as such since public health programmes are in place.

Preventive measures should be included when they relate to clinical services e.g. ANC, Under Fives´ Clinics, contraception etc. Otherwise prevention and health promotion will remain under the responsibility of the MoH including the provision of vaccines for the national vaccination programmes.

The inclusion of dental care beyond simple procedures such as extractions and fillings is probably not feasible because of cost and service availability.

In ophthalmology sight saving and restoring procedures should be covered while glasses should not be included at this time.

Special consideration needs to be given to the increasing number of **chronic/degenerative diseases** e.g. hypertension, diabetes etc. which are becoming a major problem with an aging population. This results in long term treatment needs. This disease pattern has to be addressed by health promotion efforts of the MoH. The acute phases of chronic diseases should nevertheless be covered by the NSHIF.

Separate provisions have to be made for HIV/AIDS-related VCT and ARV treatment in certified centres. ARV treatment may relieve health care providers of cost for opportunistic infections on one side, but requires life-long treatment at annual cost of well above 500 € per year. The experience with large scale treatment schemes in Africa is so limited that no firm estimates can be given at this time.

In the design of the benefit package some of the following principles may be considered:

1. A **registration fee** staggered by level of care may prevent over-utilisation and inappropriate self-referral to higher levels of the health care system. E.g. 10 Kshs for level 1 to 50 Kshs for level 5 out-patient visits.
2. 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. 5 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 daily food in hospitals especially for guardians may be considered (e.g. 30 Kshs).
   The benefit package may also limit the number of in-patient days per NSHIF member per year.
3. **Long term treatment** e.g. diabetes and hypertension or cancer treatment may have to be excluded initially until reliable information is available on cost implications. Quality assurance and access to essential generic drugs at cost may help to alleviate the cost to the NSHIF and the patient.
4. 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. If flat

rates are used as the basis for remuneration, strict minimum quality standards have to be introduced.

5. **Remuneration levels** should also consider the level of care provided by different institutions using a similar grading systems as currently in use by the NHIF. The list of essential drugs to be included in the benefit package should be regularly reviewed against the background of WHO recommendations.
6. **Special review procedures for expensive drugs** may have to introduced.
7. **Mortuary storage time** should be strictly limited (e.g. maximum 3 days). All extra services like embalming have to be charged at cost.
8. **Accidents** which are covered by third party insurance should be charged directly to the insurer.

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 health care 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

3.4.2 Sources of financing: a further discussion

3.4.3 Contribution collection and registration

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 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 controlling mechanisms will be established.

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

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 a low number of employers outside Nairobi comply with the current obligation to pay contributions. It will be an important task for the NSHIF to include these companies and to ensure compliance.

It is also considered in the National Social Health Insurance Strategy Report how the contributions for the informal sector population can be collected by various organisations that are close to the population. These organisations include cooperatives, welfare organizations, trade associations and churches. Inded, these organizations may well collect contributions more effectively than a NSHIF branch office. These organizations will be contracted for this purpose and remunerated for the service of contribution collection that they deliver. Some of these organizations may well be licensed to issue or stamp the social health insurance card. In addition, adequate control will be necessary, however, so as to ensure that the contributions collected by these organisations is transferred regularly to the NSHIF.

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.

3.4.4 Other possible sources of revenue to be considered

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

We use the most recent National Health Accounts (NHA) data for 2001[3] :

[3] Kenya National Health Accounts Estimates, 28th May 2003 (NHA unit, WHO)

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**

We observe from the table above that Government and NHIF together have a share of 25 % of total health expenditures. Private sources add up to 75 %. The expenditure by the new NSHIF are estimated at 40 bn Kshs annually. 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.

Possible sources of Financing of the NSHIF according to the Strategic 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**

The earmarked taxes of Kshs 11 bn would raise the budgetary allocation of the Government to Kshs 25.9 bn out of Kshs. 246 b. (Kshs 235 bn plus 11 bn additional VAT) , which corresponds to 10.5 % of total government expenditure.

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 is that employers would approximately halve their expenditure on health care, one half being paid for by the NSHIF.

Assuming that Government and NSHIF will account for 75 % of the health care expenditures (according to the Strategic Plan), the total health care expenditures after introducing the NSHIF could be as follows:

Total Health Care Expenditures after introducing NSHIF

Source	Bn Kshs. (2001)	Share in %
Out-of Pocket	8.7	12
NSHIF	40.0	55
Government from tax revenue	14.9	20
Private prepaid health plans	2.5	3
Non-profit institutions	1.1	2
Employer paid medical services	6.0	8
Total Health Care Expenditures	**73.2**	**100**

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

Impact on the economic sectors (in bn Kshs)

	2001	with NSHI	Absolute Change
Private households			
- out-of-pocket	37.3	8.7	- 28.6
- Contributions NHIF / NSHIF	2.8	6 *	3.2
- Contributions of self-employed	0	10	10
-Payroll Harmonization (teachers and civil servants)	0	3.5 *	3.5
Total private households	40.1	28.2	- 11.9
Employer			
- Contributions NHIF / NSHIF	0	6	6
- Payroll harmonization (teachers and civil servants)	0	3.5	3.5
- Employer paid medical services	11.5	5.5	- 6
Total Employer	11.5	15	3.5
Government			
- general taxes	14.9	14.9	0
- earmarked VAT	0	11	11
Total Government	14.9	25.9	11
NHIF / NSHIF	2.8	40	37.2

* 50% of payroll

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 II. 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 necessary pharmaceuticals, 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 II. The projected expenditure vary between a minimum of 33.617 bn Ks (low cost/low utilisation) to 70.525 bn Ks (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

One 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 450 Ks per child. In Table 3, we present alternative scenarios whereby this flat contribution is lowered to 200 Ks and 100 Ks. We then indicate which efforts are required from either government or employees and employers in order to ensure a financial equilibrium.

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

3.4.6.2 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 will have to assess which implementation schedule would be most realistic.

We refer to Table 4 in Annex II for 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 health care facilities in which health care services are delivered are not allocated in such a way that all Kenyans have the same access to health care. 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 health care facilities all over Kenya.

During a transitional period mobile health care 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 health care. It will also be considered if health care 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 health care facilities. This regulation will ensure the provision of quality health care 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. Health care provision will therefore be divided 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.

3.4.7.2 Provider payment method

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 health care.

For the future NSHIF, the payment method is not yet defined, however. The payment methods at all levels of the health care system need to be defined. The following payment methods will be assessed:

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 health care. Another disavantage is that the administrative costs for checking the claims are high. From the point of view of the NSHIF, forecasting total health care 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 health care 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 health care 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 health care 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 health care 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 health care 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.
5. Combination. A combination of the above mentioned methods can be considered, e.g. a flat or lump sum for basic health care at outpatient and inpatient level, but a fee-for-service for highly specialized health care services.

It is expected that the NSHIF would be more interested, 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. In the current context of Kenya with its highly mobile population, capitation would seem to be very difficult to implement.

Whatever the payment method, the payments of the NSHIF will only be made on the basis of contracts with health institutions. These health facilities must be registered in the Health Institution Network. Through the contracts, the NSHIF will commit itself to pay for the health care 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.

4 Organizing health insurance via the National Social Health Insurance (NSHIF)

4.1 Acceptance of the proposed NSHIF

4.2 Structure of the NSHIF

4.2.1 Objects of the NSHIF

We suggest to insert after (i):
(ii) Use the pooled contributions to pay for the utilization of health services by covered beneficiaries.
(v) Change ‘minimum benefit package’ into ‘benefit package’
(vii) skip completely (there is no need for reinsurance)

4.2.2 An overview of organs of the NSHIF

4.3 Management of the NSHIF

4.3.1 Organizational chart

The organisational chart could be more elaborated. Some central functions are missing, such as:

- Membership & Contributions
- Claim Review
- Benefits Development
- Accreditation
- Corporate Planning

One could think of setting up a Grievance & Appeals Review Office. Perhaps it would also make sense to separate Legal Services from Finance & Administration.

4.3.2 The Board of Trustees

4.3.2.1 Functions and Powers

The two central functions of a health insurance management Board are setting a) the benefit and b) the contribution levels. In Annex III related to the National Social Health Insurance Fund Act, we suggest a couple of amendments to section 13 of the law which would equally apply to this chapter.

We recommend to delete 'including re-insurance' under (vii), and to change 'minimum benefit package' to 'benefit package'.

4.3.2.2 Composition of the Board of Trustees

We suggest that key stakeholders (e.g. representatives of the self-employed or the National Social Security Fund) can be added to the Board if deemed necessary.

4.3.2.3 The process of selecting the Board of Trustees

It is recommended to check the figure under (iv). It says that the National Council will select 16 members to the Board from the nominations received from each District Council. According to Section 12 of the law, only eight representatives are selected from the Provinces, and four from Interest Groups.

4.3.3 Decentralised management

For managerial purposes we strongly suggest to address the feasibility of decentralizing the management of the NSHIF as much as possible to the provincial and district offices.

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 health care provision, utilization levels, satisfaction of the insured population and of providers, and operation of the NSHIF at all levels.

4.4 Relationship between the NSHIF management and Grassroots

4.4.1 Pyramid of representation from grassroots

The National Council in its current set-up will produce a large number of office holders. There might also be expectations for remuneration (160 representatives from estimated 80 districts). A reduction to one representative per district instead of two might have to be considered.

Perhaps it should be made explicit that the issue of grassroots representation will be reviewed in the light of the constitutional reform.

4.4.2 National Council

4.4.2.1 Functions and powers

The chairman and vice-chairman of the National Council could be given the role of ombudsman and receive complaints about the working of the NSHIF.

4.4.2.2 Secretariat

Since the Secretariat of the National Council will be responsible for facilitating the activities of the National Council which will meet only once a year, there should be some regulation whether the Secretariat is therefore a periodic rather than a permanent institution. It could also be clarified how the representation from the Province works and where the candidates come from.

4.4.3 Functions of the District Council

We suggest that (iv) be skipped as it does not appear in the Law.

4.4.4 Functions of the Sub-locational Committee

It is recommended to cross-check the functions here with those stipulated in the law.

4.5 Relationship between the NSHIF and the Ministry of Health

4.6 Relationship between the NSHIF and other stakeholders

We suggest to add that 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.

5 Legal framework

5.1 Current legal framework

5.1.1 The Insurance Act

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

5.1.3 The National Social Security Fund (Cap258)

The NSSF could play a role if it were possible to deduct a fraction of the pension as contribution to the NSHIF. In this way, membership of the retired in the NSHIF could be ensured.

5.1.4 The Workmen's Compensation Act (Cap 236)

The health care costs as a result of injuries suffered in the workplace should not be covered by the NSHIF. Generally, it is the employer who is responsible for this. The NSHIF might temporarily bear the costs, but the employer should be obliged to reimburse the Fund.

5.1.5 Employment Act (Cap 226)

5.2 The proposed legal framework

5.2.1 The proposed health insurance Act

This Act should contain the following essentials:

- The role and responsibilities of the MoH (regulatory, supervisory and co-ordinating function, preventive and promotive health care, rehabilitation, quality assurance, HIV/AIDS programme, staff payment, human resource development, health care infrastructure etc.)
- Harmonization of laws related to health and insurance
- Regulation of private health insurance (incl. HMOs)
- Regulation of community-based health insurance organisations
- The transformation of NHIF to NSHIF
- Any additional regulation related to health insurance.

5.2.2 The proposed NSHIF Act

- It could be considered to begin the Act with some Guiding Principles, e.g.
    - NSHI shall contribute to the vision of the Kenyan MoH to create an enabling environment for the provision of sustainable quality health care that is acceptable, affordable and accessible to all Kenyans.
    - It will be compulsory for every Kenyan and every permanent resident to become a member through enrolment and payment of a subscription.

- 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.
- 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.
- 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.
- The NSHIF shall build on existing community initiatives for registration procedures, contribution collection and human resource requirements.
- The NSHIF shall balance economical use of resources with quality of care. It shall provide effective stewardship, fund management, and maintenance of reserves.
- 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.
- The NSHIF shall assure that all participating health care providers are responsible and accountable in all their dealings with the Fund and its members.
- 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.

- For management efficiency and implementation purposes we would suggest exploring the possibility of multiple funds or management units catering for the different needs of either geographical regions or occupational groups (e.g. formal vs. informal urban und rural sector). If left open in the Bill, it could be decided by the management board of the NSHIF.
- A key question to be addressed is who decides on the contribution and benefit package ? We would suggest that the Board of Trustees submits the prescribed contribution and benefit package to the members of the Council for approval.
- It is suggested that some of the language of the text be reconsidered, e.g. the capability of the fund to lend money (§5 c), to receive gifts and donations (§13c), the investment policy (§§ 9, (1)b; 13 e (III), 43).
- Some sections of the text have been much elaborated and could perhaps be partly put into regulation rather than law (e.g. §§ 17; 18, 34 (2)). One could also imagine leaving out a few more options to the management of the Fund (e.g. methods of registration, due dates of contribution).
- We would suggest including the principles of the benefit package (outpatient care, inpatient care, essential drugs). Since the benefit package is expected to be rather comprehensive, we would think the term "benefit package" is more appropriate than the term "*minimum* benefit package" (§13 e (l)).
- The fee collected from foreigners entering the country will not always be easy to implement, for instance when refugees enter the country. Still, tourists officially entering the country via land, air- or seaports can be charged. While being a contribution to the NSHIF, the payment of this fee does not imply membership in

the NSHIF. No benefits should be provided to this group, precluding the entry of medical care tourists into the country.
- Some sections of Part VI (Misc.) could be phrased more simply and should be re-examined in this context include §§ 47, 48, 51 (2).
- In order to reduce over-utilization and adverse selection, options include the establishment of registration and/or referral fees and a waiting period.

For details regarding the Act, we refer to the ANNEX III.

5.2.3 Organs of the proposed NSHIF

5.2.3.1 National Council

5.2.3.2 The Board of Trustees

5.2.3.3 District Council and Sub-locational committees

See above. There is duplication in the Strategy Report since the functions of the organs are already described in Chapter 3.2.

5.3 Conclusions

We suggest the following modifications:

- The introduction of the Health Insurance Act and the National Social Health Insurance Fund Act will improve access to quality health care services to all Kenyans.
- The Kenyan public will accept the NSHIF only if it is properly planned and well managed by men of honesty and integrity.
- The NSHIF Act provides directly for the payment of providers for the use of medical services by members of the Fund.
- There is currently no law regulating the business of a large number of private health insurance providers. It is necessary to have such a law in order to give legal protection to members of the public who choose to insure themselves privately in addition to their NSHIF membership.
- The place of the NSSF Act and the Workmen's Compensation Act vis-à-vis the National Social Health Insurance law will need to be considered.

6 Key concerns and success factors

6.1 Acceptance

6.2 Issues of stewardship/governance

6.2.1 The National Council

It is recommended that, as a major financier and provider of health services, Government ought to have a stake in the Board of Trustees. There is first the *Ministry of Finance* who ought to be represented. Secondly, the *Ministry of Health* should be part of the Board, as it has major stewardship functions with

regard to standards of health care and accreditation of providers. It will also retain its important role in health promotion and prevention. In addition, as a major provider of health services, its incorporation in the Board of Trustees should improve the dialogue related to the quantity, quality and distribution of health services. Thirdly, other governmental departments, such as the *Ministry of Education*, could have a seat on the Board of Trustees, provided they play a role in the health system. For instance it is advantageous to the health insurance operations that NSHIF is also aware of school health promotion activities. Promotion of social health insurance and the importance to register could be incorporated in such activities. It would be good that children, especially adolescents, become acquainted as early as possible with the new health financing system, which would facilitate compliance during adult life.

6.2.2 Board of Trustees and the General Fund Management

6.2.3 Elimination/Curbing/Reduction of Fraud/Theft

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 or design features. The sources of information for these indicators and desing features should normally include Reports of the NSHIF, results from Demographic and Health Surveys, and the Economic Survey.

A. Revenue collection

A1. 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.

A2. 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 of health care.

- Prepayment ratio by socioeconomic group

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

b) 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.

c) Protection against catastrophic expenditure

- Percentage of households with catastrophic spending

It is expected that social health insurance would lower this percentage of households. Catastrophic spending arises when households are spending more than a certain percentage of their net income (income minus food) on health care ; that percentage could be defined for instance as 40% or 50%. Through this indicator, it can be checked what the 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 health insurance scheme is. Catastrophic spending is likely to be a greater problem amongst the poorer socioeconomic groups, but a well performing scheme would limit such spending even amongst such population groups.

B. The degree of risk pooling

- Does a single pool exist, or do multiple pools exist ?

- If multiple pools exist, 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 multiple pool system almost as effective in terms of risk sharing as a single pool.

C. ***Purchasing***

a) 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 health interventions, with all members of the pool entitled to a specified benefit package. A fundamental performance indicator is ensuring that this benefit package is fully received by all those who are entitled to it. Without full information readily available on claimant rights, members may unknowingly not be accessing the full range of services they are entitled to.

b) Efficiency and equity of benefit package

- Design of benefit package incorporates explicit efficiency and equity criteria?

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

c) 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 ?

d) Administrative efficiency

- Is there a ceiling on the percentage of administrative expenditure in total NSHIF expenditure ?

6.3 Access to quality and equitable health services

6.4 Goodwill of contributors/members

7 Conclusions and recommendations

The activities related to the implementation of the NSHIF that have so far been undertaken have been very important, including the preparation of the Strategy Report by the intersectoral Task Force, as well as the National Social Health Insurance Bill. The support from Government has also been crucial for the completion of these tasks.

In the coming period, the implementation needs to be prepared by a whole series of further practical studies concerning the contents of the benefit package, the provider payment methods to be adopted, health financing issues and implementation before launching the NSHIF. In addition, the legislation and regulations related to the social health insurance law need to be reassessed. Finally, a communications strategy for all concerned stakeholders and for all population groups will need to be developed.

ANNEX I Overview of proposed technical assistance over the period July-December 2003

1. Technical assistance on 'Management, Legislation/Regulation, 'Benefit package' and 'Provider payment methods'

Management

- Administrative structure
  - Recommend appropriate ways of transition of NHIF into NSHIF, including staffing by department and basic tasks
  - Evaluate options for decentralised management, including staffing and basic tasks of district, interdistrict or regional health insurance offices
  - Assess options for multiple sub-funds within the NSHIF, and the resulting adjustment of the administrative structure
- Operations
  - Recommend registration procedures for workers & employees and their dependants, rural workers & self-employed and their dependants
  - Assess appropriate ways for health insurance certification (individual vs. family health insurance card)
  - Evaluate options for efficient collection of contributions
    - For workers and employees
    - For rural workers and self-employed
      - Timing of collection
      - Options for collection points
  - Recommend efficient methods for management of provider claims and their remuneration
  - Evaluate options for computerized information systems (database for membership, providers, cost and utilization review, feedback on quality assurance)
- Contribute to an initial time schedule and network plan for implementation

Requirement:

- Expertise in health insurance management
- Expertise in insurance-related informatics

Legislation/Regulation

- Assess the current NSHIF Bill and related bills, and propose amendments if appropriate
- Work out the principles of mechanisms to adjust regulations according to the desired performance of the NSHIF
- Propose further regulations, among others, and if appropriate, for
  - Conditions of entitlement (eligible members of the family)
  - Ascertaining entitlement (insurance card)
  - Fraudulent use
  - Payments due to providers

- Assess and/or propose set of regulations for the organisation of the NSHIF at the central and decentralised level
- If appropriate, propose regulations for the organisation of multiple funds within the NSHIF
- Assess and/or propose regulations for the relationships between the NSHIF and
  - Ministry of Health (including its role in the Board of Trustees, in technical advisory committees of the NHSIF, in accreditation of providers and quality assurance)
  - Ministry of Finance (including its financial obligations to the NSHIF, and its role in the Board of Trustees and technical advisory committees)
  - Other government departments
- Assess and/or develop proposals for relationships with the insured population at central and decentralised level (including management of complaints)
- Assess and/or develop proposals for relationships with providers (including contracts and quality assurance)

Requirement:

- Legal expert with extensive experience in social health insurance

Benefit package

- Make recommendations as to the content of the final and possible 'interim' benefit packages
  - Define the role of HIV/AIDS treatment within the benefit package
- Assess the cost of the benefit package, by health care system level, with due regard for pricing of services that takes account of the principles of rational diagnosis, treatment and prescription

Requirement:

- Expert in public health/clinical services

Provider payment methods

- Assess current methods to establish fees at all health system levels and evaluate the role of the Kenyan Medical Association and other professional associations
- Assess how current fee-for-service methods can be transformed into more comprehensive ways of provider payment (including flat payment per day or admission in hospitals, DRGs, flat fees for groups of primary care services and overall capitation)
  - Evaluate ways whereby cost-accounting can be introduced systematically at all levels of the health system, including the use of software
  - Propose mechanisms to establish schedules of provider payment
    - Use of software
- Assess the best ways of achieving decisions about the provider payment schedule, evaluating thereby the respective roles for the Kenyan Medical Association, the NSHIF and the Ministry of Health

Requirement:

- Expertise in establishing provider payment schedules
- Expertise in cost-accounting and related software

2. Technical assistance on 'Financing' and Implementation'

Financing

- Make projections at the national level of the expenditure of the NSHIF, making use of cost estimates of health services (per outpatient consultation and inpatient day at each level of the health care system)
  - thereby assessing the financial requirements due to HIV/AIDS
  - administration of the NSHIF at central and decentralized levels
- Make projections of the revenues of the NSHIF
  - Contributions of members
  - Government contributions (subsidies) for the vulnerable population
  - Other revenue, including from international grants
- In the case of multiple funds
  - analyze and project the financial position of each of the sub-funds
  - propose efficient ways for risk-equalization between the sub-funds
- Analyze and project the net financial position of the NSHIF
- Suggest ways, if necessary, to adjust contributions, benefit packages and/or level and structure of co-payments
- Propose efficient methods to allocate revenues to health care benefits, administration, reserves and other components including staff training

Requirement:

- Expertise in health economics/health financing/actuarial science

Implementation

- Analyze alternative scenarios for implementation of social health insurance in stages
  - Feasibility of interim benefit package focused on children and the poor population
  - Implementation stages for each of the possible NSHIF sub-funds
  - Time schedule and network plan
- Provide a check-list of conditions to be fulfilled before launching
  - Administrative structure and staffing of different departments
  - Contributions and revenue collection
  - Provider payment schedules
- Propose a communications strategy, including a schedule of workshops/seminars/meetings to inform and discuss about the principles of health insurance, targeted at
  - The member population (Workers and employees, rural workers and self-employed)
  - Employers and trade unions
  - Key providers and provider associations
  - Parliament
  - Relevant academic institutions

- National and international donors

Requirement:

- Expertise in health insurance management
- Expertise in health information, education and communication

8 Annex II 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 health care	Utilisation of health care	
	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 in 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 Ks (2004)	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%

TABLE 4 Gradual implementation of NSHIF (low cost-high utilisation)

Assumed time path for the expansion of coverage

Category	Expansion of coverage (in %) in year …								
	04	**05**	**06**	**07**	**08**	**09**	**10**	**11**	**12**
Self-employed	**25**	**30**	**40**	**50**	**60**	**70**	**80**	**90**	**100**
Employees	**80**	**85**	**90**	**95**	**100**	**100**	**100**	**100**	**100**

Projections of income and expenditure of the NSHIF
Selected years

	2004	**2007**	**2010**
Expenditure	**10.859 bn Ks**	**33.553 bn Kshs**	**62.837 bn Kshs**
Revenue	**24.264 bn Ks**	**40.811 bn Kshs**	**55.297 bn Kshs**
%diff	**+55.2%**	**+17.8%**	**- 13.6%**

Table 5 Detailed results of the gradual impementation scenario (low cost/high utilisation)

In 1000 Kshs

	2004	*2005*	*2006*	*2007*	*2008*	*2009*	*2010*
Total Cost	**10859145.1**	**19422347.3**	**25952045.7**	**33553462.2**	**42371903.5**	**51887935.1**	**62837054.1**
of which							
Admin+reserves+other	804381.1	1438692.4	1922373.8	2485441.6	3138659.5	3843550.8	4654596.6
Health care expenditure	10054764.0	17983654.9	24029672.0	31068020.5	39233244.0	48044384.4	58182457.5
Total Revenue	**24263600.0**	**31939288.0**	**36127490.5**	**40811530.1**	**46046860.5**	**50454289.5**	**55297339.6**
of which							
Contributions	12263600.0	19099288.0	22388690.5	26111014.1	30317308.4	33623668.7	37288575.4
Government subsidies	11000000.0	11770000.0	12593900.0	13475473.0	14418756.1	15428069.0	16508033.9
other	1000000.0	1070000.0	1144900.0	1225043.0	1310796.0	1402551.7	1500730.4
Balance of the NHIF	**13404454.9**	**12516940.7**	**10175444.8**	**7258067.9**	**3674957.0**	**-1433645.7**	**-7539714.5**
Balance as % of revenue	**55.2%**	**39.2%**	**28.2%**	**17.8%**	**8.0%**	**-2.8%**	**-13.6%**

9 ANNEX III The proposed National Social Health Insurance Fund Act

Part I

We suggest inserting some Guiding Principles at the beginning of the Act (see our comments related to the Strategy Report)

Furthermore, we would suggest including clear definitions of

- dependents
- employees
- self-employed (both, the registered and unregistered ones)
- family

Part II

4. Object of the Fund
Change Section 26 into Section 27

5. Fund to be corporate body
This Section should perhaps also have a stipulation that the fund is exempted from taxes.

6. Common Seal

9. Functions and powers of the National Council
(1) In order to use the same language as in the Strategy Paper, change (c) to:
"receive, consider and approve the annual budget of the Fund for the following financial year".
Add after (b):
"propose the contribution and benefit structure"

(2) Change sentence to:
"The Council shall collaborate with the Ministry of Health in matters relating to the efficient delivery of health care".

12. Board of Trusties
(2) Change (e) into:
"four persons, at least one each from the following areas - …"

We would suggest adding after (2):
"Key stakeholders can be added to the Board if deemed necessary" (e.g. Representatives of the Self-employed, National Social Security Fund).

Remark:
In the Strategy Paper, another group is mentioned under Subsection (2e), i.e. health care workers.

13 Functions and powers of the Board
(e) We would suggest the following changes:

(iii) "the investment proposals for the fund subject to the limits stipulated in Section 43";

(f) "prudently make short-term investments in order to optimize the liquidity of the Fund";

(g) "ensure the adequate insurance of the Funds' physical assets with reputable insurer or insurers";

(h) "submit the prescribed contribution level to the Council";

(i) "define the benefit package";

(m) "define the formulary of registered essential drugs to be used in the benefits package, and ensure the utilization thereof;

There is one important function missing from the Strategy Report (3.2.6., (xiii)) :
"Establish such departments or units as may be deemed necessary for the efficient discharge of the functions of the Fund."

14. Tenure of members of the Board
We would suggest increasing the term to 4 years.

We would also suggest including the allowances and per diems of Board members in order to make clear the distinction between remuneration of Board Members and voluntary service of District Councils.

19. District Council
We would suggest that only adult members of the Fund shall elect their representatives to the District Council, so it could be phrased:
"Each District Council shall consist of one representative democratically elected from the adult Fund members of each sub-location in the district".

20. Functions and powers of the District Council
(1) Change (b) according to the Strategy Paper to:
"receive and consider complaints relating to the Fund at the district level".

21. Tenure of members of District Council
We would suggest adding:
"The members of the District Council perform their task as a service to the nation. However certain allowance might be given for transport …."

Part III

27. Membership
(2) Since there are also dependents of workers who will become members of the fund through the contribution of an employed parent, we would suggest changing (a) to:

"Every member shall pay to the Fund either directly or indirectly a monthly or annual contribution at such rate and in such manner as the Board may from time to time decide".

28. Contributions to the Fund
(1) Change (b) to:
"in the case of the self-employed persons by annual contribution in the manner set out in rules made under this Act".

There should also be stipulation regarding dependents and the (temporary) unemployed.

(2) Change to:
"For purposes of this section, "employer" includes and employer who employs not more than five employees who earn a monthly salary not exceeding a certain amount stipulated in the rules made under this Act".

32. Due dates for contribution
(1) To be more flexible on the registration we would suggest:
(a) "in the case of annual contributions, on or before the expiry of the card".

35. Contracted health service providers
(3) "A declaration under this section shall be subject to fulfilment by the health service provider of such criteria including quality assurance as the Board may from time to time prescribe".

36. Payment of benefits
(1)"The Board shall make payments to contracted health service providers for expenses incurred at their facilities by any member of the Fund according to the …"

Insert a new section with reference to the benefit package regulation, incl. budgetary constraints, role of essential drugs etc.

Suggestion for the determination of the benefit package:
"The benefit package will be determined by a special ad hoc committee composed of representatives from selected stakeholders".

Part IV

38. Sources of Funds
To be added:
"such sums recovered from other insurance funds if these are liable for health".

39. Payments out of the Fund
Add sub-section (2)
"The administrative costs should not exceed 8 per cent of annual expenditures. This shall include the reserves (§ 43) and the expenses listed under (b), (e) and (f) in section 41 (1). Administration costs can be revised downwards".

42. Accounts and audit

(3) (d) We suggest to check the sentence.

43. Investment of funds
We would suggest a sentence similar to:
"The Fund shall built up a reserve of 3 per cent of annual expenditures to safeguard the operation from unexpected expenses and fluctuations in revenues".

Part V

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Part VI

52. Power to make regulations
To be included in the following sub-section after (c):
"… establishing the provider payment schedule;"
To be included in the following sub-section after (e):
"… setting up a schedule of implementation"

53. Missing