Commissioned by

the Ministry of Medical Services

Government of Kenya

KENYA

Draft Health Financing Strategy

Report of an External Review

June 2012

Supported by the members of

P4H Providing for Health Social Health Protection Initiative

Contributing partners:

World Health Organization

giz Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH

Executive summary

Introduction

In order to update and adopt a National Health Financing Strategy, it is recommended that the Government of Kenya (GOK) revive its Interagency Coordinating Committee on Health Financing (ICCHF) as soon as possible, making sure that it is headed up by a government official of the highest possible level in order to overcome possible contradicting views of ministries and stakeholders who may have vested interests not consonant with the GOK's ambitions for social health protection (SHP) and universal health coverage (UHC). SHP is to have no financial barriers to accessing necessary essential health services for individuals and to prevent impoverishment due the use of these services and UHC aims to achieve this for the whole population.

This is the key message of an external review undertaken at the request of the Kenya Ministry of Medical Services (MOMS) by the team put together by the Providing for Health (P4H) initiative. The aim of the review was to provide expert advice on the reform process so far and to obtain a road map towards the establishment of a health financing strategy (HFS) designed to gradually achieve UHC by improving SHP, allowing for equity in funding of equally accessible essential health services and preventing financial hardship and impoverishment due to necessary health care use.

This report is based on the team's review of documents and interviews with the main stakeholders undertaken during its one week mission which ran from 11 to 16 March 2012[1].

After a short introduction, describing the background for the request and reflecting the terms of reference (TOR) of the review team (Chapter 1), a description of the current situation (Chapter 2) highlights the problems to be solved and the context within which the HFS would need to be developed and implemented. This is followed by a description of the approach the team used (Chapter 3), the results of the analysis of the reform process so far (Chapter 4), the proposed road map towards the HFS (Chapter 5) and some final conclusions (Chapter 6).

Process towards a Health Financing Strategy

During the protracted HFS development process which started in 1999, the Ministry of Health (MOH) and other stakeholders were unable to achieve consensus about the health financing model to be used, or how it might be implemented. Intense discussion focused on key issues such as the role of insurance and budget funding in health care financing, the feasibility of establishing a single purchaser by pooling all revenues, the use of competition between health insurers for the implementation of a basic benefits package (BBP) and the viability of a public/private mix in health financing.

[1] Unfortunately a meeting with organizations of employers and employees could not be organized.

Establishing UHC by improving SHP cannot be achieved by the MOH alone. Intersectoral involvement, coordination and agreement within the Government and between the ministries of health, social welfare, labour and finance is therefore a key pre-requisite for successful reform. The lack of an in-depth stakeholder analysis and social impact assessment was one of the main obstacles to the consultative process that underpinned the development of the HFS, making it more or less impossible to articulate and bridge the different interests between the various stakeholders. Apparently, the main points of contention relate not so much to ***what*** needs to be done but to ***how*** health financing should be implemented and ***who*** should play which role.

Despite this, several ***areas of consensus*** were identified. These include the need for UHC, the examination of out of pocket payments (OOP), the improvement of effectiveness, efficiency and quality of health service delivery and administration, the design of a uniform basic package (BP) of essential health services accessible to the whole population, the development of purchasing capacity complemented by some level of autonomy for health care providers, and lastly the need to retain the pluralistic, public/private mix in health services delivery. The mission fully acknowledges the importance of these issues, which are in a sense the fabric out of which the HFS has to be cut. It is hoped that further discussions and progress will operationalize the need for UHC in the Kenyan context, define its specific objectives, and modalities, including key strategic functions, while establishing a timeframe to help finalize the draft strategy.

The mission found that there are several ***grey areas,*** which need further examination. These include: the financing of community-oriented public health (although the review team recognizes that disease prevention is an important feature of the GOK's health policy); the need for a separate AIDS Trust Fund; the creation of a mandatory insurance system; the establishment of new intermediary health financing institutions; the content of a universal benefits package as part of UHC and the criteria used in its formulation; the mandate and tools of purchasers and the organization of oversight and auditing.

The review team noted that there was ***explicit disagreement*** on the proposed changes, i.e. to separate contribution collection, pooling and purchasing with the establishment of a single fund pool and purchaser, and the introduction of a mandatory contribution scheme in the draft strategy.

During the review, the team noted ***several gaps in the process as well as in the drafting of the HFS,*** reflecting the above-mentioned differences in opinion and interests. Therefore, the team recommendations mainly aim to close these as follows:

With regard to process:

- Revive the ICCHF to discuss and agree on specific UHC goals and related objectives before considering the different financing models discussed in the draft HFS.

- Implement a stakeholder analysis.
- Translate and harmonize UHC policies across all relevant sectors.
- Involve the highest level political executives in the UHC endeavour.
- Initiate a public debate on UHC and ensure continuous public information on the HFS development, content and significance for the public at large, patients in particular, and for health sector workers.
- Adopt an action plan for the revision of the HFS content.

With regard to content:

- Foster common understanding of the issues, options and possible tools to take concrete steps towards UHC
- Discuss and decide the ***financing model***
    - Assure the adoption of an effective financing mechanism, most likely reliant on public revenues, and sufficient funding for community-oriented, public health care.
    - Discuss and agree on a mandatory or voluntary scheme.
    - Examine the pros and cons of the single versus multiple payer model.
    - Clarify the role of public and private insurers and the reformation of the National Hospital Insurance Fund (NHIF) with, perhaps, restricted private insurance to offer supplementary benefits.
    - Examine the degree of competition between health insurers, while understanding the immense complexity of a competition-based model and the administrative and oversight capacity required to achieve UHC this way, notably in terms of preventing the possible negative consequences of competition.
    - Discuss and decide the qualification strategies and criteria for multiple UHC financiers.
    - Discuss ways of reducing existing and avoiding future fragmentation of funding, which would add to administrative costs and decrease effectiveness and efficiency in service delivery.
    - Take into account the continuous need for assured subsidies for the poor, whichever the model chosen.
    - Design effective enrolment strategies for the informal sector, including the full or partial subsidy of contributions from general revenues if the decision is taken to introduce a mandatory health insurance scheme.
    - Take into account international experiences and recent developments in UHC.
    - Elaborate on the implications of the new Constitution as regards entitlements to regular services and emergency care, and the consequences of the devolution of administrative power to the Districts.

The review team suggests several ***other issues in the draft HFS*** that need to be clarified and decided on. To this end:

- It will be helpful if decisions on issues such as, who will be covered, where do financial resources come from, what resource level is needed, how are resources to be collected, and pooled are strongly informed by the collectively defined UHC goals and related objectives.
- There is a need to design and implement efficiency improvement strategies for administration and health services delivery, based on sound analytical work.
- OOP seems to be the major financial barrier in accessing to health care. Therefore, actions are needed to examine current financing practices, including the distribution of services and public spending, and their possible geographic variations linked to OOP, in order to design and implement OOP reduction strategies.
- The criteria for selection and content of the BBP and its formulation as an entitlement also need to be clarified.
- Efficiency improvements can be obtained by adopting health-care purchasing strategies such as selective contracting, setting fee for service schedules and levels, and provider performance review.
- The establishment of new financing institutions and an accreditation agency require more in-depth discussion, the accreditation agency to be discussed in the framework of a national quality-improvement strategy for health services delivery.
- The regulatory, oversight and auditing functions need improvements to move towards UHC.
- The HF consequences for institutions and their capacity enhancement need to be taken into account together with appropriate monitoring and evaluation as part of the implementation strategy.
- The overall risks to successful implementation of the HFS need to be identified, and corresponding mitigation measures adopted.

The review ends with conclusions, summarizing the above-cited issues and recommendations. The review team believes that despite the protracted development process and existing differences of opinion on certain issues, the country has a great opportunity to update and finalize the HF strategy in the near future because of increasing government interest in UHC and changes in the social context, notable in this regard being the passage of the new Constitution. The process may require some additional studies and technical work to back up the proposed changes and strategic actions. Lastly, the team notes that all participants in the ***Development Partners for Health Kenya*** stand ready to further support the GOK in the process of finalizing the HFS and its implementation.

Acknowledgements

The external review team is grateful for the invitation by the Ministries of Medical Services (MOMS) and of Public Health and Sanitation (MOPHS) and for the opportunity to partner with these Ministries in the review of the draft Kenya Health Financing Strategy as it currently stands. It is also thankful for the guidance provided by Mr. Elkana Ong'uti and for his support and the support of his Policy and Planning Department (MOMS) in organizing the meetings and providing the necessary documents in a timely manner. Mr. T.Maina has been especially helpful in this regard. The World Health Organization Kenya Country Office complemented this effort with an abundance of documents and provided all the necessary logistic support.

Mr. Chris Lovelace, Senior Health Advisor World Bank, and Mr.Stephen Muchiri, Advisor Health Systems 20/20 gave valuable background information and feedback to the team.
Last but not least, the team is grateful for the time and candid discussions it was able to have with many officials and stakeholder representatives during its stay in Nairobi.

The coordination of this mission has been facilitated by the Providing for Health (P4H) network and Harmonization for Health in Africa (HHA).

Providing for Health (P4H) is a global network aimed at improving social health protection (SHP) and strengthening health financing systems to promote universal health coverage (UHC) in low and middle-income countries. P4H operates through an open network of partners, to date including the African Development Bank, France, Germany, the International Labour Organization, Spain, Switzerland, the World Bank and the World Health Organization. The purpose and focus of P4H is to support countries in developing effective, efficient, equitable and sustainable health and social protection systems for UHC and SHP, in particular for the poor and other disadvantaged populations.

List of Abbreviations

AA	Accreditation agency
AEF	Access and equity fund
AIDS	Acquired immune deficiency syndrome
BBP	Basic benefits package
BP	Benefits package
BTB	Benefits and tariff board
DP	Development partners
DPHK	Development Partners for Health Kenya
EAC	East African Community
GIZ	German International Cooperation
GDP	Gross Domestic Product
GoK	Government of Kenya
HAKI	Health for All Kenyans through Innovations
HFS	Health financing strategy
HHA	Harmonization for Health in Africa
HRA	Health benefit regulatory authority
HIV	Human immune-deficiency virus
HMIS	Health management information system
ICCHF	Interagency Coordinating Committee Health Financing
ILO	International Labour Organization
LGA	Local government authority
MDGs	Millennium Development Goals
M&E	Monitoring and evaluation
MOF	Ministry of Finance
MoH	Ministry of Health
MoMS	Ministry of Medical Services
MoPHS	Ministry of Public Health and Sanitation
NHRA	National health revenue collection agency
NHIF	National Hospital Insurance Fund
NHST	National Health Services Trust
OBA	Out based aid (voucher program)
OOP	Out of pocket payment
PBF	Performance based funding
P4H	Providing for Health (network)
PHC	Primary health care
SHI	Social health insurance
SHP	Social health protection
ToR	Terms of reference
UC	Universal coverage
UHC	Universal health coverage
UN	United Nations
WB	World Bank
WHO	World Health Organisation

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1 Introduction

Background

Kenya is a multi-ethnic, East-African country with a population of around 40 million people (2011). According to the World Bank ranking, Kenya is a low-income country with a per capita Gross Domestic Product (GDP) of US$745 as of 2010[2]. The economic outlook is positive with GDP expected to grow between 4-5% , driven by an expansion in tourism, telecommunications, transport and construction. Kenya's population is estimated to be growing at a rate of 2.3%. Roughly 43% of the population is below 15 years of age, 55% between 15-64, and less than 3% above 65 years. The agricultural sector employs 75% of the labour force, and represents 22% of GDP[3]. Industry and manufacturing accounts for just 16% of GDP, the remainder contributed by other sectors. Annual growth of the working population exceeds growth in new jobs and the unemployment rate is estimated to be about 10 %. 46% of the population lives below the national poverty line, the majority of the poor living in rural areas.

Kenya has a heavy burden of diseases, comprising mainly preventable communicable diseases including Malaria, and HIV/AIDS, but it is increasingly burdened by non-communicable diseases. Average life expectancy at birth is estimated to be 56. Some progress has been noted in population health, particularly with regard to child health, but maternal mortality remains a major concern. To attain the MDG target, Kenya needs to reduce maternal mortality from 488 to 150 deaths per 100,000 live births by 2015.

Health services in Kenya are provided through a mix of public and private providers. Although utilization of health services among the population is increasing, access to quality health care is still limited for a large number of people due to the unavailability of health services, geographical, financial, and other barriers.

The prevailing high poverty rate also acts as a constraint on demand for health care. Free care is provided in public hospitals for certain diseases such as tuberculosis, sexually transmitted diseases and AIDS. In addition, several schemes provide social health protection, but the coverage, and benefits provided as well as the degree of financial risk protection offered are still inadequate. The largest financial risk protection scheme is the National Hospital Insurance Fund (NHIF) which covers about a quarter of the population or roughly 2.5 million actively contributing members with their 7.5 million dependents. Because of this high dependency ratio, the contribution level is set high, making it unaffordable for many low-income families.

Membership of the NHIF is compulsory for formal and voluntary for informal workers, and the scheme covers more than 50% of the cost of curative health care in government hospitals. The

[2] http://data.worldbank.org/country

[3] Kenya: Developing an integrated national social protection policy. Social Security Department, International Labour Office Geneva, September 2010

administrative costs of the NHIF are seen as high compared with other mandatory health insurance organizations. An unknown portion of NHIF revenue is invested in real estate. This is an unusual practice for social health insurance schemes operating in resource-limited countries like Kenya and is not necessary in a "pay as you go" system. It also limits the Fund's liquidity.

The overall health financing situation in Kenya is characterized by inadequate funding, an underdeveloped health services infrastructure, a shortage of human resources for health and essential medical supplies including medicine, and limited administrative and management capacity – all of which restricts health service delivery and coverage. It is therefore imperative to make changes in the financing and delivery of services. Some of the health financing reforms undertaken in the past to address these issues have been partially successful. The National Health Policy 2011-2030[4] sets out policies and strategies for health-care financing that support UHC, equitable access, and adequate financial protection in the years to come. However, it is increasingly accepted that there is a need to implement comprehensive reform of the way the health system is financed. It is also worth noting that a multi-stakeholder task force was established in 2006 to develop a long term, fiscally sustainable, equitable and efficient health financing strategy. The draft this task force has developed is the subject of this review

A health financing draft strategy[5] has been developed which defines 7 key pillars that include: i) social health protection; ii) universal health coverage; iii) evidence-based policy;iv) efficiency and equity in revenue collection; v) efficient and effective risk pooling; vi) purchasing; and vii) availability of services and choices with diversified providers. The draft strategy emphasizes the fact that Kenya has some limitations in terms of political and general public support, the role of the state, effective communications, working with the private sector, health service delivery, management, information and monitoring.

In general, the draft strategy is designed to improve efficiency, accountability and transparency, to strengthen revenue collection and risk pooling, and to harness the informal sector financing potential. The draft strategy also calls for the broadening of the BP, the strengthening of provider incentives, greater protection for the poor and vulnerable, the improvement of aid effectiveness and sustainability. It proposes transforming the NHIF into a national health services trust (NHST) creating a benefits and tariff board (BTB), establishing an independent national health revenue collection agency (NHRA), a health benefit regulatory authority (HRA), an independent accreditation agency (AA) and an access and equity fund (AEF) to meet the specific objectives outlined above.

The Ministry of Medical Services (MOMS) has shared the draft strategy with national stakeholders and received a range of different feedback. For example the private sector felt that the draft was put together without adequate consultation with major health system players, and

[4] Kenya Ministry of Health. Comprehensive National Healt Policy Framework 2011 - 2030

[5] Kenya Ministry of Public Health and Sanitation & Ministry of Medical Services: Accessible, Affordable and Quality Health Care Services in Kenya, Financing Options for Universal Coverage. Version March 2010 (provided in March 2012)

found the attempt to analyse all the potential sources of financing and their contributions insufficient. Other interesting views included comments on the limits to providing comprehensive strategies, efficient and effective mechanisms for revenue collection from different sources, including households, to ensure UHC.

Repeating a request made in 2011, in February 2012 the government of Kenya called for health sector development partners including the World Bank (WB), the World Health Organization (WHO) and the German Development Corporation (GIZ) to independently review both the content and development process of the draft strategy and to provide a road map for finalization and implementation in support of national health policies and objectives aimed at UHC. The partners responded as Providing for Health (P4H) initiative and put together a team of international experts[6] not previously involved in the development of the health financing strategy to undertake a mission.

Terms of reference

The main goal of the mission, as stated above, was to provide a road map and recommendations to update, finalize and implement a national HFS, based on a review of the content and development process of the existing draft HFS. The full terms of reference are provided in Annex 1. The aim was to produce a report which presents the overall assessment and roadmap for the process of developing and implementing the HFS. The work consisted of two phases – a desk review of documents and in-country work, which took place between 12 and 16 March 2012. Lists of reviewed documents, and persons met are provided in Annexes 2 and 3. On the last day of its visit the team gave a briefing of its preliminary findings to management and staff at the Ministries of Health (see annex 4 for a list of attendees).

Review team approach

In order to achieve their aims, the team came up with a frame of reference for key informant interviews and the review of the health financing strategy together with an outline of issues to be examined during the visit. These were aimed at reviewing the soundness of the health financing reform agenda, existing support, broad multi-sector participation and the willingness to implement the reform agenda and strategy with the active involvement of stakeholders.

This report reflects the team's main findings and provides a road map and recommendations to improve the content and process to finalize and implement the strategy aimed at universal health care coverage in Kenya.

With regard to the content of the strategy, the following has been reviewed.

1. Clarity of purpose, targets, actions, proposed indicators and their connections with national health policy goals and objectives.

[6] The team was composed of Mr. Dorjsuren Bayarsaikhan, Health Economist WHO/Geneva, Team Leader; Dr.Michael Adelhardt, P4H Coordinator; Mr.Netsanet Workie, Senior Health Economist World Bank/East Africa Hub; and Mr Jan Bultman, Health Financing Consultant GIZ, lead author.

2. Overall policy environment, country administration arrangements and relevant generic legislation within which the health financing strategy would have to be implemented.
3. Comprehensiveness of the situation analysis in terms of population and service coverage, access, risk protection e.g. who is covered, what services are available and accessible and what proportion of costs is covered by pooled schemes and what are the coverage and funding gaps. Further: the organizational set up, governance (finance and services delivery), legal aspects and international treaties (EAC).
4. Current funds and availability of future finances from domestic sources through taxation, health insurance and other financing arrangements in the context of macroeconomic development.
5. Assessment of existing constraints and limitations in relation to the defined strategy targets and proposed actions, combined with an identification of risks and a policy to mitigate these.
6. Feasibility of the proposed strategy in terms of reaching the objectives set.
7. Availability of independent monitoring and evaluation (M&E) capacity to provide information about the process and effectiveness of the implementation of the HFS adopted as well as to evaluate possible pilots (ongoing or new), the results of which could inform further implementation. Availability of well-designed and measurable process and outcome indicators.

More detail can be found in the above-mentioned frame of reference (annex 5).

2. Current situation

Increasing demand for health care along with inadequate funding, underdeveloped infrastructure, shortages in human resources for health, and essential drugs and medical supplies constitute a compelling argument for substantial investments in the health sector.

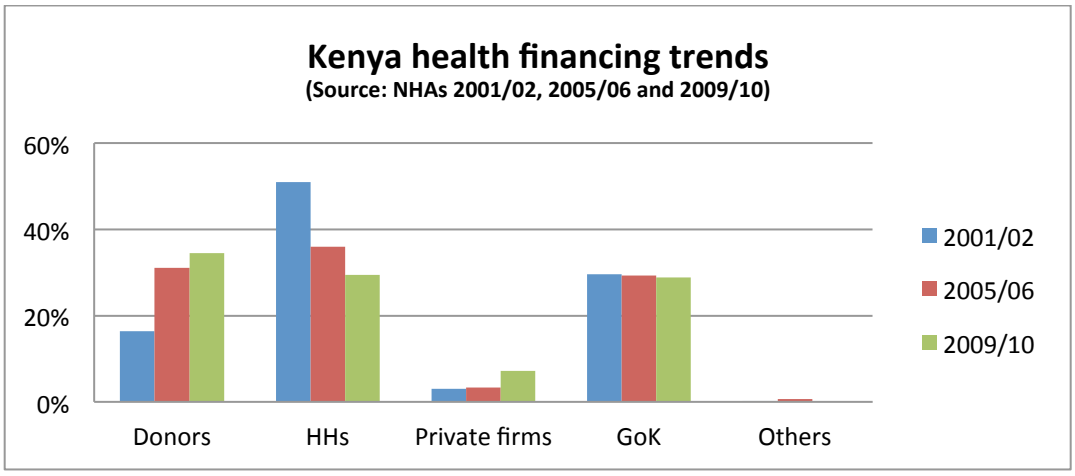
In 2009/10, Kenya spent 5.4% of GDP on health (or US$ 42.2 per capita). Government health expenditure accounts for 4.6% of general government expenditure, the equivalent of 1.5% of GDP (or US$ 12.0 per capita). About 63.3% of total health expenditure is funded publicly, including external (donor) support and health insurance, the latter being responsible for 11% of total health expenditure. The remaining 36.7% is funded privately, with OOP at the point of service being predominant7. Private health insurance is limited[8].

Investment in the health sector has steadily increased over the years. Total health expenditure increased from US$33.5 per capita in 2001/02 to US$42.2 in 2009/10, but within this overall increase there are some interesting trends (figure 1).

[7] Kenya National Health Accounts
[8] Kenya National Health Accounts 2009/10, Ministry of Medical Services and Ministry of Public Health and Sanitation, 2011

- Flat (slightly declining) share of government health expenditure of the total health expenditure.
- Increasing share of donors out of total health expenditure, more than doubled from 16% in 2001/02 to 35% in 2009/10.
- Declining share of households out-of-pocket expenditure as a proportion of total health expenditure, from about 50% in 2001/02 to 25% in 2009/10.

Figure 1



The Abuja declaration target agreed by signatories in 2001 is to allocate 15% of government budget to health. Currently, the share of health expenditure from total general government expenditure is 4.6% (down from 8% in 2001/02), a third of the amount committed to.

Currently, about 25% of the population is covered by the NHIF. It is assumed that the majority of those covered are formal sector salaried employees and their dependents. 46% of the population lives below the national poverty line, and 30% of the population is considered to be indigent. Covering 70% of the population via health insurance, including community-based health insurance and private health insurance is obviously a very challenging task. The elimination of user fees for the poor is a central element in the draft strategy.

The strategy proposes the reduction of the state's role in the delivery of health-care services and calls for the effective use of the private health services sector. It also assumes that OOP can be reduced if informal sector employees can be persuaded to join insurance schemes and pay health insurance contributions.

The current burden of disease suggests that Kenya needs to allocate more resources to disease prevention, health promotion and PHC, and to strengthen PHC in order to avoid unnecessary referrals to higher (and more costly) levels of care. The investment in prevention and public

health programs has substantially increased in the last decade – from 9% of total health expenditure in 2001/02 to 23% in 2009/10.

The efficiency of public health services remains low due to various factors. Health workers are unevenly distributed within the country, with greater numbers in hospitals and urban and non-arid areas. Further, there is a general decline in the number of health workers in all provinces[9]. At the same time policies designed to attract health workers to underserved areas are mostly ineffective and it is still unclear how the nearly 3,000 staff recruited under the economic stimulus package will be regularized. Meanwhile, despite recent reforms in the Kenya Medical Supplies Agency, the overall government allocation for pharmaceuticals remains low and, coupled with poor supply chain management, often results in stock outs of essential medicines, and medical supplies. This forces the facilities to buy medicines and medical supplies locally, paying higher prices without effective oversight on quality.

Limited administrative and management capacity probably restrict health service delivery and coverage. This would need to be examined further in order to see what gains the country could make from the proposed suggestions to reduce the role of the state, decentralize, and provide greater autonomy to health-care providers. Several key reforms started by the Government focus on improving administration and management capacity, access, equity, service delivery and quality of care. The most important actions include:

- The 10/20 policy for user fees – limiting the user fees per visit to Ksh10 at dispensaries and Ksh20 health centres.
- The successful pilot and current scaling-up of "*reproductive health vouchers*" with support from development partners.
- The Health Sector Services Fund - direct cash transfers to health facility committees. Initially piloted in the Coast and North Eastern provinces, and scaled up nationally with funding from GoK, WB and Danida. Three categories of transfers exist: a) to cover basic recurrent costs – adjusted to include a focus on poverty and regional disparities in service delivery, b) for operational activities within and outside the facility, and c) related to performance.
- Performance based financing (PBF) – being piloted in Samburu county. The first tranche of PBF funds to PBF pilot facilities was disbursed in the 1st week of April, 2012. A quasi-experimental, facility-based evaluation was designed for PBF facilities in Samburu Central and in a sample of non-PBF facilities in Samburu East and Samburu North to provide baseline measures of the quality of care and utilization of key services at facilities. Data collection for the baseline facility survey was completed in August 2011. A draft report on the baseline survey is being developed. An end-line assessment following two PBF quarterly payments will determine the extent to which quality of care and management has improved (proposed for June 2012).

[9] Health Situation trends and distribution 1994-2010 and Projects for 2011-2030.

- The Health for All Kenyans through Innovations ("HAKI") approach aims to increase equitable access to quality healthcare, especially for the poor, by removing the financial barrier to accessing health services in two selected districts in Kenya. It uses existing *scientific* and *community-involved* methods to identify the poor. The pilot is designed to run two models: Social Health Insurance (Kericho) and a Waiver Mechanism for the poor (Kwale). HAKI is financially supported by DFID, GIZ, KFW, USAID and WB.
    - The social health insurance for the poor scheme aims to enrol 15,000 people from a selection of the poorest households and to contribute premiums on their behalf; the benefit package is similar to that of NHIF.
    - The Waiver Mechanism for the poor – waives user-fees for inpatient and outpatient care for the selected poorest households, and pays user-fees on their behalf. The mechanism targets 90,000 people and the benefit package includes both inpatient and outpatient care as in KEPH.

These and other ongoing innovations provide an evidence base and will help enrich the dialogue in the development of the national Health Financing Strategy.

3 Approach of the review team and summary of activities

In answer to the GOK request, an expert review team representing GIZ, WB and WHO was formed under the umbrella of Providing for Health (P4H)[10]. Using teleconferences, the team discussed and agreed the method of work in two phases. The first phase started with a desk review of general country background documents, general and health sector specific policy documents and available reviews of the health sector. This provided additional information to review the draft health financing strategy[11]. A list of documents reviewed by the mission is provided in Annex 2. Along with the document review, the team developed a report outline and a critical issues list (frame of reference) to be examined during the second work phase planned in Kenya. The team conducted key informant reviews and discussions on the development process and content of the draft strategy during its mission to Kenya between 12-16 March 2012. A list of the people met during the mission is provided in Annex 3.

The review of the draft HFS development process aimed to:

(i) examine whether all relevant stakeholders including political parties, government ministries, non-governmental agencies, public and private sector entities, industries, civil society organizations and consumer groups are sufficiently involved in the strategy development process;

(ii) learn stakeholders' expectations re health systems financing in Kenya.

[10] P4H is a global network for UHC and SHP hosted by WHO; www.providingforhealth.org

[11] Kenya Ministry of Public Health and Sanitation & Ministry of Medical Services: Accessible, Affordable and Quality Health Care Services in Kenya, Financing Options for Universal Coverage. Version March 2010 (provided in March 2012)

(iii) evaluate the evidence and information that is used to discuss and develop the draft strategy through broad consultations.

The team agreed to review the different opinions and positions of the stakeholders and the ways of discussing them to reach a common understanding and consensus among the team regarding these differences. The team also considered that it is important to examine the use of different means of communication such as focus group meetings, discussions, publications, news media and public hearings, as appropriate, in the country-specific settings.

With regard to the content of the strategy, the team reviewed the need for health financing reform, goals set, guiding principles and the strategic framework to attain these goals. Assessment of the strategy related to the basic functions of health financing, namely: (i) revenue collection, which aims to ensure adequate financial resources; (ii) pooling of resources that enhances the degree of financial risk protection; and (iii) purchasing, which promotes efficiency. The major focuses of the assessment included coverage, equity, access and financial protection of the population against individually unbearable costs of illness and care and the effectiveness and administrative efficiency under the current and proposed health financing modalities presented in the draft strategy. Bearing in mind the goals, principles and strategies to be pursued, it was also important to assess overall governance, the regulatory framework, and the roles, responsibilities and capacities of different health financing actors in delivering quality health services responsive to the needs of the population.

The team also agreed to review the draft strategy in terms of the constitutional and administrative changes that would affect overall health system financing and service delivery arrangements, i.e. the devolution process and subsequent rearrangement of responsibilities for the implementation of health services and of government health financing. It was assumed that political support and leadership are necessary to attain the health financing goals and policy objectives of UHC and SHP. Accordingly, the team examined not only the content of the strategy, but also the necessary preconditions, likely limitations, additional data and information requirements, which might be helpful to finalize and implement the strategy.

The review of the process and content of the draft strategy as well as major findings would lead to the development of a road map and recommendations on the next steps to move forward in the development and finalization of the health financing strategy.

The review's main points of focus, findings, suggested next steps and recommendations are discussed in the following sections.

4. Observations on the development of the Health Financing Strategy

This chapter reflects the observations of the external review team, based on their reading of GOK policy documents, external review reports, factual information from statistics and budget reports, the close reading of the Draft Health Financing Strategy (HFS) as well as on their interviews with major stakeholders.

The overarching message of the team is that the GOK should revive its Health Financing Coordinating Committee as soon as possible and ensure that it is led by a high-ranking government official in order to deal with possible contradicting views from ministries and stakeholders who represent partial interests in the health sector and/or in social health protection and universal coverage.

4.1 Policy vision and commitment

In line with Kenya's new Constitution, the overall goal of the National Health Policy is "attaining the highest possible health standards in a manner responsive to population needs"[12]. It aims to attain "***universal coverage*** with critical services that positively contribute to the realization of the overall policy goal."[13] The Comprehensive National Health Policy Framework in its policy objective 4 aims to "provide essential medical services ... affordable equitable, accessible and responsive to client needs" (P.17), with "adequate finances mobilized, allocated and utilized, with ***social and financial risk protection*** ensured" via the establishment of "a national social health insurance mechanism that includes the employees, employers and the informal sector for universal coverage". The National Health Policy reflects the commitment of the Government to the implementation of the above-stated goal (P.36). This commitment is also shown in the GOK's Vision 2030[14], which is also specified for the health sector[15]. The GOK is also one of the signatories of the Abuja Declaration committed to allocating 15% of government revenue to the health sector. These policy visions and commitments can be considered as the main guiding principles for developing a health financing strategy in Kenya.

4.2 Strategy development process

The development of an HFS has been widely discussed since 1999, and the need to improve health financing has been universally recognized. However it is yet to result in a nationally endorsed strategy. Early on in the process, stakeholders made study tours to countries in South-East Asia and Latin America. More recently a ministerial study tour was undertaken in France, Germany and the UK where differences between health financing systems could be discussed, and lessons learned.

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[12] Republic of Kenya Ministry of Health: Comprehensive National Health Policy Framework 2011-2030 (draft two, final). Page 15
[13] Republic of Kenya Ministry of Health: Comprehensive National Health Policy Framework 2011-2030 (draft two, final). Page 16
[14] Government of the Republic of Kenya. Kenya Vision 2030. A Globally Competitive and Prosperous Kenya. Nairobi. October 2007; Government of the Republic of Kenya. Kenya Vision 2030, The Popular Version. Nairobi 2007
[15] Government of the Republic of Kenya, Ministries of Medical Services and Public Health and Sanitation. Kenya Vision 2030. Sector Plan for Health 2008-2012. Nairobi 2009

Change of focus and lack of clarity.

During this protracted process the focus has changed and broadened from social health insurance (SHI) to improving SHP and to achieving UHC. The then Ministry of Health (now MOMS and MOHPS) initiated a strategy development process, involving a broad range of different stakeholders. The review team noted a range of perceptions regarding the effectiveness of the dialogue engaged, perceptions influenced by particular stakeholder expectations and possible interests in health financing reform taking a specific direction. It seems that lack of decision-making power in the leadership of the MOH (MOMS & MOHPS) may also have been a factor. Such perceptions and interests may also have elicited calls for more transparency in decision making. Confusion exists among the stakeholders about the definitions used and even about basic concepts such as insurance. Meanwhile, it is not universally understood that health insurance can also be financed from general revenues.

Changed external environment

The different dynamics between the stakeholders was not the only issue. The changing external environment also affected the process. This was true of the political changes after the last Parliamentary elections and the introduction of a new Constitution, for example. The latter set in motion a devolution process which makes the environment for health financing and possible health financing reform more complex, taking into account a centralized NHIF and a devolved system for decision making and implementation of government funded health services by local government authorities (LGA's) at the County level.

New territory

The Ministries of Health in Kenya were confronted with the need to make profound improvements in the health financing system and had to enter hitherto uncharted territory. That territory is the subject of this review and concerns the many possible ways of organizing a health financing system, the necessary institutional arrangements involved, and the consequences of the different options available.

Limited mandates

Creating the conditions for SHP goes beyond the mandates of the MOMS and MOPHS and the cooperation of other ministries such as of the Ministry of Labour and Social Welfare and the Ministry of Finance is needed, though not always easy to obtain. The devolution process further complicates the task because of the yet to be defined mandates of the Counties. What the remaining mandate of the health ministries will be and what will be delegated to the LGA's has yet to be decided, although some hints are provided in the Comprehensive National Health Policy Framework.

Interests differ

During the draft strategy development process, different views, interests & positions came to light; some were of a technical nature and remained unresolved and some went beyond the

technical scope of the deliberations, including issues such as (i) the resource base, (ii) the domains and demarcation of public and private insurance schemes, (iii) a possible two tier insurance system giving free choice of insurer or having one universal mandatory insurer, and (iv) free choice of health services provider. These issues proved too complex or contentious to resolve.

Process halted

Due to these different difficulties, the general process came to a halt. Nevertheless some action was taken. For example, benefits for public servants were introduced and there was a review of NHIF[16]. External partners were not fully involved and thus did not play an active role in these steps. However continued interest in the opinion of the external partners was shown and the request for an external review is an indication of this.

Gaps

The review team identified several gaps in the process, as discussed below:

a) The apparent absence of an effective connection of related processes taking place in different sectors at the same time. For example, when developing a social security policy separately from a health financing strategy. This can also be attributed to insufficient involvement and coordination of top level GOK executives.
b) Not all stakeholders were identified. For example the drugs, equipment & supply industries were left out. Although this is understandable given the differences in objectives of these industries and those of the ministries of health, these industries nevertheless fulfil important roles in making products available, and hopefully in offering quality products for reasonable prices. The ministries also have an interest in preventing over-prescription of drugs and the use of unnecessarily expensive drugs. Thus, policies that limit the influence of these industries on the prescription and use of medical products are worth bearing in mind when developing a health financing strategy.
c) An explicit and systematic stakeholder analysis was not performed. Such an analysis could have helped to identify all relevant stakeholders and may have provided timely information about problems which have since come to light, notably the differences in definitions, concepts, and expectations among stakeholders, and the differences in interests between them as regards the public or private implementation of health insurance and of health services delivery. A social assessment, based on the stakeholder analysis could have indicated the support of or resistance to change and the winners and losers of the proposed reform.
d) Existing differences in views were not made explicit in the strategy, nor balanced against each other, and decisions were not explicitly taken.

[16] Deloitte. NHIF Strategic Review and Market Assessment of Prepaid Health Schemes, Measuring up. 14 October, 2011

e) The MOH has given many press briefings about health financing issues, but there was no public debate and news media showed little sustained attention.

Balancing interests and making decisions

Although the review team commends the Ministries of Health for their attempt to reach a consensus, it has to be accepted that all of the interests of all of the stakeholders cannot be satisfied at the same time. The existence of conflicting interests and hence of different potential directions for health financing reform needs to be recognized, and some trade-offs will eventually have to be accepted. The different interests of the pharmaceutical industry, which wants to sell drugs and make a profit, and social health insurance, which needs to contain costs, cannot always be reconciled, for example. The same is true of profit-seeking private health insurers and private health service providers on the one hand, and the providers of care for low-income or indigent people on the other.

Development partners

The possibility of a more extended role for external partners, who could play a more prominent role in facilitating policy dialogues for the development, and implementation of health financing policies, and interact with various national stakeholders, may not have been sufficiently explored in the HFS development process.

4.3. Content of the strategy

The draft strategy called: *"Accessible, Affordable and Quality Health Care Services in Kenya, Financing Options for Universal Coverage"* [17] is a robustly analytical, evidence-based document which provides a good basis for further elaboration. It provides a description and analysis of the health sector situation, including current health financing arrangements and the problems these present. The health financing system is characterized in the strategy by:

- *"Wide inequality in access to services;*
- *Major gaps in infrastructure, shortages and inefficient distribution of human resources;*
- *Low levels of public spending;*
- *Disproportionate funding allocated to urban-based, curative care;*
- *Low productivity;*
- *Weak financial management systems, lack of transparency and low levels of predictability;*
- *High levels of aid dependency and poor alignment of such funding with government needs;*
- *Heavy reliance on out-of-pocket spending as a source of healthcare financing;*
- *Over reliance of public facilities on user-fees to meet operational costs;*
- *Limited protection from the NHIF."*

[17] A copy of the Executive Summary is provided as Annex

The draft strategy further offers an overview of the strategy drafting process thus far, and of the priority health sector reform policies and strategies that are being discussed and pursued in the country, including the GOK's Vision 2030[18], which is also finds specific expression in a separate document addressing the health sector[19]. The document is comprehensive in its scope and integrated in the wider health sector reform as laid down in the Comprehensive National Health Policy Framework[20]. It discusses options for achieving UHC. The values on which the strategy is based and the drive to achieve UHC and SHP are clearly spelled out.

Although a lot of effort has gone into drafting the document, the structure could be clearer and more precise. For example, UHC and SHP are presented as two of the seven strategy pillars, but are in fact not separate. Meanwhile, the "options" presented in section 4.2 of the strategy are in fact objectives.

Agreements reached

In order to finalize the strategy, the team recommends first identifying the topics on which agreement exists among the stakeholders. This would make it possible to focus further discussions and decision-making on grey areas and issues on which agreement is thus far lacking. The team has the impression that agreement exists on the following:

- The need to strive for UHC by improving SHP, enrolling all Kenyans in some finance scheme or health plan that contributes to achieving these objectives.
- The need to analyse OOP, which can be a financial barrier to accessing health care, especially for low-income and vulnerable people. As a whole, the country should move to a pre-payment system, which can be either tax funded and/or achieved via health insurance, or a mix of both.
- The need to improve the effectiveness, quality and efficiency of the health sector and its health financing system, including the NHIF and public budget execution mechanisms.
- The implementation of the recommendations of the NHIF Strategic Review[21], in particular those concerning administration and governance.
- The need to develop a uniform basic benefits package (BBP), providing entitlements for Kenyans and covering their identified health service needs as far as is feasible.
- The need to further develop purchasing capacity and suitable instruments for purchasing by third party payers.
- Retaining and further pursuing pluralistic health service delivery arrangements, i.e.

[18] Government of the Republic of Kenya. Kenya Vision 2030. A Globally Competitive and Prosperous Kenya. Nairobi. October 2007; Government of the Republic of Kenya. Kenya Vision 2030, The Popular Version. Nairobi 2007

[19] Government of the Republic of Kenya, Ministries of Medical Services and Public Health and Sanitation. Kenya Vision 2030. Sector Plan for Health 2008-2012. Nairobi 2009

[20] Kenya Ministry of Health. Comprehensive National Health Policy Framework. Final Draft.

[21] Deloitte. NHIF Strategic Review and Market Assessment of Prepaid Health Schemes, Measuring up. 14 October, 2011

continuing with some mix of public and private health facilities, the latter as not-for-profit, faith based, or for-profit legal entities.

- Realizing a greater degree of autonomy for public hospitals as regards managing their budget, staff and facilities, albeit within a structure of transparency and accountability.

Grey areas

The review team noted several areas where the level of agreement was unclear. These include:

- Although the draft health financing strategy has to be seen as one of the implementation strategies of the National Health Policy, the latter aims at national health insurance, but also seeks to "promote community-based health financing mechanisms" (P. 26). The question thus arises: how can community-based health financing be aligned with a national health insurance scheme? This would need to be clarified.
- The financing of community-oriented public health does not receive much attention in the National Health Policy but public health itself does. This is another issue that deserves attention in the formulation of the HFS.
- The extent to which the values reflected in the draft Strategy are endorsed by stakeholders.
- How community-oriented public health should be financed, notably with regard to disease prevention and health promotion? Presumably to a great extent from public revenues. However, this is not made clear in the strategy.
- Whether a proposed AIDS Trust Fund will fit into the new set up. Key considerations here might include the need to have continuous, secured funding for HIV prevention, to support timely identification of HIV positive persons, and to avoid interruption of therapy, which could lead to virus mutations resistant to current antiviral drugs. On the other hand, although AIDS is important and the relevant MDG needs to be achieved, tuberculosis and other infectious and non-communicable diseases are also important. The establishment and resourcing of a government trust fund as such is no more of a guarantee than an item incorporated in the GOK's budget. It all depends on the political will of a government to secure the necessary funds and execute agreed budgets. A trust fund will also perpetuate the separation of health services in a vertical disease oriented approach from an approach targeting all individual health risks and disease via the mainstream health services delivery system of primary, secondary and tertiary care. The usefulness of such a separation and its pros and cons should be carefully discussed and appropriate decisions made.
- Whether a move to one or more mandatory schemes is supported among stakeholders. A mandatory national scheme would offer the best options for UHC, but would face challenges in enrolling the informal sector as international experience shows. In any case, budget transfers from the GOK will remain necessary to cover the poor in the informal sector.
- The operating of a National Health Services Trust Fund as an intermediary pool from which providers can be paid, instead of direct payment by purchasing institutions such

as public health authorities or insurers. The pros and cons should be clearly stated in the follow-up draft strategy document.

- The establishment of the proposed Access and Equity Fund, Health Benefits Regulatory Authority, Benefits and Tariff Board and independent Accreditation Agency, including the possible organizational consequences of the development and operation of such institutions.
- How the future benefits package would look, which criteria would be used for its composition and for regular adjustments.
- How purchasing would take shape, i.e. what the mandates would be for purchasers in contracting providers, their services, the payment methods and actual prices.
- Whether competition between public and private insurers should be fostered.
- How oversight and auditing of health financing institutions would be organized and which bodies would get the mandate for this.

Not agreed

What has not been agreed upon until now are the following options:

- The establishment of a National Health Revenue Authority, which would collect all revenues.
- Using a single pool for all revenues.
- The establishment of a single purchaser model.
- The separation of collection of contributions, pooling and purchasing.
- The introduction of mandatory employer contributions into a health financing scheme.

Areas not covered

The team identified several gaps in the draft strategy which it recommends closing:

- There is a need to understand that UHC and SHP go beyond health financing, that health financing goes beyond health insurance, which in turn goes beyond the NHIF. Hence attention needs to be directed to other options and institutions, in a balanced way. There is also a need to understand that health insurance and budget funding (from general revenues) are not opposing concepts. Health insurance can be financed from general revenues; indeed, as is often the case in many countries, it has to be in order to cover those who cannot pay the contribution rates and/or to keep the mandatory wage related contributions low enough to sustain business competitiveness.
- Although the new Constitution was adopted after the development of the strategy was halted, its consequences and implications for the health sector have yet to be identified as regards the impact of the planned devolution on public finance flows and the establishment of new mandates, of possible County pools, and the coordination between the devolved public system and centralized health insurance [22]. The

[22] The Ministry of Health's Comprehensive National Health Policy Framework provides the implementation framework on some of the aspects of devolution and the role the County level could play, restricting the Financial role of Counties to financing of County

entitlements as referred to in the Constitution will also need to be specified, especially the right to emergency care.

- The level of understanding and the commitment of stakeholders to achieving SHP objectives is not specified. For example in terms of what UHC means in the Kenyan context and how a basic package of essential health services for the whole population would be established.
- The current and future role of the private sector in financing and delivering health services is not sufficiently clear, and would require multi-sector dialogue and harmonisation of health, social and economic policies and objectives.
- The strategy does not provide information about the resource requirements for the implementation of the planned strategy or for its operation. Furthermore, it does not analyze and indicate the fiscal space available for the health sector, nor the fiscal consequences once the strategy is implemented. An analysis of the possible costs of the proposed system and of the transition process towards this system, including the administrative costs of establishing new health financing structures, is missing; the strategy is also silent on how the proposed changes fit in with the current and future socioeconomic, political, health and demographic context and square with implementation capacity.
- As regards the possible resources collection, pooling and purchasing arrangements, no attention is paid to the possible mandates for purchasers in the collection and pooling of resources, in selectively contracting health services providers, in setting fee schedules and fee levels, and in provider performance review. Nor is attention given to the different options available for organizing these mandates, together with a discussion of the pros and cons of, for example, a single versus multiple purchaser model in a geographically demarcated organization or working nationally as competitors.
- Possible activities of purchasers such as selective contracting of health services, provider performance and financial claims review, including the need to review the appropriateness of the care provided against developed yardsticks, deserve explicit attention and should be explicitly linked to quality improvement. Although some attention is given to accreditation, an overarching National Quality Improvement Strategy, including national practice guidelines does not exist. Such guidelines could foster quality improvement and efficiency and could be used as a yardstick in provider performance and claims review.
- Governance: clearly formulated responsibility, transparency and accountability and the need for regulatory changes have not been given the attention they deserve. Apart from basic financial auditing, the issue of value-for-money auditing is not addressed.
- The strategy does not sufficiently cover the issues of accountability and transparency, and one of the team's practical suggestions would be the publishing of yearly financial

level health services, development of investment plans, asset financing and ownership, channelling public and other funds to develop health facilities and mobilize resources for County health services (P. 31 & 32).

and (in summary) audit reports of health financing institutions as a means to support good governance.

- There is limited consideration and analysis of alternative options for health financing and implementation, including the pros and cons, and their relation and contribution to the values of UHC.
- Limited attention is paid to the international context, such as the EAC and the UN and ILO treaties, and their significance for the future health financing system, and the coverage of services and for example cross-border workers.
- Operationalization and implementation plans for the HFS are missing.
- No specific and quantified targets are set in the strategy.
- The strategy lacks a monitoring and evaluation plan, or any reference to the creation of independent capacity to undertake M&E on an ongoing bases to inform stakeholders about the results of pilots, implementation problems and successes, the achievements of health financing reforms or the lack thereof, together with the determinants of progress or delays.
- A thorough risk assessment is also missing together with appropriate mitigation strategies, the most important of which would be ensuring political leadership and political continuity at the highest level possible.

Lastly, though this is not a grey area or gap, the document provides a lot of information, but could be improved in terms of focus, prioritization and internal coherence.

The team proposes that the Ministries of Health and stakeholders seek a common understanding about identified areas of agreement, disagreement, grey areas and gaps in the current draft strategy and clarify their positions. The Ministries of Health could subsequently initiate the decision process as is indicated in the next chapter.

5. Next steps and recommendations

This chapter reflects on possible ways forward, building on the substantial and valuable work that has already gone into the strategy process in recent years. A first step would be to revive, extend and strengthen the ICC HF. The chapter then details the issues in the draft HFS that require further discussion and consensus building. It outlines a number of steps and work packages for a roadmap to enhance the process and content of the HFS. Recommendations on the process range from a stakeholder analysis, connecting sectors, raising the profile by encouraging government officials at the highest possible political level to engage in a public debate. The section on content highlights the importance of carrying out essential analytical work before moving onto the broader system changes. Controversial issues are signaled, and will have to be explicitly discussed, such as the creation of a **single funding / risk pool**; the establishment of a **single purchaser**; the **separation of collection, pooling and purchasing**; and any **employer contribution**. The chapter concludes with a brief discussion of the role of DP support and the need for capacity development.

5.1. Major recommendations for the way forward

Revive, extend and strengthen the Interagency Coordinating Committee (ICC) Health Financing. The complex process and extensive work ahead requires a functional platform for exchange and dialogue, guidance and oversight, and for the coordination of activities. It is therefore suggested that the ICC Health Financing be revived in order to ensure multi-sector government coordination and regular meetings to fast-track the finalization of the strategy. This committee is key to broadening the ownership of and commitment to the HFS and its implementation. It should also facilitate the effective connection of the sectors involved, including health, social (e.g. social security policy), finance and others (e.g. county administrations, employers, etc.).

Further work on the UHC agenda needs to take into account the upcoming **elections in 2013**. It may be difficult to predict to what extent political decisions on the controversial issues outlined in the previous chapters can be taken before the elections. However, the interim period may well be used to strengthen the evidence-base, rethink stakeholder involvement and multi-sector dialogue, to initiate public debate, advocate for and raise the profile of UHC/SHP, and, possibly, to prepare for political decision making.

The following recommendations are intended to improve the HFS development process.

Carry out a stakeholder analysis

One of the proposed initial steps is to carry out an in-depth and inclusive **stakeholder analysis** in order to generate knowledge about the relevant actors so as to understand their attitudes, intentions, interrelations, objectives, agendas, expectations, interests, and the influence or

resources they have brought - or could bring - to bear on the decision-making processes. This analysis can then be used to develop strategies for managing these stakeholders, to facilitate the implementation of specific decisions or organizational objectives, or to understand the policy context and assess the feasibility of future policy directions[23]. The analysis will also help to clarify who should be involved in the health financing strategy process, at what stage of the process, and at what hierarchical level, and will reveal to what extent different stakeholders will support the solutions under consideration, the options and possible directions for reform needed to achieve UC by improving SHP. A related **social assessment** could also be helpful in identifying the potential winners and losers of reform and show where the resistance to change is located and what measures could be taken to create, as far as is possible, a win-win situation for most if not all of the stakeholders.

Where possible, each step in the process should be taken in dialogue with the relevant stakeholders. However, at some point decisions will have to be made that may not please all stakeholders. Because of trade-offs between the various options, not every stakeholder can be a winner at all times. The process and intermediary results should also be communicated to the media.

Harmonise policies across sectors

In order to contribute to policy coherence at the national level, the ICC HF needs to identify opportunities to create more **effective links** between the social security policy and the HFS for policy harmonisation in overlapping areas such as SHP.

Involve the highest political level in the UHC endeavour.

Top level government involvement has been shown to be beneficial in accelerating the transition towards UHC. In the Kenyan context, the engagement of top level officials could help to facilitate decision making in the apparent current stalemate. Thus it is recommended that windows of opportunity be used to **push the process up to the highest political level**. One suggestion is to re-establish the task force under the Prime Minister, which allows for monthly updates on progress in developing the national health financing policy and strategy, to signal any hiccups especially in the collaboration between ministries, and to foster ownership and dialogue on UHC by improving SHP and related issues, options and solutions based on the main guiding principles.

Initiate a public debate on UHC

The upcoming elections in 2013 may be an opportunity to initiate a **public debate** about UHC/SHP, which has been missing so far. This would be an excellent opportunity to get the attention of the news and media to facilitate UHC advocacy.

[23] Ruairi Brugha and Zsuzsa Varvasovszky; Stakeholder analysis: a review; Health Policy and Planning 15 (3): 239-246, Oxford University Press 2000

Action plan for the process going forward

The team recommends the development of a time-bound action plan as early as possible to define which steps in the ongoing process will be taken and what topics will be decided by which date. To support this plan: indicate who should do what, by what time and establish what possible financial and technical support would be needed both for the process itself and the development of the content of the strategy. It should also identify the topics to conduct further analytical work.

The following recommendations are intended to improve the HFS content.

Foster a common understanding of UHC in Kenya.

An important initial step of the roadmap is to **reflect on what UHC** means and to translate this concept into the Kenyan context. While the mission team commends the shifting of the earlier focus on health insurance and the NHIF towards the broader aspects of UHC and SHP, it is important that all stakeholders share a common understanding and vision of UHC by improving SHP in Kenya. In particular the trade-offs between the dimensions of population coverage, health service coverage and cost coverage need to be discussed in the Kenyan context, keeping in mind the scarcity of available resources. The strategy will need to clearly show how every Kenyan can have access to at least a minimum basic package of quality health services without facing financial hardship. The strategy process needs to build consensus on the importance of values such as solidarity, equity in financing, equality in rights, good governance, the rule of law and culture and gender sensitivity.

Take concrete steps towards UHC. This should include the following:

a) The model used to organize the financing of the system

Any discussion of moving towards a national ***mandatory scheme*** should take into account that ***voluntary scheme***s have so far been unsuccessful in achieving and sustaining UHC. Offering the possibility of opting out of a mandatory insurance scheme to chose a private voluntary insurance scheme may undermine solidarity unless cross-subsidization and necessary financial support are ensured to pool the risks and funds among large population categories as far as feasible.

Discussions are needed regarding the pros and cons of a ***single*** *versus* ***multiple-payer system***. For example, with regard to multiple payers, they can be oriented towards a mandatory basic package of services and/or the basic and supplementary packages. The question is: will there be a clear demarcation of the basic package and possible voluntary supplementary packages?

The development of qualification strategies and qualification criteria for registration and licensing for ***becoming a UHC financier*** *will be necessary*. This means that the criteria for UHC financing needs to be well defined, including what is expected from any mechanism(s) for revenue collection, pooling and purchasing in terms of governance and management,

accountability and transparency, technical and administrative capacity, and efficiency. This would help existing potential players to adapt to the new requirements, provide guidance for the creation of possible new entities, and allow for the development of a level playing field and a unified national system. If the financier(s) are health insurance organization(s), the criteria used could resemble those applicable to general insurers, but with added criteria appropriate for the area in which the insurer would be active, and the insurers should offer access to potential clients to facilitate their enrolment as well as the capacity to contract a sufficient number of providers to guarantee local access for the insured to the nationally defined benefits package. In other words cream-skimming by limiting capacity to relatively richer geographical areas should be prevented. If there are to be competing insurers, requirements such as the prohibition of risk rating, risk selection and the prohibition or refusal of clients because of pre-existent health problems and diseases needs to be given thought.

What financing model to use. Several choices will have to be made: notably between an insurance model, a national health system, general revenues based model or a mix of these. If the basic package is to be implemented via an insurance model with multiple payer/insurers, should it be left to social insurance, implemented by public insurer(s), or can private insurers also participate? Should insurers be geographically divided in their mandates or can they work nationwide, and is competition the way to foster the implementation of UHC?

It is worth reflecting on the lessons learned from pilots such as OBA, HAKI and PBF when considering a health financing model for adoption.

If the preferred health financing model is ***competing*** insurers covering the basic benefits package, several safeguards would need to be considered to prevent the negative side-effects of competition including risk selection and risk rating of contributions by financiers/insurers, which leaves the bad and costly health risks out of their portfolios, and not contracting providers who are favoured by chronic patients.

Safeguards could include:

- a mandatory and uniform benefits package;
- the obligation to accept all persons willing to enrol;
- if insurers can set all or part of their contribution rate: mandate a uniform contribution rate for the uniform package for all enrolled people with a particular insurer irrespective of pre-existing diseases and personal health risks, i.e. no individual risk rating;
- mandatory national or county coverage to prevent concentrating on a few rich areas with lower health risks;
- a financial risk equalization mechanism between the different insurers in order to create a level playing field.

Regulate competition. A robust regulatory framework implemented by capable regulatory and audit bodies with the mandate to sanction or even disqualify insurers not abiding by the rules is necessary to implement and enforce these safeguards. This implies a capacity to:

- regulate the market, by setting the rules of the game and giving instructions;
- audit
    - financial
    - value for money
    - performance vis-a-vis the insured
    - performance vis-a-vis the providers
    - numbers of insured and their distribution over risk categories for the implementation of a risk equalization mechanism between competing insurers, the audit to take place at least two times per year.
    - Implement a risk equalization mechanism to ensure that insurers have a level playing field and to take away possible incentives for cream-skimming (risk selection).
- collect the necessary information for regulation, auditing and the implementation of an equalization scheme.

In addition to this, insurers will also need to have the capacity to implement such a scheme, not only handling the common tasks of enrolment, resource collection and administration, the contracting of providers, claims review and provider performance review, but also running a an administrative system that is capable of offering the reliable, detailed data needed to run a risk equalization scheme.

It should be noted that a system of competing insurers will be very complicated, requires sophisticated infrastructure and capacities and generates high administration costs, while the jury is still out as to the advantages of competition in health financing. It will also take a long time to establish a working system. For example it took the Netherlands about 10 years to get its risk equalization system to the point it is now and to be accepted by all parties as more or less fair. New diseases or shifts in morbidity numbers and new treatment methodologies demand regular adjustments to the mechanism. Besides this, there is the basic actuarial work to be done to adjust contribution rates.

It would be helpful to look at whether Kenya has the capacity or can build the capacity in the short term to run a competition-based health insurance scheme.

b) Urban and Rural population

Preparing the ground to move closer to UHC also requires strategies for dealing with the social and economic differences of ***urban and rural populations*** in Kenya. The HFS should seek to reduce inequalities in access and coverage rather than aggravating them. This would also include avoiding fragmented funding arrangements for specific population categories such as

civil servants. The provision of effective coverage and financial support for the poor, indigent and marginalized people, as well as the informal sector is crucial for the transition to UHC and should receive particular attention in the next step of the HFS development process.

An early decision would be beneficial, since categories that receive coverage first, such as the formal sector, usually push for increased benefits or reduced contributions, but not to extend coverage to others, especially those unable to contribute[24]. Singling out special population categories that are entitled to more and more extensive benefits, may also lead to health-care providers favouring the clients of such schemes and induce a migration of health staff to places where these benefits are reimbursed, and hence exacerbate disequilibria in staff distribution across the country. The prevention of funding fragmentation and the active enrolment of the poor needs to be complemented by making health services accessible for them, if not via the already established network of providers then perhaps via outreach services to difficult to reach categories of the population or mobile services for areas where regular facilities are absent or hard to reach.

c) Subsidizing the poor

The poor, indigent and marginalized people, who do not have the means to contribute to the UHC scheme would be especially dependant on subsidies. It will thus be important to determine the additional resource requirements and to agree on how to mobilize them in a sustainable manner. Resources could be made available through cross-subsidization between health insurance schemes, transfers from the government budget and the inclusion of the poor in existing or to be established insurance schemes without paying contributions or only minimal or symbolic ones.

d) Covering the informal sector via insurance

Another huge challenge is effectively covering **the informal sector.** Developing and deciding on an enrolment strategy for informal sector employees and their families in health insurance is a crucial aspect of the transition to UHC. International experience shows that voluntary enrolment, by individuals or groups, has not been very successful in covering the informal sector unless their coverage is financed from general revenues. On the other hand, using government subsidies to cover the informal sector (as is done in Thailand) would need to keep in mind the trade-offs between population, service and cost coverage, notably the fact that covering more of the population would lead to a smaller benefit package or lower cost coverage.

e) International aspects

Given Kenya's membership in the EAC, it would be useful to give some thought to the implications of international agreements and treaties such as those of the United Nations (UN), the International Labour Organization (ILO), the World Trade Organization etc. for the BBP

[24] World Health Report 2010, page 49

composition, copayments, cross border care and the mutual recognition of regulations, standards, as well as for the registration of pharmaceuticals and other medical products.

f) Further analysis

The analytical work recommended below will facilitate decision-making on technical aspects of UC implementation, and identify the constraints and opportunities that exist in the broader health system context. This would then form the basis for the development of alternative strategic options for the final version of the HFS.

Elaborate on the implications of the New Kenyan Constitution. This should include the following:

a) Entitlement to health services.

The HFS needs to elaborate on the implications of the new Kenyan Constitution for the path to UHC, bearing in mind that access to health services has become a constitutional right. What are the implications for: mandatory versus voluntary participation in SHP mechanisms; resource generation and risk pooling, and flow of funds in a decentralized context; the development of a national benefit package; financial risk protection; equitable access to quality services, etc. There needs to be an in-depth discussion about the opportunities provided by the new Constitution, but also the critical issues that need to be addressed in order to align the HFS with the new Constitution, for example by defining criteria for central and county responsibility.

As regards the impact of the new Constitution on the BBP, it is noted that the Constitution does not give a "right to health" as some seem to believe. No human being or authority on earth can guarantee a right to health. The Constitution is more moderate in its formulation[25], aiming at realizing a right to health care.

b) Emergency care

It will also be important to indicate the extent of **emergency care** to which citizens are entitled (Art.43.2 of the Constitution does not provide further specification). This may even require some specific legislation to allow for a uniform interpretation of the term, "emergency care".

c) *Devolution*

[25] Constitution. Article 43 *"(1) Every person has the right—*
(a) to the highest attainable standard of health, which includes the right to health care services, including reproductive health care;
(b) to accessible and adequate housing, and to reasonable standards of sanitation;
(c) to be free from hunger, and to have adequate food of acceptable quality;
(d) to clean and safe water in adequate quantities;
(e) to social security
(f) to education.
(2) A person shall not be denied emergency medical treatment."
Quoted from: The Constitution of Kenya. Revised Edition 2010. Published by the National Council for Law Reporting with the Authority of the Attorney General. http://kenyaembassy.com/pdfs/The%20Constitution%20of%20Kenya.pdf

The **consequences of the devolution** of mandates in different areas to the districts for future health financing governance and the practical arrangements this implies will also require attention. It seems that the criteria to be used to assign specific mandates to the districts and the national level health authorities and agencies need to be explored and formulated, and the same is true of the functions and mandates assigned together with mandates for instruction and reporting as well as for coordination between the different government levels and mandates.

If health insurance is chosen as one of the preferred financing modalities, one of the crucial aspects will be the relation between general revenue-financed, vertically organized, health services, such as services for HIV and TB (for which the **mandate could be shifted to LGA's)** and health insurance-financed, mainstream health services delivered via Kenya's six level system, from primary health care centres to national referral hospitals. Preventing uncertainty about which services are paid from which source is important to prevent patients falling between the cracks and/or providers either not getting paid at all or being paid twice for the same service. So, the more important question is: how to integrate and mainstream individual-oriented services as much as possible, including services for TB and HIV/AIDS patients.

d) ***Constraints to UC***

Identify constraints & opportunities for UC implementation in the health system context. This might include geographical aspects, and the real availability of health services and the staff needed to deliver them.

Clarify and decide on issues in the draft HFS.

In terms of content, there are a number of issues, some of which have been flagged in the draft strategy by different stakeholders, that require validation in order to move the process forward. A number of technical aspects will need to be decided, including:

a) Who will be covered as part of UHC

- The main question is will all residents, including foreign workers, be covered. The issue of foreign workers may also have particular relevance in the context of Kenya's membership in the EAC and the portability of entitlements across borders. (It should be noted that many countries exempt foreign diplomatic personnel from enrolment in otherwise mandatory national health insurance schemes.)
- Or will only resident citizens be covered?
- Will coverage include Kenyan citizens living abroad and paying taxes/contributions in other countries. For example, in Tanzania.
- Specific attention may be needed for people living in border areas and working across the borders, including traditionally migratory people which move around with their livestock.

b) Resources for health

- Where do the resources for health come from: general revenues, earmarked taxes, payroll taxes, co-payments or a mix of these?
- How are they to be collected: via the general revenue services; by involved insurance institutions; by health services providers or by a mix of these? Effectiveness and administrative efficiency are generally the main criteria for allocation of a collection mandate, for example with the support of the tax collection system.
- Where are they to be pooled? In the government treasury system or at commercial banks? The key consideration here is the avoidance of financial risks, administrative and banking costs, including the loss of money due to the pumping of money back and forth among commercial banks. The cheapest and simplest system seems to be the depositing of the collected resources at the MOF Treasury, in a special account with drawing rights for the identified purchasers for pre-identified purposes such as paying for benefits and admin costs, all on specific dates to minimize losses.
- There is a need to estimate the cost of providing services at different levels of health care delivery. Such estimates would be useful to inform decision making on the BBP and the possible funding requirements and contribution rates for health insurance. It would also be useful to use such estimates to underpin decisions on fee/tariff levels for services.
- The HFS should define the resource needs, sources of funding and funding arrangements for prepayment, and cross-subsidization from other schemes and for transfers from general revenues while making sure that equity in finance is being achieved.
- **The current spending of US$ 12 per capita on health may not be sufficient to meet the universal coverage agenda proposed for all Kenyans as called for in the new Constitution**. More research and evidence is needed to get a better understanding about the resource requirements for defined UHC modalities, including the administrative costs for new entities, the available fiscal space, but also the collective social and economic gains of investing in UHC by improving SHP in Kenya. This would help build effective partnerships and provide solid reasons for resource mobilisation, which need to be translated into suitable language for dialogue with the MOF and other relevant stakeholders, as well as the broader public to encourage buy-in of the UHC agenda.
- Thus, execute analytical work to strengthen evidence to underpin the need for increased resource mobilization.
    - Identify total resource requirements for defined UC modalities, based on, among others:
        - Cost analysis of benefits, including estimated frequency of use by the population;
        - Fiscal space analysis, including not only opportunities to raise more external revenue, but also options for potential savings by making

effective care delivery and administration more efficient.

Therefore:

- Perform efficiency analysis and identify possible savings (see hereafter);
- Build effective partnerships for resource mobilization and harmonization and multi-sector cooperation, for example with other ministries responsible for government finance, local government, social security, environmental hygiene, infrastructure etc;
- Identify collective social and economic gains of investments in the health sector. However, it should be noted that health is of value in itself and should not to be seen as just an engine of the economy. Indeed the new Constitution does not deny access to health services to non-productive citizens. On the contrary it provides for equal rights.

c) Designing efficiency improvement strategies.

The above recommendations are closely linked to the issue of efficiency. On a global scale, WHO estimates that 20-40% of all health spending is wasted through inefficiency[26]. What is the situation in Kenya? Again, more evidence is required. The HFS needs to examine and eliminate resource waste at all service delivery and management levels and in HF administration; for example by carrying out an administration efficiency study. It should design and implement an effective referral system; review and agree on suitable provider payment methods, fees and co-payments; examine and define necessary conditions and requirements to improve efficiency in line with new developments on provider autonomy and devolution, taking into account possible gains in quality of care by applying up-to-date clinical practice guidelines and medical protocols; carry out a provider performance review capacity (claims review, appropriateness of care review); and build and strengthen capacities in budgeting, financial planning and management at all levels.

- However, in order to avoid having the health sector lose any hard-earned efficiency gains, it would be important to **advocate for a reinvestment guarantee** of the MoF for such efficiency savings.

d) Defining strategies to control OOP

Direct payments (out-of-pocket payments) are the most inefficient and inequitable way of financing health services. However, moving towards a system of prepayment and pooling, and sharing the financial risks of ill health, requires a deeper understanding of the motives for charging copayments, of the modalities of OOP (who pays and for what services) and their impact on access, household income (poverty) and benefit package extent;

Formal copayments come in different forms:

- A fixed amount for specified services (e.g. per bed day, per lab test, per drug, if demanding services without mandatory referral from a lower level of care);

[26] World Health Report 2010, page 79.

- A percentage of the costs of the services or of the usually charged, predetermined fee;
- The amount over a specified threshold for the cost of services;
- A combination of the above.
- The burden on care seekers can be kept in check by:
    - Limiting the copayment to a certain maximum per period and/or making the copayments and the level of copayment income-dependent;
    - Exemptions for categories of patients,
        - e.g. poor people, pregnant women, children etc.;
        - patients having a referral letter from a lower level of care; and
        - patients getting pre-approval by the health authority or third party payer, e.g. for hospital admissions or very expensive interventions or drugs.

Income-dependent copayments can also help finance a broader benefits package while exempting the poor and granting the poor access to a larger package. However, administering income-dependent copayments will require more effort and thus financing.

Working on an OOP control strategy is closely linked to the above cited issue of defining the subsidies needed for specific population categories and services (fee exemptions, free health care at lower level versus subsidised insurance premiums).

e) Agree on nationally defined basic health services and benefits

Irrespective of what the health financing system will eventually look like, that is to say how funds are being raised and pooled, or what service provision arrangement would be in place, the new Constitution prompts the HFS process to define the basic health services every Kenyan will be entitled to. This should be guided by the preferred focus on disease prevention (Vision 2030), PHC and other cost effective interventions. This would imply a possible expansion of health insurance benefits to out-patient care if health insurance is chosen as the main financing mechanism for the basic package, as well as alignment across all schemes including public and private service delivery. An estimation of the cost of delivering at different levels will help to determine the affordable and appropriate level of care. Another important task will be to define the resource needs and funding arrangements for this package of services through prepayment. While defining the benefits depends on what Kenya can afford, the amount set for the proposed package should probably follow WHO recommendations and honour the Abuja commitment, rather than the unacceptably low level of current spending.

f) Formulation of BBPs as entitlements for citizens/insured

Criteria for the inclusion of health-related interventions in the Kenyan benefit packages should precede the decisions on their content. Criteria could include: (i) Effectiveness of the intervention; (ii) cost/effectiveness where equivalent options for dealing with a medical condition (or preventing it) exist; (iii) medical necessity: life saving, preventing handicap or

disease and curing non-self limiting disease; (iv) burden of disease; (v) impossibility of individually bearing the costs of the intervention.

Thereafter: agree on nationally defined basic health services and health insurance benefits.

- Make specific provisions for disease prevention, health protection and health promotion within the strategy.
- Decide which activities require a community-oriented approach; for examples in cases where no active demand can be expected as compared with curative care, and where an individually-oriented approach may work. The latter could be included in an insurance-financed benefits package; the classic public health activities would be better financed from general revenues. If the basic health care packages is to be financed by competing, for-profit insurers, community-oriented prevention would be better left out of their mandate. Such insurers may not be interested in insuring activities for which the possible financial returns are only likely to be realized over the long term, by which time the insured may already have changed insurer.
- Focus on disease prevention, PHC and other cost-effective interventions. Such a focus should be accompanied by complementary planning of health services, ensuring that necessary infrastructure and trained staff are available. This means that the growth of high-tech, high-risk interventions, and the facilities that provide them, may have to be contained.
- Expand health insurance benefits to out-patient care. This will prevent unnecessary admissions where people are simply seeking free medicines and diagnostic tests where these are provided. It will also prevent the admission of patients for complications of diseases such as asthma and diabetes which could have been prevented by timely outpatient treatment. The analysis of common reasons for admission and a focus on preventable causes, possibly accompanied by cost-benefits analysis, could be helpful in convincing policy makers, including the minister of finance.
- Connect the legal description of identified entitlements or health-relevant interventions to the options for cost-containment and quality assurance by:
  - Using a contracted provider who is able to specify the type of provider;
  - Defining the place where services can be received: inpatient, outpatient and/or at home;
  - Defining the conditions for access, such as: -
    - Existence of an objective medical need;
    - Copayment;
    - A referral;
    - Pre-authorization by the insurer or health authority;
    - Territorial restrictions, i.e. whether a provider close to home has to be used or whether the patient is free to go to anywhere, for example in cases where necessary/covered care is not available in the home District/Province. Cross-border care is also to be considered.

- Choose between a disease-oriented or a services-oriented description of the entitlements. A disease-oriented description has the disadvantage that patients and providers may be uncertain whether certain interventions are covered under this description, at least during the diagnostic phase. It causes also problems in case of not covered co-morbidity. A services-oriented description would reduce such uncertainty.
- Decide which mode would be applicable:
    - Benefits in kind where patients are entitled to the services as listed and the providers are paid by the third party payer directly via bulk billing;
    - A reimbursement system, where the patient pays the provider and is entitled to a reimbursement of the costs of services as listed. This system is more costly to administer than the benefits in kind system because of the need for individual billing. The patient also has to find a suitable provider willing to treat him, and cannot ask for support from the third party payer. Such a system also offers fewer options for cost and quality control, unless the third party payer creates an expensive information system and uses a system of contracting;
    - Benefits in cash system where, in the event that a health problem arises, the patient receives an amount of money and is free to spend it on whatever he likes, even outside the health sector. This approach is unlikely to be beneficial in Kenya and may be susceptible to fraud;
    - Benefits in vouchers. Such a system is supposed to empower patients vis a vis the health staff, since the income of the staff and revenues for their health facility depends on attracting patients. However, such a system may be costly to administer and only works if patients have a choice of provider.

Make a clear distinction between individual-oriented health benefits versus public health and possibly services still being provided through a vertical systems.

If a mandatory health insurance system is favoured for the provision of UC the following question will have to be faced: should contribution rates be ***geographically differentiated*** in accordance with differences in service availability, thus posing limitations to actual benefit utilization which cannot be solved by providing insured transport. Or, differently formulated: is it fair that people pay contributions for services they cannot utilize because these are out of reach for them?

g) Purchaser

Decisions will have to be taken regarding the use of an independent purchaser or purchasers, what its/their mandate(s) will be, and the kind of purchasing arrangements it/they will employ such as contracts and provider performance review tools. Regarding the mandate, can a purchaser selectively contract providers (especially public providers) or is the purchaser obliged to contract all providers regardless of the need for these providers to cover the enrolled

population and regardless of their service quality? Selective contracting can also take the form of selecting only specific services and/or contracting a certain volume of services. The mandate to selectively contract providers and their services pre-supposes some level of autonomy on the part of providers to adjust to changing demands.
Consequences resulting from greater selectivity, such as reduced revenue for providers and the possibility of bankruptcy, need to be taken into account.

Purchasers could also be mandated to agree fee schedules and levels of fees with providers. Such a mandate could lead to several different schedules running in parallel which may become an administrative burden for the providers, and may therefore not be very efficient. So, the mandate can be restricted to agreeing volumes of services and prices, although prices may also be set at the national level. If different fee schedules were used, they would need to be introduced in a way that encouraged patient-oriented, appropriate care in sufficient volumes, administrative simplicity, ensured complementarity of schedules for different levels of care, and avoided adverse incentives such as unnecessary referrals, and interventions, and notably interventions that are recommended on the basis of profitability, regardless of their value-added for patient health.

h) Health services

Services delivery matters and depends on: (i) the availability of sufficient providers to deliver the covered services in an equitable way; (ii) the level of autonomy of public providers; (iii) effective capacity regulation, especially for high-tech and high-risk medical interventions; (iv) the possible regulation of prices and fees and their possible applicability in the private sector; (v) the existence of external assessment mechanisms for quality assurance and, in the absence of these, their gradual development; and (vi) the universal availability of the pharmaceuticals covered and other necessary supplies.

i) Funding of community-oriented public health

The proposed special AIDS Trust Fund should be reconsidered. The fragmentation of funding, caused, for example, by creating separate funds for specific diseases, may lead to further fragmentation of services and thus inefficiencies. So the HFS should avoid parallel funding models of questionable sustainability and aim for the maximum integration of public health services in mainstream funding mechanism. Community-oriented public health should not be left to insurance and insurance companies, but is best financed from general revenues. Individual-oriented prevention activities, aiming at individual life styles and risk factors such as high blood pressure, obesity etc., could become part of a possible insured package of benefits. However, insurers working in a competitive environment may not be inclined to stimulate and invest in prevention, the benefits of which may take a long time to materialize, and may push clients to go to competitors who do not offer prevention services and as a result charge lower contribution rates. The dangers of possible inclusion can be mitigated by a combination of a mandatory package and good oversight to prevent cream-skimming by insurers.

Clarify the role of new institutions

The role, and positioning of the proposed **access and equity Fund** and the establishment of various other **new structures** such as a ***national health revenue authority***, ***a national health services trust fund***, a ***health benefits regulatory authority***, a **benefits and tariffs board,** and an ***independent accreditation agency*** should be given further consideration taking into account the organizational consequences, necessary staffing and HMIS needs, and likely administrative costs. Some of the functions that these structures are supposed to execute could perhaps be combined and organized in a single institution, thus saving money and creating synergies in information flow and decision making; for example by combining the functions of the proposed access and equity Fund, the national health revenue authority, the health benefits regulatory authority and the benefits and tariffs board. Different functions could possibly be handled by by sub-committees under a unified board. As mentioned before, the functions of the health revenue authority could also possibly be taken up by the MOF Treasury system.

Improve quality of care

The level of financing and the way that financing is used are two of the factors influencing the quality and outcome of health service provision. The question therefore arises as to how health financing can be used as a lever for improving the **quality of health service provision**. With regard to this issue the ICC HF could suggest that the MOMS develop a national quality assurance strategy which would clarify, among other things, the role of accreditation and national practice guidelines within the UHC agenda, and the role of financiers as purchasers of quality care,

Improve regulation

It would be helpful to develop appropriate, ***independent regulatory, oversight and auditing mechanisms*** at existing or to-be-established institutions, that are aligned with the preferred health financing model. It is also important to make sure that not just external financial auditing but also value for money auditing takes place and that results are reported and made publicly available, possibly on the internet.

Analyse and decide on capacity needs

The transition to UHC through the improvement of SHP requires a broad spectrum of skills, ranging from the analysis and adaptation of health financing policy to the management of change, and broader systems thinking to administrative capacity for implementing reform. Before making strategic decisions and starting the implementation of the UHC agenda, it is advisable to carry out a ***needs assessment of required capacities*** regarding the health financing functions, including financial resource collection, resource pooling, purchasing arrangements, service delivery, and human and other necessary, non-financial resources.

Following the needs assessment, decide on the institutions that need to be established in order to incorporate these capacities, or identify existing institutions that could be strengthened to serve this function. In other words, it might be possible to establish or expand institutional capacity to for, among other things: (i) repeated actuarial analysis to allow for the regular adjustment of government transfers, contribution levels and copayments; (ii) health technology assessment[27] in support of benefits package and planning decisions, and fee determination, as well as for input in clinical guidelines development; (iii) for value for money auditing and provider performance review.

With every step in the process described, it is advisable to check the feasibility and credibility of the action undertaken in order to make sure that it advances the purpose of the proposed health financing strategy, that is to say the transition towards UHC and SHP. Part of this exercise should include the identification of risks to implementation, which may be political, institutional, economic, or behavioural etc., and the proposal of risk-mitigation measures.

5.2. Revise and finalize the draft strategy

Having completed the work described above, the ICC Health Financing should then summarise the most appropriate, feasible and acceptable health financing **options and organisational models** for UC - including their pros and cons in relation to the values and goals of UHC - and prepare the process for political decision making. As part of this process, the ICC Health Financing could:

- Consider further ***targeted piloting*** as part of strategy implementation, to guide implementation and test modes of organization. This should be connected to the establishment of sufficient independent capacity for monitoring and evaluation of health financing reform implementation as indicated in the Comprehensive National Health Policy Framework[28]. Documenting reform results and health financing modalities is a good way of providing policy makers with timely, accurate data they can use to support decisions to stay the course or change it, but only based on substantial evidence of the failure of specific measures and an understanding of the reasons for that failure.

To support this process it is necessary to:

- Construct a baseline for review
- Identify meaningful indicators related to structure (institutional capacity building), process (defined milestones related to a set time-frame), outcomes (e.g. OOP, referral rates etc) and impact (on identified morbidity and feasible mortality indicators).

[27] The Ministry of Health's Comprehensive National Health Policy Framework refers to this as "Establish a national appraisal mechanism for Health Products and Technologies" to provide "guidance on the clinical and cost-effectiveness of new health products, technologies clinical practice and intervention procedures" (P 27).
[28] Ministry of Health. Op cit. P 33

- Identify sources of information and easy collection methods, together with reporting processes and data auditing requirements, supported by appropriate incentives (e.g. feedback to data providers)

The HFS should also include a section on M&E with feasible and measurable targets, which allow the stakeholders to monitor the progress of implementation of reform and to periodically assess to what extent the proposed UHC goals have been achieved. Some suggestions can be found in the WHR 2010[29]. .

5.3. Improve editing.

Eventually, the draft HFS will require some editing in order to make the strategy short, precise and focused, to come up with a stronger title, and to make sure that SHP and UHC, the guiding principles, have centre stage. Focus on decision points and their necessary underpinning, including the pros and cons of considered options. This is important partly to do justice to those who have communicated dissenting opinions on reform directions and chosen options during the strategy preparation process.

5.4. Harmonize and align support: coordination, networking and collaboration

The coordination of development support for the health sector is organised through various ***Interagency Coordination Committees,*** led by the GoK. The ***Development Partners for Health in Kenya (DPHK)*** group is another forum for information exchange, coordinating support for the various technical and support system ICCs, and ensuring the division of labour among DPs. The coordination mechanisms have worked well in ensuring continuity of support. Though the ICC on HF may have lost some momentum after the HFS process slowed down, the fact that MOMS has called for this external mission is a clear sign of continued commitment to the UHC/SHP agenda.

The external review team recommends building on and strengthening the existing coordination mechanisms (ICC HF and DPHK) to improve and scale-up support for the Kenyan UHC agenda. As stated above, one of the main recommendations of this external review report is to rekindle the ICC Health Financing to ensure multi-sector government coordination, and to have regular meetings to fast track the process of finalisation of the HFS.

Further suggestions:

Development partners could play a supportive role in connecting different sectors, for example by linking the discussion on social security policy with the HFS development process, or discussions on the implications of decentralisation for HF. Health, labour and social protection, finance, the private sector, but also local government need to be involved in consensus building in order to move the UHC/SHP agenda forward.

[29] World Health Report 2010, page 98

Considering the technical and political aspects of UHC by improving SHP, the development partners should provide continued support to enhance the evidence-base for informed decision making, and join forces to raise the profile of the process to the highest political level for decision making.

The prospects for scaling-up support to the UHC/SHP agenda are positive. The network partners at country level would need to discuss their possible support to the roadmap and clarify their contributions to a joint action plan. Any gaps in the joint action plan should be communicated to the P4H Coordination Desk or the HHA secretariat to assist in mobilising complementary support for ensuring continuity of support. Furthermore, the mission team would also be open to carry out a follow-up visit during the second half of 2012 or first half of 2013 depending on the progress of proposed steps and activities.

6. Conclusions

Based on its review the external review team would like to conclude and make the following recommendations:

1. The Ministries of Medical Services and of Public Health and Sanitation are commended for their efforts in preparing for a comprehensive draft health financing strategy and for entering into a national and international dialogue about the way forward to finalize the strategy.
2. Given the rather protracted development process, and the changes in the external situation, including the passage of the New Constitution, the development of a social security policy will need to be taken into account as part of the next step in development of the HFS. The distribution of mandates for health financing at the national and county levels in parallel with the governance of health insurance is crucial if the fragmentation of funding, and inefficiencies in implementation are to be avoided, and patients saved from falling between the cracks of poorly-aligned central and devolved health financing functions and fund flows.
3. As regards the next step in developing the HFS, revitalizing the Health Financing Coordination Committee is of the utmost importance, preferably carried forward at the highest political level possible in order to avoid obstruction and to guarantee multi-sector involvement.
4. Continue the inclusive process of strategy development, supported by stakeholder analysis and social assessment. This can be achieved by referring to the relevance of the universal coverage agenda to each individual stakeholder, including the gains, and benefits that will accrue and the compromises that will have to be made in order to move forward, ultimately attaining universal coverage for the entire nation. This will require broad discussions and consultations taking into account all aspects, possible consequences and differences of opinion and interests. Ultimately, decisions are needed as early as possible on crucial aspects, including: (i) the future financing model and resource mobilization requirements, including additional government investment in health and the mandates of health insurance in different forms (public, private and community insurance); (ii) the distribution of mandatorily assured/insured basic essential health services and of supplementary voluntarily assured/insured services; (iii) the role of competition in the insurance of basic health care services, i.e. a single payer/purchaser or multiple ones; (iv) the financing of public health services and the delineation of public health services as distinct from individual-oriented, preventive, curative, palliative and rehabilitative health services; (v) the need to avoid fragmentation of funding as much as possible. This would also include discussions about whether the country needs a separate AIDS Fund; (vi) the creation of new institutions for the collection, pooling and distribution of funds, for quality assurance, for regulation and oversight and auditing, or whether these functions should be assigned to existing institutions while reconsidering the need for some of the newly proposed ones.

5. Support the process by further analytical work such as costing and actuarial studies, fiscal space, and stakeholder analysis. Studies on the benefit package are also needed as are studies of clinical and administrative efficiency as part of an overall efficiency improvement and capacity assessment, as mentioned in this review. Such studies should not be seen as one-off efforts. They need to be repeated on an ongoing basis during the implementation of the chosen strategy. Therefore, capacity building and institutionalization of these analytic and monitoring functions is essential.
6. Early on in the process, draft a work plan for the next step in the development process with deadlines, and an indication of who does what with what means, including the required analytical work.
7. The process of preparation and implementation of the strategy should be supported by an ongoing public information campaign.
8. Given the large informal sector and the level of poverty, universal coverage and SHP cannot be achieved without substantial government subsidies for years to come and public funding for the health sector should be increased. However, some other (complementary) sources can also be explored such as cross-subsidization from private health insurance schemes.
9. Realize that in drafting and implementing a health financing strategy, the devil is in the detail. Several details are already given much thought in the current draft of the HFS, and this review report offers more details that need careful consideration and decision making if a health financing system that supports universal coverage and social health protection, is sustainable, well governed, adjustable to evolving needs preferences and provides access to quality health services is to be achieved.
10. Continue the use of pilots in the implementation of the strategy and establish the capacity needed for the continuous monitoring and evaluation of such pilots, and of the implementation of the strategy.
11. Development partners stand ready to further support the Government of Kenya in finalizing the strategy and support its implementation.

7. Annexes.

7.1 Terms of reference

Terms of Reference for a mission to review progress with development of a Health Financing Strategy

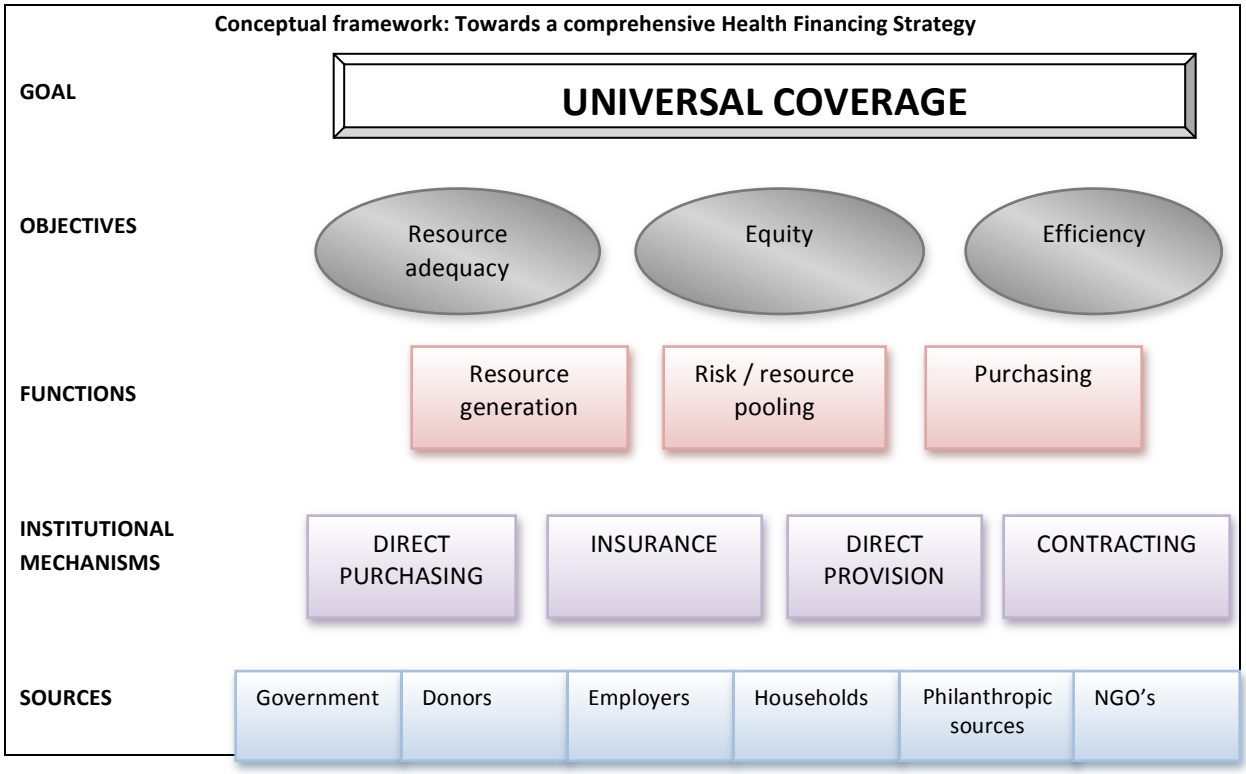
Introduction

Kenya's health sector identifies several modes of financing health services that include public through taxation, user fees, donor funds and health insurance – public and private. These modes of financing have become increasingly important for funding health services in the country, but they should reflect both the cost of service provision and the population's ability to pay. In the non-government sector, health services are financed primarily through revenue collected from fees and insurance premiums charged to service users. These premiums are a trade-off between the costs of service provision and the ability of the clients to pay for the services. By and large health care financing in Kenya is dependent on the government's budget provision which depends on the performance of the economy.

The Kenya government is constrained in its capacity to finance health care as evidenced by the low public sector spending on health. The general level of funding to the public health sector has increased marginally. However, the overall allocations (recurrent and development) have been between 6-8 percent of total Government allocations to the health sector, which is just about half of the Abuja declaration target of 15% and the Economic Recovery Strategy (ERS) target of 12% of total Government allocations.

In May 2006, the Heads of State and Government adopted the Abuja Call towards Universal Access to health services in the context of achieving the MDGs. This was a bold declaration that was meant to ensure access to health care services to the population in some meaningful ways.

Kenya has made several attempts to introduce healthcare financing reforms to eliminate chronic under-funding of the sector, minimize out-of-pocket expenditures and ensure universal access to quality healthcare and therefore achieve the Vision 2030 goals on health. In 2005 attempts to implement Social Health insurance were unsuccessful largely as a result of pressures from interest groups. Following on the SWAP process and the stakeholder workshop held on December 6, 2006, the MOH established a task Force comprising of representatives of stakeholders to develop strategies on health financing.
The overall goal for the Health Financing Strategy is to assure a form of Universal Coverage. This is to be attained through a focus on objectives, relating to resource adequacy, efficiency, and equity. To achieve these objectives, the sector needs to put in place adequate means to assure effectiveness in functions of resource generation, risk / resource pooling, and purchasing of services. These functions are carried out through four main institutional mechanisms for managing health resources: direct purchasing of services, insurance (social, or private), direct provision of services, and contracting of care. These apply to the different sources of financing. This is captured in the conceptual framework below.



The emergent Health Financing Strategy will look into all aspects of this framework – that is:

a) Scope of different sources of financing
b) Proposed mix and form of institutional arrangements to manage resources from the different sources
c) Expected functions to be carried out, and roles of the different institutional mechanisms
d) Quantify the expected objectives to be attained, and
e) Characterise the overall goal to be attained.

The different performance measures that need to be defined, to review / target the attainment of the objectives are:

a) Level of funding
b) Fairness in financing mechanism
c) Level of financial risk protection
d) Level of solidarity
e) Population coverage
f) Value for money
g) Services coverage, and
h) Sustainability

The efforts in country have so far led to elaboration of a draft health care financing strategy. This, however, is facing a lot of challenges in building consensus around it, due to, amongst other issues:

- The fact that some stakeholders feel that they were not adequately consulted in its development has generated a lot of resistance especially from key stakeholders like the private sector and other institutions;

- The draft strategy did not adequately attempt to critically analyse all the potential sources of financing, their contribution to financing of health care in the country; and
- The draft strategy does not also provide a broad range of strategies or mechanisms to maximise resources from the different sources of financing health care in the country to ensure universal coverage. For instance, the draft strategy is silent on the issue of maximising resources from one of the key financials of health, Households, and therefore generate resources in an equitable and efficient manner

Rationale for Mission

At present, a draft Health Financing Strategy has been elaborated, but has not yet achieved wide ranging consensus for it to become a formal sector strategy. The mission is aimed at understanding what issues the sector needs to focus on, to lead to a comprehensive, and implementable Health Financing Strategy

Overall goal

The overall aim of the mission is to review both the content, and process leading to the current draft of the Health Financing strategy, with a view of providing recommendations to the Ministries of Health on a roadmap leading to a comprehensive and implementable Health Financing Strategy. Specifically, the mission will focus on:

i) Documenting the process of elaboration of Health Financing Strategy in the Country, in the past 10 years
ii) Analyse the process of elaboration of the current draft of the Health Financing Strategy, in terms of who has been involved, how they have participated, and the process taken
iii) Reviewing the comprehensiveness of the content in the draft strategy – vis-à-vis the overall conceptual framework
iv) Develop a roadmap for discussion on the way forward, towards a comprehensive and implementable Health Financing Strategy for the Country.

Expected outcomes

From the mission, the following should be delivered

1. A document roadmap for the process of developing the Health Financing Strategy, covering the past 10 years
2. Assessment of the draft Health Financing Strategy content – identifying missing content that needs to be included
3. Definition of a roadmap leading to finalization of the comprehensive, and implementable Health Financing Strategy

Methods of work

It is expected the mission would involve not more than 5 international Health Financing experts. Information would be mainly from documents reviews, and Key informant interviews. It will have two phases **of** work

- Phase 1: Prior to 12th March: Preparatory work, primarily focusing on document **review**.
- Phase 2: 12 – 16 March 2012: In country work, primarily focusing on Key Informant interviews

Documents to be reviewed include (but are not limited to) the following:

i) Vision 2030
ii) Final draft of the Kenya Health Policy, 2011 – 2030
iii) Sessional paper on Social Health Insurance, 2004
iv) Strategic review of the National Hospital Insurance Fund
v) Health Sector review of the 1994 – 2010 Health Policy Framework
vi) Draft Health Financing Strategy
vii) National Health Accounts, 2009/10

viii) HIV/AIDS sustainable financing concept note
ix) Health Sector Services Fund and Hospital Management Services Fund Legal notices
x) Public Expenditure Reviews: 2008 – 2011
xi) Public Expenditure Tracking Survey, 2008

Key informants that would be interviewed include (but are not limited to) the following

a) Ministry of Medical Services: Minister, Permanent Secretary, Director of Medical Services, Director of Administration, Chief Economist, Head of Technical Planning
b) Ministry of Public Health & Sanitation: Minister, Permanent Secretary, Director of Public Health and Sanitation, Director of Administration, Chief Economist, Head of Technical Planning
c) National Hospital Insurance Fund: Chief Executive Officer, Chairman of the board
d) Kenya Private Sector Alliance
e) Development Partners in Health: World Bank, IMF, GIZ, WHO, USG, DPHK secretariat.

The above analytical phases will enable the drafting of a comprehensive health care financing strategy that will define the medium term fiscally sustainable, equitable, and efficient approach to financing health services in Kenya.

7. 2 Literature list

Australian Aid, The World Bank. Navigating the storm, Delivering the promise; with a special focus on Kenya's momentous devolution. Kenya Economic Update December 2011. Edition 5

Carrin, Guy et al. Health financing reform in Kenya: assessing the social health Insurance proposal. World Health Organization, Geneva, 2006

Carrin, Guy et al. Health Financing Reform in Kenya-assessing the social health insurance proposal. SAMJ. February 2007.Vol.97, No2.

Collins, David et al. Hospital Autonomy in Kenya: Deloitte. NHIF Strategic Review and Market Assessment of Prepaid Health Schemes, Measuring up. Final Draft (5). 14 October, 2011

Deloitte. NHIF Strategic Review and Market Assessment of Prepaid Health Schemes, Measuring up. 14 October, 2011

Economist Intelligence Unit. Country Commerce Kenya. London, March 2009

Economist Intelligence Unit. Country Report Kenya. London. April 2008

Flessa, Stephen et al. Basing care reforms on evidence: The Kenya health sector costing model. BMC Health Services Research 2011, 11:128. http://www.biomedcentral.com/1472-6963/11/128

Government of the Republic of Kenya, Ministries of Medical Services and Public Health and Sanitation. Kenya Vision 2030. Sector Plan for Health 2008-2012. Nairobi 2009

Government of the Republic of Kenya. Kenya Vision 2030, The Popular Version. Nairobi 2007

Government of the Republic of Kenya. Kenya Vision 2030. A Globally Competitive and Prosperous Kenya. Nairobi. October 2007

Government of the Republic of Kenya. The Government Financial Management (Hospital Financial Management Regulations 2009. Kenya Gazette Supplement No. 68, 16 October 2009

International Labour Organization. Kenya, Developing an integrated national social protection policy. Geneva, 2010

Kenya Cabinet Memorandum to seek additional and sustainable financing for HIV and AIDS care in Kenya. Draft (obtained 14 March 2012)

Kenya Health Law Draft. 13 March 2012

Kenya Institute for Public Policy Research and Analysis. Kenya Economic Report 2009, Building a Globally Competitive Economy, Nairobi, 2009

Kenya Institute for Public Policy Research and Analysis. Review of the Kenya Health Policy Framework 1994-2010. Consolidated Report, Stream 2. October 2010

Kenya Local Government Financial Management Act (No.5 of 2004). Kenya Gazette Supplement No.68. 16 October 2009

Kenya Ministry of Health. 2008 Public Expenditure Tracking Survey

Kenya Ministry of Health. Comprehensive National Health Policy Framework 2011-2030

Kenya Ministry of Health. Ministerial Public Expenditure Review 2011. Nairobi 2011

Kenya Ministry of Health. Public Expenditure Tracking Survey 2007, Nairobi, December 2007

Kenya Ministry of Health. Sessional Paper No.2 of 2004 on National Social Health Insurance in Kenya, May 2004

Kenya Ministry of Medical Services & Ministry of Public Health and Sanitation. Kenya National Health Accounts 2009/10

Kenya Ministry of Public Health & Sanitation and Ministry of Medical Services. Kenya Health Policy Framework 1994-2010, Analysis of Performance Health situation trends & distribution: 1994-2010, and Projections for 2011-2030

Kenya Ministry of Public Health & Sanitation and Ministry of Medical Services. Accessible, Affordable and Quality Health Care Services in Kenya, Financing Options for Universal Coverage. Version March 2010 (provided in March 2012)

Kenya Ministry of Public Health and Sanitation. Guidelines on Financial Management for Health Facilities through the Health Sector Service Fund. December 2008

Kenya National Social Health Insurance Bill, 2004. Kenya Gazette Supplement No.29 (Bills No.10). Nairobi, 28 May 2004

Kenya Public Health Act 2009

Nafula, Nancy N. Budget mechanisms and Public Expenditure tracking in Kenya. Kenya Institute for Public Policy Research and Analysis. KIPPRA Discussion Paper No.37. June 2004

Oxford policy management**.** projected costs of delivering health care services – Kenyan Essential Package of Health – and non-KEPH Services to the total population using (a) actual and (b) normative costs? (Version 3)

Oxford policy management. The cost of health care in kenya - actual costing of KEPH and non-KEPH services. 22october 2008

Republic of Kenya. The Constitution of Kenya. Revised Edition 2010. Published by the National Council for Law Reporting with the Authority of the Attorney General. http://www.kenyalaw.org/klr/fileadmin/pdfdownloads/Acts/ConstitutionofKenya2010.pdf

Republic of Kenya Ministry of Health: Comprehensive National Health Policy Framework 2011-2030 (draft two, final)

Ruairi Brugha and Zsuzsa Varvasovszky; Stakeholder analysis: a review; Health Policy and Planning 15 (3): 239-246, Oxford University Press 2000

The Experience of Kenyatta National Hospital. Nairobi, June 2006

Transparency International. The Kenya Health Sector Integrity Study. 2011

7. 3 List of persons met

Institution	Name	Position
Ministry of Medical Services		
	Mr.N.Ong'uti	Chief Economist
	Mr.S.Muga	Head HMSF Secretariat
	Mr.G.Kimani	Deputy Chief Economist
	Mr.D.Nyambok	Head Finance Department
	Mr.T.Maina	Principal Economist
Ministry of Public Health and Sanitation	Dr. S.K.Sharif	Director Public Health and Sanitation
	Mr.U.Munguti	Deputy Chief Economist
Ministry of State for Public Services	Mr.T.M.Ndambuki	Permanent Secretary
	Mr.W.Kamau	Chief Economist
	Mr.S.Calvin	Chief Finance Officer
	Mr.R.Olofkway	Public Relations Officer
	Ms.Alice Muita	Human Resources Secretary
Ministry of Finance	Mrs.E.Kikew	Deputy Director of Budget
	Mr.K.Woidini	Budget Officer
	Mr.L.Suke	Budget Officer
Ministry of Gender, Culture and Social Services	Dr.J.W.Nyikal	Permanent Secretary
National Hospital Insurance Fund	Mr.R.L.Kerich	Chief Executive Officer
National AIDS Control Council	Prof.A.S.S.Orago	Director
	Mr.P.Kinuthia	
World Health Organization	Dr.A.D.Jack	Representative for Kenya
	Dr.H.Karamagi	Health Systems Advisor
	Mr.S.Cheruiyot	National Program Officer, Health finance
World Bank	Mr.J.Lovelace	Senior Health Advisor
Health Sector Board KEPSA Kenya Health Care Federation	Mr.A.Thakker	Secretary/CEO
	Mrs.Diana Patel	Member; Executive Director Avenue Health Care
	Mr.M.N.Kuria	Member; Manager Strategic Planning, Aga Khan University Hospital
	Mr.M.Ookok	Chairman; Director Kenya Private Sector Alliance
	Dr.E.Rukwaro	Member; Regional General manager AAR Health Care

		Ltd.
EPOS Health Management	Mr.H.Bergmann	Project Coordinator Integrated PHC
	Dr.A.Beaston-Blaakman	
Development Partners in Health Kenya	Ms.S. Erickson	Technical Advisor/Secretariat
USAID Health System 20/20	Stephen Muchiri	Advisor
Health NGO's Network (HENNET)	Ms.N.W.Hungu	Member; National Coordinator Kenya Community Based Health Financing Association
	Dr.A.Gatome	Member; National Executive Secretary, Catholic Health Commission of Kenya (K.E.C.)
	Dr.S.M.Rukunga	Member; General Secretary Christian Health Association of Kenya
	Mr.J.Kamau	Member; CEO Kenya Treatment Access Movement
Gertrude's Children's Hospital	Mr.G.O.Odundo	CEO
Melchizedek Hospital	Ms.R.Kariuki	CEO

7.4. List of attendants of briefing meeting.

Briefing P4H review team on the draft Healthcare Financing Strategy
16th March, 2012,
Afya house

No	NAME	ORGANIZATION
1.	Geoffrey Kimani	MOMS
2.	Elkana Ong'uti	MOMS
3.	Henry Onyiego	MOMS
4.	Dr. H.M. Kiambati	MOMS
5.	Dr. Elizabeth Ogaja	MOMS – Dept. of Pharmacy
6.	Dr. Judith Bwonya	MOMS – DSRS
7.	Dr. Lillian Kocholla	MOMS
8.	Atia Hossain	GIZ
9.	James Christopher Lovelace	World Bank
10.	Dr.Ramana Gandham	World Bank
11.	Humphrey Karamagi	WHO
12.	Sam Munga	MOMS
13.	Michael Adelhardt	P4H/WHO
14.	Netsanet Workie	World Bank
15.	Jan Bultman	GIZ
16.	D. Bayarsaikhan	WHO
17.	Dhimn Munguti	MOPHS
18.	Thomas Maina	MOMS
19.	Dr. Makau Matheka	MOMS
20.	Mirasi Tom	MOMS
21.	Dr. Stephen Irungu	MOMS- Surgery Dept Oral Health
22.	Stephen Cheruiyot	NPO/WHO
23.	Sarah Wamunyu	MOMS

7.5. Yardstick for Kenya health financing strategy review

The listed items are not meant to be reviewed as such by the review team but could be checked whether these received attention in the process of HFS preparation and have been considered and/or included in the proposed draft strategy:

1. ***Process***
    a. Actively managed (and coordinated) by Government?
        i. Relevant ministries involved?
            1. MOMS
            2. MOPH
            3. MOL
            4. MOF
            5. Ministry in charge of the economy
            6. PM's office
            7. President's Office
        ii. LGA's?
    b. All stakeholders identified and (sufficiently?) involved?
        i. Public bodies (oversight, auditing etc)
        ii. Political parties
        iii. Public insurers
        iv. Private insurers
        v. Social partners
        vi. Public Providers
        vii. Private providers
        viii. Civil society (including faith based organizations
        ix. Consumer organizations
        x. Industry (drugs, supplies & equipment)
    c. Presented facts, evaluations and opinions of stakeholders documented, discussed and
    d. Included in intermediary reports and draft strategies?
    e. Focus group meetings or conferences with stakeholders?
    f. Frequency of involvement?
    g. Public hearings?
    h. News Media involved (publishing/airing)?
    i. Identified issues (where lies the problem in the process)?
2. ***Content***
    a. Values expressed?
    b. Values endorsed by stakeholders and by advocates of interested parties?
    c. Constitutional obligations?
    d. International obligations/Treaties (e.g. EAC; TRIPPS; ILO)?
    e. Description, analysis and evaluation of current system?
        i. Identified SWOT
        ii. Burden of health & disease
        iii. Soundness of analysis?

iv. Need for reform explained?

f. Objectives?
   i. SHP (use Framework for assessing promoting SHP. 8 September 2009)
   ii. Good governance
   iii. Cost containment
   iv. Quality assurance
   v. Efficiency (providers and administrators)

g. Comprehensive?
   i. All HF functions covered?
      1. Resource generation
         a. Sources of funding
         b. Collection (effectiveness, efficiency and transparency in admin)
         c. Pooling (single, multiple, cross-subsidization between multiple schemes; pooling at commercial banks or Government Treasury) and funds flow and distribution of monies to ..., based on relevant criteria.
         d. Budget/resources planning and execution
            i. Process
            ii. Tools
            iii. Participatory
         e. Investment planning & financing vs operational costs
         f.
      2. Purchasing?
         a. By whom
            i. Public and/or private
            ii. Single or multiple purchaser(s)
            iii. Individual (with vouchers)
         b. Mandates
            i. Selection of providers (public and private)
            ii. Selection of services/volumes/providers
            iii. Procurement of drugs, supplies and equipment
         c. Instruments
            i. Contracts
            ii. Price/fee setting (aiming at cost containment, performance or both
            iii. Performance review
            iv. Fines
            v. Conflict resolution
   ii. Benefits package?
      1. Who decides
      2. What is covered
      3. Who delivers
      4. Where to receive

5. How to get access (conditions, such as copayment; medical need, referral; pre-authorization)
6. Demarcation vis a vis public health

iii. Services delivery?
1. Capacity to deliver
    a. HR
    b. Physical
2. Categorization (levels)
3. Distribution (geographic)
4. Access (physical)
5. Public and/or private
6. Regulation
    a. Capacity
    b. Functions
    c. Prices
    d. Quality
7. Level of autonomy of providers commensurate with purchasing mandate

iv. Admin infrastructure
1. Business support systems
2. Costs

v. Governance?
1. Clear mandates/responsibilities described?
    a. On all the above
    b. Planning of health facilities: capacities and functions, distribution; Involvement of purchasers in process?
    c. Coordination of LGA's and purchasers
    d. Two ministries of health , impact on
        i. Effectiveness and efficiency in finance planning and execution?
        ii. Alignment and coordination of financing and implementation of curative and preventive activities?
2. Transparency in operations?
3. Participatory process?
4. Accountability?
    a. Reporting (publicly/internet)
    b. Oversight & Auditing
        i. Financial
        ii. Value for money
        iii. Quality of care
5. Independent external evaluation of HF reform implementation and impact foreseen?
6. Identification of regulatory and institutional consequences;

a. Assessment & proposals of regulatory updates needs
b. assessment of capacity enhancement needs?
c. Consequences for existing institutions?
    i. Interests taken care of?
    ii. Future chances/prospects (getting part of the pie)?

vi. Expenditure framework identified and realistic?
vii. Approach to implementation/reform process?
    1. Big bang?
    2. Incremental?
viii. Operational plans prepared? Indicating
    1. Who is in charge of what
    2. Which means to use
    3. Time line
ix. Costing of HF reform implementation done and funding sources for the reform process identified?
x. Management and process of reform identified?
xi. M&E arrangements and joint reform process evaluation prepared?
    1. Indicators identified?
    2. Info flow assured
    3. Capacity to independently analyse and report?
xii. Social assessment done? (who wins, who loses?)
xiii. Identification of risks and proposed mitigation strategies?
    1. Political and leadership continuity?
    2. Feasibility?
        a. Goal attainment
        b. Institutionally
        c. Politically?
    3. Sustainability
    4. Capacity
    5. Stakeholder endorsement
    6. International aspects
xiv. Feasibility and credibility of HFS to achieve:
    1. SHP objectives?
    2. Cost-containment?
    3. Quality assurance?
    4. Efficiency?
    5. Sustainability?
    6. Flexibility to adjust to changing circumstances?
xv. Political economy

7.6. Executive summary of Kenya health financing draft strategy

ACCESSIBLE, AFFORDABLE AND QUALITY HEALTHCARE SERVICES IN KENYA

Ministry of Public Health and Sanitation **Ministry of Medical Services**

EXECUTIVE SUMMARY

Introduction

Human dignity, social justice and equal access to resources and opportunities are the foundations upon which Kenya's nationhood is built. The right to good health, and enjoyment of long life, is the cement that binds these foundations, without which, balanced and sustainable social or economic development cannot be achieved. As well as being a fundamental human right, access to good health services provides a country with a healthy, productive population; essential for sustainable social prosperity and economic growth

Although total health expenditure is increasing, some of the key health indicators have continued to decline; rendering the status quo of health financing an unacceptable option for the medium- and long-term. Reforms are needed to help accelerate improvements in health outcomes and to narrow health inequalities to also provide healthcare for the disadvantaged, vulnerable and poor in Kenyan society.

Reforms will need to be based on a thorough analysis of requirements, feasibility and affordability; take into account evidence from other countries, but ultimately provide the framework to provide sustainable healthcare tailored to Kenya's specific circumstances. Financing reforms, in particular, will have to be complemented by a range of other system reforms. In order to succeed, the support of all key stakeholders within Kenya, as well as from global initiatives such as Providers for Health (P4H) and the International Health Partnership (IHP), will be required.

It should be noted, however, that simply designing good policies and strategies will not suffice - they need to be acted on and implemented as planned.

Current Situation

Following independence, a healthcare financing system in Kenya was initially supported primarily through general tax revenue. However, in the late eighties, as resources became tighter, the potential for cost-sharing started to attract considerable policy attention. However, despite a number of policy changes since, the potential for revenue generation has remained limited and on-going concerns remain about its impact on access for poorer groups.

The healthcare financing system in Kenya is currently characterised by:

- Wide inequality in access to services;
- Major gaps in infrastructure, shortages and inefficient distribution of human resources;
- Low levels of public spending;
- Disproportionate funding allocated to urban-based, curative care;
- Low productivity;
- Weak financial management systems, lack of transparency and low levels of predictability;
- High levels of aid dependency and poor alignment of such funding with government needs;
- Heavy reliance on out-of-pocket spending as a source of healthcare financing;
- Over reliance of public facilities on user-fees to meet operational costs;
- Limited protection from the NHIF.

This financing system prevails against a backdrop of poor health indicators: high infant mortality rate (74/1000 live births), high maternal mortality rate (414/100,000 live births), low life expectancy (52 years), high prevalence of HIV/AIDS (7.4%) and silent epidemic of non-communicable diseases.

Initiating the Process

In January 2007, the Planning Department of the Ministry of Health (MoH) invited stakeholders involved in healthcare financing issues to contribute to the development of a medium- to long-term Healthcare Financing Strategy in line with Vision 2030 and a task force was subsequently formed. The results from the National Health Accounts, Public Expenditure Tracking System, the Costing Study and the MPER would inform the process.

The Minister for Medical Services then travelled with senior officials from the Ministry of Public Health, Ministry of Finance and the National Hospital Insurance Fund to France, Germany and the United Kingdom, to obtain a common understanding of the way forward.

Stakeholder workshops were held to plan for the study tour, receive results from the study tour and review the draft policy/strategy, respectively. The aim was to assist the government to develop and introduce a Healthcare Financing Policy and Strategy that would promote universal coverage and social health protection in the country.

Finally, with the guidance and participation of the National Economic and Social Council, the Final Draft of the strategy for affordable, accessible and quality healthcare services was formulated.

Comprehensive Reforms

After an in-depth analysis of health determinants, feasibility considerations and the potential for high returns, the priority areas targeted for reform include: *strategic human resources management; the upgrading and modernising of the health infrastructure; transformation of management practices in the health sector; promotion of community participation and ownership; increased efficiency and accountability in procurement; strengthening the collaboration between the public and private health service providers and, transformation of the healthcare financing system.*

To facilitate this, the government will shift from its traditional personnel management approach and adopt more modern approaches to ensure the availability and equitable distribution of a well motivated workforce. Secondly, the government will strengthen its hospital sub-sector through greater autonomy, efficient and effective management practices, rehabilitation, restocking of facilities and introduction of advanced treatment modalities. Through strategic partnerships with the private sector, the government will create Centres of Medical Excellence which, while offering advanced care, will also promote Kenya as a preferred destination for patients from the region.

The implementation of the Community Strategy, a flagship project in Vision 2030, will promote community engagement, ownership and participation in healthcare, as well as supporting ongoing reforms. The strategy aims to strengthen community and household capacities in healthcare planning, management and allocation of resources; more importantly, to promote better governance and accountability within the community.

The weakness of supply channels to effectively deliver drugs and other medical provisions has continued to undermine the quality of healthcare and access to services. As part of Public Procurement Reforms, the government will revise KEMSA legislation in order to provide more autonomy and better governance, and transform it into a business-oriented government enterprise. Simultaneously, capacities at facility level will be developed to ensure efficient logistics management and transparent operation of the stores.

One of the goals of government is to reduce its involvement in direct service provision and concentrate on policy development, standards setting and on its leadership and regulatory functions. One of the exit strategies is to foster public/private partnerships in the health sector. These partnerships will not only cover healthcare service delivery, but with extend to other areas of policy formulation, financing and the creation of the proposed National Centres of Excellence.

Finally, the government will embark on shifting the financing of healthcare services from the current over-reliance on out-of-pocket, tax financing and user-fees methods, to more efficient and inclusive Social Health Insurance. Details of the envisaged policies and enabling strategies for achieving universal coverage are discussed in detail in the full policy version. However, the policy document is not a prescription of what must be done in healthcare financing reforms, but a set of reinforcing financing strategies that, while based on the Kenyan context, have worked elsewhere and are therefore supported by empirical evidence.

It is important to note that while increased financing for health services are needed, the initial thrust of these policies is to make the best use of the funds that are already in the system, and are currently being used in an uncoordinated, fragmented and inefficient way. Significant resources are already devoted to health services, including public funds, out-of-pocket payments, and donor resources. It is important to coordinate these sources of funds and align the incentives for providers, financiers and consumers to ensure that the maximum value is obtained from these funds.

Options for Universal Coverage

Aims, Goals and Guiding Values - Kenya is committed to achieving the highest obtainable standards of health for every individual and developing a fair and equitable society by adopting a series of guiding values which will underpin reforms.

The **aim of the health financing strategy** is to contribute to national welfare, economic growth and increased productivity through the establishment of a health financing system to provide the highest attainable standard of health for all Kenyans.

The **purpose of the health financing strategy** is to: devise a health financing system that best fits the national context and flexible to future changes.

The **goals of the health financing strategy** are to:

- Create a financing system which guarantees access to quality healthcare for all Kenyans;
- Protect all Kenyans from health related financial shocks;
- Promote efficiency in the provision of health services;
- Improve the effectiveness and efficiency of revenue collection and risk-pooling;
- Increase the quality of healthcare to an acceptable and sustainable level;
- Improve governance and transparency to optimise resources;
- Improve aid effectiveness in the health sector;
- Ensure sustainability of the new health financing system.

Guiding Values	
Equity: ALL Kenyans should be able to access services according to their needs and not according to their ability to contribute financially. There will be no discrimination on account of age, gender, race, religion, political affiliation or any other socio-economic considerations - access to quality healthcare in Kenya shall be all inclusive.	***Solidarity:*** The better-off in society should support the cost of healthcare for the poor; the young to support the ageing and old; and the healthy to contribute towards the cost of care for those who are sick. ***Subsidiarity:*** Authority should be as close as possible to the citizens
Responsibility: All stakeholders should accept their duties and obligations and address their health seeking behaviour and reciprocal responsibility between stakeholders in order to avoid miss-use, fraud, etc., to ensure sustainability of the system.	***Transparency:*** That purchasers, providers and users should have access to information regarding the operation of the system and/or as required by any law or professional etiquette; patients should receive sufficient information about their treatment, health and well-being.

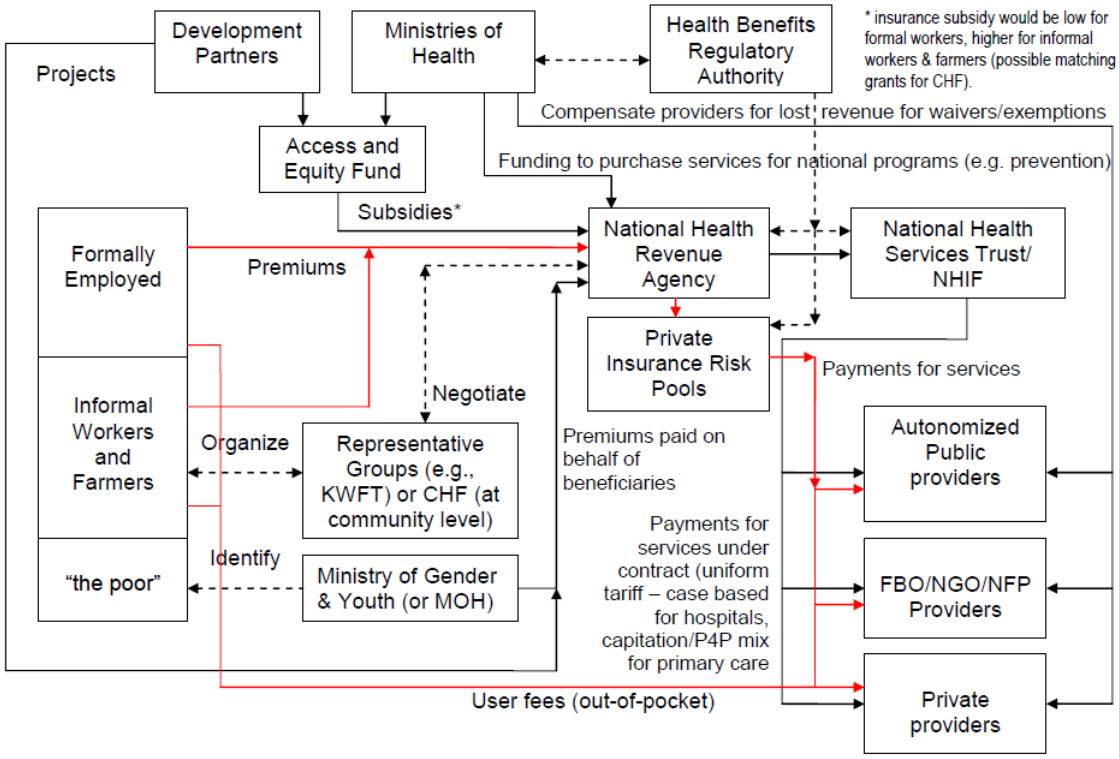
Policy Options for Universal Coverage

A set of mutually reinforcing policy approaches is required that will lead to universal coverage of the population providing a basic package of health services where barriers to access are minimised. Various aspects of the system need to be examined including: revenue collection, pooling of funds, purchasing of services and the actual provision of services. Options exist in each of these areas and require review to develop a cohesive financing system. The key questions to be answered in relation to the various healthcare financing functions - and the possible choices on offer - are provided in detail in the full text of this policy and strategy.

Social Protection Policies

Figure 1 below illustrates the broad financing option proposed. It includes elements of social insurance financed through payroll taxes but also leverages existing public funds provided through general tax financing, channels donor resources and provides for additional private financing through a choice of health insurers. Within this broad model a range of approaches related to revenue collection, purchasing, pooling and provision which will be developed and introduced. Because of the mix of public and private health insurers, semi-autonomous bodies will be needed to collect and distribute the premium and other revenue, and to deal with licensing, regulation and tariff issues. Existing or new public sector bodies would likely not be seen as independent to private sector insurers.

Figure 1: Proposed Social Healthcare Insurance System



Key: ---- = private funds
---- = public funds
- - - = non-funding activities

This would involve the following **financing components**:

- Channelling of all revenue collected (government and development partner funds as well as the premiums that are collected to a National Health Revenue Agency, which will in turn allocate the pooled funds to both public and private insurers on the basis of the number of people enrolled and other relevant factors;
- Measures to encourage those working in the informal sector to enrol in the insurance scheme;
- Incentives including tax-deduction facility for employers who co-pay for social health insurance of their contributing employees and all contributors;
- Effective cost control mechanisms to counter potential effects of greater reliance on output-based approaches;
- Changes in how providers are reimbursed with a shift towards output-based financing for hospital care and capitation for primary care;
- Increased channelling of donor support through these mechanisms, either in un-earmarked form or earmarked to particular uses;
- Private insurance and Risk Pooling Plans to provide complementary coverage and supported to develop capacity to venture into social health insurance in healthy competition and within an effective regulatory framework;
- Other community-based insurance, provider-based schemes pre-payment schemes and demand side financing instruments will be promoted to operate in a regulated environment.

Supportive **systems reforms** would need to include:

- The establishment of Equity and Access Fund to allow both the government and development partners to support increased access to health insurance through subsidized premiums;
- Restructuring and strengthening of NHIF into a National Health Services Trust;
- Downsizing of the Ministries of Health to focus purely on an oversight role only;
- Greater autonomy for public providers;
- The establishment of the Health Benefits Regulatory Authority to define benefit package, license social and private health insurance providers, and all Health Plans, and to develop appropriate tariffs which all insurers are should pay for insured services;

Key assumptions and risks:

- Effective governance;
- Donor support channelled through the proposed mechanisms;
- Political will to downsize MoH, autonomy for providers and more resources flow outside of public providers;
- Public willingness to enrol in social health insurance schemes;
- Reforms introduced in line with capacity and implemented effectively;
- Effective cost control mechanisms;
- Steady progress towards universal coverage. A key risk is that the benefit package is too expensive and that government cannot afford to extend coverage to the poor;
- Reimbursement rates can be set at realistic levels.

Healthcare Financing Strategies

Based on the situation analysis, principles and options described above, the following elements are proposed:

- Improving efficiency, accountability and transparency;
- Strengthening revenue collection;
- More effective risk pooling;
- Harnessing the informal sector financing potential;
- Broadening the benefits package;
- Strengthening provider incentives;
- Protecting the poor and vulnerable groups;
- Improving aid effectiveness;
- Ensuring sustainability.

The above are to be considered as a package designed to be mutually supportive and reinforcing.

Implementation Framework

A phased and incremental approach is advocated to bring about these far-reaching changes. A set of principles will guide the transformation encompassing: s*tart from where you are; gradualism; inclusiveness; prioritising children, the poor and vulnerable groups; a concomitant application of the policy values and principles.*

Immediate Period FY2009/10: Involve core groups in the process in view of developing a strategy to expand NHIF coverage; replace fee-for-services in primary care facilities; improve efficiency in NHIF; commission analyses and studies on revenue collection, hypothecated taxes, payment mechanisms; institutional assessment of NHIF, quality and tariffs setting; establish a strong Working Group to steward the process.

Short-Term: Refine mechanisms for identifying the poor; abolish FFS and provide full compensation; enrol 30% of contributors from the informal sector and 60% of the poor; expand out-patient NHIF package to 100% of contributors; change the role of the state to that of a regulator; grant autonomy to all provincial hospitals; improve the management capacity of facility and service managers; introduce essential amendments into the NHIF Act; introduce Health Benefits Regulatory Authority Act; strengthen NHIF management capacity and introduce new payment mechanisms.
Medium-Term: Increase coverage of the informal sector to 50% and the poor to 80%; expand out-patient benefits package to all contributors; grant autonomy to 30% of district hospitals; appoint only trained managers to run autonomous hospitals; establish Health Benefits Authority; all donors to use country mechanisms and are part of HSWAps.

Long-Term: Increase coverage to informal sector to 75% and 100% of the poor; introduce out-patient NHIF coverage to all facilities with a proper referral system and gate keeping role; transform NHIF into the National Health Services Trust; channel general health tax revenue through Equity Funds and the Revenue Collection/Pooling agency; use NHST to procure services for the state run Social Health Insurance; liberalise the Social Health insurance market; grant autonomy to all public health facilities; establish Primary Care Trusts in the country; ensure universal access to healthcare with 80% of financing from Social Protection in Health and 20% from complementary sources.

Monitoring and Evaluation

The introduction of this policy and strategy should be within the framework of the National Economic and Social Development Council, under the stewardship of the Health Sector Coordinating Committee. The HSCC will install a Working Group on Healthcare Financing (WGHF) to execute the strategy, while the Ministry of Medical services will provide the secretariat, jointly resourced with the Ministry of Public Health and Sanitation.

The monitoring framework will draw from existing routinely available data, and where not possible, will commission specific analyses or studies, if required. Indicators should be limited in number and in no way attempt to cover everything but be based on a small sample of indicators which, taken together, should give a broadly balanced picture of progress.

In view of the key goals, the following indicators are recommended:

- Adequate funding;
- Commitment to health;
- Improved efficiency;
- Increased utilisation of development budget;
- Long-term sustainability;
- Enhanced risk protection.

Financial Implications

At its core, the healthcare financing strategy proposes the twin components of increased social health insurance coverage and improved tax-funded coverage to shift health expenditure from OOP towards prepayment, as well as to raise revenue for health. These will be complemented by efficiency gains through

better accountability and rationalisation of the referral system with optimisation of the utilisation of the private sector. These efficiency gains will, in turn, release about 10% more resources into the healthcare services which translates to about KSh 8.3 billion in 2010, and about KSh 10.5 billion in 2012.

NHIF will increase penetration of the informal sector from the current 5% to 80% within a period of 5 years. This will be achieved via a mixture of strategies, but in particular through an aggressive marketing approach, the introduction of branded products and use of supportive legislative framework. This measure will increase revenue from KSh 6 billion to 12.6 billion in 2012. The change of contribution regime linking this to income at levels of between 2 -3% will also increase contributions from the formal sector from KSh 15 billion in 2010 to KSh 16 billion by 2012.

To increase access and attain efficiency in the private sector, the government through taxes and contributions from Development Partners and philanthropist, will pay premiums to the NHIF on behalf of the poor and vulnerable. The estimated contributions will rise from KSh 1.8 billion in 2010 to KSh 2.2 billion in 2012. NHIF will contain the administrative costs to less than 10% in the first 2 years, and thereafter to 5% or less. The NHIF products will cover a universal basic package of healthcare for all without exclusions on any medical conditions.

Tax funding for the health sector will grow within the existing fiscal space at 5% of GDP. This will finance the development and operational costs of public services and contributions of the premiums. In addition, tax funds will offset revenue loss as a result of the removal of user-fees in the public FBO primary care facilities. The corresponding allocation will rise from KSh 59 billion in 2010 to KSh 71 billion in 2012. This will include KSh 1 billion and KSh 1.3 billion respectively to compensate for the removal of user-fees, and the afore mentioned contribution towards SHI. As social health insurance coverage grows, the need for tax funding and compensation for removal of user-fees will gradually decline to a minimum. This is will be partially due to the mechanisms of solidarity and increased wealth creation as the majority of the poor enter informal or formal channels.

As a result of the above measures, universal coverage will rise from 24% in 2009 to 55% in 2012 and to at least 80% in 2017. Concurrently, the quality of healthcare will improve across all service providers not only as a consequence of increased financial inflows but more importantly as a result of change in payment mechanisms. Government involvement in direct delivery of curative services will also decline to the point where the primary responsibilities of the Ministries responsible for health will be limited to policy development, standards and regulatory functions, disease prevention and health promotion.

Impact of Healthcare Financing Reforms on GDP

Universal coverage will have a positive impact on the growth of Kenya's GDP. It is estimated that by 2030, about one-third of GDP will be derived as a result of improvement in health outcomes. The initial group of Kenyans born at the commencement of this healthcare financing strategy are expected to enter the labour market at the beginning of 2030, free from the long-term effects of preventable childhood diseases.

Expected Outcomes of Healthcare Financing and other Reforms

During the medium-term (by 2012), effective implementation of the reforms in the sector, particularly through universal coverage, will lead to the following outcomes:

- **Under-5 year mortality rate reduced** from 74 to 33 per 1000 live births;
- Maternal mortality ratio reduced from 414 to 147 per 100,000 live births;
- The proportion of **women receiving care** from skilled health personnel during delivery **increased** from 41% to 90%;
- The proportion of **immunised children** of age below one year **increased** from 71% to 95%;
- The number of **TB cases reduced** from 888 to 444 per 100,000;
- The proportion of **in-patient malaria fatality reduced** to 3%;
- The rate of national **new adult HIV cases reduced** to less than 2%.

7.7 Health Sector Coordination Structures

(June 11)