Kenya – Pooled Financing Arrangement supporting Universal Health Coverage

Concept Note

Background:

Kenya is currently going through a number of transformational changes in the health sector. The responsibility to deliver health services is now with 47 counties and the integrated Ministry of Health (MOH) is responsible for policy setting and strategic direction. The Government has shown strong commitment for achieving Universal Health Coverage (UHC) for all Kenyans and introduced new policies such as elimination of payment at point of service delivery for primary health care and elimination of user fee for maternal health services in public health facilities. The MOH is also finalizing the phase I of UHC by testing the operational feasibility of providing health insurance subsidies for the poor.

Several partners are supporting these initiatives started by the Kenyan Government with the MOH providing leadership. In particular the JICA, German Development Cooperation, USAID, DFID and the World Bank/IFC are closely supporting or planning to support the boarder health financing reforms leading to UHC in Kenya. WHO has been facilitating the process and the Partnerships for Health (P4H) Network is providing technical assistance.

The partners supporting UHC are keen to harmonize their support by creating a pooled financing arrangement to ensure:

a) one benefit package
b) one quality assurance/accreditation system
c) one beneficiary targeting mechanism
d) one M&E & claim processing system; and
e) one provider payment system

While the National Hospital Insurance Fund remains an important player, the pooled financing arrangement will have flexibility to work with private insurance providers depending on the need.

This concept note is linked to another concept note on TA support to MOH for UHC, which sees to providing harmonized and coordinated donor support in the area of Technical assistance to the Ministry of Health with regard to UHC in Kenya.

Pooled financing arrangement

A harmonized national program required an extremely strong leadership by the Ministry of Health which is why a joint 3-year TA-Plan is being proposed to strengthen capacity within the Ministry of Health.

Interested counties will contribute to the “Healthcare subsidy pool” from their own budget and in return will receive access to the program, including its systems and subsidy-funds, from national government and donors.

UHC-Steering Committee

The Ministry of Health and the relevant DPs will form a Steering Committee for Universal Health Coverage. All other Steering Committees for currently ongoing Health Financing Pilots (HISP, OBA, HSSF, HAKI) will be merged into this single Steering committee.

The Terms of Reference of this Steering Committee are (adapted from ToR of HISP):

1. *To provide project oversight and guidance on strategic issues and direction*
2. *To approve the annual work plan of the Social Health Protection Unit*
3. *To review the progress and quality of the project outputs and outcomes*
4. *Ensure compliance with performance standards and targets*
5. *Review and respond to the management/operational, financial and audit reports*
6. *Sign-off on project deliverables*
7. *Periodically review and approve the benefit package and premium rates*
8. *Ensure transparency and accountability in the project operations*
9. *Decide on Capacity Development requirements*

The membership of the UHC-Steering Committee will be determined by the national Ministry of Health.

Oversight and Fund management

The national Ministry of Health will establish a Social Health Protection Unit (SHPU) in its Healthcare Financing department. This SHPU will be responsible for the following:

- Lobbying and advocating for the pro-poor healthcare financing
- Estimating healthcare financing needs for poor and vulnerable
- Liaison with social protection agency to identify poor and vulnerable
- Allocation funds to implementers of pro-poor healthcare financing schemes such as NHIF, County health systems and facilities and others.
- Monitoring and Evaluation of the HCFP and holding implementers accountable for results.

The SHPU will be supported by an external auditor in the day-to-day fund management and reporting to MOH and donors. Donor funds will either flow into an account at Treasury or an account at a private commercial bank, where the Ministry and the auditor are signatories *(mechanism needs to be checked with Treasury/MOH*)

Capacities required:

- Strong capacities for fiduciary and administrative responsibilities (to manage DP funds in a reliable and transparent manner)
- Strong M & E capacity including analytical capacity for policy development (to provide good quality reports)
- Strong capacity in oversight and performance assessment (to allocate funding across various insurance schemes according to performance and customer satisfaction and between primary/secondary care according to equity principles and utilization patterns)
- Capacity to understand costing analyses and to estimate financing requirements, also involving counties and other stakeholders (to ensure sustainable funding for the health insurance pool)
- Liaise with other important institutions (KENAS, IRA, Social Protection Secretariat) to ensure overall functioning of the system (to ensure transparency, functioning, oversee selection mechanisms (e.g. poverty identification) and avoid fraud)
- Support in policy development processes, i.e. develop strategies to implement government health policy through the pooled financing arrangement incl. innovative models for achieving specific outcomes and adapt the basic benefit package according to policy and need.

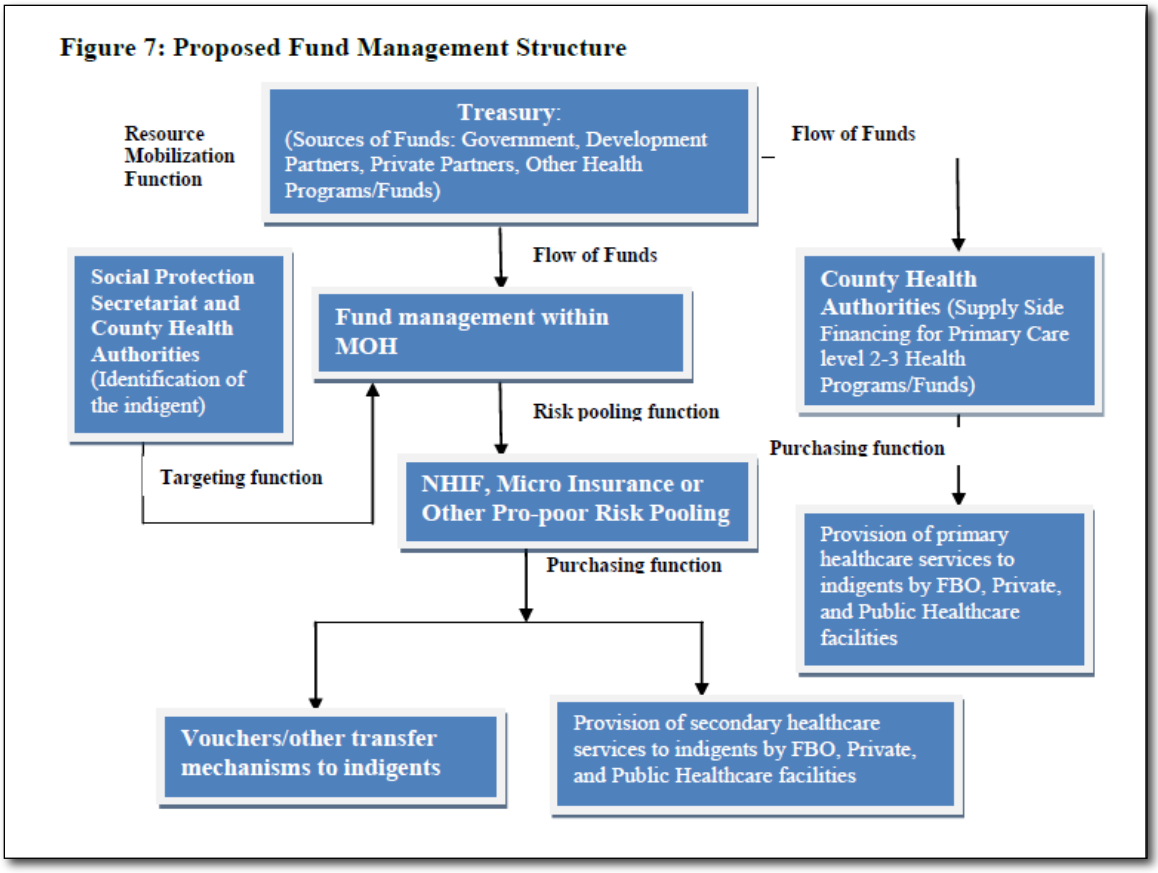
The external capacity development support within the Ministry of Health will be identified by a consultant under HHA who will develop a three-year TA-plan for the Ministry of Health.

Regulatory Framework

- Capacity Development to IRA and AA together with Department of Standards
- The accreditation agency will charge a fee (depending on level of care) to undertake regular accreditation of facilities
- All insurers participating in the program are required to work with accredited providers only (accredited according to national accreditation system)
- All participating insurers are required to offer the defined basic benefit package and will be paid a pre-determined premium (100% of that premium for indigent households, a smaller percentage for informal sector households)
- All insurances (public or private) will be regulated by IRA

Fund flows:

Figure 7: Proposed Fund Management Structure



1) Basic healthcare provided through tax funds

The fund will channel a part of the funds directly to primary health facilities using the existing HSSF accounts. In future, the funding will be provided by the county governments who will disburse directly to primary health facilities' accounts.

In this way, a very effective mechanism of providing access to basic health care is achieved and primary services are mainly utilized by lower-income group. This thus involves a self-targeting mechanism.

2) Secondary healthcare through insurance (public and private)

Another part of the fund will be allocated to NHIF and/or private health insurance schemes for basic secondary care.

The target group will benefit from the joint program as follows:

The poorest (indigents) will receive a full basic cover without any co-payment. They need to be identified as poor according to the national targeting mechanism.

The people who are poor (but not the poorest of the poor) and who are thus not selected by the national mechanism or those who do not want to undergo the mechanism will co-pay for the health

insurance cover and the funding arrangement will cater for a premium subsidy for this target group. This target group will be required to sign up at any microfinance institution or mobile-payment provider which will perform an income check and identify the average monthly income of the household. The household should pay a contribution of x% (6-8%?) of their income on the health insurance.

3) Marketing and sensitization

Marketing and sensitization activities will be financed from the fund as well to create awareness and increase the willingness to pay and the trust into health insurance.

Measures that can be financed through the fund according to the needs are for example: vouchers for priority services or transport costs, preventive measures for specific at-risk-groups; information and sensitization measures; market and operational research to identify the target group's perception and specific needs.

Implementation Strategy

A step-wise approach should be adopted in which the development partners who are actively engaging in Healthcare financing start off with the pooled financing arrangement, at the same time maintaining the possibility to include more partners (donors, private sponsors) who might want to join the pooled arrangement.

The same stepwise approach should be adopted by the counties in the sense that counties who are interested in joining the system will put their own budget into the fund, while the subsidies from national government and donors will be matched to leverage the subsidy amount for that county's health financing activities. Once a county decides to participate in the system, its facilities will get access to the SOPs, the systems and to the subsidies as well as technical support by national level incl. training. Any county can decide to join the program at any given point in time, thus stimulating voluntary participation and ownership by the county. By sharing information between counties, those counties enrolled in the program can share experiences and encourage other counties to come on board.

Annex: Lessons learnt which may be relevant to Kenya

Japan:

- scope of benefits (benefit package), proportion of co-payments and medical fees are uniformly structured (nationally defined), fees to providers are revised regularly by MOH
- start with small BBP and gradually increase scope with economic growth
- private sector alignment through alignment of delivery (quality) and finance (reimbursement /medical fee schedule) → multiple insurers, but same benefits covered and same medical treatment fees applied to all of them
- system is largely funded by insurance premiums and taxes
- government subsidy to benefit payments – risk-based - (17.4% / 50%)
- claims processing undertaken by examination and payment organization
- benefits in kind method (patients don't have to pay full medical bill) for service provision
- Employees' health insurance law (based on Germany): compulsory enrolment, contribution based on wage, service provision in kind.
- Infrastructure for accurate information management is essential
- CBHI – regional targeting; managed directly by municipalities (→ counties?), who also increased prevention and promotion activities – better placed to collect compulsory contributions
- Community-based service provision – flexible to adapt to local context and needs
- Design of the system was done by one single authority: MOH
- Problem with opting-out (for the rich): decreased revenue base, decreased redistributive effect, adverse selection. → decision against opt-out-option is highly political
- Effective and efficient administration: (1) eligibility of insured person (targeting), (2) mechanism to set premiums, (3) premium collection, (4) mechanism to set fee schedules, check hospital bills and reimburse medical fees, (5) setting of contribution levels (incl. subsidized ones)

Switzerland:

- strong public oversight + mandatory HI + private insurance provision
- positive definition of benefit package (defines what is included, not what is excluded)

Germany:

- health fund (insurers pay fixed premium into health fund. Health fund allocated risk-adjusted payments to insurers. Insurers who make losses need to increase premiums to insured people / insured people are free to change the insurer
- possibility to opt-out of public insurance for the rich is there (not ideal in terms of risk pool, but probably easier to implement politically)

any other lessons? – Health Equity Funds? South American Experiences (Brazil, Columbia?)