Kenya –Pooled Financing Arrangement supporting Universal Health Coverage

Concept Note

I. 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.

The Kenyan Government has projected an estimated need of 4 billion KSH per year to cover all pregnant women in Kenya for free maternity services. This is around the same budget that would be required to scale up the reproductive health voucher program country wide (according to an estimation by Population Council, this would cost between 38 and 40 million USD p.a.). An allocation covering 90% of this requirement was allocated for Free Maternity Services in the national budget for 2013/14.

Extending the cover beyond free basic and maternity services requires more resources because of (1) a larger target group, (2) a larger scope of benefits and (3) higher utilization rates. Using the current premium for the HISP-benefit package of 34 USD per person per year, if Kenya wants to fully subsidize all indigent in the population (19%), then the budget requirements would be 23.3 billion KSH per year. While the overall government health budget amounted to 35.4 billion KSH in the year 2009/10, the projections as per the MTP II for healthcare subsidies for the poor indicate a much higher budget to be allocated for this purpose, rising from 18.5 billion in year two to 60 billion KSH in year 4. Variations in the scope of services covered (e.g. only inpatient, see Box 1 below) or applying a rate of 13,000 KSH per household as currently applied by a number of micro-health insurance schemes, will result in varying coverage rates and financial requirements.

Box 1: Cost and coverage scenarios under various assumptions

Table 3: Risk Pooling Estimates for Secondary Healthcare applying the NHIF Civil Servants Scheme Premium (Ksh 2,850 per household per annum – M+4)

	Year 1	Year 2	Year 3	Year 4	Year 5
Amount in Ksh	522 Million	1.2 Billion	1.9 Billion	2.9 Billion	3.8 Billion
Total Indigent Households covered	183,250	433,137	683,024	1,016,206	1,349,388

Table 4: Risk Pooling Estimates for Secondary Healthcare Applying a Market Rate of Ksh 13,000 per household per annum – M+5)

	Year 1	Year 2	Year 3	Year 4	Year 5
Amount in Ksh	2.4 Billion	5.6 Billion	8.9 Billion	13.2 Billion	17.5 Billion
Total Indigent Households covered	183,250	433,137	683,024	1,016,206	1,349,388

The estimates compare favourably against the Ministry of Health's budget allocation in MTP II under goal 4 to subsidize healthcare for the absolutely poor indicated in table 5.

Table 5: Ministry of Health's Budget Allocation under MTP II to subsidise HCFP

Year 1	Year 2	Year 3	Year 4
1 Billion	18.5 Billion	31 Billion	60 Billion

Several partners are supporting these initiatives started by the Kenyan Government with the MOH providing leadership. In particular the JICA, German Development Cooperation, USAID 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 closely collaborating with the above mentioned development partners under the umbrella of the P4H - Social Health Protection Network (a global network for greater coherence of multi/bilateral technical support for UHC).

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.

II. Pooled financing arrangement

We propose a pooled financing arrangement which takes into account that (1) the Ministry of Health and the Counties lead this process and will provide the strategic direction for the implementation of all donor programs; (2) the complex political and technical aspects of the path to UHC require high political ownership, national dialogue and inclusive stakeholder involvement; (3) development partners themselves have different administrative requirements and financing modalities as per their political guidance, however, being bound by the common objective of UHC and principles of theP4H network,intend to undertake a joint and coherent approach to supporting health financing in Kenya.

For the joint framework described above, the following recommendations are made with regard to the respective areas:

(1) Benefit Package

There are a number of benefit packages currently in use. The most prominent one, the Kenya Essential Package of Health (KEPH),aims at broad and comprehensive health service coverage at public facilities. Nevertheless, a number of issues and experiences need to be considered:

- There is no common understanding by health facilities of what exactly the KEPH entails, (i.e. service providers have different views of what is included in the KEPH and what not), hence costing the KEPH remains a challenge;

- In the event that the Kenyan Government wants to provide all Kenyans with access to a comprehensive KEPH through an insurance mechanism, such a broad package will require a substantial increase in domestic financing for health, which in turn mayraise questions about affordability and sustainability;

- International experience from various countries suggests that starting with a "modest benefit package" (suggestion for the wording: "equity package") and gradually expanding the package along with economic growth is preferable;

- A condensed and costed version of the KEPH was obtained through prioritizing services under the HAKi-program and could be an entry point for discussion.

The second benefit package is the HISP benefit package. This is based on the comprehensive in- and outpatient package under the NHIF's civil servants' scheme. Albeit the attractive benefits, a national scale-up may not be feasible. In general, it is recommended to identify an "equity package" which includes basic in- and outpatient services.

We also propose to offer a subset of the proposed national "equity package" package for persons with special needs, e.g. pregnant women, small children, disabled, GBV-survivors. As a start, a sub-module will be provided to pregnant mothers for maternal and neonatal services. The rationale behind this is as follows:

- the solidarity principle is not yet very developed and thus insurance might not be accepted by a wide range of persons

- due to still high poverty levels, some households might not be able or willing to afford the health insurance premium (even a co-subsidized one)

- the provision of free maternity services is a priority of the Kenyan government

- providing a benefit package specifically for women in reproductive age helps many poor households to minimize their health risks in the immediate term and thus would be a suitable entry point for sensitizing the target group about the benefits of wider insurance cover. It also includes benefits that are essential to reducing access barriers to health, such as transport costs.

The assumption here is that the Government of Kenya ensures an adequate supply-side strengthening approach by enabling public health facilities to provide free primary Health services at level 2 and level 3 facilities.

(2) Regulation, Quality Assurance and Accreditation system

Two regulatory areas are directly linked to health insurance interventions, i.e. (1) regulation of health insurance, and (2) regulation of service quality at provider level

a. Regulation of insurers

- 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)
- Participating insurers shall not be allowed to refuse an application for the above defined basic package for the pre-determined premium, e.g. in case of pre-existing medical conditions and risks; or discrimination of age, economic status, ethnicity, etc.
- Indicators need to be defined, according to which IRA will monitor the performance of the insurers and report to MOH (e.g. incurred expense ratio, incurred claims ratio, net income ratio, renewal rate ratio, coverage ratio, growth ratio, promptness of claims settlement, solvency ratio, liquidity ratio)
- All insurances (public or private) will be regulated by IRA

b. Accreditation of Health providers

- All service providers participating in the insurance have to be accredited according to the national quality standards and protocols by an authorized accreditation body;
- Maternal mortality audits, spot-checks and routine information gathering has to be undertaken by the accreditation body
- facilities with low quality standards will be enrolled in a quality improvement program

There are some open questions that need to be answered jointly with the Ministry of Health:

- How will the accreditation agency finance its regular accreditation activities? Will they charge providers a fee (depending on level of care) to undertake regular accreditation of facilities? This is being done in a number of countries (e.g. India)

c. Capacity Development to IRA and AA together with Department of Standards

(3) Beneficiary targeting mechanism

Enrolment into the nationally defined health cover is likely to become mandatory, since voluntary participation in health insurance has shown not to work in various other countries.

The targeting mechanism is proposed to operate as follows: the Social Protection Secretariat at national level develops the rules and eligibility criteria for identifying indigent households countrywide. The capacities of the Social Protection Secretariat to undertake this exercise regularly, competently and nation-wide will need to be assessed and strengthened. The processes for collaboration with Counties and the Ministry of Health will need to be defined clearly.

The representation of the Social Protection Secretariat on county level will undertake the poverty identification exercise every 1-2 years and will group the population into income quintiles.

The Social Protection Secretariat at national level will undertake (1) systematic cross-checks by checking the list of identified persons with the database where ID numbers are registered; and (2) regular physical spot-checks at county level (through proxy-means testing) to check whether the selection process has really reached the target group.

A complaints mechanism will be set up (ideally operated by civil society organizations) where people who have been rejected for the subsidy program can report to. This will ensure that those who need to be included in the subsidy really can benefit.

There are two options for having the near-poor contribute to the insurance – either as a share of their annual income or as a fixed contribution share depending on the grouping into income quintiles.

The people who are near-poor (but do not qualify for the full subsidy) 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 8% of their income on the health insurance.

The second option would mean, for example, that people living in the second quintile receive a 40% subsidy, while people living in the third quintile receive a 20% subsidy.

<u>Subsidies for different Target Groups:</u>

We propose three types of subsidy for different beneficiary target groups:

(1) Full subsidies for indigents

(2) Partial subsidies for informal sector

(3) vouchers (incl. transport) for all mothers

Under (1), the approach piloted under the Health Insurance Subsidy Program (HISP) will be used and further strengthened, i.e. this model will address the access to quality health care by indigents. These will be identified by the Social Protection Secretariat in all counties. The insurer currently covering the indigents is NHIF. In case of good performance, the engagement of NHIF will continue as this component expands. The applied benefits package iscurrently the civil servants package – a rather comprehensive

package which is not costed. In the long run this should gradually transition to a nationally defined and costed essential package. The premium was recently lowered from 50 USD per person per year to 34 USD (i.e. approx. 200 USD for a household of 6 p.a.).

Under (2), 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.[1]The insurers (private and/or public, TPA possible) are identified through an open tender process. The following aspects of the insurance are going to be prescribed: the counties in which the insurance will be offered (this includes all counties who have successfully applied to participate in the matching subsidy mechanism, and who have committed own contributions to the fund). The benefit package will be the nationally defined essential package.

Under (3), all mothers will be able to access vouchers at a subsidized fee (approx. 200 KSH).

(4) M&E and claim processing system

A set of 5 to 10 Performance Indicators for the health insurance will be defined jointly by the Ministry of Health and development partners and will be followed up by the Steering Committee.

An Insurance Management Information System (IMIS) will need to be set up, which captures electronic claims data and can perform automatic cross-checks with an underlying database such as to limit systematic fraud (i.e. automated checks of member identity and verify whether the premium has been paid, pre-authorizations, prospective case management, rules engine for automated medical checks[2], e.g. retrospective reviews of medical necessity and service utilization, check negotiated rates as per provider contract (incl. discounts, modifications etc.), check provider details (incl. specialized services offered, case status and history).

Furthermore, detailed claims data (e.g. medical data (diagnosis and treatment) and utilization patterns) helps to manage providers more effectively (e.g. to adjust capitation payments).

It is recommended to set up an integrated single core IT system performing automatic checks in the background and allowing for different levels of data access (full access only by specialized staff).

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[1]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.

[2] Current systematic checks are administrative and non medical like same invoice number, overlapping dates of admissions that could be for different family member sharing one common enrolment number.

The M&E-System should be closely linked to the Health Management Information System (HMIS/DHIS) as well as to the UHC measurement framework developed by WHO and World Bank. This framework will ensure monitoring of overall achievements in the area of UHC.

(5) Provider payment system

The provider payment system will consist of consistent pre-negotiated rates to providers, while providers in turn deliver a service to the client directly and then claim with the insurance. A capitation or case-based reimbursement mechanism is suggested such as to ensure a cost-efficient service provision.

In General the Insurance-providers will insure their clients under the agreed benefit package at an agreed premium. The fund will channel subsidies to the insurers according to the agreed subsidy element, i.e. 100% subsidy for the poor and for voucher clients, 40% subsidy for Q2, 20% subsidy for Q3. When a client seeks service, this service is provided by the provider "in-kind" and then reimbursed by the insurance to the service provider at a pre-negotiated fee. The capitations or case-based reimbursement fees will be negotiated between the insurance providers and the health service providers.

In the objective to create a level playing field between public and private health facilities, private facilities can receive higher reimbursement rates than public facilities since they receive no inputs (such as salaries, equipment) from the government (county and national) and are subject to paying taxes. The rates need to be made transparent and need to be reported to the UHC Steering Committee on a regular basis.

The respective insurers will be responsible for undertaking marketing and sensitization activities and to enroll the clients into health insurance. The community health workers can assist in information and sensitization on health matters and can refer interested clients to the insurer's distributors.

Table 1: Summary of products supported by the fund

	(1) Health insurance subsidy	**(2) Health Insurance Promotion Subsidy**	**(3) Vouchers for maternal and newborn health**
Region	All counties	All participating counties	All counties
Insurance Product / Benefit Package	Currently: Civil servants; future: nat. defined ess. package	Nationally defined essential package + possibly additional benefits (for marketing purposes)	Sub-Set of the essential package: Delivery-related services plus transport
Insurer	NHIF	NHIF/Private: to be identified through tender process	
Target group	Indigents (20% of population)	Informal sector	
Premium subsidy element	100%; 34 USD	8% of household income?	90%

and premium cost		40% Q2 20% Q3[3]	
Regulation / Quality Accreditation	All providers offering services need nationally accepted accreditation All insurers are regulated by IRA.		
Marketing and sensitization			

III. Funding Mechanism

The three products can be funded either from a pool where donors jointly pool together their funding, together with tax funds from GOK (Option A). The Steering Committee will regularly decide on the allocation of subsidies for the three areas that the pool supports.

Another option, in case donors may not be able or willing to pool funds, donors can choose to opt for funding either of the three above-mentioned products by channelling the funds directly to NHIF (1), to the insurance consortium (2) or to vouchers for maternal health (3) – (Option B).

	Strengths	Weaknesses
Option A (pooled funding)	Highest degree of harmonization/coordination &lowest transaction cost for MOH	-Possibly more difficult to set up -might exclude some DPs
Option B (Parallel funding)	High degree of accommodation of donor's requirements	-more coordination effort for MOH

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 technical oversight and ensure the functioning of the overall implementation of the joint financing arrangement by:

- Lobbying and advocating for the pro-poor healthcare financing
- Estimating healthcare financing needs for poor and vulnerable
- Liaising with Social Protection Secretariat to identify poor and vulnerable
- Allocating funds to implementers of pro-poor healthcare financing schemes such as NHIF, County health systems, facilities and others.

[3]Decision needs to be taken on whether there is a fixed subsidy according to income quintile, or an income-dependent (progressive) contribution by the insured member.

- Monitoring and Evaluation of the implementation of the financing arrangement and holding implementers accountable for results.

The SHPU will be supported by a fiduciary agency in the day-to-day fund management and reporting to MOH and donors. Donor funds will flow into an account at a private commercial bank, for which the Ministry of Health and the auditor are signatories.[4]

IV. Governance Structure on national level

(1) UHC-Steering Committee

The Ministry of Health, County representatives 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:

1. *To provide project oversight and guidance on strategic issues and direction*
2. *To approve the annual work plan of the joint financing arrangement which will be prepared by MOH (SHPU)*
3. *To review the impact of the funding arrangement on access to quality services using the joint M&E framework*
4. *Ensure compliance with performance standards and targets*
5. *Review and respond to the management/operational, financial and audit reports*
6. *Periodically review and approve the benefit package and premium rates as well as reimbursement rates*
7. *Decide on Capacity Development requirements*

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

[4] Capacities required: fiduciary &administrative capacities (to manage funds transparently), M & E capacity including analytical capacity for policy development (good quality reports), oversight and performance; costing analyses and estimating financing requirements, also involving counties and other stakeholders (to ensure sustainable funding for the health insurance pool), strategic capacity 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.

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 get additional (supplementary/complementary) insurance from private insurers