Kenya

Health Financing Strategy Development

Options for Reform and choices to be made

Paper in support of decision making by the Kenya Ministry of Health

Providing for Health (P4H) initiative

Draft 15 April 2014

Executive Summary

It's time to bite the bullet on health finance reform and decide on a model for the future health financing architecture of Kenya. That is the main recommendation of this paper, requested by the Ministry of Health (MOH) of Kenya, in support of the finalization of the Kenya Health Financing Strategy (HFS)[1] development process towards Universal Health Coverage and preventing impoverishment due to necessary health services consumption. Enough information is available for charting a course towards a health financing model and to take a decision despite a possible perception that some details are not yet clear. Although the devil is always in the detail and stakeholders may want to know more about these details, also as a tactic to delay for them possible unfavorable decision making, ***more analysis leads only to paralysis***.

Universal health coverage is related to Kenya's new Constitution which states the Right to highest attainable health status and in practice could mean:

> *Moving from high OOP, limited physical and financial access to substandard care in a suboptimal regulatory and institutional setting towards equitable physical, psychological, financial and timely access to quality essential health services for the poor and not well-off without the risk of impoverishment by way of a cost-effective prepayment system that expresses the values of our society and supports the individual and societal development*.

This formulation of the UHC objective is modest and focuses on the poor. The aim of equal access for all to the same BP as is currently offered to e.g. the civil service seems not attainable within the short term. Reducing the current BP of the civil service is not very likely. So, Kenya will have to live for the time being with a multi-tier system in health care and real equity in access for all to the same BP is far off. However, Kenya can freeze the BP for the civil NHIF members and add all newly made available resources to increasing the BP for the poor, thus increasing the speed with which UHC is achieved.

The past

Attempts are going on already since the Nineties of last century to put the health financing system and the wider health sector more in support of achieving universal health coverage of all Kenyans (UHC) and

[1] The request coincided with the organization of a High Level Forum (HLF) in Nairobi, 18 – 20 March 2014. This forum on "*Improving Health Outcomes and Services for Kenyans: Sustainable Institutions and Financing for Universal Health Coverage"* was organized by the MOH together with the World Bank and USAID. The partners in the Providing for Health (P4H) initiative were requested to synthesize draft reports of national experts into options for health financing reform, firstly into a draft presentation to be made by MOH during the HLF and secondly into a paper. GIZ financed a consultancy to perform these tasks, which was implemented by Jan Bultman, MD, supported by representatives of P4H as regards the content of the consultancy and by the GIZ Nairobi office for the logistics.

of providing social health protection (SHP) by offering equal access to quality health services without its users running into financial barriers or into impoverishment.
Coping with difficult economic circumstances, a disastrous HIV/AIDS epidemic, the emergence of chronic diseases and change of the Country's Constitution with wide ranging consequences, the country has seen until now mostly project based or isolated activities to improve access to health services for the poor. The development of a coherent health financing architecture and a ditto health financing strategy to achieve this has been hampered by differences of perceptions and of opinions of important stakeholders, mainly about the possible re-assignment of mandates and the distribution of health financing functions. The obvious question of every stakeholder in health financing and care delivery reform is: ***"what's in it for me?"*** What matters more, though, is how to achieve UHC and SHP as quickly and as efficiently as possible in the Kenyan context. Hence, pleasing stakeholders because of their market interests is not the priority. It's how stakeholders can best contribute to the UHC goals and in which configuration of mandates and assignments.

It seems that the time has come to take decisions on the future direction of health finance system development. The political will exists. The economy is growing, creating some fiscal space to expand public funding of the health sector. Innovations such as mobile finance via the spread of smart phones offer new chances for enrolment of people into health schemes. Many previously noted unknowns have been clarified via numerous studies and surveys on e.g. fiscal space, benefits package, health insurance market structure and institutional issues in health financing. Coordinated support from development partners (DPs) is available. The devolution process, started with the Constitution change in 2010, is running its course and impacting health financing though not everything is yet crystal clear, hence contributing to the need for decision making on a health financing model.

Functional instead of institutional approach

What matters for such model is to provide an answer to the question: ***which institution, existing or new, will get which mandate in decision making, implementation and regulation of the health financing functions: determining the sources of funding, the collection and pooling of revenues and the purchasing of services as listed in a benefits package.*** Although the limited existing capacities of existing institutions should be handled prudently, if the shifting of current mandates to other institutions would be beneficial for achieving UHC and SHP more quickly and improves effectiveness and efficiency in health financing administration and in health services delivery, then there is no reason to avoid the changing of current institutional mandates unless this would be against Kenya's Constitution. All other legal mandates can in principle be changed.

Although in private health insurance the insurance company decides and implements itself the health financing functions of collection, pooling, purchasing, the benefits package and the contribution rates. In mandatory insurance there are more interests at stake than the profits of an insurance company or the interests of e.g. members of a cooperative. Besides the fact that MOH and Counties have a Constitutional mandate, reflected in their mandates in health policy, health sector regulation, population oriented (public) health and monitoring and evaluation (M&E) of the implementation of health policy, most of the health facilities are publicly owned.

Further, ***no country with a large informal sector of mainly poor people will achieve UHC without substantial contributions from general revenues*** hence involving government as an important stakeholder. Individual and/or employer contributions into a mandatory health insurance scheme affect labor costs and hence the economy and national and international competitiveness, which are a concern of the government of any country, including Kenya.

Deciding a universal benefits package (BP) to be financed from general revenues and/or mandatory charges is the heart of health policy and hence the very mandate of MOH. The cost of implementing such package determines the overall health sector costs and should thus be government concern. Involvement of the ministries of finance, economy, social welfare and health, and in the Kenya Constitutional context, representatives of the Counties, is the obvious conclusion.

Because previous health finance reform actions in Kenya stranded due to concerns at the highest government level about viability and sustainability of a proposed system, efficiency in assigning health financing functions and adopting tools for health sector related cost-containment are most important in the assignment of functions to institutions.

The limited institutional and management capacity in the health sector and the need to keep admin costs as low as possible to save monies for spending on health services, similar to many other developing and developed countries, add to the need for simplicity in organizing and implementing health financing functions and to avoid complex solutions. Current mandates of stakeholders should not act as unchangeable entitlements if reassigning these mandates to other institutions would yield better results for the Country's health sector and in achieving UHC.

Recommendations

Based on these above principles and criteria, which are spelled out in more detail in this paper, it is recommended that:

- The ***Government has the mandate and decides the overall budget*** for the health sector and all its activities that impact the country's overall economy, fiscal pressure, health status and social welfare.
- The government subsequently decides ex ante the ***distribution of estimated health sector costs*** over general revenues, social charges, user charges and solidarity charges (cross-subsidization) of private health insurance. The actual distribution over the contributing sources is ***the main instrument for enhancing and achieving equity in health financing***: everyone paying into the system to his /her ability to pay and for ***achieving equal access to services*** without impoverishment risk. So, the poor should be the first priority in this decision making process and its outcome.

  In order to be responsive to the dynamics in the economy, in society and in the health sector the above mandates would be best regulated in a ***framework Act,*** leaving e.g. the actual distribution

of costs and the levels of contributions from general revenues, social and user charges to the mandated government body.

- ***Contribution collection*** for mandatory insurances is collected by the Kenya Revenue Authority (KRA).
- ***Collected contributions*** from all resources, including donors, are parked at the National Treasury or National Bank of Kenya. This would limit the financial risks and offers the possibility of reducing the need for reserves at public insurance bodies if MOF offers a financial back up in case of unexpected shortages.
- The level of ***poolin***g, the number of pools and hence the size of the risk pools, i.e. the distribution of monies over the payers and purchasers of health services is dependent of the chosen health financing model and hence of its main actors.
- The ***actual size of the budget envelop*** is based on a mix of historic costs, actuarial analysis, health risks of counties and/or insurer portfolios and County absorption capacity. The latter factor relates to the intended gradually equalizing and reducing the differences in health services facilities availability between Counties.
- The overall budget is ***separated between investment costs and operating costs***, albeit it in a flexible way to prevent problems in budget execution and leaving available resources unspent, to cater for services level differences eradication.
- The ***investment budget*** should be coupled with a ***needs based health services planning and licensing Act*** which regulates the distribution, level and quantity of health services providers over the Country and has a special regime for high-tech/high-risk/high-cost health technologies. Such instrument would also be necessary for quality control and cost-containment. The latter contributing to the ***viability*** of the chosen health financing model, a main government concern.
- The overall health sector budget is further split into a ***budget for population based services***, such as immunization, health promotion, disease prevention, disease surveillance and disease outbreak management and ***a budget for individual oriented health services***. This latter budget is for individual prevention, diagnostic, curative, palliative and rehabilitative services. Most countries finance population based services from their national budget. Occasionally countries tap into a public health insurance fund to finance e.g. vaccines and immunization programs.
- ***Population based services*** will be the responsibility of MOH and the Counties which can use the health professionals working in individual oriented care for the implementation of these services.
- ***Individual oriented services*** financing and delivery can be distributed over MOH, Counties and/or insurers and over users. The options for such distribution are the mainstay of this report and define the health financing architecture. This distribution can also be regarded as the most contentious one. A ***split between purchasing and providing of services*** is recommended as the more cost-effective health services financing method. Hence, granting some level of autonomy to public health providers and thus MOH and Counties staying out of direct purchasing would be a consequence of such choice.

To implement such split, current ***vertical disease oriented systems*** should be integrated: partly in population based services and partly in individual services

- The ***MOH determines the package of benefits*** of individual oriented services which would become universally available, taking into account and negotiating the budget for it with concerned ministries and Counties. This package will be derived from the Kenya Essential Package of Health services (KEPH). To speed up the achieving of equal access to health services, the current BP of NHIF should be frozen and only expand once all residents have been granted access to the current NHIF BP for the civil service. For future adjustments MOH can be supported by advice from an ***independent expert body,*** which should include epidemiologists, health economists, health professional and para-professionals, statisticians, health insurers, consumer organizations and experts in health technology assessment.
- For the development and decision making of the health financing strategy it is more important to decide on the mandate and the ***criteria for assembling a BP*** and for future adjustments than to already provide a list of health interventions which should be covered. The reason is not the possible lack of costing study results but to allow for flexibility and to deal with dynamics in medicine and population needs.
- In all proposed options for a health financing model, ***private health insurers (PHI***) continue to offer complementary and supplementary health insurance. The need and market to offer duplicative insurance may gradually disappear when the universally covered BP and service quality expands and improves. One of the reflected health financing models explores a possible role of PHI in a competing health insurers model.
- The ***governance structure*** and mandates of the health sector follows from the above and is further to some extent dependent of the chosen health financing model. In any case:
    - The ***Insurance Regulatory Authority (IRA***) should regulate and supervise public and private health insurers, not only as regards their financial activities but also concerning their functioning with respect to achieving cost-effectiveness and quality in financial administration and in health services delivery , the latter in their role as purchasers. It is suggested that ***IRA and MOH/Counties agree on a protocol*** for the auditing and supervision as regards the health services financing activities, clarifying the mandate of each actor and preventing duplication.
    - The ***National Hospital Insurance Fund*** will need to be reformed in conformity with its future mandate, taking into account the decisions on the aforementioned functions and principles of good governance. It will most likely have to change its name and become a health insurance fund. It already deals with primary health care (PHC) for the civil service, policy and military staff.
    - If and when the aforementioned health facility planning and licensing Act is adopted, an ***equal position for public and non-public health facilities*** in the delivery of the universal BP can be considered vis a vis the purchasing body. The timing is important to prevent an outflow of public staff in unregulated private facilities. For the time being, private facilities can be contracted on an as needed basis.

- The equal position of providers would have consequences for the fee level setting: ***investment costs of licensed private providers*** should be taken into account in case they are contracted for the delivery of the universal BP.
- The establishment of a ***health tariffs forum*** or official body would be helpful in the underpinning of health services fee levels and in advising about the payment methods. Such forum or body should take into account the instructions of the government as regards available sector and sub-sector budgets.
- A dedicated health facilities ***accreditation body*** for external quality assessment and continuous quality improvement should be established, covering all health institutions irrespective of their legal status and whether they are contracted or not by the purchasing agent for the delivery of the universal BP. The establishment of such body would take away the accreditation mandate of NHIF, also in any of the proposed options.
- Although M&E is a genuine task of MOH, as long as MOH has a particular stake in the health sector as owner and payer of health services it is recommended to use an independent outside health services research capacity for the evaluation of the implementation of an adopted health financing strategy.

Assuming that the aforementioned options are adopted as the most cost-effective and politically acceptable way of organizing some important health financing functions, the distribution of mandates as regards purchasing and paying of health services is left to be decided. Several options are possible.

Options for the health financing architecture

This paper describes 6 options for a future health financing architecture. Each of these options can support, in principle, achieving some level of UHC albeit at different speed and with wide ranging differences in complexity and hence admin costs and risks. Far apart from each other are a model of gradual evolution of the current fragmented system and a more revolutionary big bang model of public and private insurers, competing to enroll residents into a mandatory health insurance covering the uniform benefits package derived from the Kenya Essential Health Services Package (KEPH). The options are described and evaluated against explicitly formulated criteria. The pros and cons of these models are indicated. See Table 1 for a summary of the options.

One of the new challenges, since the writing of the 2010 health financing strategy and the P4H review is related to the implementation of the health sector mandate of the Counties as part of the devolution, especially in relation to the centralized character of the National Hospital Insurance Fund. These two important stakeholders will have to find common ground in the best interest of their residents respectively their members. This paper offers some options that may do justice to the split responsibilities of these actors while also reducing fragmentation of funding and creating a single purchaser. Other options may be seen as more controversial by the Counties and other stakeholders but could be considered as more cost-effective.

Table 1 Pros & Cons/SWOT of options, proposed for consideration

Options	**1**	**2**	**3**	**4**	**5**	**6**
All Options have elements as indicated below	**Evolution model**	**NHIF complements Counties model**	**NHIF for All model**	**County NHIF contract model**	**Counties Regional public health insurers contract model**	**NHIF & PHI competion model**
Population based services paid from general revenues via MOH/Counties; **Individual services** paid from mix of GOVT Budget & insurance contributions Cover KEPH derived **dynamic BP**; Have **poor as 1st priority;** Need **cntd public funding**; **Freeze current NHIF BP**; Improve **equity in funding** dependent of imposed resource structure & cross subsidization; Are **viable & sustainable** dependent of governance & granted cost-control tools; Need **governance improvement** of all institutions; **NHIF** becomes national health insurance fund **MOH focus** on policy making, regulation & M&E; PHI offer duplicative, complementary or supplementary HI; Move towards integrated uniform broad and deep BP in mandatory insurance for all; Streamline, simplify and risk-proof **collection and pooling** functions; **Autonomization** of providers; Need **tariffs board**; Introduce **facility planning and needs based licensing**; Need **accreditation inst**.; Ultimately offer **equal position to public & private providers;**	NHIF gradually expanding its coverage of the poor and near poor, number-wise & BP-wise.	NHIF purchases SHC & THC for non-members according to KEPH BP; Continued current services.	NHIF as single purchaser in national mandatory HI of all residents for KEPH BP; Continued current services.	NHIF contracted by MOH & Counties to cover all residents for KEPH BP; Continued current services.	Regional insurer contracted by (groups) of Counties to cover all residents for KEPH BP & offer current coverage to current members.	NHIF and PHI on equal terms for mandatory enrollment of all residents to assure access to KEPH/BP in strictly regulated environment to prevent risk selection & cream skimming. NHIF & PHI continue their current member services.
Achieving UHC	+	+	+	+	+	±
BP breadth & depth; hence best option for the poor?	+	++	+++	++	+	±
Effective & efficient insurers; hence more to spend on BP for poor.	±	+	+++	++	±	--
Effective & efficient health services	±	+	+++	++	_	____
Simplicity in health financing	+	++	+++	++	+	_ _ _

system and implementation						
Realization period	ST	ST	ST-MT	ST- MT	MT - LT	LT
Specific Capacity requirements	Nihil -Low	Low	Medium	Medium	Medium to high	Very high
Additional regulatory burden & costs	Low	Low to Medium	Medium	Medium	Medium to high	Very high
Cost-effectiveness HF Model	-	-	++	+	+	±
Acceptance						
• Insurers						
○ NHIF	+	+	++	+	±	±
○ private	+	±	--	±	±	++
• Providers	±	±	-	±	-	+
• Public						
○ Poor	±	+	++	++	+	-
○ Non-Poor	±	±	±	_	±	+
• GOVT						
○ Nat	±	+	++	±	+	±
○ County	+	+	-	+	++	-

In the above table, the abbreviations and indications mean:

UHC	Universal health coverage, i.e. access for all and no risk of impoverishment
BP	Benefits package
KEPH	Kenya Essential Package of Health services
HF	Health Financing
HI	Health insurance
NHIF	National Hospital Insurance Fund and its possible successor: National Health Insurance Fund
PHI	Private health insurer or health insurance
SHC	Secondary health care
THC	Tertiary Health Care
ST	Short term
M&E	Monitoring and evaluation
MT	Mid term
LT	Long term
L	Low
M	Moderate
H	High
+	Possible or likely
++	Very well possible or very likely
±	More or less; or neutral
_	Negative or less likely
_ _	Very negative or unlikely

Conditions for success in the implementation of a chosen model

To make any of the chosen models work cost-effectively, sustainably and viable, several parallel actions should be considered:

- **Increasing of public spending** on health to cover the poor informal sector. The health sector should get a larger share of government expenditures and possibly also from specific health

and/or sin taxes and levies. Increased insurance premiums can be used for cross-subsidization those who cannot pay contributions themselves.

- Implementing **NHIF reforms, aiming at** good governance including public disclosure of information on finance, the organization and the assets and earnings of key individuals).
- Improving the regulatory and auditing mandates and legal frameworks for IRA and Auditor General to allow for health insurance specific regulation and functional and value-for-money auditing of insurers.
- Creating a level playing field for public and private service provision in reference to having equal positions of public and non-public providers in health financing of services according to the universal BP. This means that payments would reflect differences in infrastructure funding and other structural costs.
- Creating a fully-funded benefit package for the informal sector's poor and near poor.
- Reforms needed outside of direct health financing:
    - Development of an independent quality-oriented improvement and accreditation system
    - Introduction of a needs-based planning and licensing system for all health facilities, public and private and including free-standing laboratories, diagnostic centers and other support facilities.
    - Massive capacity development initiatives, of which the need and focus would be dependent of the chosen model

The road ahead

This paper and the options presented in it can act as a vehicle for:

1. Engaging the leadership of MOH in a dialogue about the options and subsequently for stating a preliminary preference for one of the options and the further process.
2. Discussion and obtaining feedback of the Technical Working Group on Health Financing Strategy.
3. Stakeholder consultations, especially the Counties but also including the private sectors of insurers and providers, the associations of employers and unions , consumer organizations etc
4. Possibly after incorporating feedback of the previous rounds of consultations: engaging the Inter-agency Steering Committee and getting its feedback on the preferred option.
5. After the choice of an option, a summary draft implementation plan, including an indication of the timing and the costs of the implementation process, and a draft Bill can be developed. This package, embedded in the updated 2010 health financing strategy can be submitted to the Cabinet of Ministers, the President and Parliament. Obtaining the consent of the President at an early stage seems important in order not to get stuck at a later stage in the process.

Some of the above steps may have to be repeated, dependent of the received feedback.

The report

The report provides for a short introduction and background of the consultancy. Then the report reflects some major agreements reached and the remaining challenges. The mainstay of the report is a detailed description of the health financing options and subsequently an indication of pros and cons, followed by recommendation and suggestion for the road ahead.

List of abbreviations

AIDS	Acquired Immunodeficiency Syndrome
BP	Benefits Package
DP	Development Partner
DRG	Diagnosis Related Group
FBO	Faith Based Organization
GIZ	German Development Corporation
HC	Health Center
HIV	Human Immunodeficiency Virus
HLF	High Level Forum
HMIS	Health Management Information System
HP	Health Post
HPP	Health Policy Project
ICCHF	Inter-agency Coordination Committee on Health Financing
IP	Inpatient
IRA	Insurance Regulatory Authority
KENAS	Kenya National Accreditation System
KEPH	Kenya Essential Package of Health Services
KEPH	Kenya Essential Package of Health services.
KRA	Kenya Revenue Authority
M&E	Monitoring and Evaluation
MOH	Ministry of Health
NHIF	National Hospital Insurance Fund as well as National Health Insurance Fund
OP	Outpatient
P4H	Providing for Health

PBF	Performance Based Financing
PHC	Primary Health Care
PHI	Private Health Insurance/Insurers
SHC	Secondary Health Care
TB	Tuberculosis
THC	Tertiary Health Care
TWG	Technical Working Group
UHC	Universal Health Coverage
USAID	United States Agency for International Development

Acknowledgement

The consultant is grateful for having had the opportunity to work together with the Kenya MOH and especially with Mr. Ongu'ti and Mr.Munguti, the Ministry's Chief respectively Deputy Chief Economist, in trying to further the development of a health financing strategy for the Country which could lead to more equal access for its residents to essential health services of good quality and without financial pains for the poorest categories of the population in case of use of these services.

Great support and input has been provided by the representatives of the P4H partners, especially by Mr. Mathew Jowett , Health Economist at WHO Geneva, and Mr.Kai Strailer-Pohl of GIZ Head Quarters, Eschborn.

The work in country would not have been possible without the professional and logistical support of the GIZ Nairobi office and especially of Dr.Joanne Muigai.

Table of Content

1. Introduction and background

Kenya is currently going through 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 testing the operational feasibility of providing health insurance subsidies for the poor.

In light of the high profile of health issues and UHC during the 2013 elections and in the Government agenda, there is high pressure to move forward with the reform process and to deliver tangible results for Kenyans within a limited time frame.

The MOH is currently developing a "Roadmap to UHC", an action plan laying out the major steps it aims to take to expand effective access to quality care and financial risk protection. One of the major milestones in this process is the agreement of a "Health Financing Strategy", which will define the major pathways and implementation arrangements through which Kenya will strive towards UHC.

The efforts of the MOH in this process and the support rendered by Development Partners (DPs) are coordinated in the Technical Working Group (TWG) UHC under the Health Financing Inter-Agency Coordination Committee on Health Financing (ICCHF). Three technical papers have been commissioned by the MOH. Drafts of these papers[2] have been delivered. However, the many comments of MOH and development partners have not so far led to updating and finalizing these papers and none of the papers include the originally requested options of which this report was supposed to provide a synthesis. That's one of the reasons why this paper is somewhat different from the one that was originally planned.

The attempt to extend health services and financial coverage is already going on for some time. A draft national health insurance bill stranded in 2005 due to lack of a credible roadmap on implementation, to assure affordability for the poor and viability. However, the 1966 established National Hospital Insurance Fund (NHIF) continued its course, currently mandatory covering the staff of the civil service and of the defense and police forces and besides financing hospital care offering also outpatient (OP) and primary health care (PHC). Other people can enroll and are offered inpatient (IP) care only.

[2] Chuma, Jane: Assessment of the Health Financing Institutional Design and Organizational Arrangements in Kenya and proposal of feasible options.
Okech, Timothy: Review of On-going Efforts in the Implementation of the Health Financing Functions and Proposal for Feasible Financing Options.
Ayah, Richard: Current status of coverage in terms of services, financial depth and population covered and proposal of options for an affordable benefits package.

A health financing strategy document has been drafted and issued in 2010 by the then Ministries of Public Health and Sanitation and of Medical Services[3]. This document was widely discussed but no agreement could be reached on all aspects with stakeholders. In March 2012, a team of the Providing for Health (P4H) network provided an external review, indicating points of agreement and items about which no agreement could be reached until then[4]. The P4H team recommended several actions of which some have been followed up by MOH and DPs, among these are the commissioning of the aforementioned papers.

Most of the observation and recommendations of the 2012 P4H review are still valid and useful to consider for the further process, content and implementation of an updated national health financing strategy. The 2010 Draft strategy document offers still a good starting point for this process together with the P4H review. NB, the content of the P4H review is not repeated in this document.

Another important development since the 2012 P4H Review is the implementation of the new Constitution which gives the citizens of Kenya a perspective on striving for the "highest attainable level of health" and introduced the devolution of previous national government mandates towards the Counties, accompanied by a larger share of the national general revenues with which Counties are supposed to implement their new mandates, including their mandate for the provision of health services via the public health facilities existing on their territories, except for the National and tertiary care hospitals.

Focus of paper

Hereafter, this paper reflects the agreements reached so far among stakeholders and the remaining issues that were identified, among others, during the 2012 P4H review. To further the process of development of the Health Financing Strategy, the paper concentrates on the priority topics that need a decision and from which other choices and decisions to be made will flow The paper sketches 6 options for a future health financing architecture which can lead to a preliminary decision of MOH and subsequent follow up consultations with stakeholders, including those stakeholders that have not yet been thoroughly involved in the discussion about the future health financing architecture. Subsequently the paper could form the basis for getting the go-ahead of the Cabinet of Ministers and the Country's President to develop the health financing strategy and necessary legislation to be ultimately adopted by Parliament.

[3] Ministry of Public Health and Sanitation & Ministry of Medical Services: Accessible, Affordable and Quality Health Care Services in Kenya. March 2010.
[4] Providing for Health (P4H): Kenya, Draft Health Financing Strategy; Report of an External Review, 8 May 2012

2. Approach

Because of the course of developments being different from the one foreseen when adopting the terms of reference for the consultant[5] (Annex 1), this paper concentrates on the health financing structure options.

It is based on the authors international experience, his earlier involvement as lead author in the 2012 P4H Review of the 2010 draft health financing strategy, on the literature and policy documents as listed in Annex 2, on reviews of and discussion with the authors of the three aforementioned papers o national consultants, on interviews with MOH officials and with representatives of DPs and on information provided during a High Level Forum (HLF) from 17 – 20 March 2014 (program attached as annex 3).

Although the requested presentation with a synthesis of options was timely prepared by the international consultant and discussed with stakeholders and MOH officials and staff, it was decided to focus the MOH presentation (annex 4) during the HLF on the issues to be tackled and on listing some difficult choices to be made. The character of the HLF offered a chance for getting a broad overview of health sector issues from international and national perspectives which were further explored during short question and answer sessions. But this character and the lack of time ***did not allow to for achieving agreement between stakeholders on a future health financing architecture***.

This latter could anyway have been only a preliminary exercise since not all stakeholders, such as private insurers, regulators, employers and Unions were present. Nevertheless some pickets were placed, especially by the representatives of the Counties who stressed their interest and commitment to taking on their new Constitutional mandates while stressing the need to and the wish for close collaboration with MOH and other national stakeholders.

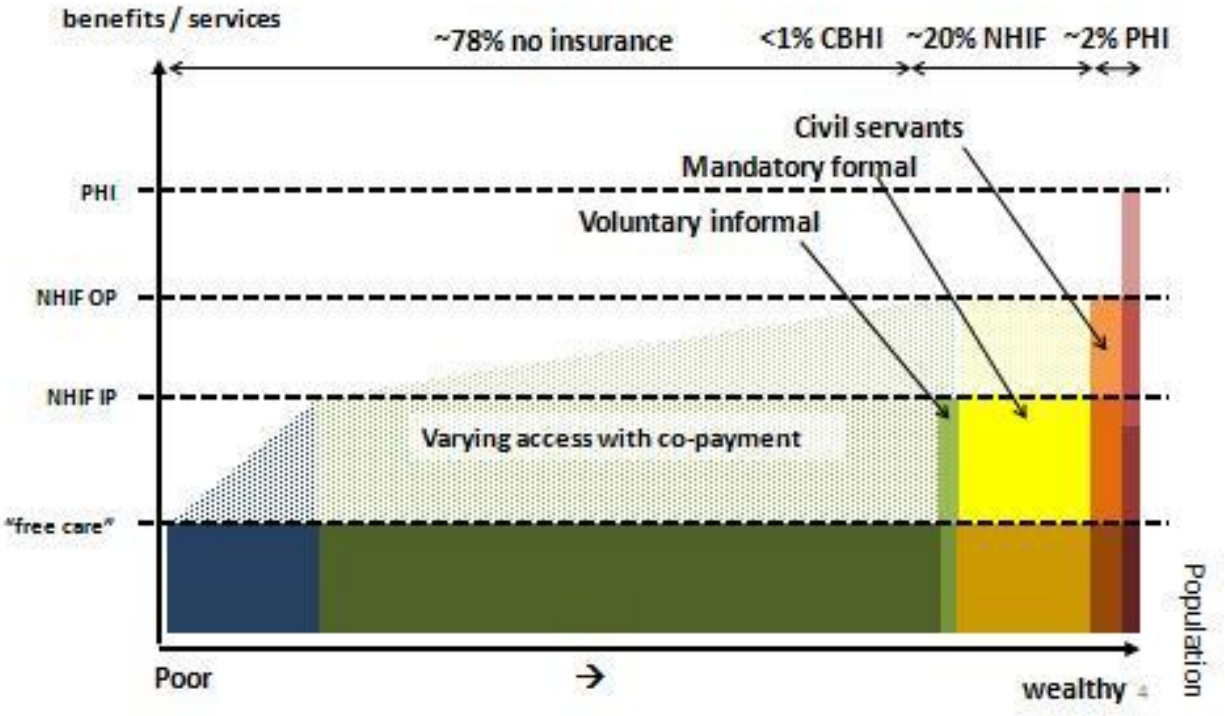
3. Main issues in health financing

The main issues in Kenyan health finance are described in the draft 2010 health financing strategy[6], commented on in the 2012 P4H Review[7] and further detailed in the three aforementioned draft reports of the national experts.

[5] Jan Bultman, MD. Consultant Health Systems and Financing. Contracted by GIZ on behalf of P4H partners.
[6] Ministry of Public Health and Sanitation & Ministry of Medical Services: Accessible, Affordable and Quality Health Care Services in Kenya. March 2010.
[7] Providing for Health: Kenya, Draft Health Financing Strategy; Report of an External Review, 8 May 2012.

The current health services prepayment systems are fragmented, as visualized in graph1.

Graph 1. KE health service coverage profile



On the vertical axis of graph 1: the breadth of the benefits packages (BP), reflecting the differences between the different third party payer's offerings. It differentiates between the NHIF package for the civil services, i.e. inpatient (IP) and outpatient care (OP), and for other members of NHIF, covering only IP care. On the horizontal axis one can see the percentages of population categories with their type of coverage. Free care in this graph means care in public facilities and care without copayment. In reality, this straight line is a waved line because of the differences in services availability and actual access between Counties and for people, dependent of where they live and whether drugs and supplies are in stock in public facilities.

The ***fragmentation of prepayment schemes*** is one of issues when trying to achieve UHC. Other issues can be summarized as follows:

- The public spending on health is rather low
- The poor have very limited access and many people run the risk of impoverishment when in need of using health services. Funding sources, fund flows and pooling of financial resources are fragmented with 1 MOH, 47 Counties, an NHIF with two distinct risk pools and benefits package, and several private health insurers, all administering their own risk pools

- Health services are fragmented, not only in the common hierarchical order of primary, secondary and tertiary care but also in public and non-public, for profit and not-for profit health services providers and besides general population oriented (public) health services also with vertical disease oriented systems for e.g. HIV/AIDS, TB and Malaria. An effective working system of referrals to enhance efficient use of expensive and relative scarce resources is lacking.
- The distribution of staff & services over the country is skewed, mostly along urban/rural lines.
- The public health services sector has limited capacity to absorb higher budgets and provide more services. Scarce human resources and management capacity are some of the reasons for this.
- Uncertainty exists about the concrete effects of the devolution process and implementation and its effects on the health sector and especially on health financing.
- The costs of the Kenya Essential Package of Health Services (KEPH) were, and still are, not known.

Figure 1[8]

UHC-related indicator	Year	Value
THE per capita [1]	2009/10	USD 42.2
OOPS as % of THE[1]	2009/10	24.5%
GEH as % of GGE[1]	2009/10	4,6%
Catastrophic expenditures[2]	2007	14.8%
defined as: Health expenditure > 40% of non-food expenditure		
Skilled attendant at delivery[3]	2008/09	44%
Travel to health facility < 5km[4]	2008	89%

4. Agreements reached and disagreements noted

The 2012 P4H review team noted that, although dissenting opinions were noted on some points, agreement existed on many others as regards the further development of a 2010 draft health financing strategy, i.e. the need to:

[8] The references in figure1 relate to:

1. Ministry of Health (n.d.): National Health Accounts 2009/10.
2. Chuma, J. and T. Maina (2012)
3. Kenya Demographic and Health Survey 2008/09
4. Noor et al 2010

- Strive for universal health coverage and social health protection and the need for all Kenyans to join a prepaid health plan, paid from taxes and/or health insurance contributions.
- Improve efficiency, specifically as regards Public budget execution, the NHIF and health services providers.
- Implementing the recommendations of NHIF Strategic Review[9].
- Improve pooling and purchasing arrangements.
- Facilitate pluralistic services delivery, by public and non-public health services providers.
- Introduce some level of autonomy of public hospitals.

Several health financing strategy proposals were not met with consent, i.e.: ***differing views existed on***

- The introduction of a single pool and single purchaser of health services
- Making health financing schemes mandatory.
- The introduction of employer-based contributions.
- The introduction of new institutions, e.g. for determining the health services benefits and the tariffs of health services, and for revenue collection.
- The introduction of new special sequestered funds such as for HIV/AIDS.

This means that ***the main sticking points and hence the most important decisions to be made are related to the distribution and assignment of mandates as regards the decision making on and the implementation of the health financing functions and the way these functions are arranged and related to each other.*** Simpler said: it is all about the future health financing architecture or financing model and which institution does what and how the health financing market of health insurers will be divided. The possible options are discussed in the next chapter.

Of course, other issues are also important in the implementation of a new health financing strategy, e.g. ***the costs of the Kenya Essential Package of Health Services (KEPH***) derived benefits package matter for its inclusion in a health financing prepaid scheme, but whatever the results of a costing study will be, they will keep changing due to e.g.:

- The very inclusion as such of the benefits in a prepaid scheme and its impact on demand, i.e. materializing current latent demands, supported by improved health literacy;
- The establishment of health services capacity in areas were these did not exist or were not sufficiently available;
- Indication creep, i.e. using a medical intervention for other purposes outside its initial and cost-estimated medical indication.

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

So, what matters more than a list of prepaid benefits is to decide on the criteria and on having the tools for adjusting the benefits package or list of covered interventions, for cost containment and quality assurance of listed services irrespective of the legal status of services providers, for controlling admin costs and for assuring that the health functions are implemented as intended and in accordance with the set rules, i.e. having effective oversight, auditing and enforcement of good governance. These tools will determine the viability and sustainability of the future health financing system,

5. Options for the future health financing architecture

Core functions

A number of options can be considered and one of these options preferred to become the model for the future health financing architecture of Kenya. The options are distinguished by the different choices in assigning to defined actors the core functions of health financing, i.e.

1) Identifying sources of finance,

2) Collection of resources,

3) Pooling of collected resources,

4) Where to post the pooled monies

5) Purchasing of services in accordance with:

6) A defined benefits package (BP), based on explicit criteria and situated in an explicit governance structure with defined procedures.

This latter concerns topics such as who will decide about contributions from different sources, such as general revenues, earmarked taxes, individual health insurance contribution and formal copayments as well as who decides on the health services or benefits package that will be covered from a defined scheme. Important aspects are also the issues that relate to ownership of public health facilities, to employment of staff in public health facilities, to devolution and the subsequent interpretation of the new mandates of Counties, MOH and other ministries and to the governance aspects of NHIF or more in general the policy making, regulatory and Monitoring and Evaluation (M&E) functions.

Although the above mentioned functions need to be linked to each other, it is not necessary to put these into one institution. Especially in mandatory health insurance and its impact on the health, the welfare and the economy of the Nation, the government has undeniably a role to play in deciding the BP, the sources of funding, the fiscal impact, the impact on labor costs and the social impact of employer and/or individual contributions. The government will care for getting the highest possible value for money out of the spent monies and therefore may want to assign the functions to get the lowest admin costs and the highest health services outputs and outcomes. This means that some functions currently

executed by NHIF and its possible successor(s) can be better assigned to institutions that can do it cheaper, have a broader reach or make regulation and supervision simpler, i.e.

- Collection of contributions can be left to the Kenya Revenue Authority (KRA), which has also taken up the collection of general social charges while reducing costs

Assigning functions to actors

To this end and from a strategic view, the assignment of functions to actors and the regulation of these functions, procedures to follow and criteria to be used are more important than the actual content of e.g. a benefits package or the percentage of wage based contributions. These strategic functions should figure in the proposed National Health Financing Strategy and subsequently figure in proposed framework legislation assigning the mandates but leaving the details on e.g. the listing of covered KEPH interventions and the contribution rate to the mandated actors. Regulatory functions such as licensing of insurers, financial and functional auditing of actors, licensing of health services providers, external quality assessment of providers, protection of consumers/patients and the establishment and implementation of conflict resolution and arbitration mechanisms are not in themselves decisive for the health financing architecture but these aspects create the environment within which health financing can function effectively if well formulated, participatory and enforceable.

One of the biggest and possibly most controversial challenges in ***assigning mandates is the alignment of a centralized prepayment scheme such as NHIF with devolved ownership and payment of health services by Counties***. From a purely analytical and rational viewpoint, criteria such as simplicity and hence low admin costs, preventing potential conflicts of interests, de-fragmentation of health financing functions and health services while creating the most cost-effective purchaser of health services would matter most. The options presented hereafter offer different solutions for the alignment of these potentially conflicting mandates.

Population oriented services

In line with the draft National Health financing Strategy to separately pool money for public health, for all options presented hereafter it is recommended to have community/population-oriented health services, e.g. health protection, health promotion and disease surveillance financed directly from general revenues via MOH and the County Health Departments as most other countries do. Health insurance focuses on individuals and their entitlements while these individuals will not demand protection of the collective.

Private insurers are not interested in prevention of which the results may take years to materialize and the insured may already have changed insurer and the fruits of prevention are reaped by the successor insurer. However, it can be decided to finance population oriented services from a health insurance contribution based fund to which also private insurers can be demanded to pay via mandatory cross-subsidization. In such situation, based on MOH public health policy, MOH and Counties would decide what population based activities can be undertaken within the given budget framework.

Splitting and subsequently integrating current vertical systems for e.g. HIV/AIDS, TB and Malaria in regular public health and personal health services can be considered and hence financed through the different channels for these two different types of services.

Modalities of some health financing functions can to some extent be separated from some of the most crucial decisions on the assignment of main mandates which MOH may first want to get clarity about.

Reference points

The options for the different possible health financing architectures provided hereafter are constructed taking into account:

- The current health financing landscape and its different actors.
- The health sector and public finance aspects of devolution.
- The Government's policy objectives as regards the health sector, especially striving for UHC and improving the health of the Nation.
- The agreements reached among stakeholders about the future health financing strategy as identified in the P4H supported external review[10] of the draft Kenya health financing strategy[11].
- International experience and best practice.

Criteria for assessing the options

The different options are assessed against criteria such as:

- The extent to which an option can support achieving UHC, equity in financing and equality in access to quality care for the population.
- The level of effectiveness and efficiency of administration for financiers and health services providers. Related to this is the possibility to keep the number of policy and admin institutions as limited as practical and legally feasible and especially avoiding the establishment of new ones which will require capacity building activities. Cost-effectiveness, added value and good governance should be the principles to apply when deciding new institutions and merging current ones.
- The extent to which the option contributes to and/or creates optimal conditions for effectiveness and efficiency in care delivery.
- How well the option is positioned to assure overall cost-control and quality improvement in health care.
- The chances the option would promote good governance, i.e.
    - Provides a clear description of responsibilities of actors, without overlaps and potential conflicts of interests between actors in health financing and care delivery.
    - Transparency in operations

[10] Providing for Health: Kenya, Draft Health Financing Strategy; Report of an External Review, 8 May 2012,
[11] Ministry of Public Health and Sanitation & Ministry of Medical Services: Accessible, Affordable and Quality Health Care Services in Kenya. March 2010.

- Accountability of actors
- The ease with which it can be implemented, taking into account the management capacity of involved actors and the possible uptake by the population and the patients among them.
- The flexibility to adjust to changing needs and circumstances.
- The likelihood of acceptance by main actors. However, as already mentioned in the P4Hreview, not all stakeholders can always be pleased to the same extent. Sometimes, tough decisions are needed.

The Options

The different options possible to be distinguished follow hereafter and are described with a focus on actors and the changes to be made in their mandates.

Option 1: Evolutionary model with split responsibilities re health services financing

This option gradually evolves from the existing situation and has:

MOH focusing on policy making, regulation and M&E which are core stewardship functions of a ministry of health in any country. Other functions such as health services delivery can be left to either publicly or privately owned health facilities or to both. However, in option 1 MOH continues to own and operate tertiary care/National hospitals.

To assure access for the poor and near poor to tertiary care, ***NHIF*** will be assigned in this option with this responsibility and needs to be subsidized from the General revenues and for the time being from available and dedicated donor funds. NHIF will create a special pool for this function. Over time, when the benefits for the poor are gradually broadened and deepened, this special pool can be merged with NHIFs other pools for its general and civil services members into a single pool. This will be dependent of the growth of funds available for the poor while as soon as possible freezing the current benefits packages of the two schemes the NHIF is currently running. This would speed up the process of merging pools and prevent further widening of the equity gap in access to care. Obviously the current interventions of which the two current schemes are composed can be replaced for more cost-effective ones if this could be done with macro-budget neutrality for NHIF.

Counties are **providing and purchasing,** i.e. owning and funding, primary & secondary care via public service providers in their respective areas. To assure access for its residents, Counties will allocate significant resources to the health sector from their discretionary budgets.

Although not strategically important at this moment, Counties are proposed to shift to output oriented financing of primary and secondary health services through capitation and incentives. Incentives can be flexibly attached to different searched for outputs. However, infrastructure and e.g. ambulances will also need to be maintained and funded, which cannot be purely output based. It is more important that Counties have the mandate to choose and vary payment schedules, incentives and incentive levels for paying staff in public health facilities and of contracted private ones in order for the counties to adjust the schedules and incentives as needed for facilitating cost-effective services delivery by particular categories of providers and to avoid adverse incentives. Counties can be supported by MOH and/or a

dedicated tariffs setting body, which would need to be established for such role and could serve the public and private markets.

The NHIF covers **all residents** in the County, but purchases **tertiary care** services only for all residents and other services only for its members according the schemes they are enrolled in.

Private Health Insurers (PHI) will continue offering policies as current, possibly **duplicating** some public cover. However such duplication leads to extra revenues for health facilities.

Similar to other options and irrespective of the breadth and depth of the benefits packages of different payers, these packages will need to be sharply delineated from each other to avoid confusion for beneficiaries of one or the other scheme and for the providers about who covers and reimburses which medical interventions and to prevent arbitration and other legal procedures.

Pros and cons

On the **pro side** of this option, one can consider at first sight the limited demands for extra capacity because of the limited changes in the overall health financing structure. Hence, this option can be quickly implemented. Some actions are already taken in this direction with the establishment of special funds to pay services for the poor and for specific health conditions.

Since this option comes with limited changes in the current distribution of mandates, it will meet little resistance from current actors and vested interests.

However, on the ***con-side:*** this option comes with multiple relatively small risk pools, i.e. of 47 Counties besides MOH, NHIF and several private health insurers. Thus this option shows limited solidarity between the people belonging to the different risk pools and hence limited equity in paying for the services unless there is an equalization mechanism and cross subsidization between the different risk pools. As a consequence of these many pools there will be multiple purchasers. The fragmentation of pooling and purchasing will in turn lead to fragmentation of care, e.g. between PHC and secondary health care (SHC), resulting in suboptimal quality of care and inefficiencies in care delivery and admin. There will not be a single purchaser overseeing all possible steps in a patient career from PHC till tertiary health care (THC) and reviewing the appropriateness of referrals, timely back-referrals and the care provided on each level.

The different financial actors and the providers contracted by them may be tempted to shift costs to another payer and level of care by referring the patients unnecessarily, hence not contributing to effectiveness and efficiency in care delivery and patients running the risks of bad quality.

Because the benefits package of NHIF for members of the civil services and the like, e.g. defense and police forces, contains secondary and primary care services this overlaps with the services covered by the Counties. However, this particular category of NHIF members has currently preferential access to services and hence comes with the risk of reducing access for other residents, dependent of provider capacity.

In order to overcome the above problems and to contribute via this option to UHC this option will require substantial capacity to organize and secure good governance, to assure value for money for payers and consumers of health services and to implement an equalization mechanism between the Counties. Such equalization mechanism would need to separate investment funding and funding of operational costs. Under-resourced Counties should get priority in expanding their services to reach the same levels as high resourced ones. The increase in funding of operational costs should keep pace with the increase in service availability.

Option 2 NHIF purchases secondary and tertiary level hospitals for current non-members

MOH and Counties, similar to Option 1 and all other options, fund all population-oriented health services and need to allocate sufficient resources dedicated to public health interventions.

MOH focuses on policy making, regulation and M&E and operates tertiary care hospitals. It provides subsidies to enroll the poor in NHIF for tertiary care coverage only.

MOH regulates and continues to own tertiary level hospitals. The services of these hospitals are purchased by NHIF in accordance with the determined benefits package(s), carved out of KEPH, and available to residents, dependent of their enrollment status.

Autonomy. Public hospital management will become sufficiently autonomous to allow efficient use of resources and act as capable contracting partners of NHIF and of PHI in the contracting process, in contract implementation and in services delivery, i.e. facilitating a purchaser-provider split and leaving the purchasing of all non-population based services conform KEPH to NHIF. Thus will help avoiding possible conflicts of interest and increasing the chances of effectively using purchasing tools, such as selectively contracting providers, selecting their services to be delivered to their beneficiaries and reviewing the legitimacy of the used services and the appropriateness of the care provided.

County budgets are split into four different parts. First - a fixed amount for population oriented health protection and health promotion activities; second – a variable part for contracting NHIF to purchase services from district/previous provincial hospitals; third - a fixed amount for basic service provision at Health Posts (HPs) and Health Centers (HCs) based on capitation; fourth - a variable amount for performance-based payments to HPs and HCs.

NHIF continues to offer the same comprehensive benefits package to the categories of members belonging to the civil services and defense/police forces; and its secondary level care package to its other members. In order to gradually realize equity in access to quality health services, the comprehensive package should be frozen except for those interventions that replace more costly ones. Same for the secondary level package albeit that the use of the services as included in this package should be controlled by a referral system, combined with a sizeable copayment for self-referrals, and close collaboration of counties and NHIF.

PHIs are supposed to continue their activities and their prospects are not influenced by this option which is focusing on the poor and informal sector albeit that counties and public insurers can possibly make use or contract the admin and management capacity of private insurers.

Contracting NHIF to purchase on behalf of MOH and Counties, except PHC
According to current policy, Health Dispensaries and Health Centers are to be used free of charge in the counties. Using NHIF for these services as purchaser has limited value although it would facilitate the claims review role of NHIF and help it to assure appropriate use of health services by the county residents. However, an overhaul would be needed to shift this responsibility from counties to NHIF. For the time the NHIF could focus on purchasing outpatient specialist level and inpatient care from the district hospitals. For most services at this level it should be possible to distinguish a limited number of service categories and list the interventions to be provided, e.g. based on recent costing by the German Development Corporation (GIZ) and/or the USAID funded Health Policy Project (HPP). If reimbursements are only provided in case a – eventually tentative - diagnosis and where relevant a treatment plan is provided in a claims form, improved data would be generated to allow further refinements of the payment schedules e.g. towards a case-based, episode based or DRG-like system. Counties would need to employ or contract in or out at least one staff to work exclusively on forecasting volumes of hospital service demand – i.e. an epidemiologist/health economist. Such expert(s) should collaborate closely with a counterpart at NHIF or its successor(s) to get on "the same page" and avoid differing opinions afterwards.
Importantly, initially, the NHIF would not have a role in purchasing primary /secondary care, at least not for all, i.e. NHIF will have to do this for its civil-services enrollees for PHC/SHS and for its other members for SHC. Whether the NHIF is to continue purchasing PHC/SHC for some of the categories of its enrollees needs to be discussed. An argument against it would be consistency of the system avoiding preferential treatment of these. At the same time, if the NHIF only pays PHC & SHC for civil servants and some other categories of members and no one else, the budgetary consequences of double payments may be limited and a reform should not stall on this.

Virtual County budgets for their health facilities.

At the same time, all lower level facilities should receive a capitation-based ***virtual budget***, incl. all recurrent expenses (an open question concerns the payment of salaries to health staff: if it is included, facilities that are understaffed could use unspent budget for salary top-ups and overtime payments to incentivize improved service provision; at the same time, it can also be excluded, i.e. handled directly by County, if there are overriding governance concerns). The value of delivered drugs would be deducted from the virtual budget. The balance and the remaining allocation for other running expenses would be paid to the facility, enabling it to purchase minor maintenance services as well as drugs and supplies when faced with approaching stock-outs at the public provider. One could also include supervision visits in the virtual budget of facilities - facilities would only be charged for supervision actually carried out. Else, they would have additional budget (and the county health management team a reduced budget - creating incentives to actually provide supervision). Enrollment for the capitation system could be

initially residence-based. This could (especially in urban areas) later be changed to open enrolment by choice. The tool to provide pay-outs to facilities would be for the time being the HSSF. This can be transferred to a national or regional single (national or regional based) pool agent, e.g. a reformed NHIF.

When the reformed NHIF or its split-offs are capable of adequate purchasing of hospital-based services counties can/should decide to contract the NHIF or its regional split-off for further services to optimize purchasing and making health service delivery more efficient. Optional packages could be (1) inpatient services at HCs, (2) ambulatory services in HCs, (3) all remaining primary services. Regulation of these service packages would be the task of the MOH. This option would be for individual counties, it would not be strictly necessary that all or several counties would join at the same time although it can be seen as preferable for reasons of admin efficiency and to facilitate cross-county care. Each joining county would enter the same and hence unified risk pool. At the same time, a tipping point should be defined when remaining counties have to join, to avoid that the healthiest or otherwise richest and administratively most versed counties permanently out of the solidarity risk pool. Equally one could define a minimum number of counties to start the system with a minimum size to enjoy the economies of scale. For the high volume, low cost interventions at primary level, risk pool size does not seem overly important for its financial stability although it remains for income redistribution/progressivity and for allowing the higher remuneration of staff in remote and otherwise understaffed counties. Including private facilities in the publicly paid P/SHC system would depend off the need for these facilities to provide the set benefits package and list of h ealth interventions to the eligible population. If one would like to have the performance incentives of competing providers, this system is difficult.

Performance-incentives

Counties would budget a fixed amount related to performance indicators at facility level, in line with the current state-of-the-art research on performance based financing (PBF) and with the admin capacities of the counties while those services that are not under the microscope for PBF should not be ignored and also monitored. Apart from incentives for quantity and quality of policy priority services, there should also be incentives for data provision to increase options for changes in payment mechanisms in the future.

Option 3 *NHIF single purchaser with mandatory enrollment of all residents*

This option concentrates all purchasing responsibility for KEPH related benefits at a National Health Insurance Fund. The health financing architecture will incorporate a thoroughly reformed and re-regulated National Hospital Insurance Fund, the current “NHIF” as regards its mandate, its governance and the way it implements this revised mandate. To avoid confusion the national health insurance fund can also be named National Health Insurance Trust.

MOH and Counties, similar to Option 1 and all other options, fund all **population-oriented health** services and need to allocate sufficient resources dedicated **to public health interventions.**

Counties continue to own the PHC and SHC health facilities on their territory

MOH formally owns *referral facilities.*

> ***Autonomy***. Public hospital management will become sufficiently autonomous to allow efficient use of resources and act as capable contracting partners of NHIF in the contracting process, in contract implementation and in services delivery. This option and the proposed autonomy for public hospitals will facilitate a purchaser-provider split and leaves the purchasing of all non-population based services as derived from KEPH to NHIF. Hence it will help avoiding possible conflicts of interest between owners, i.e. MOH and Counties, the purchaser and increases the chances of effectively using purchasing tools, such as selectively contracting providers, selecting their services to be delivered to their beneficiaries and reviewing the legitimacy of the used services and the appropriateness of the care provided.

MOH will subsidize NHIF to have it cover the referral facility and tertiary level services, including the National Hospitals to be used by the poor and to guarantee access for the poor and near-poor to these services.

PHI would have only a complementary and supplementary insurance role, i.e. cover benefits outside of the KEPH related national benefits package for all and the package for the mandatory insured civil and military/enforcement services staff; residents should not be allowed to opt-out of the NHIF for the national BP. Such possible opting out would undermine solidarity and weakens the financial basis of NHIF and leaves it with the relatively bad health risks because it will be the healthy and wealthy that would opt out.

So, in this option ***NHIF*** will be the **single purchaser** for all individual-oriented (primary to tertiary) prevention, cure & care, as included in the KEPH related BP and made accessible for all its categories of enrollees.

Changing the Mandate, Structure and functioning of current NHIF and its regulators.

For this far reaching option to happen not only the legal mandate of the current NHIF will need to be changed from “hospital” to general health insurance but also its governance structure and the way it operates to become a trustworthy, effective and efficient financier of health services in which Counties, residents and health services providers will recognize a reliable partner. Essential elements in such revamping of NHIF are:

- An independent (of NHIF) working health services accreditation body for all health facilities, including the private ones. A possible choice for the Kenya National Accreditation Services (KENAS) should be based on an assessment of its capacities and performance.
- A limitation of admin costs to maximum 10% of benefit costs. Investment costs would need to be amortized.
- Gradually selling all fixed assets within a set time frame and revenues used for subsidizing the poor and/or expanding the BP for them.

- Establishing a professional Board and professional and competent management of which listed decision categories will need the approval of MOH and/or other Ministers to allow for a purchaser/provider split and at the same time for government control of essential health, economy and public finance related aspects of NHIF without interference of the ministries in NHIF's daily activities. Social partners, i.e. employers and employees, agricultural entrepreneurs, consumer organizations and health services providers can propose their representatives in an advisory board. MOH and County representatives should not be members of the NHIF Board to avoid conflicts of interests because of their ownership of health facilities.
- The CEO of NHIF needs to be competitively selected, based on an explicit job profile en specified search and past-performance criteria and, after appointment, periodically assessed against explicit future performance criteria allowing for continuation or ending of assignment.
- NHIF should establish an independent – of the line organization- internal financial control unit, directly reporting to the Board.
- Board members and key management and staff and their families should yearly declare their assets, to be disclosed online and in line with applying the principles of e-government.
- NHIF should disclose periodically all decisions and financial transactions online.
- An effective health management information system (HMIS) is key for the performance of NHIF. It should be complemented by HMIS at the provider level.
- A reformulated mandate of the Insurance Regulatory Authority (IRA), specified for health insurance in general and social health insurance in particular, allowing for financial and functional auditing of NHIF and PHI, possibly done in collaboration with the Auditor General. Such reformulation should be based on a functional assessment of IRA's current mandate and performance and on IRA's newly to be established mandate.

Pros and cons of option 3

Option 3 has the ***advantage*** of the clearest separation of mandates between the different actors and avoids inbuilt potential conflicts of interest, thus creating the best possible environment for good governance of the health financing system.

It will have one ***national single purchaser with mandatory enrollment*** for all residents and coverage of a BP as explicitly decided and over time possibly gradually expanded. MOH owned hospitals will become autonomous, hence facilitating a purchaser-provider split and leaving the purchasing of all non-population based services conform KEPH to NHIF, thus avoiding possible conflicts of interest between MOH and Counties as owners and providers of services on one side and the purchaser, i.e. the NHIF on the other side. It increases the chances of effectively using purchasing tools, such as contracting selectively providers, selecting their services to be delivered to their beneficiaries and reviewing the legitimacy of the used services and the appropriateness of the care provided.

This option allows for ***purchasing of health services in the most cost-effective way***, i.e. across all levels of care and irrespective of the place where people live and/or work. The health insurer can look at the

health services consumption of its enrollees not only with contracted providers, in contracted health facilities but also across facilities and review provider performance, including appropriateness of referrals.

It allows also for the ***lowest admin costs*** on condition of a suitable structure of the reformed NHIF, and strengthened oversight/regulation, as indicated in the above.

This option will further ***concentrate the scarce health financing management capacity*** in Kenya

Counties focus in this option on ***public health*** and will as owners take care of the health services infrastructure. They will further act as their resident's ***advocate*** in their contacts with NHIF and MOH in order to assure sufficient funds, health care services capacities and hence in budget and services planning. The concentration of the Counties on population based health services, including on disease surveillance positions the Counties excellently for performing their ***planning roles***.

This means all in all that ***Counties will not face governance and management capacity problems and less coordination problems*** because they can leave the burden of purchasing and provider review to NHIF. Counties can concentrate on other policy areas shifted to them in the framework of devolution, including population based health services.

Cons

This option comes with the strongest shift in mandates, for MOH, Counties and NHIF. So, the potential ***disadvantages*** of this option are possible opposition by the Counties because of having to leave a part of their just gained mandate to NHIF besides a possible interpretation of this option as conflicting with the new Constitution. However, if Counties would cede voluntary their mandate to NHIF via e.g. a collective contract then there is no reason to actually manifest this potential conflict.

Another potential disadvantage and risk is the creation of a big insurance Moloch having a near monopoly, also vis a vis the health services providers, including the private ones: the for-profits and the not for profits and faith based organizations (FBOs). This problem can be solved by:

- Changing the governance structure of NHIF as indicated above;
- Strengthening the oversight and auditing of NHIF;
- Establishing transparent procedures and explicit criteria for the selective contracting of providers, accompanied by an effective and fast working conflict resolution mechanism;
- Similarly establishing a complaints handling and appeals mechanism for the members to solve conflicts about benefits access and contribution payment;
- Leaving accreditation to a designated body outside NHIF while NHIF obviously can take a provider's accreditation status into account in its contracting such provider and in selecting providers to be contracted or prolonging their contracts;
- Leaving contribution collection to KRA and
- Posting the collected monies at the Treasury/National Bank of Kenya.

Such slimming down of NHIF would also reduce its admin costs and its overall burden and it would facilitate it in expanding its enrollment and purchasing activities and hence making it suitable to play its role as single purchaser. Obviously, NHIF would need to have a sufficient number of satellite offices, distributed over the Country and with at least one per County.

Option 4: MOH & Counties contract NHIF to purchase personal health services for all residents

The difference with Option 3 is that the expanded mandate of NHIF is not based on change in the legal basis of NHIF but on contracting by MOH and Counties.

MOH and Counties, similar to Option 1 and all other options, fund all **population-oriented health** services and need to allocate sufficient resources dedicated **to public health interventions.**

MOH focuses on policy making, **regulation** and M&E and operates tertiary care hospitals. It provides subsidies to enroll the poor in NHIF for tertiary care coverage only.

Counties provide (operate & own) primary & secondary care. They contract NHIF to execute on their behalf the purchasing of PHC & SHC services from public and private facilities on their territories.

County budgets for NHIF purchasing are to be based on price and volume of services.

Based on their contract with NHIF, Counties subsidize NHIF to enroll the poor in NHIF – to cover primary and secondary level care.

All residents have to mandatory enroll in NHIF irrespective of their employment status**.**

The above health service financing arrangements result in NHIF covering all residents of Kenya and in NHIF purchasing services at all levels of care in accordance with the KEPH derived BP.

PHI continues offering policies as current, partly duplicating the public system. However this can only generate more revenues for public health facilities and is thus a way of unregulated cross-subsidization.

Pros and Cons

This option may be perceived as paying more tribute to the devolution consequences than Option 3 because Counties are in the driver‘s seat as regards possibly contracting NHIF and negotiate the terms of the contracts on behalf of their residents

Continuity of care is better assured and can be better monitored than under Option 1.

Cons

This option comes with multiple pools and thus with fragmentation, possibly decreasing efficiency. But the possible negative effects of such multiple pools are to some extent prevented by Counties collectively contracting and using NHIF as independent purchaser.

A further ***disadvantage*** is the absence of influence on county budgets to be made available by the Counties to the NHIF. Counties may not allocate sufficient staff to achieve quality care. However, adequate M&E by MOH and benchmarking of Counties by NHIF and subsequently informing Counties and other stakeholders may convince the sub-par funding Counties to make more budget available.

Another disadvantage of this option can be the limited capacity of Counties to accurately forecast the necesary level of health expenditure for their County. However, NHIF as County partner can support the Counties with providing information on previous health services consumption and supporting Counties with actuarial expertise.

Option 5 Regional Public Insurers assure access to KEPH and more

MOH and Counties, similar to Option 1 and all other options, fund all population-oriented health services and need to allocate sufficient resources dedicated to public health interventions.

MOH focuses on policy making, regulation and M&E and operates tertiary care hospitals. It provides subsidies to enroll the poor in NHIF for tertiary care coverage only.

MOH regulates and owns referral facilities

- Also an additional option for autonomous management of hospitals can be established.

MOH regulates the national benefit package (reflecting KEPH), allowing equal access, and premiums to be paid by the formal and informal sector people. These premiums should be national income dependent premiums which enhance equity in financing. However, as mentioned in the 2012 P4H review, a regional differentiation of the contribution rates can be considered during the period in which there are substantial differences in services availability and hence the insured cannot enjoy their entitlements in case of medical need in a specific region. Such period would preferably be as short as possible. Regional differentiation will increase the admin costs for the collecting authority, for NHIF and for IRA and other auditors and regulators.

Counties contract the regional insurers

- County health budget for insured care depends of estimated volume/price of insured services. It is in this option not a discretional decision of the Counties, the estimated and agreed services needs and hence costs will need to be covered.

Autonomous regional public insurers are contracted by groups of counties to

- Offer national standard package; based on national premium, assuming that the services as listed in this package can be made accessible all over the country, possibly by mobile clinics and/or reimbursing transport costs if no other options in the region of the insured exist.
- Cover formal & informal sector.

PHI offers voluntary insurance duplicative (overlapping KEPH), complementary and supplementary services

National catastrophic and equalization fund. This option will require a national institution, e.g. the successor of the NHIF to distribute the monies over the autonomous regional funds, i.e. also this system would need a health-risk equalization system though less complicated than in option 3 and it can deal with localized catastrophes and with differences in health risks and hence costs of Counties.

Pros and cons

This option will not be perceived as the Moloch, possibly perceived in Option 3.

It will offer the possibility of benchmarking of the regional insurers on e.g. efficiency in operation, client orientation, effectiveness of purchasing and hence be used for efficiency improvement and client orientation and satisfaction.

It may be perceived as closer to the Counties and more aligned with the devolution principle although perhaps not wholly in conformity with the new Constitution. This aspect possibly deserves attention of a national legal expert in constitutional law and in the legal positions of Counties and National bodies.

This option does not come with the negative side effects of competition.

To make this option work, the county health facilities should be granted some level of autonomy to facilitate the purchasing function of the regional insurer.

Disadvantages of this option are that it comes with high capacity needs of insurers and counties. Although the regional insurers can be established on the basis of current branch offices of NHIF and supported by the successor of NHIF on the national level, they will nevertheless need competent management, financial management, purchasing and actuarial capacity.

This option generates many small risk pools at insurers and hence fragmentation of resources and risking less efficient care, especially as regards care across the regions and the use of national hospitals. It will also come with higher admin costs and general more admin costs on the national level though benchmarking may prevent/counter this possible effect.

It will need an ex-ante and ex-post equalization system and extensive regulation. The equalization system will be less complicated than the one for Option 3 because there is no chance of risk selection by the insurer. However, regional insurers and counties may be inclined to fully spend their budgets in order not to see these decreased the following year. Such inclination may lead to ineffeciencies in care

delivery and creation of different remuneration levels, not conducive for better staff distribution over the country. So careful auditing of financial and functional performance of the regional insurers will need to take place to check the legitimacy of expenses and of the appropriateness of financed health services. This will also form the basis for the conclusion of the equalization (ex-post) process after the equalization year has ended.

Option 6: NHIF and private insurers compete to assure coverage of KEPH based BP

MOH and Counties, similar to Option 1 and all other options, fund all population-oriented health services and need to allocate sufficient resources dedicated to public health interventions. Although Counties have a constitutional role to play in the health sector they are best suited to participate in community oriented public health. To the extent that health professionals need to be engaged, this would be most cost-effectively done by staff already working in the clinics, health centers and hospitals in the County. This implies also the integration of vertical programs, partly in public health and partly in individual oriented health.

MOH focuses on policy making, regulation and M&E and operates tertiary care hospitals. It provides subsidies to enroll the poor in NHIF and possibly also in licensed PHI for tertiary care coverage only.

MOH regulates and owns referral facilities

- An additional option exists for establishing autonomous management of hospitals (see option 2)
- In this option, MOH will refrain from direct control of health care facilities and of purchasing and paying health services.

A purchaser-provider split will be realized, avoiding possible conflicts of interest and increasing the chances of effectively using purchasing tools, such as contracting selectively providers, selecting services and service volumes to be delivered to their beneficiaries and reviewing the legitimacy of the used services and the appropriateness of the care provided.

Counties own county health facilities and pay **population-oriented health** services,

- Their allocations are limited to **public health interventions**

NHIF, will become a national ***health*** insurance fund and **one of several** purchasers for individual-oriented prevention, cure & care, as included in KEPH

- Increased allocations will be necessary to finance primary & referral care, subsidize the poor. To create a level playing field, private health insurers would also need to receive subsidies to enroll the poor.

- ***Private health insurance*** competes with NHIF in insuring the KEPH derived BP

Competition between health insurers, perceived as a way to not only enhance efficiency and client orientation but ***also to achieve UHC***, means that several conditions need to be set for this option to prevent risk selection and risk rating by insurers and hence reducing access for the less healthy and less well off. See special section hereafter.

Competition between Health Insurers[12]

Several countries have embarked on using competition between mandatory insurers and hope that this works as an instrument for improving client orientation and efficiency in health insurance administration and the delivery of health services as included in the legal BP. However, the supposed effects on efficiency have never been proven and have shown to be difficult to evaluate due to many concomitant other interventions in country health systems[13]. Given the market failure in health care as regards guaranteeing access to basic care, countries that care for access and affordability of care have regulated the competition of health insurers.

Challenges

Those countries that have embarked on competition between insurers in the implementation of mandatory health insurance have been faced with many challenges, most of all with the problem of risk selection by insurers, also called "cream skimming". To stay within their budget, risk selection is easier to do than trying to reduce health services expenditures by improving efficiency of health services providers via purchasing and in-depth provider performance review. It is for the insurer a more effective and efficient policy to stay within budget and prevent premium increases and losing out in the competition. However, ***risk selection reduces access to health insurance and hence to health care for those most in need.***

Risk selection comes in many forms, e.g.:

i. Selective marketing by focusing on the relatively healthy, e.g. the young, the well off and going for collective contracts with enterprises in non-health-risky sectors, and avoiding a focus on the high risk categories: elderly and chronically ill.
ii. Selective contracting, e.g. not with medical specialists preferred by the chronically ill.
iii. Using enrolment barriers to supplementary insurance to fend off the chronically ill, in case statutory competing insurers are allowed to also offer voluntary insurance for which they can do risk rating and excluding the high health risks.
iv. Giving discounts on other insurances, offered in a package together with health insurance, especially via collective contracts with companies

[12] This section draws heavily from the articles of Van de Ven and Thomson and from the study of Schneider, quoted hereafter as well as from the personal experience of the author of this report while he was working in the Dutch health insurance system from 1981 till 1998, and a later study of him on "Risk adjusted funding in the Netherlands, Bultman, World bank, December 2004. This section is earlier used in a modified version to discuss the health insurance market structure options for Tanzania.

[13] Thomson, Sarah et al. Statutory health insurance competition in Europe: A four-country comparison. Health Policy, 1020130 20-225

Pre-conditions

To respond to the posed challenges several conditions need to be met, which e.g. neither Belgium, Germany, Israel, the Netherlands and Switzerland have done yet in full despite many years of implementation of a system of competitive health insurance. See annex x for more details on competition based health insurance.

a. Meeting these conditions is very demanding for a health insurance and health services system and are costly to meet (see annex X)

Competition tools

Assuming that all conditions are met, the following instruments can be used by the insurer as instrument for competition and to distinguish itself from its competitors, if the regulation grants these tools or doesn't prevent their use::

i. Selective independent purchasing by an insurer of a sufficient number of providers to allow access to necessary care for its insured and using with all possible purchasing features as described above. This does not mean that insurer and providers need to become adversaries. The insurer can reward good performance of providers which offer good quality care, from a professional and a patient perspective. In e.g. Belgium such independent contracting does not exist, all contracts are centrally negotiated. The trade-off in selective purchasing can be the lack of trust in the insurers among insured who fear that they may lose their favorite provider or particular doctor
ii. An alternative to purchasing is the integration of health services providers into the health insurer as is done by Kaiser Permanente[14] in the USA with mixed success[15] and is also allowed in the Netherlands.
iii. Giving free choice of provider to the insured. This obviously contradicts the selective purchasing power of the insurer.
iv. Giving an insured the choice between an in kind system and a reimbursement system, the latter more costly to operate.
v. Offering additional benefits on top of a defined minimum package, which is not a supplementary insurance with additional premiums.
vi. Offering different levels of general deductible to insured within legally set margins.
vii. Being the advocate of the insured, e.g. in finding suitable providers in case of long waiting times for elective treatment.
viii. Being friendly to its insured in explaining his rights and obligation, and being easily accessible.
ix. Charging a low contribution rate to insured.
x. Offering an attractive supplementary insurance. However, if not regulated, insurers can do risk rating and/or exclude people from access to this insurance, thus reducing the possibility for those people to switch insurers and consequently limiting competition.
xi. Offering discounts on other products the insurer may have on offer.

Obviously, purchasing tools will only work if insurers have the freedom to contract or not to contract and if providers have some level of autonomy to respond to the challenges of purchasers and to improve the quality and cost-effectiveness of their services. Selective purchasing presupposes also some

[14] see http://www.kaiserhealthnews.org/?utm_source=khn&utm_medium=internal&utm_campaign=nav-bar
[15] Abelson, Reed. The Face of Future Health Care New York Times, March 20, 2013; http://www.nytimes.com/2013/03/21/business/kaiser-permanente-is-seen-as-face-of-future-health-care.html?pagewanted=all&_r=0

level of oversupply in order to have something to choose from. However, such oversupply comes at a cost, i.e. for additional infrastructure and training of staff, luxuries that are hard to afford in developing countries.

In case providers get their investments paid or subsidized by e.g. the government than they have less incentives to economize their care.

Countries differ as regards the extent they regulate competition and offering more or less instruments for insurers and more or less options for insured to choose from[16]. However, countries can adjust their systems based on evaluation results. Resistance from providers, secrecy from insurers and political opposition will impact regulation and its effectiveness. Differences on supply side regulation also have an effect on the regulation of insurers.

Risk adjusted capitation based funding of insurers comes also with many requirements (see annex x) to operate in accordance to its intention: adjusting for differences in the risks between insurers as regards the differences in the health status of the enrollees in their portfolios as to prevent risk selection and hence people with high health risks being left without health insurance or only on inequitable terms**..**

Despite the long trying to improve systems, especially information systems, and to meet the conditions, no system of ex ante risk equalization between insurers is able to fully predict the health risks, the best is explaining only a meager 22% of expenditures[17]. It took the Dutch 15 years to build a reasonable risk equalization scheme and to still arrive at such meager outcome of 22% prediction. This is caused by the complexity of such system, the vast amounts of required data, spread over 73 cost-categories, and the need to periodically update the set of parameters due to perceived unjustified budget distribution over the insurers because of not incorporated costs for unevenly spread high cost insured. That's why, besides ex ante also ex post equalization for high costs cases was introduced, further adding to the complexity of the system and hence its admin costs. The total cycle took in 2005 four years, from predicting the costs, setting the budgets for the different insurers, paying advances, auditing the numbers of insured and the designated costs, to adjusting the budgets based on actual numbers and acceptable costs and settling on the final amount. The imperfections in the equalization systems in the five review countries offer still substantial incentives for risk-selection by insurers[18].

Besides elaborating on an equalization system a decision needs to be taken on which institution will operate the system, complying with conditions:

1. Not implementing itself health insurance
2. Independent and impartial
3. Trustworthy for contributors and insurers
4. Necessary human resources capacity, infrastructure and business support systems.

In conclusion, using competition between insurers requires quite some regulations and regulatory and supervisory capacity and hence budget while the advantages as compared with a non-competition based system are thus far unproven (See text box 1)

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[16] Ven, Wynand van de. Ven, Wynand van de, et al: Preconditions for efficiency and affordability in competitive health care markets: are they fulfilled in Belgium, Germany, Israel, the Netherlands and Switzerland? Health Policy 109 (2013) 226-245.

[17] Schneider, Pia et al: Health Insurance and Competition. World Bank, Report N0.44316-ECA, May 5 2009

[18] Ven, Wynand van de. op cit

Text box 1

"In theory, health insurance competition can enhance efficiency in health care administration and delivery only if people have free choice of insurer (consumer mobility), if insurers do not have incentives to select risks, and if insurers are able to influence health service quality and costs. In practice, reforms in the four countries have not always prioritised efficiency and implementation has varied. Differences in policy goals explain some but not all of the differences in implementation. Despite significant investment in risk adjustment, incentives for risk selection remain and consumer mobility is not evenly distributed across the population. Better risk adjustment might make it easier for older and less healthy people to change insurer. Policy makers could also do more to prevent insurers from linking the sale of statutory and voluntary health insurance, particularly where take-up of voluntary coverage is widespread. Collective negotiation between insurers and providers in Belgium, Germany and Switzerland curbs insurers' ability to influence health care quality and costs. Nevertheless, while insurers in the Netherlands have good access to efficiency-enhancing tools, data and capacity constraints and resistance from stakeholders limit the extent to which tools are used. The experience of these countries offers an important lesson to other countries: it is not straightforward to put in place the conditions under which health insurance competition can enhance efficiency. ***Policy makers should not, therefore, underestimate the challenges involved****."* (bolds are from the author of this report)

Thomson, Sarah. op cit

implement an equalization mechanism between insurers.

- It also comes with a big shift of mandates for counties, MOH, NHIF, PHI and IRA or another regulator.
- The regulatory costs will be highest of all options
- The risks of this option as regards achieving UHC in a cost-effective way are high and the chances of risk-selection cannot be ignored and difficult to prevent and/or to correct.

6. The options compared

Hereafter follow in table 2 the 6 discussed options, presented with their pros & cons and strengths & weaknesses indicated. Attention is paid to the main elements of the models and the criteria by which these can be evaluated and valued, especially as regards equity (solidarity) in finance, equality in access, cost-effectiveness of administration, promotion of cost-effectiveness in services delivery, viability and ease of implementation.

All options have a number of similar and important elements, some of which are crucial for the success of the models. So, a choice for one of the options should go together with decisions on the items as reflected in the first column of the table. Providing the necessary tools related to some of the elements is not as such part of the health financing architecture but nevertheless critical for the success, viability

and sustainability of the preferred model and these tools would need to become available even if no decision is made on the HFS and any of the models. So, the appropriate actions on the first column elements make up also the conditions for the success of the future system.

The details and discussion of the options can be found in the previous chapter.

Because at this stage the models are not yet discussed with the stakeholders and no social assessment is done, it is a bit speculative to indicate the acceptance of the different models. However, the given appreciations are the author of this paper's best guesses which may act as incentive for underpinning and reflecting the actual mood of the different stakeholders.

Table 2 Pros & Cons/SWOT of options, proposed for consideration

Options	**1**	**2**	**3**	**4**	**5**	**6**
All Options have elements as indicated below	**Evolution model**	**NHIF complements Counties model**	**NHIF for All model**	**County NHIF contract model**	**Regional public health insurers model**	**NHIF &PHI competion model**
Population based services paid from general revenues via MOH/Counties; **Individual services** paid from mix of GOVT Budget & insurance contributions Cover KEPH derived **dynamic BP**; Have **poor as 1st priority;** Need **cntd public funding**; **Freeze current NHIF BP**; Improve **equity in funding** dependent of imposed resource structure & cross subsidization; Are **viable & sustainable** dependent of governance & granted cost-control tools; Need **governance improvement** of all institutions; **NHIF** becomes national health insurance fund **MOH focus** on policy making, regulation & M&E; PHI offer duplicative, complementary or supplementary HI; Move towards integrated uniform broad and deep BP in mandatory insurance for all; Streamline, simplify and risk-proof **collection and pooling** functions; **Autonomization** of providers; Need **tariffs board**; Introduce **facility planning and needs based licensing**;	NHIF gradually expanding its coverage of the poor and near poor, number-wise & BP-wise.	NHIF purchases SHC & THC for non-members according to KEPH BP; Continued current services.	NHIF as single purchaser in national mandatory HI of all residents for KEPH BP; Continued current services.	NHIF contracted by MOH & Counties to cover all residents for KEPH BP; Continued current services.	Regional insurer contracted by (groups) of Counties to cover all residents for KEPH BP & offer current coverage to current members.	NHIF and PHI on equal terms for mandatory enrollment of all residents to assure access to KEPH/BP in strictly regulated environment to prevent risk selection & cream skimming. NHIF & PHI continue their current member services.

Need **accreditation inst**.; Offer **equal position to public & private providers;**						
Achieving UHC	+	+	+	+	+	±
BP breadth & depth; hence best option for the poor?	+	++	+++	++	+	±
Effective & efficient insurers; hence more to spend on BP for poor.	±	+	+++	++	±	--
Effective & efficient health services	±	+	+++	++	_	____
Simplicity in health financing system and implementation	+	++	+++	++	+	_ _ _
Realization period	ST	ST	ST-MT	ST- MT	MT - LT	LT
Specific Capacity requirements	Nihil -Low	Low	Medium	Medium	Medium to high	Very high
Additional regulatory burden & costs	Low	Low to Medium	Medium	Medium	Medium to high	Very high
Cost-effectiveness HF Model	-	-	++	+	+	±
Acceptance						
• Insurers						
○ NHIF	+	+	++	+	±	±
○ private	+	±	--	±	±	++
• Providers	±	±	-	±	-	+
• Public						
○ Poor	±	+	++	++	+	-
○ Non-Poor	±	±	±	_	±	+
• GOVT						
○ Nat	±	+	++	±	+	±
○ County	+	+	-	+	++	-

UHC Universal health coverage, i.e. access for all and no risk of impoverishment
BP Benefits package
KEPH Kenya Essential Package of Health services
HF Health Financing
HI Health insurance
NHIF National Hospital Insurance Fund and its possible successor: National Health Insurance Fund
PHI Private health insurer or health insurance
SHC Secondary health care
THC Tertiary Health Care
ST Short term
M&E Monitoring and evaluation
MT Mid term
LT Long term
L Low
M Moderate
H High
+ Possible or likely
++ Very well possible or very likely
± More or less; or neutral
_ Negative or less likely
_ _ Very negative or unlikely

7. Conditions for success

To make any of the chosen models work cost-effectively, sustainably and viable, several parallel actions should be considered:

- **Increasing of public spending** on health to cover the poor informal sector. The health sector should get a larger share of government expenditures and possibly also from specific health and/or sin taxes and levies. Increased insurance premiums can be used for cross-subsidization those who cannot pay contributions themselves.
- Implementing **NHIF reforms, aiming at** good governance including public disclosure of information on finance, the organization and the assets and earnings of key individuals).
- Improving the regulatory and auditing mandates and legal frameworks for IRA and Auditor General to allow for health insurance specific regulation and functional and value-for-money auditing of insurers.
- Creating a level playing field for public and private service provision in reference to having equal positions of public and non-public providers in health financing of services according to the universal BP. This means that payments would reflect differences in infrastructure funding and other structural costs.
- Creating a fully-funded benefit package for the informal sector's poor and near poor.
- Reforms needed outside of direct health financing:
    - Development of an independent quality-oriented improvement and accreditation system
    - Introduction of a needs-based planning and licensing system for all health facilities, public and private and including free-standing laboratories, diagnostic centers and other support facilities.
    - Massive capacity development initiatives, of which the need and focus would be dependent of the chosen model

8. The road ahead

This paper and the options presented in it can act as a vehicle for:

a) Engaging the leadership of MOH in a dialogue about the options and subsequently for stating a preliminary preference for one of the options and the further process.
b) Discussion and obtaining feedback of the Technical Working Group on Health Financing Strategy.
c) Stakeholder consultations, especially the Counties but also including the private sectors of insurers and providers, the associations of employers and unions , consumer organizations etc

d) Possibly after incorporating feedback of the previous rounds of consultations: engaging the Inter-agency Steering Committee and getting its feedback on the preferred option.
e) After the choice of an option, a summary draft implementation plan, including an indication of the timing and the costs of the implementation process, and a draft Bill can be developed. This package, embedded in the updated 2010 health financing strategy can be submitted to the Cabinet of Ministers, the President and Parliament. Obtaining the consent of the President at an early stage seems important in order not to get stuck at a later stage in the process.

Some of the above steps may have to be repeated, dependent of the received feedback.

9. Recommendations

Based on these above principles and criteria, which are spelled out in more detail in this paper, it is recommended that:

- The ***Government has the mandate and decides the overall budget*** for the health sector and all its activities that impact the country's overall economy, fiscal pressure, health status and social welfare.
- The government subsequently decides ex ante the ***distribution of estimated health sector costs*** over general revenues, social charges, user charges and solidarity charges (cross-subsidization) of private health insurance. The actual distribution over the contributing sources is ***the main instrument for enhancing and achieving equity in health financing***: everyone paying into the system to his /her ability to pay and for ***achieving equal access to services*** without impoverishment risk. So, the poor should be the first priority in this decision making process and its outcome.

  In order to be responsive to the dynamics in the economy, in society and in the health sector the above mandates would be best regulated in a ***framework Act,*** leaving e.g. the actual distribution of costs and the levels of contributions from general revenues, social and user charges to the mandated government body.

- ***Contribution collection*** for mandatory insurances is collected by the Kenya Revenue Authority (KRA).
- ***Collected contributions*** from all resources, including donors, are parked at the National Treasury or National Bank of Kenya. This would limit the financial risks and offers the possibility of reducing the need for reserves at public insurance bodies if MOF offers a financial back up in case of unexpected shortages.
- The level of ***poolin***g, the number of pools and hence the size of the risk pools, i.e. the distribution of monies over the payers and purchasers of health services is dependent of the chosen health financing model and hence of its main actors.

- The ***actual size of the budget envelop*** is based on a mix of historic costs, actuarial analysis, health risks of counties and/or insurer portfolios and County absorption capacity. The latter factor relates to the intended gradually equalizing and reducing the differences in health services facilities availability between Counties.
- The overall budget is ***separated between investment costs and operating costs***, albeit it in a flexible way to prevent problems in budget execution and leaving available resources unspent, to cater for services level differences eradication.
- The ***investment budget*** should be coupled with a ***needs based health services planning and licensing Act*** which regulates the distribution, level and quantity of health services providers over the Country and has a special regime for high-tech/high-risk/high-cost health technologies. Such instrument would also be necessary for quality control and cost-containment. The latter contributing to the ***viability*** of the chosen health financing model, a main government concern.
- The overall health sector budget is further split into a ***budget for population based services***, such as immunization, health promotion, disease prevention, disease surveillance and disease outbreak management and ***a budget for individual oriented health services***. This latter budget is for individual prevention, diagnostic, curative, palliative and rehabilitative services. Most countries finance population based services from their national budget. Occasionally countries tap into a public health insurance fund to finance e.g. vaccines and immunization programs.
- ***Population based services*** will be the responsibility of MOH and the Counties which can use the health professionals working in individual oriented care for the implementation of these services.
- ***Individual oriented services*** financing and delivery can be distributed over MOH, Counties and/or insurers and over users. The options for such distribution are the mainstay of this report and define the health financing architecture. This distribution can also be regarded as the most contentious one. A ***split between purchasing and providing of services*** is recommended as the more cost-effective health services financing method. Hence, granting some level of autonomy to public health providers and thus MOH and Counties staying out of direct purchasing would be a consequence of such choice.

  To implement such split, current ***vertical disease oriented systems*** should be integrated: partly in population based services and partly in individual services

- The ***MOH determines the package of benefits*** of individual oriented services which would become universally available, taking into account and negotiating the budget for it with concerned ministries and Counties. This package will be derived from the Kenya Essential Package of Health services (KEPH). To speed up the achieving of equal access to health services, the current BP of NHIF should be frozen and only expand once all residents have been granted access to the current NHIF BP for the civil service. For future adjustments MOH can be supported by advice from an ***independent expert body,*** which should include epidemiologists, health economists, health professional and para-professionals, statisticians, health insurers, consumer organizations and experts in health technology assessment.

- For the development and decision making of the health financing strategy it is more important to decide on the mandate and the ***criteria for assembling a BP*** and for future adjustments than to already provide a list of health interventions which should be covered. The reason is not the possible lack of costing study results but to allow for flexibility and to deal with dynamics in medicine and population needs.
- In all proposed options for a health financing model, ***private health insurers (PHI***) continue to offer complementary and supplementary health insurance. The need and market to offer duplicative insurance may gradually disappear when the universally covered BP and service quality expands and improves. One of the reflected health financing models explores a possible role of PHI in a competing health insurers model.
- The ***governance structure*** and mandates of the health sector follows from the above and is further to some extent dependent of the chosen health financing model. In any case:
    - The ***Insurance Regulatory Authority (IRA***) should regulate and supervise public and private health insurers, not only as regards their financial activities but also concerning their functioning with respect to achieving cost-effectiveness and quality in financial administration and in health services delivery , the latter in their role as purchasers. It is suggested that ***IRA and MOH/Counties agree on a protocol*** for the auditing and supervision as regards the health services financing activities, clarifying the mandate of each actor and preventing duplication.
    - The ***National Hospital Insurance Fund*** will need to be reformed in conformity with its future mandate, taking into account the decisions on the aforementioned functions and principles of good governance. It will most likely have to change its name and become a health insurance fund. It already deals with primary health care (PHC) for the civil service, policy and military staff.
    - If and when the aforementioned health facility planning and licensing Act is adopted, an ***equal position for public and non-public health facilities*** in the delivery of the universal BP can be considered vis a vis the purchasing body. The timing is important to prevent an outflow of public staff in unregulated private facilities. For the time being, private facilities can be contracted on an as needed basis.
    - The equal position of providers would have consequences for the fee level setting: ***investment costs of licensed private providers*** should be taken into account in case they are contracted for the delivery of the universal BP.
    - The establishment of a ***health tariffs forum*** or official body would be helpful in the underpinning of health services fee levels and in advising about the payment methods. Such forum or body should take into account the instructions of the government as regards available sector and sub-sector budgets.
    - A dedicated health facilities ***accreditation body*** for external quality assessment and continuous quality improvement should be established, covering all health institutions irrespective of their legal status and whether they are contracted or not by the purchasing agent for the delivery of the universal BP. The establishment of such body

would take away the accreditation mandate of NHIF, also in any of the proposed options.

- Although M&E is a genuine task of MOH, as long as MOH has a particular stake in the health sector as owner and payer of health services it is recommended to use an independent outside health services research capacity for the evaluation of the implementation of an adopted health financing strategy.

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10.Annexes

Annex 1. Literature

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Annex 2

MINISTRY OF HEALTH

Terms of Reference for Defining Options for Health Financing Reforms in Kenya

1. Background

Kenya is currently going through 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.

In light of the high profile of health issues and UHC during the 2013 elections and in the Government agenda, there is high pressure to move forward with the reform process and to deliver tangible results for Kenyans within a limited time frame.

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 are closely supporting 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 MOH is currently developing a "Roadmap to UHC", an action plan laying out the major steps it aims to take to expand effective access to quality care and financial risk protection. One of the major milestones in this process is the agreement of a "Health Financing Strategy", which will define the major pathways and implementation arrangements through which Kenya expects to reach UHC.

The efforts of the MOH in this process and the support rendered by Development Partners are coordinated in the Technical Working Group UHC under the Health Financing ICC. The following three technical papers have been commissioned by the MOH[19] (in brackets: contracted consultants):

- Assessment of the Health Financing Institutional Design and Organizational Arrangements in Kenya and proposal of feasible options (Dr. Jane Chuma)
- Review of On-going Efforts in the Implementation of the Health Financing Functions and Proposal for Feasible Financing Options (Dr. Timothy Okech)
- Current status of coverage in terms of services, financial depth and population covered and proposal of options for an affordable benefits package (Dr. Richard Ayah)

The three reports are expected to be completed by mid March 2014.

At the same time, in order to mobilize political attention and backing for the UHC reform agenda and deliver within the tight timelines expected, the MOH intends to host a High Level Forum on UHC on 18/19 March 2014 to bring together the main UHC stakeholders under the auspices of the Minister of Health. During this meeting, the MOH will present a summary of the main options for decision-making coming out of the three technical papers. While it is not expected that any decisions will be taken during the Forum, it provides a unique opportunity to initiate the discussion among relevant decision-makers, focus their minds on the key questions for reform and garner high-level support for steps to be taken.

The three technical papers will not be formally completed by the proposed dates of the Forum, but key lessons and reform options will have been identified by each consultant. The MOH is now looking for a consultant to synthesize these options and produce a document for presentation at the high level forum.

2. Objectives and Tasks

The objective of this assignment is to:

1. Assess the reform options identified in the three technical papers on alignment/compatibility and screen them for interdependencies;
2. Identify a sequence of decision points and the decisions to take at each point alongside key factors to be taken into consideration.
3. Synthesize the three technical papers to develop an options paper that can guide development of the strategy and road map for attaining Universal Coverage in its three dimensions – population coverage, services and direct costs.

To successfully achieve these objectives, the following tasks are to be undertaken:

- Review the three draft technical papers;

[19] See: ToR_UHC-situation analysis.doc

- Review selected additional documents as needed;
- Conduct individual and group interviews with the authors of the draft papers;
- Synthesize the findings in a way that closes the gaps and areas of disagreement of the draft health financing strategy (which were identified by a P4H-mission in March 2012)
- Produce a draft document summarizing the key findings;
- Produce a draft revised health financing strategy document on the basis of the above findings (as a document to be discussed and finalized by MOH)
- Present the findings to the MOH and the wider TWG UHC prior to the High Level Forum;

3. Deliverables

Three deliverables are agreed under this assignment (due dates in parentheses):

- One PowerPoint presentation summarising key findings to the TWG UHC (3 days prior to the High Level Forum)
- An options paper to guide development of the UHC strategy and road map for attaining Universal Coverage in its three dimensions – population coverage, services and direct costs.

- Draft revised health financing strategy document (as a basis for discussion and finalization by MOH)

4. Steering

The GIZ will suggest suitable consultants to the TWG UHC on behalf of P4H network partners. The successful consultant will be reporting to the chair of the UHC TWG and will work closely with a person designated by MOH. Contracting will be done upon approval by the TWG UHC and payments will be made upon approval of deliverables by GIZ on advice of the MOH and the TWG.

5. Professional requirements

The consultant will have a qualification at the level of a Masters or PhD in the fields of health economics / health systems with significant experience in advising decision makers on health financing reforms in low- and middle-income countries. S/he will have experience with systems of mixed financing (tax and social health insurance), especially in devolved systems.

6. Limitations and Other Arrangements

The consultant will not be responsible for any arrangements concerning the High Level Forum except for his contribution.

The consultant's contact person for all technical questions and information in the Ministry of Health is Mr, Nzoya Munguti (Deputy Chief Economist) on behalf of the Director, Policy, Planning and Health Financing. The consultant will be supported by the GIZ (Health) and WHO Kenya country office as regards logistics in country and the preparation of a meeting schedule. Editing support will be provided by the UHC-TWG appointed members.

Annex 3

Improving Health Outcomes and Services for Kenyans: Sustainable Institutions and Financing for Universal Health Coverage

Kenya Health Policy Forum

18-20 March, 2014, Windsor Hotel, Nairobi

Motivation:

Kenya is currently going through transformational changes in its health system with the ongoing devolution. While Kenya has made some impressive gains in reducing child mortality and control of communicable diseases, the health system is underperforming. The renewed strong political commitment to achieve universal health coverage requires Kenya to take strategic decisions. This involves (a) implementation of well-tailored programs relevant to the Kenyan context to improve equitable access to quality health services, especially for the rural poor, and (b) enhancing governance and efficiency of the health systems to get better value for money.

Pathways need to be explored based on lessons within Kenya, and from other countries with devolved health systems, to find appropriate mechanisms for pooling resources and strategic purchasing of health services with a focus on the poor and vulnerable. Recent decisions taken by the Government to eliminate payment at the point of primary health care service delivery and free access to maternal health services are in the right direction. The challenge however is in delivering these important commitments by the Kenyan health system and ensuring sustainable financing.

There are several innovations taking place in Kenya as well as in the region to improve delivery of health services for the poor and enhance accountability for results. The reproductive health voucher program and performance based financing are some of the good examples while some countries have made remarkable progress in improving access for their citizens through client-responsive incentives. Kenya can build on these experiences. Similarly, many countries have devolved health systems and lessons learnt from such countries would be useful for Kenya.

The motivation for this high level forum comes from priorities identified by the Kenyan policy makers,who expect that the forum will help them to make better informed choices to transform the Kenyan health system.

Objectives of High Level Policy Forum:

The Kenyan Ministry of Health, in collaboration with World Bank Group and USAID, is convening the Kenya Health Policy Forum to address strategic challenges in the country's quest for Universal Health Coverage. The Forum, to be held on 18-20, March 2014, with focus on:

- Delivering services to improve health outcomes among women and children, with emphasis on poorer segments of the population.
- Enhancing the governance and effectiveness of the health system to deliver quality health care in a devolved setting.
- Ensuring sustainable health financing to achieve universal health coverage.
- Promoting client safety and quality of health care.

Guiding Principles:

- ❖ Leadership by Kenyan experts and institutions with global experts and institutions sharing knowledge and experiences.
- ❖ Learning with emphasis on practical know-how from countries with devolved health systems (Brazil, Ghana, India etc.)
- ❖ Providing analytical and advisory inputs to inform pros and cons of different options,and ensuring that choices are compatible with the Kenyan context.

March 18, 2014– Policy Perspectives		
Moderator: Mr. Francis Musyimi, Secretary Administration, MoH		
09:00 –09.55 Chair – Mr. Francis Musyimi, Secretary Administration, MoH	Opening Session: introduction of institutions	Mr. Francis Musyimi, Secretary Administration – Ministry of Health
	Expectations from the Forum	Dr. Masasabi, Directorate od Policy, Planning and Healthcare Financing (15Mins)
	The Challenge of UHC and its relevance to Kenya	Dr. Timothy Evans, Director, Health Nutrition and Population, The World Bank (15 Mins)
		Dr. Ariel Pablo-Mendez, USAID/ Global Health Administrator (15 Mins)
09.55-10.15	Tea	
10:15-10:30	Summary of expectations	Mr. ElkanaOnguti, Chief Economist, Ministry of Health
10:30-13:00	Delivering health services for rural women and children: Access and Quality Panel chair: Mr. ElkanaOnguti, Chief Economist, Ministry of Health	• Key challenges in service Delivery-DrWilliam Maina,MoH(20 Mins) • Key findings from Efficiency Study –DrUrbanusKioko, UON (20Mins)
		Panel Discussion: **Kenyan Experiences** 1. Primary Health Care especially maternal health: Challenges and progress: Dr. David Ojakaa, AMREF - (10 Mins) 2. Supply side constraints – Evidence from PETS Plus Survey, 2012: Mr. Thomas Maina, USAID/HPP (10Mins) 3. Role of Private Sector in service delivery: Dr. Sam Thenya, Nairobi Women's Hospital (10 Mins) 4. Role of Faith Based Organizations in service delivery: Dr. Sam Mwenda, CHAK (10 Mins)
		Q &A followed by panel chair Summary (40 Mins)
13:00-14:00	Lunch	
14:00-17:00	Ensuring sustainable financing to achieve universal health coverage for Kenyans Panel Chair: Dr. J. MasasabiWekesa-Head, Directorate of Policy Planning and Healthcare Financing	• Key health financing challenges and efforts towards UHC - Mr. ElkanahOnguti, Chief Economist, MoH (20 Mins) • Healthcare utilization and expenditure – Evidence from the Household Survey of 2013: Mr. Stephen Muchiri-USAID/HPP (20 Mins)
		Panel Discussion: **Kenyan Experiences** 1. Fiscal space options for Health financing in Kenya– Ms. Benadette M. Wanjala, KIPPRA, Kenya (10 Mins) 2. Sustainable HIV Financing : Ms. Regina Ombam, NACC(10 Mins) 3. Benefits Incidence Analysis: Dr. Jane Chuma, USAID/HPP(10Mins) 4. Health Insurance Subsidies for the poor and Role of NHIF: Ms. Nellie Keriri, NHIF (10 Mins) **International Lessons:** 5. Lessons from India: Dr. SomilNagpal, World Bank - Health Insurance Regulation (20 Mins) 6. Developing sustainable health insurance programs - Lessons

		from Mexico: Mr. Jorge Coarasa, IFC (20 Mins) 7. Global lessons from health financing reform for UHC: Dr. Matthew Jowett, Senior Health Financing Specialist, WHO (20Mins)
		Q&A followed by panel chair summary (40 Mins)
18:00 – 20.00	Reception	All invited Participants.
March 19, 2014Implementation Perspectives		
8:30-11:00	Enhancing governance and effectiveness of the health systems to deliver quality health care Panel chair: Tawhid Nawaz, Acting Sector Director, Human Development, Africa Region	• Key Health Systems Governance Challenges - Dr. S. K. Sharif, Former Director of Public Health and Sanitation (20 Mins) • Emerging issues on governance in health sector – County experience: Dr. Maurice Siminyu, CEC-Busia County (20mins)
		Panel Discussion: **Kenyan Experience** 1. The role of Parliamentary Health Committee in supporting governance in the health sector: Dr. James Nyikal, MP and member of the Parliamentary Committee on Health (20Mins) 2. Governance in Pharmaceutical supply chain system in the public sector: challenges and opportunities: Dr. Maureen Nafula, Strathmore University(15Mins) **International Lessons** 3. International experiences in promoting governance in pharmaceutical supply chain: Prof. PrashantYadav, Director, Healthcare Research, University of Michigan (20mins)
		Q&A followed by panel chair Summary (40 Mins)
11:00-11:30	Tea	
11:30-13:00	Strengthening Health Systems in devolved Setting: The Kenyan challenges Panel Chair: Dr. Sharma Suneeta, Project Director, USAID/HPP	• Kenyan Devolution: Opportunities and challenges for the health system: Dr. Ruth Kitetu – Ministry of Health (20Mins) • Opportunities and challenges in devolution in the health sector, county experience: Dr. Elizabeth Ogaja, CEC – Kisumu County (20Mins)
		Panel Discussion **Kenyan Experiences** 1. Devolution in the health sector. Transition Authority's own experiences and challenges with devolution in the health sector: Dr. DabarAbdi Maalim, Transition Authority(10Mins) **International Experiences** 2. Prof. David Peters, Head, International Health, Johns Hopkins University (20Mins)
		Q&A followed by panel chair summary (30 Mins)
13:00-14;00	Lunch	

14:00-17:00	Health Systems in a devolved setting: More Kenyan experiences and International experiences Panel chair: Dr. OlusojiAdeyi, Sector Manager, Health Nutrition and Population, Eastern and Southern Africa.	**International Experiences** 3. Indian experiences in managing devolved health systems. National Rural Health Mission -Ms. Sujatha Rao, Former Secretary of Health, Government of India (20 Mins) 4. Lessons from Ghana in health sector devolution – Dr. AbdulaiTinorgah–Former Director, Health Services, Govt. of Ghana (20 Mins) 5. Brazilian experiences in devolution: Ms. Marcia Huculak– Superintendent of Health - Brazil, State of Parana (20 Mins) 6. Ethiopian experiences in effective delivery of primary healthcare services in devolved health systems: Ms. Roman Tesfaye, Director General - Heath Insurance Agency, Ethiopia (20 Mins)
		Q&A followed by panel chair Summary (40 Mins)

March 20,2014Service Quality Perspectives		
09:00-11:00	Promoting client safety and quality of health service delivery Panel Chair: Dr. J. MasasabiWekesa-Head, Directorate of Policy Planning and Healthcare Financing	• Regulatory and Quality assurance challenges in Kenya – Dr. Pacifica Onyancha, MoH (20Mins)
		Kenyan Experience 1. Role of KENAS in regulating quality of health services – Ms. Doris Mueni, KENAS (20Mins) 2. NHIF step-wise accreditation process – Early experiences : Ms. Julia Ouko, Senior Benefits and Quality Assurance officer, NHIF (20Mins) **International Lessons** 3. International experiences in measuring Quality and Safety- Mr. Jishnu Das, The World Bank (20Mins) 4. Experiences on quality improvement in Nigeria and Tanzania – Ms Nicole Spieker, Director of quality, Safecare, PharmAcces Foundation (20 Mins)
11.00-11.30	Tea Break	
11.30-12.15		Q&A followed by panel chair Summary (40 Mins)
12:15-12:45		Way forward – NzoyaMunguti,Deputy Chief Economist (30Mins)

Annex 4 Presentation of MOH at High Level Forum on 17 March 2014