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Ministry of Health

Options for Kenya's health financing system

A P4H Policy Brief

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Based on: ***Bultman, Jan (2014): Kenya. Health Financing Strategy Development. Options for Reform and choices to be made***

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Executive Summary

"Every person the right to the highest attainable standard of health, which includes the right to health care services" in Kenya, by guarantee of the Kenyan Constitution 2010 (Art. 43 (1)). In line with this, the Government of Kenya (GOK) has made Universal Health Coverage (UHC) a priority.

A Health Financing Strategy is meant to guide the way to a health financing system that is sustainable, equitable, accountable and efficient. Much analytical groundwork has been done and it is now time for GOK to start implementing various essential reforms and to decide on the direction of institutional reform.

This Policy Brief summarizes the findings of a recent expert report commissioned by GOK, Ministry of Health (MOH), which itself was based on a wide literature review of analytical and legal documents related to and important for the Kenyan health (financing) sector. It suggests a set of basic reforms necessary for UHC and provides an overview of institutional health financing reform areas and provides six scenarios that combine possible choices into coherent health financing systems. These scenarios are the only possible ways to UHC, but they can act as reference points.

The nine basic reform recommendations are the following:

1. Structure services for financing recurrent costs: finance public/community-oriented services input-based and individual-oriented services output-based
2. Continue financing public investments via MOH and Counties
3. Agree on a framework and criteria for defining and revising benefit packages for all public health financing schemes through MOH (incl. NHIF benefit packages)
4. Adapt and introduce a classification system for diseases
5. Establish a health tariffs forum or an official body
6. Let the Kenyan Revenue Authority collect all revenue for health financing
7. Establish a dedicated health facilities accreditation body for external quality assessment and continuous quality improvement
8. Reformulate the mandate of the Insurance Regulatory Authority (IRA).
9. Increase provider autonomy

The six reform scenarios for pooling funding for purchasing individual-oriented services are summarized by the labels that reflect their key characteristics:

1. **Evolution of the current system** – keep the current set-up and provide funding to cover the poor via NHIF
2. **NHIF complements Counties** – simplify care provision and let Counties contract NHIF for secondary care
3. **NHIF for all** – make NHIF the single purchasing mechanism for care; MOF funds NHIF directly
4. **NHIF for all through MOH/Counties** – NHIF is single purchaser; funds flow MOF → MOH/Counties → NHIF
5. **Regional Social Health Insurers** – new regional public insurers are created, contracted by Counties
6. **Health Insurance Competition** – NHIF and private health insurers compete for clients

The scenarios are assessed briefly on their technical merits, their effects on stakeholders and on their capacity requirements. There are clear trade-offs. Typically, more simplicity means more change and therefore more need for stakeholder consultations. The simplest reform model is scenario 1 – at the same time, it also offers a high chance of just continuing with the status quo. Other scenarios increase in the extent of the challenge to the status quo and their capacity requirements. All scenarios are theoretically possible, but the capacity requirements for scenario 5 are a substantial challenge. For scenario 6 the challenges are so substantial that it is not recommended for the time being in Kenya.

GOK, especially the MOH, should now push the UHC agenda with the clear goal to expand access to care to all Kenyans, especially the poor. To succeed in implementing its strategy, GOK will need to build a broad-based coalition of stakeholders that can broker consensus and overcome vested interests.

1. Introduction – The context of health financing reform

"**Every person the right to the highest attainable standard of health, which includes the right to health care services**" in Kenya (Kenyan Constitution, 2010, Art. 43 (1)). This constitutional objective provides the framework for health care and health care financing reform in Kenya.

In line with this, one key objective of the current **Government of Kenya (GOK)** is that "Every Kenyan should have access to high quality health care" (Jubilee Coalition 2013). GOK recognizes that access to care not only entails the physical availability of services, but also the protection from financial hardship. In short, GOK is committed to achieving **Universal Health Coverage**.

Developing a Health Financing Strategy is a key concern for the Ministry of Health (MOH) in this context. It is expected that this document will provide the basis for developing a system of **universal access to essential health services** that is viable, **sustainable, equitable, accountable and efficient**. A key concern is to provide those people currently without physical, financial or socio-cultural access to health care services with a set of essential services that can be expanded as additional resources come into the system. This means that a specific **focus is on poor and vulnerable** individuals, households and communities. This in turn implies a strengthening of **inclusive pre-paid risk-pooling schemes**. Only when the healthy and wealthy contribute via taxes or premiums according to their economic ability, can the sick and poor benefit according to their need.

The MOH can draw on the experiences of more than a decade in this Strategy development process, which came close to success twice but fell short: The first attempt was aborted in 2003/04 during the legislative stages due to three factors: One, influential private health financing and health services interests were not sufficiently included in the reform process; two, there were questions about the financial sustainability of the proposals; and three, there were doubts about the seriousness to reform institutions tainted by maladministration (esp. NHIF). The second attempt had to be suspended between 2007 and 2010, due to a constitutional reform process that devolved government in Kenya to the County level.

The Kenyan economy is growing and the Government has made universal access a priority. This needs to be translated into additional public funding for health. International evidence has shown that giving access to the poor and achieving UHC requires additional public funding from general revenues; no country has managed to collect sufficient contributions from a large and poor informal sector to finance UHC. The specific finance requirements depend on the entitlements of Kenyans (i.e. the benefit package), but in 2009/10 GOK provided only USD12 against the USD42 estimated by the WHO as necessary for a basic set of services. This in turn means that it will be important to have backing by the Ministry of Finance and Cabinet at large when additional funding is requested. Evidence-based arguments for impact and efficiency may support these efforts.

Devolved County governments and the centralized NHIF are both declared key vehicles of GOK for health financing reforms. A key challenge for designing reforms is therefore to define the respective roles of the Counties, the NHIF and the MOH. It is important to note that the responsibility of Counties for the health of their residents does not mean that they should take on all health financing functions. Between being the service financer/provider and being (only) the steward of the County health system is a continuum of possible solutions. Since this decision will determine the flow of public finances, it will be important to not let political considerations override technical ones.

Private stakeholders will define their positions and protect interests. Kenya has strong non-governmental actors, which will demand to be heard in the reform process. Challenges to the status quo can expect to face opposition (as in previous reform efforts). One risk mitigation strategy is to design an inclusive process; a second strategy is to clearly define the roles of actors whose interests are touched. Much will depend on how strong the resolve of reform champions in GOK, especially MOH, will be and what partners inside and outside government are able to mobilize in support of reforms.

In summary, **the success of the current reform efforts** will depend on designing a system, which reflects the newly devolved government system; which is adequately backed by public financing; which assures sound governance of key institutions; and finally, which is developed in an inclusive process and is backed by a coalition broad enough to overcome isolated vested interests.

Methods: This *Policy Brief* is based on ***Bultman, Jan (2014): Kenya. Health Financing Strategy Development. Options for Reform and choices to be made*** commissioned by the Government of Kenya, Ministry of Health, and implemented by GIZ with the support of P4H partners including the *World Health Organization*, the *World Bank*, *KfW* and the USAID-funded projects *SHOPS* and *Health Policy Project*. JICA also provided valuable inputs. Funding for the report and this policy brief was provided by the Swiss and German Governments. The report itself was based on the review of three papers commissioned by the MOH (Chuma 2014, Okech 2014 and Ayah 2014) as well as a large number of other documents, most notably the P4H Network independent review of the 2010 health financing strategy draft, and the draft strategy itself.

2. Background – Health financing challenges in Kenya

Kenya faces three sets of key challenges in health financing. First, access to services for individuals and households is fragmented by coverage scheme, while the poor and vulnerable are largely excluded. Second, the fragmentation of health financing schemes also brings inefficiencies in service provision and investments. Third, a diverse set of challenges exist that are related to health systems and public governance issues; key among these are the lack of an effective quality assurance mechanism and ineffective corporate governance and accountability mechanisms, which has led to a trust-deficit in Kenyan health financing institutions. All areas need to be addressed urgently to make significant progress towards UHC.

2.1. Access to health services in Kenya – challenges in risk pooling

Financial access to health care services is a serious problem in Kenya. While average total health expenditure (THE) per Kenyan at USD 42.2 in 2009/10 was sufficient to buy a basic package of essential health services, there is strong variation around this mean. Out-of-pocket spending was 25% of THE, showing that many Kenyans cannot rely on equitable pre-paid financing mechanisms (MOH: NHA 2009/10, n.d.). In fact, nearly 15% of Kenyans spent more than 40% of non-food expenditure on health care. Health care is thus a major source of financial distress for Kenyans.

The small share of the health sector in the Government budget (in 2009/10 only 4.6%) points to a general underfinancing of publicly provided services, even though for some services (especially HIV/AIDS and Malaria) some of the gap is made up by spending by development partners (MOH n.d.).

This is related to the co-existence of several different coverage schemes. The main ones among these are the GOK free-care initiatives at primary health care facilities (dispensaries and health centres) and for free maternal care (esp. deliveries) at higher levels, GOK subsidized access for other care at referral levels, the National Hospital Insurance Fund (NHIF), as well as Private Health Insurance (PHI). Some small Community Based Health Insurance also exists. The existing schemes are isolated and are not connected through financial or risk equalization mechanisms.

Figure 1 provides an overview over the current coverage among the population (ranked by wealth on the X-axis) and across different service categories included in different benefit packages (on the Y-axis). It simplifies the scheme coverage by wealth categories (i.e. some wealthier Kenyans may not be covered by NHIF or PHI, while some less wealthy are), but by and large this principle does hold. **Access to health services is very unequal and the poor are currently financially excluded from access to many services.**

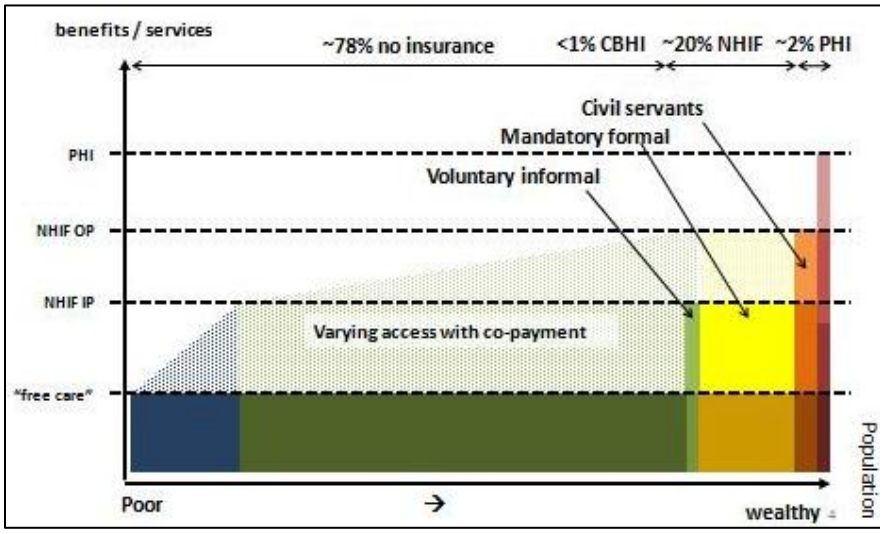

Figure 1: Population and service coverage by health financing scheme

Devolution adds to the complexity, as Counties are now expected to finance health service provision for primary and secondary care services from their block grant allocation. Access to publicly provided services (the "free care" and subsidized / "co-payment categories" in Figure 1) therefore depends on the budget allocations at County-level, which further fragments financing of health services and hinders equal access to care.

2.2. Health Financing and Service Provision – challenges in purchasing

The fragmentation of the health financing system also creates obstacles for an integrated service provision. Ideally, patients are treated where medically most effective and economically most efficient. Fragmented financing mechanisms can create incentives working against this principle.

Patients have an obvious incentive to seek care where they are covered against the costs of treatment. Where hospital treatment is covered, patients may bypass primary facilities where adequate treatment can be provided at the lowest possible costs.

Providers also have incentive for unnecessary referrals if costs can be avoided by referring patients to another "budget". For example County facilities may refer patients to tertiary hospitals since these are not financed by the County, but by the MOH. Varying payment mechanisms may compound this issue. The more fragmented the financing system, the more difficult it is to avoid negative effects.

In addition, the flow of medical information is often inhibited where different funding sources are involved in data collection. This can have obvious negative impacts on health outcomes and on the governance of the health sector.

A fragmented health financing system can also create challenges for assuring equitable and efficient investments into services if no integrated system of investment planning and/or licensing is in place. On the one hand, some areas in need may fall between the gaps of different funders (especially if the areas are poor and providers are motivated by profits). On the other hand, some areas may also be oversupplied with care, especially high-cost technologies. This does not only reduce available funding for investments into disadvantaged areas, but also increases recurrent costs. This is especially the case for diagnostic devices, where providers can induce demand while quality of care may suffer.

2.3. Funding sources – challenges in revenue collection

Fragmentation of pools is also an issue for revenue collection. Schemes collect, bank and invest their own revenue. This is administratively inefficient.

The bigger challenge, however, is the insufficient amount of (especially domestic) public funds in the system. In 2009/10, domestic public health expenditure was only USD 12 (MOH, National Health Accounts 2009/10). While the specific financing requirements depend on the package of services made available under UHC, the WHO estimated that USD42 was necessary to purchase a package of basic services in 2010, rising to USD60 by 2015 (WHO, World Health Report 2010).

2.4. Service quality, administrative efficiency and accountability

Several other key challenges related to health financing exist. Key among them is the lack of a quality assurance mechanism to guarantee that scarce funding is used to fund care of sufficient quality only. The different external quality assessment systems of health insurers including the NHIF are not harmonized and/or sufficient for assuring high quality services across all facilities, which means that providers face varying requirements and may be able to get away with providing inadequate care.

Another key observation, especially with regards to the NHIF, is the need to reduce administration costs in the health sector. Despite recent improvements, administration costs at the NHIF are still a multiple of internationally observed norms. Since money spent on administration is lost for service provision, bringing admin costs down to an acceptable level is a requirement for any reform package.

Similarly, a lack of trust in health financing institutions – and here again especially the NHIF – due to maladministration, fraud and corruption have created a trust deficit that will need to be addressed in some way in future reforms.

3. Key reform recommendations

Based on the contextual and technical analysis, two sets of reform options are offered. First are recommendations, which relate to reforms that are necessary regardless of the health financing context. These cover the base on which reforms of the pooling and purchasing institutions can be built. They are recommended independently of choices made on options in the second set.

The second set of reform options relate to the assignment of mandates to health financing actors in pooling and purchasing. For these various options exist with different strengths and weaknesses. Six possible reform scenarios are presented connecting possible choices into health financing systems. The scenarios may be modified in line with GOK preferences, but care needs to be taken to maintain the consistency of the different choices implied by the models.

3.1. Reform recommendations for any future health financing system

1 – Structure services for financing recurrent costs: finance public/community-oriented services input-based and individual-oriented services output-based. This approach follows the approach taken in Mexico. In general, community-oriented services should include services that are non-exclusive (i.e. they can be consumed by many people simultaneously, like a drained swamp), or that have large positive health externalities (such as the herd-immunity effect created by vaccines). Individual demand for such services is typically insufficient, so MOH/County-based supply-driven provision is appropriate. Benefits from individual-oriented services are exclusive and have limited spill-overs. Individuals demand efficient services, and financing can and should follow patients. It should be noted that defining the two categories is no exact science. The dividing line is often a negotiated outcome between stakeholders (especially if fund flows depend on the definitions of community and individual oriented health services).

2 – Continue financing public investments via MOH and Counties. Public infrastructure investments financing should continue via coordinated input-based financing from the budgets at MOH and the Counties, depending on the level of health infrastructure. This reflects their role as a key driver of equity of access. In order to rationalize public investments and better align public and private investments, a "Needs-based health services planning and licensing Act" is suggested, which would regulate the distribution, level and quantity of health service providers and high-cost and high-risk health technologies and activities. Licensing of private investment may require access via public financing mechanisms to ensure that universal access is provided also under private provision. At the same time, costs for private investments into licensed health infrastructure need to be refinanced via recurrent costs, i.e. public and private providers will be paid the same reimbursements for recurrent costs of contracted services, but private providers will receive an "investment top-up" based on standard price lists and depreciation rules for investment items if contracted to deliver services to people enrolled in public schemes.

3 – Let MOH define benefit packages for all public schemes (incl. those of NHIF). Benefit design is a classical stewardship function**.** In the absence of detailed and reliable costing result of the various NHIF packages (esp. the "general scheme", the "civil service scheme") it is considered likely that rolling out the full package (whether inpatient only or in- and outpatient) to all Kenyans with general revenue financing is not feasible. At the same time, it is considered equally unlikely that a down-scaling of the NHIF package currently offered would be politically feasible. In this situation, defining a smaller benefit package for Treasury-funded Kenyans seems unavoidable. This is the path **Thailand** has taken. At the same time, a clear and time-bound path for closing the coverage gap to the standard NHIF packages should be defined. Having defined the public benefit packages also

implicitly defines the operating space for PHI as duplicative, complementary, and supplementary services to the publicly financed services. **Importantly, the key step now is to focus on policy and agree on a framework and criteria for defining and revising the benefit packages in accordance with shifting needs and available health technologies.** A concrete proposal needs time and can be formulated by a technical committee.

Possible criteria for designing an essential benefits package:

- Orientation towards burden of disease
- Cost-effectiveness in improving health
- Effectiveness in providing financial risk protection
- Feasibility of universal provision
- Affordability of universal coverage
- Social preferences (e.g. exclusion of life-style risks, behavioural risks,…)

Based on: Bitrán & Giedion 2012

4 – Adapt and introduce a classification system for diseases. Disease classification systems can contribute to ensuring better quality and continuity of care. They are also the basis for case-based payment mechanisms such as DRGs. Substantial capacity building will be required to succeed in this.

5 – Establish a dedicated health facilities accreditation body for external quality assessment and continuous quality improvement. This function can be housed in the MOH – but only to the extent that management of referral facilities is sufficiently independent of MOH to avoid conflicts of interest. This body would cover 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.

6 - Establish a health tariffs forum or an official body. This can help underpinning agreements between stakeholders in health services fee levels and in advising about the payment methods. It would add to transparency in tariff setting.

7 – Implement an integrated system of cost-containment methods. Several steps outlined above contribute to this: The needs-based licensing system supports containing unnecessary service provision, especially diagnostics (see point 2). A disease classification system allows for using case-based payment system, which would give efficiency incentives (see point 4; until the system is running, systematically combining prospective payment mechanisms based on expected workloads with retrospective methods based on observed work-loads may be more feasible). The tariff forum could contribute to cost-containment if it were mandated to take into account the instructions of the government as regards available sector and sub-sector budgets (see point 6). It should be noted that incentives only work if facilities have sufficient autonomy to act accordingly (see point 8).

8 – Increase provider autonomy. Public providers should have a sufficient level of autonomy to efficiently manage their resources and accommodate fluctuating demands, and to act in line with the incentives provided for quality (point 5) and efficiency (point 7).

9 – Let the Kenyan Revenue Authority collect all revenue for health financing, including health insurance contributions to avoid inefficiencies in revenue collection. To cut down banking fees and administration costs, revenue should be posted at the National Bank of Kenya or at Treasury. A GOK guarantee would limit the need to hold cash reserves for unexpected payments.

10 – Reformulate the mandate of the Insurance Regulatory Authority (IRA) to cover health insurance (esp. social health insurance) in order to allow financial and functional audits of NHIF and PHI. This may be done in collaboration with the Auditor General.

3.2. Reform options and scenarios for purchasing individual-oriented care

At the core of health financing reforms is the institutional arrangement of purchasing individual-oriented care. It is this area that has been the subject of stakeholder discussions in Kenya over the last years and in which devolution opens up most options of reform.

When describing institutional options, it is useful to divide three levels of services, each with its own structure: Primary health care (PHC – facility-based, basic ambulatory services), secondary health care (SHC – first referral level of ambulatory care and basic inpatient services), and tertiary health care (THC - mostly specialist inpatient care). This is somewhat of a simplification of the current situation, but it will help to draw out the differences more clearly.

Key areas to make institutional choices

1 – The target population of each health financing mechanism. Based on the current health financing architecture, the key population groups to be considered are: The informal sector (incl. the poor), the formal private sector, and the civil service / public sector employees.

2 – The financing source of each mechanism. These can be general revenue, health insurance premiums or a mix of these

3 – The funding pool. This is the place where funding is administered, before it is passed on to the purchaser. The pooling options considered are the MOH, Counties and health insurers.

4 – The purchasing agent. The purchaser is the organization buying services from the providers, with money passed on by the pool. The purchaser can be the same or different from the pool holder. The purchasing options considered are the MOH, Counties and health insurers.

5 – The providers of services to each financing mechanism. This indicates which providers are eligible for receiving funding from the financing mechanism of choice.

In addition, in the two scenarios with several insurers on for the same level of services, risk equalization and reinsurance mechanisms are considered.

Options for Kenya

Table 1 outlines the six options along the institutional choices for purchasing individual-oriented services (investment costs and population oriented services are to be financed in each model by the MOH/Counties from general revenue, see subsection 3.1). Option 1 is a gradual evolution (or scaling-up) of the current system to UHC. Options 2-6 contain changes from Option 1 towards an alternative health financing arrangement. To draw attention to changes from each option to the next, these are highlighted in bold italics.

Option 1 sees the Counties funding PHC for the informal and the formal private sector at public facilities (which they also operate). For SHC they do this only for the informal sector. For THC, the MOH funds services at THC level for the informal sector. The NHIF, funded by premiums, meanwhile pays for PHC for civil servants only, and for SHC and THC for the formal private sector and civil servants. It also buys THC for the informal sector, but from general tax revenue (which is the main difference to the status quo). The NHIF can purchase at all levels from both public and private facilities (see subsection 3.1 for the equal treatment of facilities). **This is an evolutionary option**.

Option 2 differs from Option 1 in two regards: First, as an option, all PHC could be funded by the Counties – this would mean that the PHC benefits of the NHIF civil servants scheme would be

revoked. This would simplify the payment structure for PHC, but may face resistance from civil servants. Second, the Counties would contract NHIF to purchase SHC services on their behalf. **The NHIF complements the Counties.**

Option 3 sees a more radical break with current mechanisms. All individual-oriented services at all levels would be purchased by NHIF, with premiums paid by the formal private sector and civil servants themselves and for the informal sector by the MOF from general revenue. **This is the NHIF for all.**

Option 4 differs from option 3 only in that instead of MOF paying for premiums for the informal sector, in this case, the money would come from the Counties for PHC/SHC and from MOH for THC. This would leave the Counties and MOH with a bigger budgetary responsibility. This may increase acceptability of the proposal for Counties and MOH, but that reaching UHC would depend more on the willingness of Counties to allocate sufficient funding for the health sector. **This is NHIF for all, contracted by MOH/Counties.**

Option 5 is a complete break with current mechanisms, and relies on the establishment of Regional Social Health Insurers. These would act like the NHIF in option 4. The potential benefit of this option is also the ability to benchmark different regional insurers against each other, which can act as a sanctioning mechanism for monopolistic tendencies and related inefficiencies. Regionally adapted benefit packages and contribution levels can be used to reflect differences in services availability. At the same time, a complex risk equalization and reinsurance mechanism would need to be implemented, pushing capacity limits. Also, there would be duplications of certain functions at regional insurers, driving costs up. **This is the regional social health insurance option**.

Option 6 is similar to option 5, but in this case, private health insurance would be allowed and licensed to compete with the NHIF for offering the public benefit packages (i.e. substitutive insurance; in all previous five options, they were only allowed to offer duplicative, supplementary and complementary insurance). To avoid selection of healthy clients only, it would be necessary to create a risk equalization pool that would collect contributions (from premiums and from contributions by MOH on behalf of the informal sector) before they are distributed to health insurers based on their risk structure. These can be complemented by flat fees charged to insurance enrollees. Profit margins of PHI and surpluses of NHIF would depend on their ability to keep admin costs down and effectively exercising their purchasing mandate. The challenge is that data availability and capacities in the Kenyan social health protection system make it highly unlikely that in the foreseeable future, such a system could be implemented successfully. Several high-income countries with advance data availability and data processing capacity are still struggling. **This is the health insurance competition option.**

Table 1: Options for pooling and purchasing options of individual-oriented services

Option	Level	Target population	Financing source	Pool	Purchasing agent	Providers
1 - Evolution of the current system	PHC	Informal & formal private sector	General revenue	County	County	Public
		Civil service	NHIF premiums	NHIF	NHIF	Public & Private
	SHC	Informal sector	General revenue	County	County	Public
		Formal private sector & civil service	NHIF premiums	NHIF	NHIF	Public & Private
	THC	**Informal sector**	**General revenue**	**MOH**	**NHIF**	**Public & Private**
		Formal private sector & civil service	NHIF premiums	NHIF	NHIF	Public & Private
2 – NHIF complements Counties	PHC	***All*** (possible: excl. civil service)	***General revenue***	***County***	***County***	***Public***
		Possible: civil service	NHIF premiums	NHIF	NHIF	Public & Private
	SHC	Informal sector	General revenue	County	***NHIF***	***Public & Private***
		Formal private sector & civil service	NHIF premiums	NHIF	NHIF	Public & Private
	THC	Informal sector	General revenue	MOH	NHIF	Public & Private
		Formal private sector & civil service	NHIF premiums	NHIF	NHIF	Public & Private
3 – NHIF for all (direct finance option)	PHC	***Informal sector (esp. poor)***	***General revenue***	***MOF***	***NHIF***	***Public & Private***
		Formal private sector & civil service	***NHIF premiums***	***NIHF***	***NHIF***	***Public & Private***
	SHC	Informal sector	General revenue	***MOF***	***NHIF***	**Public & Private**
		Formal private sector & civil service	NHIF premiums	***NIHF***	NHIF	Public & Private
	THC	Informal sector	General revenue	***MOF***	NHIF	Public & Private
		Formal private sector & civil service	NHIF premiums	***NIHF***	NHIF	Public & Private
4 – NHIF for all (MOH/Counties contracting option)	PHC	Informal sector (esp. poor)	General revenue	***County***	NHIF	Public & Private
		Formal private sector & civil service	NHIF premiums	MOF	NHIF	Public & Private
	SHC	Informal sector	General revenue	***County***	NHIF	Public & Private
		Formal private sector & civil service	NHIF premiums	MOF	NHIF	Public & Private
	THC	Informal sector	General revenue	***MOH***	NHIF	Public & Private
		Formal private sector & civil service	NHIF premiums	MOF	NHIF	Public & Private
5 – Regional social health insurers (RSHI)	PHC	Informal sector (esp. poor)	General revenue	County	***RSHI***	Public & Private
		Formal private sector & civil service	***RSHI premiums***	***RSHI***	***RSHI***	Public & Private
	SHC	Informal sector	General revenue	County	***RSHI***	Public & Private
		Formal private sector & civil service	***RSHI premiums***	***RSHI***	***RSHI***	Public & Private
	THC	Informal sector	General revenue	MOH	***RSHI***	Public & Private
		Formal private sector & civil service	***RSHI premiums***	***RSHI***	***RSHI***	Public & Private
	NHIF to act as a risk equalization and reinsurance mechanism for the RSHIs					
6 – Insurance competition	PHC	***Informal sector (esp. poor)***	***General revenue***	***MOH***	***REP***	***NHIF & PHI***	***Public & Private***
		Formal private sector & civil service	***NHIF premiums***	***NHIF & PHI***	***REP***	***NHIF & PHI***	***Public & Private***
	SHC	Informal sector	General revenue	***MOH***	***REP***	***NHIF & PHI***	**Public & Private**
		Formal private sector & civil service	NHIF premiums	***NHIF & PHI***	***REP***	***NHIF & PHI***	Public & Private
	THC	Informal sector	General revenue	***MOH***	***REP***	***NHIF & PHI***	Public & Private
		Formal private sector & civil service	NHIF premium	***NHIF & PHI***	***REP***	***NHIF & PHI***	Public & Private
	Risk equalization pool (REP) to receive all contributions from , risk adjusted payments to all insurers (NHIF & PHI)					

An assessment of the options

Option 1's biggest advantage and also drawback is its proximity to the status quo. This proximity means that there will be only limited stakeholder opposition to the reform, provided that funding is made available (a precondition for all options). At the same time, the chances that business as usual continues without any real improvements in effective coverage, efficiency and governance are also relatively high. This would mainly hit the poor. Effectiveness and efficiency in this system would be medium, as there are no incentives and duplicated structures in NHIF, Counties and MOH continue to exist. On the positive side, implementation could start straight away.

Option 2 may be a more acceptable reform for the Counties, as they would keep the power to contract NHIF. The purchasing structure would be somewhat simplified, by having all services from SHC upwards purchased by the NHIF. This would be even more simplified if all PHC services would be funded by Counties. At the same time, this may increase opposition by the civil service who was previously covered for PHC by NHIF. A drawback could be a lack of continuity of care between PHC and SHC, due to the change in funder. How effective this option will be in increasing coverage for the poor will depend strongly on the willingness of Counties to allocate funding.

Option 3 is the simplest option: One pool, one purchaser for everyone for all level of services. This can reduce admin costs and improve coordination of care across different levels. At the same time, this option relies strongest on effective regulation of the monopoly-insurer (i.e. NHIF). Other countries (e.g. Estonia) have been successful at this this, but the Kenyan track record on sound governance and compliance with financial regulation is weak. This means that the potential benefits may not materialize and the NHIF could continue running a highly inefficient and opaque administration.

Option 4 connects the acceptability to Counties with simplicity in funding streams (i.e. option 2 and 3). Handing budgets to the Counties and MOH to contract NHIF for all will likely decrease resistance to change on the side of the Counties and NHIF, but at the risk of inadequate allocations by Counties and MOH. Equity across Kenya, esp. for the poor, might become an issue.

Option 5's main appeal is the ability to benchmark funds and create an incentive for efficiency by competition if Counties can change their Regional insurer in case they are not happy. This would counter the dangers of an inefficient monolithic single payer as under option 3. If all goes well, this would balance the extra costs in duplicated administrations. At the same time, the regional insurers may become similarly inefficient as the unreformed NHIF while multiplying administrations. The complexity of a risk equalization and reinsurance mechanism requires strong human and data collection capacities. It is doubtful if Kenya has these.

Option 6 aims for the strongest incentives for efficiency but has the highest risk of risk selection by insurers, causing inequity in access**.** It has thus the most complicated risk equalization needs. The capacities do not currently exist in Kenya and developing them in the medium term will be a big challenge. Evidence from PHI systems worldwide do not point to cheaper administrations, but rather to higher costs and decreased access to insurance for the neediest individuals. While this model will doubtless appeal to private insurers and to the privately insured Kenyans, it can hardly be recommended as a viable road to UHC.

4. Concluding remarks

To honor the constitutional right to health services and the electoral pledge of the Kenyan administration, decisions how health care is to be financed in Kenya need to be taken now. The political will exists. The economy is growing, creating fiscal space to expand public funding of the health sector. Technical innovation has removed administrative hurdles.

This policy brief has laid out several key reform recommendations and scenarios for the consideration of Kenyan policy makers. A preference for one the options would need to be based as much as possible on explicit criteria such as chances of improving access for the poor, administrative efficiency and optimal purchasing capacity. Tthese options further need to be assessed for their desirability and feasibility. Those found least likely to succeed in guiding Kenya towards UHC should be discarded. A smaller selection of most preferred options should be presented to the Cabinet Secretary and discussed with stakeholders.

I**n the process, some adaptations and changes may need to be made,** but GOK should have the general direction clear and pursue UHC as its goal. Vested interests should not be allowed to derail the process again.

Even though some uncertainties still exist, including the important question what UHC will cost, **now is the time for taking decision** on major institutional health financing architecture issues, while accompanying reforms should be tackled immediately. Issues such as the benefit package and provider payment system design and actual fee structures can be sorted out later. An immediate step to ensure availability of funding for the poor is to limit or even stop expansion of the current NHIF packages.