Comments from P4H on the UHC-Concept Note (submitted before 3rd October 2014)

Comments from Jan Bultman [*lead writer of P4H HFS review in 2012 and the Options paper in 2014, as GIZ consultant]*

Starting from the preferred MOH option, i.e. not expressing my personal preference for one or the other option:

1. To overcome the further fragmentation of health financing and the subsequent risk of trying to shift costs to the other fundholder,: the NHIF/SSHIA should also act as the purchaser of tertiary care and the GOK funds also pooled at the Treasury while MOH concentrates on policy making, regulation and M&E of the overall health sector.

2. The issue of inequality in physical access to health facilities, although in theory having universal access, could be, at least partly, solved by a combination of reimbursing transport costs and allowing cross-county care for the insured or by offering a discounted contribution rate while other opportunity costs may still pose a problem for the poor.

3. A gradual development of a risk equalization model for recurrent costs is a good and very practical idea. Starting with a per capita based system sounds logical but still requires a good population data base which is kept actual and offering mutations every quarter of the year. It will also require the auditing of county population data bases and their regular updating. The actual transfers of monies should take into account the absorption capacity of the receiving counties, i.e. their capacity to really use the extra monies given their possible supply side issues. Adding a poverty rate criteria would also require auditing of the poverty assessors/chiefs. Preferably the equalization should be ex ante and ex post while auditing the high consumption counties on the justification of the used financial resources to prevent counties from paying for not strictly necessary care, possibly out of fear of loosing resources for the next year. After the per capita step a next step could be to introduce age and gender but this makes sense only after having data about consumption per age and gender cohort, which will be quite something to establish. Most important is that all parties realize and accept that the equalization mechanism needs to be an adjustable instrument, adjusted on developing/refining equalization criteria and better definitions of the sub-sets of the population. Transparency in operation of an equalization mechanism is key for building trust among all parties and for playing according to the rules. The issue of cross county care will also need to be addressed.

4. Because of the human resources problems, especially the shortage of family physicians and of doctors in rural areas while the emphasis is on PHC, the best bet might be to invest in upgrading nurses to nurse-practitioners since nurses are in general more likely to remain in their communities.

5. The monopoly [monopsony] problems of a single purchaser can be prevented/solved by having a strong/independent oversight authority.

6. NHIF management costs should be not more than 15%: propose to add: of benefits expenditures. Further, it needs to be clear whether the 15% also includes the investment costs of NHIF or its successor.

7. It would be useful to consider the trade offs between a small and deep benefits package and a broad benefits package. The latter partly financed from income dependent copayments at the points of services. The broader the package the more the insured are protected against overcharging by providers and receiving inappropriate care because of the possibility of setting the tariffs and revieiwing the performance of providers by the purchasing agent. A broader package also prevents the utilization of more costly services that are covered and included in the BP: If paracetamol would be sufficient but not reimbursed by health insurance while diclofenac is on the reimburseable drugs list, doctors will prescribe the latter and patients will beg for such drug. So, include paracetamol in the BP but charge a a little copay for all drugs just enough to prevent jumping to more expensive ones for the sake of avoiding payment for not-included drugs. .

8. Besides the costs of the BP also the general conditions for entitlement to benefits in general and for selected (expensive or scarcely available) services/benefits are recommended to be formulated as a tool for cost-containment and preventing the overload of higher level care. Formulating referral criteria are just one of possible conditions. Individual need for a particular intervention is another one. Any diagnostic algoritms and treatment standards should be seen as guidelines and not as obligatory to be followed except in perhaps a few cases. Most clinical guidelines are for single morbidity and do not take into account multimorbidity and many times based on weak scientific evidence. However, the purchaser should be mandated to review and question the performance of the contracted provider and possess appropritae sanction mechanisms.

9. A per capita financing of providers is a way of risk shifting from purchasers to providers and providers may be tempted to lower their burden by referreing patients. Combining per capita with FFS for particular interventions or with some limited RBFmight be useful if and when the purchasing infrastructure and capacity will allow for this.

10. It needs to be realized that being accredited is comparable with having a driving license: such license allows the owner to be on the road with his vehicle but does not prevent causing accidents. For this latter, there is a separate authority (the police). So, MOH may also want to maintain an independent medical inspection services.

Best regards,

Jan

Being aware that Ministry may have started revising the paper reflecting the already-available comments, followings are the JICA's Comments on 'A Model for Health Financing Reforms in Kenya' drafted on August 8th, 2014.

Comments from Kumiko Yoshida (JICA)

1. The Preferred Health Financing Model (3.1): “NHIF for All”

In this document, the new role of the NHIF and the role of the new Social Health Insurance are not clear. Also, the NHIF has many stakeholders including the civil servants who contribute to the premiums. As this document mentions at the end, it is critically important to inform thoroughly all stakeholders and actors and assure participation in order to create ownership feeling on all levels from MOH and NHIF to counties, health facilities, staff, and community.

2. The Preferred Health Financing Model (3.1): “Pooling at Counties”

Fund pooling at the County level is a rational debate from the view point of the current constitution. However, it is not clear whether pooling at counties is efficient and effective from the view point of providing primary health services equally. It is required to design the equalization fund carefully.

3. Collecting Premium from the informal sector (3.2.2)

What is the rationale to collect the flat premium from “half (73%)” of the informal sector? It is necessary to analyze which is cost-effective; collecting premium (including identification of the informal sector, administration costs, and so on) from the informal sector or covering it by general revenue.

4. The Purchasing Agency (3.3.3): “Minimum package of essential health care”

As the MoH clearly mentioned in this document, UHC can only be achieved by defining a minimum package of essential health care for all Kenyans due to limited resources. Based on its definition, the MoH can decide whether the preferred health financing model “the NHIF for all” is financially feasible and sustainable. Therefore, we recommend that the MoH work on defining its minimum package immediately after finalization of this document and the UHC Road Map.

Thank you and best regards,

Kumiko Yoshida

Comments from Bayar Dorjsuren (WHO)

Please, find below and attached comments from **WHO** on the proposed policy brief for health financing reform in Kenya as requested. I also updated my comments made in the draft itself by using the track change mode. Our overall intention is to support this initiative with better understanding of the proposed model, linkages between problems, proposed changes, and arrangements. We also emphasized our interest in finalising the health financing strategy that we supported so far.

General comment

We appreciate the work progress led to this policy briefs proposing a model for health financing reform. At the same time, we remain interested in progresses to finalize the draft

strategy for health financing reform that was supported by high level commitments to UHC, related studies, discussions, policy options, and briefs. Likewise, substantial efforts and investments were made in this direction so far. In our view, the value of having a health financing strategy would help to see the whole financing picture and understand the main issues, challenges, set goals, objectives, time-bound targets if necessary, and take strategic actions e.g. to develop, implement, monitor and evaluate health financing reforms. In other words, it would clarify how and what time frame Kenya will change its health financing arrangements by improving their revenue collection, pooling, purchasing, benefit design, and overall governance of the system and move towards UHC. In fact, the importance of having a strategy was felt in several places of the presented model.

Specific comments

Below comments are intended to understand, clarify and improve the proposed model, linkages between stated problems, proposed changes, consistency of reform measures and institutional arrangements to ensure that they suite to the country settings and produce desirable results and effects.

1. The proposed policy brief emphasized about 9 issues and 4 policy focuses that would be helpful to examine how this proposed model will address them. Some issues and policy focuses likely need clarities. For example, how the high burden of out-of-pocket payment will be reduced or will the minimum benefit package of essential services for all people funded through central, local governments and health insurance reduce it? If the proposed model is only about financing of minimum essential packages of services, then it may have still limited impacts on removing financial barriers. The statement to introduce standard packages of essential care for all levels and use fee recommendation for all services (page 9) suggests that people still need to pay from their pocket to obtain both for essential and non-essential health care.

2. The statement to raise more funds through health insurance in order to reduce the deficit (page 7) is probably not very relevant or important objective in the given context. It will be difficult to make an immediate shift to inclusive pre-paid risk pooling schemes (page 7) when both resources and benefits are limited. Therefore, it will be helpful to define realistic, and time bound targets e.g. to reduce out-of-pocket payment as a result of implementation of the proposed reform measures.

3. Fragmentation was recognised as one of the issues. Again, how the proposed model will address this concern. The model suggests separate revenue mobilization, pooling and management arrangements with involvement of 5 different categories of agency like MoF, MoH, NHIF, Counties, and SSHIA. The Country level pooling may indicate that there might be 47 different pools with limited benefits unless this arrangement is clarified in the proposal. The idea about equalisation funds (page 8) needs to be well linked to the part which discusses the model (page 6).

4. Setting up a new SSHIA in parallel with NHIF will increase administrative cost. In resource constraint settings, it is preferable that newly mobilised resources are used to

solve the main issues through investments to increase health coverage, service delivery, quality and financial risk protection rather than in setting up new institutions and structures. This may involve some discussions whether to ensure all people with minimum essential package of services or invest in services and people to ensure that those who are currently excluded from health care coverage have equal access to needed health care. The concept of essential minimum package needs to be clarified with those who already have more than the minimum package through different coverage schemes such as NHIF. In principle, strengthening NHIF is critically important. It might be more realistic and acceptable to consider some elements proposed in the second policy option of the P4H policy brief that suggested NHIF reforms to complement Counties.

5. Recommended costing of the minimum package will largely depend on costing methodologies. It is possible that after investing substantial time and resources in costing, the results make the package unaffordable with available revenue resources, because of many inflated factors.

6. In general, the model narrows discussions to financing schemes, institutions (what form of insurance), and minimum packages, but not much about improvements of health financing functions to address the issues and attain objective. This indicates that a health financing strategy can be valuable to fill these gaps looking at the issues and policy focuses from the wider health financing and systems perspectives.

Best,
Bayar

Comments from Kai Straehler-Pohl (GDC)

GDC comments

One remark: The set-up for tertiary care is relatively clear, with the MOH contracting SSHIA/NHIF for purchasing care. Most of the following comments relate to PC/SHC (i.e. unless otherwise stated), which is to be financed by Counties. There still seem to be a few issues to be settled.

– **Non-poor informal sector**: The paper needs to be clear on the treatment of the non-poor informal sector people. Currently this group is often lumped together with the poor informal sector, which leads to conflicting statements: in section 3.1, it is stated that all informal sector households will be tax funded, while in section 3.2.2 it is stated that they are to make a contribution. Section 3.2.2 makes clear that this is considered to be a question of “fairness”. This is a common feeling and often an issue of political acceptability – “everyone should contribute”. At the same time, evidence abounds that it is very hard to reach universal coverage with informal sector contributions. In order not to hold up the

whole process at this stage, I would suggest planning a trial to evaluate the cost-effectiveness of such an approach, and base future decisions on evidence.

– **Purchasing**: It may also be useful to consider DRGs and mixed financing arrangements especially for tertiary care (e.g. mix global hospital budgets with FFS or DRGs); Ghana is currently setting up a system that may provide lessons.

– **Risk equalisation** between Counties: Others have commented on this, I agree with them on the need for a mechanism that needs to be worked out.

– **Purchasing**: It may also be useful to consider DRGs and mixed financing arrangements especially for tertiary care (e.g. mix global hospital budgets with FFS or DRGs); Ghana is currently setting up a system that may provide lessons.

[footnote: There was a comment about not drawing boundaries between PC/SHC/THC in order to ensure the continuum of care. While this is clearly desirable, having two financiers – Counties and MOH – who are to finance different sets of services within the individual oriented care domain, some border needs to be drawn. If there is a better idea than to use THC vs PC/SHC, then this should be spelled out and considered.]

Comments Kai Strähler-Pohl and Jan Bultman

CD notes: exchange between Jan Bultman and Kai Strähler-Pohl

Here some additional food for thought we picked up from an internal discussion between Kai and Jan on Option 4, in particular the **role of Counties** as future health financiers and the issue of national level **risk equalization**. I thought it would be a waste to not share this with the broader group. Thanks to Jan and Kai for allowing me to post parts of this interesting exchange, which in my view helps to clarify some of the issues.

*In **Option 4**, the **cost-effectiveness, equity in financing** and **equality in access** all depend on the extent the Counties can be prodded to contract NHIF (or its successor) for purchasing the universal benefits package (BP), including THC. Obviously, all Counties entering into the same single contract with NHIF would be the best. It allows the **NHIF to act as the de facto equalizing agent between Counties** but it is based on the willingness of the counties to indirectly subsidize the other ones. However, it could possibly lead to poor Counties subsidizing rich ones because of differences in supply side and actual consumption, which would seem a bizarre result. Individual or regional contracts are all less preferable from a cost-effectiveness point of view. Such choice would only be based on political/feasibility assumptions and/or on the negotiating/policy making capacity/power of MOH and/or GOK.*

However, the fundamental problem of a devolved government administration, having a mandate in health services AND in health financing on the one hand and a national health insurance on the other hand will not be solved. Hence, Option 4 could be somewhat compared to symptom-oriented therapy or a band aid.

*On the need for a **risk-equalization system between counties:** It is up to the County to decide how much they would like to spend on health facilities and on health services. Since differences exist between the Counties as regards the supply side (physical infrastructure, medical equipment and HR capacity) and as regards the poverty level and population density/geography, the question arises how to compensate for these.*

*So, realizing universal access to a universal BP while having 48 counties having each their own specific contract with NHIF and each county deciding itself about the amount of money it would like to spend on the health sector in its County will be possible only with some level of **equalization** between the Counties **unless**, the Constitution allows for, and the GOK/Parliament adopts, **legislation that either obliges the Counties to facilitate universal access to the uniform BP irrespective of their poverty level by providing NHIF with sufficient budget** or **to earmark part of the yearly County budget to health sector funding.** The latter being conditional grant funding by the National government. Again, this is still band aid while the fundamental problem of the devolved admin system and the national health insurance system is not solved.*

*To allow a **County adjusted BP** runs the risk of continuing inequality in access. Differences in BP between counties are also not necessary to deal with differences in morbidity. A universal BP will in principle reimburse all included health interventions but the extent to which services are actually offered and contracted by NHIF depends of the specific needs in a County.*

*Charging a **"premium" to be paid by a County to the NHIF** raises the question of criteria or of the basis for the determination of the premium: will this be uniform across the country for each enrolled individual irrespective of the supply side or adjusted to the actual and/or estimated consumption level of a county. This latter option would continue to favor those counties with a large supply side, relatively wealthy residents and hence patients not being barred from seeking help due to opportunity costs.*