Summary of highlights and issues

There is **high level commitment** of the new Jubilee government to health (one of the President's 100-day priorities after the elections in March 2013) and a strong interest in moving towards UHC; the P4H members consider this as a great window of opportunity to revive the HFS process and move the UHC agenda forward; however, the technical level now needs to catch up: help with clarifying what UHC means in Kenya and providing feasible and sustainable options in due time.

The 'elephants'. There are currently two major issues and moving targets that feature prominently in - and may possibly skew - the discussions about UHC in Kenya:

1. NHIF reform is part of the new government's priorities. The CEO (S. ole Kirgotty) reports that 'political interference' has been much reduced since he took office; he thinks that the NHIF performance is far ahead in the region, and is trying to make a case for the NHIF as the main vehicle for UHC in Kenya. However, in the P4H members' view the NHIF still needs to demonstrate that it qualifies as a UHC financier in terms of governance, reduction of high admin costs (47%!), population coverage and strategic purchasing.
In this context, the World Bank and JICA have started supporting the **Health Insurance Subsidy for the Poor (HISP)** programme, a government initiative to extend health insurance coverage, through the NHIF, to poor people in Kenya ($ 20 Mio. as grant, 40 Mio. as loan). This may also provide an entry point to support NHIF reforms. However, caution is advised to avoid similar situations as in pre-UHC Thailand, Philippines or Indonesia, where in particular the informal sector lacks coverage. To address this effectively would require a national discussion and solution.

2. Decentralisation. The responsibility of delivering public health services has been devolved to counties; government budget for health is being split: 1/3 to MoH central, 2/3 to county governments. Decentralisation has been a major challenge for UHC in many countries due to huge regional disparities in terms of poverty levels (e.g. from 20% in Nairobi to 80% in Turkana), varied political interest in health, supply side readiness, etc. It will be of paramount importance to involve the county governments in the national UHC discussion.

Health Financing Strategy (HFS). The revival of the Inter-agency Coordination Committee on Health Care Financing (ICC-HCF), the sub-sequent formation of three Technical Working Groups (TWG) on UHC, NHIF reform and quality and regulation have broad a new dynamic to the development/finalisation of the HFS. The visiting team had a chance to interact with three local consultants (Jane Chuma, Timothy Okech, Richard Ayah) who are currently working separately on three UHC assessment components as specified in their individual TOR: institutional arrangements, health financing functions and services/benefits. Summary of points raised:

- **Bigger picture.** UHC is a complex political and technical objective going *beyond health financing and health*; consider context: pre- and post devolution in particular new funding arrangements under devolution (2/3 to counties); provide *more info for decision making*, e.g. fiscal space projections for next 10 years, change in DP contributions, etc.); caveat limitations of technical tools and frameworks; also consider a *political analysis*; think in terms of a national *system*, not schemes (NHIF, PI, CBHI, etc.);

- **Vision.** *UHC vision should come first* to clarify what UHC means in Kenya, which then would guide the assessment and development of options and structure the report outline; e.g. what would be the public/private mix? Strengthening public sector or promoting private sector would require different rules; etc.

- **Assumptions.** One needs to be careful about the assumptions, e.g. 'NHIF will be the main insurer for all Kenyans' as these are important policy decisions still to be made after the evaluation of options; hence, the assumptions need to be revised, secondly all three consultants should work with the same assumptions;

- **Options.** Work on options for *Benefit Package (BP)*. Analyse it from different aspects: financial requirements and in terms of service provision. BP design: aim at what is affordable and sustainable, not what would be ideal: broad and shallow, or narrow and deep (prepare options for political decision); not to confuse facts, opinions and options; develop 3-4 scenarios and analyse their pros and cons; avoid presenting only some favoured option. The visiting team (KSP) presented a possible thinking tool visualising the process of developing options for population and service coverage. To view KSP's presentation click here.

- **Purpose and focus.** The reports are only snapshots using rather out-dated NHA data, not producing any new data or insights; descriptive of status quo of rules and practice, however not asking broader questions, e.g. if current setup of institutions and organisations makes sense in view of UHC goal; reports need to include *trade-offs* and *scenarios* for decision making; should not shy away from key questions such as establishment of a single pool especially in context of devolution, how to deal with informal sector, contributions from employers, role of private sector (service provision and insurance); take into account fiscal space study, efficiency study, costing of KEPH, look for NHIF data, etc.; identify and recommend ways to address efficiency issues in the system;

- **One report.** Though it would have been preferred to have ONE report, the contractual arrangements and lack of a lead consultant seem to be in the way; the TWG UHC asked for a synthesis report to be prepared by an international consultant/team provided by the P4H members (probably in Feb 2014); the compiled report needs to go beyond the current scope of the three reports and focus on feasible and sustainable options for UHC in Kenya.

Interactions with ICC - HCF *[Inter-agency Coordinating Committee - Health Care Financing]*
Brief intro based on team discussions by P4H CD: UHC does not mean health insurance - not to confuse goals and means; the development of options needs to be guided by UHC vision (see also WHR 2010); importance to discuss *'who's business UHC is'* and the need for broad stakeholder involvement (MoH, MoF, MoL, counties, private sector, employees and employers, etc.); assessing and developing capacity for UHC; including M&E system for keeping track with implementation of HFS and progress towards UHC; P4H members happy to support these processes.

Content input (by BH) sharing some global lessons in planning and implementing National Health Insurance; pointing out that insurance coverage is not the same as effective coverage; BH emphasises that quality service provision is at the core of UHC (service coverage); raising critical issues about developing a benefit package using a *UHC pyramid* (modified WHO UHC cube) tailored to the Kenyan situation (46% poor), which illustrates population and service coverage options in more detail; discussing alternative sources of funding and stage-by-stage strategies in terms of risk pooling, public/private mix and institutional arrangement. To view BH's presentation click here.

Discussion: questions about the role of civil society and levels of solidarity; coverage across borders, e.g. for treatment abroad; what does UHC mean in the Kenyan context?

[Dr. Sharif]: since health has been part of the ruling party's manifesto and the President appears to be enthusiastic about health, we need to look at upcoming windows of opportunity (e.g. 50 years Kenya) to take agenda forward; as the political will is there, he sees pressure building up for developing concrete options as soon as possible (1 year after elections would be 'too late').

[Elkana]: mentions the importance of the on-going UHC assessments and options development.

[Ahmed]: Suggestion for (interim) key message for top leadership: UHC is a priority for Kenya and we as Kenyans should do whatever it takes to take this forward.