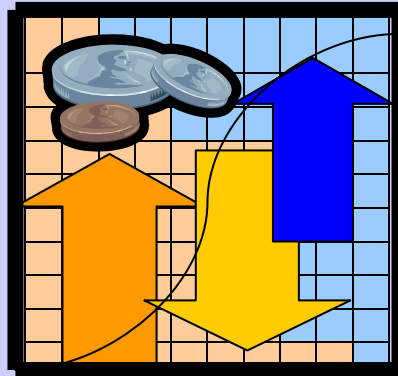




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# **Health financing reform in Kenya: assessing the social health insurance proposal**

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# **Health financing reform in Kenya: assessing the social health insurance proposal**

by

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## **SUMMARY**

Kenya has had a history of health financing policy changes since it gained independence in 1963. Recently, significant preparatory work was done on a new Social Health Insurance Law that, if accepted, would lead to universal health coverage in Kenya after a transition period. One of the key features of this proposed Law is that it ensures access to health care among the poor by granting them full social health insurance membership status. In this paper, we assess the 'expected' performance of the Social Health Insurance Fund that would be set up if the Law was passed. We also give an overview of how the reform would be financed, and initial responses of different stakeholders to this reform.

**Keywords: health financing reform, social health insurance, health policy process**

## **1. INTRODUCTION**

Since independence in 1963, Kenya had a predominantly tax-funded health system, but then gradually introduced a series of health financing policy changes. User charges had been in place as well but were later removed, inspired by concerns about social justice. However, user charges for health services were introduced more formally in 1989. Today, these user fees still exist and their impact on health care access has been the subject of several empirical studies. A National Hospital Insurance Fund (NHIF) was also introduced in 1965, but this was only compulsory for the formal sector workers and has been associated with an inadequate insurance benefit package. However, in November 2004, a new health financing reform was submitted to Parliament, involving the establishment of National Social Health Insurance Fund (NSHIF) with the intent to cover all of the Kenyan population.

The implementation of a well run and effective NSHIF will be a formidable challenge. The main objective is nothing less than granting all population groups, including the poor, access to a comprehensive benefit package of health services. In addition, any remaining out-of-pocket payments for insured health services, i.e. co-payments, should not be such that households remain confronted with catastrophic health care expenditures or fall into poverty.

In this paper, the focus is on key design features of the proposed NSHIF, assessing expected performance of the fund along with its financing and organisation (section 3). Initial responses from selected stakeholders and challenges in implementation are also briefly explored (sections 4 and 5). Before this analysis, we first give an overview of health financing reform initiatives in Kenya, in section two below.

## **2. HEALTH FINANCING REFORM IN KENYA: AN OVERVIEW**

### *The introduction of user fees*

User fees, or 'cost-sharing' as it commonly referred to in Kenya, was not part of the policy discussion between 1963 and 1989. The health financing system in Kenya was then supported primarily via general tax revenue. However, in the late eighties, cost-sharing would start to attract considerable policy attention. In 1989, structural adjustment policies and severe government budgetary constraints led to the introduction of user fees for outpatient and inpatient care at government health facilities. Yet, for children under five and for specific ailments, an exemption from fees was introduced. In addition, health care at dispensaries would still be delivered free of charge. A detailed account of the policy process around this time, which included a discussion of different health financing options, can be found elsewhere (Dahlgren, 1991). In 1990, as a result of widespread protest the user fee policy was reformed with outpatient registration fees being removed, while keeping the other fees. This was later reversed after pressure from some Development Partners. Several studies have pointed at the negative impact of user fees on utilization of health care services in Kenya. A study on the use of health services in Kibwezi, a poor rural region, revealed that outpatient care increased again after the lifting of the registration fees

(Karanga et al, 1995). Similarly, a study on health care seeking behaviour in Kisumu and Embu districts showed that outpatient attendance at government health facilities had dropped by about 50% during the initial cost-sharing period of 1989; attendance rose again by about 41% subsequent to the suspension of the outpatient registration fees (Mwabu et al, 1995). Results from research on the impact of user fees on attendance at a referral centre for sexually transmitted diseases (STD) confirm the empirical findings above; at Nairobi's Special Treatment Clinic for STD, attendance by men dropped by 40% during the user-fee period and rose again when fees were suspended, although only to 64% of the attendance level in the period before the introduction of user charges (Moses et al, 1992). Waiver and exemption mechanisms have also not been particularly effective (Bitrán and Giedion, 2003).

The fiscal situation in Kenya remained problematic, however, and the Government decided to reintroduce 'treatment' fees in 1992. Knowing about the negative effects on utilisation, the Government introduced these fees in phases, first in national and provincial hospitals and then district hospitals and health centres. Treatment fees would only have to be paid when treatment was effectively available. Utilization of outpatient care in hospitals did drop although more modestly, namely by 6% compared to the period where fees were suspended. This modest reduction was not only attributed to the linkage of fees to effective treatment, but also to better exemption rules (Collins et al, 1996). However, the cost of healthcare remains an important problem: 40.5% of those households not accessing health services cited financial difficulties as the principal reason (Xu et al, 2005).

The user fee system has been extended until the present day. In June 2004, there was a policy statement by the Minister of Health, however, stipulating that health care at dispensary and health centre level would be free for all citizens, except for a minimal registration fee in government health facilities.

#### *Interest in social health insurance*

However, the most significant event since the introduction of user fee policies in 1989 has been the government's interest in social health insurance as a health financing method and its possible implementation in Kenya.. The purpose of such a system is to ensure access to outpatient and inpatient health care among all Kenyans and to significantly reduce the out-of-pocket health care expenditure of households, especially of the poorest (Ngilu, 2004). Already in May 2002, an inter-sectoral Task Force was established to prepare a national strategy and legislation which would be a first step in the preparation of Kenya's National Social Health Insurance Fund (NSHIF) (Ministry of Health, 2003; Mboya et al, 2004). After a series of policy debates and subsequent deliberations in parliament, the latter passed the NSHIF Bill on December 9<sup>th</sup> 2004. However, the president, who was expected to ratify the NSHIF Bill following parliament's acceptance, decided it still needed amendments and returned it to parliament for debate.

It is important to note that Kenya already has hospital care insurance, provided via the 40-year old National Hospital Insurance Fund (NHIF), with all salaried employees and their dependents compulsory insured and making monthly statutory contributions. The new

NSHIF Law, however, entails a formidable challenge for the Kenyan health financing system, as it has universal coverage as its main principle (van Lente, 2004). It is the NHIF that will be transformed into this new Fund. Another important challenge is to drastically improve the financial protection provided through social health insurance. Indeed, although it reaches about 7 million beneficiaries, the NHIF only covers the 'hotel' part of inpatient health care costs. That is, insured NHIF members still need to pay out-of-pocket fees for treatment, diagnosis and pharmaceuticals. It can therefore be understood that financial protection by the NHIF is quite weak.

### **3. KEY DESIGN FEATURES OF THE PROPOSED NSHIF**

When evaluating the proposed NSHIF, information from Kenyan government policy discussion papers are assessed, notably the *Sessional Paper on National Social Health Insurance in Kenya* (Ministry of Health, 2004a) and the *National Social Health Insurance Fund Bill* (Ministry of Health, 2004b). These will be referred to as the "Sessional Paper" and the "Bill" respectively. Unless otherwise stated, figures used in this section come from one of these two documents.

#### **3.1 ASSESSMENT OF EXPECTED PERFORMANCE**

We introduce below a conceptual framework, to help monitor and evaluate progress in implementing social health insurance (Carrin and James, 2005). We briefly summarise this framework (section 3.1.1), then adapt the framework to the NSHIF in Kenya (section 3.1.2). Note that we assess expected performance of the new NSHIF rather than performance of the current NHIF. This assessment is largely based on a series of six technical reports (TMRs) that resulted from advisory missions by WHO, GTZ, ILO, KfW and DFID (2004) between June 2003 and June 2004. These reports contain the technical suggestions formulated by the advisers that were part of these missions.

##### **3.1.1 Framework of analysis**

The performance of a social health insurance (SHI) scheme, or indeed any type of health financing system, can be evaluated in terms of achieving universal coverage: securing access to appropriate health care for all at an affordable cost. Indeed, the World Health Organization (WHO) stated earlier that “the purpose of health financing is to make funding available, as well as to set the right financial incentives for providers, to ensure that all individuals have access to effective public health and personal health care” (WHO, 2000: 95). Hence we evaluate how well the NSHIF is expected to perform in its initial years of implementation in relation to the following health financing targets:

- Resource generation (sufficient and sustainable)
- Optimal resource use
- Financial accessibility of health services for all

Assessing performance in these health financing targets is done by analysing performance in the three broad functions of health financing - revenue collection, pooling and purchasing (WHO, 2000; Kutzin, 2001) - where for each function key performance issues and associated indicators are specified.

*Revenue collection* can be defined as the process by which the health system receives money from households, enterprises, government and other organizations including donors (WHO, 2000: 95). It is by definition related to resource generation, but also to the target of financial accessibility of health services for all, since the way in which revenues are collected affects financial accessibility. The key performance issues for revenue collection are: **population coverage** and **method of finance**.

*Pooling* is the accumulation and management of these revenues in order to spread the risk of payment for health care amongst all members of the pool; and thus individual persons no longer bear their risk on an individual basis (WHO, 2000: 96). It is related most closely to financial accessibility of health services for all. However, it is also associated with resource generation (since who exactly joins the SHI risk pool/s affect its sustainability) and optimal resource use (through how well risk pools are managed). The key performance issues for pooling are: **composition of risk pool/s**, **fragmentation of risk pooling** and **management of risk pool/s**.

*Purchasing* is the process by which these pooled contributions are used to pay providers to deliver a set of specified or unspecified set of health interventions. Purchasing can be either passive or strategic, with passive purchasing simply following predetermined budgets or paying bills when presented. Strategic purchasing is generally preferred, as it is where there is a continuous search for purchasing the best health services, how to purchase them and from whom (WHO, 2000: 97). That is, better purchasing is important for the target of optimal resource use. The key performance issues for purchasing are: **benefit package**, **provider payment mechanisms** and **administrative efficiency**.

In applying this framework to the NSHIF, it can help policymakers both in the evaluation of expected performance, as well as in monitoring progress in implementation. Table 1 below summarises the relation between performance in the health financing functions and realisation of health financing targets, with a cross indicating the existence of a strong relationship. Performance in the health financing functions is evaluated through easily measurable indicators in the following section.

**Table 1: Health financing functions and targets**

Performance in the health financing functions	Health financing targets		
	Resource generation (sufficient and sustainable)	Optimal resource use	Fin. accessibility of health services for all
<b>REVENUE COLLECTION</b>	<b>X</b>		<b>X</b>
1. Population coverage	X		X
2. Method of finance	X		X
<b>POOLING</b>	<b>X</b>	<b>X</b>	<b>X</b>
3. Composition of risk pool/s	X		X
4. Fragmentation of risk pooling			X
5. Management of risk pool/s		X	
<b>PURCHASING</b>		<b>X</b>	<b>X</b>
6. Benefit package		X	X
7. Provider payment mechanisms		X	
8. Administrative efficiency		X	

### 3.1.2 Application to the proposed health financing reform in Kenya

#### *Revenue collection*

#### 1. Population coverage

*Rationale: Maximise the number of people with improved financial protection*

*Performance indicator: Percentage of population covered by SHI*

The NSHIF intends to systematically enrol the entire population over a transition period, with universal coverage initially envisaged to take nine years following implementation. That is, there is some recognition by Kenyan policymakers that revenue collection from the self-employed is less straightforward than from the employed, although international experience suggests that nine years is still an optimistically rapid timeframe (Carrin and James, 2005). Subsequent technical mission reports (TMRs) (WHO, GTZ, ILO, KfW and DFID (2004), envisaged more gradual transitions to universal coverage, with coverage levels at 60%-80% nine years after implementation (TMR No.6). Ensuring rapid inclusion of all of the poor, though, is seen as an important priority in the Sessional Paper, even if there is still debate on the best way of financing this.

#### 2. Method of finance

*Rationale: Ensure adequate financial protection for SHI members*

*Performance indicator: Ratio of prepaid contributions to total costs of the SHI benefit package*

This ratio should be close to 100%, with the NSHIF financed through members' contributions (income-rated for employees and employers, flat-rated for the self-employed), and government contributing on behalf of the poor. Contributions will be set so that the NSHIF can cater for the complete cost of a comprehensive benefit package in all public, all

mission and most private facilities (in 11 more expensive private hospitals, members will pay for the difference in costs through out-of-pocket spending or supplementary private insurance - TMR No.6). This is a response to the current NHIF's limited financial protection, with principally only "hotel" costs being covered.

As a result of NSHIF implementation, there is expected to be a radical change in the structure of total health expenditure: whereby 75% of total health expenditure is through the NSHIF and the Ministry of Health, as compared with 44% in 2002 (WHO, 2005: Annex Table 5). The former percentage is comparable to the average share for general government expenditure in 27 countries with mature social health insurance systems (Carrin and James, 2005).

At the same time, contribution setting has also been sensitive to concerns of significant adverse effects on employment and compliance, with caps on contributions and lower flat-rate fees for dependents from larger households (TMR No.6). It was suggested to consider penalties for self-referral and minimal registration fees of 10-20 KSh at the outpatient level to help counteract potential moral hazard behaviour (TMR No.3).

*Performance indicator: Percentage of households with catastrophic spending*

In 2003, high out-of-pocket (OOP) health care expenditures led to 10% of households that used healthcare facing catastrophic expenditures (Xu et al, 2005). This study also demonstrated that so far the NHIF had no significant impact on reducing catastrophic expenditures, and only offered limited financial protection, with the poor, those aged over 60 and patients with chronic illnesses having lowest access. By including all of the poor within the scheme and offering a more comprehensive benefit package, the NSHIF is expected to improve access and be more effective in reducing catastrophic spending.

<b><i>Pooling</i></b>
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### **3. Composition of risk pool**

*Rationale: Limit problems of adverse selection*

*Performance indicator: Is membership compulsory in all/some contributing population groups?*

Currently, membership to the NHIF is compulsory for all employees and their dependents but voluntary for the self-employed. With the new NSHIF, membership will be compulsory in principle. However, during the transition period, coverage will not be compulsory for the self-employed. Policies are being considered to ensure that it is not only the high risk self-

employed who enrol into the scheme. For example, community organisations are scheduled to assume a role in signing up groups of people from their locality.

*Performance indicator: What percentage of each contributing group is covered by SHI?*

For private employees and, to a lesser extent, public employees, the main reason for coverage not being 100% immediately will be compliance. Few employers outside of Nairobi seemed to have complied so far. Measures to improve compliance have been discussed, based on improving the process of information exchange with business-registering authorities for registration, and with tax revenue authorities for contribution collection (TMR No.2). In addition, inspectors have been employed at the NHIF-branch level, with anecdotal evidence already referring to an improved compliance. For the self-employed and their dependents, coverage targets were initially 60% after five years, although subsequent analysis has also analysed more gradual implementation (TMR No.6).

*Performance indicator: Are dependents of contributing groups compulsorily insured?*

Dependents will be compulsorily insured, as is the policy with the current NHIF, with each individual above a minimum age having his own membership card. This will also help tackle fraud (TMR No.2).

#### **4. Fragmentation of risk pooling**

*Rationale: Minimise horizontal inequities*

*Performance indicator: Multiple risk pools? If yes, are there risk equalisation measures in place?*

The NSHIF will operate as a single risk pool, with all members entitled to the same benefit package. In this way, fragmented risk pools are avoided. Health Maintenance Organizations (HMOs) are envisaged to continue to play an important but modified role in financing the health system, by providing top-up supplementary health insurance.

Despite the single risk pool, fragmentation may still be implicit in that there is potential variation in the services received, due to variation in provider quality. Indeed, for the current NHIF, membership and access to health services is lower in poorer, more remote geographical provinces (Xu et al, 2005). To limit disparities between the services offered in public and private facilities, public facilities will continue to receive partial subsidisation from the Ministry of Health - for personnel costs and large infrastructure investments - for a number of years (TMR No.3).

Provider payment mechanisms could also contain incentives to maintain and upgrade quality, as the level of payment is linked to the level of quality. Efforts at the NHIF are underway through its new Department of Standards and Quality Assessment, to define health services quality and to monitor and evaluate this.

#### **5. Management of risk pools**

*Rationale: Enhance technical efficiency*

*Performance indicator: Are there efficiency incentives for the management of risk pool/s?*

The role of local branch offices was found to be quite limited, with claims processing finalised at the central level, and with only limited data available for surveillance and enforcement. Further, there has been little discussion on policies to ensure local branch offices actively engage in advocacy to speed up coverage and to contract with providers (TMR No.2) who can deliver quality health care at agreed upon remuneration levels. Decentralisation has been promoted, and it has been mentioned that local offices would be able to process claims with a fair degree of autonomy. A recent decision also gives more discretion to the local branch offices in dealing with informal sector workers and their families. However, a full account of managerial responsibilities for local offices is still needed.

## *Purchasing*

### **6. Benefit package**

*Rationale: ensure adequate healthcare services are received*

*Performance indicator: Is the benefit package based on explicit efficiency and equity criteria?*

A comprehensive standard benefit package (SBP) is being developed for health services at each of the five levels in Kenya<sup>1</sup>. It is both input-related and for different types of services. For certain services, notably long term care, patients may have to co-pay, although still a lower amount out-of-pocket than is currently the case. Excluding certain services, such as orthopaedic appliances and limited mortuary storage time, have also been discussed (TMR No.2, Kimani et al, 2004). Services for HIV/AIDS and tuberculosis will be included but accounted for separately, with these services potentially co-financed initially through external mechanisms and NGOs. Health facility-based preventive care will also be included, although other preventive and health promotion services will be under the remit of the Ministry of Health (TMR No.3). In general, exclusions and/or greater levels of co-payments seem to be based purely on cost containment reasoning rather than also on explicit efficiency or equity criteria.

Further, as of yet no detailed costing of the benefit package has been done (costing estimates have so far been based on provider remuneration and aggregated costs at different levels of services). This is necessary to ensure that the package offered can be provided within specified remuneration levels. There will also be some variation in the benefit package offered, as not all facilities will be able to immediately provide all of the services in the package.

*Performance indicator: Are monitoring mechanisms - patient appeals mechanism, full information on claimant rights, peer review committee and claims review - in place?*

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<sup>1</sup> These are: level I - dispensary; level II - health centre; level III - district/sub-district hospital; level IV - provincial hospital; level V - national referral and teaching hospital.

Active involvement of the population in the running of the NSHIF, along with an Appeals Tribunal, was originally planned for within the structure of the NSHIF. In recent discussions, active involvement of the population is no longer viewed as strictly necessary. Appointing an independent ombudsman has also been offered as another possible mechanism (TMR No.3). More general sensitisation of the population on the benefits offered by membership is underway (TMR No.5). It should also be explained to the population that ultimately the benefit package will be determined by considering the financial constraints of the government, enterprises and households, and will need to reflect an overall societal consensus.

## **7. Provider payment mechanisms**

*Rationale: ensure good quality care is provided at the lowest possible cost*

*Performance indicator: Do provider incentives encourage the appropriate level of care?*

A flat rate remuneration per inpatient day (daily payment) has been proposed. Reduced rates after the first few days to discourage excessive stays could also be examined. For outpatient care, a flat fee per visit (case payment) will be paid to providers (TMR No.2). Maximum provider payment levels and special approval for treatment abroad have also been discussed to help contain costs (TMR No.2). The exact remuneration levels are still under discussion, with suggested ranges of 1500-2500 KSh per inpatient day and 100-400 KSh per outpatient visit, based on selected health facilities (TMR No.2). These rates were based on the assessment of current financial needs reported by Mission and Government Hospitals with an extra allowance for higher quality services and infrastructure development. Reductions in fee levels may also be considered in the short run if health facilities can not provide the full benefit package.

These initial provider payment mechanisms were chosen on the basis of their ease of administration and resemblance to current practice, with more intricate methods such as disease-related groups (DRGs) considered in the future. The remuneration level will depend on the type of provider, and will cater for the complete cost of treatment - i.e. including drug provision and not permitting supplementary cost-sharing fees - unless explicitly specified (e.g. lower remuneration for long-term care).

Both methods create an incentive to treat patients at the lowest possible cost, as this increases hospital's net income. This is beneficial for efficiency, but conversely could lead to lower quality treatment to save money (e.g. not using all necessary inputs). A daily payment for inpatient care could also lead to supplier-induced lengths of stay. Such potentially perverse incentives could be addressed by accrediting and renewing contracts with providers only if they adhere to clear quality guidelines. Part of the tasks of quality assurance officers at branch level can also include tracking down artificial extensions in the length of stay. Adherence to a set of health standards defined in the criteria used by NHIF for the accreditation of hospitals and the *Kenya Quality Model* (Mboya and Adelhardt, 2003), along with the extent to which the SBP is provided, will be used to determine reimbursement levels for different providers (TMR No.2).

## **8. Administrative efficiency**

*Rationale: Enhance technical efficiency*

*Performance indicator: Percentage of expenditure on administrative costs*

Administrative costs and reserves will have a limit of not exceeding 8% of total NSHIF expenditures. Further, investments in new health facilities and expensive equipment are not seen as part of the NSHIF's remit. These are, in part, a response to major criticism of the NHIF, which in the past spent more than 25% of its budget on administration and 53% on investments. The 8% limit seems reasonable, given international experience: administrative costs recently accounted for a mean share of 4.2% of health spending in established SHI systems, but could be higher in initial years, as was the case in the Republic of Korea (Carrin and James, forthcoming).

### **3.2. FINANCING OF THE NSHIF**

Following initial estimates of how much will be needed to finance the NSHIF, and what the different sources of financing would be, there has been much debate on precise contribution levels from these different sources. First concerns centred around important surpluses in early years and high government contributions (TMR No.1). More recently, following the presentation of the draft NSHIF bill to parliament, the main issues have been related to the precise contributions expected from employees and their employers, and the potential for reimbursement of patients visiting high cost private hospitals. These are summarised in section 3.2.1, with the main results of financially simulating alternative contribution scenarios given in section 3.2.2.

#### **3.2.1 Areas of recent debate**

*Gradual implementation*

As mentioned in section 3.1, recent TMRs envisaged a more gradual transition to universal coverage than initial Sessional Paper estimates. This gradual transition is also more in line with international experience. This also corresponds to views expressed in other studies (Njeru et al, 2004). This would mean not only incomplete population coverage during the transition, but also that public health facilities would continue to receive (decreasing) subsidies from the Ministry of Health. The implications of this are that contributions from government and from members could be set at lower rates than was initially estimated.

*Contributions from government tax revenues*

The Sessional Paper stressed that earmarked taxes should contribute 11 billion KSh (2001 figures). However, within government it has not yet been agreed that this would be a financially feasible policy. International donors also expressed concern about the level of tax revenue needed, and the overall impact of taxation on economic growth. In light of this, and given a more gradual implementation and that initial analysis had anyway demonstrated likely significant surpluses in the early years after implementation, lower contributions from government were explored (see 3.2.2 for results of this analysis). At the same time, maintaining some government contributions was seen as imperative, given that contributions from the salaried sector would not be fully able to cross-subsidise the poor.

### *Contributions from employees and their employers*

The initial projections of the potential sources of finances for the NSHIF assumed that it would be possible to plough back into the scheme the amounts paid to civil servants and teachers as medical allowances. However, following opposition by the concerned groups to this payroll harmonisation (as they view these allowances as part of their income), alternative policies based on paying a slightly higher rate contribution were also analysed (see 3.2.2).

Capping of contributions was also suggested, as some high-income earners would contribute amounts that are likely to be greater than that needed to secure private health insurance. While contribution capping is a pragmatic option for securing the participation of the high income earners, further analysis is needed to specify an appropriate ceiling.

### *Reimbursement of patients visiting high cost private hospitals*

To maximize choice of provision for the insured, recent discussions have proposed that patients wishing to visit one of eleven "high cost" private hospitals can do so, but with the NSHIF reimbursing only up to the amounts paid for public, mission and other private facilities. Such patients would meet the balance of expenses through out-of-pocket spending or private top-up insurance (TMR No.6).

## **3.2.2 Financial projections: feasibility of alternative contribution scenarios**

Different financing options have been explored through the use of SimIns<sup>2</sup>, a health insurance simulation model. Following criticism of the initial Sessional Paper estimates, these simulations have focused on more closely analysing how much government and others would need to contribute over time, within the context of a more gradual implementation of the NSHIF. The following table illustrates required government contributions, given different contributions from the salaried sector and assuming a more realistic implementation scenario<sup>3</sup>.

These results demonstrate that government contributions can be lower than the Sessional Paper recommendations in the early years of NSHIF implementation. This is due to only partial autonomy of government health facilities and with lower population coverage of the self-employed (whose contributions are partially cross-subsidised by the salaried sector). In later years, required government contributions will need to be at levels consistent with the Sessional Paper, with the government likely to make more difficult tradeoffs between health and non-health sector allocations.

## **3.3. ORGANISATION OF THE NSHIF**

The NSHIF Bill will require an adjustment of the structure of the insurance organization. A key component of this structure is a reformed *Board of Trustees*, including representatives

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<sup>2</sup> Using version 2 (forthcoming). Version 1 is available via both the WHO and GTZ websites.

<sup>3</sup> For a broader range of different expansion scenarios, the reader is referred to TMR No.6 and TMR No.3.

from civil society, which appoints a *Chief Executive Officer* (CEO) who is responsible for defining the detailed vision and strategy of the NSHIF. The CEO is accountable to the Board of Trustees.

Various new departments have also been proposed. First, in addition to an *Audit panel* reporting to the CEO, a new *Fraud and Investigation department* is suggested, which will check the NSHIF's financial activities. It will report directly to the Board of Trustees, and should be established as an independent entity, so that oversight of the Board of Trustees is strengthened, and transparency and accountability of the NSHIF is ensured. Secondly, a new *Controlling department* should complement the present Finance department. Whilst the Finance department will continue to develop the annual budget, the Controlling department intends to focus on implementing procedures to check the budget allocation within the various NSHIF departments, and thus help change the NSHIF into an organisation managed by objectives. Thirdly, a new *Information Technology* department is proposed, since greater computerization of the NSHIF is an essential task not only for operations but also for contracting and quality assessment. Fourthly, a new *Marketing* department is recommended to develop and implement the communications strategy of the NSHIF. Fifthly, a department of *Benefits and Quality* will define: (i) the standards of the services available for NSHIF members at the various levels of care; and (ii) the criteria for assessing the quality of health service delivery at individual health facilities. Finally, a *Contracting* department has been suggested, crucial in negotiations on provider payment methods and levels. Figure 1 below gives an overview of the proposed structure.

**Table 2: Required government support for different contributions from the salaried sector, moderate population expansion scenario**

***Population expansion scenario***

Coverage	Years following implementation				
	+1 year	+2 years	+3 years	+6 years	+10 years
<i>Total population coverage</i>	26%	34%	45%	53%	62%
<i>Exempted population coverage</i>	12%	20%	30%	30%	30%

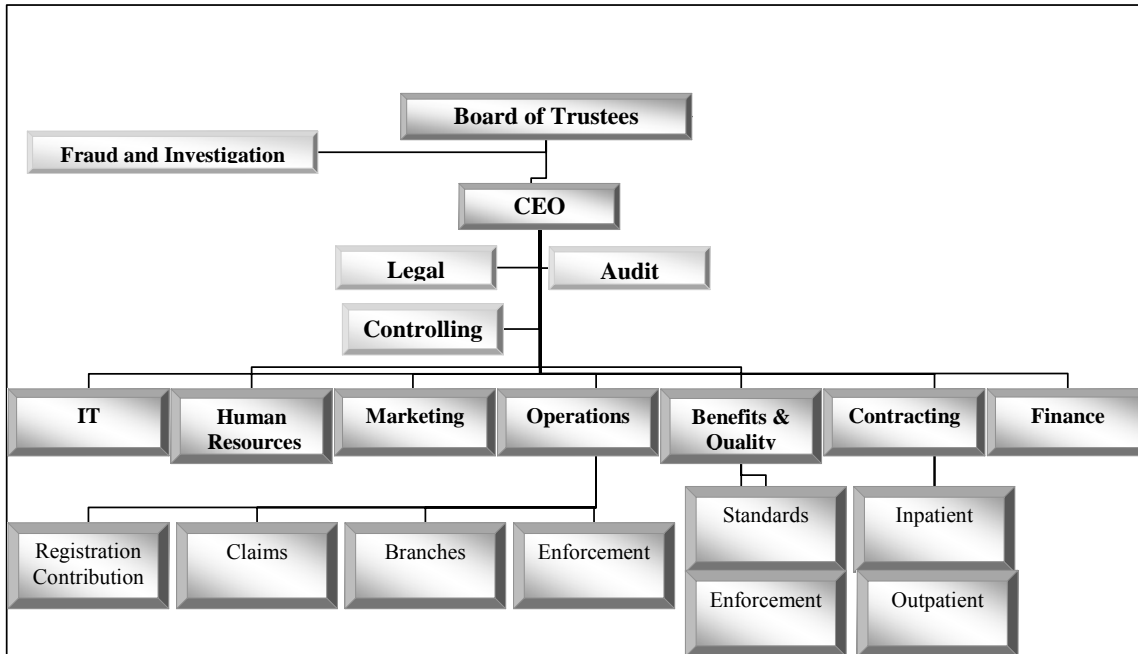
***Required government contributions***

(KSh billion, 2004 prices, with % of general government expenditure in brackets)

Employee / employer contributions (% of salary)	Years following implementation				
	+1 year	+2 years	+3 years	+6 years	+10 years
2.9% + 2.9%	2.1 (0.69%)	5.6 (1.77%)	11.3 (3.41%)	16.1 (4.24%)	30.3 (6.70%)
3.5% + 3.5%	0.5 (0.17%)	3.9 (1.23%)	9.4 (2.84%)	13.7 (3.61%)	27.3 (6.03%)
4.5% + 4.5%	0.0 (0.00%)	1.0 (0.32%)	6.3 (1.90%)	9.8 (2.58%)	22.4 (4.95%)
<i>less ART provision*</i>	-1.0	-1.6	-2.4	-3.9	-6.6

\* in this scenario, the non-poor pay a 50% co-payment for anti-retroviral treatment. The poor, though, are fully covered.

**Figure 1: Proposed structure of the NSHIF**



#### 4. INITIAL RESPONSES TO THE SOCIAL HEALTH INSURANCE PROPOSAL

##### 4.1 Stakeholders outside Government

A number of non-government associations and interest groups henceforth referred to as stakeholders, have reacted to the initial social health insurance proposal. Whilst a survey based on structured interviews and/or focus group discussions has not been done, analysis of media reports and other statements<sup>4</sup> can capture some of the most important concerns of these stakeholders. Table 3 below lists the key stakeholders together with the issues raised since the announcement of the NSHIF proposal.

As can be seen from this table, the *Health Maintenance Organisations* have raised quite a number of issues, with a particularly important concern being that their business would decline as a result of the introduction of NSHIF. A quantitative analysis has not been undertaken yet to prove or disprove this concern. It is interesting to note, though, that a consequence of the NSHIF law would be that HMOs and other insurance companies could sell supplementary (voluntary) health insurance. This would target citizens who are willing to pay for improved services (usually in terms of better amenities rather than quality of clinical care) than what will be provided through the NSHIF health insurance package. In fact, supplementary health insurance could be sold to a much larger share of the population

<sup>4</sup> The information is from a selection of 22 signed articles or statements between May 2004 and April 2005. The references are available on request from the corresponding author.

than is currently covered through HMOs. Apart from this fear about loss of business, an often even more strongly voiced concern has been related to potential corruption and ineffective use of health insurance contributions.

Some of the HMOs have also warned about job loss due to increased labour costs from higher employer contributions. This concern clearly warrants a quantitative analysis. The final demand for labour will depend in particular on the relative prices of labour and capital, the degree of substitution within Kenyan economic sectors, and the level and growth of the economy. Such an analysis should, though, also consider potential gains in productivity from a healthier labour force (due to the NSHIF offering greater access to healthcare for more of the population).

Concerns raised by the *Federation of Kenyan Employers* relate to their fear of paying higher contributions for their employees' health insurance. This concern, though, is only justified if employers would keep their current contracts with private health insurance companies and/or HMOs even after the introduction of the NSHIF Bill, as the benefits offered by these negotiated contracts are likely to overlap significantly with the proposed NSHIF benefit package. Such private contracts could continue, but adjusted to focus more on supplementary health insurance for health services beyond the NSHIF benefit package - in this way, higher employer contributions to health is much less likely. But the Federation of Kenyan Employers is also anxious about the transition to this new setting, as are many employees, who fear that their current health insurance benefits will be curtailed. It is therefore advisable that the Regulations of the NSHIF would allow for an interim period, whereby private contracts can be adjusted to the new situation.

**Table 3: Summary of stakeholders' responses to the NSHIF**

Stakeholders	Initial responses
<i>HMO (Health Maintenance Organizations)</i>	<ul style="list-style-type: none"> <li>- Insufficiency of information about the NSHIF and its cost</li> <li>- Private medical schemes and the quality of private care would suffer as a result of the introduction of NSHIF</li> <li>- Equal NSHIF benefits will be to the detriment of the middle class</li> <li>- Government inefficiency and corruption; low utilization of current NHIF revenues for reimbursement of health care expenditure</li> <li>- Higher contributions based on the payroll will lead to job losses</li> <li>- The poor should be protected instead via a direct budgetary allocation from the Ministry of Health</li> </ul>
<i>FKE (Federation of Kenyan Employers)</i>	<ul style="list-style-type: none"> <li>- Concern about paying higher contributions for their employees' health insurance</li> <li>- Fear of strife in the labour market due to a reduction of employee benefits</li> </ul>
<i>National Nurses Association of Kenya Kenya National Union of Teachers (KNUT) Kenya Medical Association</i>	Concern that medical allowances would be abolished
<i>Central Organisation of Trade Unions (COTU) Kenya Manufacturing Association Kenya Medical Association</i>	Concern about governance of the new NSHIF
<i>Health and HIV/AIDS Development Partner Working Group (HDWG)</i>	Concerns about: <ul style="list-style-type: none"> <li>- the transition period to full coverage, the enrolment of the poor and the provision of preventive services for this population group</li> <li>- slow process of consultation with key partners</li> <li>- insufficient attention to preventive health services and primary health care</li> </ul>
<i>Christian Health Association of Kenya Catholic Commission for Health and Family Life</i>	Agreement with the vision of NSHIF

Another important issue has been the future role of medical allowances for civil servants and teachers, as alluded to in section 3.2. This has been brought up especially by the *Kenya National Union of Teachers (KNUT)*, the *National Nurses Association of Kenya* and the *Kenya Medical Association*. Medical allowances are lump sum amounts which are intended to cover the health expenditure of these groups of employees and their families. In theory, once the NSHIF would be established, such allowances would not be needed, as these groups and their families would have access to the NSHIF benefit package. But in practice they are understood as a supplementary salary, with their deduction from final pay seriously affecting these groups' purchasing power. This has been recognized by the Kenyan government, and so these medical allowance amounts will not be deducted from final pay. Instead government, as an employer of civil servants and teachers, is scheduled to contribute to the NSHIF an amount equivalent to the 'employee' contributions of these groups.

The governance structure of the new NSHIF has been cited several times by the *Central Organisation of Trade Unions*, the *Kenya Manufacturing Association* and the *Kenya*

*Medical Association* as an additional concern, in particular the nature of the power of decision of the future NSHIF's Board of Trustees. These stakeholders prefer a situation whereby the Board of Trustees retains a large autonomy to steer and control management of the NSHIF, with a Chief Executive Officer of the NSHIF directly accountable to it. That is, direct control over funds and operations will be shared by a range of stakeholders, through their representation on the Board of Trustees.

Donors have also expressed their opinions on the proposed NSHIF Bill, through a statement by the *Health & HIV/AIDS Development Partner Working Group (HDWG)*<sup>5</sup>. A first concern is the transition period towards universal coverage. The donors' statement refers to a period of 15 years for a systematic enrolment of the poor and the informal sector. Note that such a transition is broadly coherent with the 'moderate implementation scenario' discussed in section 3.2. This transition policy, according to the HDWG, would also need to pay particular attention to ensuring that the poor have effective access to preventive services. The second general concern relates to the slow process of consulting key players, including tax payers, employers, civil society and private health providers. Finally, as with the HMOs, the potential of higher levels of health insurance contributions or taxes to be detrimental to economic growth, has been stressed.

It would be important to further analyze the interaction between donors, including international financial institutions and national policy makers, in a more systematic way. Such an analysis for the period late eighties to early nineties was undertaken by Dahlgren (1991), which focuses on the role of the World Bank and US-AID in affecting government policy on health financing.

Two other important stakeholders - the *Christian Health Association of Kenya (CHAK)* and the *Catholic Commission for Health and Family Life* - have expressed general satisfaction with the Bill, seeing it is in line with their own vision of an adequate health system for all. And although concerns from the other stakeholders discussed in this section remain, it appears from the consulted media information that most stakeholders other than the HMOs are supportive of the Bill.

## **4.2 Ongoing discussions within Government and Parliament**

As in other countries that went through similar reforms in the past, lengthy discussions within Government and Parliament about the contents of the Bill and its proposed implementation could be expected. One key goal of the health system, namely to ensure that all Kenyans have access to affordable health care<sup>6</sup>, is widely accepted. Yet intensive discussions continue to take place within government, regarding the phased implementation of the NSHIF, the inclusion of the poor population, and the allocation of government tax revenue to the overall financing of the NSHIF, as well as the contents of the health care package.

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<sup>5</sup> See DCG Demarche Points, Health & HIV/AIDS Development Partner Working Group, 30<sup>th</sup> June 2004.

<sup>6</sup> As noted in a statement issued by the State House on November 30, 2004 [www.statehousekenya.go.ke/](http://www.statehousekenya.go.ke/)

One area of special debate is the proposed Government's financial contribution to NSHIF in order to enrol the poor and fully subsidize their insurance contributions. Whilst financial projections have been made, showing the likely government contributions needed over time (see section 3.2.2), a crucial question has been whether the government should wait for the country's macroeconomic situation to improve, or whether the allocation to health from the overall government budget ought to be raised. Another important issue of debate is whether the Government should not improve the quality of health facilities first and increase investment for health infrastructure before starting to contribute to the NSHIF. These issues have been explored further in other studies (Kimani et al, 2004; Njeru et al, 2004).

## **5. CHALLENGES IN IMPLEMENTATION**

In addition to ensuring the NSHIF is well-designed (as discussed in section 3), the implementation of this design together with the required organisational changes needs to be addressed. Implementation is facilitated to an extent through experience with the current NHIF, although it is imperative that the NSHIF is seen as a new policy direction given the criticism of the NHIF by several stakeholders. Focusing first on a representative pilot region/s has been suggested as a way to test new procedures before they are introduced on a larger scale. It was also advised to establish working groups for core tasks of the NSHIF (TMR No.2) such as for quality and contracting; publicity and education; management training and IT; and monitoring and evaluation.

These working groups have now been set up and have started to explore in more detail how different design aspects of the NSHIF are to be implemented. For instance, the quality and contracting working group has begun evaluating health facilities for accreditation in selected areas, according to quality assessment and benefit package standards. Conversely, the group hasn't established pricing of services and reimbursement levels. Similarly, in the management, training and IT working group, preparation for implementation has been mixed. Progress has been made on training NHIF staff and the registration process, but much less has been done on tasks such as identifying the poor, revenue collection in local branch offices and other management issues. The reader is referred to TMR No.5 for a fuller evaluation of progress with these working groups.

## **6. WHICH WAY NEXT?**

Implementation of a nationwide social health insurance scheme represents a major challenge. Questions of economic feasibility and political acceptability continue to be discussed, with different stakeholders voicing concerns on particular design features of the social health insurance proposal submitted to the Kenyan parliament in late 2004.

This paper has assessed the submitted proposal in terms of key performance issues, evaluated the proposed financing and organisation of the scheme, addressed the challenges of implementation and presented the main concerns of various stakeholders. It is important to recognise that for economic, social, political and organisational reasons, a well prepared

transition period will be necessary. In view of international experience in social health insurance implementation, such a period is likely to last more than a decade. However, important objectives such as those related to access to health care, including the need to avoid impoverishment due to direct health care payments, should be recognized from the start so that steady progress towards effective universal coverage across the population can be planned and achieved.

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