STRATEGIC PURCHASING FOR UNIVERSAL HEALTH COVERAGE: A CRITICAL ASSESSMENT

PRIVATE HEALTH INSURANCE FIRMS IN KENYA

RESYST
RESILIENT & RESPONSIVE HEALTH SYSTEMS

RESEARCH BRIEF | Financing research theme

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With universal health coverage included among the health-related Sustainable Development Goals, the issue of how to finance health for all remains at the centre of global policy debate. A core function of healthcare financing is purchasing – the process by which funds are paid to healthcare providers to deliver services. If designed and undertaken strategically, purchasing can promote quality, efficiency, equity and responsiveness in health service provision and, in doing so, facilitate progress towards universal health coverage.

The RESYST Consortium, in collaboration with the Asia Pacific Observatory on Health Systems and Policies, has critically examined how healthcare purchasing functions in ten low and middle-income countries to identify factors that influence the ability of healthcare purchasers and other key actors to take strategic actions.

This brief presents an overview of how private health insurance firms (PHI) function as purchasers of health services in Kenya. It examines the relationship between PHI and three key actors - health service providers, government and their members – by comparing actual purchasing practices to ideal strategic purchasing practices. It identifies design and implementation gaps, factors influencing purchasing performance and provides policy implications of the findings and changes needed to attain the desired set of purchasing activities. It is a companion brief to another that examines community-based health insurance schemes in Kenya.

Figure 1: Description of the PHI purchasing mechanism in Kenya

Purchaser	PHI firms are commercial organisations limited by shares. PHI includes both insurance firms that underwrite health insurance and medical insurance providers (firms that sell insurance products on behalf of other insurance companies but do not underwrite them).
What services are purchased?	PHI offer a wide range of individual and group risk-rated packages. Packages vary by premium rates, entitlements (usually classified as inpatient, outpatient, dental and optical), claim limits and exclusions. Some packages contain options for treatment in countries outside Kenya and add-ons such as travel insurance.
Who uses the services?	Private health insurance is voluntary and is commonly offered to workers and their dependents (usually capped at 4) as an employment benefit. The 47 PHI in Kenya cover about 9% of the insured population and their beneficiaries, located mainly in urban areas.
Who provides services?	PHI contract private, public, and international service providers; this is mainly informed by client preferences.
How are providers paid?	Fee-for-service; limited use of capitation

WHAT IS STRATEGIC PURCHASING?

The purchasing function of healthcare financing involves three sets of decisions:

1. Identifying the interventions or services to be purchased, taking into account population needs, national health priorities and cost-effectiveness.
2. Choosing service providers, giving consideration to service quality, efficiency and equity.
3. Determining how services will be purchased, including contractual arrangements and provider payment mechanisms.

A critical factor in health system performance is the extent to which purchasing decisions are linked to provider behaviour and encourage providers to pursue equity, efficiency and quality in service delivery. This is strategic purchasing.

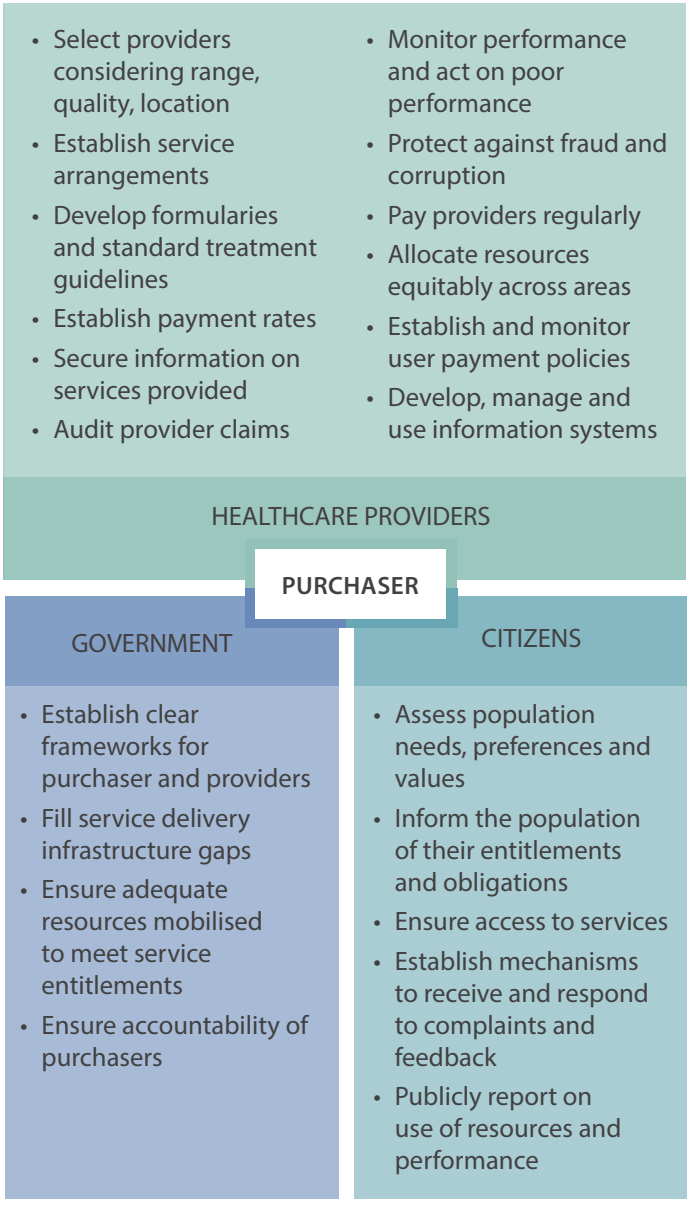
In strategic purchasing, a purchaser is an organisation that buys health services for certain groups or an entire population. The purchaser can use levers to influence the behaviour of providers to improve quality and efficiency in health service provision and facilitate equity in the distribution of healthcare providers.

However, purchasing mechanisms operate within each country's regulatory framework and, in strategic purchasing, government is required to play a stewardship role by providing a clear

regulatory framework and appropriate guidance to ensure that public health priorities are linked to resource allocation and purchasing decisions.

As the purchaser buys health services for people, it is important for the purchaser to ensure there are effective mechanisms in place to determine and reflect people's needs, preferences and values in purchasing, and hold health providers accountable to the people. The key strategic purchasing actions are shown in Figure 2.

Figure 2: Strategic purchasing actions relating to healthcare providers, government and citizens



KEY FINDINGS

1. STRATEGIC ACTION BY PURCHASERS IN RELATION TO PROVIDERS

Provider contracting, payment rates and mechanisms

- PHI contract public, private and international service providers there are no explicit legal or policy provisions about who purchasers can contract to provide services. However, service providers do need to be registered and licenced by their professional bodies.
- PHI take active decisions about who to contract based on geographical access, quality, cost and capacity. PHI scheme members can also initiate identification of providers and their preference for providers has significant influence on the contract decision.
- PHI adapt a Standard Service Agreement, a contracting document developed by the Association of Kenya Insurers (AKI) an industry lobby group. The pre-contracting process includes a capacity assessment, negotiation of tariffs and agreement on expected services. Contract terms include provisions for credit terms by providers, performance assessment and penalties for breach of contract.
- PHI negotiate rates with providers based on their assessment of average costs of services estimated using historical claims data. PHI use fee-for-service to pay for delivery of health services but also charge co-payments to beneficiaries to limit demand for expensive providers.
- The adoption of alternative payment mechanisms, such as capitation, has been slow owing to resistance from providers. Some providers are paid earlier than others or even before their claims have been filed and invoices generated. This reinforces the power of these providers who are often costly but preferred by members.

Use of efficiency measures: gatekeeping, use of treatment guidelines and formularies

- There is limited use of primary care providers as gatekeepers although approval is required from the PHI to access specialist care, often from a list of preferred providers.
- Providers are responsible for checking the eligibility of members. Members utilise their insurance cards to access entitlements and there is limited use of biometric systems. PHI have customer relations teams that collaborate with providers to ensure that clients receive services within their entitlements.
- Providers are responsible for compiling and adhering to their own essential drugs lists and standard treatment guidelines. Both providers and purchasers reported that this encroached on the professional autonomy of the healthcare workers.

Benefit package design

- There are two types of service entitlement development for PHI: pricing and benefit description. Until recently, prices were based on historical costs, comparisons with competitors and gut-feeling of purchasers. New regulations have led to the use of actuarial analysis to determine premium prices, although industry-wide actuarial capacity remains low. In addition, critical cost data are scarce and of poor quality.
- Benefits are often grouped as inpatient, outpatient, dental and optical. Exclusions and waiting periods apply for all benefit packages including for maternity care, which has a waiting period of 10 months in some schemes. Persons above the age of 65 years are often not eligible for insurance unless they were pre-existing customers and, in some cases, they have to cater for the costs of their own yearly health assessments before they can be re-insured. There is uncapped balance billing of patients and all inpatient payments are made net of National Health Insurance Fund (NHIF) reimbursements regardless of the claimant's NHIF membership status.
- Micro insurance service entitlements differ from those offered by mainstream PHI. They provide cover on a family basis, have shorter waiting periods e.g. 4 months for maternity care. In addition, some benefits target the informal sector including a daily cash benefit to make up for lost wages and funeral expenses benefit.

Monitoring provider performance and information management

- PHI are mainly interested in monitoring trends in costs of claims from providers; monitoring the quality of healthcare services is not well performed except in response to specific customer complaints. Most PHI only take severe action e.g. contract termination with providers, in proven cases of gross medical negligence or unethical conduct by provider staff. In underserved areas, PHI contract providers even when they are aware that they are poor quality.
- While PHI have internal IT systems, these systems do not communicate with other PHI or providers. They also consist of paper-based components that expose PHI to data loss and delays. However, steps are being taken by the major firms to develop a central clearinghouse. Tellingly, providers share information on purchasers and occasionally act in consort to sanction a purchaser whose performance is unsatisfactory.

2. GOVERNMENT RESPONSIBILITIES IN STRATEGIC PURCHASING

Framework for regulation and accountability

- PHI are regulated by the Insurance Regulatory Authority (IRA) under the Insurance Act. However, this is a general insurance law that does not provide specific guidance for health insurance. The Ministry of Health (MoH) has little interaction with individual PHI firms but it regularly interacts with sector representative groups at policy forums. However, there is little guidance offered by the MoH in terms of strategic purchasing.
- PHI report financial performance regularly through newspapers, websites and statements to shareholders. The IRA has created web-based portals to support reporting, and publishes annual industry-level reports.
- Health service providers are regulated by the MoH, which has delegated the responsibility to relevant professional boards, such as the Medical Practitioners and Dentists Board. These boards set fee guidelines and monitor standards of healthcare training and provision through licensees. However, the professional boards lack the capacity to effectively monitor healthcare standards, with the main instrument for compliance being licencing.
- A key challenge amongst PHI is unhealthy competition, particularly undercutting and fraud. The main form of fraud is through false claims resulting from collusion between health service providers and beneficiaries. IRA seeks to minimise this through the anti-fraud police unit, although they face challenges due to the reluctance of insurance firms to involve the providers in legal proceedings.

3. STRATEGIC ACTIONS IN RELATION TO CITIZENS

Assessing the service needs, preferences and values of the population

- PHI assess health needs through document reviews, market analysis, customer surveys and feedback. They also analyse claims data from reinsurers.

Accountability to members

- PHI use websites, policy documents and media advertisments to inform members of their entitlements and obligations.
- PHI is predominantly accountable to the Insurance Regulatory Authority (IRA) and has little interaction with citizens. Customer complaints mechanisms vary across companies. Most PHI have set up customer contact centres, as well as email addresses to enable enrolees to make complaints and give feedback. Some schemes monitor social media and respond to complaints on these platforms.
- Given that many PHI schemes are linked to members' place of work it is not always possible for them to change if they are unhappy with their healthcare provision. The absence of an 'exit-mechanism' limits the accountability of PHI to their members, and their motivation to improve the services they offer

CONCLUSION AND POLICY IMPLICATIONS

PHI fall short of ideal strategic purchasing with gaps identified in both policy design and implementation.

While provider power was a limiting factor to strategic purchasing, the actions of PHI actually reinforce their power. For example, PHI kept certain providers as part of service entitlements, even though they were costly, so as to maintain customer numbers. Provider power was also enhanced by information sharing among providers, multiplicity of revenue sources and by their control of key processes.

PHI practices, such as low limits for coverage and balance billing, expose beneficiaries to financial catastrophe and undermine the core objective of prepayment mechanisms. Beneficiaries lack voice and exit mechanisms especially where private insurance is accessed as an employment benefit. This implies the need for regulators and stewards such as the IRA and MOH to establish frameworks that address the role of PHI within the wider context of health financing and the attainment of universal health coverage.

Encouragingly, there is some evidence of the beneficial effect that strong regulation can have on the financial performance of PHI. The IRA exists as a strong regulator that is autonomous from its parent ministry (Ministry of Finance), developing internal capacity and possessing a sufficient amount of funding. This suggests there is room for PHI to take up strategic purchasing function with the IRA serving as an illustration of the attributes required to drive change.

PHI should focus efforts on effective needs assessment and take measures to increase the volume and quality of epidemiological data, improve information sharing, grow capacity in the use of data, and emphasize the link between data and the development of service entitlements.

The key policy implication, however, is the need to specify a universal service entitlement for all Kenyans.

ABOUT THE BRIEF

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Further information

Purchasing project webpage: http://resyst.lshtm.ac.uk/research-projects/multi-country-purchasing-study

Email: Kenneth Munge kmunge@kemri-wellcome.org

Related resources

Munge K. et al (2016) **Strategic purchasing for Universal Health Coverage: Community based health insurance schemes in Kenya** RESYST research brief: Available at: http://resyst.lshtm.ac.uk

Munge K. et al (2015) **RESYST working paper 7: A critical analysis of the purchasing arrangements in Kenya** http://resyst.lshtm.ac.uk/resources/WP7

RESYST topic overview and fact sheet (2014) **What is strategic purchasing for health?** http://resyst.lshtm.ac.uk/resources/what-strategic-purchasing-health

Hanson K. (2014) **Researching purchasing to achieve the promise of Universal Health Coverage.** Presentation at the BMC Health Services Research Conference, London. http://www.slideshare.net/resyst/researching-purchasing-to-achieve-the-promise-of-universal-health-coverage-37722050

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