



# A critical analysis of the purchasing arrangements in Kenya: the case of the National Hospital Insurance Fund, Private and Community-based health insurance

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## About RESYST

RESYST is a 5 year international research consortium which aims to enhance the resilience and responsiveness of health systems to promote health and health equity and reduce poverty. We conduct our research in several low and middle-income countries in Africa and Asia, seeking to identify lessons that are transferable across contexts.

Research focuses on three critical health systems components:

- Financing: focusing on how best to finance universal health coverage in low and middle-income countries.
- Health workforce: identifying effective, practical interventions to address human resource constraints.
- Governance: studying the relationships among frontline actors and mid-level management, and leadership in health policy implementation processes.

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# Contents

Contents .....	3
List of abbreviations .....	4
Executive Summary .....	5
1. Introduction.....	7
Strategic purchasing and Universal Health Coverage in Kenya .....	7
Country context .....	7
Study justification .....	12
Study aims and objectives .....	12
Conceptual framework: Strategic Purchasing .....	13
2. Methods .....	13
3. Results.....	14
3.1 Purchaser – Government relationship.....	15
3.2 Purchaser - Provider relationship .....	18
3.3 Purchaser - Citizen Relationship.....	26
4. Discussion.....	31
5. Conclusions and policy implications .....	34
6. References.....	36

## List of abbreviations

AKI	Association of Kenya Insurers
CBHI	Community Based Health Insurance
CBO	Community Based Organisation
CEO	Chief Executive Officer
CS&DFMS	Civil Servants' and Disciplined Forces' Medical Scheme
FFS	Fee for service
GDP	Gross Domestic Product
KCBHFA	Kenya Community Based Health Financing Association
KEMSA	Kenya Medical Supplies Agency
KHP	Kenya Health Policy
ICD	International Classification of Diseases
IRA	Insurance Regulatory Authority
MIP	Medical Insurance Providers
MOH	Ministry of Health
MOU	Memorandum of Understanding
NHIF	National Hospital Insurance Fund
NGO	Non-Governmental Organisation
PHI	Private Health Insurance
THE	Total Health Expenditure
UHC	Universal Health Coverage

## Executive Summary

Purchasing is the way by which financial resources are linked to the provision of health services. A purchaser is any organization that performs these functions for a specified population. Purchasing can be passive or strategic. Strategic purchasing can facilitate progress towards universal health coverage (UHC) by using mechanisms that optimise quality, efficiency, equity and responsiveness of health care service provision.

Kenya is a lower-middle income country. The UHC agenda in Kenya has gained traction at the policy formulation and implementation level since the turn of the century. Kenya is committed to moving to UHC by 2030. Initiatives towards UHC include reforms of the National Hospital Insurance Fund (NHIF), comprehensive health insurance cover for civil servants and their dependents, health insurance cover for the elderly, provision of free primary health care and free maternity care services in all public health facilities. An important impediment to these reforms is the large number of informal sector workers and indigents, which limits the growth of contributory mechanisms for financing of health services.

This study focuses on three purchasing mechanisms: the NHIF, low cost private health insurance (PHI) and community based health insurance (CBHI). This study aimed to critically assess the performance of health care purchasers in Kenya and identify factors influencing their performance utilising the multiple principal-agent relationship framework suggested by Figueras et al. (2005). In strategic purchasing, three principal-and-agent relationships can be defined: (i) citizen and purchasers (agent), (ii) purchasers and providers (agent), and (iii) the Government and the purchaser (agent).

The study employed a case study approach. We selected two networks to serve as case studies for CBHIs. For the PHI, we selected two organizations based on their involvement in medical insurance, and their mutual interest in low-income earners based on the authors' awareness of their products. We selected key informants based on their relationship with these schemes. These included officials from the national Ministry of Health (MOH), the Insurance Regulatory Authority (IRA) and the KCBHFA. Other respondents were identified through snowballing including insurance industry lobby groups, civil society groups, health service providers and their representatives. Data were collected through a mix of document reviews and in-depth interviews. Purchasing policy design was compared against the "ideal" strategic purchaser and then against purchasing actions to identify policy and implementation gaps respectively

The NHIF, CBHI and PHI all fall short of ideal strategic purchasing with gaps identified in both design and implementation. Along the purchaser-government axis, regulatory design and practice is an important enabler of strategic purchasing. The lack of an overarching regulatory framework undermined strategic purchasing as a whole though there was evidence of the beneficial effect that strong regulation had on the performance of individual mechanisms. Importantly the stewardship role of the MOH was missing from this axis.

Along the purchaser-citizen axis, inadequate beneficiary voice and exit mechanisms weakened the ability of the three purchasers to act strategically. Service entitlement design is a complex task requiring a variety of capacities and inputs. None of the purchasers demonstrated the existence of all the required capacities and inputs.

Similar limitations to strategic purchasing actions were found along the purchaser-provider axis. For example, mechanisms that should improve efficiency e.g. use of treatment guidelines and generic essential drug lists were left to providers to adapt and adopt with unclear linkages to provision of quality health services. Provider power was a limiting factor to the strategic actions of purchasers. This power asymmetry arose from limited supply in three dimensions (quality, quantity and geographical spread), better information sharing among providers, multiplicity of revenue sources and provider control of processes such as licensing and price setting. The purchasers own actions also reinforced provider power. A lack of information sharing between purchasers and between providers-purchasers also undermined strategic purchasing practices.

In summary, deficiencies along all three principal-agent axes mean that purchasing activities of these three mechanisms are unlikely to meet the ideals of strategic purchasing which may therefore undermine the attainment of UHC goals in Kenya. The policy implications of our findings include a need for stewardship, a coherent policy platform for strategic purchasing practice, needs assessment and service entitlement design to protect against financial catastrophe, and greater consideration for health system efficiency and quality by purchasers.

Finally, it is important to underscore that strategic purchasing practice on its own will not deliver on UHC goals if other health financing and health system functions are not similarly aligned. As such the attainment of UHC in Kenya requires a strategic approach, extending beyond strategic purchasing.

# 1. Introduction

## Strategic purchasing and Universal Health Coverage in Kenya

Purchasing is the way by which financial resources are linked to the provision of health services. Purchasing involves:

- Deciding what mix of services is to be provided and for which population while considering health priorities and cost effectiveness;
- Selecting providers of services while considering equity, efficiency and quality; and
- Setting out contractual arrangements with providers.

A purchaser is any organization that performs these functions for a specified population. Purchasing can be passive or strategic (World Health Organisation, 2000). Passive purchasing means decisions on mix of services, provider selection and contractual arrangements are made based on historical patterns and arrangements. Strategic purchasing can facilitate progress towards universal health coverage (UHC) by using mechanisms that optimise quality, efficiency, equity and responsiveness of health care service provision (World Health Organisation, 2010, Robinson et al., 2005).

The UHC agenda in Kenya has gained traction at the policy formulation and implementation level since the turn of the century. Kenya is committed to moving to UHC by 2030 as stated in major policy documents including its long term development plan “Vision 2030” (Republic of Kenya, 2007) and the Kenya Health Policy (KHP) 2014-2030 (Ministry of Health Kenya, 2014). Initiatives towards UHC include reforms of the National Hospital Insurance Fund (NHIF), comprehensive health insurance cover for civil servants and their dependents, health insurance cover for the elderly, provision of free primary health care and free maternity care services in all public health facilities (Ministry of Health, 2015b). An important impediment to these reforms is the large number of informal sector workers and indigents, which limits the growth of contributory mechanisms for financing of health services.

## Country context

Kenya is a lower-middle income country with GDP per capita USD 1,245 in 2013 (The World Bank, 2015). In 2010, the country ushered in a new system of government, after adopting a new constitution (Republic of Kenya, 2010). Among the radical policy shifts introduced by this constitution was devolution of health care services from the central government to 47 geographically distinct administrative units called counties. The health system is now organized around two major administrative levels: national and county level.

The national government is mandated to formulate health policy, capacity building and technical assistance to counties as well as quality assurance and standards. It is also responsible for planning for national health services provided by semi-autonomous government agencies and national referral facilities (Republic of Kenya, 2010). The county

governments are responsible for all health care services including curative, preventive, health promotion and ambulance services within county boundaries. In addition, they are responsible for veterinary services and disaster management (Republic of Kenya, 2010). County governments own health facilities through which they provide these services and are therefore responsible for managing health funds.

Health care is provided through a mix of public (49%) and private providers (48%). Public providers are tiered ranging from community health services (Tier I), dispensaries and health centres (Tier II), county hospitals (Tier III), regional hospitals (Tier IV), all managed by counties, and finally national referral hospitals (Tier V) (Ministry of Health Kenya, 2014). Private providers mimic this arrangement though most are stand-alone units without formal referral mechanisms. A significant challenge to the health sector is the insufficiency in skilled human resources. A recent assessment estimated that the number of physicians, nurses and midwives was 7.48 per 10,000 population; the number of all health workers was 16 per 10,000 population (Government of Kenya, 2013). The World Health Report 2006 estimates that countries with fewer than 23 physicians, nurses and midwives per 10,000 population generally fail to achieve adequate coverage rates for selected primary health care interventions as prioritized by the Millennium Development Goals framework (World Health Organization, 2006) There is also a wide disparity in the distribution of the health workforce. For example, 8 of the 47 counties have no obstetrics-gynecology consultant while two counties, Nairobi and Mombasa, which house the main urban areas in Kenya, have 78 (38%) of the 207 present in the country (Government of Kenya, 2013). These two counties also hold 36% of the 233 surgeons, and 25% of the anesthetists (Government of Kenya, 2013).

According to the Kenya National Health Accounts 2012/13, the government funds about 31% of total health expenditure (THE) (Ministry of Health, 2015a). Government revenues are collected by the Kenya Revenue Authority, pooled at national level and then distributed to the 47 county governments. Allocation to counties is based on a resource allocation formula developed by the Commission for Revenue Allocation (Commission for Revenue Allocation, 2015). This formula includes seven weighted parameters: population 45%, basic equal share 25%, poverty 20%, land area 8% and fiscal responsibility 2% (Commission for Revenue Allocation, 2015). Two new parameters were included in the revised formula to be used between 2015 and 2018: development and personnel emolument factor. County allocations are given as a block grant and counties are responsible for sharing them across different sectors. This means that the share allocated to a specific sector, including health, depends on a county's priorities (Commission for Revenue Allocation, 2015). County governments also collect property and entertainment taxes at devolved level and may use these funds to augment the allocation, but their fiscal space is very limited. Furthermore, in consultation with the national government, county governments may negotiate for credit facilities including from foreign lenders.

Private expenditure accounts for 40% of THE and includes out of pocket payments (27%) and prepayments as premiums paid to private health insurance (PHI) firms and contributions to community based health insurance (CBHI) schemes (Ministry of Health, 2015a). About 17% of Kenya's total population has some form of health insurance (Ministry of Health, 2014).



Donor funding accounts for 25% of THE (Ministry of Health, 2015a). However, over 90% of these donor funds in Kenya are off-budget and fund disease-specific programmes including HIV/AIDS, tuberculosis and malaria.

Five purchasers are identifiable in the Kenyan health financing system: households, the government (national and county), NHIF, PHI, and CBHIs.

### **Government**

National government expenditure is predominantly on public health services through budgetary allocations to programs for diseases such as HIV/AIDS and reproductive health. The national government controls three referral hospitals which enjoy some autonomy with their own budgets and boards of management. Half of the national government allocation for health goes towards these facilities (Health Sector Working Group, 2014). The referral hospitals also raise their own revenues through charges to patients or insurance firms.

Funds for the county health services are drawn from the general county revenue and are allocated through budgets. This process is led by the county treasury working with the county executive, overseen by the county assembly and with provisions for public participation (Republic of Kenya, 2003). The national government also allocates conditional grants to counties for specific programs. These include funds for free maternity care and reimbursements to primary health care facilities after removal of user fees. County governments also pay salaries to health workers and procure commodities and drugs through a centralized process. Unlike in the past where all procurement was handled by the Kenya Medical Supplies Agency (KEMSA), counties have liberty to procure from any source.

Though county and national governments are not explicitly mandated to fill service delivery gaps, the constitution entrenches the right to access to healthcare with an emphasis on children and marginalised groups (Republic of Kenya, 2010). It also provides for the national government to build capacity and provide technical assistance, and for county governments to provide health services including promoting primary health care

### **National Hospital Insurance Fund (NHIF)**

The NHIF is a public corporation managed under the provisions of the NHIF Act of 1998 (Republic of Kenya, 2012). The fund is steered by a board which reports to the minister of health (Republic of Kenya, 2012). Routine management of NHIF is done by a team headed by a chief executive officer (CEO) (Republic of Kenya, 2014b).

The NHIF insures 15% of Kenya's total population which is about 88.4% of all persons with health insurance in Kenya (Ministry of Health, 2014). Membership of the NHIF is compulsory for all formal sector workers, and voluntary for the informal sector. Between 1998 and April 1<sup>st</sup> 2015, mandatory contribution to the NHIF was restricted to persons earning a minimum

monthly salary of KES 1,000 (USD 11)<sup>1</sup> with premiums rising with increasing gross income up to a cap set for those earning KES 15,000 (USD 167) and above (National Hospital Insurance Fund, 2015). Most formal sector workers contributed the maximum premium of KES 320 (USD 3.50) per month. On April 1<sup>st</sup> 2015, the minimum salary from which contributions will be required was raised to KES 5,999 (USD 67) (contributing KES 150 (USD 1.6) each month), while the top contribution of KES 1,700 (USD 19) will be required from those earning more than or equal to KES 100,000 (USD 1,111) (Republic of Kenya, 2015), increasing premium contributions fivefold. Contributions from the informal sector were increased from KES 160 (USD 1.8) to KES 500 (USD 5.5) per household (National Hospital Insurance Fund, 2015). Accompanying this change in contributions is an enhanced benefit package which includes outpatient care and other services such as health promotion and disease screening (National Hospital Insurance Fund, 2015). The NHIF also earns revenue from several investments including real estate, parking fees and interest from loans offered to their staff at subsidized rates (Deloitte Consulting Limited, 2011).

NHIF covers outpatient benefits based on a positive list of services. Payments are made on a capitation basis based on the number of persons registered at a particular facility. The capitation is reported to be between KES 1000 and KES 1400 per beneficiary (Isaac Ongiri, 2015). Inpatient service benefits are pegged according to the hospital category/contract:

- Contract A: Public health facilities only. Comprehensive cover for all services offered including surgery,
- Contract B: Faith-based organizations and low cost private facilities. Comprehensive services, although facilities may charge a maximum KES 15,000 (USD 167)
- Contract C: Private facilities- Daily bed rate only of KES 400-1800 (USD 4.4-20), based on number of hospital beds and other facilities following an assessment by the NHIF.

The NHIF also manages the Civil Servants and Disciplined Forces Medical Benefits Scheme, which provides comprehensive cover for outpatient and inpatient services, group life cover and funeral expenses (National Hospital Insurance Fund, 2015). Members of this scheme can access services at accredited public and private facilities, depending on their preferences. Facilities are paid on a capitation basis and fee-for-service basis for outpatient and inpatient services respectively. Members can change their choice of health provider every six months.

### **Private health insurance (PHI)**

There are 18 PHI firms in Kenya and 29 medical insurance providers (MIP) (Insurance Regulatory Authority, 2014). The distinction between the two is that MIP do not underwrite claims; they sell health insurance products that are then underwritten by an insurance firm (Republic of Kenya, 2014a). Our use of PHI includes both insurance firms that underwrite health insurance and MIP.

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<sup>1</sup> 1 USD = KES 90

PHI firms are commercial organizations limited by shares and regulated within the Insurance Act and the Companies Act (Republic of Kenya, 2014a). PHI firms are run by management teams headed by CEOs, who are accountable to the board of directors. PHI is voluntary and is also offered to workers as an employment benefit. PHI covers about 9% of the insured population and their beneficiaries are often based in urban areas (Deloitte Consulting Limited, 2011). PHI offer a wide range of individual and group risk-rated packages for a variety of services. Packages vary in premium payment due (and consequently upper limits), services accessible (usually classified as inpatient, outpatient, dental and optical) and exclusion levels. Some packages contain options for treatment in countries outside of Kenya and travel insurance.

PHI draw revenue from premium payments and various investment income e.g. commissions and fund management. The publicly listed firms audit their accounts and publish them on a quarterly basis while the non-listed publish annually. In 2013, 10 companies controlled 95% of gross earned premium (Insurance Regulatory Authority, 2014). However, six of the 18 PHI firms reported underwriting losses (Insurance Regulatory Authority, 2014).

### **Community-based health insurance (CBHI)**

There are at least 96 CBHI schemes in Kenya (Kenya Community Based Health Financing Association, 2015). CBHIs are community owned and managed and tend to be based at village or sub-location level (the lower two tiers of administration in Kenya) implying little competition between them (Mulupi et al., 2013). Individual schemes are typically part of a network linked to a non-governmental organization (NGO). These NGOs (also called implementing organizations) are the constituents of the Kenya Community Based Health Financing Association (KCBHFA) and may in turn be supported by international donors/NGO (Kenya Community Based Health Financing Association, 2010). The networks to which they belong may be registered as community based organizations (CBOs) or NGOs with the NGO Coordination Board, a statutory body.

The size of the schemes vary from as few as 8 to many as 1,110 principal members. As of 2014, CBHIs had 17,919 principal members, and 75,846 beneficiaries (about 0.2% of the Kenyan population) and are based in 26 of the 47 counties in Kenya (Kenya Community Based Health Financing Association, 2015). This is in stark contrast to previous estimates of about 470,000 beneficiaries (Deloitte Consulting Limited, 2011). This precipitous decline may be the result of a change in strategy of one of the big CBHI towards other more formal financial products.

CBHIs do not operate as insurers; rather they are registered as community self-help groups with the Ministry of Labour, Social Security and Services. They deposit society constitutions with the ministry and are required to submit annual reports. CBHI schemes do not have any capital requirements. CBHI activities are subsidized by the sponsoring organizations in their formative stages in the form of resources for stationery, travel costs, community mobilization, technical advice and capacity building through training scheme officials in determining the contribution rates, budgeting, financial audit and communication to scheme

members. The sponsoring NGO also supports schemes in contracting providers. This support is gradually reduced as the schemes' pools grow bigger. Eventually CBHI are meant to run autonomously on finances drawn from the members' contributions.

Scheme members elect their leaders- chairman, secretary, treasurer and inspector. These leaders serve on a voluntary basis for 3 years after which they are replaced, or their mandates renewed, depending on preferences of scheme members. Importantly, all the decisions have to be endorsed by the scheme members during annual general meetings. These include contribution rates, service entitlements and the provider facilities that should be contracted. Furthermore, financial reports are presented to the scheme members for verification.

CBHI typically have multiple benefit packages with differing contributions which can be made in instalments. Most schemes require members to have completed their contribution payment by the final quarter of the year or before budgeting, to access services at contracted facilities.

At the beginning of each year, CBHI leaders, in consultation with the sponsoring organizations, make budgets for the scheme. Three main budget lines are used: for payment of hospital bills- this takes the bulk of the budget and depending on the region, is between 65-75%; administrative expenses (15-20%) while a reserve fund, for contingency, is maintained at 2.5%-5%. The sponsoring organizations monitor these budget lines monthly and advise the CBHI whenever thresholds are exceeded. Some schemes formed a network through which financial resources are pooled in order to enhance risk-pooling. The central pools are created along larger administrative boundaries usually at county level and have a similar management set up as individual CBHI with a chairman, secretary, treasurer and inspector and a board drawn from leadership of different schemes.

## Study justification

This study focuses on three of these purchasing mechanisms: the NHIF, low cost PHI and CBHI. The choice of these mechanisms was based on the recognition of the informality of Kenya's labour market, prevailing levels of poverty, and the government's stated policy to attain UHC through contributory financing approaches. The NHIF has been identified as one of the organizations that will purchase health care services for Kenyans under UHC reforms. The latter two schemes target low-income earners, the informal sector and the rural and urban poor: three segments of the population that have been largely excluded from formal social protection mechanisms. The purchasing practices of these mechanisms may hold important lessons that will inform policy in Kenya.

## Study aims and objectives

This study aimed to critically assess the performance of health care purchasers in Kenya and identify factors influencing their performance.

The specific objectives of the study were:

1. To describe the selected purchasing mechanisms;
2. To illustrate the organisational structures for the purchasing mechanisms using a framework of three core principal-agent relationships;
3. To critically assess the existing purchasing performance by examining what actually occurs in current purchasing practices (*actual practice*), and compare this with what purchasers would be expected to do under strategic purchasing (*ideal practice*);
4. To identify factors that enable or hinder effective purchasing and potential mechanisms to address these factors, examine the institutional arrangements and assess whether these institutional arrangements are capable of producing the desired outcomes;
5. To draw lessons and make policy recommendations to promote effective purchasing arrangements for universal health coverage in Kenya.

### Conceptual framework: Strategic Purchasing

This study utilises the multiple principal-agent relationship framework suggested by Figueras et al. (2005). In a principal-agent relationship, because of the effect of information asymmetry, the person requiring goods or a service (the principal) must employ strategies to ensure that the person providing the good or service (the agent) acts in a way that optimizes the welfare of the principal. In strategic purchasing, three principal-and-agent relationships can be defined: (i) citizen and purchasers (agent), (ii) purchasers and providers (agent), and (iii) the Government and the purchaser (agent).

This study assessed the relationship between the organizations involved in a purchasing mechanism while also examining the interplay between these organizations as defined by institutional arrangements. Understanding the institutional arrangements underlying organizations helps us explain organizational behaviour which is central to solving the principal-agent problem (Milgrom and Roberts, 1992).

## 2. Methods

The study employed a case study approach to investigate the research questions. We selected two networks to serve as case studies for CBHIs. The selection was based on previous work with the CBHIs, their location in different parts of the country, as well as the authors' understanding of differences in their purchasing practices for example differences in benefit packages. For the PHI, we selected two organizations based on their involvement in medical insurance, and their mutual interest in low-income earners based on the authors' awareness of their products. We selected key informants based on their relationship with these schemes. These included officials from the national Ministry of Health (MOH), the Insurance Regulatory Authority (IRA) and the KCBHFA. Other respondents were identified through snowballing including insurance industry lobby groups, micro insurance, health service providers and their representatives, consumer lobby groups and NGOs involved in improving public finance accountability, healthcare quality and health system strengthening.

Data were collected through a mix of document reviews and in-depth interviews. Statutory, policy and regulatory documents well as online editions of newspapers and reports were searched. Standardised data extraction and summary forms were used to record, process and group this information.

A total of 61 individual and key informant semi-structured interviews were conducted as outlined in the table below:

<b>Respondent</b>	<b>Number</b>
PHI	13
Providers	8
CBHI	17
IRA	2
Ministry of Health	7
NHIF	4
Independent actuaries	2
Industry associations	2
Provider regulator	1
Consumer protection groups	2
Health system support and research organization	3

Interviews were transcribed and those in Swahili translated to English. Transcriptions were checked for accuracy and consistency before being entered into NVivo software for analysis. Analysis was conducted using a thematic framework approach. Purchasing policy design was compared against the actions of an “ideal” strategic purchaser (RESYST, 2014) and then against purchasing actions to identify policy and implementation gaps respectively. Codes were based on themes drawn from the conceptual framework as well as those that emerged during the analysis. The data were coded by two researchers working independently who then agreed on the coding results and themes. Any dispute was resolved by consensus after consultation with a third researcher.

A limitation of this study is the lack of contact with individual citizens/beneficiaries as respondents. This was mitigated through inclusion of existing consumer groups as well as civil society organizations that play a role in citizen protection.

### 3. Results

The results are presented in tabular form with each purchasing mechanism compared against the ideal actions that a strategic purchaser would undertake within each principal-agent axis under consideration. In each section, based on the three principal-agent relationships, the first table compares the theoretical ideal and policy design. The second table compares policy design with actual practice.

### 3.1 Purchaser – Government relationship

#### Policy design

<p>Establish clear frameworks for purchaser(s) and providers</p>	<p><b>NHIF:</b> The NHIF Act 1998, last amended in 2014, outlines the mandates and functions of the NHIF (Republic of Kenya, 2012, Republic of Kenya, 2014b). The NHIF is also governed by provisions of the State Corporations Act, and the Public Finance Management Act while its officers comply with the Public Officers Ethics Act. The Constitution of Kenya commits public institutions and their officers to good governance, integrity, transparency and accountability in section 10(2)(c), 225(2) and 232(1)(f) (Republic of Kenya, 2010).</p> <p><b>PHI:</b> PHI are regulated by the IRA under the Insurance Act (Republic of Kenya, 2014a) which offers some guidance in terms of purchasing functions.</p> <p><b>CBHI:</b> Though CBHI are registered with the Ministry of Labour, Social Security and Services, there are no laws or regulations governing their health purchasing functions. Supporting NGOs, both local and international, are answerable to the government since they are registered with them through the NGO Board of Kenya.</p> <p><b>Providers:</b> Health service providers are regulated by the MOH which has delegated the responsibility to a variety of professional boards through statutes. The professional boards, such as the Medical Practitioners and Dentists Board (MPDB) and the Pharmacy and Poisons Board (PPB), license and inspect individual and institutional providers, set fee guidelines and monitor standards of health care training and provision by licensees.</p>
<p>Fill service delivery infrastructure gaps</p>	<p><b>NHIF:</b> The NHIF is mandated to provide finances for essential medical equipment to facilities that are financially viable and in underserved areas (Section 34)</p> <p><b>PHI:</b> PHI are not obliged to fill service delivery infrastructure gaps.</p> <p><b>CBHI:</b> The schemes are not obliged to fill service delivery infrastructure gaps.</p>
<p>Ensure adequate resources mobilised to meet service entitlements</p>	<p><b>NHIF:</b> The NHIF is a contributor-only fund, and does not receive subsidies from the government.</p> <p><b>PHI:</b> PHI are only authorised to operate if they have adequate capital; IRA monitors financial expenditures to ensure that this line of business remains profitable. PHI must also take out reinsurance.</p> <p><b>CBHI:</b> CBHI schemes do not receive any subsidies or additional resources outside of members' contributions.</p>
<p>Ensure accountability of purchaser(s)</p>	<p><b>NHIF:</b> The NHIF's Board includes various stakeholders in the health sector including the Ministry of Health, employers, trade unions, and health providers (Republic of Kenya, 2014b). The NHIF's external governance framework includes the Ministry of Health, the National Treasury, the Kenya National Audit Office and various Parliamentary committees. These mechanisms are meant to enhance transparency and accountability (Republic of Kenya, 2012). In addition the board must submit an annual report to the Minister of Health detailing its operations.</p> <p><b>PHI:</b> PHI is predominantly accountable to the IRA with little interaction with the MOH. Existing accountability mechanisms are financial and not concerned with purchasing actions</p>

	<b>CBHI:</b> Individual schemes are intended to be accountable to scheme members and to the supporting NGO.
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### Actual practice

<p>Establish clear frameworks for purchaser(s) and providers</p>	<p><b>NHIF:</b> The MOH involves the NHIF as a stakeholder during development of policy but there was no formal mechanism through which the NHIF was utilised as a strategic tool to attain health policy objectives. This is reflected in the lack of clarity around the NHIF’s role as the vehicle for UHC in Kenya, and whether this role will be contestable.  “...I think there are indications from partners, stakeholders suggest that we need more than one pool so that people can have a choice, you can choose to join NHIF or another purchaser of your choice...” KII_07_MOH</p> <p><b>PHI:</b> The IRA maintains a high degree of oversight on insurers with regular inspections and strict reporting demands. IRA closely monitors the financial flows particularly premiums and claims and overall performance of insurance portfolios. Sanctions for non-compliance range from financial penalties to de-registration. However, this oversight role was not perceived to strengthen strategic purchasing of health services by PHI. Unlike the IRA, the Ministry of Health has little interaction with individual PHIs though the MOH regularly interacts with sector representative groups through its cross-sector collaboration meetings and forums. These include round table discussions with the Cabinet Secretary for health.  “None, none. Our only interaction is with the regulator, IRA. And it is very insurance based... nothing healthcare related...” PHI_06</p> <p><b>CBHI:</b> CBHI schemes are engaging with the national government to develop a regulatory and policy framework. In addition, the schemes are engaging with devolved government units for inclusion in county level health policy and in resource allocation especially for interventions targeted at the poor. Finally, there is a route for informal involvement of the government through regular contact with chiefs who are based at the location and sub-location level, though their opinions are more important during service entitlement design.</p> <p><b>Providers:</b> The professional boards lack the capacity to monitor health care provision standards with the main instrument for compliance being licensing. This situation has been exacerbated by devolution. Also, existing mechanisms for fee guidelines are not based on costing or other studies, while their ability to enforce these fees especially for institutions is limited. Many providers find the multiplicity of professional boards a burden especially during inspections, though more joint inspections are now performed.  “Devolution has been to us a challenge because the Board’s capacity to devolve or to decentralize some services has been difficult...But issue of inspections which reaches every county we don't have the capacity to do so and moving from county to county has been quite an expensive affair.”KII_28_provider regulator</p>
<p>Fill service delivery infrastructure gaps</p>	<p><b>NHIF:</b> May give loans to public health facilities to improve their services though the process for this is unclear as is the adequacy of these resources.</p> <p><b>PHI:</b> PHI do not engage with the government to fill service infrastructure gaps even within the public-private partnership framework</p> <p><b>CBHI:</b> CBHI do not contribute to filling any service delivery or infrastructure gaps.</p>



<p>Ensure adequate resources mobilised to meet service entitlements</p>	<p><b>NHIF:</b> The NHIF’s unaudited financial reports for 2014 report a surplus of about KES 800 Million (USD 8.9 Million) (National Hospital Insurance Fund, 2015). Surpluses were also reported in 2011 and 2013 statements. Administrative expenses as a proportion of contributions are in decline, though the inconsistent layout of financial statements makes tracking expenditures over time difficult. It is expected that this proportion will decline further as premium contributions increase. The funds for the Civil Servants’ and Disciplined Forces’ Medical Scheme (CS&amp;DFMS) are held separately which means they are not pooled with other funds limiting cross subsidization. In addition, there is also a push to have counties contribute money to the NHIF on behalf of those who are unable to pay. The NHIF has also taken deliberate steps to attract the informal sector with proposed changes to the benefit package as well as administrative arrangements to encourage retention. These are described in more detail in the section on purchaser-citizen relationship.</p> <p><b>PHI:</b> Many insurers continue to report underwriting losses even with oversight from the IRA. However, the financial instability that characterised medical insurance in the past is no longer a concern.</p> <p><b>CBHI:</b> CBHI do not receive subsidies or other funding from the government; they however draw on synergies with other programs, even if no formal link is established.</p> <p>“...for example you’ll realize that there are programs within a health facility...sometimes they have like OBA [output based aid voucher] program that is ongoing . . . those who are pre-natal if they can go for clinics freely they don’t pay for anything...so if we sensitize young mothers [...] please go to this health facility for ANC’s and make sure you deliver there so those services are covered they don’t bill the scheme for such kind of services” CBHI_12</p>
<p>Ensure accountability of purchaser(s)</p>	<p><b>NHIF:</b> The NHIF currently publishes its financial statements on its website (National Hospital Insurance Fund, 2015). It also presents reports to relevant parliamentary committees and the Minister of Health. The Board’s report to the Minister for Health is not in the public domain at this time. A review of the NHIF’s procurement practices in 2010 noted general compliance with procurement guidelines though some deviations were also described (Public Procurement Oversight Authority, 2011).The latest available audit by the Kenya National Audit Office of 2011/2012 financial year was qualified because of some outstanding issues including continuing expenditure on construction of a car park and unexplained expenditure on the CS&amp;DFMS (Kenya National Audit Office, 2013) .</p> <p>“These recommendations like the thing in the car parking, it’s just repeated every year there is nothing.” KII_15_health systems support</p> <p><b>PHI:</b> Reporting of financial performance is regular and through newspapers, websites and statements to shareholders. The IRA has created web based portals to support reporting and publishes annual industry-level reports for all types of insurance.</p> <p><b>CBHI:</b> Formal mechanisms for accountability to the government are limited to the annual reports submitted to the social services department. Informally, local administrators such as chiefs are invited to CBHI meetings where they may obtain a picture of the running of the CBHI.</p>

## 3.2 Purchaser - Provider relationship

### Policy design

<p>Select (accredit) providers considering the range and quality of services, and their location</p>	<p><b>NHIF:</b> The NHIF Act empowers the board to declare any facilities as hospitals for purposes of NHIF accreditation (Republic of Kenya, 2012). Accreditation is based on international standards as well as provisions of the Public Health Act. Facilities are accredited based on size e.g. number of hospital beds, availability of equipment, infrastructure, range of specializations, environmental cleanliness.</p> <p><b>PHI:</b> There are no explicit legal or regulatory or policy provisions on who private insurers can contract to provide services. At a minimum, service providers need to be registered and licensed by respective professional bodies under various Acts e.g. the Medical Practitioners and Dentists Act.</p> <p><b>CBHI:</b> CBHI select local public health or low cost private facilities and pharmacies; main consideration is cost and ability to provide range of required services.</p>
<p>Establish service agreements/contracts</p>	<p><b>NHIF:</b> The process described involves three steps: accreditation, registration and gazette (this means publication in the <i>Kenya Gazette</i> published by the Government Printer). The accreditation grading influences the level of the reimbursement rate provided to the hospital.</p> <p><b>PHI:</b> The Association of Kenya Insurers (AKI) Standard Service Agreement is a standard contract developed by PHI through an industry lobby group Individual PHI can modify this document to suit their needs.</p> <p><b>CBHI:</b> Contracts between CBHI and health facilities are stewarded by sponsoring NGO.</p>
<p>Develop formularies (of generic drugs, surgical supplies, prostheses etc.) and standard treatment guidelines</p>	<p><b>NHIF:</b> There is no explicit mention in statute of the NHIF taking specific action to improve health systems efficiency. MOH and facility guidelines are used.</p> <p><b>PHI:</b> The AKI standard contract does not specify the use of standard treatment guidelines or formularies.</p> <p><b>CBHI:</b> By way of gatekeeping, scheme members have to present an authorisation document at the point of service. CBHI also employ a referral system: members can only get access to higher level facilities if they are referred by lower level providers. Treatment guidelines and drug lists are based on those provided by the MOH.</p>
<p>Design, implement and modify provider payment methods to encourage efficiency and service quality</p>	<p><b>NHIF:</b> There are no explicit statutory recommendations or restrictions on use of various provider payments in Kenya. The NHIF contract specifies the use of capitation for outpatient and fee for service for inpatient services.</p> <p><b>PHI:</b> AKI standard contract is on fee for service basis.</p> <p><b>CBHI:</b> CBHI pay fee for service.</p>

Establish provider payment rates	<p><b>NHIF:</b> The NHIF Board establishes provider payment rates based on the hospital category. The NHIF contract for category A hospitals requires facilities to adhere to MOH norms and standards which suggests charging MOH mandated prices. These prices are facility specific and currently county specific.</p> <p><b>PHI:</b> Provider payment levels for private providers are guided by the Medical Practitioners and Dentists Board (MPDB). The guidelines are published under section 38 of the Inspection and Licensing Rules 2014, and are subsidiary legislation under the Medical Practitioners and Dentists Act Cap 253. However, the contracting processes implicitly provides for negotiations over costs.</p> <p><b>CBHI:</b> Public health facility rates are determined by hospital or facility management teams before approval by the county assembly. Lower prices can be negotiated.</p>
Secure information on services provided	<p><b>NHIF:</b> This is supported by the contract signed between the NHIF and providers. The information includes claims data and quality monitoring data based on the Kenya Quality Model</p> <p><b>PHI:</b> The AKI standard contract allows that PHI have access to information on services though the specifics of the contract is determined by individual PHI</p> <p><b>CBHI:</b> The MOU (Memorandum of Understanding) between CBHI and providers supports information sharing between the facility and individual schemes on services provided</p>
Monitor provider performance and act on poor performance	<p><b>NHIF:</b> The contract signed between the NHIF and providers provides for monitoring of cost and quality including use of customer exit interviews and use of the Kenya Quality Model for Health.</p> <p><b>PHI:</b> The AKI standard contract allows that PHI can monitor provider performance though the specifics of the contract is determined by individual PHI. Performance is monitored through review documents, requirements for speedy submission of notifications and receipt of claims.</p> <p><b>CBHI:</b> The MOU between CBHI and providers supports monitoring of performance and specifies sanctions for non-performance.</p>
Audit provider claims	<p><b>NHIF:</b> The NHIF Act provides for penalties for fraudulent claims and has an established Benefits and Quality Assurance department whose role is to review claims.</p> <p><b>PHI:</b> Contractual agreements support auditing of provider claims. IRA guidelines require firms to establish mechanisms to audit claims along with other internal controls</p> <p><b>CBHI:</b> The MOU allows CBHI to audit claims from providers</p>
Protect against fraud and corruption	<p><b>NHIF:</b> The NHIF Act and contractual agreements provides for penalties for fraudulent claims.</p> <p><b>PHI:</b> The Insurance Act provides penalties for fraud. It also establishes the Insurance Fraud Unit, a special police unit. Industry guidelines on fraud prevention require that PHI exhaust all internal mechanisms before resorting to report fraud to the Insurance Fraud Unit.</p> <p><b>CBHI:</b> CBHI members require authorisation letters before they access services and claims made without these letters are not honoured.</p>
Pay providers regularly	<p><b>NHIF:</b> The NHIF commits to paying claims within 14 days though there is no statutory foundation for this.</p>

	<p><b>PHI:</b> Contracts specify regularity of payment as well as sanctions including contract cancellation. The AKI standard contract provides for PHI to place deposits with providers on signing of the contract</p> <p><b>CBHI:</b> MOU with providers specify when payments will be made and in what form.</p>
Allocate resources equitably across areas	<p><b>NHIF:</b> The constitution envisages the equitable allocation of resources but there is no mechanism is no statutory or regulatory mechanism supporting this for the NHIF</p> <p><b>PHI:</b> There is no statutory or regulatory requirement for this</p> <p><b>CBHI:</b> There is no statutory or regulatory requirement for this</p>
Implement other strategies to promote equitable access to services	<p><b>NHIF:</b> The constitution envisages the equitable allocation of resources but there is no mechanism is no statutory or regulatory mechanism supporting this for the NHIF</p> <p><b>PHI:</b> There is no statutory or regulatory requirement for this</p> <p><b>CBHI:</b> There is no statutory or regulatory requirement for this</p>
Establish and monitor user payment policies	<p><b>NHIF:</b> There is no statutory or regulatory requirement for this</p> <p><b>PHI:</b> There is no statutory or regulatory requirement for this</p> <p><b>CBHI:</b> There is no statutory or regulatory requirement for this</p>
Develop, manage and use information systems	<p><b>NHIF:</b> There is no statutory or regulatory requirement for this</p> <p><b>PHI:</b> There is no statutory or regulatory requirement for this</p> <p><b>CBHI:</b> There is no statutory or regulatory requirement for this</p>

### Actual practice

Select (accredit) providers considering the range and quality of services, and their location	<p><b>NHIF:</b> The NHIF contracts public and private facilities though public facilities are not rigorously assessed.</p> <p><b>PHI:</b> PHI take active decisions on who to contract with, based on geographical access, quality, cost and capacity. PHI contract private, public, local and international providers. The PHI, or their beneficiaries themselves, can initiate identification of providers; beneficiary preference has significant influence on the contract decision.</p> <p><b>CBHI:</b> Scheme leaders in consultation with supporting NGO identify local public and faith-based facilities that can offer the desired range of services; local private pharmacies are included to supply drugs that may not be stocked in the public facilities. Purchasers prefer facilities that are closest to the served population, to enhance access to services by the members. In recent times, CBHI have been forced to contract additional private health facilities because of public health workers industrial action that leads to closures.</p>
Establish service agreements/contracts	<p><b>NHIF:</b> In practice the NHIF contracting process involves four steps: facility application for accreditation, inspection by NHIF, gazettment by board based on recommendation of the inspectors and contracting. Finally, a contract is signed between the NHIF and the health facility specifying the category of the health facility, reimbursement rate and other terms of engagement. The main penalty</p>

	<p>for breach of contract is contract cancellation (through de-gazettement) though the contract specifically allows for discussions and arbitration. However these terms are difficult to apply to facilities that are in underserved areas.</p> <p>“...imagine the only public hospital in say West Pokot [6<sup>th</sup> most marginalised county in Kenya with historical underinvestment in social services and amenities], just because it doesn’t meet the standards you say you are not going to accredit that hospital... and for sure you know that members go there... It’s quite an issue, for private not so bad, but for public...” KII_13_NHIF</p> <p><b>PHI:</b> The pre-contracting process requires an inspection of facilities, resources and personnel, agreeing of tariffs and expected quality and then contract negotiation. Contract terms provide for deposits with providers, length of credit terms and penalties for breach of contract. Enforcement of contract specifications is mainly done through regular discussions with health facilities’ managers on quality improvement plans. Sanctions applied in instances of gross violation of contract terms and depending on client preferences, may include transferring clients to other providers, suing in courts of law or immediate termination of contract. Both PHI and providers were of the view that, in practice, contracts are relational.</p> <p><b>CBHI:</b> Contract documents are simplified so that the community members can easily understand them and tend more towards memoranda of understanding than legally binding contracts.</p> <p>“Our role is just to advise them on how; you know they don’t have that capacity to do a proper document...but the actual negotiation we need them to do as the community...” CBHI_06</p> <p>The limited options of facilities available to the CBHI means that contract cancellation is not a viable option. In some instances the supporting NGOs enforce contractual agreements but the overall preference is for individual schemes to handle these to strengthen their autonomy. Provider staff are regularly trained to maintain awareness of CBHI schemes and prevent disputes and enhance service delivery.</p> <p>“... you know you have to convince in a simple way, or in a cleverly manner, so that perhaps next time if your person comes back that person will not be treated badly...” CBHI_15</p>
<p>Develop formularies (of generic drugs, surgical supplies, prostheses etc.) and standard treatment guidelines</p>	<p><b>NHIF:</b> The NHIF relies on health facilities to adhere to national guidelines under the supervision of the MOH and its agents such as the Medical Practitioners and Dentists Board (MPDB), and this is specified in the contractual document. Its influence on private facilities is somewhat less probably as a consequence of the low reimbursement rate it pays them.</p> <p><b>PHI:</b> Decisions regarding the use of essential drugs lists or standard treatment guidelines are left to providers as this is thought to be encroaching on the professional autonomy of the health care workers. However, there is growing interest in the use of standard treatment guidelines for cost management.</p> <p><b>CBHI:</b> CBHI does not have any influence on the treatment process. This is due to limited technical capacity as well as preference for provider autonomy. Treatment decisions are based on the agreed packages, covering common illnesses that are not too expensive.</p>
<p>Design, implement and modify provider payment methods to</p>	<p><b>NHIF:</b> The NHIF uses capitation payments for outpatient benefits and fee for service (FFS) for inpatient benefits. There is limited information on the capitation rate per capita. In category C hospitals, FFS takes the form of a per diem payment, and for category B</p>

<p>encourage efficiency and service quality</p>	<p>surgical reimbursement rates are capped. The fee for service rate can be adjusted if quality measures are met but it is not clear which measures these are and in what proportion the adjustments are made.</p> <p><b>PHI:</b> PHI use FFS. Adoption of alternative provider payment mechanisms such as capitation was deemed difficult due to resistance by the providers. Preferred providers may be paid earlier than others or even before their claims have been filed and invoices generated. Individual practitioners frequently experience delayed payments or non-payment on account of not being on the PHIs panel of providers; some resorting to regulators for relief. Institutional providers share information concerning payment behavior of certain PHI. Those deemed problematic in meeting contractual expectations may be blacklisted by the providers, thereby losing business.</p> <p><i>“So what happens then generally because of the power of the top five providers, they generally are paid well. Because immediately they close your account, you can lose clients like you can’t believe. So those ones generally even if you don’t have the claims here with you, you pay them without even invoices and wait to get the invoices...”</i> PHI_03</p> <p><b>CBHI:</b> Provider payments are made on a fee for service reimbursement basis, the preferred payment mechanism for most providers. Supporting NGOs think that CBHIs lack the capacity to manage more complex payment methods.</p>
<p>Establish provider payment rates</p>	<p><b>NHIF:</b> There is limited information on how the capitation rate was arrived at with suggestions of use of actuarial and financial analysis of claims data and data from the civil servants’ scheme. For inpatient services, category A hospitals are expected to charge according to government guidelines. These currently differ across counties. Category B and C providers agree on rates during the contracting process.</p> <p><b>PHI:</b> PHI negotiate with providers based on their previous experience of costs and assess whether the provider can provide those services at or near this average cost. PHI require notification of rate changes. These may then be altered based on subsequent negotiations.</p> <p><b>CBHI:</b> Scheme leaders negotiate with providers regarding preferred price of services, indicating ceilings of bills for different services. Some schemes, however, do not ask for discounted prices to avoid compromising service delivery to their members. CBHI may also opt not to seek for preferential services for their members out of a sense of solidarity with the rest of the community.</p> <p><i>“...we don’t want to be seen as propagating [advocating] for special services for a special category because when even those who are not part of our schemes we still want them to be part of to achieve the quality care....”</i> CBHI_04</p>
<p>Secure information on services provided</p>	<p><b>NHIF:</b> The NHIF captures information on services provided on its IT system based on claims filled by providers. These contain details of the International Classification of Diseases (ICD) -10 coded diagnosis, age and sex of the patient. The specifics of the services offered e.g. tests done and treatment prescribed are not recorded.</p> <p><b>PHI:</b> PHI capture information on paper claim forms which are then entered into the IT systems. Attempts have been made to integrate the systems within PHI schemes but haven’t been successful. Additional data is captured through review of doctors’ notes and visits to patients though it is unclear how this integrates with the rest of the information generated.</p> <p><b>CBHI:</b> This is captured on the list of claims that the CBHI receives at the end of each month. Scheme leaders visit every scheme member who is admitted to hospital and assess the quality of care received or as a response to specific client concerns.</p>

<p>Monitor provider performance and act on poor performance</p>	<p><b>NHIF:</b> The NHIF inspects facilities regularly to assess their compliance to contractual terms. It relied on the MOH to supervise the implementation of the Kenya Quality Model for Health which is variably applied predominantly in public health facilities. The enforcement of the Kenya Quality Model is poor in private health facilities. The NHIF also commissions customer satisfaction surveys. Private providers confirmed that they rarely see NHIF officers monitoring care in the hospitals unlike PHI staff.  <i>“No, for the time I have been here, I have never met and am [I’m] always in the wards, checking processes...”</i> KII_24_PROVIDER</p> <p><b>PHI:</b> Monitoring relates to both costs and quality, though its performance is variable. Special attention to quality aspects occurs as a response to specific customer complaints particularly instances where the contract specifications for quality have been grossly violated.  <i>“No they don’t, what happens with them is that once you have a license from the board then they assume that everything is OK...”</i>  KII_20_PROVIDER</p> <p>Sanctions for poor performance include withdrawal of individual patients, denial of payment and cancellation of contract.</p> <p><b>CBHI:</b> CBHI officials receive information through informal contact with scheme members, scheme meetings and sometimes, customer satisfaction surveys. CBHI officials discuss feedback on service delivery and improvement plans with hospital management. The discussion is done in a friendly manner to enhance and maintain good relations between schemes and provider facilities and protect scheme members from reprisals by provider staff.</p>
<p>Audit provider claims</p>	<p><b>NHIF:</b> The NHIF closely monitors claims, and has included staff with medical knowledge in the benefits and quality assurance department to enhance the process.</p> <p><b>PHI:</b> PHI hire staff with clinical backgrounds to audit claims though the paper-based nature of claims means some may be lost during data entry into the IT system.</p> <p><b>CBHI:</b> CBHI officials audit claims jointly on a monthly basis. Some CBHI have hired staff at the network level to perform this task.</p>
<p>Protect against fraud and corruption</p>	<p><b>NHIF:</b> The NHIF has instituted a number of fraud mitigation measures including physical visits to hospitals, enforcement of contract clauses on maximum reimbursement rates payable, fraud training of all staff and institutionalizing risk and investigation departments.  <i>“...there was so much fraud I mean now claims were being manufactured...so that’s the time the then management decided okay then we need people [who] at least can understand what’s happening.”</i> KII_13_NHIF</p> <p><b>PHI:</b> A key challenge amongst PHI is unhealthy competition, particularly undercutting, and fraud. The main form of fraud was through false claims and is reported to result from collusion between health service providers and beneficiaries (Association of Kenya Insurers, 2013). IRA seeks to minimise this through the anti-fraud police unit though they face challenges due to reluctance of insurance firms to involve the providers in legal proceedings.</p> <p><b>CBHI:</b> Claims not backed with authorization or insufficient information e.g. membership code are not honoured. Scheme officials display spending on office walls and report on their use of funds to scheme members during meetings. Due to members’ local knowledge of one another, it seems easy to confirm expenditures of hospital bills. Some have rotational leadership to encourage transparency. Schemes’ financial flows are monitored and audited by the supporting NGO. The providers are also able to monitor payments through their accounts.</p>

Pay providers regularly	<p><b>NHIF:</b> The NHIF pays providers within 14 working days or 21 calendar days. The adoption of this measure is not required by law and was instituted to improve providers' perceptions of the NHIF</p> <p><b>PHI:</b> PHI pay providers based on contractual terms but as noted above these include prepayments to preferred providers (facilities) and delays to individual providers.</p> <p><b>CBHI:</b> CBHI schemes make payments at the end of the month. This is in part because CBHI prefer to process all claims at once to reduce administrative costs and ease the running of the scheme. The regularity of payments is also maintained to enhance the relationship with the provider. However, some providers may delay sending their claims to the scheme</p>
Allocate resources equitably across areas	<p><b>NHIF:</b> The NHIF does not take active steps to allocate resources equitably across areas. However, NHIF accredits all public hospitals and many not-for-profit hospitals, which tend to be based in geographically underserved areas, thereby enhancing services to those areas.</p> <p><b>PHI:</b> PHI do not take steps to do this</p> <p><b>CBHI:</b> CBHI are limited in resources and geographical distribution but are based in poor and underserved communities; their resources are therefore limited to the areas of operation.</p>
Implement other strategies to promote equitable access to services	<p><b>NHIF:</b> The NHIF has piloted a health insurance subsidy program, and plans to have a package for the indigent, old and disabled.</p> <p><b>PHI:</b> PHI only contract existing facilities, in areas preferred by their clients, therefore do not actively promote equitable access to services. Facilities in underserved areas tend to be a lower quality and/or higher cost than providers based in urban areas where more established and more numerous providers exist.</p> <p><a href="#">"In the underdeveloped or underserved areas we tend to go with what we can find." PHI_09</a></p> <p><b>CBHI:</b> CBHI do not employ other strategies</p>
Establish and monitor user payment policies	<p><b>NHIF:</b> Only private low cost providers are allowed to charge co-payment on surgeries, capped at 15,000 shillings. Outpatient benefits are on a capitation basis for the services offered and providers cannot charge the member extra for these services. Excluded services are borne in full by the member. Cover limits are capped at 90 days of inpatient care. Those who attend category B and category C hospitals are subject to uncapped balance billing. However, exceptions are made for mental health conditions which may have longer admissions.</p> <p><b>PHI:</b> PHI use co-payments as a disincentive to beneficiaries from using providers that are expensive. Uncapped balance billing and all inpatient payments are made net of NHIF payments.</p> <p><b>CBHI:</b> CBHI benefits are capped and vary across schemes. Schemes encourage members to take up NHIF cover to enhance their cover. Co-payments are required by some schemes especially for surgery and outpatient services.</p>
Develop, manage and use information systems	<p><b>NHIF:</b> The NHIF has a nationwide IT system including at health facilities though this is not integrated with the facilities' own systems. The IT system is used for claims management including fraud prevention. Its use for quality monitoring is limited owing to the limited amount of data captured. The IT system is also used to provide information to update the benefit package e.g. the explicit inclusion of maternity services in the inpatient benefits.</p>



	<p><b>PHI:</b> PHI have internal IT systems that are predominantly used for claims management. Some have advanced systems that integrate with other internal functions including social media monitoring. The IT systems do not communicate with those of other PHI or with providers though steps are being taken by the major players to develop a central clearing house.</p> <p><b>CBHI:</b> CBHI are paper-based with minor use of IT systems for monitoring and evaluation and budgeting mainly used by the sponsoring NGO.</p>
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### 3.3 Purchaser - Citizen Relationship

#### Policy design

<p>Assess the service needs, preferences and values of the population and use them to specify service entitlements/benefits</p>	<p><b>NHIF</b> The board of the NHIF is composed of various stakeholder groups of contributors and consumers including the MOH, health service providers, trade unions, and employer associations and currently excludes private health insurers and farmer representatives (Republic of Kenya, 2012, Republic of Kenya, 2014b). The Board is required to protect the interests of contributors including regulating contributions and benefits. This suggests that these representatives ought to voice the needs and preferences of members to NHIF. It could also be that the relationship between the MOH and NHIF was designed such that the former would assess the needs, preferences and values of citizens and communicate these to the latter. Service entitlement design is a responsibility of the Fund’s Board in consultation with the Cabinet Secretary responsible for health. The NHIF Act in section 22(2) specifies that benefits should include both inpatient and outpatient services.</p> <p><b>PHI:</b> There is no specific legal or regulatory requirement to perform needs assessment or determine preferences, values of citizens. The regulations only require that the product be sustainable, and based on the needs of customers (Insurance Regulatory Authority, 2012). The micro insurance policy includes broad guidelines for the financial design of micro insurance products including specifying waiting periods and a suggestion that all products should be simple to understand (Insurance Regulatory Authority, 2014e).</p> <p><b>CBHI:</b> CBHI perform needs assessment, develop, price and update service entitlements based on participatory decision making with the community involved at all stages.</p>
<p>Inform the population of their entitlements and obligations</p>	<p><b>NHIF:</b> There is no policy framework that supports this.</p> <p><b>PHI:</b> IRA guidelines require policies to be clear and understandable to buyers and require that all documents be submitted for its review.</p> <p><b>CBHI:</b> Entitlements and obligations are meant to be communicated during recruitment and overall awareness creation campaigns by CBHIs. Key information is communicated in annual general meetings (AGM) particularly on benefits package and contribution rates.</p>
<p>Ensure population can access their entitlements</p>	<p><b>NHIF:</b> NHIF members are required to notify the scheme within 24 hours of admission to a hospital, and to present valid identification documents and their NHIF membership card.</p> <p><b>PHI:</b> The IRA guidelines propose internal control including the use of cards to identify beneficiaries. Policy holders must also be informed of where they can access their entitlements (make their claims) though the specific means to be used are not described.</p> <p><b>CBHI:</b> CBHI identify members using an identification card and a master list which is deposited with the facility. Those who are on NHIF-linked packages also receive an NHIF card.</p>
<p>Establish effective mechanisms to receive and respond</p>	<p><b>NHIF:</b> The NHIF Act does not make specific provision for a complaints mechanism or the collection of views and reflections of members/citizens. The official website however has links for contacting the fund, including a toll free phone number.</p>

to complaints and feedback from the population	<p><b>PHI:</b> The IRA guidelines on claims management require each insurance firm to establish a customer care desk as well as a mechanism to deal with customer complaints which include details of how complaints are received, time within which problems should be resolved and keeping the complainant informed on progress of the complaint (Insurance Regulatory Authority, 2012). The complainant has the opportunity to complain to the IRA. The IRA also has an established Insurance Fraud Investigations Unit (Insurance Regulatory Authority, 2013d).</p> <p><b>CBHI:</b> The main feedback forums are CBHI meetings. Scheme leaders are also required to be accessible to members.</p>
Publicly report on use of resources and other measures of performance	<p><b>NHIF:</b> The NHIF board is required to make annual reports to the Minister of Health about its performance. It is unclear if this and other reports are publicly available as required by the constitution.</p> <p><b>PHI:</b> PHI submit financial reports to the IRA. Listed companies are also required to report to shareholders and the public</p> <p><b>CBHI:</b> AGM are the focus of reporting activities for CBHI</p>

### Actual practice

Assess the service needs, preferences and values of the population and use them to specify service entitlements/benefits	<p><b>NHIF:</b> The NHIF uses customer satisfaction surveys and commissioned surveys to determine client needs. Feedback received from Board members and of analysis of claims data are also used. However, there is a recognition that citizen engagement is an area that needs improvement. For example, media reports suggest union leaders and employers, who make up part of the NHIF Board, are unhappy with the process of implementation of new premium rates (Isaac Ongiri and Jacqueline Kubani, 2015). Informal sector workers in Nyandarua County, on the other hand, have obtained a court order restraining the NHIF from charging the new rates (James Mbaka, 2015).</p> <p>The NHIF has two approaches to growing its membership. For formal sector workers, compliance officers monitor institutions to ensure that all employees are registered and are remitting their contributions. For voluntary members, the NHIF has partnered with a variety of organizations to encourage enrollment. These include CBHI as well as not for profit, usually faith-based, private providers. The NHIF targets the poorest of the poor through initiatives such as the Health Insurance Subsidy for the Poor (HISP). Retaining voluntary members has been a challenge. This segment, made up mostly of informal sector workers, tends to take up insurance only when they are ill. Some allow their membership to lapse especially when they have not made claims that year or when they fail to access some benefits, e.g. outpatient care. Penalties for defaulters of five times the premium amount also affects membership. To mitigate this, NHIF has changed strategy to allow members to either make up the missed payments within 5 days or start over again with a 60 day exclusion period. The NHIF Act has been amended to lower the penalty.</p> <p><b>PHI:</b> PHI assess health needs through document reviews, market analysis, customer surveys and feedback, mystery shopping and intelligence gathering from competitors. They also analyze claims data including data from reinsurers.</p> <p>There are two levels of service entitlement development: pricing and benefit description. Pricing is an actuarial function influenced by morbidity experience, cost of care and underlying epidemiology/demography to project future costs and so determine price based on</p>
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these costs and solvency of the firm. However, this is a recent development; most pricing in the past was based on historical costs, comparisons with competitors and gut-feeling. PHI charge premiums on an annual basis and allow lump sum or installment payments. Some micro finance institutions may offer loans to members to cater for premium payments. Penalties are exacted for late payment of premium including cancellation of policy as well as relapse to a waiting period. On occasion, insurance companies may pay on behalf of members whose coverage limit is exhausted, and recover this from them later. Credit terms may be available to corporate clients allowing a period of a few days to weeks within which the first premium should be paid.

Exclusions and waiting periods apply for all packages. For example maternity care has a waiting period of 10 months. Corporate beneficiaries have the advantage of no waiting periods. Persons above the age of 65 years are often not eligible for insurance unless they were pre-existing customers. In some cases, they have to cater for their own yearly assessments before they can be re-insured.

“... Much of our interaction with the insurance companies is making it clear to them that they can’t refuse to put people who are living with HIV on their covers...” KII\_02\_CIVIL SOCIETY

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 and include benefits that target the informal sector e.g. daily cash benefit to make up for daily wages, funeral expenses benefit.

PHI schemes market their products through independent brokers & agents, in-house sales forces, and alternative channels usually non-insurance institutions such as banks and telecommunications companies. Those with stronger corporate focus prefer one on one engagement with human resource managers or CEOs.

“The people who are doing their businesses here, nobody will come to sell insurance to them, because they don’t have pay slips.” KII\_01\_CIVIL SOCIETY

**CBHI:** Schemes collect their members’ views during meetings and customer satisfaction surveys. Sponsoring organizations also perform community needs assessment. Informal channels are also use with members interacting with scheme officials within the community.

CBHI also obtain information on CBHI members’ needs from other sources e.g. health service providers and local administrators.

Member’s preferences on key decisions e.g. contribution rates, benefits package, and new products, are expressed through voting particularly in annual general meetings. Examples of additional benefits that reflect members’ preferences include caregiver’s allowance, developed as a response to shortages of nurses at the facilities. Others are reimbursement of ambulance costs and funeral expenses.

Service entitlements are household-based, though some schemes allow enlisting other community members under a household. Some schemes charge small top-up premiums per additional person.

CBHIs have partnered with the NHIF to develop products that are complemented by NHIF (CBHI+NHIF package). This idea was mooted by the NHIF as a means to expand its coverage leveraging on the close contacts of CBHI to community members. CBHI members who subscribe to this product contribute monthly premiums to the NHIF in addition to their CBHI contribution. Within this arrangement, the

	<p>NHIF pays bills for all medical expenses. The CBHI makes top up payments especially for surgical expenses where the NHIF's reimbursement rate at certain hospitals is capped.</p> <p>Ultimately scheme members themselves decide whether or not to adopt any service entitlement design though there is a great deal of price sensitivity in service entitlement design. Paradoxically, community members sometimes perceive low priced products as not realistic and therefore shun them.</p> <p><i>"They doubt that one could pay 500 shillings for all year coverage, in the context high costs of medication" CBHI_KI_2010.</i></p> <p><i>"...we have done these FGDs; you ask them –on top of these contributions that you are making today, how much more are you willing for these other intended services? Nobody says more than 50 bob [USD 0.56]..." CBHI_06</i></p>
<p>Inform the population of their entitlements and obligations</p>	<p><b>NHIF:</b> The NHIF displays its benefits and list of accredited providers on its website and has taken out newspaper, television and radio adverts with the aim of increasing awareness of its products. It also has forums with stakeholders including providers and employers. In addition, its compliance officers engage with employers to ensure that they are aware of what NHIF offers. How this extends to employees within these organizations is not clear, however.</p> <p><b>PHI:</b> PHI utilize websites, policy documents, media advertisements and customer relationship staff to inform members of their entitlements and obligations. PHI require providers to notify them of admissions so that critical information regarding the patient can be communicated.</p> <p><b>CBHI:</b> Annual general meetings are the predominant avenue for informing members of entitlements and obligations. Informal channels are also used during home and hospital visits.</p>
<p>Ensure population can access their entitlements</p>	<p><b>NHIF:</b> NHIF members must utilize their card to access entitlements. Outpatient services can only be accessed at the provider facilities selected by the members. NHIF requires to be notified of an inpatient case within 24 hours of admission. Evidence from interviews with community members suggest dissatisfaction with service entitlement, information on access to providers and cover for extended families and indigents within the community.</p> <p><i>"Those people who contribute to the NHIF through the [CBHI] schemes are the ones who benefit the most because they know which hospitals are good and which hospitals are bad. Those others who have deductions made from their salaries are taken here and there; no one tells you which hospital to go to." CBHI_01</i></p> <p><b>PHI:</b> Members utilize their cards to access entitlements though there is some use of biometric systems. Providers have responsibility to perform the eligibility checks. Packages have varying levels of entitlements as well as provider lists for which approval is required before access. Customer relationship staff support access to services.</p> <p><b>CBHI:</b> Scheme members require authorization letters to access entitlements and may also require membership cards including NHIF cards. Scheme officials may call or go to a facility to support members in accessing services.</p>
<p>Establish effective mechanisms to receive and respond</p>	<p><b>NHIF:</b> The NHIF website provides an email address and phone contact for use by beneficiaries. Newspaper advertisements, and interviews, specify that the phone line is toll free and operates 24 hours a day. There is a dedicated customer service department that is to be automated to support complaints resolution, at head office and branch level too.</p>

<p>to complaints and feedback from the population</p>	<p><b>PHI:</b> Most PHI have set up customer contact centers as call centers which run 24 hours a day, 7 days a week, as well as email contact pages though some have more rudimentary mechanisms such as suggestion boxes. Others monitor social media and respond to complaints on these platforms. The customer complaints mechanism vary across players but most exhibited set turnaround times and a logged system for monitoring progress in complaints resolution. However, there was evidence of customers approaching intermediaries first, including the IRA, with complaints and it is unclear how in-house complaints mechanisms handled this. In addition, beneficiaries sometimes went to providers and lobby groups for relief and used those persons as their advocates.</p> <p><b>CBHI:</b> Annual general meetings present the main forum for feedback and complaints. Scheme leaders visit members in hospital and monitor quality of care and feedback. They are also accessible to members on phone and at the CBHI scheme offices.</p>
<p>Publicly report on use of resources and other measures of performance</p>	<p><b>NHIF:</b> The NHIF publishes its financial reports online and in major newspapers. Audit reports on these statements are published by the Kenya National Audit Office. Other measures of performance are not included on the reports</p> <p><b>PHI:</b> Public reporting mechanisms were predominantly translated as financial reporting and not related to quality of service.</p> <p><b>CBHI:</b> Schemes reported on use of financial resources at AGM. Other aspects of performance were not reported on.</p>

## 4. Discussion

This study sought to critically analyse the mechanisms that various health insurance schemes in Kenya have put in place to purchase health services against the principles of strategic purchasing. The NHIF, CBHI and PHI all fall short of ideal strategic purchasing with gaps identified in both design and implementation.

Regulatory design and practice is an important enabler of strategic purchasing. The lack of an overarching regulatory framework undermined strategic purchasing as a whole though there was evidence of the beneficial effect that strong regulation had on the performance of individual mechanisms. For PHI, the IRA exists as a strong regulator as a result of enjoying autonomy from its parent ministry (Ministry of Finance), developing internal capacity and possessing a sufficient amount of funding. For example, the CEO and other staff are competitively recruited and the Board is composed of persons with knowledge of finance and insurance. As a result, the IRA enjoyed legitimacy among the key actors in insurance. On the other hand, the NHIF operates under a separate Act and is answerable to players who lack the capacity to properly monitor the NHIF's performance and tend to focus on financial performance. This incentivizes a focus on costs at the expense of quality, as well as inadequate use of autonomous powers owing to a fear of recrimination from any one of multiple stakeholders protecting their own interests. Coupled with the bureaucratic nature of the NHIF, this disincentivizes responsiveness and transparency. However, this focus on costs is present in all three mechanisms and as such is a matter that requires attention.

Importantly the stewardship role of the MOH was missing from the government-purchaser axis. The MOH has ceded some of its functions such as provider regulation, while in the case of purchasers such as PHI and CBHI, its engagement as a steward remains limited. It was also unclear just how well the MOH monitors the NHIF's performance in terms of linkage with national policy. PHI on the other hand, engage with the MOH as any other of a number of private sector stakeholders. For CBHI there are several possible explanations for lack of such engagement including that they are a relatively new phenomenon whose classification as community organisations places them under a different ministry not involved in health or finance. It is possible that the MOH's own structure, with long standing purchaser-provider integration, diminishes its ability to pay keen attention to purchasing activities as a function of the health financing system and also reduces the chances for coordination and synergy. Also, the choice of the NHIF as the vehicle for attainment of UHC may have led to the neglect of other kinds of purchasers.

Inadequate beneficiary voice and exit mechanisms weaken the ability of the three purchasers to act strategically. Exit is especially limited for formal sector employees for whom the NHIF is mandatory or who access private health insurance as an employment benefit. Voice mechanisms were absent or inadequate in design and practice. As a result, there is limited contribution of members or beneficiaries to benefit design. This may explain the uproar that met changes to the NHIF benefit package and contribution rates, the

concerns that PHI packages are out of reach for people in the informal sector and questions over the quality of services received by beneficiaries. Furthermore, the constitution of the NHIF Board lends the organization to stakeholder capture with those supposed to represent the views of beneficiaries seemingly unlikely or unable to communicate effectively with their constituencies. The NHIF's lack of citizen engagement may also be a response to its long standing uneasy relationship with the public which distrusts the organization. With the NHIF's anticipated inclusion of the informal sector, it is critical that accountability mechanisms accommodate this section of beneficiaries and undertake to be more responsive, transparent and accountable.

CBHI schemes excelled in providing mechanisms for beneficiary voice, though some arrangements such as annual general meetings could be viewed as inadequate owing to non-attendance by members. The focus on community participation and ownership of CBHI is ultimately both a strength and weakness. The strength lies in the focus on voluntariness, solidarity, trust and social accountability. This is evidenced by scheme officials going the extra mile to physically attend to members' needs as well as to review members' condition should they be admitted to hospital. The scheme officials are willing to meet members informally and are transparent about finances and performance. However, the voluntariness also creates tensions for scheme officials who must trade off their personal and scheme activities. Financial resources set aside for scheme administration are inadequate leading to out of pocket expenditure by scheme officials which may risk eroding their willingness to volunteer. The true costs of running the CBHIs is also understated, making it difficult to evaluate their performance.

Service entitlement design is a complex task requiring a variety of capacities and inputs. None of the purchasers demonstrated the existence of all the required capacities and inputs. However, there was demonstrated use of actuarial analysis for costing by PHI and the NHIF though deficiencies in information mean that these exercises do not operate optimally. As highlighted above, beneficiary needs and preferences are inadequately addressed in existing benefit packages, because voice mechanisms are virtually absent.

Similar limitations to strategic purchasing actions were found along the purchaser-provider axis. For example, mechanisms that should improve efficiency e.g. use of treatment guidelines and generic essential drug lists were left to providers to adapt and adopt with unclear linkages to provision of quality health services. The fact that MOH guidelines seem to focus on public health sector providers meant that purchasers that deal with private providers were less likely to utilise or enforce them. Regulation of providers was limited to licensing and what other quality improvement mechanisms were in place were limited to one-off inspections including by purchasers whose capacity to do this was limited. As a result, there were no mechanisms to assess efficiency and quality improvement measures even when providers said that these were in place. There was limited use of gate-keeping and referral systems again aided by a lack of or a public-sector focus in existing frameworks.

The use of fee for service as the main provider payment mechanism has resulted, as theorised, in over-servicing, some of which may be fraudulent. Providers also control fee-



setting mechanisms with a limited role for negotiation with consumers and purchasers of services. The enforcement of these fee guidelines is also limited and variability of cost of care is exacerbated by lack of information sharing between purchasers, between providers and between providers and purchasers. However, the movement to alternative provider payment mechanisms, such as capitation, is not supported by purchaser capacity to implement new mechanisms or to monitor for adverse consequences such as changes in quality. While there is some movement in this direction from the IRA and the NHIF, key processes were not transparent or accountable and as such were not structured to inform providers and other stakeholders how decisions, such as reimbursement or capitation rates, were arrived at.

Provider power was a limiting factor to the strategic actions of purchasers. This power asymmetry arose from limited supply in three dimensions (quality, quantity and geographical spread), better information sharing among providers, multiplicity of revenue sources and provider control of processes such as licensing and price setting. The purchasers own actions also reinforced provider power. For example, PHI maintained certain providers as part of service entitlements, even though they were costly, because of the need to maintain customer numbers. Also the fragmentation of purchasers, and variations in their financial power, meant that the exercise of monopsonistic power was all but impossible. The result is a tiered health system with those with the greatest ability to pay accessing services through PHI coverage, those with medium ability to pay tied to micro insurance and the NHIF and those with yet lower ability to pay seeking financial protection through CBHI. And yet, an even lower and larger tier exists representing those who are unable to contribute to pre-payment schemes and who either pay out-of-pocket or do not access services at all. In addition, practices such as low cover limits and balance billing expose beneficiaries to financial catastrophe and undermine the core objective of prepayment mechanisms. It is important to note that it is outside of the powers of purchasers to directly influence some of these processes suggesting that the absence of strong stewardship by the MOH for all the pillars of the health system can have significant knock on effects.

A lack of information sharing between purchasers and between providers-purchasers also undermined strategic purchasing practices. For example, delinked claims management systems meant that purchasers were blind to multiple claims for the same service. Also, a lack of common coding framework, e.g. for disease conditions, led to unnecessary disputes between purchasers and providers over service claims. Finally, an inadequate knowledge of morbidity experience means that the design and pricing of service entitlements has to make do with data sources of questionable quality. It is telling that providers do share some financial information between themselves that influences decisions to contract with certain purchasers.

## 5. Conclusions and policy implications

In summary, deficiencies along all three principal-agent axes mean that purchasing activities of these three mechanisms are unlikely to meet the ideals of strategic purchasing which may therefore undermine the attainment of UHC goals in Kenya. The policy implications of our findings include:

### **Stewardship**

The MOH, as the national government department in charge of health, is the steward of the health system and so bears ultimate responsibility for the welfare of its citizens. While recognizing (e.g. mentioning in policy) and at the same time ignoring (e.g. not developing comprehensive policy) the presence of non-state actors, the MOH fails to perform this role. The MOH must embrace its stewardship role and recognize the multiplicity of actors while maintaining a suitable distance from interest groups to safeguard the Kenyan citizen. The onset of devolution, which was accompanied by a realignment of roles between national and county governments, represents a unique opportunity for the MOH to reassess its role in the health system.

### **Coherent policy platform for strategic purchasing practice**

Planned and existing policies need to incorporate all elements of the health system building blocks and attempt to include all health system actors while taking into account their motives and mandates. This will lay the foundation for a more cohesive health financing framework and allow the implementation of critical health financing reform processes. This inclusiveness and coherence is critical for strategic purchasing functions. Any such frameworks should at a minimum explicitly clarify the principles under which purchasers must operate, address concerns around incentives and capacity, specify their role in responding to policy direction, identify the range of tools available to purchasers to deal with providers, and stress the need for accountability to and engagement with the beneficiary with regards to the quality of health services received.

### **Needs assessment and service entitlement design to protect against financial catastrophe**

The potential for effective needs assessment should be strengthened with appropriate measures to increase the volume and quality of epidemiological data, improve information sharing and enhance the linkage between these data and the development of service entitlements. The range of capacities required for needs assessment and service entitlement design includes more responsive and accountable organizational structures, information systems and persons with expertise in fields such as health economics, quality monitoring, actuarial and epidemiological analysis. The health economics expertise would extend beyond health technology assessment to areas such as health policy analysis, provider payment mechanisms and incentive assessment. The key policy implication, however, is the design of a service entitlement available universally to avoid the continuation of the tiered health system which contributes to health inequities.

### **Health system efficiency and quality considerations**

Policy must consider how to enhance efficiency and service quality measures and integrate them with the purchasing practices of all actors. This would also mean addressing the sources of provider power since these can undermine the use of measures to improve efficiency and service quality. For example, the use of gate keeping would be limited in the setting of a limited quantity of providers. These sources are areas that have policy implications across the health system building blocks including health workforce, information systems and leadership and governance. The use of appropriate provider payment mechanisms is an example of an efficiency and quality improvement measure whose adoption will require a holistic view of the health system e.g. the integration of information systems, health workforce training and so on.

Finally, it is important to underscore that strategic purchasing practice on its own will not deliver on UHC goals if other health financing and health system functions are not similarly aligned. A major challenge to the Kenyan health system is the inadequacy of resources. In view of the informal nature of the majority of the Kenyan labour force typified by low, erratic incomes and high poverty rates, ways of providing resources for the entire population that do not rely on contributions based on employment status are essential. These may take the form of subsidies from national and county governments' revenue sourced from progressive taxes. Coupled with this is the need to pool financial resources to allow effective cross subsidization across ability to pay, health status and productivity. As such the attainment of UHC in Kenya requires a strategic approach, extending beyond strategic purchasing.

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