



MINISTRY OF MEDICAL SERVICES

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UNIVERSAL HEALTH CARE COVERAGE IN KENYA**

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FOREWORD

Article 43 of the Kenyan Constitution states that every Kenyan has a right to quality and affordable health care, including reproductive health; it further states that no Kenyan can be denied access to emergency health services when in need. The implication of this article is that barriers to health care services of whatever kind will not hinder access, hence the government is duty bound to remove such barriers so that health rights are met in reality.

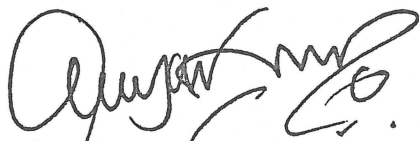
It has always been the goal of the government to fight poverty, ignorance and disease in Kenyan society. Eliminating these three enemies of social progress was set at independence, and various government initiatives have been taken with different results. While the fight against poverty still remains the most daunting task, achievements in the education and health fields have been more encouraging. But with the onset of the HIV/AIDS pandemic, the emergence of non-communicable diseases, the continued influx of populations in urban areas, growing poverty in rural areas and tremendous environmental degradation, health problems have become worse. Rather than decrease, mortality rates have gone up among all age groups as more and more people seek health care both as in-patients and out-patients. Implementing health rights as envisaged in the constitution is hence a major task at this point in time.

Health service delivery has always been shared by the public and private sectors almost in equal proportions. Since the private sector tends to cost more and demand more out-of-pocket expenditure, government services which are highly subsidized in turn get over stressed with many more people trying to get services. It has therefore always been necessary that government seeks to invest more and more in health care delivery under severe budgetary constraints.

It is in this regard that adequate financing of health care has become an urgent and important topic in government, leading to a systematic review of health care financing approaches adopted since independence, and updating them in line with present challenges and available best practices globally.

Debates have therefore intensified since 2004 regarding how best to achieve Universal Healthcare Coverage (UHC) to ensure access to quality and affordable health care for all Kenyans, whether such services are available in the private or public sectors. This policy document gives a comprehensive background to the history of public health insurance in Kenya, its evolution and challenges over the years, the necessity to transform the National Hospital Insurance Fund (NHIF) into the National Health Insurance Fund at the present conjuncture and the managerial and financial imperatives for this change.

It is hoped that Universal Health Coverage will go a long way in building the social pillar in Kenya's Vision 2030 since, over the next 5 to 10 years, the majority of poor Kenyans will have access to quality and affordable health care as the government rolls out its support for indigents under this scheme. The catastrophic expenditures that families currently experience in treating "difficult diseases" such as cancer, diabetes and cardio-vascular problems will also be minimized for all social strata in our communities.



Hon. (Prof.) P. A. Nyong'o
Minister for Medical Services

1.0 Introduction

Financing healthcare delivery in the country continues to remain an unsurmountable challenge to the economy and a hindrance to equal access to healthcare services of high standards. Several pioneering efforts to address this challenge characterize the post-independence history of Kenya. In 1965, the then Government took a ground breaking step on the continent in financing health care delivery through the introduction of a mandatory Health Insurance for all employed persons earning more than Kshs 1,000 per month. At the same time the Government abolished the user fee of five shillings that public healthcare institutions levied on the users. The combined effects of these two measures were increased access to government health facilities and services as well as an increasingly high number of Kenyans able to obtain inpatient care from private healthcare providers in the country. The momentum the changes created is felt to this day resulting into ever increasing high volumes of users particularly in the outpatient public health facilities and rapid expansion of the private health sector. The influx into the public sector and the near collapse of the Faith Based Healthcare Services was further exacerbated in 2002 when Government drastically reduced user fees to Kshs 20 in Government hospitals and Kshs 10.00 in its Health centres.

Many studies during the past fifty years repeatedly reveal an over-stretched public sector and an under-utilized private sector including the Faith Based Healthcare Services. Indeed by 1989, the public sector was at breaking point forcing Government to introduce co-payments in its health facilities. The period is also marked with re-current unrest among health workers demanding better pay and improvement in working conditions.

The Amendment of the National Hospital Insurance Fund Act in 1998, for the first time introduced profound changes on health insurance. While maintaining the principle of mandatory insurance for the wage earning workforce, the Act allowed the scheme to introduce cost related payments instead of the hitherto daily bed rate only, extension of the health package to include outpatient health costs, doctor's fees and laboratory investigations and extension of

health insurance to health centres and other lower facilities leading to better access and higher standard of the healthcare services. Today, approximately 25% of the population in the country is contributing to the Fund, enabling about 8.4 million Kenyans to benefit from health insurance. This translates to approximately 10% contribution from the Fund to the overall public expenditure in health. Unfortunately the institution has not been under pressure to increase coverage to other members of society although the Act provides for such expansion into the informal sector nor has the package broken ground into outpatient health care or increasing access through facilities other than hospitals. Moreover, National Hospital Insurance Fund continues to accumulate 'surplus' that is in reality a reflection of insufficient benefits to contributors and delayed or non-payment to government hospitals. The Minister intends to address these gaps and to stimulate rapid growth of National Hospital Insurance Fund coverage and expansion of the benefits package.

Although mandatory coverage under the NHIF Act is only applicable to wage-earning workforce, the Act in no way prohibits Government to use this mechanism as a preferred mode for financing healthcare services in the country. Cabinet should also note that despite increasing public sector expenditure that stands at Kshs 62 billion during the 2011/12 financial year.

In 2004/2005, Government attempted to redress the short comings in the financing of healthcare in the country through the enactment of the National Social Insurance Act and proposed repealing of the National Hospital Insurance Fund Act (1998). However, Cabinet would remember that the proposal generated tremendous negative reaction from many interest groups. This led to shelving of the proposed Act and with this a return to status quo ante, with regard to the challenges and shortfalls that the health sector experiences in financing. Thus access to healthcare, particularly for the poor, will remain an unattainable goal unless the Government introduces new strategies that reassure Kenyans with regard to cost containment vis-à-vis the tax wage bill. It is for these concerns that it is being proposed that financing of healthcare in the

country gradually shift from predominantly out-of pocket and tax funding to more sustainable pre-payment schemes in which Government will increasing focus attention to paying for the poor.

To help bring about the above changes, the National Hospital Insurance Fund Act (1998) will be amended to provide for Government contributions in respect of the poor, and to provide for better representation of the contributors and health service providers in the Governance bodies of the Fund. The amendments will also streamline the management of the Fund and ensure greater accountability to the contributors and other stakeholders. These changes are informed by actuarial studies already carried out by Alexander Firbes¹ on behalf of the fund and the strategic management study by the IFC and Deloitte².

2.0 ANALYSIS OF HEALTH FINANCING IN KENYA

Public expenditure on health has attained a plateau and is unlikely that more would be expected from the exchequer. Kenya Government is signatory to the Abuja and Maputo Declaration that commit African Governments to allocate at least 15% of the annual national budget to health. During this financial year, this would have amounted to approximately Kshs 150 billion for health alone. Conservative estimates indicate that the healthcare sector is under-funded by approximately 60 - 70%. This chronic under-funding of the health sector is not likely to ease in the foreseeable future, making it difficult for the country to bridge the gap in the national Millennium Development Goals by 2015.

2.1 Cost sharing

Cost sharing plays only a small part in financing healthcare services in the country. Available evidence reveals that direct out of pocket payments at the point of use are an impediment to access. Indeed when the Ministry of Health waived maternity fees in its facilities and reduced cost sharing fees to Kshs 20.00 and Kshs 10.00 respectively at the hospitals and health centres, utilization significantly increased. The net effect of the policy changes regarding cost sharing is to further scale down revenue from this source. In lower facilities, the loss of cost sharing revenue affected the quality of care due to increased numbers of users.

2.2 Out of-pocket payments

The National Health Accounts and other studies in country have shown that the Government contribution to healthcare amounts to only about 30% of the total health expenditure in Kenya and households bear the greater burden of about 40% of the healthcare costs. The rest is borne by partners. Thus the population will this year alone seek and pay for services in both public and private health facilities to the tune of Kshs 45-50 billion. This expenditure is through using

out-of pocket cash payments that on average annually drive at least 1 million economically marginal Kenyans below the poverty line, whenever sickness in the family occurs.

2.3 National Hospital Insurance Fund

Various estimates indicate that the National Hospital Insurance Fund contributes about 8% of all health expenditures in the country (after roll out of civil servants scheme). During the past decade, revenue from the Fund has continued to grow and correspondingly the payments made to meet hospitalization claims from contributors. The increase in pay out rate is not only as a result of increased number of users but reflects the deliberate policy of the Fund to increase the benefit package. Despite these promising trends, the operational costs are proportionately high as a result of the relatively small number of contributors. Other recent changes in the operations of the Fund include:

- Introduction of a comprehensive cover
- Quality Control has also been incorporated through the institution of Quality Improvement Teams, generation of Quality reports and audits.
- Access to healthcare has also been enhanced through the gazetting of 613 hospitals
- The benefit payout ratio has also improved from 22% of revenue in 2003/4 to 60% currently.

2.3.1 Growth of NHIF Membership

The performance of the National Hospital Insurance Fund during the past decade has shown positive trends of increasing proportion of claims paid as percentage of revenue and declining administrative costs (table 1). .

Table 1 National Hospital Insurance Fund Revenue and re-imburement

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
	/01	/02	/03	/04	/05	/06	/07	/08	/09	/10	/11	/12

Revenue (billion)	Kshs	2.3	2.3	2.7	2.7	3.3	3.7	4.3	4.8	5.4	6.0	6.5	9.3
Paid claims as % of revenue		14.2 %	24.6 %	30.1 %	26.3 %	28.9 %	30.3 %	43.9 %	52.3 %	52.9 %	54.6 %	56%	62%

2.3.2 NHIF Network

Currently, NHIF has a network of 30 Branches which are semi autonomous and perform the core mandate of collection of revenue, payment of claims and registration of members. These branches are connected to the head office through a Wide Area Network (WAN) which enhances real-time operations. These branches are located in all counties and serve all districts.

In addition, the Fund is in the process of connecting all hospitals to its database for facilitate smother claims processing and develop a health management information system.

2.3.3 Accreditation (Fund Approved Hospitals for Contributor use)

In Kenya, the current standing of number of beds and cots in registered hospitals are 65,971. Therefore, to ensure access to healthcare, it is important for NHIF to expand the number of Healthcare providers, bed coverage and geographical coverage.

It is proposed that accreditation should increase by 10% annually with a bias on the adversely affected areas as shown below (table 3).

Table 3 Projected growth in the coverage of accredited hospital beds in the country

	2011/12	2012/13	2013/14	2014/15	2015/16
Number of Beds	40,059	44,065	48,471	53,319	58,650
% coverage	61%	67%	73%	81%	89%

From the forgoing, it is clear that the National Hospital Insurance Fund has a large un-tapped potential and has established a nation-wide infrastructure that could support future expansion. In addition extending coverage to lower facilities will significantly contribute to improvement in preventive healthcare and result in the long term in a reduction in consumption of costly curative healthcare.

3.0 INSTITUTIONAL FRAMEWORK AND UNIVERSAL COVERAGE

In line, with the principles of universal coverage, the Fund has addressed and is continuing to improve capacity in the areas of Eligibility and registration, Administrative efficiency, Access to Quality Healthcare and Benefits. In addition, the Fund is accredited to international bodies and is certified and complying to various International Standards.

3.1 Eligibility and Registration

The Fund's Act provides for coverage of all Kenyan residents aged eighteen (18) years and above and their dependants. In this regard, the country already has legal framework that facilitates for universal coverage in line with the Social Health Insurance Principles. In this regard, the Fund has implemented online registration, magnetic stripe card and is linking with other government institutions for automatic updates.

3.1.1 Registration

The Fund has instituted an online registration mechanism, where new members can register, are assigned a membership number and can upload their photos as well as dependants photos in real time. To enhance access of the services to the members and potential members, this can be done through the internet and mobile phones.

3.1.2 Card Issuance

An electronic magnetic stripe photo card has also been introduced thus members are now able to stay or carry the portable cards as opposed to the past where the manila card was kept by the employer. The photo card is used for electronic identification through swiping the card on admission at the all the connected facilities to link to NHIF's database, where a members and

dependants details are viewed and confirmed. This assists in curbing fraud in cases of impersonation.

NHIF seeks to enhance this process by introducing biometric technology for ease of identification through the use of bio data a system that will also promote portability of health records, improve health information systems in Kenya and curb fraud.

3.1.3 *Linkage with other Government Institutions*

In addition, the Fund is integrating the National Bureau of Registration to the Fund's registration systems for automatic updates of member details. This will ensure that all births and deaths are updated at the time when such certificates are issued.

3.2 *Administrative Efficiency*

In line with Vision 2030 flagship project on Universal Coverage through Social Health Insurance, the Fund has embarked on enhancing its administrative capacity and operational efficiency through introduction of online banking, MPESA payment mode, Agency Business Model, Merchant cards, Surveillance, ICD10 and claims processing. These reforms have seen the Fund reduce its administrative expenditure from 69% in 2005/6 to 38% in 2012/2013. The major drawback has been the fixed contribution rate.

In 2010, the Ministry of Medical Services and the International Finance Corporation undertook a Strategic Review of NHIF that was aimed at improving the efficiency of NHIF as a vehicle for Universal coverage. Key recommendations included:

- The need to develop a healthcare financing strategy in consonance with the constitution
- Review of the existing regulatory framework to entrench health insurance regulation

- Strengthening the governance structures to improve trust and accountability
- Increasing funding to NHIF to support indigents and Non Communicable / catastrophic diseases
- Restructuring of the NHIF Balance sheet

3.2.1 Remittance of Contributions

i) Online Banking for employers

To enhance operational efficiency, the Fund has instituted an online banking facility for the over 50,000 employers to ease contributions remittance. This has reduced the amount of time taken by employers to queue in NHIF offices to make payment.

ii) MPESA Payment for the Informal sector

In 2009 the Fund took a strategic step and introduced payment of contribution through the MPESA service provided by Safaricom to exploit the fast growing mobile phone industry in the country and also as a deliberate effort to increase access to members. The response to this service has been positive with a daily average of over 500 members using the service during the peak period (between 1st and 9th of every month) and over 200 members daily during off peak days.

Currently, the Fund is working on getting other providers money transfer services on board in order to reach more members from the sector.

iii) Agency Business Model

The Fund is in the process of rolling out a business model aimed at improving collections and registration of members. In this model agents countrywide on a Private Public Partnership (PPP) Arrangement will register, issue cards and collect premiums on behalf of the Fund. Through this arrangement the Fund aims at reducing its administrative cost by 60% by 2013.

The system will entail introduction of a scratch card which will be used to activate new accounts for new members and subsequently make payments for contributions for either existing or new member. This method will take advantage of the increasing popularity of mobile telephony and scratch cards and affords customers increasing convenience and additional choice in the manner in which they make their transactions.

The scratch cards will be used the same way as GSM recharge cards, a method which millions of customers are already familiar with. This will save members and potential members from the inconveniency and costs they would ordinarily incur to visit physical NHIF payment points.

iii) Merchant cards

The Fund is pursuing to have a payment gateway for both receipts and payments with merchant cards such as; VISA, MasterCard, AMEX, JCI, BCP among others to facilitate quick remittances by corporate clients and Kenyans in the Diaspora.

3.2.2 Surveillance

The Fund has a strong surveillance mechanism in place, this system has resulted in reduction of fraudulent, rejected claims and improved operating efficiency of the Fund in claims processing. In addition, the Average length of stay (ALOS) has since been reduced to 4 days up from 11 in 2004 as a result of surveillance and monthly monitoring.

NHIF works closely with the health providers through participation in the hospital quality boards and have formed Quality improvement Teams in all accredited hospitals for quality monitoring through quarterly quality reports and empirical result evaluation system.

The Fund additionally, conducts clinical and quality audits on a quarterly basis; to ensure quality service is provided for not only members but Kenyans at large.

3.3 *Implementation of the Health Data Dictionary*

The Fund maintains a Health Management Information System through a Wide Area Network with all accredited Healthcare Providers. It is therefore the intention of the Ministry of Medical Services to ensure interoperability of the NHIF database and the HMIS at the Ministry through the development of a Health Data Dictionary (HDD). Initial steps would require the adoption and implementation of the International Disease Coding systems (ICD-10). This would enable the Country to analyze disease trends, plan for benefit packages as well as compare to other countries. NHIF has trained healthcare providers on ICD10 and is enforcing the use of the coding system in process hospital claims.

Key elements of the HDD will include:

- Common national patient identifier
- Common coding systems (ICD-10)
- Common electronic claim (e-claim) format

3.4 *Claims Processing*

The claims process has been continually monitored and reviewed to ensure faster service delivery to the member or health provider. The Fund introduced Electronic Fund transfer (EFT) payments to health providers and Mpesa payments for members who claim to ensure that payment is received within 21 working days.

4.0 ACCESS TO QUALITY CARE

This is a key objective that the Fund is and will continue to undertake to ensure members access quality healthcare through Accrediting and Contracting health providers and hospital connectivity to the NHIF system.

4.1 Accrediting and Contracting of Health Providers

The Fund strives to accredit as many hospitals as possible so as to ensure all members access quality NHIF benefits wherever they are across the country. Accredited facilities are those recognized and declared in the Kenya Gazette by the Fund to offer services to NHIF members and claim reimbursements thereof.

NHIF has an objective accreditation criteria and guidelines whose aim is to improve the quality of healthcare in Kenya.

Accreditation of a health provider takes into account the services, personnel, infrastructure and equipments among other issues that the institutions have which are geared towards giving the best care to our members. The level of Healthcare Provider reimbursement therefore corresponds to the grade after scoring the various aspects.

The Fund, further contracts the health facilities to ensure they provide services comprehensively. The contracts spell out the obligations of the health provider and NHIF for the benefit of the member and any one visiting the health facility. NHIF works with a wide network of over 600 accredited Government, private and mission health providers spread across the country.

Notwithstanding the commendable efforts that the Fund has placed to ensure standards in accreditation, there is need to set up a separate institution to manage Standards and Quality in Healthcare Provision in Kenya in line with best international practice. In this regard therefore, a National Healthcare Accreditation Board (NAB) is necessary to bring standardisation in the entire

Health Sector. The new Board would accredit for both NHIF and the Private Health Insurance Companies thus reducing administrative costs for both public and private players in the market.

4.2 Hospital Connectivity

All accredited facilities are connected to the NHIF ICT system. The hospitals notify the Fund on admission and discharge of a member in real time, in case the internet is down an SMS application is place for the same.

Using this system the health provider is able to confirm the member status and identity from the Fund's database; this ensures that only paid up members and their dependants can access benefits thus reducing cases of impersonation. The system is also used by the surveillance officers in pre processing of hospital claim.

4.3 Benefits

The current legislative framework provides for both In and Out Patient. The Fund currently provides a comprehensive in patient medical cover in accredited health care facilities defined as Contract A; hospitals contracted to offer inpatient care to members with no co-payment and Contract B; where hospitals are contracted to offer comprehensive care, with a co-payment of an agreed limit for surgical cases. Contract C is also available mainly for the private high cost hospitals.

A maternity package has also been introduced and implemented in line with the Millennium Development Goals (MDG) on maternal health. This has played a key role in improving of the Quality of care and safe motherhood. It has resultantly reduced the duration of stay at admission facilities with care givers tied to good quality outcomes. The undue long stays; most especially related to caesarean section have been contained thereby cutting down on the cost of reimbursement as conventional means is now used with better results on cost

cutting. The NHIF benefit package has no exclusions for any disease or existing conditions.

In 2009/2010, the Fund successfully piloted introduction of Outpatient, which it intends to roll out to all its members.

5.0 INTERNATIONAL ACCREDITATION & AFFILIATIONS

The Fund is accredited and subscribes membership to international organizations to benchmark on its operations with other similar organizations.

These international organizations are as follows:-

5.1 International Social Security Association (ISSA)

NHIF is a member of ISSA, which is the principal international institution bringing together social security agencies and organizations. ISSA's aim is to promote dynamic social security as the social dimension in a globalizing world by supporting excellence in social security administration. The ISSA provides access to information, expert advice, business standards, practical guidelines and platforms for members to build and promote dynamic social security systems worldwide.

5.2 East and Central Africa Social Security Association (ECASSA)

EASSA was formed in March 2007 as a response to the need by social protection schemes including health insurance schemes and pension funds, in East and Central Africa, to work more closely in the interest of improving the quality and effectiveness of their services to the people of the region. It creates a forum for Social Security Institutions to network and share experiences and expertise in social security management, both in the sub-region and beyond.

5.3 Joint Learning Network (JLN) for Universal Coverage

NHIF is accredited and is a member of the Joint Learning Network for Universal Health Coverage (JLN). JLN is structured to respond to the interests and demands of the participant countries and to encourage the participation of partners who can play a meaningful role in the joint learning process. Its mission is to accelerate the progress and improve the success of low and middle-income countries that are implementing demand-side financing reforms designed to improve health outcomes and financial protection for the poor and move toward universal health coverage.

5.4 International Society for Quality in Healthcare (ISQua)

NHIF has applied to be an accredited institution of ISQua. The society launched its International Accreditation Programme (IAP) in 1999. This is the only international programme that '**Accredits the Accreditors**'. ISQua offers a unique opportunity for individuals and institutions with a common interest to share expertise via an international multidisciplinary forum. It is formally recognized by the World Health Organisation as being in "Official Relations" with WHO. ISQua is assisting with technical and policy advice based on evidence and best practices and contributing to knowledge sharing as part of WHO initiatives.

5.5 INTERNATIONAL STANDARDS

To enhance operational efficiency and ensure the departments operate at optimum, the Fund has sought and maintains the certifications for functional areas as follows:-

5.5.1 Occupational Health and Safety Certification (OHSAS 18001)

NHIF is certified to the OHSAS 18001 standard, this is an Occupation Health and Safety Assessment Series for health and safety management systems. It helps the organization to control occupational health and safety risks.

5.5.2 Social Accountability Certification (SA 8000)

The Fund is complying with the global Social Accountability standard for decent working conditions, developed and overseen by Social Accountability International (SAI). The standard covers the areas of accountability in; Child labor, Forced labor, Health and Safety, Freedom of Association and Right to Collective Bargaining, Discrimination, Discipline, Working hours, Compensation and Management systems for Human Resources.

5.5.3 Quality Management System (ISO 9001:2008)

NHIF is certified to the **ISO 9001:2008** standard, which is a Quality Management System. The Fund has benefited through implementing the standard by; Creation of a more efficient, effective operations system, increased customer satisfaction and retention, improved employee motivation, awareness, and morale, growth in revenue, reduction in waste and increased productivity.

5.5.4 Records Management Certification (ISO 15489)

The Fund is implementing the ISO 15489 Records management standard requirements geared towards certification, the standard will ensure effective and efficient maintenance of records from the time they are created up to their eventual disposal. This includes classifying, storing, securing, and destruction (or in some cases, archival preservation) of records.

5.5.5 IT service management Certification (ISO 20000)

NHIF'S IT system is operating under the ISO 20000 requirements, this standard promotes the adoption of an integrated process approach to effectively deliver managed services to meet the business and customer requirements.

6.0 LEGAL FRAMEWORK: PROPOSED AMENDMENTS TO THE NHIF ACT

It is proposed that the NHIF Act No. 9 of 1998 will be amended to take into account the proposed changes at the Fund. The changes which will be in line with recommendations of the Strategic Review of the Fund (**Annex V**) proposes to change the name of the Fund and restructure the composition of the Board as well as the staff. The amendments also will allow for Government and other partners to contribute to the Fund for the coverage of segments of the Kenyan population as per the agreements with the respective contributors. Further, the amendments propose contributions to the Fund by the employers at only 1.5% of employee's salary. The full details are given in **Annex I**

6.1 *The Role of Private Health Insurances*

Although a number of well established commercial insurances provide health insurance, the contribution to the overall health expenditure in the country is almost negligible (estimated at about 1.0%). This is despite the high premiums that they charge. The total licensed medical insurers are sixteen (16) whose total premiums for the year 2009 was Kshs 5.9 Billion and total claims incurred were Kshs 4.08 Billion representing 69% of the total revenues.

7.0 BEST PRACTICE AND BENCHMARKING

Under different health systems in different countries, varying proportion of the population are provided with adequate access to health services and protection from financial risks.

At the end of the previous century, most western countries relied mainly on direct out-of-pocket payment and unregulated markets to finance and provide Healthcare. In 1938, New Zealand became the first country with a market economy to introduce compulsory participation and universal entitlement to a comprehensive range of health services, financed through the public sector. The United Kingdom followed ten (10) years later establishing the National Health Service (NHS). Universal coverage in eastern European countries - Albania, Bulgaria, the Czech Republic, Slovakia, Hungary, Poland, Romania and the USSR - was achieved through similar legislative reforms. A number of middle and low income countries have followed a similar path including most South East Asian countries and African countries like Rwanda and Ghana.

The Organisation for Economic Co-operation and Development (OECD) experience in introducing universal healthcare can be regarded as taking two phases: the policy formulation phase; and the implement phase. During the policy formulation phase, the design of the reform needs to consider both the financing and service delivery aspects. After the design of a successful system of financing universal access, the major stumbling block in most countries has been the political economy and dealing with various stakeholders with vested interests.

The OECD countries that enjoy universal access to healthcare can be separated into two groups based on:

- i) The extent of legal entitlement and physical access offered to the population under public schemes (universal versus restricted)

- ii) The nature of participation in the public or privately mandated schemes (compulsory versus voluntary)
- iii) The number of financing source (single payer versus multi-player)

Group I

Group I countries are characterized by compulsory participation and universal entitlement that are financed through a single payer. These countries include Australia, Canada, Denmark, Finland, Greece, Iceland, Italy, New Zealand, Norway, Portugal, Spain, Sweden and the UK.

Group II

The next group of countries have achieved almost universal coverage through extensive membership of different sickness funds and other insurance organizations. The characteristics of universality in this group are that entitlement is restricted; participation is compulsory and the financing mechanism is through a multi-payer system. These countries include Austria, Belgium, France, Germany, Ireland, Japan, Luxemburg, Netherlands and Switzerland.

Most Nordic countries and the UK passed through a similar historical phase before extending coverage to the whole population under a single legislative Act.

In most OECD countries that have achieved universal access, measures had to be introduced to mitigate geographic, financial, cultural, or functional barriers to access. For example, compulsory universal health insurance in Sweden in 1953, led to legislation of entitlement of health services in 1955. Nevertheless, it was the Seven Crowns Reform of 1969 that re-organised the health service and expanded access to the whole population. Likewise, compulsory universal health insurance was introduced in Finland in 1964, but it was the Public Health Act of 1972 that extended access to the whole population.

The source of financing used to achieve universal access varies greatly in the OECD, relying on a combination of general taxation, social insurance, private health insurance and direct charges. Most of these countries after passing major legislative reforms to introduce universal coverage have experienced stability in healthcare expenditure.

7.1 *Relevance of OECD experience to Kenya*

A central lesson applicable to Kenya is that whereas private sector plays an increasingly prominent role in service delivery, stronger NHIF involvement will be needed to secure adequate risk pooling, sustainability and equitable resource allocation.

It is possible to achieve universal coverage by a fast-track approach, but it needs major reforms and legislative changes, strong political will and government efforts. In Taiwan, the National Health Insurance merged all ten existing schemes in 1995. Though the National Insurance followed a half-decade of planning, it was implemented rapidly, just two months after establishment of the Bureau of National Health Insurance. Many other schemes involved gradual implementation.

Gradual implementation is desired if Kenya is to achieve universal coverage with effective risk protection at least cost possible. In recent years, increased general tax revenues for health has not been seen as an attractive option for funding universal coverage; compulsory payroll contributions seem to be considered to have greater political acceptance as well as greater acceptability to workers as opposed to increased taxation.

8.0 EXTENDING SOCIAL PROTECTION IN HEALTH WITHIN NHIF FRAMEWORK

8.1 Expanded Benefits

In introducing the Social Protection in health, it is expected that NHIF will offer comprehensive benefits for both in - and out-patient in accordance with Section 22 of the NHIF Act - as detailed in **Annex II**

8.2 Formal Sector

This segment currently constitutes approximately 20 % of the total population. Social protection in health for the Formal Sector is guided by the ILO convention No 102 that requires Employees and Employers to contribute to a National risk pooling mechanism which in Kenya is NHIF.

With exception of the NHIF, all other social protection scheme world over including the Kenyan NSSF, contribution by employees is matched by employers. In addition, NHIF contributions are among the few in the world that are not tax deductible. This has continued to remain contrary to the ILO conventions and the generally accepted principles of Social Health Insurance. These conventions are enshrined in Article 43 of The Kenyan Constitution.

To address this gap, it is proposed that employers will match their employees' contributions at an appropriate rate for the Kenyan economy. Countries implementing social health insurance share the contribution burden between Employee/Employer at a ratio of either 1:1 or 1:2 or 2:1 depending on the size of the economy.

8.3 Informal Sector

NHIF would target the informal sector through multiple marketing approaches including the cooperative movement and *Jua Kali* artisans. The target is to reach 50% of the informal contributors during the period 2011/2-2015.

The NHIF will employ innovative methods for reaching the informal sector. This will include group membership facility for SACCO members and /or use agency mechanisms for the collection of contributions, including such organizations as the Kenya Revenue Authority. Already the Kenya Women Trust Fund is making remittances on behalf of its 5,000 members. Other examples of organizations that can be approached to remit contributions on behalf of their member include Farmer's organizations (Kenya tea Development Authority with 220,000 members, Kenya Creameries Cooperative, Sugar Sub-sector - Mumias Out-growers alone has 75,000 members); Academic institutions (estimated at 300,000 in middle training colleges, polytechnics and Universities); as well as the Matatu Welfare Association with approximately 160,000 members. The Youth Fund is targeting 500,000 organized groups in the country. These are only but a few such organized groups in the informal sector that the NHIF collaborate with in the collection of revenue to accelerate the participation of the informal sector. In Kenya there are over 7,000 registered cooperative societies.

Other institutions that can play an enormous role in promoting health insurance and marketing the product include the value based service providers (Christian church groups, Muslim groups and other faiths). These institutions have strong grass root membership organizations and social support networks that members can use to channel their contributions. It is important to note that the now widely available telephone technology can greatly simplify collection and remitting of contributions from members residing even in remote rural areas of the country.

It should be noted that while the current practise is largely voluntary, Section 16 of NHIF Act requires that this segment is covered under mandatory scheme. The Government will enforce this section of the act in order to benefit the majority of the population who constitute over 60% of the population.

8.4 Indigents/Poor

Once the formal and informal sectors are covered, this will leave out of the insurance pool the poor in the community particularly in the rural areas and urban slums. As stated before it is estimated that 20% of the population are Kenyans who are unable to access good quality healthcare and currently depend on waivers available in the public sector. In those areas of the country where the government facility is not within easy reach, such poor person is denied the benefits of effective treatment and some do die unattended. It is noteworthy that in many instances where the poor live there are private healthcare providers within short distance but the services are not affordable.

The health of the poor is a public health issue. Demographic and epidemiological literature is full of scientific evidence confirming that the poor are often sick and because they are sick their social conditions progressively worsen. It is also true that the diseases that afflict the poor are easily preventable and that they are related to the living environment. Historically, in the country the protection of the health environment has comparatively received inadequate investment- thus further aggravating social, health and economic conditions of the poor people in the country. Improving environmental health will therefore go a long way towards reducing the disease burden for our curative services, hence less burden on insurance coverage.

In Kenya and the African continent there is increasing body of scientific evidence to show that unless the health needs of the poor, especially women and children are effectively addressed, the country will not attain any one of the Millennium Development Goals (MDGs). For this country, insufficient attention to the health needs of the poor is a major obstacle to the attainment of Vision 2030.

In Kenya, the fundamental issue contributing to “insufficient attention” to the health needs of the poor remains to be budgetary constraints. The experience world wide is that the allocation from the Treasuries of Government is not the most efficient way of addressing the health budget or indeed providing healthcare to the general population. An approach where economically able

members of the community contribute to health insurance to which the poor members of the community also have access, promotes financial efficiency. Through this mechanism healthy and richer members of the community contribute indirectly towards supporting the health needs of the frequently sick and poor members of the community. Government subsidy to the health insurance in respect of the poor is one method that has been successfully employed elsewhere and enabled countries particularly South East Asia to assure entire populations access to good quality healthcare that the country can afford. The system eliminates wastage through out of pocket catastrophic payments and economic loss due to high rates the sick and costs of bereavement.

It is for these reasons that it is recommended that the Kenya Government adopt the well tested approach of health insurance for all and introduce transfers of its subsidy on behalf of indigents to the NHIF. The subsidy will augment the internal cross subsidy inherent in health insurance - of the trickle down from the well-to-do contributors to the poor through the mechanism of pooling of resources. It is proposed that there be a build up of Government contributions targeting at least 65% of indigents by the year 2013. It is expected that with economic growth, the proportion of the poor will drop to the point that contributions from members will offset any further increase in Government subsidy.

9.0 CONTRIBUTIONS

In view of the above and renewed efforts to improve equity and access to benefits, the contributions will be based on a 3% rate on income as stipulated in sec. 15 of NHIF Act No 9 of 1998. This rate will be contributed by employee and employers at a ratio of 2:1. The projected revenues as a result of the review of contributions is shown in **Annex III**

This above change would make the rate flexible regardless of changes in earnings and make administration of the scheme easier. Actual contributions levels will be determined following actuarial evaluation and in consultation with the Social Sector Committee of Cabinet.

The projected membership in the formal sector is expected to grow from 1.95 million in 2011 to 2.01 million in 2016 (Table 4). This is as a result of increased compliance economic and demographic growth.

Table 4 the projected growth in NHIF membership 2012 - 2016

Year	2012/2013	2013/2014	2014/2015	2015/2016
Formal	1,946,972	1,987,469	2,028,808	2,071,007
Informal	950,000 (20%)	1,200,000 (25%)	1,716,000 (30%)	2,200,000 (45%)
Indigents	526,000 (5%)	2,690,000 (25%)	5,502,000 (50%)	7,316,000 (65%)
Total contributors	3,422,972	5,877,469	9,246,808	11,587,007
Total beneficiaries	7,680,072(21.4%)	10,632,535 (29.0%)	13,823,713 (36.8%)	16,254,364 (42.4%)

The contribution from the sector will rise from Kshs 15.2 billion to 16.2 billion. In the informal sector the number of contributors will rise by more than twofold to 2.2 million in 2015 and the revenue from this category will increase from Kshs 5.7 billion to 14.5 billion during the same period (Table 5).

Table 5 Estimated contributions for the period 2012-2016

Year	2012/2013	2013/2014	2014/2015	2015/ 2016
Formal Sector Total	15,191,483,351.92	15,507,466,205.64	15,830,021,502.72	16,159,285,949.96
Informal contributors	5,700,000,000.00	7,200,000,000.00	10,296,000,000.00	13,200,000,000.00
Indigents	504,960,000.00	2,582,400,000.00	5,281,920,000.00	7,023,360,000.00
Total	21,396,443,351.92	25,289,866,205.64	31,407,941,502.72	36,382,645,949.96

An estimated 2.08% annual increase in employment is expected based on the experience for the period 2003-2007 that saw 10% growth in the formal sector. During the period the household beneficiaries per employed worker is expected to decline from 2.5 in 2011 to 2.1 in 2016.

The total number of indigents is expected to rise from 0.5 million individual members in 2011, to 7.3 million in 2015. During the period the expected contribution from the indigent will increase from Kshs 0.5 billion to Kshs 7.0 billion.

Additional beneficial effects in terms of improvement of quality and staff attitude will come from the payments that depend on actual services provided. It rewards facilities who provide good quality and user-friendly services by generating extra money that can be used to improve infrastructure and motivate staff. At the same time it reduces inefficiency presently witnessed within the public and private sector. This has been demonstrated impressively by National Hospital Insurance Fund. This system provides for choice and competition for services thereby forcing provide to improve quality with a pre-negotiated price.

In order to increase access NHIF may consider accrediting individual health practitioners or group-practices particularly in hard to reach areas of the country.

10.0 FINANCIAL SUSTAINABILITY

The most important aspect to consider when implementing any new initiative is to ensure that it will be sustainable. These aspects has been considered by looking at all the facts on the revenues, costs and benefits using a Zeta Model and found viable. The results are shown as **Annex IV**.

10.1 PROVIDER PAYMENT MECHANISM FOR SOCIAL HEALTH INSURANCE

Provider payment systems are powerful tools that promote the development of health systems and achievement of health policy objectives. In the Kenyan context, provider payment systems properly designed will accomplish far more than the transfer of funds to cover the cost of medical services.

Indeed payment mechanisms will help achieve health policy objectives by encouraging access to necessary health services for the citizenry, high quality of care, improved equity and the same time promoting effective and efficient use of resources within the health sector. In view of these, three (3) options can be pursued:

- Direct payment to the provider by the patient
- Direct Payment to the provider by the patient, but with later full or partial reimbursement
- Direct payment to the provider with or without a co-payment paid by the patient

Decisions about which provider payment systems should respond to an explicit hierarchy of policy priorities, but typically there are practical considerations as well. Purchasers first must decide on policy objectives—increased revenues, efficiency, cost-containment, access, quality, administrative simplicity, or some combination.

The payment system chosen and the incentives used have to address one or more health sector policy objectives at that particular time. Related, incentives must be chosen in tandem with other factors such as improved knowledge about clinical outcomes, cultural factors, and providers' professional ethics.

Due to asymmetry of information, payments shall be linked to outcomes, which can be observable and verified (by both parties) than the attainment of policy objectives as envisaged in Kenya Vision 2030.

10.2 Outpatient Payment Methods

There are three main types of outpatient payment methods: line-item budget; fee-for-service (with or without a fixed fee schedule); and capitation. Each type of payment method has variations that may create a different set of incentives; the payment method may be used in combination to enhance efficiency or mitigate risk.

In line with the health policy objectives of financing outputs as opposed to inputs to promote efficiency and equity, the capitation method of provider payment is the most appropriate means of financing outputs because it is prospective and can be used to induce positive incentives in the health delivery system. To ensure that both the member and the provider are protected against undue exposure, Capitation will be applied through risk adjusters.

10.2.1 How Risk-adjusted Capitation will work

The applicability of risk adjusters will fall under two broad categories:

- (a) health-based adjusters and
- (b) non health-based adjusters; such as demographic adjusters (age and gender)

The risk-adjusted capitation payments will account for predictable variations in annual per-person healthcare expenditures, to the extent that these are

related to health status. When the risk groups are too heterogeneous, the capitation system tends to be:

- (1) unfair, that is, the system overpays providers with relatively healthy members and underpays others; and
- (2) it encourages providers to select against people whose healthcare costs are predictably (far) above their capitation payment

The appropriate capitation payment should address both the goal of a more efficient and a more equitable resource allocation in the Fund. To satisfy this, a collective purchasing arrangement will be in place whereby NHIF members and their dependants will have to enrol with service providers of their choice to access health care. In return a reimbursement rate will be contracted for all services that a patient may access in a given facility.

It is also important to determine the actual cost of treatment to fairly reimburse providers and offer a competitive benefit package. To encourage quality care to members and mitigate against this risk, NHIF will have to create a reserve and contract for a stop-loss ceiling to protect the healthcare provider.

The impact of the risk adjusted mechanism will be assessed in the context of objectives such as quality of care, cost, and targeting to the poor. Furthermore, these objectives are multiple and competing, and conflicts or tensions may arise across the multiple behaviours of purchasers, providers, and patients.

The market structure or the level of choice and competition in the system, and the ability of providers to select or refuse care to patients will enhance or mitigate the incentives created by provider payment methods.

The Accreditation system will be reviewed to provide objective measures for the quality of external evaluation and quality management. It will primarily focus on the patients and the pathways through the healthcare system - this

includes how members will access care, how they will be cared for while in the facility and the quality of service provided. The crux of the system will be a catalogue of standards which, ideally, serve to assess, evaluate in a systematic and comprehensive way the standards of professional performance at the accredited facility.

In the long run, to encourage competition and choice in the system, a disincentive may be introduced for providers to lose financially if patients become dissatisfied and choose another provider, and therefore the incentive to under-provide services will be mitigated.

One motive behind implementing capitation is to secure control of expenditures which is a macroeconomic efficiency concern. Strict budget constraints imposed by the capitation method strongly support the cost containment efforts and the rigorous budget planning process.

Secondly, the efficient allocation across various health care provisions can also be supported by the capitation method. Under the capitation scheme health care providers will have the choice to develop an optimal blend of services for their population and allocate resources accordingly provided they are compliant to the contractual agreement between the Fund and the Provider.

Allocative efficiency may further be realised if the Fund allows the patient's choice to determine to which providers the money flows by registering in accredited facilities of their choice. When there is choice, providers will compete for patients, presumably with better quality of care and patient-centred services.

The application of capitation payment to the health care delivery system has another strategic role for NHIF - enhancing equity. The population's needs across different regions are not particularly reflected in the health care delivery structure in Kenya. In certain areas people have better access to health care than in other areas and as a result the allocation of health care

resources is regarded as inequitable. The capitation method will therefore strive to address these inequities by setting aside reserve kitty to capitalize the underserved areas in line with the NHIF Act section 34 (1)(b) and (2).

The Risk Adjusted Capitation model therefore embodies different types of adjusters and compromises between the theoretically best performing but potentially biased health-based adjusters and the less accurate but more credible non health-based adjusters. An attainable model development scenario might be to:

- (a) Introduce demographic adjusters (age and sex)
- (b) Develop non health-based adjusters (e.g. social, economic, cultural, educational, infrastructural and employment factors)
- (c) Add simple measures of chronic health conditions - at first those that are easily determined and not likely to suffer from distortion effects (e.g. based on data on patients on chronic dialysis treatment)
- (d) Introduce complex health-based models, but only on condition that the system is able to control supply side effects (illegitimate adjusters and perverse incentives).

11.0 THE REFERRAL SYSTEM

A fundamental principle of public health is the close relationship between all levels of the health care system, starting at the community extending upward to clinic, health centre and district hospital and beyond.

Each patient will be connected through a seamless continuum of services and upon arrival at the appropriate level capable of giving optimal health care for any given problem. This will assure that the most common and often important measures are available nearest to home and convenient to each citizen.

Through a smoothly functioning referral system, the patient will receive advanced medical care including consultation and treatment from specialized medical practitioners. The Fund will therefore need to establish a 'special basket' for treating 'Difficult Diseases' such as Cancer, Diabetes, HIV/AIDS, Organ transplants after a proper study and institutionalization of such kind. The example of such a fund in Mexico provides a replica model.

The referral system will require clear communication to assure that the patient will receive optimal care at each level of the system. The cardinal role of NHIF will be to assure that this movement is facilitated and that proper communication accompanies it in both directions: upward, describing the problem as seen at the lower level facility and requesting specific help and, importantly, information back to the lower level facility describing the findings, the actions to be taken and the follow up needed. The referral system will be monitored through a web application. However, in areas where there is inadequate access to Information and Communications Technology (ICT) a manual referral form will be availed.

The referral form is designed to facilitate communication in both directions although effective referral can occur with written communication on the patient held record or any other convenient paper. Every patient referred

upwards should be accompanied by a written record of the findings, the questions asked, any treatment given and specific reasons for referral and expectations from the lower level facility. Such communication shall accompany the patient (usually carried by the patient) and a clear designation of to which, facility the patient is being sent.

Once the patient is seen and receives the attention at the higher level facility, back referral to the original facility is of vital importance. This communication contains answers to the questions posed with specific findings, special investigations, diagnosis, treatment offered and follow up expected from the lower level facility. The back referral may be written in the patient held record, but is most usually on a separate piece of paper, which should be delivered by the patient to the clinic, but may also be sent by fax or mail to the clinic.

NHIF shall review all referrals made from the clinic upwards each month for the appropriateness of the decision to refer. The analysis will centre on:

- Identifying cases which should have been properly treated at the clinic itself without referral
- Identifying cases which should have been referred but were handled locally.
- identifying the back referrals received to determine clinical effectiveness

Additionally, NHIF shall institute investigations on fraudulent referral cases through independent external clinical audits in conjunction with the Kenya Medical Association (KMA) and the Institute of the Certified Public Accountants of Kenya (ICPAK).

12.0 Financial implications

12.1 Government budget

Within the overall budget of Government for next year and subsequent years, the impact will be minimal. Government contributions to cover indigents will be within any planned increase in allocation to the health sector peaking at the time 100% indigents are brought on board. Thereafter, allocation to the sector will steadily decline as Social Health Insurance would be the principal medium between health service providers and users. The added value to the scheme is that gradually Government and the economy will move away to supply side financing to output based financing. This will significantly reduce wastage and make providers more accountable while protecting the users.

12.2 Individual Kenyans

In view of the proposed changes from fixed categories in the contribution rate to income related progress percentage there will be a general rise in the contributions. This has been designed to enable the Fund to expand the coverage to outpatient and to accredited Health Centres and Dispensaries. However given the shift from out of pocket to pre-paid scheme, Kenyans will realize value for money which currently is not the case. The net result to individual Kenyans will in the long term be a saving through efficient use of household incomes and the role Social Health Insurance will play in mitigating the too often catastrophic consequences of an illness in the family.

12.3 Employers

During the 5-year period employers will be encouraged to make joint contributions with the employees in line with International Labour Organization principles. The Ministry of Labour will be the arm of Government to negotiate such changes that we consider inevitable in the long run.

12.4 Private Health Insurance

A robust National Hospital Insurance will stimulate competition amongst private health insurers. The positive impact of this will be fall in private health insurance premiums and value for money for the contributors. It is expected that employers would in the long run prefer to contribute to the Social Health Insurance Scheme.

Annexure:

ANNEX I: ESTIMATED CONTRIBUTIONS BY INCOME CATEGORY

Income group	Mid Point	Contribution rate	Frequency (n)	Pessimistic Scenario Revenue	Expected Revenue (Most Likely Scenario)	Optimistic Scenario Revenue
1.) < 5,999	5,999	3%	62,622	135,240,976	135,240,976	135,240,976
2.) 6,000 - 7,999	7,000	3%	196,817	425,124,720	495,978,840	566,762,106
3.) 8,000 - 11,999	10,000	3%	178,875	515,160,000	643,950,000	772,675,605
4.) 12,000 - 14,999	13,000	3%	218,625	944,460,000	1,023,165,000	1,180,496,295
5.) 15,000 - 19,999	17,500	3%	444,597	2,400,823,260	2,800,960,470	3,200,937,625
6.) 20,000 - 24,999	22,500	3%	380,904	2,742,508,800	3,085,322,400	3,427,998,875
7.) 25,000 - 29,999	27,500	3%	329,024	2,961,216,000	3,257,337,600	3,553,340,751
8) 30,000 - 49,999	40,000	3%	170,519	1,841,599,800	2,455,466,400	3,069,271,613
9) 50,000 - 70,000	60,000	3%	75,111	1,351,998,000	1,622,397,600	1,892,797,200
10) 70,000 and Above	80,000	3%	71,177	1,793,660,400	2,049,897,600	3,197,840,256
			2,128,270	13,625,616,196	17,569,716,886	20,997,361,302

ANNEX II: PROPOSED AMENDMENTS TO THE NHIF ACT No. 9 OF 1998

i. THE NAME

The name of the Fund be changed from National Hospital Insurance Fund to National **Health** Insurance Fund.

ii. ESTABLISHMENT AND MANAGEMENT OF THE FUND

Section 4 to be corrected by inserting (e) Registrar of the Kenya Medical Practitioners and Dentists Board;

Insert (m) to read: One person nominated by the Union of Kenya Civil Servants

Insert (n) to read: The Attorney General or his representative

iii. STAFF OF THE BOARD

Section 11 be amended to read after Officers, Compliance officers and staff and deleting there from Inspectors and Servants.

All other references to Inspectors be changed to Compliance Officers, who shall include Standards and Quality Assurance Officers.

iv. CONTRIBUTIONS TO THE FUND

Section 15 be amended to include;

In the case of a person certified by the Board to be unable to pay the contributions, such contribution shall be paid by the Government in accordance with rates established by the Board with the approval of the Government.

A new sub-section be inserted as follows:

CONTRIBUTION BY EMPLOYER

- i) Every employee shall pay 1.5 % of his/her income to the Fund.
- ii) Every employer shall pay to the Fund a share of contribution matching that contribution made by each employee.
- iii) Employer's share of contribution shall not be deducted from the wages of his employee or otherwise recovered.

v. PAYMENT OF BENEFITS

Section 22 (1) be replaced and amended to read:

The Board shall pay from the Fund, Benefits to Contracted Healthcare Providers for expenses by any contributor, and his declared dependant(s).

Section 22 (2) be amended to include and end with the phrase; **Such expenses shall be prospective or retrospective as may be approved by the Board.**

vi. STAMPS

The Act shall be amended by deleting all references to stamps in sections 16(4), 21(5)(a), 24 (1) and (2), 25(2) & (3) and 26, and in place of these sections, provision be made for the identification card.

vii. PENALTY

Section 18 (1) to be amended to read "25 per cent" and not five times the amount.

viii. HEALTH SERVICE PROVIDERS

Section 30 be amended to read "Contracted Health Service Providers" and provision made with regard to the Contract, Declaration of the Health Service Providers and Gazettement.

ix. INSERT A NEW PART V - APPEALS TRIBUNAL

The new Part V to read:

S 38. There shall be an appeals Tribunal for the purposes of arbitrating in cases where disputes arise between any of the parties involved in the operations of this Act, which shall consist of-

(a) A Chairman, who shall be an advocate of the High Court of Kenya of not less than seven (7) years' standing appointed by the Cabinet Secretary

(b) Four members as follows -

i) One pharmacist or medical practitioner

ii) One accountant or financial professional

iii) One lawyer

iv) One social health insurance expert,

each of whom shall be appointed by the Cabinet Secretary from a panel of three names sourced competitively.

S 39. A person aggrieved by a decision of the Board under this Act may, within one month from the date on which the decision is intimated to him, appeal to the Appeals

Tribunal for review of such decision, and the Appeals Tribunal may uphold, reverse, revoke, or vary the decision of the Board.

S 40. The Third Schedule shall have effect with respect to the Appeals Tribunal.

x. **MISCELLANEOUS**

All references to repealed Laws such as Workmen's Compensation Act at Section 43 be deleted.

xi. **THIRD SCHEDULE (s. 40)**

Amend the Schedules of the Act to introduce a third schedule to make the new section 40 operational

PROVISIONS WITH RESPECT TO THE APPEALS TRIBUNAL

1. The tenure of office of the Chairman and members of the tribunal shall be three years renewable for one further term, provided that they do not serve for more than two consecutive terms.
2. All appointments to the Tribunal shall be gazetted by the Cabinet Secretary within fourteen days from the date of appointment.
3. The Tribunal may appoint any person with special expertise on issues which are the subject matter of any proceedings or inquiry before the Tribunal in an advisory capacity, in any case where it appears to the Tribunal that such expertise is required for the determination of the matter.
4. The Fund shall provide a secretariat for the Tribunal.
5. (1) on the hearing of an appeal the Tribunal shall have the powers of subordinate court of the first class to summon witnesses, to take evidence upon oath or affirmation and to call for the production of books and other documents

(2) Where the Tribunal considers it desirable for the purpose of avoiding expense or delay or any other special reason

(3) In the determination of any matter the Tribunal may take into consideration any evidence which it considers relevant to the subject of any appeal before it, notwithstanding that such evidence would not otherwise be admissible under the law relating to evidence.

(4) The tribunal shall have power to award the costs of any proceedings before it and to direct that costs shall be taxed in accordance with any scale prescribed by law.

(5) All summonses, notices or other documents issued under the hand of the chairman of the Tribunal shall be deemed to be issued by the Tribunal.

(6) Any interested party may be represented before the Tribunal by an Advocate or by any other person whom the Tribunal may admit to be heard on behalf of the party.

6. (1) The Tribunal shall, upon an application made to it in writing by any party or a reference made to it by the Fund on any matter relating to this Act or regulations made hereunder, inquire into the matter and make an award thereon, and every award made shall be notified by the Tribunal to the parties concerned.

(2) The Tribunal shall sit at such times and in such places as it may decide.

(3) The proceedings of the Tribunal shall be open to the public save where the Tribunal, for good cause, otherwise directs.

7. (1) the Tribunal may-

(a) Make such orders for the purpose of securing the attendance of any person at any place, the discovery or production of any document, or the investigation of contravention of this Act as it deems necessary or expedient;

(b) Take evidence on oath, and may for that purpose administer oaths; or

(c) On its own motion, summon and hear any person as a witness.

(2) Any person who-

(a) Fails to appear before the Tribunal after having been required to do so under subparagraph (1) (a);

(b) Refuses to take oath or to be affirmed before the Tribunal or to answer satisfactorily to the best of his knowledge and belief any question

- lawfully put to him in any proceedings before the Tribunal or to produce any article or document when required to do so by the Tribunal;
- (c) Knowingly gives false evidence or information which he knows to be misleading;
- (d) At any sitting of the Tribunal-
- (i) Willfully insults any member or officer of the Tribunal; or
 - (ii) Willfully interrupts the proceedings or commits any contempt of the Tribunal, commits an offence.

8. (1) For the purpose of hearing and determining any cause or matter under this Act, the chairman and two members of the Tribunal shall form a quorum.

(2) A member of the Tribunal who has a direct interest in any matter which is the subject of the proceedings before the Tribunal shall not take part in those proceedings.

(3) Any matter considered by the Tribunal shall be decided by the votes of the majority of the members constituting the Tribunal and voting, and the chairman shall have a casting as well as a deliberative vote:-

Provided that any any point of law arising in any proceeding before the Tribunal shall be reserved to, and pronounced upon, by the chairman exclusively.

Notwithstanding any other provision of this Act, the chairman of the Tribunal acting alone shall have jurisdiction to deal with all interlocutory applications which are not of such a nature as to effect a decision in any matter which is in issue between parties.

9. There shall be paid to the chairman and members of the Tribunal such remuneration and allowances as the Minister may, in consultation with the Board from time to time determine.

10. (1) the chairman or other members of the Tribunal shall not be liable to be sued in a civil court for and act done or omitted to be done or ordered to be done by them in the discharge of their duty as members of the Tribunal, whether or not within the limits of their jurisdiction; Provided they, at the time, in good faith, believed themselves to have jurisdiction to do or order the act complained of.

(2) No officer of the Tribunal or other person bound to execute the lawful warrant, orders or other processes of the Tribunal shall be liable to be sued in any court for the execution of a warrant, order or process

which he would have been bound to execute if within the jurisdiction of the Tribunal issuing it.

11. (1) any party to proceedings before the Tribunal who is aggrieved by any order of the tribunal may, within thirty days of such order, appeal against such order to the High court provided that the High Court may, where it is satisfied that there is sufficient reason for so doing, extend the said period of thirty days upon such conditions, if any as it may think fit.

(2) upon the hearing of any appeal under this section, the High Court may-

- (a) Confirm, set aside or vary the order in question:-
- (b) Remit the proceedings to the Tribunal with such instructions for further consideration, report, proceeding or evidence as the court may deem fit to give.
- (c) Exercise any of the powers which could have been exercised by the Tribunal in the proceedings in connections with which the appeal is brought; or
- (d) Make such orders as it may deem just, including an order as to costs of the appeal or of the appeal or of earlier proceedings in the matter before the Tribunal.

12. Save as expressly provided for in this schedule, the tribunal may regulate its own procedure.

ANNEX III: HEALTH BENEFITS UNDER THE PROPOSED SCHEME

In-Patient Cover

(i) Hospital Treatment and services

All necessary medical treatment and services provided as per level of care by or on the order of a physician to a Member when admitted to an NHIF accredited hospital. Cover includes hospital accommodation, nursing care, diagnostic, laboratory or other medically necessary facilities and services, physician's, surgeon's, anaesthetists, or physiotherapist's fees, operating theatre charges, specialist consultations or visits and all drugs, dressings or medications prescribed by the treating physician for in-hospital use.

(ii) Day-care services: surgery and other medical services deemed fit by the physician as defined in the NHIF benefit package.

b) Out-patient cover

Necessary medical treatment provided to a member, as per level of care, at a contracted healthcare provider and defined as follows;

- Consultation
- Laboratory investigations
- Drugs administration and dispensing
- Basic Dental health care services
- Basic Radiological examinations
- Nursing and midwifery services
- physiotherapy services.

This cover shall be accessed by a Member at the specified facilities for this scheme.

c) Maternity cover and Reproductive Health

NHIF shall cover a Member for the proportion of expenses shown on the contract data page for childbirth, provided the member is admitted in an NHIF accredited hospital. The benefit shall cover; consultation, spontaneous vertex delivery, caesarean section and treatment for both mother and child only. The cover shall also include up to six (6) pre natal visits on outpatient basis.

Reproductive health shall cover male circumcision, tubal ligation, vasectomy and family planning based on pre-authorization.

I. Expanded Membership Structures

In view of the above analysis there are a range of solutions to extend coverage to all citizens within the framework of NHIF. These range of solutions are limited to: -

- a) Formal sector being covered by a mandatory contributory scheme.
- b) Informal sector to be covered by a mandatory contributory scheme
- c) Indigents/poor to be covered by the Government.

ANNEX IV: FINANCIAL SUSTAINABILITY

The Fund's main objective is to provide health security through the provision of a branded health Insurance. The Zeta model was employed in determining the ability to remain fiscally sound overtime in order to provide insurance as well as assurance.

The Z-Score model is a linear analysis that uses five measures are objectively weighted and summed up to arrive at an overall score that then becomes the basis for classification of firms into one of the a priority groupings (distressed and non-distressed). This is useful to determine the impact that the outpatient cover will have in the Fund's long-term financial health.

In order to arrive at the final profile of variables, the following procedures are utilized:-

- (1) Observation of the statistical significance of various alternative functions, including determination of the relative contributions of each independent variable;
- (2) Evaluation of inter-correlations among the relevant variables;
- (3) Observation of the predictive accuracy of the various profiles;

The projected financial position will be as shown below:

	2012 /13	2013 / 14	2014 / 15	2015 / 16
	KSHS	KSHS	KSHS	KSHS
Revenue*	21,396,443,352	25,289,866,206	31,407,941,503	36,382,645,950
Benefit				
Out Patient	11,126,150,543	14,162,325,075	18,844,764,902	22,557,240,489
In patient	4,921,181,971	5,563,770,565	6,,595,667,716	7,276,529,190
Admin Expenses	3,965,638,397	4,550,522,146	4,655,545,039	5,227,065,124
Total Expenditure	20,012,970,911	24,276,617,787	30,095,977,656	35,060,834,803
Surplus	1,383,472,441	1,013,248,419	1,311,963,847	1,321,811,147
out patient	52%	56%	60%	62%
inpatient	23%	22%	21%	20%
Pay out	75%	78%	81%	82%
surplus	6%	4%	4%	4%

*Revenue includes Member contributions and other incomes

Prediction of Financial Distress

In line with the Z-Score model, the table below shows the progression of the Fund in the next five (5) years:

	2012 /13	2013 /14	2014 / 15	2015 / 16	2016 / 17
Working Capital/ Total Assets	0.12	0.12	0.13	0.14	0.15
Accumulated Fund / Total Assets	0.97	0.99	1.00	0.99	0.99
Earnings (Surplus) / Total Assets	0.05	0.05	0.03	0.04	0.05
Fund Actuarial Value/ Book Value of Total liabilities	1	1	1	1	1
Revenue / Total Assets	1	1	2	2	2
z score=	3	3	3	3	4

The final discriminant function is as follows:

$$Z = 1.2X_1 + 1.4X_2 + 3.3X_3 + 0.6X_4 + 0.999X_5$$

Where X_1 = working capital /total assets,

X_2 = Accumulated Fund /total assets,

X_3 = Earnings (surplus)/total assets,

X_4 = Actuarial Fund value /book value of total liabilities,

X_5 = Revenue /total assets,

Z score= overall index.

For a financially healthy state a firm is required to have a Z score of between 3 and 4 whereas any score below 3 is considered as unsustainable business.