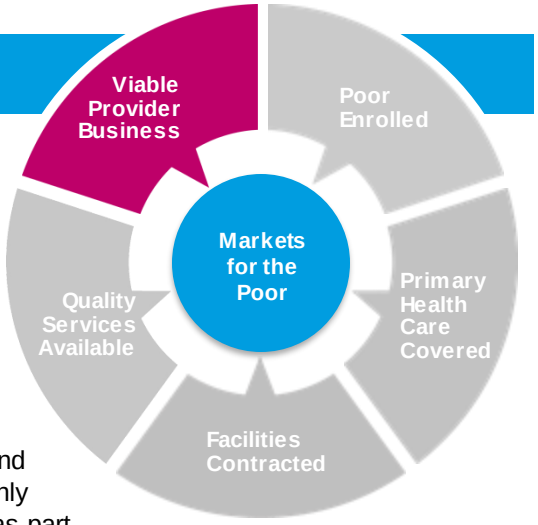
Snapshot 12 | NHIF contracts and provider business – Kenya

MSK has supported AMUA social franchise providers with empanelment in the National Health Insurance Fund (NHIF). This snapshot explores implications of contracts and capitations on provider businesses.



Background

Kenya invested early in national health insurance, with the establishment of the National Hospital Insurance Fund (NHIF) in the 1960s. The scheme, was initially focused on in-patient care through hospitals in urban areas, mainly for the formally employed and civil servants. However, with renewed effort to expand coverage of the scheme as part of Kenya's commitment to UHC, the NHIF now covers primary and preventive care through an out-patient contract.

Context and Intervention

Approximately one quarter of Kenyans are covered under the NHIF. While the NHIF still relies on voluntary premiums for the general population, effort is being made to include the poor through the Health Insurance Subsidy Program (HISP) and the availability of a low cost product for the informal sector. Outpatient services are offered on a capitation model, where the health facility signs a contract for a defined benefit package, for a pre-determined number of people. The health facility is paid in advance, and is expected to treat the patients for an unlimited number visits. The outpatient contract categories and annual capitation rates are outlined in Table 1.

Table 1. Outpatient services

Contract	Capitation
National scheme	Ksh 1,200 (~USD 11.65)
Civil servant and disciplined forces	Ksh 2,850 (~USD 27.70)
HISP	Ksh 1,200 (~USD 11.65)
Elderly and disabled programme	Ksh 1,200 (~USD 11.65)
Job Group M-T	Fee-for-service

MSK has supported private providers in the Amua social franchise with empanelment in the NHIF. At present 108 providers are empanelled with another 50 in process. Amua franchisees, tend to be "mid-level providers" – nurses and clinical officers who own and operate clinics. Most of these providers have not worked with capitation before.

Many perceive the NHIF tariffs to be low, a concern at time of empanelment. Unlike the public sector, which receives equal capitation tariffs, private providers have structural and operational costs to cover such as consumables and staff salaries.

MSK is working with providers to better understand the implications of different out-patient contracts and capitation tariffs on the "bottom" line" of their businesses. MSK devised a tool for data collection and trained Amua providers on this. In total 41 providers collected data on the civil servants scheme and 35 on the national out-patient scheme. This considered the number of patient visits under capitation and estimated profit and loss based on the price that would have been charged by providers had services been paid for out-of-pocket (OOP).

The results were complex (see Table 2). Providers in the civil and national schemes both recorded profits, including nearly a quarter with surpluses of more than $20,000. However, 27% of those under the civil service scheme were functioning at a loss, as were 20% under the national out-patient scheme.

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Results

AHME's analysis for a sub-set of empanelled providers found that 74% of social franchise providers under the civil service outpatient scheme were breaking even or making a profit, with 41% making the equivalent of more than USD10,000, and 19% reporting profits equal to USD30,000 or more. Fully 80% of outpatient providers in the national out-patient scheme were profitable. The study did not reveal which factors influenced the profitability or loss of various clinics.

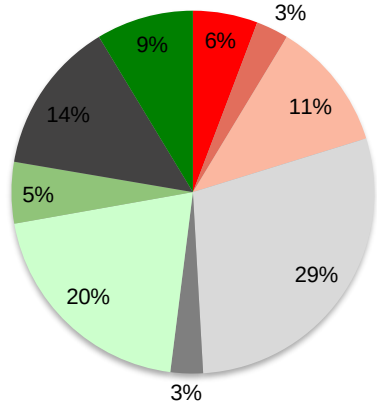
Lessons Learned

Most AMUA providers were not keeping track of how they were performing financially under either the civil servant or national out-patient scheme, and assumed that higher capitation rates for civil servants would result in higher profits for providers. But results were more mixed. Civil servants may have higher and more pricey service expectations (e.g., no generic medicines) due to their longer experience with NHIF coverage.

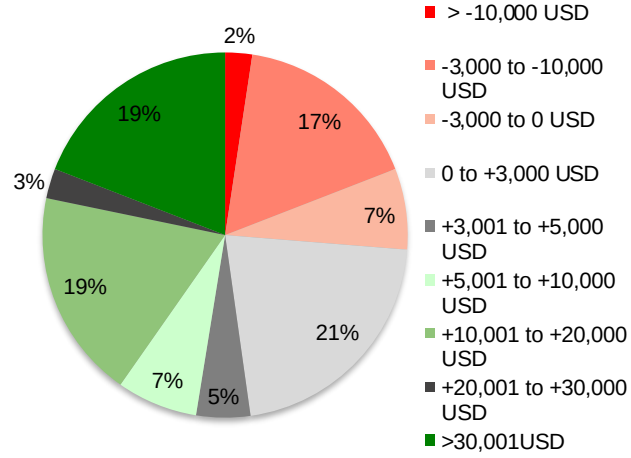
Further research is needed to understand the factors influencing provider performance under capitation. In addition, care must be taken to understand if business profitability is coming at the price of access or quality, such as under-treatment or selecting out patients who are perceived to need more care.

There may be a possibility to negotiate increased capitation rates for providers who are using the SafeCare quality improvement plan and standards, with higher payments as they rise from one SafeCare level to the next.

Surplus/Deficit under NHIF national out-patient contract



Surplus/Deficits in Civil Service Scheme under NHIF Capitation



Outlook

The Government of Kenya has proposed replacing NHIF with a consolidated national social health insurance fund (NSHIF) to provide one basic benefit package for all, based on available resources. It will eliminate the distinctions between coverage for civil service employees and others.

MSI is planning to analyze data on costs and NHIF visits within franchise facilities to develop a clearer understanding of factors such as service utilization, behaviours, and costs under capitation that can inform provider business under the new NSHIF.

MSK plans to build the business management capacity of franchisees through the development of a financial health management information system (MIS) to ease the tracking on usage of the capitation funds.