

National Hospital Insurance Fund tariffs – **what are the effects on Amua franchisee businesses?**

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Acknowledgments

African Health Markets for Equity (AHME) is a six year programme funded by the Bill & Melinda Gates Foundation and Department for International Development. The six-year project aims to deliver high quality primary health care, particularly to the poor, through the private sector in Kenya and Ghana. The AHME partnership is led by Marie Stopes International in collaboration with Population Services International and PharmAccess Foundation.

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Project Summary

Figure 1: AHME conceptual framework



The African Health Markets for Equity (AHME) project, funded by the Bill & Melinda Gates Foundation and the UK Department for International Development, aims to deliver high quality primary health care, particularly to the poor, through the private sector in Kenya and Ghana. The six-year project seeks to improve the functioning of the health system in terms of quality, access, security of supply, sustainability and equity in ways that benefit the poor. The AHME partnership is led by Marie Stopes International (MSI), with Population Services International (PSI) and PharmAccess Foundation (PAF) as sub-contracting partners.¹

The AHME partnership identified five conditions that must be met for markets financed through national health insurance schemes to work for the poor. These five conditions underpin AHME's intervention strategies (Figure 1):

1. **The poor are enrolled**
2. **Key primary healthcare services are covered.**
3. **Accessible facilities are contracted.**
4. **Accessible providers offer quality services.**
5. **Providers run viable businesses.**

This brief describes the experiences and perceptions of healthcare providers in the Amua social franchise network who participate in the National Hospital Insurance Fund (NHIF) and of NHIF branch officers, as expressed in interviews and focus group discussions (FGDs). Their views address conditions 2. key services covered; 3. accessible providers contracted; and 5. viable provider businesses. In particular, we explore the situation of family planning within capitation, as an example of an important preventive primary health care (PHC) service.

MSK's experience will be relevant to other organizations and governments embarking on domestic financing and seeking to overcome obstacles in linking private providers into a UHC scheme.

Introduction

Under the AHME partnership MSK works with private healthcare providers to improve access by the poor to quality PHC services in Kenya. One way that MSK does this is to support Amua social franchise providers with accreditation into the National Hospital Insurance Fund. While a previous case study describes this work,² **this case study focuses on provider perceptions and effects of the NHIF out-patient schemes on private providers' businesses.** These schemes operate on a capitation payment basis; that is, the scheme pays a set amount for each enrolled person assigned to a provider, per period of time, whether or not that person seeks care. There are concerns within the AHME partnership that, under this scheme, business profitability might come at the price of access or quality, through such practices as selecting out patients perceived to need more care or under-treatment of patients.

The key questions that this case study seeks to answer are: How do providers view NHIF business? How are providers handling NHIF business? What are the benefits and challenges of participating in the NHIF out-patient schemes? Does providers' receptivity towards out-patient schemes or services vary?

Capitation is relatively new to the NHIF. Thus, there is little documentation on private providers' experience and perspectives and their implications for policy.³ A specific policy aim of the NHIF is to extend coverage to lower or mid-level facilities (e.g., health centres, maternity homes and dispensaries) to improve preventative health care and reduce consumption of costly curative care.⁴ How private providers manage NHIF business has implications for this policy aim in terms of the quality of services that NHIF members receive as well as the willingness of private providers to participate in the NHIF network.

Background

The National Hospital Insurance Fund

In recent years there has been renewed effort to expand coverage of the NHIF as part of Kenya's commitment to universal health coverage (UHC).⁵ Since 1998 the NHIF has been mandated to cover out-patient services as well as in-patient. In 2012 it was estimated that approximately 25% of Kenya's population participated in the NHIF.⁶ The NHIF is compulsory for all formal-sector workers⁷ and in effect voluntary for the informal sector. Effort is being made to include indigent populations, through the Health Insurance Subsidy Programme (HISP), introduced in 2014. In 2015 the NHIF introduced a low-cost product, SupaCover, to increase the voluntary enrolment of the informal sector. The NHIF operates two main schemes:

the national scheme and the civil servants scheme. Additional sponsored programmes such as HISP and one that focuses on the elderly are modelled on the national scheme. Outpatient services are offered on a capitation basis, where the health facility signs a contract for a defined benefit package. The provider is paid quarterly in advance for the number of members registered with the health facility, and the provider is expected to treat registered members for an unlimited number of out-patient visits. Table 1 outlines the outpatient contract categories and annual capitation rates for private, faith-based and public health facilities. The civil servants scheme provides a broader benefits package and so offers a higher capitation rate.

Table 1. Outpatient services

Contract	Capitation* in private and faith-based facilities	Capitation* in public facilities
National scheme	Ksh 1,400 (~USD 13.60)	Ksh 1,200 (~USD 11.65)
Civil servants scheme	Ksh 2,850 (~USD 27.70)	Ksh 1,500 (~USD 14.56)
HISP	Ksh 1,400 (~USD 13.60)	Ksh 1,200 (~USD 11.65)
Old people and special disability	Ksh 1,400 (~USD 13.60)	Ksh 1,200 (~USD 11.65)

*Capitation figures are per person enrolled per year.

Amua social franchise

MSK has supported private providers in the Amua social franchise with accreditation in the NHIF. At present 135 Amua providers are accredited, with another 50 in process (out of 360 in the franchise). Amua franchisees tend to be mid-level providers – nurses and clinical officers who operate their own clinics. Most of these providers have not worked with capitation before. At the time they are accredited, many considered the NHIF tariffs low. Unlike the public sector, private providers have operational costs to cover, such as medicines, consumables and staff salaries. In 2016 MSK consulted providers to better understand the implications for their businesses of different NHIF outpatient contracts and capitation tariffs. MSK devised a tool for collecting data and trained Amua providers to use it. In total 41 providers collected data on the civil

servants' scheme and 35, on the national scheme. The tool recorded the number of patient visits under capitation and estimated profit and loss by comparison with foregone user fees – that is, the fee that providers would have charged if NHIF members had paid out-of-pocket. The results of this analysis were complex. Many providers in the civil servants and national schemes reported greater income under capitation, including nearly one-quarter with surpluses of more than USD \$20,000. However, 27% of those under the civil service scheme were generating less income than they would have from out-of-pocket payments, as were 20% under the national scheme. The study did not reveal what factors influenced the profitability or loss of the various clinics. It was concluded that further consultation was needed to understand the factors influencing provider performance under capitation.

Methodology

To understand the effects of NHIF capitation on providers' businesses and clients' access, MSK undertook a series of consultations with social franchise providers, NHIF branch staff and Department of Health (DoH) officials in eight counties in Kenya. Consultations took place in June–July 2017. The line of questioning focused on capitated out-patient care under the NHIF civil servants and national schemes. Table 2 outlines

the locations visited and stakeholders consulted. FGDs were scheduled during planned Amua provider 'cluster' meetings in Machakos, Nairobi and Nakuru, organised by MSK. In these settings providers from adjoining counties were also consulted (as they formed part of the cluster). In the remaining counties individual interviews were conducted at the providers' facilities.

Table 2. Case study locations and stakeholders

County	NHIF branch	DoH	Private providers	Site visits
Bungoma	1	1	1	1
Kwale	1	0	3	3
Machakos (and Kitui and Kajiado)	1	1	7 (FGD)	0
Nakuru (and Narok)	1	1	6 (FGD)	0
Nairobi	0	0	12 (FGD)	1
Total	4	3	29	5

Criteria for inclusion in consultations were:

- Participant's willingness to participate
- Geographic diversity
- Facility type (with an emphasis on mid-level providers)

Guides to semi-structured interviews were developed to facilitate discussion. Participants gave verbal informed consent to their participation in the FGDs and interviews.

Conceptual framework

AHME is centred on the premise that private markets for health delivery are critical for expanding access to care for the poor. The AHME partnership has identified five conditions that must be met for markets financed through national health insurance schemes to work for the poor. These five conditions underpin AHME's intervention strategies:

- 1. The poor are enrolled** in government health insurance schemes. To increase enrolment of the poor, AHME focuses on improving targeting mechanisms and community engagement.
- 2. Key primary healthcare services are covered.** AHME has championed the inclusion of primary healthcare services in the benefit package offered by government health insurance schemes and advocated reforms in how primary healthcare services are purchased in order to create an incentive for providers to deliver high quality services cost-effectively to all who need them.

3. Accessible facilities are contracted.

AHME works directly with smaller, low-cost private providers to assist them with empanelment and is exploring ways for franchisors to serve as intermediaries between the insurer and a network of private providers.

4. Accessible providers offer quality services.

AHME partners are working to measure and improve the quality of services offered by franchised providers.

5. Providers run viable businesses.

AHME partners are supporting providers to improve their business skills as well as gain access to credit to grow their businesses.



Findings



Primary health care covered

Providers are reaching more people, including the poor, with primary healthcare services. Providers in all counties indicated that they see a spectrum of middle-income and poorer clients. (In some instances, they referred specifically to quintiles 1–3, as they have been exposed to poverty analysis through the cluster meetings). Clients include civil servants (including public sector health workers), the formally and informally employed, as well as indigents, facilitated through NHIF-sponsored programmes (the HISP and the elderly and disability cover). NHIF branch offices reported that there has been an increase in membership, largely attributed to SupaCover and the package offered under it. From providers, there was no indication that they were ‘selecting out’ (not accepting) clients for care, due to capitation, however there were concerns voiced about the cost, frequency and treatment of patients with non-communicable diseases.

While many providers are unclear of what is, and what is not, covered under the various out-patient benefits packages, all cite a wide range of ailments and conditions that they treat under the schemes. Examples included the following:

- In Nakuru providers said that they see clients with non-communicable diseases (NCDs) and respiratory tract infections (RTIs), with one provider indicating that she treated a lot of poisoning cases (due to organic phosphate).
- In Nairobi most providers reported providing curative services as well as treating NCDs. Preventive and promotive services were not mentioned. Nairobi providers indicated that the NHIF ‘gives the wrong information to clients’ about the benefits package, creating problems for the providers, as they are left to manage clients’ expectations. This is a real concern, as members will change providers if they feel that they are not getting what they are entitled to.
- In Machakos the county official noted that the out-patient contract says that the provider is responsible for delivering ‘basic care’; however, what that includes is not clearly defined, communicated or known to the providers. Said the official, ‘We talked to other hospitals to understand what they were doing, which is to give what is available. That is what we are doing.’

Family planning under capitation Stakeholder consultation explored the coverage of family planning under the NHIF capitated out-patient schemes, as this is of specific interest to AHME from both public health and development perspectives. Stakeholder understanding varied, but broad findings can be distilled.

Irrespective of location, most providers consulted do not provide any family planning services under capitation.

These remain for-fee services, even for women enrolled in the NHIF or Linda Mama (free maternity services). This has implications for the types of methods used: Providers report that some women choose short-term methods over more expensive long-acting reversible contraception (LARC) due to cost. In many instances providers are unsure about the inclusion of family planning – in terms of specific services and methods – under capitation. This is not without reason, as NHIF guidance is vague and at times contradictory. (Figure 2 provides extracts from some of the NHIF documents reviewed as part of the case study.) Branch offices also were unsure what was in and out of the package in terms of family planning. One branch quality assurance officer noted that implants are too expensive to be included, while branch managers were unsure of the contraceptive methods and their differential requirements in terms of time, skills and consumables. The 2012 government sessional paper refers to family planning, under reproductive health, as including tubal ligation, vasectomy and family planning based on pre-authorization.⁸ This may be the source of some of the confusion.

Providers did not think it feasible to include family planning, particularly LARC – implants specifically – given the low capitation rate. Some providers recognize that free provision of family planning under the NHIF out-patient schemes would improve utilisation; MSK-subsidized ‘Amua Leo’ days suggest that, when financial barriers are removed or reduced, women flock to services. Those involved in the previous national output-based aid (OBA) scheme indicated that the fee-for-service rates under that scheme were attractive and improved access and utilisation.⁹

Providers receive some family planning commodities from county and sub-county stores – but inconsistently. For example, implants often are not available. Private providers are last in the queue to receive contraceptive commodities, after public facilities. Given this, subsidy through the provision of free commodities is not considered enough to cover family planning services under capitation.

Free maternity services
Linda Mama,¹⁰ the free maternity service scheme, is viewed as a welcome ancillary scheme to the NHIF primary care packages. The scheme is open to all pregnant women and does not require client membership in NHIF. Phase one implementation of the scheme includes private and faith-based providers. Providers must be accredited to be eligible (120 of MSK’s Amua franchisees are currently eligible). Normal delivery is reimbursed at Ksh 3,500 (US\$34) in level 2 and 3 facilities (e.g., health centres and maternity homes) and Ksh 6,000 (US\$58) in level 4 and above (e.g., hospitals).¹¹ The

rates are considered low. As one provider said, ‘If you go for what they say, you will not make it’, and, ‘Any other extra, add to the mother’. Thus, as with capitation, providers are in a quandary, as Linda Mama reimbursement may not adequately cover delivery costs in all settings and circumstances. As the scheme is quite new and not yet operational in all counties (some NHIF branches had not yet communicated to providers that they were part of the scheme), it is too early to assess performance. Future phases of the scheme are to include post-partum family planning, but it is unclear if this will attract a separate fee-for-service.

Figure 2: NHIF information on family planning

Family planning

- Consultation with a clinician
- Health education on natural and artificial family planning methods
- Assessment for appropriateness of particular methods (Natural, Hormonal and IUDs)
- Initiation/administration of a particular FP method
- Follow-up monitoring and surveillance
- Change of a family planning method

Procedures including partographing and Normal delivery

Family Planning Procedures (KCCB not to offer artificial method)

Counselling client for Family Planning

Papanicolaou smear

Natural Family Planning Method Education

NHIF SUPA+COVER

CUSTOMER INFORMATION PACK +

Be a health hero for you & your family

f. **Radiology Services** - Basic x-rays are covered under the general outpatient and inpatient care while MRI and CT scans are available in select facilities under a referral system with a pre-authorization from NHIF

g. **Inpatient Services** - including accommodation/bed charges, nursing care, consultation, Prescribed drugs/medication, laboratory services, surgery, physiotherapy, specialist consultation and treatment

h. **Maternity Services** - including prenatal care, child delivery - normal and caesarean section, postnatal care, Manual Vacuum Aspiration (MVA) and Family planning services

i. **Kidney Care package** - including Renal Dialysis through inpatient or outpatient for a maximum of two sessions in a week; Kidney transplants at approved facilities

j. **Drug and Rehabilitation services** - at accredited rehabilitation centres at maximum of one treatment session in a year.

k. **Chronic illness care packages** - Members who declare their illness for



Accessible facilities contracted

In the five counties studied, **most accredited facilities are private or faith-based**. National accreditation data show that 1,114 facilities are currently contracted to provide out-patient services under the NHIF, and 65.6% of these are private or faith-based – 52% private and 13.6% faith-based. DoH ambivalence towards NHIF accreditation in some counties has left a market niche open that private and faith-based providers have filled. Two of the four NHIF branch officials interviewed reported that NHIF contracted only with the county and sub-county public hospitals. They contended that the public health centres in their respective counties did not meet basic NHIF contracting requirements. Also, other respondents noted a lack of ‘cooperation’ by some public hospitals in terms of procedural compliance and treatment of NHIF members. The Machakos county referral hospital, an exemplar for other county hospitals, receives NHIF

reimbursements directly and has been able to profit from NHIF in- and out-patient contracts. Other county hospitals have not been able to do this, as devolution has resulted in a substantial reduction in their autonomy.¹³

In the four NHIF branches studied, **managers had targets for facility accreditation and membership enrolment**. In many counties this remains critical, as the number of contracted facilities is small relative to the population size. Table 3 illustrates this using data from the five counties. While data on enrolment by county was not available, all branch managers and providers noted increasing demand for NHIF accredited facilities, due to increasing membership and limited choice of providers in some counties. Demand has been supported through the work of AHME as well as through county-initiated membership drives.

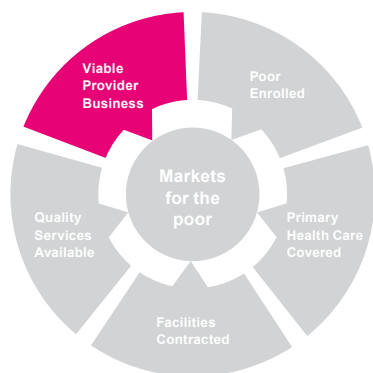
“The NHIF branch considers the Machakos county hospital is considered a ‘preferred provider’. It is clean, well-organised, provides a broad service offer and has a robust referral system through the Kenya Red Cross Society ambulatory services, which are reimbursed on a fee-for-service basis. NHIF payments account for approximately 15% of the hospital’s revenue, according to the consulted county official. Since mid-2016, NHIF reimbursement has come to the facility and not into the county central account. This has benefited the facility. While the facility profits from NHIF in- and out-patient contracts, the official viewed capitation as ‘loss-making’.

Table 3. Population per accredited health facilities

County	Accredited health facilities*	Population per accredited health facility**
Bungoma	25	55,003
Kwale	16	40,621
Machakos	22	49,936
Nairobi	87	36,073
Nakuru	38	42,193

*Numbers provided by NHIF branch offices; Nairobi estimate based on MSK data.

** Census data (2017)



Viability provider business

Providers cited a number of benefits of an NHIF contract for out-patient services. The most commonly cited reasons were the following:

- Cross-‘selling’ services – An increase in in-patient admissions from patients using out-patient services;
- Status in the community – The facility and the provider are recognised by clients and government;
- Status with other companies – NHIF accreditation is viewed as advantageous for providers contracting with private insurance companies and acts as a ‘rebate’ to these insurers;¹⁴
- Client members – An increase in client volume, promoted through word-of-mouth by NHIF members;
- Increased utilisation – This was cited as a benefit but also a challenge;
- Client confidence – NHIF affiliation is a sign of service quality;
- NHIF management information system (MIS) – Providers like the automated reporting and verification of client membership status.

The ‘depth of benefit’ tended to depend upon the maturity of the provider’s business and the total number of NHIF-capitated members registered at the facility. The number of capitated members is also a function of ability to provide in-patient services under the NHIF, as members find this ‘one-stop shopping’ attractive.

Providers also cited a number of challenges with NHIF out-patient service contracts. The main challenge cited was the low capitation rate under the national, HISP and elderly schemes (Ksh 1,200 (US\$11.65) per household member per year). Other commonly cited challenges include the following:

- **Lack of scheme specificity** – Providers raised concerns over a lack of understanding (and documentation) of the NHIF schemes. This adds to the complexity of their management, as many providers have several scheme contracts (including in-patient). In the FGDs providers referred to and compared several membership brochures, which outline broad categories of services under the schemes. However, providers do not have any detailed guidance, beyond what is outlined in their contracts.
- **Adverse selection** – Providers indicated that they were seeing a lot of ‘sick’ patients, e.g., those with chronic conditions, requiring on-going treatment. It was unclear to many of them which conditions were included under the various out-patient schemes or how referral mechanisms were to operate.¹⁵
- **Unnecessary health care** – Providers indicated that some clients come frequently for unnecessary health care. They surmised that informal workers under ‘SupaCover’ wanted to ‘get their money’s worth’ from the monthly payments (Ksh 500) that they make to the scheme even if they are not ill. (Providers have the perception that some members do not understand how insurance works.) Providers also noted that some newly enrolled members also come to ‘test the system’, as they do not believe that it is free at point of use.

One provider indicated that he had the HISP, national, civil servants and elderly out-patient schemes. For the elderly, he had never received reimbursement from the NHIF, but the patients keep coming. He noted that their cards are no longer valid and that the scheme appears to have been stopped, but without telling the providers or the clients. He felt obliged to treat them despite this.



One provider was marketing to flower farms and had seen a tremendous impact on his business. He had all of the benefits brochures and was well versed on what was in and out of the scheme. He indicated that the lump payment is like a ‘soft loan’, ‘when the money comes, we can do something’. He said that he bought drugs in advance with the funds. He was a role model for the other providers, some of whom had only recently been accredited and had joined the focus group discussion to learn more about the NHIF.

- **Slow release of the capitation payment** – Some providers indicated that the NHIF is slow to provide the capitation payment (meant to be provided in advance on a quarterly basis). This view was not universal across locations or providers, however, suggesting that delays at the branch office may impinge on timeliness at the NHIF central level, where payments are processed. As one Nairobi provider noted, ‘The capitation principle is not working’, as payment is needed in advance of utilization.
- **Provider changes** – In locations with greater numbers of NHIF-accredited providers, there was more reported provider ‘shopping’, with some challenges for those receiving the new members. In Nairobi, for example, providers reported that, when members decide to change provider, they want to use the new provider immediately, but the capitation is still going to the previous provider. There appears to be a lack of communication to members from the NHIF branch office on the process of changing providers.
- **Length of time to get accredited** – In the Machakos FGD two providers reported that it had taken them three and more than two years, respectively, to get accredited, while a third provider had taken only six months. All were from different counties, suggesting that the efficiency of the branch office is a factor. In a few instances providers said that they were asked for ‘tea’ money (and refused). One provider indicated that she was told to ‘come tomorrow’ when she tried to follow up with the branch, suggesting that her time and the inconvenience were not valued or recognised by the branch. Providers suggested that when accreditation started, the branches perceived their role as doing the providers a favour. In the last six to seven months, this has changed, as now branches have been given targets.¹⁶
- **Membership verification** – Some providers indicated that NHIF members were flocking to their facilities but had to be turned away, as the capitation from NHIF had not been provided. Some providers also reported that they did not receive a list of capitated members at their facility and so could not verify if the capitation was being paid in full. Another challenge was that, when the primary member changed facility, the NHIF did not necessarily change the family members – effectively splitting the capitation between facilities. Providers also noted that they serve clients whose capitation has not been paid to their facility, and the NHIF does not reimburse them for this.

There is limited provider analysis of business performance under the out-patient schemes. Reported losses may be more perceived than real. The majority of Amua providers indicated that they had relatively few NHIF members registered with their facilities, while many were not able to estimate.

Providers' estimates of the number of capitated members registered at their facilities ranged from 200 to just over 7,000 members. This was context-driven to some extent, as the lower end of the range was in Machakos and the higher end in Nairobi (although several providers in Nairobi also had low registration with their facility). Most providers consulted were still figuring out 'the business of NHIF', while others were better versed and a source of inspiration to the others – a benefit of the social franchise cluster meetings. Providers indicated that they prepare weekly returns and can see whether they make money or not, comparing the cost of treatment with the capitation payments. Providers indicated, however, that in reality it is difficult to figure out if they are indeed making a profit, as they need to pay overhead such as staff and operating costs. However, all agree that more registered NHIF members makes the capitation more viable. As a provider in Nairobi Country noted, 'The business model is a numbers game... Out-patient is part of the business model.'

The facility with the highest number of capitated members was contracted for NHIF in- and out-patient schemes as well as the Linda Mama scheme¹⁷ (and was proudly displaying a large sign indicating this). The facility has a large clientele, both those paying out-of-pocket and NHIF members. (The clientele is reported to have increased with the recent nurses' strike in the public sector). The director was frank: He said that, while capitation is fine, it requires that the providers cut costs. This means, in practical terms, 'shaving' quality. Examples of cost-saving tactics used by him and other providers include the choice of generic rather than branded drugs and the extent of diagnostics conducted. All providers consulted recognised that their reputations – and contracts – depend upon client satisfaction (bearing in mind information asymmetry), and so cuts to quality are not too severe and may not be apparent to clients.

Providers noted that the quarterly lump sum capitation payments provide helpful liquidity, but this 'benefit' is compromised when release of funds from the NHIF is delayed. Providers did not indicate that they used the money for investment, but some cited bulk purchasing of medicines and consumables at more favourable terms. Providers reported that, when they complained to NHIF branch officers, they were told only that payment was coming, with no indication of when. It appeared that NHIF branches were quite accessible but not very helpful with responding to providers' concerns.



Conclusion

Provider perspective

Most of the providers consulted recognized the benefits of being NHIF accredited. However, many were grappling with the risks this posed to their businesses due to uncertainty of payment and the low rate of capitation under the out-patient schemes. As one provider noted, 'The NHIF are the people in business, not us.' Some providers were concerned that the business viability of capitation came at a cost, requiring providers to compromise on quality, with cash-paying clients getting better service. Also, providers recognized that the NHIF capitation out-patient schemes were a missed opportunity for family planning.

Providers outlined several conditions that would improve the viability of their business under the NHIF. In addition to the recommendation of increasing the capitation rate, they suggested the following:

- Capitation payment received on time so that providers could plan for business outlays
- Provide assigned providers with lists of members covered
- A co-payment introduced to reduce over-use of services
- An online system so that providers could track where their payments are in the process
- Public education so that members (current and prospective) could better understand how the scheme works
- Clarity on the service packages covered under the NHIF out-patient schemes so that providers, members and branch offices are clear on what is included, what is not
- More training and support for facilities in the area of claims management. For a large county referral hospital, NHIF should second an officer to the facility

Systems perspective

The NHIF and the social franchise providers value MSK's brokerage role. Some of the NHIF branches reported that social franchise providers are better prepared for contracting with the NHIF than other providers. Also, Amua social franchise providers clearly appreciated the support that MSK is providing with NHIF accreditation. Removing affordability as a barrier to the consumer's choice of provider may serve to decongest public sector facilities, particularly hospitals. It also may drive client-focused service delivery, as members can choose providers based on preference rather than price. This is an explicit goal of Government of Kenya and NHIF policy.¹⁸

Family planning under the NHIF out-patient schemes is caught between purchaser and provider motivations for cost containment. Tensions of this nature were envisaged in the NHIF sessional paper (2012): 'Conflicts or tensions may arise across the multiple behaviours of purchasers, providers, and patients.'¹⁹ In the case of family planning, this has led to rationing of services and continued out-of-pocket expenditures for family planning clients. While capitation was selected as the preferred means of provider payment 'to induce positive incentives in the health delivery system', this may not be the case for family planning.

There is a nascent movement to review the position of family planning within the NHIF out-patient schemes. This is being led by the National Council on Population and Development (NCPD) in collaboration with the NHIF and other stakeholders. It builds on recommendations from a health financing case study prepared in 2016 as part of a Bill & Melinda Gates Foundation landscaping of 22 countries²¹ as well as subsequent the foundation supported work to develop MoH health financing guidance for family planning²² This case study of AHME providers can contribute additional provider and systems perspectives to this agenda.

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- ⁴ Government of Kenya. Sessional paper no. 7 of 2012 on the policy on universal health care coverage in Kenya. Nairobi, Kenya: Ministry of Medical Services.
- ⁵ Ibid. The NHIF has no mechanism to collect from the informal sector the way it does with the formal sector through payroll taxes. Thus, while, under the 1998 Amendment of the NHIF Act, NHIF membership is mandatory for everyone, in practice for the informal sector it is voluntary.
- ⁶ Ibid.
- ⁷ Ibid. In the sessional paper the formal sector was estimated at 20%, the informal sector, at 60%, and indigents were estimated at 20% of the population.
- ⁸ Government of Kenya. 2012. Sessional paper no. 7 of 2012 on the policy on universal health care coverage in Kenya. Nairobi, Kenya: Ministry of Medical Services, Annex 4.
- ⁹ Obare, F., Warren, C., Njuki, R., Abuya, T., Sunday, J., Askew, I., Bellows B. 2013. Community-level impact of the reproductive health vouchers programme on service utilization in Kenya. *Health Policy and Planning* 2012;1–11. <http://europepmc.org/articles/PMC3584991>
- ¹⁰ Linda Mama is the free maternity service scheme that initially was run by the Ministry of Health in public sector facilities. In April 2017, it was handed over to the NHIF.
- ¹¹ Under the NHIF in-patient contracts, normal delivery is reimbursed at Ksh 10,000 (US\$97).
- ¹² NHIF data, 2017.
- ¹³ Barasa, E.W., Manyara, A.M., Molyneux, S., Tsofa, B. 2017. Recentralization within decentralization: County hospital autonomy under devolution in Kenya. *PLoS ONE* 12(8): e0182440. <https://doi.org/10.1371/journal.pone.0182440>
- ¹⁴ The NHIF is used to partially cover certain services, while the other insurance is used as a 'top up'. For example, healthcare providers under Inpatient Contract C have bed charges covered by the NHIF, which are not covered by private insurances. In addition, private insurance such as AON Insurance, which covers Kenya's teachers, requires AON-accredited facilities to be under In-patient Contract B in order to share maternity costs with the NHIF. The NHIF pays Ksh 10,000 for normal delivery, while AON tops up with Ksh 10,000. Thus, the benefit to the provider totals Ksh 20,000.
- ¹⁵ Some providers also had NHIF members under the elderly social protection scheme, which also has its own package.
- ¹⁶ Providers speculated that this was linked with getting more people and providers enrolled for the elections.
- ¹⁷ Linda Mama is the free maternity service scheme that initially was run by the Ministry of Health in public sector facilities. In April 2017 it was handed over to the NHIF.
- ¹⁸ Government of Kenya. 2012. Sessional paper no. 7 of 2012 on the policy on universal health care coverage in Kenya. Nairobi, Kenya: Ministry of Medical Services.
- ¹⁹ Ibid, p. 34.
- ²⁰ Ibid.
- ²¹ Appleford, G. 2016. Supporting family planning within national health financing schemes: Kenya Case Study. Glastonbury, Connecticut, USA: Avenir Health.
- ²² This work was conducted by G. Appleford under contract with Avenir Health's Track20 programme. .

