

Examining National Hospital Insurance Fund reforms in Kenya



Introduction

The Kenyan government has made a commitment to achieve Universal Health Coverage (UHC) by 2030. A key part of its UHC strategy is to expand coverage of the National Hospital Insurance Fund (NHIF), which currently covers approximately 15% of the population. In 2015, the NHIF introduced significant reforms aimed at enrolling more people and expanding the range of services that enrolled members have access to.

The NHIF reforms included:

- Upward revision of premium contribution rates by 213% for informal sector members and between 25-431% for formal sector members (table 1).
- Expansion of benefit entitlements to members of the general scheme to include outpatient care and a range of 'specialized packages' including surgical procedures, radiology, chemotherapy, radiotherapy, chronic disease) (figure 1).
- Provider payment reforms including the upward revision of inpatient care per-diem payments, introduction of case based payments and capitation payment mechanisms.

KEMRI-Wellcome Trust conducted research to examine the influence of these reforms on NHIF purchasing practices. This was an in-depth qualitative study involving health financing stakeholders, facility managers, frontline healthcare workers from both public and private facilities, and members of the community. This brief presents the key findings from the research, and recommendations for NHIF and county governments on how to support the reforms towards achieving UHC goals.

Key points

- The new NHIF premium rates are unaffordable to informal sector workers, resulting in low coverage and attrition among this group.
- The new benefit packages have led to different service entitlements for different patient groups, which may entrench inequalities in access to services.
- Poor infrastructural capacity of contracted public healthcare providers and ineffective monitoring of quality by the NHIF, undermine access to quality services. Availability of services was particularly limited in rural areas.
- Capitation payment rates for the general scheme are perceived by healthcare providers to be inadequate, and payment disbursements by the NHIF in general are often delayed. This resulted in undesirable practices including the introduction of out of pocket payments, unnecessary referrals or admissions to inpatient facilities, and under-treatment or rationing of services to patients.

Key findings

Contributions rates

Increased premium rates are unaffordable to the informal sector

Following the reforms, premium rates for both formal and informal sector workers rose significantly making them unaffordable for many people (see table 1). For the lowest paid category of informal sector workers (minimum wage of KES 6,723 per month), their monthly premium contribution as a percentage of their income increased from 2% to 7%. The increased rates are also thought to have led to attrition of existing members from the informal sector.

Benefit entitlements and access to services

Improved responsiveness to population health needs and preferences

The services included in the new benefit packages are informed by the health needs of the population, based on disease patterns (revealed by claims data and national reports on disease burden) and recommendations from patient support groups and NHIF beneficiaries.

Inadequate service delivery infrastructure

Public health facilities contracted to provide services to NHIF members lack the necessary capacity to offer outpatient services and the NHIF benefit package due to:

1. Scarcity of public health facilities
2. Shortage of medical equipment and drugs
3. Poor maintenance of medical equipment
4. Inadequate human resources for health (medical officers, specialists and nurses)

This resulted in limited availability of services and long waiting times.

Geographical inequities in access to healthcare services

While the number of healthcare providers contracted to provide healthcare services to NHIF members increased significantly from 2014 to 2018, fewer than 1 in 10 of these facilities could offer secondary care under the new benefit package. Also, the majority of these facilities are in urban and peri-urban areas, particularly the private hospitals. For people living in rural and marginalised areas, access to services is much more limited.

Unequal distribution of entitlements across population groups

The new NHIF benefit packages have resulted in civil servants receiving a wider range of services compared to members of the other schemes. For example, civil servants have several additional benefits including dental procedures, vaccines, emergency air rescue and in-vitro fertilisation.

Provider payment reforms

Perceived inadequacy of the outpatient capitation rates

Both public and private providers indicated that the capitation rates offered for outpatient services do not cover the actual costs of services. This has resulted in some providers finding additional funds by introducing out-of-pocket (OOP) payments. Insufficient funding has also led some providers to under-treat patients, refer patients to other facilities, or unnecessarily admit patients who would otherwise require outpatient care.

Table 1: NHIF contribution rates

Monthly salary range	Monthly premium before reforms	Monthly premium after reforms	Contribution increase
1,000 - 5,999	30 - 120	150	25% - 400%
6,000 - 7,999	140 - 160	300	88% - 114%
8,000 - 11,999	180 - 240	400	67% - 122%
12,000 - 14,999	260 - 300	500	67% - 92%
15000 +	320	600 - 1,700	88% - 431%
Informal sector	160	500	213%

Amount shown in Kenyan Shillings

Delayed disbursements of payments to facilities

Public and private hospitals experienced delayed disbursements of NHIF payments by up to three months. This is blamed on the manual claims process and constrained capacity to carry out verification of the claims.

Delayed reimbursements to providers has had several adverse consequences on service provision, especially amongst private providers. Some facilities have introduced OOP payments to cover the costs, whilst others either denied or rationed services. In some private healthcare facilities, NHIF patients reported being treated with less respect and being subject to longer waiting times compared to patients with other forms of insurance or cash paying patients.

“It is like torture there because those who have cash are treated quickly. So at times when I go to the hospital, I feel that it is better for me to use cash than to use my NHIF card so that I can get treatment faster”

Accountability mechanisms

Inadequate monitoring of the quality of services offered in public hospitals

Public hospitals reported infrequent quality inspection visits by the NHIF despite the expansion of the new benefits. This is blamed on a shortage of quality assurance officers and a lack of transportation to reach facilities. In addition, there are no reported quality-related sanctions or rewards. Conversely, private hospitals reported frequent visits from the NHIF quality assurance teams who inspect the hospitals and conduct patient satisfaction surveys.

Loopholes in NHIF processes provides an opportunity for fraud by healthcare providers, and patients

The hospital self-assessment process, whereby healthcare providers are allowed to assess their own structural capacity prior to contracting, has led some healthcare

Figure 1: NHF poster showing the Expanded Benefits Package available to members of the general scheme



providers to exaggerate their structural capacity (e.g. number of beds, presence of major theatre) in order to get higher payment rates. Inadequate processes for identifying NHIF members has led to the use of false identity cards by non-NHIF members to obtain care, and the hiring out of the NHIF cards by NHIF members to non-members to access healthcare providers.

Communication of reforms

Poor communication limits citizens' awareness of their obligations and entitlements

The choice of mass media communication, such as television and radio adverts in major media houses and billboards on major roads, did not reach some key population groups such as the elderly, uneducated, unemployed, poor and the people living in rural and marginalised areas. These population groups are therefore less likely to be aware of their new obligations and entitlements, limiting their access to and utilisation of needed services. The complex packaging and scientific language used to explain services and benefit packages in advertisements, further limited citizens' understanding and awareness of their entitlements.

Conclusion

While NHIF reforms are intended to increase population coverage with health insurance and extend access to a broader range of needed healthcare services, their design and implementation could potentially compromise equity and quality of care. The following recommendations set out what can be done to improve the impact of these reforms.

Recommendations

Improve the service delivery infrastructure of public hospitals

County governments should invest in improving the capacity of public healthcare providers to deliver good quality care. This includes ensuring the facilities have adequate human resources for health, medicines and medical equipment.

Fair selection and distribution of contracted healthcare providers

The NHIF should re-orient its facility selection to create a balance between public and private facilities and between urban and rural facilities, to improve equity in geographical access.

Engage providers in determining provider payment rates

The NHIF should engage healthcare providers in determining provider payment rates so that providers are involved and informed about how the rates are developed. This will improve provider acceptance of payment mechanism rates, especially capitation.

Ensure timely disbursement of payments to health providers

The NHIF should ensure timely disbursements to healthcare providers for all the services under its benefit package.

Invest in fraud minimization strategies

The NHIF should invest in fraud minimization strategies by addressing loopholes in their processes. For instance, the NHIF should have a mechanism for verification of provider self-assessments. This could be implemented by using a risk-based approach to sample facilities for physical verification of self-assessment reports, and imposing tough sanctions of providers that are found to present fraudulent self-assessment reports.

Develop a uniform benefit package across all the NHIF beneficiaries

The NHIF should harmonize its benefit packages and develop one package that all its members are entitled to. This will reduce disparities in service entitlements that could entrench inequalities.

Adopt effective communication strategies

The NHIF should adopt communication strategies that are accessible not only to high income, educated, urban population groups, but also strategies that reach low income, less educated, rural population groups. The NHIF should also explicitly state the range of services offered in each benefit package.

About the brief

References

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