NATIONAL SOCIAL HEALTH INSURANCE STRATEGY

Findings and recommendations of the joint WHO/GTZ mission on Social Health Insurance in Kenya
June 28-August 8, 2003

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<tr>
<td>A.I.C.</td>
<td>Africa Inland Church</td>
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<td>AAR</td>
<td>African Air Rescue</td>
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<td>AIDS</td>
<td>acquired immunodeficiency syndrome</td>
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<td>ARV</td>
<td>antiretroviral</td>
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<td>CEO</td>
<td>Chief Executive Officer</td>
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<td>CFO</td>
<td>Chief Finance Officer</td>
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<td>CHAK</td>
<td>Christian Health Association of Kenya</td>
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<tr>
<td>CIO</td>
<td>Chief Information Technology Officer</td>
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<tr>
<td>COO</td>
<td>Chief Operating Officer</td>
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<td>DALY</td>
<td>disability-adjusted life year</td>
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<td>DMO</td>
<td>District Medical Officer</td>
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<td>DMS</td>
<td>Director of Medical Services</td>
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<td>DRG</td>
<td>disease-related groups</td>
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<td>DSRS</td>
<td>Department of Health Standards and Regulatory Services</td>
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<td>ENT</td>
<td>ear, nose &amp; throat</td>
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<td>GoK</td>
<td>Government of Kenya</td>
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<td>GTZ</td>
<td>Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH</td>
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<td>HIV</td>
<td>human immunodeficiency virus</td>
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<td>HMO</td>
<td>health maintenance organisation</td>
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<td>IT</td>
<td>information technology</td>
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<td>KNH</td>
<td>Kenyatta National Hospital</td>
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<td>KQM</td>
<td>Kenya Quality Model</td>
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<tr>
<td>KSh</td>
<td>Kenyan Shilling</td>
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<td>MoF</td>
<td>Ministry of Finance</td>
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<td>MoH</td>
<td>Ministry of Health</td>
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<tr>
<td>NGO</td>
<td>non-governmental organisation</td>
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<td>NHIF</td>
<td>National Hospital Insurance Fund</td>
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<td>NSHIF</td>
<td>National Social Health Insurance Fund</td>
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<td>OS</td>
<td>operating system</td>
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<td>PS</td>
<td>Permanent Secretary</td>
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<td>SBP</td>
<td>Standard Benefit Package</td>
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<tr>
<td>TB</td>
<td>tuberculosis</td>
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<tr>
<td>USA</td>
<td>United States of America</td>
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<tr>
<td>WG</td>
<td>working group</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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1. Part I – Background

1.1. Introduction
This report is the result of the second joint WHO/GTZ short-term expert mission to advise the Ministry of Health (MoH) of the Government of Kenya (GoK) on the proposed National Social Health Insurance Fund (NSHIF or “the Fund”). We feel privileged to have been asked to contribute to the MoH’s endeavour to provide affordable, accessible and acceptable quality healthcare to all Kenyans. The mission members were Prof. Dr. Rolf Korte (Team leader, GTZ), Dr. Manfred Zipperer (Legal Advisor), Christoph H.R. Lankers (Management Advisor, Luther & Partner) and Ole Doetinchem (GTZ).

The team would like to thank the Hon. Kaluki Charity Ngilu (Minister for Health), Mr. Wellington P. Godo (Permanent Secretary), Dr. Richard O. Muga (Director of Medical Services) and Dr. Peter Eriki (WHO) for their substantive support to this mission. We would like to acknowledge especially the efforts of Dr. Tom Mboya Okeyo (MoH) and his skilful steering of the dialogue with the many stakeholders. We also thank Mr. Justice Onesmus Mutungi as well as Ms. Elizabeth Ng’ang’a (Attorney-General's Chambers) and Ms. Maureen Onyango (Federation of Kenyan Employers) for very insightful discussions of legal issues of NSHIF. Furthermore, thanks are due to colleagues from MoH with whom we have had the pleasure to work with during this mission; this includes Mr. Chris Rakuom, Mr. Tom Maina, Ms. Zipora Mumani and Mr. Nzoya. The leadership provided by Dr. Hassan as the CEO of NHIF and the support and active involvement of his management team, especially Mr. Ismail Hasan, Mr. Robin Chweya, Mr. Adam, Mr. Joseph Gathenywa, Mr. Ondari and Mr. Mosonik, is gratefully acknowledged. Sincere thanks are due to Dr. Nyikal (Kenya Medical Association), Dr. Samuel Mwenda (CHAK), Prof. Wang’ombe (University of Nairobi), Prof. Kyambi (Kenya Medical and Practitioners Board) as well as the management and staff of Machakos District Hospital, A.I.C. Kijabe Hospital and Shalom Hospital for providing the opportunity for a fruitful dialogue on and insights into crucial issues of the health sector. Last but not least, many thanks also to Mr. Elijah for his careful driving, excellent punctuality and insightful explanations.

1.2. Overall terms of reference

a) Legislation/Regulation
- Assess the current NSHIF Bill and related bills, and propose amendments if appropriate
- Work out the principles of mechanisms to adjust regulations according to the desired performance of the NSHIF
  - Propose further regulations, among others, and if appropriate, for
  - Conditions of entitlement (eligible members of the family)
  - Ascertaining entitlement (insurance card)
  - Fraudulent use
  - Payments due to providers
- Assess and/or propose set of regulations for the organization of the NSHIF at the central and decentralised level
- If appropriate, propose regulations for the organization of multiple funds within the NSHIF
- Assess and/or propose regulations for the relationships between the NSHIF and

5
Part I – Background

- Ministry of Health (including its role in the Board of Trustees, in technical advisory committees of the NHSIF, in accreditation of providers and quality assurance)
- Ministry of Finance (including its financial obligations to the NSHIF, and its role in the Board of Trustees and technical advisory committees)
- Other government departments
- Assess and/or develop proposals for relationships with the insured population at central and decentralised level (including management of complaints)
- Assess and/or develop proposals for relationships with providers (including contracts and quality assurance)

b) Benefit package
- Make recommendations as to the content of the final and possible ‘interim’ benefit packages
  - Define the role of HIV/AIDS treatment within the benefit package
- Assess the cost of the benefit package, by healthcare system level, with due regard for pricing of services that takes account of the principles of rational diagnosis, treatment and prescription

c) Provider payment methods
- Assess current methods to establish fees at all health system levels and evaluate the role of the Kenyan Medical Association and other professional associations
- Assess how current fee-for-service methods can be transformed into more comprehensive ways of provider payment (including flat payment per day or admission in hospitals, DRGs, flat fees for groups of primary care services and overall capitation)
  - Evaluate ways whereby cost-accounting can be introduced systematically at all levels of the health system, including the use of software
  - Propose mechanisms to establish schedules of provider payment
    - Use of software
- Assess the best ways of achieving decisions about the provider payment schedule, evaluating thereby the respective roles for the Kenyan Medical Association, the NSHIF and the Ministry of Health

d) Management
- Administrative structure
  - Recommend appropriate ways of transition of NHIF into NSHIF, including staffing by department and basic tasks
  - Evaluate options for decentralised management, including staffing and basic tasks of district, interdistrict or regional health insurance offices
  - Assess options for multiple sub-funds within the NSHIF, and the resulting adjustment of the administrative structure
- Operations
  - Recommend registration procedures for workers & employees and their dependants, rural workers & self-employed and their dependants
  - Assess appropriate ways for health insurance certification (individual vs. family health insurance card)
  - Evaluate options for efficient collection of contributions
    - For workers and employees
    - For rural workers and self-employed
      - Timing of collection
Part I – Background

- Options for collection points
  - Recommend efficient methods for management of provider claims and their remuneration
  - Evaluate options for computerized information systems (database for membership, providers, cost and utilization review, feedback on quality assurance)
  - Contribute to an initial time schedule and network plan for implementation

1.3. Principles of social health insurance

Among other functions, social health insurance institutionalises the principle of solidarity and provides for risk pooling and cross-subsidisation between its members, be they young or old, healthy or sick (see diagram below). Members contribute according to ability to pay and benefit according to need. The larger the pool of members, the more the benefits of social health insurance are maximised. Therefore it is often introduced as a compulsory scheme for the target population.

The concept of social health insurance and its application to Kenya are also documented in the Sessional Paper of the MoH (DSRS) on National Social Health Insurance in Kenya (currently available as draft version, dated August 2003). This Sessional Paper is based on the earlier National Social Health Insurance Strategy Report (February 2003). The first joint WHO/GTZ mission has provided a complete assessment of the latter report. It also provided a first full draft of the above mentioned Sessional Paper.
2. Part II – Legal aspects of the National Social Health Insurance Fund Bill

By Dr. jur. Manfred Zipperer

2.1. Introduction

My main task according to the terms of reference was to assess the Draft of the National Social Health Insurance Fund Bill and to make proposals. The draft is the result of a very thoughtful and diligent discussion as it is described in the Sessional Paper. The draft does not only make use of the experiences collected in the framework of the National Hospital Insurance Fund. It establishes a completely new start of a Social Health Insurance for the whole population in Kenya utilizing observations made in other countries with social health insurance experience.

In my view the most challenging elements are the democratic concept of an insurance from the grassroots, that covers not only the employed but also the – larger – part of the Kenyan population who is unable to pay any contributions. The draft realizes an idea of a nationwide social health insurance that is not a government agency, though the government acknowledges its responsibility by paying contributions out of taxes for the very poor in the Kenyan society. It is in the contrary an independent and autonomous body, financed, owned and governed by the population paying contributions.

The draft describes this political aim very aptly. The solutions found and the structures chosen for the Fund and its organs in my view are suitable to establish a functional social health insurance. This insurance will be able – after an introductory phase of several years - to fulfil its main task: To provide all Kenyans of sustainable quality health care that is acceptable, affordable and accessible for them.

Therefore this review does not propose new concepts. It rather concentrates on how to further improve the elaborated solution and to avoid legal or administrative problems. According to the terms of reference the proposals aim at the legal aspects of the National Social Health Insurance Fund Bill by assessing the regulations of the draft and by dealing with questions concerning the legislation to be prepared.

In addition to this I have documented in annex 1 the draft of a sequence of the clauses of the bill.

2.2. General remarks

2.2.1. The bill would benefit from giving more attention to the role of the members of the Fund. Though the bill has a predominantly organizational purpose they should have a stronger position. Therefore it is suggested to place a representative of the self – employed organizations in the Board of Trustees (cf. 2.3). In the Appeals Tribunal there should be a representative of the members of the Fund and of the National Council (cf. 7.2.)

2.2.2. It is important to emphasize that health is no prerequisite to be a member of the Fund. Therefore in Section 4 and in Section 27 subsection (1) the word “health” (i.e. status) should be inserted.
2.2.3. National Social Health Insurance needs as much transparency and publicity as possible. Therefore it is suggested to oblige the Board in Section 42 to publish the annual report (cf. subsection (2)) and to send it to all members of the National Council. In addition the minutes of the National Council should be communicated to the Minister and the Board.

2.2.4. The Fifth Schedule is of extreme importance for the Bill because it contains the guiding principles and will be used to interpret and understand law. It therefore should be integrated in the text of the Bill itself after Section 4.

The text of the Fifth Schedule is formulated very “politically”. It would better fit in the legal context if it would be worded in more legal terms. It might be modified as follows:

(i) It is not the vision of the Kenyan MoH but the vision of the Kenyan people.
(ii) Members do not pay a subscription but a contribution
(iii) The NSHIF will be owned by the contributors (OK, but it should be clear that if government contributes, it should share the ownership or at least have an important role in decision-making) and not by the stakeholders
(iv) The NSHIF shall in cooperation with the Board, the District Council and the Sub-Location Committees make use of existing community initiatives for the support of registration procedures and identification of the poor, contribution collection and human resource requirements
(v) All contracted health service providers are responsible for what?

2.2.5. The financing of the poor by government tax revenue is essential for the idea of social health insurance for all Kenyans. Therefore it is very important to stipulate this obligation in the Bill very clearly, for example in no.III of the Fifth Schedule, in Section 28 lit (d) and (e) or in Section 38 lit (b). It would not be sufficient to mention this in the Sessional Paper.

2.2.6. The Bill covers all Kenyans, even those who are now covered voluntarily by private health insurance schemes. It should be clarified in the Bill that nobody is forced to give up his private insurance because he is a mandatory member of the National Social Health Insurance. Section 32 subsection (2) deals only with additional health insurance cover. On the other side there should no opting out of National Social Health Insurance Fund.

2.2.7. The bill does not define the relationship between the Fund and the Ministry of Health (MoH). Though the Fund is independent from government (should one not rather say the Fund is a ‘parastatal’? I do not think we should overly stress the ‘independence’ from government---government in fact will be an important partner to ensure the sustainable financing) and a member driven autonomous body, MoH should have a political responsibility and a general oversight over the Fund. MoH should not be allowed to interfere in the functions and powers of the different organs. The relationship between them and the MoH should be conducted in the spirit of collaboration in matters relating to the efficient delivery of health care (cf. Section 9 subsection (2)). It is suggested to describe these principles in a separate section after Section 7 and to express the autonomy and independence of the Fund and its organs.
It will be the task of a later general health bill to describe in details the role of the MoH in the health sector as a whole.

2.2.8. The primary objective of the new Social Health Insurance will be to provide better quality of benefits to all Kenyans and not to collect contributions from them. This should be expressed in different regulations, e.g. at the beginning “… to provide for payment of benefits out of the Fund; to provide for contributions thereto; …” or Section 13: the sequence of functions and powers should start with benefits (lit l and m), then contributions (lit h and i), then contracts (lit j and k) and at least financial questions.

2.2.9. Though the Fund is a member oriented body it should be clarified in the bill that the right to vote for the different organs of the Fund or to be elected as a member of one of these organs does not depend on the voter or the person to be elected being a member of the Fund.

2.2.10. The National Social Health Insurance is something new for the Kenyans. Its name in the bill is very similar to the National Hospital Insurance. It should be deliberated for psychological reasons to create a new name with a very simple abbreviation.

2.3. Organisation of the Fund

2.3.1. The National Council consists of at least 160 members. To prepare the meetings and decisions a secretariat is necessary (cf. 4.3.2 of the Sessional Paper). Therefore regulations about the establishment and the composition of a secretariat should be inserted in the First Schedule. The composition defined in the Sessional Paper is reasonable.

2.3.2. The First Schedule should also contain regulations concerning the reimbursement of expenses and per diems of the members of the National Council.

There is no regulation in Section 2 of the First Schedule about the procedural consequences if the disclosure of interest is ignored (cancellation of the decision?).

2.3.3. In Section 12 subsection (2) lit (d) the words “and insurance industry” should be inserted behind the word “investment.” In lit (e) the words “the insurance industry” should be replaced by “self employed organizations” in order to emphasize the importance of this group of contributors.

2.3.4. In Section 13 lit (f) should read as follows: ” investing monies not immediately required for purposes of the Fund either in saving accounts, treasury bills or treasury bonds;”

2.3.5. In order not to overburden the Board by minor administrative functions it should only appoint the leading management of the Fund. Section 16 should therefore restrict the appointment power of the Board to the Chief Executive Officer, his deputy and the heads of departments. All other officers and staff should be appointed by the CEO.

2.3.6. In order to facilitate the work of the District Council a secretariat is provided in Section 19 subsection (4). Its composition should also be regulated in the Second Schedule as it is defined in 4.3.3 of the Sessional Paper.
2.3.7. The Protection from liability in Section 49 should not only apply to the Board but to all members, officers, employees or agents of all organs of the Fund (cf. Section 7).

2.3.8. The Liability of the Board for damages in Section 50 should apply for any injury caused by the organs of the Fund (cf. Section 7).

2.3.9. The Second Schedule should include regulations concerning the reimbursement of expenses (e.g. for transport) and per diems of the members of the Board, which shall according to Section 25 mutatis mutandis have effect with respect to the members of the District Council and the sub-locational committees.

2.3.10. In Section 1 subsection (5) of the Second Schedule, a decision about benefits and contributions before the Board shall be taken by a two thirds majority of votes of the members present, in order to emphasize the importance of such decision.

2.4. Contributions

2.4.1. The title of Part III should read “Membership and Benefits”. A new part “Contributions” should be inserted.

2.4.2. Section 28 mixes several items and should be reformulated as follows:

(i) Subsection (1): Who pays the contributions?
- Employed persons: Employer (Section 30)
- Self-employed persons: the persons itself (no regulation)
- Children: the parent or guardian (lit c)
- Poor people: the government (lit d)
- Prisoners and other persons under lawful custody: the government (lit e)
- All other persons (e.g. pensioners, wealthy unemployed, members of religious societies if not employed, judges): the person himself (no regulation)

(ii) Subsection (2): How are the contributions paid?
- Employed persons: by a statutory deduction from the wages or salary (lit a)
- Self employed: by an annual (in some cases, contributions may have to be spread out---the self employed organizations are instrumental in that---perhaps this is something for Regulations to determine in which cases one can deviate from a strict ‘annual’ contribution) contribution (lit b)
- Children: by an annual contribution (same remark as above) (no regulation)
- Poor people: by the government from earmarked taxes (lit d)
- Prisoners and other persons under lawful custody: by the government from earmarked taxes (lit e)
- Persons temporarily in Kenya: statutory deduction from the wages or salary (if employed) or annual contribution (all others) plus a levy (lit f)
- All other persons: Annual contribution (no regulation)

2.4.3. Compared to the contribution in the NHIF Act employed persons get in a worse situation because under the NHIF Bill they have to pay contributions for the spouse and for every child. Therefore it is suggested to define only one contribution for the contributing member and three dependants (e.g. spouse and two children). If there are more dependants, reduced contributions have to be paid for them. If dependants are
included in the contribution of the member, they may be defined in Section 2. It is reasonable to prescribe an upper age limit for those dependants who are undergoing a full-time educational program.

2.4.4. In Section 28 subsection (2) the word “salary” should be amended to “monthly salary”. It is suggested not to prescribe a certain amount but to leave it to the Board of Trustees to determine the amount from time to time.

2.4.5. Pensioners pay the contribution by themselves. It should be deliberated, if for simplification and financial reasons the Retirement Funds should pay a certain percentage of the paid pensions to the NSHIF as the pensioners’ contribution. The funds may then communicate the names of the pensioners to the NSHIF for the issue of insurance cards.

2.4.6. In Section 29 lit (a) non-Kenyans who are employed should be treated like Kenyans. The employer shall deduct the contribution from the wages or salary and pay it to the fund. All other non-Kenyans should pay an annual contribution as a specified in Section 27.

2.4.7. The partition of the contribution between employer and employee is not yet regulated in the Bill. In order to avoid the employee bearing the whole contribution amount it is suggested to foresee a partition of 1:2. Other partitions such as 50:50 may also be considered. It should be ascertained that the labour cost is not affected in such a way that it would have a considerable negative effect on employment.

2.4.8. Section 31 should make it possible that a contribution payer who is willing to pay but is not able to pay at the due date shall get reprieve on request. He then may pay a small penalty in addition to the contribution.

2.4.9. The penalties in Section 31 subsection (1) and (2) are too rigorous because they do not respect the length of delay. It seems more appropriate to prescribe an upper limit or a certain percentage of the amount due for each month.

2.4.10. In Section 32 lit (a) no date should be prescribed to avoid an administrative breakdown and problems with the cash flow.

2.4.11. Section 32 subsection (2) should be taken over to the Part “Miscellaneous”.

2.4.12. In Section 34 subsection (1) only administrative data should be inscribed in the NSHIF card. If a person explicitly desires this, also stable medical data (e.g. blood group, allergies) may be inscribed.

In subsection (2) the date should be deleted to avoid administrative problems.

In subsection (3) it is suggested that each insurance card should contain the registration number of the identity card (for adults) or the registration number of the birth certificate (for children) in order to avoid fraud. On demand the member should produce his/her ID-Card or birth certificate to the contracted health service provider to give evidence of his/her identity. It is suggested that the issue and prolongation of a license to run a self-employed activity should depend on having paid the annual contribution to the Fund and producing the payment and/or the insurance card with the evidence of the payment to the licensing authority.
2.5. Contracted health service providers

2.5.1. The regulations concerning the contracted health service providers are so important for the Fund that they should have a separate chapter after part III.

2.5.2. The sections 35-37 should be amended by a regulation that all contracts with providers should be obtained by negotiations and not by a unilateral declaration or any other unilateral act of the NSHI Fund.

2.5.3. To emphasize that the contracting parties have equal rights an arbitration mechanism should be established. This arbitration should find a solution on the basis of a compromise respecting the interest of both sides. It is suggested that the arbitration institution (could this not be a ‘committee’ which would function as part of the social health insurance administration ?) is composed by an equal number of representatives from both sides (e.g. Fund and hospital representatives) with a neutral chairman who should have legal experience. The chairman should be nominated by the representatives and appointed by the Board. The Board bears the cost of the arbitration.

2.5.4. In Section 35 subsection (3) it should be clarified that quality standards are not developed by the Board but by the Ministry of Health (I would not extend an exclusive right to the MoH to define this----the Fund with its various stakeholders provides a perfect opportunity to also let them have a say in this---perhaps through a Quality Review Committee---but surely with the MoH as the major driving force . The Board takes them over as a prerequisite for the contract with the provider.

2.5.5. In Section 35 subsection (4) and in Section 37 subsection (5) the contract has to be terminated; there should be no discretion of the Board.

2.5.6. It is suggested that in Section 37 subsection (1) and (3) there should be also a minimum limit of the fine.

2.6. Financial provisions

2.6.1. In Section 39 subsection (2) the administrative costs are fixed at a rate too low. It is suggested that there should be formulated a target figure of ten percent for the first four years. Learning from the experience in the National Hospital Insurance Fund (NHIF) it should be prescribed explicitly that administration costs of the Fund must never exceed the costs of benefits.

2.6.2. In Section 39 subsection (2) it should be clarified that the administrative costs shall include only the expenses listed under Section 41 subsection (1) without (a). Reserves do not belong to the administrative costs, the word ” and reserves (Section 43)” should be deleted. I take it reserves refer to reserves for operational purposes (extra availability of cash in order to take account of fluctuations in payments to providers)

2.6.3. In Section 41 after lit (d) a new letter “investment for equipment and other movable property of the Fund and depreciation costs should be inserted”. In lit (e) after the word “National” “Council” should be inserted.
2.6.4. In Section 43 subsection (1) the beginning should read “The Fund shall…….”

Subsection (2) should read: „The reserves shall be invested or be placed on deposit in either savings accounts, treasury bills or treasury bonds as the Board may from time to time prescribe”

A subsection (3) should be added which reads as follows: “(3) The Fund must not borrow or lend more than 10 percent of the reserve under subsection (1).”

2.7. Transition of claims

2.7.1. If a member of the Fund is injured by a third person and this injury is not a work accident covered by the Workman’s Compensation Act (cap 236), he normally is not in a position to realize his claim against the damaging person or the insurance company responsible for the settlement of the claim. Nevertheless he should get medical treatment by the Fund in any case.

2.7.2. If the Fund delivers medical benefits in such a case, the claim of the member should be transferred automatically by law to the Fund. The Fund should be obliged to check each case that is supposed to be an accident caused by a third person, and it should sue the person or the insurance company if it is appropriate. This should especially happen with car accidents. It should be ensured that all cars and particularly *matatus* and trucks and their passengers are covered by an adequate liability insurance.

2.7.3. The Fund should be empowered to contract with liability insurances to settle smaller claims by lump sums in order to avoid too many suits.

2.7.4. Section 48 should be reformulated in this sense. Later on there should be regulations concerning work injuries and occupational diseases. They should be covered by the Fund too and the Workman’s Compensation Insurance should reimburse the expenses to the Fund unless it will take over the treatment by its own institutions (e.g. for rehabilitation).

2.7.5. If an employer pays contributions for an employee to the Fund, his obligation to take over the costs of medical treatment according to the Employment Act (cap 226) should expire and pass over to the Fund.

2.8. Appeals tribunal

2.8.1. Before a person appeals to the Tribunal against a decision of the Fund administration in disputes about benefits and contributions, the Board should be given the opportunity to review this decision within one month’s delay. The Tribunal should not accept an appeal without this review.

2.8.2. It is suggested that in the Appeals Tribunal there should be also a representative of the members of the Fund and a representative of the National Council in order to emphasize the democratic structure of the Fund and to give more weight to the interests of those concerned.
2.8.3. In Section 9 of the Third Schedule it should be regulated that the minister should consult the Board of Trustees before determining the remuneration and allowances paid by the Board.

2.8.4. It is suggested that the Sessional Paper should contain more detailed explanations about the Appeals Tribunal because of the importance of this institution.

2.9. Field of application

2.9.1. The Bill does not prescribe whether medical treatment by the Fund is obtained only in the Republic of Kenya or abroad, too. This should be clarified in Section 4 and in the text of the Fifth Schedule.

2.9.2. Normally, medical treatment should only be provided by contracted health service providers in Kenya. But it is suggested that the Board should allow and finance treatment abroad if a special committee of the Board has confirmed that there is no appropriate treatment in Kenya and the chosen treatment abroad is medically approved. This approval should be given only for extraordinary cases.

2.10. Transitional provisions

2.10.1. The provisions of the Fourth Schedule should be integrated in a separate part of the Bill.

2.10.2. Section 54 should be taken to this new part.

2.10.3. It should be ensured that the regulations in the NHIF Act concerning fundraising should be maintained until new regulations come into effect. Section 5 of the Fourth Schedule only deals with the rates of contribution.

2.10.4. It should be ensured that the declared (accredited) hospitals (cf. Section 30 of the NHIF Act) remain in this position until they have contracted with the new National Social Health Insurance Fund or until the Fund has revoked the declaration.

2.11. Legal-technical suggestions

2.11.1. In the enumeration of clauses in page two of the bill Section “37 – offences relating to benefits” belongs to Part III and not to Part IV.

2.11.2. Section 18 (2) and (3): Clarify that the members of the Board of Trustees are appointed by the National Council and not by the Minister. The names of the appointed persons are submitted to the Minister and then gazetted by him.

2.11.3. Section 30: correct “paragraph (a) of Section 28”.

2.11.4. First Schedule:

(i) In Section 1 subsection (3) and (4) the same wording should be used as in Section 1 subsection (4) of the Second Schedule.
(ii) In Section 3 the words “or an ex-officio member” should be deleted because according to Section 8 there is no such member in the National Council.

(iii) In Section 3 subsection (b)(i) the word “Board” should be replaced by “Council”.

(iv) Section 3 (1) should be changed into Section (4), and Section 4 (i) should be changed into Section 5.

2.11.5. Second Schedule: In Section 1 subsection (3) the words “excluding the Chief Executive Officer” should be deleted, because he is not a member of the Board of Trustees (see Section 12 (2)).

2.11.6. In the Abridged Version Draft (August, 2003) of the Sessional Paper there are two errors:

(i) page 14 no. 1 line 6: the phrase in brackets “(e.g. KSh 3,000 per day)” cannot be correct because the amount is too high.

(ii) Page 26 line 3: the phrase “however, will supervise the Fund “ is incomplete. It is suggested to insert “the Minister of Health“.
3. Part III – Benefit package

By Prof. Dr. med. Rolf Korte & Mr. Ole Doetinchem

3.1. Benefit package

The sole purpose of the NSHIF is to provide benefits for its members. All benefits paid out by the fund are in-kind in the form of payment for health care and medical treatment for both in- and outpatient services. The benefit package determines what health services are to be offered by contracted health service providers. It describes what the users may expect but also implicitly what will not be catered for under the NSHIF. Specifically, it lists the medical treatment and care procedures, incl. drugs, for which contracted health service providers are remunerated by the Fund.

The Benefit Package Drafting Committee has produced a draft document (Draft No. 10) outlining a comprehensive benefit package for health services in Kenya. We propose that an expert group elaborate, on the basis of this document, Standard Benefit Packages (SBP) that are appropriate to each of the five health service level into which health facilities are grouped. The results should be published for discussion. They should later be displayed at the health facilities to inform users which entitlements they can expect at the respective health facility. We suggest a 1 to 2-day expert workshop to review the draft benefit package document to assure consensus on the 5 SBPs for the five service levels. The experts involved should predominantly include DMOs, PMOs and representatives of the Kenyatta National Hospital (KNH). The involvement of selected private and NGO providers should also be considered. Are there any organisations that could represent the consumer side?

Draft SBPs are attached in annex 3 for consideration.

Such benefit package specifications will also aid in determining appropriate levels of remuneration for contracted health service providers (see 4.3.b: “Standard benefit package (SBP) rating” below).

3.2. Cost containment

Realising the vision of providing sustainable quality healthcare that is acceptable, affordable and accessible to all Kenyans necessitates affordability. The benefits provided by the Fund to its members must be paid for out of member contributions and government subsidies. Thus, there will have to be a ceiling to the amount of available funding and mechanisms of cost containment should be implemented to prevent bankruptcy of the Fund. The SBP approach is one way to limit services to a sound level. But additional cost containment measures may be needed. Politically, it needs to be decided whether initially a more generous approach is used, which is to be tightened later or vice versa.

Initially, there is likely to be a financial surplus that should, however, not lead to over-generous SBPs. An introductory rebate on membership contributions may be the preferred approach to avoid accumulation of funds.

Several instruments of cost-containment may be considered. They include…

- excluding certain services from the benefit package,
- declaring an upper limit to remuneration per patient per year (under the provision that this can be increased on an individual basis upon special clearance by the Fund),
- negotiating maximum yearly budgets for contracted health service providers
Part III – Benefit package

- requiring patients to pay a small registration fee upon each contact with a (outpatient) health service provider,
- obliging patients to pay a supplementary fee for self-referral to higher level health service facilities,
- retaining co-payments for chronic diseases, e.g. diabetes,
- reducing remuneration for patients that stay in a hospital for longer than a specified period, e.g. 30 days (along with encouraging the set-up of nursing homes that specialise in long-term care at lower remuneration rates than acute hospital inpatient services, and encouraging referral to these facilities) and
- requiring special approval for treatment abroad.

a) Exclusions from benefit package

The question of whether to exclude certain health services from the benefit package paid for by the NSHIF is a delicate one, which requires careful deliberation and consultation with the involved stakeholders. Overall funding of health services should follow priority as well as cost-effectiveness considerations, but at the same time not marginalise any particular group of members especially as these health conditions may have devastating effects on families.

As external advisors, we do not see ourselves in a position to prescribe a distinct catalogue of benefit package exclusions, but we would suggest a stakeholder/public discussion about the issue. The presentation of options may stimulate the discussion. The following list is therefore intended for discussion only – it does not constitute a recommendation that any of the items should or should not be excluded:

- Orthopaedic appliances, massage, embalming and mortuary above a specified time limit e.g. 3 days, transplants, palliative care, spinal/CNS injuries, some mental disorders, dental care (except fillings, extractions), chronic ophtalmological and ENT conditions incl. spectacles and hearing aids, except cataracts, cosmetic interventions, circumcisions, cleft lip, club feet etc.

In the process of selecting services to be excluded, cost-effectiveness considerations may be helpful, including DALYs gained as a result of accepting and financing the interventions. Further studies to provide sound data for this may be necessary.

Some treatments are often successfully and cost-effectively offered by not-for-profit organisations (e.g. NGOs, faith-based organisations) or medical interest groups. Their efforts should be maintained and further encouraged for the benefit of the Kenyan population. Reduced per-patient remuneration or small lump-sum payments from NSHIF to such organisations would encourage such work, while at the same time keeping their not-for-profit identity and their ability to tap into their customary sources of funding. For any such payment, the organisations must be quality assured and their obligations specified through a contract. They should be encouraged to offer their services through recognised and contracted health care providers.

Ultimately, any exclusions from the benefit package provided for under NSHIF will be subject to questioning from the public. If it is decided to exclude treatment or care for certain conditions from the normal benefit package, reasons must be given, and alternative pathways to treatment for patients be indicated. This may be the cover of such services through private insurance, treatment provision by other entities such as NGOs, or only
partial exclusion with some form of subsidy (e.g. a condition requiring life-long treatment may warrant co-payments).

b) Maximum yearly remuneration per patient

Setting a maximum yearly per-patient-remuneration to health service providers allows the fund a greater degree of cost control and discourages excessive use of health facilities by patients. Administratively, it is suggested that a hospital obtain clearance from NSHIF by the third day of a patient’s stay in hospital. This could be done via telephone or other means, depending on the technical design of membership cards chosen (e.g. data on cards).

A straightforward and timely mechanism to clear individual patients for exceeding the remuneration ceiling is a prerequisite for this. The annual ceilings will have to be communicated to the members (e.g. KSh 50,000). To achieve greater transparency, such a system could also be implemented through vouchers, i.e. each member gets a set number of free health service provider visits through a voucher booklet, valid for one year.

c) Maximum yearly service provider budgets

Using current budgets for orientation, a maximum cumulative payment per year from NSHIF to a contracted health service provider may be negotiated. Any payment from the Fund to a provider will be added up towards this budget limit, above which no more payment will be made. The maximum budget must take into account quality and volume of service and be set in the spirit of allowing providers to improve their services. Therefore it is expected that they will be set above current yearly budgets. The undesirable effect may be that service providers may exploit this limit.

d) Small registration fee

There is at this point considerable uncertainty about the increase in patient visits to health facilities as a result of the introduction of NSHIF. Insurance cardholders may tend to overuse facilities. Past experience with the introduction and withdrawal of cost-sharing mechanisms suggests an increase between 40-50% [incl. reference?]. Large-scale overuse would cause a collapse of the system, as costs outstrip income.

On the field visit to A.I.C. Kijabe Hospital, the team learned that the hospital’s own staff had caused considerable strain on its finances when services were offered to them for free. The introduction of a per-visit fee of KSh 25 has normalised this. The experience of the Chogoria Hospital Health Insurance Scheme should also be explored in this context.

We therefore recommend a small registration fee for each patient seeking care or treatment at any of the contracted health service providers at least for outpatient visits. For discussion, we suggest for outpatients KSh 20 at primary level (level I and II).

This issue may be further explored through a pilot. Political acceptability may, however, constitute an obstacle as the concern for access of the very poor is justified.

e) Penalty for self-referral

There are major efficiency losses occurring at higher-level health facilities when they are occupied with treating many patients with minor conditions (e.g. diarrhoea etc.). High-level hospitals incur much higher overhead costs and it is therefore much more efficient to treat such patients at lower levels. The problem is particularly pronounced in the Nairobi area, specifically Kenyatta National Hospital (KNH). Direct access to level III and above...
health facilities without referral from a lower level should be discouraged through self-referral penalties. Suggested payments may be KSh 100 at level III, KSh 500 at level IV and KSh 1,000 at level V per visit. A voucher given to the patient by the referring doctor could serve to identify to whom the referral penalty applies and to whom it does not apply.

This requires special consideration of the availability of entry-level health facilities in the catchment area of such hospitals. In the case of KNH low-level services would probably be best provided through NSHIF-contracted private providers. In other areas, where a high-level facility, such as a provincial hospital, represents the main health service access point, such hospitals should be encouraged to set-up a small level I or II facilities in the vicinity.

f) Co-payments for chronic diseases, e.g. diabetes
Patients with chronic conditions requiring life long treatment e.g. diabetes, hypertension etc. require special consideration. After the initial treatment, which should be fully covered by the insurance, patients may be required to purchase the drug at cost from contracted service provider or receive the required dosage for a reasonable period with an appropriate co-payment. This co-payment may also be merged with the outpatient fee.

g) Reduced remuneration for long-term care
Patients in need of long-term care are best served in nursing homes, or other facilities specialising long-duration care. Their stay in acute care institutions or wards should be limited and referral to a hospice, nursing home or nursing ward be encouraged. We therefore suggest to markedly reduce NSHIF patient-day remuneration for patients staying for more than 30 days in acute care institutions. Nursing homes or equivalent institutions will be able to continue care efficiently at these lower rates. Initial tax exemptions may be considered for investments in nursing homes.

h) Special approval for treatment abroad
In exceptional cases, such as life-threatening conditions for which treatment cannot be offered in Kenya, treatment abroad may be paid for by NSHIF. This must be subject to approval by a NSHIF expert committee. Treatment plan, quality and cost should be taken into consideration.

3.3. Prevention, disease control and cost containment
The foremost task of NSHIF is to pay for curative care, while public health measures will remain the prime responsibility of the MoH. For the provision of clinic based essential preventive, health promotive and disease control services such as immunisation, family planning, ante-natal care, under-5 care, micro-nutrient supplementation, HIV/AIDS and TB-control a binding agreement must be struck between the two to ensure their provision at adequate levels. Disease prevention and health promotion are a major factor of cost containment also for NSHIF.

Care and medical treatment for HIV/AIDS and TB patients are a major but costly issue. Innovative solutions are needed. External contributions and special allocations from MoH will be needed. But contracted service providers should be encouraged to offer such services.
3.4. Private insurance
It should be noted and communicated to the private health insurance industry that any cost containment mechanisms implemented by the NSHIF provide inroads for private insurance to cover such limitations to benefit provision. As many countries have shown, private health insurance can play a substantial and important role in co-existence with social health insurance to provide more choice and additional services for those who want them. Private insurers may be encouraged to provide amenity packages as well as other products to top-up what NSHIF provides for.

3.5. HIV/AIDS and tuberculosis
The treatment of HIV/AIDS and tuberculosis (TB) should be included in the benefit package but accounted for separately. A considerable proportion of bed occupancy in hospitals is currently used by HIV/AIDS patients, and their appropriate care is immensely important for Kenya’s future. Currently, costs are estimated at approx. KSh 3,000 for antiretroviral (ARV) therapy per person per month. This figure represents the cost of ARV therapy only, and does not include supplementary treatment or hospital overheads. A co-payment should be considered for this, e.g. KSh 100-500 per month, as otherwise the Fund’s resources will be strained and to discourage misuse.

A provision of AIDS care of about 100 patients per level III facility, and 200 patients per level IV and V institutions may be a good starting point for introducing ARV treatment. This can then be gradually scaled up to the national treatment targets. Donors may be particularly interested to finance AIDS and TB treatment through this sustainable financing mechanism.

The NSHIF may offer an important channel for efficient use of contributions from international initiatives. It provides a sustainable fund management mechanism, thus eliminating the need to set up separate structures to fund healthcare for people with HIV/AIDS. NSHIF and the MoH should make efforts to attract donor funding to be channelled through NSHIF to pay for ARV therapy and other HIV/AIDS treatment and care.
4. Part VI – Provider payment

By Prof. Dr. med. Rolf Korte & Mr. Ole Doetinchem

4.1. Current income received by hospitals

As part of the mission, the team went on brief fact-finding visits to several health facilities. They included Machako District Hospital, the private Shalom Hospital at Machako and A.I.C Kijabe (Mission) Hospital. The aim was to get a better understanding of the state of the facilities and of the level of care given, as well as collecting figures on current funds received by these facilities. The figures were then used to verify previous estimates and to help in determining appropriate and acceptable remuneration levels.

a) Machako District Hospital (Government)

Machako District Hospital is, owing to its previous function as provincial hospital, large for its level. It has over 500 beds, 71% of which are occupied on average according to its annual report. During the team visit however, the wards visited were used above capacity and the situation was described as “normal” by hospital staff. The hospital admitted 16,675 inpatients in 2002, which stayed on average for 8.3 days. The most frequent diagnosis is malaria; traffic accidents are numerous, too.

Machako District Hospital’s income comes from cost-sharing, MoH general funding and MoH drug supplies. Salaries are paid by MoH and are not included in the budget. Of the hospital’s income (without salaries) cost-sharing represents the largest single source with 39% (see diagram on the right). About 23% of potential cost-sharing income is waived due to patient’s inability to pay.

These are some examples of the fees charged by the hospital:

- treatment per day: KSh 50
- bed per day: KSh 100
- operating theatre: KSh 3,500
- delivery: KSh 1,000

The hospital receives a maximum rebate of KSh 1,000 per patient per day from NHIF for its members. About one quarter of patients are covered through NHIF, but the average claim to the insurance fund is only KSh 473.32 per patient-day.

Machako District Hospital is run at very low income levels. This is reflected in the state of the facilities and the obvious need for improvement.

b) Shalom Hospital (Private)

Shalom Hospital has 75 beds and an average occupancy rate of around 35%. The hospital has higher charges and runs at higher per-patient costs than Machako District Hospital. It has contracts with some private insurers, such as AAR, and with corporations.
These are some examples of the fees charged by the hospital:

- Nursing fees per day: KSh 200
- Bed per day: KSh 550 (KSh 750 for a private room)
- Consultation fees: KSh 350
- Outpatient consultation: KSh 250

The hospital receives up to KSh 800 per day from NHIF with the average claim being just above KSh 600. Average inpatient-day costs are estimated to lie between KSh 1,500 and 2,000.

c) A.I.C. Kijabe Hospital (Mission)

A.I.C. Kijabe Hospital provides 200 beds, of which about 60% tend to be occupied. Their patients stay an average for about one week. Traffic accidents represent a large amount of the workload as the hospital is near 2 highways, and consequently the male ward is usually occupied over capacity. The hospital includes an active HIV clinic, whose patients are mostly recruited from the hospital wards, although efforts to recruit patients from the general public are ongoing. At this facility, they offer ARV and TB multi drug treatment.

The hospital’s income is mainly derived from cost-sharing fees; other sources are fundraising and donations and NHIF claims. At the HIV clinic, patients contribute to ARV treatment costs according to ability to pay. ARV treatment cost is about KSh 3,000 per patient per month and fundraising in the USA is done specifically to subsidise these activities. The hospital benefits from donated (missionary) staff, but is increasingly employing to local staff.

The NHIF offers Kijabe hospital a rebate of KSh 1,000, and it makes use of this, as its average NHIF claim is KSh 969. However, only some 8% of patients are NHIF covered, and even those covered tend to be asked for additional cost-sharing fees, as the hospital’s per inpatient-day costs lie at about KSh 2,000.

We found high variations in the level of funding and payments received at which different hospitals are operating in Kenya. The findings at the hospitals visited indicate that the average government facility operates on a low budget of between KSh 500 and 1,000 per patient-day, whereas mission and private facilities offer their services at costs between KSh 1,000 and 2,000. Those patients that are covered by NHIF can in many cases expect free or cheap treatment at government facilities, as the NHIF rebate will cover the costs, but are most likely to be asked extra fees at mission and private hospitals to top-up the NHIF allowance.

4.2. Type of remuneration

As the introduction of NSHIF mandates already major changes to the system, the method of reimbursement should not overburden it even more. We recommend a type of remuneration that is easy to administer and that resembles current practice. Therefore, we propose a flat fee remuneration per inpatient-day and a flat fee for each outpatient visit specific to each provider and to be paid in full. This means that the flat fee is paid to the contracted health service provider in full, unlike the current NHIF system, where the provider can get only up to the agreed amount, but gets less, if the invoiced fees (for service) add up to less. To realise the potential of social health insurance, such a flat fee must be understood to cater for complete treatment, including the provision of drugs, and without permission to demand supplementary
Part VI – Provider payment

cost-sharing fees. The flat fees will allow hospitals to balance out costs and incomes over patients; the hospital may make a loss on patients requiring expensive treatment, but it will make a profit on many patients with conditions that are easier to treat. This system also provides an incentive to treat each patient cost-effectively, as this increases hospital income. More intricate payment types, like disease-related-groups (DRGs), may be considered in the future, once implementation obstacles have been overcome.

4.3. Remuneration level

To allow for a smooth transition process, it should be considered to orientate the level at which flat-fee remuneration is set on a number of criteria for each contracted health service provider. These criteria are:

- facility level (I to V)
- attainment rating against Standard Benefit Packages (SBP) in % (see also annex 3)
- compliance and implementation of the Kenya Quality Model (KQM)
- current budget
- need for additional resources for improvement of facilities and services.

a) Level of care

The five levels of care are described in detail in annex 4. All else being equal, higher-level facilities should expect to get higher rates from NSHIF.

b) Standard benefit package (SBP) rating

As outlined in 3.1. Benefit package and annex 3, SBPs may stipulate what health facility of each level (I to V) are expected to provide. Facilities may then be rated against the SBP, and the degree to which their catalogue of services attains that of the full SBP (in percent) be reflected in the remuneration level. The rated SBP may become the core of the contractual arrangement between service providers and NSHIF.

c) KQM

This quality mechanism should be expanded as fast as possible to serve as a basis for accreditation and contracting.

d) Current budget

Remuneration should take into consideration current levels of payment. Facilities currently on low income may not be able to handle a sudden, large increase in income. Facilities on high incomes may have to drop standards if forced to make do with less. The remuneration arrived at should satisfy the basic financial needs of the providers plus some allowance for improvements. To determine the current financial situation, all income sources (cost-sharing, MoH grants, MoH drug provisions, etc.) should be taken into account. The only exception to this are staff salaries in public hospitals that are at present paid by MoH. These payments for personnel and also large infrastructure investments will, for the time being, continue to be paid by MoH. We suggest replacing this by NSHIF payment in future, after a transitional period of several years.

e) Provisions for improvement

We believe it is essential that efforts are made to include those (predominantly) public facilities that at present provide below average quality services, into the new reimbursement mechanisms, through provisions for improvement. They may negotiate for increased remuneration if credible improvement plans are provided. Simply affording such providers higher payment may surpass management capacities. We would instead
propose NSHIF-sponsored capacity building with the goal to achieve the standards needed for better remuneration (e.g. providing full SBPs). This could either mean direct funding of capacity building measures by NSHIF, or increased remuneration that is disbursed subject to the achievement of specific, agreed improvements in a specified time frame. Counteracting the continuation of unacceptable inequalities in service provision to disadvantaged areas will require a major concerted action by both NSHIF and the MoH.

Taking above criteria into account, a remuneration level may be arrived at that is acceptable to both NSHIF and the provider. We find the estimate of a per inpatient-day fee of KSh 2,300 for district hospitals, given prior to this mission, to be a very generous figure. Depending on health facility level, benefit package rating, quality criteria and current budget, we propose a payment within the range of KSh 1,500 and 2,500 per inpatient-day to hospitals. For outpatient visits a realistic range may lie between KSh 100 and 400.

4.4. Provider contracts
Remuneration will be individually negotiated between NSHIF and health service providers. Group contracts with umbrella organisations of certain providers, e.g. mission hospitals, may eventually be considered for speeding up the extension the NSHIF provider network. We propose that preparation of contractual packages for a set of typical providers be started, with SBPs being an important part of that. These packages can then be individually adapted during negotiations.

All contracts must adhere to the basic principles that the treatment provided for the agreed remuneration is comprehensive and includes drugs and no cost-sharing fees may be levied.

Although any health service provider may be contracted to provide services under NSHIF, we expect the scheme to be rolled out first among public hospitals, closely followed by mission and private providers. This may differ for some regions, e.g. in the Nairobi area private providers will be signed up early on to provide level I and II functions. In the medium term, this set-up will lead to competition between public and private hospitals. This should improve services and increase customer (patient) responsiveness, but it should also be noted that even a public facility could possibly go bankrupt, if other providers offer better services.

As public facilities will continue to have their staff salaries paid by MoH during a transitional period of around 5 to 10 years, they are expected to negotiate for lower payments from NSHIF than most mission and private hospitals. Public health facilities ensure that a minimal network of available health services for the population exists, and as such the money saved from not having to finance personnel salaries (this implies therefore that the payment rates for the SBP will include ‘some’ financing for ‘some’ staff?----or will there be separate rates for public facilities and private and NGO facilities ?) should go towards ensuring that the full SBPs are provided, especially in remote areas. Ensuring access across the country will require particular attention, and investments by MoH as well as incentives through NSHIF payment may be necessary to achieve this. If such funds are provided for facility improvement and assistance to achieve quality standards and full benefit package provision, they should be tied to specific, contractual agreements of the improvements to be achieved.

As many private health providers have relatively low occupancy rates, NSHIF accreditation may offer efficiency savings through increased rates.
A cornerstone of efficient service provision is the availability of drugs as part of the contracted SBP. KEMSA may be one of the sources where providers can purchase essential drugs as prescribed in the SBP. However, to increase efficiency other suppliers like the mission-run MIMS and even private companies should be able to compete. The MoH may consider annual tenders to identify companies willing to supply quality essential drugs from which NSHIF contractees may purchase at fixed prices.
5. Part V – Present status of NHIF

By Mr. Christoph H.R. Lankers

The present focus of NHIF is to process the contributions of members and pay the claims for their stays in hospitals. The Fund is as of yet employing manual work to a large degree, especially in the branches. Most of its communication with organisations outside the fund is done on paper. Presently, all data are entered into a database only in the central organisation, the process of decentralising data entry and processing has just begun. A first implementation was done in the Nakuru branch of NHIF just recently and is to be continued in other branches in the future.

The organisation is working on the improvement of several procedures as to strengthen its administrative efficiency and effectiveness. It has also budgeted for lesser total administration cost in the running financial year, such starting to address one of the major points of critique. But administration cost remains still an expenditure significantly higher than that of benefits to NHIF customers (members).

5.1. Structure
Based on the information received from the interviews and written material, the present structure of the NHIF is as presented in the diagram above.

a) Governance (Board)
The fund is governed by the board. The board consists of representatives of various stakeholders (i.e. the permanent secretaries of the ministries of health and finance and representatives from the employers and unions as well as a representative of the insurance industry). The chairman is appointed by the President and the others are sent from their respective institutions and organisations. Look up number (NHIF Act page is missing to complete paragraph) – Dr. Zipperer, please provide this, thanks.
The board is not reporting to any other organ of the fund but is under the control of the Minister of Health, with whom consultations on various issues are required, and who may remove members of the board from their office under certain conditions.

The main tasks of the board are to receive all contributions and payments to the Fund and make payments to providers in accordance with the Act. In consultation with the Minister it sets criteria for the accreditation of hospitals and protects the interest of the contributors. It appoints the officers and servants of the fund except for the CEO, who is appointed by the Minister. Thus the board is the central and most powerful organ of the fund.

The CEO is responsible for the day-to-day business and reports to the board, whose secretary he is.

b) Departments
There are three main departments with subdivisions: Operations, Human Resources, and Finance.

c) Operations
In the Operations department the central functions of the fund are organised in different divisions.

Registration and Contribution
This division is responsible for the registering of members and for the accounting of the contributions due or paid. For doing so, the division uses the central database, to which member-data and, if applicable, employer-data are added.

Presently only a part of the membership is individually known in the system. For larger employers, esp. teachers and employees of the government, only a total sum is sent to the fund and individual member data are not entered into the system.

The number cited by NHIF for the individually registered members runs from 1.2 to 1.5 million members, the number of not individually registered members is identified at between 700,000 and 900,000, depending on the source in the fund.

All registration is done centrally as 22 of the 23 branches are not linked up with the central database (and have only very limited computer capacity). Hence, the branches identify new members and receive their membership applications, which are then sent to headquarters, where they are entered into the systems and cards are produced and sent to the member or her employer. The cards are to be renewed annually, when the new fiscal year starts.

Contributions of employees are to be paid by monthly deductions from the wages. Despite some statements that the amount due is matched by the employer no such regulation is found in the NHIF act and the amount of contributions paid to the fund do not suggest that there is additional money paid from employers.

Beneficiaries
Besides the members, dependants are also eligible for benefits under the fund. This is one spouse, and all legal or legally adopted children.
The member receives a card that proves his membership. The card states also the name of the spouse eligible for benefits and the number of dependants. It does not state the individual dependants.

In the case of the employer paying the contribution and the member not having a card, the employer receives the card (not necessarily made out to the individual member!) and may keep it until asked by the employee (NHIF Act 16 (3)(b) and (c))

Self-employed persons can enter the fund on a voluntary basis and pay an annual contribution independently of their income. They, too, have their cards issued in accordance with the fiscal year.

The fund does not automatically receive data from any other agency on the status of employees or their income, and does also not receive automatically data on the founding of new businesses. It does not have data on the self-employed. Thus it is to the fund’s enforcement inspectors (mostly located in the branches) to identify employers and their employees and to have them registered and pay the due contributions. Information on the extend of applying the penalties provided for not registering or contributing in the NHIF Act could not be obtained.

The present system does not give a full account of the beneficiaries.

**Claims**

Claims are presently sent from the hospitals to the nearest branch, where they are checked and then sent to headquarters for data entry and payment. The branches are also responsible for surveillance of the hospitals – whether the claims made are justified and correct. This is mainly done by physically checking, whether patients are in the hospital.

Due to the centralised organisation of the claims payment process, the time between making a claim and receiving payment is usually long – a reason for complaints by the hospital. Claim payments are presently made by bankers cheque. The fund has reason to believe that this is a source of fraud (cheques are written to the hospital as a recipient, but there are cases where the amount of the cheque has been taken from the cash register of the hospital). In the future, claims are to be made by transferral to the hospitals bank account directly.

**Marketing**

The fund just recently appointed one of its officers as a marketing manager. He will be responsible for developing a marketing and image campaign.

**Branches**

Presently the fund operates 23 branches, 3 of which are located in Nairobi directly. Although there are branches in all provinces, the distribution varies greatly between the different parts of the country.

The branches are as of yet not computerized or linked up to headquarters, with the exemption of the Nakuru branch, which serves as a pilot for the decentralisation process.

The main task of the branches is the surveillance of the hospitals and the employers that are to contribute to the fund for their employees. Besides that, branches offer some
membership services, for example certifying payment of contributions, which is needed in the case of a hospital stay.

**IT**
The IT division is presently located under operations and marketing. The IT structure of the fund is as of yet not very far developed. The fund operates a central database for the data of the members, the employers and the claims made and paid.

The database is presently restricted to administrative data of the areas mentioned – data on the individual items of the claims and/or the diagnosis treated are not kept in the system. The database has been developed as an application of an Informix / (future: DB 2) database within a Unix OS by an outside company. Cost of the system and cost of extensions to this system were not available.

Within headquarters, a local area network exists. It is planned to build up a wide area network with all existing branches, thus enabling them to enter data into and retrieve data from the central database. This has been done with the Nakuru branch, however reports on the present status of this pilot were not yet available. Presently it is unclear, how the decentralisation process will continue – no detailed project plan exists for this process. In the 2003 / 2004 budget the increase in assets for computers is planned at merely 4%. Assuming that most branches would need computer equipment before they could be linked into the network, it seems doubtful that the process could be completed under this budget.

Independently of the computerization process, the decentralisation of competencies has not yet begun. That means that even with the link to the network, decisions on claims and contributions will still be made in headquarters. The fund management is reserved about decentralisation of competencies for reasons of fraud and mismanagement.

d) **Finance**
The finance department is responsible for setting up an annual budget. This is done in a bottom up process, i.e. branches and departments are asked to present their required budget, and these figures are then discussed with the respective managers. The final budget is put together within the department and needs approval from the board.

There is presently no controlling process established. The department managers receive figures on their expenditure on a quarterly basis. The past practice of revised budget shows that exceeding the budget is not prevented.

e) **Human resources**
The human resources department is responsible for the files and administration of the staff. Training of staff is done mostly by an on job training, most clerks receive only a basic training that enables them to perform the limited tasks within the registration and claims process. Information on training measures for enforcement officers, inspectors or managers was not provided.
5.2. Room for improvement within NHIF

a) Registration
The registration process is presently unsatisfactory: As pointed out, only the minority of beneficiaries is individually kept in the files. The total number of members and of beneficiaries is not known. This needs to be changed.

The process for the recording of employers is also unsatisfactory: Many employers are presently not registered – there is no established process of how the fund learns about the existence of an employer, or the number of employees or the amount of salaries paid. It is rather, in the accounts of NHIF staff, a search and retrieval process done by the inspectors. As there is a need to register businesses before starting them, automatic exchange between registering authorities and the fund should be established.

b) Contribution collection
The same holds for the collection of contributions: Here, too, the process of information exchange with, e.g., tax revenue authorities is not automated (and the lawful basis for such an exchange seems to be missing). This may be one of the reasons why the fund is complaining about an amount of KSh 5 million of missing contributions (cf. Dr. Hasan in East African Standard 9. Aug.2003, p 4)

Presently contributions are only paid on that part of income labelled as “salary” and not on the “allowances”. Since employees in statal and parastatal organisations earn 50% or more of monthly income from “allowances” and not from “salary”, the fund is (not by his own fault but for legal reasons) forfeiting contributions. This is the case not only because the cap seems to be set rather low at KSh 15,000 per month but also because large portions of available income are not used as a basis.

c) Benefits
Benefits are restricted to hospital costs incurring for hospital stay, diagnosis and treatment services provided and for drugs. The benefits do not come as a full payment of services provided at the institution the beneficiary was a patient of. Rather, they come as a rebate that is negotiated with the hospitals as a daily basis. This means, that the bill of the hospital is fully covered if the bill is less than the rebate granted, but is only partly covered by the fund if it is above the rebate. Since, e.g., the rebate is KSh 1,000 per day for public district hospitals and for many of the mission hospitals offering a similar range of services, bills are usually covered completely in public facilities (on the district level) but not in private or NGO facilities. The reason is that public hospitals have the major part of their cost covered from the MoH budget (for personnel and infrastructures), while other facilities are not eligible for this money and run at higher daily rates.

NHIF does not just cover the medical treatment necessary but also pays for amenity services – hence public hospitals established amenity wards that are mostly occupied with NHIF beneficiaries, while those, who are not members of NHIF stay on the regular wards. It is disputable, whether a social health insurance should pay for amenities or whether it should not rather concentrate on paying for high quality medical services.

Despite this fact, NHIF does, under the present rebate system, encounter problems, to spend money on benefits: It regularly makes a surplus, even with the lack of contributions collected and the very high ratio of administration cost. At the same time, the budget for benefits during the last financial year was revised downward by 19%.
d) **Claims processing**
As described above, claims are accepted in the branches, but finalized and entered into the database in headquarters. The payment is also made from there, the method in effect is a bankers cheque to the hospital. Due to the split between branches, where claims are checked and possible surveillance actions are initiated, and headquarters, where data entry and payment take place, the process offers room for improving efficiency.

e) **Surveillance and enforcement**
Surveillance and enforcement are the main tasks of the branches. As described above, the means are limited, as many data are not readily available. No figures were retrieved on the ratio of (discovered) fraudulent claims and on the enforcement measures used (e.g. juridical steps) in case of non-compliance of employers.

f) **Financial structures, budgeting and controlling**
As described above, the present budgeting and controlling process gives room to uncertainty about actual financial developments and significant revisions of budgets during a year.

Revised budget 2002/2003 differs strongly in regard to administration cost (**plus 29%**) and benefits (**minus 18%**). It also differs in regard to income from rent (-94%) and interest (-57%). The total overriding of the initial budget – despite the reduced benefits’ expenditure – is 8%.

NHIF has been under harsh criticism for the fact that their administration costs are approximately twice as high as its expenditure on benefits (e.g. in the revised budget for 2002 / 2003). It has promised to cut that ratio by (1) raising the total contributions and the expenditure on benefits and (2) by cutting down real administration cost.

However, the presented budget for 2003/2004 is doubtful in regard to the reduction of the latter: The budget plan foresees a reduction from KSh 1.613 bn to KSh 1.097 bn or 32%. But, for the following reasons, it cannot be determined on the information available that this will be achieved:

- Depreciation and Amortisation of Stock have – surprisingly enough – not been budgeted. Assuming figures similar to the previous year, this would reduce the budget reduction to only 15%.
- As outlined, the revised administration budget of 2002/2003 without depreciation and amortisation is 22 % above the original budget. Figures for former years indicate that the final figures are also higher than the revised budget. This nurtures the assumption that similar overriding of the budget is to be expected. Applying the same percentage as in the last financial year, the administration cost to be expected in the running financial year is similar to the one of last year.
- As layoffs from the past financial year and the present one have not taken place (per saldo) and rise in salaries is budgeted at 4% , it would be doubtful that a reduction of 32 % could be achieved. A reduction of 15 % would require strong measures in spending control.

All this hints to two things:

- The budget set-up needs improvement, in order to have a complete and also binding budget for any running financial year present at the beginning of that year. It seems
that also a top down approach is needed in order to actually achieve a downscaling of the administration cost.

- A controlling process needs to be established on all levels, in order to improve the keeping of the budget during the running year.

g) **Health care fund or savings and loans or life insurance**

Another area of strong critique of NHIF relates to its accumulation of assets. NHIF has presently almost KSh 9 bn of assets (as presented in the balance sheet – no information on the method of assessing the value of these assets was requested). Most of these assets are in Land & Building. The revision of budgeted interest and rent during last years budget, that this source of income is anything but predictable: Interest had to be adjusted by minus 57 percent and rent was even revised downward by 94%!

Independently of these deliberations, it is disputable whether a social health insurance fund should accumulate assets over such a long period of time. Since it does not need to prepare for future payments (as, e.g. a life insurance) of its clients (members), the reason for accumulating money is not given. Since it requires specific competencies to hedge and enlarge such assets and since there are enough other institutions that have professionalised these competencies, it should be left to contributors to give their money to these institutions instead of keeping it in the health care fund.

As NHIF is a parastatal organisation, it needs to be evaluated, whether the present assets are also part of the GoK balance sheet and whether using these assets for the tasks ahead is possible.

h) **Summary**

The findings suggest that already within NHIF there is a lot of room for improvement, which needs to be addressed as soon as possible and not only after the change to NSHIF. There exists within the fund a strategic plan for the coming years, with a very large list of individual activities. However, these activities do not – in their majority – address the issues raised here. There exists a cost estimate for these activities but the status of the project management or the achievements made under this project plan so far seem not be clear. Interview partners seemed to be unclear about the plan and its relevance for their actions.

This means that NHIF should start, as soon as possible, to further evaluate the present procedures and set up a project for the improvement of these procedures. They need to be budgeted properly and an efficient project management structure needs to be put in place.
6. Part VI – Proposed processes and structures of NSHIF

*By Mr. Christoph H.R. Lankers*

Following is an overview of the necessary or suggested changes from NHIF to NSHIF. Obviously, NSHIF will continue improving those structures and procedures mentioned in the description of NHIF.

### 6.1. Structure of NSHIF

As the following diagram shows, the structure of NSHIF requires various new organisational units – some required by the NSHIF bill, some resulting from the new tasks of the fund.

![Diagram of NSHIF structure]

#### a) Governance

Within the NSHIF bill, the structure of NSHIF governance is described. It is quite different from NHIF: The board of trustees – still the main body for decisions of the fund – has no longer appointed members. Rather the members need to be elected by the National Council. The members need to represent certain competencies and also certain interest groups, but they are ultimately chosen by the National Council.

The National Council consists of 160 representatives, two from each district. Within the districts, District Councils exist, to which each Sub-location sends one representative. At the Sub-locational level, the committees to be set up there, have one representative from each village within the Sub-location. The representatives at village level are to be elected democratically by the villagers.

This requires that for establishing the governance structures, nationwide elections have to be prepared and carried out. After this task has been completed, the Councils at the district
and the national level have to be established and only then can the new Board of Trustees be elected.

The following diagram gives an estimate of the time frame for this procedure.

<table>
<thead>
<tr>
<th>Phase</th>
<th>Activity</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Getting started</td>
<td>After Bill is passed by Parliament, Minister of Health announces the</td>
<td>6 weeks</td>
</tr>
<tr>
<td></td>
<td>commencement of the fund and initiates elections on village level</td>
<td></td>
</tr>
<tr>
<td>Elections of Committees</td>
<td>Elections are prepared and held on village level and sub-committees</td>
<td>4 to 5 months</td>
</tr>
<tr>
<td></td>
<td>convene and elect representatives to District councils.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>District councils convene and elect their office-bearers as well as their</td>
<td></td>
</tr>
<tr>
<td></td>
<td>two representatives to the National Council.</td>
<td></td>
</tr>
<tr>
<td>Commencement of National</td>
<td>Minister of Health convenes the first meeting of National Council</td>
<td>2 to 3 months</td>
</tr>
<tr>
<td>Council</td>
<td>Election of the Chair and Office-Bearers of the National Council</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Selection and Appointment of the Members of the Board of Trustees.</td>
<td></td>
</tr>
<tr>
<td>Board of Trustees</td>
<td>Board of Trustees convenes and initiates process of staffing senior</td>
<td>2 to 3 months</td>
</tr>
<tr>
<td></td>
<td>management.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CEO and other Executive functions are advertised</td>
<td></td>
</tr>
<tr>
<td>CEO and Senior Staff</td>
<td>After CEO and Executives have been determined and appointed,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NSHIF can start working</td>
<td>Total: 9 to 12 months</td>
</tr>
<tr>
<td></td>
<td>Minister appoints the chair and the members of the Appeals Tribunal</td>
<td>1 or 2 months after NSHIF is operative</td>
</tr>
</tbody>
</table>

Besides the governing bodies, a new Appeals Tribunal will be established, which members can appeal to in regard to decisions of the fund. Members of this tribunal need to be appointed by the Minister of Health after the fund has been established.

The fund will need to develop its own structures for communication with the Council(s). It will probably not be possible to do this from the Board alone; especially the District Councils will after some time certainly need dialogue partners at the district level.

b) Executive officers

The NSHIF bill requests that the Board of Trustees appoints a Chief Executive Officer, responsible for the day-to-day business of the fund.

Looking at the magnitude of the tasks ahead in establishing the NSHIF, we would – different from the organisational chart presented above – suggest to have at least a CEO and a Chief Operating Officer (COO).

The CEO would then be responsible for defining the detailed vision and the strategy of the NSHIF. He would communicate these with all those concerned – both outside and inside the fund. The CEO should be a person with a good knowledge of the Kenyan health care system and experienced in the development and communication of strategies.
The COO will focus on building up and improving the structures and procedures of the fund. His major areas of concern will be the financial structure of the fund, the objective-guided development of human resources for the new tasks and the improvement of the core activities of the registration and payment procedures. He or she needs to be a seasoned manager of large administrations and should have extensive experience in changing organisations. Knowledge of the health care sector is certainly an asset but not a must.

It could be favourable for the fund, if two other management positions are moved to the Executive Office, at least after some time of operations. The Office would then also have a Chief Finance Officer (CFO), responsible for the financial planning and reporting, and a Chief Information Technology Officer (CIO), responsible for the development and implementation of a comprehensive and complete IT-structure for the fund at all levels.

Having these functions moved to an Executive Office would enhance the dialogue with the Board of Trustees. It would also put key functions to a visible level of responsibility. Enlarging the Executive Office will also help to establish a system of checks and balances within the fund (departments would report to different members of the executive office). Last but not least it would help to improve the technological competence within these areas of concern for the fund. However, since these measures would also come with a price tag, it seems advisable to establish the latter two functions only later and to have both the financial and the IT-tasks overseen by the COO.

c) Departments

As shown in the diagram above, NSHIF will have various new departments:

- A department for Benefits and Quality, defining (a) the standards of the services available for NSHIF beneficiaries at the various levels of care, and (b) the criteria of assessing the quality of the service delivery of individual institutions.
- A department for the contracting of providers at the various points of service. These will be both for inpatient (hospital) care and for ambulatory care. The department will be one of the most crucial ones, as it will define, what prices NSHIF will have to pay for the services and as it will also determine the extent to which NSHIF – via reimbursement of provided services – is giving to providers for the improvement of their facilities.
- A Marketing department, which will develop and implement the communications strategy of NSHIF (together with outside PR-Agencies).
- A new Controlling panel department should complement the presently existing Finance department. While the finance department will continue to develop the annual budget, the Controlling will focus on the implementation of procedures of checking the budget allocation within the various units of NSHIF. It will not only look at financial figures but also at activities and will help to change NSHIF in an organisation managed by objectives and using tools to assess the success of reaching theses objectives.
- The IT organisation, which is now a division under Operations should become a department, as the computerization of the new fund is an essential task, pertaining not only to operations but also contracting and quality assessment.
- In addition to the auditing panel reporting to the CEO there should be a new Fraud and Investigation department reporting directly to the board. This panel will check the financial activities of NSHIF, which will grow as contracting of partners and other tools of operation will evolve. Keeping it independent of the organisation and of the
personnel responsibility of the fund’s management will strengthen the oversight of the Board of Trustees and thus contribute to transparency and accountability of the NSHIF.

d) Branches
As NSHIF is reaching out to new members and especially those who are in the informal sector or belong to the poor it will also need to let its regional presence grow. This will require to areas of activities:

- The evolution of a de-central organisation: Besides the surveillance of hospitals, in the future branches will need to be responsible for the payment of services provided and for the collection of contribution. This will require access to the database and a full computerization of branches. As mentioned above, such a de-centralisation is planned, but it is unclear in regard to the time frame. Besides the computerisation, a decentralisation of responsibilities is also needed, i.e. the branches will have the final responsibility for paying claims; they will also be responsible for the collection of contributions in their area. Branches need also be responsible for the recruiting of members. Especially the recruiting of poor members will need co-operation with local organisations, which requires familiarity with these organisations. With a more extended membership, it may also be advisable to shift budgetary responsibility to the branches, such that they have better say in the allocation of resources for the services for their membership and for the improvement of the medical facilities of their region.
- The extension of the branch-network: Presently, the branch network is focussing on the Nairobi area and other urbanised areas. This will need to be extended to both more rural areas and to remote areas. A plan of how to serve remote areas has to be developed (by the marketing department in headquarters), optimising both on presence and on cost.

6.2. Processes
With the establishment of new structures, NSHIF will also develop new procedures. The central new procedures will be discussed in this chapter.

a) Development of comprehensive service packages for various levels of care
NSHIF will need to develop service packages that providers are required to offer at the respective levels of care (see above). This will in the beginning focus on the hospital sector, but will then include the outpatient sector as well. Especially in those areas, where primary care and outpatient care are insufficiently offered through public facilities, this will include private practitioners, who will be requested to service NSHIF members.

As the membership grows and NSHIF comes close to the coverage of all Kenyans, it will be necessary to determine the role of all medical providers in the country, as they will depend on the service delivery for NSHIF for the economical survival.

Developing a strategic plan of how the service packages are defined, when providers groups are contracted and what the co-operation between different providers at the various levels of care requires, is a central function of the new fund.
b) Quality assessment of providers

Presently, NHIF does a crude assessment of the structural quality of hospital facilities, which is – to a limited extent – used for the determination of rebates (to a limited extent only, as, e.g., all public district hospitals are granted the same rebate, independently of the status of their facilities).

It will be the task of NSHIF to improve this quality assessment. In the beginning this will be restricted to structural quality, which will be assessed on a more detailed basis and which will serve for the negotiating parties for determining the amount of the per diems.

Later on, as more data become available (and models of how to collect and analyse these data are agreed upon between NSHIF and providers) the quality assessment will be based on process quality and eventually on the quality of outcome. Given the present status of data collection within the fund and the majority of providers, such an enhanced quality assessment will need at least five to ten years of development and implementation.

c) Negotiating and contracting with providers based on quality and assessment of financial need

Based on the assessment of the degree to which the quality requested at a certain level of care and based on the assessment, which investments the facility for improving this quality is willing to make and able to manage, the fund will negotiate reimbursement rates with the facility. The nature of these rates is described in the benefits chapter. The rates and the form of the contracts will certainly develop into different forms, as the system matures and more data become available.

However, from the beginning, this department has to find a way of negotiating contracts that are on the one hand favourable to the expenditure of the fund and on the other hand give enough resources to the providers, in order to enable them to provide quality care and to keep satisfaction among providers at a good level.

It seems reasonable that the department will develop certain frameworks (together with the quality assessment and benefits department), and that it will negotiate individual contracts under this framework. The framework will include not only rules for the determination of prices (e.g. per diems) but will also need to address the issue of volume of services provided – as there is presently under-utilisation in many (non government) facilities, growing volume of services is to be expected and needs early development of steering methods to address it.

d) Registration and contribution collection

It was already mentioned that the registration and contribution collection procedures need strong improvement for securing the income side of the fund. However, NHIF is presently only addressing the formal sector and within that only those employees, who earn above a certain limit. (The self-employed are only included on a voluntary basis.) NSHIF will extend its reach and will cover people without formal employments on a compulsory basis.

e) Registering new member groups

The registration and collection department needs therefore not only improvement for the formal sector as described above, but will also need to develop procedures to include other member groups.
Even though this issue could only briefly be touched during this mission, some preliminary recommendations shall be presented:

As said for NHIF and the formal sector, the fund should seek for assistance from other agencies for the gathering of data of members. Many of these measures will probably need a legal basis through an amendment of the laws pertaining to these agencies.

- For formal employments, the assistance of the registering, licensing and tax revenue agencies at the community or government level should be sought. Data on the founding of businesses, the number of employees, the payroll of the company etc. could thus be retrieved and checked against fund files. The fund would then have a complete data set of how many members it should have in this sector and how much in contributions it should get from here.

- The informal sector can be split into several subgroups:

  Those working as self-employed (e.g. jua kali artisans, matatu drivers, taxi drivers) usually need a registration or a license. This information should be given to the fund (in a stronger version, the granting of licenses could be tied to proof of NSHIF membership); it should be complemented by data from the tax revenue authorities, such that an assessment of the income of the person is possible for the fund. Upon these data, it should be decided, under which conditions the person receives a NSHIF card. (Presently there is a flat rate for all members without a formal employment status. It seems reasonable that for the self-employed this is restricted to a certain income level, and that business people earning above that level pay on the same basis as those in formal employment. This would need, however, a corresponding rule in the NSHIF bill)

  For the registration of people working as farmers, the register of real estate owners can be used as a basis for the identification of members. The real difficulty here may be in the assessment of the persons income, as this may not always be earned as money but rather through bartering etc. As the differences may, however, be significant, a method of distinguishing poor, low income and rich farmers is desirable.

  The NSHIF bill puts the responsibility of identifying the poor to the sub-locational committee. This committee should probably seek support from community organisations in order to identify the poor (who will be eligible to NSHIF cards without payment on their own). However, the process needs checks and balances, in order to provide cronyism and fraud. It is recommended that this is one focus area of the pilot (? I am not sure whether pilot schemes were accepted by the Moh. However, one could start earlier in some provinces than in others, and then the former provinces become ‘natural pilots’. Perhaps one could say something like: …is one focus area of the schemes whose initial project phase would be established in those provinces where minimum conditions for launching are satisfied.) to be set up in the initial project phase.

- The NSHIF bill does foresee individual membership for all dependants with separate contributions. This requires that the fund identifies the new member and registers them for the fund. For this the fund should receive (or have access to) data from birth registers, so that the basis of data is as complete as possible. It requires also that the contributions for these members (annual flat rates) are collected and that an additional assessment is made on the affordability of these cards for the household. Therefore a
process of establishing, what the maximum percentage of available income should be, needs to be established. The latter should be linked of course to the above mentioned issue of identifying the poor.

f) NSHIF cards and certificates of payment

NSHIF cards should be issued in a different procedure than NHIF cards are now. Each member (i.e. each beneficiary) should receive a card directly from the fund. This card should be valid for a period longer than a year; since even today, a member needs proof for the payment of contributions before receiving services, the administrative burden of issuing cards annually should not be continued.

NHIF has already obtained offers on the implementation of smart cards as NHIF cards. Looking at the present status of computerisation of both NHIF and of the provider facilities, such an implementation seems premature: Not only would smart cards not be useable to their full extent within the existing environment; but given the speed of technological development, it is also likely that a smart card technology now implemented would be out-dated (and seem rather costly in retrospect) by the time the computer environment within NSHIF and the providers are decently developed.

Rather than introducing smart cards now, a cheap and durable solution should be sought for the new NSHIF card for the time being. As the format for the card (and the information it contains) needs to be changed, if there are, e.g., no more dependents covered with a member, it seems feasible to do this with a simple plastic card technology (similar, e.g., to credit cards). Identifying members could be done either by requiring the card together with an ID-card, or it could (at least for beneficiaries older than twelve) also hold a photograph of the member – which would raise the barrier for someone to cheat. As for the prevention of forgery of cards, they could be equipped with holograms, which are cheap to produce but difficult to forge.

As for the certification of contribution payments, either the present system (a special form with some measures against forgery printed in the branches and stamped for the receipt of contributions) could be continued. Or it could be replaced (for the time being) with a voucher system, which would have several advantages:

- The vouchers would be given to the member for a certain period (usually a year) on receipt of the payment.
- The vouchers would be presented to a contracted provider together with the NSHIF card (and possible ID-card) in order to receive services.
- The number of vouchers given to the member would be limited – this would then limit the number of elective visits by the member. If he or she needs to see doctors more often, either a referral from one of the doctors serving him or her formerly or a new voucher issued by the fund would be necessary.
- This would not only regulate the volume of member initiated visits to health care facilities, but would also lay the basis for a referral system, where the doctor visited initially would take the role of a gate keeper – since other doctors (specialists or facilities of higher care level) would need a referral for reimbursing with the fund.

Should the next paragraph not be put before the discussion on vouchers, as it is about the cards? Once the technological infrastructure of the health care system in Kenya has developed, these cards could then be replaced by other tokens, which would allow the storage of identification data (including biometrical data), exchange with central database
on the status of contribution payments, and – if so wanted – clinical data of the patient (accessible only with the patient's consent).

g) Collecting data of clinical services
In order to extend the assessment and steering of the quality of services provided, the collection of clinical data is a sine qua non. The fund will need to develop a model of how these data are collected and stored. This will require close co-operation with providers, the Ministry of Health and with various interest groups (as the data collection must not lead to disadvantages of certain member groups, e.g. those who are suffering from HIV/AIDS).

The fund will need to develop the procedures of collecting these data, and it will need to provide for computer systems, able to store and analyse the data. This, too, will require a much more developed computer infrastructure than NHIF does presently have.

h) Public relations, image campaigning and marketing
Even though the NSHIF foresees a compulsory membership for all Kenyans, the present parameters of the Kenyan economic system suggest that it will take time until all Kenyans are registered and that this will only happen, if the Kenyans are convinced of the value of the insurance under NSHIF. In the worst case, NSHIF would be seen merely as an additional tax leverage, which, obviously, everybody would try to evade.

It is therefore important that NSHIF is actively marketed. This requires the development of a positive image of the fund as well as the development of a conclusive distribution system.

i) Claims processing from various levels of care and claims payment
Presently the claims are processed both in the branches and in headquarters. They are paid from headquarters. There are only claims from hospitals, and the fund pays the negotiated rebate for the length of stay occurring, or the actual hospital bill, whichever is less.

In the future, NSHIF will not only process claims from hospitals. It will probably – as the system evolves – also have different payment schedules negotiated, depending on the institution and depending on the services received by the member. This will need a further development of the claims processing procedures, to secure a timely and accurate payment to providers, but also a tight controlling of the claims. As in the future, outpatient physicians and health care centres will send their claims (thus multiplying the number of provider), the claims processing should also establish the use of IT structures for the transmission and processing of these claims. This, however, will require that the computerisation is not only within NSHIF but providers must use computers and network access as well. Since this will require financial and human resources (especially in combination with customized software packages), the process should not be started at the beginning of NSHIF but only at a stage of established provider payment schedules.

j) Cost containment
Cost containment will be an issue from the start of NSHIF, but it will become more important as the membership grows and with it the utilisation of facilities. Cost containment can only successfully be managed by the joint effort of various departments, especially contracting, operations and controlling.

Cost containment will need a basis both in the pricing and in the volume. As it becomes more sophisticated, it will also be based on the steering of patients through the various
points of care, trying to keep the patient at that facility that offers the optimum of care and price for the respective illness.

Measures should include referral regulations (e.g., facilities above primary care need a referral for making a claim, except for emergency cases), and prospectively also budget limits, or rates declining with volume (this is justified, as many costs of the facilities, including personnel, run at rather fixed levels, and services exceeding a certain limit have only variable costs).

Cost containment should also use incentives and disincentives for members, e.g., a small utilisation fee for outpatient services, in order to avoid over-utilisation of these facilities, which could stress the financial abilities of the system.

6.3. Challenges for the organisation as NSHIF is established
Looking at the difference between the organisation of NSHIF and that of NHIF and keeping in mind the outlined deficiencies of NHIF, the challenge of changing the present organisation into the future health care insurance for all Kenyans is visible. As most of them have been addressed in detail above, the following list will merely repeat the most important ones.

a) Development of procedures for the contracting of providers
- Determining prices and volumes
- Determining quality of care
- Organisational capabilities and structures for efficient negotiating
- New health care providers also contracting partners

b) Definition of benefit packages available at the respective levels of care

c) Set-up of procedures for the quality assessment of providers
- Structure
- Process
- Outcome

d) Improving registration
- Extending to new members
- Individual accounts for all beneficiaries within database
- Individualizes dependants’ accounts
- Improving contribution collection
- Improving the rate of complying in all sectors of membership
- Enhancing the ways of contribution collection (possible employment of community organisations)
Part VI – Proposed processes and structures of NSHIF

e) Continuation of the decentralisation process

f) Set-up and implementation of cost containment measures at all levels of the treatment and payment process and including all those concerned (Providers, fund and members).

g) Improved payment of claims

h) Establishing marketing and PR of the NSHIF

i) Establishing an IT structure that is able to support the gathering and analysing of data necessary for financial, activity and quality matters

j) Controlling of budget and activities

k) Establishing of the governance structure and working with it effectively
7. Part VII – Implementation

*By Mr. Christoph H.R. Lankers*

The implementation process has been the topic of a two-day planning process. A list of tasks has been identified by the participants as well as some initial planning of these tasks. The planning was divided into the phase before passing the NSHIF bill and the time after the NSHIF law is gazetted.

Before parliament passes the bill, the tasks are the following:

**a) External and independent auditing**

As NHIF has been experiencing sharp criticism regarding finances and since there should be a clear separation between NHIF and NSHIF in this realm, it is recommended that in addition to the regular annual auditing of NHIF, an external auditor reviews the financial status of NHIF. Only with such an independent auditing the message to the public can clearly be sent, that NSHIF is a true fresh start and that it will work differently from NHIF.

This auditing should include a value assessment of the present assets of NHIF. It should also be analysed to what extent and under what conditions NHIF financial resources can be used for the build up of NSHIF; as pointed out above, NHIF’s assets as a parastatal organisation may be part of Kenya’s national balance sheet and may not readily accessible.

**b) NSHIF organisation**

As outlined in the section presenting the NHIF organisation, *many issues at stake do not need to wait until the NSHIF bill is passed*. Rather the re-engineering of procedures (e.g. keeping of registration data) should start as soon as possible. In addition, working groups should also start working on the new procedures, e.g. contracting, as these tasks should be tested as soon as possible with providers.

**c) Public information**

The process of informing the public on the planned establishing has just now started. It needs to be more specific and it needs to focus on expectation management, i.e. people need to know, what will be available to whom when. If there is no such detailed public information and no campaign “selling” the advantages of NSHIF and explaining the time frame, it is rather likely that the project will encounter huge problems because of disappointed expectations. The public information is also a prerequisite for the membership drive in the informal sector, which is planned immediately after the NSHIF has been founded.

**d) Education on social health insurance**

This is a specific part of the public information campaign, especially addressing the decision makers and the representatives on the regional level (who will, after the bill became law, be members of district councils, and govern the fund). Here the concept of a social health insurance and the rules now developed in the bill, are still widely unknown. This needs to change. Seminars and conventions should be held, where the concept and the bill as well as the implementation plan are discussed and input from the participants is taken.
e) Training of NHIF staff
The training of the NHIF staff, both for the re-engineered procedures of present operations and for the new tasks should start as soon as possible. It will require the development of training manuals and the training of trainers, who will then train the staff itself.

f) Quality assurance
This, too, should even before the bill is passed be prepared by a working group, especially since the framework for this exists in the MoH and needs to be adapted such that the fund organisation can handle it.

g) Legal issues are still to be solved
This regards, for example, the legal basis of the exchange of information with other agencies in the registering process. It also includes the preparation of a National Health Act or umbrella for the various institutions involved.

The tasks for the time after the bill has passed are equally broad and ambitious.

a) Fund organs
The first task will be the establishing of the fund organs, i.e. the election of the governing bodies. The diagram on page 35 (Time Frame: Establishing Fund Organs) gives an overview on the tasks in this realm and the time frame.

b) Membership extension
NSHIF needs to extend membership. It should do so quickly and it should include poor people very early on. Success in this area – providing poor people with health insurance (even if it will be only an initially small group) will contribute considerably to the project’s success.

Extending the membership in the informal sector and to the poor requires a membership drive – people need to know that it is advantageous for them to be a member of NSHIF. It also requires the proper identification of poor people, who receive a free card. The working group needs to establish these procedures (based on the results of the previous working groups).

c) Management of NSHIF
Management of NSHIF: This needs to be developed and will focus on re-engineering of existing procedures, training for the staff already with NHIF, recruitment of new staff (based on the job descriptions to be developed). It is a continuation of the working group dealing with NHIF organisation before passing the bill.

d) Contracting and quality measures
Contracting and quality measures are the two new core competencies that NSHIF needs to develop and which require continuing working groups.

e) Legal issues
This holds also for the legal issues: It is likely that with extended experience for various procedures, amendments to the NSHIF law are desirable. Hence a working group should continue addressing these issues and preparing them for discussion between government agencies and with members of parliament.
f) Development planning

As there is additional money foreseen in the NSHIF bill and as there is need for the channelling of money to providers for the improvement of medical facilities and of management capabilities, it is mandatory to set up a planning process of how the clinical landscape should develop over time, negotiate this with providers and with representatives of the different member groups and determine activities and milestones.

This list of challenges are to be seen in combination with the list of tasks that come with establishing NSHIF – or with changing NHIF into NSHIF – as described in the sections before. These tasks cover a very wide range, interact with each other and affect a number of institutions and of interest groups. They also will need a longer time to complete them – with the risk of failure or with strong interference from opponents to the project as a whole. Already now, there are strong interest groups opposing the proposed legislation (e.g. HMOs); there will be more opponents as the scheme evolves. The tasks require therefore – for their successful and timely completion – an efficient and effective management for the initial stage of social health insurance implementation. This management needs to address the following issues:

- Development of detailed solutions to the problems outlined by experts familiar with the problems (in working groups)
- A tight and realistic timeframe for the development tasks of the working groups.
- Effective exchange between the groups
- Controlling of project success and time lags
- Efficient steering of the different project activities
- Participation of all groups concerned in order to secure a broad ownership of the change process
- Efficient decision-making process despite the many different groups involved in the process.

For the initial stage- management (ISM), we suggest an organisation along the lines presented in the chart. It is a three tier approach, which puts (a) the development tasks into different working groups, has (b) a core team under the chairing of NHIF, i.e. the organisation that is to change, and which is responsible for the technical co-ordination of the various project parts.
The ISM tasks are (c) lead by a steering committee chaired by the Minister of Health, who is politically responsible for the change process.

The ISM should be supported at the different levels by consultants, responsible for (i) adding outside views on the development of procedures and (ii) for the keeping of the time frame.

7.1. Test region
As many procedures will be newly developed, it is highly recommended that these will be developed, implemented and tested in selected region. This will help to avoid unsuccessful procedures to be introduced on a large scale, which would then need a major effort for fixing them again.

The selection region should be typical to the Kenyan situation in several aspects; it should, e.g., have a certain portion of possible members belonging to the informal sector or to the poor. It should also be a region, where NHIF operations are developed above average and where the providers are capable of implementing new methods and new services without a long preparation phase. As the ISM as a whole – for reasons of political communication – be based in Nairobi, the test region should not impose a high logistical burden on participants, who will need to travel back and forth between this region and Nairobi.

7.2. Steering committee
The steering committee will oversee the whole ISM. It will consist of the Minister of Health (chair), the Permanent Secretary of the MoH, the DMS and the DSRS, the CEO and the Chair of the NHIF, a representative of the MoF (PS), representatives of the private sector and their respective and different interest groups, representatives of the providers (those, who are actively involved in the ISM) and the chief consultant.

The committee will initially meet on a weekly basis, as it is to be expected that many decisions on the ISM tasks and the timing of these tasks need to be taken, which will require decisions of such a high level committee. After the ISM is well established, bi-weekly sessions seem appropriate.

The committee will – as often as it seems appropriate – invite additional participants, e.g. from donors and other concerned parties.

The steering committee needs to be optimised on two parameters: On the one hand, it needs to secure ownership of the different interest groups and institutions concerned. This is especially important, as ownership of the project is very broad in the Kenyan civil society. On the other hand, the committee needs to be designed in such a fashion that it can actually decide on the project issues at hand, and is not turned into a debating committee; this will require certain restrictions regarding its size.

The steering committee will have reports from the core team and from individual working groups and decide on the issues brought to it. It will also request on its own initiative activities within the project.
7.3. Core team or senior management task force (NHIF)

The core team combines the leading personnel of the project groups, ensuring the exchange between the working groups and steering the technical direction of the different ISM tasks. The CEO of the NHIF will chair it, as he will be responsible for the change of NHIF into NSHIF. Besides the chair, the leaders of the working groups, representatives of the providers (both government operated and non-government operated), representatives of the MOH and senior managers of NHIF (who will, in all likelihood, be identical with the leaders of some working groups) as well as the NHIF branch manager of the region, where the pilot takes place.

The core team is supported by a project secretariat, consisting of consultants and of less senior staff from NHIF and MOH. The project secretariat will be responsible for the support of the working group, the summarizing of working group results, which are to be presented to the core team and / or the steering committee. It will thus facilitate the communication between the three tiers of the ISM.

7.4. Working groups

The list and the detailed tasks of the working groups need to be developed in the next stage of planning, which should be on a more detailed and technical level than the initial planning during this mission could be. However, some working groups are necessary for the ISM to get started. These are:

- A working group preparing the test, focussing initially on the organisational requirements for a successful test and assessing the training needs of the staff within the pilot (both within NHIF and with providers or other institution). It will also need to develop a plan, including measures on how to improve the delivery of health care in the facilities of the selected region.

- A working group on training of NHIF staff will draw on results of the ISM working group, but will independently develop a training plan and training procedures (manuals, schedules, seminars, training of trainer and so on). The working group should also evaluate the possibilities of trainings by internships, either in different health care systems (sending designated staff to internships or other forms of training to health care funds in different countries), or by twinning of institutions within Kenya (e.g. a public district hospital with a private or mission hospital, in order to improve the management capabilities of the former).

- A public relations working group will be responsible for the development of a public relations campaign, addressing as well peers in the health care sector and the general public. This working group should complete its task together with professional PR-agencies familiar with the health care sector.

- A working group on NSHIF operations will develop a plan for the change of the organisation. It will, regarding the content of procedures, closely co-operate with the pilot working group. It may, however, start to develop procedures that are not in the primary or initial focus of the test.

- A special working group should be established for the areas of contracting and quality assessment. As these are two core tasks of the new fund organisation, setting up a specific working group for these issues is appropriate. The group will need to come up
with models for the assessment of the quality of care provided and with models of how to design prices for the various levels of care. It will also need to address the question of how resources can be allocated to the providers for the improvement of their facilities or of their clinical and administrative management.

As said above, this is an initial list, which needs to be checked within the following detailed planning phase, and to which items may be added or altered, if this seems appropriate.

7.5. Adequate funding for implementation tasks
The next planning phase should also provide a cost estimate of the ISM itself. Including consultants into the project as well as enhancing technical capabilities will come with a significant price tag. It will be one of the major tasks of the core team and the steering committee during initial ISM phases to secure the funding for these processes, either from resources available within NHIF and MOH or from other sources.
8. Part VIII – Threats and opportunities while introducing NSHIF

By Mr. Christoph H.R. Lankers

Introducing NSHIF and extending comprehensive health care coverage to all Kenyans is a very ambitious task. Expectations are very high and the risk of failing is significant. The previous sections already contain a number of hints, which we view as important for the project’s success. One of the most important ones is the signal that NSHIF is a true fresh start for Health Insurance. As pointed out, this should especially emphasize the financial aspects; for that reason, we suggest an external and independent auditing before the NHIF assets, rights and obligations are turned over to NSHIF.

There are some other critical issues, that do not directly pertain the project structure or the implementation process, but which should be made explicit here:

8.1. Guiding principles

Implementing NSHIF will require the development and the ample communication of guiding principles for the justice and solidarity between the various groups of the population. For success, it will be necessary that it is a shared view that NSHIF has established rules and regulations, which ensure that all groups are contributing according to their abilities and receive benefits according to their need and to the capability of the system as a whole. It will not only be necessary that these regulations are established, but that NSHIF is keeping to them in its day-to-day business.

8.2. Do not deprive those presently insured under NHIF of benefits

NHIF already provides a significant group of the population with health care benefits, if restricted to hospital care and even there only to a limited extend. Those presently insured belong to the better off groups of the population and they are also more influential on the development of the public opinion. They will watch closely, how changing the system to NSHIF will affect their own situation.

It is therefore crucial that these groups are not worse off under NSHIF than they were under NHIF – or that a change for the worse in certain areas is balanced by improvements in other (e.g., an increase in contribution leads to an extension of the benefit package).

Presently, these members receive hospital care independently of their diagnosis, but benefits are limited to a certain financial size. It seems, therefore, in our view, better to design the necessary restriction of benefits in the hospital by financial dimensions. A restriction of the list of illnesses treated under NSHIF will lead to continuous discussions with various interest groups; it will also give present NHIF members cause for complaint of a worsened benefit situation.

8.3. Setting priorities

With the wide range of tasks to be addressed, the risk of setting the wrong priorities is very high. It is important to design the process over a longer time period and address issues in a sequential order. The main task at the beginning will be to establish a transparent, accountable, efficient and effective fund organisation. This will, for the beginning lead to an exclusion of interesting areas, such as a radically enhanced computerisation (Smart cards) or
an intricate system of quality assessment. Though these issues are of enormous interest, they would come too early if the basic organisation of the fund and its operations have not yet been developed.

Many tasks are new for the fund, the providers and for the members (and their employers). Hence, many procedures have to be developed for the first time. Here again, procedures should be kept as simple as possible, even if this may not yet be the state of the art, or may even lead to certain inadequacies in the process (e.g., a single per diem for hospital is easier to manage for both sides, even if a specific one for different departments or even different reimbursement schedules for different treatments may seem more just). But the organisations need to learn how to handle these new procedures. And only then more intricate procedures should be developed and introduced.

Simplicity is also a must for the public communication. What is available, who is eligible and who is responsible for providing it, should be kept as simple as possible, in order to avoid confusion and frustration among members.
9. Annex 1: Proposed structure of the NSHIF Bill

The National Social Health Insurance Fund Bill
Arrangement of Clauses
- Proposed Structure -

Part I – Preliminary
1. Short title and Commencement
2. Interpretation

Part II – Establishment and Objects of the Fund
3. Establishment of the Fund
4. Object of the Fund
5. Guiding Principles of the Fund
6. Relations between the Fund and the MOH

Part III – Organs and Structure of the Fund
7. Organs and Structure of the Fund
8. National Council
9. Functions and Powers of the National Council
10. Tenure of Members of the National Council
11. First Schedule to apply
12. Board of Trustees
13. Functions and power of the Board of Trustees
14. Tenure of the members of the Board of Trustees
15. Chief Executive Officer
16. Staff of the Board of Trustees
17. Enforcement Officers
18. Appointment of the members of the Board of Trustees
19. District Council
20. Functions and powers of the District Council
21. Tenure of the members of the District Council
22. Sub-locational Committee
23. Functions of Sub-locational Committee
24. Tenure of the members of Sub-locational Committee
25. Procedure at meetings of District Councils and Sub-locational Committee
26. Disqualification from holding office in the organs of the Fund

Part IV – Membership and Benefits
27. Membership of Kenyans
28. Membership of Non-Kenyans
29. Benefit Package
30. Exclusions of benefits and Co-payment
Annex 1: Proposed structure of the NSHIF Bill

Part V – Contributions

31. Contributions to the Fund
32. Method of paying contributions
33. Delay in payment of contributions
34. Due dates for the payment of contributions
35. Failure to pay contributions
36. Cards as evidence of contributions paid

Part VI – Contracted Health Service Providers

37. Contracted Health Service Providers
38. Principles of negotiation
39. Arbitration
40. Remuneration of benefits
41. Offences relating to providing benefits


42. Sources of the Fund
43. Payments out of the Fund
44. Financial year
45. Annual estimates
46. Accounts and audit
47. Investment and reserves of the Fund

Part VIII – Appeals Tribunal

48. Review Procedure of Board Decision
49. Appeal from Board Decision
50. Appeals Tribunal

Part IX – Miscellaneous

51. Common Seal of Fund
52. Exemption form stamp duty
53. Evidence
54. Recovery of compensation or damage
55. Protection from liability
56. Liability of the Board for damages
57. General Penalty
58. Power to make regulation
59. Relations to Private Health Insurance Schemes

Part X – Transitional Provisions

60. Repeal of Act. No 9 of 1998
61. Maintenance of parts of Act No 9 of 1998
62. Modification of Employment Act

Part XI - Schedules

First Schedule
Second Schedule
Third Schedule
Forth Schedule
10. Annex 2: Comments and recommendations regarding the Benefit Package Document, Draft 10

- Rename the “Benefit Package” into “Standard Benefit Package, SBP (for levels I-V) for National Social Health Insurance Fund (NSHIF)” to indicate that this will be the standard against which health providers will be assessed.

- Chapters 1.1. to 1.6.4 should be retained. They give a useful overview of the background and rationale of the principles of SBPs.

- Chapter 1.6.5., Decentralization of Government Health Services, may be slightly modified to give greater emphasis to the need for financial reforms at provider level, linkage with the Council Members and quality Management to read:

  For Government health facilities to participate properly in this scheme, a high level of autonomy is necessary. Financial management will need considerable strengthening, personnel management and procurement should be done locally. Local participation in management as in the proposed health boards and close collaboration with NSHIF Council representatives should be established.

  Since this benefit package has described the services to be offered at every level in detail, it is hoped it will form a basis for evaluation of the current state of the facilities i.e. whether the facilities have adequate equipment, personnel, infrastructure and supply to offer services as described. Information obtained from such evaluation will assist in needs assessment and to work out improvement strategies. At a later stage quality management should offer opportunities to compare the performance of different institutions especially medical outcomes.

- Chapter 1.6.6. Establishment of Protocols and Standards of Care to be retained

- Chapter 1.6.7., Cost and fees, may have to be modified in view of the proposed remuneration structure to be based on current income rather than desirable remuneration for tasks multiplied by actuarial data to read:

  The service provider remuneration will initially be based on current income plus allowances for the gradual improvement of services. The remuneration will be standard flat rates per day in hospital and per out patient visit by level of care and degree to which the Standard Benefit Package is adhered to.

- Chapter 2.0 ESTIMATION OF THE NATIONAL COST OF THE NSHIF BENEFIT PACKAGE, to be retained

- Chapter 2.1, Proposed steps of cost calculation, should partly be retained. Those parts suggesting an itemised and actuarial approach should, however be modified to read:

  Step I: to be retained
  Step II: Proposed Modification:
Annex 2: Comments and recommendations regarding the Benefit Package Document, Draft 10

Determine the cost of care for an average in- or outpatient across all specialties based on current facility income divided by the average number of patients in order to retain the income level of the facility yet

Retain (i) –(iv)

- The description of STEP III may be somewhat modified to read:
  The sum total of figures calculated as in 5 above for all levels gives a fair estimate of the national cost of the implementation of the NSHIF SBP per year.

  “Costs for average in- and outpatients treated at various levels of government facilities should be worked as follows” continue as in the draft and then:

  “The details of these calculations are as in pages 6-20” may be deleted in view of the modified remuneration assessment. The list of variables should, however be retained, e.g. (ii) The number of outpatients seen in all government health centres countrywide in one year etc.

- Chapter 2.2, Sample patients and calculation of the cost of the package per level of care, should be deleted as it is proposed to negotiate flat rate remunerations for in- and outpatients at different levels of care (e.g. KSh 2,000 per inpatient day, KSh 100 for level II outpatient care.

- Chapters 2.2.1 to 2.3.10 should be replaced by the new remuneration schedule but may be a basis for “amenity” services for which supplementary insurance may be obtained.

- Chapters 2.3 Adjustment of cost benefit packages and 2.4. will have to be modified in view of the new flat rate remuneration mode.
11. Annex 3: Draft Standard Benefit Packages (SBP) for discussion

In the following SBPs for levels of care I and II are provided as a basis for further discussion. They are based on the Benefit Package Document Draft No. 10. If service providers will not be able to offer all services a down-rating will have to be effected and remuneration adjusted accordingly. But such institutions should receive support to attain the standard level as soon as possible. For patients not holding a NSHIF-card the originally proposed itemised remuneration levels may ultimately be applied.

For cross reference it may be useful to structure the list following the WHO essential drug list. The standard should also include TB drugs and ARV drugs according to national guidelines.

Further consideration should be given as to the type of radiological services to be provided at level II and whether e.g. general anaesthesia should be provided at level I as a standard. I would rather suggest referral for those cases.

11.1. Level I care

1. Staff

<table>
<thead>
<tr>
<th>Available</th>
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</thead>
<tbody>
<tr>
<td>Nurse/Midwife</td>
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<tr>
<td>Clinical Officer</td>
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</table>

2. Laboratory Tests and investigations

<table>
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<th>Available</th>
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<tbody>
<tr>
<td>Haemoglobin</td>
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</tr>
<tr>
<td>Differential white cell count</td>
<td>[ ]</td>
</tr>
<tr>
<td>Peripheral Blood Film</td>
<td>[ ]</td>
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<tr>
<td>Sickle Cell Test</td>
<td>[ ]</td>
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<tr>
<td>Syphilis Screening</td>
<td>[ ]</td>
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<tr>
<td>Gram Stain</td>
<td>[ ]</td>
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<tr>
<td>Ziel Nielsen Stain</td>
<td>[ ]</td>
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<tr>
<td>Potassium Hydroxide Preps</td>
<td>[ ]</td>
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<tr>
<td>Wet preparation</td>
<td>[ ]</td>
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<tr>
<td>Urinalysis</td>
<td>[ ]</td>
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<tr>
<td>Stool o/c</td>
<td>[ ]</td>
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<tr>
<td>Blood Slide for Malaria Parasites</td>
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<tr>
<td>Pregnancy Test</td>
<td>[ ]</td>
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<tr>
<td>Cervical swab</td>
<td>[ ]</td>
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<tr>
<td>Blood Glucose</td>
<td>[ ]</td>
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<tr>
<td>Urine Microscopy</td>
<td>[ ]</td>
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</table>

3. Drugs administration and dispensing (as per MOH essential drug list and clinical guidelines)

3.1. General Anaesthetics & Theatre Agents

<table>
<thead>
<tr>
<th>Available</th>
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<tbody>
<tr>
<td>Diazepam Inj. 5mg/ml (ampule)</td>
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3.2. Local Anaesthetics

<table>
<thead>
<tr>
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</tr>
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<tbody>
<tr>
<td>Lignocaine HCl Inj 2% (50ml bottle)</td>
<td>[ ]</td>
</tr>
<tr>
<td>Lignocaine Dental Cartridge</td>
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</table>

3.3. Non-Opioids and NSAIDS

<table>
<thead>
<tr>
<th>Available</th>
<th>Not available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin Tabs 300mg</td>
<td>[ ]</td>
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</tbody>
</table>
3.4. Anti-Allergics & Drugs used in Anaphylaxis

- Adrenaline Tart Inj 1mg/1ml (ampoule)
- Chlorpheniramine Maleate Inj 10mg/ml (ampoule)
- Chlorpheniramine Maleate syr 2mg/5ml (bottle)
- Chlorpheniramine Maleate Tabs 4mg

3.5. Antidotes & other substances used in poisoning – Non-Specific

- Charcoal Tabs 125 mg

3.6. Antiepileptics/Anticonvulsants

- Diazepam Inj 10mg/2ml (IV&IM) (ampoule)
- Phenobarbitone Tabs 30mg

3.7. Anti-infective drugs - Anthelminthics

- Niclosamide Tabs 500mg
- Albenazole chewable Tabs 400mg
- Albenazole Syrup 400 mg/10ml (bottle)
- Levamisole Hydrochloride Tabs 50 mg (3 tabs pkt)
- Levamisole Hydrochloride Syrup 40mg/5ml (bottle)

3.8. Antibacterials – Oral Liquids

- Amoxicillin Susp 125mg/5ml(100ml bottle)
- Co-trimoxazole Susp 200:40/5ml (50ml bottle)

3.9. Antibacterials – Oral Tabs/Caps

- Amoxicillin Caps 250mg
- Co-trimoxazole Tabs 400:80
- Doxycycline HCl Caps 100mg

3.10. Antibacterials - Injectables

- Benzathine Penicillin Inj 2.4 IV (vial)
- Benzy1 Penicillin Inj 1MU (vial)
- Fortified Procaine Penicillin Inj 4.0 MU (vial)
- Triple Penicillin Inj 6:3:3 (vial)

3.11. Antifungals

- Benzoic acid 6% + Salicylic acid 3% Oint.(tube)

3.12. Antiprotozoal Drugs

- Metronidazole Tabs 200mg
- Amodiaquine 200 mg tabs
- Amodiaquine susp 50mg/5ml (bottle)
- Sulfadoxine 500mg + Pyrimethamine 25mg Tabs
- Sulphametopyrazine + Pyrimethamine Drops 10mg

3.13. Antimigraine Drugs

- Aspirin Tabs 300mg
- Paracetamol Tabs 500mg

3.14. Dermatological Drugs

- Benzy1 Benzoate Emulsion 25% x 500mls
- Compound Benzoic acid 6% + salicylic acid 3%
- Calamine lotion 100ml
- Gentian Violet Crystals Powder 10gms (25gm unit)
- Hydrocortisone Skin Oint 1% 10g

3.15. Hormonal Contraceptives

- Ethinylestradiol + Norethisterone Tabs (35mcg+mcg1.0mg pkt)
- Ethinylestradiol + Levonorgestrel Tabs (30mcg+150 smcg pkt)

3.16. Immunologicals (Vaccines) (to be provided by MOH EPI Programme)

- BCG Vaccine Dried Powder (10 doses vial)
- Diptheria-Pertussis-Tetanus Vaccine
Hepatitis B Vaccine | [ ] | [ ]
Measles Vaccine | [ ] | [ ]
Poliomyelitis Oral Vaccine (10 doses vial) | [ ] | [ ]
Tetanus Toxoid Vaccine | [ ] | [ ]
Pentavalent Vaccine | [ ] | [ ]

3.17. Ophthalmologicals & ENT Preparations
Tetracycline Eye Oint 1% 3.5g (tube) | [ ] | [ ]
Oxytetetracycline 3% + Hydrocortisone 1% ear drop(tube) | [ ] | [ ]

3.18. Oxytocics & Antioxytocics
Ergometrine Maleate Inj 500mcg/ml | [ ] | [ ]

3.19. Gastrointestinal Drugs
Compound Magnesium Tricilicate Tabs | [ ] | [ ]

3.20. Respiratory Tract Drugs
Salbutamol Syrup 2mg/5ml (100mls bottle) | [ ] | [ ]
Salbutamol Tabs 2mg | [ ] | [ ]
Salbutamol Tabs 4mg | [ ] | [ ]
Solutions for Water, Electrolyte & Acid-Base Disturbance [ ] | [ ]
Water for Inj (10ml ampoule) | [ ] | [ ]
Oral Rehydration Salt Powder (WHO Formulation) | [ ] | [ ]

3.21. Vitamins and Minerals
Ferrous Sulphate Tabs 200mg | [ ] | [ ]
Folic Acid Tabs 5mg | [ ] | [ ]
Vitamin B Complex Tabs | [ ] | [ ]
Multivitamin Tabs | [ ] | [ ]

3.22. Miscellaneous
Suture materials | [ ] | [ ]
Sterile Medicated (Antimicrobial) | [ ] | [ ]
Paraffin Gauze 10cmx10cm (pkt) | [ ] | [ ]

Available Not available

4. Dental Services
Tooth Extraction | [ ] | [ ]

Available Not available

5. Nursing and Midwifery Services

5.1. Regular Nursing Care
Drugs and vaccines Administration | [ ] | [ ]
Observations of vital signs | [ ] | [ ]
Temperature | [ ] | [ ]
Pulse | [ ] | [ ]
Respirations | [ ] | [ ]
Blood Pressure | [ ] | [ ]
Tepid Sponging | [ ] | [ ]
Specimen Collection | [ ] | [ ]
Blood | [ ] | [ ]
Sputum | [ ] | [ ]
Swab (Cervix, Pus, Throat, etc) | [ ] | [ ]
Stool | [ ] | [ ]
Urine | [ ] | [ ]
Pap Smear fixation | [ ] | [ ]
Suction | [ ] | [ ]
Disinfection and sterilization (per pack) | [ ] | [ ]

5.2. Specific Nursing Proceeders
Ear syringing | [ ] | [ ]
Giving Enema | [ ] | [ ]
Giving suppository | [ ] | [ ]
Eye swabbing/irrigation | [ ] | [ ]
Surgical Dressing | [ ] | [ ]
5.3. Family Planning Procedures

Counselling client for Family Planning [ ] [ ]
IUCD insertion/removal [ ] [ ]
Barrier method (Condom, Diaphragm) [ ] [ ]
Surgical Contraception/Norplant Insertion and removal [ ] [ ]
Natural Family Planning Method [ ] [ ]
Education/Training [ ] [ ]
Hormonal Contraceptives [ ] [ ]
   Oral [ ] [ ]
   Injectables [ ] [ ]

6. Surgical Services

6.1. General Surgery

Minor Surgery [ ] [ ]
   Incision and Drainage [ ] [ ]
   Suturing of cut wounds [ ] [ ]
Intermediate Surgery [ ] [ ]
   FB excision [ ] [ ]
   Toe Nail Excision [ ] [ ]

6.2. Obstetrics and Gynaecology

Minor Surgery [ ] [ ]
   I and D of Cyst/Abscess [ ] [ ]
   Norplant Insertion/Removal [ ] [ ]
   Pap Smear [ ] [ ]

6.3. E.N.T – Surgery

Intermediate Surgery [ ] [ ]
   Emergency Tracheostomy [ ] [ ]
   Suturing of Wounds (facial) [ ] [ ]

6.4. Oral and Maxillofacial Surgery

Minor Procedures [ ] [ ]
   Drainage/excision facial sebaceous syst [ ] [ ]
   Minor facial soft tissue repair [ ] [ ]
   Incision/excision biopsy minor oral/facial lesion [ ] [ ]
   Labial/lingual fraenoplasty/fraenectomy [ ] [ ]
   Removal of IMF [ ] [ ]

11.2. Level II Care

1. Staff

1.1 Out Patient
   Nurse/Midwife [ ] [ ]
   Clinical Officer [ ] [ ]
   Community Oral Health Officer [ ] [ ]
### 1.2 In-patient

<table>
<thead>
<tr>
<th>Service</th>
<th>Medical Officer</th>
<th>Dental Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Bed and meals per day</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

#### Available | Not available

### 2. Laboratory Tests and investigations

<table>
<thead>
<tr>
<th>Test</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Haemoglobin</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Differential white cell count</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Peripheral Blood Film</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Sickle Cell Test</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>ABO &amp; Rh Grouping</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Syphilis Screening</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Gram Stain</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Ziel Nielsen Stain</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Potassium Hydroxide Preps</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Wet preparation</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Urinalysis</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>HIV Test</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Pregnancy Test</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Widal Test</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

*Note:* This test is highly unsatisfactory and should probably be deleted and replaced by more appropriate clinical guidelines.

<table>
<thead>
<tr>
<th>Test</th>
<th>Medical Officer</th>
<th>Dental Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stool for o/c</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Blood Slide / thick film for Malaria Parasite</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>+++Cervical Smears – cytology (including evaluation?)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Urine Microscopy (deposit)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Blood Glucose</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Blood Transfusion Collection, Screening and Storage Compatibility Test and Blood Unit</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

*Note:* This should be reviewed in an expert panel of DMOs.

### 3. Drugs administration and dispensing (as per MOH essential drug list and clinical guidelines)

#### 3.1 General Anaesthetics & Theatre Agents

<table>
<thead>
<tr>
<th>Drug</th>
<th>Medical Officer</th>
<th>Dental Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diazepam Inj. 5mg/ml (ampoule)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Oxygen Inhalation</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

#### 3.2 Local Anaesthetics

<table>
<thead>
<tr>
<th>Drug</th>
<th>Medical Officer</th>
<th>Dental Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lignocaine HCl Inj 2% (50ml bottles)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Ethyl Chloride Spray 100 ml.</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Lignocaine Dental Catridge</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

#### 3.3 Non-Opioids and NSAIDS

<table>
<thead>
<tr>
<th>Drug</th>
<th>Medical Officer</th>
<th>Dental Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin Tabs 300mg</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Indomethacin Caps 25mg</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Paracetamol Paediatric Oral Sup 120mg/ml (100ml bottle)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Paracetamol Tabs 500mg</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Ibuprofen Tabs 200mg</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Ibuprofen syrup 100mg/5ml/60ml (bottle)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Linement 100ml/s</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

#### 3.4 Anti-Allergics & Drugs used in Anaphylaxis

<table>
<thead>
<tr>
<th>Drug</th>
<th>Medical Officer</th>
<th>Dental Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adrenaline Tart Inj 1mg/1ml(ampoule)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Chlorpheniramine Maleate Inj 10mg/ml (ampoule)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Chlorpheniramine Maleate syr 2mg/5ml(bottle)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Chlorpheniramine Maleate Tabs 4mg</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Hydrocortisone Sodium Succinate Inj 100mg Base (vial)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

#### 3.5 Non – Specific Antidotes & other substances used in poisoning

<table>
<thead>
<tr>
<th>Drug</th>
<th>Medical Officer</th>
<th>Dental Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Charcoal Tabs 125 mg</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

#### 3.6 Specific Antidotes & other substances used in poisoning

<table>
<thead>
<tr>
<th>Drug</th>
<th>Medical Officer</th>
<th>Dental Officer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Atropine Sulphate Inj 1mg/ml (IV &amp; IM per vial)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Pralidoxime Mesylate (PAM) Inj (review need at this level)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>
### 3.7 Antiepileptics/Anticonvulsants
- **Diazepam Inj 10gm/2ml (IV&IM per ampule)**
- **Phenobarbitone Tabs 30mg**

### 3.8 Anti-infective drugs - Anthelminthics
- **Mebendazole Suspension 100mg/5ml (bottle)**
- **Mebendazole Tabs 100mg**
- **Niclosamide Tabs 500mg**
- **Albendazole chewable Tabs 400mg**
- **Albendazole Syrup 400mg/10ml**
- **Levamisole Hydrochloride Tabs 50mg (pack of 3)**
- **Levamisole Hydrochloride Syrup 40mg/5ml (bottle)**
- **Praziquantel Tabs 600mg**

### 3.9 Antibacterials – Oral Liquids
- **Amoxycillin Susp 125mg/5ml (100ml bottle)**
- **Co-trimoxazole Susp 200:40/5ml (50ml bottle)**
- **Erythromycin Ethyl Succ, dry 200mg/5ml**
- **Ampicillin/Cloxacillin Neonatal drops 60mg/30mg**

### 3.10 Antibacterials – Oral Tabs/Caps
- **Amoxycillin Caps 250mg**
- **Amoxycillin Caps 500mg**
- **Amoxycillin 250mg+Clavulanic Acid 125mg Tabs**
- **Co-trimoxazole Tabs 400:80**
- **Doxycycline HC1 Caps 100mg**
- **Nitrofurantoin Sodium Tabs 100mg**
- **Nalidixic acid Tabs 500mg**
- **Tetracycline Caps 250mg**
- **Norfloxacin 400mg tablets**

### 3.11 Antibacterials - Injectables
- **Benzathine Penicillin Inj 2.4 IV (vial)**
- **Benzyl Penicillin Inj 1MU(vial)**
- **Fortified Procaine Penicillin Inj 4.0 MU (vial)**
- **Triple Penicillin Inj 6:3:3**
- **Gentamycin 80mg/2ml**
- **Gentamycin 20mg/2ml**

### 3.12 Antifungals
- **Clotrimazole Cream 1% 15gms**
- **Clotrimazole Vaginal Pessaries 100mg**
- **Clotrimazole ear drops 1% 20gms**
- **Benzocid acid 6% + Salicylic acid 3% Oint.**
- **Nystatin Oral Suspension 100,000 Units/ml (24ml)**
- **Nystatin Ointment**

### 3.13 Antiprotozoal Drugs
- **Metronidazole Tabs 200mg**
- **Amodiaquine 200 mg tabs**
- **Amodiaquine suspension 50mg/5ml**
- **Sulfadoxine 500mg + Pyrimethamine 25mg Tabs**
- **Sulphamethopyrazine + Pyrimethamine Drops 10mg**

### 3.14 Antimigraine Drugs
- **Aspirin Tabs 300mg**
- **Paracetamol Tabs 500mg**

### 3.15 Dermatological Drugs
- **Benzyl Benzoate Emulsion 25% x 100mls**
- **Compound Benzoic acid 6% + salicylic acid 3%**
- **Calamine lotion 100ml**
- **Gentian Violet Crystals Powder 10gms**
- **Hydrocortisone Skin Oint 1% 10g**

### 3.16 Gastrointestinal Drugs
- **Compound Magnesium Trisilicate Tabs**
- **Oral Rehydration Salts Powder (WHO Formulation)**
### 3.17 Hormones, Endocrine Drugs and Contraceptives

<table>
<thead>
<tr>
<th>Item</th>
<th>Available</th>
<th>Not available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compound Magnesium Trisilicate Mist (100ml bottle)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Adrenal Hormones and Substitutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hydrocortisone Sodium Succinate 100mg Base</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Hormonal Contraceptives (to be provided by national programme)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ethinylestradiol + Levonorgestrel Tab (30mcg+150mcg packet)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Ethinylestradiol + Norethisterone Tab (35mcg+1.0mcg packet)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Oxytocics &amp; Antioxytocics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ergometrine Maleate Inj 500mcg/ml</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

### 3.18 Immunologicals (Vaccines) (to be provided by national programme)

<table>
<thead>
<tr>
<th>Item</th>
<th>Available</th>
<th>Not available</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCG Vaccine Dried Powder (per 10 dose vial)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Diphtheria-Pertussis-Tetanus Vaccine (ampoule)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Hepatitis B Vaccine</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Measles Vaccine</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Poliomyelitis Oral Vaccine (per 10 dose vial)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Rabies Vaccine (is this part of national vaccination policy?)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Tetanus Toxoid Vaccine</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Pentavalent Vaccine</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Anti-venom (10ml ampoule) (appropriate for this level of care?)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

### 3.19 Ophthalmologicals & ENT Preparations

<table>
<thead>
<tr>
<th>Item</th>
<th>Available</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Tetracycline Eye Oint 1% 3.5g</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Zinc Sulphate 0.25% Eye Drops</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Oxymetacaine 3% + Hydrocortisone 1% Ear Suspension</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

### 3.20 Psychotherapeutic Drugs

<table>
<thead>
<tr>
<th>Item</th>
<th>Available</th>
<th>Not available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlorpromazine HCl Inj 50mg/2ml</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Chlorpromazine HCl Tabs 100mg</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Chlorpromazine HCl Tabs 25mg</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Fluphenazine Decanoate Inj 25mg/1ml</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

### 3.21 Respiratory Tract Drugs

<table>
<thead>
<tr>
<th>Item</th>
<th>Available</th>
<th>Not available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aminophylline Inj 25mg/ml IV (10ml)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Salbutamol Syrup 2mg/5ml (100mls)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Salbutamol Tabs 2mg</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Salbutamol Tabs 4mg</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

### 3.22 Solutions for Water, Electrolyte & Acid-Base Disturbance

<table>
<thead>
<tr>
<th>Item</th>
<th>Available</th>
<th>Not available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Darrow Solution ½ Strength (500ml)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Dextrose Inj 50% W/V (50ml)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Dextrose Inj 10% W/V (500ml)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Dextrose Inj 5% W/V (500ml)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Normal Saline Inj 0.9% (500ml)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Water for Inj (10ml)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

### 3.23 Vitamins and Minerals

<table>
<thead>
<tr>
<th>Item</th>
<th>Available</th>
<th>Not available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ferrous Sulphate Tabs 200mg</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Folic Acid Tabs 5mg</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Vitamin B Complex Tabs</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Multivitamin Tabs</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Multivitamin Syrup 100ml</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

### 3.24 Pharmaceutical Dressings

<table>
<thead>
<tr>
<th>Item</th>
<th>Available</th>
<th>Not available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sterile Medicated (Antimicrobial)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Paraffin Gauze 10cmx10cm (pkt)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Sterile Medicated (Antimicrobial)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Paraffin Gauze 15cmx20cm (pkt) (delete at this level?)</td>
<td>[ ]</td>
<td>[ ]</td>
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</table>

### 4. Dental Services

<table>
<thead>
<tr>
<th>Item</th>
<th>Available</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Tooth Extraction</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

Available  Not available
5. **Radiology Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>Available</th>
<th>Not available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hand and Finger – AP/LAT</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Wrist Joint - AP/LAT</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Forearm - AP/LAT</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Chest - PA</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Chest – PA &amp; LAT</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Clavicle – PA/AXIAL</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Scapula – AP/LAT</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Sterno-Clavicular</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Foot and Toes – AP/LAT</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Ankle Joint – AP/LAT</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Leg – AP/LAT</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Knee Joint – AP/LAT</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Skull – AP/LAT</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Plain Abdominal x-ray</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Facial Bones – A.P.&amp;LAT</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Orbits – O.M.&amp; LAT</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Mandible – A.P &amp; Obliqs</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Dental (I.O.P.A)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Dental (OCCLUSAL)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Bite Wings</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

6. **Nursing and Midwifery Services**

6.1 **Regular Nursing Care**

<table>
<thead>
<tr>
<th>Service</th>
<th>Available</th>
<th>Not available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs and Vaccines Administration</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Observations of vital signs</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Temperature</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Pulse</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Respiration</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Personal Hygiene Care</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Bed bath</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Skin Care</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Treatment of pressure areas</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Tepid Sponging</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Specimen Collection</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Blood</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Sputum</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Swabs (Pus, throat, etc)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Stool</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Urine</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Pap Smear</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Oxygen Administration and care per hr.</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Disinfection and Sterilization(pack)</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Suction</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Intravenous infusion care</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>

6.2 **Specific Nursing Procedures**

<table>
<thead>
<tr>
<th>Service</th>
<th>Available</th>
<th>Not available</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ear syringing</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Giving Enema</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Giving suppository</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Last offices</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Eye swabbing/irrigation</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Tube feeding</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Surgical Dressing</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Small wound</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Medium wound</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Catheterization and Removal of urinary Catheter</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Washout/lavage</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Stomach</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Suturing</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
</tbody>
</table>
### 6.3 Midwifery Procedures
- Labour monitoring including partographing and Normal delivery

### 6.4 Family Planning Procedures (to be remunerated separately under the national RH Policy)
- Counselling client for Family Planning
- Papanicolaou smear
- IUCD insertion/removal
- Barrier method per month
- Surgical Contraception/Norplant Insertion
- Natural Family Planning Method Education
- Hormonal Contraceptives
- Injectables

<table>
<thead>
<tr>
<th>Available</th>
<th>Not available</th>
</tr>
</thead>
</table>

### 7. Surgical Services

#### 7.1 General Surgery
- Minor Surgery
- Incision and Drainage
- Circumcision (optional service to be remunerated privately)
- Excision of lipoma
- Excision of Ganglion
- Excision of Sabaceous Cyst
- Incision and Drainage
- Excision of lipoma
- Lymph Node Biopsy

#### 7.2 Orthopaedic Surgery
- Minor Surgery
- Skin Traction
- Joint Aspiration
- POP Applications
- Intermediate Surgery
- I & D of pyomyositis
- Surgical toilet/debridement
- Hip Spica Application
- Manipulation Under GA and POP application

#### 7.3 Neurosurgery
- Minor Surgery
- Suture of scalp wounds (GA&LA)

#### 7.4 Cardiothoracic Surgery
- Minor Surgery
- Thoracocentesis

#### 7.5 Paediatric Surgery
- Minor surgery
- Release of Tongue Tie

#### 7.6 Endoscopy (refer to level III ?)
- Minor Surgery
- Proctoscopy
- Rectal Snip

#### 7.7 Urology
- Minor Surgery
- Supra pubic Cystostomy

#### 7.8 Obstetrics and Gynaecology
- Minor Surgery
- I and D of Cyst/Abcess (MVA)
Norplant Insertion/Removal [ ] [ ]
Pap Smear [ ] [ ]
Intermediate Surgery [ ] [ ]
  Cervical Tear Repair [ ] [ ]
  Evacuation of placenta [ ] [ ]
  Normal Delivery [ ] [ ]
Major Surgery [ ] [ ]
  Caesarean Section [ ] [ ]
  Ectopic Pregnancy Rupture [ ] [ ]
  Salpingectomy [ ] [ ]

7.9 Oral and Maxillofacial Surgery
Minor Surgery [ ] [ ]

Available Not available

8. Physiotherapy Services
Exercise therapy (per session) [ ] [ ]
  general exercise [ ] [ ]
  pre & post natal [ ] [ ]
  pre & post operative [ ] [ ]
  specialized exercise training [ ] [ ]
  keep fit / group exercise [ ] [ ]
manipulative therapy [ ] [ ]
  reduction of joints, fractures and POP immobilization / splinting [ ] [ ]
  passive stretching [ ] [ ]
  active movements [ ] [ ]
  firm / pressure banging [ ] [ ]
traction [ ] [ ]
  intermittent [ ] [ ]
  continuos [ ] [ ]

Available Not available

9. Occupational Therapy Services

[ ] [ ]

Available Not available

10. Orthopaedic Services and Appliances
The fund will not pay for orthopaedic services (except Orthopaedic surgery under surgical services) and appliances at the initial stages, but may consider their inclusion into the payment scheme at later dates (See appendix ## for details).

Available Not available

11. Mortuary Services (available at level II?)
Cold storage up to a maximum of three days for facilities within inpatient services only [ ] [ ]
12. Annex 4: The five levels of the Kenyan health care system

From the Benefit Package Document, Draft 10.

12.1. Level I – dispensary
Constitutes Primary Curative care services and only limited Preventive and Promotive Care given to clients and patients in their homes, clinics, dispensaries, outreach services, school health and any other facilities that may be classified under this category by nature of the services rendered. Services at this level are exclusively out-patient in nature.

12.2. Level II – health centre
Constitutes higher curative and limited preventive and promotive care above and in-addition to those offered in Level I. This is the lowest level where limited in-patient services are offered in-addition to out-patient services.

12.3. Level III – district/subdistrict hospital
Constitutes higher in-patient and out-patient services above and in-addition to those given at Level II, which are comprehensively general with limited specialised care.

12.4. Level IV – provincial hospital
Constitutes comprehensive specialised in-patient and out-patient care above and in-addition to those services rendered in Level III, and limited high skilled health care.

12.5. Level V – national referral and teaching hospital
Constitutes comprehensive high skilled in-patient and out-patient care above and in-addition to those rendered in Level IV.
13. Annex 5: Team presentation of key issues

See separate PowerPoint file.

See separate PowerPoint file.

Implementation of NSHIF

Suggestions for the project management
Christoph Lankers
GTZ / WHO mission Team
Nairobi, 8 August 2003