



**DFID**



## **National Social Health Insurance**

### **Progress review of the initial implementation stage and recommendations**

Joint WHO – GTZ - DFID – ILO Mission<sup>1</sup> to Kenya

29<sup>th</sup> March to 2<sup>nd</sup> April 2004

---

<sup>1</sup> Mission Members: Dr. Guy Carrin (WHO), Prof. Dr. Rolf Korte (GTZ), Mr. Christoph Lankers (Luther and Partner), Dr. Xenia Scheil-Adlung (ILO), Mr. Daniel Whitaker (DFID).

## TABLE OF CONTENTS

Acknowledgements.....	3
Abbreviations.....	4
<b>1. Background.....</b>	<b>5</b>
<b>2. Assessment of the activities of the NHIF Working Groups.....</b>	<b>6</b>
<b>2.1 Quality and Contracting.....</b>	<b>6</b>
2.1.1 Accreditation and benefit package standards.....	7
2.1.2 Contracting.....	9
2.1.3 Registration.....	11
<b>2.2 Publicity and education.....</b>	<b>11</b>
2.2.1 Inter-NHIF organizational issues.....	11
2.2.2 Internal information provision.....	12
2.2.3 External information provision.....	12
2.2.4 Collection and dissemination of feedback.....	13
<b>2.3 Management, Training and IT.....</b>	<b>13</b>
<b>2.4 Monitoring and Evaluation.....</b>	<b>18</b>
<b>3. Additional issues.....</b>	<b>21</b>
3.1 Consultation process.....	21
3.2 Challenge of covering the poor and informal sector workers.....	22
3.3 Inclusion of HIV/AIDS/TB/Malaria in the benefit package (NSHIFplus).....	22
<b>4. Conclusions and milestones.....</b>	<b>23</b>
<b>5. Proposed TOR for forthcoming technical assistance mission.....</b>	<b>24</b>
<b>Annex 1 Draft structure of the Quality Report.....</b>	<b>25</b>
<b>Annex 2 Summary Tables.....</b>	<b>27</b>
<b>Annex 3 Summary of Activities.....</b>	<b>33</b>
<b>Annex 4 Proposed technical assistance (2004-2005).....</b>	<b>34</b>
<b>Annex 5 Electronic mail addresses of mission team members.....</b>	<b>35</b>

## **Acknowledgements**

The Mission received strong support through the leadership of the Hon. Charity Kaluki Ngilu, Minister for Health and PS W.Godo. We would also like to express our appreciation to Dr. Tom Mboya Director DSRS and Dr. Hassan, CEO NHIF. Mr Willis Okumu Obam and Mr Chris Rakuom were most helpful in facilitating our work. We are indebted to the team leaders and the members of the different NHIF Working Groups for the open discussions about their current activities, the difficulties and the progress. The discussions with the area managers and their staff in Thika and Machakos districts, as well as with the senior staff of the health facilities visited were most helpful.

We also wish to express our appreciation for the cooperation and encouragement received by Dr. P. Eriki, WHO Representative and Dr Henri v.d. Hombergh, GTZ Country Programme Coordinator. Dr Joyce Onsongo (WHO Country office) provided valuable assistance during the mission. We also thank our drivers for facilitating the transportation during the mission. Finally, thanks to Manique Abayasekara for her assistance on the editing of this mission report.

## Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal clinics
ART	Anti-Retroviral Therapy
DFID	Department for International Development (UK Bilateral Aid Agency)
DMO	District Medical Officer
DMS	Director of Medical Services
DSRS	Department of Standards and Regulatory Services
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH, (German Technical Cooperation)
HMO	Health Maintenance Organisation
ILO	International Labour Organization
IT	Information Technology
ITN	Insecticide-treated Nets
JICC	Joint Inter-agency Co-ordination Committee
KEMSA	Kenya Medical Supplies Agencies
KMA	Kenya Medical Association
KRA	Kenya Revenue Authority
MDG	Millennium Development Goals
MEDS	Mission for Essential Drugs and Supplies
MOH	Ministry of Health
NGO	Non-Governmental Organization
NHIF	National Hospital Insurance Fund,
NSHI	National Social Health Insurance
NSHIF	National Social Health Insurance Fund
NSSF	National Social Insurance Fund
PEPFAR	Presidential Emergency Plan for Emergency AIDS Relief.
PRSP	Poverty Reduction Strategy Paper
RBA	Retirement Benefit Authority
SBP	Standard Benefit Package
TB	Tuberculosis
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

## 1. Background

This report presents the findings of the fifth mission concerning the development of national social health insurance (NSHI) in Kenya by WHO-GTZ together with DFID and the International Labour Organisation (ILO). The main objective of this mission was to review the progress of the initial stage of the implementation of the new NSHI, to make recommendations and to formulate milestones in the development of the NSHI.

This fifth mission builds upon findings and recommendations of the previous four missions. The first mission (June 03) made a thorough review of the Strategy Paper and draft bill of NSHI, which led to the current draft of the Sessional Paper of National Social Health Insurance. The second mission (August 03) focused on the legal aspects of the NSHI Bill, the benefit package and provider payments, the transition of the current National Hospital Insurance Fund (NHIF) into the National Social Health Insurance Fund (NSHIF), and the initial implementations tasks of the scheme. The third mission (October 03) has focused on health insurance management and on the financial feasibility of the implementation of the NSHI. The fourth mission (January 04) concentrated on progress toward implementation of the NSHI, addressing thereby the change management process. It also interacted with the newly established NHIF Working Groups on quality and contracting, public information and education, and training and management.

The present mission was in Kenya from 29<sup>th</sup> March to 2<sup>nd</sup> April 2004. The mission team had the following members: Dr Guy Carrin (senior health economist, WHO and team leader), Dr Rolf Korte (senior health policy advisor, GTZ), Mr Christoph Lankers (management advisor, Luther and Partner), Mr. Daniel Whitaker (health economist, DFID) and Dr Xenia Scheil-Adlung (senior health specialist, ILO)<sup>2</sup>.

The terms of reference for the mission were as follows:

- Review progress and milestones towards implementation of the NSHIF;
- dialogue with selected national stakeholders, including the health service providers, and with international donors concerning the progress of implementation;
- technical consultations with the NHIF's Working Groups on quality and contracting, publicity and information, training and management, and monitoring and evaluation;
- advise on the implementation of NSHI in three pilot districts;
- assess methods for identification of the poor;
- review of training needs for district health staff and NHIF area office personnel, including training-of-trainers.

The mission team wants to highlight first the important progress made through the further development of activities within the three above mentioned Working Groups (including the establishment of a sub-Working Group on Information Technology) and creation of a fourth Working Group on Monitoring and Evaluation. In general, the Working Groups have been assessed as confident and dynamic and highly motivated. Furthermore, the establishment of a *Master Workplan* for the management of the future NSHIF is an important step.

In the next chapter, we assess the activities undertaken by the four Working Groups as well as the impact of these activities for the operations in two pilot districts (Thika and Machakos). Additional issues of importance for implementation of the NSHI are discussed in chapter 3.

---

<sup>2</sup> The electronic mail addresses of the mission team members can be found in Annex 5.

Finally, in chapter 4, conclusions and milestones are presented. For a summary of activities of the mission team during its stay in Kenya, we refer to Annex 3.

## **2. Assessment of the activities of the NHIF Working Groups**

The Project on implementing NSHI and on setting up the pilot areas in Thika, Machakos and Migori has started and made considerable progress since the last mission in January 2004. NHIF established a project structure with the National Steering Committee (chaired by the Hon. Minister of Health), a Management Task Force staffed from NHIF and MOH (chaired by the CEO of NHIF) and a Project Secretariat, coordinating and supporting the individual Working Groups, of which there are four: (1) Quality and Contracting, (2) Management, Training and IT, (3) Publicity and Education, (4) Monitoring and Evaluation. For IT a sub-Working Group has been established.

The implementation of the various tasks is now guided by the Master Workplan. The latter was proposed as a major planning tool during the 2<sup>nd</sup> mission in August 03. While there is still need to further specify and improve the implementation process (and strengthen the coordination capabilities), the process in general is very promising and will facilitate considerably the starting up of the NSHIF in the pilot areas. We now present the mission findings and suggestions from the different Working Groups.

### **2.1 *Quality and Contracting***

The team leader of the Working Group on Quality and Contracting is Dr G.J. Midiwo, Chief Manager Standards and Quality Assurance at NHIF.

Since the last mission, the Working Group progressed significantly by following clearly defined objectives to be reached on a weekly basis. The tasks aimed particularly at ensuring

- Efficiency in accreditation and contracting and
- Quality of care and service provision in NSHI.

It had been decided to start the implementation of NSHI in three pilot areas in order to test the functioning of important scheme features such as

- Accreditation criteria for identifying providers
- Process of accreditation
- Application and use of Standard Benefit Packages (SBP)<sup>3</sup>
- Effectiveness of contracting health care facilities.

The three pilot areas selected were Thika, Machakos and Migori. Criteria for selection included proximity to Nairobi, industrial, urban, peri-urban and rural populations in the case of Thika and Machakos and a more difficult remote, predominantly rural poor population in Migori.

---

<sup>3</sup> On Standard Benefit Packages, see 'National Social Health Insurance Strategy. Findings and Recommendations of the joint WHO/GTZ mission on Social Health Insurance in Kenya (July 28-August 8,2003), Part III.

### 2.1.1 Accreditation and benefit package standards

The accreditation process is initiated by voluntary applications of hospitals and health care facilities. Requests for application need to be forwarded to the NSHIF. Following the application a team of peer-reviewers is carrying out an on-site evaluation.

The evaluation is based on the Kenya Quality Model (KQM), which describes structure, process and outcome related standards for the provision of health services. A selection of specific KQM process-related standards has been further developed for the purpose of accreditation. Besides accreditation, they aim at improving delivery and quality of services, thereby introducing cost containment elements. The standards are also used in the establishment of the referral system.

Based on these standards, hospitals and health care facilities are classified into five different levels:

Level I:	Private ambulatory services
Level II:	Dispensaries providing outpatient care
Level III:	Health care centers or equivalent providing outpatient and some forms of inpatient care
Level IV:	District, sub-district or equivalent hospitals providing both outpatient and inpatient care
Level V:	Provincial hospitals or equivalent providing both outpatient and inpatient care
Level VI:	Teaching and referral hospitals providing both outpatient and inpatient care.

Criteria for distinction of the different levels include availability of equipment and staff of health care institutions for purposes such as

- Consultations
- Laboratory investigations
- Administration and dispensing of drugs
- Dental health care services
- Radiological examinations
- Nursing and midwifery services
- Physiotherapy services
- Surgical services
- Occupational therapy services
- Orthopedic services
- Mortuary services
- Specialist treatment etc.

In turn, the health services available at these different levels are linked to the NSHI Standard Benefit Packages (SBPs) as well as to the schedule of provider payments or rebates. The SBP standards could profit from improved clarity. Improved clarity would lead to more consistency in accreditation, reduce possibilities of manipulating classifications and facilitate monitoring activities at hospital level.

Refining standards on patient safety and quality of care would be beneficial for patients and improve the overall performance of facilities. It needs to become a major focus of contracting to strengthen the usage and the controlling of quality standards, possibly starting with the

implementation of acknowledged standards for surgical procedures. In addition, the contractual arrangements should encourage the gradual adoption of clinical guidelines e.g. the WHO IMCI (Integrated Management of Childhood Illnesses) and the presentation of facility related quality reports that have to be submitted not later than 3 months before application for re-accreditation. A draft for the structure of a quality report is attached in the Annex 1. Thus, initially a facility-based mechanism is proposed. At a much later stage, standards or clinical guidelines could be harmonized by the NSHIF.

In the two pilot areas visited, a number of hospitals and health care facilities have already been selected and undergone the process of accreditation:

- In the area of Machakos nine hospital facilities (including Machakos Provincial Hospital, The Shalom Hospital and Bishop Kioki Mission Hospital) and three health centers have been accredited. Teams composed of staff from the NHIF area office and headquarters carried out peer-reviews of the accredited facilities. These teams did not yet include medical professionals, however.
- In Thika:
  - Five facilities have been accredited, while others could not meet the standards particularly due to lacking hygiene. Accredited facilities in Thika include the District Hospital, the Githumu Mission Hospital, two health centers and one nursing home with a dispensary.
  - In the Thika area, the private health care facilities of Del Monte Company (4 dispensaries) were not included as pilot projects as they provide employer-based health services to their staff. Del Monte facilities would, however, be a competent partner to further develop outpatient procedures and perform cost analyses. It is, therefore, recommended to include at least one of these facilities into the testing phase.

A number of recommendations can now be formulated:

1. It is recommended to incorporate the principle of quality management in the contracts between the NHIF and service providers.
2. In the longer run it is recommended to take patient satisfaction into account. Introducing a survey of selected patients or residents who are under care in the facility and discussing results in the context of the accreditation process might achieve higher patient satisfaction. Further, the accreditation process could be facilitated and carried out more effectively if a self-assessment of the facilities would be introduced before the on-site visit takes place. The self-assessment could be based on a quality report drafted along a general framework. The report should be provided to NHIF, which could then carry out a control based on the indications received.
3. Additional steps in improving the accreditation process include establishing autonomous bodies, in charge of accreditation and quality assurance, which is already being planned.
4. It is also recommended to introduce several levels of accreditation, e.g. full accreditation, provisional accreditation and conditional accreditation in order to provide incentives for continued improvement and to allow accreditation of health facilities in underserved areas.
5. Future peer-reviews would probably benefit if neutral medical expertise would be included in the team. This would allow to effectively review clinical procedures and medical equipment such as laboratories and their maintenance.
6. It is recommended to include in the on-site evaluation process the development of a plan of action for improving health facilities. An evaluation of progress should be carried out

during periodic reviews before the end of the accreditation period. This will lead to a more continuous process of accreditation and thereby provide incentives for ongoing compliance with standards and continuous quality improvement.

7. The mission got the impression that particularly providers are not yet fully aware of the process of accreditation, contracting and its implications. Therefore, communication and training remains a major task for NHIF.
8. It will be important to ensure that facilities in rural and remote areas will be equally included in the accreditation process in order to improve access for the mostly poor population living in these areas. When standards are not met (e.g. due to a lack of infrastructure) and accreditation of facilities in such areas is not (yet) possible, it is suggested to develop measures such as upgrading of facilities in order to be accredited. The MoH needs to ensure that capital funds are made available for such regions so that eventually such sub-standard facilities can become accredited.

There are other means to improve access of the poor to health care. It might be useful to study which financial incentives could be designed in order to stimulate improvements in quality. For example, provider payments (rebates) in underserved regions need to especially account for costs related to distance. In addition, financial allowances for staff on top of their basic wage may be considered in order to ensure their availability in such regions. Geographical targeting of financial incentives might be linked to a ranking of communities, e.g. based on the percentage of the poor among the population and availability of health care infrastructure. The members of the mission have been informed that a ranking of communities has been carried out on the national level.

Further measures on the demand side consist of reimbursement of transportation costs for the poor in case of severe illnesses or referral from lower level facilities to higher level facilities and development of home-based care can also be explored.

### *2.1.2 Contracting*

A number of activities in this area of work are currently undertaken by the NHIF, but will obviously serve the future NSHIF. Providers meeting the accreditation criteria will be offered a contract by the future NSHIF [a provider may still decline, however]. An early draft of a model contract between the NSHIF and service providers has been developed by the NHIF. This draft contains many essential items. It is foreseen to introduce a limited duration (which should not extend 2 years nor be less than 1 year), which might be extended after re-evaluation of the facilities.

Further, the contract defines the provider payments corresponding to the level of standards met. It specifies issues such as conditions of payments, obligations and rights of both providers and NSHIF.

The members of the mission see, however, scope for further refinement of the contract particularly regarding specification of duties and rights of providers and NSHIF:

1. The contract should mention that health care is provided following the Kenyan treatment guidelines, alternatively the respective WHO guidelines or guidelines that have been specifically adapted for use at the facility following the principles of evidence based medicine.
2. It should be clarified, that the drugs are to be procured from reputable MoH approved suppliers.

3. Before reaccreditation the facility should prepare a quality report using the prescribed structure as a basis for the external assessment. The quality report should be published.
4. The provider should assure that membership documents are genuine. No rebates should be payable in case of improper or fraudulent use.
5. For treatments anticipated to take longer than seven days, prior clearance from the respective NSHIF area office should be obtained.
6. NSHIF should be informed about treatment required after road traffic accidents. It should be clarified that treatments required after road traffic accidents will initially be covered by the NSHIF. The full cost will be claimed to the respective insurance through NSHIF. In such cases the full treatment cost (in contrast to the flat rate payments for other treatments) will be refunded to the healthcare provider after settlement with the insurance.
7. Obligations of NSHIF should also be included in the contract, including the obligation not to exceed a maximum period for the payment of rebates.

The following structure of the provider contract is proposed:

- a. Designation of contracting partners
- b. Classification of facility
  - Accordingly to the level of Benefit Package Standards met the facility is supposed to provide comprehensive medical care including generic drugs as contained in the national formulary.
- c. Overall objectives of the contract
  - This section should contain operational objectives and scope for improvement of the services offered
- d. Specific development targets for the contracted period
  - The facility should develop a plan of action and establish a quality improvement team following the guidelines of the KQM and participate in quality assurance measures that facilitate a comparison with the performance of comparable providers
- e. Essential background documents
- f. Obligations of the contractor
- g. Obligations of NSHIF
- h. Breach of contract
  - Termination of the contract should not be the only sanction foreseen in the contract. In view of the need to ensure continuous health services, the use of financial sanctions might be a useful additional instrument to penalize poor performance
- i. Sanctions
- j. Termination of contract
- k. Annexes

Further aspects that should be addressed in the contract deal with the following questions: Who will bear the costs in case of medical disagreement? Should co-payments be introduced for self-referral? Who will judge whether revisits were inappropriate, and should these be excluded from payment, ?

In addition, it might be useful to specify some of the terms used in the draft contract such as “critical illness” and define the maximum length of stay for certain treatments.

### *2.1.3 Registration*

Further issues tackled in the Working Group on Quality and Contracting concerned activities related to registration of members.

Registration of members requires identification of applicants and family members through identity cards or passports and photos. Application forms have been designed and 500.000 copies will be available for the pilot areas.

It is not clear if this form of registration will also be used to register persons living and working in the informal sector. Potential problems related to such an approach might include lack of proof of identity such as passports, birth certificates, and addresses. Overcoming these issues will be key in avoiding fraud and misuse of member cards.

It is suggested to develop specific registration methods for persons living in the informal sector, e.g. based on additional information such as names of parents, maiden names, spouse's name etc.

Registering the poor also requires a specific methodology for assessing the income status. Despite the Government's commitment to provide free cards to about 30 per cent of the Kenyan population living in poverty no specific procedures have yet been developed beyond the broad concepts presented in conjunction with the development of the sessional paper

A common problem with registration of employers relates to evading registration. Particularly, small enterprises and enterprises in the informal economy might try to evade payment. It is therefore recommended to use all available information from authorities in districts and communities in order to identify employers to support the registration process. Some policing and enforcement powers may have to be given to NSHIF similar to the Kenya Revenue Authority (KRA)

We refer to Table 1 in Annex 2 for summarized information on:

- The status of major tasks achieved with regard to accreditation, contracting and registration
- An assessment of the situation
- Suggestions for further improvement.

## ***2.2 Publicity and education***

This Working Group is led by Emily Mworira. It was at first charged with providing information about the new NSHIF system to interested parties. These duties have since grown also to include gathering feedback information on perceptions of the NSHIF proposals and the dissemination of this intelligence to other Working Groups in order to aid them in their work.

### *2.2.1 Inter-NHIF organizational issues*

As with other Working Groups, there were initially problems of coordination with other groups and over use of resources. The Project Secretariat needs to strengthen its coordinating function. Now that a Master Workplan is in place, the groups can see what tasks each other have accomplished and are planning to do. Regular meetings have been held, with a coordinator appointed (Mr Pius Metto). However, there still needs to be improvement in the exchange of more detailed information between groups. For example, if accreditation policy changes, the Publicity and Education (P&E) group needs to know this, so that it can inform prospective

members and their associations. Equally, if the P&E group detects concern regarding care provision in a certain area, this must be transmitted to the Quality and Contracting Working Group so that the latter can take action.

The P&E Working Group, which must by its nature be especially mobile, continues to be hampered by delays in the availability of transport resources, in the form of both cash and vehicles. The group has stated the need for a dedicated vehicle, which would ease its access to groups interested in NSHIF across the three pilot areas. The mission team believes it is important for the Secretariat to act quickly to improve coordination between Working Groups, and to make transport more available. Investments in these various elements now will prove valuable as the new NSHIF scheme is rolled out.

### *2.2.2 Internal information provision*

NHIF staff can only roll out the new NSHIF scheme effectively if they fully understand it, support its aims and have a sense of 'ownership'. The P&E group has attempted to generate this via a series of workshops. Examples are the sensitisation of NHIF senior management (13-14 November, 2003), the workshop for the NHIF board of directors (14-16 January, 2004), training provided for the three pilot area managers and for selected providers within the pilot districts. Where the mission team has been able to speak to the recipients of such training (e.g. Machakos and Thika area managers), the response has been positive. However, it must be realised that particularly the area managers are pivotal in the success of NSHIF, since they will manage the main point of contact for members, prospective members and providers in the pilot areas. The CEO may want to write clear performance contracts with area managers. Area managers should be expected to be actively involved in the piloting process and have a thorough knowledge of their respective areas and the capabilities of the facilities. The mission team believes that this means that further training and support are warranted. This may particularly be the case in Migori. Coordination with the Training and Management Working Group will be important.

### *2.2.3 External information provision*

This area activity provides the bulk of the P&E group's work. A great deal has been accomplished in a short space of time. Yet the challenge of effectively communicating the NSHIF plans to millions of Kenyans in the pilot areas and nationally means that much more remains to be done.

A key method of communication has been meetings. Examples include: a meeting with media executives (20-22 January 2004) and a workshop with editors and reporters (5 March, 2004); meetings and seminars with leading civil servants (4 and 11 February, 2004); meetings with District Commissioners from Thika and Kiambu (2 March, 2004), Machakos (3 March, 2004) and Migori (9 March, 2004); meetings with stakeholders from Thika (12 March, 2004 and Machakos (19 March, 2004). Many further meetings are scheduled, including with health care providers and staff, trade unions and religious organisations.

Other methods of communication include newspaper 'advertorials', radio 'infomercials', participation in radio and TV talk shows (8 planned); TV commercials; and printed pamphlets and posters (English and Swahili). A PR agency has been appointed to advise in this process, and messages have been carefully varied according to audiences. Key NHIF staff have not yet been designated as permanent media contact points, but the mission team has suggested this and believes it will soon occur. The P&E Working Group has also proposed establishment of an information desk, or telephone 'hotline', in order to respond to public queries. The secretariat

needs to ensure that other Working Groups have input into the messages given. An example is how to handle the issue of the voluntary subscription changing from 160/- per family per month (until July 2004) to 400/- per individual per year when the new NSHIF is officially launched.

The Working Group seems to understand well the need to vary the emphasis and language of the message conveyed according to the characteristics of the audience group. However, to refine this, it is important that good feedback be received. Special attention need to be given thereby to the very critical and vocal private sector particularly HMOs

#### *2.2.4 Collection and dissemination of feedback*

The P&E group has been doing this on an ad-hoc basis since the start of their work. Examples of what they have revealed are that in Migori the key concern is that contribution levels may be too high for many prospective members, whereas in Machakos the main worry is that the NSHIF scheme will not be sustainable. All Working Groups need to be aware of these concerns so that they can address them in their contacts with groups and individuals in the pilot areas.

The mission team has suggested that more formalised means of registering feedback be used, such as questionnaires directed at participants in meetings. The P&E group immediately tested this at a meeting with Nairobi health care providers (30 March, 2004). The secretariat needs to establish processes which mean that other Working Groups can have input into the feedback questions asked, and that the feedback results are effectively disseminated.

We refer to Table 2 in Annex 2 for a summary of the assessment of the tasks and issues discussed in this section, and for basic suggestions.

### ***2.3 Management, Training and IT***

The team leader of the Management and Training (M&T) Working Group is Mr Richard Kerich. The impression gained during the mission was that in regard to the topics of management and training, the implementation process has started and that there is an active exchange with the pilot areas. The focus so far was on the information of the current NHIF staff on the new task of NSHIF and on the design of the initial processes. For these, initial solutions have been designed and are being implemented. They will need further detailing, which will continue after July 1<sup>st</sup> (presently, the Master Workplan is designed only until that date). The training of the staff has begun, both with short workshops for all staff members on the setup of NSHIF (in the form of an orientation workshop) and with two week courses to train trainers. The training manuals for the revised structures will still need to be developed.

Another area of attention of the Working Group has been the financial assumptions for NSHIF, which will serve as one basis for the development of a Strategy Plan for NSHIF. Especially this latter task will need a lot of attention, in order to produce a strategy plan that serves both to describe the general objectives of NSHIF (also for communication with stakeholders) and a steering of the complex and decentralized organization in its many aspects (this will need to be supplemented by proper monitoring and controlling tools, see section 2.4 on monitoring and Evaluation).

In the following the status of the major tasks at hand are described and comments and suggestions of the mission are presented:

## 1. *Developing an initial calculation of revenues and expenditure for NSHIF (initial working budget)*

Presently cost calculations on the basis of hospital cases occurring in the regions are undertaken. This will help to arrive at better estimates of the expenditure necessary for the SBPs under status quo conditions. A method of how to precisely predict effects of alterations in usage and provisions after the start has not yet been developed. It is, however, expected that usage per member will go up initially and then stabilize at a certain level. The calculation of the cost will be countered by an account of contributions received. It will also serve to establish cost-containment measures in order to avoid the burden of excessive health care costs on the budget.

In the past NHIF was setting up only a budget for the cost of the administration. The introduction of a budget of the health care expenditure and relating this expenditure to the income is a new and very big step forward. Going one step further ahead, it should be considered to calculate the expected expenditure in various ways (e.g. on the level of present cost, on the level of provide remuneration developed by the last missions and potentially also using econometric methods) and to also test these through various scenarios. In this respect, one could use the earlier financial projections made with the SimIns financial simulation model<sup>4</sup>. This task of the Working Group should receive technical support by economists from the MOH and or NHIF and via future technical assistance.

## 2. *Strategy Plan development*

The Working Group is responsible for the development of a Strategy Plan, outlining the objectives and the derived activities of NSHIF for the coming years. The task is waiting for the finishing of the budget. Next to the budget, the existing Strategy Plan of NHIF and the Sessional paper will be used as starting points for the development of the strategy. The focus of the mission in regard to the Strategy Plan has been on the methodical side. NHIF asked for support in order to develop the strategy plan in a manner that ensures that it is used *within* the organization – which was not the case with the old strategy plan. Emphasis was given on the necessity of both a *top-down* and a *bottom-up* approach in the development of the plan: The management team (first and second level of health insurance managers) needs to design the first outline of objectives, which then need to be discussed in the organization and translated with actual working processes. This will include prioritizing of activities and will also lead to some changes in the set of overall objectives – which needs to be consolidated finally.

The Working Group came to the conclusion that the initial time frame for the development of the plan was too ambitious. Additionally, the communication of the strategy within the organization is also an important task which should be structured in an analogous way as the outside communication (see below). In the medium term the introduction of a quality management system may be considered.

The Working Group will start the process as outlined. It asked further support in reviewing the intermediate results and also possible support in guiding the process. The future technical support will need to design a way of how to deliver that support.

---

<sup>4</sup> See 'National Social Health Insurance Strategy. Key findings and prerequisites for implementation. WHO/GTZ/KfW mission, December 22, 2003, chapter 5.

### *3. Strategy communication*

The general objectives and the purpose of NSHIF need to be formulated in a way that can be communicated to the public – both in related organizations and the general public. This will help to establish a clear image of NSHIF with institutions and persons outside the organization.

Once the strategy – or at least the main objectives within the strategy – have been developed, the M&T and the P&E Working Groups will need to work together and design a plan of how this can be communicated to the various interest groups.

### *4. Registration process*

Presently NHIF is upgrading the membership database, which previously had only incomplete accounts of individual members. Individual members (including dependants) are now being entered into the database, which will then need to be provided to NSHIF. The basic data contain both information on the member and on her employer.

The major shift is that with the new database, individual membership cards will be issued and given to the member (instead of issuing these only at request and giving cards to the employers, who were responsible for giving them to the member). As for the membership card, see below.

The other important change of operations is that the area offices will be able to access the membership database, which is as of yet not possible. The present focus is on members from the formal sector, and the main purpose is to identify members in regard to the contribution due or paid.

It should be analyzed whether the present registration process is also appropriate for covering the poor, who will be members without individual contributions, and whether a sufficient definition of database fields is designed.

In addition to the internal process of designing the database and data entry, it has to be worked out, how new members are addressed and registered. This, it seems, has until now not been the focus of the Working Group.

### *5. Identification of the poor*

This has not yet been addressed by the project. The reasons are that setting up the new registration procedures consumes resources and the expectations and precise criteria of providing free cards for the poor are not yet spelled out completely. The task will be addressed in the coming months.

Identification of the poor is a major task, for which the NSHIF will need further support. The criteria of how to pre-identify the poor need to be tested in the pilot areas. For this, NHIF should design as soon as possible a process of how to issue free cards to a limited number of poor in the pilot areas, using support from existing structures (NGOs etc) familiar with the socio-economic conditions in the area. In addition, results from the Health Expenditure and Utilization Survey should also be used in the identification of the poor<sup>5</sup>.

---

<sup>5</sup> See Health Expenditure and Utilisation Survey (2003), Ministry of Health (responsible staff: S.N.Muchiri)

## *6. Revenue collection in the formal sector*

The collection of revenues is still to a large part a manual process done by cheque in most cases. It should be replaced or supplemented by money transfer into NSHIF bank accounts. The Working Group has already designed a data exchange format with employers for contribution payment in order to decrease the workload of data entry of contribution data, which will replace the paper format presently used by the majority of employers (according to the Thika Area Manager many smaller employers do not have computers). In the area offices that are part of the Wide Area Network (WAN), the data of the revenues collected can be put into the database. For the other area offices, data entry is still done in headquarters.

## *7. Revenue collection for the informal sector*

Members from the informal sector have to pay contributions in advance. As the annual pre-payment proved too large a burden for many members, there is also the possibility to pay on a quarterly basis (the latter possibility is currently available in Machakos).

In the pilot areas it should be tested, which payment methods and payment periods can be applied to various groups of the informal sector. This should be done using several approaches.

## *8. Revenue accounting for the poor*

The process of how to distribute accounts for the poor to the area offices needs to be designed. The task of accounting for the poor has not been addressed yet. This should be done as soon as possible initially for a small fraction of the poor with available financial resources. Subsequently, government financing will have to cover greater numbers. Indeed, the Government of Kenya is financing those cards, and procedures need to be worked out to secure the funding. In addition an objective mechanism needs to be developed to allocate membership cards to areas according to poverty levels to avoid political conflicts.

## *9. Membership Card*

NSHIF will replace the old paper card of NHIF with a plastic card, bearing the identity information of the member. Every insured person (including dependants) will receive a card. One could opt for only including pictures for persons of age 6 and above. Yet, the option of including a picture of a child below the age of 6 should also be considered. While children at such a young age might not be easily distinguishable, this option would further reduce misuse (such as reducing the likelihood that a mother would present a card with the picture of a child that is not hers).

The focus of the NSHIF implementation is presently on the process of issuing the cards, especially of how to reach members best.

The decision for a simple plastic card (instead of a smart card) seems appropriate given the IT-environment with providers and the more pressing issues at hand. However, the card design does presently not have information on its period of validity. Rather, the member will still need additional proof of contributions paid before she can receive treatment. One of the problems noticed in the past was that members had to get a certificate of payment of contributions before they could receive treatment. It should be analyzed whether this cannot

be replaced by a validity date on the card, so that the member can receive treatment without prior contact to the fund and the institutions know that they reimbursed during this period.

#### *10. IT exchange with providers*

The IT-Working Group is intending to design an electronic data exchange with providers, which would allow an online check against the data base and would also allow exchange of claims and treatment related data. While the design of an electronic data exchange with providers is a valuable task, the present IT situation within the provider community makes it unlikely that this can be applied in most institutions in the near future. Rather, the electronic data exchange should be piloted with a very small number of providers that are already using computers, in order to design and test the exchange.

#### *11. Decentralization / IT issues*

The decentralization of tasks to area offices was started by NHIF last year. The objective is to shorten process chains and to shift competencies to the area offices. The Wide Area Network has been set up with eight area offices including the pilot areas. The project is at the very beginning and in the pilot areas the use of the access to central databases has just started.

The decentralization of the IT structure needs to be continued. The usage should be extended to other fields besides registration and claims. E.g., reporting of the area offices could also be using the WAN.

It should also be evaluated, to what extent the WAN is already used, and where this leads to a decrease of workload within the organization

#### *12. Decentralization / Staff*

The decentralization will lead to a higher responsibility at the area office level for both revenues and expenditure. The training for these new responsibilities has begun with a focus on registration and claims processes.

The design of new working processes has just begun and the pilot areas should serve for further developing these processes and to put them into manuals, which can be used for the roll-out to other offices.

Besides the training of new processes decentralization requires also training for the increased managerial responsibilities. This requires detailed description of responsibilities and of processes at the area office level and a process of implementing them. This task seems as of yet not fully addressed (see suggestion of performance agreements above).

#### *13. Training*

The major focus of the training up to now was the training of trainers (TOT), who will be responsible to train staff in area offices for the new or redesigned tasks. For this, managers from the area offices and from headquarters have attended two-week-courses, which focused on training techniques and had also parts on the new NSHIF requirements. The exact number of people already trained, could not be obtained during the mission.

As many aspects of the administration of NSHIF are not yet clear, the training needs to be

made more specific as these aspects evolve.

The training process should be designed in more detail. Presently, the focus is on the training of trainers, but it is not clear, how their training in the area offices will be organized and how it will be evaluated. This is bound to lead to a situation with differing training approaches and consequently different working processes in the various offices. The Working Group should work out a detailed schedule and also work out standard manuals for the different tasks, which can then be used in the education of staff.

Presently, project management and controlling issues are not emphasized in the training. There should be a training course for the office managers, which further enhances their capabilities in using (project-) management and controlling tools, thus enabling them to better steer the implementation process.

We refer to Table 3 for a summary of tasks and issues, discussed in this section, and for basic suggestions.

#### ***2.4 Monitoring and Evaluation***

This Working Group has been recently established with Mrs Omino as team leader. NHIF has been using some monitoring and evaluation tools in the past. This includes the financial reports of the area offices as well as staff assessment forms. However, as with many other organizations, there is room for increased use of monitoring tools.

As a first step, NSHIF management needs to establish a standard monthly reporting system from all operational units on the key indicators. The presently used reporting system could be used as a basis but it should be seriously overhauled.

It is clear to NHIF management as well as the Working Group that enhanced monitoring and evaluation will be needed in order to steer the complex organization of NSHIF and in order to answer stakeholder questions on the performance and effects of NSHIF. To put it more precisely: NSHIF needs to develop a full set of monitoring and evaluation tools, both for internal efficiency and for measuring the impact of its work on the health status of the Kenyan population. And it needs to establish the procedures to actually apply these tools in the administration. This can best be done, using a Management by Objectives approach, where organizational units are operating according to measurable objectives agreed upon. While it takes some time to establish such a management method, it would be advisable to further strengthen the capacities of the critical NSHIF management and staff in using and introducing these methods as soon as possible.

During the missions, working sessions were held with the Working Group in order to outline the major areas, where monitoring and evaluation tools should be developed and implemented.

It is clear to NHIF management as well as the Working Group that enhanced monitoring and evaluation will be needed in order to steer the complex organization of NSHIF and in order to answer stakeholder questions on the performance and effects of NSHIF. A working manual produced by ILO<sup>6</sup> on evaluating health care funds is scheduled to be translated and will be made available to the Working Group to support the set up of the monitoring tools.

---

<sup>6</sup> ;ILO-STEP/CIDR, Guide de suivi et d'évaluation des systèmes de micro-assurance santé, 2001, Tomé 1 : Methodologie, Tome 2 : Indications pratiques, Geneva, 2001.

We now present the results of the working sessions:

### *1. Reports of Branches*

Presently bi-weekly reports on revenue and expenditure are prepared on paper and sent to HQ. They include also some figures on members and issuance of cards. The impression of the team is, however, that these reports do not yet create information readily available within the organization (“at your fingertips”).

NSHIF may therefore want to extend the reporting, as the responsibilities of branches increase and is in the process of designing a new format for these reports.

These reports need to reflect the key indicators of the business. These indicators will include

- Revenue according to sector (formal, informal, poor (revenue distribution from VAT))
- Claims primary care
- Claims hospital care
- Other Claims, split by institution
- Benefit ratio – expected ratio
- Ratio of revenue going to “pool” (equalizing variance of income between districts)
- Membership development
- New members from each sector
- Leaving members (discontinued payment)
- Number of poor (free cards)
- Membership ratio with claims
- On central level also administration cost; broke down by branch

Together with the implementation of these reports, the method of management by objectives should be strengthened: E.g., area office managers should receive clear objectives for the indicators, and their achieved results should always be compared to the objectives.

### *2. Satisfaction of Members, Employers, Providers*

The satisfaction of stakeholders has in the past been measured on an irregular basis with questionnaires and incidental reports. NSHIF wants to establish a continuous measuring of the satisfaction, as this will help to communicate the performance of the organization. Drafts for the questionnaires for the various groups have been designed.

The questionnaires need to be finalized and tested in the pilot areas. A schedule for the surveys needs to be established. It should be analyzed, whether it is useful to also establish panels from the stakeholder groups, as panels can have a more informed opinion, thus rendering a more detailed information of the development of satisfaction.

### *3. Development of health status*

The success of NSHIF will also be measured by the development of the health status. Therefore tools for measuring the health status and its development should be designed. This task should be performed together with MOH, drawing on existing data bases and survey

Forms (including the questionnaires used in the World Health Survey methodology). They will need to be adapted to a format usable for NSHIF.

#### *4. Development of Quality in medical institutions*

NSHIF contracts with health facilities will also include steps on how to improve the quality of their services (both medical and hotel functions). In order to evaluate the progress made, reports need to be designed and implemented. With one or two hospitals of the pilot areas, talks on these tools should start as soon as possible. It seems necessary for all parties to build up the capacities of measuring quality and to improve the capacities of managing quality improvement projects. Obviously, there needs to be interaction with the Working Group focusing on contracting which should build quality standards into contracts.

#### *5. Management by objectives*

NHIF in the past did not apply (measurable) objectives for the management of organizational units. In order to manage the decentralized organization, it will be necessary to establish a process of setting objectives for the units (and potentially for individual staff members) and to control the units against these objectives. The implementation of such a method will require sufficient data and its implementation will take significant time (one to two years). It should start with the identification of the data available and then continue with setting up initial objectives on key indicators with, e.g. the branch offices.

#### *6. Quality Management within NSHIF*

Internal quality management has until now not been addressed by the Working Group. A continuous quality improvement method is, according to the information gathered, not yet in place.

As NSHIF requests quality improvement from its business partners, it will also need to improve the internal quality of working procedures. This is a continuous process which needs to be facilitated. In a first step an enhanced understanding of quality improvement methods and measuring seems suitable.

Again, this process will rely on available data and process descriptions, which need to be worked out first. A first reasonable step would be the education of designated managers on quality improvement and quality measuring.

#### *7. Implementation plan for Monitoring and Evaluation*

Presently, the Working Group is in the phase of the initial design of some of these items. The implementation plan needs to be worked out, based on the items described above. The list of tasks for the monitoring is quite complex and the implementation of the various items will require time and continued management support. The process can only gain this continued support, if the steps are transparent and success can be monitored. Therefore the Working Group needs to design an implementation plan and communicate it with the management of NSHIF.

## 8. *Project controlling*

Presently the monitoring of the project is based on weekly meetings and status reports delivered at these meetings. The present project on setting up NSHIF is in itself complex and divided into several sub-projects. It will become even more complex, when the new procedures are tested in the pilot areas. Transparent and accountable information on the status of the various tasks is needed.

Given the complexity of the project, the present reporting form may prove insufficient. Together with the Project Secretariat, the project should design report forms on the status of individual task should be designed. These can be collected, so that progress can easily be reviewed. Using the existing Project Software is a basis, which should be supplemented by additional tools.

Additionally, a process of entering new tasks (which will evolve during the project) into the plan and of consolidating possible conflicts between tasks (and sub-projects) needs to be established.

Table 3 in Annex 2 summarizes the assessment of major tasks and issues related to this section, and presents basic suggestions.

## **3. Additional issues**

### **3.1 Consultation process**

During the field visits and a discussion held among NHIF staff and health care providers based in Nairobi, a clear need for further discussion and consultation on issues related to accreditation and contracting has been observed. In order to avoid misunderstandings, it seems to be important to find adequate measures incorporating opinion leaders of the private health sector (private providers, HMOs) and NGOs including major churches and Islamic organizations.

Against this background, it might be useful to strengthen dialogue and consultations among all stakeholders in social health insurance, in particular on the local level. Until today, only few activities providing and open exchange among all key players took place.

Regular discussions involving local authorities, employers, employees, providers and representatives of the insured, the poor etc. contribute to reaching agreement on and compliance with the new scheme. Such activities provide a mean of sharing information on current issues and concerns among all participants and thereby promoting transparency, mutual understanding, and trust. In addition, regular consultations constitute a negotiation mechanism and lead to sustainable decision-making.

Therefore, the members of the mission recommend further developing consultative mechanisms (social dialogue---based on ILO Convention 144 on Tripartite Consultations ratified by the Government of Kenya) during the process of implementation and monitoring and evaluating the new scheme.

### **3.2 Challenge of covering the poor and informal sector workers**

Voices of the non-profit private sector, pointing to the needs of poor, should be taken into account during the implementation process. This would help to improve the overall outcome of the test period in the pilot areas and contribute to a positive perception of the new scheme, which primarily aims at improving access to affordable quality health care for all Kenyans.

In addition, accelerating coverage of informal sector workers and the poor is recommended. For the time being, the process of identification of the poor has not gone beyond the discussion of broad concepts. Given the importance of improving access for these groups, it ought to be planned urgently to test related features of the bill in the three pilot areas.

It is important to note that the implementation of this part of the bill in an effective manner may muster significant support for the reform process. It is therefore strongly suggested to test the free cards system in at least one of the three areas.

Given the current budget situation it will not be necessary to wait for further budget provisions of the Government for testing purposes. The current budget situation would allow testing mechanisms for identification and registration of the groups concerned.

It should be considered to issue free cards could be issued to a limited number of persons in the pilot area, e.g. 1000 persons. After the test period, it may be advisable to initially aim at covering 10 per cent of the poor, which can be expanded later when funding becomes available.

Identification of the poor, could in a first step be carried out using alternative approaches corresponding to the various characteristics of informal sector workers and the poor. The most common approach includes a self-assessment mechanism at the community level e.g. involving authorities, churches and charities could be considered. Such a self-assessment should be based on a catalogue of formalized criteria and knowledge of individuals with low income.

Further approaches taking into account particularities of the informal sector and the poor include:

- Identification of informal sector workers when seeking licenses, e.g. for driving and opening a business
- Using information regarding the poor received from hospitals and health care facilities
- Business contacts, e.g. on markets or when receiving daily payments at plantations
- Targeting poor areas, remote regions, slums
- Information received from activities focusing on poverty alleviation, such as PRSP and efforts striving for achievement of health-related MDG's. MDG's targeting health include reducing child mortality, improving maternal health and combating HIV/AIDS, malaria and other diseases.

Further, it should be considered to lower barriers for entering the formal sector and legalizing informal sector work. This could be carried out among others in cooperation with the Ministry of Labour. Such a measure would ensure a broader coverage of the social health insurance scheme.

### **3.3 Inclusion of HIV/AIDS/TB/Malaria in the benefit package (NSHIFplus)**

A proposal has been prepared to facilitate the inclusion of HIV/AIDS, Tuberculosis and malaria in the SBPs. As this would normally overwhelm the fund financially, a separate

funding facility is required to include these important public health problems. A proposal including innovative approaches to the sustainable financing of these important diseases was prepared requesting a total amount of 26 mio US\$.

As an interim strategy and with the support of GFATM, NSHIF will provide subsidised membership to specific groups of people on the basis of their need for services and/or treatment in the three major disease categories. Membership could be automatic for an initial period of 1-3 years for persons in highly effected and poverty endemic areas who:

- Submit for VCT at an accredited site
- Are HIV+ and receiving treatment
- Are suffering from AIDS and are on ART and/or receiving home- based care through an accredited health care facility
- Are suffering from TB and are receiving treatment at an accredited facility
- Attend an ANC and collect an ITN.

This list will require further adjustment as experience with the implementation becomes available.

#### **4. Conclusions and milestones**

A number of important milestones as formulated in the last mission report of January 04 were achieved, such as continued work on the membership, the establishment of contracts, the preparation of a manpower analysis for the NHIF, the establishment of a Master Workplan and the beginning of implementing the new social health insurance scheme in three pilot districts.

New milestones address the following issues:

- (i) Extending coverage of the social health insurance scheme to the informal sector and the poor will be the major challenge for the near future. Successful implementation could be reached by testing the free card system in at least one of the three pilot areas on a limited number of persons. The steps to be followed include:
  - Ensuring accreditation of hospitals and health care facilities in remote parts of the pilot areas characterized by a high level of poor inhabitants.
  - Mobilization and training of local authorities, churches and charities of the need and mechanisms to identify the poor
  - Informing the poor about their rights to access quality health care and prevention without having to pay co-payments
  - Avoiding misuse and fraud of free cards could be limited by making lists of names of persons eligible for free care, established at area level, accessible to providers and other concerned stakeholders
  - Close evaluation and monitoring of utilization of health care facilities and cost by the poor and related cost impact during the pilot period.
- (ii) Extending accreditation of providers to selected multinational partners of the private health sector (e.g. Del Monte, pilot mission hospitals) in order to share their expertise and knowledge regarding calculations of costs and maintaining high quality facilities.

- (iii) Improving and monitoring the accreditation process through including medical expertise in the peer-review and conclude peer-review of all applications received within the pilot regions.
- (iv) Intensify training of NHIF staff and providers.
- (v) Negotiate, test and evaluate the provider contract with one type of each facility.
- (vi) Development of a more effective travel capacity for the Publicity and Education Working Group, with a dedicated vehicle or greatly more streamlined vehicle-loan and travel-funding system.
- (vii) Further training and support for area managers in the three pilot districts, so that each becomes an effective ambassador and driver of change for the new NSHIF system.
- (viii) Improvement in system of external contact, with establishment of permanent media contact points and information desk/hotline.
- (ix) More developed system of inter-Working Group coordination, such that all groups have, for example, input into externally communicated messages and collection of feedback.
- (x) Strengthening the secretariat of the Management Committee to coordinate the Working Groups and to steer and control the implementation process

## **5. Proposed TOR for forthcoming technical assistance mission**

- Participate in workshops with the NHIF Working Groups
  - Interact with the Project Secretariat and to support the various Working Groups on the current and planned activities.
    - Review of the Strategic Plan for the pilot districts and for the NSHIF as a whole, including of methods used to estimate revenue and expenditure
    - Review of registration and membership card design
    - Review of the accreditation process (quantitative and qualitative)
  - Review of progress in publicity and education
- Assess the inclusion of the informal sector and the poor in the NSHIF
  - Assessment of methods of poverty identification and registration of the poor used at the level of pilot districts
  - Review progress regarding the extension of coverage to the informal sector and the poor
- Review of Government budget allocation for
  - improving infrastructure in rural areas
  - free health cards for the poor
- In collaboration with MOH and NHIF Management, to organize an meeting with donors to discuss coordination of technical assistance
- Assist in the establishment of an independent accreditation body

For an overview of the proposed technical assistance during the period 2004 and 2005, we refer to Annex 4.

## Annex 1 Draft structure of the Quality Report

The quality report based on the self assessment of the institution may take the following structure:

1. Self assessment report using the NSHIF accreditation criteria
2. Quality management
  - a. Introduction of a QM system
  - b. Quality targets
  - c. Data collection related to QM
  - d. Questionnaire use related to QM
  - e. Patient needs and complaints
  - f. Leadership
    - i. Development of a vision and mission statement
    - ii. Strategic and medium term planning
    - iii. Organisational structure
    - iv. Finance and investment planning
    - v. Structured leadership processes incl. management committees
    - vi. Information policy
    - vii. Promotion of trust among staff, with the general public and financing organisations
    - viii. Ethical guidelines
    - ix. Conflict management
    - x. Dying and dead patients
  - g. Patient orientation
    - i. Examination on admission and information of patient
    - ii. Use of previous medical records
    - iii. Determination of the treatment plan jointly with the patient
    - iv. Utilisation of clinical guidelines
    - v. Patient information on treatment progress
    - vi. Interdisciplinary consultations
    - vii. Nutrition of patient
    - viii. Visits of responsible medical doctor
    - ix. Nursing standards
  - h. Patient and hospital safety (confidential report on adverse events)
    - i. Workplace safety
    - ii. Fire protection
    - iii. Non medical emergencies
    - iv. Medical emergencies
    - v. Hygiene guidelines and implementation
    - vi. Drugs
    - vii. Blood and Blood Products
    - viii. Environmental protection
  - i. Staff orientation
    - i. Planning of human resources
    - ii. determination of qualification levels
    - iii. Continuous education
    - iv. Financial resources for staff development
    - v. Evaluation of effectiveness of educational

- vi. Participation of staff in management decisions
- vii. Quality improvement teams
- viii. Handling of staff suggestions, wishes and complaints
- j. Information system, Monitoring and Evaluation
  - i. Rules for documentation of patient data
  - ii. Availability of patient data
  - iii. Internal communication of patient data
  - iv. Use of IT and communication technology
- k. Outcome/performance indicators
  - i. Clinical
  - ii. financial

Annex 2 Summary Tables

Table 1 Quality and contracting: summary of tasks & issues, and basic suggestions

Tasks/Issues		Assessment	Suggestions
<i>Accreditation</i>	<b>Development of accreditation criteria</b>	The standards could profit from <b>improved clarity</b> . This might help to develop consistency of accreditation, reduce possibilities for manipulation and facilitate monitoring. Key areas for improvement relate to patient safety and quality of care.	Develop clinical guidelines with the assistance of stakeholder groups e.g. KMA, society of surgeons etc.
	<b>Establishment of a process of accreditation</b>	Introducing more efficient <b>forms of peer-reviews</b> could help to effectively assure quality:	
		<ul style="list-style-type: none"> <li>• The peer-reviewers should be supported by neutral medical expertise.</li> </ul>	Engage neutral physicians in peer-review
		<ul style="list-style-type: none"> <li>• Create a <b>more continuous process of accreditation</b> through mid-cycle reviews would be an incentive for improvement</li> </ul>	Introduce periodic performance review
		<ul style="list-style-type: none"> <li>• Introducing <b>several levels of accreditation</b> might serve as an incentive to improve quality</li> </ul>	Introduce full, provisional and conditional levels of accreditation
		<ul style="list-style-type: none"> <li>• Developing procedures <b>for self-assessment</b> would lead to a more cost efficient and less time-consuming accreditation process.</li> </ul>	Develop a general framework for quality report drafting
		Developing and implementing an <b>action plan for quality improvement</b> would accelerate overall system performance.	Introduce possibilities for developing action plans

		In the longer term establishing an <b>autonomous body for accreditation</b> and quality assurance might lead to more consistency.	
		Design a programme of continuous education of health care provider personnel, in particular related to standards and quality of care.	-
	<b>Application and use of benefit package standard</b>	It will be important to insure that <b>facilities in rural and remote areas</b> will be equally included in the accreditation process equally in order to improve access for the poor and informal sector workers.	Upgrade facilities through MoH funds. Consider financial incentives for providers in underserved areas. Consider to reimburse transportation costs for the poor.
		<b>Include at least one of the four Del Monte facilities in the pilot area</b> of Thika would be beneficial for further development of outpatient procedures and performing cost analyses. Similarly an efficiently run model Mission Hospital e.g. Kijabe should become a partner for developing the tools of the new scheme	Prepare the accreditation process of at least one of the Del Monte dispensaries.
		Monitor application of benefit standards and compliance of facilities with the established plan of action for quality improvement; patient satisfaction surveys ought to be considered as a tool in this respect.	Carry out a patient survey
		<b>Intensify training and communication of providers</b> regarding accreditation and contracting	Prepare manual for training and information leaflets

<i>Contracting</i>	<b>Development of a draft contract</b>	Further specification of obligations and rights of providers and of NSHIF is recommended	<p>Introduce the following aspects into the contract:</p> <ul style="list-style-type: none"> <li>• Health care should be provided on the base of Kenyan treatment guidelines</li> <li>• Drugs are to be procured from reputable MoH approved suppliers</li> <li>• Facilities should produce a quality report before on-site peer-review</li> <li>• The provider should assure that NSHIF membership cards are genuine</li> <li>• Treatments anticipated to take longer than 7 days need prior clearance of NSHIF area office</li> <li>• Treatment related to traffic accidents should be communicated immediately to NHIF area offices.</li> </ul> <p>Clarify questions related to medical disagreement, co-payments for self-referral and unnecessary treatment revisits</p>
<i>Other issues</i>	<b>Registration of the poor and informal sector workers</b>	Application forms need to be adjusted to characteristics of the poor and informal sector workers	Develop methodology for registration of the poor and informal sector workers
	<b>Registration of employers in the informal sector</b>	Evasion of employers in the informal sector is a common problem and should be addressed	Identify employers through using available information from authorities in districts and communities

**Table 2 Publicity and Education: Summary of assessment of tasks & issues and basic suggestions**

<b>Tasks/Issues</b>	<b>Assessment</b>	<b>Suggestions</b>
<i>Intra-NHIF organizational effectiveness</i>	Group coordination requires improvement. Obstacles to mobility of P&E Working Group. Secretariat must act to improve organizational effectiveness.	Secretariat should provide designated vehicle, or at least improve loan of occasional vehicles and travel funds.
<i>Internal information provision</i>	Information/training provided for various levels of NHIF staff. More needed for area managers.	P&E group must provide further training and support (in collaboration with Training and Management group). Performance agreements with CEO
<i>External information provision</i>	Major progress, using a variety of media. Increased efforts needed.	P&E group must designate permanent media contact points, establish information desk/hotline. Secretariat must ensure all-group input into messages.
<i>Collection and dissemination of feedback</i>	Carried out on ad-hoc basis to date. Need to formalize feedback gathering.	P&E group should use questionnaires (begun). Secretariat must ensure all Working Groups have input into feedback agenda.

**Table 3 Management, Training and Evaluation and Controlling: Summary of assessment of major tasks & issues and basic suggestions**

Tasks/Issues	Assessment	Suggestions
<b><i>MANAGEMENT AND TRAINING</i></b>		
<b><i>Initial Budget calculation</i></b>	In the past, budgeting was only done for administration costs, and the basis for the development of an overall budget is limited. There is an expectation that usage will go up, but no clear model how to calculate it	It should be considered to calculate the expected expenditure in various ways (e.g. on the level of present cost, on the level of reimbursement developed by the last missions and potentially also using econometrical methods) and to also test these through various scenarios.
<b><i>Strategy Plan</i></b>	The task is awaiting the finishing of the budget. Next to budget, the existing strategy plan of NHIF and the Sessional paper will be used as starting points for the development of the strategy. During the mission, emphasis was given on the methodology, e.g. the necessity of both a top-down and a bottom-up approach in the development of the plan	The working group will start the process as outlined. It asked further support in reviewing the intermediate results and also possible support in guiding the process.
<b><i>Registration</i></b>	NHIF is upgrading the membership database, which previously had only incomplete accounts of individual members. Individual members (including dependants) are now being entered into the database. The major shift is that with the new database, individual membership cards will be issued and given to the member. The other shift is that the area offices will be able to access the membership database, which is up to now not possible.	It should be analyzed whether the present registration process is also appropriate for covering the poor, who will be members without individual contributions, and whether a sufficient definition of database fields is designed.  In addition to the internal process of designing the database and data entry, it has to be worked out, how new members are addressed and registered. This, it seems, has until now not been the focus of the working group.
<b><i>Identification of the poor</i></b>	This has not yet been addressed by the project.	NHIF should design as soon as possible a process of how

		to issue free cards to a limited number of poor in the pilot areas, using support from existing structures (NGOs etc)
<b>Revenue collection</b>	For the formal sector procedures have been developed and need to be implemented. For the informal sector procedures need to be designed and tested	Design and testing of revenue collection methods for the informal sector in pilot areas.
<b>Training</b>	Until now, training of trainers was the focus. It is unclear, how many people have been trained to what extend and how the process will continue – this affects especially the new tasks of NSHIF, e.g. including the formal sector and the poor or contracting.	Workout of specific training manuals at process level  Design of training course for managers on project management and controlling
<b>MONITORING AND EVALUATION</b>		
<b>Branch reports</b>	Bi-weekly reports are now being used, but need to be extended	The new report format should reflect key indicators and need to be designed for usage in a management by objectives environment
<b>Management by objectives</b>	The decentralization of tasks within NSHIF makes it imperative to introduce a system of objectives, which the branches need to achieve and against which they are measured (linked to (dis-)incentives)	MbO needs to build upon data. Hence, establishing proper data bases and reports is the first step  Initial objectives should be used, based on available data
<b>Satisfaction levels</b>	There are various questionnaires designed for measuring satisfaction levels of members, employers and providers	These questionnaires need to be tested in pilot areas and will consecutively serve as basis for regular satisfaction monitoring
<b>Project controlling</b>	The present project controlling may be insufficient for monitoring and steering the process, once the pilot areas are operational	Status reports for the individual tasks need to be designed and the role of the Secretariat (together with M&E) needs to be strengthened in monitoring and steering the various work groups.

### **Annex 3 Summary of Activities**

Monday 29<sup>th</sup> March 2004\$

- Review of programme with Dr. T. Mboya and Dr Hassan
- Working Group sessions with
  - Management, Training and IT
  - Publicity and Education
  - Quality and Contracting
  - Monitoring and Evaluation

Tuesday 30<sup>th</sup> March 2004

- Stakeholder Workshop with Providers from Nairobi Area
- Working Group meetings with (a) Management and Training, (b) IT, (c) Monitoring and Evaluation

Wednesday 31<sup>st</sup> March 2004

- Field trips to two pilot areas
  - Team 1: Thika pilot area, visiting NHIF area office and Mission hospital
  - Team 2: Machakos pilot area, visiting NHIF area office, district hospital, mission hospital, private hospital and health centre

Thursday 1<sup>st</sup> April 2004

- Working Group sessions with
  - Management, Training and IT
  - Public Relations
  - Benefits and Contracting
  - Monitoring and Evaluation
- Briefing of international donors and NGOs on mission results and implementation status

Friday 2<sup>nd</sup> April 2004

- Debriefing of WHO country representative
- Writing of mission report draft
- Debriefing of the Honourable Minister of Health
- Debriefing of NHIF Executive Board

## **Annex 4 Proposed technical assistance (2004-2005)<sup>7</sup>**

### **Capacity building**

Kenya Professional Promotional Programme in Social Health Insurance comprising a 3-week technical visit to:

- WHO, Geneva (1 week)

Objective: training in the use of the WHO-financial projection model for Kenya, and in principles and features of contracting

- GTZ, Eschborn (1 week)

Objective: comprehensive advanced training on social health insurance, combined with technical visits to AOK

- ILO, Geneva (1 week)

Objective: further capacity-building and training on social health insurance

In the future, these technical visits may be complemented by participation in an advanced course on social health insurance (this course is under discussion among ILO, WHO and GTZ, including the updating of the ILO/WHO Social Health Insurance guidebook) .

### **Long-term technical assistance**

Full-time adviser on social health insurance (GTZ Back-up Initiative) 2004/2005.

### **Technical assistance**

- WHO, GTZ, DFID and ILO to provide technical expertise on the various aspects of implementation of social health insurance, including poverty identification, quality and contracting, training and management, social marketing, and monitoring and evaluation.

### **Studies**

- Study on the poverty identification procedures in the pilot districts, with the support for this study to be confirmed by the interested technical agencies

- Comparative research on the key role of social health insurance in poverty alleviation and sustainable economic development, supported by ILO and possibly by DFID, GTZ and WHO

- The impact of social health insurance on catastrophic payments and poverty in Kenya (in collaboration with WHO/FER/FAR and the MOH/Kenya (focal point Mr S.N.Muchiri).

---

<sup>7</sup> This proposed technical assistance is subject to official clearance by the WHO, GTZ, DFID and ILO.

## **Annex 5 Electronic mail addresses of mission team members**

Guy Carrin	<a href="mailto:carring@who.int"><u>carring@who.int</u></a>
Rolf Korte	<a href="mailto:rolf.korte@swiftkenya.com"><u>rolf.korte@swiftkenya.com</u></a> <a href="mailto:rolf.korte@gtz.de"><u>rolf.korte@gtz.de</u></a>
Cristoph Lankers	<a href="mailto:lankers@lutherpartner.de"><u>lankers@lutherpartner.de</u></a>
Xenia Scheil-Adlung	<a href="mailto:scheil@ilo.org"><u>scheil@ilo.org</u></a>
Daniel Whitaker	<a href="mailto:danielwhitaker@yahoo.com"><u>danielwhitaker@yahoo.com</u></a>