National Social Health Insurance

Progress Review and Recommendations

Joint WHO – GTZ - DFID Mission¹ to Kenya

22nd to 30th January 2004

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Our work was made so much easier by our drivers Mr. Stanley, Mr. Kaptum and Mrs Kalundo.
Abbreviations

DMO District Medical Officer
DMS Director of Medical Services
DSRS Department of Standards and Regulatory Services
HMO Health Maintenance Organisation
IT Information Technology
JICC Joint Inter-agency Co-ordination Committee
KEMSA Kenya Medical Supplies Agencies
KMA Kenya Medical Association
MEDS (mission based medical supply facility)
MOH Ministry of Health
NHIF National Hospital Insurance Fund,
NSHI National Social Health Insurance
NSHIF National Social Health Insurance Fund
NSSF National Social Insurance Fund
RBA Retirement Benefit Authority
1. Background

This report summarises the findings of the fourth WHO-GTZ Mission, which was joined by a representative from DFID to review together with the Ministry of Health (MOH) and the National Hospital Insurance Fund (NHIF) the progress towards implementation of the proposed NSHIF.

The first mission dealt with 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 focused on the legal aspects of the NSHI Bill, the benefit package and provider payments, the transition of the current National Health Insurance Fund (NHIF) into the National Social Health Insurance Fund (NSHIF), and the implementations tasks.

The current fourth mission was organised from 22nd January to 30th January 2004. The Mission members were: Dr. Rolf Korte, senior health policy advisor and team leader (GTZ), Dr. Manfred Zipperer, legal advisor (GTZ), Mr. Daniel Whitaker, health economist (DFID).

The mission was asked to
- review progress towards implementation of the NSHIF,
- assist in drafting the final version of the bill to be presented to Parliament,
- look at opportunities for integrating retirement schemes of the Armed Forces,
- propose terms of reference for an infrastructure assessment mission
- propose next implementation steps
- outline terms of reference for the proposed March Mission.

2. Management structure:

The change management process towards the National Social Health Insurance Fund has started under the leadership of the CEO. A number of initiatives have commenced. At the same time most of the eight hundred headquarters staff had to move into the new office building. These concurrent activities pose a major challenge to the operation and reform of the NHIF.

The proposal by the last mission in October/November 2003 to create a technical advisory group (TAG) was modified. Instead the management of NHIF has established three working groups:
- Quality and Contracting (Team Leader, Dr. G.J. Midiwo)
- Public Information and Education (Team Leader, E. Mworia)
- Training and Management (Team Leader, Jeniffer Muriuki)

The coordination of these working groups is effected by a secretariat under the leadership of the Acting Chief Manager, Mr. Willis Okumo Obam.
The senior Management Team of NHIF has been meeting weekly to review plans and progress since September 2003. Progress is documented in the minutes of meetings.

The mission re-emphasised that these teams and especially the team leaders have to spend a very large proportion of their work time on the change management issues. As mentioned in previous mission reports, it may be useful to consider establishing additional working groups. One may be for monitoring and evaluation, and it may look for opportunities to adapt the HMIS’s which was developed e.g. in Mombasa. In view of the major information technology needs of the new organisations it may also be necessary to establish a special IT working group. The working groups are encouraged to seek backup from local and international experts. At the same time the donor consortium should be able to respond at relatively short notice to facilitate progress.

Other proposals concerning the management structure by the previous mission were modified according to the needs of the organisation.

The decentralization of the NHIF area offices has been pursued and 8 areas are being served from largely autonomous offices. Some of them have already been effectively linked electronically with headquarters to handle claims independently.

3. Legal Aspects of the National Social Health Insurance Bill

As a result of the second mission in July/August 2003 numerous suggestions on the legal aspects of the NSHI Bill had been forwarded to the Kenyan partners. They were the basis of the discussion in an ad hoc working group of legal experts and administrators, who met on four consecutive whole days.

Written proposals from the NHIF administration, comments and recommendations from participants of a meeting with the KMA Governing Council and suggestions of a meeting with Board Members of NHIF during the mission were included as well. The working group noted comments by the HMO Avenue Healthcare on the Sessional Paper on NHSI in Kenya. The working group considered all suggestions made very carefully. Most of them were settled and resulted in changes or amendments to the respective clauses of the Bill. The following arguments illustrate the most important questions under consideration.

A very intensive discussion arose about the legal relationship between the MOH and the NSHIF. In the Bill there is no particular provision about a legal supervision of the MOH over the NSHIF and the provision in Section 9, Subsection 2 of the Bill seemed to be too weak. The working group agreed to retain the independence of the NSHIF but recognised the necessity of defining the legal relations to the MOH. The solution of this problem depends on the legal character of the NSHIF, which is not quite clear at this point in time. If it is considered a State Corporation, the State Corporation Act
would apply; this Act makes provisions for the relationship under consideration. This question will be checked by the Attorney General Chambers.

The working group made a firm recommendation to integrate the guiding principles in the Fifth Schedule into the main body of the Bill and to reword them in legal terms. The working group advocates a provision in Part I of the Bill defining the supplementary role of Private Health Insurance.

The working group discussed extensively the financial consequences of the Bill’s provision that each individual member pays contributions to the NSSF whereas the NHIF stipulates that only the member contributes and his named spouse and dependants are covered without extra contribution. Changing this legal provision would worsen the financial burden of fund members because they would have to pay membership for each member of their family. In full recognition of this problem the members of the working group nevertheless backed the Bill’s solution as it helps to avoid fraud.

The working group confirmed the need to define the financial obligations of the Government for those who are unable to pay contributions as up to eleven percent of earmarked consumption taxes, or alternative bases of taxation as discussed in the previous mission report (#3). The text of the Bill in Section 28 Subsection 1 lit. d) and Section 38 lit. b) was considered to be too imprecise.

A long discussion took place on issues relating to the transition from the NHIF to the NHSIF. It became obvious that ideas of accumulating financial reserves other than for day-to-day operation still were very strong. On the other side the working group agreed to dissolve the assets of the NHIF, which were not operationally necessary. The transitional provisions of the Bill should contain a clause that obliges the NHIF within a certain period after the enactment of the Bill (e.g. six to eighteen months) to dissolve all its assets not operationally and legally necessary.

Unfortunately the working group could not start discussing the numerous legal questions of the Bill before the 26th of January. Therefore the time was very short to go through each section of the Bill and all suggestions submitted. Despite this time constraint the working group succeeded in dealing with most questions concerned. After four days of intensive and comprehensive discussion of all legal items to be considered the participants agreed in formulating a revised text of the Bill, that reflects all the solutions proposed. This should be done within the following week in order to present the updated version to the Board of Directors of the NHIF and the permanent Secretary of MOH for further discussion and then forward it to the Attorney General Chambers to be introduced in the parliamentary procedure.2

4. Quality and Contracting

In November new legislation regulating rebates to contracted service providers was passed. The contracted institutions and the respective rebates for inpatient days are

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2 In the meantime the draft has been reviewed by the Attorney General’s Chamber
gazetted. In the same Bill new provisions are made for voluntary membership for a minimum of 160 KShs. per family and month. This amounts to a level of payment at a similar level to the payments proposed in the Sessional Paper. Ambulatory care is in principle also provided for under this legislation. Experience with the new voluntary scheme is not yet available due to the recent introduction.

The quality and contracting team is working on the following tasks:

- To ensure that health care provider facilities are improved to provide quality services.
- Write rules and regulations governing the relationship between NHIF and provider facilities.
- Adapt benefit packages in health care services as basis for developing standards for health care providers.
- Use of agreed standards as basis for accreditation of provider facilities.
- Develop model contractual agreements between NHIF and health care providers.
- Re-engineer registration and claims process in line with the national social insurance scheme.
- Develop policies for identification of service points (provider facilities)
- Give terms of reference for an actuarial study.
- Create and distribute new identification cards for insured members and their beneficiaries

The group has been meeting weekly and is planning a retreat to develop specific procedures for accreditation, contracting the standard benefit package, claims and registration to be tested in the pilot areas in early February.

Two pilot areas have tentatively been identified, Migori and Thika. Machakos is also under consideration. Migori was selected as being a particularly difficult district with special challenges to operational and financial transparency of service providers. This remote rural area presents special demands to the introduction of the new operating pattern of NHIF/NSHIF which will include the provision of ambulatory care for its members and will offer an opportunity to find appropriate mechanisms and to address the question of how to reach the poor effectively. The remoteness of Migori poses special challenges which requires a strong management and investments into communication infrastructure.

Thika is a more accessible district and a partly industrialised area, which offers opportunities to develop efficient collection methods and assure regular contributions from employers and start a membership drive among employers who are not yet contributing to NHIF. It is recommended to document the selection criteria for the pilot areas more clearly.

Machakos should also be included into the piloting as it may present characteristics of the other two areas and a high rate of families with the head of family working in Nairobi.

One of the most important steps towards improved operation of the NHIF and the future of NSHIF is to determine the number of members and beneficiaries, which is estimated to be in the order of ten million. It is proposed to issue membership cards to each beneficiary. This task alone will take considerable time and the design of the membership card should be decided upon as soon as possible. The mission
recommends adopting a relatively simple design that, however, allows for the reliable identification of beneficiaries in order to avoid fraud. Smart cards with complex electronically stored information are currently not recommended as it would require respective electronic equipment at all service delivery points including ambulatory care facilities.

The following graphic illustrates the stages necessary in order to have these membership cards ready for use:

Figure 1: Sequence of steps needed for use of NSHIF membership cards
Initially the NHIF itself will have to accredit contractual partners using the quality management principles developed by the Ministry of Health (Kenya Quality Model, KQM). In the medium term some of these functions will be taken over by the proposed self-governing accreditation body. Contracted hospitals may be obliged to publish annual quality reports that may be made public.

The benefit package that was reviewed during the second mission has not yet been developed further. It still requires revision by a team of Provincial and District Medical Officers. There appears to be consensus that initially a flat rate remuneration for in-and out-patients will have to be adopted for administrative convenience. The mission recommends intensifying the dialogue with potential service providers to reach contractual arrangements that are acceptable to both sides. The quality criteria need to be communicated to the general public as informed patients will be an important pillar of the quality management system.³

The mission does not recommend commissioning an actuarial study as this would have to rely heavily on assumptions. A carefully designed, conducted and evaluated pilot study will most likely provide more relevant results.

The proposed pilot areas are considered suitable even though Migori will pose special challenges. St. Joseph Mission Hospital has good resources and operating facilities while the Government district hospital that evolved from a mere health centre lacks essential facilities. A renewed effort is needed to find a suitable mode of co-operation between the two institutions. While it is difficult to assess the quality of private institutions on a short mission, care may have to be taken that particularly private providers do not overemphasise “hotel services” to attract patients while the qualification of staff and essential structures and equipment may be wanting.

The field visit confirmed previous observations that most facilities feel they can provide full in-patient service (bed, diagnosis, treatment, drugs) for between 1500 and 2000 KShs.

Private and Mission facilities are currently under-utilised (25-30% bed occupancy) and struggle at the same time with the issue of waivers and non-payment by poor patients. They are likely to benefit considerably from a comprehensive insurance cover. The time from submission of reimbursement claims to payment is currently reasonable at around 4 weeks. A shorter turn around time is of course demanded by service providers. This will, however, be unrealistic without online computer linkages.

5. Training and Management

In transforming the NHIF into the NSHIF, there will be a need for a thorough reorganisation of the NHIF’s staff skills and responsibilities. The Training and Management Working Group is charged with assessing how this should be done and

³ In the meantime a thoroughly revised Standard Benefit Package has been prepared by MOH, which may serve as a basis for contractual arrangements
then helping to carry it out. Little of this has so far been achieved and it remains a pressing concern. A necessary first step is to define all of the functions, which the new NSHIF will have to carry out. Each of these functions must then be allocated to future staff members, noting the skills that will be required. Once this future staff and skill requirement is compared to the profile of existing staff members and their skills, it will be clear whether new staff are needed, and what retraining of existing staff members will be necessary.

The Training and Management Working Group is also responsible for designing registration procedures for existing, voluntary and ‘free card’ members. This task has not yet substantially begun, although some ideas on, for instance, how religious organisations might help in identifying ‘free card’ recipients, have emerged in Group discussions. In carrying out this task, the Group will be obliged to liaise closely with the Quality and Contracting Working Group, which will, for example, be designing the new membership identification card. There may in fact be some overlap between the two Groups’ work in areas such as registration, something which must be addressed by the Secretariat.

Another vital task of the Training and Management Working Group is to assess the needs and improve the capabilities of the NHIF’s IT function. Here too there is not yet any evidence of progress to date.

Only once the staff’s responsibilities have been decided and allocated, with any required new staff hired, and only once the new IT systems have been decided, purchased and tested, can formal training actually begin. As with the other Working Groups, the pilot areas will provide an important testing ground. Substantial work will be required to be ready even for the pilot stage of implementation.

Management may consider creating two working groups, one for management questions, the other for training, as the current working group may be overloaded, is making only slow progress and is therefore a brake on the other groups, which are dependent on its results.

6. Public Information and Education

The Public Information and Education Working Group has generated a number of positive ideas on how to convey messages about the new NSHIF to the general public and key stakeholders. These include the use of various forms of advertising, possibly via an advertising or PR agency. They also involve messages, which will be varied according to the target recipient groups in question. There have already been sensitisation sessions for key senior NHIF staff and board members.

However, it is impossible for the Public Information and Education Working Group to advance much further until the other two Working Groups have produced policy decisions, which can then be communicated on to target groups.

One issue which emerged in discussions with the Public Information and Education Working Group was the interests of NHIF staff themselves as regards their own
health insurance. Staff see current proposals as involving both the potential for some reductions in cover (at some Nairobi hospitals) and some increases in premiums (e.g. for those staff with families). This could cause discord and low morale, and should be addressed by NHIF senior management. While the issue of supplementary insurance may not be the most pressing at this time, early consideration should be given to it.

7. Integrating NSSF and Armed Forces retirement schemes

There is interest by the armed forces and NSSF to make health insurance available to its beneficiaries. NSSF is currently considering changing the provident fund to a monthly pension including health benefits as health has been recognised as an important reason for early death among retirees. The current retirement age is moved from 55 years to 60 years. Proposals to join the two institutions have been discarded as the purpose of a pension fund is fundamentally different from a health insurance. Similarly the Armed Forces are interested to let their veterans join. Fund have been accumulated but not yet used.

A careful study may have to be done to assess the cost of such a scheme. While NSSF members will have contributed to the SHI during their working life, veterans would be a very selective group with high risk due to old age while active soldiers, whose number is not disclosed, are not contributing. This issue requires further financial analysis and projection.

The mission proposes that the inclusion of retirees be considered at a later point in time, when the new NSHIF is operating and financial trends can be assessed. However, the question of health care for the elderly may gain political momentum rather early in the process.

8. Additional Necessary Reforms

Infrastructure improvement

There can be no question that the public health infrastructure needs to be improved in parallel to the introduction the NSHIF. Utilisation rates are likely to increase and demand from the formally employed for amenity services will grow. It will not be financially feasible to offer access to private facilities for all these patients. Therefore public facilities need to be improved as soon as possible.

The mission displayed some difference of opinion over this matter, but the mission leadership feels strongly that it is not recommended to use NHIF assets for this purpose, e.g. through loans, as the assets are currently not known and more importantly it would contradict the operational principles of the NSHIF. Care must also be taken, that loans may default and thus put the financial situation of NSHIF in jeopardy. The fund may also not have the capabilities to manage loans. Initial surpluses should rather be used invest in the operational efficiency of NHIF/NSHIF and to temporarily reduce the demand for tax subsidies. This problem highlights
again the need to undertake a careful audit to determine what the level of assets of the organisation actually is and to help rationalise the discussion about them. In addition the financial credibility to both donors and the general public would benefit from an audit.

Infrastructure improvements should primarily be financed through improved rebates to service providers and international development banks. This would also serve as an incentive to service providers to become more “customer” oriented. The savings to MOH should also be used for infrastructure improvements as e.g. drugs will in future have to be purchased by facilities from the rebates received.

To assess the needs for infrastructural improvements a sample survey of institutions in districts should be conducted. The study should also make proposals for sustainable financing mechanisms for the maintenance and improvement of the infrastructure of the health system. The study should be commissioned locally to make use of Kenyan infrastructure and prices in preparation for the next mission in March. This could serve as a baseline for national cost estimates. In parallel the MOH will have to develop a master plan for facility distribution and improvement for the country as a whole. Development banks may be interested to assist with the financing of the initial facility improvement drive if perspectives for sustainable financing mechanisms are established.

KEMSA

The Kenya Medical Supplies Agencies (KEMSA) has been an autonomous body since 1st July 2003. Its policy is to make available essential drugs and equipment primarily but not exclusively, to public facilities. Eight regional depots have been established. KEMSA is aware of the challenge to compete with other suppliers, e.g. the mission based medical supply facility (MEDS) and even private wholesalers. Competing private suppliers if should, however, also be obliged to serve remote areas.

While KEMSA is preparing for the challenges it urges MOH to make provisions for special funds in case of epidemics. KEMSA can play an important role to reliably supply future NSHIF contractors with quality drugs but a monopolistic relationship must be avoided.

9. Medium- and long-term concerns

Despite the clear progress being made in a range of aspects of the NSHIF, there remain some concerns regarding certain key medium- and long-term issues:

Transition arrangements

The Government’s proposed launch date for the NSHIF is extremely soon (July 2004). Experience from other countries show that it is likely that a number of years (perhaps decades) will pass before the NSHIF covers the entire Kenyan population. This is because for around a third of the population, NSHIF membership will be effectively voluntary, and many of these people will be unconvinced that joining will be worth the contributions, even if they can afford them. In some cases, a lack of NSHIF-accredited facilities in their locality may be the reason.
experience suggests full coverage will come only gradually. Given this, there is an urgent need to develop effective transitional arrangements. For example, once the NSHIF has incorporated the 30% of Kenyans who are poorest as ‘free card’ members, how will the MOH target the remaining its resources in new ways than at present? There is a danger that a ‘two-tier’ health system may develop, with growing differences in quality between NSHIF- and non-NSHIF facilities. The development of a largely fraud-proof mechanism for the identification of the poor is urgent and need to be addressed in the pilot areas. Current waiver systems are obviously deficient as a recent study has shown (IPAR).

**Equity of ‘free card’ issuance**

Arrangements for non-NSHIF members are made particularly important because it is not yet clear what mechanism will be used to identify accurately those deserving free cards. There is a danger that if a sub-optimal mechanism is employed, many genuinely deserving poor Kenyans will be excluded from the NSHIF system, possibly with less access to cost-sharing waivers than at present.

**Danger of resource migration from primary and preventive care to the hospital sector**

Most of the provider facilities which will quickly qualify for accreditation by the NSHIF will be hospitals, whereas as many MOH primary care facilities will struggle to improve their infrastructure enough to qualify. Furthermore, although NSHIF members will be covered for primary care, it is normally the case that patients prefer specialist care whenever it is available. These two features of the new NSHIF system could easily lead to the start of a steady shift of resources from primary care to the hospital sector. One way to limit such a tendency would be to charge a fee for patients that go to specialists without first passing through general practitioners, as mentioned in previous mission reports. Primary care facilities could also be provided with drugs on preferential terms compared to hospitals. However, this might be politically difficult to implement, and would also make NSHIF membership less attractive.

**Stability of NSHIF**

There also remains a concern that the financial stability of the NSHIF may be precarious. One danger is that member utilisation of services may be much higher than predicted. Financial modelling scenarios point to increasing financial shortfalls after initial surpluses. Careful attention to cost control will be necessary to address this danger. This must include attention to the incentive properties of provider payment mechanisms, and the development of chronic care facilities. Surcharges for self referral may be needed as a disincentive against overuse of high level facilities. It must be remembered that there will be a close link between eth composition of the benefit package and the NSHIF’s expenses.

**Link with MDGs, PRSP**

On the positive side, in planning overall health sector strategy, it should be remembered that some features of the NSHIF plan may be useful in moving towards the meeting of Kenya’s Millennium Development Goals (MDGs) and its Poverty Reduction Strategy Paper (PRSP). First, the NSHIF is likely to produce an increased
flow of funds generally into the Kenyan health sector, and the possibility of a decreasing funding requirement for the Ministry of Health compared with what would otherwise be the case. This should allow increased resources to be switched to continuing MOH provision of care. Secondly, those Kenyans that receive ‘free card’ membership of the NSHIF should be precisely those that must be targeted in order to reach the objectives of the MDGs and the PRSP.
Integration of HIV/AIDS

It is hoped that funds can be found, possibly in part through accessing the Global Fund, to integrate HIV/AIDS treatment into NSHIF coverage. This should assist Kenya in its attempt to meet HIV/AIDS treatment targets, although it must be remembered that provision must also be made for non-NSHIF HIV/AIDS sufferers also. The new US PEPFAR initiative may also offer opportunities that should be used effectively.

10. Conclusions and next Steps – Milestones

The change management process towards Social Health Insurance has commenced, and important steps that can be taken even before the bill is passed in Parliament, have been taken. It is recommended that working groups harmonise their efforts using the MS Project planning tool, which will also offer senior management a better insight and overview of the implementation process. The management may also consider the gradual introduction of a quality management system in its own organisation as a management tool.

It is suggested that by the next mission in March distinct milestones are reached e.g.:

- Membership cards designed and tested ready for implementation
- Identify one hundred thousand existing/new members and beneficiaries in pilot areas
- Present operational concept for poverty identification mechanism on the basis of field study in pilot areas
- Present draft contracts for pilot areas for facilities level I - III and complete manpower analysis (compare required tasks and available manpower), including for the pilot areas
- Conduct ‘focus groups’ in order to ascertain the views of current NHIF members and potential future NSHIF members towards the NSHIF plans
- Present updated master plan using MS project
- Present final draft bill to parliament
- Draft NHIF rules and regulations on the basis on pilot area experience

In the mean time the study on the infrastructure needs should be completed to be discussed during the March Mission.

11. TOR for next mission

The current mission differed from previous missions in that NHIF and MOH are now beginning to implement the proposed NSHIF. External missions are no longer needed to develop concepts as these are well established. Instead more specific
technical inputs are needed as identified by the different working groups. The following TOR are therefore proposed for the March mission:

- Review of progress / milestones with WHO-GTZ-DFID team. This would also offer an opportunity to introduce new international stakeholders such as EC, ILO and WB to the project.
- Dialogue of international partners with national stakeholders e.g. Parliamentarians, employers, trade unions, Public Service Commission etc.
- Technical consultations with working groups on draft rules and regulations, progress in pilot areas and as required
- Assist in the design of financial and operational monitoring and evaluation tools for the pilot areas.
- Review of the methodology for identification of the poor
- Review the training needs for district health staff and NHIF area office personnel, including training-of-trainers
Annex 1

Summary of Activities

Thursday January 22\textsuperscript{nd} 2004
- Kick-off meeting with Permanent Secretary W.P. Godo
- Courtesy call on NHIF Board Chairman
- Review of programme with Dr. T. Mboya

Friday 23\textsuperscript{rd} January 2004
- Fieldtrip to Migori accompanied by Mr. W.O. Obam and Mr. C. Rakuom (Potential pilot area)

Saturday 24\textsuperscript{th} January 2004
- Review of programme developed and activities undertaken by the Quality and Contracting NSHIF Team (Team leader, Dr. G.J Midiwo)

Sunday 25\textsuperscript{th} January 2004
- Review of documents

Monday 26\textsuperscript{th} January 2004
- Meeting with NHIF CEO, Dr. Hassan and senior management committee.
- Discussion of draft bill with legal experts
- Review of activities with NHIF Board of Management and Senior Management Committee.

Tuesday 27\textsuperscript{th} January 2004
- Meeting with Managing Trustee of NSSF, Mr. N.O. Mogere
- Meeting with CEO Retirement Benefit Authorities (RBA)
- Continuation of legal consultations
- Visit of Kenya Medical Supplies Agencies (KEMSA), director, Mr. Charles Kandie
- Briefing of WHO Country Director, Kenya, Dr. Eriki and Team

Wednesday 28\textsuperscript{th} January 2004
- Meeting with steering committee (MOH, NSHIF chaired by PS W.P. Godo)
- Briefing session with Dr. T. Mboya
- Continuation of legal consultations

Thursday 29\textsuperscript{th} January 2004
- Discussion with deputy chief economist Ministry of Health, Mr. Muchiri
- Briefing session with Dr. Hassan, CEO NHIF on preliminary findings of mission
- Continuation of legal consultations

Friday 30\textsuperscript{th} January 2004
- Presentation of Mission findings to JICC chaired by Minster for Health, Hon. Charity K. Ngilu