IPF
INSTITUTE OF PUBLIC FINANCE

HEALTHIER DEBATE NEEDED:

DRAWING LESSONS FROM PAST EXPERIENCES TO ENSURE SUCCESS OF KENYA'S SOCIAL HEALTHY INSURANCE (SHI)

Jason Lakin and Gladys Wachira

2024


NHIF
Afya Yetu. Bima Yetu
FROM
TO
SHA
Social Health Authority

TABLE OF CONTENTS

LIST OF ABBREVIATIONS

CHPs-	Community Health Promoters
CT-OVC-	Cash Transfer for Orphans and Vulnerable Children
DMOH-	District Medical Officer of Health
FBOs-	Faith Based Organization
FIF-	Facility Improvement Fund
HFMC-	Health Facility Management Committee
HISP-	Health Insurance Subsidy Program
HSNP-	Hunger Safety Net Program
HSSF-	Health Sector Services Fund
KASAPI-	Kayasa PhilHealth Insurance
LMIC-	Low-and Middle-Income Countries
MOHSW-	Ministry of Health and Social Welfare
NGOs-	Non-Government Organizations
NHIA-	National Health Insurance Authority
NHIF-	National Health Insurance Fund
NHIS-	National Health Insurance Scheme
OOP-	Out-of-Pocket
OPCT-	Older Persons Cash Transfer
PBF-	Performance Based Funding
PHC-	Primary Health Care
POGI-	PhilHealth Organized Groups Interface
RMNCAH-	Reproductive, Maternal, Neonatal, Child and Adolescent Health
SAGA-	Semi-Autonomous Government Agencies
SHA-	Social Health Authority
SHI-	Social Health Insurance
SHIF-	Social Health Insurance Fund
SOE-	State Owned Enterprises
THS-UCP-	Transforming Health System for Universal Care Project
UHC-	Universal Health Coverage

EXECUTIVE SUMMARY

In 2023, the Government of Kenya proposed ambitious legal reforms to transform the country's health system. The reforms aim at universal health coverage through a new social health insurance (SHI) scheme, to be run by a new Social Health Authority (SHA). This Authority replaces the National Hospital Insurance Fund (NHIF), which has long provided public health insurance to the formal sector and a segment (about 25 percent) of the informal sector.

While there is widespread support for enhancing health coverage in Kenya, there is little clarity about how the reform will work. Moreover, there is a paucity of real debate about the potential pitfalls of such reform, and meagre attempts to draw on practices from around the world, or even from Kenya's own history, to inform the current approach to SHIF. This is surprising, because social health insurance reform has been advocated for and pursued aggressively in low and middle-income countries for nearly three decades, and a recent literature review found tens of thousands of articles on the topic.[1] Surely, Kenya can learn something from these experiences.

In this paper, we break down the Kenyan SHI reform into a set of elements that we believe constitute the core pillars of the proposed system. We ask whether we can learn anything about these ideas from cases around the world. Here we describe our major findings with respect to each key area:

- **Affiliation:** Insurance programs require citizens to become members. Globally, efforts by national health insurance schemes to achieve universal affiliation of the informal sector have not been successful. Voluntary approaches often struggle to attract significant participation from the sector due to affordability issues and the perceived lack of value attached to insurance by informal workers, while mandatory enrolment often relies on punitive measures, which tend to be difficult to implement, or run afoul of the law.

  To address this, Kenya could adopt a set of pilots to test out different incentives to encourage informal sector enrolment. Successful approaches could then be rolled out at scale as the SHA works towards a long-term goal of universal health insurance.

- **Progressivity/means-testing:** Social health insurance relies on financing from premiums. To be progressive, it must allow for reduced or no premiums from the poor, which requires some form of assessment of who is poor. Means -testing to target indigents is prone to errors, regardless of the approach. More effective targeting is possible but is costly and requires a politically autonomous, professional agency. On the other hand, a universal scheme without means-testing (based on a single low premium) could eliminate these challenges but would require significant financial resources from the budget and may not be feasible in the current context.

1^ Jamal MH, Abdul Aziz AF, Aizuddin AN and Aljunid SM (2022) "Successes and obstacles in implementing social health insurance in developing and middle-income countries: A scoping review of 5-year recent literatures." Front. Public Health 10:918188. doi: 10.3389/fpubh.2022.918188

Given that some form of targeting is inevitable, at least in the initial stages of SHI implementation, the government's priority should be to ensure that the means-testing process is implemented by an independent entity with minimal errors. Ideally, Kenya should create a single autonomous agency to manage means-testing across the social protection sector.

- **Empanelment of facilities:** Insurance schemes rely on a network of facilities that are "empanelled," meaning that they are licensed to provide insured services to affiliates. This is not new in Kenya, as NHIF also relied on empanelled facilities. Empanelment of facilities under NHIF has historically been hindered by factors such as infrastructure gaps in rural areas, resulting in inequitable access to care. Rolling out the insurance without first filling the infrastructural and human resources for health gaps will likely perpetuate the existing disparities in access to healthcare.

  The government should set up a dedicated fund to improve health infrastructure in marginalized areas. If necessary, the government could phase the rollout of the full package as the supply of services is improved. This could be done either by offering a reduced package more broadly, or a larger package in certain areas first, before expanding geographically.

- **Reimbursements:** Insurance typically means that members can access services in different types of facilities, both public and private. Private facilities often receive inadequate reimbursement rates in public health insurance schemes, which are insufficient to cover their operating costs, while payments are frequently delayed. This problem arises because public facilities are subsidized from general revenues (e.g., for health worker salaries), while private facilities are not. Addressing this requires transparent and meaningful engagement by government with private providers regarding tariffs and ensuring timely compensation for services rendered.

  The government should begin providing services in public facilities as it undertakes negotiations with private sector facilities on fair financing terms for provision of services, expanding only gradually to the network of private providers.

- **Financing:** A core motivation for SHI is to generate resources from members, rather than through general taxation. This means that premium rates and compliance must be high. Poorly financed health insurance schemes often face the risk of overpromising and underdelivering to citizens. An analysis of the projected revenues under the new financing approach in Kenya indicates that the social health insurance scheme should raise substantial new resources for health care in Kenya. However, total health expenditure hinges on the combined resources from the national and county budgets, as well as the new insurance scheme. Whether the new resources are sufficient depends on assumptions about what happens to health budgets, how much investment is needed in infrastructure to ensure that services can be provided across the country, how much demand increases under the system, and the final shape of the covered package.

  The government should immediately publish its forecasts for costs and revenue for the new

system, including the assumptions used to generate these forecasts, and these should take into account changes in demand and the need to invest in infrastructure.

- **Efficiency and Performance:** Governments typically implement SHI because it is believed that splitting purchasers and providers will yield efficiency gains in the health system. This in turn depends on whether the public system genuinely changes its financing model to respond to demand, which is often difficult given that public budgets are tied to existing staff and existing infrastructure. While Performance-Based Financing is under consideration for the Kenyan health system, evidence suggest that it does not consistently lead to significant improvements in health system efficiency. In some cases, outcomes that require higher investments under PBF can be achieved more cost-effectively through Direct Facility Financing (DFF). DFF provides greater autonomy to facilities, but its impact is still conditional on how sizable and flexible the resource pool is at the facility level.

  The government should gradually provide greater autonomy to facilities and provide a roadmap for more comprehensive human resource reforms. Unless there is considerable freedom to reallocate staff across facilities and roles in response to demand, there are limits to what facility autonomy can achieve.

- **Transparency:** Semi-Autonomous Government Agencies (SAGAs) in Kenya, such as NHIF, have long faced criticism for a lack of transparency and mismanagement of funds. Any insurance program, even one which is mandatory, relies on trust. Willingness to comply with premium payments and other regulations is eroded when agencies are opaque. As the Social Health Authority (SHA) assumes responsibility for more funds than NHIF, it is crucial for the authority to be more transparent, including publicizing financial documents as required by law for better accountability.

  Government should begin publishing financial statements for SHA from the start, and audited statements related to the transition from NHIF to SHA. In addition, it should publish quarterly updates on the payout ratio, infrastructure gap investments, and analysis of leading cost drivers under the SHIF benefits package.

INTRODUCTION

In late 2023, the Government of Kenya introduced a set of health laws designed to transform the Kenyan health system. These laws have been subject to litigation and are in various stages of implementation. Nevertheless, taken together they represent an ambitious package of reforms geared toward expanding health access and making the health system more equitable, efficient and effective.

The Kenyan approach anticipates moving toward universal health coverage through expanded social health insurance (SHI) coverage. The attempt to introduce a universal social health insurance program in Kenya, as elsewhere, requires new approaches to a host of issues, from affiliation of members and empanelment of facilities to new financing streams and changes in human resource policies. Kenya's reform also involves ancillary reforms that are not necessarily logically tied to the insurance model, but may be expected to support system efficiency, such as overhauling the referral system.

While this agenda may be ambitious, Kenya is not the first country to attempt to achieve UHC through expanded social health insurance. Relevant experiences abound: not just of the overall SHI reform, but also of specific pieces of it. For example, we might look to a country like Mexico, which introduced a similar social health insurance reform in 2004, to understand the challenges of comprehensive social health insurance reform, but we might also look to Kenya's own experiences with a range of social protection programs to understand specific challenges, such as those related to means-testing.

In this paper, we do both: we consider experiences from Kenya's own history of reform, while also examining global experiences, drawing heavily on the rollout of Mexico's 2004 Seguro Popular reform, which one of the authors has studied closely.[2] Our approach is to try to first unpack the Kenyan reforms into key components. Unfortunately, while there are a set of laws and numerous public statements, there is no single, comprehensive and coherent policy framework guiding reform. We triangulate among various laws and policy documents to try to understand what the reform is aiming at and how. We then anticipate potential challenges with implementing these components, pointing to lessons from other cases. Our goal is not so much to criticize the reform path as it is to support reformers, by drawing their attention to areas that may not have received sufficient attention.

The areas we focus on are:

- Affiliation
- Progressivity/means-testing

2^ Mexico's Seguro Popular was piloted in 2003 and rolled out starting in 2004. It operated until 2020, when the Mexican government opted for a different approach to health system reform.

- Empanelment of facilities
- Reimbursements
- Financing
- Performance
- Transparency

Our central claim is that the government must do more to explain how it plans to address the challenges we describe here. We take it as a given that Kenya should move toward universal health coverage. And we take no position here on whether the specific reform direction of the current government is correct: SHI reforms are challenging to implement, but done well, they can improve health access. To the extent that a successful reform would lead to greater access to health services and a more effective and efficient health care delivery system, we want to see it succeed. But we do believe that without a clearer set of policies that demonstrate awareness of potential reform pitfalls, the reform process is likely to be derailed.

Based on our analysis, we recommend that the government:

1. Consider incentives to encourage SHI affiliation for the informal sector. The mandate approach might be effective, but the courts have ruled that sanctioning those who fail to comply is unconstitutional. When sticks fail, there must be carrots.

2. If the government is committed to the use of means-testing, it should create a single, politically autonomous agency to manage means-testing for SHI and all social (protection) programs in Kenya. This will ensure that SHI benefits from a robust, reliable targeting regime and will reduce classification error. This recommendation aligns with the proposal made by the Budget and Appropriations Committee in 2021, to consolidate certain social protection programs.

3. Create a special fund to fill health infrastructure gaps, so that insurance can effectively be utilized around the country. This fund should be set up now but can also accrue a share of the insurance resources or be agreed to under the national revenue sharing framework with counties (in coordination with the Commission on Revenue Allocation). If the infrastructure gaps in the country can only be addressed gradually, consider implementing a more reduced benefits package in the initial years, to be expanded along with infrastructure.

4. Undertake immediate and transparent negotiations with private sector facilities on fair financing terms for provision of services, with an intention to start with provision in public facilities and expand only gradually to the network of private providers.

5. Publish estimates of the required resources to ensure sustainability of SHI, including resources from premia, the budget at both national and county level, and incorporating estimates of

demand and the need to fill infrastructure gaps.

6. Move gradually to provide greater autonomy to facilities and provide a roadmap for more comprehensive human resource reforms to enable proper demand-side financing. Unless there is considerable freedom to reallocate staff across facilities and roles, there are limits to what facility autonomy can achieve.

7. Develop and publish financial statements for SHA from the outset, and audited statements related to the transition from NHIF to SHA. In addition, provide quarterly updates on the payout ratio, infrastructure gap investments, and analysis of leading cost drivers under the SHIF benefits package.

SOURCES AND METHODS

We briefly say a word about sources and methods. Our method is opportunistic: we have drawn on relevant experiences that we are aware of and that emerged from a limited literature review of recent SHI reforms. We also draw heavily on one of the author's experiences and published work on the Mexico SHI reform, which shares many of the goals and features of the Kenyan reforms. Unless otherwise cited, findings from Mexico draw from Jason Lakin, "The End of Insurance? Mexico's Seguro Popular, 2001 – 2007," *Journal of Health Politics, Policy and Law*, Vol. 35, No. 3, June 2010. Other sources are cited in the usual manner.

We do not make claims of comprehensiveness, as no such claims are necessary for our purposes. Our goal is to point to similar reform episodes from which Kenyan policymakers may be able to learn, not to provide a rigorous assessment of all such reforms. In any case, given the complexity and heterogeneity of such reforms, no such rigorous assessment would yield meaningful results for policymakers.

In the next section of the paper, we describe key components of the reform as we understand them and raise questions and concerns about each that we think need to be addressed for reform to succeed.

REFORM COMPONENTS: GOALS AND CHALLENGES

AFFILIATION

The government aims to expand health insurance coverage to the informal sector. Unlike traditional national health services, which are meant to treat anyone who walks through the door, insurance programs require members of the public to affiliate. Affiliation entails both registration and payment of fees. Around the world, the focus of social health insurance reform is typically affiliation of the informal sector, as formal sector workers are usually affiliated automatically through their employers.

Kenya's approach

As per the Social Health Insurance Act, 2023, Article 27, every Kenyan household shall be affiliated to the new Social Health Insurance Fund (SHIF). Formal sector workers shall continue to be affiliated (registered and pay) through their employers, as has been the case under the erstwhile public insurer, the National Hospital Insurance Fund (NHIF). All others shall pay based on their income on an annual basis, but the law does not explain the affiliation process in any detail for those in the informal sector. The SHI Regulations, 2024, do indicate that the mode of registration shall be directly to the Social Health Authority. The regulations are somewhat unclear on this point, but it appears that even formal sector workers will need to register with the Authority and that registration is to be done in person.[3]

Experience and Challenges: Kenya

Around the world, enforcing mandatory contributions from the informal sector has always been difficult (see below). Kenya's own experience with NHIF has been similar: NHIF hospital cover was mandatory for the informal sector for more than two decades before these new reforms, yet coverage was always minimal.[4] The coverage rate of the informal sector averaged at nearly 25 percent between FY 2017/18 and FY 2019/20. The data suggest that, as in other countries, the informal sector, primarily the poor and near-poor informal sector, finds insurance too costly and of limited value.[5] This may in part be due to lack of information: generally, informal workers seem to have been ill-informed around the NHIF benefit package.6 But information alone is an insufficient

3^ SHI Regulation 2024, 11, "Initial registration" appears to apply to all Kenyan residents, and mobile registration is to be availed only to special groups, such as the disabled.

4^ See National Hospital Insurance Fund Act of 1998. Section 15 requires both formal and self-employed workers to participate, though there was a minimum income threshold of 1000 Ksh for the self-employed.

5^ Maritim B, Koon AD, Kimaina A, Lagat C, Riungu E, Laktabai J, Ruhl LJ, Kibiwot M, Scanlon ML, Goudge J. "It is like an umbrella covering you, yet it does not protect you from the rain": a mixed methods study of insurance affordability, coverage, and financial protection in rural western Kenya. Int J Equity Health. 2023 Feb 6;22(1):27. doi: 10.1186/s12939-023-01837-2. PMID: 36747182; PMCID: PMC9901092.

6^ Maritim B, Koon AD, Kimaina A, Goudge J. Citizen engagement in national health insurance in rural western Kenya. Health Policy Plan. 2024 Apr

explanation.

From 2022, the NHIF began to offer more comprehensive coverage, including outpatient cover, through the National Health Scheme ("Supacover"). This scheme was voluntary for the self-employed, and only 12 percent of the informal sector were active NHIF members.[7]

Experience and Challenges: Global

Countries around the world have tried to affiliate the informal sector using a wide range of tools. These tools have often proven ineffective. As with Kenya's NHIF experience, one major challenge relates to mandating payments that are too high for many informal sector households to afford. At the same time, if the price of insurance is too low, then it will be taken up by higher-income households that are easier to affiliate, while poorer households remain on the margins of the policy. Finally, what makes the informal sector "informal" is precisely that its activities and data are not well-captured by formal systems (e.g., tax, insurance, and regulatory systems), and that the costs and benefits to informal workers of formalizing are skewed toward remaining informal. Simply wishing that it be otherwise does not solve this problem.

In Mexico, the government initially proposed that all informal sector workers should pay a graduated premium to access services. Later, the bottom two deciles of the income distribution were exempted. In actual fact, the program struggled to affiliate any informal sector households that paid for the program.

10;39(4):387-399. doi: 10.1093/heapol/czae007. PMID: 38334694; PMCID: PMC11005831.

7^ The calculation was based on the number of active informal sector members as reported by the Office of the Auditor General (OAG) in the audit report on National Health Insurance Fund for the Year Ended 30 June, 2023. This was then compared to the total informal sector numbers as provided by the Kenya National Bureau of Statistics (KNBS) in the 2023 Economic Survey.

As of 2008, several years into program implementation, the share of affiliates paying any premium at all was just three (3) percent.

While the government claimed that the low share of paying affiliates was due to the fact that over 90 percent of members were poor, independent assessments suggested that at least half of the affiliated families had incomes above that level and should have been paying a premium. In this case, in other words, the effective premium for most households was too low, which led to more affiliation from beneficiaries above the poverty line, while not all poor households were reached.

Because poorer informal sector workers often see little value in prepaying for health care, the result is often a tension between affiliation and financing: if the government tightens the financial contribution mandate, fewer households will affiliate to the program.[8] But if it loosens it, then it will end up with less financing than planned. As noted, the relative tightness of the payment regime affects not only overall affiliation, but its distribution. Looser payment requirements may lead to higher affiliation, but mainly from higher-income households. We look at this issue in more detail in the section on means-testing.

Tightening the regime for affiliation generally means using some form of punitive measures for those who fail to register. Initially, the Kenyan government proposed measures such as denying medical care and other government services to individuals who had not paid their premiums, aiming to incentivize compliance. In addition to being punitive, implementing these measures tends to be difficult, as they require collaboration with various government agencies that might lack the incentive or capacity for enforcement. They may also face legal challenges, as has already occurred in Kenya with the High Court declaring denial of care unconstitutional, as the basic law guarantees emergency medical treatment to all citizens.[9] Because the proposed measures lacked exemptions for emergency care, the court determined that they infringed upon this fundamental right by denying essential medical services to those unable to afford insurance.[10] A mandate might still be feasible with certain exemptions, but difficult to implement.

Some countries have tried alternative mechanisms to enrol the informal sector, both poor and non-poor, such as community enrolment, rather than individual registration. However, these approaches have had limited success. The Philippines national health insurance program, PhilHealth, for example, began with individual registration, but found that individual mandates were insufficient to raise non-poor informal sector participation above 60 percent.[11] The government then tried to form partnerships with organized groups, such as self-help and savings groups, to increase participation and collect contributions from the informal sector through something known as the PhilHealth Organized Groups Interface (POGI). However, the participation incentives provided to the groups, such as discounts on premiums, were not sufficient to sustain group collection efforts.[12] Eventually, the group collectors were

8^ See Abhijit Bannerjee and Esther Duflo, Poor Economics, Gurugram: Penguin Random House, 2011, Chapter 3, which shows that the poor often have low demand for preventive care, relative to curative care.

9^ Republic of Kenya. Constitution of Kenya. 2010. Available from: http://www.parliament.go.ke/sites/default/files/2023-03/The_Constitution_of_Kenya_2010.pdf

10^ Republic of Kenya. In the High Court, Nairobi – Constitutional and Human Rights Division – Petition No E473 of 2023 – SHIF Judgment. 2024. Available from: https://judiciary.go.ke/download/in-the-high-court-nairobi-constitutional-and-human-rights-division-petition-no-e473-of-2023-shif-judgment/ /

11^ Bonfert, A., Özaltin, A., Heymann, M., Hussein, K., Hennig, J., Langenbrunner, J. Closing the Gap: Health Coverage for Non-poor Informal Sector Workers. Joint Learning Network for Universal Health Coverage, 2015. Available from: https://r4d.org/wp-content/uploads/ClosingTheGap_FINAL.pdf

12^ Bonfert, A., et al. Closing the Gap: Health Coverage for Non-poor Informal Sector Workers. 2015

no longer willing to collect the funds, and PhilHealth therefore had to transition back to individual membership which was marked by high default rates.[13]

The POGI initiative was followed by the Kalusugan Sigurado at Abot Kayasa PhilHealth Insurance (KASAPI) initiative where the government tried to enrol the informal sector through microfinance groups. This was equally unsuccessful.[14] Of the 600,000 members registered under the 14 organized groups in the program, only about 23,000 were enrolled in the health insurance scheme.[15] A common challenge across the initiatives was that members from the informal sector could not sustain the premiums after enrolment and therefore dropped out of the program.

Rwanda has had more success with community-based enrolment. The introduction of the Community Based Health Insurance (CBHI) scheme- Mutuelle de santé- has enrolled 87 percent of the informal sector. This is higher than what most countries have achieved. However, the financial viability of the scheme remains a significant concern as it has consistently faced deficits since 2011.[16] The deficit has increased from 3.9 billion Rwandan Francs (RWF) to 19.2 billion RWF in FY 2018/19, requiring further injections of general revenue to cover shortfalls, which have averaged close to a third of total costs.[17,18] A significant challenge in the scheme is the failure of members to pay their premiums. Many members in the informal sector have incomes that fluctuate throughout the year. This seasonality makes it hard for them to budget for fixed premiums, leading to payment lapses.

A second issue has to do with means-testing, an issue we discuss further below. The

Ubudehe scaling categorizes households into four economic tiers, and the government covers the premiums for only those in Ubudehe I.[19] However, the system sometimes places households in the wrong tier, meaning they are charged a higher premium than their financial situation allows, which ultimately leads to non-payment.[20]

Is there a way forward?

Are there alternatives to punitive mandates or community affiliation to ensure program uptake? The most obvious is to make the program free. At that price, everyone has an incentive to join. However, offering free insurance undermines a key goal of any insurance regime, which is prepayment. The alternative to sticks is always carrots: if the program is not free, then it must offer benefits that are so attractive, people are willing to pay for them freely, without threat of

13^ Cristina G. Bautista, Maria. National Health Insurance, the Informal Sector, and Elements of a New Social Contract in the 2019 UHC Act of the Philippines. Health Insurance, IntechOpen, 19 Oct. 2022. Crossref, doi:10.5772/intechopen.1037206

14^ Paterno RP. The Future of Universal Health Coverage: A Philippine Perspective. Global Health Governance. 2013; VI.No.2 (Summer 2013). Availabble from: https://blogs.shu.edu/ghg/files/2014/02/GHGJ_62_32-52_PATERNO.pdf

15^ Manasan RG. Expanding Social Health Insurance Coverage: New Issues and Challenges. PIDS Discussion Paper Series. 2011 Nov; No. 2011-21.

16 Ministry of Health. Health Sector Annual Performance Report 2020-2021. 2021. Available from: https://www.moh.gov.rw/fileadmin/user_upload/Moh/Publications/Reports/Health_Sector_Annual_Performance_Report_2020-2021.pdf

17 Nyandekwe M, Nzayirambaho M, Kakoma JB. Universal health insurance in Rwanda: major challenges and solutions for financial sustainability case study of Rwanda community-based health insurance part I. Pan Afr Med J. 2020 Sep 14;37:55. doi: 10.11604/pamj.2020.37.55.20376. PMID: 33209182; PMCID: PMC7648486.

18 Rwanda Social Security Board. Annual Report and Financial Statements for the Year Ended 30 June 2019. Available from: https://www.rssb.rw/uploads/Annual_Report_Financial_Statements_2018_2019_ae6yxn_baa0ed14bf.pdf

19 Rwanda Social Security Board. Community Based Health Insurance (CBHI): An Overview. Aug 2023. Available from: https://www.shareweb.ch/site/Health/Slides%20%20SDC%20Health%20F2F%202023/Rwanda%20Social%20Security%20Board%20RSSB.pdf

20 ILO Social Protection Department. Rwanda: Progress towards Universal Health Coverage. 2016 Available from: https://www.social-protection.org/gimi/gess/Media.action;jsessionid=rcN1flVoZMFnV5WLC63QeLvRlOdWnYrUCFbL_gFyB8pXtgQPtqQn!11591451?id=12831

sanction. This same problem plagues the tax sector: in theory, the way to get informal sector businesses and workers to pay tax is to offer them something appealing in exchange. This has proven notoriously difficult, while experiments with associational tax (similar to community-based health affiliation) havesimilarly had relatively few successes.[21]

Turning punitive measures into incentives means thinking about what families want: would households be more likely to pay insurance premiums if they received free books and school uniforms, for example? What alternative "carrots" would the informal sector embrace, if any? Experimental results have shown that free food is a strong enough incentive to get rural Indian families to immunize their children, though it tends to work well for the first shot and be less effective in stimulating parents to finish the vaccine course.[22] That might not be a problem if insurance enrolment was relatively infrequent. In the Kenyan context, different carrots might be more or less effective. Piloting few approaches might be worthwhile. Of course, however, if the cost of incentives is too high, this will undermine the financing goals of the reform: instead of generating new funding from premiums, the government will be paying for people to join.

21 See Roel Dom and Wilson Prichard, "Taxing SMEs," Chapter 4 in Dom, Roel, et al, "Innovations in Tax Compliance: Building Trust, Navigating Politics and Tailoring Reform," World Bank, 2022. https://issuu.com/world.bank.publications/docs/9781464817557/s/15149210

22 Bannerjee and Duflo, Poor Economics, Chapter 3.See Roel Dom and Wilson Prichard, "Taxing SMEs," Chapter 4 in Dom, Roel, et al, "Innovations in Tax

PROGRESSIVITY AND MEANS-TESTING

Kenya's Approach

The social health insurance scheme is meant to ensure that access to health is not constrained by ability to pay, but also that those who can contribute more do so. To make the social health insurance scheme more progressive than the previous NHIF (Supacover) scheme, the Kenyan government is charging formal sector employees 2.75 percent of their income as premiums, rather than relying on the previous graduated rate approach, where contributions ranged from Ksh. 150 to Ksh. 1700.

Table 1: NHIF vs SHIF Premiums

Gross Income (Ksh.)	NHIF Monthly Premiums (Ksh.)	SHIF Monthly Premiums (Ksh.)
Up to 5,999	150	300
6,000 – 7,999	300	300
8,000 – 11,999	400	300-330
12,000-14,999	500	330-412
15,000-19,999	600	412 - 550
20,000 – 24,999	750	550 - 687
25,000 – 29,999	850	687 – 825
30,000 – 34,999	900	825 - 963
35,000 – 39,999	950	963 – 1,100
40,000 – 44,999	1,000	1,100 – 1,237
45,000 – 49,999	1,100	1,237 – 1,375
50,000 – 59,999	1,200	1,375 – 1,650
60,000 – 69,999	1,300	1,650 – 1,925
70,000 – 79,999	1,400	1,925 – 2,200
80,000 – 89,999	1,500	2,200 – 2,475
90,000 – 99,999	1,600	2,475 – 2,750
100,000 and above	1,700	2,750 and above

Moreover, the poor will receive government subsidies to cover their premiums. The Act is not clear on whether the poor will be wholly subsidized or only partly subsidized. The regulations suggest that the poor will be fully subsidized, but the law appears to contradict this, suggesting that the minimum premium for informal sector workers is Ksh.300 per month.

The regulations indicate that a means-testing instrument will be used to identify those who should receive subsidies. Means-testing is

already used in Kenya for a variety of purposes, but there is no single approach across social programs.

Experience and Challenges: Kenya

The Health Insurance Subsidy Program (HISP), a government program under NHIF aimed at providing financial protection to vulnerable populations, also used means-testing, but evidence from a 2015 baseline survey of the HISP program suggests that undeserving individuals benefited from the program. The program had high levels of inclusion errors with 65 percent of the beneficiaries being in the richest two quintiles.[23] Given that the program was developed to target poor households, most of the beneficiaries should have been in the poorest quintile, rather than the richest.

Like HISP, the targeting schemes used in other social protection programs in Kenya also exhibit significant inaccuracies. For example, the Hunger Safety Net Program (HSNP), which relies on proxy means testing, was found to have both high exclusion errors (62 percent) and high inclusion errors (68 percent) in its second phase of implementation.[24] A large portion of truly needy individuals were missed by the targeting system, while others who were not eligible benefited.

Kidd and Athias's (2019) review of multiple social protection programs based on Proxy Means Testing (PMT), including the HSNP, found that the programs, 'could have used a lottery, and the result would not have been much different.'[25] Silva-Leander and Merttens (2016) had previously reached a similar conclusion after reviewing the HSNP program in 2016.[26] Furthermore, the Cash Transfer for Orphans and Vulnerable Children (CT-OVC) and Older Persons Cash Transfer (OPCT) programs were found to have inclusion errors of 50 percent for the two programs. [27]

Experience and Challenges: Global

Of course, all means testing is subject to error, but experience suggests that the level of error is also a political decision. In Mexico, at the time of the health reform, a highly effective conditional cash transfer program was in place based on a rigorous means-testing regime (Progresa/Oportunidades). In spite of having such a credible regime in place, the government opted to use a less robust approach for means-testing in the health program, presumably as part of a strategy to ensure higher levels of affiliation by bringing in families above the poverty line without requiring them to pay for the program.

This evidence suggests that, in the absence of a rigorous means-testing approach that is insulated from politics, many beneficiaries will participate in the program without paying. As long as the poorest are able to access the program, this might not be problematic from an equity perspective. But if non-poor participants manage to participate without contributing, this will undermine program

23 Barasa E, Rogo K, Mwaura N, Chuma J. Kenya National Hospital Insurance Fund Reforms: Implications and Lessons for Universal Health Coverage. Health Syst Reform. 2018;4(4):346-361. doi: 10.1080/23288604.2018.1513267. Epub 2018 Nov 6. PMID: 30398396; PMCID: PMC7116659.

24 Gardner C, Riungu C, O'Brien C, Merttens F. Evaluation of the Hunger Safety Net Programme Phase 2 The legacy of HSNP Phase 2: Systems, Practices and Lessons Learned. Oxford Policy Management. 2017.

25 Kidd S, Athias D . Hit and Miss: An Assessment of Targeting Effectiveness in Social Protection. March 2019. Available from: https://www.developmentpathways.co.uk/wp-content/uploads/2019/03/Hit-and-Miss-March13-1.pdf

26 Silva-Leander S, Merttens F. Assessment of Programme Targeting. 2016. Available from: https://www.opml.co.uk/files/Publications/a0013-evaluation-kenya-hunger-safety-net-programme/assessment-of-hsnp2-targeting.pdf?noredirect=1

27 Republic of Kenya. Kenya Social Protection Sector Review. Jun, 2017. Available from: https://www.unicef.org/esa/sites/unicef.org.esa/files/2019-04/PER-and-Sector-Review-of-Social-Protection-in-Kenya-%282017%29.pdf

finances. Accessing health without paying is an attribute of traditional national health services; an insurance model is explicitly designed to be based on pre-payment, usually with the intention of increasing the available resources for health. If the ultimate goal is simply to increase financing for health without any insurance premiums, it would be more efficient to direct general revenues to the existing system than to set up a new benefits administration that does not function.

Is there a way forward?

Means-testing is generally introduced to conserve scarce public resources and ensure that they are targeted to those most in need. But means-testing is not always effective, as the discussion above shows. Kenyan and global experience suggest that if means-testing is to function, there needs to be a strong political commitment to using the best available means-testing scheme, one that is independent and rigorous. Such schemes have costs, however, both financial and political. If the government is willing to create a truly independent agency to elaborate and implement a means-testing system, this is a viable option.[28,29]

An alternative is a universal scheme without means-testing, where informal sector workers pay a fee that is low enough that everyone can afford it (such as the minimum payment of Ksh. 300, though that may still be too high). Such a scheme will inevitably also subsidize those who do not need support, but many higher-income Kenyans will still opt out of the public system and for private care. Ineffective means-testing, as discussed, also provides a subsidy to the non-poor, and in addition wastes resources that could be used to provide health care. We discuss the financial implications of these alternatives further below, in the section on financing.

28 See The Budget and Appropriations Committee Report on Estimates of Revenue and Expenditure for the Financial Year 2021/22, which has a discussion on p.20 regarding the merging of social protection programs, which would presumably lead to a unified means-testing approach. However, there has been no movement in this direction yet.

29 See Wangari Ng'ang'a, Mercy Mwangangi and Gatome-Munyua, Health Reforms in Pursuit of Universal Health Coverage: Lessons from Kenyan Bureaucrats. Health Systems & Reforms. 2024;10(3). This review argues that had a unique identifier system been developed through cross-sectoral collaboration, the Health Insurance Subsidy Program could have been implemented more efficiently.

EMPANELMENT AND INFRASTRUCTURE

Kenya's approach

The SHI laws allow for both private and public facilities to apply for empanelment, indicating the government's commitment to competition, and to ensuring that facilities meet certain standards to be able to provide care. Empanelment is a critical aspect of insurance, and a foundation for contracting across the public and private sector.

However, the empanelment process is likely to face challenges. What happens when critical facilities in an area fail to meet the minimum empanelment requirements, particularly in areas where only one facility is available? There is no clear policy or legal document that lays this out for Kenya, but we can nevertheless consider the possibilities. In such cases, several options exist, with each having significant implications for health access:

1. *The facilities could be excluded from the program entirely. Doing so would restrict access to the benefits especially for residents in remote or underserved locations. This would likely replicate the situation of NHIF, where most of the accredited facilities were concentrated in urban areas due to their better resources and equipment. Such an approach would perpetuate geographical inequities in healthcare access.*

2. *Empanelment could be jettisoned, so that these sub-standard facilities can continue to provide services. This is likely to compromise the quality of care, as there would no longer be minimum requirements in place for compliance. Many facilities would be unable to provide services, and any "guaranteed" package would no longer be guaranteed.*

3. *A third option involves mandating infrastructure improvements for the facilities that wish to be empanelled. However, this approach raises a critical question: who bears the financial burden for these improvements and over what time period will they be permitted? The "catch-up" costs of building or improving infrastructure in under-served regions is an additional cost that is not intrinsic to the insurance system. It requires more resources and an equalization plan.*

Empanelment is also challenging as it requires continuous accreditation. If facilities are only accredited once, then there is no guarantee that over time they are still able to provide adequate services. It is not clear that the reform package foresees a process of continuous accreditation or has budgeted for it.

Experience and challenges: Kenya

The accreditation process for facilities under NHIF was a barrier to the participation of some health providers. Many facilities found it difficult to meet the accreditation requirements, particularly regarding infrastructure. Facilities often needed to make costly infrastructural changes, which they could not afford. Affordability was not the only challenge: for example, while facilities in rented

spaces might want to make the improvements, they were limited by their tenancy agreements.[30]

Moreover, there were delays in the inspection and accreditation process, with some facilities not receiving any feedback on their inspection. Unscrupulous NHIF officials took advantage of this and began asking for bribes to complete or speed up the accreditation process for the facilities.[21]

While the private facilities had to upgrade their infrastructure to get accredited, not all public facilities had to meet the same requirements. Some of the contracted public hospitals, especially in rural and marginalized areas, lacked the appropriate infrastructure and human resources for service delivery, but were accredited anyway. Therefore, even if patients had NHIF cards, they could not receive comprehensive treatment from these facilities. Such infrastructural gaps are one reason why most of NHIF's contracted facilities were private facilities in urban and peri-urban areas.[31]

NHIF was required to make annual inspections of the accredited facilities to ensure that they maintained the standard of care. To do this, a benefits and quality assurance management committee and organizational department was established. However, annual inspections were a rare occurrence.[32]

A significant disparity emerged in the distribution of those that were ultimately successful in being accredited. A recent study found that Kenyans take an average of 3 hours and 30 minutes to reach any NHIF contracted facility. The inequities in access are amplified at the county level. In only 4 of the 47 counties- Kiambu, Kisii, Nairobi and Nyamira- do residents live within a maximum of 1 hour travel radius of an accredited facility. Travel times vary dramatically across the other regions: while a resident of Vihiga county can access a NHIF contracted facility in just 10 minutes, a person in Garissa would take 33 times longer! Unfortunately, access to NHIF-contracted facilities is significantly lower in counties already facing challenges of marginalization. All counties with less than 60 percent of their population within an hour's reach of an NHIF facility are considered marginalized: Narok, Isiolo, Garissa, Marsabit, Tana River, West Pokot, Samburu, Turkana, Mandera and Wajir.[33]

Beyond infrastructural gaps, inadequate human resources for health have continued to be a persistent challenge in the Kenyan health system. A Health Labour Market Analysis for Kenya undertaken in 2023 revealed that the current health workforce covers only 76 percent of the demand, and is expected to decline to 60 percent by 2035, if no corrective action is taken. The projected widening of the health worker supply gap is due to increasing health needs arising from population growth and increasing disease burden. Not only are the health workers insufficient, they are also inequitably distributed across the country. These disparities occur, in part, because marginalized counties struggle to provide sufficient incentives to attract and retain qualified healthcare officials, even under devolution. Counties such as Lamu have 4 times as many healthcare workers as expected for their share of total population, while Kajiado and Nakuru only have 30 percent and 40 percent

30 Sieverding M, Onyango C, Suchman L. Private healthcare provider experiences with social health insurance schemes: Findings from a qualitative study in Ghana and Kenya. PLoS One. 2018 Feb 22;13(2):e0192973. doi: 10.1371/journal.pone.0192973. PMID: 29470545; PMCID: PMC5823407.

31 Mbau R, Kabia E, Honda A, Hanson K, Barasa E. Examining purchasing reforms towards universal health coverage by the National Hospital Insurance Fund in Kenya. Int J Equity Health. 2020 Feb 3;19(1):19. doi: 10.1186/s12939-019-1116-x. PMID: 32013955; PMCID: PMC6998279.

32 Munge K, Mulupi S, Barasa EW, Chuma J. A Critical Analysis of Purchasing Arrangements in Kenya: The Case of the National Hospital Insurance Fund. Int J Health Policy Manag. 2018 Mar 1;7(3):244-254. doi: 10.15171/ijhpm.2017.81. PMID: 29524953; PMCID: PMC5890069.

33 Kazungu J, Moturi AK, Kuhora S, Ouko J, Quaife M, Nonvignon J, Barasa E. Examining inequalities in spatial access to national health insurance fund contracted facilities in Kenya. Int J Equity Health. 2024 Apr 18;23(1):78. doi: 10.1186/s12939-024-02171-x. PMID: 38637821; PMCID: PMC11027528.

of their share of the total national population.[34] For the inadequately staffed counties, this means longer wait times for medical care. While insurance plays a role in improving access to care, it alone cannot address the underlying challenges faced by these regions.

Experience and challenges: Global

Where it is challenging to empanel facilities due to infrastructure gaps, accreditation programs are sometimes discarded. Rather than directly halting empanelment of facilities, this might happen indirectly, by simply going slow on enforcement of empanelling requirements. In Mexico, for example, empanelment never ceased, but poorer states were quietly allowed to continue operating without providing all of the services expected under the program. This ensured continuity of care but undermined the claim of a guaranteed essential package. Mexico's poorest state, Chiapas, was explicitly permitted to offer a reduced set of services from the beginning, while in other poor states it was simply not possible to provide the full package of services, at least for several years after implementation began. In addition, across the country, accreditation was ultimately reduced to a one-off process, as the government lacked the capacity to carry it out on a regular basis.[35]

In Mexico, reformers understood from reform inception that a special financing stream would be needed to address infrastructure gaps ("catch-up"), and a fund was built into the initial law. The Budgetary Provision Fund allocated 2 percent of total reform resources to infrastructure investment in marginalized areas.[36] These funds were not necessarily spent: data from 2008 shows that only 21 percent of the allocated funds were even transferred to the states, and it is not clear how much of that was actually executed.[37] As with all policies, getting it right means not just having good policy, but securing the funding, and executing. As of now, it is not clear that the Kenyan reform has done any of these with respect to preparing to address infrastructure gaps.

On the other hand, we also know that as Seguro Popular was rolled out in Mexico, various compromises were made between the desire to provide access to more people, and the desire to invest in more hospital infrastructure. In order to encourage states to accelerate implementation of the reform, the national government permitted states to credit infrastructure investments from previous years against the requirement to inject new resources into service delivery. This meant, in effect, that service delivery costs were under-financed to allow states to invest more in infrastructure. Where both the supply of health services and the demand for health services are not met, health insurance programs need more funding to address each simultaneously, raising their costs.

Is there a way forward?

One approach is to spend a year or two investing heavily in the infrastructure and equipment gaps that undermine service standards in marginalized areas of the country, prior to rolling out insurance. Any delay in rolling out social insurance coverage may be politically challenging, but investments in infrastructure are also politically appealing. Infrastructure investments are costly, however, at a time when the government's finances are precarious.

34 Ministry of Health. Health Labour Market Analysis for Kenya. 2023 Sept. Available from: https://labourmarket.go.ke/media/resources/Final_Kenya_HLMA_Report_2023_v8.pdf

35 OECD, Review of Health Systems: Mexico, 2016

36 OECD, Review of Health Systems: Mexico, 2005

37 Lavielle B. Influenza y gasto público en salud. Fundar, Centro de Análisis e Investigación; 2009.

An alternative is to focus the program, and therefore the facility requirements, on a more reduced set of services in the first couple of years before expanding further.

Expanding healthcare infrastructure alone is insufficient to improve health care access. It must be accompanied by investments to ensure that there is an adequate, well-trained and equitably distributed health workforce. The deployment of health workers should be done strategically, taking into account factors such as population density. Moreover, incentives such as higher salaries, better working conditions and career growth opportunities can be offered by the government to encourage medical personnel to serve in underserved areas, though these are costly. However, this is a decentralized function, and any individual county's recruitment strategy has externalities for other counties to ensure equity. Thus, there is a need for coordination across counties and with the national government.

REIMBURSEMENT TO PRIVATE AND PUBLIC PROVIDERS

Kenya's Approach

The MoH, in consultation with the SHA Board, has developed and released proposed new tariffs for SHIF.[38] The regulations mandate a single tariff system, applicable to the benefits package for all facilities. While consultative engagements with different sector players have yet to be held, there are concerns regarding the fairness to private sector providers of a single tariff.[39]

The inclusion of the private sector offers several advantages in an insurance scheme: it expands the network of providers, giving beneficiaries more options, and introduces competition into the system. This competition incentivizes both private and public providers to improve their quality of care. Additionally, the private sector facilities help reduce the burden on public hospitals.

However, unlike public health facilities, private facilities bear the full cost of their human resources for health, which means that they must be reimbursed more, since they receive no wage subsidy for their employees, unlike public facilities. Uncompetitive tariffs that ignore this difference would disadvantage private providers. This might result in adoption of unethical practices by private providers to increase their reimbursements, such as undertreating patients to minimize costs or admitting patients who could have been treated through less expensive outpatient care.

Private facilities might also opt out of the program entirely. This would reduce the availability of higher-level care under SHIF, such as that provided by Level 4 and 5 facilities, which tend to be privately owned. Currently, 49 percent of Level 4 facilities are privately owned, compared to 39 percent owned by the government and 12 percent by Non-Governmental Organizations (NGOs) and Faith Based Organizations (FBOs). At Level 5, 44 percent of the facilities are privately owned

38 Ministry of Health. Tariffs to the Benefit Package under the Social Health Insurance Act No. 16 of 2023. 2024. Available from: https://health.go.ke/sites/default/files/2024-06/Tariffs%20to%20the%20Benefit%20Package%20under%20the%20Social%20Health%20Insurance%20Act.pdf

39 Kinyanjui M. Moh Releases Benefit Tariffs for New SHIF Scheme. Citizen Digital; 2024. Available from: https://www.citizen.digital/news/moh-releases-benefit-tariffs-for-new-shif-scheme-n343776

while 41 percent and 15 percent are government and NGO/FBO owned respectively.[40] Reduced private sector participation would place a greater burden on already strained public facilities.

Experience and Challenges: Kenya

Over the years, both public and private providers have complained that the reimbursement rates offered by the NHIF were not sufficient and did not reflect the actual costs of service delivery incurred by the facilities. The decision-making process for the rates was opaque, with NHIF stating that the rates were decided upon by relying on costing data and in consultation with both public and private providers. The providers however, countered that they were never involved, and were not aware of any costing studies being undertaken.

While NHIF, through its service charter, promised prompt disbursement of funds, this has not been the norm in the sector.[41] Outpatient capitation fees, which ought to be paid at the beginning of each fiscal quarter, are often delayed until mid-quarter. Fees for inpatient and specialized services are to be reimbursed within 14 days of claims submission, but facilities have been waiting for 2-3 months to be reimbursed.[42]

These delays create a significant burden for facilities. NHIF currently owes facilities an estimated Ksh. 20 billion, with some outstanding claims dating back as far as 5 years.[43,44] As a result, facilities have been forced to reject patients with NHIF cards (resulting in OOP expenditures for patients),[45] charge fees to patients despite having paid up insurance covers[46] and close down some units due to low cash flows hindering their ability to pay back suppliers.[47] On 26th March 2024, the troubles encountered by some of the Level 5hospitals in Nairobi County due to the delays in the disbursement were raised in the Senate.[48] This prompted a follow up interrogation of the Health CS by the Senate on 17th April 2024, where she stated that, 'I want to assure facilities that there is no cause for alarm…Once they have provided services and their claims have been verified and reconciled, they will be paid *once resources are available* (italics added).'[49] But the lack of clear timelines for clearing the backlog of claims suggests that this problem will persist.

Experience and Challenges: Global

In Mexico, the government also aimed at including private sector facilities in the social insurance program. However, the goal of contracting with the private sector was

40 Ministry of Health. Kenya Health Facility Census Report. 2023. Available from: https://www.health.go.ke/sites/default/files/2024-01/Kenya Health Facility Census Report September 2023.pdf

41 National Health Insurance Fund (NHIF). Service Delivery Charter. 2022. Available from: https://www.nhif.or.ke/wp-content/uploads/2022/12/NHIF-Service-Charter.pdf

42 Mbau R, Kabia E, Honda A, Hanson K, Barasa E. Examining purchasing reforms towards universal health coverage by the National Hospital Insurance Fund in Kenya. Int J Equity Health. 2020 Feb 3;19(1):19. doi: 10.1186/s12939-019-1116-x. PMID: 32013955; PMCID: PMC6998279.

43 Oketch A, Njeru L. Questions over SH20BN NHIF payments delay as patients suffer [Internet]. Nation; 2024. Available from: https://nation.africa/kenya/news/questions-over-sh20bn-nhif-payments-delay-as-patients-suffer-4566750

44 The Senate, The Hansard: Wednesday, 17th April 2024.

45 Oketch A. Patients' agony as hospitals reject broke NHIF cards [Internet]. Nation; 2023. Available from: https://nation.africa/kenya/news/patients-agony-as-hospitals-reject-broke-nhif-cards-4257678

46 Citizen Reporter. Rural Hospitals effect ksh.1000 fee for NHIF Beneficiaries Seeking Outpatient Services [Internet]. Citizen Digital; 2023. Available from: https://www.citizen.digital/news/rural-hospitals-effect-ksh1000-fee-for-nhif-beneficiaries-seeking-outpatient-services-n333885

47 Kenya Renal Association. Statement by the Kenya Renal Association regarding the risk to the lives of dialysis patients caused by unpaid bills by NHIF. 2024 Dec 30th. Available from: https://kenyarenal.org/press-release/press-release-on-nhif-pending-payments-to-dialysis-hospitals-dec-2023/

48 The Senate, The Hansard: Tuesday, 26th March, 2024.

49 The Senate, The Hansard: Wednesday, 17th April 2024.

generally not realized. The vast majority of services continued to be provided within public facilities, undermining one of the main goals of the program. This reflected a lack of trust and agreement on fees and modalities, just as under NHIF. While there was some increase in contracting between public facilities, it remained rare for those covered by the new insurance program to access services in other public or private facilities.[50]

Ghana's National Health Insurance Scheme (NHIS)system typifies the struggles of many insurance systems with delayed reimbursements. A 2016 study revealed a significant decline in timely claim settlements between 2011 to 2014. In 2011, only 22 percent of the claims were settled within 31-60 days. The figure dropped to zero in 2013, with only 10 percent of the claims being settled within 90 days. By 2014, all claims were settled beyond 100 days. [51] The delay in reimbursements has continued to persist to date, with the average reimbursement waiting period being 4 months in 2021.[52,53]

These delays have had consequences including:

- **Reduced service provision:** Faced with late payments, healthcare providers are forced to withdraw services. For instance, the Christian Health Association of Ghana, which provides 42 percent of healthcare in the country, halted service provision for a week due to outstanding payments.[54]

- **Compromised quality of care:** Some facilities may resort to risky cost-cutting measures, such as reusing single-use medical supplies, thereby jeopardizing patient safety.[55]

- **Reversion to out-of-pocket payments:** To maintain revenue flow, healthcare providers may demand OOP payments from insured patients. Studies in Ghana found that there is a 66 percent likelihood that an insured individual will have to make an out-of-pocket payment.[56] Rural populations are more than twice as likely to make these payments as compared to urban populations due to the scarcity of alternative health care facilities in rural areas. The fear of being blacklisted by providers discourages insured patients from reporting the payments. For cases that are reported, the National Health Insurance Authority (NHIA) does not respond to 81 percent of them.

Is there a way forward?.

Inclusion of private facilities requires a consensus-building approach with private providers around tariffs. In the absence of high levels of trust and agreement, it is better to focus on improving the public sector facilities at the heart of the insurance program, and to delay private sector

50 OECD, Review of Health Systems: Mexico 2016

51 Nsiah-Boateng E, Aikins M, Asenso-Boadi F, Andoh-Adjei FX. Value and Service Quality Assessment of the National Health Insurance Scheme in Ghana: Evidence from Ashiedu Keteke District. Value Health Reg Issues. 2016 Sep; 10:7-13. doi: 10.1016/j.vhri.2016.03.003. Epub 2016 May 19. PMID: 27881281.

52 Aryee EY. Delay in payment of NHIS claims affecting healthcare delivery at Margaret Marquart Hospital at kpando. 2023. Available from: https://www.gbcghanaonline.com/general/delay-in-payment-of-nhis-claims-affecting-healthcare-delivery-at-margaret-marquart-hospital-at-kpando/2023/

53 Ministry of Health, Republic of Ghana. Health Sector Annual Program of Work. 2021 Holistic Assessment Report. 2022. Available from: https://www.moh.gov.gh/wp-content/uploads/2022/08/2021-Holistic-Assessment-Report_v1.7.3.pdf f

54 Ebenezer Owusu-Sekyere, Daniel A. Bagah, Towards a Sustainable Health Care Financing in Ghana: Is the National Health Insurance the Solution?, Public Health Research, Vol. 4 No. 5, 2014, pp. 185-194. doi: 10.5923/j.phr.20140405.0

55 Akweongo P, Chatio ST, Owusu R, Salari P, Tedisio F, Aikins M. How does it affect service delivery under the National Health Insurance Scheme in Ghana? Health providers and insurance managers perspective on submission and reimbursement of claims. PLoS One. 2021 Mar 2;16(3):e0247397. doi: 10.1371/journal.pone.0247397. Erratum in: PLoS One. 2021 Jun 10;16(6):e0253357. doi: 10.1371/journal.pone.0253357. PMID: 33651816; PMCID: PMC7924798.

56 Amporfu E, Arthur E, Novignon J. Billing the Insured: An Assessment of Out-of-Pocket Payment by Insured Patients in Ghana. Health Services Insights. 2023;16. doi:10.1177/11786329221149397

contracting to a later stage of reform. Any attempts to work with the private sector require a high degree of transparency both to ensure private sector engagement and quality service delivery, but also to reassure the public that the insurance program is not a giveaway to private providers with links to wealthy or influential actors. SHIA will need to establish a far higher degree of transparency than NHIF achieved, a point we take up further below.

FINANCING THE REFORM

Kenya's Approach

The new laws have mandated an increase in contributions by the formal sector and require the non-poor informal sector to pay premiums. But there are many new costs associated with the program. The introduction of the Primary Health Care (PHC) fund and the Emergency, Critical and Chronic Illness funds, as well as the new remuneration requirement for the Community Health Promoters (CHPs), indicate a substantial increase in health financing. As noted above, there are also infrastructure gaps that need to be filled for wider insurance access to be effective. Will these costs be covered by the current financing model?

Outside of general revenue, which is increasingly scarce in Kenya's current financial straits, the principal *new* revenue source for the reform is the increase in formal sector worker contributions, from a flat rate, where different income groups contributed varying amounts with a maximum contribution of Ksh. 1,700, to a percentage rate of 2.75%. There are about 3 million formal sector workers in Kenya, with an average monthly income of Ksh. 72,000. The majority of these workers (88 percent) earn less than Ksh.100,000 p.m. Applying the new rate to Kenya's average wage and number of workers (in 2022) yields approximately Ksh 72 billion.[57]

57^ This figure could be higher if a significant number of richer Kenyans exist and pay into the scheme. The KNBS wage data does not clarify the distribution of income for Kenyans earning above Ksh 100,000. If the

This is Ksh. 23 billion more than what the old flat rate collected from formal sector workers.[58]

Table 2: NHIF Formal Sector Revenues

Ksh. Billions	FY 18/19	FY 19/20	FY 20/21	FY 21/22	FY 22/23	Average	SHIF Projection
Formal Sector in the National Health Scheme	31.1	32.3	31.5	34.3	35.9	33.0	N/A
Enhanced Scheme	12.7	10.8	12.7	21.1	16.4	15.3	N/A
Total Formal Sector Revenues	43.8	43.1	44.2	58.4	52.3	48.4	71.8

Source: National Assembly (2024)[59]

Informal sector workers are mandated to pay as well, as we described earlier, but we have also seen that enforcing this is challenging. Nevertheless, if the informal sector workers did contribute a minimum of 300 Ksh per household, that would yield nearly Ksh. 58 billion, over ten times the average annual collections from the sector between FY 2018/19 and FY 2022/23. If, as was the case with NHIF, only a quarter of informal households contributed, then this would yield Ksh. 14 billion.[60] This is compared to an average revenue collection of Ksh. 5.6 billion from the informal sector under NHIF between FY 2018/19 and FY 2022/23.

average wage of this group is much higher than Ksh 100,000, then this could generate considerable revenue. For example, if the average wage of this group was Ksh 550,000, then the new rate would generate an additional Ksh 44 billion.

58 This is based on the average NHIF revenue collections from the formal sector between FY 2018/19 and FY 2022/23, which were Ksh. 48 billion.

59 National Assembly Departmental Committee on Health. Report of the Departmental Committee on Health on its Consideration the inquiry into alleged Fraudulent Payments of Medical Claims and Capitation to Health Facilities by the National Health Insurance Fund 2024. Available from: http://www.parliament.go.ke/sites/default/files/2024-06/Report of the Departmental Committee on Health on its Consideration the inquiry into alleged Fraudulent Payments of Medical Claims and Capitation to Health Facilities by the National Health Insurance Fund.pdf

60 The Kenya National Bureau of Statistics (KNBS) estimates that there were 15,964,700 workers in the informal sector in 2022.

Table 3: SHIF revenues from the informal sector

Ksh. Billions	*All informal*	*All informal excluding bottom quintile*	*¼ of the informal sector (as under NHIF)*	*¼ of the informal sector excluding bottom quintile*
Average Revenues from the informal sector under NHIF (FY 2018/19 – FY 2022/23)	N/A	N/A	5.6	N/A
SHIF Revenues (Based on the minimum contributions of Ksh. 300)	57.4	36.2	14.4	9
SHIF Revenues (Calculated using the average minimum wage and contribution of 2.75%)[61]	99.4	62.6	24.8	15.7

Clearly, the reform measures *could* result in considerable additional funding for the health system: assuming ¼ of the informal sector joins as before under NHIF, and assuming that they pay 2.75% of income, the SHIF would bring in an additional Ksh 23 billion from the formal sector, and an added Ksh 19 billion from the informal sector, for a total of Ksh 42 billion more funding.

However, this new revenue has to be compared to new costs, and it is not clear what the total cost of the reforms and new benefit package will be. Per capita revenues are projected to increase from approximately Ksh. 4,498[62] to Ksh. 12,298 if a quarter of the informal sector enrols and to Ksh. 6,810 if the entire informal sector participates (based on informal sector contributors paying the minimum amount of Ksh. 300). This demonstrates the importance of the formal sector contributions to the increased revenue: as more informal sector workers contribute, the per capita resources available decline due to the much lower incomes and contributions of the informal sector. If the informal sector were permitted to affiliate without paying, as occurred in Mexico, the per capita revenues would continue to drop, possibly even below the NHIF figures.[63]

61 This is the average of the gazetted minimum wages for the informal sector. This average falls between the average earnings of enterprise owners and operators (Ksh. 19,712) and those of paid employees (Ksh. 14,315) as found in the Informal Sectors Skills and Occupations Survey (ISSOS). Accessible from: https://www.labourmarket.go.ke/media/resources/ISSOS_BASIC_REPORT_2020_-_Combined.pdf

62 This per capita calculation is based solely on revenue from the formal and informal sectors under NHIF. When revenues from sponsored schemes and other investment incomes are included, the NHIF per capita revenue is higher, at Ksh. 5,567.

63 When roughly 80% of the informal sector affiliates without paying, the per capita revenues for SHIF are exactly the same as they were under NHIF, meaning that new revenues from the program can provide exactly the same services that NHIF provided. If more than 80% of the informal sector affiliates without paying, per capita revenue will fall below the NHIF levels.

Table 4: Total SHIF revenue estimates

	All informal	All informal excluding the bottom quintile	¼ of the informal sector (as under NHIF)	¼ of the informal sector excluding bottom quintile
Average Revenues from the formal and informal sector under NHIF (FY 2018/19 – FY 2022/23) in Ksh. Billions	N/A	N/A	54	N/A
NHIF Per Capita Revenue (Ksh.)	N/A	N/A	4,498	N/A
Informal sector calculation based on the minimum contributions of Ksh. 300				
SHIF Total Revenues from the Formal and Informal Sectors in Ksh. Billions	129.3	108	86.1	80.8
Per Capita Revenue (Ksh.)	6,810	5,689	12,289	11,531
Informal sector revenue calculated using the average minimum wage and contribution of 2.75%				
SHIF Revenues from the formal and informal sectors in Ksh. Billions	171.2	134.4	96.6	87.4
Per Capita Revenue (Ksh.)	9,017	7,080	13,783	12,472

While the assumption is that new funding will be additional to what the sector currently has, this is a political question: there will be political and fiscal pressure to reduce general budget support to health if there is a dedicated revenue stream from the social insurance premiums. The current national health budget for FY 23/24 in Kenya is Ksh. 119 billion, meaning that a considerable part of Kenya's health budget could be substituted by these SHI payments without increasing overall health expenditure.

Table 5: Kenya's Health Budget, NHIF Revenues and Projected SHIF Revenues64

Ksh. Billions	Amount
National Health Budget	**115.4**
County Health Budget	**127.2**
Total Health Budget	**242.6**
NHIF Revenues	**67.4**
SHIF Projected Revenues:	
If entire informal sector enrolls	**129.3**
If only ¼ of the informal sector enrolls	**86.1**

Note: The SHIF revenue projections presented in the table are based on the minimum contribution of Ksh. 300 for the informal sector.

Experience and Challenges: Kenya

Insufficient revenue collections have over the years threatened NHIF's financial stability. Despite achieving collection rates averaging 91 percent of the targets between FY 2020/21 and FY 2022/23, the actual revenue remains insufficient to meet the needs of Kenyans. In FY 2020/21, social health insurance accounted for a mere 15 percent of the country's current health expenditure.[65]

The benefits paid out have been steadily increasing, with a 42 percent increase between FY 2020/21 and FY 2022/23. Unfortunately, revenue growth has not kept pace, increasing by only 32 percent over the same period.[66] This imbalance between rising costs and stagnant revenue has resulted in a worrying financial trajectory for the NHIF.

The suspension of some of the measures intended to enforce mandatory contributions from the informal sector by the Court of Appeal, means that it is likely that the government will have to continue relying on voluntary mechanisms for the sector. Voluntary contributions have proven to be an ineffective revenue mechanism due to high attrition rates, and low overall participation from the sector. Data from FY 2022/23 illustrates this. While the overall retention rate for the NHIF was

64 The figures presented for the national health budgets, county health budgets, total health budget and the NHIF revenues are the average calculated over FY 18/19 to FY 22/23.

65 World Health Organization. Global Health Expenditure Database. Available from: https://apps.who.int/nha/database/ViewData/Indicators/en

66 Republic of Kenya. Health Sector Report. Medium Term Expenditure Framework (MTEF) for the period 2024/25 – 2026/27. 2023. Available from: https://www.treasury.go.ke/wp-content/uploads/2023/12/HEALTH-SECTOR-REPORT.pdf

44 percent, the formal sector was at 78 percent, while the informal sector was at 22 percent only.[67] With fewer contributions from the informal sector through voluntary contributions, the NHIF's revenue streams will weaken.

Experience and Challenges: Global

Relying solely on increased taxes from the formal sector and premiums from the informal sector may not suffice to achieve UHC. A study undertaken across 24 developing countries found that mandatory premiums make up only 10 percent of the total UHC program expenditures while voluntary premium contributions contribute about 1 percent. 70 percent of the costs are covered by the government through general revenues. Of the 24 countries, those that adopted a SHI approach (Costa Rica, Philippines, Chile, Vietnam, Ghana and Kyrgyz Republic), had a higher average contribution from mandatory social insurance at 46 percent compared to government funding of 43 percent and voluntary contributions at 6 percent.[68] This suggests that SHI is a viable plank of a larger strategy to UHC attainment, but it does not eliminate the need for governments to explore additional revenue streams. While the laws state the government will explore innovative financing mechanisms to increase funding, there are no specific details on what these mechanisms are.

An inadequately financed national health insurance scheme risks facing financial strain, as seen in the case of Ghana's NHIS scheme. The NHIS experienced increases in claims expenditure, driven by increase in health service utilization, expansion of coverage and rising unit costs which outpaced its revenue generation. In 2009, the scheme began drawing down from its investment funds, as it was running on a regular annual deficit. This was not sufficient as it had to contract a loan in 2011 worth 100 million Ghanaian cedis to finance the deficit of the scheme. [69] The scheme has continued to face financing constraints and received funding from the World Bank in 2023 worth US$ 27.7 Million to increase active membership and facilitate claims processing and payment for PHC providers.[70, 71]

The Kenyan reform should collect substantially more than the Ghanaian reform, if it is fully implemented, but it seems to rely on a co-financing model between the national and county governments to cover some of the costs of the reforms. For example, remuneration costs to CHPs are to be shared equally between both tiers of government. However, there are no mechanisms to ensure compliance with this, raising a concern about the potential abandonment of fiscal responsibilities.

In Mexico, which is a federal system, the national government was not able to compel states to contribute to the SHI reform. As a result, the reform was rolled out through a series of negotiations over how much states would contribute and in exchange for what. As mentioned previously, this resulted in many states contributing less than required, which was usually orchestrated by allowing them to

67 National Assembly Departmental Committee on Health. Report of the Departmental Committee on Health on its Consideration the inquiry into alleged Fraudulent Payments of Medical Claims and Capitation to Health Facilities by the National Health Insurance Fund 2024. Available from: http://www.parliament.go.ke/sites/default/files/2024-06/Report of the Departmental Committee on Health on its Consideration the inquiry into alleged Fraudulent Payments of Medical Claims and Capitation to Health Facilities by the National Health Insurance Fund.pdf

68 Cotlear D, Nagpal S, Smith O, Tandon A, Cortez R. Going universal: How 24 developing countries are implementing Universal Health Coverage from the Bottom Up. 2015. doi:10.1596/978-1-4648-0610-0

69 Wang H, Otoo N, Dsane-Selby L. Ghana National Health Insurance Scheme. Improving financial sustainability based on expenditure review. 2017. World Bank. doi:10.1596/978-1-4648-1117-3

70 World Bank. Development projects: Primary health care investment program - P173168. Available from: https://projects.worldbank.org/en/projects-operations/project-detail/P173168

71 National Health Insurance Authority. NHIS to receive $27.7 Million from the World Bank Group. 2023. Available from: https://www.nhis.gov.gh/News/nhis-to-receive-%2427.7-million-from-the-world-bank-group----5519

take 'credits' for other investments, some in the past, that were not always directly related to the program. As of 2007, this had led to a financing gap equivalent to tens of billions of shillings.

AUTONOMY AND PERFORMANCE

Kenya's Approach

The government aims to improve the quality-of-service delivery in public health facilities in two ways: increasing the facilities' financial autonomy and adopting output-based financing. Facility autonomy is to be achieved by allowing the facilities to directly manage their own revenue, both funds from the budget and from SHA.

Output-based financing (OBF) is meant to incentivize health facilities to improve their performance in service delivery, by linking funding to service delivery outcomes, rather than just inputs. The government has not outlined the civil service reforms needed to accompany this change in financing. These reforms might include incentives aimed at motivating health workers to achieve the desired outcomes. It is also unclear which performance metrics will be linked to compensation.

Moreover, there are no guidelines on how the government will adapt to scenarios where the skills within the civil service fail to align with the desired outcomes. For example, what action will be taken if health workers in a facility lack the skills to meet a specific goal?

Experience and Challenges: Kenya

Recent history suggests there will be delays in transferring funds. Part of the funds to be managed by health facilities include money paid as reimbursement for services by SHA. We have already discussed above the history of delayed payment by NHIF. The absence of clear guidelines outlining the turnaround time for processing claims made by facilities in the Social Health Insurance (General) Regulations, 2024 are also a cause for concern regarding timeliness of transfers.

Facility autonomy, as proposed in the new reforms, is not a novel concept in Kenya. Before devolution in 2013, healthcare facilities operated with a degree of autonomy, directly receiving funding from the national government and enjoying operational flexibility. This system facilitated efficient service delivery. However, devolution drastically curtailed this autonomy, centralizing financial control at the county level. The subsequent years have underscored the challenges of centralization, with service delivery often hampered by bureaucratic bottlenecks.

A similar approach to that outlined in the Facility improvement Financing (FIF) Act, where facilities manage their revenues and involve communities in the decision-making process, was previously attempted through the Health Sector Services Fund (HSSF) from 2010 until the introduction of devolution. Under HSSF, facilities received government allocations and user fee revenues directly into their bank accounts. This direct management of financial resources resulted in improved health facility conditions and quality of care. Facilities had easier access to funds for necessary repairs, renovations and supplies, leading to faster procurement and better working conditions. In turn, staff were more motivated, resulting in better quality of care to patients.[72]

To facilitate community involvement, the FIF Act introduces the Health Facility Management Committee (HFMC), just as in HSSF. Despite the success of the HSSF program, HFMCs

72 Waweru E, Nyikuri M, Tsofa B, Kedenge S, Goodman C, Molyneux S. Review of Health Sector Services Fund Implementation and Experience 2013. Available from: https://assets.publishing.service.gov.uk/media/57a08a31e5274a27b2000495/HSSF.pdf

encountered some challenges that hindered their effectiveness in their roles and are likely to be encountered under FIF implementation as well.

HFMCs hold promise in improving community involvement, transparency and accountability, but their effectiveness hinges, in part, on their proper constitution. Unfortunately, under HSSF, selecting the right individuals for the committee was often a significant challenge. While different approaches were used for selection of members, most of the community members were selected during barazas (public meetings). However, the lack of adequate public awareness limited community participation in the selection process. In other areas, the committee members were nominated by the District Medical Officer of Health (DMOH) or other authority figures such as chiefs.[73] This approach, however, often led to concerns about favouritism and a lack of transparency.

Despite the requirement for at least a secondary level education for members, limited community participation, and low literacy levels in some regions, resulted in the selection of participants who were not well-suited to contribute effectively, including the elderly and illiterate.[74] Other challenges encountered by HFMCs outside of the HSSF program include the politicization of the selection process and non-adherence of guidelines such as underrepresentation of vulnerable groups in the committees, absenteeism of elected officials and poor training of committee members on their new roles.[75]

Performance-Based Financing (PBF), a type of OBF, has been employed in various health sector projects in Kenya, primarily through donor funding. However, a significant challenge has been the unsustainability of these initiatives beyond the donor funding period. One of the PBF projects, the Transforming Health System for Universal Care Project (THS-UCP), aimed to enhance reproductive, maternal, child and adolescent health (RMNCAH) between 2016 and 2021. One of the objectives of the project was to improve Primary Health Care (PHC) Outcomes. The PHC component was structured as PBF, where counties meeting the eligibility criteria (increased health allocations and submission of annual reports), received allocations based on the county revenue allocation formula and their performance in six selected indicators such as percentage of births attended by skilled health personnel.[76]

THS-UCP faced two major challenges, both of which could plague new attempts at PBF in Kenya. One of these challenges was, again, the delay in fund transfers from the national to county governments. Most of the disbursements in the project were made between December and January which constrained counties' capacity to absorb the funds, as they had less than half a year to utilize them.

These delays are likely to undermine the implementation of PBF. Without timely funding, health facilities may struggle to meet their performance targets, particularly if specific activities and interventions were planned based on the anticipated disbursement dates.

73 Waweru E, Opwora A, Toda M, Fegan G, Edwards T, Goodman C, Molyneux S. Are Health Facility Management Committees in Kenya ready to implement financial management tasks: findings from a nationally representative survey. BMC Health Serv Res. 2013 Oct 10; 13:404. doi: 10.1186/1472-6963-13-404. PMID: 24107094; PMCID: PMC3853226.

74 Goodman C, Opwora A, Kabare M, Molyneux S. Health facility committees and facility management - exploring the nature and depth of their roles in Coast Province, Kenya. BMC Health Serv Res. 2011 Sep 22;11:229. doi: 10.1186/1472-6963-11-229. PMID: 21936958; PMCID: PMC3197493.

75 Okedi WN, Adungo F. Effectiveness of hospital management committees in Busia County, Kenya. Scientific Research Publishing. 2021;13(10):1129–44. doi: 10.4236/health.2021.1310084

76 Owino B, Ileana V. The Transforming Health Systems for Universal Care Project in Kenya: A Review. Kenya Brief 6. Thinkwell; 2020. Available from: https://thinkwell.global/wp-content/uploads/2020/12/THS-UCP-review-11-Dec-2020.pdf

Moreover, delays in payments of incentives may demotivate health workers.

Another significant challenge was data quality. PBF relies heavily on accurate and timely data for performance measurement and subsequent resource allocation. The THS-UCP faced data quality issues stemming from methodological flaws, limited automation and incomplete vital events registration. These shortcomings hampered the quantification of family planning commodity needs and monitoring of some indicators such as the use of modern contraceptives among women aged 15-49. Data collection of facilities undertaking inspections was largely manual. To address this, the project supported the development of an electronic joint health inspection checklist (e-JHIC) for more efficient real time monitoring of the inspection results, but not all facilities underwent the transition.[77]

Experience and Challenges: Global

Given that most health funding goes to pay health workers, there is no way to shift toward output financing without changing the terms and conditions for the health workforce, a notoriously challenging prospect. In the absence of this, "output" financing reduces to changes in how the marginal costs of services are financed, rather than their overall costs. In Mexico, the government initially attempted to achieve civil service reform indirectly, by hiring mainly temporary, non-union workers to support the expansion of health care under the social health insurance reform. However, this tactic ultimately failed, as these workers, supported by the health worker union, eventually achieved similar terms and conditions as other civil servants. Unionized health workers could not be easily shifted from one post to another, which made it difficult to transform the system into a truly output-driven one. Given the centrality of health workers to the production of health care (accounting for nearly half of all expenditure in the sector, and two-thirds of county health spending), if the principal input has fixed pay and a fixed post, the notion of output-based financing loses much of its lustre.[78]

A significant concern associated with the implementation of output-based financing is the extent to which such a system is cost effective in Low- and Middle-Income Countries (LMICs). In Tanzania, the pay-for-performance pilot incurred financial costs of $1.3 million.[79] Despite these significant investments, only 2 of the 9 targeted services saw improved utilization. [80,81]

Equally, the output-based financing scheme implemented in Afghanistan between 2010-2015 was found to be cost ineffective. The program incurred financial costs totalling approximately $11 million. The average annual costs for the PBF facilities were nearly ten times those for non-PBF facilities. [82] Despite the massive costs, the program was found to have had no significant impact on increasing

77 World Bank. "Implementation completion and results report to the Republic of Kenya for the Transforming Health Systems for Universal Care Project." World Bank; 2024 May. Available from: https://documents1.worldbank.org/curated/en/099052924155042642/pdf/BOSIB19c73401b0391b63a13e454085c6d8.pdf

78 See https://labourmarket.go.ke/media/resources/Final_Kenya_HLMA_Report_2023_v8.pdf

79 The economic costs, which included the value of all resources and time, were $2.3 million over 13 months. Most of the costs were associated with the management of the program which accounted for nearly half of the financial costs and nearly a third of the economic costs.

80 The economic costs, which included the value of all resources and time, were $2.3 million over 13 months. Most of the costs were associated with the management of the program which accounted for nearly half of the financial costs and nearly a third of the economic costs.

81 Borghi J, Little R, Binyaruka P, Patouillard E, Kuwawenaruwa A. In Tanzania, the many costs of pay-for-performance leave open to debate whether the strategy is cost-effective. Health Aff (Millwood). 2015 Mar;34(3):406-14. doi: 10.1377/hlthaff.2014.0608. Erratum in: Health Aff (Millwood). 2015 Sep;34(9):1611. doi: 10.1377/hlthaff.2015.0989. PMID: 25732490.

82 Salehi AS, Borghi J, Blanchet K, Vassall A. The cost-effectiveness of using performance-based financing to deliver the basic package of health services in Afghanistan. BMJ Global Health 2020;5: e002381. doi:10.1136/bmjgh-2020-002381

coverage or equity of the targeted services.[83]

These high costs might explain the lack of home-grown PBF strategies in LMICs, as they have all been initiated and developed with donor support.[84] Tanzania's program was implemented by the Ministry of Health and Social Welfare (MOHSW) in Tanzania with support from the Clinton Health Access Initiative (CHAI), and funding from the Norwegian Ministry of Foreign Affairs.[85] Afghanistan's program was started with support from the World Bank.[86]

Given the high costs and limited impact observed in these programs, it is reasonable to question the efficiency of OBF compared to alternative investments such as investing directly in strengthening the health care system's infrastructure, equipment and workforce through improved wages. In Nigeria, a study was undertaken to establish the difference in impact achieved from using a Performance-Based Financing approach versus a Decentralized Facility Financing approach (non-performance based). The findings of the study showed that both PBF and DFF achieved similar results, and that the DFF model could be implemented at a lower cost.[87]

The DFF model in Nigeria aligns closely with reforms in Kenya's Facilities Improvement Financing (FIF) Act, suggesting potential cost-efficiencies mirroring those of the DFF model. Both approaches grant facilities financial autonomy by allowing them to directly manage their revenues. Like in DFF, the FIF Act requires that facilities maintain a single bank account where all funds received will be paid. These funds are to be utilized to cover operational expenses such as maintenance and drug procurement. To foster community involvement and ownership, both models incorporate community participation mechanisms: Ward Development Committees in Nigeria and Health Facility Management Committees in Kenya.

Is there a way forward?

There are good reasons to doubt that output-based financing will make a significant short-term contribution to improving health system efficacy in Kenya. Direct facility financing may permit some degree of improved efficiency by allowing facilities more flexibility to manage their non-staff costs. This is a positive aspect of the reform, but its potential should not be exaggerated. Given the large share of costs attributable to staff, which is not a flexible input, there is a limit to what such autonomy can achieve.

TRANSPARENCY

Kenya's Approach

The 2023 health laws require major changes in the health system, and major new flows of funds, but have little to say about how transparency and accountability of these funds will be ensured. The government, through the

83 Engineer CY, Dale E, Agarwal A, Agarwal A, Alonge O, Edward A, Gupta S, Schuh HB, Burnham G, Peters DH. Effectiveness of a pay-for-performance intervention to improve maternal and child health services in Afghanistan: a cluster-randomized trial. Int J Epidemiol. 2016 Apr;45(2):451-9. doi: 10.1093/ije/dyv362. Epub 2016 Feb 13. PMID: 26874927.

84 Paul E, Albert L, Bisala BN, Bodson O, Bonnet E, Bossyns P, Colombo S, De Brouwere V, Dumont A, Eclou DS, Gyselinck K, Hane F, Marchal B, Meloni R, Noirhomme M, Noterman JP, Ooms G, Samb OM, Ssengooba F, Touré L, Turcotte-Tremblay AM, Van Belle S, Vinard P, Ridde V. Performance-based financing in low-income and middle-income countries: isn't it time for a rethink? BMJ Glob Health. 2018 Jan 13;3(1):e000664. doi: 10.1136/bmjgh-2017-000664. PMID: 29564163; PMCID: PMC5859812.

85 Borghi J, Mayumana I, Mashasi I, Binyaruka P, Patouillard E, Njau I, Maestad O, Abdulla S, Mamdani M. Protocol for the evaluation of a pay for performance programme in Pwani region in Tanzania: a controlled before and after study. Implement Sci. 2013 Jul 19;8:80. doi: 10.1186/1748-5908-8-80. PMID: 23870717; PMCID: PMC3724689.

86 Engineer CY et al, Effectiveness of a pay-for-performance intervention to improve maternal and child health services in Afghanistan: a cluster-randomized trial, 2016.

87 World Bank. Impact Evaluation of Nigeria State Health Investment Project. 2018. Available from: https://documents1.worldbank.org/curated/en/589301552969360031/pdf/NSHIP-IE-Report.pdf

Digital Health Act, has introduced the health information system. By centralizing all data on clients, health facilities, healthcare providers, health products and technologies, it has the potential to improve transparency and inform better decision-making in healthcare.

However, there is a lack of transparency provisions for finances managed by the SHA: transparency of financial information appears to have been neglected in the regulations, raising concerns about possible mismanagement of the funds. This is unfortunate, given the trust deficit inherited from NHIF.

Transparency is particularly vital for evaluating the degree to which the reforms are addressing long-standing inequities in Kenya. If the reform is successful in certain ways but does not significantly increase access to health among more marginalized groups or reduce catastrophic health expenditure, then it will not have achieved all of its aims. As discussed earlier, if the private sector will be financed under this insurance program, there is also a need for transparency in tariff setting and transfers to allay any concerns about abuse of public funds for private benefit.

There are also concerns around the extent of transparency by the transition committee in the transfer of assets and liabilities from NHIF to SHA. While the transition committee can make reports on the transfer process, there is no mandatory requirement to disclose them publicly. The only provision that exists is that the secretariat can 'disseminate any information deemed relevant', which is subject to a narrow interpretation. Undertaking the transfers in secrecy increases the risk of losing some resources in the process due to lack of public accountability.

Experience and Challenges: Kenya

NHIF's operations have been marked by high levels of opacity, hindering public trust and accountability. A 2022 study revealed a complete lack of transparency as NHIF did not make crucial documents like annual reports, financial statements, quarterly reports or audited reports publicly available on its website.[88] Information on NHIF revenues and expenditures have to be sourced from different documents such as the Health Sector Working Group Report. However, the details in these reports are limited, and highly aggregated. For instance, there is no information on how much is collected from the

CONCLUSION

Our review suggests numerous areas where the Government of Kenya needs to engage in thoughtful deliberation about how to avoid the pitfalls of SHI implementation in other contexts. The evidence suggests that a number of these challenges have already been encountered domestically as well in other programs. There is no one way to address these matters, no single "best practice" that can act as a silver bullet. But ignoring the challenges is unlikely to work.

PREPARED BY:

INSTITUTE OF PUBLIC FINANCE
P.O. Box 21753-00100, Nairobi Kenya
Tel: **+254 758 728 882** Email: **info@ipfglobal.or.ke**