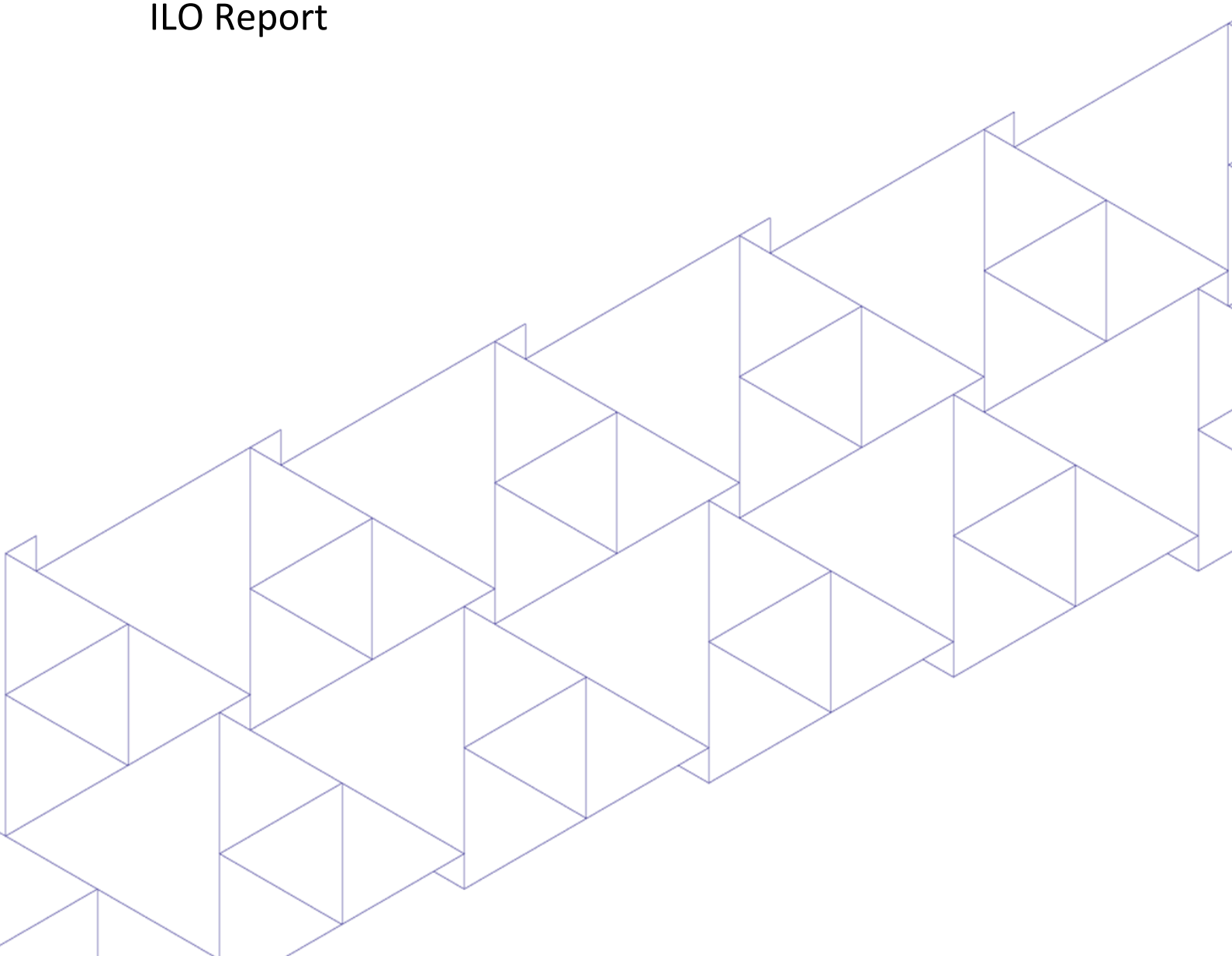
International Labour Organization

PROSPECTS PROJECT REPORT

Extension of Social Health Protection to enhance NHIF Coverage for Populations Left Behind

ILO Report



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List of Abbreviations

CDOH	County Departments of Health
CBHI	Community-based Health Insurance
CSS	Civil Servants Scheme
ERP	Enterprise Resource Planning
FBO	Faith-based Organizations
FGD	Focus Group Discussion
FMNCH	Free Maternal Neonatal and Child Health
GoK	Government of Kenya
HEF	Health Equity Fund
HISP	Health Insurance Subsidy Program
HNA	Health Needs Assessment
ICT	Information and Communication Technology
JICA	Japan International Cooperation Agency
KMPDB	Kenya Medical Practitioners and Dentists Board
KRA	Kenya Revenue Authority
KES	Kenya Shilling
MOH	Ministry of Health
NGO	Non-Governmental Organization
NHIF	National Health Insurance Fund
NIIMS	National Integrated Identity Management System
OOP	Out-of-pocket payment
POCE	Point-of-Care Enrolment
SASS	State Authority Social Security
SHI	Social Health Insurance
SSO	Social Security Organization
UHC	Universal Health Coverage
UCS	Universal Coverage Scheme
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

Introduction

1.1 Background

For many decades, social protection has been on the agenda of the Government of Kenya, through the enactment of programs in areas of social security, social health protection as well as social assistance. Social security throughout the course of life is a basic human right that is embedded in the Universal Declaration of Human Rights (1948) signed by Kenya with the right to access quality healthcare guaranteed by the 2010 Kenyan constitution to all citizens. The ILO's Social Security (Minimum Standards) Convention, 1952 (No. 102) and the Social Protection Floors Recommendation, 2012 (No. 202) provide a framework for comprehensive social protection systems and establish minimum levels of protection, including to ensure adequate financial protection against the costs of a wide range of healthcare services.

The National Health Insurance Fund (NHIF) was established in 1966 with a view to contribute to guarantee the right to social health protection to Kenyans (Government of Kenya 2011). Social health protection is a rights-based contribution to reach the objective of Universal Health Coverage (UHC). Since 2018, the Government of Kenya has been implementing policies to progress towards Universal Health Coverage (UHC), such as the UHC coverage policy 2020-2030, outlining the strategic direction for the health sector with a system-wide improvement commitment (Government of Kenya 2020). The NHIF has been identified by the government as one of the institutions responsible for the progress towards UHC by expanding social health insurance coverage to uncovered groups and reforming it into a strategic purchaser of healthcare. A significant increase in the number of people covered by the NHIF can be observed over time, from 3.8 million in 2013 to 15.5 million principal members[1] of NHIF in 2022 (Government of Kenya 2022b).

In 2022, the National Health Insurance Fund Amendment Act was signed into a law in an attempt to expand social health insurance coverage on a mandatory basis and with a broader funding base. Indeed, under the former Act, only workers in the formal economy were covered on a mandatory basis in practice. Notably with this act, with the majority of Kenyan populations in working age are in informal employment, this category of population and their families remains largely unprotected.

Reforms within the NHIF were successful in expanding coverage to different population segments, those included introducing digital tools and establishing nation-wide service points. Despite progress, it still falls short in supporting Kenya's UHC target, particularly in extending coverage for the informal sector, refugees, migrant workers, and vulnerable groups. In this context, The International Labour Organization (ILO) is providing technical support to the NHIF in its efforts to expand social health insurance coverage to uncovered populations. ILO's support to the NHIF is guided by its mandate for realization the right to social health protection; the ILO Convention 102 on Social Security (Minimum Standards) and the ILO convention 130 on medical care and sickness benefits and the NHIF objective to achieve UHC.

During this assignment, the president of Kenya has passed a series of bills to reform and improve the social health protection system in the country. These included, The Social health insurance bill, Primary Health Care Act, the Digital Health Act, and the Facility Improvement Financing Act. Currently, there is

[1] The principal member is the main member paying contributions, can be anyone above 18. Registration offers either individual or family membership, with family membership covering the principal member, legally declared spouse and children with no limitation on the number of added legal children.

an ongoing review for the legal framework pertaining this legislation. This report provides a critical assessment of the current NHIF, offering a roadmap for reform to transform the national health insurance authority operational and structural management to further enhance the extension of SHI coverage to uncovered populations.

1.2 Objective and Scope of Work

The present report aims to provide technical advisory to the NHIF for exploring strategic options to extend the social health insurance scheme to uncovered populations, including those in informal economy and vulnerable populations.

This work aims to provide an overview of the health system delivery and financing in Kenya; critically analyse the design, organization, and operation of the National Health Insurance Fund (NHIF) and Identify gaps and shortcomings in coverage. Based on the assessment, this work provides technical recommendations to support the improvement of operational capacity and to further enhance the feasibility of the extension of SHI coverage and related services to uncovered populations.

This report focused on presenting background information and assessment of the NHIF's current policies, organization and key functions' performance guiding the delivery of health insurance benefits. This report also presented the perception and feedback on the experiences, satisfaction level and expectations of current and potential beneficiaries of the NHIF scheme based on qualitative data obtained from a range of consultations with relevant stakeholders.

The report was structured as follows: Section 1 provides an introduction including background, objective and scope of work, and the methodology of the assessment report. Section 2 gives an overview of the healthcare system in Kenya including governance, delivery, and financing. As for section 3, it demonstrates a rapid assessment of the National Health Insurance Fund. Section 4 provides the results of focus group discussions on the performance, as well as the perception, and satisfaction of the NHIF, that was conducted among current and potential members representatives of the informal economy and refugees. Section 5 provides key considerations and recommendations for extension of social health protection, based on the assessment of the NHIF operations to overcome the current shortcomings of the system. Furthermore, Section 6 concludes the report by showcasing examples of countries that have extended social health coverage to uncovered populations highlighting the strategies implemented.

1.3 Methodology

This report used qualitative -primary and secondary- data collection methods to provide an evaluation of the NHIF key functional areas and current approaches for the implementation of the social health insurance (SHI). It also provides key considerations and recommendations for expansion of coverage to the entire population. Information collection has been gathered as combination of the following methods:

- Desk review of policy and regulatory documents providing an assessment of different aspects of service delivery and key operation functions of the NHIF.
- Interview with key stakeholders representing staff members in different NHIF management and operational departments.

- Data collected using Focus Group Discussions (FGD) with representatives from the informal sector and refugees.

Desk review of policy and regulatory documents

The desk review was conducted through a scoping review of the current NHIF regulatory documents, available descriptions of the system design, regular NHIF reports to the board and documents that provide assessment of different aspects of service delivery. The search was performed using open access sources, including online resources such as Cochrane and google scholars' databases as well as snowball method to identify relevant documents.

Interview with key stakeholders

Interviews was conducted with key staff members of the NHIF from key functional areas (See list of the interviewed NHIF experts in Annex). Interview design used a semi-structured method with key informants covering conceptual and technical features of the management and operational system of the NHIF, special attention was paid at two dimensions:

- The current organization of work and key challenges in implementing the purchasing role and delivering SHI benefits,
- Assessment of the NHIF capacity to cope with potential increase of the membership and other related SHI services. The need for digital solutions was addressed at conceptual level.

Information was collected from NHIF interviewees, and from other available external stakeholders. Discussions were also organized with the executive team on key findings and development options for further NHIF capacity building in key functional areas. In addition, inputs from beneficiary and health service provider surveys have been considered to support key findings from desktop work and stakeholder interviews. As a result of the integration of all inputs, strategic options have been developed to support development of the SHI and NHIF organization.

Focus group discussions with representatives from the informal economy and refugees' population

Focus Group Discussions (FGD) were used for data collection with representatives from the informal sector and refugees, targeting two groups: current and potential beneficiaries of the NHIF scheme. This aimed at presenting a deeper understanding of the population of concern care-seeking behaviour and awareness regarding health insurance. In addition to other factors including their understanding of benefits, willingness, and capacity to contribute, as well as experience and satisfaction with the system.

▶ 2. Overview of the healthcare system in Kenya

2.1 Healthcare system governance

Kenya has a pluralistic healthcare system, involving both public and private providers. The public health care system in Kenya is classified into two operational levels, namely the national and county levels, after devolved system of government was introduced in 2013, which gave rise to one central government and 47 county administrations. According to the 2010 constitution, the national government is responsible for financing counties so that all sectors including the health department can function effectively and smoothly. It also deals with health policy; national referral hospitals; capacity-building and technical assistance to counties. County governments are responsible for coordinating and managing delivery of primary and secondary health-care services through county facilities, pharmacies, ambulance services, and preventive services at the community level (Di Giorgio,Laura, Jison Yoo,Katelyn, and Maina 2018).

The system involves various actors who play different roles in ensuring the provision of health care services to the population. Some of the key actors include:

1. Ministry of Health (MoH): The MoH is the national government body responsible for policy formulation, regulation, and coordination of health services in Kenya. It sets health care standards, develops health policies, and oversees the implementation of health programs across the country. The MoH also manages health facilities and provides technical guidance to county governments on health matters.

2. County Governments: Kenya has a decentralized system of government, and health care services are primarily delivered at the county level. County governments are responsible for planning, budgeting, and managing health services within their jurisdictions. They operate health facilities, employ health workers, and implement health programs based on the national health policies and guidelines.

3. National Health Insurance Fund (NHIF): The NHIF is a state corporation that manages the national health insurance scheme in Kenya. It collects contributions from members and employers and uses the funds to provide health insurance coverage to its members. The NHIF plays a critical role in ensuring access to health care services by providing financial protection against the cost of health care.

4. Health Regulatory Bodies: There are several regulatory bodies in Kenya that play a role in health care delivery. These include the Kenya Medical Practitioners and Dentists Board (KMPDB), the Nursing Council of Kenya, the Pharmacy and Poisons Board, and others. These bodies are responsible for regulating the practice of health professionals, ensuring compliance with standards, and maintaining professional ethics.

5. Non-Governmental Organizations (NGOs): There are numerous NGOs operating in Kenya's health care sector that provide a wide range of health services. These organizations often focus on specific health issues, such as HIV/AIDS, maternal and child health, or water and sanitation, and work in partnership with the government and other stakeholders to deliver health care services.

In terms of purchasing structure, the Kenyan health care system is a mix of public and private sectors. Public sector purchasing is carried out by three main entities: the National Health Insurance Fund (NHIF), the national ministry of health (MOH), and the county departments of health (CDOH) across the 47 semi-autonomous counties. These purchasers are guided by legal frameworks, such as the National Health Insurance Fund Act of 1998 for NHIF, the Health Act of 2017 and the Public Finance Management Act of 2012 for MOH and CDOH, and possibly subnational level acts like the County Finance Act for CDOH.

Despite the presence of strong legal and regulatory frameworks, the government lacked effective implementation and oversight in various areas. For example, the Ministry of Health (MOH) has limited oversight over semi-autonomous or vertical programs that procure healthcare services on its behalf. Additionally, there were insufficient linkages between MOH policies and the National Health Insurance Fund (NHIF) to facilitate proper stewardship and oversight. The accountability of the NHIF to the government focused more on financial matters, while operational accountability was overlooked. As a result, while the government has mechanisms in place to hold the NHIF financially accountable, there was a lack of clear mechanisms to ensure the NHIF adhere to strategic purchasing objectives (Kazungu et al. 2021).

2.2 Health care delivery

The health care delivery system is structured into four tiers: community services, primary health care services, county referral services (secondary care) and national referral services (tertiary care). The community level generates demand for healthcare services while the primary health care services consist of level 2 dispensaries and level 3 health centers. The county referral services (secondary care-level) consists of public, large faith-based, and large private facilities that provide inpatient, outpatient, and specialized services, alongside some public teaching hospitals. Finally, the national referral services (tertiary care) comprise of national public referral hospitals that offer highly specialized services and conduct research and training for the country. In this system the county governments are responsible of providing services at levels (1) through (3), while the national government is in charge of providing national referral services (Kabia, E, Kazungu, J, and Barasa, E 2022), (Marita, A 2019).

Within the above health care delivery system, a network of over 12,000 facilities exists, across the public sector, parastatal organizations, private for-profit organizations, faith-based organizations (FBOs), and NGOs. These facilities provide health services to the general population. In 2020, the public sector accounted for less than half of the facilities, while over 93 percent of the facilities in 2019 were Level 2 and 3 facilities. Out of these, 40 percent were private, 8.5 percent were faith-based, and 3 percent were NGOs. The government runs all tertiary care facilities (Di Giorgio,Laura et al. 2018).

2.3 Health care financing

Kenya's health care system is financed from multiple sources, out of which the government (Ministry of Health and Counties) and NHIF (mandatory and voluntary insurance) play the dominant role. There is an over-reliance on out-of-pocket payments (OOP) (Government of Kenya 2018), (Salari, P et al. 2019). In addition, minor share comes from private insurance, and donors. Over the past decade, the health financing landscape in Kenya has changed with the government taking an increasing role, while donor contributions are dwindling. In 2018/19, the government was the major financier of health contributing

52% of total health expenditure (THE) up from 27% in 2009/10, while donor contribution saw a decline from 32% in 2009/10 to 18% in 2018/19. In the same year, the household contribution to THE also declined from 30% in 2009/10 to 24% in FY 2018/19 (Di Giorgio,Laura et al. 2018).

Although Kenya's government spending on health has increased over time and now even surpass some neighbouring countries like Ethiopia, Uganda, and Tanzania, yet financial resources generated for health is still rather low. In 2018, the government spending on health was 8% of total government spending and 2.2% of GDP. The amount of financial support provided by development partners for health financing is expected to continue declining in the future, and this trend could cause significant disruptions to essential health services. Additionally, Kenya is rapidly approaching the accelerated transition phase from Gavi, given that the gross national income per capita in 2018 was $1,620.12[2] (Di Giorgio,Laura et al. 2018). Therefore, Kenya needs to plan for a transition phase to ensure that there are no disruptions in the provision of essential health services (Di Giorgio,Laura et al. 2018).

[2] Countries are eligible for Gavi's support, if their average gross national income (GNI) per capita has been less than or equal to $1,630 over the past three years.

3. Rapid assessment of the National Health Insurance Fund (NHIF)

3.1. Background

Soon after independence in 1963, Kenya introduced a tax-based national health service system with the aim of providing free health care to all. But with a stagnating economy and budgetary constraints to cope with the increase in health care demand, user fees were introduced in 1989. The following years were marked by a suspension in 1990, followed by the gradual reintroduction of user fees spanning from 1991 to 2003 (Obare et al. 2018). With the re-introduction of user fees, few mechanisms were put in place to provide a level of protection for the poor, including free services for children below 5, subsidized and free preventive and some primary healthcare services (Chuma and Okungu 2011), (Okech and Gitahi 2012).

In 1966, The National Hospital Insurance Fund was established by an act of Parliament as a department in the Ministry of health. The aim was to respond to the high out-of-pocket payments (OOP) on hospitalization as a supplementary measure to 'create a national contributory hospital insurance scheme for all residents in Kenya'. Though the fund was meant to reach all Kenyans, it was implemented on a mandatory basis to those in formal employment and financed solely through contributions from social security contributions from workers. Furthermore, since the fund only covered inpatient care, it was highly polarized in the urban areas making it less accessible for the rest of the population and consequently much less attractive to populations living in remote areas (Chuma and Okungu 2011), (Kimani, D, Muthaka, D, and Manda, D 2004).

The scheme was expanded to include informal sector households on a voluntary basis in 1972 (ThinkWell 2021), (National Health Insurance Fund n.d.). In 1998, the NHIF was restructured by the repeal of the National Hospital Insurance Act and the enactment of the National Hospital Insurance Fund Act No. 9. This new Act made the NHIF an autonomous parastatal, providing financial and management autonomy separated from MOH, while the MOH moved to an oversight function as part of the board of the NHIF. The Health Insurance Act of 1998 made no distinction between formal and informal sector and indicated that membership shall be mandatory for all Kenyans at least 18 years of age. The act states that any "ordinary resident of Kenya," whether "salaried or self-employed," shall be "liable as a contributor" to NHIF. In practice, however, the scheme has remained voluntary for those in the informal sector, given the difficulties of enrolling and collecting contributions (Government of Kenya 2021a), (Government of Kenya 2022a).

With the aim of promoting a more equitable system, the Government in 2004 proposed to transform the NHIF to a national social health insurance fund. The national social health insurance fund (NSHIF) had the objective of providing a comprehensive coverage to all Kenyans for both outpatient and inpatient services and proposed the replacement of cost sharing schemes with prepayment contributions. It also proposed that the government would subsidize those who cannot afford paying contributions. Consequently, the NHIF bill was passed in parliament but was later declined by the president due to a mix of technical and political reasons. The country currently is using the NHIF Amendment Act, 1998 with suggestions for changes in contributions, exemption criteria and benefit packages taken from the previous NSHIF proposal (Kimani, D et al. 2004), (Abuya, Maina, and Chuma 2015), (Carrin, G et al. 2007).

The 2022 amendment act[3] aimed to modify the national hospital insurance fund act of 1998 to create the national health scheme and strengthen the NHIF's ability to provide adequate benefits through additional revenue generation, including: A) Introducing mandatory enrolment in the NHIF for Kenyans aged 18 years and above, which would increase the number of contributors and consequently expand the financial base for coverage to all Kenyans; B) Introducing matching contributions by both workers and employers, in line with ILO C102, in lieu of the worker-only contribution, which would significantly increase revenues and improve the financial sustainability of the scheme. Additionally, the NHIF board planned to review applicable tariffs payable to healthcare providers every two years, allowing them to increase their funding pool periodically to match rising treatment costs (Government of Kenya 2021b),(Kagwe, M 2022).

Despite its good intentions, the 2022 Act faced opposition from employers and private healthcare facilities who feared it would decrease their own revenues. The Employment and Labour Relations Court in Nairobi ultimately ruled in their favour. Additionally, it allowed employers providing private medical insurance that offers benefits equal to or better than the NHIF benefits to be exempt from NHIF contributions (Macharia, F 2022). The National Health Insurance Fund Regulations, 2023 were established to facilitate the implementation of the changes made to the NHIF Act in 2022. The 2023 regulations outline the contribution levels, the enrolment process, and the criteria for hospitals to become NHIF service providers.

In October 2023, the president of Kenya enacted four health reform laws to address financial barriers to healthcare and to progress towards extending coverage to the entire population. These laws included the new Social Health Insurance Act, 2023 and the Primary Health Care Act, 2023. Additionally, two other bills were enacted; the Digital Health Act, 2023; the Facility Improvement Financing Act, 2023. The Social Health Insurance Act, will repeal the NHIF amendment Act, establishing a new Social Health Authority to replace the National Health Insurance Fund. This new law also will establish three new funds: the Primary Healthcare Fund; the Social Health Insurance Fund; and the Emergency, Chronic and Critical Illness Fund. Currently, there is an ongoing review for the legal framework pertaining this legislation (Government of Kenya 2023b), (Government of Kenya 2023c).

3.2. The National Health Insurance Fund

Population coverage

The NHIF provides coverage to 24% of the population (Barasa et al. 2018). Membership into the NHIF is mandatory for formal sector workers and voluntary for the rest of the population.

Contribution levels

Formally employed workers pay a wage-rated monthly contribution on a graduated scale that is deducted automatically from their salaries and remitted to the NHIF by their employer (Barasa et al. 2018). As per the NHIF Regulation, formal sector workers are expected to contribute 2.75% of their gross

[3] The NHIF (Amendment) Act, 2022 was signed into law by former president H.E. President Uhuru Kenyatta on 10th January 2022, with an effective date of 28th January 2022. This law amends the National Health Insurance Fund Bill, which was presented to the national assembly in June 2021 and approved by the senate in December 2021 (Government of Kenya 2021a), (Government of Kenya 2022a).

monthly income towards the fund. Contribution for members of the informal sector in Kenya, such as self-employed individuals, unemployed individuals, and vulnerable populations is voluntary at a flat rate of 500 KES on a monthly basis which has been set since 2015 (Barasa et al. 2018).
With a view to introduce some progressivity in the contribution scale, in the NHIF regulation of 2023, self-employed members were expected to contribute 2.75% of their declared or assessed gross monthly income. While self-employed members whose declared or assessed income is less than 300 KES will contribute 300 KES instead of 500 KES. Additionally, the contribution for unemployed members who are not considered as indigents or vulnerable populations will be a flat rate of 1000 KES (twice the amount of the previous rate of 500 KES). For those members who are considered as indigents or vulnerable households, the National Government shall subsidize their contribution with 13,300 KES per household (Government of Kenya 2023a). The new Social Health Insurance Act (2023) deemed enrolment in the Social Health Insurance fund mandatory for all Kenyans. Currently new regulations regarding contribution rates are being drafted (Government of Kenya 2023b), (Government of Kenya 2023c).

Level of protection

Different population groups access different benefits packages with different cost coverage, creating important inequities within the pool of protected persons.

Financing

Financing of the NHIF is predominantly from contributions which accounts for 95% of the revenue source and 5% from government for the provision of free or subsidized care for specific population groups such as orphans and vulnerable children, secondary school students, pregnant women, elderly people, and people living with severe disabilities (SPARC 2021). Risk between the different population groups is pooled, meaning there can be cross-subsidization between the different groups and sources of revenue.

Delivery

NHIF has 95 fully autonomous branches across the country. Each of these branches offers all NHIF services including payment of benefits to hospitals, members, or employers. Smaller satellite offices and service points in district hospitals also serve these branches. In addition, NHIF has 47 Huduma Centers across the country (NHIF 2023d).

3.3. NHIF Schemes

The NHIF operates several different schemes for its members each enjoying different benefit packages as listed below (See Benefit Packages section).

In NHIF Kenya, the principal member of the SHI schemes is the person who is registered with NHIF and actively contributing to the health insurance scheme or alternatively, the national government covers the contributions on their behalf. The principal member should be above the age of 18 years and can either be an employed person, a self-employed, un-employed or vulnerable populations that are subsidized by the Government and partner agencies. Foreigners with alien registration are also allowed to enrol in NHIF as part of the sponsored program. By law, membership in the NHIF is compulsory. However, given the lack of enforcement mechanisms among the informal sector, the membership is de facto voluntary (Munge et al. 2019).

Eligible household members are the dependents of the principal member who are covered under the NHIF health insurance scheme. The eligible household members are defined as follows:

- Spouse - The legally married partner of the principal member.
- Children - Biological or legally adopted children of the principal member under the age of 18 years or up to 25 years if they are still in school or college.
- Members can also add orphans and/or adopted children to their coverage by obtaining proof of legal guardianship/adoption from the county offices' children's department (NHIF 2023b).

Parents and siblings of a principal NHIF member are not considered dependents and therefore not eligible to receive social health benefits through them. It is important to note that eligible household members are only covered under the NHIF health insurance scheme as long as the principal member is making monthly contributions to the scheme. If the principal member fails to make contributions, the coverage for eligible household members will be suspended until penalties are paid and contributions are resumed.

I) The National Health Scheme (NHS) also known as "UHC Supacover" is the primary health insurance cover for all members and their declared dependents. Membership is mandatory for formal sector workers and on voluntary basis for the informal sector workers. According to the general policy to move towards UHC and amendments into NHIF Act from 2022 "a person who has attained the age 18 years and is not a beneficiary shall register as a member of the Fund". However, the change in this regulation has not been implemented, and the general obligation of the mentioned age group regarding NHIF membership has not been achieved. Members of the national scheme can access inpatient, outpatient service and special benefit packages. The formal sectors pay their contributions through a monthly automatic deduction calculated on a graduated scale based on income, while for voluntary members and their declared dependents, membership is contributory and is available for a fixed contributions of 500 Kenya Shillings per month (NHIF 2023c).

II) The Enhanced Scheme: Established in 2012, the enhanced scheme is an enhancement from the National Health Scheme (NHS) and covers Civil Servants, National Police and Prison Service (NPS/KPS), County Governments, Parastatals/private company schemes & Pension Schemes for Retired Public officers. Under this scheme, the government redirects previous medical allocations of civil servants to the NHIF as contributions. Funds for the CSS (Civil Servants Scheme) are managed separately from other NHIF funds, and beneficiaries enjoy a broader benefit package, including comprehensive outpatient and inpatient services and an extended generous benefit package which comprises of air rescue, overseas treatment, annual medical check-up, eye, and dental care. The package also offers an opportunity to bypass the PHC referral system through direct access to specialist care (Barasa et al. 2018).

III) Linda Mama Scheme: In 2013, Kenya abolished all fees on maternal services in public facilities upon the introduction of the free maternity service policy. This policy was then revised in 2016, expanding access to services to include private providers, and transferring its management from the ministry of health to the NHIF under the Linda Mama scheme (Orangi, S et al. 2021). Women who are not covered by any other insurance scheme can benefit from the Linda Mama scheme, through which the NHIF reimburses facilities for pre-natal, delivery and post-natal care services. The scheme is supported by GoK, World Bank and JICA and is open to all Kenyan pregnant women. The cover period is one year which commences from the time the cover is activated at the healthcare facility (NHIF 2023c).

IV) Health Insurance Subsidy Program (HISP) for the poor, older persons and persons with severe disabilities: The health insurance subsidy program was launched in 2014 by the GoK as a pilot health insurance program for selected poor and vulnerable children. The HISP pilot has progressively scaled up to cover 10% of the population identified through proxy means and community verification. HISP beneficiaries receive comprehensive fully subsidized services from contracted public and private providers (Barasa et al. 2018). NHIF also has a memorandum of understanding (MoU) with UNHCR which allows for refugees identified by UNHCR to enrol with NHIF and access the same benefits as NHIF members. The contribution is paid by UNHCR for targeted poor refugees' households in camps or urban settings.

V) Edu Afya: is a comprehensive medical scheme for all public secondary students covering all students captured under the National Education Management Information System (NEMIS) and registered with NHIF. It covers all children in public secondary schools in Kenya (NHIF 2023c).

VI) The Inua Jami Senior Citizens' scheme: is a tax financed social pension offering universal pension coverage for all citizens of Kenya once they reach 70 years of age. All older persons aged 70 years and above who receive the universal social pension also gain membership of the NHIF, with their contributions paid by the Government, at a rate of 500 KES per month. The NHIF covers the cost of inpatient treatment, with specified ceilings based on the costs of treatment in Government hospitals and other facilities (ILO 2019).

3.4. Management and operations of the NHIF

3.4.1 Governance

The NHIF is a semi-autonomous government agency (SAGA) under the MoH. Following the transfer of the NHIF from a department of the MoH to a State Corporation, the management of NHIF switched to become an all-inclusive and is currently governed by Board of Directors with members nominated from designated stakeholder organizations such as civil society, employers, and local governments. The Board makes the primary decisions regarding the management of NHIF and is responsible for review and approval of policies, including strategic decisions on the benefit package, contracting and provider payment. The Board also suggests an annual budget which is voted on by the National Assembly (SPARC 2021), (NHIF 2018).

In order to ensure accountability, The NHIF has instituted different mechanisms in place such as the Board's Audit and Integrity Subcommittee, the Auditor General of the Kenyan Government (which files annual reports to the Parliament on the performance of each government agency, including the NHIF), the NHIF's Efficiency Monitoring Unit (which handles complaints and performs periodic audits of the operations of the agency) and finally the NHIF Ombudsman (which receives and mediates complaints) (UHCforward n.d.).

Composition of the Board is defined by the NHIF Act, which ensures diverse representation. However, that does not necessarily guarantee that the Board members always possess the leadership or technical competencies pertinent to guiding strategic directions and oversight of NHIF development, capacity building and strategic performance. Accountability of the Board to governmental authorities is regulated, but it lacks the competencies to contribute to the NHIF governance in strategic areas.

3.4.2 Enrolment and registration

NHIF offers enrolment options for employed members, self-employed individuals, unemployed individuals, and sponsored members. In the formal sector, registration is carried out through employers who must register with NHIF to provide medical coverage to their employees. Employers are assigned a unique employer code number to remit NHIF deductions and are required to provide updated employee and household lists to NHIF every month. NHIF compliance officers monitor the registration and contribution payments of employees, but NHIF notes that the current volume of control is insufficient, and more compliance officers would improve the quality of insured data and contribution payments.

For those who are self-employed, individuals can register at any of the NHIF branches, Huduma centers[4] or online using various platforms. Individuals are expected to pay a 3-month advance fee- for the first registration and the monthly contribution on the third month and every month before the 9th (NHIF 2023b). Members who are not employed or listed as an indigent or vulnerable person use the same registration process as the self-employed. For the EduAfya scheme, enrolment is automatic for all public secondary students and includes biometric registration by the NHIF onsite at respective schools.

For sponsored members who are categorized as vulnerable households', registration is done via the sponsoring organization and membership fee is covered by institutions such as the National Government through the Ministry of Health, County Governments, Social Protection Programs under the National Government Constituencies Development Fund, and partners such as Pharm Access and UNHCR.
NHIF has incorporated a waiting period for applicants to become active members. As per the current practice, the waiting period for the formal sector is 30 days while it takes 90 days for voluntary contributors to access all NHIF benefits. With the revised NHIF regulation 2023, it was suggested that the waiting period for all members is revised to 60 days. Upon registration, NHIF members should select a primary health care provider to access any out-patient services. Members may change their choice of selected health care provider if conditions aren't met in a manner determined by the Board (NHIF 2023b).

NHIF membership has seen a significant increase of 51.6% in June 2022 compared to the previous financial year, including the formal and informal sectors, as well as sponsored members. However, despite this positive trend, there is a high attrition rate among NHIF members, particularly among informal sector workers. This can be attributed to challenges related to the affordability of monthly contributions required to maintain NHIF membership. Furthermore, the disorganized nature of the informal sector poses administrative difficulties in recruiting, registering, and collecting regular contributions. Additionally, low uptake and poor retention rates are common due to the voluntary nature of membership and contributions payment. Rules aimed at improving the fund's sustainability, such as requiring three-month advance contributions and imposing late payment penalties, are viewed as punitive and inflexible, present additional restrictions to access for uncovered groups (NHIF 2021).

[4] Physical one-stop shop service centres that provide public services from a single location.

Membership	F/YR 2020/21 (million)	F/YR 2021/22 (million)	F/YR 2020/21 (%)	F/YR 2021/22 (%)	F/YR 2020/21 Vs 2021/22 VARIANCE
Formal sector					
Active	3.25	3.94	72%	42.3%	21.2%
Inactive	1.29	0.88	28%	14.4%	31.8%
Sub total	4.50	4.82	45.0%	31%	7.15
Informal sector					
Active	1.75	5.37	32.0%	57.7%	206.8%
Inactive	3.50	5.26	68.0%	85.6%	50.3%
Sub total	5.59	10.64	55.0%	69%	90.3%
Total	10.13	15.46	100.0%	100%	56.2%

Table 1: Comparative Analysis; Membership in the Formal and Informal Sector for Active and Inactive Member (NHIF 2021)

Digitalization of the registration process

For registration, NHIF assigns unique insurance numbers verified based on the national IDs. In 2021, NHIF introduced a biometric registration and verification system instead. The main purpose behind digitalization was to limit fraud (Nairobi News 2021). Implementing digital registration could have positive implication, enhancing data exchange capabilities, meeting compliance requirements, and improving costumer experience. Consequently, this could result in increased efficiency, reduced human errors and improved customer satisfaction.

The voluntary nature of the enrolment of the informal economy posed challenges to both the NHIF and its prospective members. This can be attributed to the lack of technological capacities to fully affiliate the large numbers of enrolee on one hand. On the other hand, the members faced challenges related to enrolment in terms of lack of awareness of SHI obligations and benefits. Representation of informal economy members through organized unions or associations by professions can be one potential solution to facilitate the enrolment process. This would also make it easier to manage insurance in the future, further extend the mandatory insurance for other groups of the population in informal economy.

3.4.3 Contribution collection, revenue raising, and pooling

Contribution collection

The NHIF is the responsible body for collecting insurance contributions. Collection is monitored through a multi-step process that includes collecting funds, pooling, monitoring payments, information exchange, enforcement measures, and evaluating collection rates against targets.

Collecting of funds

For formal sector workers, contribution deductions are made automatically through their payroll. For the informal workers, enrolees used to make direct cash transfers to NHIF offices. A new form of contribution payment was introduced to facilitate payments, with the option to contribute through direct cash and check deposits with partnered banks, or through mobile money payment platforms, such as M-Pesa (a Safaricom mobile money transfer application) and electronic wallet (Saya, M 2023).

NHIF also receives contributions from the government and other sources on behalf of sponsored members.

Enforcement measures

Compliance to contribution payments is enforced by the NHIF through penalties and fines on members or employers who fail to remit contributions on time. The NHIF penalties for late payment apply differently for those in the formal than those in informal sectors. When an employer fails to make payment on time, they are required by law to make double the principal amount, whereas informal members are required to pay an additional fee of 50% (250 KES) of the NHIF payment rates. Failure to pay contributions for more than a year, requires reinstatement with NHIF as a new member including the three-month payment as well as two months waiting period to become active (NHIF 2023b). NHIF also conducts audits and investigations to identify and address any potential fraud or abuse.

Monitoring of payments

NHIF monitors the payments received from members and other sources to ensure that they are accurate, complete, and timely. This includes verifying the amounts, tracking the frequency of payments, and reconciling any discrepancies or irregularities.

Information exchange

NHIF maintains an information exchange system that enables communication and data sharing with various stakeholders, including employers, members, healthcare providers, and government agencies. This helps in tracking contribution payments, coordinating services.

Collection rate against the target

NHIF sets annual targets for contribution collection, and the collection rate is regularly evaluated against these targets to assess the performance of the program. This helps in identifying any gaps, challenges, or areas for improvement in contribution collection and addressing them proactively.

Despite regular goal setting and contribution planning, NHIF has not been successful in achieving its target. This is due to several reasons, including unrealistic estimation of the contribution target, unstable behaviour of the informal sector and their lack of interest in insurance coverage against financial difficulties, and inadequate compliance by the formal sector with mandatory insurance requirements. In addition to, NHIF's inability to monitor insurance enrolment and contribution receipt or effectively implement necessary measures for regulating the process.

NHIF Revenue

In the financial year 2021/22, the National Health Insurance Fund (NHIF) in Kenya generated a total revenue of 40 billion Kenyan shillings (KES), with contributions from the formal sector presenting 79.2% of the total revenue. The informal sector and sponsored program accounted for 18.9% and 1.88% of NHIF's revenue, respectively (NHIF 2021).

Sector	2017/18	2018/19	2019/20	2020/21	2021/22
Formal	27,797,380,969	30,194,404,705	30,578,489,502	29,895,973,158	31,952,618,971

Informal	4,803,798,784	6,215,765,871	6,755,389,387	7,262,695,825	7,635,055,741
Sponsored	210,686,088	600,562,906	643,147,215	521,613,712	757,187,043
Total	32,811,865,841	37,010,733,481	37,977,026,104	37,680,282,695	40,324,405,612

Table 2: Revenue collection per sector (5 years) (NHIF 2021)

Pooling

Once the funds are collected, NHIF pools the contributions together to create a common fund that is used to finance healthcare services for its members. The pooled funds are used to reimburse health service providers for delivered services. The NHIF operates as a single risk pool making it the largest risk pool in the country. However, it has several schemes that offer different benefit packages. The multiple fragmented benefit packages undermine the effectiveness and efficiency gains of risk-sharing and cross-subsidization of one large pool (Barasa et al. 2018).

Other revenues

In addition, NHIF has the right to invest under the terms set by the Board to generate returns that can be used to sustain the program and provide benefits to members. In general, investing the collected contributions in different assets under the SHI system should be considered inappropriate, as it involves a high risk of losing the value of the asset instead of a return. Usually, national health insurance funds do not accumulate funds outside of their technical reserves.

3.4.4 Benefit Package

The NHIF benefit package is divided into two level tiers. The two main scheme categories are, The National Health Scheme (UHC Supacover) and the Enhanced Scheme. These scheme categories have different benefit packages, which generally include a wide range of primary healthcare services, outpatient services, inpatient services, specialized services (e.g., renal dialysis, specialized diagnostics), and treatment outside of Kenya (Barasa et al. 2018). NHIF provides financial coverage within the packages listed below to its members throughout the network of accredited facilities (NHIF 2015).

National Benefit Scheme	Enhanced Scheme
Outpatient care	Outpatient care
Inpatient care	Inpatient care
Maternity	Maternity & reproductive health
Renal dialysis	Renal dialysis
Mental and behavioural	Mental and behavioural
Radiology	Radiology
Surgical	Orthopaedic and other appliances
Oncology	Surgical
Emergency	Organ donor

Foreign treatment	Oncology	
	Dental	
	Optical	
	Emergency	Enhance services
	Foreign treatment	
	Annual medical check-up	
	Last expense	

Table 3: List of Benefit package of the major schemes of the NHIF

Prior to 2015, NHIF was only providing inpatient coverage to its scheme members except for the civil servant's scheme who enjoyed an extended benefit package of both inpatient and outpatient services. In 2015, the NHIF expanded the benefit package for its national scheme members to include outpatient services and a range of special packages such as renal dialysis, oncology, radiological services, kidney transplant, diabetes, and hypertension. Expansion of the benefit package was accompanied with an increase in contribution and provider reimbursement rates. As a result, monthly NHIF contributions for informal workers increased from 160 KES to 500 KES. NHIF contributions were revised in 1998 followed by another revision in 2015 and recently through the NHIF regulation 2023 (Government of Kenya 2023a). It is currently being revised after the enactment on the new Social Health Insurance bill in October 2023. The creation of two additional funds for specific conditions with the new legislation, may have an impact on the benefit package.

The expansion of the benefit package was lauded for enhancing financial risk protection especially for informal sector and HISP members who could now access comprehensive healthcare without incurring out-of-pocket expenditure. The addition of the special packages also improved access to members with chronic conditions to their regular treatment whom under the previous package would have been excluded. The reimbursement for the special packages was done separately as bundled packages, which served as an incentive to health care providers to provide those services (ISSA 2017).

However, there have been concerns regarding the enhanced scheme benefit package due to lack of service entitlements specification, lack of provider awareness of entitlements, and a geographically limited network of providers. Furthermore, facilities have been facing issues of shortages in medical personnel, medications, and equipment to adequately deliver the package. There is also a raising concern on the financial sustainability of the enhanced package and possibly adverse cross-subsidization due the mismatch between contributions and benefit costs. This was highlighted by a threefold increase in the contributions compared to five-fold increase in benefit cost within the period 2013/14 to 2017/18 (Kabia, E et al. 2022).

The design of the current benefit package was developed taking into account various factors such as a demographic analysis, location, age, gender, utilization rates of health care services rather than a comprehensive and participatory assessment of health needs. The classification of inpatient and surgical services into two main packages may lead to potential overlap with other more specified packages, where these services are also included.

NHIF calculations shows discrepancy between revenue raised from contribution rates and services costs. The recent impact analyses indicate that the current benefits per household exceed the revenue collected from contributions by 50%. As shown in table 4 below, the average calculated cost of benefits

per household is slightly higher than 9000 KES, whereas annual contributions from the informal economy amount to 6000 KES only.

	Category of Health Services	Payment Mode	Limitation Type	Annual Cost per Family
1a	**Inpatient** Local Treatment	Fixed Rebate	Days Admitted	2405
1b	**Inpatient** Local Treatment ICU &HDU	Fixed Fee for Service	Prescribed Limit	
2	Inpatient **Foreign Treatment**	Fee for Service	Benefit Limit	444
3	**Emergency Services**	Capitation	N/A	68
4	**Renal Dialysis**	Fixed Fee for Service	Prescribed Limit	587
5	**Surgeries**	Fixed Fee for Service	Prescribed Limit	2004
6	**Oncology**	Fixed Fee for Service	Prescribed Limit	783
7a	**Maternity** (Delivery Only)	Fixed Rebate	Prescribed Limit	550
7b	**Maternity** (Ante/Post Natal)	Fixed Rebate	Prescribed Limit	
8a	**Outpatient**	Capitation	N/A	1650
8b	**Outpatient** (NCD)	Fixed Fee for Service	Benefit Limit	
9	**Radiology**	Fixed Fee for Service	Prescribed Limit	231
10	**Drug and Substance Abuse**	Fixed Fee for Service	Benefit Limit	185
11	**Mental Health**	Fixed Fee for Service	Prescribed Limit	118
12	**Mortuary/ Last Expense**	Fixed Rebate	Days in Mortuary	

Table 4: Impact Analysis: Expected Benefit Utilization per household (source NHIF)

3.4.5 Contracting

NHIF contracts with accredited health facilities that are managed by the public, private and mission (faith-based) organizations. Members can access their benefits at any of the hospitals affiliated with NHIF regardless of locations. Overall, there are more than 12000 health facilities in Kenya with 5700 of them being NHIF accredited (Obadha et al. 2020).

The process for contracting is guided by the NHIF accreditation regulations of 2003 and involves four major steps: 1) facility application for accreditation- providers must first be licensed with the Kenya Medical Practitioners and dentists board before undergoing an on-site assessment, 2) inspection by NHIF- The inspection process covers aspects of the facility such as infrastructure, human resource management, availability of equipment, and infection prevention measures 3) gazettement by board based on recommendation of the inspectors and 4) contract signing between the NHIF and the health facility specifying the category of the health facility, services to be provided, reimbursement rate and other terms of engagement. The final process of signing the contract accredits providers into three categories (Category A-C) based on the type of the facility and the requirement for additional co-payment (Suchman 2018),(Munge, K et al. 2018)

I. Category A: Government hospitals.

Hospitals under this category do not charge out of pocket payments since NHIF fully caters for all admissions if the covered member fully paid their NHIF contributions.

II. Category B: Faith based and medium sized private hospitals.

Hospitals under this category may require co-payments to be made for certain services offered. Members in the national scheme can access only selected hospitals under this category, while members in enhanced scheme can access services in all category B hospitals.

III Category C: High- Cost private hospitals.

Like category B, these hospitals also require out of pocket payments for some of the services rendered. Members in enhanced schemes can access services in these hospitals.

The NHIF engages in selective contracting mainly with private healthcare providers based on defined quality standards. On the other hand, contracting public facilities is different, due to shortage of providers in certain areas in which the public providers, are the only option. Also, as a state-owned agency, it is not easy for NHIF to reject a public health facility even if they do not fulfil the requirements to be contracted (Kazungu et al. 2021).

NHIF signs a unique contract with each licensed provider participating in the scheme, but the existence of multiple schemes within the NHIF each with its own benefit package and payment mechanism can act as a barrier to optimize negotiation on prices (Bunyi, M, Holtz, J, and Odeyo, J 2021). Currently contract management is largely focused on the legal process rather than defining the volume of purchased services or setting the budget framework. Contracts are basically open obligations, where the service provider can provide unlimited services as they deem necessary. Also planning and concluding contracts is not based on the analysis of the health needs of the population, nor the content and volume of the services to be purchased are prioritized. Purchasing is therefore not maximizing its strategic potential. The quality of service and the provider performance is not linked to contractual monitoring. Indeed, agreed-upon targeted terms for provider performance in the contract, serve only for the purpose of "soft" feedback.

3.4.6 Provider payment methods and claim management

Provider payment

Provider payment mechanisms have a significant impact on encouraging the quality of health services through incentivizing desired providers behaviour. The NHIF contracts with public and private providers and uses different provider payment methods for its various schemes. For instance: capitation method is used by the general scheme and the civil servant's scheme to pay primary care facilities, fee for service for outpatient specialist service, and a mix of case-based payment, fee for service and per diems is used for inpatient services. The Linda Mama scheme pays fixed fees for antenatal care, deliveries, and postnatal care while the Edu Afya scheme pays a fixed fee for each visit (Obadha et al. 2020).

If harmonized well, the different payment methods are expected to create the right incentives to improve health service delivery and boost efficiency. However, NHIF provider payment methods are criticized for being incoherent- with overlapping provider payment mechanisms and different payment rates for the different schemes within a single contracted facility. For instance, NHIF pays an annual capitation rate of 2,850 KES for members of its civil servants' scheme while it pays the same facility an annual capitation rate of 1,200 KES for outpatient care for the general population. For normal delivery, the NHIF pays 10,000 KES under the general scheme but pays 5,000 KES under the free maternity

scheme. Also, there are different tariffs applied for the same service at different levels of care, which is not justified economically nor clinically. This fragmentation sends mixed signals to providers that may encourage "cream-skimming" and supply-induced demand, which consequently hinder equity, efficiency, and quality of services provided (Barasa et al. 2018).

While assessing the provider payment methods a broader picture should be considered than NHIF's payment methods only, as NHIF financing forms less than 50% out of the total health care financing. The biggest share of provider payments comes from County Governments and National MOH who finance their owned providers on the basis of line-item and global budgets accordingly.

The existing tariff system of the NHIF is fragmented, favouring service providers interests over equitable universal principle. Provider payment mechanisms are dominantly input-based rather than output-based methods to incentivize providers to deliver efficient and value-based quality care.

Claim management

Claims are submitted by hospitals directly to NHIF after discharge from the hospital. In the past, paper-based claims were used but were found vulnerable to fraud prompting the adoption of electronic system. The system verifies claims against NHIF regulations, and approved claims to be paid to providers. The processing time vary depending on claim type and the information provided accuracy. It's important to note that delays in the past, were reported to be caused by technical issues, inaccurate or incomplete information, or other factors (Njiri,R 2016) & (NHIF 2023a) However, recent delays in payment were rather caused by the financial unsustainability of NHIF.
Overall, the electronic claims management system has enhanced efficiency and accuracy, reduced reliance on paper and helped speeding-up the claims processing. However, the technical issues have led to delays in paying providers, particularly in areas with poor internet connectivity. Electronic claims management would help potentially to lower the fraud cases if electronic controls have been widely implemented. Despite these improvements, delays in payments persist due to financial constraints of the NHIF scheme with liabilities surpassing available resources.

3.4.7 Data management and competencies

The NHIF employs several data management systems to manage the significant data influx from members, healthcare providers, and other stakeholders. They utilize an online portal for members' registration, contributions payments, medical records access, facilitating claim submissions and providers payments. The NHIF has also integrated data management systems with other government systems to improve efficiency and reduce duplication of efforts. Additionally, NHIF adopts an EHR system for electronic patient health information storage and Enterprise Resource Planning (ERP) System for streamlined operational and data management (Paton, C and Muinga, N 2018) & (Macharia, M and Iravo, M 2018).

Despite the above efforts, the information management system of NHIF is very outdated from the early 1990's, has no or little capacity to satisfy today's needs to manage exponentially growing data volumes. This outdated system constantly face challenges including limited system integration, capacity, and user adoption. Addressing these challenges will require ongoing investment in

technology and data management capabilities, as well as efforts to improve user adoption and data accuracy.

4. Focus Group Discussions on perception and satisfaction with NHIF scheme

Upon the assessment of the NHIF organization, FDGs were conducted in Nairobi, Mombasa, Nakuru and Turkana simultaneously among representatives of the informal economy covering two target groups:

- First, current beneficiaries, including workers in the informal economy as well as refugees that are currently members of NHIF.
- Second, potential beneficiaries – including workers in the informal economy and refugees that are currently not members of NHIF (or have defaulted payments).

The study was designed as qualitative research to develop a deeper understanding of the informal economy units' behaviour regarding NHIF. All together 48 FGD's were conducted, 24 FGD's covering the current members of NHIF and 24 FGD's covering of potential members. FDG interviews covered all together 211 interviewees.

A. Current Beneficiaries

The overall research question guiding this study is, **"What are current beneficiaries' perceptions of the NHIF and the services provided?"** The data collected through FGDs was meant to help understand the Current Beneficiaries' views on what would improve their current experience with the NHIF. As such, the specific research objectives were the following:

1. To understand beneficiaries' knowledge and awareness of their social health insurance entitlements;
2. To understand their current experience with the NHIF's enrolment process, the NHIF's benefit package and facilities;
3. To identify key areas for improvement of the NHIF beneficiary experience (with specific focus on refugees);
4. To identify key areas of satisfaction of the NHIF beneficiary experience.

A1. Current NHIF Beneficiaries' Knowledge and Awareness of their Social Health Insurance Entitlements

The knowledge and awareness of current beneficiaries of NHIF on their social insurance entitlements are mixed. Majority of beneficiaries have limited knowledge of their entitlements and benefits under the scheme. This is especially the case with the refugees. However, there are a few beneficiaries who have a good understanding of the benefits provided by the NHIF. One of the main reasons given by the respondents, for this variation in knowledge is the lack of effective communication and awareness creation about NHIF's services and benefits. Language barrier is also cited as a reason for limited knowledge especially for the refugees.

A2. Current Beneficiaries Experience with the NHIF's enrolment process, Benefits Package and Facilities:

Enrolment Process

The enrolment process for NHIF varies depending on the method chosen by the individual. For instance, one can register for NHIF services online, through the mobile phone or visit the NHIF offices to enrol. About a half of the beneficiaries reported to have experienced challenges such as long queues and unresponsive NHIF staff to their needs and welfare. There are however those that reported smooth process. Refugees face difficulties in providing the required documentation. Language barriers can make it challenging for refugees to navigate through the enrolment process.

Benefits Package and Facilities

NHIF offers a comprehensive benefits package that covers hospitalization, surgical procedures, cancer treatment, dialysis, among other services. However, majority of the beneficiaries have raised concerns about the quality of facilities where NHIF covers them. Some NHIF-accredited facilities have personnel shortages, leading to long waiting times for patients. Additionally, some beneficiaries report having to pay extra fees for services that should be covered by NHIF. This was of special concern to refugees, as some of them are not fully covered with their families because of the family size. They are required to pay out of their pocket for the excluded members.

A3. Key Areas for Improvement of the NHIF Beneficiary Experience

Some areas of improvement for NHIF to better serve refugees as beneficiaries include:

- Simplifying the enrolment process: NHIF can work with organizations serving refugees to streamline the process and make it easier for refugees to access the scheme.
- Increased awareness and information: NHIF can work with organizations serving refugees to improve awareness and information regarding the benefits offered by the scheme. This can include providing information in different languages, conducting targeted outreach, and providing clear and concise information on how to access healthcare services.
- Addressing language barriers: NHIF can provide translation services, either through trained staff or the use of interpretation services, to help refugees understand their benefits and access healthcare services.
- Expanded benefits package: NHIF can consider expanding its benefits package to better address the specific healthcare needs of refugees, including mental health services, reproductive health services, and access to specialized care.
- Capacity building for healthcare providers: NHIF can implement training programs for healthcare providers to improve their cultural competency and better understand the healthcare needs of refugees. This can help to improve the quality of care offered to refugees, leading to improved health outcomes.
- Improved complaint mechanisms: NHIF can improve its complaint mechanisms to ensure that refugees have access to channels to lodge complaints if they experience any issues or grievances while accessing healthcare services under NHIF.

A4. Key Areas of Satisfaction of the NHIF Beneficiary Experience

Key areas of satisfaction of NHIF include:

- Comprehensive Coverage: A comprehensive coverage policy that includes a wide range of healthcare services, including preventive care, hospitalization, medications, and specialized treatments, is highly valued by beneficiaries. When NHIF provides coverage for essential medical needs, it ensures that beneficiaries can access necessary healthcare without incurring substantial out-of-pocket expenses.

- Customer Service and Support: Beneficiaries appreciate responsive and helpful customer service from NHIF. Having dedicated support channels to address inquiries, complaints, and grievances in a timely manner demonstrates a commitment to beneficiary satisfaction and contributes to a positive experience.
- Affordable Contributions: Beneficiaries appreciate affordable contributions that are commensurate with the coverage provided. Ensuring that NHIF contributions are reasonable and manageable for beneficiaries' income levels enhances their satisfaction with the insurance program.
- Efficient Enrolment and Membership Management: Simplifying the enrolment and membership management processes contributes to beneficiary satisfaction. When NHIF makes it easy for individuals to enrol, update their information, and access their benefits, it reduces administrative burdens and enhances the overall experience.

B. Potential Beneficiaries

The overarching research area guiding the study was **"what are the perceptions of informal economy workers/refugees about health insurance, their needs and preferences to enrol into the health insurance and satisfaction with NHIF performance".** The specific research objectives were the following:

B1. To understand their care-seeking behaviour and identify priority health care services;

B.2. To understand how they currently pay for healthcare;

B.3. To get a sense of their understanding of health insurance, trust in NHIF and willingness to pay health insurance contributions;

B.4. To identify their contributory capacity and ability to pay health insurance contributions; and

B.5. To identify (dis)incentives for their enrolment in NHIF.

The following key findings were observed during the focus group interviews.

B1. Potential beneficiaries care-seeking behaviour and their perception on health insurance and NHIF performance.

Care-seeking behaviour refers to the actions taken by individuals to seek healthcare services when they need medical attention. Potential beneficiaries have varied behaviours when it comes to healthcare services and can be influenced by various factors.

Care-seeking behaviours

- Delayed or limited care-seeking due to concerns about the cost of services. They only seek medical attention when their condition worsens or becomes unbearable.
- Due to financial constraints, individuals without insurance usually resort to self-medication or home remedies for minor ailments.
- The potential beneficiaries often rely on public healthcare facilities that provide low-cost or free services.
- Utilization of charity clinics and non-profit organizations that offer free or subsidized healthcare services to underserved populations with a focus on primary care, preventive services, and basic treatments.

Priority health services

- Most of the respondents mentioned that they mostly require **primary care services**, including routine check-ups, acute illness management and chronic disease management.
- Access to **affordable medications** is a priority for uninsured individuals.
- The need for **mental health services**, including counselling, therapy, and psychiatric care, and integrating mental health into primary care settings was addressed.
- **Maternal and child health services** are essential for all individuals including prenatal care, postnatal care, well-child visits, immunizations, and access to obstetric care.

Additionally, many refugees rely on humanitarian organizations such as the United Nations High Commissioner for Refugees (UNHCR) and other non-governmental organizations (NGOs) for health care services. In terms of identifying priorities, refugees often prioritize their immediate needs, such as treatment of acute illnesses and injuries over preventive care.

Refugees may also have specific health care needs related to their forced migration trajectory. For example, they may require adapted services such as psychosocial support, treatment for trauma related to conflict or displacement, and care for chronic diseases exacerbated by living conditions in refugee camps.

B2. Potential Beneficiaries Current Mode of Payment for Healthcare

They pay for healthcare through the following means:

- **Cash payments by individuals** from their resources in cash or mobile applications like Mpesa.
- **Sponsorships from well-wishers and family** members who take care of the medical bills.
- **Employer-sponsored insurance** through their employment, which is partially or fully paid for by their employer.
- Some of the respondents get their healthcare services from **free medical camps** held by community and charity organizations. Like in Langata, the domestic workers could access medical care for free at the government hospital and have to buy the unavailable medication from outside the hospital.

B3. Potential Beneficiaries understanding of health insurance, trust in NHIF and willingness to pay NHIF contributions.

- **Understanding of health insurance:** Most of the respondents had limited knowledge and /or misconceptions about health insurance, on how much was contributed and on what was covered in the NHIF. They did not fully understand the details of the coverage and felt it should be explained more for them to understand. Moreover, they relied more on the hearsay than on the facts available mostly due to a lack of awareness.
- **Trust in NHIF** was not fully embraced by all, mostly because the respondents are acting on hearsay than facts. Some of the respondents have heard someone was helped when they were in dire need of health services, but others have heard the opposite. Transparency in fund management was raised by participants who felt that they should have a way of knowing what is covered beforehand.
- **Willingness to pay NHIF contributions.** Sentiments which influence the willingness to contribute were as follows:

- **The perceived value of NHIF coverage** is that NHIF coverage plays a significant role in healthcare services and provides financial protection against high medical expenses, which makes them more likely to be willing to join the NHIF coverage.
- **The affordability of NHIF contributions** is a crucial factor in willingness to pay. Individuals assessed their financial situation and weighed the cost of NHIF contributions be lowered to between 150 KES to K 300 KES as affordable.
- The **quality of healthcare services** was mentioned by most respondents that if they can access quality healthcare services, including timely appointments, skilled healthcare professionals, and modern medical facilities, they may be more inclined to trust the system and contribute.
- **Socioeconomic factors**, such as income level, employment status, and access to alternative healthcare options, can influence individuals' understanding of health insurance, trust in NHIF, and willingness to pay contributions. Most of the potential beneficiaries are either low-income earners, have unstable income or have refugee status. Their economic status is limited and constrained. Healthcare insurance is a necessity but the least of their worries and would prioritize other essential needs instead.
- Most of the respondents due to their levels of education and environmental exposure have varying levels **of awareness about the services provided by NHIF**. Lack of information about the benefits, coverage limitations, and healthcare providers associated with NHIF impacts their trust and willingness to contribute.
- **Trust in the healthcare system**, including healthcare providers and facilities, can impact individuals' willingness to engage with NHIF. Negative experiences or perceptions of inadequate quality of care may erode trust and discourage their willingness to participate in a health insurance scheme.

Refugees have varying levels of understanding of health insurance and the NHIF, coupled with limited exposure to health insurance, leading to lack of familiarity of how it works. Additionally, refugees have limited trust in the NHIF and other government institutions due to their experiences of displacement and marginalization. They may view the NHIF as an extension of the government and may be sceptical of its ability to provide equitable and accessible health care services.

B4. Potential Beneficiaries contributory capacity and ability to pay NHIF contributions.

Some of the factors that influence the ability of potential beneficiaries to contribute are:

- **Casual employment relationship, low-income level** and limited resources makes informal economy units marginalized in terms of contributions. Being a person with refugee status does not allow one to have a proper identification card, most are not employed and are dependent on UNCHR subsidies for their survival and try to do small-scale businesses.
- **Subsidies** are available only for limited low-income earners or specific vulnerable groups and they do not always know how to apply for subsidized support.

Refugees in general face significant financial challenges that make it difficult for them to pay NHIF contributions as they face other competing priorities such as paying for food, shelter, and other basic needs.

B5. Potential Beneficiaries (dis)incentives for their enrolment in NHIF.

Incentives for potential beneficiaries to enrol in NHIF:

- NHIF provides **access to affordable healthcare** services to its members.
- NHIF provides **financial protection** to its members by covering the cost of medical treatment. The potential beneficiaries saw this as one of the major factors because it reduces the financial constraints when healthcare is needed.
- **Family coverage** was a relief for the potential and a positive influence to join the insurance scheme.
- **Convenience** of accessing a wide network of accredited healthcare providers across the country.
- **Health promotion** programs to its members, including health education and disease prevention services. These programs help members stay healthy and prevent the onset of chronic diseases.

Disincentives for enrolment in NHIF:

- **NHIF contributions** may be perceived as **unaffordable** for some individuals, especially those with lower incomes or financial constraints.
- **Limited perceived benefits**: expectations to the coverage of benefits not aligned with their healthcare needs may not motivated to enrol. This can be due to concerns about the scope of coverage, but also unrealistic expectations to coverage or low awareness of the benefit scheme.
- NHIF may have **limitations on provider options** or specific networks, which may restrict individuals' preferred choices of healthcare providers.
- **Administrative complexities** such as complex registration processes, cumbersome paperwork, and lengthy waiting periods for enrolment approval discourage individuals from enrolling in NHIF.
- **Limited awareness or misconceptions** about NHIF and its benefits can discourage enrolment.
- **Perceived poor quality of healthcare services** provided by NHIF-accredited facilities. This may be due to a lack of information or negative experiences with healthcare providers in the past.
- **Requirements for registration of refugees:** There are difficulties in obtaining legal recognition and personal documents; the complexities, and delays in the processes of obtaining asylum and related legal documents from UNHCR and/or local authorities; the serious implications of lack of legal documents including fear of being arrested and harassed; and limited data on urban refugees which makes it difficult to extend social health protection to them in Kenya.

There are several challenges and obstacles encountered by refugees specifically in their efforts to access essential health care services, including: irregular refugee status, duration and type of residence permit, language barriers, lack of refugee-inclusive health policies and laws, lack of knowledge of legal entitlements, lack of awareness on services, services being irresponsive their specific health needs, inaccessibility of services due to inconvenient opening times, geographical inaccessibility, and direct and indirect costs. For the case of refugees in Kenya, they generally experience challenges in access to health care, whether they are in the rural camp complexes like Kakuma/Kalobeyei, or urban areas like Nairobi, Mombasa or Nakuru.

5. Key considerations and recommendations to extend Social Health Protection

5.1. Financing, revenue collection and pooling of funds

Key findings

- Main sources of revenues for NHIF are contributions from formal (including civil servants) and informal sectors collected by NHIF branch offices and pooled together at national NHIF level.
- Subsidies from the Government for vulnerable population groups are rather modest and subsidies from donors indicate a decreasing trend.
- Broad risk-pooling is ensured via a single pool. However, the efficiency gains from a single large pool through redistributive capacity and cross-subsidization is limited by the current differences in entitlements between various populations groups with different benefit packages. The fact that each benefit package uses different payment methods at times weakens the purchasing power of NHIF and its ability to cover the actual expenses incurred by the service providers is limited. The share of NHIF pool in total health expenditures is still relatively low.
- Planning of contribution revenues is based on historical data and on "optimistic expectations", however, often targets for revenue collection are not met. Particularly challenging is to meet the revenue targets from the informal sector that indicates overestimating of the motivation of the informal sector to join the SHI.
- The recent change of linking formal sector contributions to percentage of income is a positive step ensuring more progressivity, but also more stability in financing of SHI. However, the process and feasibility assessment leading to the establishment of the contribution levels remains unclear.
- The contribution rate for the informal sector was until recently 500 KES valid from 2015 and is further lowered to 300 KES which does not consider real changes in the cost base of service providers over the last 8 years. It does not consider potential implications for financial sustainability and how this may eventually affect the sustainability of service providers and the quality of care negatively.
- Under current circumstances the informal sector significantly relies on the formal sector for cross-subsidies. While this can create positive re-distributory effects, it also needs to be financially sustainable overall otherwise social acceptability in the formal sector group may reduce (especially since employers are not contributing and workers already bear alone the burden of contribution), potentially endangering the long-term viability of the scheme. Insufficient revenue flow and increasing level of people's health needs are challenges that need to be tackled for the sustainability of coverage over time.
- One of the NHIF strategic goals is to achieve financial surplus rather than equilibrium (including technical reserves) which should not be a driver for SHI. Rather, maximizing the health system performance and value-based health care quality using the pooled funds should be the main driver of the NHIF.

Recommendations

- Moving towards a predominantly publicly mandated and financed system through either or a mix of contributory and non-contributory methods is one crucial step for progress towards

Universal Health Coverage. Public sources of health financing are those prepaid and compulsory and its funding sources are either from government's general revenue or contributions to social health insurance systems.

- Increase public spending on health based predominantly on general revenues sources (for example, direct and indirect taxes) and contributions (based on the ability to contribute), while trying to improve and expand fiscal spaces for health can provide a significant enhancement in revenue raising for health. Increasing fiscal spaces for health can be done through various pathways such as exploring innovative financing measures, eliminating financial waste and illicit flows, reprioritization in budget formulation, enhancing health taxes, ect.
- To progress towards UHC and ensure sustainable financing of SHI, it is important to have a robust assessment and planning for financial sustainability of the SHI, a stable and predictable flow of funds and high budget execution. International Social Security Standards recommend conducting periodical actuarial valuations based on robust monitoring systems with a view to assess financial sustainability on a regular basis.
- An actuarial feasibility should be the basis for establishing contribution levels that secure sustainability within any reform.
- To optimize the potential advantage of a single large pool for cross-subsidization, reduce fragmentation and administrative costs, improve efficiency gains and potential purchasing power, it is imperative to transition to harmonized benefit package, contracting arrangements and health service providers. A benefit incidence analysis could support the NHIF in better understanding trends in cross-subsidization and assess its redistribution and equity impact.
- Although changes have been introduced for the formal sector contributions, it is recommended to ensure transparent analyses of whether the current contribution levels can realistically cover the costs of benefit packages. It is also important to consider a broader base for contributions, including through formalization of business units that would be able to meet the conditions (several countries have put in place incentive programmes in this respect with contribution rebates and presumptive or simplified tax regimes), contributions shared with employers, broader government subsidies (i.e. partial subsidies for the informal economy for instance) as well as enhanced subsidies based on actual costs for the fully subsidized groups funded by excise taxes on harmful products or other general revenues.
- It is recommended that the Government plans within the mid-term financial framework realistic and prospective funds to match contributions to subsidize the most vulnerable population groups.

5.2. Population coverage, registration, and communication

Key findings

- Using multiple ways of member identification (national ID, unique insurance number, NIIMS) causes confusion in the clarity, consistency, and quality of data use. This situation hinders the quality of data analysis and service use and, accordingly, the quality of services and contracts planning.

- Registration of formal sector employees and related data accuracy is still a rather burdensome process executed by compliance officers of NHIF branch offices. Currently, there is a shortage of officers to perform comprehensive controls of formal sector organizations rendering incomplete registration activities on a random basis. To ensure the quality of registration and monitoring of contribution payments, the NHIF sees the main opportunity to increase the number of compliance officers. However, this solution might also result in increasing the administrative costs of the overall scheme management process.
- Individual registration of people in the informal economy is a very extensive and burdensome process for both parties the subscriber and NHIF. At the same time, the active status of the membership of people from the informal economy is rather unpredictable and has frequent drop-outs.
- Low retention of members from the informal economy and inactivation of their status leads to application of rather high penalties, which are higher for voluntary subscribers from the informal sector than for members from the formal sector.
- Availability of comprehensive information about SHI's benefits and the availability of services is not sufficient nor well-targeted which hinders people's awareness to make motivated decisions to join health insurance and ensure financial protection for their household. Considering the need to attract significantly more people to join SHI makes this task very important.
- The protection of the rights and needs of NHIF members need to be enhanced, especially considering the potential increase in the number of people joining in the medium and long term.

Recommendations

- Consider shifting towards adhering to the legal requirements governing compulsory enrolment in the NHIF for the whole population. As evidence showed voluntary membership tends to expose the scheme to inefficiency and financial sustainability concerns. Nevertheless, execution of such transition requires a robust feasibility assessment for integration, the implementation of enforcement systems alongside willingness and fiscal capacity of the government to subsidize for those who lack the ability to contribute, or it is too difficult to collect contributions from.
- In order to make the monitoring of formal sector compliance with registration and contribution payment more efficient, it can be considered to introduce data exchange with KRA to monitor the employment related data in the formal sector and tax behaviour of employers.
- Consider establishing reliable liaisons with organized bodies from community and professional segments of informal economy who could play supportive roles in raising awareness for those are not insured and while also become reliable partners to NHIF in extending the SHI. It is recommended to organize the registration of informal sector members by organized unions and professional representation bodies where available. These bodies can also participate in collectively paying contributions on behalf of their members. That will simplify the registration and membership relations and reduce the burden of NHIF structures. Potentially it will also have a positive impact on sustainable member relations and reduce the drop-out rate of the informal economy members from NHIF scheme.
- It is recommended to assess the feasibility of using only national ID as one unique member identification number in the SHI system in a medium-term perspective, while taking into consideration providing an alternative mean of identification for people that don't have a

national ID. This ensures the consistent and stable use of member-related data, the reduction of duplicated or interrupted data entries and, in the long term, high-quality data for time series analysis, that support evidence-based decision-making and planning.

- The scope, content, and quality of NHIF's customer communications should be strengthened as important factors in ensuring member retention and satisfaction. Also, it is recommended to review the policy about penalties in general and consider moving towards policies that motivates informal sector registration. An example, to reward a member from the informal sector after 12 months continuous membership and contributions with 1-month free membership on the following year.

5.3. Benefit package

Key findings

- The provision of different insurance schemes with different benefit packages undermines the efficiency gains of having a single large pool of funds and subsequently purchasing power. It also in contrast with the overall policy towards UHC and equity among all population groups.
- While the National Scheme and Enhanced Scheme have 10 similar benefit packages, the Enhanced Scheme members are entitled for 6 more packages. The coverage of services included in the benefit package design is not well-balanced or systematically assigned. For example, there are 2 dominant packages covering inpatient and surgical care broadly while the remaining packages are for specialty care to ensure diagnostic or treatment cover in areas such as renal dialysis, emergency, radiology, etc.
- The development of health packages has been historically random and is not based on data analysis nor health needs assessment. The current health benefit package design does not reflect the highest morbidity statistics or the burden of disease analysis.
- Health benefit packages under the Enhanced Scheme include additional 6 packages but they hardly add value to address people's main health needs. There is certainly a space to meet people's priority health needs with well-designed benefit packages.
- NHIF's analysis shows that determining the level of contributions and cost of services is neither balanced nor sustainable, as current benefit utilization per household exceeds contributions by 50%. Recent political statements to further lower contributions for the informal economy will significantly increase the gap between the revenues and ability to reimburse services purchased and might eventually drive NHIF into insolvency.
- Tariffs assigned of health services differs in different levels of care so that prices for the same service may differ 2,5 times depending on the level of hospital. It is primarily defined based on service providers' preferences rather than unified tariff system for the same service.

Recommendations

- Progress towards UHC requires ensuring a universal national insurance scheme for all groups of residents. Ensuring harmonized benefit entitlements across the members of the scheme is important with a view to simplify management and guarantee equity. The implementation of supplementary insurance schemes is usually on the purview of voluntary private insurance or, in some cases, regulated complementary packages, but for which the funding is separate and additional to a fully funded primary package.

- It is important also to design benefit packages that includes cost-effective and clinically effective services with focus on strengthening primary health services. Priority should be given to preventive care and health promotion to enhance health outcomes and reduce healthcare costs in the long term. The articulation between a tax-funded PHC and the NHIF package needs to be carefully thought through to avoid adverse incentives on health seeking behaviours.
- It is recommended to use for design of benefit packages an evidence-based participatory methodology with focus on people's priority health needs and alignment with international social security standards. Consider a more balanced approach for developing benefit packages that represent health conditions and health needs accordingly and that are aligned with other classifiers in use (for example, ICD 11) and where international practice has positive evidence.
- The impact of expanding health benefits should be assessed through an actuarial valuation that allows to identify adequate financial resources to cover the expenditure increases. When proper analysis is not done, the most likely is that the system ends up in a financial deficit and insolvency for the NHIF or, if costs are cut, to a lower quality of service. Therefore, it is highly recommended that periodical actuarial valuations are conducted, in order to plan for any needed reforms to ensure the sustainability of the system.

5.4. Contracting, purchasing and claim management

Contracting

It is important to consider contractual arrangements that are aligned with strategic purchasing mechanisms. This entails specifying the scope and volume of purchased services based on population health needs and priorities. Defined budgetary frameworks and performance indicators for provider are crucial elements for value-based service delivery. This differs from the current practice of where contracting providers is primarily a "legal" process lacking strategic purchasing criteria and incentives. It is important to link contracts to a defined list of services that providers are entitled to deliver, rather than open commitments without defined service volume or budget limits.

Key findings

- Empanelment of service providers serves the purpose to contract only those providers whose physical conditions / infrastructure are in compliance with the requirements of service delivery set by MOH, Kenyan Medical Board and NHIF. All together NHIF contracts little more than 8000 providers out of 12000 providers in the country.
- Contracting of service providers is primarily a "legal" process and less defined by strategic purchasing criteria and incentives. Contracts are very bulky documents, rather formal and rich of general and legal terms with significantly less attention on defining the content and subject of the purchase.
- There is defined a list of services that providers are entitled to deliver; however, the contracts are as open commitments with no defined service volume nor budget caps for contracting.
- Contracting is not based on assessment of people's health needs and providers have the freedom to deliver services they consider necessary.
- There are no arrangements in place for systematic monitoring of provider performance and execution of the contract terms. Also, no regular feedback to providers by NHIF or using contracts as guiding plans for both sides, the purchaser and provider.

Recommendations

- It is recommended that contractual arrangements for service providers have a more strategic content, defines the volume and content of purchased services by service packages based on an assessment of the health needs and priorities of the population. It has also defined budgetary frameworks of the contracts and implementation monitoring while gradually introduces quality and efficiency indicators for service provision.
- In the medium and long term, it is advised to consider contracts with providers for a longer period than 1 year to provide more strategic scope and perspective for purchasing. Specific terms such as service volumes and contract budgets will be handled on an annual basis, but a longer time perspective can indicate expected changes in service volume or structure and other criteria that would be important for both parties.
- Regular monitoring of contract execution is important with a focus on implementing the service volumes and budget execution, monitoring of provider performance, accuracy of submitting claims and raising fraud/data quality issues. Regional branches should be involved in monitoring and providing regular feedback to providers on issues raised and overall satisfaction of NHIF with provider performance.
- It is recommended that claims management and monitoring contract execution are closely integrated, that will bring a more evidence-based approach to managing both areas. In general, it is recommended that contracting follows health policy priorities in terms of focusing on priority level of care, priority health needs and using contracting as a main instrument to ensure financial protection of people and developing SHI.

Purchasing arrangements

Purchasing arrangements should be designed and tailored to support the service delivery objectives, enhance efficient allocation of funds, and consequently progress towards UHC. For meeting the service delivery objectives and quality requirements, it is recommended to use a blend of outcome-based payment methods to incentivize the preferred provider behaviours and performance measures. Pay for performance and case-based payment methods require robust information, performance indicators, quality data to monitor provider performance and better accountability mechanisms for both the purchaser and provider. Currently provider payment methods are dominantly input based and limits purchasers' ability to influence the care delivery process and outputs.

Key findings

- Provider payments in Kenya are dominantly input based and limits purchasers' ability to influence the care delivery process and outputs through financial incentives.
- The provider payment mix consists of following payment methods: County Governments apply line-item budgets, national MOH use global budget and NHIF use a mix of capitation for PHC, fee for service for outpatient care and rebates for inpatient care. There are limited packages only where NHIF uses a case-based payment method.
- Tariffication of services by NHIF is fragmented between the schemes and levels of care that makes it difficult to apply uniform and fair payment methods and which would treat service providers equally and send the right signals on preferred provider performance.

- Frequency of updating the tariffs of services and adjusting the cost base / inflation is higher than adjusting the contribution rates. That puts NHIF under pressure to ensure increasing payment obligation in a situation where the growth and updating of contributions is less frequent and lags behind the pace of growth of expenses.

Recommendations

- It is important to use evidence-based purchasing decision contingent on the population covered health needs, available health services, healthcare provider performance and quality of service.
- Purchasing arrangements should be designed and tailored to support the service delivery objectives, enhance efficient allocation of funds and consequently progress towards UHC. It is critical to link provider payment methods using a mix of them to the service delivery objectives and quality to incentivize the preferred provider behaviour and performance measures.
- Ensure unified tariffication principles for health services and unified application of payment methods to service providers to improve administrative efficiency and negotiation capacities on tariffs according to volumes.
- In the medium and long-term, it is advised to consider moving towards output-based payment methods in order to create provider incentives towards efficiency and quality of care. Pay for performance and case-based payment methods require robust monitoring systems, quality data to monitor provider performance and better accountability mechanisms for both the purchaser and provider.
- It should be considered that one of the prerequisites to motivate output-based payment methods are higher autonomy and accountability of providers. Given the fact that public sector service providers belong to either the national MOH or the County Government, and a considerable part of their financing still comes from input-based financing, it may prove difficult to implement output-based financing and therefore close coordination with MOH on this is required.
- Consider alignment of revision of tariffication and contribution rates for the same time period to ensure balance of NHIF assets and liabilities.

Claim Management

- Claims management has gone through a big development leap in the last year, and the e-claims system is in the process of being implemented on a large scale. The process has led to development in automation, reduction in the need for physical labour, and accelerated the speed of claim processing throughout time. Although that was not reflected in the speed of payments, stemming from the NHIF liquidity problems.
- The introduction of e-claims has reduced the share of fraud claims, but due to insufficient automated control functions, a considerable share still happens, according to interviewees, from the private sector and faith-based service providers.
- A significant share of patients referred for hospitalization require pre-authorization by NHIF. It is a large task that is still done manually within a limited time. According to the interviewees, 20% of pre-authorizations are not approved for various reasons.
- Despite the E-claims application being implemented, there is no proper storage solution and claims can't be accessed retrospectively by different users. Claims are stored in Enterprise

Resource Planning that is not meant to provide data handling and analyses functionality. Basically, there are very limited and not user-friendly options provided through ICT department data requests to search claims for analytical and planning purposes.

- The NHIF has a very limited application for the data of claims despite its utilization potential that can create information value. For example, claims are not used for service-usage pattern analysis, health needs assessment analysis, benefit package design, service pricing, contract planning and many other necessary directions.
- Claims management is primarily built on extensive pre-payment control, but post-payment medical audit, either random or based on analysis, is essentially not performed. In the case of today's solution, the focus of the control is on automated pre-payment technical checks, and after payment, a targeted and in-depth medical audit is performed only on those claims that require more attention.

Recommendations

- It is recommended to implement the already started automation of claims management on a wider scale as soon as possible, as it eases the work process and frees up resources for other activities. The quality and speed of implementing the e-claims system depend a lot on the provider's motivation and capacity. The successful implantation may clear vision, responsibility and timeline of the project.
- It is recommended to automate the pre-authorization process as much as possible as it is a rather burdensome process and there are short deadlines for the approval of pre-authorization. It should be possible to build technical controls to verify required data and conditions concerning patients where cases entitled to get specialist attention are those who have attached X-ray, other images, or medical tests which are not machine readable.
- There is a need for ICT upgrade, including the core systems, plugged-in application, and business intelligence analytical tools to support analyses of available data and generate more value and decision support. Once technical applications allow the use of claims data, it is recommended to start using the data for many purposes and directions which are of high priority for NHIF, as part of the M&E framework of the scheme.

6. Expanding coverage universally: examples from other countries

Expanding the number of informal sector workers and their families who participate in health insurance programs is crucial for achieving universal health coverage (UHC), especially in low- and middle-income countries (LMICs) where this group makes up the majority of the population (Maritim et al. 2023)

NHIF has implemented several structural reforms to improve healthcare access for poor and vulnerable populations who previously had limited access to healthcare services. These reforms include expanding the benefit package to cover outpatient services and specialized treatments, which has enabled NHIF members to access more comprehensive healthcare services. NHIF has also introduced various subsidy programs, such as the Linda Mama scheme that provides free access to maternal and child health services, the HISP scheme which covers the cost of health insurance for the poorest households, and the Edu Afya scheme which provides free coverage for secondary school students. These programs aim to reduce financial barriers to healthcare access for vulnerable populations and improve their health outcomes. Furthermore, the NHIF Act of 1998 and the amended act of 2022 require mandatory health insurance for both formal and informal sector workers with the aim of increasing coverage for vulnerable populations. The amended act of 2022 specifically seeks to enhance coverage for informal sector workers who have historically had limited access to healthcare services (NHIF 2018) &(Maritim et al. 2023)

Despite the progress made, there are still challenges facing NHIF in expanding coverage to vulnerable populations. One challenge is the unaffordability of monthly contributions required to maintain NHIF membership for many people in this population. Additionally, the disorganized nature of the informal sector makes it difficult to recruit, register, and collect regular contributions. Low uptake and poor retention rates are also common due to voluntary membership and contributions payment. The rules aimed at improving the fund's sustainability, such as paying three-month advance contributions and imposing late payment penalties, are seen as punitive and inflexible, and could limit the extension to uncovered groups. Enforcing mandatory coverage without subsidies has also shown limited success given the challenges of contributory capacity and collecting regular contributions from informal sector workers. (Barasa, E et al. 2017)

Countries that have succeeded in expanding health insurance coverage to vulnerable populations have done it using a mix of various strategies. These strategies include tax-funded or community-driven schemes, subsidies for the poor, comprehensive benefit packages, and innovative approaches like income-tiered contributions, contribution collection linked with harvest period, and creating separate schemes for the vulnerable. Countries like the Philippines, LAO PDR, Indonesia, and the Republic of Korea have extended coverage of existing health insurance schemes by waiving user fees or providing full contribution subsidies for the poor. This approach has several benefits, including better redistribution through larger financial and risk-pooling and reduced discrimination against the poor. Thailand, on the other hand, created a new subsidized scheme for population groups not covered by any other health protection scheme, which complemented the existing scheme towards universality. These countries have also given priority to preventive care and health promotion to enhance health

outcomes and reduce healthcare costs in the long term. In the Ethiopian community-based health insurance scheme, regions have varying time frames for contributions which are linked to their productivity/harvest period. These approaches have been effective in expanding insurance coverage to vulnerable populations in many countries. However, each approach has its strengths and limitations, and the choice of approach depends on a country's specific circumstances and priorities (ILO 2021a).

6.1. Thailand

Advancing Health Achievements through expansion of UHC, Thailand's Experience of covering 76% of its population in less than two years

In 2001, Thailand introduced a Universal Health coverage scheme (UCS) which was funded by taxes. Within two years, the scheme was able to provide health coverage to 76% of the population. The primary goal of the scheme was to offer health protection to those who had no coverage and inadequate protection, especially the poorest 20% of the population. The scheme's achievement was primarily due to a combination of political will, involvement of civil society, and technical expertise.

Even though the Thai constitution of 1997 and 2007 granted all Thai citizens the right to access healthcare and free healthcare for the poor, the country struggled to provide coverage to its informal sector workers, who made up 47 million people. Despite implementing pro-poor social protection and health policies since the 1970s, out-of-pocket payments remained high, accounting for one-third of total healthcare expenditures in 2001. In response, a group of 11 Thai NGOs formed a coalition in October 2000 to support universal coverage. The newly elected government in 2001, which campaigned with the slogan "30 baht treat all diseases," supported the coalition's goals and implemented bold financing reforms to achieve universal coverage within a year. The Universal Health Coverage Scheme (UCS) was launched in six provinces in April 2001, 15 additional provinces by June 2001, and nationwide by April 2002.

The UCS aimed to provide healthcare coverage to the 76% of the population who were not covered by any other social health protection scheme, with a particular focus on the poorest 20% of the population. Within two years of launching the UCS scheme, Thailand was able to achieve coverage of this 76%.

The success of the UCS was attributed to its key features, which included:

- Being financed by taxes and providing free healthcare at the point of service (with co-payment removed in 2006).
- The UCS also offered a comprehensive benefit package that emphasized primary care, and it was almost identical to the social security scheme's benefit package (which is a mandatory scheme for the formal sector).
- To control costs and ensure the scheme's financial sustainability, a fixed annual budget and a cap on provider payment were implemented.

The development of the UCS was done alongside a significant expansion and enhancement of healthcare facilities on the supply side to ensure that they could accommodate the increased demand for healthcare services (ILO 2021d).

6.2. Indonesia

Indonesia's largest single-payer health insurance scheme in the world

Indonesia's National Health Insurance Program, known as JKN (Jaminan Kesehatan Nasional), is one of the largest single-payer health insurance systems in the world. The program was launched in 2014 with the aim of providing universal health coverage to all Indonesians (ILO 2021b).

The JKN mandates all individuals to be covered by the scheme regardless of their income or employment status and aims to provide coverage to the entire population through a single public health insurance program. Prior to JKN, there were multiple healthcare schemes in the country, targeting different groups such as the formal sector and the poor, who enrolled through mandatory payroll tax deductions and government subsidies respectively. However, with the implementation of JKN, these different schemes were integrated into a single national social health insurance scheme, with one management system and unified rights and benefits for all members. Although the implementation of a single-payer program was deemed as a crucial step in the JKN program, the idea was faced with opposition from various stakeholders such as insurance companies, employers, and labour unions. The mandatory nature of the scheme was a point of contention for some employers, while labour unions expressed concerns about how the contribution requirements would affect their workers. However, the passage of Law 24 of 2011 led to implementation of the program (ILO 2021b) & (Mboi 2015). The JKN scheme was able to achieve a high enrolment rate of around 46% of the population in its first month of implementation, largely due to the transfer of members from previous schemes into JKN. The JKN also opened membership opportunities for the informal sector by establishing monthly contribution rates for the sector, depending on the level of care required. Membership has initially been dominated by the subsidised groups, both from the Government of Indonesia and district governments and other schemes that were targeting the formal sector (Mboi 2015).

JKN also changed the payment modality to enhance efficiency and cost-control. Before JKN, healthcare providers were mostly paid through negotiated rates and a fee-for-service model, with civil servants having a special fee schedule. However, JKN reintroduced capitation as the primary payment method for primary healthcare providers, where they receive a fixed monthly payment based on the number of JKN members in their catchment area. Additionally, hospital services are reimbursed based on Diagnosis-Related Groups (DRGs) as a cost-control measure, due to a rise in service utilization (Mboi 2015).

The JKN system was thus able to achieve the below milestones:

- The largest single-payer system in the world
- Increased Access to Healthcare: JKN has significantly increased access to healthcare for Indonesians, particularly those from low-income background. This improved access is the result of subsidies from the Government of Indonesia towards the JKN for low-income and vulnerable-income groups, and through the creation of an income tiered contribution rate for the non-poor informal sectors.
- Reduced Out-of-Pocket Costs: JKN has also reduced the financial burden of healthcare on Indonesian families. Before the program, many people had to pay for healthcare out of their own pockets, which often led to catastrophic health expenditures and pushed families into poverty.

- Improved Health Outcomes: Since its launch, JKN has helped to improve health outcomes in Indonesia. According to the Ministry of Health, the program has contributed to a decrease in infant mortality rates, an increase in life expectancy, and a reduction in the prevalence of certain infectious diseases.
- Increased Efficiency: JKN has helped to increase efficiency in the Indonesian healthcare system by streamlining administrative processes and reducing waste. The program has also encouraged the use of electronic medical records, which has improved the accuracy and accessibility of patient data (Maulana, N, Limasalle, P, and Pattnaik, A 2022), (Prabhakaran , S et al. 2019)

The overall success of the JKN is largely attributed to strong political commitment, multisectoral participation in developing and implementing the plans, comprehensive analysis of the national health system and continuous monitoring and evaluation of the system (ILO 2021b).

Although the JKN program is the largest single payer program in the world, it is not without shortcomings. These includes regional disparities in healthcare services, inadequate funding due to reliance on government subsidies alongside mandatory payroll tax deductions and issues with the quality of services provided (Agustina et al. 2019) & (Wiseman et al. 2018).

6.3. The Philippines

The Philippines' social health insurance fund-PhilHealth

The Philippines' social health insurance fund, PhilHealth, is often cited as a success story in the region. PhilHealth was established in 1995 to provide health insurance coverage for Filipinos, with the goal of ensuring that every citizen has access to affordable and quality health care services (Obermann, K, Jowett, M, and Kwon, S. 2018)

One of the key factors in PhilHealth's success is its ability to expand coverage to a large percentage of the population. As of 2021, PhilHealth has over 107 million members, which represents over 90% of the population. This high coverage rate has been achieved through a combination of government subsidies, mandatory contributions from employed individuals, and voluntary contributions from self-employed and informal sector workers (Obermann, K et al. 2018)
PhilHealth, also known as the Philippine Health Insurance Corporation, has a mandate to provide social health insurance coverage to all Filipinos, particularly to the vulnerable and marginalized sectors of society. In line with this, PhilHealth has implemented various programs and initiatives aimed at extending health insurance to the most vulnerable groups: One such program is the Sponsored Program, which provides health insurance coverage to indigent families or those who are unable to pay for their own health insurance. Under this program, the national government, in partnership with local government units, covers the insurance contributions for eligible beneficiaries. Despite not being able to contribute financially to the program, indigent individuals are still entitled to the same health care benefits as those who are able to pay for their PhilHealth coverage (Silfverberg 2014).

Another program is the Point-of-Care Enrolment (POCE) program, which provides immediate PhilHealth coverage to patients who are admitted to hospitals and are unable to pay for their medical bills. Under

this program, hospitals are authorized to enrol patients on the spot and submit their enrolment forms to PhilHealth for processing (PhiliHealth 2014)

PhilHealth also offers a Primary Care Benefit Package, which provides free primary health care services to indigent families and those who are not yet enrolled in PhilHealth. This program aims to provide preventive and promotive health care services to the most vulnerable members of society (Obermann, K et al. 2018)
Despite its success, PhilHealth faces ongoing challenges in ensuring that all Filipinos have access to quality health care services. These challenges include funding constraints, the need to improve the quality of health care providers, and the need to address health care inequities in the country. However, the success of PhilHealth demonstrates that it is possible to achieve universal health coverage in a developing country, and that government-led health insurance programs can play an important role in achieving this goal (Bredenkamp and Buisman 2015) .

6.4. Mexico

Mexico's Seguro health insurance program

Mexico's Seguro Popular health insurance program is widely regarded as a success story in providing healthcare access to its citizens. The program was launched in 2004 with the aim of providing affordable health coverage to those who were previously uninsured or underinsured, including low-income families, rural communities, and indigenous populations (Chemor Ruiz, A, Ratsch, A, and Alamilla Martínez, G. 2018).

Since its inception, the Seguro Popular program has made significant strides in improving healthcare outcomes for the vulnerable population. For example:

- Increased Enrolment: The program has been successful in increasing enrolment among vulnerable populations. According to the National Health Survey, enrolment in Seguro Popular increased from 42.6% in 2006 to 65.6% in 2018. This has helped to improve health outcomes for millions of Mexicans.
- Access to Healthcare: The program has also been successful in improving access to healthcare for vulnerable populations. By providing financial protection and removing financial barriers, Seguro Popular has helped to ensure that people receive the care they need when they need it.
- Health Outcomes: Studies have shown that Seguro Popular has helped to improve health outcomes among vulnerable populations. For example, maternal mortality rates have decreased, and child vaccination rates have increased (Knaul, F et al. 2012)

Mexico's success in achieving high enrolment rates for its Seguro Popular health insurance program among vulnerable populations was due to a combination of tactics used, including:

- Targeted Outreach: Seguro Popular utilized targeted outreach strategies to reach vulnerable populations, such as low-income families, rural communities, and indigenous populations. These strategies included community health fairs, door-to-door campaigns, and outreach through local community organizations.

- Simplified Enrolment Process: The program simplified the enrolment process, making it easier for people to sign up for coverage. The process was streamlined, and the program provided assistance to those who needed help completing enrolment forms.
- Financial Protection: The program provided financial protection to vulnerable populations by eliminating or reducing out-of-pocket costs for healthcare services. This helped to remove financial barriers that prevented many people from accessing healthcare.
- Political Will: The Mexican government showed strong political will to make the program successful. The government provided funding and support for the program, which helped to ensure its success.
- Public Education: The program also invested in public education campaigns to raise awareness about the importance of healthcare and health insurance. These campaigns helped to reduce misconceptions and increase understanding about the benefits of health insurance (Garcia-Diaz 2022).

Overall, while Seguro Popular has been successful in increasing enrolment among vulnerable populations and improving access to healthcare, there are still challenges that need to be addressed to ensure the program's sustainability and equity in enrolment.

6.5. Lao PDR

Subsides in Lao PDR

Providing free access to health care to the poor and vulnerable has been a long-standing priority for the Government of Lao PDR, which established several programmes to strengthen the Lao population's financial health protection. Established in 2004, under the management of the Ministry of Health, the Health Equity Fund (HEF) provided coverage to the poor and vulnerable, with full subsidies. In parallel, non-poor workers and their family members dependent of informal employment could be covered through the government's implemented CBHI scheme. In 2010, the Free Maternal Neonatal and Child Health (FMNCH) policy was implemented, contributing greatly to improving health services utilization. However, after years of implementation, affiliation to CBHI remained below 10 per cent and OOP health spending remained at high level for the entire population. In 2012, the government engaged the merging of CBHI, HEF, FMNCH with health insurance schemes dedicated to the formal sector (SASS and SSO) into a single National Health Insurance scheme. In recognition of the difficulties inherent in extending coverage to informal economy workers through voluntary health insurance, a further step was taken in 2017 when the government adopted a predominantly tax-based financing model: the NHI now covers on a non-contributory basis all those who are not affiliated to SASS or SSO, hereby replacing contributions from informal economy workers with full public subsidies directly transferred to the NHI Fund. These public subsidies led to rapid coverage expansion nationwide, bringing the coverage rate up to 94 per cent in 2021. While co-payments apply at the point of services, members identified as poor, pregnant women, children under-five and monks, are all exempted (ILO 2021c).

ANNEX: List of Interviewed NHIF Staff

Name	Designation
Josephine Muli	Senior Assistant Manager – UHC
Stella Nduku	Senior Officer – UHC
Mathew Mnene	Senior Assistant Manager- Finance & Revenue
Mercy Mutua	Senior Officer - Benefits, Design, & Actuarial services
Dr. Samson Kuhora	Ag. Director- Beneficiary & Provider Management
Margaret Macharia	Senior Officer- Benefits, Design, & Actuarial services
Halima Saney	Senior Assistant Manager – Contracting & Quality Assurance
David Gambo Dawe	Claims Officer
Judith Otele	Manager- Case Management
Don Ochiel	Senior Assistant Manager – Marketing
Michael Wario	Senior Assistant Manager – ICT Business Systems
Mary Nyachae	Regional Manager- Nairobi
Daniel Mulinge	Manager – Strategy, Planning & Policy
Susan Kafuto	HR Officer- Performance
Rehema Mudzo	Legal Affairs Officer

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