POLICY BRIEF

KENYA

Changing the Game in Purchasing Health Services: Findings from Provider-purchaser Engagement in Kenya.

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Key messages

- Provider-payer challenges were identified to result from understaffing, staff turnover (human resource gaps), infrastructure gaps (both hardware and software), knowledge and skill gaps, and governance issues attributed to bureaucratic processes, poor accountability mechanisms and poor mechanisms of communication.
- Providers and purchasers emphasized the need for automated processes, revamping of provider payment mechanisms (PPMs), regular training of providers, use of provider-friendly communication channels and development of public-private contracting frameworks as key actionable solutions for implementation.
- Providers and purchasers highlighted short-term, medium-term and long-term actionable solutions as a joint action plan that can be implemented in a phased approach.
- Strengthening provider-payer engagements can be leveraged as a strategic health purchasing reform to accelerate progress towards universal health coverage in Kenya.

Introduction

Kenya has committed to achieve universal health coverage (UHC) by 2030. This goal requires health system-wide reforms, including strategic purchasing reforms. Strategic purchasing entails a continuous pursuit of evidence-based ways to define the benefits package, provider selection and contracting and reimbursement methods.

Engagement between providers and purchasers is critical to improving strategic purchasing given the roles that providers and purchasers play in ensuring the population receives all needed healthcare services and are protected from experiencing financial hardship.

Kenya's healthcare system is comprised of a mix of public, private-for-profit and faith-based healthcare providers. Besides the pluralistic distribution of providers, the health system in Kenya also comprises public purchasers (MoH, 47 County Governments and NHIF) and private purchasers (comprised of several private health insurances and community-based health insurances). Consequently, there is a need to strengthen provider-purchaser engagements towards achieving UHC.

Provider-purchaser engagements are considered effective when purchasers and providers co-exist in harmony, and both providers' and purchasers' actions are aligned to the ideal strategic purchasing decisions for provider selection (such as selective contracting) and payment (including having an adequate payment rate to cover the costs of services, timely and predictable reimbursement).

We assessed the challenges for provider-purchaser engagement and based on an understanding of the root causes we identified actionable strategies. Based on these, key stakeholders from both providers and purchasers co-developed a joint action plan.

Findings

Root causes to challenges hindering effective provider-payer engagement

- **Resource Gaps**

Resource gaps were manifested in two ways. First, human resource gaps resulted from understaffing and staff turnover both at the provider and purchaser levels. These gaps contributed to increased workload, delays in claim audits/verification led to poor or lack of communication between providers and payers.

Secondly, there were infrastructure gaps by providers. These include; hardware gaps (lack of equipment to facilitate the payment process such as computers and printers) and software gaps from payers; limited access to network especially for public health facilities, lack of automated systems to empanel providers and to raise/lodge and follow-up claims.

- **Training or Capacity Gaps**

Capacity gaps refer to healthcare providers' unmet knowledge and skill gaps from high staff turnover and the lack of regular training especially when payers make changes in benefit packages and/or terms and conditions of the schemes. Providers highlighted that the high staff turnover resulted in the loss of key staff with the requisite knowledge, skills, and established relations with purchasers. These contributed to delays in lodging claims, errors in documentation for the submitted claims and a high workload.

In terms of regular training, healthcare providers highlighted the need for refresher training for their staff handling claims, especially when payers change benefit packages and full training for new staff employed by providers to handle claims. The training can be done in person or using online platforms.

- **Governance issues**

Stakeholders highlighted three key governance issues that contribute to challenges hindering effective provider-payer engagements. One was **BUREAUCRATIC PROCESSES** that delayed reimbursement of claims. For instance, providers reported complicated administrative procedures, especially with the NHIF when claims are submitted for payment. The claims may have to go through several departments at the branch level and then at the NHIF headquarters. Besides the bureaucratic procedures at NHIF, other bureaucracies with the national treasury have caused financial delays from the national treasury to NHIF and, in turn, delays from NHIF to providers. Case in point, poor budget projections, poor cash flows and revenue collection result in delayed remittances of funds from the national government/treasury to NHIF (for schemes such as EduAfya and Linda Mama).

Secondly, there are currently **POOR ACCOUNTABILITY MECHANISMS** from both providers and payers. The monitoring arrangements that guard against corruption and fraud were not adequate. For instance, private healthcare providers highlighted bribe demands from officers from the purchaser to enable their facilities to be empanelled. Furthermore, there are no mechanisms for providers to hold purchasers accountable for breaching contracts. Case in point, there is no recourse if a purchaser delayed payment for no reason.

Third, there are **NO FORMAL COMMUNICATION** platforms that purchasers and providers could engage. The inadequate utilization of communication channels unfavourable to providers contributed to poor communication and ease of access to give feedback on challenges. These led to a communication breakdown as information from purchasers did not reach providers or providers did not know the right channel to address specific issues.

Fourth, there are **NO CLEAR MECHANISMS TO INTRODUCE AND REVIEW PPMS.** Besides, existing PPMs are input-based and do not incentivize providers to improve their performance. For instance, providers indicated a lack of knowledge about how current PPMs such as capitation were designed and expressed the need to review the rates considering current costs of care.

Recommendations

Ministry of Health

- **SPEARHEAD THE REVISION AND IMPLEMENTATION OF STANDARD TREATMENT GUIDELINES:** Standard treatment guidelines are essential for an adequate understanding of the costs of care for purchasers to minimize both differential quality and cost of care.
- **DEVELOP A FRAMEWORK FOR PUBLIC-PRIVATE CONTRACTING**: This will entail the development of a framework that would allow private payers to contract public providers. Public-private contracting will create an avenue for providers' competition that can be leveraged to reduce the cost of care, enhance the quality of care and efficiency. This is also an important aspect of cost containment.

NHIF and Private purchasers

- **REVIEW PROVIDER PAYMENT MECHANISMS TO INCLUDE OUTPUT-BASED PAYMENTS;** Fast-tracking the revamping of PPMs with a focus on introducing output-based payment mechanisms will provide an avenue for linking purchasing decisions to performance.
- **SCALE UP THE AUTOMATION OF PROCESSES:** All payers to move to automated systems that permit automated empanelment, claim submission, pre-authorization, and the utilization of an electronic health records system across all providers.
- **CAPACITY BUILDING OF PROVIDERS;** Purchasers to adequately train providers on new systems and facilitate regular refresher training.
- **IMPOSE STRICT SANCTIONS FOR FRAUD CASES:** This will provide an avenue for fraud management.
- **DEVELOP AND UTILIZE FORMAL CHANNELS OF COMMUNICATION:** Utilize these formal channels to engage providers frequently.
- **ESTABLISH COMPLAINTS MANAGEMENT FRAMEWORK**

Regulators

- **ESTABLISH CENTRAL MEDICAL INSURANCE MANAGEMENT SYSTEMS:** This will be quintessential in improving purchaser regulation and promoting health system goals.

Providers

- **INVEST IN TECHNOLOGY:** Providers to invest in adopting technologies such as automation through the e-claim system.
- **AVAIL STAFF FOR CAPACITY BUILDING:** All providers should ensure that at least more than one staff has been trained and/or facilitated to attend refresher training where necessary.

Conclusion

This assessment reveals that the challenges hindering effective provider-payer engagements result from human resource gaps, infrastructure gaps, capacity gaps and communication & accountability gaps. Building staff's payment process capacity, reviewing PPMs, adopting health information systems/technology to automate processes, developing and implementing a public-provider-private-payer contract framework and establishing working communication channels can be leveraged to address these gaps. Consequently, addressing these gaps would promote effective provider-purchaser engagements in Kenya as the country implements reforms for UHC.

About the Research

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Joint Action Plan

Table 1 highlights the actionable solutions, resources needed and timelines for implementation. Policymakers and other actors can leverage the short-term and medium-term actionable solutions as low hanging fruits for implementation

Tableau 1. **List of actionable solutions, resource needs, indicators for assessing progress and timelines**

Actionable Solution	Resource Mapping	Mapping Departments / Organization	Indicators for assessing progress	Timelines
Short-term Actionable solutions (To be Implemented in 1 year)				
1. Regular purchaser/provider engagements and capacity building Requirements: • NHIF/PHI and Provider Liaison • 24-hour contact centres • Communication framework with clear SLAs • Feedback surveys • Quarterly meetings (in-person and online platforms)	• Human resource • Feedback tools	• NHIF • PHIs • Private provider • Public provider	• % Of providers allocated to a Provider Liaison Officer • % of communications responded within SLA • No of feedback surveys done & response rate • % of quarterly meetings held • % of providers trained on claims management process	**6 months**
2. Develop and utilize formal channels of communication	• Human resources • Computers • Internet connectivity • Power	• All providers • All purchasers	• % of communication responded within SLA • No of feedback surveys done & response rate	**6 months**
3. Fraud management Requirements: • Capacity building • Sanctions • Fraud analytics • Controls • Automation • Strategic purchasing	• Healthcare Fraud Policy	• NHIF • PHIs • Private provider • Public provider • IRA • AKI	• Action plan for a Healthcare Fraud Policy • Annual fraud training for providers • % of staff trained on fraud	**6 months**
4. Review PPMs to include output-based payments Requirements: • PPM reforms • Price control for medical services, pharmaceutical, professional fees	• PPM	• NHIF • MOH • PHIs • All providers • HMIS providers • IRA • AKI • MoICT	• Review of EBPH • Costing studies • Adoption of risk-adjusted capitation payments for primary care • % Adherence to Recommended Retail Prices for pharmaceuticals	**1 year**
5. Complaints Management Framework Requirements: • Comprehensive framework with clear SLAs • Appoint an independent arbitrating body	• Complaints Management Framework	• NHIF • MOH • PHIs • Private provider • Public provider • HMIS providers • IRA • AKI • MoICT	• Completion of the complaints management framework • Appointment of the independent arbitrating body (Ombudsman) to arbitrate serious provider-payer conflicts	**1 year**

Actionable Solution	Resource Mapping	Mapping Departments / Organization	Indicators for assessing progress	Timelines
6. Common framework on debt management Requirements: • 30-day credit period • Quarterly reconciliations • Annual sign off and clearance	• Debt management policy	• NHIF • PHIs • Private provider • Public provider • IRA • AKI	• % of claims outstanding after the 30 days • % of providers signed off within the next financial year • Quarterly published reports on debt management • Timely disbursements of NHIF funds • % of corporate clients who have premium outstanding after 30 days.	**1 year**
Medium-term Actionable solutions (To be Implemented in 1 – 2 years)				
7. Scale-up automation – e-claims, online pre-authorization, electronic health records, both private and public providers and purchasers Requirements: • Interoperability • Standardization	• Computers • Software • Biometric devices • Internet connectivity • Power	• NHIF • PHIs • MOH • MoICT • ISPs • Kenya Power	• % of providers with HMIS (HER) • % of providers with internet connectivity • % of providers with power • % of providers connected to e-claims • % of claims transmitted electronically • % of claims processed automatically	**1 – 2 years**
8. Revise standard treatment guidelines Requirements: • Dissemination • Enforcement • Regular audits	• National Standard Treatment Guidelines	• MOH & stakeholders	• Completion of guidelines of priority healthcare needs • Monthly/Quarterly Clinical Audits on Adherence to NSTGs	**1 – 2 years**
9. Develop a framework for public-private contracting Requirements: • Financial autonomy for public providers	• Public provider – Private Payer Contracting Framework	• MOH • COG • PHIs • AKI	• % of counties achieving financial autonomy • % of public providers that have contracted PHIs	**1 – 2 years**
Long-term Actionable solutions (To be Implemented in over 2 years)				
10. Central medical insurance management system **Requirements:** • Mandatory data sharing • Interoperability • Legal framework as a regulatory requirement	• Computers • Software • Biometric devices • Internet connectivity • Power	• All payers • All providers • HMIS providers • IRA • AKI • MOH • MoICT	• Development of the architecture and policy of the CMIMs	**2 – 3 years**


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