PRIVATE INSURERS-PRIVATE PROVIDERS WORKSHOP REPORT

November 22, 2012
InterContinental Hotel
Nairobi, Kenya

"Strengthening Partnerships in the Private Health Sector to support greater access of health care insurance coverage"

Strengthening Health Outcomes through the Private Sector

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ACRONYMS

AKI	Association of Kenya Insurers
CBHF	Community Based Health Financing
DRG	Diagnosis Related Group
FFS	Fee-for-Service
HPP	Health Policy Project
ICT	Information and Communication Technology
IFC	International Finance Corporation
IRA	Insurance Regulatory Authority
KAPH	Kenya Association of Private Hospitals
MIPs	Medical Insurance Providers
NHA	National Health Accounts
NHIF	National Hospital Insurance Fund
OOP	Out-of-Pocket
PPM	Provider Payment Mechanism
SACCOs	Savings and Credit Cooperative Organizations
SHOPS	Strengthening Health Outcomes through the Private Sector Project
USAID	United States Agency for International Development

EXECUTIVE SUMMARY

INTRODUCTION

The penetration of health insurance in Kenya is minimal. Only 20 percent of Kenyans have access to health insurance, 86 percent of whom are covered by the public sector through the National Hospital Insurance Fund and 24 percent covered by the private sector (Deloitte, IFC et al., 2011). Due to this low insurance coverage, Kenyans continue to be exposed to high out-of-pocket expenditure and the catastrophic costs associated with health care. There exists a large potential for affordable health insurance within the Kenyan market for the private sector. For this to be realized, there is a need for a paradigm shift of both private insurers and private providers from a high margin-low volume business model to a low-margin-high volume model. To achieve this, there needs to be sharing of information between insurers and providers; collaboration in design of innovative products; and increased efficiencies at both insurer and provider level to reduce administration and transaction costs of health insurance products.

On November 22nd, 2012, the Strengthening Health Outcomes through the Private Sector (SHOPS) project in Kenya facilitated a meeting for both private insurers and private providers in Nairobi to discuss and to brainstorm strategies on improving efficiencies and increasing the reach of private health insurance. Discussions were informed by technical presentations and a question and answer session that led to group debates. The following sections give a summary of the presentations and discussions that took place.

INTRODUCTION TO SHOPS PROJECT KENYA

SHOPS is an United States Agency for International Development (USAID)-funded five-year, global project implemented by Abt Associates, Inc. to increase the role of the private health sector in delivering sustainable and high quality information, products, and services. Mr. Mbogo Bunyi, chief of party, SHOPS project Kenya introduced the project and shared the activities in Kenya for the next year. The activities contribute to the main goal of increasing the quality and coverage of private sector health products and services in Kenya by supporting innovative health financing mechanisms to increase private health insurance coverage; facilitating the engagement of the private sector in policy processes; and promoting service delivery through the private sector. To support the private sector, the project provides data for decision making, through the development of policy briefs and is currently co-financing a national health care costing exercise across the public and private sectors.

INDUSTRY OVERVIEW

Mr. Jorge Coarasa, policy officer, International Finance Corporation gave a global perspective of the health financing debate based on a World Bank publication “Scaling-Up Health Insurance, Staying the Course” that is soon to be released. To achieve universal coverage, no one mechanism alone will achieve the strategic objectives of equity, income smoothing, and risk management. Instead a multi-pillar approach is required with both public and private financing. As a way forward, Mr. Coarasa noted that governments must take robust policy and strategic

steps to create the necessary institutional and administrative environment to increase investments in the sector, improve quality of services, and therefore increase willingness to pay for health insurance and reduce over-reliance on out-of-pocket (OOP) expenditure.

Dr. Nelson Gitonga, Policy Advisor, SHOPS Project Kenya, shared relevant findings from the study, *Market Assessment of Private Prepaid Schemes in Kenya*, which will inform health financing reforms. Important recommendations from this assessment were: promote a stable, sustainable, and efficient health insurance market; and address market failures. These strategic steps should include development of a regulatory framework and defining the role of prepaid schemes in the health care financing strategy.

TECHNICAL PRESENTATIONS

Three technical presentations were given by Dr. Nelson Gitonga, Dr. Edward Rukwaro, Group CEO of Mediheal; and Dr. Richard Ayah Lecturer, University of Nairobi.

> The single most important thing that would make health markets better in Kenya is getting health insurance right.
>
> Jorge Coarasa – IFC

Dr. Nelson Gitonga underscored the importance of collaboration between insurers and providers in the development of health insurance products. Innovation can be achieved in product design of the benefit package to suit the needs of the targeted beneficiaries, product packaging, distribution, administration ***processes***, and operational design of the product. With technology, all parties can achieve further efficiencies. Innovation reduces costs and makes products more affordable.

Dr. Edward Rukwaro illustrated how different payment mechanisms influence the behavior of providers through positive and negative incentives. No single mechanism provides all the right incentives, thus trade-offs are required based on policy objectives to contain costs, improve efficiency, and improve quality of health care, and combinations of schemes may be necessary.

Dr. Richard Ayah proposed that market failures within the health insurance industry are largely due to informational asymmetry that leads to moral hazard, adverse selection, and supplier-induced demand. This has led to unpredictable and high costs that have forced insurers to increase health insurance premiums and engage in cream-skimming. For the relationship between insurers and providers to improve, it would need to be grounded on trust. A key component of trust is availing information to all the people within the market, including patients, insurers, and providers.

GROUP DISCUSSIONS

The last session was a working group session. Participants sat in four groups to discuss the following areas:

1. Opportunities to increase health insurance coverage;
2. The ideal design of affordable health insurance products;
3. Mechanisms to foster dialogue between insurers and providers; and
4. Opportunities to improve efficiencies and reduce risk through innovative provider payment mechanisms.

CONCLUSION

The participants concluded with a way forward with a commitment to continue dialogue between the private insurers and private providers. Key recommendation was to continue the dialogue between both groups through their associations and ensuring private sector participation in discussions of the National Health Financing Strategy to ensure the role of the private sector is clearly defined. SHOPS Project Kenya was tasked to continue facilitating the dialogue.

I. BACKGROUND

Kenya has taken meaningful strides in developing its health care financing system. For example, in the public sector, the Government has drafted a National Health Financing Strategy with the aim to achieve universal coverage. Key stakeholders in the health sector have been debating the need to increase health insurance coverage through various models to facilitate access to health care services to the majority of the population which is currently uninsured. To this end, several health care financing initiatives have been developed by both the public and private sector including a mix of demand and supply side initiatives such as disease-specific subsidies, vouchers/out-put based financing, community based health insurance, health micro-insurance products and performance based financing.

Even so, much remains to be done to get adequate funding and the right mix that would facilitate universal access to quality health services. The Kenya Market Assessment of Prepaid Health Schemes estimates that only 20 percent of Kenya's population has health insurance (Deloitte, IFC et al., 2011). 85 percent of these are covered by the public sector through the National Hospital Insurance Fund (NHIF) and 15 percent are covered by the private sector. Of the 15 percent, community based health insurance covers six percent of the insured population and private health insurers cover the remaining nine percent. There is huge potential for affordable and quality health insurance.

In May 2012, Strengthening Health Outcomes through the Private Sector (SHOPS) Project held a health care financing consultation meeting to identify priorities for technical assistance for SHOPS interventions. Key stakeholders highlighted the need to build stronger partnerships between private insurers and providers. The "Private Insurers and Private Providers Workshop" was a response to this call.

Workshop Objectives

- To bring private insurers and providers together to foster dialogue;
- To identify opportunities for collaboration between private insurers and providers to provide affordable health insurance; and,
- To identify concrete actionable next steps towards strengthened partnerships.

2. WELCOME REMARKS

By: Dr. Bedan Gichanga, USAID

United States Agency for International Development (USAID) supports 600,000 lives in ARV programs in Kenya. This important program has a limited tenure so there will be a need to shift to another program with more sustainable funding and implementation. Many people on ARV do not have the means to sustain treatment on their own, least of all through out-of-pocket (OOP) means. Availability of and enrollment into affordable health insurance schemes can be the sustainable mechanism in which these people can continue to gain access to lifesaving treatments. Given its commitments to health in Kenya, USAID is interested in the setting up an effective health insurance industry in Kenya.

The growth of the health insurance industry in Kenya has been slow with a three-fold increase over 15 years. For the last three years, most health insurance industries have been making losses. The adversarial relationship between key players has only served to worsen the performance in the sector. Health providers argue that the insurance sector serves no meaningful purpose. On the other hand, health insurers view health providers as complicit in fraudulent claims. These sharp differences in the sector need to be bridged; else health providers may lose at least 70 percent to 80 percent of assured payments from patients from health insurance coverage.

Moving forward, providers need to be more flexible and innovative in levying charges, including simplifying or consolidating bills. There is merit in allowing for negotiations between providers and insurers to arrive at pricing levels with which the latter would be comfortable. The provider sector still uses a fee-for-service (FFS) system whereby the provider passes all the risk to the patient or insurer. This is unfair and needs to change. Worldwide, health care payments are made through capitation or global pricing. FFS is no longer in use.

Through this workshop, USAID anticipates that players focus on building collaborative relationships. Unless this is done, the goal of developing low cost insurance packages will not materialize. Collaboration is imperative.

3. INTRODUCTION TO SHOPS PROJECT KENYA HEALTH FINANCING ACTIVITIES

By: Mr. Mbogo Bunyi, Chief of Party, SHOPS Project Kenya

Mr. Bunyi described the role of SHOPS and shared activities undertaken by the Project in Kenya.

SHOPS is a five-year USAID-funded global project aimed to increasing availability, improving quality, and expanding coverage of essential health products and services in family planning and reproductive health, maternal and child health, HIV/AIDS, and other areas through the private sector. The goal of SHOPS Project Kenya is to increase the role of the private health sector in delivering sustainable and high quality information, products, and services. Achieving this goal will require multi-sectoral dialogue and strong partnerships.

Emphasis on the private sector is based on the fact that 49 percent of all health facilities in Kenya are in the private sector. The sector is the largest single source of health financing (37%), and 22 percent of all health expenditures are spent in private health facilities.

The mandate of SHOPS needs to be understood in the following context: 24.5 percent of expenditure for health is OOP and only 20 percent of Kenyan's are covered by health insurance. One of the objectives of SHOPS Project Kenya is to increase health insurance coverage through private financing mechanisms. It also seeks to augment the availability of quality health services and products in the private sector. Towards this end, SHOPS hopes to generate data for decision-making and ensure participation of the private sector in health care policy development.

SHOPS health care financing activities in Kenya include the following:

1. SHOPS has done an evaluation of the *Changamka* saving scheme. This initiative enables users to pre-save onto a medical card against which health bills can be paid.
2. Jointly with GIZ, SHOPS will support a costing activity, based on actual unit costs, to gather evidence to compare health costs across different providers and benefit packages; compare provider-payment mechanisms; perform actuarial analysis to calculate optimal premiums; and design insurance products. This activity will be undertaken in collaboration with major stakeholders including the Ministries for Health, International Finance Corporation (IFC), the NHIF, and USAID-funded Health Policy Project (HPP)[1].
3. SHOPS will support the involvement of the private sector in policy forums and policy development by keeping them abreast on changes in national strategy and policy decisions of relevance to the health sector.

[1] HPP is undertaking a similar analysis but based on normative costs

4. INDUSTRY OVERVIEW

4.1 SCALING UP AFFORDABLE HEALTH INSURANCE: STAYING THE COURSE

By: Jorge Coarasa, IFC

Jorge Coarasa's presented on the role of health insurance in increasing access to health care with a global focus and was based on a World Bank publication titled "Scaling-Up Health Insurance, Staying the Course" that is soon to be released.

Coarasa stated the IFC's desire and commitment for health markets in Kenya becoming more efficient and equitable. The importance of this Workshop was initiating the discussion on "how to get health insurance right" in Kenya.

Health Insurance does not exist in a vacuum; Health Insurance exists in the context of a broader health financing debate

He gave the following reasons on why OOP payment is undesirable:

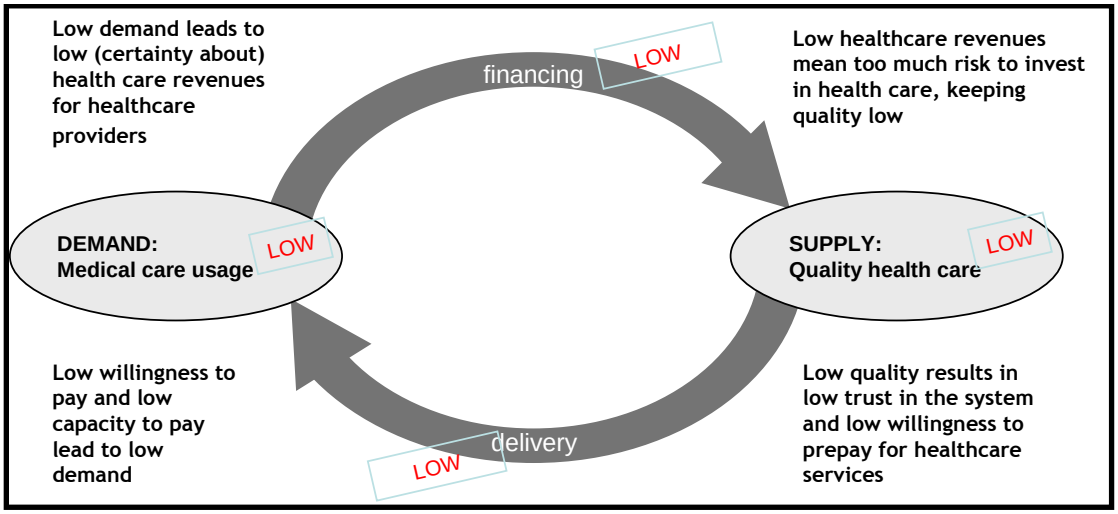
- OOP has an impoverishing effect to the end consumers; and,
- OOP deprive health providers of steady revenue streams.

Ideally, for every shilling spent on OOP, four should be in the form of prepaid expenses. This ideal is unlikely to be met simply by economic growth; instead, attaining this ideal will require well-calibrated policies.

If the objectives of health financing systems including income smoothing, equity, and risk management are to be met, then health financing must equally be multi-pronged with subsidies, insurance, and savings forming part of the mix. No country in the world has achieved universal health coverage without government playing a substantial role in providing revenue streams. Therefore, to achieve universal health coverage, public, voluntary and private health insurance, and government expenditures will be needed.

Deepening health insurance has far reaching implications on health system functioning.

FIGURE 1: CURRENT STATE OF KENYAN HEALTH CARE DEMAND AND SUPPLY

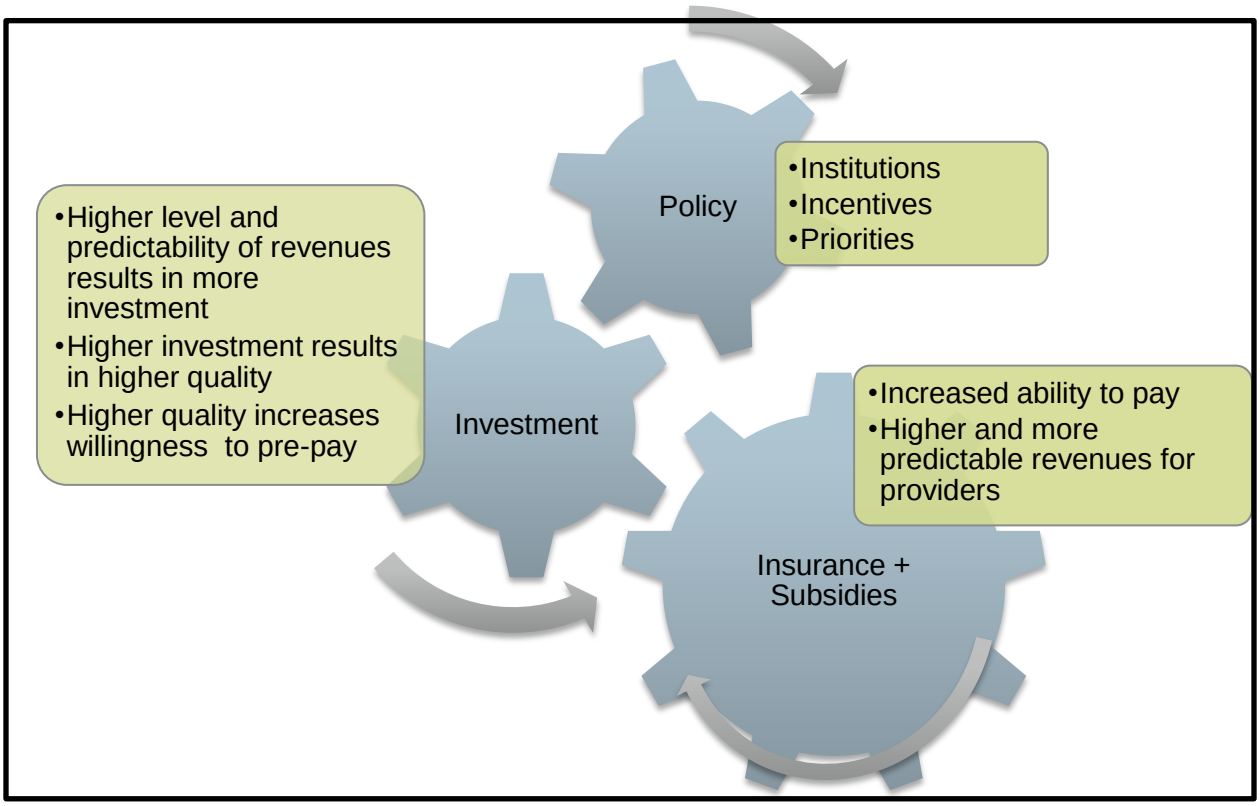


As illustrated above, low demand for insurance results in restricted investments to quality health services. When health services are sub-optimal, demand for health care dampens. As such, investors would be sluggish in investing in the health sector. On the supply side, low quality results in diminished trust in the health system and low willingness to prepay for health care services. Low health care coverage translates into sub-standard services. This vicious cycle needs to be broken.

To scale up health insurance, there is need to see the following antecedents in place:

- An increased ability to pay for *health insurance and subsidies* results in higher and more predictable revenues for providers.
- A higher level of predictability of revenues results in more *investments*, which yields higher quality of service, which triggers increased willingness to pre-pay.

FIGURE 2: A NEW PARADIGM TO SCALE UP HEALTH INSURANCE



Nevertheless, these steps cannot be attained without proper strategies, policies, and institutions. In closing, Coarsa challenged participants to reflect on the following questions:

- Is more health insurance good for private providers?
- Is the relationship between private providers and health insurers/ medical plans a zero sum game or a win-win one?
- Do private providers stand to win from policy changes such as mandatory health insurance or expansion of NHIF through subsidies?
- How will moves to introduce mandatory health insurance or expand the scope of NHIF through subsidies affect private insurers/ medical plans?

4.2 MARKET ASSESSMENT OF PREPAID HEALTH SCHEMES: SUMMARY OF FINDINGS

By: Dr. Nelson Gitonga, Policy Advisor, SHOPS Project Kenya

Dr. Gitonga reported on the findings of a study commissioned in 2010 by Ministry of Medical Services and IFC which reviewed the NHIF and private insurers (Deloitte, IFC et al., 2011). The study sought to assess prepaid health schemes to determine their scope and probable role in the on-going health care financing reforms. Specifically, the study aimed to determine the best way to structure the sector to support the broader goals of health care financing in Kenya and to provide a basis for its strategic growth

Health care financing in Kenya is still fragmented and very little of the total health expenditure is in formal risk pools.[2]

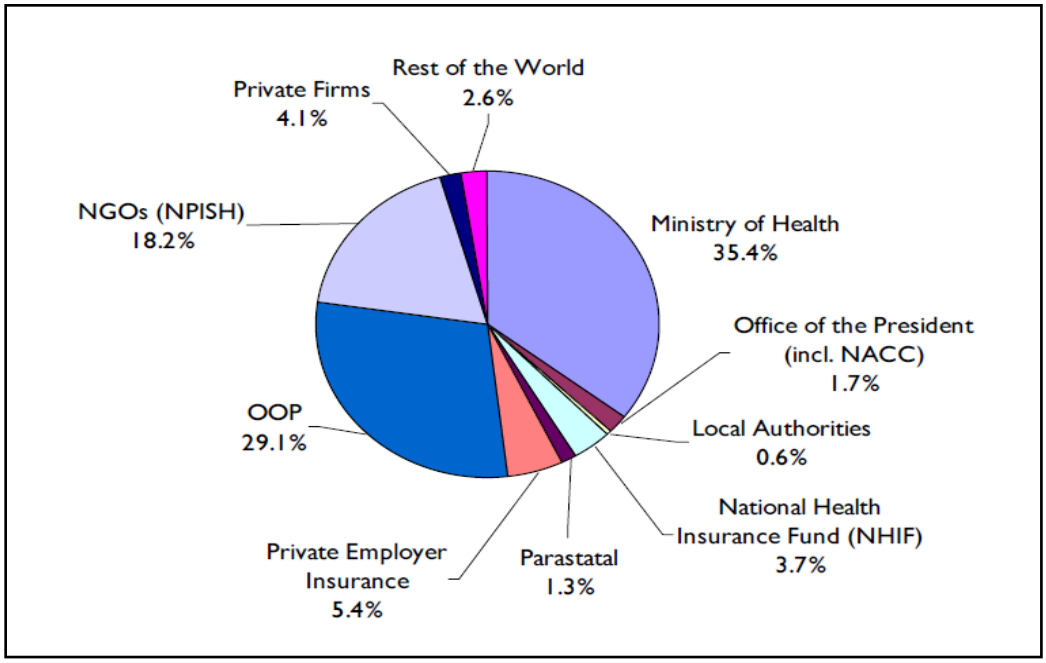
TABLE 1: POPULATION COVERED BY PRE-PAID SCHEMES

PREPAID SCHEME PROVIDER	2010 ESTIMATES FROM SCHEMES (19.9% COVERED)	% OF 2010 POPULATION (39M COVERED)
NHIF	6,600,000 (85%)	16.9%
Private Insurance Companies & Medical Insurance Providers (MIPs)	700,000 (9%)	1.8%
Community-Based Health Financing (CBHF)	470,000 (6%)	1.2%
Total	7,700,000	19.9%

Kenya has several pre-paid schemes, but all operate under different regulators. The main scheme is managed by the NHIF, which is a mandatory arrangement. Several voluntary schemes that make up the private insurers segment are overseen by the Ministry of Finance and the Insurance Regulatory Authority (IRA). Only 30 percent of all registered insurers provide health insurance. Only four of the MIPs are doing significant business. CBHF schemes cover a significant number of people. Unlike the foregoing arrangement, rather than the IRA and Ministry of Finance, CBHFs are regulated by Ministry of Gender, Children and Social Development. There are numerous and large employer self-insured schemes that are currently unregulated.

[2] The latest National Health Accounts (NHA) show that only about 16 percent of the total health expenditure is in prepaid schemes. The rest of the money goes through inefficient channels to finance health care.

FIGURE 3: HEALTH FINANCING ACTORS IN KENYA



Source: (Government of Kenya and Health Systems 20/20 Project, 2009)

There is minimum cover for the poor and indigent in the country. The government has a responsibility to cover the poor and indigent with NHIF or a contracted private scheme. However, the poor and vulnerable (who constitute 80 percent of all Kenyans) are excluded from prepaid schemes. Some of the key barriers to access of health insurance include perceived high cost of health insurance premiums; lack of information and knowledge on benefits of risk pooling; and credibility problems of insurance companies and MIPs. The government has a role to play in enrolling the indigent population in health schemes. By providing health insurance coverage to the poor, the financial barrier to care is reduced, the risk of catastrophic spending decreases, and risk pools increase making the market more efficient.

According to the Ministries of Health data, the leading cause of out-patient care utilization is preventable primary health conditions. These problems constitute 70 percent of the country's morbidity. The country faces an emerging problem regarding how to deal with chronic and non-communicable conditions.

Private Insurance schemes cover most health conditions with some limitations on maternity and HIV. Private insurance has the largest pool of financing but population coverage remains low with small fragmented risk pools making the insurance market inefficient. However use of Information and Communication Technology (ICT) can improve efficiency by reducing administration and transaction costs.

Policy and regulation must be in place to foster this market development. The Health care Finance Strategy is still outstanding, which needs prompt enactment to allow clarity about the roles of key players, such as the NHIF, private Insurers, and CBHFs, and answer taxation questions.

In concluding, Dr Gitonga proposed the following recommendations:

- Government needs to complete the health care financing strategy process to clear uncertainty on policy direction and to implement specified changes.

- Government needs to institute legal and regulatory reforms to develop a comprehensive health insurance law and strengthen IRA to regulate health insurance. The areas needing specific attention are as follows:
    - Redefining the various types of risk pooling and prepayment mechanism;
    - Redefining various health insurance vehicles and capitalization;
    - Setting performance benchmarks for health insurers (e.g. breadth and depth of coverage, pay-out ratio, administrative expenses, and efficiency); and,
    - Regulation of health care quality and cost-effectiveness (supply side).
- There is need to standardize consumer protection with the following specific measures in mind:
    - Define prescribed minimum benefits, choice, disclosure, and marketing standards;
    - Institute mechanisms of handling grievances and appeals; and,
    - Consumer empowerment – education, charter, and advocacy mechanisms.
- There is need to clarify the role of private schemes in providing mandated national health insurance. In this regard, there is need to address the following puzzles:
    - Should these schemes play a supplementary role and complementary one only?
- Should they be part of providing mandated social health insurance for the entire market or to just parts of it? In this case there is a need to develop criteria to measure performance of health insurance schemes, such as risk pool size and efficiency. Consider opt-out options of mandated social health insurance scheme for private insurance. There is need to identify areas for possible Public-Private Partnerships with public insurance (e.g. marketing/distribution, benefit purchasing, claims, and administrative services).

5. TECHNICAL PRESENTATIONS

5.1 DEVELOPING AFFORDABLE AND INNOVATIVE HEALTH INSURANCE PRODUCTS

By: Dr. Nelson Gitonga, Policy Advisor, SHOPS Project Kenya

In this presentation, Dr Gitonga identified the different stakeholders in the health insurance market[3]. Developing health insurance products single-handedly is ill-advised especially when best practice suggests this should be done collaboratively and inclusively. Therefore, there is need for an appreciation of the interests and expectation of key players.

Health insurance providers are interested in meeting the diverse needs of their clients and in operating profitably. They expect predictability in costs of claims and desire a departure from FFS payment mechanism to fixed reimbursements. Health care providers want profitable health insurance products, which are simple to administer and has wide coverage to minimize their risk of accruing bad debt. On their part, health professionals want to meet the specific needs of their clients, while health institutions need to realize their core business imperatives of providing high quality care to consumers while making a profitable health delivery business with returns for shareholders or investors. Clients and users desire health services that are convenient, affordable, adaptable, prompt, innovative, adequate, and comprehensive. Distributors and intermediaries would wish to make profits and provide suitable products and services.

On the periphery, consumer organizations are keen on consumer protection – on ensuring clients get value for money. The government wants to promote greater access to quality and affordable health care. Finally, donors want to support government in achieving its national health goals, including promoting efficient and effective health care financing and supporting innovative health care financing concepts.

There is need to i) align or reconcile these interests and constitute a partnership framework that ensures all players have a win-win situation, and ii) to strive to encourage these players to own the initiative and accept the products subsequently developed.

In developing appropriate products and services, we need to be sensitive to the needs of particular segments of the market and on other important criteria, such as benefits package, ease of use, and pricing. There are opportunities for innovation, not just from the technical features of products, but also from the process of packaging, distribution, and administration. Exploiting opportunities for innovation therefore requires planned and adequate stakeholder engagement and understanding of what each player expects or wants. It is vital to appreciate the instrumental roles of government and development partners in deepening health care services. On top of this, some private insurance companies have attempted to develop low cost insurance packages. Several initiatives have been attempted in which private insurers have worked with the microfinance institutions, Savings and Credit Cooperative Organizations (SACCOs), and even donors. So far, these efforts have met with mixed success.

The role of government and development partners is increasingly important due to the large coverage gap and the need to secure access to health care for all. All mechanisms therefore

*3*The word Insurance is used broadly to mean any risk pooling or prepayment mechanism (indemnity scheme, HMO/Managed care products, provider based schemes and group self-funded schemes).

need to be engaged fully to help in cost reduction and expand coverage even towards poor people.

5.2 EFFICIENT PROVIDER PAYMENT MECHANISMS

By: Dr. Edward Rukwaro, Group CEO, Mediheal Group of Hospitals

Dr. Rukwaro's presentation gave different options of provider payment mechanisms (PPMs) and elaborated on the advantages and disadvantages of each. Sound payment systems have implications on health system functioning. Each payment method has a different impact on efficiency, quality, and access. Such systems can help providers operate more efficiently and effectively due to the manner in which payment mechanisms impact risks and costs. For health providers, these mechanisms define their operational risks and efficiency, and they can also influence the quality and access criteria of health services.

Kenya's health financing system currently faces several challenges, such as low efficiency, inequity, poor quality, poor access, low risk pooling, high OOP, poor financial and management systems, and a weak regulatory environment. Payment methods can be broadly defined as prospective or retrospective. In the prospective method, the rate for a defined set of services is fixed before payment. This method leaves providers exposed to risk, especially when actual costs turn out to exceed projected ones. To hedge against risk, providers may then compromise quality of services. Unlike the prospective method, the retrospective method involves billing during or after service has been given, which means the burden of risk falls on the payer. Providers can be tempted to inflate costs and to over-service.

The other criterion for looking at payments is in the sense of "aggregate" versus "disaggregated" units. In the former, payment is made for a set of services for one treatment. In the latter, payment accrues on disaggregated units, with items like consultation, X-rays, and drugs, all treated discretely.

In general, there are seven types of PPMs to facilities:

1. **Budget**: Prospective or retrospective payment; aggregated mechanism; line-item allocation of funding can limit flexibility, but global budget allocation can be used for advanced payment and can be flexible in resource use; tendency for facilities to spend entire budget to ensure continued level of support
2. **Capitation**: prospective, aggregated payment mechanism; fixed amount paid based on number of patients enrolled; low administrative costs and incentivizes efficiency improvements, but can induce facilities to lower quality
3. **Diagnosis Related Group** (DRG): Prospective, aggregated mechanism; fixed payment of predetermined amount per case; development of case-based system of payment, with reliable data and health information system, can be complex and time consuming
4. **Fee-for-service** (FFS): Retrospective, disaggregated mechanism; high administrative costs for both provider and payer; may encourage over-servicing and unnecessary interventions
5. **Pay for Performance**: Retrospective mechanism; can be aggregated or disaggregated; payment rate determined by performance indicator of the facility (such as readmission of patients); administration and monitoring can be costly
6. **Per Diem**: Retrospective, aggregated mechanism; pays daily aggregate fee for all expenses; may encourage increase in number of admissions and longer lengths of stay
7. **Salary**: Prospective, aggregated mechanism, where objective is to make doctors focus on core business of service provision; salaries often lag behind especially in the public sector leading to low job satisfaction; can be a source for health workforce shift from the public sector to private sector with more attractive packages

Each of the payment mechanisms has drawbacks; as such, there is need to make trade-offs that allow for the fulfillment of the following criteria: obtain the needed operational efficiency, enhance patient risk selection, promote higher quality service, and minimize costs.

TABLE 2: PROVIDER PAYMENT MECHANISMS AND POLICY TRADE-OFFS

OPTIMAL POLICY CONDITION	HIGHER EFFICIENCY	LOWER PATIENT RISK SELECTION	HIGHER QUALITY	BETTER COST CONTROL
	Capitation	FFS, Salary	DRG	Capitation
	DRG	Per Diem	FFS	DRG
	Salary, Per Diem	DRG	Per Diem	Per Diem
	FFS	Capitation	Capitation	FFS
NEGATIVE POLICY CONDITION	**LOWER EFFICIENCY**	**HIGHER PATIENT RISK SELECTION**	**LOWER QUALITY**	**WORSE COST CONTROL**

To strike a balance, providers need to earn a decent income, uphold quality service, operate efficiently and avoid waste and unnecessary service provision. Achieving this is difficult. In designing PPM, there is need to consider the management capacity and systems of both the insurer and health providers. Overly complex payments mechanism should be avoided, as they are burdensome to administer. Competition to promote quality and spur consumer satisfaction should instead be encouraged.

No single provider payment method provides all the right incentives, thus a combination of payment methods may be necessary.

5.3 FOSTERING DIALOGUE BETWEEN PRIVATE INSURERS AND PRIVATE PROVIDERS

By: Dr Richard Ayah, University of Nairobi

Dr Ayah raised four key questions to guide the debate.

1. Where does the conflict exist between the insurer and provider?
2. What does this mean?
3. What maintains the relationship between the insurer and provider?[4]
4. Do they each have the same goals

Emerging Issues:

Despite the reforms in the health industry, little growth has been seen. For example, between 1998 and 2012, the media has grown in value by 30 times, but the health insurance industry has grown only three times. Dialogue is clearly needed by the different stakeholders. One group of people missing in the discussions between the insurer and provider is the patient and their role in the conflict.

For the relationship between insurer and provider to thrive, it would need to be grounded on trust. A key component of trust is availing information to all the people within the market. As it is,

4 There is an assumption that for the relationship to exist and thrive there is need for trust between the various parties. A key component of trust is information.

some players are reluctant to avail other players with information, while in other cases, some players, including patients, feel that there is no incentive to divulge such information.

Market failures within the health insurance industry are largely due to informational asymmetry that leads to moral hazard (tendency for patients to access care more because they are covered by health insurance than they would have if they did not have health insurance), adverse selection (tendency for patients with risky behaviors to prefer getting health insurance), and supplier-induced demand (tendency for providers to over-treat because the health insurance pays by FFS). This has led to unpredictable and high costs that have forced insurers to increase health insurance premiums and engage in cream skimming.

To improve this, Dr. Ayah suggested better continuity of care to contain costs, provide positive incentives to providers through contracting, and conducting studies to better understand the prevalence of chronic diseases which will inflate health care costs.

Consumers and patients need protection and require education on their health insurance policy to reduce instances of uncompensated care. In addition, patients require information on quality of care from health providers, which can be addressed through a market mechanism to monitor the quality of care of the provider and the insurer.

6. QUESTION AND ANSWER SESSION

6.1 Q&A

In the market assessment of prepaid schemes where do provider based schemes fall?

- Since there is only one provider-based scheme in the country, not much information was obtained in the study.
- There is need to have in place comprehensive health insurance laws that recognize the various forms of risk pooling and paying for health, including provider-based schemes. For example, Uganda is almost at the point of completing a health insurance law that includes provider-based schemes.

There is a preference for capitation schemes in an outpatient health setting. But this form of capitation is best done in a facility with both inpatient and outpatient services.

- PPMs can be used in different setups and for different purposes. One cannot say one mechanism is better than another per se. Capitation is suitable to apply at the primary care level, where it is likely to operate at high scale and frequency, no less lower risk of procedures going awry. If not applied well, capitation could undermine service quality. But the severity of eroded quality would be worse were capitation applied at the tertiary care. Using capitation for inpatients is risky because of the risk of a procedure going wrong, which could cause costs to escalate. For this reason, providers are slow to use capitation at the inpatient level.

Is there any initiative to collect data on health care costs?

- SHOPS together with GIZ and IFC will conduct a major initiative on costing. This step will be taken because in the last couple of years debates on health care financing have not been based on any serious costing information. Insurance companies may be walking in the dark when developing products and pricing. Indeed, this could be the reason for the poor performance of products: costing models are not arrived at using scientific means.
- What has not happened is moving away from unit costs to an actuarial analysis of costing. The latter approach is not widely used because it is involving and expensive. There is however need to overcome this constraint and use actuaries to set proper prices. The method being used currently is one that uses raw averages.

The biggest problem lies in developing products for chronic illnesses. Have these illnesses been properly costed? For instance, a model should be developed to manage diabetes.

- The key question is whether existing products have been properly costed and whether the focus ought to be on just managing the chronic conditions, paying for curative services, or including preventative services.

Is managed care and benchmarking therefore the way to go?

- Managed care may be the answer. The existing indemnity schemes that exist in the

country have many aspects of managed care.

When the system does not work well, there is typically collusion between two of the three players. Which players are the colluding players and who are the beneficiaries?

- Example: Who benefitted from the losses made by the insurance industry in 2011?

Should there be a system to provide a hierarchy of information for all health providers?

- There is need for a neutral body to house information of relevance to the industry. In such a scenario, information is given to the repository by the industry players and then fed back to them as and when needed. *Example*: The University of Nairobi can be used to house this information.

Concerning relationships and trust, one area that has been ignored is fraud. How can fraud be dealt with to reduce costs? The nature and prevalence of fraud may be the reason there is mistrust between payers and providers?

- Both staff within and without insurance companies propagate fraud, no less by providers and the insured.
- The industry is sitting in pockets of darkness whereby the payers 'do not talk' and have no information. This makes it easy for fraud to occur. Information on costs can help stem fraud. Instead of players forwarding their private interests, they should be interested in making the industry operate more efficiently.

What measures are players taking to reduce fraud, which contributes to 40 percent of costs in a health facility? Such joint measures are being taken in the banking sector. Why is not the same happening in the health insurance sector?

- All insurance leaders (CEOs) need to attend this meeting to discuss fraud, more so as it is a major cost item, constituting 40 percent of costs in an institution.
- The kind of fraud in which clients are given a cheaper product than they paid for needs to be fully addressed. This practice has eroded relationships between providers and consumers.

Regarding capitation, there is a law that says that one cannot underwrite. Is it legal to pass on risk to providers?

- When looked at from a classical insurance perspective, capitation should not be legal simply because it transfers risk to somebody ill qualified to manage risk. The begging question yet is the position of the health care sector on this matter.
- The insurable risk in capitation can be provided under the traditional indemnity insurance, under the class of catastrophic cover. Risk at the outpatient setting is minimal is however minimal.
- Capitation is unregulated in Kenya; however, it is not illegal. Capitation (provider based) is not about taking the risk to pay other providers, yet the provider is actually the one providing the service. Capitation is a different payment mechanism that only needs regulation.
- In a capitation model, how is the consumer protected? This problem needs to be immediately addressed by regulations.
- One of the key issues faced by providers is uncompensated care. Who pays for uncompensated care? The traditional approach is that the provider has to engage in some form of cost shifting to enable the provider keep afloat.

The benefit of the cooperation between providers and the insurers is different in a rural setting as compared to an urban one. In the rural setup, most populations cannot afford insurance and pay for health care OOP. How can providers serve this people? What approach can insurers take in having them as their clients and providing them with health services in totality?

- *Comment:* Insurance companies have been considering how to get into the low-income market. Several initiatives have been attempted, with private insurers working with microfinance institutions, SACCOs, and even donors in developing various models with mixed success.

6.2 GENERAL COMMENTS AND RECOMMENDATIONS

Comments

- On information sharing, it is paramount that this is disseminated to players, especially those who run health institutions. Such information can be beneficial in helping players make evidence-based decisions, especially by benchmarking information on costs and quality outcomes.
- Insurance providers are obliged to provide policy documents to patients and give information to providers about existing products. The insurance industry is moving towards standardization of all policy documents to enable consumers understand what products entail.
- The main reason health insurance markets are undeveloped or inefficient is due to adverse selection. The most effective way to deal with adverse selection is through mandates, which can then be combined with other options. Mandates therefore need not represent a 'straight jacket' for providers. Rather, they need to antecede the promise of universal health coverage. *Example:* The key ingredient in the health care reforms in America was the use of mandates.
- Infinite choice does not make people happier; sometimes limiting the extent of choice may be more effective.
- The IFC/World Bank is looking to working with Indian companies, which has developed a low cost delivery model. The IFC is thinking of how to transplant the idea to Kenya. The cost of getting a consultation in Kenya is high and can be twice as expensive as the cost of seeing say an obstetrician in India of comparable qualification.
- Whatever decision the Kenya government makes about the NHIF will affect profoundly anyone doing microinsurance. This reality has made some players avoid investing in the area. The debate on health care financing strategy and health insurance law must be concluded because without it, all players are walking in the dark.

Recommendations

- The next meeting should observe a balance in presenters between insurance providers, hospitals, and doctors.
- The aspect of the 'Process' needs to be first addressed and gotten right before moving towards the product and its construction. We must first build trust and relationships.
- The private sector providers and insurers should take the sophistication of the debate on mandates a notch higher and try to understand how mandates could work in the Kenyan market. They should not rule it out.

7. WORKING GROUP SESSION

Participants broke into four groups to discuss the following questions:

1. Opportunities to increase health insurance coverage;
2. Ideal design of affordable health insurance products;
3. Mechanisms to foster dialogue between insurers and providers; and
4. Opportunities to improve efficiencies and reduce risk through innovative PPMs.

The section that follows describes the key ideas that emerged. See Annex B for group work member list and Annex C for detailed group feedback.

Group 1: Opportunities to increase health coverage

Improving coverage is achievable if products are developed that create incentives for clients, buyers, and payers. Such products should bear the following characteristics:

- Have flexible premiums,
- Carry low margins (high volume), and
- Aggregated payment mechanism based on true cost information.

To achieve these objectives, there is need to explore novel options for provider payments, increase literacy levels, and deepen use of ICT. Compulsory health education would be welcome too.

Increased coverage, however, carries serious barriers that would need to be overcome. Measures are needed to reach out to low income groups, address quality concerns in health centers, curb fraud, and encourage insurers to be more sensitive to the needs and circumstances of various segments of the market.

As a way forward, the group suggested to the need to nurture trust among key stakeholders, lobby governments to fulfill its burden on health care provision, address cost of medication, and reduce exclusions.

Group 2: Design affordable health insurance products

There is need for a clear understanding and identification of the target group and address the pricing structures of existing products. The ideal package should include both in-patient and out-patient care to reduce fraud (exclusions need to be agreed). The package should motivate patients to manage their own health and encourage the reduction of costs of medication. The package should be comprehensive, complete with a wellness program and would entail collaboration between insurers and providers: these players need to be aligned on standards of care (uniform coding, diagnosis, and medication). The Health Benefits Authority could help in enforcing the standardization criteria. A suggestion to discount unused covers or upgrade unused covers to higher levels of cover was raised to add value to products.

Group 3: Mechanisms to foster dialogue between insurer and provider

Existing mechanisms for dialogue include those that involve settling of claims or dealing with crises. To deepen this dialogue, there is a need to solicit the support of the leadership of insurance companies, with CEOs being targeted. The setting of uniform standards provides

opportunities to enrich dialogue among players. There is a need to overcome negative attitudes and resistance to change.

As a way forward, the group identified the need to build relationships between insurers and providers through information sharing, carry out surveys and take action on outcomes.

Group 4: Opportunities to improve efficiencies and reduce risk through innovative PPMs

The opportunities of four key players were discussed: providers, payers, patients, and regulators.

Providers' opportunities include integrated IT systems, investing in management and operational capacity, and lobbying for the streamlining of regulatory agencies. Providers can protect themselves by hedging risks, while applying scientific costing models to reduce payer's risk. Mandatory health insurance with a choice of insurer could improve efficiency and reduce risks. Payers require capacity building on PPM, and they can also benefit from discounts from early payments negotiated with providers.

Patients need better information on their rights and need access to compliant mechanisms. Co-payments can be used to reduce over-use of services.

Regulators should standardization ICT policy in health and create institutions that harmonize provider regulation and quality standards. Mandatory cost reporting and tax incentives are required to promote efficiency.

The challenges to addressing the opportunities include lack of consensus on a benefit package, affordability of health insurance, fragmented interests of both providers and insurers and the time consuming aspects of quality control.

As a way forward, the group proposed a private sector working group to design a benefit package. This working group requires endorsement by the leadership of private insurance and provider institutions. Capacity building on PPM would be required and better partnerships between insurers and providers to align incentives.

8. WAY FORWARD

- Disseminate the Workshop report to all invited institutions.
- Continue this forum of engagement going forward and ensure inclusion of the right participants.
- Work through the professional associations[5] to continue the dialogue. SHOPS will continue facilitating the discussions.
- Both the private providers and insurers need to participate in the on-going policy and legal discussions around health financing.
- Consider how to use universities to analyze and store information on health management. The Universities of Nairobi and Strathmore have shown a keen interest in improving health management in Kenya, including health care financing issues.
- Identify a competent and reliable party to keep and disseminate information about the industry when required.
- Map the on-going initiatives in the country to avoid duplication and to help support the efforts to completion.
- SHOPS and IFC will continue to help insurers and providers access available information.

[5]Association of Kenya Insurers (AKI), Kenya Association of Private Hospitals (KAPH), KAH, health professional associations, Central Organization of Trade Unions, Federation of Kenya Employers, and Consumer Federation of Kenya

ANNEX A: LIST OF PARTICIPANTS

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ANNEX B: GROUP WORK MEMBERS LIST

Group 1: Opportunities to increase health coverage

- Catherine Waiyaki, Pacis Insurance Company Ltd
- Dr. Thiakunu, KAPH
- Paul Karanja, Catholic Health Commission
- Alex Onsongo, BRITAM
- Bedan Gichanga, USAID
- Lucy Kuria, APA
- Manal Moussa, Coptic Hospital
- Winnie Mbugua, Equity/Insurance

Group 2: Design of affordable health insurance products

- Dr. Benson Chum, Equity Group Foundation
- Irene Chesire, AON Kenya
- Dr. Gakombe, Metropolitan Hospital
- Gibson Muthamia, APA
- Kate Waiganjo, Microensure
- Dr Nelson Gitonga, SHOPS

Group 3: Mechanisms to foster dialogue between insurer and provider

- Winnie Rotich, AAR Health
- Dr. Lwai Lime, The Nairobi Hospital
- William Kiama, AKI
- Dr. Peter Kamunyo, AON Kenya
- Gordon Odundo, Gertrude's Children's Hospital
- Richard Ayah, University of Nairobi

Group 4: Opportunities to improve efficiencies and reduce risk through innovative PPMs

- Franciscah Nganga, Microensure
- Caroline Munene, AAR
- Dr. Denis Ogola, Avenue Hospital
- Lawrence Muiga, Mater Hospital
- Liza Kimbo, Viva Afya

ANNEX C: DETAILED GROUP FEEDBACK

Group 1

QUESTION	FEEDBACK
What opportunities exist to increase health insurance coverage?	· Develop products that: ✓ Bundle up conditions and cost them ✓ Give options to the client, provider, payer · Have flexible premiums · Increase efficiency to the client · Provider = low margin/high volume · Review the commission fees as it reduces on the benefits · Partner with providers and negotiate charges
How can we exploit these opportunities?	· Affordability of premiums = prorata payments · Target the 'chamas' /SACCOs · Increased literacy level & use the ICT and partner with low cost providers · Products targeting the BOP · Industry approach in partnership with providers on charges · Regulation & compulsory Health insurance · Education on all products to the clients
What challenges do you foresee in exploiting these opportunities?	· Market teams for the low income · Industry approach in negotiation with providers · Poor quality Health centers in the rural areas · Insurers not in touch with the mass market · Low volume / high margins · Private providers focus on urban areas · Lack of integrated ICT platform to access services · Collusion with providers (Fraud)
How can we move forward after this meeting?	· Build TRUST among the insurance industry/providers · AKI /KAPU meetings · Insurers & providers lobbing government on their role in care and accountability. · Private sector lobbing on the charges on drugs etc.

	· Customer care role of providers promoting insurance. · Reduce the exclusions = add value to consumer · Affordable height of cover · Reduce the avenues of FRAUD by having comprehensive products

Group 2

QUESTION	FEEDBACK
Feedback on Product Design of Affordable Innovative Products	· Costing of products do not address the needs of the patients. How do we deal with that? · There needs to be focus on the big picture. Where is the real problem? Are there poorly priced products? Should there be more cooperation on design? Should insurance companies consult service providers? · Is consultation necessary? Who should be seated at the design table? Would this be a solution for enhancing trust? One consults people they trust. Average cost initiative, how does is it cut? · Poor market perspectives creates a great barrier in designing affordable innovative products · While providers may be a poor channel to sell insurance, they are an excellent resource in product development. · Could we use data that is available? It could create a good trend on pricing · Who's customer is the patient? Service provider or Insurer?
What would be the ideal benefit package for affordable health insurance products?	· Should have all primary care conditions. STD/Is should they be excluded? · OP/IP should be part of the package. This reduces cases of fraud. With IT challenges, it exacerbates · Products should incentivize to manage cost. · They should be simple · Implement managed care. Seek care/provider at the appropriate level with Immunization provided by specialist, circumcision by professors. This should be an industry initiative….good example; Ultra-sound done sonographers not radiographers · Should include preventative care. Will deal with preventing/reduced chronic illness. · Disease management, treatment guidelines, affordable drugs. · Patient incentives on self-management care to manage health · Patient-centered care, they play a big role in disease management
What opportunities exist for collaboration between insurers and providers in design of affordable health	· Standardize care. Engage all parties (providers/Insurers) to create standards on care. Coding of diagnosis, procedures and drugs. (70% of hospital bills are on drugs). There are existing codes…ICD 10 is currently in use · Standardizing administrative functions to ensure efficiency

insurance products?	· Collaboration on information share. Form a neutral body to host data and share with the market. Universities, research institutions…etc. · Insurers are groping in the dark. They should engage the right professionals. Lack of business focus and adequate investment in health insurance for insurance companies leads to them designing poor products. · Create wellness programs within the product offering. · Discounting on unused covers to higher levels of cover at no extra pay to add value on the products · Health Benefits Regulatory Authority to help in standardization. Can it be hosted at AKI/MPAC/KHF and perhaps mediated by SHOPS

Group 3

QUESTION	FEEDBACK
What mechanisms currently exist for dialogue between insurers and providers?	· Settling claims · Forums · Crisis
What opportunities exist to improve or foster dialogue between insurers and providers?	· Client orientation · Involvement by the insurance company leadership
How can we exploit these opportunities	· Education, e.g. at University level · CEO's Relationship · Standardize approach
What challenges do you foresee in exploiting these opportunities?	· Attitude · Resistance to change
How can we move forward after this meeting?	· Create a good relationship between the insurer and provider through dialogue for mutual benefit and for the benefit client (patient) · Carrying out surveys and taking actions on the outcomes · Advocacy affluence · Information sharing- The information should be defined.

Group 4

QUESTION	FEEDBACK
What opportunities exist to improve efficiencies and reduce risk through innovative PPMs?	<u>Provider</u> · Integrated IT systems ✓ Internal HMIS Interfacing hospital HMIS with payers ✓ Interfacing with applications like smart · Insurance can offer provider up grading

	· Capacity building programs ✓ Management capacity ✓ Financial policy · Regulation – too many bodies · Hedging of risks <u>Payers</u> · Mandatory organized health financing mechanism (can choose insurer) · Negotiate incentives e.g. discounts for early payments · Capacity building on PPMs · Proper actuarial input · IT systems <u>Patients</u> · Knowledge of rights · Complaint channel · Co-payments <u>Regulation</u> · Standard ICT Policy in Health · Quality institute that regulates, similar to KEBS ✓ Autonomous · Harmonize provider regulation · Mandatory cost reporting to regulatory authority · Incentives, e.g. tax incentives
What challenges do you foresee in exploiting these opportunities?	· Fragmented interest in both insurers and providers · Quality control: Time consuming and requires a lot of man power · Consensus on health package · Affordability of package especially for the poor
How can we move forward after this meeting?	· Private sector initiated work group on implementation ✓ Develop a private sector lead minimum package of health · Executive endorsement/leadership for the working group · Partnership between providers and payers to align incentives · Start on capacity building on PPMs (source funding from donor partners)

ANNEX D: BIBLIOGRAPHY

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