September 13, 2021

Dr. Peter Kamunyo Gathege
Chief Executive Officer
National Hospital Insurance Fund
P.O. Box 30443 - 00100
Nairobi, Kenya

Dear Dr. Kamunyo,

We are writing on behalf of the Economic & Social Rights Centre-Hakijamii and the Center for Human Rights and Global Justice (CHRGJ) to request a response to the attached questions regarding the growing role of the private healthcare sector in Kenya.

Hakijamii is a leading national human rights organization that supports marginalized groups to claim their economic and socio-cultural rights. CHRGJ is a premier human rights center based at New York University School of Law in the United States. The Human Rights and Privatization Project at CHRGJ is focused on how the privatization of essential sectors and services affects the realization of human rights, particularly for low-income people. We will soon release a report on privatization of healthcare in Kenya. The report is based on extensive interviews and focus group discussions with community members, public and private healthcare workers, and community health volunteers living and working in informal settlements in Isiolo, Mombasa, and Nairobi; interviews with health and human rights experts, government officials, and other stakeholders; and a review of public documents, surveys, and laws related to health in Kenya.

Our research to date documents significant concerns about the growing role of the private sector in healthcare. These include high costs for individuals and the government, safety and quality concerns, and shortcomings with regard to public health priorities, accountability, and workplace conditions. People interviewed raised serious human rights concerns, reporting that they were denied and excluded from private facilities, received inadequate care from private providers, and were pushed into debt and economic hardship due to the high cost of private sector care. People in poverty, those with disabilities, rural residents, and women have raised particularly acute concerns.

We are writing to a number of government entities including the Ministry of Health, the National Treasury, the National Hospital Insurance Fund, the Public Private Partnership Unit, and the Auditor General. To ensure that our report accurately reflects the National Hospital Insurance Fund's position on these issues, we have attached an annex of questions to this letter. In order for us to reflect your responses in our upcoming report, we request that you respond to us by October 1, 2021; alternatively, we would be happy to discuss these questions and our report in a meeting at your convenience. We can be reached at rebecca.riddell@nyu.edu.

Thank you for your attention to this matter.

Philip Alston
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Annex: Questions for the National Hospital Insurance Fund

Does the National Hospital Insurance Fund (NHIF) have a response to the preliminary findings of our research?

At first, we couldn't give an adequate response to this question because we hadn't accessed your mentioned preliminary findings. However, after sharing with us the hard copies of your report, which we have gone through, and which is also accessible via url: https://chrgj.org/kenya-health/ ,we have found your recommendations towards rethinking the support for the private sector timely and welcome and we support the idea of ensuring that both the health policy and expenditure are prioritized in favor of the existing public system to guarantee accessible, affordable and quality care for all Kenyans.

What is the total number of NHIF principal members and dependents? What is the total number of currently active NHIF principal members and dependents? Of those who are currently active, how many are NHIF SUPA Cover principal members and dependents?

As at 30th June 2021 the data is as follows: -

No.	***Members***	***Totals***
1	*Total Principal Members*	*12,921,364*
2	*Dependants*	*16,797,773*
3	*Active Members*	*5,325,744*
4	*Active members and Dependants*	*12,249,211*

For the most recent year available, how many total facilities are empaneled with the NHIF, and of those, how many were private for-profit facilities, how many were faith-based/NGO facilities, and how many were public facilities? And in 2011?

Hospital Category	**Total No. of Facilities in the Country**	**No of facilities Contracted by NHIF**
Government	6,039	5,831
Faith-Based	1,061	311
Private	5,803	1,524
Total	**12,903**	**7,666**

As at 30th June 2021

Service rates and expenditure

Independent research suggests that the NHIF reimburses private facilities at higher rates than public facilities for certain inpatient and outpatient services.[1] Does the NHIF make public any information about the rates it pays to private and public facilities for services, including both capitation rates and fee for-service rates? If so, could you direct us to that information? If not, could you kindly provide us with the information?

[c m,k]; Mbau, R., Kabia, E., Honda, A. et al. "Examining purchasing reforms towards universal health coverage by the National Hospital Insurance Fund in Kenya," Int J Equity Health 19, 19 (2020), Table 3: NHIF Provider payment methods and rates, https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1116-x/tables/3.

Reimbursement rates are based on individual contractual agreements between NHIF & the hospitals. It is possible to obtain this information from individual hospitals. The Fund strives to declare and contract as many hospitals as possible so as to ensure that all members access NHIF benefits regardless of their geographical location across the country. NHIF has an objective declaration and contracting criteria and guidelines that aims at encouraging hospitals to move towards quality improvement. Accredited healthcare providers are those recognized by the Fund and allowed to offer services to NHIF members and claim reimbursements thereof. Declaration and contracting of a healthcare provider takes into account the services, personnel, infrastructure and equipment among other issues that the institutions have. The level of rebate therefore corresponds to the grade after scoring the various aspects.

The Fund engages providers to offer the benefits the members are entitled to. The contractual agreement with the provider defines the liability to the Fund. For the beneficiary, the information given is related to the benefit and the provider where the member can access the service. The deviation to this is the Optical and Dental benefits for the enhanced schemes where members are informed of the limits of cover.

In the contractual terms of engagement and the claims management process, eligibility and disclosure of the services covered and liability to the Fund, is an obligation of the provider.

On the reimbursements, historically, the reimbursement amounts have been higher in non-GOK providers. The implementation plan on benefits revision sought to standardize the scope, nomenclature, and reimbursement amounts, and this has been implemented in the 2021-2024 contract cycle with the providers.

Does the NHIF disaggregate its spending on benefits and claims at private for-profit facilities, faith-based/NGO facilities, and at public facilities? If so:

- **Please provide the total NHIF expenditure on claims every year between 2010/2011 and 2020/2021, as well as the NHIF expenditure on claims at private for-profit facilities and at public facilities, for each of those years**.

Disaggregating spending on benefits in terms private for-profit facilities, faith-based facilities and public facilities has not been the major lens through which benefits utilization are viewed. However, it is still possible to generate this data as illustrated here below:

NHIF BENEFITS EXPENDITURE FROM 2010/11 TO 2020/21

CATEGORY	FY 2010/11	FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15
GOVT (G)	1,210,546,085	1,613,370,547	1,758,808,352	1,933,455,546	1,935,215,711
FAITH BASED (M)	1,438,841,641	1,320,841,643	2,172,643,542	1,448,621,188	1,806,490,433
PRIVATE (P)	1,109,039,736	2,518,664,783	3,251,789,201	3,949,696,986	4,649,832,871
OTHER SERVICE PROVIDERS	-	546,892,300	1,053,035,064	1,105,207,981	1,675,818,797
OVERSEAS (F)	-	-	-	95,981,613	202,042,603
TOTAL	**3,758,427,461**	**5,999,769,274**	**8,236,276,159**	**8,532,963,314**	**10,269,400,415**

CATEGORY	FY 2015/16	FY 2016/17	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21
GOVT (G)	2,999,131,981	4,275,243,985	5,641,120,389	10,451,769,441	10,840,082,004	10,641,071,393
FAITH BASED (M)	2,780,945,394	4,179,638,606	6,639,978,273	9,312,672,663	9,024,247,671	8,364,439,750
PRIVATE (P)	7,008,473,532	16,876,195,852	24,413,574,348	31,718,898,921	32,626,231,782	34,412,458,046
OTHER SERVICE PROVIDERS	1,788,724,705	1,135,549,712	2,093,455,374	1,794,642,767	1,605,783,288	643,769,429
OVERSEAS (F)	482,116,094	57,552,191	273,212,853	146,563,480	266,247,228	-
TOTAL	**15,059,391,706**	**26,524,180,346**	**39,061,341,237**	**53,424,547,272**	**54,362,591,972**	**54,061,738,618**

Please provide the total number of services the NHIF covered every year between 2010/2011 and 2020/2021, as well as how many of these services were provided by private for-profit facilities and by public facilities in each of those years.

Benefit Utilization for the Period 1st July 2020 to 5th July 2021 for the Financial Year 2020/21

Benefit Package	Count	Total Claim	Government	Faith Based	Private
Inpatient	717,015	11,758,039,949	2,351,607,990	1,998,866,791	7,407,565,168
CS Delivery	63,090	1,666,544,994	333,308,999	283,312,649	1,049,923,346
Normal Delivery	174,509	1,182,436,133	236,487,227	201,014,143	744,934,764
Renal Dialysis	284,838	3,072,830,472	614,566,094	522,381,180	1,935,883,197
Rehabilitation	625	129,608,771	25,921,754	22,033,491	81,653,526
Outpatient	1,615,110	7,890,758,804	1,578,151,761	1,341,428,997	4,971,178,047
Minor Surgery	26,501	752,846,298	150,569,260	127,983,871	474,293,168
Major Surgery	70,365	6,217,138,668	1,243,427,734	1,056,913,574	3,916,797,361
Optical	43,780	474,376,529	94,875,306	80,644,010	298,857,213
Dental	33,143	313,471,955	62,694,391	53,290,232	197,487,332
MRI	27,426	420,020,841	84,004,168	71,403,543	264,613,130
CT Scan	24,179	272,778,800	54,555,760	46,372,396	171,850,644
Basic Chemo	32,150	566,375,018	113,275,004	96,283,753	356,816,261
Complex Chemo	11,417	860,918,790	172,183,758	146,356,194	542,378,838
Radiotherapy	1,035	62,388,914	12,477,783	10,606,115	39,305,016
Specialized Surgery	4,174	1,260,062,378	252,012,476	214,210,604	793,839,298
FMC Antenatal	81,357	45,097,478	9,019,496	7,666,571	28,411,411
FMC Postnatal	19,957	5,449,085	1,089,817	926,344	3,432,924
PET scan	927	35,398,450	7,079,690	6,017,737	22,301,024
Covid 19	614	358,707,050	71,741,410	60,980,199	225,985,442
Overseas Treatment	195	122,369,918	24,473,984	20,802,886	77,093,048

	3,232,407	37,467,619,296	7,493,523,859	6,369,495,280	23,604,600,156

NOTES:

The above table shows claims received and processed up to payment for the various benefit packages and for the different schemes as at 5th July 2021 for the 2020/21 FY. It excludes claims received and processed past 5th of July 2021.

It also excludes payout made for emergency road and air evacuation services, group life, last expense, and scheme administration fees.

The huge variance as to payout to the different facility ownership (i.e., Government, Faith Based and Private) can be explained as follows;

- NHIF's financing mechanisms are designed in such a way that they accommodate the cost of health service delivery to the different facilities. Reimbursement rates accorded to government hospitals is significantly less than that set for private-for profit and not-for-profit facilities due to the highly subsidized rates, and government free programs for certain disease conditions like HIV/AIDs, TB, Immunization programs and under 5 medical treatments. Additionally, the cost of rent and workforce emoluments is not included in the fees.
- Most of our Government healthcare providers fail to remit any claims for services accessed by our beneficiaries due to poor infrastructure i.e., lack of laptops or computers, internet connectivity and lack of essential services including medicines and basic diagnostic investigations especially in Level II-IV facilities countrywide.
- In the spirit of promoting equity and equality with respect to access of our benefits, the Fund does not control where her beneficiaries access services, it is solely the beneficiary's choice. Most of our beneficiaries prefer accessing services in private and faith-based facilities. In the financial year 2020/21, 18% of our members preferred accessing GOK facilities with 7% of them visiting Level 5 and 6. The rest of the 88% preferred to seek services in Private and Faith based facilities

As you will see from the sample data extract, Majority of NHIF members have chosen private and faith based facilities to access their outpatient facilities. This explains why reimbursements are higher in the non-government healthcare providers.

Medical OP services

PPM: Capitation

Selection: Self selection from a pool of 6,800 providers, >75% are GOK

Assumption: Selection as an indicator of preference

New_NS		Q1_20/21	Q2_20/21	Q3_20/21	Q4_20/21
	GOK	1,121	1,221	1,357	1,463
	PVT	2,392	2,392	2,519	2,531
	FB	482	515	516	529
		3,995	4,128	4,392	4,523
		Q1_20/21	Q2_20/21	Q3_20/21	Q4_20/21
	GOK	28%	30%	31%	32%
	PVT	60%	58%	57%	56%
	FB	12%	12%	12%	12%
Cum		Q1_20/21	Q2_20/21	Q3_20/21	Q4_20/21
	GOK	447,398	536,479	720,063	713,214
	PVT	1,624,072	1,803,903	2,113,263	2,270,705
	FB	659,139	733,388	835,003	898,630
		2,730,609	3,073,770	3,668,329	3,882,549
		Q1_20/21	Q2_20/21	Q3_20/21	Q4_20/21
	GOK	16%	17%	20%	18%
	PVT	59%	59%	58%	58%
	FB	24%	24%	23%	23%

Please Note:

Using self-selection data for OP services as an indicator of the beneficiary preference, about 18% of the population currently covered would prefer to access services at GOK providers, despite >75% of the providers in the panel of facilities offering OP services being GOK facilities.

- **For the most recent year available, how much did the NHIF pay in outpatient benefits, and of that total, how much went to private for-profit facilities and how much went to public facilities? And in 2011?**
  -Make reference to the benefit utilization table above.

- **For the most recent year available, how many outpatient services did the NHIF cover, and of that total, how many were in private for-profit facilities and how many were in public facilities? And in 2011**?
  -Make reference to the benefit utilization table above.

Inpatient benefits and services

- **For the most recent year available, how much did the NHIF pay out in inpatient benefits, and of that total, how much went to private for-profit facilities and how much went to public facilities? And in 2011?**
  -Make reference to the benefit utilization table above.
- **For the most recent year available, how many inpatient services did the NHIF cover, and of that total, how many were in private for-profit facilities and how many were in public facilities? And in 2011?**
  -Make reference to the benefit utilization table above.

Accreditation and regulation of private facilities

The designers of Social Health Insurance (SHI) which is what NHIF offers, have to consider how to promote the efficiency and quality of health care under SHI framework. Essentially, they have three

strategies to choose from: create competition, use rational payment methods, and decentralize. For each strategy, the designer has to consider the role of the private sector and how to create a level playing field between the public and private sectors to harness the private sector's resources and enterprising spirit. Private providers (charity and for-profit) play a major role in delivering health services and these resources have to be harnessed and managed for people's benefit. In this regard, NHIF encourages healthcare provision by public, faith-based and private facilities.

Does the NHIF impose any requirements on accredited private facilities regarding?

- what services must be offered; Yes
- what medical equipment must be operational; Yes
- how much they can balance bill patients for services whose cost is only partially covered by NHIF reimbursement; NO NHIF does not dictate the max payable amount for top ups
- in what areas of the country or neighborhoods they must operate; No
- staffing levels, qualifications, or ongoing education; Yes
- staff compensation rates or benefits; In order for staff to access NHIF benefits, their respective employer (HCP) must be actively paying NHIF contributions. NHIF does not dictate facilities' employees' salaries.

Or any other public health related obligations or requirements? Yes, they must follow all laws and rules as guided by the Constitution of Kenya and Ministry of Health guidelines and protocols.

Does the NHIF terminate the accreditation of private facilities due to fraud or poor standards? If so, over the past five years, how many private facilities have lost their accreditation?

NHIF terminates contracts and revoke the declaration status if investigations done qualify for fraud and if the quality of standards is poor. This is guided by Health Care Providers (HCP) contracting policy, Quality Assurance policy and the NHIF ACT No 9 of 1998. 11 HCPs have lost their declaration status since 2018/19 FY.

Does the NHIF track the amount of money lost to fraudulent medical claims from private facilities? If so, could you please provide this figure for the last five years?

NHIF has an active Fraud unit that undertakes investigations for fraudulent cases. As guided by section 25 (4) (i) & (ii) hospitals found engaging in fraud should face a punishment in form of convictions, fines and suspension from the list of declared hospitals. Due to the complex nature of healthcare services, it is not always obvious to give an exact figure of the amount lost in fraud and other healthcare inefficiencies. The World Health Report 2010 estimated that 20% to 40% of all health spending is lost through inefficiency.

What accountability measures, if any, are in place for those whose rights are affected by accredited private facilities?

Reported offences related to benefits would be subjected the criteria established under NHIF Act section 25 (4) (i) & (ii) and the applicable action determined accordingly. In addition, persons whose rights have been violated are free to seek any other legal redress availed by the Constitution and other applicable laws of the land.

Affordability

Has the NHIF performed any assessment of the affordability or economic impact of the Ksh 500 SUPA Cover monthly fee on households? If so, what are the results of the assessment and can you share a full copy of the findings?

The success of an SHI system depends largely on its ability to enroll and collect premiums from the population and the government's ability to subsidize premiums for the poor. Extending SHI to cover the non-poor, the self-employed, and employees in the informal sector presents the greatest challenge to Social Health Insurance (SHI), as they do not work for organizations where SHI premiums could be deducted from their salaries. In addition, it is not always easy to ascertain the exact earnings for each individual employed in the informal sector. However, considering that Universal Health Coverage cannot be achieved without providing a health insurance cover to this category of the population an attempt to keep the premiums as reasonable as possible is made to provide an incentive for them to enroll. A premium of **KES 500** which translates to **KES 17** a day has been shown to be non-sustainable with the current scope and depth of the benefits offered. From internal and external actuarial reports, correcting for the impact of adverse selection and poor retention in the informal sector voluntary contributors, a KES 10,200 premiums per household per year; or a reduction of the scope of cover or external financing to bridge the KES 46 billion financing gap projected in year 1 of whole population coverage; will be necessary to sustainably cover the projected population of 12.74 million households.

For the most recent year available, how many households and individuals were beneficiaries of the national health insurance subsidy programme? In that year, what were the eligibility criteria?

The beneficiaries of the national Health Insurance Subsidy Program (HISP) constitutes of the Orphans & Vulnerable Children who benefit from Cash Transfer Programme (OVC-CTP). The cash transfer beneficiaries are targeted, identified, and registered to receive cash transfers by the Ministry of Labour and Social Protection. HISP provides membership not only to the Orphan but to all members of the household. The total number of households under HISP is **181,968**

In 2020, the government announced its intention to cover the cost of NHIF membership for one million vulnerable households unable to pay. Could you please provide an update on the status of that initiative? Specifically:

- how many households are currently being covered as a result of this initiative;

The identification of the intended beneficiaries was done in all the 47 counties by the county governments themselves and data submitted to NHIF to verify through **Integrated Population Registration System** (IPRS) and auto register as payment of the premiums by the government is awaited. An accurate figure will be ascertained once the verification process is completed

- what criteria were used to identify the households; and

The county governments were responsible for identification of the households guided by data from Ministry of Labour and Social protection.

- how long will each household's membership be covered for?

The Government will pay annual premiums for each household of the identified vulnerable persons

An estimated 17.1 million people lived under the national poverty line in 2015. Aside from HISP and the government's announced plan to cover one million vulnerable households, what measures, if any, does the NHIF take to ensure that coverage is affordable for poor Kenyans?

NHIF is committed to make a contribution towards universal health coverage in the provision of affordable accessible, sustainable and quality health insurance through strategic resource pooling and healthcare

purchasing in collaboration with stakeholders. In ensuring that the coverage is affordable for poor Kenyans, some of the initiatives that have been put in place include a recommendation to have the government pay for the poor households in the ongoing reforms. In addition, NHIF has engaged County Governments to extend coverage to the vulnerable persons through sponsorships. Several County Governments have subscribed to the UHC Sponsored programs. They include Lamu, Kisumu, Busia, Laikipia, Baringo and Marsabit County among others.

Moreover, NHIF lobbied the NG-CDF Board together with the National Assembly Select Committee to support provision of a budget for sponsorship of vulnerable persons. Consequently, it was resolved that funds set aside for the social security program shall be used for health care financing of the vulnerable persons in the community in line with the National Government's goal of providing affordable healthcare in tandem with the Big Four Agenda. Consequently, there are 30 NG CDFs who have sponsored the vulnerable in their respective constituencies.

The National Hospital Insurance Fund (Amendment) Bill, 2021

What is the status of the National Hospital Insurance Fund (Amendment) Bill, 2021? Is the Government still seeking to achieve passage of the Bill and, if so, what is the timeline for passage?

On 28th September 2021 Parliament passed the National Hospital Insurance Fund (NHIF) Amendment Bill 2021 at the sitting of the committee of the whole house.

On the 29th of September the Bill then proceeded for Third Reading where it was passed and forwarded to the Senate for consideration.

With the introduction of bicameralism under the Constitution of Kenya 2010, the consideration of bills affecting County governments that originate from Parliament are referred to the Senate for deliberation. The NHIF Bill will affect the health sector and considering Health is a devolved function that squarely falls within the purview of the county government, it is trite law that it be forwarded to the Senate.

The Bill was forwarded to the Senate after Third Reading in the National Assembly, for consideration and passage .The Senate will process the Bill following the same process of considering ordinary Bills, beginning with First reading through to the Third reading.

If the Senate passes the NHIF Amendment Bill without amendments, the Senate, by way of message will refer the Bill back to National Assembly .Thereafter, Speaker will presents the NHIF Bill to the President for assent.

We are aware of reports that the National Assembly Committee on Health has rejected the proposal in the Bill that NHIF membership be made mandatory. Is the Government still seeking make membership mandatory, or has this proposal been dropped?

The proposal to make membership mandatory for all was still intact when the bill was forwarded to the senate

Has the NHIF prepared any projections for estimated revenue and expenses over the next ten years if the Bill were to pass with the mandatory membership provision included?

There are very elaborate projections for both revenue expenditure and the details of the same are available in Health Financing Reforms Expert Panel For The Transformation and Repositioning of National Hospital Insurance Fund as a Strategic Purchaser of Health Services For The Attainment of Universal Health Coverage By 2022 Report (HEFREP Report 2019) [pg. 164-166]

What type of NHIF coverage would households receive under the Bill? Is this information publicly available?

A team was selected from MOH and NHIF to develop a harmonized UHC benefit package. The team evaluated the NHIF Supa cover benefit package and the UHC Health Benefits Package proposed by the Health Benefits Advisory Panel and came up with a harmonized proposed benefit package which is yet to be validated. Once validated, the information will be made public.

Did the NHIF assess the affordability or impact of mandatory monthly contributions for poor households? If so, what are the primary findings?

The focus of NHIF and the Government is to ensure Universal Health Coverage (UHC). As such, a lot of attention has been directed to this noble goal. Underpinning UHC is the goal to promote individual well-beings as well as the collective good of all Kenyan residents. Under the UHC arrangement, the government intends to provide a health insurance cover to the poor households.

What is or was the plan to support individuals who could not afford a monthly NHIF contribution? Please include specifics regarding how these individuals will be identified, how their coverage will be funded, and where in the government responsibility lies for ensuring that those who need support are receiving it.

The categorization of members in the journey to Universal Health Coverage consist of formal sector workers, who make income rated premium contributions automatically through payroll deductions, and informal sector workers who remit a monthly premium contributions at a flat rate of KES 500 per month per household and the third category of poor households that are supposed to be identified and supported by Government through subsidies.