DEVELOPING PREPAID HEALTH PROGRAMS IN KENYA:

A PRIVATE INSURANCE ASSESSMENT

MARCH 16 TO APRIL 22, 1994

by

Michael Enright, PROFIT Project
Danel Kraushaar, Sc.D., Kenya Health Care Financing Project
Derek J. Oatway, Kenya Health Care Financing Project
Gerrishon K. Ikiara, Kenya Care Health Financing Project

Contract Nos.: DPE-3056-C-00-1040-00
DPE-3056-Q-1041-00

June 2, 1994

TABLE OF CONTENTS

SECTION I. EXECUTIVE SUMMARY

As part of USAID/Kenya's ongoing assistance to the Ministry of Health ("MOH") with its Five Year Implementation Plan for Financing Health Care in Kenya, a five-week consultancy was designed to explore opportunities for expanding the role of private sector health insurance. The consultancy was conducted under the supervision of USAID/Kenya and its Kenya Health Care Financing Project ("KHCF"), managed by Management Sciences for Health ("MSH"). The consultancy was financed by PROFIT, a centrally-funded project mandated to work on commercial sector family planning initiatives. PROFIT, USAID/Kenya and KHCF jointly selected a US-based consultant, Mr. Michael Enright, who worked with three counterpart consultants while in Kenya including Mr. Derek Oatway, an insurance consultant for KHCF; Professor Gerrishon Ikiara, an Economist from the University of Nairobi; and Dr. Danel Kraushaar, Chief of Party for the KHCF. This document represents the final report of the consultancy.

Objectives

The objectives of the consultancy were to determine private insurance options in Kenya for health and family planning services, identify and recommend the most feasible options for private health insurance initiatives, and develop a plan of action for implementing the recommended initiatives. Through its work with the MOH, the KHCF project has worked closely with the National Hospital Insurance Fund ("NHIF"), the government's health financing mechanism. While important changes to NHIF's role may be forthcoming, significant concern still remains with regard to the NHIF's current limitations. As importantly, private medical options in Kenya are also quite limited, and few public/private sector initiatives have been considered. Thus, the rationale for the consultancy arose from an urgent need for a thorough review of the current obstacles to, and requirements for, the expansion of private insurance options in Kenya and potential opportunities for public/private sector collaboration. This potential expansion of private sector options is viewed as a complementary effort to working towards improving the effectiveness of the NHIF, and Kenyan health financing in general.

Insurance Schemes

The five-week consultancy was structured to include an initial workshop, three weeks of information gathering and a final workshop. At the workshop sessions, representatives from the private health insurance industry, NHIF, KHCF and the consultants gathered to exchange information, offer insights and make presentations. At the initial workshop, the group identified three prepaid insurance schemes most appropriate and feasible for Kenya, including "managed care", "cooperatives" and "indemnity". These schemes, or areas of activity, served to organize the subsequent information-gathering efforts and company visits managed individually by each of the three counterpart consultants.

As part of the information-gathering process, and in the context of the three schemes, existing insurance models in Kenya were analyzed to determine obstacles to growth and potential areas for support. Emphasis was placed on those entities with an established infrastructure, organizational structure and readily identifiable, if not active, subscribers. The analyses of the schemes and existing models appear in Section III of this document. A summary of each follows below.

The managed care scheme is defined as having characteristics normally associated with traditional health maintenance organizations ("HMOs"). Although not HMO's properly defined, three existing models in Kenya were identified as having operationalized certain aspects of the managed care model, including; African Air Rescue ("AAR"), Royal Medicard ("RM") and Chogoria Hospital.

The second type of prepaid scheme considered was using cooperatives as a venue for offering insurance. This option was attractive because of the economic strength of some cooperatives, their relationships with members which would facilitate collecting premiums, and their sizable membership, which is seen as a large enough pool to be a reasonable insurance risk. The only example of existing insurance models found under this scheme was Chogoria Hospital, which was providing coverage to area cooperative members and utilizing their cooperatives as a financing mechanism, albeit to a limited degree.

The third scheme, traditional indemnity plans, was explored with the intent of enhancing the effectiveness of existing plans. Traditional indemnity insurers in Kenya have not been able to provide more than a few products. Indemnity health insurance often has been offered to groups that were too small, made of self-selected subscribers, and who have tended to consider health insurance a short term rather than a long term investment. It was recommended that two ideas within this scheme be pursued. First, was to focus support on mutual companies, the primary model being Cooperative Insurance Services ("CIS"). Secondly, was to pursue a pooling approach, or the development of insurable pools by the grouping of several small companies together for the purpose of creating an attractive insurance risk.

Findings and Recommendations

As a result of the work completed during the consultancy, a work plan was formulated which set out ideas for specific initiatives to support the growth, development or broadening of services of selected models. The work plan is pragmatic in its listing of specific tasks, and is divided into short term and long term initiatives. The short term plan sets out tasks for which much of the required funding can be identified immediately and initiated with current USAID authorized funds. The second component of the work plan is of a longer term nature, identifying tasks which will require resource support from other donors. A summary of the work plan follows below:

Short Term

1. Assist AAR expand and improve its service delivery on both a geographic and socioeconomic basis. Explore the potential for developing AAR into a fully integrated HMO.

2. Assist Royal Medicard develop into (or towards) a true Independent Practice Association.

3. Assess the Chogoria Hospital (rural hospital) financing arrangement with Apollo Insurance and area cooperatives. If financially sound, develop a replication plan and train the CHAK Management Support Unit to implement it.

4. Pilot a program oriented towards providing health insurance to small employers, presently with little or no access to private health insurance, through a pooling concept.

5. Provide support to Cooperative Insurance Services ("CIS") to initiate development of a plan for one medium-sized cooperative.

6. Explore a pilot project with AAR on contract management of GOK hospital ancillary services, e.g., lab or x-ray.

Resources available for these potential initiatives would likely come from the remaining resources of the KHCF project, USAID/Kenya or from the PROFIT project. For certain cases, additional resources will be sought from other donors. The KHCF project is in the process of proposing to direct much of its remaining resources towards working with private sector health insurance. Consistent with its mandate, the PROFIT project is interested in providing family planning technical assistance and financial support to initiatives involving family planning service delivery in a substantive manner.

Long Term

An outline of a longer term set of activities was recommended as part of this report. It is envisioned by those participating in this consultancy that the time horizon for developing meaningful prepaid health schemes will be longer term in nature due to the magnitude of the social change involved, and the degree of economic development required. Development of a more detailed long range plan will be a critical step in such a planning process. Specific ideas for other donors and over the longer term include:

1. Assistance in replicating Chogoria and CIS models.

2. Strengthening and further development of CIS support and effort to develop insurance for cooperatives.

3. Support in the development of other managed care models.

4. Exploration of the extensive privatization of Government ancillary services as part of the expansion of managed care arrangements.

5. Training of insurance industry.

6. Formulation of public/provider education on insurance

SECTION II. BACKGROUND AND INTRODUCTION

Health Financing in Kenya

Due to decreasing government resources for health and poor economic performance in Kenya, the quality and accessibility of health care services for Kenyans have declined over the last decade. Currently the Ministry of Health is involved in an extensive health care reform program which is designed increase revenue generation, rationalize resource allocation, and increase efficiency of public sector health care. This program also involves efforts to augment the overall resources available for health care by increasing the population covered by health insurance, and expanding insurance benefits. An increased role in health financing for the government-funded social insurance program, the National Hospital Insurance Fund, and private insurance sector forms the basis for these efforts.

Currently, available health insurance options through both the public and private sector are limited with only 25% of population covered by any type of health insurance. Eligibility for NHIF benefits is restricted to civil servants and those employed by the formal sector and coverage includes only in-patient costs. Low claims payout, delays in reimbursement, general weakness in claims management and administration of the fund, and exclusion of the non-wage sector and rural populations negatively impact the quality and access of NHIF coverage.

Up to now the private sector has had only nominal involvement in the provision of health insurance in Kenya, serving almost exclusively upper and upper-middle class urban dwellers. According to a recent insurance study, only two of the 38 registered insurance companies in Kenya provide stand-alone health care coverage. Insurance companies do not consider health insurance as a profitable investment and only offer it as a loss-leader. Overall, the available health insurance products tend to be expensive and highly selective.

KHCF Activities

The USAID-funded Kenya Health Care Financing Project ("KHCF") has worked closely with the MOH it its efforts to strengthen Kenya's health financing and service delivery systems of Kenya through the Five Year Implementation Plan for Financing Health Care. In light of the current health financing situation in Kenya, KHCF now sees the expansion of health insurance as one means of increasing access to health services, increasing quality and allowing for adequate financing of services.

While continuing to assist the NHIF in broadening its coverage and strengthening its operations, the KHCF project is also engaged in developing alternative insurance options through the private sector. These activities are intended to complement the NHIF, and in some cases cooperate with it administratively if proposed legislation to revise the Insurance Act are passed.

Building on past efforts to understand the private sector health financing in Kenya, this consultancy was conceived to recommend specific approaches to expanding private health insurance coverage. The consultancy entailed a review of existing approaches to private

insurance, an assessment of current status of insurance in Kenya, identification of specific insurance options most appropriate to the Kenyan context, and definition of a detailed plan of activities to be conducted following the assessment.

Rationale for Expanding Private Sector Involvement

The overall objectives for the development of private insurance in Kenya are to increase access and improve quality of health services for as many persons as possible. There was discussion throughout the assessment process about the validity of supporting efforts to expand involvement of the private sector in Kenyan health financing. It was agreed that the primary benefits would be the following:

- Strengthening private health insurance will increase the overall pool of resources available for the health care system.

- Shifting the burden to the private sector for those who can afford to pay for services relieves the government of some cost subsidization. Eventual decompression of the public health system is possible by financing care at the upper limits, so that skills and services developed efficiently and at low cost can be more affordable for poorer persons.

- Developing private insurance provides an opportunity to combine many private sector options for financing health care including user fees, insurance and employee benefits, health maintenance organizations, and other non-governmental organizations, and perhaps some government revenue, or legislative authorization.

Developing the options proposed through this consultancy provide an opportunity to test the significance of these assumptions in the Kenyan context.

PROFIT Project Involvement

As a project mandated to increase the for-profit private sector's contribution to family planning activities in developing countries, the PROFIT project is deeply involved in addressing these issues. A.I.D.'s Office of Population designed the PROFIT Project to develop creative approaches to the provision of high quality, sustainable family planning services and products. This is achieved through investment in commercially sustainable ventures with private sector partners. PROFIT's subproject investments are made in collaboration with other local partners, and on a recuperative basis. Emphasis is placed on commercial viability and achievement of specific family planning objectives, including greater access to services, improved quality of care, and increased overall resources for family planning activities.

PROFIT has developed significant experience in the area of private health insurance specifically expanding the coverage and provision of family planning services and products through prepayment plans. Relevant subprojects include a joint venture with the largest HMO in Brazil and the development of a pilot low cost health insurance plan with PhilamCare, one of the Philippines largest insurance providers. PROFIT's subproject experience indicates that there are

substantial benefits to working with private health insurance providers, including; the existing service infrastructure, large client base, management expertise, and market knowledge.

PROFIT's participation in this Kenyan consultancy arose from discussions with KHCF as a part of PROFIT's assessment of private sector family planning initiatives in August 1993. The symmetry between PROFIT's mandate and private sector experience and the objectives of KHCF's private health insurance initiatives gave rise to an effective cooperation on this assessment.

In addition to selection and management of the consultant to conduct the assessment and participation in the closing workshop, PROFIT will likely contribute funds and technical assistance to pursue a subproject in collaboration with one or more of the models identified in the assessment.

Purpose and Methodology

The purpose for undertaking this consultancy was to assist USAID/Kenya and the KHCF Project to explore alternatives for developing prepaid health care schemes in Kenya. In preparation for the consultancy, background information was compiled on primary issues related to prepaid health schemes, and health insurance experiences from other countries, summarized in Appendix A. The method for doing the work was to convene two workshops to discuss available options for private insurance. The workshops were attended by 30 participants including health care providers, insurance company representatives and health system planners. For a listing of all participants and persons contacted see Appendix B.

The first workshop focused on two areas of discussion. One was a discussion of the functioning of health insurance in other countries. The second was group discussion which resulted in the identification of three prepaid health schemes which were considered most suitable to the Kenya; including managed care, cooperatives and indemnity plans. The group also identified several organizational settings as models for immediate feasibility assessment.

During the three week period between workshops, field investigation was conducted on the models identified by each working group at the first workshop. Each option had a principal consultant assigned and regular meetings were held for coordination and supervision. Many interviews were attended by persons from more than one group because of the opportunity to discuss more than one scheme. The results of the interviews were summarized and distributed to the attendees of the first workshop five days prior to the second workshop. At the second workshop, criteria for evaluating insurance schemes were reviewed, the results of the field work was discussed, and comments were elicited from attendees. The criteria for evaluating health schemes are presented in Appendix C. The comments elicited have been incorporated in Section IV of this document. In the following section, a summary of the presentations on each insurance model investigated is presented.

SECTION III. HEALTH INSURANCE MODELS - MANAGED CARE SCHEME

AAR MODEL

Overview

AAR was reviewed because it is the best example of an HMO in Kenya. Africa Air Rescue (AAR) is a fully operational pre-paid staff model Health Maintenance Organization (HMO). Enrollment is voluntary through large employers or by (more expensive) individual membership. Outpatient care is provided through AAR's own Medical Center utilizing AAR's own clinical staff. Members may also select in-patient coverage for an additional premium. In-patient coverage is made available through agreements with existing insurance companies but arranged for members by AAR.

For the outpatient medical scheme, premiums are based on the number of people a given employer wishes to insure. Premiums are reduced as the number of employees to be covered increases. Enrollment in the Medical Center outpatient scheme entitles employees to unlimited outpatient provider consultations, lab tests and x-rays and drugs without any co-payment. Specialist charges are also covered provided that the member is referred after consultation with AAR's own medical staff.

As in any HMO, AAR tries to control costs and reduce unnecessary, more costly in-patient care through its outpatient services. By controlling costs AAR is able to increase its profit margin and provide a competitive premium to members and employer. By running its own clinic it eliminates the administrative burden faced by employers in receiving and making payments for independent and unverified claims from providers and pharmacies. Inpatient services, insured under AAR through a brokered in-patient plan with a local insurance company, has all the strengths and weaknesses of a traditional indemnity plan, with the exception of the gatekeeper function provided by AAR salaried physicians.

AAR is interested in expanding its current operations/methods to other parts of Kenya and is also interested in other types of expansion provided that limited technical and possibly financial assistance is obtained.

Strengths

A. AAR has a keen and highly professional management staff who recognize the lack of information in many areas; and have a keen desire to improve their operations. Limited, focused technical and financial assistance would be welcomed.

B. AAR is planning its expansion with or without external support and is willing to commit its own resources to the expansion effort.

C. AAR is working from success to success. It operates a very profitable and functional Medical Center and wishes to expand the same model to other areas of Kenya which exhibit the same or similar conditions as Nairobi.

D. AAR is willing to be innovative in organizing itself for expansion.

E. AAR won't need a great deal of hand holding as it expands.

F. AAR does not reject expansion into other target population groups (e.g., poorer classes) provided AAR's "commercial" motivation is not compromised.

Weaknesses

A. AAR's management is not fully aware of or familiar with managed care concepts or options. This may be due to the fact that their marketing of services is to a small segment of the potential market.

B. AAR's management systems, although satisfactory for its current operations, may need to be strengthened as its operations expand.

C. AAR's management and staff need training in systems and methods which would make AAR 1) more competitive, 2) more efficient 3) more able to resist cost and price inflation and 4) able to continue to prevent fraud and abuse even with a larger organization.

E. AAR has limited its target population to a very select group of employers and people. Large employers have offered the best risk pool and have been the target of much of AAR's marketing effort. Reflecting their pooled risk AAR has offered a very competitive premium. On an individual level the premiums charged are high enough to discourage many middle and most lower income people. Full scale expansion to the middle income population of Kenya has not been planned for.

F. While AAR wishes to expand the AAR model to other parts of Kenya there is no "business plan" which documents the entire operation and which would be used for replication of the model.

Questions Remaining

A. How to expand AAR towards the middle income population of Kenya?

B. How much capitalization is required?

C. Will the Ministry of Health and the Commissioner of Insurance cooperate with AAR in its expansion?

ROYAL MEDICARD MODEL

Overview

The Royal Medicard program was explored because it approximates an Independent Practice Association (IPA) Model HMO. The Royal Medicard program is similar to an Independent Practice Association with several significant differences which are outlined below. Royal Medicard offers a GOLD scheme which is a standard indemnity insurance plan for inpatient care. Enrollment is arranged by Royal Medicard through a broker. Premium rates for members are based on an agreement, which is a time-limited contract between an insurer and a broker representing Royal Medicard. Rates will change with the renewal of this agreement.

Outpatient services are not provided by Royal Medical. Royal Medicard offers a silver scheme instead. It provides administrative support to employers who wish to eliminate or reduce the paperwork associated with payment of outpatient claims to hospitals, pharmacists and other providers. Royal Medicard reviews and selects out patient providers and pharmacists. It provides a credit card for members to use with these providers. It is the intermediary between the patient, provider and employer for payment of bills for services rendered.

The concept of a true IPA or PPO model HMO is not known to Royal Medicard management. It is significant to note, however, that they have approximated this type of program with little background knowledge. Royal Medical management seems keen to know more about how an IPA or PPO might operate. It seemed evident in the interview that they would be willing to improve their systems and incorporate cost containment aspects once they know how they work. They may or may not be willing to accept the risk associated with insuring access to health services for their customers' employees.

Currently, Royal Medical's objectives are being met and demand for this type of service is growing. However the proposed program may offer increased utilization by facilitating Royal Medical members' access to health care without cash.

Royal Medical's Relationship with Providers

Royal Medical "certifies" out patient providers as eligible to participate in the Royal Medical program. Certification does not require that providers adhere to a fee schedule or constrain the number and type of services offered to or consumed by members. Certification allows members to use the designated provider and allows the provider to bill RM and be paid by Royal Medical rather than by the member or his/her employer.

"Certification" is done by nurse and physician consultants hired directly by Royal Medical. No provider has ever had his/her certification revoked as the result of improper practice and new providers are added at the request of covered employees.

Providers are guaranteed payment by Royal Medical but, in turn, they must abide by Royal Medical's rules. One rule is pre-authorization of services by Royal Medical before service is given. There is no negotiation with providers relating to fees for services rendered and all services are paid in full.

Royal Medical also has procedures designed to monitor and regulate use of prescription drugs. If a provider writes a prescription, the type of drug, number of medications, authorization code, and provider name are listed on the prescription. Before a "certified" pharmacy gives out the medication they contact Royal Medical for authorization thus avoiding unnecessary, inappropriate or fraudulent claims.

Royal Medical's Relationship with Patients/Employers

To ensure that the employer can cover the bills of its enrolled members, membership is contingent upon a credit reference which Royal Medical conducts on all employers. When a person is sick that person goes to a "certified" provider and is given care free of any coinsurance and no money changes hands at that time if the member produces the Royal Medical Card. Payment is only allowed after a phone call to Royal Medical to obtain an approval code. If approved the provider bills Royal Medical who pays the provider and receives payment in turn from the employer.

Conditions such as ceilings on insurance coverage are established by the employer and these records are kept on computer at the Royal Medical headquarters. Each time the provider requests the approval code, these conditions are reviewed. Approval is given in any one year only up to the amount approved by the member's employer. If a member wants services at a cost in excess of that allowed by Royal Medical the provider and the member negotiate the uncovered balance.

For those members selecting the "insured option" for in-patient coverage, members must go to "certified" hospitals. The authorization and payment procedures are the same here as for the providers and there are no limits to bills or services provided except those placed on Royal Medical by the member's employer. Appropriateness of hospitalization is checked by Royal Medical health personnel during visits to the hospital.

Setting the Fees for Membership

Membership fees for the outpatient portion are based on the costs of administering the process and Royal Medical's credit card experience. There is no risk sharing involved in the outpatient program and the costs are similar to other credit card commissions.

Membership fees for the in-patient portion are based on a rate agreed to between the broker and the insurance company and passed on to Royal Medical. This rate will likely increase in time due to lack of cost controls, a situation analogous to the problems faced in the US in the 1960's where "full and reasonable charges" were reimbursed on demand.

Strengths

A. Royal Medical providers are screened and approved thus eliminating poor performing providers and possibly reducing those prone to fraud, abuse or collusion with patients. Royal Medical has agreements with many providers around Kenya and providers are used to requesting approval before treating patients.

B. Royal Medical eliminates the need for cash transactions and computerization of the process is possible. Royal Medical's existing commercial credit card operation makes expansion of the system relatively easy, particularly the methods of identifying the member and processing transactions automatically.

C. Some controls on fraud and abuse already exist although they are not exhaustive.

D. The mechanisms for computerizing the system for invoicing and making payments exist through Royal Medical's credit card business. As a result, efficiency in management is possible.

E. Royal Medical management is willing to make improvements in the system and willing to consider changing the program into a true IPA or PPO type managed care plan.

Weaknesses

A. The Royal Medical approach is inflationary because providers are paid in full without cost or utilization controls and the provider has no financial risk.

B. There are no limits imposed on members' utilization (e.g. copayments) or selection of provider (other than those "certified"). As such, the potential for over-utilization is real.

C. Control over the quantity, quality and appropriateness of care is becoming increasingly difficult to monitor as the pool of certified providers continues to grow. As of now the list of certified providers is extensive and new providers are added at a patient's request.

D. There is little understanding of the use of incentives to motivate providers and members to behave in certain ways.

E. The current system of monetary caps on utilization is inflationary. Significant potential exists for over consumption of services particularly at the end of a year if not all "entitled" services are used. As witnessed in the Chogoria system people may consider the "cap" (e.g., Ksh 100,000/year) to be their entitlement and they will use services until the entitlement is exhausted. Members may feel that the ceiling allowed by the employer is like income to be received.

Questions Remaining

A. Is Royal Medical willing to become a real IPA-style HMO?

B. Is Royal Medical interested in any social-insurance related approaches?

C. Can Royal Medical limit its provider pool?

CHOGORIA MODEL

Overview

The Chogoria Mission Hospital currently operates a burgeoning pre-paid insurance scheme for people who reside in Chogoria District. Chogoria Hospital has set up a scheme for covering out-patient services for enrolled members through satellite clinics and the referral hospital. All services, including in-patient services, are insured through Apollo Insurance.

Members are enrolled in two ways. First, a person can become a member through voluntary self referral and second, a person can become a member through his/her cooperative. While about 4% are cooperative members, self referred members are in the majority. Enrollment requires a two week waiting period and absence of exclusions such as chronic illnesses and preconditions. All enrollment is on an individual or family basis with no pooling by employer or other form of grouping mechanism.

Several schemes are offered.

- The Budget Scheme (2 policies) provides outpatient care and is the lowest insurance category catering for the poor.

- The Standard Scheme which is the most popular (976 policies), provides for outpatient care and inpatient care.

- The Silver Scheme (326 policies) provides for both outpatient and inpatient care in the amenity ward and a guarantee that they will be provided by a physician. The Silver Scheme is the second largest and members have an annual Ksh 15,000 ceiling on reimbursements.

- The Gold Scheme has 60 members and they are guaranteed access to the private ward, food from the restaurant, a television room and basic outpatient and inpatient nursing coverage. Gold Scheme members have an annual ceiling of Ksh 20,000 on reimbursements.

If a person is a cooperative member and does not have enough money to join, he/she can receive a "cooperative voucher" from the cooperative guaranteeing payment when the person receives payment for coffee harvested. With this guarantee the person can enroll in the plan and immediately begin receiving services at the hospital.

Demand for the scheme is high and membership is growing. It is believed that members utilize services at a higher level than the general population and abuse of the system is evident. Abuse primarily takes the form of services being provided to children of non-members.

Chogoria hospital has an arrangement with Apollo Insurance whereby Chogoria's general fees are sent to Apollo and, based on the fees structure, premiums are set. Chogoria hospital's

responsibilities are to recruit members, enroll members, provide clinical services, complete claim forms and submit premiums and claims to Apollo for payment. Apollo's responsibility is to pay claims to Chogoria Hospital and assume some financial risk. Indications point to premium income being lower than the cost of services rendered resulting in an accumulating net loss in income.

Strengths

A. The hospital has succeeded in designing and marketing a program and enrolling nearly 1500 policy holders, covering up to 9000 beneficiaries.

B. The Chogoria plan has two key elements of managed care plans. These are a known patient population and salaried providers of care. These circumstances are pre-requisite to developing managed care controls such as 1) triage before referral for treatment, 2) limitations on encounters per spell of illness 3) identification of malingerers 4) and referrals to known practitioners.

C. The plan is reported to be serving persons from throughout their district. The largest part of their subscribers live near the hospital. But many live near the hospital's ten dispensaries.

D. The plan does not permit treatment for pre-existing conditions under any circumstances. Chronic disease contracted after the enrollment eligibility is covered.

E. The staff of the plan and the cashiers cooperate to reduce fraud and are highly motivated to improve the program.

F. Individual subscribers may pay before enrollment and eligibility begins two weeks after payment is received. If payment is not timely in successive years, when treatment is sought, the premium is collected for the period of one year from the annual due date.

Weaknesses

A. The number of beneficiaries is not known precisely because data is not kept on size of families enrolled. The maximum number of persons eligible under a family plan is two adults and four children.

B. The actual cost of services used by members is not known because costing of patient services is not routinely done.

C. The frequency of beneficiaries' encounters at the hospital is not recorded or analyzed however the data is accessible. Inpatient data could be collected from a retrospective analysis of inpatient records. Although outpatient data is not available in hospital records because patients keep their own records, it may be available from analysis of pharmacy records or a prospective study of patient encounters.

D. There may be an issue of adverse selection. The fact that a large number of enrollees are hospital employees who have too easy access to hospital care may inappropriately increase utilization. Also, they are among the highest paid employees in the community and subscribe to the program because they consider it a bargain.

E . The large number of subscribers from near the hospital may constitute adverse selection because of their proximity to care with no restrictions. Enrollees from locations far from the hospital are also self selected. Only the relatively well-off or sick will travel significant distances in order to get service.

F. Cash flow is compromised by extensive delays in the submitting of bills (up to 90 days) and lesser delays in approval of bills (up to 120 days). In the case of cooperatives, premiums for their members are not made prior to the year covered, but rather for the year just ended. Thus the hospital is carrying the cash burden for both groups.

G. Even when the premium is payed more than a year after the expiration date, the period of coverage lasts one year from the date of payment of the premium. Since enrollment is optional, some persons may attempt to avoid premiums for a year. They may succeed and incur no penalty.

Questions Remaining

A. How to prevent adverse selection?

B. How to prevent moral hazard?

C. How to collect premiums large enough to cover cost?

D. How to avoid eliminating the most needy from the scheme?

HEALTH INSURANCE MODELS - COOPERATIVE SCHEME

COOPERATIVE MODEL

Overview

A major challenges for the Kenya health care system is to devise prepaid health schemes to serve rural populations. An effective prepaid health plan would require low premiums and special payment schemes due to the low levels and irregular flows of income in agricultural areas. Cooperatives may provide a suitable mechanism to achieve these conditions.

Cooperatives contribute as much as 40 per cent of the country's GDP. About fifty percent of the total population is directly or indirectly involved in the cooperative movement. Due to its dominance in the Kenyan rural economy, the cooperative movement is increasingly regarded as a potentially strong mechanism for enabling health insurance to reach a large proportion of the rural and low income populations who cannot now access health insurance schemes.

Currently, the limited role of cooperatives in health insurance in Kenya demonstrates considerable potential. A review of available information and the nature of current participation of cooperatives in the provision of health financing reveals the following:

A. A few cooperatives have provided a check-off system to enable their members to join the National Hospital Insurance Fund (NHIF). This role is still highly limited but if fully exploited could enable rural agricultural population to join the NHIF which has so far mainly covered the modern sector non-agricultural wage employees. However, the benefits of NHIF scheme are limited and there are other shortcomings of the government managed NHIF scheme.

B. Some cooperatives make arrangements with nearby mission hospitals so that their members are treated in the hospital without cash payment. The cooperative issue a voucher to the sick member to enable him/her to receive treatment. The hospital bills the cooperative, which settles the bills and later recovers the money when the members produce is sold through the cooperative. This is not an insurance scheme, but merely a credit scheme arranged by cooperatives to ensure that their members have access to health care when they need it.

C. Savings and credit cooperative societies (SACCOs), especially in urban areas give credit facilities to their members to settle hospital bills and other emergencies. Credit facilities from the SACCOs are popular because, unlike banking and non-banking financial institutions, SACCOs do not require collateral from the members. The member's share capital in the SACCO and continued employment are regarded as adequate security; with these, a member may obtain credit amounting to about three times the member's total contribution at the time.

D. In some cases, arrangements between a cooperative, a mission hospital and an insurance company, have enabled cooperative members to have formal group health insurance. Where there is a well-managed, and equipped mission or other NGO hospital, this form of arrangement could allow cooperative members in the rural areas to have access to high quality health services at insurance premiums that they can afford. This arrangement allows the insured members access to health care services from a specified health care provider(s) in the area. The preference for mission or NGO health facilities is based on their relatively low prices for services and drugs. They are not profit-maximizing health care providers. They are better able to control abuse and fraudulence.

   This type of participation of cooperatives in financing health care seems to have great potential for facilitating expansion of health insurance to rural populations and low and middle income urban populations who are members of SACCOs.

At the time of this report, discussions have been initiated with the Kijabe, Maua, Isiolo and Nyeri hospitals on the Chogoria model and the possibility of replicating it.

Strengths

Examples of current and potential local health financing arrangements include:

A. Direct provision of services by health staff employed by the cooperative.

B. Direct reimbursement of health providers by the cooperative.

C. Contract health care arrangements with local mission or private providers.

D. Purchase of group health insurance.

E. Credit facilities for health care.

The conditions which are necessary for these arrangement to work well appear to be the following:

F. Strong and well managed cooperative society.

G. Availability of a well managed, staffed and equipped mission or NGO, health facility.

H. A financial intermediary (insurance company, provider organization, or other entity) that is able to arrange a scheme which is both affordable to the cooperative and sufficiently remunerative for the providers.

I. Public awareness of the benefits of prepaid health care coverage.

There are significant benefits that can be derived by the three types of participants: cooperative members, health facilities and insurance companies.

J. The cooperative members are assured of access, at all times, to affordable health care services in a nearby facility.

K. The health facility is assured greater utilization of its services and payment.

L. The insurance company has an opportunity to expand its business.

Weaknesses

A. Currently, the role of cooperatives in health financing in Kenya is limited.

B. The extent of these programs, the financing, and the actual benefits are not known.

C. There is wide variation in the actual cash positions of different cooperatives. Some will loan eighty percent of deposits to members. Some will loan forty percent of deposits. Others are heavily mortgaged in real estate investment. Their potential is therefore not known at this time.

D. Bureaucracy and the requirements of the Cooperatives Act complicate and hinder quick decision making in cooperatives.

E. Actual organizing of members into a universal insurance scheme for a cooperative has not occurred despite rumors to the contrary.

F. The present mode of recruiting members has no protection against adverse selection.

G. Many cooperatives have weak financial management.

H . The income of most cooperative members restricts any prepaid scheme to very minimal benefits.

I. There is limited general awareness of health insurance among cooperative members.

J. It is believed that cooperative members will prefer schemes that provide both inpatient and outpatient services. Insurers are not yet able to control abuse in such schemes and are reluctant to offer them.

Questions Remaining

A. The actual role of cooperatives in financing prepaid health programs is not documented.

B. No interested partner for a health financing scheme has yet been identified.

C. Although efforts were planned to document the operations of some of the more promising schemes, no operational assessments of promising schemes have yet been made. Preoccupation of some of the cooperatives with other activities meant that their interest in developing prepaid health plans could not be explored in time for the next workshop.

D. Efforts are needed to document practical experiences in Kenya and, in other countries of Africa, Asia, and Latin America.

E. A plan and methodology for an inventory of local cooperative-based and community-based health financing schemes has been prepared.

F. An implementation plan for cooperative based health schemes has been outlined.

HEALTH INSURANCE MODELS - INDEMNITY SCHEME

The workshop also recommended exploring two indemnity plan schemes, the grouping of small companies to form insurable pools and the formation of mutual companies to provide affordable health care coverage to large groups like cooperatives.

The first indemnity approach is the development of insurable pools by the grouping of several small companies together for the purpose of creating an attractive insurance risk. It will encourage insurance carriers to tender for the coverage at attractive competitive rates. This would expand the number of persons eligible for coverage, reduce the cost and fiscal difficulty for the employer, and be interesting to the insurer.

Initial discussions have been held with insurance carriers which have established their conditions for group eligibility, reviewed their premium structures and established that there are no regulatory impediments. Methods to contact potential small groups of professional employers, not now eligible for insurance have been developed.

The second indemnity strategy is the development of mutual companies to act as vehicles to provide insurance coverage. Mutual companies were originally non-profit making and therefore non tax-paying. The fiscal advantages enable the organization to obtain insurance for their members at a saving. Mutual plans are owned by the members and therefore they are more responsive to the members needs and actively pursue saving measures for their mutual benefit. Profits or losses from operations are passed on to the members by reducing or increasing their premiums.
The concept being considered would involve testing the viability of the mutual approach in providing in-hospital coverage to large groups or affiliations such as cooperatives, which are well-positioned to benefit from this kind of approach. Meetings have already been held with cooperatives in Nairobi and the initial responses were positive.

POOLING MODEL

Overview

This approach is intended to provide group medical insurance for a number of employees now working in the formal white collar sector who are currently uninsurable because they are employed by small firms which are unable to obtain medical insurance because of their size. The small company employee has to rely on the generosity of his employer to assist in meeting medical expenses. He cannot join with his fellow employee to obtain group medical coverage because the number of employees is too small to be of interest to an insurer. Relief comes from his employer or out of pocket. The small company employer is faced with unbudgeted expenses which can cause a drain on cash flow, create morale problems if not readily addressed, and generally cause a distraction to the primary business focus.

Insurance companies avoid small groups because the spread of risks is absent, the total premium is low, the expense of administration is too high, and there is only limited potential for profit.

Companies often find they must provide such coverage in order to secure the more lucrative lines, or to neutralize competition. In most cases, the health insurance creates losses which offset some of the profit from the primary line.

The purpose of this approach is to establish a vehicle which will assemble a number of similar small companies into a sufficiently large group to be of interest to insurance companies and enable them to obtain adequate benefits at competitive rates. The concept will solve both the employees' and the employers' problems with regard to medical coverage. The larger group will be able to secure adequate cover at competitive rates, demand efficient service, and possibly obtain rate reductions if experience dictates. The employer will budget his medical expenses, eliminate violent fluctuations in cash flow, and avoid dealing with individual medical problems.

Administratively, it will be necessary to establish an intermediary in the person of a Health Care Administrator who would assemble the pool of at least 100 persons from a number of similar small companies, explain the benefits to management and staff, convince the majority of the viability of the project, and perform the administrative tasks necessary. In consultation with the pool members, the HCA would determine the benefit levels for in-hospital medical reimbursement, establish a PPO among an agreed number of acceptable doctors, arrange for out-patient facilities (such as those owned by AAR), and solicit tenders from qualified insurers for the in-hospital risk. Once the contract is signed, the HCA would arrange for prompt collection of insurance premiums, monitor enrollment changes, assist in claims form preparation, and pursue prompt settlement of claims.

The HCA will identify a number of hospitals, acceptable to the majority, and negotiate room and board rates for the group. The HCA will establish agreed-upon charges for various surgery and attendant fees with the members of the PPO; and arrange a facility to handle out-patient benefits which will be excluded from the insurance contract. As the highest incidence of fraud historically has been associated with this aspect of medical reimbursement, extra care will be required to establish adequate controls on this sector of the program.

Strengths

To make the pilot project successful, open and objective discussions must be held with the employers, representatives of the employees, the hospitals to be used, the doctors in the PPO, the out-patient facility, and the insurance companies. As all parties involved have something to gain from the project, once the concept is understood, and the opportunities for each partner is explored, the benefits of cooperation will be appreciated and drive the project to success.

A. Medical insurance schemes are well known to target the group so the concept should not be difficult to sell to employers or employees.

B. Employers and employees want protection from unexpected medical expenses and the high cost of hospitalization is readily appreciated by both parties.

C. Target group is very attractive to insurance companies. It is their major source of individual life business so access to this group would be very attractive to insurance companies.

D. Creating groups of 100 or more people, all of whom must join the scheme, eliminates anti-selection, the insurer's greatest concern.

E. The target group is better paid, enjoys better health, and works in a non-hazardous environment.

F. The pooling facility allows employees to obtain medical insurance at group rates which is much less expensive than original coverage and something not currently available to them.

G. Small companies can be easily identified through associations, trade magazines, professional registers etc.

H. Only employers who have been reimbursing employees' medical expenses will be invited to participate initially. Also employers will have to be too small to obtain regular group coverage and meet a class 'A' criteria in terms of risk and moderate average age of employee.

Weaknesses (and Strengths). In this context weaknesses can also be perceived as strengths. Sound business practices are regarded by some as weaknesses because they do not support cross-subsidies or other forms of social insurance.

A. Profit making insurance companies have a number of strict criteria which must be met before they will consider providing group medical cover. Some examples are:

1. The group must be a duly registered company.
2. Only in-patient benefits will be considered.
3. AIDS will be excluded from coverage.
4. Group life must be included in the benefits package.
5. The group must be at least 10 employees.

B. The pilot project will try to obtain a group with high professional integrity and low incidence of medical problems. Therefore, such professions s lawyers, accountants, small NGOs, architects etc, will be solicited. Associations and trade magazines will help identify prospects.

Weaknesses

A. The concept will likely be met with some reluctance given that insurance companies have had bad experiences with medical insurance. The question remains whether medical insurance can be underwritten profitably.

B. Losses incurred in other lines which form the bulk of their business, might make companies unwilling to try this concept at this time.

C. Industry may want to wait to see if the Government will support greater involvement in medical insurance from the private sector by offering tax incentives.

D. Emphasis on investment income during these times of high interest rates, rather than underwriting for profit, may reduce pooling schemes overall acceptance.

E. It will be difficult to assemble sufficient numbers of target groups to explain the concept and make sale.

F. Success of the pooling scheme is dependent on the effectiveness of the person who is to coordinating the groups, arranging premium collection, administering the scheme, and settling claims.

G. Preoccupation with out-patient benefits or the restrictions imposed on them, will be an obstacle to overcome when selling employees.

H. How AIDS exclusions and beneficiaries with AIDS will be handled in the scheme has not been determined.

Questions Remaining

A. Schedules of rates and benefits must be established; current ones are now offered as guides only. Each category of benefits will have maximum limits. Companies will be more flexible when deductibles are introduced or the plan has a coinsurance element, usually 80/20. Where necessary, they will handle out-patient cases on an administrative services only (ASO) basis.

B. Some carriers take medical business only on an accommodation basis because they do not consider the medical line as a profit maker. The extent of their willingness can only be discovered by actual experience.

C. The extent of out-patient benefits to be provided varies with the companies involved.

D. Some companies would be interested in the pooling concept provided adequate measures were taken to reduce anti-selection. They would like all members of the small companies in the pool to be included. This would relieve their anti-selection concerns.

E. Issues to be discussed with employees concern amount of coverage needed; whether dependents are to be covered; how many dependents; procedures in the event of more than one spouse; hospitals to be used; doctors to be invited to join the PPO; if out-patient benefits are to be covered; if so, at what facility; if coinsurance is required, what percentage is acceptable; exclusions to be applied; how AIDS victims will be handled etc.

D. A question exists as to whether all controls required to guarantee success can be implemented effectively and permanently. Special emphases will be need to eliminate fraud. No cash reimbursement situations will be encouraged. The HCA will attempt to obtain the best deal for the group from the provider.

MUTUAL MODEL

Overview

The large mutual insurance companies of the world had their origins in meeting the insurance needs of a particular group or association of tradesmen, professionals, union members, of similar related bodies. As mutual companies, they were non-profit making and therefore non tax paying. The absence of these two significant fiscal elements enabled the organizations to obtain benefits for their members at considerable savings. As mutual companies, they were owned by the members, and thus they were more responsive to the members needs and actively pursued cost saving measures for their mutual benefit. Profits or losses from operations were passed on to the members by reducing or increasing their premiums.

The second indemnity strategy under review is to determine if the mutual approach could be applied to large groups or affiliations in Kenya, such as cooperatives, to enable the members to obtain in-hospital medical cover.

In cooperatives, members contribute monthly to the association's treasury through a check-off system of payroll deduction arranged with their employer. In accordance with their rights under the cooperative, they are allowed to borrow funds in case of emergencies. Such emergencies often come in the form of unexpected medical expenses. In most cases, the members do not have medical insurance.

Given the need for in-patient coverage and the nature of the cooperative system, cooperative groups, teachers unions, farmers associations and similar organizations are well suited to benefit from this concept. In Kenya this approach would enable the members to obtain insurance protection which is not presently available at an attractive rate. Meetings have been held with well managed cooperatives in Nairobi with up to 5,000 members and the initial reaction has been enthusiastic.

If the concept is feasible, a pilot scheme would be started and a team of professional insurance managers would be hired to run the scheme for the cooperative. They would also establish a Preferred Provider Organization, complete with approved hospitals, doctors, pharmacies, and laboratories, to ensure the members get the best possible service at affordable rates, while maintaining controls on utilization and costs and eliminating fraud.

Using actuarial assumptions and local knowledge, the managers would establish a rating structure by age for the cooperative's members and convince them to allow deductions from their monthly contributions as the Mutual's premium income. Other controls considered are to restrict

coverage to members only for the first year or till such times as reasonable estimations of utilization, costs and operational procedures are fairly well established.

If the pilot scheme is successful, the concept could exported to many other large organizations throughout the country.

On 29 March, a meeting was held with the Cooperative Insurance Services (CIS), a mutual fund which provides insurance to cooperative members and the general public, to discuss their willingness to provide services for the mutual group considered. It was learned that the company is actually owned by a cooperatives now. As such, it is the mutual vehicle that could be used to provide medical insurance to the cooperative's members. The managers we spoke with fully appreciated the opportunity presented and asked for an invitation to our 19 April workshop. The existence of the mutual may have overcomes a major obstacle, as there is no such vehicle permitted under the present Insurance Act.

An equally enthusiastic response was received on 30 April from the President of the Afya Cooperative, the cooperative for employees of the Ministry of Health. These developments confirm the breadth of opportunities available to cooperatives in developing prepaid health schemes.

Strengths

A. The existence of Cooperative Insurance Services which is a mutual fund. Cooperative Insurance Services (CIS) is owned by 800 of the 3500 cooperatives in the country. They provide insurance products to cooperative members and to the general public. The profits from the operations go back to the coops in some form. It is a mutual because the members own it. A recently conducted survey showed hospitalization was of major interest. In rural areas, concern was for out-patient benefits as NHIF was only help if they went to hospital. The rural populations want low premiums and need lower level benefits. They may pay annually when harvest money comes in.
CIS could be the vehicle to run medical insurance programs through the coops. As strong professional management would be needed, KHCF might have to provide the technical expertise and marketing know-how, but the apparatus is in place. Staffers seem concerned about pressures from outside to compromise sound insurance principles, like paying premiums on time as opposed to deducting premiums from claims.

B. Identification of a major cooperative which has a relationship with the above mutual. The AFYA cooperative is one of the biggest, wealthiest, and best run coops in the country. Membership countrywide may total 40,000. The concept of establishing a mutual type insurance company to cater for the medical needs of the employees of the coop was discussed. However, before pursuing the mutual insurance concept as a start up, the idea of using the CIS as the insurance vehicle was examined. Since AFYA is already an owner of CIS, the fit is a natural. An officer of the Cooperative allowed that CIS had not quite lived up to expectations, but he felt the general membership would be more comfortable dealing with CIS than with an outside or unknown entity.

C. Tentative approval of this scheme by the Insurance Commissioner. The concept of providing in-hospital medical coverage for members of cooperatives was explained in detail. The possibility of creating a mutual type insurance entity to administer the program was explored. The Commissioner felt that the present Insurance Act would not permit a mutual-type company as such.

The possibility of using CIS was greeted with much enthusiasm as the Commissioner felt given that CIS was not living up to expectations in other areas. He was so encouraging that he called the M. D. Mr. Kobia, and recommended that the matter be discussed in detail. He felt this could be financially beneficial for CIS and would welcome any technical advise we could provide the company.

Weaknesses

A. There may be difficulties in designing a pilot program because insurers may be reluctant to offer family coverage and subscribers would not be interested in singles- only coverage. Preliminary discussions with AFYA were encouraging and the management is aware of the financial problems caused by unexpected medical expenses. They also recognize the inadequacy of NHIF in providing relief in such circumstances. They believe their members would be interested in securing additional medical insurance. A test of a smaller group, such as Nairobi members, was agreed upon, but they felt that members only coverage would be difficult to sell, even as a test.

B. There was reluctance among the cooperative management to try a new approach. Consensus would be difficult to obtain from large cooperatives with many members spread over wide area.

C. Support for CIS involvement may not be readily understood or encouraged and there would be a need for extensive education among cooperative officials and lower ranks.

D. Selecting a small representative group from a large cooperative like AFYA will be difficult. Members may be reluctant to let part of their membership enjoy better benefits, even for a short while.

E. Management of cooperatives often hide behind provisions of the Cooperative Act to negate change or experimentation.

F. Management of CIS will have to be convinced that the effort required to introduce the pilot scheme is worthwhile, given their experience in dealing with uncooperative cooperatives. They went to the market because 'Captive' business from the coops was not sufficient to sustain their operations.

Questions Remaining

How will the following aspects of this plan be developed?

A. Premium rating,
B. Collections,
C. In-hospital limits,
D. Enrollment procedures,
E. Membership controls,
F. Hospitals to be used,
G. Doctors to be used and
H. Charges agreed, and many other features.

SECTION IV. FINDINGS AND RECOMMENDATIONS

As a result of the consultancy, a work plan was formulated which has a short term and long term component. The short term plan set out specific initiatives to be followed up upon in the near term, and for which resources were generally available. The long term activities include work that will have a longer time horizon, and for which other donor funds will likely be necessary.

Short Term Plan of Activities

1. Assist AAR to expand and improve its service delivery on both a geographic and socioeconomic basis. AAR has plans to replicate its successful outpatient medical scheme to other areas in Kenya and is interested in expanding its coverage of middle income groups. AAR management is also considering the possibility of expanding AAR into a fully integrated HMO. The following assistance will be necessary:

   - short term technical assistance
   - training in managed care and development of systems
   - financial support (from PROFIT)

   Additional activities may include:

   - arrangement of a study tour
   - explore potential for contract management of GOK facilities by AAR

2. Assist Royal Medicard to develop into (or towards) a true Independent Practice Association. Royal Medical management expressed interest in developing the necessary cost and utilization controls necessary to avert inflationary aspects of their operations and are willing to consider changing their program to a managed care plan. The following assistance is proposed.

   - short term technical assistance
   - training in managed care and development of systems
   - financial support

   Additional activities may include:

   - arrangement of a study tour
   - explore potential for contract management of GOK facilities by Royal Medicard

3. Assess the Chogoria Hospital (rural hospital) financing arrangement with Apollo Insurance and area cooperatives. If financially sound, develop a replication plan and train the CHAK Management Support Unit to implement it. Additional information about the plan's beneficiary pool, costing of services, and utilization, and claims management must also be collected. The plan for development of the Chogoria model will include the following activities.

- ! evaluation of systems
- ! short term technical assistance
- ! documentation of the improved model
- ! development of a replication manual
- ! definition of a plan with CHAK for replication
- ! train CHAK and CCS to implement the scheme
- ! training with selected CHAK hospitals

4. Pilot a program oriented towards providing health insurance to small employers, presently with little or not access to private health insurance, through a pooling concept. Implementing this pilot program requires the hire of an intermediary to assemble the employers, establish a PPO with area providers, arrange for outpatient services, and help establish management systems. To execute the pilot program and replicate it if successful, the following steps are necessary:

    - ! hire Health Care Administrator for six (6) months
    - ! explore idea of having AAR provide outpatient services
    - ! provide short term TA
    - ! document the model
    - ! develop a "replication manual"
    - ! provide a plan for replication to the World Bank
    - ! hold training with insurance companies and others
    - ! promote concept to the MOH and to the World Bank for replication

5. Provide support to the mutual insurance company, Cooperative Insurance Services, to initiate development of health insurance coverage for one medium sized cooperative. KHCF may look to other donors to implement the following activities:

    - ! Develop the cooperative model starting with AFYA coop in Nairobi
        - ! ! short term technical assistance
        - ! ! documentation of current successes
        - ! ! develop strategy for expansion
        - ! ! put expansion plans into next health sector support program
    - ! Develop relationship to the Cooperative Insurance Services (CIS) in order to expand the cooperative model.
    - ! Link CIS and cooperatives into longer term health sector support program.

6. Explore a pilot with AAR on contract management of GOK hospital ancillary services, e.g., lab or x-ray.

To initiate the short term plan a local consultant would take the lead role in the Pooling and CIS models development, Dan Kraushaar would provide support to AAR, and would also take prime responsibility for improvement of the Royal Medical and Chogoria models.

Long Term Plan of Activities

In the course of the assessment a number of activities were identified which will require a longer time for implementation due to the extensive social and economic change involved. The specific activities identified include the following:

1. Assist in replicating Chogoria and CIS models.

2. Strengthen and further develop the Cooperative Insurance Services's (CIS) support and effort to develop insurance for cooperatives.

3. Support the development of other managed care models.

4. Explore the extensive privatization of Government ancillary services as part of the expansion of managed care arrangements.

5. Implement training of insurance industry.

6. Develop a public and provider education campaign on insurance

7. Explore privatization of GOK facilities

It was the belief of the consultants that a comprehensive long term plan should be developed for those activities listed above. A detailed list of tasks for developing such a long term plan was established during the consultancy and is set out in Appendix D. Several general ideas to think about in formulating a long term plan were put forth, including:

1. Designing experiments without a realistic projection of their effects and total impact is not in the best interest of the country.

2. Designing experiments that establish improper incentives is not good economic planning.

3. Partnerships with all other sources of health care through cost sharing, administrative strengthening, and reasonable cross subsidies can promote and perhaps achieve some equity

4. Cross subsidies are customary in hospitals when some patients are insured and some are not; or where some can pay and others not. Analogues should be designed for out-patient care in managed care settings.

5. Activities that have a similar appearance to cross subsidies are not the same if the apparent cross subsidy benefits an investor instead of funding the health sector.

Resource Mobilization

An attempt will be made to interest other donors in some activities listed within the short term and long term assistance plans developed through this consultancy. The World Bank is involved in overall health sector reform in Kenya and is also developing an insurance project. Other donors have expressed interest in the plans that have resulted from the efforts reported here. Areas of work which KHCF may recommend are:

1. Exploring the possibility of expanding other managed care plans in Kenya.

2. Exploring the possibility of contract management of MOH in-patient ancillary services as part of the expansion of AAR outside Nairobi. This would be done in conjunction with KHCF.

3. Developing a public and provider education plan on health insurance.

Other Areas for Investigation

Discussions at the workshops also gave rise to issues and activities that should be explored to gain a fuller understanding of the manner by which expanding private health insurance in Kenya can be most effectively achieved. They are briefly described below, and do not necessarily relate directly to each other.

Private / Public Sector Partnerships

In Kenya, the availability of funds to support the health sector are limited. Therefore, despite past difficulties in developing government payment schemes, it is to the advantage of both to promote partnerships between private health services and insurance and public health programs and insurance. One suggestion is that private insurance be marketed as an additional benefit to public insurance. This might involve the private insurer as the intermediary for their insured and government reimbursement and perhaps also the providers and clinical institutions.

Another suggestion that may be worth exploring is to use private insurers and collection agents for the NHIF. In this capacity, the private insurer could use their systems to administer the collection of premiums. A commission would be taken for the collections, which would provide an increase in collections for NHIF. Negotiations would be required to determine if the remittance would be sufficient to cover the increased obligations of NHIF.

Donor Interests, Authorizations and Capabilities

A task that should be undertaken in anticipation of seeking donor funding is to identify activities that need to be carried out during the long-term development of prepaid schemes in Kenya. These activities need to be categorized and compared to the type of assistance available from different cooperating agencies, foreign governments and international agencies. A well conceived and thorough plan that calls on specific resources available has several positive effects. It provides a sound rationale for funding as an activity can be seen as part of an ongoing plan in which successive activities are interdependent rather than episodic. This will likely improve the effectiveness and probability of success of each component, if the overall implementation is planned and well coordinated. If a well-designed plan is in place, these circumstances reduce the time required for assessments and project building that delays funding by donors. And the existence of an overall plan that has timetables for funding can be used to foster cooperation in implementation locally.

Additional Kenyan Health Care Financing Practices

Other potential areas for private sector involvement in health financing were also discussed and proposed for investigation including the payment systems of private practice physicians to hospitals; and other existing schemes and payment plans for health care in Kenya.

Social Change for Prepaid Schemes

Because of the duration anticipated for meeting the objectives of this assessment, attention must be paid to the social structure, and the avenues that need to be created to promote the necessary social change. Several activities were identified and each requires a commitment of funds for direction and sponsorship. Plans for publicizing the progress of the private sector initiatives must be formulated and implemented. Tasks may include:

1. Organizing a steering committee or committees.

2. Continuing prepaid health scheme workshops to strengthen and expand the constituency

3. Developing methods to disseminate information to communities and obtain their opinions. Methods could include newsletters, advertising, and focus groups to gather opinions and attitudes toward health insurance.

4. Development of other leadership groups for disseminating information about insurance through persons who can inform communities about options.

5. Involvement of local groups, communities and cooperatives in the process so as to provide them awareness leading to their participation, when timely; and enabling them to decide the nature of their local health care funding plan

APPENDIX A. HEALTH INSURANCE BACKGROUND INFORMATION

Background Issues for Prepaid Health Schemes

1 Kenya is at an early stage in the development of a strong health care economy.

2 There exist ample lessons learned on prepaid health schemes from other countries.

3 Many of the mistakes made in other countries are avoidable.

4 Because Kenya is in the early stages of the development of private health insurance schemes, it is well positioned to adopt the strategies that are now proving effective in other countries.

5 Appropriate administrative structures, laws, policies, social responsibility and other characteristics that seem to accompany economic growth and health insurance growth will have to be conceived and nurtured in Kenya.

Fundamental Goals of National Prepaid Health Programs

1 Coverage must be mandated and a tax collected on a sliding scale.

2 The maximum range of health services that is economically feasible must be determined.

3 These levels can be estimated empirically and experientially.

4 Levels of funding for health can increase as the economy grows using controlled micro and macro supply and demand side controls.

5 Permit the development of the private sector and foster partnerships between the public and private insurance sectors.

6 Implement industry controls that have proven necessary and effective in other countries, within the limits of the available capital.

7 Supplement it to the extent possible with support that will have an identifiable impact on the target population for which funds are provided.

Factors to Consider in Planning Prepaid Health Schemes

1 User fees do not contain fast growth of aggregate demand.

2 Demand side strategies of deductibles and co-insurance have little or no effect in middle income and developed countries.

3 Limits on coverage for prolonged stays have some effect, but they too late.

4 The time to abandon these strategies is at the beginning of growth of demand in the health sector.

5 It is important to abandon ineffective strategies before they become customary in Kenya. This should be apparent from experience in other countries. However, policy makers still use coinsurance and deductibles because they are easy to implement and they are effective with indigent. These strategies, should be a last resort. Private insurance should not be started with the wrong incentives. It will distort the desired development of health insurance and there will be generations of persons to re-educate when the economy of the country improves.

6 The fact that all countries have two or more tiered health systems should be acknowledged. Resources should be used to develop the tier for which the are authorized. In some cases this may be done by strengthening other tiers.

Health Insurance Information from Other Countries Experience

SOCIOECONOMIC AND POLITICAL OBSTACLES TO EFFECTIVE HEALTH INSURANCE FOR THE POOR

1 Poor health of low-wage earners
2 Manpower shortages in rural areas,
3 Drug and foreign exchange shortages,
4 Drought and security problems,
5 The projected costs of caring for persons with AIDS,
6 The flight of needed specialists from the country.

COMMON MISPERCEPTIONS ABOUT PRIVATE HEALTH INSURANCE

1 If the poor can pay for health care, they can pay health insurance premiums
2 Establishing private health insurance and improving urban health care will somehow trickle down to meet the needs of the rural people.

INCREASED DEMAND FOR INSURANCE AND THE IMPACT OF FAMILY PLANNING COVERAGE IN ZIMBABWE

1 The number of individuals seeking private insurance coverage is increasing by 10% each year.
2 In 1989, adding family planning to its insurance benefits package triggered a shift from a subsidized public sector approach to family planning to significant private sector involvement.
3 The cost of providing family planning services was estimated to be under 75 cents/beneficiary/year.
4 This achieved a saving of us$120,000 over a 5-year period through reduced maternity and pediatric claims.

CIRCUMSTANCES THAT ENHANCE THE POSSIBILITY OF A SUCCESSFUL NATIONAL HEALTH INSURANCE PROGRAM

1 Acknowledging that poverty, underdevelopment, and poor distribution of health and related services have a negative impact on the health of the whole population.
2 Realistically funded primary health care.
3 Funding that actually improves health status.
4 Restricting the expansion of private health care facilities.
5 Committing health care workers to rural areas.
6 Supplying essential drugs.
7 Giving free health care to those earning less than poverty wages.
8 Adequate medical manpower.

HEALTH INSURANCE PLANS CANNOT BE EFFECTIVELY IMPLEMENTED WHERE THERE ARE:

1 Declining health budgets,
2 Deficiencies of supplies of drugs and equipment,
3 Longstanding inefficiency and misallocation of resources.
4 Poorly administered cost recovery/user fees fraught with misappropriation and exemptions.
5 Persistent problems of inefficiency and inequity.
6 Continued bias towards salaries and complex curative services in urban hospitals.

HEALTH INSURANCE IS MORE LIKELY TO SUCCEED WHERE

1 Effective cost recovery has been instituted,
2 Preceded by improvement in perceived quality of services,
3 Accompanied by equitable and efficient allocation of services,
4 And there is reliable access to for drugs and tertiary services through fee for service.

TYPICAL SCENARIO EVOKING INTEREST IN PRIVATE HEALTH INSURANCE

1 The ministry of health system lacks sufficient financing to meet the demand for free service.
2 Constraints on the ministry of health include
  2.1 Paid patient bills for services rendered,
  2.2 Shortages of supplies and medications,
  2.3 Shortages of physicians,
  2.4 The private sector provides higher quality outpatient services,
  2.5 Private sector expenses include drugs, physicians services, and hospital services,
  2.6 Patients are financing these costs out of pocket.

POSSIBLE PROBLEMS PERSISTING AFTER PRIVATE INSURANCE IS ESTABLISHED

1 Continued payments by patients due to adverse insurance policies.
2 Increase of costs for physicians' services.
3 Gradually increasing actual costs of health services to consumers.

DATA NEEDED FOR ESTIMATING HEALTH INSURANCE COSTS INCLUDE

1 Present use of inpatient and outpatient facilities by socioeconomic groups of patients,
2 A population-based survey to determine individuals' rates and individual expenditures,
3 Survey of private health insurance companies to determine group policies.

IS EQUITY ACHIEVABLE?

1 Currently, there is a 2-tier system in which the public sector provides for the needs of the poor majority and the private sector cares for those who can afford to pay.
2 Poor want more and better services.
3 Middle class strive to retain their present services.
4 Costs are increasing
5 Public policy may or may not accept such biases in the provision of health care.
6 Rising health care costs / capita will increase private insurance premiums and private out of pocket costs, and declining ability for the government to sustain services.

PRIVATE HEALTH INSURANCE CAN INCREASE DEMANDS ON GOVERNMENT FOR

1 Equitable health services.
2 Efficient delivery of health services.
3 A shift of non-health-care resources to health services.

ECONOMIC CIRCUMSTANCES WHICH GENERATE THE NEED FOR PRIVATE HEALTH INSURANCE

1 General world recession
2 Depressed commodity prices
3 Burgeoning debt
4 Drought
5 Cuts in social expenditure funds.

NECESSARY PROGRAM STRATEGIES TO COMPLEMENT DEVELOPMENT OF INSURANCE

1 Cost recovery
2 Risk sharing
3 Rationalization of all health resource use.

WARNINGS AND LONG TERM CONSIDERATIONS

1 Beware of simplistic solutions.
2 Consider lessons learned from other regions.
3 Include ongoing evaluation of both insurance plans and subscribers ability to continue to pay for present levels of services
4 Be sure to consciously parallel public and private insurance program policies on cost-sharing for services and drugs,
5 Consider the extent and necessity and likelihood for external support and cooperation of communities, governments, and donors.

JAMAICA AS A TYPICAL EXAMPLE

1 Among the best in the developing world
2 Health services are provided free or at nominal cost
3 Network of relatively easily accessible services
4 Decline in the real value of total resources available for health
5 Underfinanced public hospitals
6 Deteriorating physical infrastructure
7 Poorly functioning equipment.

CIRCUMSTANCES IN JAMAICA WHICH FACILITATED GOVERNMENT SUPPORT FOR PRIVATE INSURANCE

1 Public increasingly opting for private care.
2 Even in the private sector, only 1 in 7 hospitals operate at profit due to
  2.1 mismanagement
  2.2 old equipment
  2.3 rising costs
  2.4 limited pool of potential clients
3 Majority of users pay for services despite the availability of free government services.
4 With private insurance, government can target resources to the indigent, while also encouraging greater reliance on private health care.

WAYS FOR GOVERNMENT TO SUPPORT DEVELOPING PRIVATE INSURANCE

1 Obtain or provide technical and financial assistance to expand private operations.
2 Provide incentives to employers to expand insurance coverage to workers.
3 Support health care reform by revising user charges, divesting nonmedical services, and privatizing public hospitals

ROLE FOR PRIVATE INSURANCE

1 Shifts burden to the private sector for those who can afford to pay for services.
2 Consolidates client ability to pay.
3 Relives government of some cost subsidization.
4 Combines many private sector options for financing health care including user fees, insurance and employee benefits, health maintenance organizations, and other non-governmental organizations.

ADDITIONAL WAYS FOR GOVERNMENTS TO SUPPORT PREPAYMENT SCHEMES

1 Promoting quality care through seed capital grants or loans to promising institutions
2 Training or retraining a broad range of health providers to enabling them to provide higher quality health care services
3 Modifying the tax system to encourage modern private sector expansion, especially into areas which are currently inaccessible
4 Establishing and enforcing health care delivery standards so that the type of expansion which is being encouraged does not sacrifice quality
5 Subsidizing preventive health care where the demand is low, and people are not as willing to pay for these services
6 Developing important community controls which have been absent from existing health care programs.

REQUIREMENTS FOR PREPAYMENT AS A MEANS OF ORGANIZING AND DELIVERING SERVICES TO BENEFICIARIES:

1 Strong management capabilities
2 Sound preexisting health care infrastructure upon which to add additional health services.

HMOS IN THE US HAVE NOT BEEN SUCCESSFUL IN 3 AREAS:

1 Providing service to the poor,
2 Providing services to rural areas and
3 Providing services to areas where physicians and other health providers are maldistributed.

HEALTH CARE COST CONTAINMENT STRATEGIES

1 Micro demand side strategies
1.1 Patients
1.2 Deductibles
1.3 Coinsurance
1.4 Reimburse
1.5 Exclusions
1.6 Premiums
1.7 Providers
1.8 Review of clinical decisions
1.9 Managed care
1.10 Utilization review

2 Micro supply side strategies
2.1 Capitation fees
2.2 DRG's
2.3 Fee schedules
2.4 Educating providers about cost effective care
2.5 Constraints on ownership of facilities
2.6 Control of drug dispensing

3 Macro demand side strategies
3.1 Limit physician income by caps
3.2 Prospective budgets for hospitals

4 Macro supply side strategies
4.1 Redistribution of resources among regions
4.2 Redistribution of resources among income groups

WHAT DRIVES UP HEALTH CARE COSTS

1 Induced services by availability of money and competing providers
2 Increased hospital admissions
3 Increased patient days
4 Increased doctor visits
5 Increased drug consumption
6 Increased medical procedures
7 Increased medical technology
8 Intensification of care

FINANCIAL INCENTIVES TO CONTROL COSTS

1 Avoid cost plus services reimbursement which stimulate use
2 Promote reasonable earnings and regulated return on investment regardless of volume
3 Avoid retrospective cost reimbursement which has no incentive to contain costs or be efficient
4 Avoid cost increasing behaviors which lead to supply induced demand
5 Permit fee-for-service models in circumstances where they are determined by consensus among providers, payers, patients and regulators.

ADMINISTRATIVE INEFFICIENCY VARIES WIDELY AMONG COUNTRIES.

1 Size of insurance beneficiary pools influence economies of scale (in Korea, groups of between 30,000 and 200,000 members have administrative costs ranging from 12 to 22 percent of their premium.
2 Blue cross in U.S. is at 7% of costs
3 Private U.S. insurers at 10%

COST OF ADMINISTERING INSURANCE AS A PERCENT OF TOTAL HEALTH EXPENDITURES

1 Canada - 2.5%
2 U.K. - 2.6%
3 U.S. - 5.8

TOTAL ADMINISTRATIVE COSTS OF MEDICAL CARE INSTITUTIONS AND PRACTITIONERS OFFICES

1 Canada 8.4 - 11 %
2 U.S. 19 - 24 %

INEFFICIENCIES WHICH CONTRIBUTE TO HIGHER FINANCIAL COST

1 Administrative expense of fragmented insurance system.
2 Over-prescription of drugs.
3 Performance of lesser tasks by highly skilled persons.
4 Unnecessary and inappropriate care.
5 Rivalry among doctors.
6 Profit maximizing behavior among hospitals, doctors, pharmacists and others.

SUMMARY

Private insurance can assist the radical and necessary transformation of the organization, internal dynamics, mechanisms of financing, and redistributive power of the health sector if it is accompanied by:

1 Strengthening the guiding capacity of health ministries and limiting their role in direct provision of services

2 Integrating and coordinating public and private health services to produce local and regional health systems

3 Progressive expansion of coverage of government sponsored national health insurance systems until it is universal and integrated with private insurance

4 Improving the focus of public health and nutrition programs in accordance with social, geographic, demographic, and epidemiologic necessity

5 Increasing the efficacy of health services through establishment of administrative norms and incentives to regulate the supply and demand

NECESSARY DATA FOR BASELINE ASSESSMENT

1 Health care expenditures as a percentage of GNP.
2 Per capita expenditures.
3 Per capita health expenditures by income level.
4 Per capita income.
5 Per capita health expenditures by percentage of income.
6 Percentage of U.S. Per capita health expenditures.
7 Costs per prescription.
8 Costs per physician visit.
9 Costs per hospital day.
10 Costs per hospital admission.
11 Costs per hospital admission by diagnosis.

12 Costs per dispensary visit.
13 Rate of urbanization.
14 Rate of industrialization / job creation.
15 Education trends.
16 Housing trends.
17 Nutrition trends.
18 Public health trends.
19 Life expectancy.
20 Population profile.
21 Mortality profile.
22 Disease trends.
23 Manpower supply and distribution.
24 Wages.
25 Beds per population.
26 Length of hospital stay.

APPENDIX B. PERSONS CONTACTED

OKUDO AKUMU	CONSULTANT ACTUARY	
GEORGE ANGILA	HEALTH CONSULTANT	KCHF
CYPRIAN A. O. AWITI	DIRECTOR	PHS/MARIE STOPES BOX 53928, NAIROBI
BENGT BECKMANN	CHAIRMAN	AAR
CHAIRMAN	KIRIANI COFFEE COOPERATIVE	CHOGORIA
ROBIN CHEWYA	MARKETING MANAGER ML&G	
KATE COLSON	PROJECT OFFICER KHCFP	USAID/K/PH BOX 30261, NAIROBI
AMIN M. DATOO	GENERAL MANAGER JUBILEE INS CO	JUBILEE INSURANCE
SR. ELIZABETH DOOLEY	MEDICAL SECRETARY	KENYA CATHOLIC SECRETARIAT P.O.BOX 48062, NAIROBI
RICHARD T. EDDY	INSURANCE PLANNING SPECIALIST	WORLD BANK WASHINGTON, D.C.
LORD ENNISKILLEN	MANAGING DIRECTOR	AAR
MICHAEL ENRIGHT	CONSULTANT PROFIT PROJECT	WASHINGTON, DC
JAGI GAKUNJU	MARKETING	AAR BOX 41766, NAIROBI
KARA HANSON	HEALTH ECONOMIST HARVARD UNIVERSITY	DATA FOR DECISION MAKING PROJECT
IBRAHIM M. HUSSEIN	KHCFP SECRETARIAT	MOH / HCFS
GERRISHON K. IKIARA	CONSULTANT ECONOMIST KHCFP	UNIV OF NAIROBI
KARANJA KABAGE	MANAGING DIRECTOR	KABAGE & MWIRIGI INSURANCE
ELIJAH KAMAU		KIJABE HOSPITAL
MARY KILONZO	PLANNER KHCF SECRETARIAT	KHCFS / MOH

CAROLE KIMANI	GROUP MANAGER ALICO	
SILAS KOBIA	MANAGING DIRECTOR	C.I.S.
DAN KRAUSHAAR, Sc.D.	CHIEF OF PARTY	KHCF PROJECT MOH
R. KRISHNASWANY	GENERAL MANAGER	
SARA MARAMBII-CHEGGE	ADMINISTRATOR	KHCFP BOX 41869, NAIROBI
PETER MBUGUA	MARKETING REP. ROYAL MEDICARD	ROYAL CREDIT BOX 7468, NAIROBI
GERALD MIRITI	HEALTH PLANNING OFFICER	BOX 1488, KAKAMEGA KFPHCP/FINNIDA
ELIUD M. MURIITHI	DIVISION MANAGER	MADISON INSURANCE CO. BOX 47382, NAIROBI
M. MURUTHI	COMMISSIONER OF INS	
FRANCIS MWORIA	CHIEF HOSPITAL SECRETARY CHAIRMAN	KMOH AFYA SAVINGS AND CREDIT COOPERATIVE SOCIETY
J.N. NAMASALE	EXECUTIVE OFFICER	F.K.E.
JASON N. NAMASAKE	SR. EXECUTIVE OFFICER	FEDERATION OF KENYA EMPLOYERS
FESTUS NKONGE	ADMINISTRATOR	CHOGORIA HOSPITAL BOX 35, CHOGORIA
DEREK J. OATWAY	INSURANCE CONSULTANT	AAR
G.N. ODENY	DEPUTY DIRECTOR	NHIF BOX 30443, NAIROBI
NORMAN OLEMBO, M.D.	MEDICAL DIRECTOR	CHAK BOX 30690, NAIROBI
GILBERT H.J. ONYANGO	PRINCIPAL	COLLEGE OF INSURANCE
JONATHAN QUICK. M.D.	TEAM PHYSICIAN	KHCFP
DAVID RONO		CIS
ALASTAIR SAMMON, M.D.	DIRECTOR IN-CHARGE	CHOGORIA HOSPITAL BOX 35, CHOGORIA

ALFRED SCHIHACHI	UNDERWRITING MANAGER	CIS LTD BOX 59485, NAIROBI
IAN SLINEY	SENIOR PLANNER	MOH
MICHAEL SMYSER	DIRECTOR	MINNESOTA INTERNATIONAL VOLUNTEERS
E.D. TENAMBERGEN, M.D.	CONSULTANT MANAGING DIRECTOR	DCH/UON/GTZ
JENNIFER THEURI	ASST. MARKETING MANAGER ROYAL MEDICARD	
PATRICK TUMBA		CIS
MICHAEL VAN VLECK	DIRECTOR INVESTMENTS PROFIT PROJECT	WASHINGTON, DC
ALNASHIR A. VISRAM	DIRECTOR	AGA KHAN HOSPITAL
JOSEPH WANG'OMBE	HEALTH ECONOMIST	HEDRA
GABRIEL O. WENDOH	LIFE MANAGER	CIS LTD BOX 59485, NAIROBI
CHRISTOPHER WILSON	DIRECTOR	AAR

APPENDIX C. CRITERIA FOR HEALTH INSURANCE SCHEMES

KENYA PREPAID HEALTH PLANS - WORKSHOP 2 - MONDAY - 8 APRIL 1994		
General Criteria for Evaluating Prepaid Health		
Please read the criteria and rank their importance for developing prepaid health schemes for Kenya in Column 3. Use one (1) for the most important. Use thirteen (13) for the least important.		
Criteria	Definition	Importance
Acceptable	Meets the expectations of the people buying and receiving the services offered.	
Accessible	Able to serve the health care needs or rural and urban populations of individuals, small employer groups or large groups such as cooperatives.	
Affordable	Cost is within the budget of the target population.	
Anti-inflationary/ Cost Effective	Discourages unnecessary use of services by both doctors and patients. Controls prices managerially rather than by market forces. Limits access to control unnecessary use. Redistributes some resources to increase equity.	
Appropriate	Offers the services that are most necessary for the health needs of the population.	
Continuous	Maintains institutional records of the patients medical history so care does not start new at each visit.	
Effective	Returns a high percentage of premiums to subscribers as benefits; has low administrative overhead; minimal profit margin; returns profit to beneficiaries as services rather than to stockholders.	
Efficient	Provides services at a low cost per unit of service; good procurement and supervisory practices; low losses.	
Equitable	Provides some benefits to persons based on their need rather than on their ability to pay; attempts some cross subsidies.	
Fraud resistant	Has controls built in to prevent fraud by subscribers and/or providers and/or managers.	
Replicable/Low Risk/Proven	Familiar approach, known to have succeeded with tolerable risk of failure. Likely to be replicable in similar circumstances.	
Quality	Providing care that includes capable diagnosis and effective treatment.	
Sustainable	Soundly designed scheme capable of workshop its ongoing obligations from ongoing revenue; not paying today's obligations with tomorrow's revenue.	

REVISED CRITERIA FOR HEALTH INSURANCE SCHEMES

KENYA PREPAID HEALTH PLANS - WORKSHOP 2 - MONDAY - 8 APRIL 1994		
General Criteria for Evaluating Prepaid Health		
Please read the criteria and rank their importance for developing prepaid health schemes for Kenya in Column 3. Use one (1) for the most important. Use thirteen (13) for the least important.		
Criteria	Definition	Importance
Acceptable	Meets the expectations of the people buying and receiving the services offered.	
Accessible	Able to serve the health care needs or rural and urban populations of individuals, small employer groups or large groups such as cooperatives.	
Affordable	Cost is within the budget of the target population.	
Anti-inflationary	Discourages unnecessary use of services by both doctors and patients. Controls prices managerially rather than by market forces.	
Appropriate	Offers the services, which can be met through insurance, that are most necessary for the health needs of the population	
Effective & Efficient	Returns a high percentage of premiums to subscribers as benefits; Provides services at a low cost per unit of service; meets productivity goals.	
Equitable	Provides some benefits to persons based on their need rather than on their ability to pay; attempts some cross subsidies.	
Fraud & abuse resistant	Has controls built in to prevent fraud by subscribers and/or providers and/or managers and insurers.	
Replicable	Based on features that are sufficiently similar in different communities that successful experiences can be repeated.	
Quality	Providing care that includes capable diagnosis and effective treatment.	
Sustainable.	Soundly designed scheme incorporating proper incentives for rational health system development.	

APPENDIX D. TASKS FOR DEVELOPING LONG TERM PLANS

- DEVELOP CONCEPT
  - Review literature
  - Introduce concept
  - Discuss with potential partners
  - Formulate plan

- PRODUCT DEVELOPMENT
  - Review regulations
  - Identify Carriers

- MARKETING
  - Identify Subscriber Groups
  - Test concept appeal
  - Create benefits package

- SECURE FINANCING
  - Develop Business Plan
    - Revenue Projections
      - Cost benefits package(s)
      - Estimate premiums
  - Expense Projections
    - Operating budget
  - Present Proposal to Donors
  - Financing Secured

- BUDGET CYCLE
  - Revenue Forecasts
    - Estimate First Draft Revenues
    - Receive Revisions
    - Final Revenue Projections
    - Revenue Forecasts Approved
  - Expense Forecasts
    - Prepare Expense Guidelines
    - Estimate First Draft Expenses
    - Receive Expense Revisions
    - Final Expense Review
    - Expense Forecasts Approved
  - Final Budget Review
  - Budget Approved

- MARKETING PLAN
  - Marketing Plan
    - Market Analysis
      - Target Market
      - Competitive Analysis
    - Establish Objectives
    - Develop Tactics
    - Sales Forecasts
    - Staffing Requirements

- Draft Complete
- Review Plan

" Advertising Plan

" Public Relations
- Press Release
- Product Brochure
- Mailing

! FACILITY PLANNING
" Site Selection
" Lease Negotiation
" Plans & Permits
" Space Planning
" Purchases as needed

! IMPLEMENTATION
" Identify provider sites
" Contracts
" Develop policy and procedures
" Staffing
" Training

! OPEN FACILITY

APPENDIX E. REFERENCES CONSULTED

Abel-Smith B, Health economics in developing countries. JOURNAL OF TROPICAL MEDICINE AND HYGIENE. 1989 Aug;92(4):229-41.

Alan Guttmacher Institute [AGI], Abortion. STATE REPRODUCTIVE HEALTH MONITOR. 1992 Sep;3(3):1-28.

Anonymous, Private sector joins family planning effort. FRONT LINES. 1989 Dec;:6, 13.

Assistencia Medica a Industria e Comercio [AMICO], Assessing costs and benefits of incorporating family planning services delivery into a prepaid health maintenance organization plan in Brazil, CI 85.21A. Final report: AMICO Assistencia Medica, Sao Paulo, Brazil. [Unpublished] [1987]. 73 p.

Badran A, Structural factors/requirements in utilizing cooperative concepts: a Perspective from the consumer and producer viewpoints. In: National Council for International Health [NCIH], Cooperative League of the U.S.A., Group Health Association of America. Alternative health delivery systems: can they serve the public interest in Third World settings? Occasional papers. Washington, D.C., NCIH, 1984 Aug. :36-40.

Barry M; Cullen MR; Thomas JE; Loewenson RH, Health care changes after independence and transition to majority rule. Letter from Zimbabwe. JAMA. 1990 Feb 2;263(5):638-40.

Berman HA, The HMO as an alternative health care system. In: National Council for International Health [NCIH],

Bloom G, Two models for change in the health services in Zimbabwe. INTERNATIONAL JOURNAL OF HEALTH SERVICES. 1985;15(3):451-68.

Carrin G, Community financing of health care. WORLD HEALTH FORUM. 1988;9(4):601-6.

Central African Republic, Act No. 1989.003 of 23 March 1989 fixing the general principles of public health in the Central African Republic. ANNUAL REVIEW OF POPULATION LAW. 1989;16:190-1. From: International Digest of Health Legislation, Vol. 40, No. 3, 1989, pp. 557-558.

Central Bureau of Statistics, Ministry of Planning and National Development, Statistical Abstract, Republic of Kenya, 1991, 192 p.

Coalition for Health Insurance Availability, Statement in support of health insurance risk pooling. [Unpublished] 1986 Apr 22. 2 p.

Costanza R, Balancing humans in the biosphere: escaping the overpopulation trap. NPG FORUM. 1990 Jul;:1-6.

Danforth N; Fairbank A, Private-sector ORT delivery systems. In: Manual for assessment and planning of national ORT programs, edited by John LeSar, Polly Harrison, and Ann Buxbaum. Arlington, Virginia, Management Sciences for Health, PRITECH, 1985 Dec. :17 p.

Dorward JA, Underfunding: an African perspective. BMJ. 1992 Apr 11;304(6832):990.

Dumm, John J., et. al., Helping Srvices Meet Demand:An Assessment of A.I.D. Assistance to Family Planning in Kenya, The Center for Communications Programs, The Johns Hopkins University, 1992, 30 p.

El Bindary A, The national policy for population and family planning. POPULATION STUDIES. 1980 Apr-Jun;:44-51.

Fernandez Montoto NE, Cuba. In: The right to health in the Americas, a comparative constitutional study, edited by Hernan L. Fuenzalida-Puelma and Susan Scholle Connor. Washington, D.C., Pan American Health Organization, 1989.: 216-25. PAHO Scientific Publication No. 509

Fisher P, A review of the KHDI health insurance pilot project in Okgu County, South Korea. [Unpublished] 1980. 21 p.

Frenk J, Financing as an instrument of public policy. BULLETIN OF THE PAN AMERICAN HEALTH ORGANIZATION. 1988;22(4):440-6.

GIRARD RD, Legal issues in contracting with HMOs. Hospital Progress 55(8): 45-50. August 1974.

Gish O Sr; Malik R; Sudharto P, Who gets what? Utilization of health services in Indonesia. Washington, D.C., International Science and Technology Institute, [1990]. v, 17 p. Consultant Report Series Report 28; Health Sector Financing Project, Ministry of Health, Republic of Indonesia; PNABE 819; USAID Contract No. ANE-0354-C-00-8030-00

Griffin CC, Health care in Asia: a comparative study of cost and financing. Washington, D.C., World Bank, 1992. xvii, 226 p. World Bank Regional and Sectoral Studies

Griffin CC, Trip Report for Kenya, Health Financing and Sustainability Project, Abt Associates, 1993 May, 25 p.., USAID Contract.

Hilsenrath PE; Joseph H, Health economics: issues for South Africa. SOUTH AFRICAN JOURNAL OF ECONOMICS / SUID-AFRIKAANSE TYDSKRIF VIR EKONOMIE. 1991 Jun;59(2):146-59.

Hinman E, Cooperatives and health maintenance organizations: the U.S. experience. In: National Council for International Health [NCIH], Cooperative League of the U.S.A., Group Health Association of America. Alternative health delivery systems: can they serve the public interest in Third World settings? Occasional papers. Washington, D.C., NCIH, 1984 Aug. :12-6.

Holshauser T, An employer-sponsored, pre-paid health care system in Brazil--AMICO (Assistencia a Industria e Commercio, Ltda) In: National Council for International Health [NCIH], Cooperative League of the U.S.A., Group Health Association of America. Alternative health delivery systems: can they serve the public interest in Third World settings? Occasional papers. Washington, D.C., NCIH, 1984 Aug. :86-93.

Hunter HR, Options for delivering health and family planning services in India through managed health care insurance. In: Corporate sector and family welfare program in India. Vol. I, edited by Bhabani Sengupta, Anil Guha, P.P. Talwar. New Delhi, India, Council of Indian Employers, 1990. :114-31.

International Labour Office; United Nations Fund for Population Activities, Report to the government of Iran on the incorporation of family planning care within the medical services of the social insurance organization. Geneva, ILO, 1971. 35 p.

Jancloes M; Seck B; Van De Velden L; Ndiaye B, Financing urban primary health services. TROPICAL DOCTOR. 1985 Apr;15(2):98-104.

Janowitz B; Nakamura MS; Brown ML; Clopton D, Do the poor get sterilized? access to services in Campinas, Brazil. [Unpublished] [1980]. 27 p.

John Short Associates, Promoting Family Planning as an Insurance Benefit, Technical Information on Population for the Private Sector, 1991 Mar. 16 p.

John Snow [JSI]. Resources for Child Health [REACH], Nairobi Area Study. Volume III. Appendix. Arlington, Virginia, JSI, REACH, 1988 Nov. [2], 55 p. USAID Contract No. DPE-5927-C-00-5068-00

Kneedler WS, The HMO in U.S. and Third World settings. In: National Council for International Health [NCIH], Cooperative League of the U.S.A., Group Health Association of America. Alternative health delivery systems: can they serve the public interest in Third World settings? Occasional papers. Washington, D.C., NCIH, 1984 Aug. :77-80.

Korte R; Richter H; Merkle F; Gorgen H, Financing health services in sub-Saharan Africa: options for decision makers during adjustment. Dept. of Health, Population and Nutrition, Deutsche Gesellschaft fur Technische Zusammenarbeit GmbH, Dag-Hammarskjold-Weg 1-2, 6236 Eschborn, Germany SOCIAL SCIENCE AND MEDICINE. 1992 Jan;34(1):1-9.

Lande RE; Geller JS, Paying for family planning. POPULATION REPORTS. SERIES J: FAMILY PLANNING PROGRAMS. 1991 Nov;(39):1-31.

Lee RD; Miller T, Population age structure, intergenerational transfers, and wealth: a new approach, with applications to the U.S. [Unpublished] 1992 Aug 16. 27, [12] p.

Lewis MA, Financing health care in Jamaica. Arlington, Virginia, John Snow, Inc. [JSI], Resources for Child Health Project [REACH], 1988 Nov. viii, 113 p. USAID Contract No. DPE-5927-C-00-5068-00

Lewis MA, The AID experience in health care financing, 1978-1986.
SOURCE: Arlington, Virginia, John Snow, Inc., Resources for Child Health Project [REACH], [1987]. 104 p.

Lewis MA, The private sector and health care delivery in developing, countries:
definition, experience, and potential. Arlington, Virginia, John Snow, Inc. [JSI], Resources for Child Health Project [REACH], 1988 April. [6], 85 p. USAID Contract No. DPE-5927-C-5068-00

Lewis MA; Miller TR, Public-private partnership in water supply and sanitation, in Sub-Saharan Africa. HEALTH POLICY AND PLANNING. 1987;2(1):70-9.

London B, Dependence, distorted development, and fertility trends in noncore nations: a structural analysis of cross-national data. AMERICAN SOCIOLOGICAL REVIEW. 1988 Aug;53(4):606-18.

McMahon, Alene, John Snow [JSI]. The Enterprise Program, Guide to Conducting Cost/Savings Analysis of Private Sector Family Planning Programs, Arlington, Virginia, JSI, Enterprise, 1991 May., 38 p. USAID Contract No. DPE-3034-C-00-5072-00

Marquez PV; Engler T, Crisis and health: challenges for the decade of the 1990s. [Crisis y salud: retos para la decada de los 90.] EDUCACION MEDICA Y SALUD. 1990 Jan-Mar;24(1):7-26.

McIntyre PS, Norplant. JOURNAL OF THE TENNESSEE MEDICAL ASSOCIATION. 1992 Jul;85(7):333-4.

Mills A, Economic aspects of health insurance. In: Lee K, Mills A, ed. The economics of health in developing countries. Oxford, England, Oxford University Press, 1983. :64-88.

Muchiri, S.N., and Quick, J.D., Five Year Implementation Plan for Financing Health Care in Kenya, Health Care Financing Task Force, Aug 1993, 16 p.

Mutungi, O.K., Legal / Regulatory Framework Within Which the Private Sector on Health Policy in Kenya Operates, Nairobi, Kenya. No date. 48 p.

Mwabu, Germano, Financing Health Services through Insurance, HEDRA LTD., for Health Financing and Sustainability Project, Abt Associates, 1993 Oct, 93 p., USAID Contract.

Nathan C, Patients' rights in a Third World southern African country, with special reference to Bophuthatswana: is there any potential for privatization? MEDICINE AND LAW. 1989;7(6):585-93.

Naylor CD, Private medicine and the privatization of health care in South Africa. SOCIAL SCIENCE AND MEDICINE. 1988;27(11):1153-70.

Ogunbekun IO, Which direction for health care in Nigeria? HEALTH POLICY AND PLANNING. 1991 Sep;6(3):254-61.

Phillips C, Private firm offers family planning. FRONT LINES. 1990 Jul;:5.

Population Council, Assessing costs and benefits of incorporating family planning service delivery into pre-paid health maintenance organization plan in Brazil.
[Unpublished] [1986]. [1] p.

Procter J, The provision for health needs in less developed countries with reference to Bophuthatswana. MEDICINE AND LAW. 1989;8(6):581-7.

PROFIT Project, Investment Document: Phillipines: Philamcare's Low Cost Health Care Plan, Nov 1993, 38 p. USAID Contract No. DPE-3056-C-00-1040-00

Raffel MW, Dominant issues: costs and values. In: Comparative health systems: descriptive analyses of fourteen national health systems, edited by Marshall W. Raffel. University Park, Pennsylvania, Pennsylvania State University Press, 1984.: 587-600.

Segall M, Planning and politics of resource allocation for primary health care: romotion of meaningful national policy. SOCIAL SCIENCE AND MEDICINE. 1983;17(24):1947-60.

Sherraden MS; Wallace SP, Innovation in primary care: community health services in Mexico and the United States. SOCIAL SCIENCE AND MEDICINE. 1992 Dec;35(12):1433-43.

Siegrist, Richard B., National Hospital Insurance Fund, Government of Kenya, Health Financing and Sustainability Project, Abt Associates, 1992 Feb.

Spurgeon D, What do young black South Africans think about AIDS? IDRC REPORTS. 1992 Jul;20(2):10-2.

Staver S, Nation's AIDS epidemic triggers insurance woes for millions of people. AMERICAN MEDICAL NEWS. 1986 Apr 11;:1, 37-8.

Stevens CM, Implementation of health care financing schemes component of, primary health care in the Philippines. [Unpublished] 1983. 23 p.

Stevens CM, A.I.D. health projects: comments on the "sustainability" issue. [Unpublished] 1987 Feb. 9, [11] p.

Stevens C, Rationalizing health sector financing in less developed countries. In: National Council for International Health [NCIH],

Terris M, The three world systems of medical care: trends and prospects. American Journal of Public Health 68(11):1125-1131. November 1978.

Toufexis A, Birth control: vanishing options. TIME. 1986 Sep 1;:78.

Vernon R; Lopez-Canales JR; Carcamo JA, Post-partum family planning in Honduras. [Unpublished] 1991. [25] p. Presented at the 119th Annual Meeting of the American Public Health Association [APHA], Atlanta, Georgia, November 11-14, 1991.

Vogel RJ, Cost recovery policy in the Cote d'Ivoire. In: Cost recovery in the health care sector: selected country studies in West Africa, by Ronald J. Vogel. Washington, D.C., The World Bank, 1988. :87-125. World Bank Technical Paper No. 82

Vogel RJ, Cost recovery policy in Ghana. In: Cost recovery in the health care sector: selected country studies in West Africa, by Ronald J. Vogel. Washington, D.C., The World Bank, 1988. :126-58. World Bank Technical Paper No. 82

Widgren J, Asylum seekers in Europe in the context of south-north movements. INTERNATIONAL MIGRATION REVIEW. 1989 Fall;23(3):599-605.

Wilson JB, Women and poverty: a demographic overview. WOMEN AND HEALTH. 1987;12(3-4):21-40.

Wu X, Provide comprehensive service for state policy. RENKOU XUEKAN. 1991 Apr;(2):47-50.

Wunsch B; Aved B, Trends in health care financing: opportunities for family planning agencies. FAMILY PLANNING PERSPECTIVES. 1987 Mar-Apr;19(2):71-4.

Zukin P, Evaluation guide for the feasibility of a health maintenance organization]. Piedmont, California, Health Management Group, 1985. vi, 117 p. Printed for the PRITECH Project , Management Sciences for Health, Suite 700, 1655 North Ft. Myer Drive, Arlington, VA 22209, USA