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**Kenya Health Care Financing
Program and Project
MID-TERM EVALUATION REPORT**

Submitted to:

USAID/Nairobi

By

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ABBREVIATIONS

AAI	Abt Associates Incorporated
A.I.D.	Agency for International Development
A-in-A	Appropriations-in-Aid
CIDA	Canadian International Development Agency
DANIDA	Danish International Development Agency
DH	District Hospital
DHMB	District Health Management Board
DHMT	District Health Management Team
EOPS	End of Project Status
FY	Fiscal Year
GDP	Gross Domestic Product
GNP	Gross National Product
GOK	Government of Kenya
HCF	Health Care Financing
HFS	Health Financing and Sustainability
KHCFP	Kenya Health Care Financing Program and Project
KL	Kenyan Pounds
KNH	Kenyatta National Hospital
KSH	Kenyan Shillings
LOE	Level of Effort
MOF	Ministry of Finance
MOH	Ministry of Health
NHIF	National Hospital Insurance Fund
NPA	Non-project Assistance
ODA	Overseas Development Agency
PAAD	Program Assistance Approval Document
PGH	Provincial General Hospital
PIL	Project Implementation Letter
P/PCH	Preventive and Primary Health Care
SIDA	Swedish International Development Agency
TA	Technical Assistance
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations International Childrens Education Fund
USAID	United States Agency for International Development
WHO	World Health Organization

**KSh 30 = U.S. \$1.00

EXECUTIVE SUMMARY

The mid-term evaluation found the Kenya Health Care Financing Program (KHCFP) to be an innovative and successful means to promote the review, reform, and implementation of health care finance policy. Through the implementation of the reforms, the institutions have strengthened their capacities in these areas and improved the sustainability of both policies and process. The reforms being implemented appear technically well-conceived and likely to have a major impact on the finances of the health sector. Commitment to the Program's reform agenda appears firm. The Program is an excellent example of how non-project assistance (NPA) is intended to encourage collaborative, development, and implementation of policy reform. A great deal of hard work remains ahead as the implementing institutions seek to strengthen systems developed so far and to expand their coverage.

BACKGROUND TO THE EVALUATION

The USAID/Nairobi Health Care Financing Program (615-0245) is a policy based dollar resource transfer program to promote the implementation of policy reforms that will assist the Government of Kenya (GOK) to provide sustained, increased financial resources for the delivery of efficient, quality preventive, primary and curative health services. Policy reforms promoted by the Program are designed to:

- Promote the reallocation of financial resources within the health sector in favor of preventive and primary services and
- Increase the overall financial resources available to the health sector in order to improve services and make reallocation feasible.

Under the cash transfer component of the Program (U.S. \$9.7 million), tranches of funds are disbursed to each of three institutions [the Ministry of Health (MOH), Kenyatta National Hospital (KNH), and the National Hospital Insurance Fund (NHIF)] based upon meeting predetermined and mutually agreed upon policy reform and implementation bench marks. In the Project component (U.S. \$5.3 million) the three implementing institutions receive technical assistance, training, and commodities required to meet the policy reform bench marks.

A three person team conducted a mid-term evaluation of the program between 22 April and 15 May 1992.

CONDITIONALITIES

General conditionalities contained in the Program are intended to guarantee that revenues generated by the direct payment of user fees at government facilities ("cost sharing") or reimbursement of hospital fees by the NHIF will be considered to be additional to (and not a substitution for) constant levels of budget support for the health sector by the Treasury. Cost sharing revenues

are also to be considered "no-year" funds and unspent revenues are not to be returned to the Treasury at the end of the fiscal year. The GOK has agreed to this "off-budget" approach and has met the terms of the general benchmarks for tranche one of the Program.

FINDINGS

A summary of the evaluation team's conclusions and recommendations for each of the implementing institutions follows:

MINISTRY OF HEALTH

The implementation of cost sharing at the seven Provincial General Hospitals (PGH) is on track and appears capable of generating substantial revenues at the facility level. The systems developed and implemented by the Health Care Finance Secretariat and the technical assistance team to support the collection of fees, accountability of both collection and expenditures, and reporting appear well-designed and feasible. Separate systems intended to increase the rate of claims filed for reimbursement from NHIF are functioning although the administrative cost of filing claims remains high. A system of exemptions and waivers designed to insure that no one is denied access to services as a result of cost sharing has been developed. Plans to develop a comprehensive monitoring and evaluation system are, as yet, incomplete. Plans have been developed to extend coverage of the cost sharing systems to the level of the 45 District Hospitals. The Secretariat is also setting policy and developing systems to allow for the phased reintroduction of outpatient treatment fees.

Cost sharing revenues appear to have a significant impact on the availability of resources at the PGH level. Revenues currently represent between 30 and 80 percent of non-wage operating costs at those facilities. Revenues at those levels continue to rise each month as collection and accounting systems improve.

The MOH has developed a policy that guarantees the local retention of all cost sharing revenues at the district level. The policy allows the collecting facility to retain 75 percent of all revenues to be used according to guidelines for improvement of the facility. The remaining 25 percent is to be used by the District Health Management Team (DHMT), under the guidance of a District Health Management Board (DHMB), to improve the delivery of preventive and primary health services within the district. As yet, the DHMBs have not been gazetted and the DHMTs have made little use of their cost sharing resources to improve services.

The MOH has developed methods to document shifts in resource allocation within its budget toward non-wage recurrent costs generally and specifically toward P/PHC services. The ability of the MOH to shift resources in favor of priority programs is threatened by its large wage bill which creates imbalances between budget estimates and actual expenditures.

The MOH has not yet completed the design of a comprehensive system to monitor the implementation and evaluate the impact of cost sharing. Such a system is necessary in order to guarantee that cost sharing mechanisms in place do not restrict access to health care by the poor and vulnerable populations. Components of a system are in place, but design and implementation must be completed.

The reintroduction of outpatient treatment fees to replace consultation fees suspended in 1990 marks a significant design innovation for the cost sharing system. The "no treatment-no fee" aspect of the fees has been developed in order to increase patient acceptance of the fees and to increase incentives for the system to deliver quality services and increase drug availability.

The MOH is currently undertaking a major exercise to develop a health care finance policy for the next five to ten years. The development of this plan should be considered a major priority as it sets the blueprint for the development of the health sector.

The Secretariat is currently understaffed and has no MOH budget support for recurrent operating costs. The MOH must immediately assign staff according to the approved staffing plan. An interim source of financial support must be identified until MOH budget support becomes available in FY 93/94.

KENYATTA NATIONAL HOSPITAL

Conditionalities pertaining to KNH are intended to encourage the implementation of policy reforms aimed at improving the quality and efficiency of services and to improve the revenue generation capacity of the facility through the implementation of cost sharing and other measures.

KNH has developed and installed fee collection and accounting systems in support of the implementation of cost sharing. Fee schedules have been established and KNH is beginning to generate substantial revenues. As KNH organizes to file claims for a greater percentage of patients covered by NHIF, revenues should continue to climb. The accounting and management systems appear feasible and KNH and the technical assistance team have made significant efforts to supervise their installation and operation.

Although action has been taken to study and improve the efficiency of operations, KNH has completed only two of the six required quality assessments. Several of the recommendations from the two studies have been implemented.

KNH, like the MOH, has not yet fully developed a comprehensive monitoring and evaluation system that will allow staff to adequately assess the impact of cost sharing on its patients. Current systems to monitor revenues and utilization of services work well.

KNH has had difficulty in reaching projected levels of revenue. These projections were based on fees that were significantly higher than those currently charged. KNH should continue to project revenues and monitor fee collection performance against those projections. It will be necessary to adapt projections as their underlying assumptions change.

KNH remains under the financial control of the MOH. This has produced difficulty in KNH actually receiving all of the funds provided under the Treasury's allocation. This has placed greater pressure on cost sharing revenues than intended and makes proficient financial management of KNH difficult.

NATIONAL HOSPITAL INSURANCE FUND

The NHIF rests within the organizational framework of the MOH. Staff are recruited for NHIF from the MOH or the Treasury. NHIF suffers from inadequate staffing at the senior management level as well as in several technical areas (computer programming, actuarial analysis, etc.). Efforts to fill these positions (or retain trained, qualified civil service employees) are hampered by civil service salary levels that are below market value. The Program supports proposed legislation that will grant NHIF state corporation status. This will alleviate constraints to filling all staff positions with qualified personnel. A bill granting state corporation status has been drafted and reviewed by the Attorney General's office. The MOH should submit the bill to the Cabinet without delay so that it may be approved by Parliament during the current session.

The Program seeks to encourage NHIF to adopt a progressive fee structure and increase benefits through increased payments and new products. A progressive fee structure has been developed and adopted. NHIF reimbursement rates have increased dramatically, thereby increasing revenue at public and private hospital facilities. The fee and reimbursement rate changes have allowed NHIF to accumulate a significant cash surplus. This surplus exceeds the levels of reserve normally held by health insurance organizations.

Development of new benefits has been hampered by the absence of data bases to permit actuarial analysis. With the aid of project technical assistance, NHIF has begun refining its claims data base. Progress has been hampered by the lack of in-house computing capacity. The membership data base must be cleaned before analysis may begin. NHIF lacks a comprehensive system design that links its needs with available software and hardware configurations. Lack of corporate status has impeded NHIF efforts to procure required computer equipment.

NHIF is well on the way to development of a strategic plan. This is a priority activity that will allow NHIF to define its role in financing the health sector. The plan will become an important component of the overall strategic plan for health financing being developed by the MOH.

CONCLUSIONS

The KHCFP has proven to be an effective means to promote and develop the GOK's capacity to review, reform, and implement health sector policy reform. Commitment to Program reforms is firm. The systems being implemented appear well-designed and feasible. They must be modified and their coverage extended.

The reform process and its results have put Kenya in the forefront of health finance reform efforts in Sub-Saharan Africa. The combination of NPA and the project's technical assistance component have formed an effective package by which important policy reforms have been developed and implemented.

Overall priorities call for the MOH to extend the systems developed and implemented at the PGH level to collect, spend, and account for revenues to the level of the District Hospitals and Health Centers. In addition, the least developed areas of the reform agenda which must be considered major priorities and require additional attention for the remainder of the Program are:

- Development and implementation of a comprehensive monitoring and evaluation systems to assess the impact of cost sharing on health delivery and the population and
- Development of a comprehensive strategy for financing the health sector.

To permit the implementing institutions to adequately address these priority issues (as well as others), it will be necessary to extend the end date of the Program by at least one year. The evaluation also recommends that USAID provide technical assistance resources beyond the end of the current contract.

RECOMMENDATIONS

MINISTRY OF HEALTH

- Areas of emphasis to be addressed as priorities by the Secretariat and technical assistance team during the remainder of the Program:
 - Continued development and expansion of cost sharing systems and mechanisms to District Hospitals and Health Centers
 - Increased effort to develop mechanisms to shift budget resources toward non-wage costs and P/PHC services
 - Definition and development of systems to be implemented at the district level to allow the DHMBs and DHMTs to effectively plan, spend, and account for cost sharing revenues
 - Development and implementation of an adequate system to monitor implementation of and evaluate the impact of cost sharing and
 - Continued emphasis on the development of the MOH health finance strategy statement.

- The MOH should immediately assign additional staff to the Secretariat as agreed in the recently approved staffing plan. Financing necessary to support the recurrent cost of Secretariat operations should be included in FY 93/94 forward budget estimates.
- The KHCFP Secretariat must refine and closely monitor the development of systems that permit accountability and transparency in the collection, management, and spending of cost sharing revenues at both facilities and districts.

KENYATTA NATIONAL HOSPITAL

- The MOH, Ministry of Finance (MOF), and KNH should seek to develop measures to give greater financial autonomy to KNH. This should include the establishment of a separate budget for KNH that is not under general MOH budget control.
- KNH should continue to review its revenue projections periodically and adjust targets as mutually agreed upon with USAID.
- KNH should carry out the quality assessment of its pharmacy service. The other assessments should be completed by KNH staff or in conjunction with the World Bank project.
- Areas of emphasis to be addressed as priorities by KNH during the remainder of the Program:
 - Continued development of fee collection and financial management systems
 - Implementation of the proposed plan to develop KNH in-house management training capacity as proposed
 - Development of adequate cost sharing monitoring and evaluation systems that are integrated with overall MOH efforts in this area and
 - Continued refinement of overall KNH/HCF strategy that is fully integrated with current MOH strategy and development efforts.

NATIONAL HOSPITAL INSURANCE FUND

- NHIF must be granted state corporation status if it is to meet Program objectives.
- NHIF must continue the process of development of a strategic plan, fill senior management positions and seek further technical assistance to increase its operational efficiency.
- NHIF should complete the cleanup of its claims and membership data base in order to make possible the actuarial analysis necessary for the development of new benefits.

- Old plans for computerization of NHIF operations should be reviewed and adapted to emphasize available software and minimal hardware needs.
- NHIF should continue to streamline claims processing procedures and develop and test options for innovative reimbursement methods.

GENERAL

- USAID should extend the Program completion date by at least one year.
- USAID should extend the technical assistance team contract to allow all three MOH based long-term advisors to remain until the end of the Project and provide additional funds for training, monitoring and evaluation.
- USAID should explore mechanisms to extend technical assistance in the form of short-term assistance coordinated by a resident long-term advisor beyond the end of the Project.
- USAID and implementing institutions should review feasibility of meeting cost sharing revenue targets after additional experience with current fee structure and collection systems.

The KHCFP reforms are well underway. Commitment to the reform agenda is high and cost sharing is already having an apparent impact on the quality of care and availability of resources where it is being implemented. The impact will grow as cost sharing is extended to the District Hospital and Health Center levels. Attitudes among health personnel and the population are changing as they participate in financing their health care. Partnerships are being developed.

The Program benefits from being the latest in a series of A.I.D.-sponsored activities in health financing going back over the last ten years. Those activities set a solid analytic base from which the MOH has been able to develop and choose between realistic options. The options were developed on a collaborative basis and consensus developed among a broad circle of stakeholders. This successful process is being repeated under the KHCFP.

PREFACE

The Kenya Health Care Financing Program and Project is a U.S. \$15 million, four year (1989-1993), non-project assistance program with policy reform and technical assistance components. The purpose of the Program is to provide sustained, increased financial resources for the delivery of efficient quality care in both the curative and primary-preventive health services in Kenya. Specifically, the Program is to result in:

1. Reallocation of the financial resources in favor of preventive and primary health services; and
2. Increased financial resources available to the overall health sector, made possible by cost-sharing and improved efficiency.

Under the policy reform component, the program supports implementation of reforms in health care financing that are well-defined but flexible to reflect the dynamic reform process, and sequenced to reflect GOK progress. Key policy reforms supported under the Program include:

- Establishment and implementation of a clear GOK policy with respect to cost-sharing (user fees and insurance reforms) in public sector health facilities, including KNH (a State Corporation).
- Establishment of policy permitting at least 50 percent of the revenue generated through cost sharing to be retained by the public sector provider facilities, with the balance used to increase funds for primary and preventive services.
- Reforms in the NHIF to introduce progressive premium rates, to introduce modest (initially) employer contributions, and to increase reimbursement levels to registered providers to bring them in line with actual costs.
- Agreement with the GOK on a mechanism and timetable for increasing the level of non-donor financing, both in absolute and percentage terms, for preventive and primary services within the MOH's recurrent budget.

By 1992, the Program Assistance Authorization Document (PAAD) stated expectations that the share of the primary and preventive health care within the MOH budget would rise by four to five percent of the total allocated and that cost-sharing revenues would be equivalent to 10 percent of the total MOH budget.

The GOK lead implementing agency for this Program is the MOH, in conjunction with the NHIF and KNH. The program provides U.S. \$9.7 million in direct program support (cash disbursements) to the GOK, conditioned on achievement of agreed-upon bench marks for each component, relating both to the establishment and implementation of policies on health financing.

The technical assistance and training component is budgeted at U.S. \$5.3 million and is administered under an A.I.D.-direct contract with a United States institution. The objectives of the Technical Assistance Project are defined as integral to achieving the purpose of the KHCFP, that is, to:

- Assist the three implementing institutions to establish or strengthen the administrative systems necessary to implement cost sharing and related improvements in operational efficiency
- Assist in further defining the GOK's long-term reform agenda in the health sector
- Assist the GOK in monitoring program impact and
- Strengthen the implementing agencies' institutional capacities.

The Health Care Financing Program and Project Agreements were signed by the GOK and USAID on August 29, 1989, with an estimated life of project of August 29, 1993, and estimated life of program of November 1, 1993. On December 1, 1989, cost sharing at GOK facilities was implemented. Although adjustments have occurred in the fee schedule, revenue continues to be generated from inpatient fees, selected outpatient fees (e.g., x-ray, dental, laboratory, etc.,) and NHIF claims. Collectively, these revenues constitute an important source of non-wage recurrent financing, especially in provincial and district hospitals.

In early 1992, fees will be enhanced providing more revenue to the facility and districts where earned. At the same time, the waiver, monitoring, and accounting systems have been assessed and recommendations for improvements are being implemented.

This mid-term evaluation focused on achievements to date in relation to program objectives and the performance of the technical assistance contractor in assisting the agencies with implementation. The evaluation also focused on the results or impacts of the Program as defined through the end of program status (EOPS) and higher order output indicators included in the Logical Program and Project Matrixes of the PAAD

The mid-term evaluation was important for two reasons:

- To assess whether the Program and Project were on target and to make mid-course corrections in the current Program and Project implementation and
- Based on the results of the mid-term evaluation and recommendations, to produce in collaboration with USAID and the implementing agencies, a PAAD supplement to describe any necessary adjustments in the program.

In Chapter One, below, further background information is provided on the approach taken to the evaluation and structure of the findings, conclusions, and recommendations contained in the evaluation report.

1.0 INTRODUCTION

1.1 PURPOSE OF THE EVALUATION

The Health Care Financing Program and Project began in August 1989. The purpose of this mid-term evaluation is to assess the status of inputs, outputs, and progress. By contrast, a later final evaluation will focus on impacts of the program and project. In the mid-term evaluation, attention was given to three general areas:

- Evaluation of progress towards attainment of the objectives of the program and project
- Identification and evaluation of problem areas or constraints which may inhibit such attainment and
- Assessment of how such information may be used to help overcome such problems.

The complete work scope for the mid-term evaluation is given in Appendix A.

1.2 EVALUATION TEAM MEMBERS

The three-person team for this evaluation was funded by USAID and conducted under the Health Financing and Sustainability (HFS) Project of the USAID Bureau for Research and Development, Office of Health. James Setzer (team leader) is Senior Health Analyst for Abt Associates Inc. (AAI) with extensive experience in health planning and epidemiology in many parts of Africa. Dr. Charlotte Leighton is Senior Policy Economist for AAI with experience in policy and economic analysis, program planning and implementation, primarily in the health sector. Robert Emrey is Health Technical Officer in the Office of Health, Bureau for Research and Development, USAID, Washington, D.C. On detail from the International Development Management Center, University of Maryland, he serves as project officer for the HFS Project.

1.3 METHODS USED IN EVALUATION

During the three week period, April 22 through May 15, 1992, the evaluation team conducted its work as follows:

- Review of key documents for participating entities (MOH, KNH, and NHIF) and program
- Individual and group interviews in each participating entity and MOF
- Site visits to headquarters and field operations; specifically to Provincial General Hospitals in Embu and Nyeri; Provincial Headquarters in Embu; and Consulate (Mission) Hospital in Nyeri

- Draft report presented at end of week two for discussion
- Discussions of findings and recommendations with MOH, KNH, NHIF, and USAID
- Preparation of final report

1.4 BRIEF HISTORY OF HEALTH FINANCING REFORM IN KENYA

For more than 10 years, there has been a dialogue in Kenya among leaders in government, private institutions, and the international donor community concerning the need to reform financing of the health sector. The chronology of these developments is summarized below in Table 1-1. This dialogue was successful in focusing attention in Kenya on the most important and difficult obstacles facing the health services of all countries in the late twentieth century:

- Insufficient government resources to provide free services for the total population
- Difficulty in controlling costs of complex acute care services
- Declining quality of health care for many parts of the population and
- Differing views among individuals, government health officials, employers, and various care providers as to how best to protect the poor, spread the risk of costly catastrophic illness, and achieve ready access to preventive and primary health care.

TABLE 1-1. Brief Chronology of Kenya Health Care Financing Reform	
Event	Date
Minimal charging at MOH facilities; revenue returned to Treasury	Ongoing
National Hospital Insurance Fund created	1966
Health Centers & Dispensaries taken over by MOH from Local Governments, without adequate additional budget	January 1, 1970
Cost sharing included in Kenya National Development Plan, 1984-1988	1984
Economic study of Kenya health sector by Prof. Carl Stevens under USAID	1984
Corporate Status and Board of Directors Initiated for Kenyatta National Hospital	1987
Health Financing Studies conducted by USAID REACH Project: KNH Study; Nairobi Area Study; Provincial and District Study	1987-1989
Studies of Health Financing by Joint Teams from Kenya, World Bank, UNICEF, and USAID	1989
Cabinet Paper establishing the tenets of cost-sharing	August 1989
GOK/USAID Program and Project Agreement signed	August 1989
Health Financing Secretariat created by MOH	October 1989
USAID health financing study trip by Health Officials to Africa, Europe, Latin America, North America	October 1989
Cost sharing at KNH and MOH hospitals and health centers	December 1989
"Agenda for Action" by MOH--quality and efficiency	January 1990
MOH and KNH Tranche 1 under USAID Program approved & dispersed	Feb/Apr 1990
GOK announcement of new inpatient and outpatient fees	March 1990
NHIF Act amendment for progressive fee structure passed in Parliament/implemented	Apr/July 1990
GOK outpatient fee dropped	September 1990
NHIF Tranche 1 under USAID Program approved/dispersed	October 1990
Project technical assistance Chief of Party arrived	December 1990
USAID Project assistance start-up workshop, Thika	January 1991
KNH Renovation Project signed with World Bank	November 1991
MOH & KNH Tranche 2 submission under USAID Program received by USAID; conditions not fully met	December 1991
KNH instituted outpatient treatment fee	April 15, 1992

In many important ways, the reform program evaluated in this report represents an historic and significant partnership of political leaders, technical specialists from many fields, and members of the Kenyan public to address their future needs for health services. International agencies and several bilateral donors have joined with these partners to participate in the search for solutions to these complex problems. On the African continent, the health financing reforms in Kenya are being watched carefully as other countries proceed to address similar problems.

1.5 NON-PROJECT ASSISTANCE APPROACH TO POLICY REFORM

Under the A.I.D. program of non-project assistance, a combination of grant payments and technical assistance is used to support agreed changes in economic and social policy. The grant payments serve to satisfy short-term losses which may accompany policy shifts and to provide a safety-net for unforeseen impacts affecting populations in need. Anticipating that the reforms will best be approached on a step-by-step basis, the grant program typically is arranged to provide progress payments. Associated with each major step in the grant program on the way to the central goal are specific conditionalities, which are agreed to in advance. An example of such a condition in the Kenya health financing reform program is: Government expenditures on health will be adjusted over time to emphasize greater funding for primary and preventive care. When conditionalities are accomplished or completed, the next funding tranche is transferred to the participating government agency. Although broad latitude is typically given by A.I.D. to the recipient agency in deciding on uses for each tranche of funds, a plan of spending within broad outlines and within the purposes of the reform program is agreed to between A.I.D. and the agency. A companion project is usually designed to provide technical assistance to participating agencies in the reform program.

In developing the reform program, several complex steps were followed in Kenya: (a) policy research and analyses; (b) establish purposes of reform; (c) consensus building discussions and workshops; (d) determine conditionalities for changes; (e) prepare bench marks; (f) plan needed technical assistance to provide for accomplishments of reforms; (g) document program (in PAAD) and technical assistance project (in contract); (h) begin implementation with technical assistance; (i) over time, document reforms for each tranche and submit for review by USAID, followed by (if accepted) release of agreed tranche funding; (j) completion of reforms with technical assistance funding.

1.6 ORGANIZATION OF EVALUATION REPORT

After this chapter, eight additional chapters are provided to present the findings, conclusions, and recommendations of the mid-term evaluation. Chapter Two provides a review of the current context of health care financing reform. Chapter Three reviews the health financing reform general conditionalities and provides an assessment of progress made in completing them.

Chapters four through six review the status of conditionalities and progress in implementing agreed changes in the three participating institutions: MOH (Chapter Four); KNH (Chapter Five); and the NHIF (Chapter Six).

Chapter Seven discusses the progress of the technical assistance contractor, documenting outputs achieved and steps remaining to be done. Chapter Eight provides a summary of general and cross-cutting recommendations. Chapter Nine provides a summary of conclusions and lessons learned from the Program and Project. Appendices are included at the end, containing summaries of the evaluation scope of work, a list of all conditionalities and their status, technical assistance inputs, lists of documents consulted and people contacted during the evaluation.

2.0 CURRENT CONTEXT OF HEALTH CARE FINANCING REFORM IN KENYA

2.1 ROLES OF PRINCIPAL INSTITUTIONS INVOLVED IN THE HEALTH CARE FINANCING PROGRAM

The KHCFP has three principal implementing institutions: the MOH, the KNH, and the NHIF. Each institution has specific objectives, bench marks, and conditionalities to fulfill in the context of the overriding Program purpose to provide sustained and increased financial resources for the delivery of efficient quality health care in Kenya. Subsequent chapters of this report describe these specific responsibilities in detail.

In general, the main policy reforms require activities to raise revenue and to improve quality, efficiency, and resource allocation. Both the MOH and the KNH have specific objectives for raising revenues through fee collection and for improving quality and efficiency of their service delivery. The NHIF has revenue raising objectives through refinement of its fee and benefit structure. The MOH also has the principal implementing responsibility for reallocation of resources toward primary and preventive health care. All implementing institutions are to take care that the reforms have a positive impact on equity and health service utilization.

The institutional relations among the three entities are somewhat complicated by the differing public and parastatal characteristics of the entities. KNH was transformed into a state corporation in 1987 and legal transformation of the NHIF into a state corporation has been pending for some time. In KNH's case, all employees remain civil servants under the MOH and the hospital continues to receive a budget allocation through the MOH. In the case of the NHIF, which is not yet a state corporation, employees are currently already paid through the proceeds of the Fund, though are subject to civil service salary levels and are secured from the MOH and the MOF. Although the Fund receives no subsidy for operating costs, various budgetary transactions are still conducted through the MOH and MOF.

In spite of these intricacies, the MOH has, in effect, the overall coordination and policy setting responsibility for the policy reforms under the KHCFP. For example, the Minister of Health approves all fee levels and structures for MOH facilities, the KNH, and the NHIF.

The MOF also has a major role to play for the GOK in assuring that general conditionalities with respect to the Government's budget allocations are met. Essentially, it is Finance's role to assure:

- That revenues raised through the health financing policy reforms do not replace, but are additional to, the Government's base funding for the implementing institutions (as of the GOK Forward Budget for FY 1988/89)

- Revenues from the policy reforms are available for use as "no-year" funds and
- GOK funding does not fall below the FY 88/89 level.

2.2 ECONOMIC FACTORS AFFECTING POLICY REFORM UNDER THE PROGRAM

2.2.1 MACROECONOMIC CONTEXT

Kenya's early economic expansion period, 1963-1980, was among the highest in Africa. Real GNP grew by over six percent annually and real GNP per capita grew at an annual rate of over three percent. The early 1980s were marked by substantial economic declines with real per capita growth of minus 0.2 percent per year and a current account deficit of over 12 percent of GDP.

The latter half of the 1980s marked a recovery period, with Kenya's economy achieving a growth rate of about five percent per year and per capita growth of 1-1.5 percent annually. Kenya's population growth rate began to slow in the late 1980s, from 4.1 percent in 1984 to 3.8 in 1989. However, the annual rate of job creation averaged 3.7 percent, compared with a 4.2 percent annual growth rate of the work force. The GNP was valued at U.S. \$8.3 billion in 1990, with a per capita income of U.S. \$370.

The most recent income distribution studies indicate that income distribution remains relatively unequal, with the top 20 percent of the population receiving 60 percent of national income and the bottom 20 percent receiving less than three percent. Real wages have decreased over the past 20 years and the level of poverty may even have increased from over 50 percent of the rural population below the poverty line.

Prospects for the early 1990s indicate that real economic growth is likely to decrease, while inflation is re-emerging as a major problem. After averaging under 10 percent in the late 1980s, the annual inflation rate in the early 1990s has been 15-20 percent. Foreign private investment is continuing to decline, tourism growth rates are unlikely to increase, reliance on foreign assistance is growing, revenues from traditional exports are declining, and the government budget deficit is increasing.

Kenya's total work force is expected to double from 7.2 million in 1987 to over 14 million by the year 2000. Most secondary school dropouts will become unemployed over the decade of the 1990s unless the job creation rate improves. Informal sector employment has been expanding and was estimated to provide 22 percent of total employment in 1988.

These economic trends and prospects have direct implications for the KHCFF, with its emphasis on cost recovery through fees and insurance reimbursement from the employed population. The economic constraints that make it difficult for the GOK to finance adequate health services also reduce the capacity of the population to pay fees for those services. Higher rates

of unemployment and informal sector employment lowers average incomes and ability to pay health service fees. A declining percentage of the population with formal sector, salaried employment limits the growth potential of health insurance coverage, as presently constituted.

Substantially uneven income distribution also means that some parts of the country, and health facilities serving different population groups, will have markedly different revenue raising potential. Increasing government budget deficits that lead to efforts to reduce government spending by implementing cost recovery measures in a variety of sectors (e.g., health, education) and reducing or eliminating subsidies to agricultural and other producers result in higher demands on lower incomes.

These prospects do not mean that health financing reforms that require cost recovery or insurance funding are not viable. These larger economic conditions do, however, mean that it is especially important to design and implement the reforms to take into account these variations to achieve the goals of increasing access and equity.

2.2.2 HEALTH SECTOR FINANCING CONTEXT

Kenya has three major health sub-sectors: public, voluntary, and private. The public sector provides about 70 percent of hospital beds, eight percent through the KNH; private sector beds are 10 percent and PVO are 20 percent of the total. The MOH employs almost one half of all doctors, the majority of clinical workers, and about two-thirds of registered nurses. Similarly, the MOH operates about 70 percent of health centers and dispensaries.

The GOK has placed a high priority on health. The health sector's share of the total government budget during the last half of the 1980s averaged around eight percent--roughly double the proportion of many other African countries. The MOH's budget expenditures moved from KL 114 million - 128 million (U.S. \$75 million -85 million, at current exchange rates) from FY 88/89 to FY 90/91. The MOH budget authorization for FY 92/93 is likely to be in the range of KL 150 million (U.S. \$100 million).

Real government expenditures for recurrent costs of health services rose at an average annual rate of two percent from 1985-1990. This growth rate was not, however, sufficient to keep pace with an annual population growth rate over three percent during the same period.

Estimates of allocations of the Government budget for the MOH for the recurrent costs of preventive and primary health care range from 10-45 percent, depending on definition and estimating methodology. Estimates of increases or decreases in MOH expenditures for preventive and primary health care have been liable to the same methodological problem. Estimates under any methodology, however, suggest that there is a substantial gap in absolute funding levels between actual and needed expenditures.

All estimates of Government spending on health service delivery suggest there is an imbalance between the shares allocated to personnel costs and recurrent expenditures for non-wage costs, such as medicines, medical supplies, transportation, and routine health facility maintenance. These imbalances have increased over the past two years, with an increasing percentage spent on personnel.

Overall health status indicators for Kenya mask a significant degree of regional and district variation. Problems in the distribution and allocation of health resources contribute to this pattern. Resources for the preventive and primary health care services that address the main and most common health problems of the population have not been adequate. During the 1980s health funding was unable to keep pace with the growing demand from Kenya's rapidly growing population and the need for fiscal restraint imposed severe constraints on the Government's ability to finance expansion into under-served areas. These fiscal constraints also led to cutbacks in spending for drugs, consumables, medical equipment, and maintenance, while personnel costs continued to rise.

These trends combined to produce a concentration of spending on urban hospitals, which consumed a larger and larger share of the Government budget for health. They also limited the scope for expanding services to under-served areas and for strengthening and expanding preventive and primary health programs, especially in rural areas.

These conditions have created strong pressures on the Government to adopt policy reforms that would change the way health services are financed and alter resource allocation in the sector.

2.3 POLITICAL FACTORS AFFECTING THE HEALTH FINANCING POLICY REFORMS

The political sensitivity of initiatives to change health financing policies has been demonstrated in all countries attempting to make these changes. It takes particular political courage for a government to reverse long-held "free care" policies, as many African countries are now considering or attempting to do. Kenya has been in the forefront of this effort. It has been especially difficult for Kenya to alter a basic independence manifesto. Embarking on the policy reforms under the KHCFP has also required concerted efforts, skills, and commitments of many people and institutions to ensure its survival to date.

The political commitment to revenue raising through user fees in Kenya has, understandably, gone through periods of ambivalence and retrenchment. The principle of paying for health services in the public sector had been in operation prior to independence with a flat five shilling (about U.S. \$.15 at current exchange rates) consultation fee. The independent government declared health services to be available free of charge in 1965. In 1989 the Government reintroduced the principal of charging fees, termed "cost sharing," in a Cabinet Paper that established the concepts of retention of fee revenues at the facility level, allocation of a portion of the revenues to preventive and primary health care, creation of District Health Management boards, an

exemption structure (e.g., children under age five), and a waiver system for people unable to pay. A variety of fees (e.g., inpatient, dental, X-ray, outpatient, maternity) were introduced under these principles at public hospitals and health centers.

Ambivalence about the new principle has been most evident with respect to decisions to change, reduce, postpone, and in some cases, temporarily withdraw some fees once they had been established and were in operation. These changes have been made in direct response to perceived and real negative public reaction. Subsequent chapters of this report present details of these changes.

Although there have been some retrenchments, the recent re-introduction of outpatient fees, for example, demonstrates an important responsiveness and innovation in the evolving policy reform process. The original outpatient fee was a flat consultation fee of 50 shillings (about U.S. \$1.60 at current exchange rates). Given the apparent unpopularity of this fee, the Government restructured it at the time of its reintroduction in April 1992. The new outpatient fee structure requires payment for medicines (10 sh per prescription) and for specific treatments (e.g., for sutures, dressings). Public reaction to date indicates that this new outpatient fee structure appears to be more acceptable.

In the current period, there appears to be an increasingly solid political consensus--within the present government, among various organized political groups, and in the population more generally--in favor of the concept of charging fees in public health facilities. The consensus is presently based on the belief that there is little alternative to maintaining or increasing resources to the health sector; that the Government does not and is not likely to have adequate resources to subsidize directly and completely an adequate level of health services to the growing population.

Many people with whom the evaluation team talked attributed this growing political consensus, in part, to the existence and operation of the KHCFP. The experience gained under the Program has played a role in demonstrating that fee collection can work without major problems. However, this experience and the perceived potential of the policy reforms to improve health services is very fragile. The population's willingness to pay fees at public health facilities is especially dependent on concrete evidence of subsequent improvement in services--especially availability of medicines--and on demonstrable assurance of the integrity of the fee collection, maintenance, and use.

2.4 DONORS' ROLES IN THE HCF PROGRAM

Donor collaboration has been exceptionally strong in the design, planning and implementation of the HCF policy reform process in Kenya. The overall process has been viewed as long-term, to take place over 10-15 years, requiring several phases and concerted, coordinated donor assistance working

toward common goals. A.I.D. and the World Bank, in particular, have collaborated with the three implementing institutions to design reform activities and objectives and to plan them in coordinated and complementary phases.

For example, the World Bank's Rehabilitation Project has been specifically designed to complement the KHCFP's work at KNH and the MOH, and the intended Sector Adjustment Loan will build on experience gained and analyses conducted during the HCF Program's operation. A.I.D., the World Bank, and UNICEF together conducted an assessment of financing needs and options in 1988. An HCF Steering Committee, with membership composed of several GOK ministries, multilateral and bilateral donors, and the private and PVO sector met regularly in the planning and early implementation stages of the KHCFP. Regular meetings that include discussion of HCF Program issues are also held by a donor committee composed of A.I.D., the World Bank, ODA, SIDA, JICA, DANIDA, CIDA, FINIDA, the Netherlands Development Aid Program, the African Development Bank, WHO, UNFPA, and UNICEF.

USAID has been in a leadership position in the policy dialogue and consensus building stages leading up to and during the KHCFP. It has established an exceptionally strong collaborative relationship with the respective GOK officials. Senior GOK officials have described the KHCFP as "the most important donor program in the health sector" and refer to "donor pressure" as one of the elements that maintains the policy reform process. Such comments, however, as made to the evaluation team, were always stated in a context that reflects a clear sense of mutual Kenyan responsibility for and commitment to the reforms.

2.5 ROLES OF HEALTH CARE FINANCING MECHANISMS

The overall role of the health financing mechanisms under the KHCFP is to provide increased and sustained financial resources for the delivery of efficient quality care in both curative and preventive health services in Kenya. It is important to keep in mind that the role of health financing activities is to support and improve health service delivery, and ultimately better health. The financing activities are not ends in themselves.

The two principal health financing mechanisms involved in the policy reforms under the KHCFP are 1) cost recovery through user fees and 2) social financing, especially insurance schemes. The Program is also initiating two other major activities to address the financing constraints of the public health sector in Kenya: resource allocation and use; and involvement of private sector health care providers and insurance mechanisms.

The term "cost sharing" has come, to a large extent, to stand for "health financing reform" in Kenya. More particularly, "cost sharing" came to mean principally the first outpatient consultation fees introduced under the Program in late 1989. The term acquired corresponding negative connotations to the extent that it was associated with one specific, unpopular fee. Similarly, the withdrawal of the outpatient consultation fee appeared to signify that "cost sharing" was no longer viable.

Given this history, it is important to emphasize the array of policy reforms that the KHCFFP is actually undertaking, and the respective roles of the multiple approaches they represent.

2.5.1 COST RECOVERY

The term "cost recovery" in the health sector has become generally accepted to mean fees charged to people who use the health services at the time they use them. The user fees--for inpatient and outpatient services at hospitals and health centers, for dental care, maternity services, X-rays, medications, and other items that Kenya has adopted--serve the function of paying the costs of those services. As presently designed, however, these public sector fees are not intended to recover the full costs of the services, nor are the revenues from these fees intended to be used for all categories of health service delivery costs.

The revenues are intended, at present, to augment the GOK budget funding for non-wage operational (recurrent) costs of health care, such as drugs, medical supplies, routine maintenance, and transportation. That is, they are not intended to help pay for salary and related personnel benefit costs. Within this framework, the revenues are also intended to increase resources available to both preventive and primary health care, as well as secondary level, hospital-based health services.

One other important function of the user fee system in Kenya is to encourage people to use health services appropriately. Under this principle, for example, fees for primary health services for the simpler and more common health problems are set at a lower level than fees for inpatient hospital services that treat more complicated or advanced health problems in order not to discourage people from seeking treatment at an early stage. Fees for primary health services provided at less elaborate health facilities are also generally set lower than fees for the same services at facilities with more sophisticated technologic equipment and higher trained health personnel in order to discourage people from seeking care unnecessarily at the higher level health facilities.

2.5.2 SOCIAL FINANCING

The term "social financing" in the health sector refers generally to a variety of financing schemes that spread the costs of health care among members of a community or other group. These schemes in the Kenya setting may range from various systems in which communities periodically contribute voluntarily to pay one of the member's health care costs for a hospital stay or for expensive medication to employer-based health insurance to health insurance or workmen's compensation programs required by the GOK. In the case of the health insurance mechanisms, payments by group members are made in advance for premiums and often, also at the time of illness when services are used.

The main social financing mechanism presently involved in Kenya's HCF policy reforms is the NHIF which covers civil servants, as well as private sector employees. The NHIF has approximately one million members, seven million beneficiaries including families, and covers the costs of inpatient hospital services.

The KHCFP seeks to expand the use of NHIF as a source of financing for health services, and especially to expand its use in public sector hospitals. Because of the resources available to NHIF from its premium collections and risk sharing mechanism, it can pay higher rates for hospital services, and thereby cover a greater portion of the costs of delivering those services, than the current level of user fees alone can cover. The Program has also sought to make this source of financing more equitable for beneficiaries by establishing a more progressive fee and benefit structure.

The KHCFP is also exploring the feasibility of expanding the use of private health insurance and further developing private sector insurance coverage for the population.

2.5.3 RESOURCE ALLOCATION AND USE

Resource allocation activities under the KHCFP emphasize the need to provide increased resources for preventive and primary health care and for non-wage recurrent expenditures. The objective is to begin to fill the gap between current funding levels and levels that would provide a more adequate quantity and quality of care.

As indicated above, the revenues from fees and insurance reimbursement are to be allocated to non-wage expenditures for these purposes and are the main source of the increased funding. A key tenet of the Program is that base levels of government budget funding of health services will be maintained over the life of the Program, so that these revenues represent additional, increased resources to the health system. As additional resources allocated in this way, these locally generated revenues also serve the function of beginning to substitute Kenyan resources for the resources international donors are now contributing to preventive and primary care and to drugs, vaccines, transportation and other non-wage recurrent costs.

The KHCFP is also addressing the problem of inadequate funds to provide a sufficient quantity and quality of health care to the population by examining the way health resources are currently being used. One of the primary roles of the resource allocation efforts is to improve the efficiency and effectiveness of the use of the resources that are available. Containing costs, or reducing unnecessary costs, can also free up resources to be used for improving the quality and availability of health services.

2.5.4 PRIVATE SECTOR INVOLVEMENT

The KHCFP is seeking ways to involve private and PVO sector providers of health services in a collaborative effort to ensure greater availability and accessibility of services across the country. These activities also involve exploration of the constraints and opportunities for expansion of private health insurance and other non-governmental social financing mechanisms.

In general, the present objective of these activities in Kenya is to expand the service delivery base and meet the increasing demand for health services through the private instead of the public sector. The longer range goal is to encourage and expand private sector delivery and funding of curative care services sufficiently that government can devote its health resources primarily to promoting public health and preventive services.

The emphasis of private sector efforts in this first phase of HCF policy reform in Kenya is on fact-finding and analysis, and on building closer communication and collaborative ties among the various actors and organizations involved.

2.6 CONCLUSIONS

Kenya is undertaking a complex array of health financing reforms that are designed to address a number of resource problems at once. It is an ambitious undertaking in a changing political environment under difficult and conflicting economic constraints. It is also institutionally complex, involving several Government ministries and agencies, at the central, provincial and district levels, parastatal organizations, international donors, and selected private sector organizations.

The current commitment to continuing with these policy reforms has been generated and sustained by the economic and financial necessity for the Government to find alternative ways to finance the health sector in the country. It has also been sustained by the technical, institutional and political consensus built up during planning and design stages, by continuing deliberate efforts to maintain that consensus, and by innovation, adjustment, and not moving beyond the limits of the perceived political acceptability of the reforms.

To maintain a context that permits the reforms to continue will require the same diligence, systematic analysis, and innovative solutions that the Kenya HCF Program has shown to date. It will also require consolidating and expanding the basic health financing systems so that concrete results, even if not dramatic in these early stages of reform, are evident to the population, health personnel, and political entities.

3.0 GENERAL REFORM PROGRAM CONDITIONALITIES

3.1 INTRODUCTION

The KHCFP attempts to focus attention and efforts within the GOK in order to bring about reform and implementation of policies related to the financing of the health sector. A deteriorating public health system and recent economic difficulties appear to have convinced many policy makers within the sector of the necessity to search for alternatives to previous policies that promised free health care for all at government facilities. There appears to be broad recognition that a health care delivery system based upon such a policy is no longer sustainable or even viable. The KHCFP is designed to encourage policy makers, therefore, to develop alternative and innovative mechanisms to improve the financial sustainability of health care delivery.

The primary mechanism chosen for the expansion of the financial base for the health sector is the introduction of direct patient user fees for selected services and increasing the level of hospital insurance claims at government facilities. The KHCFP provides support for policy reforms and implementations steps related to this important reform. It also seeks to encourage policy makers to better allocate resources available to the sector in order to improve both the quality and availability of the services delivered. This is to be accomplished through shifts within government budget allocations intended to increase the percentage of expenditures for drugs, medical supplies and other non-wage costs and to increase the resources available for the delivery of cost effective primary and preventive health care services.

The Program (through its associated project component) provides technical assistance (long and short term), commodities and training support to the implementing institutions to reinforce their capacity for planning and policy reform. It is intended that through collaborative efforts with the technical assistance provided that the MOH will further develop and reinforce its own institutional capacities to review, reform and implement policies in all areas. The strengthening of this capacity within the MOH is an important objective of the technical assistance resources provided under the program.

The conditions precedent contained in the program are divided into four categories: those addressing sector wide or general policy issues and those dealing with policy reform and implementation specific to the three implementing institutions, MOH, KNH and NHIF. Grant funds total U.S. \$9,700,000 and are released in "tranches" to the individual implementing institutions (the amount of each tranche varies depending upon the institution and program year) based upon the satisfaction of both the general program conditionalities as well as the specific conditionalities (as defined by interim bench marks) pertaining to each institution. Discussions of the specific interim bench marks pertaining to each of the implementing institutions are found in Chapters Four, Five, and Six).

3.2 GENERAL REFORM CONDITIONALITIES

3.2.1 TRANCHE ONE CONDITIONALITIES

The general policy reform conditionalities contained in tranche one of the KHCFP are intended to encourage the GOK to:

- Improve the financial sustainability of the public health care delivery system through constant levels of support to the sector through GOK budget allocations
- Expand available financial resources through the introduction of policies of direct user fees or "cost sharing" and provision of grant funds and
- Expand the financial resources available through the expansion and development of reimbursement mechanisms through the NHIF.

Additionally, the reform agendas of the individual implementing institutions are designed to develop and encourage a dynamic and ongoing process for strategic planning and policy reform.

The introduction of "cost sharing" through user fee mechanisms at public health facilities should be seen as an important and significant departure from previous "free" health care policies. The intent of the program conditionalities is to support the introduction of these fees and guarantee that the revenues they generate will become additional resources available to the health sector rather than serving as a substitution for GOK allocations. This is accomplished by requiring that all revenues generated through cost sharing (including insurance reimbursements to facilities) be considered "additional" and "no-year" funds by both the MOH and the MOF. The general policy conditionalities therefore require that GOK budget allocations to the MOH be no less than the preceding year's allocations and that any cost sharing revenues that have not been expended at the termination of the fiscal year not be returned to the treasury. Cost sharing revenues will therefore serve as a supplement to GOK allocations. The conditions precedent also stipulate that the funds released to the implementing institutions under the program will also be treated by the MOF and MOH as both additional and no-year.

The interim bench marks required to meet these general policy reform conditionalities were outlined in PIL No. 2 dated 12 October 1989. The PIL indicates that the MOF must submit in writing that the principals of additionality and no-year status will be respected with regard to both cost sharing revenues and funds released under the grant program. The required letters were submitted by the MOF and the general conditions precedent for tranche one satisfied in early 1990.

Meeting of these general conditions precedent did not, by itself, trigger the release of grant funds to the MOH. It did allow the individual implementing institutions (MOH, KNH, NHIF) to submit documentation of having met the specific conditionalities pertaining to them. As a result, tranche

one funds were released to the MOF for the MOH in February 1990 and to KNH in April 1990. Tranche one funds for the NHIF have been released to the MOF. The NHIF has not requested the release of these tranche one funds from Treasury, but the MOH has done so on their behalf.

3.2.2 TRANCHE TWO CONDITIONALITIES

The general conditions precedent for tranche two (and tranche three) require that the MOF and MOH continue to adhere to the principals of additionality and no-year status for cost sharing revenue and grant funds. Once again, compliance with these conditions alone will not trigger the release of funds but is required in order for funds to be released to the individual implementing institutions (subject to meeting institution specific conditionalities as in tranche one). Appendix E of this report gives the current status of compliance with these general conditions precedent.

3.3 ISSUES

There is ongoing discussion between the MOF, the MOH, and USAID as to whether cost sharing funds should appear in GOK budget estimates as "Appropriations-in-Aid (A-in-A)". The MOF maintains that inclusion of cost sharing revenues as A-in-A will not jeopardize their additionality (or, less clearly, their no-year status). The representation of the revenues as A-in-A is, in the view of the MOF, necessary to maintain proper central level accountability for the funds. The cost sharing funds are accounted for through the district treasury. There may be a need to streamline procedures for expenditures and accounting. This is necessary to minimize incidents of misuse or disappearance of cost sharing revenues.

The MOH (through the KHCFP Secretariat) maintains that adequate accounting systems are in place at the district level through the district treasurer's office. The Secretariat is also installing accounting mechanisms to guarantee the central level accountability of revenues and expenditures so that it maintains that the inclusion of these revenues as A-in-A in the GOK budget presentation for the MOH is not warranted. USAID in PIL Number 12 indicates that cost sharing revenues (including KNH revenues that were included as A-in-A in the FY 91/92 budget) should not appear in the Draft Printed Forward Budget Estimates for FY 92/93.

MOF officials indicate that the funds will not appear as A-I-A in the FY 92/93 budget when it is released in June 1992 in accordance with the tranche two conditions precedent. MOF staff indicate that a token amount will appear as A-I-A in the FY 92/93 budget but this is purely for internal accounting and audit purposes. USAID has stated that this is acceptable under the terms of the Program.

USAID approved disbursements of tranche one grant funds for KNH in April 1990 and funds equivalent to U.S. \$2,000,000 were deposited in the MOH special account for transfer to KNH. The MOH has not yet transferred the entire amount to KNH (a balance of approximately Ksh 100,000 remains outstanding).

3.4 CONCLUSIONS

3.4.1 The MOH has met the general conditions precedent under the first tranche (and appears capable of meeting them for tranche two as well) of the KHCFP Program. The ability of the MOH to adhere to both the spirit and letter of these reforms appears, however, to be quite fragile due to current general budget constraints and especially those created by overspending to cover its large wage bill. Additionality and no-year funds are key elements to health finance policy reforms.

3.4.2 The MOH, through the Secretariat, does not appear to have fully convinced the MOF that it can maintain proper accountability for cost sharing revenues "off budget." The MOH must, therefore, continue to develop and refine its accounting systems. Accountability for both revenues (and expenditures) is essential to the sustainability of cost sharing. It may be necessary for the Secretariat to include mechanisms for independent, external audit of cost sharing accounts in order to insure accountability is maintained for the funds.

3.5 RECOMMENDATIONS

3.5.1 The MOH must accelerate efforts to design, install, and refine its accounting systems for cost sharing revenues and expenditures. This must be seen as an absolute priority for the Secretariat. It must begin to produce regular reports from the accounting systems as soon as possible.

3.5.2 The Secretariat should insure that annual independent, external audit of cost sharing accounts are part of its accounting system.

4.0 MINISTRY OF HEALTH

4.1 INSTITUTIONAL CONTEXT

The KHCFP is designed to support the development of the MOH capacity to review, reform, and implement policy. The required reforms and implementation steps are carried out under the guidance of the KHCFP Implementing Committee principally through its Secretariat. The Secretariat is assisted by the contract technical assistance team provided under the project assistance portion of the Program. A primary task of the technical assistance team is to develop the capacity of the Secretariat and Committee to carry out health finance policy reform.

The ability of the Secretariat to work effectively suffers from the lack of a clear mandate and position within the organizational framework of the MOH. It also currently lacks sufficient human and financial resources to carry out the tasks that it has been assigned. It does not yet have a budget or funding to cover routine operations. Limited, full-time personnel were assigned to the Secretariat from its inception, however, full-time, exclusively dedicated staff were not available until early 1992. As a result, for much of the time since their arrival, members of the technical assistance team have functioned without effective MOH counterparts. This has limited necessary skills transfer and institutional strengthening. Several potential staff members have been provided with opportunities for long term graduate level training in the United States under the project, and have therefore been unavailable to the Secretariat. They will soon return and it will be important that they be retained by the Secretariat as permanent staff members.

The MOH should take steps to reinforce the position and role of both the Committee and Secretariat within the organizational framework of the Ministry. It should seek to position the Secretariat at a level compatible (perhaps unit or department reporting directly to the Permanent Secretary) with its need to coordinate and orient activities involving a number of other Departments (Planning, Primary Health Care, Medical Services, Hospital Administration, etc.) and organizations outside of the MOH (KNH, Nairobi City Commission, donors, etc.). Such actions would give the Secretariat a stronger administrative basis and serve to reinforce the broad scope required by health finance policy reform and implementation.

In the long run, several major concerns facing the MOH may counterbalance the positive effects of the reforms carried out under the KHCFP:

- Escalating personnel costs and the lack of health manpower planning and
- Unavailability of drugs and other medical supplies.

These issues are not fully addressed by the KHCFP agenda. The evaluation team believes, however, that they must be addressed by the MOH as part of a longer term agenda designed to improve the viability of the health system.

The issues of personnel costs and health manpower planning must eventually be addressed in an institutional context that extends beyond the confines of the MOH. To examine the issue thoroughly, dialogue must include at least the MOF, Ministry of Education and the Office of the President's Department of Personnel Management.

Of major concern is the current pressure placed upon the MOH's non-wage recurrent budget allocation due to overspending on personnel costs. Overspending of personnel costs is taken in part from allocations intended for non-personnel recurrent costs. As the funds actually available to pay non-wage recurrent costs shrink, greater pressure will be placed on the revenue generating capacity of facilities to collect fees. This situation severely limits the MOH to effectively plan and execute its budget.

A shift in financial responsibility to a heavier reliance on fee collection over the long run may constitute a de facto change in the objectives for cost sharing. Under present objectives cost sharing (as defined by the KHCFP) is intended to generate 10 percent of total recurrent expenditures. Greater objectives may not be compatible with MOH equity concerns or the economic environment in the country. The KHCFP does not expect that Kenya's health system should reach the point of several other African countries where government allocations are sufficient to provide personnel costs and all other recurrent expenditures must be covered by revenues generated by cost recovery schemes.

As a result of limited supply of drugs and other medical supplies, facilities currently use cost sharing revenues to purchase "emergency" supplies on the local retail market often at the highest possible cost. National drug policy must be reviewed and modified in order to provide facilities access to supplies of low cost essential drugs. It is likely that a system that allows facilities to procure essential drugs on a cash and carry basis using cost sharing revenues must evolve. Any system developed should complement not replace the current drug kit system. Drug availability is the acknowledged key to patient satisfaction in Kenya. The sustainability of cost sharing will require that the MOH make critical changes in its system for drug procurement and distribution.

In response to tranche one and two conditions precedent requiring local retention of cost sharing revenues the MOH developed a policy that allows the collecting facility to retain 75 percent of revenues. The remaining 25 percent will be retained at the district level and programmed by the District Health Management Team (DHMT). Oversight and approval for DHMT spending plans would be given by the District Health Management Board (DHMB). The DHMBs have not been gazetted and are not, yet, functional. The DHMTs in a number of districts have not begun to spend their cost sharing revenues. The

development of the DHMTs capacity to plan for and spend these funds according to Preventive and Primary Health Care (P/PHC) and local priorities should be seen a major institutional development issue that must be addressed as part of the Program's agenda.

In late FY 90/91, the MOH "borrowed" Ksh 15 million of these unspent funds from 17 (of a total of 42) district accounts. To date, this "loan" (which was used to pay for drugs and medical supplies that had arrived in country at the end of the fiscal year, after the MOH recurrent budget had been exhausted) has not been repaid in full. The MOH has assured USAID and the districts that the funds were required to address an urgent situation and does not represent a lack of commitment to the policy of local retention of revenues. Repayment of the loan in full (approximately 50 percent remains outstanding) has been included in tranche two interim bench marks. MOH officials assured the team that repayment would take place as soon as FY 92/93 budget allocations become available.

It is clear that the MOH must tighten its overall budget and planning systems to avoid such "urgent" situations in the future. The use of cost sharing revenues as a source of liquidity will surely undermine and jeopardize its reform agenda.

4.2 REFORM PROGRAM CONDITIONALITIES

4.2.1 TRANCHE ONE CONDITIONALITIES

The institution specific conditionalities assigned to the MOH under tranche one (total disbursement: U.S. \$2,500,000) of the program address policies and implementation measures related to the introduction of a user fee mechanism at government health facilities. The interim bench marks for tranche one require the MOH to develop a policy to insure that all revenues generated from the collection of user fees will be retained at the local (District) level with not less than 50 percent being directly retained by the facility that has collected the fees and the remaining portion committed to the development of P/PHC services. They also require that the MOH establish a Health Care Finance Implementation Committee which reports to the Permanent Secretary of the MOH. The committee is required to develop a detailed plan for the implementation of the chosen user fee mechanism ("cost sharing"). The cost sharing implementation plan is to indicate:

- The fees to be charged for specific services
- Plans to develop administrative, accounting, and audit procedures
- A system of fee waivers and exemptions
- Projected shifts in MOH expenditures from wage to non-wage and from curative to P/PHC

- Plans for analyses to monitor and document the effects of cost sharing on patients and sector finances
- Resources available (from cost sharing revenues and GOK budget allocations) for P/PHC programs and
- Revenue projections and guidelines for the use of revenues generated at both facility and district level.

The interim bench marks developed for the tranche one conditions precedent provide additional details of the required components of this plan. The tranche one interim bench marks were transmitted to the MOH in PIL Number 2 dated 12 October 1989. The KHCFP PAAD anticipated that tranche one conditionalities would be met by November 1989.

The required shifts in GOK budget resources from wage to non-wage and from curative services to P/PHC programs should be seen as one of the most important elements of the reform agenda under tranche one (and subsequent tranches as well). The shifts are essential for the KHCFP to meet its objectives. The shifts are intended to insure that the MOH allocates additional resources (generated through fee collection or by internal reallocation of budget resources) to programs and activities that are stated priorities.

The Primary Health Care Resources Gap Study carried out in 1990 estimated that, at that time, there was a gap of Kshs 429,000,000 between available resources and those required to fully operate P/PHC services and programs. Cost sharing revenue projections make it clear that the earmarking of a portion (no more than 50 percent) of these revenues alone will not close this significant gap. The conditionalities therefore seek to encourage internal redeployment of budgetary allocations by the MOH to further reduce the gap. The Program anticipates that the MOH will be able to reduce the gap in real terms by 30 percent by 1994.

The MOH (through the MOF) submitted evidence of having met the terms of the tranche one interim bench marks in letters to the USAID Director dated 4 January 1990 and 26 January 1990. PIL Number 6 dated 5 February 1990 indicates USAID's agreement that the MOH had satisfied the tranche one conditions precedent. Tranche one funds of U.S. \$2,500,000 were released to the MOF for the MOH following a formal request for disbursement.

Tranche one funds (transferred By MOF to the MOH special account as Ksh 54,196,310) were used by the MOH to purchase supplies and equipment necessary for the implementation of cost sharing (Ksh 24,107,507, 44.5 percent), supplies (drugs, dressings, linens, etc.) for facilities implementing cost sharing (Ksh 29,313,964, 54 percent) and monitoring workshops (Ksh 774,839, 1.4 percent). There remains a balance of KSh 6,379,260 remaining from tranche one funds. The MOH has not yet requested that these funds be released by the MOF. The expenditure of these funds took place during FY 89/90 (70 percent) and FY 90/91 (30 percent). As such it is clear that the funds were considered both additional and no-year by both MOF and MOH as required by the general conditions precedent.

4.2.2 TRANCHE TWO CONDITIONALITIES

The interim bench marks required to meet the conditions precedent for the release of tranche two funds were transmitted to the MOH in PIL Number 12 dated 29 October 1990. They require that the MOH continue to adhere to the policies developed in response to tranche one conditionalities that guarantee cost sharing revenues will be retained locally and that no less than 50 percent of the revenues will be retained by the facility where they are collected. The conditions precedent also require that the MOH demonstrate that it has "substantially progressed" in the implementation of its cost sharing implementation plan. Additionally, they require the MOH to develop a comprehensive national health care strategy that defines the roles of the public sector, parastatals, private sector, municipalities and donors in financing the health sector. This plan is intended to move the MOH towards the development of a broad policy framework beyond cost sharing alone for financing the sector.

The MOH submitted documentation of its progress towards meeting the associated interim bench marks for tranche two on 11 October 1991. The KHCFP PAAD had anticipated that the MOH would have met its institution specific bench marks by May 1991. Although the documentation submitted indicated an impressive amount of work on the part of the MOH in the implementation of its cost sharing plan, analysis by USAID indicated that several of the interim bench marks had not been met. In fact, the MOH had disregarded several of the policies that had been instituted under tranche one. Most notably it had not transferred the totality of tranche one funds to KNH and had "borrowed" cost sharing revenues from several districts in order to make drug purchases. The funds had not been repaid to the districts (and currently remain, in part, unpaid). PIL Number 17 dated 23 December 1991 indicates actions that must be taken prior to the satisfaction of the tranche two conditionalities (including transfer of the remainder of KNH's tranche one funds and the repayment of the districts) and trigger the release of funds (U.S. \$2,000,000).

The suspension of outpatient consultation user fees in August 1990 and the announcement in April 1992 of their phased reintroduction (1 July 1992 at PGH level, 1 January 1993 at District Hospitals and 1 March 1993 at Health Centers) required the MOH to make substantial revisions in its cost sharing implementation plans (including all revenue projections). In order to accommodate this development and facilitate the availability of grant funds to the MOH an amendment to the Program Grant Agreement was signed 11 March 1992. This amendment splits tranche two funds into two equal parts of U.S. \$1,000,000. The release of the first half of tranche two will be conditioned upon meeting all tranche two interim bench marks and reintroduction of outpatient user fees at PGH level facilities for a period of at least 60 days. The MOH will not, therefore, be eligible to receive any tranche two funds before September 1992 (60 days after the projected 1 July reintroduction of the fees at PGHs). The release of the second half of tranche two funds will be conditioned by meeting the tranche two interim bench marks and collection of outpatient user fees at District Hospital facilities for a period of at least 60 days.

Appendix B provides a summary of the current status of MOH efforts to meet tranche two interim bench marks, based upon interviews with MOH Implementation Committee members. It appears from these interviews that the MOH is (with sufficient effort and the assistance of the contract team) capable of completing the work required to meet the majority of tranche two interim bench marks by September 1992. Results of the upcoming workshop on the development of the required KHCFP strategic plan will dictate whether the plan can be finalized and adopted by that time.

Progress towards meeting program bench marks and conditionalities has been encouraging. Given the time frame dictated by the phased reintroduction of outpatient user fees the second partial disbursement under tranche two can take place no sooner than early (March - April) 1993. The program end date is November 1993. There seems little possibility that the MOH (or perhaps the other implementing institutions) can meet all tranche three conditionalities by that date. It may be necessary for USAID to consider mechanisms to extend the Program beyond November 1993 in order to give the implementing institutions sufficient time to meet tranche three conditionalities.

4.3 POLICY REFORM

The MOH is making encouraging progress in the implementation of many aspects of the KHCFP reforms. It should be noted that while the Program's reform agenda has been adhered to (with some delay) the introduction within the MOH of a more analytic capacity to review policy and develop reform options still requires strengthening. The MOH will require more time and assistance in order to further develop its capacity to reform and implement in health care financing and other areas. With the anticipated departure of the contract technical assistance team this becomes an issue of major concern.

The reforms undertaken to date by the MOH as part of the Program have had a significant positive impact on attitudes and operations at the MOH. One should not underestimate the significant changes required to move forward with cost sharing. The reform agenda weathered a major policy storm with the suspension of outpatient consultation fees in August 1990. The reintroduction of those fees at KNH in April 1992 has been met with little public outcry or debate. The new fees are to treatment fees instead of the previous system of consultation fees. Under this system, the patient will pay a set fee (Ksh 10) for each treatment or drug received. If required treatments or drugs are not available, the patient pays nothing. This innovation ("no treatment-no fee"), has been developed due to dissatisfaction under the previous system that the quality of services (i.e. drug availability) had not improved despite payments by patients.

The importance of functional systems for monitoring and evaluation is clear in allowing the MOH to document the impact of Program reforms. Several patient exit surveys were carried out prior to the suspension of the consultation fees and are to be repeated to study the effect of the new fee system has on patient satisfaction. Comprehensive and complete documentation of the effects of the fees will be necessary to refine policies as well as defend them against attack. The development of these systems should be seen

as a priority for the Secretariat and the technical assistance team. The Secretariat must devote sufficient human resources to this effort and should consider assigning at least one full time staff member to be responsible for system development and implementation. It may also be necessary for the team to devote additional resources to the effort as well. It may be necessary for the team to look for ways to shift resources (primarily short term technical assistance) away from other lower priority areas to this activity. Commitment to cost sharing within the MOH appears firm at all levels.

The Program must now move to address policy reform options in a much broader sense. It must develop an agenda for health finance reform and not simply cost sharing. The initial emphasis on the implementation of feasible systems required by the introduction of cost sharing is understandable. The development of the required systems and their implementation appears well underway and on track (if slower than originally anticipated).

The development of a national health finance strategy paper is a step towards expanding the scope of policy discussion within the ministry. The process emphasizes analysis of available data and its integration into a dynamic process of option development and review. This process should be encouraged and all necessary resources made available to insure that the broadest possible consensus is achieved as a result. This statement of policy will constitute a blueprint for the development of the health sector for years to come. It is anticipated that this plan will provide donors (notably the World Bank) with a framework for planning health sector assistance for the future. Given its importance, the Chief of Party of the technical assistance team should consider taking responsibility for the management of this activity. The technical assistance team should also study options to allow short term technical resources to be shifted from other, lower priority, activities to assist in the development of this plan.

Although the KHCFP is relatively young, it is nonetheless relevant to address the question of its sustainability. Two levels of sustainability are relevant in discussions of a program of this type:

- Will cost sharing and resource allocations in favor of non-wage recurrent costs and P/PHC survive after the grant and its conditionalities has expired? and
- Will the policy review and reform process that the Program encourages be extended to policy areas beyond cost sharing and health finance?

In the case of the KHCFP, it would appear that cost sharing is on its way to effective implementation. This has, so far, proved to be a time and labor intensive activity. It will, in all likelihood, continue to be so as implementation extends to district and local levels and necessary emphasis is placed on the development of the district capacity to plan and spend revenues within an agreed upon context of P/PHC priorities.

The policy reform process within the MOH will require considerable attention and development to become sustainable. It will require time in order for mechanisms to be developed to promote (require!) the integration of results of the monitoring and evaluation systems to be developed into the policy and budget (as perhaps the most concrete manifestation of policy) process.

The KHCFP requires that the MOH perform a number of analyses of budget and expenditure data in order to assess resource shifts in favor of P/PHC programs. While the MOH has provided the required reports based upon these analyses, it does not appear that they play a role in the budget development process or resource allocation decisions. At present, the analyses appear to represent no more than a requirement to satisfy Program conditionalities. The MOH must be encouraged and assisted to move beyond this stage so that the effort does not become an example of "empty reform." The Program seeks to encourage the development of a systematic mechanism for the reallocation of budgetary resources in favor of P/PHC. Such a system is not yet in place. The MOH should study its internal decision making and budget process in order to understand points in the process where such a mechanism might function. Such a study would assist the MOH to further define the types of information that would be required for the mechanism to be effective. The cost sharing monitoring and evaluation efforts would then be modified accordingly.

4.4 HEALTH FINANCING SYSTEMS DEVELOPMENT

The development of financial management systems has been a major focus of KHCFP Secretariat and technical assistance team activities to date. The systems under development appear feasible and adequate for the needs of the MOH to track the implementation of cost sharing. These financial accounting systems have actually been in operation at seven PGH facilities since early 1992. Given their newness, the systems must be considered somewhat fragile and will continue to require considerable nurturing in the form of training (perhaps formal and certainly on the job) and supervision in the near term. The Secretariat must adequately plan and identify resources that will be required to strengthen the current systems, further develop remaining components, and expand coverage to the district and local level. In order to carry out this role the Secretariat must insure that it has the necessary financial and human resources as reflected in the FY 93/94 forward budget.

The systems in place at the PGH level appear well designed given the human resources available at that level. The PGHs have demonstrated a significant increase in revenue generation (especially with respect to NHIF claims reimbursement) since their introduction. Staff at the two facilities visited expressed a desire for clearer guidelines for the use of revenues. Further development and refinement of these guidelines is planned by the Secretariat.

Systems to allow the Secretariat to track expenditures by facilities and DHMTs require further development and should be developed quickly in order to provide clear evidence that revenues are not being misused. Expenditure tracking by the District treasurer is being carried out in accordance with GOK accounting requirements. The installation of these systems should be carried out in conjunction with institutional development and training activities at those levels.

The KHCFP financial information system is not yet providing MOH decision makers with regular reporting on cost sharing performance. This is largely in part to its newness and regular reporting is planned. Thought should be given as to the potential users of such information and their information needs. Information system development and feedback should be considered a dynamic or iterative process since it is often difficult to define all management information needs and uses in advance. This is especially true in the case of managers who have not previously had timely and relevant information available. The Secretariat should work closely with facility managers, MOH central level staff, and others (e.g. MOF) in order to develop information systems and appropriate feedback mechanisms. Feedback mechanisms should be considered a priority. During a visit to one PGH, accounting personnel were not able to answer a question concerning levels of revenue generated. The evaluation team was told that "they do that analysis in Nairobi," and that he had not received the appropriate report.

To date, there appear to have been no efforts undertaken to estimate the cost of implementation and operation of the financial accounting and information systems. As experience is gained in the operation of these systems it would be of interest to evaluate these costs. The ability of the system to produce additional revenues for health services should be assessed as a function of these costs as well as the value of fees collected. Analysis of this type will help the Secretariat to insure that the systems developed and implemented are the most efficient possible.

The Secretariat must give thought to its own human resources needs as the financial information and management system develops and expands. With the current volume of work required to support cost sharing at the PGH level the centralized system employed appears feasible. It is clear that without additional personnel (approved but not yet assigned) that the Secretariat will have difficulties in keeping up with the demands of the current management system once cost sharing is expanded to all 45 district hospitals and more than 300 health centers. Even at the anticipated full staffing of thirteen, the administrative burdens (and ensuing delays) may prove overwhelming. The Secretariat should consider options for the decentralization and/or streamlining of certain procedures as cost sharing expands its coverage.

4.5 MONITORING AND EVALUATION

The development of a system that allows the MOH to monitor the implementation and impact of cost sharing has not been completed. There is, as yet, no comprehensive plan that explains in detail the data needs of such a system nor the analyses that it would perform. A variety of data collection

activities are currently underway or planned. The MOH must develop a more comprehensive plan and framework for the system that demonstrates how it will use these data as pieces of a puzzle to answer important questions about the functioning and effects of cost sharing.

A committee has recently been formed that should logically be charged with the development of the overall framework. The committee includes KHCFP Secretariat staff, staff from the Health Information System office and Department of Planning staff and technical assistance team members. The committee has begun to address technical questions related to several patient and household surveys that are planned as part of monitoring and evaluation efforts. This may be somewhat premature. The committee does not currently have official MOH recognition. The committee should seek to continually assess that the systems under development will adequately address the concerns of MOH and GOK decision makers. It is important to note that the monitoring and evaluation system must be designed to meet both technical and political criteria (reconciliation of these two concerns is sometimes difficult but essential).

A draft document dated 20 February 1992 distinguishes between performance monitoring and impact evaluation for the purposes of the design of the KHCFP monitoring and evaluation system. It appears that the financial management systems being put into place at the PGH level will provide necessary data to perform most types of performance monitoring described in the document. The document, however, lacks sufficient detail to be considered a true plan for such a system. Efforts at analysis of data generated by the PGH financial accounting systems does not yet appear to be systematic. The Secretariat's system to adequately monitor the expenditure of cost sharing revenues at the facility or district levels is not yet fully developed. The document developed is, unfortunately, not sufficiently detailed to evaluate the adequacy of the components it describes. The committee and Secretariat should consider efforts to strengthen this aspect of the performance monitoring system immediately.

There does not appear to be a comprehensive plan for the development of the impact evaluation system described in the document mentioned above. The document outlines several types of data that could be included in such a system and their relative advantages and disadvantages in answering the type of questions to be asked of the system. The document proposes a framework for a system based upon data derived from service delivery records, patient exit surveys and household surveys. A plan for the analysis of the data from these sources is not included. At present the document does not describe a system so much as a series of loosely linked data collection efforts.

The lack of a comprehensive monitoring and evaluation system is a major shortcoming of MOH cost sharing implementation activities to date. Finalization of the design and implementation of this system must be considered an immediate priority for the MOH. The Technical assistance team must take the lead in this activity. System development should become the major responsibility for the long term monitoring/evaluation advisor for the remainder of the project. The team should realign long and short term technical assistance resources to devote sufficient attention to system

development and implementation. This may involve reduced levels of effort with respect to lower priority activities (e.g. facility level drug management, staffing norm development, quality of care improvements, etc.) by long term staff and/or the realignment of short term resources.

The introduction of cost sharing represents a significant and courageous policy initiative on the part of the MOH. The lack of an adequate system to monitor the collection of fees, the uses of revenues it produces, and the impact on the population leaves the MOH unable to assess its performance.

4.6 ASSESSMENT OF OUTCOMES

4.6.1 REVENUE GENERATION AND RESOURCE ALLOCATION

Evidence indicates that the system of user fees and increased NHIF reimbursement for hospital charges currently in place at KNH and PGH level facilities is capable of generating substantial revenues. It appears that the system will generate far more revenue in FY 91/92 than the KL 1.9 million reported as collected in FY 90/91. Those FY 90/91 revenues represented less than one percent of actual MOH recurrent expenditures (reported as KL 128 million) and 3.5 percent of non-wage recurrent expenditures (KL 53.6 million) for the same year. Obviously major improvements in revenue generation must be made if the MOH is to achieve its objective of ten percent of total recurrent and twenty percent of total non-wage recurrent expenditures. Calculation of FY 91/92 revenues should be performed as soon as data are available. It may be necessary to adjust these target once revenue projections may be made based upon greater experience.

The ability of facilities to meet revenue projections and a greater percentage of recurrent expenditures was effected by the suspension of the outpatient consultation fees in August 1990 and the lack of adequate collection, accounting and management systems at most facilities. The lack of systematic procedures for submitting NHIF claims and NHIF's lengthy reimbursement processes have had a significant negative impact on revenue as well. The production of revenue projections and comparison against actual revenues should be an ongoing and routine part of the financial information system.

The MOH with the assistance of the KHCFP, however, appears to have made substantial progress in improving revenue generation at PGH facilities during the last six months. Revenues have shown steady increases linked to the implementation of vastly improved collection and accounting systems. Mechanisms have been implemented to assist facilities in submitting a greater percentage of NHIF claims. This has had, and will continue to have, a major impact on revenue generation since as much as 80 percent of potential PGH cost sharing revenues are projected to come from NHIF reimbursements. The Secretariat is currently developing proposals intended to streamline NHIF reimbursement mechanisms and test alternative benefits packages and thereby further increase revenues to facilities.

The revenue generating capacity of these facilities will be further enhanced when outpatient treatment fees are reintroduced at the PGHs in July 1992. The effect of the reintroduction of these fees on total revenues, however, may be effected due to the extremely broad categories of patients who will receive exemptions. It will be necessary to monitor the levels of revenue generated after the reintroduction of the outpatient treatment fees in order to assess whether revenue projections being made by the MOH are realistic. It will be necessary to reproject revenues based upon relevant experience with the new systems and fees. Systems have not been in operation for a sufficient period of time to assess their full revenue generating potential (i.e. revenues at PGHs continue to each month due to improved collection and NHIF claiming procedures). It will be necessary to examine whether the ten and twenty percent objectives of MOH total and non-wage recurrent expenditures are reasonable goals for the cost sharing as currently implemented.

It is less clear that cost sharing and the KHCFP has induced the MOH to reallocate resources in favor of P/PHC services as intended. The program requires that a systematic mechanism be put into place for the reallocation of budgetary resources. It does not appear that the MOH has adopted a systematic approach to the either the analysis or allocation of recurrent costs within the budget. It has (and appears willing to) performed the analyses required by the Program to document shifts taking place but does not appear to have integrated the results into its budgetary process. The pressure placed upon the budget and resource allocation process by the high personnel expenditures incurred by the MOH constitutes a threat to the MOH's ability to allocate resources as it wishes. Overspending of personnel costs means that the amounts actually available (expenditures) for non-wage recurrent costs are routinely far lower than the voted (budgeted) amount. This creates a situation where (potentially) the MOH can demonstrate increased P/PHC allocations (budget) but decreased P/PHC resources available (expenditures).

Application of the "Budget Application Programme" that was written as part of the P/PHC Resource Gap Study on printed budget estimates for FY 90/91 and forward budget estimates for FY 91/92 and FY 92/93 indicate that the P/PC gap will be closed by some KL 4.5 million through MOH budget reallocations. Another KL 3.3 million will be available to close the gap from projected revenues from the 25 percent of cost sharing revenues to be dedicated to P/PHC. The model has not yet been run using the more accurate FY 91/92 printed estimates. This should be done as soon as possible. Since it uses budget estimates, the utility of the Gap Model in assessing whether increased resources were actually made available to the target P/PHC programs should be addressed.

The KHCFP team has expressed reservations over the use of the Gap Model as the sole means to assess resource shifts towards P/PHC. The team has suggested that, at the least, the model be modified in order to help all analysts assess its applicability. These modifications would require a modest

amount of effort on the part of a computer programmer and should be carried out as soon as possible. Consensus should then be reached as to the accepted method to demonstrate resource shifts within the MOH budget. It will be necessary for the MOH to redo its projections of cost sharing revenues available to P/PHC after the reintroduction of outpatient treatment fees.

Cost sharing revenues retained at the district levels will help the MOH to close the P/PHC gap on paper only until the DHMTs begin to effectively use these funds to finance improvements in P/PHC services at their level. Currently it appears that P/PHC cost sharing funds are for the most part not being spent at the district level. The need for means by which to assess who is and who is not currently spending these funds is obvious.

Analysis of actual expenditure data for FY 89/90 indicate that there were reductions from the previous year in resources available to (as a percentage of overall expenditures) for P/PHC, family planning and maternal and child health, rural services, the essential drug program and non-wage items. The revised budget estimates for FY 92/93 indicate that resources for all these items will be restored to levels higher than those in FY 88/89. It is important that the MOH analyze the actual expenditure data for FY 90/91 as soon as they become available in order to document these shifts. Once again, the threat posed by high personnel costs to the MOH's ability to execute its budget as planned cannot be over emphasized.

4.6.2 EFFICIENCY AND QUALITY OF CARE

The MOH has undertaken a number of initiatives intended to improve the efficiency of service delivery and the quality of care delivered at government facilities. Efforts have been concentrated in the areas of hospital drug management, facility level staffing needs, patient waiting time at hospitals and development of clinical guidelines for the treatment of the most common diseases. These initiatives appeared well targeted and on track.

A manual on hospital drug management has been developed and will be field tested in the near future. Once the test has been completed, the MOH should develop plans (perhaps for presentation to potential donors) for further implementation. This would not be an activity to be carried out by the KHCF Secretariat.

PIL Number 17 requests that the MOH "present evidence that each PGH has an adequate inventory of the most critical drugs and medically related supplies stocked to the desirable stock levels for at least a two month period". It is not clear that application of methods for improved drug management contained in the manual will satisfy this bench mark. The spirit of the interim bench marks seeks to insure that adequate supplies of drugs be made available as cost sharing is introduced. The link between drug availability, fee collection and patient satisfaction is clear. Meeting this benchmark may require that the MOH increase the resources available to supply facilities with required drugs as donor support to the essential drug program dwindles.

While these efforts address the issue of increased drug availability through improved management techniques at the facility level, national drug procurement policy and availability remain questions of major concern. The KHCF Program does not seek to address these important issues but it should be noted that long term policy reforms in this area are absolutely essential for the sustainability of health care delivery.

The threat of excessive personnel costs to the viability of the entire government health care delivery system is clear. A first step towards bringing this problem into focus is the development of appropriate staffing norms for all levels of facilities. Development of norms based on time/task analysis of activities for MOH hospitals is under way. Once adopted the MOH must then develop a plan for management and development of personnel. It must be remembered that the development of norms alone will not resolve the critical problem faced by the MOH with respect to its wage bill. This problem will have to be addressed as part of the MOH's (and donor) longer term program for health care finance reform.

The Secretariat should assess its role in the area of service delivery efficiency and quality of care issues. While it may be appropriate for the Secretariat to initiate MOH discussion of these issues as they apply to the implementation of cost sharing, the implementation of recommended actions should be seen as a low priority. It would appear that personnel for other departments (medical services, hospitals, pharmacy, etc.) might be more logically charged with implementation. This would allow scarce Secretariat resources to be devoted to higher priority questions such as monitoring and evaluation system and health finance policy development. The same priorities should apply to the technical assistance team.

4.6.3 FINANCIAL MANAGEMENT

The introduction of cost sharing in government health facilities has necessarily been accompanied by the development and installation of accounting and management systems at the facility level. These systems are currently operating in seven PGH facilities (and KNH). The systems appear capable of providing the accountability and management information required by both the facilities and the Secretariat. The systems and the on-the-job training and supervision that has been a part of their installation appear to have had a major impact in the ability of those facilities to improve revenue generation significantly during the last six months.

At the facility level, the systems use receipts issued at the point of payment and patient registers at the point of service delivery in order to cross check charges, receipts and services. The various records kept may be reconciled on a daily or weekly basis. An important aspect of the systems is that they allow the facility to calculate the number and value of fee waivers issued. Separate procedures and tracking system has been developed that aides

the facility in filing and tracking claims for reimbursement from the NHIF. Several of the PGHs have, for the first time, begun to claim and receive reimbursement from NHIF as a result of the installation of the accounting and management systems. This is significant in that an estimated 80 percent of the PGHs potential revenue comes from NHIF reimbursements.

Using the registers and cash books, monthly reports are written and transmitted to the KHCFP Secretariat. The reports will allow the Secretariat to track revenue generation on a facility by facility (or eventually district by district) basis.

The Secretariat is required to approve all requests for expenditures made with cost sharing revenues. The Secretariat currently promises 24 hour turn-around of these requests. The Secretariat appears to have a less developed system for accounting for the actual expenditures that are then made. This is a major weakness of the current systems and should be addressed by the Secretariat and the technical assistance team. While this centralized system of expenditure approval and accounting may be feasible with the current number of reporting facilities and revenue levels, as the system expands to cover District Hospitals (45), Health Centers (304), and DHMTs (45) modifications may be necessary. The Secretariat may require additional staff (perhaps even beyond the currently approved 13) in order to handle the volume of request for authorization of expenditures.

The Secretariat is revising a manual for the operation of the system. The manual will be used to extend the system to the level of the District Hospital. The Secretariat should develop a comprehensive plan and budget for this important activity. Plans to install the systems at the district level should be coordinated with donor agencies who may be active in those areas.

No estimates have yet been made of the cost of installation or operation of the financial accounting systems in use. Such estimates should be performed in order to allow the Secretariat to assess the net revenue generated by the system and to insure that the systems are the lowest cost and most efficient possible.

The Secretariat has not yet developed a system that will allow it to accurately account for expenditures made by the DHMTs using the 25 percent of cost sharing revenues dedicated to the improvement of P/PHC services. This is a major weakness that must be corrected.

4.6.4 EQUITY

Equity is a major concern in the design of any health care financing strategy. The MOH is insistent upon the principal that no one will be denied medical care as a result of the implementation of cost sharing mechanisms. To this end it has developed a system to grant fee waivers to those deemed unable to pay. Granting of waivers is usually based upon the subjective judgement of

the health care provider and approved by the facility director. The financial accounting systems being put into place will allow each facility (and the MOH) to track both the number and value of waivers granted under the system. The system is not yet producing regular reports on the granting of waivers.

Anecdotal evidence indicates that the number and value of waivers being granted is very low, probably less than one or two percent of the total patient volume or revenues at any given facility. This maybe explained by a number (or combination) of scenarios including:

- The truly poor do not know that waivers are available and therefore do not seek treatment
- Prices are so low that only a small percentage of the population actually require fee waivers in any case or
- The availability of exemptions for fees to a wide number of patients (approximately 30 percent at KNH) means that most of the poor do not require waivers since they are already considered exempt.

The lack of an functioning monitoring and evaluation system makes it difficult to draw conclusions as to why the level of waivers is so low. The MOH must await the results from the monitoring and evaluation system in order to adequately address the question of equity.

4.6.5 INSTITUTIONAL DEVELOPMENT

Institutional development has taken place at a number of levels as a result of the KHCFP. Recent developments within the MOH and the KHCFP Secretariat are encouraging. There remains a substantial amount of institutional development work to be done at the level of the Hospital Executive Management Committees and the District Health Management Teams and District Health Management Boards. The strengthening of these institutions must become a priority if the implementation of cost sharing is to meet its objectives.

The Implementation Committee meets more regularly and appears to be taking an increased interest in the implementation of cost sharing. Its Secretariat responsible for cost sharing implementation continues to suffer from an acute shortage of human resources. This situation appears to be improving and indications are that with the return and assignment of several persons from long term overseas training to the Secretariat that it will continue to improve. The Permanent Secretary has recently approved a new staffing plan for the Secretariat that would bring the total staff to thirteen. This staffing plan must be implemented.

A an unambiguous definition of the Secretariat's mandate and official placement of the Secretariat within the organizational framework at an appropriate level remain constraints to further institutional development. The lack of resources to allow the Secretariat to function has also been a

constraint. The MOH has agreed to include operating funds for the Secretariat in the FY 93/94 budget. This is an encouraging indication of institutional support by the MOH for the Secretariat and the KHCFP. A proposal to fund operations as an interim measure of the Secretariat until MOH funds become available has recently been submitted to the World Bank.

The continued development of the Secretariat will require a clear definition of its role in the review and reform of not just cost sharing policy but of health care finance policy in general. Many in the MOH apparently regard health care finance as a question limited to cost sharing and the revenues that it is currently generating. This is clearly not the case and the Secretariat must play an instrumental role in expanding the MOH's vision and capabilities in this area. This will require that the Secretariat develop a number of linkages with other departments and institutions within the MOH, other GOK institutions, private sector and donor community.

The experience to date (especially recently) with regards to the development of the Secretariat is very encouraging. It is however a young institution and will require nurturing. It will continue to require technical assistance for some time to come. It will also require that the MOH follow up on the approved staffing levels and appoint adequate personnel as soon as possible so that they may benefit from the presence of long term technical assistance team.

As revenues are being generated at the PGHs it is now appropriate to develop plans for the institutional development of the facilities and the DHMT and DHMBs that will be responsible for planning and executing expenditures. The installation of the financial management systems for cost sharing could be combined with cost sharing management training for facility staff targeted to improve the ability of staff to plan and use cost sharing revenues. One aspect of facility management is already being addressed by the drug management manual under development. The Secretariat could develop training modules for this purpose and test them in a number of facilities.

The lack of development plans for the DHMTs and DHMBs must be addressed by the Secretariat. Revenues dedicated to the improvement of P/PHC services at the district level are currently being accumulated and not spent. It must be anticipated that the development and improvement of the management capacity of these institutions is critical and promises to be time and labor intensive. The development of these district level institutions may require a phased or pilot test approach in order to accurately assess the resources required to develop them. The Secretariat should develop such a plan (perhaps in collaboration with donors likely to finance and organize implementation). The development of this plan should be a major priority for the Secretariat.

4.6.6 KHCFP STRATEGY DEVELOPMENT

Development of a comprehensive KHCFP strategy was begun by the Strategic Planning Group within the KHCFP Secretariat in November 1991. At that time, the group outlined a plan to produce a strategic health care finance plan and to present the plan for approval by senior MOH policy and decision makers by

late May 1992. It was suggested that the approved plan could possibly be submitted to Parliament as a sessional paper and also serve as the basis for the health section of the upcoming five year national development plan.

The development of this strategic plan should be considered an extremely important exercise. It will serve as the basis, perhaps, for the development of health policy the sector for years to come. It will also serve to provide a coherent framework for redefining the partnership that needs to exist between the MOH, the community through cost sharing, the private sector and foreign donors to finance and delivery health care in Kenya. The development of such a plan will also represent an important step in strengthening and institutionalizing the MOH's capacity to review and develop policy.

The plan for the development of the strategy paper calls for a series for background papers to be drafted in order to focus on the relevant issues and provide important background information in order to develop and ultimately assess policy options. Several of the drafts to date do neither. The drafts that have been developed so far will require extensive attention in order to fulfil their role in framing policy discussions. It may be both desirable and necessary to broaden the circle of persons participating in the development of the papers (e.g. local experts in health economics and other relevant areas and/or external technical assistance) in order to benefit from a broader range of experiences and outlooks. It may be necessary to call upon additional outside technical resources and inputs in order to fully develop these background papers and the process itself. The importance of this activity dictates that the technical assistance team Chief of Party take primary responsibility for its management and progress. The team economist must continue to provide technical guidance to the process if it is to succeed.

A plan for the development of the strategy was developed in November 1991 and should be consulted as the Secretariat further develops the background papers and the process by which they will guide the development of the strategy statement. The upcoming workshop (22 May) should be seen as an immediate first step in this process.

It appears unlikely at this time that the strategic plan will be sufficiently developed to be presented to senior MOH policy in early June 1992 as planned. It may be necessary to postpone the proposed workshop in order to allow the strategic planning group more time to develop the background documentation required and then draft the strategic policy statement before its presentation for adoption by the MOH.

4.7 CONCLUSIONS

4.7.1 The progress that the MOH has made towards the long term financial sustainability of priority programs under the KHCFF is impressive. Much work remains in order to fully implement cost sharing and install required systems. Without these systems cost sharing will remain in a politically precarious position and may not meet objectives in terms of equity or improvements in the

quality and accessibility of services. The time is ripe for the MOH to objectively review finance policy for the sector and redefine the partnership between the public and private sectors, the community and external donors to deliver health services. The KHCFCP appears to be making a substantial positive contribution towards efforts in these areas.

4.7.2 The Secretariat must pay particular attention to the development and refinement of systems that will allow it to document and account for expenditures made with cost sharing revenues by facilities and DHMTs. The concern for accountability must be of the utmost concern for the Secretariat. Accounting systems may require regular independent, external audit and should be developed with this in mind. Accountability and transparency will be the keys to the long term sustainability of cost sharing and sector reforms.

4.7.3 Due to delays in the implementation of several of the policy reforms contained in the Program, the MOH may have difficulty in meeting all of the tranche three interim benchmarks assigned to it by the anticipated end of the Program in November 1993. If tranche two interim benchmarks are met at the earliest possible instant (March 1993) there will remain less than eight months to complete all tranche three benchmarks before the Program end date. This may not be feasible given the volume of work required and the available resources.

4.7.4 The MOH may have difficulty meeting overall revenue targets for cost sharing. There is, as yet, insufficient experience with cost sharing and revenue generation to adequately assess the feasibility of meeting current targets of ten percent of total recurrent allocations and 20 percent non-wage recurrent allocations (due to the current ratio of wage to non-wage of approximately 65 to 35 the MOH could, in fact, generate 20 percent of non-wage allocations and not meet 10 percent of total allocations). Certainly these targets will not be met by 1992 as shown in the PAAD.

4.7.5 There is currently no consensus as to the best method to use in order to document shifts in resources towards non-wage recurrent costs and P/PHC services. The two methods proposed in the PAAD (application of the Gap Model to MOH budget estimates and analysis of line item expenditures) appear capable of producing contradictory results (and did so for 91/92 estimates and 89/90 expenditures respectively). The attainment of targets as using these indicators as interim benchmarks under tranche three benchmarks should be studied.

4.7.6 Efforts to develop and install fee collection and accounting systems, while incomplete, appear well underway. The systems are new and facilities will require significant assistance to implement them successfully. The Secretariat should develop revised guidelines for the planning expenditures made with cost sharing revenues. Complete systems must be developed and installed to allow the Secretariat to produce periodic (initially monthly) reports on cost sharing at PGH facilities.

4.7.7 Major areas which MOH and Program resources should be targeted to address in the time remaining until its end in November 1993 are:

- Continued development of facility level cost sharing systems and expansion of those systems is planned to the District Hospital and Health Center level
- The MOH budget and development of mechanisms to shift resources towards P/PHC priorities
- Development of the DHMTs and DHMBs in order to institutionalize the use of cost sharing revenues to reinforce P/PHC activities at the district level
- Finalization of plans for the operation of a system capable of monitoring the implementation and impact of cost sharing policy; and
- Continued emphasis on efforts to develop a strategic plan for the MOH to address health finance issues.

As noted the implementation of cost sharing systems is well under way at the level of the PGHs. These systems should be adapted as necessary and installed at the District Hospital and health center level. The Secretariat is developing plans to this effect.

Although the MOH is capable of producing the budget analyses and revenue projections as required under the interim bench marks of the grant it is not clear that their results play a role in budget allocation decisions. The Secretariat should continue to assist the MOH in developing adequate methods for these analyses. Encouragement of the MOH to make major shifts in the allocation of its resources should be a priority for the Secretariat and the program.

The DHMTs and DHMBs have been relatively neglected until now as efforts were concentrated on systems required for revenue generation. It appears that now that those systems are beginning to function effectively, greater attention must be focused on assisting districts to effectively plan, spend and account for their growing P/PHC resources. The Secretariat should develop (in conjunction with interested donors) a plan to develop procedures and systems aimed at this. These systems could then be implemented on a limited basis (as has been done with the facility based systems at the seven PGHs) in order to test and refine them. The actual testing of the systems and their extension beyond the test phase may be beyond the capacity of the Secretariat. It should therefore take the lead in development of a plan and then seek to coordinate and manage available resources.

The Secretariat must finalize its plans for a comprehensive monitoring and evaluation system as soon as possible. The detailed plan for the collection of data and their analysis must be approved and implemented. The plan for analysis should take into account the various users of system results. The system is required to fine tune the cost sharing mechanisms and defend the system against attack.

The Secretariat must continue the development of background papers to be used in framing discussions of a national health finance strategy statement. This statement will guide the development of the sector for the near to medium future. The secretariat should allocate whatever resources are necessary to the production of this plan. This may require additional outside assistance to fully develop several of the key background issues papers. Building the broadest possible consensus around both process and product are essential.

4.7.8 Major efforts must be made to eventually address the chronic problem of overspending of wage and other personnel costs. Efforts to match actual personnel and payrolls in order to reduce unnecessary personnel costs are to be encouraged. The development of staffing norms is underway with KHCF Project assistance. These two efforts together will allow the MOH to develop plans to redeploy its human resources more efficiently. It does not seem possible that the current program and resources can go beyond these initial steps in addressing this situation. Efforts to reduce personnel costs, although an essential component to addressing the long term problems of financing the health sector, should not be seen as the direct responsibility of the Secretariat.

4.7.9 The Secretariat's current human and financial resources are not adequate for it to fulfill its role in the policy reform and implementation process. The current staff will not be sufficient to extend cost sharing systems to the level of the District Hospital as planned. The Secretariat does not currently have funds for its operations. Interim and long term solutions to this lack of funds must be found.

4.7.10 Secretariat efforts to address the priority areas described above will require continued long and short term technical assistance beyond the scheduled completion of the current contract. All MOH based members of the technical assistance team except the Chief of Party will leave the Secretariat by January 1993. The Secretariat, by that time, will have completed neither the tranche two interim benchmarks nor acquired the technical skills to complete the without some level of assistance. The team and MOH should study possibilities to reposition more of the contract's short term technical assistance resources in order to address these areas as well.

4.7.11 In order to address the priority areas described above, it will be necessary to reallocate technical assistance efforts (long and short term). The technical assistance team and the Secretariat must reallocate technical assistance resources to address the priority issues. This will mean

allocation of fewer resources (less time) to lower priorities such as those associated with drug management and quality of care activities in favor of greater resources being made available for the development of monitoring and evaluation systems and the statement of national health finance strategy.

4.8 RECOMMENDATIONS

4.8.1 USAID should extend the Program completion date by at least one year beyond November 1993 in order to give the MOH additional time to meet all of the Program conditionalities. This will require a minimum 12 month extension.

4.8.2 USAID should respond favorably to MOH requests to extend the contracts of the technical assistance team members based in the MOH until November 1993 to enable the team to complete implementation of cost sharing systems at the PGH level, expand coverage of the systems to the District Hospital and Health Center level, and strengthen the institutional capacity of the Secretariat.

4.8.3 USAID should consider the provision of long term technical assistance to the Secretariat and MOH beyond November 1993 to support the development and initial implementation of the sector reform program expected to be financed by the World Bank.

4.8.4 The MOH must refine and improve methods to be used to document anticipated revenues and resource shifts within MOH budget estimates as well as actual revenues and expenditures. The results of these analyses must be integrated into a more dynamic budget process that more fully reflects MOH programmatic priorities.

4.8.5 USAID and the MOH should continue to closely track progress towards cost sharing revenue targets and resources shifts. As additional experience with the current fee structure and its revenue generating capacity is acquired it may be necessary to revise certain of these targets. Their use as tranche three interim benchmarks without close study may affect the MOH's ability to access tranche three funds.

4.8.6 The Secretariat and the technical assistance team must design and fully implement a cost sharing monitoring and evaluation system. This an immediate priority and the major priority for the long term monitoring/evaluation advisor. The system must be fully operational prior to the departure of the technical assistance team. This activity may require additional short term technical assistance and resources should be reallocated in favor of this priority activity.

4.8.7 The Secretariat and the technical assistance team must install mechanisms to better account for the expenditures of cost sharing revenues by facilities and DHMTs.

4.8.8 The Secretariat should refine guidelines and plans for the planning and spending of cost sharing revenues for P/PHC activities by DHMTs under the oversight of the DHMBs. The Secretariat will not have sufficient resources to fully implement these plans and guidelines at the district level.

4.8.9 The MOH should immediately gazette the DHMBs so that they may become operational.

4.8.10 The Secretariat (and technical assistance team) should allocate additional technical assistance resources to the development of the comprehensive health finance strategy statement. It should seek to broaden the circle of participants (to include local and external experts) and resources available to the development of the plan. This will require a reallocation of short term technical assistance resources in favor of strategic plan development.

4.8.11 The MOH should immediately assign additional staff to the Secretariat as agreed in the recently approved staffing plan. Financing necessary to support the recurrent cost of Secretariat operations should be included in FY 93/94 forward budget estimates. This should be done in order to maximize opportunities for skills transfer before the departure of the technical team and extend coverage of cost sharing systems according to schedule.

4.8.12 The Secretariat should develop plans to adequately monitor the cost of cost sharing fee collection and financial management systems in order to assess the net revenue effect of cost sharing. This will allow the MOH to insure that the systems developed and employed will incur the lowest administrative cost possible.

5.0 KENYATTA NATIONAL HOSPITAL IMPLEMENTATION

5.1 INSTITUTIONAL CONTEXT

At least three main institutional factors affect KNH's ability to implement health financing policy reform: its size and complexity; its recent status as a state corporation; and its relationship to the availability and capacities of other public and private health facilities in the Nairobi area.

The Kenyatta National Hospital is Kenya's only public sector tertiary care hospital, has almost 2000 (1928) beds, 50 wards covering all clinical disciplines, and generally more than 100 percent occupancy rate. The hospital runs 33 speciality clinics during the week. It has 3400 full-time employees. The Hospital has been operating with a Government funded annual budget of KL 12.5 - 11.2 million (U.S. \$8-7 million at current exchange rates) over the past three years, FY 88/89 - FY 90/91.

The Hospital currently serves several missions which can have conflicting impacts on health financing and cost containment efforts: 1) teaching, through the College of Health Sciences of the University of Nairobi, the Medical Training College; 2) research, through the Kenya Medical Research Institute; as well as 3) provision of primary, secondary and tertiary services in both the public wards and newly created private wing of the Hospital.

The KNH was converted to a state corporation in 1987. As such it is intended to attain eventual financial self sufficiency, but currently continues to receive a budget allocation from the Ministry of Finance, and is accountable for public health and financing policies to the Minister of Health. As a state corporation, the KNH is accountable to a Board which has planning and management oversight responsibilities. With transition to parastatal status, KNH needed to adopt a new organizational structure, hire or appoint at least eight senior managers, define new roles and responsibilities, and adapt its financial and other information systems to meet requirements of a financially autonomous, private sector institution. Numerous problems are to be expected, and have arisen, in establishing the new organizational relationships, authorities, and responsibilities deriving from this transition.

Other public sector health facilities in the Nairobi area are under the Nairobi City Commission's authority. Ministry of Health resources often complement the Nairobi Area resources, however. The inadequacies of lower level Nairobi health facilities and the absence of a functioning referral system have made it difficult for KNH to decrease its role in primary and secondary care. The differing institutional and financial bases of the Nairobi Area Commission, the MOH, and the KNH complicate planning, negotiation and coordination of health service delivery resources.

5.2 REFORM CONDITIONALITIES

The conditions precedent that apply to the Kenyatta National Hospital involve health financing reforms that require revenue generation through implementation of new and revised user fees, creation of a doctors' practice plan (charges for consulting physicians offices), and establishment of a private wing (amenity ward). KNH is also required to implement measures to improve quality and efficiency in selected priority departments. The conditionalities are phased in three funding tranches to require, first, development of a cost sharing plan; second, substantial progress in implementing the plan; and finally, completion of all implementation benchmarks in its cost sharing plan.

The general conditionalities related to maintaining a base funding level, additionality, and no-year funding also apply to KNH for each tranche release.

KNH has met requirements for the release of tranche one funds. Several requirements are still outstanding for tranche two funds. The following section discusses the main points and status of the conditions for release of tranche funding.

5.2.1 TRANCHE ONE REQUIREMENTS

Conditions precedent for the release of the first tranche (U.S. \$2,000,000) required meeting: 1) the general conditionalities as they applied to KNH funds, and 2) preparation of a cost sharing plan that would include (as provided for in PIL No. 2, dated October 12, 1989):

- Measures to ensure access of all persons to KNH services
- Proposed fee schedules, arrangements for collecting, administering and use of cost-sharing revenues
- A methodology for assessing the impact of revenue generating plans on hospital services
- Proposed administrative structures related to cost sharing and measures to improve efficiency
- Time schedules with midterm and final implementation bench marks for implementation of the cost sharing plan.

5.2.2 TRANCHE ONE FINDINGS

KNH had satisfied these conditions by April 1990 (PIL No. 9, dated April 11, 1990). The original projection for date of compliance with these conditionalities was November 1, 1989. KNH spent almost half of the tranche

one funds for drugs and dressings. Most of the balance was spent for supplies for dental services, diagnostic services, renal unit, and assistance with an accounting and personnel analysis. Tranche one funds also paid for theatre (surgery), maintenance, transport, I.C.U. and linen supplies.

5.2.3 TRANCHE TWO REQUIREMENTS

Conditions precedent for the release of the second tranche (U.S. \$1,000,000) required: 1) meeting the general conditionalities as they applied to KNH funds, and 2) documentation that KNH had substantially progressed in the implementation of the cost sharing plan. PIL No. 12, dated October 29, 1990, provided guidance on fulfilling these conditions. Specific conditionalities applicable to KNH included, as a minimum:

- An operational private wing
- Adoption and use of the fee schedule system
- Achievement of mid-term bench marks established in KNH's cost sharing plan.

With inclusion of each of the mid-term bench marks, PIL No. 12 required a total of eleven specific groups of actions.

5.2.4 TRANCHE TWO FINDINGS

KNH submitted a status report on these conditionalities in September 1991. The original date of compliance had been projected for May 1, 1991.

In its review of this submission, the Kenya Health Care Financing Program Committee concluded that KNH had met seven of the eleven conditions, related to a private wing, doctor's practice plan, fee collection systems, monitoring systems, financial management, average length of stay, and KNH management staffing. The USAID Committee concluded, however, that four sets of activities--implementation of fee schedules, fee waiver systems, quality assessments, and an updated implementation plan for the balance of the Program period--required further steps. The USAID committee also concluded that the general conditionalities had not been met with respect to KNH budget allocation from the Ministry of Finance.

PIL No. 16, dated December 16, 1991, lays out these USAID decisions and their reasons. **Appendix B** provides a detailed list of actions required to meet these conditionalities for tranche two and shows the implementation status as of the issuance of PIL No. 16.

5.2.5 TRANCHE TWO GENERAL CONDITIONS

The USAID Committee identified two principal problems with respect to the general conditionalities for budget allocations for KNH:

- Although the authorized amount for KNH in the MOH budget for FY 87/88 through FY 90/91 increased each year, the amount KNH actually received was substantially below the level approved. The base funding amount was thus not maintained, as required.
- MOF documentation indicated conformance with the additionality principal for FY 90/91. But review of amounts that KNH actually received from the MOH for FY 90/91 indicated that neither cost sharing revenues nor disbursements from tranche one were in addition to KNH's budget allocations. Rather, KNH had not received the full amount of its tranche one funds, nor the full amount of the increased budget allocation the MOF had authorized for KNH.

As corrective action prior to re-submitting a claim for release of tranche two funds, the USAID review committee requested verification that: 1) actual budget allocations be current through the two months preceding KNH's resubmission of documentation for tranche two, as well as 2) a substantial reduction of the supplier debt that KNH had incurred due to significant underfunding as a result of these budget allocation problems.

5.2.6 TRANCHE TWO SPECIFIC CONDITIONS

The main problems with respect to KNH's implementation of the fee schedule were that:

- The Government had not reintroduced the outpatient fees that had been cancelled in August 1990 and
- Actual KNH fee revenues had not matched their projections.

The USAID committee noted that the proportion of operating expenditures-financed with fee revenues exceeded the implementation plan targets for FY 88/89 and FY 90/91 (4.2 and 5.2 percent respectively). They also noted that new projections in the KNH submission indicated that, by 1994, revenues would exceed the target of 10 percent of operating expenses specified in the PAAD for 1992. But these four and five percent targets would not have been met had the KNH received its full budget allocation from MOH. In addition, the KNH had not prepared a plan to address issues related to reintroduction of outpatient fees (e.g., adequate supply of drugs and other medical supplies, functioning equipment, functioning waiver system, and monitoring plan to measure the impact on low-income patients).

With respect to the other specific problem areas, the Committee noted that KNH had completed only two (casualty and radiology) of the six quality assessments, had not yet revised its fee waiver system, and had not developed an adequate implementation plan for the balance of the project period.

The USAID Committee required follow-up action on all four of these areas, including requesting that a revised fee schedule be in effect for a period of at least 60 days. They extended the time for satisfaction of the Conditions Precedent to April 30, 1992.

5.2.7 CURRENT STATUS OF TRANCHE TWO CONDITIONALITIES

The evaluation team's review of the current status of pending conditionalities for tranche two suggests that KNH has made progress on some of them, but is not yet in a position to meet all the remaining conditions for tranche two.

Progress has been made with respect to implementation of planned fees. In August 1991, the Cabinet approved reintroduction of outpatient hospital fees for January 1, 1992. The Government announced on April 11, 1992 that KNH would begin charging outpatient fees on April 15, 1992. The new outpatient fee structure requires payment for medicines (Kshs 10 per item) and for specific treatments (e.g., for sutures, dressings), rather than the flat consultation fee that had been in place from December 1989 - September 1990.

The new structure is an innovation designed to remove the problem of paying for a consultation, but having to pay again for medication at a private pharmacy because the hospital was out of stock or receiving inadequate treatment because the Hospital had no antiseptics or gauze. The potential to raise revenue and generate patient satisfaction will, of course, continue to depend on KNH's ability to maintain adequate stocks of drugs and medical supplies.

The new outpatient fee structure appears to be more acceptable to the public than the consultation fee. No critical commentary in the newspapers or other obvious discontent has been expressed since the KNH began implementing the new fees.

In addition, progress appears to have been made on improving the design and operation of the fee waiver system. An updated, detailed and comprehensive implementation plan for activities related to fee collection, financial management and accounting systems also exists.

Nevertheless, action on quality assessments continues to lag and a comprehensive updated implementation plan, along the lines specified in PIL No. 16, (e.g., actions to ensure adequacy of drugs and medically related supplies) is still under development. In addition, while the Ministry of Finance and the Ministry of Health have taken some steps on the budget allocation issues, these are not yet resolved. MOH and MOF officials indicate they expect resolution in the course of final negotiations for the FY 92/93 budget authorization for MOH. These negotiations and subsequent calculations related to meeting the conditionalities are expected to be completed by the end of June 1992.

5.2.8 TRANCHE THREE

Conditions precedent for release of the third tranche (U.S. \$1,000,000) require: 1) satisfaction of the general conditionalities as they apply to KNH and 2) documentation that KNH has completed the final implementation benchmarks in its cost sharing plan. The compliance date originally projected for these conditions was November 1, 1992. Since KNH has not yet met all conditionalities for tranche two, USAID has not yet issued specific guidances for meeting requirements for release of the last tranche.

5.3 POLICY REFORM

The overall results of the KHC FP as it applies to KNH were to be implementation of the policy reforms as defined at the start of the Program, further definition of the reform agenda, and enhancement of KNH's capacity to design, implement and evaluate the reform programs.

The health financing policy reforms applicable to KNH were designed to support and strengthen its financial viability as a state corporation. They were also designed as an integral component in the larger reform program to increase revenue to the health sector through cost sharing, or charging user fees.

The system of user fees at KNH was to be integrated with other fees in the MOH system in such a way as to encourage appropriate referral and utilization of each service delivery level, and discourage inappropriate use of hospital facilities. It was also to include a waiver or other system to ensure that no one was denied access because of income. To the extent that user fees could increase financial autonomy for KNH, they would also serve the goal of reducing the need for Government subsidy to a health facility that has drawn on approximately 10-12 percent of the Ministry of Health's operating budget.

The KHC FP design intended that KNH would establish a comprehensive cost sharing program, implement a system for managing and monitoring that program, and institute changes to improve efficiency and quality. Revenue generated through the cost sharing measures was expected to finance at least 10 percent of the recurrent budget of KNH by year three (FY 91/92) of the Program. The original Program design also expected that the portion of the KNH budget financed by GOK grants would decrease by an equal percentage, with GOK grants reduced by five and 10 percent by the end of year two and three respectively.

5.3.1 REVENUE GENERATION GOALS

As indicated above, KNH met the initial conditions for developing a cost sharing plan early in 1990 and has implemented a series of inpatient, laboratory, X-ray, and outpatient fees since the start of the KHC FP in 1989. The process of establishing and authorizing these fees has, however, been erratic, and, not unexpectedly, highly sensitive politically.

For example, after establishing the initial level and structure of these fees in 1989, the Government reduced the maternity and inpatient fees in January 1990, exempted civil servants in March 1990, and abolished the outpatient consultation fee altogether at the end of August 1990. Inpatient and other fees (e.g., dental, X-ray, mortuary) remained in effect during this period. The Government announced these early fee revisions primarily because of a combination of perceived and real negative public reactions to the new system. Most of the top MOH officials and the management staff at KNH have consistently supported the concept of fees and currently view fee collection as an absolute necessity.

5.3.2 GOK FUNDING GOALS

Trends with respect to the goal for GOK funding of KNH have also been erratic. Budget support to KNH did decline in the first two years of the Program. But this was unintended and due to the MOH not releasing the full MOF (increased) allocations to KNH. For the coming year, FY92/93, the MOF will again authorize an increase for KNH over the prior year. KNH requested an increase from KL 16 million to 45 million (U.S. \$11 million to 30 million at current exchange rates) for FY 92/93 and the MOF plans to grant about one third of the addition requested.

5.3.3 DONOR COLLABORATION

The KHCFP policy reforms for KNH, as well as for the KHCFP as a whole, represent the first phase in a long term effort, designed in tandem with plans for a U.S. \$31 million World Bank Health Rehabilitation Project. The Rehabilitation Project is an investment project to support the Government's health financing and expenditure reform in conjunction with the USAID KHCFP. The Bank also plans to undertake a subsequent Health Sector Adjustment operation to build on the implementation experience of both the Rehabilitation and the HCF programs.

In addition to rehabilitation of the KNH physical facility, the Bank's Rehabilitation Project also provides for complementary institution building, strengthening of financial and other management capabilities, improvement of efficiency and quality assurance capabilities, and achievement of various revenue and expenditure targets. For example, the longer term funding goal under the Rehabilitation project is to reduce GOK funding for KNH to 50 percent of operating costs.

Components of the KNH activities undertaken with the Bank are described further, as applicable, in subsequent sections of this chapter. Subsequent sections also identify other components of the Rehabilitation Project, as they apply to KNH.

The Bank made available a Project Preparation Advance of U.S. \$615,000 in September 1989, with an increase to U.S. \$1.5 million in November 1990. The Project loan was signed in November 1991, but start-up has been awaiting the meeting of conditionalities similar to USAID's. It is now expected that the Project will start in July 1992.

5.4 HEALTH FINANCING SYSTEMS DEVELOPMENT

The KHCFP has devoted the most intensive implementation efforts at KNH to developing fee collection, fee waiver, and accounting systems. The Project is providing in-service training in converting the hospital's cash accounting system to an accrual system and has provided assistance with design and training related to use and maintenance of fee collection registers, receipts, cash books, waiver forms and registers. The evaluation team's review indicates that these efforts are well underway and the technical assistance is appropriate and highly appreciated. Practical and useful forms and registers have been developed and are being used. Simple computer-based spreadsheet models have been developed for projecting revenues and for tracking and displaying the hospital's revenues and expenditures.

The USAID KHCFP Committee also determined that the KNH clearly met the second tranche Conditions Precedent related to establishing systems for revenue collection, retention and use. With respect to establishing a central area for both admissions and fee collection, the Committee accepted the KNH point that construction of a central area for these purposes was pending start-up of the Bank's Rehabilitation Project.

The Finance Department, working with the Project team, has also developed a detailed, comprehensive draft workplan through 1993 that identifies goals for the Department as a whole, and for financing systems, revenue collection, budgeting and costing, accounting and reporting for donor funds, management reports, computerization, departmental reorganization, and longer term goals for cost containment. The plan requires additional clerical, accounting, and senior financial staff, as well as continuing collaboration with the HCF Project team. The need for additional staff resources is primarily due to the new demands of revenue collection--both cash and NHIF insurance--and related recording, monitoring, accounting, estimating, and tracking activities.

The Advance for the Bank's Rehabilitation Project has also included some technical assistance that complements the KHCFP in, for example, organization and management, finance, inventory control, asset valuation and data generation for financial forecasting.

5.5 MONITORING AND EVALUATION

Systems for monitoring and evaluating the impact of health financing reforms are not as well developed as the financial systems. The primary goal of the HCF Program's emphasis on monitoring and evaluation is to track the impact of the financing changes on service utilization, referral patterns, socio-economic characteristics of patients using and not using the health services, and patient perception of quality.

Some efforts have been made to collect two of these types of data: socio-economic and utilization. A baseline survey was conducted of the socio-economic and referral status of patients in the months immediately before the introduction of cost sharing in 1989. A follow-up survey was conducted in 1990 soon after fee collection started. In the fall of 1991, KNH initiated an exit survey of patient perception of quality of care. KNH plans to conduct another exit survey after the new outpatient fees have been in effect for a few months.

Household or other surveys of both users and non-users have apparently not been conducted. The World Bank's Health Rehabilitation Project includes a component to develop a National Household Welfare Monitoring and Evaluation System in the Ministry of Planning and National development. This component would support evaluation of the impact of Government policies on household welfare and develop capacity to carry out relevant analytic work.

The utilization record-keeping system is the most fully developed component of this aspect of the monitoring system at KNH. A detailed system has been developed for recording and reporting daily inpatient and outpatient utilization data by clinic or department, and by new and old patients. Updated statistics are produced daily.

5.6 ASSESSMENT OF OUTCOMES

5.6.1 REVENUE GENERATION

As indicated in the section of this chapter that reviewed the status of the conditionalities, KNH did not meet the tranche two conditions related to fee schedules and revenue targets.

Actual revenues from fees at KNH have consistently lagged behind projected revenues and projected revenues tend to be consistently overly optimistic. Estimates for annual revenues from cost sharing for the years FY 90/91 - FY 93/94 have ranged from KSH 33.4 million to 71.6 million (U.S. \$1 - 2.4 million at current exchange rates). Subsequent revised actuals and estimates for these years cut the expected revenues in half. One of the main reasons for these inconsistencies is that fee assumptions that underlie the projections are frequently overturned by unexpected political shifts that change fee levels.

For example, KNH inpatient (Ksh 100/day) and outpatient fees (Ksh 50/month) in effect in January 1990 were each reduced by more than 50 percent in March and the outpatient fee level was dropped altogether September 1, 1990. Variable X-ray fees in place in January 1990 were changed to flat fees (Ksh 50) in September 1990. The combined impact of these shifts in fees caused a nearly 50 percent reduction in projections made in the original implementation plan developed for KHCFP purposes, compared with revised revenue projections for FY 90/91.

More recently, dates for the re-introduction of outpatient fees at KNH were originally scheduled for January 1992, but did not take effect until mid-April. Assumptions for the NHIF reimbursement rate for an inpatient day at KNH have had to change at least three times since 1991. And the age at which exemptions to the outpatient fee at KNH applies has already changed once in 1992 from 10 to 15 years.

Another major reason for the gap between KNH revenue projections and actual revenues is continuing weaknesses in collection procedures. Many clerical staff responsible for these duties are recently hired and still in in-service training. Even with recent hirings, the Finance department is still not adequately staffed for additional fee collection and related duties now that outpatient fees have been reintroduced. In addition, supply shortages (e.g., X-ray film, medicines, gauze) mean fees cannot be charged and collected. Delays in NHIF reimbursement and difficulty in identification of eligibles and other claims procedures slow the collection of NHIF revenues. Delays in opening additional capacity (e.g., in X-ray, in the private wing) also reduce actual revenues below projections.

There are unavoidable difficulties with revenue projections in a constantly changing situation with respect to major variables and little operating experience for guidance. These difficulties make it virtually impossible to meet revenue targets with much accuracy. Since assumptions about budgeted amounts actually received have also been unreliable, total amounts for operating expenditures have varied unexpectedly. This situation, combined with difficulties of projecting revenues, means that meeting targets, set well in advance, for revenues as a percent of operating expenditures is next to impossible. These fluid conditions also mean that a percentage-based revenue target can be met or exceeded for purely arithmetical reasons, as often as for deliberate or controllable ones.

It should also be noted that, even with increased revenues from fees, the KNH has requested increases in GOK budget funding. These requests, and MOF authorizations, are in the opposite direction from the Program's goal of reducing the GOK share of KNH operating expenditures. On the other hand, the Hospital is and has been underfunded and cannot provide adequate health services with the funds available. Fee revenue cannot be expected to make up this gap in the very short run.

The general conditions precedent that require maintenance of base (or priori year) funding and additionality of cost sharing revenues recognize this funding need. This general conditionality is basically in conflict, however, with the end-of-Program goal of reducing GOK funding to KNH.

5.6.2 EFFICIENCY AND QUALITY OF CARE

As noted in the review of the status of conditions precedent for tranche two, KNH has not completed all planned studies of efficiency and quality of care. Two, casualty and radiology, were completed in 1990 with technical assistance. Plans have existed for a long time for an internal team of KNH administrative and medical personnel to conduct the remaining four assessments. The demands of the full time duties of these personnel may be among the most important constraints to completing these studies.

KNH staff report that most of the low-cost, high-impact recommendations of the two completed studies have been implemented. Other improvements (e.g., those classified as high cost, high impact) have been delayed due to lack of funds. These are planned once the Bank's Rehabilitation project makes funding available.

5.6.3 FINANCIAL MANAGEMENT

KNH and Project assistance efforts in establishing a range of financial systems have clearly helped lay a base for improved financial management at KNH. The USAID KHCFP Committee noted, in PIL No. 16, that KNH and Project technical assistance efforts had led to demonstrated, increased capacity to manage the accounting of the cost-sharing revenues and KNH financing in general. In addition, the Hospital has recently appointed a highly qualified senior accountant to head the Finance office. He has stepped up efforts to improve control over collection of cash, claiming and collecting from the NHIF, and supervision of cashiers' work.

Plans to continue training, supervision, and monitoring in this area through the end of the Project appear to be absolutely necessary, however, to consolidate and extend these capabilities.

5.6.4 EQUITY

The impact of the policy reform and implementation activities under the HCF Program on equity with particular respect to the population served by KNH is unclear. Surveys that have been conducted are inadequate to provide appropriate and reliable information. The evaluation team did not see evidence that a systematic or comprehensive monitoring and evaluation system or plan exists at KNH to address impact on equity.

The specific outcome of the current waiver and exemption systems in place for KNH is also difficult to measure. But the exemption structure itself would appear, in principle, to provide more "protection" than is necessary for middle and even upper income patients. Exemptions granted at KNH have been running at about 30 percent of all inpatient and outpatient visits. Since the exemptions--for age, employment, and disease categories--are so broadly defined, very few waivers (less than five percent) are requested.

5.6.5 INSTITUTIONAL DEVELOPMENT

In the original design of the KHC FP, the institutional goal for KNH was to demonstrate improved management competence in administering finances and implementation of cost sharing. The Program and Project have most clearly had positive results for improving the financial management competence and procedures at KNH. With continuing intensive effort, those systems and capabilities are likely to be at a level of relatively smooth operation--if not institutionalization--by the end of the Program and Project.

Various planning, fee collection, and budget committees have been established and are reportedly functioning. The evaluation team did not have an opportunity, due to insufficient time, to meet with any of these committees to assess directly how effectively they are functioning.

The Project team has developed an excellent management training plan that will soon be released for tender. The plan is designed to provide assistance which will create a self-sustaining, ongoing, internal management development capability serving the KNH. It calls for training of KNH managers/trainers in the areas of financial management, general management, supplies management, drug management, nursing management, and quality assurance. If it is carried out successfully, the Project will have enabled KNH to establish a good base for further institutional development work planned under the Bank's Rehabilitation Project.

KNH staff have recently been involved with the MOH and the Nairobi Area Commission to plan and negotiate better coordination of KNH and Nairobi area health services within the framework of preparation for the Rehabilitation Project. Such contacts represent a continuation of similar planning and analytic efforts carried out with USAID support just prior to the start of the HCF Program. These activities can further develop the institutional ties that will be necessary to make the Nairobi area health service delivery system more efficient and effective.

Additional activities are planned under the Bank Project to clarify the broader inter- and intra-institutional relationships in which KNH is involved. For example, the Bank and KNH have agreed to various assurances, targets, and objectives from the KNH Institutional Development Plan, the 5-year Implementation Plan and the Strategic Plan for the Nairobi Area that is to be developed with the formal start of the Project.

5.6.6 HEALTH CARE FINANCING STRATEGY DEVELOPMENT

The original design of the KHC FP anticipated that the first stage of the Program would lead to a further definition of the policy reform agenda, as well as produce implementation of policy reforms already defined by the start of the Program. In the case of the KNH, the design expected that the Hospital would plan for and implement further efficiency reforms and quality improvements throughout the institution. KNH would also define a strategy that links its reform agenda with an overall investment program.

As noted above, KNH has not advanced the reform process under the KHCFP as it pertains to quality, efficiency, or cost-containment. Though ideas for these matters exist, most action seems to have been taken under, or is awaiting the start up of, the Bank Project.

Similarly, the framework for a strategy linking the current level of reforms with future plans and with an overall investment program has been developed as part of planning for the World Bank Rehabilitation Project. For example, that Project plans 1) to address the relationship and utilization patterns between KNH and Nairobi area health services, 2) to reduce KNH's burden on the Government's budget, and 3) to rehabilitate KNH's physical facility, including completion of the private wing. The Rehabilitation Project also includes a component to strengthen health planning and analysis and to prepare for further sector reform, including a public investment program for the sector.

5.7 CONCLUSIONS

KNH is in the first stages of implementing the KHCFP's policy reform program. It has concentrated on implementing the fees that the Government has authorized, and on plans to develop a revenue-producing private wing and consulting doctors' offices. Efforts to improve quality and efficiency--the second emphasis area in KNH's reforms under the KHCFP--are less well developed.

5.7.1 POSITIVE IMPACT

KNH and the Project have made an especially concerted effort to implement the reforms related to fee collection. They have shown the most positive results in this area and have met the conditionalities that are directly in their control and that are most directly related to this goal.

Donor collaboration has also been an especially positive feature of the KNH component of the KHCFP. USAID and the World Bank have worked closely together with KNH to plan and design policy reform activities and objectives. These plans have also been designed to follow in coordinated phases, building on prior work.

5.7.2 CONDITIONALITIES

Several of the conditionalities not met for release of tranche two funds are not within KNH control. If plans are realized for making MOF budget allocations directly to KNH are realized, some of the constraints in meeting conditions for additionalities and base year funding may be resolved.

Of the three unmet conditions that are within KNH control, only one (quality and efficiency assessments) appears to pose difficult implementation problem for KNH. Related activities to improve quality, efficiency, and cost containment, have, however, been undertaken, or are planned, under the Bank's Rehabilitation Project. As such, prospects for meeting the intent of these objectives under the HCF Program are good.

5.7.3 REVENUE AND FUNDING TARGETS

One currently unmet conditionality, achieving a fee revenue target equal to 10 percent of operating costs, is only partially within KNH control. KNH and the Project have developed an adequate methodology to address these targets and have made every effort to apply it. Recent re-introduction of outpatient fees and increased efforts to collect NHIF reimbursement will certainly help meet this target in the near future. Stability of fee levels and reimbursement rates would also help.

Difficulties in meeting this target may persist, however, particularly if the GOK budget allocation to KNH increases, which would substantially raise the total fee revenues necessary to meet 10 percent of the new operating expenditure total. At the same time, such GOK budget increases would constitute non compliance with a condition at the end of the Program for GOK funding decreases.

5.7.4 OTHER PRIORITY ACTIVITIES

Two sets of activities that are critical to the longer-run viability of the reforms have not been adequately addressed under the Program: monitoring and evaluation and further development of KNH financing policy and strategy.

5.7.5 FINANCING POLICY DEVELOPMENT

KNH has further defined a longer run reform agenda, beyond that developed by the startup of the KHCFP, in its Five Year Plan, developed in conjunction with the Bank Rehabilitation Project. But policy and strategy development work under the HCF Program has not adequately included financing issues and implications of KNH policy reform. It is time to begin analysis of the impact of KNH fee collection experience to date, with a view toward further policy and strategy development in the context of broader policy reform development under the KHCFP.

For example, the impact of the present graduated fee system--of KNH fees, in relation to those charged by the MOH and to Nairobi area facilities--has not been determined. The equity and utilization impact of the waiver and exemption systems are unclear and not yet well analysed. The financial viability of the private wing has not been demonstrated. And the reimbursement rates for the National Health Insurance Fund reimbursement rates for KNH are not yet based on systematic principles. Nor have the implications of the current rate structure for KNH been assessed for KNH and Program cost containment, revenue generation, and hospitalization utilization goals.

5.8 RECOMMENDATIONS

5.8.1 CONDITIONALITIES

The following recommendations for conditionalities concentrate on the requirements that have not yet been met for release of tranche two for KNH.

- **GENERAL CONDITIONALITIES RELATED TO GOK BUDGET FUNDING FOR THE KNH**

The Ministry of Finance and Ministry of Health should take the remedial action to meet these conditions (related to base funding, additionality, and reduction of supplier debt, as specified in PIL No. 16) in the shortest possible time frame. Concrete assurances should be provided that actions creating non-compliance with these conditionalities were caused by extraordinary circumstances and that necessary steps have been taken to prevent their re-occurrence.

The MOF, MOH, and KNH should seek to develop measures to give greater financial autonomy to KNH. This may include the establishment of a separate budget for KNH that is not under general MOH budget control.

- **REVENUE AND FUNDING TARGETS**

In six to nine months, USAID and the Government should review and adjust as necessary the KNH targets for 1) cost sharing revenue--that these revenues equal 10 percent of total KNH operating costs and 2) for GOK funding for KNH--that the portion of KNH budget funded by GOK decrease by five and 10 percent by the end of years two and three respectively. The revenue target goal should be clarified to apply to a percentage of non-wage expenditures, rather than a percentage of total KNH expenditures. This clarification would take into account the original intent of the objective in the short run of the Program and Project period. The longer run objective (10-15 years) of revenues meeting a substantial portion of total KNH operating costs should remain.

- **QUALITY AND EFFICIENCY ASSESSMENTS**

Of the four remaining quality assessments, USAID continue to require, as a conditionality for release of tranche two funds, the pharmacy assessment, but should drop the other three. KNH and the Project should undertake the pharmacy assessment in the soonest possible time frame. One KNH staff and one long term technical assistance advisor from the Project team should jointly direct, coordinate, and manage the assessment, with appropriate KNH staff to conduct the work.

The pharmacy assessment and implementation of related improvements is critical to the success of the fee reforms, especially the new outpatient treatment fee. This recommendation is not intended to deny the importance of assessments in the other areas. But it recognizes the need to identify a reasonable number of priorities. And it assumes that the Rehabilitation Project will be effective within two to three months and that its components for efficiency, cost containment and quality assurance can begin soon to follow up on the balance of the assessments.

- **WAIVER SYSTEMS AND UPDATED IMPLEMENTATION PLAN**

These requirements are reasonable and necessary and KNH should have no difficulty meeting these requirements soon.

5.8.2 PRIORITIES UNTIL THE END OF THE PROGRAM AND PROJECT

- **FEE COLLECTION SYSTEMS AND FINANCIAL MANAGEMENT**

The KNH and Project assistance should place their top priority on continuing with ongoing and planned activities to consolidate and complete this work.

- **MONITORING AND EVALUATION**

KNH, the Secretariat, and the Project team should jointly develop a systematic plan for monitoring and evaluating the impact of KNH reforms to be incorporated into an overall KHCFF plan. (Chapter 4 provides detailed recommendations for a monitoring and evaluation plan for the Program.)

- **HEALTH CARE FINANCING STRATEGY DEVELOPMENT**

KNH, the Secretariat, and the Project team should jointly identify issues related to KNH policy reform that should be incorporated in the overall HCFP activities for further strategy development. (Chapter 4 provides detailed recommendations for strategy development for the Program.) They should also coordinate these efforts with those under the Bank's Rehabilitation Project to assure that the Bank's Project undertakes the necessary complementary activities related to KNH's five year implementation and strategy plan.

- **MANAGEMENT TRAINING**

The Project should implement plans as soon as possible to conduct the proposed management training as detailed in the tender and should make every effort to maintain the high standards set in the plan when making the final selection of an implementing agency.

5.8.3 OTHER AREAS

- **INFORMATION SYSTEM DEVELOPMENT**

KNH and the Project should concentrate information system development only on 1) fee collection and financial management information systems, and 2) development and installation of a practical, routine system for monitoring and evaluating the impact of financing policy reforms on beneficiaries and on increasing availability and accessibility of services. They should develop the monitoring and evaluation systems in conjunction with such systems development activities in the overall Program plan for monitoring and evaluation.

The Project should allocate 24 person weeks of the remaining short term technical assistance funds planned for KNH to monitoring and evaluation (10 weeks), management information system development (10 weeks), and development of a unit costing system (four weeks). The Project should reprogram the balance (50 person weeks) for the Program-wide HCF policy and strategy development activity.

This recommendation assumes that the KHCFP can rely on other assistance (e.g., from the International Health Group, from the Rehabilitation Project) for development of the balance of information systems. It also assumes that planned work in fee collection and accounting systems will produce most of the basic information systems related to financial management.

The recommended reprogramming will serve both KNH and the Program more broadly by helping establish baseline analyses required in the development of the Bank's planned Sector Adjustment loan.

6.0 NATIONAL HOSPITAL INSURANCE FUND

6.1 INSTITUTIONAL CONTEXT

During the past year, the National Hospital Insurance Fund celebrated its twenty-fifth anniversary and affirmed its central role among agencies responsible for health sector financing. Established soon after Independence as a social insurance organization, NHIF has grown to around one million members and around five million total beneficiaries. In return for their fees, members and their families are covered for up to 180 days of hospital costs. Depending on the level of amenities and related pricing of the hospital selected, members' benefits cover part or all of a patient's total bill. As is discussed below, recent revisions under the reform program have increased fees and made them progressive by setting them at two percent of basic wages; daily benefits were increased, also.

NHIF is a statutory body, which functions as a department of the Ministry of Health. In the headquarters office and seven regional sub-offices, NHIF has a total of around 400 staff members. Staff members are seconded to NHIF from the Ministries of Health and Finance, thereby limiting Fund managers' latitude to recruit and develop staff for long-term needs. Several senior specialists, covering areas such as insurance operations, computer system management, and planning, are needed urgently to ensure orderly future development of the Fund.

NHIF is financially self-supporting, with operating expenses and benefits totally paid by members fees (insurance premiums). Even so, NHIF budgeting, procurement, and payroll processes pass through the Ministry of Health or the home ministry of non-MOH staff members in such a way that each expenditure reflects during the fiscal year on the ministries' already tight budgets. At year's end, transfers are made from Fund accounts to reimburse the Ministries that provided staff or services to NHIF during the preceding year--including all salaries and related (fringe) benefits. Owing largely to its present legal status, expenditures for developmental purposes at NHIF are restricted such that nearly all insurance and accounting functions are still carried out using manual, non-computerized methods. It is not stretching the point to say that the Fund is drowning in paper.

NHIF headquarters operates in a rented office building which has for some time been crowded and difficult for the public to access. Fund managers announced publicly some time ago that they planned to undertake construction of a large office structure to house the headquarters, with additional space for rental to private parties. Any move to more suitable quarters--built or purchased--are on hold pending changes in NHIF legal status. Current procurement restrictions prevent NHIF from readily purchasing needed vehicles for inspection and supervision purposes. Maintenance and replacement of critical equipment and vehicles is needed also.

At the present time, a substantial unobligated surplus has developed in the Fund balance. It is the Team's understanding that such balance is considerably above any expected amount of claims that would materialize at current levels of benefits. Unlike the reserves needed to assure viability of life insurance coverage, health insurance reserves typically are much lower, with payouts set at over eighty percent of premiums in a given year. While investments of necessary surpluses are a proper function of the Fund, managing large reserves would further stretch the time available to Fund managers and remove them from critical issues more central to their health insurance mandate.

6.2 REFORM PROGRAM CONDITIONALITIES

Under terms of the reform program, the next step (sub-tranche two) for the National Hospital Insurance Fund covers several specific milestones covering three areas, which may be paraphrased as follows:

- Adoption of a progressive fee structure and increased benefits, based on program approved by Parliament in 1989
- Medium and long-term strategic plan establishing the goals and objectives of NHIF and its role in the National Health Care System and
- GOK to publish a bill to establish NHIF as State Corporation.

In the remainder of this section, the present status of the Sub-tranche Two conditionalities is reviewed. A complete listing of the bench marks for these conditionalities is given below in Appendix B.

6.2.1 FEE STRUCTURE AND BENEFITS

Considerable progress has been made by NHIF in establishing a progressive fee structure and increased benefits. The new fee structure was published April 12, 1990 (Legal Notice Number 171). Increased benefits are now in place, also. With participation of the technical assistance team and NHIF officials, several steps have been taken to permit an increased level of claims to be filed for members' stays in MOH facilities. Workshops were held with MOH field staff and additional follow-up training has been conducted with newly designated account clerks who file NHIF claims in Provincial General Hospitals.

6.2.2 STRATEGIC PLANNING

Progress in development of medium and long-term strategic plans has been slow but continues to move forward. A very successful workshop was held on September 30 to October 3, 1991, which brought together NHIF, MOH, and private sector participants.

A follow-on workshop, facilitated by the project technical assistance contractor, is scheduled for late May 1992 to develop a strategy document. If the strategy document contains required details, only one additional step will be needed to complete this condition: analyses of options for NHIF within Kenyan health policy.

6.2.3 STATE CORPORATION

It is clear that a great deal of attention has been given by NHIF and MOH staff, among others in Government, to establishing NHIF as a state corporation. By late 1991, the Attorney General had approved the needed legislation. A submission to Cabinet is expected soon for approval to table the bill in Parliament during the present session, March to June 1992. NHIF officials believe the bill will be passed by Parliament by June 1992. Additional parts of this condition are focused on documenting progress in the following: (a) filling five key senior management positions; (b) purchasing needed computer systems; and (c) establishing an actuarial capacity; and (d) scheduling implementation for the reform program. Only the first item, hiring of senior personnel, has progressed thus far. Department of Personnel Management recently approved of NHIF recruiting for these positions. Without approval of State Corporation status, though, NHIF officials anticipate considerable difficulty in filling these newly approved posts. Because the needed senior managers were anticipated to be key participants in and counterparts to the computerization, actuarial studies, and other reform activities, further delays in their hiring represents an obstacle to progress in other important parts of the program.

In the next several sections of this chapter, we review progress under the companion project to assist implementation of the reform program.

6.3 POLICY REFORM

6.3.1 STRENGTHENED ROLE OF NHIF IN SECTOR FINANCING

Changing NHIF to a State Corporation should be done in a manner that is consistent with the intent of Health Care Financing Program of reforms. In strengthening the role of NHIF, the Team believes that functions and controls assigned to the Fund should ensure it can perform effectively, with its concentration remaining on social financing of the demand for health services. The Evaluation Team did not have an opportunity to study the present draft NHIF Bill proposing State Corporation status. We learned about some of the functions and controls under discussion for the NHIF Bill. Based on our discussions, we offer those participating in health financing reforms in the GOK and donor community the following partial list of functions and conditions for the NHIF:

- **PURPOSE.** NHIF should be given broad latitude to develop products and services which provide social financing of the demand for health services while ensuring quality of care, control of costs, and protection of members' funds.
- **BOARD OF TRUSTEES.** NHIF Board should be given responsibility for guiding all aspects of NHIF operations.
- **MEMBERS' RIGHTS.** NHIF Board should be responsible to prepare, with guidance from members and employers, a list of members' rights and to make staff, membership, and employers aware of those rights.
- **ACCOUNTABILITY.** NHIF funds should be accounted for properly, audited at frequent intervals by independent accountants, and be protected from fraud, misappropriation, and other forms of misuse; specific penalties should be assigned under law to Board members, managers, staff members, or employers who are found guilty of failing to protect NHIF funds or of seeking personal gain beyond their salary from their work in NHIF.
- **RESERVES.** NHIF funds should be reviewed by certified actuary to ensure soundness of reserves; NHIF should not be permitted to maintain reserves larger than actuarial requirements to meet obligations; NHIF should be responsible for investing funds prudently; NHIF should be prohibited from making investments that would raise a conflict of interest.
- **CONDUCT BY STAFF.** NHIF Board should be responsible to prepare a list of rules of conduct for staff, protecting members, employers, and their funds, which would be the basis for disciplinary action or removal from employment.
- **PROFESSIONAL MANAGEMENT.** NHIF Director and managers should be required to have professional training and experience in relevant fields of health insurance.

Certain functions and conditions that have been considered for inclusion in a Bill establishing an NHIF State Corporation could distort otherwise beneficial effects of seeking State Corporation status. Two specific proposals would have undesirable effects:

- **CAPITAL DEVELOPMENT.** It was proposed that NHIF would be permitted or encouraged to own, invest in, or make loans to selected health care projects, such as hospitals, from its surpluses. By taking on such a role, NHIF Board and managers could easily come under several types of adverse pressure, including: pressure to expand reserves beyond needed levels, pressure to manage health facilities, pressure to invest in other than highest grade returns on members' fees, or pressure to favor one public or private health care provider over others--the MOH and private investors should address capital development needs of the sector; and
- **PRICE REGULATION.** It was proposed that NHIF would be directly involved in regulating health provider prices, such as by establishing hospital charges or determining what a hospital can charge. NHIF should be

active in cost containment and in developing managed care products which use capitation or other forms of prepayment. NHIF should not, however, take on the role of price regulation of the health provider market. Hospital care charges are set for numerous reasons in addition to actual cost, and taking a role as regulator would cause NHIF to enter a highly political arena that would likely divert its managers from critical needs of the Fund.

Both capital development and cost containment represent critical needs of the Kenyan health care market, which the Team believes can and should be addressed carefully as roles in health financing are assigned to various public and private institutions in Kenya.

6.3.2 NHIF STRATEGY DEVELOPMENT

As discussed above, strategy development is critical to ensure NHIF can meet long-term needs of the Kenyan public for social financing of health care. Many aspects of the staffing, information systems, and even its requirements for office space should be premised on a thoughtful strategy which joins NHIF managers with the Fund's many other stakeholders. The upcoming Mombasa strategy workshop can accomplish a great deal in establishing a framework for future development of the Fund. Issues to be addressed in the NHIF Strategy should include the following, among others:

- Increased benefits, additional products, and especially, managed care arrangements
- Changes in reimbursement mechanisms to address the need for streamlined payments and maintaining of low administrative costs
- Expansion of membership base, including new worker groups.

Follow-up after the workshop will be critical to ensure that the Fund managers have a step-by-step understanding of what will need attention, starting from the days immediately after the workshop's conclusion.

6.4 HEALTH FINANCING SYSTEMS DEVELOPMENT

6.4.1 PLANNING AND ACTUARIAL STUDIES

A series of special studies was initiated in the first year of the project, aimed at further definition of the reform agenda and clarifying the actuarial status of certain operations. Some of these studies were designed to depend on the availability of a database of previously processed NHIF claims. These claims data came from computer tapes which had been stored by NHIF officials during the course of processing.

To make the computer tapes useable for actuarial analysis, it was determined by the project team that certain additions and restructuring was necessary. At the time of the evaluation, the Team was shown partial results from some of the studies, but none was available in completed form due to unforeseen delays in completing the assembly of the database.

A separate "Unit Cost" Study was designed by the project team with participation of NHIF officials. The study is intended to provide concrete information on the present costs of services in NHIF participating hospitals. When completed, the Unit Cost study can provide valuable information to guide future reimbursement levels and efforts to encourage cost containment by providers.

Although there is extensive discussion in and out of NHIF of extending coverage to include outpatient services, studies are needed to determine whether or how such coverage might be arranged. No other studies or demonstrations of new products for NHIF were being developed at the time of the evaluation. Only within the context of the strategic planning process, did the evaluation team find that possible new benefits products were being considered.

6.4.2 COMPUTERS AND MANAGEMENT INFORMATION SYSTEMS

Extensive study was made by several specialists prior to the arrival of the technical assistance contractor to determine NHIF needs for computerization. Over the nearly three years since the first study was conducted under USAID Project REACH, computing technology has evolved and the need for NHIF to have access to modern computing equipment has increased. Among the current obstacles to progress in the development of the computing systems needed by NHIF are:

- Lack of progress in hiring computer specialists (affected by corporate status issues)
- Need to prepare an adequate membership database from the existing members' registration materials (preparation of membership database is planned work item for the technical assistance contractor under the Computer Line Item) and
- Need for an information systems analysis tied to planned development of NHIF functions (previous studies of computer systems were tied to existing organizational functions and need to be updated; and some additional work to develop computer specifications is planned under the technical assistance contract under the Computer Line Item).

The evaluation team was shown the recently completed microcomputer room at NHIF headquarters, in which the technical assistance contractor has installed several microcomputers on a local area network. This initial computer facility will be used for some of actuarial analyses, computer user training, and, if upgraded with a few peripherals, some database development.

Plans under the project to develop a microcomputer-based claims processing operation would require additional space and hardware beyond this initial facility.

6.4.3 REGISTRATION AND CLAIMS

Aside from computerization of the registration and claims data, there remains the problem that a heavy burden is placed on members, employers, and providers in the preparation and communication of needed NHIF data. Efficiency improvements in the area of claims processing were identified as a critical area for attention under the project, especially the claims processing burden faced by government hospitals, which had never previously submitted claims.

It appeared to the evaluation team that assistance and supervision from the technical assistance contractor, the HCF Secretariat, and NHIF to Provincial General Hospitals was proving beneficial. PGHs had successfully initiated work on claiming for its NHIF-member patients over the past few months. Even with the outside assistance to PGHs, the process was slow, cumbersome, and probably fraught with some amount of clerical errors in preparing the necessary claims documents for submission to the Fund.

In a study related to government hospital claiming, the technical assistance team is analyzing payments by wage level and employer, along with data on facility usage. It appears in preliminary results of this study that lower-paid civil servants pay a considerable amount into the Fund as premiums which does not in any significant amount reach the facilities they typically use--that is, government district hospitals. Some streamlining of the processes used by government hospitals to complete claims has been attempted already. It is clear, however, that a considerable additional amount of time and therefore money will be needed to increase the percentage of rightful NHIF claims that actually get filed by government hospitals.

Exploratory studies by the technical assistance team's actuary were partially completed as to the soundness of making bulk payments, advance payments, or block grants to government hospitals in lieu of individual claims. These exploratory studies were not sufficiently complete at the time of the evaluation to permit a determination of the appropriateness of such alternate methods of payment. It is clear that current methods of revenue and expense accounting in government hospitals are geared to protecting public funds from abuse but not to providing management information to hospital officials. In some cases, private sector (not-for-profit and profit-making) hospitals have adopted record-keeping methods which permit easier revenue and expense record-keeping and management reporting. The marginal additional cost of producing claims documentation for NHIF may be less to those facilities than for government hospitals. Further, in times of short resources by all public and private health providers, the Fund must ensure that any reimbursement methods adopted are sufficiently protected from abuse, false claims, or overcharging.

Additional study is needed of the costs of claiming for all providers, government and non-government, before a change should be considered. In the near-term, streamlining of claims preparation and processing procedures at the district level deserves high priority attention.

6.5 MONITORING AND EVALUATION

Selected studies were in process by the technical assistance team, including some innovative actuarial and cost studies. Also, a study is planned of the views of employers and labor groups on changes in the fee structure and the potential for further refinements in fees. At the time of the evaluation, however, no finished products were available from this work.

6.6 ASSESSMENT OF IMPACTS

6.6.1 REVENUE GENERATION

In the past year since the revised fee structure was implemented, a number of changes were put into place but there has been no systematic study of impacts of those changes in fees.

Administrative procedures are accommodating the new, more complex collection arrangements. Revised forms are being prepared to streamline the collection of the new schedule, in which premiums are a function of wage levels. Previously, a flat fee was collected for all members. For small and medium-sized firms, NHIF revenue stamps were purchased and affixed to members' cards. NHIF plans to control abuse of stamps and streamline collections by encouraging the firms to submit employee lists and checks for required fees instead of purchasing stamps.

As yet, there is no study relating the increased premiums faced by all NHIF participants to their socioeconomic circumstances. Even before the fee changes, persons having wages of less than Kshs 1000 per month are exempted from payment or membership in the Fund.

6.6.2 EFFICIENCY

For collection of fees and payment of the increased benefits, the Fund's internal arrangements were not greatly affected. To facilitate members' making claims, distribution of membership cards was decentralized and certificates of coverage were provided to local personnel managers. While these changes were defined in principle, execution of the changes remains incomplete.

Changes were made, also, in the procedures of government hospitals to permit their claiming for inpatient charges. These government hospital claims are arriving at the Fund in increasing numbers each month, especially since the beginning of calendar year 1992. Some streamlining of the process to

prepare a claim has been accomplished. Instead of employees coming to Nairobi for certification of current NHIF membership, a government employee can obtain certification from local personnel officials. Nonetheless, the documentation required for an acceptable NHIF claim requires a considerable amount of time and effort to the designated clerks processing NHIF claims at government hospitals.

6.6.3 QUALITY OF CARE

Under the Unit Cost Study discussed above, one of the key components is an assessment of the quality of care delivered at various hospital institutions. When the methodology is refined, it is planned that hospital inspectors will be able to make some objective measurements of the quality of care for comparison with the level of charges assigned by the hospital. It is clear that NHIF can plan an important role in providing encouragement to upgrade and maintain the quality of care given in hospitals, while identifying ways to contain costs.

6.6.4 FINANCIAL MANAGEMENT

Because financial management functions are totally manual at this time, there is much room for improvement in the financial management functions of the Fund. Plans are now for the computerization efforts to include applications for financial accounting and financial management information at early stages in the effort.

6.6.5 EQUITY

A considerable improvement in the equity of fees was made with the recent revision from flat fees to progressive rates tied to wages. It will be important for Fund managers and Ministry of Health policy makers to ensure that future revisions to fees do not return to regressive fee structures.

Equity issues in the structure of benefits were studied under the technical assistance contract, as mentioned above in Section 6.4.2. It may be inequitable for lower income members's to pay fees, but then take services at government hospitals which do not receive adequate reimbursement. Streamlining of claims payment procedures is being examined by the project as a way to remedy the situation.

6.6.6 INSTITUTIONAL DEVELOPMENT

Although a great deal of attention is being given to the beneficial effects of changing NHIF to corporate status, many other aspects of institutional development as yet lack attention. Among the areas needing attention are:

- Training of key personnel in management and technical aspects of insurance
- Delineation of departmental and job descriptions for the planned structure of NHIF and
- Development and documentation of internal working procedures for all aspects of NHIF operations.

6.6.7 KHC FP STRATEGY DEVELOPMENT

As reported above, considerable progress was made in the initial strategy workshop, but not much has occurred since that time. It will be important for there to be extensive follow-up after the upcoming workshop to the gains are preserved from that meeting.

6.7 CONCLUSIONS

6.7.1 STATE CORPORATION STATUS ESSENTIAL TO REFORMS

NHIF cannot accomplish the reform objectives nor meet PAAD and Agreement objectives unless they become a state corporation with functions and conditions spelled-out which establish responsibilities of the Fund that are consistent with the health financing reform program.

6.7.2 STRATEGIC PLANNING PROCEEDING SLOWLY

Forward movement on strategic plan has been affected by lack of new senior managers planned to be hired under the reform program. Also, strategic plans will require that a number of management issues to given attention very soon to prepare organizational descriptions and job descriptions for the proposed sections of the NHIF.

6.7.3 ACTUARIAL ASSISTANCE FROM PROJECT HAD LIMITED EFFECT

A number of very useful actuarial and operational studies are partially completed under Project assistance. There have been many obstacles to their completion, including lack of useable claims database (which therefore was developed); lack of new senior specialist in planning to work as counterparts to Project; and difficulties in gaining access to computer resources needed to complete studies.

6.7.4 NEW BENEFITS PRODUCTS AND CLAIMS PROCEDURES WILL NEED DEMONSTRATIONS

There are great benefits possible of planning and executing demonstrations for possible new benefits and claims procedures.

6.7.5 COMPUTERIZATION STALLED

Progress on information systems is stalled by several obstacles: current legal status which would permit hiring of needed computer specialists; studies to identify building blocks for a practical operational plan for computing; and preparation of needed space for computer systems.

6.7.6 LARGE CURRENT SURPLUS RESERVES CAN CAUSE PROBLEMS

Large current surplus needs to be reduced through careful actuarial study and experiments with new benefits. Presence of the surplus funds represents an additional burden that even a fully-staffed health insurance organization should not undertake trying to manage; obtaining adequate return on members' fees in such excess reserves represents a diversion of managers' time from central problems facing the Fund.

6.7.7 CLAIMS PROCESSING COSTLY TO MEMBERS AND EMPLOYERS

Current procedures for processing claims place a large burden on those outside NHIF to certify current paid-up membership, complete claims information, and seek payment. NHIF has supported the reform program for cost-sharing and has begun a process of changing procedures to streamline the preparation and processing of claims.

6.8 RECOMMENDATIONS

6.8.1 CONDITIONALITIES

No changes are needed to current conditionalities. Bill establishing State Corporation status should contain provisions that are consistent with the health care financing reform program. MOH should prepare necessary Cabinet Paper and submit proposed Bill to Cabinet with urgency in present March to June 1992 Session of Parliament.

6.8.2 STRATEGY DEVELOPMENTS

Under the project, a continued dialogue and management analysis should accompany the completion of the strategic plan.

- **FOLLOW-UP ON WORKSHOPS.** A number of organizational and operational matters will need attention in the future for which planning needs to begin immediately after the strategic plan workshop ends.

- **NEED FOR FURTHER MANAGEMENT ASSISTANCE.** Within project resources if available or from some other source if not available from the project, management assistance by a person knowledgeable about insurance program management should be provided to work with NHIF senior managers for the purpose of improving efficiency of operations, for example: defining departmental responsibilities, describing new and existing jobs, and preparing a systematic procedure manual. This activity can be accomplished in part with project resources discussed below under Section 6.8.4.

6.8.3 PLANNING AND ACTUARIAL STUDIES

The studies initiated under the project, such as those which depend on the historical claims database, should be completed and made available to NHIF managers. Those studies requiring matching of historical claims to historical membership data should not be completed within the project resources.

- **COMPLETE PREPARATION OF DATABASES.** The historical claims and provider database preparation should be completed as planned for the period 1989-90 through 1991-92 as soon as possible and the remaining studies depending on availability of that data should be completed.
- **ADD ACTUARIAL ITEMS TO CURRENT CLAIMS DATE.** For future claims, the needed actuarial items should be incorporated into the data being recorded in computer records. This activity is covered below in Section 6.8.4.
- **OTHER STUDIES.** The studies originally planned (such as: Benefit Option Study, Labor Market Study, and Consumer Preference Study) should proceed to be completed.

6.8.4 COMPUTERS AND INFORMATION SYSTEMS

Several problems should be addressed in moving forward with the computers and information systems: (1) revision of previous NHIF systems plans; (2) search for insurance software packages; and (3) placing emphasis on smallest hardware that fits NHIF needs. These problems are discussed next, followed by specific recommendations for the programming of the technical and commodity assistance in this area.

- **REVISE OLD SYSTEMS PLANS.** Given the limited time remaining under the project, attention should be given to preparing a complete plan for computer development, with emphasis on establishing an orderly set of development stages.

- **FIND SOFTWARE PACKAGE(S).** Because none of the analyses thus far has moved to identify the one or more acceptable software packages for insurance operations (claims processing, membership registration, operational analysis) that can meet NHIF needs, this step should be a part of the process. Actuarial analysis processes using registration and claims data should be one of the functions provided in the package. NHIF should not plan its computer system on the basis that its operational needs must be met by software programs that were written solely for its own use. Purchase of computer hardware under the project would facilitate moving forward with this step, in place of using government procurement mechanisms, but the hardware should be a lower priority to completion of the needed systems analysis, development planning, forms preparation, and software identification.
- **EMPHASIZE SMALLEST HARDWARE THAT FITS.** Because of changing plans for NHIF programs and rapid developments in computer technology, NHIF should not purchase (or seek donor support to purchase) computer hardware that exceeds its known requirements in terms of capacities and functions. Also, careful attention should be given to developing compatible, modular microcomputer-based network systems for most of its computing requirements.
- **PROGRAMMING OF TECHNICAL AND COMMODITY ASSISTANCE.** Specific assignment of existing Project resources under the Computer Line Item should be as follows:

--The total of \$600,000 for computer system purchases should be assigned to a combination of system design studies, training, hardware purchases, software purchases, and computer program tailoring. The originally planned minicomputer, as described in the Program Agreements, should not be purchased.

--Of the total amount above, we understand that \$250,000 has been committed or spent thus far on: database clean-up computer time for claims and providers; technical assistance for data clean-up for claims and providers systems; and on five microcomputers.

--Of the remaining \$350,000 in the Project, the following three areas should be addressed:

Membership database--\$100,000. Clean-up of membership database for purposes of enabling future on-line claims processing (not to clean-up historical membership databases) should be conducted with Project resources, but with specific and strict limitations on the time and money to be applied to the effort. It will be critical to conduct careful studies and develop exact plans with outside specialists to prepare the sub-contract workscope for this effort and to ensure that NHIF staff and employers' inputs to updating membership records is completed on a timely and accurate basis. We believe that the objective of this database development activity should be to achieve a reasonable degree of accuracy, acknowledging that it will be impossible to reach complete

accuracy in the membership database. Project funds should be used for planning the database development, programming needed data conversion routines, supervising the implementation, and for computer processing. Consideration should be given to buying or leasing additional peripherals for the NHIF microcomputer laboratory installed under the Project in lieu of buying outside computer time.

Short-term technical assistance--\$100,000. Assistance should be provided under the Project in the following three areas, with highest priority going to the Computer Systems Design:

--**Computer systems design.** Prior to purchase of additional computer hardware or software, a computer system design should be prepared using previous studies of NHIF requirements and new analyses. Identify a team of specialists covering the following areas (among others): insurance operations computing, microcomputer system development, and management information systems development. The team should prepare analyses to guide NHIF computer system development over the next three to five years, including, at a minimum, the functions of: claims processing, membership registration, operational analysis, actuarial database maintenance, and financial management of the Fund. Such analyses should cover at least the following elements: functional requirements; systems conceptual design; staged and modular implementation plan; staffing and training plan and training specifications; specifications for software and hardware requirements; and analysis identifying available insurance software packages to meet Fund requirements. The analyses should recognize: the organizational and staffing realities of NHIF (such as potential obstacles to retaining computer specialist staff); the upcoming strategic plan for NHIF; the realities of government purchasing procedures (applying to NHIF as MOH department or as State Corporation); and the cost-effectiveness of selecting available insurance organization software packages under licensing agreements.

--**Management analysis and development.** Provide management assistance as discussed above under Section 6.8.2.

--**Other technical assistance.** Provide other technical assistance as needed to support on-going studies discussed above, including: Unit Cost Study, Pilot Reimbursement Methods Demonstration; Streamlining Claims Preparation and Processing at the District Level; and such additional special actuarial studies as are deemed of high priority.

Computer Software and Hardware Purchase--Up to \$150,000. When the computer system staff members discussed in the Reform Program conditionalities are available to NHIF and after completion of Computer System Design, computer purchase should be accomplished as follows: Computing software and equipment (including electric power conditioning and UPS) needed for membership and claims processing should be purchased under the Project. Installation and training of staff members for specific computer applications of membership and claims processing should be completed under the Project. Computer hardware and software, installation, and training should adhere to specifications in the first stage of development under the systems plans described above, preparation of the computer rooms, upgrading of electrical systems and other requirements should be specified by computer specialists under the Project but should be completed with funds and supervision from NHIF.

6.8.5 REGISTRATION AND CLAIMS

Continued attention is needed to streamlining the registration and claims processes.

- **COMPLETE UPDATION DATABASES.** As described above under the Section 6.8.3, a high priority should be given to completing the historical claims database.
- **STUDY AND IMPLEMENT OPTIONS FOR STREAMLINED CLAIMS.** NHIF should proceed with studies, using Project assistance as needed, to study and implement options for government and private claims and payments. The analysis of options for alternative payments to government facilities should be completed with great care and given careful study to ensure that long-term implications of any recommendations from the analysis are acceptable to NHIF managers.

7.0 TECHNICAL ASSISTANCE CONTRACTOR

Under the three-year technical assistance (TA) contract with Management Sciences for Health, a team of specialists was assembled as long-term advisors, with additional support provided from short-term visits from additional advisors. In the contract scope of work, it was intended that the Contractor's assistance would cover all three KHFP participating institutions and that their time would be split between assistance to policy reform and to technical assistance. Over-all, the evaluation team found ample evidence of progress toward policy reform and technical objectives of the Program. By carefully involving the participating institutions in preparing TA work plans, the Chief of Party provided needed leadership to ensure that project resources would use to maximum benefit. Management of the TA contract required careful planning and supervision by the Chief of Party and the United States-based coordinator; their effective joint effort enabled the Program to move forward without major difficulty, even where the work required complex scheduling of expatriate specialists and participant trainees.

7.1. OUTPUTS ACHIEVED

In earlier chapters of this report, the specific output achievements of the Contractor are described and analyzed. The purpose of this chapter is to examine the effectiveness of the Contractor's approach to assisting the KHFP and to summarize evaluation conclusions about Contractor services. Because the assistance requirements of the three participating institutions differed greatly, it is useful to examine outputs for the three groups separately.

In the Ministry of Health program, the Contractor responsibilities were arranged to give emphasis to implementing cost-sharing and implementing efficiency improvements (see details in Chapter 4). In addition, there were to be steps taken to develop long-term strategies, establish monitoring and evaluation systems, and to strengthen institutional capacity in the health financing area. In providing assistance in these varied areas, the Contractor team was involved during its first year with many preparatory steps which did not result directly in much in the way of visible outputs. Beginning toward the end of 1991, however, a great deal of progress was made on many fronts, as can be seen from the discussion in Chapter 4, above. It is perhaps in the area of monitoring and evaluation that the least progress has been made thus far.

In the Kenyatta National Hospital program, the Contractor responsibilities were focused on: financial management, efficiency improvements, strengthening institutional capacity, and monitoring program impact. Contractor personnel had to be linked, in some cases, with other consulting teams working at the Hospital as well as with subcontractor specialists hired for the Project; these linkages appear to be functioning effectively. Contractor specialists working within KNH are making good progress except in the areas of monitoring and evaluation where only initial steps have been taken thus far.

For long-term institutional development, the KNH part of the Project called for an intern and mentoring arrangement to be established by the Contractor. Under this arrangement, several individuals from KNH staff were sent to work under practicing managers in U.S. medical centers for up to several months. On return, their U.S. mentors will be coming to Kenya to follow-up. Although interns were only beginning to return at time of the evaluation, Contractor arrangements in Kenya and the U.S. appear to be well-organized and likely to accomplish intended objectives.

At the National Hospital Insurance Fund program, the Contractor was required to supply an health insurance specialist for a one-year period full-time to concentrate on general organizational issues at the Fund and the Contractor was to provide additional assistance in the areas of computer system development, strategic planning, and actuarial and planning studies. Although some progress was made through workshop meetings in preparing strategic plans for NHIF, little progress was made on management inputs to increase efficiency of NHIF as an insurance organization. Some progress was made under the Contract in computer system development, actuarial studies, and studies aimed at improving NHIF efficiency and strengthening quality of care assessment. Due to a combination of foreseen and unforeseen obstacles related to establishing an actuarial data base out of historical claims data on old computer tapes, only one draft report was available to the evaluation team from the actuarial studies. An additional obstacle to progress for work on the computerization and actuarial studies was lack of available counterparts. Counterparts' hiring was held up both by NHIF differences with the Government's Department of Personnel Management and by failure to complete the approval process for legislation naming NHIF a State Corporation.

7.2 PROCESS AND RELATIONS WITH IMPLEMENTING AGENCIES

In providing TA to the three institutions, the Contractor's Chief of Party and personnel were careful about involving counterparts and establishing close relationships with the Senior and Mid-Level managers as they worked. In general, these institutions' managers reported to the evaluation team their great satisfaction with the approach taken by Contractor personnel and to the competence and depth of experience which these specialists brought to their work. Among the three institutions, only with the NHIF would our findings suggest that there is a need by both Contractor and NHIF officials to increase the level of interaction in planning and executing work. To address this need, we would recommend that the Contractor and NHIF officials meet no less than monthly to review progress and ensure requirements are being met on both sides.

A special set of linkages was required under the Project to ensure progress in policy-level and strategic plans. Contractor personnel and consultants have been very effective in work with the MOH and NHIF to gain mutual respect, engage in dialogue, and develop workable approaches to strategic planning. Although pre-Project dialogue with KNH officials concentrated on strategic plans for the Hospital, the Contractor was not expected to be involved directly in strategic planning exercises there beyond those to ensure progress in World Bank-led reform efforts.

7.3 INPUTS USED

The over-all assessment of TA inputs was very positive. Selection of specialist advisors was approached by the Contractor with great care and, while not every individual advisor succeeded in accomplishing one hundred percent of his or her objectives, there was an excellent rapport developed with clients and counterparts. In reviewing each institution's activities under the Project team, the evaluation team identified needs for redeploying contractor resources in several areas. Specific guidance on Contractor repositioning of TA time and other inputs is given in Chapters 4 to 6, above. The next two sections provide a summary of the main areas needing adjustment of resources under the Contract.

7.4 CONCLUSIONS

In conclusion, the evaluation team agrees with the original design calling for technical assistance to be combined with the reform Program in health care financing. The rather modest inputs of TA time and related commodities under the Contract have provided necessary and effective services to the Program. Both quantity and quality of inputs to the Project have been scheduled properly and managed well.

In the next section, we provide a summary without specifics of the adjustments recommended under the Contract for technical assistance.

7.5 RECOMMENDATIONS

The recommendations, in summary, as outlined above will have contract implications of three types: (a) scope of work changes for long-term consultants; (b) level and type of short-term technical assistance; and (c) cost implications. Cost implications will result from the reduction in the purchase of computer equipment, shifting from out-of-country to in-country training¹ requiring the shift of funds from the training line item to the subcontract line item and from extensions of long-term advisors to the end of the Project.

7.5.1 PROPOSED SCOPES OF WORK FOR LONG-TERM ADVISORS

The following work scopes are recommended for the long-term advisors; note that tasks which will be phased-out are marked with an asterisk (*):

¹Less international travel and the contracting of a local firm to carry-out the training.

- **HEALTH ECONOMIST**

- Facility and district-level management of cost-sharing
- Completion and implementation of the KHCSP strategy document with emphasis on the private sector strategic
- Monitoring and evaluation, with focus on exit interviews to be implemented in conjunction with the Health Planner
- Assistance in the design and implementation of NHIF pilot projects and
- Assist the Planner on wage to non-wage shifts in budgets and expenditures for the MOH.

- **PLANNER**

- Monitoring and evaluation system design and implementation for KNH, PGH, and DH level. This will need to involve the Nairobi City Commission.
- Utilization of cost sharing revenues--improvements to current methods, plus training, and implementation at the PGH, DH, and support to the Secretariat at the DH level.
- Program planning process in the MOH for shifting revenues between wage and non-wage areas, including allocations to P/PHC
- *--Staffing norms--completion of this study and transfer to MOH
- Drug management--complete field testing of the manual, implementation at PGHs only, and turn-over to Drug Management Program in the MOH
- Support and facilitate cost-sharing implementation
- *--Clinical guidelines manual: complete field testing and turn-over to the MOH. Extensive editing and printing to be left to other donors.

- **FINANCIAL MANAGEMENT ADVISOR**

- Financial management and cost sharing design and implementation at KNH and MOH as well as support to HCF Secretariat at District Hospital level
- Monitoring expenditure plans
- Cost-sharing training materials for MOH, KNH, and DHMB's
- Develop a simple unit cost system for KNH
- General support for cost-sharing implementation.

- **CHIEF OF PARTY**

- Oversee project with special emphasis on shepherding the implementation of changes, studies and STTA at NHIF
- Otherwise, the duties remain as before.

7.5.2 SHORT-TERM TECHNICAL ASSISTANCE

As is discussed in detail in Chapters 4 to 6, certain areas will need additional attention while others will not require all of the assistance previously planned. In Table 7-1, we provide a brief summary of the technical assistance arrangements recommended by the evaluation team. Table 7-2 recaps the level of effort implications of the changes in short-term assistance.

Table 7-1. Short Term Assistance (Level & Type) Recommended by Evaluation Team	
Assignments	Approx. Person- Weeks
Ministry of Health	75
1. Monitoring and evaluation	
2. Clinical guidelines field testing	
3. JHMB orientation and training	
4. Training of trainers for CHMB and District Hospital; cost-sharing implementation	
5. Outpatient management operational issues	24
Kenyatta National Hospital	
1. Monitoring and evaluation	
2. Management Information System development	
3. Unit costing system development	27
4. Continue Subcontract in Accounting (CSG)-- Level of effort not included here	
National Hospital Insurance Fund	
1. Benefit options study	
2. Labor market study	
3. Consumer Preference Study	28.6
4. Insurance Software Review	
5. Pilot Project	
Transfer of NHIF Computer Line to Short-Term Technical Assistance	
1. Computer Consultant	154.6
2. Management Specialist	
3. Streamline Claims Processing at District Level	
4. Actuarial Analyses	
TOTAL	

Table 7-2. Summary of Short-Term Assistance (Life of Project in Person Weeks)						
Agency	Contract Total LOE	Proposed Shifts of LOE		Re- vised LOE Total	Used or Com- mitted LOE to Date	Avail able LOE (See Table 7-1)
		In- crease	Reduce			
Ministry of Health	81	50		131	56.4	75
Kenyatta National Hospital	97		50	47	23	24
National Hospital Insurance Fund	35			35	8	27
Original Contract Total LOE	213	50	50	213	87.4	126
Proposed NHIF Transfer of Computer Line Item to STTA				55	26.4	28.6
Proposed Revised Total LOE				268	113.8	154.6

7.5.3 COST IMPLICATIONS

In terms of cost under the Contract, the major change to the contract budget would be:

- Shift funds in the amount of approximately U.S. \$375,000 from the training line item to the subcontract line item to accommodate the new in-country training strategy
- Reduction in the commodities line item for NHIF from \$600,000 to approximately \$210,000
- Increase in consultant line item by approximately \$200,000 to accommodate Short-Term Technical Assistance necessary to clean-up NHIF data base and provide actuarial and management assistance
- Increase the Other Direct Cost line item to allow for the purchase of approximately \$200,000 of computer time for data base clean-up; and
- Change Level of Effort ceiling if needed to accommodate proposed changes.

8.0 GENERAL AND CROSS-CUTTING RECOMMENDATIONS

The following recommendations represent recommendations that apply generally to the Program or Project and that apply to more than one of the implementing institutions (MOH, KNH, NHIF).

8.1 PRIORITIES UNTIL THE END OF THE PROGRAM

- Continue cost sharing and insurance reimbursement activities; consolidate and extend the related financial management systems for fee collection, retention, and use and accounting
- Develop a monitoring and evaluation plan and implement the necessary information systems and data collection and analysis processes (see Chapter 4 for detail on the activities included in this recommendation)
- Develop further the policy reform agenda with a series of analyses and activities in the areas of: cost sharing, resource allocation, private sector involvement, social financing, and efficiency; conduct related activities to strengthen Kenyan capacity to design and conduct KHCFP policy analysis (see Chapter 4 for detail on the activities included in this recommendation)

8.2 PROGRAM CONDITIONALITY MODIFICATIONS

- USAID and the respective GOK institutions should jointly review for realism and appropriateness, and adjust as necessary, the conditions precedent and end-of-project indicators for revenue and funding targets.

This recommendation applies to 1) the requirements that cost sharing revenues equal 10 percent of the total recurrent (operating) budgets for MOH and for KNH by 1992, and 2) the requirement that the portion of KNH's budget financed by the GOK be reduced by five and 10 percent by the end of years two and three respectively.

- USAID should extend the deadlines for tranche three conditions for one year, especially to take account of the fact that the MOH cannot meet the second tranche deadlines until March 1993, six months before the current end of the Program (see Chapter 4 for detail).

8.3 PROJECT EXTENSIONS

- USAID should extend the three MOH long term advisors until the end of the Project, September 1993.
- USAID should extend technical assistance support to the Program beyond the current 1993 Project end-date, for two years, to include short term technical assistance coordinated by a Resident Advisor.

8.4 DONOR ROLES

- Donors should continue close collaboration and joint programming efforts in KHCFP policy reform.
- The KHCFP Steering Committee should meet semi-annually.
- USAID should maintain the in-house staff resources to continue to make a strong contribution to KHCFP policy dialogue and evolution in Kenya.

9.0 GENERAL CONCLUSIONS AND LESSONS

9.1 ANALYTICAL BASE DEVELOPED FOR PAAD WAS GOOD INVESTMENT

Over several years, a series of studies was conducted under USAID sponsorship on important issues in health care financing for Kenya, which were used to design the reform program and establish baseline information on key indicators. These studies covered such issues as: supply and demand for health services; the level of efficiency and quality of care for various types of governmental and private sector health services; regional differences in access to and funding levels in health services, and special studies of the developmental needs of the Kenyatta National Hospital. Additional studies were conducted by a joint World Bank, USAID, and UNICEF group in 1989 to establish health financing priorities. The full set of analytical studies provided the basis for jointly determining feasible and high priority conditionalities and their benchmarks for the reforms. Further, needs for technical assistance were designed for the assistance project on the basis of the baseline studies.

9.2 CONSENSUS BUILDING PROCESS AMONG STAKEHOLDERS WAS ESSENTIAL

In developing the reform program and proceeding with its implementation, careful attention was paid to collaboration by stakeholders, including individuals and groups in public and private organizations and from donor agencies. Extensive consultations were held among individuals who are affected by the way health services are financed. A variety of methods was used to accomplish the consensus on proposed policies and systems, including:

- Key studies were prepared and executed jointly by participants from several institutions
- Policy formation workshops were conducted to allow open discussion away from the workplace, involving individuals representing divergent points of view and
- Study trips were made by health officials to see and discuss policy and operational options in use by health programs in other countries.

9.3 URGE TO TAKE QUICK ACTION BROUGHT PROBLEMS

Although extensive plans preceded most of the reforms and adjustments made under the health financing program, in a few cases officials took quick action before plans were ready. An example of such quick action would be the decision to implement the new government fee structure early in the reform process. A great deal of study had preceded adoption of the cost sharing program, but not enough explanation got delivered to the press or directly to the public in advance of implementing the fees. Soon after the new fees were

in place, complaints were raised by some politicians and private citizens. At least in part, dissatisfaction over the fees stemmed from the belief that medical care quality was too inadequate to pay for. With the passage of time and some careful study of the issues involved, MOH and KNH officials decided to propose a "treatment fee" rather than reinstating the previous "attendance fee." Under this arrangement, patients would only pay an out-patient fee if they received a treatment--which relied on there being personnel, drugs, and supplies available at the facility. This innovation in cost sharing concepts was instituted at the KNH prior to the mid-term evaluation. Initial indications are that public and political acceptance has been much higher than was the case with the previous attendance fee. The excellent concept behind the treatment fee places an incentive on health care providers to organize and fund needed support to the treatment process. In fact, the new fee functions as a bureaucratic "admission of guilt" when patients pay nothing because they get nothing for outpatient services.

9.4 REFORM PROGRAM VIABLE WITH FIFTEEN-YEAR TIME FRAME

In preparing the reform program in health financing, key participants laid-out objectives in several time frames. There were immediate needs to address early-on, but also they considered various future scenarios extending up to fifteen years. By focusing on long-term goals and continuing to monitor carefully the experience at each stage of the reform, the viability of the program was greatly enhanced. Policymakers have been willing thus far to recognize that errors may occur along the way to accomplishing the aims of the reform. With a long view on the reforms, political leaders from differing parts of the new multi-party spectrum should be able to collaborate in providing needed support to each succeeding step.

9.5 COMPANION PROJECT ASSISTANCE IS NECESSARY TO PAAD

Project assistance was designed to complement and catalyze efforts under the policy reform program. A contract was awarded for technical and commodity assistance to both the policy reform and the system implementation aspects of the program. This assistance is providing much needed technical guidance and, also, represents a resource to encourage policy dialogue. The combined Kenyan and expatriate staff of the Contractor's team is providing an essential strengthening of the program's effort.

9.6 MISSION STAFF ROLE IN NPA IS CRITICAL TO SUCCESS

From the earliest studies of economic issues of the health sector in 1984 through to the completion of the analyses of Tranche 1 and Tranche 2 documentation under the reform program, the USAID Mission staff has been needed to play a significant role in the Program. Under USAID Non-Project Assistance, dialogue over policy matters can become the centerpiece of Mission programming in a given sector, such as health. With the combined leverage available from the program grants and project assistance in an NPA effort, policy dialogue related to health care financing in Kenya has progressed well.

A key lesson from the NPA experience in this Program is that Mission staff are indispensable contributors to the progress made thus far. Further progress under the reform program will continue to depend on the availability of Mission staff having specialized knowledge of the areas under discussion.

9.7 PROGRAM IS ACCOMPLISHING GOAL OF NPA

The goal of the non-project assistance effort to assist the reform of health financing and contribute to the effectiveness of health improvement in Kenya is being accomplished. Long-term benefits from the reform process can be gained only by careful attention to the contributing roles of several key institutions. Through the NPA program, participants from public and private organizations related to the health financing situation have been brought into discussions of the very complex problems facing the health sector. Continued momentum toward reform will depend greatly on the willingness of stakeholders to collaborate, analyze, develop efficient systems, and think carefully about the health improvement goals for which financing reform can be of help.

Appendix A
SCOPE OF WORK

I. BACKGROUND

USAID/Kenya's Health Care Financing Program/Project is a \$15 million, 4 year non-project assistance program (1989-1993) with policy reform and technical assistance components. The purpose of the program is to provide sustained increased financial resources for the delivery of efficient quality care in both the curative and primary-preventive health services in Kenya. Specifically, the program is to result in:

1. Reallocation of financial resources in favor of preventive/primary health services; and
2. Increased financial resources available to the overall health sector, made possible by cost-sharing and improved efficiency.

Under the policy reform component, the program supports implementation of reforms in health care financing that are well-defined but flexible to reflect the dynamic reform process, and sequenced to reflect GOK progress. Key policy reforms supported under the program include:

- Establishment and implementation of a clear GOK policy with respect to cost sharing (user fees and insurance reforms) in public sector health facilities, including Kenyatta National Hospital (a State Corporation).
- Establishment of policy permitting at least 50 percent of the revenue generated through cost sharing to be retained by the public sector provider facilities, with the balance used to increase funds for primary and preventive services.
- Reforms in the National Hospital Insurance Fund (NHIF) to introduce progressive premium rates, to introduce modest (initially) employer contributions and to increase reimbursement levels to registered providers to bring them in line with actual costs.
- Agreement with the GOK on a mechanism and timetable for increasing the level of non-donor financing, both in absolute and percentage terms, for preventive and primary services within the MOH's recurrent budget.

Note: By 1992, the PAAD stated expectations that the share of the primary/preventive health care within the MOH budget would rise by 4-5 percent of the total allocated and that

cost sharing revenues would be equivalent to 10% of the total MOH budget.

The GOK lead implementing agency for this program is the Ministry of Health (MOH) in conjunction with the National Health Insurance Fund (NHIF) and Kenyatta National Hospital (KNH). The program provides U.S. \$9.7 million in direct program support (cash disbursements) to the Government of Kenya, conditioned on achievement of agreed-upon benchmarks for each component, relating both to the establishment and implementation of policies on health financing.

The technical assistance and training component is budgeted at \$5.3 million and is administered under an AID-direct contract with a U.S. institution. The objectives of the technical assistance project are defined as integral to achieving the purpose of the KHCf program, i.e., to 1) assist the three implementing institutions to establish or strengthen the administrative systems necessary to implement cost sharing and related improvements in operational efficiency, 2) assist in further defining the GOK's long-term reform agenda in the health sector, 3) assist the GOK in monitoring program impact, and 4) strengthen the implementing agencies' institutional capacities.

The Health Care Financing Program and Project Agreements were signed by the GOK and AID on August 29, 1989, with an estimated life of project of August 29, 1993 and November 1, 1993, respectively. On December 1, 1989, cost sharing at GOK facilities was implemented. Although adjustments have occurred in the fee schedule, revenue continues to be generated from inpatient fees, selected outpatient fees (e.g., x-ray, dental laboratory, etc.), and NHIF claims. Collectively, these revenues constitute an important source of non-wage recurrent financing, especially in provincial and district hospitals.

In early 1992, fees will be enhanced providing more revenue to the facility and districts where earned. At the same time, the waiver, monitoring, and accounting system have been assessed and recommendations for improvements are being implemented.

This Delivery Order will provide for a mid-term evaluation which will focus on achievements to date in relation to program objectives and the performance of the technical assistance contractor in assisting the agencies with implementation. The evaluation will focus on the results or impact of the program as defined through the end of program status (EOPS) and higher order output indicators included in the Logical Program and Project Matrixes of the Program Assistance Authorization Document (PAAD).

This mid-term evaluation is important for two reasons:

- to assess whether the Program and Project are on target and to make mid-course corrections in the current Program and Project implementation; and
- based on the results of the mid-term evaluation and recommendations, A PAAD supplement to describe any necessary adjustments in the program will be prepared.

II. OBJECTIVES

The purpose of this Delivery Order is to obtain the services of a qualified organization for the evaluation of the Kenya Health Care Financing Program and Project objectives.

III. SCOPE OF WORK

In order to achieve the above stated objectives, the Contractor shall provide a team of specialists to conduct the evaluation, focussing on the following concerns and questions:

A. Overall Health Care Financing Reform Conditionalities

1. Briefly review and summarize the status of general reform conditionalities and those conditionalities related to each implementing entity (MOH, KNH and NHIF);
2. For each implementing entity, briefly review and summarize the status of their implementation plans;
3. Assess the impact of the budgetary/financial reforms on the financial condition and operations of the KHCF institutions (MOH, KNH and NHIF);
4. In the remaining project/program period, what are the key elements of conditionality that must be stressed, supported, and met to achieve the overall goals and objectives of the Program?
5. To what extent have interim benchmarks described in the PAAD been met? What is the likelihood that key benchmarks will be met by the end of the Program period? What, if any, modifications should be made in these benchmarks?

B. Specific Implementing Agency Issues

1. Ministry of Health

- a. To what extent has the MOH established a basis for reducing recurrent wage expenditure and for addressing non-wage recurrent expenses?
- b. What has been the MOH reached revenue targets as revised?
- c. To what extent are MOH and KNH financial projections of cost sharing revenue accurate?
- d. What is the potential revenue from MOH patients who are NHIF members? To what extent has this potential been realized?
- e. Has improved efficiency (i.e., ensuring drug availability, staffing norms, protocols of care, reducing average length of stay) been accomplished as a result of the direct or indirect influence of the Project, and to what extent vis-a-vis targets?
- f. Of the efficiency measures currently focused on by the Project, what would produce the greatest return in increased quality of health services and reduced costs?
- g. To what extent have the intended subsystems for cost sharing been developed, improved and institutionalized including: DHMBs; collection, safeguarding and use of cost sharing revenue; approval of facility- and district-level plans to expend cost sharing revenue; waiver system.
- h. Has a monitoring system to measure the impact of cost sharing been developed, improved and institutionalized within the MOH as a result of the Project, i.e., impact on the poor, utilization, people's health care seeking behavior, improvements in the client's perception of quality of care. Have the poor been disproportionately affected by cost sharing in MOH facilities?
- i. What effect on Project performance are the HCF Secretariat and Implementation Committee having?

- j. What further institutional or administrative changes are necessary for cost sharing to be implemented within the MOH structure?
2. Kenyatta National Hospital
- a. To what extent are KNH's revised revenue targets reasonable and likely to be met?
 - b. Has KNH developed, refined, and successfully implemented a system to monitor revenue collection, waivers, exemptions, and credit options, and NHIF collections against estimated revenues projections given utilization? What are additional requirements for institutionalizing this system?
 - c. To what extent have the results of individual quality assessments been addressed by KNH and institutionalized as a management tool?
 - d. How effectively are the various KNH cost sharing committees functioning?
 - e. Are contractor inputs, e.g., technical assistance, commodities, and training assisting KNH to achieve anticipated PAAD results?
 - f. Given limited GOK and donor resources, what key efficiency measures should the Project support to produce the greatest return in increased quality services and reduced cost?
3. National Hospital Insurance Fund (NHIF)
- a. What has been the impact of NHIF's implementation of progressive fee structure and increased benefits to contributors?
 - b. Can NHIF accomplish its reform objectives and meet PAAD and Agreement objectives without becoming a state corporation?
 - c. What is the impact of NHIF's newly developed actuarial analysis, computerized data bases and claim processing on its operation and revenue generation targets for MOH institutions?
 - d. Has NHIF explored and been successful in

5. What has been the appropriateness and effectiveness of the two other sources of technical assistance in addition to the TA contractor: 1) interim technical assistance provided before the technical assistance contract was signed and 2) complementary buy-in for as-needed TA?

D. General Issues

1. To what extent, if any, has Kenya's macro-economic and fiscal policy performance affected the original objectives of the HCF Program?
2. To what extent has the Ministry of Finance provided the necessary and expected budget support to the respective implementing agencies?
3. To what extent and at what levels does political will within the MOH, MOF and Office of the President exist to support the Program?
4. Based on progress to-date, will purpose-level indicators be met and do these targets reflect accurate and realistic benchmarks in the current program time frame, i.e., PACD 8/93?
5. Is the TA contract properly structured and financed to accomplish program and project objectives (current or revised). If not, what revisions are recommended?
6. Are there any constraints and/or innovations that have emerged that were not foreseen in the design of the project?
7. Given the progress made to date and how this policy reform program has evolved, does the logical framework require modification? If so, what modifications are recommended?
8. What do anticipated benefits and costs reveal in terms of financial and economic benefits to invest in GOK HCF reform agenda?
9. To what extent has the Program influenced/leveraged other donor funding for health care financing reform?

In conducting research to resolve the above issues, the Contractor shall perform the following specific tasks:

identifying, selecting and introducing new benefits?

- e. How effective are streamlined procedures for claims processing for hospitals, particularly for civil-servants, in reducing cost and earning more revenue? Are further modifications in the process or structure recommended?
- f. What is the status of efforts to NHIF's to develop a clear medium and long-term strategic plan? Does it establish clear goals and objectives of NHIF and its role in the National health care system? What is the possibility of implementing this plan?

C. Contractor specific issues

- 1. To what extent has the contractor achieved the objectives of its contract to:
 - a. Assist the three implementing institutions to establish or strengthen the administrative systems necessary to implement cost sharing and related improvements in operational efficiency;
 - b. assist in further defining the GOK's long-term reform agenda in the health sector;
 - c. assist the GOK in monitoring program impact; and
 - d. strengthen the implementing agencies' institutional capacities.
- 2. Are the senior and mid-level managers in the implementing agencies satisfied with the quality and quantity the TA team involvement through technical assistance, commodities and training?
- 3. To what extent has the contractor established effective linkages to senior policy makers to develop and refine the health care financing policy agenda?
- 4. Are the contractor's inputs, i.e., schedule quantity, personnel, correctly defined in order to achieve the programmatic objectives? Should the contractor reposition some of their assistance for the balance of their contract?

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- Meet with USAID/Kenya and the MOH, KNH and NHIF to discuss and refine the scope of work and evaluation methodology.
- Visit the HCF Implementation Committee, Secretariat and HCF contractor's technical assistance offices to interview key personnel and become acquainted with project records in the field office.
- Interview key USAID/Kenya personnel both within and outside the Office of Population and Health and become familiar with project documents kept by the USAID/Kenya Project Manager.
- Meet with members of the HCF Implementation Committee and HCF Secretariat in the Ministry of Health plus key senior staff in Kanyatta National Hospital and the National Hospital Insurance Fund to review progress and become acquainted with key program documents.
- Interview key donors on the HCF Donor Committee, e.g., UNICEF, World Bank and other related MOH offices, e.g., Health Information Systems.
- Develop and administer short questionnaires to ascertain strength and weaknesses of the program, e.g., policy makers, implementors, donors, and to guide interviews.

It is envisioned that the work schedule to be followed is as follows:

- Week One:
 - Planning Meeting - Finalize schedule; assign responsibility; decide on report format.
 - Interview key MOH, KNH, NHIF staff including HCF Implementation Committee and HCF Secretariat.
 - Meetings/interviews with HCF TA team.
 - Field visit to KNH and PGH.
- Week Two:
 - Completion of interviews.
 - Draft complete report.

- Week Three:

Present to MOH, KNH, NHIF and USAID for discussion on findings and recommendations.

Finalize evaluation report and draft Project Evaluation Summary.

Draft recommended changes in PAAD supplement including logical framework.

IV. REPORTS

The final report (see Article III., above) shall be submitted by the Contractor to USAID/Kenya (20 copies in the English language) prior to departure from Kenya. A Project Evaluation Summary (Form 1330 to be provided by the CTO) shall accompany findings. Three copies of the complete package shall be provided to the CTO upon return to the U.S.

V. LEVEL OF EFFORT

The level of effort required in the performance of this Delivery Order totals _____ person days, as follows:

<u>Specialist</u>	<u>Days Required</u>
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[This may be provided by the Contractor; subject to negotiation. AID envisions the services of two specialists for a three week period in-country (18 work days each). A third individual, AID direct-hire, shall participate as a third team member. This individual shall be funded entirely outside this Delivery Order.

Within the total level of effort provided for herein, the Contractor may adjust the number of days actually employed by labor category, with the prior written approval of the R&D/H CTO. In no event is the Contractor authorized to exceed the total level of effort set forth herein without the prior written approval of the Contracting Officer.

VI. RELATIONSHIPS AND RESPONSIBILITIES

The Contractor shall report to the R&D/H CTO designated on the cover page of this Delivery Order, or his designee. As directed by the CTO, the Contractor shall work with and keep informed select host government officials and USAID/RDO/C.

Appendix B: Conditions Precedent and Interim Benchmarks; Kenya Health Care Financing Program

Note: Conditions Precedent are shown as found (and condensed) in the Program Grant Agreement 28 August 1989 and subsequent amendments to the Grant Agreement dated 11 July 1990 and 11 March 1992. The interim benchmarks are designated with the symbol • and are found in Program Implementation Letter No. 12 dated 29 October 1990.

Conditions Precedent

Status
(5/1/92)

Tranche Number Two (Total to be disbursed to implementing institutions: U.S. \$3,100,000)

General Conditions Precedent and Interim Benchmarks

2.3.1 The Grantee will continue in compliance with Conditions Precedent found in Subsections 2.2.1 (maintenance of GOK budget support to implementing institutions) and 2.2.2 ("additionality" and "no-year budgeting" for cost sharing revenues) of the Grant Agreement.

- letter from MOF confirming that funds (cost sharing revenues and those released under the Grant) generated during the life of the Grant are (i) additional to and not in substitution of GOK grant funds to be allocated to the implementing institutions and (ii) if unexpended, will not be returned to the Treasury

letter not yet written, awaiting release of FY92/93 budget estimates

- letter from MOF confirming that funds generated in FY 90/91 will be additive to forward budget for FY 91/92

see above

- documentation to confirm that the GOK grant to the implementing institutions for FY 91/92 is no lower than the GOK grant for FY 90/91

see above

2.3.2 The Grantee will provide documentation confirming fulfillment of conditions precedent as set forth in Subsection 2.3.2 (a) - (c) pertaining to disbursement of subtranches under the Grant.

Tranche Number Three (Total to be disbursed to implementing institutions: U.S. \$2,000,000)

General Conditions Precedent

2.4.1 The Grantee will continue in compliance with Conditions Precedent found in Subsections 2.2.1 (maintenance of GOK budget support to implementing institutions) and 2.2.2 ("additionality" and "no-year budgeting" for cost sharing revenues) of the Grant Agreement.

- no interim benchmarks cited

2.4.2 The Grantee will provide documentation confirming fulfillment of conditions precedent as set forth in Subsection 2.3.2 (a) - (c) pertaining to disbursement of subtranches under the Grant.

Specific Conditions Precedent and Interim Benchmarks

Subtranche Two for KNH (U.S. \$1,000,000)

Status
(5/1/92)

2.3.2 (a) Documentation that KNH has substantially progressed in the implementation of cost sharing plan as outlined in Section 2.2.3 (a) of the Grant Agreement and achievement of midterm benchmarks as per PIL 12.

- description of the private wing satisfied
(PIL 16)
- implementation of fee schedule and report of revenues generated compared against agreed upon targets for percentage of operating costs to be covered by cost sharing revenue and plan for the reintroduction of outpatient fees not satisfied
- assessment of systems for fee collection, credit options, retention and use of cost sharing revenues, centralization of admissions and fee collection satisfied
(PIL 16)
- monitoring system for utilization, referral patterns, socio-economic profile of patients patient perceptions of quality of care satisfied
(PIL 16)
- implementation of fee waiver system and review of fee waiver committee operations review not completed
- completion of quality assessments in six departments and plans for use of assessments to improve services, assignment of 2 full time staff to implement quality assessment reviews and plans to carry out quality reviews in remaining KNH departments assessments not completed
- implementation of manual accounting, budgeting and financial management system including completed accounts for FY 90/91 and training of KNH staff in financial management/accounting satisfied
(PIL 16)
- implementation of plans to reduce the average length of stay (ALOS) from 9.1 to 8.1 in the hospital or selected departments satisfied
(PIL 16)
- staffing of six key positions (Planning, Nursing, Clinical Services, Administrative Services, Finance and Personnel) satisfied
(PIL 16)

- feasibility study and business plan for establishment of a doctor's practice plan for consulting physicians including estimated costs, proposed prices, projected occupancy rates, anticipate time path to profitability and time schedule for implementation

satisfied
(PIL 16)

- updated time/activity chart for implementation of health care financing program through 29 August 1993

chart not
submitted

Subtranche Three for KNH (U.S. \$1,000,000)

2.4.2 (a) Documentation that KNH has completed the final implementation benchmarks in its cost sharing plan as approved pursuant to Section 2.2.3 (a) of the Grant Agreement.

- no interim benchmarks cited

Specific Conditions Precedent and Interim Benchmarks

Subtranche Two for MOH (U.S. \$2,000,000)

Subtranche Two for MOH has been divided into two equal parts by the second amendment to the Program Grant Agreement dated 11 March 1992.

Part One, Subtranche Two for MOH (U.S. \$1,000,000)

Status
(5/1/92)

2.3.2 (b) (1) (a) Documentation confirming the reintroduction and implementation of the revised fee schedule (including outpatient fees) in Provincial general Hospitals for a minimum of 60 days.

scheduled;
1 July 1992

- no interim benchmarks cited

2.3.2 (b) (1) (b) Confirmation that MOH facilities instituting cost sharing will be permitted to retain not less than 50 percent of all revenues generated at that facility and that those revenues not retained by the facility shall be used for primary/preventive health care services.

not satisfied

- refer to interim benchmarks cited under Section 2.2.3 (b) (i)

2.3.2 (b) (1) (c) Documentation that the MOH has made substantial progress in the implementation of plans prepared in compliance with Condition Precedent 2.2.3 (b) of the Grant Agreement.

- critical assessment of revenues collected in FY 89/90 and FY 90/91 by level of facility and district

analysis not performed

- comparison of cost sharing revenues with projections submitted to USAID on 17 September 1990

analysis not performed

- documentation of analysis showing the percent of actual recurrent expenditures financed from cost sharing revenues for FY 89/90 and projections for the ratio of fee revenues to recurrent expenditures (total and non-wage) for FY 91/92 through 93/94

analysis not performed

- documentation that cost sharing revenues retained locally were expended in accordance with MOH guidelines

satisfied
(PIL 17)
- documentation that all district and facility expenditure plans have been approved by the MOH

satisfied
(PIL 17)
- proposed modifications (if necessary) in MOH guidelines for the expenditure of cost sharing revenues (emphasis on primary/preventive services and repairs to facilities and equipment)

satisfied
(PIL 17)
- adoption of systematic mechanism for reallocation of budgetary resources for phased application beginning with forward budget for FY 91/92

satisfied
(PIL 17)
- documentation of efforts designed to reduce the finance gap for primary/preventive health services by not less than 30 percent in real terms over the period FY 91/92 through 93/94

satisfied
(PIL 17)
- documentation of analysis of GOK actual expenditures for FY 89/90 showing the breakdown by curative and preventive services, increases in budgets for the essential drugs and family planning programs, and increases in allocations to non-wage categories

analysis not performed
- documentation of analysis of GOK printed budget estimates for FY 90/91 showing the breakdown by curative and preventive services, increases in budgets for the essential drugs and family planning programs, and increases in allocations to non-wage categories

analysis not performed
- documentation of analysis of GOK forward budget estimates through FY 93/94 showing the breakdown by curative and preventive services, increases in budgets for the essential drugs and family planning programs, and increases in allocations to non-wage categories

analysis not performed
- plan for the allocation of GOK grant resources among facilities and districts for FY 91/92 to compensate for poorer districts' capacity to generate cost sharing revenue

analysis not performed
- assessment of the adequacy of administrative arrangements for fee collection, data collection, safeguards for funds, audit and the plan-

satisfied
(PIL 17)

ning and budgeting of expenditures from fee revenues

- plans for the correction of observed weaknesses in administrative arrangements noted above

satisfied
(PIL 17)

- performance report of the fee exemption (waiver) system based upon information produced by the routine monitoring system that will document the availability of exemption forms and stamps and the adequacy of the system to identify those unable to pay

analysis not performed

- recommendations for the modification of the fee exemption (waiver) system to take place no later than 1 July 1991 as required

analysis not performed

- plans to ensure that adequate supplies of drugs and medical supplies are available at MOH facilities

plan not submitted

- recommendations concerning the on-going monitoring of utilization of all levels of MOH facility by the Division of Planning

plan not submitted

- recommendations for exit surveys designed to show changes in patient socio-economic characteristics, referral patterns and satisfaction

design not complete

- recommendations for household surveys in four districts to assess changes in health seeking behavior

design not complete

- schedule of field visits by HCF Secretariat and Division of Planning staff to provide support to Districts for improved planning and data collection

satisfied
(PIL 17)

- recommendations for modification in the monitoring system designed to assess changes in utilization, socio-economic characteristics, referral patterns and perceptions of quality

system design not complete

- staffing norms for dispensaries and health centers approved by the MOH

satisfied
(PIL 17)

- draft staffing norms for MOH hospital facilities

satisfied
(PIL 17)

- inpatient treatment protocols for the ten most common diseases approved by the MOH

satisfied
(PIL 17)

- baseline data for preceding 12 months and plans for the reduction of ALOS at Provincial General Hospitals satisfied (PIL 17)
- minutes of meetings of the HCF Implementation Committee minutes to be submitted
- updated time/activity chart for the implementation of the HCF program through 29 August 1993 chart not submitted

2.3.2 (b) (1) (d) MOH document which defines the respective roles for the public sector, parastatals, private sector, municipalities and foreign donors in national health care strategy.

- analysis of roles of providers in the sector considering their relative abilities to provide services, finance operating costs, provide services to those unable to pay, risk sharing arrangements analysis not complete
- criteria for subsidization of services, vulnerable groups, geographic areas and facility location analysis not complete
- analysis of incentives and disincentives affecting the private sector analysis not complete
- recommendations and timetable for further studies and analyses to be performed and timetable for the preparation for issuing strategy as a Sessional Paper timetable not complete

Part Two, Subtranche Two for MOH (U.S. \$1,000,000)

2.3.2 (b) (2) (a) Documentation confirming the reintroduction and implementation of the revised fee schedule (including outpatient fees) in Provincial general Hospitals for a minimum of 60 days. scheduled: 1 Jan. 1993

- no interim benchmarks cited

2.3.2 (b) (2) (b) Confirmation that MOH facilities instituting cost sharing will be permitted to retain not less than 50 percent of all revenues generated at that facility and that those revenues not re- see above

tained by the facility shall be used for primary/preventive health care services.

see above

- refer to interim benchmarks cited under Section 2.2.3 (b) (i)

2.3.2 (b) (2) (c) Documentation that the MOH has made substantial progress in the implementation of plans prepared in compliance with Condition Precedent 2.2.3 (b) of the Grant Agreement.

- refer to interim benchmarks cited for Section 2.3.2 (b) (1) (c)

Subtranche Three for MOH (U.S. \$950,000)

2.4.2 (b) (i) Confirmation that MOH facilities instituting cost sharing will be permitted to retain not less than 50 percent of all revenues generated at that facility and that those revenues not retained by the facility shall be used for primary/preventive health care services.

- refer to interim benchmarks cited under Section 2.2.3 (b) (i)

2.4.2 (b) (ii) Documentation that the MOH has achieved final implementation benchmarks as contained in the cost sharing plan approved pursuant to Section 2.2.3 (b) of the Grant Agreement.

- no interim benchmarks cited

2.4.2 (b) (iii) Documentation that the MOH has completed a evaluation of methods for the allocation and monitoring of the use of supplemental resources for primary/preventive services.

- no interim benchmarks cited

2.4.2 (b) (iv) Documentation that operation expenses devoted to primary/preventive services (as a percentage of total MOH budget) in FY 91/92 have increased by no less than four percent over FY 88/89 levels.

- no interim benchmarks cited

Specific Conditions Precedent and Interim Benchmarks

Subtranche Two for NHIF (U.S. \$100,000)

Status
(5/1/92)

2.3.2 (c) (i) Documentation that NHIF has adopted a progressive fee structure based upon the interim reform program approved by Parliament in 1989.

- documentation of a new progressive fee structure and increased benefits package
- verification of training of MOH staff in procedures for claiming NHIF reimbursements

changes as per NHIF plan
training not verified

2.3.2 (c) (ii) A medium and long term strategic plan establishing goals and objectives of NHIF and its role in the national health care system.

- draft paper which defines NHIF medium and long term goals and objectives
- documentation of ongoing strategy for achieving goals and objectives and improving efficiency and effectiveness of services provided
- analysis of options for NHIF within Kenyan health policy (including advantages and disadvantages and possible combinations and their interaction affects)

paper not submitted
paper not complete
analysis not completed

2.3.2 (c) (iii) Documentation that the GOK has published a Bill to establish NHIF as a State Corporation.

bill not published

- documentation of progress in purchasing a computer system and establishing an actuarial capacity as outlined in the NHIF HCF implementation plan submitted to USAID in May 1990
- documentation that key senior management positions (Chief Planning Manager, Finance Manager, Computer Manager, Operations Manager and Administrative Manager) have been filled
- an updated time/activity chart for the implementation of the HCF program through 29 August 1993

computer and actuarial capacity not established
positions not filled
chart not completed

Subtranche Three for NHIF (U.S. \$50,000)

2.4.2 (c) Documentation that NHIF has achieved midterm implementation benchmarks set forth in the strategic plan as approved pursuant to Section 2.3.2 (c) (ii).

- no interim benchmarks cited

Appendix C: List of Documents Consulted

- Alexandre, Leslie M. & Stephen G. Franey. "Assessment of Proposed Reforms of Kenya's National Hospital Insurance Fund. prepared for East Africa Department, World Bank, Washington, D.C., June 1989.
- Kenyatta National Hospital. "Status Report on Conditions Precedent for Kenya Health Care Financing Programme." September 1991.
- "Kenya Health Care Programme/Project Evaluation; KNH - Overall Health care Financing Reform Conditionalities." (April 1992).
- "KNH Revenue Projections for 91/92 - 92/93." Provided to Evaluation Team 28 April 1992 (prepared November 1991 (GET LATEST:28 february 1992).
- KNH Revenue returns for the Months July 1991-March 1992." Provided to Evaluation Team 28 April 1992.
- N.O. Mogere, Finance Manager, Memorandum to The Finance Director, Re: Workplan, 2nd April, 1992.
- N.O. Mogere, "Kenyatta National Hospital. Allocation of Funds 1992/93 financial Year." and "KNH Development Budget 1992/93." 7 May 1992.
- Ministry of Health. Kenya Health Care Financing Project. "Six Month Technical Report: May 1, 1991 through October 31, 1991.", Submitted by Daniel Kraushaar, Chief of Party.(USAID Contract No: 623-0245-C-00-0040-00). December 31, 1991.
- "Second Year Work Plan: November 1,1991 through December 31, 1992.", Submitted by Daniel Kraushaar, Chief of Party. (USAID Contract No: 623-0245-C-00-0040-00).
- "Health Care Financing Programme, Monitoring and Evaluation Programme". 20 February 1992.
- "Status Report on Conditions Precedent for Kenya Health care Financing Programme." October 1991.
- "Annotated Bibliography of HCF Studies." No date.
- David Collins. Memorandum to Dan, Jono, Nzioki. RE: P/PHC Gap Estimates.
- David Collins. Memorandum to W. Oliech, I, Hussein. RE: MOH Financial Analysis. 7 April 1992.
- David Collins. Memorandum to I. Hussein, W. Oliesh. RE: MOH FIF Potential Revenue. 16 April 1992.

- Health Care Financing Secretariat. "Health Care Financing Programme Position Paper." 1st July 1991.
- Health Care Financing Secretariat. "Facility Improvement Fund Status Report." 15 April 1992.
- Health Care Financing Secretariat. "Cost Sharing Systems Checklist for Facilities/Districts."
- Memorandum to field offices "Re: Introduction of Outpatient Treatment Fee," 14th April, 1992.
- "Project Briefs: Kenya Health Rehabilitation Project." 30/4/1991.
- National Health Insurance Fund. "A Report on the Action Planning Workshop, 30 November to 1 December 1989. Prepared with Information and Planning Systems Project and REACH Project, USAID, December 1989.
- REACH Project. "Agenda for Action: Implementation Plan for Improving the Quality and Operational Efficiency of GOK Health Services." (A.I.D. Contract Number: DPE-5927-C-00-5068-00). January 1990.
- "National Hospital Insurance Fund, Hardware and Software Specifications." Nairobi: USAID/REACH Project, April 1990.
- Republic of Kenya. "Statements of Excesses." No.2 of 1981/82 and No.1 of 1988/89.
- "The Exchequer and Audit ((Health Care Services Fund) Regulations, 1990". Kenya Gazette supplement No. 48. Legal Notice No. 268. The Exchequer and Audit Act. (Cap. 412). Appendix 1. 29th June, 1990.
- Laws. The National Hospital Insurance Act. (Chapter 255). Revised Edition. Nairobi, Government Printer, 1977.
- Shaw, Samuel E. "Actuarial Requirements at Kenya's National Hospital Insurance fund." prepared for Office of International Health, U.S. Department of Health and Human Services, Rockville, Maryland. March 1990.
- Solnick, Sara "Claims Processing and Automation at the National Hospital Insurance Fund. July 1989.
- "Member Maintenance Systems and Automation at the National Hospital Insurance Fund. August 1989.
- USAID/Nairobi. "Kenya Health Care Financing Program PAAD (Program Assistance Approval Document). (615-0245) June 30, 1989.
- "Country Development Strategy statement and Action Plan. FY 1990-95. Kenya. february 1990.

- "Summary of the Joint NHIF/USAID Review Meeting on the Kenya Health Care Financing Program/Project held on 01/31/92 at NHIF."
- "Summary of the KNH/USAID Kenya Health Care Financing Program/Project Review Meeting on February 4, 1992 at KNH."
- "Summary of the Joint MOH/USAID Review Meeting on the Kenya Health Care Financing Program/Project Held on February 6, 1992 at Afya House, MOH."
- "Program Grant Agreement between The Republic of Kenya ('The Cooperating Country') and The United States of America acting through the Agency for International Development ('A.I.D.') For Health Care Financing Project for Technical Assistance." A.I.D. Project No.615-0245. August 20, 1989.
- "Program Grant Agreement between The Republic of Kenya ('Grantee') and The United States of America acting through the Agency for International Development ('A.I.D.') For Health Care Financing." A.I.D. Program No.615-0245. Program Agreement No. 615-T-6083. August 28, 1989.
- "First Amendatory Agreement to Program Agreement For Kenya Health Care Financing Program between the Republic of Kenya and the United States of America." A.I.D. Program No.615-0245. Program Agreement No. 615-T-6083. July 11, 1990.
- Connie Johnson. Semiannual Project Review Reports for Kenya Health Care Financing Program. posted on 9/30/90, 3/31/91, 10/17/91.
- Linda Lankenau. Semiannual Project Review Reports for Kenya Health Care Financing Program. posted on September 30, 1989, 4/90, 3/31/90.
- Steven W. Sindig, Director, to Charles Mbindyo, Permanent Secretary, Office of the Vice President and Ministry of Finance, Nairobi. Subject: USAID Program No. 615-0245. Kenya Health Care Financing Program Implementation Letter No.2 (Program). October 12, 1989.
- Steven W. Sindig, Director, to Permanent Secretary, Office of the Vice President and Ministry of Finance, Nairobi. Attention: G. Kioko-wa-Luka. Subject: USAID Program No. 615-0245. Kenya Health Care Financing Program Implementation Letter No.6 (Program). February 5, 1990.

- Steven W. Sindig, Director, to Charles Mbindyo, Permanent Secretary, Office of the Vice President and Ministry of Finance, Nairobi, and N. Ayata, Director. Kenyatta National Hospital, Nairobi. Subject: USAID Program No. 615-0245. Kenya Health Care Financing Program Implementation Letter No.9 (Program). Kenyatta National Hospital Implementation Plan. 11 April 1990.

- John R. Westley, Director, to Charles Mbindyo, Permanent Secretary, Office of the Vice President and Ministry of Finance, Nairobi. Subject: USAID Program No. 615-0245. Kenya Health Care Financing Program Implementation Letter No.12 (Program). October 29, 1990

- John R. Westley, Director, to W. K. Koinange, Permanent Secretary, Office of the Vice President and Ministry of Finance, Nairobi, and Daniel Mbiti, Permanent Secretary, Ministry of Health, Nairobi. Subject: USAID Project No. 615-0245. Kenya Health Care Financing Program (KHCFP) Implementation Letter No. 17 (Program). Ministry of Health Submission for Subtranche Two (\$2,000,000) December 23, 1991.

- World Bank. Staff Appraisal Report. Kenya. Health rehabilitation Project. PHR Division, Eastern Africa Department . Report No. 9174-KE October 7,1991

- Kenya. re-investing in Stabilization and Growth Through Public Sector Adjustment. Vol. 1. The Main Report. Country Operations division, eastern Africa Department. Report No. 9998-KE. January 10, 1992.

Appendix D. List of People Contacted

MINISTRY OF HEALTH

Daniel Mbiti	Permanent Secretary
M.P. Githae	Deputy Secretary, Administration
J.G. Njoroge	Chairman, HCF Implementation Committee & Deputy Secretary, IPD
F. Mworia	Chief Hospital Secretary, & Secretary, HCF Implementation Committee
S.N. Muchiri	Economist, Planning Department
F.K. Mwenda	Senior Assistant secretary, Finance
C.K. Sigei, M.D.	Director, Health Information System
W.O. Wanyanga, M.D.	Senior Pharmacist
W. Oliech	Chief Accountant

Health Care Financing Secretariat

Ibrahim Hussein	Director
Mary Kilonzo	Hospital Secretary
W. Oliech	Chief Accountant

Eastern Province

Jorwar, M.D.	Provincial Medical Officer
Magati	District Hospital Secretary

Embu Provincial Government Hospital

J.N. Njage, M.D.	Hospital Superintendant
K.W. Njeru	Nursing Officer
P.M. Kinga	Hospital Secretary
W. Njenga	Senior Nursing Officer

Nyeri District Hospital

S.K. Sharif, M.D.	Hospital Superintendant, District Medical Officer
D. Kibanya	Senior Hospital Secretary
A.S. Nzimbi	Matron
M. Mutua	Hospital Secretary

MINISTRY OF FINANCE

B.B.C. Kangela	Budgetary Supplies Officer
D.R. Ongalo	Director, External Resources Dept.
G. Kioko-wa-Luka	USAID Desk Officer

HOSPITAL

Chief Executive Director
Director of Nursing
M.D. Deputy Director, Clinical Services
Casualty Manager
Planning Manager
Deputy Planning Manager
S.P.A. Finance Manager
Cash Points
Revenue Accountant
Public Relations Officer
Senior Medical Records Officer
Hospital Secretary, Private Ward

NYERI

Hospital Secretary
Matron
Medical Officer in Charge

INSURANCE FUND

Director
Deputy Director
Chief Inspector
Chief Accountant
Senior Executive Officer
Senior Machine Operator (Data
Processing)

Senior Project Officer, Health &
Nutrition
Project Officer

DBI

Policy Economist
Resource Economist
D. Health Economist

WORLD BANK

John McGreggor	Senior Operations Officer, Regional Mission in Eastern Africa, Nairobi
Nicholas Burnett	Senior Economist, Population and Human Resources, Eastern Africa Department

KENYA HEALTH CARE FINANCING DONOR COMMITTEE MEETING ATTENDEES

Maria Nordenfelt	SIDA
Yoshiyuki Takahashi	JICA
Heli Sirve	FINIDA
Caroline B;aor	UNFPA
C. Kahangi	African Development Bank
A.H. Huitzing	Netherlands Development Aid Program
John McGreggor	World Bank
David Oot	USAID
Connie Johnson	USAID

HEALTH FINANCING AND SUSTAINABILITY PROJECT

Charles Griffin, Ph.D.	Health Economist
Richard Siegrist	Financial Management Specialist

HEALTH CARE FINANCING PROJECT TEAM-Management Sciences for Health

Daniel Kraushaar, Ph.D.	Chief of Party
Jonathan Quick, M.D.	Planning and Evaluation
David Collins	Financial Advisor
Leslie Okundo Akumu	Actuary, Insurance Specialist
Nzioki Kibua	Economist
Paul Inda	Consultant, Computer Specialist
Charles Stover	Consultant, Insurance Management Specialist

USAID/NAIROBI

John Westley	Mission Director
David Oot	Director, Office of Population & Health
Connie Johnson	Project Officer, OHPN, HCF Program/Project
Benson Obonyo	Economist, OPHN
Kitanga Kathurima	Financial Analyst, OPHN
Carla Barbiero	Projects Office
Cyrylla Bwire	Program Office
Victor Barbiero, Ph.D.	Health Officer, Regional Office for East Africa
Larry Forgy, Ph.D.	Health Economist, Regional Office for East Africa

Appendix E: Capsule Summary of Conclusions

Capsule Summary of Conclusions from the Kenya Health Care Financing Program	
C	Collaboration promotes understanding; involvement of stakeholders at each stage in policy development and implementation was essential to progress in health financing reforms in Kenya.
A	Analysis can solve problems and remove unwanted surprises; solid data and competent analysis can contribute greatly to policymaking success.
S	Systems are essential to ensure accountability for financial resources and successful strengthening of quality of health care.
H	Health improvement remains the goal of health financing reforms; reforms in financing are not seen as an end in themselves.