



REPUBLIC OF KENYA
EXECUTIVE OFFICE OF THE PRESIDENT

POLICY BRIEF

APRIL 2020

Provider Payment Mechanisms in Private
Health Sector

Provider Payment Mechanisms in Private Health Sector

Key Messages

1. Medicines and surgical services remain the greatest driver of medical inflation in the private health sector in Kenya.
2. Fee for Service as a reimbursement mechanism engenders in higher costs of services hence a driver of supplier induced demand as well as medical inflation.
3. Due to supplier induced demand, insurers with the highest volume of cases, are not able to leverage economies of scale.
4. Pricing and reimbursement methods in the private sector affect price and inflation in the entire sector. Understanding how the providers and payers are setting their current prices is essential for effective price regulation.
5. Quality of care outcomes are a neglected component in reimbursement strategies by purchasers and the insurance regulator.
6. The regulator is too passive for a Government pursuing UHC through strategic purchasing.
7. Health insurance experts can help guide development of policies that will incentivize efficiency, quality and financial protection by health insurers through evidence-based costing, benefit package design, strategic purchasing and reimbursement models.
8. Multisectoral engagements (including health, architectural, engineering, finance sectors *inter alia*) are key for successful implementation of quality strategies.
9. Prospective reimbursements can allow providers to make large fixed cost investments e.g. state of the art equipment for diagnostics, eye surgery, hip replacements etc, that would otherwise be unprofitable. They can also remedy the liquidity challenges faced by providers.

Introduction

Payment mechanisms adopted by purchasers to strategically allocate resources have the potential of creating incentives for efficiency and quality in healthcare delivery. Further, when healthcare providers with market power compete on both price and quality, more competition often leads to lower quality as providers compete on price at the expense of quality. However, if prices are set in advance, firms can only compete on quality yielding quality improvements if coupled with efforts to make quality more visible such as through transparency of outcomes. As the Government of Kenya pursues Universal Health Coverage and NHIF reforms, insights from this analysis can inform government's policy and regulatory response. This comparative analysis sought to analyse reimbursement trends, determinants of the reimbursement patterns as well as existing quality incentives in select private sector payers and providers. This policy brief summarizes the key findings and recommendations.

Key Findings

a. Providers

The Problem: The existing service package designs and delivery strategies do not fully enhance efficiency, quality and financial protection. This engenders in higher costs of care borne by the patients and for services of substandard quality.

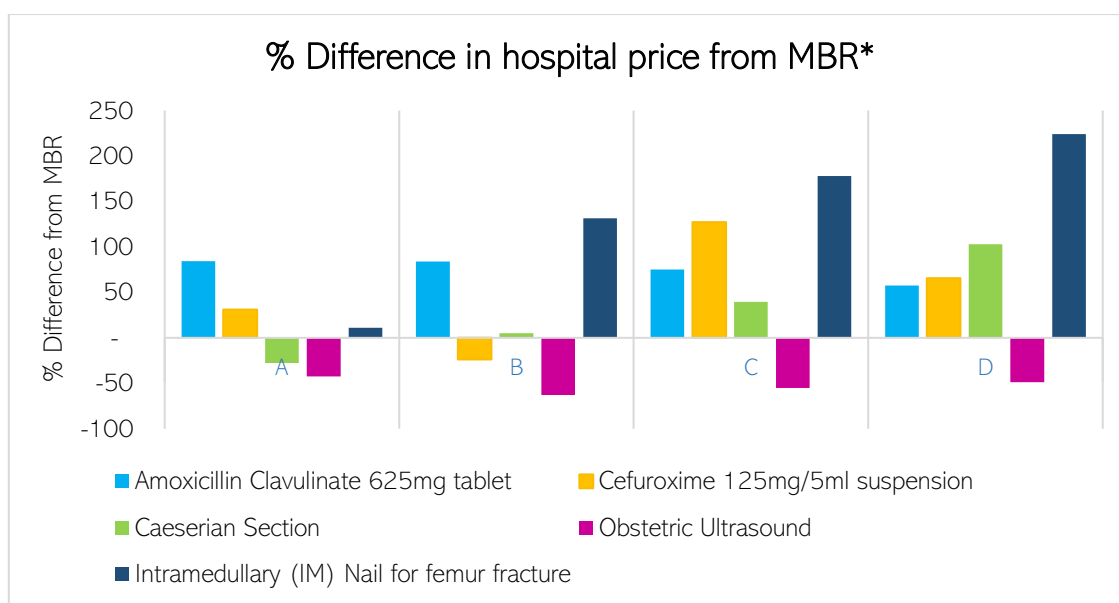
Findings

Figure 1 below reflects the variances of the prices of the tracer interventions from the recommended median base rate (MBR) across the sampled facilities.

Facilities and services reimbursed through fee for individual service were more expensive relative to those with bundled services as seen in facility C and D which had most of the services reimbursed through Fee For Service while most medical prescriptions across all sampled hospitals had a higher variance from the median recommended rate.

Prescriptions and operative services are key drivers of medical inflation. Medical prescriptions and operative services (caesarian sections and fixing of intramedullary nail for femur fracture) had higher variances from the median recommended rates in most of the hospitals sampled.

Figure 1: Percentage variance in hospital price of tracer interventions from the MBR



Operative services offered in bundled packages were relatively cheaper than when offered as separate services as seen in caesarian sections in Hospitals A and B.

Providers can drive financial protection through pricing as seen in the lower pricing of ultrasound services relative to the mean base rate across all the sampled hospitals.

The price differentiation within facilities proves that it is possible to work out mandated price points that safeguard standards, ensure the business remains operational but starts reigning in on inflation and therefore the affordability of care. This is demonstrated by the varied pricing for similar services reimbursed by different purchasers e.g. Hospital B charged Kes. 50,000 for CS under the Teachers' Service Commission (TSC) scheme, Kes. 115,000 for Resolution Health Insurance and Kes. 145,000 for Madison Insurance.

There is limited transparency in dissemination of quality outcomes to the public across all the sampled facilities. This hinders the potential of leveraging on transparency to enhance accountability and quality through citizen participation.

Providers experience varied challenges in enforcing quality including; a) expensive quality requirements on human resources, structural adjustments, and accreditation; b) poor training standards for health workers; c) cashflow strains and losses due to defaults in payment for services rendered. The latter is further compounded by retrospective reimbursements which are the predominant mechanism across all facilities.

b. Purchasers/ Insurance Companies

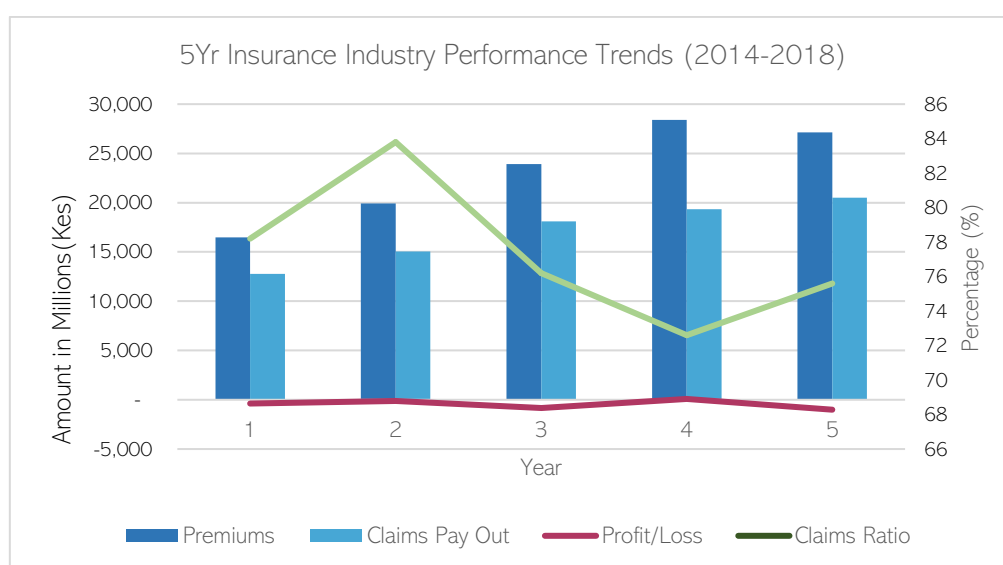
The Problem: Purchasers of healthcare services do not consider quality of care outcomes and strategic purchasing in their reimbursement strategies. This results in low quality of care to patients, high costs of care and ultimately higher premiums levied on patients.

Findings

Figure 2 above demonstrates the trends in financial performance of the private medical insurance business in Kenya between 2014 and 2018.

Private health insurance spending in Kenya has increased over the last five years with rising premiums and claims paid out.

Figure 2: 5yr Medical Insurance industry performance trends



Medical insurance business performance has worsened over the past five years with increasing losses (Kes 0.12-1B) and high claims ratios between 72-84% against the recommended range of 50-70%.

The unpredictability of healthcare costs, high costs of services, high inflation rate, lack of price guidelines, inefficient reimbursement strategies, and lack of standardized care further compound the poor performance of most insurance companies.

Figure 3: Percentage variance of insurance reimbursement rates from the recommended price.

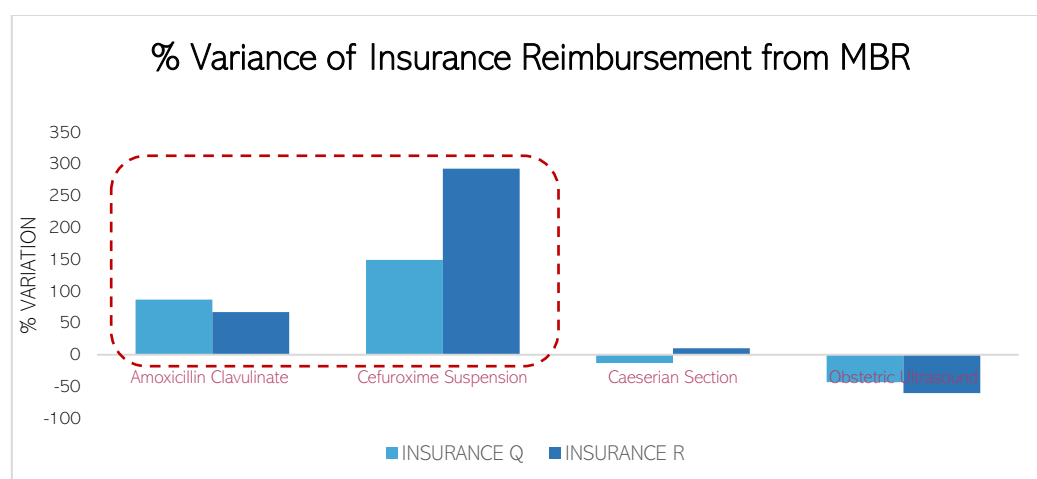
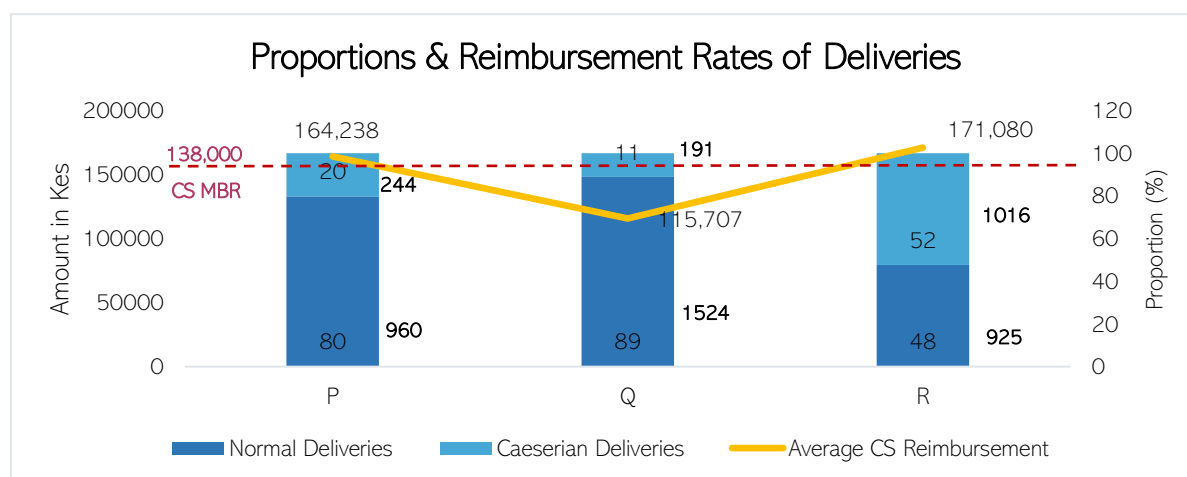


Figure 3 above demonstrates that pharmaceutical products are a key driver of medical inflation within the private health insurance sector. The reimbursement rates of the tracer drugs are 67-300% higher than the recommended MBR.

Figure 4 shows the reimbursed deliveries disaggregated by numbers, proportions and reimbursement rates for CS deliveries across all the sampled insurance companies in 2019.

Reimbursement rates have the potential of incentivizing an oversupply of services to patients by the providers. As depicted in Figure 4 above, the higher reimbursements by Insurance R (Kes. 171,080) and P (Kes. 164,238) for caesarean deliveries may account for the higher CS rates in Insurance R (52%) and P(20%) relative to Insurance Q(11%) which has a lower reimbursement rate of Kes. 115,707.

Figure 4: Proportions and Reimbursement Rates for Deliveries in 2019



Larger pools of insureds afford insurers better negotiating power which can be leveraged upon to draw better pricing and quality of services from providers thus achieving strategic purchasing. Despite having the largest number of deliveries (1941) amongst the sampled insurance companies, Insurance R had the highest reimbursement rates for both normal and caesarian deliveries while Insurance Q, which had fewer deliveries (1715), had the lowest CS reimbursement rate and the lowest proportion of CS deliveries. This signals the value of strategic negotiations by insurers for cost reduction.

c. Insurance Regulatory Authority (IRA)

The Problem: The regulator is too passive in a “market” with inherent inefficiencies resulting in weak regulation and coordination of health insurance practice in the private sector. This ultimately exposes the patients/ policy holders to unfavourable pricing and suboptimal quality of care.

Findings

- Optimal regulation within the healthcare requires sector specific regulations which are currently not in place.
- IRA can leverage on existing legal structures to monitor quality incentives by insurers to providers and enforce evidence-based pricing by insurers.
- Building capacity in health finance and insurance will help improve the regulator's influence in guiding costing, benefit package design, strategic purchasing and reimbursement models by health insurers.
- IRA has the capacity to inculcate quality of care as a key component in training curricula for health workers and health insurance trainees.
- There is need for multidisciplinary and multisectoral engagement in the bid to entrench quality in healthcare.

Recommendations

Entity	Behaviour	Possible Reason for behaviour	Recommendations
Provider	Suboptimal quality of care.	Lack of transparency on quality outcomes.	Inculcate evidence based care guidelines in service delivery.
		Weak adoption of care guidelines.	Facilitate in-service training of staff to improve quality.
			Make quality of care more visible through transparent dissemination of quality outcomes to the public.
	High cost of care	High cost of enforcing quality requirements.	Evidence-based redesign of service packages.
	Supplier induced demand	Weak regulation of the health insurance sector.	Co-create service packages and negotiate reimbursement strategies (e.g. prospective) with providers.
			Active evidence based regulation by the government.
Insurer	Inefficient pricing and policy design.	Lack of evidence-based pricing guidelines.	Co-create service packages with providers.
	Unpredictable health costs.	Inadequate health finance/ insurance capacity.	Develop capacity/ expertise in health insurance for better policy design.

		Lack of enforcement of standard of care guidelines.	Align reimbursements to standards of care guidelines.
			Align reimbursement to quality of care outcomes.
Regulator	Weak health insurance sector coordination.	Lack of health specific legislation.	Develop sector specific legislation/ policies for better sector regulation.
	Weak executing capacity.	Inadequate health finance/ insurance capacity.	Develop capacity/ expertise in health insurance for better policy design.

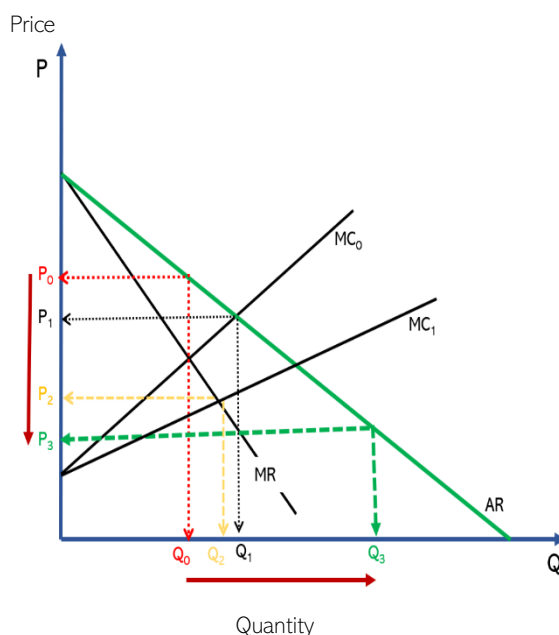
Way Forward: Prospective reimbursement

Figure 5 below shows the hypothetical market response to prospective reimbursement. Prospective reimbursements have the potential of delivering the following benefits:

- Elimination of monopolist output distortion by eliminating the incentive to restrict output to obtain a higher price as seen in P1.
- Cost reducing investments that were previously nonprofitable may become profitable as depicted in P2 & P3.
- It affords predictability and stability of healthcare costs to the payer.
- It guarantees cashflow to the providers.
- It provides a form of price regulation through yardstick competition where the reimbursement price suffices as the yardstick.

Figure 5: Graph of the market response to reimbursement strategies

Market Response to Prospective Reimbursement



Key:

$P_0 Q_0$ = Monopolist's choice: highest price for lowest quantity where $MR=MC$ (output distortion)

$P_1 Q_1$ = Socially efficient quantity and price in a perfect market

$P_2 Q_2$ = Fixed cost investment WITHOUT prospective reimbursement. Lower price for higher quantity = lower profits

$P_3 Q_3$ = Fixed cost investment WITH prospective reimbursement allows a monopolist to make a fixed cost investment that would have previously been unprofitable

MC_0 = Marginal Costs before fixed cost investment

MC_1 = Marginal Costs with fixed cost investment

MR = Marginal Revenue

AR = Average Revenue

Figure 6: Deliveries in Hospital B under the TSC Scheme

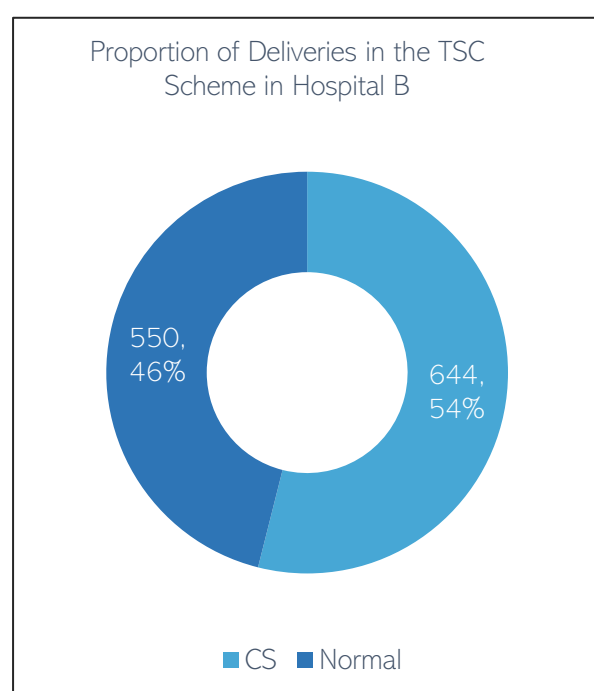


Figure 6 depicts the proportion of deliveries in the TSC scheme in one of the sampled hospitals. It also mimics the potential impact of prospective reimbursement of pre-negotiated rates i.e. lower costs and higher quantities of services offered.

Whilst the TSC scheme had the lowest CS reimbursement rate (Kes. 50,000), Hospital B had a higher volume of CS deliveries (46%).

It is the opinion of the authors of this brief that the tenets of prospective reimbursements can inform the administration of pooled funds (e.g. COVID19 catastrophic fund) that is contributed to by (all) insurers upon consensus on a set of terms (e.g. fixed bundled payment for the following) for beneficiaries:

- Diagnostic tests
- Management of moderate disease (oxygen but no intubation)
- Management of severe disease
- Management of COVID-19 plus co-morbidity

Successful design and implementation of prospective reimbursement of services must have multi-stakeholder engagement including healthcare workers delivering the services so as to embed appropriate incentives for all the stakeholders.

Conclusion

Purchasers, providers and regulators have a great potential to influence the quality and cost of services rendered to populations. The government can further guide this process by providing a conducive environment through appropriate legislation and regulation to ensure that the reimbursement models adopted not only cover the costs of services delivered but also incentivize efficiency in service delivery, maximize quality of outcomes, ensure affordability and guarantee sustainability.

This evidence brief was prepared by Dr. Wangare Ng'ang'a and Dr. Caleb Mike Mulongo for the Presidential Advisory & Strategy Unit (PASU), Executive Office of The President, Republic of Kenya in response to the health financing and strategic purchasing reforms supporting the implementation of Universal Health Coverage in Kenya.