INTRODUCING PROSPECTIVE PAYMENT MECHANISMS IN KENYA: WORKSHOP REPORT

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Lake Elementaita Serena Camp
Naivasha, Kenya

"Strengthening Partnerships in the Private Health Sector to increase private health insurance coverage"

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SHOPS
Strengthening Health Outcomes *through* the Private Sector

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ACRONYMS

AKI	Association of Kenya Insurers
DRG	Diagnosis Related Group
FFS	Fee-for-Service
NHA	National Health Accounts
OOP	Out-of-Pocket
PPM	Provider Payment Mechanism
SHOPS	Strengthening Health Outcomes through the Private Sector Project
USAID	United States Agency for International Development

I. INTRODUCTION

1.1 THE PRIVATE HEALTH INSURANCE MARKET IN KENYA

Over the years, the private sector has significantly grown to finance and deliver health services in Kenya. As donor investments wane and resources in the public sector are stretched, there is significant opportunity for the private sector to support public sector efforts to improve health outcomes. For instance, private sector contributes 33 percent of HIV spending and 25 percent of HIV-infected adults and adolescents obtain ART from private for-profit health facilities (NHA, 2010; NASCOP, 2012). However, over-reliance on out-of-pocket (OOP) spending hinders access to private health services for most Kenyans leading them to forego care or risk impoverishment due to catastrophic health spending (Deloitte 2011). Health insurance programs provide a channel to spread risk across the population and mitigate the challenges associated with OOP. With 80% of Kenyans uninsured, there is potential for both insurers and providers to expand their market share through affordable insurance products. An increase in private health insurance coverage facilitates greater access to private sector health services for more Kenyans.

To realize this market potential, insurers must be able to offer more affordable health insurance products. However, to enable such product development, insurers and healthcare providers must control the cost drivers of their business. Current retrospective fee-for-service (FFS) model adversely incentivizes over-treatment as well as high administration costs leading to approximately 78 percent of collected premiums paid out for claims reimbursement (AKI, 2012). High claims ratio leads to high premiums, making health insurance products unaffordable to many while being an unprofitable product for most insurers. Market growth hinges upon realization of efficiencies that makes health insurance a more viable investment for insurers while also making the product more affordable and accessible to the Kenyan population.

Introducing prospective payment mechanisms (PPMs) such as capitation and case-based payment using diagnostic related grouping (DRGs) controls the incentives associated with FFS that escalate healthcare costs. For insurers, PPMs present an opportunity to significantly lower administration costs and contribute to reduction of premiums. Prospective payments also give providers the advantage of pre-negotiated payments with a lower administrative burden, an assured catchment, and predictable revenue streams.

In capitation, rates are set prospectively to provide a defined package of care at a fixed sum per person enrolled with a provider for a defined period of time (WHO 2010). Payment is typically based on the number of people assigned to a provider within the agreed duration that the payment is supposed to cover. Capitation is frequently used for management of outpatient medical schemes. Capitation creates incentives for providers to be cost effective and actively discourages over-prescription, deters patient-induced fraud, and encourages roll-out of preventive health programs.

This report summarizes the discussion points and outputs from the two-day capitation workshop held on 22-23 May, 2014 supported by the SHOPS project. The workshop brought together major private health insurers and health providers for the first time to concretize opportunities for

collaboratively addressing the rising costs of private health care through innovative payment mechanisms.

1.2 INTRODUCTION TO THE SHOPS PROJECT IN KENYA

The Strengthening Health Outcomes through the Private Sector (SHOPS) Project is a global five-year project funded by USAID whose goal is to expand the role of the private sector, including non-governmental organizations (NGOs) and for-profit entities in the sustainable provision and use of private sector products and services. One of the main objectives of the SHOPS Project in Kenya is to increase coverage of private health insurance among the uninsured. SHOPS is supporting private insurers to develop strategies that will increase access and affordability to low-cost health insurance products that will meet the needs of uninsured Kenyans. In line with this, SHOPS sees the potential of PPMs to control medical inflation, which can be translated to lower premiums and greater depth of coverage.

1.3 WORKSHOP OVERVIEW

The purpose of the workshop was to build consensus and identify opportunities for partnership between insurers and providers to help reduce cost inefficiencies associated with private health insurance. SHOPS received interest from private insurers and providers to introduce PPMs. SHOPS is working with the insurance industry to explore options to shift from the retrospective FFS provider payment mechanism to PPM arrangements.

The workshop was well-attended with leadership from both private insurer and provider institutions. Participants included representatives from insurers interested in PPM (Jubilee, UAP, APA, and CIC), and providers (Gertrude's Children's Hospital, Mater Hospital, Aga Khan University Hospital, Avenue Hospital, Meridian Medical Centre, Savannah Healthcare Ltd., and MP Shah Hospital). The participant list can be found in Annex 1.

Participants' expectations and objectives for the workshop were:

- To promote the understanding of what capitation has to offer for all stakeholders
- To explore partnership opportunities between providers and insurers
- To envision how participants might establish a capitation model design and work plan

Day one was composed of facilitated discussions with small breakout group discussion sessions on various issues pertaining to current and proposed payment mechanisms. Participants also discussed various strategies for implementing capitation models in the country.

Day two had presentations on international lessons on capitation from Ghana, Thailand, Philippines, and South Africa. Participants discussed a case study based on a real-life tender that was to be issued by the Kenyan government for medical services to a large group of civil servants.

The participants were unanimous in the need for a paradigm shift in how business is done, with PPMs being a key approach to bring the industry players together collaboratively to manage costs of health care and increase insurance coverage.

2. WORKSHOP DAY ONE

2.1 INTRODUCTIONS AND WELCOME NOTE

The workshop started with a welcome note from SHOPS Chief of Party, Mbogo Bunyi. Mbogo gave an overview of SHOPS activities and interest to partner with the private sector in Kenya by offering technical assistance that would ultimately help increase private health insurance coverage of Kenyans. Mbogo highlighted that there has been continuous engagement between SHOPS and the private sector players in different initiatives. The workshop was a result of several consultations with industry players who identified a need for improved dialogue and collaboration to address high administrative and cost burdens associated with private health insurance. PPMs, such as capitation, help control claims and administration costs, which in turn, can make insurance products more affordable.

2.2 SESSION: KENYAN PRIVATE SECTOR AND CHALLENGES WITH CURRENT PAYMENT SYSTEMS

This session began with a competitive quiz with questions on the Kenyan private sector fielded to the participants in groups of providers and insurers. The quiz focused on highlighting the significant size of the Kenyan private sector, poor insurance uptake among Kenyans, poor financial performance of medical insurers, and the sources of financing for healthcare in Kenya amongst others.

After the quiz, SHOPS's Health Care Financing Specialist, Josef Tayag, led a session focusing on the challenges with, and opportunities to overcome the challenges of current provider payment methods. A summary of these challenges, related to FFS payment is given in Table 1:

TABLE 1: OVERVIEW OF FEE-FOR-SERVICE

Type of payment mechanism	Retrospective: providers are paid after they deliver care and submit claims
Payment rate to health care providers	Variable, based on the intensity of care delivered and resources used
Number of services delivered per payment	Each payment covers a single service delivered by providers
Are payments risk adjusted for patient characteristics?	No, because providers are reimbursed for the delivered services and costs incurred
Is there a timeframe for each payment?	No, because FFS is paid retrospectively
What types of services are covered?	Can include all services
Who is covered?	Anyone enrolled under a FFS-based, health insurance scheme

2.3 GROUP WORK SESSION: CHALLENGES ARISING FROM FEE-FOR-SERVICE MECHANISM

To outline challenges of FFS, participants divided into groups composed of either insurers or providers. Each group came up with a list of challenges they faced from their experience using FFS as a provider payment method. The groups then brainstormed on challenges their

counterparts faced, i.e. health care providers outlining challenges faced by insurers and vice versa. Individual group responses are shown in Annex 2.

1.1.1 CHALLENGES FACED BY INSURERS

High claims ratios and poor cost predictability were the top challenges that insurers cited arising from FFS. Various factors were seen to contribute to this as outlined below:

- FFS is associated with high administration costs arising from cost of stationary, staff, amongst other cost drivers.
- FFS creates little or no incentives for providers to control costs. In addition, FFS lacks mechanisms for discouraging patient- or provider-induced over-provision of care. FFS is also associated with high levels of fraud which includes both provider and patient induced fraud.
- Medical inflation is high in Kenya, leading to high claims ratio with the effect exacerbated by the predominance of FFS.
- Insured patients are charged higher than 'cash paying' patients by providers who apply a markup due to delays in reimbursement. Insurers feel they are over charged.
- Insurance companies tend to compete based on premium price despite recognizing that they are set too low. This is due to various market forces and inefficiencies as stated below:
    - The target market of private health insurers is composed almost exclusively of corporate clients (typically employer-based medical schemes) with relatively limited growth. These clients tend to have more power over the product design than what is actuarially feasible.
    - Some corporate clients with other larger and more 'attractive' non-medical business with these insurers frequently have had more negotiating power, which they leverage to compromise medical premium rates.

2.1.1 CHALLENGES FACED BY HEALTH CARE PROVIDERS

Cash flow was the main challenge for providers due to unpredictable revenues associated with FFS. Various factors contribute to this as summarized below:

- Delays in reimbursement associated with unpaid claims pending at the insurer end. This results in huge credit risks at the provider end when large amounts are outstanding.
- FFS is associated with high administrative costs due to the significant human resources costs in processing claims.
- Products that are currently available are complicated with varying levels of benefits, exclusions, limits, and sub-limits. These variations create administrative and operational complexities that are costly for providers.
- FFS predisposes providers to financial risks of rejected claims by insurers. For example, providers may not receive reimbursement due to exclusions or patient fraud. Some providers are forced to establish debt recovery systems.
- Pre-authorization processes associated with FFS are cumbersome leading to perceptions of poor customer service amongst policy holders
- The discharge process is complicated for some inpatient cases as providers have to bill for each service offered.

2.4 GROUP WORK SESSION: POTENTIAL SOLUTIONS TO THE CHALLENGES

Participants discussed solutions to the challenges raised in the previous session. The group agreed that the continued focus by private providers and insurers to targeting corporate clients is unsustainable with limited market growth. Participants also noted that there was need to increase access to private care through improved health insurance uptake. Private health insurance uptake is low; only about 2 percent of approximately 38 million Kenyans in 2009 had private health insurance coverage (Deloitte, 2011; KNBS, 2010). Although not all Kenyans can afford private health insurance and private medical care, a significant proportion could arguably afford them. Those who work in the formal sector, as well as those working in the informal and agricultural sectors have some disposable income to put towards paying for health insurance premiums; they comprise 23 percent and 28 percent of the Kenyan population, respectively (Deloitte 2011). However, to target these population segments, appropriate product design and better cost control strategies are required.

The group identified capitation for outpatient care as a credible intervention with significant potential to accelerate progress towards this goal. Other necessary preconditions for capitation models to succeed include:

- Collection and analysis of claims and membership data.
- Establishment of collaborative partnerships and relationships between private providers and insurers.
- Introduction of industry-wide transparent pricing methodologies.
- Formulation and implementation of clinical protocols.

The participants agreed that capitation, if designed and implemented in a collaborative manner by both private insurers and providers, could lead to increased market share for both, and improved access to private health services for more Kenyans.

Insurers and providers appreciated the fact that their challenges arising from FFS were known to the other party. Insurers admitted that it was the first time they had heard providers clearly articulate their problems and vice versa.

2.5 GROUP WORK SESSION: DESIGNING A BETTER PROVIDER PAYMENT MECHANISM

In this session, the participants were divided into two groups, each comprised of a mix of insurers and providers, to design an improved provider payment mechanism that addressed the challenges associated with FFS. The groups were also tasked to think about what problems they would encounter in implementation as well as strategies to overcome such challenges.

Group presentations are summarized in the following table.

TABLE 2: OUTLINE OF GROUP WORK PRESENTATIONS ON DESIGNING BETTER PROVIDER PAYMENT MECHANISMS

Features	Group 1	Group 2
Payment Mechanism	• Capitation for outpatient • FFS for inpatient and specialized services including dental and optical care	• Prepayment revolving fund with pre-negotiated case based payment (FFS) for services/conditions
Advantages	• Reduces administrative costs for insurer and provider • Improves cost predictability and control • Improves cash flow for provider • Incentivizes health promotion	• Improves cash flows for provider • Insurer gets a discount on services
Challenges	• Lack of standardization in care • Need for consumer and provider engagement • Providers maybe exposed to too much risk	• Does not fully eliminate risk of high claims ratios • May lead to undercutting amongst insurers • Does not reduce administrative burden because providers still need to complete claim forms
Strategies to overcome challenges	• Standardized, robust quality assurance systems • Tiered reimbursement for providers as they are not similar • Copayments to reduce provider risk • Reinsurance of provider to reduce risk • Active client and provider training and awareness creation on capitation • Simplified product design • Predefined capitated outpatient services including the common outpatient conditions • Insurers could develop non-insurance value-added services such as health promotion in partnership with healthcare providers	• Negotiating on feasible discount rates for both insurer and provider • Robust quality assurance systems

The group 1 model emerged stronger while the group 2 model did not fully address the challenges arising from FFS such as high administrative costs and better cost control/predictability. Various points were raised during discussions on implementation challenges and strategies to overcome these challenges as noted below:

Strategies to overcome providers' concerns included:

- Adequate change management in response to changes in procedures for billing and client care.
- Provision of further training for providers on how to manage capitation schemes.
- Inclusion of co-payments as vital piece of the mechanism to control use of services as well as preventing unnecessary access to specialist services.
- Reinsurance of providers to control providers' risk exposure.
- More effective communication regarding benefit exclusions by the insurers to clients to avoid patients blaming the provider for declining to deliver care that is outside of patients' benefit packages.

- Investment in managing relationships with clients. This would involve raising awareness and education on capitation to ensure there is buy-in from the clients.

Strategies to overcome insurers' concerns included:

- A tiered rate for providers operating at varying levels of efficiency and quality. Generation of data to inform pricing decisions.
- Standardization of products and pricing especially for common conditions. Standardized pricing methodologies would also enable insurers to compete on product quality and customer service as opposed to under-cutting one another as historically done.

Josef Tayag closed the day with a recap of the gains expected by a shift from FFS to capitation and comparisons of the impacts of the two models on both providers' and insurers' behavior as shown in the following two tables.

TABLE 3: OVERVIEW OF FEATURES OF FFS COMPARED TO CAPITATION

	Fee-for-Service	Capitation
Type of payment mechanism	Retrospective: providers are paid after they deliver care and submit claims	Prospective: providers are paid before they deliver care
Payment rate to health care providers	Variable, based on the intensity of care delivered and resources used	Fixed, regardless of the intensity of care delivered and resources used
Number of services delivered per payment	Each payment covers a single service delivered by providers	Each payment covers all agreed upon services delivered by providers
Are payments risk adjusted for patient characteristics?	No, because providers are reimbursed for the delivered services and costs incurred	Yes, because payments must consider the risk profile of the patients who are in the scheme
Is there a time frame for each payment?	No, because FFS is paid retrospectively	Yes, each payment lasts for a set period of time-typically one month
What types of services are covered?	Can include all services	Typically only out-patient services
Who is covered?	Anyone enrolled under a FFS-based, health insurance scheme	Anyone enrolled under a capitation based health insurance scheme

TABLE 4: COMPARISON OF THE IMPACTS OF FFS AND CAPITATION ON PROVIDERS AND INSURERS

	Fee-for-Service	Capitation
Financial risk for provider	• Delayed or unreliable reimbursement • Greater ability to control for all costs incurred	• Predictable and timely payments made in advance • Can make profits if costs are below capitation payments • At financial loss if costs are above capitation payments
Financial risk for insurers	• Unpredictable costs • Cannot control how much care is delivered • Must generally reimburse costs incurred by providers	• Predictable payments • Risks remain the same regardless of how much care is provided • Makes profits if costs are below the capitation payments • At financial loss if costs are above the capitation payments
Impact on administrative costs and care delivery	• More paperwork • Higher administrative costs • Less time spent delivering care •	• Establishing capitation rate is complex • Less paperwork • Lower administrative costs • More time spent delivering care
Incentives for providers	• Deliver high volume of care • Focus on curative care • Focus on less cost-effective delivery practices • Constant negotiations with insurers over reimbursement rates	• Deliver low volume of care • Focus on preventative care • Focus on more cost effective delivery practices • After agreeing on capitation rate can collaborate with insurers to improve efficiency
Incentives for insurers	• Constant negotiations with providers over reimbursement rates	• Develop capitation rate that aligns with provide costs and patient characteristics • After agreeing on capitation rate, can collaborate with providers to improve efficiency

3. WORKSHOP DAY TWO

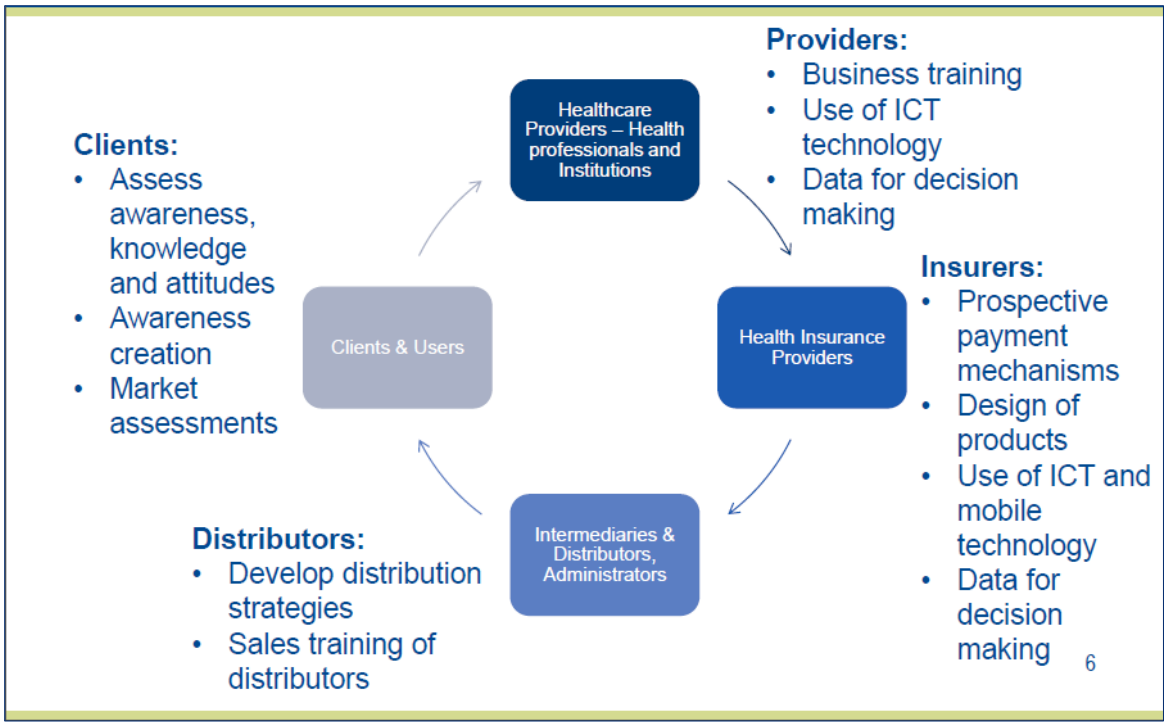
Day two started with a presentation from Agnes Munyua who gave more detail on the SHOPS project and its health care financing initiatives in Kenya. SHOPS Project goals in Kenya are to strengthen the private health sector to:

1. Increase number of lives covered through private healthcare financing mechanisms
2. Increase access to private sector services and products
3. Increase participation of private sector in policy processes
4. Provide data for decision making

Agnes demonstrated the untapped market potential for the private health sector in Kenya. An estimated 20% of the Kenyan population have health insurance while 23 percent of the population (approximately 9 million) employed in the formal sector and an additional 28 percent (approximately 11 million) working in the informal and agricultural sectors can arguably afford some form of private health insurance. This presents significant untapped potential for growth of the private health insurance industry.

SHOPS is developing interventions to increase health insurance coverage of Kenyans through the private sector by addressing the needs of different stakeholders in the health insurance value chain, as illustrated in the following figure.

FIGURE: OVERVIEW OF SHOPS INTERVENTIONS ACROSS THE PRIVATE HEALTH INSURANCE VALUE CHAIN



Agnes also highlighted other additional interventions by SHOPS Kenya beyond those presented above which include the following:

- Evaluation of the feasibility of forming a network among several Community Based Health Insurance schemes
- Evaluation of Changamka maternity card (a medical savings card for maternity care)
- Advocating for private sector engagement in healthcare financing policy processes

3.1 INTERNATIONAL EXPERIENCES AND LESSONS LEARNED

Josef Tayag presented lessons learnt from various countries which have implemented capitation schemes as shown in Table 5. These countries included Ghana, Thailand, Philippines, and South Africa.

TABLE 5: OVERVIEW OF LESSONS ON CAPITATION FROM INTERNATIONAL EXPERIENCES

Technical and Human Capacity	• Training health providers, hospital administrators, and health insurers on capitation-based systems is crucial to ensure buy-in and long term sustainability
Information Systems	• Providers and insurers need time and resources to develop new information systems for capitation-based payments • This is an administratively complex undertaking but is essential for capitation to work effectively • Developing these systems take time.
Regulatory Capacity	• Accountability and regulatory mechanisms are crucial for ensuring that providers and insurers work together effectively and reap the benefits of capitation-based systems
Adequate Capitation Rate	• Adequate risk adjustment is critical for creating a sustainable and effective capitation rate • Starting with a higher capitation rate and then reducing it allows providers to adjust to the new system (easier for national health schemes than private health insurers)
Risk Selection	• Providers may seek out healthier patients so as to reduce total costs; this needs to be monitored and regulated carefully.
Quality of Care	• To ensure satisfaction remains high, constant feedback from patients is crucial • Must track patient health outcomes and make sure that quality of care is not negatively impacted by changes in payment systems
Provider Satisfaction and Motivation	• Ensuring that providers are trained effectively and are paid adequately is critical for long term success and sustainability of capitation based systems • Changing payment systems requires communication and patience. Within provider and insurer organizations concern and conflict may arise over how such changes impact profits and job security
Resources use and Referrals	• To cut costs, providers may refer patients elsewhere for complex or costly medical care • They may also reduce the resources used to treat patients • This can reduce care coordination and negatively impact patient health outcomes
Trends in health Expenditure	• Capitation may initially result in rising health care costs, because the capitation rate starts too high or there is a soft cap on expenditures • It can take a while for providers and insurers to become efficient at using capitation

Access to and Utilization of Medical Care	• Monitoring patients' access to and utilization of medical care is crucial, as sick or low income populations can be negatively impacted from capitation based systems. • Patients may incur informal payments if providers are not regulated well

3.2 SESSION: CASE STUDY BASED ON AN UPCOMING GOVERNMENT TENDER FOR MEDICAL COVER

Participants were assigned to two groups with a mix of insurers and providers to respond to a mock tender for medical insurance cover, based on features of the recently released tender for disciplined forces, with the following features:

- The tender had been issued for provision of medical insurance cover for the disciplined forces spread across the country.
- This cover had previously been offered by the National Hospital Insurance Fund for the previous financial year ending June 30th 2014.
- There would be approximately 110,000 members and their beneficiaries estimated at a combined total of 440,000 lives.
- Medical cover would include including outpatient and inpatient care.

Both groups had similar concepts of capitation for outpatient services and FFS for inpatient services. The details for each group are included in Annex 3.The features that were seen as necessary for a successful capitation scheme are outlined below:

- Product benefits and exclusions should be simple to understand and administer.
- Robust quality assurance and cost containment measures.
- Inclusion of co-payments to ensure adequate risk protection for participating providers.
- Intensive client engagement from roll-out through to implementation.
- Development, implementation, and adherence to clinical protocols to ensure quality
- Traditional capitation models would likely need to be adapted by combining with FFS. This is essential when applied to large scheme whereby members are entitled to varying benefits. Majority of the members with similar benefits could be put on a capitation model with the minority with enhanced benefits put on FFS.
- Use of information technology to manage varying financial sub-limits for clients.
- Robust and customer-friendly referral systems.
- The size of the pool in capitation schemes is critical with smaller sized pools posing higher risks from past provider experience.
- There exists a perception that capitation is associated with lower income population as well as lower quality of care. Hence this may significant require outreach and promotion for new initiatives to overcome this perception.

4. CONCLUSION AND RECOMMENDATIONS

The workshop closed on a high note with providers and insurers eager to work together. Participants expressed renewed momentum to collaborate and partner in the introduction and adoption of PPMs and, in particular, capitation.

SHOPS committed to continue engaging with the industry to implement PPMs. SHOPS intends to pilot capitation within the private sector but requires opportunities that can be accommodated in the project's remaining life. The project ends September 29th, 2015. Possible areas of support from SHOPS include the following:

1. Design and setup of monitoring and evaluation systems for capitation.
2. Support for provider and client training.
3. Support for quality assurance systems for capitation.
4. Support in claims processing which could possibly ride on ongoing electronic claims processing initiatives.
5. Support in data generation and actuarial analysis.

The workshop closed with a satisfaction survey (Annex 4). Responses were positive and participants expressed their willingness to participate in the rollout of capitation models.

ANNEX 1: LIST OF ATTENDANTS

Name	Organization
Benson Chuma	SHOPS
Mbogo Bunyi	SHOPS
Agnes Munyua	SHOPS
Josef Tayag	Abt Associates
Catherine Kamau	SHOPS
Catherine Karori	Jubilee Insurance
Sammy Gakundi	Jubilee Insurance
Dr. Edward Rukwaro	CIC Insurance
Dr. Nelson Githonga	Consultant (GE)
Dr. E Wairira Murage	Savana HealthCare
Dr. Anne Wachira	Savana HealthCare
Dr. Frasia Karua	UAP Insurance Group
Isaac Nzyoka	UAP Insurance Group
Reyaz Shariff	MP Shah Hospital
Gordon Odundo	Gertrude's Children's Hospital
Daniel Etyang	Gertrude's Children's Hospital
Dickson Makau	Savana HealthCare
Winrose Kirima	UAP Group Insurance
Stephen A. Ongare	Mater Hospital
Mary W. Njuguna	Aga Khan Hospital
Dr. Denis Ogolla	Avenue Hospital
Dr. Paul Wangai	Avenue Hospital
Dr. Rose Kiura	Meridian Medical Centre
Dr. Richard Gichohi	Meridian Medical Centre
Pauline Ngatia	Aga Khan Hospital
Suresh Kumar	APA Insurance

ANNEX 2: GROUP WORK RESPONSES ON CHALLENGES OF FFS

	Provider Challenges	Insurer Challenges
Group One (insurers)	• High administration costs • Multiple insurers with different requirements • Delay in reimbursement	• Unpredictable and high claims ratios leading to losses • High administration costs • Mismatch in diagnosis and treatment • Provider over servicing; no incentives to be cost effective • High medical inflation worsened by FFS
Group Two (insurers)	• High administration expenses • Unpredictability of revenues • Claims rejection and delays in reimbursement	• Losses due to high claims ratios • Fraud and over servicing by providers • Costly paperwork and lack of data • Lack of standardization in care given • Significantly higher charges for insurances patients compared to cash paying patients
Group Three (providers)	• Delays in reimbursement with instances of no payment due to partial or full claims rejection • High admin and operational costs including high staff costs • Clients not understanding products and client dissatisfaction (e.g., due to unexpected exclusions) • Tedious preauthorization processes	• High administration costs • Costly paper work and lack of data
Group Four (providers)	• Significant cost of credit due to delayed reimbursement • Need to establish debt recovery units • Complexity managing different products with different benefits, exclusions and sub-limits • Pre-authorization processes associated with FFS are cumbersome leading to perceptions of poor customer service amongst clients • Discharge process complicated for some inpatient cases as providers have to bill for each service offered	• High operational costs thus inability to lower costs and make products affordable leading to low insurance uptake • Creation of mistrust and wrong perceptions between insurer and provider hence limiting partnership and collaboration

ANNEX 3: OUTLINE OF GROUP WORK ON CAPITATION STUDY

Group 1 Case Study Presentation

FEATURE	DETAILS
Inpatient	• 100% insured and on fee for service

Outpatient	• On a hybrid payment model:
	  ○ Capitation for primary health conditions: pre-determined common outpatient illnesses
	  ▪ Co-pay to control provider risk exposure
	  ▪ A form of sub-limits managed from the provider side to cater for members having varying benefits
	  ○ Fee for service for other conditions and specialist care
	  ○ Dental and optical care on fee for service with a limited co-pay
	• Lowered inpatient benefits /limits in the overall scheme in exchange for wider outpatient scheme benefits

Services	• Outpatient: comprehensive care for pre-agreed common primary health out-patient conditions that are capitated • Maternity cover for self or one spouse only • Referrals to specialists on FFS • Optical cover for limited pre-agreed services at select providers • Dental cover for extractions, fillings and specific tests at select providers
Critical factors to success	• Use of ICT especially for scheme administration and generation of data • Use of data for design making such as pricing mechanisms and negotiations with providers/beneficiaries • Improved working relationships between providers and insurers • Robust M&E and quality assurance systems with a joint accreditation team (insurers, providers and clients) • Rigorous consumer education, engagement and inclusion in decision making and quality assurance processes • Well-structured benefits, exclusions and limits

Group 2 Case Study Presentation

FEATURE	DETAILS
Inpatient	100% insured Supplemental cover to national social insurance scheme
Outpatient	Capitation-2 Options: 1. Consortium of various service providers or; 2. Set up of scheme specific clinics o Need to be branded according to staff and services available o Need to agree on minimum catchment population per clinic • In-house Clinics • Dental and Optical on Capitation with select providers
Services	• Outpatient: Primary care-consultations, lab and investigations, basic drugs per formulary, KEPI immunizations, radiology, routine X-ray and one U/sound per pregnancy, basic non communicable disease care • Referrals to panel of physicians as FFS • Specialized care: providers to manage specialized care on a referral basis which would be factored during pricing
Other features	100% insured last expense/funeral benefits
Critical factors to success	Use of ICT especially for Identification, enrolment and administration Well-structured benefits, exclusions and limits

ANNEX 4: SUMMARY OF WORKSHOP SATISFACTION SURVEY

1	**Overall, how satisfied were you with the speakers/presenters?**	**Answered**		**Very Satisfied**	**Satisfied**	**Dissatisfied**
		17		65%	29%	0%
2	**Did you feel the length of workshop sessions were too long, just about right, or too short?**	**Answered**		**Too long**	**Just about right**	**Too short**
		17		0%	88%	12%

		Answered		**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
3	**The content of workshop sessions was appropriate and informative.**	17		71%	29%	0%	0%
4	**The group sessions were of great value.**	17		76%	24%	0%	0%
5	**The objectives of the workshop were achieved.**	17		35%	59%	0%	0%
6	**The overall setting of the workshop was good.**	17		82%	12%	0%	0%

7	**What kinds of sessions would have improved the workshop?**
	- More players, - Actual financial analysis of capitation - Participants giving short personal input; more participant cases; sharing case studies of successful models around the world; more time on the case study - More background information to bring everyone up to speed - Some literature given ahead of time to study the theories and concepts
8	**List one or two promising business contacts established today.**
	SHOPS Providers: Avenue, Mater, MP Shah, Aga Khan University Hospital Insurance leaders and insurance companies serious on capitation
9	**Recommendations for next steps.**
	Continuous engagement; Technical Working group; working paper for further discussion Expression of Interest Action plan with timelines Request for session with Boards of Directors for providers Providers need further support understanding capitation
10	**Any other comments.**
	Excellent team; Program was well organized, Great workshop, the facilitators style and knowledge was exceptional It's a great start and we must not let this die

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