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RESEARCH ARTICLE

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Stakeholder perspectives regarding transfer of free maternity services to National Health Insurance Fund in Kenya: Implications for universal health coverage

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Summary

Background: Kenya is developing strategies to finance health care through prepayment to achieve universal health coverage (UHC). Plans to transfer free maternity services (FMS) from the Ministry of Health to the National Health Insurance Fund (NHIF) are a step towards UHC. We examined views of health workers and women regarding the transition of FMS to NHIF to inform the process.

Methods: In-depth interviews among 14 facility-level managers and providers, 11 county-level managers, and 21 focus group discussions with women who gave birth before and after the introduction of FMS. Data were analyzed thematically.

Results: The transfer is a mechanism of achieving UHC, eliminating dependency on free services, and encouraging people to take responsibility of their health. However, skepticism regarding the efficiency of NHIF may limit support. Diverse and robust systems were recommended for enrollment of clients while standardization of services through accreditation and quality assurance linked to performance-based reimbursement would improve greater predictability in the payment schedule and better coverage of referrals and complications.

Conclusion: Transitioning FMS to NHIF provides an opportunity for the Ministry of Health to sharpen its role as policymaker and develop a comprehensive health care financing strategy for the country towards achieving UHC.

KEYWORDS

free maternity services, health insurance, Kenya

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1 | BACKGROUND

Many low- and middle-income countries are exploring ways of financing their health systems. Appropriate mechanisms for mobilizing financial resources for health care remain high on the policy agenda for most low- and middle-income countries.[1-3] Chronic underfunding, weakly regulated health systems, and poor economic performance have necessitated alternative health care financing (HCF) mechanisms.[4,5] Additionally, health systems in sub-Saharan Africa have largely been funded through out-of-pocket payments.[1] Such payments constitute a barrier to utilization of health care services for the poor and disadvantaged and inhibit adherence to long-term treatment among vulnerable groups.[6,7] Out-of-pocket payments also contribute to household poverty and generate little revenue for the health system.[8-14] These concerns led to a shift in policy debates away from user fees as a way to finance health care towards development of prepayment and risk-pooling schemes,[15] which have gained momentum under universal health coverage (UHC) initiatives.[16]

In Kenya, several HCF reforms have been implemented since independence. In 1965, the government made universal health care a major policy goal by abolishing user fees. The National Hospital Insurance Fund (NHIF) was established in 1966 to provide health insurance for formal employees with mandatory payroll deductions. This continued until 1998 when the NHIF Act was amended to allow all formally employed Kenyans above 18 years to contribute to the fund, in addition to providing for voluntary contributions from Kenyans in the informal sector. Meanwhile, free public sector services continued up to 1988, when the government introduced user fees due to poor economic performance, inadequate financial resources, and declining budget.[12,17] The user fees were suspended in 1990 and later reintroduced in phases[12,17,18] in 1991. Following the reintroduction in 1991, fees were only charged for individual services such as drugs, injections, and laboratory services but not for consultation. A fee waiving policy to protect the poor was put in place, and children under 5 received free services.

In 2004, the Ministry of Health (MoH) implemented the "10/20 policy" for maternal health services in public facilities, which established a fee of 10 shillings at dispensaries and 20 shillings at health centers to register clients with a maternity card. This policy was intended to remove user fees in dispensaries and health centers that had been in place since 1991. The 10/20 policy did not identify replacement funding for these public facilities. In response, direct facility funding (DFF), a pilot project supported by Danish International Development Agency, was introduced in Coast region in 2005 to provide funds to supplement operating budgets at public dispensaries and health centers and enabled facilities adhere to the 10/20 policy.[19,20] Facilities receiving DFF were required to open a bank account into which funds were transferred directly from the national level. Decisions on how to spend DFF funds were made by the facility management team, in compliance with national guidelines.[21] An assessment of the pilot scheme indicated that the approach was a valuable intervention and increased finances for primary care facilities.[19]

During the same period, a health financing strategy was proposed through the creation of the National Social Health Insurance (NSHI) scheme for all Kenyans.[22] Under that arrangement, NHIF was to be reformed and linked to the comprehensive health insurance for all Kenyans. The 2004/2005 NSHI bill was debated in parliament but was met with resistance from various stakeholders. Although contested, the bill was passed in parliament but the president declined to sign it into law due to technical and political reasons.[23] In 2007, the Kenya MoH rededicated itself to expanding free maternal health services in public facilities. The 10/20 policy was removed, and a policy of no user fees was declared; however, no alternative source of funding was offered and informal fees remained in place.

In addition to the removal of user fees, the Kenyan government tested several strategies to increase access to services for the poor and improve financing for facilities where user fees had been removed. One such initiative aimed at subsidizing maternal and reproductive health services for the poor through the use of a targeted voucher to the beneficiary and results-based reimbursements to contracted public and private facilities.[24] The voucher program was piloted by the Government of Kenya as an alternative approach for further expanding access to care. The reproductive health output-based approach voucher program aimed to make high-quality maternal health, family planning, and gender-based violence services more available and affordable for poor women.[24,25] On the demand side, the

voucher program sought to reduce the undue financial burden of seeking maternal health services by selling highly subsidized safe motherhood vouchers covering the costs of 4 antenatal care (ANC) visits, facility delivery (normal and cesarean), and postnatal care. These vouchers were sold for $2 and specifically targeted poor women, as determined by a standardized poverty grading assessment administered to each potential user. On the supply side, the voucher program sought to expand provider choice and improve quality of care by enrolling both public and private sector lower-level and referral facilities into the program. Facilities that met certain minimum standards could be accredited for participation in the program and were reimbursed at standard, prenegotiated rates for each voucher service provided. Additionally, periodic quality assurance assessments were conducted and facilities that failed to uphold the minimum standards risked losing their accreditation. The voucher program was implemented in phases from 2006 to 2016 by the Kenyan government with support from the German Development Bank (KfW). In the first phase, from 2006 to 2009, the voucher intervention was piloted in 4 counties (Kiambu, Kisumu, Kitui, and Nairobi). Following the pilot, the program was expanded to one additional county (Kilifi) as well as to additional facilities in the pilot counties, and implementation continued until late 2016. The results of this initiative indicated promising opportunities for improving access, coverage, and quality for targeted low-income beneficiaries.[26-30]

Following the failure of the 2005/2006 NSHI bill, 2 years later, Kenya embarked on a process to develop a HCF strategy. A draft HCF strategy was started in 2009, but this was not finalized due to lack of effective linkages with social security sectors; limited involvement and coordination of key government departments and lack of explicit and systematic stakeholder analysis; poor communication; and limited public debate.[31] The 2009 HCF strategy proposed 4 central pillars: (1) Kenya moves towards UHC through social health protection; (2) all Kenyans must belong to a health plan; (3) health needs of poor and vulnerable Kenyans be catered for through direct government support and subsidy; and (4) a health benefits regulatory authority for the sector be established. In 2011, the government developed a session paper towards UHC that sought to transform the NHIF into a Social Health Insurance Fund in line with Kenya's Vision 2030.[32]

Later in 2012, the MoH commissioned a review of HCF options with support from the Partners for Health consortium. The review identified strengths and challenges to be addressed in the finalization of the strategy. Key areas of consensus included the need to (1) improve social health protection, by enrolling all Kenyans in a health financing plan; (2) move towards prepayment system, which can be financed either through tax and/or health insurance; (3) improve the effectiveness, quality, efficiency of the health financing system and NHIF, and public budget execution mechanisms; (4) develop a uniform basic benefit package; (5) develop purchasing capacity and sustainable instruments for third party payers; and (6) retain pluralistic services delivery and autonomy of public hospitals.[31] Following the recommendations, the MoH put in place the HCF interagency coordinating committee and established a UHC steering committee.

Amidst all the initiatives to reform the sector, the 2013 general elections led to a change in government and subsequent shift in policy with the new government announcing that maternity care and primary care would be free in public health facilities. Under this system, the government directs output-based payments to public facilities that report quarterly numbers of maternal deliveries. A few studies have been conducted to assess the implementation and experiences of free maternity services (FMS) with varying results.[33-35] Given discussions and the evidence generated on FMS implementation, the idea to consolidate FMS policy with the existing prepayment scheme was suggested in 2016. Plans were made to transfer FMS to NHIF and potentially transition to a health insurance in future in line with the current health policy framework.[36]

To inform implementation of shifts in government policies on user fees in Kenya, we examined the views of frontline health workers (providers, facility, and county managers) and women in the corresponding communities regarding the transition from FMS to NHIF. Understanding the perspectives of these stakeholders is important for informing the design and implementation of health care policy initiatives as they play a crucial role in service delivery or uptake. The paper specifically focuses on the lessons learnt from the implementation of FMS that can inform the transition to the NHIF, the changes needed to make the transition feasible, and how the process could contribute to wide uptake of a prepaid scheme.

2 | METHODOLOGY

2.1 | Study design

Findings presented here are part of a larger study that aimed to assess the effect of changes in user fee policies on maternal health care utilization from 1995 to 2014 in Kenya. The larger study used a pretest and posttest design with a comparison group. Preintervention (pre-FMS policy) data were from a 2012 study that evaluated the effect of the reproductive health vouchers program in Kenya on health outcomes by comparing communities in voucher and comparable nonvoucher sites.[26-30] The postintervention data were collected in the same communities included in the 2012 study and involved both quantitative and qualitative components. The qualitative component, which provides data for this paper, aimed to identify the process and complexities of implementing FMS, understand factors that influence women to seek facility-based deliveries with and without user fees, and examine stakeholders' views regarding the transitioning of FMS to NHIF.

2.2 | Study sites

Data were collected between August and September 2016 at the facility and community levels in counties where the reproductive health vouchers evaluation project was implemented. These included former voucher sites of Kisumu, Kitui, and Kiambu and nonvoucher sites of Makueni, Nyandarua, and Uasin Gishu counties.

2.3 | Data collection

At the facility level, in-depth interviews were conducted with 2 categories of purposively identified key informants, namely, facility-level managers and providers (n = 14) from primary health facilities with high-volume deliveries and one referral hospital and county-level policy makers (n = 11). We explored the process and challenges of implementing FMS and the key informants' views regarding transitioning FMS to NHIF.

At the community level, focus group discussions (FGDs) were conducted with purposively identified women aged 18 years and above who gave birth before and after the introduction of FMS (Table 1). A total of 12 FGDs were conducted in the former voucher sites—3 each with women who gave birth before and after the policy shift and used a voucher and another set of 3 each with women who gave birth before and after the policy shift but did not use a voucher. Eleven FGDs were conducted in nonvoucher sites: 2 with women who gave birth in facilities before the policy shift, 3 with women who gave birth in facilities after the policy shift, and 3 each with women who delivered at home before and after the policy shift. Trained research assistants with experience in qualitative studies and had undergone training in research ethics collected the data. The interviews were conducted in English or Kiswahili depending on the preference of informants and were audio-recorded with the consent of participants.

2.4 | Data management and analysis

The data were transcribed, translated into English where applicable, and exported to NVivo (version 11) for analysis. Concurrent data collection and document review facilitated the interpretation of results and allowed refocusing of issues to be explored further during interviews. We analyzed the data in an iterative process by describing the nature of the implementation of the FMS policy at facility and county levels and examining respondents' views regarding transitioning from FMS to NHIF.

Analysis was based on inductively derived themes from the transcripts. Broad issues identified during the analysis were validated through a consultative process among the research team and the implementing agency (MoH) in dissemination meetings and other forums. This discursive, team-based approach to analysis corroborated information from multiple data sources, along thematically organized ideas that shaped inferences made. Data were then organized in analysis charts within and across sites and by type of participant to provide in-depth understanding of issues.

TABLE 1 Summary of study participants

Category of Study Participant	Nonvoucher Sites	Former Voucher Sites
In depth interviews—facility level		
Maternity in charge	1	2
Facility in charge	2	0
Nursing officer in charge	2	2
Medical Superintendent	3	2
In depth interviews—policy level, county		
Chief executive for health	2	2
County director of health	1	2
Deputy Director of Medical Services	1	0
Health administrative officer	0	1
Reproductive health coordinator	0	1
NGO stakeholder	1	0
Focus group discussions		
Women delivered in facility before policy shift	3	NT[a]
Women delivered in facility after policy shift	2	NT
Women delivered at home before policy shift	3	NT
Women delivered at home after policy shift	3	NT
Nonvoucher users after policy shift	NT	3
Nonvoucher users before policy shift	NT	3
Voucher users after policy shift	NA	3
Voucher users before policy shift	NA	3

[a]Not targeted in the study.

Written informed consent was obtained from all study participants. The research protocol was approved by the MoH, AMREF's Ethical Review Board (P222/2016), and the Population Council's Institutional Review Board (Protocol 727).

3 | RESULTS

Perceptions of stakeholders regarding the transfer of FMS to NHIF is presented under 2 main cluster of themes. Firstly, we present views on transition of FMS to NHIF by illuminating support for the transfer, perceived benefits, and challenges of the transition. The second cluster of themes describes the future of provision of maternity services under managed care in NHIF including processes for registration and enrollment of clients, accreditation and quality assurance, reimbursement process, managing referrals and complications, and the benefit package. Additional information is presented on the mechanisms for sustaining the fund once the transfer is effected.

3.1 | Perceptions regarding the transfer of FMS to NHIF

There were varied levels of support for the transition from an output-based reimbursement scheme under the MoH to a managed fund approach under NHIF. County and facility managers reported that, in principle, the transfer is good as it will help in achieving UHC. However, they pointed out that the process should be anchored within the law that governs financial processes under the devolved structures of government:

Let me say to begin with, the idea is well-thought out, because I believe that the idea is towards having UHC, which is where the country should be moving to … But every system must work according to the law. The Public Finance Management Act states that all County money must come through the County Revenue Account. Reimbursements for maternity are meant for the County, so as much as it's a well-thought idea, it should be aligned to the law—County Manager, former voucher site

Some participants viewed the transfer as an opportunity to eliminate dependency on free services and encourage people to take responsibility of their health and free resources for development.

No government can provide free things because somebody must work, even if we are getting free services somebody is being taxed somewhere. The example is the issue of free primary education and now free maternity, then we are talking about a very high taxation so that you cannot support most of these free things, that is why we need to move towards the insurance way where everybody chips in a little to cover those with a problem—Provider, nonvoucher site

Over time, you know, as more and more people enroll, it lessens the burden on the government so that the government can invest more in development projects. You know, you develop the country if people start taking responsibility for their health …—County Manager, nonvoucher site

Managers recommended that the government should support the transition before individuals begin paying. They suggested that eventually, the approach should adopt a contributory element to reinforce a sense of responsibility. They noted that the move will increase coverage of comprehensive services and improve standardization of services provided. They, however, pointed out that support for the transfer will be realized if funds are availed in a predictable manner and the efficiency of NHIF is improved.

I said insurance is the way to go but …. I look forward for that day when every Kenyan will want to take responsibility for their own health and enroll in an insurance scheme to broaden the scope of coverage so that for those who have taken up the covers, they get services for most ailments—County Manager, nonvoucher site

You see, NHIF already has a wide reach; it is already national. All that is needed is how NHIF records its clients; it needs to be more aggressive in recruiting clients, in creating awareness because as we know currently NHIF mostly reaches people in the formal sector. Those who are employed get deducted from their sources but we have most Kenyans who are in the informal sector, they form the larger part of the entire population and so that should be the first target—Facility Manager, former voucher site

Despite the common understanding of health insurance as a driver for achieving UHC, participants raised several concerns. Many pointed out the challenge that poor women would face in paying the premiums. Women and providers reported that the transfer will improve insurance cover for other illnesses and the family at large. However, they expressed fears of dropping out if the monthly premium of KES 500 (USD 5) is retained. Lack of flexibility in the monthly premiums to cater for the diverse populations working in the informal sector was mentioned as a likely barrier to enrollment of clients in the scheme and effective utilization of services.

This will be costly because with the NHIF there are monthly payments that are required yet you find that most women are not employed. They are housewives. So, for her to get money to pay monthly is difficult. You cannot rely on the husband with the little money he gives you for food. You save a little and go pay at the end of the month and doing the same the following month might be very difficult—FGD, nonvoucher user in former voucher site, delivered after policy shift

The poverty levels here are quite high so some people are not able to afford even the little KES 500 per month. Some people will have a challenge, some are living from hand to mouth; they don't have stable jobs. Others are also single mothers depending on their parents—Provider, nonvoucher site

Other participants noted that lack of personal responsibility contributes to poverty and needs to be addressed through appropriate information, education, and communication approaches:

> *There's a lot of education that needs to be done on the need to plan and take responsibility through financing health through insurance and not expecting the government to take the responsibility. Because the same way you don't expect the government to pay your fare from here to (name of place) and that's where you go to work and come back here every day and somehow you will get the fare. A day's fare is enough to pay a whole month's insurance but you just want free things … I tend to think the sustainable way is people taking responsibility and owning their own health—County Manager, nonvoucher site*

Participants suggested 3 alternatives for addressing the cost concerns. First, both managers and women concurred that the system should allow women to pay through a flexible model with less frequency to cater for unpredictable income. Second, there were suggestions to reduce the monthly premiums to the previous amount of KES 160 (USD 1.60) or KES 200 (UD 2.00) and subsidize the remainder. Alternatively, there were suggestions of having graduated payment of KES 250 (USD 2.50) or KES 160 (USD 1.60) for informal workers and KES 500 (USD 5.00) for in formal employees or those with spouses in such employment. Similarly, some women recommended discount approaches.

> *It can be that we pay one hundred shillings [USD 1] after every two months so that we pay in the first month then we skip the second month and pay in the third month—FGD, nonvoucher user in former voucher site, delivered after policy shift*

> *… We can ask NHIF to discount because the only time she may seek any services out of that money is for that delivery; however, it can be used for other services. Secondly, it would mean that all pregnant mothers would have access and this will discourage home delivery because they know when they come they will get the best services, almost like what you'd get in a private institution … so it's a win-win for everyone. We minimize inconveniences, the hospitals get more money, if it's expanded properly we reduce mortalities and morbidities—Facility Manager, former voucher site*

Some participants preferred group and flexible payment schedules for logistical purposes and to reduce penalties. One manager suggested that renaming the program was another solution that may alleviate discontent among beneficiaries:

> *I think we need to rename it … it needs to be called universal health care rather than free—County Manager, nonvoucher site*

Critics of the transfer of FMS to NHIF viewed the existing Public Finance Management Act as hindering easy access of funds by facilities.

> *The intention is having that money sent through NHIF, which I am yet to look at the mechanisms against the current one where money is being sent to the county revenue account. Either system will work, so long as the money reaches the hospital on time. The only problem is I do not know how well the Act will allow the money to go to facilities. I do not know whether there will be a problem there, but either way all we are asking is that the money gets to the hospital, to the user, on time—County Manager, former voucher site*

Skepticism about the efficiency of NHIF was linked to late payments and general distrust of public institutions. Doubts were cast on NHIF's ability to manage the added responsibility and process claims promptly.

> *NHIF has a developed system and it is not as bad as the FMS fund. So perhaps the issue of delay may be addressed with the NHIF. What I do not know is whether NHIF has grown, whether the capacity currently*

as enjoyed by NHIF will be able to handle this added responsibility. That is something that will need to be addressed. For example, the NHIF regional office is grossly under staffed and they will come and tell you we have a problem with staff so I'm only worried that with this added responsibility things may not be as smooth—County Manager, nonvoucher site

There are so many changes which need to be done to the NHIF. Why the managers don't trust NHIF is because of the delays. We are not sure of what we are being paid for. The community [members] feel that they are putting their money where that [NHIF] card cannot be used, it can only be used in the government facility; it cannot be used in a private facility because they say that your money is not enough. You see, so these are the things which make them say no to NHIF. If I have a problem and I want to go to [name of private facility], they are told that your card cannot give you service here—Health Administrator, former voucher site

There were also questions about NHIF's ability to target all pregnant women. Participants indicated that given high levels of poverty (and low awareness of changes in health policy), effectiveness of the transfer would be challenging without adequate sensitization of the community. They reported that the transfer might be an easy sell in a context where voucher cards were used; however, in locations where NHIF is not visible, it will take time to get acceptance with people adopting a wait-and-see attitude.

Previous history of NHIF might also affect the transition. The perceived lack of transparency, NHIF performing all health insurance roles, little reimbursement rates for private sector, and a history of delays drew mixed reactions. A perceived mismatch of the accreditation process that NHIF uses versus that of quality assurance for maternity services and changing the perception of people from free to any form of payment might generate resistance and create mistrust.

You see, it's the reversal from free to a payment method that will bring speculation as to whether free maternity concept was well thought out at inception because probably people will start saying why were they not asked to continue paying to supplement the government? Of course, the other bad thing is when you have the free thing coming it gives a bad impression to the public. There is nothing for free; someone is paying for it, so now reversing that culture of getting used to free things will also come with its own resistance—Facility Manager, former voucher site

3.2 | Registration process and enrollment of clients

One crucial element of the transfer is ensuring the right clients are enrolled into the system. Respondents opined that logistically, the registration of women can be done during ANC visits, in churches, or through local chiefs' *barazas* (meetings). They noted that although registration through chiefs' *barazas* might be expensive, it will help in effectively targeting of poor women. They indicated that targeting women through ANC is, on the other hand, likely to help profile potential complicated cases early and reduce potential emergencies.

The most convenient place maybe is our antenatal clinics; and then maybe we can use the community health volunteers to map the villages because pregnancies are seen by everyone so they can reach them easily. Maybe through chiefs' barazas [meetings] or churches—Provider, nonvoucher site

This could happen at multiple fronts …. so if I have to make sure that this thing succeeds I must do all I would do; the radios, the press, use the civil society on the ground; people must be taught. I always believe that NHIF may not have done much because nobody talks about it in the village and we have been doing a lot of harambees [fund-raising] to pay medical bills. Some sell their land for the same, so if you ask me, let the government also develop a good policy to reach the community—County Manager, nonvoucher site

Women proposed that the distribution points for the NHIF cover be diversified, with some suggesting that the enrollment of women could be done using organized groups. They, however, pointed out that correct information must be given to clients at recruitment to avoid questions about how they should pay under NHIF.

3.3 | Accreditation and quality assurance

The discussion on the accreditation process focused on 3 main areas: need to increase coverage of services, standardization of care, and performance linked to reimbursement. Regarding coverage, some respondents noted that lack of accreditation limits coverage of public sector services as many facilities are not accredited under NHIF. They suggested that a grace period to allow facilities to adhere to standards with funds advanced to them to improve their status was one way of bridging the gap as lack of funds limits improvement of facilities to meet the minimum standards required:

> *They have been trying to insist that the hospitals do accreditation but you will find that as far as accreditation is concerned, there is what you can do without finances and some you must have finances. One of the biggest problems you will find in management is that finances are low. If, for example, you will look at some of the things you want to improve but then your needs far much outstrip the amount of money you have, so quality will still be an issue. Take for example the lab. You know the services that should be provided by a level 5 facility and you're willing to budget for the same but the amount that is available for you to budget [with] is not adequate. So, it means that there are some services that will not be provided to the standards. That will affect accreditation—Provider, nonvoucher site*

Accreditation was perceived as a means of ensuring standardization of care for a minimum package of services with extra services being charged separately, particularly in areas where private sector facilities increase client choice and competition.

> *I think we should make sure we have one accreditation system for health facilities, which means that you assess the services you want to provide against your ability to provide those services per standards. If that can be done for any facility, that means that the woman can go anywhere because there will be a minimum standard which these people will expect you to comply with. But if you want to give additional services like in the private hospital, mostly related to hospitality then that is charged separately—County Manager, former voucher site*

Other participants noted that facilities should be accredited based on the nature of services they offer, structured by level of care, and linked to reimbursement rates. Some felt that if facilities were accredited based on performance, people would have a sufficient pool of outlets to choose from.

> *It is welcome because it ensures women continue to receive quality care and it would even be better if it is standardized nationally so that there is some national accreditation process that is agreed [upon] and therefore the service provided to a woman in one part of the country is the same as in any other part of the country. And then the facilities can be accredited based on the complexity of the services they offer and even the reimbursement can be classified based on the accredited level—Facility Manager, former voucher site*

> *We have never had a framework where we can categorize all our institutions using performance as a benchmark. What we have been doing is categorize them by levels of care, we have never accredited them either using ISO [International Organization for Standardization] or any other modality to categorize performance. As far as I am concerned, the time to accredit institutions has come so that people can also choose for themselves that this institution performs better than this one so the ones that are underperforming can also start emulating and vice versa—Facility Manager, former voucher site*

3.4 | Reimbursement process

Most respondents noted that the existing levels of reimbursement are generally low and do not reflect actual costs, which is an indication of the need to cost services to ensure that the rates fully consider the cost of consumables. In addition, there were concerns of cost escalation with some participants suggesting the need to regulate cost of maternal health services, especially delivery and cesarean sections. They proposed that reimbursements should reflect the existing NHIF rates for delivery services. Under FMS, rates were differentiated by level of care, which led to a general perception that such rates were discriminatory, particularly when considering the private sector whose costs are higher than those of the public sector. Some participants mentioned that NHIF's low reimbursement rates and delayed payments would negatively affect private sector participation in the scheme.

> *They will not participate. Private facilities depend on money; they pay their workers using money. Unlike the government where the money comes from central government, these guys have to pay their workers. They must pay supplies, they must provide the services, they pay in cash and there is an extent to which they can get credit lines extended. It means within a short time if the money is not being reimbursed, they no longer accept to attend to the NHIF patients or other insurance agent who might be providing services—Provider, nonvoucher site*

Participants suggested that careful considerations should be made regarding the reimbursement process to improve the predictability and consistency of payment schedules to help managers plan appropriately. They suggested that the notion of facility autonomy, with direct access to funds, should be reinforced with guidelines that ring-fence the funds to ensure that the county governments do not use it for other purposes. They felt that such actions, when accompanied with flexibility for facilities to use the funds without restrictions, could improve operational efficiency. One participant suggested the creation of an emergency or reserve fund, which counties could use to support facilities whenever there are delayed payments from NHIF. Overall, participants were of the view that the reimbursement process will require a strong automated claims process to create credibility and efficiency and to ensure that funds reach facilities without violating the finance act. They suggested that to improve accountability on use of funds, there is need for the MoH to provide guidance on how the funds could be utilized to ensure structured utilization of funds to improve maternity services. They further pointed out that efficiencies can be improved by ensuring that NHIF core functions (such as claims review and payment) are decentralized to ease the process of claims and transfer of funds.

3.5 | Benefit package

Women and providers preferred a basic package that could be adjusted as needed over time. They felt that the package should cover ANC consultation fees, drugs, pregnancy-related tests, treatment for newborns and the mothers up to 1 year postdelivery, complications, cesarean sections, and treatment for children under 5 years. They also suggested that the package could include the whole family although some were quick to point out that cost barriers may limit sustainability beyond the pregnancy period.

> *I thought that it should cover them through the antenatal period, during delivery and the postnatal period because all the phases are very important. We not only look at the antenatal period and even delivery, we are also interested at the end of the day they are healthy by the time they finish postnatal period—Provider, nonvoucher site*

> *I think the package ought to have antenatal care including laboratory test during antenatal care. It needs to have the emergency transport, referral for the delivery itself whether normal or abnormal delivery, caesarean section, because sometimes even normal delivery complicates and people end up in intensive care unit. I think those ought probably to be taken care of in the package and probably some element of postnatal care, after deliveries, because for us, we have observed that there are a lot of mothers dying after delivery, so postnatal care would be important to include—County Manager, former voucher site*

I also think that if this card [NHIF] could take care of the period after discharge, because the baby might get sick. I should be able to bring the baby back to the hospital for some considerable months and the card takes care of the bills. I, as the mother, could also get sick. Apart from that, if they could include other things like towel then the treatment could be better—FGD, nonvoucher user in former voucher site, delivered after policy shift

Suggestions to cover other additional elements like basic needs for delivery, such as cotton wool and sanitary pads, were common among women who had received additional incentives such as soap or a packet of sugar.

I am talking from experience, you can get to the house but even a piece of soap to clean the baby's stuff is not available. So, they can give us things like half kilogram of sugar and half bar of soap—FGD, nonvoucher user in former voucher site, delivered after policy shift

Finally, there were confusions among women as to what is likely to be included in the benefit package after transfer. The process of accessing the benefits was also perceived as cumbersome due to the identification process of the user via existing NHIF system.

3.6 | Managing referrals and complications

There were several suggestions on how to manage referrals. First, participants noted that compensation for services provided before referral is not catered for currently. They therefore suggested that facilities should be reimbursed based on the services they offer. For example, facilities that offer services prior to referral could be compensated for consumables, which requires a structured claims process with details of service type and a well-defined cost structure.

I think referrals should be dealt with individually; a facility should be reimbursed separately for the treatment of the patient or delivery … if mother complicates and necessitates a referral, now the facility receiving the referral will provide a different service which should now be paid for separately. Maybe the fund should have such an allowance—Facility Manager, former voucher site

Participants felt that the transfer of FMS to NHIF has the potential to improve documentation, claims processing, and data management. They indicated that inclusion of transport costs and private facilities in the scheme may improve referrals, but the government and communities should co-pay to ensure high enrollment and sustainability of the program.

Referrals are a bit complicated but the facility that is making the entire management to the end is the one seeking reimbursements. I think this will be a bit complicated … because when they refer in normal circumstances they say they get their payment from their client and the hospital gets the rest, but when it comes to free maternity, they may not share this one client. Maybe the data goes to another facility so I think there will also be a lot of confusion—Provider, nonvoucher site

3.7 | Sustaining financing for maternity services

To develop and sustain the behavior for saving for health care, participants reported that educating people on the need to save for health would build a culture of prepayment, a key ingredient for successful transition and sustainability. Notably, they mentioned that the transition provides an opportunity to improve not only general infrastructure for maternity services but also health system broadly.

To ensure financial continuity during health policy reforms, participants noted that setting up a seed fund for facilities may help to minimize financial gaps that negatively affect service delivery. Additionally, implementing a

consumption tax on tobacco and alcohol (eg, "sin taxes") earmarked and channeled to a county health fund could cushion facilities from challenges of untimely disbursements. Others suggested that diversification of sources of funds at local level such as the constituency development fund (introduced in 2003 to support grassroots development projects in Kenya), women's savings groups, and other initiatives from donors could further support such a fund.

Participants recommended a wider resource base by focusing on informal sector through flexible payment mechanisms. They suggested that where people cannot afford, an effective waiver through NHIF can be implemented. This could be in the form of a social security system to cater for the indigent with supplements from the county. They, however, pointed out that such initiative will require strong accountability systems and a well-designed electronic system that manages claims and reimbursement processes.

> *I think with the good IT [information technology] and data system, it will be very easy like if we all went computer way; it will be easy for us to monitor to know what is really being contributed versus what people are spending—Nursing officer in charge, former voucher site*

Participants noted that the strategy needs to be anchored in law and policy to remove uncertainties of continuity of FMS beyond the term of the current government. Overall, the respondents observed that if well supported with better and efficient system, the FMS can positively impact maternal health. They felt that any reversals in the policy will mean a major setback as the system has begun to wean people out of home deliveries. Respondents spoke of the need to consolidate all financing programs for maternal and newborn health under one roof and to improve efficiency and rates of reimbursement to reflect actual costs. They observed that a results-based financing option to create competition for supply of health services can be developed to ensure that a substantial proportion of funds reimbursed is used to improve maternity and other health services.

4 | DISCUSSION

This paper examined the views of women, providers, facility, and county managers regarding the transfer of FMS to NHIF as part of managed fund. Overall, participants supported the transfer but observed that this should be a transitional process towards introducing health insurance together with adequate health sector development strategies. They felt that such an approach will contribute towards achievement of UHC goals.

To ensure effective implementation of FMS by NHIF, 4 issues are pertinent. They include (1) adequate stakeholder consultation; (2) better fund management when FMS is transferred to NHIF; (3) well-defined costed benefit package; and (4) activities to minimize attrition.

First, a consultative process is critical in ensuring stakeholders are informed of changes needed at both user and system levels. There appeared to be limited understanding among all study participants of the details of the transfer. This was the case especially on issues of enrollment, reimbursements, the benefit package, and how the transition from managed care to a prepayment scheme will be actualized. Lack of sufficient information was also evident from discussions with women, implying that hurried implementation of the transition may make it difficult for intended beneficiaries to understand the dynamics and requirements just like the case of FMS, which was implemented within 100 days following a presidential directive. Adequate communication process and working with county teams to facilitate understanding of the transfer will be a critical driver of success. Lack of proper preparation often leads to poor implementation of policies as was evident from user fee removal initiative.[17,37] In addition, there has been a disconnect between knowledge on removal of user fees for health care, on the one hand, and how that knowledge is taken into account in public policies, on the other,[38] a gap that will need to be bridged when implementing UHC policies.

Secondly, the transfer of FMS to NHIF will need efficient fund management including reimbursement processes. Ability to access funds on time at facility level and align the transfer with devolution laws such as those that govern public finance is likely to lead to success. The reimbursement process should be accompanied by approaches that ensure facility autonomy, which has the potential to increase efficiency, create greater local accountability and

participation of communities, improve staff motivation and performance, increase resource mobilization, strengthen hospital management capacity, and improve quality of health service delivery.[39] Recent assessment of the effect of devolution in Kenya indicates that devolution of health services to county level has reduced health facility autonomy.[40] This has compromised functioning of health facilities by weakening management and leadership capacity, reducing staff motivation, and limiting community participation in facility affairs. It has also created inefficiencies in service delivery due to delays in procuring supplies and increased bureaucracy, thereby compromising quality of care.[40]

Thirdly, ensuring that the benefit package under the scheme is well defined, costed, and aligned with other prepaid schemes under NHIF management will be critical. The process provides a unique opportunity to consolidate existing schemes under NHIF and build capacity of claims processing at the county level. This will create trust in future endeavors geared towards implementation of an NSHI fund. Transitioning of women enrolled under the managed fund program to a prepayment scheme within NHIF will offer an opportunity to increase the coverage of health insurance. However, there appears to be a "black box" in the transition process that needs to be defined and communicated effectively to users. If well managed, the transfer is likely to contribute towards a culture of health insurance and UHC in general. In essence, this will increase transparency, help mitigate demand-side costs of services, and provide funding that promotes transparent charging for services.[41]

Finally, there were several concerns around the transition to the prepaid scheme after delivery and the need to design innovative strategies to minimize attrition. Due to wider economic challenges, unaffordability of the requisite premium among most women may necessitate adequate targeting and use of subsidies. There may be need to design packages that will define a flexible prepayment model that fits various income groups as a way of preparing the population towards a mandatory social health insurance scheme. Suggested strategies such as graduated payments, subsidies, and discounted approaches can be consolidated via technology as several mechanisms have already been tested in the market through private sector initiatives.

5 | CONCLUSION

Transitioning FMS to NHIF provides an opportunity for the MoH to use lessons learnt and existing evidence to develop a comprehensive HCF strategy. Our evidence suggests that health system managers, providers, and beneficiaries are likely to support a prepayment scheme that will increase coverage of health insurance as part of UHC. However, there may be need to harmonize this process and interrogate suggestions on design as well as practicality of the transition towards a social health insurance scheme. Suggestions to define a benefit package and cost it, improve the accreditation system, improving the registration process, and use technology to support a robust reimbursement system will help create structures for UHC goals. Finally, a lack of understanding of the details of this policy shift calls for a targeted communication strategy that accompanies the transition with clear strategies of sustainability of the program.

AUTHOR CONTRIBUTIONS

TA was involved in the conceptual design of the study, data collection, analysis, drafting, and revision of the manuscript. FO was involved in conceptual design, data collection, and revision of the manuscript. DM was involved in the analysis, drafting, and revision of manuscript. MLD was involved in the data analysis and revision of the manuscript. BB was involved in the overall conceptual design of the study and revision of the manuscript. All authors have read and approved the final manuscript.

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