KENYA NATIONAL ASSEMBLY

TENTH PARLIAMENT- FOURTH SESSION

THE DEPARTMENTAL COMMITTEE ON HEALTH

REPORT ON ALLEGED IRREGULARITIES ON THE ROLLING-OUT OF THE CIVIL SERVANTS' OUT-PATIENT MEDICAL INSURANCE SCHEME

May 31, 2012

(VOL. I)

Clerk's Chambers
Parliament Buildings
NAIROBI

May, 2012

CONTENTS

PREFACE 7

ACKNOWLEDGMENT 11

ADOPTION OF REPORT 12

THE NATIONAL HOSPITAL INSURANCE FUND: BACKGROUND 13

THE HEALTH SECTOR 13

Section 43 (Chapter 4 – Bill of rights) 13

The Heath Sector 13

Health Financing 13

Human Resources 14

Physical Infrastructure of public health facilities 14

The Disease Profile 14

Health Sector Insurance 15

Recent Growth 17

Mandate of NHIF 18

Legal Framework 18

THE PILOT PHASE ON CAPITATION (2009-2011) 20

Background 20

Out-Patient Pilot 20

Out-Patient Cover Pilot Rationale 21

Out-Patient Cover Pilot Benefits Package 21

Sample Population under Capitation Method 22

Accreditation of Healthcare facilities 22

Project Implementation 23

Findings 23

Findings with Capitation Payment 24

THE MEDICAL INSURANCE COVER FOR CIVIL SERVANTS & DISCIPLINED FORCES 26

Background 26

Policy Change 27

Scheme implementation 27

Tender Processes 27

How the NHIF was approached and identified 30

THE "CAPITATION" MODEL IN HEALTHCARE INSURANCE 33

Definition 33

Merits and Demerits 34

MATTERS BEFORE THE COMMITTEE 35

List of witnesses 37

SUMMARY OF WITNESS EVIDENCE 38

EVIDENCE OF THE BOARD AND MANAGEMENT OF THE NHIF 38

EVIDENCE OF THE MINISTER OF STATE FOR PUBLIC SERVICE 45

Related previous appearance before the Committee in 2011 45

Minister's Second appearance- May 15, 2012 46

EVIDENCE OF THE CHIEF EXECUTIVE OFFICER, MEDICAL PRACTITIONERS & DENTISTS BOARD 50

EVIDENCE OF THE UNION OF KENYA CIVIL SERVANTS (UKCS) 51

Conceptualization of the scheme 52

Choice of health facilities 52

Existence of facilities 53

Roll-out of the scheme 53

EVIDENCE OF THE MINISTER FOR MEDICAL SERVICES; 54

Background to the Insurance Scheme 55

The Role of the Ministry in conceptualizing and rolling out of the pilot project 56

Action taken by the Ministry following allegations of irregularities 57

The view of the Ministry on the capitation approach as an alternative to provision of universal out-patient healthcare services 58

View of the Ministry on the rolling out of the fist quota of the said scheme 58

EVIDENCE OF SECRETARY GENERAL AND CHAIRPERSON, KENYA NATIONAL UNION OF TEACHERS 59

Commitment of the Signing of the Contract between KNUT and the NHIF 59

Roll-Out of the scheme in the last and current quota 60

EVIDENCE OF REPRESENTATIVES, KENYA PRIVATE HEALTH SERVICE PROVIDERS 61

EVIDENCE OF THE REGISTRAR, MEDICAL PRACTITIONERS AND DENTISTS BOARD 62

Process of Registration & Licensing 62

Accrediting NHIF's Facilities 64

EVIDENCE OF CHIEF EXECUTIVE AND MANAGEMENT, MERIDIAN MEDICAL CENTRE 66

Company profile 66

Branches 66

Payment of 1st Quarter from NHIF and criteria used to select Facilities 66

Explanation regarding the Renovation of Meridian Medical centre, Kitengela 67

EVIDENCE OF REPRESENTATIVES AND MANAGEMENT OF CLINIX HEALTHCARE LTD. 67

Brief History of Clinix Health Care 68

Payments 70

EVIDENCE OF THE REGISTRAR GENERAL 71

Shareholding of Pharma Investments Holdings 71

History of Annual Returns filed by Clinix Healthcare Limited 73

Application of Section 365 of the Companies Act 73

MEMORANDUM RECEIVED THE KENYA PHARMACISTS, MEDICAL PRACTITIONERS AND DENTISTS UNION. 74

COMMITTEE INSPECTION VISITS 75

FINDINGS OF THE COMMITTEE 78

The Piloting Phase of the Capitation Model 78

Conceptualization of the scheme and exercise of free Choice 79

Process of registration of healthcare providers 82

Geographical locations of beneficiaries' residences and Non-existent facilities 83

Identification of public and private service providers 86

Payments made to some private service providers: 88

The Scheme's Bank balances 95

Expansion of the private service providers 96

Capacity of public and private service providers 97

Shareholding of some private service providers 98

Misrepresentation by witness before the Committee 99

Conflict of interest 101

Suspension of the Chairman of the NHIF Board the CEO 101

Actions taken by the Parent Ministry on the Alleged Irregularities 101

Minister for Medical Services and Mr. Jayesh Saini 102

Registration of foreign companies having place of business in Kenya 102

RECOMMENDATIONS 104

Continuation of the Scheme 104

Inter-Ministerial Committee 104

Further Investigations 105

Access to services by members 106

Inspection of facilities and capitation rates in public facilities 106

Third Party Providers 106

Registration of foreign companies 106

DISSENTING VIEW **108**

Appendix 1:	Minutes of the Proceedings of the Committee
Appendix 2:	Paper laid by CEO, NHIF on Choices made by members
Appendix 3:	Letter by the Ministry of State for Public Service
Appendix 4:	Minutes of the NHIF Special Board
Appendix 5:	List of facilities licensed under Meridian Medical Centre and Clinix Healthcare Ltd for 2006 to April, 2012
Appendix 6:	Letter by the Director of Medical Services (DMS) to the Ministry of State for Public Service (MSPS)
Appendix 7:	DMS List of non-existent facilities
Appendix 8:	Branches of Clinix Healthcare Ltd.
Appendix 9:	NHIF Segregated list of Meridian and Clinix payments
Appendix 10:	Letters by the Registrar General
Appendix 11 :	Ministry of State for Public Service's Circulars
Appendix 12:	MSPS Letter of January 16, 2012
Appendix 13:	NHIF Advertisements
Appendix 14:	DMS's Letters on Clinix Healthcare
Appendix 15:	Bank Statements and Schedule submitted by the NHIF

PREFACE

Mr. Speaker,

The Departmental Committee on Health was constituted in June 2009 pursuant to provisions of Standing Order 198. The Committee is mandated to among other things, to *investigate, inquire into, and report on all matters relating to the mandate, management, activities, administration, operations and estimates of the assigned Ministries and departments.* The Members of the Committee are-

(i) The Hon. (Dr.) Robert O. Monda, M.P.- Chairman
(ii) The Hon (Dr.) Nuh Nassir Abdi, MP
(iii) The Hon. Sheikh Mohamed Dor, MP
(iv) The Hon. Cyprian Omolo, M.P
(v) The Hon. Thomas M. Mwadeghu, MP
(vi) The Hon.(Dr.) Victor Kioko Munyaka , M.P.
(vii) The Hon. (Dr.) Eseli Simiyu, MP
(viii) The Hon. Joseph Oyugi Magwanga, M.P
(ix) The Hon. Fredrick Outa, M.P
(x) The Hon. Joseph Lekuton, M.P

Mr. Speaker,

The provision, access to and maintenance of affordable and the highest quality of health care to all citizens is a condition precedent for achieving faster socio-economic development in both developed and developing countries. The vision for a healthy nation in Kenya was contained in the 1965 landmark national building and socio-economic development blue print – the Sessional Paper No. 10 on African Socialism and its application to Kenya – that emphasized the elimination of disease, poverty and illiteracy. The momentum for health development and reforms in Kenya is bolstered by the Constitution of Kenya, 2010 in Chapter 4 – Bill of rights, which provides in Section 43(a) that (1) every person has the right to the highest attainable standard of health,

which includes the right to healthcare services, including reproductive healthcare"; further, subsection (2) stipulates that "a person shall not be denied emergency medical treatment.

Mr. Speaker,

The key challenge for the Government is manifested in its insufficient health budgets, competing socio-economic development demands, deteriorating economic conditions, combined with burgeoning health problems such as the HIV/AIDS pandemic. These have led to an acute shortage of health workers (WHO; 2006) shortage of drug and medical supplies, unaffordable out-of pocket costs for health services' consumers, poorly remunerated health personnel or non-payment of health workers, poor quality of care, and inequitable health care services in many low income and transition countries.

Mr. Speaker,

Summarized in this Report, are excerpts of the evidence adduced by various key individuals from the private and public health sectors including senior government officials from the , findings and recommendations of the Committee.

Key among the matters that the Committee sought to investigate and establish were:-

(i) Whether the NHIF accredited facilities run by the private health service providers had the requisite infrastructure and capacity to offer the services enlisted under the Scheme;

(ii) Whether civil servants and members of the disciplined forces were accorded the opportunity to make a choice on the facilities from which they could access medi-care – a basic principle of the capitation model in healthcare provision;

(iii) Whether the private health facilities had the appropriate geographical spread;

(iv) Whether some of the facilities/clinics accredited by the NHIF were actually located in the designated areas or were non-existent.

Mr. Speaker,

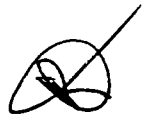
This Report also documents the Committee's findings. In summary, the Committee found out that the conceptualization and subsequent roll-out of the Medical Insurance Scheme for Civil Servants was highly rushed; the process of registration of healthcare providers was done in an uncoordinated and unsatisfactory manner. Further, members were assigned to some accredited private health facilities under the Scheme without due regard to their actual geographical locations. The Committee also found out that the NHIF failed to undertake assessment of the capacity of the service providers accredited to ascertain their ability and capacity to offer primary healthcare and also establish their actual branch network in the country.

Mr. Speaker,

The Committee made several recommendations. In spite of the emergent challenges facing the Medical Insurance Scheme for Civil Servants and Disciplined Forces, the Scheme should continue. Further, an Inter-Ministerial Committee should be constituted to advise the parties on the smooth implementation of all aspects of the Scheme including their capacities and appropriate geographical spread. Members must be accorded ample time to indicate a facility of their choice. The Committee also recommends appropriate audits to be undertaken to ascertain value for money on the four (4) aspects of the scheme including In-patient and Out-patient, Group Life and Last expense. The Committee also recognizes that there are already ongoing investigations and proposes that they expedites their work. In addition, the Committee proposes that appropriate structures be put in place to ensure that all members access quality healthcare. The Committee also proposes establishment of a healthcare regulatory authority that will oversee and regulate the administration of all healthcare insurance and benefits schemes including those offered by the NHIF.

Mr. Speaker,

In sum, the Committee confirmed that there were irregularities on the rolling out of the Civil Servants out-patient medical insurance scheme. They were, however, unanimous



that with proper safeguards and due diligence, the benefits of the Scheme far outweigh the shortcomings. Volume 1 of this report contains the main report of the Committee, while Volume 2 contains the minutes of the proceedings of the Committee, papers laid and other annexures.

Mr. Speaker, It is therefore my pleasure to present and commend this report to the House.

SIGNED.....

HON. (DR.) ROBERT MONDA, MP

CHAIRMAN, DEPARTMENTAL COMMITTEE ON HEALTH,

March 31, 2012

ACKNOWLEDGMENT

Mr. Speaker, on behalf of the Committee, I wish to sincerely thank you and the Presidium of the House for the enormous support accorded to the Committee during the period of the inquiry.

We also thank the Office of the Clerk for facilitating the Committee to undertake this assignment.

I also wish to share my gratitude to the staff of parliament, particularly the Committee's Secretariat who assisted the Committee to compile this Report.

I am also thankful to my colleagues in the Committee for their commitment and dedication during the inquiry. Together, they made the completion of this process worthwhile.

ADOPTION OF REPORT

WE, the undersigned Members of the Departmental Committee on Health were present during the meeting that adopted this Report. We participated in the said meeting, adopted the Report and requested the Chairperson to submit the Report to the House-

(i) The Hon. (Dr.) Robert Monda, M.P.- Chairman: .....

(ii) The Hon. Nuh Nassir, MP: .....

(iii) The Hon. Sheikh Dor, MP : .....

(iv) The Hon. Cyprian Omolo, M.P : .....

(v) The Hon. Thomas M. Mwadeghu, MP: .....

(vi) The Hon. Munyaka Kioko, M.P: .....

(vii) The Hon. (Dr.) Eseli Simiyu, MP: .....

(viii) The Hon. Joseph Oyugi Magwanga, M.P: .....

(ix) The Hon. Fredrick Outa, M.P: .....

(x) The Hon. Joseph Lekuton, M.P: .....

May 30, 2012

THE NATIONAL HOSPITAL INSURANCE FUND: BACKGROUND

THE HEALTH SECTOR

Section 43 (Chapter 4 – Bill of rights)

1. Section 43 (a) of the Constitution provides that *"(1) Every person has the right to highest attainable standard of health, which includes the right to health care services, including reproductive healthcare"; further, sub-section (2) stipulates that "A person shall not be denied emergency medical treatment"*

The Heath Sector

2. The Health Sector comprises of Ministries of Medical Services, Public Health and Sanitation, Research and Development sub-Sectors. The latter is a new sub- Sector, borne out of the realization that the government must harness in a structured and coordinated manner, the best possible human capital and research technology. This was intended to position the country among the modern world economies that are increasingly globalized and knowledge based.

Health Financing

3. To ensure universal and equitable access to quality health services, the Governments have been encouraged to earmark a sufficient share of the public revenues for healthcare. As per the Abuja Declaration of 2001, countries were to earmark 15% of the national budget for the health sector but Kenya is yet to meet this target. The proportion allocated to Kenya's health sector for the current financial year stands at 8.5 percent.

4. Currently, Public financing for the Sector (recurrent and development) as a percentage of total Government expenditure estimated at about 2 percent of GDP and the public per capita health spending was $12.6 in 2010/11. However, this amount remains inadequate when compared to the WHO recommendation of an average of $44 per capita on health care.

Human Resources

5. Kenya has an average of 16 doctors and 153 nurses per 100,000 populations, compared to WHO recommended minimum staffing levels of 36 and 356 doctors and nurses respectively per 100,000 population. Regarding the optimal staff establishment, the two ministries have staff establishment of 72,234 but only 47,247 have so far been approved. However, of the approved establishment, only about 38,000 positions are filled, leaving almost 9,000 positions vacant. The annual recruitment has not drastically altered the numbers because of the high level of attrition. Against the above background, it is apparent that the Sector is not able to adequately provide services to the citizens. These shortages in Human Resource have negative impact on the Sectors capacity to deliver services.

Physical Infrastructure of public health facilities

6. Out of 7,395 health facilities in the public sector, the Government owns and operates 48 percent (273 hospitals, 579 Health centres and 2,716 dispensaries) of the facilities in the sector. The Private and Faith-Based Organizations (FBOs) health facilities complement the provision of health care through the remaining 46 percent (1,044 FBOs and 2,352 private) of health facilities. In view of the low investment in infrastructure, most of the public health facilities are old and dilapidated. Given the increases in population and the increase in demand for services, these facilities do not conform to current infrastructure norms and standards. Accessibility to the health facilities is estimated at 52 percent based on the 5km radius norm. However, there are variations in access in different parts of the country, with the worst areas being in the Northern part of the country. On average, 50 percent of the equipment in our public medical facilities and research laboratories are obsolete /unserviceable.

The Disease Profile

7. The Kenyan epidemiological profile indicates that disease burden is still high. Top five causes of outpatient morbidity namely Malaria, Diseases of the Respiratory System, Diseases of the Skin, diarrhoea, and accidents account for about 70per cent of total

causes of morbidity. Malaria contributes about a third of total morbidity. The leading causes of mortality are: Infectious and parasitic diseases (42 percent of total mortality in 2008) followed by Diseases of Respiratory System (11 percent), and Diseases of Circulatory System (7 percent). HIV prevalence estimates vary widely, but the latest estimates from the 2008/09 Kenya Demographic and Health Survey (KDHS) place the prevalence rate at 6.3 percent, slightly lower than the previous estimate of 6.7 percent (KDHS 2003). Although this reduction is minimal in terms of number of cases as compared to the total population, effective prevention programmes are considered for keeping infection rates low in the future.

Health Sector Insurance

8. According to the National Health Accounts, the population coverage of private insurance is small but at about 700,000 lives only, compared to NHIF about 6.6million lives by 2010 estimates. At the same time, although private insurance companies and Medical Insurance providers MIPs controlled the largest share of health insurance funds (63%), they only covered about a tenth - of the population that NHIF covers. However, an analysis of the NHIF's membership profile carried out in June 2010 showed that, even though he Fund had increased its coverage from 3.3 million persons covered in 2003 to 6.6 million persons in 2010, only 17% of the total population of Kenya was covered as at 30th June, 2010.

THE NATIONAL HOSPITAL INSURANCE FUND (NHIF)

9. The National Hospital Insurance Fund (NHIF) was established based on the recommendation of Sessional Paper No. 10 of 1965, *titled "African Socialism and its Application to Planning in Kenya"*. The Fund was originally set up under the NHIF Act of 1966 as a department under the Ministry of Health. At the time, NHIF's monthly contributions were Kshs. 5 per month. The original Act of Parliament has over the years been reviewed to accommodate the changing healthcare needs of the Kenyan population, employment and restructuring in the health sector. Currently, the Fund derives its mandate from the NHIF Act (Act No. 9 of 1998). The Fund has had its fair share of challenges of governance structures, mostly in 1980s and 1990s. However, since 2003, following significant public sector reforms instituted, particularly those focusing on ensuring that State Corporations actively executed - their mandates, the Fund has recorded tremendous growth in terms of corporate governance, medical insurance market access and increased benefit payout ratio.

10. As the Government's key medical insurance vehicle in health financing, the Fund has been undergoing major reforms, mostly since 2006. These include: reformed governance structures with the Board playing a keener role in protecting the interests of contributors; expansion of medical insurance coverage, mostly, through roll-out of additional branches and innovative technology; targeting of the informal sector and roll-out of new products; improved efficiency has also become the focus of the Fund and its employees with continued restructuring of the employee complement so as to reduce the previously bloated workforce and improve productivity and efficiency; recovery of lost assets through litigation against collapsed institutions in which investments were held; and enforcement of compliance by employers in statutory deductions to ensure timely contributions and remittance of workers' dues is a key strategic initiative.

11. Instructively, NHIF is said to be perceived as a healthcare institution and not so much as a healthcare financier, which is its actual core function. The Fund's link to the Ministry of Medical Services has enhanced this perception.

Recent Growth

12. According to a study by *Delloite* titled "Strategic Review of the NHIF _ Kenya (October 2011), as at August 2011, NHIF remains the main provider of health insurance in the Country in terms of number of contributors compared to other schemes. However, it is the only mandatory insurance scheme in Kenya. The Fund's membership is said to have grown by more than 85% during the period, 2006 to 2011, with the highest growth being in the informal sector, which grew by over 700%. It was reported that the Fund had 102,000 members from the informal sector in 2006, which rose to 2.5 million by August, 2011, with a two- fold rise in accredited hospitals from 300 to 610 during the same period. At the same time, the Benefit Payout Ratio (BPR), which is a measure of the proportion of contributions that goes into payment of medical bills was said to have grown by 94.3% from 35% in 2005 to 68 %. WHO standard recommends a BPR of 80%.

13. According to the same source, the Fund has also experienced growth in membership cover, from a rebate based cover that could only meet the cost of bed charges to comprehensive In & Out-Patient services. However, the Committee has been of the view that the current cover is not sufficient and should be expanded to cover In & Out-Patient services at **all** public and private hospitals. The enhanced cover should be gradually expanded and payable through reduced administrative costs at the NHIF. The Fund has also gradually embraced use of technology by replacing the paper based membership cards with electronic cards and electronic collection of contributions, including by way of the *M-Pesa, money transfer* that mainly target the informal sector.

Mandate of NHIF

14. The Fund's core mandate, from inception, was to provide medical insurance cover (hospitalization cover) to all its members and their declared dependents (spouse and children). The NHIF membership is open to all Kenyans who have attained the age of 18 years and have a monthly income of more than Kshs.1,000. NHIF's mandate ensured that formally employed salaried people were required by the Act to contribute to the Fund through their employers.

Legal Framework

15. NHIF is regulated under the NHIF Act of 1998 which outlines the mandate and core functions of the Fund. This legal framework is the main driver of the governance within NHIF. As a parastatal, NHIF is also governed under State Corporations Act, Public Audit Act and other statutes relevant to state corporations.

16. The legal framework of NHIF recognizes that the Fund's main responsibility is protecting the interests of its contributors. This is because NHIF receives contributions from members (contributors) and provides the benefit package to its contributors and their dependents. The Fund does not receive any contributions from any other source other than members. Indeed, the Management of the Fund and the Ministers of State for Public Services and for Medical Services have, before the Committee, rightfully described the NHIF as a "**members club**". Therefore, under the current mandate, **NHIF is not a universal health insurer.**

17. According to the study by *Delloite* (2010), NHIF operates as a parastatal, mainly due to its historic evolution from being a Department under the Ministry of Health. The legal framework builds-in the autonomy for the Fund. This autonomy is ensured through the governance structures which include the Board of Directors comprising representatives of contributors. The corporate identity, which is how NHIF sees itself and conducts its operation, is directly influenced by its legal framework. As a result,

NHIF is an autonomous contributor's organization which is a state corporation by law.

18. Because of its history and governance structure, disclosure and accountability of NHIF is mainly to the Government and not directly to members. Information is mainly provided to Government and not to members. Indeed, during the roll-out of the Comprehensive Medical Scheme for Civil Servants and members of the Disciplined Forces, the Board and the Management of the Fund were seen to focus more on satisfying the requirements of Government than responding to the needs of the contributors. Probably, this approach explains the magnitude and extent of public outcry experienced when the Committee pointed out that there were possible irregularities in rolling-out the said Medical Scheme.

19. Save for self employed contributors, the contributors to the NHIF are connected to the Fund through their representatives in the Board of Management as defined in the NHIF Act. The assumption is that the Board Representatives report back to their nominating bodies and seek input on major decisions or general feedback on the Fund.

THE PILOT PHASE ON CAPITATION (2009-2011)

20. In February and March 2011, the Committee inquired into the manner of rolling out the Pilot programme of the Capitation scheme under the NHIF. The Committee was informed that-

Background

21. In 2007, the NHIF Board of Management and Senior Management Staff visited nine (9) countries in Europe, Asia and Latin America with the aim of learning lesson on health care systems with a focus on Out-patience Cover. Part of the observations made include that all the countries with successful Out Patient Cover is financed through the Capitation system, with focus on primary health care coverage; Quality of health care in ensured through clinical governance systems; Group related Diagnosis (GRD) is used as a measure for cost control;

22. The Management commissioned an actuarial study to establish the feasibility and sustainability of introducing Out Patient Cover. The study was conducted by Alexander Forbes & Actuaries in September 2007. Amongst other, the study recommended that the Fund offers both In and Out Patient Covers;

23. Periodic market and customer satisfaction surveys carried out since 2007 revealed the need for Out Patient cover and NHIF members' willingness to contribute more so as to enjoy Out Patient benefits;

24. The Board has several occasions deliberated on the modalities of implementing Out Patient Cover (OPC) through various management papers presented to it.

Out-Patient Pilot

25. From the above studies, experiences, Management papers, Board deliberations and directions, the Management - commissioned a six months Out Patient pilot, effective 1st December 2009 to provide lessons for the eventual roll out of an Out Patient Cover. The pilot was conducted in Nairobi and Mumias. The two regions were

chosen to represent the urban and rural settings due to diversity the regions present in terms of public and private sector employers and taking care of members from various socio-economic groups;

26. The Out Patient Pilot project was commissioned to determine the options of NHIF to extend the Out-Patient package to its members. This was because there was demand for ambulatory care and establishing the costs for OPC services. Both variables, however, were widely unknown in the Kenyan health care system. Since adequate data was lacking, it was extremely difficult to predict the "real" and sustainable demand for OPC. This limitation was said to be mainly due to the uncertainties regarding epidemiologic disease patterns, population needs and healthcare demands;

Out-Patient Cover Pilot Rationale

27. The Out-Patient cover Pilot was also intended to establish the most appropriate category of healthcare provider to offer primary healthcare and secondary/tertiary healthcare and whether it is beneficial to members that in and out patient be offered in all accredited facilities without delineation. The pilot was also supposed to determine the most appropriate and sustainable method of provider payment – fee for service or capitation and possibly how a mix of both can work; The study was also intended to determine the real cost of OP Healthcare with the aim of ascertaining appropriate premium levels;

Out-Patient Cover Pilot Benefits Package

28. The Fund undertook to pay for Out Patient services which are medical and surgical interventions/procedure/tests that are done in qualified medical centre, these included: General consultation with general practitioners and specialists; Prescribed laboratory tests/investigations, Histopathology; Drugs/Medicines; Approved X-rays, Ultrasound and Computer Tomography (CT Scans); Diagnosis and treatment of common ailments; Ear Nose Throat (ENT) services; Management of chronic ailments (HIV/AIDS, diabetes, asthma, hypertension, etc); Prescribed Physiotherapy; Treatment of Sexually Transmitted Diseases (STDs); Echo Cardiogram (ECG); Treatment, dressing

or diagnostic testing; Health and wellness education; Specialized counseling services; Referral to specialist doctors within the scheme; Family Planning; Anti Natal Care; Basic Dental Services (consultation, cleaning, filling, extraction, x-ray); Basic Optical (consultation, frames, refraction);

29. All services were unlimited, subject to the mode of payment assigned to the member. Under capitation each beneficiary was capitated at the rate of Kshs.2,000 for unlimited services in the facility assigned, while under Fee- for–Service (FFS) each family was allocated Kshs.2,000 for the six-month study period and could access benefits to the extent of the amount allocated with any excess to be paid by the member.

Sample Population under Capitation Method

30. Given that capitation is based on the number of heads covered in the scheme, it was estimated that 100,000 beneficiaries would be represented by approximately 43,300 contributors;

Accreditation of Healthcare facilities

31. The healthcare facilities were accredited through a competitive tender process that took into account the response by the facilities as opposed to their accessibility to the targeted members. However, facilities in Mumias were reported to have been non-responsive to the tender requirements and therefore the Fund resorted to accreditation process to bring them on board;

32. The pilot had four healthcare providers contracted in Nairobi, of which three were from the private category while one was a Government of Kenya (GoK) facility. In Mumias, nineteen (19) facilities were contracted out of which seven (7) were GoK while twelve (12) are in the private category. The official launch was done on 30th-November, 2009 in Mumias by the Minister for Medical Services;

Project Implementation

33. Members started accessing benefits during the month of February 2010 in the following facilities in Nairobi under both capitation and Fee-for-Service payment systems in:-

    (a) Mbagathi District Hospital

    (b) Thika Road Health Services

    (c) Meridian Medical Centre

    (d) Clinix Healthcare Ltd

34. The NHIF disbursed funds for the providers contracted in the roll-out , including Ksh. 54 million, Ksh. 96 million to Meridian Medical Centre and Clinix HealthCare Ltd, respectively. A further Ksh.18 million was paid to Thika Road Health Services and Mbagathi District Hospital,. ;

35. The initial pilot arrangement in Mumias also revealed that majority of members capitated did not reside in the localities selected for them. The shortcomings therefore, posed a challenge of accessibility to members. Taking cognizance of the challenges noted above, the management decided to put all facilities in Mumias under the fee for service to minimize financial wastage as well as accord members the opportunity to decide on more convenient and accessible facilities for the Out-Patient cover.

Findings

36. The Pilot Study findings revealed that members under both Fee-for-Service (FFS) and capitation visited the accredited facilities for the out- patient care. The facilities were drawn from across level 2 to 4. These levels are representative of the facilities that majority of members seek out patient services from.

37. The Management also indicated that the beneficiaries who visited facilities offering both in and out-patient services, none of the cases ended up being an admission case. This position has also been confirmed through surveillance programmes.

Findings with Capitation Payment

38. The working definition for Capitation payment in the OPC pilot was a system where providers received payment according to the size of the population served. The method operates from the premise of risk averseness where risk is transferred wholly to the health provider;

39. During the project implementation period, the Fund was concerned about the risk of underproduction that the method of reimbursement may present. As a result, an effective monitoring system was developed to ensure that the providers extended unlimited quality services to members;

40. In summary, the total number of visits was 13,925 for both capitation and fee-for-services. The claims severity ration of 7% was observed during the pilot period. There were a total of 8,393 visits under the capitation method. Pediatrics cases accounted for 1,904 cases or 23%; for male adults the cases accounted for 32% while adult females accounted for 45%;

41. It was reported that, if the NHIF rolls out the OPC, it will inject an additional Kshs.10 billion to the Health sector. This will grow the Funds' contribution from the current 4% to 21% of Total Health Expenditure (THE). It was also envisaged that the government would increase its participation in preventive and promotive healthcare from the current 12% to 25%.

42. The experience gained from the OPC pilot project showed that the two modes of reimbursement; Capitation and Fee for Service can be applied with considerable high level of success. According to the NHIF Management, experience from countries that have implemented OPC successfully show that the Capitation Model is more

applicable to developing countries. Further, various studies and lessons learned locally indicated that the Fee-for-Service led to the collapse of most of the Health Management Organizations (HMOs) that operated in the country in the 1990s and early 2000.

43. According to the NHIF Management, the findings from the pilot showed that Risk Adjusted Capitation was the preferred option for the roll-out of OPC on the basis of equity, ease of administration, low financial risk protection and strategic purchasing to improved health system and responsiveness;

44. The Committee however, raised concerns that the pilot phase concentrated mainly in Nairobi. In this regard, the study was not representative and its findings cannot be deemed to be comprehensive and reliable. Further, the manner of identifying the four service providers, including two private service providers was questionable;

45. Further, the Committee could not ascertain the propriety or value for money on the funds spent in the Pilot Phase, especially taking into account that a substantial part of funds was spent on studies and administration of the Pilot programme;

THE MEDICAL INSURANCE COVER FOR CIVIL SERVANTS & DISCIPLINED FORCES

Background

46. It was reported that, over the years, Civil Servants have complained over the inadequacy of the medical benefits the Government as an employer had given them. Prior to 1st January, 2012, Civil Servants and Disciplined Services in Job Group "A"- "T" i.e, pay Group1-14 were drawing monthly medical allowances ranging from Kshs. 375 to 2,490 (pre-tax). These categories of employees were also entitled to a refund of in-patient expenses for self, spouse and children under 22 years at the rate of 1,500 per day for Job Group "L" and above and Ksh. 1,000 per day for Job Group 'K' and below;

47. Employees could also apply for medical ex-gratia assistance of up to 75% of in-patient medical expenses (net NHIF rebate). Under these provisions, the employee had to pay the bills first, and then claim reimbursement or seek ex-gratia assistance. Granting of ex-gratia assistance was at the discretion of Government and the subject to availability of funds. In many cases, employees were unable to access this assistance and this caused considerable financial hardships. Further, in other cases, employees had to settle their medical bills either through *private fundraising initiatives*, salary or loans;

48. It was also reported to the Committee that civil servants at all levels constantly complained that the monthly medical allowance could not even cover the cost of a medical subscription or a visit to a moderately priced healthcare facility. Under these arrangements, it was felt that the Government, as an employer, was not fully meeting its obligation under the Employment Act, 2007 and the Constitution of Kenya, 2010 to provide access to quality healthcare to its employees.

Policy Change

49. In trying to address these concerns, the Government commissioned an Actuarial Study in 2007/2008. The study recommended conversion of the existing medical benefits for Civil Servants into Comprehensive Insurance Scheme.

50. The Government, through a Cabinet decision on June 2, 2011 approved the conversion of the medical allowance, in-patient refunds and ex-gratia assistance budget amounting to **Ksh.2.83 billion** in the financial year 2011/2012 to a Medical Insurance Scheme. The Cabinet also directed the Treasury to avail additional funds amounting to **Ksh. 1.078 billion** to enable the Ministry of State for Public Service to procure the Medical Insurance Cover for Civil Servants and Disciplined Services. **The total amount that was available for the cover was Ksh.3.9 billion;**

Scheme implementation

51. Following the Cabinet approval, the Ministry of State for Public Service in June, 2011 invited tenders for provision of a Medical Insurance Cover to Civil Servants, Kenya Police, Administration Police, Prisons Service and National Youth Service. The Scheme was to take effect from 1st August, 2011 for a period of three (3) years renewable, subject to satisfactory performance.

Tender Processes

52. Ministry of State for Public Service invited tenders from Consortia of not less than five (5) registered medical underwriters. Two Consortia submitted their bids. One Consortium comprised of eight Medical Underwriters (British -American Insurance Company, CIC Insurance Group Ltd, First Assurance Company Ltd, GA Insurance Ltd; Jubilee Insurance Company of Kenya Ltd, Madison Insurance Company Ltd, Mercantile Insurance Company Ltd and UAP Insurance Company Ltd). They submitted a quote of a premium of **Kshs.12.2 billion per year.** The other Consortium also comprised of eight companies (Cannon Assurance Ltd, Pioneer Assurance Company Ltd, Kenya Reinsurance Corporation Ltd, East African Reinsurance Company Ltd, Resolution Health East Africa Ltd, Metropolitan Life

Kenya Ltd, Real Insurance Company Ltd; and CAPEX Life Assurance Ltd. They gave a quote of Ksh. 3.8 billion per year.

53. A Technical Evaluation Committee comprising of Ministry of State for Public Service officials and technical advisors from the Insurance Regulatory Authority (IRA) was formed to evaluate the bids. The Ministry of State for Public Service was however, unable to award the Tender due to failure of the two Consortia to meet all the requirements of the Tender, as follows-

(a) the quotation by the first Consortium at a premium of Kshs.12.2 billion was way beyond the budgetary limits for the cover as approved by the cabinet;

(b) although Consortium 2 had quoted a premium of Kshs.3.8 billion per year which was within the budgetary limits, it lacked capacity and network to underwrite and administer the Medical Insurance Cover. Out of the eight Firms, only two Firms Cannon Assurance Ltd and Pioneer Assurance Co. Ltd were licensed to Underwrite Medical Insurance business while the other six (6) firms were Ordinary Life Insurance Companies and Stock Brokerage Firms;

(c) in addition, the proposed medical covers had inhibiting limitations, such as In-patient admission for all members was to be in general wards irrespective of their grades, and did not cover out-patient dental treatment,, with only 20% of in-patient for HIV/AIDS, congenital, pre-existing conditions, psychiatric illness and chronic illness being covered. Further, hospitalization outside the country was limited to emergency cases on reimbursement basis;

(d) the second consortium also had similar limitations, in addition to a requirement for pre-authorization from Scheme Administrator for MRI, CT

Scan, Physiotherapy Services, Radiotherapy, Chemotherapy, Endoscopy and tonsillectomy, while New born baby cover was 30 days on discharge from the hospital. Further, it had a waiting period varying from 6 to 12 months for maternity, cancer, tonsillectomies, hernia cases among others;

(e) the two Consortia required payment of premium up-front to cover the period 1st January to 31st December as opposed to Government financial year of 1st July to 30th June.

54. Consequently, in September, 2011, the Ministry of State for Public Service re-advertised the Tender in which bids were received from two Consortia as follows-

(a) **The First Consortium** : comprising of Ten firms (British American Insurance Company, CIC Insurance Group Ltd, First Assurance Company Ltd, GA Insurance Ltd; Insurance Company of East Africa Ltd, Jubilee Insurance Company of Kenya Ltd, Madison Insurance Company Ltd, Mercantile, Insurance Company Ltd, Pioneer Assurance Company Ltd and UAP Insurance Company Ltd). **The Consortium quoted a premium of Kshs.4.26 billion and was found to be technically responsive and had the capacity to administer the Scheme but the cover had excessively inhibitive limitations such as:** The list of health care facilities available for the Civil Servants was mainly from Government and Mission hospitals. Major private hospitals were excluded; In-patient admission for all members was to be in general wards irrespective of their grades; Dental and optical treatment limited to cases of accidents with a limitation of Kshs. 10,000 for officers in Job Groups 'A'- 'M'. No mention was made of officers in Job Groups 'N' and above; General medical check-up, miscarriage, maternity or Caesarian- section were excluded; Waiting period on commencement of the cover of up to thirty(30) days; Cover was for only 20% of the cost of treatment for psychiatric illness; Hospitalization outside the country limited to emergency treatment to members abroad for a period not

exceeding 6 weeks and critical illness were covered up to 30% of the benefit of the member;

(b) **The Second Consortium** - Had five insurance Firms (Apollo life Assurance Ltd, Pan Africa Life Insurance Ltd, Kenya Alliance Insurance Company Ltd, Geminia Insurance Company Ltd and Old Mutual Life Insurance Company Ltd). None of these firms was licensed by the insurance Regulatory Authority to underwrite medical insurance business. They were all ordinary Life Insurance Companies.

How the NHIF was approached and identified

55. The Government had undertaken to roll-out a compressive medical insurance scheme, for civil servants. However, from the experiences gained from the tendering, evaluation and negotiation process of the tender, it became evident that private Insurance players in the market did not have the capacity required to undertake the programme. Where they did, it was too costly. The Ministry of State for Public Service informed the Committee that the private insurance providers had indicated, in their bid documents, that, they would sub-contract NHIF to provide services to officers in JG A to M/PGI-9, who comprised of about 96% of the employees target in the scheme;

56. Due to above challenges, the Ministry of State for Public Service initiated negotiations with NHIF to provide the cover. According to the Minister of State for Public Service, the NHIF had shown capacity to implement the cover since it had practical experience and had contracted Health facilities across the entire country's geographical spread. Further, the procurement process was easier since section 4(2) of the Public Procurement and Disposal Act, (2005) allows an agency or a department of Government to acquire stores, equipment and services from another department or Ministry without necessarily having to enter into competitive tendering process;

57. NHIF quoted a premium of Kshs 4.32 billion per annum. The NHIF quotation was preferred since it was affordable, with provision for quarterly premium payment which were aligned to the Government's financial year. The cover also had an assured countrywide network with NHIF accredited Healthcare providers which included Government, private and mission hospitals. The cover had fewer exclusions comprising mainly of the standard exclusions in medical insurance industry. The cover had out-patient and in-patient cover for the principal member, spouse and three other dependent children with an option for addition dependants at a reasonable additional cost. The Committee also learnt that, the option was preferred because, the NHIF funds were to be used to improve public health facilities to give quality care to the members of the scheme;

58. The Ministry of State for Public Service, through the Ministerial Tender Committee approved the NHIF quoted premium of Ksh. 4.32 billion per annum. A contract between the Government and NHIF was signed for the period January 1, 2012 to 30th June, 2012 which was an initial phase and subsequent renewal would depend on satisfactory performance by NHIF. The Premium payable for the six (6) months was Ksh 2.16 billion;

59. The scheme caters for the principal member, one spouse and three dependent children below 18 years of age and up to 25 years old if attending full time formal education. In summary, the scheme covers in-patient and out-patient costs and also provides a group life cover and last expenses. The Committee was informed that NHIF was to identify appropriate service providers as per the contract.

60. It is the process of rolling out the scheme, identification and contracting of the private and public service providers that the Committee sought to inquire into, following objections from the intended beneficiaries. Amongst the concerns raised in the complaints included-

(i) **Process of Conceptualization of the scheme and exercise of free Choice:** That, the process was poorly conceived and civil servants were not allowed

to chose their preferred facilities, but were forced to seek services from private and public facilities as per lists allocated;

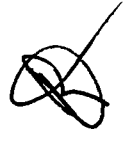
(ii) **Lack of awareness: That**, some intended beneficiaries did not even know about the roll-out of the scheme or the facilities accredited to offer the services under the Scheme;

(iii) **Geographical locations of residences:** That, some of the allocations made did not take into account actual geographical locations of the beneficiaries' residences. Cases were cited where a public officer would be allocated a facility in one location, far from their place of residence, even when there existed a better healthcare facilities in close proximity;

(iv) **Non-existent facilities:** That, some of the private facilities indicated in the NHIF's website and locations availed to the civil servants did not exist on the ground. Some were said to be putting up new structures in the allocated centers during the period from January-March, 2012, when they were supposed to be offering the services; Further, by the time some of the private providers signed contracts, they did not have sufficient branch network, which they later claimed to have after the roll-out;

(v) **Capacity:** That, some of the private facilities allocated lacked capacity to offer basic primary healthcare services to the members. This was in terms of equipment, inadequate infrastructure and personnel; and,

(vi) **The Capitation method:** That, given the fact that service providers were paid in advance, the members were not assured of quality service and value for money.



THE "CAPITATION" MODEL IN HEALTHCARE INSURANCE

61. The Committee also learnt that, after being contracted by the Ministry of State for Public Service, the NHIF employed an approach known as "capitation" to roll-out the out-patience Medical Insurance Scheme for civil servants and members of the disciplined forces;

Definition

62. Capitation is conventionally described as *"a provider payment method in which providers are paid, typically in advance, a pre-determined fixed rate to provide a defined set of services for each individual enrolled with the provider for a fixed period of time. The amount paid to the provider is irrespective of whether that person would seek care or not during the designated period*";

63. Simply put, "capitation" refers to a method of compensating physicians that is based on the number of patients who list that particular doctor as their Primary Care Physician. Insurance carriers pay physicians a specified amount for every patient covered by one of their managed care policies. These are normally arrived at every month, and are often referred to as PMPM, (Per Member Per Month or Quota). Capitation can be Fixed, Age-based capitation, Premium-based or Share-based;.

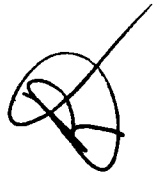
64. The NHIF's choice was the fixed amount type, which is typically expressed on a Per Member Per Month or Quota basis. Under this payment system, the member or subscriber selects a preferred primary provider to provide all the services under the capitation basket in exchange for the capitation rate. The capitation basket refers to the services and medicines that are to be paid for by the insurance (NHIF) per capita rate. The total capitation amount is transferred to the provider at the beginning of the service period. The amount is calculated based on the total number of members who have selected a given provider.

65. Capitation is a well-established provider payment method in several countries, mostly in high and middle income nations as a way of pre-paying for the health services used by residents. Payments made are spread over the subscribers and over time in the form of some agreed regular contributions. Services are provided according to need;

Merits and Demerits

66. Studies have shown that, while Capitation has many advantages to the Insurance, such as reduced risks, reduced administrative costs and business processes that would otherwise be occasioned by processing of claims, reduced fragmentation of care and assured continuity of care since clients are tied to one provider and also allowing doctors to nurture long-term relationships with their patients, enabling them to know their needs and medical histories comprehensively, Capitation also has various shortcomings. Registration at one facility when the population is mobile is a major problem since the patients are required to access treatment from the accredited provider who they are registered to;

67. Further, optimal treatment may not be delivered- A big risk of under provision of the services since the physicians are also entitled to incentives for delivering quality and well-managed services to their patients and therefore are required to keep the costs minimal to earn yet better incentives. Further, under a capitation system, physicians can potentially lose some of their earnings in a complex treatment case when the cost of the services provided goes above the monetary value assigned to them. Providers thus tend to ignore complex cases in favor of choosing patients who are easier to care for. It is also said that Patients with many complicated medical cases are likely to be left out of the enrollment system for a capitated plan. This is due to the high cost involved in treating them, so providers would realize little profit, as opposed to the situation when ordinary cases are treated;



MATTERS BEFORE THE COMMITTEE

68. The Committee examined matters related to rolling-out the scheme, identification and contracting of the private and public service providers. In this regard, the Committee sought to inquire into, following objections from the intended beneficiaries. Amongst the concerns raised in the complaints included-

(i) **Process of Conceptualization of the scheme and exercise of free Choice:** That, civil servants were not allowed to chose their preferred facilities, but were forced to seek services from private and public facilities as per lists allocated;

(ii) **Lack of awareness:** That, some intended beneficiaries did not even know about the roll-out of the scheme or the facilities accredited to offer the services under the Scheme;

(iii) **Geographical locations of residences:** That, some of the allocations made did not take into account actual geographical locations of the beneficiaries' residences. Cases were cited where a public officer would be allocated a facility in one location, far from their place of residence, even when there existed a better healthcare facilities in close proximity;

(iv) **Non-existent facilities:** That, some of the private facilities indicated in the NHIF's website and locations availed to the civil servants did not exist on the ground. Some were said to be putting up new structures in the allocated centers during the period from January-March, 2012, when they were supposed to be offering services; and,

(v) Capacity: That, some of the private facilities in the scheme lacked capacity to offer basic primary healthcare services to the members. This was in terms of equipment and personnel.

(vi) Capitation Model: That, given the fact that service providers were paid in advance, the members were not assured of quality service and value for money.

EVIDENCE SUBMITTED

List of witnesses

69. On diverse dates, the Committee held a total of twenty four meetings with different witnesses, including-

(i) The Board and Management of the National Hospital Insurance Fund;

(ii) The Minister of State for Public Service;

(iii) The Minister for Medical Services;

(iv) The Secretary General and Chairperson, Kenya National Union of Teachers;

(v) The Secretary General and Chairperson, Union of Kenya Civil Servants;

(vi) Chairperson , Kenya Private Health Service Providers;

(vii) The Registrar General, State Law Office;

(viii) Registrar and Chief Executive Officer, Medical Practitioners and Dentists Board;

(ix) Chief Executive and Managements, Meridian Medical Centre; and,

(x) Representatives and Management of Clinix Healthcare Ltd.

The Committee also received a written memorandum from the Kenya Pharmacists, Medical Practitioners and Dentists Union.

SUMMARY OF WITNESS EVIDENCE

EVIDENCE OF THE BOARD AND MANAGEMENT OF THE NHIF

70. Appearing before the Committee on March 8, April 2, and April 11, the Board and Chief Executive Officer of the NHIF informed the Committee that-

(i) On November 10, 2011, the Ministry of State for Public Service wrote to NHIF requesting for assistance in provision of medical insurance cover for civil servants and disciplined forces. In the letter, the Ministry indicated that previous attempts to get the cover from the private insurance companies had failed, owing to lack of capacity, incompetence and numerous exclusions provided by a consortia of private bidders;

(ii) Later, a meeting between the Ministry of State for Public Service and the NHIF was held on November 16, 2011 where NHIF was introduced to a scheme that would cover 221,720 principal members plus spouse and four dependent children under the age of 18 and up to a maximum of 25 years of age, if still in school. The medical insurance cover entailed in and out-patient without exclusions. In patient treatment was to have three categories of staff, covering job groups A to M, N to Q, and R-S-T.

(iii) On November 17, 2011, the Ministry of State for Public Service wrote again, providing further details on the proposal and requiring the NHIF to submit a technical and financial proposal for provision of the Medical Insurance Cover for further internal consultations;

(iv) NHIF responded on November 25, 2011, with a technical and financial quote of Ksh. 4.76 billion, comprising of Ksh.1.47 billion for in-patient, Ksh. 2.56 for out-patient, Ksh. 646 million for Group Life cover, Ksh.84 million for Last expense

and levies of KSh.2.76 million. The In- & Out-Patient services had non-exclusivity and expanded family cover of principal, spouse and 4 dependants for all 221,720 civil servants and disciplined forces. The Fund also indicated that Out-Patient cover was to be accessed at service providers as per the contract between the NHIF and the service providers. They also indicated that Out-Patient facilities shall be choice-based, where members and their dependants will chose their preferred health facility, with an option of changing after an agreed period with the Ministry of State for Public Service. The proposal also indicated that there will be a charge of Ksh.100 and Ksh. 200 for out-patient visits in government and private facilities, respectively;

(v) The Ministry of State for Public Service wrote back to NHIF on November 30, 2011, seeking more clarifications on ten items of the proposal and technical aspects and requesting for financial implication, should the scheme be revised to include three children/dependants from four. They also asked for a copy of the Agreement entered between the NHIF and the Private Health Service providers. The NHIF responded on December 1, 2012, with clarifications and a financial quote of 4.32 billion. comprising of Ksh.1.31 billion for in-patient, Ksh. 2.24 for out-patient, Ksh. 646 million for Group Life cover, Ksh.84 million for Last expense and levies of KSh.2.76 million They however, indicated that a copy of the agreement with the service providers would only be signed after the Fund and the Ministry of State for Public Service had agreed on all aspects of the service provision and signed a contract;

(vi) Following a meeting between Ministry of State for Public Service and the NHIF on December 15, 2011, the Ministry wrote to the NHIF on December 16, 2011, communicating their acceptance of the proposal to procure services for provision of comprehensive In & Out-Patient cover for civil servants and members of disciplined forces, their spouses, and up-to three dependants, Group Life Insurance Cover and Last Expense Cover for principal members. The letter also

indicated that the Medical Insurance Cover should commence on January 1, 2012. NHIF was required to submit a Draft Contract to the Ministry, acting as the client.

71. The Committee further heard that on January 5, 2012, NHIF signed the contract covering amongst others, the following aspects-

(a) **In-patient cover Hospital Treatment and Services:** All necessary medical treatment and services provided as per level of care or on the order of a physician to a member when admitted as a registered general patient to an NHIF accredited hospital.

(b) **In-patient cover Hospital Treatment and Services cover include;** hospital accommodation, nursing care, diagnostic, Laboratory or other medically necessary facilities and services, physician's, surgeon's, anesthetist's, or physiotherapist's fees; operating theater charges, specialist consultation or visits and all drugs, dressing or medication prescribed by the treating physician for in-hospital use.

(c) **Daycare services:** surgery and other medical services deemed fit by the physician as defined in the NHIF benefit package;

(d) **Pre-Hospitalization:** Laboratory-Xray and other necessary medical diagnostic procedures ordered by a physician and which results in a member being admitted (on the same day the test are done)as a registered general patient to a hospital for treatment of the specific medical condition diagnosed;

(e) **Local Road Ambulance Services:** -Ambulance services for transportation and transfer of a sick member for treatment from facilities where

adequate care is not available to the next available NHIF accredited hospital or medical facility will be covered within the annual inpatient limit if applicable;

(f) General out-patient services: Out-patient services provided by or the order of a clinician/physician who is licensed as a general practitioner;

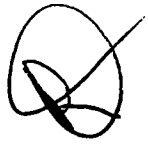
(g) Out-patient laboratory and X-ray services: laboratory testing, radiographic procedures used to diagnose or treat medical conditions- such services must be ordered by a clinician/physician and must be covered;

(h) Maternity cover: NHIF shall cover a member for the proportion of expenses for childbirth, the benefit shall cover delivery fees, consultation and treatment for both mother and child only- this benefit may be available to dependent children at an additional cost;

(i) Optical cover: A member shall benefit in the proportion of expenses for the cost of the eye glasses and eye testing;

(j) Dental cover: NHIF shall cover a member a proportion of expenses, cost of dental consultation, fillings, x-rays, extractions including surgical extractions together with anesthetist`s fees, hospital and operating theatre cost;

(k) Group life cover: NHIF shall pay death benefit upon demise of a member whilst in service, subject to provision and receipt of full documentation; and,



(l) From the onset the fund offered the following insurance covers: Inpatient , out-patient, Group life and Last expense

72. The Board also informed the Committee that, following acceptance of the offer, the NHIF entered into agreements with private health service providers to roll-out the Scheme. Given the short notice and strict deadlines provided by the Ministry of State for Public Service, the Fund used the experience obtained during the 2010/2011 pilot project on capitation approach, wherein three services providers (Meridian Medical Centre, Clinix Healthcare Ltd. Thika Road Health Services and Mbagathi District Hospital) were contracted to roll-out a six-month pilot phase. The pilot phase covered Nairobi, Industrial Area and Mumias areas. The pilot was found to have been a success, since it proved to be easy to administer, had reduced risks on the part of the NHIF and possible exposure of members, had very good costs containment levels and that members accessed unlimited out-patient services at a low and constant cost of Ksh. 2,000 per member;

73. The Committee also heard that-

(i) On November 2, 2011, the Fund had advertised, through an open process, for expression of interest for those interested in offering out-patient services. The private, mission and public facilities that were responsive were declared "service providers". In this regard, most private providers initially quoted Kshs.6,000-9,000 for Capitation, per head per annum.

(ii) The NHIF's actuaries had proposed that, while most of the private consortia and private health service providers had offered a fee of between Ksh.4,500 and 6,500 (during second revision) for provision of Out-Patient services through Capitation and assured volume of an allocation, the experience of the pilot phase showed that a fee of between Ksh.2,500 and 3,000 would be feasible to run a sustainable out-patient scheme providing primary healthcare services. In this

regard, about 377 private and public health service providers, who included Meridian Medical Centre and Clinix Healthcare Ltd. were responsive to the Funds requirement of an Out-Patience Scheme at Ksh. 2,850 per member;

74. Regarding the roll-out of the scheme, the Board Chairperson informed the Committee that , following the launch of the Scheme, The Fund entered into agreements with the public and private health service providers to provide the Out-Patient Scheme at Ksh. 2,850 per member for six months period, commencing January 1, 2012. Payments were to be made on quarterly basis. As part of the contract, it was agreed that members would be allowed to indicate their facility of choice, with provision for change of choice every three months; Public facilities that were responsive were to provide the Out-Patient services at Ksh.1,500 per member

75. The Committee also heard that-

(i) On January 1, 2012, the local print dailies and electronic media carried a major news item indicating that, Government had signed a contract with the NHIF for provision of Medical Insurance Cover for all civil servants and members of the disciplined forces, commencing on the same day. The item was given a lot of prominence, with assertion that, the Ministry of State for Public Service was providing the package as a "**New Year gift for civil servants**". By January 2, 2012, the members were visiting the facilities and demanding services;

(ii) Due to the tight deadlines, the Ministry of State for Public Service advised the NHIF to use the payroll's "**Point of Pay**" to initially allocate facilities to the members. This is where each member is allocated a facility located in the region where their salary is normally remitted. In this regard, on January 4, 2012, NHIF wrote to the Ministry of State for Public Service informing them to remind their members to select their facility of choice. Further, by way of an advertisement appearing in the dailies on January 10, 2012, the NHIF informed all civil servants, TSC secretariat and members of the disciplined

forces of the facilities assigned to each of them. They were also advised to change the facilities within two weeks. They were to do this by filling and submitting a form availed to them through the website, district offices and at the selected private and public health service providers;

(iii) Out of 377 public and private facilities contracted to offer the Out-Patient Services to the 221,720 principal members, their spouses and dependents, Meridian Medical Centre and Clinix Health Care Ltd were chosen by 32,824 and 56,747 principal members, respectively. A total of 211,219 members had participated in the free choice. Following the two facilities were Nyeri PGH (1,958), Consolata Hospital-Nyeri (1,548), Muranga District (1,128), Rift valley PGH (1,313) and Kenyatta National Hospital –Amenity Wing (248). He laid a paper on the breakdown **(Appendix 2: Paper laid by CEO, NHIF on Choices made by members)**;

(iv) In this regard, on March 8, 2012, the NHIF paid a total of Ksh.**634,749,376** to the 377 private and public and service providers, including Ksh. 116,935,500 and Ksh. 202,161,188 paid to Meridian Medical Centre and Clinix Health Care Ltd, respectively. **The payments were made in accordance with the number of possible patients, as chosen by each member, calculated as follows- Ksh. 2,850 X number of persons per facility X 5 pax, divided by four, for each quota;**

(v) It was the view of the Fund that the capacity of service delivery of the healthcare providers had been assessed, certified and licensed by amongst other, the Medical Practitioners' & Dentists' Board. The Health workers working for the private and the public service providers were also licensed by, Kenya Medical Practitioners' and Dentists' Board, Nursing Council of Kenya, Clinical Officers Board, Kenya Medical Laboratory Technicians and Technologist Board and Pharmacy and Poison's Board.

(vi)The Chief Executive Officer also added that the NHIF Board was constantly apprised of the development on the civil servants scheme. He also indicated that the Board had approved the rolling-out of the scheme during their special meetings to consider the scheme. In this regard he tabled before the Committee, copies of Minutes of the Special NHIF Full Board Meetings of January 3, 4, 10, and 19, 2012; and,

(vii) The NHIF Chairperson also indicated that while the first quota of rolling-out the Out-Patient Scheme had "teething problems", the scheme is a good choice and the lessons learnt can be used as the programme is rolled over to the next phase;.

EVIDENCE OF THE MINISTER OF STATE FOR PUBLIC SERVICE

Related previous appearance before the Committee in 2011

76. The Minister of State for Public Service had appeared before the Committee on February 22, 2011 when the Committee was enquiring into the feasibility of the Pilot Project under the Capitation scheme. As at the time, he was also the Ag. Minister for Medical Services. He informed the Committee that the Capitation method was intended to push the risk for out-patient covers to the service providers. This was due to the fact that universally, out-patient covers are the most difficult and risky. He also indicated that pilot project being undertaken only in Mumias and Nairobi was inadequate for the entire population. It ought to have covered a larger population. He added that-

(i) The manner of identification of the private facilities was questionable and may need to be reviewed. The government ought to improve the existing healthcare facilities so that they will, after the roll out, provide improved services. Further, while the employees should contribute partly to the scheme, there are fears on the part of the NHIF, that the funds may be spent on the excessive administrative expenditure;

(ii) On Consultations, every stakeholder will be allowed to make proposals. In this regard, this will require much longer planning period to allow sufficient consultations. In addition, the "members- only" benefit scheme needed to be expanded and the government should budget for the non-contributors, and indigents;

(iii) The proposed out-patient scheme by the NHIF is not a universal scheme and it is not prudent to plan on the assumption that donors will chip, since it may not be realizable. The Fund has poor capacity to roll-out the programme. However, whatever gaps exist may be filled during the period of the implementation. In addition, expansion of government facilities should take priority before the scheme is rolled out; and,

(iv) Whereas the out-patient scheme is long overdue, the matter be reviewed by the substantive Minister with a view to allowing more simulated implementation, consultations, research and review of the risks involved. The programme requires more planned approach. In this regard, if the scheme is implemented as proposed, it may crumble down due to the gaps in the implementation process.

Minister's Second appearance- May 15, 2012

77. Appearing before the Committee again on May 15, 2012, the Minister for Public Service corroborated the evidence of the NHIF Board Management on the chronology of events leading to the launch of the Scheme, save for adding that-

(i) At no time did the Ministry of State for Public Service advice or suggest to the NHIF to use capitation method to roll-out the scheme. Capitation was NHIF's idea;

(ii) The Ministry of State for Public Service is responsible for Human Resource policy formulation and review. In so doing, the Ministry ensures that the

Terms and Conditions of the civil servants are in line with best practices and existing legislations, i.e. the Constitution and Labour laws. The Ministry also frequently consults with the Union of Kenya Civil Servants on various aspects of employees' welfare. One of the benefits that the union was pressing the Government on was provisions of a medical insurance cover. The Union had already filed a case in the industrial court to push for this demand;

(iii) In order to obtain Government approval for the intended policy shift, the Permanent Secretary, MSPS prepared a cabinet memorandum which was presented by the Minister to the Cabinet on June 2, 2011;

(iv) Following the proposed scheme by the Cabinet, the Ministry requested the Treasury to facilitate conversion of monthly medical allowance, ex-gratia medical assistance, in-patient refund and give additional fund as directed by the cabinet. Tenders were advertised for the provision of the medical cover. Further, the Ministry consulted with the Union of Kenya Civil Servants and thereafter, negotiated and signed the contract with NHIF. Thereafter, the Ministry also released circulars to the service providers on introduction and implementation of the scheme;

(v) Following the launch of Scheme and in order to ascertain that the roll-out of the Out-Patient scheme was done as intended, the Ministry, in liaison with NHIF and other stakeholders, conducted inspection visits in February, 2012. The purpose of the visits was to establish the level of preparedness of the health facilities for the scheme and find out how accessible the services are to members;

(vi) The Inspection team found out that, while employees had started benefiting from the scheme, there was need to more information to members and service providers on the roll-out of the scheme. Further, not all listed service

providers had signed contracts with NHIF and members were being turned away when they sought services from such facilities. In addition, most Government facilities had inadequate medical supplies including drug shortages. The team also found out that there were numerous complaints that some members of staff had been allocated to service providers that were not convenient to them.

78. The Minister also informed the Committee that, the inspection team found out that some private facilities that were listed in some areas were non-existent. These included-

(a) Clinix Healthcare, Kitui
(b) Clinix Healthcare, Mwingi,
(c) Clinix Healthcare, Lamu,
(d) Clinix Healthcare, Malindi
(e) Clinix Healthcare, Kilifi
(f) Clinix Healthcare, Murang'a
(g) Clinix Healthcare, Embu
(h) Clinix Healthcare, Namanga
(i) Clinix Healthcare, Loitoktok
(j) Clinix Healthcare, Migori
(k) Clinix Healthcare, Bungoma
(l) Meridian Medical Centre, Malindi

(Appendix 3- Letter by the Ministry of State for Public Service)

79. He added that most of the findings of the inspection team were regarded as "teething problems" which were brought to the attention of NHIF which promised to address them;

80. Regarding capitation and the choice of rolling out the out-patient scheme, the Minister indicated that the Ministry relied on technical advice by NHIF in which it was informed that the fee-for-service financing approach was prone to fraud and administrative delays, and that capitation had been successfully implemented in many developed countries. In

view of the size of the Scheme based on 216,000 principal members plus four (4) dependants each, all totaling to approximately 1.080 million beneficiaries, the Ministry was persuaded that capitation was a better option. Further, in the re-advertisement Tender, the first Consortium had planned to enter into a capitation arrangement with NHIF if the contract was given to them which is a clear indication that capitation is the most economically viable method of managing a Scheme of this proportion.

81. The Minister further informed the Committee that-

(i) Given the magnitude of the Civil Servants and Disciplined Services Medical Insurance Scheme and the fact that it is the first time such a programme is being implemented in the country, the Ministry was of the view that it should be given time to stabilize and the Government accorded an opportunity to learn lessons useful for its improvement;

(ii) Notable achievements in the medical Insurance Scheme have been made in respect of in-patient, last expense and group life benefits. NHIF has promptly paid in-patient bills including emergency cases for members of the Disciplined Forces who have been airlifted from far flung areas in Northern Kenya and have received treatment under the Scheme;

(iii) Twelve beneficiaries had received specialized treatment outside the country. The next of kin of deceased Civil Servants have benefited from payment of Group Life expenses under the Scheme. This has been received very well by beneficiaries due to the timelines in settlement of the claims. A total of 152 claims have been settled so far at a cost of Ksh. 39 million. Due to the successful implementation of the Scheme Teachers under KNUT negotiated a similar contract which was rolled out with effect from March 1, 2012;

82. The Minister also asserted that the Civil Servants Medical Insurance Scheme was initiated with best intentions. He added that the Scheme has the potential to provide quality healthcare benefits to Government employees and that the Ministry was still convinced that the Scheme can achieve this objective. The Scheme would also inject much needed capital to improve the local Healthcare System throughout the country considering the geographical spread of Public Servants. He concluded that the Scheme can provide useful lessons before the introduction of universal social healthcare financing beyond the Public Service.

EVIDENCE OF THE CHIEF EXECUTIVE OFFICER, MEDICAL PRACTITIONERS & DENTISTS BOARD

83. Mr. Daniel M. Yumbya, Chief Executive Officer, Medical Practitioners and Dentists Board accompanied by Dr. Fatma Abdalla, Board member, appeared before the Committee on April 11, 2012. He took the Committee through the registration criteria, licensing and inspections of medical facilities, including mobile clinics. The CEO informed the Committee that the Board had never been consulted by NHIF, with regard to the rolling-out of the new medical scheme and would not therefore in a position to tell whether any or all of the outlets and facilities used by the Fund to provide Out-Patient services for the Civil Servants had been licensed or not;

84. The Committee was concerned that there were unconfirmed reports that some clinics outlets under Clinix HealthCare and/or Meridian Medical Centre were operating without a license and called on the CEO to clarify these allegations. In this regard, the Meeting heard that all new facilities whether operating as a branch, outlets or annex of a parent medical facility must apply individually to the Board for licensing. He also informed the meeting that no facility outlet under Meridian has ever been closed for flouting this provision.

85. The Chief Executive Officer *Tabled* a list showing sixty (60) branches of Clinix Healthcare Ltd. and Thirteen (13) branches of Meridian Medical Centre that had been licensed by the Board as at January 1, 2012;

86. Asked who the known directors of the two providers were, the Chief Executive indicated that, according to their records, the known directors of Meridian Medical Centre were Dr. Ndiba Warioko and Dr. Peter Wambugu Ngunjiri, while those of Clinix Healthcare Ltd. were Jiwanatil Chandara Dabral and Anthony Kalatil Chacko;

87. The Committee raised queries on the licensing of mobile clinics under Clinix HealthCare in Nairobi and Thika yet there were other medical facilities which could offer the same services. The meeting heard that the Board licensed the facilities on the basis that the mobile clinics were to render services in the informal sectors in the two towns;

88. The Committee called on the CEO to clarify why some of the facilities were licensed before they were registered and was informed that the process of licensing of medical facilities takes little time as opposed to that of registration. The Committee was, however, dissatisfied with the answer as no institution should be licensed to operate without having first to be registered as an entity.

EVIDENCE OF THE UNION OF KENYA CIVIL SERVANTS (UKCS)

89. Mr. Tom M. Odege, Secretary General of the Union of Kenya Civil Servants (UKCS) accompanied by Mr. Noah K. Rotich, National Chairman of UKCS, Mr. Justus K. Mugo, Treasurer of UKCS and Mr. Jerry S. Ole Kina, 1st Deputy Secretary General appeared before the Committee on May 8, 2012 and gave evidence on matters related to the rolling out of the new medical scheme under the Fund.

Conceptualization of the scheme

90. The Union informed the Committee that they had been lobbying the government to provide a medical scheme for civil servants since 2007/2008 but after the scheme under NHIF was introduced, they felt that this could be realized through the scheme;

91. The representatives of the Union also indicated that UKCS was involved when the government was looking for a private health insurance provider and before they settled for NHIF. They added that UKCS attended a meeting convened by the Ministry of State for Public Service to discuss the implementation of the same and the agreement of that meeting was that NHIF to implement the roll out of the medical scheme for civil servants and teachers. More planning meetings were held but UKCS did not participate in all and only got an overview of the implementation process through KNUT representative briefing for the public sector;

92. The Union Secretary General added that, in the month of December 2011, the UKCS management, the Ministry of State for Public Service and NHIF Board and Management met UKCS, was apprised on the implementation of the proposed medical scheme. This was followed up with stakeholders sharing forum in Kabete. Further, on January 5, 2012, UKCS attended the launch of the Medical scheme by the Ministry of State for Public Service as witness to the signing of the contract between the Ministry and NHIF;

Choice of health facilities

93. Regarding Choice of health facilities, the Union informed the Committee that Civil Servants were allocated hospitals without their knowledge using pay-point centres that the Ministry of State for Public Service had forwarded to the NHIF management. The Pay-Point Centres list was to be used for allocation of health facilities to the members, a proposal that the Union had objected to and asked the Ministry of State for Public Service and the NHIF to urgently review; they added that the accredited facilities were not equitably distributed according to the Kenya geographical set-ups e.g. Tana River County had been allocated only two health facilities which are very far from the

beneficiaries, leaving other existing public facilities, which would have been more suitable;

Existence of facilities

94. In connection with the existence of facilities, the Union informed the Committee that at team of officers, from the Union, the Ministry of State for Public Service, the NHIF the Medical Services, and the Kenya Police Department, toured Kenyatta National Hospital, Mbagathi District Hospital, Meridian Clinic (Capital Centre, Mombasa Road), Clinix Health Care (Comcraft House- Haille Sellasie Ave.) and Clinix Health Care (Teleposta Plaza) in mid February, 2012. The intention of the visits was to ascertain that the roll-out was according to the information provided by the Fund and the Ministry of State for Public Service. They found out that, while Clinix Healthcare, (Haile Sellasie branch - Comcraft House) was evidently overcrowded and showed limited capacity to meet the high demand of services, their Tele-posta outlet was in a "tiny corridor" and was still under refurbishment. Services were not being provided at the latter; Services at the other four facilities visited were ongoing. He added that, from the information obtained, Meridian Medical Centre had showed consistent growth. From the visits, the Capital Centre Branch, for instance, had sufficient key medical staff and exhibited capacity to offer services; and,

95. The Union later asked the NHIF Board to ensure that Kenyatta National Hospital, Mbagathi District Hospital, Mama Lucy Hospital and Mathare Hospital were fully accredited to provide the healthcare services because of their current high number of out-patients.

Roll-out of the scheme

96. The Union informed the Committee that the Ministry of State for Public Service and the NHIF only allowed the UKCS to come on board after realization that the scheme would not be effective unless their branch officials were involved. The Secretary General also informed the Committee that the whole process was hurriedly done without proper planning and involvement of the civil servants. The sensitization process of scheme

would have preceded the roll-out. Some healthcare service providers accredited to provide the services lacked the commensurate capacity in relation to the number of persons allocated to them;

97. The Union Secretary General also indicated that the scheme lacks an effective referral system where members outside the geographical setup could also benefit from the services. He also indicated that the co-payment of Kshs. 100 - Kshs. 200 under the scheme was being misused and the charges per visit were unaffordable to some civil servants. He noted that, despite the fact that some government hospitals were allocated money to provide the health care services, most of them had reputation of lack of basic pharmaceuticals. He implored upon the Ministry of State for Public Service and the NHIF to market the scheme and not leave that aspect to the accredited facilities. The Union also indicated that there were fears amongst the members that capitation model being used could not ensure quality adherence since most of the accredited health care providers were concerned on maximization of profit rather than provision of the primary healthcare services.

EVIDENCE OF THE MINISTER FOR MEDICAL SERVICES;

98. The Hon. (Prof) Peter Anyang' Nyong'o EGH, MP, Minister for Medical Services, accompanied by Ms. Mary W. Ngari, Permanent Secretary, Ministry of Medical Services,Dr. Francis Kimani, Director of Medical Services, Mr. Adana A. Adan, Ag. CEO NHIF, Mr. Elkana Onguti, Chief Economist in the Ministry, Mr. Abdi Ibrahim, Acting Under Secretary in the Ministry, Mr. Chacha Marwa, Manager Strategy NHIF, Mr. Victor Nyangaya, Chief Probation Officer/ Personal Assistant to the Minister and Mr. Abdala Wanga, CEO MTTLB; appeared before the Committee on May 15, 2012 and to adduced evidence on the alleged irregularities in the rolling up of the newly introduced out-patient healthcare insurance scheme for public servants and teachers under the National Hospital Insurance Fund.

99. The Minister adduced evidence on matters related to the rolling-out of the Scheme, as follows-

Background to the Insurance Scheme

(i) The outpatient scheme for the civil servants was an initiative of the Ministry of State for Public Service. However, prior to this NHIF was in the process of establishing ways of realizing universal health coverage. In this regard, the NHIF together with Alexander Forbes undertook a pilot study on out-patient scheme in Mumias and Nairobi as one of its reform process in order to realize universal health coverage. This was followed later by the study on Strategic Management of the NHIF. Further, the Ministry of State for Public Service who is the client/insured also sits in the Board of NHIF to represent the interest of the Public Service sector;

(ii) Regarding the outpatient scheme for civil servants, a Cabinet approval was obtained by the Ministry of State for Public Service and thereafter an advertisement for expression of interest was carried out. He added that, from the information obtained from the Ministry of State for Public Service, one of the private insurance consortia had quoted Ksh. 12 billion. The lowest bidder had quoted an amount of Ksh.4.3 billion, but had inhibitive exclusions and failed on the parameter of technical capacity. Following failure by the private insurance firms to meet the requirements of the tender, even after they were given a second opportunity, the Ministry approached NHIF to offer the services. The choice of NHIF was strengthened by the fact the Fund had undertaken a successful pilot and that even one of the insurance consortia that tendered had indicated in the tender documents that they would sub-contract the NHIF to offer the out-patient services on their behalf;

(iii) Following the roll-out of the scheme, the NHIF made payments to the private service providers, for the first quarter. Due to delays in disbursement of funds from the Ministry of Public Service to execute the Agreement made between the Fund

and the Ministry on January 5, 2012, the NHIF subsequently delayed to make the payments until March 8, 2012;

(iv) Like any other new programme, the out-patient Insurance Scheme had experienced "teething problems" in the first quarter of its existence. These included inadequate time for preparations, poor infrastructure, shortage of human resource, inadequate equipment, and shortage of drugs. In this respect, the Government was in the process of addressing the challenges experienced;

(v) Even though the entire Medical Insurance Scheme for Civil Servants and Disciplined Forces had four components namely:- In-Patient, Out-Patient, Group Cover and Last Expense, only the Out-Patient had experienced challenges;

The Role of the Ministry in conceptualizing and rolling out of the pilot project

100. The Minister informed the Committee that the pilot project of 2009/10 was meant to test the rolling out the universal health coverage scheme and did not envisage the coming of the Civil Servants Scheme. The new Civil Service and Discipline Forces Scheme was negotiated between the Ministry of State for Public Service (MSPS) and NHIF where the Ministry's role included service provision and regulatory issues. The cover is a Premium Scheme designed by Ministry of State for Public Service and administered by the NHIF through a Contractual Agreement. The Fund, through the Board of Directors made independent decisions during their Special meetings of January 3rd , 4th , 10th and 19th, 2012; wherein the proposal to offer and roll-out the Scheme on behalf of the MSPS was presented to the Board, discussed and adopted. The Minister laid a document containing copies of the Minutes of Board for the said sittings **(See Appendix 4: Minutes of the NHIF Special Board)**. He added that the participation of the Ministry in the Board matters is also limited to guidance and the general direction of the Board.

Action taken by the Ministry following allegations of irregularities

101. The Minister informed the Committee that-

(i) Following allegations of the irregularities the Minister has held several meetings with the NHIF Board Chairman and Chief Executive Officer, with a view to advising them to address the said allegations and ensure that the programme runs smoothly, in accordance with the Agreement;

(ii) On 2nd May 2012 a special board meeting to receive the first Report on the implementation of the scheme turned out deliberate on matters that were not in the agenda. This was a missed opportunity to receive the report in order to identify implementation challenges. It was unfortunate that instead of the Board addressing the agenda, there was "drama" in the full glare of the media resulting in the ultimate suspension of the Board and the Chief Executive Officer;

(iii) Following the continued disagreements in the Board as exemplified during the public spat between the Board Chairperson and Vice-Chairperson, the government upheld the decision to suspend the entire Board and Chief Executive Officer. Further, on 14th May 2012, the government appointed a caretaker committee and Ag.CEO to run the affairs of the Fund for a period of three months. The, Government also invited the Efficiency Monitoring Unit, the Ethics & Anti-Corruption, the Kenya National Audit Office and the Inspectorate of State Corporations to conduct a forensic audit of the Out-Patient Scheme;

102. The Minister asserted that his decision to suspend the Chairperson of the Board was informed by the fact that the Chairperson acted *ultra-vires* as he had no power to suspend the Chief Executive officer without an express resolution of the Board considering and approving such action. Further, the "drama" that followed the announcement of the intended suspension of the CEO was not in tandem with conduct expected of a public or state officer.

The view of the Ministry on the capitation approach as an alternative to provision of universal out-patient healthcare services

103. The Minister informed the Committee that Capitation is a prospective payment mechanism where a fixed sum per person is paid in advance of the coverage period to a healthcare provider in consideration of its providing, or arranging to provide, contracted healthcare services to the eligible person for the specified period. The Minister added-

(i) That, capitation has the advantage of improving operating costs due to appropriate use of agreed healthcare products and the fact that it reduces the bureaucratic red-tape that slows reconciliation exchanges between the service provider and payers. In addition, market dynamics between different competing providers results in a focused balance on quality and cost. This makes the provider customer responsive, and also reduces the likelihood of wastage, over-servicing and fraud due to the transparent nature of the contract. Capitation is very appropriate when a payer is dealing with a large number of members and providers.

(ii) That, the only major disadvantage of the system is the potential for reduction in the quality of care especially if tangible and realistic service level agreements are not implemented. Capitation can also, if not checked, lead to exclusion of patients considered by providers to be "high risk".

(iii) Arising from the fore-going therefore, the Ministry did not have any objection with the NHIF and the client Ministry to use capitation as per the contractual obligations. It should be noted too, that the Capitation method has been supported by a Sessional Paper No.2 of May 2004 on the National Social Health Insurance in Kenya.

View of the Ministry on the rolling out of the fist quota of the said scheme

104. Regarding the role of the Ministry in the Scheme, he informed the Committee that-

(i) although the implementation of the scheme had faced challenges, the scheme was noble and the Ministry endeavors to work and mitigate the challenges. Indeed, the contract has provision to review the implementation of the scheme after every six months;

(ii) the Ministry of Medical Services has since advised the NHIF to readily reform the Quality Assurance department and establish a joint accreditation committee comprising all the regulatory bodies and the department of Standards in the Ministry. Further, the Ministry has also advised the NHIF and the MPDB to conduct a countrywide inspection to ascertain existence and capacity of all the private and public health providers under the Scheme.

EVIDENCE OF SECRETARY GENERAL AND CHAIRPERSON, KENYA NATIONAL UNION OF TEACHERS

105. Mr. David O. Osiany, Secretary General of KNUT, accompanied by Mr. Wycliffe E. Omucheyi, 2nd National Vice-Chairman, Mr. Albanus Paul Mutisya, National Treasurer, Ms. Jacinta W. Ndegwa, 2nd National Women representative and Mr. Ekirapa G. Okwara, Senior Executive Officer appeared before the Committee on May 8, 2012 and gave evidence on matters related to the rolling-out of the new medical scheme under the Fund.

Commitment of the Signing of the Contract between KNUT and the NHIF

106. The Secretary General of informed the Committee that, from October 2011, KNUT had indicated its wish to negotiate for a medical scheme for its members with NHIF different from the one for Civil Servants. A negotiation team comprising of fourteen (14) members-seven (7) drawn from either side. The Union held seven meetings with NHIF that culminated in signing of an Agreement for provision of a comprehensive Medical Insurance Cover for Teachers. He also informed the Committee that the two teams reached a compromise that the scheme should cover all members of KNUT (i.e. teachers, KNUT officials and workers). Further, the Scheme should provide full medical cover for the physically challenged members. Further, the scheme will provided for

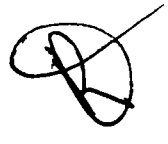
more than one spouse to be covered, with an extra charge for the additional spouse in the Agreement, KNUT will monitor the roll out of the scheme by having a KNUT official chair the Quality Assurance Committee of the NHIF's Board. At the branch level, the NHIF Branch managers will also work closely with the KNUT branch officials to ensure smooth roll-out and continued quality services. From the above set of agreements, the Union found the deal to be attractive and acceded to the same;

107. The Committee also heard that the Union relied on NHIF to provide them with a list of registered and accredited hospitals to HNIF. The teachers, through the guidance of the KNUT branches, chose their preferred facilities from the list supplied from NHIF. The Committee was also informed that, unlike the Civil Servants Scheme, the teachers' scheme did not have the "Last Respect Expense" and 'Life Insurance" provisions as this was already provided for under the Union's Benevolent Fund for its Members. The Secretary General also informed the Committee that the annual payment that the Teacher Service Commission is expected to be remitting to the NHIF under the Scheme is Kshs. 4.2 billion per year to cover over 250,000 members of the Union.

Roll-Out of the scheme in the last and current quota

108. The Committee heard that, the KNUT has had no complaints from its members. The Union's view is that the roll-out should continue and any person found to be culpable for any corruption should be reprimanded. However, the Committee also heard that the views held by the national Chairman of the Union on the management of affairs at the NHIF were not necessarily those of the KNUT.

109. The Union representatives also said that their confidence on the NHIF's capacity to roll-out the scheme had dwindled based on the current crisis facing the Fund. However, the Union felt that their scheme should continue as the terms were different from those of the civil servants.



EVIDENCE OF REPRESENTATIVES, KENYA PRIVATE HEALTH SERVICE PROVIDERS

110. Dr. Peter Omoga, Secretary General of the Consortium Kenya of Private Healthcare Providers accompanied by Dr. David Kanyenje Gakombe, Vice Chair and Mr. John Mariti Chief Executive Officer, Private Health providers Consortium appeared before the Committee on May 9, 2012 and gave evidence on matters related to the rolling- out of the new medical scheme under the Fund.

111. The Vice-Chairperson informed the Committee that, whilst Consortium of Kenya Private Healthcare Providers supports the Civil Servants Medical Scheme and the Capitation model employed, they had concerns on the manner in which it was being rolled-out. He informed the Committee that there was no equity in identification of facilities to offer services and the NHIF took away the right of patients to choose a facility and initially chose the facilities for them. The Committee further heard that, NHIF ought to have accredited facilities after they had been registered, but not to accredit a firm as a block, without ascertaining their capacity to roll-out.

112. Asked whether they participated in the Pilot project, he informed the Committee that, the Association had asked for a meeting with NHIF Board after some of their members were left out and they also felt that some private health service providers were given undue advantage after participating at the pilot project yet they did not have a national geographical spread.

113. They suggested that the NHIF and the Ministry of State for Public Service should have first defined the basic package of the cover to the members, consider the geographical capacity of the facilities in each region, including equipment and staffing, before the roll-out. He was of the view that most of the facilities had put up their infrastructure long after being accredited to NHIF.

114. The Committee enquired why Association failed to give any positive side of the Capitation and/or the roll-out. The Members asked whether Association's members had quoted for the scheme. He informed the Committee that capitation model was foreign where facilities quoted for outpatient services without any bill of quantities and explained that is why most private health service providers declined the NHIF capitation offer of Kshs. 2850 per annum. He indicated most members of the Association had given their offer for capitation at Kshs. 6,000 to 9,000 per year. He also indicated that both Clinix and Meridian were not members of the Association.

EVIDENCE OF THE REGISTRAR, MEDICAL PRACTITIONERS AND DENTISTS BOARD

115. Dr. Francis Kimani, the Registrar of the Medical, Practitioners and Dentists Board (MPDB) who is also the Director of Medical Services and Member of the NHIF Board, accompanied by Dr. Stephen Ochiel, Member of the Board and Mr. Joseph Kariuki of the Registry Board Members appeared before the Committee on May 14, 2012 and adduced evidence on the registration of private health services providers under the Out-Patient Insurance Scheme for Civil Servants. He informed the Committee that the MPDB as established under Cap 253 is mandated to regulate the practice of medicine and dentistry in the country. He added that the Board also has powers to register and license Private and Faith- Based Medical Institutions and has since has registered a total of 2,623 Private and Faith -Based Medical Institutions.

Process of Registration & Licensing

116. Registrar took the committee through the process of registration and licensing of Private and Faith- Based Medical Institutions highlighting that prior to registration, a facility should be inspected by the Medical Officer of Health institution. He added that Medical Health Professionals, such as doctors, nurses and pharmacists working therein must also be registered and licensed by their respective Boards or Councils. Further, it may be a requirement for other Health Regulatory Authorities to obtain their licenses for their facilities, such as Laboratory, Pharmacy and Radiology Services;

117. The Registrar also informed the Committee that after receiving the applications senior Licensing Officers at the MPDB processes the applications and forwards them to the Chief Executive Officer and Chair Private Practice Committee, with advice of either approval or rejection. Upon approval, the Annual License is prepared and forwarded to the Registrar for signature and seal. Subsequently, registration Certificate is prepared for the signature of the Chairman and the Registrar. Thereafter, the License/Registration Certificate is dispatched to the Institution.

118. At the end of the process, a list of approved institution is submitted to Private Practice Committee of the Board for adoption. The adopted list of approved institutions by the Committee is submitted on quarterly basis to the Full Board of the MPDB for ratification.

119. The Registrar also informed the Committee that, in most cases, medical clinics must have a minimum of two rooms and that the Board can license a medical clinic/dispensary which is run by either a Medical Doctor, Dentist, a Clinical Officer or a Registered Community Health Nurse. Further, acknowledgement letters are at times given to enable the facility be inspected, processes single business license from local authorities or at times obtain drugs from MEDS by Faith -Based Institutions.

120. The Registrar added that the Board has licensed a total of 492 private and faith based health institutions since November 2010. Out of these, 161 facilities were licensed between January 1, and end of April 2012. He added that since 2006, the Board has licensed a total of 17 Meridian Medical Centre's facilities and 71 Facilities belonging to Clinix Healthcare Ltd. **(Appendix 5: List of facilities licensed under Meridian Medical Centre's and Clinix Healthcare Ltd. from 2006 to April, 2012);**

121. The Committee also heard that, licenses are renewed annually. In this regard, the Board has issued annual licenses for 1,553 facilities which are the only ones allowed to practice

in the year 2012. The list included the Meridian Medical Centre's facilities and the facilities belonging to Clinix Healthcare Ltd;

Accrediting NHIF's Facilities

122. Following the advertisement of the Medical Insurance Scheme by the Ministry of State for Public Service on June 2011 (Ref. Tender No. MSPS/HRM (P) 01/2011/2012), the Registrar wrote on June 24, 2011 to the Secretary, Public Service Commission and advising that the Medical Practitioners and Dentist Board should be involved in the process to ensure that institutions involved are licensed and registered to offer the services. **(Appendix 6: Letter by the DMS to MSPS).** The letter was neither acknowledged nor acted upon;

123. He added that the Civil Servants and Disciplined Forces Scheme started on January 1, 2012. The NHIF Board was called for a meeting on January 3, 2012, and informed that the Ministry of State for Public Service (MSPS) had approached NHIF to provide the covers to Civil Servants. In its deliberations, Board also recommended that most Public, Faith Based Organizations and low cost private health service provider be involved in providing the services;

124. To ensure that the Scheme was beneficial to public health facilities the Director of Medical Services (DMS) on January 5, 2012 called a meeting of all Provincial Directors of Medical Services and Medical Superintendent of large volume hospitals. They were sensitized by the CEO, NHIF and the DMS and agreed on the following-

(a) all Provincial Directors to inform Government Hospitals to identify where Civil Servants Clinic may be set within their facilities and ensure renovation of these facilities, where required were undertaken using the cost sharing funds;

(b) All civil servants seeking services must be attended to and the facilities need to open registers for all Civil Servants and their families seeking services under the Scheme;

(c) The Provincial Administration (DC's, DO's Chief and Sub-Chiefs) were to inform the public that Government hospitals were providing out -patient services under the new Civil Service Scheme;

(d) The Faith-Based hospitals were to be invited for a meeting and be briefed about the Scheme and how they should be involved. This was done during the 2nd week of January, 2012.

125. The Registrar further informed the Committee that, initially, Civil Servants were allocated to various facillities and within the same month due to complaints, they were advised to change to facilities of their own choice within a period of two weeks. Thereafter, before the end of January 2012, complaints were received that Civil Servants were allocated to non-existing clinics and "Clinix" was mentioned as one of them. The NHIF Board advised that all non-registered and non- licensed facilities to be removed from NHIF website and were therefore not to be allocated patients. The Board also insisted that Civil Servants be allowed to choose facilities of their choice.

126. He also said that he had tabled, before the NHIF Board, a list showing Clinix's facilities which were not registered and licensed as of 20th January 2012 and which were not supposed to be included in the NHIF's list; **(Appendix 7: DMS List of non-existent facilities)**

127. On conclusion, he added that he was surprised that, at the end of the 1st quarter, Government and Faith- Based facilities, which he would have expected to get the largest portion of the funds, especially outside Nairobi, had not substantially benefitted from the Scheme.

EVIDENCE OF CHIEF EXECUTIVE AND MANAGEMENT, MERIDIAN MEDICAL CENTRE

128. Dr. Peter Wambugu, Chief Executive Officer & a Director, Meridian Medical Centre accompanied by Dr. Ndiba Warioko, Director, Operations, Meridian Medical Centre, Dr. Richard Gichohi, Clinical Services Manager, Mr. Martin Njeru, Management Accountant and Ms. Caroline Mwangi Muhoro, Human Resources; appeared before the Committee on May 2nd 2012 and gave evidence on matters related to the rolling out of the new medical scheme under the Fund.

Company profile

129. He informed the Committee that the Meridian Medical Centre is an indigenous Kenyan Company established in 1995 to provide integrated health solutions. He added that the company has grown from one Brach in 1995 to the current 19 branches, with an average growth of at least one new branch per year, even though the highest growth was recorded from 2007 to 2011, after the company rebranded and adopted an expansion oriented strategic plan. In this regard, the Company changed its Board to bring in the required corporate management and has been employing more medical and other staff. He tabled a list of their medical staff and some of their registration certificates. He added that they have also since entered into strategic partnership with a Dutch investment firm, TBL Mirror Fund.

Branches

130. He also informed the Committee that they opened four branches in 2012, and that all the 19 branches have since been accredited to NHIF, including the Meridian Equator Hospital, which they acquired in 2010. He tabled a list of their branches ;

Payment of 1st Quarter from NHIF and criteria used to select Facilities

131. The Committee heard that the payment made for Meridian facilities for the 1st quarter was done in March 2012 and was based on the number of clients allocated to the service provider and not on the number of facilities under Meridian. The

Committee also heard that, this followed the signing of the agreement between the Firm and the NHIF to provide health-care to civil servants and members of the disciplined forces, their spouses and up to three of their dependents. In this regard, Meridian Medical Centre accepted the annual capitation rate of 2,850 per person proposed by NHIF for the 32,000 principal members plus their dependents allocated to them, payable in four quarters, per year. The management alluded that Meridian has not been involved in any irregularities under the contract, as alleged and that the growth of the firm was as per their strategic plan, 2008-2013.

Explanation regarding the Renovation of Meridian Medical centre, Kitengela

132. During the tour to inspect facilities in Nairobi accredited to NHIF, the Committee found the Kitengela Meridian under renovation and was closed for services. The Committee enquired to know whether Meridian had informed NHIF. The Committee heard that Meridian did not inform NHIF on the disruption of services, yet they were supposed to continue rendering the already paid for services.

EVIDENCE OF REPRESENTATIVES AND MANAGEMENT OF CLINIX HEALTHCARE LTD.

133. Mr. Zac T. A. Madahana, Chief Executive Officerr, Clinix Health Care Ltd., accompanied by Mr. Anthony Kalathil Chacko, Executive Director, Ms. Rose Kingatua, General Manager- Business Development, Mr. Edward Aboki Begi, General Manager-Corporate Affairs, Mr. Peter Okwatsa, Medical Administrator and Mr. Samuel Karanja, Clinix Health Care External Lawyer; appeared before the Committee on April 26, May 3 and May 8, 2012 . During the meetings of April 26 and May 8, the Chief Executive officer gave evidence on oath. The management gave evidence on matters related to the rolling- out of the new medical scheme under the Fund, how they were identified as service providers under the NHIF capitation scheme, details of facilities under Clinix including their registration/licensing and physical location and addresses.

134. During the appearance of May 8, 2012, the Management was accompanied by a Mr. Jayesh Saini, who introduced himself as the Chairperson of Clinix Health Care Ltd and also gave evidence on oath.

135. Regarding the shareholding of the firm, the Chief Executive Officer and Chairperson of Clinix Healthcare informed the Committee that Clinix Healthcare Ltd. is owned by two companies namely: Pharma Investment Holding Limited and Beneficial Investment Limited. The Committee was further informed that, Pharma Investment Holdings Ltd owns 990 shares while Beneficial Investment Ltd ownes the balance of 10 shares in Clinix Heath Care Ltd. Pharma Investment Holdings Ltd is represented by Mr. Anthony Kalathil Chacko as a Director in Clinix Health Care Ltd while Beneficial Investment Ltd is represented by a Mr. Jiwan Chandra Dabral. At the meeting of May 8, 2012 Mr. Jayesh Saini claimed to own Pharma Investment Holdings Ltd.

Brief History of Clinix Health Care

136. The Chief Executive Officer took the Committee through a brief history of Clinix health Care Ltd and informed the Committee that, Clinix was incorporated on June 23, 2006 and bears Certificate of Incorporation No. 125937 with its registered offices as Nairobi West, off Muthaiti Road Avenue, LR. No. 37/242/2, Nairobi.

137. The Committee was also informed that Clinix had seventy one (71) registered outlets, spread all over the country. The Committee also heard that, Clinix has outlets in Uganda, Tanzania, Burundi, Congo, Ghana and Nigeria and over 50 other branches awaiting inspection and registration. The 71 branches have over 600 employees. The Committee was further informed that, Clinix offers a range of products and services that include but not limited to doctor's consultation, outpatient and nursing care, laboratory tests and investigations, ultrasound and radiography services, MRI/CT scan services, drug dispensing, immunization, minor surgery, ambulance services, specialist clinics (e.g. Gynecology, ENT, Ophthalmology, General Surgeon, Orthopedic Surgeon, Physician, Psychiatry, Physiotherapy, Dietician and Clinical Psychologist), casualty, Maternity and Pediatrics services, pharmacy and

mobile clinics. The Committee was also informed that Clinix had qualified medical personnel to offer the above services;

138. The Committee further heard that, Clinix had a wide range of clientele that included the Parliamentary Service Commission, private companies, state corporations and local authorities. The Chief Executive Officer indicated to the meeting, the seventy one (71) Clinix Branches were ostensibly accredited by the NHIF to offer out-patient services. They comprised of- Athi River Daystar Clinix ; Valley Road Daystar Clinix ; Haile Selassie Clinix; Embakasi Clinix; Kisumu Clinix; Nakuru RVR Clinix ; Mombasa Clinix ; Voi Clinix ; Eldoret Clinix ; Buruburu Clinix ; Central Workshop Clinix ; Eastleigh Clinix ; Garisa Clinix ; Mobile Clinix ; Isiolo Clinix ; Jogoo Road Clinix ; Kitui Clinix ; Mumias Clinix ; Pipeline Clinix ; South C. Clinix ; Teleposta Clinix ; Enterprise Road Clinix ; Kibera Clinix ; Pangani (Park Road) Clinix ; Bomet Clinix ; Bungoma Clinix ; Busia Clinix ; Chogoria Clinix ; Chuka Clinix ; City Hall Clinix ; Eldoret B Clinix ; Embu Kangaru Clinix ; Kakamega Clinix Kapsabet Clinix ; Kiambu Clinix ; Kiambu B. Clinix ; Kilifi Clinix ; Kiserian Clinix; Kwale Clinix ; Likoni Clinix ; Litein Clinix ; Machakos Clinix ; Malindi Clinix ; Meru Central Clinix ; Molo Clinix ; Naivasha Clinix ; Narok Clinix ; Nandi Hills Clinix ; Ngong Road Clinix ; Kongowea Clinix ; Olkalau (Nyandarua) Clinix ; Ongata Rongai Clinix ; Sameer Africa Clinix ; Ukunda Clinix ; Webuye Clinix ; Annex Nairobi West Clinix ; Gatundu (Thika B) Clinix ; Gilgil Clinix ; Iten Clinix ; Karbarnet Clinix ; Kerugoya (Kirinyaga) Clinix; Kimili Clinix ; Kitale Clinix ; Kutus (Kirinyaga) Clinix ; Lamu Clinix ; Maua Clinix; Moi's Bridge Clinix ; Nyali Bridge Medical Centre (Kongowea) Clinix ; Loitoktok Clinix ; Vihiga Clinix and Wundanyi Clinix. The CEO presented to the Committee copies of previous and current registration certificates of the branches and laid a paper indicating the physical locations of the branches. **(Appendix 8: Branches of Clinix Healthcare Ltd, showing locations)**

139. The Committee was also informed that, in areas where Clinix Healthcare does not have branches/out-lets; it has engaged with "Third Party Service Providers" through

level service agreements to render services on its behalf and bill Clinix Healthcare for payment.

140. The firm further presented to the Committee, physical details and addresses of the above branches/outlets. However, some of the branches did not have details of their physical addresses and locations at all, while others, provided details were not clear e.g. the Pipeline Clinix whose physical address has been given as "Along Outering Road". They however informed the Committee that 63,299 NHIF members visited Clinix facilities throughout the country between January and March, 2012.

Payments

141. The management informed the Committee that, following the signing of an Agreement with the NHIF to offer out-patient services to Civil Servants, members of the Disciplined Forces, their spouses and dependants on behalf of the NHIF, Clinix Health Care Ltd was chosen by 56,747 principal members.

142. The Committee also heard that, while the Capitation Agreement signed between NHIF and Clinix Healthcare stated that the NHIF ought to have paid the healthcare providers on quarterly basis at the beginning of the programme, the Fund only released the amount of Ksh. 202,161,188 in March, 2012,three months later;

143. The Management and the Chairperson of Clinix Healthcare refuted claims that they were paid as per branches and insisted that, they were paid according to the Capitation Agreement which indicated that Clinix was engaged as one entity, and not per branches. The management also asserted that the List tabled by the NHIF (Appendix 9: NHIF's Schedule of Segregated Payments to Clinix and Meridian) was strange to them and the tabulations indicated on it were not factual since they payments were not based on the number of branches, but on the number of persons that choose Clinix. In this regard, they indicated that the amount of Ksh. 202,161,188 was arrived at as follows- Ksh. 2, 850 (capitation per head)X 56,747 principals X 5 persons (principal, spouse + three dependants).

144. Asked whether any of his firms or himself has ever been under any investigations by Anti-Corruption agencies, Mr. Saini responded in the negative.

EVIDENCE OF THE REGISTRAR GENERAL

145. The Committee first wrote to the Registrar on March 26th 2012, regarding the directorship of Clinix Healthcare and Meridian Medical Centre. The Registrar replied, indicating the directors of Meridian Medical Centre as Peter Ngunjiri Wambugu; Warioko Ndiba; TBL Mirror Fund-BV (Netherlands); and Nicholas Nyaga. She indicated that Directors of Clinix Healthcare Ltd were Pharma Investments Holdings (99%) and Beneficial Limited (1%). The registered office of Clinix was indicated as LR.No. 209/5788 Shell/BP House. The Registrar gave directors/shareholders of Beneficial Ltd. As Eric Mutua Munzyu and Mtalaki Mwashimba, both Kenyans of address 44642-00100, Nairobi. The Directors of Pharma Investments Holdings were not indicated in the written response. **(Appendix 10:Letters by the Registrar General)**

Shareholding of Pharma Investments Holdings

146. Thereafter, the Committee requested for information regarding the shareholders of Pharma Investments Holdings. The Registrar replied on April 18, 2012, that *"Pharma Investments Holdings is not registered in Kenya. However, documents presented for registration of Clinix Healthcare Limited indicate that Pharma Investments Holdings Limited is a company registered in the British Virgin Island under number C.1028943"*

147. Later, the Registrar-General, Ms. Bernice Gachegu appeared before the Committee on May 10, 2012 and informed the Committee that-

(i) Documents relating to the registration of Clinix Health HealthCare Limited were lodged at the Company's Registry, on June 13, 2006 and subsequently the company was registered on June 23,, 2006 as C.125937. The share capital of the company is Kshs.100,000, divided into 1,000 shares of Kshs.100. Further, according to the Form No.201 – Notice of Situation of Registered Office or of

any Change Therein – lodged at registration, the registered office was LR.209/5788 Shell/BP House, Nairobi Haile Selassie Road P.O. Box 43375 Nairobi;

(ii) At registration, the shareholders of the company were Pharma Investment Holdings Limited (C.1028943) P.O. Box 428 Town Road, British Virgin Island with 990 shares and Beneficial Limited (C.105,953) of P.O. box 52439-00200 Nairobi with 10 shares. The above mentioned companies were also the directors of the company, according to Form No.203.

148. She provided the details of the shareholders and directors are as follows-

(a) Pharma Investment Holding Limited

While lodging the incorporation documents the applicants attached a Certificate of Incorporation for Pharma Investment Holdings Limited (The certificate indicates that the company was registered under the "Territory of the British Virgin Island BVI Business Companies Act, 2004". It was registered on 19th of May 2006 as BVI Company:1028943 and signed by the Registrar of Corporate Affairs.

(b) Beneficial Limited C.105953

Documents relating to this company were lodged at the Company's Registry on the 25th of September 2003 and the company was subsequently registered on the 25th of September 2003 as registration number c. 105953 (a copy of the certificate of incorporation is attached). The nominal capital of the company is Kshs.20,000,divided into 1000 shares of Kshs.20.

149. The Registrar added that, at incorporation, the shareholders of Beneficial Limited were Eric Mutua Munzyu of P.O. Box 44652 Nairobi with one (1) share and Mtalaki Mwashimba of P.O. Box 4465-00100 Nairobi also with one (1) share. Said persons

are also the directors of the company according to Form No.203. The registered office of the company according to Form No.201 is Jubilee Insurance Place, Wabera Street Nairobi, L.R. No.209/2652 P.O. Box 44652-00100 Nairobi. She added that no Annual returns have been in the company file since its inception.

History of Annual Returns filed by Clinix Healthcare Limited

150. The Registrar informed the Committee that the first Annual Return is dated 31st December 2007 and was filed on 15th January, 2008. The shareholders of the company were Pharma Investment Holdings Limited and Beneficial Limited. The directors of the company were Jiwan Dabral and Anthony C. Kalathil. The second return was dated 31st December 2008 and was filed on 15th January 2009 and the shareholders and directors were the same as the previous year;

151. Further, the third return is dated 31st December 2009 and was filed on 14th January 2010 and again the directors and shareholders were the same. The fourth return in the file is dated 31st December 2010 and was filed in 14th January, 2011. The details in the return remain the same as in the previous year's i.e. Shareholders, Pharma Investment Holdings Limited with 990 shares and Beneficial Limited with 10 shares and directors as Jiwan Dabral and Anthony C. Kalathil.

152. She also added that even though the Annual Returns for the year 2007 indicated a change in directorship of the company from Pharma Investment Company Limited and Beneficial Limited to Jiwan Dabral and Anthony C. Kalathil, it has been noted that the company did not file a Form 203A as evidence of the appointment of the new directors as per the Annual Returns they had previously filed. In this regard, in another letter dated 27th April 2012, the company was informed that they should file form 203A and the Annual Return for 2011.

Application of Section 365 of the Companies Act

153. The Registrar also informed the Committee that, in her interpretation of Section 365 of the Companies Act (Cap 486), Pharma Holdings was a foreign company, not

having a place of business in Kenya, but doing business through an agent, In this regard, Sections 366 to 375 of the Act, do not apply to Pharma Holdings Ltd. The said sections require a foreign company to submit certain documents to the Registry such list of their directors, certified copies of memorandum and articles of association, addresses of registered principal office, make annual returns, and exhibit the name of company and country in which the company is incorporated.

154. However, the Registrar did not satisfy the Committee as to who was the agent of Pharma Holdings. While she initially indicated that the agent was deemed to be Clinix Healthcare Ltd, she withdrew the statement later after further questioning.

155. The Committee directed the Registrar to use all means possible within the law to establish the owners of Pharma Investment Holdings Ltd. and advise the Committee before they report to the House.

MEMORANDUM RECEIVED THE KENYA PHARMACISTS, MEDICAL PRACTITIONERS AND DENTISTS UNION.

156. In their Memoranda, the Union commended the nobility and the efforts behind the launch of the medical cover for all civil servants through NHIF. They described it as a step towards achieving universal health care in Kenya. The Union indicated that they had noted the following shortcomings in the implementation of the Scheme-

(i) Health facilities & infrastructure, recruitment and retention of skilled health workers and the supply chain for drugs, surgical and other consumables have continued to be under short supply in public facilities, which aspect undermines the implementation of the Scheme;

(ii) Since the Civil Servants had forfeited their medical allowances to the Scheme, the proposed increase in contribution by all NHIF members would amount to a double deduction on the part of the civil servants;

(iii) In response to the new scheme, there has been an increase in hospital utilization. However, some facilities have also NHIF patients by providing a specific drug list for them and another for patients seeking care under different schemes of payment. The drugs for NHIF patients are cheaper and of questionable scientific efficacy. Here we see another gamble with the life of Kenyans;

(iv)That, there was reported "discrimination" of NHIF members by some service providers. Further, the Union could not vouch for the capacity of some of the private health service providers accredited to roll-out the Scheme, on a national scale;

(v) While many members of the scheme had been allocated facilities without their choice, the Scheme had unjustified limitations on some of the Members of the Union who are Civil Servants below Job Group "M"

COMMITTEE INSPECTION VISITS

157.The Committee undertook inspection visits Clinix Health Care Ltd and Meridian Medical Centre Ltd. Two of the firms accredited to offer out-patience services under the new Scheme onFriday, April 20, 2012. The Committee was represented by the Honourables Dr. David Eseli, MP, Hon. Fredrick Outa, MP, Dr. Kioko Munyaka, MP, Cyprian O. Omolo, MP and Joseph Oyugi Magwanga, MP. They were accompanied by Chief Executive Officer MPDB ,Dr. Fatma Abdalla, a Board Member of the Medical Practitioners and Dentists Board (MPDB) and the Chief Executive Officer of the NHIF and the, amongst other officers from the NHIF.

158.The Committee visited Meridian Capital Centre - Mombasa Road, Meridian Medical Centre Kitengela, Clinix Healthcare Ltd - Haile Selassie Avenue/Motor Gallery, Clinix Healthcare-Sameer(Opposite General Motors), Daystar University Clinix and the Nairobi West Hospital Clinix. The inspections were against the parameters of

Licensing, Registration and Operations of NHIF accredited facilities and their capacities to offer services allocated to them under the Out-patient scheme.

Findings of the inspections

159. The members found out that the Meridian Capital Center was registered in August, 2011 and shares the same License Number with Meridian Kisumu, operates from 8.00am to 8.00pm daily. The members heard that around 10 patients per day under the capitation scheme visit the facility in a day. The members established that, the facility has only one Doctor, one nurse, one pharmacist and one laboratory technologist also works at Meridian Medical Centre – Donholm.

160. Regarding, Meridian Medical Centre Kitengela - the members found the facility closed and renovation works on-going;

161. At Haile Selassie Avenue Clinix, registered as Motor Gallery Clinix, the members found out that the facility was heavily congested and was informed by the management that they handle 150 to 180 patients per day with NHIF accredited patients being approximately 90-100 per day. The facility operates from 8.00am to 7.00pm with only one doctor. The members also found that the medical personnel are very few compared to the heavy work-load and the space of the facility in relation to the out-patients visiting the facility.

162. At Clinix Healthcare - Sameer, the members faced challenges accessing the facility as it is situated inside Sameer Park and held that, the facility was inaccessible;

163. At Daystar Clinix, the members found that, the facility handles 40-60 patients per day. The members also heard that medical capacity was not proportionate to the huge workload arising from the high number of students at Daystar University;

164. Regarding Nairobi West Hospital Clinix, the members found the facility has two doctors with a huge workload. The Members heard that the facility has a strategic-working alliance with Nairobi West Hospital;

165. In conclusion, Members observed that, the limited medical personnel capacity and limited equipment could greatly compromise quality health service provision in the two facilities. With the number of medical staff engaged and limited medical equipment, it is evident that the facilities could not handle the high number of members and their dependents they had indicated they would handle.

FINDINGS OF THE COMMITTEE

166. From the evidence adduced, papers laid, and written submissions, the Committee made the following findings-

The Piloting Phase of the Capitation Model

167. From the explanation made by the NHIF management, there was no connection between the reasons for undertaking the pilot phase of the Capitation Model and the conceptualization of the Civil Servants Scheme. The NHIF Management explained that the idea for capitation was started in 2007 when an actuarial study conducted by Alexander Forbes Consultants & Actuaries recommended that the Fund offers both In & Out-Patient Covers. This was followed by study visits by the then Board and Managements to several countries. The NHIF Board thereafter resolved, to roll-out the pilot phase in 2009, with the objective of testing the success of Capitation. The Management had explained that the Pilot was meant to expand the NHIF's capacity and expand the government's participation in preventive and promotive healthcare from the current 12% to the WHO's requirement of 25%.

168. This finding is also explained by the fact that the NHIF did not involve the Ministry of State for Public Service in the Pilot Phase of the Capitation Model. Indeed, at the time, the Public Service Ministry described the Pilot as non-representative. Four years after the conceptualization of the pilot phase at NHIF, the Public Service Ministry mooted the idea of the Civil Servants Medical Insurance Scheme.

169. Given that the pilot phase concentrated mainly in Nairobi, it was not representative and its findings cannot be deemed fully reliable. Further, the manner of identifying the four service providers, including two private health service providers remains questionable; and, the six months period of the Pilot phase was not adequate.

170. Even though the NHIF indicates that they were not given sufficient time to prepare for the roll-out, it was unfair on their part to accord undue advantage to the two

private health service providers who participated in the pilot phase to also roll-out the Civil Servants Insurance Scheme.

171. The Committee could not ascertain the propriety or value for money on the funds spent in the Pilot Phase, especially taking into account that a substantial part of funds was spent on studies and administration of the Pilot programme;

Conceptualization of the scheme and exercise of free Choice

172. From the evidence adduced by witnesses, papers laid and copies of other correspondences submitted. The Committee was of the view that the government seemed to be in hurry to roll-out the scheme and to meet the January 1, 2012 deadline to announce the "new year gift" for civil servants, without according ample time to the process of planning for the roll-up. While the consultations with private insurance companies started in June 2011 and collapsed in November, 2011, the Government only reverted to using the NHIF as a last option. The rushed manner of conceptualizing and rolling-out the scheme was evident throughout the inquiry by the Committee. For instance-

(a) Formal negotiations and engagement with the NHIF started on November 10, 2011 when the Ministry of State for Public Service wrote to NHIF requesting for assistance in provision of medical insurance cover for civil servants and disciplined forces. Within less than two months, several correspondences had been exchanged, culminating in the launch of the scheme on January 5, 2012;

(b) According to the Contract between the Ministry of State for Public Service and the NHIF, the scheme was to commence on January 1st , 2012. The Committee found out that, as at this date, the two parties were still grappling with interpreting the implications and the actual requirements for rolling-out the scheme. Further, the contract was

signed on January 5, 2012 days after this date implying that the parties were inadequately prepared for the roll-out;

(c) The first formal communication to the consumers of the services was made on December 21, 2011 by way of circular No. MSPS 2/7/2A VOL.III/ (18). **(Appendix 11: MSPS Circular).** The Circular was sent to all Permanent Secretaries, the Commissioner of Police, Administration Police Commandant, Commissioner of Prisons and the Director, National Youth Service. The NHIF indicated the contents of the circular were crucial for them in conceiving the roll-out. However, the same was not copied to the Fund, and they only received it through other parties, on December 27, 2011, three days to the deadline; and,

(d) A similar circular No. MSPS 2/7/2A VOL.III/(51) of February 10, 2012 indicates that the NHIF was yet to institute systems to implement important aspects of the Scheme such as payments of direct claims by beneficiaries.

173. The process was so hastened that, the NHIF and the Ministry signed the agreement within less than two months after commencement of the negotiations. Important matters such as the mode of rolling-out the scheme and the health facilities to be used were overlooked as focus shifted to meeting the January 1st deadline;

174. It was evident that, while the Ministry was quick to deduct and convert the medical allowances, inpatient refunds and ex-gratia grants payables to civil servants, into a medical insurance scheme, only modest attention was paid to the most important aspects of ensuring **value for the civil servants' money;**

175. The NHIF only joined the rush, such that they did not formally advise the Client (Ministry of State for Public Service) that they were not adequately prepared to roll-out the scheme within such a short period;

176. The Ministry of State for Public Service failed to formally involve the Board of the NHIF in conceptualizing the Public Servants Scheme and exploring possible alternatives for smooth roll-out.

177. It was evident that Civil Servants were allocated to specific public and private facilities and thereafter requested to choose facilities of their choices. It was evident that civil Servants were assigned to specific public and private facilities and thereafter requested to choose facilities of their choices. Due to the rushed manner, of conceptualization and roll-out Civil Servants were initially assigned to facilities at the start of the Scheme according to the "pay-points". This is where each member is allocated a facility located in the region where their salary is remitted.

178. The Ministry of Public Service thereafter asked the members to change and indicate their preferred choices of facilities (**Appendix 12: MSPS Letter of January 16, 2012**). However, the Committee found out that the members were bound to remain with the assigned facilities since any changes would not have been effected until after the expiry of that quota at the end of March, 2012. The Service Providers were paid quarterly in advance. Furthermore, since the members were also supposed to obtain information on their assigned facilities by visiting the accredited centres, it was not possible for some members to apply for change since their accredited facilities did not exist;

179. The NHIF had made advertisements in the dailies and the Ministry of State for Public Service wrote to inform the members on how to access the lists showing their assigned facilities. However, the Committee held that these publicity efforts were not sufficient to inform the members. Further, the methods used failed to have a feed-back mechanisms to respond to queries. **(Appendix 13: NHIF Advertisements)**

Process of registration of healthcare providers

180. There was evident contradiction on the part of the Medical Practitioners and Dentists Board (MPDB) in regard to the process and the actual number of Private health service providers registered by the Board for the last eighteen months. In fact, submissions presented by the Chief Executive Officer of the MPDB and those submitted by the Registrar (MPDB) touching on the registration of Clinix Healthcare and Meridian Healthcare did not tally with the actual number of branches opened by the two service providers, per month;

181. The Committee also found out that the Board of MPDB only meets once in three months to "ratify" decisions of the Chief Executive and the Registrar regarding applications for registration of premises. The Committee held that this practice amounts to merely "rubber-stamping" the decisions. The practice also also exposes the health sector and the well-being of the citizenry to risks associated with malpractices. The Committee also held that the tendency indicates that the Board had abdicated its statutory duties conferred on them by the Medical Practitioners and Dentists Act, (Cap 253);

182. In so far as the Medical Practitioners and Dentists Board as established under Cap 253 Laws of Kenya has power to register and license Private and Faith Based Medical Institutions, the Committee found out that the Board has been flouting the procedure of registration of these facilities. The findings of the Committee were informed by the evidence adduced by the CEO of the Board when he appeared before the Committee on April 11, 2012 and reinforced by the Registrar of the Board when he appeared before the Committee on May 14, 2012. The Committee found that the registration of facilities, issuance of certificates was done and awaited MPDB's ratification in their quarterly meetings. The Committee found this to be irregular and against the provision of the Medical Practitioners and Dentist Act, CAP 253.

183. There was contradicting evidence by the MPDB's CEO and Registrar before the Committee. Given this finding and the fact that that registration certificates were

issued by the Board to facilities which may not have existed at the time of registration, the Committee held that the MPDB significantly contributed to the irregularities in the rolling-out of the scheme. The private health service providers used the registration certificates issued by the MPDB to convince the NHIF that they had the many branches and the requisite capacity;,

184. The Committee also faults the Registrar of the MPDB for the manner in which his office discharges the mandate of licensing. During the hearing, the Registrar said that he could not confirm the actual existence of facilities before registration. Further, the Registrar indicated that "he just signs" the certificates, as they are brought before him and has no count, at any time, of how many he has signed, in a day. Further, the Registrar who is also a member of the NHIF Board and is also the Director of Medical Services. While he reported to the Committee that he had noticed malpractices at the roll-out of the scheme, he did not inform the Permanent Secretary or the Minister. The Committee therefore held that it was unsatisfactory for him to only advise the NHIF about the possibility of the non-existent facilities, but fail to take any action on the owners of the said facilities or the NHIF, at the Ministry and/or the MPDB's level.

185. The Committee also found out that, after making applications for registration/licensing, some health providers were using "*Acknowledgment Letters*" issued by the MPDB, as licenses to operate their premises.

Geographical locations of beneficiaries' residences and Non-existent facilities

186. The Committee also found out that there were cases where a private facility was accredited to offer the services under the Scheme without due regard to the actual geographical locations of the members. While the Committee was of the view that it would be difficult to satisfy each beneficiary to visit their nearest facility, the NHIF and the Ministry of State for Public Service ought to have worked closely, prior to rolling-out the scheme to ensure that each principal is accorded ample time to locate and identify a facility of their choice. This is a basic principle of the Capitation model.

187. The matter of non-existent facilities was confirmed by several witnesses. For instance, the Ministry of State for Public Service informed the Committee that, as at Mid-February 2012, eleven branches of Clinix Healthcare Ltd and one branch of Meridian Healthcare Centre were not -existent **(Appendix 3 Letter by the Ministry of State for Public Service)**. Further, the Chief Executive officer of the MPDB indicated that, as at January 1, 2012, Clinix Healthcare had twenty two (22) branches while Meridian Medical Centre had thirteen (13) branches. At the same time, the Registrar indicated that, Clinix had 29 braches while Meridian had thirteen (13) branches at the time of the roll-out. The information by the Registrar and the CEO was contradicting. At the same time, the Registrar tabled letter showing that as at February 20, 2012, sixty two (62) outlets of Clinix Healthcare were not existing at the time. He also tabled a letter, showing that Clinix Healthcare had 45 branches as at the same date. **(Appendix 14: DMS's Letters on Clinix Healthcare)**;

188. In addition, the Secretary-General Union of Kenya Civil Servants indicated that when they undertook their inspections in February 2012, they found out that, Clinix Healthcare, (Haile Sellasie branch -Comcraft House) was overcrowded and showed limited capacity to meet the high demand of services. Further, their *Tele-posta* outlet was in a "tiny corridor" and was still under refurbishment." They also gave the Committee a list of several out-lets of Clinix as non-existent, as at Mid-February , 2012;

189. From the evidence of the Registrar and the CEO, MPDB it appears that some service providers accredited by the NHIF, were not existent. The non-existence of facilities was threefold, as follows-

(a) Unlicensed healthcare providers who were reported to have been accredited by NHIF, but were not in existence;

(b) Licensed Healthcare providers, listed in the NHIF list of accreditation, but did not have any presence on the ground; and,

(c) Licensed Healthcare providers, who even though were present, were not operational, since the branches were either under construction or under refurbishment and services were not being offered.

190. The NHIF accredited private healthcare providers on the basis of the licenses issued by the MPDB to notwithstanding that some the facilities were not operational. The NHIF did not confirm the actual existence of the facilities. The Committee also noted that the service provision contracts entered between the private service providers mention any aspect of braches under each branch.

191. While both the NHIF and the Service providers were agreeable that the Capitation payment under the Scheme was based on the number of the principles assigned to each service provider, the NHIF went ahead to segregate the payments into branches that the NHIF deemed to have been used by the providers in the roll-out. Some of the braches listed by the NHIF were non-existent. Notably, the providers were not agreeable to the list tabled by the NHIF. **(Appendix 9: NHIF Segregated list of Meridian and Clinix payments)**

192. The Segregated List tabled by the NHIF showed that Clinix Healthcare was paid for 56 branches while Meridian was paid for 17 branches. However, the list tabled by the Registrar showed that the time of Launching the Scheme on January 1, 2012, the two providers had 30 and 13 branches, respectively. The Committee considered the excess branches paid as part of the non-existent branches.

193. The NHIF's Quality Control Unit did not confirm the existence of most of the service providers before the accreditation. NHIF did not have the requisite capacity to verify the existence of service providers.

Identification of public and private service providers

194. The Committee found out that NHIF employed part of the service providers in its prequalified and accredited list of public and private health service providers to roll-out the scheme. The process of identifying service providers commenced as early as 2010, through several advertisements inviting public and private providers to express their interest in the tender. The Committee noted that advertisements were made in August 28, 29 and 30, 2010. Another advertisement was made later in November 9, 2011. (Appendix 13: NHIF Advertisements). The latter was specific to primary healthcare service providers and advised the applicants that had been shortlisted earlier not to apply again, meaning they were already enlisted;

195. Given the rushed manner in which the conceptualization was done and a tight deadline set for the roll-out, the NHIF reverted to the accredited lists, However, the Committee held that the Fund should not have accepted to be part of the rush, but should have asked for more time;

196. The NHIF's Quality Control Unit failed to undertake assessments of the capacity of the service providers accredited to ascertain their ability and capacity to offer primary healthcare and also establish their actual branch network in the country;

197. The NHIF Board was fully apprised of the roll-out of the scheme. Indeed, Minutes of the Board submitted to the Committee show that the Board held several *Special meetings* and deliberated on the matter, severally, as follows-

(a) Special Board Committee (Operations and Quality Assurance) meeting of January 3, 2012- Board discussed the Public Servants and Disciplined Forces Scheme, including the aspects of the capitation rate, advance payments on quarterly basis and premium of Ksh.2.162 billion for January to June 2012 and thereafter, Ksh. 4,324 billion for July 2012 to June 2013. At this meeting, Special Board Committee approved the scheme and recommended approval by the full board;

(b) Special NHIF Full Board meeting of 4th January, 2012- (11 members of the Board were present). The Board **approved** the recommendations of the Board Committee (Operations and Quality Assurance) and also resolved to use Capitation Model for out-patient services, with advance quarterly payments at Ksh.1,500 for public facilities and Ksh.2,850 for private facilities. The Board also tasked the DMS to establish an appropriate network to inform the government facilities of the benefits to be given to members and to maintain the standards;

(c) Special NHIF Full Board meeting of 10th January, 2012- (11 members of the Board were present)- The Board was informed of the progress of implementing the scheme, including the allocation of members based on the existing list of accredited facilities and notifications for change of facilities;

(d) Special NHIF Full Board meeting of January 19, 2012- The Board was further informed of the progress of implementing the scheme. The Board also considered a presentation by the General Manager (Operations and Marketing) on use of appropriate mechanisms and technology to ensure that those who wish to change facilities do so with ease and ensures payment of extra premiums by those wishing to include additional dependants under the Scheme; The Board also considered and approved the Contract for Medical Scheme for Teachers.

(Appendix 4: Minutes of the NHIF Special Board)

198. From the evidence obtained (Board Minutes), the Director of Medical Services (DMS) misrepresented facts before the Committee when he alluded that the aspects of the Scheme related to Capitation, roll-out and approval of the contracts were not approved by the Board. The Committee confirmed, from the Minutes, that he was

recorded as present in all the above-referenced Special meetings of the NHIF Board. The Committee held that the DMS was doing so to avoid responding to queries related to the roll-out;

199. Even though the representatives of the Kenya Private Health Service Providers who appeared before the Committee opposed the Capitation for the first quota, they also admitted that most of their members failed to express interest during the 2010 and 2011 advertisements by NHIF. Further, when asked to quote by the NHIF for the civil servants scheme, their members gave a final lowest quote of Ksh.4,500 per person for the capitation. In their evidence before the Committee, they asserted that, the optimum fee chargeable and alluded that the NHIF should focus more on in-patient covers due to capacity problems. Some of their members found the amount of Ksh.2,850 to be uncompetitive and declined to be part of the roll-out of the Scheme;

200. The Committee also found out that the Kenya Private Health Service Providers had informally advised the Ministry of Medical Services in February, 2012, that the roll-out of the out-patient scheme was likely to fail because of the relatively low capitation fee and the fact that the idea of capitation was foreign;and there was inadequate information and awareness on the scheme.

Payments made to some private service providers:

201. The NHIF paid out an amount of Ksh. 634,749,376; to public and private health service provider identified to offer the services. Of this amount, Ksh.120,747,518 18.9(5)was paid to public facilities, Ksh. 68,998,837 (10.7%)to mission facilities and 447,230,678 (70.4%) to private service providers. Of the amount paid to private service providers, 45% and 25 % was paid to Clinix and Meridian, respectively. The payment was for the First Quota of the Scheme covering the period January 1st to March 31st, 2012.

202. Details on payment from NHIF (Appendix 8) indicate that Clinix Healthcare was paid Kshs. 202, 161,188. The Committee observed that this was paid to 56 outlets. However, from the Schedule laid by the NHIF CEO, the amount paid to the 56 outlets totaled Kshs. 194,908,523, leaving a variance of Khs. **7,252,665** whose six (6) could not be explained. According to the Registrar, MPDB 30 outlets of Clinix Healthcare had been registered as at the time of roll-out on January 1, 2012. Out of this number, 20 outlets were capitated to the tune of **Kshs.94,700,769.** A further 36 outlets were capitated to the tune of **Kshs.100,207,753** yet they were not operational at the time of roll out. The Committee held that the payment to the 36 branches was irregular. (Table 1)

Table 1- Clinix Healthcare Branches Registered Before December 31, 2011 (Registrar of MPDB lists) and payments against each branch:

	Clinix Healthcare- Outlets: (Registered Before December 31, 2011 as per Registrar, MPDB Records)	Amount capitated
(i)	Central Workshop Clinix	2,607,581
(ii)	Valley Road Daystar Clinix	6,042,079
(iii)	Athi River Daystar Clinix	4,260,664
(iv)	Embakasi Clinix	3,679,108
(v)	Enterprise Road Clinix	4,022,079
(vi)	KCB Clinix Jogoo Road	3,507,109
(vii)	Kibera Clinix	5,468,148
(viii)	Motor Gallarey- Haile Selassie Clinix	2,262,470
(ix)	Nairobi West Annex Clinix	4,282,465
(x)	Pangani (Park Road) Clinix	4,238,863
(xi)	Nakuru RVR Clinix	3,260,664
(xii)	Mombasa RVR Clinix	6,521,328
(xiii)	Kisumu RVR Clinix	8,542,656
(xiv)	St. James Church Buruburu	7,771,328
(xv)	Teleposta Clinix	4,238,863
(xvi)	Thika Town Clinix	3,781,992
(xvii	Uganda Road Eldoret Clinix	4,075,830
(xvii	Voi B RVR Clinix Mtito Andei	3,260,664
(xix)	Wanandege (Imara Dama) Clinix	7,358,216
(xx)	Sameer Africa Clinix-Industrial Area	5,518,662
	Total	94,700,769

	Clinix Healthcare- Branches Registered After January 1, 2012 to end of April, 2012. (as per Registrar, MPDB Records)	Amount capitated
(i)	Along Kisumu Webuye Road	3,260,664
(ii)	Naivasha Clinix Barclays Bank	1,500,00
(iii)	City Council	2,819,581
(iv)	Medicross Pipeline Medical Centre	1,103,732
(v)	Eastleigh Clinix	7,014,219
(vi)	Embu Town Clinix	3,260,664
(vii)	Enkore Building Clinix Nakuru	2,149,442
(viii)	Equity Bank	3,260,664
(ix)	Imerial Bank -Eldoret	4,075,830
(x)	Embu Kangaru Plaza Clinix	3,260,664
(xi)	Kapsigar Plaza Clinc Buret	2,149,664
(xii)	Keten Clinix -Kapsabet	521,328
(xiii)	Kiambu Clinix	3,260,664
(xiv)	Kianyaga Market Clinix -	3,260,664
(xv)	Kilifi Town Clinix Malindi	940,000
(xvi)	Kipsigis Teachers Sacco Clinix Bomet	4,371,664
(xvii	Kerugoya (Kirinyaga) Clinix	4,075,830
(xvii	Kiserian - Ongata Rongai Clinix	3,260,664
(xix)	Kitui Town Clinix	260,664
(xx)	Koimen Clinix – Eldoret	5,054,029
(xxi)	Kongowea Clinix	3,260,664
(xxii	Kwale Clinix	4,260,664
(xxii	Likoni Clinix	4,080,664
(xxiv	Machakos Town Clinix	3,260,664,
(xxv	Malindi Clinix	560,000
(xxv	Medicross -South C. Clinix	735,822
(xxv	Meru Town Clinix	6,521,328
(xxv	Molo Stadium Clinix	4,371,886
(xxix	Motor Plaza Clinix Meru Chuka	3,260,664
(xxx	Naivasha Laincete Clinix	2,500,00
(xxx	Ngong Road Clinix	2,302,460
(xxx	Olkalau (Nyandarua) Clinix	500,000
(xxx	Ongata Rongai Clinix	4,260,664
(xxx	South C Clinix Industrial Area	1,471,643
(xxx	Ukunda Clinix	3,260,664
(xxx	Saada Arcade Nanyuki/Isiolo	4,000,000
	Total	100,207,753

203. Similarly, given the breakdown indicated in the NHIF's Schedule, the Committee held that the amount ought to have been paid to Meridian for the first quarter was Kshs. 88,855,511. The amount of Ksh. 28,079,989 paid to their branches in Nyali, Nyeri, Meru, Malindi and Nakuru was an irregular payment. (see Table 2)

Table 2- Meridian Medical Centre Branches Registered Before December 31, 2011 (Registrar of MPDB lists) and payments against each branch:

	Meridian Medical Centre- Outlets Registered Before December 31, 2011 (Registrar of MPDB) Records)	Amount capitated
i.	Meridian Medical Centre-Yaya;	2,461,800
ii.	Meridian Medical Centre-Westlands;	7,155,200
iii.	Meridian Medical Centre-Buruburu;	8,435,200
iv.	Meridian Medical Centre-Ongata Rongai;	4,834,500
v.	Meridian Medical Centre-Thika;	7,474,500
vi.	Meridian Medical Centre-Kitengela;	6,735,200
vii.	Meridian Medical Centre-Nation Centre;	9,847,200
viii.	Meridian Medical Centre-Land Mark Plaza;	7,385,400
ix.	Meridian Medical Centre-Jeevan Bharat, City Square;	4,923,600
x.	Meridian Medical Centre-Capital Center/Industrial Area;	16,182,800
xi.	Meridian Medical Centre-Kisumu	4,874,500
xii.	Meridian Medical Centre Mombasa	8,545,611
xiii.	Meridian Medical Centre Donholm	NIL
	Total	88,855,511
	Branches Registered after January 1, 2012(Registrar of MPDB) Records)	
xiv.	Meridian Medical Centre-Nyali;	5,043,389
xv.	Meridian Medical Centre-Nyeri;	7,434,500
xvi.	Meridian Medical Centre-Meru;	4,874,500
xvii.	Meridian Medical Centre-Malindi;	5,573,800
xviii.	Meridian Medical Centre-Nakuru	5,153,800
	Total	28,079,989

(List excludes Meridian Equator Hospital)

Table 3- Clinix Facilities Opened After the Roll-Out Date of January 1, 2012

Branches opened in January 2012

	Facility	Amount	County	Date Registered	Current Licence	Licence Number
1.	Kiambu Town Clinix	7,385,400	Kiambu	19/1/2012	23/1/2012	12451
2.	Ongata Rongai Clinix	8,435,200	Ongata Rongai	17/1/2012	23/1/2012	12438
3.	Kiserian-Ngong Clinix	16,182,800	Ongata Rongai	16/1/2012	7/2/2012	15157
4.	Thika Town Clinix	4,874,500	Thika		23/1/2012	12439
5.	Likoni Coast Clinix	6,735,200	Mombasa	16/1/2012	7/2/2012	15158
6.	Central Workshop Clinic	2,607,581	Nairobi		9/1/2012	12239
7.	City Council Clinic	2,819,581	Nairobi		9/1/2012	12247
8.	Medicross Pipeline Medical Centre	1,103,732	Industrial		9/1/2012	12236
9.	Medicross South C	735,822	Industrial		9/1/2012	12232
10.	Rvr Building Clinix	8,542,656	Kisumu		9/1/2012	12250
11.	Kirinyaga Town Clinic	4,075,830	Embu		23/1/2012	12449
12.	Thika Town Clinix	3,781,992	Thika		23/1/2012	12439
13.	Central Workshop Clinic	2,607,581	Nairobi		9/1/2012	12239
14.	City Council Clinic	2,819,581	Nairobi		9/1/2012	12247
15.	Medicross Pipeline Medical Centre	1,103,732	Industrial		9/1/2012	12236

Branches opened in February 2012

	Facility	Amount	County	Date Registered	Current Licence	Licence Number
1.	Voi B Clinix	3,260,664	Voi	23/2/2012	23/2/2012	12533
2.	Kongowea Town Clinic	3,260,664	Mombasa		23/2/2012	12526
3.	Kwale Town Clinix	4,260,664	Ukunda	23/2/2012	23/2/2012	12537
4.	Kilifi Town Clinic	940,000	Malindi	23/2/2012	23/2/2012	12538
5.	Pangani Clinic	4,238,863	Nairobi	28/2/2012	23/3/2012	12536
6.	Eastleigh Clinic	7,014,219	Buruburu	16/1/2012	7/2/2012	15156
7.	Ngong Road Clinic	2,302,460	Nairobi		23/2/2012	12531
8.	Ukunda Town Clinix	3,260,664	Ukunda	16/1/2012	23/3/2012	12534
9.	Kilifi Town Clinic	940,000	Malindi	23/2/2012	23/2/2012	12538
10.	Kianyaga Market Clinic	3,260,664	Embu		7/2/2012	15160
11.	Kongowea Town Clinic	3,260,664	Mombasa		23/2/2012	12526
12.	Ngong Road Clinic	2,302,460	Nairobi		23/2/2012	12531

Branches opened in March 2012

	Facility	Amount	County	Date Registered	Current Licence	Licence Number
1.	Motor Plaza Clinic	3,260,664	Meru	8/3/2012	9/3/2012	15239
2.	Meru Town Clinic	6,521,328	Meru	8/3/2012	8/3/2012	15231
3.	Kangaru Plaza Clinic	3,260,664	Embu	8/3/2012	9/3/2012	15235
4.	Embu Town Clinix	3,260,664	Embu		9/3/2012	15237
5.	Kipsigis Teachers Sacco Clinix	4,371,664	Bomet	5/4/2012	16/3/2012	12058
6.	Machakos Town Clinix	3,260,664	Machakos		9/3/2012	15233
7.	Along Kisumu Webuye Road	3,260,664	Kakamega		8/3/2012	15228

	Clinix					
8.	Along Kisumu Webuye Road	3,260,664	Kakamega		8/3/2012	15228
9.	Embu Town Clinix	3,260,664	Embu		9/3/2012	15237
10.	Machakos Town Clinix	3,260.664	Machakos		9/3/2012	15233
11.	Enroke Building Clinix	2,149,442	Nakuru		16/3/2012	12051
12.	Imperial Bank Clinix	4,075,830	Eldoret		16/3/2012	12052
13.	Koimen Clinic	5,054.029	Eldoret		16/3/2012	12055

Branches opened in April 2012

	Facility	Amount	County	Date Registered	Current Licence	Licence Number
1.	Koimen Clinic	5,054,029	Eldoret		16/3/2012	12055
2.	Imperial Bank Clinix	4,075,830	Eldoret		16/3/2012	12052
3.	Molo Stadium Clinic	4,371,886	Nakuru	16/3/2012	16/3/2012	12048
4.	Naivasha Lancete Clinix	2,500,000	Naivasha	7/5/2007	16/3/2012	12049
5.	Keten Clinix	521,328	Nandi Hills	9/3/2012	16/3/2012	12050

Table 4- Meridian Medical Centre Facilities Opened After the Roll-Out Date of January 1, 2012

	Centre	Amount	County	Date Registered	Current Licence	Licence Number
1	Meridian Medical Centre	5,573,800	Malindi			
2	Meridian Medical Centre	4,874,500	Meru			
3	Meridian Medical Centre	5,153,800	Nakuru			
4	Meridian Medical Centre	7,434,500	Nyeri			
5	Nyali Medical Centre	5,043,389	Mombasa	13/04 2012		

204. Even though the NHIF, the service providers and the Ministry of Medical Services insisted that the payments were under a Capitation formulae, , the Committee held that, had the NHIF, the Ministry of State for Public Service and the MPDB undertaken due diligence on the capacity of the service providers and had the beneficiaries been allowed sufficient period to exercise freedom of choice, the allocations would have been different, and evenly spread amongst the providers;

The Scheme's Bank balances

205. The Committee found out that the total premium payable per year for the entire Civil Servants and Disciplined Scheme was Kshs. 4.32Billion. This was as per the contract signed between the NHIF and the MSPS on January 5, 2012;

206. The amount payable for the six (6) month period ending June 30, 2012, was Kshs. 2.16 Billion. The six months period was based on the fact that the Government Financial Year ends on June 30; The Ministry of State for Public Service remitted the amount of Kshs. 2.16 Billion, (including an amount of Kshs. 1,242,326,250 for Out-Patient) to NHIF;

207. The NHIF opened an operation current account No. 01141162180500 at the Cooperative Bank, Upper Hill Branch on February 3, 2012 to be used for transaction related the Civil Servants and Disciplined Forces Scheme. The NHIF had paid an amount of Ksh. 634,749,376 to the various service providers under the Out-patient scheme;

208. From the schedules provided by the Ag. Chief Executive Officer, an amount of Ksh. 644,802,607.50 had been spent on the Out-Patient Scheme, including an amount of Ksh 131.7 million indicated as administrative costs.

209. The Ag. Chief Executive forwarded a Schedule to the Committee on May 25, 2012 indicating that the amount of money spent on the entire Scheme was Ksh.

1,177,421,029.10 leaving balances of Ksh. 984,852,179.40 covering the four aspects of the Scheme- i.e: In-Patient, Out-Patient, Group Life and Last Expense. The bank statements provided showed that, as at May 24, 2012, the account had a balance of Ksh. 393,274,019.40 which was reported to be still held in the account. He also indicated that another **account no. 017229645243**, at Kenya Commercial Bank (Moi Avenue) held Ksh. 1,019,843,832.11 as at May 26, 2012. **(Appendix 15: Bank Statements and Schedule of balances submitted by NHIF).** However, the Committee could not relate the latter account to the scheme nor confirm the said balances.

Expansion of the private service providers

210. Clinix Healthcare Ltd showed inexplicable exponential expansion during the period January to April, 2012, with a record fifty four (54) newly registered branches during the four months period. Eleven (11) of these new branches were registered in March with another twenty one (21) branches being registered in April, 2012; While the Management also indicated that the they intended to rollout about three hundred (300) braches by the end of the year, the Registrar indicated that, as at May 8, 2012, they had eighty one applications pending consideration for registration. The Company was said to have been registered in June, 2006. The Registrar, MPDB also described the growth of the healthcare firm as "**suspect**" considering the ordinary growth pattern in private healthcare provision;

211. At the same time, Meridian Medical Centre grew from thirteen (13) branches as at December 2012 to nineteen (19) branches in April, 2012. Six of the branches were said to be awaiting registration as at January, 2012, The Committee was of the view that the growth exhibited by Meridian Medical Centre during the period January to April, 2012 was also unusual;

212. The Committee held that, part of the funds paid out to the private health service providers was used to expand the private facilities instead of providing healthcare services, and at the expense of public health facilities

213. Whilst the NHIF Management indicated that, by the time of rolling out, they used the private and each public health service provider as one entity, the Fund's Management laid two schedules **(Appendix 9: NHIF's Schedule of Payments to Clinix and Meridian)** showing how the Ksh. 202,161,188 & Ksh.116,935,500 was paid to Clinix Healthcare Ltd and Meridian Medical Centre, respectively. Thereafter, the managements of Clinix Healthcare and Meridian Medical Centre dismissed the two schedules as "strange". The list showed that Clinix was paid for undertaking to provide healthcare services through Capitation in fifty six (56) of its branches. Further, Meridian Healthcare was paid for undertaking to provide the services in all its branches, which were seventeen (17) at the time, whereas at the time of signing the contract, Clinix had 56 branches and Meridian Medical Centre had thirteen (13) branches;

214. Given that the Ksh. 634,749,376 paid out by the NHIF in the First Quota of the Scheme covered the period January 1 to March 31st 2012, the Committee held that, any monies paid to any of the 377 public and private health services providers on basis of branches that were not existent constituted irregular payment. In this regard, the amount of Ksh. 92.4 Million and Ksh. 28. 1 million being monies paid out for ten branches of Clinix Healthcare and five branches of Meridian Healthcare, respectively which did not exist at the time, were irregular payments.

Capacity of public and private service providers

215. The Committee was of the view that, while public health facilities have challenges of equipment and human resource, most of them have the basic capacity required to offer primary healthcare services. Moreover, if the public health facilities were able to plug into the Civil Servants, Disciplined Forces and Teachers scheme, the funds can be used to improve the public healthcare system;

216. It was evident that some service providers lacked capacity to offer the services to the number of persons who they claimed chose them. For instance, Clinix Healthcare Ltd.

was said to be chosen by 56,747 principals, which translates to 283,735 persons (56,747, X 5). Assuming that only a fifth of that number sought services, from the inspections made by the Committee, the MSPS and the Union of Kenya Civil Servants (UKCC), it was evident that they could not satisfactorily serve the patients.

217. Conversely, given that the Meridian Medical Centre the inspections by the Committee, the UKCC and by the MSPS did not find fault in their capacity., a third of which constitutes of NHIF' s patients.

218. Similarly, Meridian Medical Centre was said to have been chosen by 32,824 principles. This translates into 164,120 persons, per quota. Even though they indicated that they currently handle half of their capacity, it was evident that they could not offer satisfactory services to that number of persons, in addition to their other regular patients.

219. It was not prudent for the private service providers to be capitated at the amount of Ksh. 2,850 while the public facilities was capitated at Ksh.1,500, given that their capacities were not in any way different, from the inspections undertaken by the Committee. The Committee held that the criteria used were unfair. Further the Committee could not confirm the criteria for determining the capitation figures and held.

220. It was negligent on part of the NHIF and the MPDB to fail to undertake prior inspections to ascertain the capacity of the public and private service providers to handle the number of persons they claimed they could handle.

Shareholding of some private service providers

221. From the evidence adduced and information availed by the Registrar of Companies and the company's Management, Meridian Medical Centre was established in 1995 to provide integrated health solutions. Its Directors were indicated as Peter Ngunjiri Wambugu (74.91% shareholding) Warioko Ndiba (8.32% shareholding); TBL Mirror

Fund-BV (Netherlands (16.76% shareholding). A Mr. Nicholas Nyaga is a non-shareholding director;

222. The Committee was unable to confirm the actual owners of Clinix Healthcare Ltd. Only shareholders of one of the two companies forming Clinix Healthcare Ltd. i.e, Beneficial Ltd are identifiable at the Registry of Companies. The owners of the majority shareholder, Pharma Investments Holdings (99%) were untraceable and the company is said to be registered in the British Virgin Island. Even though a Mr. Jayesh Saini appeared before the Committee and claimed to own 100% of the Pharma Investments Holdings, the Committee was unable to ascertain the claim, since-

(a) save for a copy of a registration certificate (number C.1028943) allegedly issued by the registration authorities in the British Virgin Island, neither the Registrar nor the management of Clinix Healthcare had any other documentary evidence to ascertain the claim; and,

(b) Mr. Jayesh Saini, a Kenyan residing in the country, was unable to explain to the Committee why he found it prudent to register Pharma Holdings in an offshore island country, while his company trades in Kenya.

223. It is worth noting that the Committee had requested the Registrar of Companies to use all means possible to ascertain the ownership of Pharma Holdings. As at the time of completing the report, the Registrar had forwarded copies of correspondences between her office and various persons, including the firm of advocates that had incorporated Clinix Healthcare Ltd. **(Appendix 10: Letters by the Registrar General).**

Misrepresentation by witness before the Committee

224. At the commencement of the inquiry, the Committee requested the Medical Practitioners and Dentists Board to advised them on the registered names of directors of Clinix Healthcare Ltd, The Chief Executive advised the Committee that the known directors are- Jiwanatil Chandara Dabral and Anthony Kalatil Chacko. Later, these

persons appeared before the Committee as part of the management of Clinix and were introduced as representatives of Beneficial Ltd. and Pharma Holding at Clinix Healthcare Ltd, respectively. They also were accompanied by a Mr. Zac Toddy Madahana who introduced himself as the Chief Executive Officer.

225. The Committee found out that the CEO, Clinix Healthcare Ltd, Mr. Toddy Madahana Asiavuga of National ID. No. 3422611 who made three appearances before the Committee deliberately misidentified himself to conceal his true identity to the Committee by using the different names. At one such time, he introduced himself as Zac T. Madahana, later as Zac T. Madana and gave evidence on oath.

226. In its effort to establish the real identity of Mr. Toddy Mahadana, the Committee wrote to the Kenya Medical Supplies Agency (KEMSA) and the National Intelligence Security Service. The Chief Executive, KEMSA conveyed that the said person had worked for KEMSA from 2005 to 2010. He however indicated that he could not confirm the identity of the person from the pictures provided by the Committee. The Director, NSIS wrote that the said officer was once a staff of the Agency but was dismissed from service in 2004. The Committee was also informed that the said person was a former employee of the National Intelligence Security Service but was dismissed from Service on September 28, 2004. Mr Mahadana had previously served in the Police Force rising from a Cadet Inspector of Police to a Senior Superintendent of Police between 1989 and 1996. Later, he served as Manager, Security Services at the between 2005 and 2010 before his appointment as Chief Executive Officer of Clinix Healthcare Limited in January, 2012.

227. The management of Clinix appeared before the Committee later, following the above-mentioned confirmations. The Management asserted that the said Mr. Madahana was their Chief Executive Officer since January 2012. He also indicated that, although the name "Zac" was not in his official documents, it was part of his names.

Conflict of interest

228. It was reported that a health facility named "The Star Hospital" which belonged to the NHIF Board Chairperson, was amongst the private service providers which were capitated by the NHIF. It was however not indicated whether the chairperson had declared his interest in the Board, when the matter of the roll-out was considered by the Board.

Suspension of the Chairman of the NHIF Board the CEO

229. The reading of Section 4 (1)(a) of the National Hospital Insurance Fund Act provides that the chairman of the NHIF Board shall be appointed by the President. Paragraph 2 (b) of the Second Schedule of the Act empowers the Minister to remove any member of the Board from office except the Chairman or ex-officio member.

230. Whilst the Committee abhors the conduct of the Board Chairperson and Vice-Chairperson as displayed before media following the alleged initial suspension, the Committee held that the Minister also did not have the powers to suspend the Board Chairperson as that is the prerogative of the President, who is also the appointing authority.

231. Section 10 (1) of the National Hospital Insurance Fund Act provides that the Chief Executive Officer of the Board shall be appointed by the Minister. However, the Committee found that the Chairman acted *ultra-vires* as he had no power to suspend the Chief Executive Officer without an express resolution of the Board considering and approving such action.

Actions taken by the Parent Ministry on the Alleged Irregularities

232. Following allegations of the irregularities, the Minister indicated and proved to the Committee that he had written to the Ethics and Anti-Corruption Commission (EACC) asking the Commission to carry an audit on these allegations. The Minister did not table any evidence, save for the letter to the EACC. He indicated that, he did not invite other investigatory agencies e.g. Kenya National Audit Office, Efficiency

Monitoring Unit and Criminal Investigation Department as he assumed, being government bodies, they could do it under their own volition. Although the Ministry invited the other bodies to carry out to The Committee is of the view that the Ministry had not done enough to put in motion any investigations on these matters.

Minister for Medical Services and Mr. Jayesh Saini

233. The Committee enquired the Minister for Medical Services whether he knew Mr. Jayesh Saini, the alleged owner of Pharma Holdings and Chairman of Clinix Healthcare Ltd. The Minister replied that, he knew only him as a business man who he had met severally as Mr. Saini frequented his office asking for business favours. However, the Minister denied having any business ties with him indicating that he always referred Mr. Saini to the procurement authorities, such as NHIF and KEMSA.

234. The Minister also confirmed that he also met Mr. Jayesh Saini as they participated in a Health Business Forum held in May 2011, at Crown Plaza, Nairobi. He also confirmed having met him earlier in September, 2010, when they were booked in one hotel during a Pharmaceutical Sector Conference in Hyderabad, India.

235. The Minister was aware that Mr. Jayesh Saini does business with NHIF and concurred that his involvement in the Pilot project could have given Clinix Healthcare Ltd an undue advantage during the Civil Servants Scheme.

236. Given the admission by the Minister, the Committee was concerned, especially due to previous allegations that a Ghesto Pharmaceutical Ltd, a firm owned by Mr. Jayesh Saini was precluded from award of government tenders due to gross procurement. The company was later ordered to close operations by the Pharmacy and Poisons Board irregularities and supply of substandard pharmaceuticals.

Registration of foreign companies having place of business in Kenya

237. Section 365 of the companies Act, provides that-

"365(1). Sections 366 to 375 shall apply to all foreign companies, that is to say, companies incorporated outside Kenya which, after the appointed day, establish a place of business within Kenya and companies incorporated outside Kenya which have, before the appointed day, established a place of business within Kenya and continue to have a place of business within Kenya on and after the appointed day;

Provided that the said sections shall not apply to any such company which is registered under the Building Societies Act

(2) A foreign company shall not be deemed to have a place of business in Kenya solely on account of its doing business through an agent in Kenya at the place of business of the agent."

238. Sections 366 to 375 require foreign companies submit certain documents to the Registry such list of their directors, certified copies of memorandum and articles of association, addresses of registered principal office, make annual returns, and exhibit the name of company and country in which the company is incorporated.

239. The Committee held that the claim by the Registrar General that sub-section 2 of section 365 exempts Pharma Holdings Ltd from the said requirements since "Clinix Healthcare Ltd" was an "agent of Pharma Holdings Ltd in Kenya", was subjective and skewed interpretation of the law to favour the circumstances. Such selective interpretation of the law by the State Law Office only exposes the country to risks associated with possible registration of companies owned or associated persons of adverse character.

RECOMMENDATIONS

240. The Committee recommends-

Continuation of the Scheme

(i) THAT, Government ensures continuity of the Civil Servants and Members of the Disciplined Forces Medical Insurance Scheme currently underway.

Inter-Ministerial Committee

(ii) THAT, the Ministers for Public Service, Medical Services and Public Health & Sanitation and the Board of the National Hospital Insurance Fund constitutes a Committee comprising of representatives from each of the parties and representatives of the Union of Kenya Civil Servants and The Kenya National Union of Teachers to advice the parties on the implementation of all aspects of the Scheme, including their capacities and appropriate geographical spread;

(iii) THAT, the Inter-Ministerial Committee, having determined the maximum capacity under each service provider at a given time, should ensure that all public servants, members of the disciplined forces and members of KNUT are accorded ample time to indicate a facility of their choice, including a second and third alternative. A member should be assigned to his/her facility of first choice. Should a facility exhaust the maximum determined capacity, the member should be assigned the second or third alternative of choice;

Value for money and forensic audits

(iv) THAT, the Auditor General undertakes-

(a) Value for money (performance) audit to ascertain if the beneficiaries are getting value for money on the four aspects of the Scheme- i.e.- In-Patient, Out Patient, Group Life & Last Expense; and,

(b) Forensic audit to ascertain whether there was prudent use of the funds so far disbursed under the Scheme. Any funds found to have been paid-

out irregularly, be recovered and any other appropriate action taken against those found culpable.

Further Investigations

(v) THAT, within three months, all the investigative agencies of the government currently undertaking investigations on the Scheme concludes their investigations and appropriate actions taken based on the findings of the investigations.

(vi) THAT, the Ethics and Anti-Corruption Commission institutes investigations to ascertain the roles of the following persons in the irregularities in the Scheme, including the Pilot Phase-

(a) The Registrar General
(b) The Director of Medical Services
(c) The Chief Executive Officer, NHIF
(d) The Members of the NHIF Board
(e) The Permanent Secretary, Ministry of Medical Services
(f) The Minister for Medical Services
(g) The Minister of State for Public Service

(vii) THAT, within three months, the Attorney General Reports to the House, the finding of the Registrar General on the identities of the shareholders and directors of Pharma Investment Holdings Ltd and TBL Mirror Fund (BV), both shareholders of Clinix Healthcare Ltd and Meridian Medical Centre, respectively;

(viii) THAT, Mr. Toddy A. Madahana, Chief Executive Officer of Clinix Healthcare Ltd be investigated for possible misrepresentation before the Committee and prosecuted, if found culpable;

Access to services by members

(ix) THAT, the NHIF and the Ministries of Medical Services and Public Service establishes appropriate structures to ensure that all members access healthcare services at any accredited facility in the country, under the Scheme;

(x) THAT, the NHIF decentralizes their services to the counties, including all services related to the Scheme and puts in place appropriate systems to ensure access to the services;

Inspection of facilities and capitation rates in public facilities

(xi) THAT , the Medical Practitioners and Dentists Board urgently initiates a process of inspecting all the accredited service providers under the entire Scheme to ensure sufficient capacity;

(xii) THAT, The Ministries of Medical Services, Public Health & Sanitation and the NHIF Board ensures that public facilities are reoriented to be able to fully participate in the Scheme, considering their wider geographical spread;

(xiii) THAT, the capitation rate of Ksh. 1,500 per member for public facilities to be reviewed to be equal to that of private healthcare service providers;

Third Party Providers

(xiv) THAT, the NHIF Board ensures that subcontracting of their services to third party providers by accredited Service Providers under the Scheme is not allowed;

Registration of foreign companies

(xv) THAT, the Attorney General ensures that due diligence is carried out to avoid possible registration of companies associated with any persons of undesirable character. Further, the Attorney General ensures that the Companies *(Repeal and Replacement)* Bill, 2011 is expedited;

Healthcare Benefits Regulatory Authority

(xvi) THAT, the Minister for Medical Services expedites the proposal to establish a healthcare benefits regulatory authority that will oversee and regulate the administration of all healthcare insurance and benefit schemes, including those offered by the NHIF.

DISSENTING VIEW

The Committee recorded a dissenting view on a proposed recommendation, whose question was negatived (The Dissenting view was Recorded under Min. No. 182/2012 and 186/2012- Appendix I: Minutes of the Proceedings of the Committee)