**Health care purchasing in Kenya: experiences of health care providers with capitation and fee-for-service provider payment mechanisms.**

Melvin Obadha1, Jane Chuma1,2, Jacob Kazungu1, and Edwine Barasa1,3

1Health Economics Research Unit, KEMRI | Wellcome Trust Research Programme, Nairobi, Kenya.

2The World Bank Group, Kenya Country Office, Nairobi, Kenya.

3Nuffield Department of Medicine, University of Oxford, Oxford, United Kingdom

**Correspondence:** Melvin Obadha, Health Economics Research Unit, KEMRI | Wellcome Trust Research Programme**,** P.O Box 43640 – 00100, Nairobi, Kenya. Tel: +254 721 868709 Email: [MObadha@kemri-wellcome.org](mailto:MObadha@kemri-wellcome.org)

# **ABSTRACT**

**Background**: Provider payment mechanisms play a critical role in universal health coverage due to the incentives they create for health care providers to deliver needed services, quality, and efficiency. Therefore, when designing provider payment mechanisms, understanding providers’ experiences with- and preferences for- the characteristics of these payment methods is useful. For this reason, we set out to explore public, private, and faith-based health care providers’ experiences with two common provider payment mechanisms in Kenya; capitation and fee-for-service. In doing so, we aimed at identifying the attributes of provider payment mechanisms that providers considered important.

**Methods**: We conducted a qualitative study in two counties in Kenya between September and December 2017. Data was collected using semi-structured interviews with 29 management team members in six health providers (two private, two faith-based and two public providers) accredited by the National Hospital Insurance Fund (NHIF). A framework approach was applied in data analysis.

**Results**: Providers had a good understanding of capitation and fee-for-service payment methods and how they worked. Capitation and fee-for-service payments from the NHIF and private insurers were reported as good revenue sources as they contributed to providers’ overall income. The expected fee-for-service payment amounts from NHIF and private insurers were predictable while capitation funds from NHIF were not because the providers did not have information on the number of enrolees in their capitation pool. Moreover, capitation payment rates were perceived as inadequate to the cover costs of services provided. Additionally, capitation and fee-for-service payments from NHIF and private insurers were disbursed late and NHIF’s reporting requirements for fee-for-service payments was perceived as complex, which led to monetary losses to health care providers. Finally, public providers had lost their autonomy to access and utilise capitation and fee-for-service funds from the NHIF.

**Conclusion**: Through their experiences, public, private, and faith-based health care providers revealed characteristics of provider payment mechanisms that they considered important. These include the extent to which provider payment mechanisms contributed to the overall revenue envelope, the predictability of the timing of payment disbursements, the predictability of amounts disbursed, the adequacy of the payment rate to cover the cost of services, complexity and burden of reporting and claims mechanisms, and autonomy over resources.

Considering these characteristics in the design of provider payment mechanisms while also involving health care providers in the process is a crucial step towards improving quality, efficiency, and coverage of needed services.