# Kenya data governance perspectives

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***Digital Health Forum***

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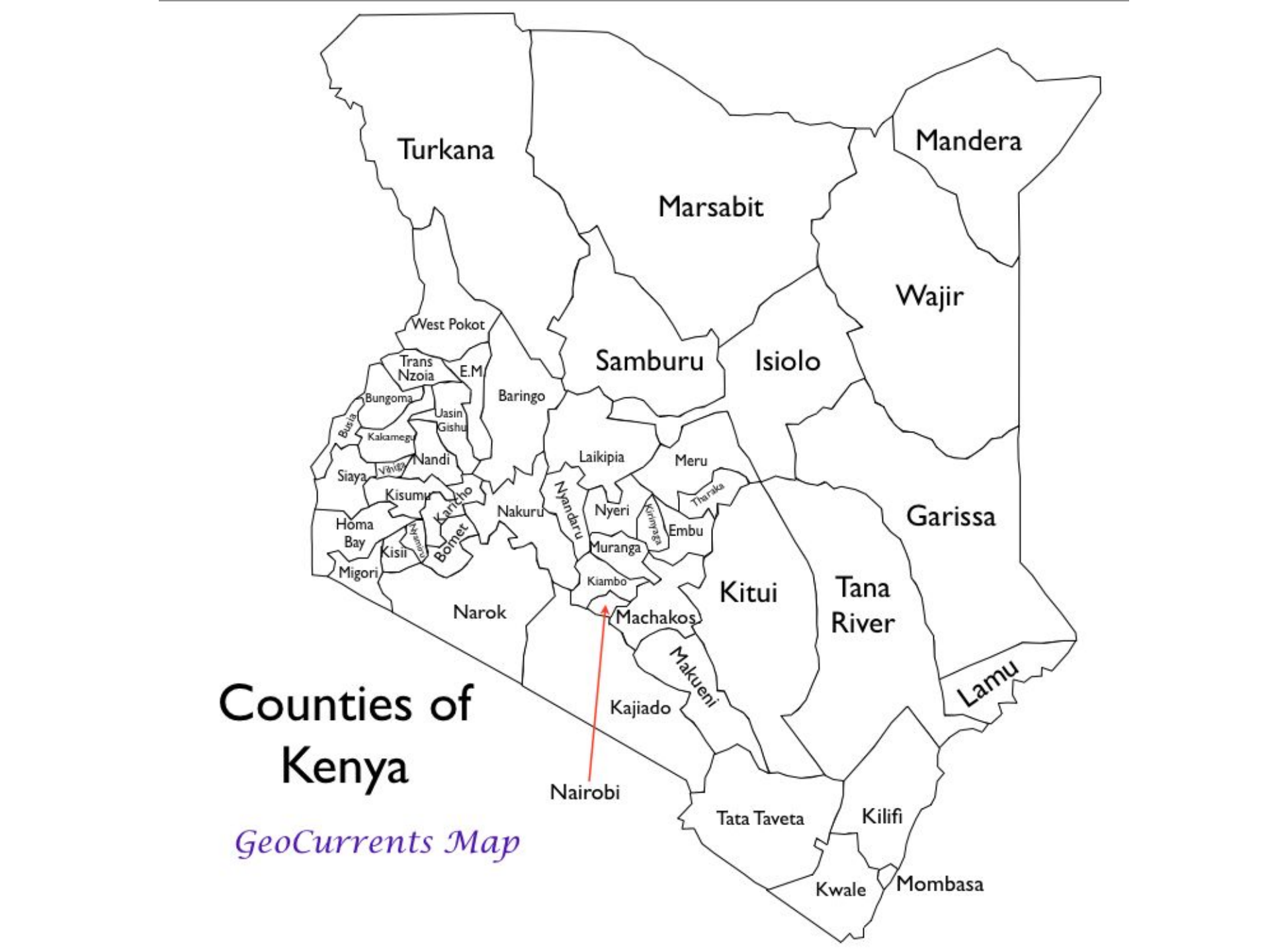
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Kitui
Tana River
Narok
Machakos
Makueni
Lamu
Kajiado
Nairobi
Tata Taveta
Kilifi
Kwale
Mombasa
Counties of Kenya
GeoCurrents Map

# Kenya – Country Overview

- Key statistics
  - Population: 45.4 million (2016)
  - GDP/capita: USD 1,376.7
  - THE per capita: USD 77.7
- Agrarian economy
- Famous for its marathon runners and wildlife

# Kenya – Data governance landscape

- Kenya's current political administration has committed to implement UHC by 2021
- Elaborate roadmap towards achieving UHC within five years drawn
- One of the main focuses towards UHC is to prevent and control chronic diseases
- Primary healthcare targeted to be the main focus for UHC implementation

# Kenya – Data governance landscape

Existing efforts in the country for accountability;

- DHIS system for routine health information
- Annual performance review mechanisms at both county and national level
- RMNCAH and health facility scorecards.
- Process of establishing the Kenya Health observatory are on-going
- Kenya Health Data Collaborative established to increase accountability and improve quality data for decision-making

# Kenya – Data governance landscape

**Data availability -Systems**

- Routine data collection system have matured over time to a National wide reliable systems (DHIS2, KMFL, MCHUL, LMIS, Claims data)
- EHR and EMR have been deployed in most public facilities with various levels of functionality
- Many programs have reliable systems for data collection (HIV, TB, Malaria)
- Several dashboard are in use for specific uses- (RMNCAH, situation room, Nutrition)

# Kenya – Data governance landscape

**Data availability**

- Communicable diseases including HIV, Malaria and TB, enjoy substantial funding support including in M&E
- Systems to collect and analyse data from the community level are in place but not well utilized
- Reporting on chronic diseases has historically been a challenge - data was not well integrated into national health surveys or the national reporting system.
- Poor vital statistics data

# Kenya – Data governance landscape

**Patient level data**

- Data collected is not individualized data, mainly recording visit records rather than patient registered
- Variety of EMRs deployed in facilities- most don't share data with DHIS
- Thus patient level data not easily available
- Chronic disease mgmt. data is not well reported at health facilities and consequently under reported
- No unique ID system for linking data across collection systems

# Kenya – Data governance landscape

## Data integration

- DHIS2 not well deployed in  private facilities
- Infrastructure and Data-Many data sources, many parallel systems, not integrated
- Limited  data sharing between national agencies (such as NHIF) and MOH – *Claims data, commodity management data not linked to service delivery data/*Health facility data

# Kenya – Data governance & policy

## Data policies & Analytical capacity

- Limited analytical capacity
- Over-reliance on DPs for support of HIS systems –little investment by Government
- Lack of clear data privacy guidelines leads to conservative sharing of data

# Recommendations /lessons from other countries

- Drive e-health policy so that data systems can talk to each other
- Build analytics within systems/ Build HR analytical capacity
- Embrace real-time monitoring, disaggregated data, including profile of patients (age, sex) to aid in planning
- Aggregating and integrate data from all levels into one system

# Recommendations- lessons from other countries

- Strengthen systems  for collection and management of chronic diseases

- Use unique ID system for linking data across collection systems -
  - Building data warehouse based on individual case that should contain all needed variables.

# Recommendations- lessons from other countries

- Innovative engagement of private sector in order to facilitate private sector reporting
- Legal mechanisms for private facilities not reporting/ link to loss of accreditation if not using DHIS2
- Add chronic disease screening as a benefit from national health insurance system - *Korea*

# Kenya – Current or future focus areas:

- Interactive dashboards –*UHC, SDG, Management*
- Data warehousing /Development of a national health observatory
- Build HR and systems analytical capacity
- Strengthening of CRVS
- Improving capacity for data analytics
- Unique Health Identifier
- Strengthen Policy environment

December 11, 2018

# Data use governance for Universal Health Coverage (UHC):

## *from theory to practice*

Global Digital Health Forum

**Caren Althauser**
**Program Manager, Digital Health**

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# The Joint Learning Network for Universal Health Coverage

*A collaborative learning network for health systems practitioners*

The JLN receives generous funding from the following partner organizations:

Bill & Melinda Gates foundation

The Rockefeller Foundation

german cooperation
DEUTSCHE ZUSAMMENARBEIT

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giz Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH

The World Bank

# The Value of Country-Driven Joint Learning

- Centers on **country ownership**
- Highly **relevant to** country defined priorities **UHC priorities**
- Creates space to **analyze root causes** of **challenges**
- **Builds trust,** safe space and community for **peer-to-peer learning**
- Results in **practical tools and knowledge** that can be shared and **applied**

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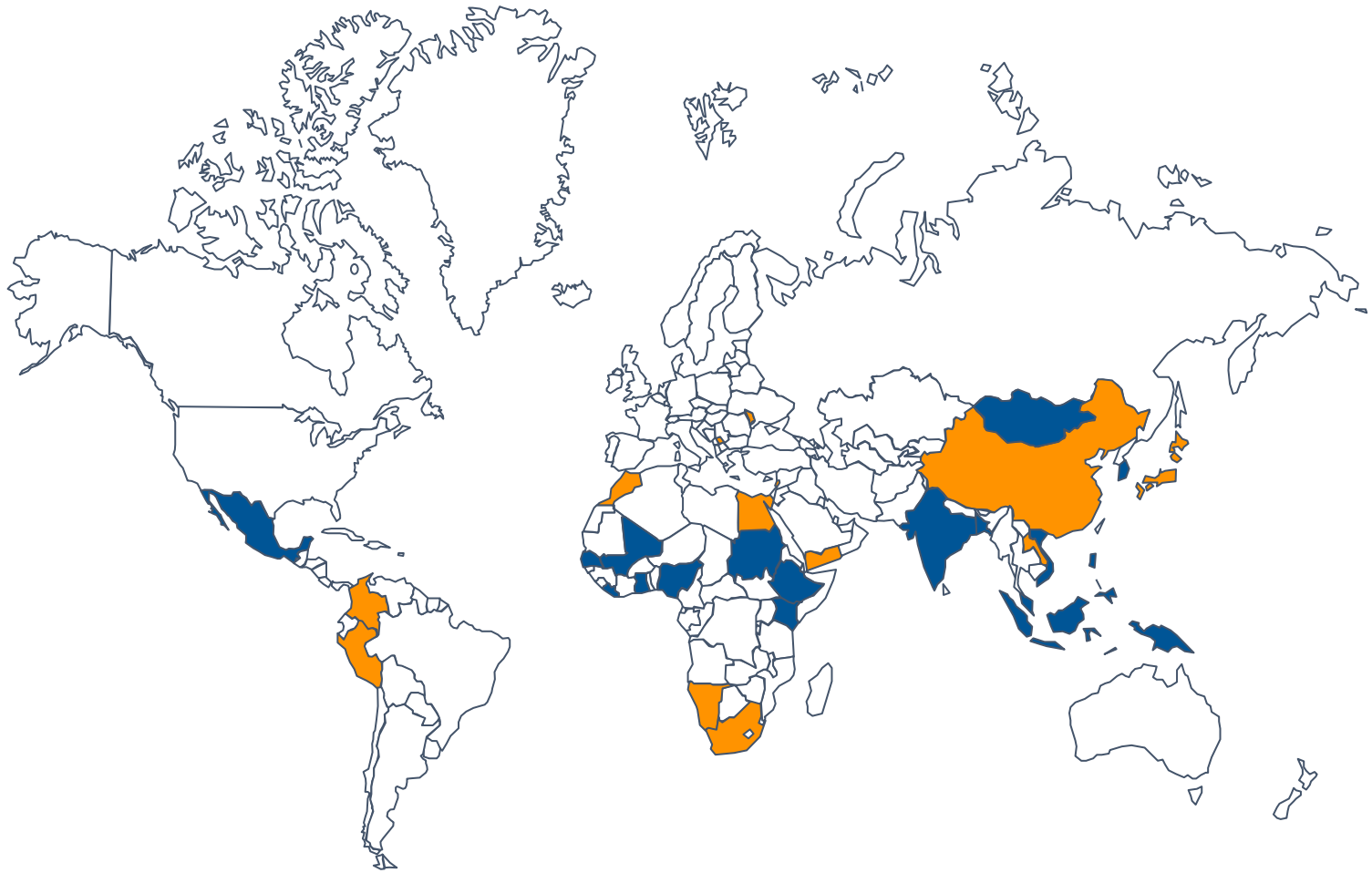
# A Vibrant, Growing Network of Policymakers and Practitioners

## Full Members

| | |
|---|---|
| Bangladesh | Mali |
| Ethiopia | Mexico |
| Ghana | Mongolia |
| Indonesia | Nigeria |
| India | Senegal |
| Kenya | South Korea |
| Liberia | Sudan |
| Philippines | Vietnam |
| Malaysia | |

## Associate Members

| | |
|---|---|
| Bahrain | Lebanon |
| China | Moldova |
| Colombia | Morocco |
| Egypt | Namibia |
| Japan | Peru |
| Kosovo | South Africa |
| Lao PDR | Yemen |



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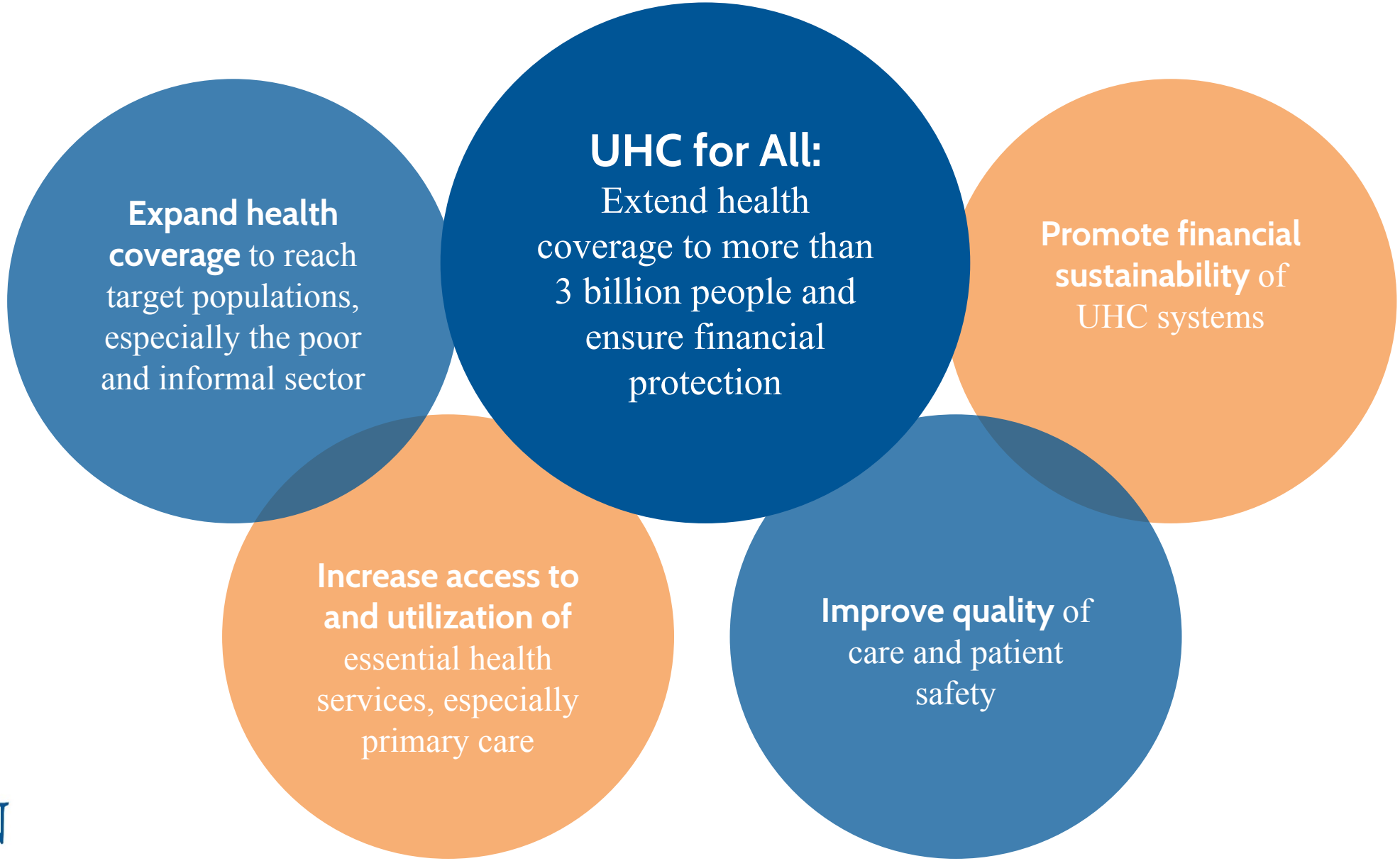
# JLN's Ultimate Goal: UHC

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# The Joint Learning Approach

Practitioners engage in **collaborative learning** to **co-develop global knowledge on the practical how-to's** of achieving universal health coverage.

1. Identify a common challenge
2. Collectively problem solve
3. Synthesize new knowledge
4. Apply knowledge within JLN countries
5. Share knowledge globally

# JLN facilitates collaborative learning around technical focus areas.

## Population Coverage

Improve coverage across the populations that require help.

## Primary Health Care

Improve access to preventive and promotive primary health care services.

## Provider Payment

Ensure that reforms are financially sustainable.

## Information Technology

Accelerate the development of national health insurance information solutions.

## Quality

Ensure patient safety.

## Revisiting Health Financing

Navigate resource needs, availability and utilization.

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# The Information Technology Initiative

**Information Technology**

Accelerate the development of national health insurance information solutions.

The IT Initiative network is comprised of IT professionals from ministries of health and national health insurers working together to develop and share artifacts, knowledge, and tools that can be used by countries to implement and operationalize national health insurance schemes.


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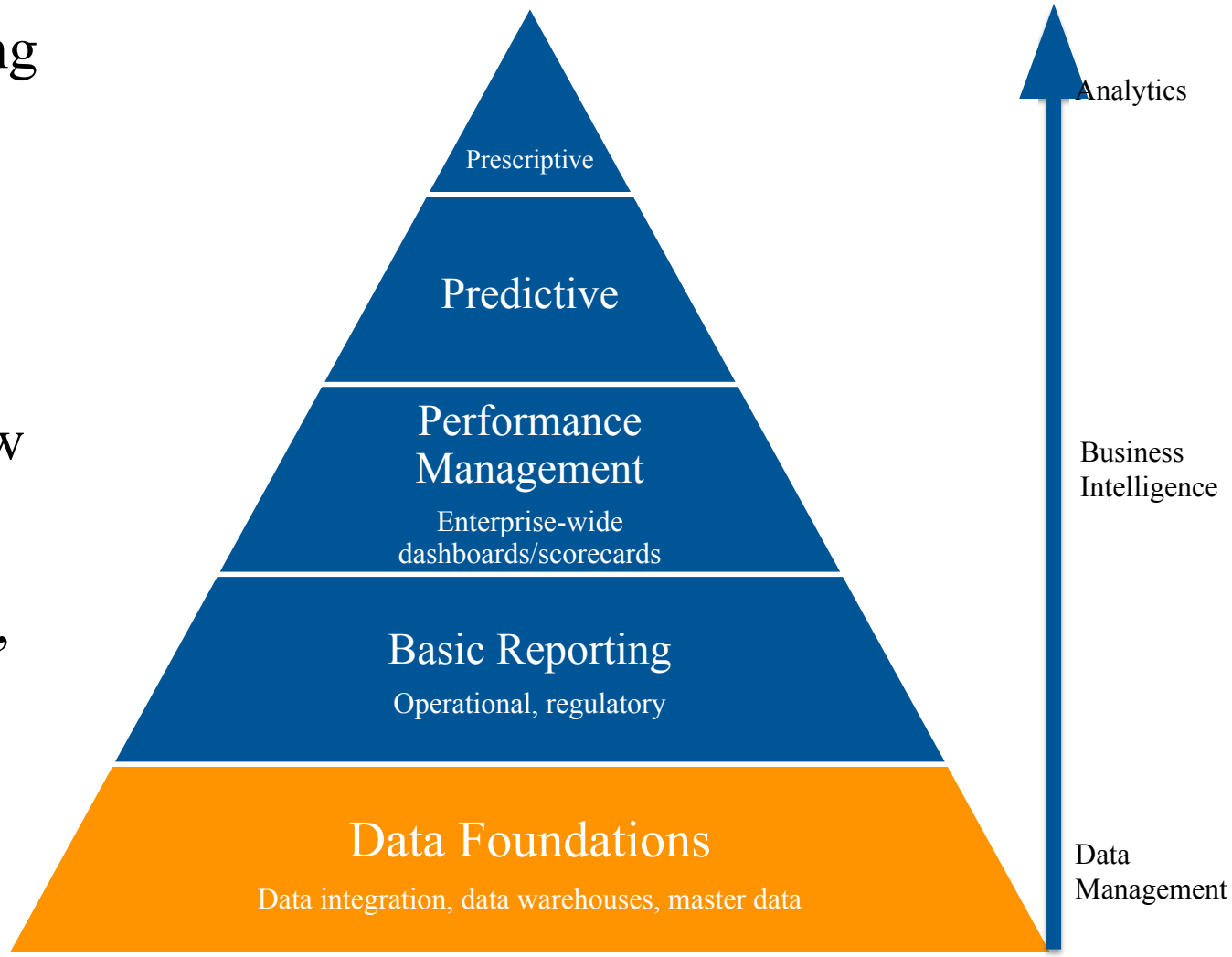
# The Data Foundations collaborative

- 23 participants from 10 countries:
- Participant profiles:
  - IT or data management professional
  - Health purchaser claims or other major operational department
  - Policy-level data management
  - Data analytics or researcher
- Technical Facilitators:

wipro PATH

# The Data Foundations collaborative: Building from the bottom, up.

- Common trends related to implementing UHC require data to inform policy, monitor results, and effectively implement care delivery and financing at national scale.
- IT can play a critical role in turning raw data into valuable information.
- All stakeholders play a part in creating, managing, and using data. IT professionals are challenged with putting the infrastructure in place to make data accessible and usable.




Source: Dell Healthcare Services (November 2013) Healthcare Analytics: The Way Forward

# Data Foundations Workshop: Seoul, South Korea, April 2018


- Deep dives into Korea's experience with data use supporting UHC goals
  - Chronic Disease Management
  - Financial Management
  - Claims Data Utilization
- Site visits to NHIS and HIRA
- Group work to share and synthesize country experiences and challenges

# Three Health Insurance Data Analytics Case Studies

## Chronic Disease Management

For prevention and care of chronic conditions such as diabetes and heart disease, we will examine:

- How national health programs have leveraged population health management strategies to segment and identify people at risk, shape new care models, reduce care variation, and improve outcomes with evidence-based treatment
- Approaches for tracking chronic care outcomes over time

## Financial Management

How can health insurance data support effective budgeting and financial management? Examples include:

- Annual budgeting (expenditure setting, funding stream management)
- Real time financial management through real time budget data access tools
- Financial risk analysis cadence
- Using statistical analysis to calculate budget projections

## Claims Data Utilization

Claims data can be harnessed to better understand improve operational efficiency.

- How countries store, access, visualize, and translate data
- What data sets are linked to claims data
- Opportunities for using claims data to improve the health system
- Prevent improper spending and improve quality of service, including claim review, quality assessment, fraud detection, and monitoring of systems

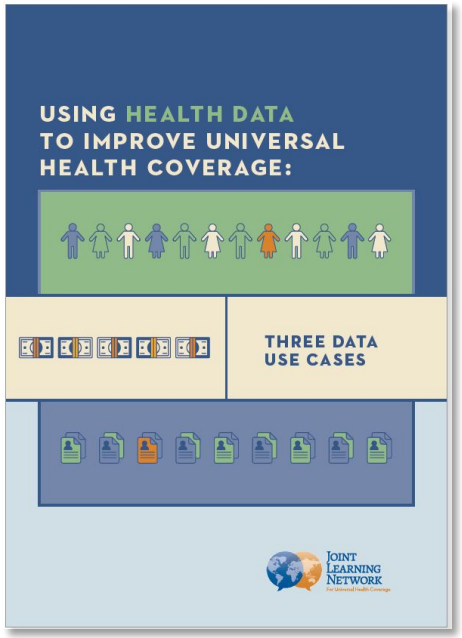
# New JLN Data Use Cases

## Using Health Data to Improve Universal Health Coverage:

**Chronic Disease Management**

**Financial Management**

**Claims Data Utilization**




The Data Foundations collaborative presents three examples of how data is supporting UHC.

Using South Korea as an inspiration example, these case studies look at country experiences and challenges in collecting, analyzing, and applying health data.

**Available December 2018**
www.jointlearningnetwork.com/resource/using-health-data-case-studies

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# Additional Resources: jointlearningnetwork.org

- National insurance terms glossary
- Promoting Interoperability of Health Insurance Information Systems through a Health Data Dictionary
- openHDD: an open-access health data dictionary
- e-claims: a common e-claims standard
- Determining Common Requirements for National Health Insurance Information Systems
- Functional business processes and IT requirements
- Software comparison tool
- Provider Payment Reform and Information Technology Systems
- Connecting Health Information Systems for Better Health – eBook on standards and interoperability
- Toolkit for developing provider payment monitoring indicators


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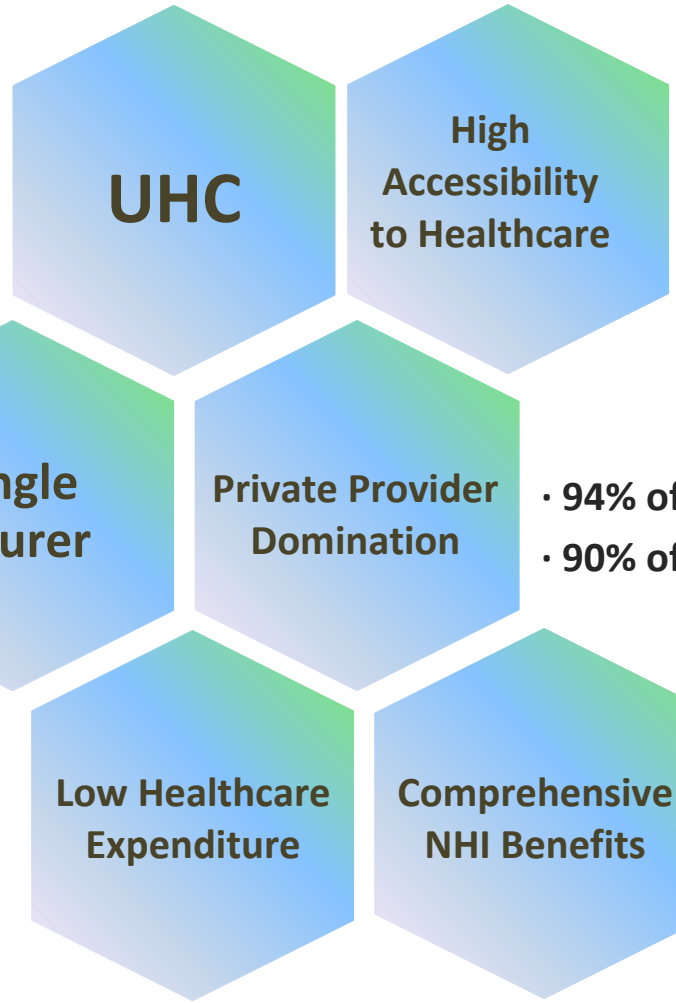
# Data use/governance perspectives

## : Based on Korean National Health Insurance system

Won Whang
Manager,
National Health Insurance Service of Korea

# Major characteristics of Korean NHI




Healthcare coverage for all by National Health Insurance (NHI) system

Mandatory Participation (Korean, healthcare providers) under the NHI legislation

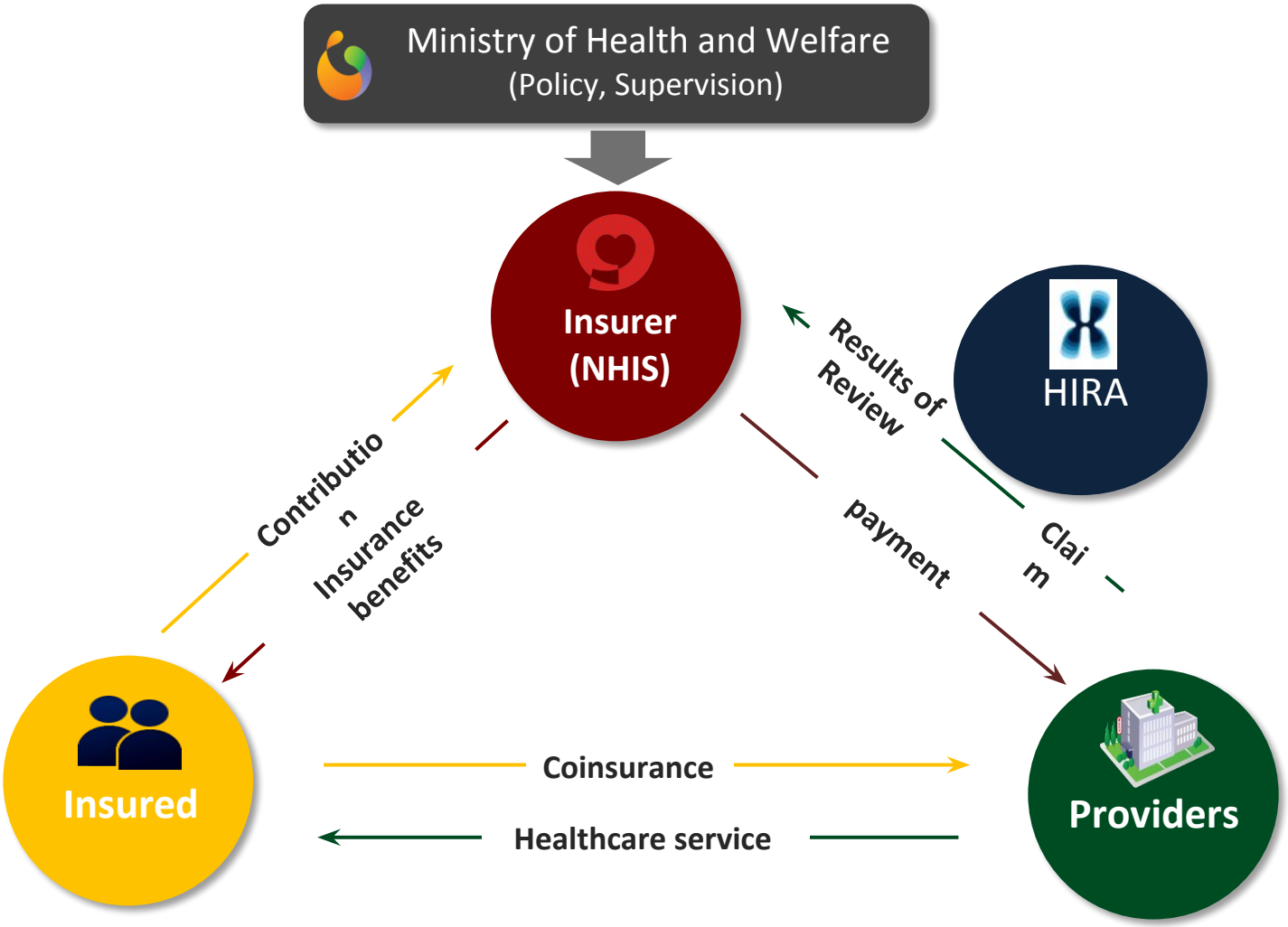
· National Health Insurance Service(NHIS)
· Purchasing : Monopsony power

· 94% of Healthcare Institutions
· 90% of beds

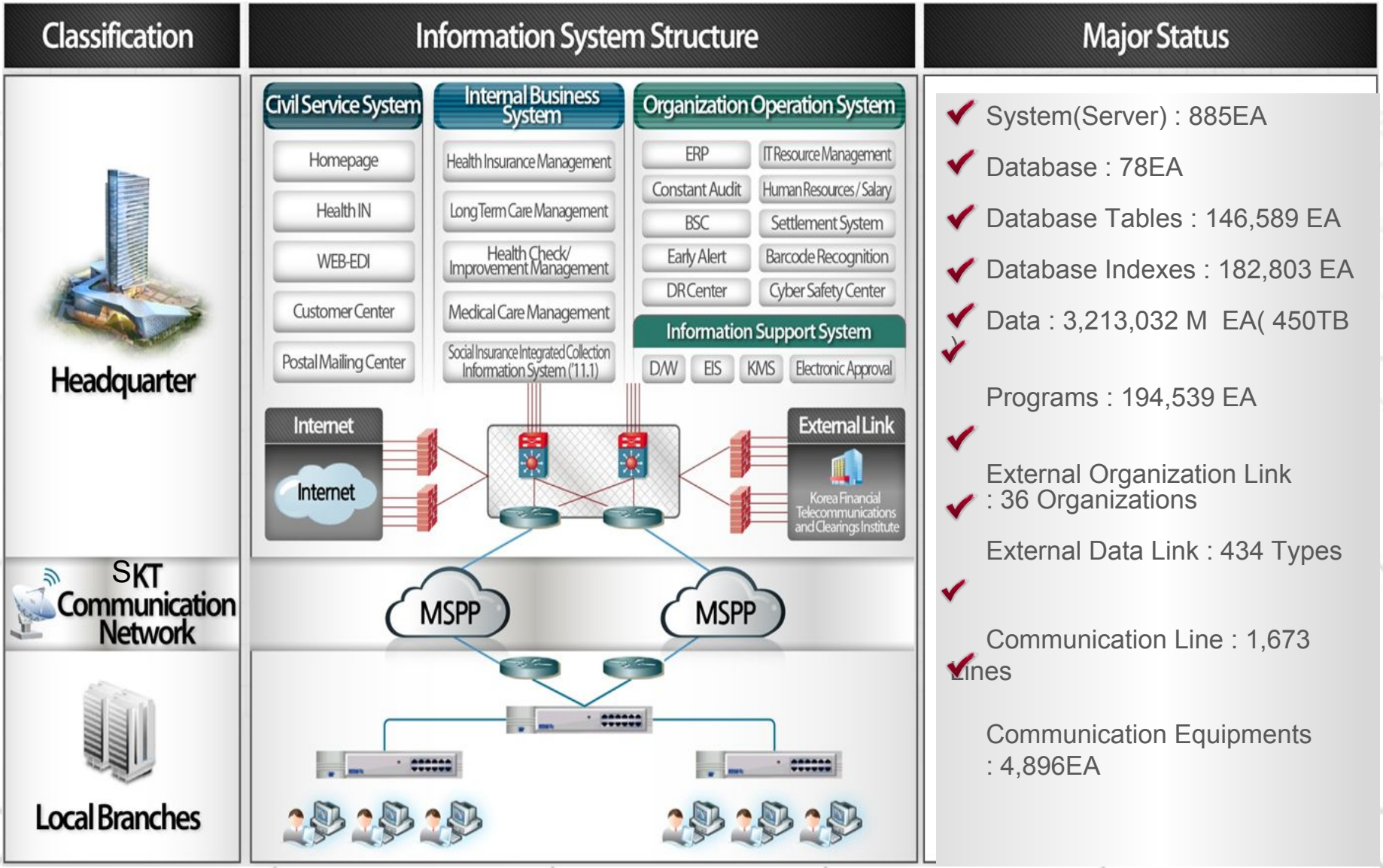
7.7% of GDP(2016)
* OECD average : 9.0%

62.6% of cost coverage (as of 2016)
* 80%-90% for catastrophic or rare diseases

# Governance of Korean NHI



# Data use/governance- in general



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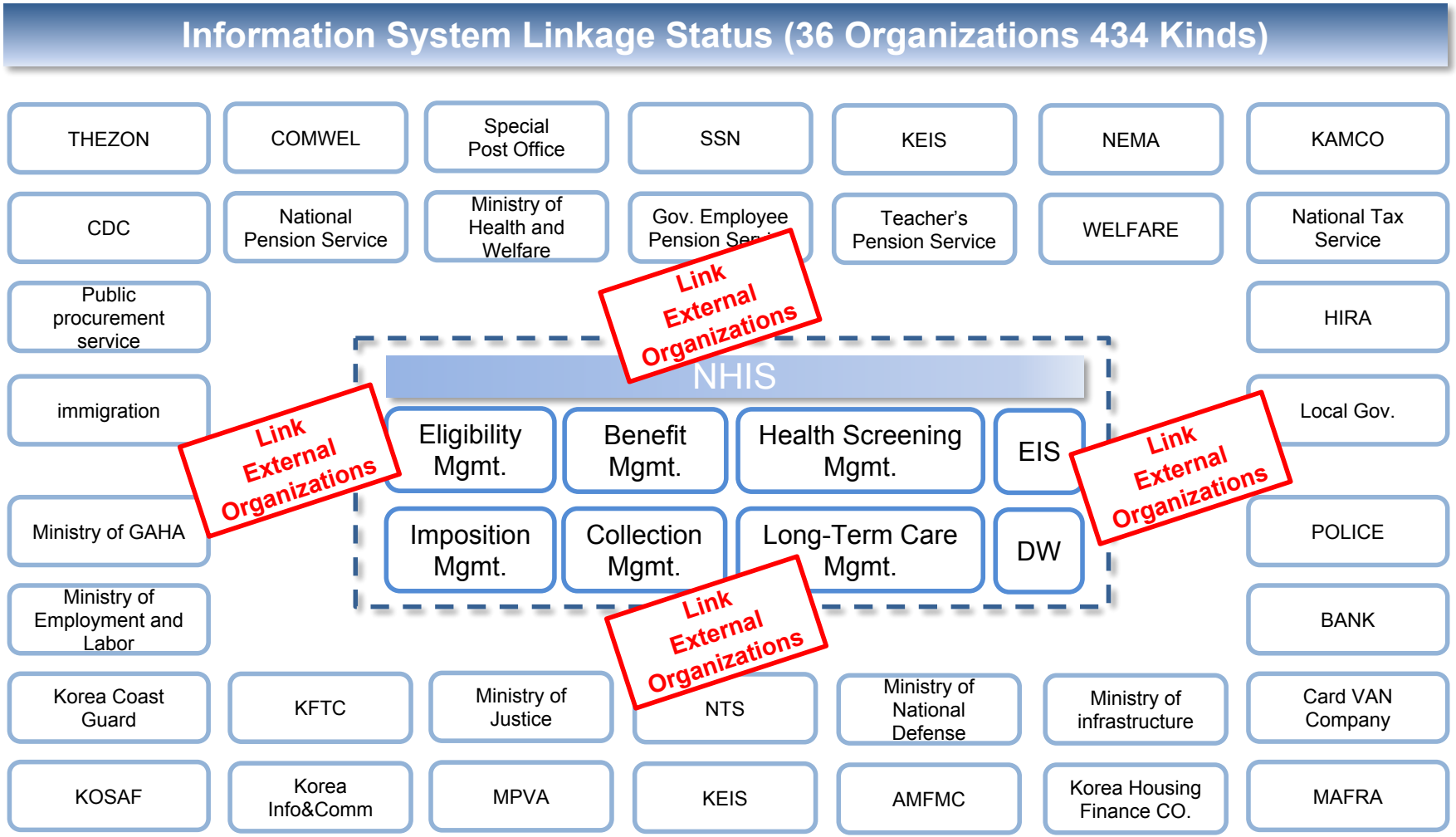
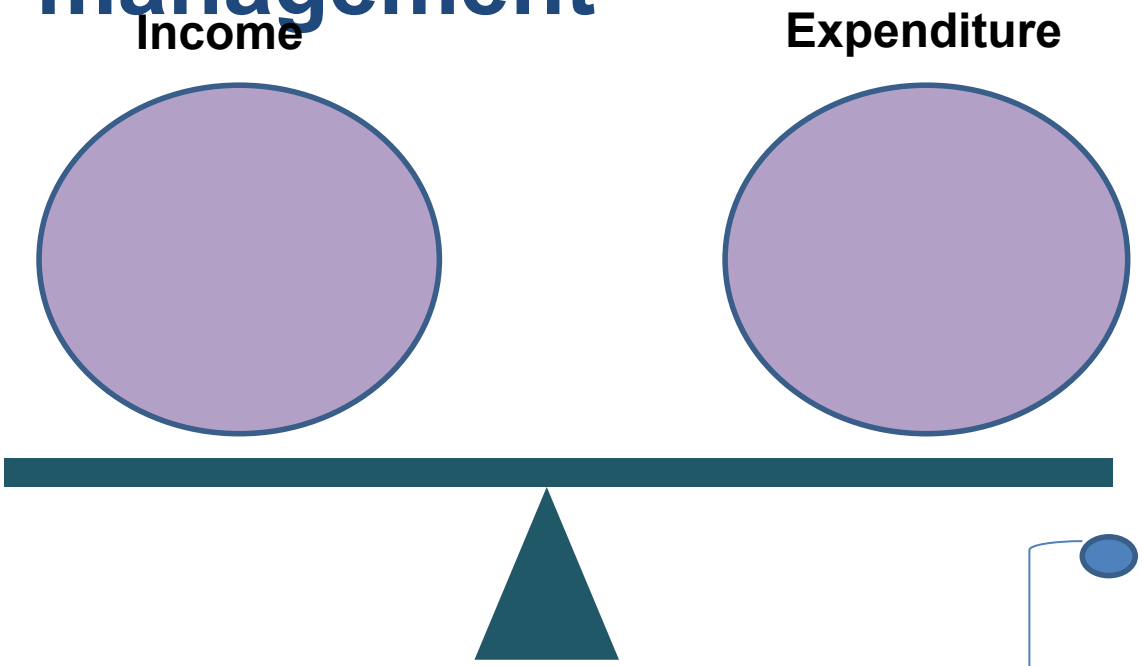


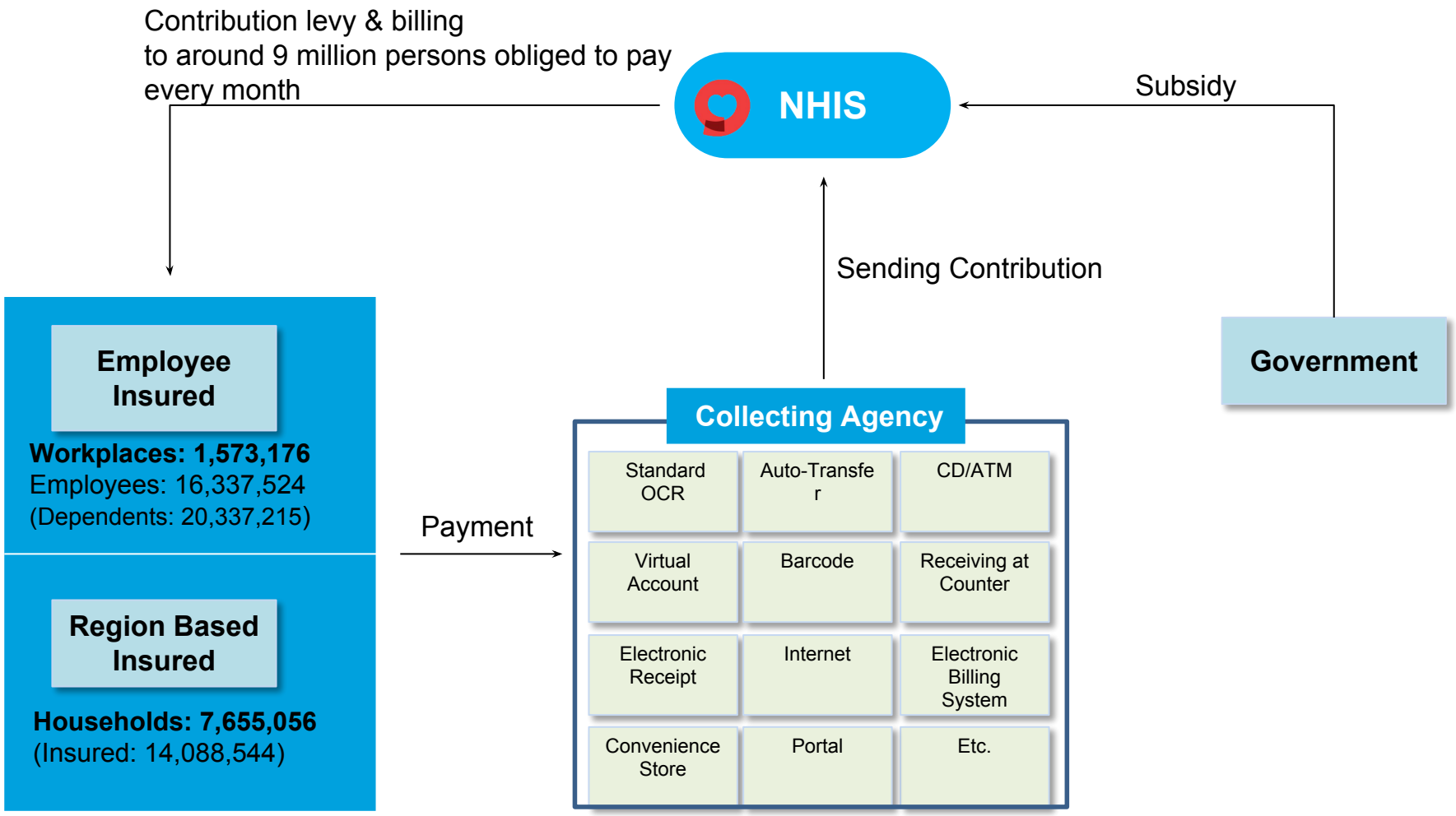
# Data use/governance- financial management



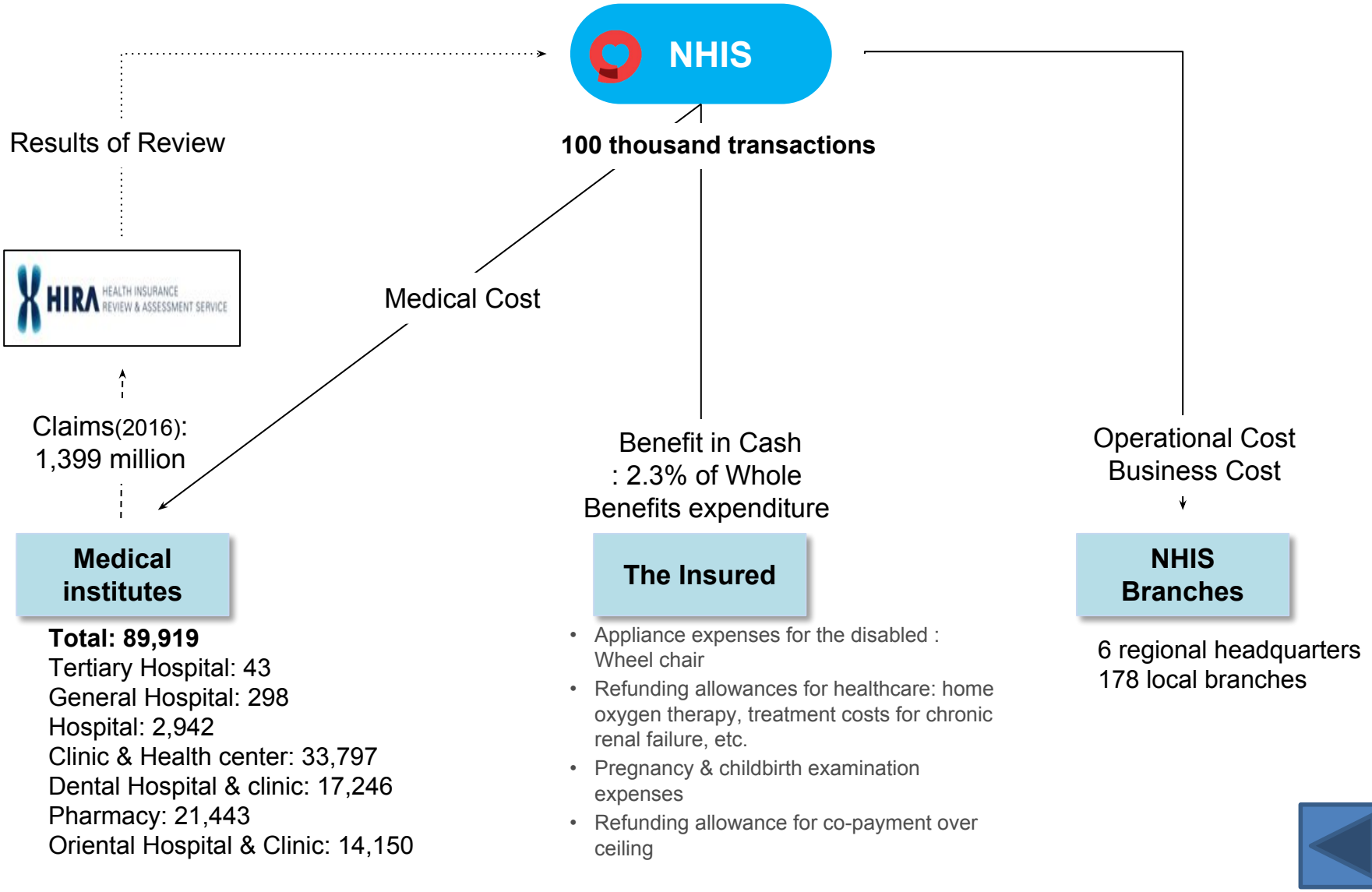

Financial Management

- Annual budgeting
- Real-time Financing Mgt.
- Financial Risk Mgt.

# Data use/governance- income management

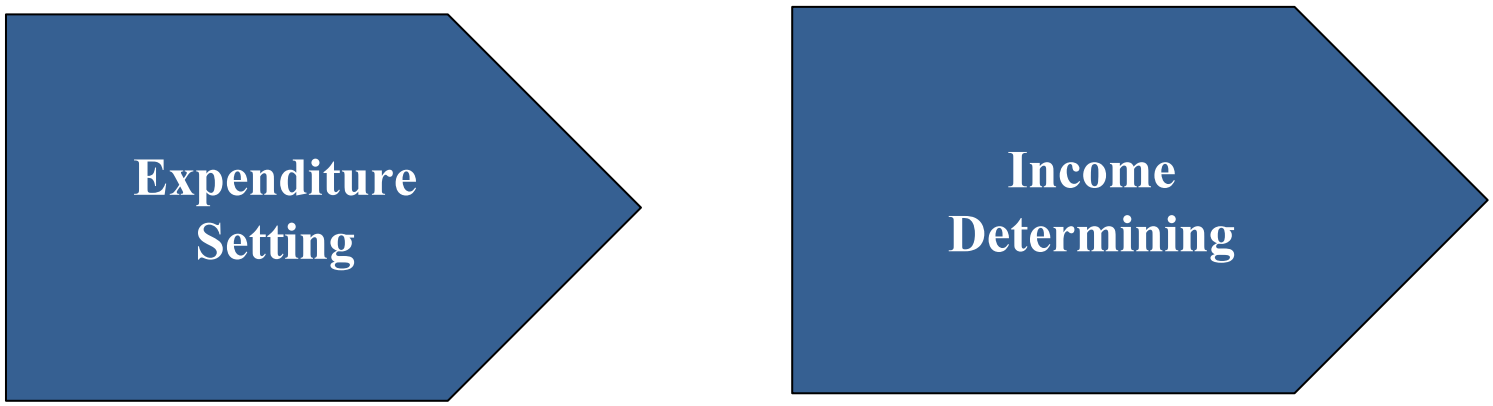


# Data use/governance- expenditure management



# Data use/governance- annual budgeting

- **The amount of expenditure is firstly set, and then that of the income is determined**

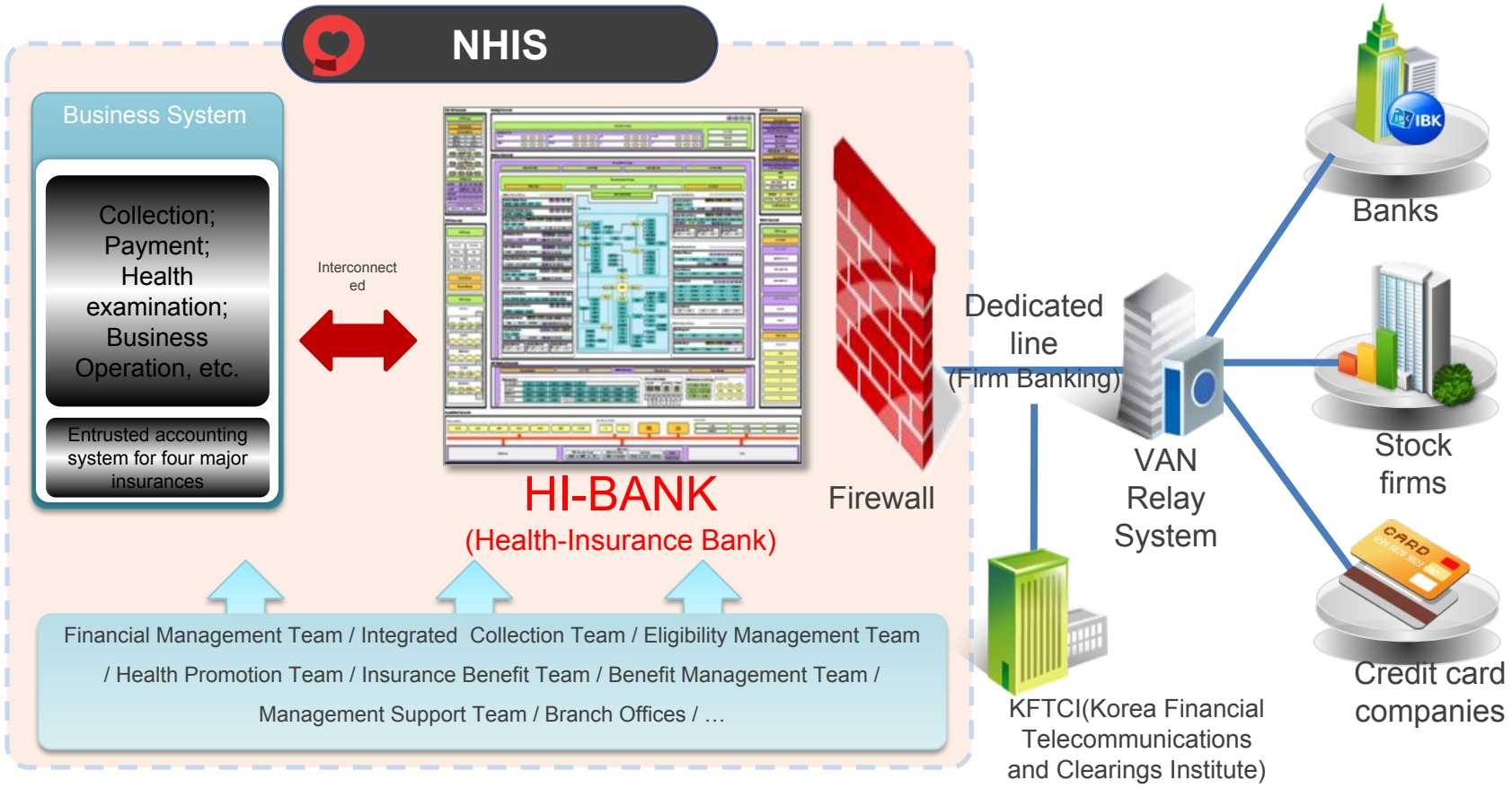



Contract of fee schedule between NHIS and Providers

Contribution rate
Gov. subsidy

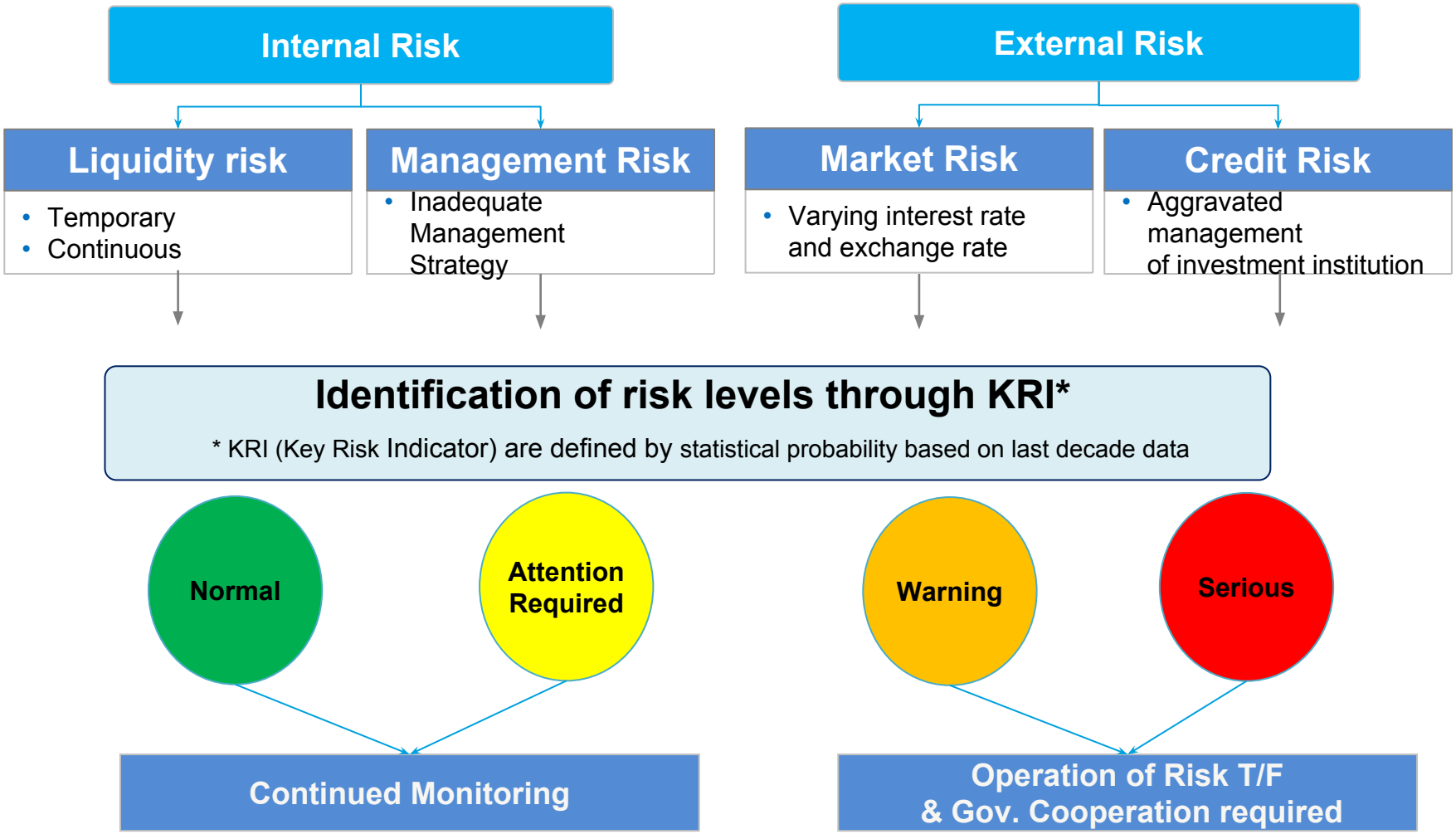
# Data use/governance- real-time financial management

**The Cash flow can be verified on daily basis by HI-Bank linked between NHIS Business system and each Financial Agency Systems(Bank, Securities Firm, Credit card Agency and others).**



# Data use/governance – financial risk management

***Financial Risk defines as The Status of Inability to pay reimbursement normally***



# Lessons from Korea's cases

- Good model in terms of NHI data use/ integration / security/ privacy
- Why is ICT-based system important?
- How to cooperate with Korea's NHIS?


Q & A

# *THANK YOU*

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# NIGERIA HEALTH INSURANCE:
# DATA USE LANDSCAPE

by

**Joshua Kolajo**
**National Health Insurance Scheme, Nigeria**

*A Presentation at Global Digital Health Forum,*
*Washington DC, USA, 11th December 2018.*

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# Nigeria Health Care System: Brief Overview


Nigeria is a Federal Republic composed of 36 States, a Capital Territory, and these states divided into 774 local Government with a population of over 180 million and 53 years Life expectancy. It is rated as the largest economy in Africa with GDP per capita of 1,968.56 USD (World Bank 2017)

The Nigerian healthcare system rests on three (3) tiers of administration namely: primary, secondary and tertiary levels. Originally, the primary level is run by the local government, the secondary by the state, while the tertiary is run by the federal government.

FMOH in 2017, estimated 23,640 HCFs in Nigeria (85.8% Primary, 14% secondary, and 0.2% Tertiary)

Health Care in Nigeria is financed by a combination of: budgetary provision by the federal, state and local governments, Out of pocket payments, Donor funding, Health insurance (private, public, social and community).

National Health Insurance Scheme in Nigeria covers mostly the formal sector of Federal Government employees (mandatory). Over 95% coverage has been achieved..

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# HEALTH CARE FINANCING IN NIGERIA

- Health Care Financing
  - Yearly budget for FMOH, SMOH
  - 1% of Consolidated Federal Government revenue is to be allocated for Basic Health Provision Fund (NHA 2014)
  - Social Health Insurance
  - Private Health Insurance
  - Community Financing
  - Out of pocket expenditure by individuals and households
  - Others (Aids, Grants, Local and International NGOs, Philantropists)

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# PAYMENT FOR SOCIAL HEALTH INSURANCE

- Payment for Health Insurance
  - **Capitation payment**
    - Fixed Fee paid in advance to a provider for provision of services for a fixed period of time.
    - The Providers are paid according to the number of enrolees attached to the facility
    - The Capitation is meant for provision of Primary healthcare services only.
    - This is paid from pool of funds contributed by employer and employee (15% of basic salary or 5% of consolidated salary)
  - **Fee for Service**, (for secondary and tertiary healthcare services) Paid to the HMOs to settle bills incurred for referral to secondary and tertiary Health institutions.
  - **Co-Payment**. enrollee paying 10% of total cost of prescribed drugs
- **Different Health Insurance Programmes by NHIS**
  - FSSHIP, VCSHIP, TISHIP, CBSHIP, Vulnerable Group social Health insurance scheme

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For Universal Health Coverage

# SUCCESSES

## ❖ Our Success Stories

- ➢Provision of Health insurance coverage to over 95% Federal Government- employees, one spouse and 4 biological children.
- ➢Protect of enrollees families from the financial hardship of huge medical bills.
- ➢Equitable distribution of healthcare costs among different income groups.
- ➢Maintenance of high standard of healthcare delivery services within the Scheme.
- ➢Equitable patronage of  different levels of healthcare.
- ➢Availability of funds for the health sector for improved services.
- ➢Promotion of State Health Insurance Scheme.
- ➢Accreditation of over 6,000 HCFs
- ➢NHIS/MDG MCH programme won a best practice award from International Social Security Association, 2011, Arusha Tanzania.

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# CHALLENGES


- Lack of legal provision to make health insurance mandatory for all
- Providers giving Suboptimal Care through under utilisation of Care Services to maximise profit
- Delay in payment of capitation due to lack of integrated system
- Problem of interoperability, fragmented and silos data sources
- Lack of sufficient investment in ICT due to lack of budget from government
- Lack of skills and Personnel deficiency for large data collection, processing and analysis for data informed decision making
- Poor infrastructure for real time electronic data collection (poor Internet penetration, irregular power supply).

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# LESSONS LEARNED FROM OTHER COUNTRIES AND WAY FORWARD


- Automation of claim management system (Korea, Ghana)
- Automation of Drug Utilization Review system, to prevent the unsafe use, overuse, and misuse of pharmaceutical drugs. (Korea)
- Effective system to monitor and followup on patient on treatment for chronic diseases for better health outcomes (Korea)
- Compulsory annual health screenings for particular age group (Korea)
- Real time financial management of Healthcare budget and expenditure (Korea and Philippine)
- Harmonisation and integration of data with other government agencies. (Korea)
- Need for capacity building in big data collection and analytics.(Korea)
- Strengthen policy on data governance (Korea)

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