JACOBS PUBLISHERS

OPEN ACCESS

Jacobs Journal of Community Medicine

Research Article

Underutilization of Social Health Insurance by Kenya's Informal Sector Populations: Staid Voices

Omar Egesah[1*]

[1]*Department of Anthropology and Human Ecology at Moi University, Kenya*

**Corresponding author: Prof. Omar Egesah, Department of Anthropology and Human Ecology at Moi University, P. O. Box 30100 3900, Eldoret, Kenya, Tel: +254(0)714416408; Email: omagesa@gmail.com*

Received: 06-30-2015

Accepted: 07-14-2015

Published: 08-10-2015

Abstract

Globally, health insurance is increasingly being preferred to finance health care costs. Countries like Kenya with existing National health insurance schemes for formal sector workers have recently extended social health insurance (SHI) programmes to people outside the formal sector in an effort to increase access to healthcare. However, developing effective approaches for access to health care through SHI for people in the informal sector still faces challenges of enrolment. This paper evaluates sustainable strategies to enhance participation of people in the informal sector in the National Hospital Insurance Fund (NHIF) Scheme and presents stolid voices of disenchanted potential users from the informal sector using a descriptive qualitative approach. People in the informal sector in Kenya are aware of the value and importance of participating in the NHIF scheme to access quality health care. However, they are dissatisfied with the service as a result of a rigid scheme design, dearth of user information about the benefits offered by the scheme and enrolment bureaucracy. This paper recommends policy review for an attractive penalty free package for users in the informal sectors and expansion of access points to the scheme.

Keywords: Health; Insurance Scheme; Participation; Access; Informal Sector Populations; Kenya

Introduction

Healthcare access is still a global problem which attests to the elusive health for all (HFA) principle. Many people all over the world cannot afford costs of health services [1]. Most households still rely on out-of-pocket payments for health care and this deters people from seeking health care when needed and those who do seek quality health care face a problem of financial constraint [2]. This problem is particularly severe in low income countries (LICs) around the globe where many people live in abject poverty [3]. Over the last decade, Social Health Insurance (SHI) has emerged as a preferred form of financing health care costs in most countries [4]. Health insurance mechanisms help people to pool resources and transfer risks of unforeseeable healthcare costs for a pre-determined fixed contribution thereby avoiding catastrophic financial burden. In SHI schemes, people can access health care based on the need and not on ability to pay for health services. Kenya has a National health insurance program for formal sector workers but has recently extended SHI programmes to people outside the formal sector in an effort to increase access to healthcare in line with WHO [5] recommendations. The major challenge here has been adoption of SHI to integrate the poor and encapsulate the ever expanding informal sector that comprises a majority of the workforce in Kenya. The bulk of working age adults in developing countries, Kenya not being an exception is comprised of the unemployed, subsistence farmers, and those working in the informal sector [6]. Social Health Insurance is

especially designed for poor and vulnerable people to provide them health and medical facilities since they may not afford the cost of medicine and hospitalization. A number of studies show that households in the informal sector rely on traditional coping responses such as selling assets and informal borrowing to deal with the adverse consequences of ill-health [7]. These coping responses are in most times stymied by financial costs and are not cost free but entail a compromise, protecting current consumption at the cost of future vulnerability [8]. To navigate around this problem, the WHO recommended social protection in 2005 as a strategy to attain "universal health coverage" [9]. Since the 2005 World Health Assembly Resolution -WHA R 58.33 [9]. Policy formulators in most developing countries have embraced SHI as a strategy to attain universal health coverage because SHI supports the purpose of promoting equity in access to health care. However, developing effective approaches for access to health care for people in the informal sector through SHI can be wrought with myriad of challenges, particularly in low and middle-income countries [10]. Approaches based on health insurance still face challenges of enrolment of a sufficient number of people into a common risk pool, collection and repayments of contributions.

Kenya's SHI; the National Hospital Insurance Fund (NHIF) scheme is an accessible medical cover offering insurance at costs that are considerably below the actuarially fair price suitable for most socioeconomic groups in the country [11]. Private health insurance is available but predominantly accessible to the middle and higher-income groups, while, the Community Based Health Insurance (CBHI) schemes still have limited coverage countrywide [12,13]. The benefits of NHIF membership include coverage of inpatient expenses (costs of bed, meals, treatment and drugs) with the share of expenses covered determined largely by the type of health facilities (Hospitals, Nursing Homes, Health Centers and Dispensaries). Beneficiaries of the scheme also include the contributor's dependents (the spouse and children less than 18 years of age). People in the informal sector above the age of eighteen years can join the scheme voluntarily by paying a minimum monthly contribution of Kshs.160 (about US $ 2). Although the scheme is open to all since 2011, the paper messages slow uptake from the informal sector and the unemployed in joining the scheme. Low participation by people in the informal sector in the scheme has been blamed on both user and supply factors. People in the informal sector face difficulties of low and irregular incomes; this makes them unable to make timely contributions [14]. People in the informal sector also face difficulties created by inflexible scheme design features such as penalties, inflexible payment schedules, non-portability of scheme services, cumbersome enrolment and contribution procedures [15]. Poor participation weakens service delivery by the scheme largely because the principle of risk pooling requires sufficient membership and regular contributions to pay for health services. It is therefore necessary to establish mechanisms or approaches that can be applied to improve informal sector participation to make the NHIF scheme viable and sustainable. This paper elucidates strategies to enhance participation of people in the informal sector in Kenya in the National Hospital Insurance Fund (NHIF) Scheme. The objective of this study was to evaluate sustainable strategies to enhance participation of people in the informal sector in the National Hospital Insurance Fund (NHIF) Scheme to access and benefit quality health services.

Methods

This descriptive qualitative study assessed existing needs and adequacy of health services as argued by Creswell [16]. Bulk of the data were collected in Kakamega County, west of Kenya which is robust with informal sector work activities. Kakamega County is the second most densely populated County in Kenya with majority of residents deriving livelihoods through the informal sector [17,18]. People in the informal sector often work in poor, sub-standard working conditions and are exposed to various hazards without proper knowledge concerning the use of personal protective equipment, and stand higher risks of injuries. However, little is known about social health scheme patterns of the informal sector populations in the County and in Kenya as such. Maximizing participation in the NHIF scheme has rippling effects of benefitting the citizenry (especially the poor and people in the informal sector) by reducing out of pocket expenditure and increasing access to legitimate healthcare, thereby helping to improve their health related quality of life.

A qualitative approach was used to understand people's experiences and opinions from which to base suggestions for service delivery and utilization of the NHIF scheme. The paper discusses factors that influence participation of the informal sector populations in the NHIF Scheme and strategies that could be adopted to enhance participation in the Scheme. Purposive sampling techniques were employed in selecting the informants. Purposive sampling was preferred in this study so as to gain breadth and depth of experiences and opinions on the subject. Ten (10) focus group discussions were conducted with members of various informal sector engagements (mechanics, hawkers, artisans, drivers, passenger motor cycle riders (*bodaboda*), farmers and house helps) who were engaged in two-hour group discussions that were recorder and transcribed. Sixty (60) Key Informants were enlisted by quota and purposive sampling into the study and interviewed using an interview schedule. In total, 10 FGDs of 8-12 people and 60 key informants provided data for the study and this paper (table 1). Four research assistants were trained and internalized the research purpose, objectives, questions and tools; which they piloted prior to the data collection process. Focus group discussions elicited data on various variables including people's attitudes, perceptions, abilities and willingness to enroll and participate in the NHIF SHI scheme. Although there were di-

vergent attitudinal views from the discussants, consensus was reached over NHIF enrolment matters. Key informants provided data on a wide range of variables; merits and demerits of enrolment in the NHIF scheme; NHIF scheme structure and design; quality of NHIF services including enrolment and health care service compensation and; user and provider challenges in utilizing the NHIF scheme.

Data were laid open and inductively coded by developing themes from within the data. These themes were dropped from the objectives thus the following topics were eventually identified and analysed; NHIF enrolment process; Sustainable strategies to enhance participation in NHIF scheme; NHIF health services; User and provider challenges in NHIF utilization. Constant comparative analyses were made in NVivo10. The study is overly qualitative and thus we used research questions that were answered by data. The author participated in data collection and even moderated four FGDs, something that enable us to speak to the point from an informed vintage position. The qualitative data analysis took an exploratory or conceptual content analysis process which was more ideal. Interpretation was used to give meanings and explain phenomena such as attitudes, perceptions and willingness to enroll and participate in the NHIF scheme. Spearman's rank order correlation was used to analyze data on strategies to enhance enrolment of people in the informal sector into the NHIF Scheme based on ranking by FGDs and Key informants. The research protocol had approval of the Kenya National Commission of Science Technology and Innovation (NACOSTI). A summary of the sampling strategies adopted in the study and samples is presented in table 1 below.

Table 1. A summary of sampling strategies adopted in the study.

Study population unit	Sampling method	Sample size
County administrators	Purposive	4
NHIF management officers	Purposive	3
Hospital administrators	Purposive	4
Managers with other insurance firms	Purposive	4
Managers of small and medium enterprise schemes	Purposive	4
Community health workers	Purposive	5
Opinion leaders	Purposive	10
Managers of NGO's in health sector	Purposive	5
Manager with the Kenya Red Cross	Purposive	1
Patients in health facilities	Quota	20
FGDs (various informal sector groups)	Purposive	10 (8-12)

Findings

By inductive coding, six overreaching themes across the ten focus group types and key informant interviews were identified. The themes converged on difficulties to participation in the NHIF scheme and proposed strategies to overcome the difficulties. The themes included difficulties faced in NHIF enrolment; Contributions; Unavailability of the NHIF or alternative schemes; Scheme design features (attractiveness of the scheme, level of copayments, customer orientedness, penalties, waivers and exemption); Payment modes (frequency, timing, place of collection, flexibility); Effectiveness of outreach strategies to improve implementation of NHIF scheme and to expand enrolment. Overwhelming reports indicate that participation in SHI has the potential to reduce out of pocket expenditure and increase access to legitimate quality healthcare, thereby helping to improve health related quality of life. There was widespread agreement that participation in the NHIF scheme is, in fact, important for access to health services, regardless of the difficulties people faced to participate. The appropriateness of the NHIF scheme was especially strong among people in the public transport sector; bus drivers and passenger motor cycle riders popularly known in Kenya as *'Boda Boda'* since there was a sense of accident risks in their daily business. Reports showed that people were clear about merits and demerits of subscription to the NHIF scheme. People expected persons engaged in any income generating activity to enroll and benefit from the NHIF. Thus, informants could not understand why eligible persons working in the informal sector had not subscribed to the scheme. While the benefits of NHIF subscription were evident in reports, informants were overtly skeptical about quality of health care services found at health facilities where enrollees are expected to access and use the services. For instance, there was concern over inadequacy of essential drugs in health facilities serving the poor and populations serving in informal sectors. In addition, informants in the transport industry, in particular, were skeptical about government plans to increase NHIF contributions and if this will be congruent to improved health care services. A majority of the key informants acknowledged that participation in the NHIF scheme has the potential of reducing catastrophic out of pocket expenditure. However, some opined that using the NHIF medical scheme cover did not make any difference on health care expenditure. One patient said:

'The costs of travel from my home to this health facility and the fact that I still have to purchase drugs yet I contribute to the NHIF scheme means that participation in the NHIF scheme is not helpful'. [Male patient at the referral hospital aged 35].

This finding reveals that the level of satisfaction of NHIF support to offset health care expenditure is still low. The same trend was observed when the issue of the actual time spent at the health facilities seeking health care was sought for both

the insured and uninsured. Insured outpatients spent more time in the health facilities than the uninsured. They spent much more time on the arduous and bureaucratic process of using the scheme card during admission and discharge from the health facility. As a result, some patients who are bona fide enrollees choose neither to use their NHIF cards nor to seek re-imbursement for health care expenditure. Moreover, even the key informants who were aware of the provision to seek re imbursement complained of delays and bureaucracies in getting refunds for money spent on health care. Only 4 out of 24 enrolled key informants that were interviewed had ever applied for re-imbursement of medical expenditure incurred in the past.

The concept of sustainable strategies for participation in the NHIF scheme medical cover is a positive and acceptable one for most participants, regardless of their level of understanding or familiarity with the process. It did, however, raise questions for some who felt that the scheme needed to provide more qualitative and quantitatively clear cut sets of information and procedures for health care services. Participants in all the FGDs for example, expressed a concern over the ability for the NHIF scheme to provide quality services within its mandate, as well as to achieve a long-term outcome of improved health care services. It was interesting to note that when references were made to spouse and children under the age of 18 years as beneficiaries of the scheme, participants appeared less reassured. This indicated a lack of understanding by users over their holistic entitlements from the scheme. Participants in all groups had difficulties acknowledging that the scheme offered health care subsidies beyond what the ministry of health and the government provides. There was little mention of contributions people can make to the NHIF scheme through savings, credit and cooperative societies (SACCOs) that they affiliate to, yet this was a clear provision in the NHIF manifestos. When prompted further on this issue, informants expressed fear that they would lose their savings and assets invested in SACCOs if they were to use this approach. In Kenya, SACCOs are perceived as banks for low income earners where people save and borrow money from and not as depositories through which people can draw from for health care.

The NHIF was portrayed as a rigidly designed scheme with features and operations that discouraged people to voluntarily enroll in. In fact Kenyan's in formal employment are mandatorily recruited into the scheme by employers whether they desire to or not. From this study, people in the informal sector were of the opinion that access to health care through the NHIF scheme was cumbersome. In addition, they argued that enrolment and monthly contribution procedures were difficult and disparaging. The main reason given for low participation in the NHIF scheme by informal sector workers was the high cost of premiums (63%), and also only 30% of the respondents were scheme enrollees. The other reasons given for non-participation included fixed timelines to make subscription contributions and harsh penalties for late payment of premiums. In addition for example, when informants were asked their main source of information about the NHIF scheme, both enrolled and non-enrolled pointed to media and friends/workmates and not NHIF itself. Both user and provider challenges were reported in utilizing the scheme. Demand side factors from the scheme included inflexible modes of premium payment, harsh penalties for late payment and restricted and selective service domains that the scheme covers in its health services. Furthermore, supply side challenges facing utilization of the scheme by informal employment populations included; reported poor quality of public health services in health facilities designated by NHIF scheme and restriction on type of health care services to subscribe to by NHIF enrollees. Informal sector workers had a low impression and opinion of NHIF services and they reported that the scheme had poor information dissemination mechanisms about the health services they offered coupled with mistrust by potential users about service and costing accountability in the scheme.

Moreover, the procedures of enrolment and contribution to the scheme were reported as cumbersome and burdensome; for example to register, one needed photographs of themselves and dependants, sociobiographic information about themselves and family members, birthdays of the children etc information that most people do not often readily have or remember easily. The procedure of contribution involved monthly deposits of money through a prescribed bank account deposit process or the "MPesa" (Electronic Money Transfer System) and both processes required that subscribers accessed and used these banks or owned and could use mobile telephones in this respect. After making these contributions, one was expected to upload the details to an NHIF recipient meaning that people were to spend extra money in cybercafés to do this every month (travel, banking fees, telephone charges, cybercafé charges etc), assuming every user was literate. Participants suggested that the NHIF scheme should set up more registration centers. Across the board, informants wondered why NHIF operations could not be decentralized to health facilities where after all, users eventually end up.

Informants proposed an array of suggestions aimed at mitigating user barriers including removal of barriers such as harsh penalties when one delays to pay monthly subscriptions and conditions of having to read present proof such as birth and even marriage certificates for children and spouse to use the scheme. The NHIF scheme regulations were seen as stiff, rigid and punitive for example, any member who fails to make contributions on time (usually by the 5th of the subsequent month) will pay a penalty of five times the usual contribution (i.e. Kshs.800 (USD=10) instead of Ksh.160 (USD=2) to be readmitted and be guaranteed of benefiting from the scheme any further. The NHIF scheme management argued that the condition was meant to discourage defaulting in contributions to the scheme although they admitted that harsh penalties dis-

courage potential members. However, the participants were particularly unhappy about penalties; as one FGD summarized their disapproval:

'With the kind of low and irregular incomes we get in our informal income activities, why would one risk to subscribe to the NHIF scheme when it is apparent that you may not be sure to have Ksh.800 for penalty if you make contribution late by the 5th of the subsequent month?' [FGD summary note].

Reports indicated that the NHIF scheme outreach strategies to improve implementation of NHIF scheme services and to expand enrolment were poor. Most participants had low and poor information about the insurance functions and roles and its processes. Almost all the key informants observed that the NHIF scheme had suffered negative publicity as a result of media reports of mismanagement of funds contributed by members. Similarly, most participants had a misconception that the NHIF medical cover was only meant for inpatient services. Twelve (12) of the 24 registered users in the study said that they had only presented their NHIF cards when they had serious illnesses that required hospitalization. In addition, the patients on the study appeared confused about medical insurance cover function as opposed to the general life insurance policy functions. A similar observation was made across all the FGDs and for most key informants. One Key informant argued:

'Why is the NHIF scheme called an insurance scheme yet we never see any bonus being paid to contributors the way it happens with other insurance policies?' [Key informant aged 54].

Clearly, people lack important information about the functions of the NHIF medical cover in risk pooling at fair actuarial prices as opposed to profit making private health insurance companies. Managers with other insurance firms who were studied explained that their programs succeeded because contributions to their medical schemes were calculated at actuarial prices that sustain the risk pool. The managers admitted that their schemes have very few people from the informal sector. Furthermore, Key informants on the study had another suggestion on contributions; they suggested that contributions to the scheme should not be a lifelong event; it should end when one attains a certain age, preferably 55 years. Their argument was that after the age of 55, members had been contributing for long supporting dependents and should therefore be supported by the active working age groups. This they argued would make the NHIF scheme more attractive.

Discussion

The study established that the NHIF scheme was perceived by participants as beneficial in promoting access to health care for people in the informal sector. Both the insured and uninsured respondents appeared to agree on the usefulness of the NHIF scheme in enabling people access health care. Findings from the FGDs revealed that a majority of the people in the informal sector are willing to use the NHIF scheme to access health services. However, participation in the scheme appears to be stymied by rigid scheme design features, low levels of knowledge about the insurance function of the NHIF medical cover, a blurred image of the scheme and unclear access strategies by the scheme. The observed poor participation in the NHIF scheme can be explained by unmet health care needs for NHIF members, especially when members of the scheme still have high out of pocket expenditure like costs of travel to accredited health facilities, buying drugs just like nonmembers of the scheme and inflexible scheme design features such as strict remittance deadlines and harsh penalties. This finding corroborates with findings of a similar study by Kimani *et al* [14] in which he reported that the NHIF scheme design features were an impediment to enrolment by people living in the slums of Nairobi, Kenya. There was a gap between what the NHIF scheme proclaimed to offer in terms of benefits to members and what was actually available including deficiency of essential drugs at health facilities served by people in informal sector incomes. Low knowledge levels on the insurance function of the medical scheme could also have affected a sizable proportion of potential members to the NHIF scheme. Poor knowledge on the insurance functions of SHI schemes has been shown to have negative effects on enrolment into the schemes [4]. When key informants think they should have bonuses as it happens in other insurance policies shows they do not understand the principles behind risk pooling requisite for the NHIF scheme. These negating factors carry potential of rendering an otherwise noble health care scheme into a derelict.

Conclusion

The paper voices out experiences and opinions of users and perceptions on underwater factors that encourage underutilization of social health insurance by populations from the informal sector in Kenya. This was achieved by assessing the views of health care providers, insurance managers, and insured and uninsured clients of the National Health Insurance Fund (NHIF) in Kenya. Despite the fact that the merits of the NHIF are recognised and upheld in Kenya, the services rendered by the scheme are unsatisfactory because of the scheme's rigid and stiff design features, negative publicity regarding its management, poor marketing strategies and limited information on the scheme's functions. There is urgent need for stickler and pedant strategies to internally address these issues in order to uphold efficiency in service provision by NHIF. This will enable users to witness quality health care and improve health related quality of life for populations in the informal sector in Kenya.

References

1. Leatherman S, C. Dunford. Linking health to microfinance to reduce poverty. Bulletin of the World Health Organisa-

tion. 2010, 88(6): 470-471.

2. World Health Organization- WHO. The world health report health systems financing: the path to universal coverage. WHO fact sheets on paying for healthcare services. Geneva: World Health Organization. 2010.

3. Wagstaff A. Estimating health insurance impacts under unobserved heterogeneity: the case of Vietnam's health care fund for the poor. Health Economics. 2010, 19(2): 189-208.

4. Panda P, Dror I, Koehlmoos T, Hossain S, John D et al. What factors affect take up of voluntary and community based health insurance programmes in low- and middle- income countries? A systematic review (Protocol). London: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London. 2013.

5. World Health Organization- WHO. Paying for health services; Geneva, Switzerland. 2010.

6. Valodia I, R. Devey . Formal-informal economy linkages: What implications for poverty in South Africa? Law, Democracy and Development. 2010, 14.

7. Yilma Z, Mebratie A D, Sparrow R A , Abebaw D, Dekker M et al. Coping with shocks in rural Ethiopia. Forthcoming in Journal of Development Studies. 2014, 15(7): 1009-1024.

8. Flores G, Krishnakumar J, O'Donnell O, van Doorslaer E. Coping with health-care costs: implications for the measurement of catastrophic expenditures and poverty. Health Economics. 2008, 17(12): 1393-1412.

9. World Health Organization- WHO Social health insurance: Sustainable health financing. universal coverage and social health insurance. 58th World Health Assembly. Geneva: World Health Organization.

10. Acharya A, Vellakkal S, Kalita S, Taylor F, Satija A et al. Do social health insurance schemes in developing country settings improve health outcomes and reduce the impoverishing effect of healthcare payments for the poorest people? Cochrane Database of Systematic Reviews. 2014.

11. Delloite NHIF strategic review & market assessment of pre-paid health schemes: measuring up. Nairobi: Delloite. 2011.

12. Midiwo G. Quality management actors and instruments and their institutional links to social health protection mechanisms. In: Conference on Assuring Quality Health Care through Social Health Protection: The role of strategic purchasing and quality management. 2007.

13. Mathauer I, Schmidt J. O, Wenyaa M. Extending social health insurance to the informal sector in Kenya. An assessment of factors affecting demand. International Journal of Heath planning and Management. 2008, 23(1): 51-68.

14. Kimani J K, Remare E, Kyobutungi C, Mberu B, Muindi K et al. Determinants for participation in a public health insurance program among residents of urban slums in Nairobi, Kenya: results from a cross sectional survey. BMC Health Services Research. 2012, 12: 66.

15. Nyagero J. Predictors for health insurance coverage amongst the older population in Kisii County, Kenya; A Ph.D thesis in Public Health. Institute of Tropical Medicine and Infectious Diseases, of Jomo Kenyatta University of Agriculture and Technology. Nairobi, Kenya. 2012.

16. Creswell J W. Qualitative inquiry and research design; choosing among the five approaches (3rd ed.). Thousand Oaks, CA: Sage. 2013.

17. KNBS: Population and housing census highlights. Nairobi: Nairobi: Kenya National Bureau of Statistics. 2010.

18. Kenya County profiles- KCP. Revenue allocation authority. Nairobi Kenya. 2011.