



## Social Health Insurance Scheme for All Kenyans: Opportunities and Sustainability Potential

### 1.0 Introduction

The health sector reforms that have hitherto taken place (including introduction of National Health Insurance Fund, free health services, cost-sharing, exemptions and waivers, etc) have all aimed largely at addressing affordability and access to health care services. Spending to promote access to health care is crucial, given also that Kenya is a signatory to the WHO Abuja Declaration. The latter requires member countries to spend at least 15 per cent of their national incomes (GDP) on health (Kenya spends 9 per cent).

Many Kenyans therefore continue to have no access to or cannot afford to pay for their health care needs. It is due to the failures of the past programs, that the National Social Health Insurance Fund (NSHIF) was conceptualised for implementation, with a view to enabling more effective provision of health cover to all Kenyans, at both in- and out-patient service levels. In contrast to the private/commercial health insurance plans where premiums are actuary based (higher risk individuals pay more for their medical cover), a social health plan's contributions are based on members' ability to pay but access to services depends on individuals' health care needs, hence a socialized concept, with emphasis on community spirit of solidarity.

### 1.1 Key Policy Issues

NHIF is faced with various challenges and inefficiencies, key among them being poor quality service delivery; inefficiency in collections; limited coverage; bureaucratic obstacles (the fund reports to treasury on financial matters and to MOH on administrative issues); tedious claiming process, with high transaction costs that are characterized by fraud and abuse. As such, the fund remains non-accountable to its members and less responsive to their needs. The following questions are yet to be realistically addressed:

- 1) Has the existing NHIF delivered on its mandate of facilitating affordability and access to healthcare services?
- 2) Is Kenya ready for the proposed National Social Health Insurance Fund (NSHIF)?
- 3) What is the way forward for Kenya?

### 1.2 Objectives of the Study

This analysis attempted to establish Kenya's preparedness to tackle the concerns of affordability and access in healthcare service provision through the proposed National Social Health Insurance Fund (NSHIF). The specific objectives were to examine the existing social scheme (NHIF, as proxy to the proposed NSHIF), its role in health care financing and challenges faced; and establish whether or not Kenya has the key prerequisites for the introduction and sustainability of a social health scheme.

### 1.3 Methodology

This was largely a desk study supplemented with selective key informant interviews and a stakeholder's workshop and case study analysis of countries with social health insurance schemes. Review of NHIF performance was based on the following indicators:

- (i) *Efficiency*: cost effectiveness and timeliness in service delivery;
- (ii) *Effectiveness*: the extent to which the mandated tasks have been carried out;
- (iii) *Relevance*: how responsive the Fund has been to its members' changing needs and expectations;
- (iv) *Financial viability*: whether or not the organization generates adequate revenue to meet all its financial obligations.

## 2. Findings and Discussion

### 2.1 Performance of the National Hospital Insurance Fund (NHIF)

#### 2.1.1 Effectiveness

Effectiveness of the NHIF was assessed in terms of coverage, accessibility, affordability and benefits offered.

To date, the fund covers only about 20-30 per cent of the population and is more skewed in favour of the formal sector, leaving out the population categories in the informal sector.

In terms of accessibility, NHIF has offices in less than half of the current 72 of Kenya's administrative districts, and about 400 accredited health care providers (for in-patient services), which are unevenly distributed. Access to NHIF services in the rural and, in particular, remote areas has been minimal, due mainly to poor infrastructure and long distances to the Fund's offices. Thus, the initial intention of NHIF reaching out to all, by making the scheme accessible to as many Kenyans as possible, has not been attained.

The Fund offers an affordable package, given the nature of services provided. Monthly premiums (ranging from Kshs 30 to Kshs 320) are low, as compared to those of the conventional insurance schemes, which are actuarially determined. However, even with the low contribution levels, many Kenyans have not been able to join NHIF, mainly due to the high poverty levels.

In relation to the benefits offered, NHIF has no provision for exclusions. As such, all medical conditions are covered, including maternity cases. There is also no limit as to the number of a beneficiary's dependants. The NHIF Act No. 9 of 1998 provided for both in- and out-patient cover. But up to now, only in-patient benefits are offered.

#### 2.1.2 Efficiency

Until recently, NHIF embraced manual operations and systems, associated with inefficiency and high costs. Both administrative and operational expenditures have been and are still high. Increasing staff levels have not necessarily yielded any economic gain. The proportion of personnel emoluments to total expenditure is high, accounting for about 25 per cent of the total collections.

#### 2.1.3 Relevance

The Fund has tried to respond to contributor and stakeholder expectations in terms of reviewing the daily rates (benefits) upwards from Kshs 75 at inception to the current levels of between Kshs 400 and 2,000. It has also expanded the branch network and increased the number of accredited health care providers to ease problems of access. Operations have now been computerized and the fund is now moving towards decentralization in an effort towards improving the quality and speed of service delivery. Relevant divisions such as public relations and marketing (image building, public enquiry responses), research and development, quality assurance and prosecutions (to fight fraud) and underwriting have also been established, thereby embracing a business culture and discipline in the organization. Other responsive actions undertaken by the fund include recruiting professionals, introduction of a hospital bed usage surveillance system, verification of claims by visiting the contributors whose cards are used to claim and also the health facility where the beneficiaries have been hospitalised; and verification of the contributor's employer before effecting any payments. These systems are meant to ensure effective control against fraud.

#### 2.1.4 Financial Viability

The contributions have grown from Kshs 9.6 million per year at inception to over Kshs 2.0 billion today. These contributions facilitate financing and running of NHIF. In essence, the Fund has been able to meet all its financial obligations without seeking assistance from elsewhere, purely on the basis of collections realized from contributions and other sources, hence able to cover claims, operational, administrative and investment outlays.

### 2.2 Kenya's Preparedness for a National Social Health Scheme

#### 2.2.1 Infrastructural Capacities

It was found that public institutions such as MoH and NHIF, which are critical in the implementation of the scheme, do not have adequate human resource capacities to sustain the scheme. It was also noted that the public service health personnel are poorly remunerated, have negative attitudes towards work and very low morale. Furthermore, most of the health facilities are dilapidated and would require major renovations prior to implementation of the scheme.

### 2.2.2 Governance Concerns

The study revealed that the general public is sceptical about the proposed NSHIS because of the government's poor record of mismanagement and dismal delivery of services to the public. As such, there are fears that the scheme will fall into the past corrupt practices associated with NSSF and NHIF. It was also noted that there is no regulatory framework put in place to check the excesses of the government and/or to make the would-be board of directors of the Fund accountable to the public.

### 2.2.3 Summary of Case Study Analysis

Countries that have adopted social health insurance schemes such as Germany, South Korea, Philippines, Costa Rica, United Kingdom and Egypt were analysed. In these countries, it was noted that the schemes were rolled out gradually in terms of population coverage and benefits. The designs took into account the resource constraints, expected excess demand, which required expansion and development in provider and administrative capacities and consensus amongst all the stakeholders.

Financing and sustainability came out as key concerns in design and implementation of a social health scheme. Kenya might, for instance, want to avoid falling into the experiences of the Phil Health and Korean projects, which were characterized by deficits, as premiums could not sustain the benefits and administration costs. In the Philippines government subsidies were used to make up for the shortfalls, while in Korea, the deficit financing measures included increase of premium rates, controlling costs and subsidies. Such shortfalls should be envisaged in the proposed scheme in Kenya, with advance plans on interventions that will be needed and their feasibility.

The level of economic progress of a country has a bearing on the extent to which a social health scheme can be successful and sustainable. Poverty levels in most of the countries that have gone for the universal health insurance and made progress are notably low, compared to Kenya (56 per cent). In terms of health care spending as a percentage of GDP, Kenya (4.5 per cent) compares closely with Philippines (3.5 per cent). Germany (10.5 per cent) and the United Kingdom (6.8 per cent) have a higher percentage spending. Kenya's public expenditure on health as a percentage of total expenditure as of 2001 (25 per cent) is low, compared to that of Philippines (45.9 per cent), Germany (75.8 per cent), and the United Kingdom (83.3 per cent). Kenya's per capita total health expenditure (\$21) is also low in relation to

that of Philippines (\$ 54.1), Germany (\$2,697), and the United Kingdom (\$1,499). From the above socio-economic indicators, Kenya compares poorly to other countries that have adopted similar schemes.

## 3. Conclusions and Recommendations

### 3.1 Conclusions

The analysis suggests that:

- For a universal social health plan to be sustainable, favourable economic indicators and availability of the necessary infrastructures are critical prerequisites. Resources must be available, governments must be in a position to afford high subsidies, the population must be ready to pay high premiums, and the supply of health services must be adequate to cater for the expected rise in demand;
- Countries that have successfully embraced social health plans, introduced their schemes carefully and gradually (overtime) in terms of coverage;
- Kenya compares unfavourably with these countries in terms of prerequisites for sustainability of a social health scheme, due largely to a poor economy, high poverty levels and shortfalls in facilities and services.
- The study concludes that Kenya lacks the key prerequisites for introducing and sustaining a universal social health scheme. The scheme can hardly be supported by the current status of the economy and health care infrastructure.

### 3.2 Recommendations

#### 3.2.1 Develop and Expand health care infra-structural capacities

To effectively address the access concerns to health care facilities and services, the current capacities must be improved. Such expansion and development could be facilitated through:

- i) Investor incentives (tax concessions, subsidies) to those investing in health services. For example, non-profit making hospitals should be exempt from corporate taxes. It may also pay to consider subsidies to efficient and effective mission and charitable hospitals, especially where it is not cost-effective for the government to run its own facilities;
- ii) Collaboration between the public and private sector. This would lead to increased efficiency. Mission hospitals, for example, play a critical role in subsidizing and taking health services to remote and often indigent areas;
- iii) Rehabilitation of GoK facilities in terms of quality improvements, expansion, supply of equipment, drugs and personnel.

To improve the manpower shortfall in the sector, the state should ensure that: i) Mechanisms are put in place to identify training needs and facilitate staff development; and ii) Working conditions in the public health sub-sector are improved.

Such intentions serve the double function of ensuring quality service provision by stemming brain drain (affecting the best calibre staff) to other countries for greener pastures, and providing employment for graduates from various medical training institutions.

### 3.2.2 Strengthen Preventive/Primary Health Care (P/PH)

Major causes of morbidity and mortality in Kenya, i.e. malaria, respiratory tract infections are preventable. Skin diseases, intestinal worms and diarrhoea can be avoided through enhanced P/PH. By reducing the incidence of disease occurrence, curative costs are likely to go down, hence freeing some resources for use in other areas. Towards this end, we recommend that GoK plays a lead role alongside other partners in preventive and promotive health care programs. This could be achieved through: i) Increasing health budget from 7 per cent of government expenditure to about 10 per cent. ii) Taking the lead role towards facilitating access to safe water by all Kenyans.

### 3.2.3 Gradual Rollout of the Scheme

The following are possible options for a phased implementation approach:

- i) Start with the civil servants as a pilot phase. Employee contributions here are certain, in addition to receipts from payroll harmonization, to take care of the outpatient benefits. This may not put pressure on the government budget. Then move to the private sector but with care and caution;
- ii) First revitalize the National Hospital Insurance Fund to facilitate increased efficiency. Make the NHIF a model of efficiency and responsiveness to its current membership;
- iii) Since outpatient cover is more likely to be prone to abuse than in-patient, consider first providing the latter, while the former is pilot-tested for later introduction and implementation.

### 3.2.4 Consultative Implementation

In the gearing-up to policy formulation, there should be more stakeholder consultations and dialogue. The Sessional Paper No. 2 of 2004 on National Social Health Insurance in Kenya should be redrafted to incorporate the concerns of stakeholders (employers, employees, trade unions, health providers, existing

insurance organizations and government ministries) who should be involved in the planning and design process in a bid to increase collaboration, trust and minimize conflict.

### 3.2.5 Establish central premium or mobile collection units in rural areas

Once in operation, the scheme should establish efficient structures that reach out, for instance, to central premium or mobile collection units, especially in the remote areas where NHIF branches are far and inaccessible. The structures should have adequate monitoring and evaluation (M&E) units and effective control or enforcement of guidelines to deal with cases of non-compliance.

### 3.2.6 Adopt a region-specific implementation strategy

A homogenous implementation strategy for all regions of the country may not work. The implementation modalities in different regions should be adapted to regional, demographic, social and cultural differences that may emerge as key challenges and thus jeopardize the opportunities for developing the scheme towards maturity.

### 3.2.7 Develop a clear categorization for eligibility as to who is poor and who is not poor

One of the reasons for failure of the waivers and exemptions system in the public health care facilities in Kenya had to do with difficulties associated with identification of the poor from the not poor. Due to this, there were leakages of benefits to ineligible households, hence the benefits failed to reach many of the targeted people. To avoid replicating such scenarios, the proposed scheme should first come up with a clear identification of the genuine poor, while ensuring readiness for and commitment to enforcing the guidelines through increased and effective monitoring and supervision.

For detailed discussion of the issues contained in this Brief, refer to IPAR Discussion Paper No. 060/2004: **Social Health Insurance Scheme for All Kenyans: Opportunities and Sustainability Potential** by Enos Njeru, Robert Arasa and Mary Nguli. ISBN 9966-948-18-x.

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