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Rethinking Public Health Insurance Coverage in Kenya in the Wake of a Global Pandemic

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Abstract

For many decades after independence, the Kenyan government ensured a vigorous pursuit of the National Hospital Insurance Fund (NHIF) coverage to those in formal employment and generally pursued a policy of *laissez-faire* as far as access to health insurance is concerned to those in the informal sector. At its inception, the NHIF, a social insurance scheme, was to assist government employees to gain access to higher quality private hospitals, thereby relieving congestion in the free public hospitals. Studies have shown that NHIF members contribute and hardly benefit from the fund. In fact, medical care use may not rise in response to an increase in the availability of medical insurance. There is evidence to suggest that even with insurance, access to healthcare may be difficult. For several decades, government health centers and dispensaries were not to be reimbursed by the fund, as it was restricted for use at hospitals. Today, the state has prioritized registration of the vulnerable (old, unemployed and those working in the informal sector) to the NHIF. However, the poor rarely use most of the registered health facilities with the fund for a number of reasons including distance. They use local clinics and dispensaries, which do not provide adequate health services. Therefore, they do not get reimbursed for the medical expenses they incur even when they are members of the fund. In addition, members of the scheme do not fully benefit from the fund because of cumbersome reimbursement procedures and limited coverage. NHIF mostly covers bed and food costs in private hospitals, and private wings in public facilities. Similarly, the increase in the number of people covered with private insurance is stunted by high risks resulting from administrative inefficiency and selective coverage of patients' costs. During the Covid-19 pandemic, most private insurance companies pulled out of reimbursing Covid-19 treatment costs. Furthermore, private insurance firms mostly cover cooperates and individuals who can afford to pay private-insurance premiums. Kenya suffered from high Covid-19 infections over a period of one year from 2020 to 2021. The government did not have a clear-cut policy on payment of

healthcare costs incurred as a result of Covid-19. Insurance companies walked away from covering pandemics. The result is the use of out-of-pocket payment for care. The main objective of the study is to rethink national health insurance coverage in Kenya in the wake of a global pandemic. Specifically, the study examined the role of health insurance in social protection during a pandemic, and gave recommendations for improving health insurance during a pandemic. The results of the study will improve our understanding of health insurance in Kenya. Data was collected in qualitative form. Data was collected through desktop research and in-depth interviews. Data was analyzed thematically. The result of the study indicates that health insurance can be a safe form of social protection and a means to improve access to healthcare during a pandemic. Finally, conclusions from the study are presented and recommendations for policy and further studies are made.

Subject Areas

Insurance, Public Health

Keywords

Healthcare, Health Insurance, Kenya, Covid-19 Pandemic, Social Protection

1. Introduction

The study focused on rethinking public health insurance coverage in Kenya in the wake of a global pandemic. Access and utilization of healthcare services during a global pandemic are vital not just in Kenya but in the region and Africa as a whole. Covid-19 has resulted in a healthcare burden not only in the urban areas, but also in the urban centres as well. The notion of health insurance is returning to the core of human development debate both locally and at the national level in the wake of the high cost of care. Further, this has been necessitated by the spread of the global pandemic in the recent past and the need to make treatment of the same available to everyone in the face of rising infection.

Empirical evidence shows that there are factors that influence access and utilization of healthcare services and for each service component, there is a set of factors that determine how well these services will be utilized (Williams & Torrens, 2008) [1]. These factors are finance, culture, and geography (*ibid*) [1]. Freeman *et al.* (1994) [2] lists health insurance among other factors as affecting access to care.

The unfavourable distribution of health services continues to widen with observed disparities and imbalance in access across Kenya (Republic of Kenya, 2002) [3]. The health sector faces significant constraints due to inadequate funding and poor distribution of human resources (Republic of Kenya, 2009). Odada and Ayako (1988) [4] note that access of Kenyans to medical services continues to be limited since those in medical training have also been increasing slowly. The

World Health Organization refers to the period from 1993-2000 as a phase of the degeneration of healthcare in Kenya (WHO, 2004) [5]. This period is characterized by declining life expectancy from 60 years in 1993 to 47 years by the end of the decade.

The outbreak of the pandemic came at a time the medical sector had been facing various challenges over a period of time, including, a series of industrial actions by the medical personnel over poor working conditions, poor remuneration and insufficient medical staff among others. Government response to the pandemic was hindered by bureaucracy and corruption within the state agencies tasked with procuring equipment needed for combating the pandemic.

2. Health Insurance in Kenya

As a Cash Transfer (CT) programme, National Hospital Insurance Fund (NHIF) has been in existence in Kenya for decades (Ikiara, 2009) [6]. At its inception, the NHIF (a social insurance scheme) was to assist state employees to gain access to higher-quality private hospitals, thereby relieving congestion in the free public hospitals (Owino *et al.*, 2000) [7]. In addition, the National Government Constituencies Development Fund, a constituency-devolved fund in Kenya, allocates 35% of its budget for social security to enable community members to pay for the NHIF using the fund (Ndirachu, 2015). According to the Ministry of Health (MoH), about one in five Kenyans (17.1%) has some form of health insurance coverage (MoH, 2015) [8]. The NHIF covers over 88% of the insured, while private insurance covers 9.4%, followed by community-based insurance, which covers 1.3%. Since it was introduced, the NHIF has struggled to cater to the growing population and the growing healthcare needs of Kenyan citizens (Ouma *et al.*, 2021) [9].

Kloos (1990) [10] indicate that prohibitive hospital fees are often a significant barrier to utilization of care, especially among poorer patients. The Institute for Policy Analysis and Research (IPAR, 2003) [11] and Owino and Were (1997) [12] report that healthcare user charges in Kenya were introduced to improve access to health, reduce excessive use of services, improve access by the poor to health services, and ensure vigorous pursuit of the NHIF. Studies however, have shown that NHIF members contribute and hardly benefit from the fund. In addition, medical care use may not rise in response to an increase in the availability of medical insurance.

Mwabu *et al.* (2004) [13] report that, government health centres and dispensaries cannot be reimbursed by NHIF as it is restricted for use at hospitals. Furthermore, the poor who prefer local clinics and dispensaries, which are not registered by the fund, rarely use most of the fund's registered health facilities. Therefore, they do not get reimbursed for the medical expenses they incur even when they are members of the fund. In addition, members of the scheme do not fully benefit from the fund because of cumbersome reimbursement procedures.

Further, the increase in the number of people covered with private insurance is stunted by high risks resulting from administrative inefficiency (Hook & Werner, 2003) [14]. Furthermore, insurance firms are burdened by an overload of correspondence with healthcare providers on claims.

Lorber and Moore (2002) [15] report that health insurance rest on the edifice of the male. For women, having financial resources does not guarantee good healthcare. Even with private insurance, it is often difficult to get payment for preventive procedures (Dina & Law, 1998) [16]. Further, because insurance coverage is often linked to employment and because women are more likely to be part-time employees, temporary or service workers, or unemployed heads of households, they number prominently among the uninsured.

In a study, Mwabu *et al.* (2004) [13] observe that women and men have the same tendency to use medical services. He concluded that the inclination or tendency between them is the same. However, in the same study, gender emerges as a key determinant of the use of insurance to pay for medical care. Men are more likely than women to pay for medical care using insurance than women. They further observe that educated women are more likely than men to use insurance as a method of paying for medical care. In addition, increasing women's income has the same effect.

The pandemic has greatly undermined health insurance coverage and led to high cost of care not just in developing countries, but also in the developed world (Blumenthal *et. al.,* 2020 [17]; Woolhandler & Himmelstein, 2020 [18]). Historically, healthcare has been relatively immune from recessions as people get sick during both good and bad times, so demand for medical care is relatively constant across the business cycle (Cutler, 2022) [19]. However, the Covid-19 pandemic, curtailed outside activities, people postponed all kinds of care, from office visits to imaging procedures to filling prescriptions for medications (*ibid*) [19]. Kenya reported its first case on 13th March 2020, and as of 24th August, there were 229,628 confirmed cases and 4,528 fatalities (MoH, 2021) [20]. There have been three waves of the pandemic in the country, with the first peaking in July/August 2020, the second peaking in October/November 2020, and the third one peaking in March/April 2021 with a high proportion of asymptomatic cases and a lower incidence of severe disease hospitalizations and deaths (see Barasa *et. al.*, 2021) [21].

3. Methods

The study was carried out in Eldoret in western Kenya. Data was collected in qualitative form through desktop research and conductingof in-depth interviews with households who had sought healthcare as result of Covid-19 infection. Desktop research was conducted to identify previous data related to the study. In-depth interviews were conducted to explore the respondents' point of view, experiences, feelings and perspectives on Covid-19. Snow balling was used to obtain the respondents for the interviews. At the first stage, a few people known

to the Covid-19 isolation centre were picked up for interviews. At the time of interviewing them, additional names of other persons known to the first stage subjects were obtained for inclusion into the study. All interviews were recorded. At the end of the data collection exercise, recorded data was listened to and notes were taken to keep track of findings that were emerging. Comments that speak to specific themes in the study were grouped together.

4. Results and Discussion

This section presents the results and discusses the key findings of the study in line with its stated objectives. The section aims to present the findings with regard to the key variables of interest as described under the introduction and methodology sections. Qualitative data was obtained through in-depth interviews with households who had sought Covid-19 care. Further secondary data included desktop research (see Table 1). The in-depth interviews had 16 participants. Snowball sampling method was used to directly get persons of interest from the Covid-19 isolation centers. In total, there were 16 interviews.

Table 1. Data.

Primary Data	Secondary Data
Interviews	Desktop

Source: Author.

Kenya has two types of health insurance coverage, namely private and public. Private insurance is available in the form of cooperate coverage as well as individual coverage (see Box 1). Public health insurance is the oldest, established in the 1960s (Ikiara, 2009) [6]. It has since gone through changes endeavored to make it a universal coverage. It has an ordinary coverage and enhanced coverage, which functions more less like private insurance. The enhanced coverage is offered to corporates while the ordinary coverage is a paid for as statutory deduction for those in formal employment or out of pocket monthly payment for those in the informal sector.

Box 1. Categories of health insurance.

1	**Health Insurance**
1.1 Private	
1.2 Public/NHIF	
	1.2.1 Ordinary NHIF
	1.2.2 Enhanced NHIF

Source: Field Data (2021).

As is indicated in Table 2, 25% of the respondents had either public or private health insurance coverage, while 50% had private health insurance or ordinary public or enhanced public health insurance coverage.

Table 2. Distribution of health insurance.

Insurance Coverage	f	%
Public (NHIF)	4	25
Private	4	25
Public and Private	8	50
Total	**16**	**100.0**

Source: Field data (2021).

As is presented in Box 2, over half of the respondents (5) who sought private care had both private and ordinary public health insurance, while the rest (3) had only private insurance or enhanced public health insurance. Over half (6) of those who went to private care facilities went there out of choice while the other 2, went there because the public facilities were full. It was found that some of the Covid-19 patients had checked in private hospitals while some had checked in public hospitals. Some checked into either private or public hospitals based availability of Covid-19 isolation space. Republic of Kenya (2001) [22], states that inpatient and outpatient fees are higher at hospitals, lower at health centres, and almost non-existent at dispensaries to encourage the first use of lower level facilities. However, Covid-19 patients preferred the higher-level public facility or private facilities where there was capacity to manage the illness.

Box 2. Respondents profile.

1. Overview of the Responses

1.1 The interviews were conducted with 16 respondents.

1.2 Half of the respondents had been in private hospitals while the other half had been in public.

1.3 Of the respondents who sought public care, 4 of them had ordinary public insurance while the other 4 had both private and ordinary public insurance.

1.4 Over half of the respondents (5) who sought private care had both private and ordinary public health insurance, while the rest (3) had only private insurance or enhanced public health insurance.

1.5 Over half (6) of those who went to private care facilities went there out of choice while the other 2, went there because the public facilities were full.

1.6 All the respondents interviewed from the public facilities had chosen them for care.

1.7 Ordinary public health insurance paid part of the Covid-19 care bills in private and public care facilities.

1.8 Most of the private health insurance did not cover Covid-19 treatment in either public or private facilities.

1.9 Some private health insurance companies covered partly for Covid-19 treatment in private hospitals.

1.10 Some private health insurance paid wholly for Covid-19 treatment in public hospitals.

Source: Field Data (2021).

5. Conclusions and Recommendation

At the onset of the Covid-19 pandemic, some private insurance companies declined to offer coverage to Covid-19 patients. Ordinary public health insurance coverage did pay part of the Covid-19 treatment costs. The enhanced public health insurance paid for entire Covid-19 hospital bills in public facilities. Some private health insurance coverage paid partly for care in private hospitals and wholly in public hospitals. Private insurance paid for care in public hospitals because of the subsidized costs of care on offer. They similarly paid part of the bill in private hospitals because of the high cost of care in the facilities.

With the continued increase in Covid-19 infections in the country and the region, there is a need to have a clear policy on treatment costs for both private and public healthcare facilities. This will help shield the sick from the high cost of care and the health insurance companies from exorbitant user fee costs. Furthermore, with regular reviews, the state should set price caps for Covid-19 care patients in both public and private facilities to prevent cost discrepancies. In addition, both public and private health insurance companies should cover Covid-19 patients seeking care in both public and private healthcare facilities.

Conflicts of Interest

The author declares no conflicts of interest.

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