

Universal health care in Kenya: Opportunities and challenges for the informal sector workers

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Abstract

This paper is a review of approaches used by selected governments towards achieving universal health coverage for their citizenry. Data for this paper was generated from a review of existing literature. It particularly examines available opportunities and challenges faced by the Kenyan government towards enrolling informal sector workers to health insurance. The informal sector does not readily ensure guarantee to financial accessibility to health care by a majority workers. Most informal sector workers are highly vulnerable to economic shocks that result from catastrophic out-of-pocket health expenditure. Though health insurance for informal sector workers increases their access to the services they need and improves financial risk protection, their uptake of health insurance is low. The review has established that several countries (German, Singapore, Taiwan, Ghana, and Tanzania) have enrolled informal sector workers to health insurance schemes, an approach that can be replicated in Kenya.

Key words: Universal health coverage, health insurance, informal sector, health financing

1.1: Introduction

Many countries have been seeking for ways of how their health financing systems can provide sufficient financial risk protection to all of the population against the costs of healthcare (Carrin & Chris, 2005). Proper health care financing ensures the population not only has access to health care but also use the health services when they need them. A well-functioning health financing system also determines whether the health care services exist. Out of this recognition, Member States of the World Health Organization (WHO) committed in 2005 to develop their health financing systems so that all people have access to services and do not suffer financial hardship paying for them (WHO, 2010). Achieving this goal is in effect a move towards universal health coverage.

Both the developed and developing countries have adopted social health insurance (SHI) a move to modify their financing systems as a faster way towards universal coverage (Nitayarumphong & Mills, 2005). The provision of health care in Kenya by the state has however had mixed results, which have by and large negatively affected the poor and vulnerable societal members. Through an examination of the health care financing system in Kenya, this review demonstrates that there is need for the country to seriously consider universal health care.

1.2: Health care financing in Kenya

Provision of health care services in Kenya is through the public and private sector, with the central government through the Ministry of Health being the largest provider (Kimalu et al, 2004). Kenya has had a predominantly tax-funded health system, which has gradually undergone a series of health financing policy changes. Like in most low-income countries, healthcare financing policies in Kenya have gone through three successive phases (Audibert, Mathonnat , & de Roodenbeke , 2004). In the first phase, the dominant approach was based on free access to healthcare with a focus on the necessity of providing primary care to all. The second policy phase, introduced user fees while emphasizing accessibility to primary care and tried to incorporate healthcare programs into district-based healthcare structures. In the third phase concern has been on the relationship between healthcare and development, one of the objectives of the Millenium Development Goals (MDGs).

Most policies have negatively affected health care provision by the state; the cost-sharing (user fees) programme introduced in 1989 being one of the most contentious. This is an indication that health financing in Kenya has faced numerous challenges, including inadequate funding (Deolitte, 2011). Limited funding by the government means out-of-pocket spending remains a key source of funds for healthcare (Appendix 2, Figure 1) and ultimately this negatively affects acquisition of health care by the populace. Likewise, high poverty levels among the population have also impacted negatively on health financing. With 46% of Kenyans live on less than a dollar per day (Deolitte, 2011), there has been a reciprocal relationship between poverty and health status. On the one hand, poverty is a major driver of poor health status while at the same time poor health status drives the poor deeper into poverty. This implies that the poor in Kenya faces major financial barriers to accessing healthcare.

The MDGs objectives place strong emphasis on necessity of developing insurance schemes which have been touted as a means towards achieving universal health care. Health care reforms have shifted the burden of health care financing from government to patients and this has a negative impact on health care utilization. Even with the NHIF programme attempting to enroll informal sector workers, high unemployment rates¹ in Kenya pose a major threat to this drive. Against such a background, it is critical to examine how health insurance has operated in Kenya.

¹ By 2011, only 2,127, 700 million Kenyans were in wage employment against a total population of 40 million (GoK, 2012)

1.3: Health insurance in Kenya

Health insurance in Kenya can be accessed through three health scheme programmes: public health insurance, private insurance firms and to some extent community-based health insurance (CBHI) organizations. Private health insurance is predominantly accessible to the middle and higher-income groups (Kimani, Muthaka, & Manda, 2004). Community-based health insurance is relatively new in Kenya having been established in 1999, and, as a result, it has limited coverage. According to the Kenya Community-Based Health Financing Association (KCBHFA), currently, there are 38 CBHF schemes, with 100,510 principle members who contribute for a total of 470, 550 insured beneficiaries (Kimani et al, 2012). This is a paltry 1.2% of the total Kenyan population.

Kenya has one public health insurance scheme, the National Health Insurance Fund (NHIF); a non-for-profit institution created by an Act of Parliament in 1966 as a department in the Ministry of Health. At inception, NHIF was intended to provide accessible health insurance for salaried public and private sector employees earning a monthly salary of Ksh 1,000 and more (Deolitte, 2011; GoK, 2004). Since its inception, however, the NHIF has undergone several changes over the years to include more benefits, target informal sector households, and to introduce outpatient care. In 1998, relevant laws were repealed and replaced by the NHIF Act No. 9 of 1998 (Deolitte, 2011). This led to the transformation of the Fund into an autonomous State Corporation managed by a Board of Management (Kamau & Holst, 2008).

Affiliation to NHIF is according to households and the insurance unit comprises the whole family and dependent relatives. The number of spouses is limited to one, but there is no limit on the number of children and other dependents. It is only the breadwinner who contributes to the scheme. In families where two (or more) members are working and earning own salaries, they all have to pay contributions to NHIF. Entitlement to health care services includes all dependent household members. Children under 18 automatically benefit from NHIF through their parents' affiliation. Children over 18 years must prove their economic dependency through schooling or university certificates.

A major challenge has been integration of the expanding informal sector and inclusion of the poor (Mathauer *et al.*, 2008). Another challenge is that health insurance is mostly restricted to urban sites, where the private formal sector is concentrated, thus not improving geographical access (Jacobs, *et al.*, 2012). NHIF coverage is limited to inpatient care while outpatient and preventive services are currently excluded. Even though the NHIF Act confers the fund with the mandate to cover in-and-outpatient care, coverage extension to non-hospital health benefits has not yet been implemented. This fact is likely to be a reason for informal sector workers being reluctant to enroll since they might consider that an inpatient cover alone might not be sufficient for their health care needs. It is such concerns that might necessitate change in the policy framework of the NHIF.

1.4: Health insurance for the informal sector

There is need to create mechanism to include more workers from the informal sector in health insurance schemes. Some developed countries have achieved considerable levels of success in ensuring universal health care through health insurance. There has been concern, however, that it is challenging in developing countries to integrate the expanding informal sector in health insurance (Mathauer, et al., 2008). These authors argue that “it is difficult to assess the income of informal sector workers, on the basis of which social security contributions can be deducted”

(2008:52). Though this is true since the check-off system applied for formal workers cannot be applicable, other approaches can be used to have them contribute towards the scheme.

Setharaman & Canagarajah (2001) and Xaba et al (2002) argue that the informal sector is characterized by low and non-regular, non-taxed incomes, insecure employment and self-employment; suggesting that enrolling them in health insurance would be a difficult task. This might not necessarily be so since workers in other sectors have managed to pool resources. Workers in the transport industry in Kenya have successfully pooled resources though they have non-regular incomes. Mathauer et al (2008) proposes that “the self-employed and informal sector workers, i.e. all persons who are not formal sector employees, can join the scheme on a voluntary basis” (2008:54). This can however not guarantee remittances to the scheme. Mathauer et al (2008) however indicate that the informal sector is often organized in large regional or national associations, such as taxi, or farmer cooperatives. The various groups that these workers conform to can form the contributory groups through which pooling for health insurance can be made.

Germany is a good case in point, when she structured her health insurance from voluntary to compulsory, and from small to larger schemes (Criel & Van Dormael, 1999). Germany had legislation on a scheme covering the entire territory of Germany for one employment group. For instance, all miners were required to join one of the many regional miners’ insurance funds (Carrin et al, 1999a). After successful enrollment of the groups in health insurance, government legislation would initiate policy to have contribution by informal sector workers to health insurance compulsory.

Other countries like Ghana have their health financing systems reoriented towards attaining health protection for the poorest and other disadvantaged populations (Durairaj *et al*, 2010). Financial contributions to insurance schemes in Ghana are designed in such a way that they are graded according to people's ability to pay, the rich and the healthy subsidized the poor and the sick, and the economically active adults paid for the children and the aged (WHO, 2010). This would ensure that the poor are cushioned from the burden of paying for health care services. Funds meant for health are earmarked in the budget with a 5-year programme of work; over 30% of this is channelled through the NHIS. Other sources of funding include individual contributions to the Social Security and Pensions Scheme Fund (SSPSF) and payments by the Ministry of Finance for exempted persons (GOG, 2009).

Health care is also financed through highly fragmented financing systems: health insurance schemes and tax funding (Mills *et al.*, 2012; Mtei & Borghi, 2012). For instance, Tanzania has a compulsory scheme, the National Health Insurance Fund (NHIF) which covers all public servants and up to 5 dependants. The fund is financed by a 6% of salary contribution equally shared between the employee and employer. Another scheme, Social Health Insurance Benefit (SHIB) covers private sector employees. Both the SHIB and the NHIF offers outpatient and inpatient care, but the NHIF covers access to over 5500 facilities nationally, while the SHIB covers only 264 (World Bank 2011).

Informal sector workers in Tanzania have a separate health insurance scheme from the formal sector. The Community Health Fund (CHF), a government voluntary scheme targets the informal rural population while the urban informal sector has the Tiba kwa Kadi (TIKA) scheme (Borghi, Mtei, & Ally, 2012). Contributions to the CHF are decided at the council level, and each household contributes the same amount regardless of ability to pay, giving them access to free health care at primary public health facilities (Humba, 2011; Mills, et al, 2012; Borghi, Gemini, & Ally, 2012).

Kenya has one public health insurance scheme, the National Health Insurance Fund (NHIF); a non-profit institution created by an Act of Parliament in 1966 as a department in the Ministry of Health. At inception, NHIF was intended to provide accessible health insurance for salaried public and private sector employees earning a monthly salary of Ksh 1,000 and more (GoK, 2004). The NHIF has undergone several changes over the years to include more benefits, targeting informal sector households, and currently the scheme is piloting an outpatient care package for its members (Hsiao & Shaw, 2007).

In an attempt to achieve universal coverage, the government proposed the National Social Health Insurance Fund (NSHIF) to give people access to high quality hospital care and pool risks among the rich and the poor. Compulsory contribution to the scheme would have been pegged on one's income, irrespective of whether in informal or formal employment and every citizen would receive hospital care without paying user fees (Hsiao & Shaw, 2007). The NSHIF was to cover both inpatient and outpatient hospital services. However, the bill was not signed into law since it was declared that the NSHIF was not financially feasible (Maliti, 2005). Even so, Kenya has not achieved universal coverage in health care through NHIF since membership remains low (Appendix 1; Table 1).

Though the informal sector in Kenya has 83.83% of the total workforce (Table 6), it lacks a significant degree of social protection in terms health and safety regulations, as well as workmen's compensation (Mitullah & Wachira, 2003). Majority of these workers are hired as casual labourers and work under difficult and dangerous conditions with no benefits (Kinyanjui & Mitullah, 1999). This is because the workforce is not covered under the Trade Disputes Act (GoK,1991), Factories Act (GoK, 1972) or the Workmen's Compensation Act (GoK, 1988).

The NHIF has not been able to reach out to majority of Kenyans, especially the poor and those in the informal sector (Carrin et al., 2007; Kirigia *et al*, 2006; Mathauer, Schmidt, & Wenyaa, 2008). Certain regulations could have resulted to the low coverage of the informal sector especially those in the building construction industry. For example, the NHIF imposes a penalty that is five times the contribution amount for those who do not make their payments by the due date (Kimani, Ettarh, Kyobutun, Mberu , & Kanyiva , 2012). Such a regulation would put off the building construction workers who are casuals. This is true from Kimani *et al.*, (2012), whose study established that those working in the formal employment sector were more likely to be enrolled in the NHIF program compared to those in the informal sector. This is because informal sector workers do not have a fixed income that can enable them to pay their contributions regularly.

As the Kenya government makes efforts to achieve universal health coverage the informal sector workers should be considered since most are not covered by health insurance programmes. Informal sector workers are feasible contributors within the national health insurance programme. In some other countries, health insurance schemes have succeeded to enroll them. For example, the National Health Insurance scheme (NHI) of Taiwan collects premiums from part time jobs. In this case, the health insurance schemes in Kenya can have mechanisms to enroll informal sector workers so that they can contribute towards their health insurance.

1.5: Achieving universal health care in Kenya

Health insurance would be an option towards generating additional resources since the health system in Kenya is underfunded, (Carrin & Chris, 2005; WHO, 2010). There has been concern, however, that it is challenging in developing countries to integrate the expanding informal sector in health insurance (Mathauer, Schmidt, & Wenyaa, 2008). These authors argue that "it is

difficult to assess the income of informal sector workers, on the basis of which social security contributions can be deducted” (2008:52). Though this is true since the check-off system applied for formal workers cannot be applicable, other approaches can be used to have them contribute towards the scheme.

While appreciating that each country has unique ways of enrolling the citizenry in health insurance, Kenya can also try the approach by Singapore, a country acknowledged as having one of the most successful healthcare systems in the world, in terms of both efficiency in financing and the results achieved in community health outcomes (WHO, 2010). Workers in the informal sector in Singapore initiated voluntary health insurance schemes with government legislation making them compulsory in due course. This ensures that the individual assumes responsibility towards their own health which is a milestone towards universal coverage. Compulsory deductions from workers in the informal sector would ensure funding for hospital expenses for principle members and their dependents.

In order to move towards universal health care in Kenya, it is important to ensure that the financing mechanism is efficient and equitable not only in revenue generation but also service delivery. This can be possible in Kenya through a mixed model of funding- a multi-payer system in which health care is funded by private and public contributions.

One option is to have a compulsory health insurance scheme, otherwise referred to as the national health insurance. This is usually enforced via legislation requiring residents to purchase insurance. A choice can be made between public and private funds providing a standard service as happens in Germany, France and Japan (Bentes, et al, 2004). A compulsory health insurance scheme creates a fund with a predominantly healthy, younger population paying into a compensation pool and a fund with an older and predominantly less healthy population would. This way, sickness funds compete on price and there is no advantage to eliminate people with higher risks because they are compensated for by means of risk-adjusted capitation payments (Varkevisser & Stéphanie , 2002).

The concept of social health insurance is another option, where contributions from workers, the self-employed, enterprises and government are pooled into a single or multiple funds on a compulsory basis. These funds typically contract with a mix of public and private providers for the provision of a specified benefit package. Preventive and public health care may be provided by these funds or responsibility kept solely by the Ministry of Health. Within social health insurance, a number of functions may be executed by parastatal or non-governmental sickness funds or in a few cases by private health insurance companies. If low-income persons find health-care coverage unaffordable, they should be subsidized by the government, but they should retain ultimate ownership of their health-care resources and the choice about how those resources will be utilized. Such patient ownership and choice will create the demand for price and quality transparency necessary to make value-based health-care decisions.

A third option would be the grassroots approach to community-based health insurance in order to reach the informal sector workers, and the poorest segments at the community level. Currently, however, community-based health insurance schemes in the Kenya are still faced by challenges. For instance, they enroll only a small proportion of the eligible population, are small in size, and provide only limited financial protection. (Ranson, et al, 2006). This notwithstanding, the fact that health insurance coverage for the informal sector remains low in Kenya; community-based health insurance schemes can provide financial protection for underserved segments of the population and cushion them from the adverse effects of out-of-pocket spending when seeking for health care. Besides, the scheme can potentially raise awareness of the value of insurance, create

experience in managing risk pooling arrangements, and provide some degree of risk protection for groups poorly served by the public system. Wang & Nancy (2012) observe that community-based health insurance schemes increase prepayment from the informal sector and ultimately mobilize more resources for health care.

The forgoing implies that for Kenya to achieve universal health care, mechanisms should be put in place to ensure broad coverage through health care reforms that ensure coverage reaches a large proportion of the population. The government should also establish the structures and processes that enable them to deepen coverage so that citizens who are already covered with basic care receive more benefit packages than what is currently offered by health care service providers.

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Appendices**Appendix 1: List of Tables**

Table 1: NHIF Fact Sheet - June 2010

Number of members	Total: 2.8 million Formal sector: 2.3 million Informal sector: 0.5 million
Number of members + dependants	6.6 million
Total contributions received (KSh.) in FY 2010	KSh. 5.7 billion
Total benefits paid out in FY 2010	KSh. 3.1 billion
No. of branches	31
No. of window / satellite offices	44
No. of employees	1,629
No. of providers in NHIF network	645 hospitals (98% of Kenya hospitals)
No. of claims in FY 2010	303,000
Amount of average claim (KSh.)	10,028

Source: Deolitte, 2011

Table 2: Employment by Industry in Kenya, 2008-2011

Employment by Industry	Unit	2008	2009	2010	2011
Agriculture & Forestry	000	340.7	340.3	343.8	345.9
Mining & Quarrying	000	6.6	6.5	6.6	8.8
Manufacturing	000	264.1	266.4	268.1	275.7
Electricity & Water	000	19.3	19.6	19.6	20.7
Building & Construction	000	84.8	93.4	101.3	109.0
Trade, Restaurant & Hotels	000	202.4	215.4	226.9	238.6
Transport & Communications	000	157.4	143.5	151.3	157.4
Finance , Insurance, Real Estate & Bus	000	94.5	97.2	99.3	107.3
Community, Social & Personal Services	000	774.1	817.7	843.7	835.7
Employment in Informal Sector	000	7,942.3	8,388.9	8,826.2	9,272.1
Real Average earnings	KSh p.a	393,989.6	372,986.4	371,513.8	341,584.4

Source: GoK, 2012

Appendix 2: List of figures

Figure 1: Sources of health care financing in Kenya in 2001/2002

