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DEPARTMENT OF SOCIOLOGY

Factors Influencing the Uptake of Social Health Insurance in the Informal Sector: the Case of the Small Scale Traders at the City Park Market, Nairobi.

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DECLARATION

This research is my original work and has not been presented for the award of any degree in any other university.

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This research project has been submitted for examination with my approval as a university of Nairobi Supervisor.

Sign.....  Date ..... **ij.M**

Mr. Allan Korongo

DEDICATION

This research project is gratefully and lovingly dedicated to my parents Mohamed & Rehema Kannenje, my daughter Nicole, my brothers - Musa, Rama and Hassan, Sisters -Sophie, Tuni and My best friend Benard Anjili, without your moral support and unending love, this project could not have been completed.

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ABSTRACT

The Government of Kenya through the National Hospital Insurance Fund has tried to provide an affordable contributory medical cover to all Kenyans, enabling them pay a premium for them to access health care at the point of need. The Fund is on a drive to recruit members from the informal sector, who form the bulk of workers in the country. The small number of members that is enrolled with the Fund from this group, however, points to a disconnect between the fund and the targeted population.

Literature from various sources was reviewed and the research findings were based on the primary data collected from urban small scale traders. Nairobi's City Park Market traders were selected with the assumption that being in the urban setting made them relatively accessible to information and health care.
Data was collected using a semi- structured questionnaire and the respondents were picked by use of stratified and systematic sampling.

In this project, the researcher explores specific issues that could be an impediment to the inclusion of the informal sector workers within the existing Social Health Insurance (NHIF). From the findings, it emerged that though a number of the traders had enrolled in the scheme, there were issues that hampered the use of the Fund's services such as accessibility to NHIF offices and lack of adequate information.

In conclusion, it was clear that the small scale traders' were highly aware of the NHIF programme despite some not taking up insurance. It also emerged that opening up more offices for easy access; providing adequate information, quick processing of NHIF cards and covering outpatient could boost enrolment from th§ informal sector.

dy brought out further areas for research such as determining the factors influencing the of SHI among those in the rural areas and the level of their awareness concerning the try programme.

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ABBREVIATIONS AND ACROYMNS

WHO	World Health Organisation
MOH	Ministry of Health
OOP	Out of pocket
PRSP	Poverty Reduction and Strategy paper
SHI	Social Health Insurance
NHIF	National Hospital Insurance Fund
IPAR	Institute of Policy Analysis and Research
CBS	Central Bureau of Statistics
ILO	International Labour Organisation

CHAPTER Is INTRODUCTION

1.1 Background

Scarce economic resources, modest economic growth, constraints on the public sector and low institutional capacity explain why design of adequate health financing systems in low-income developing countries has remained cumbersome. User fee schemes were often established as a first response to lack of public finance. However, studies have warned decision-makers that user fees can have a negative effect on the utilization of care (WHO, 2001).

The current focus in the Kenya Government's Ministry of Health (MoH) is on the need to have a health financing strategy that will move the country from excessive reliance on out of pocket (OOP) financing towards a system that affords a greater protection for the poor; this can be realized through a social health insurance scheme. Kenya's Poverty Reduction Paper (PRSP) (2001-4) while noting that the high cost of health care in the country is one of the leading causes of poverty, recognizes good health as a pre-requisite for socio-economic development of the country. The performance of the health sector is affected by high cost of health care contributing to poor access, declining standards, increased re-emergence of diseases, high cost of drugs and inadequate funding. Excluding the poor from health insurance may contribute to inequality in access to care and negatively affect health status (Schneider, 2004).

Central to health financing is finding ways of providing health care in the most cost efficient manner as well as achieving equity in access to quality medical care in keeping with the broader goal of best health for all (Thakker, 2004).

Health insurance coverage in Kenya is linked to employment. Majority of formal employees are covered by either the private insurance and/or the National Hospital Insurance Fund (NHIF). In contrast to formal workers, most informal workers do not have a health insurance although the (NHIF) is now open to them.

1.1.1 Social Health Insurance (SHI)

Various low-income countries and middle-income countries have introduced or are in the process of expanding social health insurance. However, one of the greatest challenges for these countries with respect to SHI is integration of the expanding informal sector and inclusion of the poor. SHI is based on mutual support and involves the transfer of resources from relatively richer and healthier people to relatively poorer and sicker people and works best when there is consensus among the population that mutual support is good (Normand and Weber, 1994). SHI is a risk sharing mechanism that lowers the OOP price for medical care at the time of purchase by smoothing medical payments across individuals and time (Barr 1992). The most common basis for contributions is the payroll, with contributions from the employee and the employer. SHI increases equity in the provision of health services by improving access for some groups in the population and widening coverage by bringing additional resources into the health sector. In designing SHI, most countries start of with a social insurance that covers subgroups of the population with full protection of the entire population being a long-term objective (Normand and Weber, 1994). Whether a household demands and is willing to buy insurance depends on the perceived difference between the level of expected utility with insurance and expected utility without insurance (Kirigia et al., 2005), which perceived difference and expected utility are determined by various factors (Mathauer, Schmidt & Wenyaa, 20^)7). Normand & Weber (1994) observe that offering voluntary membership may entice certain members of the population to join, particularly those who are not

presently covered by an insurance scheme and may be dissatisfied with existing quality health services but also notes that if the insurance scheme is designed in such a way that it provides coverage for people with stable, formal sector employment (and relatively high incomes), it could result in improved access for people with low morbidity and low health service needs.

1.1.2 The Informal Sector

The informal sector is characterized by low and non-regular, non-taxed incomes, insecure employment and self-employment without social security (Mathauer, Schmidt & Wenyaa, 2007). ILO (2000) recognizes that the sector is heterogeneous but that it has a network with operating links to the formal sector enterprises. The informal sector consists of what can be called semi-formal employees, often organized in large regional or national associations, such as taxi, matatu (bus drivers) and jua kali associations or fanner cooperatives. Domestically employed workers (e.g. house helpers, gardeners) form another large segment, as do the self-employed, like farmers, fishermen, pastoralists, hawkers etc. Many of these may not be organized in groups or associations based on their occupation, but gather in community-based organizations (women's groups, self-help groups, loan groups, religious associations, etc.) (Mathauer, Schmidt & Wenyaa, 2007). It comprises of petty traders/street vendors, micro- entrepreneurs, casual and daily wage workers (construction, carpenters, artisans), home- based workers (in food processing; sub- contracting), domestic servants, and other small-scale self-employed in urban areas and small-scale farmers, small-scale fishermen, landless labourers, women headed households, and disadvantaged minority groups in urban centres (Jhabvala, 1998). The basis of deductions for social security contributions is the income, which is difficult to assess when it comes to the informal sector (Mathauer, Schmidt & Wenyaa, 2007). Schneider (2004) points out that the poor tend to have liquidity and other behavioural constraints that cause tfiem to remain uninsured even when they might be better off with insurance.

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behavioural constraints that cause them to remain uninsured even when they might be better off with insurance.

1.1.3 The National Hospital Insurance Fund (NHIF)

NHIF was established in 1966 to provide hospitalization insurance coverage to members and other beneficiaries in order to enable them access high quality care. Up to 1998 it existed as a department of the Ministry of Health (MoH). Act No. 9 of 1998 enhanced NHIF to autonomous status managed by NHIF management board. The Act attempts to promote all-inclusiveness and participation of all sections of society in the management of the Fund and allows contributions to the Fund from both persons who are in salaried employment as well as those whose income is derived from the informal sector. (Hakijamii Trust, 2007). The Fund offers monthly premiums that are low (ranging from Kshs 30 to Kshs 320) compared to those of conventional insurance schemes, which are actuarially determined. 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. It provides for both in-patient and out-patient cover although, in practice, up to now only in-patient benefits are offered. The Fund is a compulsory membership one for all salaried employees who earn a minimum of Kshs 1000 per month. Members from the informal sector pay a monthly fee of Kshs. 160 that offers protection to the whole family.

The Fund's relationship with hospitals is categorized on the basis of services to members with the first category of government hospitals eliciting comprehensive cover including maternity and surgery for beneficiaries while the category of mission and private hospitals attracts comprehensive cover except surgery on which there is cost sharing. In the last category of private hospitals, the Fund pays specified daily benefits of between Kshs.800 to Kshs. 2,400 per day.

Currently the fund provides in-patient cover for between 20-30 percent of Kenyans but is skewed in favour of the formal sector (IPAR, 2005). Its current mandate is to enrol all population categories, from both formal and informal sector. The informal sector has not been totally brought onboard, with the recognition that identification, enrolment, monitoring and administering the informal sector is possible but a difficult and arduous task. The Fund has at least 1.8 million members from the formal employment and another 230,000 members from the informal employment. Members are able to enjoy in-patient health services from at least 400 hospitals across the country that have partnered with NHIF (NHIF, 2008).

However, the Fund imposes a penalty equal to five times the amount of the contribution to members for not paying on due date. IPAR (2005) identified more challenges for the Fund as including management obstacles, inefficient ways of collection of dues, fraud and abuse, limited coverage, poor quality service delivery, unresponsiveness to members needs. Moreover, poor infrastructure and inaccessibility of NHIF offices especially in the rural areas made it difficult to access the Fund's services (Hakijamii Trust, 2007).

1.2 Statement of the Problem

Health care expansion for the informal sector and the poor is an important objective of Kenyan health sector strategy (MoH, 2005b). Considering that 56% of Kenyans are poor (living on one dollar or less a day per capita) (CBS, 2005) and poverty compounds health problems, alternative methods for financing health care is necessary. Private health insurance is only accessible to the higher income, while community-biased health insurance (CBHI) is not yet well developed in the country (Mathauer, Schmidt & Wenyaa, 2007).

It is within this background that the NHIF approach to open voluntary membership to the informal sector which has about 7 million workers, extend benefit packages to cover up to 100% inpatient care depending on the hospital's services and the negotiated rebate (Mathauer, Schmidt & Wenyaa, 2007), offer monthly premiums that are low, cover all medical conditions including maternity cases, open benefits to all of the beneficiary's dependants in addition to future plans to cover for outpatients (Hakijamii Trust, 2007) was bound to be attractive to the informal workers.

The small numbers in NHIF from the informal sector, however, suggest that there are factors impeding individuals from enrolling. Studies elsewhere show that low understanding of the rationale of SHI (Brown and Churchill, 2000), unaffordable premium levels, cultural aspects, mistrust in the health care system and inferior quality of care encumber enrolment (Carrin, 2003; Jutting, 2004: Schneider, 2004) in social health insurance. If SHI is to improve access to care for the poor then, health policy needs to understand and address the reasons why poor households insure or remain uninsured.

The purpose of this study was to determine the factors influencing the uptake of social health insurance in the informal sector. A review of literature reveals studies that limit focus on SHI scheme for all Kenyans (Njeru, 2004; Arasa & Njeru, 2004) or SHI universal coverage (Bennett, Creese, & Monasch, 1998; Carrin, & Chris, 2005), insurance provision for low-income communities (Brown & Churchill, 2000), social health insurance in developing countries (Carrin,, 2002), CBHI (Carrin. Waelkens, & Criel, 2005), health insurance for the rural poor in Senegal (Jutting, 2001) and demand for health insurance (Phelps, 1973; Osei-Akoto, 2003; Mathauer, Schmidt, & Wenyaa, 2007). I did not coijie across any study on factors influencing the uptake of

social health insurance in the informal sector with specific reference to the small scale traders at the City Park, Nairobi. This study attempted to fill that void.

1.3 Objectives

General Objective

- To determine the factors influencing the uptake of social health insurance in the informal sector.

Specific Objectives

- To establish the extent to which small scale traders at the City Park Market, Nairobi had taken health insurance.
- To establish the perception of the traders regarding social health insurance with emphasis on NHIF.
- To determine the information level among the traders regarding the voluntary NHIF scheme for the informal sector
- To identify the reasons for the small scale traders being insured/uninsured in the NHIF.

1.4Research Questions;

The study attempted to answer the following questions:

i) Had the small scale traders at City Park, Nairobi taken health insurance?

ii) What are the perceptions of the traders regarding social health insurance?

iii) What information gaps existed between what the traders knew about NHIF and what the Fund was offering to voluntary members?

iv) Why had the traders insured or not insured with NH1F?

v) What factors influenced the traders' uptake of SHI?

1.5 The Significance of the Study

The benefits of this study accrued, to among others:

i) Policy makers - It would provide pertinent information to policy makers at MoH and NHIF board on important specific factors that could enhance or impede the inclusion of informal sector workers within the existing NHIF programme.

ii) Informal Sector workers - The study may be found an important information tool to the informal sector workers.

iii) The Public - The general public will find this study useful in its relation with NHIF

iv) Academia - The findings of this study are expected to provide an insight into, and stimulate interest in the subject of SHI.

1.6 Study scope and limitations

The precise remit of the study had to be established as relating only to the scale_traders based at the Ci^ParkJV^ket, Nairobi. For technical reasons, other tracers or informal sectoi^workers were not included.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

Simple market solutions, as are common in other sectors of the economy, do not work well in the health sector owing to a number of types of market failures. The major sources of market failures in the health services are the monopoly power of providers, ignorance and uncertainty among consumers, and an element of externality (Normand & Weber, 1994). In order to protect the public and counter market failure, SHI is necessary.

The main categories of funding for health services are government financing through tax, social insurance, private actuarial insurance and direct payment of services by patients. Systems of health financing such as insurances provide an element of mutual support with those at higher risk with low incomes being supported in part by those in high incomes and low risks (Brown, & Churchill, **2000).**

2.2 Social Health Insurances

Social insurance systems pay for health services through contributions to a health fund. Health insurance is a risk sharing mechanism that lowers the OOP price for medical care at the time of purchase by smoothing medical payments across individuals and time (Barr 1992). Normand & Weber (1994) explain that the most common basis for contributions is the payroll, with contributions from the employee and the employer. It is typical for the total contribution to be contributed as a percentage of income. This amount is normally split between the employer and the employee. For example the employee's contribution could be 8% while the employer's is 4% if the total requirement is 12%. Social insurance therefore works best in the context of a relatively large formal sector where there is a large proportion of the population working as employees with little

doubt about their incomes. Although it is difficult to assess contributions for a self-employed person, it is possible to operate a social health insurance for self-employed people.

Contributions are based on ability to pay, and access to services depends on need. The health fund is usually independent of the government, but operates within a tight regulatory framework. Entitlement to services can be given in detail with contribution rates being set at a level intended to ensure that these entitlements can be met (Bennett, Creese, & Monasch, 1998).

One of the greatest challenges for low-income and mid-income countries that have introduced or are in the process of expanding social health insurance is integration of the expanding informal sector and inclusion of the poor (Jhabvala, 1998). As to whether a household demands and is willing to buy insurance, however, depends on the perceived difference between the level of expected utility with insurance and expected utility without insurance (Kirigia *et al.,* 2005).

2.2.1 The Need for Social Insurance

Health is essential to wellbeing and to overcoming other effects of social disadvantage. In countries with huge income disparities, health care costs tend to adversely affect the poor most, resulting into inequities in medical care provision. Inequities in health systematically put groups of people who are already socially disadvantaged (for example, by virtue of being poor, female, and/or members of a disenfranchised racial, ethnic, or religious group) at further disadvantage with respect to their health (Braveman & Gruskin, 2003).

Normand and Weber (1994) observe that social insurance is based on mutual support and involves the transfer of resources from relatively richer and healthier people to relatively poorer and sicker people. It increases equity in the provision of health services by improving access for some groups

in the population and widening coverage by bringing additional resources into the health sector. They however, point out that, notwithstanding this, if the insurance scheme is designed in such a way that it provides coverage for people with stable, formal sector employment (and relatively high incomes), it could result in improved access for people with low morbidity and low health service needs.

2.2.2 Benefits and Shortcomings of a SHI

Social health insurance is one method of financing health services as either the main or supplementary funding mechanism. Moreover, it can provide a stable source of revenue for services, establish patients rights as customers of the health care providers, combine risk pooling with mutual support by allocating services according to need and distributing financial burdens according to ability to pay, can operate in pursuance of government health policy and can be associated with efficient provision of health services (Mathauer, Schmidt, & Wenyaa, 2007). Two methods are identified by Normand and Weber (1994) for providing and receiving payment for health care services from a social health insurance: the patient can access services without paying the provider though there may be co-payment or the patient pays for services and receives a refund from the insurance fund which may cover all or part of the cost. Both methods may be used with contracted providers or insurance-owned providers. This means that either the health fund contracts with providers (e.g. hospitals or physicians) in order to guarantee service for its members or the health fund runs its own hospitals and employ its own physicians.

Social insurance, however, encounters the dilemma of high administrative costs, cost containment difficulties and problems in ensuring coverage for workers in agriculture and the informal sector (IPAR, 2005).

2.2.3 Designing Social Health Insurance

Health policy goals and targets should be clearly stated before plans for social health insurance are developed. The insurance plans must be compatible with policy goals which in turn may be stated at the level of overall objectives (e.g. long life and good health) and in terms of targets associated with these goals (e.g. access to effective and efficient services, equity, etc.) (Jutting, 2001). It is an expression of social solidarity that a social health insurance protects everyone in the population against the financial burden of health care in case of sickness (Normand & Weber, 1994). Nevertheless, most countries start with a social insurance that covers subgroups of the population with full protection of the entire population being, at best, a long-term objective *{Ibid.).* Some countries, e.g. Germany, do not cover employed people. It is useful to consider the possible targets of the population such as excluding persons who can easily make their own insurance arrangements or employees whose earnings exceed a certain upper limit *{Ibid.).*

2.2.4 Voluntary Membership

Normand and Weber (1994) point out that offering voluntary membership may entice certain members of the population to join, particularly those who are not presently covered by an insurance scheme and may be dissatisfied with existing quality of health services. However, Jutting (2001) argues that voluntary membership may also result in adverse risk mix (too many bad risk groups and not enough good risks) and has been known to increase risk of fraud such as making false declarations about income in order to pay lower contributions or applying for membership when seriously ill.

Some people may not buy insurance because they misperceive the risk or consequences of the decision, some because they are poor and others because the premiums are high relative to expected benefits (Diamond, 1992)! Jhabvala (1998) observes that the informal sector workers are

willing to pay a premium for insurance, if they can pay the premium which depends on their annual incomes and if the services provided by the insurance schemes match their needs.

2.2.5 Factors Affecting Demand for Insurance

Whether a household demands and is willing to buy insurance depends on the perceived difference between the level of expected utility with insurance and expected utility without insurance (Kirigia et al., 2005). According to Mathauer, Schmidt & Wenyaa (2007) the perceived difference and expected utility are determined by various factors, which can be grouped into personal/household characteristics; health care market characteristics; community characteristics; insurance scheme design features and; availability of risk management alternatives.

The value attached to and demand for health insurance is influenced by knowledge of the full costs of health care. Health insurance would have diminishing marginal utility for someone who underestimates the high costs of inpatient care and the likelihood of high-risk events by comparison with someone who is fully aware of the high cost of inpatient care and whose demand would therefore be higher (Osei-Akoto, 2003). Even if the potential benefit of health insurance is seen, there is no utility in insurance if informal sector workers have no geographical access to health facilities that are accredited by a health insurance. Similarly, the non-availability of quality health care services (including lack of drugs and other quality deficits) negatively affects demand for health insurance (Carrin, 2003). Thus if informal sector workers perceive quality of health care as a problem, health insurance membership will be less attractive to them. The availability and effectiveness of protection through alternative risk management institutions that cater for meeting people's health care needs and costs would also serve to decrease demand for health insurance.

Informal institutions such as group saving mechanisms usually constitute ex-post-risk management strategies that help to prevent or reduce catastrophic health expenditure (Mathauer, Schmidt &

Wenyaa, 2007). Low understanding and acceptance of the rationale of insurance has been blamed for the reluctance of low-income households from joining the insurance which they think would be like paying for services they might never use (Brown and Churchill, 2000). Platteau (1997) argues that people join such micro-insurance arrangements based on the principle of'balanced reciprocity'. This means that members expect a roughly equal return from their contribution or payment, rather than being guided by a 'true logic of mutual insurance' with winners and losers through income redistribution between 'lucky' and 'unlucky' individuals *(ibid).* On the other hand, according to Jutting (2001), if solidarity is strong, people may be less concerned whether the benefits of their contributions accrue to themselves or to other community members. Lack of credibility and trust in fund managers may also negatively affect demand for health insurance (Schneider, 2004). Insurance scheme design features, particularly the benefit package, payment modes and the enrolment basis (as an individual or family), influence people's expected utility of health insurance (Carrin, 2003). Finally, demand for health insurance is also determined by the ability to pay membership contributions. Lack of money is indeed a major reason why many do not join (Jutting, 2004). As expenditure studies show, higher-income quintiles are more likely to be covered by insurance (Carrin et al., 2005).

In her study, Schneider (2004) found that risk aversion; higher income levels; low insurance premiums and high user fees; knowing with certainty that illness will occur; the over-weighting of occurrences with small probabilities including illness; risk aversion against impoverishment; and trust in providers' quality of care level and SHI management were factors that could stimulate health insurance demand. She found the possible reasons for non-insurance as: low user fee levels; individuals' risk-seeking behaviour if illness is uncertain; their risk aversion against something new and unknown like insurance; the»necessity for current consumption because they are too poor to insure against eventual future risk; mistrust in the insurance mechanism; the veil of experience

and their dislike of eventual feelings of regret and disappointment; and unaffordable premium levels causing them to rely on alternative risk-sharing mechanisms.

2.3 The Informal Sector

The informal sector comprises of petty traders/street vendors, micro- entrepreneurs, casual and daily wage workers (construction, carpenters, artisans), home- based workers (in food processing; sub- contracting), domestic servants, and other small-scale self-employed in urban areas and small-scale farmers, small-scale fishermen, landless labourers, women headed households, and disadvantaged minority groups in urban centres (Jhabvala, 1998) and is characterized by low and non-regular, non-taxed incomes, insecure employment and self-employment without social security (Mathauer, Schmidt & Wenyaa, 2007). Studies on the use of health care services show that the poor and other disadvantaged sections are forced to spend a higher proportion of their income on health care than the better off with the burden of treatment being unduly large on them when seeking inpatient care (Gumber and Kulkarni, 2000). Informal sector workers have been defined to include all workers in informal enterprises, some workers in formal enterprises, self-employed workers, and those doing contract work for informal or formal sector enterprises and contractors (Kantor, 1997). A large proportion of the populations in developing countries find an income-generating source in economic activities outside the formal or modern sector of the economy, the bulk of who live in poor areas, are vulnerable to disease and poor health resulting from a combination of undesirable living and working conditions (1LO, 2000). Mathauer, Schmidt & Wenyaa (2007) observe that it is difficult to assess the income of informal sector workers which would be for social security contributions deductions, as such policymakers wishing to introduce or upscale a national social health insurance for the informal sector in order to include the poor are faced with a number of questions regarding insurance scheme design with respect to enrolment, revenue collection, risk pooling and purchasing of health services. ILO (2000) discounts w i d ^

held myths about the sector as being synonymous with poverty, being unorganized and operating illegally. Instead, it recognizes that the sector is heterogeneous, has a network with operating links to the formal sector enterprises and the illegal situation in which the sector may find itself in is owing to non-applicability of existing regulations to the economic conditions of informal sector activities and lack of knowledge of the regulations, rather than an outright desire to circumvent the law. Nevertheless, it is worth noting what Schneider (2004) points out as issues to consider with regard to the poor: that they have liquidity constraints and other behavioural constraints that cause them to remain uninsured even when they might be better off with insurance. They may rely on solidarity from family and friends to smooth out consumption and financial shocks related to ill health over time. This indicates that offering SHI to low-income groups might not improve access to health care, because there are other factors that cause them not to enrol. Focusing on addressing factors such as, she points out, the insurance design, the socioeconomic situation, and the informational context is crucial.

2.4 The Theoretical Framework

This section analyzes the theoretical framework from an informal sector point of view in relation to the uptake of social health insurance. The theories identified attempt to explain the underlying factors in enrolment into a social health insurance programme. Among the theories that will be considered include consumer theory and those theories that analyze decision-making under uncertainty such as expected utility (EU), state-dependent utility and prospect theory.

2.4.1 The Expected Utility (EU) Jheory

Under expected utility theory, the demand for insurance reflects individuals' risk aversion and demand for income certainty (Schoemaker 1982). Poor households are expected to become

increasingly risk averse if they move closer to or further below the poverty line (Wagstaff 2000). Schneider (2004) explains that under EU theory people are assumed to be risk averse and make choices between taking a risk that has different implications on wealth. At the time of insurance choice, consumers are uncertain whether they will be ill or not, and of the related financial consequences. Insurance reduces this uncertainty. Through insurance, they can level out their income over two different states, ill/not ill, which makes the aggregate outcome relatively certain. This certainty allows the insured to reach a higher utility in case of illness than those without insurance. Accordingly, the insurance demand reflects individuals' risk aversion and demand for certainty, implying that the more risk averse individuals are, the more insurance coverage they will buy (Begg et al. 2000). This theory is, however, silent about the association between households' socio-economic status and insurance enrolment and about the level of consumers' income and its impact on the insurance choice (Schneider, 2004).

Criticism has been levelled against the model's prediction of choice behaviour which has been stated to be poor requiring additional factors such as the societal context about prudent behaviour or regret considerations (Schoemaker 1982). Moreover, Schneider (2004) posits, individuals' insurance decisions may not only be affected by risk aversion but also by the access motive of insurance. The access motive reflects the gains from the availability of medical care that would otherwise be unaffordable for the poor. Gaining higher access to care when insured may cause the poor to insure if they are unable to obtain needed health care when uninsured. This study was founded on the theory of expected utility (EU).

2.4.2 Consumer Theory

Under Consumer theory, it is assumed that if consumers are perfectly informed, they maximize their utility as a function of consuming various goods, given relative prices, their income and tastes

and preferences (Schneider, 2004). Changes in prices and income influence how much of different goods rational consumers will buy (Begg et al. 2000). Health insurance is expected to be a normal good with a positive income elasticity of demand, implying that the poor are less likely to insure. A price increase of a substitute for insurance - such as user fees - is expected to raise the insurance demand, as is a decrease in insurance premium (Schneider, 2004). However, Cameron *et al.* (1988) have pointed out that due to uncertainty about the unknown future health, insurance choice is not made based on utility alone but on consumers' expectation about factors such as their health status.

2.4.3 State-dependent Utility Theory

This theory posits that consumers' utility level and tastes are influenced by their state, such as their health or socio-economic status and so people may have different degrees of risk aversion, which could influence their insurance decision and the magnitude of their expected insurance pay-off. Most people insure when they are healthy (Schneider, 2004). A healthy person might optimistically expect to remain healthy in the near future, which has implications on the insurance choice. The resulting insurance coverage may be below full loss coverage, if the anticipated insurance pay-off is below the real loss in case of illness. Hence, the anticipated need for medical care given the current state, and the magnitude of the related insurance pay-off in case of sickness will affect individuals' insurance demand (Phelps 1973).

Studies by Manning and Marquis (1996) showed that enrolment in insurance is not affected by household income and premium levels but rather by the expected pay-off individuals will receive when sick with the poor expecting less payoff when sick - which could influence their insurance decision - while the rich may not enrol because the magnitude of the expected pay-off from SHI is not 'good enough' for them preferring instead to pay user fees or purchase private insurance coverage allowing them to use more expensive hospital care.

2.4.4 Prospect Theory

Questioning the assumptions made by EU theory, prospects theory states that the choice is about prospects of gains or losses, and not the level of uncertainty because individuals assume an optimal risk level for every expected gain or loss (Schneider, 2004). The point from which an individual perceives gains and losses to occur may influence the choice; and gambles are judged in terms of their deviations from this optimal risk level (Kahnemann and Tversky 1979). Schneider (2004) explains that when applied to insurance, the theory suggests that people insure from a gain perspective and not because insurance reduces uncertainty, such that given a premium level, people will first assess their individual health risk level and the eventual deviation from it (e.g., my health is bad and it could get worse). They may decide not to insure because of a gain prospect: they expect to pay less for their health risk than the deviation from it. This is a risk because the deviation may be greater than expected and cause a loss. So, prospect theory says that, with respect to losses, individuals are risk preferring. Following from this, individuals will only insure if the loss will occur with certainty, and not because they are risk averse as suggested by EU theory (Kahnemann and Tversky 1979).

CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Site selection and description

Citypark market is located in Nairobi's Parklands area .It serves a relatively affluent population of the city and the traders are likely to have access to information concerning SHI.

3.2 Research Design

This research used a sample survey design to determine the factors influencing the uptake of SHI in the informal sector. This design is appropriate in collecting information on a subset of the elements of the target population and using the information to determine summary characteristics about the population (Leedy, 1989).

3.3 Population

The population of this study was 600 traders licensed and operating at City Park Market, Nairobi. 250 of them were involved in trading clothing and shoes; 220 in cereals and fresh vegetables and fruits; 52 general kiosks; 48 food kiosks; and 30 shoe shiners.

3.4 Sampling procedure and sample size.

The sample for this study was 60 drawn from all categories of the small enterprise operators (traders) and representing 10% of the traders at City Park Market. Using stratified sampling at a ratio of 0.1 of the categories comprising the population, 25 clothing and shoes traders, 22 from cereals and fresh vegetables and fruits, 5 general kiosk dealers, 5 food kiosk operators and 3 shoe shiners were picked through simple random sampling that resulted to a sample of 60, which the rule of thumb as proposed by Roscoe (1975) states is appropriate for statistical techniques.

Sampling frames for each category were derived from the member register kept by the Citypark welfare officials. Respondents were picked using the systematic sampling frame of the tenth element after the first was picked randomly,and the eleventh would be picked if the tenth was unavailable.

3.5 Data Collection, tools and method.

The main tool for data collection was the questionnaire.

Data was collected using semi-structured questionnaire that the researcher issued to the respondents after a brief explanation of what was required. The questionnaire consisted of both open and closed ended questions. The questionnaire was divided into three parts. Part A collected data on the profile/general information about the respondents and Part B and C collected data addressing the objectives of the study.

3.6 Data Analysis

SPSS software was used.The data was analysed using descriptive statistics such as tables, charts and percentages to represent the response rate and information on the variables under study. Mean scores, proportions and frequencies were used to analyse categorical data.

CHAPTER FOUR: DATA ANALYSIS AND FINDINGS

4.0 Introduction

This chapter covers data analysis and findings of the study. Data was collected from 60 small enterprise operators (traders) representing 10% of the traders at City Park Market drawn from all categories of the business. Out of the 60 sampled, 59 responded which was a reasonably high response rate of 98%.

Descriptive techniques were used to organize and interpret the information. The data is presented in the form of proportions with illustrations in form of pie charts and frequency tables. It documents the factors that influence the uptake of health insurance by the small scale traders at the City Park.

4.1 Respondents' Profiles

This section presents data on personal characteristics of the respondents, all of whom were traders at the City Park market. The characteristics include gender, level of education and age.

4.1.1 Gender

The respondents were asked to indicate their gender. Out of the 59 who were sampled, 38 (64.4%) were male and 21 (35.6%) were female. Thus, the representation of male small traders was double that of females, a reflection the population at the City Park where there are more male proprietors of small scale enterprises than women.

Fig.1: Gender

		Frequency		Valid Percent	Cumulative Percent
Valid	Male	38	64.4	64.4	64.4
	Female	21	35.6	35.6	100.0
	Total	59	100	100.0	
Total		59	100.0		

Gender representation at City Park market

4.1.2 Highest Academic Qualification

The level of academic qualifications has a bearing on the understanding of the issues under study. Respondents were asked to indicate their highest academic qualifications. Out of those sampled, 74% indicated that they had secondary level education, about 9% had university level education and at least 3% had postgraduate education. Five percent (5%) had studied up to higher secondary ('A' level). Only 8% had only primary education.

Fig. 2: Highest Academic Qualification

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Primary Level	5	8.5	8.6	8.6
	Secondary Level	43	72.9	74.1	82.8
	Higher Secondary Level ('A' Level)	3	5.1	5.2	87.9
	University Degree	5	8.5	8.6	96.6
	Postgraduate	2	3.4	3.4	100.0
	I			100.0	
Total		59	100.0		

Thus, most of the respondents were had average education having learnt up to ordinary level and therefore had the right aptitude to understand the issues under study.

4.1.3 Professional Qualifications

Respondents were asked to indicate whether they had any professional qualifications. From the results, 83% did not have any professional qualifications. However, 17% had professional qualifications in different fields ranging from accountancy, journalism, insurance etc.

4.1.4 Age

Respondents were asked to give their ages. From the results of the research data, out of the 59 who responded, about 41% were below 30, a similar number were between 30-39 years, 13% were between 40-49 years. Only 5% were above 50 years.

Fig.3: Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Below 30 years	24	40.7	40.7	40.7
	30 - 39 years	24	40.7	40.7	81.4
	40 - 49 years	8	13.6	13.6	94.9
	Above 50 years	3	5.1	5.1	100.0
	Total	59	100.0	100.0	

Distribution of age among traders at City Park market

From the research results, most traders are at their productive ages and still young. Probably this is the age when sicknesses are yet to be a serious issue of concern as many in these age bracket are quite healthy.

4.2 Type of Trade

Respondents were asked to indicate the type of business they were engaged in. Thirty eight percent (39%) were engaged in engaged cloth and shoe trade, 37% were in cereals, fruits and vegetables, 9% had general kiosks, those in food kiosks were 9%, 5% were shoe-shiners while 1% dealt in other business.

Fig.4: What business are you engaged in?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Clothing/Shoes	23	38.9	38.9	38.9
	Cereals/Fruits/ Vegetables	22	37.2	37.2	76.1
	General Kiosk	5	8.5	8.5	84.6
	Food Kiosk	5	8.5	8.5	93.1
	Shoe Shining	3	5.08	5.08	98.18
	Other	1	1.82	1.82	100.0
				100.0	
Total		59	100.0		

Resj •ades

This distribution was in line with the proposed stratified composition of traders intended for proportionate representation.

Respondents were further asked to indicate if they had been in formal employment before their current business. Prior to introduction of NH1F scheme for the informal sector, the programme's benefits accrued only to those in formal employment. The introduction of the programme into the informal sector may be attractive to those who had enjoyed the benefits as formal employees. Of those who responded to the question, 46% had been in formal employment while 54% had not been in formal employment.

Fig.5: Before this job, had you been in any formal employment

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	25	42.4	46.3	46.3
	No	29	49.2	53.7	100.0
	Total	54	91.5	100.0	
Missing	System		8.5		
Total		•69	100.0		

Previous employment status by traders at City Park market

Those who had earlier been in formal employment were further asked to state the number of organizations they had worked for. Eighty five percent (85%) had worked in 1-3 organizations, while 15% had been employed 4-6 organizations.

4.3 Health Insurance

Prior experience with health insurance can have a bearing on future uptake of insurance cover. This is because they would be making options on the basis of informed position. Respondents were asked to indicate if they had ever had health insurance cover. Seventy one percent (71%) of the small scale trader at City Park market indicated that they had never taken health insurance cover. Only 29% had ever taken health insurance cover.

Fig.6: Have you ever had a health insurance cover?

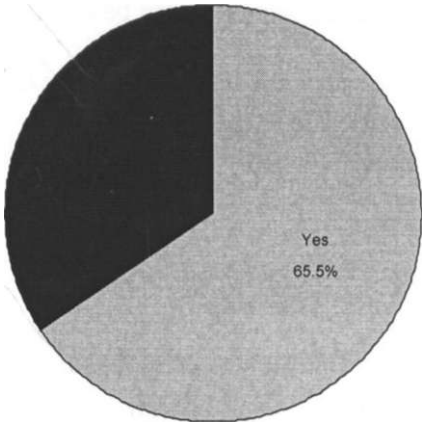
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	17	28.8	29.3	29.3
	No	41	69.5	70.7	100.0
	Total	58	98.3	100.0	
Missing	System	1	1.7		
Total		59	100.0		

Prior insurance cover among the traders at City Park market

Health isessential to wellbeing and to overcoming other effects of social disadvantage. In countries with huge income disparities, health care costs tend to adversely affect the poor most, resulting into inequities in medical care provision. Inequities in health systematically put groups of people who are already socially disadvantaged (for example, by virtue of being poor, female, and/or members of a disenfranchised racial, ethnic, or religious group) at further disadvantage with respect to their health (Braveman & Gruskin, 2003> Moreover, NHIF's current mandate is to enrol all population categories, from both formal and informal sector (NHIF, 2008). Respondents were asked to

indicate if they had insurance cover. The results from the research data, illustrated in figure 7 below, indicated that 65.5% had insurance cover against 34.5% who didn't have.

Fig.7: Do you have insurance cover?



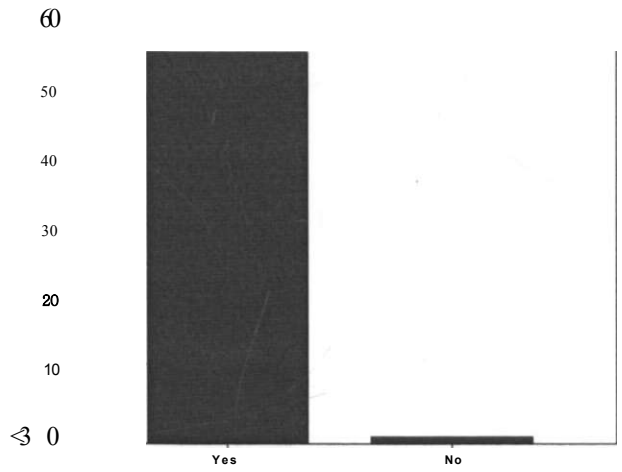
Distribution of those with health insurance cover at the City Park market

This is an indication that a majority of the small scale traders are informed about health insurance and the greater proportion having taken health insurance cover.

Social health insurance is one method of financing health services as either the main or supplementary funding mechanism. Moreover, it can provide a stable source of revenue for services, establish patients rights as customers of the health care providers, combine risk pooling with mutual support by allocating services according to need and distributing financial burdens according to ability to pay, can operate in pursuance of government health policy and can be associated with efficient provision of health services (Mathauer, Schmidt, & Wenyaa, 2007). Low understanding and acceptance of the rationale of insurance has been blamed for the reluctance of low-income households from joining the insurance which they think would be like paying for services they might never use (Brown

and Churchill, 2000). Under expected utility theory, the demand for insurance reflects individuals' risk aversion and demand for income certainty (Schoemaker 1982). Thus, gaining higher access to care when insured may cause the poor to insure if they are unable to obtain needed health care when uninsured (Schneider, 2004). Respondents were therefore asked to indicate if they believed health insurance is desirable. From the research results data, only 2% did not believe health insurance is desirable; otherwise the overwhelming majority (98%) believed health insurance is desirable as illustrated in figure 8 below.

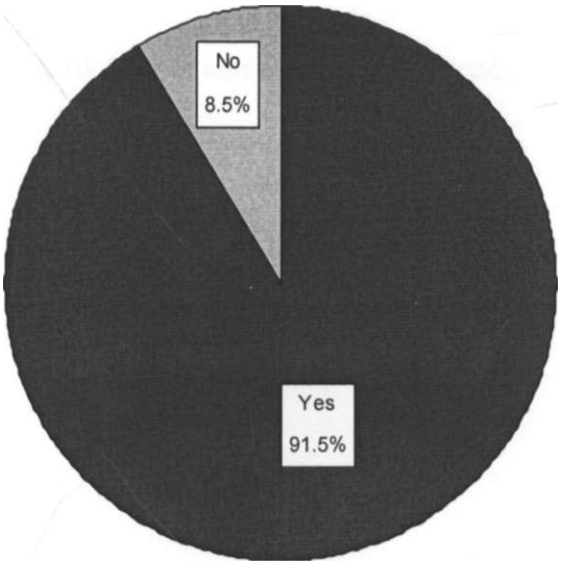
Fig.8: Is health insurance desirable?



4.4 Awareness of NHIF Programme

Under Consumer theory, it is assumed that if consumers are perfectly informed, they maximize their utility as a function of consuming various goods, given relative prices, their income and tastes and preferences (Schneider, 2004). Respondents were asked to state if they were aware of the voluntary NHIF programme for those in the informal sector.

Fig.9: Awareness of the voluntary NHIF programme



Are you aware of the voluntary NHIF social programme for those in the informal sector?

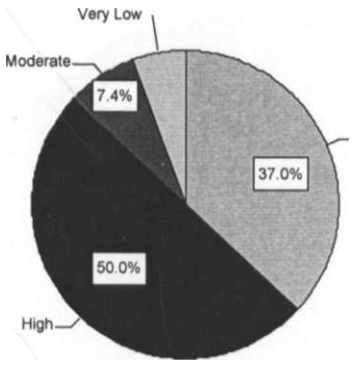
As illustrated in figure 9 above, only 8.5% did not know of the programme; else the majority - 91.5% - indicated they were aware.

4.5 Cost of Inpatient Care

On the basis of the consumer theory, a price increase of a substitute for insurance - such as user fees - is expected to raise the insurance demand, as is a decrease in insurance premium (Schneider, 2004). A high cost of inpatient care can therefore result in increased demand for insurance. Moreover, the value attached to and demand for health insurance is influenced by knowledge of the full costs of health care. Health insurance would have diminishing marginal utility for someone who underestimates the high costs of inpatient care and the likelihood of high-risk events by comparison with someone who is fully aware

of the high cost of inpatient care and whose demand would therefore be higher (Osei-Akoto, 2003). Respondents were asked to rate the cost of inpatient care in the country.

Fig. 10: Cost of inpatient care in the country



Rate the cost of inpatient care in the country

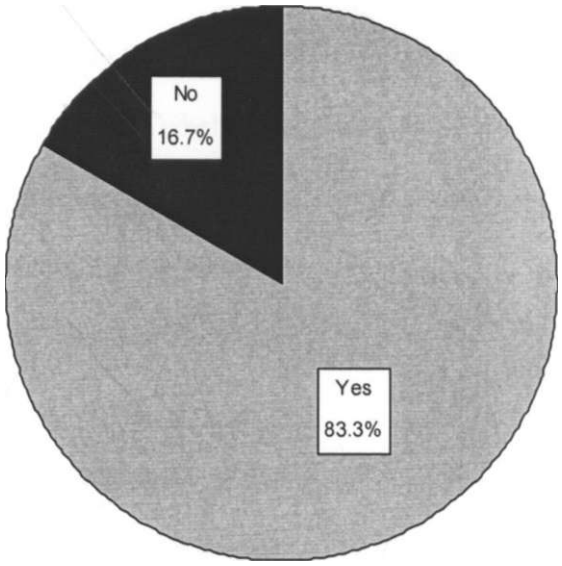
From the research results, 50% rated the cost as high, 37% as very high, only 7.4% regard it as moderate and 5.6% indicated it is very low. This implies that there is high potential of enrolment from the informal in view of their understanding that inpatient care costs are quite high.

4.6 Uptake of NHIF Cover

The current mandate of NHIF is to enrol all population categories, from both formal and informal sector (NHIF, 2008). Offering voluntary membership may entice certain members of the population to join, particularly those who are not presently covered by an insurance scheme and may be dissatisfied with existing quality of health services (Normand & Weber, 1994). Under expected utility theory, the demand for insurance reflects individuals' risk aversion and demand for income certainty (Schoemaker 1982). Accordingly, the insurance demand reflects individuals' risk aversion and demand for certainty, implying that the more risk averse individuals are, the more insurance coverage they will buy (Begg et al. 2000). Respondents were asked to state if they had

taken up the NHIF cover. As shown in figure 11, most (about 83%) respondents had taken the cover.

Fig. 11: Uptake of NHIF cover



Have you taken up the NHIF cover?

Only about 17% had not taken up the NHIF cover. Thus, most respondents had health insurance from NHIF.

According to the prospect theory, people insure from a gain perspective and not because insurance reduces uncertainty, such that given a premium level, people will first assess their individual health risk level and the eventual deviation from it (e.g., my health is bad and it could get worse). They may decide not to insure because of a gain prospect: they expect to pay less for their health risk than the deviation from it (Schneider, 2004). The respondents who had not taken the NHIF cover were asked to state why they had noj. From the results of the research, 60% indicated that the

monthly premium is unaffordable to them, 20% were planning to enrol in due course while the remaining 20% responded that they had not received enough details to make the enrol.

4.7 NHIF Cover Offer

Respondents were asked to indicate their knowledge of certain aspects of the NHIF offer to the informal sector workers. This included whether they knew that NHIF had opened its doors to them, the premium paid, the instalments relative to other insurance offers, the extent of the medical coverage and the dependants included in the cover.

4.7.1 NHIF and the Informal Sector

It has been noted that, under consumer theory, it is assumed that if consumers are perfectly informed, they maximize their utility as a function of consuming various goods, given relative prices, their income and tastes and preferences (Schneider, 2004). Respondents were therefore asked to indicate if they were aware that NHIF offers coverage to workers in the informal sector. From the research results data, the level of awareness was quite high as illustrated below in Figure 12.

Fig. 12: Knowledge of informal sector cover

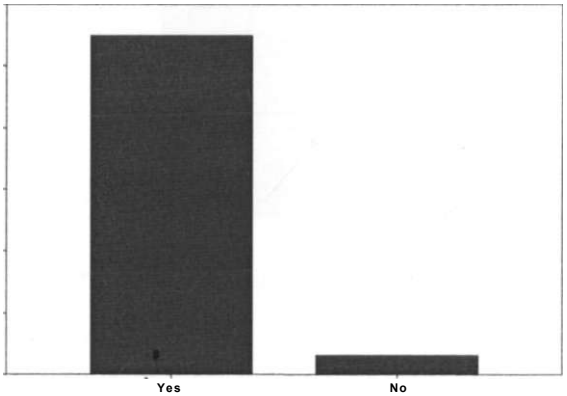


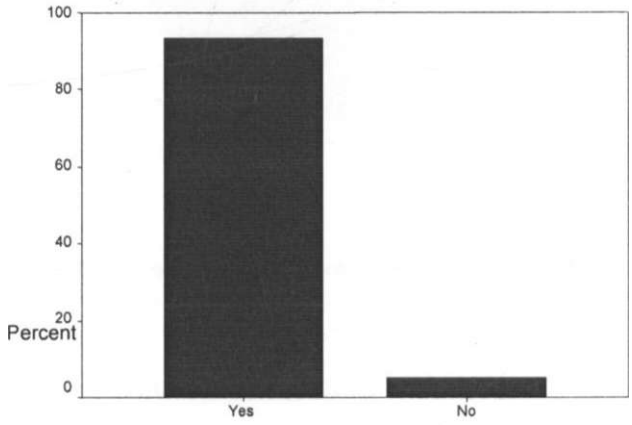
Fig. 12: knowledge of NHIF coverage of informal sector

Ninety five percent (95%) of the respondents were aware of the NHIF offer to the informal sector workers. A meagre 5% were not aware. Thus, NHIF has been able to make the informal sector workers highly aware of its programme for them.

4.7.2 NHIF Premiums

The value attached to and demand for health insurance is influenced by knowledge of the full costs of health care. Health insurance would have diminishing marginal utility for someone who underestimates the high costs of inpatient care and the likelihood of high-risk events by comparison with someone who is fully aware of the high cost of inpatient care and whose demand would therefore be higher (Osei-Akoto, 2003). Respondents were asked to indicate if they were aware that the NHIF coverage for the informal sector required the members to pay only Ksh. 160 per month.

Fig.13: Knowledge of monthly premium

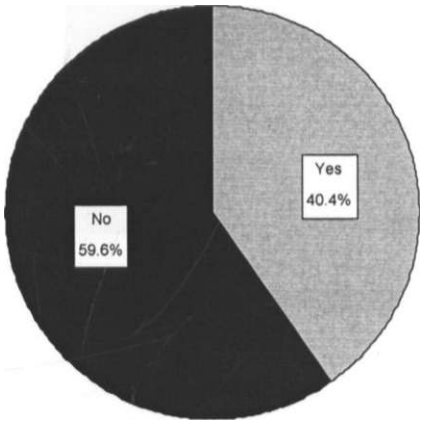


Only 5% indicated that they were not aware that the monthly premium is Ksh. 160. The majority of the respondents were aware that the monthly premium paid to benefit as a member is currently Ksh. 160.

4.7.3 Comparison with other Insurance Charges

NHIF monthly premiums for the informal sector are priced at Ksh. 160 per month. The Fund offers monthly premiums that are low compared to those of conventional insurance schemes, which are actuarially determined (Hakijamii Trust, 2007). Respondents were asked to state whether they knew that these were the lowest charges.

Fig.14: NHIF's charges are low



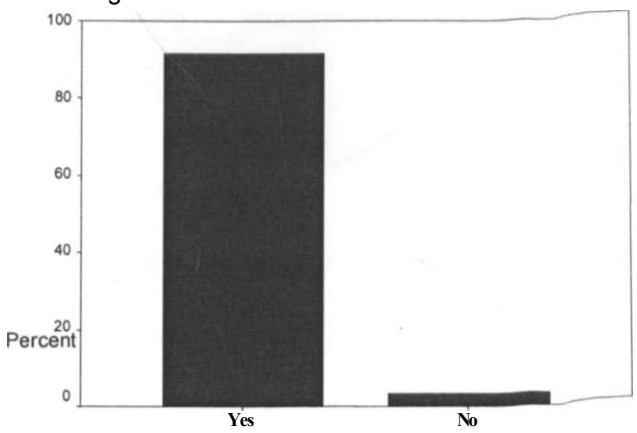
Are you aware these are the lowest charges for insurance in the country?

As shown in figure 14 above, about 60% responded in the negative. Only 40% agreed that NHIF monthly charges were the lowest. There is therefore need for the Fund to let potential members to be aware that its charges are the fairest in the country.

4.7.4 Covered Medical Conditions

NHIF has no provision for exclusions; as such, all medical conditions are covered, maternity cases (NHIF, 2008). Respondents were asked to indicate whether they were all medical conditions, including maternity, are covered for those who have enrolled in N^y^ members. From the results illustrated below (figure 15), 96% indicated that they ^ However, 4% of the respondents indicated that they were not aware that all medical condit,0^11 covered once one enrols into NHIF membership. y

Fig.15: All medical conditions included



All medical conditions, including maternity, are covered?

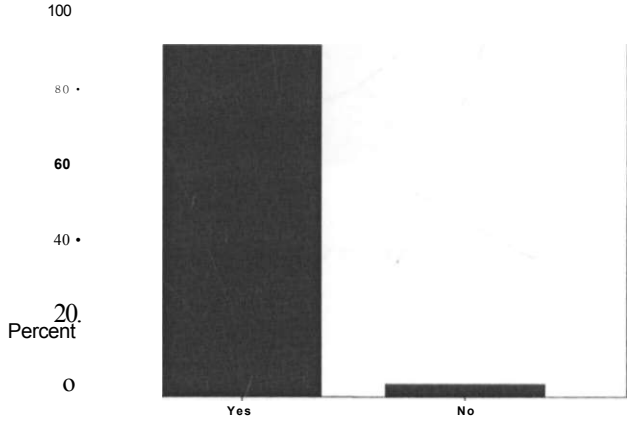
4.7.5 Dependants Cover

NHIF membership places no limit to the number of a beneficiary's dep^en(^ants CNHIF, 2008) i.e. it offers protection to the whole family of a member. **Respondents** were asked indicate if they were aware that there was no limit to the number of dependants ot a member. The results indicated that only 36% agreed with that statement; the rest (64 /o) not agree that all dependants of a member are covered. This is as **illustrated** in figure l 6 below. The question was wrought with controversy that only emerged during data

4.7.4 Covered Medical Conditions

NHIF has no provision for exclusions; as such, all medical conditions are covered, including maternity cases (NHIF, 2008). Respondents were asked to indicate whether they were aware that all medical conditions, including maternity, are covered for those who have enrolled in NHIF as members. From the results illustrated below (figure 15), 96% indicated that they were aware. However, 4% of the respondents indicated that they were not aware that all medical conditions are covered once one enrols into NHIF membership.

Fig.15: All medical conditions included



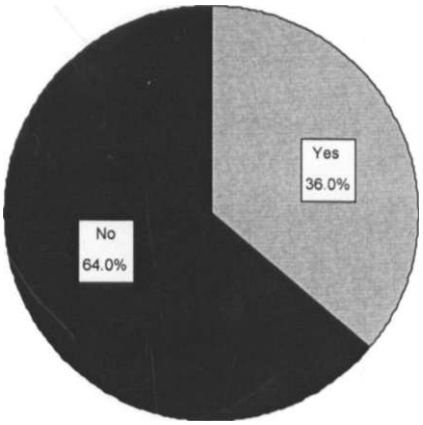
All medical conditions, including maternity, are covered?

4.7.5 Dependants Cover

NHIF membership places no limit to the number of a beneficiary's dependants (NHIF, 2008) i.e. it offers protection to the whole family of a member. Respondents were asked to indicate if they were aware that there was no limit to the number of dependants of a member. The results indicated that only 36% agreed with that statement; the rest (64%) did not agree that all dependants of a member are covered. This is as illustrated in figure 16 below. The question was wrought with controversy that only emerged during data

collection. In the traditional set up, dependants are not defined by the nuclear family. Dependants go beyond the definition given by NHIF. This could probably explain the type of answers received.

Fig.16: No limit to dependants



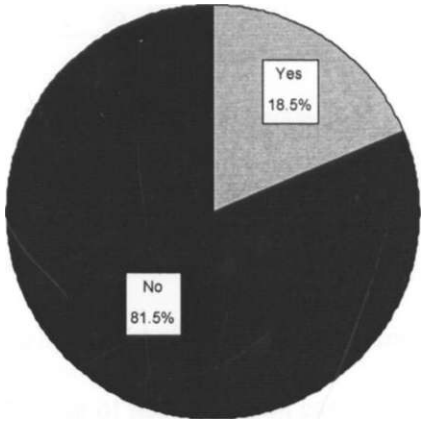
There is no limit to the number of dependants of a member

4.7.6 In-patient and Outpatient Cover

NHIF set up to offer protection to both inpatients and outpatients (NHIF, 2008). In practice the Fund offers only inpatient benefits. Respondents were asked to state whether they were aware that the Fund provides for both inpatient and outpatient coverage. As may have expected, the responses confirmed what is in practice rather than what is in principle. Eighty two (82%) of the respondents did not agree with the statement that the coverage includes out-patients and in-patients. Only 18% responded in the affirmative. This is illustrated in figure 17 below. As to why 18% of the respondents would answer that they are aware that the NHIF coverage includes both in-patients and out-patients when in real

that is not the case is intriguing; but could be owing to limited experience with sicknesses and hospitalization and therefore basing responses on assumptions.

Fig. 17: It covers both inpatient and outpatient



The coverage includes both in and out patients

4.7.7 Free Treatment

Two methods are identified by Normand and Weber (1994) for providing and receiving payment for health care services from a social health insurance: the patient can access services without paying the provider though there may be co-payment or the patient pays for services and receives a refund from the insurance fund which may cover all or part of the cost. Respondents were asked to indicate whether they were aware that with NHIF insurance they, or their dependants, could be admitted to some hospital, get treatment and be discharged without paying anything. Most of the respondents were aware of this as 91% responded that they were aware with only about 9% indicating that they were not aware that it is possible. The results of the research are shown in the table/figure 18 below.

Fig.18: With NHIF insurance cover, you or your dependant can be admitted get treatment and be discharged without paying anything?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	52	91.2	91.2	91.2
	No	5	8.8	8.8	100.0
	Total	57	100	100.0	
Total		59	100.0		

It is possible to get free treatment

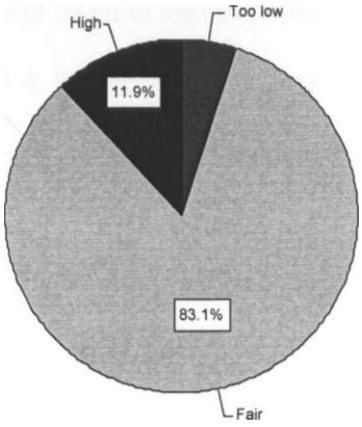
4.8 Cost of NHIF Premiums

It is an expression of social solidarity that a social health insurance protects everyone in the population against the financial burden of health care in case of sickness. Although it is difficult to assess contributions for a self-employed person, it is possible to operate a social health insurance for self-employed people (Normand & Weber, 1994). Contributions are based on ability to pay, and access to services depends on need (Bennett, Creese, & Monasch, 1998). Some people may not buy insurance because they are poor and others because the premiums are high relative to expected benefits (Diamond, 1992). Respondents were asked to state their opinion regarding the cost of the NHIF premium at Ksh. 160 per month for the informal sector. The results showed that 83% of the respondents regarded the cost as fair, 5% find it too low. However, 12% find the cost too high. This is as shown in figure 19 below.

Respondents were then asked to indicate if they were themselves able to pay the NHIF premiums for informal sector. Ninety five (95%) indicated that they were able to meet the NHIF premium costs with only 5% showing inability to pay the amount. It can therefore safely be concluded that

the NHIF programme offer to the informal sector can be well serviced as most in the industry find it affordable.

Fig.19: The cost of NHIF premiums



What is opinion about the cost of NHIF premiums?

However, when asked to indicate if there are people in the sector who cannot pay the NHIF premium for the informal sector workers, the respondents (64%) stated that there are those in the sector who can't pay. Only 36% doubted that there could be colleagues in the sector who couldn't pay. When further asked to explain their responses, 39% stated that the cost of living is high for a number in the sector to afford the monthly instalments, 24% cited the low daily incomes which cannot enable others to pay, 5% referred to the seasonal nature of their business which makes it difficult to meet the cost at all times, 2% indicated others cannot pay because of lack of information. However, 30% of the respondents indicated that the monthly instalments are fair and affordable.

4.9 Benefits of Social Insurance

Social insurance is based on mutuaf support and involves the transfer of resources from relatively richer and healthier people to relatively poorer and sicker people. It increases equity in the

provision of health services by improving access for some groups in the population and widening coverage by bringing additional resources into the health sector. If the insurance scheme is designed in such a way that it provides coverage for people with stable, formal sector employment (and relatively high incomes), it could result in improved access for people with low morbidity and low health service needs (Normand & Weber, 1994). This section deal with respondents responses issues relating to the benefits of pooling resources together, out of pocket medical prices and equity in the provision of medical care.

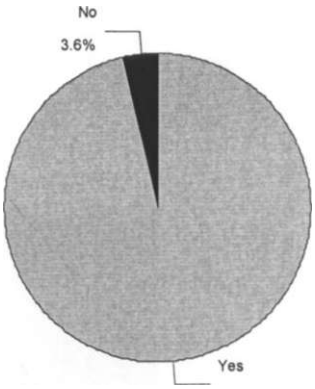
4.9.1 Cost Reduction through Pooling of Resources

Social health insurance is one method of financing health services as either the main or supplementary funding mechanism. It can provide a stable source of revenue for services, establish patient's rights as customers of the health care providers, combine risk pooling with mutual support by allocating services according to need and distributing financial burdens according to ability to pay (Mathauer, Schmidt, & Wenyaa, 2007).

Respondents were asked to indicate their level of awareness regarding NHIF's programme which is meant to pool funds together with others in order to reduce the cost of health care for members. From the research results, most respondent are aware that NHIF programme is meant to pool resources together in order to reduce the cost of health care as 96% responded in the affirmative. A paltry 4% were the ones who didn't know as indicated in figure 20 below.

Hence, there is potential for the Fund to grow in the informal sector as most respondents are aware of the objectives and benefits of pooled resources.

Fig. 20: NHIF meant to pool resources together



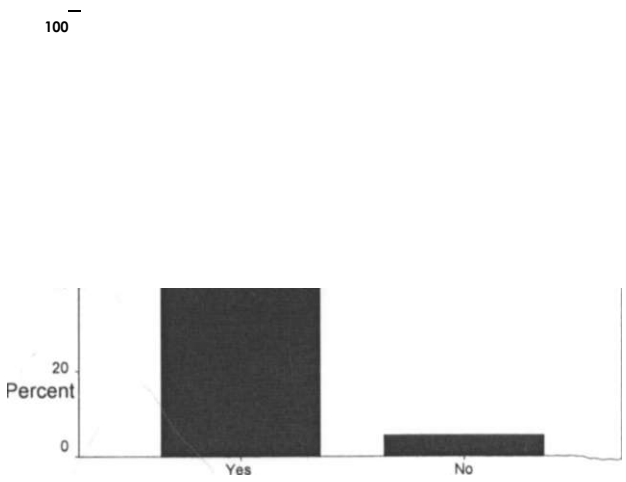
Pooling resources together

4.9.2 Low OOP

Health insurance is a risk sharing mechanism that lowers the out-of-pocket (OOP) price for medical care at the time of purchase by smoothing medical payments across individuals and time (Barr 1992). Respondents were asked if they knew that by enrolling in the NHIF programme for the informal sector they lowered the out of pocket price for medical care. As can be seen in figure 21 below, an overwhelming number of 94% are aware that the OOP is lowered when insured while a small number of 6% did not know. The Fund can therefore increase enrolment from the informal sector as most of the respondents are aware of the benefits that accrue from being a member. This is more when noting that social health insurance is one method of financing health services as either the main or supplementary funding mechanism. Moreover, it can provide a stable source of revenue for services, establish patients' rights as customers of the health care providers and combine risk pooling with mutual support by allocating services according to need. It can also distribute financial burdens according to ability to pay and can be used to operate in pursuance of

government health policy. In addition, social insurance can be associated with efficient provision of health services (Mathauer, Schmidt, & Wenyaa, 2007).

Fig.21: OOP is lowered

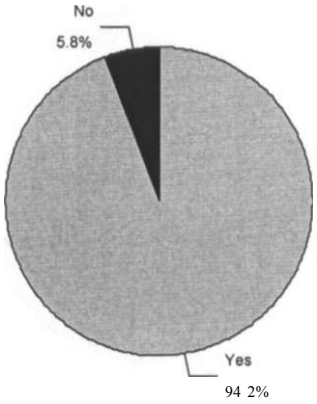


Lowers OOP price of medical care

4.9.3 Increases Equity

Social insurance increases equity in the provision of health services by improving access for some groups in the population and widening coverage by bringing additional resources into the health sector (Normand & Weber, 1994).

Fig.22: It increases equity



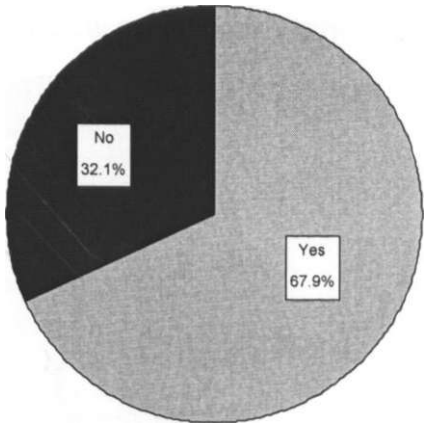
Increases equity in the provision of health care

Respondents were asked if they knew that the NHIF programme increases equity in the provision of health care by improving access to many and widening coverage. From the results which are shown in figure 22, only 6% did not know, else the majority 94% were aware. Again, it is worth noting that this is important for the Fund as it can be used to raise enrolment into the Fund since most potential members are assured of equitable health care provision.

4.10 Accessibility of Partnering Hospitals

Even if the potential benefit of health insurance is seen, there is no utility in insurance if informal sector workers have no geographical access to health facilities that are accredited by a health insurance (Carrin, 2003). Challenging some aspects of the expected utility theory, Schneider (2004) posits that individuals' insurance decisions may not only be affected by risk aversion but also by the access motive of insurance.

Fig.23: Accessibility of hospitals



Are the hospitals partnering with NHIF accessible enough for you?

Respondents were asked to indicate whether the hospitals that NHIF has partnered with are accessible enough for them. From the results as shown in figure 23 above, 68% of the respond believe the hospitals are accessible enough while 32% believe they are not accessible enough $_{t<}$ a substantial number of respondents are comfortable with the accessibility of the hospitals partnering with NHIF. This is congruent with Schneider's (2004) observations that the access motive reflects the gains from the availability of medical care that would otherwise be unafforn for the poor. Gaining higher access to care when insured may cause the poor to insure if they $_{are}$ unable to obtain needed health care when uninsured.

4.11 Quality of Medical Services

If informal sector workers perceive quality of health care as a problem, health insurance membership will be less attractive to them. Similarly, the non-availability $_{0}$f quality health

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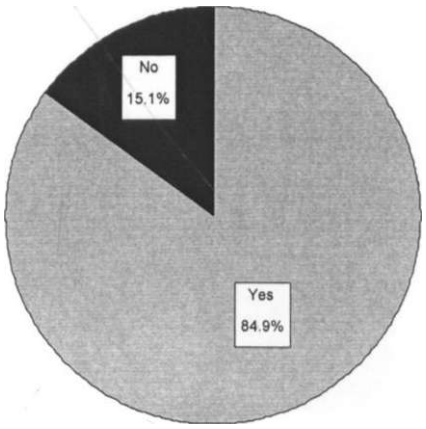
care services (including lack of drugs and other quality deficits) negatively affects demand for health insurance (Carrin, 2003).

Fig.24: Quality of medical services in partnering



Do you believe the quality of medical services in hospitals partnering with NH1F is good?

Respondents were asked to state whether they believed the quality of medical services (treatment, drugs, x-rays, theatres etc.) in hospitals partnering with NHIF were good. Figure 24 above gives an illustration of the responses. Eighty Five percent (85%) of the respondents indicated that the quality of medical services in hospitals partnering with NHIF was good. Only 15% posited contrary responses.

This is further vote of confidence in the NHIF programme for the informal workers and its partners, implying that many more from the informal sector can be enrolled.

4.12 Accessibility of NHIF Offices

Individuals' insurance decisions may be affected by the access motive of insurance (Schneider, 2004). Respondents were therefore asked to indicate if NHIF offices are located adequately for their reach.

Fig.25: Accessibility of NHIF offices

Are NHIF offices located adequately for your reach?

From the research results (as illustrated above in Figure 25), 50.9% indicated that the offices are not located adequately for their reach, with 49.1% indicating that they were within their reach. Hence, there is need for the Fund to open offices within reach of many potential customers.

4.13 Insurance and Uncertainty

Under expected utility theory, the demand for insurance reflects individuals' risk aversion and demand for income certainty (Schoemaker 1982). Poor households are expected to become increasingly risk averse if they move closer to or further below the poverty line (Wagstaff 2000). At the time of insurance choice, consumers are uncertain whether they will be ill or not, and of the related financial consequences. Insurance reduces this uncertainty (Schneider, 2004). The certainty*allows the insured to reach a higher utility in

case of illness than those without insurance. Accordingly, the insurance demand reflects individuals' risk aversion and demand for certainty (Begg *et al.,* 2000).

Respondents were asked if they believed insurance could reduce uncertainty for themselves or their dependants when they fall sick. As shown in figure/table 26, 98% of the respondents responded in the affirmative, else ***2%*** of the respondents did not believe that insurance reduced uncertainty during sickness.

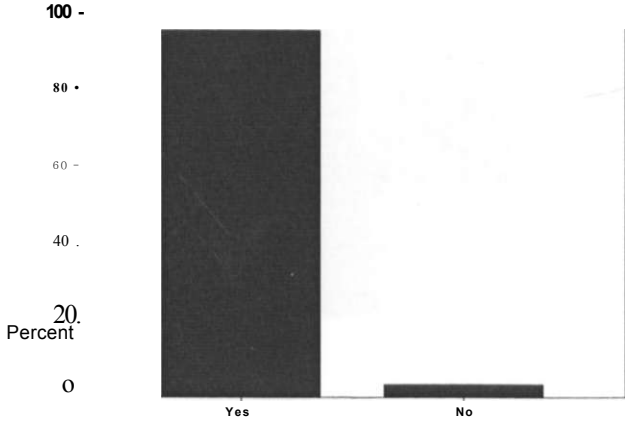
Fig.26: Do you believe insurance can reduce uncertainty if you or your dep idants happen to fall sick?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	58	98.2	982	98.2
	No	1	1.7	1.8	100.0
	Total	59	100	100-0	
Total		59	100.0		

Can insurance reduce uncertainty?

According to the expected utility theory, insurance demand reflects individuals' risk aversion (Begg *et al.*, 2000). However, Kirigia *et al.* (2005) have also pointed out that whether a household demands and is willing to buy insurance depends on the perceived difference between the level of expected utility with insurance and expected utility without insurance. On the other hand, the state-dependent theory contends that the anticipated need for medical care given the current state, and the magnitude of the related insurance pay-off in case of sickness will affect individuals' insurance demand (Phelps 1973). Manning and Marquis (1996), expounding on the state-dependent theory, showed that enrolment in insurance is affected by the expected pay-Qff individuals will receive when sick. However, the prospects theory posits that people insure from a gain (Schneider, 2004).

Fig.27: Can be sick and need NHIF



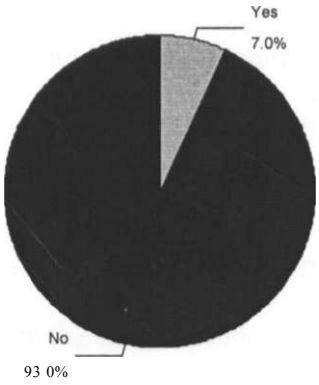
Do you believe you can be sick in future and need NHIF financing?

Asked if they believed they could be sick in future and need NHIF Financing for their medical treatment, their responses, as indicated in Figure 27 showed that almost all (97%) responded in the affirmative. Only 3% believed otherwise.

4.14 Current Health Status

Under state-dependent utility theory, consumers' utility level and tastes are influenced by their state, such as their health or socio-economic status and so people may have different degrees of risk aversion, which could influence their insurance decision and the magnitude of their expected insurance pay-off. Respondents were asked whether they or their dependants were suffering from any ailment whose cost of treatment has been high.

Fig.28: Suffering from an ailment?



Suffering from any ailment whose cost has been high?

From the assessment illustrated in figure 28, most respondents (93%) nor their dependants, were not suffering from an ailment whose cost of treatment was high requiring NHIF financing.

4.15 NHIF Membership

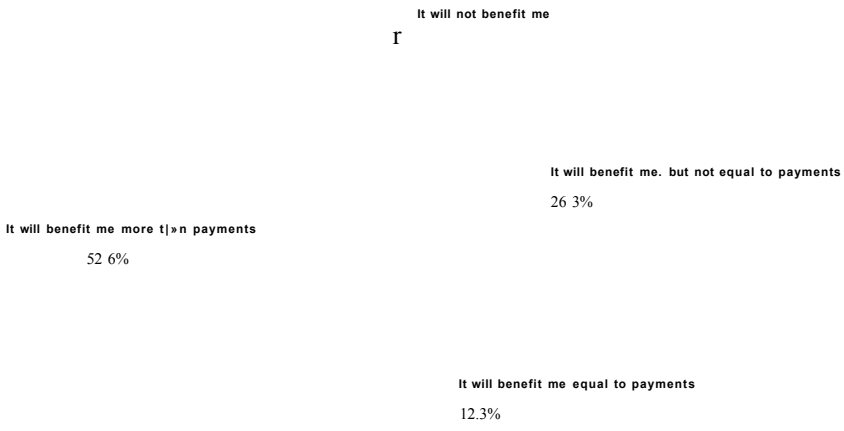
Platteau (1997) argues that people join insurance arrangements based on the principle of "balanced reciprocity'. This means that members expect a roughly equal return from their contribution or payment, rather than being guided by a 'true logic of mutual insurance' with winners and losers through income redistribution between 'lucky' and 'unlucky' individuals.

Responding on their belief regarding voluntary membership to the NHIF programme, specifically on whether it will benefiyhem regardless, or it will benefit but not equal to the

payments, or it will benefit them equal to their payments, or it will benefit them more than the premiums they pay, the respondents assessments were as shown in figure 29.

From the results, a majority of the respondents (53%) believe that the programme would benefit them more than the premiums they pay, 26% believe that the programme would benefit them but not equal to the premiums paid. However, 12% believed that the programme would help them equal to their payments, while 9% believed the programme would not benefit them. In tandem with the state-dependent utility theory, a healthy person

Fig.29: Belief on NHIF programme



How do believe you would you benefit from the NHIF programme?

might optimistically expect to remain healthy in the near future, which has implications on the insurance choice. The resulting insurance coverage may be below full loss coverage, if the anticipated insurance pay-off is below the real loss in case of illness. Hence, the anticipated need for medical care given the current state, and the magnitude of the related

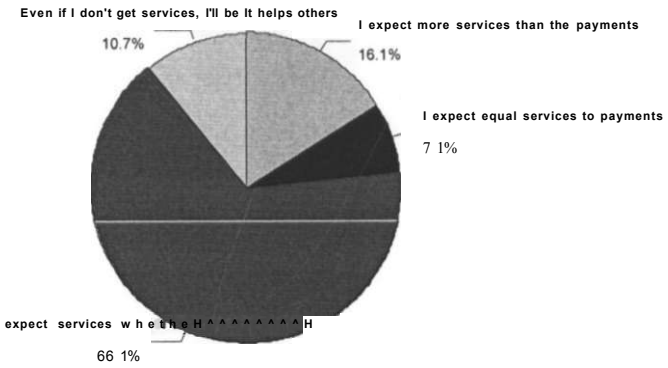
insurance pay-off in case of sickness will affect individuals' insurance demand (Phelps 1973).

4.16 Expectations from NHIF Voluntary Membership

Whether a household demands and is willing to buy insurance depends on the perceived difference between the level of expected utility with insurance and expected utility without insurance (Kirigia et al., 2005). Nevertheless, Jutting (2001) argues that if solidarity is strong, people may be less concerned whether the benefits of their contributions accrue to themselves or to other community members.

Regarding expectations if they are enrolled or will enrol in the NHIF voluntary membership programme, 66% indicated they expect services when they need them irrespective of

Fig.30: Expectations on enrolment



What are your expectations once enrolled in NHIF voluntary programme

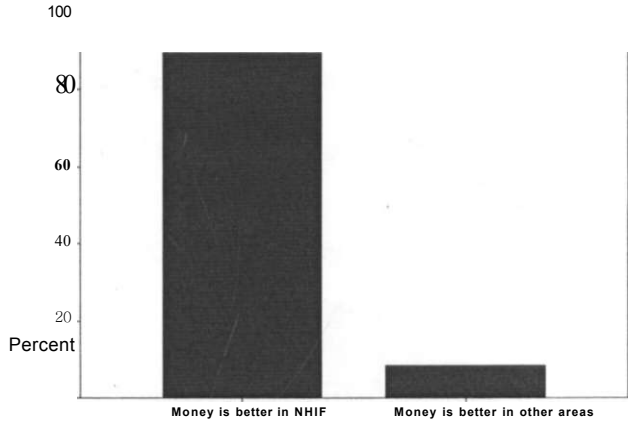
whether they are less or more than the cost they pay, 16% expect more services than the cost of the premium, 11% would be content in the knowledge that others have benefited from their contribution. Only 7% expected equal services to their premium payments. This somehow agrees with Platteau's observations (199^) that people join insurance arrangements based on the principle

of'balanced reciprocity'. This means that members expect a roughly equal return from their contribution or payment.

4.17 NHIF Services

The research also sought to establish respondents' beliefs on the utilization of their money vis-a-vis membership into the voluntary NHIF programme. They were asked to state whether their money was better utilized contributing into the NHIF voluntary programme or if it was better utilized in other areas other than NHIF.

Fig.31: Is your money better off in NHIF?



Money better utilized in NHIF or other areas?

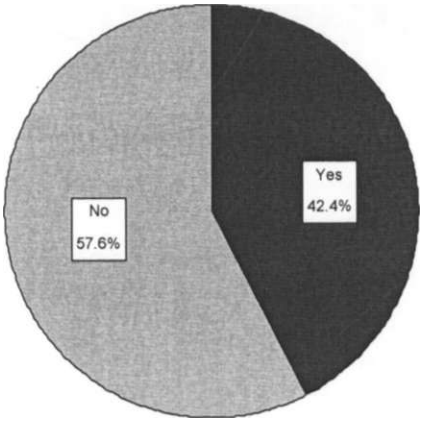
Ninety one percent (91%) of the respondents believed their money was better utilized in contributing into NHIF compared to only 9% who believed their money would be better utilized in other areas.

4.18 SHI and Other Self-help Groups

Issues to consider with regard to the poor include liquidity constraints and other behavioural constraints that cause them to remain uninsured even when they might be better off with insurance. They may rely on solidarity from family and friends to smooth out consumption and financial shocks related to ill health over time. This indicates that offering SHI to low-income groups might not improve access to health care, because there are other factors that cause them not to enrol (Schneider, 2004). Informal institutions such as group saving mechanisms usually constitute ex-post-risk management strategies that help to prevent or reduce catastrophic health expenditure (Mathauer, Schmidt & Wenyaa, 2007).

Respondents were asked to indicate if they belonged to any group-saving/self-help/community association/welfare groups. From the research results summarized in figure 32, 58% did not belong to other groups while 42% admitted to belonging to other social groups.

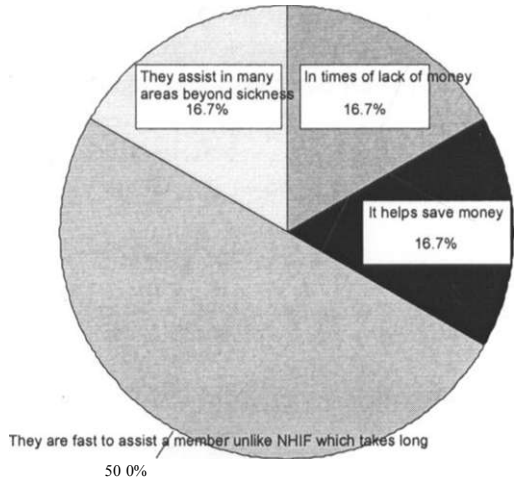
Fig.32: Membership in other groups



Do you belong to any other social group?

Asked if the groups served them better than the NHIF programme would, 72% indicated they didn't while 28% stated they did. When further asked to indicate in which areas they assist that NHIF cannot, those who believed the other social groups served them better had the following responses summarised in Figure 33: fifty percent (50%) stated that the groups were fast to assist a member unlike NHIF which takes long, 16.7% indicated that they assist in many more areas than just sickness financing, 16.7% posited that the social groups assist members in financial need which NHIF cant, while the remaining 16.7% stated that the social groups serve as tools for saving money.

Fig.33: What better services do the social groups offer?

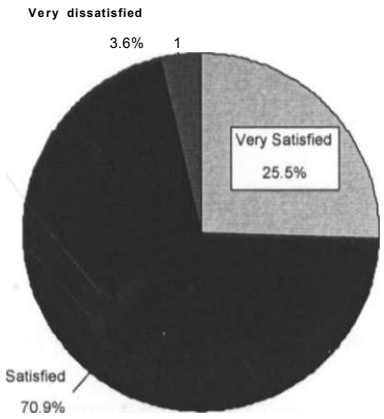


Advantages of social groups

4.19 Level of Satisfaction with NHIF

Most respondents (70.9%) indicated that, in view of the NHIF programme, they were satisfied with user fees as currently offered, 25%'were very satisfied while 3.6% were very dissatisfied.

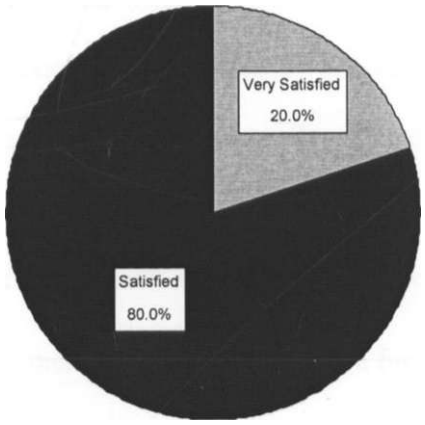
Fig.34: Level of satisfaction



Level of satisfaction with user fees

On the level of satisfaction with the private insurance for those who have, 80% were satisfied, 20% were very satisfied, and none was dissatisfied.

Fig.34: Satisfaction with private insurance



Level of satisfaction with private insurance.

With regard to the cost sharing arrangement in government hospitals and dispensaries, 82% of the respondents indicated they were satisfied, 14% were very satisfied while 4% were very dissatisfied.

4.20 Herbal Treatment

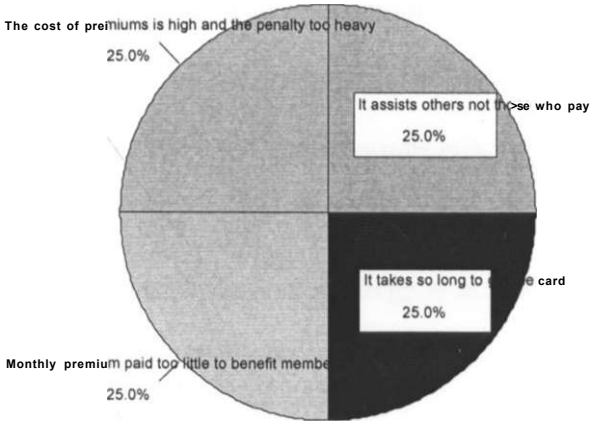
The availability and effectiveness of protection through alternative risk management institutions that cater for meeting people's health care needs and costs would also serve to decrease demand for health insurance (Mathauer, Schmidt & Wenyaa, 2007). Respondents were asked to indicate if they use herbal treatment. Ninety two percent (92%) responded in the negative, only 8% admitted to using herbal medicine. When those who use herbal medicine were asked to state their opinion on the efficacy of herbal medicine compared to traditional modern medicine, none of them responded.

4.21 NHIF Voluntary Membership Principles

Normand and Weber (1994) have argued that offering voluntary membership may entice certain members of the population to join, particularly those who are not presently covered by an insurance scheme and may be dissatisfied with existing quality of health services. The respondents were asked to state whether they agreed with NHIF voluntary membership programme principles. Ninety percent (90%) of them found it congruent although 10% did not find them so.

Those who did not find the voluntary membership agreeable were further asked to explain.

Fig.35: Disagreement with NHIF



Why NHIF programme is not suitable

As shown in figure 35, 25% of the respondents indicated that NHIF voluntary membership rationale was not good as it assist others, not those who pay the premiums, 25% indicated that it takes too long before one gets the NHIF card to enable them access NHIF services, 25% indicated that the cost of the premium was too high and the penalty when a member defaults too heavy. Interestingly, a further 25% indicated that the monthly premiums paid by members were too little to impact and benefit members.

4.22 Reasons for Insuring/not Insuring

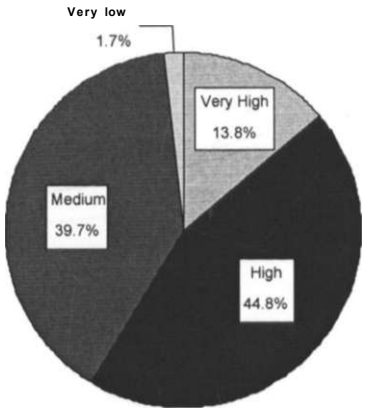
Respondents were asked to indicate if they are insured or not insured. Eight nine percent (89%) indicated they are insured; only 11% are not insured. Kirigia *et al.* (2005) have argued that whether a household demands and is willing to buy insurance depends on the perceived difference between the level of expected utility with insurance and expected utility without insurance. Some people may not buy insurance because they misperceive the risk or consequences of the decision, some because they are poor and others because the premiums are high relative to expected benefits

(Diamond, 1992). On why they are insured or not insured, 60.9% stated they were insured in order to handle emergencies, 18.3% to reduce costs of hospitalization, 2.2% because the insurance is cheap; high monthly premiums (4.3%), high costs and conditions of living (2.2%) and lack of information on insurance (2.2%) were cited as the reasons making those who were not insured not to. Thus, most of the respondents tend to go in line with the EU theory that insurance reduces uncertainty and reflects respondents' risk aversion (Begg *et al.* 2000).

4.23 Trust in NHIF Management

Lack of credibility and trust in fund managers may also negatively affect demand for health insurance (Schneider, 2004). On the question, what is your level of trust of NHIF management, 44.8% indicated it was high, 39.7% stated it was medium, 13.8% indicated it was very high, and only 1.7% stated it was very low. This is as shown in figure 36.

Fig. 36: Level of trust of NHIF management



Trust of NHIF management

4.24 Suggestions for Improvement

Respondents were asked to give suggestions of what they would like to be included in the NHIF voluntary membership programme. Sixty five point one percent (65.1%) indicated that they would wish outpatients to be included in the programme, 21.6% wanted a reduction in the monthly premiums, 12.9% want an increase in the number of dependants who benefit, and interestingly, 4.3% indicated that they would wish the monthly premiums to be increased.

On further suggestions they would wish to make to the NHIF management in order to improve services to them, respondents made the following recommendations: open more NHIF offices/increase efficiency in the issuance of cards/partner with more hospitals/let outpatients use the NHIF card (54.2%); increase the number of dependants who benefit (24.3%); lower default penalty/reach those in remote areas/enhance customer relations among NHIF staff (19.2%); and 2.3%.again interestingly, suggested that the monthly premiums be increased so that more benefits could accrue to members.

CHAPTER FIVE: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The major purpose of this study was to determine the factors influencing the uptake of social health insurance in the informal sector. The study also sought to determine the extent to which small scale traders at the City Park Market, Nairobi have taken health insurance and the perception of the traders regarding social health insurance with emphasis on NHIF. It further sought to determine the information level among the traders regarding the voluntary NHIF scheme for the informal sector as well as identify the reasons for the small scale traders being insured/uninsured in the NHIF.

5.2 Summary

Small scale traders at the City Park, Nairobi were the respondents in this study. The traders were drawn from all areas of the sector such as shoe-shining, food kiosks, general kiosks, cereals/fruits/vegetables and clothing/shoe trade. More males (double the number of women) are represented in this trade and most of the traders have up to ordinary level education. Most of them do not have professional qualifications and the larger proportion is aged below 40. At City park Market, many of the traders deal in clothes, shoes, cereals, fruits and vegetables.

A majority of the traders have not been in formal employment; however, among those who had been in formal employment, most had worked in only 1-3 organizations. Prior to the introduction of the NHIF voluntary programme, most of the traders had not taken health insurance but at the moment a majority have taken it. An overwhelming majority of the small scale traders also believe that insurance is desirable and are aware of the voluntary NHIF programme. Moreover, they

reckon that the cost of inpatient care in the country to be quite high and a majority have enrolled in the NHIF voluntary programme, with the few who had not enrolled mainly citing unaffordability. Some of the findings on the level of awareness of the small scale traders about NHIF products to the informal sector are: they are aware of the voluntary cover for the informal sector; they are aware that the monthly premium required to get coverage by NHIF is Ksh. 160: they are not aware that this monthly fee is the lowest by any insurance in the country; they are aware that all medical conditions are covered for members; they did not agree that it offered protection to the whole family of a member; they did not agree with the assertion that it covers both inpatient and outpatients - which in reality is only in principle but the practice is that NHIF covers only inpatients, and; they are aware that members or their dependants can be admitted, get treatment and be discharged without paying anything.

On the cost of the NHIF monthly premiums, most small scale traders find the monthly fee as fair and within their ability, but acknowledge that there are many in the business who cannot afford it. The reasons given for some not to be able to pay this fee were (in their order of merit): the high cost of living, the low daily incomes, the seasonal nature of their business, and lack of information. The traders are aware that the NHIF programme is meant to pool resources together in order to reduce the cost of health care, they also know that the OOP (out-of-pocket) payment in a hospital is lowered when insured, that the NHIF programme increases equity in the provision of health care by improving access to many and widening coverage. Majority of the traders find the hospitals partnering with NHIF accessible and the quality of their medical good. However, there is almost equal number of those who believe the NHIF offices are accessible enough to members as those who believe they are not adequately located for their reach.

Majority of the small scale traders believe that insurance can reduce uncertainty for themselves or their dependants when they fall sick. They also believe that they could be sick in future and need NHIF financing for their medical treatment. However, only a small number of them or their dependants were suffering from an ailment whose cost of treatment has been high. While a majority of the traders believe the voluntary NHIF programme will benefit them more than the premiums they pay, they expect services when they need them irrespective of whether they are less or more than the cost they pay. They further believe that their money is better utilized when contributing into the NHIF v imme.

eSs?"'*, Hr; -fffm

Although a majority of the traders stated they do not belong to other social groups, an almost equal number belong to them. Nevertheless, for many, the groups do not serve them better than NHIF. For those who believe the groups serve them better, the areas in which the groups were better than NHIF were: they were fast to assist members unlike NHIF which delays; they assist members financially, and; the groups also serve as tools for saving money. They were satisfied with user fees as currently offered in view of the NHIF programme. Those with private insurance were satisfied with them. The traders were also satisfied with the cost sharing arrangement in government hospitals and dispensaries. Despite the strong registration of its presence, most traders at City Market do not use herbal treatment and the few who admitted to using it did not state their opinions on the efficacy of the treatment over traditional modern medicine.

The traders are in agreement with the NHIF voluntary membership principles, but those who don't agree with them gave the following reasons for that stand: it assists others, not those who pay the premiums; it takes too long before one gets the NHIF card to enable them access NHIF services; the cost of the premium was too high and the penalty when a member defaults too heavy, and; the

monthly premiums paid were too little to impact and benefit members. The traders who are insured gave the following reasons for insuring: to handle emergencies; reduce costs of hospitalization, and; because the insurance is cheap. Those who had not insured cited the following: high monthly premiums; high costs and conditions of living, and; lack of information on insurance.

City park Market traders have trust in NHIF management, however, they wish outpatients to be included in the programme, a reduction in the monthly premiums, and an increase in the number of dependants who benefit. They also recommend that NHIF opens more offices, increases efficiency in the issuance of cards, partners with more hospitals, let outpatients use the NHIF card, increase the number of dependants who benefit, and lower default penalty reach those in remote areas, as well as enhance customer relations among NHIF staff.

5.3 Conclusions

Based on the results of data analysis and findings of the study, it can be concluded that:
First, the small scale traders at City Park market comprise mainly men and most of the traders have average education and aged below 40 years. The traders are engaged in different business but mainly clothing and shoes; cereals, fruits and vegetables; food and general kiosks and; shoe shining. Most of the traders have had no experience with formal employment and had no prior experience with social health insurance before the NHIF voluntary programme.

Second, City Park market traders are highly aware of the NHIF voluntary programme for the informal sector and have enrolled into it in tandem with NHIF's current mandate to enrol all population categories, from both formal and informal sectors (NHIF, 2008). They also understand that health insurance is desirable thus establishing congruency with the EU theory on risk aversion.

Under the EU theory, the more risk averse individuals are, the more insurance coverage they will buy (Begg et al. 2000). The high enrolment by the City Park market traders vindicates the theory. On the basis of the consumer theory, a price increase of a substitute for insurance - such as user fees - is expected to raise the insurance demand, as is a decrease in insurance premium (Schneider, 2004). A high cost of inpatient care can therefore result in increased demand for insurance. The traders know the cost of inpatient care in the country is high. Together with the EU theory, consumer theory could explain the high membership in NHIF when inpatient cost care is put into consideration.

Third, the traders do not believe that the NHIF premium charges are the lowest in the country, but they know that the Fund covers all medical conditions. They also don't believe that NHIF membership places no limit to the number of a beneficiary's dependants i.e. it offers protection to the whole family of a member. This could be explained by the fact the understanding of the traders of dependants is not merely what is constituted by the nuclear family. Dependants go beyond the definition given by NHIF. While NHIF set up to offer protection to both inpatients and outpatients (NHIF, 2008), in practice, the Fund offers only inpatient benefits. The traders are aware that the Fund does not provide cover for outpatients, but they acknowledge that with NHIF insurance they, or their dependants, could be admitted to some hospital, get treatment and be discharged without paying anything.

Fourth, the traders regard the cost of the NHIF premium at Ksh. 160 per month for the informal sector as fair and they are able to pay. However, they admitted that there are others within the sector that cannot pay the premium owing to the following reasons: the cost of living, the low daily incomes, the seasonal nature of their business, and lack of information. This agrees with Diamond's (1992) observation that some people may not buy insurance because they are poor.

Fifth, the small scale traders at City Park market know that NHIF's programme is meant to pool funds together with others in order to reduce the cost of health care for members, a position shared by Mathauer, Schmidt, & Wenyaa (2007) that social health insurance (SHI) combines risk pooling with mutual support by allocating services according to need and distributing financial burdens according to ability to pay. They are also aware that by enrolling in the NHIF programme for the informal sector, they lower the out of pocket price for medical care in line with Barr's (1992) statement that health insurance is a risk sharing mechanism that lowers the out-of-pocket (OOP) price for medical care at the time of purchase by smoothing medical payments across individuals and time. Further, the traders are aware that the NHIF programme increases equity in the provision of health care by improving access to many and widening coverage.

Sixth, the potential benefit of SHI is in informal sector workers having geographical access to health facilities that are accredited by a health insurance (Carrin, 2003), which .as established by the study, the City Park market traders indicated that the hospitals that NHIF has partnered with are accessible enough for them. They also believe the quality of medical services (treatment, drugs, x-rays, theatres etc.) in hospitals partnering with NHIF are good.

Seventh, NHIF offices are not located adequately enough for the reach of the traders. This can be a hindrance to the NHIF voluntary programme as individuals' insurance decisions may be affected by the access motive of insurance (Schneider, 2004).

Eighth, they believe insurance can reduce uncertainty for themselves or their dependants when they fall sick. This is harmonious with expected utility theory which posits that the demand for insurance reflects individuals' risk aversion and demand for income certainty (Schoemaker 1982), and that insurance rediites this uncertainty (Schneider, 2004). On the

other hand, they also believe they could fall sick in future and need NHIF Financing for their medical treatment. This again fits well the state-dependent theory, which states that enrolment in insurance is affected by the expected pay-off individuals will receive when sick and that people insure from a gain perspective (Schneider, 2004). Most traders and their dependants are not suffering from an ailment whose cost of treatment is high requiring NHIF Financing. On this issue, the traders' states and their large enrolment into NHIF is contrary to the contention by the state-dependent utility theory that consumers' utility level and tastes are influenced by their state, such as their health or socio-economic status and so people may have different degrees of risk aversion, which could influence their insurance decision and the magnitude of their expected insurance pay-off.

Ninth, the traders' belief regarding voluntary membership to the NHIF programme is that the programme would benefit them more than the premiums they pay. This matches well with the state-dependent utility theory that people insure from a gain perspective (Schneider, 2004) and with Platteau's (1997) argument that people join insurance arrangements based on the principle of'balanced reciprocity'. Moreover, there is strong solidarity among the traders as they expect services when they need them irrespective of whether they are less or more than the cost they pay, which is compatible with Jutting's (2001) position that if solidarity is strong, people may be less concerned whether the benefits of their contributions accrue to themselves or to other community members.

Tenth, the small scale traders at City Park market believe their money is better utilized in contributing into NHIF than in other areas, and most of them do not belong to group-savings, self-help groups, community associations oriwelfare groups. Those who belong to groups reckon that the groups do not serve them better than the NHIF programme. However, among those who

believe the groups serve them better cited the fact that the groups are fast to assist a member unlike NHIF which takes long, that they assist in many more areas than just financing sickness, that the social groups assist members in financial need which NHIF can't, and that the social groups serve as tools for saving money. Nevertheless, the traders are satisfied with NHIF programme in view of user fees as currently offered and the cost sharing arrangement in government hospitals and dispensaries. It is worth noting that the few traders with private insurances are satisfied with them. In addition, despite an increase in the usage of herbal treatment in recent years in the country, City Park market traders do not use herbal treatment.

Eleventh, the traders agree with NHIF voluntary membership programme principles, but the few who do not agree with NHIF voluntary membership rationale stated it was not good because it assists others, not those who pay the premiums; takes too long before one gets the NHIF card to enable them access NHIF services and; the cost of the premium is too high and the penalty on defaulting too heavy. The traders are insured and the reasons for their uptake of insurance are: to handle emergencies, to reduce costs of hospitalization, and because insurance is cheap. Those who are not insured cited high monthly premiums, high costs and conditions of living and lack of information on insurance. Thus, the traders' reasons are attuned to the EU theory that insurance reduces uncertainty and reflects respondents' risk aversion.

Lastly, the small scale traders at City Park market have trust in NHIF management; however, they recommend inclusion of outpatients into the programme, opening of more NHIF offices, and increased efficiency in the issuance of cards, partnership with more hospitals and an increase in the number of dependants who benefit.

5.4 Recommendations

Arising from the findings and conclusions of this study, the following recommendations should be considered by the NHIF so as to address identified problems:

a) In principle, NHIF purposes to cover both inpatient and outpatient medical conditions. However, in practice only inpatients are catered for. From the feedback from the members, there is high need to include outpatients in the cover.

b) NHIF offices are fewer than the members' need for services. It is recommended that more offices be opened to reach more clients. Moreover, issuance of NHIF cards - which s conditional for the Fund's services is wrought with inefficiency. Improvement in the speed with which the cards are processed as members' uptake of the insurance is based on their utilization especially in emergency cases as propounded by the EU theory.

c) Partnering with more hospitals would make the Fund's services available to most medical conditions and clients and increase proximity to many. It is therefore recommended that the Fund links with more hospitals in order to reach their many diverse members in the informal sector.

d) The penalty for defaulting to pay was found to be a deterrent to enrolment to the Fund and subsequent failure to benefit from the Fund's offering by the informal sector. It is recommended that this penalty be reduced.

e) The high cost of living has negatively impacted on a section of those in the informal sector who deserve to be members to a level of inability to pay the premiums. This is further worsened by the seasonal nature of their business, which may not guarantee availability of the monthly premiums on time. For some, their earnings are on a daily basis and too small to pay the total monthly requirement. Noting the special challenges faced by those in the informal sector, it is recommenfled that other means, that will involve close ties with NHIF staff be established through which the informal sector can make their payments. This

should be in addition to allowing the members to pay through the banks rather than limiting them to NHIF offices.

f) The number of dependants that qualify from a beneficiary as defined by the NHIF is limiting to those in the informal sector. This is owing to the traditional set up which includes more than just the nuclear family. For many in the sector, medical cover that takes care of a beneficiary's spouse and children but leaves out the parents is not inclusive enough. It is recommended that the parents of a beneficiary be included.

5.5 Suggestions for Further Research

The researcher recommends:

- A study to be carried out to determine the factors that influence the uptake of health insurance among those in rural areas.
- A study on the impact of user fees on the uptake of health insurance among those in the informal sector.
- The extent of awareness of the NHIF voluntary programme for the informal sector among rural people.
- The level of access to members and potential members of the hospitals partnering with the Fund in rural areas.

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APPENDICES

APPENDIX 1A: INTRODUCTION LETTER

University of Nairobi

Faculty of Arts, Department of Sociology

P.O.Box 30197

Nairobi.

TO RESPONDENT

Dear Sir/ Madam,

RE; A STUDY ON FACTORS INFLUENCING THE UPTAKE OF SOCIAL HEALTH INSURANCE IN THE INFORMAL SECTOR: THE CASE OF SMALL SCALE TRADERS AT CITY PARK MARKET, NAIROBI

I am a student at the University of Nairobi pursuing a Master of Arts in Medical Sociology. This research is part of the requirement of the course. You have been carefully selected to form part of this study. It is my humble request that you kindly spare some time to Fill the attached questionnaire as accurately as possible. The information you give will be used purely for academic purposes and all responses will be treated with confidentiality. A copy of the research report will be availed to you on request.

Yours faithfully,

Rukia N. Kanenje

APPENDIX IB: QUESTIONNAIRE

Please tick the appropriate response

PART A: PARTICIPANT'S PROFILE

1. Name (Optional)

2. Gender Male [ ] Female [ ]

3. What is your highest academic qualification

   a) Primary level [ ]

   b) Secondary level [ ]

   c) Higher secondary level ('A' level) [ ]

   d) University degree [ ]

   e) Postgraduate [ ]

4. Professional qualifications (if any) e.g. Journalism, CPA, Librarianship etc. [Please state level e.g. CPA 3]. . . . . ,

5. Age

   a) Below 30 years

   b) 30-40 years [ ]

   c) 40 - 50 years [ ]

   d) Above 50 years

PART B

6. What business are you engaged in? [Check *J* appropriately].

Clothing/Shoes	
Cereals/Fruits/Vegetables	
General Kiosk	
Food Kiosk	
Shoe Shining	

7. Before this job, had you been in any formal employment?

   Yes [ ] No [ ]

   If so, in how many organizations?

8. Have you ever had a health insurance cover? Yes [ ] No [ ]

9. Do you have a health insurance cover now? Yes [ ] No [ ]

10. Do you believe health insurance is desirable? Yes [ ] No [ ]

11. Are you aware of the voluntary NHIF social health insurance programme for those in the informal sector? Yes [ ] No [ ]

12. How would you rate the cost of inpatient care in the country?

    a)Very high [ ] b)High [ ] c)Moderate [ ] d) Very low [ ]

13. Have you taken up the NHIF cover? Yes [ ] No [ ]

    If not, why?

14. Please answer the following aspects of NHIF by ticking *[J]* what you know about the Fund. Are you aware that:

	Yes	No
NHIF offers coverage to workers in the informal sector?		
To be a beneficiary (a member), you only pay Ksh. 160 per month?		
These are the lowest charges for any insurance in the country?		
All medical conditions, including maternity, are covered?		
There is no limit to the number of dependants of a member i.e. offers protection to the whole family?		
The coverage includes both in-patient and out-patient?		
With NHIF insurance cover, you or your dependant can be admitted to some hospitals, get treatment and be discharged without paying anything?		

15. What is your opinion about the cost of NHIF premium at Ksh. 160 per month for the informal sector?

    a) Too low [ ]

    b) Fair [ ]

    c) High [ ]

    d) Too high [ ]

16. Are you able to meet this cost yourself? Yes [ ] No [ ]

17. Are there people in this sector who can not meet this cost? Yes [ ] No [ ]

    Please explain your answer

18. Do you know that?

	YES	**NO**
NHIF's programme is meant to pool your funds together with others in order to reduce the cost of health care for members your community?		
You lower the out of pocket price of medical care when you enroll in the programme?		
The programme increases equity in the provision of health care by improving access to many and widening coverage?		

19. Are the hospitals in which NHIF has partnered accessible enough for you?

Yes [ ] No [ ]

20. Do you believe the quality of medical services (treatment, drugs, x-rays, theatre etc.) in hospitals partnering with NHIF are good? Yes [ ] No [ ]

21. Are NHIF offices located adequately for your reach? Yes [ ] No [ ]

PART C

22. Do you believe insurance can reduce uncertainty if you or your dependants happen to fall sick?

Yes [ ] No [ ]

23. Do you believe you can be sick in future and need NHIF Financing of your medical treatment

Yes [ ] No [ ]

24. Are you or any of your dependants currently suffering from any ailment whose cost of treatment has been high? Yes [ ] No [ ]

25. Please state your belief regarding voluntary membership to the NHIF programme

a) It will not benefit me

b) It will benefit me, but not equal to my payments

c) It will benefit me equal to my payments

d) I will benefit more than the premiums I pay

26. What are your expectations if you have enrolled or will enroll in NHIF voluntary membership?

a) I expect more services than the cost of the premium [ ]

b) I expect equal services to the cost of the premium [ ]

c) I expect services when I will need them irrespective of whether the are less or more than the cost I pay [ ]

d) Even if I don't get any services, I will be contend in the knowledge others have benefited from my contribution [ ]

27. Do you believe? [Check *J* one]

a) Your money will be utilized better if)jou contribute into NHIF membership [ ]

or

b) Your money is better utilized in other areas now rather than contributing to NHIF membership [ ]

28. Do you belong to any group saving/self-help/community association/welfare groups? Yes [ ] No [ ]

29. If Yes to 7 above, do you believe the groups serve you better than the NHIF programme?

Yes [ ] No [ ]

If Yes, in which ways do the groups serve your interest better than NHIF programme. Please explain

30. Considering the NHIF programme, are you satisfied with following existing health services as currently offered?

	Very Satisfied	Satisfied	Very Dissatisfied
Are satisfied with user fee service for your health care?			
Are you satisfied with your private insurance (if any)?			
Are you satisfied with the cost-sharing arrangement in government hospitals and dispensaries?			

31. Do you use herbal medicine? Yes [ ] No [ ]

32. If Yes, what is your opinion on the efficacy of herbal treatment as compared to traditional modern hospital treatment

33. Do you agree with NHIF voluntary membership principles? Yes [ ] No [ ]

If not, why not?

34. Why are you insured/uninsured? Yes [ ] No [J

Please explain your answer

35. What is your level of trust of NHIF management?

a) Very high [ ] b) High [ ] c) Medium [ ] d) Very low [ ]

36. What would you like to be included in the NHIF voluntary membership programme?

37. What other suggestions would you wish to make to the management of NHIF in order to improve its services to you?

I WISH TO TAKE THIS OPPORTUNITY TO SINCERELY THANK YOU FOR YOUR COOPERATION