

**UNIVERSITY OF NAIROBI**

**SOCIAL HEALTH INSURANCE IN KENYA-  
PROSPECTS AND CHALLENGES TO  
IMPLEMENTATION**

**BY**

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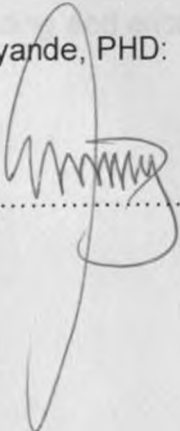
**DECLARATION**

I, Katherine Nthenya Malonza certify that this dissertation is my original work and that it has not been presented for the award of a Degree in any other University.

Signed.....*K Malonza*.....Date *23<sup>rd</sup> November, 2009*.....

This dissertation has been submitted for external examination with my approval as University Supervisor.

Prof. Peter Wanyande, PHD:

Signature..........Date *23/11/09*.....

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## **DEDICATION**

To my Mum, Agnes Mutanu Kisila.

Thank you for all that you are and all that I am.

Your gentle guidance has immeasurably influenced all that I have done and all that I will ever do.

## **ABSTRACT**

The purpose of this study is to analyse the feasibility and viability of social health insurance as a mode of financing healthcare. Social Health Insurance aims at protecting all population groups against financial risks due to illness.

This study addresses prospects and challenges to the implementation of the proposed NSHIF in Kenya. It examines Social Health Insurance, as a financing mechanism and as a means of social protection.

There are substantial difficulties in the implementation of social health insurance schemes and this study will highlight these and recommend solutions to counter them.

The study is informed by the Social Liberalism Theory also referred to as New Liberalism or Reform Liberalism. Social liberals believe that lack of economic opportunity, education and health care are threats to individual liberty.

The study examines the evolution of SHI from 19<sup>th</sup> Century Germany to the present day implementation of SHI in developing and transition countries.

The examination of Kenya's healthcare system traces the historical background and development of healthcare financing in Kenya, highlighting successes, shortcomings, and lessons learnt.

The research findings are analysed under the chapter on implementation of SHI, followed by conclusions.

## LIST OF ABBREVIATIONS

AKI	ASSOCIATION OF KENYA INSURERS
CHAK	CHRISTIAN HEALTH ASSOCIATION OF KENYA
CHFS	COMMUNITY HEALTH FUNDS
ERS	ECONOMIC RECOVERY STRATEGY
FKE	FEDERATION OF KENYA EMPLOYERS
GOK	GOVERNMENT OF KENYA
GTZ	DEUTSCHE GESSELLSCHAFT FUR TECHNISCHE ZUSAMMENARBEIT (GERMAN AGENCY FOR TECHNICAL COOPERATION)
HIV/AIDS	HUMAN IMMUNO DEFICIENCY VIRUS/ACQUIRED IMMUNE DEFICIENCY SYNDROME
HMOs	HEALTH MANAGEMENT ORGANISATIONS
KEPSA	KENYA PRIVATE SECTOR ALLIANCE
KMA	KENYA MEDICAL ASSOCIATION
KNUT	KENYA NATIONAL UNION OF TEACHERS
MDGs	MILLENNIUM DEVELOPMENT GOALS
MHIS	MICRO-INSURANCE PROJECTS
MIS	MANAGEMENT INFORMATION SYSTEM
MOH	MINISTRY OF HEALTH
MOMS	MINISTRY OF MEDICAL SERVICES
NHA	NATIONAL HEALTH ACCOUNTS
NHIF	NATIONAL HOSPITAL INSURANCE FUND
NHSSP	NATIONAL HEALTH SECTOR STRATEGIC PLAN

NNA	NATIONAL NURSES ASSOCIATION OF KENYA
NSHIF	NATIONAL SOCIAL HEALTH INSURANCE FUND
NSHIS	NATIONAL SOCIAL HEALTH INSURANCE SCHEME
NSSF	NATIONAL SOCIAL SECURITY FUND
OOP	OUT OF POCKET (EXPENDITURE)
PRSP	POVERTY REDUCTION STRATEGY PAPER
SAPS	STRUCTURAL ADJUSTMENT PROGRAMMES
SHI	SOCIAL HEALTH INSURANCE
SUS	SISTEMS UNITARIES DE SAUDE, BRAZIL
TNCHF	TANZANIA NETWORK OF COMMUNITY HEALTH FUNDS
WHO	WORLD HEALTH ORGANISATION

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## CHAPTER ONE

### INTRODUCTION

#### **Background to the Study**

This Chapter provides the background to the study, statement of the research problem, objectives and justification of the study, scope and limitation of the study, hypothesis, research methodology, literature review and theoretical framework.

Social Health Insurance (SHI) is one of the five main ways of financing health care. The others are direct payments by patients (user fees, informal payments and out of pocket spending); general taxation whereby the health system is funded by taxes such as the United Kingdom's National Health Service (NHS), private (commercial) health insurance which is for profit and is open for those who obtain insurance cover through payment of prescribed premiums; and community health insurance whose membership is drawn from the grassroots through community based initiatives such as the ones in Ghana. A country may have a mixture of several of these types, even if one may dominate. The mixture, a product of policy, history and the nature of society will have a major impact on the way healthcare is delivered in the country and on future healthcare policies.<sup>1</sup>

Social Health Insurance (SHI) is a method for financing and managing healthcare that is based on pooling of members' health risks, on the one hand, and pooling of contributions of enterprises, households and government on the other. This means that while

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<sup>1</sup> Social Health Insurance; A Quick Guide through the Key Issues htm, pl.

beneficiaries of SHI make contributions according to ability to pay, they access healthcare according to need. In order to realize successful pooling of contributions and risks, It is imperative that SHI be mandatory by Law. Generally, Social Health Insurance schemes define the health risks that will be covered. The benefits package should include at the minimum, those services, that in the absence of insurance, would entail a financial burden on households as a consequence of cost of treatment.

In Social Health Insurance schemes, contributions are set in such a way that predefined entitlements to health services (or health insurance benefits) are guaranteed to those who need care, irrespective of their individual health risk or socio-economic status. Contributions are paid to one or several health funds that are mandated to purchase health services for their members according to priority needs and other criteria such as cost-effectiveness. These health funds generally have some degree of autonomy from Government but operate within a framework of Government regulation.

In principle, Social Health Insurance involves compulsory membership involving the entire population. Every citizen and, at times, permanent resident becomes a member of a SHI scheme through enrolment and payment of either monthly or annual subscription or as may be deemed convenient to different socio-economic groups. In this way, Social Health Insurance steers clear of the pitfalls of health insurance that operates on a voluntary basis. It avoids the chance that certain population groups, such as the poorest and most vulnerable become excluded. Exclusions can however arise in a voluntary scheme due to lack of political interest in including vulnerable groups or because the

poorest simply do not have the capacity or will to pay the proposed health insurance contributions.

SHI in principle involves compulsory membership whereby all of a country's workers, self-employed enterprises and the government are required to make contributions into a social health insurance fund. The basis for workers' and enterprises contributions is usually the worker's salary and emoluments. The contributions of self-employed persons are either flat-rate or based on estimated income. Government may make contributions for those who otherwise would be unable to pay, such as unemployed people and low-income informal workers. SHI either owns its own provider networks, works with accredited public and private healthcare providers, or uses a combination of both. Within SHI, a number of functions such as registration, collection of contributions, contracting and reimbursement of providers may also be executed by parastatal or non-governmental institutions, often referred to as sickness funds.<sup>2</sup>

Universal coverage, that is, secure access to basic health care for all at an affordable price, is the ultimate objective of SHI. A well performing SHI scheme contributes not only to a greater fairness in financing and improved responsiveness, but also the final goal of better health for all the citizens and residents.

The World Health Organisation defines the purpose of health financing as follows: "the purpose of health financing is to make funding available, as well as to set the right

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<sup>2</sup> G Carrin & C James, *Social Health Insurance: Key Factors Affecting the Transition Towards Universal Coverage*, WHO Geneva 2004.

financial incentives for providers, to ensure that all individuals have access to effective public health and preventive health care.<sup>3</sup> A well performing SHI scheme, should have the following targets;

- i. To generate sufficient and sustainable resources for health
- ii. To use these resources optimally and give incentives to providers through appropriate use of these resources
- iii. To ensure that everyone has financial accessibility to health services

The WHO report 2000 notes seven distinct aspects of responsiveness of a health system. These are respect for the dignity of the persons, their desire for confidentiality and autonomy to participate in choices about their own health and client orientation in terms of prompt attention, amenities of adequate quality, access to social support networks and choice of provider.<sup>4</sup>

### **I. Respect for the dignity of persons**

A responsive health system focuses on ensuring that people access health services in an environment that is customer-oriented. This ranges from how patients are received at the health care providers' front office, to health workers handling them with courtesy and respect.

#### **ii. Desire for confidentiality**

It is imperative that health care personnel exercise professionalism and maintain confidentiality of medical records. This is because health issues are considered to be matters private between the patient and the health care personnel.

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<sup>3</sup> World Health Organisation (2000), World Health Report, Health Systems: Improving Performance (Geneva: WHO), <http://www.who.int/whr/2000/en/>

<sup>4</sup> Ibid p 23

### **iii. Autonomy**

A responsive health system is of necessity autonomous in its operations and functions. Autonomy from Government in administration and management ensures reduction of bureaucratic red tape in decision making, procurement of drugs and other essential supplies and even recruitment and retention of the right quality and quantity of health workers.

### **iv. Client orientation**

A client oriented health system is one whereby focus is on client or patient-friendly service delivery or benefit package in the case of health insurance.

### **v. Amenities of adequate quality**

A responsive health system has quality at its core. Here amenities include bed, food, pharmacy and sanitation which must be of internationally accepted standards of quality.

### **vi. Social Support networks**

The World Health Organisation considers social support networks to be an important aspect of a responsive health system. Social networks include community based initiatives such as self-help groups and welfare associations which contribute to the socio-economic well-being of the citizenry.

### **vii. Choice of provider**

A responsive health system assures those in need of health care services have a choice of where they can access services.

Financial contributions are considered fair when health expenditure is distributed according to ability to pay rather than to the risks of illness, and should ensure that

everyone is financially protected from this risk. These final goods of responsiveness and fairness in financial contribution also impact on the primary goal of health, as well as being important in their own right.<sup>5</sup>

A well-designed SHI scheme should be an effective way of realising the goal of equity in financial contribution, as SHI shares risks and acquires its funds according to ability to pay. SHI, as with any kind of health financing scheme, also impacts on both the distribution of resources and the overall health status of a population, by providing resources for health and defining how these resources are used.<sup>6</sup> Access to healthcare services depends on factors beyond health financing, such as the level of economic development and a number of socio economic and epidemiological characteristics. It cannot be overemphasized that health financing, of which SHI is one model, is a very critical aspect of the health system.

By 2004, twenty-seven countries worldwide had established the principle of universal coverage via this method, and several low and middle income countries are currently interested in extending their existing health insurance for specific groups, such as the poor and vulnerable, to eventually cover their entire populations.<sup>7</sup>

A question that remains unanswered in a majority of the world's countries is how their health financing systems can provide sufficient financial risk protection to all citizens

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<sup>5</sup> G Carrin and C James, Reaching universal coverage via social health insurance: key design features in the transition period. , WHO, Geneva 2004 p 18.

<sup>6</sup> Ibid p 19.

<sup>7</sup> G Carrin and C James: Reaching Universal Coverage via Social Health Insurance. Key Design Features in the Transition Period. WHO, Dept of Health Systems Financing and Resource Allocation, Geneva 2004.

against the costs of healthcare. The latter objective is critical to the aim of universal coverage, which is to secure access to adequate healthcare for all at an affordable cost. A crucial concept in health financing policy towards universal coverage is that of society risk pooling, whereby all individuals and households share the financing of total healthcare costs.

## **STATEMENT OF THE RESEARCH PROBLEM**

Less developed countries, particularly in Africa, have been faced with the challenge of providing access to equitable healthcare for their citizenry. African governments have tried to address the problem of access to healthcare through Government subsidies and even through cooperation with non-state actors such as faith-based organization (FBOs) and the private sector.

Health indicators have not markedly improved, consequently there are initiatives in a number of countries to introduce SHI schemes. The endeavour to reform healthcare financing and improve access to health services has informed the thinking that SHI is the way to go.

The focus of inquiry in this study was to answer the question; is Social Health Insurance the ultimate means of financing healthcare that will ensure universal access to healthcare in Kenya? What are the opportunities and challenges the country is likely to experience in its efforts to implement SHI? This is the problem the study sought to find answers to.

## **OBJECTIVE OF THE STUDY**

The general objective of the study is to provide insights on the suitability of Social Health Insurance as a means of financing healthcare in Kenya and as a means of ensuring equitable access to healthcare for all. The study's specific objective is to :

- i. Consider reforms in Kenya's health system and analyze the suitability and feasibility of SHI as a means of financing healthcare.
- ii. Examine the challenges of SHI as a health financing mechanism and prospects of achieving universal coverage through SHI.
- iii. Assess the interplay amongst the parties involved in the policy debate on SHI in Kenya and how their varied concerns can be addressed for successful implementation of SHI in the country.
- iv. Assess the viability of a voluntary SHI scheme in Kenya and the problem of adverse selection.

## **JUSTIFICATION OF THE STUDY**

At the United Nations Millennium Summit held in September 2000 in New York, USA, one hundred and forty-seven heads of state and government adopted eight development goals, known as the Millennium Development Goals (MDGs) that mark the beginning of a global partnership for development. They are; fighting extreme poverty and hunger, achieving universal primary education, promoting gender equality and empowering women, reducing child mortality, improving maternal health, combating serious diseases



like HIV/AIDS and malaria, ensuring environmental sustainability and forging global partnership for development.

That three out of the eight MDGs focus on issues of health, only underscores the fact that universal access to health care services is a most significant socio-economic issue for most countries. It is therefore important to understand the ways by which governments, especially in Africa can best achieve universal access to healthcare for their nationals. This understanding should form the basis of healthcare policy in Africa.

This study will be useful for policy makers in Africa, and Kenya to be specific, to assist them chart the way forward in reforms in the public health sector. The study will also generate literature and therefore serve as a useful reference for academics pursuing similar studies in Africa and elsewhere.

### **SCOPE AND LIMITATION OF THE STUDY**

The scope of the study is a consideration of prospects and challenges to the implementation of SHI in Kenya. The period 1990 to the present is the selected timeframe as it covers the time when user fees were introduced in public health facilities in Kenya ostensibly to supplement the Ministry of Health budget.

The study's main limitation was that the National Social Health Insurance Scheme has not yet been introduced in Kenya. This posed a challenge of measureability of successful implementation or otherwise of the same. Literature review that covers the experience in other countries has gone a long way in addressing this limitation. Several people were

interviewed and their responses comprehensively address prospects and challenges to implementation of SHI in Kenya.

The study was further limited by the clear *battle lines* which were drawn particularly at the height of the SHI debate in Kenya in 2004-2006, and which are revived each time the subject comes up. This saw the proponents of SHI on one side and the critics and strong opponents of the scheme on the other. This raised limitation with regard to objectivity on the subject. SHI is by its very essence a reformatory measure, and human beings have varied responses to change. The study captures the varying shades of opinion on implementation of SHI, with a view to presenting a balanced view of SHI in Kenya, and an objective picture on the way forward.

## **HYPOTHESIS**

Potential challenges to the successful implementation of SHI in Kenya provided the independent variable that affect successful implementation of SHI which is the dependent variable.

1. Political will shall facilitate successful implementation of SHI in Kenya.
2. Successful implementation will be determined by improvement and development of public health sector facilities to ensure equitable access to quality healthcare services.
3. Support from the private sector and stakeholders will contribute to successful implementation of SHI in Kenya.

## **RESEARCH METHODOLOGY**

The bulk of data for this research was obtained from relevant secondary sources such as textbooks, published and unpublished academic papers, journals, periodicals and relevant newspaper articles . Internet sources were also used.

Primary data was collected vide interviews with the Chief Economist, Ministry of Health, Kenya, who was instrumental in the formulation of the proposed National Social Health Insurance Scheme (NSHIS), and the then Minister for Health under whose docket the proposed NSHIS falls and who is conversant with the objectives of SHI. The General Manager, Quality Assurance & Standards and the General Manager Operations and Customer Service , at the National Hospital Insurance Fund (NHIF) were interviewed. The two oversee the key departments that would be critical to the successful implementation of SHI. This is because NHIF had been identified by Government as the vehicle that would be transformed into a national SHI.

GTZ's Technical Advisor on SHI and the Head of Healthcare Financing at the World Health Organization (WHO) in Geneva, Switzerland were interviewed as representatives of international institutions that provided technical assistance to the Government of Kenya on SHI. The Chairman of the Parliamentary Committee on Health, Social Welfare and Housing was interviewed as it is this committee that deals with issues of health. We also interviewed the Chairman of the Association of Kenya Insurers (AKI). This is the

body that represents private/commercial for-profit insurance and was at the forefront in the opposition to the introduction of SHI in Kenya. AKI can also be taken as representative of employers as it falls under the purview of the Federation of Kenya Employers (FKE). The interviews were rounded up with interviews of several retired public servants, informal sector workers and would-be beneficiaries of the proposed SHI scheme.

Primary data was obtained through a questionnaire comprised of open-ended questions. The limitation of this method of data collection are that responses present difficulties in data analysis. Notwithstanding this, closed questions were found inappropriate for this study.

Material for the study was gathered using a combination of methodological elements depending on the issues being investigated and the character of relevant subjects or respondents. The key elements were:

#### **Review of secondary data**

A review of secondary data was undertaken to furnish the study with models for SHI initiatives. This review focused on international, regional and local efforts.

#### **Interviews of key respondents**

Interviews with identified key informants was undertaken to clarify basic issues of the research and to source for information which was otherwise not readily available.

Individuals conversant with issues of governance from both the private and public sectors were interviewed. Of key importance were individuals heading institutions addressing healthcare services in Kenya.

### **Qualitative data Analysis**

The researcher sought to find out how the general statements on themes of the data were related. Data collected underwent processes of organization, clustering, interpreting and conclusion. Data was organized by selecting, simplifying and deduction from written field notes. This was to ensure that the data was manageable and comprehensive, and could be used to give preliminary conclusions. Analysis also included drawing conclusions and verifications where data irregularities, explanations and causal flaws were noted. Final conclusions were tested for plausibility and conformability.

The challenges to the veracity and validity of primary data in this study revolved around objectivity. The majority of persons interviewed have in their personal and official capacities played a significant role in the formulation of public healthcare policy in Kenya generally and with regard to SHI in particular. This in effect means that they hold definite views on the subject which facilitates analysis. On the upside, however, all the interviewees, including the would-be beneficiaries are representative of the broad spectrum of stakeholders critical to the successful implementation of a NSHI in Kenya. Their views are therefore invaluable to this study.

## THEORETICAL FRAMEWORK

Social liberals argue that government has a duty to intervene in society especially to aid the poor. This is done through pro-poor schemes such as SHI. SHI is premised on the doctrine of solidarity whereby the rich support the poor and the vulnerable, the young support the old, and the healthy support those who are sick. SHI schemes are funded in part through taxes, which social liberals perceive as taking wealth from some, especially the wealthy to assist the poor.

A well functioning SHI scheme involves cooperation among government and public sector institutions and the private sector. Social liberals emphasise this cooperation and collaboration rather than the threat or use of force.

SHI schemes and implementation thereof is potentially politically controversial, social liberals believe such controversy can be resolved through consensus building among stakeholders. Social liberals are proponents of state provision of public services. This is evidenced in social protection programmes such as SHI schemes, which are by and large government mandated and regulated.

In the late nineteenth century and early twentieth century in Britain, a group of thinkers known as the New Liberals made a case against *laissez-faire* classical liberalism and in favour of state intervention in social, economic and cultural life. The new liberals, who included T H Green (1836-1882) and L T Hobhouse (1864-1929), saw individual liberty

as something to be achievable only under favourable social circumstances. The poverty, squalor and ignorance in which most people lived made it impossible in their view for freedom and individuality to flourish. The new liberals believed that these conditions could only be ameliorated through collective action coordinated by a strong welfare-oriented state.

Social liberalism is very different from the ambiguous term *neo-liberalism*, a name given to various proponents of the free markets and also to some conservative opponents of free trade, such as mercantilistic conservatives, in the late 20<sup>th</sup> century's global economy.

Classical liberals like Fredrich August Von Hayek (1889-1992), and Robert Nozick(1938-2002) reflect social liberalism as false liberalism. Hayek was opposed to the concept that public institutions could be designed to meet human requirements and intentions. He preferred an almost *laissez-faire* approach in which public order evolved from specific ideas and actions. Thus he was opposed to the highly-centralised economics of the various shades of socialism, which denied the economics of the market place. Baroness Margaret Thatcher, Britain's longest serving Prime Minister in the 20<sup>th</sup> Century; was greatly influenced by Hayek's ideas of personal liberty and market economics, and based many of her government's conservative policies upon her interpretation of Hayek's concepts. Hayek's economic philosophy also helped to foster the global capitalism of the late 20<sup>th</sup> and early 21<sup>st</sup> Centuries.

For Nozick, all efforts to redistribute wealth, for instance, by taxing the rich for the sake of the poor; involve interference in the people's lives. Castigating the paternalism of the

welfare state, supporting the primacy of the individual, and defending Capitalism; he called for the most minimal of governments, one that would protect its members against violence, theft, and do very little more. For these authors, government has no duty to intervene in society to aid the disadvantaged as this means taking wealth from others (as taxes). They also consider that interfering in the market is destroying freedom and doing this to make people comfortable is self-contradictory.

The principle of Social Health Insurance is informed by the Social Liberalism Theory. Social liberalism is a political philosophy that emphasises mutual collaboration through liberal institutions, rather than the threat or use of force to solve political controversies. A well functioning SHI scheme involves cooperation among government and public sector institutions and the private sector.

Social liberalism as a branch of liberalism, contends that society must protect liberty and opportunity for all citizens and it advocates some restrictions on economic competition, such as anti-trust laws and price controls or wages such as minimum wage laws.

In social liberalism, the government is expected to provide a basic level of welfare supported by taxation, intended to enable the best use of the talents of the population for 'public good'.

Rejecting both radical capitalism and the revolutionary elements from the socialist school, social liberalism emphasises positive liberty, seeking to enhance the freedoms of



the poor and disadvantaged in society. Like all liberals, Social Liberalism believes in individual freedom as a central objective, but also believes that lack of economic strength as seen in many African states, Kenya included, can be just as damaging to liberty as can an oppressive State.

As a result, social liberals are generally the greatest defenders of human rights and civil liberties. They combine this with support for a mixed economy with an enabling state providing public services to ensure that people's social rights as well as their civil liberties are upheld.

Social liberals argue that government has a duty to intervene in society to aid the poor. This is done through pro-poor schemes such as SHI. SHI is premised on the doctrine of solidarity whereby the rich support the poor and the vulnerable, the young support the old, and the healthy support those who are sick. SHI schemes are funded in part through taxes, which social liberals perceive as taking wealth from some to assist others.

SHI schemes and their implementation thereof is potentially politically controversial. Social liberals believe such controversy can be resolved through consensus building among stakeholders. Social liberals are proponents of state provision of public services. This is evidenced in social protection programmes such as SHI schemes, which are by and large government mandated and regulated.

## LITERATURE REVIEW

### Definition of Social Health Insurance

Social health insurance is a relatively new concept in Africa. Relevant literature on the subject is therefore limited.

While there is no universally accepted definition of social health insurance, Kraushaar and Akumu (1993) outline some broad characteristics, which are generally agreed upon.

These are;

- Coverage is generally compulsory by law.
- Eligibility for benefits is derived from contributions made to the scheme, by members.
- The benefits for one individual are not usually directly related to contributions made by that individual but often those benefits aim to redistribute income between different income groups. This redistribution is usually from the more endowed to the less endowed .

The World Health Organisation in December 2004, urged all member countries to consider mechanisms for pooling financing for healthcare including Social Health Insurance in order to achieve universal coverage.<sup>8</sup> The principle of SHI is solidarity and risk pooling whereby members make contributions to the scheme and access benefits according to need or at the time illness occurs. Although SHI has not been implemented on a large scale globally the fact that WHO has called upon all member countries to

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<sup>8</sup> Pambazuka News – Weekly Forum for Social Justice in Africa.

consider it in order to achieve universal coverage, shows its importance as a healthcare financing mechanism.

Healthcare expenditure has risen drastically from 3 percent of world gross domestic product (GDP) in 1948 to 7.9 percent in 1997.<sup>9</sup> Prof Guy Carrin says however, this has certainly not been accompanied by an equally drastic improvement in universal coverage. 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 remains cumbersome and the subject of significant debate.<sup>10</sup> The majority of African countries, Kenya included, are low-income developing countries. These countries are confronted with the challenges Guy Carrin elucidates above.

Saltman and Van Otter see Social Health Insurance not simply as an insurance arrangement but rather as a 'way of life'. In this view, SHI is a key part of a broader structure of social security and income support that sits at the heart of civil society. As such, SHI helps define how "social order is established".<sup>11</sup> These writers are correct in their view that SHI is more a way of life than an insurance arrangement in the genre of commercial, for profit insurance. This is because SHI's success depends on societal

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<sup>9</sup> WHO, 2000 World Health Report 2000 - Health Systems: Improving Performance, Geneva, World Health Organisation, Geneva 2000.

<sup>10</sup> G Carrin; Social Health Insurance in Developing Countries: A Continuing Challenge, WHO Geneva, 2002, p1.

<sup>11</sup> R B Saltman and C Von Otter (eds), Implementing Planned Markets in Health Care: Balancing Social and Economic Responsibility, pp 45-64, Buckingham: Open University

support and consensus, thus making it a way of life . In defining how social order is established, SHI contributes to the realisation of equity in the provision of and access to healthcare. This is because all members/contributors access benefits which are not contingent upon the amount of contribution made to the SHI scheme. It is a part of the “fabric of society” supported by a “social consensus” that is deeply rooted in the balance of society as a whole”.<sup>12</sup> A central (and if not entirely correct) presumption is that financiers and providers are in the private sector. Thus crucially, the State is not seen to be the owner of these social security structures, but rather their guardian and administrator-their steward.<sup>13</sup> This is critical to the concept of ownership of the SHI schemes by members rather than by the state, but is only true to the extent that SHI schemes are generally state administered through legislative provisions and regulations.

In consequence, there is a firm belief that these health care systems are not artificial bureaucratic structures but rather “living entities”. To operate successfully, they require major commitments of energy and time by many parties involved, often on a voluntary basis. They also require a high level of trust among many actors leading to a conclusion that “certain non-written rules are essential”.<sup>14</sup> Issues of health insurance are essentially matters of life and death, and have to be handled in consideration of human sensitivities that come into play. This trust among government officials, fund administrators, contracted healthcare service providers and members; is critical to the success of SHI

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<sup>12</sup> C Le Pen Comment at Workshop, 5 October 2001

<sup>13</sup> R B Saltman and O Davis, (2000). The Concept of Stewardship in Health Policy, Bulletin of World Health Organisation, 78 (6): 732-9

<sup>14</sup> M Pfaff Comment at Workshop, Storkow, Germany, 6 October 2001

schemes. This applies to the Kenyan situation and is an issue that is addressed in this study.

Lessons learnt from the Kenyan experience will serve as a useful reference in other parts of Africa and the world at large. In Germany, for example, traditions and unwritten rules play a critical part in managing its SHI system.<sup>15</sup> These include the political tradition of solidarity which is ingrained in Germany, self-governance of the German SHI system, subsidiarity and decentralization. These traditions and unwritten rules have evolved over time to give the German SHI system its character and can serve as a lesson to other countries which are considering the option of SHI as a healthcare financing mechanism. However, it is instructive to note that each country's SHI scheme is bound to have unique features which are determined by socio-economic, and even political factors.

SHI reflects core values that are "socially embedded" in the very heart of how societies understand themselves. This organic view of SHI is an important reason why policy making in SHI systems must be cautious and incremental, why institutions once established are rarely uprooted, and consequently, why the overall pattern in SHI systems continues to be one of stability and resilience. This essentially means that policy on SHI schemes should be made in a carefully considered and phased manner. As a major policy shift in most countries, the foundation of SHI needs to be built on existing social networks in order to realize stability in the long run.

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<sup>15</sup> C Normand and R Brusse Social Health Insurance (SHI) Financing in E Mossalows, A Dixon, J Figueras and J Kutzin (eds) Funding Health Care: Options for Europe, pp 59-79, Boking Lane: Open University Press.

As Massalows *et al* argue in '*Funding Healthcare: Options for Europe*', it is useful to address the question of how sustainable economically, politically and socially, SHI is. Although proponents of SHI may not see SHI first and foremost as an economic system, the European experience shows that economic challenges to SHI arrangements appear at each level of the institutional structure. The central question is how to reduce the seemingly inherent structural tension between the socially embedded character of SHI systems on the one hand, and the specific practical requirements of efficient economics on the other.<sup>16</sup> It is easy for proponents of SHI to emphasise the social benefits of SHI systems, while downplaying its economic effects. Opponents of SHI argue that it is not economically feasible in the modern world and cannot be an efficient health financing mechanism. Yet SHI continues to feature prominently in deliberations at local and international fora on healthcare financing.

Questions have been asked in Kenya, whether SHI should not wait to be implemented when the economy stabilizes. However, lack of access to healthcare services for Kenyans particularly the majority of the population who live below the poverty line remains a formidable challenge to economic growth and development. In this regard, Kenya's immediate former Minister of Health holds the view that we cannot talk of economic revival in the country as long as a majority of our people are unable to access affordable services at all times.<sup>17</sup>

The emphasis here is on the interdependence between economic growth and healthcare indicators of the country.

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<sup>16</sup> R B Saltman, R Busse and J Figueras eds; *Social Health Insurance Systems in Western Europe*, McGraw-Hill, Open University Press, p 10,2002

<sup>17</sup> Ngilu promises return of disputed medical plan. *Daily Nation*, 2<sup>nd</sup> November 2006, p 52.

In a book entitled "Social Health Insurance Systems in Western Europe", it is argued that financial sustainability is at the top of concerns over SHI. National premiums must be kept at appropriately pocket friendly levels to the low income earners. The importance of the state in intervening to provide a remedy to funding problems is paramount. The future of SHI systems depends on the ability to operate efficiently. The degree of competitive forces to be incorporated within SHI systems and especially, on the funding side between different insurers is a major issue of concern with regard to sustainability. Market style funding mechanisms may be incorporated into SHI but without jeopardising the self-governing principles of a solidaristic system. This means that members contribute according to their ability to pay, and access benefits as need arises. Specific competitive incentives may be utilised to produce greater operating efficiency without shifting greater risks to vulnerable groups. Thus high standards and quality assurance must be maintained in an efficient scheme, while ensuring equity in contribution levels and access to services.

In Germany, "de-solidarisation" has begun to creep in around the edges of the German SHI system, where savvy entrepreneurs have exploited the time lag in the risk adjustment process to target younger and healthier subscribers. A successful SHI scheme must maintain the principles of solidarity and inclusiveness of the entire population irrespective of age, economic, health or social status. This is to ensure that there is a large pool of scheme members who contribute according to ability to pay, and access healthcare services according to need. Inclusiveness of the entire population also

mitigates against the effects of adverse selection whereby the most vulnerable and sick people register as members of a SHI scheme causing rapid depletion of the scheme's funds. The balance between low affordable premiums and operational efficiency is a delicate one, upon which successful implementation of SHI depends.

In Kenya, critics of SHI have said that the proponents of the proposed SHI scheme disregarded concerns of employers and the private hospitals making the scheme virtually impossible to implement.<sup>18</sup> These concerns centred around financial sustainability, in particular amount of premiums; and the controversial proposal that employers, government included make contributions to the scheme. Issues of sustainability must be considered in the light of encouraging competition among insurers while guaranteeing solidarity. The poor and vulnerable must not be exposed to more suffering. How this can be achieved whilst curbing adverse selection; will be explored in this study.

Whether or not it is possible to have equal ground rules between statutory and commercial competitors in a solidaristic health insurance system is critical to economic sustainability of SHI. What is required to make competition and solidarity compatible rather than anti-ethical operating models for funding healthcare will determine the sustainability of SHI.

SHI systems are premised first and foremost on a set of strongly held social values and beliefs. The 'non-economic benefits' of an SHI approach are understood by both citizens and policy-makers as equal to if not more important than the strictly economic benefits of

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<sup>18</sup> Ibid p 11



such systems. The government and key stakeholders must maintain a reasonable balance between social and economic advantages of SHI. A critical question for the future, however, concerns the degree to which the economic challenge threatens to erode the strength and scope of these core social values thus substantially reducing the ‘non-economic benefits’ of the SHI model. Such an imbalance could put the long-term survival of the entire model at risk. The core of SHI policy making should focus on transforming a socially successful but historically based model for a new, volatile and uncertain economic era.

### **The concept of solidarity in SHI schemes**

The concept of solidarity provides the core animating principle of SHI systems. Houterpen and Ter Meuler<sup>19</sup> view the individual as “embedded in social contexts” rather than as an independent agent, and thus solidarity is not a characteristic of particular individuals but instead reflects “a specific type of association among people”. Saltman *et al* are correct in their argument that solidarity in the health sector is sometimes presented as “operationalising social justice” that is, as putting physical flesh on the abstract philosophical belief that all individuals should be treated equally.<sup>20</sup> Indeed, this is in tandem with social liberals’ belief in human rights and civil liberties, and even social rights. High prevalence of poverty limits access to healthcare and other essential services, which according to social liberals inhibits the flourishing of freedom and individuality. Solidarity in this view grows organically out of the natural needs and behaviours of

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<sup>19</sup> R Houterpen and R Ter Meuler (eds) Special Issue: Solidarity in Health Care, *Health Care Analysis*, 8(4): 329–40, 2000.

<sup>20</sup> R B Saltman et al, *Social Health Insurance Systems in Western Europe*, Open University Press, 2004, p 27.

communities. It is not an artificial construction that is externally imposed by decree upon an individual or a community. It sits at the centre of the way of life of the social understanding of SHI systems.

Solidarity frames how citizens view health and social security concerns and it is at the very core of national policy-makers' thinking and of the policy judgements they make. Solidarity may be regarded as the engine that animates the pluralistic administrative structure of SHI systems. Solidarity is therefore not just a set of financial cross-subsidies but is a central element in transforming the technical administration of SHI from just a health insurance into a "way of life".

Scholars portend that solidarity amongst different segments of the population is critical to long-term stability of SHI. Whether the prior balance between social and economic pressures can be sustained in an era of economic regionalisation and globalisation presents one of the greatest challenges that policy makers will confront in considering how to implement SHI. The specific structure and organisation of a SHI scheme is grounded in the bedrock of social solidarity and social cohesion that reflects national culture and social preferences. Solidarity is seen as the touchstone of social insurance and is the core principle around which policy-making has (or is at least expected to) orient itself. An analysis of public healthcare policy in Kenya since independence with particular focus on SHI elucidates how policy makers and shapers have addressed SHI. Challenges and prospects of implementation of SHI will be considered in this study in light of the balance between social and economic pressures on SHI schemes.

## **Governance and self-regulation**

Issues of governance and self-regulation are critical to SHI systems. Plumptre and Graham described the 1990s as the decade of 'governance', political science and public policy. For an increasing range of public and social activities, traditional distinctions between government, the private sector and the non-profit sector, which had become quite well developed and accepted, were no longer adequate for either analysis or management. Governance has been defined as 'the art of steering societies and organisations'. A broader concept would hold that governance is the process whereby, within accepted traditions and institutional framework, interests are articulated by different sectors of society, decisions are taken and decision makers are held to account.<sup>21</sup>

In this view, governance is more a 'process than an institution. Thus, governance can be viewed as the process of accountable decision-making in society that interlinks the various sectors. The nature of governance will vary across different social endeavours. SHI can be expected to display unique characteristics of governance. SHI combines elements of civil society, institutional mechanisms for negotiation and decision-making among stakeholder groups and government regulation. Governance of SHI schemes in accordance with Plumptre and Graham's views will form the basis of the balance amongst stakeholders and government in Kenya and facilitate charting of a way forward for the country's public healthcare financing structure.

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<sup>21</sup> Plumptre and J Graham; *Governance in the New Millennium: Challenges for Canada*. Ottawa, Institute of Governance, 2000.

In SHI systems, focus is more on procedural rationality, reflected in aspects of corporatism, legislation and the role of the private sector. The stakeholders that are the subject of governance in SHI are many and varied. Employers (and their associations), employees (and their unions), insurers (both private not-for-profit and for profit) and providers come together to set the rules of the game regarding health insurance collectively.<sup>22</sup> Stakeholders must in essence operate in an environment mandated by government. The role of governments include bringing stakeholders together for structured negotiations, establishing public consensus and nurturing social solidarity. The management of the interactions between stakeholders in SHI systems contributes to the fabric of society. Governance in SHI systems goes beyond the 'make or buy' decision that has been emphasised by some.<sup>23</sup>

Writing on developing health insurance in transitional Asia, Ensor says that the capacity of governments to make health insurance compulsory is crucial for sustainability of a SHI system. Strong stewardship on the part of governments is therefore needed. European Governments have surely exemplified stewardship, although in perhaps different ways and in different periods of time. In Germany, Bismarck made a just move towards universal coverage with the 1883 Health Insurance Law, and built upon the experience of voluntary schemes. In earlier decades, politics have often played a role. For instance, it

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<sup>22</sup> B Saltman et al (eds), *Social Health Insurance Systems in Western Europe*, Open University, 2004, p 158.

<sup>23</sup> A Preker et al, *Make or buy Decisions in the Production of Healthcare Goods and Services: New Insights from Institutional Economics and Organisational Theory*. *Bulletin of the World Health Organisation*, 78(6), 779-90. <http://www.who.int> 2004.

is recognised that Bismarck used this law to counteract the political weight of workers and trade unions so as to strengthen the German state.<sup>24</sup>

SHI must be of necessity compulsory by law, otherwise it is left to the vagaries of adverse selection with the majority of members being the most vulnerable. Critics of SHI in Kenya argue that it should be voluntary and left to the operation of market forces. The politics surrounding social security and SHI in particular cannot be overemphasized, as this study demonstrates. The NARC manifesto refers to introduction of a National Social Health Insurance Scheme. Nearly two years after the NARC era and well into Hon Kibaki's second term in office, the scheme is yet to be implemented.

### **Universal Coverage through SHI**

Carrin and James state that a number of factors are judged crucial in facilitating universal coverage through a SHI scheme. These are; the level of income, the structure of the economy, the distribution of the population, the country's ability to administer SHI and the level of solidarity within a society. SHI development in a particular country to a large extent depends on that country's specific socio-economic and political context. Universal coverage, that is secure access to basic healthcare for all at an affordable cost, is the ultimate objective of SHI. A well performing and sustainable SHI scheme can contribute not only to a greater fairness in financing and improved responsiveness, but also the final goal of better health for the entire population.<sup>25</sup> The inter-mesticity of these factors in the

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<sup>24</sup> T Ensor, *Developing Health Insurance in Transitional Asia*, Social Science and Medicine, Vol 48, nr 7, pp 872-879, 1999.

<sup>25</sup> G Carrin and C James, *Reaching Universal Coverage Via Social Health Insurance. Key Design Features in the Transition Period* World Health Organisation, Geneva, 2004 p 42.

Kenyan scenario is the focus of this study, the aim being to assess how SHI can best be implemented, and if indeed it can promise improved access to healthcare in the country.

### **Health insurance in Africa**

Health insurance is a subject of major interest in Africa, because it includes the advantage of risk pooling and is seen as a way to increase the level of resources for health. Southern African countries such as South Africa and Zimbabwe have considerable experience with health insurance, although coverage has yet to be extended to the broad population. No country in Southern Africa has a health insurance scheme that provides national coverage.<sup>26</sup>

Zimbabwe's social health insurance was developed out of the existing private, industry and employer-based health insurance schemes, its ultimate goal is to expand and incorporate the entire population. A central organisation cooperating with local organisations is in charge of managing the scheme. For those in the informal sector, participation is compulsory. The informal sector participates voluntarily with payments timed for ease of payment.

In Ghana, there are a number of community-based health insurance schemes. The pioneer scheme of this kind in the country is the Nkoranza Community Financing Health Insurance Scheme. The scheme has served as an example for other community based schemes around the country.

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<sup>26</sup> Implementing Health Financing Reforms in Southern Africa- A Paper from an EDI Health Policy Seminar held in Johannesburg, South Africa, June 1996.

One of the major problems facing the health system in Rwanda is how to reconcile within a context of poverty, the objective of improving financial accessibility to healthcare and equity in the health system on the one hand, and the need to mobilize domestic resources for improving the financial viability of health services on the other hand. Hon Charity Ngilu, when she was in charge of the Health docket stated that alternative mechanisms for community funding based on anticipated payment and risk pooling, such as mutual health insurance initiated in Rwanda in 1999, have demonstrated their considerable potential to reconcile these two objectives. Establishing mutual health insurance across the country will ensure that Rwanda's population, especially rural communities and the informal sector have equitable access to quality healthcare services. Mutual health insurance which is community based health insurance, is intended to complete existing social and private health systems in Rwanda.<sup>27</sup>

The cases of South Africa, Zimbabwe, Ghana and Rwanda cited here, highlight the willingness of some governments in Africa to implement health insurance schemes. The need for risk pooling, social marketing, information and education campaign, information systems, self-financing, efficient administration and management cannot be gainsaid.<sup>28</sup>

For low-income African countries with GDP per capita of less than US\$1000 such as Zambia, it has been predicted that it will take 45 to 50 years before reaching universal coverage.<sup>29</sup> This is primarily because of poor health indicators caused by high poverty

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<sup>27</sup> Ministry of Health, Mutual Health Insurance Policy in Rwanda, December 2004, Kigali, Rwanda, p 3.

<sup>28</sup> M Sock & C Atemi; An External Evaluation of the Nkoranza Community Financing Health Insurance Scheme of Abt Associate Inc. March, 2000.

<sup>29</sup> G Carrin and C James, 2002; 'The Determinants of Universal Coverage: An Empirical Analysis'.

levels. Germany took basically a century to develop its SHI system. Its first *sickness* law was passed in 1883, covering about 10 percent of the population from the start.<sup>30</sup> The coverage rate proceeded to 35 percent in 1914 and 88 per cent currently. In the Republic of Korea (ROK), the compulsory health insurance programme was introduced in 1977, and universal coverage was achieved after a mere 12 years in 1989, a period marked by unprecedented economic growth. However the years 1977-89 were preceded by a voluntary programme period between 1965 and 1977.<sup>31</sup>

### **Health insurance in Europe**

In order to provide protection against financial effects of health risks, a few European countries at the end of the 19<sup>th</sup> century introduced health insurance systems for workers later followed by accident, old age, and disability insurance provisions (e.g. in Germany between 1883 and 1889). In developing countries, social insurance is still confined to a minority of the population for instance through contributions to pension and health insurance funds that are directly deducted from the pay. According to a World Bank study in 1987, at the end of the 1980s, only seven of 33 sub-Saharan African countries studied had a health insurance system. In these countries, the proportions of the population with health insurance ranged at that time from only 0.001% in Ethiopia to 11.4% in Kenya<sup>32</sup>.

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<sup>30</sup> P.A Kohler and H.F Zacher (eds), *The Evolution of Social Health Insurance 1981-1991*. New York, St Martin's Press.

<sup>31</sup> O R Moon; 'The Korean Health Insurance' Programme, in S Nityarumphong and A. Mills (eds). *Achieving Universal Coverage of Health Care*. Nontaburi Office of Health Reform, Ministry of Health, 1998 p

<sup>32</sup> *Social Exclusion and Access to Healthcare in developing Countries*-Novartis Foundation, 2004.



## SHI in Kenya

The National Health Accounts (NHA) 2001-2002 further brought out the need for an alternate financial mechanism for healthcare in Kenya. The NHA, a tool for health sector management and policy development, measures total public and private (including households) health expenditures. It tracks all expenditure flows across a health system and links the sources of funds to service providers and to ultimate use of funds. Thus NHA answers the questions: who pays, how much, for what?<sup>33</sup>

The objectives of The National Health Sector Strategic Plan (1999-2004) are inter alia to ensure equitable allocation of Government resources to reduce disparities in health resources and enhance the regulatory role of the Government in all aspects of health care provision.<sup>34</sup>

The key features of a national Social Health Insurance Scheme in Africa must of essence, factor in cost containment methods, design and new products, the impact of HIV/AIDS and related illnesses and the possibility of covering disabilities<sup>35</sup>Cost containment is critical in a continent where poverty levels are very high. While 60 percent of Kenya's population lives on less than a dollar a day, 30 percent of the population is what the World Bank describes as *hardcore poor*. Affordability and equity in access to healthcare services has to be considered if cost containment is to be achieved. There is no *one size fits all* design of a SHI scheme. A national SHI scheme must factor in the unique socio-

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<sup>33</sup> Kenya National Health Accounts, 2001-2002 p ix.

<sup>34</sup> Ministry of Health, National Health Strategic Plan (1999-2004) p 5.

<sup>35</sup> A Forbes, Actuarial Study of the National Hospital Insurance Fund-Kenya Final Report, 2004, p 3.

economic characteristics of a country, so as to ensure appropriate design and health care products that are responsive to the population's needs. The HIV/ AIDS pandemic is the biggest health challenge that Kenya faces today. It is imperative that a national SHI distinctly provides a benefit package for HIV/AIDS sufferers.

Kenya's health sector situation is not unique particularly in sub-Saharan Africa. While Social Health Insurance is not the panacea for the state of health care services in Kenya, it is an important component of healthcare financing. The Government must take a lead in improving infrastructure and providing preventive healthcare services to the population. Social health insurance must be contextualised in view of the many challenges less developed countries like Kenya face. It cannot be over emphasised that access to health care should be a Constitutional right.

The distribution of health care services in Kenya, as in most sub-Saharan countries is very unequal. The poor often have to make a choice between feeding their families or seeking medical treatment. "Maintenance and promotion of good health is one of the primary responsibilities of a modern state and cannot be left to market forces"<sup>36</sup> Anver Verse: writing in *African Business*, December 2004; said "Kenya's National Social Health Scheme is a bold and very necessary initiative. It is also a vital experiment in the African continent; it could be the beginning of a bright and healthy new era for Africa."

Literature perused and reviewed thus far clearly brings to the fore issues of applicability, sustenance, appropriateness and modes of implementation of SHI. Kenya has unique conditions that render universal access to healthcare a continuing challenge, yet

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<sup>36</sup> African Business, December 2004 p 33. Quoting Kenya's Minister for Health, Hon Charity Ngilu.

enhancing prospects for SHI. This is the subject of this study. This study endeavours to fill in the gaps and voids left by research done so far on Social Health Insurance in Africa in general, and in Kenya specifically.

An overview of literature on the subject of SHI shows that although rising costs and actual or feared lack of coverage have produced widespread calls for reform and an outpouring of specific proposals, no consensus has emerged on the character of reform in many states in Africa and Kenya in particular.

All major plans recognise that government compulsion is necessary to achieve universal coverage, although they differ on the form of compulsion and in the way they seek to control rising costs.

The study endeavours to fill the gaps in literature on social health insurance by considering whether SHI can credibly promise universal access to healthcare. The study does this by considering how those who are too poor can be subsidised and how those workers who earn too little can be catered for. The study endeavours to come up with proposals on how Kenya can provide *social safety nets* to assure that people in dire need of healthcare receive it, and if indeed these can be provided through SHI.

## **CHAPTER TWO**

### **THE EVOLUTION OF SOCIAL HEALTH INSURANCE**

Chapter One dealt with the background to the study, the principle and concept of SHI, statement of the research problem, objective, justification, scope and limitation of the study, hypothesis, literature review, and theoretical framework.

This Chapter will focus on the evolution of SHI from voluntary worker based co-operatives in Western Europe in the 19<sup>th</sup> century to the state-mandated legislative organs in contemporary Africa, Asia and elsewhere. The chapter will endeavour to bring out the variants in SHI globally and the unique features of each country's SHI system. The object of this being to show that SHI systems are indeed a product of policy, history and society.

The chapter also considers how governments have viewed their role in the provision of access to healthcare. The cultural core of social health insurance is deeply rooted in the societies which first spawned it. Germany is often considered to be the source of this approach to health insurance. It was the first European country to codify existing voluntary structures into mandatory state-supervised legislation in 1883. The history of SHI in Europe, however, as well as its arm-reaching principle of social solidarity, extends

considerably earlier than 1883 and more widely than Germany.<sup>37</sup> For the purpose of this study, 1883 Germany shall be considered as the base year as it is historically the date SHI can be first traced to.

### **Bismarck's Germany**

The modern era in SHI was ushered in by Prussian Chancellor Otto Von Bismarck in 1883. Worried about Marxist-influenced labour unions and consumed by his desire to build a powerful German state, Bismarck seized upon the idea of retaining independent occupation-based sick funds but placing their activities under state tutelage. The resulting legislation established both the legal and social foundations for sickness funds not just for Germany but for much of Western Europe as well.

Austria followed suit in 1887, and in 1892 the Danish government adopted a variant plan that gave subsidies to existing voluntary insurance funds so that those who were already ill would be admitted. Belgium adopted similar legislation, establishing state subsidies for sickness funds in 1884. In Switzerland, although an 1899 referendum to adopt the German-style model was rejected, a 1911 law required voluntary funds that accepted federal subsidies to register and abide by state-imposed regulations. In the United Kingdom, Lloyd George successfully passed a health insurance act in the same year.<sup>38</sup> After the conclusion of World War 1, France, confronted by existing health insurance in the re-acquired region of Alsace-Lorraine, passed a compulsory health insurance law in 1920 which was not implemented until ten years later.<sup>39</sup> The Netherlands was the last of

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<sup>37</sup> R B Saltman and H F W Dubois, *The Historical and Social Base of Social Health Insurance Systems in Western Europe*, Open University Press, 2004, p 19.

<sup>38</sup> *Ibid*, p 24

<sup>39</sup> Y Saint-Jouis, France in PAA Kohler and H F Zacher (eds), *The Evolution of Social Insurance 1881-1981*, pp 105, 119-20, Frances, Printer, 1983.

northern European countries to adopt compulsory health insurance in 1941 under German occupation when it passed legislation that was retained after World War II in 1945.

It is worthy of note that this period of state activity was characterized by rising rates of insurance coverage of the population. The legislation passed during this period not only established the principle of state supervision and regulation of sick funds, but also required certain segments of the population (typically various groups of workers) to obtain coverage hence the application of the term "compulsory". However, rates of coverage still fell substantially short of universal. Depending upon the country, a number of steps were required after 1945 to complete the process of covering all regular workers below a fixed income threshold, their dependants, and also the unemployed and pensioners. This process extended through 1996 in Switzerland. The governments of the European states cited here were primarily spurred by the endeavour to provide social safety nets for their citizenry, through ensuring access to healthcare services. Initiatives in national health insurance begun after the two world wars, as governments sought to mitigate the suffering of their peoples through social welfare programmes.

In the traditionally SHI heart of Western Europe-Austria, Belgium and Germany increasing government presence in national health insurance as has been witnessed in the United Kingdom, Denmark, Finland and France; is less apparent. Here there is still strong attachment to the SHI model, and regulation by government is typically exercised with caution. This is to say that SHI schemes are typically self-regulatory. The concept of solidarity provides the core animating principle of SHI systems. The long historical

evolution of solidarity in Europe parallels that of social insurance generally. Henrich's and Stone<sup>40</sup> argue that it is because of the political upheavals in Western Europe in the first half of the twentieth century that solidarity remains the dominant political principle that defines key elements of national and now European Union social policy. The understanding of solidarity as cooperation based on identification with a common cause is consistent with the German idealist philosophical understanding of the relationship between the individual and the society, that individuals obtain their freedom in and through the social group, making mutual relationships a 'precondition' for individual development.

Health systems around the world are currently under siege and many will be unsustainable in 15 years unless fundamental change occurs. The siege is attributed to financial constraints which then lead to poor infrastructure, shortage of healthcare workers, inadequate supply of drugs and other essential supplies. Africa and other developing regions of the world are under the greatest threat, being financially and technologically challenged while shouldering a disproportionately heavy burden in terms of diseases like Malaria and HIV/AIDS. Rising costs, diminished resources and growing demands are creating a crisis that is prompting healthcare policy makers around the world to seek urgent solutions often outside their own borders.

Global convergence is already changing the way countries think about health. Financing future demand for health services is crippling national health systems and economies.

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<sup>40</sup> K Henrichs, *The Impact of German Health Insurance Reforms on Redistribution and the Culture of Solidarity*, *Journal of Health Policy and Law* 20(3), p 653-88, 1995., D A Stone, 1995, *Commentary: The Durability of Social Capital*, *Journal of Health Politics, Policy and Law*, 20(3), p 689-94

Creating a sustainable health system, one that balances cost controls with the need to provide citizens with safe, quality care, will be not only a moral obligation but also a global economic imperative.<sup>41</sup>

The basic values and core principles of social health insurance systems are solidarity, plurality of function and organization, self-administration and co-determination; decentralization and subsidiary.

National health insurance systems in the continental-European mould can boast a tradition going back more than 100 years. In the intervening time, they have proved successful in other non-European countries and are now an important source of impulses, concepts and learning experiences for the endeavour to set up and structure health systems in developing countries. Social Health Insurance schemes are based on an understanding of health as a societal asset, which falls into a different category from typical market products. SHI schemes work on the assumption of an inter-individual, needs-based concept of fairness: people pay according to their means and receive services according to their needs. This differs fundamentally from the individualistic approach of managing social protection primarily by building up personal reserves, whereby it is considered unfair to use one person's contributions to cover another person's care.<sup>42</sup> Social health insurance schemes, in contrast, aim to overcome the exclusion of needy people. When properly structured, they also improve equal opportunities, fairness and customer satisfaction in the healthcare system.

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<sup>41</sup> Healing a sick world, Janine Prinsloo, *Business in Africa*, May 2006 p.72

<sup>42</sup> R Saltman; R Busse; E Mosslalus, *Regulating Entrepreneurial Behaviour in European Health Care Systems*. Open University Press, Buckingham, 2002.



Looking beyond the simple business economics, they can contribute to macroeconomic efficiency. With effective regulation, they also facilitate a constructive interplay of public interest and market mechanisms.

In many developing countries, there is growing criticism of traditionally hierarchical structures, where a top-level health ministry can determine the fates of all subordinate services and institutions. The ministries responsible for health are increasingly concentrating on their regulatory role, while the responsibilities for administrative procedures, funding and the organization of provision are being transferred to service providers and insurers. The resulting horizontal structure of health systems calls for stronger integration and participatory management. By their very structure, Social Health Insurance schemes are suitable means of delivering adequate responses to the growing complexity of funding and the provision of health care. SHI schemes achieve the foregoing through involvement of all stakeholders, that is government, health insurance funds, workers, employers, and health service providers. In the process, they are capable of achieving a high level of participation and democracy. They offer numerous approaches for interdisciplinary and multisectoral cooperation and for preventative and health promotion programmes.<sup>43</sup>

Jeffrey Sachs says that Africa's development crisis reflects the interactions of history, geography, domestic policy and geopolitics. These interactions have left Africa stuck in

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<sup>43</sup> M. Laaser, *The Institutionalisation of Public Health Training and the Health Sciences*, Public Health Reviews 30/14 pp 71-95

a poverty trap. Worse, as of the mid – 1990s, Africa has been careening headlong into an HIV/AIDS pandemic, one of the most ferocious contagions in history.

Western governments enforced draconian budget policies in Africa during the 1980's and 1990's. The IMF and World Bank virtually ran the economic policies of the debt-ridden continent, recommending regimens of budgetary belt tightening known technically as structural adjustment programs. These programs had little scientific merit and produced even fewer positive results. By the start of the twenty first century, Africa was poorer, (drought, diseases, population growth and environmental degradation) than during the late 1960s when the IMF and World Bank had first arrived on the African scene.

By the turn of the new millennium, sub-Saharan Africa's life expectancy stood at forty-seven years, more than two decades lower than in East Asia (Sixty-nine years) and thirty-one years lower than the average age in developed countries (Seventy-eight years). In parts of Africa, life expectancy has plummeted by almost twenty years as a result of the spread of AIDS. SHI provides opportunity for states in a continent that suffers the heavy burden of chronic disease exacerbated by poverty to progress towards universal access to healthcare for their citizens. This is because SHI presents a health care financing mechanism whereby people contribute according to their ability to pay, and access healthcare services according to need. Further SHI is based on the principle of solidarity whereby the healthy support the sick and the wealthy support the poor in terms of healthcare.

The WHO Commission on Macroeconomics and Health (CMH) in its December 2001 report, *Investing in Health for Economic Development*, noted *inter alia* that disease is a cause of poverty, a result of poverty and vice versa. That is to say that causation runs strongly in both directions. Poor health causes poverty and poverty contributes to poor health. The Commission identified eight areas that accounted for the vast proportion of the gap in disease burden in Africa; AIDS, Malaria, TB, diarrhoeal diseases, acute respiratory infection, vaccine- preventable disease, nutritional deficiencies, and unsafe child birth. Africa's problems are especially difficult but still solvable with practical and proven technologies. A combination of investments well attuned to local needs and conditions can enable African economies to break out of the poverty trap<sup>44</sup>.

Health is an essential human right, a societal asset and a necessity in order to work and earn income in developing and transition countries, ill health care is one of the risks most likely to result in poverty.<sup>45</sup> Hence, ensuring an adequate standard of healthcare and setting up insurance systems to provide coverage against the financial, social and health risks of sickness are core elements of social protection. Social health insurance is garnering increasing respect worldwide as a possible route towards sustainable financing, organization and administration of the health sector.

Developments in Europe and in other countries such as Japan, South Korea and Chile have shown that social health insurance schemes are capable of achieving pro-poor socio-economic growth and boosting human productivities. Social Health Insurance schemes

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<sup>44</sup> J. Sachs, *The End of Poverty*, Penguin Books, 2004, p. 204

<sup>45</sup> A Wagstaff and E Van Doorslaer, Catastrophe and impoverishment in paying for healthcare: with application to Vietnam 1993-1998. *Health Econ* 12(11), S 921-34

can also develop into a crystallization point for co-determination and transparency in a society. Experience has shown that social health insurance needs to be adopted in different forms depending on the context and needs.

The German approach of compulsory social insurance represents just one system among many, but has shown to be flexible and capable of adapting to different situations on several occasions in the course of its 120-year history. Advances in medical science and technology, an aging population and persistence of chronic – degenerative diseases are now confronting this model with major challenges in Germany and in other industrialized countries.

Employers and employees enrolled in compulsory contribution systems can only absorb rises in the costs of healthcare as long as these do not impact negatively on growth and employment. To set up systems on a sustainable basis from the outset, equitable and innovative financing structures are needed. Experience in Germany and the rest of Europe in the field of social protection cannot function as a blueprint but may contribute in a variety of ways to the establishment or reform of social security systems in Africa, Asia and Latin America.

Poverty and disease are indivisible and there are a variety of linkages between them. Worldwide, 1.3 billion people in developing and transition countries are without adequate and affordable access to health services. The problems are not confined to the poor health care provision often found in rural areas, or the inadequate quality of services in

many countries. A key issue is the high cost of obtaining medical services when income is barely enough to survive on, there is no money to spare for transport to hospital or to pay for treatment. At the same time, illness may result in incapacity to work and hence loss of income. Where there is no insurance protection, serious illnesses often leave entire families indebted and impoverished. They are forced to sell their meager possessions and ultimately the very basis of their livelihoods, in order to meet the costs of medical treatment. Thus, the poor population in developing countries is caught up in a vicious circle- the "illness poverty trap".

The health status of poor people is fundamentally worse than that of people belonging to higher social classes. All over the world, such disparities can be traced back largely to differences in income. Most major health problems are closely related to global inequalities and poor people in developing countries are disproportionately affected.<sup>46</sup>

Health in its own right and as the basis of the ability to work productively has clear implications for individual and family income but is also of wider importance. It is an essential prerequisite for a country's economic development and for the reduction of poverty. On the other hand, economic growth and productivity are keys to improving the population's health status.

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<sup>46</sup> Macro economics and Health Investing in health for economic developing. WHO Geneva  
[http:// www.cmhealth.org](http://www.cmhealth.org).2001

According to WHO and World Bank estimates raising life expectancy by 10%... *results in...* annual economic growth of 0.3 to 0.4. Growth in per-capita income in a developing country by 10%... *results in...* a 2 to 3.5 reduction in child mortality.

Although it is the poorest 84% of the world's people who bear 93% of the global burden of illness, this vast group benefits from only 11% of worldwide health expenditure<sup>47</sup>.

In the endeavor to achieve international development goals, social health insurance schemes have a substantial role to play; in many countries they are demonstrably helping to overcome the illness poverty trap, to improve the supply and quality of healthcare and to stimulate growth and good economic practice in the health sector. In the words of Zambia's Poverty Reduction Strategy Paper for example; "The wealth of poor people lies in their capabilities and their assets. Of these, health is the most important. Health allows poor people to work. A sick, weak, and disabled body is a liability both to the persons affected and to those who must support them. Thus, if health is an asset and ill health a liability, protecting and promoting health care is central to the entire process of poverty reduction and human development. In the recognition of the link between poverty and ill health, it is important to note that for Zambia, ill health is more likely to lead to further impoverishment amongst the poor than among the wealthy. For the country, meeting the health needs of the poor is an important means to prevent the increase of poverty as they suffer a heavier burden of disease."<sup>48</sup>

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<sup>47</sup> Rich-Poor Difference in health financing, A Preker, World Bank and International Labour Organisation, Washington DC 2002, p.143

<sup>48</sup> Zambia Ministry of Finance and National Planning 2002, p.83

Improving access to decent health services is a central concern of Social Health Insurance. The challenges are many times greater in developing countries than in countries, which are already industrialised. The problem is not just to enroll the whole of a small formal sector, but to provide social insurance for the needy in the event of ill health. However, on the evidence of numerous examples from Asia, Latin America and increasingly also Africa, setting up a functional health insurance system is a viable method of improving access to decent health care. This can be achieved within a reasonable time frame, increasing individual and collective prosperity and fighting poverty in the long term.<sup>52</sup>

Nevertheless, the expansion of an affordable health system must be accompanied by structural improvements in health infrastructure, education systems and conditions of production in developing countries. These in turn will have impacts on health over the longer term.

### **SHI in developing and transition countries**

The experience of Brazil, Chile, South Korea and Rwanda is considered here to bring to the fore the experience of various countries in their endeavour to achieve universal access to healthcare through national health insurance and SHI.

Contrasting the trend towards market-oriented systems on the Latin American subcontinent, the region's largest country Brazil, made an early start in setting up its Unified Health System (*Sistema Unitário de Saúde, SUS*). The Constitution of 1988,

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<sup>52</sup> R Holzmann and S Jorgensen; Social Risk Management | A new conceptual framework for Social protection and beyond. World Bank Social protection Discussion paper No.6., pp.6ff, Washington DC, 2000

which is still in force, establishes health care as a civil right and a public responsibility. On this basis, Brazil integrated the existing social insurance schemes into a new, tax-financed health service.

The SUS, organised on the Beveridge model, guarantees all citizens the right to appropriate medical care. The Beveridge model is named after William Beveridge, a social reformer who designed Britain's National Health Service. In this system, healthcare is provided and financed by the Government through tax payments.

The objective of the new health service was to overcome the great disparities in health service provision among different population groups and between urban and rural communities. The core elements of the Brazilian health reform are universality, equity of access, participation and integrated provision. In this federative republic, decentralisation is also an important principle: the states have a major influence on all health policy decisions, while the municipalities are responsible for health care provision and make a 15% contribution towards its funding<sup>49</sup>.

The remarkable feature of the Brazilian system is the combination of public financing, which at least theoretically guarantees universal coverage, with heterogeneous provision of health services including private provision on a significant scale. Whereas three-quarters of outpatient care takes place in public health centres and outpatient clinics, the majority of inpatient treatment under the SUS is provided in private hospitals and clinics. The separation of financing and service provision facilitates competition between service

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<sup>49</sup> LGiovanella and M Firpo; Health Insurance and the poor in low income countries, Johann Wolfgang Goethe University, Frankfurt, 2003 p.14, 18f



providers, which in principle can be expected to increase the efficiency of the system. But the great fragmentation of provision, and above all the predominance of user fees for services within the payment structure, creates harmful incentives and cost-inflating induction of demand.

Moreover, coexistence with private health insurance schemes, which sell additional insurance to the majority of the upper and middle classes, gives rise to considerable fairness and efficiency problems. Thus, in spite of the tax-financed state system, medicine remains a multi-tier system, particularly as SUS provision outside the major cities is extremely sketchy and inadequate. At the same time, service providers, who are often closely connected with insurance providers, tend to implicitly privilege private health insurance schemes by charging expensive services to the state scheme even if patients are insured privately, on the basis that all Brazilians are legally entitled to use the SUS.<sup>50</sup>

SHI in Brazil can be said to be working fairly well, considering it was introduced just two decades ago. The Brazilian model has all the prerequisites for a successful NSIS, although challenges of equity in access and affordability remain.

### **Chile**

The Government health service or National Health Service (NHS) covers the working class, the peasantry, the unemployed, the poor and a small fraction of the lowest-paid white collar workers ;a group that represents approximately 70 percent of the Chilean population. Voluntary insurance (SERMENA) covers the middle class which represents

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<sup>50</sup> Ibid p 20

approximately 22 percent of the Chilean people. Out of pocket (OOP) "market" medicine covers the bourgeoisie, approximately 8 percent of Chileans.

Not unexpectedly, expenditures per capita were for a long time lowest in the Government sector, higher in the insurance sector and even higher in the private sector. It is worthy of note that in 1925 it was written into the Chilean Constitution that healthcare is a human right and that the state has responsibility of guaranteeing healthcare for its citizens. The primary aim of the NHS was "to produce a healthy and productive labour force (Gaet and Castanon,1973:12),and the statutory law establishing the NHS actually states that a prime objective of the service is to guide the development of the child and the young and the maintenance of the adult for their full capacity as future and present producers."(Chilean Ministry of Public Health ,1950)

The Chilean health service has come to general attention as a market-based model since its reform in 1981. The introduction of private health insurance funds was intended to bring about worthwhile efficiency gains and help to overcome existing bottlenecks in provision and funding. Instead, in the more than two decades of its existence, the private health insurance market exhibited substantial shortcomings in terms of fairness and sustainability, and did remarkably little to advance the cause of universal social security. The debate finally shifted its focus towards the public sector, where major efficiency gains are being noted.

Today, Chile is one of the few countries in Latin America, which provides its population with universal protection against the risks of illness. This has been facilitated by a public

Social Health Insurance Fund, which combines a *Bismarckian* contributions system with tax-financed care as under the Beveridge model for those without income. Everyone in formal employment and some parts of the informal sector pay income-related contributions and receive comparatively broad insurance protection. The poor are likewise insured by the public health insurance fund, which receives substantial subsidies for this purpose from general taxation. Apart from certain conceptual differences and relatively high co-payments for contributory members, both solidarity-based parts of the system combined guarantee progressive financing and effective redistribution in the public financing of health. Various exemptions for the poor in the public health service alleviate the negative social consequences and discriminatory effects of co-payments in the event of ill health.

The Chilean experience reflects the experience of other countries, be they socialist or capitalist that when a political party or group is committed to a national health program intended to benefit the citizenry and to curtail the privileges of the health service providers, its chances of implementation are inversely related to the length of time required for implementation.

### **South Korea**

South Korea is one of the world's most rapidly industrializing countries. Along with industrialization has come universal health insurance. Within the span of 12 years, South Korea went from private voluntary health insurance to government-mandated universal coverage. Since 1997, with the intervention of the International Monetary Fund, Korean

national health insurance (NHI) has experienced deficits and disruption. However, there are lessons to be drawn for Kenya in her endeavour to achieve universal coverage.

South Korea achieved universal health insurance in 12 years. Most Western analysts were surprised. Many predicted Korean NHI would falter financially, but trends in financial receipts and disbursements from 1990 to 1995 showed no sign of financial instability. Everything went smoothly in both administration and financing in the first half of the 1990s. However, with the advent of the economic crisis of 1997 throughout southeast Asia, Korean NHI began to run a financial deficit. At the end of 1997, despite some Korean resistance, the International Monetary Fund (IMF) intervened in Korean financial affairs, causing a dramatic increase in the NHI's deficit, which then grew each year until 2002.

When the Government announced that NHI would separate reimbursement for pharmaceuticals from medical care in July of 2000 westernized medical practitioners closed their clinics and refused to treat patients. This policy of separating reimbursement for pharmaceuticals from medical care is regarded as the most significant factor in disrupting the financial structure of Korean NHI.

Before 1977, Korea had only voluntary health insurance. In 1977, President Park Chung-Hee and the legislature passed a law that mandated medical insurance for employees and their dependents in large firms with more than 500 employees. Gradually health insurance coverage was expanded to different groups in the society: in 1979 to government employees, private school teachers, and industrial workplaces with more than 300 employees , and in 1981 to industrial workplaces with more than 100

employees. In the late 1980s, health insurance expansion became regionally based, first to rural residents in 1988 and then to urban residents in 1989. Each of these expansions was mandated by Government.

According to the legislation, as in the Japanese model, the employer and the employee each paid half the premium. There was some Government subsidy, not for the beneficiary but for the operating budgets of "medical insurance societies." Premiums were determined by multiplying the standard monthly salary by the health insurance contribution rate, which ranged from 3% to 8% of wages.

Why did the Park government choose the medical insurance society as the administrative organ responsible for implementing NHI? What are the policy implications for the country of this choice? The issue of whether or not to have a decentralized medical insurance society-based administrative system has been a hotly debated policy issue in Korea. Several factors favored the choice of decentralized administration, implicit in the organization of medical insurance societies.

First, this was essentially the structure of the Japanese health insurance system. Second, the Park government considered the decentralized health insurance system as an intermediate step between a completely private voluntary health insurance system (e.g., health maintenance organizations) that would emphasize cost containment and a state-administered health insurance system (e.g., single-payer NHI) that might place substantial financial burdens on the state. Third, the bureaucratic machinery to administer an NHI system just did not exist within the Korean government in 1977, when President Park decided to mandate health insurance for large employers. Therefore, medical

insurance societies appeared to be the best vehicle for gradually extending health insurance to the whole nation.

Since 1977, when the Park government endorsed decentralized medical insurance societies, there has been a continual political and policy struggle between those favoring unification of the medical insurance societies under a national system and those opposed to unification, preferring decentralization without government regulation. This struggle has shaped the unique development of the Korean national health care system.

Four lessons can be learnt from the Korean experience with health care reform. The first centers on the question, "Is decentralization or unification more desirable for the initiation of an NHI program?" In Korea, neither of these two administrative systems has proven to be more efficient and effective than the other. Progressive policy experts and non-governmental organizations (NGOs) insist that unification is logically preferable. However, even in a small country such as Korea, there have been serious problems after unification.

The second lesson focuses on the newly recognized role of governmental policies in regulating the supply side of the market. Cost containment-centered government policies had worked effectively in Korea for 20 years until the IMF intervened in 1997. The Korean case shows that governmental cost containment in the absence of enhanced capacities for regulating the supply side of the market is no longer effective in controlling health care expenditures.

Korea's success in developing NHI over two decades can be attributed to this policy of tightened cost controls by Government. However, the Korean Government failed to

recognize the significance of the supply-side aspects of cost containment in maintaining the financial stability of NHI. The following examples of Government failure to regulate the supply side of the market have resulted in excessively high health care expenditures in (1) a laissez-faire approach to practices by medical specialists, (2) private sector-centered hospitals and clinics' overuse of high medical technology, and (3) multinational pharmaceutical enterprises' campaigns promoting the use of expensive antibiotics and other drugs. Without successful regulation on the supply side, little financial stability in health insurance is possible, whether the insurance is nationalized or private.

The third lesson emphasizes the balance of power between the state and civil society. The Korean experience demonstrates that in order to establish any public system such as an NHI program, the state must, first of all, transform the private-centered health care system into a public-centered one.

The last lesson stresses the role of Non state actors. Many Korean Non state actors, including progressive labor unions and health care-related professional organizations, aggressively called for government intervention in health care reform in response to the failure to regulate the supply side of the market. They asserted that market-driven health care reform in Korea weakened the financial structure of NHI. As Beauchamp argues in *Health Care Reform and the Battle for the Body Politic*, "the purpose of reform is not simply to solve the health care crisis, but also to reconstruct the disorganized public." Given the strong interest-group influence in South Korea's NHI, Non state actors and stakeholders outside Government remain the only sector that can empower the public to demand a financially stable national health program.

## Rwanda

Aiming at universal health coverage for its 9.5 million population, Rwanda has spearheaded the development of a number of schemes that together constitute its SHI system. The three most important ones are the Rwandaise d'assurance maladie (RAMA), the Medical Military Insurance (MMI) and the Mutuelles de Sante. The RAMA Social Health Insurance is compulsory for Government employees and voluntary for private sector employees. Its contribution rate is 15% of basic salary (shared equally between employees and employers). MMI covers all military personnel, who pay a contribution rate of 22.5% of basic salary (5% paid by employees and 17.5% by Government). Mutuelles de Sante are community-based health insurance schemes whose members are mainly rural dwellers and informal sector workers in both rural and urban areas. They make up the majority of the population. At the end of 2007 about 5.7 million Rwandans were covered by Mutuelles. Members usually contribute 1000 Rwandan Francs (1.85 US\$) per person per year which is matched by the Government and development partners.

An important innovation has been the launch and extension of the Mutuelles. Despite its voluntary character, the Mutuelles have benefited from a steady increase in membership. One of the principal factors of this success has been the collaboration among all stakeholders, and especially the financial support from government and development partners. Still, the Mutuelles face many challenges including making contributions more affordable to the poorest and improving financial management capacity of scheme administrators and managers.



In general, there is the challenge to further reduce the fragmentation in this SHI system, but overall progress is steady. Rwanda has developed a legal framework for governing Social Health Insurance and continues with its expansion. In particular, a recent law (April 2008) stipulates the future requirement of compulsory health insurance for every Rwandan.

The results of Rwanda's efforts in building up a SHI system can also be seen from the improvement in several health financing indicators, which include a greater availability of financial resources for health (34\$ per capita in 2007 vs. 13\$ in 1999), an increased coverage of the rural and informal sector population by the Mutuelles (from 1.2% in 1999 to 75.6% in 2007) , and a lower burden of out-of-pocket payments (from 24.7% of total health expenditure in 2000 to 15.9% in 2005 ).

The Rwandan experience shows that there is potential for SHI in Africa . This reflection is reinforced by the positive outcomes from the Social Health Insurance policies in Rwanda. However, generalization cannot be made of this assessment to the African region as a whole. Indeed a number of conditions for adequate implementation of SHI need to be satisfied. In terms of finances, with contributions from all stakeholders, sometimes including development partners, SHI can indeed be a vehicle for universal health coverage. The assumption here, however, is that countries' overall income level and income growth are sufficient, enabling households, enterprises and Government to make contributions commensurate to their legal obligations. Sustained financial support from development partners would strengthen the revenue base of the SHI schemes.

Furthermore, sustained efforts would be needed to build new SHI-related organizations and reinforce administrative capacities to manage them. Crucially, progress with implementation will depend on political consensus and effective collaboration between stakeholders. In particular, accepting a minimum degree of solidarity involving pooling of contributions and risks from all groups in society is a must .

Quite a number of possible paths exist with mixes of SHI, tax-based funding, community-based and private health insurance. Each country has to decide what is most optimal in its own context. Should SHI be adopted, there is no doubt that implementation will be accompanied by various challenges of a political, organizational and financial nature. These should not discourage countries, however. A perfect road to universal health coverage does not exist. In fact, international experience shows that the development of SHI in the now high-income countries was far from smooth. In the meantime, the experience of countries such as Rwanda is noteworthy and promising.

## CHAPTER THREE

### HEALTH CARE SYSTEM IN KENYA

Chapter two traced the evolution of social health insurance from Bismarck's 1883 Germany to its introduction in developing countries such as Rwanda and Chile. This chapter will delve into a situation analysis on Kenya's public health sector from pre-colonial times to the present but with particular focus on the period 1990-2005 which is the scope of this study. The chapter will analyse the various policy papers that have addressed public health sector reform. Policy papers that specifically address SHI will be considered.

In pre-colonial Kenya, long before the advent of the Missionaries; traditional health practitioners administered healthcare to the citizenry. These traditional health practitioners preserved and passed on knowledge of the treatment of various types of diseases to each generation. (Ndirangu Simon, A history of Nursing in Kenya, p.5). In 1898 the Church of Scotland Mission set up a medical station in Kikuyu. This station developed to the PCEA Thogoto Mission hospital which is today regionally renowned for specialized eye care treatment. In 1901 with the Government's growing interest in the health needs of Africans, a Department of Health was created as one of the civil departments of the Central Administration. In 1903 healthcare providers were requested by the colonial Government to preserve the health of European community, to keep the African and Asian labour force in good health and to prevent the spread of tropical diseases like Malaria.

The period 1901-1920 saw the British develop more interest in Africans' health. In 1923 the Public Health Ordinance was enacted. The Ordinance's objective was the provision of preventive health services. After World War Two, faced with the health needs of a population that was reeling from the devastating effects of War, Britain launched its National health System (NHS). In the same year the colonialists set up a Ministry of Health in Kenya and appointed a senior officer to head the Ministry at Cabinet level

At independence Kenya's health system was divided into the three colonial racial divisions of African, Asian and Arab and European. The divisions were however abolished by the new Government. During colonial times there was a standing Kshs.5 fees for all races at healthcare facilities inclusive of in-patient care regardless of number of days admitted. This fee remained in force after Independence when Kenya *inherited* a three-tier health system in which the central Government provided health services at District, Provincial and National levels. Missionaries provided services at sub-district level, and the local Government provided services in urban areas, (Chris Rakuom, Chief Nursing Officer, Ministry of Medical Services, Kenya in an Interview on 9<sup>th</sup> November, 2009).

It is worthy of note that in 1965, the Government waived the Kshs 5.00 charged to every person who attends a health facility in the line with the pronouncement of Sessional Paper No. 10 on African Socialism and its Application to Planning in Kenya. The Sessional Paper states that "the best of Kenya's African social heritage and colonial

economic legacy must be reorganized and mobilized for a concerted , carefully planned attack on poverty, disease and the lack of education in order to achieve social justice, human dignity and economic welfare for all.” According to the Sessional Paper, the aim of the Government was to provide medical and hospital services to all Kenyans; particularly the poor and destitute (African Socialism and its Application to Planning in Kenya, Republic of Kenya,1965 pps.1, 30,31).In Sessional Paper Number 10 the Government of Kenya outlined its plans to provide welfare on a large scale through a National Provident Fund and National Health Insurance among other mechanisms.

In 1970, failure by Local Authorities to offer satisfactory health services in conformity with Sessional Paper No. 10 led to the transfer of Health Centres and Dispensaries from Local Authorities to Central Government. However, no budgetary allocation was made to cater for these extra costs. In the same year, the Government made Health Centers the focal points for comprehensive provision of preventative, promotive and curative health services in rural areas and turned them over to local councils to manage them. With the Government’s free healthcare occasioned by the scrapping of the Kshs 5 fee, Kenyans were unwilling to pay for healthcare, the local councils were thus unable to sustain health services; and Kenya’s health system begun its decline. In 1972 central Government took over the management of all health facilities and staff. Without a corresponding increase in budgetary allocation from the Treasury, the Ministry of Health suffered the financial and infrastructural burden that subsequent policy reform sought to address.

On attaining independence in 1963, the Government of Kenya (GOK) committed itself to providing 'free' health care services as part of its development strategy to alleviate poverty and improve the welfare and productivity of the nation. However, in the 1980s the government felt it was no longer able to provide unlimited free health care. Lack of adequate resources for the health sector was identified as a major problem. The resource gap, with severe impact on the financing for the health sector was a result of various factors key among these are the rise in the population which caused an increase in the demand for preventive and curative healthcare services. Further, constraints on the resources available which was evidenced by fiscal constraints on Government and Non-governmental organisations involved in healthcare provision. Out of pocket (OOP) expenditure by individuals was also constrained by inflationary trends and the rise in the cost of living .

Complex epidemiological and demographical profiles is another key factor. Statistical data on births, death, income and the incidence of disease illustrates the changing structure of Kenya's population during the 1980s. Incidence, distribution and possible control of disease and other factors relating to health proved complex. Economic pressures and subsequent implementation of structural adjustment programmes (SAPs) Economic growth was at a decline and the implementation of SAPs only exacerbated the socio-economic conditions in Kenya.

The objective of the World Bank's structural adjustment programs (SAPS) was to address structural weaknesses in the economy. The dictates of SAPS called on workers and peasants to tighten their belts and contribute to their own development-euphemisms which meant digging deep into their pockets to survive. SAPS involved cuts in health

expenditure by the Government of Kenya, which negatively affected the provision of health services through charging “user fees” at health facilities . (Immanuel Ness, Ed. The International Encyclopaedia of Revolution and Protest, 2009) .

SAPS significantly made access to healthcare become more of a challenge in Kenya. Donor fatigue closely followed the SAPS. All in all, donor support for development projects and the budget begun to decline, and can best be described as donor fatigue. This meant that donor funds for health care sector were no longer forthcoming. This served to further reduce resources to the healthcare sector in the country.

It was imperative that some health care financing policy measures had to be instituted to address the problem of financial constraints in the health system and the attendant challenge of limited access to healthcare. In 1989, the Government of Kenya introduced cost sharing in an endeavour to meet the cost of maintaining healthcare facilities which it had failed to renovate over the years, due to severe budgetary constraints and declining support from donors. User fees were temporarily suspended by an Executive Order in 1990, but reintroduced in 1992 and are still in force today.

The Government of Kenya’s (GOK) policy of cost-sharing was ostensibly to bridge the gap between actual budgets and the level of resources needed to fund public health sector activities. Revenue from the cost-sharing programme has continued to grow in absolute terms, and as a percentage of the recurrent government budget. In 2003/4 cost sharing contributed over 8% of the recurrent government budget of the then Ministry of Health (MOH). The MOH has since changed its cost-sharing policy and replaced it with the

10/20 policy. This policy basically involves payment of Kshs.10 or 20 at public health facilities by those seeking healthcare. The 10/20 policy has not had the expected impact of increased use of healthcare services due to high levels of poverty in the country.. Further, the policy has caused reduction in MOH revenue as cost sharing in whatever form inhibits health seeking behaviour of those who are unable to pay for health care.

No country has limitless financial resources to expend on health, thus, while arguing for an increased share of funding for health, the Ministry of Health expenditure as a share of the total budget stands at about 8% a figure well below the Abuja Declaration target of 15%), a major focus has to be on obtaining maximum returns on health for the available resources .

Healthcare services are delivered to the 33 million people in Kenya through a network of 15,400 healthcare facilities. These facilities include an estimated 400 hospitals, 5000 primary healthcare facilities and over 10,000 private clinics. 60% of healthcare facilities are owned by the Government while the remaining 40% are run by NGOs, Faith based organizations and the private sector.

In terms of the overall health insurance budget. Kenya spends 5.1% of its gross domestic product (GDP) on health. This is comparable to other countries in sub-Saharan Africa, which average 5.7% but well below the high-income Organisation for Economic Development and Cooperation (OECD) countries average of 9.8%. Kenya's per capita spending on healthcare is Kshs.1,506 (US\$19).<sup>51</sup> These figures show that spending on health in Africa is inadequate when compared with developed countries. In the year

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<sup>51</sup> Kenya National Health Accounts 2002.



2000, there were 4,355 health institutions in Kenya, which increased to 4,557 in 2003. In 2004, the number of these institutions stood at 4,767.<sup>52</sup> In the rural areas, only 25 percent of the population has access to health facilities within eight kilometers from their home. The ratio of practising medical doctors to the population is disproportionately inequitable at 1:33,000 compared to 1:1,700 in urban areas.<sup>53</sup> These indicators illustrate the state of healthcare services in Kenya and demonstrate the urgent need for radical reform if universal access is to be realised.

Health service provision by the private sector is well developed in Kenya and accounts for a substantial share of overall provision of health care. Private sector health services are mainly concentrated in the urban areas essentially providing curative services. Pharmacies/chemists are responsible for substantial distribution of pharmaceutical goods, which are mainly paid for by households out-of-pocket spending. Commercial health insurance is increasingly available, but only a small proportion of the population is covered because of cost. Large employers provide medical benefit schemes to their workers. Kenya operates the National Hospital Insurance Fund (NHIF), which provides health insurance coverage.<sup>57</sup> The National Hospital Insurance Fund was established through an Act of Parliament in 1966, making Kenya the first country in Africa to introduce compulsory health insurance. However, it is limited primarily to workers, employees and their dependents who comprise no more than 20% of the

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<sup>52</sup> Kenya Facts and Figures 2005 Edition, Central Bureau of Statistics, Nairobi, Kenya, p 12.

<sup>53</sup> Kenya Development Cooperation Report 2004, United Nations Development Program (UNDP), June 2005, p 9.

<sup>57</sup> Ministry of Health, Household Health Expenditure Utilization Survey Report 2003, p 3-4

population.(Hsiao, W C; Shaw P R; and Fraker A; Social Health Insurance for developing countries, World Bank,2006)

Kenya's Poverty Reduction Strategy Paper (PRSP) 2001-2004 states that the high cost of healthcare in the country is one of the leading causes of poverty. The PRSP recognizes good health as a prerequisite for the socio-economic development of the country. The performance of the health sector in Kenya is affected by high cost of healthcare contributing to poor access, declining standards, increased re-emergence of diseases like tuberculosis, high cost of drugs and inadequate funding.

By 2001, households out of pocket expenditure (OOP) accounted for 53.1% of the total cost of healthcare in the country with the remainder being tax-financed by the exchequer through budgetary allocation to the Ministry responsible for health. OOP essentially refers to direct payments for healthcare services for those in need. OOP expenditure is largely untenable in a country with high poverty levels such as Kenya. Government expenditure on health amounted to 21.4%; expenditure by the National Hospital Insurance Fund 3.9% pre paid private plans (such as commercial insurance) 3.6%; firms and employer paid medical services 16.4%, NGOS and non-profit institutions 1.6%.<sup>58</sup> Thus, in the current healthcare financing system, private financing dominates 74.7% of total health expenditure. The high level of out of OOP financing of healthcare which includes cost sharing is an important concern as it is likely to sustain and/or exacerbate poverty among Kenyan households.

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<sup>58</sup> Ministry of Health, 2003 and National Health Accounts (WHO/NHA unit, 25.5.03).

In view of the fact that almost 60% of Kenya's population lives below the poverty line, there is need to reduce the healthcare expenditure of households. Reducing healthcare burden of households thereby ensuring equity and access to all Kenyans and increasing service utilization patterns will move health expenditure in the direction of patterns in many developed countries. This can be realized through drastic reform in public health care financing and SHI presents viable prospects of achieving the foregoing.

The ideal situation should be a position where the Government, through a National Social Health Insurance scheme and tax-financed Ministry of Health expenditure, carries 75% of the national health expenditure burden while private health expenditure is reduced to 25%. The National Social Health Insurance Strategy<sup>59</sup> suggests that this can be done by converting the cost-sharing scheme in public health facilities into a social health insurance scheme.

In November 2001, the first National Congress on Quality Empowerment in Health Medical Research and Traditional Medicine was held. At the opening ceremony, the President of the Republic of Kenya directed the Minister responsible for Health to take necessary action that would lead to the establishment of a mandatory national social health insurance scheme (NSIS) for all Kenyans. Delegates were urged to discuss the feasibility of a mandatory NSIS, which would facilitate all Kenyans to have equitable access to quality healthcare. The delegates adopted a resolution calling on the Government to include in the Constitution of Kenya the following statement: "The right to health shall be a fundamental right and ... the Constitution protects the right of every

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<sup>59</sup> National Social Health Insurance Strategy, Ministry of Health 2003, p.3.

Kenyan to have access to quality healthcare”. This is yet to be enshrined in the Constitution and decent healthcare remains beyond the means of the poorest people in Kenya. The delegates resolved that the implementation of the Constitutional provision be through the establishment of a mandatory national Social Health Insurance Scheme. The recommendations of the Congress were approved by Cabinet in January 2002 paving way for further policy formulation with regard to the proposed NSIS. The Economic Recovery Strategy for Wealth and Employment Creation, 2007 (ERS) states that the government will set up a “special health care endowment fund to target vulnerable groups, such as the aged and disabled.”<sup>60</sup>

The second National Health Sector Strategic Plan 2005-2010 (NHSSP II) intends to reverse the decline in the health status of Kenyans. The vision of the sector is an efficient, high quality healthcare system that is accessible, equitable and affordable for every Kenyan household. The sector’s mission is to promote and participate in the provision of integrated and high quality curative, preventive, promotive and rehabilitative health care services for all Kenyans. The design of the plan is envisaged to contribute to the accomplishment of Kenya’s Economic Recovery strategy (ERS) and the achievement of the Millennium Development Goals (MDGs). The NHSSP states that its main goals are to reduce inequalities in healthcare and reverse the trend in health related impact and outcome indicators. Improvement of the financing of the health sector is a key policy objective of the NHSSP II.<sup>65</sup>

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<sup>60</sup> Ministry of Health, National Social Health Insurance Strategy. February 2003

<sup>65</sup> Ministry of Health, Health Sector Reform Secretariat, The Second National Health Sector Strategic Plan NHSSP II 2005-2010 p. xi.

The NHSSP II was formulated ostensibly with the aim of reversing the downward trends in health indicators observed during the implementation of the first strategic plan (NHSSP 1999-2004), applying the lessons learnt and searching for innovative solutions to the problem of access to healthcare. It is intended that NHSSP will reinvigorate the Kenya Health Policy Framework elaborated in 1994 which underlined the need to pursue the principles of primary healthcare in improving the health status of the Kenyan population.

Evaluation of NHSSP I brings reveals the fact that it did not manage to make a breakthrough in terms of transforming the critical health sector interventions and operations towards meeting the most significant targets and indicators of health and socio-economic development as expected by the plan. The shortcomings of NHSSP I may be attributed to the following mostly inter-related factors. Absence of a legislative framework to support decentralization which is critical for effective delivery of healthcare services. Lack of well articulated, prioritized and costed implementation strategies. Inadequate consultations amongst the Ministry of Health and key stakeholders involved in the provision of health care services such as Faith Based and private for profit health care providers . Lack of institutional coordination and ownership of the strategic plan leading to inadequate monitoring of activities. Weak management systems, occasioned by poor institutional framework, low personnel morale at all levels occasioned by poor remuneration, poor working conditions and inadequate communication regarding the NHSSP I strategy. Inadequate funding and low level of

resource accountability which have plagued implementation of public sector policies in general.

Efforts made during NHSSP I did not contribute to the improved health status of Kenyans. Rather, health indicators showed a downward trend with increases in infant and child mortality rate and declining use of health services. The decline in doctor population ratio during the 1990s compared to the 1980s and stagnated funding from the exchequer to healthcare (from US\$ 12 per person in 1990 to US\$ 6 per person in 2002) was noted.

The contribution of all actors involved in promotion, maintenance and/or restoration of health is necessary if the NHSSP II is to achieve its objectives and not simply become another well articulated, public sector reform policy. These actors include the public sector represented by the ministries of Medical Services and Public Health and other government institutions, the private health sector, traditional healers, individuals, households and development partners.

The NHSSP II states that the challenges in implementing the waivers and exemptions system are in large part due to administrative inefficiencies and reduce income even further. The fact that the cost-sharing programme has become a barrier to health service utilization by the poor has caused the Government to put in place an alternative financing mechanism for the health sector. To this end, the government plans to implement the National Social Health Insurance Fund (NSHIF) in what the NHSSP II refers to as "*the coming years*" to ensure that basic health services are equitably available to all Kenyans.

While the NHSSP II covers the years 2005-2010, it is noteworthy that although the plan underscores the government's plans to implement the NSHIS it does not expressly state when this will be done.

The Economic Recovery for Wealth and Employment Creation 2003-2007 (ERS) says that the achievement of good health is critical in enhancing human development. Improving health conditions reduces production losses caused by worker illness, increases the enrolment of children in school and increases learning ability.<sup>67</sup> The ERS sets out several measures the Government will take to meet the objectives of the health sector to improve affordability and access, particularly for the poor. These measures include enactment of legislation converting the National Hospital Insurance Fund into a National Social Health Insurance Fund that will cover both in-patient and out-patient medical needs, sharing of costs between the exchequer, employers and employees, informal sector and other productive segments of society.<sup>68</sup> The NHSSP II is an integral part of the ERS from which it is derived. The ERS policy as it relates to the health sector includes focus on investments to benefit the poor. This is intended to be done through reallocation of resources towards promotive, preventive and basic health services. The ERS also envisaged increase in GOK funding of the health sector from the 2003 level of 5.6% of total public expenditure to 12% by the end of the ERS period in 2007.

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<sup>67</sup> Government of Kenya, Economic Recovery Strategy for wealth and Employment creation, June, 2003, p 40

<sup>68</sup> Ibid p. 5

If the regulatory and supervisory role of the ministries responsible for health is reinforced through expansion of geographical and financial access to services, commitment to health as a human right, improvement in resource allocation targeting underserved and poor areas, the intention of NHSSP II to reverse the decline in the health status of Kenyans will have been realized.



## **CHAPTER FOUR**

### **IMPLEMENTATION OF SOCIAL HEALTH INSURANCE**

Chapter Three presented a historical perspective of Kenya's health system and a situation analysis of health sector financing in Kenya. Government endeavours to address the issue of access to healthcare services from Independence to the present were considered in the light of the policies promulgated in this regard.

This chapter will address challenges to and opportunities for implementation of SHI in Kenya as well as highlight research findings.

It is instructive to consider at this point how the policy on SHI was formulated in Kenya, from the National Social Health Insurance Strategy, to the National Social health Insurance Fund Bill, 2004.

In May 2002, the Minister for Public Health established and launched an Inter sectoral Task Force to prepare a national strategy paper on SHI in Kenya and a draft Bill. This was expected to lead to the establishment of a National Social Health Insurance Scheme in Kenya. In order to understand the problems in the delivery of health care services in Kenya the Task Force studied and analysed documents on key policies relevant to health care. These included the Poverty Reduction Strategy Paper 2001-2004 and the National Health Sector Strategic Plan (NHSSP I) 1999-2004. The Task Force rightly observed that

whereas lack of access to healthcare in the country is one of the leading causes of poverty, the objectives set out in NHSSP I had not been achieved as anticipated. For example, equitable allocation of government resources to reduce disparities in healthcare provision had not been effected and the regulatory role of government in healthcare provision was below par.

Analysis and examination of the legal and regulatory framework of such key institutions as the National Social Security Fund (NSSF); the National Hospital Insurance Fund (NHIF) and the Kenya Medical Supplies Agency (KEMSA) revealed certain institutional weaknesses. The need for urgent reform of these institutions became clear. For instance, the NSSF statute does not provide for any fraction of the members' contribution to be committed or applied to healthcare. It would be prudent to consider applying part of NSSF contributions to healthcare in the spirit of global social security. The NHIF on the other hand fell short of expectations despite its long experience in healthcare financing. This was evidenced by limited coverage country wide and inadequate benefit packages for members and their dependants. Imprudent and inefficient application of resources entrusted to it and low quality and standards enforcement weaknesses, were attributed to NHIF.

The Inter Sectoral Task Force gained an understanding of the concepts and distinguishing features of the various forms of SHI in Central and Eastern Europe, Latin America and South East Asia and concluded that a mandatory SHI in Kenya is feasible. The findings

of the Task Force were captured in the National Social Health Strategy which formed the basis for Sessional paper No.2 of 2004 on National Social Health Insurance in Kenya.

The Task Force found that the acceptance of SHI was unanimous except for the common concern as whether or not the proposed NSHIS would be appropriately implemented and perform to expectations of the people of Kenya for a countrywide, transparent, and efficient scheme. Success of the proposed SHI would depend on political will, which at the time was high. Support for implementation of NSHIF had been expressed by the Head of State himself. Ownership of the scheme by the people for instance, contributors, members and their dependants was critical to its success. If the scheme would be affordable, equitable, free of fraud, accountable and with user-friendly contribution methods, access to healthcare by all Kenyans would soon become a reality. Improvement and development of infrastructure in GOK facilities countrywide was found critical to the success of the SHI scheme. Training, discipline and competitive terms and conditions of service for health workers in the public service would engender a positive attitude and boost efficiency in healthcare service delivery. Mobilization through public education and sensitization on NSHIF would be key to the successful implementation of NSHIF.

Sessional Paper No. 2 of 2004 on National Social Health Insurance in Kenya was tabled in Parliament for debate after Cabinet approval on 13<sup>th</sup> May 2004, and was unanimously approved and adopted on 19<sup>th</sup> May 2004. The Sessional Paper is the culmination of work done by the Intersectoral Task Force and the contribution of various stakeholders coordinated by the World Health Organization. The Sessional Paper provides information

on the need for social health insurance, the role of the private sector and considers opportunities and challenges during the implementation process.

The elaborate consultation process that was undertaken within Kenya and abroad and the sentiments expressed by Kenyan citizens and residents who made presentations to the Taskforce with regard to the proposed NSHIS are captured in the Sessional Paper. The Sessional Paper covers the healthcare benefits package and financing framework of the proposed NSHIS together with institutional framework of the scheme. Key concerns and success factors are encapsulated in the Sessional Paper, which paved way for the publication of the National Social Health Insurance Fund Bill, 2004.

The National Social Health Insurance Fund Bill, 2004 was published on 28<sup>th</sup> May 2004. The Bill was described as "... a critical piece of legislation with very fundamental changes that promised to stop the trend of decay that has characterized the provision of healthcare in the public sector for many years".<sup>61</sup>

The NSHIF Bill, 2004 was the precursor to an Act of parliament to establish the National Social Health Insurance Fund. The Bill provided for payment of benefits out of the fund, contributions thereto and set up the organs of the fund.<sup>62</sup> The Act would apply to all Kenyans including beneficiaries of private health Insurance schemes. The NSHIF would be the successor of the National Hospital Insurance Fund established under the NHIF Act, which would be repealed. The object for which the fund would be established is to

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<sup>61</sup> Hon Dr. Gurach Galgalo, MP (Deceased) Chairman, Parliamentary Committee on Health, Housing, Labour and Social Welfare in a report on the NSHIF Bill, 2004, (October, 2004).

<sup>62</sup> The National Social Health Insurance Fund Bill, 2004 clause 1, Government Printer, 2004.

facilitate the provision of accessible healthcare services to its members irrespective of age, economic, health or social status<sup>63</sup>.

Numerous consultations preceded and followed parliamentary debate on the NSHIF Bill. These consultations were extended to trade unions, private health insurers, health management organizations (HMOs) and employers. Officials of the Ministry of Health, public servants from all departments and Ministries in Government were engaged in forums aimed at sensitization and education on the proposed NSIS with a view to obtaining views on the scheme and garnering acceptance for the same.

The NSHIF Bill was passed by Parliament in November 2004 and thereafter presented to the President for his assent. In keeping with the powers conferred by the Constitution of Kenya, the President declined to assent to the Bill <sup>64</sup> and instead submitted a memorandum to the speaker indicating the specific provisions of the Bill which in his opinion should be considered by the National Assembly. The Memorandum included the President's recommendations for amendments to the Bill. In March 2005, the Bill was tabled in parliament for reconsideration and it is still pending before the National Assembly.

There are increasing challenges to the economic, political and social sustainability of SHI systems. Those who support SHI systems consider them seemingly private in both the funding and delivery of health services. As seemingly private, SHI systems appear to be self-regulating, managed by the participants themselves who include fund managers,

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<sup>63</sup> Ibid, clause 6.

<sup>64</sup> Constitution of Kenya section 46 (2) – (4), Government Printer, 2001, p. 35.

contracted health service providers and to a lesser degree, the patients. Perhaps the most important consequence of being seemingly private and self-regulatory is that SHI systems are perceived as stable in organizational and especially financial terms<sup>69</sup>.

In structure, SHI schemes are very different from standard commercial insurance. SHI schemes are designed to achieve a series of societal objectives which include solidarity and equitable access to health care services . Through a set of financial cross subsidies – not just from healthy to ill but also from the well off to less well off, from young to old and from individuals to families SHI reinforces the solidarity principle. Taking an exclusively economic and / or financial view of SHI , revolves around how sustainable economically, politically and socially sustainable SHI is. Although its proponents may not see SHI as an economic issue, the social structure of SHI schemes and efficient economics require a balance.

Political sustainability of SHI schemes is dependent upon the regulatory role of the state vis a vis the self-regulatory channels of representation and communication that characterize SHI schemes. Social sustainability of SHI will be premised upon prevalence of SHI's non-economic benefits as understood by policy – makers and citizens over the strictly economic benefits of such schemes.

A consideration of the policy debate on SHI in Kenya will help to crystallize the issues surrounding challenges to implementation of SHI in the country.

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<sup>69</sup> R B Saltman et al, eds; Social Health Insurance Systems in Western Europe, Open University Press, 2004 pg 4.

Since the introduction of user fee policies in 1989 the most significant development in health financing reform has been the government's consideration of social health insurance as a health financing method and its possible implementation in Kenya. The objective of the SHI in Kenya would be to ensure access to health care among all Kenyans and to significantly reduce the out of pocket expenditure of households especially the poorest.<sup>71</sup> It has been opined that the proposed legislation on NSHIF in Kenya entails a formidable challenge for the Kenyan health financing system, as it has universal coverage as its main principle.<sup>72</sup> Another important challenge is to drastically improve the financial protection provided through SHI.

Dr James Nyikal,, Director of Medical Services, Ministry of Health Kenya, as he was then when presenting a paper on Social Health Insurance in Kenya :underscored that high cost of healthcare limits access and that there is catastrophic spending on health with out of pocket expenditure comprising 53% of total health expenditure. Dr Nyikal stated that the framework for Social Health Insurance exists in Kenya and that at the time, there was strong political will and strong social demand for a National Social Health Insurance Scheme.<sup>54</sup>

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<sup>71</sup> C K Ngilu, "We have to make health the engine of development," Social Health Insurance Systems of Solidarity (Eschborn, Germany, GTZ), p 17

<sup>72</sup> E J Van Lente, "Kenya A National Act of Courage," Social Health Insurance Systems of Solidarity, GTZ, Eschborn, Germany, 2004, pp 16-18.

<sup>54</sup> National Social Health Insurance in Kenya, Dr James Nyikal, May 2004.

The Sessional Paper stressed that the earmarked taxes should contribute Ksh 11 billion<sup>73</sup> (2001 figures) to the NSHIF. Within the government, there was no consensus that this would be a financially feasible policy. The Treasury was particularly circumspect on financing of the NSHIF. This was notwithstanding that prior to the publication of the NSHIF Bill and debate in the National Assembly, high-level consultations on a Civil Service medical scheme to be administered by a private insurance firm were at an advanced stage. The government was required to contribute as an employer as per the NSHIF Bill<sup>74</sup> which provided that employers match employee contributions. There was reluctance to make such contributions into the proposed Fund, which was to be a body corporate falling under the purview of the State Corporations Act. Indeed, the policy shift appeared to be directed in favour of private health insurance for the over half a million civil servants and teachers. This would right away compromise the survival of the NHIF as established, since its backbone is statutory contributions drawn from those in formal employment.

The provision that the government would make contributions for the indigent, those who are unable to pay; also became a major bone of contention within government. Proponents of SHI argued strongly that social protection for the poor could only be fully achieved with government contribution. Critics of SHI proposed that the scheme be membership based on payment of contributions. Indeed, the President's memorandum to parliament reflected this position. The memorandum<sup>75</sup> even proposed that the scheme be

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<sup>73</sup> Ministry of Health Sessional Paper No.2 of 2004 on National Social Health Insurance in Kenya, May 2004, page 25.

<sup>74</sup> The National Social Health Insurance Fund, Bill, 2004: Government Printer

<sup>75</sup> Memorandum on the National Social Health Insurance Fund Bill, 2004, 30<sup>th</sup> December 2004.



voluntary. This flies in the face of the very basis of SHI which is premised on the mandatory principle of solidarity. Indeed transforming the current NHIF into voluntary scheme would rid it of most of its members and contributors, and leave behind primarily those who are most vulnerable. Adverse selection would be the order of the day, as those most in need of health insurance would register for membership.

There were serious divisions in the government's position with regard to SHI implementation. The then Minister for Health on the one hand appeared to be a somewhat lone crusader for the scheme, while some of her cabinet colleagues seemed bent on thwarting its implementation. The sideshows surrounding Parliamentary debate on the NSHIF Bill, 2004 bear witness to the fact that though it was a government Bill, there was no consensus in government on the way forward with regard to SHI in Kenya. Indeed there was no common government position on the implementation of SHI in Kenya. What appeared to be taking place was power play between proponents and opponents of SHI in government.

Advocates of private for profit insurance with interests in enterprises involved in the same (who and stood to benefit from a private sector administered Civil Service Medical Scheme) made their influence felt. It has been suggested that they contributed to the decision by the President not to assent to the Bill. The Kenya Private Sector Association (KEPSA) was party to a suit filed against the the then Minister for Health and Board of Management, National Hospital Insurance Fund (NHIF), seeking orders of Judicial Review to stop assent to the Bill. The Suit was dismissed in April 2009 for want of

prosecution :a clear pointer to the fact that the suit had been filed solely to interfere with successful coming into effect of the law on SHI in Kenya.

The following excerpt from a daily newspaper brings some of the political intrigues over the NSHIF Bill into focus. “ ...*The Health Minister believes she fought a host of enemies over the NSHIF Bill. Her fight saw her engage in public verbal exchange with then Finance Minister, David Mwiraria ...the NSHIF Bill 2004 had at one stage been withdrawn from the Parliamentary order paper at the eleventh hour as MPs prepared to debate it. The Bill was withdrawn by Vice President Moody Awori but was put back after the President intervened and directed that it be debated.*<sup>76</sup>

It is important to note that Treasury support for the proposed scheme would be critical to its successful implementation. The Government was expected to contribute to the scheme on behalf of the poor through an increased proportion of gross expenditure which would amount to KShs.11 billion when the NSHIS is fully operational. Treasury involvement and support would also be critical for payroll harmonization which was envisaged to bring in KSh.7 billion annually to the NSHIS.<sup>77</sup>

Outside Government, a number of non-governmental associations and interest groups henceforth referred to as stakeholders, had varied reactions to the SHI proposal. Health Management organizations (HMOs) such as Avenue Healthcare raised a number of issues with particular concern being that their businesses would decline as a result of the

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<sup>76</sup> The Sunday Standard, “Ngilu’s Clash with Michuki Part of Bitter War with President’s Men”, September 10<sup>th</sup> 2006. page 10.

<sup>77</sup> Ministry of Health Sessional Paper No. 2 of 2004 on National Social Health Insurance in Kenya, May 2004 p 24, 25.

implementation of the proposed scheme. HMOs were concerned that a mandatory SHI that covered all Kenyans would create a monopoly in health insurance, thus eat into their market niche.

Legislation on NSHIF, would provide the basis for quality , accessible and affordable healthcare services ,while still leaving room for HMOs and other insurance companies to sell supplementary (voluntary) or top-up health insurance for those who can afford it. This would target Kenyans who are willing and able to pay for services other than the basic benefit package that would be provided through the NSHIF. Some analysts believe supplementary health insurance could be sold to a much larger share of the population than is currently covered through HMOs. The often more strongly voiced concern is related to potential corruption and ineffective use of health insurance contributions by a body such as the proposed NSHIF would be.<sup>78</sup> Proprietors of HMOs strongly felt that the NSHIS would be a monopoly which would drive them out of business.

Some HMOs also warned that job losses would occur due to increased labour costs occasioned by higher employer contributions envisaged in the proposed scheme. Development partners have suggested that a qualitative analysis would address the relationship between SHI and labour costs . The final demand for labour will depend in particular on the selective prices of labour and capital, the degree of substitution within Kenya's economic sectors and the level and growth of the economy. Potential gains in

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<sup>78</sup> World Health Organisation, Discussion Paper No.1 1-2006, Health Financing Reform in Kenya; Assessing the Social Health Insurance Proposal, p 16-17.

productivity to the NSHIF offering greater access to health care for more of the population should be considered in such an analysis.

Concerns raised by the Federation of Kenya Employers (FKE) revolve around the unwillingness by their members of making higher contributions to their employees' health insurance. This concern though is only justified if employers maintain their current employer based health insurance contracts with private health insurance companies after the introduction of NSHIF, and/or continue to pay medical allowances to their employees. It is worthy of note that the benefits offered through such contracts are likely to overlap significantly with the proposed NSHIF benefits package. FKE thus voiced reserved support for the scheme, and stated that more consultations were needed before the implementation of the same.

The issue of medical allowances for civil servants and teachers was championed especially by the Kenya National Union of Teachers (KNUT), the Kenya Medical Association (KMA) and National Nurses Association of Kenya (NNAK). In theory, once NSHIF is established such allowances would not be applicable as these groups and their families would have access to the NSHIF benefits package. In practice though, the allowances are perceived as a supplement to salary, whose deductions from final pay are perceived to seriously affect the beneficiary's purchasing power. After protracted debate, the government, as an employer of civil servants and teachers, was expected to contribute to the NSHIF an amount equivalent to the employee contributions.

Development partners also expressed their opinions on the proposed NSHIF through a statement by the Health and HIV/AIDS Development Partner Working Group (HDWG).<sup>79</sup> The transition periods to universal coverage is of utmost concern to the development partners. Their statement refers to a 15-year period for a systematic enrollment of the poor and the informal sector. According to the HDWG there was need to pay particular attention to ensuring that the poor have effective access to preventive services during the transition period. Development partners stated that the government had been slow in the process of consultation of key players, including taxpayers, employers, civil society and private health service providers as well as HMOs. The HDWG stressed the potential of higher levels of health insurance contributions or taxes to be detrimental to economic growth. Although the proposed scheme was planned to be entirely financed by Government and members contributions with only a negligible contribution from development partners, their views cannot be entirely disregarded, coming as they do from Countries with considerable experience in implementation of SHI.

Two important stakeholders, the Christian Health Association of Kenya (CHAK) and the Catholic Commission for Health and Family life, expressed general satisfaction with the Bill and what it stood for. These bodies saw the Bill as being in line with their own vision of an adequate health system for all.

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<sup>79</sup> DCG Demarche Points, Health and HIV/AIDS Development Partner working Group, 20<sup>th</sup> June, 2004.

Various stake holders expressed legitimate concerns regarding the proposed scheme which necessitate further consultation. Caution though must be taken to avoid *paralysis by analysis* whereby excess time and resources are expended on talk with little or no action.

As in other countries that have been through similar reforms in the past, lengthy discussions within Government and parliament regarding the content of the Bill and other policy papers on NSHIF were expected. It has been noted that one key goal of the health system, namely to ensure that all Kenyans have access to affordable healthcare<sup>80</sup>, is widely accepted. Intensive discussions have taken place within government, regarding the phased implementation of the NSHIF, inclusion of the poor population, allocation of government tax revenue to the overall financing of the NSHIF as well as the contents of the healthcare benefits package.<sup>81</sup>

Questions over whether the government should wait for the country's economy to improve before introducing SHI, or whether the provision to health from overall government budget ought to be raised abound. Another important issue of debate has been whether the government should not improve the quality of health facilities first and increase investment for health infrastructure before starting to contribute to the proposed NSHIF. The state of GOK facilities which has been on the decline in the past was a major source of concern during the debate on the SHI policy in Kenya. Indeed opponents

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<sup>80</sup> As noted in a statement issued by State House on 30<sup>th</sup> November, 2004, [www.statehousekenya.go.ke](http://www.statehousekenya.go.ke)

<sup>81</sup> D N Kimathi et al, "Healthcare Financing through health insurance in Kenya: the shift to a National Social Health Insurance Fund", Kenya Institute for Public Policy Research and Analysis, Discussion Paper No.42, (2004) p 22-23.

of SHI were definite that the Government, considering the current state of its healthcare infrastructure; lacks the capacity to implement a National Social Health Insurance Scheme. This was and still remains a major challenge to implementation of SHI in Kenya.

### **Research findings and discussions**

The following is a highlight of the survey data and analysis based on the objectives set for the study and hypothesis outlined in Chapter 1. This study sought to examine whether or not implementation of SHI in Kenya is dependent on political will. The study examined if successful implementation of SHI will be determined by improvement and development of public health sector facilities to ensure equitable access to quality healthcare services. The study also examined whether the role of the private sector will contribute to successful implementation of SHI in Kenya.

The analysis from interviews highlights seven key issues for reflection and action:

### **Reasons why the National Social Health Insurance Bill was not assented into law by the President**

After the Presidential intervention of 30th November, 2004, the National Social Health Insurance Fund Bill 2004, was listed in Parliament's Order Paper and the Bill appeared set to become law. On Thursday December 9th 2004, Parliament passed the Bill into law. However, President Kibaki declined to assent to the Bill becoming law. Among the reasons Respondents in this study stated that the President did not sign the Bill into law because he was not convinced that the national budget would be able to cover all the

expected costs of NSHIF. Respondents stated that the President may have taken cognizance of the poor state of GOK health facilities whilst contending that allocation of scarce funds be done in a prioritized manner. Further, key stakeholders especially employers, private insurers and HMOs lobbied the President not to sign the Bill as they thought it would be too much of a burden to employers who would be required to match their employees' contributions to the proposed scheme and a threat to private insurers and HMOs on the other. Respondents further revealed that the Head of State was of the view that there had been inadequate consultations between the Treasury and the Ministry of Health in order to ensure fiscal viability and sustainability of the scheme. The President's advisors may not have comprehensively looked at the Bill and devised ways of implementing it. The President may have doubted the commitment of the population who were to contribute and support the poor so he decided it was best not to commit the Government to implementation of NSHIF.

However, in his speech during official opening of the fourth session of the Ninth Parliament on 16 March 2005, the President stated the following, "During the last Session of Parliament, a Bill proposing the introduction of National Social Health Insurance Fund was passed. The primary focus of the Bill is to increase access to healthcare services. The Government regards the health of our people as a top priority and, therefore, fully supports this initiative. However, this Bill has far reaching cost implications, which cannot be met under our current financial circumstances. My Government will therefore re-submit the amended Bill to Parliament. The amended Bill provides for the phased implementation of the scheme in line with the current fiscal framework".



Respondents who harbour reservations on the viability of SHI in Kenya stated that political competition was at the fore in the passage of the Bill in Parliament. They are of the view that the needs of the poor and vulnerable were sacrificed at the pedestal of political gains while it was evident that the Government was unable and/or unwilling to implement NSHIF in the form outlined in the NSHIF Strategy, Sessional Paper and Bill. Members of Parliament were aware that they passed a Bill whose implementation would be fraught with challenges. These Respondents stated that proponents of NSHIF in Parliament did not advance the cause of the poor, but intended merely to raise their political fortunes.

Political competition, to the extent that it is legitimate, must never be at expense of the greater public good. Public interest lies in a workable, viable health financing mechanism that is affordable and accessible to all Kenyans. Utopia is beyond our reach; so it is irresponsible for leaders to raise false hope in the citizenry.

### **Challenges in accessing healthcare services in Kenya**

Kenya faces serious challenges to improving the health and well-being of its people. These include continuing disparities in health outcomes between the poorest and the richest Kenyans and those in rural and urban areas, barriers to service experienced by the poor due to distance, formal and informal health charges, and other obstacles. Results from qualitative analysis results have summarized these challenges into the following themes:

**Poverty:** is one of the greatest challenges facing mankind and the miseries it inflicts should be checked urgently to improve the quality of human life. It prevails when one cannot afford a decent life. Being a multidimensional phenomenon, it is a state of human deprivation with regard to personal incomes, clothing, housing, health care, education, sanitary facilities and human rights. In Kenya, wealth distribution is uneven with a huge proportion of wealth in very few hands. In Kenya, 76 percent of the poor cannot afford healthcare in private facilities while 81 percent of the urban poor rely on public health facilities whose services are over- stretched. However, 20 percent and 8 percent of the urban and the rural poor respectively, find government health services unaffordable. 58 and 56 percent of the same groups of people do not seek public health services due to the unavailability of drugs. Besides, only 37 percent of poor mothers give birth in hospital compared to 58 percent of the women living above the poverty line.

**Access :**The Ministry of Medical Services is the major owner and manager the health care facilities in Kenya. Out of about 5,000 health facilities in the country, the Ministry controls and runs about 52 % while the private sector, Faith based organisations and of Local Authorities respectively run the remaining 48%. The public sector controls about 79% of the health Centers, 92% of the sub-health centres and 60% of the dispensaries. The NGO sector is dominant in health clinics, maternity and nursing homes where it commands 94% and in medical centres where they own 86% of the facilities. Both the public and the private sector are proportionately engaged in healthcare provision . It should be noted however , that the health sector is riddled with inequalities. Only 30% of the rural population has

access to health facilities within 4km, while such access is available to 70% of the urban dwellers. The quality of health services is low due to inadequacy of essential supplies and equipment as well as lack of adequate personnel.

Health services are often inaccessible by the very poor and by women in particular. Key obstacles are health care charges, long distances to facilities, inadequate and unaffordable transport systems, poor quality of care, poor governance and accountability mechanisms. The shortage of skilled health service providers continues to persist and is an area of concern for stakeholders, Government included. Discrimination against clients who are not able to pay and poor referral systems all result in low quality of health care.

**Health care charges:** A household healthcare utilisation and expenditure survey carried out in 2003 indicated that the cost of health service delivery in Kenya is financed 30% by the government, 16% by donors, 51% by households and 3% by well wishers and private institutions. This means that more than half of healthcare financing comes from households. Financial constraints remain a challenge to access to health care by the poor.

Revenue generated by cost sharing has not necessarily impacted positively on quality of health care. User fees are not the only charges; other costs include transport costs, unofficial costs including bribes, payments for drugs and supplies, and time spent away from income-generating activities which are particularly critical for people living in poverty. There is no clearly defined Government policy on exemptions and waivers, which leaves it open to abuse by healthcare providers in the public sector. The quality of

care in public facilities has not improved with the additional funds generated from cost sharing or user fees.

**Budgetary Allocation:** There has been an issue of low budgetary allocation absorption in the health sector. The absorption capacity declined from 97.8% of the total budget in 2006/07 to 93% in 2007/08. The allocation to the health sector in the financial year 2008/09 translated to 9% of the total Government expenditure which is below the ERS target of 12%, and the Abuja Declaration, to whereby the Government committed to allocate 15% of total public spending to providing quality healthcare. A budgetary deficit of Kshs 35 billion in the fiscal year 2008/9 limits the realization of the NHSSP II.

The development budget is lower than the recurrent budget which means that the necessary infrastructure for provision of health services development is also low. Consequently, underserved areas where health services are not available or insufficient, may never access the service unless the Government increases the development budget.

The lack of funding for public health facilities contributes to the emergence of a two-tiered health care system in Kenya, which discriminates against poor and prevents or delays access to much needed care. While services at GOK facilities cost less money, they tend to have long queues, are characterized by congestion, lack supplies, and unequal treatment of patients.

**Exemptions and waivers:** Exemptions, and in particular waivers, are not systematically implemented and are not effective as a means of protecting vulnerable social groups and the poorest of the poor. Respondents were of the view that even if exemptions or waivers are effected, the poor and vulnerable still end up having to pay for drugs, transport, small charges (e.g. cards, materials), and sometimes bribes. The exemption and waiver system is poorly implemented partly because accountability mechanisms are not in place, and because health service providers by and large do not follow procedures that are often unclear to them to begin with. An equally important factor is the low uptake and lack of insistence on free services by the poor, primarily because they are not aware of their rights. A lack of clear criteria and policy guidelines for identifying people who are eligible for waivers has resulted in subjective and ad hoc decisions, without clear records or follow-up.

The process of determining who qualifies for a waiver based on financial need is a lengthy and degrading one that delays care and gives rise to serious human rights violations, largely in the form of detention. Detention of patients who cannot pay their medical bills occurs in both public and private facilities. Private facilities generally use detention to pressure the patient's relatives to pay the bill. Public facilities also use detention for this purpose and to determine whether or not a patient really is poor enough to qualify for a waiver. Thus, recuperating patients who are eligible for discharge, are often forced to sleep on the floor or share a bed with others, are underfed, and suffer verbal abuse from staff over their failure to pay.

**Lack of infrastructure and supplies:** Health facilities often lack the most basic supplies, such as anaesthetics, gloves, syringes, surgical blades, soap and disinfectant, speculums, and bed linen. Patients are often asked to bring their own supplies; when they have not done so, they must beg medical staff to buy the needed item for them or go without it. Moreover, staff shortages result in overworked and overstressed staff with low morale. Health care providers observed that poor work conditions demoralise staff and interfere with quality care. The Government has been unable to recruit and retain the right quality and quantity of health care personnel to meet health care needs of Kenyans. Of 5000 doctors in Kenya in 2003 only 1000 worked in the public health sector (MOH data). Without sufficient staff, patients do not receive the personalised quality care they require.

**Governance and accountability:** The respondents in this study expressed dissatisfaction with critical governance issues such as abuse of power, political interference in the running of the health sector, financial mismanagement and corruption. While there exist some cases of health users and authorities working together, systems are generally not in place to ensure that services respond to the priority needs of beneficiaries. Adequate management systems have not been instituted to ensure appropriate collection of fees and allocation of these locally-generated resources.

Other issues raised by respondents to the study include:

- i. Lack of an all inclusive National Social Health Insurance in the country is a major cause of lack of access to healthcare.
- ii. The bulk (70%) of health care expenditure is out of pocket.
- iii. Belief in traditional medicine and religions which impacts on health seeking behaviour. Some faiths forbid their adherents from seeking health care in the formal health system, resulting in preventable illness and mortality.
- iv. Shortage of healthcare personnel particularly in GOK facilities
- v. The challenge of the high incidence of terminal diseases such as HIV/AIDs
- vi. Bad politics especially that which discredits efforts made by the Government of the day to increase access to healthcare.

### **How poverty affects access to healthcare**

Respondents to the study made the following observations with regard to the effect of poverty on access to healthcare. Majority of the poor people usually have a lower education level which may promote unhealthier living conditions that may result in different preventable diseases. Most of them cannot afford co-payments or top-up payments which deters them from seeking health care when needed. Poor people cannot purchase health care therefore will not visit health facilities even if they are available. Many of the poor have fallen deeper into poverty as they end up using their limited and critical assets to pay for treatment. They use meagre savings (if they have any) and sell their crops, animals, land and their labour. Those who can, borrow money or take a loan, or bond their assets. They are often forced to reduce their food intake and to take their

children out of school in order to pay for treatment. These strategies to pay for care drive poor people deeper into poverty and increase their vulnerability significantly.

Typically, poor people's incomes are sufficient for their subsistence needs only. They are frequently forced to resort to self-treatment, seek ineffective alternatives, or report much too late for care, often with fatal consequences. Many resort to traditional healers. If people can afford treatment at all, government facilities are normally the only option, especially in rural areas, as they may be nearby and possibly less expensive. This is responsible for the poor health indicators Kenya currently has, and we are not likely to meet MDGs in health by 2015.

Inadequate allocation of funds to health care providers (mostly GOK) results in lack of resources for improvement of services. Those living below the poverty line and cannot cost share in any way depend on good will of well wishers, including the Government to meet the costs of healthcare. While the Government has a duty to address the health needs of all vulnerable groups, it is severely resource constrained, hence the need to reform healthcare financing through implementation of NSHIF in Kenya.

### **Proposals on how the government can ensure equitable access to healthcare for all Kenyans**

In order for the goals of the PRS,ERS, NHSSPII and even Vision 2030 to be realized, particular commitments must be made to those who are impoverished, marginalized and otherwise vulnerable (R&AWG 2002, Hutton 2003). Action must go beyond policies and



guidelines to meaningful changes in service delivery and health outcomes. To realize this, Respondents in this study suggested that the Government should immediately implement a mandatory National Social Health Insurance Scheme and commit to making contributions for the poor into the scheme.

It would be an exercise in futility to implement NSHIF without developing and equipping primary health care facilities across the country. A dispensary in every village and health centre in every location / sub location, and increase in the number of health workers would go a long way in improving access to healthcare services in Kenya. Respondents to the study proposed that the Government's role needs to be decentralized, whereby the Ministry of Medical Services / GOK focuses on preventive healthcare , policy making and regulation; while health service providers address curative health care. Other interventions proposed by respondents include:

- i. Review of financing policy strategy
- ii. Develop and implement pro- poor programmes
- iii. Include non –governmental and Faith Based health service providers in planning and implementation of NSHIF
- iv. Encouraging competition between providers by providing necessary incentives.
- v .Enhancing public-private partnerships amongst health service providers.
- vi. Reduce out of pocket expenditure by introducing a mandatory NSHIS.

### **Suitability of Social Health Insurance as a method of financing healthcare in Kenya**

Respondents were of the view that if designed properly, SHI has potential to be a sustainable way of financing health care in Kenya if the macro – economic situation remains stable. While underscoring the fact that Kenyans embrace the solidarity principle in the national motto of *harambee*, respondents noted that this provides good prospects for SHI in the country. The economy has been steadily improving since 2003 and Kenya boasts a relatively robust health provider network of GOK, private and Faith Based facilities that is fairly good and will encourage people to seek membership with a NSHIS. However, the government should increase allocation to primary health care.

While atleast 56% of Kenyans are poor; 30% of these are absolute poor and therefore unable to insure themselves against the risk of illness and disease. The Government can contribute for the absolutely poor - to NSHIF to enable them access acceptable health services.

NHIF has over 40 years experience in the country in financing health care through national health insurance therefore the institutional framework exists which can be used for implementing SHI.

### **Challenges the country is likely to experience in its efforts to implement SHI**

SHI is recognized to be a very powerful method for granting the population access to health services in an equitable way. However, there are challenges to its implementation.

information generated from key informant interviews in this study, three main  
are highlighted.

It is particularly difficult to arrive at a consensus on the part of the population  
the basic role of SHI, which is to guarantee similar health service benefits to  
similar healthcare needs, regardless of the level of contributions made. This is  
generally people expect to accrue benefits that are proportionate to their  
contribution into any fund or scheme, be it insurance, or welfare and self help groups  
such as the increasingly popular "merry go rounds" in Kenya. Indeed, this  
is very acute in countries with a significant inequality of incomes and assets  
like Kenya.

SHI schemes need to assure their members that they will in fact receive the  
health insurance benefits. This implies that the health services that are part of  
the insurance benefit package need to exist or be created by the health insurance  
scheme. It is evident that the health services infrastructure, the human resources and the  
financial components of health services, such as drugs and laboratory  
services, all need to be available in order to produce adequate health services. While  
there are inadequate and dilapidated health services provider infrastructures, there  
is an opportunity for development and improvement of the same. Mechanisms to finance  
these are limited while infrastructure is poor. This is a challenge to implementation  
of health services cannot be delivered, it makes little sense to start an SHI  
scheme. Should a government go ahead with implementation of such a scheme, it will

From information generated from key informant interviews in this study, three main issues were highlighted.

First, it may be particularly difficult to arrive at a consensus on the part of the population to accept the basic rule of SHI, which is to guarantee similar health service benefits to those with similar healthcare needs, regardless of the level of contributions made. This is because generally people expect to accrue benefits that are proportionate to their contribution into any fund or scheme, be it insurance, or welfare and self help groups groups such as the increasingly popular "*merry go rounds*" in Kenya. Indeed, this problem is very acute in countries with a significant inequality of incomes and assets such as Kenya.

Second, SHI schemes need to assure their members that they will in fact receive the promised health insurance benefits. This implies that the health services that are part of the health insurance benefit package need to exist or be created by the health insurance funds. It is evident that the health services infrastructure, the human resources and the other necessary components of health services, such as drugs and laboratory examinations, all need to be available in order to produce adequate health services. While Kenya has inadequate and dilapidated health services provider infrastructures, there exists opportunity for development and improvement of the same. Mechanisms to finance healthcare are limited while infrastructure is poor. This is a challenge to implementation of SHI. If health services cannot be delivered, it makes little sense to start an SHI scheme. Should a government go ahead with implementation of such a scheme, it will

quickly find out that the trust of the population disipates, leading to non-compliant behavior such as a refusal to pay scheduled health insurance contributions.

Other challenges that are likely to affect the implementation of SHI include:

**Moral Hazard:** over-use of health services due to the feeling of *free* health care. This essentially means that the demand for health services is enhanced by availability or ease of access. Health seeking behaviour is thus directly influenced by access and affordability. **Over prescription:** health service providers may apply medical procedures and prescriptions which are not needed in anticipation of higher payments by the NSHIS such as was the case in South Korea's NHI. **Inadequate political will:** if the scheme is not embraced across the country's political divide successful implementation will be constrained. **Opposition from key stakeholders:** If consensus is not built with employers, trade unions, private Insurers and HMOs there will be continuous opposition to the scheme.

Lack of confidence in the capacity and competence of the National Hospital Insurance Fund to be converted into the NSHIF. NHIF needs to implement an integrated marketing and communication strategy to inform and educate Kenyans on NHIF benefits and register more people. NHIF also needs to step up efforts to reach a larger proportion of Kenya's population, particularly the informal sector, pensioners and senior citizens.

Contributions to a mandatory National or Social Health Insurance Scheme are generally perceived as taxes. Increase of this taxation of the already tax-burdened working class to supplement to those who cannot afford is another challenge to implementation of SHI in Kenya. The challenge of equitable distribution of medical personnel, equipment and

medication between urban and rural settings stands in the way of successful implementation of SHI in Kenya.

### **How social protection for the poor and vulnerable can be realized in matters of access to healthcare in Kenya**

In a broader sense, social protection could be described as all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks, and enhance the social status and rights of marginalised groups, with the overall objective of reducing the economic and social vulnerability of poor, vulnerable and marginalized groups. This definition recognizes that social protection is a “right” as opposed to being a “welfarist” approach to addressing risk and vulnerability.

Social protection includes formal and non-formal schemes ranging from social insurance and social assistance to community-based schemes. Social insurance and social assistance can generally be included as the formal schemes, while community-based schemes can be referred to as a kind of informal social protection (Suharto, 2006; Suharto 2007).

Social protection should consist of all interventions from the public and private sectors, together with community-based organisations to support individuals, households and communities in preventing, managing and overcoming risks and vulnerabilities. To achieve this, respondents in this study proposed the following strategies: Availing *free* membership to the scheme and creating awareness about benefits .Introduce SHI and contributions for the poor and vulnerable be made by government from funds voted by

parliament for that purpose.. Increase funding to GOK health facilities to improve services .Expansion of the health service provider network to minimize traveling and incidental costs. Good health must be a constitutionally guaranteed right. The government must undertake to provide a budget specifically for the health needs of the poor and vulnerable . The government has to put in place pro-poor schemes to support the poor and vulnerable through making direct payments to a National Social Health Insurance Scheme for them and / or subsidising their health care costs. The health needs of the poor and vulnerable to be identified, quantified and then the government would seek support from the private sector and the bilateral / multilateral development partners to finance them. Some ailments are a consequence of poor nutrition and sanitation which causes preventable ailments such as the water borne diseases. To counter this, there will be urgent need to step up public health initiatives and increase the availability of portable water.

#### **Adverse selection in a SHI scheme**

Adverse selection, whereby those most in need of health care services such as terminally ill people register to be members of SHI schemes can pose a serious threat to the viability of the scheme. In order to ensure that the scheme is open to all people without prejudice, yet scheme funds are not depleted by one segment of the membership respondents to the study made the following proposals.

A mandatory SHI scheme would go a long way in ensuring a large membership base and expanded risk pool. To achieve this, membership has to be compulsory for whole population for groups e.g. families, households and organized groups. A case in point is

the Philippines' national health insurance scheme, Philhealth where the informal sector can only join in groups of not less than 1,000 people. Member registration and contribution rates must be based on actuarial studies. Education and sensitization of the populace on the benefits of SHI will also encourage larger numbers to register into the scheme and curb adverse selection..

### **How to implement SHI in Kenya**

Implementation of the National Social Health Insurance Scheme should be approached in planned phases so that it does not weigh heavily on the national budget as other sectors of the economy need to get due attention and budgetary provision. For successful establishment of the NSHIF, organizational re- structuring, recruitment of skilled personnel and capacity building of all fund administrators and managers is critical.

It may not be necessary to enact new legislation for NSHIF. The legal framework for the National Social Health Insurance Scheme can be based on review and amendment of the National Hospital Insurance Fund Act and other applicable legislation to incorporate critical provisions on SHI such as mandatory membership of all Kenyans , contributions for the poor and vulnerable, and inclusion of key stakeholders in the Board of Trustees. In view of the controversy surrounding the NSHIF Bill, 2004 respondents to the study recommended avoidance of new legislation, and proposed review and amendment of existing laws against the backdrop of a SHI policy framework that takes cognisance of the prospects and challenges to its implementation in Kenya addressed in this study.



### **The place of commercial for profit health insurance in Kenya's healthcare financing system**

Commercial for profit insurance is very important because it provides top –up insurance for those who can afford it. This means that members enjoy *hotel* facilities not available to ordinary NHIF and later, NSHIF membership. As the economy grows, this sector will become increasingly popular and shall supplement NSHIF once introduced. However, the number of its clientele remains very low as people are not risk averse in Kenya. Commercial for profit insurance should be allowed to exist to cater for those who wish to be attended at high cost hospitals but the same groups would still contribute to NSHIF.

### **The place of Health Management Organisations (HMOS) In Kenya's healthcare financing system**

Most HMOs have developed financial problems, had to close and are required by amendments to applicable law to be either providers or financiers; but not both. Private for profit health insurers and HMOs have their niche since there are citizens who will want to seek health care in high cost health care facilities where co-payments are high. Some may even want to seek health care overseas. Private insurance will thus continue to cater for that market segment. On the other hand once the majority realize SHI is meeting a significant level of their health care needs they may rethink the risk and cost implication of private health insurance.

Since HMOs have not been very successful in the country, it is necessary that the legislation requiring them to be either providers and financiers and not both is enforced. HMOs should not feel threatened by the prospect of implementation of NSHIF because

there will still be a segment of the population that opts to maintain both HMO and NSHIF membership. The two can still operate side by side on the premise that the scheme caters for all Kenyans especially low income earners, the poor and vulnerable.

### **Gains that can be made through state deregulation of a National Social Health Insurance Scheme**

Deregulation is the removal or reduction of government rules and regulations that constrain the operation of market forces. This does not mean elimination of laws against fraud, but eliminating or reducing government control of how business is done, thereby moving toward a more free market. Analysis of key informant information revealed that it is expected that in the competitive market environment health service providers will become more powerful and effective competitors in the marketplace by consolidating services and increasing market presence. It is further assumed that there are likely to be decreases in health care costs and revenues as a result of price negotiations in a deregulated environment. Health service providers will not be able to totally offset these decreases by cost reductions and increased outpatient revenues. Consequently, there will be a deterioration of financial performance of health service providers.

Deregulation will increase affiliation activities in that areas of high competition will have a greater degree of affiliation activity than that in the low competition areas. Increased affiliation will increase the level of integration among scheme members. Deregulation will enhance competition for membership of the NSHIS because non state actors will be able to provide healthcare services. However, actual deregulation of SHI will only be

possible if the government has a strong control of the institution that is charged with implementation of the scheme. SHI can be implemented through several independent private health insurances where the government controls the market through strong regulations.

Other expected gains of deregulation include: exposure of the scheme to competitive forces in the endeavour to attract and retain members. The element of cross- subsidisation may be affected since SHI may not fully meet costs of care at private health providers making the wealthy detach from the SHI scheme. State de-regulation may result in neglect of the poor and vulnerable by fund managers and administrators. However, the State can counter this by ensuring prompt remittance of contributions for this segment of the population. Stakeholders would have a say on how the scheme should be run. State deregulation exposes the scheme to competition and encourages high standards in service delivery.

#### **Impact on health service providers**

Health service providers will most likely resort to compromising quality of services as with deregulation, more providers would offer substandard services and try to attract clientele by lowering prices . The wealthy and healthy may opt not to take health insurance meaning less cross subsidisation and poor cash flow to health service providers if SHI schemes are not solvent. With favourable emoluments , better qualified personnel would seek employment in health service providers accredited to the scheme. Other anticipated impact on health service providers are summarized as follows; Cost of care will be high and inaccessible to the majority. Many people will not be able to pay their

bills. Top-up insurance will become expensive; people will resort to out of pocket expenditure or not go to hospital at all. Qualified health workers will be too expensive to retain. Planning will be constrained as providers will not be certain where their revenue shall come from. Developing and poor countries need SHI to avoid out of pocket spending and the resultant cash-strapped institutions.

### **Impact on members**

Deregulation would only affect members if contributions to the scheme are made voluntary. Members would be subjected to inefficient and expensive SHI and thus opt out of the scheme and purchase health care out of pocket. This will reduce access to health and health service provider visits. People will look to cheaper forms of medication and health care services from unqualified providers, with dire consequences. State regulation enhances choice for members.

### **Impact on fund managers / administrators**

Fund managers and administrators will be faced with a market challenge. There would be lay-offs to streamline operations. With increased efficiency coupled with the good will of the citizenry competition shall flourish. Fund managers/administrators will require clear marketing strategies to attract and retain members. However, there will be opportunities to come up with innovative and competitive health products that are affordable and deliver high value to scheme members. It would be prudent to focus on lower middle class and low income earners in the early phases of implementation of SHI. Strong

regulation is necessary where there are many fund managers as it would enhance competition.

### **Concerns over management, accountability and transparency**

If concerns over management, accountability and transparency are taken into consideration successful implementation of NSHIF will be achieved. Kenya's SHI needs to be properly designed and regulated. The scheme's Board of Trustees should consist of representatives of all key stakeholders. Independent audit of the scheme annually to be followed by publication and publishing in daily print media with nationwide circulation will ensure accountability to the public. Surplus or unspent funds should be used for risk equalization or pro-poor programmes. A legal ceiling for administrative expenses should be set. This is proposed at 10% of total revenue, once the scheme is fully implemented as is the practice in Europe's highly developed SHI schemes. The statutory cap on administrative expenses ensures the scheme focuses its revenue and resources on its primary mandate which is to finance health care.

The NSHIF should adopt good fiscal management of members' funds. Stringent enforcement of compliance will ensure that all who are required to make contributions do so and ensuring only authentic claims are paid. The scheme should ensure quality services through an effective standards and quality assurance mechanism. Accessibility of health providers to members will elicit confidence in NSHIF. Appointment of trustees should be done by stakeholders right from the grassroots for ownership and sustainability. The Chair of the Board of Trustees ought to be elected by the members

from their number to avoid political interference as in the common practice currently where by and large Chairmen of public bodies are appointed by the President. The CEO and top Management of the scheme should be recruited through a transparent process and on merit.

## CHAPTER FIVE

### Conclusions

Chapter four addressed challenges to implementation of SHI in the country and examined findings from field research.

This chapter will focus on conclusions of the study.

Results from this study show that the health sector is seriously under-funded despite the fact that it is a critical component in the Poverty Reduction Strategy. It cannot be gainsaid that a healthy population is a basic ingredient of socio-economic growth and development. Lack of equitable access by the very poor to health care services characterises much of the current situation.

These factors have resulted in a health care system that requires not only massive investments of funds but also a renewed commitment and vision among all stakeholders particularly government, policy makers, non-governmental organizations, faith based organizations and health workers to generate fundamental change. This call for change is a imperative for Kenyans living in abject poverty, for whom healthcare remains inaccessible and unaffordable. The challenge then, is how to make quality care available to all especially the poor and vulnerable in an environment of limited and insufficient financial resources and severely constrained human and material resources.

### **Lack of infrastructure and supplies**

In order to provide quality services, health service providers must have the necessary infrastructure and resources. The government must give priority to improvement and development of health care infrastructure so as to enhance health seeking behaviour amongst Kenyans, and lay the groundwork for successful implementation of NSHIF.

The key role of the state will be to ensure that quality, affordable health care is within the reach of all Kenyans. In this respect, the state has a key role in defining policy framework for development of health systems and in ensuring implementation of such framework through the use of its convening, regulatory and financing instruments. Transparency and accountability are key ingredients for efficient management of the scheme as they facilitate monitoring of success or challenges and provide opportunity for corrective measures concerning individual functions of the system or redefinition of existing policies.

### **Demand for setting up a National Social Insurance Fund**

The Government needs to review the policies relevant to the establishment and expansion of SHI in Kenya to ensure present socio-economic and political dynamics are addressed. The Government must provide stewardship of the scheme and give direction in health financing policy in general. Methods of revenue collection, pooling arrangements, the definition of health insurance benefit packages, and the purchasing of health services must have government input. Issues of rational health care, quality of and access to care,



proper utilization of care and patient flow, and cost-containment, which are crucial to Social Health Insurance development, require government and stakeholder attention.

### **Functions of Government**

This study proposes four basic functions for government with regard to SHI: that of promoter of the principles of SHI, monitoring and evaluating NSHIF, capacity building of fund managers and administrators and that of co-financier of the scheme. With regard to promotion of the principles of SHI, government should take a lead role in steering the country in the direction of Social Health Insurance. The Government must overcome the challenge of incomplete and asymmetric information. Potential beneficiaries of the scheme have to be consulted on their expectations of the scheme. It should not be assumed that fund administrators and managers have the monopoly of knowledge about the health risks of different population groups, as there is a tendency of SHI schemes to define health insurance premiums on the basis of 'average' health risks.

Given a choice, members of the healthier population groups may judge that the SHI contribution is too high compared to their risk, so that they may reject the NSHIF offer. This will leave NSHIF with a disproportionate fraction of the population with high health risks, which forces it to increase contributions and renders it unsustainable. The process of healthier people withdrawing from the scheme may continue, leading to enrolment of the people with bad risks only. In its extreme form, there is no longer risk pooling and cost sharing between the healthy and the sick. Generally, bad risks are associated with a low-income earners thus compromising solidarity between the higher income and lower income population groups.

The Government could help reduce the problem of adverse selection whereby the sick and vulnerable register into SHI schemes, by putting achievable regulations in place. Waiting periods between the time of registration and eligibility to access benefits as is the case in the current NHIF are recommended, so as to deter people from signing up with a scheme only when they are ill.

The government should recommend registration on family and organized groups basis particularly for the informal sector. Besides enrolling as much of the population as possible, the size of the scheme is an equally important concern. Excessively small schemes, for instance with only a few hundred members, do not constitute a solid risk pool capable of insuring its members adequately. Larger risk pools are thus advisable, for instance via the establishment of an alliance of SHI funds. The government ought to require the scheme's administrators and managers to develop a SHI development plan that would aim at increasing population coverage and greater risk pooling over a defined period of time.

#### **Alternative benefit package**

The Government could formulate recommendations on the composition of alternative health insurance benefit packages. These packages would have to reflect the health care needs of the population, and be designed in a cost-effective way, for instance through standard treatment protocols. In order to ensure cost-effectiveness, the benefit package would integrate regulations for a rational health care delivery system. From a purely insurance point of view, insurance against the costs of inpatient care would be of prime benefit to the insured, because the relatively high financial consequences of such events

would be avoided. However, the costs of outpatient care for the chronically ill, and the treatment cost of ambulatory care for certain communicable diseases like tuberculosis, also entail risks worth insuring.

### **The role of the Government in preventive health care**

The government has to step up its preventive role in the decrease of disease incidence, immunization, ante -natal care and under- five growth monitoring, and public health education. To address public health demands, basic outpatient care has to be included in the benefit package in order to reduce the negative externalities from communicable diseases and curb unnecessary admissions. There are economic and financial reasons for insuring outpatient care. Certain infections when untreated may result in a greater amount of workdays lost. With SHI enabling members to receive adequate treatment, this economic loss could be averted.

### **SHI Management Information System**

Government ought to assist NSHIF in establishing a management information system (MIS) at the outset of implementation in view of the envisaged size of the membership and the scheme's administrative capacity. This MIS could be simple at first, focusing on recording membership and basic characteristics of members (e.g. age, occupation, size of household to which they belong), insured members' contributions, demand for health care (inpatient admissions, attendance for curative, preventive and promotive activities) and costs of health care delivery. The MIS would be very helpful in establishing and/or adjusting social health insurance contributions so as to ensure the scheme's financial

equilibrium. It can also be helpful in spotting elements of adverse selection and tracking progress towards expanded population coverage. A simple MIS could also be the precursor of an information network linking the various components of NSHIF to government.

### **Monitoring and evaluation**

The Government can offer to monitor and evaluate performance of the scheme, track progress across the different players through time, and perform comparative analysis. Monitoring should not be understood as passive, but as an active early warning mechanism and an opportunity to offer practical advice concerning emerging issues. An important recommendation is for the Government to develop a standardized monitoring protocol which could be applied throughout the scheme, and which would facilitate comparative analysis. The monitoring and evaluation protocol would be facilitated through an efficient MIS as discussed above. The results from monitoring and the promotion activities also provide a natural input into capacity building activities that Government could support. The scope of these activities would cover the entire range of issues that concern the establishment and adjustment of SHI, i.e. determination of the benefit package, contribution levels, modes of collection of contributions, enforcement of compliance, management information systems and the establishment of SHI development plans.

### **The Government as a co-financier of NSHIF**

The Government has a critical role of co-financier of the scheme in terms of social protection for the poor and vulnerable and as an employer. Government could subsidize, partially or fully, the SHI contributions of the poorest. These subsidies would be financed out of general tax revenues. Government could seek the support of development partners and enterprises, once its own commitment to subsidizing the poor and vulnerable is made. Government could enact an inter-NSHIF solidarity rule, whereby some percentage share of contributions is hived off from the main scheme into a *solidarity fund* that would be used to finance unexpected expenditure such as epidemics or to cater for deficits caused by financing health care of the poor and vulnerable. Engagement of the government as co-financier partner is necessary to counteract, to some extent, the regressive character of flat contributions by households in many national and SHI schemes worldwide. The presupposition here is that the taxation system itself is progressive, which is not necessarily guaranteed.

While noting that the Government co-finances capital costs of health facilities as well as recurrent costs such as personnel emoluments ; In the short run, the Government should, in principle continue to co-finance those budget items. It is only as the scheme matures and becomes financially stable that new ways of cost sharing may be considered. Though a co-financier it is expected that the government would reserve its role as a contributor in a nation-wide SHI scheme, such as can be observed in many mature social health insurance systems around the world.

### **Oversight role of Government in NSHIF**

It should be understood that the Government should not have a role in the day-to-day management of NSHIF. Rather, the Government should assume a role as prime facilitator with the objective of expanding the population's access to SHI. Morduch (1999) writing on macro-insurance schemes states that when these schemes are operated directly by Governments, borrowers default more rapidly on the loans. Governments are also likely to better tolerate such non-compliance, for political reasons.

### **The issue of timing**

It is clear from experience that attaining universal health coverage takes time. The country's socio-economic development and political consensus is critical in this regard. It is of utmost importance however that Kenya engages in the process of SHI implementation without further delay. It is a feather in Kenya's cap that NHIF is the oldest national health insurance scheme in Africa. NHIF therefore provides the experiential and institutional framework from which NSHIF can be developed. The legislative and regulatory framework for NSHIF should not take more than two years to be established. It is imprudent to predict, how much time it will take to achieve coverage of the entire population, but going by international experience a ten to twelve year period seems reasonable. Adequate risk pooling is a central concern during the transition from NHIF to NSHIF.

Note that during the transition, certain regions may well remain without SHI coverage for some period of time. It is imperative that the Government maintains its regulatory and

oversight role to support the scheme in identification of health risks, setting premium and co-payment levels, initiating efforts to curb adverse selection, definition of benefit packages and protocols for curative, preventive activities, monitoring of contracts with health service providers and an efficient SHI management information system.

While taking the lead role in SHI, Government has to actively engage all stakeholders concerned with healthcare service delivery and financing. The role of private for profit insurers and HMOs, faith based and non governmental organizations, employers, professional and informal sector associations and health care workers in the successful implementation of SHI in Kenya cannot be overstated and should be clearly defined in a reviewed NSHIF policy paper aimed at achieving universal coverage.

Poverty and disease are a vicious circle in which a large part of humankind is currently trapped. Poor living and working conditions increase the frequency of ill health for poor people. Sickness in turn gives rise to expenses, which are sometimes prohibitive, and in the worst cases can rob people of the fundamental basis of their livelihoods. Health is essential in order to work and earn income, and therefore lays the foundation for the sustainable reduction of global poverty. Insurance protection against the economic and social consequences of ill health is thus an essential condition for the reduction of extreme poverty, which is set to be halved worldwide by 2015, if the targets of the Millennium Development Goals are to be met..

Since independence, the Government has endeavoured to implement comprehensive health policies to guide its activities in meeting the health needs of the population. Networks of health facilities have been established in all parts of the country, and a sizeable private health sector has taken root.

However, access to quality healthcare remains a dream for most Kenyans. This situation is occasioned by high poverty levels which are exacerbated by cost-sharing in health. Radical reform is therefore needed in public health sector financing. There is no dearth of policy papers; the challenge lies in effective implementation, monitoring and evaluation to achieve the vision of the health sector.

Implementation of a nationwide social health insurance scheme represents a major challenge to policy makers and administrators in Kenya. Issues of economic feasibility and political acceptability need to be addressed. It is important to recognize that for economic, social, political and organizational reasons, a well-planned transition period from the present health care financing system to NSHIF will be necessary. In view of international experience in social health insurance implementation, such a period is likely to last more than a decade.

Issues of access to health care, and the need to avoid impoverishment due to direct health care payments should be recognized from the outset so that steady progress towards universal health coverage can be planned and achieved.



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**QUESTIONNAIRE**

Less developed countries, particularly in Africa, have been faced with the challenge of providing access to equitable and affordable healthcare for their citizenry. Since Independence, the Government of Kenya has endeavoured to implement comprehensive health policies to enable it improve access to healthcare services. In spite of Government subsidies and cooperation with non-state actors such as Faith Based Organisations (FBOs) health indicators have not markedly improved. The endeavour to reform healthcare financing and improve access to health services has informed the thinking that Social Health Insurance(SHI) is the way to go.

The questionnaire is for a study entitled:

**IMPLEMENTATION OF SOCIAL HEALTH INSURANCE IN KENYA-  
PROSPECTS AND CHALLENGES**

Your responses will add valuable insights to the study.

1. In 2004, the Government of Kenya introduced the National Social Health Insurance Fund Bill to Parliament for debate. The Bill was passed by the House but the President declined to assent to it. Yet the National Health Sector Strategic Plan 2005-2010 refers to Government plans to introduce a National Social Health Insurance Scheme to address challenges of Healthcare financing.

i) Why do you think the President declined to assent to Bill?

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ii) What is the way forward in this regard?

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2. What are the challenges to access to healthcare for all in Kenya?

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3. What principles should form the basis of healthcare services in Kenya?

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4. What should the Government do to ensure equitable access to healthcare for all Kenyans?

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5. Comment on the suitability of Social Health Insurance as a method of financing healthcare in Kenya.

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6. What are the challenges the country is likely to experience in its efforts to implement SHI?

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7. If social health insurance is to be implemented in Kenya, what would be the best way to go about it?

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8. How does the high percentage of Kenya's population living below the poverty line affect access to healthcare?

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9. How can social protection for the poor and vulnerable be realised in matters of access to healthcare in Kenya?

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10. Adverse selection, whereby those most in need such as terminally ill people register to be members, can pose a serious threat to the viability of a Social Health Insurance Scheme.

How can this be dealt with to ensure that the scheme is open to all people without prejudice, yet scheme funds are not depleted by one segment of its membership?

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11(i) What is the place for Commercial *for profit* health insurance in Kenya's healthcare financing system?

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ii) What is the place of Health Management Organisations (HMOs) in Kenya's healthcare financing system?

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**12.a) What gains can be made by State deregulation of a National Social Health Insurance Scheme ?**

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**b) How will State deregulation of the health sector impact on:**

**i) health service providers**

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**ii) Members**

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**iii) Fund managers/administrators**

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13. Stakeholders have expressed concerns over management, accountability and transparency of the proposed NSHIF . How can these concerns be addressed?

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