

**CHALLENGES IN PROVISION OF UNIVERSAL HEALTH CARE
BY THE NATIONAL HOSPITAL INSURANCE FUND, KENYA**

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**A RESEARCH PROJECT SUBMITTED IN PARTIAL FULFILMENT
OF THE REQUIREMENT FOR THE AWARD OF DEGREE OF
MASTER OF BUSINESS ADMINISTRATION, SCHOOL OF
BUSINESS, UNIVERSITY OF NAIROBI**

NOVEMBER, 2014

DECLARATION

This project is my original work and has never been submitted for a degree in any other university or college for examination/academic purposes.

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ACKNOWLEDGEMENTS

I am indebted to the almighty God who has given me the grace to go through the course work and undertake the research to this far.

I wish also to pass my sincere gratitude to my supervisor Ms Caren Angima for her valuable encouragement, critique, corrections, advice and proper guidance throughout the research work. I too recognize my classmates and friends for their positive criticism and for their great support in the entire study period.

I wish also to thank my parents and siblings for the great support and encouragement throughout. Special recognition goes to Emmanuel Orangi for his overwhelming support and encouragement through the course work and the research period.

DEDICATION

I dedicate this research work to my beloved father Martin karanja, my mother Veronica karanja, and my siblings Antony kahinga, John Muthama, Stephen Njoroge and Grace Wambui. God bless you all for your continued support and prayers.

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LIST OF ABBREVIATIONS/ACRONYMS

CHF	:	Community Health Fund
GDP	:	Gross Domestic Product
GOG	:	Government of Ghana
GOK	:	Government of Kenya
ILO	:	International Labour Organization
NHIF	:	National Hospital Insurance Fund
SHIB	:	Social Health Insurance Benefit
SSPSF	:	Social Security and Pension Scheme Fund
TIKA	:	Tiba Kwa Kadi
UHC	:	Universal Health Care
UNDP	:	United Nation Development Programme
UNICEF	:	United Nations Children Fund
WHO	:	World Health Organization
WHR	:	World Health Report

ABSTRACT

There is precedent for moving Kenya towards Universal Health Care. The Kenyan Constitution states that every Kenyan has a right to quality and affordable health care, and recognizes the role of the government in removing barriers to access. This was recently affirmed in Sessional Paper No. 7 of 2012 on Universal Health Care. The Kenya government's commitment to providing health care for all of its citizens is clearly moving in the right direction. This study sought to find the challenges and solutions in provision of Universal Health Care. The data was collected from top management employees, members of staff, trustee and the secretariat of NHIF. The data collected was analysed using content analysis and the results presented in prose form. A combination of primary and secondary sources was used to collect data for the study. The study found that provision of universal health care has its challenges in Kenya which are shortage of government budgetary resources, weak health systems, high poverty levels, reaching vulnerable people, selecting the right package of benefits, integration of the informal sector, and misuse of resource. It was concluded that the government can use mechanisms to curb this challenges with include, increasing the efficiency of revenue collection, initiate schemes for informal sector, and the government should ensure broad coverage through health reforms in the whole country. The study concluded that universal health care is essential to all people in Kenya and this translates to the acceptance of the fact that the economically strong will have to pay more than the poor. Since the study was conducted in Kenya, it is recommended that similar studies be conducted in other NHIF organizations regionally to provide more information. It is also recommended that other studies on universal health care in Kenya be done to avail more information on the health situation in Kenya.

CHAPTER ONE

INTRODUCTION

1.1 Background of the study

Universal Health Care (UHC) is a system in which everyone in a society can get the health care services they need without financial hardship. The underlying theory is that universal care can increase access to essential health services, improve financial protection and ultimately lead to better health outcomes. The definition of universal care embodies three related objectives: equity in access to health services-those who need the services should get them, not only those who can pay for them. That the quality of health services is good enough to improve the health of those receiving services and financial risk protection ensuring that the cost of using care does not put people at risk of financial hardship. UHC has two fundamental goals: maximizing health impact and eliminating or reducing impoverishment and bankruptcy due to healthcare costs (WHO, 2010). Health and wellbeing are affected by many factors, and those that are associated with ill health, disability, disease or death are known as risk factors.

Risk is part of every human endeavor. From the moment we get up in the morning, drive or take public transportation to get to school or to work until we get back into our beds, we are exposed to risks of different degrees. While some of these risks may be trivial, others make a significant difference in the way we live our lives. Holton (2004) argues that there are two ingredients that are needed for risk to exist. The first is uncertainty about the potential outcome from an experiment and the other is that the outcomes have to matter in terms of providing utility. He therefore defined risk as a high probability of

an event occurring, that is viewed as undesirable, and an assessment of the expected harm from the event occurring.

Ill health brings out the risk of incurring heavy medical expenses among individuals. This risk can be managed in various forms which include UHC; this refers to a health care system which provides health care and financial protection to all its citizens. It is organized around providing a specified package of benefits to all members of a society with the end goal of providing financial risk protection, improved access to health services, and improved health outcomes. This is usually provided by governments of various states for example its provision in Kenya through NHIF. The risk can also be managed through other various forms for example, private insurance, community-based health insurance, social health insurance and compulsory health insurance (WHO, 2010).

1.1.1 Universal Health Care

UHC means that everyone in the population has access to appropriate promotive, preventive, curative and rehabilitative health care when they need it and at an affordable cost. Universal care thus implies equity of access and financial risk protection. It is also based on the notion of equity in financing; this means that people contribute on the basis of ability to pay rather than according to whether they fall ill. This implies that a major source of health funding needs to come from prepaid and pooled contributions rather than from fees or charges levied once a person falls ill and accesses services. UHC involves judgments' about whom the potential recipients are, the range of services included within health care, and the quality of that care (WHO, 2005).

The principles that should guide the formulation of a successful UHC include universality and social solidarity. Universality refers to the essential right to access health services and have financial protection from the costs of those services taking into consideration that all should have the same entitlements in relation to quality of health services. The second principle, social solidarity refers to common responsibilities and interests within society. Within the context of a health system, it particularly relates to the need for cross-subsidies in the overall health system. This includes both income cross-subsidies (from the rich to the poor, whereby individuals contribute to financing health services on the basis of their ability to pay) and risk cross-subsidies (from the healthy to the ill, whereby individuals benefit from health services on the basis of their need for services). Social solidarity is about equity. Income cross subsidies are required so that payments towards health service financing are in line with one's ability to pay. Risk cross subsidies ensure that use of health services is in line with individuals' need for health services (UNDP, 2009).

1.1.2 Challenges in provision of universal health care

Countries in Africa (and in most other parts of the world) face an array of health care financing problems that leave their health systems far from achieving the objectives of good health status, equity, efficiency, acceptability, and sustainability. The main problem is simply a shortage of government budgetary resources for health care relative to increasing demand and need for care. One manifestation of the budgetary shortfall is deterioration in the quality and effectiveness of publicly provided health services (Barnum and Saxenian 1995). In a macroeconomic climate that has been characterized by slow or no growth in national income or government budgets, and often a per capita

decline in real terms, governments are seeking ways to limit their financial responsibilities for health services (ILO 1993). The reforms being considered or implemented constitute strategies to improve the use of existing resources and/or mobilize additional nongovernmental resources for health.

In addition to an absolute shortage of resources going into the health sector, patterns of spending in most countries cause or reflect an inequitable and inefficient allocation of inputs and services. The clearest example of this is the concentration of government resources in large, urban hospitals. On average, people who live in urban areas have higher incomes than those in rural areas, yet the urban bias in government health spending means that the costs of gaining access to good quality care are highest for the most remote, and usually poorest, groups of the population. Moreover, evidence from several countries, for instance, Kenya, and Tanzania (Griffin and Shaw 1995), indicates that non poor people tend to consume more publicly financed hospital care per capita than poor people, which implies that they receive a disproportionate share of government subsidies. This pattern of government resource allocation may also be inefficient because the most cost-effective clinical interventions that health systems can provide are those that are most appropriately delivered in a health center or other nonhospital setting.

Hammer and Berman (1995), argue that the challenge in many developing countries is exacerbated by a host of additional obstacles including inadequate tax collection system, corruption, weak management and oversight, insufficient skilled personnel and difficulties in identifying and reaching the most vulnerable citizens. High levels of waste

and other forms of technical inefficiency also plague health systems in these countries. These problems are a threat to any gains that reforms to improve cost-effectiveness.

1.1.3 National Hospital Insurance Fund

Kenya has one public health insurance scheme, the NHIF. It is a non-profit institution created by an Act of Parliament in 1966 as a department in the Ministry of health. At inception, NHIF was intended to provide accessible health insurance for salaried public and private sector employees earning a monthly salary of ksh 1,000 and more (GoK, 2004). The NHIF has undergone several changes over the years to include more benefits, targeting informal sector households and currently the scheme is piloting an outpatient care package for its members (Hsiao and Shaw, 2007). NHIF is the primary provider of health insurance in Kenya with a mandate to enable all Kenyans to access quality and affordable health services. A resident of Kenya who has attained 18 yrs is eligible to be a member and contributions are calculated on a graduated scale based on the income, which a majority contributing between Kshs 30 to Kshs 320 per month. The fund is governed by a Board of Directors with representatives from civil society, employers and local government.

The NHIF's hospital network is broken into three tiers of hospitals. At "Contract A" hospitals, which include primarily government hospitals, NHIF beneficiaries receive comprehensive cover with no overall limit on the amount of benefits received, this means that members walk in, are treated and walk out without additional payments; the fund in this case also covers maternity expenses and does not exclude any disease. At "Contract B" hospitals, which include certain non-state providers (this are non profit private

hospitals, mission hospital, and private hospitals in rural areas or areas not sufficiently served by the public sector), coverage remains comprehensive, but an annual limit of 432,000 ksh per member (including the member and all dependants) applies. Finally, at “Contract C” hospitals, which include many higher cost private hospitals, the NHIF provides a rebate only. The benefits package includes comprehensive medical coverage for maternity cases. NHIF works with more than 600 accredited Government, private and mission health providers (Deloitte, 2011).

Evidence of NHIF’s increasing prominence in Kenya’s health system comes from both explicit policy decisions, and financial data that reflect an enhanced financial role for the organization. At the policy level, in 2004 the Government of Kenya proposed a universal health insurance system based on an NHIF-style social health insurance model (contributions from employers and employees would form a principal financing pillar). This led to the drafting of the National Social Health Insurance Fund Bill, which would have put a reformed NHIF at the heart of an expanded national insurance system. However, although the proposed reform passed Parliament, the President declined to sign it, and the bill died. Conversations have nevertheless continued about how to expand health insurance in Kenya, and it is clear that NHIF is seen to be at the core of this process.

For this reason, the government contracted Deloitte Consulting to conduct a review of NHIF’s capabilities in 2011. The resulting report states quite clearly that the review was undertaken in order to “position the Fund for the enhanced role” it would play under a

universal coverage scheme. Moreover, in early 2012, NHIF began to implement a new scheme to provide outpatient coverage to civil servants, in addition to the inpatient hospital cover it has long provided. Public discussions of this scheme and coverage in the media have strongly suggested that this is the first step in a wider effort to enhance the coverage by the Fund, the share of the population covered, and the state corporation's role in financing both public and private facilities (Carrin, 2012).

Health care in Kenya has faced numerous challenges, including inadequate funding. Limited funding by the government means out of pocket spending remains a key source of funds for healthcare and ultimately this negatively affects acquisition of health care by the populace. Likewise, high poverty levels among the population have also impacted negatively on health financing. 46% of Kenyans live on less than a dollar per day there being a reciprocal relationship between poverty and health status. On the one hand, poverty is a major driver of poor health status while at the same time poor health status drives the poor deeper into poverty. This implies that the poor in Kenya faces major financial barriers to accessing healthcare. Even with the NHIF programme attempting to enroll informal sector workers, high unemployment rates in Kenya pose a major threat to this drive (Deloitte, 2011).

1.2 Research Problem

As national incomes have risen across diverse countries along with the burden of non-communicable diseases, demand has intensified for quality and affordable health services. Many countries today are actively seeking to bring about UHC ensuring quality health services for all at a price that does not create undue financial pressure for

individuals seeking care. The effort has stirred expanded interest and guidance from international organizations such as the World Health Organization and the World Bank, and led to new platforms for developing countries to learn from each other. UHC will remain a work in progress for many countries for many years and it has the potential to attract greater attention to health spending, health systems, and improved equity, advances that will benefit human development more broadly.

The new Constitution of Kenya has entrenched the right to health; however, enjoyment of this right by the poor will depend on what measures are implemented to improve access to health care services for all including the poor (universal access). Irrespective of where poor people seek health care, this depends to a large extent on their access to cash or household assets that can be sold to meet the required out-of-pocket health expenditures.

Many Kenyans continue to have no access to or cannot afford to pay for their health care needs because most people live below the poverty line. The government of Kenya provides health care cover through NHIF, which only covers only inpatient benefits to its members and their beneficiaries. In the recent past, there have been attempt to provide UHC to the Kenyan population by NHIF, and it was officially rolled out in 2012 to civil servants. The need to provide UHC to all Kenyans is bound to have challenges, therefore justifying the need to study on the possible challenges in provision of UHC in Kenya.

In previous studies Wamai (2009) studied the health system in Kenya, analyzing the situation and challenges facing health insurance in Kenya and concluded that health cost

remains the greatest barrier to health care in Kenya. Deloitte (2011) studied the reciprocal relationship between poverty and health status in Kenya and concluded that 46% of Kenyans live on less than a dollar per day, and this high poverty levels among the population has also impacted negatively on health financing. Carrin and Chris (2005) studied the need to create mechanism to include more workers from the informal sector in health care system in developing countries. He concluded that countries can emulate countries like Germany, Ghana and Tanzania in their highly fragmented financing system that will enable provision of health care to the whole citizenry. Hsiao & Shaw (2007) studied the mode of health financing and provision of health care services in developing countries through the public and private sector and concluded that health financing in developing countries has had a predominantly tax funded health system thereby illustrating that the poor bear a large share of the costs.

According to the previous studies done, there are few known studies in Kenya done on the challenges in the provision of UHC in Kenya, especially by NHIF. This study therefore sought to fill this gap by answering the research question, what are the challenges faced by NHIF in provision of universal health care in Kenya?

1.3 Research Objectives

The objectives of this study were to:

- I. Determine challenges in provision of Universal health care by the NHIF.
- II. Determine the possible solutions to challenges in provision of Universal health care in Kenya.

1.4 Value of the study

The findings of this study will contribute value to the existing body of knowledge on universal health care in Kenya and will therefore act as future reference to the researchers and scholars who will pursue the subject in the future. The research will be of importance to academics and researchers taking up topics on universal health care in relation to NHIF.

The findings of this study will also be important to the NHIF. The findings will provide crucial information on the challenges in provision of UHC. The study will also determine the possible solutions to the challenges in provision of UHC, and the results can be used by NHIF to understand the challenges that are bound to come up in provision of UHC and ways that it can solve or mitigate those challenges to enable smooth flow of the UHC project.

The analysis will be of importance to policy makers (government) at an early stage such that they will ensure mechanisms are in place to allow the equal access of health care for all the Kenyan citizenry despite financial hardships for the poor in the society. The study will enlighten the government on the various ways of health care financing and therefore the policy makers can identify mechanisms for UHC financing in Kenya. The outcome of this study will enlighten the government on the challenges in provision of UHC and possible solutions to these challenges.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents the literature review of the study. The chapter discusses the theoretical foundation of the study, UHC, health care financing, public policy of UHC, access of UHC and challenges of provision of universal health care.

2.2 Theoretical Foundation of the Study

In health care, several principles support a right to health care and equal access to health care. This study looks at a theoretical foundation of neo-classical welfare economic theory that is concerned with the moral foundation of Universal health care.

Grossman (1972) developed a theoretical model based on the neo-classical framework. This model assumed the existence of certainty in demand for health. In his theoretical formulation, individuals make choices to maximize their preferences over time, and the goal of society is to maximize social welfare, or aggregate preferences. It assumes that individuals make rational choices based on cost-benefit calculations under varying conditions. This approach asserts that the free market is the best way to allocate resources, as it values efficiency over equity. Risk-averse individuals are predicted to choose insurance against large risks, leaving smaller risks uncovered, thereby improving their overall welfare. Health insurance markets are also not entirely free. Insurance companies have an information advantage, which they can use to ‘cherry pick’ both the kinds of consumers they insure and the kinds of coverage they offer them, in order to

increase their profits. In consequence, more comprehensive coverage tends to be confined to wealthier individuals, reducing the pooling of risk across the population. Conversely, poorer individuals often fail to choose coverage that meets their health needs.

Human beings are all different; they all have their own individualities, own ways of thinking and acting; but these are all actualities of human beings. Actualities of human being allow the existence of subjectivity. However, objectivity and universality come into existence when we consider human potentialities. Noticing here that Aristotelian notion of human being allows the coexistence of subjectivity and objectivity ever since the beginning. Also, if we take a step further and look into Maslow's work, we would roughly see a hierarchical structure exists in human potentialities for that some of the human potentialities would not be fulfilled without the fulfillments of the others. With the Aristotelian notion of human being in hand, health then, to a large extent, is associated with some very basic human potentialities positioned in the basis of the hierarchical structure of human potentialities, because we can argue that without being healthy, many other potentialities such as learning, exercising, and working would be impaired. Therefore, from this regard, it is theoretically establishes health as a human right, instead of a human choice in neoclassical framework (Hunt, 2005).

2.3 Universal Health Care

Although the concept of UHC is not new, over the last few years its importance and visibility have significantly increased. In 2005, the 58th World Health Assembly adopted a resolution encouraging countries to plan the transition to UHC in their health systems.

The current movement to promote UHC has been encouraged by other key actors in the field of global health such as the World Bank, the United Nations Children's Fund (UNICEF), the United States Agency for International Development, the Inter-American Development Bank, the Rockefeller Foundation, and the Bill and Melinda Gates Foundation. UHC interventions in low- and middle-income countries improve access to health care, and it often has a positive effect on financial protection, and in some cases it seems to have a positive impact on health status (Bump, 2010).

A closer look at UHC schemes and available evidence reveals the following three lessons, all of which have implications for both policy and future UHC research. First, affordability is important. Although improving the affordability of services is often achieved by UHC schemes, improvements in affordability do not always translate into improvements in access to health care, more holistic approach to the dimensions of access need to be understood and incorporated in the invention's design. Second, target the poor, but keep an eye on the nonpoor. Since the common UHC schemes designs are less effective for the nonpoor when extending coverage to them, other dimensions of access may gain in relative importance, and therefore different strategies may be needed. Also, in extending coverage to the nonpoor, it is important to look at how moral hazards effects may change across income groups. Third, benefits should closely be linked to target populations' needs. Policy makers with a definite budget have to manage the tradeoffs between what and how much is covered. In doing so, they should carefully examine the target population's needs by looking at indicators such as population

epidemiological profile, major barriers to access, unsatisfied demand and major sources of financial hardship (Savedoff, 2012).

2.4 Health care Financing

Various mechanisms for funding UHC exist. There are two main categories of health financing mechanisms: Out-of-pocket payments, which means that a person using a health service pays the provider directly (out of his or her own pocket, e.g. paying a user fee at a public health facility or paying cash to a private doctor for a consultation or for drugs at a pharmacy); and Pre-payment funding, which refers to paying towards the costs of health services before needing to use a health service (e.g. through paying tax or contributing to a health insurance scheme), and then health service providers are paid from these prepayment funds when the need to use a service arises. Pre-payment mechanisms can be further categorized into mandatory and voluntary prepayments. The distinction between these categories is whether there is a legal compulsion to make these pre-payments. Mandatory pre-payments require that individuals and companies to pay various taxes and contribute to a mandatory health insurance (usually called social or national health insurance). In contrast, in the case of voluntary health insurance schemes, there is no legal requirement to become a member of or contribute to these schemes (Kutzin, 2010).

The first area of consensus is that out-of-pocket payments are the least desirable way of funding health services. Out-of-pocket payments place the full burden of paying for health services on the individual who needs to use a health service at the time of need; it

does not allow for any income or risk cross-subsidies. It constitutes a major barrier to health services, particularly for poor households. The World Health Organization estimates that 100 million people are pushed below the poverty line each year due to out-of-pocket payments for health services (Kutzin, 2008).

There is now a global focus on maximizing pre-payment funding for health services, but with particular emphasis on mandatory pre-payment funding mechanisms. The WHR states that it is impossible to achieve universal care through insurance schemes when enrolment is voluntary. There are several reasons for this. First, voluntary health insurance schemes are not able to cover services for those who are too poor to pay insurance premiums. This is a major concern in Africa with high poverty levels. Second, if prepayment is not mandatory, the rich and healthy will choose not to contribute to funding for services needed by the poor and the sick (i.e. it is only possible to achieve strong cross subsidies through mandatory pre-payment mechanisms). Third, voluntary insurance is frequently fragmented into many small schemes, which creates efficiency and sustainability problems. Voluntary insurance is divided into private commercial insurance and community based insurance (Ekman, 2004).

For countries choosing to introduce mandatory health insurance, a key decision is whether mandatory health insurance will be restricted to formal sector employees or will attempt to cover everyone. Many countries around the world have initiated their mandatory health insurance by covering only formal sector workers, with mandatory health insurance contributions being made by both the employees and employers (Carrin

and James, 2004). This has been the experience of a number of high-income countries as well as middle-income countries in Latin America. It is also the approach adopted by some African countries. A key issue for policy makers appears to be the perceived need to generate some revenue from this group given the large informal sector in many African countries. If this is the main rationale, it is important to consider whether there are other, more efficient and equitable, mechanisms of generating revenue from the informal sector that can be devoted to funding health services, such as indirect taxes.

2.5 Public policy and incentive setting of universal health care

In relation to UHC, public policy looks at what different governments are doing or have done to achieve UHC. Germany, Ghana and Tanzania development examples will be of essential input to the Kenyan government in its endeavor to achieve UHC. Germany is a good case in point, when she structured her health insurance from voluntary to compulsory and from small to larger schemes (Criel & Van Dormael, 1999). Germany had legislation on a scheme covering the entire territory of Germany for one employment group. For instance, all miners were required to join one of the many regional miners' insurance funds (Carrin & Chris, 2005). After successful enrollment of the groups in health insurance, government legislation would initiate policy to have contribution by informal sector workers to health insurance compulsory.

Ghana has their health financing systems reoriented towards attaining health protection for the poorest and other disadvantaged populations (Durairaj et al, 2010). Financial contributions to insurance schemes in Ghana are designed in such a way that they are

graded according to people's ability to pay, the rich and the healthy subsidized the poor and the sick, and the economically active adults paid for the children and aged (WHO,2010). This would ensure that the poor are cushioned from the burden of paying for health care services. Funds meant for health are earmarked in the budget with a 5-year programme of work. Other sources of funding include individual contributions to the social security and pension scheme fund (SSPSF) and payments by the Ministry of Finance for exempted persons (GOG, 2009).

Tanzania health care is financed through highly fragmented financing system: health insurance schemes and tax funding. For instance, Tanzania has a compulsory scheme, NHIF which covers all public servants and up to 5 dependants. The fund is financed by a 6% of salary contribution equally shared between the employee and employer. Another scheme, SHIB covers private sector employees in Tanzania. Both the social health insurance benefit (SHIB) and the NHIF offers outpatient and inpatient care, but the NHIF cover access to over 5500 facilities nationally, while the SHIB covers only 264. Informal sector workers in Tanzania have a separate health insurance scheme from the formal sector. Community health fund (CHF), a government voluntary scheme targets the informal rural population while the urban informal sector has the *tiba kwa kadi* (TIKA) scheme Contributions to the Community health fund are decided at the council level, and each household contributes the same amount regardless of ability to pay, giving them access to free health care at primary public health facilities (Mtei et al., 2012).

2.6 Challenges in the provision of universal health care

The challenges in provision of UHC are many especially for low and middle income generating countries and they include: Health Inequalities, despite progress in improving health indicators in many countries, inequalities in health status—both between and within countries—remain large (European Commission, 2010). Inequalities are largely driven by socioeconomic factors, such as income, education, and occupation, and thus are determined outside the health care sector (Joumard et al., 2010). Some features of health care systems, contribute to inequalities in health outcomes. For example, informal payments for health care services, which are prevalent in many emerging economies, disproportionately burden the poor (Jakab, 2007).

Another challenge is escalating cost; health care costs have been growing rapidly in the past several decades. Since 1970, total real per capita health spending has increased fourfold, while spending as a share of GDP has increased from 6 percent to 12 percent in advanced economies. In emerging economies, total health spending has increased from below 3 percent of GDP to 5 percent. These increases have put great fiscal pressure on governments and financial pressure on households and businesses. The primary drivers of growth in health spending include rising income, population aging, and technological advancements. An additional factor that will drive spending is the change in disease profiles and associated risk factors (WHO, 2010).

Inefficiencies, in health spending are large this include allocative inefficiencies and productive inefficiencies. Because of inefficiencies, many countries could achieve the

same level of health outcomes with a lower level of spending. A study by the Organization for Economic Cooperation and Development suggests that reducing inefficiencies in health systems by half in the OECD would raise life expectancy at birth, on average, by more than one year (Joumard et al., 2010). By comparison, a 10 percent increase in health care spending per capita would increase life expectancy by only three to four months. The WHO estimates that 20 to 40 percent of resources spent on health are wasted. The most common causes of inefficiency include inappropriate and ineffective use of medicines, medical errors, suboptimal quality of care, waste, corruption, and fraud (WHO, 2010).

The imperfections in the health care market imply that governments must play an important role. However, there is no single model that delivers the best results across all countries. The pervasiveness of market failures and a desire to ensure that access to basic health care reflects need and not ability to pay have motivated extensive government involvement in this sector in advanced and emerging economies (Musgrove, 1996). These differing approaches to providing and financing health care, and the resulting differences in the level of public health spending across countries, reflect differences in country preferences and constraints. Therefore, there is no unique “optimal” level of public health spending that can provide a benchmark for comparing countries. Countries may place different weights on equality of access, face differing fiscal constraints, or attach different weights to health spending as opposed to other uses of public funds. Yet there is a need to ensure that whatever “model” for health care is adopted, public health care services are provided in an efficient way (Savedoff, 2007).

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter explains how the research was done. This includes the research design, data collection and data analysis procedures.

3.2 Research Design

The study adopted a case study method. Research design refers to the overall strategy that one chooses to integrate the different components of the study in a coherent and logical way, thereby, ensuring one will effectively address the research problem; it constitutes collection, measurement, and analysis of data.

The case study design was relevant since the research was specific to an organization and case studies allow a researcher to collect in depth information with the intention of understanding situations or phenomenon. A case study is a powerful form of analysis and involves careful and complete observation of a social unit be it a person, group or an entire community or institution.

3.3 Data Collection

The study used both primary and secondary data. Qualitative primary data was collected using an interview guide that was developed based on the research question. Interview guide was highly favored because it is an inexpensive way to gather data from 8

respondents from NHIF comprising of 3 managers from NHIF top management team.³ NHIF members of staff who were involved in the day to day administration of the fund. A member of the fund secretariat involved in the move toward UHC and one trustee of the NHIF fund. The choice of the respondents was based on the need to represent all the members charged with the running of NHIF fund and decision making in all policy matters relating to UHC.

Secondary data was collected from four different sources, the principal sources of information and data was from the Government of Kenya publications, this is because NHIF is a parastatal in Kenya and a national health insurance company, WHO publications, NHIF publication and Kenya National Bureau of Statistics publications, this was of importance because it is a Government agency that collects, analyses and disseminates socio-economic statistics needed for planning and policy formulation. Secondary data used involved reviews of related literature on universal health care.

3.4 Data Analysis

The type of analysis that was suitable for this research was content analysis; it was particularly relevant because the data was qualitative in nature and also the research applied narrative texts such transcribed interviews, and published literature, and the analysis wanted to elucidate, through close examination of the content and language of these texts, what was learned from the respondents' understanding of phenomena and terminology, as well as their beliefs on UHC. Before processing the responses, data was

edited, then coded and entered into a spreadsheet and analyzed using qualitative and quantitative techniques.

In particular the method examined the respondents view and understanding on issues concerning UHC. Content analysis has been used by various researchers such as (Weber, 1990) who claims that is easy and convenient for data collected from interviews, open ended survey questions or analysis of secondary data.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION, INTERPRETATION AND DISCUSSION

4.1 Introduction

This chapter presents the findings of the study. The chapter presents the findings from the top management, the members of staff, the Trustee and secretariat. The chapter presents data on the demographics, impacts, challenges in provision of Universal Health Care in Kenya and solutions to those challenges.

4.2 Response Rate

The study planned to acquire the requisite information from 8 respondents in NHIF. All the 8 respondents were able to respond, giving the study a 100% response rate. The study acquired information from 3 top management representative; 3 NHIF members of staff; 1 member of the secretariat and 1 member of the NHIF trustee. This response rate was 100% due to the fact that the number of respondents was small which enabled the researcher to interview all the participants. The researcher also works near NHIF which made it easy to access all the information required as well as receive co-operation from the respondents.

4.3 Demographic information

The study was conducted through interviews done to top management team at NHIF, staff of NHIF, one trustee and secretariat. According to the findings, the 3 respondents who represented the top management in this study had worked at NHIF for a considerable amount of time such as for 27years for one 18 years for the other and 12 years for the

third. This means that the information gathered from the top management was based on experience and knowledge of NHIF. The study also established that most of the NHIF members of staff who took part in the study had worked in NHIF for a period of more than five (5) years. The study found that members have different perception about universal health care. The trustees of NHIF were represented in the study by one (1) Trustee who provided the requisite insights on universal health care. The respondent was observed to have been working with NHIF for ten (10) years. The study also collected data from the scheme secretariat personnel. It sought the requisite information from one (1) secretariat member who has worked with NHIF for quite a long period of time of twelve (12) years.

This indicates that the respondents of the study were all well acquainted with the operations of NHIF and the information provided was based on observation and experience and therefore can be taken as the real situation. This shows that the research information collected was credible and reliable to provide the insights required to make concrete understanding of the study.

4.4 Impact of Universal Health Care by NHIF

The study found that the adoption of universal health care has been of great impact to NHIF, civil servants and the country as a whole. Universal health care was observed to have the following impact:

4.4.1 Equity in public health service utilisation

Universal health care has ensured equity in public health service utilization which is ensuring that there is no exclusion and social disparities in the provision of health care services. The health services are being provided equitably to all individuals in the community irrespective of their gender, age, caste, color, geographical location and socio-economic status. The main focus of NHIF in provision of universal health care is inclusiveness, nondiscrimination, social accountability, and gender equality. The health services are affordable, equitable, accessible and responsive to client's needs.

4.4.2 Fair distribution of health care financing burdens

The study established that a sound financing system has ensured a fair distribution of the burden of paying for health services, protect households against the risks of catastrophic levels of expenditure on health services, reduce barriers to health service use and promote an equitable distribution of public expenditures. The conventional categorizations of health financing sources in Kenya are taxation, social health insurance contributions, private health insurance premiums, and out-of-pocket payments.

The findings indicated that most Kenyans rely on out-of-pocket payments. According to the top management only 10% of people in Kenya have health insurance, so this means that 90% rely on out-of-pocket payments. Health insurance coverage is higher among the urban population (19.7%), compared to the rural population (7.4%); and among the richest (26.4%) compared to the poorest population (1.9%). Out-of-pocket payments lead to inequitable health financing systems and a higher prevalence of households facing catastrophic health spending and resulting impoverishment. Universal health care has

been seen to fairly distribute health care financing burdens because people will be contributing on the basis of their ability to pay rather than according to whether they fall ill.

4.4.3 Financial risk protection

The measure of financial risk protection is the ratio of the out-of-pocket payments to total health expenditure. The study established that Out-of-pocket payments create financial barriers that prevent millions of people each year from seeking and receiving needed health services. In addition, many of those who do seek and pay for health services are confronted with financial catastrophe and impoverishment. The study also showed that the Kenyans who do not use health services at all, or who suffer financial catastrophe are a big percentage of the population. Many others might forego only some services, or suffer less severe financial consequences imposed by user charges, but people everywhere, at all income levels, seek protection from the financial risks associated with ill health.

The study found out that Universal health care has focused its attention on two health financing functions and related specific policy norms which will help on financial risk protection associated with ill health. This include revenue collection, whereby financial contributions should be collected in sufficient quantities, equitably and efficiently and pooling of contributions so that costs of accessing health services are shared and not met only by individuals at the time they fall ill, thus ensuring financial accessibility.

4.4.4 People driven health services delivery

People driven health services delivery is one of the major impact that universal health care has to the people of Kenya. The findings of the study showed that health insurance is addressed by ensuring that a rights-based approach to health is adopted and applied in the delivery of health services. A comprehensive and people driven health service delivery has ensured that every person has the right to the highest attainable standard of health and that every person is not denied emergency medical treatment. People driven health services delivery has also ensured that the government of Kenya provide appropriate social security to persons who are unable to support themselves and their dependants.

4.5 Challenges in provision of Universal Health Care

The study also looked at the challenges in provision Universal health care. The respondents explained some challenges the organization is facing in provision of Universal health care. These challenges are as explained.

4.5.1 Shortage of government budgetary resources

The findings of the study showed that in order to finance the scheme yearly, the organization needs a total of 40 billion. Kshs.12 billion of the 40 billion, is projected to be received from the people in formal employment (employers and employees); Kshs.10 billion from those in informal and self-employment; Kshs.7 billion from government and its employees (civil servants and teachers); Kshs.11 billion from additional taxation on consumption and Kshs. 1 billion from grants and miscellaneous sources. The government cannot afford to provide universal health care without utilizing other sources and these may strain financially the people of Kenya. This implies that there will be undue financial

pressure in the provision of care to the population and therefore resulting in the need for direct out-of-pocket payments for those seeking care, causing severe financial hardships for individuals and also reducing the chances of universal health system expansion in Kenya.

4.5.2 Selecting the right package of benefit

Universal health care should cover treatment and hospital care regardless of disease but subject to limits and conditions that may be imposed by the Board managing the fund. For outpatient care the cover caters for kshs.250 and 400 per visit up to a maximum of 5 visits per member per year on all-inclusive basis. For Inpatient the cover will cater for a maximum of kshs.3000 per year for 60 days per member per year all inclusive basis. The member will pay for additional or alternatively the provider will refer the patient to a higher level facility where relevant services will be covered. The providers are expected to sign a contract, which shall bar them from charging extra money to the member. Nonetheless, the bill is silent on certain conditions and services, the most conspicuous being anti-retroviral drugs for HIV positive patients. This implies that universal health care will not be able to provide everyone with all the health services they need at an affordable price which means that the covered services may not necessarily provide the best health outcome for money spent.

4.5.3 Reaching vulnerable population

The key component to moving towards universal health care is ensuring benefits reach the people who need them the most: the poor, vulnerable and marginalized who typically have the worst access to health services who often pay directly out-of-pocket at the time

of care and who are the most likely to either skip needed care or be impoverished if they seek it. In order to ensure quality services are conveniently available to those who need health care it may require the organization that they offer care for free to people who are not in a position to contribute. The organization is also finding it difficult in figuring out who are the most vulnerable, and how to reach them with health care. This implies that the poor, vulnerable and marginalized people in Kenya will continue to have little access to health services, leading to out-of-pocket payment and this may lead to them skipping the needed care or they may be impoverished if they seek it. This means that those who lack care in Kenya now may continue to go without.

4.5.4 High poverty levels

Health financing is facing numerous challenges, including limited funding by the government. Limited funding by the government means out-of-pocket spending remains a key source of funds for healthcare and ultimately this negatively affects acquisition of health care by the populace. Limited funding is a direct result of the high poverty levels in the country. Additionally, those who cannot afford to pay their contributions because of poverty will be exempted from payment. There is no provision though for determining those who cannot pay, this in a country in which 56% of the population is reportedly poor. With many Kenyans living on less than a dollar per day there has been a reciprocal relationship between poverty and health status. On the one hand, poverty is a major driver of poor health status while at the same time poor health status drives the poor deeper into poverty. This implies that the poor in Kenya faces major financial barriers to accessing healthcare. The life expectancy has been declining and is now close to 59 years, while out of every 1,000 children born in Kenya, 116 are likely to die before age five.

4.5.5 Integration of the Informal sector

The major challenge has been integration of the expanding informal sector and inclusion of the poor. This is mainly because health insurance is mostly restricted to urban areas, where the private formal sector is concentrated, thus not improving geographical access, this is true since the check-off system applied for formal workers cannot be applicable, other approaches have to be used to have them contribute towards the scheme. This also is a major concern because the informal sector in Kenya has 83.83% of the total workforce and it lacks a significant degree of social protection in terms health and safety regulations, as well as workmen's compensation. There is also no equity between formal and informal sector contributions. While an employee in the formal sector will be required to make a contribution based on his or her income, a person in the informal sector will pay a fixed rate of Kshs 400 per year irrespective of his income. Further the employee in the formal sector will be required to pay contribution for his dependants. This implies that a big percentage of the Kenyan population especially in the rural areas will not have access to health care, and therefore the considerable levels of success in ensuring health care to the population will be minimal and limited to the urban areas.

4.5.6 Using Resources Efficiently

The greatest challenge in establishing and sustaining universal health care in Kenya is efficiently using scarce resource. In Kenya it is however difficult to deny the dismal performance of the government in managing the public basket effectively for the good of all. The legitimate need for Government intervention in the market is, therefore, badly damaged by its record and only serves to create doubt over its ability to effect universal health care effectively. It is this inherent clash between the need for government to

intervene in the market and the dismal history of government management of public resources that explains the apparent contradiction between support and objections to the health scheme. The political cost of mismanagement and corruption has drastically risen. This implies that health care providers will not be able to deliver high quality, appropriate and needed care to patients without the need of out-of-pocket payment.

4.5.7 Weak health systems

The health systems in Kenya lack adequate infrastructure, supplies and human resources. This leads to a constant struggle in accessing health care systems in Kenya. There are huge gaps in supply and infrastructure such as laboratories, labour rooms, equipment and human resources. The gap also is also burdened with communicable diseases that require a substantial component of preventive health. There is also a challenge in the country where many health care services providers are ranging from highly trained medical specialists to traditional healers, and significant disparities in access. Most of health care services are provided by a largely unregulated private sector. Problems arising from an unregulated private sector include misuse of medicines and lack links to higher levels of care for referral purposes. Regulation of health services is an area that is receiving insufficient attention. This implies that the assumption that with provision of care, services will be available to meet demand may not be valid in Kenya since there are broken health systems with huge gaps. The country will continue to be burdened with communicable diseases that only require substantial components of preventive health care.

4.6 Solutions to challenges in provision universal health care in Kenya

The study also looked at the possible solutions to the challenges in provision of universal health care. The respondents explained some solutions for challenges in provision of Universal health care. These solutions are as explained.

4.6.1 Pooling of resources

The government in increasing the efficiency of pooling health care resources will go a long way in the support of larger health financing pools. The government can expand health care through tax-based systems or compulsory social health insurance systems. In tax based system the general tax revenue will be the main source of funding and the government will provide or purchase health services. In social insurance based system, workers, the self-employed, commercial entities and the government will all contribute to the health pool. The goal of the government should to have an expanded health care whereby they pool resources to share financial risk among participants. The government by removing the need for direct out-of-pocket payments at the time of care is the most effective way to ensure that individuals seek the care they need and do not face undue financial pressure in the process.

4.6.2 Broad coverage of the population

The government of Kenya should set mechanisms in place to ensure broad coverage that ensures coverage reaches a large proportion of the population. The government should also establish the structures and processes that enable them to deepen coverage so that citizens who are already covered with basic care receive more benefit packages than what is currently offered by health care service providers. In order to ensure quality services

are conveniently available, reaching those who need care the most may require that care be offered for free to people who are not in a position to contribute, but even then the country can find it difficult figuring out who the most vulnerable are and how to reach them with care. The options that the government can use are subsidies for health insurance premiums, health care vouchers and equity funds.

4.6.3 Voluntary schemes for the informal sector

The staff respondents agreed in unison that the government of Kenya should initiate voluntary schemes for workers in the Informal sector with government legislation making them compulsory in due course. This will ensure that individuals assume responsibility towards their own health which is a milestone towards universal health care. The informal sector is often organized in large regional or national associations such as taxi, or farmer cooperatives. The various groups that these workers conform to can form the contributory groups through which pooling of resources can be made. This will ensure that most informal sector workers are enrolled to the health care scheme and contribute even for their dependants.

4.6.4 Prioritizing on preventive and primary care

The government in selecting the right package of benefits should consider having a health scheme that is comprehensive, prioritize preventive and primary care, and address the diseases most prevalent in each are being considered. Decisions about the services that can be guaranteed to the population initially and which ones should be added over time are based on people's needs, public opinion and costs. In developing packages there can be a minimum inclusion of health services for HIV, tuberculosis, malaria, non

communicable diseases, mental health, sexual reproductive health and child health. Therefore the government should strive to provide an increasing number of health services over time especially in primary care.

4.6.5 Regulation of the private sector health providers

A safe, efficient and accessible health care system is the backbone of universal health care. The government should regulate the private sector, by this it means they need to acknowledge the larger role of other providers currently play in the health care, even informally trained providers. They can do this by connecting traditional healers and informal providers with formal health systems and set standards for practice. Also they can train informally trained workers to meet a certain level of competency. Also government can mitigate the increasing private sector provision of health services by adequately funding government institutions.

4.6.6 Using resources efficiently

The government should fully exploit the resources available; this will involve looking clearly through the procurement process, medicine use, human and technical resources and also administration of resources. The government can put in place public health experts to analyze and identify cost effective medicines and their use in the population this will ensure regulations and procedures for pricing medicines are transparent and will save the government a lot of money that is used to purchase medicines that end up wasted or misused. The government should also ensure efficient way of payments for health services so that health care providers deliver high quality, appropriate and needed care to patients.

4.7 Discussion of findings

According to the findings of this research, the impacts, challenges and solutions of Universal health care can be related to theory and literature. According to the neo-classical framework by Grossman, the model assumes the existence of certainty in demand for health and the goal of society is to maximize social welfare this conforms to the impacts of universal health care which are equity in public health utilization and fair distribution of health care financing burdens in both cases health services are provided to all individuals in the community irrespective of social disparities. The theory also observes that health insurance is with charge and may cost the country and individuals a lot of money; this conforms to the need of the government to pool resources in order to finance the scheme yearly. The theory also asserts that the poor individuals often fail to choose care that meets their health needs, this conforms to the finding that priority should be given to a health scheme that is comprehensive, prioritizing preventive and primary care and addressing the diseases that are most prevalent in each individual considered.

According to Maslow hierarchy of needs by Hunt, health is associated with some basic human needs, such that without being healthy, many other potentialities such as learning and working can be impaired, he therefore puts it as a human right, this also conforms to the finding that the government should pool resources and remove the need for direct out-of-pocket payments so that individuals do not face undue financial pressure. This also goes in line with the fact that the government should set mechanisms in place to ensure broad coverage reaching a large proportion of the population, in order to reach those who need the care the most, it may require that care be offered for free to people who are not in a position to contribute as it is a basic human need.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter presents the summary of findings, conclusion and recommendations of the study. The study was motivated by the need to establish the challenges in provision of Universal Health care in Kenya and possible solutions to the challenges. The chapter is divided into sections. The chapter discusses the summary of the findings, conclusion, recommendations and suggestions for further studies.

5.2 Summary

The study was conducted at NHIF. The data was collected from senior management team, the staff members, and one trustees and secretariat member. Most of the top management team members had very good work experience of above 12 years. The staff who took part in the study had worked with the company for more than 5 years that ranged between 5-15 years. The secretariat staff had worked with the company for 12 years while the trustee had worked with the company 10 years. Thus the respondents were well versed with the operations of the company and its operations. This shows a normal distribution, since the respondents had necessary characteristics of a study population. The respondent provided concrete information which was reliable and necessary for this study.

The study established that universal health in Kenya to civil servants took effect on January 1 2012. The findings of the study showed that universal health care has the following impacts to the people of Kenya, equity in public health service utilization

ensuring no exclusion and social disparities in provision of health care, fair distribution of health care financing burden therefore reducing barriers to health services, financial risk protection resulting in sharing of health services costs and people driven health services delivery leading to social security to persons who are unable to support themselves.

The study found out that despite the impacts or benefits there are challenges. Respondents identified the challenges as shortage of government budgetary resources, selecting the right package of benefit this depends on individual health care needs, reaching vulnerable population, high poverty levels in the country, integration of the informal sector in Kenya which is 83.83% of the population therefore composing a huge percentage of the population, using resources efficiently which is especially in regard to transparency of medicine use and resources available to the government for health care and weak health systems in the country which lack adequate infrastructure, supplies and human resources.

The possible solutions to this challenge are pooling of resources in order to support larger health financing pools, broad coverage of the population both in the urban areas and rural areas therefore reaching the vulnerable population in the country, voluntary schemes to be in place for the informal sector which can be organized in large regional or national associations, giving priority to preventive and primary care based on people's needs and also addressing the diseases most prevalent, regulation of private sector providers in order for them to meet a certain level of competency and using resources efficiently.

5.3 Conclusion

This study showed that Universal health care goes hand-in-hand with social justice, health equity and the nation's responsibility to uphold two basic human rights, the right to health and the right to social security as enshrined in our constitution. The first key issue the government should consider is how to balance the goal of health improvement and financial risk protection, this is because with the need for health improvement, the people of Kenya can face financial catastrophe to the extreme. The second issue the government should address is whether to have a universal approach where everyone is included or target certain disadvantaged groups for care. Although there have been health programmes targeted at certain populations, most of the services at both public and private health facilities do not 'openly' discriminate between the better off and the disadvantaged groups, what matters is your ability to pay for the service.

The study showed that every Kenyan and every person who is ordinarily resident in Kenya and any person who enters and resides in Kenya for a period exceeding one year will be a member of the scheme. Contributions to the fund will come from the members, employers of members, government and temporary residents. Parents and guardians will be expected to make contribution on behalf of their children, while the government will contribute on behalf of those certified to be unable to pay as well as those in prisons and in lawful custody. In specific terms, those in formal sector will be required to pay a proportion of their salaries 3% for employees and 6% for employers, while those in the informal sector will be required to pay a fixed rate of ksh 400 per annum. Civil servants

and teachers will be required to surrender their existing medical school to the common pool.

The study also showed that an acceptance of the need of the universal health care necessarily translates into an acceptance of the fact that the economically strong will have to pay more than the poor. How much more and on what basis is therefore the issue, not the mere fact that some will pay more than others.

5.4 Limitations of the Study

This research was a case study in relation to universal health care in Kenya and therefore the research was limited to NHIF in Kenya. Thus the findings on universal health care in Kenya are limited only to that Scheme and as such they cannot be generalized to other firms in other countries in Africa and the world. The study focused on interviewing some of the very busy executive team members and scheduling appropriate interview timings was a challenge, in some instances rescheduling of interviews was necessary. However, the study eventually managed to interview the key decision makers of the Scheme. It's also important to note that the data collected from the respondents may have suffered from personal biases and may therefore not fully represent the opinion of the Scheme in some cases.

5.5 Recommendations of the Study

The study findings indicate NHIF will revise the contribution upwards for both employees and employers. The recommendation for this is that the contribution of both

employees and employers should not be increased to the new proposed amounts. This is because the scheme requires to first optimize the use of existing budgetary resources without impulsive resources to new taxes and statutory deductions. The example of the universal primary education which was implemented by the NARC government in early 2003 without additional taxes deductions should serve as a guide.

The study also found out that the number of government appointees in the board of universal health care will be 12 out of the total 19 members. Out of the 12 will be 8 provincial representatives, in which the bill doesn't specify the nominating authority. The recommendation to this is that the membership to the board should be reviewed so as to reduce the number of government nominees and increase the representation of employers and workers. Also a mechanism for the nomination of the eight provincial representatives should be put into place.

The study also concludes that prevention is better than cure, hence the scheme should be readjusted to give more focus on preventive rather than curative health care. Preventing diseases is cheaper. More accessible to the poor and sustainable in the long run compared to curative treatment. The study also recommends that the package of benefit and conditions attached to its enjoyment by members should be established in advance, this is because current public planning requires that objectives, targets and indicators be established prior to determining the resource requirement.

5.6 Suggestions for Further Studies

The study was done in NHIF which is a government parastatal, the experiences, responses and the functionality of the corporate may be different in other countries, and also private insurance companies if given the mandate to handle universal health care. It is recommended that similar studies be done on all providers of health care in Kenya and in other countries both in Africa and the world to avail more knowledge on Universal Health Care. More studies should also be done regionally to provide more information on challenges in provision of Universal health care. The study conducted centered on the challenges in provision of universal health care at NHIF in Kenya. It is recommended that other studies on universal health care in Kenya be done to avail more information on the health situation in Kenya.

5.7 Implications for Policy and Practice

The findings of the study were on the impacts of universal health care, challenges of universal health care and possible solutions to the challenges. The findings of this study will be of so much importance to NHIF and the government of Kenya as the study has provided challenges in provision of universal health care and the possible solutions to these challenges. It is recommended that the government of Kenya use the knowledge on possible solution to each challenge to solve or mitigate the challenges to enable smooth flow of the universal health care exercise.

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APPENDIX 1

INTERVIEW GUIDE

Opening Questions

Whats your name sir/madam?

How long have you worked in NHIF?

What exactly do you do for NHIF?

What benefits has NHIF brought to the country Kenya?

National Hospital Insurance Fund management

1. About how much does NHIF generate annually from contributions, subsidies & investments?
2. Outline usage of the funds received.
3. What's your overall recommendation of UHC coverage?
4. What are the main challenges of UHC coverage and what are the possible solutions?

Fund Secretariat

5. Comment on the funding of UHC?
6. What led to the decision to enroll UHC first to civil servants?
7. What challenges is the fund facing in provision of UHC to civil servants and possible solutions?
8. What strategies are in place to include others (informal sector & unemployed people) in UHC?

NHIF Staff

9. How long have you worked in NHIF?

10. What are your views and recommendations on the proposed new NHIF rates?
11. NHIF has in the past covered inpatient only; share your experience especially on its advantages and shortcomings.
12. What are your views of the UHC to civil servants? Explain challenges encountered so far and what are the possible solution.

Trustees

13. What changes have you experienced since introduction of UHC to civil servants?
14. Has the adoption of UHC to civil servants made a difference in the governance of the fund?
15. What challenges have you faced since introduction of this UHC?
16. What are your views and recommendation on the proposed UHC to all Kenyans?

THANK YOU FOR YOUR PARTICIPATION