EXTENDING SOCIAL HEALTH INSURANCE TO THE INFORMAL SECTOR IN KENYA: A CASE OF TRADERS IN GIKOMBA MARKET

By

Mumbi Lillian Wangechi

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DECLARATION

This management research proposal is my own original work and has not been submitted for a degree in any other university.

Signed: _____ Date: 03/12/2012

MUMBI LILLIAN WANGECHI

Reg No: C50/P/7428/2005

This research proposal has been submitted for examination with my approval as the candidate's University Supervisor.

Signed: _____ Date: 05/12/2012

PROF. E. K. MBURUGU

Senior Lecturer,

Department of Sociology.

DEDICATION

This work is dedicated to my son Jayden, my husband Victor and to my entire extended family. I love you all.

ACKNOWLEDGEMENT

I wish to thank God Almighty for his abundant blessings that he has bestowed upon me and my family.

I also wish to thank my husband for being patient and supportive through my entire schooling period. To my son Jayden, your constant nagging as I wrote my project reminded me just how important it was that I finish it.

To my Mum and sister, thank you for your support, and may God Bless you

Special thanks go to my supervisor Prof Mburugu whose wise counsel and kindness made the writing this paper to the best standards possible.

Finally I thank my colleagues at NHIF, especially my manager Miss Matilda Mwangemi for her encouragement as I worked on the paper.

ABSTRACT

The general objective of the study is to establish factors influencing the demand of social health insurance by workers in the informal economy in Kenya

The study used stratified random sampling technique to select a sample of 45 traders in Gikomba market from a population of 1850 businesses The main identified were 450 traders in Muthurwa market, 200 wholesalers in the main Gikomba market, 800 retailers in the main market, and 400 traders in the fresh produce market.

This study generated both qualitative (open-ended questions) and quantitative data (open- ended questions). Quantitative data was coded and entered into Statistical Packages for Social Scientists (SPSS Version 17.0) and analyzed using descriptive statistics. Qualitative data was analyzed based on the content matter of the responses as responses with common themes or patterns will be grouped together into coherent categories. Only the relevant non-redundant content was presented.

The study was done to establish factors influencing demand of social health insurance in the informal sector in Kenya. One of the objectives was to establish the extent to which workers' awareness on social health insurance influence their demand for the service. Awareness has created a good impact as the study has shown that majority 56% of those in the informal sector were registered for the services.

The study found out that majority of their family members had not registered for the NHIF services since majority were not aware of the services and others had not registered due to the high costs. Majority in the informal sector were low-income earners, felt that the cost was too high for them, and therefore could not afford the services.

Further studies should focus how the National Hospital insurance fund can designing a cost effective demand driven benefit package for the informal sector. This study will help the stake holders come up with a way of ensuring all in the informal sector voluntarily register for the social health insurance services.

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CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Interest is growing among policymakers and academics in the establishment of insurance programs for poor and vulnerable populations throughout the world as a way of increasing access to priority health services and protecting families from catastrophic health care costs.

Evidence exists; however, that uptake of voluntary health insurance among informal and low-income workers is typically low. Moreover, collecting premium payments from this population is challenging (Abel-Smith 1992), and insurers are concerned that insuring the poor will attract those who are less healthy. Existing synergies between the delivery of financial and health services to clients in the informal sector have led policymakers to believe that microfinance institutions (MFIs) may be a promising and innovative delivery agent to extend health insurance to low-income and other vulnerable groups. In particular, there may be economies of scale for collection of payments in settings where MFI penetration is high.

There is growing international consensus on the importance of extending social protection in health to the whole population (ILO, 2001a, 2001b; Carrin and Preker, 2004; WHA, 2005; Gottret and Schieber, 2006) in order to reduce financial barriers to health care services for the needy and to avoid catastrophic health expenditures. Social health insurance schemes are generally understood as health insurance schemes provided by governments to its citizens, especially to low and middle income populations. Recently, apart from governments, several non-government organizations at the community level provide social health insurance in developing countries (Churchil 2006, Dror et al 2002). Social health insurance pools both the health risks of its members, on the one hand and the contributions of enterprises, households and government, on the other, and is generally organized by national governments (Carrin 2002, WHO 2001). Social health insurance

can bring about welfare improvement through improved health status and maintenance of non-health consumption goods through ensuring that health expenditures are smoothed over time and that there is no significant decline in household labor supply (Varian 1994, Townsend 1994).

Most social health insurance schemes combine different sources of funds, with government often contributing on behalf of people who cannot afford to pay themselves (WHO 2004). Social health insurance differs from 'tax based financing' which typically entitles all citizens (and sometimes residents) to services thereby giving universal coverage. However, social health insurance entitlement is linked to a contribution made by, or on behalf of, specific individuals in the population (WHO 2004).

In Africa, schemes intended for the informal sector are confronted with the target populations' low and irregular incomes and consequently negligible profit-making potential. Of necessity, therefore, schemes for the informal sectors have social welfare dimensions rather than commercial characteristics. This is made more apparent in Mutual models since they involve actions by social institutions, communities, and the state (the latter through regulation and legislation). The Mutual schemes represent public action taken to reduce human deprivation and eliminate vulnerability (Burgess, 2001). They facilitate explicit or implicit participation by communities in scheme design and implementation. Depending on the community's composition and control norms, emphasis will be placed either equally or preferentially on achieving the schemes' social and financial functions.

Although they are intrinsically linked, the social and financial functions performed by a social welfare oriented health insurance scheme may be considered separately. The social function affects risk protection for the individual, whereas the financial function leads to resource mobilization for the group.

As health insurance is a mechanism for spreading the risks of incurring health care costs over a group of individuals or households constitutes. This definition is not dependent on the nature of the administrative arrangements employed, but on the outcome of risk sharing and subsequent cross-subsidization of health care expenditures among the participants An arrangement designed to provide risk sharing for illness related events, and which is accessible to households in the informal sectors in low-income countries, is a health insurance scheme regardless of the orthodoxy of its operational modalities. In such an arrangement, an insured individual acquires "a state-contingent income claim" before the state of the world is known and is entitled to resources and/or income to address the event for which he or she is insured if the event occurs.

Some studies have reported that low-income households are initially reluctant to join insurance schemes because they do not readily accept the idea of "paying" for services they might not use (Brown, 2000). Interpreting such findings as evidence that these households have risk attitudes non-supportive of insurance (risk neutral or risk-loving attitudes) would predict limited potential for insurance schemes targeting these households. In contrast, three studies in Ghana, Burundi, and Guinea-Bissau suggest that households in rural areas are risk averse with regard to health care (Arhin, 2006). Such differences in population attitude and WTP for health insurance would theoretically lead to predictable variation in insurance scheme enrollment.

1.1.1 Background of National Hospital Insurance Fund

National Hospital Insurance Fund is a State Parastatal that was established in 1966 as a department under the Ministry of Health. The original Act of Parliament that set up this Fund in 1966 has over the years been reviewed to accommodate the changing healthcare needs of the Kenyan population, employment and restructuring in the health sector. Currently an NHIF Act No 9 of 1998 governs the Fund.

The transformation of NHIF from a department of the Ministry of Health to a state of corporation was aimed at improving effectiveness and efficiency. The Fund's core

mandate is to provide medical insurance cover to all its members and their declared dependants (spouse and children). The NHIF membership is open to all Kenyans who have attained the age of 18 years and years and have a monthly income of more than Kshs 1000. NHIF has 35 fully autonomous branches across the country. Each of these branches offers all NHIF services including payment of benefits to hospitals or members or employers. Smaller satellite offices and service points in district hospitals also serve these branches

1.1.2 Social Health Insurance to the Informal Sector

Historically, social health insurance originated in developed countries as work related insurance programs and the coverage has been gradually expanded to the non-working parts of the population (Saltman 2004). In recent years, social health insurance is being introduced in parts of the developing world as an alternative to tax financing and out-of pocket payments (Vietnam 1993, Nigeria 1997, Tanzania 2001 and Ghana 2005).

Discussions on implementation of schemes are underway in several countries (South Africa, Zimbabwe, Cambodia, Malaysia) and countries with social health insurance already in place are making vigorous efforts to extend coverage to the informal sector (self-and unemployed, retired people such as Colombia, Mexico, Philippines, and Vietnam (Wagstaff 2010). There are examples of social health insurance schemes arising out of community-based health insurance organized through NGOs and often involving other elements such as micro- credit. These initiatives are generally weak in terms of efficiency and sustainability but have provided a means of development for government supported extensions to enable greater population coverage (Atkenbrack 2008).

The effects of different social health insurance schemes have in recent years been evaluated (Hsiao 2007) including trials looking into specific effects of these schemes (Ranson 2007, King2007, De Allegri 2008). Moreover, social health insurance does not provide complete insurance even if it covers the health care costs. Wagstaff (2009) alluded that with incomplete social health insurance there may also be a significant impact on household production through changes in labor supply, reshaping durable consumption or postponement of important life cycle events, drawing down of precautionary savings and borrowing Gertler (2002), Russell (2004), Flores (2009), Wagstaff (2009). Management of risk within the household may well imply that even with the presence of social health insurance, a substantial amount of borrowing enhances the ability to smooth consumption over the period of major illnesses (Dercon 2007, Gertler 2002, and GTZ 2005)

It is well recognized that the contribution of the informal sector to the government economy is enormous. It is estimated that about two-fifths of the country's Gross Domestic Product originates from and almost 90 per cent of families earn their livelihood from the informal sector. Despite this fact, a large number of workers engaged in the informal sector in both rural and urban areas are illiterate, poor and vulnerable. They live and work in unhygienic conditions and are susceptible to many infectious and chronic diseases. A vast majority of them neither have fixed employer-employee relationships nor do they get any statutory social security benefits. This implies that workers in the informal sector do not get health care benefits, paid leave for illness, maternity benefits, insurance, old age pension, and other benefits.

They receive very low wages; and, as own-account or self-employed workers, they obtain meager piece-rated earnings. At the same time, most workers of the unorganized sector have not formed their unions or associations. They thus remain without their representative organizations, which could otherwise help them, fight against the many injustices they face every day. They also do not have the bargaining power or

collective strength to demand just policies and laws, including laws for social protection and social security (Ahmad et al. 1991).

Overall, the health insurance coverage is very low. Only nine per cent of the Kenyan workforce is covered by some form of health insurance through, National Social Security Funds (NSSF) and other insurance firms), a majority of them belonging to organized sector (AKI, 2004). The low level of health insurance coverage is due to the fact that the government policies have been to provide free health services through the public hospitals/dispensaries/clinics. In reality, despite having a poor outreach, the public sector providers charge for various services

According to estimates based on the National Sample Survey (NSS) 1986- 87, 12 and 30 per cent of inpatients and outpatients, respectively, using public sector facilities had paid for various services; the percentages varied substantially between rural and urban areas and amongst states (AKI, 2004). Further, over time the cost of health care has increased enormously. A comparison of NSS data for 1987 and 1995-96 suggest that the cost of inpatient care and outpatient care grew annually at 26-31 per cent and 15-16 per cent respectively, which in turn has put severe strains on achieving equity in health (AKI, 2004).

A pioneer study undertaken by Gumber and Kulkarni (2000) looked into issues related to the availability and needs of health insurance coverage for the poor, especially the women, and the likely constraints in extending current health insurance benefits to workers of the informal sector.

1.2 Statement of the Problem

In recent years, interest has grown in providing health insurance programs to poor and vulnerable populations throughout the world as a means of increasing access to priority health services and protecting families from catastrophic health-care costs. Implementation of such programs, however, may be difficult. Research suggests that take-up of voluntary health insurance among the poor is typically low (Jowett, 2003 and Chankova et al., 2008). Moreover, collecting payments from this population, who are generally employed

in the informal sector, is challenging (Abel- Smith, 1992). Finally, if the program is not carefully designed and marketed, insurance schemes targeted to the poor may be particularly prone to adverse selection, disproportionately attracting those who are relatively sick.

The social health insurance literature has reported multiple outcome measures including utilization of health care, reduction in health care expenditure by income class, use of health care by income class (Wagstaff 2010, WHO 2005). Which outcome is reported may depend on what administrative data were collected or the survey used to carry out a study.

Internationally, literature on extending social health security has been done; Hanratty et al (2007) focused on equity in use of curative health services in universal systems, were limited to developed countries and did not specifically examine the impacts of health insurance. The results indicated a pro-rich bias in use of specialist hospital services and an equitable access to primary health care by different socioeconomic groups. Ekman (2004) focused on community-based health insurance in low-income populations in developing countries. He concluded that community-based health insurance provides some financial protection by reducing out-of-pocket spending. The purpose of this study will be to establish factors that hinder extension of social health insurance to the informal sector in Kenya.

1.3 Research Objective

The general objective of the study is to establish factors influencing the demand of social health insurance by workers in the informal economy in Kenya

1.3.1 Specific Objectives

The specific objectives of the study will be:-

1) To establish the extent to which workers' awareness on social health insurance influence their demand for the service.
2) To find out informal sector workers perception of social health insurance and its effects on demand.
3) To ascertain if the nature of employment and level of income have effect on extension of social health insurance to workers in the informal sector.

4) To examine how legal regulations affect workers demand for social health insurance.

1.4 Significance of the Study

The study will provide information to potential and current scholars on extension of insurance policies to the public. Even though the study is limited to the informal sector, the finding will present the general perception of the public in regard to insurance policy. This will expand their knowledge on social health insurance and also identify areas of further study. The study will also highlight other important areas that need relational studies; these may include measures to be taken to encourage and enlighten public on the importance of the social health insurance.

The finding of the study will be of great value to the as the aggrieved parties such as insurance firms and agency as they will use the finding of the study to indentify hindrance of extension of social health insurance and act in accordance to the recommendation given.

The study will also be useful in the Ministry of Public Health and Medical Services as it will reveal information relating to social health which will be useful in dealing with all issues that relates to the public health.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter explains past relevant literature from other researchers who have conducted research in the same field. It contains opinions, attributes, research outcomes and conclusions thereon from previous research work done by other people and organizations.

2.2 Health Insurance

Countries around the world attempt to cover their populace by providing publicly-funded governmental healthcare plans. Dror and Jacquier (1999) argue that public programs are not enough. They promote group-based community health insurance as a bottom-up solution to inadequate healthcare insurance. In proposing their concept of micro-insurance, Dror and Jacquier (1999) address moral hazard, free-riding, adverse selection, underinsurance, cost escalation, and risk-pooling.

Wiesmann and Jutting (2001) use voluntary community-based health insurance (CBHI) in rural Sub-Saharan Africa as the context to discuss determinants of viable health micro-insurance schemes. They argue that there are three main factors of viability, membership, and access to health care: scheme design and management, viability and behavior of health care providers; and household and community characteristics. Within the scheme design paradigm, Wiesmann and Jutting discuss the choice of the benefit package and premium level, general problems in insurance markets (moral hazard, adverse selection, and covariant risk), accounting/management, and community participation. They next stress that unless the poor have adequate health care provider availability, a micro-insurance scheme is not viable (or valuable) to clients. For the final factor, Wiesmann and Jutting point out that the socio-economic position of a specific population has a large impact on the viability of micro-insurance.

Health insurance is an institutional and financial mechanism that helps households and private individuals to set aside financial resources to meet costs of medical care in event of illness. It is based on the principle of pooling funds and entrusting management of such funds to a third party that pays for healthcare costs of members who contribute to the pool . The third party can be government, employer, insurance company or a provider (Kraushaar, 1994). In health insurance, every member of the insurance scheme pays the premiums irrespective of whether he or she gets sick. As such, insurance schemes have a higher potential for cost recovery (Lenambergen 1994, Shaw 1988). Cholleteta (1997) observes that by pooling the risk of large healthcare expenditures of many people, health insurance can make necessary healthcare affordable to all

Health insurance attempts to reduce the financial and non-financial risks associated with chronic illness or injury, since individuals are uncertain about health status and expenditures in future. The risks include loss of life and deterioration of health. Deterioration of health reduces the ability of an individual to work, or reduces the productivity while working such that the individual faces the risk of lost (market and non-market) wages. Another risk may arise, as an individual may be unable to enjoy other forms of consumption, Like participation because of their health status, or they may suffer emotional and psychological trauma ,associated with physical deterioration. These events and consequences are uncertain both in size and in occurrence. Individuals are therefore always willing to pay to reduce this risk (Jack, 1999). Due to this risk aversion behavior, many individuals will seek insurance and they will effectively pool their risks through an insurer Given large numbers, the condition that the risk of any one individual suffering the loss is statistically independent of that of another should be satisfied for insurance cover. This explains why natural disasters like epidemics and earthquakes that affect large regions do not qualify for insurance cover.

Pauly (1968) and Jack (1 999) demonstrate that the dead-weight loss to the consumer is the difference between the individual 's net surplus with and without insurance. Therefore, when the demand curve is not perfectly inelastic, the individual 's choice between facing

risk or insurance will depend on the mean of the probability distribution of the medical care expenses in both cases . If the demand curve is perfectly inelastic, the individual will prefer having insurance to risking the cost of medical care The elasticity of demand for healthcare will be important in choosing the optimal insurance policy risk-averse individuals. The dead-weight loss depends on the slope of the demand curve. When the demand curve is nearly vertical, (inelastic) the dead- weight losses are small and relatively high levels of insurance will be desirable. For more elastic demand curves, the dead-weight losses are large and the: appropriate coverage will be much lower. that is, higher premium will be charged and individuals may prefer risk to insurance.

Empirical research initiated by the Ministry of Health and undertaken from 1993 to 1995 in a rural district in southern Ghana concluded that household preferences and WTP were compatible with high membership in, and satisfactory performance of, a proposed health insurance scheme. The research findings led a health ministry team to work with households in Dangme West District to design and implement the Dangme West Health Insurance Scheme (Dangme Hewami Nami Kpee). The scheme is collaboration between a mutual society and government health providers at the district level and therefore it is a Mutual Provider-Partnership Model. The scheme was part of research carried out to: improve the quality of health care provided by Ministry of Health facilities and increase access of households, and evaluate the outcome of the intervention and draw policy-relevant lessons. Quality-related objectives were to be addressed in three ways. The first was by the providing in-service training of health workers to improve technical competence in patient diagnosis and treatment, drug supply and management procedures, and interpersonal skills. The second was supportive supervision to ensure the use of skills acquired during training. The third was the refurbishment of health ministry facilities to ensure that basic physical and laboratory investigations could be carried out. The health insurance scheme was the main strategy to increase access by eliminating user fees for participating households.

2.3 Determinants for insurance in informal sector

2.3.1 Knowledge of full health care costs

The value attached to and demand for health insurance is influenced by knowledge of the full costs of health care and experience or knowledge of how and when health care costs become 'catastrophic'. In other words, health insurance would have diminishing marginal utility for someone who underestimates the high costs of inpatient care and also the likelihood of high-risk events by comparison with someone who is fully aware of the high cost of inpatient care and whose demand would therefore be higher (Osei-Akoto, 2003).

In health insurance markets, people do not perfectly forecast their preferences or desires under different conditions, nor can they always estimate the consequences of changes in their circumstances. They also have relatively little knowledge of individual health insurance plans when choosing between them. Neo-classical theory predicts that consumers will insure against catastrophic medical events and cover lower-cost services themselves; in reality consumers typically choose policies with low deductibles and co-payments.

2.3.2 Availability of quality health care

Even if the potential benefit of health insurance is seen, there is no utility in insurance if informal sector workers have no geographical access to health facilities that are accredited by a health insurance. Similarly, the non-availability of quality health care services (including lack of drugs and other quality deficits) negatively affects demand for health insurance (cf. Carrin, 2003). Thus if informal sector workers perceive quality of health care as a problem, health insurance membership will be less attractive to them.

2.3.3 Absence of alternative risk management institutions

The availability and effectiveness of protection through alternative risk management institutions that cater for meeting people's health care needs and costs would decrease demand for health insurance. Informal institutions such as group saving mechanisms usually constitute ex-post-risk management strategies that help to prevent or reduce catastrophic health expenditure. Yet as Waelkens et al (2005) point out, there are various constraints (institutional, social and financial) that limit their effectiveness, more so in a changing world

in which the traditional mechanisms are less adept. Waivers and exemptions equally serve to provide financial protection.

However, they have not been particularly effective in Kenya (Bitran and Giedion, 2003) and there are no clear waiver policy and criteria so far. Given the access barriers to health services faced by a large part of the population (see Section 'Country Context'), it is questionable to what extent the existing risk management institutions provide sufficient support and financial protection. According to Ahuja and Ju'tting (2003), community-based health insurance is more aligned to people's needs than state or private insurance mechanisms. If this is the case there may be competition between CBHIs and the NHIF in those areas of Kenya where they exist.

2.3.4 Understanding and acceptance of the insurance rationale

The literature on community insurance refers to people's limited understanding and acceptance of the insurance rationale. Low-income households may therefore initially be reluctant to join insurance schemes because they do not readily like the idea of 'paying' for services they might not use (Brown and Churchill, 2000). Platteau (1997) argues that people join such micro-insurance arrangements based on the principle of 'balanced reciprocity'. This means that members expect a roughly equal return from their contribution or payment, rather than being guided by a 'true logic of mutual insurance' with winners and losers through income redistribution between 'lucky' and 'unlucky' individuals (ibid). On the other hand, according to Ju'tting (2001), if solidarity is strong, people may be less concerned whether the benefits of their contributions accrue to themselves or to other community members.

2.3.5 Credibility of and trust in fund management

Lack of credibility and trust in fund managers may negatively affect demand for health insurance (cf. Wiesmann and Ju'tting, 2001; Schneider, 2004). In Kenya, where corruption in public services and parastatals has been a huge problem, they have been often faced with negative attitudes. Hence the NHIF, a parastatal, might equally suffer from these perceptions, thus decreasing demand for NHIF membership.

2.3.6 Customer-oriented insurance scheme design features

Insurance scheme design features, particularly the benefit package, payment modes and the enrolment basis (as an individual or family), influence people's expected utility of health insurance (Carrin, 2003; Schneider, 2004). For the Kenyan case many informal sector workers faces a major challenge of the relatively high amount of upfront payment and (previously) inflexible collection schedules constitute barriers to joining the NHIF

2.3.7 Vulnerability and Insecurity

Vulnerability and insecurity in health care are an inescapable fact of life. However, because the risk of ill health is uncertain in frequency, timing and magnitude, it is difficult to insure against at the individual level. Most measures of risk give equal weight to both upward and downward variation in factors such as income, but downward changes both affect and concern most people far more than upward changes do.

Lack of health care access increases risk exposure: failing to meet health needs when they occur can expose individuals to even greater risk of illness or injury later on. Illness itself bring vulnerabilities: a potential further decline in health, lost income due to medical expenses, and lost opportunities at work or school. The irreversibility of worst-case scenarios, such as severe disability or death, heightens individuals' insecurity and vulnerability.

Without health insurance, individuals and households must be self-insured, use informal risk sharing arrangement, diversify assets, draw down savings, sell assets, borrow, or go into debt to cover needed services, all of which offer moderate to little effective income smoothing over time. In many cases, individuals who lack health insurance must go without necessary medical care.

2.3.8 Ability to Pay

Demand for health insurance is also determined by the ability to pay membership contributions. Lack of money is indeed a major reason why many do not join (cf. Preker et al., 2002; Jutting, 2001 for Senegal). As expenditure studies show, higher-income quintiles are more likely to be covered by an insurance (Carrin et al., 2005), which is also the case for

Kenya (Xu et al., 2006). In Kenya, the non-poor spend 2.6% of non-food expenditure on health insurance schemes, while this figure is only 0.7% for the poor (CBS, 2000). However, studies of community-based health insurance schemes in East Africa also reveal that the majority of members fall below the poverty line (Waelkens et al., 2005).

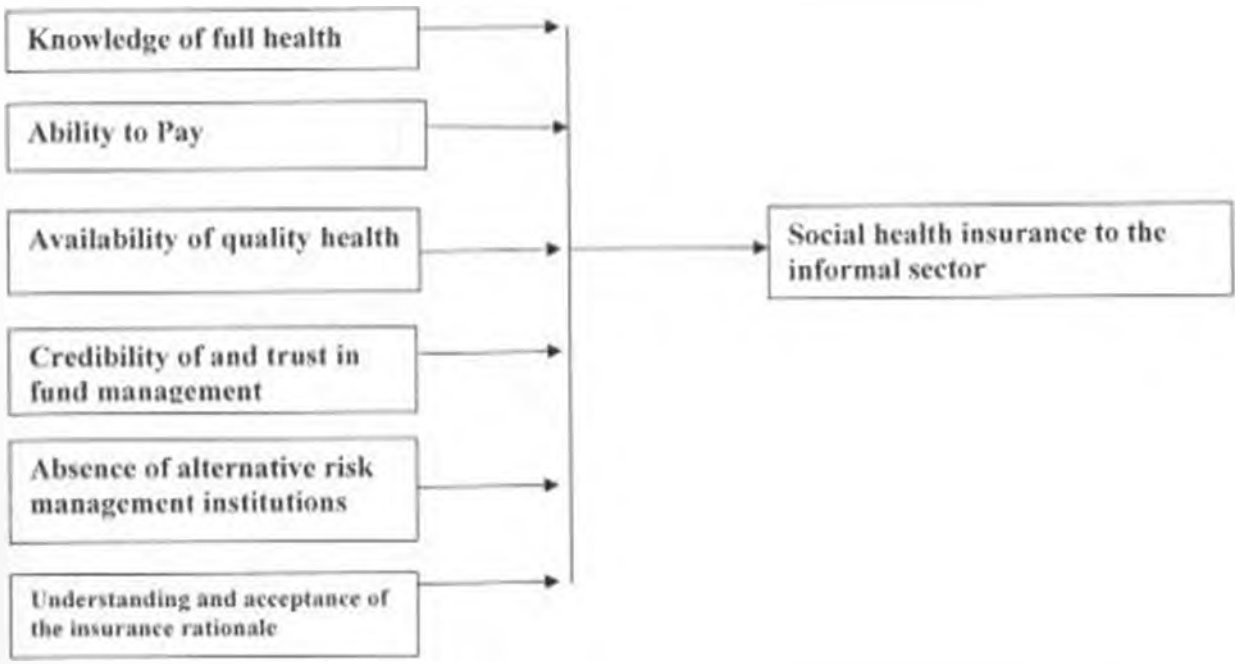
2.3.9 Understanding and Acceptance of the Insurance Rationale

The literature on community insurance refers to people's limited understanding and acceptance of the insurance rationale. Low-income households may therefore initially be reluctant to join insurance schemes because they do not readily like the idea of 'paying' for services they might not use (Brown and Churchill, 2000). Platteau (1997) argues that people join such micro- insurance arrangements based on the principle of balanced reciprocity'. This means that members expect a roughly equal return from their contribution or payment, rather than being guided by a 'true logic of mutual insurance' with winners and losers through income redistribution between lucky' and unlucky' individuals. On the other hand, according to Jutting (2001), if solidarity is strong, people may be less concerned whether the benefits of their contributions accrue to themselves or to other community members.

2.4 Conceptual framework

Figure 2.1 summarizes the variables of the study. It shows the conceptualization of the relationship between the dependent and independent variables.

Figure 2. 1: Study Variables



Independent Variable **Dependent variable**

Source (Author) 2012

2.5 Theoretical Orientation

2.5.1 Rational Choice Theory

The fact that people act rationally has, of course, been recognised by many sociologists, but they have seen rational actions alongside other forms of action, seeing human action as involving both rational and non-rational elements. Such views of action recognise traditional or habitual action, emotional or affectual action, and various forms of value-oriented action alongside the purely rational types of action.

Max Weber (1920), for example, built an influential typology of action around just such concepts. His ideas were taken up by Talcott Parsons (1937) and became a part of the sociological mainstream

In a similar way, the social anthropologists Bronislaw Malinowski (1922) and Marcel Mauss (1925) looked at how social exchange was embedded in structures of reciprocity and social obligation. What distinguishes rational choice theory from these other forms of theory is that it denies the existence of any kinds of action other than the purely rational and calculative.

All social action, it is argued, can be seen as rationally motivated, as instrumental action, however much it may appear to be irrational or non-rational. Rational choice theorists also recognise that the threat of punishment or the promise of a reward may motivate people just as much as the punishment or reward itself. The threat of punishment, for example, may call forth appropriate behaviour from those who wish to avoid the punishment. This assumption allowed Homans to recognise the motivating role of threats and inducements in the conditioning of human behavior.

Rational choice theory can improve our understanding of decision-making that preserves the rich and complex texture of social life. Catching this sociological dimension of decision-making in various circumstances is a prominent rationality for studies in this tradition (Callon & Muniesa 2005) including the empirical account of national healthcare portals. Also, we argue that the concepts of calculation sensitize social scientists to the importance of the

competition for advantage that functions in spheres of life normally considered to lie in the realm of non-instrumental values (Beckford 2000). In other words, there are processes of decision and evaluation of individual benefit in situations of choice in healthcare.

2.5.2 Exchange theory

Exchange theory is based on the premise that human behavior or social interaction is an exchange of activity, tangible and intangible (Homans, 1961), particularly of rewards and costs (Homans 1961).

It treats the exchange of benefits, notably giving others something more valuable to them than is costly to the giver, and vice versa (Homans, 1961), as the underlying basis or open secret of human behavior (Homans, 1961) and so a phenomenon permeating all social life (Coleman, 1990). Not only is the market permeated by exchange but also the non-economic realm--the social relations situated between extremes of intimacy, self-interest or cost-benefit calculation and disinterested, expressive behavior (Blau, 1961) Social exchange is composed of actions of purposive actors that presuppose constellations of their interests and resources.

The complex of interdependent exchange processes constitutes the market functioning within a definite social and institutional structure, though admittedly the latter has not been systematically examined within rational choice theory. Since these processes are assumed to be governed by reciprocal relations—viz.

Exchange is defined as social interaction characterized by reciprocal stimuli—they would not continue in the long-run if reciprocity were violated. The concept of exchange ratio or balance-imbalance, leading to the concepts of power, dependence, and cohesion, is implied in the attribute of reciprocal reinforcements (Emerson, 1969). In consequence, exchange theory examines the processes establishing and sustaining reciprocity in social relations, or the mutual gratifications between individuals

The basic assumption of exchange theory is that individuals establish and continue social relations on the basis of their expectations that such relations will be mutually advantageous.

The initial impetus for social interaction is provided by the exchange of benefits, intrinsic and extrinsic, independently of normative obligations (Blau, 1994).

Exchange theory has been used to check on performance of the healthcare systems since there is little known about the power exercised in the healthcare systems to control costs, improve quality and achieve other objectives. Exchange theory is used to examine exchanges between traders and the healthcare systems. Collective action is a common strategy at all levels for reducing dependence and therefore, increasing power in exchange relations. The theoretical and research implications of exchange theory for the comparative study of health care systems have been discussed.

CHAPTER THREE

RESEARCH METHODOGY

3.1 Introduction

This chapter discusses the research methodology that was used in the study. It presents discussions on the research population, sampling, data collection instruments and data presentation, analysis and interpretation.

Research methodology encompasses the steps, activities and tools involved in the conducting of a study and collecting data appertaining to the study and the logic behind these steps, activities and tools (Bryant & Miron, 2006). These steps and tools include identification of the research population, sampling, data collection tools and data analysis tools and the justification of each of the tools selected (Blaikie, 2007; Jespresen, 2005, Lauriol, 2006). In other words, research methodology is the operational framework within which facts are placed more clearly.

Kothari (2004) observes that when we talk of research methodology, we not only talk about the methods used to collect data but also, "consider the logic behind these methods we use in the context of the study and explain why we are using a particular method" to draw a sample and collect data and not another method A research methodology defines what the activity of research is, how to proceed, how to measure progress, and what constitutes success.

3.2 Research Design

The study adopted descriptive research design aimed at extending social health insurance to the informal sector in Kenya. A descriptive study is concerned with determining the frequency with which something occurs or the relationship between variables (Bryman & Bell, 2003). Thus, this approach was appropriate for the study, since the study intends to collect detailed information through descriptions and is useful for identifying variables. Mugenda & Mugenda (1999) noted that a descriptive design seeks to obtain information

that describes existing phenomena by asking questions relating to individual perceptions and attitudes.

3.3 Target Population

Hair, (2003) defines population as an identifiable total group or aggregation of elements (people) that are of interest to a researcher and pertinent to the specified information problem. This includes defining the population from which our sample is drawn. The target population of this study consists of 1850 businesses in Gikombu market as per below table

Table 3. 1: Target Population

Category of Population	Population size
Muthurwa market	450
Wholesalers (main market)	200
Retailers (main market)	800
Fresh produce market	400
Total	1850

3.4 Sampling procedure

The respondents were selected using probability sampling procedure, thereby reducing any bias that might affect the findings of the study. Every respondent was given an equal and calculable chance of either being included or excluded from the sample. Respondents consist of small scale traders within or carrying out business in Gikomba open air market.

The research employed stratified random sampling. A stratified sample is obtained by independently selecting a separate simple random sample from each population stratum. (Denise, Keri & Rachel,2008; McNeil & Chapman, 2005; VanWynsberghe & Khan,2007; Kothari,2005; Mugenda & Mugenda, 1999).

Purposive sampling was used to identify key informants. In purposive sampling, according to Mugo (1995), a researcher handpicks subjects to participate in the study.

3.4.1 Sample size

A sample is a subsection of population that was chosen in such a way that their characteristics reflect those of a group from which they were chosen (Henn, Weinstein and Ford, 2006).

The study used stratified random sampling technique to select a sample of 45 traders in Gikomba market from a population of 1850 businesses. The main identified were 450 traders in Muthurwa market, 200 wholesalers in the main gikomba market, 800 retailers in the main market, 400 traders in the fresh produce market.

To calculate the percentage in each group, each group size was multiplied by the sample size (45) and divided by the total population size (1,850).

Table 3. 2: Sample Size

Category of population	Population size	Sample size
Muthurwa market	450	10
Wholesalers (main market)	200	6
Retailers (main market)	800	19
Fresh produce market	400	10
Total	1850	45

Key informants were:

i) Business representative of Gikomba market.
ii) Sub-chief Kamukunji sub location
iii) District Officer-Kamukunji Division
iv) Councilor Pumwani ward

3.5 Data Collection Method

Data collection is a term used to describe a process of preparing and collecting data (Freeman & Hoddow, 2008). A formal data collection process is necessary as it ensures that data

gathered is both defined and accurate and that subsequent decisions based on arguments embodied in the findings are valid. The process provides both a baseline from which to measure from and in certain cases a target on what to improve. Data Collection is an important aspect of any type of research study. Inaccurate data collection can impact the results of a study and ultimately lead to invalid results. The data collection tools that were used are questionnaires and key informant interviews.

Freeman & Haddow (2008) defines a questionnaire as an ordered set of questions written and given to the respondent to answer, either by choosing the answer in cases of structured questions or by expressing his/her opinion in case of open-ended questions. According to Mugenda and Mugenda (1999), the merits of questionnaires are that questionnaires are easier to administer and one is also able to get direct response from the respondents by providing a greater depth of response while close-ended questions are easier to analyze.

According to Kumar (2005), not all questions are bound to be answered by the respondent; structured questions are difficult to construct because order, categories and possible answers have to be thoroughly thought out; open-ended questions are usually difficult to analyze; it is not possible to clarify questions to the respondent. Questionnaires will be administered as they represent a large sample of the population. The study will use open-ended questionnaires to facilitated unstructured responses due to its qualitative nature.

Face to face interviews was the primary data collection instrument for the study. This is because the study is qualitative and quantitative in nature and interviews will provide a good means of probing for information. An interview is a conversation between two or more people (the interviewer and the interviewee) where questions are asked by the interviewer to obtain information from the interviewee.

A research interview is a structured social interaction between a researcher and a subject who is identified as a potential source of information, in which the interviewer initiates and

controls the exchange to obtain quantifiable and comparable information relevant to an emerging or previously stated hypothesis.

The most commonly used are structured, semi structured and unstructured interviews (Raudenbush, 2005). Structured interview comes more under quantitative research methods as it is more like a questionnaire. Unstructured interview is when the researcher asks little questions and lets the interviewee do all the talking, to find out as much information as possible. Semi Structured Interviews involves a combination of both structured and unstructured interviews. In this mode, the researcher develops some questions for purposes of gathering information on the essential areas required to be later compared with responses from other respondents or interviewees and at the same time create room for unstructured environment where the interviewee can give additional information that may not have been anticipated by the researcher.

3.6 Data Collection Procedures

Interviews using the questionnaire were done through physical visits to the Gikomba Market by undertaking personal interview with the selected respondents and it gave a good response rate, clarification of concepts was also made easier, the researcher was able to read from the visual aids and probe for more information from the respondents.

3.7 Data Analysis, Presentation and Interpretation

This study generated both qualitative (open-ended questions) and quantitative data (closed-ended questions). Quantitative data was coded and entered into Statistical Packages for Social Scientists (SPSS Version 17.0) and analyzed using descriptive statistics. Qualitative data was analyzed based on the content matter of the responses as responses were common themes or patterns were grouped together into coherent categories. Only the relevant non-redundant content was presented.

Descriptive statistics involves the use of absolute and relative (percentages) frequencies, measures of central tendency and dispersion (mean and standard deviation

respectively). Quantitative data was presented in tables, graphs (pie charts and bar graphs) while the explanation to the same, and qualitative data was presented in prose.

CHAPTER FOUR

DATA ANALYSIS AND INTERPRETATION

4.1 Introduction

The main objective of the study was to establish the factors influencing the demand of social health insurance by workers in the informal economy in Kenya. The results are presented in figure and tables to highlight the major findings. They are also presented sequentially according to the research questions of the study. The raw data was coded, evaluated and tabulated to depict clearly the results on extending social insurance to the informal sector in Kenya.

4.2 Demographic Characteristics

4.2.1 Gender of the respondents

Male respondents were more than the female respondent since the males were 53 percent while females were 47 percent as shown in figure 4.1 below. Gender bias in health care use continues to persist with men having better access to facility as compared to women due to various socio-economic and cultural reasons. More specifically, poor women are most vulnerable to diseases and ill-health due to living in unhygienic conditions, heavy burden of child bearing, low emphasis on their own health care needs, and severe constraints in seeking health care for themselves

Figure4.1 Gender

4.2.2: Age group of respondents

The studies showed that majority (51.1%) of the respondents were in the age bracket of 31-40 years. Those in the age bracket 21-30 followed with 37.8 percent Those aged 41-50 were 6.7percent, while age bracket 15-20 and 51-60 were very few since each bracket had a 2.2 percent. This implies that those aged 31-40 were the majority people doing business in the area and therefore they were in good capacity to understand the need of health insurance. They would also appreciate the need for the study as their needs would be addressed since they do not have bargaining power or collective strength to demand just policies and laws for social protection and social security.

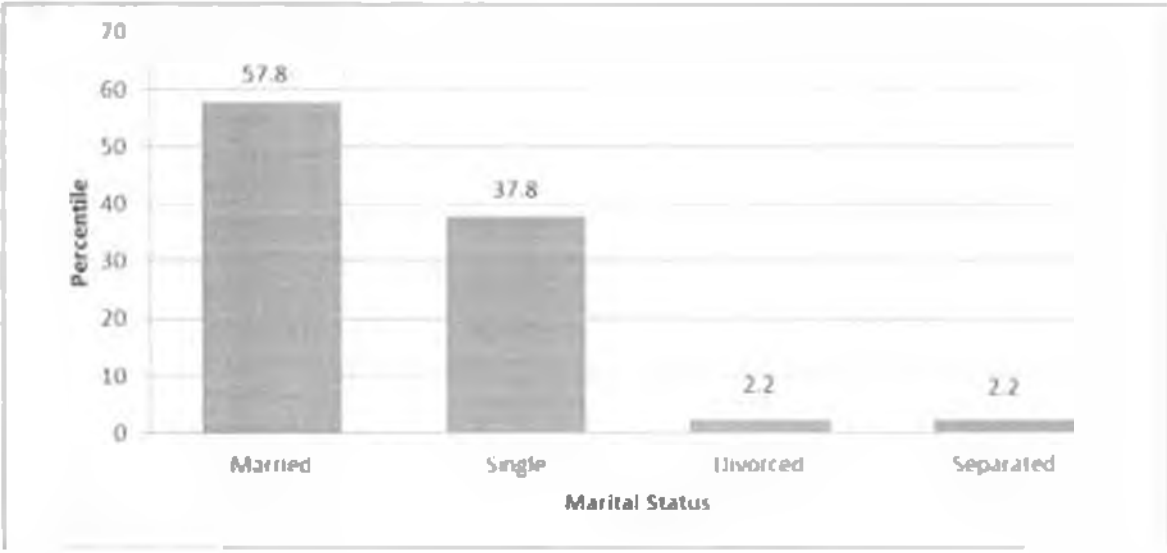
Table4.1: Age Group

Age bracket	Frequency	Percentage
15-20	1	2.2
21-30	23	37.8
31-40	17	51.1
41-50	3	6.7
51-60	1	2.2
Total	**45**	**100**

4.2.3 Marital Status

The respondents were asked about their marital status, majority of the respondents 57.8 percent who participated in this study were married followed by singles 37.8 percent whilst divorced and separated formed the least number 2.2 percent each.

Figure4.2: Marital Status



4.2.4 Head of the house hold

The respondents were asked to disclose who headed the household and majority 58% indicated it was the father, followed by the mother with 33%. Four of the respondents (9%) of the total population indicated that it was headed by other which included auntie, uncle, brother and sister.

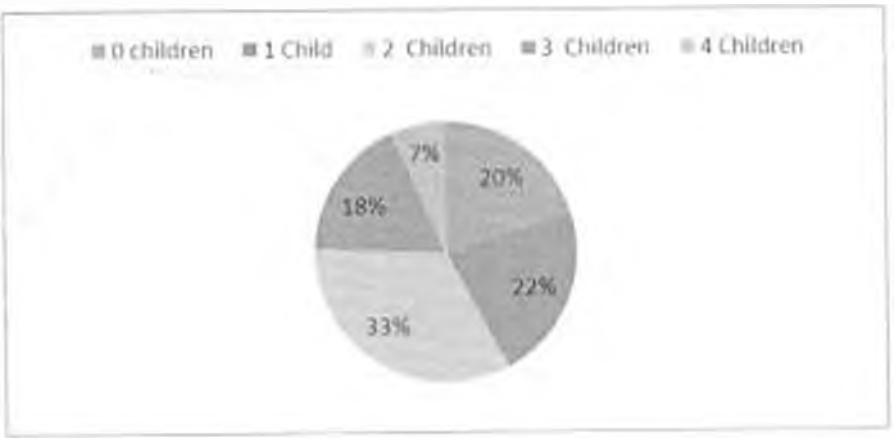
Table4.2: Head of household

	Frequency	Percent
Father	26	57.8
Mother	15	33.3
Other	4	8.9
Total	45	100

4.2.5 Number of children

The respondents were asked to indicate the number of children they had and majority (33%) had two children, followed by those with one child which was 22%, those with no children were 20%, those with 18% while only a few (7%) had more than four children.

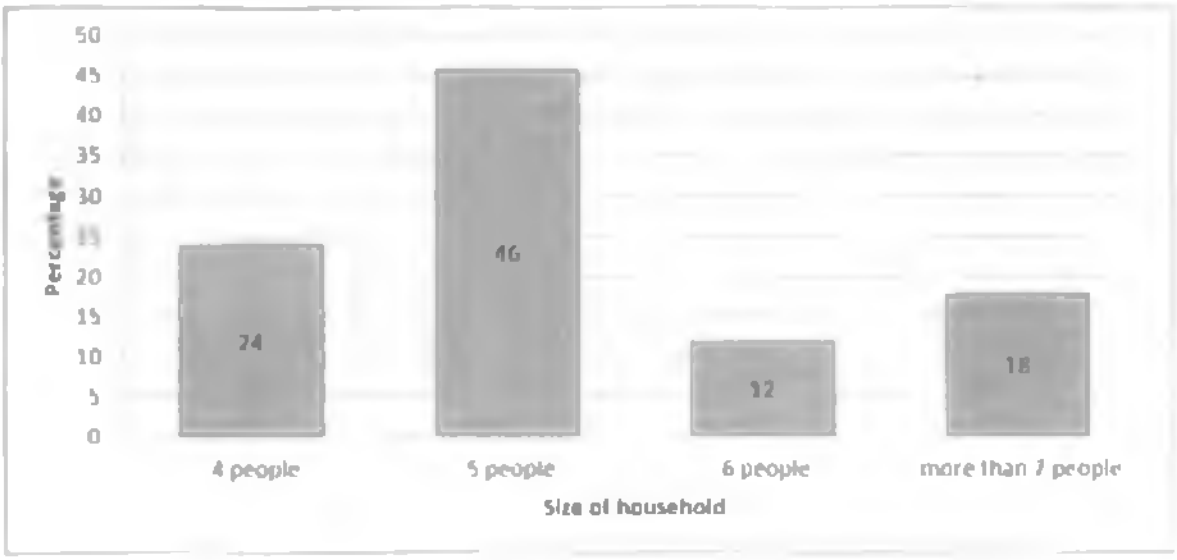
Figure4.3: Number of children



4.2.6 Size of household

When asked about the size of house hold, majority of the respondents indicated they were more 5 persons, 24% indicated they were 4 persons, 18% indicated that they were more than 7 persons while 12% indicated that they were 6 persons. Figure 4.4 shows the study findings.

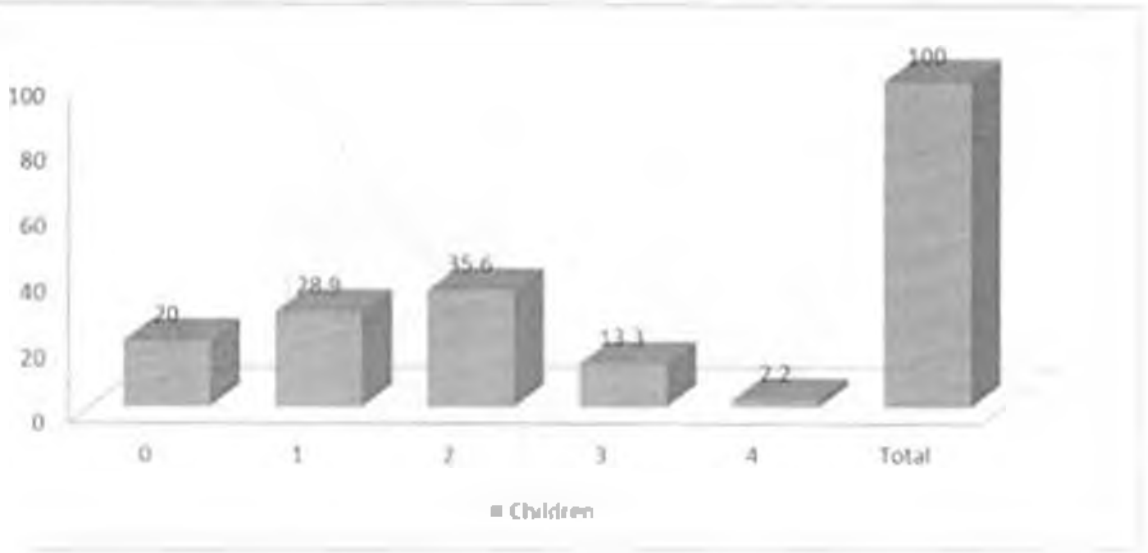
Figure4.4 : Size of household



4.2.7 Number of children dependent on them

Majority 35.6 % of the respondents indicated that they had more 3 children, 28.9 said they had two children, 20% indicated they had only one child. 13.3 had 1 while 2.2% had 5 or more.

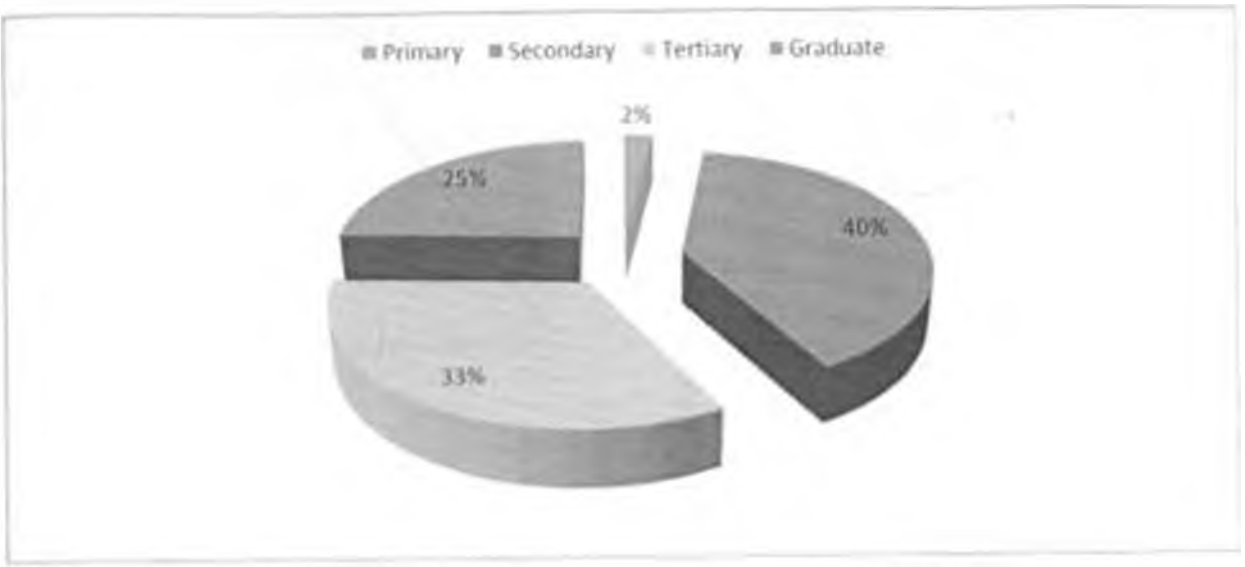
ure4.5: Children dependents



el of education

lts presented in the figure below shows that a large proportion 40% of the ts had gone up to secondary school, 33% had acquired a tertiary education, 25% iates while the lowest proportion were those highest level was primary school

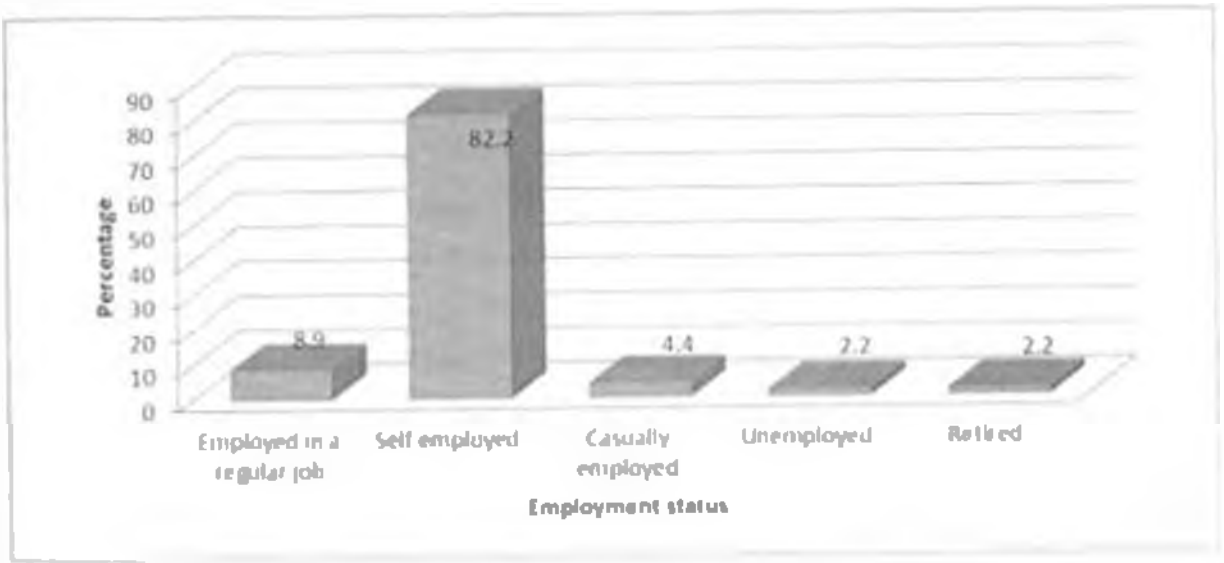
Figure4.6: Level of education



4. 3 Employment status

The respondents were asked to disclose their employment status and majority (82.2%) were self employed. 8 9% were employed in a regular job, 4.4% were casually employed 2.2 were unemployed while the remaining 2.2 were retired. Figure 4.8 show the findings.

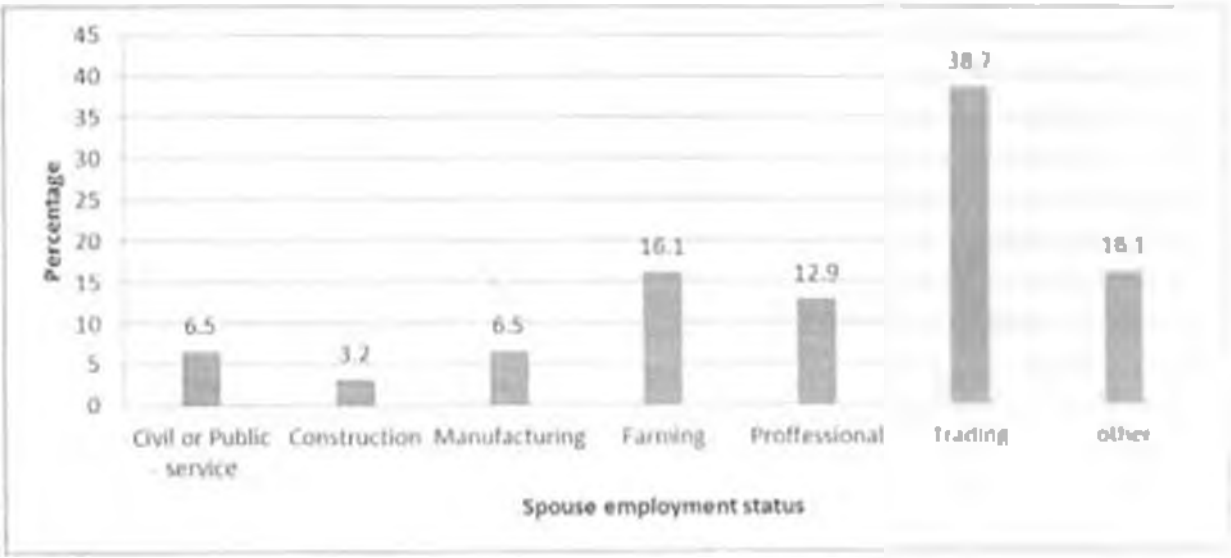
Figure4.7: Employment status



4.3.1 Spouse employment category

When asked to disclose about their spouse employment status majority 38.7% indicated that their spouse was in trading, 16.1% were in farming, 12.9% were professionals, and 6.5% were in civil or public service, while another 6.5 were in manufacturing. A few 3.2% were in construction while there was another category of others, which was 16.1, and the categories included retailing, figure 4.9 shows the study findings.

Figure4.8: Spouse employment category



4.3.2 Estimated Gross monthly house hold income

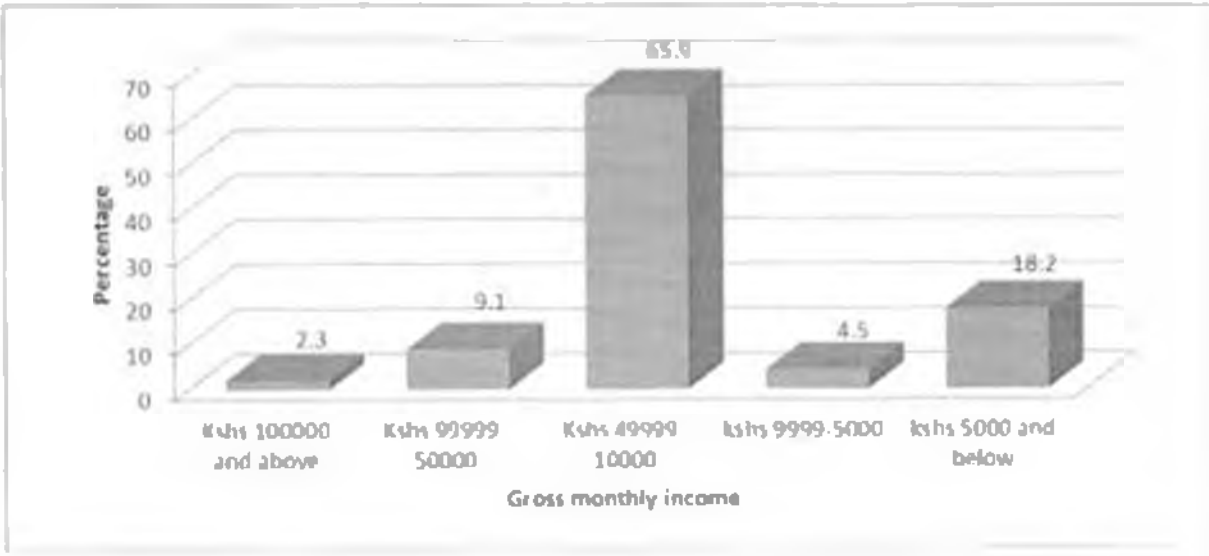
The respondents were asked to disclose gross monthly income. Majority (65.9%) of the respondents indicated that their gross monthly income were in kshs.4,999-10,000 category. 18.2% indicated that they earned Kshs 5,000 and below, 9.1% indicated that they earned Kshs 99,999-50,000, 4.5% indicated that they earned kshs 9,999-5,000 while only a few 2.3% indicated they earned Kshs 100,000 and above. The findings are shown in figure 4.11

Since majority in the informal sector are low income earners, it was noted that they prefer not to join the health insurance. Majority of them do not have a steady income and are therefore not comfortable joining the health insurance as they had a feeling that they could not afford

for the services. This has resulted to them registering to NHIF at a very slow rate.They feel that they should be given free services or the amount should be reduced to a figure that is affordable to them.

One key informant, a district Officer in Kamukunji said that "lack of steady income has hindered workers in informal sector from joining NHIF".

Figure4.9: Monthly gross incomes



4.4 Accessibility to health facilities

4.4.1 Accessibility to a health delivery facility

The respondents were asked to indicate whether they had access to health delivery facilities. Majority (91%) of the respondents indicated that they had access to health delivery facility while 9% indicated that they had no access to health delivery facility. Figure 4.12 shows the results of the findings.

According to the key informants, the government has put up health facilities so that those living in the informal sector can be able to access health care.

Figure4.10: Accesses to health delivery facility

4.4.2 Types of health facility available

Respondents were asked to indicate to indicate the types of facility that were available to them. The respondents were asked to indicate if multiple facilities were available to them. Chemist / Pharmacy were indicated as the most available facility with 84.4%. 82.2 indicated that Private clinic was available, 75.6% indicated that Government hospital and Mission Hospitals were available, while 33.3% indicated that there was herbalist was available. Table 4.3 shows the findings.

According to the key informants, the government has put up health facilities so that those living in the informal sector can be able to access health care.

Table4.3: Types of health facility available

Health facility	Frequency	Percentage
Private clinic	37	82.2
Chemist Pharmacy	38	84.4
Government clinic	31	68.9
Government hospital	34	75.6
Mission Hospital	34	75.6
Herbalist	15	33.3

4.5 Membership to Health Insurance Fund

4.5.1 NHIF membership

The respondents were asked to indicate whether they were members of NHIF. Majority (56%) of the respondents indicated that they were members while 44% indicated that they were not members of NHIF. Figure 4.14 shows the study findings.

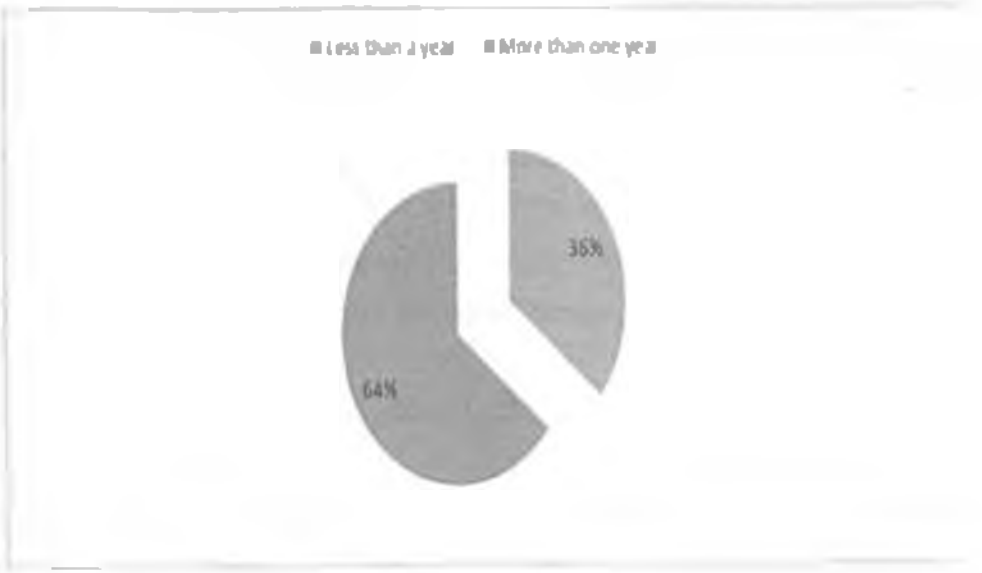
Figure4.11: NHIF membership

4.5.2 Duration of membership

The respondents were asked to indicate how long they had been into NHIF membership. Majority 64% indicated that they were members for more than one year while the rest 36% indicated that they were members for less than one year. Figure 4.15 shows the study findings

It was noted from the key informants that there has been more people joining NHIF since it pays for them once they get admitted, but more awareness needs to be done.

Figure4.12: Duration of membership



4.5.4 NHIF family membership

The respondents were asked to indicate whether their family members were members of NHIF. Those who indicated that their family members were not members of NHIF were of 74% which was very high compared to those who indicated that their family members did not have NHIF membership (26%). The findings are shown in figure 4.16.

Figure4.13: NHIF family memberships

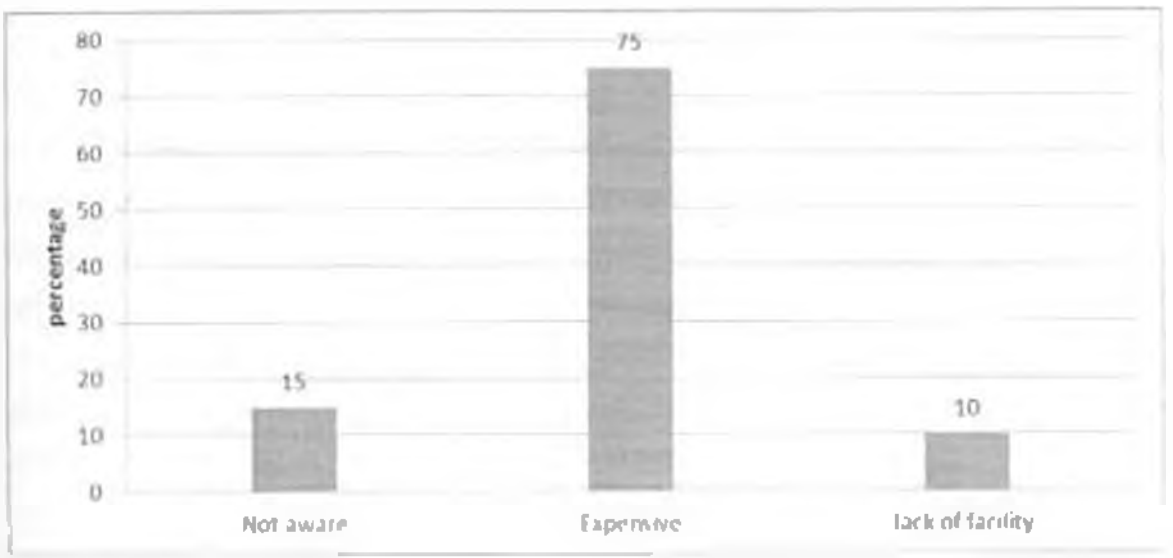
4.5.5 Reason for family not being NHIF members

The respondents were asked to indicate why other members of the family were not members of NHIF. Majority of the respondents indicated that it was expensive 75%. 15% indicated that the members were not aware of NHIF services while 10% indicated that the family members were living in a place where the health facilities were not available Figure 4.17 shows the findings.

The same reasons were given by the key informants; that the NHIF contributions were high and many can't afford them since their income is unstable.

Councilor from Pumwani Ward said 'they earn too little to be able to make monthly contributions, most of them are more concerned with putting food on the table'

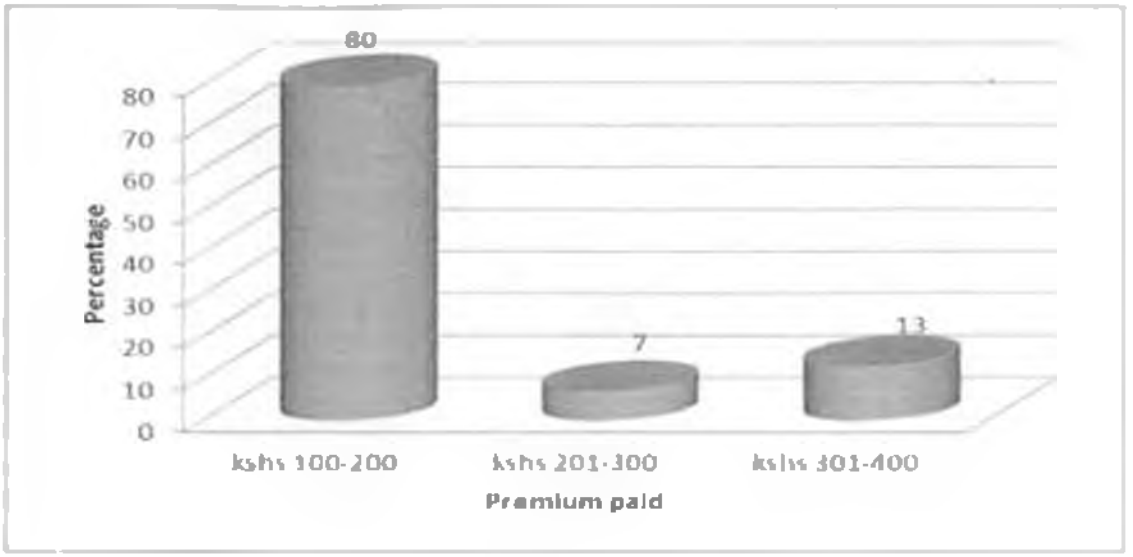
Figure4.14: Reason for family not being NHIF members



4.5.6 NHIF Contribution

The respondents were asked to indicate how much they pay for their membership. Majority of the respondents indicated that they paid a fee ranging from Kshs 100-200. 13% indicated that they paid a premium of Kshs 301--400 while the remaining 7% indicated that they paid a premium of kshs 201-300.Figure 4.18 shows the findings.

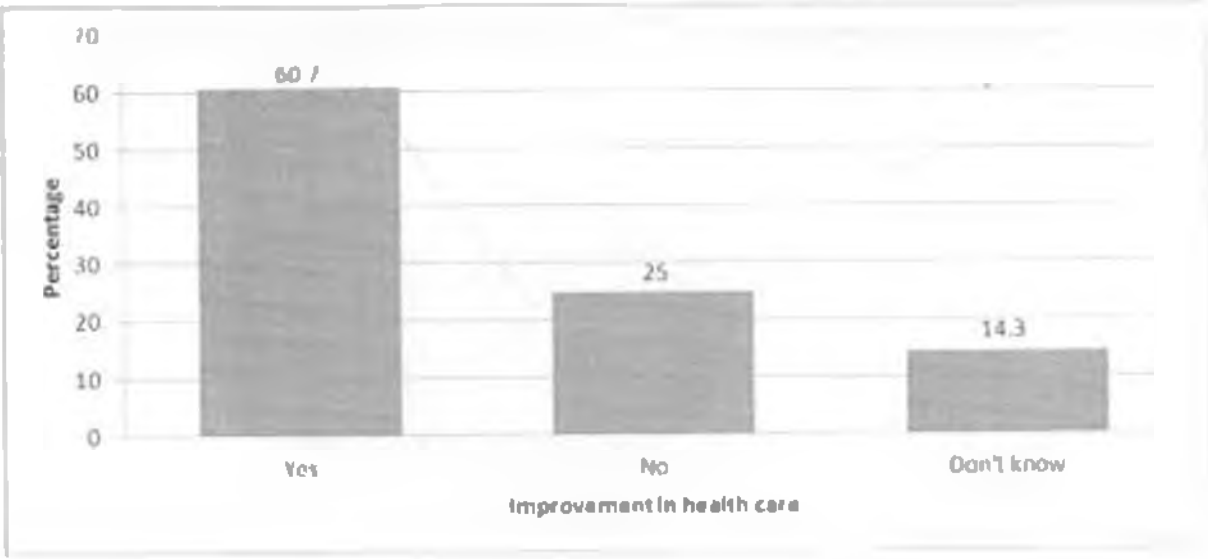
Figure4.15: Premium paid



4.5.10 Health care services improvement

The respondents were asked to indicate whether their membership had helped in improvement of their health care. Majority 60.7% of the respondents indicated that the their membership had improved their access to health care, this was followed by 25% of the respondents indicating that their access to health care had not improved despite their membership while 14.3% of the respondents did not know whether it had improved their access or not. Majority of those who said there was improvement in healthcare facility went ahead and indicated that it was easy to access and the healthcare services were good. The results of the study are shown in figure 4.22 shown below.

Figure4.16: Health care services improvement

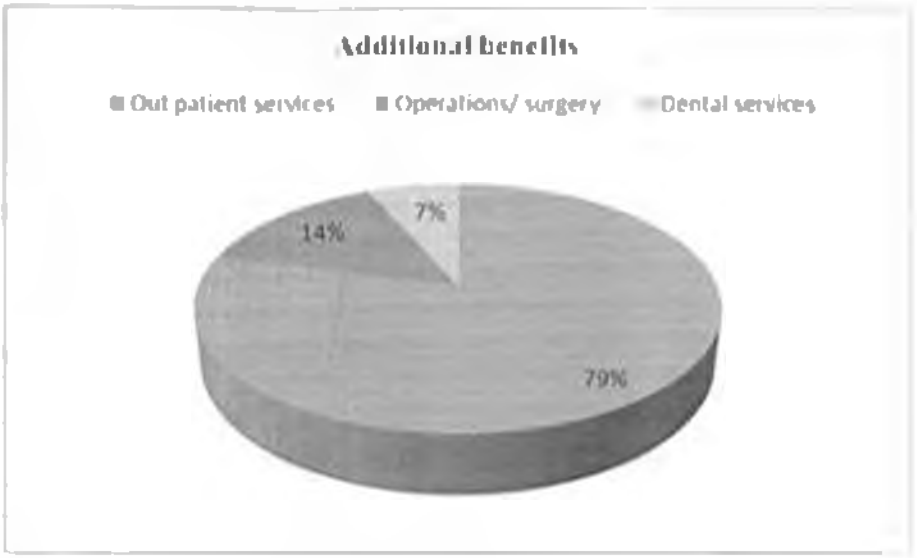


4.5.11 Additional benefits

The respondents were asked to indicate the additional benefits they would want the scheme to offer. Majority of the respondents indicated that they would want NHIF to offer out patient services, this was represented by 79%. 14% indicated that they would want NHIF cover to include operations and surgical services while & indicated that they would want NHIF to offer dental services. The results of the study are shown in the figure 4.23.

The business representative of Gikomba market suggested that NHIF should ofler outpatient services to all the Kenyans s well as increase more benefits.

Figure 17: Additional benefits



4.5.12 Willingness to rejoin Health insurance scheme

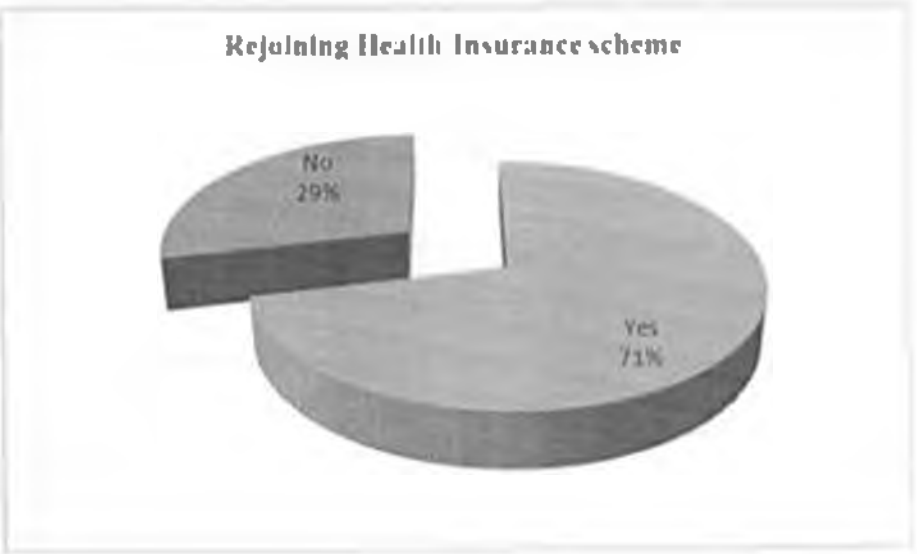
Those who left NHIF were asked whether they would be willing to rejoin the Health insurance scheme, majority of the respondents were willing to rejoin, this was represented by 71% while the rest who were represented by 29% indicated that they were not willing to rejoin due to the expensive rates. The study findings are shown in figure 4.24. The responses indicate a strong inclination towards subscription to health insurance schemes by the households in general and specifically by workers in the informal sector. A majority of the low-income households wish to get enrolled to any health insurance scheme, despite the perception of many, in both rural and urban areas, that their health status is 'good' or 'excellent'.

Awareness needs to be created and the people encouraged to register. When creating the awareness they should inform the people on the benefits of joining. This awareness can be fruitfull as majority of will registerer or rejoin the scheme.

Across the informal sector, the respondents indicated that the main determinats of social health insurance were the household perspective, the quality of the healthcare system, and the characteristics of the health insurance policy itself. Income was also been found to significantly determine the number of household members covered or the amount of health

insurance purchased. The poor quality of available public health services is a problem for many health insurance schemes. Health insurance systems are, after all, only as good as the healthcare system in which they operate. It is therefore essential to improve the overall quality of healthcare so that scheme membership ensures good quality healthcare outcomes for its members. Depending on the individual situation, different measures can be factored in to an insurance system to manage the quality of health care provision, such as different provider payment mechanisms

Figure 18: Rejoining Health insurance schemes



4.5.13 Priority to give when joining NHIF

Respondents were asked to rank some of the services offered by NHIF. It was findings indicated that majority indicated that they would want a reduction in the premium; this was ranked highly with a 72% In terms of improving quality of service the study showed that this was also a point of concern as 42.3% of the respondents ranked in 1 and 2. Another area was a wider choice of concern and majority 60% of the respondents ranked it 3. The table 4.4 below shows the study findings

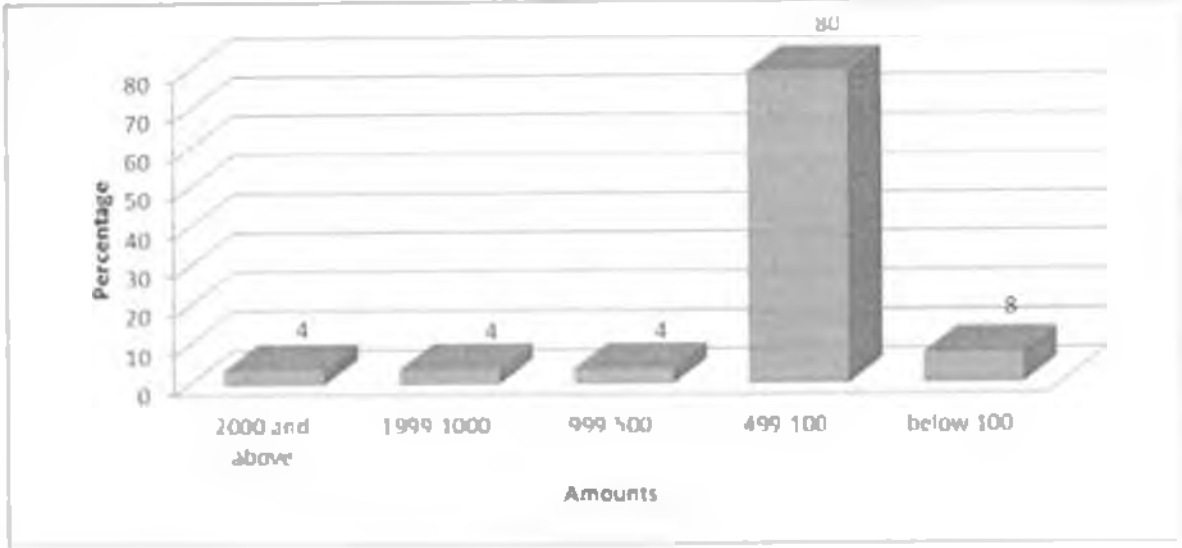
Table4.4: Priority of joining or rejoining NHIF

	Rank 1 in percentage	Rank 2 in percentage	Rank 3 in percentage
Reduction in premium	72	16	13
Improve quality of service	42.3	12.3	15.4
Wider choices of benefit	24	16	60

4.5.14 Suggested amount to be paid

When the respondents were asked to indicate the amount they were willing to in order to join NHIF or any other health insurance scheme, the responses were as follows: majority of the respondents indicated that they would be comfortable paying a premium of not more that Kshs 500 and not less that Kshs 100. Those who indicated that they would want a premium of Kshs 100 and below followed this. The three groups in category above Kshs 500 and not above Kshs 200 were each represented by 1% of the respondents. Figure 4.25 shows the study findings

Figure 19: Suggested amount to be paid



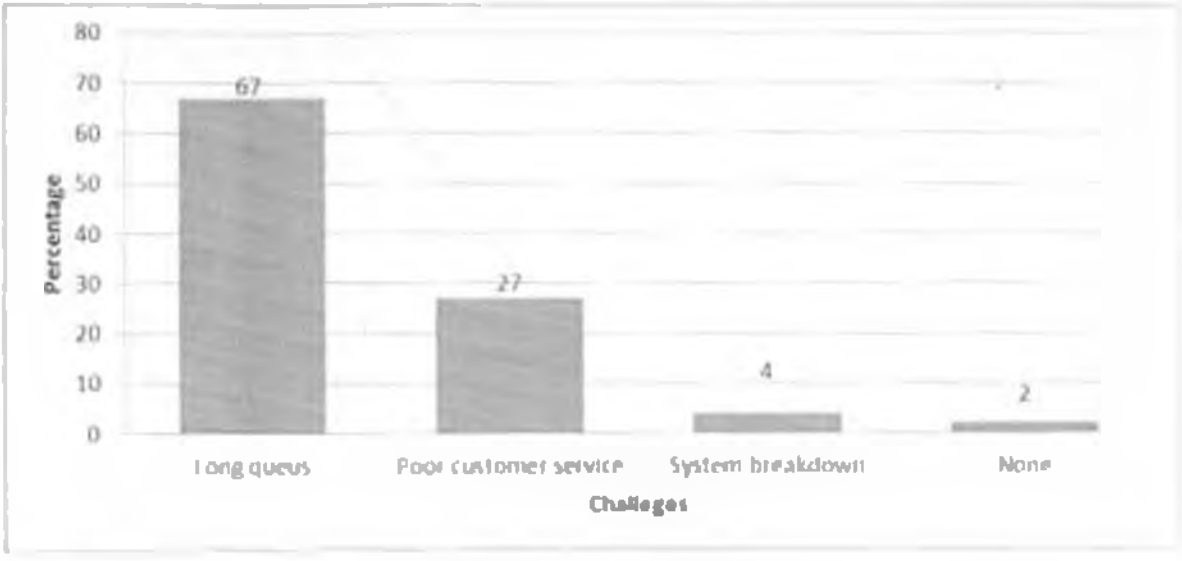
4.5.15 Challenges experienced

The respondents were asked to indicate the challenges or problems they have faced since joining NHIF Majority (67%) of the respondents indicated that they were experiencing long queues when making contributions ,27% indicated that they experienced poor customer service, 4% experienced system breakdown while a few (2%) indicated that they had experienced no challenges. Other challenges experienced include lack of steady income.

They receive very low wages and, as own account or self-employed workers, they obtain low piece rated earnings. There are also concerns about problems in the accessibility and use of subsidized public health facilities. A majority of the low-income earners reside in and remote regions where neither government facilities nor private medical practitioners are available.

Due to inadequate health protection, households have to spend their savings, take out loans, sell valuable productive assets, take children out of school, and/or reduce the quality or quantity of nutrition when medical costs need to be met. Majority households face financial ruin because of direct health care expenditure and are forced into poverty through having to pay for health services and therefore levels of poverty would reduce if the majority in the sector were provided with the social insurance services.

Figure4.20: Challenges experienced



4.5.16 kind of services expected

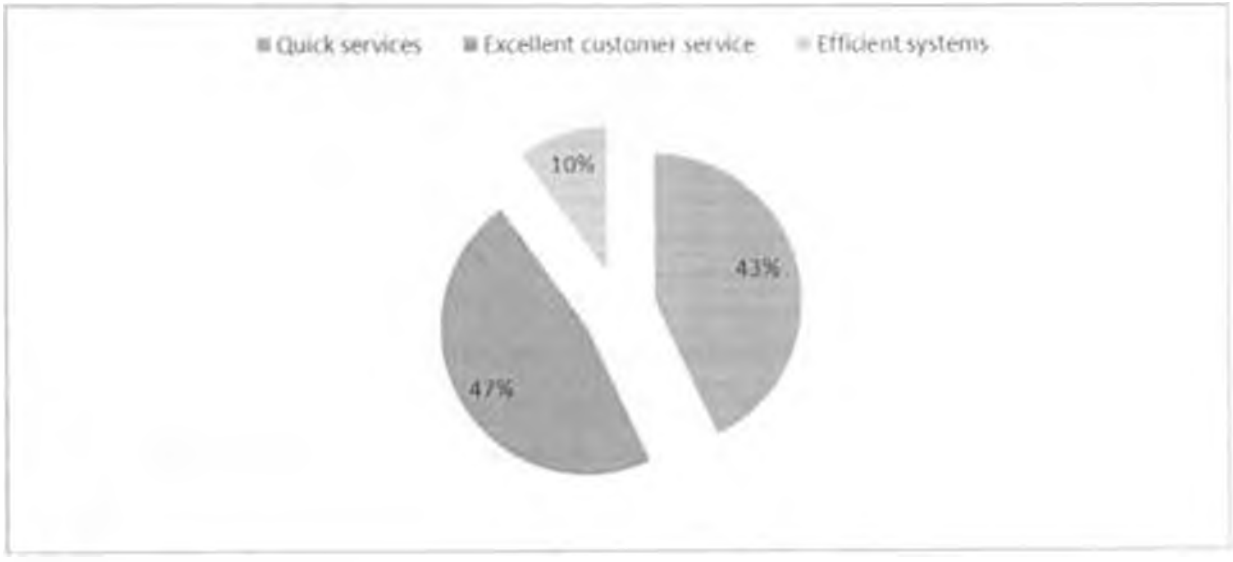
The respondents were asked to indicate the kind of services they would want Majority 47% indicated that they wanted excellent customer service, 43% indicated that they wanted quick services while 10% indicated that they wanted the NHIF systems to be efficient. The study findings are shown in figure 4.27.

Other expectations which the people were concerned with include the insurance coverage of all illnesses and timely attention. Though, it is the price of the insurance scheme that seems to be the most important factor considered for determining the enrolment. Among the specific medical care benefits, coverage of hospitalization expenditure is desired. Hospitalization being expensive, there is a strong demand for the coverage of the costs among the respondents. The coverage includes should include fees, medicines, diagnostic services, and hospital charges. They also expect specialist consultation (as part of the coverage of hospital expenses).

Majority had a view that the health insurance is expensive and it is for only those who get a high income.Others had fears that they will loose their money the latest scandals in NHIF has also brough fear and uncertainity among those in the informal sector. There is also the perception that the social insurance does not honour claims, this perception is now changing

after the awareness and they are now registering for the service. However, due to training, the people have changed their perception and they now know the importance of registering for the service. they have been shown how little the contribution is compared to the amount they pay at the hospitals whenever they are admitted. This has resulted to an increase in subscription of the services in the informal sector.

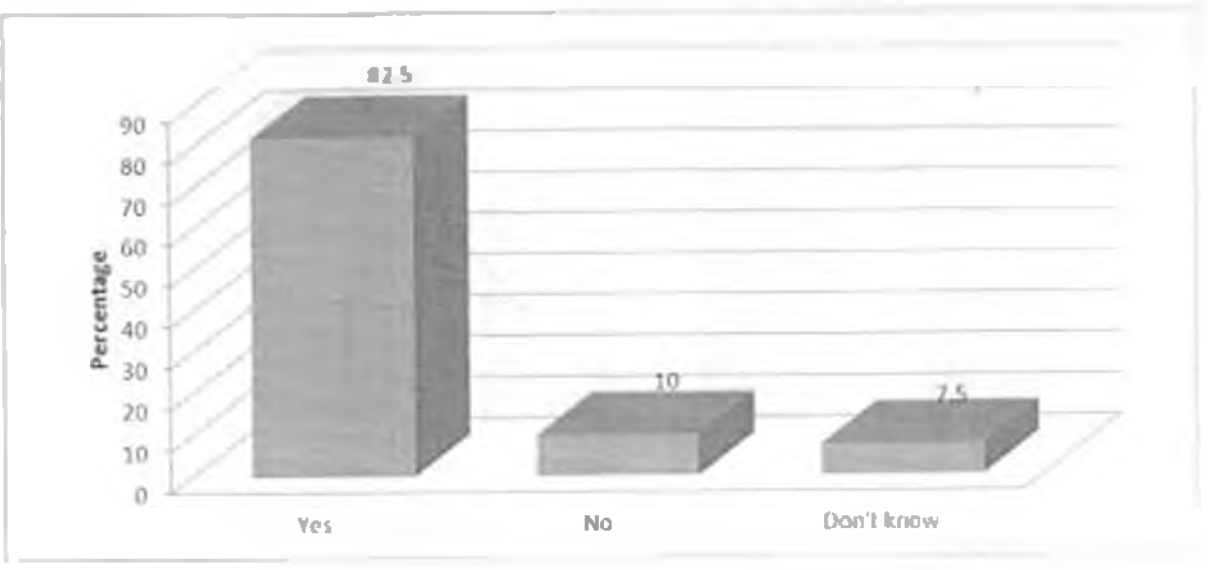
Figure4.21: Kind of services expected



4.5.17 Opinion on free access to health services

The respondents were asked to give their opinion on whether people should be given free health care services. Majority 82.5 % indicated yes. This was followed by those who indicated there should be no free access or less payment while 10% indicated that the services should not be free figure 4.28 shows the study findings.

Figure4.22: Free accesses to health services



4.5.18: Who should Free access to health services

The respondents were asked to indicate who should get the free access or pay less. Majority (33%) of the respondents indicated that the unemployed should get free access or pay less. This was followed significantly (32%) by those who indicated that the slum dwellers should get free services or pay less. 23% indicated that those in rural areas should have free access while 12% indicated that free or payless services should be given by the elderly. Figure 4.29 show the findings.

Figure4.23: Who should get free accesses to health services

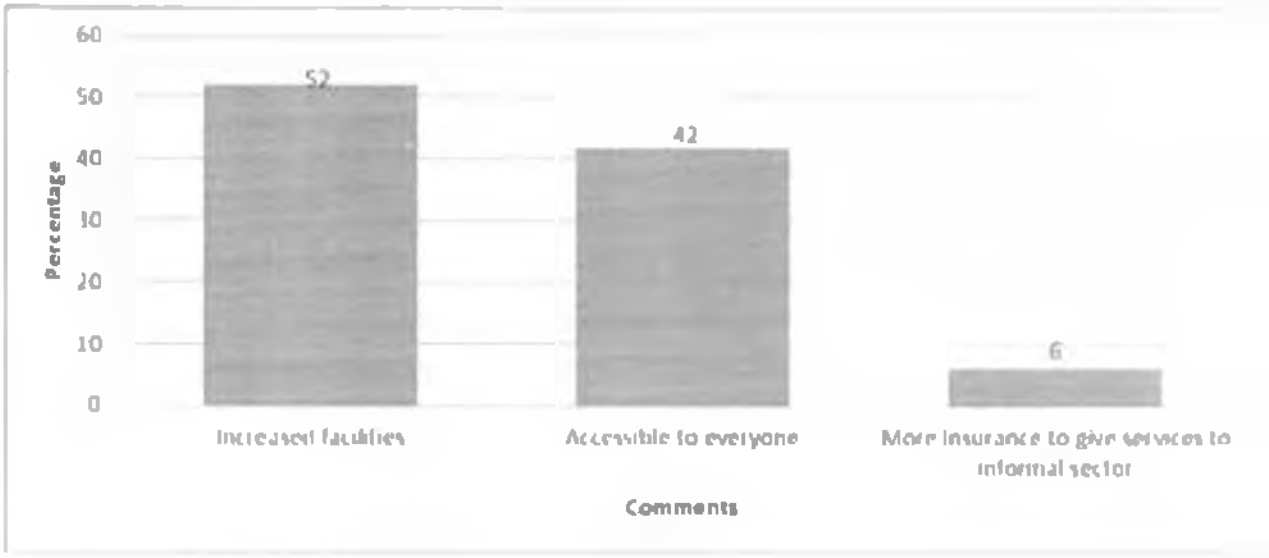
4.5.21 Comments or suggestions

The respondents were asked to give their comments and suggestions. Majority of the respondents indicated that there should be increased health facilities as they were few. 42% indicated that the health facilities should be accessible to everyone while 6% indicated that more insurance should cover those in the informal sector. Figure 4.32 shows the study findings. The room for improvement as suggested by the respondents lies in increasing the coverage of family members and coverage of services. The beneficiaries are, in particular, interested in the coverage of additional household members. This was also raised by the key informants.

It was noted that Extending social insurance to the informal sector has led to an increased number of people who are low income earners access health services since when they are admmited they do not pay anything since they pay little or nothing when admitted Without adequate health protection, households have to spend their savings, take out loans, sell valuable productive assets, take children out of school, and/or reduce the quality or quantity of nutrition when medical costs need to be met Majority households face financial ruin because of direct health care expenditure and forced into poverty through having to pay for

health services, therefore levels of poverty would reduce if the majorities in the sector are provided with these services.

Figure4.24: Comments or suggestions



CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents summary of findings as discussed in chapter four and interpretations of the data analysis, conclusions, and recommendations based on the findings.

5.2 Summary of findings

The study was done to establish factors influencing demand of social health insurance in the informal sector in Kenya. One of the objectives was to establish the extent to which workers' awareness on social health insurance influence their demand for the service. Awareness has created a good impact as the study has shown that majority 56% of those in the informal sector were registered for the services. It was noted that their majority of their family members had not registered for the services since majority were not aware of the services and others had not registered due to the high costs. Majority in the informal sector were low-income earners, felt that the cost was too high for them, and therefore could not afford the services.

Health facilities are not widely distributed and majority of those in the rural areas have no access to the facilities, this has caused low turnout in the rural areas as they will have to travel for long distance to search for a health organization that provides the services

The main challenges faced by the informal sector people were accessibility. The low-income earners of society are unable to access the NHIF, as they cannot afford the full cost of insurance and the government has insufficient resources to subsidize the cost. Critically, the large informal sector is untouched by the NHIF, due to a lack of systematic methods to reach informal workers.

Another challenge is that there lacked a comprehensive coverage NHIF only covers inpatient expenses, and does not address outpatient expenses. The distribution of claims by the NHIF

is unevenly skewed towards private hospitals and nursing homes, as opposed to government and mission facilities, where most people access their health services. The NHIF also does not provide coverage for preventive health care services, which are critical to improving health outcomes in Kenya. Another challenge is the quality of services offered, majority felt that the services were of not good quality, and there was need for this to be addressed. Quality and efficient services should be offered for the people to comfortable register for the services.

Majority of the respondents were in view that the medical scheme is quite expensive and would want the premium amount reduced to an affordable rate. Most of those in the informal sector earned a low income and could not afford the rates. They could also not afford to pay for their family members and therefore it has caused low turnout. Reimbursement of funds was a view that the respondents saw the need of it addressed. The utilization of these excess funds is another subject of debate; many feel that these excess funds should be invested in Corporate Social Responsibility initiatives, while others believe they should be invested in profit-making endeavors that will increase returns to the Fund's contributors. It is important to note that the current levels of contribution are capped at a very low rate, and do not reflect the earnings of persons. However, many argue that before contributions are increased in any way, management and governance issues within the Fund must be adequately addressed.

5.3 Conclusion

The study concludes that factors influencing the demand of social health insurance by workers in the informal economy in Kenya were mainly access to health facilities, access to affordable services and poor quality of services. A major obstacle to access has been the absence of a mechanism to finance the utilization of available public and private facilities by the poor and vulnerable sections of the society as well as the absence of incentives for investment in health facilities in lower income areas.

The quality of services provided to the public is a big issue within the health sector. The poor quality of services is attributable to inadequate supplies and equipment as well as lack of

personnel. Moreover, regulatory systems, standards, as well as compliance remain poor. There is inability of rural health facilities to access funds on time because of poor financial management capacity has hindered their operations and almost brought to a standstill the implementation of public health activities. The government needs to put efforts to decentralize health services management to the districts, health-financing reforms, staff rationalization, and restructuring the operations of institutions in the health sector requires adequate management skills, which are currently in short supply within the sector

5.4 Recommendations

The mandate of the NHIF is to enable all Kenyans to access quality and affordable healthcare services. However, there lacks mechanism that enables members to participate in the governance of the neither Fund, nor does the NHIF have representation from the grassroots level; those who should derive the greatest benefits from NHIF have a very limited role in the Fund.

For its successful implementation in the informal sector, improving access is essential. This can be done by Increasing the number of NHIF outlets throughout the country; Utilize community based organizations, micro-finance institutions and others to reach out to informal workers and increase their participation in the Fund; Vulnerable groups, such as women, and persons with disabilities, should be provided with information on NHIF so that they may enroll and enjoy the benefits of membership; Utilize civil society organizations for mobilization and provision of information about the Fund, as well as collection points for the Fund; Create clear criteria for recruitment into the NHIF; Invest resources and surplus funds in social mobilization activities; Develop a clear policy on the manner in which members' funds should be invested and the role of Corporate Social Responsibility in the NHIF's operation; and also encourage annual payments to decrease the cost of resources needed to make monthly contributions

There is also need to improve coverage and benefits this can be done by revising individual contributions to reflect income level; Increase penalties for NHIF fraud; Improve guidelines

for the timely management of claims and appeals: and include coverage of preventive health care services within the benefits package.

5.5 Further studies suggestion

Further studies should focus how the National Hospital insurance fund can designing a cost effective demand driven benefit package for the informal sector. This study will help the stake holders come up with a way of ensuring all in the informal sector voluntarily register for the social health insurance services.

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APPENDIX I

QUESTIONNAIRE

Instructions

Please fill in the blank or tick your answers from the choices given and don't write your name on the questionnaire or any other form of identification.

Part A: Background information

Sex of interviewee

1. Male [ ] Female [ ]

2. Age .....

3. Age group of respondents

   15-20[ ] 21-30[ ] 31-40 [ ] 41-50 [ ] 51-60 [ ] 61-70[ ] 70+ [ ]

4. What is your marital status?

   Married [ ] Single [ ] Divorced [ ] Separated [ ] Widowed [ ]

5. Who is the head of this household?

   Father [ ] Mother [ ] Other [ ]

   If other specify.....

6. How many children do you have?

   [0] [1] [2] [3] [4] [5 or more]

7. What is the size of your household? How many people live with you and eat from the same pot?

   Write number.....

8. How many of your children are below 18 years?

[0] [1] [2] [3] [4] [5 or more]

9. How many of your children under 18 go to school?

[0] [1] [2] [3] [4] [5 or more]

10. How many of your children depend on you for a living?

[0] [1] [2] [3] [4] [5 or more]

11. How many other dependants (apart from your children) do you have for whom you take care of?

[0] [1] [2] [3] [4] [5 or More]

12. What was your highest level of Education?

None [ ] Primary [ ] Secondary [ ] Tertiary [ ] Graduate [ ]

Others [ ]

Specify.....

PART 2: Employment and Income

13. Are you employed in?

Employed in a regular job [ ] Self employed [ ] Casually employed [ ] Unemployed [ ]

Retired [ ]

14. If spouse is employed or self employed, specify which category

Civil/Public Service [ ] Construction [ ] Manufacturing [ ]

Financial [ ] Farming [ ] Professional [ ]

Mining Quarrying [ ] Fishing [ ] Livestock [ ]

Trading [ ] Office/administration [ ] other (specify) [ ]

.....

.....

.....

.....

15. Are any other members of the household in work?

Yes [ ] No [ ]

16 Please estimate your total gross monthly household income

Up to 50,000 [ ] 50,000 to 200,000 [ ]

200,000 to 300,000 [ ] 300,000 to 500,000 [ ]

Above 500,000 [ ]

PART 3: HEALTH

17. Do you have access to a health delivery facility in this town / village?

Yes [ ] No [ ]

18. What types of facilities are available to you? (Tick all boxes that apply, multiple response)

Private clinic [ ]

Chemist Pharmacy [ ]

Government clinic [ ]

Government Hospital [ ]

Mission Hospital [ ]

Herbalist [ ]

Others (give details) [ ]

.....

.....

PART 4: MEMBERSHIP TO HEALTH INSURANCE FUND

19 Do you belong to any health insurance fund (NHIF)?

[Yes] (Complete 38-52) [No] (Proceed to 53)

20. If yes, how long have you been a member?

Less than a year [ ] More than a year [ ]

21. Do all members of your family belong to the NHIF?

Yes [ ] No [ ]

22. If not all members belong to the NHIF, why have others not joined?

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.....

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.....

23. How much do you normally pay for your membership of the NHIF (the premium)? (Obtain approximate amount if exact not available)

.....

.....

.....

24. Considering your other items of expenditure, e.g. Food, Clothing, School fees, etc would you say that premiums were?

High [ ] Low [ ] About right [ ] Don't Know [ ]

25. As a member of the scheme do you consider the amount you spend on the premium in relation to your other commitments as?

High[ ] Low [ ] About right [ ] Don't Know [ ]

26. Has your membership of the NHIF improved your access to health care?

Yes [ ] No [ ] Don't Know [ ]

If yes, how?

.....

.....

.....

.....

27. What additional benefits would you want the scheme to offer its members?

.....

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.....

.....

28. Are you still a member?

Yes [ ] (Go to Q34) No [ ] (Ask Q29)

29. If not, give reasons

.....

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.....

.....

30. Would you be willing to join or re-join a Health insurance scheme?

Yes [ ] (Go to Q32) No [ ] (Ask Q31 and don't ask Q32)

31. If not give reasons

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32. If you were considering joining or rejoining an NHIF what priority would you give to the following:

	Rank 1	Rank 2	Rank 3
Reduction in premium			
Improve quality of service			
Wider choice of benefits			

33. What amount would you be ready to pay to join the NHIF or any other health insurance scheme?

50,000 - 100,000 [ ]

40,000 - 50,000 [ ]

30,000 - 40,000 [ ]

20,000 - 30,000 [ ]

10,000 - 20,000 [ ]

5,000 - 10,000 [ ]

34. What problems and or challenges have you experienced since your joining NHIF? (Question only for NHIF members)

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35. What kind and quality of services would you expect?

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36. Do you think there are some people who should have free access to the health facilities without paying or by paying less?

Yes [ ] (Go to 37) No [ ] (Go to 39) Don't know [ ]

37. If yes, who do you think should have this help? (List some characteristics)

.....

.....

.....

.....

.....

.....

38. Who do you think should decide if those people should have free access?
Government [ ] NIHP administrators [ ] Community leaders [ ] Other [ ] Don't know [ ]

39. If no, why?

.....

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.....

40. Do you have any comments or suggestions on this survey?

.....

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APPENDIX II

KEY INFOMANT GUIDE

1. What is the impact of Social Health Insurance to the Informal Sector?
2. Are Workers' aware of the social health insurance and the influences their demand for the service?.
3. What is the informal sector workers perception on the social health insurance and its effects on demand?
4. How has the Nature of employment and level income affected the extension of social health insurance to workers in the informal sector
5. Has the legal regulations affected workers demand for social health insurance?
6. What are the challenges of Social Health Insurance to the Informal Sector?
7. What are the determinants for insurance in informal sector?