UPTAKE OF PRIVATE HEALTH INSURANCE AMONG REGISTERED EMPLOYERS IN NAIROBI - KENYA

BY

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DECLARATION

I, Francisca Mumbua Mwangangi, declare that this thesis is my original work and that it has not been presented to any other institution for purposes of obtaining a degree.

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To my parents Mr. Mwangangi Kilungu and Mrs. Sera Mwangangi, my siblings Peter, Angela, Veronica, Maggie and Jacinta, nieces and nephews; I will always love you.

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LIST OF ABBREVIATIONS/ ACRONYMS

AAR	Africa Air Rescue
AIDS	Acquired Immunodeficiency Syndrome
AKI	Association of Kenya Insurers
CAI	Car Accidental Insurance
COTU	Central Organization for Trade Union
EU	European Union
FKE	Federation of Kenya Employers
GDP	Gross Domestic Product
GOK	Government of Kenya
HIV	Human Immunodeficiency Virus
HMO	Health Management Organization
IRA	Insurance Regulatory Authority
KDHS	Kenya Demographic Health Survey
KNBS	Kenya National Bureau of Statistics
MIPs	Medical Insurance Providers
NHIF	National Hospital Insurance Fund
NHSSP	National Health Sector Strategic Plan
NSHIF	National Social Health Insurance Fund
OECD	Organization for Economic Co-operation and Development
OOP	Out-of-Pocket
PHI	Private Health Insurance
SHI	Social Health Insurance
SPSS	Statistical Package for the Social Sciences
SSS	Social Security Scheme
THE	Total Health Expenditure
WCS	Workmen Compensation Scheme
WHO	World Health Organization
WIBA	Workmen's Injury Benefit Act

DEFINITION OF OPERATIONAL TERMS

Employer	This referred to a person or institution that hires employees for wages or salary. For the purpose of this study, employer referred to the highest decision and policy maker in the company
Company	In this study, a company is defined as a legal, social and economic entity. For the purpose of this study 'Establishment' will be used interchangeably with 'company'
Formal company	Companies which encompasses all jobs with normal hours and regular wages, and are recognized as income sources on which income taxes must be paid
Health	State of physical, emotional and spiritual well being and not merely the absence of infirmity or disease
Health Insurance	This refers to an institutional and financial mechanism that helps households, individuals and institutions to set aside financial resources to meet costs of medical care in the event of illness
Private health insurance	Voluntary, for profit commercial insurance where all money comes from household or employer income and paid to the risk pooling entity
Supplementary insurance	Private health insurance that covers services not included in the publicly funded package
Complimentary insurance	Insurance that compliments coverage of publicly insured services

nployer –provided health surance	Health Insurance cover offered by the employer to the employees (based on employment and excludes NHIF)
emium	Fixed contributions of cash paid within defined periods of time by members of an insurance scheme
nnual turnover	The value of all supplies that are made within a twelve-month period
ofit margin	The percentage of profit realized by a company

ABSTRACT

Striking the balance between the health needs of Kenya's population and its resources will continue to require a careful balance of healthcare financing strategies. As the country's needs change over time, the government will need to continue to strengthen and adapt healthcare financing policies and implementation mechanisms.

Employer –provided health insurance is one of the financing mechanisms, which can be explored to increase economic growth by increasing productivity and shift part of financial burden from the government to private health insurance schemes.

Although employer- provided health insurance cannot be used solely to finance health care because it is based on employment, it can supplement and or compliment the already existing National Hospital Insurance Fund (NHIF). It is also a foundation block for developing a National Social Health Insurance (NSHI).

Employer-provided health insurance will reduce the effects of adverse selection associated with private health insurance (PHI) markets because risks are usually spread among many employees and at the same time inject resources to the health system, increase supply of highly qualified health personnel in both private and public health institutions and lead to faster access to health services with private health care providers (Custer 1999, OECD 2004).

However, employer-provided health insurance has not played a significant role in financing health care in Kenya with only 541,000 people covered by year 2008 either through employer or through personal initiative (AKI 2008).

This study investigated the factors which determine whether an employer will or will not purchase Private Health Insurance policy for his/her employees among registered employers in

Nairobi province. Sampling was done by randomly selecting 422 companies from a sampling frame of 9,685 companies obtained from the Kenya National Bureau of Statistics (KNBS). Data were collected through structured interview questionnaire with both open and closed ended questions.

A total of 347 employers were interviewed. Among the companies interviewed 37.8% had less than or equal to 20 employees, 22.5% had between 21 and 40 employees and about 19.6% companies had over 100 employees at the time of the study. A few companies had between 61 and 100 employees. Most of the companies interviewed were Kenyan owned representing 88% and 12% were foreign owned. The mean age of companies interviewed was 19 years with a range of 105 years in existence. Four factors were found to be significant in relation to PHI subscription. Increasing annual turnover and number of employees is associated with increasing the probability of the employer providing health insurance to employees when all the other factors were controlled.

In companies where employees are more professionals than non-professionals was found to be associated with increased probability of the employer providing health insurance to employees and when a company had union workers there was an increased probability of the employees being provided for health insurance cover. Age and ownership of a company were found to be significant when the other factors were not controlled for. This study concludes that these factors are important to consider if uptake of PHI among employers is to be increased. Cost of premiums is to be considered if a policy to increase PHI is to be adopted. There is a great potential for SHI in Kenya as 66% of employers were willing to participate.

This study recommends that the Kenya employment act should be revised and reinforced to ensure that employers give health benefits to employees with emphasis on health insurance. In this study, 70% of employees perceived PHI to be very important and 73% perceived it to increase productivity. However 47% of employers had no knowledge about the effect of PHI on company's profit. The government through IRA should organize educational programmes to employers on the effects and importance of PHI on the company's well being. Insurance Regulatory Authority should also organize for open day between employers and MIPs for employers to learn more about products available and for MIPs to learn the challenges employers are facing with the products.

Education on importance of health insurance to the public is also crucial as this study found that employees prefer other modes of health benefits which may not be as beneficial as insurance in event of illness.

The major reason why most employers do not offer PHI to employees is because PHI is expensive. With the escalating cost of living the government needs to consider increasing the tax relief for employers who offer PHI as an incentive. In developed countries like the United States and Canada, governments intervene in the market by subsidizing employer provision of health benefits by excluding employer contributions to these benefits from the employee's taxable income, which is one factor that has lead to the predominance of employer provided health insurance in these countries (Finkelstein 2002). Medical insurance providers should also be flexible to the mode of payments by the employers.

CHAPTER ONE: INTRODUCTION

1.1 Introduction

Health as defined by World Health Organization is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (WHO 1978). Health is a prerequisite for economic development (GOK 1997). In most developed countries, good health is regarded as a basic right for all people, as declared by the World Health Organisation (WHO 1978) and health sectors are allocated substantial financial resources by their governments, in addition to financing from health insurance schemes.

Although health is also considered as a human right in most of the developing countries, health services are chronically underfinanced and resources are insufficient, inequitably allocated and inefficiently used (WHO 2000). Developing countries like Kenya have always used general tax revenues to finance a major proportion of health care. This has however, been a challenge over the years owing to a reduced tax base and less capacity to collect taxes. Low tax ratios often translate into insufficient public finance for health care.

User fees have been implemented in many countries since the 1980s. The large body of empirical evidence on the impact of user fees on utilization of health care services, however, suggests that user fees are regressive and inequitable, in that poor people pay a greater proportion of their incomes out of pocket for health care than those who are better off, unless there are effective exemptions in place to protect them and the quality of health care is simultaneously improved (GOK 2004).

The challenge facing governments is that if services are to be provided for all, then not all services can be provided (WHO 2000). The government of Kenya budget allocation to health

sector is inadequate to deliver the minimum package for health. Though the proportion allocated to the health sector increased from 6.7% in 2008/2009 to 7% in 2009/2010; the allocation of the total government resources for the healthcare sector is still not even half of the expected 15 % (GOK 2009).

In order to achieve greater health coverage, it thus seems indispensable to pool resources by bundling available funds and spreading the risk of illness and heath care financing. Realizing the inadequacy of solely relying on the general taxation and user fees, there is need for countries to seek alternative mechanisms for health financing like health insurance.

Health insurance is an institutional and financial mechanism that helps households, individuals, and organizations set aside financial resources to meet costs of medical care in the event of illness (Hall 1994).

By pooling financial contributions from many people, insurance plans can cover the cost of accessing health care. Without access to such insurance, many people are unable to obtain treatment or must incur debts to pay hospital bills. Broad availability of medical insurance level is believed to be a panacea for the social exclusion typically associated with user fees. The great merit of medical insurance is that it facilitates payment for care in advance of illness, thus enabling households to obtain treatment regardless of their economic status. Insurance also promotes equity in use of health services, because the sick benefit from insurance premiums contributed by households who do not get sick. Thus, strong efficiency and equity reasons support public investment in institutions that promote the spread of medical insurance (Wang'ombe et al 1994).

Insurance mechanisms can also generate large volumes of revenue for health services. Health insurance is virtually the only practical instrument through which governments can get out of

the expensive business of across the board subsidies for hospital care and thus release fund for public health, preventive and primary services that benefit the poor (Collins 1996).

Therefore, insurance becomes the only health financing mechanism which will ensure equity and efficiency in health systems.

Employer-provided health insurance is one of the insurance schemes which can be explored to shift part of the health care financing burden to private health care providers.

Although employer- provided health insurance cannot be used as the only health care financing mechanism because it is based on employment it can supplement and or compliment the already existing National Hospital Insurance Fund (NHIF). It is also a foundation block for a National Social Health Insurance. History shows that the social insurance systems of several developed countries evolved from voluntary private health insurance schemes based on professional guilds or communities for example in German and Netherlands (Gress et al. 2002).

Employer-provided health insurance can reduce the effects of adverse selection associated with Private Health Insurance (PHI) markets because risks are usually spread among many employees and at the same time inject resources to the health system. Private health insurance also increases supply of highly qualified health personnel in both private and public health institutions and lead to faster access to health services with private health care providers (OECD 2004; Sekhri and Savedoff 2006).

In addition, employer-provided health insurance is a way for the organization to promote and assist employees in remaining healthy and, therefore, productive at work. This will in turn foster economic growth by reducing production losses caused by worker illnesses especially when the worker has no access to healthcare (Custer et al 1999; Kimalu et al. 2004).

This study aimed to establish the determinants of demand for employer provided health insurance among employers in Nairobi. The background of the study looks at the situational analysis of the health care sector financing policies, how health relates to work productivity, the provisions Kenya employment Act and the development and structure of PHI market in Kenya. In addition, the background looks at the contribution of PHI to healthcare systems in different countries. The literature review looks at the employer provided health insurance in developed, developing and underdeveloped countries and factors influencing its uptake in these countries.

The results are presented in three sections. Section I presents a description of the study frequencies in tables and graphs. Section II is the cross-tabulations of the company characteristics and the probability that an employer will purchase private health insurance policy for employees. The chi-square ($X^{2)}$ and p-values are also computed to test for significant relationships. Section III reports the logistic regression results, which show the effect of each independent variable on the uptake of private health insurance controlling for confounding variables.

1.2 Background Information

1.2.1 Introduction

The Kenya health system is a pluralistic system with both public healthcare providers and private health care providers (Berman et al. 1995).

The public healthcare sector physical infrastructure has expanded rapidly since independence, although maintenance and rehabilitation has been a problem. Most equipments essential to effective and efficient provision of quality healthcare is in need of repair, rehabilitation, or replacement. Hursh-Cesar et al., 1994 explain that this poor quality is because physical expansion has not been complemented with a parallel rise in financing (Hursh-Cesar et al. 1994 as quoted by Muthaka et al. 2004). Leonard et al. 2000 as quoted by Muthaka et al. 2004, observe that government health services have failed to provide reliable and good quality healthcare despite the fact that patients exhibit willingness to pay for quality healthcare. It is this willingness to pay which need to be harnessed, packaged and delivered as a save method of healthcare payment. To try and deal with the problem of underfunded healthcare system, the government has strived to achieve a mix of healthcare financing strategies and systems with an aim of enabling the country to provide its citizens with universal access to adequate basic health services. However, most of the health care financing policies adopted by the government have not yield fruits to improve the situation.

One of the policies was use of revenue from general taxation by government to finance health services between 1965 and 1989 in line with its policy of free medical care. This was not sustainable due to the economic crises in the late 1970s which led to reduced budgetary allocation to health sector (GOK Sessional Paper No.10 of 1965).

In 1989 user charges for health services in public health facilities were introduced because of

severe budgetary constraints and declining support from donors. This raised the cost of medical treatments in Kenyan public hospitals and health centers both for inpatients and outpatients.

Mwabu and Wang'ombe 1995 and Collins et al. 1996 have shown that these charges in fees reduced attendance at government health facilities by some 40% to 50%. In addition to reducing the utilization of health care facilities, it also impoverishes households when families use their savings to pay for medical bills (Mboya 2004).

The government response to this has been to allow the poor to be waived from the payment of fees, a policy directive that has not worked well because of the difficulties involved in identifying the poor (Huber 1993). The fee which were temporary suspended in 1990, were reinforced in 1992 and it is in use up to today. The out- of –pocket health care expenditure still remain high at 53.1 % of the total health expenditure(THE) according to Sekhri and Save doff 2006, which is likely to exacerbate poverty among Kenyan households unless better methods of health care financing are established.

These deteriorating conditions in public health facilities, have promoted the growth of private healthcare system which is a relevant factor for growth of private health insurance schemes (Kumaranayake 1998). Private healthcare system in Kenya has grown tremendously over the last three decades due to various reasons, among them lack of adequate and quality public healthcare services and introduction of user fees.

The Kenya Health Policy Framework which was formulated in 1994 outlines one of the agenda for reforms as generation of increased levels of financial resources by shifting part of the financial burden of essential care from Ministry of Health budget to insurance schemes (social, private and community insurance schemes).

This reform is emphasized further by the National Health Sector Strategic Plan II (1999-2004) that health insurance is crucial in shifting part of the curative burden to private health care providers. The NHSSP also points out that the health insurance market in Kenya is however currently dominated by the relatively centralized National Hospital Insurance Fund (NHIF). To create additional resources and enhance efficiency, the Strategic Plan states that there is need to remove monopoly by opening up the health insurance market to multiple firms and agencies for healthy competition which includes private health insurance firms. The growth of the health insurance sector has been very slow since independence. However, several examples of promising insurance schemes emerged in post-independent Kenya (Wang'ombe et al. 1994).

Employers are some of the agencies through which private health insurance can be promoted and in turn shift part of the financial burden from the Ministry of Health.

1.2.2 Health and economic growth

As clearly stated in the Kenya National Development plan 1997-2001, health is one of the fundamental determinants of economic growth and poverty reduction. There is a direct link between the health of a population and its productivity. This relationship has been demonstrated in industrialized countries, which are now benefitting from years of investment in health services (Schultz 1993). Provision of good health services satisfies one of the basic human needs and contributes significantly towards maintaining and enhancing the productive potential of the people (Kimalu et al. 2004).

The positive impact that health has on economic growth occurs through increased productivity. Real economic growth consists of an increase in production input and an increase

in productivity. Labour is one of the key factors of production and so employee health is an indirect component of any organisation's production function (Miller and Haslam 2008).

When the labour force is affected by sickness, the result is reduced productivity in company and nation in general. Haefeli et al. 2005, has clearly demonstrated that absence from work due to illness increases costs of production which includes the cost associated with the time needed for a replacement employee to reach the productivity level of the previously employed employee which includes training and induction costs. Lost productivity also occurs when employees come to work ill and perform below par because of that illness (Haefeli et al. 2005). Health and well-being of employees extend far beyond avoiding or reducing the costs of absence or poor performance (Cooper and Dewe 2008).

The message is clear 'good health is good work' and there is growing evidence to support the case that investing in employees make good business sense. The potential benefits for employers of investing in health could be very significant. There is definitely a good reason why a country should be interested in health of its working population and why policies should be set to protect the health of this group. As stated clearly by Bollinger et al. 1999, poor health of young adults in their most productive years will affect overall economic output. The very presence of employer provided health insurance will afford the working population healthcare access when needed and also gives the employers a chance to share the burden of health care financing with the Ministry of Health (Bollinger et al. 1999).

1.2.3 The Kenya employment Act

The Employment Act Chapter 226 in Kenya expects employers to provide quality health care to their employees except where government gives it for free. However, the manner in which the health care is to be provided is not indicated (GOK Employment Act Cap 226 Revised

2007). As a result, provisions of this act have been implemented haphazardly. Wang'ombe 1994 identifies that there are three forms of employment based health insurance. The NHIF which is compulsory to all formal sector employees, the workman's compensation which covers injuries at work place and private health insurance (Wang'ombe et al. 1994).

1.2.4 The National Hospital Insurance Fund (NHIF)

This was started in 1966 for all persons above the age of 18 years in formal employment earning Ksh.1000 and above (GOK, Sessional Paper No.10 of 1965). Individuals in the informal sector interested in joining the fund were allowed to register since 1990. Initially all members contributed a fixed premium of Ksh 20 per month. However, the premiums were increased to amounts between Ksh 30 for the lowest earner to ksh320 for the highest earner per month (Mwabu and Wang'ombe 2002). Currently, this social fund covers approximately 25% of the Kenyan population. The National Hospital Insurance Fund (NHIF) reimburses accredited health providers for services rendered to members. The providers include Government of Kenya hospitals, private hospitals and nursing homes. It does not pay for outpatient services, the doctor's fee and cost of drugs.

National Hospital Insurance Fund is not without problems however. In a study done by Mwabu and Wang'ombe in 2002, revealed that only a small percentage of households with NHIF cover used it to pay for medical care. Beneficiaries often do not use the fund, because of the time cost involved. Patients choose to pay in cash rather than spend time at the hospital to fill out the forms that the hospital uses for reimbursement of treatment expenses from the fund. The time cost involved in using the NHIF exceeds the level of fees at government hospitals and so people prefer to pay cash. Institutional constraints also came out as one of the problem. The probability to use health insurance increases with urban residence and private health

institutions. The National Hospital Insurance Fund, despite its weaknesses, is perceived to have a major role to play in the financing of medical care in the country. In the year 2001, NHIF contributed 4% of the total health expenditure through statutory contributions from the employed people (GOK 2001). This is a small contribution in a country faced by a double burden of diseases. In Nairobi, NHIF compensates Ksh 2400 per day for Kenyatta National Hospital which is the National referral hospital and Ksh 1900 for the major private hospitals per day, yet a hospital bed in a private hospital in Nairobi costs on average Ksh 6000 (Unpublished data from Kenyatta National Hospital,Nairobi Hospital, Aga Khan Hospital and Mater Hospital 2009). For the people with no complimentary insurance, they have to pay the fee difference from their pocket. Therefore, this means that the National Health Insurance Fund so far has not managed to reduce out-of –pocket spending on health.

When it comes to reimbursement, the fund benefits the government hospitals more than private hospitals. In fact, patients wait for months to have a surgery or radiation done in Kenyatta National Hospital because NHIF will pay a good part of the bill and they cannot afford the private institutions. This puts the patient's life in danger. This has in turn brought about overcrowding in government hospitals and very long waiting times. The government hospitals are characterized by lack of diagnostic equipments and the ones which are there are old and keep breaking down (Hursh-Cesar et al. 1994 as quoted by Muthaka et al. 2004). Most times patients in these hospitals are referred to private institutions for these services. This leaves quality in these institutions very little to be desired. The policy makers must have noticed this problem, and thus one of the reforms in the National Health Sector Strategic Plan is to remove monopoly and allow private health insurance into Kenyan health care market (GOK 2004).

Some private insurance plans have emerged since independence. In addition to the private health insurance plans, community health financing schemes have also been tried. For example, the Chongoria hospital based insurance scheme which was started early 1990s but failed was a form of rural based community health financing scheme. A study done in Tanzania shows that the main reasons why such schemes fail is because of poverty levels in the community level, the fact that it is a small group insurance and poor management (Chaligha 2004). It is therefore a challenge to the policy makers to come up with a health financing mechanism or mechanisms that are sustainable.

1.2.5 Structure and development of Private Health Insurance market in Kenya

Historically (before independence), health insurance services were provided only to non-Africans in urban areas where high-quality health services were available on a fee-for-service basis, mainly in the private sector. As a result of this, a small health insurance industry began to thrive in urban areas (Wang'ombe 1992).

Between 1967 and 1989, the government provided free health services. During that period, the majority of the population did not need to consider private health insurance as a serious mechanism for paying for medical care. This situation changed in late 1989, however, when the government instituted a system of user charges in government health facilities (Wang'ombe 1992).

Historically, health insurers have not been subjected to regulation and supervision. This however changed in 2003, with the amendment of the insurance Act to provide for regulation of companies that were involved in health care financing. In accordance with the Act, all persons transacting the business of financing medical insurance should be registered as

'Medical Insurance Providers' (MIPs). These regulations have had a rather dramatic impact on the health insurance industry in Kenya.

This Act expects MIPs to charge a risk based premium as given by the underwriter's schedule of premium rates and an appropriate loading of a maximum of 40% to cover their acquisition administrative and management fees.

The MIP structure in the country has three distinct entities:

- Insurance brokers who act as intermediaries for insurance companies in all lines of business including medical insurance. These MIPs place health insurance business either with insurance companies or with health maintenance organizations. The brokers also administer self-funded outpatient schemes.

- Companies that utilize managed care principle and only deal in health care financing. These companies work with a wide range of health care providers to deliver services to their members.

- Health maintenance organizations (HMOs) - The distinctive feature of HMOs is that healthcare is also provided through dedicated clinics, which they own. Africa air rescue (AAR) was the only HMO registered by 2009.

There has been a growth on the number of health insurance schemes. Study done in 1994, established that there were thirty eight insurance organizations in Kenya out of which only five provided purely health insurance, currently there are forty four MIPS of which eight specialize only in health care financing and thirty six insurance companies involved in medical insurance. Most of these are concentrated in Nairobi (AKI 2008). The private health insurance

industry in Kenya is an urban phenomenon. Most people with PHI purchase their health care from the private health providers (Wang'ombe et al. 1994).

The MIPs cover a total of 541,000 members. The gross premium from medical insurance is Ksh. 6.34 billion which is only 0.35% of the GDP. Medical insurance covers not only the working population but also spouses and other dependants and hence the current figures indicate a very low penetration of medical insurance in the general population (AKI 2008).

The potential for medical insurance in the country is therefore immense.

When the employer wants to purchase health cover for employees he or she has to present size of the group (the number of employees to be covered and their names), the age range (that is the minimum and maximum age) and the number of dependants for each.

The employer however decides how many dependants under the principal shall be insured.

There is no medical check –up for group insurance however, the insurance company gives time mostly 3 months within which if one falls sick, then he or she will be subjected to medical check -up.

Using this information from the employer, the insurance company then determines the cost of the pool and the premium the employer should pay. The insurance companies expect employers to pay full amount at the beginning of the year (whereby a year refers to 12 months from when the cover started).

The insurance market in Kenya is regulated by the Insurance Regulatory Authority (ARI).

The authority regulates the pricing of the insurance products by looking at the pricing models, and does onsite inspection.

The agents and brokers introduce a strong competitive element in the insurance industry.

Most people in Kenya who own PHI is through their employers than individual purchase. The reason for this is that premiums are expensive for individual purchase. The reason MIPs give

for these higher premiums is that they believe that when an individual come to purchase health insurance, is because they are driven by a motive most likely an experience of a disease. Therefore, they set the cost of managing the risk higher than in group insurance. Most of the MIPs cover groups with not less than ten people. However, this is not a standard rule among all of the Medical Insurance Providers.

CHAPTER TWO: LITERATURE REVIEW

2.1 Employer provided health insurance in developed markets

Employer provided health insurance in the United States began as a way for employers to attract and retain employees (Employee Benefits Research Institute 1995). Additionally, employers view health insurance as a way for the organization to promote and assist employees in remaining healthy and, therefore, productive at work. In the United States, almost 90% of the non-elderly with Private Health Insurance are covered through their employer (Employee Benefits Research Institute 1995).

Employment remains the primary factor enabling individuals to obtain health insurance.

In the United States, the cost of job-based insurance rose between 4 and 5 percent, on average, from 1977 to 1998, but then started to rise dramatically (8.3% in 2000, 11% in 2001 and 12.7% in 2002). Some employers have shifted some costs to employees, but majority have absorbed the costs of premium increases. Employers have also used changes in cost sharing mechanisms such as copayments and deductibles to control premium rates rather than raising employee contributions to premiums (Gabel 1999).

Even so, employment by itself does not guarantee coverage as many are not offered coverage due to employment restrictions or the employee may decline coverage due to cost issues. Studies by Custer and Ketsche 2002; Collins 2004 in the United States established that, income is correlated with coverage (higher income employees were more likely to be offered and less likely to decline coverage). Other factors related to coverage included firm size (smaller firms were less likely to offer coverage), education (the more education, the more likely to be offered coverage), hours worked (full-time employees were more likely to be offered coverage), and gender (men are slightly more likely to be offered coverage and women

are more likely to decline coverage and more likely to remain uninsured if they do decline coverage). Study by Besleya et al. 1998, in the Unites States established that occupational differences of employees had influence on employer provided insurance coverage. In addition, if employers differ in their ability to pass on all of the costs of the insurance to employees in the form of lower wages, then their willingness to subsidize private health insurance would certainly differ. Another factor which was found related to insurance schemes was the flexibility of insurance coverage (Besleya et al. 1998). The government intervenes in the market by excluding employer contributions to these benefits from the employee's taxable income.

Just like in the United States, the employer provided health insurance plays an important role in Canada health system. Though Canada has a predominantly publicly financed health insurance system that provides universal coverage with no user costs for a wide range of physician and hospital services there are services not covered under this universal coverage (Gentry 1994). The single largest expense not covered by the Canadian public system is expenditures on outpatient prescriptions drugs. Other services not covered by the national insurance include semi-private or private hospital accommodation, eyeglass and hearing aid plans, certain medical equipment such as prostheses and wheelchairs, rehabilitation, private nursing care, cosmetic procedures, out-of-country medical and hospital coverage, and dental benefits (Finkelstein 2002).

In Canada, almost all private health insurance which primarily covers out of hospital prescription drugs since these are not covered by the public health insurance system and other services mentioned above is provided through an employer. Over half of employer plans in Canada require employee participation, sometimes allowing for opt outs only if the individual is already covered as a dependent under a spouse's plan (Finkelstein 2002).

There are efficiency reasons for the prevalence of such insurance through the workplace. Economies of scale in the administration and underwriting of policies make it cheaper for firms (particularly large ones) to provide benefits. In addition, by pooling workers of different health risks in a workplace-based insurance pool, employer provision of health insurance can reduce the scope for adverse selection that is present in the market for individual health insurance. Just like in the United States, the Canadian government intervene in the market by subsidizing employer provision of health benefits by excluding employer contributions to these benefits from the employee's taxable income which is one factor which has lead to the predominance of employer provided health insurance in these countries (Finkelstein 2002).

Unlike United States and Canada, PHI has not played a major role in financing health care in United Kingdom accounting for only 4 percent of health expenditure and covering 11 percent of the population. In the United Kingdom, PHI plays a complementary role to the National Health Service (NHS) which is responsible for 85 percent of total health expenditure. Both for-profit and not for-profit insurers cover private medical care, which private insurance offers the advantages of choice of specialist, avoidance of long waits for elective surgery, and higher standards of comfort and privacy than the NHS. Nonetheless, after a rapid increase in membership in the 1980s, there has been almost no growth in private insurance coverage in the past ten years (Laing and Buisson 1999).

Survey evidence looking at the motivation for employee health and safety initiatives has found that two main factors motivate organizations in the United Kingdom to initiate health and safety improvements are the fear of loss of corporate credibility; and a belief that it is necessary and morally correct to comply with health and safety regulations (Wright 1998). Wright and Marsden (2005) cite survey data from 500 organizations that found that 73% of employers believed health and safety requirements benefited their business as a whole, and

64% said they save money in the long term. Surveys of large organizations (Smallman and John 2001) indicate that concern about corporate responsibility and reputations are important drivers for managing health and safety.

Greece is one of the countries in the European Union with Social Insurance. However, the health care system in Greece is financed in almost equal proportions by public and private sources. Private expenditure consists mostly of out-of-pocket and under-the-table payments. Such payments strongly suggest dissatisfaction with the public system, due to under financing during the last 25 years. This gap has been filled rapidly by the private sector.

Public expenditure, at 50% of total health expenditure, is financed by taxes and compulsory health insurance contributions by employers and employees. Voluntary payments by individuals represent a very high percentage of total health expenditure (more than 47.2% in 2004), making the Greek Health Care System one of the most privatized among European Union (EU) countries. Among the companies with more than 20 employees, 23% offer group life and health insurance contracts to their personnel in addition to contributing to the Social Insurance. Despite of the high out-of-pocket expenditure, there is low uptake of PHI by employers and individuals. Factors identified which are endogenous to the PHI industry and have influence on its uptake included, market policies, low organizational capacity, cream skimming, and the absence of insurance products meeting consumer requirements, which explain the relatively low state of development of PHI in Greece (Siskou et al. 2009)

In Thailand, compulsory insurance consists of three insurance schemes: Workmen compensation scheme (WCS); the social security scheme (SSS); and car accidental insurance (CAI).The WCS was introduced in1974 to protect workers from illness, injuries, death, and disability caused by work or work-related conditions.

The target populations are employees in firms with more than 10 workers. Benefits include medical compensation for work-related illness and injuries, temporary and permanent disability benefits, survivor's pension, funeral grants and rehabilitation expenses.

2.2 Employer provided health insurance in developing and underdeveloped countries

With the successful achievement of three consecutive 5-year economic development plans between 1962 and 1977, the Republic of Korea did not only emerge from absolute poverty but also became one of the most economically successful countries among developing countries. The economic success had been accompanied by improvements in social welfare.

In the fourth 5 year economic development plan which began in 1977, the Korean government achieved real capital to consider health insurance in order to relieve households of the excessive medical care expenses and to promote the health status of the Korean people.

The Korean Government overhauled the health insurance act in December 1996. The new health insurance system was offered on a compulsory basis (Lee 2003).

In 1977, based on the new Health Insurance Act, all companies with more than 500 employees were required to provide health insurance. During the next several years, the compulsory coverage requirement was gradually expanded to include companies with more than 300 employees, 16employees, and finally all companies with at least 5 employees in 1988. It was believed that big companies were more capable of absorbing the increased costs of health insurance coverage than small companies. In 1979, the insurance programme was expanded to cover government and private school employees. These were the initial stages in development of universal health insurance coverage in Korea (Lee 2003).

In the formal sector, Zairian laws require that employers pay for health care services for their employees and employee's dependants. Firm employees and their dependants represented about 18% to 27% of the country's population by 1999. Private or parastatal firms in the formal sector provide medical allowances, reimburse workers for expenses, operate clinics and hospitals for their employees or contract with private and mission hospitals and clinics to provide services. The employer-organized insurance schemes comprised about 30% of revenue in Kasongo Health District with a catchment population of 30,000 urban and 165,000 rural residents, and about 60% of the district hospital's revenue derived from insurance sources by 1999 (Criel et al 1999).

In Zimbabwe, private insures covered less than 5% of the population by 1987, yet were responsible for almost 17% of total health expenditure on health care. These expenditures were concentrated largely on the provision of curative care for relatively well-off Zimbabweans. Their expenditure was the equivalent of one-third of central government expenditures, and about one and one-half times the level of foreign assistance and they freed up Ministry of Health funds for public health goods and services (Phalatsi 2004).

Public health services are still free at the point of consumption in Malawi (Makoka et al. 2007). A study to investigate the determinants of demand for private health insurance among formal sector employees in Malawi, indicate that formal sector employees prefer to receive medical treatment from private fee-charging health facilities. The results suggested the potentially important roles that can be played by information and interventions that address the affordability factor such as through employer contributions that take into consideration income and family size (Makoka et al. 2007).

In Kenya, the only compulsory insurance for employees is wokerman's compensation scheme governed by the Work Injury Benefit Act (WIBA) Cap 236. The NHIF is compulsory for the

formal employees, however the employer has no role to play in this scheme. In Kenya, employers' proposals to improve their uptake of PHI included revision of government policies to consider subsidizing health insurance (Wang'ombe et al. 1994).

2.4 Summary of factors influencing uptake of PHI by employers

In the United States, employment remains the primary factor enabling individuals to obtain health insurance. Mostly, contributions to the scheme are made by both the employer and the employee and therefore the ability to pass some of insurance costs to employees is an important factor in determining whether a particular employer will offer health insurance or not. Employers have a positive attitude as they view health insurance as a way for organization to promote and assist employees in remaining healthy and being productive at work. Other factors include firm size, occupational differences of the employees; education of employees and gender (men being more likely to be offered employer provided health insurance). In addition, government intervention by giving incentives also has influence in determining the possibility that an employer will offer health insurance in the United States.

Canada has some similarity with the United States case in that contributions to the scheme are made by employer and employee, government incentive through tax relief and employers attitude influence health insurance uptake by employers.

Employers in the United Kingdom have a positive attitude towards health insurance as they believe that employees' health benefit business in terms of increased productivity. Legal reasons, that is to comply with health and safety regulations and ethical reasons to keep the corporate image and reputation seem to have a strong link to why employers offer health insurance to employees.

In Greece, quality gap between the public and private health sector has influence on Private Health Insurance as a whole. Other factors include size of company and legal reasons as employers' contribution to social insurance is compulsory.

It is compulsory in Korea for employers' to offer health insurance. Firm size is a factor as companies with at least five employees are supposed to give insurance.

In Zaire, the major factor making employers offer health insurance is the law which expects them to do so.

The results of a study to investigate the determinants of demand for private health insurance among formal sector employees in Malawi suggested the potentially important roles that can be played by information and interventions that address the affordability factor such as through employer contributions that take into consideration income and family size.

In Kenya, employers' proposals to improve their uptake of PHI included revision of government policies to consider subsidizing health insurance.

CHAPTER THREE: RESEARCH PROBLEM

3.1 Contribution of PHI to the Health Care System

Literature shows that if well managed, private health insurance can yield benefits to a country's health system.

Countries like Germany have used PHI among other schemes, as a foundation block to come up with a social Health insurance (Barnighausen et al. 2002). If compulsory insurance already exists for some people, like the employed through their employers, extending it incrementally to other regions and social groups will, if well managed, be a feasible way to achieve universal coverage (Barnighausen et al. 2002). Kenya can follow this as an example to develop the already proposed National Social Health Insurance Fund.

Private health insurance has served as a sole source of insurance coverage for certain populations. Private health insurance provides a source of insurance in systems with targeted, non-universal access to health care coverage. It plays a particularly large role in countries with a history of private health coverage and an absence of universal coverage. For example, in the Netherlands, nearly all of the population without access to social insurance purchases PHI (about a third of the population) , and the majority of the socially insured rely on PHI for coverage of services not included within social insurance(supplementary role of the private health insurance) (Van de Ven et al. 2008) .

Ruger and Kim, 2007 suggests that in countries with already a history of private and voluntary coverage, private health insurance can be developed to reduce the high levels of out -of - pocket expenditure. Kenya already has a history of PHI, and this can be developed further even after the establishment of the universal social insurance.

Wang'ombe et al., 1998 notes that user fees are a necessary but not sufficient condition for the development of health insurance markets. In Kenya, prior to 1967, for example, user fees were charged for health services, but health insurance markets did not develop outside the urban areas. The structure of health systems and PHI roles influence differences in access to healthcare by insurance status (Wang'ombe et al. 1998; OECD 2004).

Privately insured individuals enjoy better access to more timely care in health systems where publicly financed delivery is plagued by long waiting times, representing a clear advantage offered to those who purchase PHI (OECD 2004). In particular, private health cover has enhanced access to timely elective care in countries where it has a duplicate function, and private delivery facilities with additional capacity have developed, for example in Ireland, Australia, the United Kingdom, Denmark, Italy, and New Zealand (OECD 2004). There is indeed a strong link between demand for private health insurance and waiting times for elective surgery in some of these countries. Uncertainty over the length of waiting times for publicly financed elective treatments and dissatisfaction with public health systems are among the main reasons for buying private health cover. Those who lack private insurance in these countries have a comparatively reduced choice over providers and the timing of care, unless individuals choose to self-pay for such care (Sekhri and Savedoff 2006). This is a good example for Kenya where public facilities are overcrowded and offer low quality services.

Individuals can benefit from enhanced peace of mind, less anxiety, less pain and better health outcomes when provided with speedier access to care, as afforded by private health insurance in duplicate PHI markets.

Private health insurance has increased service capacity and supply in some systems. Private health insurance has injected financial resources into health systems, which has contributed to the financing of additional capacity and services in countries where it plays a major role

(OECD 2004). Considering Kenya's underfinanced health system, the move to encourage PHI can really shift part of financial burden from the government to private providers. In a study done in Tanzania, (a country similar to Kenya in terms of its economy) Abel-Smith and Rawal 1994, found that relatively well-off Tanzanians and their dependants comprised 13% of the population in 1991, yet consumed 21% of public hospital in-patient services, 44% of outpatients in referral hospitals, 36% of in regional hospitals and 27% in district hospitals. The authors' estimate that compulsory insurance programmes for the employees (about 200,000) could have financed 27% of the Ministry of Health recurrent budget in fiscal year 1990/1991. This is a clear indication of how sub-Saharan countries would shift financial burden from the government to insurance schemes.

Duplicate PHI has provided financing for capacity development in the private hospital sector in some countries, thereby helping to alleviating consumer inconvenience generated by non-price rationing in public hospitals. Australia has especially emphasized the role private cover plays as the main mechanism for shifting demand away from overburdened public hospitals (Hall et al. 1999).

Countries including Australia and Ireland allow public hospitals to treat privately financed patients. This provides a mechanism to improve revenue collection because public hospitals benefit from this private financing source. It also assures better retention of doctors within the public sector due to this additional physician income stream, while providing private patients with free choice of doctor and upgraded hospital accommodation (Harmon and Nolan 2001) and this is important in Kenya where poor remuneration in the public healthcare sector has forced doctors to resort to private clinics or seek employment in other countries (Nyangena 2000). Kenya's government hospitals adapted the amenity wards with an aim to generate more income and in turn this revenue to be used to upgrade quality in these hospitals (GOK 1986).

Private health insurance in Kenya can benefit the public institutions through these amenity wards.

In Ireland, Italy, Portugal, Spain, and the United Kingdom, access to private health insurance has also been found to have had a positive effect on the probability of visiting a specialist (Jones et al. 2002). In that, first, utilization increases with comprehensiveness of insurance (Manning et al. 1987), hence when PHI covers benefits in addition to those covered by existing public programmes it is likely to result in higher utilization. Second, where private health insurance gives individuals' access to providers that they cannot finance through public coverage, PHI affords them an increased level of care. Third, different payment mechanisms for publicly and privately insured patients can encourage providers to furnish more services in the private sector. Kenyans are more enlightened, educated and informed, hence increased demand for specialized quality health care. Therefore, PHI schemes are necessary to satisfy these demands (Manning et al. 1987).

The very presence of a PHI market affords consumers with choice and increased flexibility in financing their health care. In the absence of such a market, they may not have any ability to insure against health costs not covered publicly; PHI provides them with the choice to do so. Benefits of PHI can include coverage of public system co-payments (complementary PHI), insurance coverage of drug costs or providers not included in some public coverage (supplementary or duplicate PHI, respectively), as well as the ability to purchase private insurance if no public coverage is available (principal PHI) or if individuals can "opt out" of public cover (substitute PHI). In all of these cases, in the absence of PHI, consumers would have to rely on out-of-pocket payments and personal savings tools to cover these costs, which are a more regressive source of financing health care. Privately insured individuals have more choice (providers, benefits) (Neelam and Willian, 2005).

Private health insurance enhances choice of health care providers and care settings in several countries, although in most of the cases, it has done so for a limited population segment only. The extent to which PHI enhances provider choice depends upon the structure of the health delivery system, and, in particular, whether public and private schemes cover all or a portion of the providers within the health system. For example, in the duplicate systems, PHI provides enrollees with a broader choice of providers because it reimburses the cost of care in private hospitals which are not, or only partly, publicly funded. As private hospitals have spare capacity and offer mainly elective care, PHI also provides quicker access to non-emergency treatments. Doctors' ability to charge higher fees to PHI enrollees in several countries' with duplicate PHI cover has provided the privately insured with preferential access to the doctors of their choice, an advantage not offered by certain public systems (OECD 2004).

Insurers have responded to consumer demand by tailoring products, finding innovative and flexible coverage solutions, and quickly adopting coverage of new benefits. In the United Kingdom, as demand for PHI is linked to excess waiting times, some insurers have designed low-cost products covering only elective treatments in private hospitals (Propper 2000).

In Ireland, private insurers offer primary care products to fill gaps in eligibility to public coverage for two-thirds of the population (OECD 2004).

The presence of multiple purchasers (both public and private) has been a factor stimulating the adoption and diffusion of medical technologies in the United States, especially across hospitals (Ferlie et al. 2001). Competition in the hospital sector encourages the early adoption and a fast rate of diffusion of technologies, which is in part encouraged by competition between multiple insurers.

Private health insurers can promote the delivery of high-quality care if they utilize tools to influence the delivery of health care, such as selective contracting based upon quality

indicators. In United States, where insurers and employer-sponsored health plans, particularly "managed care" companies have been very involved in directing and overseeing certain aspects of care delivery, by exerting better leverage over the care they purchase, insurers seek to secure a competitive advantage through products offering good "value and quality for money". These efforts have largely stemmed from a combination of market developments, voluntary accreditation efforts, and consumer and purchaser demand, such as from employers. There also has been some regulatory impetus by the states (Ferlie et al. 2001).

The lack of adequate incentives that reward quality care, such as value-based provider payments, and inadequate information are among the reasons why insurers still do little in this area.

However in most countries, private health insurers have not engaged in significant efforts to influence the quality of the health care services they finance. Several factors are likely to contribute to this trend. First, efforts to improve quality typically require significant resource investments, which may not be warranted where PHI plays a limited role. In addition, such interventions often result in efforts to steer consumers to certain providers, an activity that may restrict choice and therefore be unwelcome in countries where consumer demand for PHI is highly linked to its provision of additional provider choice. Policymakers have seldom established quality of care standards for private insurers.

Instead, policy attention with respect to quality is generally focused upon providers as an accountable unit, rather than on insurers. Quality of care is also often self-regulated by the provider community or voluntary accreditation bodies (OECD 2004).

According to Wang'ombe et al. 1994, there are three conditions that must prevail for private insurance market to thrive: First, providers of health services must charge for their services. Insurance will not thrive in situations of free services. In such situations, households would

have no incentive to buy insurance coverage because they would face no financial risk from illnesses. This explains why most people with PHI purchase their health care from the private health providers.

Secondly, the insured population must be able to maintain in regular payments of insurance premiums. Regular payment of premiums guarantees that whatever scheme is in operation is adequately financed. Otherwise, insurers and medical care providers will not be able to operate since there would be no funds to meet their costs. For these two above mentioned reasons, PHI is not always affordable; hence if not well managed it can lead to serious equity issues because the poor will not be able to maintain the monthly payments.

Third, the legal and administrative framework must be supportive of private insurance entrepreneurship. The government might need to enact enabling legislation specifically for such a purpose. Existing legislation may also need to be amended if it introduces entry barriers to the insurance market.

If not well managed, PHI can lead to skewness of resources towards the private providers. Ability to choose PHI over public coverage may diminish the risk pooling within public insurance.

Private health insurance can be grouped in two categories. The direct private health insurance which is acquired directly by the individual or the household and the employment provided health insurance which is acquired by employers for their employees.

As a group insurance, employer-sponsored health insurance's ability to pool risks and influence both the quality and the cost of care offers significant administrative efficiencies and results in coverage that costs less than the equivalent individual coverage does (Custer et al 1999).

Secondly, persons generally considered to be good health risks remain in the employer's risk pool, which effectively reduces the premium and makes employment-based health insurance more cost-effective than the individually purchased PHI. Employment-based insurance spreads risk more broadly and therefore more efficiently than individual health insurance and, consequently, is less affected by adverse selection.

The group purchase of health insurance through the workplace makes that coverage affordable to poorer risks.

Lastly, the decision to purchase coverage in the individual market is different from the decision in the employer-sponsored market. Individuals tend to make economic decisions that are in their own financial best interest. In a voluntary individual health insurance market, each purchaser must compare the cost of coverage with the likely value of the benefits that will be received, and thus a consumer's expectations for future health care needs become the primary factor driving the purchase of coverage. This result in a market that operates in a fundamentally different fashion than do the employer sponsored group market and most social insurance programs. The individual-purchase dynamic of the individual market make market turnover rates very high (Custer et al. 1999).

In a country like Kenya with 56 percent of the population living below the poverty line and even among workers employed 40 hours or more per week, nearly 50 percent of them living in poverty (Pollin et al 2007), individual purchase of private health insurance will only make the situation worse.

Employer- provided health insurance has been referred to as a quasi-social insurance (Enthoven and Fuchs 2006) because of the characteristics stated above. It therefore remains the most effective mechanism for pooling of health insurance risks in the private health

insurance market. The contribution of private health insurance to Kenya health expenditure by 2006 was as follows:

Table 1: The contribution of private health insurance to health expenditure in Kenya

Total health expenditure as %of GDP	Private health expenditure as % of the Total health expenditure	Private insurance as % of Total health expenditure	Private insurance as % of Private health expenditure	Out-of –pocket payments as % of private health expenditure	Out-of pocket payments as % of Total health expenditure
7.8	78.6	7.5	9.5	67.6	53.1

Source: Sekhri and Save doff, 2006

From table 1, it is clear that PHI has not played an active role in financing health care in the country.

Against this background, employer-provided health insurance can therefore increase insurance coverage among the employed, offer access to quality health care, reduce out-of pocket payments for health care among the Kenyan households and in turn increase productivity which will lead to economic growth. Currently, the government is looking in to the possibility of a universal National Social Health Insurance fund (NSHIF). In this proposed insurance, employers will be expected to contribute to the employee account, as the employee contributes the other percentage. Employers' response to this initiative will depend on the factors which already exist among employers towards insurance.

The employment act in Kenya expects employers to provide quality health care to their employees. However, the manner in which the health care is to be provided is not indicated (GOK 2007). As a result, provisions of this act have been implemented in different ways. For this reason, employers have gone ahead to offer schemes like employer organized prepayment schemes. These are schemes organized by employers for their workers. The employer sets a

medical allowance for each worker. It is then pooled with a certain contribution from the employer. The employees are given personal numbers and the list of health providers to visit. They are also informed of the limitations of their entitlement. When a member spends more than their maximum amount allowed, then the extra cost is deducted from their salary. The employer pays providers. Most of these schemes are concentrated in urban areas where formal employment is available (Wang'ombe et al 1994). Examples of organizations that have these schemes include parastatals such as the Central Bank, Kenya Power and Lighting Company, universities and private banks. Nevertheless, this act does not limit the growth of employer-provided health insurance.

Another factor which supports the expansion of Employer-Provided Health Insurance is the fact that Kenya has a pluralistic health system. Health services are produced by the government and private providers which include faith based organizations and the for-profit private sector. The major sources of finance for these health care providers (Berman et al. 1995) are:-

a) For the Government of Kenya (GOK) facilities: tax revenues, NHIF premiums, cost-sharing/cost-recovery, and foreign assistance.
b) For mission facilities: direct user fees, subsidies from overseas churches, grants from the GOK, NHIF reimbursements, volunteer labour of religious personnel, and private insurance.
c) For the for-profit sector: NHIF, private insurance and direct user fees Policy makers can take advantage of the fact that private insurance is already in use in non-governmental health providers to foster its growth.

Approximately 500,000 Kenyans have health insurance cover with private firms through their employers in formal sector with approximately 2 million people. This low demand on private health insurance can be explained by good understanding of demand factors.

This study aims to answer the question of what are the determinants of demand for employer provided Private Health Insurance among employers for their employees in Nairobi?

3.2 Statement of the problem

According to the Kenya Human Development Report (2003), government financing of health expenditure is about 60% of what is required to provide minimum health services, therefore implying that health care delivery in Kenya is underfunded. This makes it impossible for the government to deliver even the minimum package for health which is beneficial mostly to the poor. There is therefore a need to share this burden with other private health financing schemes.

The government uses 70% of its contribution to health on curative services. This is a serious problem in a country faced by challenge of HIV, malaria and tuberculosis which require more of preventive strategies (GOK 1999). This has lead to lack of cost-effectiveness, in the health system.

Kenyan government hospitals are inadequate. Most of the diagnostic machines are lacking; the ones which are there are old and keep breaking down. In addition, these institutions are overcrowded and waiting times are long. The overall result is lack of quality health care. People then opt to purchase health care in the private sector where services are considered to be faster and of higher quality. In private sector those without complimentary or supplementary insurance end up paying directly from their pocket (Mwabu 1993).

Out of pocket payments for healthcare remains high at 53.1 % of the total health expenditure, with the assumption that majority of people can afford to pay medical care at the point and time of treatment (Sekhri and Save doff 2006). Out-of-pocket payments are a very inequitable mechanism for health sector financing because they usually place a significant burden on households and present an obstacle to poor people who need to access health services. The consequences of out-of-pocket payments for health services can be catastrophic because the timing of such payments usually cannot be determined in advance and can threaten the livelihood of households (WHO 2000).

There is monopoly with the National Hospital Health Insurance. The consequences of an insurance monopoly are excess profit, poor quality products and underproduction, problems which can be identified within the NHIF (Hsiao 1995). In pluralistic insurance system equity, efficiency, risk pooling and spreading can be enhanced, if funds merge (Barnighausen et al. 2002).

To deal with all these problems of underfunded health system, it is important to embrace other ways of financing healthcare such as employer provided health insurance.

There is a low uptake of PHI in Kenya with approximately 541,000 people covered by 2008 through individual and group cover. The number of people covered under group insurance being approximated at 500,000 (AKI 2008). It is however important to note that this number includes both the principals and their dependants. Therefore the number of principals covered is much smaller.

This is a low uptake of employer provided health insurance considering that the formal employment has approximately 2 million employees (Pollin et al. 2007). Medical insurance providers also discourage companies with less than ten employees from purchasing health insurance.

Employers feel that it is the responsibility of the government to provide health financing for every citizen (FKE 2009-unpublished). The employment Act revised 2007 chapter 226, does not state that employers must have health insurance for their employees except the wokerman's compensation for work injury. This gives a leeway for employers not to buy insurance for employees. This study aims to investigate the demand factors which influence the uptake of insurance by employers. By doing so, the policy makers will be well informed as they make decision on how to increase the uptake of insurance by employers.

3.3 Conceptual Framework

The extent to which any company dedicates its finite resources towards employee health issues is driven by some combination of ethical, legal and economic factors (Loeppke et al. 2007; Miller and Haslam 2008).

First and foremost, employers aim in business is considered to always want to maximize productivity and profit. Employee health issues have the potential to increase costs and decrease revenue and the same time increase productivity and profit for any company (Miller and Haslam 2008). This is the fundamental economic incentive for companies to manage employee health issues. The health stock of the individuals within an organisation/company will in some way affect their supply of labour, in terms of quality (productivity and performance) and quantity (absence and exit), which will impact the efficiency and cost of labour. Labour is one of the key factors of production and so employee health is an indirect component of any company's production function (Miller and Haslam 2008). Furthermore it is clear that a company's outputs can be compromised if employee health issues affect product/ service quality or reputation. What this means is that employers' willingness to give benefits including health benefits depends on greater deal, their perception on how these benefits will

affect the productivity or profit in the company. Their attitude and knowledge on how health insurance for employees will affect this goal are fundamental factors, in determining whether a particular employer will offer employer provided health insurance or not. A particular employer may also not be in a position to offer health insurance to the employees because of the inability to absorb the increased costs of health insurance coverage especially in the case of small companies.

For the employer, the decision to employ a worker depends on the overall cost of wages and other payroll costs including health benefits. If these costs (including health insurance premiums) are too high, employers may in the circumstances shift the burden to the employees by paying lower wages than they would have paid in the absence of employer contributions. Employers may also respond by employing casual staff or employ on short-term contracts.

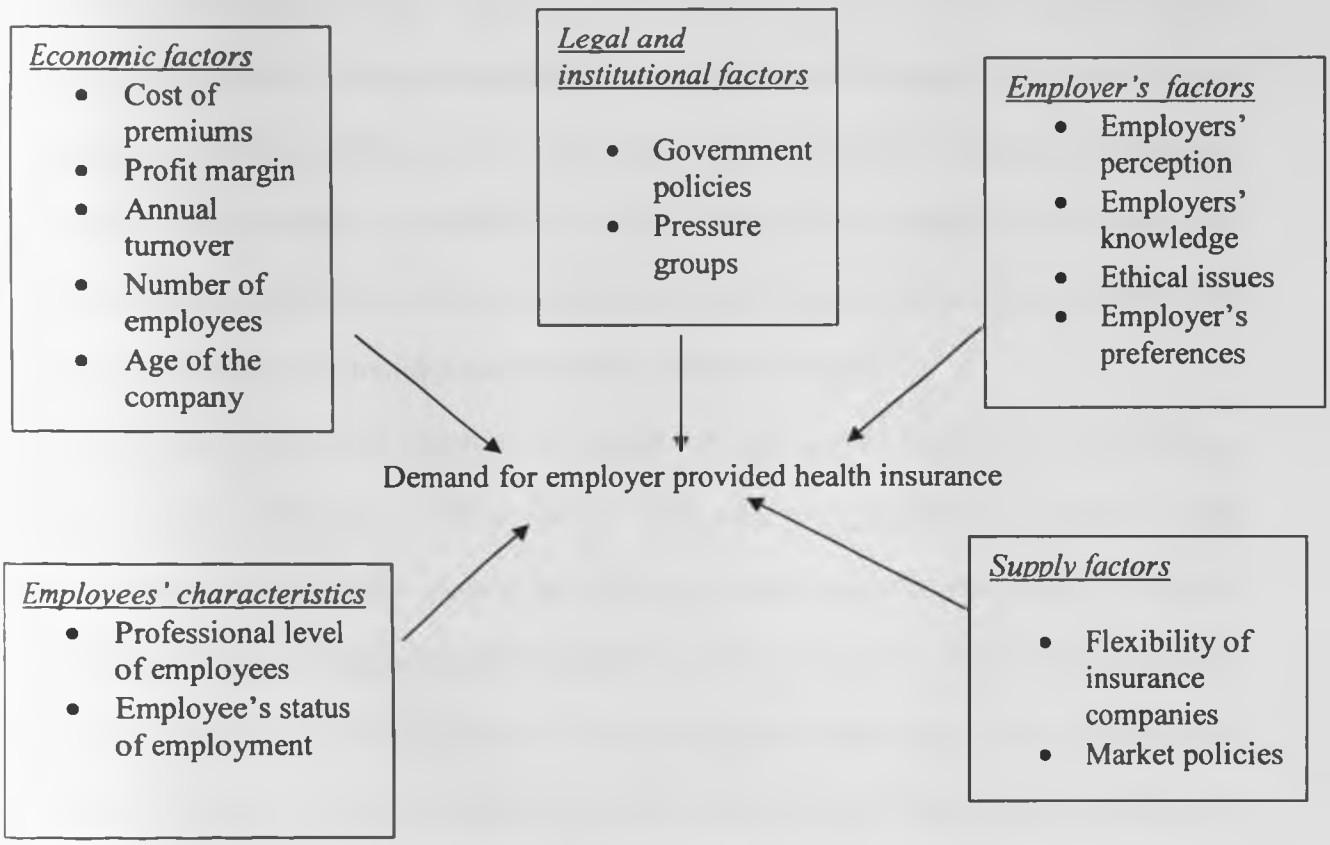
Failure to comply with legal (or even ethical) requirements for employee health may indeed have economic consequences in terms of longer-term customer loyalty and attracting and retaining talented employees. In case of a government policy, which expects employer to mandatory give insurance to employees, the employer then in this situation will have to comply. The employer may also comply because of pressure from groups like workers union. A situation like in Kenya where it is not mandatory for employers to give health insurance to employees then they may be reluctant to do so.

Availability of other alternatives might also have influence in willingness to offer employee insurance, for example in-house clinics. In Kenyan situation whereby employees only contribute to the National Health Insurance Fund, employers in this case might not consider purchasing health insurance for employees.

Flexibility of the medical insurance providers will also determine whether employers will purchase and sustain employee health insurance.

If employers who have always contributed to employee health insurance are to contribute through the National Social Health Insurance, the expected is that, there will be less resistant compared to the employers who do not offer health insurance to employees. The conceptual framework has been explained in Figure 1.

Figure 1: Conceptual framework



3.4 Justification

As policy makers consider how to move towards financing mechanisms that will protect their people from the financially catastrophic effects of illness, they have three broad options to consider: taxation, social security, and private health insurance which consist of non-profit and for-profit plans, and community health insurance schemes.

Unlike taxation and social security, which are commonly viewed as promoting equity, private insurance often conjures up visions of unequal access, large numbers of uninsured people, and elitist health care for the rich. Experience indicates that unregulated or poorly designed private health insurance systems can indeed exacerbate inequalities, provide coverage only for the young and healthy, and lead to cost escalation.

However, when appropriately managed, private health insurance can play a positive role in improving access and equity in developing countries for several reasons. First, out-of-pocket spending on health services is the most common form of health financing in developing countries and represents a significant financial burden for households. To the extent that private insurance gives households an opportunity to avoid large out-of-pocket expenditures, it can provide access to financial protection that is otherwise lacking.

Secondly, many developing countries have public expenditures for health of less than $10 per capita per year, with large informal sectors. Their ability to generate tax revenues or fund social insurance systems to provide broad financial protection for health care is limited. Private coverage, when appropriately regulated, may be one way to move towards prepayment and risk pooling until publicly funded coverage can expand sufficiently. It also allows policy makers to target limited public resources towards the most vulnerable groups, while those who can afford it, can contribute to their medical costs.

Thirdly, history shows that the social insurance systems of several developed countries evolved from voluntary private health insurance schemes based on professional guilds or communities, for example in German and Netherlands. These historical lessons in building institutional capacity and the changing role of private coverage as public financing if strengthened may be useful in informing policy debates in developing countries like Kenya, as

they consider moving towards public insurance systems. This study therefore acts as a baseline for the implementation of National social health insurance fund.

Finally, private health insurance continues to be important even in countries where universal coverage has been achieved. Policy makers who plan ahead for this role will be better prepared to ensure that private coverage complements public systems as they develop. Employer based health insurance is one other practical way to increase coverage through private health insurance in Kenya where 56% of the population live below poverty line.

The study will find out factors that influence employers to purchase private health insurance for their employees. By understanding these factors then, policy makers can establish ways to encourage employers to purchase private health insurance for their employees hence a shift of part of financial burden from the government to employers.

3.5 Study Objectives

3.5.1 Main Objectives

This study aimed at establishing factors that influence the uptake of private health insurance policy among registered employers in Nairobi.

3.5.2 Specific objectives

1. To establish company characteristics' influence on Private health insurance subscription;
2. To document the medical benefits provided by employers for their employees;
3. To determine the challenges faced by employers who purchase private health insurance for their employees;
4. To determine the perception of employers towards private health insurance;
5. To determine the willingness of employers to participate in social health insurance;
6. To establish the effect of cost on private health insurance subscription.

3.5.3 Hypotheses

- There is no association between company characteristics and subscription to PHI.
- There is no association between employer's perception and subscription to PHI
- There is no relationship between cost of PHI and subscription to PHI

CHAPTER FOUR: METHODOLOGY

4.1 Study design

This was a cross-sectional descriptive study investigating the factors determining the possibility that an employer will purchase private health insurance for employees. Cross-sectional descriptive study refers to a survey where data are collected at a particular point in time. In this study, data were collected through a survey among all employers at one point in time.

4.2 Study area

The study area was Nairobi province in Kenya. Nairobi has a population of approximately 2,807,155 people (KDHS 2008). Nairobi was chosen as the appropriate study area because of several reasons:

- It is the country's administrative and industrial capital making it the main trading and business centre.
- Most large employers are located in Nairobi.
- Most of the medical insurance providers (MIPs) are located in Nairobi -Twenty one private health insurance companies out of forty four are in Nairobi (AKI 2008).
- Main private hospitals and a national referral hospital are located in Nairobi (Berman et al 1995).
- The bulk of modern health facilities and specialized medical units are situated in Nairobi (Berman et al 1995).

4.3 Study variables

4.3.1 Independent variables

- **Age of establishment** –This refers to the number of years the company has been in existence at the time of the study.
- **Size of establishment**-This refers to the profit margin in percentage, the number of employees and the total annual turnover at the time of the study.
- **Ownership of establishment**-This refers to the nationality of the real owner of the company at the time of study.
- **Cost of subscription to PHI**-This refers to the amount the employer pays for to MIP at the time of study.
- **Status of employment** –This refers to the number of permanent employees compared to number of casual employees at the time of study.
- **Level of employees**-This refers to the number of professional employees compared to number of non-professional employees at the time of study.
- **Union workers**- This refers to whether a company had workers who are members of trade union at the time of study.
- **Type of company**-This refers to the primary function of the company
- **Employer perception on private health insurance**-This refers to their perception of employers on PHI in terms of cost, importance and its effect on profits and productivity.

4.3.2 Dependent variable

This refers to the likelihood that an employer has private health insurance cover for the employees. During the survey, the dependent variable was given a value of one if an employer had health insurance for the employees and a value of zero otherwise.

4.4 Study population

The study population consisted of formal companies/employers within Nairobi province. The sampling frame consisted of the registered companies in Nairobi.

4.5 Sampling

4.5.1 Sample size

The sampling frame consisted of the registered companies in Nairobi.

It was not possible to come up with a good outcome estimate for the purpose of sample size calculation. For this study, P was set equal to 0.5 at 95% C.I. (Fisher's formula as quoted by Mugenda and Mugenda 1999). The sample size was obtained using the following formula:

$$n = \frac{Z^2 (P (1-P))}{d^2}$$

$$n = \frac{1.96^2 \times 0.5 \times 0.5}{0.05^2}$$

$$n = 384 \text{ companies}$$

Where n is the sample size, Z is the z-statistic at 95% confidence interval, P is the proportion of employers who were approximated to have PHI set at 50%, d^2 is the degree of precision.

A 10% allowance for non-response insurance (i.e 38 companies) was given making the total sample size to be 422 companies (Mugenda and Mugenda 1999).

4.5.2 Sample Selection

The sampling frame used in selection of this sample was the list of companies maintained by the Kenya National Bureau of Statistics (KNBS) in Appendix 3.

A random sampling method was used. The companies were then selected using a table of random numbers from the list of companies.

4.5.3 Inclusion criteria

- Registered formal companies in Nairobi
- Parastatals
- Private companies

4.5.4 Exclusion criteria

- Companies with no employees
- Central and local government institutions

4.6 Pre-testing and minimization of errors and biases

Four research assistants were recruited and trained on how to administer the questionnaire.

The pre-testing of the questionnaire was done by interviewing a sample of 23 employers within the selected sample in Nairobi over a period of one month. The research assistants were involved in pre-testing of the questionnaire.

4.7 Data collection method and instrument

Data were collected through interview using structured questionnaire with both closed and open-ended questions. The respondent was the most senior policy maker in the company. Four research assistants including one field supervisor were trained to collect data. A call was first

made prior to the company for appointment. English was used to administer the questionnaire. Filled questionnaire were edited daily to check for completeness. There was a non-response was 13 %; in that 32 companies declined to participate, 9 companies could not be located and 11 companies insisted to complete on their own but never did until the time of data collection elapsed.

4.8 Data processing and analysis

Information collected was cleaned, coded and entered into the Statistical Package for Social Sciences (SPSS) version 13.0. The qualitative (open-ended) questions were categorized and coded. There was double entry of data to check for data entry errors. Descriptive statistics were calculated using SPSS. Cross-tabulation and p-values were computed to confirm relationship between company characteristics and PHI status and logistic regression analysis was done to determine the relationship between company characteristics and PHI status when confounding factors were controlled.

4.9 Ethical issues

Clearance certificate to carry out this study was obtained from Kenyatta National Hospital and College of Health Sciences, University of Nairobi ethical research committee. Informed consent for willingness to participate in the study was obtained from all the participants. Anonymity and confidentiality was maintained throughout the research process voluntary participation was emphasized.

CHAPTER FIVE: RESULTS

The overall objective of this study was to determine the factors, which influence the uptake of private health insurance (PHI) among the formal employers in Nairobi province in Kenya. This was a cross-sectional descriptive study carried out between January 2010 and May 2011.

Results are presented in three sections. Section I presents descriptive statistics of characteristics of the sample companies. Section II explores the relationship of the different company characteristics and the PHI status. Chi-square (X^{2}) and p-values are also computed to test for significant relationships. Section III is the logistic regression model that was used to estimate the effect of each independent variable on Private Health Insurance policy status when other confounding variables were controlled.

5.1 Company characteristics

Although the unit of observation in this study was the senior most policy and decision maker in the company also defined as the employer in this study, the unit of analysis is company. A total of 347 employers were interviewed representing the same number of companies. Data on all 347 companies were analyzed.

5.1.1 Number of years the company has been in existence

The years of existence of the companies interviewed ranged between 2 and 107 years with a mean age of 19 years. Most of the companies interviewed were below 10 years representing 42.1%, 25.9% were between 11-20 years and about 15.3% were between 21 and 30 years. Companies which were 30 years and above were represented 15%. Table 2 shows the distribution of the companies according to the age.

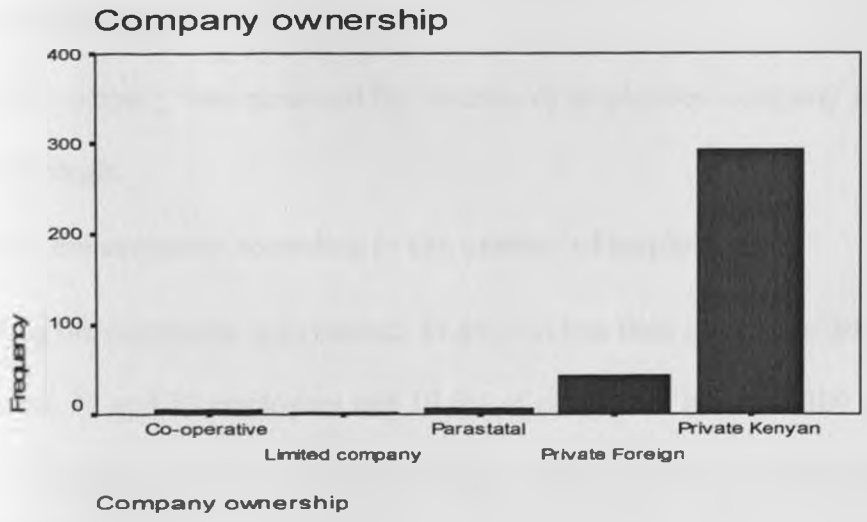
Table 2: Number of years the company has been in existence

Age by years	Frequency	Percent
< 10	146	42.1
11-20	90	25.9
21-30	53	15.3
31-40	21	6.1
41-50	14	4.0
> 50	17	4.9
Non-response	6	1.7
Total	347	100.0

5.1.2 Company ownership

Company ownership was measured by the nationality of the real owner of the company. There were 88% Kenyan owned and 12% foreigner owned companies. Among the 88% companies owned by Kenyan nationalities, 2% were parastatals and a few were co-operatives and limited companies. Figure 2 shows the distribution of companies by ownership.

Figure 2: Distribution of companies by ownership (n=347)



5.1.3 Type of company

Type of company was measured by the function of the company. Among the companies interviewed 66% were in service industry, 15% were manufacturing companies, 8% in trading and 3% were in agriculture. Others included construction and ICT, which represented 9% as shown in table 3.

Table 3: Distribution of companies according to type

Type of company	Frequency	Percent
Service(marketing, advertising, healthcare, financial services, transport, tourism, legal firms)	229	66.1
Manufacturing	51	14.7
Trading	28	8.1
Agriculture	9	2.6
Others(mining construction, hotels)	30	8.6
Total	347	100.0

5.1.4 Company size

Size of company was measured by: number of employees, company annual turnover and the profit margin.

Size of the company according to the number of employees

Among the companies interviewed, 37.8% had less than or equal to 20 employees, 22.5% had between 21 and 40 employees and 19.6% of companies had over 100 employees. There were few companies with 61 to 100 employees. Table 4 shows the distribution of companies by number of employees.

Table 4: Size of the company according to the number of employees

Number of employees	Frequency	Percent
< 20	131	37.8
21-40	78	22.5
41-60	35	10.1
61-80	20	5.8
81-100	13	3.7
> 100	68	19.6
Not sure	2	.6
Total	347	100.0

Size of company according to the annual turnover

According to the responses given 63.1% of companies reported annual turnover of below 50 million Kenya shillings and 13% reported an annual turnover of between 51 and 100 million Kenya shillings. A few companies reported an annual turnover of above 100 million Kenya shillings and 5% of companies did not disclose the annual turnover. This distribution is shown in table 5.

Table 5: Size of companies according to annual turnover

Annual turnover (Ksh millions)	Frequency	Percent
<50	219	63.1
51-100	46	13.3
101-150	18	5.2
151-200	6	1.7
200-250	12	3.5
251-300	3	.9
> 300	25	7.2
Not disclosed	18	5.2
Total	347	100.0

Size of company according to profit Margin

Among the companies interviewed, 43.5% had a profit margin of less than 10%. Companies which reported profit margin of 30% and above represented 15%. According to the responses 20.5% had profit margin of between 11% and 20% and 17% had profit margin between 21% and 30%. Companies, which declined to disclose their profit margin level, were 14%, table 6.

Table 6: Size of company according to profit Margin

Profit margin (%)	Frequency	Percent
< 10	151	43.5
11-20	71	20.5
21-30	59	17.0
31-40	24	6.9
41-50	17	4.9
> 50	11	3.2
Not disclosed	14	4.0
Total	347	100.0

5.1.5 Level of employees

Level of employees was defined as the status of the employees in terms of whether the majority of workers were professionals or non-professionals. Among the respondents interviewed, 77% of companies had more professional employees than non-professionals and 23% of companies had more non-professionals than professionals as shown in the table 7.

Table 7: Distribution of companies according to number of professional and non-professional employees

Level of employees	Frequency	Percent
More professionals	267	76.9
More non-professionals	79	23.2
Non response	1	.3
Total	347	100.0

5.1.6: Status of employment

Status of employment was measured by whether a company had more permanent employees than casuals. According to the responses, 12% of companies had more casual than permanent employees and 88% had more permanent than casual employees according to table 8.

Table 8: Status of employment

Status of employment	Frequency	Percent
Casual>permanent	42	12
Permanent>casual	279	80
No response	26	8
Total	347	100

5.1.7 Union workers

This variable was measured by a question asking if any of the workers were members of a trade union. About 80% of companies had no union workers and 19% had union workers. Table 9 shows the distribution of companies by presence of union workers.

Table 9: Distribution of companies by employees in trade union

Union workers	Frequency	Percent
No union workers	276	79.5
Presence of union workers	67	19.3
Non response	4	1.9
Total	347	100.0

5.1.8 Presence of PHI

Presence of PHI was the outcome variable in this study .Presence of PHI was measured as whether the employer had private health insurance cover for employees or not at the time of the study. According to the respondents, 50% of companies had private health insurance policy for their employees and 49% did not have private health insurance policy for employees as shown in table 10.

Table 10: Distribution of companies by presence of PHI

Presence of PHI	Frequency	Percent
Present	174	50.1
Absent	170	49.0
No response	3	.9
Total	347	100.0

5.1.9 Type of health insurance cover offered

Among the employers who offer health insurance to employees, 45% offered only group medical insurance, 21% offered only workman's compensation and 34% of employers offered both group medical insurance and workman's compensation as shown in table 11.

Table 11: Type of health insurance offered in the studied companies

Type of insurance cover	Frequency	Percent
Group medical insurance	78	45
Workman's compensation	37	21
Both (Group medical insurance and Workman's compensation)	59	34
Total	174	100

5.1.10 Reasons for not having employees insurance cover

According to the responses, 54% of employers said PHI is expensive, 51% said employees are covered by NHIF and 20% of employers were in the process of getting the cover at the time of study. Other reasons included; employees' preference to other modes of health benefits and mistrust and dissatisfaction with the MIPs, never experienced an accident which demanded action, not aware that PHI is necessary, several illnesses not covered, to allow employees freedom of choice, high turnover, company prefers to provide life insurance to the employees, dealing with PHI companies is hard, some collapse without warning and employees felt

dissatisfied with the services. Table 12 shows the reasons why employers do not have cover for their employees.

Table 12: Reasons why there is no employees' insurance cover

Reason	Frequency	Percent
Expensive	54	15.6
Employees have NHIF	51	14.7
Company in the process of getting a cover	20	5.2
Employees have individual's health insurance cover	9	2.6
Nature of work	8	2.3
Employees prefer medical allowance	5	1.4
Management is yet to decide	5	1.4
Contracted private clinic	3	.9
Employees prefer to have the re-imbursement arrangement	3	.9
Others	8	2.4
Total	164	100.0

5.1.11 Other health benefits

The study also investigated other (apart from PHI) medical benefits employees get from their employers. Among the employers interviewed, 55% had at least one medical benefit excluding insurance while 45% did not give any other medical benefit at the time of the study. According to the responses, 38% had reimbursement arrangements for their employees, 36% gave medical allowances to their employees, 11% had contract with health care providers and 9% had in-house clinics.

5.1.12 Mode of payments

This study also investigated the mode through which the employers make their payments to the PHI. Most of the employers who offer health insurance cover to employees pay the whole amount to the insurance company at the beginning of the year. Thus 69%, while 5% pay in installments quarterly. Table 13 shows this distribution.

Table 13: Distribution of respondents by mode of payments

Mode of payment	Frequency	Percent
All the amount at the beginning of the year	120	69%
Installments monthly	40	23%
Quarterly	9	5%
Non response	5	3%
Total	174	100

5.1.13 Source of premiums

According to the responses, employer is the main source of premiums representing 75.9%. In cases where premiums are shared between the employer and employees and fully from employee wages represented 17% and 5% respectively as shown in table 14.

Table 14: Source of premiums among companies offering PHI

Source of premium	Frequency	Percent
Fully by employer	132	75.86
Shared between employer and employee wages	30	17.24
Fully from employees wages	4	2.30
Non response	8	4.60
Total	174	100.0

5.1.14 Dependants covered

Among the employers who offer health insurance to employees, 84 % cover the employee, spouse and all children younger than 18 years and about 10% cover the employee only. None response was reported in about 18% of the employers. Table 15 shows these results.

Table 15: Dependants covered

Dependants covered	Frequency	Percent
Spouse and children under 18	125	71.8
Employee only	18	10.3
No response	31	17.8
Total	174	100.0

5.1.15 Conditions hindering employees from being covered by PHI

According to the responses, 86% employers did not report any condition hindering employees from being covered by PHI, while 14% reported that there were conditions, which hindered employees from being covered in the group policy because they require a different insurance cover package. Out of the 24 employers who respondent yes to this question, 58% reported that employees with HIV/AIDS were not covered in the group medical insurance while 41 % reported that pre-existing and chronic conditions hinder the employee from being covered under the group medical insurance.

5.1.16 Health institutions

The responses showed that 61% employers reported that private health insurance companies cover both inpatient and outpatient while 39% reported that insurance companies offer only inpatient cover.

Among the employers who offer health insurance to employees 67% said there are specified health institutions for employees to attend in an event of illness while 33% said there are no specified health institutions for employees. Among the specific health institutions 50% were specified public and private health institutions while 49% were specific private health institutions. Most of the employers (54%) said that the private insurance company gives a list of the specific health institutions for employees to attend while 10% said that the employees are given the opportunity to choose the health provider.

5.1.17 Challenges faced by employers with PHI

One of the specific objectives of this study was to establish the challenges employers face with PHI. The biggest challenge was the high cost of premiums as reported by 24% of the respondents, followed by delay in compensations to employees as reported by 19% of the respondents and limitations on the services covered by PHI as reported by 16% of the respondents. According to the responses, 12% of the respondents had a challenge with the mode of payment, 10% reported that there were limited health institutions for employees and 6% reported challenges with trusting PHI companies stating that they collapse without warning. Employers who did not report any challenge with PHI on the time of study represented 8% and one of the reasons being they have not been with the medical insurance provider for long. Table 16 shows the challenges faced by employers who offer health insurance to employees.

Table 16: Challenges faced by employers with PHI

Challenge	Frequency	Percent
Expensive premiums	42	24.1
Delay in compensation	33	18.9
Limitations on services covered	28	16.1
Mode of payments	20	11.5
Limited health institutions for employees	17	9.8
No Challenge	14	8.1
Unreliable MIPs/trust	10	5.7
Abuse by employees	5	2.9
MIPs not flexible	3	1.7
No response	2	1.2
Total	174	100

5.1.18 Perception on PHI

Another specific objective of this study was to establish the perception employers have on PHI. Perception was measured by use of four questions each of which had a grading scale. The four questions were perception of the employer on cost of PHI, importance of PHI, effects on business core issue and productivity. Each of these questions was analyzed independently as shown in the frequency table 17. On cost, 38% perceived PHI to be too expensive while 28% perceived PHI to be affordable. On importance, 80% perceived PHI to be very important while 1% perceived PHI to be not important. On effect of PHI on business core issue, 47% of employers were not sure of the effect, 42% employers perceived PHI increases profit and about 7.2% perceived PHI to bring losses to the company. On productivity, 74% of employers perceived PHI to increase productivity, 21% were not sure of the effect of PHI on profit and 3% perceived PHI to reduce productivity.

Table 17: Perception on PHI

Perception on cost of PHI	Frequency	Percent
Affordable	98	28.3
Fairly expensive	116	33.4
Too expensive	131	37.8
No response	2	.6
Total	347	100.0
Perception on importance		
Fairly important	62	17.9
Not important	5	1.4
Very important	277	79.8
No response	5	1.5
Total	347	100.0
Perception on effects on profit		
Brings losses	25	7.2
Increases profit	146	42.1
Not sure of effect	161	46.5
No response	15	4.3
Total	347	100.0
Perception on productivity		
Increases productivity	255	73.5
Reduces productivity	11	3.2
Not sure	74	21.3
No response	11	3.3
Total	347	100.0

5.1.19 Employer willingness to participate in Social Health Insurance

The fifth objective of this study was to determine the willingness of employers to participate in Social Health Insurance (SHI). Responses indicated that 67% were willing to participate in SHI, while 29% were not willing to participate in SHI as shown in the table 18.

Table 18: Willingness to participate in NSHIF

Willingness to participate on NSHIF	Frequency	Percent
Agree	232	66.9
Disagree	100	28.8
Non response	15	4.3
Total	347	100.0

5.1.20 Reasons for not wanting to participate in Social Health Insurance

According to the responses given by employers who were not willing to participate in social health insurance, 43% did not agree to participate because it would be a big burden on the employer and government should take full responsibility. About 27% would not want to participate because it will be expensive on the company and this will translate to reduced employee salaries. Other reasons included, that employer already gives workman's compensation and the employees contribute to NHIF, NHIF has already failed and that employer will have to terminate any private insurance for the employee due to this law. These reasons are shown in table 19.

Table 19: Reasons for not wanting to participate in social health insurance

Reason	Frequency	Percent
Big burden to the employer. Government should take full responsibility	43	43
It will be expensive on the employer and this will translate to reduced salaries	27	27
Employer should take full responsibility regarding medical health care for its employees	7	7
NHIF has already failed	5	5
Already contributes to NHIF, workman's compensated	4	4
Private health insurance is much preferred than public insurance	3	3
The employer will have to terminate any private insurance for the employee due to this law	3	3
Free market principles should apply, employer should only subsidize	2	2
Employees should be the ones to contribute not employers	1	1
Others(What if employment is short term ,no lobbying)	2	2
Non response	3	3
Total	100	100.0

5.2 Relationships between company characteristics and PHI subscription

In this section, cross-tabulations of the company characteristics and the probability that an employer will purchase private health insurance policy for employees will be computed. The chi-square ($X^{2)}$ and p-values are also computed to test for significant relationships (Confidence level of 95%)

5.2.1 Company characteristics

Years of company existence

Among the respondents who were entered for this cross-tabulation, 75% of the companies which had PHI were above 50years compared to 25% of companies which did not have PHI in the same age bracket. For the companies which were below 10years of age, 56% did not have PHI compared to 44% which had PHI.

There was an association between age of the company and presence of private health insurance (p-value =0.006). This implied the older the company has been in existence the more likely the employer will have insurance cover for employees. This distribution is shown in table 20.

Table 20: Years of company existence in relation to presence of PHI

	Presence of PHI				Total
Years of company existence (years)	No	%	Yes	%	
< 10	79	56	61	44	140
11-20	43	53	38	47	81
21-30	21	41	30	59	51
31-40	8	38	13	62	21
41-50	2	14	12	86	14
> 50	4	25	12	75	16
Total	157		166		323

X^2=16.5 p=0.006

Number of employees

Majority of the companies which had more than 100 employees had PHI for employees (75%), compared to 26% who did not have PHI within the same bracket as shown in table 21. Number of employees was found to have an association with presence of private health insurance (p=0.000). This implied that as the number of employees increases the more likely an employer will have insurance cover for employees.

Table 21: Number of employees in relation to presence of PHI

	Presence of PHI				Total
Number of employees	No	%	Yes	%	
< 20	79	65	42	35	121
21-40	37	49	38	51	76
41-60	14	41	20	59	34
61-80	6	33	12	67	18
81-100	5	41	7	59	12
> 100	17	26	49	74	66
Total	158		168		326

X^2=28.065 p=0.000

Annual turnover

When results for presence of PHI and annual turnover were cross-tabulated as shown in table 22, 99% of companies with annual turnover above Ksh 300 million had PHI for employees compared to 0.04% who did not give PHI. Among the companies that had annual turnover below Ksh 50 million, 56% did not give PHI compared to 44% of companies that did not give PHI in the same age bracket, (table 22).

Annual turnover was statistically significant in relation to presence of PHI, implying that as the annual turnover increases; the more likely the employer will have health insurance policy cover for employees (p=0.000).

Table 22: Annual turnover in relation to presence of PHI

	Presence of PHI				Total
Annual turnover in million (Ksh)	No	%	Yes	%	
< 50	122	56	95	44	217
51-100	24	52	22	48	46
101-150	8	44	10	56	18
151-200	2	33	4	67	6
200-250	2	17	10	83	12
251-300	0	0	3	100	3
> 300	1	0.04	24	99.96	25
	159		168		327

X^2=29.647 **p=0.000**

Profit margin

Among the companies which had profit margin of above 50%, 70% gave PHI compared to 30% within the same profit margin bracket, while 52% of companies with profit margin below 10% did not give PHI compared to 48% of companies who offered PHI in the same profit margin bracket as shown in table 23. However, profit margin was not statistically significant in relation to private health insurance presence (p= 0.711).

Table 23: Profit margin in relation to presence of PHI

	Presence of PHI				Total
Profit margins in %	No	%	Yes	%	
< 10	75	52	70	48	145
11-20	37	53	33	47	70
21-30	24	43	32	57	56
31-40	7	33	14	67	21
41-50	9	56	7	44	16
> 50	3	30	7	70	10
Total	155		163		328

X^2=2.927 **p=0.711**

Company ownership

Among the companies, which gave PHI to employees, 67% were owned by a foreigner compared to 49% owned by a Kenyan as shown in table 24.

Company ownership was found to be statistically significant in relation to PHI presence (p=0.038). This implies that foreign employers are more likely to give medical insurance cover compared to the Kenyan employers.

Table 24: Company ownership in relation to presence of PHI

	Presence of PHI				Total
Company ownership	No	%	Yes	%	
Foreign	13	33	26	67	39
Kenyan	141	51	136	49	277
Total	159		168		327

X^2=4.307 **p=0.038**

Level of employees

Generally, most companies with majority of the workers being non-professionals did not provide health insurances to their employees in contrast to those that had majority of the employees being professionals in which a higher percentage provided PHI to their employees. The difference between the different companies in relation to their PHI status was however not statistically different (p=0.088) (Table 25).

Table 25: Level of employees in relation presence of PHI

	Presence of PHI				Total
Level of employees	No	%	Yes	%	
Non professionals majority	43	58	30	42	73
Professionals majority	114	45	138	55	252
Total	159		168		329

X^2=2.913 **P=.088**

Status of employment

Status of employment was measured by whether the company had more permanent employees than casual employees or more casual than permanent employees. As shown in table 26, companies, which had more permanent than casual employees, 52% had employees' cover compared to 48% in the same category. Status of employment was not found to be statistically significant to PHI subscription.

Table 26: Status of employment in relation to presence of PHI

	Presence of PHI				Total
Number of employees by category	No	%	Yes	%	
Casual>permanent	21	50	21	50	42
Permanent>casual	135	48	144	52	279
Total	159		168		327

X^2= 19.94. p=.983

Presence of union workers

Generally, majority of the companies who had unionized workers gave PHI compared to those who did not have unionized workers as shown in table 27.

Presence of unionized workers was statistically significant in relation to presence of PHI (p=.000). This implies that where there are trade union workers, employers are more likely to give health insurance compared to where there are no trade union workers.

Table 27: Presence of unionized workers in relation to presence of PHI

	Presence of PHI				Total
Union workers	No	%	Yes	%	
No	143	54	118	48	261
Yes	15	24	48	76	63
Total	159		168		327

X^2=22.016 p=.000

5.2.2 Perception on PHI

Perception was measured by use of four questions each of which had a grading scale. The four questions were perception of the employer on cost of PHI, importance of PHI, effects on business core issue and productivity. Each of these questions was cross-tabulated independently with presence of PHI.

Perception on cost of PHI in relation to Presence of PHI

As shown in table 28, among the employers who perceived PHI to be affordable, 61% had PHI for employees compared to 39% who did not have PHI. Among employers who perceived PHI to be too expensive, 53% did not have PHI compared to 47% who had PHI. However perception on cost was not found to be significant to uptake of PHI (p=0.167).

Table 28: Perception on cost of PHI in relation to presence of PHI

	Presence of PHI				Total
Perception on cost of PHI	No	%	Yes	%	
Affordable	38	39	59	61	97
Fairly expensive	68	56	51	44	119
Too Expensive	69	53	62	47	131
Total	175		172		347

X^2=12.89 **p=0.167**

Perception on importance of PHI in relation to presence of PHI

Perception on importance of PHI was measured on whether it was very, fairly or not important. Among the employers who perceived PHI to be very important, 55% had employees' cover compared to 45% who had no cover for employees. Employers who perceived PHI not to be important, majority had no PHI. Perception on importance was statistically significant in relation to presence of PHI (p=0.000). This implied that employers who perceived PHI to be very important were more likely to cover employees. This relationship is shown in table 29.

Table 29: Perception on importance of PHI in relation to presence of PHI

	Presence of PHI				Total
Perception on importance of PHI	No	%	Yes	%	
Not important	8	75	1	25	9
Fairly Important	43	69	19	31	62
Very important	125	45	151	55	276
Total	176		171		347

X^2= 84.43 **p= 0.000**

Perception of effects of PHI on profit in relation to presence of PHI

Perception on business core issue was based on whether the respondents perceived PHI to bring losses or increase profit to the company. Among the respondents who perceived that PHI increases profit to the company, 62% had PHI and 38% did not have PHI cover for employees. On the other hand, 52% of employers who perceived PHI to bring losses to the company had PHI cover for employees compared to 48% who did not have PHI cover for employees as presented in table 30. Perception on effect on profit was not found to be statistically significant in relation to presence of PHI (p=0.034).

Table 30: Perception of effects of PHI on profit in relation to presence of PHI

	Presence of PHI				Total
Perception on effects on profit	No	%	Yes	%	
Brings Losses	12	48	13	52	25
Not sure of effect	105	60	71	40	176
Increases profit	55	38	91	62	146
Total	172		175		347

X^2= 26.27 **p= 0.034**

Perception on productivity in relation to presence of PHI

The responses on perception on the effect of PHI on employees' productivity showed that 56% of employers who perceived PHI to increase productivity, gave cover compared to 44% in the same category. Among the employers who perceived PHI to reduce productivity, 73% did not give cover compared to 27% in the same category. However, perception on productivity was found to be significant in relation to presence of PHI (p= 0.017). Table 31 shows this relationship.

Table 31: Perception of PHI on productivity in relation to presence of PHI

	Presence of PHI				Total
Perception on productivity	No	%	Yes	%	
Reduces productivity	8	73	3	27	11
Not sure	54	67	27	33	81
Increases productivity	111	44	144	56	255
Total	173		174		347

$X^{2=}$ 28.74 **p= 0.017**

5.3 Importance of each company characteristic in relation to PHI when confounding factors are controlled for.

One of the hypotheses of this study was that company characteristics have no influence on subscription to Private Health Insurance. Certain company characteristics were found to influence the subscription to PHI in previous section. These included age, number of employees, annual turnover, ownership and presence of union workers. In this section, logistic regression estimated the significance of company characteristics in relation to PHI status when confounding factors were controlled for. Table 36 shows the results of the analysis.

The following Logistic regression equation was used to analyze insurance status:-

Logit (P) = $\beta_0 + \beta_1 X_1 + \beta_2 X_2 + \beta_3 X_3 + \ldots\ldots + \beta_k X_k$

Where P is the probability of presence of health insurance to employees measured by 1 if the response was 'yes' there is PHI, and 0 if the response was 'no' PHI; $\beta_0 \ldots\ldots \beta_k$ were the regression coefficients to be estimated and X_1, $X_2 \ldots\ldots X_k$ were particular values of the independent variables. P in the above equation can also be specified as:

odds = p/1-p = probability of having health insurance provided/probability of not having health insurance, so that the log-odds ratio can be expressed as-

logit (P)= ln (P/1-P)

The above expression (logit (P)) can also be viewed as a linear probability model of insurance status, where P is a dummy that takes the value of 1 if a company has insurance for its employees and a value 0 otherwise. In linear form, the model is estimated using ordinary least squares (OLS) method and in non-linear form (logistic form), it is estimated using the maximum likelihood method (LM).

Table 32 shows the study variables included in the logistic regression and how they were measured.

Table 32: Measurement of key study variables in the logistic regression

Variable	Measure
Presence of PHI (P)	Measured by a question asking if the employer offered health insurance to employees at the time of study; Yes =1 No=0
Age of company (X_1)	Years
Ownership of company (X_2)	Measured by a question asking the nationality of the owner of the company; foreigner =0 Kenyan=1
Union workers (X_3)	Measured by asking, if the company had union workers at the time of study Yes=1;No=0
Size of establishment (X_4)	Measured by profit margin in percentage
Status of employment(X_5)	Permanent employees were more than casual employees=1,Casual employees were more than permanent employees=0
Level of employees(X_6)	Majority of employees were professionals=1 Majority of employees were non-professionals=0
Number of employees (X_7)	Measured in numerical number of employees
Annual turnover (X_8)	Measured in Kenya shillings

Table 33: Probability of insurance regressed against company characteristics

Variables in the equation	β	S.E.	Wald's	p-value	Odds ratio
Number of employees	.007	.003	6.578	**.010**	1.007
Annual turnover	.000	.000	4.672	**.031**	1.000
Profit margin	-.007	.009	.697	.404	.993
Age of company	.000	.001	.022	.882	1.000
Company ownership	.621	.392	2.504	.114	1.861
Employment status	.102	.383	.071	.790	1.108
Employee level	-.864	.344	6.305	**.012**	.421
Union status	-1.318	.405	10.592	**.001**	.268
Constant	.837	.461	3.291	.070	2.310
Dependent Variable: Presence of PHI			R^2=0.16 (significant)		

Four variables namely; number of employees, annual turnover; employee level and union status from the above equation have a significant relationship (p-values 0.010, 0.031, 0.012 and 0.001 respectively) with presence of PHI.

The resulting reduced model had the following coefficients

Table 34: Significant company characteristics after confounding factors are controlled for

	β	S.E.	Wald's	p-value	Odds ratio
Annual turn over	.001	.000	7.702	.006	1.000
Level of employees	.827	.310	7.109	.008	2.285
Union status	1.179	.360	10.727	.001	3.250
Number of employees	.007	.003	6.578	.010	1.007
Constant	-1.206	.307	15.464	.000	.299
Dependent Variable: Presence of PHI					

In the model, an increase in annual turnover and in the number of employees is associated with a higher probability of the employer providing health insurance to employees. Cases where employees are more professionals than non-professionals is associated with increased probability of the employer providing health insurance to employees and when a company has union workers there is an increased probability of the employees being provided for health insurance cover.

CHAPTER SIX: DISCUSSION

This chapter discusses the results based on the specific objectives of the study.

Objective 1

To establish company characteristic and how they affect the uptake of PHI

The company characteristics studied include age of the company, ownership, size of the company, employment and level status of the employees in the company and presence of unionized workers in the company.

Age of company

Age of the company was defined as the number of years the company has been in existence. In a cross-tabulation age was found to be statistically significant in relation to subscription to PHI. This means that the longer the company has been in existence the more likely the employer will offer health insurance to employees. This can be explained by the need of the employer to retain the most experienced employees. It is also possible that older companies have sustainability in terms of resources. The employer in this case can allocate resources to cover the employees. When all the other factors were controlled in logistic regression however, age was not significant meaning that as a single factor age has no effect on PHI subscription.

Ownership

Ownership was defined as the nationality of the owner of the company. About 88% of the companies interviewed were owned by Kenyan and about 12% by foreigners. Ownership was found to be statistically significant in relation to PHI subscription in that the foreigners were

more likely to give PHI to employees. This can be explained by the knowledge on insurance in that the foreigners have more knowledge on health insurance. Another explanation to this can be the fact that employers insure employees as moral obligation and to be on the safe side of the law (Loeppke et al 2007, Miller and Haslam 2008).

Size of the company

Size in this study was measured using 3 variables: - profit margin, number of employees and annual turnover. Profit margin had no statistically significant effect on PHI subscription against expectation. This can be attributed to the fact that during the interview employers felt that profit margin was a private matter and those who answered this question may not have given the right figure.

Number of employees and annual turnover was found to be statistically significant in relation to PHI in the cross-tabulation and in the regression model. This means that the likelihood of an employer to give PHI increased with increase in number of employees and annual turnover. This can be explained by the fact that big companies are able to absorb the increased costs of health insurance coverage unlike small companies as supported by literature (Custer 2002; Collins 2004).

Unionized workers

This was measured by establishing whether any or all workers belonged to a trade union. This was found to be statistically significant in relation to PHI subscription in that companies with union workers were more likely to have health insurance cover for employees. This significant relationship can be explained by the presence of pressure groups in these companies. In

keeping with literature, presence of pressure groups can pressure an employer have health benefits including health insurance for employees.

Status of employment

Status of employment was measured by number of permanent employees versus number of casuals. This study found no significant relationship with PHI subscription against expectation. This occurrence can be explained by the small representation in one category i.e. majority of the companies had more permanent employees than casuals compared to a small percentage of companies who had more casual employees than permanent (88% and 12% respectively).

Level of employees

Level of employees was measured by establishing whether employees in the company were professionals or non-professionals. Generally most companies with majority of the workers being non-professionals did not provide health insurances to their employees in contrast to those that had majority of the employees being professionals. When all the other confounding factors were controlled in logistic regression, level of employees was found to be statistically significant. This implied that a company is more likely to provide cover for employees if majority of the employees are professionals. This can be explained by the reason that one of the reasons why employers give benefits including health benefits like insurance is to attract and retain the qualified professional employees as supported by literature (Besleya et al. 1998, Employee Benefits Research Institute 1995, Finkelstein 2002).

Objective 2

To establish medical benefits provided by employers for their employees

Medical benefits were determined by asking whether employers gave other medical benefits apart from health insurance. It was found that, 55% of the companies had at least one medical benefit excluding insurance while 45% did not give any other medical benefit at the time of the study compared to 51% who had PHI. This may mean that though some employers did not have PHI for employees, they provided other medical benefits to the employees. Responses showed that 38% had reimbursement arrangements for their employees, 36% gave medical allowances to their employees, 11% had contract with health care providers and 9% had in-house clinics. Demand is defined as the willingness and ability to purchase a good or a service at the going price. An employer's decision to purchase PHI will depend not only on his employees' preference but also on his own preference, especially his preference to make profit. In this case an employer may not be in a position (ability) to afford PHI or may prefer other forms of health benefits for employees. In addition the employment act does not define clearly the form in which an employer should provide healthcare to employees.

Objective 3

To determine the challenges faced by employers who purchase PHI for their employees.

The third specific objective of this study was to establish the challenges employers face with PHI. The biggest challenge was the cost of premiums as stated by 24% of the companies followed by mode of payment at 20%; delay in compensations to employees at 19% and limitations on the services covered by PHI at 16%. About 10% employers reported that the insurance companies are unreliable and cannot be trusted as may collapse anytime and 8% of the employers did not report any challenge with PHI on the time of study and one of the

reasons being that they have not been with the Medical Insurance provider for long. This implies that affordability is a challenge even to the employers who give insurance cover as expressed by the majority who felt that premiums cost is too high. From the study majority of employers pay the entire amount to the MIPs at the beginning of the year which can be very challenging to the employer. As expressed by majority of them, the company might not be in a position to pay the whole cost of premiums at once as expected by the MIPs. Employers seem not to trust MIPs which could be related to some of them collapsing without warning an issue most of the employers expressed during the interviews. Insurance companies collapse due to cost escalation problem which has to do with health providers charging more for a service than expected.

Objective 4

To determine employers' perception towards private health insurance

Perception was measured by use of four questions each of which had a grading scale. The four questions were perception of the employer on cost of PHI, importance of PHI, effects on business core issue (profit) and productivity. Each of these questions was analyzed independently. On cost, 38% perceived PHI to be too expensive while 28% perceived PHI to be affordable. On importance, 80% perceived PHI to be very important while 2% perceived PHI to be not important. On effect on business core issue, 45% of employers were not sure of the effect, 42% employers perceived PHI increases profit and about 7% perceived PHI to bring losses to the company. On productivity, 73% of employers perceived PHI to increase productivity, 21% were not sure and 3% perceived PHI to reduce productivity. In keeping with literature, perception on PHI by employers has an effect on whether the employer will insure the employees or not. Perception on cost was not found to have a relationship with presence

of PHI. This can be explained by the fact that employers aim in business is to maximize profit and therefore the cost of health insurance might not matter if it is likely to increase profit by increasing employees' productivity (Miller and Haslam 2008). Cost of PHI seems to have a strong impact on subscription to PHI as demonstrated by the outcome of several questions in this study. However, perception on cost Employers who perceived PHI to be important to the company were likely to give PHI the same as those who perceived PHI to increase profit and productivity. In keeping with literature, employers' perception on the effect of health insurance on the business is crucial in determining whether they will have employees insurance or not (Wright and Marsden 2005).

Reasons for not having employee insurance cover

According to the responses given, the main reason why employers have no insurance cover for employees is because PHI is expensive representing 54% .About 51% said employees are covered by NHIF. About 20% were in a process of getting the cover at the time of study. Other reasons included employees' preference to other modes of health benefits representing 3% and trust and dissatisfaction reasons representing 8%. A company may not be in a position to absorb the expenses of health insurance and in this case the employer will choose not to cover employees. In developed countries like the United States and Canada government intervenes in the insurance market by subsidizing employer provision of health benefits by excluding employer contributions to these benefits from the employee's taxable income which is one factor which has led to the predominance of employer provided health insurance in these countries (Finkelstein, 2002).

Employees may not have knowledge on the importance of insurance or the fact the employees perceive that having insurance cover from the employer may mean reduced wages and

salaries. As a result employees may prefer other modes of health benefits especially medical allowance and reimbursement as demonstrated by this study.

Objective 5

Willingness to participate in the Social Health Insurance

From the responses given, 66% of employers were willing to participate in the Social Health Insurance compared to 29% who were not willing to participate. This was based on the proposed SHI bill that employers will be required to pay 50% to the employees health insurance account (GOK 2005). Reasons for not wanting to participate were that SHI would be a big burden to the employer and Government should take the full responsibility (43%); it would be expensive to the employer and this would translate to low salaries on the employees. Other reasons included lack of hope with government run health insurance as NHIF has already failed.

These results implied that there is a great potential for Social Health Insurance as 66% employers were willing to participate. In addition these results implied that cost is a big challenge to employers when it comes to Social Health Insurance and the government will have to consider this if Social Health Insurance policy will be adopted.

LIMITATIONS OF THE STUDY

1. One limitation of the study was that many employers did not want to disclose the profit margin of the company terming it as a private issue. This could lead to false figures from those who answered this question.
2. Some employers could not differentiate between Private Health Insurance and the National Hospital Insurance Fund; therefore, it is possible that the number of companies which provide PHI was less than indicated.

CHAPTER 7: CONCLUSIONS AND RECOMMENDATIONS

7.1 CONCLUSION

In conclusion, this study found that company characteristics have an influence on the uptake of PHI by employers. Age and ownership of the company, presence of union workers, number of employees, annual turnover and professional status of employees seem to influence the decision of employer to take up PHI. Therefore, these factors are important to consider if uptake of PHI has to be increased among employers.

Cost is a factor to consider as it was found to greatly influence the uptake of PHI as it came out as the main reason why employers do not have PHI cover for employees. Cost of premiums was one of the challenges employers' face with PHI. Employers also stated cost as one of the reason why they were not willing to participate in SHI. Any policy to increase the uptake of PHI by employers will have to take these factors in to consideration.

There is a great potential for SHI in Kenya, as 66% of employers were willing to participate in the scheme. A policy to implement SHI in Kenya will have to consider the effect this policy will have on companies and employees' salaries as this may translate to low salaries for employees.

7.2 RECOMMENDATIONS

In this study, 70% of employers perceived PHI to be very important and 73% perceived it to increase productivity. However 47% of employers had no knowledge about the effect of PHI on company profit. Educating employers about the effects and importance of PHI on the company well being is essential. The Government through Insurance Regulatory Authority

should organize for training sessions for employers. Insurance Regulatory Authority should also organize for open day between employers and Medical Insurance Providers (MIPs) where employers can learn more about products available. MIPs will also learn the challenges employers are facing with these products.

Education on importance of health insurance to the public is also crucial as this study found that employees prefer other modes of health benefits which may not be as beneficial as insurance in event of illness. Insurance Regulatory Authority (IRA) should organize with MIPs so that they can visit companies and talk to employees and company policy markers about the importance of health insurance.

The major reason why most employers do not offer PHI to employees is because PHI is expensive. With the escalating cost of living, the government needs to consider increasing the tax relief for employers who offer PHI as an incentive. The Medical Insurance Providers (MIPs) should be flexible in terms of mode of payments of premiums as it was found to be one of the challenges employers are facing with PHI especially when MIPs demand that employers have to pay the whole amount at the beginning of the year. MIPs should also allow employees to choose the health institutions to attend in event of illness instead of the MIPs choosing the facilities. This way employer and employees will have the freedom of choice, an advantage which comes with PHI.

This study recommends further research to:-

1. Establish why employers feel that NHIF has failed
2. Determine knowledge on the effect of health insurance on business among employers

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APPENDICES

APPENDIX 1: INFORMED CONSENT.

Introduction

Hello. My name is Francisca Mwangangi, a student at the University of Nairobi. I am conducting a survey, as part of my course work, on factors influencing the uptake of private health insurance by employers for their employees. I would like your permission to interview you as an employer or senior policy maker in this company. This consent form contains information about the survey I am conducting and will help you to decide whether or not you would like to participate. I will read some information to you so you may understand why I am asking to talk to you. Please ask me to explain anything you may not understand. After reading this to you, you can decide if you wish to answer the questions or not.

General Information about the Interview

I am requesting to ask you questions related to this company which will include company characteristics and your perception towards private health insurance. I would appreciate it if you answer the questions openly and honestly so that we can gain the views of members of the groups. Remember, you do not have to answer any question you do not want to. You may also stop the interview at any time.

All the information that you provide will be considered private and confidential and will be used only for the purposes of this study. Any report from this study will not use your name, name of the company or any other information that may identify you or the company. You will be able to find out about the results by contacting me on the contact given below.

If you agree, you can indicate your agreement by making a mark here. Alternatively, I can sign to say that I have witnessed your agreement. If you have any questions about the research, please contact **Francisca mwangangi -0722-988 173.** After listening to this information, do you have any questions? 0=NO, 1=YES (If Yes, record the questions)

I _____ have understood the purpose of the study and what it entails and I hereby do agree/not agree to participate in this study.

_____	_____	_____
Interviewer's signature	Date	Name of interviewer

APPENDIX 2: STUDY INSTRUMENT

QUESTIONAIRE NUMBER:

Name of the Interviewer----------Date----------

1. Respondent designation

   1. The Chief Executive Officer
   2. Human resource manager
   3. Public Relations Officer

   Other (specify----------

2. For how long have you worked in this company (if not the owner) ----------years.

Section 1: Company characteristics

3. Size of company

   1. By number of employees----------
   2. Annual turnover (in Ksh)----------
   3. Profit margin (in %) ----------

4. Age of company ---------- (In years)

5. Company ownership

   1) Private (Kenyan)
   2) Private (Foreign)
   3) Parastatal
   4) Cooperative
   5) Other (specify) ----------

6. Type of company

   1) Agriculture
   2) Manufacturing
   3) Service
   4) Other (specify) ----------

7. What is the number of employees by category?

   1) Casuals----------
   2) Permanent ----------

8. Which category would best describe your employees?

1) Professionals majority

2) Non-professional majority

9. Any union workers.....

1) Yes

2) No

Section 2: Health insurance status

10. Do you have private health insurance cover for your employees?

1) yes

2) No

11. a If yes**(in Q. 10 above)**, which one,

1. NHIF

2. Group medical health insurance

3. Workman's compensation

4. Group medical insurance and Workman's compensation

11.b If no **(in Q. 10 above)**, why----------?

12. Apart from the health insurance, do you provide any other health benefits to your employees?

1) yes

2) no

12a. If yes which ones

1) medical allowance

2) Reimbursement arrangements

3) In -house clinic

4) Contract with health care providers

5) Others(name)----------

If No in question 10 above, skip Q.13 to Q. 21

13. How much do you pay per employee subscription to the PHI per year----------?

    1) For Casuals (Ksh)----------

    2) For permanent employees (Ksh)----------

14. How do you make your payments to the Private health insurance company?

    1) All the amount at the beginning of the year

    2) Installments monthly

    3) Quarterly

    4) Others (Specify) ----------.

15. What is the source of premiums?

    1) Fully by employer

    2) Fully from Employee wages

    3) Shared between employer and employee wages

16. How many dependants per employee are covered?

    1) Spouse only

    2) Children only

    3) Spouse and children below 18years of age

    Others (specify) ----------.

17. Are there health conditions which hinder employees from being insured?

    1) yes

    2) No

17a If yes which ones?

    1. HIV/AIDS

    2. Chronic diseases (name) ----------.

    3. Other (Specify)----------

18. Which services are your employees covered for?

    1. Inpatient (limit in Ksh----------

    2. Outpatient(limit in Ksh----------

19a. Are there specified Health institutions for the employees to attend?

1. yes
2. No

19b If yes please specify

1. Specific private
2. Specific Public
3. Both

20. Who specifies these health institutions?

1. employer
2. Private health insurance company
3. Employees

21. What challenges do you face with Private health insurance----------
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---?

Section 3: Policy

19. Are you aware of any Government policy which hinders you from purchasing a health insurance policy for your employees?

1) Yes
2) No
3) Not aware

19.a If yes please state----------

---

20. Is there a policy which encourages you to purchase PHI for your employees?

1. Yes
2. No
3. Not aware

20a If yes which one----------?

Section 4: Attitude

23. Please tick the appropriate answer for each of the questions below about your perception towards Purchasing insurance for your employees.

Question	0	1	2
Cost of Insurance	too expensive	Fairly Expensive	Affordable
Importance of Insurance	Not important	Fairly Important	Very important
Effects on business core issue	Brings losses	Not sure of effect	Increases profit
Productivity	Reduces productivity	Not sure	Increases Productivity

25. a) Have you ever heard about the proposed National Social Health Insurance bill?

1. Yes
2. No

26. b)If yes, what is the role of the employer in this proposed new bill?

1. To pay 50% to the employee account
2. None
3. Don't know
4. Other (Specify)----------

27c) As a company, do you agree or disagree with this role for the employer.

1. Agree
2. Disagree

If you disagree, why? ----------.

Thank you very much for your time!

APPENDIX 3: MASTER FILE LIST OF COMPANIES IN NAIROBI FROM KNBS

Structure of Central Register of companies (Master file)

Section	Divisions	Major Activity	Employment Size							
			0	1-4	5-9	10-19	20-49	50+	Total	%
A	01-03	Agriculture forestry and fishing	0	4	4			9	17	0.2
B	05-09	Mining and Quarrying				1	1	1	3	0.0
C	10-33	Manufacturing	28	117	12 6	110	107	209	697	7.2
D	35	Electricity, gas, steam and air conditioning	0	0	2	2	1	5	10	0.1
E	36-39	Water supply, sewerage, waste management and remediation activities	1	3	4	0	4	5	17	0.2
F	41-43	Construction	11	27	28	46	31	46	189	2.0
G	45-47	Wholesale and retail trades, repair of motor vehicles and motorcycles	231	1,31 4	65 9	399	278	127	3,008	31. 1
H	49-53	Transport and storage	20	62	90	32	47	24	275	2.8
I	55-56	Accommodation and food services activities	27	55	11 9	135	112	69	517	5.3
J	58-63	Information and communication	20	151	13 3	77	27	24	432	4.5
K	64-66	Financial and Insurance activities	33	241	12 3	60	68	45	570	5.9
L	68	Real estate activities	9	93	49	33	25	9	218	2.3
M	69-75	Professional, scientific and technical activities	65	481	29 9	135	76	28	1,084	11. 2
N	77-82	Administrative and support service activities	31	291	17 1	88	56	55	692	7.1
O	84	Public administration and defense; compulsory social security								0.0
P	85	Education	59	147	24 7	263	154	51	921	9.5

Q	86-88	Human Health and social work	31	168	10 3	58	42	29	431	4.5
R	90-93	Arts, entertainment and recreation	5	10	12	16	11	10	64	0.7
S	94-96	Other service activities	32	230	15 6	87	39	11	555	5.7
T	97-98	Activities of households employers, undifferentiated goods and services,								0.0
		producing activities of household for own use								0.0
U	99	Activities of extraterritorial organizations and bodies	1	0	1	0	2	1	5	0.1
Total									9,685	

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8th December 2010

Ref: KNH-ERC/ A/650

Mwangangi Francisca
Dept of Community Health
School of Medicine
University of Nairobi

Dear Francisca

Research proposal: "Factors influencing uptake of private health insurance among registered employers in Nairobi" (P389/11/2010)

This is to inform you that the KNH/UON-Ethics & Research Committee has reviewed and approved your above cited research proposal for the period 8th December 2010 – 7th December 2011.

You will be required to request for a renewal of the approval if you intend to continue with the study beyond the deadline given. Clearance for export of biological specimens must also be obtained from KNH/UON-Ethics & Research Committee for each batch.

On behalf of the Committee, I wish you a fruitful research and look forward to receiving a summary of the research findings upon completion of the study.

This information will form part of the data base that will be consulted in future when processing related research study so as to minimize chances of study duplication.

Yours sincerely

PROF A N GUANTAI
SECRETARY, KNH/UON-ERC

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The Dean, School of Medicine, UON
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