Benefits of public-private partnerships in health microinsurance: the Kenyan context

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In its constitution enacted on 27 August 2010, the nation of Kenya enshrined the right 'to the highest attainable standard of health, which includes the right to health care services' for all Kenyans.[1]

Furthermore, by adopting the United Nations' Sustainable Development Goals, the country has signaled its commitment to ensure good health and well-being for its citizens. This paper briefly discusses the country's public health insurance scheme—the National Hospital Insurance Fund (NHIF)—and presents ways in which the programme can partner with health microinsurers (HMIs) to achieve the goal of universal access to healthcare services.

Background

Health insurance—both public and private—can play a key role in improving access to healthcare services. Insurance can reduce the out-of-pocket costs that an individual incurs at the point of service. Health insurance can also provide discounted access to healthcare facilities via networks set up between health insurers and healthcare providers. Finally, by potentially reducing the opportunity cost incurred while seeking care, access to health insurance can be especially valuable to low-income people. The people in this population typically pay more for healthcare because they may have to rely on mechanisms such as high-interest loans from moneylenders and the sale of productive assets in order to fund catastrophic medical spending. According to research done by Koven et al., while support from family and friends is a commonly used method to finance healthcare expenses in Kenya, only an average of 30% of expenses can be financed this way. Therefore health insurance still has an important role to play in financing healthcare expenses for the low-income population.[2]

Despite the benefits of health insurance, the uninsured rate in Kenya remains high. According to the Kenya Demographic and Health Survey (KDHS), 81% of the population between the ages of 15 and 49 do not have any type of health insurance, including microinsurance.[3] Furthermore, regional and gender disparities in the country's health insurance coverage are evident. Of people living in rural areas, 87% do not have health insurance as compared to 72% in urban areas. Eighty-two percent of women between the ages of 15 and 49 do not have health insurance while the uninsured rate among men of the same age group is 79%.

The NHIF and reasons for low participation in the programme

In order to help expand insurance coverage, the government of Kenya founded the NHIF in 1966 with a mandate to provide health insurance access to all employed Kenyans 18 years of age or above who have annual incomes of at least KES 12,000 (USD 116).[4,5] The NHIF is the predominant form of health insurance among those aged 15 to 49. It is interesting to note that, while 74% of this population is employed, only 16% participate in the scheme. Other forms of health insurance coverage account for 4% (per KDHS). The NHIF programme provides comprehensive inpatient and outpatient coverage throughout all government health facilities and a selection of private health providers. The coverage includes maternity care as well as dialysis sessions in a selection of facilities. The member/contributor and that person's spouse and children are included in the coverage. Membership in the NHIF is compulsory for those working in the formal sector. Participation is voluntary for informal sector workers as well as retirees. Required annual contributions by programme members range from KES 1,800 (USD 17) to KES 20,400 (USD 198), depending on the member's income.

1 Constitution of Kenya (2008). Retrieved 8 December 2017 from http://kfcb.co.ke/wpcontent/uploads/2016/07/Constitution.pdf.

2 Koven, R. et al. (1 March 2014). Balancing Client Value and Business Case in Kenyan Health Microinsurance. Microinsurance Centre at Milliman. Retrieved 8 December 2017 from http://www.microinsurancecentre.org/resources/documents/business-case-for-microinsurance/balancing-clientvalue-and-business-case-in-kenyan-health-microinsurance.html.

3 Kenya National Bureau of Statistics et al. (December 2015). Kenya Demographic and Health Survey 2014. Retrieved 8 December 2017 from http://dhsprogram.com/pubs/pdf/FR308/FR308.pdf.

4 National Hospital Insurance Fund, Kenya. Retrieved 8 December 2017 from http://www.nhif.or.ke/healthinsurance/customers.

5 Currency conversion based on an exchange rate of 1 USD = KES 103, as of 21 November 2017. See http://www.xe.com/currencyconverter/convert/?Amount=1&From=USD&To=KES.

While the NHIF leads the way in providing health insurance in Kenya, the current proportion of citizens covered by the scheme still falls short of national goals related to achieving universal access to health services. One reason for low participation in the programme is that employment in Kenya is dominated by the informal sector. According to an economic survey conducted by the Kenya National Bureau of Statistics, 83% of workers in 2015 were employed in the informal sector.[6] Because membership in the NHIF is not compulsory for informal sector workers, NHIF participation among this group has been low. This observation is confirmed by a statistical study done by Kimani et al. in which they find that employment in the formal sector is a significant determinant of participation in the NHIF programme.[7]

Another explanation for low participation in the NHIF programme is geographical. Individuals who live in rural areas may not value NHIF benefits as highly as their urban counterparts. Because high-quality healthcare facilities such as referral hospitals are typically concentrated in urban areas, rural residents may face difficulties in reaching these facilities. The time, transportation costs and the opportunity cost of lost income incurred while attempting to seek medical treatment may provide an incentive not to seek care in facilities that are located long distances away from one's residence. These costs may pose a barrier to seeking treatment even for those who are insured—particularly the self-employed. In their discussion of the determinants affecting health insurance demand, Mathauer et al. suggest that 'there is no utility in insurance if informal sector workers have no geographical access to health facilities that are accredited by health insurance.'[8]

Finally, a lack of information, the persistence of poverty and the hesitance of some workers to engage with the government also explains low participation in the NHIF. Some individuals may simply not be aware of the existence of the NHIF or the benefits it provides. This may be caused by low levels of financial literacy and the lack of prior experience with formal health insurance schemes. Furthermore, individuals may be reluctant to pay for a product that they may not use regularly (per the Mathauer study). Also, the required contributions for voluntary participation in the NHIF may be too costly for some households to bear on their own. Month-to-month incomes in some households may be too unpredictable to keep up with the monthly contributions required by the NHIF programme.

6 Kenya National Bureau of Statistics. Economic Survey 2016. Retrieved 8 December 2017 from **https://www.knbs.or.ke/download/economic-survey-2016/**.

7 Kimani, J.K. et al. (19 March 2012). Determinants for Participation in a Public Health Insurance Program Among Residents of Urban Slums in Nairobi, Kenya: Results From a Cross-Sectional Survey. BMC Health Services Research. Retrieved 8 December 2017 from: **http://www.biomedcentral.com/1472-6963/12/66**.

8 Mathauer, I., Schmidt, J.-O. & Wenyaa, M. (2008), Extending social health insurance to the informal sector in Kenya: An assessment of factors affecting demand. *Int. J. Health Plann. Mgmt*., 23: 51–68. doi:10.1002/hpm.914.

Finally, low participation in the NHIF may be explained by the self-employed not wanting to provide any financial information to the government for fear of taxation.

Partnering with HMIs to increase health insurance coverage

Within the past few years, the NHIF has made significant strides towards increasing the participation rate in the programme, especially among informal sector workers. In 2011, 24% of NHIF participants were in the informal sector while in 2015 this figure rose to 38% (per the Kenya National Bureau of Statistics economic survey). Despite these improvements, health insurance participation rates among rural residents and informal workers remain low. One key way in which the NHIF can improve participation rates is by partnering with health microinsurers (HMIs).

HMIs offer simple and affordable benefits that, when paired with public schemes such as the NHIF, can encourage beneficiaries to participate in and use their public insurance benefits when necessary. An example of such a benefit offered by many HMIs is 'hospital cash.' Hospital cash pays a fixed amount of money to the beneficiary when a qualifying inpatient hospital stay is triggered. This money can be used to pay for costs related to seeking treatment such as transportation, food and partial replacement of lost income. These costs aren't covered by the NHIF and would present a barrier to some individuals seeking treatment. The SAJIDA Foundation in Bangladesh and the Microfund for Women in Jordan are examples of organisations that have successfully launched hospital cash products.[9]

A second way in which the NHIF can increase its reach is by pairing its benefits with an HMI policy that provides value-added services. Examples of such services may include access to discounted medication and access to preventive services such as free health check-ups. Value-added services are included in some HMI policies in order to increase client value by making the benefits more tangible. Beneficiaries don't have to wait for catastrophic events such as an inpatient admission in order to use their benefits. An example of an HMI that has successfully implemented value-added services is Uplift in India. Its 'dial-a-doctor' service is popular among beneficiaries.[10]

9 International Labour Organization & Impact Insurance Facility. Case briefs. Retrieved 8 December 2017 from **http://www.impactinsurance.org/publications/cb3** and **http://www.impactinsurance.org/videos/hospital-cashmicroinsurance**.

10 International Labour Organization & Impact Insurance Facility (June 7, 2011). Emerging Insight #19: Improving Client Value Through Better Access to Health Care. Retrieved 8 December 2017 from **http://www.impactinsurance.org/emerging-insights/ei19**.

The government can also partner with HMIs in order to increase awareness of the NHIF programme. The Impact Insurance Facility describes the lack of awareness of public benefits as a key emerging lesson in Ghana. In discussing a field test conducted to gauge citizens' awareness of the country's National Health Insurance Scheme, the Facility states that the test group did not know about the costs and eligibility requirements of the programme. It went on to state that 'this lack of understanding is an initial barrier to enrolment and a factor in low retention in the scheme – even with a government sponsored scheme intended to provide universal cover.'[11] In order to distribute their products effectively, HMIs typically build valuable partnerships with entities such as local community groups, unions and cooperatives. The NHIF can leverage these partnerships in order to promote the programme effectively in remote areas that the government would otherwise be unable to reach.

Finally, the NHIF may consider using innovative financing techniques to increase participation in the programme. For example, the NHIF can enter into capitation arrangements with HMIs that serve rural residents. In such arrangements, the NHIF would pay a fixed amount per member per month to the HMI for each enrolled member. The HMI would then take on the risk of covering all NHIF benefits for these members.

11 International Labour Organization & Impact Insurance Facility. Health Microinsurance Emerging Lesson #25. Retrieved 8 December 2017 from http://www.impactinsurance.org/hwg/lessons/health-microinsurance-emerginglesson-25.

Such an arrangement is predicated on the assumption that the HMI has extensive knowledge of the needs facing the local population it serves. This knowledge may include demographic trends, common risks faced by the population and the level of premiums/contributions that individuals would be willing to pay. This knowledge can be used to design benefits that are meaningful to beneficiaries living in a particular locality. These arrangements can be started as pilot projects and later scaled up if they are deemed to be successful by the NHIF.

Conclusion

Kenya's NHIF provides a foundation for providing access to health insurance and healthcare services. In order to improve coverage rates across the country, particularly in rural areas, the programme may consider partnering with health microinsurers (HMIs).

HMIs can offer simple benefits such as hospital cash that encourage people to use their NHIF benefits when needed. Microinsurers can also offer value-added services that may complement public benefits. The NHIF can leverage the relationships that microinsurers have with entities such as community groups to reach people in remote areas that the government would otherwise be unable to reach. Finally, microinsurers can serve as laboratories for innovation where new healthcare financing and organisation methods can be piloted before being scaled up by the NHIF.

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