FINANCING HEALTHCARE: AN INVESTIGATION OF THE ROLE OF MEDICAL INSURANCE UNDERWRITERS

BY

KAARA, PRISCILLAH WANJIKU

D53/10202/04

A RESEARCH PROJECT SUBMITTED IN PARTIAL FULFILLMENT FOR THE AWARD OF MASTER OF BUSINESS ADMINISTRATION FINANCE OPTION

SCHOOL OF BUSINESS KENYATTA UNIVERSITY

Kaara, Priscillah
Financing healthcare: an investigation of

NOVEMBER 2007
DECLARATION

This research is my original work and has not been presented for examination in any other University.

Signature ______________________ Date ______________________

PRISCILLAH WANJIKU KAARA

This is to certify that this project has been submitted for examination with my permission as the University Supervisor.

Signature ______________________ Date ______________________

MR. A.K. KHASIANI
LECTURER
ACCOUNTING AND FINANCE DEPARTMENT
KENYATTA UNIVERSITY

This is to certify that this project has been submitted with my approval as the Chairman of Accounting and Finance Department.

Signature ______________________ Date ______________________

MR. J.M. MUTURI
CHAIRMAN
ACCOUNTING AND FINANCE DEPARTMENT
KENYATTA UNIVERSITY
ACKNOWLEDGEMENTS

The production of this paper would not have been possible without the support and valuable contributions of various individuals. Special thanks to my supervisor for his great undivided support.

Thanks to my parents, sisters, brothers and friends who encouraged me to press on.

To God be glory, great things he has done.
# TABLE OF CONTENTS

DECLARATION .................................................................................................................. II

ACKNOWLEDGEMENT ................................................................................................... III

TABLE OF CONTENTS ................................................................................................... IV

ABSTRACT ...................................................................................................................... VI

DEFINITION OF TERMS ................................................................................................. IX

1 INTRODUCTION ........................................................................................................ 1

1.1 BACKGROUND .................................................................................................... 1

1.2 STATEMENT OF THE PROBLEM ..................................................................... 3

1.3 JUSTIFICATION OF THE STUDY ..................................................................... 4

1.4 RESEARCH QUESTIONS ..................................................................................... 5

1.5 SIGNIFICANCE OF THE STUDY ........................................................................ 5

1.6 LIMITATIONS OF THE STUDY .......................................................................... 6

1.7 ASSUMPTIONS OF THE STUDY ......................................................................... 6

2. CHAPTER TWO ....................................................................................................... 8

2.1 LITERATURE REVIEW ......................................................................................... 8

2.2 MOBILIZING GREATER DOMESTIC RESOURCES FOR HEALTH ............... 19

2.3 FINANCING OF HEALTHCARE ....................................................................... 19

2.4 USER FEES ........................................................................................................ 21

2.5 COST SHARING ................................................................................................. 22

2.6 OUT OF POCKET PAYMENT ............................................................................. 24

2.7 HEALTH INSURANCE ....................................................................................... 25

2.8 ROLE OF PRIVATE SECTOR ............................................................................. 26

3. CHAPTER THREE .................................................................................................... 30

3.1 RESEARCH DESIGN AND METHODOLOGY ................................................ 30

3.2 DATA COLLECTION ............................................................................................ 30
Health care in Kenya is financed through the government, development partners, and the private sector including non-government organizations, self-help and community contributions. [Kenya Health Policy Framework (KHPF) 1994; Kenya National Health accounts (KNHA) 2003; Ministry of Health (MOH) 1999; Household Health Expenditure and Utilizations Survey Report (HHEUSR) 2003]. Health care in Kenya is under funded since the government finances 60% of what is required to provide minimum health services (Kimalu et al 2004). This is made worse by the inherent inefficiency of the system and lack of cost-effectiveness. The Ministry of Health which runs all public health facilities is unable to cope with the medical care demand partly due to increase in population among other factors. As a result the financial contributions of households have exceeded those of the government. Other sources of funds also experience limitations. For example, NHIF has limited coverage while private sources are regressive due to their demand for out of pocket payments.

This Research examines the role of health insurance companies in trying to bridge the financial gap in the health sector. It will be carried out among insurance companies offering Health Insurance in Nairobi province which is the capital city of Kenya and home to people of different economic classes. Literature was reviewed from books, data from health records from the government, magazines, journals, internet and research work conducted earlier by other people. Primary data was collected using questionnaires with both closed and open ended questions.

The researcher adopted both exploratory and descriptive research design. All the insurance companies offering Health Insurance will form the sample for this study. The data was analyzed using descriptive statistics and with the aid of SPSS and presented in tables tabulations, graphs and charts.

The study found out that health insurance is still beyond reach of many Kenyans as the premiums have been rising since 2003 making the schemes only affordable to the middle and upper bracket income earners. The study recommends that measures be put in place to encourage the lower income earners to take up the schemes.
## ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHIF</td>
<td>National Hospital Insurance Fund.</td>
</tr>
<tr>
<td>NHA</td>
<td>National Health Accounts</td>
</tr>
<tr>
<td>GDP</td>
<td>Gross Domestic Product</td>
</tr>
<tr>
<td>HMO</td>
<td>Health Maintenance Organization</td>
</tr>
<tr>
<td>NSHIF</td>
<td>National Social Health Insurance Fund</td>
</tr>
<tr>
<td>KIPPRA</td>
<td>Kenya Institute of Policy Research Analysis</td>
</tr>
<tr>
<td>IPAR</td>
<td>Institute of Policy Analysis and Research</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>OOP</td>
<td>Out of Pocket</td>
</tr>
<tr>
<td>SPSS</td>
<td>Statistical Package for Social Scientists</td>
</tr>
<tr>
<td>CBS</td>
<td>Central Bureau of Statistics</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immuno Deficiency Syndrome</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immuno Virus</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>MSH</td>
<td>Management Sciences for Health</td>
</tr>
<tr>
<td>USAID</td>
<td>United States of America Agency for International Development</td>
</tr>
<tr>
<td>KNHA</td>
<td>Kenya National Health Accounts</td>
</tr>
<tr>
<td>PER</td>
<td>Public Expenditure Report</td>
</tr>
<tr>
<td>KHPF</td>
<td>Kenya Health Policy Framework</td>
</tr>
<tr>
<td>NSHIF</td>
<td>National Social Health Insurance Fund</td>
</tr>
<tr>
<td>HHEUSR</td>
<td>Household Health Expenditure and Utilization Survey Report</td>
</tr>
</tbody>
</table>
DEFINITION OF TERMS

1. **APHIA** means health. It stands for AIDS, Population and Health Integrated Assistance. The acronym APHIA was chosen because Afya means health in Swahili. It was a Financing and Sustainability Project in Kenya sponsored by USAID.

2. **MSH** Stands for Management Science for Health

3. **AFS** a part of the USAID-sponsored health project that means Health Financing and Sustainability Project.

4. **Co-Payment** – this is an arrangement where the insurance covers a percentage of the cost of a medical service and the individual pays the other percentage of that cost.

5. **OOP** - Those payments made by patients at the point of receiving health care (both public and private)” (WHO, 2005).

6. **Utilization** – as used in this study refers to guaranteeing effective and needed health services for the promotion of health, prevention and treatment of illness and rehabilitation of good health.

7. **Health** – a state of complete physical, mental and social well being and not merely the absence of disease or infirmity.
CHAPTER 1

1 INTRODUCTION

1.1 BACKGROUND

One of the goals of the government of Kenya is to promote and improve the health status of all Kenyans by making health services more effective, accessible and affordable. Upon independence the government of Kenya promised to fight three things poverty, ignorance and disease. It has therefore continued to design and implement policies aimed at promoting coverage of and access to modern healthcare in an attempt to attain the long-term objectives of health for all. Like most services consumed by man Health care requires financing.

The alternative forms of health care financing including cost-recovery strategies like user fees have been heavily criticized. The option of insurance though a promising alternative has not been heavily used. Healthcare through insurance financing is the pooling of risks and transferring unforeseeable health care costs to fixed premiums. Medical insurance is an important feature of a health care system in which patients pay user charges to get medical treatment. Without insurance, many people would not afford acceptable care in a fee-for-service system. Since health is a merit good, making insurance broadly available in communities is a major policy issue in countries where user fees finance medical treatments.

Many African countries face the challenge of improving access to health care while struggling with the burden of the recent HIV/AIDS pandemic, other persistent infectious diseases and severe overall economic constraints. In Sub-Saharan Africa and specifically in Kenya medical insurance schemes have emerged. Such operate in conjunction with health care providers, mainly hospitals in the area.
The organizational and financial arrangements of health systems play a critical role in improving health services access and protecting households from severe financial loss.

Most countries have an important tax-based component in their health financing system; however other forms of financing such as private sources and external cooperation are used as supplemental ways. Such health financing mechanisms include, statutory insurance, health maintenance organizations (HMO), private health insurance, community based insurance and various mutual help groups known as Harambee. In Kenya NHIF covers 7% of the population (National Health Accounts Statistics 2001).

Total health spending in Kenya includes prepayment through general tax, insurance both social and private insurance, Out-of-Pocket payment and external sources which forms 16.4% of total health expenditure.

Although both prepayments and out of pocket payment are expenditures made eventually by households, they are fundamentally different in financing health care. Prepayments mechanisms improve equal access to services and protect households from financial loss while Out-of-Pocket payments can be a barrier to accessing health services and a heavy financial burden to the household.

The relative spending on health in Kenya stands at 4.9% of GDP. The government spending on health consists of 44% of total health expenditure, private prepayments schemes and NGO’s contributes 11.2% while Out-of-Pocket payments are 44.8%.

From poverty -related perspective the most significant aspect of current health care financing in Kenya is the large share of out-of-pocket payments. Concerns about the adverse equity impact of user fees have been growing throughout 1990’s but more recent research focuses on the effect of health care costs on household livelihood has placed this financing mechanism in the international spotlight.
1.2 STATEMENT OF THE PROBLEM

The unstable economic trends in the past two decades and the reduction in foreign assistance coupled with the debt servicing demands have made financing of health difficult. Over the years there has been a reduction in real funds available to Ministry of Health. At the same time the population has continued to increase, new services have been established and existing ones expanded.

Action is required to combat shortfalls and mobilize resources for the health care. More revenue for public health goods and services is clearly needed. This goal can be achieved by mobilizing resources from tax and non tax revenues, strengthening the political commitment to public spending on health and making more efficient use of public funds. Restructuring the financing and provision of health care is crucial and one of the financing options available is health insurance.

With the number of people living in poverty in Kenya growing from 3.7 million in 1972-73 to 11.5 million in 1994 and estimated to have reached 17 million or 56.8 percent of the population in 2003 and the ever rising cost of health the common man can not afford to pay For this reason financial intervention is required if the low and middle income brackets have to access medical care.

This study looks at the role of the insurance companies in bridging the existing financial gap in health care sector.
1.3 JUSTIFICATION OF THE STUDY

Despite the continuously increasing share of the government health spending year after year, there is no major improvement apparent in the system. Most of the reforms of the health financing systems implemented do not get to the bottom of the problems. Research has shown that without a conducive financing and policy environment the benefits realized in this sector may not be sustained. This has lead to growing interest in exploring alternative financing options so as to achieve sustainable development in this field.

**Percentage of persons reporting ill 4 weeks prior to the HHEUSR and did not seek treatment by reason.**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Lack of money/High cost of care</th>
<th>Self Medication</th>
<th>Long distance to provider</th>
<th>Considered illness not serious</th>
<th>Poor quality service</th>
<th>Religious or Cultural Reasons</th>
<th>Fear of discovering serious illness</th>
<th>Other reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>43.6</td>
<td>41.2</td>
<td>18.1</td>
<td>9.5</td>
<td>1.9</td>
<td>1.3</td>
<td>1.3</td>
<td>3.3</td>
</tr>
</tbody>
</table>

*Percentage do not add up to 100 because multiple responses were allowed*

Source: Adopted from the Household health Expenditure and Utilisation Survey Report 2003, Pg 37

In light of the above it is clear that there are inadequacies of the current health financing schemes by a way of not adequately addressing the health needs of the Kenyans especially the poor. It is noted that Kenya’s aggregate funding on health sector is very low (approximately 1.5 per cent of GDP) while per capita expenditure on health is US $6.2 far below the US $34 per capita recommended by World Health Organization (Public Expenditure Review 2004).

**Total Public Spending on Health 1999/00 – 2002/03 as a Percent of Total Expenditure.**

<table>
<thead>
<tr>
<th></th>
<th>1999/00</th>
<th>2000/01</th>
<th>2001/02</th>
<th>2002/03</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Public Spending</td>
<td>10.0%</td>
<td>11.9%</td>
<td>13.6%</td>
<td>15.0%</td>
</tr>
<tr>
<td>Share of GoK spending</td>
<td>8.4%</td>
<td>7.7%</td>
<td>8.9%</td>
<td>-</td>
</tr>
<tr>
<td>Share of GDP</td>
<td>1.3%</td>
<td>1.4%</td>
<td>1.5%</td>
<td>-</td>
</tr>
<tr>
<td>Spending per capita (US $)</td>
<td>4.72</td>
<td>5.04</td>
<td>5.61</td>
<td>6.43</td>
</tr>
</tbody>
</table>

Source: Kenya Public Expenditure Review, 2004
1.4 OBJECTIVES

The objectives of the study will be:

1. To determine the cost of basic healthcare in Kenya.
2. To examine whether the average Kenyan can afford the above cost.
3. To establish the health insurance covers available in the market.
4. Determine the role of health insurance schemes in bridging the financing gap in the health sector.
5. Recommend steps that can be taken to improve enrolment of households to health care insurance schemes.

1.5 RESEARCH QUESTIONS

1. What are the cost components of medical services?
2. What is the average income for the lower and middle grade people in Kenya?
3. Is the income adequate to finance households’ medical care on average?
4. What financial interventions are available in the market?

1.6 SIGNIFICANCE OF THE STUDY

The study will be useful to the policy makers concerned with medical insurance schemes both in private and public sector. It will be handy while assessing the prospects and limitations of the potentially profitable investment sector and to assist come up with lasting solutions to this sector.

It will be useful to employers who are increasingly opting for Insurance Plans rather than medical allowances for their employees as they make decisions on cost and financing of their preferred plans.
The study will contribute to household economies since individuals will have more information about Insurance Schemes while making decisions on how to finance their individual health care.

The government will benefit from the study by getting relevant and timely information on the matters of health financing as it pursues the Millennium Development Goals (MDG's) and as it tries to establish a Social Health Insurance Scheme for all Kenyans.

It will be of great interest to the health care providers who are the main clients of the Medical Insurance Schemes.

Health Insurance Management Organizations generally known as the HMO's which administer most insurance schemes will benefit from the study which seeks to analyze the prospects and limitations of such schemes.

1.7 LIMITATIONS OF THE STUDY

The state of bad health or being sick is subjective since some people may have higher tolerance levels than others.

1.8 ASSUMPTIONS OF THE STUDY

In effort to realize these objectives, the study makes some simplifying assumptions. It assumes that health care is a good at all levels of consumption (non-satiation assumption).

It also assumes that

- Providers act in a professional way and do not induce demand.
- The respondents will provide honest and sincere views.
- The respondents will be co-operative and avail the required data during data collection.
- Kenyans will act rationally and buy a policy for future medical financing to spread risk.
- The variables of the study will not change in the course of the study.
2. CHAPTER TWO

2.1 LITERATURE REVIEW

Good health is both an investment and consumption good. Ralph Waldo Emerson famously wrote “Health is the first wealth”. It is an investment because it enables people to engage in the production process effectively. It is a form of human capital that enhances economic performance both for the individual and of the macro economy. It is consumption good because it enables people to enjoy life to its full extent (without pain). Sickness and disability constrain human capability and have a negative impact on welfare (Bloom, Canning, and Jamison, 2004). Health affects economic performance through direct and indirect mechanisms (Boom and Canning, 2000). Ill health leads to losses in productivity and time put into production, healthy workers are generally more physically and mentally robust than those afflicted with disease or disability and are less likely to be absent from work because of personal or household illness. Conversely, poverty leads to poor living conditions, malnutrition and illiteracy, thereby leading to ill-health, hence the vicious cycle of ill health and poverty. Past research has shown that health affects earnings and productivity.

A substantial body of evidence has demonstrated that population health is a robust predictor of growth in per capita income (Barrow, 1991; Bhargava et al, 2001; Bloom, Canning, & Sevilla, 2004). A lot of evidence links higher levels of socioeconomic status to more favorable health outcomes (Antonovsky, 1967). When there is affordable healthcare, individuals face less financial risk and this leads to better health and an increase in labor productivity. Health sector financing is a rapidly evolving policy area in which important progress is occurring alongside inherent tensions.
The current trends indicate a widening scope of factors involved in the ongoing and worsening troubles of health care. In the 1980's health care costs continued to soar faster than food costs, faster than inflation. Kenya being a signatory to WHO Abuja Declaration is absorbing more than 15% of the GDP on health care, yet as a system, it is beset by bizarre distortions that lead only to frustration, extravagance and financial burden on massive scale. Why do hospitals cost so much? What economic forces shape their services? How much of our health expenditures actually pay for health care?. These questions have developed into the medical insurance plans. Past research and keen analysis has revealed how the contradictions and irrationalities in the health-care system are reflected in health insurance. They have noted faults of health care cause unnecessarily additional costs to individuals, employers and the nongovernmental health sectors amounting to billions of dollars while at the same time negatively affecting the health care of the public. Insurance theory posits that the desire for insurance represents an attempt to avoid risk by persons who want to maximize utility in the face of uncertainty. People do not know whether they will be sick and would rather take a certain, moderate loss by paying an insurance premium than take the chance of financial loss from serious illness. Because many people are avoid taking risks, and tax code allows wage and salary workers to pay health insurance with pretax earning, many people would rather have the insurance. Health is the largest service sector in the world economy. It is significant to each economy and an inalienable human right such that governments cannot ignore it. These two sides of the same coin prompt the state to take on a role. Clear and binding agreements are needed on the different roles of stakeholders. These roles must be defined and scrutinized by the state. It should give individual actors, including the private sector, sufficient flexibility to allow them to develop within the clearly defined framework. Health Insurance Plans are not by
themselves responsible for achieving the medical millennium goals but they have an important part to play.

One of the major limitations to universal accessible and affordable health care in Kenya is its financing and financial management. Changes in health care financing arrangement would lead to significant improvement in the performance of the health system and in the health services people receive. Health care reforms would lead to improved equity of access services, improved efficiency and quality of service provision.

There is need to critically look at the financial related issues of health care sector such as, how state budget allocations are pooled, how services are purchased, how benefit entitlements and co-payment obligations are specified and linked to purchasing methods and how different public and private funding resources are coordinated explicitly to provide health care services for the entire population. From 1989 to 1995, Management Sciences for Health (MSH) worked closely with the Kenyan Ministry of Health to improve health services, through the five-year Kenya Health Care Financing Project, funded by the US Agency for International Development (USAID). Together, MSH, USAID, and the Ministry of Health built on that project's achievements through a second five-year effort: the APHIA Financing and Sustainability Project (AFS Project). From 1996 to 2001, the AFS Project engaged partners from the public, private, and nongovernmental health sectors throughout the country to strengthen and expand health care services

Past research has expressed a strong need to explore public and private sector collaboration an important mechanism with potential for significant resource mobilization for health service delivery. There is need to determine the role and scope of insurance and then establish
strategies to build on for best utilization. Limited research however has discouraged a thorough assessment of their possible contribution.

Despite progress, the achievement of the Mellinium Development Goals (MDGs) will not be easy and remains an important challenge. A better protection of the poor against health risks is crucial in this endeavor. Poor health drastically impedes the social economic development of a country. Beyond directly affecting people’s well being poor health also lowers the productivity of labour and is a menace to the entire economy.

Access to health services typically requires out-of-pocket payments. According to WHO (2003) data “Out of Pocket payments” (OOP) account for 30% of total heath care spending in 2/3 of all low-income countries.

In most African countries the amount of OOP is well above this average (Prechsler and Jutting 2005). Such payments can lead individuals or households to reduce their expenditures for basic needs, to borrow money and to sell household assets. As a result some households are pushed into poverty. On the other hand OOP may lead to denied access to needed services or prevent one from receiving a full course of needed treatment. This might result in a vicious cycle of poverty from which it is difficult to escape in an already impoverished environment. Providing access to affordable health services can alleviate the financial burden of household and improve ability to generate income.

There has been increasing focus on health protection through taking insurance as a better way to deal with the challenge of health risks in developing countries. However, evidence as to whether taking insurance has effects of better health is still very thin. Little research has been
done on medical insurance schemes and plans and most of them are started without proper understanding of challenges facing the health sector.

The way health insurance is financed determines to a large extent the way the health care system is structured and health services are delivered. Health insurance is mainly shaped by government regulations and programs than the actual health needs and concerns of individuals and desires of health providers like doctors and other health-care workers in provision and administration of health care. Changes in insurance coverage for health care if well implemented and enforced would lead to changes in health care services and the costs of health care.

The 1977 WHO World Assembly resolution states that there should be “the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life, (resolution WH A 30.43). Clearly Kenya has not attained the objective of this resolution. Though the conference held in Alma-Ata USSR in 1978 defined primary health care as essential health care made universally accessible to individuals and families by means acceptable to them, through their full participation and at a cost that the community and country could afford this is still to be seen in Kenya. Affordability and accessibility of quality care have not been attained by all.

An increasing number of countries throughout the world have established compulsory insurance programs which will finance health care for a section of the population.

In developing countries the proportion of the population covered tends to be relatively small as such schemes are normally confined to persons with a regular cash income leaving the
majority of the population without any other way of financing their health care but from the Out of Pocket option.

The private sector in most economies caters for provision of accessible and affordable healthcare through insurance schemes and plans. Such schemes have not in the past been extensive in many developing countries. They only cover the higher income group. They are usually faced with myriads of problems and many have fallen under.

The question of financing health care has preoccupied many researchers and policy analysts over the years. In his evaluation of alternative health care revenue sources, Schieber and Maeda (1997) observed that health care is a priority that has presented a critical problem to developing countries due to their inherent inability to generate the required funds. An apparent under-funding and inefficiency in health care exists, which according to Owino (1997) would remain a problem for some time to come. The World Health Organisation (2005) attributes this unfortunate scenario to the fact that no one particular health financing scheme that has been found to be optimal in meeting the health needs of the citizens concerned.

Previous studies have addressed most of the health care financing sources either public or private. Authors who have studied the government financing have done so by using certain reflections, which include universal coverage and access to affordable quality health care. Such government sources of finance include Social Health Insurance (Njeru, et al 2004; WHO, 2005); user fees (Owino & were, 1998., Owino, 1998., David et. el 1996., Quick & Musau, 1994); and taxation (Savedoff, 2004).
Each author in their studies have utilised a set of certain criteria to undertake their intended assessment. For example, Njeru, Arasa & Nguli (2004) assessed the National Hospital Insurance Fund’s effectiveness, efficiency, relevance and financial viability as a gauging mechanism for its possible conversion to the proposed NSHIF. Using a desk study and selective key informant interviews they concluded that the proposed National Social Health Insurance Fund could hardly be supported by the current status of the economy and health care infrastructure. The study’s inherent shortcoming is that it set out to examine the policy position in Kenyan health care financing with regard to the proposed NSHIF out other health care financing mechanisms.

In a related study Njeru & Kioko (2004) analysed the funding of HIV/AIDS’s activities both by government and otherwise using secondary data and utilising comparative study focusing on Kenyan case study. Primary data was also used. The analysis dealt with equity and efficiency in resource allocation and expenditures to HIV/AIDS programmes. They concluded that there is an urgent need to improve the budget and available expenditure data within the health sector. The said paper which emphases on HIV/AIDS programme has its reference on the Abuja Declaration by African governments. The specific concentration of the said paper on funding of the HIV/AIDS activities is a limitation in that it does not address other health care issue.

In its report, the World Health Organisation (2005), using secondary data studied social Health insurance in relation to its sustainability and universality in coverage. The report asserts that universal coverage of a financing modality ensures equity in access to health care. The report concluded that efficiency and equity of financing systems is determined by how funds are contributed, pooled and utilised to provide effective health interventions. The
widespread emphasis on universal coverage is because of its implication on equity of access and protection against financial hazards (WHO 2005). The study was not specific to a particular country but referring to all countries and studied only the social insurance.

Savedoff (2004) did an assessment of financing through taxation by considering its implication on equity, effectiveness and sustainability. Utilising desk study relating to four countries that finances health care using tax-based systems Savedoff observed that the use of tax revenues to finance health care ensures universal coverage because of its ability to pool health risks across many people. The paper discusses exhaustively the use of tax revenues as a predominant source of health care financing without tackling the other forms of contribution. Similarly, in a technical brief for policy makers on developing a health care financing system that can attain universal coverage the World Health Organization (WHO, 2005), used aspects, which includes administrative efficiency and transparency, stability, equity, pooling and purchasing. The report showed that decisions for any financing modality should take into account these said aspects. The limitation with the policy paper is that it addresses only the policy considerations that a country should have when designing to finance a scheme that ensures achievement of universal coverage.

In addition, Xu et al (2006) used theoretical hypotheses on determinants of health insurance membership, utilization of health services, out of pocket payments and catastrophic health expenditure to study the impact of the Kenyan health financing methods on access and health spending. The data used in the paper came from the 2003 HHESUR survey conducted between February and March 2003. The analysis of the study was an empirical modelling that led to the conclusion that there are many problems of access that have to be addressed and
that the proposed NSHIF will have to take on board critical and unmet needs by specific population groups (Ibid). The study is limited in that it focuses on analysis of the proposed NSHIF by tracing previous reforms in health care with a view to develop policy recommendations. There was no attempt to assess other financing methods.

A more critical study was done by Schieber & Maeda (1997) who examined various government funding modalities using an evaluation criterion of economic efficiency, fairness, administrative simplicity and effects on the distribution of income. The analysis was based on related literature in respect of low income countries Vis a Vis the high income countries and concluded that there are trade-off between equity and efficiency with all revenue raising efforts.

In health care delivery there is always a conflict between maximizing efficiency and equity the same time and hence the need to establish a way of balancing the two. In this regard, James et el (2004) notes that allocations to the health sector are always based on traditionally sustained interests and not any other factor however known. The study examined a number of key efficiency and equity criteria and in that way explored how potential trade-offs could be used into decision-making process. They used priority setting between health interventions as an important first step to approaching optimal allocation of resources in health sector. This work supplements earlier researches including: Hoedemaekers & Dekkers, 2003; Maynard, 1999; Musgrove, 1999; Nord et el, 1999; Robinson, 1999; Rutten & Busschach, 2001 (James et al 2004).
It is should be noted that a number of authors have addressed some common health issues including efficiency, equity, sustainability, effectiveness, and coverage, among others. However, different authors define and/or measure these variables differently as noted below.

For example, efficiency in health care is defined by Njeru et al (2004) and Collins et al (1996) as administrative and operational expenses while WHO (2005) describes efficiency as administrative simplicity and transparency while Njeru & Kioko (2004) define efficiency as the adequacy of funds. Obonyo & Owino, (1997) in a report of a seminar on promoting access to health care through efficiency improvements which was organized by IPAR explains efficiency as being a combination of financial, managerial and organizational problems as portrayed by the malfunctioning of equipments and machines, shortages of drugs and other supplies. In this paper, efficiency is used to refer to how well the various government-financing schemes are organised as evidenced by the proportion of administrative costs, the balance between primary and curative care.

On the other hand, regarding equity, Njeru & Kioko (2004) describes it as spending on priority areas while Owino (1997) making reference to Mwabu’s contribution states that equity is addressing the problems of the vulnerable. Mwabu notes that policies such as cost sharing have not upheld access to modern health care since the targeting approach remains ineffective (Mwabu et al 1996). On the other hand Owino & Were (1998) while assessing the effectiveness of waivers and exemptions under cost sharing in addressing equity objectives noted that the success of waivers and exemptions would ensure equity in health care access. Likewise, the World Health Organisation asserts that equity especially in access is achieved through universal coverage when people access key promotive, preventive and rehabilitative health interventions at affordable cost (WHO 2005). Schieber & Maeda (1997) discusses
equity as fairness of a financing modality to everyone a thought that is shared by James and others (James et al, 2004). Equity in this paper refers to the fairness of a financing scheme as revealed by extend to which a financing scheme addresses issues of geographical and beneficiary coverage as well as addressing differences in resource endowments.

In light of the reviewed documents it is realized that there is growing interest to understand the performance of the various health care funding mechanisms. Previously attempts have been made to assess how these schemes meet the objectives of “Health for All”. There also seems to be a convergence of focus, which rotates around the issues of fairness, efficiency, and the ability to generate funds now and in future.

As earlier noted in this paper, the foregoing studies have addressed themselves to some specific health care financing schemes and thereby assessing their performance subject to certain evaluation criteria. This paper to some extent borrows from the evaluation criteria used by Schieber & Maeda (1997), which is considered to provide an articulate, useful, relevant and meaningful basis to examine the performance of different sources of health care finance. It can be noted that none of the studies mentioned in this section have addressed collectively the performance of the various government sources, which this paper attempts to do. The methodology used by other studies utilised secondary data for varied years as well as primary data especially from selected key informants. This paper utilises substantially the report of the 2003 KNHA and borrowing from Schieber & Maeda (1997) to develop a selection criteria, which four government-financing schemes are subjected to.
2.2 MOBILIZING GREATER DOMESTIC RESOURCES FOR HEALTH
The inadequate levels of health spending are, first and foremost a reflection of the basic arithmetic of poverty. When a country has a GNP of just $500 per person even health outlays equal to 5 percent of GNP amount to merely $25 per person per year. Health expenditures were determined mainly by national income. Each one percent rise in income leads to a slightly more than 1 percentage on health spending. Poor countries mobilize a smaller share of GNP in tax revenues leading to low budget allocation to health sector.

2.3 FINANCING OF HEALTHCARE
Health services and programmes in Kenya are financed from three main sources: the government through

1. Exchequer both directly to the ministry of Health and indirectly to other sectors with health-related functions (National Council for Population and Development, Ministry of Water Development, Ministry of Home Affairs, National Heritage, Culture and Social Services). All concerned with the well being of citizens in various aspects which indirectly impart on health.

2. Donors who fund ministry of health programmes

3. Private sector and NGOs

Many African countries are struggling to meet international debt obligation amidst adverse and declining economic growth rates. The adoption of structural adjustment programmes and economic/trade liberalization policies have thrown many households into deprivation and despair. Many governments have been forced to cut down on public expenditure, abolishing free and subsidized healthcare in favour of market-oriented health services backed by cost sharing and user fees (WHO, 2001a).
In 1989 Kenya introduced user fees in the public health sector under the structural adjustment programme. The cost-sharing programme was put in place to generate additional revenue for health facility operations, increase quality of health services in government facilities, strengthen the referral system and rationalize of health services and improve equity and access to health. At the inception of the cost-sharing programme in the public health sector in Kenya, it was recognized that charging user fees would lead to inequities in the provision of health care services. The poor would not afford as much health care as the relatively well off. Cost sharing was necessitated by decline in government health spending and decline in donor support. The money to purchase drugs and pay medical personnel had to come from somewhere. With increasing budgetary pressure, it became a reality that the health sector was financially unstable as the government could not fully support the health sector single handedly. This has led to the development of alternative financing mechanisms such as cost sharing (KIPRRA working paper no.11, 2004). User fees constitute a financial burden to the poor and other vulnerable groups, restricting their access to health care services due to their inability to pay (IPAR, volume 9 issue 7, 2003).

The Ministry of Health has used several financing mechanisms to support the health sector for example cost sharing, health insurance, taxation, harambee and direct community contributions. According to Kenya Human Development Report (1999), government financing of health expenditure is about 60% of what is required to provide minimum health services, therefore implying that the healthcare delivery in Kenya is under-funded (KIPRRA working paper no.11, 2004).

There is substantial scope in the developing world for redirecting current public spending away from discretionary services. Cost recovery in government hospitals, especially from the
wealthy and insured is one important mechanism. Though in Kenya insurance may account for less than 5% of total health spending, a combination of limited private insurance and the ability of upper-income groups to pay make it feasible for government to charge discretionary care delivered in public hospitals.

In middle-income countries insurance becomes more important as a mechanism of financing discretionary services. In South Africa private health insurance covers about 15% of the population and accounts for more than a third of total health spending. In Brazil, even though everyone is eligible for publicly financed health services, about a fifth of the population is also privately insured.

Insurance offers away for the government to redirect its spending by phasing out subsidies and instead the subsidies form both direct budgetary transfers to insurance institutions and tax concessions for employers’ and employees’ insurance contributions. The limitation of this mechanism though, is that it benefits the better off and is therefore regressive.

2.4 USER FEES
Much of debate on fees at the global policy levels has focused on the efficiency and equity aspects of user charges. Proponents of user charges suggest that fees could make the health system more efficient by guiding demand to cost-effective health care at appropriate levels. Further they argue that the approach could also improve equity as well if revenues raised are allocated to addressing the health needs of the poor. The opponents argue that this allocation is not in fact guaranteed and in the absence of effective exemption policies or other forms of financial protection, user charges actually price the poor out the market for health care with potentially dire consequences for their health status (Health Financing Technical Brief: Draft March 2003; Reviewing the Impact of User Fees: The African Experience).
In Kenya the emphasis on fees as a financing mechanism was in response to a resource crisis in the health sector and the fees were endorsed as a means to raise additional revenues. It was envisioned that this would bridge the resources gap in improving access and provision as well as allow for investments in better quality. Since their wide spread introduction under the Bamako Initiative (BI), which aimed to improve the quality of service and ensure equity in access to care, the user fee experience in Africa has been reviewed extensively with respect to actual versus theoretical and planned outcomes (Creese and Kutzin, 1995). Previous reviews indicate that predicted levels of resource mobilization have not been realized and that, in fact, revenues raised from implementing user fees fell short of estimates, being on average about 7% of non-salary costs rather than the anticipated 15%. This has limited both the envisaged increase in utilization as well as reallocation of resources, through exemption schemes to protect the poor (Carrin, 1992).

2.5 COST SHARING

Government health services decreased in quantity and quality throughout the 1980s. Non-governmental organizations, though committed to serving the poor, could not increase their services sufficiently to supplement declining government services. While the private health sector grew in response to increasing demand, it primarily served higher-income groups, not the poor.

To address the growing gap between health needs and health services, the APHIA Financing and Sustainability (AFS) Project and the Ministry of Health worked to strengthen and expand services in the public, private, and non-governmental sectors. Through a health reform model that targeted all three sectors of the national health system, the AFS Project and the MOH
expanded and improved the services available throughout Kenya. The project had four major components:

• Supporting the public-sector cost-sharing program;
• Improving health financing in the private sector;
• Increasing the sustainability of nongovernmental organizations that provide health and family planning services;
• Ensuring a reliable supply of essential drugs and family planning commodities through the public sector.

To address the growing gap between services available to those in higher-income groups and those available to the poor, the AFS Project worked with the Kenyan government to implement a series of health reforms targeting cost-effectiveness, quality, and sustainability in the public sector. These reforms included:

• strengthening the cost-sharing program to increase revenues;
• introducing cash registers at government hospitals to reduce theft and increase revenues;
• Using increased hospital revenues to dramatically improve health services.

The revenues from the cost-sharing initiative supported the institution of the cash register program; this both strengthened the cost-sharing initiative and funded the employee incentives program, which, in turn, has helped to launch new health services for the poor.

The government of Kenya adopted one of its strongest options for expanding health programs: cost sharing. The cost-sharing program helped government hospitals and health centers to increase revenues by charging nominal fees to most patients as well as seeking reimbursement from the National Hospital Insurance Fund. While this program means that
the government no longer provides free services to everyone, revenues generated from this cost-sharing strategy are used to improve the quality and availability of health services.

In the first five years of the cost-sharing program (1990-1994), MSH worked with the Kenyan Government to successfully introduce cost sharing in all the provincial general hospitals, district hospitals and health centers throughout Kenya. In subsequent years the government focused on transferring the management of cost-sharing programs to the provinces. The revenues from the nationwide cost-sharing have supplemented declining government revenues and supported significant improvements in the quality of health services.

Given Kenya’s economic and political circumstances, the future if its health care system is uncertain. However, this uncertainty is no reason for postponing new health initiatives. There is never a perfect time for reform and improvement. The best time is nearly always the present.

2.6 OUT OF POCKET PAYMENT
Direct payments from individuals or households for health services generally represent a large proportion of the total expenditure of the health sector although this fact is not always recognized. Such payments can lead individuals or households to reduce their expenditures for basic need, to borrow money and to sell household assets. As a result some households are pushed into poverty. On the other hand OOP payments may lead to denied access to needed services or prevent one from receiving a full course of needed treatment. This might result in a vicious cycle of poverty from which it is difficult to escape in an already impoverished environment.
2.7 HEALTH INSURANCE

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

Health insurance is a mechanism for protecting families against the unexpected high costs of illness by sharing the risks of future costs among healthy and sick populations in the form of regular predictable payments. Insurance is becoming more important as a mechanism for financing discretionary services. In studying resource mobilization in five countries DDM found the health insurance was of increasing policy interest as a method of raising resources and potentially improving the supply and provision of health services. Proponents argue that people may be more willing to pay for health insurance rather than being heavily taxed or charged user fees. DDM research, however, indicated that only small percentages of the populations studied had any kind of health insurance and that insurance schemes also tend to cover mainly the more wealthy income groups or the formally employed, limiting the reach of such schemes into lower income or rural populations (HHRAA/DDM Workshop Proceedings, Zimbabwe, 1997).
Health insurance in Kenya has been provided by both private and public systems. The main objective of the health systems has been to insure Kenyans against health risks that they may encounter in future.

2.8 ROLE OF PRIVATE SECTOR

There is strong need to explore public and private sector collaboration as an important mechanism with the potential for significant resource mobilization for health service delivery. Health insurance is considered private when the third party (insurer) is a profit organization (Republic of Kenya, 2003a). In private insurance people pay premiums related to the expected cost of providing services to them. Therefore, people who are in high health risk groups pay more and those at low risk pay less. Cross subsidy between people with different risks of ill health is limited. Membership is usually voluntary. Kenya's health reform policies have consistently called for the private sector to play a greater role in meeting the health needs of Kenyans and offsetting the burden the public sector faces in providing health services.

Health insurance attempts to reduce the financial and non-financial risks associated with chronic illness or injury, since individuals are uncertain about health status and expenditures that might arise in future. The risks include loss of life and deterioration of health. Deterioration of health reduces the ability of an individual to work, or reduces the productivity while working such that the individual faces the risk of lost (market and non-market) wages. Another risk may arise, as an individual may be unable to enjoy other forms of consumption, like participation in sports because of their health status or they may suffer emotional and psychological trauma associated with physical deterioration. These events and consequences are uncertain both in size and in occurrence. Individuals are therefore always
willing to pay to reduce this risk (Jack 1999). Due to this risk avoidance behavior, many individuals will seek insurance and they will effectively pool their risks through an insurer. Given large numbers the condition that the risk of any one individual suffering the loss is statistically independent of that of another should be satisfied for insurance cover. Paula (1968) and Jack (1999) demonstrate that the dead-weight loss to the consumer is the difference between the individual’s net surplus with and without insurance.

It has been shown that by Arrow (1963) that many risks are not covered, and indeed the markets for the service of risk coverage are poorly developed or non-existent.

The use of annual or case by case deductibles often gives insurers an opportunity to categorize risks better. Unfortunately deductions are calculated less to reflect individual’s behavior than administrative running costs and to reduce the price of insurance.

Tracking changes in health costs reveals that their steady and rapid rises increase the risk of budgetary imbalance in health insurance schemes and may damage their very underpinnings. The most commonly quoted example is over-consumption of medical care, especially pharmaceutical products. One of the main reasons for rising cost is the increasing expenses of diagnostic procedures and treatments due to highly specialized exploratory techniques the other is cost of drugs especially where a medical scheme is abused. When insurance covers costs in the health sector, new alternative therapies can be developed. Hence insurance helps to boost health-care costs.

Since marginal costs of more expensive treatment will be borne not by the individual policy holder but by the policyholders at large the health care provider will tend to increase the
number of services performed and propose the most expensive treatment in a process called as supply-led-demand. As confidence in the medical profession’s ability to deal with health problem grows, people’s individual sense of responsibility diminishes. If an insurance scheme meets all the costs of health care, care is perceived as free resource and there is a tendency to over-consume.

Health insurance in Kenya has been provided by both private and public systems. The main objective of the health systems has been to insure Kenyans against health risks that they may encounter in future. The simple idea of making the consumer aware of costs or of making those who incur avoidable costs bear the consequences of their behavior is hard to implement. “The bonus-malus” systems being tested in some countries where policyholders wish to pay in accordance with their needs represent a retreat from the principle of solidarity. Co-insurance whereby the policyholder has to pay a certain percentage of the costs, an arrangement known as the ticket mederateur in some countries, has proved universally ineffective as a means of controlling health expenditure.

A progressive reduction in premium (bonus) provided no claim is submitted probably has a pernicious effect on health over the longer term since people will wait linger before seeking treatment even when they need it. Making the policy holder pay a real percentage of the costs is customarily regarded as more effective than applying a deductible but a high co-insurance factor is more beneficial for people on low income earners, the elderly and the chronically ill. A ceiling (annual, per service, per type of care) leaves out certain kinds of expenditure or mutualizes them since they are considered too trivial or on the centrally too extravagant or unnecessary. The kind of ceiling imposed often depends on the degree of mutuality or service.
3. CHAPTER THREE

3.1 RESEARCH DESIGN AND METHODOLOGY

This research was both descriptive and exploratory. It relied extensively on primary and secondary data. A wide range of secondary data and information will be collated from various government publications and private sources including National Health Accounts, World Bank Report, Central Bureau of Statistics, Ministry of Health, Health Insurance reports among others. The primary data was gathered by use of questionnaires.

Target Population

The target population was the health and medical insurance underwriters in Nairobi. Refer to appendix 3 for the list of Health Insurance Underwriters’.

Study Site

The study will be conducted around Nairobi. All the 23 health insurance providers will form the study target group.

3.2 DATA COLLECTION

Data sources were multiple including both primary and secondary sources. A semi-structured questionnaire on a range of enrolment and financial related issues was prepared. The questionnaire included both open and closed ended questions.

3.3 DATA ANALYSIS

Quantitative analysis was limited and was intended for exploratory purposes. This approach allowed in-depth investigation of issues as well as for the assessment of causal factors of insurance as an alternative to healthcare financing from more than one scheme using data from several sources. SPSS was used to analyze the data collected. Charts and graphs of central tendencies will be used to present data.
4.1 INTRODUCTION
This chapter presents results of the analysis of data collected through questionnaires. The questionnaires had been distributed to 23 medical insurance companies in Kenya with the 12 interviewees. The interviewees consisted of the human resources manager, the deputy human resources manager in charge of performance management and 10 representatives from other departments of the company.

4.2 OPERATIONS
The respondents were asked to indicate the category that best describes their medical insurance. From the responses, it was clear that 80 offer private medical insurance while 20 per cent operate as health maintenance organisations. This analysis is summarized in Figure 4.1 below.

Figure 4. 1: Types of medical insurance

The respondents were also asked to state who were targeted by the medical insurance cover. From the responses, it was clear that the target were employed people who were also allowed to cover their spouses and the children who have not attained the age of majority.

The study also sought to know the total number of members enrolled in the firms. The study found out that on average the firms have 52 corporate members and 1280 individual
members. This translates to 4% for corporate members and 96% for individual members. This is presented in the pie-chart below.

**Figure 4.2: Composition of enrolled members**

![Pie Chart](image)

The researcher then sought responses to the total health insurance annual claims cost for the period 2003 to 2006. The study found out that on average, the annual claims are Kshs. 315 million. This has been growing for the last 4 years as presented in the graph below. For 2003, the claims were worth Kshs. 273 million, Kshs. 296 million in 2004, Kshs. 327 million in 2005, and Kshs. 352 million in 2006. In Figure 4.3 below, it can be observed that more claims have been paid to the individual members than corporate ones.

**Figure 4.3: Health insurance claims per year**

![Bar Chart](image)

The study also sought to find out the total premiums collected from corporate members and from individual members for the period beginning 2003 to 2006. The average annual health insurance premiums were found to be Kshs. 1285 million. This is presented in the figure below.
Total premiums from corporate members as presented in the graph above was found to be Kshs. 1065.6 million in 2003, Kshs. 1205.76 million in 2004, Kshs. 1272 million in 2005 and Kshs. 1307.52 million in 2006. For individual total premiums collected from 2003 to 2006, the study found out that on average, the premiums were Kshs. 44.4 million, Kshs. 50.24 million, Kshs. 53 million and Kshs. 54.48 million respectively.

The study found out that the percentage of claimants in relation to the total persons insured was 25% in 2003, 24% in 2004, 25% in 2005 and 26% in 2006. This suggests a growth which can be captured in the figure below. It is clear from the analysis that percentage of claimants fell from 2003 to 2004 but has been rising steadily ever since up to 2006.

The respondents were then asked to explain how they come up with different premiums for different clients. The study found out that there are several factors that are considered when calculating premiums paid. These factors are age, level of income, health conditions and nature of occupation.
On the issue of whether insurance is open to all ages, the study found out that insurance covers could only be taken up by those who had reached the age of majority. It was also found out that the minors are not allowed to take insurance covers but can be covered by adults.

The respondents were then asked how many dependants could be covered by the health insurance covers. The study found out that not all dependants are covered. Some firms cover the spouse and the siblings who have not reached the age of majority. This excludes dependants who are over the majority age and their relatives. Some cover a specific number of dependants in the family such as the assured’s parents, his/her spouse and the children below 18 years.

**Figure 4.6: Coverage of HIV/AIDS patients**

The respondents were also asked if their firms cover HIV/AIDS patients. From the responses, many firms have taken up the task to cover those with HIV/AIDS but these pay higher premiums. The idea has been filtering into the insurance industry at a very slow pace. The analysis shows that 20 per cent of the firms do not cover HIV/AIDS patients. However, 80 per cent of the firms studied claimed to cover the HIV/AIDS patients. The summary of the analysis is presented in the figure above.

The respondents were also asked to state whether the companies cover people with terminal illnesses. It was found that all the firms studied cover people with terminal illnesses such as cancer but these assured persons pay higher premiums that the other category of assured persons. It was also found that life insurance covers in the firms include coverage for critical
illnesses, long-term care, disability and supplemental health benefits other than cancer and HIV/AIDS.

The respondents were asked what income bracket most of their clients fall in. The categories were upper bracket, middle bracket and lower bracket. The analysis in the table below shows that most of the clients fall within middle bracket.

**Table 4.1: Clients’ income bracket**

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Upper bracket</td>
<td>6</td>
<td>30</td>
</tr>
<tr>
<td>Middle bracket</td>
<td>11</td>
<td>55</td>
</tr>
<tr>
<td>Lower bracket</td>
<td>3</td>
<td>15</td>
</tr>
</tbody>
</table>

From Table 4.1 above, it can be observed that 30 per cent of the firms consider their clients to be in the upper income bracket, 55 per cent consider theirs to be from the middle income bracket while 15 per cent of the firms have their major clients from the lower income bracket. This shows that the lower income bracket market have not been much targeted by the life insurance services. Firms are targeting middle income and upper income earners.

The researcher also wanted to know what services the insurance firms cover. The category of services included inpatients only, outpatients only, inpatient and outpatient, and others. The study found out that 80 per cent of the life insurance companies cover both inpatients and outpatients. 15 per cent of the firms cover inpatients only while 5 per cent cover outpatients only. This analysis is presented in Figure 4.5 below.

**Figure 4.7: Insurance services covered**

80%

15%

5%

- Inpatients only
- Outpatients only
- Inpatient and outpatients
The respondents were also asked to state what percentage of the cost is covered by the insurance. It was found that 60 per cent of the firms cater for full cost while 40 per cent cater for a percentage of the medical costs. This is presented in Figure 4.6 below.

**Figure 4.8: Percentage of cost covered by insurance**

On the issue of whether insurance have maximum entitlement limits per year for clients, the study found out that there is indeed a maximum entitlement limit per year for clients. The medical insurance providers peg an upper limit in terms of how much a client is entitled to every year. On average, the maximum entitlement is Kshs. 250,000 per year.
CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

5.1 DISCUSSION AND CONCLUSION

This study was designed to investigate the role of medical insurance underwriters in financing healthcare. Specifically, the study was designed to determine the cost of basic healthcare in Kenya, establish health insurance covers in the market, and to determine the affordability of the above cost for average Kenyan. This chapter discusses the findings and offers conclusions.

The study also found out that 96 per cent of members enrolled in the health insurance institutions are individual members. Only 4 per cent of the members are corporate. But this does not mean that more premiums come from the individual members. Despite the fact that corporate members are out-done in terms of numbers by individual members, most of the firms receive more premiums from the corporate members. As the study found out firms receive, on average, Kshs. 1283 million in claims annually from the enrolled members.

The analysis further revealed that the insurance claim costs have been growing over the years from 2003 to 2006. On average, the claims have cost the firms Kshs. 315 million. The growth in claim costs has been attributed to the increasing road carnage which has claimed many lives and left others with physical disabilities. The increase is also attributed to the increasing vulnerability of the population to HIV/AIDS and malaria. Most of the claims that have been expensive for the firms have been for critical illnesses, long term care and supplemental health benefits.

The total premiums collected have also been growing over the years from 2003 to 2006. On average, the premiums have been about Kshs. 1263 million per year. Corporate enrolled members have contributed more to the high premiums averaging at Kshs. 1213 million while individual members have contributed an average of Kshs. 51 million per year for the last 4 years. This suggests that 96 per cent of the premiums are contributed by corporate members while 4 per cent are a contribution from individual members.

Another important finding of the study is the fact that the percentage of claimants has been growing over the years. The average percentage claims was found to be 25% per year. This
shows that the risk has been increasing over the years hence the realization that affordability of health insurance cover has escaped the reach of lower level income earners in Kenya. Only 15% of the members of the health insurance schemes are from the lower bracket income earners. The premiums have been rising making the services to appeal to only high income earners and middle income earners at 30% and 55% of the clients respectively.

The study also found out that 15% of the firms offer insurance covers for inpatients only while 80% cover both the inpatients and the outpatients. The remaining 5% cover exclusively outpatients. It was also found that 60% of the firms cover full costs while 40 per cent cover a percentage of the costs. There is no entitlement limits per year for the clients in all the firms and persons can cover their family including their spouses and children who have not attained majority age. It was also found out that 20% of the firms cover HIV/AIDS patients while all the firms were found to cover people with terminal illnesses such as cancer.

It can therefore be concluded that the cost of basic healthcare in Kenya is high and has been rising for the last 4 years. Given that 46% of Kenyans live on less than one dollar per day, it is clear that most of the ordinary citizens cannot afford the cost of healthcare in Kenya. Insurance premiums have been rising further escalating the problem of unaffordability of healthcare in Kenya. It can also be concluded that the health insurance covers available in Kenya cater for all ages, those with terminal diseases and those with HIV/AIDS. Health insurance schemes have come in handy but have not explored the people who need their services most: lower income earners.

5.2 RECOMMENDATIONS

The study recommends that policy makers take notice of the fact that not many people, especially the lower income earners, have been reached by the health insurance schemes. Policies should be made that encourage health insurance providers to reach this market.

The study also recommends that employers be encouraged by the findings of this study so that they can take the burden of maintaining the health of their employees off their shoulders by exploiting the advantages provided by health insurance schemes.
This study also recommends that households take up health insurance schemes so as to reduce their health costs by taking health insurance covers for their whole families. This will reduce the burden of having to take care of the medical expenses as an individual.

The government is also asked to put in measures that can excite interest in the citizens to take up health insurance covers. As one of the pillars of the Millennium Development Goals (MDG), the government should encourage citizens to be concerned about their health matters. Given that the life insurance premiums have been increasing, the government should provide avenues that can lead to reduction in health risks, for instance, by encouraging and providing preventive measures. The government should also take care of the unemployed and the underpaid who can not afford the higher health insurance premiums by providing NHIF cover for them.

Healthcare providers are the major clients of medical insurance schemes. The findings of the study have implications on the healthcare providers as they are able to understand the dynamics of healthcare costs and the implications. The HMOs are also encouraged to evaluate the prospects and limitations of health insurance schemes as discussed in the study.

5.3 AREAS FOR FURTHER RESEARCH

The study recommends that researchers and academics who would like to study more on financing healthcare should study the implication of the government providing health insurance cover for all citizens on the future and survival of health insurance schemes and medical providers.
REFERENCES


Kara Hanson and Peter Berman. Private Health Care Provision in Developing Countries: A Preliminary Analysis of Levels and Composition. Data for Decision Making Project


*Kenya National Health Accounts (KNHA) 2003*


APPENDIX 1

1. AAR Health Services Ltd
2. AIG Kenya Insurance Co. Ltd.
3. APA Insurance Limited
4. Apollo Insurance Co. Ltd.
5. Blue Shield Insurance Co.
6. British American Insurance
7. Executive Health Care Solutions Ltd
8. General Accident Insurance Co. Kenya
9. Goldstar Healthcare Limited
10. Healthfirst International Limited
11. Healthline Solution Limited
12. Ken India Assurance Co.
14. Lifecare Insurance Ltd
15. Lion of Kenya Insurance Co.
16. CFC Life Insurance
17. Pan African Life Assurance
18. Pioneer Assurance Co. Ltd.
19. Planned Healthcare Ltd
20. Prosperity Health Kenya Ltd
21. Resolution Health East Africa
22. The Co-operative Insurance Co. of Kenya Ltd.
23. UAP Provincial Insurance Co. Ltd.
APPENDIX 2

PART 1 – ORGANISATION

Name of Insurance Company

Address

PART 11 - OPERATIONS

1. Please indicate the category that best describes your Medical Insurance

   I. Public (NHIF)

   II. Private

   III. Health Maintenance Organization

   IV. Employer Provided Insurance

   V. Other

2. Who are your main targets for medical insurance cover?

3. What is the total number of the enrolled members?

   i. Corporate Policy

   ii. Individual

4. What is the total health insurance annual claims cost in the years

   2003

   2004

   2005

   2006
5. What were the total premiums collected in the years

<table>
<thead>
<tr>
<th>Year</th>
<th>Corporate</th>
<th>Individual</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td>2003</td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td>2004</td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td>2005</td>
<td></td>
</tr>
<tr>
<td>2006</td>
<td>2006</td>
<td></td>
</tr>
</tbody>
</table>

6. What is the percentage of claimants in relation to the total insured persons?

7. How do you come up with the different premiums for different clients?

8. Is the insurance open to all ages? If not what is age limit ---------------

9. How many dependants can one cover?

   All --------

   Number --------

10. Do you cover HIV/AIDS patients Yes------ No ---------------

11. Do you cover people with terminal illness Yes ------ No ---------------

12. Which income bracket would you say that most of your clients fall in?

   Upper bracket

   Middle bracket

   Lower bracket
13. What services does the insurance cover

- Inpatient only
- Outpatient only
- Inpatient and Outpatient
- Others

14. What percentage of cost does the insurance cover

- Full
- Percent

15. Does the insurance have maximum entitlement limits per year for the clients?

- Yes
- No

16. If yes how much?