**Exploring perceptions and enabling factors for the National Health Insurance System (NHIF). An interview-based study in Kenya.**

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# **ABSTRACT**

**Introduction**

Several LMICs have attempted to adopt SHI for financing healthcare. It especially gained momentum after 2005, when the WHO called upon its member states to deliver UHC to their citizens by 2030. Kenya’s National Hospital Insurance Fund (NHIF) was established in 1966 as a department under the ministry of health and was then a reserve for civil servants only. The introduction of the SHI agenda in the millennium saw the NHIF undergo a series of developments and various reforms to model it into an effective SHI system. Like other LMICs, the development of SHI in Kenya has been met with difficult challenges, inhibiting the delivery of UHC.

**Aims and objectives**

The aim of the study was to explore the population’s perceptions and enabling factors of the NHIF within the Kenyan context.

The objectives of the study were to review literature on SHI in LMICs and documents on the NHIF policy in Kenya to gather evidence. Then, adopt the Walt & Gilson Policy triangle framework for analysis of the policy. Then collect primary data by conducting interviews with various actors and triangulate these findings alongside the document review. Eventually, draw policy recommendations on the application of SHI in Kenya and other LMICs.

**Methodology**

The study adopted the health policy triangle to perform a retrospective and prospective policy analysis of the NHIF. It employed a realist approach which enabled an assessment of actors’ perceptions of the NHIF policy. Data was collected from document reviews and interviews. For the document reviews, a google search of key words was done, and a further search into organizations websites to obtain reports and policy documents. For the primary research, ethics approval was obtained from QMERC and the research licensing board in Kenya (NACOSTI). Respondents were obtained through purposive sampling from LinkedIn and organizations website profiles, and a few more through snowballing. A total of 21 semi-structured interviews, averaging 40minutes each were conducted.

**Findings**

The analysis found NHIF to be instrumental in increasing coverage and access to affordable healthcare. However, the big informal sector proportion, low incomes among other contextual factors were found to challenge its potential to deliver UHC. The recently introduced mandatory membership was found to be untimely as there were more disabling than enabling economic and structural factors at the time of its implementation. The subsidy schemes were noted to be a progressive step, albeit inadequate, to promoting equity in accessing healthcare. In contrast, the enhanced benefit packages were found to widen the equity gap. The purchasing role of the NHIF was found to be marred with claims of fraud and corruption, raising questions as to the viability of the fund to play both the pooling and purchasing role. Political goodwill and actors’ engagement was noted to be essential for success.

**Conclusion**

Like SHIs in other LMICs, the NHIF is instrumental in increasing coverage. However, various contextual factors hinder its potential leading to delay in attaining UHC. Alternative co-financing measures should be considered to reduce the timelines and afford the citizens the much-deserved right to equitable healthcare through UHC.

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# **INTRODUCTION AND BACKGROUND**

## **1.1 Introduction**

Health is a fundamental human right without which all other rights cannot be fully attained. The Committee on Economic, Social and Cultural Rights (CESCR) explains that the right to the highest attainable standard of health implies that good quality and acceptable healthcare should be physically, economically and non-discriminately available and accessible to all. Poor states of health, lack of risk pooling and health resource pooling exposes populations to health-related financial catastrophes (WHO 2000). Health systems in many low- and middle-income countries are underfunded leading to inability to provide their citizens with the very basic right to health.

A country’s healthcare system is comprised of three main interacting components: regulation, financing and service provision which enable the process of purchasing and providing healthcare services. These components are influenced by various actors including the state, societal and private actors (Wendt et al.,2009; Bohm et al., 2013). Actors within a context also influence the political, economic and social structures within their contexts. As a result of the cross interaction with actors, a country’s choice of healthcare systems reflects the society’s regard for moral values and social welfare (Olmen et al., 2012).

Health systems financing involves the mechanisms and systems employed to collect health revenue, how the revenue is pooled and ultimately how it is allocated and utilized. Health systems are broadly categorized based on their systems of healthcare financing. There are various classifications of healthcare systems, with the main one being the standard tripartite classification which classifies healthcare systems into 3: Social Health Insurance (SHI), Voluntary Insurance (VI) and Universal Coverage (UC) (Toth, 2016).

This study sought to analyse Kenya’s healthcare system through the policy triangle framework. The paper begins with an introduction and a review of literature on SHI in Low- and Medium-Income Countries (LMICs) and thereafter provides a summary of Kenya’s country profile and healthcare system. Chapter provides the rationale for the study, the aims and objectives of the research and the research questions. This is followed by a detailed description of the study methods and conceptual framework in section 3. Section 4 is the core of the study and presents the research findings and analysis. Thereafter is the discussion in section 5 and implication on policy, and a conclusion in the final section 6.

## **1.2 Origin and characteristics of SHI models**

The idea of Social Health Insurance (SHI) originated from Germany in 1883, during the medieval and Bismarkian times when employers contributed to employee’s sickness funds (Saltman, 2004). Initially, the aim was to maintain the workers to avoid losing productivity due to sickness. These contributions were later made compulsory and eventually evolved into the SHI model, which then spread to other countries in Western Europe and to the rest of the world. The SHI model are stable and self-regulating non-state corporations and, in most cases, receive state stewardship. They are considered as social security structures and part of the social fabric that makes a civil society. This societal stance distinguishes from other insurance options and other healthcare financing alternatives which are more economic oriented. A SHI model aims to promote solidarity and socialism within a society through subsidization and cross-subsidization between the old and young, ill and healthy and between the rich and poor for the overall benefit of the entire society (ibid).

SHI models ensure a large central pool of funds which gives provide monopoly of the markets therefore enabling better negotiation hand in the purchasing of healthcare services. The resources are earmarked for financing healthcare only and the spending par capita is also better than in tax-based systems. Additionally, SHI systems are modelled to promote equitable resource allocation, opposed to inequity caused by demands and bias in the private sector (Toth, 2016). On the downside, SHI systems adopt the Bismarckian model where compulsory contributions are made to the government through employee payroll deductions therefore seeming like indirect tax (Saltman et al., 2004). Payroll based contributions are regressive as the lowest paid end up contributing a bigger proportion of their employment income, compared to those in higher pay scales. SHI models are also non-inclusive since membership is by contribution therefore affords access to healthcare to members only whereas the rest of the population remains exposed to health-related financial catastrophe.

## **1.3 SHI in LMICs**

Nearly half of all the first world countries adopted SHI to finance their healthcare. Due to this, the SHI got recognition for enabling the provision of affordable and equitable healthcare (Carrin, 2002). When the WHO called upon its members to deliver UHC to their citizens by 2030, the WHO commission further thereafter recommended SHI as a powerful model for pooling both risks and resources (WHO, 2005). Arguably, these recommendations caused a wave of LMICs attempting to model the SHI for financing their healthcare systems.

In Asia, China and Vietnam modelled the SHI, making it compulsory for civil servants and voluntary for the informal sector. Carrin (2002), in his review of the two countries found various factors to influence SHI in LMICs. The capacity to contribute to the SHI was found to be dependent on the level of income in the given country. This therefore implies that LMICs with low GDPs and low per capita incomes had lower potential to succeed with SHI. Low incomes would mean collecting low premiums which result reduced risk protection as observed in parts of China.

Furthermore, acceptance of the SHI concepts such as cross-subsidization was especially difficult where incomes were significantly unequal (Carrin, 2002). The SHI model proposes equal access to healthcare despite individual levels of contribution. However, unless the society understands and accepts the concept of cross subsidization that is instigated by SHI, its application remains a challenge. Contrasting beliefs about poverty, such as that it results from laziness as opposed to unequal access to opportunities further influenced attitudes on cross subsidization. In addition, populations engagement with policy making was found to be important yet lacking especially from the informal sector due to lack of structures to represent them (ibid; Carrin, 2005).

### **1.3.1 Inclusion of the informal sector into the SHI model in LMICs**

Several studies found the inclusion of the informal sector and the unemployed into the SHI model to be the biggest challenge for LMICs trying to employ SHI to deliver UHC (Carrin, 2000; Hsiao, 2007; Carrin, 2005; Abiiro and Mcintyre, 2012; Acharya et al., 2012). The proportion of formal to informal sector workers was observed to be a major determining factor for the success of SHI in LMICs. The structure of the SHI being compulsory for civil servants and formal workers and voluntary for informal workers as is in many countries, causes imbalance in payments when the proportion of the informal sector is high. This is due to the irregular and unpredictable incomes from the informal sector, the challenge of assessing income levels and collecting the premium contributions from this population group. The burden therefore remains on the formal sector to pay premiums to the SHI to cross subsidize for the rest of the population Evidence indicates that attempts to convince the informal sector to voluntarily join the SHI does not always result in universal coverage and in some cases may be counter effective.

In the Philippines, subsidies were given to cooperative societies to encourage group enrolment. The cooperative societies paid the premiums for their members at the subsidized rates and offered flexible repayment terms for the members. This was found to be effective in scaling up informal sector membership. Furthermore, it was found that a significant proportion of the loans taken by the members are usually medical related. The introduction of the SHI through the micro-finance and cooperative societies was therefore welcomed as it was understood to stand in place of medical loans and offered cheaper and flexible terms (Hsiao and Shaw, 2007). Reduction of premiums was noted to be a counter-effective strategy to incentivise the informal sector in some villages in China (Hsiao, 1995; Carrin, 2000). Rather than increasing voluntary enrolment, the reduced premiums meant that the insurance covers were reduced. The reduction of risk protection meant that people were still exposed to health-related catastrophes therefore the role of the SHI would become redundant.

### **1.3.2 SHI timelines for delivery of UHC**

The timelines taken by SHI models before achieving universal coverage were noted to be quite lengthy. The classic example being Germany, which took in overall a century, before attaining UHC through its SHI. Korea had a way shorter timeline of about 26years through its SHI. This case was different as the country enforced mandatory contributions in the last 11 years before the UHC attainment (Ruyen, 1998). It is important to note that the success of the mandatory contributions policy was unique, as it benefitted from a set of concurrent enabling factors. Korea was at the time experiencing a season of significant economic growth, which led to creation of jobs and improved household revenues, thereby improving the populations capacity to contribute premiums (Carrin, 2002; Ruyen, 1998).

Various studies predict that the timeline may be longer for LMICs, to achieve UHC through SHI, and even so, a series of enabling factors would need to be achieved beforehand. These include significant economic growth leading to increased household incomes and stable economic conditions which would enable the populations to contribute premiums. Furthermore, the proportion of the informal sector would need to be lower and socio-economic inequalities reduced to foster acceptance of cross subsidization (Carrin, 2002).

### **1.3.3 Co-financing strategies in LMICs**

An alternative recourse adopted by some LMICs to tackling the long timelines is co-financing. In Columbia, the government co-financed contributions of the poor and vulnerable, leading to about 75% increased coverage as of 2000. Similarly in Ghana, a proportion of VAT was earmarked as taxes were used to co-finance premiums for the poor and vulnerable and the informal population, leading to 75% coverage as of (Abiiro & Mcintyre, 2012; Suchman et al., 2020). In Thailand, after several attempts to model the SHI to include its informal population and failure of its voluntary scheme, the government resorted to pay premiums for the informal population through general taxes. With this, the country was able to attain UHC (Hsiao, 2007). Other LMICs such as Rwanda, dropped the original SHI model for Community Based Health Insurance (CBHI) (Nyandekwe et al., 2020).

## **Kenya’s Health System**

### **1.4.1 Country profile**

Kenya is a democratic republic located in the Eastern part of the Sub-Saharan Africa. It is a lower middle-income country with a population of approximately 55,864,655 million as of 2019. An estimated 36% of the country’s population live below the $1.90 a day poverty line (World Bank, 2019). Kenya has a devolved governance system; the national government and 47 devolved governments called counties. The county’s health system is equally devolved and comprises of both private and public healthcare. Public healthcare is classified as community healthcare, primary healthcare, county referral and national referral hospitals. The country’s health system is mainly financed through Out-of-Pocket Payments (OPP), being 26% of the country’s health spending. This is followed by the SHI at 17% and Private Health Insurance (PHI) and donor funding at a distant 2% (Okungu et al., 2017). Kenya’s GDP per capita at USD 1,838.21 as of 2020 and a health expenditure of 4.59% of the GDP, being USD 84.4 per capita. The health professional’s density was 0.16 physicians and 1.166 nurses and midwives per 1000 people. Hospital beds were 1.4 units per 1000 population (Barasa et al., 2020).

### **1.4.2 SHI in Kenya-The National Health Insurance Fund (NHIF)**

Since the country attained its independence in 1963, health was mainly financed through tax. However, lack of sufficient resources and economic crises caused austerities in the health sector and the national budget could efficiently fund healthcare for all citizens. The region’s population grew and so did communicable and non-communicable diseases (Carrin et al., 2007). The National Hospital Insurance Fund (NHIF) was enacted in 1966 as a department under the ministry of health (NHIF Act, 1966). Its mandate was to provide a medical insurance scheme for government employees. The NHIF lay dormant for several years, until 2000, when the then president-initiated SHI as a national agenda. This led to several developments and reforms over the last two decades and continues to undergo periodic evaluation and amendments as the country is yet to fully attain UHC (Okungu, 2018; Barasa, 2018).

# **2. RATIONALE FOR THE RESEARCH, AIMS AND OBJECTIVES**

## **2.1 Rationale**

The NHIF, like other SHI models, is employment-based and therefore stratifies the population into either the employed or unemployed. The employment structure in Kenya consists of about 83% of workers from the informal sector and only about 17% from the formal sector (KNBS, 2021). The informal sector is characterized by few to no regulations owing to the irregular and insecure nature of jobs. Most informal income go unaccounted for due to lack of efficient systems and structures to assess informal income (World Bank, 2019). Resultantly, as observed with SHI models in other LMICs, the inclusion of the informal sector into the NHIF has been slow and full of setbacks. NHIF membership in in 2019/2020 was at about 22million, comprised of 9.5million principal contributors and 12.5million dependants. Of the 9.5 principal members, about 49.9% were from the formal sector and barely 50% from the informal sector (KNBS, 2021) implying low coverage from the informal sector.

In 2021, membership to the NHIF was made mandatory to all residents of the country, presumably to compel the inclusion of the informal sector thus drive delivery of UHC. An effective health financing mechanism that intends to deliver UHC should include all citizens through a mechanism that affords them sustainable protection from health-related financial catastrophes (Carrin et al., 2017, WHO, 2000). It is for this reason that the study set out to analyse perceptions and enabling factors of the NHIF policy in Kenya. Kenya’s health financing system has been a subject of many studies, especially with the mounting push to deliver UHC (Okungu et al., 2018; Abuya et al., 2015; Barasa et al., 2018; Carrin et al., 2007;). However, studies to analyse the viability of the NHIF policy to deliver UHC basing on evidence from other LMICs remain scarce.

## **2.2 Research Aim**

The aim of the study was to explore the population’s perceptions and enabling factors of NHIF within the Kenyan context.

## **2.3 Research Objectives**

The objectives of the study were: to review literature on SHI in LMICs and documents on the NHIF policy in Kenya. Then, adopt the Walt & Gilson Policy triangle framework for analysis of the policy. Then collect primary data by conducting interviews with various actors and triangulating these findings alongside the document review. Eventually, draw policy recommendations on the application of SHI in Kenya and other LMICs.

## **2.4 Research Questions**

To achieve its aims, the study sought to answer the following questions:

1. What factors enable enrolment of members from the informal and formal sectors and continuity of contributions to the NHIF?
2. What factors hinder enrolment of members from the informal and formal sectors and continuity of contributions to the NHIF?

# **3. METHODOLOGY**

## **3.1 Conceptual Framework**

This study was based on the Walt and Gilson public health policy triangle. The policy triangle suggests that a comprehensive policy analysis requires an interplay of the context, content, process and actors, and that focussing on only one aspect undermines the complexity of policy making (Walt & Gilson, 1994). This study adopted the policy triangle framework to analyse the content and process of designing, developing and implementing the social health insurance scheme in the Kenyan context while rationalizing the importance of actors’ involvement in policy making. This framework was initially developed for developed countries, and several policy analysis studies have been for developed countries. The concepts of the framework have great relevance for research and policy analysis in developing countries such as Kenya. However, for effective transfer of the concept, as with all other evidence and interventions, the policy environment needed to be contextualized (Walt et al., 2008).

To make the framework more relevant for the study, some adaptations were made to the original framework. The geographical context of the analysis was in Kenya. Buse et al. (2005) define context as a set of complex social, political and economic factors which can be categorized as situational, structural or cultural factors, and which influence health policy. The study based its analysis of the context of the NHIF policy to this definition, and carried out an analysis of how the political, economic, and social contexts influence the health systems financing policy in Kenya. Furthermore, actors’ perceptions and experiences are also variously influenced by these non-geographic factors. The study therefore found it important to sub section the context as afore mentioned, to allow an analysis of the policy and actors perceptions within each context sub section.

The policy process involves “the way in which policies are initiated, developed or formulated, negotiated, communicated, implemented and evaluated” (Buse et al., 2005, p. 13). The NHIF policy did not categorically stem off from an identified problem nor was its formulation and implementation linear. The process analysis applied in this study therefore slightly deviated from the commonly used stages heuristic model (Sabatier and Jenkins-Smith, 1993). Instead, to analysis the NHIF process, the historical account of the NHIF was reviewed, and all significant developments and reforms that the NHIF had undergone since its inception till date were highlighted and presented in a chronological order. This presentation was able to show the various events of the policy process, starting from the era when the NHIF existed but no special attention was given to it, through to when the agenda was set leading to serious reforms and implementation started. The content of the policy was sub sectioned into 3 main categories: premiums collection, benefit packages and the claims/reimbursements.

Finally, the actors were the main subject of the study, as it sought to obtain actors’ perceptions of the policy content (premiums, benefit packages and the NHIF claims procedures) and their interplay with the social, economic, and political context and the policy processes. Despite the proposal of many policy analysis authors to include actors as much as the content in their analysis, most of the focus was on state actors such as the public sector and the politicians involved in running the state. The recent past has seen a major shift in the policy scene, where wider spectrum of actors, including private sector and independent actors, are involved in policy-making processes (Walt et al., 2008; Buse et al., 2005). Though noted as a huge challenge, a comprehensive policy analysis should involve more actor networks and an appreciation of people’s experiences and perspectives, and not strictly a bureaucratic top-down process (Buse et al., 2005). This study attempted to obtain perspectives from an array of actors including national policy experts on matters health systems, private and public service providers, NHIF officials, Ministry of Health (MoH) officials, members of the public drawn from the formal, informal, self-employed and unemployed population groups.

## 

## **3.2 Research design**

The study employed a retrospective analysis of the NHIF and a prospective analysis for the health financing policy. Policy analysis provides an understanding of why and how states and other stakeholders develop various policies, who they are made for, what assumptions are made by the enactment of these policies and their resulting effect on the populations for whom they are made (Browne et al., 2019). A retrospective study was essential to explore how the NHIF policy became an agenda for healthcare financing, how it was initiated, what its contents were and its strengths and failures. A prospective analysis on the other hand was to attempt to predict what the current NHIF policy and future reforms will potentially result in, and thus important for informing policy reforms or state action.

The study employed a relativist research approach. Gilson et al. (2011) propose that relativist approach is a valuable method in health systems and policy research. This research paradigm proposes that human behaviour and perceptions influence health policies, and appreciates that the interaction of actors to manage, deliver or access healthcare is paramount to the success of healthcare systems. A relativist approach studies participants behaviours in their natural environment and acknowledges their interpretation of experiences. In seeking to obtain populations’ perceptions on the NHIF policy, this study engaged with actors, observing their behaviour, conversations and interpretation of their lived experiences as shared through the interviews.

**3.3 Data collection**

The study data was collected through document reviews and in-depth interviews.

### **3.3.1 Document review**

A general google search was done to identify documents to be included in the review. Key words included Social Health Insurance in Kenya, National Health Insurance (NHIF) reforms, national health policy. The search yielded several documents including Acts of Parliament, policy briefs done by various organizations and government agencies. A further search was conducted into the Ministry of Health and NHIF websites where various reports and guidance documents were obtained. The full list of documents reviewed in in Table1 below.

Table : List of Documents Reviewed

|  |  |
| --- | --- |
| Item | Title |
| 1 | National Health Insurance Act 2012 |
| 2 | NHIF Universal Health Coverage |
| 3 | NHIF Amendment Act 2022 |
| 4 | Civil Servants Medical Insurance Scheme Handbook |
| 5 | Historical Account of NHIF formulation in Kenya |
| 6 | NHIF Financing Reform in Kenya |
| 7 | NHIF plays a major role In Social Health Protection through Subsidy Programs for UHC |
| 8 | NATIONAL SOCIAL HEALTH INSURANCE STRATEGY Findings and recommendations of the joint WHO/GTZ mission on Social Health Insurance in Kenya June 28-August 8, 2003 |
| 9 | SENSITIZATION ON THE COMPREHENSIVE MEDICAL INSURANCE SCHEME FOR NATIONAL POLICE SERVICE & KENYA PRISONS SERVICE MEDICAL CONTRACT 2021/2022FY |
| 10 | SESSIONAL PAPER N°·2 ·. on National Social Health Insurance in Kenya April, 2004 |
| 11 | Kenya Universal Health Coverage Policy 2020 – 2030 |
| 12 | Kenya National Hospital Insurance Fund Reforms: Implications and Lessons for Universal Health Coverage |
| 13 | Health financing reform in Kenya – assessing the social health insurance proposal |

### **3.3.2 Interviews**

A total of 21 interviews were conducted for this study. Interviews were conducted online via zoom and telephone conversations in July 2022. To recruit the study participants, purposive sampling was applied. A google search of national health systems experts was done and various names noted. Their profiles were reviewed on various organizations websites and on LinkedIn. This was to particularly find out about their engagement with the NHIF policy process. A generic email or LinkedIn message was sent to potential respondents to brief them about the research and request their participation (copy attached as Appendix 1).

Many targeted respondents did not respond to the invitation therefore they could not be included in the study. Some responded to the affirmative, but due to their busy schedules the researcher was not able to get a time slot within the allocated interview timeline. For those who responded within the interview timeline, formal emails were written, information sheet and consent forms sent, and the interviews scheduled at the respondents’ convenient date and time. 14 key respondents were obtained through this process and the rest of the respondents were obtained through snowball sampling.

A semi structured interview guide was developed basing on the adapted policy triangle framework. Guiding questions were asked under the various categories of the policy triangle framework. On the policy process, the questions sought to know about the actors’ involvement in the NHIF policy process, and their views regarding how the policy was initiated, developed, communicated, and implemented. For the context analysis, questions were asked regarding the actors’ views on how the political, social, and economic contexts influence the NHIF health financing policy, and the practicability of its application within the said contexts. For the content analysis, questions were asked on various sub-contents of the policy such as the claims process, issues regarding premium contribution and benefit packages. Additional questions were asked around the use of evidence in the formulation and implementation of the NHIF policy, and the enablers and disablers of the policy. (A generic interview guide is attached as Appendix 2).

Interviews were conducted in English except for 2 participants who were not able to communicate in English due to their education backgrounds. The interviews were on average 40mins each and were recorded using an end-to-end encrypted audio-recorder. The researcher periodically reviewed and reworded the interview guide to include emerging themes requiring further discussion. When there seemed to be no more new information coming, the researcher assumed a saturation point and data collection through interviews was stopped (Saunders et al., 2017).

### **3.3.3 Research Ethics**

In compliance with the QMUL requirement for conducting primary research, an application for ethics approval was submitted to the QMUL Ethics Committee, together with the information sheet and consent form. The study was low risk and did not require the ethics committee to convene. After some fast-tracking, an approval was obtained, reference number QMERC22.151 (copy attached in appendix 3). Simultaneously, an application for research approval was made to the Kenya National Commission for Science, Technology and Innovation (NACOSTI) Research Licensing Board. Research approval was obtained license number: NACOSTI/P/22/16580 (Research License in Appendix 4).

## **3.4 Data Analysis**

The study employed the thematic approach to data analysis (Kiger & Varpio, 2020). The audio recordings were transcribed using the Ms word Voice typing app. Data were organized on an excel sheet and coded. Themes and sub-themes were then identified and organized into columns. Responses were then assigned to the various columns and additional columns created as more themes were identified. Themes were color-coded to represent either interview data or document reviews. Common themes emerging from both data sets were triangulated alongside one another. This was particularly important to compare the findings from the interviews with the document reviews, thereby increasing the strength and quality of the evidence. New themes observed from either data sets were independently analysed. Analysis was done according to the research objectives stated.

Table : List of themes identified in the policy analysis

From document reviews:

* Improved coverage and access to healthcare
* Informal sector enrolment
* Regressive system
* Financial consequences; fines
* Political goodwill or/and lack of
* Corruption and embezzlement of funds
* Inequality in access to healthcare
* Subsidies for the poor and vulnerable
* Enhanced schemes for some occupation groups

From interviews:

* Poverty, unemployment and irregular informal incomes
* Misunderstanding about the SHI concept
* Lack of communication; little engagement with stakeholders
* Fraud; kickbacks
* Fines for defaulting payments
* Inequality in access to healthcare
* Improved coverage and access to healthcare
* Subsidy for the poor and vulnerable
* Enhanced schemes for some occupation groups

# **4. FINDINGS**

This section jointly presents the findings obtained from both the documents review and interview data. The triangulation of the findings from document reviews alongside those obtained from interview data served to strengthen the quality of the evidence. However, the small number of interviews (21) was a major limitation for the study, thus limiting the validity of the evidence. Further research may be considered before the application of these findings. Nonetheless, the findings of the policy analysis are reliable and an important addition to the body of knowledge on SHI in LMICs. The findings are organized around the policy triangle framework, beginning with the process, then the policy content, thereafter, followed by the context and lastly actors’ analysis.

## **4.1 PROCESSES**

Since its inception in 1966, the NHIF has undergone a myriad of reforms. This section presents a historical review of the NHIF, highlighting the significant reforms that the fund has undergone.

The first most notable reform was the invitation of the public to membership. Before then, membership had been a reserve of government employees only. Though open to the public, the fund was still run as a welfare department under the ministry of health, which meant that it lacked the desired efficiency and accountability. Soon after, the NHIF was restructured and made a state corporation. These steps were significant in converting the NHIF into a national scheme, accessible to any and every resident of the country who registers. At this point, a standard contribution was paid by all members irrespective of their employment status, income or employer. At this point the NHIF had an aspect of equality, despite the financial pool being too inadequate to supply quality healthcare for all.

Two decades later, a graduated scale system of contribution was introduced. However, this only applied to the formal sector whose salaries are processed through a payroll system. This was meant to increase the contributions whereby the highest salary scales paid the highest contribution. The downside to it was that it created a further rift between the formal and informal workers with regards to participation in the scheme. The graduated scale system meant that a formally employed worker was compelled to contribute a certain amount of premiums whereas an informal worker was not compelled regardless of their income. Like other LMICs , the optional clause caused reluctance in enrolment by informal sector workers, a status quo which remined until 2021, when NHIF was made mandatory for all residents of the country.

**SHI Agenda Setting**

The millennium saw the inception of national discussions on health insurance, with the then president giving a directive to cabinet ministers to find measures of introducing a mandatory Social Health Insurance System for all Kenyans. Before then, there were user fees paid by patients at the points of accessing healthcare services. The idea of having a SHIS in the country was born out of the idea to pre-collect the user fee way before it is needed at the point of service, by way of paying regular premiums. This was not to be a brand-new concept as the NHIF already existed. However, the SHIS was a more intentional and enhanced version of the NHIF. This was not to be a straightforward task and the country sought technical support from the WHO to assess the reports, provisions, and processes of the conversion of the NHIF to a SHIS. Six WHO missions latter, a myriad of recommendations and the bill passed in parliament, the then president declined to assent it to law citing affordability, technical and sustainability concerns.

At the time, NHIF reported corruption scandals with huge amounts of the fund lost, poor management and misappropriation causing only 22% benefit pay-out, 25% administrative costs and 53% on projects such as the NHIF headquarters (IFC,2011). An assessment into the performance of NHIF five years later reported consistently low coverage and inefficiency of the fund, citing 45% pay out to administrative costs and only 55% to healthcare. The commission recommended reforms in efficiency, effectiveness, financial sustainability, governance and policy and regulation. The decline of presidential assent to the healthcare bill 5years prior reflected the level of political influence that the country’s healthcare is subject to, and which set the pace not only for the NHIF reforms but every healthcare reforms. The report of the assessment 5years later proved that it may take a long time for concerns such as sustainability and affordability to be resolved. However, political goodwill and small steps in the right direction would be essential in reforming the country’s healthcare policy.

In 2018, the sitting president re-introduced NHIF to the national agenda when he declared UHC as one of his big four deliverables during his tenure and fronted the NHIF as the main vehicle to be used to deliver UHC. This declaration was accompanied by a significant level of political goodwill that saw several reforms made and implemented to the NHIF. In overall, the NHIF has progressively transformed over the years, significantly increasing coverage and access to affordable healthcare. Political goodwill and good leadership were especially found to be essential for effective health policy reforms in the country.

*“A Social Health Insurance is necessary. It is the only way through which our country can make sure we have UHC…as a country, we need to make that decision and, in a way, make it happen.”* Respondent 2

Table : Major NHIF reforms from inception to date

|  |  |
| --- | --- |
| Year | Occurrence |
| 1966 | The National Hospital Insurance Fund (NHIF) was established as a department under the Ministry of health with the mandate to provide a contributory hospital cover for every formally employed citizens earning more than Kes 1000=$10. |
| 1972 | Voluntary contribution to the fund was open to members of the informal sector and those earning below Kes 1000=$10. |
| 1989 | A healthcare cost-sharing system was introduced in the form of user fees. These were soon after abolished in 1990 due to concerns and lobbies on social justice. The national budget was critically constrained and could not single headedly finance the county’s health. This led to user fees being re-introduced in 1992. |
| 1990 | a graduated scale contribution system was introduced, and minimum salary subject to contribution was capped at Kes 15,000=$150. This increased the amount of contributions with the lowest being Kes 30=$0.3 and the highest being Kes 320=$3.20 |
| 1998 | The 1966 NHIF Act which made the fund a department under the MOH was repealed and the fund was reinstated to an autonomous state corporation under the NHIF Act of 1998. The aim of this change was to improve the efficiency and relevance of the fund. |
| 2001 | The idea of a SHIF was hatched with a strategy of pre-collecting the out-of-pocket user fees before the need for use arises. The president gave a directive to cabinet ministers to find measures of introducing a mandatory Social Health Insurance System for all Kenyans. |
| 2003 | The Economic Recovery Strategy (ERS) for Wealth and Employment Creation was adopted. Its agenda was to transform the existing NHIF to a NSHIF. Having receive the report from the assigned taskforce, the MOH approached the WHO/GTZ for technical support to establish a SHIF. |
| 2003-4 | 6 expert missions reviewed, suggested amendments, and trained on the proposed mandatory SHIF. The bill was discussed and passed by parliament at the end of 2004. However, the presidential assent was declined citing affordability, sustainability, and technical concerns. |
| 2015 | The NHIF revised the monthly contribution rates for the national scheme and expanded the benefit package. Up until then, the lowest contribution graduated on salary scales was Kes 30=$0.3 and the highest Kes 320=$3.20. This revision caused an increase of 400% and 431%, and 213% for the lowest and highest, and the informal sector premiums respectively. |
| 2018 | Kenya embarked on a journey to deliver UHC by 2022. This was championed by the president under his big 4 national Agenda. NHIF chosen as the financing mechanism to deliver UHC. |
| 2021 | Parliament passes a bill to make NHIF mandatory for all citizens. |

“*The Bill, which is now awaiting Presidential assent to become law, provides the necessary legal framework for the attainment of Universal Health Coverage (UHC). Accelerating the attainment of UHC is one of the best gifts the legislators could have given their electorate coming at a time when the world is battling Covid-19”* (Cabinet Secretary for Health; People’s daily newspaper).

## **4.2 POLICY CONTENTS**

A review of the NHIF policy content found three broad and distinct but interdependent components namely, premium contributions, benefit packages and claims/reimbursement.

### **4.2.1 NHIF Premium Contributions**

The NHIF was initially meant for employees of the formal sector but was later opened on voluntary basis to the informal sector and the public, and eventually made mandatory for all Kenyans above 18years. Membership is by registration and an NHIF card is issued. Dependants are limited to nuclear family including one declared spouse, biological and adopted children where document evidence is issued. A review of the premiums component of the policy identified inefficiency in engagement and communication with the public, regressivity of the contribution system and stringent consequences to non-compliance. The multi-functional aspect of the NHIF was also found to potentially brew conflict of interest with could lead to privatization of the fund and resultantly increase inequality in accessing healthcare in the country. One main contribution of the scheme was the involvement with the national government to provide coverage for the vulnerable population groups.

#### **4.2.2.1 Insufficient engagement and communication**

The review found gaps in populations engagement in the development and implementation of the NHIF policy. For members employed in the formal sector, premiums are contributed to the fund as a statutory deduction from employee salaries on a graduated scale. All employers have a statutory mandate to deduct the appropriate premiums from their employees and to remit them before the 9th of each month. This regulation made membership to the NHIF more obligatory to the formal sector. However, some formally employed citizens, though members of the fund for years, do not actually understand the concept of social health insurance and therefore do not appreciate this deduction from their salary.

*“That (SHI) is not justifiable. We pay taxes to the government, which should be able to budget for health. Why should we again be deducted-it’s like taxing again. It doesn’t make sense that on top of the tax which you Pay As You Earn, they deduct NHIF from our salaries to pay for other people.”* Respondent 11

Some employees within the formal sector who understood the SHI concept pegged it to their employer’s own initiative to train staff. Co-production, especially with the general population was found to be widely lacking as members felt like the NHIF policy is imposed on them.

*“Staff used to complain about the deduction until one time my employer invited an NHIF staff who came and taught us about the benefits of NHIF. Since then, I understand why I have to pay NHIF. I am unemployed at the moment but I still make sure to pay the KES 500 every month.”* Respondent 13

#### **4.2.1.2 Regressive System**

Additionally, the graduated scale payment system was found to be regressive. Those with lower incomes ended up paying a higher percentage of their incomes to the fund than those in higher salary scales. A regressive system increases the poverty gap in the country. For the case on NHIF premiums, a member earning KES 15000 and paying KES 500 to NHIF contributes 3.3% of their monthly income whereas one earning KES 100,000 and contributes KES 1700 contributes half as much (1.7%) of their income. Furthermore, the NHIF Amendment bill, 2021 mandates employers to top up premiums for their respective employees whose earnings do not qualify for a deduction of the KES 500 ($5) base premium contribution. However, no such provision was made for members of the informal sector who more often than most fall in the lower pay categories. While the graduated payment system is regressive for all members, those in the formal sector are fairly cushioned by the new bill. The review found this aspect of the policy content non-inclusive and inconsiderate of the informal and unemployed population and inconsistent with the ideals of a SHIS.

Table : NHIF premiums salary graduated scale (Before and after reforms)

|  |  |  |  |
| --- | --- | --- | --- |
| Sector | Salary Scale | Monthly Contribution 1990-2015 | Monthly Contribution 2015-Date |
| Formal Sector Employees | KES 1,000-5999 ($10-59) | KES 30-120 ($0.30-1.20) | KES 150 ($1.50) |
| KES 6,000-7999 ($60-79) | KES 140-160 ($1.40-1.60) | KES 300 ($3) |
| KES 8,000-11,999 ($80-119) | KES 180-240 ($1.80-2.40) | KES 400 ($4) |
| KES 12,000-14,999 ($120-149) | KES 260-300 ($2.60-30) | KES 500 ($5) |
| KES 15,000-19,000 ($150-190) | KES 320 ($3.20) | KES 600 ($6) |
| KES 20,000-24,999 ($200-249.99) | KES 750 ($7.50) |
| KES 25,000-29,999 ($250-299.99) | KES 850 ($8.50) |
| KES 30,000-34,999 ($300-349.99) | KES 900 ($9) |
| KES 35,000-39,999 ($350-399.99) | KES 950 ($95) |
| KES 40,000-44,999 ($400-449.99) | KES 1,000 ($100) |
| KES 45,000-49,999 ($450-499.99) | KES 1,100 ($110) |
| KES 50,000-59,999 ($500-599.99) | KES 1,200 ($120) |
| KES 60,000-69,999 ($600-699.99) | KES 1,300 ($130) |
| KES 70,000-79,999 ($700-799.99) | KES 1,400 ($140) |
| KES 80,000-84,999 ($800-849.99) | KES 1,500 ($150) |
| KES 90,000-99,999 ($900-999.99) | KES 1,600 ($160) |
| KES 100,000 ($1,000) and above | KES 1,700 ($170) |
| Informal Sector | Flat rate for all salaries/wages for workers, self-employed and unemployed members | KES 160 ($1.60) | KES 500 ($5) |

#### **4.2.1.3 Tough financial consequences**

A fine of 50% of the premium amount is imposed on members who do not remit their full premium by the 9th of every month. While this policy may encourage consistency in payment, the review found that it was favourable to and seemed to be structured for the formal sector only. The structure of the formal sector in Kenya is that employees are certain to get a salary at every end of month. Moreover, premiums in the formal sector are deducted at source therefore any liabilities on non-payment or late payment of NHIF premiums would fall on the employer.

Inversely, in the informal sector and the unemployed population, incomes are extremely unpredictable and unreliable and mostly received as small wages as and when work is done. Such income is difficult to accumulate, budget with or manage, especially when there are more immediate basic needs to meet. The review found the fines to be very costly and demoralizing especially for most of the informal sector population who live from hand to mouth. Furthermore, the conditionality to pay up the defaulted premiums plus all accrued fines before accessing healthcare without possibly considering the reasons for defaulting or state of the patient was found to contravene the whole logic around social health insurance and provision of accessible healthcare for all.

*“…Sometimes when you can’t afford it and you miss some months, and you go to the hospital critically ill, you cannot be seen until you pay all the months that you missed plus all the fines.”* Respondent 14

#### **4.2.1.4 Supplementary Schemes**

The review found several enhanced schemes under NHIF covering various occupational groups. Under the NHIF enhanced schemes, employers pay extra premiums beyond their employees’ individual NHIF contributions in exchange for lucrative medical benefit packages and options of facilities from which members can access healthcare. Under this category, the NHIF was found to be the best insurer in the country, providing lucrative packages and services ranking higher than all other private medical insurers in the country. A quick comparison to the benefit packages and services offered on the national scheme, which is the social health insurance scheme and the main function of the NHIF found significant variations in member benefits, payment types and accessible facilities.

While the enhanced schemes promote enrolment and therefore increase the resource pool, the review found it to present potentially big challenges to the fund. First, running parallel schemes presents a potential for competition between the enhanced schemes, which could result in neglecting the national scheme. Secondly, the review found that for the enhanced schemes propelled inequity through the comprehensive covers which were way better than the national cover. Given the significant difference between the covers, including air ambulance and foreign treatment, the review observed that cross subsidization would be harder thus failing to promote equity in accessing healthcare. Finally, the review observed that running the schemes in parallel puts the fund at risk of huge inefficiencies such as misappropriation of payments, misallocating reimbursements and registration of members in multiple schemes.

Table : Other NHIF Insurance Schemes/Enhanced Covers

|  |  |  |
| --- | --- | --- |
| Insurance Scheme | Beneficiaries | Mode of payment of premiums |
| National Scheme, dubbed Supa Cover | This is open to every resident of the country and their dependants. Members pay at-least the base monthly premium:  Members include:  Formal sector employees who are not signed to an enhanced scheme.  Informal sector employees  Unemployed residents | Deducted at source for formal employees.  Previously voluntary, now made mandatory for informal sector workers. |
| Civil Servants’ Scheme | Civil servants and their dependants (One declared spouse and up to children of ages 0-21years and up to 25y/o if in fulltime formal education. | Monthly NHIF deductions are made by employers and remitted. An additional amount agreed between the employer and NHIF under the enhanced medical insurance scheme is also paid. |
| County Government Scheme | Employees of county governments which have contracted NHIF to provide medical cover, and their dependants (One declared spouse and up to 5 children of ages 0-21years and up to 25y/o if in fulltime formal education. | Monthly NHIF deductions are made by employers and remitted. An additional amount agreed between the employer and NHIF under the enhanced medical insurance scheme is also paid. |
| Government Parastatals | Employees of government parastatals which have contracted NHIF to provide medical cover, and their dependants (One declared spouse and up to 5 children of ages 0-21years and up to 25y/o if in fulltime formal education. | Monthly NHIF deductions are made by employers and remitted. An additional amount agreed between the employer and NHIF under the enhanced medical insurance scheme is also paid. |
| National police and Prisons service | Members of the national police and prisons service, and their dependants (One declared spouse and up to 5 children of ages 0-21years and up to 25y/o if in fulltime formal education. | Monthly NHIF deductions are made by employers and remitted. An additional amount agreed between the employer and NHIF under the enhanced medical insurance scheme is also paid. |
| EduAfya Scheme | All students in public secondary schools registered under the National Education Management Information System (NEMIS). | Ministry of Education contracted NHIF to provide medical cover. The students do not contribute. |
| Health Insurance Subsidy for the Poor [HISP] Scheme | Households of the indigents, older persons and the disabled in Kenya. | Premiums are fully subsidized by the government and through donor support. |
| Linda Mama Free Maternity Scheme | All pregnant women who are residents of the country, expires 6 months after delivery and covers the babies till age 5. | National budget expenditure. Free for all users. |

#### **4.2.1.5 Subsidized schemes**

Different from the enhanced schemes, are the tax-funded subsidized schemes to cover the vulnerable in the population (last 2 columns on of the table above). These include pregnant women and children below 5years and the poorest in the population. These covers were noted to have made healthcare a lot more affordable and accessible to the country’s poor and vulnerable, reflecting the state’s effort and ability to support the social health insurance course to deliver equitable healthcare to all citizens. However, these subsidy schemes did not cover all the poor and vulnerable indicating that healthcare still remains unaffordable to a significant proportion of the population.

*“The government through the exchequer paid NHIF for about 1million poor and vulnerable families during the last financial year. It is a tax-funded NHIF. These people do not themselves pay premiums to NHIF, but they get the same benefit cover as the National Scheme.”* Respondent 1

Further to the subsidized cover, the review found the EduAfya scheme to be an effective strategy to expanding coverage. This scheme is funded by the ministry of education to pay premiums and thereby provide health covers to all students in public secondary schools in the country for the period that they remain registered as active students. Such coordination between functions of the government was found to be a potentially effective way to scale up membership of the NHIF and ensure all population groups are covered, especially those in the informal sector.

### **4.2.2 NHIF Benefit Packages**

As mentioned above, members registered under various premium covers access varied benefit packages and access healthcare from varied facility options. Benefits under the enhanced covers are way more than those under the national scheme, and include but not limited to dental, optical, air ambulance services and in some cases foreign treatment. The review of the benefit packages found concerns on equity and inequality of healthcare access as discussed in the previous section, limited outpatient coverage for the national scheme, and long administrative approvals for already listed benefits.

#### **4.2.2.1 Limited outpatient coverage**

The national package was found to be very limited in its outpatient package. Members expressed dissatisfaction in the outpatient services offered to them despite contributing premiums consistently and argued that comprehensive service should be the least reward for their consistent participation and contribution.

The review observed that the informal and the unemployed population were at most disadvantaged by the limited outpatient coverage. This is because unlike other formal government or private employees who have additional private insurance or enhanced schemes with the NHIF. Furthermore, for most low-income members, paying NHIF premiums and further having to pay out of pocket to receive some healthcare service was demotivating.

*“NHIF has not helped me, yet I have contributed for 6 years consecutively now. Twice I needed a tooth filling, NHIF could not cover for my filling and I had to pay cash. So what is the point of paying NHIF”* Respondent 9

#### **4.2.2.2 Administrative approvals**

Services such as radiology, oncology, renal dialysis, and kidney transplant, though listed under the benefit packages, require pre-authorization from the NHIF before the services are delivered. This was found to delay timely access to healthcare and the waiting time pauses a risk of fatalities such as death where emergency services were required. For many, members end up paying out of pocket despite having contributed premium consistently.

*“Users do not know when or where to present their issues, especially when they can’t access the services that ought to be covered. Some services require too many administrative approvals to be provided, and many patients end up dying while waiting.* Respondent 4

*“With the national police service, I had an enhanced cover which covers for dental but I could not get a filling because they had to seek approval. Imagine being in pain for 3 days. I had to pay cash because the pain could not have me wait for approval from NHIF.”* Respondent 10

### **4.2.3 Claims & Reimbursements/ Purchasing Role of the NHIF**

Payment for healthcare services from facilities contracted by NHIF is by a reimbursement system whereby facilities make claims to NHIF through a claim’s procedure. The analysis into the claims and reimbursement procedure unveiled a number of issues around bureaucracy and fraud in the NHIF, facilities failing to claim reimbursements due to lack of knowhow and the purchasing function of the NHIF.

#### **4.2.3.1 Non-claims**

The claims procedure involved filling up a claims form and attaching various evidential documents such as patient’s identity card, patient’s date of admission and discharge, the invoice for the services offered among others. The review found that some facilities, especially the small public healthcare facilities, do not always claim for services. This could be due to negligence of the hospitals administration or a training gap. Failure to claim means that the facility do not get reimbursed for equipment, drugs or administrative expenses, which ultimately compromises the quality of healthcare offered to people.

*“Some facilities do not even claim for that money because they don’t even know how to. Sometimes it is ignorance on the part of the administrators, sometimes it is lack of knowhow by the hospital clerks because NHIF has a lot of paperwork and if you don’t do it properly you don’t get the funds.”* Respondent 6

#### **4.2.3.2 Bureaucracy & Fraud**

Stakeholders review of the system cited claims of bureaucracy and fraud in the claims and reimbursement process. There were claims of some healthcare providers defrauding the NHIF by claiming for services that they have not actually done. This claim

*“Some providers claim that they have done surgeries that they have not done and the documents are doctored in a way to show that they provided a service that indeed they did not provide.”* Respondent 1

The fraud was found to be furthermore multiplied by claims of NHIF staff colluding with providers to obtain funds.

*“NHIF colluding with the providers to give kickbacks when they are paying for claims. People create bureaucracies within the system, or they make it difficult to investigate that quality in a way that makes it easy to collude with those providers.”* Respondent 1

In public hospitals where the facility administration would not often give the kickbacks, reimbursement process found to be very frustrating for the facilities.

*“Reimbursement for services is very frustrating for public hospitals especially. They know that this is government to government, so the attitude is like why should the government give to the government?*” Respondent 6

#### **4.2.3.3 The Purchasing Function of the Central Pool**

The NHIF is the biggest finance pool and purchaser of healthcare in the country. The review found concerns about impartiality of the fund in purchasing healthcare services. NHIF was found to pay more to private than public facilities. Private hospitals were therefore found to be a preference for many because patients are assured of efficiency and quality. In the contrary, due to the insufficient or low purchasing power, public hospitals were found to be left without supplies, staff demotivated and ultimately compromising healthcare services given to patients.

*“The reimbursement rules are not aligned with sustainable UHC as there has to be changes in other factors to make healthcare providers be able to provide quality healthcare at the reimbursement rates provided for in the Act.”* Respondent 3

*“I work in a very resource poor setting, but patients that I see are registered with NHIF, yet I as a provider, do not have even the most basic of drug like Iv or paracetamol.”* Respondent 7

The fraud and corruption claims, and the imbalance of the NHIF purchasing power between the private and public facilities pointed to conflicting interests in the operations of the fund. This cast mistrust and questions as to the viability, efficiency and sustainability of the NHIF in playing both the resource pooling and purchasing role.

## **4.3 POLICY CONTEXT**

### **4.3.1 Socio-cultural Context**

The review found that the health insurance concept remains a foreign concept to some population groups. Various cultural and religious beliefs hinder engagement with health insurance, with some believing that insuring oneself against health is like pre-empting illness and therefore culturally unacceptable. Religious beliefs also played part in hindering enrolment. Members of various religious groups attribute good health to being a blessing and an advance insurance from God, therefore find no need to pay premiums.

*“They do not believe in waiting for sickness, so when paying for insurance yet they are well, they ask if you are waiting/intending for them to get sick. They do not see the need. They cannot accept”* Respondent 7

*“The Lord already paid for my health in advance, He covers me and my children. I have 8 children and truly God has kept us all in good health.”* Respondent 15

While social structures such as cultures and religious beliefs take time to change, repetitive education and lobbying on risk protection would lead to progressive change and better populations engagement with the social health insurance.

### **4.3.2 Political Context**

The state regulates the NHIF and the politicians and leaders in powerful positions majorly influence the health policy making in the country. The review found that the political environment and the leaders in positions of political power especially have big influence on the healthcare financing policies. Many political pronouncements were noted to be made during campaigns and in order to lure votes but were not fulfilled post elections. Some political pronouncements were found to negatively influence the public whereby in wanting to please the public, politicians promised free to cheap premiums which would mean that provision of services is compromised. Unfortunately, the unknowing public would trust the politician and blame facilities when they are underserviced.

*“As we witness now in the political scenes, many politicians are promising affordable healthcare to be elected, but once in office, nothing happens.. there is need for political goodwill.”* Respondent 4

An assessment of the major enablers of NHIF from key stakeholders viewpoints indicated: the constitution of Kenya 2010, the President’s Big4Agenda, Vision 2030, and the Health Act 2017; all of which are acts of parliament. Political goodwill was therefore found to be particularly essential for the formulation, development, and successful implementation of the NHIF policy.

### **4.3.3 Economic Context**

The review of the economic context found a number of factors challenging the success of the NHIF. Poverty and unemployment, challenges of the informal sector, corruption and embezzlement of funds were factors found to highly influence the formulation, implementation, and success of the policy.

Poverty and unemployment continue to be a big hindrance to developing an affordable and sustainable health system in Kenya where 37% of the population live below the poverty line as of 2021 (World Bank, 2021) while unemployment rates stand at 10.4%. Furthermore, the lack of regulation and clear structures in the informal sector was found to influence the performance of individuals. Unlike in the formal sector where premiums are deducted at source, the informal workers income is received by the individuals directly and the people themselves chose to pay the premiums, therefore the amendment seemed to lack practicality. Due to the low economic statuses and the void of proper structures or incentives to encourage and ensure regular payment of premiums, many members of the informal sector observed health insurance as a secondary need thus not prioritized.

*“I have so many more immediate needs that I cannot afford to save that KES 500 every month to pay NHIF.”* Respondent 14

Health does not always present as an immediate need despite the poor health states experienced especially in poor resourced countries such as Kenya. Despite the predisposition, the poor who are most vulnerable to disease as evidenced by the health disparities between the poor and the rich end up needing access to healthcare even more.

The review found that this dilemma of not being able to afford premiums causes some members of the public to pay premiums only when they need to access healthcare and stop immediately afterwards. Some members of the informal sector though able to afford regular premiums, also misused this gap and defrauded the fund in the same way thereby making the fund unstable and unsustainable. To curb this, the fund introduced a waiting period of 3 months before which a member can access healthcare using NHIF services.

*“NHIF Act having been amended to require a waiting period for claims is now more aligned with the fact that majority of the targeted pool is from the informal sector. Before, informal sector subscribers would only pay NHIF when they know they’ll need healthcare and stop paying after they received care, which would make the fund unsustainable.”* Respondent 3

The review found that though appropriate for the members of the informal sector who intentionally defraud the system, the restriction was not consistent with social justice, especially for the indigents. Verification of informal incomes was found to be a persistent challenge requiring grassroot structures and increased administrative efficiency.

The newest reform to the NHIF was the introduction of mandatory enrolment for all citizens. Given the above discussed economic hurdles, the review found this policy to be untimely, and without the enabling economic and structural enabling factors that would propel its success.

## **4.4 ACTORS**

The NHIF policy affects every resident of the country including include politicians, the state, ministry of health, policy experts and the general population. The review found politicians and the state to be the biggest influence, given that all reforms had to be tabled in parliament, passed and accorded presidential assent. Political interference, conflict of interest and lack of political goodwill were cited from the review of the NHIF.

“…*But this is a decision that can only be made politically and people committing to it. Unfortunately, we have not really put money where our mouth is for now it’s mainly all talk about UHC*" Respondent 2

The review also revealed a gap in the engagement and communication with other relevant stakeholders. Actors involved in the NHIF policy. revealed a huge lack of engagement with relevant stakeholders and in some instances where they were engaged, suggestions were either shelved or not passed in parliament.

*“We gave comments and suggestions which were not taken into account.” Respondent 2*

*“Even though stakeholders are often involved in drafting and reviewing the policies, there is always limited time for participation, and sometimes zero involvement of the public..In some instances where this is done, the policies end up in shelves.”* Respondent 4

# **5. DISCUSSION**

This section begins with a summary of the finds, followed by the interpretation of the same. The final part of this sections provides alternative options and recommendations for policy and further research.

## **5.1 Summary of findings**

This policy analysis found that in general, the NHIF made healthcare more accessible and affordable to the country’s population. Whereas the subsidy schemes were noted to promote equity in healthcare, the enhanced schemes counteracted this by segregating the health benefits offered based on occupational groups. The salary graduated scale for collection of premiums was noted to be highly regressive and the financial consequences placed on defaulting payments was found to be especially harsh and inconsiderate to the informal sector workers and the unemployed whose incomes are usually irregular and unpredictable. The outpatient benefit package for the national scheme and the subsidy scheme was noted to be limited, leading to continued use of OPP among the informal workers who in many cases do not have alternative insurance.

The claims procedure and the purchasing function of the NHIF was found to be marred with claims of fraud, bureaucracy, competition between the private and public facilities and excessive administrative processes, reflecting the NHIF as inefficient and ineffective in justly carrying out its mandate. In the structural context, political goodwill and interference, poverty, and economic strains and social beliefs were found to influence the acceptance and success of the health financing policy. Inclusion of the informal sector into the fund was noted to be the biggest challenge of the NHIF, leading to the latest reform which made NHIF mandatory. The review found this policy to be very untimely, with foreseeable unintended consequences. As for the actors, the state and the politicians in power were found to have the biggest influence on the NHIF policy reforms and implementation. It was noted as a matter of concern that stakeholders were not adequately engaged in the NHIF policy processes, and communication on the contents of the NHIF policy to the public was equally inadequate. Political goodwill was found to particularly essential for the success of healthcare financing policy.

## **5.2 Interpretation of findings**

Like many other LMICs that tried to adopt the SHI model for the delivery of UHC, Kenya continues to fall short of the UHC target. This discussion argues that the SHI model has potential to surely increase coverage and access to affordable healthcare. However, it has ingrained limitations which hinder universal coverage, especially in LMICs whose employment structure and dependency ratio is skewed. The NHIF, like all SHI systems was built to be occupational and payroll based, where premium deductions are made at source. This implies that the SHI model was built for such formal population, in which it would achieve its full potential to deliver UHC. Unfortunately, this is far from the reality of the employment structure in Kenya, where the employed population is majorly from the informal sector (KNBS, 2021).

Inclusion of the informal sector workers and the unemployed population into the NHIF has been the biggest challenge for Kenya, as in other LMICs previously discussed. In 2021, Kenya resorted to tackle this challenge by making membership to NHIF mandatory to all, including the informal sector workers and the unemployed. No specific guidelines or structures were put in place to assess the informal income to distinguish those who can afford it from the indigents. There were no structures developed to promote the populations capacity to contribute premiums. Evidence suggests that successful application of mandatory contributions need to be accompanied by enabling factors such as significant economic growth and increased household revenues, job creation and a reduction of the informal sector population as was in Korea (Ruyen, 1998).

Contrary to this, the mandatory contribution was introduced in Kenya at a time when the country was adverse effects of the Covid 19 pandemic which saw a great reduction in economic productivity, leading to loss of jobs (both formal and informal) and increased poverty levels (KNBS, 2021). In addition, the financial consequences for defaulting or irregular payment are unjust where an assessment of financial ability to comply is not done. This policy aspect therefore introduces a case of gross social suffering, whereby institutions and policies that were developed to alleviate populations suffering by providing protection from health-related catastrophes, may end up causing more suffering to the population (Kleinman, 1997). The NHIF being payroll based with deductions done at source automatically shields the formal sector from such consequential suffering. Resultantly, inequality in the access to healthcare is propelled.

The compulsory NHIF policy reform, being the latest attempt at including the informal sector, may be a temporary solution for upscaling coverage as people may initially react by enrolling in order to comply. However, ensuring sustainability and regular remission of premiums will be extremely difficult, especially if the economic conditions remain constant. In the long run, it may lead to unintended consequences (Merton, 1936) such as increased member fall-out, increased inequality in healthcare access and continued OPPs by the informal sector population, resulting in low economic statuses and poverty traps.

Until the employment structure and economic conditions improve in Kenya, NHIF’s goal to deliver universal coverage remains only a distant desire. To fast-track the timeline, the government would have to co-finance the NHIF by supplementing member contributions with general and earmarked taxes (Hsiao, 2007; Abiiro & Mcintyre, 2012). Only two NHIF schemes are currently financed by general taxes in Kenya: the poor and vulnerable and the maternity schemes. The former has a target to cover up to the poorest 10% in the country. For a country where over 30% of the population lives below the poverty line, this target falls far short and leaves a big proportion of the population exposed to health-related financial catastrophes. Additionally, the imposition of mandatory NHIF membership upon all citizens, and yet committing to only provide coverage to a few exposes the structural violence embedded in our institutions and instigated through the policy. Through corruption and a lack of genuine political goodwill, state actors enable the poor economic conditions that result in reduced capacity to pay premiums, then absolves itself from responsibility to provide accessible healthcare by making contributions mandatory despite uncertain and unfavourable conditions.

The lack of genuine goodwill is traced through to the purchasing role of the NHIF. As mentioned before, the analysis found claims of corruption, fraud and under-dealings in the claims procedure. While claims of fraud were observed from all three main stakeholders: service providers, service users and the NHIF, this discussion holds that the NHIF has so far been inefficient in satisfying its mandate to ensure equity, equality and transparency in the access of affordable healthcare. As observed in other LMICs, SHI thrives on financial solidarity which is achieved through engaging and attaining the trust of the people. It is plausible therefore, that the corruption in the system adds up to the reasons as to why voluntary enrolment failed. It is therefore socially unjust to compel the public to contribute premiums to a corrupt system. Ultimately, the analysis of the sustainability of the NHIF in playing both pooling and purchasing roles could benefit from more research.

In overall, retrospectively, NHIF has expanded coverage and access to affordable healthcare. Prospectively, evidence from the application of SHI in LMICs indicates a need to redefine the expectation of the NHIF with regards to delivering UHC. Relying mainly on the NHIF member contributions will delay attainment of UHC for as long as most of the population remains informal. Making membership mandatory may be effective in the short term and counter-effective in the long term. Furthermore, evidence points that attempts to include the informal sector into the SHI model only delayed the UHC timelines and provided no assurance of UHC that at the end. Eventually, alternative courses of co-financing had to be adopted. The following section provides alternative policy options and recommendations for financing Kenya’s healthcare system.

## **5.3 Policy options and recommendation**

The NHIF to employ highly complex and effective information technology to enhance efficiency in its operations and provide clear audit trails, and to promptly train all stakeholders on appropriate use.

Regular evaluation be done to assess the effectiveness of the newly introduced mandatory NHIF policy. This will enable early identification of any unintended consequences that may require the policy to be modified.

State to increase the fiscal space for health such as by creating earmarked taxes such as on alcohol, tobacco and other unhealthy goods, or through allocating proportions of already existing taxes like VAT. This will expand its capacity to co-finance the NHIF thus increase coverage.

Regulations such as introducing conditionalities to informal occupations needing registration such as public service drivers and motorbike riders. Such conditions which are tied to occupational registers, could include mandatory and periodic filling of NHIF returns to ensure.

Device grassroot level systems to enable assessment of informal sector income, such as through coordination with informal occupational groups like the transport and agricultural cooperative societies. The NHIF could offer subsidies to group membership to encourage the societies to recruit members. The cooperative societies may in turn make advance payments to the NHIF on behalf of their members and allow flexible re-payment terms to their members.

Increase populations engagement. SHI flourishes on financial solidarity, which takes trust from those whom premiums are taken. When the populations are more engaged, it provides an opportunity to coproduce policies that have more potential for success.

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# **6. CONCLUSION**

SHI has received international recommendation for being a powerful mechanism for promoting equitable access to healthcare. While it has been a successful health system financing model in many industrialized countries, application of SHI to LMICs has so far been a challenge. This is due to the structure of the SHI model to be occupational based. The employment structure in LMICs however, contrasts to what is ideal for SHI. LMICs have a greater proportion of informal to formal workers. Studies of SHI application in LMICs suggest that the biggest challenge faced by LMICs is the inclusion of the informal workers to the SHI schemes. Many countries have voluntary membership for the informal sector whereas civil servants and other formal employees contribute as a statutory regulation.

The voluntary aspect was found to limit enrolment, with many members of the informal sector opting not to register just because they are members. To incentivise members, approaches such as lowering premiums have been used, but this turned counter-effective, leading to reduced risk protection. The inverse alternative is to make contributions mandatory for all. The challenge then is in assessing the informal sector incomes so that the truly vulnerable are not subjected to unjust regulations. So far, LMICs have not achieved the operational capacity to do this. In a bid to deter the social injustice of compulsory payments, some LMICs adopted co-financing strategies whereby the governments, through general and earmarked taxes, co-finances their SHI to cover the informal and vulnerable population.

This study sought to assess perceptions and enablers of Kenya’s SHI, the NHIF. Through document reviews and in-depth interviews, the study adopted the Walt and Gilson policy triangle to retrospectively and prospectively analyse the NHIF policy. A historical account of the NHIF was done to review the processes through which the policy was initiated, developed, and implemented, and the major reforms that have been done to date. The content analysis reviewed three main subcomponents of the policy: premium collection, the NHIF benefit packages and the reimbursement of providers. Analysis of the political, social and economic contexts revealed how each of these structural factors influence the development and implementation of the health financing policy in the country. Eventually, analysis of key actors was done to determine their level of engagement and influence on the NHIF policy.

In general, the study found NHIF to be very instrumental in increasing coverage and making healthcare more accessible and affordable. However, the aim of achieving UHC through NHIF was found to be a distant goal due to the estimated 86% proportion of the informal sector workers. Due to the failure of the voluntary scheme to achieve this, the government recently made NHIF membership mandatory for all. However, the review found no structures put in place to assess informal incomes. Additionally, at the time of the implementation, the country had no enabling conditions for mandatory contributions. Instead, the country was in a period of economic recession resulting from Covid 19 and world wars, there was increased loss of jobs, and the informal sector incomes were more unpredictable. The prospective analysis of the NHIF policy therefore found that it may be counter-effective, with little potential to deliver UHC.

Eventually, the study drew recommendations for regular evaluation of the policy to enable early identification of unintended consequences. Increasing the fiscal space for health through earmarked and general taxes to co-finance the NHIF was also provided. Alternative options such as encouraging CBHI and informal sector cooperative societies to register their members were further recommended. Ultimately, genuine political goodwill was advocated for the success of equitable healthcare financing reforms.

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# **Appendix 1: Generic email to invite participants for interview**

Dear………………………………………………,

RE: Invitation to Participate in an Academic Fieldwork.

I am a post-graduate student at Queen Mary University of London (QMUL). As part of my degree in Msc. Global Public Health & Policy, I’d like to conduct fieldwork in Kenya to collect qualitative data on population’s perceptions around the National Hospital Insurance Fund (NHIF).

I will conduct the interviews online via zoom, and each session will take a maximum of 45 minutes. This fieldwork poses no ethical issue and has received ethics clearance from the Queen Mary Ethics of Research Committee and the The National Commission for Science Technology and Innovation (NACOSTI), Kenya.

It is hoped that this research will generate evidence to help The Government of Kenya implement its health financing reform plans. Your input will be of high value. I therefore wish to invite you to participate towards achieving the objective of this fieldwork.

Please feel free to contact me at any time for any further clarification about the fieldwork.

I look forward to working with you on this important fieldwork.

Kind regards,

Susan Nungo

*Student Investigator*

# **Appendix 2: Interview Guide**

**Content of NHIF Policy:**

1. Please share with me what role you have played (if any) in the formulation of the NHIF policy as it is today
2. Briefly summarize your understanding of the regulation and NHIF strategies in place today.
3. Does this policy apply the use of evidence in its formulation? (If yes):
4. What are some of the practical or systematic issues/discrepancies with regards to the transfer of this evidence to the Kenyan context?

**Context of NHIF Policy:**

1. What is your view on the practicality and applicability of the policy to the Kenyan context, particularly, being the country’s chosen main health financing strategy:

Please consider the following contexts:

* Social context
* Political context
* Economic context
* Employment structure of the country: Ratio of formal to unregulated informal employment:
* Country being on timeline to attaining UHC

**Process of NHIF Policy:**

1. What is your view on how the NHIF strategies and regulations are:

* Initiated:
* Developed:
* Negotiated:
* Communicated:
* Implemented:
* Evaluated:

1. Is the use of evidence applied in these processes?
2. In your view, from who’s perspective is the NHIF strategy applied? State? Societal? Please explain your view

**Enablers of NHIF Policy:**

1. What would you highlight as being the major enablers of NHIF as a health financing strategy?

**Dis-enablers of NHIF Policy:**

1. What would you say are the main issues hindering the NHIF strategy?

In overall, is the social health insurance approach (NHIF) the best health financing mechanism for the country or would you recommend a different strategy? Please justify your recommendation briefly.

# **Appendix 3: QMERC Approval**

Graphical user interface, text, application

Description automatically generated

# **Appendix 4: Kenya Research Board Approval**

A picture containing text

Description automatically generated